Medication Safety Series: MSS 21

Pharmacological Management of Severe Agitation

Key references: Rapid Tranquillisation Policy (Trust intranet); NICE: NG10

Tees, Esk and Wear Valleys NHS Foundation Trust

Key principles:

- Individuals with behaviours that challenge should be identified, risk assessed and have a regularly reviewed intervention plan - this can include pro-active prescription & administration of **oral** PRN medication.
- Rapid tranquillisation should only be used where a patient is highly aroused, agitated, overactive or aggressive, or is making serious threats towards themselves or others, or is being destructive to their surroundings, when pro-active interventions have been ineffective in supporting a reduction in such behaviour.

What is Rapid Tranquillisation (RT):

✓ RT is a **reactive** management strategy; it is the **intramuscular** administration of medication, usually under restraint, to calm or sedate an agitated, violent or aggressive patient.

× RT is not the proactive use of oral PRN medication to manage an agitated patient to prevent escalation to violence or aggression

Administration of Rapid Tranquillisation:

! **Physical restraint should not be used for more than 10 minutes without considering RT or seclusion.** RT or seclusion may be used sooner if deemed clinically appropriate; conversely, physical restraint may continue without RT or seclusion if the event is resolving, but the need for RT or seclusion must be continuously reconsidered.

× Never mix two drugs in the same syringe

✓ Use a site for IM administration which maintains patient dignity and reduces risk.

Post-administration monitoring:

✓ The highly aroused condition of the patient may intensify the effects of RT medication. Physiological observations must be monitored for 3 hours after RT administration, using the NEWS2 tool.

! **NEVER events:**

× **NEVER** use RT prior to pro-active interventions, unless the patient's behaviour presents a serious risk to themself, other patients, staff or the physical ward environment.

× **NEVER** administer a combination of drugs for RT in the same syringe.

× **NEVER** leave a patient unmonitored for physical or mental health deterioration after administration of RT.

Prescribing Rapid Tranquillisation (RT):

! The MHA/MCA status of the patient must be considered before RT medication is prescribed

× **DO NOT routinely** prescribe RT medication on admission.

✓ If an event is highly likely, a single dose may be prescribed as "once only" on EPMA for initial management. A doctor **MUST** attend or be consulted before a second dose is prescribed / administered.

✓ In the absence of medical staff on the ward (e.g. over a weekend), the administration of second and subsequent doses of RT must be discussed with the duty doctor on-call and, if possible, the duty nurse co-ordinator.

✓ RT may be prescribed "PRN" for individuals who have undergone a thorough psychiatric assessment prior to or during admission which has identified a high risk of disturbed behaviour likely to result in violence and aggression which would require restraint and intervention.

✓ The rationale for PRN prescribing must be recorded in the electronic patient record (EPR).

✓ All prescriptions of RT medication must be reviewed within 72 hours of admission, and regularly thereafter, and discontinued when appropriate to do so.

✓ Drugs suitable for RT:

- First-line options - Haloperidol* +/- promethazine (off-label), **OR** lorazepam
- Alternatives available for IM administration: Aripiprazole & olanzapine

× Do not use zuclopenthixol acetate (Clopixol Acuphase®), chlorpromazine and diazepam for RT

! Caution is required in antipsychotic naive patients e.g. risk of NMS

✓ See the RT policy for age-specific algorithms

! Consider anti-cholinergic burden in the elderly

✓ Prescribe RT medication separately to regular or PRN prescriptions for the same drug orally

× Do not use two drugs of the same class for RT

✓ Prescribe PRN procyclidine in case of dystonia with haloperidol

*baseline ECG recommended prior to use; if hasn't been done, or QT-interval prolonged, document risk vs benefit in EPR if prescribed/administered.

Title	MSS21 – Pharmacological Management of Severe Agitation	*To obtain a more accessible version of this document, please email:* Tewv.pharmacyadmin@nhs.net
Approved	22 May 2025 V2.0	
Review by	01 June 2028	