

CLINICAL PRACTICE GUIDELINE

Pharmacological Management of Agitation

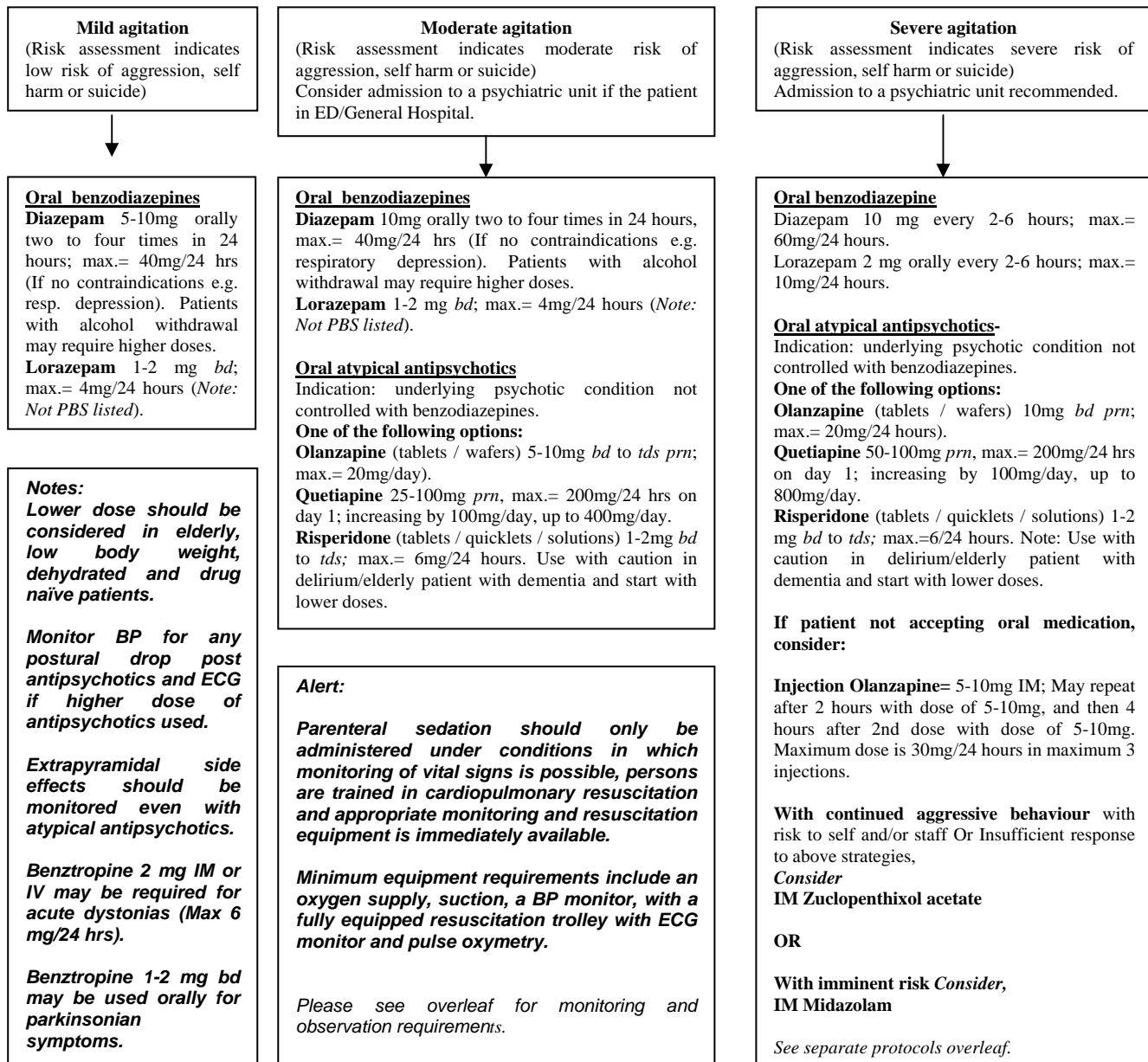
SCOPE (Area): Ballarat Health Services Psychiatric Services

SCOPE (Staff): Ballarat Health Services Psychiatric Services Medical & Nursing Staff

Management of patients that are agitated can be a complex clinical challenge to medical and nursing staff. Behavioural management is strongly recommended for the management of patients that are presenting with agitation. However, when severe, it can be a behavioural emergency that requires urgent pharmacological intervention to reduce risk to patients, families and staff and to assist patients to recovery.

Please read the following before administering pharmacological interventions to manage agitation:

- This guideline is designed to assist to manage agitation as a result of severe mental illness **in adult patients**.
- Attempt to establish underlying diagnosis prior to making any treatment decision.
- Consider pharmacotherapy only if appropriate behavioural therapy fails.
- Treatment options are explained to the patient that is agitated.
- If possible obtain an informed consent and document it.



ISSUES TO CONSIDER

Behavioural Management:

Behavioural strategies that are useful in the management of agitation:

1. Clear, calm and quiet communication with the patient.
2. Talk with the patient with respect and dignity and ensure appropriate privacy.
3. Create an opportunity for patient to ventilate his anxiety, fear and frustrations.
4. Discuss with the patient options available to alleviate the agitation.
5. Take a non-confrontational approach, e.g. do not challenge delusions.

Monitoring:

Whenever parenteral medications are administered, patients should remain in an appropriate clinical area, with suitable resuscitation equipment available. Monitoring of vital signs (BP, Pulse, Airway patency, Respiratory rate) should always follow administration of parenteral sedation. Routine use of pulse oxymetry in heavily sedated patients should always be considered. Signs of airway obstruction, respiratory depression, aspiration and profound hypotension should be carefully monitored for in sedated patients. Laryngospasm adds to this list when antipsychotics have been used. Monitor for other extrapyramidal side effects following administration of antipsychotics. Monitor for possible alcohol withdrawal.

Observation:

The patient should be under constant visual observation until it is clear that the patient is not oversedated and can maintain an independent patent airway. Observations are carried out at least every 15 minutes for 1 hour, if the patient's mental state/alertness permits. In addition, following Acuphase or multiple IMI, supine and erect BP and pulse twice daily minimum.

Examination and Investigations:

As soon as safely possible conduct comprehensive physical examination, Full Blood Counts, Serum electrolytes, blood glucose, ECG and other relevant investigation.

Acuphase (Zuclophenthixol acetate)

Usual dose= 50-100mg IMI (Dose determined by patient's age, gender, size, physical health).

Current medications to be reviewed, especially if the patient has received other antipsychotics or is on a depot antipsychotic.

Dose can be repeated after every 48-72 hours. The patient needs to be medically reviewed prior to each dose.

Acuphase should not be used as *prn* medication. At least 24 hrs must elapse between 2 injections.

Small females/elderly/antipsychotic naïve may require lower dose (25 mg). It is usually not used for 1st episode psychosis. Caution in patients with cardiac disease.

First injection is usually most sedating; some sedation may initially be seen between 15-90 minutes after injection and peaks after 8 hours.

During the course avoid giving other IMI antipsychotic medications.

Carefully monitor for signs of EPSE (dystonia, parkinsonian signs, akathisia) and NMS (neuromuscular malignant syndrome).

Midazolam

If extreme and imminent risk and not responding to oral medications, IMI Midazolam could be used.

Contraindications: alcohol intoxication, respiratory depression.

Midazolam **not** to be administered without Flumazenil in sight and available to be drawn up immediately if required. Oxygen and CPR trained staff must be immediately available.

Dose: Fit adult 5-10 mg IMI. Need to look into cumulative drugs received within previous 24 hours. May warrant lesser dose (2.5 mg IMI), mainly in elderly. A total 24 hour maximum dose of 15 mg in fit adult and 5 mg in elderly and medically ill.

Not to be repeated within 2 hours of the first injection.

Observation: Constant visual observation until it is clear that the patient is not over sedated and can maintain a patent airway.

Use Flumazenil if necessary to reverse respiratory depression induced by Midazolam- Flumazenil 0.2 mg IV followed by 0.1 mg every minute as required up to a total dose of 1 mg. (this may induce withdrawal seizures in patient chronically dependant on Benzodiazepines).

Key References:

Royal Australian and New Zealand College of Psychiatrists Clinical Practice Guidelines for the treatment of Schizophrenia and related disorders (2004).

Kaplan & Sadock's Comprehensive Textbook of Psychiatry. Eighth Edition (2005)

Therapeutic guidelines: Psychotropic Version 5 (2003).

The Assessment and Management of Psychiatric Emergencies Resource Folder: Alfred Psychiatry Clinical Practice Guidelines.

Management of Acute Arousal. University of Melbourne: St Vincent's Guidelines.

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