Title: People with Dementia in the Emergency Department: behavioural symptoms and use of restraint

Dear Editor,

People living with dementia are high users of emergency department (ED) services, with up to 40% of older people in ED estimated to have cognitive impairment or dementia (1, 2). The unfamiliar and overstimulating ED environment along with the presenting acute illness can worsen behavioural symptoms associated with dementia.

Behavioural and psychological symptoms of dementia (BPSD) include symptoms such as aggression and psychosis. BPSD is common, complex and multifactorial and can be associated with the environment and unmet needs such as hunger and pain (3). Guidelines recommend using non-pharmacological strategies as the first line approach to manage BPSD, and reserve use of antipsychotic medications for severe symptoms where the behaviour is distressing to the person, or where there is a risk of harm to self or others (4).

The aim of this retrospective audit was to assess the prevalence of BPSD, and use of chemical and mechanical restraint, among people with dementia admitted to the ED of a metropolitan teaching hospital.

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A standardised form was used to review ED notes and collect data (10). All cases were audited by one reviewer who was an advanced trainee and medical registrar in aged care.

The presence of a provisional principle diagnostic code for dementia was used to identify cases: total 142 cases during year 2014, of which 100 were randomly selected for review. The median age was 83 years, 55% were female, 60% living in the community and most arrived by ambulance. The median time in ED was 6 hours and 82% of cases were admitted to hospital.

Thirty-nine percent of cases experienced behavioural symptoms during their ED stay, with aggressiveness (35%) being the most common symptom – this included verbal and/or physical aggression and agitation (Table 1). It was difficult to determine severity of symptoms. Fifteen patients were administered antipsychotics during their ED stay, with one patient administered two types of antipsychotics. Two-thirds of those administered antipsychotics in ED commenced above the recommended low start dose. Six patients received a benzodiazepine, with one patient receiving both antipsychotic and benzodiazepine medications.

The medical notes recorded the following justifications for the application of chemical restraint: agitation (8, 40%), inability to provide care and perform investigations (7, 35%) or aggression towards others (5, 25%). Non-pharmacological strategies such as use of family and reorienting the patient were not well documented (Table 1).

Mechanical restraint was used on 3 patients during their ED stay, for duration of 1.5 hours, 4 hours and 7 hours. The reason for mechanical restraint use was to manage agitation and aggression (n=1), and prevention of harm to self or others (n=2).

Although based on one hospital, this study adds to the limited research on dementia care in hospital and provides important local baseline information that could be used to drive improvement.

In summary, behavioural symptoms were common among people with dementia who presented to ED. Antipsychotic medications were used to manage symptoms such as agitation and aggression, but start doses did not always meeting guideline recommendations.

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