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Divergence From the Archaic Norm of “Restrain and Sedate” Optimization of ER Triage Strategies for Agitated Bipolar Disorder and Schizophrenia Patients

Announcer:
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Dr. Zeller:
Hello, my name is Dr. Scott Zeller. I'm an Assistant Clinical Professor of Psychiatry at the University of California Riverside School of Medicine in Riverside, California. I've also been the author of a number of textbooks on agitation, and led the International Guidelines Project on best practices for the evaluation and treatment of agitation over the past several years.

And what I'd like to talk with you today is about how we might be able to diverge from that archaic norm of what we call restrain and sedate, which is still far too common when an agitated person enters an emergency department, and the initial thought is, let's get that person into restraints, and let's give them heavy sedation. And that's the way we treat people? There's a lot of things that we can do better compared to that. And that's what I'd like to chat with you about today.

So first of all, when somebody comes into the emergency department, if they're agitated, if you're thinking it's an agitation from a psychiatric source, that doesn't mean it's necessarily psychiatric. There's a lot of different things that can cause agitation, including a lot of very serious medical conditions. So when somebody comes in, it's really incumbent upon your team, and you as the provider to find out what the presenting problem is, how come this person is there in the ED in the first place. That's what you do with basically everyone who comes to the emergency door anyway. But the next part is really, really important. And that is that you really ensure that there's no medical or organic problems that are causing what appears to be a psychiatric condition of agitation. Far too often overlooked or ignored. And unfortunately, I have far too many sad stories of people thinking a person's condition was, quote unquote, just psych, and so they kind of put them on the back burner, and didn't realize that under that hat and big head of hair, that somebody had had a really bad head injury. And they were - they had an intracranial bleed and some really bad outcomes. So it's really incumbent on everybody to make sure that whatever looks like agitation, and especially if any kind of like confusion agitation, delirium agitation, can very likely be due to a serious medical or organic issue.

And then if we're able to rule those out, then we can focus on those psychiatric issues, if that's indeed what's causing the agitation. And there's many ways we can stabilize folks without having to overstate or restrain. And by doing this, we're actually fulfilling our federal obligations under EMTALA.

So what do we do in triage? Again, what's the presenting problem? And a really focused history is important when somebody comes in who's agitated. You don't need to find out how many years they worked, or their level of education, or whether they're a smoker or anything like that, that all can come later. Those are important things for history. But right now, it's got to be really focused on what's going on, what can we figure out, and what do we need to do right away so that we will have the benefit of that time later to get that more comprehensive history.

Vital signs are in extremely important part. And so many of the nonpsychiatric conditions that lead to agitation can be identified by a rapid heartbeat, a high blood pressure, you know, seriously high respirations, temps that are way out of control. And a visual evaluation is really important. Is somebody's diaphoretic? Are their pupils are extremely dilated? Those kinds of things are going to give you suggestions of other causes of medical comorbidity.

And the other thing that you want to be able to do at that triage level, and it's something that you're now required to do by surveyors is determine the level of risk and observation that you need for your patient while they're in your emergency setting.

So said there are some scary things that can mimic psychiatric agitation, here's just a few of them. I mentioned head trauma, encephalitis, or other infections of the brain or the brain layers, very, very scary. And you know, those act very, very quickly as you know, and can lead to really bad outcomes in a matter of hours. Encephalopathy can look just like psychiatric conditions, especially with people with end-stage, liver failure, you know, end-stage alcoholic disease. Metabolic hypoglycemia can look just like Schizophrenia, when somebody's got a really low blood sugar. A finger stick can tell you the difference between that and somebody who's having a decompensation from a psychiatric condition. And some of these others as certainly hyperthyroid can look like mania, and we need to really, really worry about overdoses, toxic level of meds, poisons, and even seizures in a postictal state can look like the confusion of serious medical conditions.

So it's really important that we use rating scales, just like we do is so many other medical conditions, so that we can communicate between our staff members so that we're all on the same page when we're talking about a patient. And agitation scales are something that really you should be thinking of including in this. And the good news is there's some really, really simple ones that have 100% interrater reliability, I like the what's called the Behavioral Activity Rating Scale. It's just a real quick 7-point scale. So instead of you having a nurse come to you and say, ‘Hey, we've got a patient, he's loud, he's boisterous, he's not sitting still. He's doing all kinds of things, he's refusing to listen, and he's causing problems.’ Instead of all that and taking a minute of your time before you can even start thinking about what to do, they could just come and say, ‘Hey, we got a BARS 6, what do you need?’ And that's where you can actually really start to throughput your triage that much more quickly, and help that person who's suffering and get - needs your help so badly, much, much more quickly.

And along the same lines on throughput times, you know, a lot of times, we've talked to docs who say, ‘Yeah, we see these agitated patients coming in, and the easiest thing for us to do is to put them into physical restraints, give them three shots into their bare bottom. That's going to make them unconscious. They won't even wake up due to a sternal rub. And the good news about that is not only are they not going to wake up until the next shift, so it's not going to be my problem, but they're not going to be threatening or hurting anybody or causing any disruption.’ Well, that might have made sense at some point in the past when these patients were kind of more rare, and you knew you had an inpatient bed waiting as soon as became available. But in recent years, there's far more patients than there are inpatient beds. And indeed, we find that the vast majority of them probably don't even need inpatient beds if you change your paradigm, and start treatment rather than just thinking of restraining and sedating. So you can actually, if you change their mindset from, ‘Let's put people into restraints and heavily sedate them,’ to, ‘Hey, we have a lot more opportunities for this individual. If instead of knocking them out, we chill them out. Let's calm them down. Let's use de-escalation. Let's keep them awake, because that's going to help them continue to move through the system.’ If we call a hospital, refer a patient to, and they say, ‘What's the patient doing now?’ And you say, ‘They're unconscious,’ they'll say, ‘Call us back when they're awake.’ If you call for a consult, same thing, ‘Call us back while they’re awake.’ That's going to lead to big backups in your emergency setting. So it's much better that you have somebody who may be mellow, maybe chilled out, maybe even a little sleepy, but still awake and easily able to wake and somebody who will answer questions.

And those medications that you're giving in your emergency setting, those are not chemical restraints, by the way. Chemical restraints are too often used as a stand-in for medications for psychiatric conditions that are given intramuscularly, let's say. But those are not chemical restraints. The definition of a chemical restraint is a medication that's used for a condition, it's not indicated for solely to restrict the freedom of movement and liberty of an individual or for staff convenience. That sounds really horrible, doesn't it? You're not doing that. You're giving a medication to treat a patient in a well-established protocol, that is the treatment of agitation. And remember that, you're not chemically restraining somebody, you're actually treating their condition of agitation. And that can be really huge because if you call it chemical restraints you need to do the same type of documentation and observation as physical restraints. You call a treatment, which is what it is and what it should be. That's a whole different documentation.

But if you can avoid physical restraints altogether, that's going to lead to a length of stay of your psychiatric patients in the typical hospital general medical emergency department 4, almost 4.5 hours longer than if you had not put them into restraints. So if you're concerned about throughput time, if you're concerned about wall time, if you're concerned about door-to-discharge time, it's a good thing for you to avoid restraints whenever possible. And if you might say, ‘Wait, if we don't restraint people, there's going to be more injuries, more assaults,’ actually, all the research shows that if you reduce restraints in your emergency department, the number of

injuries and assaults go down because two-thirds of staff injuries involving placing a patient into restraints happened during that process of putting them into restraints, and that's where the combativeness is. That's where somebody gets an elbow or a knee or kick or things like that. If you can find ways to stop using restraints and replace it with a more therapeutic alliance, collaboration, and de-escalation, you're going to have wonderful, wonderful outcomes as a result.

Indeed, everything result - revolves around de-escalation with an agitated patient. You can do much better if you use some basic calming de-escalation techniques that will help you do the medical eval, the psych eval, and even offer medication. Medication is part of de-escalation. You can say, 'Hey, you're going through a tough time, I think some medication would work now. What's worked for you in the past, and maybe I can get that for you and get a couple pills in a glass of juice?' How different is that then tying somebody down, pulling their pants down, and sticking three needles into their bare bottom? All of these things help prevent the need for seclusion and restraint.

And so that's why it's really incumbent upon teams who work with psychiatric emergency patients to really get good at de-escalation. It's a pretty basic technique that anybody can learn. It doesn't take long to learn it, a lot of it is a philosophy and approach. And once you start doing it, it just makes all the difference in the world.

If there's one thing I can tell you, that you can take away from today about learning de-escalation, it's a very simple one. It's almost like the golden rule. If somebody is agitated, don't be agitated back to them. Be the mellow person, listen, listen, ask questions, that's going to help people to calm down. And you might say, 'Well, I don't have time to do that. It's easier for me to write an order to put somebody in restraints and give medications.' But you know what, the average de-escalation only takes a couple of minutes. And when you think of what all your team is doing, putting that person in restraints, calling up medications, that might be several different people working for 20 or 30 minutes to pull that off. So you've like lost your whole team. So maybe it's a little bit easier for you, but everyone else in the emergency department is working 10 times harder, where all it took was a minute or two of a sympathetic ear, and really working towards getting that patient the help that they needed. If you can avoid that containment procedure, putting people in restraints, like I mentioned, far fewer injuries to both staff members and patients. And you're going to get some other nice outcomes. patients aren't going to see you as their adversary, they're going to be more trustful. Maybe they're going to listen to you later if you found ways to avoid tying them down and injecting them, and instead work with them collaboratively and offered medications willingly.

And when you're trying to move those patients to those outside facilities, those psychiatric hospitals or other psychiatric programs, you know, if you call them up and say, 'We've got a person in restraints, will you take them?' and they say, 'No,' and hang up the phone, 'Call us back when they're out of restraints.' But if you've got somebody who you can document was cooperative, did well, took meds willingly and was never in restraints, that person is going to go to the top of your list in terms of interest from the psychiatric hospitals.

So really quickly, just to sum up, when we do give medications, those are not chemical restraints, but they're actually targeted, appropriate treatments that you're choosing to treat the symptoms of agitation. And agitation is a disease state. And you need to think of it that way. You're not punishing anybody. You're not restraining anybody with medications, you're treating the underlying condition that has caused agitation as one of its disease state symptoms. Best to use nonpharmacologic approaches first, that's de-escalation and calming techniques. And again, use medication to chill people out, not knock them out. You don't get any benefits from having somebody unconscious and snoring. A lot of benefits by somebody who's a little bit sleepy, but is still able to talk over things with you. If you come in, give them a little, you know, touch on the shoulder, they'll wake up and be able to chat with you. Miles and miles ahead of the game if you do that. And it's also important to actually ask your patients what medications work for them. It's really good to say, 'Hey, can we help you out? What meds worked for you in the past?' And 9 times out of 10, they're going to ask for oral meds.

So that's our talk for today. And thank you very, very much. I really, really appreciate everybody listening in. And I'm Dr. Scott Zeller from University of California, Riverside, and I'm happy to chat with you, anybody, if you'd like to speak more about agitation, it's a passion of my career. Thank you.

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