CLINICAL PATHWAY:
Agitation

THIS PATHWAY SERVES AS A GUIDE AND DOES NOT REPLACE CLINICAL JUDGMENT.

Inclusion Criteria: Patients ≥ 5 years old experiencing agitation, including those admitted for mental health concerns and those with Autism Spectrum Disorder
Exclusion Criteria: Patients < 5 years old and/or < 25 kg, patient already has an agitation plan per Psychiatry team

Note: *in patients presenting with agitation and concern for delirium, please also refer to* ***Delirium Pathway***

[1]Definitions: Levels of Agitation:

- **Agitated** (distressed): a low level change in baseline behavior that doesn't engage others, such as voicing distress or fear, hand ringing, rocking, pacing, fidgeting
- **Disruptive** (drawing attention): raised voice, gesturing, clenched fists, threatening posture, pacing
- **Destructive** (losing control): disruptive AND breaking or throwing things
- **Dangerous** (lost control): harmful to self or others, head banging, attempting to cut or strangle self/others, property destruction
- **Threat of Lethality** (stop me)

Initial Management:

- Notify primary team
- Consider initiation of Behavioral Response Team (if patient located on Med-Surg or PICU)
- Consider underlying etiology[2]
- Recognize agitation before patients escalates to the 3Ds (disruptive, destructive, dangerous)
- Ask patient/caregiver what interventions and/or medications have helped in the past
- Consult Psychiatry for assistance in determining etiology, providing verbal de-escalation, behavioral planning, and medication management

Appendix A:
Agitation Prevention Strategies

[2]Possible Underlying Etiology

- **Basic Needs:** hunger, pain, constipation, urinary retention, access to support person, is patient feeling safe
- **Medical Causes:** head trauma, substance use, neuroleptic malignant syndrome, serotonin syndrome, hyper/hypoglycemia

Agitated[1]

- Verbal De-Escalation **(Appendix B)**
- Behavioral Techniques **(Appendix B)**
- Consider giving scheduled medication early

Disruptive[1]

- Verbal De-Escalation **(Appendix B)**
- Behavioral Techniques **(Appendix B)**

Medications:
(may refer to ***Appendix C****: Medication Dosing and Safety Tips)*

First Line:

- **Diphenhydramine PO/IV***
  - Child 25-50 kg: 25 mg up to q4h PRN (max 150 mg/day)
  - Adolescent >50 kg: 50 mg up to q4h PRN (max 200 mg/day)
  - If patient with autism or developmental delay, consider starting with lorazepam (see **Appendix D:** Medication Considerations for Comorbid Conditions)

Second Line:

- **Lorazepam PO/IM/IV ****
  - Child 25-50 kg: 0.5-1 mg up to q6h PRN (max 4 mg/day)
  - Adolescent >50 kg: 1-2 mg up to q6h PRN (max 8 mg/day)
  - If ineffective, may repeat dose 60 min after initial dose

Suspicion or Known Substance Use:

- Start with lorazepam to reduce the risk of worsening an underlying toxidrome

Offer PO medications first if appropriate, then IV/IM if refusing PO

Destructive, Dangerous or Threat of Lethality[1]

- Verbal De-Escalation **(Appendix B)**
- Behavioral Techniques **(Appendix B)**

Medications:
(may refer to ***Appendix C****: Medication Dosing and Safety Tips)*

First Line:

- **Olanzapine (Zyprexa) PO/ODT/IM**
  - Child 25-50 kg: 2.5 mg once
  - Adolescent >50 kg: 5 mg once
  - Do NOT use within 1 hour of Lorazepam administration due to risk of cardiorespiratory depression
  - If ineffective, repeat x 1 after 45 minutes

Second Line:
Call Psychiatry to discuss before moving onto 2nd line therapy

- **Haloperidol IM*****
  - Child 25-50 kg: 2 mg once (max 6 mg/day)
  - Adolescent >50 kg: 5 mg once (max 15 mg/day)
  - May repeat in 4-6 hours
  - AND
- **Diphenhydramine IM***
  - Child 25-50 kg: 25 mg once (max 150 mg/day)
  - Adolescent >50 kg: 50 mg once (max 200 mg/day)
- If patient is >70 kg, consider addition of **Lorazepam**** 2 mg IV once

- For patients with comorbid conditions (Autism, Anxiety or Trauma, Mania or Psychosis, ODD or Conduct Disorder, ADHD), see **Appendix D: Medication Considerations for Comorbid Conditions**
- If patient is demonstrating signs/ symptoms of delirium, see **Delirium Pathway**

Consult Psychiatry to determine an agitation plan that is tailored to the patient's specific needs moving forward

TAKE A PAUSE to check your ***IMPLICIT BIAS***

- Implicit biases are unconscious attitudes that affect our actions and decisions
- Learn more in the pathway **educational module** and consider this checklist prior to use of chemical and/or physical restraints (**Appendix G**: Checklist for Implicit Bias in Restraint Use)

Threat of Lethal and/or when above interventions have failed AND patient is at imminent risk to self /others:
proceed to physical restraint per Connecticut Children's Restraints and Seclusion Policy.

** Diphenhydramine may cause paradoxical reaction in young children and those with neurodevelopmental differences.*
*** Higher/ frequent doses of benzodiazepines can lead to idiosyncratic reactions, disinhibition +/- delirium.*
**** Neurolpetics such as haloperidol carry risk of acute dystonic reaction (ie, acute/sustained muscle contraction).Use simultaneously with diphenhydramine.*

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Appendix A: Agitation Prevention Strategies

The Agitation Continuum: *It is easier to engage when someone is calm than when someone is escalated. Proactively identifying triggers and helpful interventions can provide a helpful framework.*

Ask Before it's a Problem:

- For ALL patients at risk for agitation, when obtaining a history, ask:
  - What is your preferred method of communication?
  - What do you enjoy doing?
  - What helps you feel calm?
  - What happens when you feel upset or anxious?
  - What helps you when you feel upset or anxious?
  - What happens when you feel angry?
  - What helps you when you feel angry?
- Consider filling "Getting to Know Me" document (**Appendix E**) and developing a daily schedule in collaboration with Child Life (**Appendix F**)
- Document a plan for agitation

Be Proactive with Communication:

- Engage caregivers early and often
  - What triggers anxiety/agitation/escalation?
  - What signs/symptoms indicate escalation?
  - What prn interventions/prn meds have worked in the past?
- Set clear expectations for the admission
- Discuss exams, procedures, and interventions before they occur
- Offer choice and control when possible
- Strategize with nursing staff and Child Life staff
- Collaborate with Consultation & Liaison (C&L) Psychology/Psychiatry
- Become familiar with **Appendix B: Verbal and Behavioral Deescalation Strategies**

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GOAL: *Recognize the signs of early agitation before it becomes disruptive and utilize verbal and behavioral de-escalation in an effort to avoid need for chemical and/or physical restraint.*

BEHAVIOR DE-ESCALATION STRATEGIES:	VERBAL DE-ESCALATION STRATEGIES:

Maintain Personal Space
• Maintain respectful distance from escalating patient
• Position yourself at least 2 arms lengths from patient
• Get yourself to safety, back to exit (not to wall), and call for help
 	
Body Language
• Maintain a calm demeanor and posture, and neutral stance
• Stand at an angle and keep hands visible
 	
Minimize Stimulation
• Dim lights, reduce noise, minimize clutter
• Minimize staff in room (1-2 at a time ideal)
 	
Address Needs
• Consider hunger, thirst, and pain
• Are there communication difficulties/limitations that can be easily addressed to assist with expression of needs?
 	
Simple Instructions
• Use soft tone, maintain good eye contact
• Give patient 1 step at a time
  ○ "First this, then this" when giving instructions
• Give patient adequate time to process and respond
• Repeat instructions
 	
Reward Cooperation and Praise
• Calmly thank the patient for cooperating or taking med
• Give verbal praise (for example, "Great job showing me safe hands!")
 	
Consider Sensory Soothing Tools
• Child Life or OT can assist
• Distractions
	Establish Verbal Contact
	• Introduce yourself by name and role
	• Ask patient's name/preferred name
	• <u>One person should take the lead in speaking with patient</u>
	
	Active Listening
	• Understand; what is the patient's perception?
	• Use phrases such as, "Tell me if I have this right…", "What I heard is…"
	• Consider the use of silence and just listening
	
	Building Empathy
	• Validate what the patient is experiencing
	  ○ "I know this can feel overwhelming to be in the hospital"
	  ○ "What you are going through is difficult"
	
	Partner with Patient/Caregivers
	• Ask patient/caregiver what helps
	  ○ "I am worried about your safety. What helps you in times like this?"
	  ○ "What has worked in the past?"
	
	Set Clear Expectations and Consequences
	• Use a quiet voice
	• Be clear and consistent
	  ○ "If you are having a hard time staying safe, we will…"
	
	Offer Forced Choices
	• Offer two options: "Would you like X or Y?"
	
	Redirection/Distractions
	• "What else could we do? "What (Activity) would help?"
	• "Let's try (activity) together"

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Medication†	Dose	Max Daily Dose	Onset of Action	Relative Contraindications	Comments	Side Effects
Diphenhydramine [Benadryl] (antihistaminic)	Child 25-50 kg: 25 mg PO/IM	100 mg	~1-2 hours May repeat one dose in 4 hours.	Prior paradoxical response, developmental delay or current anticholinergic/TCA medication	May cause paradoxical reaction in children with neurodevelopmental differences (e.g. autism) and may worsen delirium	Sedation
	Adolescent >50 kg: 50 mg PO/IM	200 mg				
Lorazepam [Ativan] (benzodiazepine)	Child 25-50 kg: 0.5-1 mg PO/IM/IV	4 mg	IV: ~15-20 min PO: ~30 min May repeat one dose in 60min.	Disinhibition, respiratory instability	Higher/frequent doses of benzodiazepines can lead to idiosyncratic reactions including disinhibition +/- delirium	Respiratory depression, disinhibition
	Adolescent >50 kg: 1-2 mg PO/IM/IV	8 mg				
Clonidine [Catapres] (alpha 2 agonist)	0.05 mg-0.1 mg PO	3 doses	30-60 min May repeat one dose in 6 hours.	Hypotension, bradycardia	Consider in patients that may be undergoing opioid withdrawal Avoid giving with benzodiazepines or atypical antipsychotics due to risk of hypotension	Hypotension, bradycardia
Olanzapine [Zyprexa] (antipsychotic)	Child 25-50 kg: 2.5 mg PO/ODT or IM	10 mg*	~15 min May repeat one dose in 60 min.	**QTc >500 use with caution,** anticholinergic intoxication, active seizure disorder	Do NOT use within 1 hour of IV benzodiazepine (e.g. lorazepam) administration due to risk of cardiorespiratory depression.	**QTc prolongation,** extrapyramidal symptoms including acute dystonic reaction
	Adolescent >50 kg: 5 mg PO/ODT or IM	20 mg*				
Risperidone [Risperdal] (antipsychotic)	Child 25-50 kg: 0.25 mg-0.5 mg PO	1-2 mg*	60 min May repeat one dose in 6 hours.	**QTc >500 use with caution**		
	Adolescent >50 kg: 0.5-1 mg PO	2-3 mg*				
Quetiapine [Seroquel] (antipsychotic)	0.5 mg/kg/dose PO	1.5 mg/kg/day or 150 mg* (max 25-50 mg/dose)	30-60 min May repeat one dose in 6 hours.	**QTc >500 use with caution**		
Haloperidol [Haldol] (antipsychotic)	Child 25-50 kg: 1-2 mg IM	3 -6 mg* or 3 doses	15 min May repeat one dose in 6 hours	**QTc >500 use with caution** anticholinergic intoxication, active seizure disorder, withdrawal syndrome	Do NOT use IV. Administer concurrently with diphenhydramine If patient >70 kg, with severe agitation consider addition of lorazepam 2 mg IV	
	Adolescent >50 kg: 2.5-5 mg IM	7.5-15 mg* or 3 doses				

** Consider previous medications (including home medications) that have yielded positive or negative response. If on a prescribed anti-psychotic, consider administering early or giving an extra dose. Review current or recent medications for drug interactions. If inadequate response from multiple doses, consider an additional medication class. Max dose depends on antipsychotic exposure history as patient may tolerate higher doses.*

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CLINICAL PATHWAY:
Agitation
Appendix D: Medication Considerations for Comorbid Mental Health Conditions

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AUTISM/ DEVELOPMENTAL DISABILITIES	ANXIETY/TRAUMA	MANIA/PSYCHOSIS	ODD/CONDUCT DISORDER	ADHD	SUBSTANCE USE
• **Assess for underlying cause of agitation** (Am I hungry? In pain? Physical or emotional trigger?) **Medications** • **Diphenhydramine** may cause disinhibition. • **Lorazepam** could possibly disinhibit also, but is a safe 1st line medication • Avoid IM if possible for additional sensory assault • Trial an extra dose of home medication, such as **Risperidone** *OR* • ODT **Olanzapine** (Zyprexa) is a good 1st or 2nd line medication. Remember that Olanzapine needs to be separated from Ativan by minimum of 1 hour. **Other Options:** • PO **Clonidine**	**Medications** • PO hydroxyzine (Vistaril, Atarax) • PO **Lorazepam** is also helpful anxiolytic	**Medications** • Consider extra dose of home medication • *First Line* ○ ODT **Olanzapine** (Zyprexa) *OR* ○ PO **Lorazepam** • *Second Line* ○ IM **Haloperidol** combined with IM **Diphenhydramine**	**Medications** • *First Line* ○ PO **Lorazepam** *OR* ○ ODT **Olanzapine** (Zyprexa) • *Second Line* ○ IM **Lorazepam** *OR* ○ IM **Olanzapine** (Zyprexa)	**Medications** • *First Line* ○ PO **Clonidine** *OR* ○ PO **Lorazepam** • *Second Line* ○ IM **Lorazepam** *OR* ○ IM **Diphenhydramine**	**Medications** • *ETOH or Benzodiazepine Intoxication:* ○ **Haloperidol** with IM **Diphenhydramine** • *PCP or Stimulant intoxication*: ○ **Lorazepam** +/- **Haloperidol** with **Diphenhydramine** • *Synthetic Cannabinoids or Cathinones (bath salts):* ○ **Lorazepam** +/- **Haloperidol** with **Diphenhydramine**

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Patient Label

Observer Handoff Tool

Preferred Name:

Room:

Observation Status:

Diagnosis and Background History (verbal report)

Known Triggers:

Behaviors to Watch For:

Social Information/Concerns:

Approved Activities/Privileges:

Additional Information:

Getting to know me…

Favorite Movie:

TV Show:

Music:

Hobbies:

Pets?

If you were a superhero….

Dream job…

Favorite season…

Any jokes?

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Date	Initials	Time & Update Made

Initials	Name & Title	Initials	Name & Title	Initials	Name & Title

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My Daily Schedule

TODAY IS _____

- ☐ Lights ON and awake by 8 AM
- ☐ Get out of bed to chair for breakfast
- ☐ Daily Hygiene Tasks **(brush teeth, take a shower/wash up, comb hair, get dressed, make the bed, etc.)**
- ☐ Laps around unit **(goal: #_____ laps)**
- ☐ Participate in an activity **(art, reading, schoolwork, play a game etc.)**
- ☐ Get out of bed to chair for lunch
- ☐ Laps around unit **(goal: #_____ laps)**
- ☐ Participate in an activity **(art, reading, play a game--check with child life for available options)**
- ☐ Get out of bed to chair for dinner
- ☐ Laps around unit **(goal: #_____ laps)**
- ☐ Lights OFF, TV OFF, electronics & activities put away, and in bed, by ____ PM

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Checklist for Implicit Bias in Restraint Use:

Check your implicit biases prior to ordering chemical and/or physical restraint

1. Have I tried to listen to the patient's desires, employ verbal de-escalation, and other alternatives to chemical/physical restraints (such as offering food/drink)?
2. Is a different staff member, outside of myself or the patient's primary care team, better at de-escalating this patient based on demographic similarities (or differences, such as agitated male patient who responds better to female staff)?
3. Is my fear of this patient exaggerated by their appearance?
4. Are there cultural differences in the patient's expression of frustration and control?
5. Am I using racial, gender, socioeconomic, or other potentially harmful bias in determining my agitation care plan for this patient?

Jin RO, Anaebere TC, Haar RJ. Exploring bias in restraint use: Four strategies to mitigate bias in care of the agitated patient in the emergency department. *Acad Emerg Med.* 2021 Sep;28(9):1061-1066.

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