



JOHNS HOPKINS ALL CHILDREN'S HOSPITAL

Agitated Patient Clinical Pathway

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This pathway is intended as a guide for physicians, physician assistants, nurse practitioners, and other healthcare providers. It should be adapted to the care of specific patient based on the patient's individualized circumstances and the practitioner's professional judgment.

Johns Hopkins All Children's Hospital

Agitated Patient Clinical Pathway

Rationale:

This clinical pathway was developed by a consensus group of Johns Hopkins All Children's Hospital (JHACH) physicians, advanced practice providers, nurses, and pharmacists to standardize managing children hospitalized or presenting for care in an agitated state. It addresses the following clinical questions or problems:

1. What defines an agitated state in a pediatric patient?
2. How can one determine safety in agitated patients?
3. What are appropriate pharmacologic interventions for agitation in the pediatric population?
4. When to evaluate for mental health crisis in an agitated patient?
5. When should admission be considered for further evaluation of symptoms?
6. When to consult subspecialists for organic causes of agitation?
7. When should medical intervention for an agitated patient be considered?

Background:

Agitation is extreme restlessness, irritability, and hyperactivity, often accompanied by emotional distress or aggression. This condition can arise from various medical, psychiatric, or situational causes and poses significant challenges in managing the patient and keeping the healthcare team safe. Agitation may be associated with psychiatric disease, developmental disorders, and medical conditions including infections and substance abuse. In pediatric patients, agitation often involves brain neurochemistry and circuitry disruptions in regions responsible for emotion regulation, impulse control, and executive function. The prevalence of pediatric agitation in Emergency Departments (ED) has increased in recent years, particularly with the rise in pediatric mental health crises. ED visits have seen a significant increase, with a reported 60% rise in psychiatric emergency visits for youth between 2007 and 2016 in the United States (U.S.). Approximately 1 in 5 children in the U.S. experiences a mental health disorder, and about 15 – 30% of these children may present to the ED in an agitated state.

Unfortunately, agitation in pediatric patients can lead to both short- and long-term complications such as injury to self and others, worsening emotional dysregulation, poor social functioning, or the development of post-traumatic stress disorder (PTSD), hospitalization and prolonged ED stays with restraint use, or sedation, leading to potential delays in care and increased healthcare resource utilization. Some patients may require psychiatric hospitalization or transfer to specialized care facilities. Also, managing agitated pediatric patients is stressful and risky for healthcare workers. It may lead to burnout or psychological distress among providers due to the physical and emotional challenges involved in the care process. Agitated patients are challenging to treat and can occasionally be associated with life-threatening complications such as suicidality, complications of sedation, and restraint use, which in turn, can mask other

medical complications such as intoxication, metabolic disturbances, or life-threatening infections. Pediatric agitation is a multifaceted condition that demands prompt, thorough evaluation and management to prevent harm to the patient and others. While the direct mortality risk of agitation is low, the associated risks of self-harm, untreated medical issues, or complications from intervention require careful, multidisciplinary care to ensure the safety and well-being of the patient and medical staff.

Diagnosis:

The etiology of pediatric agitation is multifactorial. Establishing both medical and psychiatric pre-existing conditions before the agitated state will help guide the overall approach. Details regarding how and why the excited, aggressive behavior began and whether or not there is a pattern of excited states in the past will also help. Medications, previous therapies, treatments, hospitalizations, and specialty schooling or program participation are also helpful. Clinicians will need to determine a baseline behavior for patients to determine the severity of symptoms, as well as a clear explanation of what led to the escalation in behavior (i.e., have there been any new medications, change in medication dosages, changes in family structure, changes to the daily routine, recent therapeutic changes, recent head injuries, new foods). During acute agitation, it may not be realistic to obtain a complete history before needing to address the agitation for patient and staff safety. Clinicians will consider the following diagnostic testing for each patient individually. Sometimes, the diagnostic approach is stepwise, while other clinical presentations may be safer to assess all at once, during a brief period of restraint or sedation.

Clinical Evaluation and Management:

The evaluation of the agitated patient usually requires a multidisciplinary approach. Below are tables to assist in evaluating agitated patients including medical etiologies, laboratory tests, and studies. Additionally, a table describes medications that may cause or worsen agitation.

Medical Etiologies to Consider in the Agitated Patient		
	Disease/Disorder/Condition	Examples/Key features
Metabolic & Endocrine	Hypoglycemia Hyperglycemia/DKA Electrolyte imbalances Thyroid dysfunction Uremia Hepatic encephalopathy Hyper/hypocortisolism Nutritional deficiency	Can progress to seizures, unconsciousness Can progress to AMS, cerebral edema Commonly Na, K, Ca, Mg Thyrotoxicosis or myxedema severe cases Consider ammonia level
Infections	Sepsis Meningitis/encephalitis Urinary tract infections Pneumonia or lower RTI HIV-related infections Neurosyphilis	Viral, bacterial, post-streptococcal, PANDAS Consider immunocompromised patients Especially with associated hypoxia CNS infections, toxoplasmosis, etc. May occur at any stage

Abbreviations: AMS, altered mental status; Ca, calcium; CNS, central nervous system; DKA, diabetic ketoacidosis; HIV, human immunodeficiency virus; K, potassium; Mg, magnesium; Na, sodium; PANDAS, Pediatric Autoimmune Neuropsychiatric Disorder associated with Streptococcal Infection; RTI, respiratory tract infection

Medical Etiologies to Consider in the Agitated Patient (continued)		
	Disease/Disorder/Condition	Examples/Key features
Toxicology	Carbon monoxide Heavy metals Anticholinergics* Psychiatric medications* Steroids Post-sedation emergence	Headache, confusion Lead, mercury, <i>and possibly</i> aluminum Antihistamines, TCAs, antiemetics* Some antidepressants and antipsychotics* Usually with high doses of ~ > 2 mg/kg/day ketamine, propofol, midazolam, dexmedetomidine, sevo-/des-/isoflurane
Substance Use	Intoxication with stimulants Intoxication with alcohol Intoxication with hallucinogens Co-ingestions Withdrawal from alcohol Withdrawal from opiates Withdrawal from benzodiazepines	Cocaine, amphetamines, ecstasy, caffeine Marijuana, synthetic cannabinoids, LSD, PCP, jimson weed, psilocybin, peyote/mescaline, MDMA/ecstasy/'Molly', DMT/ayahuasca, salvia, ketamine Delirium tremens occurs with agitation, hallucinations and autonomic instability Seen with abrupt cessation Seen with abrupt cessation
Neurologic	Stroke or TIA Seizures TBI Encephalitis Vasculitis Tumor/mass Superimposed delirium Encephalopathy, ADEM Hydrocephalous	Particularly when in the frontal lobe Non-convulsive seizures or post-ictal state Consider concussion if normal imaging Autoimmune, paraneoplastic, anti-NMDA receptor Hypertensive, hepatic, vitamin deficiency, chronic traumatic, radiation, systemic lupus erythematosus Consider shunt malfunction
Hypoxia/ Hypercarbia *Any condition leading to poor oxygenation of the brain tissue, with or without, poor ventilation, leading to elevated serum carbon dioxide level*	Pulmonary Embolism (PE) Asthma exacerbation Congenital heart disease Congestive heart failure Arrhythmia Hypoventilation Chronic lung disease	Consider tachyarrhythmias without hypoxia
Psychiatric	Manic episode Psychosis Personality disorders Conduct, PTSD Delirium	Bipolar disorder Schizophrenia, severe depression Antisocial, paranoid, or borderline Acute stressor Febrile, prolonged ICU/hospital stays for children
Developmental and Communication Disordered Patients, and Patients with Pain & Terminal Agitation *Poorly managed or undiagnosed pain is more frequently seen in nonverbal patients*	Undiagnosed fractures Undiagnosed abdominal pain Palliative care Untreated pain Disrupted sleep cycles Disorientation Hunger	Hip dislocations, buckle fractures, rib fractures Constipation, flatulence, gastroparesis, medication side effects Metabolic disturbances, organ failure, terminal delirium Corneal abrasion, hair tourniquet, testicular/ovarian torsion, renal stone, hypoxia/SOB/dyspnea

Abbreviations: ADEM, acute disseminated encephalomyelitis; ICU, intensive care unit; LSD, lysergic acid diethylamide; MDMA, methylenedioxymethamphetamine; NMDA, N-methyl-D-aspartate; PCP, phencyclidine; PE, pulmonary embolism; TCA, tricyclic antidepressants; TBI, traumatic brain injury; TIA, transient ischemic attack

Medications That May Cause or Worsen Agitation			
*most agitation secondary to anticholinergic side effects			
Antihistamines	diphenhydramine chlorpheniramine hydroxyzine meclizine	Antimuscarinics	oxybutynin tolterodine solifenacin darifenacin
Antiemetics	promethazine prochlorperazine	Antispasmodics	dicyclomine hyoscyamine
Antidepressants	TCAs: amitriptyline imipramine nortriptyline doxepin paroxetine	Antivirals	acyclovir valacyclovir oseltamivir amantadine ribavirin Interferon-based therapies
Antipsychotics	clozapine olanzapine quetiapine chlorpromazine	Muscle Relaxants	cyclobenzaprine orphenadrine
		Other	ipratropium tiotropium benztropine trihexyphenidyl

Studies to Consider When Evaluating the Agitated Patient		
Diagnostic Studies	Purpose	Indication
Computed tomography (CT), brain	To rule out structural causes of AMS or agitation, such as intracranial hemorrhage, stroke, mass lesions (tumors), or TBI	If there is suspicion of head trauma, neurological deficits, or signs of increased intracranial pressure (e.g., altered consciousness, focal deficits, seizures)
Magnetic resonance imaging (MRI), brain	To evaluate for more subtle causes of neurological dysfunction (e.g., ischemic strokes, demyelinating disease, encephalitis) that may not be visible on a CT	Reserved for cases with persistent, unexplained agitation and negative findings on initial evaluations
Chest radiograph (x-ray)	To evaluate for pneumonia, PE, rib fractures, pulmonary contusions, or foreign body	If there are signs of respiratory distress, hypoxia, fever, drooling, coughing, choking
Electrocardiogram (ECG)	To identify any cardiac abnormalities, such as arrhythmias, ischemia, or prolonged QT interval, especially if medications contribute to agitation (e.g., antipsychotics)	If there is a history of drug use, metabolic disturbances, or cardiovascular symptoms or disease
Electroencephalogram (EEG)	To assess for seizure activity, particularly in patients with agitation due to unknown causes or those suspected of being in non-convulsive status epilepticus	If there is AMS with no clear etiology or concern for seizures
Plain x-rays	Patients with autism or developmental disorders could be agitated from pain due to fractures, constipation, ileus, or foreign body	Consider in patients with new limp, refusal to ambulate, or physical exam findings suggestive of possible fracture, or per caregiver history

Laboratory Tests to Consider When Assessing the Agitated Patient	
Complete metabolic panel	To assess for electrolyte imbalances, dehydration, kidney function, hepatic dysfunction, & metabolic abnormalities, which can cause/exacerbate agitation
Complete blood count	To detect infection, anemia, or other hematologic conditions that might contribute to altered mental status (AMS) or agitation
Blood glucose level	Hypoglycemia or hyperglycemia can lead to agitation, confusion, or AMS
Acetaminophen level	Identify the presence of acetaminophen in the bloodstream which could be the cause and/or consequence of overdose and agitation
Salicylate level	Identify the presence of salicylates or aspirin in the bloodstream which could be the cause and/or consequence of overdose and agitation
Ethanol level	Identify the presence of alcohol in the bloodstream which could be the cause and/or consequence of toxicity with agitation
Urine drug screen	Identify the presence of prescription or illicit substances in the bloodstream which could be the cause and/or consequence of agitation
Thyroid function tests	To assess for thyroid dysfunction, as both hyperthyroidism (thyrotoxicosis) and hypothyroidism can lead to agitation or mood disturbances
Arterial blood gas (ABG) Venous blood gas (VBG) Capillary blood gas (CBG)	To assess for metabolic or respiratory acidosis/alkalosis, oxygenation, and ventilation issues that could contribute to AMS or agitation
Serum ammonia level	To evaluate for hepatic encephalopathy, especially in patients with liver disease or suspicion of metabolic encephalopathy, which can cause agitation
Gamma-glutamyl transferases	To assess for bile duct or alcohol-related liver damage
Albumin	Low levels could indicate reduced liver protein production or poor kidney filtration mechanism helping to identify the etiology of agitation
Lactate level	To assess for sepsis or hypoperfusion, as elevated lactate may indicate tissue hypoxia or severe infection, both of which can contribute to delirium or agitation
Creatine kinase	To monitor for rhabdomyolysis, especially in patients who are agitated due to prolonged physical activity or substance abuse (e.g., stimulant intoxication)
Blood cultures	To rule out bacteremia & sepsis which can contribute to agitation or delirium
Urinalysis	To rule out urinary tract infection which can contribute to agitation or delirium
Magnesium and phosphate	Electrolyte disturbances, especially low magnesium or phosphate levels, can contribute to agitation, confusion, or seizures
Prothrombin time	To assess liver clotting factor production as a measure of liver function/failure

Assessing Patients with Mental Health Crisis:

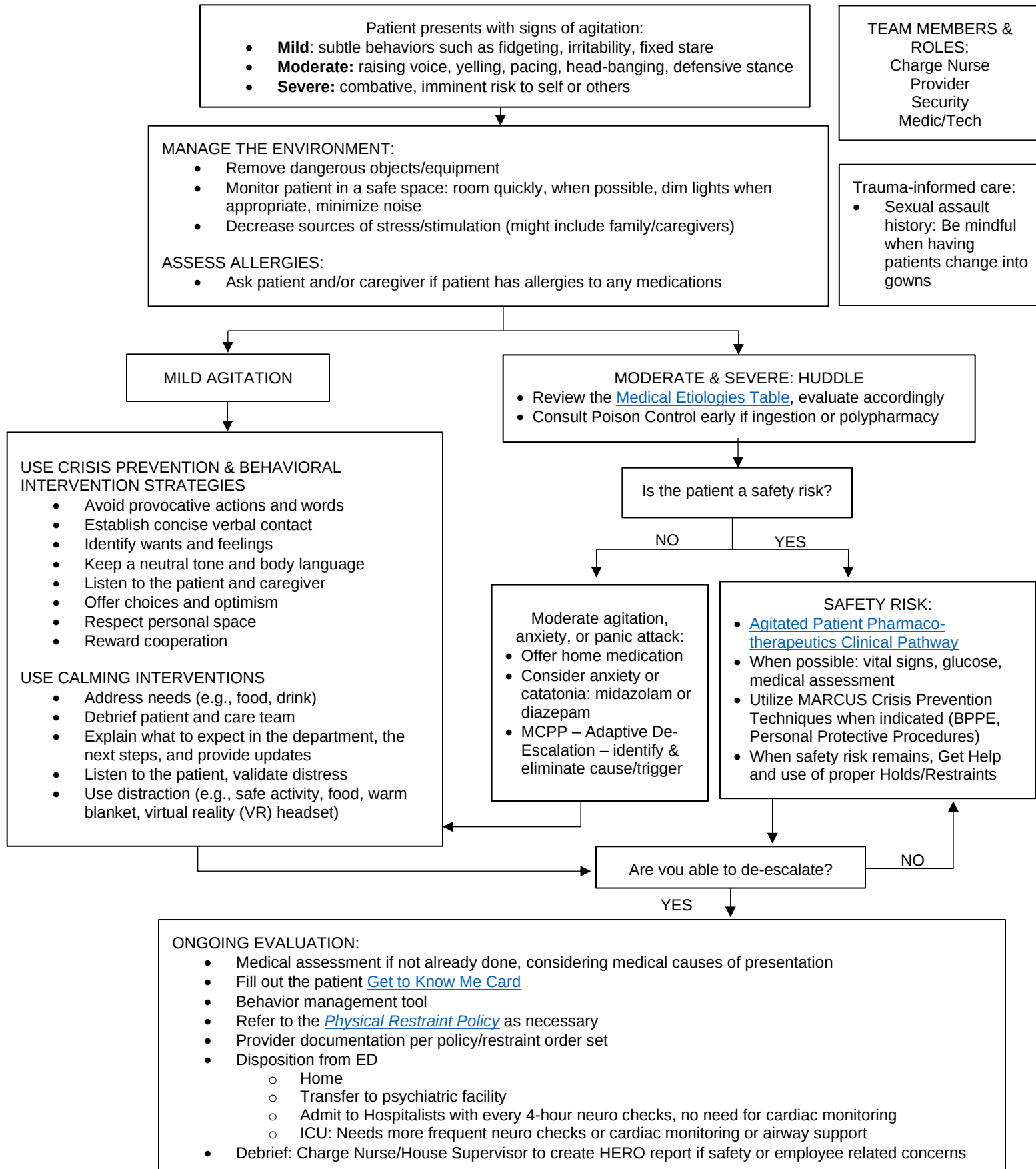
Some patients may suffer from an organic, chemical, or complex cause when presenting with agitation. Others may experience a mental health crisis, and sometimes a combination of all. The following eight domains must be addressed every time a patient presents for a mental health crisis. If your patient could be suffering from a mental health crisis as the cause or contributing to their agitated state, addressing these domains ensures safety, proper care, and emotional support for patients and care team members.

1. Immediate safety and risk assessment (refer to [Agitated Patient Clinical Pathway](#) below)
 - a. Suicidal ideation or self-harm risk
 - b. Risk to others (e.g., aggression, violent behavior)
 - c. Environmental safety
 - i. The patient deserves a safe, secure environment free from potentially harmful objects or triggers

2. Stabilization
 - a. De-escalation of acute distress (refer to [Appendix B: Agitation De-escalation Resources](#))
 - i. Implementing calming techniques, medication(s), and/or therapeutic interventions to stabilize their mental state
 - b. Addressing any medical concerns
 - i. Ensure there are no underlying medical issues (e.g., hypoglycemia, overdose, injury) requiring urgent intervention
3. Mental health evaluation
 - a. Psychiatric evaluation to understand the underlying causes of the crisis
 - b. Screening for substance use with history, examination, and testing when necessary
4. Communication and support for the patient
 - a. Trauma-informed care that is sensitive and non-judgmental
 - b. Patient-centered approach by involving the patient in decisions about their care as much as possible
 - c. Comfort measures because a mental health crisis can be physically exhausting and mentally overwhelming
5. Family and caregiver involvement
 - a. Communication with family/caregiver
 - b. Support for family/caregiver stress, offer them emotional support and resources
6. Disposition and follow-up care planning
 - a. Determine whether the patient needs to be admitted for inpatient psychiatric care or can be safely discharged with outpatient follow-up
 - b. Coordination of care with clear plans for follow-up care, including referrals to psychiatrists, therapists, or social workers
 - c. Access to resources such as crisis hotlines, community resources, or outpatient programs
7. Legal and ethical considerations
 - a. Navigate issues related to informed consent, particularly with minors, and maintain patient confidentiality while ensuring patient and others safety
 - b. Involuntary holds may be needed to protect the patient if they are a danger to themselves or others
8. Cultural and social sensitivities
 - a. Understand and respect the patient's cultural, religious, and social background, which may influence their views on mental health care
 - b. Consider factors such as housing instability, abuse, or lack of access to resources that may have contributed to the mental health crisis

By addressing these concerns, the care team provides comprehensive, compassionate care that stabilizes the patient in the moment but also sets the stage for long-term mental health recovery. In some instances of patient agitation, not all these domains can be immediately addressed due to medical conditions or patient cooperation. When this occurs, please ensure the care team reassesses the patient's needs at a future time.

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Agitated Patient Pharmacotherapeutics Clinical Pathway

Best practices:

- Safety first
- Ask or look up allergies
- Monitor and protect airway
- Severe safety risks: therapeutic dosing and combination dosing

Signs of agitation associated with (SAFETY CONCERN)

Unknown Cause OR Primary
Psychiatric Diagnosis
(ODD/Conduct Disorder/Mania/Psychosis)

Developmental Delay, Autism

Substance Intoxication or Withdrawal

1st LINE

1. droperidol
2. haloperidol

*Use IV/IM medications with caution
1. Home medication if not given
2. olanzapine

ALCOHOL OR
BENZODIAZEPINE
1. droperidol
2. haloperidol

STIMULANT OR
ANTICHOLINERGIC
1. midazolam
2. lorazepam

OPIATE
WITHDRAWAL
1. clonidine

Reassess: If able to de-escalate go back to [Agitated Patient Clinical Pathway](#)
If unable to de-escalate after fully optimizing dosing for the above agents, go to 2nd line

2nd LINE

Reassess:
No improvement in 10 – 15 minutes
1. midazolam
2. lorazepam

1. diphenhydramine

1. midazolam
2. lorazepam

Consult Pain Team
for opioid
replacement
therapy

Reassess: If able to de-escalate go back to [Agitated Patient Clinical Pathway](#)

SEVERE
SAFETY RISK

*For severe immediate safety risks:
antipsychotics (e.g., droperidol,
haloperidol) and midazolam can be
administered together
Reassess, repeat dose as indicated
*For refractory agitation or violence
consider ketamine

1. midazolam
2. lorazepam
Reassess, repeat dose as indicated
*For refractory agitation or violence
consider ketamine

Reassess, repeat dose as indicated
Ketamine is contraindicated
Consult Anesthesia

Abbreviations: ODD, oppositional defiant disorder; IM, intramuscular; IV, intravenous

Medications to Reduce Agitation in Pediatric Patients							
Medication	Route	Dose	Onset	Dosing Interval	Peak	Total Max	Comments
droperidol	IM/IV	< 50 kg: 0.05 mg/kg/dose ≥ 50 – < 100 kg: 2.5 mg/dose ≥ 100 kg: 5 mg/dose	3 – 10 minutes	10 – 15 minutes	30 minutes	10 – 20 mg	
haloperidol	IM	0.025 – 0.075 mg/kg/dose (usual range: 0.5 – 5 mg/dose)	15 – 30 minutes	20 – 30 minutes x 2 doses	20 – 30 minutes	≤ 40 kg: 6 mg > 40 kg: 15 mg	• Causes hypotension and QT prolongation • Can also cause extrapyramidal symptoms
midazolam	IM	< 50 kg: 0.1 mg/kg/dose ≥ 50 kg: 5 mg/dose	5 minutes	5 – 10 minutes	15 – 30 minutes	10 – 20 mg	• IN route has a comparable time of onset to the IV route, but higher doses are needed due to incomplete absorption from the mucosa of the nose
	IN	< 50 kg: 0.4 mg/kg/dose ≥ 50 kg: 10 mg/dose	~5.5 minutes	15 minutes	10 minutes	10 mg	
	IV	< 50 kg: 0.1 mg/kg/dose ≥ 50 kg: 2 mg/dose	1 – 5 minutes	5 minutes	3 – 5 minutes	5 – 10 mg	
lorazepam	IM	0.05 – 0.1 mg/kg/dose (0.5 – 2 mg/dose)	15 – 30 minutes	20 – 30 minutes x 2 doses	1 – 2 hours	Child: 4 mg Adolescent: 6 – 8 mg	• Can cause delirium and disinhibition in younger and developmentally delayed children
	IV		Within 10 minutes		10 minutes		
olanzapine	IM/IV	< 50 kg: 0.1 mg/kg/dose ≥ 50 mg: 5 mg/dose	IM: 15 minutes IV: 3 – 10 minutes	15 minutes x 2 doses	IM: 15 – 45 minutes	30 mg (including PO doses)	• Avoid use within 1 hour of a benzodiazepine due to risk of respiratory depression
	PO	2.5 – 10 mg/dose ODT	20 minutes	4 – 6 hours	5 – 6 hours	10 – 20 mg	
*ketamine	IM	50 – 59 kg: 150 mg/dose 60 – 79 kg: 200 mg/dose 80 – 99 kg: 250 mg/dose ≥ 100 kg: 300 mg/dose	3 – 4 minutes	1 x dose	5 – 30 minutes	---	**Concentration for IM administration is 100 mg/mL

Abbreviations: IN, intranasal; ODT, orally dissolving tablet; PO, by mouth; *IM ketamine 100 mg/mL currently available in the Radiology CT pyxis

Admission:

Admission criteria include:

- Significantly abnormal vital signs
- Impaired mental status from their neurologic baseline
- Respiratory distress
- Monitoring of cardiovascular depression or development of arrhythmia
- Need for further diagnostic or therapeutic intervention
- Risk of harm to self or others (see section for [Consultation and Referral](#) below)
- Inability of the caretaker to care for the patient (see section for [Consultation and Referral](#) below)

Discharge:

Discharge should be considered when patients meet the following criteria:

- Resolved agitation with lucid mental status
- Etiology of agitation identified, and prevention strategies addressed

Consultation and Referral:

- For all suspected or confirmed ingestions, contact the Poison Control Center at 1-800-222-1222
- Consider Neurology consultation for abnormal neurologic examinations, concern for ADEM, encephalitis, or nonconvulsive seizures
- Consider Social Work for ingestion/overdose, suicidal or homicidal ideations, and other psychiatric disorders that may benefit from inpatient psychiatric and substance abuse treatment (Florida: Baker Act-52) or referral services

Documentation Reminders:

- Clearly define the indication for use of all pharmacologic interventions or physical restraints
- Use the Pediatric Emergency Medicine Restraint/Hold/Violent or Destructive Behavior and Face-to-Face evaluation for Intervention Response Age 17 and Younger Epic order set when necessary

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Outcome Measures:

- Number of physical restraints used/time
- Number of medications used/time
- Frequency of needed rescue medications after initial dosing

Clinical Pathway Team**Agitated Patient Clinical Pathway****Johns Hopkins All Children's Hospital**

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Date Approved by JHACH Clinical Practice Council:

Date Available on Webpage:

Last Revised:

Disclaimer:

Clinical Pathways are intended to assist physicians, physician assistants, nurse practitioners, and other healthcare providers in clinical decision-making by describing a range of generally acceptable approaches for the diagnosis, management, or prevention of specific diseases or conditions. The ultimate judgment regarding the care of a particular patient must be made by the physician in light of the individual circumstances presented by the patient.

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Appendix A: Agitation Assessment: Bedside/lanyard card – Based on CHOP PRESS Algorithm and Lurie Agitation Strategies

FRONT

PRESS Quick Assessment for Agitation

P	Past History	Review Medical & Behavioral History; Current Medications
R	Reasons for Agitation	Identify the Reason for Behaviors; Identify Triggers & Interests
E	Environment	Implement Safety & Therapeutic Interventions
S	Social	Review Caregiver Supports, Consents
S	Severity	Assess Severity & Plan Response

(From Children's Hospital of Philadelphia clinical pathways)

Severity of Agitation

(Consider baseline and developmental level)

MILD	MODERATE	SEVERE
Subtle behaviors such as fidgeting, irritability, fixed state	Raising voice, yelling, pacing, head-banging, defensive stance	Combative, imminent risk to self or others

BACK

Non-Pharmacological De-escalation Strategies for Agitation

Verbal Strategies	Language
Ask the patient & caregiver what helps.	"What helps you in times like this?" "What has worked in the past?"
Set expectations and consequences	"If you are having a hard time staying safe, we will..."
Offer forced choices	Two options: "Would you like to do X or Y?"
Redirection/Distractions	"What else could we do?" "Would [activity] help?" "Let's try [activity] together"
Active listening: what is the patient's perception of the problem?	"Tell me if I have this right..." "What I heard is..." Consider the use of silence
Build empathy: validate what the patient is experiencing	"What you are going through is difficult." "It can feel overwhelming to be in the hospital"
Behavioral Strategies	Tips
Use one voice & give simple instructions	Ensure the team is on the same page. "First this, then this" when giving instructions Give patient adequate time to process and respond, repeat instruction if necessary
Reward cooperation and praise	Catch the patient "being good." "Great job showing me safe hands!"
Maintain personal space & consider body language	Respectful distance from the escalating patient At least two arms-length distance Calm demeanor, posture Neutral stance, neutral facial expression, and tone of voice
Minimize stimulation.	Dim lights, reduce noise, minimize clutter. Minimize staff in the room (1-2 at a time ideal)
Consider soothing sensory tools or consult	Child life or Occupational Therapy can assist. Offer food or items for comfort

Appendix B: Agitation De-escalation Resources

Marcus Autism Center Crisis Prevention Program: [Crisis Prevention Program | Marcus Autism Center](#)

- Can register for the Marcus Autism Center Crisis Prevention Program through MyLearning or by contacting Wendy Castano-Arbelaez at JHACH

American Academy of Pediatrics (AAP) Wellness Strategies Quick Guide

- Box breathing
 - <https://www.calm.com/blog/box-breathing>
- Grounding exercises: 5-4-3-2-1
 - <https://www.calm.com/blog/5-4-3-2-1-a-simple-exercise-to-calm-the-mind>
- Body scan: 1-minute meditation
 - <https://www.headspace.com/meditation/one-minute-meditation>
- Diaphragmatic breathing
 - <https://www.health.harvard.edu/healthbeat/learning-diaphragmatic-breathing>

Appendix C: Bedside Handoff “Get to know Me” Card

 Children's National		Get to know Me!	Patient Label
Name Preference _____ Your Pronoun: ☐ He/Him/His ☐ She/Her/Hers ☐ They/Them/Theirs Person I trust most: _____ What are you hoping will happen today for you in the hospital? _____ Things I enjoy/I'm good at (in the hospital): ☐ Playing Cards ☐ Board games ☐ Fidgets ☐ Sticker by Number ☐ Coloring ☐ Reading Books ☐ Watching TV ☐ Quiet Time ☐ Drawing ☐ Word searches/crossword puzzles ☐ Other: _____	Triggers (make me feel mad, sad, or upset): ☐ Arguments ☐ Being alone ☐ Being teased ☐ Being touched ☐ Being stared at ☐ Contact with family ☐ Feeling Pressured ☐ Loud noises ☐ Feeling lonely ☐ Flashbacks ☐ Not being listened to ☐ Particular person: _____ ☐ Particular time of day/year ☐ People yelling ☐ Lack of privacy ☐ Darkness ☐ Needles/injections ☐ Other: _____		
Things that make my triggers worse: ☐ Being around people ☐ Being alone ☐ Loud noises ☐ Being touched ☐ Other: _____ What would others see if you're starting to get upset: ☐ Becoming very quiet ☐ Being rude ☐ Breathing hard ☐ Shaking/bouncing legs ☐ Sweating ☐ Wringing hands ☐ Red faced ☐ Pacing ☐ Crying ☐ Damaging things ☐ Clenching fist ☐ Can't sit still/Rocking ☐ Eating more ☐ Eating less ☐ Loud voice ☐ Isolating/avoiding people ☐ Poor hygiene ☐ Heart racing ☐ Other: _____	Coping skills that help me calm down: ☐ Playing Cards ☐ Sleeping ☐ Lying down/sleeping ☐ Watching a funny movie ☐ Talking to my family ☐ Squeezing a ball ☐ Talking to a trusted adult (CL, MD, RN, CPS, etc.) ☐ Screaming in a pillow ☐ Deep breathing ☐ Being around others ☐ Crying ☐ Coloring/drawing ☐ Writing in journal ☐ Reading a book ☐ Pacing ☐ Exercise ☐ Other: _____ _____		

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