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Time needed to complete: 1h 15m

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As Different as Day and Night: Managing Acutely Agitated Patients in the Emergency Setting

Announcer:
Welcome to CME on ReachMD. This episode is part of our MinuteCME curriculum.

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Dr. Gooch:
Hello, I'm Dr. Michael Gooch, and welcome to As Different as Day and Night, a case study about the management of acutely agitated patient there in the emergency setting. I'm an emergency and flight nurse practitioner. I practice here in the middle Tennessee area. And I'm also Assistant Professor of Nursing at Vanderbilt University in Nashville.

So let's meet Jason Bradshaw. So you're on your typical shift there in the ED, and he respond to triage for staff assist call. We've all heard this before, 'We need some help.' And so you arrive and you find Jason there in the triage room. He's very agitated, he's shouting, he's pacing in the room. What are you going to do? What's your intervention here? He's not making any threats to anyone else yet. He's agitated, but he has not threatened anybody. The triage nurse has left the room. So, what's your plan?

So let's start off, let's introduce ourselves, let's try to assess the situation, kind of do that across the room assessment of the situation, try to ask, 'Can I enter?' give the patient some autonomy, maybe he's going to respond to you in a good manner, maybe he doesn't. But - and that may start that rapport of having that good relationship. And in this case, he kind of just pauses, he looks at you, but he goes back to pacing. So let's ask again. And he responds, 'Yeah, sure.' So maybe as we step in the room, we start talking to him. Try to establish that rapport, earn some trust. That can be really important here. Goal is try to be nonconfrontational, that doesn't always happen, is not the best manner. But I reintroduce ourselves and ask him, how can you help. And he responds, 'Let's make this all stop.' ' Can you help me understand little bit better, Jason, what's going on today? What can I help you with?'

So here's Jason's story. He's got a history of Schizophrenia. He's been well controlled in his medications, but unfortunately, he lost his job and his insurance. And now he's been out of his medications for at least 5 days. This is unfortunately something that we run into often. And that patient wants to get back on his medications. He wants to be in control of what's going on. But he admits he started having some audible hallucinations about 2 days ago. And he just feels he's well out of control. He's very anxious. And during your conversation with him, he just yells out to, 'stop, leave me alone.' And you're looking at him, and obviously, it looks like he's having some more of those hallucinations. You're very concerned for his well-being, you're concerned for everyone else's well-being. He had been well controlled on olanzapine. So what can we do for him now?

How about we ask him, 'Hey, would you like to go somewhere more private? Can we go somewhere away from everyone else, so we can talk a bit better, because probably by now we've drawn a crowd.' Everyone's there. Sometimes law enforcement security, depending on where you practice. And sometimes their presence can be helpful, and sometimes their presence can add to more agitation. So let's see if we can go somewhere to get more private to talk with him.

So let's get him to a secured room. Some of us may have that room that safe for these patients. This may be the room that has nothing

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in there they can use to hurt themselves, or others, ideally limited supplies. One of the EDs I practiced at before actually had the ability to turn a key, and this garage door would come down. And it would set off everything else. So the patient couldn't access the monitor or any of the equipment was there. And ask them, 'Hey, can I do a brief exam?' and he agrees. And luckily, on physical exam, there's no red flags. There's no big concerns that come up when doing his assessment. He agrees to let you do some lab tests. And probably most of us have our center policy we're going to do for these patients to rule out any other concerns. And this might be a metabolic problem. And since he's been taking olanzapine at home, let's try an oral dose, maybe a little bit of lorazepam there as well. And he agrees to this. And I just want to make sure he's in a safe environment, and that we are in a safe environment.

So about 10 minutes later, unfortunately, you get called back to Jason's room. He's now more agitated he's more aggressive. And talking to the nurse there, he was doing great. She'd come to help get him settled in, and unfortunately, 'I've got to get you undressed. Let's put the scrubs on.' And that did not go well. He became more agitated. He's now not wanting to talk to me. He's not becoming very interactive. And he really has that, just shakiness to him. He didn't get his medicines yet. So now what are we going to do for this guy? I want to take care of him. I need to make sure he stays safe and that we stay safe as well.

So we have a couple of options out there. Maybe this is a patient who we might go with something I.M. like haloperidol/lorazepam. Or maybe we could go with second-generation, maybe some olanzapine and midazolam. I like the midazolam because it absorbs faster and has a little bit shorter duration than we see with lorazepam. I need to have my game plan. So whether I'm working with a couple people, maybe I have security involved, maybe not. Let's work this out before we get in that room. So we're going to go in, let's talk to him. If the de-escalation doesn't work, we're going to go to medications. And if I have to get these medications I.M., it's going to be straight through whatever he's got on. I want a good muscle group. Ideally, the thigh is the best. But if I had to go to an arm, I can use the deltoid. But let's have that plan, I need to get all hands on deck. And having your tailored work for each patient is what we want to do. Let's try this first. And then let's try this. But maybe he's a little bit more cooperative. Maybe we could do the dexmedetomidine sublingual. He's agitated. He says he wants help. He wants to make these voices stop. So this might be a good agent here.

What else could we consider? What if I don't want to use an antipsychotic? What if I don't use a benzo? This might be a good time to consider ketamine. Ketamine is going to give us control of his agitation, but not have that long-lasting sedation that we might see with these others. Anytime we do a combination, we tend to have longer sedation and more problems. That's definitely something for us to consider.

So we're going to do the haloperidol and lorazepam. That's probably everybody's favorite to go to. Unfortunately, it's going to be very sedating. But it is going to help me help us control him, we've got to secure this patient, and I need as many hands as possible. I want to get him physically restrained to do this medication if de-escalation therapy doesn't work. We give the medication, and let's wait. It may take several minutes for this to work. Try to give him some space. It's not going to work, you know, within an instant, like we see in some of the TV shows and movies.

But definitely after a couple of minutes, he becomes more calm. And he actually he becomes more cooperative. And he allows us to continue with the therapy and he is actually kind of thankful that he's now got some more control of this. And for Jason's safety, we're going to put him in a psych hold and then get some mental health evaluation. Unfortunately, sometimes using these medications may delay that. And sometimes our mental health counselors might not come and talk with that patient until they're back fully awake. So we want to transition him to some oral things, once he starts to wake up more without going to parenteral, if at all possible.

So now for Jason's disposition. Fortunately, we didn't find any red flags, because there were no abnormalities in his physical assessment, his laboratory workup. And once he gets more awake, he's more coherent for the medications, mental health might come talk with him. And that may be 12 or 24 hours from now, depending on your resources. But we're going to get Jason admitted to inpatient services. We're going to get him back on his medication therapy, we're going to work with case management, we're going to try to get him access to his medication so we can get him back home, back to his family, and maybe even have resources to help him find another job so we can get him back as being part of society.

This is a great outcome for Jason, it's been kind of rough for him at first, but hopefully through either de-escalation therapy or sometimes pharmacological therapy, we can help get him control of his agitation. We definitely want to make sure we keep him safe, and we keep us safe as well. So this may not work for every patient. Tailor your plan to every patient. But hopefully we can think about the benefit of verbal de-escalation and if we need to elevate that to meds and try to go oral if at all possible. Maybe that sublingual route before we have to go to an injection, but definitely have your plan and anticipate what it's going to do and what your side effects are.

Thank you.

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