Ashford and St. Peter's Hospitals NHS
NHS Trust

WOMEN'S HEALTH AND PAEDIATRICS
PAEDIATRIC DEPT

Rapid Control of Acutely Disturbed Children & Adolescents (age 8-17 years) in Paediatric settings

Amendments			
Date	Page(s)	Comments	Approved by
Sep 2009	New Guideline		Paediatric Guideline Group
Sept 2013		Whole document review	Paediatric Guideline Group
March 2018		Whole document review – no changes	Paediatric Guideline Group

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In Consultation with:

Ratified by: Paediatric Guidelines Group

Date Ratified: Sept 2013

Date Reviewed: December 2019

Next Review Date: December 2023

Target Audience: Doctors, nurses and support staff working in Paediatrics

Impact Assessment Carried Out By:

Comment on this document to: Dr Bhatti and Dr Baksh Consultant Paediatrician

INTERVENE WITH NON-PHARMACOLOGICAL APPROACHES AS SOON AS POSSIBLE

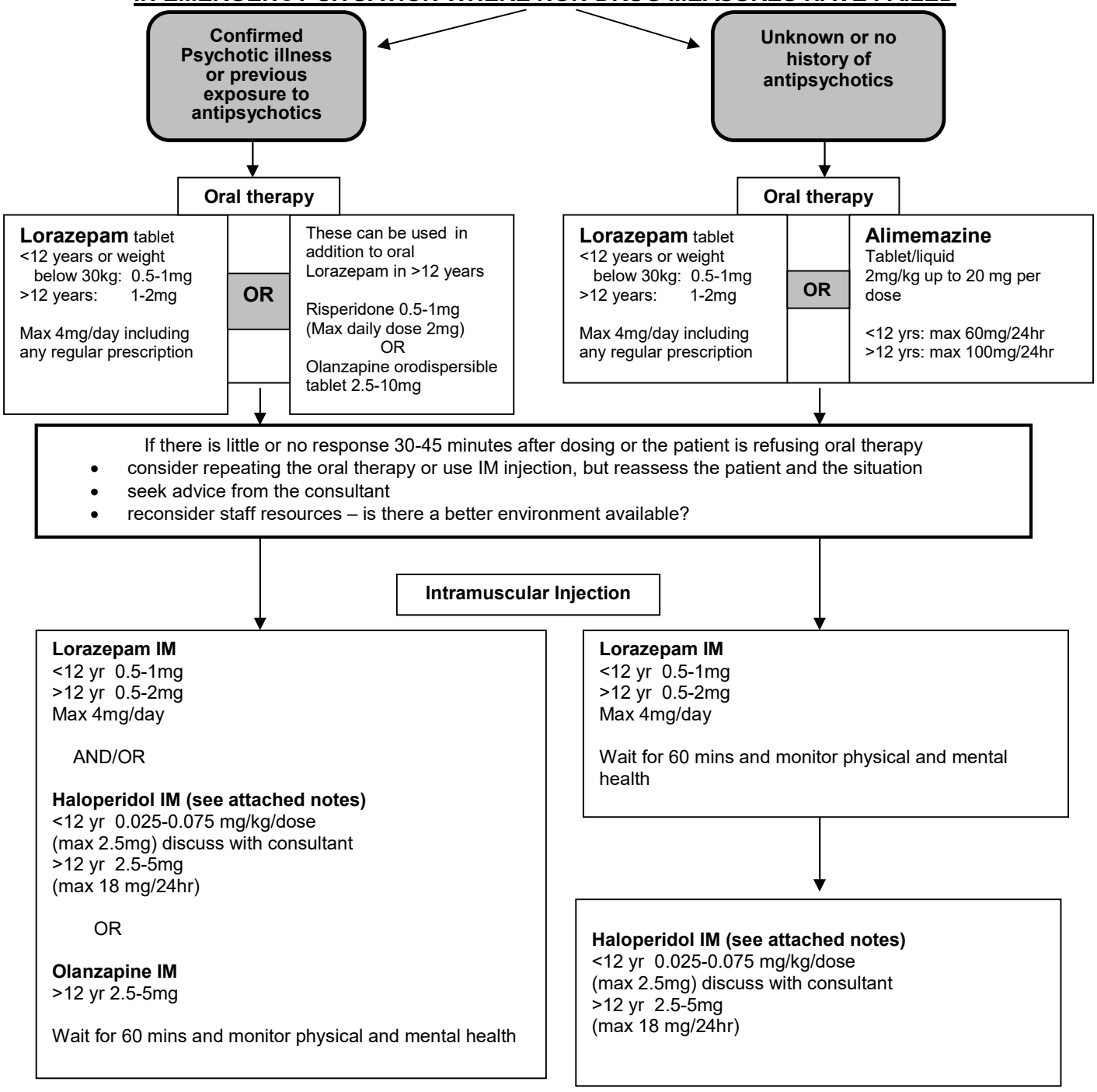
- Aim to calm the patient, reduce risk to patient and others
- Talk to the patient, use distraction, remove to low stimulus area
- Additional staff may be needed
- Note any illicit drug use, overdoses, alcohol or benzodiazepine use
- Review physical health (cardio or respiratory disease, renal or hepatic impairment)
- Allergies/sensitivities/severity of drug adverse effects
- Obtain consent of young person or parents if possible

Proceed to rapid tranquilization only when routine measures fail
Ensure facilities for resuscitation are available

KEY PRINCIPLES

- Seek consultant paediatrician's opinion
- Seek advice from CAMHS on call consultant child & adolescent psychiatrist
- Choice of medication should be guided by (a) current medication; (b) diagnosis; (c) what has been effective in previous episodes of acute disturbance
- Review all medications prescribed in the last 24 hours (Adverse effects? BNF limits?)
- Simplify the medication, agree on therapeutic goals
- Avoid combinations of medications where possible, unless these have been effective in similar episodes in the past, or monotherapy has been shown to be unsuccessful
- Ensure adequate fluid balance and food intake
- It is essential to keep non-medication aspects of management under review e.g. is the patient's current environment the most appropriate to manage the current disturbance?
- All steps taken must be documented, with particular care being taken to document in detail any departures from this algorithm, and the reasons for these
- If there is a threat to safety of other patients or staff, call security and/or police

IN EMERGENCY SITUATION WHERE NON-DRUG MEASURES HAVE FAILED



- **Procyclidine** should be **co-administered with Haloperidol** to prevent acute dystonic reactions (all ages: 2.5mg PO/IM)
- Flumazenil IV must be given if respiration rate falls to <10/minute after Lorazepam has been given
  (<12 years: 150 microgram IV injection over 15 seconds
  >12 years: 200 microgram IV injection over 15 seconds
  Repeat at 1 minute intervals with half initial dose until recovering or a maximum of 5 doses).
- Give **Lorazepam IM and Haloperidol IM** in **separate syringes**
- Care when injecting a struggling child/adolescent, as an IV bolus can result.
- Nursing observations – constant visual observations, BP, pulse, temperature, respiratory rate, Oxygen saturation, consciousness level.

Important points to remember with use of Haloperidol

- Beware of Neuroleptic Malignant Syndrome when using anti-psychotics (fever, muscular rigidity, altered mental status, and autonomic dysfunction)
- Check family history of cardiac disease, especially arrhythmia and sudden death
- Cardiovascular examination should be noted
- Patient receiving Haloperidol should be on ECG monitor
- Check blood electrolytes
- If repeat Haloperidol dosage needed, perform ECG