Rapid tranquilisation

See also the separate Bipolar disorder article.

What is rapid tranquilisation?

The National Institute for Health and Care Excellence (NICE) 2015 guidelines define rapid tranquilisation (RT) as 'the use of medication by the parenteral route (usually intramuscular (IM) or, exceptionally, intravenous) if oral medication is not possible or appropriate and urgent sedation with medication is needed'.

The aim should be to maintain the service user in as calm a state as possible whilst being able to maintain communication with them. It is recognised that RT may lead to deep sedation/anaesthesia, although this is not the overt intention. [1]

Always consider any antecedents to the acute situation: has the situation been exacerbated by poor communication, lack of privacy, overcrowding, boredom, long waiting times or lack of information? The British Association for Psychopharmacology and the National Association of Psychiatric Intensive Care and Low Secure Units developed a joint evidence-based consensus guideline of 2018 that recommends de-escalation as a preventative measure. [2]

NICE guidance recommends that after an RT episode, the patient should be invited to record their own experience of the incident and that the decision to use RT should be explained to them and recorded in the notes. [3]

Initial assessment

This should ideally include:

- Full history - from as many sources as possible.

- Legal status - establish whether the patient is already under the Mental Capacity Act.
- If the patient is already on a psychiatric ward (informally or under section 5(2)), RT treatment can be given under common law.
- Mental state examination.
- Previous psychiatric history.
- Full medication history - including alcohol and substance abuse.
- Physical examination (if safe to do so).
- Recent drug screen (if available).

Always think of organic causes (particularly if there are fluctuating levels of consciousness, disorientation, visual hallucinations) or any previous head injury.

Legal issues

- RT should be humane, ethical, legal and clinically effective.
- Consider the presence of any advance care planning.
- A primary concern in violent situations should be for the safety of all. Where possible, treatment without consent should be under one of the treatment sections of the Mental Capacity Act (usually section 3). Decisions made in good faith by medical staff in the acute situation, taken to avert serious risk, can however be sanctioned by common law without recourse to the Mental capacity act. All treatment should be reasonable and proportionate.

Risk factors for rapid tranquilisation

Risks are increased in children, frail elderly, pregnancy, those with Lewy body dementia, or those with concurrent medical illness.

These risks are:

- Loss of consciousness.
- Airway obstruction.

- Respiratory depression ± arrest .
- Hypotension or cardiovascular collapse.
- Cardiac arrest.
- Seizure.
- Extrapyramidal side-effects (EPSEs) or neuroleptic malignant syndrome.

Exclude medical contra-indications to RT (eg, cardiac disease or respiratory disorders) and ensure facilities for basic CPR and flumazenil are available. In particular, if there is a prolonged QT interval (or no ECG available), IM lorazepam is preferable to IM haloperidol and promethazine.

Parenteral regimens [1] [2] [4]

- Use IM lorazepam alone, or IM haloperidol and promethazine combined.
- If only haloperidol is available, this can be used alone, but there is evidence to support the addition of promethazine when available.
- When making the decision on which drug to use, take into account the following:
    - Service user's preferences or advance statements.
    - Co-morbidities, pregnancy and interactions with other drugs.
    - Possible intoxication.
    - Previous use of these drugs and any adverse effects, including the total daily dose if a dose has already been given that day.
- If there is a partial response to IM lorazepam, give another dose, however if there is a partial response to IM haloperidol and promethazine, consider a dose of IM lorazepam.

Monitoring

- After the use of RT, pulse, blood pressure, respiratory rate, temperature, hydration and level of consciousness should be monitored every hour, along with any side effects. This should continue until there are no concerns about physical health.
- Monitoring should be every 15 minutes if any of the following apply:
    - The maximum dose as per the BNF has been exceeded.
    - The patient has taken illicit drugs or alcohol.
    - There is a pre-existing physical health problem.
    - Restrictive intervention has caused harm.

Documentation

Consider documenting the following:

- The reason for using RT.
- Legal situation (ie which part of the Mental Health Act used).
- Physical assessment - any medical hazards recognised.
- Patient's diagnosis.
- Drugs given - in what sequence and dosage.
- Outcome.
- Monitoring chart and ongoing plan.

Debrief

Discuss, as a significant event, whether the need for RT could have been anticipated and prevented. Discuss the patient's account if available.

Prevention: de-escalation[2]

There is a paucity of evidence for de-escalation but its practice is accepted as good clinical practice and is thought to be associated with fewer recurrences of aggressive or violent behaviours.[5] It varies across units but key components may include:

- The establishment of verbal contact.
- Avoiding being provocative.
- Being concise.
- Listening closely to the patient.
- Respecting the patient and their personal space.
- Negotiating and trying to agree or agreeing to disagree.
- Offering choices and optimism.
- Setting clear limits.
- Identifying the wants or feelings of the patient.
- Debriefing the patient and staff.
- Proactive de-escalation planning.

Further reading

- Bipolar disorder - the assessment and management of bipolar disorder in adults children and young people in primary and secondary care; NICE Clinical Guideline (Sept 2014 - last updated December 2023)
- Rehabilitation for adults with complex psychosis; NICE guidance (August 2020)

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