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

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

Ethanol intoxication
or other CNS depressant

Haloperidol[1] 2-10 mg IM

Add midazolam 2-5 mg IM if more severely agitated

Monitor for withdrawal

Ethanol / BZN Withdrawal
or
CNS stimulant intoxication

1. Oral benzodiazepine
lorazepam 1-2 mg
diazepam 5-10 mg
chlordiazepoxide 50-100 mg

2. Parenteral benzodiazepine
diazepam 10-20 mg IV
lorazepam 1-2 mg IV
midazolam 2-5 mg IM

May require rapid re-dosing and dose escalation, especially in alcohol or BZN withdrawal

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**[2] and injections **through clothing** are acceptable

Combination of haloperidol[1] (≥10 mg) and midazolam (≥10 mg), or
Dissociative dose ketamine (5 mg/kg)

Resuscitation-level monitoring[3]
rectal temperature
room air pulse ox (or supp. O_2 + $ETCO_2$)
telemetry & blood pressure

Loosen any tight restraints
loose restraints ok if needed[4]

Head of bed up

Capillary blood glucose

Vascular access
crystalloid bolus

Identify and treat dangerous causes and effects of severe agitation

hypoxia, hyperthermia
hypoglycemia, hypoperfusion
hyperkalemia, acidemia
ICH, CNS infection, seizure
withdrawal, thyrotoxicosis, rhabdomyolysis
trauma (may be occult)

Further resuscitation, treatment, and calming medications tailored to clinical trajectory and cause of agitation

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

reuben j. strayer · @emupdates · **emupdates.com/danger**