Safety Assessment

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Disclosure: Liliya Gershengoren MD

With respect to the following presentation, in the 24 months prior to this declaration there has been no financial relationship of any kind between the party listed above and any ACCME-defined ineligible company which could be considered a conflict of interest.

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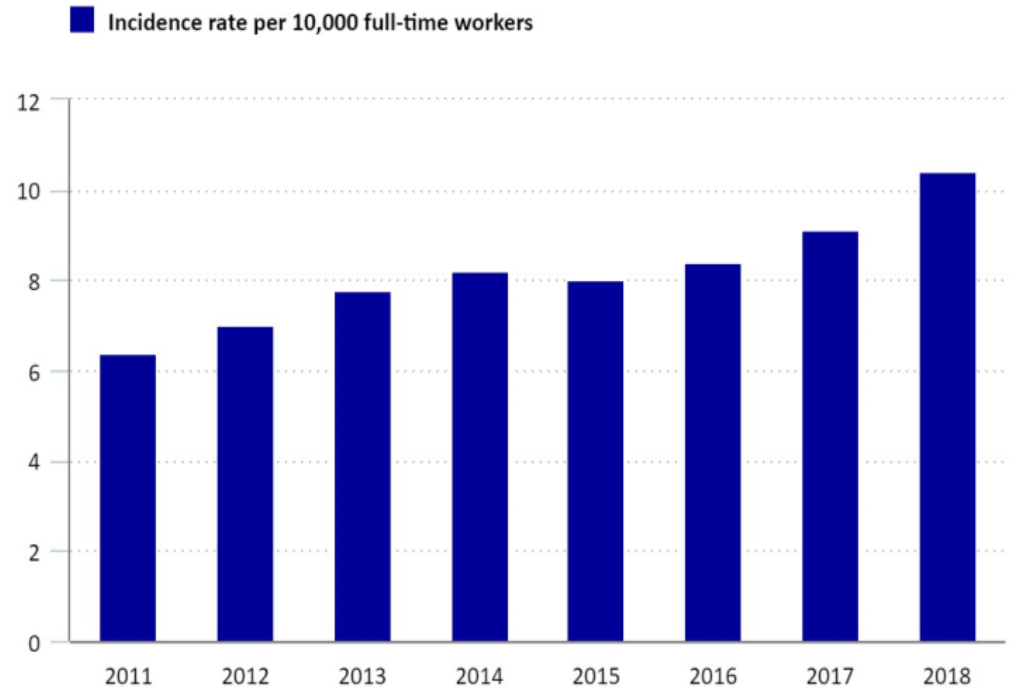
Learning Objectives

1. Recognize the risk and protective factors pertinent to safety assessments
2. Identify different etiologies of agitation
3. Become familiar with the stepwise approach to manage acute agitation

Violence in Healthcare

In 2017, the Bureau of Labor and Statistics reported that healthcare workers are five times more likely to experience violence on the job than the average worker in the United States.

Chart 1. Incidence rate of nonfatal workplace violence to healthcare workers, 2011-18



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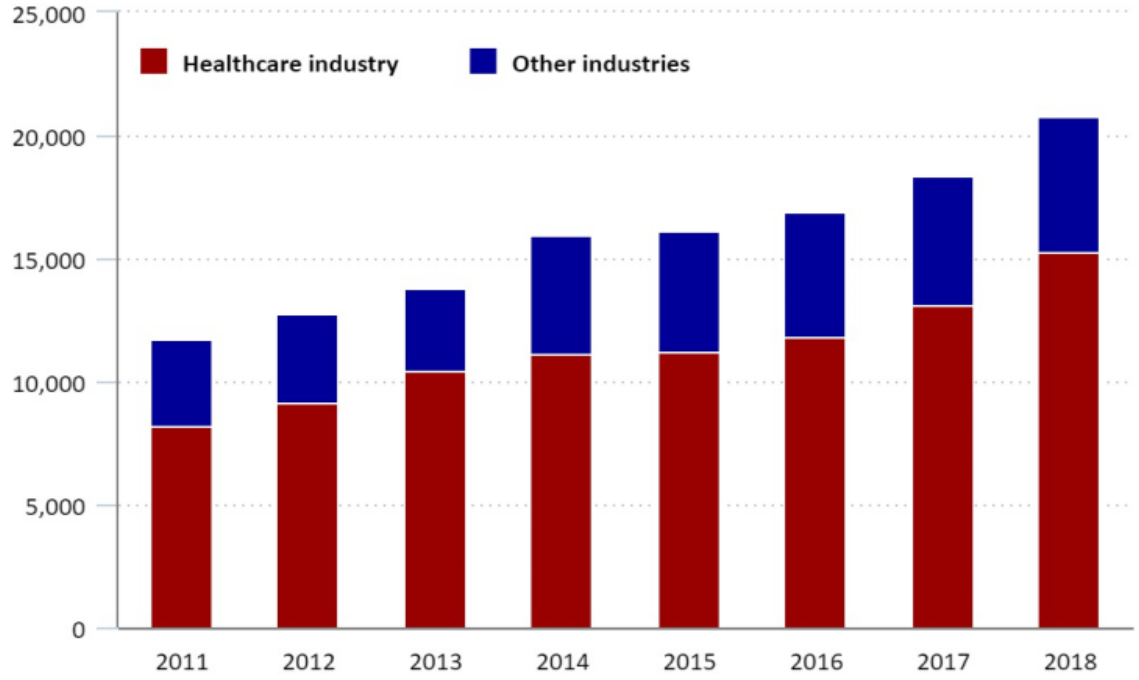
Source: U.S. Bureau of Labor Statistics.

Chart 2. Number of nonfatal workplace violence injuries and illnesses with days away from work, 2011-18



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Source: U.S. Bureau of Labor Statistics.

What is Agitation?

Nonaggressive behaviors	Aggressive behaviors
Restlessness (akathisia, fidgeting)	Physical
Wandering	Combativeness, punching walls
Loud, excited speech	Throwing or grabbing objects, destroying items
Pacing or frequently changing body positions	Clenching hands into fists, posturing
Inappropriate behavior (disrobing, intrusive, repetitive questioning)	Self-injury (repeatedly banging one's head)
	Verbal
	Cursing
	Screaming

Safety First

1. The patient's, caregivers', and healthcare workers' safety
    a. Is there a behavioral intervention team?
2. Prompt detection or exclusion of life-threatening medical and psychological conditions
    a. A comprehensive differential diagnosis is considered to discover or rule out other common etiologies

Universal safeguards during the initial evaluation:

1. Searching and disarming of patients on a regular, non-confrontational, and nondiscriminatory basis
2. Interviewing in a calm, quiet, private, but non-isolated environment
3. Objects that could be used as weapons are not allowed in the environment
4. Observation of non-verbal cues

Critical Information

Critical information elicited from the primary team

1. Timing of agitation
2. Nature of agitation
3. Concomitant substance use
4. Medication details: changes, new medicines, stopped any medicine
5. Adherence to medications
6. Other medical conditions

Etiology of Agitation

Primary psychiatric conditions	Medical conditions
Delirium	Head injury
Dementia	CNS infections- meningitis, encephalitis
Substance intoxication (alcohol, cannabis, cocaine, stimulants, hallucinogens, inhalants)	Encephalopathies (hepatic, renal, etc.)
Substance withdrawal (alcohol delirium)	Brain tumors/metastases
Schizophrenia	Stroke
Bipolar affective disorder	Wernicke-korsakoff's psychosis
Agitated depression	Metabolic abnormalities (electrolytes, glucose, calcium, etc.)
Anxiety disorder	Hypoxia
Personality disorder-antisocial	Toxins/poisoning
Autism/intellectual disability	Hormonal (thyroid dysfunction)
Posttraumatic stress disorder	Seizure (postictal state)
	Adverse effects/toxicity of mediations

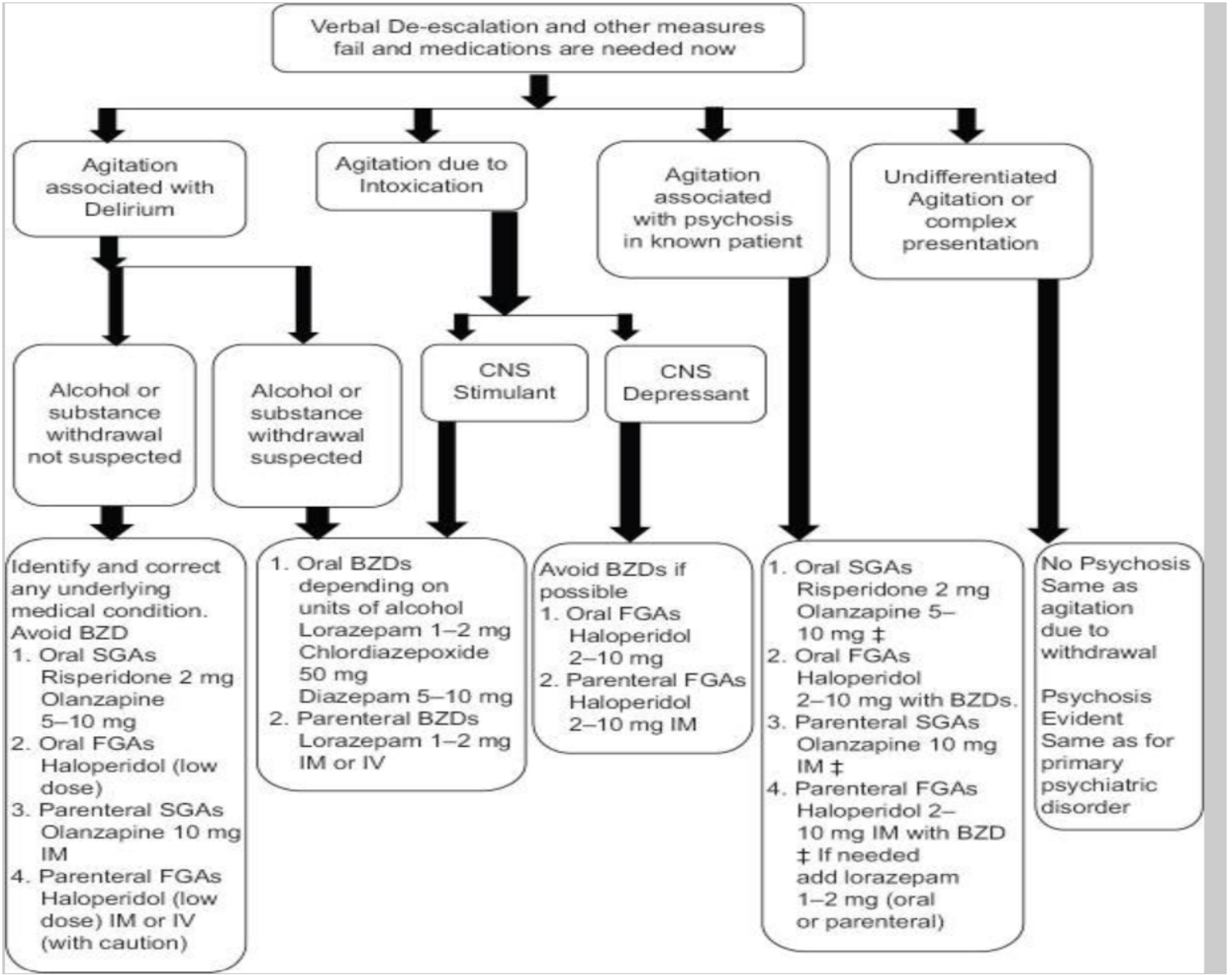
CNS – Central nervous system

Verbal/Nonverbal Interventions

Nonverbal	Verbal
Maintain a safe distance	Speak in a calm, more transparent tone
Maintain a neutral posture	Personalize yourself
Do not stare; the eye contact should convey sincerity	Avoid confrontation; offer to solve the problem
Do not touch the patient	
Stay at the same height as the patient	
Avoid any sudden movements	
Aligning goals of care	Monitoring intervention progress
Acknowledge the patient's grievance	Be acutely aware of progress
Acknowledge the patient's frustration	Know when to disengage
Shift the focus to a discussion of how to solve the problem	Do not insist on having the last word
Emphasize common ground	
Focus on the big picture	
Find ways to make small concessions	

Factors To Consider: Medication

- Patient's details: Age, gender, comorbid medical conditions, substance use, allergies
- Agitation details: Cause, presentation
- Pharmacological considerations: Route of administration, rapidity of action, duration of action, adverse effects and interaction with other medications, past good response to any particular psychotropic
- Patient's preference of route of administration
    - Route of administration
        - Oral: Tablets or syrups can be preferred if the patient accepts
        - IM/IV: Helps in rapid elevation of drug plasma levels and faster onset of action
          (IV Haldol requires telemetry)


Verbal De-escalation and other measures fail and medications are needed now
Agitation associated with Delirium
Agitation due to Intoxication
Agitation associated with psychosis in known patient
Undifferentiated Agitation or complex presentation
Alcohol or substance withdrawal not suspected
Alcohol or substance withdrawal suspected
CNS Stimulant
CNS Depressant
Identify and correct any underlying medical condition.
Avoid BZD
1. Oral SGAs Risperidone 2 mg Olanzapine 5–10 mg
2. Oral FGAs Haloperidol (low dose)
3. Parenteral SGAs Olanzapine 10 mg IM
4. Parenteral FGAs Haloperidol (low dose) IM or IV (with caution)
1. Oral BZDs depending on units of alcohol Lorazepam 1–2 mg Chlordiazepoxide 50 mg Diazepam 5–10 mg
2. Parenteral BZDs Lorazepam 1–2 mg IM or IV
Avoid BZDs if possible
1. Oral FGAs Haloperidol 2–10 mg
2. Parenteral FGAs Haloperidol 2–10 mg IM
1. Oral SGAs Risperidone 2 mg Olanzapine 5–10 mg ‡
2. Oral FGAs Haloperidol 2–10 mg with BZDs.
3. Parenteral SGAs Olanzapine 10 mg IM ‡
4. Parenteral FGAs Haloperidol 2–10 mg IM with BZD ‡ If needed add lorazepam 1–2 mg (oral or parenteral)
No Psychosis Same as agitation due to withdrawal
Psychosis Evident Same as for primary psychiatric disorder

Factors to Consider: Physical Restraints

- What are the objectives of physical restraint?
- What are the risks associated with particular physical restraint?
- Management plan of anticipated risks associated with the particular restraint plan
- Consensus about the exact timing of using a specific physical restraint
- Patient-specific risk factors: age, gender, degree of cooperation, possible intoxication, any medications given, presence of cardiovascular, respiratory, neurological, or musculoskeletal disorders
- Availability of emergency medicines, oxygen, required medical equipment
- Vulnerability to significant psychological trauma, especially for minors and the elderly
- Any cultural connotations

Physical Restraints

Indications	Contraindications
Risk of imminent harm to self	Unstable medical condition
Risk of imminent harm to others	Severe drug reaction or overdose
Serious destruction to the environment	Punishment
Patient's voluntary reasonable request	Staff convenience
Decrease sensory overstimulation*	If experienced by the patient as positive

Adverse Outcomes Related to Physical Restraints

Patient-related adverse events	Staff-related adverse events
Asphyxiation	Spit upon
Choking/aspiration	Fracture or skin injury
Dehydration	Eye injury
Joint injuries	Permanent disability
Blunt chest trauma	Adverse emotional reactions (e.g., sadness, guilt, self-reproach, retribution)
Skin problems (e.g., Bruising)	
Cardiac arrest/death	
Rhabdomyolysis	
Thrombosis (e.g., PE, DVT)	
Escaping restraint	
Escalating agitation	
Re-traumatization	
Emotional distress	
Feelings of humiliation, fear, dehumanization, isolation, being ignored	

Special Populations

Acute Agitation in Pregnancy

- The same initial steps for assessment and de-escalation should be used in pregnant patients as in non-pregnant patients
  - Verbal interventions should be utilized whenever possible
- If medication is required, the minimal effective dose should be utilized
  - for mild to moderate cases of agitation, oral or intramuscular diphenhydramine 25-50 mg may suffice;
  - for severe agitation, haloperidol is the medication of choice, oral or parenteral 2-5 mg

Elderly Patients

- Agitation in elderly patients in the hospital setting should be presumed to be delirium until proven otherwise if the mental status is altered
  - Constipation, urinary retention, untreated pain, etc
- Non-pharmacological strategies first
- Cautious use of antipsychotics is recommended: start with low doses (e.g., risperidone 0.5 mg) and slowly titrate with small increments; monitor closely for signs of confusion or over-sedation

Awareness of Bias

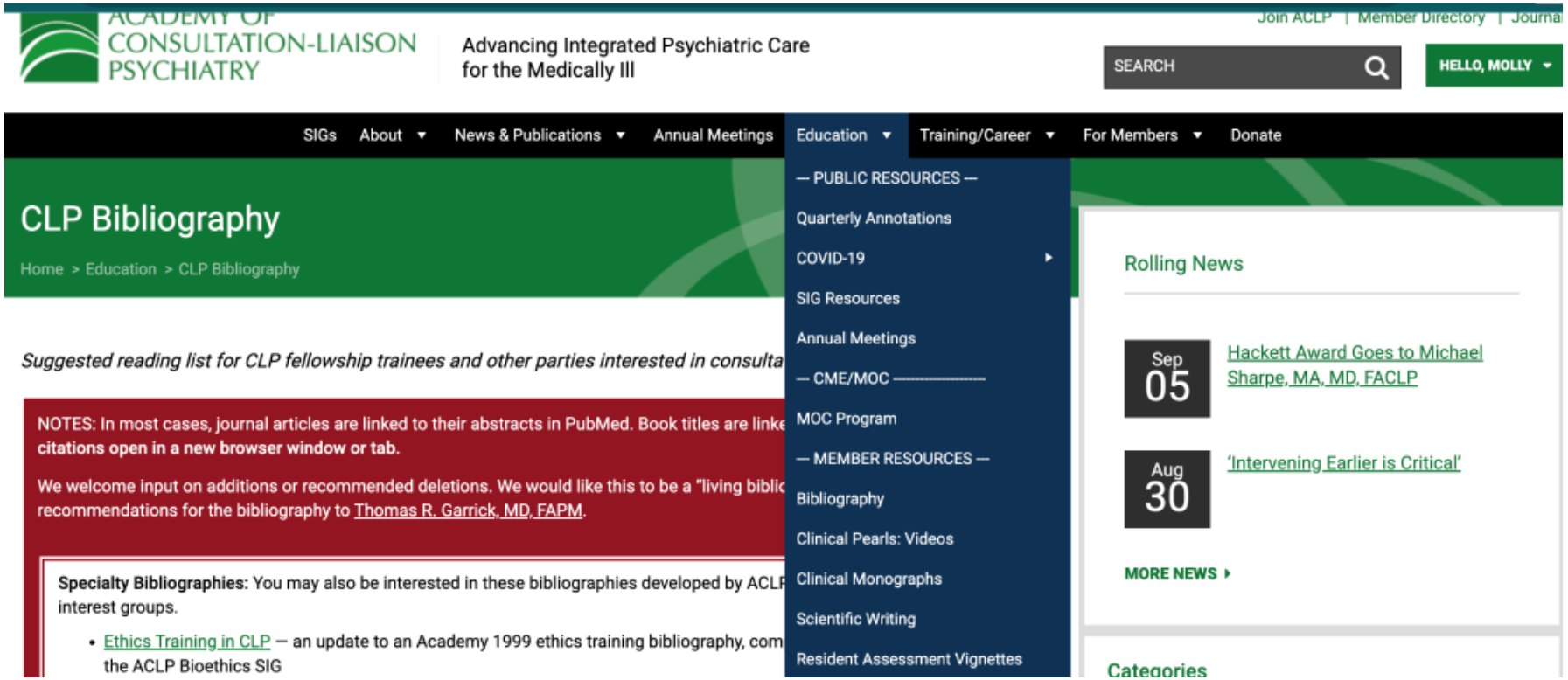
- Addressing agitation and violence in the clinical setting is a high stress encounter that has the potential to exacerbate underlying biases
- Increased likelihood of utilizing physical restraints for black patients (Schnitzer et al 2020)
- Black patients and their visitors have been shown to be twice as likely to have security called as their white peers (Green et al 2018)
- Mitigating strategies:
  - Incorporating training around bias
  - Recruiting a diverse workforce
  - Trauma-informed care (Agboola et al 2021)

Clinical Pearls

- Consider possible etiologies of agitation
- Verbal de-escalation should be attempted first
- Offer oral medications to agitated patients prior to parenteral medications
- Choice of medication may be based on the suspected etiology of agitation
- Restraints should be avoided
- Consider possible sources of bias and mitigating strategies

ACLP resources

- Education tab → Bibliography → acute agitation
  - https://www.clpsychiatry.org/educationcareers/clp-bibliography/
- Education tab → Resident assessment vignette on acute agitation



Clinical Case

Chief Complaint: "Hospitalized for acute exacerbation of Crohn's Disease"

History of Present Illness: John Doe, a 28-year-old male with a known history of Crohn's Disease, presented to the hospital with a 1-week history of worsening abdominal pain, bloody diarrhea, and weight loss. Due to the severity of the symptoms, he was admitted for an acute exacerbation of his condition.

Hospital Course: John's medical management was initiated with IV steroids and hydration therapy. His response to the treatment was favorable with a decrease in abdominal pain and an improvement in his diarrhea. Diet was gradually advanced from clear liquids to a regular diet as tolerated.

Incident: On the third day of admission, John became agitated and threatened to punch the nurse. No physical contact occurred, and the nurse was able to de-escalate the situation temporarily by leaving the room and alerting the medical team.

Psychiatric Consult: Given the potential for violence, a consult was placed to the psychiatry service for a safety assessment. The medical team would like to put the patient in restraints or transfer him to inpatient psych

Question 1: What are the common causes of agitation in hospitalized patients?

Clinical Case

Day 3 of admission: Upon further clarification, the nurse shares that the patient become agitated due to the late delivery of his breakfast and then threatened physical violence

Question 2: What immediate actions should the nursing staff take in this situation?

Question 3: What are key components of a psychiatric safety assessment?

Question 4: How can the interdisciplinary team work together to prevent future incidents of aggression?

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