This is an example produced by one trust detailing what a local protocol for rapid tranquillisation might look like. (Adapted from Pereira et al, 2004, ‘Management of Acute Disturbance’ (in press), Journal of Psychiatric Intensive Care, September 2004).

North East London Mental Health NHS Trust

Management of acutely disturbed patients (under 65) – rapid tranquillisation protocol

This protocol should be used unless there is an advance directive (written in front of the prescription chart) with the patient that may be appropriate. Ensure the patient is not allergic to medication used.

**AIMS:**
- To reduce suffering for patients (psychological and self harm)
- To reduce harm to others by maintaining a safe environment
- To do no harm

**STEP 1**

Unsuccessful

1. Check existing regular and prn prescribed medication and dosage.
2. Check co-morbid medical illness, ie cardiac disease, diabetics.
4. Impaired hepatic/renal function may need dose reduction.

**STEP 2**

Offer oral therapy

- **lorazepam 2mg**
  (sedation in 30-45 mins, peaks 1-3 hrs, lasts 4-6 hrs)
- +/- **olanzapine 10mg**
  (peaks 5-8 hrs, half-life 30-38 hrs)
- **or risperidone 2mg**
  (peaks 1-2 hrs, half-life 24 hrs)
- **or haloperidol 5mg**
  (sedation in 1 hr, peaks 1-6 hrs, half-life 1-2 hrs)

Patient refuses oral medication

**Guidance notes**

When rapid tranquillisation is used, there should be comprehensive documentation in the case notes.

**Legal status**
- Try to obtain informed consent.
- Cannot enforce medication on MHA section 5(2), 4 and 136 except under Common Law of necessity
- In detained non-consenting patients one requires treatment under MHA section 62 Urgent Treatment.

**Medication**
- Discuss with multidisciplinary team regarding continuation of regular medication during rapid tranquillisation.
- Need to monitor total daily doses (reg and prn) of each medicine used and this needs to be reviewed every 24 hours. Highlight concerns with senior doctor.
- If there is cardiac disease or patient is neuroleptic naïve use lorazepam alone if possible.
- In some circumstances up to 4 mg of lorazepam may be appropriate as a single dose.
- Atypical drugs should be considered in the choice of first-line treatments.
- For faster onset of action combine lorazepam and an antipsychotic (not for IM olanzapine).
- For very urgent tranquillisation use combination of IM Lorazepam and IM haloperidol.
- IM lorazepam should always be diluted with equal volume of water for injection to prevent muscle necrosis.
**STEP 3**

**Option 1**
- IM lorazepam 2mg
  - (Sedation in 30-45 mins, peaks 1-3 hrs lasts 4-6 hrs)
- IM haloperidol 5mg
  - (Sedation in 10 mins, peaks in 20 mins, half-life 12-35 hrs)

Wait 1 hour, no response inform duty doctor

**STEP 4**

**Option 2**
- IM olanzapine 10mg
  - (5 mg or 7.5 mg may be given on the basis of individual clinical status, i.e., 5 mg in renal/hepatic impairment)
  - (Peaks 15-45 mins, half-life 30-38 hrs)
- Wait 2 hours, no response inform duty doctor and consult senior doctor if maximum dose of olanzapine reached

**STEP 5**

- IM lorazepam 2mg
  - (Sedation in 30-45 mins, peaks 1-3 hrs lasts 4-6 hrs)
- IM olanzapine 5-10 mg
  - (5 mg in renal/hepatic impairment)
  - (Peaks 15-45 mins, half-life 30-38 hrs)

Wait 1 hour, no response inform duty doctor

**STEP 6**

- Give zuclopenthixol acetate (Clopixol Acuphase)
  - Avoid in neuroleptic naïve patients
  - 50-150 mg IM
    - First dose between 50 and 100 mg depending on size of patient, risk, clinical picture, and previous response. Sedation in 1-2 hrs; peaks at 36 hrs, lasts 72 hrs.
    - DO NOT REPEAT within 24 hours.

Consult senior doctor for further advice regarding other strategies, i.e., option to repeat step 4 or go to step 6

(Check total daily dose of regular and prn medication)

Consult senior doctor for further advice regarding other strategies, i.e., option to repeat step 4 or go to step 6

(Need to monitor excessive sedation and cardiorespiratory depression)

**DO NOT MIX the injections in the same syringe**

**Mandatory medical/nursing observations**
- Record observations at least every 15 minutes for one hour, then every 30 minutes until patient is ambulatory. Need to monitor respiration, pulse, BP, temperature on form RT1. If
  - Respiration rate is less than 10/min
  - Pulse less than 60/min
  - Fall in blood pressure
  - Systolic < 80 mm/Hg
  - Diastolic < 50 mm/Hg
  - Increased temperature > 37°C

**Post rapid tranquillisation**

Patient and staff need to be offered the opportunity to discuss the incident requiring rapid tranquillisation, and patients need to be encouraged to record their account in the notes/RT1 form.

Ensure availability of:
- procyclidine injections for acute dystonic reactions 5-10 mg IM repeated after 20 minutes if necessary, followed by procyclidine orally
- flumazenil
  - For benzodiazepine induced respiratory depression
    - 200 micrograms over 15 seconds then 100 micrograms repeated every 60 seconds until desired level of consciousness is obtained.
    - Read instructions carefully at this point.
  - flumazenil has a short half-life and respiratory function once recovered may deteriorate again
  - Seizures can occur