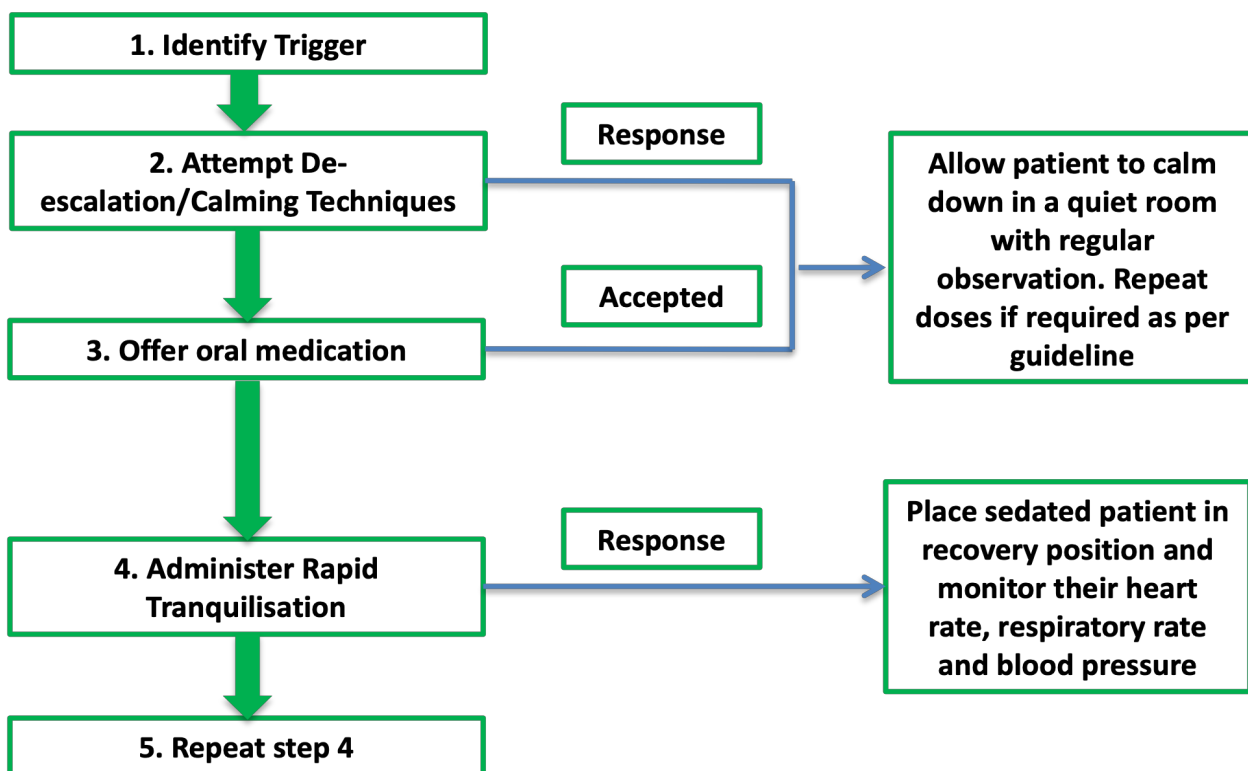


Rapid Tranquilisation and the Management of Violent and Aggressive Paediatric Patients

INDICATIONS

Rapid tranquilisation should only take place in clinical areas where resuscitation facilities and equipment is immediately available with appropriately trained staff.

Establish a close working relationship with patients at the earliest opportunity and sensitively monitor changes in their mood or composure that may lead to aggression or violence.



The decision to medicate a patient should always be made by a Consultant Paediatrician and referral should then be made to a senior member of the psychiatry team

**RAPID TRANQUILLISATION
(RT) FOR PAEDIATRICS
UNDER 12 YEARS OLD**

Appendix 1

**RAPID TRANQUILLISATION
(RT) FOR ADOLESCENTS
AGED 12-18**

Appendix 2

Appendix 1: Rapid Tranquillisation (RT) for Paediatrics under 12 years old

PRIOR TO RAPID TRANQUILISATION

STEP 1 – Identify Triggers

- Keep the patient safe and choose the appropriate pathway;
- Consider physical causes and conditions (acute infection, akathisia, alcohol/illicit substance intoxication, physical co-morbidities)
- Review medicines given in the last 24 hours. If greater than BNF max contact senior doctor

STEP 2 – De-escalation and Calming Techniques

- If a patient becomes agitated or angry, a single member of staff should take the primary role in communicating with them and:
- Assess situation for safety
- Negotiate with patient to resolve situation in a non-confrontational manner
- Use emotional regulation and self-management techniques to control verbal/non-verbal expression of anxiety/frustration
- Use a designated area/room to reduce emotional arousal/agitation

The decision to medicate a patient should always be made by a Consultant Paediatrician and referral should then be made to a senior member of the psychiatry team.

STEP 3 – Offer Oral/Buccal Medication

Consider the following as first line options:
Lorazepam 0.5-1mg PO
Promethazine hydrochloride 5-10mg PO (max 25mg/day)
Buccal Midazolam
5-10 years 7.5mg PO
10-12 years 10mg PO
Consider an antipsychotic if NOT already taking a regular oral or depot anti-psychotic
1st choice: Risperidone 0.5-1mg PO
2nd choice: Olanzapine 2.5-5mg PO

START CHECKLIST

STEP 3 – Consider Rapid Tranquillisation where 2 doses of oral treatment have failed or sooner if patient is placing themselves or others at risk

- Intramuscular (IM) treatment**
- Lorazepam 0.5mg-1mg IM (or by slow IV injection)**
 - Ensure flumazenil available for benzodiazepine induced respiratory depression
- Promethazine hydrochloride 6.25-12.5mg IM (or by slow IV injection)**
 - Useful option in benzodiazepine-tolerant patients
- Olanzapine 2.5-5mg IM (Depot injection unsuitable for RT)**
 - Olanzapine and lorazepam administration should be separated by 2 hours
 - Consider procyclidine oral/IM (EPSEs more common in adolescents) Give 5mg initially (MAX 10mg/24hours)

- Start Physical Health Monitoring and at 1 hour review mental state
- Repeat IM (or IV where appropriate) dose after 30 – 60 minutes if no response.



DETERIORATION

If no response arrange urgent team review. Maintain communication with psychiatry team.

Appendix 2: Rapid Tranquillisation (RT) for adolescent aged 12 - 18

PRIOR TO RAPID TRANQUILISATION

STEP 1 – Identify Triggers

- Keep the patient safe and choose the appropriate pathway;
- Consider physical causes and conditions (acute infection, akathisia, alcohol/illicit substance intoxication, physical co-morbidities)
- Review medicines given in the last 24 hours. If greater than BNF max contact senior doctor

STEP 2 – De-escalation and Calming Techniques

- If a patient becomes agitated or angry, a single member of staff should take the primary role in communicating with them and:
- Assess situation for safety
- Negotiate with patient to resolve situation in a non-confrontational manner
- Use emotional regulation and self-management techniques to control verbal/non-verbal expression of anxiety/frustration
- Use a designated area/room to reduce emotional arousal/agitation

The decision to medicate a patient should always be made by a Consultant Paediatrician and referral should then be made to a senior member of the psychiatry team.

STEP 3 – Offer Oral/Buccal Medication

Consider the following as first line options:
Lorazepam 0.5-2mg PO
Promethazine 10-25mg PO (max 50mg/day)
Buccal Midazolam 10mg PO
Consider an antipsychotic if NOT already taking a regular oral or depot anti-psychotic
1st choice: Risperidone 1-2mg PO
2nd choice: Olanzapine 5-10mg PO

DETERIORATION

If no response arrange urgent team review. Maintain communication with psychiatry team.

START CHECKLIST

STEP 3 – Consider Rapid Tranquillisation where 2 doses of oral treatment have failed or sooner if patient is placing themselves or others at risk

Lorazepam 0.5mg-2mg IM (or by slow IV injection)
[Dose is 0.5mg-1mg if less than 30kg]
(Maximum 4mg/24 hours)

Ensure flumazenil available for benzodiazepine induced respiratory depression

Partial response

No response

Consider Repeating IM Lorazepam

Consider Olanzapine or Haloperidol (Avoid if known cardiac problems, ECG abnormalities or on other medication known to interact or cause QT prolongation)

- Start Physical Health Monitoring and at 1 hour review mental state
- Repeat IM dose after 2 hrs (for Olanzapine) OR 1 hr (for Haloperidol) if no response.

Olanzapine 2.5 – 5mg IM (Depot injection unsuitable for RT)
Do not give with IM Lorazepam – wait 2 hours after lorazepam before giving
Consider procyclidine oral/IM (EPSEs more common in adolescents)– Give 10mg initially (MAX 20mg/24hours)

Haloperidol 1-5mg IM (NOT for IV)
MAX 5mg/24hours
Consider combining with promethazine IM 10-25mg (max 100mg/24hours) to improve tolerability to haloperidol or procyclidine oral/IM