


The Agitated Patient

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Case Presentation: Day 1

- 22 yo male is brought to ED for strange and unruly behavior at home
- No sleep for 4 nights, not eating
- Pacing the apartment stating “Jesus is coming”
- Denied any drug use
- No medications, and no allergies
- He agreed to speak to a psychiatrist but did not understand why

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Physical Exam

- BP 130/75, pulse 90, respirations 14, temp 98.5. He was well kept and mildly agitated
- HEENT: EOMI, PERRL, neck supple
- Heart: S1S2 RRR no MRG
- Lungs: clear to bases
- Abdomen: soft, nontender, no masses
- Extremities: atraumatic, no C/C/E
- Neuro: strength 5/5, sensory intact, normal gait

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Laboratory workup

- CBC: normal
- Chem: normal
- Urine toxicology screen: negative
- Serum toxicology screen: negative
- Alcohol: negative

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Psychiatric Assessment

- Diagnosis: mania
- The patient was not felt to be a harm to himself or others
- Agreed to take lorazepam
- He was given a follow up appointment in 2 days

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Case Presentation: Day 2

- Mother brought the patient to the front door of the ED
- He refused to come into the front door because “the people here are going to kill me”
- Refused to take the medication he was prescribed
- Throwing plates, glasses and furniture around the apartment, yelling, “Jesus is coming, here I am”

Case Presentation: Day 2

- The patient is convinced to come into ED by a clerk he bonded with the day before
- The patient refuses to enter an exam room
- Pacing up and down the main ED hall
- Tries to punch a security officer

The Agitated Patient



Key Clinical Questions

- Who should be placed in restraints?
- What chemical restraints are available?
- What is the legality of restraints?

Agitation is defined as an abnormal increase in psychological or motor hyperactivity

The Agitated Patient

- 80% of ED's have had an injury in the past 5 years
- 43% have a staff member attacked every month
- 53% of all hospital assaults occur in ED
- Survey of 170 hospitals
 - 23 reported weapons threats each month
 - 32 restrained at least one patient a day

The Agitated Patient : Warning Signs

- Exhibits or threatens violence
- Makes ED staff anxious
- Wide swings in behavior
- Expresses fear of losing control
- Uncooperative, agitated, pacing

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The Agitated Patient : Warning Signs

- Intoxicated: alcohol or drugs
- Past history of violence
- Tense, rigid posture
- Gang signs or symbols

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Avoiding Violence

- Avoid eye contact
- Always leave a way out
- Maintain a safe distance
- Treat patient as you expect him to behave

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Avoiding Violence

- Offer food or drink
- Avoid provocative remarks
- Do not turn your back
- Never underestimate

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ACEP and Violence

- Provide adequate security
- Coordinate security with local law enforcement
- Written protocols for violence
- Educate the staff

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The Agitated Patient

- "Talking the patient down"
- Enlist the help of family or friends
- Restraints

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Restraints Should Be the Least Restrictive Possible

Seclusion

- Placing a patient alone in a locked room
 - Monitoring
 - Documentation of reason
 - Specific room that is safe for the patient

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Physical Restraints

- Team approach
- 6 member team
- Wear protective gear
- Start with 4 point restraints

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Physical Restraints

- Explain why to the patient
- Once decided, do not negotiate
- Undress the patient
- Document the reason
- Frequent monitoring

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The order in which restraints are used does NOT need to be physical and then chemical

Providing the patient with options for modifying his/her behavior allows a patient/doctor relationship to be maintained

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Chemical Restraints

- If the patient is willing to take the medication then give it
- Contact the consultant prior to giving any medication

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Haloperidol

- Clinton 1987; 136 cases of agitated patients
- Majority of who were intoxicated
- 83% efficacy rate within 30 minutes

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Lorazepam and Haloperidol

- Battaglia et al. Lorazepam alone, Haloperidol alone, combined
- The most rapid tranquilization occurring with the combination treatment
- Two major side effects
 - 35% of the patients were still asleep at 12 hours
 - 6% - 20% of patients receiving haloperidol experienced extrapyramidal symptoms (EPS)
 - Sedation can be both a positive and negative effect

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Droperidol

- Antipsychotic and antiemetic
- 2001 the FDA placed a black box warning for prolonged QT, risk of torsades de pointes
- FDA warning has effectively removed droperidol from many hospital formularies
- Some authors believe that the evidence for the warning is small
- Review of 396 patients that received droperidol in the ED found no difference in the change of the QTc interval

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Prolonged QT and Hypokalemia

- Acutely psychotic or agitated patients have been found to have a prolonged QT
- May be associated with the hypokalemia that is seen in agitated patients

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Atypical Antipsychotics

- Block the 5-HT₂ serotonin receptor with relatively low D₂ blockade
- Clozapine (Clozaril)
- Olanzapine (Zyprexa)
- Quetiapine (Seroquel)
- Risperidone (Risperdal)
- Ziprasidone (Geodon)

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Clozapine

- High doses are needed to cause an immediate change of behavior
- Serious side effects
 - Seizures
 - Agranulocytosis

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Quetiapine

- Recommended slow titration of dose so cannot be used in doses needed to change behavior abruptly

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Olanzapine

- Potentially beneficial sedating effect
- 160 times the antihistamine potency of diphenhydramine
- Associated with weight gain and diabetes

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Risperidone

- Equivalent to haloperidol in the treatment of psychosis
- May be more effective than haloperidol in treating aggression
- Miller et al. Oral risperidone + oral lorazepam = IM haloperidol + IM lorazepam
 - Time to sleep was 43 minutes in the risperidone group
 - 44 minutes in the haloperidol group

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Risperidone

- Available in liquid and dissolving tablet
- Important if worried about non-compliance
 - "cheeking" the medication

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Ziprasidone

- IM atypical antipsychotic
- Brook et al. Ziprasidone more effective than haloperidol in psychosis
- Less movement disorder side effects
- Prolong QT

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Atypical Antipsychotics

- Overall decreased incidence of prolonged QT compared to classic antipsychotics
 - This is dose related
 - This is medication specific
- EPS decreased compared to classic antipsychotics
 - Related to the ratio of 5-HT2 to D2 receptor blockade

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Legality of Restraints

- Three things that need to be considered
 - Competency of the patient
 - Patient right to refuse
 - Protection of the patient and other ED staff
 - Supreme Court decision Youngberg v. Romero
 - Protection of third parties

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Legality of Restraints

- The Hartford Courant October 1998
 - 142 patients died while in restraints
- HCFA published regulations for the use of restraints for acute medical and surgical care
- State law governs the restriction of patients rights
- Advocacy groups protect these rights

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Complications of Patient Restraints

- Determine the type and rate of complications of patients restrained in the ED.
- 221 patients were restrained in the ED
- The mean age was 36.35 years (range 14-89).
- 71.7% were male.
- No major complications such as death or disability
- Minor Complication rate 5.4%
 - Getting out of restraints

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Legality of Restraints

- There have been many more malpractice suits lost by ED physicians for having NOT detained a patient who went on to commit suicide, then there have been for unlawful imprisonment.

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Chart Documentation

- Reason for restraints (patient has the potential to harm self or others)
- What measures have been taken to avoid restraints, such as “talking down” or enlisting family help
- Type of restraints being employed and why
- A plan for removal of restraints when the patient exhibits behavior of self-restraint

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Case Summary

The patient was physically restrained by 4 security officers, a nurse and a physician. This calmed him considerably and he agreed to take 2mg of risperidone and 2 mg of lorazepam orally. The patient was ultimately admitted to the psychiatry ward with a diagnosis of mania with psychotic features.

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Key Learning Points

- **Who needs to be restrained**
 - Competency, autonomy, threat to others
- **Which chemical restraints**
 - Oral vs. IM
 - oral haloperidol and risperidone
 - IM haloperidol and ziprasidone
- **Legality of restraints**
 - Protect the patient
 - Protect the ED staff
 - Protect third parties

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Questions?