Quick Access:

Source of Behavioral

Escalation Management and

Medications

POPS (Parents Offering

Parent Support)

Children's Mercy KANSAS CITY

Inclusion Criteria:

- Agitation Restlessness, pacing, hand ringing, etc.
- Aggression Change in body language, argumentative or defensive, verbal or physical threats
- Self Harm Behavior Expressed thought to harm self/others, present injurious behaviors or plan
- Threat to Harm Others -Expressed thought to harm others, present threatening behaviors
- Elopement Verbal request to leave, movement towards exit, physical attempt to leave

Exclusion Criteria:

· Any non-CM patient

Sources of Escalating Behavior

- Pain
- Hunger
- Environmental factors
- Delirium
- Substance abuse or withdrawal
- Consider nicotine withdrawal (Nicotine cessation pathway)
- Consider Toxicology Consult
- Developmental delay or autism
- Psychiatric diagnoses

(Source of Behavioral Escalation Management and Medications)

Indications for Restraints

- First line of care should be seclusion (if available) **before** medications or restraints.
- If seclusion fails (risk of self-harm or while in seclusion) proceed to medications and/or restraint as needed (See Restraint or Seclusion Policy).

Associated CM Policies:

- Behavior Management
- Internal Transport of Disruptive and Flight Risk Patients
- Patient Transport within the Facility Guidelines
- Restraint or Seclusion
- · Continuous Patient Observation



Patient demonstrating escalating behavior in the ED (If known history of escalating behavior, review Multidisciplinary Behavioral Plan in Progress Notes)

Ensure Patient/Staff Safety

Assess Environment:

- Remove other pts from hallway or surroundings
- Family/siblings step out of the room if needed
- Remove dangerous objects when able (e.g., dangling cords)

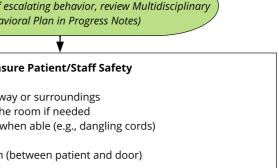
Staff Safety:

- Assure safe location in room (between patient and door)
- Gather appropriate PPE
- Do not enter room alone (tell another staff)
- Beware of items that could be grabbed (i.e. stethoscope, jewelry, hair or lanyard)

Are patient or

staff in immediate

danger?



Assess the source of escalation Provide quick/easy interventions such as food, a blanket, and, if available, Child Life

Policy)

Contact

Initiate 1:1 observation, (See,

Continuous Patient Observation

- Security
- Care Team
- Charge nurse
- Consider contacting Pharmacy
- · Consider psych nursing (Adele Hall only)

Initiate seclusion

- May need to move pt to Safer Room, if possible
- Have physical restraints readily available (See Restraint or Seclusion Policy)
- If brought in restrained, evaluate need of continuing restraints.

Consider administration of behavioral medications based on source Note: If prior visits, review notes for effective pharmacologic strategies

De-escalation Strategies

If patient has a prior Multidisciplinary Behavioral Plan, review recommended strategies

Verbal Interventions and Active Listening	
Validate their emotions	"I understand you're feeling angry right now"
Use reflective statements	"I notice that you are tense"
Use "I" statements	"I am concerned about your safety"

Distraction Techniques

Engage the patient in calming activities: Deep breathing exercises, music, drawing, books, toys, or other activities through Child Life (if available)

Establish firm limits without threatening	
Offer limited choices when possible	"Would you like to sit here or there?"
State what is not allowed, but start the statement with yourself	"We cannot allow you to hurt yourself or others here" "I can only provide you with one blanket right now"
Praise for acceptable behavior and adherence to rules set forth	"Thank you for remaining in the room; it helps everyone make sure you are safe" "I'm impressed you can stay calm in these circumstances, thank you"
In	nclude the caregiver whenever possible

Provide emotional support and updates to the caregiver

Recognize if the caregiver is a trigger for the agitation

Proceed to the next page



for mobile

Contact: EvidenceBasedPractice @cmh.edu

Link to synopsis and references

Last Updated: April 2025

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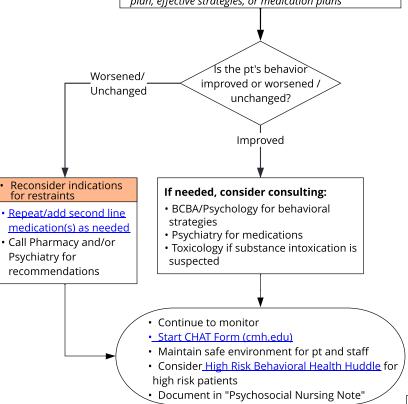
Huddle with Care Team

- Involve family when possible
- Verify and administer home medications
- Have security at bedside, if needed
- Collaborate with Social Work, House Shift Supervisor, Child Life and Staff Advocacy Team, as needed
- Discuss whether or not 1:1 is needed

Consider the following as needed, if not already done:

- 1:1 observation (See, Continuous Patient Observation Policy)
- Move to Safer Room, if possible
- Seclusion
- Consider physical restraints if seclusion has been unsuccessful (See Restraint or Seclusion Policy)
- Administration of <u>behavioral medications based</u> on source.

Note: If prior visits, review notes for previous behavioral plan, effective strategies, or medication plans





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