Take CAUTION in emergency and inpatient psychiatric settings

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Mental health care professionals are at increased risk of being assaulted by patients, especially in emergency and inpatient settings. Less experienced clinicians are at an even higher risk: Studies estimate that up to 56% percent of psychiatric residents have been physically assaulted by a patient.[1] Some researchers have examined systematic approaches to improving violence risk assessment[2]; however, the assessment and interview process itself poses a risk to residents and medical students. We recommend using the mnemonic CAUTION to remind clinicians about safety considerations when working in psychiatric settings.

Communication. Talking about safety should be a priority during daily rounds. Routinely ask staff and other personnel about safety concerns. In inpatient settings, post a safety board where hospital staff can record aggressive behaviors and other safety issues displayed by patients. Notify staff whenever you plan to interact with patients at risk for aggression or when a patient seems agitated.

Attire. Follow proper dress codes to ensure personal safety and improve your ability to quickly assist others in need. Avoid wearing necklaces, ties, and high heels in inpatient psychiatric units. Valuable accessories (eg, expensive wrist watches) should not be worn because they may be broken during a "take down."

Untreated symptoms. Be aware of patients with untreated or undertreated symptoms, including psychosis or substance intoxication. Emergency room patients or newly admitted inpatients often present the greatest risk because of their untreated symptoms (eg, patients with paranoid delusions).

Threats. Patients who express threats are at significantly increased risk of assaulting someone.[3] Patients who have recently voiced threats should not be engaged alone or without adequate staff support. Inform all residents and students about specific patients who have voiced threats. Agitated and threatening patients can pose a risk to everyone in the unit, regardless of whether they have worked directly with the clinician.

Impulsivity. Approach impulsive and aggressive patients with particular caution. Until the aggression is controlled, these patients are at risk for sudden assaults when they feel provoked. Warning signs include punching a wall or breaking objects on the unit, facial muscle tightening, clenching of fists, and pacing. If a patient does not respond to redirection from staff, he or she may require seclusion, emergency medications, or both.

Options. Whenever possible, provide patients with choices, especially when a patient requests discharge or demands a particular medication. Avoid taking an authoritarian stance by clarifying reasons why the patient's requests are being denied and by providing alternatives and options. For instance, if discharge is not indicated, direct a patient to contact the patients' rights advocate. You also can give some agitated

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This month's instantpoll

Ms. Z, age 31, has a history of bipolar I disorder, which has been well controlled with risperidone, 2 mg/d, for 5 years. She recently learned that she is 6 weeks pregnant with her first child. She is concerned about risperidone's effect on her baby. **How would you treat her?**

- ☐ Maintain Ms. Z's risperidone dose and educate her about the risks of untreated illness
- ☐ Switch Ms. Z to quetiapine, 400 mg/d
- ☐ Switch Ms. Z to lurasidone, 40 mg/d
- ☐ Discontinue risperidone and schedule frequent follow-up appointments

See **"Atypical antipsychotics during pregnancy"** *page 12-20*

Visit CurrentPsychiatry.com to answer the Instant Poll and see how your colleagues responded. Click on "Have more to say?" to comment.

MAY POLL RESULTS

Ms. M, age 24, has continued to take sertraline, 50 mg/d, since her depressive symptoms were treated successfully 1 year ago. However, recently she begins to again experience depressed mood, insomnia, difficulty concentrating, and low appetite. She says she has not had any recent stressors that she feels could have triggered these symptoms. **How would you treat her?**

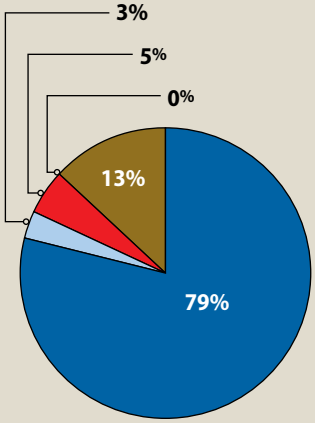
79% Increase sertraline until her symptoms resolve

3% Augment sertraline with an antidepressant from a different class

5% Augment sertraline with an atypical antipsychotic

0% Switch her to an antidepressant from a different class

13% Refer her for cognitive-behavioral therapy




Pearls

Depressive recurrence on antidepressant treatment (DRAT): 4 next-step options

SUGGESTED READING:
Dunlop BW. CURRENT PSYCHIATRY. 2013;12(5):54.

Data obtained via CurrentPsychiatry.com, May 2013

Pearls

patients the option of taking a voluntary "timeout" or going to an isolated area to calm down.

Navigate safely. Identify potential exits from the room before the encounter. Residents and medical students should have a clear understanding of where to escape from a potential assault. Also, it is important to point out to patients where the door is should they feel threatened. Do not block the door when interviewing paranoid patients.

We suggest that less experienced clinicians refer to this mnemonic before starting work in emergency and inpatient psychiatric settings. Safety is an important consideration. By considering these basic concepts, we believe that safety can be improved.

References

1. Antonius D, Fuchs L, Herbert F, et al. Psychiatric assessment of aggressive patients: a violent attack on a resident. Am J Psychiatry. 2010;167(3):253-259.
2. Teo AR, Holley SR, Leary M, et al. The relationship between level of training and accuracy of violence risk assessment. Psychiatr Serv. 2012;63(11):1089-1094.
3. Maier GJ. Managing threatening behavior: the role of talk down and talk up. J Psychosoc Nurs Ment Health Serv. 1996;34(6):25-30.