TYPES OF SEDATION

ANXIOLYSIS

- Inducing relief of apprehension / agitation

HYPNOTICS

- Sleep inducing medication
- Help treat Insomnia

RAPID TRANQUILLISATION

- **Medicines given to a person who is very agitated or displaying aggressive behaviour and is a risk to themselves or others**
- **Aim to quickly calm patient and reduce risk**

TYPES OF MEDICATION

BENZODIAZEPINES

LORAZEPAM

Short-acting Benzodiazepine hypnotic agent used in treatment of anxiety / agitation

Common starting dose PO IM:
- Adult: **1-2mg**
- Elderly / Renal or Liver Failure: **0.5-1mg**

Maximum Daily Dose:
- **4mg daily**
- **2mg daily** in Elderly / Renal or Liver Failure

Avoid:
- Severe Renal or Liver failure
- CNS / Respiratory depression
- Sleep aponea
- **Poor mobility / falls risk**

DIAZEPAM

Medium-acting Benzodiazepine hypnotic agent used in treatment of anxiety / agitation

Common starting dose PO TDS:
- Adult: **2mg**
- Elderly / Renal or Liver Failure: **1mg**

Avoid:
- Severe Renal or Liver failure
- CNS / Respiratory depression
- Sleep aponea
- **Poor mobility / falls risk**

Z DRUGS

ZOPICLONE

Non-benzodiazepine hypnotic agent used in treatment of short term insomnia

Common Dose PO ON:
- Adult: **7.5mg**
- Elderly / Renal or Liver Failure: **3.75mg**

Avoid:
- Severe Renal or Liver failure
- CNS / Respiratory depression
- Sleep aponea
- **Poor mobility / falls risk**

TYPICAL ANTI-PSYCHOTIC

HALOPERIDOL

D2 receptor antagonist

Common starting dose PO or IM:
- Adult: **2.5mg**
- Elderly / Renal or Liver Failure: **0.5mg**

Maximum Daily Dose:
- **1-10mg** daily in 1-3 divided doses
- **0.5-5mg** daily in Elderly / Renal or Liver Failure

Start lowest dose and adjust increments 2-4 hours as required. Not to exceed maximum daily dose

Avoid:
- Parkinsons disease
- CNS / Respiratory depression
- Cardiac disease - especially prolonged QT
- **Poor mobility / falls risk**

ATYPICAL ANTI-PSYCHOTIC

OLANZAPINE

Not routinely used for organic confusion but controlling agitation in schizophrenia and mania

D2 receptor antagonist + $5HT_2$ receptor antagonist

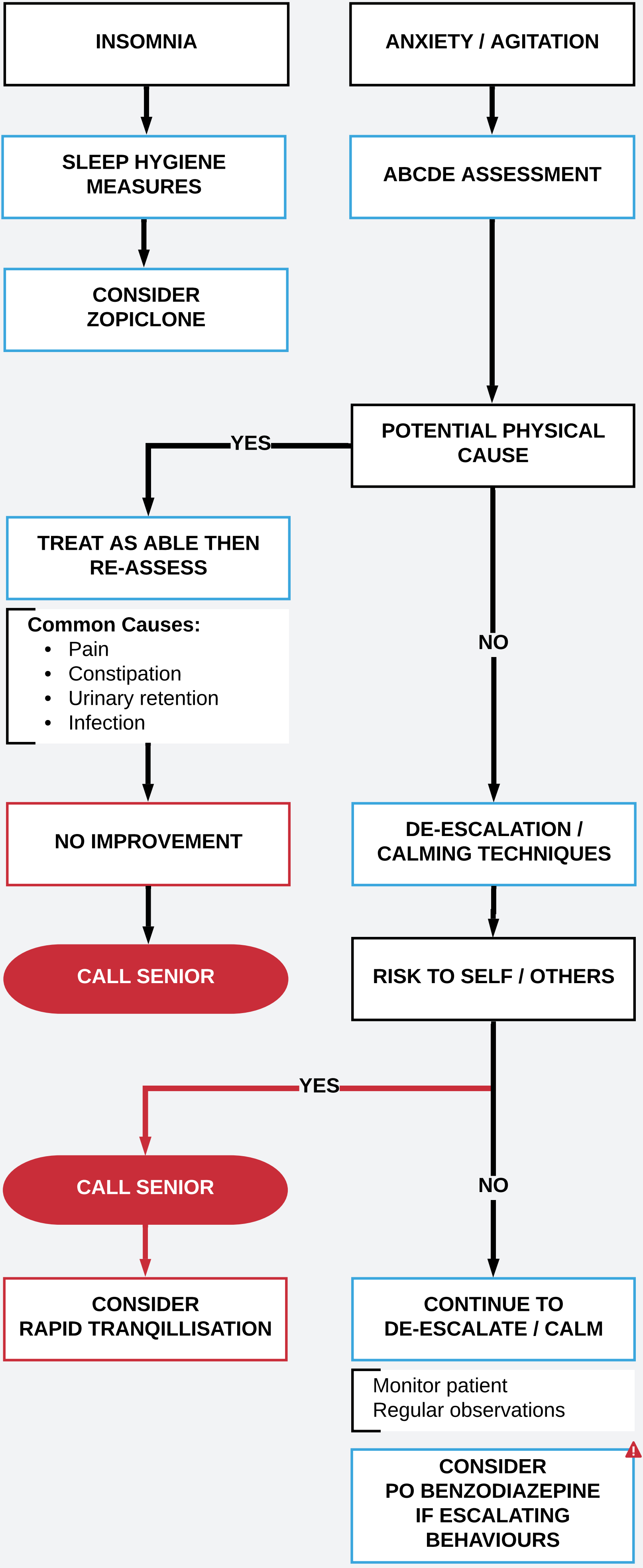
Common starting dose IM:
- Adult: **10mg**
- Elderly / Renal or Liver Failure: **2.5mg**

Maximum Daily Dose:
- **20mg** daily in 1-3 divided doses

Start lowest dose and adjust increments 2 hours as required. Not to exceed maximum daily dose

Avoid:
- Parkinsons disease
- CNS / Respiratory depression
- Cardiac disease - especially prolonged QT
- **Poor mobility / falls risk**

GENERAL MANAGEMENT ADVICE



INSOMNIA

SLEEP HYGIENE MEASURES

CONSIDER ZOPICLONE

ANXIETY / AGITATION

ABCDE ASSESSMENT

POTENTIAL PHYSICAL CAUSE

YES

TREAT AS ABLE THEN RE-ASSESS

Common Causes:

- Pain
- Constipation
- Urinary retention
- Infection

NO IMPROVEMENT

CALL SENIOR

NO

DE-ESCALATION / CALMING TECHNIQUES

RISK TO SELF / OTHERS

YES

CALL SENIOR

CONSIDER RAPID TRANQUILLISATION

NO

CONTINUE TO DE-ESCALATE / CALM

Monitor patient
Regular observations

⚠ **CONSIDER PO BENZODIAZEPINE IF ESCALATING BEHAVIOURS**

RAPID TRANQUILLISATION

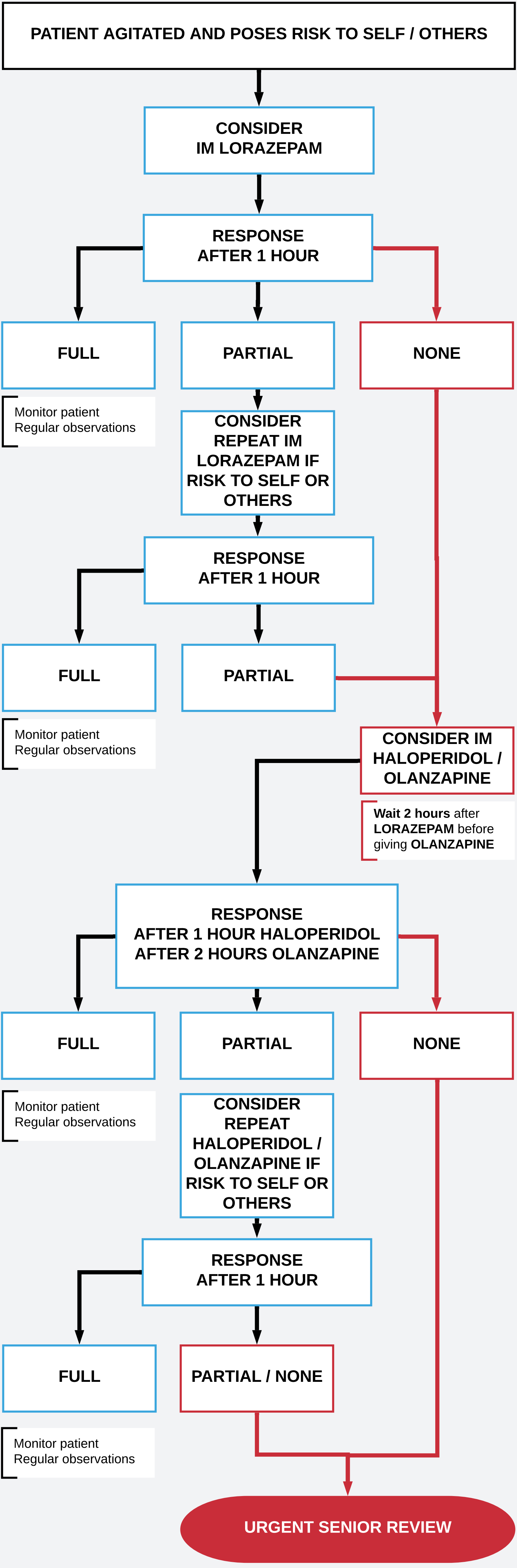
Rapid Tranquillisation is used when patients pose a risk of harm to themself or others. It is not a method of making a patient easier to manage

Rapid Tranquillisation has risks and should be avoided unless absolutely required. Always discuss with your SENIOR

Rapid Tranquillisation Risks:

- Over-sedation causing loss of consciousness
- Loss of airway
- Cardiovascular collapse:
  - Arrhythmias / Hypotension / Sudden death
- Respiratory depression
- Acute dystonia
- Neuroleptic Malignant Syndrome
- Interaction with medication (prescribed or illicit including alcohol)
- Damage to the therapeutic relationship
- Underlying coincidental physical disorders

Always consult local guidelines on Rapid Tranquillisation administration and patient monitoring



PATIENT AGITATED AND POSES RISK TO SELF / OTHERS

CONSIDER IM LORAZEPAM

RESPONSE AFTER 1 HOUR

FULL

Monitor patient
Regular observations

PARTIAL

CONSIDER REPEAT IM LORAZEPAM IF RISK TO SELF OR OTHERS

RESPONSE AFTER 1 HOUR

FULL

Monitor patient
Regular observations

PARTIAL

NONE

CONSIDER IM HALOPERIDOL / OLANZAPINE

Wait 2 hours after **LORAZEPAM** before giving **OLANZAPINE**

RESPONSE
AFTER 1 HOUR HALOPERIDOL
AFTER 2 HOURS OLANZAPINE

FULL

Monitor patient
Regular observations

PARTIAL

CONSIDER REPEAT HALOPERIDOL / OLANZAPINE IF RISK TO SELF OR OTHERS

RESPONSE AFTER 1 HOUR

FULL

Monitor patient
Regular observations

PARTIAL / NONE

NONE

URGENT SENIOR REVIEW

RAPID TRANQUILLISATION COMPLICATIONS AND MANAGEMENT

ALWAYS CALL SENIOR URGENT REVIEW

IRREGULAR PULSE BRADYCARDIA	• Monitor, assess rhythm and manage as per guidance • **Crash trolley if signs of syncope**
HYPOTENSION	• Fluid resuscitation as required
ACUTE DYSTONIA	• **PROCYCLIDINE 5-10mg IM**
REDUCED RESPIRATORY RATE	If RR < 10 and due to **LORAZEPAM**: • **CONSIDER FLUMAZENIL 200mcg IV 15secs (DISCUSS WITH SENIOR -risk of seizure)** ◦ Further 100mcg after 1 minute if no response ◦ Can repeat 100mcg after 1 minute to maximum 1mg in 24 hours **May require ITU intervention**
NEUROLEPTIC MALIGNANT SYNDROME	**Signs:** • Fever • Muscle rigidity • Autonomic disturbance **Bloods:** • FBC / U&E / CK **May require ITU intervention**

Always consult BNF for dose / administration and contraindications for all above medications