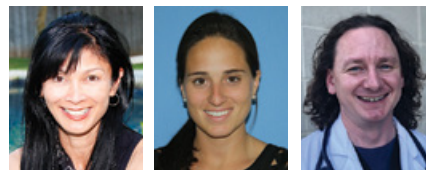




# Hostile Workplace

## Emergency Management of the Agitated Patient

### LESSON 3



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#### OBJECTIVES

On completion of this lesson, you should be able to:

1. Identify and quickly assess an agitated patient.
2. Determine the best way to approach an agitated patient.
3. Evaluate the medication options for treating agitation.
4. Describe the indications for and risks associated with the use of physical restraints.
5. Determine which agitated patients should be admitted and which can be safely discharged.

#### FROM THE EM MODEL

19.0 Procedures and Skills Integral to the Practice of Emergency Medicine

19.4.9 Psychobehavioral

#### CRITICAL DECISIONS

- What underlying etiologies can cause agitation?
- How should the severity of a patient's agitation and risk of violent behavior be assessed?
- How should emergency clinicians approach agitated patients?
- What medications can be used to manage agitation?
- When should a patient be physically restrained?
- What is the appropriate disposition for an agitated patient?

**Agitation is not a diagnosis but rather a symptom with a variety of potentially life-threatening etiologies.**

Defined as excessive verbal or motor behavior that can be loud, hyperactive, disruptive, threatening, or combative, agitation can result in physical and psychological trauma to both patients and clinicians.<sup>1-3</sup> Frequent emergency department overcrowding can result in high noise levels, long wait times, and high stress — all of which can increase the risk of agitation and even violence.<sup>2,4,5</sup> The emergency department is at high risk for workplace violence for a number of well-documented reasons, including the simple truth that emergency providers are mandated by federal law to medically evaluate every patient who seeks care.<sup>4</sup>

## CASE PRESENTATIONS

### ■ CASE ONE

A 32-year-old man is brought in for erratic and aggressive behavior. He has a history of schizophrenia, and his family is unsure if he has been taking his medications. He has not seen a psychiatrist for many years. When the physician approaches, the patient yells, “The Lord is coming! You have been called as a disciple! Stop living in sin, and embrace your faith!”

The family explains that he has not bathed in a week and has had very little to eat or drink. The patient denies any fevers, chills, headaches, cough, abdominal pain, back pain, or any other symptoms. He has no other medical history and denies a history of smoking, alcohol use, or drug use.

His vital signs are blood pressure 126/80, heart rate 90, respiratory rate 16, temperature 36.6°C (97.9°F), and oxygen saturation 99% on room air. He is alert and oriented, disheveled in

appearance, but in no acute distress. He has dry mucous membranes. His heart sounds are regular, without evidence of a murmur; his lungs are clear to auscultation; and his extremities are warm and well perfused. The patient becomes increasingly agitated, however, and refuses the nurse’s attempts to draw his blood for laboratory studies.

### ■ CASE TWO

A physically agitated 26-year-old woman arrives via ambulance. She is pulling at her clothing and speaking gibberish. The paramedics explain that she became violent at a dance club earlier in the evening and was arrested. On arrival, the patient appears diaphoretic and anxious. Her pupils are markedly dilated. Her vital signs are blood pressure 160/99, heart rate 143, respiratory rate 24, temperature 38.0°C (100.4°F), and oxygen saturation 98% on room air.

She refuses to answer the clinician’s questions and is placed in a resuscitation

room. The patient violently resists the staff’s attempts to transfer her onto another bed, so the decision is made to physically restrain her.

### ■ CASE THREE

A developmentally delayed 42-year-old man is brought in by EMS from a group home. He is crying, combative, and yelling loudly, requiring two paramedics to hold him down. The patient’s heart rate on a cardiac monitor is 130, with a respiratory rate of 20. However, his agitation prevents the nurse from obtaining blood pressure or temperature readings. There are no signs of trauma, and he is moving all four limbs purposefully. The nurse prepares an intramuscular (IM) dose of haloperidol and midazolam. She would like to administer the sedatives immediately but waits for the physician to confirm the order.

Furthermore, its around-the-clock availability makes the emergency department a haven for patients at risk for combative behavior, many of whom are brought in against their will.<sup>2,4,6</sup> Other factors that contribute to the risk of workplace violence include limited security, insufficient clinical staffing, and a complacent mentality that accepts violence as “just a part of the job.”<sup>6,7</sup>

The American College of Emergency Physicians (ACEP) recognizes the risk of violence in the emergency department and believes that optimal care can only be rendered when patients and clinicians are protected. ACEP has encouraged states to enact legislation to prosecute those who commit violent acts against health care workers, and has urged hospitals to enact security systems and develop written protocols that address the management of these dangerous situations.<sup>8</sup>

Despite these measures, studies continue to document the ongoing threat of emergency department violence and its effects on health care providers. A recent national survey of emergency

physicians from 65 programs revealed that 78% had experienced at least one violent workplace act in the previous 12 months, and 21% described being physically assaulted by a patient. Unfortunately, only 16% of the programs reported offering any special training in workplace violence.<sup>6</sup>

Significantly more violent events are described by nurses than by doctors, and nurses report feeling less safe than doctors when dealing with combative patients.<sup>9</sup> In addition, violent events appear to be significantly underreported; hospital employees file safety reports an estimated 42% of the time and police reports only 5% of the time.<sup>9</sup> In another recent survey of New York emergency medicine residents, 66% reported being physically assaulted during their training. (This startling statistic is the largest reported incidence of physical violence in the emergency department.)<sup>10</sup>

The best way to decrease hospital violence is to *prevent* it before it occurs. To do so, physicians and staff must be better prepared to predict when a situation is likely to escalate.<sup>11</sup> In 2012,

the American Association of Emergency Psychiatry published Project BETA (Best Practices in Evaluation and Treatment of Agitation), a series of articles written by emergency medicine physicians and psychiatrists. Project BETA provides thorough but practical, evidence-based recommendations for the evaluation and treatment of agitated patients. These guidelines, which form the foundation of this review, provide strategies for making the emergency department a safer place for clinicians and patients alike.<sup>12-17</sup>

## CRITICAL DECISION

### What underlying etiologies can cause agitation?

Agitation can stem from a multitude of pathologies, including trauma, withdrawal, toxidromes, endocrinopathies, metabolic derangements, substance abuse, infections, and neurological and mental illnesses.<sup>4,13</sup> Agitated behavior should be prioritized and promptly evaluated with the same urgency as any other high-risk presentation, starting with an assessment of the patient’s chief complaint and vital signs. Any concerning sign or symptom

— abnormal vital signs (eg, an elevated temperature), alterations in mental status, trauma, acute psychosis (especially with visual hallucinations), difficulty breathing, or neurological deficits — should trigger concern for a life-threatening condition (Table 1).<sup>4,13</sup>

Several metabolic and physiological disturbances can produce delirium, which is frequently associated with agitation. For example, hypoglycemia, hypoxia, head trauma, and infection can all manifest as agitation.<sup>4,13</sup> Any patient with a possible intoxication or ingestion warrants a thorough medical evaluation, as clues in the history or clinical presentation can influence how the agitation should be addressed.

Unfortunately, behavioral health emergencies are on the rise. According to the Agency for Healthcare Research and Quality, emergency department visits for depression, anxiety, and stress reactions increased by 55.5% between 2006 and 2013. Visits for substance abuse increased by 37% during the same period, and visits for psychosis and

bipolar disorders increased by 52%.<sup>18</sup>

Although mentally ill patients frequently seek care for medication refills or acute exacerbations of their psychiatric illness, only 16.9% of emergency departments report having access to an on-call psychiatrist.<sup>19</sup> While physical aggression is rare, even in mentally ill patients, violent acts are often associated with substance abuse, environmental stressors, or a history of violence.<sup>20</sup>

Mentally ill patients who present with agitation typically suffer from an underlying psychiatric history. Some may report auditory hallucinations or psychiatric complaints such as anxiety, depression, paranoia, or suicidal/homicidal ideations.

### CRITICAL DECISION

#### How should the severity of a patient's agitation and risk of violent behavior be assessed?

Several validated scoring scales can be used to describe the severity of a patient's agitation and help predict the risk for

violent behavior. Such measurements can be used to justify clinical decisions (eg, physical restraints or the administration of sedatives) and help emergency clinicians communicate with other health care providers.

One such tool is the Behavioral Activity Rating Scale (BARS) (Table 2), a simple system that does not require the patient to answer any questions.<sup>21</sup> A BARS score of 4 indicates a normal, calm state. Patients can rapidly escalate from a mild (BARS 5) to a severely (BARS 7) agitated state (ie, combative and violent behavior).

The Brøset Violence Checklist is a simple scale that scores patients based on the presence (1) or absence (0) of six variables (Table 3). Based on the sum of the score, a clinician can predict a patient's risk of violence within the next 24 hours and the need for intervention.

These scales and other similar instruments can be used to assign agitation levels that correspond to preformulated emergency department interventions. Because acute presentations are often dynamic, a patient's agitation and response to treatment should be frequently reassessed and documented.

Although it is not uncommon for patients to verbally assault staff by arguing or using profanity, it is critical to understand that these scenarios can quickly escalate to violence.<sup>2,5,6</sup> Health care workers who experience verbal threats and other forms of nonphysical violence are an estimated 7.17 times more likely to experience physical violence than those who have not.<sup>23</sup> As such, patients who verbally assault staff must be treated with the same vigilance as any other agitated patient to mitigate the risk of bodily harm.

### CRITICAL DECISION

#### How should emergency clinicians approach agitated patients?

##### Initial Management

To minimize the risk of violence, agitated patients should be placed in an appropriate area that minimizes additional stimulation and provides adequate space for clinical management. Clinicians should only get close to a patient when it is safe to do so. Before

**TABLE 1. Life-Threatening Medical Causes of Acute Agitation<sup>4,13</sup>**

<b>Thermoregulation</b>	Hypothermia
	Hyperthermia
<b>Respiratory</b>	Hypoxia
	Hypercarbia
<b>Infection</b>	Meningitis, encephalitis, sepsis from other infections
<b>Trauma</b>	Head injury
<b>Toxicological</b>	Adverse drug reaction
	Drug overdose or intoxication
	Sedative-hypnotic agent withdrawal
<b>Metabolic</b>	Thyroid storm
	Hyperglycemia or hypoglycemia
	Electrolyte abnormalities
<b>Neurological</b>	Stroke
	Subarachnoid hemorrhage
	Encephalitis
	Seizure (postictal)

**TABLE 2. Behavioral Activity Rating Scale<sup>21</sup>**

1 = Difficult or unable to arouse
2 = Asleep but responds normally to verbal or physical contact
3 = Drowsy; appears sedated
4 = Quiet and awake (normal level of activity)
5 = Signs of over (physical or verbal) activity; calms down with instructions
6 = Extremely or continuously active; does not require restraint
7 = Violent; requires restraint

**TABLE 3. Brøset Violence Checklist<sup>22</sup>**

<b>Confusion</b>	1 point
	0 points
<b>Irritability</b>	1 point
	0 points
<b>Boisterousness</b>	1 point
	0 points
<b>Physical threats</b>	1 point
	0 points
<b>Verbal threats</b>	1 point
	0 points
<b>Attacks on objects</b>	1 point
	0 points

Score 0: Low risk of violence

Score 1-2: Moderate risk of violence →  
Preventative measures should be taken.

Score ≥3: High risk of violence →  
Preventative measures are required.

evaluating a patient's ABCs (airway, breathing, and circulation), it is important to ensure that the situation is under control and adequate staffing is available to provide restraint if needed.

Physical restraints and sedation increase the risk of harm to both patients and staff and should be used only as a last resort.<sup>12</sup> A model in which the physician promptly identifies agitated behavior and intervenes immediately through a less coercive approach can help mitigate symptoms and reduce the need for physical restraint.

Initial priorities include ensuring the safety of the patient and staff; de-escalating the situation; providing pharmacotherapy to calm the patient, if needed; and identifying any life-threatening problems that warrant immediate attention. Whenever possible, a brief patient history should be taken and a physical examination, including a mental status evaluation, vital sign and oxygen saturation measurements, and bedside point-of-care glucose testing, should be initiated. In addition, it is crucial to address pain, a symptom that is often overlooked in agitated patients.

Mentally ill patients whose presentation is consistent with an ongoing psychiatric disease seldom require a medical workup. Alternatively, those whose symptoms are *inconsistent* with a previous diagnosis warrant

further evaluation.<sup>13</sup> Red flags that can indicate a nonpsychiatric etiology include extremes of age, vital sign abnormalities, trauma, delirium, visual hallucinations, neurological abnormalities, acute intoxication/ingestion, substance withdrawal symptoms, and comorbidities (eg, immunosuppression) that can place patients at risk for serious pathologies.<sup>13</sup>

Delirium is an acute medical emergency with multiple life-threatening etiologies that can be easily confused with underlying psychiatric conditions or chronic cognitive issues. Patients with delirium typically have an altered level of awareness and problems with directing, focusing, sustaining, or shifting attention.<sup>24</sup> In such cases, the medical workup should target the underlying condition and may include directed laboratory studies, neuroimaging (eg, CT scan of the head), or a lumbar puncture (to evaluate for infection), as indicated. Patients who are taking high doses of antipsychotics or have ingested medications in an apparent suicide attempt may also require an ECG.

### Psychiatric Assessment

The acute psychiatric evaluation of an agitated patient is aimed at diffusing the situation and determining the most likely cause of the agitation. Once the patient is under control and able to communicate, and medical causes for the agitation have been ruled out, a more extensive assessment can be completed. Patients who are intoxicated or too sedated to undergo a mental health evaluation should be monitored closely, and the assessment can be postponed until the patient is able to communicate.<sup>14</sup>

When initiating a psychiatric evaluation, priorities include establishing an initial differential diagnosis, identifying safety concerns, and developing an appropriate treatment and disposition plan.<sup>14</sup> Although the initial assessment may be performed by an emergency clinician, a more detailed examination typically requires the assistance of a psychiatry consultant (often a social worker who specializes in behavioral emergencies). In particular, it is important to determine if the patient's

agitation is due to an underlying psychiatric disorder and identify any psychotic features.

Suicidal and homicidal risk should also be ascertained. In many cases, verbal de-escalation, with or without pharmacotherapy, may be all that is necessary to calm the patient. Laws that support an emergency physician's decision to place a patient on involuntary status or provide medical interventions (eg, pharmacotherapy for agitation) without the patient's consent typically relate to concerns about physical safety, significant impairment in self-care, or the need for treatment in the presence of a mental disorder.<sup>14</sup>

### De-escalation Process

Words can be used to powerful effect to calm combative patients while the clinician assesses for life-threatening etiologies. The clinician must engage the patient, establish a collaborative relationship, and verbally de-escalate the situation.<sup>15</sup> Only one person should attempt the initial de-escalation, and measures should be taken to ensure the process is safe and respectful of the patient's space.<sup>3,13</sup>

Clinicians should greet and call patients by name; ask affirmative, open-ended questions; and emphasize that the emergency department is a safe place. It is important to listen patiently with sincere respect and kindness, as nonverbal communication must be congruent with what is actually being said. Any words or actions that may be perceived as confrontational or demeaning should be avoided. When appropriate, simple gestures like providing a blanket or pillow or offering the patient a snack or beverage can go a long way toward building a therapeutic relationship.<sup>9</sup>

Clear limits must also be set; patients should understand which behaviors are acceptable — and which will not be tolerated. The physician can help coach the patient on how to stay in control, but there should be reasonable consequences for noncompliance.

The de-escalation process often takes the form of a verbal loop, in which the physician listens to the patient, responds in a way that validates the

patient's concerns, and states the next steps. Oftentimes, this message must be reiterated at a later time, when the patient is more receptive.<sup>15</sup> Although the de-escalation process can take 5 minutes or longer, it is a valuable investment that can prevent time-consuming problems later in the course of treatment, including oversedation or injury.

## CRITICAL DECISION

### What medications can be used to manage agitation?

When medications are required, the goal should be to *calm* the patient (not simply restrain movement) to pave the way for a proper clinical assessment.<sup>16</sup> Some agents, including benzodiazepines, can cause oversedation, which can make it difficult for patients to answer questions or cooperate with an examination. Furthermore, oversedation can lead to respiratory depression in those with underlying respiratory conditions or if given in combination with other central nervous system depressants.

Oral medications are preferred to parentally administered drugs, especially for the treatment of mild agitation. IM administration is reserved for severely agitated patients who pose an immediate threat. In such cases, five additional staff members should restrain the patient, and the IM injection should be placed in the lateral

thigh or the superior lateral quadrant of the gluteal muscle.

If a patient's agitation is believed to be the result of a medical condition (eg, hypoxia, hypoglycemia), treatment should be focused on the underlying pathology, rather than on the agitation itself. However, if the cause of the patient's behavior cannot be immediately identified, a pharmacological intervention may be required (Table 4).

### Benzodiazepines

Benzodiazepines act on GABA receptors, the brain's primary inhibitory neurotransmitters.<sup>16</sup> As a result, well-known side effects include sedation, respiratory depression, and hypotension, which can be more dramatic in those suffering from an underlying respiratory disorder or are under the influence of alcohol. Benzodiazepines are the treatment of choice for patients under the influence of any drug that causes a sympathomimetic response (eg, cocaine, methamphetamines) and for the management of withdrawal from alcohol or certain sedative-hypnotic drugs. They are also the treatment of choice for agitation of unknown etiology.<sup>15,16</sup>

### Typical Antipsychotics

Haloperidol and droperidol, two first-generation (typical) antipsychotics sometimes used to treat agitation, can cause QT prolongation, especially with repeat dosing. When combined with

certain other drugs, these agents can lead to life-threatening arrhythmias. Because fatal arrhythmias have been associated with the use of droperidol, the FDA placed a black-box warning on this once commonly used drug, which is now unavailable to most emergency physicians.<sup>16</sup> Haloperidol is permitted in oral and IM forms; however, some physicians still administer the drug by IV.

Other side effects associated with the use of typical antipsychotics include extrapyramidal symptoms (eg, tardive dyskinesia, akathisia, dystonia, parkinsonism) and neuroleptic malignant syndrome. To minimize the risk of side effects, these agents are often coadministered with other medications, including antihistamines or benzodiazepines.<sup>16</sup> However, there is no evidence to support the use of both agents with haloperidol, as the combination may cause oversedation.

### Atypical Antipsychotics

Second-generation (atypical) antipsychotics (eg, olanzapine, ziprasidone, aripiprazole, risperidone, and quetiapine) have fewer side effects than first-generation agents because they are more selective in the brain receptors they antagonize.

It is important to remember that all antipsychotics can reduce the seizure threshold to varying degrees. Clozapine is the atypical agent most frequently associated with seizures, while

**TABLE 4. Medications for Agitation<sup>16</sup>**

	General Considerations	Medication Recommendations
<b>Agitation due to intoxication</b>	Intoxication due to stimulant drugs without psychosis	Benzodiazepine
	Intoxication due to stimulant drugs with psychosis	Antipsychotic (SGA* preferred) plus benzodiazepine — use caution with an SGA like olanzapine, which is very sedating.
	Intoxication due to alcohol	Benzodiazepines should be avoided if there are no symptoms of withdrawal due to respiratory depression. Antipsychotics such as haloperidol are preferred.
<b>Agitation due to a psychiatric illness</b>	Psychosis present in a patient with a psychiatric disorder	Antipsychotic (SGA* preferred). Add a benzodiazepine, if needed — use caution with an SGA like olanzapine, which is very sedating.
<b>Agitation associated with delirium</b>	Delirium due to a benzodiazepine or alcohol withdrawal	Benzodiazepine
	Delirium not due to a benzodiazepine or alcohol withdrawal (Note: Treat the underlying medical condition; if delirium is due to acute ingestion, symptoms may be self-limited.)	Antipsychotic (SGA* preferred or haloperidol at low doses). Benzodiazepines can exacerbate delirium.
<b>Agitation of unknown etiology</b>	No psychosis	Benzodiazepine
	Psychosis present	Antipsychotic

\*SGA = second-generation antipsychotic

**TABLE 5. Side Effects of Commonly Used Antipsychotics for Agitation<sup>32</sup>**

	Anticholinergic	Extrapyramidal	Hyperglycemia	QT Prolongation	Sedation
<b>Atypical</b>					
Olanzapine	+++	+	+++	+	+++
Quetiapine	++	+	+++	+	+++
Risperidone	+ (rare)	++	++	+	++ (initially)
Ziprasidone	+	+	+	++	++
<b>Typical</b>					
Haloperidol	+	+++	++	+	+

risperidone and haloperidol appear to confer a relatively low risk.<sup>25</sup> If a patient with a history of seizures requires an antipsychotic for psychosis, the benefits of haloperidol outweigh its risks. Of note, the coadministration of a benzodiazepine may help mitigate the risk of seizure.

### Indications and Precautions

Antipsychotic medications (Table 5) should be avoided in patients who are actively seizing, hyperthermic, or demonstrating other signs of anticholinergic toxicity. Atypical antipsychotics, which can effectively treat acute agitation with relatively few extrapyramidal side effects, are preferred over haloperidol.<sup>16</sup> Caution should be used, however; some second-generation antipsychotics pose risks that can influence the management of certain patients. For example, ziprasidone causes the most QT prolongation of any antipsychotic drug. Although olanzapine has more anticholinergic side effects than other antipsychotics, it is more sedating and available in both oral dissolving tablets (ODT) (for mild agitation) and IM (for severe agitation) formulations.

Antipsychotics can be used in agitated patients with suspected alcohol intoxication, as benzodiazepines can further increase the risk for respiratory depression.<sup>16</sup> Because of their ability to address underlying psychosis, antipsychotics are also preferred for patients whose agitation is thought to stem from a mental illness. Risperidone is the agent of choice for any agitated patient willing to take an oral medication, followed by olanzapine ODT.<sup>16</sup> IM ziprasidone or olanzapine can be used to manage severe agitation caused by a psychotic condition.<sup>15</sup>

Midazolam, which has a quicker onset and shorter duration than

lorazepam, is being used more frequently for the treatment of agitation. A recent comparison of IM midazolam, olanzapine, ziprasidone, and haloperidol for the treatment of acute agitation found that midazolam achieved more effective sedation than antipsychotics. Olanzapine achieved more effective sedation than haloperidol at 15 minutes.<sup>26</sup> It is also important to keep in mind that populations with pharmacokinetic sensitivities (eg, elderly patients) require different dosing regimens.<sup>27</sup>

### Ketamine

Ketamine IM also has been recommended for the treatment of severe, uncontrollable agitation. In one recent study, 4 mg/kg IM ketamine (either alone or combined with 2 mg IV midazolam to prevent ketamine-induced emergence phenomenon) was used in the prehospital setting for the rapid sedation of agitated patients. Ketamine was chosen because of its fast onset, high efficacy rate, and low hemodynamic and respiratory side effects. Nearly every patient who was treated with the drug (50/52) was adequately sedated within an average of 2 minutes. Significant respiratory depression occurred in three subjects (6%). In all three cases, the patients had also received midazolam.<sup>28</sup>

Despite these promising results, ketamine has not yet been accepted universally by the emergency medicine community for controlling severe agitation. The drug may be of greatest benefit to patients with excited delirium whose agitation cannot be de-escalated.

## CRITICAL DECISION

### When should a patient be physically restrained?

The Centers for Medicare and Medicaid Services support the use of seclusion and restraint only after less

restrictive measures have failed.<sup>17</sup> These methods should never be imposed as a means of coercion, discipline, convenience, or retaliation.<sup>17</sup> In addition to complying with specific documentation requirements, health care professionals must follow specific rules and regulations. Clinicians should avoid combining restraints and seclusion, and patients who are a danger to themselves should not be placed in seclusion.

Restraints, which must be ordered by a licensed medical practitioner and not “as needed,” should be discontinued as soon as the patient regains self-control. Continuous visual monitoring is essential. The patient should be examined by a trained clinician within 1 hour of the restraint order, and a follow-up order is required if the restraint lasts longer than 1 hour. In addition, a face-to-face encounter with the ordering physician or designee is necessary if the restraint lasts longer than 1 hour for a child younger than 10 years, 2 hours for a patient between 10 and 18 years old, or 4 hours for an adult older than 18 years.<sup>29</sup> To prevent complications, close cardiac, pulse oximetry, and end-tidal CO<sub>2</sub> monitoring are mandatory. In addition, frequent assessments of vital signs, agitation level, and mental status are required.<sup>17,29</sup>

### Precautions

Ideally, physical restraints should be implemented by a team of five people, including security or police officers trained to manage combative patients, the nurse responsible for administering medication, and/or the clinician in charge of the patient’s care. One person should be stationed at each limb and a fifth should be available to hold the patient’s head. If only two limbs can be tied down, the contralateral arm and

leg should be secured with one arm tied upward and the other downward, which theoretically decreases the amount of force and momentum that struggling can generate.<sup>4</sup> The preferred position for restraint is supine, as placing a patient prone or in hobble restraints (binding/handcuffing the wrists, binding the ankles, and then attaching the wrists to the ankles) can compress the neck and chest wall, increasing the risk for asphyxiation.<sup>4</sup>

Measures should be taken to prevent any undue pressure on the airway, neck, or chest. Ideally, the physician should not take part in physically restraining the patient, but rather should continue to attempt to verbally de-escalate the situation while explaining what is happening.<sup>4</sup> An oxygen mask can be applied over the face of any spitting patient to prevent bodily fluid exposure.

The most common complication of this approach is skin breakdown at the site of the restraints. Rhabdomyolysis and acidosis also become possibilities in patients who continue to fight the restraints.<sup>4</sup> In addition, restrictive positioning can interfere with respiratory compensation for acidemia, which can be severe enough to cause cardiac arrest.<sup>30</sup> To help avoid these complications, physical restraints should always be combined with medications to calm the patient and continuous monitoring.

## CRITICAL DECISION

### What is the appropriate disposition for an agitated patient?

Patients who pose a threat or are too impaired by their psychosis to care for themselves should be admitted to inpatient psychiatry. Once this decision is made, hospital staff should remain with the patient until a transfer can be arranged.

Most cases of delirium require medical management and inpatient admission. However, if the cause of the agitation can be reversed in the emergency department and no further workup is warranted, the patient can be discharged if the physician deems it appropriate. For example, patients who

were agitated due to drugs or alcohol can potentially be sent home after a period of observation, assuming they are clinically sober upon discharge and have a safe ride home. Although certain medications may prolong the patient's stay, safety is always more important than an expeditious disposition.

Disposition becomes difficult when a patient refuses treatment that the clinician considers necessary. To better appreciate this scenario, it is helpful to understand the concept of *capacity*. Decision-making capacity refers to a patient's ability to make informed, logical choices that could be reasonably construed as being in his or her best interest. This requires patients to understand, process, and deliberate over information relayed by health care providers and make reasonable decisions based on that information.<sup>31</sup>

In many instances, it is relatively easy to ascertain whether a patient possesses decision-making capacity. However, capacity is not an all-or-nothing concept; it is a dynamic process that can fluctuate over time. When patients' cognitive skills are compromised by drugs, alcohol, or delirium, for example, their thought processes can change.

Despite the common misconception that only a trained psychiatrist can accurately measure a patient's capacity, most emergency physicians are well-equipped to make such judgments. If uncertainty exists, however, a low threshold to consult psychiatry should be maintained. If a psychiatrist is unavailable, it is reasonable to detain patients until their decision-making capacity can be more clearly

ascertained. In these situations, thorough documentation is paramount.

## Summary

Agitated patients who present to the emergency department should be treated as high risk. Clinicians must recognize when a situation has the potential to become violent, and also be prepared to address the numerous life-threatening medical conditions that can lead to agitation. When managing such cases, Project BETA recommends using a noncoercive approach with an emphasis on de-escalation. Physical restraints should be used only as a last resort.

Medications should be administered based on the level and etiology of a patient's agitation. Every attempt should be made to mitigate injury to patients, visitors, and staff, while minimizing other complications (eg, oversedation) that can arise from interventions used to control agitation.

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## Pearls

- When managing any agitated patient, clinicians should evaluate for life-threatening etiologies while using a noncoercive approach aimed at de-escalation.
- Physicians should make every attempt to identify reversible causes of agitation, including medical illness or drug toxicity or withdrawal.
- Emergency department safety protocols can reduce the risk of violence and facilitate a more effective and efficient response by hospital staff.



## CASE RESOLUTIONS

### ■ CASE ONE

The clinician was able to calm the schizophrenic man by gently initiating conversation. The patient agreed to take a tablet for his “nerves” and ate the sandwich offered to him. He received a psychiatric consultation in the emergency department and was discharged with an outpatient psychiatry follow-up.

### ■ CASE TWO

The combative woman was placed in four-point restraints after receiving multiple doses of midazolam and haloperidol for severe agitation. She subsequently became obtunded with respiratory depression and required

intubation. Blood was drawn for laboratory studies, and IV fluids were initiated for tachycardia. The patient’s basic laboratory workup revealed a creatinine level of 1.7 mg/dL and a creatine kinase level of 32,000 U/L. Her urine drug toxicology screen was positive for amphetamines. She was admitted to the medical ICU, where she received ventilatory support and further treatment for rhabdomyolysis. An inpatient psychiatric evaluation was performed after she was medically stabilized.

### ■ CASE THREE

While making eye contact with the developmentally delayed man, the

attending physician gently reassured him that the team was there to help him. The physician agreed to withhold the physical restraints and clear the room, except for one police officer, if the patient remained cooperative. Through a dialogue with the patient, the physician discovered that the man suffered from a speech impediment, had been sexually abused at his group home, and was afraid to return. After a long discussion, the patient relaxed and did not require sedatives, diagnostic studies, or a psychiatric evaluation. He was willing to meet with a social worker and law enforcement, and was transferred to a new group home 4 hours later.

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## Pitfalls

- Failing to recognize that medications used to treat agitation have potentially serious side effects. Caution should be used when administering benzodiazepines to patients with alcohol intoxication, as these agents can precipitate respiratory depression.
- Neglecting to show empathy toward agitated patients. Failing to treat these patients with courtesy can lead to ill feelings and exacerbate violent behavior.
- Attempting to initiate physical restraints on a severely agitated patient without a coordinated team approach and the prompt administration of an IM medication.