Management of the agitated patient

January 2021 SRFT V1.0

Diagnosis

- It will be very obvious that the patient is agitated, but the cause may well not be clear and some things need to be excluded urgently- This needs an A.B.C.D.E.F.G approach.
- Airway/Breathing- If you can't breath you will be agitated. Excluding an airway or breathing problem means checking the airway is not blocked or displaced, then checking the ventilator and tubing or oxygen tubing and then the patient's chest. This should be done in a structured way and by getting help.
- Circulation- You will be agitated if there is not enough blood going around your body- check the drugs like Noradrenaline are still getting into the patient and that they have not gone into pulmonary oedema or had a PE. (C can also stand for a blocked catheter).
- DEFG- Don't ever forget glucose! Check the glucose on a blood gas and glucometer.

Other things to exclude

- Is the patient in pain or do they have some other reason to be uncomfortable?
- Does the patient have any of the multiple causes of delirium as set out in slide 4 of the presentation on delirium?
- Has the patient just woken from sleep? Some patients may be very confused and agitated on first waking, a condition known as *hypnagogia.* It should be possible to calm them by orientating them.

Treatment *(apart from the underlying cause)*

- Get help! There are a lot of things that need to be sorted out quickly!
- Talk to the patient- Orientate them: Think of the 6 things to introduce yourself (Delirium slide 2). *Follow the guidance on talking to confused patients in the delirium policy*. Talk quietly, listen to the patient, don't disagree/argue, keep what you say short and simple and be reassuring that you are keeping them safe, try to just have one member of staff talking. Relatives are VERY helpful even on Facetime.
- Some people use a SAVE pneumonic: **S**upport: "Let's work together…" **A**cknowledge: "I see this has been hard for you." **V**alidate: "I'd probably be reacting the same way if I was in your shoes." **E**motion naming: "You seem upset."
- *Talking may well not be enough, other actions are again summarised in slide four of the delirium presentation*

Treatment & other management

- Stop the patient injuring themselves- Remove any lines or catheters that aren't needed. Make sure other devices are as secure as possible- if you think a patient may become agitated think about nasal bridals and anker fast tube holders in advance.
- Have a special to help you and the patient.

- Senior staff may decide to use Posey mitts to stop the patient pulling. They will explain how to observe the patient and the legal implications.
- Consider using a side room and lowering the bed

Medications. Start low, go slow

- This is covered in more detail in the delirium protocol. Medications are generally a second line treatment.
- Opiates- e.g. Morphine 2.5mg repeated to10mg IV- For pain or opiate withdrawal
- Nicotine- for nicotine withdrawal
- Olanzapine 2.5 repeated to 10 mg for delirium in non neurosciences patients with no QT abnormalities
- Midazolam 2.5 mg repeated to 10mg Neurological patients and alcohol withdrawal
- Low dose Propofol infusions- consultant only request.
- Clonidine- see separate presentation
- *Managing very agitated patients is hard work, stressful and emotionally draining, but it can be very rewarding to see them begin to return to the same reality as the rest of us!*