

## TAKE-HOME NOTES:

**Rapid tranquillisation of the acutely disturbed patient**

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Rapid tranquillisation (RT) is an important component of the management of violence and acute agitation. The aim of RT is clear-cut i.e. to calm the patient and not to put them to sleep or sedate them – yet sometimes sedation is unavoidable.

Staff and doctors delivering RT must be adequately and regularly trained in methodological and legal aspects of RT. Before using RT, attempts should be made to control behaviour by non-pharmacological methods.

RT should be practised using a multidisciplinary team approach. Often it is necessary to restrain a patient before giving RT. It is vital to use correct restraining techniques.

Oral medication should be used first where possible and sufficient time should be given for it to act before giving parenteral. Intramuscular is a safer route but in exceptional circumstances intravenous tranquillisation can be used.

Lorazepam is a better choice when diagnosis is not known, the patient is non-psychotic, suffers from physical illness or from agitation due to drug and alcohol use.

Recently changes have been made in the SPC (Summaries of Product Characteristics) for haloperidol requiring that it should not be prescribed with other antipsychotics and ECG should be done as a baseline before starting it.

Use of phenothiazines is not recommended in various guidelines because of troublesome side effects.

IM olanzapine has been found to have more troublesome side effects when used above BNF doses and can cause respiratory depression when used with lorazepam. Hence both of these medications should never be used simultaneously or within one hour of each other.

Zuclopenthixol acetate (Acuphase) has variable and usually late onset of action and its effects last longer, hence it is not a good choice for RT.

Every treatment facility where parenteral benzodiazepines are used should have flumazenil available. It can be life saving if a patient develops respiratory depression due to benzodiazepines.

Buccal midazolam is highlighted as a recent new treatment. It is used to control seizures in status epilepticus as an alternative to rectal diazepam.

Midazolam has been found to be effective by intramuscular route in the TREC study but the buccal route is yet to be investigated for this purpose. Patients are likely to have better acceptability of this route compared to intramuscular.

It is worth mentioning the difference between PRN prescribing and RT. PRN prescribing is non-specific and it is the major cause of high dose antipsychotic prescribing. RT is very specific in its aim and such aims should be written clearly on medication cards to avoid confusion.

To reduce the chances of adverse outcomes, vitals and oxygen saturation (using pulse oximeter) should be measured regularly at a frequency set by local guidelines. All antipsychotic drugs are associated with adverse effects on cardiac conductance hence an ECG should be done to monitor QTc interval.

RT should be avoided in secluded patients, but it is not contra-indicated. There are no evidence-based guidelines for rapid tranquillisation of an old age patients but by and large principles are the same except extra care is required. A guideline by the Royal College of Psychiatrists has been developed for learning disabled patients.

RT can be used by medical staff in A&E but senior medical staff should be involved and the mental health team should be informed. RT can also be used under common law for unwilling informal patients.

RT is a safe procedure if used properly. All treatment facilities using RT should have resuscitation equipment ready to minimise serious adverse outcomes.

### Reflection

(2.6) You are called in to control a situation where a patient has taken another patient hostage. He is demanding to be released from the unit – otherwise he will either kill himself or the hostage with a knife. What is your approach to managing this situation?

(3.1.13) A 40-year-old alcoholic patient admitted to a medical ward three days ago presents with severe agitation and threatens other patients because they appear like demons and are 'evil'. He is disorientated and has icterus, suggesting presence of alcoholic liver disease. He is not willing to take oral medications. What options do you have for RT?

(3.2.8) A medical registrar seeks your advice in finding a safe medication to tranquillise an extremely agitated and delirious patient suffering from decompensated chronic obstructive pulmonary disease (COPD) and acute MI. What advice would you offer?

(4.4) Think about your responses to the following questions: 1. In what circumstances would you use IM medication? 2. What safety measures should be taken if IV medication is used? 3. What route would you choose to administer antimuscarinic medications when a patient develops severe dystonia?

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## Further reading

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## Useful websites

British Association of Psychopharmacology [[website](#)]

National Association of Psychiatric Intensive Care Units [[website](#)]

National Institute for Clinical Excellence [[website](#)]

Royal College of Nursing [[website](#)]

Royal College of Psychiatrists [[website](#)]

United Kingdom Psychiatric Pharmacy group [[website](#)]