Ministry of Health Malaysia
Block E1, Parcel E,
Federal Government Administrative Centre,
62590 Putrajaya, Malaysia
Tel: 603-88831047 Fax: 603-88831427
www.moh.gov.my

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MOH/P/PAK/323.16(GU)

GUIDELINES ON
MANAGEMENT OF AGGRESSIVE PATIENTS
IN MINISTRY OF HEALTH FACILITIES

Medical Development Division
Ministry of Health Malaysia

MOH/P/PAK/323.16(GU)

GUIDELINES ON MANAGEMENT OF AGGRESSIVE PATIENTS IN MINISTRY OF HEALTH FACILITIES

MEDICAL DEVELOPMENT DIVISION
MINISTRY OF HEALTH

This policy was developed by the Medical Services Unit, Medical Services Development Section of the Medical Development Division, Ministry of Health Malaysia and the Drafting Committee for the Guidelines On Management of Aggressive Patients In Ministry Of Health Facilities

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ABBREVIATION

AMT	**Aggression Management Team**
BZN	**Benzodiazepine**
BVC	**Broset Violence Checklist**
CABG	**Coronary Artery Bypass Graft**
CAM	**Confusion Assessment Method**
CK	**Creatinine Kinase**
CMHT	**Community Mental Health Team**
CMHC	**Community Mental Health Centre**
CNS	**Central Nervous System**
ECG	**Electrocardiograph**
EPS	**Extra Pyramidal Side effects**
ETOH	**Alcohol**
FGA	**First-Generation Antipsychotic**
FMS	**Family Medicine Specialist**
HDU	**High Dependency Unit**
HOD	**Head of Department**
ICU	**Intensive Care Unit**
IM	**Intra-Muscular**
IV	**Intra-Venous**
MHA	**Mental Health Act**
MHR	**Mental Health Regulation**
MMSE	**Mini-Mental State Examination**
MO	**Medical Officer**
MOH	**Ministry of Health**
PHC	**Primary Health Care**
PNH	**Psychiatric Nursing Home**
RCA	**Root-Cause Analysis**
SIS	**Six-Item Screener**
SGA	**Second-Generation Antipsychotic**
WHO QR	**World Health Organization Quality Rights**

MESSAGE BY THE DIRECTOR-GENERAL OF HEALTH

Healthcare providers may frequently encounter aggression in the patients they are treating. Such incidents not only result in property damage and physical injuries, but psychological impact and trauma to healthcare providers.

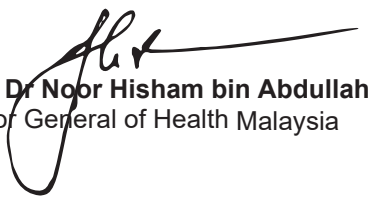
To mislabel aggressive persons as emotionally disturbed is also stigmatizing. Constrained by limitations and inadequate information, they are repeatedly handled harshly which may transgress their human rights.

This guideline helps healthcare providers manage aggressive patients in different settings. The principles of human rights, medical ethics and professionalism are upheld whilst at the same time a clear and easy stepwise approach is provided in managing aggression.

The inclusion of the early warning signs of aggression are in tandem with the approach in healthcare services towards pro-activeness and preventive measures rather than responding reactively. This is vital in reducing untoward sequelae and healthcare costs.

The emphasis on de-escalation as the core primary method of management is a challenge to healthcare providers. I am confident that with appropriate training, the ability to focus on the matters at hand and with the containment of the emotions of the healthcare providers involved during the critical period of aggression, successful resolution can be achieved in all instances.

I applaud the tireless and well-thought efforts of all those involved in the development and publication of this much awaited guideline encompassing the various sectors of healthcare services. It is my expectation that this guideline will serve as the applicable reference for health care professionals to equip them with skills, psychological and physical, in caring for patients who show aggression.



Datuk Dr Noor Hisham bin Abdullah
Director General of Health Malaysia

MESSAGE FROM THE HEAD, PSYCHIATRY SERVICES, MINISTRY OF HEALTH

This guideline of management of aggressive patients in the Ministry of Health facilities is a valuable resource and provides guidance on managing patients who show violent behavior. It is hoped that healthcare providers use the guidelines to ensure that their management of patients who are aggressive is effective and safe.

The guideline covers adults, children and elderly patients who have aggressive behavior. It is intended to guide and empower healthcare providers in prevention and management of aggression in various settings i.e. from the Emergency Department to Primary Health Care setting. Special population groups are also addressed. This would provide a safer environment for staff and patients whilst providing high quality healthcare to them.

I would like to thank the Aggression Guideline Development Team for their hard work and time in creating this Guideline.

I encourage all healthcare providers to read and incorporate this guideline in their clinical practice. Continuous education and training would empower us in creating a safer and better health services in Malaysia.

Thank you.

Dr Toh Chin Lee
Senior Consultant Child and Adolescent Psychiatrist and
Head, Psychiatry Services, Ministry of Health

1. INTRODUCTION

Aggression and violence refer to a range of behaviours or actions that can result in harm, hurt or injury to another person, regardless of whether :

- the aggression or violence is physically or verbally expressed
- physical harm is sustained or
- the intention is clear.

The impact of aggression and violence is significant and diverse, adversely affecting the health and safety of the patient, other patients, carers, staff and others in the vicinity.

According to unpublished data by Jamaludin *et al*[1] 2012, aggression and violence in the psychiatric ward Kuala Lumpur Hospital not only resulted in physical injuries but also adversely affected the psychological well being of staff causing them to have anxiety, low motivation, insomnia, depressive feelings, disturbed appetite and irritability.

A study conducted by Ruth *et al*[2] on workplace violence experienced by nurses in Universiti Kebangsaan Malaysian Medical Centre revealed that workplace violence among the nursing staff was 3.7% with an average of 1.2% being abused per month and one nurse being abused every other day. Staff nurses were the most common victims and the perpetrators were mainly patients (40.6%) or patients' relatives (37.5%).

Between 2013 and 2014 there were 68,683 assaults reported against NHS staff in England: 69% in mental health or learning disability settings, 27% against ambulance staff, 25% involving primary care staff and 26% involving acute hospital staff[3].

Aggression of patients is an important patient safety issue particularly when dealing with psychiatric patients or patients with certain medical conditions (e.g. delirium, intoxication). Healthcare organisations need to take preventive

actions and effective remedial measures to protect patients from being harmed during the process of care.

In order to establish patient safety, we need to ensure that the healthcare system is safe. Focusing on clinical management alone is not sufficient. Hence, a holistic approach which looks at all the following factors is required:

- Management and organizational factors
- Work and care environment
- Task and technology factors
- Team factors
- Individual staff factors
- Patient factors

We also need to improve from being

(i) "reactive" (i.e. taking action when an incident has already happened) to

(ii) "proactive" (taking preventive action) and to be

(iii) "predictive" (i.e. assessing the possibilities and taking early preventive action).

2. OBJECTIVE

The objectives of this guideline are:

i. To enhance the understanding, knowledge and skill in the evaluation, risk assessment, diagnosis, treatment and management of patients presenting with aggressive behaviour.

ii. To prepare healthcare providers for a concerted and coordinated multidisciplinary collaborative response to emergency aggressive situations.

iii. To uphold dignity and respect for the aggressive patient in accordance to human rights and medical safety regulations.

iv. To facilitate safety and prevent danger to the aggressive patient and healthcare providers.

v. To reduce physical and psychological consequences of aggression among healthcare providers.

vi. To be used as an informative source of reference in the holistic management of aggression.

3. SCOPE

This guideline is to be used in the management of aggressive patients in MOH facilities including primary care, hospitals and community settings. It also covers the management of aggression in special patient populations such as children and adolescents, the elderly and pregnant women. However, the management of aggression in non-patient population is beyond the scope of this guideline.

4. DEFINITION

The term **aggressive patient** refers to a patient who shows aggressive behaviour in any Ministry of Health (MOH) facility. **Healthcare provider** refers to clinical staff of MOH.

5. ACT & REGULATION

This guideline has been developed in line with the requirements of the following:

5.1 THE MENTAL HEALTH ACT (MHA) 2001 AND MENTAL HEALTH REGULATIONS (MHR) 2010

- The MHA 2001[4] serves to consolidate the laws relating to mental disorder in Malaysia and provides for the admission, detention, lodging, care, treatment, rehabilitation, control and protection of the mentally ill.

- Part V of the MHR 2010[4] deals specifically with the use of restraints and/or seclusion in psychiatric hospitals. (Refer Appendix 1)

- This act is mandatory in all psychiatric settings.

5.2 OCCUPATIONAL SAFETY AND HEALTH ACT 1994[5]

- This Act states clearly the need of the organization to secure the safety, health and welfare of persons at work against risks to safety or health arising out of the activities of persons at work. This includes protection from violence or aggression at the healthcare facilities which might arise from other staff, patients, visitors, contractors or public.

- This Act also describes the need to promote persons at a place of work other than persons at work against risks to safety or health arising out of the activities of persons at work. In the context of healthcare facilities, apart from ensuring the safety of staff, it is the responsibility of the healthcare organization to ensure the safety of patients, visitors and contractors at the facility.

5.3 WORLD HEALTH ORGANIZATION (WHO) QUALITY RIGHTS (QR)

The WHO QR addresses care quality and human rights in mental health and social care facilities of inpatient and outpatient services by assessment of services provided based on an agreed set of criteria, standards and themes. The themes include the right to an adequate standard of living, the right to enjoyment of the highest attainable standard of physical and mental health, the right to exercise legal capacity and the right to personal liberty and the security of the person, freedom from torture or cruel, inhuman or degrading treatment or punishment and from exploitation, violence and abuse and the right to live independently and be included in the community[6].

5.4 Legislation in Non-Psychiatric Setting

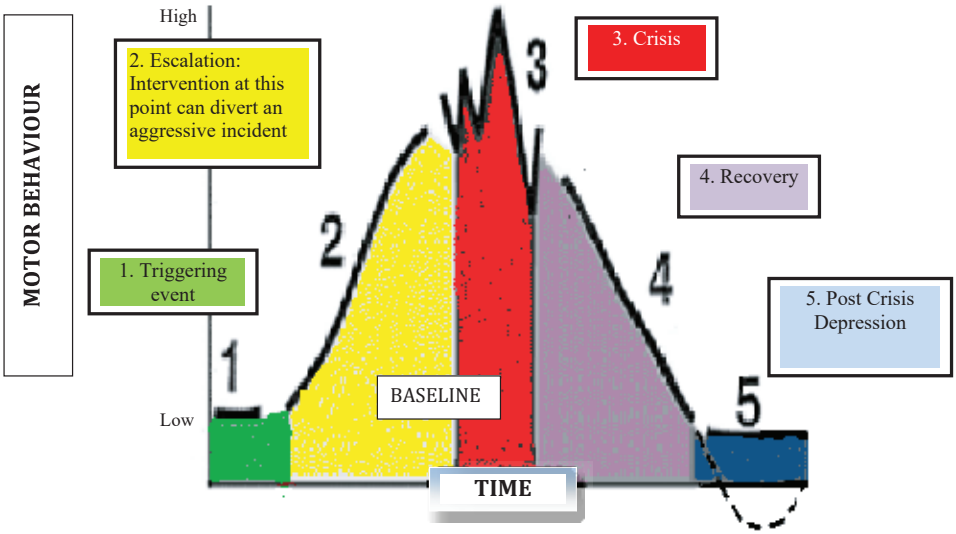
As of date, there is no legislation on the use of restraints in non-psychiatric settings. However, the use of restraints in non-psychiatric settings should only be considered in emergency situations or if deemed clinically appropriate and justified. The principles of human right to health[7] must be adhered to at all times. The assessment and implementation should be done by competent healthcare providers. Documentation of observation and procedures should be meticulous. Restraint should not be used as a form of punishment[8].

6. STAGES OF AGGRESSION

Aggression progresses through several stages. Recognition of the stages would enable the healthcare provider to apply the most effective intervention.

6.1. **The Assault Cycle** (Figure 1)

The display of physical, psychological and motor behavioural response to perceived threat is called the assault cycle. It consists of 5 phases.[9]



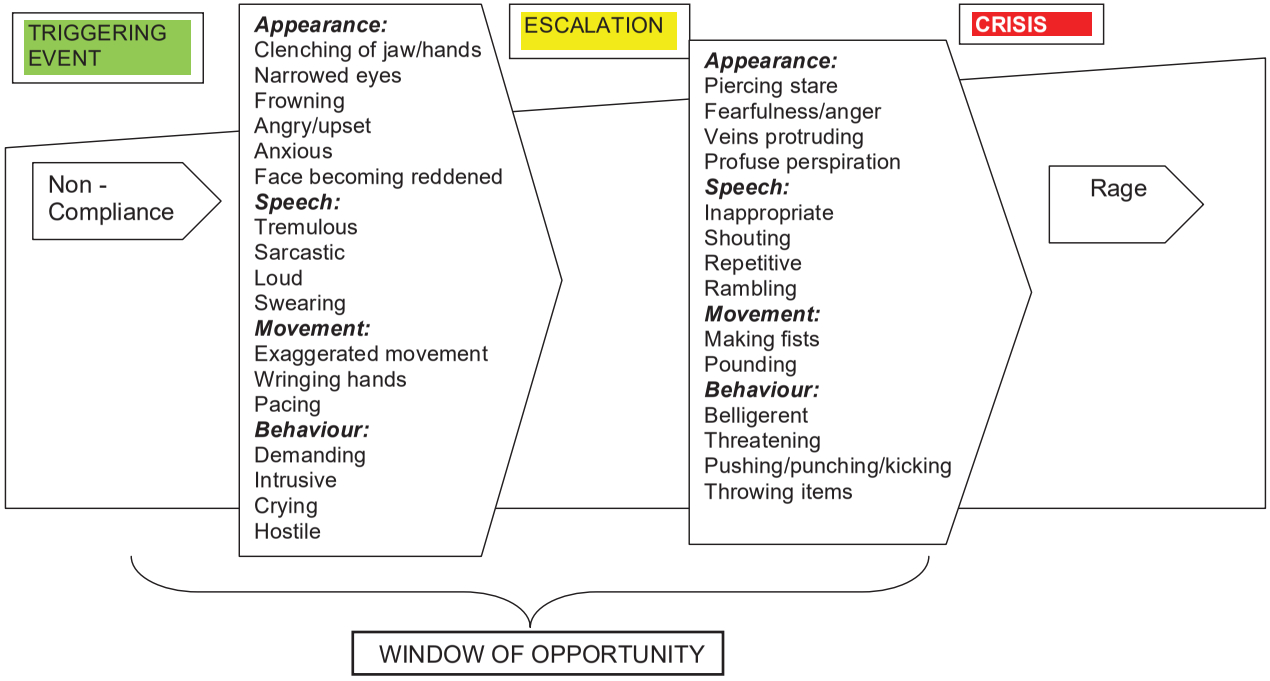
Adapted from H.V. Hall 1998

The table below clarifies the assault cycle.

Phase	
1. Triggering Event	Triggers are perceived by the patient as a serious threat. Triggers may occur well before you meet the patient. e.g. pain, substance abuse, language difficulties, unrealistic expectations, miscommunication, home situation, violation of personal space.
2. Escalation	'Fight or Flight' response of the patient. The things you can see, hear & feel that provide clues that the patient is getting more aggressive are: □ Rude or vulgar words □ Aggressive body language □ Physical & psychological changes. Intervention at this point can divert an aggressive incident.
3. Crisis	When the aggressive patient becomes physically violent. At this stage the breakaway technique may be of help.
4. Recovery	The body relaxes & the mind decreases its vigilance. Whilst the confrontation is seen to be over, the crisis can re-ignite at any time. Monitoring of the patient at this point is critical to avoid the re-ignition of the crisis.
5. Post Crisis Depression	The physical and emotional aspects of the crisis often reappear in this phase as fatigue, depression or feelings of guilt. The potential for severe guilt or remorse may result in a suicide attempt.

6.2. Signs of Escalation of Motor Behaviour in the Assault Cycle (Figure 2)

Aggression is rarely spontaneous. The ability to identify the signs of escalation and intervene appropriately early during this window of opportunity is crucial to prevent the violent incident.[10]



7. RISK FACTORS

There are various factors that predict aggressive behavior. These factors should be considered as part of risk assessment to ensure that specific interventions for the management of aggressive behaviour have been included in the clinical treatment plan.[11,12,13,14.]

The following risk factors should be considered on an individual basis:

- Demographic / personal history
- Clinical variables
- Situational variables

TABLE 1: RISK FACTORS FOR AGGRESSION

Demographic/ personal history	Clinical variable	Situational variable

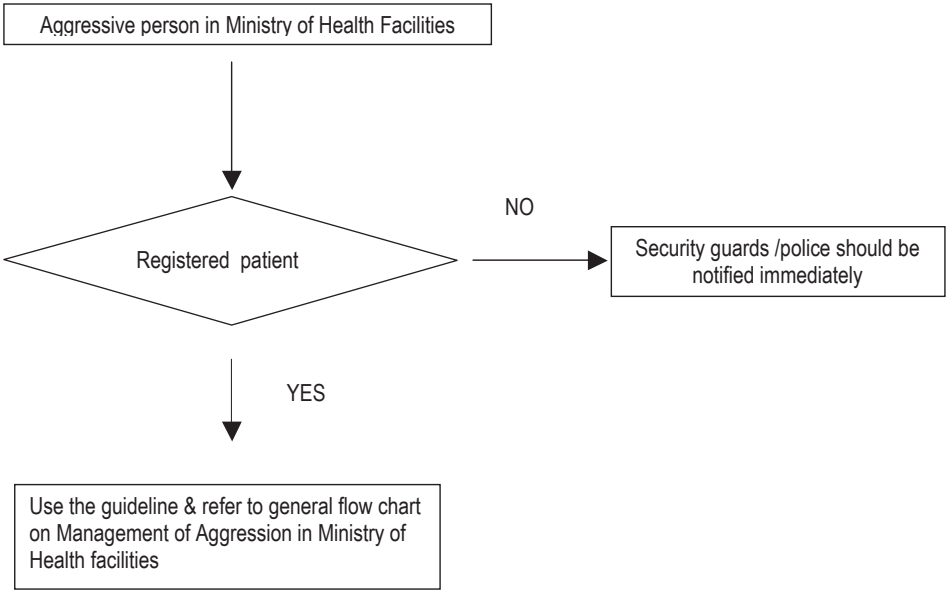
History of disturbed/violent behaviour.
 	
History of misuse of substances or alcohol.
 	
Carers reporting patient's previous anger or violent feelings.
 	
Previous expression of intent to harm others.
 	
Previous use of weapons.
 	
Previous dangerous impulsive acts.
 	
Denial of previous established dangerous acts.
 	
Severity of previous acts.
Known personal trigger factors.
	Medical factors:
	- Head injury with vascular lesions, especially subdural haematoma
	- Delirium tremens
	- Delirium
	- Intoxication/withdrawal from illicit drugs or alcohol
	- Overdose of prescribed drugs e.g. anticholinergics
	- Meningitis/ Encephalitis
	- Hypoglycaemia
	- Diminished cerebral oxygenation of any aetiology, e.g. vascular, metabolic or endocrine
	- Hypertensive encephalopathy
	- Wernicke's encephalopathy
	- Temporal Lobe epilepsy
	- Neoplastic conditions
	- Dementia
		Environmental factors:
		- Unpredictable routine and structure
		- An institutional rather than a homely environment
		- Temperature (usually too hot or too cold)
		- Overcrowding and a lack of privacy
		- High noise levels
		- Poor air quality
		- Inadequate nutrition
		- Too little/ too much stimulation
		- Group/ peer pressure
		- Lack of personal space, or place to store possessions securely.
		- Possession or access to weapon
		- Long waiting time in outpatient setting
		
		Healthcare provider factor:
		- Paramedic training (young untrained more likely to be victim)
		- Poor leadership
		- Inadequate staff resources
		- Attitude – e.g.:
		  - Healthcare providers are perceived as inaccessible
		  - Healthcare providers are perceived as too controlling
		  - Healthcare provider responses are

Verbal threat of violence. Evidence of recent severe stress, particularly a loss event or the threat of loss.	□ Drug effects (disinhibition, akathisia). □ Poorly controlled pain Active symptoms of schizophrenia or mania, in particular: □ Hallucinations or delusions focused on a particular person □ Command hallucinations □ Preoccupation with violent fantasy □ Delusions of control (especially with violent theme) □ Agitation, excitement, overt hostility or suspiciousness **Patient factors:** Inability to communicate effectively Fear, anger, anxiety Not in control of one's own situation Not feeling respected Feeling one's personal space or property is being invaded Feeling overwhelmed by information or a lack of information Past experience of being 'rewarded' for violent behaviour Antisocial or impulsive personality traits or disorder/ Poor impulse control	inconsistent □ Healthcare providers refuse fair requests from patients □ Healthcare providers are perceived as forcing patients to take medications □ Healthcare providers are perceived to be ignoring or indifferent to the patient □ Healthcare providers possess ineffective listening skills (or Staff appear as if they are not listening) □ Healthcare providers exercise rigid limit setting coupled with a lack of opportunity for negotiation Limited social support. Easy availability of potential weapons. Relationship to potential victim (for example, difficulties in relationship are known). Access to potential victim.

8. MANAGEMENT

The general principles of managing aggressive person(s) varies on the status of the person (patient or non-patient) and localities where the incident occurs as illustrated below. Security guards or police should be called when needed (e.g. a person is in possession of a weapon). (Figure 3)

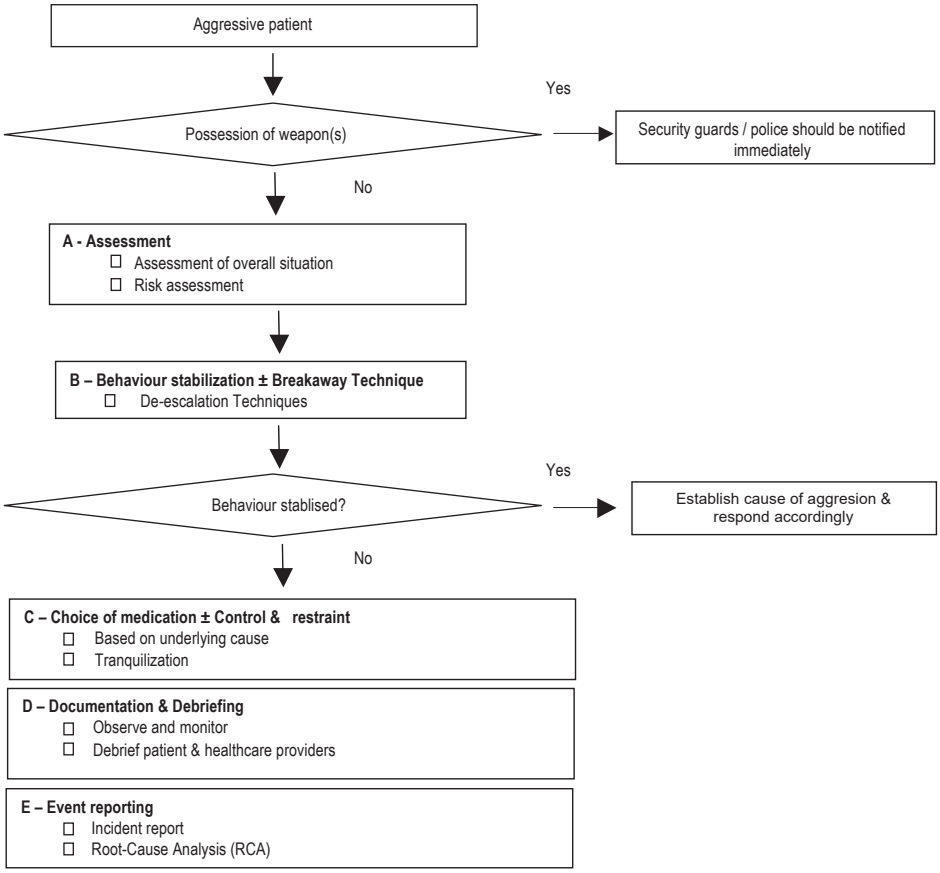
Figure 3 : General principle of managing aggressive person(s)



The management of patients with aggression follows the ABCDE algorithm below :

A – Assessment
B – Behaviour stabilization ± Breakaway Technique
C – Choice of medication ± Control & restraint
D – Documentation & Debriefing
E – Event reporting

Figure 4 : Flow Chart on General Management of the Aggressive Patient (ABCDE)



If the patient is suspected to have an underlying medical cause, he / she should be treated accordingly and referred to the respective discipline for further management.

8.1. ASSESSMENT[10,15]

This section is on the assessment of risk for aggression. The information on risk factors above (Table 1) will assist in the assessment.

Prediction is the cornerstone of the assessment, mitigation and management of violence and aggression. It is challenging due to the diversity of clinical presentations and a single broad predictive (assessment) tool is unlikely to be valid and reliable in all circumstances.

A combination of clinical judgement and a more objective risk assessment tool e.g. Risk Assessment of Violence – HKL[16] (Appendix 2) or Brøset Violence Checklist (BVC)[17] (Appendix 3) are recommended for better monitoring and to reduce the incidence of violence and aggression and to help develop a risk management plan in inpatient psychiatric settings. The tools are to be completed by the paramedics. They must be trained to use the tools and regular audit must be done to ensure the checklist correlates with the clinical findings.

8.2 INTERVENTION

All healthcare providers must have the required skills to prevent and manage aggressive behaviours among patients.

8.2.1.Brief assesment of the overall situation[10,15]

8.2.1.1. The approach to patients presenting with aggression and violence in varied settings should observe these fundamental goals of medical/psychiatric care:

- Manage all medical causes accordingly
- Rapid and effective stabilisation of the acute crisis
- Minimise coercion/confrontation
- Provide treatment in the least restrictive setting
- Build therapeutic alliance
- Formulate effective disposition, discharge and aftercare plan

8.2.1.2. Patients with acute medical illnesses or with co-existing psychiatric and medical conditions may present with psychiatric symptoms. Failure to identify these conditons may result in high rates of morbidity and mortality.

8.2.1.3 Thorough medical history, physical examination, mental status examination, monitoring of vital signs and appropriate investigations are vital in delineating these medical conditions.

8.2.1.4 Collateral history from next of kin, relatives, friends, other healthcare providers and previous medical records are useful in emergency situations where the information from patient is usually inadequate.

8.2.1.5 Identify risks for medical causes of aggressive behaviour as listed below:

- First onset of psychiatric symptoms
- The elderly
- History of medical illness
- Active user of illicit substances
- Medically ill patients who are non-adherent to or irregular with healthcare treatment and management
- Abnormalities in vital signs, physical examination and mental status examination.

8.2.1.6 Mental status examination must be done to exclude delirium which is an acute reversible medical condition resulting in an altered level of consciousness, with fluctuating mental status.

8.2.1.7 A Validated assessment questionnaire developed for emergency settings can assist clinicians to identify patients in delirious states. Meta-analysis done by Wong *et al* [18] found that Confusion Assessment Method (CAM) (Appendix 4) was the most useful in diagnosing delirium; and Mini-Mental State Examination (MMSE) was the least useful. Another tool that can be used is the Six-item Screener (SIS) (Appendix 5).

8.2.1.8 After stabilisation, the aggressive patient should be managed and referred to the respective discipline/ centre, accordingly.

8.2.2 De-escalation techniques

De-escalation is a technique used to reduce aggression. It is defined as 'gradual resolution of a potentially violent and / or aggressive situation through the use of verbal and physical expressions of empathy, alliance and non-confrontational limit setting that are based on respect'. De-escalation techniques should be used prior to other interventions such as pharmacological or physical interventions as they are less intrusive for the patient, allow healthcare providers to build rapport with the patient and prevent the patient from entering into a cycle of restraint and seclusion. There are a number of different theoretical approaches with no gold standard.[19]

When performing verbal de-escalation, healthcare providers must remain calm by monitoring their own emotional and physiological response[20]. Strategies to help them control their anxiety include focusing their attention on assessment of the aggressive patient rather than their own feelings, or acknowledging their feelings of fear rather than denying them.[21] The 10 domains of de-escalation are to be applied when managing the aggressive patient.[20,22]

Table 2 : TEN DOMAINS OF DE-ESCALATION

a) Respect personal space

b) Do not be provocative

c) Establish verbal contact

d) Be concise

e) Identify wants and feelings

f) Listen closely to what the aggressive patient is saying

g) Agree or agree to disagree

h) Lay down the law and set clear limits

i) Offer choices and optimism

j) Debrief the aggressive patient and the healthcare provider(s)

a) Respect personal space

- It is important to respect the aggressive patient's and your own personal space.
- Do not invade their personal space and maintain the two times arm's length distance rule.
- Do not make the aggressive patient feel trapped and maintain an "escape route" for both, the aggressive patient and the healthcare provider.
- If an aggressive patient tells you to "get out of the way", do so immediately.

b) Do not be provocative

- Healthcare providers should be aware of their own body language (eye contact, facial cues, touch, body posture and movements and proximity to the aggressive patient) and demonstrate that they are actively listening, will not harm the aggressive person and want everyone to be safe.
- The healthcare provider should adopt a calm demeanour
- A degree of eye contact is important for assessment and maintain rapport. Excessive and direct eye contact such as staring should be avoided.
- Avoid clenched fists or concealed hands which may imply concealed weapon.
- Avoid closed body language such as having the arms crossed or turning away from the patient which indicate a lack of interest.
- Healthcare providers should stand at an angle to the aggressive patient and avoid directly facing the patient as not to appear confrontational.
- The knees should be slightly bent.
- The healthcare providers' body language should be congruent with what they are saying.
- They should closely monitor and ensure that the aggressive patient is not further provoked by bystanders.

c) Establish verbal contact

- Only one person should verbally interact with the aggressive patient and the first health care provider who makes contact with

the aggressive patient should be in charge of de-escalating the aggressive patient.

- If the health care provider is not trained or unable to perform this duty, another trained team member should be identified immediately to take up this role.
- Other team members should ensure there are no bystanders around and alert staff regarding the incident for assistance.
- Healthcare providers should introduce themselves to the aggressive patient and provide him/ her with orientation and reassurance.
- Use tactful language and be polite.
- Inform the aggressive patient your name, title and role.
- Reassure the aggressive patient that the healthcare providers are there to keep him/her safe, to ensure no harm comes to him/her and to help him/her regain control.
- The aggressive patient should be oriented as to where he/ she is and what to expect.
- Ask for the aggressive patient's name, if not known. It may be helpful to ask the patient how he/she would like to be addressed as this will indicate that he/she is important and has some control over the situation.

d) Be concise

- Use short phrases/ sentences and simple vocabulary.
- Complex verbalizations can increase confusion and this may lead to escalation.

- Before providing the aggressive patient with more information, allow him/her not only time to process what has been said but also to respond.
- Repetition is essential when setting limits, offering choices or proposing alternatives to the aggressive patient.

e) Identify wants and feelings

- Healthcare providers can use free information to help them identify the aggressive patient's wants and needs.
- ''Free information'' comes from his/her body language, trivial things said, or even the past experience one has with the aggressive patient.
- This will allow the healthcare provider to respond to the patient empathetically.

f) Listen closely to what the aggressive patient is saying

- Healthcare providers must be able to demonstrate through conversation, verbal acknowledgement and body language that they are really listening and paying attention to what the aggressive patient is saying and feeling.
- Clarify by repeating to the aggressive patient what he/ she has just said. This will tell the aggressive patient that the healthcare provider is listening attentively and understands what he/ she is saying.
- Try to understand the aggressive patient by using Miller's law. Miller's law states that, ''To understand what another person is saying, you must assume that it is true and try to imagine what it could be true of.''

- By using this law, the aggressive patient will feel that the healthcare provider is interested in what he/ she is saying and this will result in the aggressive patient engaging in conversation with the healthcare provider regarding what is driving his/ her agitation and subsequently help to foster de-escalation.

g) Agree or agree to disagree

- The act of agreeing with the aggressive patient is an important part of de-escalation as it can help the healthcare provider to develop a relationship with the aggressive patient.

- There are 3 techniques to agree with the aggressive patient:

    - ***The first is agreeing with the truth:*** If the aggressive patient becomes agitated after being spoken rudely to by a healthcare provider, one might say, ‘‘I understand you are upset with the way the doctor spoke to you, do you mind if I try instead?**”**

    - ***The second is agreeing in principle:*** If the aggressive patient becomes agitated as he felt betrayed that his parents had lied to him about bringing him into the ward, the healthcare provider can agree with the aggressive patient **in principle** but by saying, “I believe everyone deserves to know the truth.”

    - ***The third is to agree with the odds:*** If the aggressive patient becomes agitated as he does not like the food in the ward and states that anyone else there would also not like it, an appropriate response would then be, ‘‘Probably, there are other patients who do not like the food here also.’’

- It may be easy to find a method of agreeing by using these techniques and healthcare providers should agree with the aggressive patient as much as possible.
- If there is no method to agree honestly with the aggressive patient, then **agree to disagree**.

h) Lay down the law and set clear limits

- It is important to establish basic working conditions.
- The aggressive patient should be clearly informed about acceptable and unacceptable behaviours, and that there are consequences to his/ her behaviour.
- Healthcare providers should tell the aggressive patient that injury to him/ her or others is not acceptable and that arrest by police and prosecution may happen if he/ she assaults anyone.
- Ensure that this is not perceived as a threat when communicated to the aggressive patient.
- Limit setting must be reasonable and demonstrate the healthcare provider's clear intent and earnest desire to be of help.
- The healthcare provider and the aggressive patient should treat each other with respect.
- Once a relationship with the aggressive patient has been established and his/ her capability to stay in control determined, the aggressive patient should be taught on how to stay in control.

i) Offer choices and optimism

- Offering choices to an aggressive patient can be a powerful tool and it is a source of empowerment for the aggressive patient.
- Be assertive and quickly offer the aggressive patient alternatives to violence.
- Offer the aggressive patient things that he/ she may perceive as acts of kindness and is willing to accept such as food or drinks, blankets or access to a phone.
- Do not promise the aggressive patient something that cannot be provided.
- The role of medication is to calm the aggressive patient and not to sedate him/ her.
- Offer the aggressive patient choices when medications are indicated as this can help to give the aggressive patient some sense of control.
- Timing is also important. Do not rush or delay giving the aggressive patient medications when needed.
- Using increasing strategies of persuasion is an effective technique.
- Tell the aggressive patient that things will improve and that he/ she will be safe and regain control.
- Agree to help the aggressive patient work on the problem he/ she is facing and give a realistic period of time for solving a problem.

j) Debrief the aggressive patient and the healthcare provider

- Some patients will end up in seclusion or restraints when de-escalation fails. It is important to restore therapeutic relationship with the patient after this involuntary intervention.

Table 3 : MISTAKES TO AVOID

- Arguing with the aggressive patient
- Empathic failure
- Trying to dissuade a fixed belief or delusion
- Being punitive or threatening
- Provoking the aggressive patient
- Humiliating the aggressive patient
- Traumatizing or re-traumatizing the aggressive patient
- Inadvertently accepting the aggressive patient's projection

Adapted from Behavioural Emergencies for the Emergency Physician, Cambridge

8.2.2.1 Environmental change

It is very important for the patient to be placed near the nursing counter where the patient can be observed closely.

Table 4: MEASURES TO REDUCE RISK OF VIOLENCE IN WARD SETTINGS

- A pleasant environment in which there is no overcrowding
- A predictable ward routine
- A good range of meaningful activities
- Well-defined staffing roles
- Good staffing levels
- Privacy and dignity without compromising ward observation

Adapted from Royal College of Psychiatrists, 1998 and National Institute for Clinical Excellence, 2004.

8.2.3 Breakaway Techniques

At times, when dealing with an aggressive patient, the healthcare provider might be attacked. Breakaway techniques can be applied in such situations. However, only those who have been trained in these techniques should use them (Appendix 9).

8.2.4 Pharmacological Intervention[14,23,24]

The aggressive patient may need pharmacological intervention. Correct working diagnosis has to be made to avoid overuse or misuse of medication. The main purpose of medication is to calm / tranquilize the patient. However, the patient's underlying general medical and physical condition should be taken into consideration and caution should be exercised. Side effects of the medications should be monitored and antidotes should be readily available.

8.2.4.1. Tranquilization

- Medication should be used to calm the patient so that he / she can be more accurately assessed by healthcare providers, not to induce sleep.

- If possible, the patient should be involved in the process of selecting the medication (e.g. oral or parenteral), as a way to encourage the patient's sense of control and autonomy, which can help reduce the level of agitation.

- The three groups of medication commonly used are: first generation antipsychotics (FGA), second-generation antipsychotics (SGA) and Benzodiazepines. Side effects should be anticipated and antidotes should be readily available. (Appendix 6)

- The choice of medication depends on the underlying cause of the aggression (Figure 5)

  - Aggression associated with psychosis in patient with known psychiatric disorder: Antipsychotics are preferred over benzodiazepines as they address the underlying psychosis.

  - Aggression associated with delirium: If benzodiazepine or alcohol withdrawal is suspected, a long acting benzodiazepine (diazepam 10mg oral/ intravenous) is the drug of choice. Otherwise, benzodiazepines should be avoided as they can worsen the delirium and cloud the patient's mental state. Lower doses of antipsychotics should be used as a delirious patient is more prone to extrapyramidal side effects.

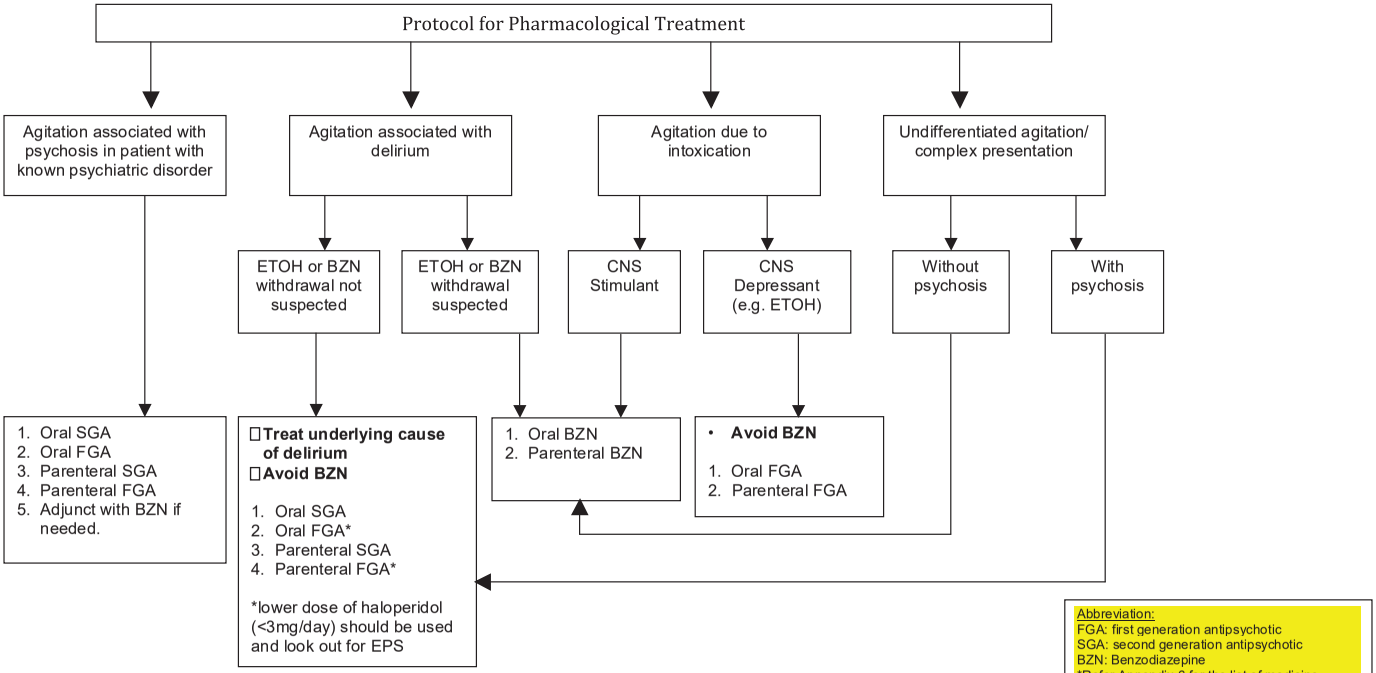
- Aggression due to intoxication: For intoxication by CNS stimulants, benzodiazepines are the choice. For intoxication by CNS depressants (e.g. alcohol), benzodiazepines should be avoided to reduce the risk of respiratory depression.

- Undifferentiated aggression / complex presentation: If the cause of aggression is undetermined, or multiple causes are involved, the choice of medications should be based on the clinical presentation. If there are psychotic features, antipsychotics should be considered. ~~Otherwise,~~ Benzodiazepines can otherwise be used.

8.2.4.2. Post- tranquilization management

- Patients should be managed in a safe position with a clear airway and if possible supplemental oxygen given.
- Documentation including recorded observations are required. (Appendix 8)
- An awareness of the potential adverse effects and possibility of overdose is essential.
- The degree of sedation can be assessed using the Glasgow Coma Scale and recording the pulse, temperature, blood pressure, respiratory rate and pupillary size.
- The blood glucose, ECG and oxygen saturation should be monitored.
- Physical examination, looking for possible organic medical illnesses should be done.

Figure 5 : Protocol For Pharmacological Treatment



8.2.5. Control and Restraint[30-34]

Some aggressive patients will require physical restraints when de-escalation and pharmacological interventions fail or when one-to-one nursing is not feasible. The use of physical restraints may be necessary for the aggressive patient's own safety and protection of others. In a psychiatric facility, one has to comply with the MHA 2001[4] and MHR 2010 (Appendix 1). However, in non-psychiatric facilities, healthcare providers are advised to follow the restraint procedures in this guideline.

De-escalation techniques should be continued throughout the restraint procedure.

There are various types of physical restraints. This guideline only focuses on the four-point restraint (Appendix 7).

8.2.5.1 Healthcare providers must be aware of the potential complications that may occur when restraining patients:

- Escape from restraints.
- Abrasions, bruises, dislocation, contusion, numbness, tingling, fracture, or muscle strain.
- Risk of suffocation with prone positioning.
- Risk of aspiration and subsequent respiratory problems without head elevation.
- Hyperthermia, lactic acidosis, and elevated creatinine kinase (CK) levels due to prolonged struggling.
- Increased risk of infection to healthcare providers following exposure to blood or bodily fluids.

8.2.5.2 Removal of physical restraint

- In psychiatric facilities the decision to remove the restraints can be made by the nurse on-duty. The medical officer must be informed of the termination of restraint.
- In non-psychiatric facilities, the decision should be made by the medical officer.

8.2.6 Documentation, Observation and Monitoring

8.2.6.1 Documentation

ALL aggressive episodes must be documented in the patient's case notes and monitoring form (Appendix 8).

The following information must be included in the aggressive patient's case notes:

- Precipitants to the event
- Indication for restraint
- Alternative interventions attempted
- Medications administered (also recorded in the medication chart).
- Any adverse events relating to the incident (towards patient and others)
- Any contact with the primary carer or other people about the incident (including date and time of the advice and the name of the person notifying).
- Post incident interviews and processes.
- A notation that the patient's management plan has been updated following the incident.
- Name of specialist and medical officer in charge who gave the authorisation for intervention.

8.2.6.2 Observation and Monitoring

Close observation and monitoring should be performed in all settings. The primary aim of observation and monitoring should be to engage therapeutically with the patient. This involves a two-way relationship, established between the patient and the healthcare provider.
Observation must be done to ensure patient's dignity and privacy.

Table 5 : MONITORING DURING PHYSICAL RESTRAINT

a) Review by paramedics every 15 minutes including vital signs monitoring
b) Review by medical officer at least every 4 hrs
c) Review by specialist if restraints exceed 8hrs continuously or 12 hours intermittently
d) Ensure basic needs are met (intake, output, bedding, clothing, hygiene)

8.2.7 DEBRIEFING

- After using a restrictive intervention (rapid tranquilisation and /or restraint) to manage aggression, post-incident debriefing should be conducted including the aggressive patient, healthcare providers and witnesses.[35] It should be done by trained personnel.

- The aim of debriefing is to[36,37]:
  - communicate their experiences, concerns and anxieties related to the incident
  - freely express their feelings and ideas
  - acknowledge the emotional response & assess the need for emotional support
  - promote relaxation and feelings of safety
  - support a return to normal patterns of activity

- identify and address ongoing risks and physical harm to patient or healthcare provider.
- make recommendation(s) for future improvement

8.2.7.1 Debriefing the patient

- Explain why the intervention was necessary.
- Allow the aggressive patient to explain from his/her point of view.
- Discuss appropriate alternatives to manage future aggression.
- Get feedback from the aggressive patient whether his/her concerns have been addressed.
- Work with the aggressive patient to solve the precipitating event.

8.2.7.2 Debriefing the healthcare providers

- In essence, the debriefing process looks for answers to the following questions:
    i. What went well? (areas of good practice)
    ii. What did not go well? (with regard to our decisions or the operational plan)
    iii. What did you learn?
    iv. What can we do better in the future?
    v. Is there a need for training to be modified?

- It is important to avoid blame, promote good practice, and to ensure the process does not cause unnecessary trauma or conflict by re-living the experience.

8.3 INCIDENT REPORTING & LEARNING SYSTEM[38,39]

An incident report should be made in the case of a patient and /or the healthcare provider being harmed (which led to injuries, death etc.) in MOH facilities. The main objective is for the healthcare facility to learn from previous incidents and past mistakes to prevent recurrences of similar incidents.

Investigations need to be made using the Root Cause Analysis (RCA). The main reason to conduct an RCA is to find the contributing factors and the root cause of the problem and to take the necessary remedial measures. It also enables a more systematic and comprehensive approach in managing patient safety.

Incident reporting is the preferred method to measure aggression in healthcare settings objectively.[40]

9. SPECIAL SITUATION

9.1 Special Population

The management of aggression may be different in certain populations because of differences in procedures, dosages of medications and other issues related to the particular groups. This section focuses on three special groups i.e. children and adolescents, the elderly and pregnant patients.

9.1.1. Children & Adolescents

The behavioural approach (de-escalation techniques) is preferable when managing aggression in children and adolescents. In our country, there are no regulations on the use of restraints on children and young people. However, the Human Rights Act (Human Rights Act 1998)[41] and Capacity Assessment (UN Convention on the Rights of the Child (1989)[42] **MUST** be considered when the use of restraint in this special population group is planned.The healthcare providers should be aware that physical restraint can result in the child feeling out of control, anxious and distressed[43].

Restraint is **NOT** allowed for children below the age of 12 years (MHR 2010)[4] in psychiatric facilities.

Separate consideration is given to medication choices, dosages and routes of administration. (Appendix 6)

Parents must be informed of the management.

9.1.2 The elderly

Managing aggression in the elderly is challenging especially in those with cognitive impairment. Among the challenges are medical comorbidities, poly-pharmacy, physical frailty and susceptibility to side effects of medications.[44]

The general principles of managing aggression apply to this group. However, apart from the risk factors mentioned in Table 1, assessment needs to focus on other potential risk factors for aggression in the elderly e.g. symptom of an acute illness, such as pneumonia or a urinary tract infection; chronic medical problem, such as constipation; pain due to illness; cognitive impairment; psychiatric illnesses and drug history.

Wherever possible, collateral history should be sought from family, friends and healthcare providers.[45,46]

The principle of pharmacological intervention in the elderly is to start low and go slow and the oral route of medication is preferable (Appendix 6).

9.1.3. Pregnant patients

Managing aggression in pregnant patients bears special considerations to the mother and the foetus. Safety of the mother always takes precedence.

The following are special considerations in using pharmacological treatment for pregnant patients (Appendix 6):

- Benzodiazepines
  - First trimester:
    - Benzodiazepines are to be avoided if possible.
    - If a woman requires a benzodiazepine in pregnancy, she and her husband/ next of kin should be advised of the risk and benefit.

- There is insufficient evidence to prove that benzodiazepines are human teratogens.[47] The absolute risk for clefts, if present, remains small (incidence of oral clefts in the general population is about 1/1000) so the 2-fold increase translates to 2/1000.[48]

- Second and third trimesters:
  - Risk of aspiration increases as pregnancy progresses to the second and third trimesters. [49]

- Postpartum:
  - After delivery, the neonate should be examined by the paediatric team for respiratory depression.

- Antipsychotics:
  - There is no evidence that the use of conventional antipsychotics increases the rates of major malformations during pregnancy.[50]
  - Atypical antipsychotics can be an alternative to consider if the mother is unable to tolerate the side effect(s) of typical antipsychotics.[51]

9.2 Specific Setting

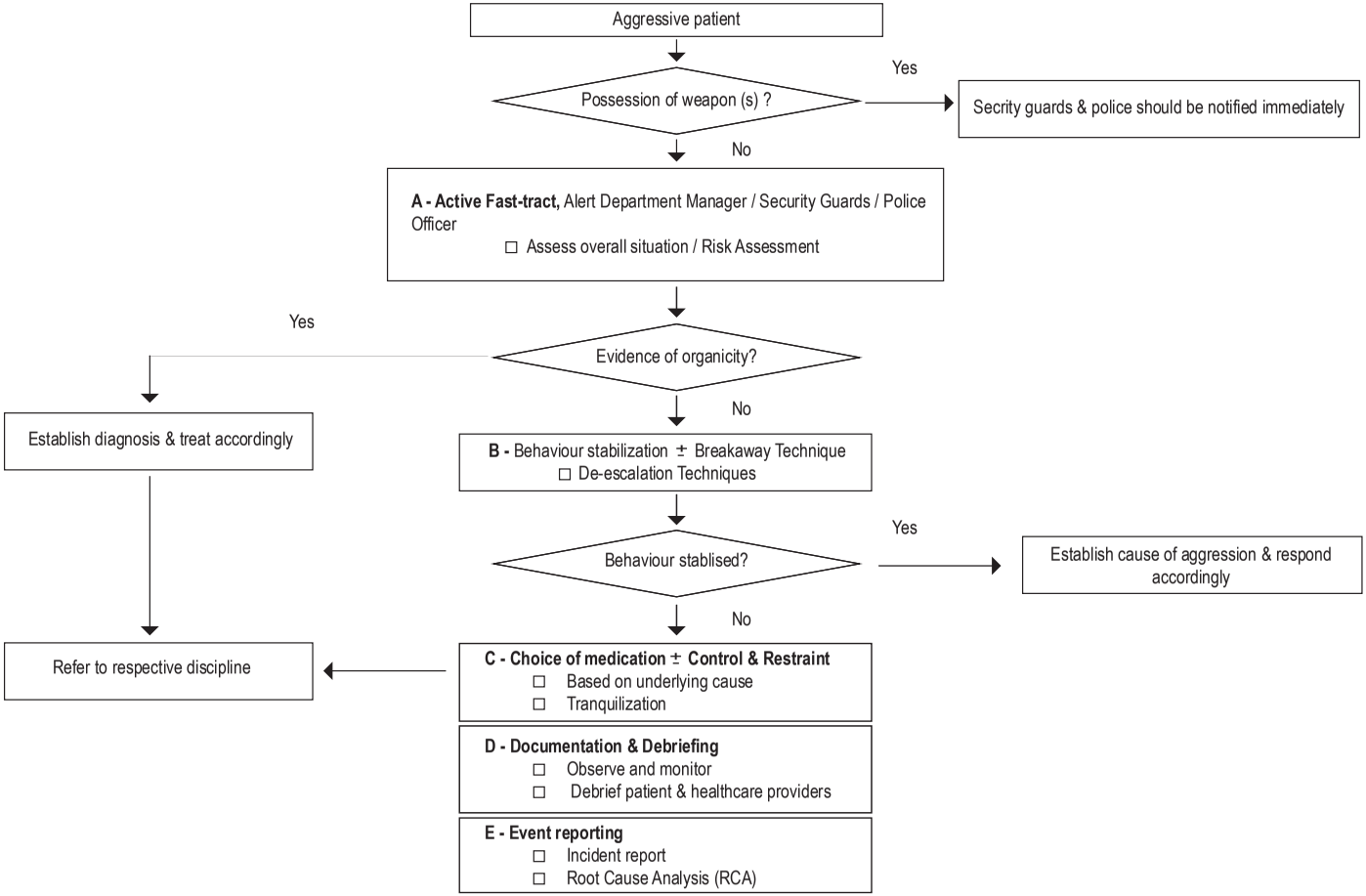
9.2.1. The Emergency Department

- At triage, the staff should:
  - Assess all patients for possible violent behaviour / history of violence.[52]
  - If the patient is in possession of any weapons,
    - police and /or security guards should be notified as soon as possible.
    - suggest to the patient to voluntarily place the weapon down and move away from it. The weapon should be retrieved once he / she has been taken away from the area.
    - Activate team as per hospital emergency department

procedure.

- Place patient in an area where he /she can be easily observed by paramedics.

Figure 6 : Flow Chart on Management of the Aggressive Patient in the Emergency Department



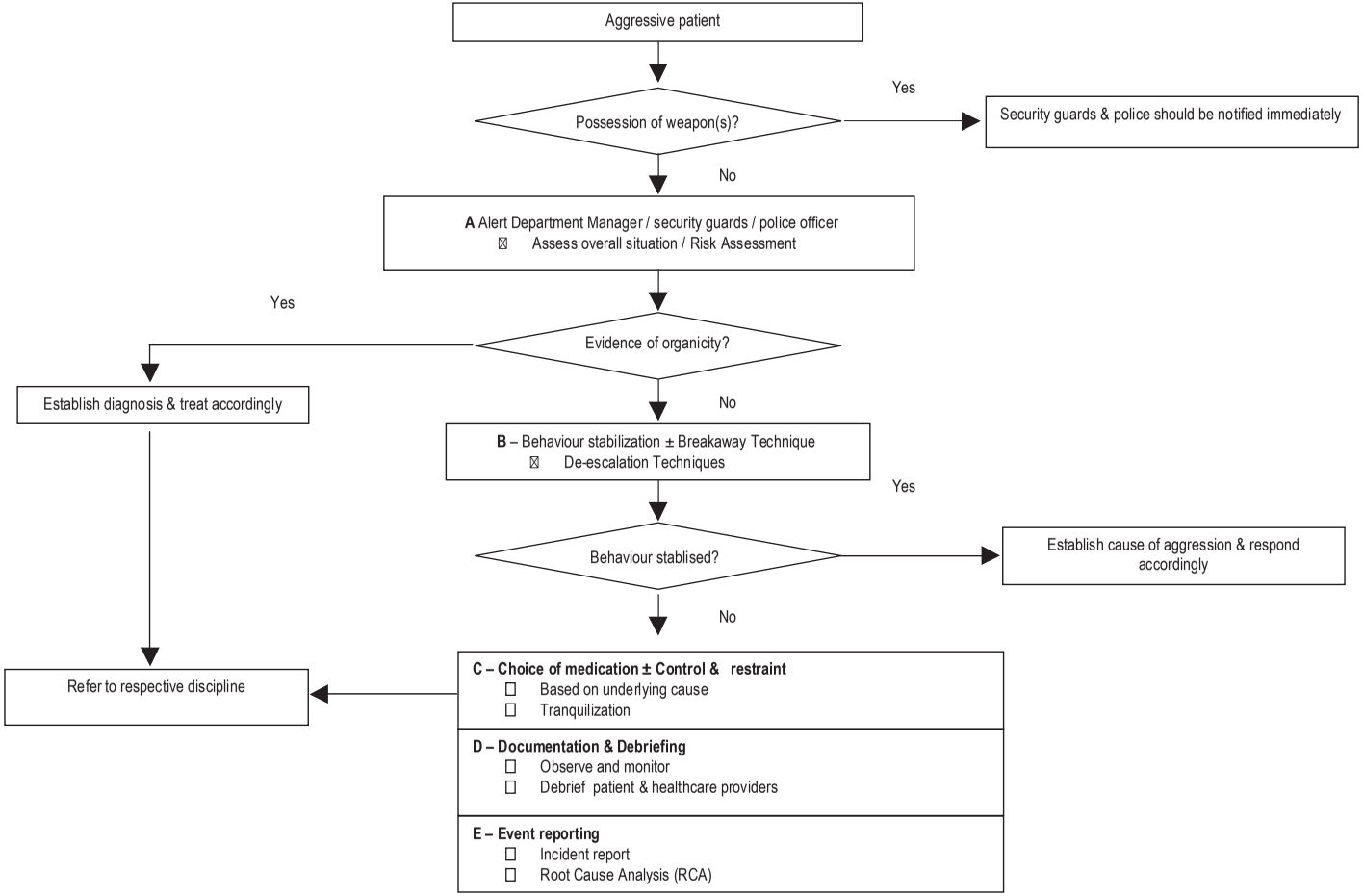
9.2.2 Outpatient setting in a hospital including Methadone Clinic, Pharmacy and Specialist Clinic (Figure 7)

- Suggest displaying zero tolerance policy towards abusive and aggressive behaviour at the area.
- Healthcare provider at registration counters to be familiar with patterns of patients who are potentially aggressive and warn relevant personnel.
- Alert the security team closest to the clinic and alert additional healthcare providers from nearby clinics.
- Ensure personal and healthcare providers' safety.
- Inform & transfer the patient to the Emergency Department for further management.

9.2.3. Inpatient setting (Non-psychiatric) (Figure 7)

- Managing aggression in a non-psychiatric ward setting can be challenging due to the lack of trained healthcare providers to manage the situation.
- Consider the need to alert security guards to standby for assistance, depending on the gravity of the situation.
- Refer to respective discipline for co-management.

Figure 7: Flow Chart on Management of the Aggressive Patient in Outpatient & Inpatient Settings (Non-Psychiatric)



9.2.4. Community Mental Health Centre (CMHC) (Figure 8)

According to the Community Mental Health Centre Implementation Guidelines 2013[52], the following patients are to be excluded from care at the CMHC:

- Acutely disturbed and in need of intense 24-hour care and supervision.
- Those who display overly aggressive or suicidal behaviour, which indicate a security risk to themselves or to others.

The Medical Officer (MO) on-site shall refer patients who are aggressive while undergoing rehabilitation activities at CMHC to the nearest psychiatric hospital after assessment. Patients may be restrained if required, and transfer should be arranged as soon as possible (MHR 2010).[4] Next of kin/ relatives should be informed and relevant forms should be signed (Forms 1/3/4/5).

The MO must inform the receiving hospital Psychiatry team and Emergency Department. Transport to be arranged (preferably an ambulance) and vital signs should be monitored during the transportation. Paramedic must accompany the patient and they should be able to administer additional parenteral medications if needed.

9.2.5. Psychiatric Nursing Home (PNH) (Figure 8)

The person in charge of a psychiatric nursing home shall examine any patient who shows signs and symptoms of mental deterioration (including aggression) and may administer emergency treatment before recommending the patient to be admitted into a psychiatric hospital (MHR 2010).[4]

If a patient becomes aggressive, the paramedic should inform the MO and Psychiatrist in charge. Just as in a CMHC, patients may be restrained if required, and transfer should be arranged as soon as possible (MHR 2010).[4]

9.2.6. Primary Health Care (PHC) (Figure 8)

The Family Medicine Specialist (FMS) or MO in charge shall examine any patient who shows signs and symptoms of aggression and may administer emergency treatment before referring the patient to the nearest psychiatric facility. The choice of medications is in Appendix 6.

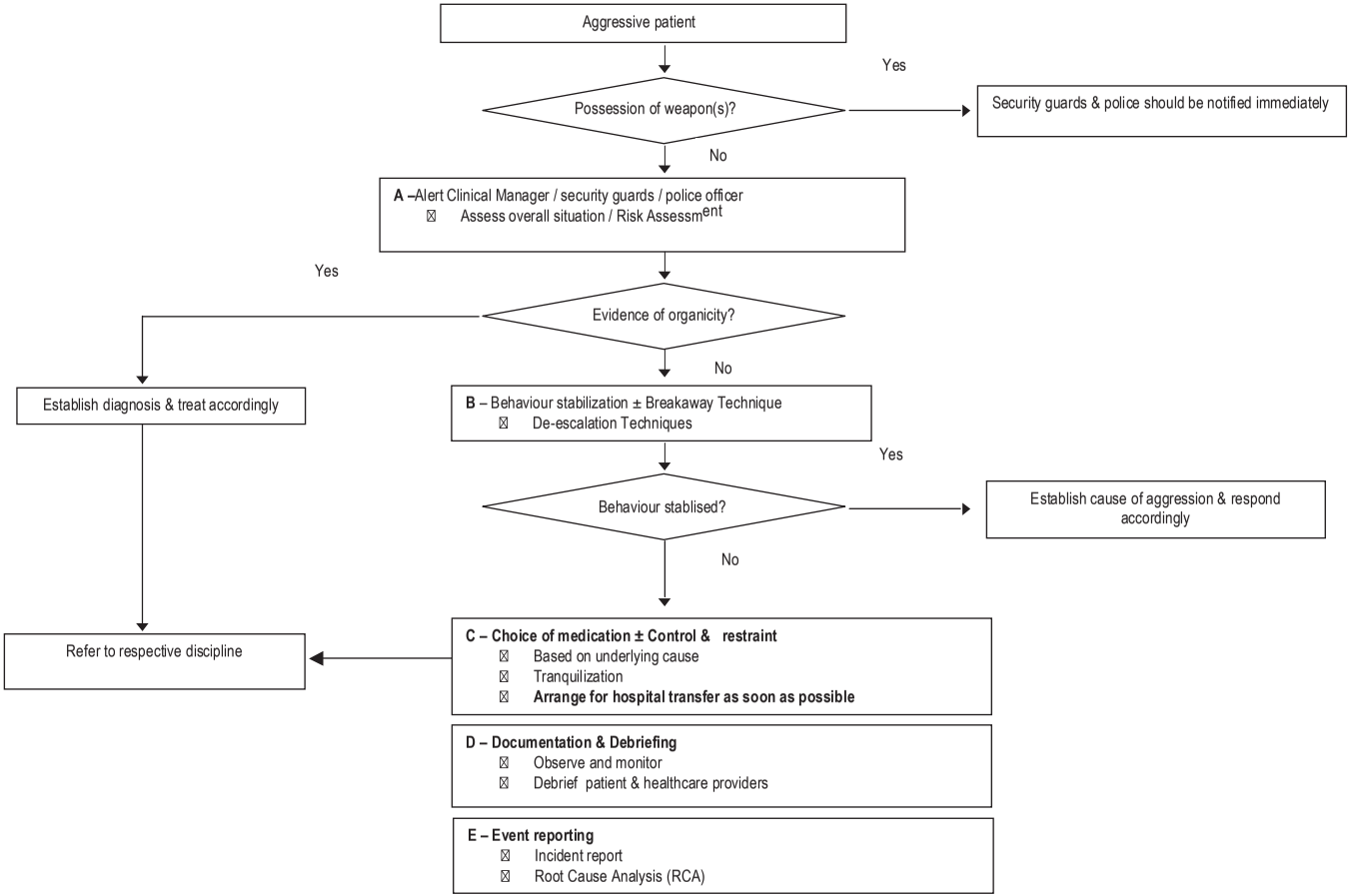
Patients may be restrained if required, and transfer should be arranged as soon as possible (MHR 2010).[4] Next of kin/ relatives should be informed and relevant forms should be signed (Forms 1/3/4/5).

The MO must inform the receiving hospital Psychiatry team and Emergency Department. Transport to be arranged (preferably an ambulance) and vital signs should be monitored during the transportation. Paramedic must accompany the patient and they should be able to administer additional parenteral medications if needed.

9.2.7. Community Mental Health Team (CMHT)

Community Mental Health Team (CMHT) is a service provided at the patient's home. Generally, patients with suicidal tendency, aggressive and/ or homicidal behaviour are excluded from the care of CMHT (Psychiatry Operational Policy).[54] Occasionally, the patients may turn aggressive. When the CMHT is faced with this situation, personal safety is of paramount importance. They should move to an area of safety and the family members should make a police report for further action.

Figure 8: Flow Chart on Management of the Aggressive Patient in the CMHC / PNH / PHC & CMHT



9.2.8 Public Area within MOH facilities

If a person(s) who is not a registered patient is aggressive in a public area, members of the public are not encouraged to intervene and they should move to an area ensuring personal safety. The witness of the incident should alert the security personnel for further assistance.

9.2.9. Weapon & Hostage Situation

In all situations, patients who are armed should **NOT** be evaluated until disarmed. Security personnel & police need to be alerted of the situation immediately. Everyone in the vicinity must move to an area ensuring personal safety.

In summary,

- Preparedness involves a level of awareness and some planning for the possibility of aggression and violence particularly with regard to facility design, policies, procedures and healthcare provider training.
- Organic illness can mimic or coexist with psychiatric illness and both may cause behavioural disturbances.
- De-escalation is a useful first-line technique.
- In the uncommon situation that sedation is needed in a non-hospital setting, an early call for police and/ or hospital assistance should be made.
- Oral sedation can be effective, but intramuscular or intravenous medication is needed in some cases.
- Post-sedation physical assessment and monitoring are essential.
- A review of practice preparedness and healthcare provider debriefing should be undertaken after an event.

10. TRAINING

The training should be done regularly to as many healthcare providers as possible in all disciplines. A template for training is available in Appendix 10.

11. AGGRESSION MANAGEMENT TEAM (AMT)

All disciplines/ centres are encouraged to have their own aggression management team who are trained to handle aggression and violence[55].

Definition:

- First responder: Any healthcare provider who first encounters the aggression.
- Healthcare provider at the location: Any healthcare provider at the scene of the incident.
- Coordinator: The senior most healthcare provider in the vicinity.

FIRST RESPONDER

- Assess the situation
- Call for help
- While waiting for others to arrive
  - De-escalation
  - Provide safe and quiet room
  - Remove dangerous objects
  - Diversion
- Prevent involvement of non-health care providers

AGGRESSION MANAGEMENT TEAM (AMT) - MO

- Evaluate the situation
- Assess the risk
- Assist in administration of medications
- Document details of incident

AGGRESSION MANAGEMENT TEAM (AMT) – Paramedics

- Ensure the scene is safe and under control
- Assist AMT members in handling the aggressive patient
- Facilitate smooth disposal / aftercare plan
- Accompany the aggressive patient in accordance with the disposal plan

AGGRESSION MANAGEMENT TEAM (AMT) - Coordinator

- Respond to distress call urgently
- Briefing to team members
- Communicate with the aggressive patient to encourage sharing his/ her concern
- Facilitate de-escalation
- Manage the individual in a safe and quiet environment
- Instruct healthcare providers to assist in providing medications or physical restraint where necessary
- Decide on the safe disposal/ referral of the aggressive person
- Documentation of incident
- Post incident evaluation and debriefing

AGGRESSION MANAGEMENT TEAM (AMT) – Security Personnel

- Assist in controlling the situation at the scene of the incident
- Help manage the aggressive patient – breakaway technique by the AMT Coordinator

12. CASE SCENARIO

12.1. MEDICAL

Mr. C is a 63 year-old man who was admitted for Coronary Artery Bypass Grafting (CABG) procedure. He made good recovery until he developed difficulty to sleep at night on Day 3 post procedure. He started to become restless and confused and was frequently found trying to leave the ward. He also became irritable and verbally abusive towards the nursing staff when his demands were not met and he was not cooperative during his physiotherapy sessions. On one occasion, he almost hit a physiotherapist who came to assist him with ambulation. The nursing staff saw him talking to himself at night. He told them that his late mother had been visiting him in the ward. He believed they were going to poison him with medications. Hence, he refused to take his medications.

Mr. C was orientated and cooperative most of the day. Frequently, he spent his daytime sleeping. During morning rounds, he was coherent and relevant with the doctors. However, in the evenings, his behaviour would be more difficult to manage and he was often disturbed. He would however, become more manageable when his family members were around. He often complained that his post-operative wounds were painful. His oral intake was poor due to his sleeping pattern.

Question:

1. What is the cause of aggression in this patient?
2. What is the appropriate management for Mr. C?

Answer:

a) Careful history taking and investigations revealed that the patient had delirium secondary to poor pain control and dehydration associated with low potassium due to poor oral intake.

b) The hallmark of delirium management is identification and correction of the underlying abnormality - optimisation of the clinical condition (pain control, rehydration and correction of electrolytes)

a) Conservative management – for delirium

i. Continuously re-orientate patient regarding his condition, as well as time/ place/ person.

ii. Make sure patient is placed in the acute area where nurses are able to monitor him. Also ensure a well-lit area where the patient is able to appreciate changes in the time of day. Avoid placing patient at the end of the ward or in dark places. Re-organize his sleeping pattern by encouraging physical activities during daytime.

iii. Whenever possible, encourage a family member to stay with the patient in the ward as this would facilitate orientation and a familiar face around would be less intimidating for the patient. (However, if family members are unable to accompany patient in the ward, ensure he is nursed by the same nurse every day).

iv. Make sure the environment is safe.

b) Pharmacological management – low doses of antipsychotics (e.g. haloperidol or risperidone) may be necessary. However it has to be used with caution as US FDA has issued a 'black-box' warning of greater mortality when atypical anti-psychotics are used in the geriatric population.

c) Management of aggression

i. This patient's aggression is mostly verbal; hence address the patient with non-threatening, calm, clear and simple statements. Repeat the statements if necessary to make certain points clear, e.g. importance of medication and wound-care.

ii. If aggression escalates, be calm and with a firm voice inform the patient that aggressive behaviour is not tolerated.

iii. If the patient becomes physically aggressive (e.g. hitting healthcare providers) or his behaviour disrupts his clinical management (e.g. pulling off IV drips), physical restrain may be necessary and commence antipsychotics.

iv. Monitoring, documentation and event reporting must be exercised.

12.2. SUBSTANCE USE DISORDER

Mr A is a 26-year-old Malay gentleman who has had 8 years history of Schizophrenia with co-morbid polysubstance abuse. He initially presented to the psychiatric clinic with symptoms consistent with psychosis. The symptoms included auditory and visual hallucinations, poor sleep and disorganized behaviour. He also admitted to abusing drugs since young but claimed that he was able to stop his habit with the medications given.

Recently Mr A came to the psychiatric clinic insisting to see his treating doctor urgently and asked for sleeping tablets (benzodiazepines). He refused to wait ~~for~~ his turn and entered the doctor's room without permission. He showed signs and symptoms indicative of opiate withdrawal which he denied. The doctor ordered a urine for drugs screening. He refused to give his urine and later admitted that he was abusing morphine, syabu, cannabis and "air ketum" mixed in cough syrup. When the doctor rejected his request for sleeping medication as he came earlier than his appointed date, he shouted angrily at the doctor and complained about the poor services that he had received. He threatened to write a complaint letter to the authorities. He also made a verbal threat that he might hurt someone and kill himself so that the doctor will be blamed and become responsible for his actions.

Suddenly he lifted a chair in front of the counter and threw it towards the doctor's room and another chair to the staff at the counter. He also dislodged a fire extinguisher and sprayed it towards the doctor's room. He was physically aggressive and using foul language at the staff and doctor.

Question:

1. What could the reasons for the patient's aggression be?
2. What are the signs of impending violence?
3. How would you manage the situation?

Answer:

1. The reasons for the aggression were:
    a) Having to wait
    b) Substance dependence in withdrawal state
    c) Schizophrenia with comorbid substance abuse. He could be in early relapse stage
    d) Drug-seeking behaviour

2. The signs of impending violence are:
    a) Anxious, clenching jaw, pacing, trembling
    b) Loud, swearing, shouting
    c) Demanding, crying
    d) Angry
    e) Threatening, pushing & throwing things

3. Management includes:
    a) Safe room / secure area for personal protection
    b) Appropriate space (including access to an exit door)
    c) Ensure patient has adequate personal space
    d) Secure storage for potentially dangerous items
    e) Duress alarm / panic buttons – make other staff aware of the risk of aggression and call for help
    f) Initiate security backup
    g) Minimum of 2 staff managing the incident
    h) Comprehensive Risk Assessment
    i) De-escalation techniques
    j) Control & Breakaway Techniques if being held by the patient
    k) Consider pharmacological intervention and/or restraints if required
    l) Observation and documentation
    m) Debriefing
    n) Report the incident to the specialist in charge / HOD. Complete an incident report.

12.3. PSYCHOTIC DISORDER

Mr. A ~~is~~ a 33-year-old gentleman, single and unemployed, was brought to hospital by police officers for aggressive behaviour on the same day. He had smashed a car windscreen with a wooden club. He was calm upon arrival and cooperative during history taking and physical examination. He complained of hearing a female voice for one month prior, commanding him to smash car windscreens to release souls of angels trapped inside the cars. He believed that if he did not follow the instruction, God would punish him. Further history revealed that Mr A had been receiving outpatient psychiatric treatment for 10 years but defaulted follow-up and medication for the past 3 months.

There were no suicidal or homicidal intentions. There was nothing suggestive of an organic medical problem. Urine toxicology for illicit substances was negative. When a staff nurse approached him for blood taking, he became agitated, slapped the nurse on her face and shouted that the nurse was trying to trap his soul into the syringe. Verbal de-escalation was carried out by the doctor in charge by explaining to him the purpose of the procedure, but Mr A became even more agitated as he believed the doctor was the main culprit behind this soul trapping business, and tried to punch the doctor too.

Question:

1. How can the aggression be prevented in this scenario?
2. How would you manage the aggression?

Answer:

1. In all situations, one must:
    a. Assess the patient's risk at regular intervals.
    b. To reduce delusional misinterpretation, effort must be made to explain any procedure to the patient (e.g. the patient might become aggressive due to fear of being hurt by medical personnel).
    c. When managing an agitated patient, one must make sure that there is enough manpower available should the aggression escalate.

2. As the aggression escalates and patient becomes physically aggressive, chemical and/or physical restraints are the next option. I.M. antipsychotic medication is useful in the agitated patient with psychotic symptoms who refuses oral medication. As with any administration of medication, the side effects must be monitored. Documentation and debriefing must be done.

12.4. BEHAVIOURAL RESPONSE TO A PHYSICAL CONDITION

Mr AA a 30-year-old man presented to the Accident & Emergency Department (A&E) for abdominal pain. He had been waiting for more than 2 hours to see a doctor in the waiting area of the crowded A&E.

After a while, he became restless. He paced up and down ~~in~~ the waiting area and started being verbally abusive towards the staff. As no one paid heed to him, he became aggressive and started banging the counter table and shouted, “I’ve waited for so long!” “Are you going to help me?”, “You are not doing your work!” repeatedly. He continued to bang the counter table and threw things off the counter.

Upon seeing Mr AA’s behaviour, the other patients in the waiting area became frightened and fled from their seats.

Question:

1. What were the causes for the aggression?
2. How would you manage the situation?

Answer:

1. The aggression could have been due to:
    a) Worsening of the pain
    b) Felt he was ignored. Felt no one cared.
    c) Long waiting time
    d) Overcrowding

2. De-escalate the situation:

This patient was beyond certain de-escalation strategies, e.g., offering a drink.

Throughout the assessment and de-escalation, be acutely aware of your communication skills (verbal and non-verbal).

    a) Usher the patient to a designated area
    b) Find out his name
    c) Introduce yourself and tell him you are there to help him
    d) Find out the cause of his frustration & address according to urgency
    e) If his frustration is due to a medical condition (e.g. pain), it is pertinent to give him the required medical attention.
    f) When the cause of the delay is established, an explanation must be offered to the patient in a transparent, concise and non-defensive manner.
    g) Debriefing and reporting should be done once the situation calms down.

13. APPENDIX

APPENDIX 1

Mental Health Regulation (MHR) 2010.

PART V

RESTRAINT OR SECLUSION

Indication and procedure for restraint or seclusion

25. (1) The indication and procedures for physical or chemical means of restraint or seclusion may be applied to patients detained in psychiatric hospitals shall be as specified in the Third Schedule.

(2) No minor patient below the age of twelve shall be subjected to physical means of restraint or seclusion in psychiatric hospitals.

(3) The privacy and safety of a patient shall be observed at all times during the restraint or seclusion procedures.

(4) No physical or chemical means of restraint or seclusion shall be applied to patients in any psychiatric nursing home or community mental health centre, except during an emergency and the patient shall then be transferred to psychiatric hospitals without delay.

(5) If the period of physical means of restraint of a patient exceeds eight hours, a psychiatrist shall review the patient on the need for further restraint.

(6) No seclusion shall be carried out on a patient for more than eight hours consecutively or for more than twelve hours intermittently over a period of forty eight hours, without an independent review by a psychiatrist or any other medical practitioner of similar seniority who was not directly involved in the care of the patient at the time of the incident which led to the seclusion of such patient.

Restraint area

26.(1)There shall be a designated restricted area with a dedicated observation bay manned by a qualified, trained and experienced staff for the purpose of monitoring of patients.

(2)The area referred to in subregulation (1) shall be adequately lit and ventilated.

Restraint equipment

27.The equipment allowed or prohibited to be used as physical means of restraint of patients shall be as specified in the Third Schedule.

Application of physical means of restraint

28.The physical means of restraint of patients shall be -

*(a)*carried out or supervised by qualified, trained and experienced personnel; and
*(b)*applied only to the limbs of a patient.

THIRD SCHEDULE

[Regulations 25, 27 and 30]

A. Indication for chemical means of restraints

(1) The restraints are for the purpose of the medical treatment of the patient.

(2) To prevent the patient from causing injury to himself or herself or any other person.

(3) To prevent the patient from persistently destroying property.

(4) When other less restrictive method of treatment to calm the patient has not been successful.

B. Procedures for chemical means of restraints

(1) Approved chemical means of restraint

(a) The medical officer or registered medical practitioner shall prescribe the drug to be administered.

(b) In the case of an emergency, the medical officer or registered medical practitioner shall authorise the nurse or medical assistant on duty to administer the drug.

(c) The nurse or medical assistant on duty shall notify to the medical officer or registered medical practitioner the drugs administered.

(2) Consent for chemical means of restraint. Consent shall be obtained from a voluntary patient prior to chemical means of restraint.

(3) Care of the patient under chemical means of restraint

(a)If the patient is acutely disturbed, a member of the nursing staff shall visit at 15 minutes interval.

(b)A medical officer or registered medical practitioner shall examine the acutely disturbed patient at intervals of not more than 4 hours.

(c) The vital signs of the patient shall be monitored frequently as ordered by the medical officer or registered medical practitioner.

(d)The patient shall be supplied with bedding and clothing at appropriate times.

(e)The patient shall be provided with adequate toilet facilities.

(f)The patient shall be provided with food and drinks at the appropriate times.

(4) Information to be recorded by the medical officer or registered medical practitioner

(a)The drug and mode of admission for chemical means of restraint used.

(b)The indication for the restraint.

(c)The name and signature of the person who approved or authorized the use of that restraint.

(d)The name of the person who administered the chemical means of restraint.

(e)The time of administration of chemical means of restraint.

(f)This information shall be documented in the patient's record.

C. Indication for physical means of restraint

(1)A restraint is for the purpose of the medical treatment of the patient.

(2)To prevent the patient from causing injury to himself or any other person.

(3)To prevent the patient from persistently destroying property.

(4)When other less restrictive method of treatment to calm the patient has not been successful.

D. Procedure of physical means of restraint

(1)Approved physical means of restraint

(a)The medical officer or registered medical practitioner shall approve the form of physical means of restraint.

(b) In the case of an emergency, the psychiatric nurse on duty shall be authorised to administer any form of physical means of restraint.

(c)The form of physical means of restraint administered by the psychiatric nurse on duty shall be notified to the medical officer or registered medical practitioner without delay.

(2)Consent

It shall not be necessary to obtain a person's consent to the application of physical means of restraint.

(3)Care of the patient during physical means of restraint

(a)No physical restraint is allowed in the psychiatric nursing home and community mental health centre, EXCEPT at the time of transportation of patients to a psychiatric hospital.

(b)If the patient is acutely disturbed, a member of the nursing staff shall visit at intervals of not more than fifteen minutes.

(c)A medical officer or registered medical practitioner shall examine the acutely disturbed patient at intervals of not more than four hours.

(d)The patient shall be supplied with bedding and clothing at appropriate times.

(e)The patient shall be provided with adequate toilet facilities.

(f)The patient shall be provided with food and drinks at the appropriate times.

(4) Removal of physical means of restraint

(a)Decision to remove the restraints shall be made by the psychiatric nurse on-duty.

(b)The medical officer or registered medical practitioner must be informed of the termination of restraints.

(5)Information to be recorded by the medical officer or registered medical practitioner

(a)The indication for the restraint.

(b)The form of physical means of restraint used.

(c)The name and signature of the person who approved or authorised the use of that restraint.

(d)The name and signature of the person who applied the physical means of restraint.

(e)The name and signature of the person who authorised the removal of the physical means of restraint.

(f)This information shall be recorded in the patient's record.

E. List of equipment prohibited to be used as physical means of restraint:

(1) Strings, ropes and raffia;

(2) Handcuffs, shackles and pasung

(3) Body restraint;

(4) Strait jacket;

(5) Chains (from whatever material);

(6) Wire;

(7) Bandage; and

(8) Equipment with tears, protruding metal parts or any defect that may endanger patient.

F. List of equipment allowed to be used as physical means of restraint:

(1)Restraint bed;

(2)Restraint chair;

(3)Padded restraints made of either calico cloth or cotton , leather , nylon, vinyl polyurethane, silicone or rubber based materials; and

(4) Any other equipment approved by the Director General.

I. Information to be included in the Physical Restraint Record:

(1)The following particulars of patient:

(a)Name;

(b)Age;

(c)Sex; and

(d)Identification Number.

(2)Reasons why physical means of restraint was used.

(3)Name and signature of the person who approved or authorised the use of physical means of restraint.

(4)Name and signature of the person who monitors the patient on restraint.

(5)The period of time for which the patient was kept in restraint.

(6)List of injuries and complications sustained during the physical restraint

APPENDIX 2

RISK ASSESSMENT OF VIOLENCE

NAME: I/C or RN:

	RISK FACTORS	DAY 1/ ADMISSION			DAY 2			DAY 3			DAY 4			DAY 5			DAY 6			DAY 7		
		AM	PM	ON	AM	PM	ON	AM	PM	ON	AM	PM	ON	AM	PM	ON	AM	PM	ON	AM	PM	ON
HIGH	***Command hallucination** *(Halusinasi menyuruh mencederakan diri sendiri dan/ atau orang lain)*																					
HIGH	***Provoking behaviour** *(Tingkah-laku mencabar atau memprovokasi)*																					
HIGH	**Restless** *(Resah/Cepat meradang)*																					
HIGH	**Uncooperative** *(Tidak mahu bekerjasama)*																					
MODERATE	**Increased tone** *(Meninggikan nada suara)*																					
MODERATE	**Verbally abusive** *(Menggunakan kata-kata kesat)*																					
MODERATE	**Hostile looking** *Kelihatan merbahaya:* - *Mengugut (secara lisan/fizikal)* - *Merenung tajam* - *Menggenggam tangan* - *Marah*																					
MODERATE	**Persecutory delusion** *Delusi paranoia*																					
	SIGNATURE																					

Please indicate / *Sila lengkapkan:* Yes/*Ya:* ✓ No/*Tidak:* x

GUIDE TO DETERMINE OF RISK AND INTERVENTION

HIGH RISK FACTORS	INTERVENTION	MEDORATE RISK FACTORS	INTERVENTION
● HIGH RISK (> 2 FACTORS) – ● ONLY ONE FACTOR (*) NEEDED IF THERE IS PRESENCE OF COMMAND HALLUCINATION OR PROVOKING BEHAVIOUR	● Inform doctor to review ● Assault caution ● For parenteral sedation ● Observation every 15-30 minutes ● Acute bay ● BD review ● Pass over to doctor on call	HIGH RISK (≥ 2 FACTORS)	● Inform doctor to review ● Assault caution ● For oral sedation ● Observation every 4 hours ● Acute bay ● BD review ● Pass over to doctor on call

QA/QI Team/Dept of Psychiatry & Mental Health HKL/September 2013

Risk Assessment of Violence-HKL

The instrument has been developed for an inpatient setting use. It is easy to use by the paramedics and may be easily implemented as part of routine shift work particularly for the first few days of admission when the risk of aggression is high.

APPENDIX 3

The Brøset Violence Checklist©(BVC) - quick instructions: Score the patient at agreed time on every shift. Absence of behaviour gives a score of 0. Presence of behaviour gives a score of 1. Maximum score (SUM) is 6. If behaviour is normal for a well known client, only an increase in behaviour scores 1, e.g. if a well know client normally is confused (has been so for a long time) this will give a score of 0. If an **increase** in confusion is observed this gives a score of 1.	Patient/Client data

Monday / /			
	Day	Evening	Night
Confused			
Irritable			
Boisterous			
Verbal threats			
Physical threats			
Atacking objects			
SUM			

Tuesday / /			
	Day	Evening	Night
Confused			
Irritable			
Boisterous			
Verbal threats			
Physical threats			
Atacking objects			
SUM			

Wednesday / /			
	Day	Evening	Night
Confused			
Irritable			
Boisterous			
Verbal threats			
Physical threats			
Atacking objects			
SUM			

Thursday / /			
	Day	Evening	Night
Confused			
Irritable			
Boisterous			
Verbal threats			
Physical threats			
Atacking objects			
SUM			

Friday / /			
	Day	Evening	Night
Confused			
Irritable			
Boisterous			
Verbal threats			
Physical threats			
Atacking objects			
SUM			

Saturday / /			
	Day	Evening	Night
Confused			
Irritable			
Boisterous			
Verbal threats			
Physical threats			
Atacking objects			
SUM			

Sunday / /			
	Day	Evening	Night
Confused			
Irritable			
Boisterous			
Verbal threats			
Physical threats			
Atacking objects			
SUM			

The Brøset Violence Checklist:

The Broset Violence Checklist (BVC) is a useful instrument in predicting violence within the next 24-hour period of completing the questionnaire.

Interpretation of scoring:

Score = 0 The risk of violence is small

Score = 1-2 The risk of violence is moderate. Preventive measures should be taken.

Score > 2 The risk of violence is very high. Preventive measures should be taken

In addition, a plan should be developed to manage the potential violence.

Operationalization of behaviours/items:

Confused	Appears obviously confused and disorientated. May be unaware of time, place or person.
Irritable Boisterous	Easily annoyed or angered. Unable to tolerate the presence of others. Behaviour is overtly "loud" or noisy. For example slams doors, shouts out when talking etc.
Physically threatening	Where there is a definite intent to physically threaten another person. For example the taking of an aggressive stance; the grabbing of another persons clothing; the raising of an arm, leg, making of a fist or modelling of a head-butt directed at another.
Verbally threatening	A verbal outburst which is more than just a raised voice; and where there Is a definite intent to intimidate or threaten another person. For example verbal attacks, abuse, name-calling, verbally neutral comments uttered in a snarling aggressive manner.
Attacking objects	An attack directed at an object and not an individual. For example the indiscriminate throwing of an object; banging or smashing windows; kicking, banging or head-butting an object; or the smashing of furniture.

APPENDIX 4

Confusion Assessment Method (CAM)

- A 4-item questionnaire
- Takes about 5 minutes to administer

1. Acute onset and fluctuationg course: Is this new and change from baseline?	
2. Inattention: Are they having difficulty focusing?	
3. Disorganised thinking: Is the patient rambling or unclear?	
4. Altered level of consciousness: Alert (normal), Vigilant, Lethargic, Stupor, or Coma	

Diagnosis for delirium: Positive/Abnormal rating for (1) AND (2); PLUS (3) OR (4)

APPENDIX 5

Six-item Screener (SIS)

- Developed by Carpenter CR et al (2011)
- A 6-item questionnaire requiring verbal responses
- Administration time is less than 1 minute
- Applicable to elderly with difficulties to write or draw

Ask patient to remember three objects; e.g GRASS, PAPER, SHOE	
1. What year is this?	
2. What month is this?	
3. What is the day of the week?	
Ask for the three objects:	
4. GRASS	
5. PAPER	
6. SHOE	

Scoring: 1 point for each correct answer

: Total is 6 points

: Two or more errors indicate high risk for cognitive impairment

APPENDIX 6 Choice of Medication and Antidote

Choice of medications for general population[23,56,58,59,60]

Medication	Route of administration / Dosage	Time to max plasma concentration	Approx. plasma half-life	Common side effects
First generation antipsychotics (FGA)				
Haloperidol	Oral (tablet) 5-10mg, repeat in 30-60min (Max 10-20mg) Paediatric: Oral 0.01mg/kg to 0.1mg/kg 12 hourly (Max. 0.5mg per day)	20min	20h	Acute dystonia **(refer to antidotes)** Parkinsonism **(refer to antidotes)** Neuroleptic Malignant Syndrome Seizure
	IM (Haloperidol lactate) 5mg, repeat in 30-60min (Max 10-20mg) Paediatric: IM 0.025-0.075mg/kg/dose (Max 2.5mg) Adolescent >12 years can receive the adult dose (2.5-5mg)			
Second generation antipsychotics (SGA)				
Olanzapine	Oral (dispersible tablet) 5-10mg/dose (usually single dose)	6h	21-54h	As haloperidol (but less common motor disturbance) Metabolic syndrome
Risperidone	Oral (tablet/ solution) 0.5-1mg/dose (usually single dose) Paediatric: 0.02mg/kg 12-24Hrly	1h	20h	As haloperidol (but less common motor disturbance) Hyperprolactinemia

	Oral tablet or solution, max 0.15mg/kg			
Benzodiazepines (BZN)				
Lorazepam	Oral (tablet) 1-2mg, repeat in 30-60min (Max 4-8mg) Elderly or frail half of adult dose IM 4mg/ml must be diluted 1:1 with water for injection or normal saline (Max 4mg) Elderly or debilitated half adult dose <u>Paediatric</u> (6-12 year old): PO / IM 0.05mg/kg (Max 4mg/dose)	30-60min	12.9h	Over sedation **(refer to antidotes)** Respiratory depression Paradoxical agitation Abuse/Dependence
Diazepam	Oral (tablet) or IV 5-10mg, repeat in 30-60min (Max 20-60mg) <u>Paediatric:</u> 0.1-0.4mg/kg IV or PR *Do NOT give as IM or IV infusion 0.04-0.2mg/kg 8-12 hourly oral Maximum dose: 10mg (IV), 20mg (PR)	30-90min	3 to 7days	
Midazolam*	IM 0.07-0.08mg/kg (Usual dose 5mg) <u>Paediatric:</u> 0.1-0.2mg/kg, up to 0.5mg/kg	30-60min	1-4h	

Parenteral Midazolam should ONLY be used in settings where specialized resuscitation is available [22-26]

Antidotes for general & paediatric populations[23,57,58]

Antidotes			
Medication	**Indication**	**Administration**	**Side effect/Caution**
Flumazenil	Benzodiazepine overdose	Adult: 0.2 mg IV over 30 sec (IF no response after 1min, administer 0.5 mg over 30 sec, at 1min interval) Max dose: 3mg Paediatric: 5mcg/kg IV every 60sec to max total 40mcg/kg	Confusion Convulsion Arrhythmia Autonomic instability
Orphenadrine	Acute dystonia (due to antipsychotics)	Adult: 60mg IM/ IV, 12Hrly (Max.dose 120mg/ day) Paediatric: 1-2mg/kg 8Hrly Oral	Anaphylaxis, Anticholinergic side-effect (dry mouth, constipation, urinary retention, confusion, hallucination)
Procyclidine (Kemadrin)	Acute dystonia (due to antipsychotics)	Adult: 5-10mg IM/ IV, repeat after 20min if necessary (Max dose 20mg/ day) Paediatric: 0.05-0.2mg/kg 6-8Hrly Oral.	Anticholinergic side-effect (dry mouth, constipation, urinary retention, confusion, hallucination)
TrihexyPhenydil (Artane)	Parkinsonism	Adult: 2mg Oral, 8-12Hrly (Max dose: 4-6mg/day)	Anticholinergic side-effect (dry mouth, constipation, urinary retention, confusion, hallucination)

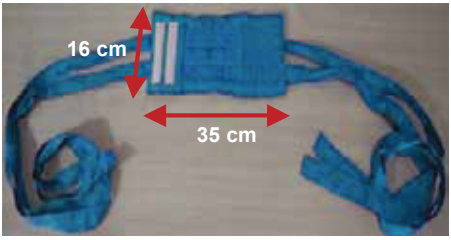
		Paediatric: >3yr: 0.02mg/kg Oral, 8Hrly, can be increased up to to 0.1-0.3 mg/kg 8Hrly	
Diphenhydramine hydrochloride	Acute dystonia (due to antipsychotics)	Paediatric: 1-2mg/kg 6-8Hrly Oral	Sedation, dizziness, disturbed coordination, anticholinergic side-effect (dry mouth, constipation, urinary retention, confusion, hallucination)

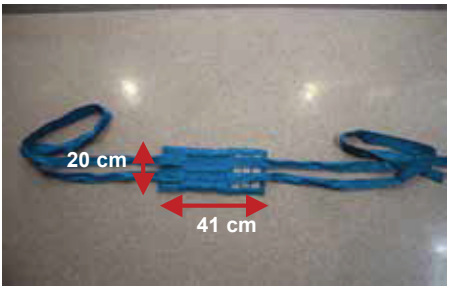
APPENDIX 7

THE FOUR-POINT RESTRAINT

THE Four-point restraint is an application of limb restraints on both arms and legs using soft, padded cuffs that are wrapped around the aggressive patient's wrists or ankles, and attached to the frame of the bed.

RESTRAINT MEASUREMENT



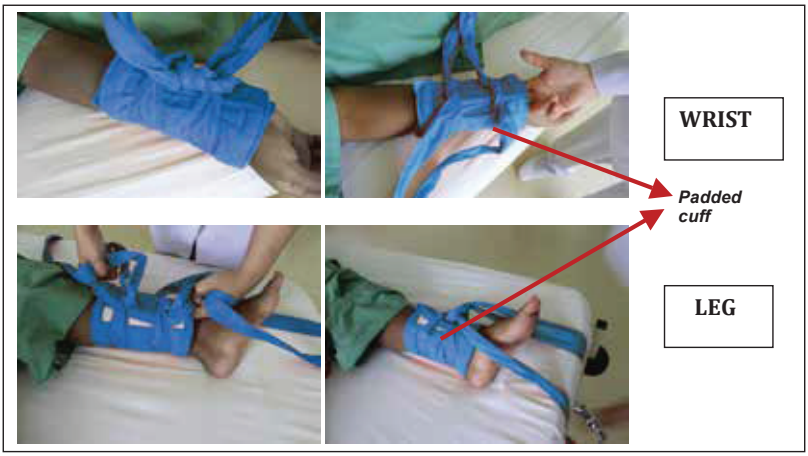


Hands Strap :
Length : 35 cm
Width : 16 cm

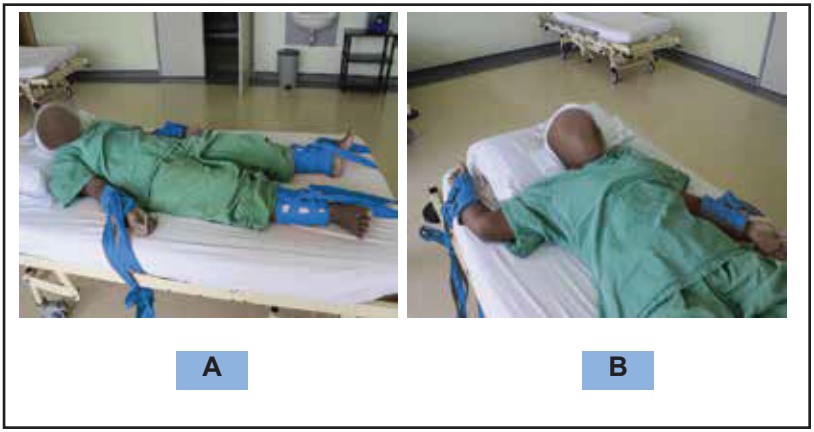
Length of the restrainer :
Length : 295 cm
Width : 3.5 cm

Legs Strap :
Length : 41 cm
Width : 20 cm

RESTRAINT PROCEDURE



PATIENT POSITIONING FOR FOUR-POINT RESTRAINT



Positioning the patient in the supine position is the preferred option. Position of the hand should be changed hourly. The head of the bed should be **elevated to approximately 30 degrees** to decrease the risk of aspiration. See the image below.

Position B is preferred than Position A as it is more secure and less exhaustive.

Positioning the aggressive patient in the ***prone position increases the risk of suffocation*** and should only be used as a secondary option. Do not use any pillows under the aggressive patient's head in this position.

Approach to Four-Point Restraint

- Ideally, there should be a five-member team, with one leader and one member for each limb.
- Explain to the aggressive patient what you are doing as the restraints are being applied and the reason/s for it.
- Each member applies a restraint to each limb in a coordinated manner, and then secures the restraint to the base of the bed or stretcher. Do not apply the restraints to bed rails.
- Restraints may need to be applied one at a time while the other limbs are held down. Healthcare providers should be familiar with the restraints used by their settings and how to tie quick-release knots.
- After the restraints are secured, all aggressive patient's limbs should be examined for any signs of circulatory compromise.
- Offer the patient medication, but if necessary, administer medication or chemical restraints involuntarily.

The patient should be continually assessed, monitored, and re-evaluated.

APPENDIX 8

RESTRAINTS: DOCUMENTATION

Restrain Chart

Name of Patient: .....

IC No/MRN: ..... Ward: .....

Restrain Applied On: Date: ..... Time .....

Reason(s) for restrain: .....

.....

Restrain Removed On: Date: ..... Time: .....

Restrain Ordered by:

.....
(name & signature)

Restrain Released by:

.....
(name & signature)

Time	**Behaviour**	**Observations**			**Intake** (If Fluids, estimate volume)	**Toileting** (offered 4-hourly)	**Name & Signature**
		Pulse	BP	Colour			

Time	Behaviour	Observations			Intake (If fluids, estimate volume)	Toileting (offered 4-hourly)	Name & Signature
		Pulse	BP	Colour			

Review of need for further restrain:

Is further restrain necessary? Are the conditions that exists prior to restrain being applied still present? Reason for continued restrain?

Date: **Decision:** ☐ Release ☐ Continue Restrain

Note: Restrain is only to be used as a last resort

APPENDIX 9

BREAKAWAY TECHNIQUES

http://jknpenang.moh.gov.my/jknpenang/index.php/en/artikel-hpp/551-video-jabatan-psikiatrik-dan-kesihatan-mental-hpp
or
https://drive.google.com/uc?export=download&id=0BxQrixbtrE5ranpUTUI5QWJKQ3M

*(*Courtesy of Department of Psychiatry and Mental Health, Hospital Pulau Pinang).*

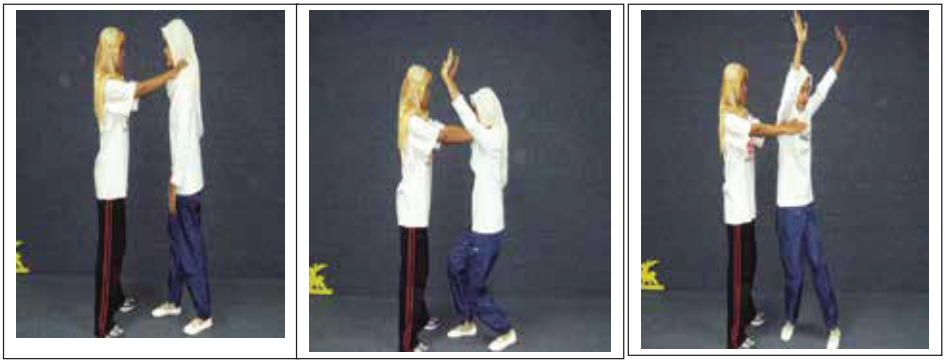
The objective of this technique is to escape when attacked by aggressive patient individually. This technique focuses on

- Changing the direction of attack
- Go towards the direction of attack so that the patient will lose his/ her balance
- Find a point of weakness in the limbs of the patient such as thumb, fingers and wrist to escape
- Using whole body strength towards the point of weakness

1. **Escape from hand grip**
    - When the aggresive patient holds the healthcare provider's hand, the healthcare provider should move towards the patient to weaken the patient's grip with their hand close to their body.
    - Then the healthcare provider pulls their hand by turning their whole body away from patient in circular motion using the strength of their whole body.

2. Escape from being strangled from the front (I)

- When strangled from the front, the healthcare provider lowers their body so that the patient loses his/ her balance while lifting both hands up at the same time.
- Then the healthcare provider turns their whole body away from the patient in an upward circular motion.



3. Escape from being strangled from the front (II)

- While strangled from the front, the healthcare provider lowers their body while holding both the hands together.

The healthcare provider pushes patient's hands from inside while moving upward.



When strangled from behind, the healthcare provider lowers their body so that the patient loses his/ her balance while lifting both hands up at the same time.

Then the healthcare provider turns their whole body away from the patient in an upward circular motion.



5. Escape from clothing, tie and hair grab (front)

- When the patient holds the healthcare provider's clothing, the health care provider should lock the patient's wrist with both hands and pull his/ her wrist near to their body.
- The healthcare provider then steps close to the patient to weaken the patient's grip and at the same time puts pressure on the patient's wrist.
- While bending down, the healthcare provider pushes the patient's hand down to increase the pressure on the patient's wrist till the healthcare provider escapes.
- This technique can be used for tie grab. The healthcare provider needs to bring the patient's wrist close to their body to ensure that patient's wrist is locked firmly.
- This technique can also be used for hair grabbed from the front. The healthcare provider needs to ensure that his wrist is locked tightly above the healthcare provider's head before moving towards the patient. Use the same technique of lowering the body to increase pressure on the patient's wrist till the patient releases the healthcare provider's hair.
- If the patient's wrist is not locked tightly at the body or head, this technique will not work.

6. Escape from clothing, hair or head scarf grab (back)

- When the patient holds the head scarf of the healthcare provider from behind, the healthcare provider steps backward towards the patient to loosen the patient's balance while at the same time ensuring that the patient's wrist is locked firmly above the healthcare provider's head.
- Then the healthcare provider turns their body towards the patient.
- If the patient is still holding the head scarf after turning, continue turning till escape.
- This technique can also be used for head scarf grabbed from the front.

7. Escape from patient's bite

- When the patient bites the healthcare provider's hand, the healthcare provider should push their hand towards the patient's face (the aim is to reduce injury when bitten by patient and to weaken the strength of the bite).
- If the patient continues bitting, the healthcare provider should insert their fingers into the attacker's nose and push upwards.
- This technique can be used for bites at other parts of the body.
- The aim is not to pull the healthcare provider's hand away from the patient's mouth but to push it towards his/ her face.

8. Escape from being grabbed from behind

When grabbed from behind, the healthcare provider takes a step backward so that the patient loses his/ her balance.

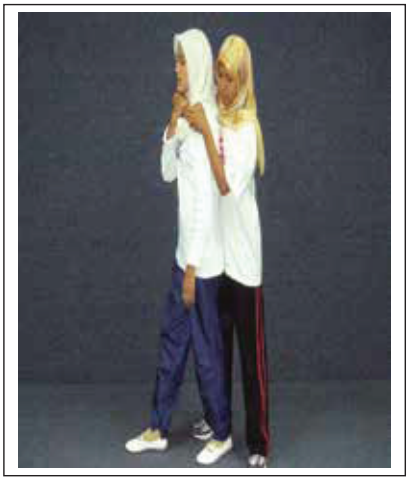
Look for the patient's thumb and pull it outward using the strength of the whole body till escape from the patient is possible.

Both steps must be done together without delay.

Therefore the healthcare provider must look for the patient's thumb before taking a step behind.

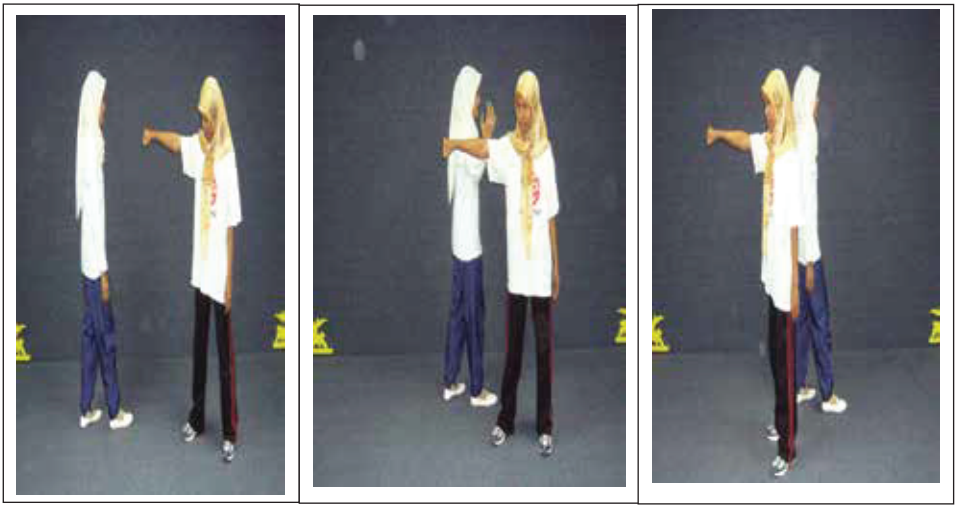
9. Escape from arm strangle from behind

- When the patient strangles the healthcare provider from behind with his/ her arm over the healthcare provider's neck, the healthcare provider should grab the patient's arm and pull it downward.
- With the other hand, try finding the patient's thumb while moving backward so that the patient loses his/ her balance.
- Quickly pull the patient's thumb outward using the strength of the whole body and then run away from the patient

10. Punching and Kicking

- When the patient punches at the healthcare provider, the healthcare provider moves forward while pushing the patient's hand away.
- Then the healthcare provider escapes by going behind the patient.
- This technique can be used to avoid being kicked.



- In conclusion, breakaway techniques should be reflective and used in conjunction with de-escalation. Training is essential for all health care providers. These techniques **SHOULD NOT** be used if the patient has a weapon.

APPENDIX 10

TRAINING PROGRAMME

TIME	AGENDA	TASK
8.00-8.15am	Registration Pre-test	
8.15-8.30am	Welcome address	
8.30-9.00am	Introduction Objectives Acts and Regulations	Slides and Interactive discussion
9.00-9.30am	Stages of aggression Risk factors Risk Assessment	Slides and Interactive discussion
9.30-10.30am	De-escalation Techniques	Slides, Interactive discussion and video presentation
10.30-10.45am	Tea break	
10.45-11.15am	Pharmacological intervention	
11.15-1.00pm	Practical Session -Control and Restraint -Breakaway	Practical Video presentation
1.00-2.00pm	Lunch break	
2.00-2.45pm	Action Card Documentation & Monitoring Debriefing Incident Reporting Special Situation	Slides and Interactive discussion
2.45-5.00pm	Case Vignettes (4 cases) Post-test Closing	Role play

14. **REFERENCE:**

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15. **DRAFTING COMMITTEE**

ADVISORS

Datuk Dr. Jeyaindran Tan Sri Sinnadurai
Deputy Director General of Health (Medical)
Ministry of Health Malaysia

Dato' Dr. Hj. Azman B. Abu Bakar
Senior Deputy Director
Medical Development Division
Ministry of Health Malaysia

Datin Dr. Nor Akma Binti Yusuf
Deputy Director
Medical Development Division
Ministry of Health Malaysia

Dr. Toh Chin Lee
Senior Consultant Child and Adolescent Psychiatrist
Hospital Selayang
Head of Psychiatric Services
Ministry of Health, Malaysia

CHAIRPERSONS

Dato' Dr Nor Hayati Arif
Senior Consultant Psychiatrist
Hospital Pulau Pinang

Dr Siti Nor Aizah Ahmad
Consultant Psychiatrist
Hospital Kuala Lumpur

MEMBERS

Dr Abdul Kadir Abu Bakar
Senior Consultant Psychiatrist
Hospital Permai

Dr Anita Codati
Psychiatrist
Hospital Keningau

Dr Azizah Saie
Psychiatrist
Hospital Umum Sarawak
Kuching, Sarawak

Dr Choo Shell Pinn
Psychiatrist
Hospital Taiping, Perak

Dr Fariza Yahya
Psychiatrist
Hospital Kuala Krai, Kelantan

Dr Lazli Bakar
Consultant Psychiatrist
Hospital Sultan Ahmad Shah
Temerloh, Pahang

Dr Ng Su Huey
Psychiatrist
Hospital Bahagia Ulu Kinta
Tanjung Rambutan, Perak

Dr Nurzuriana Md Zaki
Psychiatrist
Hospital Kuala Lumpur

Dr Ruzita Jamaluddin
Psychiatrist
Hospital Tuanku Fauziah
Kangar, Perlis

Dr Sapini Yacob
Psychiatrist
Hospital Putrajaya

Dr Tiong Chea Ping
Psychiatrist
Hospital Bentong
Pahang

Dr Zuraida Ahmad
Psychiatrist
Hospital Bukit Mertajam
Pulau Pinang

REVIEW COMMITTEE

Dato' Dr Abdul Jamil Abdullah
Senior Consultant Surgeon
Hospital Sultanah Nur Zahirah
Kuala Terengganu
Head, General Surgery Services
Ministry of Health, Malaysia

Datin Dr. Inderjeet Kaur Gill
Head of Medical Services Unit
Medical Development Division
Ministry of Health, Malaysia

Dr Faisal Salikin
Consultant Emergency Physician
Hospital Kuala Lumpur

Dr Fuziah Paimin
Family Medicine Specialist
Klinik Kesihatan Kajang, Selangor

Dr Kavitha Abamutu
Family Health Development Division
Ministry of Health, Malaysia

Dr Mohd Khairul Anwar Kamdi
Principal Assisstant Director,
Medical Care Quality Section
Ministry of Health, Malaysia

Datuk Dr Rohaizat Haji Yon
Deputy Director
Medical Development Division
Ministry of Health, Malaysia.

Dr Ngau Yen Yew
Senior Consultant Physician
Hospital Kuala Lumpur

Dr Nor'Aishah Abu Bakar
Public Health Physician
Head of Patient Safety Unit
Medical Care Quality Section
Medical Development Division
Ministry of Health, Malaysia

Dr Nur Hanani Mat Daud
Principal Assistant Director
Medical Development Division
Ministry of Health, Malaysia

Dr Mohd Syazmin Zuwary Mohd Sharial
Principal Assisstant Director
Medical Care Quality Section
Ministry of Health, Malaysia

Dr Rosidah Ibrahim
Emergency Consultant Physician
Serdang Hospital, Selangor

Dr Salamah Nordin
Family Medicine Specialist,
Klinik Kesihatan Batu 9
Cheras, Selangor

Dr Zalina Abd Razak,
Head & Consultant
Anaesthesiologist
Department of Anaesthesiology
Putrajaya Hospital

Dr Adibah Hani Bt Haron
Senior Principal Assistant Director
Medical Development Division
Ministry of Health, Malaysia

Dr Nor Azilah Binti Abu Bakar @ Mansor
Senior Principal Assistant Director
Medical Development Division
Ministry of Health, Malaysia

PROOF READ BY :

Dr Eni Rahaiza bt. Muhd Ramli
Consultant Child and Adolescent Psychiatrist
Taiping Hospital
Taiping, Perak

Dr Selvasingam Ratnasingam
Consultant Child and Adolescent Psychiatrist
Hospital Umum Sarawak
Kuching, Sarawak

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