01 - Chapter 20 Approach to the Psychiatric Patien

Chapter 20 Approach to the Psychiatric Patient in the Emergency Department

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228 APPROACH TO THE PSYCHIATRIC PATIENT IN THE EMERGENCY DEPARTMENT Safety Assessment ■ Position yourself close to the exit Medical Clearance Orders ■ De-escalating the situation: De-escalation Techniques During the course of your psychiatry clerkship, you may be asked to see a patient who is in the Emergency Department (ED). Unlike on the psychiatry floor/ward or even a psychiatric emergency holding unit, the ED sees patients with all sorts of complaints, and is not particularly well-suited for psychiatric patients. Reasons contributing to the ED environment being challenging include staff frequently entering and exiting the patient’s room, which may interrupt your interview; a high level of activity and noise; and a large number of distractions. Psychiatric patients in the ED are from some of the most marginalized segments of society. They may be homeless, may have untreated, undertreated or mistreated psychiatric illness, and their presentation may be confounded by acute intoxication with alcohol, drugs, or co-existing medical illness. Many patients are brought in by law enforcement/police, which may unfortunately exacerbate a patient’s aggression or paranoia. When patients are hostile or scared, it is difficult to develop a rapport with them. When interviewing such patients, it is preferable to enter

the room without law enforcement as long as there does not seem to be an immediate threat of physical harm to you or your team (see Figure 20-1). How to assess whether the room/patient is safe (see Table 20-1): ■ Position yourself on the patient's nondominant side • This is usually the patient's left in 95% of cases. • Patients usually wear their watch on their nondominant hand. • Their belt buckle usually faces to the nondominant side. ■ Do a quick visual to make sure no objects that can be used as weapons are around. ED rooms designated as psychiatric rooms are usually devoid of such objects, but if the patient is in a regular medical room, then there may be many items that could be dangerous (e.g., suction canisters, trashcans, needles, intravenous [IV] poles). ■ Be prepared to de-escalate the situation. Recognize that the patient may not be there by choice; that they may be been treated poorly by law enforcement; that they fear losing their independence; that this new environment aggravates their paranoia; and that the ED may be a place that they mistrust. • Speak softly (if they have to strain to hear you, they will have to be quiet themselves). • Offer them food or drink (they rarely have to go to surgery, so keeping them NPO is not usually a concern, and most ED psychiatric patients are hungry). • Bring them a blanket (it is usually cold in the ED).

When you enter the room, do a quick visual to make sure there are no immediate hazards in sight. Ensure exit is clear in case you need to get out of there fast. Ensure your own safety and that of your team Stand on the patient's non dominant side FIGURE 20-1. Suggested steps for approaching a psychiatric patient in the ED. TABLE 20-1. Typical Medical "Clearance" Orders Undress patient, place in hospital gown Continuous pulse oximetry Cardiac monitor Electrocardiogram (ECG) Peripheral IV Complete blood count (CBC) Complete metabolic panel (electrolytes and liver function tests) b-hCG (if female) Magnesium Alcohol Salicylate Acetaminophen Urinalysis Urine drug screen Suicide precautions (sitter) Seizure precautions (padded bedrails) • Speak to them like an individual. Pick your favorite benign topic of conversation, such as the weather. One choice is: "Where were you born and raised?" It's unusual to be asked something like that, so it tends to catch the patient off guard and put them more into a conversation mode. • Ask their permission to examine them. Respecting anyone's personal space is important, but especially so with the psychiatric patient. • If they are going to be admitted to the psychiatric unit, explain what is going to happen to them. Hopefully they have been seen by an ED physician and the process has been discussed, but this is not always the case. If you are the first student they are talking to, explain that the ED will do a medical clearance evaluation (see Table 20-1), and then they will be brought to the behavioral health unit/psychiatry floor. While respecting their dignity and APPROACH TO THE PSYCHIATRIC PATIENT IN THE EMERGENCY DEPARTMENT Review patient's ED workup to see if there are urgent medical conditions that need to be addressed Determine if patient meets criteria for involuntary commitment (suicidal, homicidal). Ensure patient is in a hospital gown and has been searched for weapons Check labs for electrolyte abnormalities, replete if indicated Review any imaging (especially head CT if ordered) Review EKG

230 APPROACH TO THE PSYCHIATRIC PATIENT IN THE EMERGENCY DEPARTMENT Communication with ED WARDS QUESTION Q: What medication is used to reverse opiate/opioid overdose? A: Naloxone. Acutely Agitated Patients WARDS TIP Case: You are called to the ED to see a patient. You encounter a 22-year-old male who is very agitated, trying to break free of the numerous paramedics and security officers trying to hold him down. He is loudly yelling to be let go as well as clearly responding to internal stimuli. How should you manage the situation? Answer: Try verbally de-escalating the situation while you order chemical restraints. Order a benzodiazepine and an

antipsychotic together, as that will result in less total benzodiazepine dose being needed. ■ Assess the patient's ABCs KEY FACT Medication Interactions Flumazenil is used for benzodiazepine overdose reversal BUT its use can cause seizures, especially in those patients with a low seizure threshold. Use with caution, and have an airway cart ready in case airway control becomes necessary. Remember that benzodiazepine withdrawal can be life threatening. privacy, ED psychiatric patients should be placed in a gown and searched for items such as weapons, drugs, drug paraphernalia, and medication patches. Communicate with the ED team any plans you have made with your psychiatry attending. ■ Let them know if there are any medications the patient should or should not receive. ■ Expedite the patient's movement out of the ED if possible, as it is the least restful place for them. In the event that an acutely agitated patient cannot be de-escalated, medication(s) may be required. The most common choice is an antipsychotic with or without a benzodiazepine. Either class can achieve control on its own, but benzodiazepines tend to be more sedating. Table 20-2 lists the most common medications used to control acute agitation in the ED. The ability to administer oral or intramuscular medications is very helpful as an acutely agitated patient may not cooperate for the team to safely place an IV. [Assessment of a Sleeping or Unresponsive Patient If you walk in the room and the patient appears to be sleeping or unresponsive, you should do the following: • Airway: Can the patient speak? (if yes, airway is patent) • Breathing: Is the patient breathing? (look for chest rise, auscultate lungs) • Circulation: Does the patient have a pulse? (auscultate heart, check blood pressure) ■ If the patient's ABCs are compromised, immediately get an ED physician. Pull the panic cord if you need to. ■ If the patient's ABCs are stable but they appear somnolent, explore with the ED team whether the patient has received any medications from the ED or paramedics/emergency medical services (EMS) which could be contributing. Psychiatric medications can adversely interact with many other medications. Using a drug interaction calculator to verify interactions will be a huge service to your patient as well as your team. Do not assume that just because patient is prescribed a set of medications, that they are all safe to be taken together. Often, patients get prescriptions for various medications from several prescribers, and concurrent prescriptions are not cross-checked.

APPROACH TO THE PSYCHIATRIC PATIENT IN THE EMERGENCY DEPARTMENT Causes of Mental Status Changes Lab and vital sign abnormalities that can cause altered mental status or delirium: ■ Hypoglycemia/Hyperglycemia. ■ Hyponatremia/Hypernatremia. ■ Hypocalcemia/Hypercalcemia. ■ Hypothermia/Hyperthermia. ■ Hypothyroidism. ■ Hypovolemia. ■ Hypercarbia. ■ Hypoxemia. Geriatric patients (>65 years) are often sensitive to medications so it is recommended to start with smaller doses. Also some geriatric patients can have paradoxical agitation with benzodiazepines. Remember that it is unusual for a patient over age 40 to have a first episode of psychosis. Be sure to search for other medical causes of psychosis. KEY FACT TABLE 20-2. Common Medications Used in Adults for Control of Acute Agitation in the ED Medication (Brand Name) Drug Class Initial Dose Onset of Action (minutes) Half-Life (hours) Adverse Effects/Notes Lorazepam (Ativan®) Benzodiazepine PO, IM, PR, IV: 2 mg IM: 15 PO: 30–60 More sedating than antipsychotics alone Midazolam (Versed®) Benzodiazepine PO, IM, IN, IV 2 mg PO, IN: 12–15 IV: 2–5 1–3 Shortest onset of action Short duration of action may be both an advantage and disadvantage; intranasal route unique Haloperidol Typical (1st generation) antipsychotic PO, IM, IV: 5 mg 20 Extrapyramidal symptoms; anticholinergic symptoms; QT prolongation; neuroleptic malignant syndrome Olanzapine (Zyprexa®) Atypical (2nd generation) antipsychotic ODT: 5, 10, 15, 20 mg IM: 10 mg 15–60 20–50 Safety and efficacy not established for children less than 13 years. Life-threatening sedation and hypotension when co-administered with a benzodiazepine.

Ziprasidone (Geodon®) Atypical (2nd generation) antipsychotic IM; 20 mg 2–5 Causes QTc prolongation; important to assess known history of QTc prolongation, recent myocardial infarction, uncompensated heart failure, or if taking other medications known to prolong the QTc interval. Risperidone (Risperdal®) Atypical (2nd generation) antipsychotic ODT and solution IM: 30–60 PO: 60–120 Quetiapine (Seroquel®) Atypical (2nd generation) antipsychotic Oral tablet form only 6 Long time of onset limits use in acute agitation

232 APPROACH TO THE PSYCHIATRIC PATIENT IN THE EMERGENCY DEPARTMENT WARDS TIP KEY FACT Normal QTc—Men: <440 ms and women: <460 ms. An increase in 10 ms is associated with a 5–7% increase in Torsades de pointes. KEY FACT Visual hallucinations should always prompt search for an underlying medical pathology. Although visual hallucinations can occur with psychiatric disorders, auditory hallucinations are more common. Case: You are called to the ED to see an elderly patient who you are told is psychotic. The patient has a history of Parkinson for which he takes carbidopa-levodopa. He had vomited earlier so he was given one oral dissolving tablet of ondansetron. The ED team wants to give him some Olanzapine to help control his symptoms. As the team that will take over the care of this patient, what would you advise? Answer: Most anti-parkinsonian medications including carbidopa-levodopa can induce psychosis in Parkinson patients, usually manifested as visual hallucinations. It is the most common nonmotor disabling symptom in PD. A quick drug interaction search will reveal that carbidopa-levodopa has a serious interaction with olanzapine, in that it reduces the activity of carbidopa-levodopa. In addition, the combination of ondansetron and olanzapine can result in dangerously prolonged QTc, so be sure to check an ECG.

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