Worcestershire Acute Hospitals NHS Trust

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The Emergency Department Approach to the Management of the Agitated Adult Patient

Department/ Service:	Emergency Department
Originator:	James France
Accountable Director:	David Raven
Approved by:	Urgent Care Governance Meeting
Approved by Medicines Safety Committee: *(When medicines are included in the document)*	11th March 2026
Date of approval:	4th February 2026
Revision due: This is the most current document and should be used until a revised version is in place	4th February 2029
Target Organisation(s):	Worcestershire Acute Hospitals NHS Trust
Target Departments:	Emergency Departments
Target Staff Categories:	Emergency Department Clinical Staff

Policy Overview:
This guideline has been produced to provide the staff working in the emergency department (ED) with a structured approach for adult patients presenting with agitation, including but not isolated to, those with acute exacerbations of mental health complaints. It covers seven common scenarios including the need for rapid tranquilisation, where the agitation and threat to patient and staff safety is severe enough to require an immediate response. The guidance takes the form of a seven-column single side table but each of the seven scenarios within the table are expanded in the appendices

Contents page:

1. Introduction

This guideline has been produced to provide the staff working in the ED with a structured approach for adult patients presenting with agitation, including but not isolated to, those with acute exacerbations of mental health complaints. It covers seven common scenarios including the need for rapid tranquilisation, where the agitation and threat to patient and staff safety is severe enough to require an immediate response. The guidance takes the form of a seven column single side table but each of the seven scenarios within the table are expanded in the appendices.

2. Scope of Practice

Clinical staff working within the emergency department (ED) who may be faced with dealing with an agitated patient. For the purposes of this guidance adult refers to patients 18years and over. Related guidance includes:

- Adult Emergency Rapid Tranquilisation (ERT) in the Emergency Department,
- Guidelines to Prevent and Treat Delirium in Hospital,
- Restrictive Interventions Policy – Adults
- Paediatric Rapid Tranquilisation Guideline
- Recognition and Treatment of Alcohol Misuse in Acute Hospital Setting
- Policy for Supporting Adults with Learning Disabilities when accessing Acute Hospital Services

3. Notes on Approach to Agitated adult patient in the ED

- The aim is to present illustrative situations where the team in the ED must care for patients with undifferentiated agitation, along with a clear description of the goal the team is aiming for over the first 30-60 minutes.
- The principles of this ED guideline are:
  - **Safety** of staff and the patient and their carers is paramount. The trust has a legal responsibility to provide a safe working environment, however, an emergency department should expect to regularly manage the risk of agitated patients.
  - All agitated and confused patients are a **falls risk** if not supervised. Complete a falls assessment.
  - **Capacity** must be assessed. When patient does not have capacity, they must be treated in best interests with the overriding principle of 'preservation of life'.
  - Prolonged restraint of agitated patients is hazardous and psychologically traumatic for patients and staff. The requirement for emergency rapid tranquilisation must be treated as an **emergency**.
  - It is the responsibility of all staff involved to ensure that **restraint techniques** are safe. See trust 'Restrictive Interventions Policy – Adults'
  - Prompt **multidisciplinary** decision making is the key to an effective response. Communication and documentation of the plan must be clear.
  - Levels of restraint and/or sedation must be **proportional** to the risk posed by and to the patient.
  - Severely agitated patients should receive potent, fast-acting sedation and the potential for airway and/or critical care interventions should be **expected and planned for**.
- Despite the implied speed and urgency of the term 'Rapid Tranquilisation', it is frequently too slow in severe situations where it is 'emergency sedation' that is required, hence the terminology Emergency Rapid Tranquilisation (ERT). For the purposes of this guidance, the following broad definitions apply:
  - Emergency Rapid Tranquilisation – onset almost immediate (within minutes), parenteral administration
  - Rapid Tranquilisation – onset sometime within 20 minutes, parenteral administration
  - Tranquilisation – variable onset time, usually not involving the parenteral route
- Patients presenting to the ED in an agitated, aggressive or violent state pose a diagnostic challenge. Acute exacerbation of an underlying psychiatric disorder should be considered a **diagnosis of exclusion**.
- Unlike on the medical or psychiatry wards, the Emergency Department has access to staff and facilities capable of advanced airway management and monitoring. More potent sedatives and doses may be used if the senior skilled support is present. Heavy sedation of patients in order to facilitate treatment and/or investigations may need to occur outside of the resus critical care environment but only if there is a clear immediate plan to transport the patient to resus once the agents have taken effect.

- Where patients have been subjected to an emergency rapid tranquilisation or rapid tranquilisation procedure this must be documented on the electronic patient record (Sunrise) in the ED Coding document, in the treatment section – 'Rapid Tranquilisation'.
- In the event of the patient being deemed to lack capacity, the electronic patent record should also have clear documentation about the patient's (decision specific) capacity and how this relates to any management decisions regarding tranquilisation / sedation.
- Agitated delirium is also referred to as Hyperactive Delirium.

Agitation scenario	Head injury/ Polytrauma/ Intracranial pathology with any agitation	Severe Agitated Delirium/ Toxicology +/- psychiatric dx	Moderate agitation Ψ psychiatric dx +/- intoxication	Mild agitation Ψ psychiatric dx +/- mild intoxication +/- mild withdrawal	Delirium in the older/frail/ unwell patient	Abusive Aggressive Seems competent	Learning difficulties in pain / distress
Level of agitation	*'Unmanageable' making treatment of medical issue impossible.*	*Patient requires persistent forceful restraint often from multiple personnel*	*Patient requires occasional restraint.*	*Patient requires supervision and/or redirection. Should not require restraint.*	*Normally requires supervision (with minor restraint to give treatment.)*	*Not a pathological state. Person has capacity for their decisions*	*Variable. With carers help can normally de-escalate. Restraint should be uncommon.*
Capacity	Clearly no capacity	Clearly no capacity	Unlikely capacity	Probably has capacity	Unlikely capacity	Seems competent	Maybe capacity
Team	• ED (senior) • As required: ▪Airway (EM/ITU/An) ▪ Security	•ED (senior) • As required: ▪Airway (EM/ITU/An) ▪ Security ▪ MHL	• ED (senior) • As required: ▪ Security ▪ MHL	•ED • As required: ▪ MHL ▪ Security ▪ Alcohol LN	• ED • As required: ▪ Patient's carer ▪ Security ▪ Medics/GEMS	• Security • ED • As required: ▪ +/- MHL	•ED •Patient's carer • As required: ▪ LD Nurse ▪ Security (restraint is a last resort)
Area	RESUS 1:1, full monitoring	RESUS 1:1, full monitoring	Resus / Majors	Majors	Resus / Majors	Anywhere in ED	Quiet location
Plan	1. Team brief 2. Safe restraint 3. Attempt O2 mask* 4. Sedation to facilitate investigation + treatment 5. Start pre-oxygenation. Intubation frequently required. **O2 Mask reduces risk from spitting and provides pre-oxygenation*	1. Team brief 2. Safe restraint 3. Attempt O2 mask* 4. Robust dose, fast-acting IV/IM sedation 5. Make a plan to intubate if needed but may not need to.	1. Proportional occasional restraint 2. Capacity assessment 3. Info gather including alcohol/drug hx 4. IM/IV rapid tranquilisation - this may not be needed for all s136 5. Maintenance prescription	1. De-escalation (NB nicotine replacement) 2. Capacity assessment 3. Info gather including alcohol/drug hx 4. PO tranquilisation, in stepwise fashion 5. Appropriate environment 6. Maintenance or PRN meds prescribed	1. Reassure, 1:1 2. Capacity assessment 3. Treat cause 4. Last resort sedation +/- restraint 5. Appropriate environment 6. Info gather – care plan All agitated + confused patients are a **FALLS RISK**	1. Capacity assessment 2. De-escalation 3. Verbal warning with behavioural agreement **Zero tolerance of abuse towards staff.**	1. Capacity assessment* 2. De-escalation 3. Liaise with carer 4. Info gather – care plan? 5. Risk assessment 6. Treat the medical issue 7. Senior doctor for risk/benefit decisions. **may have capacity for some decisions, not other decisions.*
Drug Options	**THESE ARE HIGH RISK SCENARIOS.** **SENIOR NURSIES & DOCTORS NEED TO BE PRESENT** **INTRAMUSCULAR emergency sedation** USE **Midazolam 0.075-0.125mg/kg IM** onset 3-5 mins *(e.g. 5-10mg for 80kg)* OR **Ketamine 3-5mg/kg* IM** onset 3-5 mins (*for fast control use high dose ketamine *e.g. 250-400mg for 80kg* Small doses can cause more complications.) For IM sedation, use high concentrations, kept CD cupboard Resus (Ketamine) and Majors (Midazolam) Maximum IM volumes - Thigh 5 ml, Buttock 4ml, Deltoid 2ml. Two sites may be needed. *Onset of IM Lorazepam will be too slow* **INTRAVENOUS emergency sedation** USE **Midazolam 0.025-0.05mg/kg IV** onset 1-3 mins *(e.g. 2.5-5mg for 80kg)* OR **Ketamine 1mg/kg IV** onset 1-2mins *(e.g. 80mg for 80kg)* **If emergency anaesthesia is required:** • Drugs choice is case dependent (fentanyl/ketamine/rocuronium) • Sedation may be needed to facilitate pre-oxygenation for anaesthesia. • There will be high sympathetic drive so beware of BP drop at induction.	For moderately agitated, non-compliant patients who require only occasional restraint, especially those with an underlying and predominant mental health diagnosis. •IM drugs should take effect more gently over 20-40 minutes. Common 1st line choices of IM medications would be: ▪**Lorazepam 2mg IM** ▪or **Haloperidol 2.5-5mg IM** •Titrated IV benzodiazepines can be given depending on safety of IV access e.g. ▪Lorazepam 1-4mg IV in 1mg aliquots •If greater than max doses are needed within 24 hours, needs discussion with senior +/- high dependence area. Specific guidance is available to assist treating patients suffering from withdrawal from Alcohol or Opiates. Consider nicotine replacement for patients who smoke regularly. For patients with mild agitation (e.g. anxious, pacing about). Start with de-escalation, PO medication and escalate stepwise. Common 1st line oral medications: **Lorazepam 1-2mg PO** or **Haloperidol 2.5-5mg PO**	Please see Delirium Guidelines**.** The aim is to calm, not sedate. Try to do this without meds. **1st line Haloperidol 0.5 -1mg PO/IM** except in Lewy body / Parkinson's Try to avoid benzodiazepines. If needed, give small doses e.g. • **lorazepam 0.5-1mg PO** • **midazolam 0.5-1mg IM** Sedation is an occasional unavoidable side effect so prepare for it. More robust sedation may be required briefly in order to gain imaging. Enlist assistance of an airway trained senior.	Drug options not appropriate. Person may be requesting medication. If the patient de-escalates their behaviour, then this can be discussed.	Drug options normally not appropriate. Ensure patient is prioritised (even if clinical issue seems minor) as behaviour may well worsen if waiting. All attempts to manage with carers should be attempted. Small dose benzodiazepines e.g. **lorazepam 0.5mg IV / 1mg PO** In severe situations where risk is high, potent sedation may be required. Get assistance from airway trained senior and security.

Where to be in 30 minutes	**Control** **Resuscitation** **Airway Mx** **Imaging** **Diagnosis** **Critical care**	**Control** **Diagnosis** **Allow metabolism of drugs/alcohol** +/- RSI +/- CT	**Calm** **Allow metabolism of drug/alcohol** **Treat wounds/OD** **MHA** +/- s136 suite	**Calm** **Establish capacity** **Allow metabolism of drug/alcohol** **Treat wounds/OD** **MHA**	**Calm (not sedate)** **Diagnose** **Treat*** *see trust delirium guidelines*	**Establish capacity** **Behavioural agreement or escorted from ED** **+/- Police** if needed to press charges	**Prevent escalation** **Carers concerns addressed** **Diagnostic and treatment plan**

Approach to the 'unmanageable' patient with likely underlying medical or traumatic pathology

Agitation scenario	**Head injury/ Polytrauma/ Intracranial pathology with any agitation. The agitation is sufficient to significantly impair the care of the patient.**
Level of agitation	*'Unmanageable' making treatment of medical issue impossible.*
Capacity	Clearly no capacity
Team	• ED (senior) • As required: ▪Security ▪Airway (EM/ITU/An)
Area	RESUS 1:1, full monitoring
Plan	1. Team brief 2. Safe restraint – ensure airway is not obstructed and ventilation is not impeded. 3. Attempt O2 mask* 4. Sedation to facilitate investigation + treatment 5. Start pre-oxygenation. **Intubation frequently required**. *O2 Mask reduces risk from spitting and provides pre-oxygenation
Drug Options	**THESE ARE HIGH RISK SCENARIOS.** **SENIOR NURSES AND DOCTORS NEED TO BE PRESENT** **INTRAMUSCULAR emergency sedation** *Onset of IM Lorazepam may be too slow* **USE** Midazolam 0.075-0.125mg/kg IM. Onset 3-5 mins (*e.g. 5-10mg for 80kg)* **OR** Ketamine 3-5mg/kg IM. Onset 3-5 mins (*for fast control use high dose ketamine e.g. 250-400mg for 80kg. Small doses can cause more complications) For IM sedation, use high concentration preparations. They are kept in the CD cupboards; Ketamine - Resus; Midazolam (10mg/2mls) - Majors. Maximum IM volumes - Thigh 5 ml, Buttock 4ml, Deltoid 2ml. Two sites may be needed. **INTRAVENOUS emergency sedation** **USE** Midazolam 0.025-0.05mg/kg. Onset 1-3 mins (*e.g. 2.5-5mg for 80kg*) **OR** Ketamine 1mg/kg. Onset 1-2mins (*e.g. 80mg for 80kg*) **If emergency anaesthesia is required: LIKELY** • Drugs choice is case dependent (e.g. fentanyl/ketamine/rocuronium) • Sedation as above may be needed to facilitate pre-oxygenation for anaesthesia • There will be high sympathetic drive so beware of BP drop at induction.
Where to be	**Control of the situation** **Initiation of resuscitation**

APPROACH TO AGITATION IN THE ADULT PATIENT IN THE ED

Approach to the patient with severe agitated delirium, where a combination of toxins and a possible underlying mental health diagnosis is more likely

Agitation scenario	**Severe Agitated Delirium.** **Frequently involving toxins +/- psychiatric diagnosis. Life threatening emergency.**
Level of agitation	*Patient requires persistent forceful restraint often from multiple personnel.*
Capacity	Clearly no capacity
Team	• ED (senior) • As required: ▪Security ▪Airway (EM/ITU/An) ▪ MHL
Area	RESUS 1:1, full monitoring
Plan	1. Team brief 2. Safe restraint. – ensure airway is not obstructed and ventilation is not impeded. 3. Attempt O2 mask* 4. Robust dose, fast-acting IV/IM sedation 5. Make a plan to intubate if needed but **may** not need to. *O2 Mask reduces risk from spitting and provides pre-oxygenation
Drug Options	**THESE ARE HIGH RISK SCENARIOS.** **SENIOR NURSES AND DOCTORS NEED TO BE PRESENT** **INTRAMUSCULAR Emergency Rapid Tranquilisation (ERT) / Sedation** Onset of IM Lorazepam may be too slow USE Midazolam 0.075-0.125mg/kg IM. Onset 3-5 mins (e.g. 5-10mg for 80kg) OR Ketamine 3-5mg/kg IM. Onset 3-5 mins (*for fast control use high dose ketamine e.g. 250- 400mg for 80kg. Small doses can cause more complications) For IM sedation, use high concentration preparations. They are kept in the CD cupboards; Ketamine - Resus; Midazolam (10mg/2mls) - Majors. Maximum IM volumes - Thigh 5 ml, Buttock 4ml, Deltoid 2ml. Two sites may be needed. **INTRAVENOUS emergency sedation** **USE** Midazolam 0.025-0.05mg/kg IV. Onset 1-3 mins (*e.g. 2.5-5mg for 80kg*) **OR** Ketamine 1mg/kg IV. Onset 1-2mins (*e.g. 80mg for 80kg*) **If emergency anaesthesia is required: MAY BE REQUIRED** • Drugs choice is case dependent (e.g. fentanyl/ketamine/rocuronium) • Sedation as above may be needed to facilitate pre-oxygenation for anaesthesia • There will be high sympathetic drive so beware of BP drop at induction.
Where to be in 30 minutes	**Control of the situation** **Aim for a working differential diagnosis** **Allow metabolism of intoxicant drugs and / or alcohol** **Emergency anaesthesia may be required** **Advanced imaging may be required**

Approach to the patient with moderate agitation and a Predominant mental health diagnosis, possibly in combination with some intoxicant drugs or alcohol

Agitation scenario	**Moderate agitation and a predominant mental health diagnosis +/- intoxication but not severe**
Level of agitation	*Patient requires occasional restraint*
Capacity	Unlikely capacity
Team	• ED (senior) • As required: ▪Security ▪ MHL
Area	Resus / Majors
Plan	1. Proportional occasional restraint 2. Capacity assessment 3. Information gather including alcohol and/or drug history **4.** IM/IV rapid tranquilisation - **this may not be needed for all s136** 5. Maintenance prescription

Drug Options	For moderately agitated, non-compliant patients who require only occasional restraint, especially those with an underlying and predominant mental health diagnosis.
	• IM drugs should take effect more gently over 20-40 minutes. Common 1st line choices of IM medications would be:
	  ○ Lorazepam 2mg IM
	  ○ or Haloperidol 2.5-5mg IM
	• Titrated IV benzodiazepines can be given depending on safety of IV access e.g.
	  ○ Lorazepam 1-4mg IV in 1mg aliquots
	• If greater than max doses are needed within 24 hours, needs discussion with senior +/- high dependence area.
	Specific guidance is available to assist treating patients suffering from withdrawal from Alcohol or Opiates. Consider nicotine replacement for patients who smoke regularly.

Where to be in 30 minutes	**Calm** **Allow metabolism of drug / alcohol** **Treat wounds and / or overdose** **Mental Health assessment**

Approach to the patient with mild agitation and a predominant mental health diagnosis, possibly in combination with some intoxicant drugs or alcohol

Agitation scenario	**Mild agitation with predominant psychiatric diagnosis** **+/- mild intoxication** **+/- mild withdrawal**
Level of agitation	*Patient requires supervision and/or redirection. Should not require restraint.*
Capacity	Probably has capacity
Team	• ED • As required: ▪ MHL ▪ Security ▪ Alcohol LN
Area	Majors
Plan	1. De-escalation (NB nicotine replacement) 2. Capacity assessment – consider what actions are appropriate if the patient wishes to leave. 3. Information gather including alcohol and/or drug history 4. Oral tranquilisation as required, in a stepwise fashion 5. Appropriate environment 6. Maintenance or PRN meds prescribed
Drug Options	For patients with mild agitation (e.g. anxious, pacing about) Start with de-escalation, PO medication and escalate stepwise. • Common 1st line oral medications: Lorazepam 1-2mg PO or Haloperidol 2.5mg-5mg PO
Where to be in 30 minutes	**Calm** **Allow metabolism of drug / alcohol** **Establish capacity** **Treat wounds and / or overdose** **Mental Health Assessment**

Approach to the older patient with mild/moderate agitation as a complication of undifferentiated delirium

Agitation scenario	**Delirium in the older / frail / unwell patient**
Level of agitation	*Normally requires close supervision (with minor restraint to give treatment)*
Capacity	Unlikely to have capacity
Team	• ED • As required: ▪Patient's carer ▪ Security ▪ Medics/GEMS
Area	Majors
Plan	1. Reassure, 1:1 supervision 2. Capacity assessment 3. Treat the cause 4. Last resort is sedation +/- occasional light restraint 5. Appropriate environment 6. Info gather – is there a care plan eg. 'About Me' 7. Falls assessment - anyone with confusion and agitation is at risk of falling. Close supervision can mitigate this risk, but it should be acknowledged that the falls risk will still remain
Drug Options	Please see **Delirium Guidelines**. The aim is to calm, not sedate. Try to do this without medications if possible. 1st line Haloperidol 0.5-1mg PO/IM, except in Lewy body / Parkinson's (NB maximum 5mg daily) Try to avoid benzodiazepines. If needed, give small doses e.g. • lorazepam 0.5-1mg PO • midazolam 0.5-1mg IM Sedation is an occasional unavoidable side effect so prepare for it. More robust sedation may be required briefly in order to gain imaging. Enlist the assistance of an airway trained senior.
Where to be in 30 minutes	**Calm** **Diagnose** **Treat *** *** see Trust guidelines**

Approach to the competent patient with aggression and/or violence towards staff or other patients

Agitation scenario	**Abusive** **Aggressive** **Seems Competent**
Level of agitation	**N / A** *Not a pathological state. Patient has capacity for their decisions*
Capacity	Seems competent
Team	• Security • ED • As required: ▪ +/- MHL
Area	Anywhere in ED
Plan	1. Capacity assessment 2. De-escalation 3. Verbal warning with behavioural agreement **Zero tolerance of abuse towards staff.**
Drug Options	Drug options not appropriate. Patient may be requesting medication. If the patient de-escalates their behaviour, then this can be discussed.
Where to be in 30 minutes	Establish that the patient has capacity for their decisions they are making. Behavioural agreement (and subsequent medical evaluation) or person is escorted from ED +/- Police if needed to press charges

Approach to the patient with mild/moderate agitation and learning difficulties

Agitation scenario	**Learning difficulties in pain / distress**
Level of agitation	Variable levels of agitation. With carers help can normally de-escalate. Restraint should be uncommon.
Capacity	Maybe capacity*
Team	• ED • Patient's carer • As required: ▪ LD Nurse ▪ Security (restraint is a last resort) Avoid a large group
Area	Quiet location
Plan	1. Capacity assessment* 2. De-escalation 3. Liaise with carer 4. Information gathering – is there a care plan / hospital passport? 5. Risk assessment 6. Treat the medical issue 7. Senior doctor for risk/benefit decisions. *may have capacity for some decisions, not other decisions.
Drug Options	Drug options normally not appropriate. All attempts to manage the patient with carers should be attempted. Ensure patient is prioritised (even if clinical issue seems minor) as the behaviour may well worsen if waiting in an unfamiliar environment If required, try to use small dose benzodiazepines e.g. lorazepam 0.5mg IV / 1mg PO In severe situations where risk is high, potent sedation may be required. Get assistance from airway trained senior and security.
Where to be in 30 minutes	**Prevent escalation** **Carers concerns addressed** **Diagnostic and treatment plan**

5. Monitoring

Page / section key document			Page 5
Key Control	WHAT?	Recording of Rapid Tranquilisation in Sunrise ED Coding document	ED approach to the agitated adult patient content is shared with every new permanent doctor commencing work in the department. Induction programme, distribution by email, departmental posters.
Checks to be carried out to confirm compliance with the policy	HOW?	Using Business Intelligence / Informatics team	Direct questioning / online survey of ED doctors
How often the check will be carried out:	WHEN?	yearly	yearly
Responsible for carrying out the check:	WHO?	JF	ED secretarial team
Results of check reported to: (Responsible for also ensuring actions are developed to address any areas of non-compliance)	WHERE?	Senior Departmental meeting	Senior Departmental meeting
Frequency of reporting	WHEN?	yearly	yearly

6. References

1. Acute Behavioural Disturbance in the Emergency Department, RCEM, May 2025. https://rcem.ac.uk/wp-content/uploads/2025/05/Acute_Behavioural_Disturbance_in_Emergency_Departments_May2025_V3.pdf Accessed 05.09.2025
2. Violence and aggression: short-term management in mental health, health and community settings. https://www.nice.org.uk/guidance/ng10/chapter/Recommendations Accessed 05.09.2025
3. The Emergency Department Approach to Agitation. Kings College Hospital NHS Foundation Trust.

7. Contribution List

This key document has been circulated to the following individuals for consultation:

Designation
Susan Powell, Consultant Geriatrician and Dementia Care Advocate
Tina Evans, Team Lead Pharmacist for Urgent Care and Pharmacist ACPs

This key document has been circulated to the chair(s) of the following committee's / groups for comments:

Committee
Urgent Care Governance Meeting
Medicines Safety Committee

8. Supporting Document 1 - Equality Impact Assessment Tool

To be completed by the key document author and included as an appendix to key document when submitted to the appropriate committee for consideration and approval.

Worcestershire Acute Hospitals NHS Trust

Herefordshire & Worcestershire STP - Equality Impact Assessment (EIA) Form

Please read EIA guidelines when completing this form

Section 1 - Name of Organisation (please tick)

Herefordshire & Worcestershire STP		Herefordshire Council		Herefordshire CCG	
Worcestershire Acute Hospitals NHS Trust	✓	Worcestershire County Council		Worcestershire CCGs	
Worcestershire Health and Care NHS Trust		Wye Valley NHS Trust		Other (please state)	

Name of Lead for Activity	

Details of individuals completing this assessment	Name	Job title	e-mail contact
	James France	Consultant EM	jamesfrance@nhs.net
Date assessment completed	05.09.2025		

Section 2

Activity being assessed (e.g. policy/procedure, document, service redesign, policy, strategy etc.)	Title: The Emergency Department Approach to the Management of the Agitated Adult Patient

What is the aim, purpose and/or intended outcomes of this Activity?	Consistency of approach to the agitated patient attending the emergency department			
Who will be affected by the development & implementation of this activity?	√ √ √ √	Service User Patient Carers Visitors	√	Staff
Is this:	Review of an existing activity			

What information and evidence have you reviewed to help inform this assessment? (Please name sources, eg demographic information for patients / services / staff groups affected, complaints etc.	See references regarding best practice in this area
Summary of engagement or consultation undertaken (e.g. who and how have you engaged with, or why do you believe this is not required)	Consolidates existing practice across a number of different areas
Summary of relevant findings	

Section 3

Please consider the potential impact of this activity (during development & implementation) on each of the equality groups outlined below. **Please tick one or more impact box below for each Equality Group and explain your rationale**. Please note it is possible for the potential impact to be both positive and negative within the same equality group and this should be recorded. Remember to consider the impact on e.g. staff, public, patients, carers etc. in these equality groups.

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Age			√	Specifically addresses issue of management of agitation in the elderly
Disability			√	Specifically addresses issue of management of agitation in patients with learning disabilities
Gender Reassignment		√		Consistency of approach

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Marriage & Civil Partnerships		√		Consistency of approach
Pregnancy & Maternity		√		Consistency of approach
Race including Traveling Communities		√		Consistency of approach
Religion & Belief		√		Consistency of approach
Sex		√		Consistency of approach
Sexual Orientation		√		Consistency of approach
Other Vulnerable and Disadvantaged Groups (e.g. carers; care leavers; homeless; Social/Economic deprivation, travelling communities etc.)		√		Consistency of approach
Health Inequalities (any preventable, unfair & unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental & economic conditions within societies)		√		Consistency of approach

Section 4

What actions will you take to mitigate any potential negative impacts?	Risk identified	Actions required to reduce / eliminate negative impact	Who will lead on the action?	Timeframe
	n/a	.		
How will you monitor these actions?				
When will you review this EIA? (e.g in a service redesign, this EIA should be revisited regularly throughout the design & implementation)				

Section 5 - Please read and agree to the following Equality Statement

1. Equality Statement

1.1. All public bodies have a statutory duty under the Equality Act 2010 to set out arrangements to assess and consult on how their policies and functions impact on the 9 protected characteristics: Age; Disability; Gender Reassignment; Marriage & Civil Partnership; Pregnancy & Maternity; Race; Religion & Belief; Sex; Sexual Orientation

1.2. Our Organisations will challenge discrimination, promote equality, respect human rights, and aims to design and implement services, policies and measures that meet the diverse needs of our service, and population, ensuring that none are placed at a disadvantage over others.

1.3. All staff are expected to deliver services and provide services and care in a manner which respects the individuality of service users, patients, carer's etc, and as such treat them and members of the workforce respectfully, paying due regard to the 9 protected characteristics.

Signature of person completing EIA	J France
Date signed	05.09.2025
Comments:	
Signature of person the Leader Person for this activity	
Date signed	
Comments:	


Worcestershire Acute Hospitals NHS Trust
Herefordshire Clinical Commissioning Group
Redditch and Bromsgrove Clinical Commissioning Group
South Worcestershire Clinical Commissioning Group
Wyre Forest Clinical Commissioning Group
Wye Valley NHS Trust
Worcestershire Health and Care NHS Trust
2gether NHS Foundation Trust
Taurus Healthcare
worcestershire county council
Herefordshire Council

9. Supporting Document 2 – Financial Impact Assessment

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

	Title of document:	Yes/No
1.	Does the implementation of this document require any additional Capital resources	no
2.	Does the implementation of this document require additional revenue	no
3.	Does the implementation of this document require additional manpower	no
4.	Does the implementation of this document release any manpower costs through a change in practice	no
5.	Are there additional staff training costs associated with implementing this document which cannot be delivered through current training programmes or allocated training times for staff	no
	Other comments:	n/a

If the response to any of the above is yes, please complete a business case and which is signed by your Finance Manager and Directorate Manager for consideration by the Accountable Director before progressing to the relevant committee for approval.