GICU Guideline
Pharmacological management of the acutely agitated / violent patient

The purpose of this guideline is to recommend a chemical restraint policy to protect a patient from injuring themselves and / or members of staff.

See separate guidance on the Mental Capacity Act, Section 5(2) of the Mental Health Act and Deprivation of Liberty Safeguarding orders.

General guidance

- As far as possible, manage the environment to minimise the stimulation to the patient.
- CONSIDER nursing the patient on a mattress on the floor in a corner.
- Call for urgent assistance from the SECURITY TEAM by dialling x3333
- There are limits as to the extent of physical restraint the SECURITY TEAM can offer. On occasion this may require a "999" call to request Police assistance.
- If not on site, and situation permitting, please inform the on call consultant and enlist their assistance
- Plan the intervention with a team briefing - CONSIDER using a Local Procedure Safety Checklist as a prompt
- The safety of other patients, visitors and staff takes priority over the safety of the affected patient.

Rescue chemical restraint options - Use the drug / drugs you are most familiar with

Drug	Notes
Haloperidol 2.5-5.0mg IM / IV (Max 12mg/24hours)	• Potentially slow onset minutes - hours • Associated with a risk of paradoxical agitation • Issue with higher doses (>12mg/24hr) in order of risk are: acute dystonic reactions, cardiac dysrhythmias (Torsade), neuroleptic malignant syndrome. • Contra-indicated in patients with known or suspected dementia
Promethazine 25mg IM / IV (Max 100mg/24hours)	• Sedating anti-histamine • Slow intravenous injection or injected into the tubing of a freely running infusion in a concentration of not more than 25mg/mL, although it is usually diluted to 2.5mg/mL. The rate of infusion should not exceed 25mg/minute." The IV issues are veno-irritation and potential for brady or tachycardia AND hypo or hypertension.
Midazolam 5-10mg IM / IV (up to 1mg/kg bolus dose) Maintenance infusions of 0.25-0.50mg/kg/hour Diazepam 5-20mg IM / IV Lorazepam 1-8mg IM / IV	• All associated with a risk of paradoxical agitation • May induce airway and breathing failure so support plan essential
Ketamine 1mg/kg IV or 4-5mg/kg IM	• Followed (if necessary) by infusion at 0.5-4.0mg/kg/hr • Best given in combination with benzodiazepines and / or propofol
Low dose Propofol infusions (30-100mg/hr) High dose propofol (general anaesthesia)	• Occasionally effective but significant risks of airway / breathing suppression AND tachyphylaxis • Induce and maintain with airway protection • Unless limited to short duration commence maintenance therapy options ASAP (see below)
Clonidine 0.5-25.0mcg/kg/hr Consider loading at highest rate until cumulative dose of 300-600mcg then down titrate aiming for maximum infusion rate of ≤10mcg/kg/hr	• Judge efficacy based upon a 10-20% reduction in heart rate • Lower infusion rates have greater association with hypotension • MAY be effective in specific cases - delirium and alcohol withdrawal in particular, but probably not acute psychosis. There is no pharmacodynamic or kinetic advantage of using dexmedetomidine over clonidine in this setting and a considerable cost disadvantage. • CONSIDER use of propranolol or metoprolol to wean off infusions & / or switch to regular oral therapy

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Maintenance chemical restraint options - Use the drug / drugs you are most familiar with

Drug	Notes
Risperidone 1-4mg enterally (Max 16mg/24 hours in 2 -4 divided doses)	Predominant renal excretion so limit doses to 8mg / 24hr in patients with significant impairment
Olanzapine 5-20mg enterally (Max 20mg/24 hours)	
Promethazine 25mg enterally / IM / IV (up to 100mg/24hours)	Sedating anti-histamine Slow intravenous injection or injected into the tubing of a freely running infusion in a concentration of not more than 25 mg/mL, although it is usually diluted to 2.5 mg/mL. The rate of infusion should not exceed 25 mg/minute.” The IV issues are veno-irritation and potential for brady or tachycardia AND hypo or hypertension.
Lorazepam 0.5-4mg enterally (Max 16mg/24hr in 3-4 divided doses)	
Ketamine infusion at 0.5-4.0mg/kg/hr	• Best given in combination with benzodiazepines and / or propofol
Propofol infusions (30-400mg/hr)	• Try to minimise exposure to doses >250mg/hr for >12hours and look closely for PRIS • Never use high dose infusions as montherapy
Clonidine 0.5-25.0mcg/kg/hr Consider loading at highest rate until cumulative dose of 300-600mcg then down titrate aiming for maximum infusion rate of ≤10mcg/kg/hr	• Judge efficacy based upon a 10-20% reduction in heart rate • Lower infusion rates have greater association with hypotension • MAY be effective in specific cases - delirium and alcohol withdrawal in particular, but probably not acute psychosis. There is no pharmacodynamic or kinetic advantage of using dexmedetomidine over clonidine in this setting and a considerable cost disadvantage. • CONSIDER use of propranolol or metoprolol to wean off infusions & / or switch to regular oral therapy

Use adjunctive opiates as clinically appropriate, especially if pain is a possible exacerbating factor. In such a scenario use standard opiates and avoid methadone as it is a partial antagonist.