

Adult Treatment Protocols

EXCITED DELIRIUM

Date: October 1, 2014

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Excited Delirium

Purpose: In conjunction with Law Enforcement, provide timely and appropriate treatment to deal with the physically combative patient. As with any critically ill patient, treatment should proceed concurrently with evaluation for precipitating causes or additional pathology.

Indications: Defined as an imminent physical threat to personnel and/or themselves.

Pre-Medical Control

MFR/EMT/SPECIALIST/PARAMEDIC

1. Scene Survey – Responder safety is the top priority. If Law Enforcement not on-scene, call for assistance.
2. Closely monitor risk level to patient and EMS personnel. Initiate verbal coaching.
3. Coordinate patient restraint management with Law Enforcement, if possible. Refer to **Physical Patient Restraints Procedure**.

PARAMEDIC

4. If the patient remains combative, administer Midazolam 10 mg IM or 5 mg IN.
5. Transport. Request Law Enforcement to accompany to hospital. All patients should be transported on a cardiac monitor and pulse oximeter, and capnography, if possible.
6. Treat other medical problems (hypoglycemia, vomiting, etc.) as indicated.

Notes:

- As referenced in ACEP’s White Paper (2009) on Excited Delirium, the physically combative, agitated patient may require chemical restraint. Excited Delirium is characterized by extreme agitation, confusion and hallucinations, erratic behavior, profuse diaphoresis, elevated vital signs, hyperthermia, unexplained strength and endurance, and behaviors that include clothing shedding, shouting out, and extreme thrashing when restrained. It is often found in correlation with alcohol and illicit drug use, and in those patients with preexisting mental illness.
- The most immediate threat to patients experiencing this syndrome is sudden apnea and cardiac arrest, usually after thrashing against physical restraint. This is thought to commonly be the cause of “in-custody” sudden death.
- It is paramount that patient exhibiting symptoms of this syndrome be effectively and quickly physically restrained, and then calmed using Midazolam and verbal coaching.

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- The likelihood of sudden apnea and death increases the longer these patients are allowed to struggle against restraint. Managing these patients therefore requires a coordinated effort among all responders and Law Enforcement personnel.
 - Because excited delirium patients can quickly progress to apnea and death, responders must monitor their vital signs closely. When possible this must include use of pulse oximetry, ECG monitoring, and if possible, capnography. This latter monitoring tool provides the best, and most immediate, measure of respiratory rate and depth, and ventilatory sufficiency.
 - EMS personnel should be especially vigilant if a combative patient suddenly becomes quiet. This will often be the first sign that apnea has occurred. Patients who experience apnea and cardiac arrest may first complain of an inability to breathe.
 - Restraint techniques should be utilized that allow patient monitoring, and which can be removed rapidly should apnea and cardiac arrest ensue.
 - Excited delirium can mimic several medical conditions, including hypoxia,
 - hypoglycemia, stroke, or intracranial bleeding. Blood glucose should be measured, when possible. A thorough exam to rule out other causes should be completed, when possible.

Refer to Altered Medical Status Protocol.

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