Emergency Department Agitated Patient Treatment Map

When agitated patient identified: classify according to degree of agitation and degree of concern for dangerous condition

**Mild Agitation:** Anxious/restless but normal speech, persistently redirectable and responsive to engagement

- Verbal de-escalation
- Non-pharmacologic interventions:
  - Food and water
  - Symptom control
  - Provide phone/distraction/entertainment (as available)
- Oral calming medication as needed
- Evaluate for relevant medical, psychiatric, social problems

**Moderate Agitation:** Persistently agitated with loud outbursts; intermittently but not consistently redirectable, disruptive but not an immediate danger to self or others

**Sedation safety prioritized over sedation speed**

Management according to most likely etiology of agitation

- **Psychosis in patient with known psychiatric disorder**
  1. Oral 2Gen Antipsychotic risperidone Mtab 2 mg olanzapine Zydis 5-10 mg
  2. Oral 1Gen Antipsychotic haloperidol 2-10 mg + BZN
  3. Parenteral 2Gen antipsychotic olanzapine 10 mg IM ziprasidone 10-20 mg IM
  4. Parenteral 1Gen antipsychotic haloperidol 2-10 mg IM/IV+BZN

- **Ethanol intoxication**
  - Haloperidol 1-10 mg IM
  - Add midazolam 2-5 mg IM if more severely agitated
  - Monitor for withdrawal

- **Ethanol / BZN Withdrawal**
  - Haloperidol 1-10 mg + BZN
  - May require rapid re-dosing and dose escalation, especially in alcohol or BZN withdrawal

**Delirium**

Focus on underlying cause

- Non-BZN favored
  1. Oral 2Gen Antipsychotic risperidone Mtab 2 mg olanzapine Zydis 5-10 mg
  2. Oral 1Gen Antipsychotic haloperidol ≤ 3 mg
  3. Parenteral 2Gen antipsychotic olanzapine 10 mg IM ziprasidone 10-20 mg IM
  4. Parenteral 1Gen antipsychotic haloperidol ≤ 3 mg IM or IV

- **Undifferentiated agitation / complex presentation**
  - If no psychosis evident, treat as agitation due to withdrawal
  - If psychosis evident, treat as known psychiatric disorder

Alongside management of agitation, consider precipitating or coincident dangerous medical conditions—expand diagnostic testing when history and physical aren’t concordant or when patient’s clinical course diverges from expected trajectory

- **Severe Agitation / Excited Delirium:** Immediate threat to self or others; combative, violent, uncontrollable, especially if concern for concomitant dangerous medical condition (e.g. trauma)

**Activate Code White**

Agitation is highest safety threat

Immediate control is highest priority

- Assemble adequate personnel to safely approach patient
- Face mask oxygen covering mouth and nose
- Relieve dangerous restraint holds: anything covering mouth/nose compression of neck compression of chest (or back)
  - hog tie / hobble position
- Calming medication given IM
  - Injections of large volumes and injections through clothing are acceptable
  - Combination of haloperidol (≥10 mg) and midazolam (≥10 mg), or Dissociative dose ketamine (5 mg/kg)

- Resuscitation-level monitoring
  - rectal temperature
  - room air pulse ox (or supp. O₂ + ETCO₂)
  - telemetry & blood pressure
- Loosen any tight restraints loose restraints ok if needed
- Head of bed up
- Capillary blood glucose
- Vascular access crystalloid bolus

**Signs of Excited Delirium**

Not just yelling: thrashing despite pain/futility

Incoherent with fluctuating sensorium

Concerningly abnormal vitals

Excited delirium is a diagnosis made in retrospect

Decide on management based on degree of controllability and likelihood of dangerous condition

Controllability is dependent on environment: the less adequate the personnel resources, the higher the required doses of calming meds

1. Droperidol preferred over haloperidol where available, may reduce dose by 25-50%

2. If ≥ 5 mL lateral thigh or buttock preferred

3. Any patient who receives dissociative dose ketamine requires immediate PSA-level monitoring with airway equipment prepared and airway-capable provider at bedside

4. The sicker/more agitated the patient, the more important to gain control using medications and not physical restraints; there is minimal role for tight physical restraints in ED

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