A. Purpose

The purpose of this policy is to reduce and prevent patient and staff injuries during high risk interactions in treatment settings. The policy serves to assist clinicians to identify patients at high risk for aggression, decrease the emergence of aggressive behaviors, and intervene to terminate episodes of aggression expeditiously and safely limiting or preventing injuries. This policy focuses on reducing injuries by avoiding or limiting staff-to-patient physical contact. Significant emphasis of this policy is placed on prevention and consistency, and is reflected in the ODMH-approved Crisis Intervention Training (CIT) program.

B. Introduction

1. Promoting safety and preventing injuries to patients and staff is a priority during interactions with patients. This document provides information about techniques and strategies to resolve crises and minimize injuries without physical contact with patients. Most injuries to staff in treatment settings occur during staff-to-patient physical contact, particularly in pre-crisis or crisis situations. Similarly, most injuries to patients in treatment settings occur during patient-to-patient physical contact. Aggressive behavior is often predictable and preventable through non-physical intervention.

2. Information is available that can be used to assist staff to identify risks. Reports of past and recent aggressive behaviors and direct patient observation provide valuable information to prevent crises. Early detection of risks leads to initiation of behavioral and/or pharmacologic interventions to prevent or minimize aggressive behaviors. Knowing what interventions have been helpful or not helpful in the past guides a proactive plan to preempt dangerous behaviors. For patients admitted acutely to a Regional Psychiatric Hospital (RPH), information about assessments (e.g. urine toxicology screens, laboratory results) should be expeditiously obtained and reviewed.

3. To reduce incidents that may lead to injuries, staff should employ a multi-modal approach and interdisciplinary, trauma-informed, proactive intervention. The policy describes appropriate early staff intervention to maximize safety; recommended actions when symptoms of aggression erupt; and necessary debriefing, communication and medication reevaluation after an episode of aggression. In the final section, the policy outlines a staged process for the clinician role in the treatment paradigm for safe and quality care, including psychotropic medication specifics.

C. Proactive intervention
1. A culture of safety, respect and zero tolerance to patient aggression usually leads toward a therapeutic environment that is safe and injury-free.

2. Create a safe therapeutic environment for patients and staff, such as the following:

   a. Establish a positive culture at admission:
      At admission provide a friendly, reassuring greeting. Offer food, beverage, showers, clean clothes, taking care of any expressed needs, if possible. Meet patient’s basic needs with the goal of providing a clean, neat, structured and safe environment.

   b. Reinforce safety at community meetings:
      Daily meeting of all patients and staff reinforces safety and engages everyone in the goal of assuring safety. Communicate clear expectations that all patients need to work with staff to promote an environment of healing, hope and recovery.

   c. Promote positive and respectful interactions:
      Negative interactions are less likely when staff demonstrate respect and make efforts to provide autonomy. To the extent possible, provide patients with opportunities to make choices by being flexible and avoiding unnecessary restrictions. Reinforce actions patients have taken to successfully deal with crises and control aggressive behaviors in the past. Acknowledge that patients have the ability to do the right thing. Avoid the use of negative words such as “won’t”, “can’t”, “no”, “don’t.” Validate feelings and communicate appreciation for efforts to make positive choices.

   d. Promote cultural competence:
      Be aware and respectful of cultural differences that can affect the way that interactions are perceived. Listen for cultural values and the patient’s world view. Use culturally competent approaches in the treatment and safety intervention processes.

   e. Provide trauma-informed care:

      i. People who receive mental health services have experienced disproportionately more trauma than the general population. Trauma-informed care is mental health treatment directed with a thorough understanding of the profound neurological, biological, psychological, and social effects of trauma and violence on an individual. Trauma-informed treatment begins with an evaluation of the patient’s history of trauma and incorporates this vital information into a psychotherapeutic plan for the patient.

      ii. The patient’s treatment plan shall incorporate planning for safety while the patient is in the treatment environment, usually including a description by the patient of post-trauma triggers of anxiety, fear, and anger, as well as specific helpful coping strategies.

   f. Provide medically-informed care:

      i. Provide integrated mental health and other physical health care. Individuals with severe and persistent mental illness (SPMI) have a higher risk of dying at an earlier age than those without SPMI due to a combination of factors, such as increased incidence of metabolic syndrome, diabetes mellitus, cardiac disease, and consequences of poverty. Consider information such as research findings from Vanderbilt University indicating that users of typical / atypical antipsychotic drugs have an adjusted incidence rate of sudden cardiac death of 1.99 / 2.26 respectively.

      ii. Address issues of poverty in the discharge process to community care. Poverty is associated with concomitant poor nutrition and general health care, and patients come to mental health treatment centers with long-term health deficits.

   g. Provide legally-informed care:
i. Use a timely approach to application for court-ordered, involuntary medication. Initiate affidavits at time of probate, particularly with patients who we know are non-adherent with treatment and lack capacity by history.

ii. File this paperwork on the day of admission. It may be withdrawn if the situation changes. There are a number of logistic factors that can have an impact on the availability of forced-medication hearings (notification of court to request hearing, second opinion consultation requirements of forced-medication statutes, availability of court and medical staff for hearing and testimony). A lag in obtaining a forced-medication order in appropriate cases may increase the use of staff resources in managing the patient, emergency medication utilization, risk of continued patient aggression/violence, risk for utilization of seclusion/restraint.

iii. Ascertain whether or not there is a guardian of person. If so, the guardian can approve use of involuntary medication to help the patient recover and stay safe.

2. Improve communication among caregivers, such as the following:

   a. Be aware of events that have transpired in your off-shift hours (e.g., Medical Doctor on Duty (MOD) report, Unit Report, 24-hour report, etc.) and support a unit-based morning report.

   b. Improve communication flow with the MOD or other covering physicians when you are ending your duty day or will be away from the hospital. Leave an after-hours plan for any patient who has been restrained or given emergency medications or frequent prns within the past seventy-two hours.

   c. Anticipate aggressive behavior/incidents, and change treatment in an effort to prevent unwanted incidents from occurring. Be watchful for alerting behaviors such as the following:

      i. Refusing medications/treatments;

      ii. Verbal threats/taunts; verbal anger;

      iii. Shadow-boxing or martial arts maneuvers (this suggests paranoid symptoms; the patient is telling others in his environment “not to mess with him” or to “stop messing with him”);

      iv. Spitting;

      v. Paranoia/hypervigilence;

      vi. Delusions; delusional rambling;

      vii. Restlessness (r/o akathisia);

      viii. Property damage;

      ix. Irritability;

      x. Not sleeping/altered sleep-wake cycles (sleeping on 1st & 2nd shifts);

      xi. Cheeking medications/spitting out medications;

      xii. Behavior changes in response to visitors;

      xiii. Evidence of responding to hallucinations;
xiv. Aggressive body language, increased muscle tension, glaring, hyper-alert behavior;

xv. Hyperactivity such as pacing;

xvi. Hypersexuality such as provocative clothing, disrobing, inappropriate touching, public masturbation

d. Review high-risk unit behaviors daily: The unit treatment team staff should have mechanisms in place to review high-risk unit behaviors daily and respond to these with substantive modification of the aggressive patient’s treatment plan.

e. Use a more collaborative approach across the disciplines of the treatment teams and the development of proactive plans when dealing with an aggressive patient. The goal is to place focus on the development of these plans before an incident of violence occurs. Additionally, it is critical to successful intervention that treatment be clearly defined, and consistently supported and implemented by all members of the treatment team.

f. Encourage patients and staff to “speak up:”
Clinicians have a critical role in decreasing violent behavior in the inpatient setting: Early interventions improve our chances of preventing violence. It is far preferable to intervene effectively before violence has occurred, rather than waiting until after an episode of violence; this requires vigilance in watching for warning signs of violence in patients at risk. In addition, if clinical staff “speak up” about concerns about potential of imminent violence of a patient on the unit, we should take those concerns seriously. At the same time, physicians apply knowledge of risk factors, warning signs, and mental illness in order to decrease the risk of violent behavior. Clinical staff should use an interdisciplinary approach with shared suggestions among the team on how to intervene with the specific patient.

g. Provide physician presence on the acute hospital unit:
By being available to patients and visible in the milieu, physicians can have a significant positive impact on efforts to reduce aggressive behavior in the inpatient setting. Physicians are advised to: Use informal contacts with patients as opportunities to reassess and re-triage. Spend maximal time with your patients and with your staff. Attend therapeutic community meetings daily. Utilize a teaching environment where the other team staff are given support (education) by the psychiatrist and psychologist on treatment approaches with an aggressive patient.

3. Follow basic safety precautions, such as the following:

a. Working on the units:

   i. Always be watchful, aware and careful when entering and exiting the unit, nurse’s station, offices, patient rooms, unit pantry, laundry room, housekeeping closet, shower room, seclusion area, and storage rooms.

      1. Always be aware of your surroundings.

      2. Always be aware of the acuity of the milieu.

      3. Be cautious when unlocking doors.

      4. Maintain control of your keys.

      5. If concerned about proceeding alone, ask another staff member to accompany you.

      6. Always alert staff to your whereabouts if you leave the nurse’s station, and be aware of location of other staff members in case you need help.
ii. Assess the situation on the unit: Do ask for help. Do assess for risks.

1. If concerned, ask for a current status report on the patients.

2. Assess the environment for potential weapons/hazards, such as those that can be thrown (e.g., books, chairs, etc).

3. Notify staff of where you are meeting with a patient. Ask for another staff to assist if warranted. Follow the “Delivery of Bad News” protocol in (D)(3).

4. Trust your instincts. If you are uncomfortable, scared or feel threatened with a situation, take action to maintain your safety.


iii. Non-threatening protective behaviors:

1. Always position yourself so that you have access to the exit without going past the patient.

2. Never expose your back, especially to someone who is angry or threatening. Use the wall or another structure to keep someone from coming up behind you.

3. Keep a minimum distance of an arm and beyond leg length from the patient to reduce hitting, head-butting and kicking striking distance.

4. When standing and talking with the patient, hold your arms in such a way that you can use them to block a blow. Stand so that one foot is in front of the other, and turned slightly to the side so that a kick could be blocked with your leg.

5. Secure hair to prevent it from being a target.

6. Wear jewelry or clothing that is not easy to grab or pull. Wear closed toe shoes that are easy to run in if needed.

b. Working in the hospital courtyard or unit patios:

i. Always continually assess and be aware of the environment including how many patients and staff are present in the area and their locations.

ii. Always utilize a co-facilitator if you are planning a courtyard/patio activity.

iii. Always be vigilant for the presence of contraband materials and environmental items (rocks, etc.) that could pose a safety hazard. Trust your instincts; if something doesn’t seem safe, it probably isn’t. Report anything that you think is questionable to your supervisor.

c. Working in the off-unit program areas:

i. Arrange to work with a co-facilitator. Be aware of other activities underway in the area, along with the location of other staff assigned to the area.

ii. If you need to cancel an activity when an adequate number of facilitators are not available, do so. Always err on the side of safety.

iii. Be alert when entering and exiting offices and rooms in a program area.
iv. Careful discretion must be used if one allows a patient to enter an office. Discourage patients from loitering in the doorways of offices when you are inside.

v. All patients must return to their units at the end of each group to check in and to clear the program area for safety. There are no exceptions to this procedure.

vi. Be aware of the location of the nearest telephone and the nearest emergency intercom.

d. Working in transition areas or at transition times:

i. Moving patients among areas of the building must be a planned activity and is not to happen spontaneously. This allows for safe arrangements to be made in advance.

ii. Be alert to the changing nature of your environment, especially during times of transition when there will be maximum patient activity and potentially a minimum number of staff available to respond to emergencies (e.g., group movement times, shift change times, the occurrence of an emergency medical or psychiatric situation which may require staff response and hence reduced staffing levels elsewhere, etc.)

e. Working with volunteers, students, or staff who do not regularly work on the unit:

i. Special safety vulnerabilities may arise when students, volunteers, non-clinical support staff, and staff who do not regularly work on the unit, etc., enter an active patient area.

ii. With students and volunteers, the supervisor plays a crucial safety role.

1. Prior to entering the active patient area, the student or volunteer must have completed appropriate orientation and training, and obtained the approval of the supervisor to be in an active patient area.

2. Prior to entering the active patient area, the student or volunteer shall check with the nursing staff on the unit to assure safety in the active patient area and to check on specific patients with whom they are working.

3. The supervisor of the student or volunteer shall obtain continuous safety information from sources such as the following: morning report, change of shift report and nursing report. In a timely manner, the supervisor shall advise the student or volunteer as to appropriate cautions given the safety/risk information known by the supervisor.

4. The student or volunteer, with appropriate supervision, shall only participate in approved patient activities with patients approved for that activity.

iii. For any on-unit persons who are not familiar with current unit activity, the regular unit staff shall encourage them to remain constantly vigilant when in active patient areas, and to seek advice from the unit RN or licensed independent practitioner if questions arise.

iv. Regular unit staff shall maintain a protective stance to maintain milieu safety, with special attention to those who have less training and experience on the unit (including student and volunteers).

4. Provide patient education and expectations, such as the following:

a. To the extent possible, highlight aggression and threatening behavior(s) as immediate targets for treatment.
b. Educate the patient that such behaviors are important elements of their illness and that effective interventions will be utilized. Describe the behavioral and pharmacologic interventions that may be utilized. Emphasize safety with the patient with such statements as, “we want to keep you and others safe. We will not allow others to harm you and we won’t allow you to harm yourself or others.”

c. Provide ongoing education, skill building, cognitive therapy, and/or behavioral therapy to enhance the patient’s abilities to cope more effectively with aggressive impulses.

d. Focus on what has worked previously for him/her and positively reinforce that the patient has controlled his/her anger in the past and can do it again.

e. Educate the patient on the importance of seeking staff assistance when experiencing an increase in aggressive impulses or precursor phenomena such as dysphoria, irritability, anxiety, receipt of upsetting information, or negative interpersonal interactions.

f. Set limits. Be very clear that staff will assist the patient to control such behaviors as aggressive behaviors, and such behavior will not be allowed to occur in the inpatient setting due to their myriad negative impact on peers and staff.

g. Emphasize the critical need for medication compliance to assist in regaining behavioral control.

h. Utilize the “Patient Self-Assessment for Helping You in a Crisis Situation” to identify interventions that the patient says will help when she/he is losing control. Reinforce those measures with the nursing staff and in treatment plans (initial, comprehensive and/or updates).

5. Implement comfort box interventions, such as the following:

a. The Comfort Box provides a safe and responsive therapeutic intervention to patients who are experiencing an increase in stimulation, agitation and other symptoms related to their illness.

b. The patients we serve come to us with psychiatric, developmental and emotional disabilities. Many of our patients during their stay have feelings of being overwhelmed, unsafe, and bombarded by unfamiliar stimuli and become over stimulated by the new environment. Most of our patients display behaviors of agitations, head banging, wall hitting and even aggression as a way to deal with their feelings. Many of our patients lack the ability to organize what they are feeling and sensing appropriately. The tools in the comfort box will enable staff to provide the sensory diet our patients need and to help patients ‘self organize’ through activities.

c. A sensory diet involves identifying certain experiences or activities that help ground, calm, center or alert an individual. It is important to remember that what might be calming for one may not be calming for another. It is important for staff to look at the patient’s self-assessment when choosing tools to use from the Comfort Box.

d. The following table lists Comfort Box tools:
<table>
<thead>
<tr>
<th>Category and Behaviors</th>
<th>Equipment Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tactile - agitation, depression, self injurious behaviors, anxiety</td>
<td>Stress balls, molding clay, therapy putty, sensory mitts, lotions, arts and craft supplies, book, magazines, stuff animals, heated stuffed animals</td>
</tr>
<tr>
<td>Visual - hallucinations, agitation</td>
<td>Books, magazines, pictures, target games, Simon game, glitter wands, art supplies, color change balls, glow sticks</td>
</tr>
<tr>
<td>Auditory - hallucinations, agitation</td>
<td>Radio, CD player, assorted music</td>
</tr>
<tr>
<td>Olfactory - hallucinations, anxiety, difficulty sleeping</td>
<td>Aromatherapy diffuser, lotions, aromatherapy putty,</td>
</tr>
<tr>
<td>Body Awareness - agitation, head banging, hitting walls, self injurious behaviors</td>
<td>Exercise mat and instructional cards, rocker, stuffed animals, heated stuffed animals</td>
</tr>
<tr>
<td>Oral - yelling, responding to voices, anxiety</td>
<td>Hard candy, sour balls, chewing gum, mints, chewy candy</td>
</tr>
</tbody>
</table>

D. Early intervention

1. Assess risk for aggression Immediately, such as the following:

   a. A past history of violence remains the most robust predictor of future violence.

   b. Higher rates of violence occur in patients with substance use disorders and personality disorders.

   c. Younger patients and those who are involuntarily committed exhibit higher rates of violent behavior.

   d. Gender does not significantly correlate with violence in inpatient populations.

   e. Consider the patient’s history of trauma; there is a growing literature regarding trauma-informed care in managing an aggressive patient.

   f. Rule Out Substance Intoxication:

      i. Assess for withdrawal states and treat aggressively.

      ii. Assess for intoxication.

      iii. Consider whether the patient may be experiencing delirium.

      iv. If a particular agent is suspected as an intoxicant, determine whether anything can be done to hasten metabolism/elimination (e.g. acidification of urine).

2. Intervene proactively when common triggers arise, such as the following:
Staff can avoid aggressive reactions by intervening proactively. The following table lists common triggers and potential helpful interventions or coping strategies for patients:

<table>
<thead>
<tr>
<th>Common Triggers</th>
<th>Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>● enforcement of hospital rules</td>
<td>● walking</td>
</tr>
<tr>
<td>● perception of unfair treatment</td>
<td>● music</td>
</tr>
<tr>
<td>● prolonged waiting</td>
<td>● talking</td>
</tr>
<tr>
<td>● anger about past experience in the mental health system</td>
<td>● lying down</td>
</tr>
<tr>
<td>● controlling, restrictive environment</td>
<td>● time alone</td>
</tr>
<tr>
<td>● shame and humiliation</td>
<td>● reading</td>
</tr>
<tr>
<td>● fear or anxiety</td>
<td>● writing</td>
</tr>
<tr>
<td>● over-crowding</td>
<td>● warm shower</td>
</tr>
<tr>
<td>● boredom/lack of activities</td>
<td>● breathing exercises</td>
</tr>
<tr>
<td>● physical discomfort or pain</td>
<td>● calling support person</td>
</tr>
<tr>
<td>● perceived lack of control</td>
<td>● engage in a quiet activity or interaction</td>
</tr>
<tr>
<td>● perception of not being heard</td>
<td>● responding better to male staff</td>
</tr>
<tr>
<td>● bad news (see next paragraph)</td>
<td>● humor</td>
</tr>
<tr>
<td></td>
<td>● responding better to female staff</td>
</tr>
<tr>
<td></td>
<td>● crying</td>
</tr>
<tr>
<td></td>
<td>● spiritual practice</td>
</tr>
<tr>
<td></td>
<td>● being read to</td>
</tr>
<tr>
<td></td>
<td>● resources from the Comfort Box</td>
</tr>
</tbody>
</table>

3. Promote self-control and a safe environment when giving “bad news”, such as the following ‘Bad News Protocol”:

   a. Giving disturbing or bad news to patients may precipitate a patient reaction of aggression. Our patients are already in a vulnerable emotional state, and thus the delivery of disturbing or bad news needs to be done in a respectful, empathic, well-planned and well-executed manner to help the patient retain self-control and to avoid aggressive patient behavior.

   b. Some examples of disturbing or bad news may include:

      i. Death or serious illness or injury of a family member, loved one, friend, or pet of a patient.

      ii. Learning of criminal charges while a patient is hospitalized.

      iii. Learning of plans to transfer patient to a correctional setting upon discharge.

      iv. Delay in discharge or unanticipated disruption of a patient’s planned placement.

      v. Change in the treatment plan, including medication or treatment providers.

      vi. Curtailing of visitors or phone use due to clinical reasons.

      vii. Any hospital decision that one can anticipate that a patient will not like.

   c. Safe procedures for delivery of disturbing information or bad news:

      i. Consult with treatment team members to identify the best approach, time, location and staff to be involved in providing the bad news to the patient.

      ii. Consult with others, as needed, including chaplain, police, interpreter, family members/significant others or non-licensed staff person with a relationship with the patient.
iii. Consider the patient’s current mental status, stage of recovery and coping strategies. Grade the type of news and decide how to deliver the news. Psychiatrist should determine the availability of PRN medications.

iv. Do not deliver disturbing information or bad news alone. A minimum of two (2) staff should be present when delivering the disturbing information. Other support staff should be readily available and monitoring the situation.

v. If the disturbing information is expected to result in acting out or aggressive behavior, an Assist team should be present or in close proximity.

vi. If at all possible, deliver disturbing information on a shift where more clinical staff are available to assist.

vii. Select a safe location. Survey the location prior to the meeting. Remove any items that could be used as weapons. Make sure that there are no obstacles blocking the staff’s path to the exit.

viii. When meeting with the patient, identify and maintain a safe exit strategy.

ix. Be vigilant to changes in the patient’s voice, affect, mood, and behavior. Act accordingly to prevent a possible assault. Respect distance and personal space to avoid invading the patient’s comfort zone.

x. If the patient begins to perceive the information as negative or begins to get agitated, stop the disclosure, use “strategic tact” to calm the patient, and assure safety for all.

xi. Make this hand off communication evident on shift reports so that other shifts are prepared.

d. Know your patient and anticipate the patient’s response to the bad news.

i. Identify staff members with whom the patient has a positive relationship. These staff members may be good candidates to lead in delivery of the news.

ii. Be kind, empathetic and honest in your approach: Do not give disturbing or bad news in passing (e.g., from the nurse’s station).

iii. Some patients respond better to a specific setting than others. Discuss with your teammates whether the news should be best delivered in a more open or more private setting on the unit. Always choose a visible location, but consider factors such as more or less privacy in the meeting setting.

iv. Encourage the patient to retain his/her control by affirming the patient’s feelings, asking supportive questions and by encouraging responses. The patient may need time alone, want to talk, need to make a phone call, etc. Be sure to encourage the patient to begin developing an appropriate next step to the bad news. Encouraging self-control means that the patient is appropriately engaged in the problem-solving process.

v. Be sure the initial encounter is not prolonged. Offer additional support at a later time.

vi. Assure that a brief plan is in place for the next steps to occur, e.g. “meeting with your physician or social worker to determine the next best alternative”.

vii. There may be times when a patient may request an impromptu meeting with a staff person. Prior to taking the patient into a room alone, ask the patient about the topic. Give the patient a specific time the meeting will occur. Attempt to discover if any unusual or
upsetting event has occurred with the patient and then survey the area in which the meeting is to occur for potential hazards. Never invite a patient into an area that the staff cannot monitor due to closed doors, curtains or blinds.

e. Follow-up to delivery of disturbing bad news:

i. For staff who are currently on the unit, provide an update of the outcome of the meeting.

ii. Notify attending physician/or MOD. Provide a detailed hand-off of the plan for management and plan to re-assess the patient’s needs.

iii. Address relevant issues on Treatment Plan.

iv. Follow up with the patient before you depart for the day/shift to see if they’re “OK” or have other needs.

v. Communicate with all care providers. Raising awareness and sensitivity among our staff will help to solve the problems manifested by the delivery of disturbing information.

E. When symptoms erupt, use safety and therapeutic measures such as the following:

1. Avoid “hands on” physical contact

   a. Avoid physical contact or placing hands on a patient except in the following three situations:
      i. Defensive, if physically attacked, use defensive strategies to disengage with the patient while getting help;
      
      ii. In a life-threatening situation where there is a likelihood that the absence of intervention may result in the loss of life or serious injury; and;
      
      iii. As authorized by a registered nurse (RN), nursing supervisor/manager or physician, such as during a restraint procedure or emergency medication/court ordered involuntary medication administration.

   b. Never employ a one-person intervention or manual hold when working alone with an agitated or upset patient: Avoidance is preferred. Walk away to summon help when confronted or approached by an agitated or threatening patient. Do not engage in a negative or threatening interaction alone; do not engage in a negative verbal interaction with a patient. Do not place yourself alone with a patient whom you know has an aggressive history.

   c. Get assistance immediately to break-up patient fights – do not try to break-up an argument or fight alone, unless a life threatening situation ensues.

   d. Avoid close physical proximity to patients who are physically aggressive toward others. Use close observation or “eyes on” direct supervision.

2. Seek assistance: Assist Team and Code Violet

   a. The purpose of the Assist Team and Code Violet is to promote a safe environment for patients and staff. The Assist Team may be called to assist in any emergency or situation if clinical staff on the unit requires additional support in order to verbally intervene in an impending crisis.
b. The Assist Team goal is always injury-free resolution by using verbal skills to defuse an impending crisis with no physical contact or need for restraint or seclusion. The primary function is to minimize the potential for injury to anyone and execute a therapeutic resolution to a crisis. An Assist Team and Code Violet may be called at anytime should a situation escalate or additional staff be required to keep the situation safe.

c. Staff should always call an Assist Team when they believe that a patient is upset or agitated. Call Assist Team early – don’t wait for a patient to become threatening or physically aggressive, destructive, or experience escalating behaviors.

d. Any clinical staff may use the indicated emergency phone to identify self, state “Assist Team” or “Code Violet” and give location. The operator or control room staff will then page the Assist Team or Code Violet and location three times.

e. Upon arrival to the situation, the Assist Team or the treatment team/unit staff member most familiar with the patient is responsible for the staff-patient interaction; the RN, nurse supervisor/manager or physician controls the situation:

i. A designated member of the nursing staff will assign roles such as clearing and controlling the area by removing other patients and environmental hazards, posting staff at the unit door to communicate the situation to arriving staff, specific assignments if physical interventions should be necessary, and assigning the person to do the talking.

ii. Other staff will stand by for instructions, move other patients or visitors to a safe area, and remove potential hazards in the environment.

iii. A designated RN, nurse supervisor/manager/physician will authorize physical contact or higher levels of intervention, per Crisis Intervention Training (CIT) including the use of medication, if necessary.

iv. Staff should never be left alone to deal with or to conclude an assist or de-escalation process.

v. The Assist Team will remain on the unit under the direction of the unit RN, physician, or Nursing Supervisor until the situation is resolved and they are released.

f. At the conclusion of Code Violet’s function, the unit RN will conduct a debriefing to assess the team’s actions and discuss processes that can be improved. A team member will notify the hospital operator or control room that the Assist Team or Code Violet is done and ready for other assignments.

g. Assist Teams are assigned/designated on all shifts and include nursing supervisors/clinical nurse manager and unit RN. The Nursing Supervisor will assign staff to be on the Assist Team at the beginning of each shift. The Assist Team will respond to all announced Assist Teams in its assigned building. Staff assigned on the Assist Team are responsible for seeing that a replacement is assigned should they be unavailable to respond for any reason during the shift.

3. Follow requirements when using physical contact:

a. There are two requirements whenever physical contact with a patient is necessary to preserve or protect safety of patients and staff:

i. Physical contact must be authorized by a nurse, nursing supervisor/manager or physician; and,
ii. There must be sufficient staff (typically a minimum of five staff plus one observer) available to provide assistance and monitoring.

b. Each staff member serves a different function. Role definitions can be conceptualized as follows:

i. Nurse supervisor/manager, physician and RN provide direct supervision and oversight of the situation and have decision-making responsibility and accountability.

ii. Unit nursing and unit treatment team members provide direct verbal and/or physical contact with patients and are responsible for safe and injury free de-escalation procedures.

iii. Protective services officers (police and corrections officers) provide support, observation and take direction from the nurse manager, nursing supervisor, physician or RN responsible.

v. Physicians should be called and be involved as early as possible. Assessment and re-assessment, biopsychosocial treatment including medication and development of a safety plan and follow-up are key components of the physician’s ongoing role as psychiatric/medical leader of the treatment team.

c. Follow CIT guidelines when physical intervention is necessary.

d. Never carry patients unless authorized by a nursing supervisor/manager/nurse or physician, (use CIT program). Try to resolve or remediate the situation at its current location.

e. Escorting patients: The goal of a patient escort is to safely move a patient from point “A” to point “B” (e.g., from a stimulating setting to a less stimulating setting) without incident or injury. The following are requirements for a patient escort:

i. Two staff members, one positioned on the left and one on the right of the patient to escort the patient to the desired location.

ii. Other staff members assisting are well behind the escorting so as not to be a perceived threat to the patient. Other staff in area must be quiet – laughing or talking can easily be misinterpreted by patient, or serve as a distraction to the de-escalation or escort procedure.

iii. No other interventions occur during the escort procedure other than verbally reassuring the patient. Other interventions (e.g., medication administration, remediation, etc.) can occur once the patient is safely positioned at the desired location.

iv. Controlling noise and stimulus is essential during a patient escort. Staff are assigned to re-locate other patients away from scene and reassure other patients.

4. Follow requirements when using emergency medication:

a. The use of medication to help patients regain control of behaviors, agitation or aggression is not an uncommon tool for physicians and RNs (refer to hospital treatment safety procedures).

b. Medication specific considerations:

i. Loading-dose strategies in combination with frequent patient assessment may assist in providing the patient with behavioral control in the shortest, safest period of time.

ii. Implement rapid titration of psychotropic medication doses consistent with safe and efficacious use. Consider the need to supply the patient with alternative dosing forms.
iii. Consideration should be given to utilizing liquid, rapidly-dissolving, and intramuscular forms of psychotropic medications to ensure compliance.

iv. Determine meaningful thresholds for using emergency medications, particularly with knowledge of an individual patient’s pattern of escalating behaviors.

v. Check records to determine past, best medication combinations for a given patient. Determine whether there is any past record of the patient’s response to PRN and standing medications.

vi. Physician and unit RN communication is necessary to ensure appropriate use of proactive medication regimens.

c. Consider non-Adherence or “cheeking”

i. An initial consideration when a patient does not respond to prescribed medications is whether the patient is actually taking the medication? Consider obtaining a medication blood level in suspect situations.

ii. Consider concentrates and other delivery methods to minimize diversion of medication.

iii. Consider other causes of inadequate serum medication levels, such as poor drug absorption, drug-drug interactions, and drug-food interactions.

iv. The use of liquid/concentrate medications should be considered as an alternative to pills, which may place nursing staff at risk of being bit when doing a mouth check.

d. To avoid staff and patient injury during the administration of emergency medications, the following guidelines should be followed:

i. Preference for use of oral medication as opposed to intramuscular (IM) routes, unless the clinical circumstance demands IM medications.

ii. Assurance that sufficient support staff are present with the RN/physician, (at least five other staff in support).

iii. The RN (who is administering the medication) should have a “safety plan” or “safety strategy” for safe administration of the medication. The plan should include the location of the administration, verbal interaction plan (to help de-escalate the patient), and the role of the support staff. The RN must assure that safety needles are sheathed and removed from the area to prevent needle sticks.

iv. If manual restraint is needed, the RN should assign specific staff roles (i.e., restraint of limbs; stabilization of head/neck, and observation to assure patient safety).

v. “Peel off” procedure: When the medication is delivered and the patient is calm, the RN should include in the exit strategy the “peel off” procedure. Meaning that one person at a time removes or disengages him or herself from the situation at the direction of the RN. The last two persons with the patient then disengage themselves simultaneously once they have the commitment from the patient that the patient is in self control and has a “plan” upon final disengagement. Make sure that you work with the patient on his/her plan while engaged, and the patient “repeats back” to you or understands the plan upon final disengagement

F. After an episode of aggression
1. Conduct debriefings after an incident; (see rule 5122-2-17 of the OAC regarding seclusion and restraint and other special treatment and safety measures).

   a. The goals of debriefing are to: (1) minimize the negative effects of the incident on all involved individuals; and (2) identify alternatives strategies to prevent or minimize future occurrences.

   b. Each patient shall be given the opportunity to debrief each episode of seclusion or restraint, unless specifically contraindicated in the treatment plan for clear treatment reasons. As part of the debriefing, the patient shall be given the opportunity to identify techniques that would assist the patient to control his or her behavior. In addition, patient debriefing provides an opportunity to minimize trauma and reestablish the therapeutic staff-patient relationship.

   c. Each RPH shall develop procedures to debrief staff after an episode of restraint. Conduct a staff debriefing when a physical intervention occurs to:

      i. Assess for any injury;
      
      ii. Plan next steps for the patient’s care and protection for the remainder of the shift;
      
      iii. Determine how management of the situation could have been handled differently; and
      
      iv. Provide information to patient’s treatment team to assist in treatment plan revisions.

   v. The following are examples of questions that may be included in a staff debriefing.

      1. Were there alternative actions that could have been taken to prevent the incident?
      2. Could some intervention earlier in the prodrome have prevented the outcome?
      3. In the case of restraint, could seclusion have been an alternative?
      4. Would it be possible to achieve a better outcome if an assist team were called?
      5. Are we medicating optimally? Is the patient adherent? How do we respond to possible non-adherence?
      6. What environmental changes might minimize the risk for further dangerous behaviors (e.g., room changes, roommate changes, ambient noise, light, or congestion on the unit, access to exits, response to visitors, etc.)?

2. Provide essential communication:

   a. Refer to reporting requirements detailed in OAC rule 5122-2-17 regarding seclusion and restraint use in RPHs.

   b. The following internal communication and notification is required following any interaction resulting in a restraint procedure:

      1st Physician
      2nd CEO/AOD
      3rd Treatment Team, Nursing Electronic Report, Shift and Morning Report;

   c. The following internal communication and notification is required following any injury to staff or a patient due to physical contact.

      1st Physician/MOD
      2nd Nursing Supervisor/Protective Services
3rd Accident Prevention/Safety Coordinator; Benefits Coordinator
4th AOD/CEO
5th Treatment Team & Morning Report, including Patient Safety Coordinator
6th Nursing Report, Shift-to-Shift Report;

d. Monitoring and quality improvement requirements are described in rule 5122-2-17 of the OAC (re seclusion and restraint and other special treatment and safety measures). Each RPH monitors the use of seclusion and restraint in each unit, conducts quality improvement reviews and provides findings and recommendations to Administrative Executive Committee.

3. Reevaluate and adjust medication strategies (See Attachment A)

a. Use of emergency medication should prompt a mandatory review of the med regimen by the unit physician/MOD and then, if needed, the CCO the next business day.

b. Use of PRN or emergency medication doses should prompt a re-examination of the adequacy of the medication regimen.

c. Medication doses, dose forms, dosing intervals, and alternative agents may all need to be considered.

d. Timely modification of treatment is appropriate in response to continued or renewed aggression.

G. Psychotropic medication

1. The physician shall implement a staged treatment process for safe quality care in prescribing psychotropic medications (see Attachments A and B).

2. The prescribing physician shall utilize appropriate psychotropic medication strategies consistent with maintenance or emergency standard of care prescribing (see Attachment C).

Marion Sherman, M.D.
Medical Director, Department of Mental Health

Sandra Stephenson, M.S.W., M.A.
Director, Department of Mental Health
### Recommended Medication Dosing for Psychiatric Emergencies

<table>
<thead>
<tr>
<th>Medication</th>
<th>IM Dose / Frequency</th>
<th>PO Dose / Frequency</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Traditional Antipsychotics</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Haloperidol (Haldol)</td>
<td>1 – 10 mg q 30 minutes</td>
<td>1 – 10 mg q 45 minutes</td>
<td>Monitor for EPS and NMS.</td>
</tr>
<tr>
<td>Fluphenazine (Prolixin)</td>
<td>1 – 7.5 mg q 30 minutes</td>
<td>1 – 10 mg q 45 minutes</td>
<td>Monitor for EPS and NMS.</td>
</tr>
<tr>
<td>Chlorpromazine (Thorazine)</td>
<td>25 – 100 mg q 30 minutes</td>
<td>25 – 200 mg q 45 minutes</td>
<td>Under most circumstances, restrict to 50 mg IM at a single injection site; monitor for hypotension.</td>
</tr>
<tr>
<td><strong>New Generation Antipsychotics</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ziprasidone (Geodon)</td>
<td>20 mg q 4 hours</td>
<td>N/A as emergency medication</td>
<td>Up to a max of 40 mg IM/24 hours; generally not recommended as a first line emergency treatment.</td>
</tr>
<tr>
<td>Olanzapine (Zyprexa)</td>
<td>5 – 10 mg q 6 hours</td>
<td>N/A as emergency medication</td>
<td>Monitor for hypotension.</td>
</tr>
<tr>
<td>Olanzapine (Zydis)</td>
<td>N/A</td>
<td>5 – 20 mg q 6-24 hours</td>
<td>Zydis is an alternative for patients who might divert oral medications.</td>
</tr>
<tr>
<td>Risperidone (Risperdal M-tab, Risperdal oral solution)</td>
<td>N/A</td>
<td>1 – 2 mg q 8-12 hours</td>
<td>Available as an M-tab and as an oral solution. Generally not more effective at doses greater than 6mg daily and then adds increased risk of EPS. Acute aggression literature references use of oral suspension but not M-tab.</td>
</tr>
<tr>
<td>Aripiprazole (Abilify)</td>
<td>5.25mg- 15mg IM q2 hours (9.75 mg recommended)</td>
<td>10-15 mg q 6-12 hours</td>
<td>IM not to exceed 30 mg/ 24 hours; available as oral solution and disc melt.</td>
</tr>
<tr>
<td>Quetiapine (Seroquel)</td>
<td>N/A</td>
<td>50-200 mg q 1 hour</td>
<td>Monitor for hypotension.</td>
</tr>
<tr>
<td><strong>Benzodiazepine</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lorazepam (Ativan)</td>
<td>1 – 4 mg q 30 minutes</td>
<td>1 – 4 mg q 45 minutes</td>
<td>Remains the sole benzodiazepine with reliable IM absorption.</td>
</tr>
</tbody>
</table>
Attachment B
Safe and Quality Care in Prescribing Psychotropic Medication in Crisis / Precrisis Situations

<table>
<thead>
<tr>
<th>Stage</th>
<th>Process</th>
</tr>
</thead>
</table>
| Proactive (Potential for aggression exists) | 1. Good assessment  
2. Proactive biopsychosocial treatment planning (including medicating)  
3. Good teamwork. (Team: Unit physician, cross coverage, and MOD need good communication) |
| Active (Assist or crisis stage; patient displaying signs of imminent aggression / patient actively aggressive) | Biopsychosocial interventions (including emergency medications) |
| | Patient agrees to take medication? |
| | Yes |
| | Patient agrees to oral medication? |
| | Yes |
| | No |
| | No |
| | Administer Oral Medication (See Attachment A) |
| | Recommended Regimens:  
Intramuscular medication if preferred by patient  
Lorazepam 1-4 mg PO q 45 min  
and/or  
Haloperidol (tablet or concentrate) 1-10 mg PO q 45 min  
(Chlorpromazine 25 – 200 mg PO q 45 min or Fluphenazine 1-10 mg PO q 45 min as alternatives) |
| | Continue combination until aggression resolves. |
| | 1. Consider alternatives if:  
A. No behavioral improvement  
B. Behavioral worsening  
C. Emergence of severe medication-related side effects  
D. History of severe side effect/allergic reaction or non-response to recommended agents.  
E. Continue any agent not assessed to be contributor to non-response, side effects |
| | 2. Recommended alternatives:  
A. Olanzapine (tablet or rapidly dissolving preparation)  
20 mg initially, followed by 5-10 mg Q 3-4h until patient is calmed. Administer to total daily dose of 40 mg.  
B. Risperidone, oral (tablet or concentrate 1-2 mg)  
Dosing frequency / total daily does for this use is not well-established. Extrapyramidal side effects may emerge with total daily doses greater than 6 mg a day. Would not usually recommend concurrent use of haloperidol. |
| Maintenance (Following the Assist / Crisis) | 1. Develop safety plan for patient.  
2. After emergency medicating, physician checks back each hour for face-to-face proactive assessments.  
3. Once patient is non-risk for aggression, physician checks back at 4- and 8-hour intervals.  
4. Sign out w/good hand-off communication to physician / physician coverage / MOD |
Attachment C

Psychotropic Medication Prescribing for Safe Quality Care

A. Medication use shall be the clinical judgment of the treating physician without a fixed protocol.

B. For scheduled medications, the physician shall consider early use of combination therapy and consider well-accepted medications with efficacy and effectiveness in the treatment of psychosis and/or mania, such as antipsychotics, divalproate, and lithium. Psychotropic medication interventions to address underlying psychiatric conditions or chronic aggression (mood stabilizers / anticonvulsants, beta-blockers, serotonin specific re-uptake inhibitors, clozapine) should be offered and instituted as soon as the patient is able to provide informed consent. Divalproate can be rapidly initiated using doses in the range of 20 to 30 mg / kg/ day. Lithium dose requirements can be estimated utilizing a serum level result twenty-four hours following test dose administration (typically a 600 mg dose) in conjunction with a dosing nomogram. Both divalproate and lithium have demonstrated efficacy in reducing aggression in selected populations.

C. To aid with sleep and adjustment of sleep-wake cycles, the physician shall consider ordering both scheduled and prn hs doses of benzodiazepines or hypnotics such as Lorazepam (Ativan) 2mg hs and lorazepam 2 mg hs prn insomnia.

D. The high-potency benzodiazepine, lorazepam, has demonstrated consistent efficacy in rapidly reducing severe agitation and aggression. It can be dosed frequently (every thirty to sixty minutes, if necessary); has consistent intramuscular absorption; has been shown effective in a very wide spectrum of psychiatric disorders; and has a minimum of significant side effects other than oversedation. A usual dose of lorazepam utilized for severe agitation is 2mg orally or 2-4mg per Attachment A. Paradoxical disinhibition is an uncommon outcome of benzodiazepine administration. Concerns about the dependence liability of benzodiazepines do not apply if the intent of lorazepam use is to rapidly resolve severe agitation and aggression.

E. Traditional and new generation antipsychotics shall be considered for use in rapidly addressing severe agitation/aggression. Haloperidol has been widely utilized in this context. A usual dose of 5mg orally or 5-10mg intramuscularly given in a dosing schedule similar to that noted above for lorazepam. Expert consensus has suggested the use of these agents in combination with lorazepam for patients with severe agitation/aggression related to schizophrenia or mania. Intramuscular (IM) haloperidol may have little to no additional benefit after 10-15 mg had been administered and approximately fifty percent of patients may experience some EPS at this total dose of IM haloperidol. Ziprasidone (10-20mg QID) and olanzapine IM preparations (single 10mg doses) may have efficacy similar to haloperidol for this application. Chlorpromazine at doses of 25-100mg IM or 50 –200mg PO and fluphenazine at doses of 5-10mg IM or 5-10mg PO are other typical antipsychotics that may be used for selected patients with histories of poor tolerability or responsiveness to haloperidol. The physician shall monitor for orthostasis and anticholinergic side effects with the use of Chlorpromazine. Rapid dose escalation of oral olanzapine (oral loading dose) administering doses in the range of 15-25mg within the first four hours of starting the medication and utilizing up to 40mg total in the first several days of treatment, has been demonstrated to provide significant reduction of acute agitation. Combination of oral concentrate risperidone (2mg) and lorazepam (2-4-mg) may be used as an alternative to the combination of intramuscular haloperidol (5-10mg) plus intramuscular lorazepan (2-4mg).

F. The physician shall consider that there is risk of worsening agitation with the induction of extrapyramidal side effects (EPS) with any of these agents, especially injectable routes. The administration of these drugs may also cause more agitation, akathisia or NMS.

G. The physician shall continue to administer emergency medication for severe agitation/aggression until there is no longer a threat of imminent danger.
H. The physician shall be prepared to re-institute effective medication emergently if significant worsening of behavior follows discontinuation of the initial regimens of emergency medication.