CRITICAL CARE

GUIDELINES ON THE IDENTIFICATION, PREVENTION AND MANAGEMENT OF VIOLENCE AND AGGRESSION

Title: Guidelines on the Identification, Prevention and Management of Violence and Aggression	**Authors: R Pottage, A Hurry, S Gillon, C Hannah, M Connolly, F Waterson, Z Jiwaji,**
Status: Draft	**Approved by: V&A Working group, Critical Care QIT**
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BACKGROUND

The World Health Organisation defines violence and aggression (V&A) in the healthcare setting as "Incidents where staff are abused, threatened or assaulted in circumstances related to their work, including commuting to and from work, involving an explicit or implicit challenge to their safety, well-being or health".

V&A has a negative impact of the psychological and physical wellbeing of staff, reduces workplace motivation and can degrade quality of care. The DATIX reporting system demonstrates V&A to be a risk in the critical care units of NHS Lothian.

This guideline sets out strategies to identify situations where the risk of V&A is high, reduce the risk of V&A evolving, and to manage the situation when prevention fails. It does not replace the need for training or early involvement of senior staff.

Identification and Avoidance of Violence and Aggression

Identification of Patients at Risk of Violence and Aggression

Staff should **pro-actively identify** patients with whom there may be a higher risk of V&A.

Awareness of patients perceived to pose risk of V&A should be **shared** with other staff members who may have direct contact with the patient and with all senior staff on the unit on that shift. The bed meetings and huddles provide an opportunity to share this information and the identification of V&A risk should form part of the safety component of these meetings.

Active consideration should be given to interventions that may reduce the likelihood of V&A for any patient identified as being high risk.

Risk factors for V&A include.

- **Strongest association is with a history of violence and aggression**
    - Previous incidences of V&A are documented as Trak alerts
- **Particularly in males under the age of 35 year old**

- *Other factors to consider are:*
    - *Drug misuse*
    - *Alcohol misuse*
    - *Smoker*
    - *Head / Brain injury*
    - *Admission related to Acute Behavioural Disturbance*
    - *Psychiatric illness*
    - *Nursing / medical Staff intimidated.*
    - *Delirium*

Risk Assessment and Mitigation

Step 1 Patient is a high risk of violence

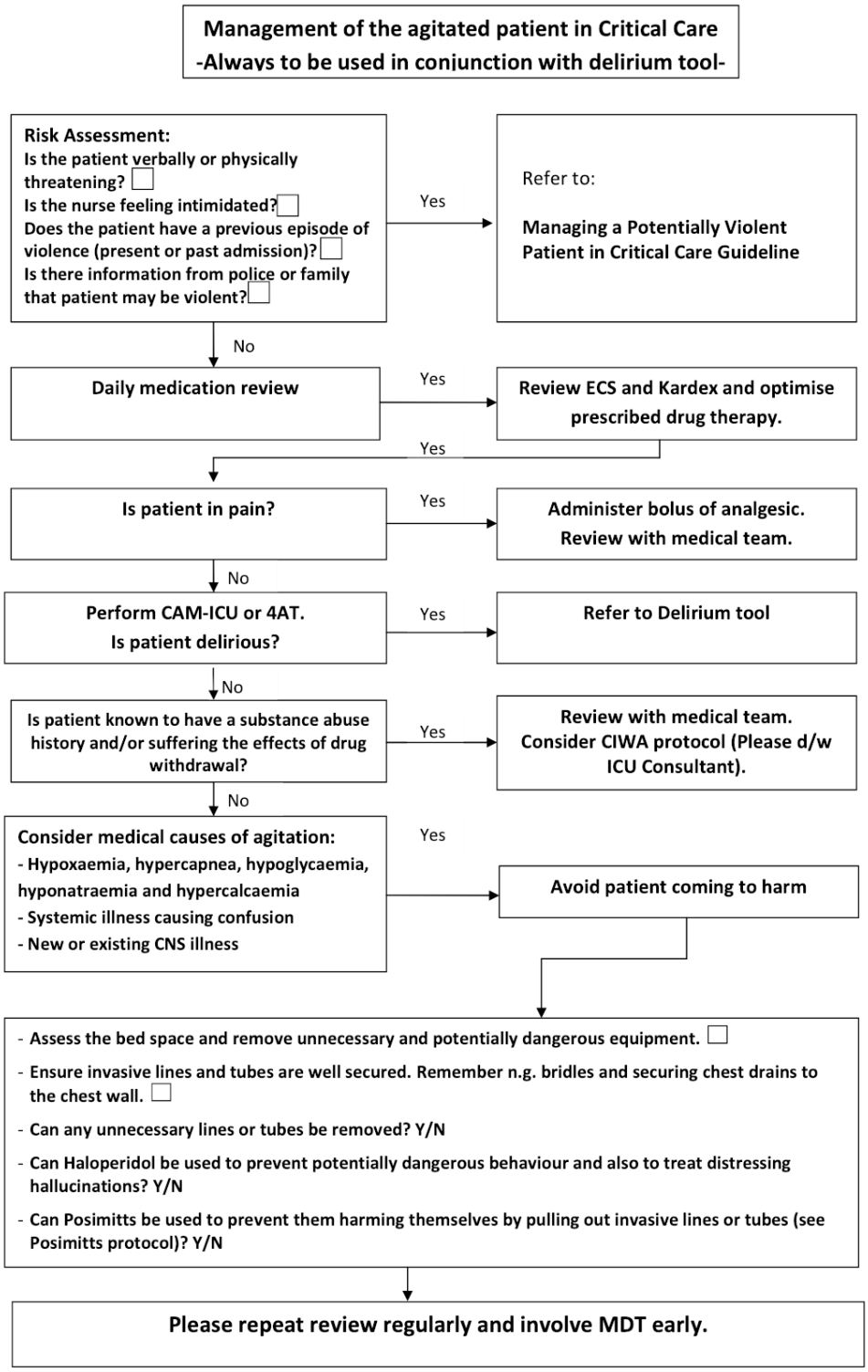
Step 2 Bed Space Nurse discusses with the nurse in charge

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 priority. This must result in a documented management plan guided by the checklist below.

Managing a potentially violent patient on critical care			
No	Actions	Recommendations	Complete?
1	Bedside Safety	Consider patient placement, would isolation be helpful. Bedspace easily visible. Remove all unnecessary or potentially dangerous equipment, cables (including monitoring if able) scissors, belongings, drip stands, O2 cylinders etc.	
2	Staff Instructions	Avoid being alone or between patient and exit, curtains left open, Staff to avoid unnecessary risk	
3	Risk Awareness	Highlight at team safety briefs/huddles and at bed meetings across floor	
4	Consider Staffing	Assess levels of staffing and ratios for patient. May need more than 1:1, 4 staff needed as minimum for restraint. Consider rotating staff after 6 hrs or less. Is there conflict between staff and patient? Consider if there is a requirement for RMN or alternative and escalate as appropriate	
5	Consider other people	Would family/friends be of benefit or are they exacerbating situation. Do you need security and or the police. Security: 23999 Police: 9999 Site and Capacity – 07872 419 400	
6	Treatment	Is there a drug treatment plan, have the rapid tranquillisation action card at bedside. Has the escalation plan and treatment been documented.	

De-escalation and Non-Pharmacological Avoidance



Pharmacological Management

For the management of delirium or agitation that does not pose an immediate threat to staff, patient or visitors please see the Delirium Management Pathway v2[DRAFT].pdf for guidance.

RAPID TRANQUILISATION FOR EXTREME AGITATION

This guideline should be used to guide the management of patients admitted to critical care displaying features of acute behavioural disturbance where safety to themselves or others has been deemed compromised. It is not intended for the management of patients with severe encephalopathy related to confirmed or suspected fulminant hepatic failure or TCA overdose – where RSI is the recommended immediate course of action.

Step 1: Patient Assessment	Episodes of suspected V&A must be promptly assessed by a senior doctor In emergencies, a response team can be summoned by calling 2222 and stating **'Group 9 to [patient location in critical care]' RIE only** The senior doctor on duty must ascertain the following: • The patient lacks capacity • The patient represents significant danger to themselves or others
Step 2: De-Escalation	Verbal de-escalation measures as per NHS Lothian V&A training Consideration of triggering situations (loud noises, lighting, pain, delirium) and their mitigation The use of exclusion/patient isolation if possible should be considered Ensuring a safe environment, removal of all unnecessary objects from bedspace Patient and staff safety is paramount – if verbal de-escalation measures are failing do not persevere **Do you need to contact on site Security and or Police (strongly encouraged)** RIE Site Call 23999 (Security) 9999 (Police) WGH Site Call 33920 (Security) 9999 (Police) SJH Site Call 52084 (Security) 9999 (Police)
Step 3: Preparation for Rapid Tranquilisation (RT)	Senior doctor (registrar/consultant) with airway experience and pod senior nurse must be present In emergencies the senior rota doctor can continue but the Consultant must be notified Oxygen and high flow reservoir mask or C-circuit immediately ready and connected to O2 supply Monitoring equipment primed for use (ECG, pulse oximeter, NIBP, ETCO2 minimum) Airway trolley prepared and readily accessible Short safety brief, plan for responsibilities, do you have adequate staff present?
Step 4: Rapid Tranquilisation Procedure	If there is reliable intravenous access the following drug choice is recommended: Ketamine 2mg/kg IV or

	Droperidol 5-10mg IV (repeated 15min up to 20mg) consider half dose in elderly. or Midazolam 5-10g IV (may also be used with droperidol) If there is no reliable intravenous access, this should not be attempted in the agitated patient and IM medicines administration should be first line: Ketamine 4mg/kg IM Or Droperidol 5-10mg IM
Step 5: Post Rapid Tranquilisation Ongoing Care	Commence monitoring immediately if not already done Establish and secure intravenous access if not already done Maintain sedation with IV bolus medication until definitive management plan agreed, documented and in place (PRN only medication NOT adequate in this situation). Intubation and ventilation may be required to safely maintain an adequate level of sedation. Is this drug or alcohol withdrawal consider longer acting benzodiazepine (Diazepam) Obtain routine bloods to include blood gas and CK and correct any electrolyte/glucose/acid-base abnormality If considered to be related to an acute psychosis or long-standing psychiatric illness can consider drug management with : Olanzapine 10mg IM If psychiatric concerns early discussion with them, may consider Aripiprazole.
Step 6: Documentation & Team After-Care	Contemporaneous note keeping is paramount Document the indication for rapid tranquilisation and any attempts at de-escalation Document your mental capacity assessment, AWI / Emergency Detention Certificate Guidance is available from the FICM LEPU Midnight Law series and on FAQs about AWI on department intranet Ensure all team members are safe and uninjured, arrange DATIX submission Debrief to be discussed and arranged for all staff involved

External Support (Security and Police)

Zero Tolerance Approach

Report all threats, acts of violence, absconding patients to BOTH Police and Security immediately.

If Police presence is required inform Site and Capacity team (Back door) - 07872 419 400 (RIE).

Police 9999

Security 23999 (RIE)

33920 (WGH)

52084 (SJH)

Legal Aspects

Legal Consideration - Common Law Doctrine of Necessity

In emergency situations where lack of capacity is suspected but not confirmed (e.g. where formal capacity and/or mental health assessment has not been performed) then common law can be used to protect the right to life.

With regard to the violent and aggressive patient, if the assessing clinician decides that restraint and/or rapid tranquilisation is appropriate then this should be clinically led. The common-law doctrine of necessity should be employed where the risks to life are significant, and the use of restraint is a proportionate response. This decision should be made by the most senior clinician available, documented clearly in the notes, and escalated to the consultant as soon as practically possible.

In-hours support from the duty StR or consultant from the department of psychological medicine can be sought by calling 21398 and out of hours, the duty psychiatrist can be contacted through switchboard.

DEBRIEF

SUPPORTING STAFF FOLLOWING AN INCIDENT OF VIOLENCE AND AGGRESSION

IMMEDIATELY AFTER INCIDENT – LED BY NIC

How are you?

Consider:

- Has the staff member been injured?
- Is the staff member able to continue?
- Should there be a change of patient allocation?

WITHIN 1 WEEK OF INCIDENT – LED BY NIC OR V&A ADVISOR

Consider appropriateness of 1:1 vs group debrief.

Let everyone have an opportunity to speak

1. Describe what happened?
2. Why did it happen?
3. What worked well?
4. What could we do differently if it happened again?
5. Are staff involved up-to-date with training?

1 MONTH FOLLOW-UP– LED BY NIC OR V&A ADVISOR

Consider Peer Support: Link Nurses:

Caroline Barker, Brenda Duncan, Mairi Gilles, Sarah Lewis (RIE)

Eileen Miller (SJH)

PeerSupport@nhslothian.scot.nhs.uk.

Consideration for further professional help and support:
NHS Lothian Staff Wellbeing

1. Here for you - NHS Lothian staff wellbeing helpline:
   0131 451 7445

2. Staff Listening Service:
   0131 242 1990 (21990)
   stafflistening@nhslothian.scot.nhs.uk

3. Staff Support and Counselling Service
   Access to the service is by self-referral. In the first instance, we advise that you call Occupational Health on 0131 536 1135 option 1, then option 6. Our phone lines are operational Monday to Friday 9:00 am to 3 pm.
   If, however, you are unable to reach us by telephone, email the service using OHSCS@nhslothian.scot.nhs.uk including a contact number and your date of birth. In the subject line please state 'Self Referral'. Your email will trigger an automatic reply which will include some questions for you to fill out. Please respond to this automatic reply as promptly as possible having answered all questions.

EDUCATION AND TRAINING

Training in the management of violence and aggression and restraint is mandatory for all Critical Care staff who work with patients. It is essential that both theory and practical elements are undertaken every 2 years.

Mandatory Online Training Courses (Learnpro) for all staff who work clinically;

- Management of Aggression Core (Clinical) - 2 yearly
- Management of Aggression Restraint (CPD section) - 2 yearly

Practical Training Sessions

- For nursing and support staff practical sessions can be arranged through Eess system and are led by the Management of Aggression Team at Comely Bank.
- Practical sessions are also regularly conducted on the unit by trained advisors who work in Critical Care. If you feel you could benefit from an update, or your training has lapsed please contact a trained advisor.

Current Trained Advisors

Robert Pottage – Senior Charge Nurse

Martin Connolly – Senior Charge Nurse

Paul Foxlow – Deputy Charge Nurse

Caiyden Neil – Clinical Support Worker

Graham Bannister – ACCP

Catriona Greig – Deputy Charge Nurse (WGH)

EMERGENCY ACTION CARD

This guideline should be used to guide the management of patients admitted to critical care displaying features of acute behavioural disturbance where safety to themselves or others has been deemed compromised. It is not intended for the management of patients with severe encephalopathy related to confirmed or suspected fulminant hepatic failure or TCA overdose – where RSI is the recommended immediate course of action.

Step 1: Patient Assessment

- Episodes of suspected V&A must be promptly assessed by a senior doctor
- In emergencies, a response team can be summoned by calling 2222, in **RIE** state

'Group 9 to [patient location in critical care]'

- The senior doctor on duty must ascertain the following:
  - The patient lacks capacity
  - The patient represents significant danger to themselves or others.

Step 2: De-Escalation

- Verbal de-escalation measures as per NHS Lothian V&A training
- Consideration of triggering situations (loud noises, lighting, pain, delirium) and their mitigation
- The use of exclusion/patient isolation if possible should be considered
- Ensuring a safe environment, removal of all unnecessary objects from bedspace
- Patient and staff safety is paramount – if verbal de-escalation measures are failing **do not persevere.**
- Do you need to contact on site Security and or Police (strongly encouraged)
  - **CALL RIE 23999 WGH 33920 SJH 52084 (Security) All sites 9999 (Police)**

Step 3: Preparation for Rapid Tranquilisation

- Senior doctor (registrar/consultant) with airway experience and senior nurse must be present.
- In emergencies the senior doctor can continue but the Consultant must be notified
- Oxygen and high flow reservoir mask or C-circuit immediately ready and connected to O2 supply.
- Monitoring equipment primed for use (ECG, pulse oximeter, NIBP, ETCO2 minimum)
- Airway trolley prepared and readily accessible.

Short safety brief, plan for responsibilities, do you have adequate staff present?

EMERGENCY ACTION CARD

Step 4: Rapid Tranquilisation Procedure, in ICU ONLY

- If there is reliable intravenous access the following drug choice is recommended:
  - **Ketamine 2mg/kg IV**

  or
  - **Droperidol 5-10mg IV (repeated up to 20mg, may be within 15mins)**
  - **Midazolam 5-10mg IV (may also be used with droperidol), up to 30mg**
  - **Consider reduced/half dose of Droperidol and Midazolam in those >65yrs**
- If there is **no** reliable IV access, this should not be attempted in the agitated patient and IM medicines administration should be first line:
  - **Ketamine 4mg/kg IM**
  - Or **Droperidol 5-10mg IM (dosing as IV)**

Step 5: Post Rapid Tranquilisation Ongoing Care

- Commence monitoring immediately if not already done.
- Establish and secure intravenous access if not already done.
- Maintain sedation with IV bolus medication until definitive management plan agreed, documented and in place (**PRN only medication NOT adequate in this situation**)
- Is this drug or alcohol withdrawal consider longer acting benzodiazepine (Diazepam)
- Obtain routine bloods to include blood gas and CK and correct any electrolyte/glucose/acid-base abnormality.
- If considered to be related to an acute psychosis or long-standing psychiatric illness can consider drug management with:
  - **Olanzapine 10mg IM**
- If psychiatric concerns early discussion advised, may include use of Zuclopenthixol(Acuphase)

Step 6: Documentation & Team After-Care

- Document the indication for rapid tranquilisation and any attempts at de-escalation
- Document your mental capacity assessment, **AWI / Emergency Detention Certificate**
- Guidance is available from the FICM LEPU Midnight Law series and on FAQs about AWI on department intranet. (www.critcare.net)
- Ensure all team members are safe and uninjured, arrange DATIX submission.
- Debrief to be discussed and arranged for all staff involved.

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