Emergency psychotropic drug administration

Introduction

At times, a nurse must administer an emergency psychotropic medication to a patient on a psychiatric unit if that patient's behavior is escalating and a threat to the safety of himself, other patients, or staff. For example, when a patient becomes increasingly out of control verbally or physically or demonstrates threatening or aggressive behavior, psychotropic medications, such as lorazepam, haloperidol, and chlorpromazine, may be administered.

The patient's psychiatrist usually writes orders for medications that may be given as needed based on the patient's behavior. These orders typically include emergency medications, which should always be considered before secluding the patient or using physical restraints.

I.M. injection is the preferred route of administration for emergency medications because the medication takes effect faster than oral forms. On most psychiatric units, the registered nurse determines the need for administering the ordered emergency medication.

Depending on the situation and the patient's treatment plan, the nurse should try alternative interventions before giving a patient an emergency medication. Such interventions may include talking with the patient, taking the patient to a quiet part of the unit, walking with the patient to expend energy (in this situation, remain in the sight and hearing of other staff members who know about the situation), and engaging the patient in a quiet activity (such as listening to soothing music) or stress reduction or relaxation exercises.

In some instances, the patient will recognize the need for medication and will take it willingly. However, sometimes the patient will refuse the medication. If the medication is deemed necessary to prevent harm to the patient or other people, the medication may be given even if the patient refuses.

Equipment

- 3- or 5-ml syringe
- 20G to 25G 1″ to 3″ needle
- Alcohol pads
- Ordered medication
- Filter needle, if needed
- Gloves

Implementation

1. Review the patient's medical and psychiatric history and his treatment plan.
2. Verify the doctor's orders for emergency medication.
3. Confirm the patient's identity using two patient identifiers according to your facility's policy.[4]

4. Assess the patient's behavior.
5. Provide alternative interventions *to help de-escalate the patient's behavior* and assess their effectiveness.

Nursing alert: If alternative interventions don't have a positive effect on the patient's behavior or if the patient's behavior continues to escalate, medication should be administered as quickly as possible. *If the staff waits until a patient loses all control, the situation becomes more difficult for the patient as well as for the other patients on the unit and the staff.*

1. Wash your hands.[5]
2. Prepare the ordered emergency medication. (See the "Intramuscular injection" procedure.)
3. Ensure that other staff members are available and close by *to assist as needed.*
4. Provide the patient with as much privacy as the situation allows, especially from other patients on the unit.
5. Put on gloves.
6. Explain to the patient that you're going to administer an injection, and ask him to remain still *to reduce the risk of the needle breaking off while it's inserted into the patient.*
7. Obtain assistance from other staff members if the patient refuses the injection.
8. If assistance is needed, explain to the patient that he'll be restrained temporarily while the injection is given. Instruct the staff to physically restrain the patient by holding him securely in an anatomically neutral position *to prevent injury.*
9. Administer the medication.
10. If assistance was used, tell the staff to release the patient immediately after the injection is administered.
11. Discard all equipment appropriately.
12. Remove your gloves and wash your hands.
13. Remain with the patient or close by and visible *in case the patient wants to talk.*
14. Assess the effectiveness of the medication.[6]
15. Notify the patient's psychiatrist of the emergency medication administration per facility policy.
16. Discuss future alternative interventions with the health care team *to possibly prevent the need for additional emergency medication use.*
17. Document the procedure.[8]

Special Considerations

- If the patient needs an emergency psychotropic medication but doesn't have an order for one, call the patient's psychiatrist and request a verbal order for the medication. Make sure that the verbal order is later signed by the doctor, per facility policy.[7]

- Witnessing inappropriate or threatening behaviors or seeing a patient being held immobile may be frightening to other patients. Without disclosing any details about the patient who received the emergency medication or violating any patient confidentiality, the patients on the unit should be reassured. Staff should be available to speak to anyone who wants to talk.

Patient Teaching

After the medication has taken effect and the patient is calm, tell the patient what medication was given and why it was administered. Discuss how the patient can manage his feelings and actions differently in the future.

Complications

Patient injury is always a risk if a patient must be restrained during the administration of medication. *To prevent injury from the needle breaking off or from inappropriate restraint techniques*, staff should be trained in appropriate physical restraint techniques.

Documentation

Record your observations of the patient's behavior, any verbal interaction with the patient, and all alternative interventions that were attempted, including the result of each action. Document the name, dose, and route of the medication given and whether patient restraint was required. Record the patient's reaction to the medication administration. Record your observations of the patient after medication administration and his response to the medication.[6] Note any patient teaching provided and verbal interactions with the patient. Also document the date and time you notified the patient's psychiatrist. In some units, the nursing staff will also have to complete an incident report and submit the report to the nursing supervisor.

References

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1. Review the patient's medical records.
2. Verify the doctor's orders.
3. Confirm the patient's identity.
4. Assess the patient's behavior.
5. Provide alternative interventions and assess their effectiveness.
6. If medication is needed, wash your hands.
7. Prepare the medication.
8. Ensure that other staff members are available and close by.
9. Provide the patient privacy.
10. Put on gloves.
11. Explain the procedure to the patient.
12. Obtain assistance from other staff members if needed.
13. If assistance is needed, explain to the patient that he will be restrained temporarily.
14. Instruct the staff to physically restrain the patient.
15. Administer the medication.
16. If assistance was used, tell the staff to release the patient.
17. Discard all equipment appropriately.
18. Remove your gloves and wash your hands.
19. Remain with the patient or close by and visible.
20. Assess the effectiveness of the medication.
21. Notify the patient's psychiatrist of the emergency medication administration per facility policy.
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