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<table>
<thead>
<tr>
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<th>MHS 40</th>
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<tr>
<td>Lead Manager:</td>
<td>MHS Prescribing Management Group</td>
</tr>
<tr>
<td>Responsible Director:</td>
<td>Nurse Director Partnerships</td>
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<tr>
<td>Approved by:</td>
<td>MHS Quality &amp; Clinical Governance Group</td>
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<td>MHS Rapid Tranquillisation Guideline</td>
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</table>
Guideline for use of Intramuscular Medication for Acutely Disturbed Behaviour in Mental Health and Associated Services.

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<td><strong>Appendix I:</strong> Best practice points for the prescribing &amp; administration of as required psychotropic drugs</td>
<td>(\text{NHS GG&amp;C SPSP Steering Group May 2015})</td>
</tr>
</tbody>
</table>

**Feedback**

If during the use of this document you have any comments or suggestions you would like to make, please email [Charles.Sellar@ggc.scot.nhs.uk](mailto:Charles.Sellar@ggc.scot.nhs.uk)

Your comments will be taken into consideration and may be used to inform any future review of the document.

Please include the title of the document in the subject line of the email. Thanks
1. **Introduction**

Emergency Intramuscular Sedation (rapid tranquillisation) in this guideline refers to the use of medication by the intramuscular route if oral medication is not possible or appropriate and urgent treatment with medication is needed.

Treatment with intramuscular medication should be seen as the culmination of an approach that incorporates individualised care planning, anticipatory care, de-escalation and oral treatment; as such it is anticipated that the majority of patients will not require it.

When considering the use of intramuscular medication the following factors must be taken into account:

- The service user’s preferences or advance statements and decisions
- Pre-existing physical health problems or pregnancy
- Consider intoxication including intoxication with a novel psychoactive substance
  - If intoxication with a novel psychoactive substance is suspected, contact a consultant psychiatrist for advice and consider transfer to an A&E department.
- Previous response to these medications, including adverse effects
- Potential for interactions with other medications
- The total daily dose of medications prescribed and administered.

2. **Scope**

The guideline is applicable to all Mental Health and Learning Disability settings across NHSGGC.

This guideline supersedes all pre-existing rapid tranquillisation guidelines.

This guideline is intended to assist healthcare professionals in the choice of disease-specific treatments.

Clinical judgment should be exercised on the applicability of any guideline, influenced by individual patient characteristics. Clinicians should be mindful of the potential for harmful polypharmacy and increased susceptibility to adverse drug reactions in patients with multiple morbidities or frailty.

If, after discussion with the patient or carer, there are good reasons for not following a guideline, it is good practice to record these and communicate them to others involved in the care of the patient.

3. **Prerequisites to Intramuscular Medicine Use**

Have an individualised treatment plan incorporating the use of de-escalation techniques and as required or discretionary oral medication as appropriate for the patient (See Appendix I: Best practice points for the prescribing & administration of as required psychotropic drugs). The plan should cover the choice of IM medication where necessary.

Where necessary, completion of relevant MHA documentation i.e. a T3/T4 form may be required in the event that intramuscular medication is administered (see Advice Notes, Medical Treatment under part 16 of the Mental Health (Care and Treatment) (Scotland) Act 2003; Mental Welfare Commission for Scotland). It should be noted that treatment under the Adults with Incapacity (Scotland) Act 2000 does not authorise the use of restraint and therefore the use of
IM medication for management of acutely disturbed behaviour. If IM administration is required the appropriate MHA documentation should be completed.

When IM sedation is administered, a doctor should be informed and available to attend the patient within 30 minutes if required\(^1\,\!^2\).

Consider the potential for inadvertent high-dose antipsychotic therapy when prescribing IM antipsychotics.

When prescribing medication for use intramuscularly, write the initial prescription as a once-only dose, do not repeat it until the effect of the initial dose has been reviewed.

4. **Choice of Intramuscular Medication**

<table>
<thead>
<tr>
<th>Alternative Medication Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aripiprazole</td>
</tr>
<tr>
<td>Olanzapine</td>
</tr>
</tbody>
</table>

Promethazine may be a useful option in a benzodiazepine-tolerant patient or where there is concern over the use of an antipsychotic medication.

5. **Intramuscular Medication Doses in Adults**
   - Use lower doses in other patient groups e.g. elderly or debilitated.
   - Care must be taken in struggling patients to avoid inadvertent i/v administration.

6. **Benzodiazepines**
   - Have Flumazenil IV available in case of benzodiazepine-induced respiratory depression.

   **Lorazepam 2mg**
   - Maximum cumulative dose (oral and/or IM) over 24 hours: 8mg.
   - Note: This dose exceeds the recommended BNF maximum licensed dose for the treatment of anxiety (4mg)

   **Midazolam 5mg-7.5mg**
   - Maximum cumulative dose over 24 hours: 15mg
See the PMG (MH) Guidance when prescribing Midazolam IM as an alternative to Lorazepam IM for more information.

**Benzodiazepine Notes:** Useful if

- There is insufficient information to guide the choice of medication, or the patient has not taken antipsychotic medication before
- There is evidence of cardiovascular disease, including a prolonged QT interval, or no electrocardiogram has been carried out, use an intramuscular benzodiazepine

**Risks associated with benzodiazepines**

- Respiratory depression or arrest.
- Loss of consciousness.

7. **Antipsychotics**

**Haloperidol 5mg**

Maximum cumulative dose over 24 hours: 18mg IM (30mg oral, for combination of oral/IM medication calculate the % of each used)

Where a patient is benzodiazepine tolerant or prescribed regular benzodiazepines, consider the use of haloperidol +/- promethazine first.

The SPC recommends a pre-treatment ECG. Ensure IM Procyclidine available.

**Olanzapine 10mg**

Maximum cumulative dose (oral and/or IM combined): 20mg

Should not be used within an hour of administering an IM benzodiazepine, particularly if alcohol has been consumed. See the Olanzapine IM (Short Acting Injection) Prescribing Guidance document for more information.

**Aripiprazole 9.75mg** - Maximum cumulative dose (oral and/or IM combined): 30mg

**Risks Associated With Antipsychotic Drugs**

- Cardiovascular complications, QTc prolongation.
- Reduction in seizure threshold.
- Adverse side effects: subjective experience of restlessness (akathisia), acute rigidity (dystonia) and involuntary movements (dyskinesias).
- Altered consciousness.
- Neuroleptic malignant syndrome: Increased temperature, sweating, restlessness, altered consciousness or marked muscular rigidity should alert staff to the possibility of neuroleptic malignant syndrome (NMS). Such signs require cessation of all antipsychotic drugs, cooling of the patient and urgent medical assessment.
Antihistamine

Promethazine 50mg
Maximum cumulative dose over 24 hours: 100mg

Note: May be a useful option in a benzodiazepine-tolerant patient or if there is concern over the use of an antipsychotic medication.

Risks Associated With Promethazine

- Promethazine is contraindicated in people with central nervous system depression and those who have taken monoamine oxidase inhibitors within the past 14 days.
- Cautions include respiratory conditions, coronary artery disease, epilepsy and hepatic and renal insufficiency.
- Possibility of QTc prolongation (if administered via i/v)
- Reduction in seizure threshold

After an initial IM Administration:

- Nursing staff commence physical monitoring
- Repeat after 30-60 minutes if insufficient effect (caution: wait 1-2 hours after promethazine and 2 hours after olanzapine IM). Response to each dose should be documented in the patients’ care record.
- Be aware of the total dose of medication administered over the last 24 hour period.

8. Monitoring Requirements
After the administration of intramuscular sedation, monitor side effects and the patient’s pulse, blood pressure, respiratory rate, temperature, level of hydration and level of consciousness at least every hour until the patient is ambulatory and there are no further concerns about their physical health status. Where full monitoring is impractical, document clearly the reasons why and ensure a minimum observation of respiration and level of consciousness.

Monitor every 15 minutes if the BNF maximum dose has been exceeded or the patient:

- Appears to be asleep or sedated
- Has taken illicit drugs or alcohol
- Has a pre-existing physical health problem
- Has experienced any harm as a result of any restrictive intervention.
9. Management of Problems Occurring During the use of Intramuscular Medication:

<table>
<thead>
<tr>
<th>Problem</th>
<th>Remedial Measures:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Contact Duty Doctor</strong></td>
<td></td>
</tr>
<tr>
<td>Acute dystonias (including oculogyric crises)</td>
<td>Give procyclidine 5-10mg IM</td>
</tr>
<tr>
<td>Reduced respiratory rate &lt;10 / minute or oxygen saturation &lt;90%</td>
<td>Give Oxygen.</td>
</tr>
<tr>
<td></td>
<td>Give flumazenil if benzodiazepine-induced</td>
</tr>
<tr>
<td></td>
<td>- Initially 200mcg IV over 15 seconds – if required level of consciousness not achieved after 60 seconds then:</td>
</tr>
<tr>
<td></td>
<td>- Subsequent dose: 100mcg over 10 seconds, repeated after 60 seconds if necessary.</td>
</tr>
<tr>
<td></td>
<td>- Maximum dose: 1mg in 24 hours (one initial dose and eight subsequent doses)</td>
</tr>
<tr>
<td></td>
<td>Monitor respiration until rate returns to baseline level.</td>
</tr>
<tr>
<td></td>
<td>If induced by other agent patient may require mechanical ventilation – <strong>arrange transfer to ITU immediately</strong>.</td>
</tr>
<tr>
<td>Reduced respiratory rate &lt;5 / minute</td>
<td>Medical Emergency – institute emergency treatment, use a bag-mask or pocket mask to improve oxygenation and ventilation, whilst calling for expert help and arrange immediate transfer.</td>
</tr>
<tr>
<td>Tachycardia (&gt;140min)</td>
<td>Refer to specialist medical care immediately</td>
</tr>
<tr>
<td>Irregular pulse or bradycardia (&lt;50 / min)</td>
<td>Refer to specialist medical care immediately</td>
</tr>
<tr>
<td>Orthostatic hypotension</td>
<td>Lie patient flat, raise legs if possible, monitor closely including blood pressure</td>
</tr>
<tr>
<td>Fall in blood pressure (systolic &lt;90mmHg or diastolic &lt;50mmHg)</td>
<td>Urgent medical assessment</td>
</tr>
<tr>
<td>Increased temperature (&gt;37.5°C)</td>
<td>Urgent medical assessment</td>
</tr>
<tr>
<td></td>
<td>Withhold antipsychotics due to potential risk of NMS and arrhythmias</td>
</tr>
</tbody>
</table>

Activate the local emergency protocol

In Hospital Dial 2222

Dial 999/appropriate local emergency number for learning disability in-patient units and Forensic Units
10. Bibliography


2. CG25, p43 Bennett Report recommendation


6. Mental Welfare Commission for Scotland; Good practice guide Rights, risks and limits to freedom

7. Mental Welfare Commission for Scotland; Advice Notes, Medical Treatment under part 16 of the Mental Health (Care and Treatment) (Scotland) Act 2003


10. Olanzapine IM (Short Acting Injection) Prescribing Guidance (NHSGGC)

11. PMG(MH) Guidance when prescribing Midazolam IM as an alternative to Lorazepam IM (NHSGGC)

12. High Dose and Multiple Antipsychotic Prescribing Guideline (NHSGGC)

13. BNF No69 March 2015
# Audit Criteria: Guideline for use of Intramuscular Medication for Acutely Disturbed Behaviour in Mental Health and Associated Services

<table>
<thead>
<tr>
<th>Criterion Statement</th>
<th>Standard</th>
<th>Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>There is evidence of an individualized treatment plan incorporating the use of de-</td>
<td>100%</td>
<td>None</td>
</tr>
<tr>
<td>escalation techniques and 'PRN' oral medication within 7 days of admission.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The rationale for initiating the use of intramuscular medication using this guideline is documented in the care record.</td>
<td>100%</td>
<td>None</td>
</tr>
<tr>
<td>Drugs used for the use of intramuscular medication are used within the doses specified.</td>
<td>100%</td>
<td>Clinically appropriate to use lower/higher doses</td>
</tr>
<tr>
<td>There is a record of medication administered for the use of intramuscular medication.</td>
<td>100%</td>
<td>None</td>
</tr>
<tr>
<td>Doses or total daily dose outwith those advised in the guideline are recorded in the care record.</td>
<td>100%</td>
<td>None</td>
</tr>
<tr>
<td>All relevant physical monitoring during a period of the use of intramuscular medication is undertaken and documented.</td>
<td>100%</td>
<td>Patient refuses to allow physical monitoring to take place</td>
</tr>
<tr>
<td>The patient’s experience of the use of intramuscular medication is recorded.</td>
<td>100%</td>
<td>Patient refuses to contribute</td>
</tr>
<tr>
<td>If no response to the first injection during a period of the use of intramuscular medication, decision to administer a second dose is documented.</td>
<td>100%</td>
<td>None</td>
</tr>
</tbody>
</table>
Appendix I:  

Best Practice Points for the Prescribing & Administration of as Required Psychotropic Drugs

Psychotropic drugs are frequently prescribed on an ‘as required’ basis when patients are admitted to mental health wards. They are intended to be available for nursing staff to administer at their discretion to patients as part of the management of acute psychiatric symptoms e.g. agitation, anxiety and distress. Local and national audits have identified on many occasions that these drugs are often prescribed without appropriate care, administered unnecessarily and the details surrounding their use is often inadequately documented. There is often lack of review leading to almost open ended prescriptions.

This document describes best practices points to support the best use of this valuable intervention.

**Prescribing**

1. As required psychotropic drugs must not be prescribed routinely on admission.
2. The need for acute as required medication must be individually assessed and if deemed appropriate once only doses should be prescribed initially.
3. If once only doses are used then the need for a routine as required prescription should be considered.
4. If routine as required psychotropic drugs are prescribed the individual dose, route of administration, frequency of administration and maximum dose to be given in any 24 hour period must be clearly expressed on the prescription sheet.
5. The indication should be expressed as clearly as possible.
6. An appropriate entry should be made in the medical notes detailing the reason for the prescription and providing a context for the indication expressed.
7. For patients detained under the terms of the Mental Health Act who are prescribed oral as required psychotropics, an appropriate entry may be required on any T2/T3 form. Intramuscular as required antipsychotics may only be included in a T3 treatment plan.
8. The need for an on-going as required psychotropic prescription should be reviewed frequently. If it has not been administered for more than 4 weeks discontinuation is recommended.
9. If haloperidol is to be prescribed consider the patient’s cardiac status and if practical do an ECG to exclude prolonged QTc before prescribing.
10. If prescribing any antipsychotic as required be aware to the potential of inadvertent high dose in combination with any regular antipsychotic prescription.

**Administration**

11. Nurses should only administer as required psychotropic drugs for the prescribed indication and then only if non-pharmacological approaches have failed or are inappropriate.
12. If a patient is prescribed more than one as required psychotropic drug for the same indication, avoid administering combinations if possible and always allow sufficient time for one drug to take effect e.g. 30-60 minutes before administering a second drug.
13. All details pertaining to each administration should be recorded in the patient's case record (where in use this will be achieved by using the as required stickers). This will include
   - Date & time
   - Reason for administration
   - Details of non-pharmacological approaches attempted
   - Drug & dose given
   - Details of response including any side effects noted
• For intramuscular doses, details of any physical health monitoring undertaken (pulse, blood pressure, respiration, level of consciousness).

14. Feedback on cumulative as required psychotropic use will be included in the discussion of each patient at each multi-disciplinary team meeting.

NHS GG&C SPSP Steering Group
May 2015