AGITATED/VIOLENT PATIENT

PURPOSE: To outline the management of the agitated/violent patient.

SUPPORTIVE DATA:

The agitated/violent patient displays a continuum of related behaviors ranging from restlessness to assaultiveness, arising from perceived physical or emotional threat. It commonly accompanies states of intoxication, mental disorders, or brain injury. Possible sources of agitation are fear, powerlessness/helplessness, frustration, sensory alteration, prolonged immobility, neurologic impairment, pain, hypoxia and hypoglycemia.

The violent patient displays verbal or physical threats and/or physical aggression directed at self, others, or against property. Verbal aggression refers to expression of verbal hostility such as statements that seek to inflict psychological harm on another or threats of physical attack. Physical aggression refers to violent action intended to inflict pain, bodily harm or death upon another or self, or destruction of property. Possible physical manifestations are posturing, pacing, challenging, belligerent, unpredictable or bizarre behavior, accelerated speech/volume, hallucinations, threatening gestures and verbal threats.

The Golden Hand signage and wristband are used in select areas as a communication tools to ensure all workforce members observe safety precautions when caring for an agitated/violent patient. The Golden Hand sign is placed outside the patient's room or in a visible location once they have been identified as being at an increased risk for agitated/violent behavior.

ASSESSMENT:

1. Assess for the following upon admission:
   - Prior history of violence or threats of violence
   - Psychiatric hold status
   - History of/current substance use, i.e. alcohol, drugs
   - Past and present mechanisms for coping with negative emotions
2. Assess the following upon admission, a minimum of every shift and with change in condition:
   - Source of agitation, if known
   - Presence of verbal and non-verbal manifestations of aggressive/violent behavior
   - Need for medication or decreased environmental stimuli
   - Need for Golden Hand precautions as applicable
3. Assess for the following a minimum of every 2 hours when patient is agitated, every 4 hours following de-escalation of agitated behavior:
   - Potential for violence toward self/others
     - Accelerated volume/rate of speech
     - Body language or behavioral changes (threatening gestures, restlessness, pacing)

SAFETY:

4. Place the Golden Hand awareness sign outside the patient's room or in a visible location and apply appropriate wristband as applicable.
5. Remove potentially harmful objects that could be used by the patient to harm self/others.
6. Maintain close surveillance by assigning staff to be within sight and sound of patient at all times.
7. Maintain a leg length from patient at all times.
8. Ensure 2 staff are present when administering physical care
9. Do not turn your back on the patient at any time
10. Request additional assistance if patient is violent toward self/others from:
    - Behavioral Response Team (Code Gold)
    - Unit/ward staff
    - Law enforcement

BEHAVIOR MANAGEMENT:

11. Relieve source of agitation, if possible.
12. Utilize therapeutic communication techniques to facilitate problem solving:
    - Active listening
    - Reflection of feelings

- Simple instructions/explanations
- Reassurance that he/she is in a safe environment

13. Set behavioral limits firmly with a matter-of-fact manner.
14. Give positive feedback whenever patient gains control of his/her behavior
15. Administer sedation as ordered
16. Apply restraints or seclusion, as ordered and indicated

COLLABORATION:

17. Collaborate with other disciplines (e.g., provider, social worker, pharmacist, law enforcement/security) to clarify causes and develop strategies for behavior management.
18. Conduct huddles at shift change to share behavior management updates

PATIENT/FAMILY EDUCATION

19. Discuss the causes and signs of impending acting out behavior.
20. Teach safety measures and action to follow when patient poses a danger to others.
21. Teach alternative ways to deal with stress or aggression prior to loss of control, such as:
    - Pain management
    - Relaxation techniques
    - Expression of anxiety and fear
    - Asking for PRN medication
    - Structured activities, quiet time, constructive physical activities

REPORTABLE CONDITIONS:

22. Notify provider immediately when patient poses a danger to self/others.

ADDITIONAL STANDARDS:

23. Implement the following as indicated:
    - Confused Patient
    - Immobility
    - Pain
    - Restraints/Seclusion
    - Suicidal Patient

DOCUMENTATION:

24. Document in accordance with documentation standards.

Initial date approved:	Reviewed and approved by:	Revision Date:
08/93	Professional Practice Committee Nurse Executive Committee Attending Staff Association Executive Committee	11/94, 10/00, 03/05, 02/08, 03/15 4/19