

PROTOCOL FOR: Haloperidol (Haldol): IV Administration

POLICY: MD must specify initial dose and maximum dose to be administered.

DESIRED PATIENT

OUTCOME: Patient will achieve effective sedation without exhibiting any extrapyramidal symptoms.

CLINICAL
ASSESSMENT

- AND CARE:
1. Monitor patient's VS's prior to the first dose and every 30 minutes during the initial "loading dose" period. Then monitor patient's VS's as previously ordered, and PRN.
 2. Maintain a patent IV line - either peripheral or central. (No local caustic effects on veins have been noted with Haloperidol).
 3. Flush IV line with NS before and after bolus if line contains Heparin (Heparin & Haloperidol form a precipitate).
 4. Haloperidol may be given as an IV bolus at a rate \leq 5mg/min (literature reports slow injection has no advantage over rapid injections because of its slow distribution and half-life).
 5. Initial Loading Dose per MD order:
 - a. Initial starting dose may range from 0.125 mg to 5 mg.
 - b. If patient continues to be agitated 20-30 minutes after initial dose, double the dose every 20 minutes until sedation occurs. Note maximum dose, which needs to be specified by MD.
 - c. Once the patient is effectively sedated, repeat the last dose given every 4-6 hours around the clock (note - if the patient appears adequately sedated 4 hours after the previous dose, then use a q 6 hours interval).
 - d. A PRN Haloperidol order should be obtained for episodes of break-through agitation between regularly scheduled doses.
 - e. If the patient requires frequent (i.e. at least once or twice per shift in a 24 hour period) PRN Haloperidol administration, then the around-the-clock dosage should be adjusted.

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6. Monitor for extrapyramidal (EPS) symptoms such as tremors, drooling, muscle spasm, jitteriness and repetitive involuntary dystonic movements. Try to differentiate EPS from continued or worsening delirium.
 - a. The greatest incidences of EPS are with patients < 40 yrs. old.
 - b. Patients with delirium and organic brain disease are more likely to exhibit EPS than those with delirium alone.
 - c. EPS may spontaneously appear or disappear but may be present for several hours.
 - d. A combination of Haldol and benzodiazapines has been shown to decrease the incidence of EPS.
7. Monitor K⁺ and Mg⁺ levels to decrease the chance of widening the QT interval per MD order.
8. Sudden discontinuation of Haloperidol - even at high doses - will not cause withdrawal dyskinesia.

TREATMENT FOR
ACUTE DYSTONIC
REACTIONS OR EPS:

1. Anticholinergic and Antiparkinsonian meds may be ordered to control either acute dystonic reactions or EPS. Examples include Diphenhydramine, Benztropine and Trihexyphenidyl.
2. Treatment involves symptomatic and supportive care. ECG and vital signs should be monitored every 2 hours and prn. Treat arrhythmias as appropriate.

SAFETY:

1. Haloperidol should be given with caution to patients with impaired hepatic function as it is metabolized in the liver.
2. Avoid the use of Haloperidol in a patient receiving Propranolol HCL. The combination of the two has been shown to cause bradycardia and hypotension resistant to resuscitation. No other B-blocker has been implicated although caution should be used.
3. Avoid Haloperidol use in patients with previous history of Parkinson's disease.
4. In use with Quinidine - Haloperidol may potentiate the long QT interval and QRS widening seen with Quinidine - use with caution.

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5. Avoid the use of Haloperidol in patients receiving epinephrine, as Haldol will allow the Beta effects of the epinephrine to dominate - causing increased heart rate, vasodilation and hypotension (this may be treated with another pressor such as Norepinephrine).

APPROVAL: ICU Standards Committee
Nursing Standards Committee
Department of Pharmacy
Cardiac Step-Down Standards Committee

EFFECTIVE DATE: 9/93

REVISION DATES: 1/95, 8/99, 10/03