Use of oral ‘as required’ medication for agitation in adults

NHS
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NHS Foundation Trust

Scope of this interactive guide:

Managing lower levels of agitation (mild to moderate in severity) with oral ‘as required’ medication, including proactive use of non-pharmacological methods to prevent escalation to more severe behavioural disturbance

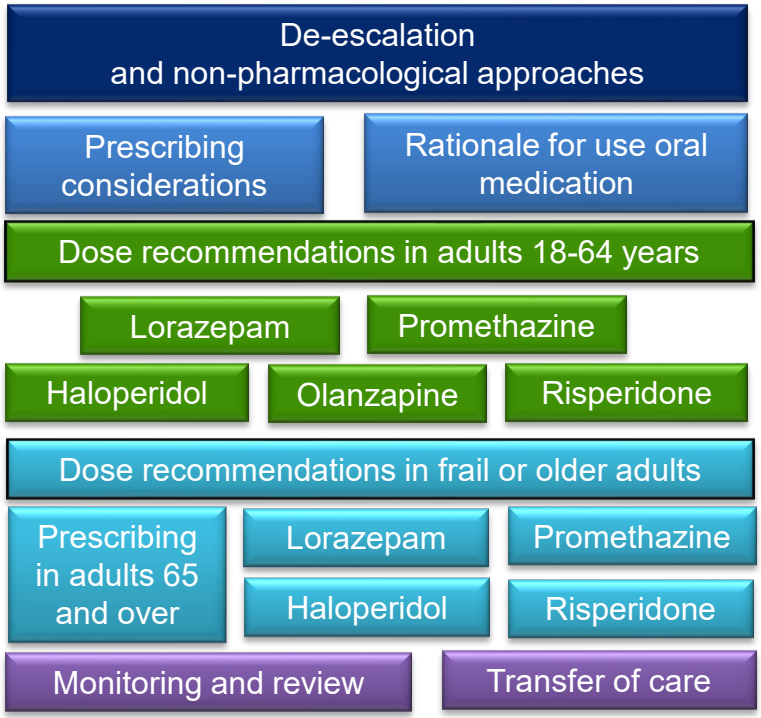
- If anxiety is the main symptom refer to anxiety medication pathway
- In the **management of severe behavioural disturbance, where pro-active use of oral ‘as required medication’ has not prevented escalation**, consult MSS21 Pharmacological Management of Severe Agitation and Rapid Tranquillisation Policy

This guide aims to encourage:

- Initial use of non-pharmacological de-escalation techniques
- Pro-active use of ‘as required’ medication to prevent escalation cycles
- Regular review and de-prescribing of ‘as required’ prescriptions
- Clear rationale and plan to minimise risk of withdrawal if longer term ‘as required’ prescribing is clinically indicated
- Safe transfer of care

The guide aims to discourage:

- Unnecessary routine ‘as required’ prescribing



These standards should be read in conjunction with: Supporting Behaviours that Challenge policy

- MSS33: Standards for ‘as required’ prescribing and administration
- Behavioural & Psychological Symptoms of Dementia – Summary of pharmacological treatment options for BPSD

Further guidance Links to the trust policies and guidance: Medicines Optimisation – Interactive Guide

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De-escalation

De-escalation and non-pharmacological approaches

- Recognise the early signs of agitation, irritation, anger and aggression.
- Understand the likely causes of aggression or violence, both generally and for each service user. Use techniques for distraction and calming, and ways to encourage relaxation.
- Recognise the importance of personal space.
- Respond to a service user's anger in an appropriate, measured and reasonable way and avoid provocation.
- On initial signs of agitation / aggression offer (and document response to) non-pharmacological methods of behavioural support to try to de-escalate.
- Consider and address physical causes for patient's presentation.
- Consult Behavioural Support Plan (if in place) before prescribing or administering 'as required'.

Patient Centred Care

Treatment and care should consider individual needs and preferences. Service users should have the opportunity to make informed decisions about their care and treatment, in partnership with their healthcare professionals.

Consider:

- using the Safewards tools available at Talk Down and Calm Down Methods
- trauma informed care and 'being with distress'

These standards should be read in conjunction with: Supporting Behaviours that Challenge policy

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Prescribing Considerations

Good practice points:

- ✓ **Advance preparation of individualised management plans** to minimise risk of acutely disturbed behaviour.
- ✓ **Regular review** of behaviour support plans including 'as required' psychotropics. On long-stay wards/units, management plans are expected for ALL 'as required' psychotropic medication.
- ✓ **Early intervention** is desirable to bring disturbed behaviour under control as soon as possible.
- ✓ **Optimise regular medication**
- ✓ **Avoid long term use of 'as required' medication to manage agitation**
- ✓ **Consider additional 'as required' doses of the regular antipsychotic** instead of introducing a second antipsychotic (N.B. potential to trigger high dose antipsychotic therapy)
- ✓ **After administration** of PRN medication document on Electronic Patient record (EPR) the presentation/symptoms managed, response and any interventions to prevent (or delay) need for PRN medication.
- ✓ **Monitor for side-effects** and adjust doses, consider alternatives or pharmacological management symptoms.
    - ✓ Antipsychotics – LUNSERS, GASS and SESCAM rating scales are available on EPR
- ✓ **Regular review of 'as required' medication** (see MSS33 for best practice)
- ✓ Aim to **stop PRN medication before discharge** by continuing to review and plan reduction (see MSS33)
- ✓ PRN medication can cause sedation and **can impair driving**. See information about driving.

Electronic Prescribing Medicines Administration (EPMA) - inpatients

- Common 'as required' drugs/doses are on EPMA as regimen. When using to prescribe, check they are clinically appropriate.
- **Always set** review date on EPMA and document these reviews on EPR or EPMA.
- When administering PRNs the 24-hour period is a rolling 24 hours.

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Rationale for use (oral PRN)

When prescribing 'as required' (PRN) medication as part of strategy to de-escalate or prevent situations that may lead to violence & aggression:

- × Don't prescribe PRN medication routinely or automatically on admission
- ✓ **Tailor PRN medication** to individual need and include discussion with the service user if possible.
- ✓ Clearly **document rationale** and circumstances in which PRN medication may be used
- ✓ Ensure **minimum interval** between PRN doses is specified
- ✓ Ensure **maximum daily dose** is clearly specified.
  - ✓ Consider the lowest effective dose for the patient, this can be lower than licensed maximum dose in 24 hours
  - ✓ if multiple routes of same drug needed and/or regular and PRN prescribing (ensuring doesn't inadvertently exceed the maximum daily dose stated in BNF).
  - ✓ Only exceed the BNF maximum daily dose (which will be 'off-label'), for a clear agreed therapeutic goal, documented and under the direction of a senior doctor. For antipsychotics consider if this is High Dose Antipsychotic (HDAT)
- ✓ Best practice is to avoid **administration of regular and PRN sedating medication together or multiple oral PRN medicines,** if clinically indicated the prescriber must indicate the order in which the medicines should be used (e.g. "1st line", "2nd line") and under what circumstances.
- ✓ Prescribe PRN for the shortest time possible to manage the clinical presentation

Pharmacological approaches click on drug links for **dose recommendations:**

Dose recommendations in adults aged 18-64 years

Promethazine | Lorazepam | Antipsychotics

Dose recommendations in adults 65 years & over

Lorazepam

Promethazine

Antipsychotics

TEWV Patient Information Leaflets (Choice & Medication)

Dose recommendations for ORAL Agitation Treatment – Adult aged 18-64 years

ALWAYS prescribe lowest effective dose

Drug	Dose	Minimum Dose Interval	Maximum dose per 24 hours	Risks, side-effects and monitoring
Anxiety & Agitation (where anxiety is the primary presenting symptoms consult anxiety medication pathway)				
Lorazepam	500 microgram to 1mg (2mg)[1]	Four hours	4mg[2] (including any IM given)	• Effective, short-acting benzodiazepine with rapid reduction symptoms • For short-term use, maximum 4 weeks; after which risk of withdrawal effects. For longer use clearly document rationale and plan for withdrawal.

Prescribing notes:

[1]can increase to 2mg on consultant recommendation

[2]higher doses only used on consultant recommendation

Other benzodiazepines:

Clonazepam – off-label indication for severe agitation / aggression for patients on PICU pyramid; initiated by consultant psychiatrist, with a plan to reduce and stop before discharge from inpatient episode

Diazepam – longer acting, can be used once a day. See Anxiety medication pathway – adjunctive medicines for further guidance

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Dose recommendations for ORAL Agitation Treatment – Adult aged 18-64 years (1 of 2)

ALWAYS prescribe lowest effective dose

Drug	Dose	Minimum Dose Interval	Maximum dose per 24 hours	Risks, side-effects and monitoring
Anxiety & Agitation (where anxiety is the primary presenting symptoms consult anxiety medication pathway)				
Promethazine (**off-label indication** with limited evidence base)	25mg (50mg)[3]	Four hours	100mg (including any IM given)	• QT-interval prolongation, particularly with other drugs which have this effect. ECG – recommended before prescribing if at risk of QTc prolongation (pre-disposing condition or interaction). • Abuse – potentiates the 'high' from opioids. May lead to dependence and risk in overdose. • Prescribing as hypnotic for insomnia alone isn't recommended • Sedating and has high anti-cholinergic effects (ACB / AEC = 3), associated with increased cognitive impairment side effects such as confusion, dizziness & falls • Despite its GREEN formulary[4] status transfer of prescribing at discharge from inpatient wards is **strongly discouraged**. See PSS3 Promethazine for managing agitation and insomnia . In community settings, initiation should be **minimised** – any request to primary care to initiate, or continue established use, should include a clear indication and rationale, and a plan for review of efficacy and tolerability

Prescribing notes: [3]can increase dose to 50mg on consultant recommendation

[4]transfer of prescribing guidance: Safe transfer of prescribing guidance & MSS18 Safe Transfer of Psychotropic Medication

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Dose recommendations for ORAL Agitation Treatment – Adult aged 18 – 64 years (2 of 2)

ALWAYS prescribe lowest effective dose

Drug	Dose	Minimum dose Interval	Maximum dose per 24 hours	Risks, side-effects and monitoring
Psychotic Agitation or Severe Agitation (where oral treatment accepted) If patient is on a regular antipsychotic, consider adding in additional 'as required' doses of the regular antipsychotic rather than adding in a second antipsychotic. Always consider if the prescription will require High Dose Antipsychotic (HDAT) monitoring.				
Haloperidol	3mg[4] to 5mg	Four hours[5]	15mg[6] (including any IM given)	• ECG before prescribing especially if antipsychotic naïve. May potentiate QT interval. Particularly with other drugs which have this effect. See QTc guidance. • Can cause EPSE (consider need for procyclidine - see MSS35), drowsiness, hypotension and increased risk falls
Olanzapine	2.5mg to 5mg	Four hours[5]	20mg (including any IM given)	
Risperidone	1 to 2mg	Four hours[5]	16mg	• Use if haloperidol not clinically appropriate
Zuclopenthixol	• Oral zuclopenthixol can be considered as alternative to Clopixol acuphase (zuclopenthixol acetate). • High potency dopamine antagonist. Risk of severe EPSE in antipsychotic naive patients or if not received medication of equal potency to or higher than risperidone.			

Prescribing notes: [4] some patients respond to lower initial dose of 1.5mg

[5]dose repeated after 1hour if used to avoid escalation to Rapid Tranquilisation.

[6]TEWV maximum recommended dose is 15mg in 24 hours. The BNF licensed dose is 20mg in 24 hours by any route.

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Prescribing ‘as required’ medication for agitation in Adults 65 years & over

Key Prescribing Principles in adults 65 years and over

- Consider co-morbid physical health problems
- Avoid medications with adrenergic or cholinergic antagonism due to hypotensive and negative cognitive effects (see Medichec for review of adverse effects)
- Caution with medications with long half-lives or active metabolites due to prolonged effects
- Use lower initial doses than for younger adult population due to potential for adverse-effects
- Potential for dependence and tolerance, consider following STOPP/START toolkit

Polypharmacy

The diagnosis of multiple medical conditions increases with age and frequently leads to polypharmacy. Medications prescribed for one condition may have negative effects on another or may interact with another medication. Polypharmacy increases the risk of adverse effects and admission to acute hospital. Polypharmacy also increases the risk of poor medication adherence (tablet burden) and administration errors due to confusing medication regimens.

Toxicity

- Older age is associated with higher rates of accidental and intentional overdose
- There are significant differences in toxicity between medication classes requiring careful consideration with people with history of overdose

Pharmacological approaches click on links for **Dose recommendations:**

Lorazepam | Promethazine | Antipsychotics

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Dose recommendations for ORAL Agitation Treatment in **Adults 65 years and over (1 of 2)**
ALWAYS prescribe lowest effective dose

Drug	Dose	Minimum Dose Interval	Maximum dose per 24 hours	Risks, side-effects and monitoring
Anxiety & Agitation where anxiety is the primary presenting symptoms consult anxiety medication pathway				
Lorazepam	500 microgram to 1mg[1]	Four hours	2mg (including any IM given)	• For short term use, maximum 4 weeks. For longer use clearly document rationale. • Risk of falls, over-sedation and confusion; and withdrawal effects if used long-term.
Promethazine (unlicenced indication) Avoid in elderly	12.5 to 25mg (50mg)[2]	Four hours	50 - 100mg (including any IM given)	• Sedating and has high anti-cholinergic effects (ACB / AEC = 3), associated with increased cognitive impairment side effects such as delirium, dizziness & falls – avoid in the elderly, and prioritise the elderly for deprescribing • QT-interval prolongation, particularly with other drugs which have this effect. ECG – recommended before prescribing if at risk of QTc prolongation (pre-disposing condition or interaction). • Use with caution in hepatic and renal impairment. No need to reduce in renal impairment but monitor for excessive sedation. • Despite its GREEN formulary status transfer of prescribing at discharge from inpatient wards is **strongly discouraged**. See PSS3 Promethazine for managing agitation and insomnia

Prescribing notes:

[1]can increase to 1mg if clinically indicated [2]can increase dose to 50mg on consultant recommendation

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Dose recommendations for ORAL Agitation Treatment in **Adults 65 years and over (2 of 2)**
ALWAYS prescribe lowest effective dose

Drug	Dose	Minimum dose Interval	Maximum dose per 24 hours	Risks, side-effects and monitoring
Psychotic Agitation or Severe Agitation (where oral treatment accepted) If patient is on a regular antipsychotic, consider adding in additional 'as required' doses of the regular antipsychotic rather than adding in a second antipsychotic. Always consider if the prescription will require High Dose Antipsychotic (HDAT) monitoring.				
Haloperidol	500 micrograms to 1mg	Four hours[2]	2mg[3] (including any IM given)	• ECG pre-prescribing / antipsychotic naïve. • Cause drowsiness, hypotension and EPSE (see MSS 35). • Increased risk of falls
Risperidone[4]	500 micrograms	Four hours[2]	4mg[4]	• Use if haloperidol not clinically appropriate • ECG pre-prescribing / antipsychotic naïve. • Cause drowsiness, hypotension and EPSE (see MSS 35). Increased risk of falls

Prescribing notes:

[2]dose repeated after 1 hour if used to avoid escalation to Rapid Tranquilisation

[3]maximum daily dose of 2mg only to be exceeded with consultant approval to a maximum 5mg orally in 24 hours

[4]reduced maximum dose 2mg in 24 hours in dementia

If managing agitation as part a dementia diagnosis see guidance Behavioural & Psychological Symptoms of Dementia – Summary of pharmacological treatment options for BPSD

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Prescribing: Monitoring & Review of PRN psychotropics

- PRN psychotropic medication should be reviewed every 7 to 14 days, with EPMA automatically prompting a review after 14 days. After the first review is complete, manually change the review date on EPMA to a further 7-14 days, unless documented on EPR or EPMA that a review is no longer required. MSS33: Standards for 'as required' prescribing and administration
- Reviews should be done more frequently if events are escalating and restrictive interventions are being planned or used.
- Monitor response, effectiveness, benefits and side effects, this should be documented either in the EPMA review section or on EPR
- Review and discontinue if symptoms have resolved or the medication has not been administered within the last 2 weeks (every 4 weeks on long stay wards)
- If there is a need for repeated administration of 'as required' psychotropics then consider review and optimisation of regular medication.
- Assess appropriateness from a case note review and analysis of 'as required' administration.
- Aim to stop PRN medication before discharge by continuing to review and plan reduction
- Consider any potential for withdrawal effects when 'as required' medication is to be stopped depending on the frequency it has been used and the duration of treatment. If there is a risk of withdrawal effects, e.g., with benzodiazepine medication, then a withdrawal plan should be implemented. See current NICE guidance around benzodiazepine withdrawal Benzodiazepine and z-drug withdrawal | Health topics A to Z | CKS | NICE

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Leave and Transfer of Care (discharge) for Psychotropic PRN medication

- The aim is not to supply psychotropic PRN medication for leave and Transfer of Care prescriptions.
- If supplied, prescriptions should specify the indication for the 'as required' medication e.g. use first for agitation, include the frequency that the medication should be used and the maximum daily dose. Prescriptions should specify the exact quantity of 'as required' doses to be supplied by pharmacy to cover the period of leave/discharge.
- For leave, the 'as required' medication should be reviewed. In most cases psychotropic 'as required' medication will no longer be required.
- If it is considered appropriate to supply the medication for leave, the prescriber should look at the number of doses administered per day over the previous five days to help decide the number of doses to issue on the prescription. Consider reducing the prescribed dose to reflect current levels of use. The patient's safety summary should also be consulted to identify and overdose risk.
- For **transfer of care**; if found appropriate to supply, the minimum quantity possible should be supplied. The prescriber should look at the number of doses administered per day over the previous five days to help decide the quantity to be issued for transfer of care. Usually, a maximum of 7 days medication would be provided. The patient's safety summary should also be consulted to identify and overdose risk.
- If psychotropic 'as required' medication is to continue then ideally this should be discussed at the transfer of care meeting. The transfer of care letter should either identify that the supply is to stop after the current issue or include information on when the medication should be reviewed, why it was continued and who is responsible for reviewing it.
- Nursing staff should give a clear description to the patient of how to use the 'as required' medication for leave or at Transfer of Care (discharge). Advice should be given around driving if required: Safe and legal driving in the UK for people with mental health problems - Handy Fact Sheet
- If appropriate, patients and/or carers should be provided with information leaflets on the medication TEWV Patient Information Leaflets (Choice & Medication)

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Appendix 1: Reference List

- Update information | Violence and aggression: short-term management in mental health, health and community settings | Guidance | NICE
- Benzodiazepine and z-drug withdrawal | Health topics A to Z | CKS | NICE
- Stopping (deprescribing) benzodiazepines and z-drugs | Right Decisions
- Ashton Manual - Benzodiazepine Information Coalition

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