Safety in the aggressive patient

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The aggressive and/or violent patient presents unique challenges. Like suicidal patients, aggressive individuals are difficult to treat and they tend to elicit strong negative reactions in hospital personnel ranging from anger to fear. Workplace violence is unfortunately commonplace within the health care setting, and is particularly prominent in the inpatient psychiatry ward and emergency department settings. These statistics on workplace violence in health care settings are likely underestimates as events are often underreported to health care supervisors and administrators . Workplace violence occurs so frequently that there is a perception among health care workers that violence is “the norm” and an expected part of their job.

There are many causes of violent behavior; some are social, medical, or biological in nature. The most common characteristic of the violent patient is alteration in mental status.

Delirium from any underlying condition is a cause of aggression. Violence risk is also associated with cognitive dysfunction such as traumatic brain injury and dementia. The comprehensive evaluation of the violent patient include a complete physical examination with the intent of revealing the underlying cause of the violent behavior as well as ensuring the discovery of secondary patient injuries.It is important to attempt to differentiate toxicity or withdrawal, cognitive impairment, delirium, and mental illness as treatment differs depending on etiology.

There are 3 main approaches to controlling aggressive behavior in order of escalation: First and foremost, there is verbal de-escalation. When this has failed, medical anxiolysis and sedation will be the next approach. Finally, under the most extreme circumstances where there is significant risk for harming self or others, the use of physical restraints are indicated.

Haloperidol is safely used in the treatment of agitation and aggression in patients with psychoses and delirium. It can be administered orally, intravenously, or intramuscularly. Various benzodiazepines are quite effective for sedation; their use has been examined in patients with psychoses, stimulant toxicity, sedative–hypnotic and alcohol withdrawal, and postoperative agitation. Diazepam is given intravenously (IV) 5 to 10 mg, with rapid repeat dosing titrated to desired effect. Because diazepam is poorly absorbed from intramuscular (IM) sites, its preferred route of administration is either IV or oral.

Isolation and mechanical restraints are also used in the treatment of violent behavior.it is not indicated for patients with unstable medical conditions, delirium, dementia, self-injurious behavior such as cutting or head banging, or those who are experiencing extrapyramidal reactions as a consequence of antipsychotics such as an acute dystonic reaction. Mechanical restraint is used to prevent patient and staff injury, although it does occasionally lead to patient and staff injury itself. Attention is necessary to assess excessive restraint and excessive straining which may lead to sudden cardiac death.

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