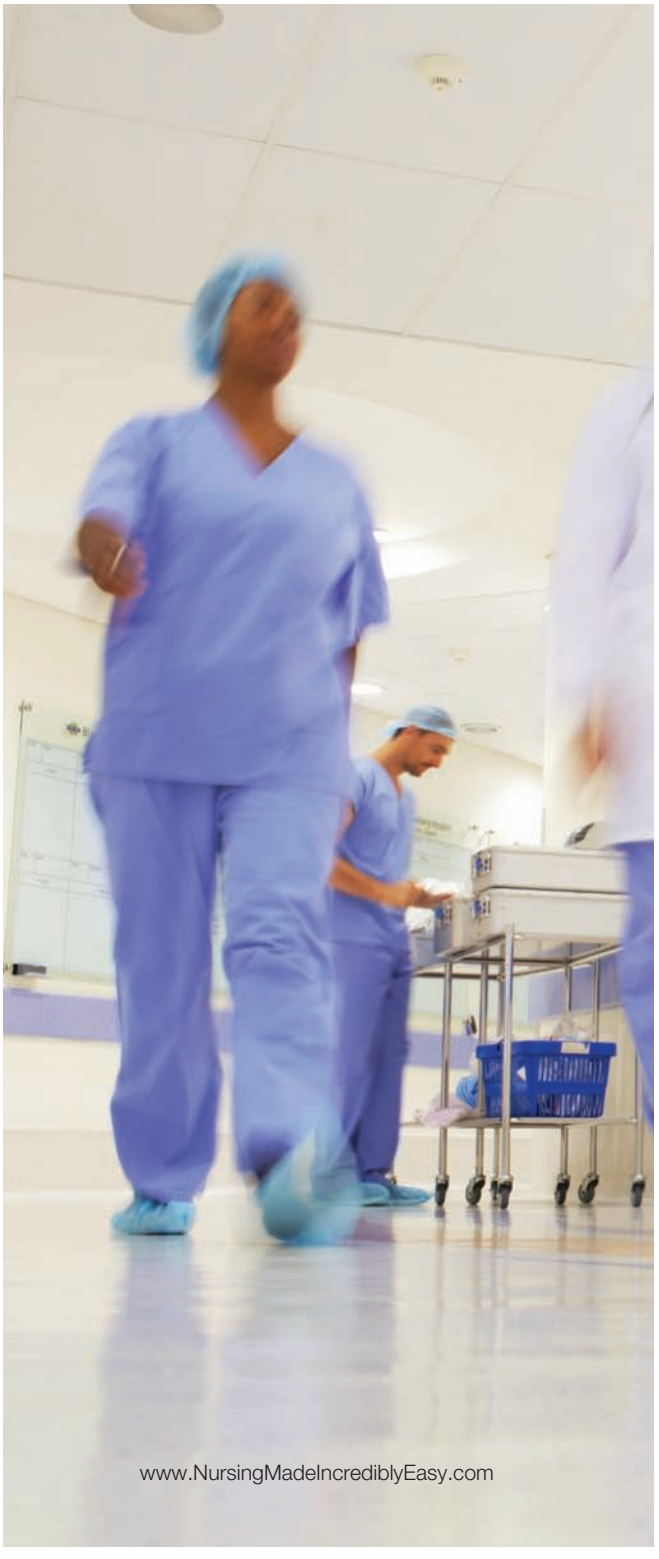
Workplace

Assessing risk, promoting safety

Patient aggression doesn't happen every day, but it's still a remarkably common occurrence for nurses in certain settings. Learn how to be aware of the danger and take action to stop it in its tracks.

By Michele Turner Sharp, PhD, MSN, PMHNP-BC



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As a nurse, you're there for people who are hurt, ill, or in crisis. Because nurses work hard to make things better for vulnerable patients, we're among the most trusted professionals. However, sometimes the work we do puts us in situations where we're at risk for being harmed. Are you prepared to assess the risk of violence and take steps to keep yourself and others safe?

This article discusses safety in the healthcare workplace, instruments commonly used to assess risk of violence, and strategies for recognizing imminent violence. It will also guide you to reduce risk and use effective strategies for deescalating behavioral crises.

Picturing workplace violence

Violence in the workplace is defined as violent acts, including physical assault or threat of assault, directed at people who are at work. This may include acts of physical aggression, such as hitting, shoving, spitting, or pulling hair; verbal threats to harm another person; and threatening gestures.

The National Institute for Occupational Safety and Health (NIOSH) conducts research and makes recommendations about improved health and safety in

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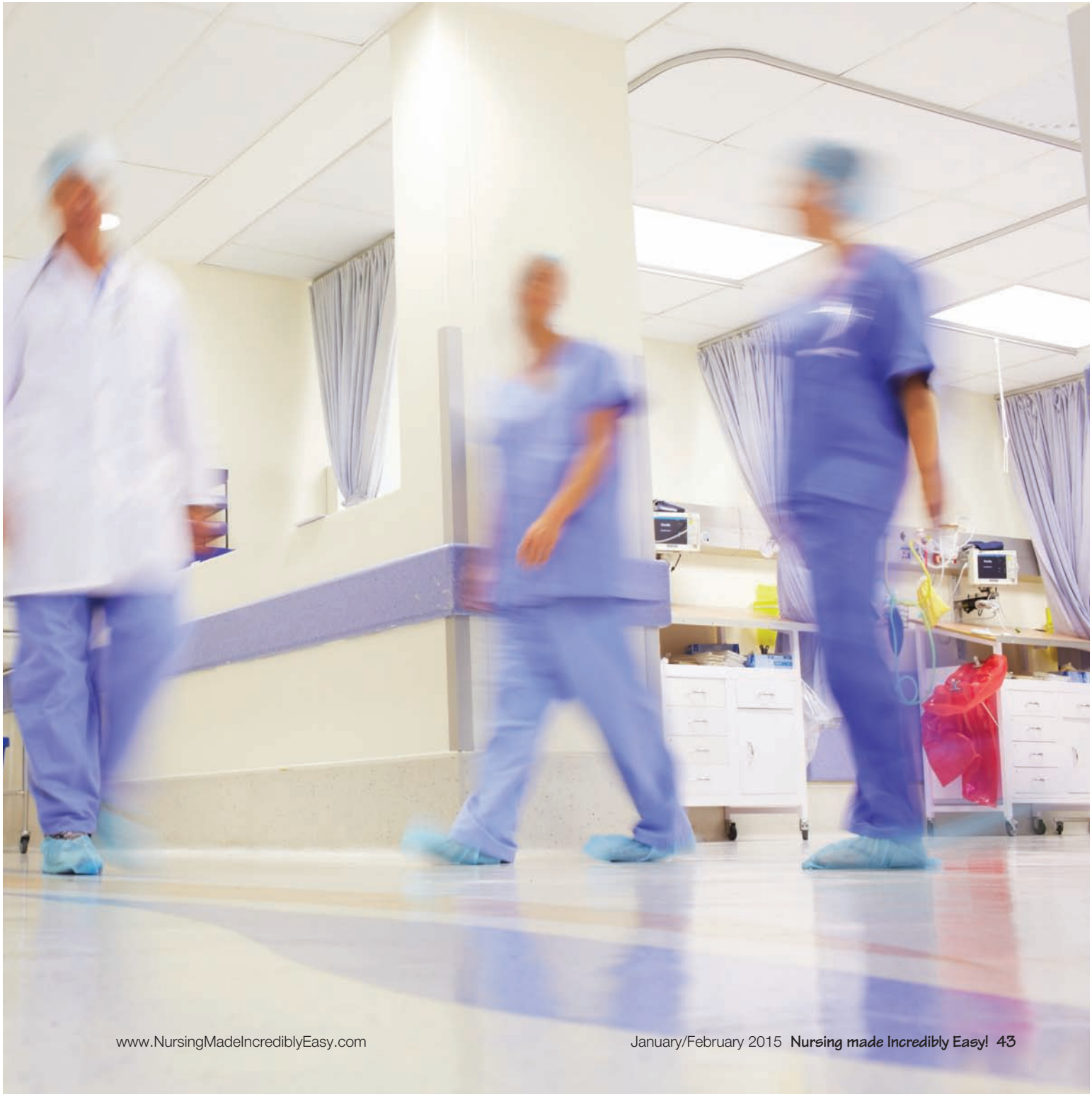
violence



did you know?

Both assault and battery are criminal acts. Here's the legal perspective:

- ***Assault*** is when you're threatened with harm or someone attempts to harm you.
- ***Battery*** is when you're the victim of offensive or harmful touching.

the workplace. Drawing on data gathered by the Bureau of Labor Statistics, NIOSH reported that 8.3 assaults per 10,000 hospital workers occurred in 1999. This is considerably higher than the rate of assault on workers in all private-sector industries (2 per 10,000 workers) during the same reporting period. Nurses and unlicensed assistive personnel face the highest risk among hospital staff due to their role in direct patient care.

Data gathered from nurses about their exposure to violence paints a startling picture. A 2011 survey of 6,504 nurses working in EDs revealed that 54.5% experienced an incident of physical violence or verbal abuse from a patient in the last 7 days; 42.5% reported experiencing verbal abuse only, 11.2% experienced both verbal and physical abuse, and 0.8% reported physical violence only.

A 2004 survey of 57,388 RNs and 21,740 LPNs in Minnesota revealed that 13.2% of the nurses had been a victim of physical violence in the past year, and 38.8% had been a victim of nonphysical violence. A meta-analysis of data from research studies on nurses' exposure to violence, comprising data from more than 150,000 nurses, revealed that 36.4% of nurses reported having been exposed to physical violence, and 66.9% were exposed to nonphysical assault.

Although most instances of violence in the healthcare workplace aren't lethal, nurses and other healthcare workers are exposed to grave risks. Between 2000 and 2011, 91 shooting incidents at hospitals took place in the United States. The Joint Commission's Sentinel Event Database reports 256 assaults, homicides, and rapes occurring in hospitals since 1995.

Nurses can encounter someone in crisis in any setting; however, EDs, psychiatric or geriatric settings (including long-term-care facilities), and ICUs have the highest risk of violence. Waiting rooms are also a relatively high-risk setting because people may be anxious about their own care or someone else's. Looking at data from the Emergency Nurses Association's 2011 Emergency Department Violence Surveillance Study, the greatest risk occurs in patient rooms, followed by corridors, hallways, stairwells, and elevators. The riskiest times? When performing triage, followed by subduing or restraining a patient and performing an invasive procedure.

The perpetrator of violence is usually the patient. The Minnesota survey identified more than 90% of perpetrators of physical aggression as patients or clients. Patients were the perpetrators in 67% of verbal aggression cases. Nurses also reported verbal aggression from patients' visitors, physicians, supervisors, and coworkers. Overall, most perpetrators of violence are male and identified as impaired due to illness or prescribed medication. In healthcare settings, the perpetrator of violence is also likely to be older than age 66.

Violence risk assessment tools

There are several instruments that can be used to estimate the risk of violence, such the Historical, Clinical, Risk Management 20 and the Short-Term Assessment of Risk and Treatability. These assessment tools are structured or semistructured; they provide guidance on how to weigh risk in light of certain variables and assist with clinical decision making.

Research on human judgment and risk assessment suggests that structured approaches yield more accurate assessments. The data that underpin such assessments help counter cognitive biases that can distort our assessments, such as giving greater risk value to events that are prominent, such as aviation

Static factors and risk of violence

cheat sheet

- Male
- Age between late teens and early 20s (in the healthcare setting, older than age 66)
- Low socioeconomic status
- Instability in housing or employment
- History of violence or property destruction
- Major mental disorder or personality disorder
- Substance use disorder

disasters, or discounting risk when it's commonplace, such as motor vehicle accidents. Getting into an accident poses a much higher risk, yet many people believe that airline travel is more dangerous than hopping in the car.

Another common cognitive bias is confirmation bias, namely, the tendency to pay attention to information that confirms a person's current belief structure and ignore or discount information that would challenge it. Confirmation bias can lead to practices such as racial profiling and inaccurately assessing actual risk.

The best assessments of violence risk incorporate both static and dynamic risk factors, while also giving weight to situational factors. Static risk factors are relatively fixed, such as a person's sex, history of first violence, or diagnosis with a medical or mental disorder. Dynamic risk factors are fluid and can change over time, for example, if a person is experiencing paranoia or is intoxicated. Situational factors include whether the person has access to weapons or has a therapeutic alliance or ready social supports.

Remember that violence risk assessments don't predict violent behavior, just as neighborhood crime rates don't predict if or when a home will be burglarized. Still, knowing the risk of a crime might influence your decision about whether to install a deadbolt or lock your windows. Likewise, even the very best violence risk assessments can't tell us where, when, or if a person will become violent. People at high risk may refrain from violence, whereas those at low risk can, under certain circumstances, act in uncharacteristically aggressive ways. Either way, knowing about risk can guide your decision making to increase your odds of staying safe.

Assessing imminent risk

Research on violence risk identifies the following static factors as contributing to increased risk:

- male
- age between late teens and early 20s (in the healthcare setting, older than age 66)
- low socioeconomic status
- instability in housing or employment
- history of violence or property destruction
- diagnosis of a major mental disorder or personality disorder (especially borderline or antisocial personality disorder)
- substance use disorder.

History of past violence correlates most strongly with current violence risk. A history of being victimized also increases the risk of violent behavior later in life, as does experiencing or witnessing violence after age 16. In healthcare settings, being older than age 66 may also be a factor, as well as medical conditions that cause confusion, irritability, agitation, decreased impulse control, or intense anxiety.

Static risk factors tell one part of the story. A good assessment of violence risk will also focus on dynamic risk factors; that is, what's happening in the moment that increases the risk of violent or aggressive behavior. Dynamic factors that contribute most significantly to violence risk include:

- intoxication
- withdrawal from substances such as alcohol, opioids, or benzodiazepines
- delirium
- psychosis, particularly the presence of command hallucinations or paranoid delusions
- physical agitation
- verbal aggression
- access to weapons
- anger
- unmet pain management needs.

Aggressive attributional style, namely a pattern of blame, hostility, and suspiciousness in stressful situations, is also associated with increased violence risk.

Dynamic factors and risk of violence

cheat sheet

- Intoxication
- Withdrawal from substances such as alcohol, opioids, or benzodiazepines
- Delirium
- Psychosis, particularly the presence of command hallucinations or paranoid delusions
- Physical agitation
- Verbal aggression
- Access to weapons
- Anger
- Unmet pain management needs

memory jogger

To remember the behavioral cues signaling imminent violence in the ED, use the mnemonic **STAMP**.

- **S**taring
- **T**one and volume of voice
- **A**nxiety
- **M**umbling
- **P**acing

Situational factors to consider include the relationship with potential victims, the availability of potential victims, the presence of social support, access to weapons, and homelessness.

Nursing researchers have identified several behavioral cues that may be associated with imminent violence risk in the ED setting. These include:

- staring and intense eye contact
- sharp, caustic, sarcastic tone of voice; demeaning inflection; or loud voice
- anxiety, including hyperventilation, rapid speech, dilated pupils, and signs of pain (such as grimacing)
- talking under one's breath, slurring, or asking the same questions repeatedly
- restless, resistive movements, such as pacing, flailing in bed, or resisting treatment.

To help remember these behavioral cues, consider the mnemonic STAMP:

- ***S***taring
- ***T***one and volume of voice
- ***A***nxiety
- ***M***umbling
- ***P***acing.

In psychiatric settings, the Dynamic Appraisal of Situational Aggression identifies a set of behaviors that's highly correlated with increased risk of violent behavior in the near-term. These include:

- irritability
- impulsivity
- unwillingness to follow directions
- sensitivity to perceived provocation
- easily angered when requests are denied
- negative attitudes
- verbal threats.

Other research identifies increased psychomotor activity, such as pacing, fidgeting, clenching fists, grinding teeth, being too restless to sit down, and sweating, especially in the context of facial expressions of hostility or paranoia, as indicating imminent risk of behavioral crisis.

Medical conditions raising the risk of violence

cheat sheet

- Dementia (Alzheimer disease, frontal lobe dementia, multi-infarct dementia)
- Multiple sclerosis
- Parkinson disease
- Huntington disease
- Traumatic brain injury
- Hypercortisolism
- Hyperthyroidism
- Hyperglycemia or hypoglycemia
- Alcohol or substance withdrawal
- Conditions resulting in low oxygen saturation

Impact of mental illness

The correlation between mental illness and violence is a topic that generates much discussion and concern, particularly in light of acts of mass violence committed by people who are mentally ill. Research on violence risk demonstrates that having a mental illness doesn't in itself increase the risk of engaging in violence. In fact, research suggests that being mentally ill makes someone more likely to be a victim of violence than to be its perpetrator.

The presence of a major mental disorder, notably schizophrenia or bipolar disorder, may raise the risk of engaging in violence as compared with the general population. Mental illness contributes to only a very small proportion of the many acts of violence that occur daily, and the prevalence of severe mental illness is itself small. It's estimated at about 0.3% to 0.7% for schizophrenia and 0.6% for bipolar disorder type 1 in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*.

Research is underway to help us understand the relationship between mental illness and violence risk. A study of 13,816 people receiving psychiatric services in Massachusetts found that 14% of them were responsible for all of the serious violence against persons committed by the individuals in the study. Moreover,

Mental illness and violence

cheat sheet

According to research psychiatrist E. Fuller Torrey, these factors are associated with an increased risk of violence among people with severe mental illness:

- history of past violence
- substance abuse
- lack of insight about mental illness together with poor adherence to treatment
- antisocial personality disorder
- paranoid symptoms
- neurologic impairment.

2% of the 13,816 were responsible for 20% of the arrests in the group.

Research psychiatrist E. Fuller Torrey identifies the following factors associated with an increased risk of violence among people with severe mental illness:

- history of past violence
- substance abuse
- lack of insight about mental illness together with poor adherence to treatment
- antisocial personality disorder
- paranoid symptoms
- neurologic impairment.

Torrey notes that among those with severe mental illness, women and men are equally likely to commit an assault. This isn't true in the general population, where men have a much higher rate of violence than women.

Increasing the odds for safety

Risk management means making decisions based on risk assessment that increase the odds for safety and decrease the chance that a dangerous incident will occur. The first consideration is deciding when, where, and how to work with a potentially violent or aggressive patient. For example, if risk is detected, steps should be taken to avoid being in an isolated or confined situation with the patient. Maintain access to an exit and make sure you can call for help. Many hospitals provide panic buttons that let you call for assistance. It may also be wise to have other staff present while working with the patient.

When working with a potentially violent patient, verbal intervention and limit setting are important tools for increasing safety. When people perceive that they can cross limits without experiencing any repercussions, it increases their willingness to cross other limits. Verbal intervention and limit setting include clearly and calmly identifying unacceptable or threatening behavior and the consequences if this behavior continues. For example, if you're working with a patient who's muttering sarcastic and angry comments, you can identify the behavior and state how it affects your ability to continue providing effective care for the patient. If a patient makes a verbal threat, you should identify the threat and let the patient know that you won't be able to provide care when the patient is threatening. A break to let the patient calm down may be in order. You might say, "Your threat makes it hard for me to help you. I'd like you to work on calming down so that we can work on helping you feel better." The key to limit setting is identifying behavior and consequences without threatening the patient or communicating that you'll withhold care.

When speaking with a potentially violent patient, try to maintain a calm appearance, speak in a neutral voice, use simple language and sentence structure, and convey both respect and empathy. Avoid arguing or taking time to defend past decisions. You may want to avoid intense eye contact because this can be perceived as confrontational and may increase the chance of escalation from threatening words or gestures to violent behavior. Keeping adequate space between yourself and the patient is also important. Space increases your ability to maintain safety or exit the area and decreases the perceived threat to the patient. Refrain from making sudden movements, touching the patient, matching threats with the patient, or raising your voice more than is needed to be heard.

When you can engage the patient in conversation, the risk of aggressive behavior may be decreased, but don't make promises

did you know?

Predatory violence occurs when the perpetrator has a planned victim and is trying to maintain power and control. ***Affective violence*** occurs when the perpetrator doesn't have a planned victim; those injured are hurt as collateral damage.

memory jogger

Remember the elements of communication in high-conflict situations with the mnemonic **LEAP**.

- **L**isten
- **E**mpathize
- **A**gree
- **P**artner

you can't keep. Giving the patient choices whenever possible tends to decrease the risk of aggression. For example, you might give the patient choices about the order in which things will be done or whether to take as-needed medications.

Finally, validating the patient's concerns or point of view is an invaluable tool in helping him or her become calm and regain behavioral control. Validation begins with maintaining your attention and focus on the patient without appearing distracted or rushed. It also includes using statements that reflect the patient's concerns, such as "I see you're angry" or "I hear that you're frustrated because no one is helping you." Validation normalizes the patient's emotional responses: "It's very frightening to be here with so many people you don't know" or "Being overwhelmed makes sense with what you're going through." Validation also increases the patient's ability to trust and form an alliance, which increases safety and the ability to problem solve.

Psychologist Xavier Amador has captured the elements of communication in high-conflict situations with the mnemonic LEAP, which stands for:

- ***L***isten
- ***E***mpathize
- ***A***gree
- ***P***artner.

When used with a patient experiencing a behavioral or emotional crisis, these tools will guide verbal intervention to increase safety. If the behavior escalates, however, you'll need to take steps quickly to minimize the risk of harm. This includes calling for assistance, leaving the area, or using physical restraint or seclusion depending on the setting. In any environment with a risk of violence, keep an eye on sharps or items that can be used as a weapon, and be sure that items on your body can't be used aggressively. This concern applies most specifically to items around your neck, such as jewelry, scarves, ties, or stethoscopes.

on the web

- **CDC:** http://www.cdc.gov/niosh/topics/violence/traumaviol_research.html
- **ECRI Institute:** https://www.ecri.org/Documents/RM/HRC_TOC/SafSec3.pdf
- **Occupational Safety and Health Administration:** https://www.osha.gov/SLTC/healthcarefacilities/violence.html
- **U.S Department of Health and Human Services:** http://www.hrsa.gov/advisorycommittees/bhpradvisory/nacnep/Reports/fifthreport.pdf

Putting a stop to violence

Because it's complex and dynamic, the healthcare workplace exposes you and your coworkers to a relatively high risk of violence. Nurses work every day with patients who are hurt, confused, angry, or highly stressed. You work with patients who are intoxicated or withdrawing from substances; some are experiencing paranoia or psychosis, others have cognitive deficits. Sometimes, patients' family members or visitors are also confused, angry, stressed, or impaired and may act aggressively with nursing staff. You need to be able to quickly assess the risk of violence and decide how to proceed with care. You also need to be able to respond to behavioral crises in ways that increase safety and decrease the risk of anyone being harmed.

This article can serve as a starting point for conversations with coworkers, supervisors, and administrators about how safety can be increased, and how best to improve your own practice to recognize and respond to the risk of violence in your work environment. ■

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