The acutely disturbed patient

Key Facts:

- An acutely disturbed patient is often suffering from acute delirium rather than a mental illness
- Acute delirium = a state of mental confusion that may resemble a psychotic disorder, but is actually caused by an acute, potentially serious organic process. It is associated with adverse health outcomes. Acute delirium can be hyperactive (patient is restless and agitated) or hypoactive (patient is withdrawn, quiet and sleepy). *Prevention* of delirium is key.
- In most cases, people with mental illness are not violent and are more likely to be the victims rather than the perpetrators.

Prevention of acute delirium

1. Identify those most at risk: age>65, cognitive impairment, severe illness, hip fracture
2. Interventions
   - Continuity of staff whenever possible
   - Avoid moving patients within and between wards or rooms unless absolutely necessary
   - Assess patients at risk for clinical factors that might precipitate delirium: cognitive impairment, dehydration, constipation, hypoxia, immobility, infection, polypharmacy, pain, poor nutrition, sensory impairment, sleep disturbance
   - For people at risk of delirium, **avoid new prescriptions of benzodiazepines**. Caution with opioids (balance with risk of untreated pain which can also trigger delirium) and other drugs (see 'causes of acute delirium' box below).
   - Staff to be vigilant for behavioural changes

Management of the acutely disturbed patient

Whether presenting to the Casualty, OPD or on the wards, *non-pharmacological strategies* are most important.

Acutely disturbed patient

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Safety – do not see the patent alone, make sure the path to the exit is clear, maintain adequate distance

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- Attempt to calm the patient using verbal techniques
- Monitor, support ABCs
- If possible, check vitals and blood sugar

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Non-pharmacological strategies

- Ensure effective communication, reorientation and reassurance e.g. explain where the person is, who they are, what your role is. Consider involving family and friends to help with this.
- Keep the environment as calm as possible.
- Try to diffuse the situation – respect the rights and dignity of the patient, avoid confrontation or arguments

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- Identify and manage the possible underlying cause
- Check PMH, DH, drug/alcohol consumption

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Common causes of acute delirium:

- CNS infection - malaria, meningitis (including tuberculosis), rabies, encephalitis
- Systemic infections
- Electrolyte disturbances - ↑Na^+ ↓Na^+
- Respiratory failure
- Other metabolic causes - ↑ or ↓ glucose, uraemia, hepatic encephalopathy
- Nutritional - Wernicke's encephalopathy
- Toxins - carbon monoxide, methanol, poisons, lead, cyanide, thallium
- Alcohol - withdrawal or excess
- Other CNS problems - head injury, stroke, ↑ICP, frontal injury, epilepsy (post-ictal), chronic subdural hematoma
- Urinary retention (especially in the elderly)
- **Drugs** – steroids, benzodiazepines, opioids, antihistamines, phenytoin, anti-Parkinson's drugs, anticholinergics (e.g. oxybutynin), antipsychotics

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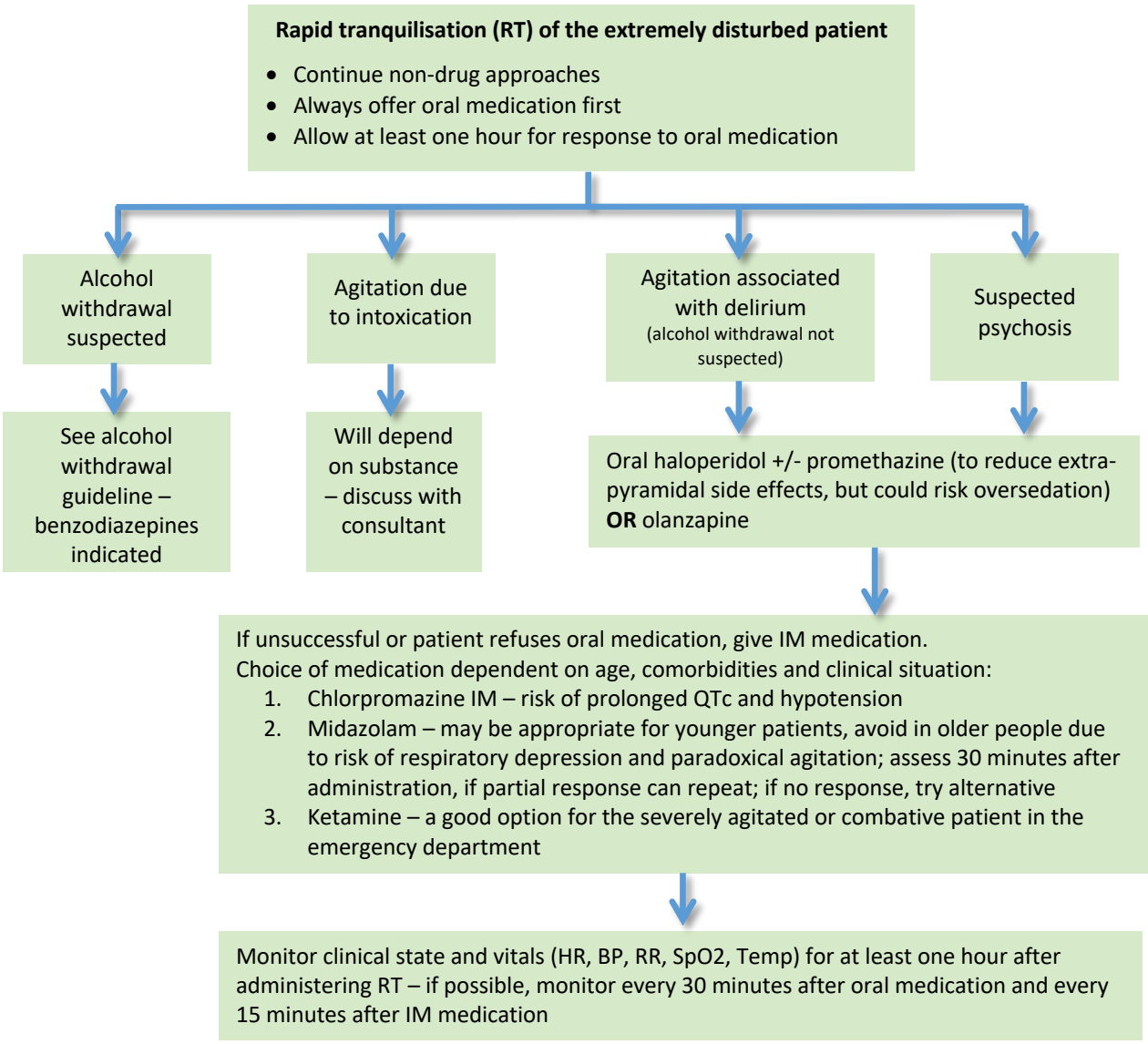
- If the cause or behavioural disturbances are not immediately reversible, it is not possible to diffuse the situation, and the patient poses a potential danger to himself or others, administer **rapid tranquillisation** (see next page)
- The need for any **physical restraints** must be determined on a case-by-case basis – looking at clinical need and safety; intervention must be reasonable and proportionate to the risk posed.



Oral Medication Dosing:	IM Medication Dosing:
Olanzapine 5-10mg; elderly initially 2.5-5mg (Max 20mg/24h); **Haloperidol** 5-10mg (Max 10mg /24h); elderly initially 2.5mg then adjust gradually according to response up to max 5mg per day in most cases **Promethazine** 25-50mg (Max 100mg/24h)	**Midazolam** 5mg IM, repeat if necessary after 30 minutes; if used in elderly 1.25-2.5mg initial dose **Chlorpromazine** 25-50mg IM (max single dose 100mg; max 400mg 24 h) **Ketamine** 4mg/kg IM or 1mg/kg IV

References

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