

Newark, NJ

Sedation of Agitated Patient in the Emergency Department

For use in patients ≥15 years old and ≥40 kg Assess ABCs and vital signs

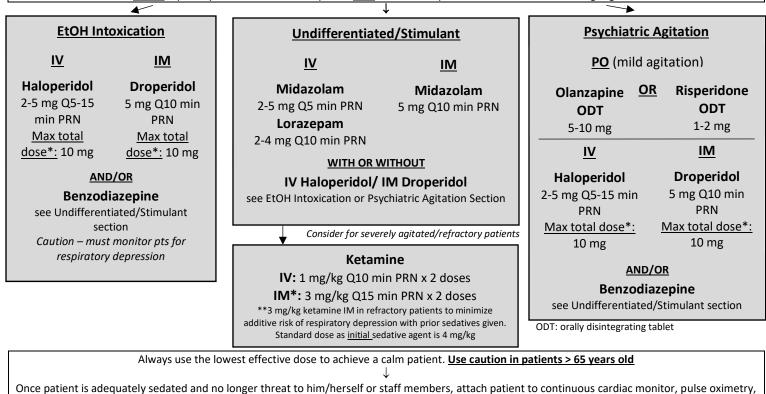
Perform rapid clinical assessment for treatable causes – trauma, glucose, temperature, oxygenation

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Ensure patient and staff safety at all times. Utilize clinical judgment.

Attempt verbal de-escalation, prioritize PO medications if appropriate \rightarrow apply physical restraints as needed (refer to restraints policy) IV therapy recommended for patients with IV access. For patients without IV access, utilize IM options

NOTE: Diphenhydramine or IM Lorazepam is NOT indicated as part of a standard sedation drug regimen



capnometry as indicated, discontinue restraints

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Consider the following as warranted: ECG, glucose, temperature, chemistry/labs, radiographic studies

Drug	Route	PK/PD		
		Onset (min)	Duration (min)	Comments
Haloperidol	IV	3-10	180-360	Concern for QT prolongation. Obtain ECG, when feasible, to assess QTc *Max cumulative dose without ECG: 10 mg IV Use caution in patients at risk for seizures or if head trauma suspected IM haloperidol not recommended due to delayed onset (>15 min)
Droperidol	IM	3-10	120-240	Concern for QT prolongation. Obtain ECG, when feasible, to assess QTc * Max cumulative dose without ECG: 10 mg IM IM droperidol has shown more rapid agitation control vs IM haloperidol Use caution in patients at risk for seizures or if head trauma suspected
Midazolam	IM	10-15	60-120	Monitor patients for respiratory depression
	IV	3-5	30-60	
Lorazepam	IV ONLY	2-5	60-120	IM lorazepam not recommended due to delayed onset (>15 min)
Ketamine	IM	3-5	60-90	Avoid in patients with a known history of psychosis
	IV	1	20-30	Appropriate monitoring required (minimum pulse oximetry)
Olanzapine	PO	Within 1 hr	-	Monitor ECG as necessary
Risperidone	PO	Within 1 hr	-	Monitor ECG as necessary

Guidelines are intended to be flexible. They serve as reference points or recommendations, not rigid criteria. Guidelines should be followed in most cases, but there is an understanding that, depending on the patient, setting, circumstances or factors, guidelines can and should be tailored to fit individual needs.



References

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- 2. DeBard ML, Adler J, Bozeman W, Chan T, et al: ACEP Excited Delirium Task Force. White Paper Report on Excited Delirium Syndrome. 2009.
- 3. American College of Emergency Physicians Clinical Policies Subcommittee (Writing Committee) on the Adult Psychiatric Patient, Nazarian DJ, Broder JS, et al. Clinical Policy: Critical Issues in the Diagnosis and Management of the Adult Psychiatric Patient in the Emergency Department. *Ann Emerg Med.* 2017;69(4):480-498.
- 4. Gottlieb M, Long B, Koyfman A. Approach to the Agitated Emergency Department Patient. *J Emerg Med.* 2018;54(4):447-457.
- 5. O'Brien ME, Fuh L, Raja AS, White BA, Yun BJ, Hayes BD. Reduced-dose intramuscular ketamine for severe agitation in an academic emergency department. *Clin Toxicol (Phila).* 2020;58(4):294-298.
- 6. Thomas H Jr, Schwartz E, Petrilli R. Droperidol versus haloperidol for chemical restraint of agitated and combative patients. Ann Emerg Med. 1992;21(4):407-13.