Code White! How to wind down the wound-up patient in the ED

25th Annual Update in Emergency Medicine
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Declaration of disclosure

- I have no actual or potential conflict of interest in relation to the program

Objectives

- Identify important warning signs to be aware of when dealing with agitated patients, and how to de-escalate
- Understand the proper use of physical restraints and pitfalls to avoid
- Understand which chemical restraints work best in the acutely violent patient
- Special considerations in management eg. elderly

How many of you have been assaulted (physically or verbally) by a patient while at work?

Did you know...

- Up to 50% of human service providers become victims of violence at some point in their career
- Among hospital workers, the majority of assaults occur in the ED, psychiatric wards, waiting rooms and geriatric units
- An average ED wait time of at least 2 hours is significantly associated with an increased incidence in violence

ED Environment

Potentially volatile
24-hour open door policy
High stress, illness, prolonged wait times
Frequent lack of communication

ED Environment

Carriage of weapons in ED population estimated at 4-8%
Accessibility to drugs...weapons....people

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Case 1

Case 1

- An 22 year old male presents at triage complaining of shortness of breath and chest pain
- He is paranoid and is pacing
- The nurses are unable to get his vitals
- During the assessment he gets up and decides to leave

What would you do next?

- Let him leave the ED - he looks fine
- Block the exit with your body
- Give him an injection of haldol IM
- Try to talk to him and convince him to stay and be assessed
- Get help

Predicting violence is challenging in the ED

- Difficult to identify -assault may come from patient, visitors or family members eg. parents of ill children
- Prediction, prevention and control of violent outbursts is difficult in ED environment

Risk Assessment

- Strongest positive predictors:
  - male gender
  - prior history of violence
  - drug or ethanol abuse
- Psychiatric illness esp. manic
- Altered mental status

"While imperative to deal effectively with violence in the ED, it's better to recognize signs of impeding violence and to prevent violence before it happens"

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Risk Assessment

- Consider all angry patients potentially violent
- Increased motor activity is most consistent sign of impending attack eg. provocative behavior, angry demeanor, pacing, loud speech, tense posture, frequent changes in body position, pounding walls, throwing things
- Beware: patients with acute medical illness may erupt violently without warning

Case 1

- You talk to the patient and convince him to come in for an assessment
- The patient is placed in monitored bed area in a private room, visible to the nursing station
- Security is called for a patient watch
- What steps should you take next?

Case 1

- Anticipate potential for escalation / violence
- Be prepared for chemical / physical restraint of patient
- FORM 1 the patient?
- Examine the patient and investigate for possible organic causes for their presentation

4 screening criteria for organic illness

1. Disorientation
2. Abnormal vital signs - always document temperature in all patients undergoing medical clearance
3. Clouded consciousness
4. No previous psychiatric history

Diagnoses associated with violence

- **"FIND ME"**
- Functional
- Infectious
- Neurologic
- Drug-related
- Metabolic
- Endocrine

What is the single most important test in violent patients with no psychiatric history?

De-escalation techniques

- Make patient as comfortable as possible
- Act as friendly host to establish trust ie offer chair, something to eat or drink (NO HOT LIQUIDS)
- Be an attentive listener
- Never, ***ever*** touch a violent patient

De-escalation techniques

- "No surprises" - do not make any sudden movements or come up from behind
- Stand at least 1 arms length away
- Be aware of your own reaction to the patient - avoid showing anger towards patient (countertransference)
- Do not deny or minimize threatening behavior, as increases your risk of injury - you are not untouchable as an MD

De-escalation techniques

- KEY MISTAKE TO AVOID: Failing to address the violence directly.
- eg. I can't help you when you threaten me or staff...Do you carry a weapon?...You look angry.

Physical restraints

Physical restraints

- If verbal techniques for de-escalation are not successful, you need to control the situation quickly
- Indication: prevention of imminent harm to patient, others and environment
- ED protocol should be in place
- Restraint team of 5+ people recommended

Procedure

- Enter room in force displaying a professional attitude
- Explain procedure, instruct patient to cooperate
- Apply restraints
- Good documentation
- Medical evaluation

Technique

- Use leather restraints if possible, as less constricting than softer restraints and stronger
- Tie restraint to solid frame of bed, not side rails
- Soft Philadelphia collar to neck minimizes head banging and biting
- Supine with head elevated is optimal, prevent aspiration

Pitfalls to avoid

- Monitor frequently with standardized form for documentation
- Change positions to prevent neurovascular sequelae eg. circulatory obstruction, paresthesias, rhabdomyolysis
- Ensure adequate chest ventilations if using chest restraints
- Remove restraints as soon as patient is cooperative

Chemical restraints

Chemical restraints

- Rapid tranquilization (RT) allows for quick chemical control of agitated patient
- Calms patient for proper evaluation and treatment, prevent patient harm to self or others
- Prevents morbidity and mortality risks from continued struggling in restraints i.e. rhabomyolysis
- Butyrophenones + benzodiazepines optimal for containing aggression

True or false?
An acutely psychotic patient has the right to refuse tranquilizing medication

Chemical restraints

- Acute sedation of violent patient
- Haloperidol (Haldol) 2-10 mg IV/IM q 20-30 min (max 6 doses in 24 hrs) OR Droperidol (Inapsine) 2-5 mg IV/IM q 20-30 min AND/OR
- Lorazepam 1-2 mg IV/IM q 30 min prn up to 120 mg/24 hr
- Combination superior to either drug alone - can be mixed in same syringe for one injection

Butyrophenones: Contraindications & Complications

Contraindications

- Avoid neuroleptics in:
  - pregnant and lactating females
  - PCP overdose
  - anticholinergic drug intoxication
- Butyrophenones controversial in sympathomimetic intoxication eg. cocaine, amphetamines

Complications

- Most common adverse side effect : Extrapyramidal symptoms (EPS)
- EPS NOT dose-related ie can occur after 1 dose
- Dystonic reaction eg. torticollis, opisthotonus, oculogyric
- Akathesia - feeling of severe restlessness
- Incidence <1%

Complications

- Neuroleptic malignant syndrome (NMS) - idiosyncratic reaction to neuroleptics
- S/S: altered mental status, hyperthermia, autonomic lability (BP), lead-pipe rigidity of muscles
- Incidence: 1%
- Rx: rapid cooling, muscle relaxants eg. benzo, dantrolene
- R

Complications

- Conduction disturbances:
- Prolonged QT interval & torsade de pointes
- Usually in middle age to older patients with pre-existing heart disease
- Also associated with high doses eg. 50 mg-2300 mg in 24 hrs

Atypical antipsychotics

- Use for *known psychiatric illness*, cooperative patient
- eg. Olanzapine (zydiss/zyprexa), ziprasidone (zeidox), quetiapine (seroquel), respiridone
- Lower EPS rates
- Olanzapine has smallest effect on QTc at therapeutic dose
- Research studies have shown rapid decreases in acute agitation with olanzapine and ziprasidone IM (with less EPS) in schizophrenia vs haldol IM

Benzodiazepines: Types and Complications

Drug choices for RT

- Lorazepam (Ativan) best
- Rapid onset, effectiveness and short half-life
- No active metabolites
- Works rapidly IM compared to other benzos
- Midazolam (Versed) similar IM, but shorter half life
- Works well in agitation due to alcohol or drug intoxication

Complications

- Sedation
- Confusion
- Ataxia
- Nausea
- Respiratory depression - esp if patient already has ingested respiratory depressant eg. alcohol

Case 2

Case 2

- 68 year old male with schizophrenia and previous history of alcoholism presents with increased agitation and confusion from the nursing home
- Vitals: BP 180/100 P 110 T 37.0
- He is known to get frequent UTIs, and was just started on an antibiotic 2 days prior
- He strikes out at you and the nurse several times as you go to examine him

What would you most likely do?

- 4 point physically restrain him
- 2 point physically restrain him
- Use soft restraints instead of leather restraints
- Use only a chest restraint
- RT with Haldol and Ativan

Important pitfalls to avoid

- Use only half the dose for RT in the elderly, as more risk of side effects
- Cardiac monitoring if history of heart disease
- Check bedside glucose and all vital signs ie PO2
- Higher risk of organic illness, so never assume is just psychiatric

4 screening criteria for organic illness

- disorientation
- abnormal vital signs - always document temperature in all patients undergoing medical clearance
- clouded consciousness
- no previous psychiatric history

Beware

- 20% elderly patients with psychiatric presentation eg. agitation, paranoia may be suffering from a drug reaction
- Important to review patient's medication list and note any changes in medications either stopped or added recently

Other considerations

Policies & Procedures

- Hospital policy for security search of patient belongings in the ED
- Clear policy for when security can restrain patients ie Form 1 not necessary to complete by MD before restraining patient
- Protocol for management of violent patients with restraint record, specific documentation of why patient restrained
- Gunshot wound reporting - Ontario Bill 68

Staff training important

- Nursing staff complete online learning module annually regarding restraint use
- Security staff train the nurses on use of restraints
- Accredited course on Non Violent Crisis intervention completed every 2 years by RNs
- Emergency physicians should be better trained in dealing with violent patients - poorly taught in medical school and residency

Key points

- Be aware of the potential for violence in agitated patients early and de-escalate as soon as possible to prevent a "Code White" being called
- Screen for reversible organic disease even in your patients with known psychiatric disease - ensure vitals are done in all patients, esp temperature, bedside glucose
- The agitated elderly patient is at increased risk for an organic cause for their behavior change

Key points

- Restrained patients may need chemical sedation to prevent rhabdomyolysis
- Haloperidol and lorazepam combined is better than either drug alone in calming patients with less side effects
- Communicate clearly to other healthcare workers if you assess a patient is agitated, so that they treat them quickly and are not unknowingly at risk of violence

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