EMA Emergency Medicine Australasia

Emergency Medicine Australasia (2020) **32**, 714–715

LETTER TO THE EDITOR

Challenge of managing patients with COVID-19 and acute behavioural disturbances

Dear Editor,

Patients with acute behavioural disturbances are a common occurrence in EDs. Previous studies in Australian EDs have shown that over 1% of presentations require security staff intervention[1] and the majority of clinical staff are exposed to some form of violence at least weekly.[2] The management of this cohort of patients is complex, often requiring the involvement of a large number of medical, nursing and security staff. The addition of the possible presence of high consequence infectious diseases such as Coronavirus 2019 (COVID-2019) to non-compliant, behavioural disturbed patients poses a unique threat to staff, other patients and members of the public.

Current discussion and planning for ED management of COVID-19 patients has almost entirely been in relation to either the compliant or the severely unwell patient. However, it is unlikely that the proportion of patients with acute behavioural disturbance will be significantly different within the COVID-19 population. Indeed, given the lifestyle factors and comorbidities of patients who frequently present with acute behavioural disturbance, this cohort may be particularly vulnerable to COVID-19. Further, with the increasing severity of illness among the elderly[3] and their predisposition to delirium,[4] it is probable that COVID-19 infection will itself cause acute behavioural disturbances in a subset of patients.

A recent case in the ED of the Royal Adelaide Hospital highlighted some previously unconsidered challenges when managing a patient with both potential COVID-19 infection and acute behavioural disturbance. The patient who was initially compliant presented with alcohol intoxication and suspected COVID-19 infection. They subsequently became agitated at being kept in isolation, barricaded the door to their room and set fire to their belongings which spread to linen and equipment within the room. This necessitated the presence of security, police and the fire service in addition to medical and nursing staff. Unexpected and potentially harmful challenges included:

- Delays in security arrival secondary to having to take a tortuous route because of the closure of doors within the department to construct an isolation area.
- Delays and ineffective application of personal protective equipment (PPE) due to inability to fit an entire clinical and security team into the antechamber where PPE is commonly kept.
- Difficulty in physically restraining a patient within a single room not designed for the behaviourally disturbed patient and a subsequent need to remove the patient from the room to adequately do so.
- Delays in pharmaceutical sedation because of medication for this being located on the other side of the department where patients with behavioural disturbance are routinely managed.
- The extended duration of the duress alarm resulting in a very large number of unnecessary clinical staff without PPE attending and entering a corridor of the COVID-19 clinical area which had become potentially contaminated by the movement of the patient who was actively spitting.
- The subsequent activation of the fire alarm, which in normal circumstances would cause little panic, but in the current environment resulted in a considerable number of patients and members of the public rushing to evacuate. This also highlighted the lack of plan if there were a need to evacuate COVID-19 patients from areas of the hospital.
- The lack of plan on how to facilitate entry of external emergency services (police, fire) into a potentially contaminated COVID-19 area.

A review of the incident estimated that at least 30 clinical staff had potential exposure had the patient tested positive for COVID-19. Given the inevitable presentation of patients to EDs with both COVID-19 and acute behavioural disturbances it is essential that health services consider methods to lessen exposure to staff and the public in such high-risk situations.

Competing interests

None declared.

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doi: 10.1111/1742-6723.13522