Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Standards for Use of 'As required' and Rescue Medication

Aims of Standards	
Aims:	To promote safe, effective and appropriate prescribing and administration of 'as required' medication, including those used for physical health conditions
	To encourage regular review of 'as required' prescriptions
	To discourage unnecessary routine 'as required' prescribing

Rationale for use of 'as required' medication	
1.	The purpose and intended strategy for using 'as required' medication should be clearly documented in the Electronic Care Record (ECR); **the indication must be clearly stated on the chart.**
2.	This should include regularly reviewed intervention plans or protocols to support 'as required' use in **ALL** cases. On long-stay wards/units, intervention plans are expected for ALL 'as required' psychotropic use and other 'as required' medication used for chronic conditions.
3.	When multiple medicines are prescribed for the same condition/indication, specific guidance should be annotated on the chart by the prescriber to indicate the order in which the medicines should be used (e.g. "1st line", "2nd line") and under what circumstances.

Reviewing and monitoring 'as required' prescriptions	
1.	Hypnotics: • Routine prescribing is undesirable • Review frequently (at least weekly) or at each MDT on long stay wards/units • Should not continue for longer than 4 weeks
2.	Parenteral medication for rapid tranquilisation should not be routinely prescribed on admission. If there is ongoing potential need after an initial event, it can be prescribed "as required" but there must be a clear plan for its use and the need must be reviewed daily (at least weekly on long stay wards).
3.	Other medication should be reviewed every 14 days. On long-stay wards/units - use should be reviewed at least every 28 days, usually via the MDT.
4.	Monitor response, effectiveness, benefits and side effects, this should be documented within the ECR.
5.	Review and discontinue if symptoms have resolved or the medication has not been administered within the last 4 weeks (every 8 weeks on long stay wards) **Exception - rescue medication for medical emergencies – see appendix 4**
6.	Assess appropriateness from a case note review and analysis of 'as required' administration

Prescription Details	
Ensure Right:	**D**ose, **F**orm, **F**requency – expressed as the **Min**imum dosing **interval** + **Max Dose in 24 hours** (including any regular doses) - **I**ndication, **D**uration (where applicable)
Always have:	Review date - this should be documented within the electronic care record as should all subsequent reviews.

Documentation of 'as required' medication	
1.	Document actions and proactive interventions taken to prevent 'as required' medication being administered. These should be clearly documented within the ECR / individualised protocols.
2.	Document specific symptoms/reasons which may result in any 'as required' medication being administered within the ECR / individualised protocols and ensure that any use is clearly recorded for both mental and physical health.
3.	Document patient's response and all monitoring outcomes/observations following administration of any 'as required' medication. (Ensure that any recordings on the NEWS are transferred into the ECR physical healthcare case note).
4.	Patients should be offered the opportunity to write an account (where appropriate) or have a "debrief" of their experience of receiving 'as required' medication for rapid tranquilisation as per Trust policy and ALL relevant documentation should be completed, including the NEWS and a Datix report

A guide to common frequencies and maximum doses can be found in the appendices (click links below):
Working age adults | Children & young people | Older people | Urgent medical treatment

APPENDIX 1 - WORKING AGE ADULTS: Guide to common frequencies and maximum doses for "as required" medication

All prescriptions for "as required" medicines should be reviewed regularly for clinical need.
Maximum recommended duration of use of benzodiazepine and "z drugs" is 4 weeks.

Drug / route	Indication	Dose *(specify exact dose on prescription NOT dose range)*	Minimum dose interval	Maximum dose per 24 hours *(including any regular doses)*	Monitoring and side effects
Haloperidol IM	Violence & aggression (rapid tranquilisation)	3 – 5 mg (*with promethazine IM*)	One hour	Usually up to 15 mg, but can go up to 20 mg	Post-administration monitoring (NEWS) required – see Rapid Tranquilisation policy Acute dystonia (procyclidine must be available)
Haloperidol PO	Agitation	3 – 5 mg	Four hours	20 mg	EPSE, drowsiness, hypotension (increased risk of falls)
Lorazepam IM	Violence & aggression (rapid tranquilisation)	1 - 2 mg	One hour	4 mg (More may be used on consultant recommendation)	Post-administration monitoring (NEWS) required – see Rapid Tranquilisation policy
Lorazepam PO	Agitation	1 – 2 mg	Four hours	4 mg (More may be used on consultant recommendation)	Drowsiness, dizziness (increased risk of falls); paradoxical increase in aggression
Procyclidine IM	EPSE	5 mg	Eight hours	15 mg (including PO)	Blurred vision, dizziness, confusion and disorientation which may increase falls risk
Procyclidine PO	EPSE	2.5 – 5 mg	Eight hours	Usually 30 mg (including IM) (Exceptionally 60mg)	
Promethazine IM	Violence & aggression (rapid tranquilisation)	25 – 50 mg *(with haloperidol or alone)*	One hour	100 mg	Post-administration monitoring (NEWS) required – see Rapid Tranquilisation policy
Promethazine PO	Agitation	25 – 50 mg	Four hours	100 mg	Drowsiness, blurred vision, dry mouth, headache, urinary retention
Salbutamol inhaler	Shortness of breath	Two puffs (200 micrograms)	As required	8 puffs (1600 micrograms) (Increased usage should prompt a medical review)	Tremor and tachycardia
Zopiclone PO	Insomnia	7.5 mg (15 mg may be used on consultant recommendation)	Once per night	7.5 mg (15 mg on consultant recommendation only)	Sedation may increase falls risk

APPENDIX 2 - CHILDREN & YOUNG PEOPLE: Guide to common frequencies and maximum doses for "as required" medication

As per Children's BNF and Rapid Tranquilisation policy. Unless otherwise stated the age range is considered to be 12 – 18 years inclusive.

Drug	Indication	Dose *(specify dose on prescription **not** a dose range)*	Minimum dose interval	Maximum dose per 24 hours	Monitoring and side effects
Haloperidol IM	Violence and aggression (rapid tranquilisation)	1 – 2 mg *(consider adult dose range [3 - 5 mg] in older adolescents)*	One hour	10 mg (including any given orally)	Post-administration monitoring (NEWS) required – see Rapid Tranquilisation policy Acute dystonia (procyclidine must be available)
Haloperidol oral	Agitation	1.5 – 5 mg	Four hours	10 mg (including any given IM)	EPSE, drowsiness, hypotension
Lorazepam IM	Violence and aggression (rapid tranquilisation)	500 micrograms - 2 mg	One hour	4 mg (including any given orally)	Post-administration monitoring (NEWS) required – see Rapid Tranquilisation policy
Lorazepam oral	Agitation	500 micrograms - 2 mg	Four hours	4 mg (including any given IM)	Drowsiness, dizziness, paradoxical increase in aggression
Procyclidine IM	EPSE	5 – 10 mg	Eight hours	Occasionally more required but usually a single dose is recommended	Blurred vision, dizziness, confusion and disorientation which may increase falls risk. Usually effective in 5-10 minutes but may need 30 minutes for relief.
Procyclidine oral	EPSE	2.5 mg	Eight hours	7.5 mg	
Promethazine IM	Violence and aggression (rapid tranquilisation)	10 – 20 mg *(consider adult dose range [25 - 50 mg] in older adolescents)*	One hour	50 mg	Post-administration monitoring (NEWS) required – see Rapid Tranquilisation policy
Promethazine oral	Agitation	10 - 25mg	Four hour	50 mg	Drowsiness, blurred vision, dry mouth, headache, urinary retention
Salbutamol inhaler	Shortness of breath	Two puffs (200 micrograms)	as required	8 puffs (1600 micrograms) (Increased usage should prompt a medical review)	Tremor and tachycardia

APPENDIX 3 - OLDER PEOPLE: Guide to common frequencies and maximum doses for "as required" medication

As per Rapid tranquilisation policy where applicable and by consensus.

Drug	Indication	Dose *(specify exact dose on prescription NOT dose range)*	Minimum dose interval	Maximum dose per 24 hours	Monitoring and side effects
Haloperidol IM	Violence & aggression (rapid tranquilisation)	500 micrograms – 1 mg	One hour	2 mg (including any given orally; only to be exceeded with consultant approval)	Post-administration monitoring (NEWS) required – see Rapid Tranquilisation policy Acute dystonia (procyclidine must be available)
Haloperidol oral	Agitation	500 micrograms – 1 mg	Four hours	2 mg (including any given IM; only to be exceeded with consultant approval)	EPSE, drowsiness, hypotension (increased risk of falls)
Lorazepam IM	Violence & aggression (rapid tranquilisation)	500 micrograms – 1 mg	One hour	2 mg (including any given orally)	Post-administration monitoring (NEWS) required – see Rapid Tranquilisation policy
Lorazepam oral	Agitation	500 micrograms – 1 mg	Four hours	2 mg (including any given IM)	Drowsiness, dizziness (increased risk of falls); paradoxical increase in aggression
Procyclidine IM	EPSE	5 mg	Eight hours	15 mg (including any given orally) Preferably the lower end of the range	Blurred vision, dizziness, confusion and disorientation which may increase falls risk. For patients with existing cognitive impairment monitor for changes.
Procyclidine oral	EPSE	2.5 – 5 mg	Eight hours	30 mg (including any given IM) Preferably the lower end of the range	
Promethazine IM	Violence & aggression (rapid tranquilisation) *Off license*	12.5 – 25 mg	One hour	50 mg (including any given orally)	May precipitate delirium; do not use in physically unwell patients; use with extreme caution in patients with dementia or delirium Post-administration monitoring (NEWS) required – see Rapid Tranquilisation policy
Promethazine oral	Agitation *(off license)* / sleep disturbance	25 mg	Four hours	50 - 100 mg (including any given IM)	Sedating and has anti-cholinergic effects monitor for changes in patients with pre-existing cognitive impairment. No need to reduce dose in renal impairment but monitor for excessive sedation.
Salbutamol inhaler	Shortness of breath	Two puffs (200 micrograms)	as required	8 puffs (1600 micrograms) (Increased usage should prompt a medical review)	Tremor and tachycardia
Zopiclone oral	Insomnia	3.75mg initially	3.75 - 7.5 mg once per night		Sedation may increase falls risk

APPENDIX 4 - POTENTIALLY URGENT MEDICAL TREATMENT: Guide to common frequencies and maximum doses for "as required" medication

On admission, prescribers should identify any pre-existing medical conditions which may require urgent treatment with medication for a complication or exacerbation. The patient may already have a supply of the relevant medication, if so this should be prescribed on their inpatient prescription chart in line with the directions on the supply or the GP records. If not, an appropriate "rescue" medication should be prescribed according to the table below. The pharmacy team will arrange a personal supply for the patient (indicated by "P" in the pharmacy box on the prescription chart and with * in the table below), or direct staff to the supply in the Emergency Drug Bag (indicated by "EDB" in the pharmacy box on the prescription chart) if administration is needed. An individualised intervention plan for the patient's pre-existing medical conditions should be agreed and recorded in the electronic patient record. The medication should only be prescribed for discharge if it was prescribed pre-admission or if there has been an exacerbation during inpatient stay.

Pre-existing medical condition	**Prescribe in "as required" medication section of Prescription and Administration Record Chart as follows:**						
	Drug	**Dose**	**Route**	**Indication**	**Min. dose interval**	**Max. dose in 24 hrs**	**Comments / special instructions**
Allergy	Adrenaline See MSS9	500 micrograms [dose for auto-injectors may differ – see BNF]	IM	Anaphylaxis / Angioedema	5 mins	See comments / special instructions	Repeat at 5 minute intervals according to BP, pulse & respiratory function; usual maximum 3 doses but may continue if symptoms persist in presence of or if verbally instruction by ILS-trained staff (medic or physical health practitioner)
Asthma	* Salbutamol 100 micrograms / puff inhaler	2-10 puffs	INH	Acute asthma attack	10 mins	No max	Each dose should be inhaled separately via large volume spacer.
Coronary Heart Disease	* Glyceryl Trinitrate 400 micrograms / dose spray	1 or 2 sprays	S/L	Chest pain	5 mins	No max	Spray under the tongue, then close mouth.
Diabetes *(patients prescribed insulin, oral hypoglycaemics or combination therapy)*	Dextrose gel	1 tube / sachet	Oral	Hypoglycaemia	10 mins	3 doses per episode	Repeat after 10-15 minutes if glucose remains low
	Glucagon	500 micrograms (bodyweight <25kg) 1 mg (bodyweight >25kg)	IM		N/A	One dose per episode	
Epilepsy / risk of seizures (e.g. alcohol detox – diazepam only)	Diazepam Rectal Tube 10 mg	One or two tubes	PR	Seizure / status epilepticus	10 mins	2 doses	Repeat once after 10-15 minutes if necessary
	* Midazolam Oral Solution	10 mg	Buccal		10 mins	20 mg	
Opioid dependence – *opioid substitute prescribed (methadone / buprenorphine)*	Naloxone See PHARM-0066	400 micrograms initially (see comments)	IM (or SC)	Opioid overdose	1 min	4 mg	If no response after 1 minute give 800 micrograms, and if still no response after another 1 minute, repeat dose of 800 micrograms; if still no response give 2 mg (4 mg may be required in a seriously poisoned patient).

Please note: Adrenaline and glucagon can be administered without a prescription in a medical emergency. The same applies to oxygen, although this isn't covered by this guidance. See MSS10: Oxygen - Administration in an Emergency.