



# Approach to the Aggressive Pediatric Patient

CONE HEALTH PEDIATRICS  
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## General Principles

Create an environment that will minimize risk of injury and agitation: minimize unnecessary noise, place patient in room near nursing desk, remove potentially dangerous objects from room. STAR sitter should be requested and should be present in the room

Daily consultation with psychiatry should occur

Physical restraints and /or Chemical restraints: **once an order is written**, then the AC and Security may assist staff to get patient into the room/bed so nurse can implement restraints/administer medication.

Involuntary administration of medications (i.e. chemical restraint) is indicated only if required to prevent harm to self or others, to prevent serious disruption of treatment, and only if all self-control or de-escalation techniques have failed. Use of chemical restraint is contraindicated if it is used as a discipline or measure of convenience, when staff are not adequately trained, or when the risks of treatment outweigh the benefits

If an **Involuntary Commitment (IVC)** is necessary social work or the AC can assist with the IVC paperwork. An IVC is typically required in order for security to physically intervene with a patient.

## **Phase 1 (De-escalation)**

Staff should attempt to verbally de-escalate the situation with the patient. The focus should be on **timely** de-escalation and the **safety** of patient and unit. Try to identify situations that trigger the patient to act out.

### **Calming the agitated patient**

1. Do not close the door when you go to see him/her. Make sure security is close by. Stay between the patient and the door. Don't allow patient to block you in.
2. Speak in a calm, soothing and gentle manner
3. Do not sit down unless he/she is sitting down
4. Ask the patient how you can help them calm down and offer food or water if indicated
5. If family member is present and is helping to calm the patient, keep him/her present; otherwise remove the family member from the room.
6. Typically have one point person communicate with the patient is better than many different people attempting to calm the patient

*(University of Manitoba, Safety Policy for Pediatric Psychotic Patients)*

### **Examples of aggressive behavior:**

Mild: Examples include: Shouts angrily, slams doors, mild personal insults and threats, curses viciously, picks and scratches self, or pulls own hair.

Moderate: Examples include: Throws objects down, kicks walls, hits fists into objects, makes threatening gestures, strikes out at people, and makes clear threats of violence towards self or others.

Severe: Examples include: Breaks objects, throws objects dangerously, mutilates self, attacking others

If the situation cannot be **quickly** de-escalated, the clinician should consider medication to assist in calming the patient.

## **RESTRAINTS for VIOLENT or SELF-DESTRUCTIVE BEHAVIOR – use as a last resort**

The patient has severe aggressive/ destructive behavior that poses a danger to self/others

1. **See & evaluate patient within ONE hour:** A telephone call is not permitted.  
Document in patient's record: description of patient's behavior & interventions, physical/mental status assessments, and any environmental factors that may have contributed to the situation.
2. **Enter *initial order***
3. **Enter new order** at the following times:
  - q 4 hours for adults
  - q 2 h for 9-17 yrs.
  - q 1 h for 8 yrs. & under
4. **See the pt. face to face** at the following times (these are minimums, typically the physician should be at or near the bedside until the situation is under control):
  - q 8 h for adults
  - q 4 h for 17 yrs. & under

## **Phase 2: Pharmacological therapy**

If de-escalation is not successful and the patient is a danger to themselves, others, and/or property, contact the PICU Attending for consideration of transfer to the PICU for appropriate management, which may include physical or chemical restraints.

### **Medication general information:**

Use IM route ONLY if oral medications are refused or trial of oral medications fails

Strongly consider CR monitoring with use of medications

***Antihistamines (Diphenhydramine and hydroxyzine):*** side effects include paradoxical reactions and anticholinergic effects. Helpful for anxiety and can be co-administered with typical or atypical antipsychotics to prevent extra-pyramidal side effects

***Benzodiazepines (Lorazepam):*** side effects include respiratory depression, especially when used with other medications. Helpful for anxiety and can be reversed with flumazenil. Will not treat psychosis/hallucinations.

***Typical antipsychotics (Haloperidol IV/IM or po):*** side effects include extrapyramidal side effects (*e.g.* dystonia (abnormal repetitive movements or posturing) & akathisia (restlessness, pacing & inability to stay still)), neuroleptic malignant syndrome (life threatening and can cause fever, muscle rigidity, altered mental status, elevated CPK and autonomic dysfunction), and QT prolongation/torsade (when given IV).

***Atypical antipsychotics (olanzapine/ziprexa IM and ODT, risperidone/risperdal ODT only, and ziprasidone/geodon IM only):*** side effects include extrapyramidal side effects and neuroleptic malignant syndrome (though not as severe as with typical antipsychotics) and QT prolongation/torsade, especially with ziprasidone. (typically only use ziprasidone if you have a normal baseline EKG).

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**GOOD COMBINATIONS**

-antihistamine + haloperidol

-lorazepam + haloperidol

### BAD COMBINATIONS

-lorazepam + olanzapine (risk of respiratory depression)

-lorazepam + clonidine -or- atypical antipsychotic + clonidine (hypotension)

**Note: IM Zyprexa and IM Geodon may only be used in consultation with psychiatry for refractory cases**

### AGE 6-12 years

*RisperiDONE* (RISPERDAL M-TABS) oral disintegrating tablet (note: no IV or IM formulations)

- 20-45 kg: 0.25 mg, Oral, Q12 hours PRN, agitation. Call MD if more than 2 doses are needed
- >45 kg: 0.5 mg, Oral, Q 12 hours PRN, agitation. Call MD if more than 2 doses are needed

And/or

*LORazepam* (ATIVAN) - **Avoid in patients suspected of intoxication with CNS depressants**

- LORazepam (ATIVAN) tab: 0.05 mg/kg/dose (max: 2 mg/dose), Oral, Once As needed, 1 dose
- Or
- LORazepam (ATIVAN) inj: 0.05 mg/kg/dose (max: 2 mg/dose), IV/IM, Once As needed, 1 dose

### AGE 12+ years

*OLANZapine* zydis (ZYPREXA) oral disintegrating tablet 5 mg. **Risk of cardiorespiratory depression when given in combination with benzodiazepines.**

5 mg, Oral,

Every 8 hours PRN, agitation. Call MD if more than 2 doses are needed

And/or

*LORazepam* (ATIVAN) - **Avoid in patients suspected of intoxication with CNS depressants. Do not give within 30 minutes of olanzapine dose as there is a risk of respiratory depression. CR monitor required if olanzapine and lorazepam both given.**

- LORazepam (ATIVAN) tab
- 0.05 mg/kg/dose (max: 4 mg/dose), Oral, Once prn, For 1 dose
- Or
- LORazepam (ATIVAN) injection
- 0.05 mg/kg/dose (max: 4 mg/dose), IV/IM, Once prn, For 1 dose

**For refractory agitated patients whom initial therapies have failed:**

**(Note: DO NOT have 2 active *ORAL* antipsychotic PRN orders on the MAR)**

*Haloperidol (HALDOL)*

Haloperidol (HALDOL) tab

0.015 mg/kg/dose (max: 5 mg/dose), Oral, divided every 12 hours PRN, agitation

(Max: do not exceed a combination of 3 PO and IM doses in 24 hours, check BP and pulse 30-60 minutes after administration)

Or

Haloperidol (HALDOL) injection. **CR monitoring required.**

0.015 mg/kg/dose (max: 5 mg/dose), IV/IM, Every 6 hours PRN, agitation

(Max: do not exceed a combination of 3 PO and IM doses in 24 hours, check BP and pulse 30-60 minutes after administration)

*If extra-pyramidal symptoms (e.g. dystonia (abnormal repetitive movements or posturing) & akathisia (restlessness & inability to stay still)):*

Diphenhydramine (BENADRYL) – **Avoid in patients with organic brain dysfunction or mental retardation**

Diphenhydramine (BENADRYL) injection

- 6-12 yo: 25 mg, IV/IM, Once As needed, extrapyramidal side effects like dystonia, For 1 dose
- >12 yo: 50 mg, IV/IM, Once As needed, extrapyramidal side effects like dystonia, For 1 dose

This clinical pathway is based upon medical evidence and a consensus of pediatric practitioners at Cone Health Pediatrics. These clinical pathways are intended to be a guide for practitioners with a special emphasis on those working at community hospital sites. Management needs to be adapted for each specific patient based on the practitioner's professional judgment, unique patient circumstances, the needs of each patient and their family, and the availability of resources at the health care institution where the patient is located.

Accordingly, these clinical pathways are not intended to constitute medical advice or treatment, or to create a doctor-patient relationship between/among Cone Health physicians and the individual patients. These clinical pathways may not be in every respect accurate or complete, and may not apply to a particular patient or medical condition.

## **Evidence Base**

Loretta Sonnier and Drew Barzman. Pharmacologic Management of Acutely Agitated Pediatric Patients. *Pediatr Drugs* 2011; 13 (1): 1-10

Acute Agitation Order Set. Rady Children's Hospital. Accessed June 2016.