Agitation/Aggressive Behavior Pathway: ED/IP Management

November 2025

Children's Healthcare of Atlanta

Patient presents with Agitation and/or Aggression: Mild, Moderate, or Severe

- **Alert provider and Behavioral Mental Health (BMH) Nursing Team as soon as possible**
- Evaluate for cause of agitation

GOAL

To provide immediate care and standardized medications to agitated/aggressive patients to ensure patient and staff safety and minimize use of violent restraints

Exclusion Criteria

Strong suspicion for any of the following:

- Metabolic disturbance
- History of Neuroleptic Malignant Syndrome (NMS)
- Traumatic Brain Injury (TBI)
- Fever
- Recent seizure activity
- Vital sign instability

Consult Psychiatry for Treatment Plan if:

- Previous PRN(s) were ineffective, caused allergic or paradoxical reaction
- Agitated delirium, if suspected
- Moderate or severe agitation
- If interventions are ineffective

[1] Patients with Autism Spectrum or Developmental Delay

- Avoid benzodiazepines, unless approved by Psychiatry, due to possible paradoxical reaction
- Extra dose of patient's regularly scheduled medication.
- If no scheduled medications:
  - PO chlorpromazine or PO olanzapine for mild/moderate agitation
  - IM chlorpromazine for severe agitation

MILD AGITATION

Verbal aggression, increased restlessness and demands, no threat to self or others

- Bedside staff can start de-escalation strategies and safety interventions immediately (see page 3 for details)
- Consult BMH Nursing Team

MODERATE AGITATION

Raising voice or yelling, aggression toward object/property, brief head banging, lightly scratching without breaking skin, no direct threat to self or others

- **Consider activating Code BERT**
- Provider to bedside
- Consult Psychiatry
- Ensure physical and environmental safety
- Use BMH Protective Equipment (BMH-PE) if patient is physically aggressive

SEVERE AGITATION

Actively harming self or others, moving or throwing large objects, destroying property, attempts to cut or deep scratching of skin, forceful or prolonged head banging, imminent risk to self or others

- **Activate Code BERT**
- Consult Psychiatry
- Immediately ensure physical and environmental safety
- Use BMH-PE if patient is physically aggressive
- Consider utilizing manual hold or violent restraints if patient is an immediate threat per **Clinical Policy 1.15**

Agitation improving?

YES

NO

If interventions above are ineffective:

- **Consult Psychiatry (if not already done)**
- Reference page 2 for medication dosing and monitoring parameters
- Administer home medications due within an hour
- Provide pharmacologic interventions below

MILD AGITATION

- Diphenhydramine (PO)
  OR
- Lorazepam (PO)[1]

MODERATE AGITATION

- Lorazepam (PO, IV, or IM)[1]

SEVERE AGITATION

- Step 1: Medication to consider alone or in combination:
- Antipsychotic (PO or IM) with Diphenhydramine (PO, IV, or IM) for EPS prevention
- Lorazepam (PO, IV, or IM) – preferred for agitation due to organic or non-psychiatric etiologies[1]

Note: Avoid giving both Olanzapine IM and Lorazepam IM as it can cause respiratory depression

- **Step 2: Consult Psychiatry**

Agitation improving?

YES

NO

Post-Agitation Care:

RN to reassess patient level of agitation, level of consciousness, and work of breathing (apply pulse ox, if possible) after PRN medication administration:

- IV/IM within 15-30 mins
- PO within 60 mins

Team debrief with BMH Nursing Team to:

- Determine triggers and strategies to include the plan of care/Coping Plan
- Develop a medication contingency plan that includes frequency and maximum daily dose

Consult Psychiatry for next steps

This pathway is based on evidence available at the time of publication as well as expert consensus of clinicians at Children's Healthcare of Atlanta and has been approved by the Medical Staff at Children's.

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Intent for Medication Administration

- Medication is administered to treat symptoms of mental illness and to enable patient to effectively function and communicate with staff
- If medications needed, attempt PO first, then IV/IM if needed
- Opt for lower limit of recommended doses so patient can participate in their own care while promoting staff and patient safety

Medication	Dosing	Notes
Lorazepam	Children < 12 yrs old: 0.05-0.1 mg/kg/dose (with a max of 2mg) Children > 12 yrs old: 0.5 mg/dose-2 mg/dose	PO, IM, or IV q6hrs Max dose: 2mg Peak effect: IV/IM 10 mins; PO 1-2 hours Do not give with Olanzapine[2] Monitor for respiratory depression and paradoxical effect
[4]Diphenhydramine	< 6 yrs old[1]: 1 mg/kg/dose (max DAILY dose 50 mg) 6-12 yrs old: 12.5-50 mg (max DAILY dose 50-100 mg) ≥ 13 yrs old: 25-50 mg (max DAILY dose 100-150 mg)	PO, IM, or IV q6hrs Peak effect: IM/IV 15 mins; PO 2 hours Avoid for Patients with Delirium Monitor for paradoxical effect
Antipsychotics		
Chlorpromazine[3]	< 6 yrs old[1]: 0.55 mg/kg/dose 6-12 yrs old: 12.5-25 mg ≥ 13 yrs old: 25-50 mg	PO or IM q4hrs Max daily dose: < 5 yrs 40 mg/day; > 5 yrs 75 mg/day Peak effect: IM 15 mins; PO 30-60 mins Monitor for hypotension and QT prolongation; consider EKG post dosing To be given with diphenhydramine to decrease risk of EPS[4]
Haloperidol[3]	< 6 yrs old[1]: 0.05-0.15 mg/kg/dose 6-12 yrs old: 2.5 mg ≥ 13 yrs old: 5 mg	PO or IM q4hrs Max 15-40kg: 6 mg/day; > 40kg 15 mg (depending on prior medication exposure) Peak Effect IM 20 mins; PO 2 hrs Monitor for hypotension and QT prolongation; consider EKG post dosing To be given with diphenhydramine to decrease risk of EPS[4]
Olanzapine[3]	< 6 yrs old[1]: 1.25-2.5 mg daily 6-12 yrs old: 2.5-5 mg daily ≥ 13 yrs old: 5-10 mg daily	PO daily Max dose 20 mg/day Peak effect: PO 4-8 hours Parenteral Benzodiazepines combined with IM Olanzapine is known to cause significant respiratory suppression and is not recommended Combination with alternate routes of administration should be monitored for hypotension and respiratory depression Monitor for oversedation especially if patient has received benzodiazepine Monitor for hypotension and QT prolongation; consider EKG post dosing

Medication Monitoring Requirements

[1]For children <6yrs old: Assess for underlying medical conditions leading to agitation, including but not limited to:
- Ingestion, metabolic disturbance, delirium, pain, developmental delay/autism
- Prior to using medications, consult with Psychiatry and Pharmacy as dosing recommendations are limited for children <6yrs old

[2]Due to risk for respiratory suppression

[3]Monitor for:
- Extrapyramidal Symptoms (EPS): Involuntary contractions of muscles in the face, neck, trunk, pelvis, and extremities
- Neuroleptic Malignant Syndrome (NMS): A rare, but serious adverse event of antipsychotics that requires immediate care. Signs and symptoms of NMS include fever, altered mental status, muscular rigidity, and autonomic dysfunction

De-escalation Strategies and Safety Interventions

- Use therapeutic communication/verbal de-escalation strategies:
  - Body language: Calm demeanor, facial expression, posture
  - Ask patient what helps, such as “What helps you at times like this?”
  - Active Listening
- Build empathy. Example statement: “What you’re experiencing is difficult.”
- Respect personal space (1-2 arm length distance)
- Decrease stimulation (dim lights, reduce noise, minimize staff, use calming techniques)
- Ask parent/guardian what works best for their child
- Offer food and/or drink options (utilize food cabinet)
- Provide age-appropriate diversions and distraction items. Ask patient, “What activity or item would help you?”
- Avoid unnecessary/non-essential demands or tasks
- Provide choices when able
- Provide patients with preferred item or activity
- Reference Coping Plan in EMR, if available
- Initiate multidisciplinary collaboration: Child Life, Social Work, Psychiatry as indicated
- If in the ED, Place patient in BMH room and complete safety sweep

Autism Spectrum/Developmental Delay:

- Assess for constipation, dental pain, or other sources of pain
- Consult Marcus Autism Center
- Provide sensory items (weighted blankets, noise cancelling headphones, tactile toys, Vecta machine, etc.)

Substance Intoxication or Withdrawal:

- Assess history, send urine tox screen, physical exam
- Assess for co-ingestion
- Consider poison control