Care of the Agitated Patient

Recognition of Agitation

Mild: subtle behaviors such as fidgeting, irritability, fixed stare
Moderate: raising voice, yelling, pacing, head-banging, defensive stance
Severe*: combative, imminent risk to self or others

Gather information, if available:
- Engage family/caregiver
- Consult patient's behavioral care plan
- Check medical record
- Collateral history from EMS or police if present

Initial Stabilization & Management

- Assess ABCs, vital signs, consider bedside glucose
- Perform brief medical assessment, if possible
- Prepare the team with a brief huddle
- Designate a team lead and patient contact person

***If immediate safety risk to patient and/or staff, see medication recommendations below. Access dosing recommendations here.**

Manage the Environment

- Remove dangerous objects/equipment
- Monitor patient in a safe space with dimmed lights, minimize noise
- Decrease sources of stress/stimulation, including family/caregivers as required to reduce patient triggers
- Avoid overuse of medications, physical restraints, and security personnel

Use Behavioral De-escalation Techniques

- Respect personal space
- Listen to patient and caregiver
- Keep neutral tone and body language
- Establish concise verbal contact
- Avoid provocative actions and words
- Identify wants and feelings
- Offer choices and optimism
- Reward cooperation

Use Calming Interventions

- Listen to patient, validate distress
- Address needs (e.g., food/drink)
- Use distraction (e.g., safe activity, food, warm blanket)
- Explain what to expect in ED, next steps, provide updates
- Debrief patient and care team

Are you able to de-escalate the patient so they are not a harm risk to themselves/staff?

Yes, no longer agitated.

Ongoing Evaluation

- Monitor vital signs and fall risks
- Initiate de-escalation strategies/calming interventions with signs of increasing agitation as needed
- Complete history and physical to potentially identify etiology for agitation

No, immediate harm risk.

Identify Etiology for Agitation

Medications

Developmental delay or autism spectrum disorder
- Involve caregiver, check behavioral care plan for strategies
- Utilize sensory tools and calming interventions
- Identify previously effective medication(s)

- PO: clonidine OR risperidone OR olanzapine; Oral Dissolve Tablet: olazapine; IM: olanzapine
- AVOID IM route if possible
- Consider an extra dose of patient's home medication
- AVOID benzodiazepine–risk of disinhibition, unless effective in past

Suspected psychiatric diagnosis
- Use behavioral de-escalation techniques
- Assess for possible organic cause
- Identify previously effective medication(s)

- Use a medication that has worked in the past or an additional dose of home medication
- If psychosis or anxiety/trauma related: benzodiazapine
- AVOID ketamine if concern for psychosis, antipsychotics if concern for catatonia

Delirium (change in cognition and/or confusion)
- Obtain critical labs: glucose, electrolytes, toxins
- Assess for head trauma, encephalopathy (infectious or toxin)
- Address vital sign abnormalities, underlying medical etiology

- PO: quetiapine OR risperidone OR clonidine OR olanzapine
- IM: olanzapine OR haloperidol
- IV: haloperidol
- AVOID benzodiazepines and anticholinergics, could worsen delirium

Pain
- Assess for and address/treat potential causes of pain
- Assess patient's past response to pain

- PO: ibuprofen, acetaminophen
- IN: fentanyl, ketamine
- IM: ketorolac, ketamine
- IV: acetaminophen, ketorolac, opioid, low-dose ketamine
- AVOID NSAIDs (if suspect bleeding); ketorolac (if renal failure); respiratory depressants (if intoxication); ketamine (if psychosis)

Withdrawal or intoxication
- Assess for multi-drug ingestion
- Closely monitor ABCs, vital signs, and temperature
- CAUTION: potential cardiac effects with unknown/multi-drug use

- Unknown substance: benzodiazepine
- Opioid withdrawal: methadone or buprenorphine

Unknown etiology
- Closely monitor patient, vital signs and temperature
- With hyperprexia, autonomic instability, mental status/neurologic changes consider catatonia, neuroleptic malignant syndrome, serotonin syndrome

- Moderate Agitation: diphendydramine or benzodiazepine
- Severe Agitation: haloperidol +/- benzodiazepine

CAUTION

- **Evaluate for medication side effects**
- **Consider medication time to onset, peak, duration of effect**
- **Consider additive effects prior to additional dosing**
- **If using antipsychotic, monitor for acute dystonic reaction (involuntary contractions, movements or postures)**

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