Management of Violence and Physically Threatening Behaviour in Adults Guideline

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Brief summary of Document:	This guideline has been developed to ensure a consistent and graduated approach is taken to the safe management of violence and physically threatening behaviour within acute mental health settings.

Scope	This guideline provides advice to all Health Board staff in regards to the safe management of violence and physically threatening behaviour; in particular advice is given on non-pharmacological methods, pharmacological methods and subsequent monitoring required for the rapid tranquilisation (RT) of adults within acute mental health settings

To be read in conjunction with:	268 - Medicines Policy (Acute, Mental Health, Learning Disabilities and Community Services) 008 - Consent to Examination or Treatment Policy 374 - Mental Capacity Act 2005 Policy 176 - Non Medical Prescribing Policy 163 - Deprivation of Liberty Safeguards: Guidance and procedure for staff NICE guideline (NG10) May 2015. Violence and aggression: short-term management in mental health and community settings. https://www.nice.org.uk/guidance/ng10 351- Monitoring and Recording of Adult Physiological Observations And The Response to Physical Deterioration Policy

Owning	Medicines Management Group

Group	

Reviews and Updates		
Version no:	Summary of Amendments:	Date Approved:
1	New Guideline	2/5/2018

Glossary Of Terms:

Term	Definition
RT	Rapid Tranquillisation
RC	Responsible Consultant
SOAD	Second Opinion Appointed Doctor
PRN	Pro re nata (when required)
ECG	Electrocardiogram
CTO	Community Treatment Order
QTc	Corrected QT interval
U&E's	Urea and Electrolytes
NEWS	National Early Warning Score

CONTENTS

1. INTRODUCTION

"Violence and aggression refer to a range of behaviours or actions that can result in harm, hurt or injury to another person, regardless of whether the violence or aggression is physically or verbally expressed, physical harm is sustained or the intention is clear" (NICE NG10).

This guideline gives advice to prescribers and other health care professionals on the use of non-pharmacological and following this, pharmacological methods in reducing the risk of violence and aggression. This guideline gives advice on the short term use of quick acting drugs, their doses and required subsequent monitoring. The use of drugs in this way is not without risks and can be distressing for patients and carers. Therefore, it is prudent to ensure that any interventions are used safely and effectively.

2. SCOPE

This guideline applies to:

- Patients over 18 years of age who are admitted to adult inpatient mental health settings.
- Who are severely agitated and needing an intervention to quickly calm, in order to reduce the risk of imminent and serious violence to self or others.

This guideline must be followed by all healthcare professionals involved in the care of severely agitated patients in an adult inpatient mental health setting. This includes inpatient psychiatric care, emergency and urgent care. Consideration should be given to the frailty of each patient and whether it may be more appropriate to use the lower doses as stated in the older person's algorithm.

This guideline does not encompass advice for the management of violence and physically threatening behaviour in paediatric patients or patients with learning disabilities. Specialist advice should be sought for an individualised management plan in these groups.

3. AIM

The aim of this guideline is:

- To ensure a safe, consistent approach is taken to the consideration and use of interventions required for the management of violence and physically threatening behaviour in mental health settings.

4. OBJECTIVES

The aim of this guideline will be achieved by:

- Prescribing safely within an appropriate legal framework
- Administration of an appropriate intervention when deemed necessary
- Reflection on the intervention

5. THE LEGAL BASIS FOR TREATMENT

Informal Patients or patients under short terms sections and other relevant sections of the MHA to which Part IV of the Act does not apply e.g. Sec 35, 135, 136, 5 (4), 5(2), 4 etc. If the patient is mentally capable of making a decision about treatment, the common law enables him to refuse to be treated for either a physical or mental disorder. However, if the patient is assessed as being mentally incapable of making a decision about treatment, the treatment can be provided under the MCA if it is deemed to be in his best interests.

Detained patients under a section to which Part IV of the Act applies (e.g. S2, S3, S37, S37/41, S36, S38, S47, S47/49, S48, S48/49 etc) who are within the first three months of medication as treatment for mental disorder can be treated without their consent under S63.

Detained patients under a section to which Part IV of the Act applies (e.g. S2, S3, S37, S37/41, S36, S38, S47, S47/49, S48, S48/49 etc) who are beyond the first three months of medication as treatment for mental disorder (section 58), must have a certificate – either a CO2 (patient consenting, RC or SOAD completes), a CO3 (patient not consenting or lacking capacity to consent – SOAD completes) or the treatment must be authorised under S62 (RC completes form) if it is urgent treatment and meets the criteria for the use of S62.

CTO patients are subject to Part IVA of the Act (treatment of community patients not recalled to hospital). For treatment a certificate is required one month from when the patient leaves hospital or 3 months from when the medication was first given to the patient, whichever is the latter. For those patients who have capacity and consent to their treatment a CO8 Certificate can be issued by the patients RC. For those patients who do not have capacity or do not consent to treatment their treatment must be certified by a SOAD (CO7 certificate).

CTO patients who have been recalled to hospital can be treated without consent if their CO7 (SOAD completes) authorises treatment on recall, or, if they meet the criteria for S62, that can be used as authority for urgent treatment.

CTO patients who have been revoked can be treated under S62 whilst provisions are made to comply with S58 – i.e. a CO2 or CO3 certificate.

In the event that treatment is prescribed and administered for those patients who require a certificate/ authorisation for treatment (recalled/ revoked CTO patients and patients to whom S58 applies) the form (whether it be a CO2/ CO3 or S62 form) must give authority for that particular medication to be prescribed and given.

6. ROLES AND RESPONSIBILITIES

Prescribers are accountable for:

- Prescribing the right drug at the right dose via the right route and under an appropriate legal framework
- Specifying minimum time between doses and the maximum dose to be administered in a 24 hour period
- Consider medication already prescribed
- Reviewing the prescription weekly
- Ensuring patients are monitored for side effects and desired effects of any medicines administered
- Documenting rationale and target symptoms treated

Nursing staff are accountable for:

- Exhausting other strategies to calm the patient, as part of the behavioural management plan, before using pharmacological methods
- The safe administration of medicines which includes compliance with minimum time between doses and the maximum dose to be administered in a 24 hour period
- The selection of the right medicines at the right dose via the right route for the purpose of managing acutely disturbed patients
- Ensure medication is administered under an appropriate legal framework
- Subsequent monitoring of patients for side effects and desired effects of any medicines administered
- Notifying medics of any physical deterioration

- Debrief patients
- Debrief staff
- Review interventions and risk management plan

Pharmacists are accountable for:

- Ensuring the prescription for medicines for RT has the right dose, right medicine and right route
- Ensuring appropriate administration of medicines
- Ensuring appropriate subsequent monitoring of side effects and desired effects of any medicines administered
- Ensuring medication is prescribed and administered under an appropriate legal framework
- Ensuring prescriptions are reviewed weekly

7. TREATMENT GUIDELINES

6.1 Non-pharmacological

Extreme agitation, aggression and potentially violent behaviour, if safe to do so, should be in the first instance managed or reduced by non-pharmacological methods deployed by skilled staff. These include behavioural approaches and de-escilation techniques, e.g. talking down, distraction, time out etc. Other non-pharmacological options include: Increased levels of observation, transfer the patient to a psychiatric intensive care unit, the use of restrictive physical interventions or the use of seclusion/segregation.

Even when they do not prevent the need for pharmacological treatment, they will help preserve the therapeutic relationship and improve safety

It is also important to ensure that any developing situation or positive intervention takes into account the individual needs of patients related to:

- Sensory impairment
- Black and minority ethnic patients
- Language, cultural and religious needs and the research that exists that shows black minority and ethnic patients have a tendency to experience over prescribing
- Patients with a physical impairment
- Patients with a cognitive impairment
- Patients with communication difficulties
- Gender and sexual orientation
- Age
- Pregnant patients (see specialist advice)
- Ensure that all interventions are appropriate and propionate to the situation

6.2 Pharmacological Treatments

The common clinical practice of Rapid Tranquilisation (RT) is used when appropriate psychological and behavioural approaches have been unsuccessful. Patients should only be treated with the following medicines after an assessment of risk and when it has been established that the risk of not doing so is greater than the risk of acute pharmacological treatment. The nurse in charge should brief all staff involved in the pharmacological intervention and the course of action required.

For clinical decision making algorithms and drug doses refer to Appendices 1 (for adults) and 3 (older adults).

Consideration should be given to any co-existing medical illnesses, and any regularly prescribed medication, for example:

- Oral antipsychotics:
  - Consider total dose for regular and prn
  - Include depot antipsychotics
- Oral benzodiazepines:
  - Consider benzodiazepines already prescribed for regular administration (additional PRN doses may have little effect)
- Substance misuse or alcohol intoxication
  - Consider using antihistamines over benzodiazepines

Avoid benzodiazepines in patients who are physically unwell, delirious or who have significant respiratory impairment. Use benzodiazepines in preference to antipsychotics in patients with cardiac disease, as these are safer, but beware of accumulation. Benzodiazepines should also be used in preference to antipsychotics in antipsychotic naive patients.

Consider the above carefully as this may impact on dose requirements and potential side effects.

If the total daily combined dose of any medication is above BNF limits, the consultant psychiatrist must be contacted to discuss, out of hours the on-call consultant can be should be consulted. Polypharmacy within a class of medication (e.g. antipsychotics), where at all possible, should be avoided.

Oral medication should be offered before intramuscular (IM) treatment is administered. If oral medication is repeatedly refused, the decision to forcibly medicate a patient (IM) will be taken jointly by medical and nursing staff. Once the decision has been made to forcibly medicate, the patient should be isolated from other patients on the ward. Nursing and medical staff involved in restrictive physical interventions should be proficient in “control and restraint” techniques and should have adequate immunisation against hepatitis B.

Older people
Many older people remain physically fit, though are still likely to have greater sensitivity to side-effects of medication. The lower minimum/maximum dose compared with adults reflects this lower tolerability.

Those least tolerant are older people who are clearly chronically frail or have a concurrent medical illness including dementia, especially Lewy body dementia. Therefore, frail older people should be given only the lowest dose of the dose range.

8. DRUGS USED IN RAPID TRANQUILLISATION

The algorithm for the management of violence and physically threatening behaviour in Adults is in Appendix 1& 3. It contains the recommended doses and medicines to be used.

8.1 Short acting antipsychotics: background information

Drug	Route	Formulations	Pharmacokinetics	Maximum Daily Licensed Doses	Major side effects	Notes
Aripiprazole	IM	7.5mg/mL	Peak 1-3hrs t½ 75-146hrs	Maximum daily dose 30mg including all formulations	Nausea, dizziness, somnolence	No more than 3 injections in 24 hrs Monitor for excessive sedation and postural hypotension
Haloperidol	Oral	5mg and 10mg tablets 2mg/ml liquid	Peak 4 hrs t½ 21 hrs	20mg	EPSE Hypotension NMS Increased QTc Arrhythmias Seizures Sudden death	Note risk of acute dystonias, which is higher in older people. If IM haloperidol is used, consider prescribing 5-10mg procyclidine IM to reduce risk of EPS Caution if using in antipsychotic naive patient. Consider using lorazepam alone or a low dose of haloperidol (2.5mg-5mg). **ECG** is recommended by manufacturer prior to treatment in all patients, owing to rare reports of QTc prolongation and ventricular arrhythmias Never mix haloperidol and lorazepam in the same syringe
	IM	5mg/ml injection	Peak 20 mins t½ 21 hrs	18mg 12mg (elderly)		
Olanzapine	Oral	5mg and 10mg tablets 5mg and 10mg orodispersible tablets	Peak 5-8hrs t½ 32-51hr	20mg including all formulations	Hypotension Bradycardia Syncope	Less likely to cause EPSE than haloperidol Monitor for excessive sedation IM administration results in initial plasma concentration 5 times higher than same dose given orally. N.B. Only an unlicensed IM formulation is available in the UK A maximum of three injections in 24hrs. Olanzapine IM should not be administered for more than 3 consecutive days **IM benzodiazepines cannot be given within 1 hr of IM olanzapine**
	IM	5mg/ml injection	Peak 15-45 minutes t½ 30hrs	20mg including all formulations		
Risperidone	Oral	1mg and 2mg tablets 1mg and 2mg orodispersible tablets	Peak 1-2hrs t½ 18hrs	16mg N.B. Doses above 6mg rarely used as increased incidence of	EPSE Hypotension	Not a highly sedative antipsychotic Can be used in combination with 1-2mg lorazepam

		1mg/ml liquid		PSEs		

8.2 Benzodiazepines

Lorazepam	Oral	1mg tablets	Peak 2hrs t½ 12hrs	4mg (Adults) 2mg (Elderly)	Respiratory depression Disinhibition	Lorazepam should be mixed in a 1:1 ratio with water for injections before administration Doses above BNF limits should be authorised by a consultant psychiatrist and be reviewed regularly
	IM	4mg/ml injection	Peak 60-90mins t½ 12-16hrs	0.1-0.12mg/kg		

Flumazenil

Flumazenil should be administered by a doctor if respiratory rate drops to below 10/min (or oxygen saturation <90%) due to the sedative effects of benzodiazepines. Repeated doses may be required as it is short acting (see section 10 for further dosing details). Flumazenil is best avoided in patients with epilepsy – start mechanical ventilation instead.

Flumazenil is kept in the emergency boxes which can be located on all wards.

8.3 Antihistamines

Promethazine	Oral	25mg tablets 5mg/ml liquid	Peak 2-3hrs t½ 7-15hrs	60mg	Prolonged sedation Seizures Cardiorespiratory depression	IM promethazine is a suitable alternative to IM lorazepam during a national shortage Give by deep IM injection into a large muscle mass. No dilution is required May be considered in those who are antipsychotic naive who have been administered the maximum dose of medication or who are benzodiazepine tolerant
	IM	25mg/ml injection	Peak 1-2hrs t½ 7-15hrs	100mg		

9. DRUGS NOT RECOMMENDED FOR RT

- Oral/IM chlorpromazine (intramuscular is extremely painful and there is a severe risk of severe hypotension)
- IM diazepam (to be avoided due to erratic and slow absorption)
- IM depot antipsychotics (including zuclopenthixol acetate (Clopixol Acuphase®) as the onset of action is delayed and the duration of action is very long.

10. RISKS ASSOCIATED WITH MEDICINES USED IN RT

In certain circumstances prescribing outside the health board guidelines may be appropriate. A risk benefit analysis should be recorded in the patient health record and a rationale in the care plan. Where the risk benefit is unclear, consideration should be given to seeking advice from clinicians who are not directly involved in the care of the patient. There are specific risks associated with the different classes of medications that are used in rapid tranquilisation. The specific properties of the individual drugs should be taken into consideration. When combinations are used, risks may be compounded. (Also see section 7). Staff need to be aware of the following:

For benzodiazepines (i.e. lorazepam)

- Loss of consciousness
- Respiratory depression or arrests
- Cardiovascular collapse (in patients receiving both clozapine and benzodiazepines)
- Paradoxical increases in aggression
- Worsening of delirium – ensure delirium is excluded before using benzodiazepines.

For antipsychotics (i.e. olanzapine and haloperidol)

- Loss of consciousness
- Cardiovascular and respiratory complications and collapse (risk arrhythmias and sudden death)
- Seizures
- Subjective experience of restlessness (akathisia)
- Acute muscular rigidity (dystonia)
- Involuntary movements (dyskinesia)
- Neuroleptic malignant syndrome
- Excessive sedation.

For antihistamines (i.e. promethazine)

- Excessive sedation
- Painful injection
- Additional muscarinic effects
- Hypotension
- Arrhythmias.

Extra care should be taken when implementing rapid tranquilisation in the following circumstances:

- The presence of congenital cardiac conduction abnormality
- The concurrent prescription or use of other medication that lengthens QT intervals on ECG both directly and indirectly
- The presence of certain disorders affecting metabolism, such as stress and extreme emotions, and extreme physical exertion (hypokalaemia, dehydration).

11. MONITORING AND MANAGEMENT OF SIDE EFFECTS

All patients who receive any parenteral drug for RT should have their

- temperature
- pulse
- blood pressure
- respiratory rate.

Monitored by ward staff every 5-10 min for 1 hour (as per table below), then half-hourly until patient is ambulatory. Refer to Appendix 2 for an outline of required safety measures.

Patients who refuse to be monitored or who remain too behaviourally disturbed to be approached should be observed for signs/symptoms of pyrexia, hypotension, over sedation and general physical well-being. For patients that refuse physical monitoring this must be clearly documented in the patient's health records.

In the event of a patient sleeping or who is unconscious, the continuous use of pulse oximetry to measure oxygen saturation is desirable. A nurse should remain with the patient until ambulatory.

ECG monitoring is recommended by the manufacturer of haloperidol prior to treatment in all patients, owing to rare reports of QTc prolongation and ventricular arrhythmias. When parenteral antipsychotics are administered (especially high doses) electrocardiogram and monitoring of U&E's is advised due to the risk of cardiac arrhythmias with hypokalameia, stress and agitation.

For details on the management of side effects after RT, refer to Table 1 below.

The nurse administering the medicine for RT is responsible for subsequent monitoring arrangements. Observations should be recorded on the NEWS chart and any physical deterioration should be referred to a doctor immediately.

Table 1: Management of side-effects

<table>
<tr><th>Problem</th><th>Remedial Measures</th></tr>
<tr><td>Patient asleep</td><td>Monitor patient's respiratory rate every 10 minutes; if unrousable monitor every 5 minutes. If respiratory rate reduced (<10/min) or oxygen saturation falls below 90%, follow guidance below.</td></tr>
<tr><td>Reduced respiratory rate <10/min

Oxygen saturation < 90% (normal is 95-100%)</td><td>Initiate continuous monitoring.

Give oxygen, raise legs, ensure patient is not lying face down.

Respiratory depression is benzodiazepine-induced.
Give flumazenil only if respiratory depression is benzodiazepine-induced.
Flumazenil is kept in the emergency boxes which can be located on all wards.

Guidelines for use of flumazenil
<table>
<tr><td>Contraindications:</td><td>Patients with epilepsy who have been receiving long-term benzodiazepines</td></tr>
<tr><td>Caution:</td><td>Hepatic impairment (titrate dose carefully)</td></tr>
<tr><td>Dose:</td><td>Initial dose: 200microgram intravenously over 15 seconds

If required level of consciousness not achieved after 60 seconds then:

Subsequent doses: 100microgram intravenously over 10 seconds, repeated after 60 seconds if necessary</td></tr>
<tr><td>Maximum dose:</td><td>1mg in 24hours (one initial dose and eight subsequent doses)</td></tr>
<tr><td>Monitoring</td><td>Monitor respiration until rate returns to baseline.
If respiratory rate does not return to normal or patient is not alert after initial doses, assume that sedation is due to another cause and refer to doctor.</td></tr>
</table>
If respiratory depression is induced by other medicines or causes patient will require mechanical ventilation – arrange transfer to ITU immediately</td></tr>
<tr><td>Orthostatic or diastolic hypotension (<50mmHg)</td><td>Lie patient flat, raise legs if possible. Monitor closely</td></tr>
<tr><td>Acute dystonia, including oculogyric crisis</td><td>Procyclidine 5-10mg IM or IV should be given
Older adults: 2.5-5mg</td></tr>
<tr><td>Irregular or slow (<50/min) pulse</td><td>Refer to specialist care immediately. ECG essential</td></tr>
<tr><td>Increased temperature</td><td>Withhold antipsychotics as risk of neuroleptic malignant syndrome (NMS) and perhaps arrhythmia.

▪ monitor closely
▪ cool patient
▪ check creatinine kinase, BP, FBC, U&Es, MSU

Refer to medical team if continued signs of NMS present:
▪ sweating
▪ hypertension or fluctuating BP
▪ tachycardia
▪ muscular rigidity
▪ confusion
▪ agitation
▪ altered consciousness</td></tr>
</table>

12. POST INCIDENT REVIEW

Post incident review by nursing staff should consist of:

- A short feedback session following restrictive physical intervention and sedation (i.e. feedback/debrief) between nursing and medical staff to enable reflection of the incident.
- Debriefing and providing the patient with a post incident support questionnaire and record in their health records. This should aid the patient to describe and discuss their experience with a member of the team if they wish. The carer and/or an advocate may be involved in this process if appropriate. Discuss completion of an advance directive for future preferred treatment options with the patient.
- Completion of a restrictive physical intervention record on Datix system and a detailed entry in the electronic recording system "care partner".
- Updating the patient's risk assessment and individual care plan.
- Sharing of any reflection or learning from staff or patient feedback that may improve the process in the future.

13. REFERENCES

1. BNF via www.medicinescomplete.com accessed Apr 2017
2. NICE guideline (NG10) May 2015. Violence and aggression: short-term management in mental health and community settings. https://www.nice.org.uk/guidance/ng10
3. NICE guideline (CG178) March 2014 Psychosis and Schizophrenia in adults
4. The Mental Health Act 1983 Code of Practice for Wales 2016
5. SmPC for listed medication within policy via www.medicines.org.uk accessed Apr 2017
6. Macpherson, R., Dix, R. and Morgan, S. (2005) A growing evidence base for management guidelines. Revisiting guidelines for the management of acutely disturbed psychiatric patients. Advances in Psychiatric Treatment. 11: 404-415.
7. TREC Collaborative Group. (2007) Rapid Tranquillisation for agitated patients in emergency psychiatric rooms: a randomized trial of midazolam versus haloperidol plus promethazine. BMJ; 335:865.
8. Huf G et al. (2007) Rapid Tranquillisation in psychiatric settings in Brazil: pragmatic randomized controlled trial of intramuscular haloperidol versus intramuscular haloperidol plus promethazine. BMJ; 335;869
9. Pratt P, Chandler-Oatts J, Nelstrop L et al (2008). Establishing gold standard approaches to rapid tranquillisation: A review and discussion of the evidence on the safety and efficacy of medications currently used. Journal of Psychiatric Intensive Care; 1:9-23.
10. Paton, C., Barnes, T., Cavanagh, M.R., Taylor, D. and Lelliott, P. (2008) High dose and combination antipsychotic prescribing in acute adult wards in the UK: the challenges posed by p.r.n. prescribing. British Journal of Psychiatry. 192: 435-439.
11. Innes J, Iyeke L. (2011) A review of the practice and position of monitoring in today's rapid tranquillisation protocols. Journal of Psychiatric Intensive Care. 0:1-10

Acknowledgements

The guidelines have also been adopted from those of:
The Maudsley Prescribing Guidelines
Southampton University Hospitals NHS Trusts. Adult Rapid Tranquilisation: Policy and Guidance for use in Patients Displaying Acutely Disturbed or Violent Behaviour Oct 2014
East London NHS Foundation Trust. Rapid Tranquilisation Policy for Adults and Older People August 2014

14. APPENDIX 1: ALGORITHM FOR THE MANAGEMENT OF VIOLENCE AND PHYSICALLY THREATENING BEHAVIOUR IN ADULTS

Acutely disturbed or violent behaviour in Adults

Start with

Non-pharmacological measures
e.g. De-escalation, time out, placement etc (as appropriate)

Then

Offer Oral drug treatment

Consider the following as first-line treatment options (especially if unknown or no history of previous antipsychotic use):

- Lorazepam 1-2mg
- Promethazine 25-50mg

Consider an antipsychotic if NOT already taking a regular oral or depot antipsychotic

- Olanzapine 10mg OR
- Risperidone 1-2mg OR
- Haloperidol 5mg (last resort, pre-treatment ECG required)

Continue non-drug measures, if that doesn't work after 45-60 minutes (wait longer with promethazine), try

Further oral drug treatment, as above
Combine sedatives and antipsychotics, if necessary

Consider IM treatment if two oral doses fail or sooner if the patient is placing themselves or others at significant risk

Intramuscular (IM) Treatment

- **Lorazepam 2mg** → Have flumazenil to hand in case of benzodiazepine induced respiratory depression

OR

- Promethazine 25-50mg → IM promethazine is a useful option in a benzodiazepine-tolerant patient

OR

- Aripiprazole 9.75mg → Less hypotension than olanzapine but may be less effective

OR

- Olanzapine 10mg → IM olanzapine and IM benzodiazepine administrations should be separated: At least 1 hour for lorazepam

OR

- Haloperidol 5mg → Haloperidol should be the last drug considered
  High incidence of acute dystonia; ensure IM procyclidine is available – pre-treatment ECG required

If that doesn't work after 30-60 minutes, try

Further IM drug treatment, as above (including combinations)
Combinations* ***Never mix 2 drugs in the same syringe**
Lorazepam + Haloperidol OR Promethazine + Haloperidol (last resort + ECG)

If that doesn't work after 30-60 minutes

Seek expert advice from the consultant or senior clinical pharmacist on-call

15. APPENDIX 2: SAFETY MEASURES

Safety Measures

Always have available for immediate use

- Flumazenil
- Facilities for mechanical ventilation
- Pulse oximeter
- Sphygmomanometer
- Thermometer

For all patients receiving parenteral treatment,
monitoring consists of:

- Temperature
- Pulse
- Blood Pressure
- Respiratory rate

Every 5-10 minutes for 1 hours, then half hourly until the patient is up and about

Patients who refuse to have their vital signs monitored or who remain too behaviourally disturbed to be approached should be observed for signs of:

- Pyrexia
- Hypotension
- Oversedation
- General physical deterioration

For patients who are fully sedated (very deep sleep or unconscious),
also monitor:

- Oxygen saturation (by pulse oximetry)
- Ensure airway is clear

Nurse to remain with patient until they are up and about

For all IM antipsychotics, it is strongly recommended to have a:

- Pre-treatment ECG

16. APPENDIX 3: ALGORITHM FOR THE MANAGEMENT OF VIOLENCE AND PHYSICALLY THREATENING BEHAVIOUR IN

Older Adults

Acutely disturbed or violent behaviour in Older Adults

Start with

Non-pharmacological measures
e.g. De-escalation, time out, placement etc (as appropriate)

Then

Offer Oral drug treatment

Consider the following as first-line treatment options (especially if unknown or no history of previous antipsychotic use):

- Lorazepam 0.5-1mg
- Promethazine 25-50mg

Consider an antipsychotic if NOT already taking a regular oral or depot antipsychotic

- Olanzapine 2.5mg - 10mg OR
- Risperidone 0.5-1mg OR
- Haloperidol 2.5-5mg(last resort, pre-treatment ECG required)

Continue non-drug measures, if that doesn't work after 45-60 minutes (wait longer with promethazine), try

Further oral drug treatment, as above
Combine sedatives and antipsychotics, if necessary

Consider IM treatment if two oral doses fail or sooner if the patient is placing themselves or others at significant risk

Intramuscular (IM) Treatment

• **Lorazepam 0.5-1mg**	Have flumazenil to hand in case of benzodiazepine induced respiratory depression
OR	
• Promethazine 12.5-25mg	IM promethazine is a useful option in a benzodiazepine-tolerant patient
OR	
• Aripiprazole 5.25mg - 9.75mg	Less hypotension than olanzapine but may be less effective
OR	
• Olanzapine 2.5-5mg	IM olanzapine and IM benzodiazepine administrations should be separated: At least 1 hour for lorazepam
OR	
• Haloperidol 0.5 – 2.5mg	Haloperidol should be the last drug considered High incidence of acute dystonia; ensure IM procyclidine is available – pre-treatment ECG required

If that doesn't work after 30-60 minutes, try

Further IM drug treatment, as above (including combinations)

Combinations* ***Never mix 2 drugs in the same syringe**

Lorazepam + Haloperidol OR Promethazine + Haloperidol (last resort + ECG)

If that doesn't work after 30-60 minutes