

Hyperactive Delirium

For Hyperactive Delirium only. NOT for psychiatric emergencies or other causes of agitation without delirium

History

- Situational crisis
- Psychiatric illness/medications
- Injury to self or threats to others
- Medical alert tag
- Substance abuse/overdose
- Diabetes
- PCP/cocaine/methamphetamine use

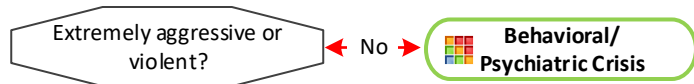
Signs and Symptoms

- Combative or violent
- Extremely aggressive or violent behavior
- Hyperthermia
- Increased physical strength
- Danger to self or others

Differential

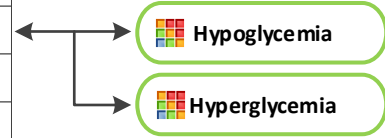
- Altered mental status
- Alcohol intoxication
- Toxin/substance abuse
- Medication effect/overdose
- Withdrawal symptoms
- Psychiatric (eg. Psychosis, Depression, Bipolar etc.)
- Hypoglycemia

Ensure scene safety. Law enforcement should be present.

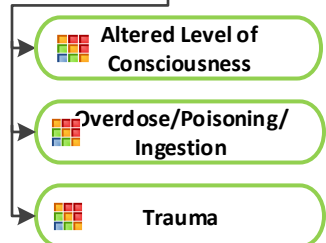


Yes

P	Midazolam IN/IM
	May repeat to maximum of 10mg
E	Consider restraints
	Monitor restraints and PMS <i>if indicated</i>
	Consider external cooling measures
	Monitor and reassess
P	Blood glucose analysis
	Cardiac monitor
	EtCO ₂ monitoring
	Establish IV/IO
	If systolic BP < 90 Normal Saline bolus 500ml IV/IO <i>Maximum 2L</i>
	For wide QRS > 0.12mm Sodium Bicarbonate



Exit to appropriate protocol, if indicated
Assume patient has medical cause of behavioral change



Notify receiving facility. Consider Base Hospital for medical direction

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Hyperactive Delirium Syndrome:

Formerly referred to as Agitated Delirium or Excited Delirium, this is a medical emergency. The condition is a combination of delirium, psychomotor agitation, anxiety, hallucinations, speech disturbances, disorientation, violent/bizarre behavior, insensitivity to pain, hyperthermia and increased strength. The condition is life-threatening and is often associated with use of physical control measures, including physical restraints, and tasers. Most commonly seen in male patients with a history of serious mental illness or drug abuse, particularly stimulant drugs such as cocaine, crack cocaine, methamphetamine, amphetamines, bath salts, or similar agents. Alcohol withdrawal or head injury may also contribute to the condition.

Pearls

- Crew/responder safety is the main priority.
- Any patient who is handcuffed by Law Enforcement and to remain handcuffed and transported by EMS must be accompanied by Law Enforcement in the ambulance.
- Caution using Midazolam for patients with alcohol intoxication.
- All patients who receive either physical or chemical restraint must be continuously observed by EMS personnel. This includes direct visualization of the patient as well as cardiac and EtCO₂ monitoring.
- Consider all possible medical/trauma causes for behavior (e.g., hypoglycemia, overdose, substance abuse, hypoxia, seizure, head injury, etc.).
- Do not overlook the possibility of associated domestic violence or child abuse.
- Do not position or transport any restrained patient in a way that negatively affects the patient's respiratory or circulatory status (e.g., hog-tied or prone positions). Do not place backboards, splints, or other devices on top of the patient.
- If restrained, the extremities that are restrained will have a circulation check at least every 15 minutes. The first of these checks should occur as soon after placement of the restraints as possible. This shall be documented in the PCR.

