MIL

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This Medicines Information Leaflet is produced locally to optimise the use of medicines by encouraging prescribing that is safe, clinically appropriate and cost-effective to the NHS.

Management of Acutely Disturbed Behaviour for Adults (including Rapid Tranquilisation)

Agitated and aggressive behaviour from patients is common. Such behaviours increase the risk of harm to the patient themselves, other patients, and hospital staff (1).

The clinical practices of **R**estraint and **R**apid **T**ranquilisation (RoRT) are used when psychological and behavioural approaches have failed to de- escalate acutely disturbed behaviour.

This policy applies to:

- Inpatients only, receiving care or treatment within the OUH NHS Trust from age 18 years upwards.

Note, for management of patients with delirium please refer to the Trust's Delirium MIL. Additionally, the Trust's Restraint and Rapid Tranquilisation policy should be consulted for further detail on all subjects covered in this MIL. For management of patients needing sedation in emergency departments, consult OUH ED Sedation Policy.

DE-ESCALATION TECHNIQUES

De-escalation should always be attempted prior to any form of RoRT (2).

During this process the members of staff should:

- Manage the environment to reduce risks for themselves and for others in clinical area. This may include being on exit side of patient, identifying and disposing of potential weapons, and having extra staff available.
- Use interaction including slow, clear, short sentences, establishing rapport, simple instructions, avoiding using threats, informing the patient, being empathic.

RAPID TRANQUILISATION

AIMS:

a. Minimise patient distress.
b. Reduce the risk of harm to others by maintaining a safe environment.

- Induce a state of calm sufficient to minimise Acute dystonia with antipsychotic medication
- Interaction with pre-existing prescribed medications, alcohol or illicit drugs
- Underlying relevant or co-incidental physical disorders
- Presence of medications that can lengthen the QTc interval
- Be aware of BNF limits through the use of PRN medication given in combination with regular medication; justify exceeding these doses
- In older patients the risks are higher, and BNF maximum dose limits are lower

ROCEDURES (3)

1. Oral (PO) medication should be offered first.
2. PO and intramuscular (IM) routes of administration are usually preferable to intravenous (IV).
3. The IV route should only be used in exceptional circumstances. Patients with a prolonged QTc interval should be medicated with caution (note benzodiazepines do not affect QT interval).

Monitoring after RT

Staff on wards should be familiar with both physical monitoring and visual observation requirements for patients requiring RT (for example 1:1 watching, if allowed off ward, if allowed in toilet alone) and this should be recorded in notes.

REFERENCES

1. NICE Guideline NG10. Violence and aggression: short-term management in mental health, health and community settings. Published: 28 May 2015. Available via: https://www.nice.org.uk/guidance/ng10
2. Patel MX, Sethi FN, Barnes TR, Dix R, Dratcu L, Fox B, Garriga M, Haste JC, Kahl KG, Lingford-Hughes A, McAllister-Williams H. Joint BAP NAPICU evidence-based consensus guidelines for the clinical management of acute

disturbance: de-escalation and rapid tranquillisation. Journal of Psychiatric Intensive Care. 2018 Sep 1;14(2):89-132.

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Pharmacological management of acutely violent or disturbed behaviour

When all non-pharmacological interventions/ de-escalation options have been attempted and failed, and there is unacceptable risk to patient or staff, follow the management algorithm below.

Note for older adults/ frail patients, use half the doses stated below.

FIRST LINE – IS THE ORAL ROUTE AVAILABLE FOR ADMINISTRATION?

YES

Choose ONE of the following:

LORAZEPAM 1-2 mg PO
or
OLANZAPINE 10mg PO
or
HALOPERIDOL 5mg PO

NO

SECOND LINE – IM ADMINISTRATION
Choose ONE of the following:

LORAZEPAM 1-2 mg IM
or
OLANZAPINE 10mg IM
or
HALOPERIDOL 5mg IM

Oral route may not be appropriate where the patient cannot swallow, there are concerns about drug absorption or the situation is urgent.

Ideally a baseline ECG should be carried out before antipsychotic administration. If in *certain circumstances* a baseline ECG is not available, the prescriber should consider the risks and benefits of treatment.

COMMENCE OBSERVATIONS
Monitor temperature, pulse, blood pressure, respiratory rate
Every 15 mins for 1 hour
Then hourly until patient is ambulatory

RESPONSE AT 45 MINUTES?

ORAL RESPONSE INSUFFICIENT:
REPEAT ORAL DOSING AS ABOVE
If 2 oral doses fail, or sooner if the patent is placing themselves or others at significant risk, consider IM treatment

IM RESPONSE INSUFFICIENT:
REPEAT IM DOSING AS ABOVE
N.B. IM lorazepam and IM olanzapine must not be administered within 1 hour of each other

Maximum BNF doses **per 24 hours (oral and IM or combined)**

- Lorazepam 4mg
- Olanzapine 20mg
- Haloperidol 20mg

Discuss with senior medical or psychiatric colleague if these doses are exceeded.

NO RESPONSE:
DISCUSS WITH A SENIOR MEDICAL OR PSYCHIATRIC COLLEAGUE

Further options may include:

- Use of promethazine
- IV sedation
- Specialist medicines including midazolam and ketamine

REMEDIAL MEASURES IN RAPID TRANQUILISATION

Antipsychotic induced acute dystonia (including oculogyric crisis)
Give intramuscular (IM) procyclidine 5 -10mg

Benzodiazepine induced respiratory depression – may require flumazenil and/or critical care intervention. Discuss with senior colleague.