Improving Safety and Decision-Making for Postictal Agitation in an Urgent Care Setting: A Quality Improvement Case Report

Sajia Mahmoodi, Leila Metellus, Dr. Lilliam Alvarez, Dr. Javier Martinez, Dr. Pierre Jecrois

Sanitas Medical Center

St. George's University SCHOOL OF MEDICINE Grenada, West Indies

Introduction

Outpatient primary care clinics must be prepared for medical emergencies that may exceed their available resources. A structured emergency plan, accessible equipment, and trained staff are essential to ensure both staff safety and optimal patient outcomes.Post-ictal psychosis accounts for approximately 25% of epileptic psychosis. Affected patients may demonstrate aggressive behavior and have an increased risk of suicide. Episodes are sudden, and treatment primarily involves controlling seizure episodes; antipsychotics with low seizure-threshold-lowering potential may be used when needed.The underlying mechanism involves loss of inhibitory control of the limbic system following a seizure, resulting in uncontrolled cortical function. The severity of this condition necessitates timely, coordinated management to protect both the patient and the clinical team.

Case Presentation

A 33-year-old male with epilepsy, recently started on oxcarbazepine 600 mg, presented confused and disoriented and was brought to urgent care for evaluation.During transfer from wheelchair to stretcher, he became increasingly agitated, attempted to stand repeatedly, and demonstrated physical aggression, requiring multiple staff to maintain safety. EMS and family were contacted.With no benzodiazepines or antipsychotics on site, IV diphenhydramine was administered without effect. EMS subsequently stabilized and transferred the patient to the nearest emergency department.

Assessment of Systems Gap

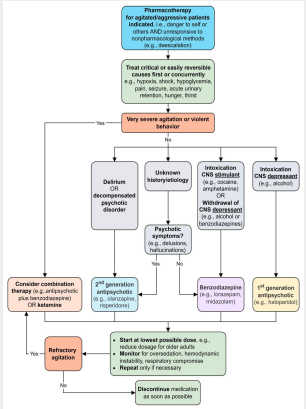
This encounter highlighted several opportunities to strengthen emergency preparedness within the clinic, particularly in urgent care scenarios.**1. Limited tools and protocols for safe management.** Multiple staff members were involved in physically assisting the patient, which increased the risk of injury and appeared to further agitate the patient. There were no clearly defined tools or workflows to safely manage patients who pose a risk to themselves or others.**2. Limited access to rapid-acting medications for acute agitation.** Only intravenous diphenhydramine was available, which did not provide a timely or sufficient calming effect. No benzodiazepines, antipsychotics, or ketamine were accessible on site.**3. Lack of clearly defined roles and emergency guidance.** Uncertainty among staff regarding next steps led to delays in coordinated action. The absence of an established behavioral emergency workflow contributed to a slower, less organized response.These gaps underscore the need for standardized emergency workflows, focused staff training, and an accessible behavioral emergency kit to enhance efficiency, safety, and patient outcomes in similar situations.

Quality Improvement Initiative

The most impactful intervention for improvement in events of this nature is the implementation of a **standardized behavioral emergency response protocol** that prioritizes early recognition, de-escalation, and environmental modification as first line interventions. **Initial measures should include clear communication, reduction of external stimuli, and limitation of personnel in the room**. When these strategies are insufficient and the patient poses an imminent risk to themselves or others, a **readily available emergency kit** should be utilized. This kit should include recommended sedating agents such as benzodiazepines, antipsychotics, and ketamine. Physical restraint devices, including soft wrist or ankle restraints, may be included in the kit but should be employed only as a last resort and in accordance with institutional, ethical, and legal standards.

It is equally important to **promote a structured, holistic, and intentional transfer of care during emergencies**. Effective handoff communication to emergency responders is critical to ensuring the well being of a patient in acute distress.Utilizing a structured communication framework such as SBAR (Situation, Background, Assessment, and Recommendation) can be beneficial during such situations. A well coordinated transfer of care improves patient safety outcomes and streamlines care so that everyone can be on the same page.

Using the **Plan–Do–Study–Act (PDSA) quality improvement framework**, regular simulations and drills should be conducted to ensure role clarity, reinforce communication strategies, and evaluate protocol effectiveness. Clear criteria for prompt activation of emergency medical services should be established, such as failure of on-site interventions, escalating violence, medical instability, or the need for advanced airway or critical care support. Finally, **thorough documentation** of the indication, duration, and patient response to interventions, as well as post-event debriefing and review, is essential to support staff well-being, ensure regulatory compliance, and promote ongoing learning and growth from these situations.



Discussion

In emergency settings, approximately 1.7 million episodes of agitation have been reported.There is a significant gap in current clinical protocols for managing patients who present with assaultive or agitated behavior. Physical restraints are no longer routinely used, and verbal de-escalation may be ineffective in cases of acute psychosis

Postictal psychosis is considered a psychiatric emergency due to the high risk of aggressive behavior, suicide, and other accidental injuries [8].

Given the severity of these conditions, outpatient settings require clear guidelines for managing psychiatric emergencies.

Due to the limitations present in the outpatient setting, the primary focus should be on ensuring safe and efficient transfer of the patient to a higher level of care to achieve the best possible outcome. Developing a standardized documentation template would help streamline notetaking and facilitate a faster, more organized transfer process. Additionally, placing a clearly visible emergency protocol poster in the office could serve as a quick reference guide for staff, reinforcing appropriate steps to take during acute emergencies.

Conclusion

Post-ictal psychosis is a rare but high- risk complication of epilepsy. This case underscores the consequences of limited access to rapid-acting medications, absence of standardized behavioral emergency protocols, and unclear team roles during acute agitation. Implementation of a structured response framework emphasizing early recognition, de-escalation, defined escalation criteria, and timely activation of emergency medical services is essential. Simulation-based training and continuous evaluation using quality improvement methodologies such as the PDSA cycle may enhance staff preparedness, improve safety, and support effective management of psychiatric emergencies in ambulatory care environments.

Works Cited

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