

Pediatric Emergency Acute Agitation Pathway

Agitation Triage Screening Tool	
Presenting sign	<ul style="list-style-type: none"> Agitation not controlled with de-escalation strategies
De-escalation strategies	
<p>Environmental: Reduce stimulation (dim lights, favorite music/TV show)</p> <p>Behavioral: Child-life, verbal re-direction, distraction, age-appropriate direction, set reasonable limits, explain consequences</p> <p>Psychological: 1-on-1 verbal support, open ended questions, listen without rushing, remain calm, care for pain/hunger</p> <p><i>*See page 2 for more de-escalation strategies</i></p> <p style="color: red; text-align: center;">*Never threaten restraints*</p>	

Staff Safety is Vital

Assess room and patient belongings for safety
1:1 sitter for patients with SI/HI

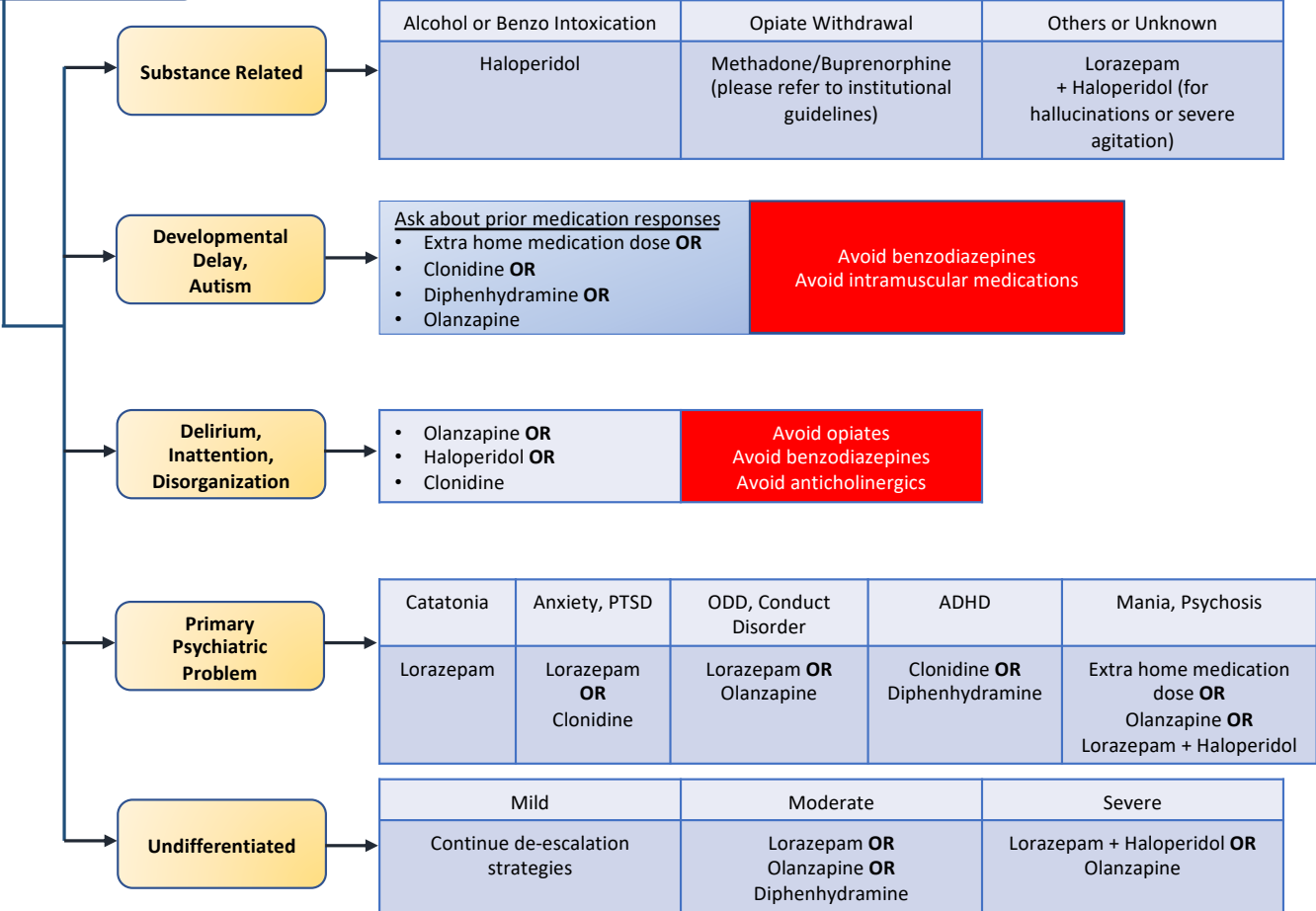
RESTRAINT USE

There is no negotiation for restraint use. When they are needed they should be used, but only when necessary for patient/staff safety.

- Minimum of 2 staff per child (usually more)
- Must have continuous monitoring
- Reassess within 15 minutes by MD and RN
- Place patient supine with head of bed elevated and allow neck range of motion
- NEVER use choke holds or cover the patient's face
- AVOID prone positioning
- AVOID use in intoxicated and obese patients
- AVOID use in medically compromised and unstable patients

NOTE: This pathway is NOT intended for patients with suspected overdose

MD/RN Swarm
Identify suspected cause



MEDICATION	DOSE	ONSET	PEAK	MAX DAILY DOSE	MONITOR
Olanzapine (Antipsychotic)	2.5 – 10 mg PO/ODT	PO 20 min	PO 5-6 hr	10-20 mg	Can cause respiratory depression
	1.25 – 5 mg IM	IM 15 min	IM 15-45 min		
Haloperidol (Antipsychotic)	0.025-0.075 mg/kg PO/IM (usual range 0.5 – 5 mg/dose)	PO 1 hr	PO 2-3 hr	15-40 kg: 6 mg	Causes hypotension and QT prolongation. Can also cause extra- pyramidal symptoms (treated with diphenhydramine)
		IM 15-30 min	IM 20-30 min	>40 kg: 15 mg	
Diphenhydramine (Anticholinergic)	1 mg/kg PO or IM (usual range 12.5 – 50 mg/dose)	PO 1 hr	PO 2-3 hr	Child: 50-100 mg	Causes delirium and disinhibition
		IM 15 min	IM 2 hr	Adolescent: 100- 200 mg	
Clonidine (Alpha-2-agonist)	0.025-0.1 mg/dose PO	PO 30-60 min	PO 2-4 hr	27-40.5 kg: 0.2 mg 40.5-45 kg: 0.3 mg >45 kg: 0.4 mg	Causes hypotension, bradycardia, and in those < 12 years disinhibition
Lorazepam (Benzodiazepine)	0.05 – 0.1 mg/kg PO/IM/IV (usual range 0.5 – 2 mg/dose)	PO 20-30 min	PO/IM: 1-2 hr	Child: 4 mg	Can cause delirium and disinhibition in younger and developmentally delayed children
		IM 15-30 min	IV: 10 min	Adolescent: 6-8 mg	

De-escalation strategies
Respect personal space: Keep at least a 2-arm length distance
Body Language: Keep a calm demeanor, facial expression and posture.
Ask patient/caregiver what helps: Ask about specific techniques, tools that have helped in the past.
Reward cooperation
Active listening
Build empathy

DO NOT give benzodiazepines and olanzapine within 1 hour of each other due to the increased risk of respiratory depression.

References:

1. Best Practices for Evaluation and Treatment of Agitated Children and Adolescents (BETA) in the Emergency Department: Consensus Statement of the American Association for Emergency Psychiatry; Gerson et. al.; West J Emerg Med. 2019;20(2)409–418.
2. Evaluation and Management of Children and Adolescents With Acute Mental Health or Behavioral Problems. Part I: Common Clinical Challenges of Patients With Mental Health and/or Behavioral Emergencies; Chun et. al.; Pediatrics 2016 Sep;138(3):e20161570. doi: 10.1542/peds.2016-1570.
3. Practice parameter for the prevention and management of aggressive behavior in child and adolescent psychiatric institutions, with special reference to seclusion and restraint; Masters et. al; J Am Acad Child Adolesc Psychiatry. 2002 Feb;41(2 Suppl):4S-25S. doi: 10.1097/00004583-200202001-00002.
4. Ann & Robert H. Lurie Children’s Hospital of Chicago Acute Agitation in the Emergency Department pathway.

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