### Pediatric Acute Agitation Clinical Guideline

**INITIATE DE-ESCALATION TECHNIQUES:**

- Assess pain, hunger, and physical needs
- Attempt verbal de-escalation *
- Attempt behavioral interventions **

---

**VERBAL DE-ESCALATION**
- Respect personal space
- Do not be provocative. Stay calm.
- Establish verbal contact (1 communicator)
- Be concise and give simple instructions
- Identify wants and feelings
- Listen closely to what the patient is saying
- Agree or agree to disagree
- Set expectations and consequences
- Offer choices and optimism.
- Reward cooperation

---

**BEHAVIORAL INTERVENTIONS**
- Give praise for adherence to requests
- Place limits on unacceptable behaviors
- Give validation and empathy
- Allow patient to clarify triggers for agitation and promote problem solving

---

**RED FLAGS—EARLY DIAGNOSIS NEEDED**
- Neuroleptic malignant syndrome and serotonin syndrome
- Head trauma
- Hyperglycemia/hypoglycemia
- Substance overdose or withdrawal

---

**DE-ESCALATION ineffective?**

Consider medications as below. If all other efforts fail to maintain patients safety, physical restraints may be utilized.

---

### DIAGNOSIS

<table>
<thead>
<tr>
<th>DELIRIUM</th>
<th>SUBSTANCE INTOXICATION OR WITHDRAWAL</th>
<th>DEVELOPMENTAL DELAY OR AUTISM</th>
<th>PSYCHIATRIC DIAGNOSIS</th>
<th>UNKNOWN ETIOLOGY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Notes: Diagnosis: acute onset with fluctuating course. Has disorganized thinking or altered LOC.</td>
<td>• Care is mostly supportive or as directed by toxidrome</td>
<td>• Attempt behavioral interventions</td>
<td>• Review charts and with caregiver to clarify diagnosis and triggers for agitation</td>
<td>• Obtain extensive H&amp;P</td>
</tr>
<tr>
<td>Evaluate for medical diagnosis.</td>
<td></td>
<td>• Assess pain, hunger, other physical needs</td>
<td>• Consider non-psychiatric etiology</td>
<td>• Rule out organic etiology</td>
</tr>
<tr>
<td>Address underlying medical issues.</td>
<td></td>
<td>• Utilize sensory tools</td>
<td></td>
<td>• Work up as appropriate</td>
</tr>
<tr>
<td>Assess pain.</td>
<td></td>
<td>• Ask what usually soothes child and employ that technique</td>
<td></td>
<td>• Consider neurology or psychiatric evaluation</td>
</tr>
<tr>
<td>Notes: PO: Risperidone OR olanzapine OR clonidine IM: Olanzapine</td>
<td></td>
<td>• Ask about prior medication response (positive or negative) especially to benzos and diphenhydramine</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### MEDICATIONS

**ETOH/BZD intoxication:**
- Lorazepam (PO/IM/IV) ± haloperidol if severely agitated or hallucinating
- Diphenhydramine (PO/IM/IV)
- Olanzapine (PO/IM)

**ETOH/BZD withdrawal:**
- Lorazepam (PO/IM/IV) ± haloperidol if severely agitated or hallucinating
- Olanzapine (PO/IM)

**PCP:**
- Lorazepam (PO/IM/IV)
- Diphenhydramine (PO/IM/IV)

**Opiate withdrawal:**
- Clonidine and/or opiate replacement (methadone, suboxone)
- Lorazepam (PO/IM/IV) ± haloperidol if severely agitated or hallucinating

**CONSIDER EXTRA DOSE OF PATIENT'S REGULAR MEDICATION**

**AVOID BENZOS DUE TO RISK OF DISINHIBITION**

**AVOID IM ROUTE**

**OTHER MEDS:**
- Clonidine (PO)
- Risperidone (ODT)
- Olanzapine (ODT/PO/IM)

**Agitated catatonia:**
- Lorazepam (PO/IM/IV)
- Haloperidol ± lorazepam

**Severe agitation (agression to self/others):**
- Olanzapine (PO/IM)
- Clonidine (PO)
- Haloperidol ± lorazepam

**Moderate agitation (agression against objects or property):**
- Diphenhydramine (PO/IM)
- Clonidine (PO)
- Haloperidol ± lorazepam

---

January 2022
<table>
<thead>
<tr>
<th>MEDICATION (BRAND NAME)</th>
<th>CLASS OF MEDICATION</th>
<th>DOSE</th>
<th>PEAK EFFECT</th>
<th>MAX DAILY DOSE</th>
<th>NOTES/MONITORING</th>
</tr>
</thead>
</table>
| CLONIDINE (CATAPRES)    | Alpha2 Agonist      | • PO | PO: 30-60 minutes | 27-40kg: 0.2 mg/day 40-45 kg: 0.3 mg/day >45 kg: 0.4 mg/day | • Monitor for hypotension and bradycardia.  
• Avoid giving benzos or atypicals due to hypotension risk. |
| DIPHENHYDRAMINE (BENADRYL) | Antihistamine      | • 1 mg/kg/dose, PO/IM, PO/IM/IV | PO: 2 hours | Child: 50-100mg Adolescent: 100-200mg | • Avoid in delirium  
• Can be combined with haloperidol or chlorpromazine if concerns for extrapyramidal side effects  
• Can cause disinhibition or delirium in younger kids or developmentally delayed children |
| HALOPERIDOL (HALDOL)    | Antipsychotic       | • 0.05-0.15 mg/kg/dose, IM | PO: 2 hours; may repeat dose after 2 hours IM: 20 minutes; may repeat dose after 20 minutes | 15-40kg: 6 mg >40 kg: 15 mg | • Monitor hypotension  
• Consider EKG or cardiac monitoring for QT prolongation if giving IV  
• EPS risk increased with IV dosing OR Max daily dose > 3 mg/day. Consider co-administration with diphenhydramine |
| LORAZEPAM (ATIVAN)      | Benzodiazepine      | • 0.05-0.1 mg/kg/dose, PO/IM/IV | PO/IM: 1-2 hours IV: 10 minutes | Child: 4 mg Adolescent: 6-8 mg | • DO NOT GIVE WITHIN AN HOUR OF PARENTERAL (IM) OLANZAPINE DUE TO RISK OF RESPIRATORY SUPPRESSION  
• Can cause disinhibition or delirium in younger kids or developmentally delayed children  
• Can be given with haloperidol, chlorpromazine, or risperidone |
| OLANZAPINE (ZYPREXA)    | Antipsychotic       | • PO/ODT/IM, PO | PO: 5 hours (range 1-8 hours) IM: 15-45 minutes | 10-20 mg | • DO NOT GIVE PARENTERAL (IM) WITHIN 1 HOUR OF ANY BENZODIAZEPINE GIVEN RISK FOR RESPIRATORY SUPPRESSION |
| QUETIAPINE (SEROQUEL)   | Antipsychotic       | • 1-1.5 mg/kg/dose, PO | PO: 30 minutes-2 hours | >10 years: 600mg | • More sedating at lower doses  
• Monitor hypotension |
| RISPERIDONE (RISPERDAL) | Antipsychotic       | • 0.005-0.01 mg/kg/dose, PO/ODT | PO: 1 hour | Child: 1-2 mg Adolescent: 2-3 mg | • Can cause akathisia (restlessness/agitation) in higher doses |