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

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)

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)

**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

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

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 naive or on QTc-prolonging regular medication

Full response  
**Continue physical health monitoring. REVIEW MENTAL STATE AT 1 HOUR**

Partial or no response  
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)

**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

Full response  
**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

<table>
<thead>
<tr>
<th>Problem</th>
<th>Remedial Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute dystonia</td>
<td>Procyclidine IM 5-10mg. Review antipsychotic Rx</td>
</tr>
<tr>
<td>Hypotension (&lt;90mmHg systolic OR &lt;50mmHg diastolic OR &gt;30mmHg postural drop)</td>
<td>Lay patient flat and raise legs</td>
</tr>
<tr>
<td>Bradycardia/arrhythmia (Pulse &lt;50bpm)</td>
<td>Immediate referral to MEAU if antipsychotic used</td>
</tr>
<tr>
<td>Fever (&gt;38°C)</td>
<td>Withhold antipsychotics. Consider Neuroleptic Malignant Syndrome</td>
</tr>
<tr>
<td>Reduced respiratory rate (&lt;10 breaths per minute OR O₂ saturation &lt;95%)</td>
<td>Immediate referral to MEAU, where flumazenil can be administered if benzodiazepine-induced. Give oxygen and lay flat with raised legs</td>
</tr>
</tbody>
</table>

**Physical Health Monitoring**

- Monitor patient **hourly** until no further concerns
- Monitor patient **every 15 mins** if any of these conditions apply

- Mental and behavioural state
- Pulse
- Blood pressure
- Temperature
- Respiratory rate

- 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**

<table>
<thead>
<tr>
<th>Drug and form</th>
<th>Time to peak plasma conc ( \text{conc} )</th>
<th>Half-life</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lorazepam</td>
<td>2 hours</td>
<td>12 hours</td>
</tr>
<tr>
<td>Promethazine</td>
<td>2-3 hours</td>
<td>5-14 hours</td>
</tr>
<tr>
<td>Haloperidol</td>
<td>3-6 hours</td>
<td>10-36 hours</td>
</tr>
<tr>
<td>Olanzapine</td>
<td>5-8 hours</td>
<td>32-50 hours</td>
</tr>
<tr>
<td>Aripiprazole</td>
<td>90 mins</td>
<td>75-146 hours</td>
</tr>
</tbody>
</table>

**Zuclopenthixol acetate (Acuphase)** is NOT rapid tranquilisation

Must only be prescribed by consultant in discussion with pharmacy