AGITATION—THE CHEST PAIN OF BEHAVIORAL EMERGENCIES

Gail Pisarcik Lenehan, RN, MSN, EdD, FAEN, FAAN

Of all the behavioral signs and symptoms of emergency department patients, agitation may cause some of the worst discomfort, and the most consternation for staff. It is the elephant in the middle of the room that needs to be recognized and addressed before it worsens, just as we would an ominous sign like chest pain.

Ranging from restlessness and irritability to verbal outbursts, threats and physical assault, agitation needs to be diagnosed and treated soon. Not treating can be life-threatening for the patient, as well as for others. Often, the cause of the agitation is uncertain. Is it a result of extreme paranoia in a patient with command hallucinations or severe anxiety in a patient who is certain he or she is dying? Is it due to drug ingestions or poisonings or, ironically, the side effects of antipsychotics and the medications used to manage extrapyramidal symptoms because of their anticholinergic side effects? Is it a sign of escalating mania in a patient with a bipolar disease? Is it neurological?

Recently at one teaching hospital, a reportedly healthy 39-year-old female presented with extreme agitation that was barely touched by repeated doses of haloperidol (Haldol), lorazepam (Ativan), and diphenhydramine (Benadryl). According to reliable family, she had absolutely no history of any mental illness or any other illness, for that matter, and had become symptomatic during the past few days. The two clues leading to the fact that it was organic or medical, rather than functional or psychiatric, were the acute onset and that the agitation waxed and waned. She was put in as few restraints as possible, and her symptoms escalated, alternating with kneeling to pray while screaming that she had to leave. In the next minute, she would briefly doze off. She was admitted and later diagnosed with encephalopathy secondary to HIV and syphilis.

It is axiomatic in acute care settings that there should be only one anxious person in the room. By the same token, there only should be one agitated person in the emergency department setting, and staff has to learn to overcome their own potential agitation in responding to the patient. Agitation, like anxiety, can engender a helplessness that makes staff avoid the patient. The most basic question becomes how to keep the patient's symptoms contained and keep the patient, other patients and staff safe.

Agitation may be similar to pain, which also was an elephant in the room when we were aware of it, but didn't focus on it, quantify it or systematically document it until relatively recently. In fact, with increasing awareness of the inconsistency that pain was addressed, the Joint Commission revised its Standard for Pain Management, and we now ask patients to quantify (i.e. rate) and routinely chart their pain at intervals.

A similarly growing awareness of agitation may improve the care of the patients it affects. One study compares agitated patients who were restrained with agitated patients who were not restrained[1] with counter-intuitive outcomes. While it is common to see the mention of agitation, there is not a consistent way to quantify it, even in such simple terms as mild, moderate and severe. It is more than semantics; it is important for trending, continuity of care and compliance with laws and regulations. We also need data to help justify the increasing use and expense, of sitters.

With increasing advocacy and mandates from patient rights groups, legislatures, lawyers, state departments of health and the Joint Commission, the clinical condition of agitation soon may become a priority subject for quality improvement and research.

The care of the ED psychiatric patient is one of ENA's three current clinical priorities for 2009 –2011. Two national ENA committees—Emergency Department Psychiatric Care Committee and Psychiatric Patient Education Product Development Work Team—will continue to address the legislative, regulatory and educational aspects of caring for the psychiatric patient. Other divisions of ENA, from Government Affairs to national conference programs to public relations, will incorporate the issue as well. Hopefully, with ENA's spotlight, we also will harness the wisdom of individual ENA members and encourage their involvement in helping to improve the care of patients with critical clinical issues such as agitation.

For example:

- Consider an ED psychiatric patient committee to review the comprehensive evidence-based literature[2] and grapple with issues like the agitated patient. Start with triage: One study revealed triage deficiencies in the recording of mental status in 56 percent of 298 psychiatric patients' charts.[3]
- Incorporate a structured orientation of staff to the therapeutic, legal and regulatory issues in caring for agitated patients.
- At an ENA chapter meeting, instead of a lecture, consider having a focused discussion on the Successful Practices (not necessarily "best," but successful for individual EDs) regarding patients with agitation, possibly including experts in the discussion.
- Commit as an emergency nurse to learning skills to de-escalate a patient with agitation with verbal and nonverbal de-escalation techniques, and learn to avoid common verbal and nonverbal ways that can increase a patient's agitation.
- Commit to working toward the least restrictive ways of ensuring safety, reducing the use of restraints and reducing the time in restraints.
- Going to graduate school? Looking for a relevant topic for a capstone, thesis or dissertation? Consider the care of the agitated patient.
- Looking for a worthwhile quality improvement project? Consider the management of patients' agitation.
- Encourage achievable practice goals. Maybe the objective portion of a nurse's note for patients with agitation could include a quick ABC (with a literal few words on the patient's Affect, Behavior and Cognition).
- A concerted effort to file reports of incidents involving agitated patients could point to common scenarios pointing to improved safety practices.
- Report your clinical initiatives and research through the literature. Consider writing clinical initiatives and/or a case review of the management of an agitated patient with valuable teaching points.
- Lastly, but far from least, it would be interesting to study the difference in safety records with regard to agitated patients where there is a well-educated professional security force with officers dedicated to the emergency department and/or where there is an experienced, well-educated ED nursing staff.

References

1 Zun LS, Downey LVA. Level of Agitation of Psychiatric Patients Presenting to an Emergency Department. J Clin Psychiatry. 2008; 10(2):108-113.

2 Lukens TW, Wolf SJ, Edlow JA, Shahabuddin S, Allen MH, Currier GW, et al. Clinical Policy: Critical Issues in the Diagnosis and Management of the Adult Psychiatric Patient in the Emergency Department. Annals of Emerg Med. 2006; 47(1):79-99.

3 Tintinalli JE, Peacock FW 4th, Wright MA. Emergency medical evaluation of psychiatric patients. Ann Emerg Med. 1994 Apr;23(4):859-62.