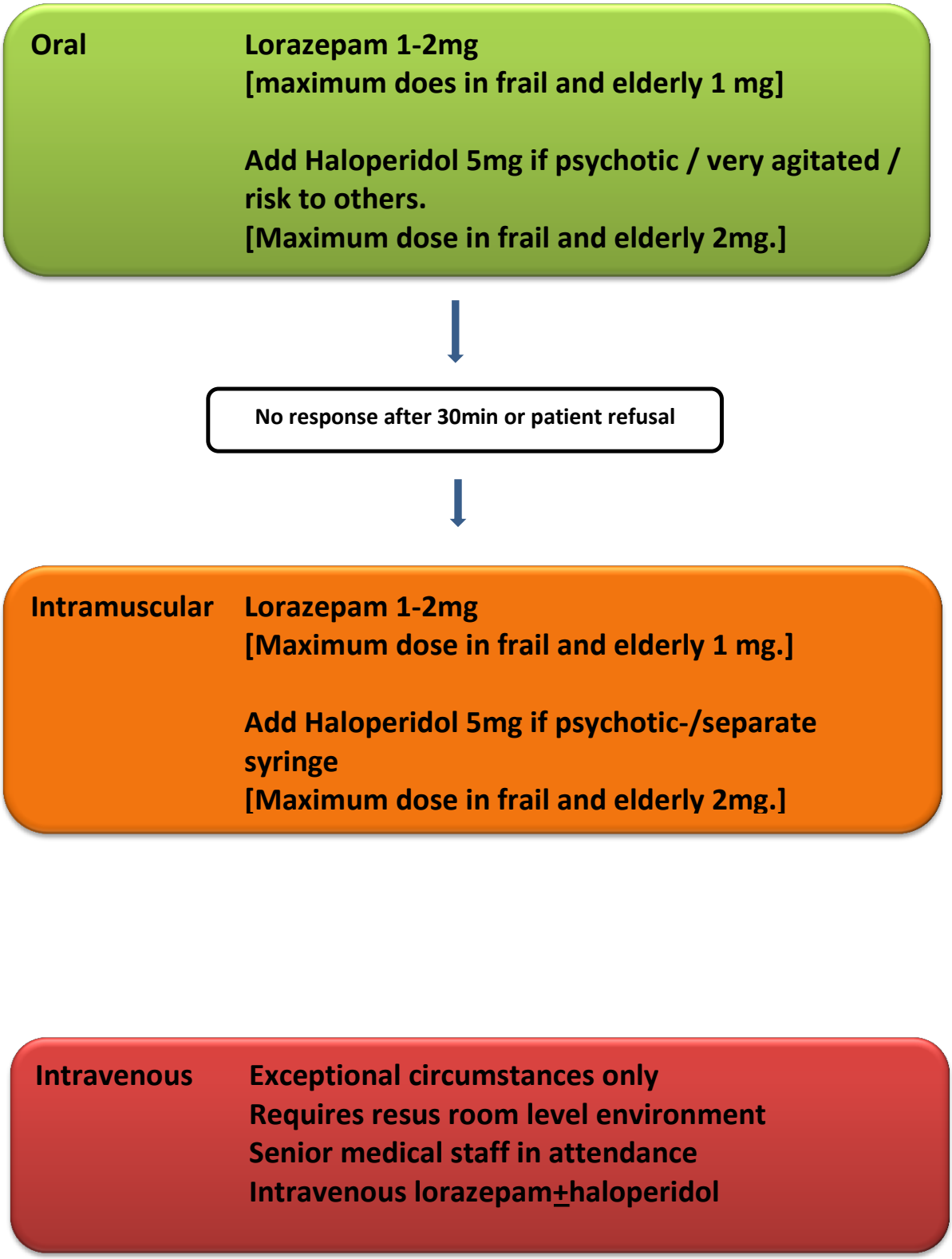
Rapid Tranquilisation protocol for patients presenting with agitation and physical aggression

- This protocol should only be used under the direction of senior medical staff
- Situation de-escalation techniques should tried first, and be continued.
- An urgent referral should be made to the Liaison Psychiatry Team.
- Use lowest doses possible, to maintain patient verbal communication for safety.
- Monitor vital signs every 15min until full recovery and watch for over sedation leading to loss of airway, cardiovascular collapse and coma
- Benzodiazapenes (Lorazepam) are the first line for drug intoxication or withdrawal
- Avoid Haloperidol if QTc prolongation or drugs that prolong it, cardiac disease, Parkinson's Disease, Parkinsonism, Lewy Body Dementia , seizures or visual hallucinations are present.
- Flumazenil if respiratory rate <10 after Lorazepam.
- Olanzapine is licensed for patients with schizophrenia or mania only instead of haloperidol. Quick release velotab available. Oral 10mg (2.5-5mg in elderly]. Note Olanzapine should not be given I.M.
- If effect essential by 30min due serious risk from prolonged restraint-consider starting with intramuscular route


Oral
Lorazepam 1-2mg
[maximum does in frail and elderly 1 mg]
Add Haloperidol 5mg if psychotic / very agitated / risk to others.
[Maximum dose in frail and elderly 2mg.]
No response after 30min or patient refusal
Intramuscular
Lorazepam 1-2mg
[Maximum dose in frail and elderly 1 mg.]
Add Haloperidol 5mg if psychotic-/separate syringe
[Maximum dose in frail and elderly 2mg.]
Intravenous
Exceptional circumstances only
Requires resus room level environment
Senior medical staff in attendance
Intravenous lorazepam±haloperidol