The Agitated Patient

Causes of acute agitation in the Emergency Department:

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| **Medical** | **Psychiatric** |
| 1. Mood disorders    1. Depression    2. Bipolar 2. Thought disorders    1. Schizophrenia 3. Non-diagnosed psychiatric disorder 4. Non-compliance with medication 5. Acute Stressor 6. Substance abuse    1. Exacerbate symptoms of known thought or mood disorder    2. Precipitate symptoms of a new thought or mood disorder | 1. Sepsis (most common)    1. General infection    2. Encephalitis, meningitis 2. Intracranial process    1. Trauma 🡪 intracranial bleed    2. Space occupying lesion (ex. abscess or tumour) 3. Endocrine    1. Thyrotoxicosis    2. Hypoglycaemia 4. Environmental    1. Heat stroke 5. Substances    1. Use       1. Sympathomimetic       2. Alpha-cholinergic       3. Serotonin    2. Withdrawal       1. Alcohol       2. Opioid |

**Approach** to the agitated patient:

Two-part approach, ensure

1. Patient is medically well
2. Safety of patient and treating staff members

**Medical:**

1. ABCs - ensure:

* Airway is patent
* Patient saturating well and ventilating properly
* IV fluids administered if patient is hypotensive

1. Vital signs – ensure a set is done
2. Blood glucose – hypoglycaemia may cause agitation

**Safety precautions:**

Ensure your **safety** when taking a history from an agitated patient.

1) **If you DO NOT FEEL SAFE LEAVE the ROOM IMMEDIATELY and get help**

2) Consider having a security guard or police in the room during the interview

3) Ensure you are between the patient and the door for a safe exit.

Management of Agitated patient:

1. Remove external stimuli
   1. Move the patient into a room that is less noisy and dimming the light,
   2. If person accompanying the patient is further agitating the patient ask them to leave. If they are calming the patient encourage them to stay.
2. Verbal de-escalation – speaking to the patient in a calm manner. This technique may be enough to be able to calm the patient to begin your workup.
3. Chemical sedation – if the patient is not calming down they may need sedation. Medication choices:
   1. Benzodiazepines (PO, IM)
   2. Short acting antipsychotics (PO, IM)

*IV route is unlikely possible, as the patient probably doesn’t have an IV in place at this point.*

Medications will start working in 10-15 minutes so it will be possible to assess the patient.

1. Physical restraints are required if patient is refusing to take medication. Restraints are placed on each limb to give IM. The patient should calm down after medication is given and restraints can be removed as soon as possible

**Workup** of agitated patient:

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| **History** | **Physical exam** | **Investigations** | **Disposition** |
| History - from patient, previous charts and from collateral information if possible. History should focus on:   1. Psychiatric history 2. Medical causes of agitation such as signs of infection 3. Endocrine causes - such as signs of thyrotoxicosis or causes of hypoglycaemia 4. New medications, or medication changes 5. Substance use and withdrawal | 1) VITAL SIGNS - specifically when assessing for toxidromes (sympathomimetic, alpha-cholinergic and serotonin syndrome)   * Fever may indicate toxidrome or infection   2) Neurological exam: focal neurological signs, signs of neuromeningitis and neuroencepahlitis.  3) Look for other signs of infection on physical exam if appropriate. | 1) Labs – CBC, lytes, BUN, Creatinine – to obtain a baseline. Drug levels – aspirin, acetaminophen   1. 2) ECG – arrhythmia, QRS, long QTc interval 2. 3) Urine analysis if suspecting infection 3. 4) Chest x-ray if suspected infection 4. 5) Specific test for specific causes  * TSH, T3, T4 for thyrotoxicosis * CT head for intracranial bleed * LP if suspected meningitis | Depends on the cause of the agitation:   1. Medical  * Treated in hospital  1. Psychiatric  * Refer to psych if an exacerbation of psych condition |