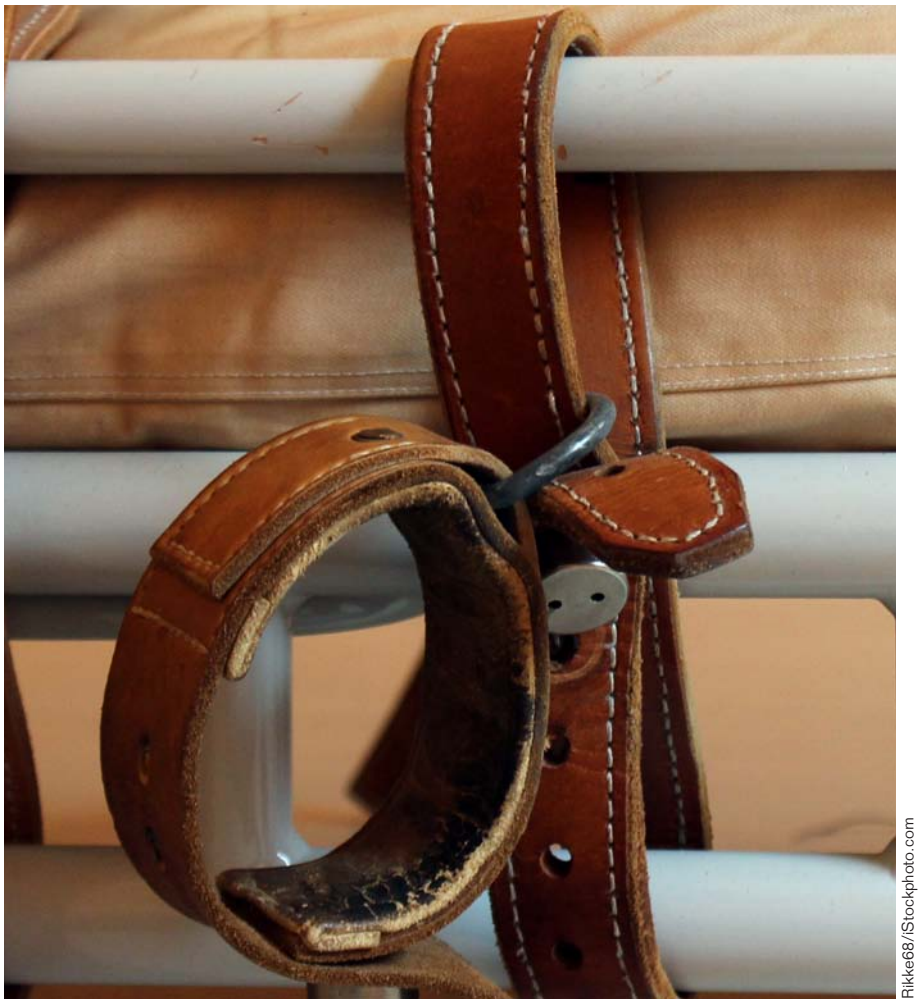
Balancing Restraint and Safety in the ED

BY GINA SHAW

'I felt like nobody really cared...I cried...I felt like I was alone."

"It was scary for me. I felt like I had no control over my body."

"I couldn't even hold my head up, I was drooling. It's terrible, and I still have flashbacks about that. I don't want to go back to that again, ever."



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These are some of the comments from a recent qualitative study exploring patient perspectives on being physically restrained in the emergency department. (*JAMA Netw Open*. 2020;3[1]:e1919381; https://bit.ly/3heQqpB.) The authors, an interprofessional team from the Yale School of Medicine led by Ambrose Wong, MD, an assistant professor of emergency medicine, interviewed 25 patients who had been physically restrained during an ED visit at one of two study sites, one a tertiary care academic referral center and the other a community-based teaching hospital.

The interviews addressed participant experiences in the ED, associated health conditions, reflections on restraint episodes, and consequences on health outlook and interactions with health care. Despite the frequency of agitation as a presenting condition in the ED—a 2018 study found it was associated with 2.6 percent of all ED visits (*Ann Emerg Med*. 2018;72[4]:361)—the *JAMA Network Open* study authors noted that "studies that are drawn directly from the perceptions and experiences of patients who experienced agitation episodes in the ED are rare."

Many of their findings were not surprising. Eighty-eight percent of participants reported a combination of mental illness and substance use as contributing to their restraint experience. A large majority (80%) also said they did not feel they had a lot of control over whether they went to the hospital. Disturbingly, the interviews also revealed that a significant number of patients who had been restrained described developing distrust and avoidance of health care interactions and left the ED with "lasting physical and psychological consequences from their restraint experience."

A 2016 systematic review found restraint by sedation was complicated by respiratory compromise, QT prolongation, paradoxical increase in agitation, and death in 37 percent of cases. (*Am J Emerg Med*. 2016;34[12]:2426.) Other studies have found significant complications stemming from physical restraint use. (*J Emerg Med*. 2003; 24[2]:119; *Forensic Sci Int*. 2008; 178[2-3]:178.)

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>
> Ambrose Wong, MD

Risks and Benefits

Using restraints in the emergency department has always been a challenging issue in so many different ways, Dr. Wong said. "This is a population that is vulnerable, marginalized, and neglected by the health care system at large," he said. "As illustrated in our study, these patients typically have mental illness, substance abuse issues, or both. But with more preventive services, they may not have gotten to the point where they became agitated in the ED. They need more focus in terms of research and services, but now with COVID-19, they are even more vulnerable because it is so hard to access care."

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>
> ED patient held in restraints

At the same time, Dr. Wong said, health care workers also face increased stress and threats to their safety from COVID-19, changing the risk-benefit equation when restraints are considered. "If someone is spitting at you or potentially being violent, your risk is increased even more given the pandemic," he said. "So the balance between keeping our staff safe and making sure we're doing the right thing for our patients is very challenging."

The American College of Emergency Physicians released its most recent statement in February supporting the use of restraints in the emergency department, though it acknowledged that patient restraint involves issues of civil rights and liberties, including the right to refuse care, freedom from imprisonment, and freedom of association. "However, there are circumstances when the use of restraints is in the best interest of the patient, staff, or the public," the statement read. "Patient restraint should be considered when a careful assessment establishes that the patient is a danger to self or others by virtue of a medical or psychiatric condition and when verbal de-escalation is not successful." (https://bit.ly/2ClrTtO.)

It may not be possible to entirely eliminate the use of restraints for agitated patients in the ED, but hospitals can work with law enforcement and EMS to establish training procedures, systems, and physical spaces that can reduce the need for their use, said Daryl Knox, MD, the chief medical officer for the Harris Center's Psychiatric Emergency Service located at the Neuro-Psychiatric Center, one of the major public mental health emergency programs in Harris County, TX.

"In some areas, including here in Harris County, our police and sheriff's departments are required to go through training in crisis intervention techniques, de-escalation, and resources available to individuals experiencing these crisis situ-

ations," Dr. Knox said. "I'm familiar with similar programs in California and Tennessee. One very helpful strategy that we have employed is to pair up law enforcement with social workers who respond to mental health-related cases together. The social worker also has access to medical records, so they can identify any relevant medical history."

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> **Daryl Knox, MD**

Dr. Knox's facility, an emergency department unaffiliated with a hospital, includes a separate police entry where police can bring crisis patients. "We have an inviting, comfortable environment with a room where they can sit down and be interviewed by staff before they are taken to the emergency unit. That area has social workers, psychiatrists, and nurses available 24/7," he said. "Our use of emergency medications or physical restraints is fairly low. We track that by how many minutes people remain in the seclusion room, and aim for that trend to go down on a continuing basis."

Project BETA

Dr. Wong co-authored a recent paper on implementing better approaches to the acutely agitated patient at Parkland Hospital using Project BETA (Best Practices in the Evaluation and Treatment of Agitation), which was derived from a 2012 interdisciplinary working group led by the American Association for Emergency Psychiatry. (*JACEP Open*. May 15, 2020; https://bit.ly/3l41U1q.) These recommendations focus on verbal de-escalation as a first-line treatment for agitation, pharmacotherapy that treats the most likely etiology of the agitation, appropriate psychiatric evaluation and treatment of associated medical conditions, and minimization of physical restraint and seclusion.

Parkland Hospital in Dallas, a county hospital with more than 240,000 patient visits each year, began implementing agitation protocols based on the BETA guidelines in 2016, creating an agitation order set in the electronic medical record along with an educational curriculum that included training in verbal de-escalation and self-defense for EPs and ED nurses. An ED Violence Prevention Response Team, composed of ED leadership, nurses, and police officers, rounds on potentially violent patients and is called to the bedside during any escalations.

De-escalation techniques taught include:

- Respecting personal space, but ensuring safety
- Using appropriate language such as a soft voice, slow movements, eye contact, not provoking, and being concise
- Identifying wants and listening closely to what the patient says
- Agreeing to disagree
- Setting clear limits and explaining what will happen in the ED
- Offering food, drinks, and blankets
- Debriefing the patient and staff

The *JACEP Open* article noted that an unpublished survey just prior to implementation found that 28 percent of the 50 Parkland emergency medicine residents who responded had been physically assaulted by an ED patient during residency. (May 15, 2020; https://bit.ly/3l41U1q.) At the time the article was published, 18 months after the BETA guidelines were put in place, there had been violent physical assaults by patients on five of the 66 emergency medicine residents in the Parkland ED, none of which involved serious injury and all but one of which could have been prevented with strict adherence to the BETA guidelines.

Yale has recently established a similar interprofessional Agitation Code Team for response to such calls, with representation from patient safety, social work, legal, emergency psychiatry, protective services, and ED leadership. "When we receive a notification that an agitated patient is en route, the Agitation Code Team is summoned," Dr. Wong said. "Security officers along with clinical staff come together with one mindset, focused on that patient's particular situation. Our goal is spending time to understand why the patient is agitated. Sometimes they're just upset and need someone to talk to. Or they are angry because of the way they've been treated. But if they do need to be restrained or sedated, we have the expertise to do it safely right there."

The ACT alert is too new for outcomes research to be reported, Dr. Wong said, but they recently published their protocol with the hope that others may be able to use a similar approach in their EDs. (*BMJ Open*. 2020;10[6]:e036982; https://bit.ly/2YgHs3m.)

Environmental Approaches

In addition to interdisciplinary response teams, policies, order sets, and training, the physical environment in which agitated patients receive care plays an important role in de-escalation and mitigating the need for restraints.

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>
> **Matthew Wynia, MD, MPH**

"Most psychiatric hospitals today don't look the way people would imagine them to look," said Matthew Wynia, MD, MPH, the director of the Center for Bioethics and Humanities at the University of Colorado's Anschutz Medical Campus, who co-authored a commentary on Dr. Wong's new study in *JAMA Network Open.* "Their spaces often look more like yoga retreats," he said. "If we take seriously the need to provide excellent quality care to people in psychiatric crisis, you could have an area purposely built for these situations. It doesn't have to be large. Maybe just a room with a window onto a pleasant outdoor space, or a little waterfall table, or posters on the wall to make it feel more homelike, less sterile and clinical.

"We also recommend engaging patients and families who live through these experiences to help with making these spaces more calming because a psychiatric emergency is the opposite of calm. I would like to think that even in a relatively small ED, there are things you could probably do to create a space designed for individuals showing up with psychiatric crisis, in the same way we clearly have specific spaces for trauma."

Dr. Wong agreed. "Many of these patients are taken care of in environments within the ED that are very loud and not conducive to helping patients to de-escalate," he said. "EDs need to make it a priority to identify spaces where we can have low lighting and low noise levels and help people to be calm."

He acknowledged the challenges emergency clinicians face in managing these patients. "They are trying to do the right thing by these patients, and they are often physically harmed or threatened," he said. "We need to create systems, policies, and environments that protect both our clinicians and our patients in these difficult situations and make de-escalation possible." **EMN**

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