Acute Management of Agitated/Aggressive Behavior

Inclusion Criteria:
- New Emergency Department patients and/or Inpatients with aggression; Patients with medical conditions/somatic factors (i.e. pain/discomfort/possible withdrawal) that have been addressed but agitation continues

Exclusion Criteria:
- Patients < 4 years old
- Patients who have been seen by psychiatry and have a specific care plan
- Patients experiencing delirium
- Patients with known adverse reactions to medications listed, contraindication to class of medication due to other medical condition (such as Long QT syndrome – be cautious using antipsychotic)
- Patients in MHIC (who have access to psychiatrist 24/7)

The following information is intended as a general non-etiology focused guideline for the acute management of patients with acute agitation/aggression.
Management of the patient may require a more individualized approach.
Please consider consulting psychiatry, particularly if agitation remains persistent.

Frequent assessments (for change in level of consciousness, work of breathing, skin color) and de-escalation techniques should be used throughout every step of this algorithm. However, if a patient's agitation does not improve/decrease with de-escalation:
- Consider medical conditions/somatic factors (i.e. address pain/discomfort/possible withdrawal) as the source of agitation.
- Consider offering oral symptomatic-specific medication. **If patient on a home antipsychotic or alpha-agonist, can consider extra dose.**
- If a patient is experiencing paradoxical reactions (i.e. worsening agitation to benzodiazepines), please consult psychiatry.
- Consider utilizing manual hold or violent restraints if patient is an immediate threat to self or others.
  - Refer to Policy D429: Restraint (Excluding MHIC) for additional assessment components.
- Consider calling a Code Grey at anytime during this process.

Can the patient presenting with agitation take Oral/G-Tube medications?

Yes

Administer:
- LORazepam **-** Oral/G-Tube:
  - 0.05mg/kg – max dose 2mg

Reassess medication effectiveness in 30 minutes

- May repeat x 1 with the same above dose of LORazepam
- If agitation still present, move to **Step 2**.
- If agitation improved, go to **Final Step.**

No

Administer:
- LORazepam IV/IM: (First Line)
  - 0.05mg/kg – max dose 2mg

Reassess medication effectiveness in 15 minutes

- May repeat x 1 with the same above dose of LORazepam
- If agitation still present, go to **Step 3.**
- If agitation improved, go to **Final Step**.

Recommendations/ Considerations

If Lorazepam NOT available:
- Administer Midazolam Intranasal(IN)/IM
  - If given IN, divide dose between nares
  - < 7 years – 1.5mg
  - 7-12 years – 2.5mg
  - >12 years – 5 mg

Reassess medication effectiveness in 15 minutes

- May repeat x 1 with the same above dose of Midazolam

Step 2 (oral/g-tube):
Administer RisperiDONE Oral/G-Tube:
- <7 years - 0.25mg
- 7-12 years - 0.5mg
- >12 years - 1mg

Reassess medication effectiveness in 30 minutes

- May repeat x 1 with the same above dose of RisperiDONE
- Consider consulting psychiatry. (CCMH consult psychology first).
- If agitation still present, go to **Step 3.**
- If agitation improved, go to **Final Step.**

Step 3:
- Consult psychiatry if not already consulted.

Administer Haloperidol IM:
- 11-14 years – 1mg
- >14 years – 2mg

AND

- Diphenhydramine IV/IM:
  - 11-14 years – 25 mg
  - > 14 years – 50 mg

Reassess medication effectiveness in 15 minutes

- If agitation still present, go to **Step 4.**
- If agitation improved, go to **Final Step.**

Step 4:
If agitation continues – consider
- ChlorproMAZINE IM:
  - 7-12 years – 0.5mg/kg – max dose 25mg
  - > 12 years – 25mg

Reassess medication effectiveness in 30 minutes

- May repeat x 1 with the same above dose of ChlorproMAZINE

➢ *Monitor for hypotension*

Final Step (agitation improved)
- Continue to monitor patient per unit standards for change in level of consciousness, work of breathing (apply pulse ox, if possible), skin color.
- Conduct de-brief and identify potential triggers to create an agitation treatment plan.

Approved Evidence Based Medicine Committee
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Reassess the appropriateness of Care Guidelines as condition changes and 24 hrs after admission. This guideline is a tool to aid clinical decision making. It is not a standard of care. The physician should deviate from the guideline when clinical judgment so indicates.

- **Behavioral Calming Interventions for Agitated Patients**
  - Clearly introduce yourself
  - Maintain a safe distance from the patient (anger = distance x 2)
  - Use simplified language, a soft voice, and slow movements
  - Explain what will happen
  - Reduce environmental stimulation, if possible (less noise or light, fewer people)
  - Remove access to breakable objects/equipment
  - Allow room for pacing, if possible
  - Offer food or drink, which is inherently calming
  - Reassure child that you are there to keep him or her safe, that this is your job
  - Listen and empathize (a treatment cornerstone)
  - Tell child how you plan to honor his or her reasonable requests
  - Clarify the child's goal and then try to link his or her cooperation to that goal
  - Find things for the child to control, like choice of drinks
  - Engage available consultants: security, social work, child life, psychology, psychiatry
  - Offer distracting toys/sensory modalities – video games
  - Remain engaged; perceived ignoring may encourage escalations
  - Remember not to take their anger personally
  - Provide positive affirmations

- **When administering multiple medications, refer to the appropriate compatibility reference.**

- **Medication side effects to watch for:**
  - **LORazepam:**
    - Sedation, respiratory depression
    - Paradoxical reaction, particularly among patients with neurological developmental delays or delirium. If such a reaction occurs, do not continue to administer.

  - **Haloperidol:**
    - IV administration reserved for Critical Care Areas only (monitor ECG closely for QT effects and arrhythmias).
    - Monitor for sedation and respiratory depression.
    - Use caution in patients with the following conditions as this medication increases the risk of QT effects and arrhythmias: electrolyte abnormalities, hypothyroidism, familial long QT syndrome, and concomitant medications that may cause QT prolongation or any underlying cardiac abnormalities.
    - Monitor for EPS.

  - **RisperiDONE:**
    - Dystonia, neuroleptic malignant syndrome (rare), sedation, reduced seizure threshold.
    - Mild QT increase.
    - Monitor for EPS.

Extrapyramidal Symptoms (EPS): Symptoms include involuntary or uncontrollable movements, tremors, and muscle contraction/stiffness. Immediately notify the provider if a patient is experiencing EPS. Symptoms can develop shortly after an antipsychotic medication is administered; however, symptoms can also develop hours to days later. Benadryl is typically administered with certain antipsychotics (i.e., Haloperidol) to prevent EPS.

References
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