3. Managing a Potentially Violent Patient in Critical Care

This is not a guideline to deal with all delirious patients. There is always a risk that patients with delirium may lash out when frightened or confused. There are various issues within the setting of Intensive Care that may make the patient behave in this way and is common to the area. i.e. sedation, fear, toxicity, lack of sleep.

This guideline is to deal with the occasional and more extreme patient

Step 1 Patient is a high risk of violence;

Verbally or physically threatening
Nurse feeling intimidated
Previous episode of violence (present or past admission)
Information from police or family that patient may be violent
TRAK Alert

Step 2 Bed Space Nurse discusses with the nurse in charge

Step 3 Nurse in charge discusses with senior medical staff (ideally consultant but may be registrar if consultant not rapidly available) If the patient has delirium or confusion a certificate of incapacity should be filled out.

Step 4 Senior doctor and nurse in charge must assess patient as a matter of priority. This must result in a documented management plan which will include completion of checklist below to be kept within the patients notes.

Title: 3. Managing a Potentially Violent Patient in Critical Care	
Authors: Michelle Jack, Alasdair Hay	**Approved by:** QIT editorial group
Status Final:	**Written:** June 2015
Reviewed on:	**Next review : June 2018**

Managing a Potentially Violent Patient in Critical Care Checklist			
No	**Actions**	**Recommendations**	**Comments/ completed**
1.	**Assess bed space**	Remove unnecessary op potentially dangerous equipment, cables, scissors etc.	
2.	**Give Instructions to staff**	Avoid being left alone with patient particularly behind curtains always ensure safe to approach(Staff should avoid putting themselves at unnecessary risk)	
3.	**Raise Awareness**	Ensure other staff working nearby are aware of the situation and primed to provide help. (highlight patient at safety huddles)	
4.	**Consider Staffing**	Assess levels of staffing and ratios for this patient. (Be aware some patients may need more than one staff member caring for them. Do the medical staff need to stay at bedside?) Relieving staff- do you need to give the nurse a break from the situation and rotate the staffing at that space after 6 hours. Is there a conflict between staff and patient?	
5.	**Consider other people**	Family and friends. Could they help or are they exacerbating the situation? Do you need security or the police? In emergency call 999 do not go through 101.	
6.	**Treatment**	Is there a plan for drug treatment of the aggression? Ensure documented within notes. Particularly important in behaviour caused by drug withdrawal or delirium. Is the situation so extreme that for the safety of the patient and staff the patient requires deep sedation and invasive ventilation?	
Completed by:			
Senior Medical staff			
Senior Nursing staff			
Date:			
REMEMBER PLANS MUST BE CLEARLY DOCUMENTED IN THE NOTES AND COMMUNICATED TO THE NURSES AND MEDICAL TEAM CARING FOR THE PATIENT.			