Pharmacological Management of Acute Agitation in patients requiring Non-Invasive Ventilation

Background

The aim of this guideline is provide information to assist with agitation in patients in acute type 2 respiratory failure who may require Non-Invasive Ventilation. In these patients, hypercapnia or hypoxaemia can manifest as agitation and/or confusion which can prevent establishing NIV if the patient is unable to tolerate the mask. This guideline will not cover the indications and the practicalities of establishing NIV or whether the patient is appropriate for NIV but will guide clinicians to an appropriate choice of pharmacological agent to establish the process.

Management of agitation to facilitate NIV

Assess the patient for confusion / agitation. If the patient is so agitated that the mask cannot be tolerated at all (despite intervention as outlined below), this is an exclusion criteria for NIV. The patient should also be assessed as to whether escalation is appropriate in the event NIV cannot be tolerated.

1st line

Ensure constant supervision as it may be necessary to hold the mask in place until ABG's correct themselves and the patient becomes less agitated. This can be lifesaving. In these situations, family members can be helpful in calming the patient.

2nd line

If the patient is for escalation and the NIV cannot be tolerated, appropriate contact with the anaesthetic team is required. Wherever possible, sedation should be avoided for patients with acute respiratory failure. However, in some instances (if not for escalation) a small dose of haloperidol may be considered.

If pharmacological management is required then haloperidol 0.5 - 2.5mg subcutaneously may be helpful in decreasing agitation to facilitate NIV.

Benzodiazepines should be AVOIDED in acute respiratory failure unless there is senior medical or anaesthetic input. In particular, the IV route should never be used for this indication.

Palliation

If standard treatment and NIV fails, or where patients have chosen not to receive this treatment and there is a documented plan not to escalate for intubation, then palliative measures are then appropriate with a focus on symptom management.

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Approved by Drug and Therapeutics Committee: January 2016
Review Date: January 2018

Breathlessness

Breathlessness can be managed with opioids and/or benzodiazepines in this situation – guidance can be found in the Doncaster & Bassetlaw Hospitals NHS Foundation Trust Palliative Care Core Formulary

http://www.dbh.nhs.uk/Library/Pharmacy_Medicines_Management/Formulary/Formulary_S4/Palliative%20Care%20Formulary.pdf

Pain

Manage with opioids as per Doncaster & Bassetlaw Hospitals NHS Foundation Trust Palliative Care Core Formulary

Anxiety

Manage with benzodiazepines as per Doncaster & Bassetlaw Hospitals NHS Foundation Trust Palliative Care Core Formulary

References:

Royal College of Physicians, British Thoracic Society, Intensive Care Society *Chronic obstructive pulmonary disease: non-invasive ventilation with bi-phasic positive airways pressure in the management of patients with acute type 2 respiratory failure.* Concise Guidance to Good Practice series, No 11. London RCP, 2008. Available at: https://www.brit-thoracic.org.uk/document-library/clinical-information/niv/niv-guidelines/the-use-of-non-invasive-ventilation-in-the-management-of-patients-with-copd-admitted-to-hospital-with-acute-type-ii-respiratory-failure/ accessed 02/12/2015

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