Emergency Department: Addressing Violent Behaviour and Early Discharge/Removal

Site Applicability

Providence Health Care: SPH and MSJ Emergency Departments

Practice Level

- RN, RPN, Social Workers and Physicians working in Emergency Departments

Need to Know

Violence and aggression in the workplace can negatively impact staff and other patients/family members and interfere with the ability to safely deliver care.

The complex issue of workplace violence encompasses multiple and competing interests about how we balance the Organization's obligations and commitments to protect staff from workplace violence, with our professional, ethical, and fiduciary duties to provide healthcare for all our patients, including those who are high risk for violence, or have a history of violence.
Healthcare professionals have an ethical duty to provide care for patients; however, the ethical duty is not absolute. When individual healthcare professionals face a risk of harm to their person that is certain and severe, the ethical duty no longer applies. *("Duty to Provide Care" BC College of Nurses and Midwives). Threats or acts of violence against persons on PHC property or against staff in the course of their duties is unacceptable and measures will be taken to hold people accountable for these actions up to and including contacting police to press charges (see Violence Prevention in the Workplace policy).*

The circumstances under which an ethical duty to care no longer applies rarely encompasses a patient's whole care encounter. Instead, an ethical duty to care should be considered in relation to a specific healthcare activity or aspect.

Guiding Principles

PHC strives towards being an environment where behaviours and interactions within the workplace are characterized by civility, respect, and non-discrimination.

When an individual chooses behaviour or acts in a manner that poses an intolerable risk of harm others, an intervention is necessary to prevent those harms to others from occurring (Young & Everett, 2018, DeBono & Blair, 2016).[1]

[1] See: J Young & B Everett, (2018) When patients choose to live at risk: What is an ethical approach to intervention? *BCMJ*, 60 (6), 315.; De Bono CE, Henry B. (2016). A positive risk approach when clients choose to live at risk: a palliative case discussion. *Curr Opin Support Palliat Care, 10*(3):214-20. doi: 10.1097/SPC.0000000000000223.

Where there are risks of harm to others, the risk must be reduced to a tolerable level. If a risk to others (e.g. healthcare provider, visitor, patient, family member) is assessed to be intolerable, there are five conditions healthcare professionals should meet when intervening:

1. Be effective
2. Be least intrusive and least restrictive
3. Not cause greater harm than seeking to prevent
3. Be non-discriminatory
4. Be fair

Overarching Goals

There are two key goals in preventing workplace violence in hospitals and EDs:

- Staff work in a safe environment and are able to provide the care patients want and need; and,
- Patients are able to receive the care they want and need

To achieve these two key goals, this guideline aims to:

- Promote both a safe working environment and a patient-centred, trauma-informed approach to caring for patients and community members
- Minimize the risk and decrease the frequency of workplace violence in the ED, while addressing the complex health and psychosocial needs of patients in our community
- Uphold PHC's Mission, Vision, ands Values, including compassion, social justice and patient/family-centred care
- Honor the professional and ethical duty to provide healthcare for patients who need and want healthcare services, including patients who act in a manner that poses risks of harm to others
- Recognize the subjectivity about what constitutes a workplace harm and a "violent act" (e.g. a verbal vs. physical threat) and what acts pose a certain and significant risk of harm to an individual
- Promote consistency for ED staff and other users of this guideline for circumstances where the risks of harm to others is intolerable and cannot be mitigated and where discharge/removal is being considered as the last resort
- Promote transparency and accountability with a *Commitment to Safety* statement for staff, patients, and family members (see Appendix A)

Essential points

- All reasonable efforts should be made to pro-actively and consistently assess risks of harm to others, mitigate/de-escalate potential violent situations, and support patients to act in a manner that does not pose risks to others
- Care plans to mitigate violence risk, including the need for removal/discharge, should be consistently supported by all team members involved Any decision to remove a patient from the ED is reserved as a last resort and should be made collaboratively between ED staff and physicians

Guideline

Exceptions: Medical or Mental Status

A patient who is exhibiting violent behaviour known or suspected to be as a result of a **medical condition** with concern for **diminished capacity** and/ or suspected to be having a **mental health crisis** must have a medical evaluation performed by an Emergency Physician to determine need for medical treatment.

Patients presenting with these conditions should **NOT** be considered for early discharge/removal unless medically cleared by the most responsible physician. Conditions can include (but are not limited to):

- Dementia
- Delirium
- Substance induced psychosis
- Acute psychosis
- Suicidal ideation or risk for self harm
- Altered level of consciousness due to acute traumatic brain injury, hypoxia, electrolyte imbalance, sepsis, etc.
- Potentially disruptive behaviours due to neurocognitive disorders or neurodevelopmental conditions etc.

Point of Care Risk Assessment and Identifying Violence Risk

A point of care risk and violence assessment should be performed on all patients presenting to the ED.

Identifying whether patients are in an emotional crisis and providing support early may help prevent escalation to a behavioural emergency. It is also crucial to recognize when there is an imminent threat to the safety of staff or patients in order to mitigate risk of injury/harm.

Early recognition of violence risk and potential for escalation facilitates decision making around the interventions most likely to be effective and appropriate for the situation. Early recognition of violence risk and potential for escalation also provides better support for the patient and increases the likelihood of achieving a safe resolution for all involved.

Risk Assessment Tools/Strategies include:

- ED Violence and Aggression Risk Screen on every patient
- Identification and review of any pre-existing Violence Risk Care Plans, Violence Process Alerts, Familiar Faces Care Plan
- Assessment of patient for signs of an emotional crisis or behavioural emergency (see Table 1)

Table 1: Behaviours

←		→
Emotional Crisis – no one is getting physically hurt	**Continuum – potential for escalation or de-escalation**	**Behavioural Emergency - Imminent risk of harm to person**
○ Yelling ○ Glaring ○ Perseverating ○ Crying ○ Pacing ○ Exaggerated movements ○ Withdrawing/mumbling ○ Talking to self ○ Auditory hallucinations ○ Slamming items down	○ Directed swearing ○ Directed racial slurs ○ Spitting ○ Threats of self harm ○ Self harm (can be a coping mechanism) ○ Responding to command hallucinations ○ Throwing objects generally ○ Intimidating staff or clients	○ Expressing suicidal ideation with a plan ○ Potentially fatal self harm ○ Threat of physical harm ○ Visible weapon (anything that can inflict harm) ○ Kick, punch, grab at staff or clients ○ Attempted strangulation ○ Throwing objects at staff or clients ○ Spitting on or at staff or clients ○ Fights/arguments with co-clients ○ Posturing, physical intimidation ○ Uttering threats to act or harm staff or clients ○ Damaging property

De-Escalation and Mitigation of Violence Risk

Use a trauma-informed approach with all patients (See Trauma-Informed Practice Guide). Recognizing that a patient's responses to their current hospital visit and coping strategies are influenced by past traumatic experiences is essential to developing a therapeutic relationship. Patients may be highly stressed in the health care setting. Staff should aim to provide culturally safe, trauma-aware care and incorporate pro-active and maximally effective prevention strategies such as avoiding triggers, using thoughtful non-judgmental verbal and nonverbal communication, and using simple language and providing clear instruction and information. Such strategies can help to mitigate risks and establish a therapeutic relationship with the patient.

All reasonable efforts should be made to de-escalate and mitigate potential violent situations

Recommended trauma-informed de-escalation strategies include:

- Identifying and removing stressors
- Assessing for pain and withdrawal
- Providing comfort measures (food, drink, etc.) where appropriate

- Clear, transparent and non-rushed explanation of care plans and processes
- Providing options, allow patient to participate in care
- Having boundary discussions with clear and consistent limit setting

Staff may need to remove themselves physically from a situation or interaction with a patient at the point of care to avoid further escalating a situation and/or risk for harm to themselves. That is, staff should recognize their own presence might escalate or contribute to the behaviour; staff should also recognize when they face an intolerable risk of harm to their person and know when they need to leave the space.

Physical interventions, including physical restraints and escorting a patient off property should only be considered as a last resort to maintain the physical safety of staff, the patient and other people. Consider early activation of Code White to involve increased clinical and security presence where appropriate (See: Code White Emergency Response and Least Restraint: Care of the Patient at Risk for or Requiring Restraint (Acute and Sub Acute Care))

Boundary Discussions and Limit Settings

Boundary Discussions are led by the most responsible nurse, clinical leader (Clinical Nurse Leader or Psychiatric Assessment Nurse) and/or physician to ensure that the client understands what is happening, the expectations for client behaviour (boundaries) and potential interventions.

Limits: Provide clear limits that outline:

- Behaviour of concern
- Behavioural expectations
- Circumstances and interventions if the patient cannot abide by the limits

Where possible, provide patients with choices that allow them to participate in care. Demonstrate support for the patient by attempting to address any immediate concerns that they may have

Example 1: "*I hear that you are frustrated and I am sorry that the wait is so long. Please do not use that language with us as we are trying to help you. We can provide you with some food while you wait, or you can step outside for a moment until you are feeling calmer".*

Example 2: "*it makes us feel very unsafe when you are yelling and directing that language towards us. We want to support you but if you continue to speak to us that way we may have to ask you to leave*

Example 3: "*I can see that you are upset. It is not appropriate to use that (derogatory) language towards staff or other people here. If this behaviour continues we may need to call security for assistance and you may be asked to leave*"

Collaborative Decision Making and Care Planning

If a risk or occurrence of violence has been identified, early communication should be established between nursing, social work (where applicable) and the most responsible physician. Collaborative care planning is performed expediently at the point of care and should consider:

- Description of behaviour of concern and violence risk/history
- Strategies to de-escalate and mitigate the situation
- Medical exceptions to discharge/removal
- Determination of whether the patient requires immediate physician assessment and potential for early discharge or removal
- Establishing an agreed upon care plan between Emergency Physician (EP) and nursing outlining the parameters for discharge

Example 1 Patient with a chief complaint of foot pain is using directed racial slurs e towards nursing and radiology staff while awaiting an x-ray in the Treatment area.
Interventions: EP informed. Attempt de-escalation by assessing for pain/discomfort and offering medication and/or food. Provide boundary discussion, provide simple and clear statement about specific Behaviours/actions that are problematic, explain that continued Behaviour will result in discharge from ED with an outpatient plan or referral Suggested script:

> *"I can't help you when you're calling me names. It makes me feel unsafe and I'm worried I'll make mistakes. For me to be able to give you the care you need, I need you to stop calling me names. It looks like you're frustrated – what would help with that before I come back? If you figure out what would help, we will try to support that. Shall I come back in half an hour and we'll try again?"*

Plan: After discussion with EP, provide a warning to the patient, informing them that the language they are using is abusive and not acceptable. If threatening language persists despite attempts at de-escalation and warnings, then nursing may follow EP orders and initiate discharge if patient has been deemed medically stable

Example 2 Patient presents to ED after falling, sustaining a head injury and has suspected alcohol intoxication. Patient is directing swear words at staff members walking by. He occasionally attempts to stand and posture aggressively, but has unsteady gait
Interventions: Attempt de-escalation by assessing for any modifiable causes. Attempt to re-direct patient to bed and re-orient to place and situation. EP to assess patient and may note concerns about capacity due to a possible head injury. Medical information indicates this patient should not be discharged/removed and may require interventions under emergency consent provisions, involvement of a substitute decision maker, etc.

Plan: Monitor for intolerable risks of harm to self or others and intervene to mitigate those harms to a tolerable level. Intrusive and restrictive measures and physical interventions such as restraints may be applied by security where imminent risk of self-harm and/or harm to others is identified. Patient must be re-assessed q15 minutes x 1 hour (refer to B-00-13-10059 - Least Restraint protocol).

When a care plan been established, it should be clearly explained to the patient and family (if present) by the care team, but at a minimum by the most responsible nurse or most responsible physician. The Care Plan should also be documented in the patient record. (See Documentation section below.)

Reassessment

Any change in the patient medical status, or a changeover of staff/MRP warrants reassessment of the patient and their care plan. If a patient requires emergent treatment in the ED or admission to hospital while continuing to display violent behaviour, interventions including restraint application, seclusion, security presence and/or medication administration should be considered to prevent intolerable risks of harm to the patient, staff and other people in the ED during the course of their time in the hospital. (See Least Restraint: Care of the Patient at Risk for or Requiring Restraint (Acute and Sub Acute Care)

Patient Removal and Discharge

As a last resort in order to maintain a safe environment, PHC ED staff and physicians may collaborate on and initiate the process of removal of persons who exhibit ongoing unacceptable behaviour and are who are medically suitable for discharge.

Exceptions: guidelines for removing patients are not applied when

- Patients are medically unstable
- Patient is known to have an underlying medical condition directly resulting in diminished capacity and aggressive/violent behaviour that requires treatment
- Patients are certified (or require certification) under the Mental Health Act

1. Behaviours indicating an emotional crisis or potentially escalating situation (see Table 1) will be pro-actively addressed using a trauma-informed approach that may involve specific statements about impact, behavioural boundaries, and expectations, and impacts. For example, acts of verbal abuse directed at any staff member may include:
    - Uttering directed threats
    - Directed derogatory or discriminatory language

A boundary discussion are led by the most responsible nurse, clinical leader (Clinical Nurse Leader or Psychiatric Assessment Nurse) and/or physician to ensure that the client understands what is happening, the expectations for client behaviour (boundaries) and potential interventions.

Second violation will result in a final warning. Persistent or escalating violent or threatening behaviour will warrant discharge (see exceptions).

If abusive/threatening language or behaviour continues despite initial warning and attempts to de-escalate, or behaviour escalates to imminent threat of violence, immediate involvement of security discharge/removal of the patient from the facility may be warranted.

If patient is able to demonstrate safer, more cooperative behaviour after initial warning/discussion continue to reassess violence risk and adjust care plan as needed. Update Violence Process Alert in Cerner as appropriate

2. Behaviours listed within a Behavioural emergency (see Table 1) that pose an intolerable risk of harm to others may warrant immediate direction for the person to be removed off hospital property and/or escort/physical removal by security or police
    - Acts of physical aggression or assault directed at any staff member including, but not limited to:
        - Direct verbal or physical threat of violence (gesturing or attempting to assault someone)
        - Punching, kicking, pushing or grabbing
        - Biting
        - Intentionally spitting on or at someone
        - Physical intimidation
        - Brandishing, threatening and or assaulting with a weapon

Subsequent Visits or Return to ED

If a decision is made to discharge/remove a person from the ED, they will be asked to leave the hospital. The person should be provided with instruction that they may return at a later time to receive care if they are able to demonstrate respectful, nonviolent behaviour and adhere to the commitment to safety (Appendix A)

If a patient returns to the hospital

- Reassess violence risk on arrival
- Violence Process Alert and previous care plan should be communicated to care providers and most responsible EP
- A proactive strategy should be established to ensure patient receives appropriate care while adhering to behaviour expectations. Parameters for discharge may need to be adjusted.
- Consider partnered care and early involvement of security personnel.

Post Incident Follow Up and Debrief

Provincial Workplace Health Call Centre: **Call 1-866-922-9464**

All incidents of workplace violence must be reported to a supervisor and the Provincial Workplace Call Centre. This included both incidents that result in a near miss and those that result in harm. Formal documentation allows for gathering of important statistical data around violence in the workplace and ensures that the employer can follow up with staff members to provide support

Refer to Occupational Health and Safety: My Safety at Work, Incident Reporting

Debrief

All staff involved in managing a violent incident, Code White and/or the removal of a patient from the hospital are encouraged to participate in debriefing in order to both diffuse a potentially emotionally distressing situation and to allow for clinical analysis. Discussing team dynamics, things that went well and identifying things that need improvement provides an opportunity to learn from each other and consider changes that can be made to improve care experiences for both staff and the patients. Debriefing also allows team members to provide each other with emotional/psychological support. All team members should be encourages to utilize and engage in employee wellness resources and self-care as needed (Bajaj et al. 2018)

When patients and family experience or witness incidences of violence in the healthcare setting it is important to provide follow-up care and identify ways to support them through potentially traumatizing experiences. Research has shown that debriefing with clients, families, SDMs and staff has been helpful in preventing future episodes involving restraint use. Debriefing can also assist in the exploration of any harmful incidents to determine what actions could have improved or prevented the outcome (Least Restraint: Care of the Patient at Risk for or Requiring Restraint (Acute and Sub Acute Care). Involve the unit Manager, CNL, Social Worker, Indigenous Wellness Team, and/or chaplaincy to support patients and families where appropriate.

Documentation

Documentation should occur as close as possible to the time of care or event.

Document concurrently to the event or immediately following using:

- ED Violence and Aggression Screening: use this tool to document risk or observed violent behaviour for **all** patients in the ED. Implement a Violence Risk Alert for patients where a risk for physical violence has been identified
- Collaborative Care Planning: Document point of care planning for violence and aggression and discharge/removal document in Cerner as “free text note” titled “ED Violence Care Plan”. The note should include:
    - Description of behaviours observed, including triggers/precipitating factors
    - Interventions, including attempts at de-escalation, assessment of patient needs, medications, security presence, restraints etc.
    - Plan for care, limits set for the patient, warnings given, staff involved and any conditions for patient discharge/removal
    - Any additional information including any outcomes following interventions (patient cooperative, discharged, etc.)

Example

TITLE: ***ED Violent Incident:***

Description of Behaviour: *Patient swearing at staff member on encounter in triage hallway.*

Intervention: *Patient given warning that language is abusive and needs to stop. Writer assessed patient for discomfort. Patient provided blanket and water. Patient notified by writer of below plan.*

***Plan**: EP notified, and agreed that if patient continues to swear at staff, patient may be discharged with security if needed.*

Afterwards patient continued to swear, despite attempting to de-escalate, threw water on the floor at writer. Code White called and patient discharged by security. EP informed.

NOTE: documenting a collaborative care plan does not replace the need to document ED Violence and Aggression screening.

Patient and Family Education

Patients and families should be supported during their care in the Emergency Department by being provided education around the measures in place to maintain a safe environment. Patients and family members should be encouraged to voice any concerns to staff regarding the safety of themselves, their family, or other patients. Additionally, patients can be encouraged to review the Commitment to Safety and or discuss ongoing concerns with the Manager or CNL.

Supporting signage

As part of the strategy to prevent and mitigate violent behaviours, signage will be displayed in ED care spaces and public waiting areas

St Paul's Emergency Department

COMMITMENT TO SAFETY

The St Paul's Emergency Department is committed to being an environment that is safe, healthy, secure, and respectful for *all* staff, patients, visitors, and volunteers.

We are committed to preventing all forms of violence. We ask that everyone abide by this commitment.

We will take appropriate and necessary measures to maintain a safe, healthy, secure, and respectful environment. This may include involving Security Staff, requiring you to leave hospital grounds, and/or taking legal action, including and up to contacting police and pursuing charges.

Thank you for helping us making this a safe space for all.

Related Documents

1. B-00-11-10190 - Code White Emergency Response
2. B-00-07-10081 - Crosstown Clinic: Communicating Violence Risk
3. B-00-11-10125 - Philosophy of Care for Patients and Residents Who Use Substances
4. B-00-11-10196 - Violence Prevention in the Workplace
5. B-00-11-10178 - Violence Risk Alert
6. B-00-13-10059 - Least Restraint: Care of the Patient at Risk for or Requiring Restraint (Acute and Sub Acute Care)

References

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4. Gibson, J., Young, J., De Bono, C. (2018) Removing Patients From The Ed Without Their Permission As A Measure To Protect Staff From Workplace Violence: Ethical Review And Analysis. PHC Ethical Review and Analysis.
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Definitions

Behavioural Emergency: An acute situation when an individual is displaying behaviour that indicates there is imminent danger of serious harm or death to self or others

Code White: an urgent call for help to increase staffing resources (clinical and security) in response to an incident involving escalating or aggressive/violent behaviour

Emotional Crisis: A process during which a person's coping skills and abilities are significantly challenged by a combination of internal and external events

Physical Intervention: A skilled manual, or hands on, method of physical restraint implemented by trained individuals, with the intention of controlling the aggressive patient, to restore safety in the clinical environment (Stubbs et al. 2009)

Workplace Violence: Any act in which a person is abused, threatened, intimidated or assaulted in his or her employment and includes any threatening statement or behaviour which gives a worker reasonable cause to believe he or she is at risk of injury. The term violence includes violence that is intentional and violence that is unintentional due to illness, injury or cognitive impairment (sometime referred to as aggression.)

Appendix A: Commitment to Safety

The following *Commitment to Safety* acknowledges that any prejudiced, discriminatory, or threatening behaviour and language is unacceptable in the SPH Emergency Department. All staff, patients, and visitors are expected to abide by this commitment.

SPH/MSJ Emergency Department

COMMITMENT TO SAFETY

The SPH / MSJ Emergency Department is committed to being an environment that is safe, healthy, secure, and respectful for *all* staff, patients, visitors, and volunteers. We are committed to the prevention and elimination of all forms of violence including (but not limited to): threatening language or behaviour, harassment, physical assault and discrimination.

Furthermore, we do not condone or tolerate any form of discrimination on the basis of:

- Race
- Sex
- Sexual orientation
- Gender Identity or Expression
- Religion
- Socioeconomic Status
- Illness or Disability
- Genetic Characteristics
- Age
- Nationality
- Family or Marital status

We ask that all persons including staff, patients, visitors, and volunteers abide by the above commitment. We reserve the right to take appropriate and necessary measures to maintain a safe, healthy, secure, and respectful environment. This may include involving Security staff, requiring you to leave hospital grounds and/or taking legal action including and up to contacting Police and pressing charges.

Thank you for your cooperation and contribution to making this a safe space for all.

Persons/ Groups Consulted

Corporate Director, Quality, Patient Safety, Risk Management, Patient Relations & Infection Prevention and Control

Clinical Ethicist PHC

PHC Violence Prevention Coordinator

PHC Occupational Health and Safety

ED Staff

- MSJ Clinical Nurse Leaders
- MSJ Clinical Site Coordinator
- SPH Clinical Nurse Leaders
- Registered Nurses
- Physician Group
- Social Workers
- Unit Coordinators
- Registration Clerks
- Medical Lab Assistants
- Cardiac Technologists
- Integrated Protection Services

Developed By:

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