# Pediatric Agitated Patient Response Algorithm for Crisis Encounters

GOALS: 1. Ensure patient and staff safety 2. Minimize use of restraints, both chemical and physical

Step-wise approach

## Behavioral Concern

**Staff/team discussion about the concern. Include YMCI clinician if possible.**

## MD talk to patient; Employ calming techniques.

Continued concern

### Consider calling:

- **Police/Security if concern for physical danger to patient/staff**
- **On call child psychiatrist accessible through YMCI**

## Offer PO medication*

Continued concern

**For panic attack, consider either:**

1. **Diphenhydramine (25-50 mg) OR Hydroxyzine (10-50 mg) PO**
2. **Lorazepam 0.5 – 1 mg PO**

**For physical aggression, consider either:**

1. **Clonidine 0.1-0.2 mg PO**
2. **Olanzapine (Zydis) 2.5-10 mg PO**

## Consider restraints and/or IM medication*

1. **Give a verbal heads-up warning: *"If we are not able to help you be safe on your own, we can help you be safe by putting you in restraints."***
2. **Call police/security**
3. **Place physical restraints**
4. **Ask, *"We are going to have to give you medication now. Do you want to take it by mouth?"***
5. **Give olanzapine (Zydis) PO if patient willing, otherwise give it IM**
6. **Wait 20 minutes before further medication. If needed, can repeat dose of olanzapine (half dose, especially if within 30 minutes of prior dose)**

Tips

All patients at risk for a behavioral concern need close monitoring with a 1:1 and early team planning for possible event. Review current/past medications. Consider PRN medication orders if meds have been prescribed in the past.

If elopement concern, call police/security and do not physically block patient.

Calming techniques:

- In a calm, slow voice ask *"What's going on?" "How can I help?" "Are you hungry? Do you need something to eat or drink?"*
- Allow physical space between you and the patient. Allow yourself access to an exit.
- Keep an open posture with arms uncrossed and hands either at your side or raised nonthreateningly with palms open and toward the patient.

*"Can I offer you a medication to help?" "Is there something that usually helps when you feel like this?"*

PO and IM medications take 15-20 minutes to have effect.

Benzodiazepines can be disinhibiting and deliriogenic. Caution with use.

If possible, avoid IM benzodiazepines due to respiratory depression risk.

AVOID Ketamine! Ketamine is psychoactive and can result in worsening confusion or psychotic like symptoms resulting in worsening agitation or paranoia

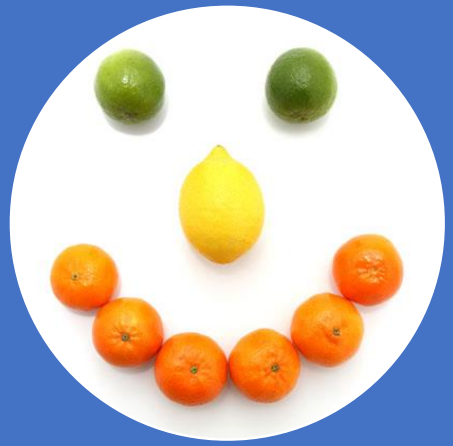
If you give IM haldol, you must also give IM diphenhydramine or IM benztropine to prevent dystonic reaction.

Key: MD = physician PRN = as needed PO = oral IM = intramuscular

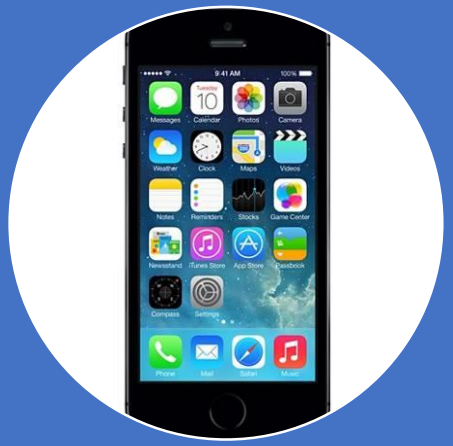
*See detailed algorithm including dosing on page 3

# Behavioral Interventions

- ❑ Interventions should be developmentally appropriate for age and ability
- ❑ Discuss potential strategies and calming techniques with guardians/staff as they know youth best
- ❑ Ensure youth can communicate – if non verbal do they have a communication device?
- ❑ HALTS (Hungry, Angry, Lonely, Tired, Sick) – screen for these common causes of irritability – use staff/guardian to help



1. Food can be useful distraction
2. Popsicles – cold can be calming
3. Check for allergies – guardian/staff can be helpful
4. Blankets, stress balls, ice, can be effective grounding tools and help youth with hx of trauma



1. After assessing safety – can youth keep mobile device?
2. Self harm and suicide – may want to avoid outside communication which could worsen symptoms
3. Neuroatypical youth may require a device to communicate needs
4. Games, cards, coloring books can be helpful

1. Calm & reassuring approach with low expressed emotion can be helpful.
2. Use clear concise language, i.e. “I need you to sit down” or “Please tell me how I can help”.
3. Avoid phrases like “Calm down!” or “Stop that!” or raising voice as these will likely make things worse, especially if past trauma.

Explore strategies with YMCI Clinician or Child Life for additional ideas

# Suggested Psychopharmacologic Management for Pediatric Anxiety/Agitation

Consider Phone Consultation with Child Psychiatrist on Call if:

- >2 restraints within 24 hours
- Pt has been in ED >48 hours with continued disruptive behaviors and search for placement still ongoing

*YMCI Clinicians have contact info for CAP on call

1) **Previously used/currently prescribed PRNs**

2) **Antihistamines** (weight based)
   - Diphenhydramine 12.5-50 mg PO/IM/IV q4-6h (max 300 mg/day) *watch for paradoxical effect in children
   - Hydroxyzine 10-50 mg PO/IM q6h (max 100 mg/day)

3) **Alpha-agonists** (weight/age based) *monitor vital signs
   - Clonidine 0.1-0.2 mg PO q4-6h (max 0.4 mg/day)

4) **Benzodiazepines** (weight/age based) *use with caution - deliriogenic/disinhibiting especially in neuroatypical youth
   - Lorazepam 0.25-1 mg PO/IM/IV q4-6h (max 4 mg/day) *if used in 2 restraints without response – consider alternatives. Repeated use may lead to further decompensation
   - If agitation due to substance use withdrawal (ETOH) consider higher doses

5) **Atypical Anti-psychotics**
   - Olanzapine (Zydis) 2.5-10 mg PO/IM (max 20 mg/day) *use caution if already given lorazepam IM as it can cause respiratory depression

6) **Typical Anti-psychotics**
   - Haloperidol 0.5-3 mg PO/IM q4-8h (max 0.15 mg/kg/day) *must be given in conjunction with anticholinergic medication to prevent dystonic reaction (more prevalent in kids than adults!) diphenhydramine 25-50 mg PO/IM q4-6 h or benztropine 0.5-1mg q12 h. PO/IM N.B. haloperidol has longer half life and diphendhydramine will need repeated dosing depending on initial dose of haloperidol to prevent late onset dystonia

**AVOID**
- Ketamine – psychedelic effects can result in paranoia and worsening of agitation
- Droperidol – prolonged QTC