Guidelines for the use of Rapid Tranquilisation in Adult Inpatients (18-65 years)

GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Caerdydd a'r Fro | Cardiff and Vale University Health Board

Definition: Use of *parenteral* psychotropic medication to control acute agitation, aggression or psychotic behaviour where **oral route is not appropriate**. Restrictive intervention – consider MHA/MCA status

Prior to use of Rapid Tranquilisation (RT):

- Non-pharmacological approach first-line: appropriate de-escalation and review of environment
- **Oral medication route to be used before IM** unless inappropriate/refused
- Ensure baseline physical examinations are done where possible: BP, HR, RR, temp and ECG
- Consider physical causes of behaviour including current intoxication
- Consider co-morbidities and possible consequences of RT administration (interactions, adverse effects)
- Daily review of cumulative doses and appropriateness of prescription with MDT/medical team
- Follow patient's Advanced Directive where applicable

NON-PHARMACOLOGICAL MEASURES UNSUCCESSFUL AND ORAL MEDICATION REFUSED/NOT WORKING

Consider IM Lorazepam 2mg

(**1mg** if frail/phys health concerns/learning disability)

Consider Promethazine 25-50mg instead if:
- Severe respiratory disease
- Benzodiazepine-tolerant
- Lorazepam contraindicated (past reaction)

Start physical health monitoring (see overleaf). REVIEW MENTAL STATE AT 1 HOUR

Full response

Follow-up physical health monitoring & incident form

Partial response

Consider repeating IM sedative 1-2 hourly

Lorazepam – max 8mg/24 hours (can be increased to 16mg by consultant)

OR

Promethazine – max 100mg/24 hours (off-license use)

Full response

Partial or no response

No response

Consider switching to (or combining sedative with) IM antipsychotic:

Haloperidol – requires ECG (or consultant approval if no ECG), consider previous EPSEs

OR

Aripiprazole – will not sedate patient. Consider where no ECG, intoxication, cardiovascular disease, antipsychotic naïve or on QTc-prolonging regular medication

INCLUDE IM AND ORAL IN MAX DOSES

Haloperidol

2-10mg 1-2 hourly, max 20mg/24 hours

Dose as per co-morbidities and level of agitation. If also using sedative, NICE recommends promethazine (may increase haloperidol tolerability) but ONLY with ECG

Aripiprazole

5.25-9.75mg 2 hourly, max 30mg/24 hours, no more than 3 injections/24 hours

Can agitate patient - consider co-prescribing lorazepam

Continue physical health monitoring. REVIEW MENTAL STATE AT 1 HOUR

Continue strategy if partial response. Contact consultant if no response

Oral Strategies – Sedation

Lorazepam 2mg 1-2 hourly, max 8mg/24 hours (can be increased to 16mg by consultant)

OR

Promethazine 25-50mg 1-2 hourly, max 100mg/24 hours

Oral Strategies - Antipsychotics

Olanzapine 5-10mg 4 hourly, max 20mg/24 hours

OR

Additional dose of regular antipsychotic

OR

Haloperidol 2-10mg 1-2 hourly, max 20mg/24 hours (only with ECG or on consultant advice)

Complications Use NEWS score to determine when to alert doctor	
Problem	**Remedial Measures**
Acute dystonia	Procyclidine IM 5-10mg. Review antipsychotic Rx
Hypotension (<90mmHg systolic OR <50mmHg diastolic OR >30mmHg postural drop)	Lay patient flat and raise legs
Bradycardia/arrhythmia (Pulse <50bpm)	Immediate referral to MEAU if antipsychotic used
Fever (>38°C)	Withhold antipsychotics. Consider Neuroleptic Malignant Syndrome
Reduced respiratory rate (<10 breaths per minute OR O_2 saturation <95%)	Immediate referral to MEAU, where flumazenil can be administered if benzodiazepine-induced. Give oxygen and lay flat with raised legs

Physical Health Monitoring	
Monitor patient **hourly** until no further concerns	- Mental and behavioural state - Pulse - Blood pressure - Temperature - Respiratory rate
Monitor patient **every 15 mins** if any of these conditions apply	- BNF maximum dose has been exceeded - Patient is asleep/sedated - Patient has taken illicit drugs/alcohol or has physical health co-morbidities - Patient has experienced any harm as a result of any restrictive intervention

Pharmacokinetics

Drug and form		**Time to peak plasma conc^{n}**	**Half-life**
Lorazepam	PO	2 hours	12 hours
	IM	60-90 mins	12-16 hours
Promethazine	PO	2-3 hours	5-14 hours
	IM	2-3 hours	5-14 hours
Haloperidol	PO	3-6 hours	10-36 hours
	IM	15-60 mins	10-36 hours
Olanzapine	PO	5-8 hours	32-50 hours
Aripiprazole	IM	90 mins	75-146 hours

Zuclopenthixol acetate (Acuphase) is NOT rapid tranquilisation

Must only be prescribed by consultant in discussion with pharmacy