1. **Inpatient treatment primary goal**

Crisis stabilization

2. **define seclusion**

involuntary confinement of an individual alone in a room or area from which the individual is prevented from leaving

3. **use of seclusion**

-Imminent risk of harm to themselves/others

-Laws differ state to state

-Only to ensure the immediate physical safety of pt and others

-Never as means of discipline, coercion, or for staff convenience

4. **Evaluating a clients capacity for decision making**

-Assess for communication barriers: language, hearing or vision impairments, dysarthria

-Evaluate for reversible causes of incapacity: infection, medications or other substances, acute neurologic and psychiatric disorders

-Identify values and cultural influences that may impact client decision making

-Ask questions: determine the pt's ability to understand the treatment and how treatment applies to their situation.

-Identify a surrogate if needed: healthcare advance directive, medical power of attorney, spouse, adult children, other close relatives

-Document

5. **involuntary civil commitment**

-legal intervention directed by a judge to order a person w serious symptoms to either remain in psych hospital/ attend supervised outpt tx.

-May be initiated by family member/mental health professional/ law enforcement

-The person in question may have the right to appear at their hearing w counsel and present evidence to dispute the case

-The max length of inpatient commitment varies by state.

-Outpatient commitment/assisted outpatient treatment (AOT)= may consist of supported housing, intensive case management, meds, and frequent therapy

--Tx may last 6- 12 mo

6. use of restraints-seclusion criteria

-Only to ensure the immediate physical safety of pt and others

-No evidence that restraints decrease risk of falls

-Last resort

-Never as means of discipline, coercion, or for staff convenience

-Face to face eval and written order required, eval must be completed within 1 hr of application of restraint/seclusion

--not allowed PRN

--must reevaluate q24h

7. risk factors of suicide

-History of substance abuse

-Physical disability/illness

-Losing a friend or family member to suicide

-Ongoing exposure to bullying behavior

8. mental health condition

-Recent death of a family member/close friend

-Access to harmful means

-Relationship problems

-Previous suicide attempts

9. physical risk assessment

-quick visual exam to evaluate

--skin color, sweating, pupil size, level of consciousness, or obvious injuries to ensure adequate airway, breathing, and circulation.

-Vital signs may be obtained if the pt permits; if not, continue assessment w/o getting vs.

10. define psychiatric emergency

-involve acute disturbances in thought, mood, behavior /social interactions that negatively impact a pt's abil to function in their environment and require immediate intervention to keep the pt/others from harm

--a state of crisis that has overwhelmed their coping mechanisms

11. psychiatric emergencies occur when

-a danger to self

-a danger to others

-unable to meet their own basic needs for food/clothing/shelter d/t a psychological impairment

12. common psych emergencies

suicidality, acute psychosis, agitation and aggression, mania, substance-related concerns, decompensation r/t personality d/o, severe anxiety, and med-related emergencies

13. early signs of aggressive behavior

threatening comments, clenched fists, shifts in body position towards a fighting stance, loud vocalizations, agitated movements / striking inanimate objects

14. interventions for aggressive behavior

When aggression is unavoidable- prioritize security, sedation, and supervision

AEIO risk assessment categories

15. Agitation/Arousal: sit still? pacing? demonstrating aggressive behaviors?

Environment: Is the pt in a safe location? Id potential exits, equipment in the room, and the distance of the room from the rest of the unit.

16. **Intent: pt have thoughts of harming themselves or others?** pt having psychotic experiences that may cause them to harm themselves/others?

Objects: pt have access to firearms, blades, medications, lighters, or clothing items that could be used to harm themselves/others?

17. de-escalation techniques

-is a first-line response to potential violence/ aggression in healthcare settings

-aka conflict resolution/crisis management, involves strategies and techniques to reduce a pt's agitation/aggression

--Clear, calm, empathetic, nonjudgmental communication

--Respect for personal space

--Non-confrontational approach

--Non-threatening nonverbal communication

--Response to pt's expressed problem/condition

--Clear limits

--Environmental controls: minimizing light, noise, and loud conversations

18. suicide warning signs

-A sense of hopelessness or no hope for the future

-Isolation/feeling alone

-Aggressiveness and irritability

-Possessing lethal means

-Feeling like a burden to others

-Drastic changes in mood and behavior

-Frequently talking about death

-Self-harm, like cutting behaviors

-Engaging in "risky" behaviors

-Making funeral arrangements

-Giving things away

-Substance abuse

-Making suicide threats

-Negative view of self

19. SAFE-T

-- Suicide Assessment Five-Step Eval and Triage

-Identify risk factors

-Note those that can be modified to reduce risk

-Identify protective factors

-Note those that can be enhanced

-Conduct suicide inquiry

-Suicidal thoughts, plans, behavior, and intent

-Determine risk level/intervention

-Determine risk

-Choose appropriate intervention to address and reduce risk

-Document

-Assessment of risk, rationale, intervention, and follow-up

20. lithium toxicity

-Lithium has a narrow therapeutic range.

-Too much lithium can quickly cause toxicity- lead to acute kidney injury and death

-Lithium toxicity may occur- d/t excessive intake related to OD or dosage modifications

--may also occur from impaired excretion; when pts experience sodium and fluid depletion from vomiting, diarrhea, fever, or a low sodium diet

--lithium is reabsorbed by the kidneys which increases serum levels of the drug

21. how to confirm dx of lithium toxicity

lithium level

22. early sxs of lithium tox

n/v/d, hand tremors, slurred speech, vision changes.

-- chronic tox may present w/o gi sxs

23. later sxs of lithium tox

-hyperreflexia and muscle spasms, nystagmus, dysrhythmias, confusion, and delirium.

-Seizures and death may occur if- serum lithium concentration exceeds 3.5 mEq/L.

24. treatment for lithium tox

-D/C lithium

-supportive care, admitted for cardiac monitoring, iv fluids, and serial lithium levels.

-Acute OD= treated with gastric lavage.

-Hemodialysis may be required for pts with severe toxicity.

-After stable, resume lithium, serial med levels, and pt edu

25. Clozapine-induced agranulocytosis (CLIA)

-in less than 1% of clients prescribed clozapine

--potentially life-threatening.

--Cause unknown, may be a genetic component to the reaction

26. sxs of CLIA

-fever and chills, increased heart rate, sudden hypotension, muscle weakness and fatigue, mouth ulcers, and sore throat

--Onset of symptoms- any time following start of clozapine, most common after 4-5 wks of drug therapy

27. how to confirm dx of CLIA

-CBC