The management of the agitated patient in the Emergency Department is a common scenario for emergency physicians. While medical issues are often top of mind, legal and ethical issues also must be considered. In addition, it is common for ED personnel to be victims of violence and staff protection must always be a high priority with any agitated or potentially violent patient.

While many cases are routine in nature and clearly psychiatric in etiology there are numerous organic conditions mimicking psychiatric disease that can easily be missed. Faced with significant time constraints, the emergency physician may overlook the possibility of organic illness in an agitated patient if the patient appears otherwise clinically well. Missing the organic nature of the patient’s illness can lead to significant morbidity and mortality especially if the patient is inappropriately admitted to an inpatient psychiatric unit.

In this interactive session we will present some cases involving agitated patients in the Emergency Department for discussion and review. We will also touch on some practical issues involving the management of agitated/violent patients in the ED.

**Background**
- Up to 50 percent of healthcare providers are victims of violence at some point in their career
- Behavioral emergencies account for 1/20 ED visits
- ED has highest rate of employee assault in the hospital
- Nurses are most common victims

**Considerations in managing the agitated patient:**
- Medical
- Legal
- Administrative
Warning Signs of Violence

- Patient exhibits or threatens violence.
- Patient makes ED staff anxious or fearful.
- Behavior alternates between shouting and dozing, and between cooperation and belligerence.
- Patient expresses fear of losing control.
- Patient is uncooperative, hostile, agitated and unable to sit still.
- Patient is intoxicated with alcohol or other chemicals or withdrawing from drugs.
- Patient has a past history of violence.
- Patient has tense, rigid posture, is easily startled and suspicious
- Patient has tattoos that suggest a relationship to a violent organization or gang.

System Actions to Prevent Violence

- Security personnel
- Alarm systems
- Monitoring ED entry
- Limiting ED Access
- Metal detectors
- Bulletproof glass
- Staff education

Actions to Prevent Violence

- Alert staff and security if you feel uncomfortable
- Pay attention to “gut” feelings
- Never underestimate potential for violence
- Make sure security personnel or police search patient for weapons
- Do not bring potential weapons into the room with you
- Ask security to stand just outside the room
- Ask patient where you should stand if they retreat from you
- Do not block exits. Make sure you and patient have route for escape.
- Maintain “buffer zone” 4X larger than usual
- Approach patients directly
- Do not turn your back on patient
- Minimize eye contact
- Adopt passive non-confrontational posture and attitude
- Do not make challenging or belligerent remarks
- Offer food or drink
- Enlist friends or family to speak to patients
Invalid Assumptions in Assessing an Agitated Patient

- Triage has classified the patient as psychiatric (e.g. placed in psychiatric area of ED); therefore this patient’s illness is psychiatric.
- Patient has a previous psychiatric history; therefore the etiology of the current presentation must also be psychiatric.
- Patient is young and otherwise healthy; therefore this must be a functional disorder.
- Patient’s abnormal vitals are due to agitation/psychiatric condition; therefore can be ignored.
- Toxicology screen is negative; therefore the patient’s presentation cannot be due to a toxidrome.

Pitfalls in Assessing an Agitated Patient

- Incomplete history from limited sources
- Incomplete review of systems
- Incomplete physical and neuropsychiatric exam (lack of patient cooperation)
- Failure to carefully review medications
- Limited testing / Misinterpretation of test results

Indications for Restraints/Sedation

- Preventing harm to the patient
- Preventing harm to other patients
- Preventing harm to caregivers / other staff
- Preventing disruption of care or physical damage to environment
- To allow assessment and management of a patient

Physical Restraints

- Generally - 4 limb restraints
- Explanation to patient
- Closely observe and monitor patient
- Careful documentation
- Standard procedure
- Minimize time in restraints
- Avoid prone position
- Caution in sympathomimetic overdose
Common Causes of Agitation

Toxicologic
- Alcohol intoxication or withdrawal
- Stimulant intoxication (e.g. cocaine, methamphetamine, MDMA)
- Other drugs or drug withdrawal

Metabolic
- Hypoglycemia
- Hypoxia

Neurologic
- Stroke /SAH
- Intracranial lesion (hemorrhage, SOL)
- Head trauma
- Seizure / Post-ictal state
- Dementia
- CNS infection

Other medical
- Hyperthyroidism
- Shock
- Hypothermia
- Hyperthermia

Psychiatric
- Psychosis
- Schizophrenia
- Bipolar disease
- Personality disorder

<table>
<thead>
<tr>
<th>Organic</th>
<th>vs.</th>
<th>Functional</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age &lt; 12 or &gt; 40</td>
<td>Age 13-40 years</td>
<td></td>
</tr>
<tr>
<td>Sudden onset (hours to days)</td>
<td>Gradual onset (weeks to months)</td>
<td></td>
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<tr>
<td>Disorientation</td>
<td>Continuous course</td>
<td></td>
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<tr>
<td>Decreased LOC</td>
<td>Scattered thoughts</td>
<td></td>
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<tr>
<td>Visual hallucinations</td>
<td>Awake and alert</td>
<td></td>
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<tr>
<td>No psychiatric history</td>
<td>Auditory hallucinations</td>
<td></td>
</tr>
<tr>
<td>Emotional lability</td>
<td>Psychiatric history</td>
<td></td>
</tr>
<tr>
<td>Abnormal physical</td>
<td>Flat affect</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Normal vitals and physical</td>
<td></td>
</tr>
<tr>
<td></td>
<td>History of substance abuse</td>
<td></td>
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</table>
Some Useful Pharmacologic Agents

<table>
<thead>
<tr>
<th>Agent</th>
<th>Route</th>
<th>Dose</th>
<th>Considerations</th>
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</thead>
<tbody>
<tr>
<td><strong>First Generation Antipsychotics</strong></td>
<td></td>
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<tr>
<td>Haloperidol</td>
<td>IV/IM/PO</td>
<td>2.5-10 mg</td>
<td>Large experience, EPS</td>
</tr>
<tr>
<td>Droperidol</td>
<td>IV/IM</td>
<td>2.5-5 mg</td>
<td>Black Box Warning, QT prolongation</td>
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<tr>
<td>Loxapine</td>
<td>IM/PO</td>
<td>12.5-75 mg</td>
<td>Sedation</td>
</tr>
<tr>
<td><strong>Benzodiazepines</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Midazolam</td>
<td>IV/IM</td>
<td>5 mg</td>
<td>Caution in elderly, use in combination</td>
</tr>
<tr>
<td>Lorazepam</td>
<td>IV/IM</td>
<td>2 mg</td>
<td>Caution in elderly, use in combination</td>
</tr>
<tr>
<td><strong>2nd Generation Antipsychotics</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Olanzapine</td>
<td>IM/PO</td>
<td>10 mg</td>
<td>Less EPS, Caution in elderly</td>
</tr>
<tr>
<td>Risperidone</td>
<td>IM/PO</td>
<td>1-2 mg</td>
<td>Less EPS, Caution in elderly</td>
</tr>
<tr>
<td>Ziprasidone</td>
<td>IM/PO</td>
<td>10-20</td>
<td>Less EPS, Caution in elderly</td>
</tr>
<tr>
<td><strong>Other</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ketamine</td>
<td>IV/IM</td>
<td>1-2 mg/kg IV</td>
<td>Fast acting. Beware BP changes, tachycardia, laryngospasm and vomiting.</td>
</tr>
<tr>
<td></td>
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<td>4-5 mg/kg IM</td>
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Some Medico-Legal Issues

The courts in Canada have made it clear that the staff working in the ED of any public hospital that offers itself as a 24-hour care facility has a duty of care to all who present for medical services—including those who are intoxicated (CMPA).

- There is a duty to attend all patients
- There is a duty to diagnose
- There is a duty to treat
- There is a duty to advise or instruct

Capacity

Although the wording of the legal tests may differ, an individual who is able to understand the nature and anticipated effects of the proposed investigation or treatment and available alternatives, including the consequences of refusing, is typically considered mentally capable to give consent. Because incapacity can be temporary, it may be necessary to reassess capacity to consent at appropriate intervals. (CMPA).

Specific legal frameworks exist in most jurisdictions:

e.g. Ontario

- The Common Law
- Mental Health Act (1990)
- Health Care Consent Act (1996)
- Patient Restraint Minimization Act (2001)

The HCCA specifically preserves the common law duty of a caregiver “to restrain or confine a person when immediate action is necessary to prevent serious bodily harm to the person or to others”.

This common law duty allows health care providers to manage emergent situations.

Any incident where this common law power is exercised should be documented in the patient chart, as is generally the practice with any use of restraint or confinement.