# Psychiatric Emergencies and ER Violence

## 精神科急症 與 急診暴力

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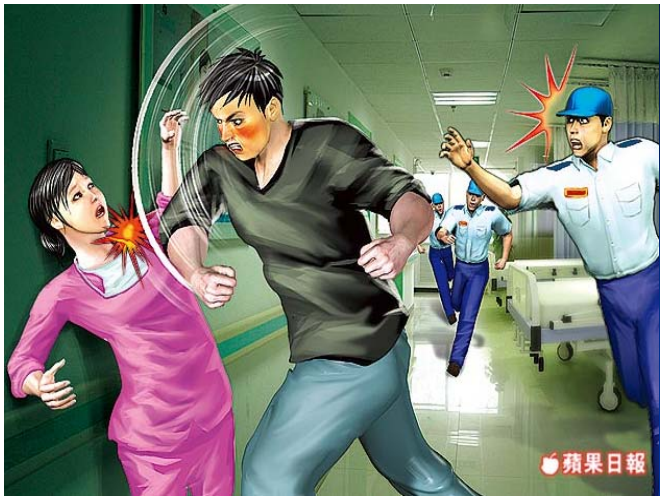
102.12.09



老刺客 闖急診 殺醫師

警員就醫 巧遇制伏

〔記者楊培華、田瑞華、徐夏蓮／綜合報導〕年近70歲的老人盧平，母親94年間因病急診仍告不治，1年多來提出告訴外，並四處陳情。昨天中午他突然闖進當時盧母就醫的基隆市署立基隆醫院急診室，持刀往急診室主任李芳年頭、臉猛刺，所幸當時正就醫的2名基隆港警局員警馬上和保全員一起將盧某制伏，李芳年被刺中多刀，急救後尚未脫離險境。



嫌犯盧平昨天中午持刀闖進署立基隆醫院急診室，正在為病人看診的急診室主任李芳年遭刺殺多刀，診間留下血跡斑斑。（記者楊培華攝）

衛生署和台灣急診醫學會昨均譴責此種暴力行為，急診醫學會理事長陳維恭要求衛生和警政單位應對多次急診暴力事件提出妥善解決辦法，並呼籲衛生署進行急診醫學評鑑時，有關急診室空間設計，不僅注重病人安全，更要注重醫師安全。

## Overview

- Safety and violence in the ER setting
- Physical restraints
- Pharmacologic support

## Keep an eye on your surroundings

- Look for potential weapons such as IV poles or things that can be thrown
- Look for objects that the patient could use for self harm
- Give yourself and the patient equal access to the door

- The comfort zone for most people is hand shaking distance
- The comfort zone for paranoid or agitated patients may be 2-3 x the usual distance
- Remember the patients history when you are in their personal space
- When you do a physical exam and you invade their space they may react defensively

## Assessing the risk of violence

- Immediate past, recent past and more distant history of violence is the best predictor of future violence
- Circumstances of violence and characteristics of people involved are important
- Substance dependence or abuse carries a 30x increase risk than the general population!!

- Antisocial personality disorder with comorbid substance abuse or dependence carries greater than 100x the risk compared to the general population
- Mental illness carries a 9x greater risk than the general population
  - paranoid schizophrenia
  - confused states related to medical problems

## Behavioral predictors of violence

- Angry words
- Loud language
- Abuse language
- Physical agitation
  - making fists
  - pacing
  - akasthisia

## How to de-escalate a patient

- Use a calm voice
- Sit down with the patient
- Maintain adequate physical distance of at least 6 feet
- Attempt to establish rapport
- Listen to the patients concerns

## When verbal de-escalation not enough

- When there is risk of imminent harm and verbal de-escalation has been ineffective
  - pharmacologic supports
  - physical restraints

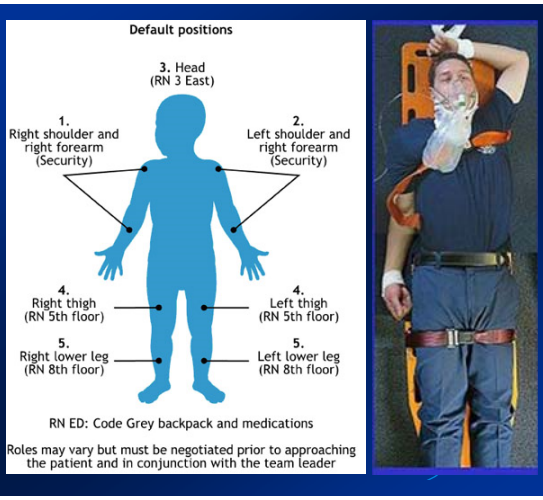
# Physical Restraints

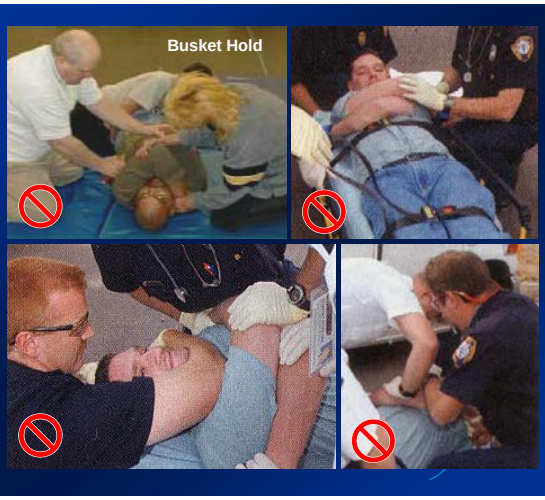
## Physical Restraints

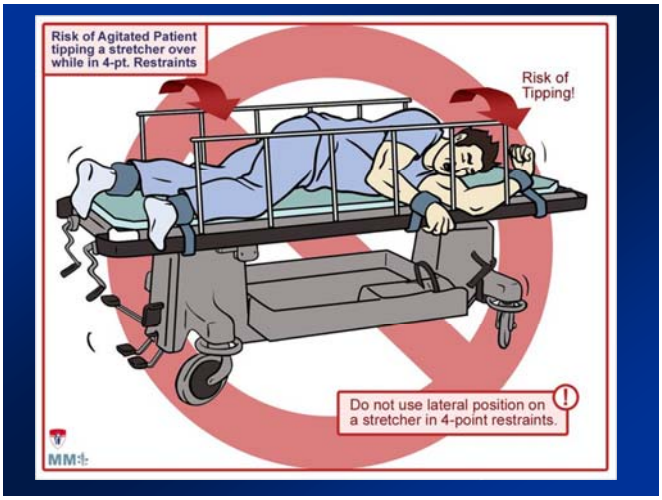
- Have restraints, stretcher and sedative & antipsychotic drugs ready
- Use a show of force with 5 or more trained staff who may need to physically lay hands on the patient
- Sometimes gathering that many clinicians will persuade the patient to comply
  - Try to talk the patient into lying on the stretcher

## Code grey procedure

- If the patient will not comply the team will put the patient in restraints
- Remember people can bite and spit so one of the team will control the head during the restraining procedure
- At least 5 people are required
- The patient should be initially held supine




## Once the patient is in restraints:

- Search the patient for potentially harmful objects such as lighters, knives
- Perform a brief survey for any physical injuries to the patient including head or neck injury and observe movement in all 4 limbs
- Check the head and eyes including eye movements and pupillary response

# Pharmacologic Support

## Benzodiazepines

- Lorazepam (Ativan, Anxicam)
  - as sedative and antipsychotic
  - best absorbed IM; available in PO, IM, liquid, sublingual (Canada)
- Midazolam (Dormicum)
  - IM is well absorbed

## Benzodiazepines

- Diazepam (Valium), chlordiazepoxide (Librium)
  - erratic absorption
  - PO or IV administration of diazepam is effective and actually has a more rapid absorption than PO lorazepam

## Cautions with BZD

- The primary reason not to use a BZD is its sedative hypnotic effect which can be additive with other such agents (ex. alcohol) resulting in excessive sedation and respiratory depression
- Patients can have a paradoxical reaction and actually become more agitated (5%)

## Antipsychotics

- Antipsychotics can be quite effective in reducing agitation
- There are options in the following forms:
  - PO
  - Quick dissolving tabs
  - IM

## IM Antipsychotics (1)

- Haloperidol (Haldol)
  - 1-5mg IM q 1h (< 20-30mg/24 h)

  [SKH] HALDOL 5mg/amp; HALDOL 5mg/TAB
- Droperidol (Dropel)
  - 2.5-5mg IM/IV
  - note black box regarding arrhythmias

  [SKH] DROPEL 2.5mg/amp

## IM Antipsychotics (2)

- Olanzapine (Zyprexa)
  - 5-10mg IM (< 20mg/24 h)

  [SKH] ZYPREXA 10mg/vial
- Risperidone (Risperdal)
  - 25 mg IM Q2W (not used in ER)
- [SKH] RISPERDAL 37.5mg/vial (im)
- Ziprasidone (Geodon)
  - 20mg IM q 4h or 10mg q 2h (< 40mg/24h)

  [SKH] GEODON 60mg/cap

## PO Antipsychotics

- Risperidone (Risperdal)
  - 1-2 mg po (< 6mg/24h)

  [SKH] RISPERDAL 2mg/tab; 1mg/ml
- Olanzapine (Zyprexa)
  - 10-20mg po (< 20mg/24h)

  [SKH] ZYPREXA 5mg/tab
- Haloperidol (Haldol)
  - 1-5mg po q 1-2 hours NTE 30mg/24h

  [SKH] HALDOL 5mg/tab

## Extrapyramidal Symptoms

- Haldol is the most likely to cause extrapyramidal symptoms (EPS) followed by risperidone
- EPS is most likely to occur in young males and older women
- EPS is usually noted as muscle tightness in limbs, tongue thickness and neck tightness
- More rarely laryngeal and pharyngeal spasm and a sense of choking

## EPS Treatment

- Give O2 if breathing problems develop
- Diphenhydramine (Vena) 50mg q 4-5 h
  [SKH] DIPHENHYDRAMINE 30mg/1ml/amp
- Trihexyphenidyl (Artane) 2mg/day ~ 5-15mg/day
  [SKH] ARTANE 2mg/tab
- Biperiden (Akineton) 2.5-5mg IM or 2mg PO
- Benztropine (Cogentin) 1-2mg PO or IM q 8-12h

## Take Home Points

- Safety is always the first concern in the emergency setting
- To maintain safety both physical restraints and pharmacologic support may be needed
  - Anxicam (Ativan), Dormicum
  - Haldol, Zyprexa, Risperdal
  - Vena, Artane, Akineton, benztropine

## References


- Emergency Psychiatry - Christos Dagadakis, MD, MPH.
- Use of Restraints, PART 1 & 2, http://www.charlydmiller.com/LIB02/2003jemstricksreview.html