Acute behavioural disturbance management (including acute sedation) in Queensland Health Authorised Mental Health Services (adults)

1. **Purpose**

   This Guideline describes the best practice processes for a systematic and safe approach to the administration of acute sedation when de-escalation of acute behavioural disturbance has not been successful.

   In circumstances where an individual’s needs dictate a variation from this Guideline, discussion with a consultant psychiatrist or emergency physician is indicated and the clinical reasoning behind such a decision must be fully documented.

2. **Scope**

   This Guideline provides information for all Queensland Health employees (permanent, temporary and casual) and all organisations and individuals acting as its agents (including Visiting Medical Officers and other partners, contractors, consultants and volunteers) working within Authorised Mental Health Services (AMHS).

3. **Related documents**

**Authorising Policy and Standard/s:**


- *Mental Health Act 2016* (Qld)
- Chief Psychiatrist Policy, Clinical need for medication 2017
- Chief Psychiatrist Policy, Notification to Chief Psychiatrist of Critical Incidents and Non-Compliance with the Act 2017
- *Health (Drugs and Poisons) Regulation 1996*
- National Standards for Mental Health Services 2010
- National Safety and Quality Health Service Standards 2012, standards 4 and 9

**Procedures, Guidelines and Protocols:**

- Guideline for acute behavioural disturbance management (including acute sedation) in Queensland Health Authorised Mental Health Services (children and adolescents)
- Guideline for management of patients with acute severe behavioural disturbance in emergency departments 2016
4. Guideline for acute pharmacological management of behavioural disturbance (adults)

4.1 Indications

Acute sedation may be the only clinically appropriate treatment option when consumers are extremely agitated, threatening violence, are actually violent and/or are a danger to themselves or others. Acute sedation should only occur after attempts to manage the behavioural disturbance with de-escalation techniques and oral medication have proven unsuccessful.

An assessment of likely contributing factors to the behaviour will assist decision making on how to proceed. These may include medical illness (e.g. causing pain or delirium), psychiatric illness, situational factors and personality issues.

The aims of the management of the acute behavioural psychiatric emergency are to:

- calm the individual and thereby manage extreme agitation, aggression and potential violent behaviour that put the individual or those around them at risk of physical harm
- reduce psychological suffering
- reduce physical distress
- maintain a safe environment for the consumer and others
- prescribe safe regimens e.g. to calm (rather than to sedate to unconsciousness)
- monitor physical health
- do no harm.

4.2 Consent/medico-legal considerations

The use of acute sedation does not preclude the consumer from providing consent to treatment. Wherever possible, consumers should be offered the opportunity to consent to treatment. If the consumer refuses treatment or cannot consent, involuntary treatment under the Mental Health Act 2016 (MHA) or the Guardianship and Administration Act 2000 (GAA) may be possible, if the criteria within the legislation are met.

Children under the age of 16 should not be sedated without the consent of the parent(s)/guardian and before conferring with a consultant psychiatrist, except in emergency circumstances. Refer to the Guideline for acute behavioural disturbance management (including acute sedation) in Queensland Health Authorised Mental Health Services (children and adolescents).

Involuntary treatment may be applied under the following:

- MHA – Treatment Authority
- MHA – Treatment Support Order
- MHA – Forensic Order (Mental Health Court)
- MHA – Recommendation for Assessment, where treatment is for the purpose of safe transfer to, within, or between AMHS
• GAA – for urgent intervention to prevent harm or distress to an adult consumer who lacks capacity to consent.

In addition, the Criminal Code Act 1899 removes criminal liability for medical treatment performed or provided in good faith, with reasonable care, and for the benefit of the consumer.

Staff must ensure that documentation is accurate, comprehensive and contemporaneous in the progress notes, observation chart and medication charts.

4.3 Principles for acute sedation

• Acute sedation must be used only when clinically indicated and must not be used as a form of punishment, for convenience, or as a substitute for other more appropriate treatments.
• No sedation guideline is 100 per cent safe. Sedation is used when de-escalation fails. Confirm that there is no other medical cause for a consumer’s altered mental state.
• Great care must be taken when considering acute sedation for children or adolescents, elderly, frail or medically compromised consumers where toxicity is more common.
• All staff involved in acute sedation must be trained in resuscitation.
• Acute sedation must be carried out in a clinical area that has ready access to emergency response equipment.
• Acute sedation must involve a medical review as soon as practicable. Acute sedation without medical review should only be used where circumstances require such action in order to prevent harm that may be caused by the conduct of that person if not acutely sedated.
• Prior to the initiation of parenteral sedation, consumers will be given every opportunity to take oral sedation.
• If parenteral treatment is necessary, the intramuscular (IM) route is preferred.
• Repeated smaller doses of oral or IM medication to achieve the desired sedation endpoint are preferred to the use of a single larger dose because it allows tolerance to be assessed.
• Be aware of the total medication load in the previous 24 hour period including PRN medication.
• Frequent administration of ‘as needed’ (PRN) medication for more than 24 hours may indicate an inadequate regimen of regular medication, necessitating a review by the treating team.
• Frequent PRN IM injections of antipsychotic medication—especially when used over extended periods of time—increases the risk of neuroleptic malignant syndrome.
• The total dose of medication prescribed in acute sedation for an acutely disturbed consumer must be reviewed regularly by a consultant psychiatrist at least every 24 hours and Pharmacist if possible.
• Acute sedation shall be clearly and accurately recorded, providing details of the medication administered, route, clinical indication, monitoring, response, adverse incidents and reviews.
• All efforts must be made to maintain the consumer’s privacy, dignity and confidentiality.
• Prior to administration, visitors and other consumers should be supported to leave the area, as witnessing the sedation may be a distressing experience for them.
• The consumer should be given an opportunity in the post-sedation phase to discuss the reasons for and circumstances of the sedation episode.
• Consumers should not be discharged from hospital until they are in an alert and mobile state.
• Due to the potential for delayed side effects, if discharged from hospital, consumers, and their carers where possible, should be given written documentation of medications, doses given, side effects and warnings.
• An operational debrief should be offered to the staff involved in the management of an aggressive incident.
• Regular local review of incidents should occur to identify common issues and quality improvement opportunities.
• Incidents must be reported to the Chief Psychiatrist as per the requirements of the Chief Psychiatrist Policy and Practice Guidelines, Notifications to Chief Psychiatrist of Critical Incidents and Non-compliance with the Mental Health Act 2016.

4.4 Precautions
Refer also to section 4.8 Adverse reactions.

<table>
<thead>
<tr>
<th>Precaution</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adolescents under 16 years and those with low body weights</td>
<td>May need much smaller doses&lt;br&gt;For further guidance refer to the Guideline for acute behavioural disturbance management (including acute sedation) for children and adolescents, and/or contact the child and adolescent consultant psychiatrist</td>
</tr>
<tr>
<td>Older adults (60 years and over)</td>
<td>May require lower doses due to reduced organ function and/or medical illness/frailty&lt;br&gt;Chlorpromazine contraindicated&lt;br&gt;For further guidance, contact the older persons mental health service consultant psychiatrist</td>
</tr>
<tr>
<td>Pregnant women</td>
<td>Use lowest possible dose for efficacy&lt;br&gt;Oral diazepam 5 mg/dose up to a max of 15 mg daily and/or oral and/IM olanzapine 5 mg/dose PRN up to a max of 20 mg daily may be administered&lt;br&gt;If higher doses are needed, discuss with on-call consultant psychiatrist&lt;br&gt;Avoid chlorpromazine&lt;br&gt;For further guidance in the absence of an on-call consultant psychiatrist, contact consultation liaison psychiatry, perinatal consultant/nurse</td>
</tr>
<tr>
<td>Medical illness</td>
<td>Avoid tranquillisation where behavioural disturbance is likely secondary to a serious medical condition for which there is a specific emergency treatment, e.g. hypoglycaemic crisis or hypoxia due to acute asthma</td>
</tr>
<tr>
<td>Intellectual impairment or acquired brain injury</td>
<td>Can be very sensitive to pharmacological sedation and high drug doses should be avoided</td>
</tr>
<tr>
<td>Substance withdrawal (including alcohol)</td>
<td>Longer acting Diazepam is preferred. Consider IM thiamine 100 mg ASAP followed by 100 mg thiamine orally three times daily to prevent Wernicke’s Syndrome</td>
</tr>
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</table>
### Precaution

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<td>Swallowing problems</td>
<td>Heavy sedation (especially with antipsychotics) or delirium is associated with increased risk of aspiration</td>
</tr>
<tr>
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<td>Prescribing for rapid tranquilisation should proceed with caution for consumers with pre-existing dysphagia</td>
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<tr>
<td>Delirium</td>
<td>Should not be treated with benzodiazepines—sedative/alcohol withdrawal delirium is an exception</td>
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<tr>
<td></td>
<td>Low dose Risperidone is preferable</td>
</tr>
<tr>
<td>History of neuroleptic malignant syndrome</td>
<td>Use benzodiazepines alone or with Quetiapine</td>
</tr>
<tr>
<td>Medically compromised, cardio-respiratory risk factors and/or on Clozapine</td>
<td>Chlorpromazine contraindicated</td>
</tr>
<tr>
<td>Medically compromised, markedly intoxicated, dehydrated or have never received antipsychotic medication (neuroleptic naïve)</td>
<td>Halve the recommended dosages</td>
</tr>
<tr>
<td>Concomitant administration of IM olanzapine and parenteral benzodiazepines</td>
<td>Avoid due to risks of extreme hypotension, bradycardia and respiratory depression</td>
</tr>
</tbody>
</table>

### 4.5 Prior to acute sedation

A medical assessment should be performed on admission and again, where possible, prior to acute sedation. The assessment should ideally involve:

- physical observations
- brief neurological examination
- blood results (urea, electrolytes, creatinine, FBC, TFT, and glucose)
- ECG (useful for establishing baseline QT interval which may be prolonged by neuroleptics)
- pulse oximetry
- signs of dehydration should be noted and must be managed accordingly (dehydration is associated with an increased risk of neuroleptic malignant syndrome).

If a medical assessment is not able to be conducted, the reasons must be documented in the clinical file and a note made regarding observations of general physical state.

**Note:** There are a number of clinical considerations to take into account such as the possibility of underlying medical/neurological conditions or the potential for female consumers to be pregnant. If this is suspected, advice must be sought from the relevant specialists to determine medication selection and dose.
4.6 Processes for sedation

Step 1: non medication measures—de-escalation

D—don’t threaten to withdraw privileges, seclude or medicate
E—ensure safety of those in the environment
E—escapes, don’t corner the person or get cornered
S—stance, adopt protective stance
C—calm, non-threatening manner
A—allow for ventilation of anger and distress
L—leave the area and person if secure and safe to do so
A—assistance, ensure enough suitably skilled staff are available
T—time out, offer time out in quiet room / lounge
I—invite to sit and verbalise concerns
O—options, offer options, e.g. large motor exercise, music, beverage
N—never turn your back

Step 2: medication—oral (preferred medication option)

Principles

• Aim to calm with light sedation.
• Prior to administration of additional PRN, calculate the total daily dose of all oral medications given in the previous 24 hours.
• If acute admission via emergency department (ED), check whether any medication was administered en route to the ED, or in the ED.
• If two doses are given without effect, nursing staff to prompt the registrar to seek consultant psychiatrist advice.
• Avoid polypharmacy (no more than two antipsychotic agents within a 24 hour period).
• The development of delirium is possible and the underlying medical cause needs to be treated first.
• Ensure concise accurate documentation of all medication given and response to it, including rationale for change.

Process

• Individual doses may be given 60 minutes apart until maximum dosage reached.
• Contact consultant psychiatrist if a higher than recommended dose is considered.
• Therapeutic choice points:
  - First line medication is the preferred option. If a sub-therapeutic response is obtained after the first dose, titrate with second dose at the lower end of interval time and dose.
  - If a nil or minimal response is obtained after the first dose, consider moving to second line medication.
### Indications: mild arousal, may be irritable, willing to talk and cooperative

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<tr>
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<td>Peak effect at 1–3 hours</td>
<td>5–10 mg; repeat after 60 minutes if needed—max 20 mg in 24 hours including regular doses</td>
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<td>1 mg orally stat; repeat after 60 minutes if needed—max 8 mg in 24 hours</td>
<td>To exceed 20 mg in 24 hours, seek advice from a consultant psychiatrist</td>
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<td><strong>Medication naïve, elderly or physically frail:</strong></td>
<td>Maximum dose must not exceed 30 mg in 24 hours</td>
</tr>
<tr>
<td>0.5–1 mg; repeat after 2 hours if needed—max 4 mg in 24 hours</td>
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### Indications: moderate or severe arousal, highly agitated, abusive, uncooperative, threat or actual violence to self or others

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<td>10 mg; repeat after 60 minutes if needed—max 20 mg by any route in 24 hours, including regular doses</td>
</tr>
<tr>
<td>2 mg orally stat; repeat after 30–60 minutes if needed</td>
<td>To exceed 20 mg in 24 hours, seek advice from a consultant psychiatrist</td>
</tr>
<tr>
<td>Do not exceed 8 mg in 24 hours</td>
<td>The maximum total dose must not exceed 30 mg in 24 hours</td>
</tr>
<tr>
<td>Can increase to 12 mg in 24 hours with consultant psychiatrist approval</td>
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</table>

Only proceed to step 3 if not accepting oral medications or response to step 2 is unsatisfactory

**Step 3: short acting IM medications**

**Principles**
- Issues of consent must be addressed—refer to 4.2 Consent/medico-legal considerations.
- IM droperidol and midazolam are not recommended.
- **Warning: do not give lorazepam IM and olanzapine IM within 60 minutes of each other.**
- If two IM doses given without effect, nursing staff to report promptly to registrar to seek consultant psychiatrist’s advice.
- Calculate the total daily dose of all oral and IM medications given in the previous 24 hours before the administration of additional PRN.
- Ensure staff are available to safely restrain the person (where necessary) during administration. Refer to restraint diagram at Figure 1.
- Medical officer to review every 24 hours and change back to oral as soon as possible.
- Ensure concise accurate documentation of all medication given and response to it, including rationale for changes.
Warning: Do not give lorazepam IM and olanzapine IM within 60 minutes of each other.

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<tr>
<td><strong>IM Lorazepam</strong>&lt;br&gt;Peak effect at 1–3 hours&lt;br&gt;2 mg repeat after 60 minutes if needed—max 8 mg in 24 hours&lt;br&gt;Can increase up to 12 mg within 24 hours with consultant psychiatrist approval</td>
<td><strong>IM olanzapine</strong> if lorazepam regimen inadequately sedates (do not commence within 60 minutes of Lorazepam)&lt;br&gt;Olanzapine 10 mg repeat after 2–6 hours if needed—max 20 mg in 24 hours&lt;br&gt;To exceed 20 mg in 24 hours seek advice from a consultant psychiatrist&lt;br&gt;The maximum dose must not exceed 30 mg in 24 hours</td>
</tr>
<tr>
<td><strong>Medication naïve, elderly or physically frail</strong>&lt;br&gt;0.5 mg repeat after 1–2 hours if needed—max 4 mg in 24 hours</td>
<td><strong>Medication naïve, elderly or physically frail</strong>&lt;br&gt;Olanzapine 2.5–5 mg repeat after 2–4 hours if needed—max 15 mg in 24 hours</td>
</tr>
</tbody>
</table>

Figure 1 Illustration of the main five immobilisation points for supine restraint

1. Head
2. Right upper arm and right forearm
3. Right thigh and right lower leg
4. Left upper arm and left forearm
5. Left thigh and left lower leg
Step 4: intravenous route

Indications: severe arousal, not accepting medication, where a rapid, predictable outcome is essential

- Notify consultant psychiatrist.
- Only use when least invasive method to secure safety of consumer and staff has failed.
- Site of administration must be secure (refer to restraint diagram at Figure 1).
- Monitor airway, pulse, O₂ saturation (pulse oximetry), respiration rate, BP, patient colour, pupils, neurological status, limb power, and temperature.
- If unresponsive and/or changes occur in level of consciousness expected, a Glasgow Coma Scale (GCS) assessment may be required, and consideration given to making a Medical Emergency Team (MET) call.
- Escalate as per Q-ADDS – mental health indicators.

Note: If the purpose of the acute sedation is to briefly anaesthetise, this must be done in consultation with an appropriately trained specialist e.g. anaesthetist or intensivist.

IV Diazepam recommendations

- Administration of medication must be at strict 10 minute intervals.
- 5–10 mg; if initial dose fails to achieve cooperation or ‘rousable’ drowsiness within 10 minutes, then administer 2.5–10 mg.
- Repeat every 10 minutes as clinically indicated not exceeding a maximum dose of 60 mg in 24 hours.
- Seek consultant psychiatrist advice if there is no response after the second 10 mg dose or a suboptimal response at a total of 60 mg.

Step 5: management of prolonged/sustained disturbed behaviour

- Longer acting IM medications—consultant psychiatrist authorised only:
  - Not recommended for routine use for acute behavioural disturbance management, but may be considered as an option when disturbed/violent over extended time (24–48 hours), past history of good response, or past history of repeated IM administration.

Warning: never administer to antipsychotic naïve, elderly or physically frail, co-administration of short acting IM medications, or as PRN. Not recommended for use in children/adolescents.

IM Zuclopenthixol Acetate (Clopixol Acuphase®) dose recommendations

- Adult dose 50–100 mg IM, repeat if necessary after 24 hours.
- Maximum dose: no more than 400 mg or four injections over a two week period.
- Individual injections should be spaced at least 24 hours apart.
- Allow 2–4 hours for onset of effect. Peak effect commonly reached after 12–18 hours.
- Effects may last up to 72 hours, therefore requiring longer monitoring.

4.7 Monitoring/observation–post acute sedation

- Ensure observation and monitoring of mental state and sedation level following administration of oral, IM or IV medication.
- Consumers must be under constant visual observation following IM and IV medication until it is clear that they are not over-sedated and have a patent airway. Treating staff may then monitor as clinically appropriate.
Note: respiratory depression can occur with Lorazepam or other benzodiazepines, particularly in combination with antipsychotics.

Flumazenil should be available for reversal if required (Use with caution in consumers who are known to be longstanding benzodiazepine users as they are likely to experience symptoms of acute withdrawal).

Physical observations may be difficult to perform on consumers who are agitated or aggressive. Reasons for not performing observations should be clearly documented and discussed with the treating doctor.

All monitoring should be recorded on the Q-ADDS for Mental Health Facilities form.

The level of observations is determined by the level of sedation:

<table>
<thead>
<tr>
<th>Arousal level</th>
<th>Level of monitoring</th>
</tr>
</thead>
<tbody>
<tr>
<td>Awake</td>
<td>Observe level of alertness every 15 mins for first hour then half hourly for 8 hours</td>
</tr>
<tr>
<td>Easy to rouse</td>
<td>Vital observations* at 30 min interval</td>
</tr>
<tr>
<td>Can’t stay awake</td>
<td>Vital observations* at 10 min intervals</td>
</tr>
<tr>
<td>Difficult to rouse</td>
<td>Vital observations* at 5 min intervals</td>
</tr>
<tr>
<td>Unresponsive</td>
<td>Call medical emergency</td>
</tr>
</tbody>
</table>

*Vital observations*—pulse, \(O_2\) saturation (pulse oximetry), blood pressure, respiratory rate, airway, sedation scale, pupils, limb power, blood glucose level (BGL).

- Temperature every four hours.
- Check for signs of dystonia or any deterioration.
- Vital observations continue until the consumer is alert and mobile.
- All observations must be recorded.
- Due to the potential for delayed side effects, if discharged from hospital, consumers and their carers if possible should be provided with written documentation of medications, doses given, side effects and warnings.

**Note:** If a consumer is uncooperative, as a minimum, observe and document the following: position and movements, respiration rate and physical signs of oxygenation, e.g. pallor, colour of extremities, normal regular breath sounds.

4.8 **Adverse reactions**

**Warning**

- Respiratory depression can occur with lorazepam or other benzodiazepines, particularly in combination with antipsychotics.

Adverse reactions may include:

- dystonic reactions and akathisia, particularly with high doses of antipsychotic agents
- hypotension secondary to benzodiazepine administration or antipsychotic use
- excessive sedation—risking aspiration and/or delirium
- hyperthermia / neuroleptic malignant syndrome
- paradoxical disinhibition (with benzodiazepines)
- prolonged QT, cardiac arrhythmia
sudden cardiac death secondary to antipsychotic use (rare). For further guidance refer to the relevant product information brochure.

For acute laryngospasm or EPSE
- Benztropine—2 mg either IM or IV should be available.

For reversal of benzodiazepine induced respiratory depression
- Flumazenil—see guidelines for use below.

Guidelines for Flumazenil use for reversal of benzodiazepine-induced respiratory depression

Indications: If after the administration of lorazepam or diazepam, the respiratory rate falls below 10/min

Precautions: Serious overdose of tricyclic antidepressants—can increase risk of seizures
Where benzodiazepines are being used to control potentially life threatening conditions e.g. unstable intracranial pressure or status epilepticus
Mixed intoxication of benzodiazepines with tricyclic antidepressants where toxicity of the antidepressants may be masked by the effects of:
- unstable intercranial pressure
- hepatic insufficiency.

Severe head injury—may precipitate convulsions
Liver disease
Known longstanding benzodiazepine users may experience symptoms of acute withdrawal and/or seizures

Dose: Initially 0.3–1 mg IV Flumazenil, repeated at 60 second intervals until the consumer awakes (up to a maximum total dose of 2 mg)
If respiratory rate does not return to normal or the consumer is not alert after initial doses administered, assess for other causes of sedation

Adverse effects: Nausea, vomiting, palpitations, agitated, anxious or fearful on wakening. Seizures may occur if history of epilepsy, hepatic impairment or regular benzodiazepine use

Monitor: Flumazenil has a short half-life (much shorter than lorazepam and diazepam) and respiratory function may recover and then deteriorate again
Continue to monitor respiratory rate, oxygen saturation (via pulse oximetry), alertness and BP until respiratory rate returns to baseline level.

5. Definitions of terms used in the policy and supporting documents

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition / Explanation / Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute sedation</td>
<td>In this Guideline refers to the emergency administration of psychotropic medications to a consumer in an Authorised Mental Health Service setting to: • relieve distress • bring severe behavioural disturbance under control to protect the consumer or other people from immediate or imminent risk to their safety</td>
</tr>
</tbody>
</table>
6. Approval and implementation

Consultation
Queensland Psychotropic Medication Advisory Committee
Queensland Health Mental Health Alcohol and Other Drugs Clinical Clusters.

Approving Officer
Chief Psychiatrist, Mental Health Alcohol and Other Drugs Branch

Policy Custodian
Director, Clinical Governance, Office of the Chief Psychiatrist, Mental Health Alcohol and Other Drugs Branch

Approval date: 6 July 2017
Effective from: 6 July 2017
Next review: July 2020

Version control

<table>
<thead>
<tr>
<th>Version</th>
<th>Date</th>
<th>Prepared by</th>
<th>Comments</th>
</tr>
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<tbody>
<tr>
<td>V1.0</td>
<td>6 July 2017</td>
<td>OCP</td>
<td>First publication.</td>
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Guidelines for acute behaviour disturbance management (including acute sedation) in authorised mental health services for adults

**STEP 1 NON MEDICATION MEASURES—DE-ESCALATION**
- Don’t threaten to withdraw privileges, seclude or medicate
- Ensure safety of those in the environment
- Escapes, don’t corner the person or get cornered
- Stance, adopt protective stance
- Calm, non-threatening manner
- Ensure safety of those in the environment

**STEP 2 MEDICATION—ORAL**

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**STEP 3 SHORT ACTING—IM MEDICATIONS**

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<td>Olanzapine, elderly or physically frail</td>
</tr>
<tr>
<td>0.5 mg, repeat after 1–2 hours if needed. Max 4 mg in 24 hours</td>
<td>2.5–5 mg, repeat after 2–4 hours if needed. Max 15 mg in 24 hours</td>
<td></td>
</tr>
</tbody>
</table>

**MONITORING/OBSERVATION**

- **Level of observations are determined by the level of sedation**
  - awake: observe level of alertness every 15 minutes for first hour then half hourly for 8 hours
  - easy to rouse: vital observations* at 30 min intervals
  - can’t stay awake: vital observations at 10 min intervals
  - difficult to rouse: vital observations at 5 min intervals
  - unresponsive: call medical emergency

*Vital observations: pulse, O₂ saturation (pulse oximetry), blood pressure, respiratory rate, airway, sedation scale, pupils, limb power, GBL.
- Temperature every four hours.
- Check for signs of dystonia or any deterioration.
- If a consumer is uncooperative, as a minimum observe and document:
  - the position and movements of the consumer
  - the respiration rate
  - physical signs of oxygenation, e.g. pallor, colour of extremities, normal regular breath sounds

**STEP 4 INTRAVENOUS ROUTE**

- Severe arousal, not accepting medication, where a rapid, predictable outcome is essential
- Notify consultant psychiatrist
- Individual doses must be at strict 10 min intervals

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>IV Diazepam</td>
<td>5–10 mg, if this fails to achieve cooperation or rousable drowsiness within 10 minutes then administer 2.5–10 mg</td>
</tr>
<tr>
<td>Repeat every 10 minutes as clinically indicated not exceeding a max dose of 60 mg in 24 hours</td>
<td></td>
</tr>
<tr>
<td>Seek consultant psychiatrist advice if</td>
<td></td>
</tr>
</tbody>
</table>
  - no response after the second 10 mg dose or |
  - a suboptimal response at a total of 60 mg |

**Monitor**

- Airway, pulse, O₂ saturation (pulse oximetry), respiration rate, BP, patient colour, pupils, neurological status, limb power, temperature.
- If unresponsive and or changes occur in level of consciousness expected, a GCS may be required, and consideration given to making a MET call.
- Escalate as per Q-ADDS-mental health indicators.

Effective from June 2017
Due for review June 2019