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NHS
Gloucestershire Health and Care
NHS Foundation Trust

MENTAL HEALTH / LD - CLINICAL POLICY
Use of Rapid Tranquillisation

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Policy Number	CLP156
Version:	V8.1
Purpose:	The Trust recognises that the use of rapid tranquillisation is a significant event for people who use our services and this policy outlines the trust approach to the use of rapid tranquillisation making this as safe as possible
Consultation:	Drugs and Therapeutics Committee, Clinical Policy Group
Approved by:	Clinical Policy Group
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Author:	[redacted]
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Audience:	All staff within the Trust in Gloucestershire
Dissemination:	This policy will be made available on the Trust intranet under Clinical Policies
Impact Assessments:	This policy has been subjected to an Equality Impact Assessment. This concluded that this policy will not create any adverse effect or discrimination on any individual or particular group and will not negatively impact upon the quality of services provided by the Trust.

Version History

Version	Date Issued	Reason for Change
V2	Mar 2011	Policy review undertaken [redacted] March 2011
V3	Nov 2011	Minor review to incorporate Hereford and HMP, [redacted]
V4	Mar 2012	Notified to Governance of amended format
V5	Sept 2013	Change in national guidance about medication uses [redacted]
V6	July 2014	Revised flow chart 14.9 and BNF changes to maximum daily dose for Haloperidol 14.8 [redacted]

V7	Nov 2016	Policy review undertaken [redacted] – Oct 2016, following revised NICE guidance in 2015
V7.1	Mar 2017	Minor review before forthcoming new [redacted] training programme– undertaken [redacted]
V7.2	Jan 2019	Minor review to incorporate policy refinements and clarification of legal positions
V7.3	Mar 2019	Minor review to incorporate NEWS2
V7.4	July 2019	Format Update
V7.5	Feb 2022	Policy review date extended to April 2022
V8	16/12/2022	Policy due for review, added perinatal [redacted] Enhanced information around post [redacted] observation and debrief. Changed training interval and who requires training, Revised legal framework, Reviewed medications used in [redacted]
V8.1	06/01/2025	Dose change in the box at the top of page 16

SUMMARY
The Trust recognises that the use of rapid tranquillisation is a significant event for people who use our services and this policy outlines the trust approach to the use of rapid tranquillisation to make this as safe as possible for the occasions where other interventions are unable to contain the situation.

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ABBREVIATIONS

Abbreviation	*Full Description*
GHC	Gloucestershire Health and Care NHS Foundation Trust
RT	Rapid Tranquilisation
BNF	British National Formulary
EPR	Electronic Patient Record
MERT	Medical Emergency Response Teams
PBM	Positive Behaviour Management
PMVA	Prevention and Management of Violence and Aggression

1. INTRODUCTION

The Trust approach to the management of violence in relation to patients broadly divides into five areas. They are: -

A. Positive engagement with patients which is a key factor in reducing levels of violence.

B. Prevention by seeking to understand the reasons for the occurrence of a violent incident and working to address these.

C. Training in the use of de-escalation/conflict management techniques / physical interventions as taught within the standard formats of PMVA and PBM below:

   I. De-escalation, prevention and management of violence and aggression (PMVA) - Working Age Adults.

   II. Positive Behaviour Management (PBM) - Learning Disability and Older Peoples Services.

   III. Physical health management and support provided by medical emergency response teams (MERT).

D. The use of medication for the purposes of rapid tranquillisation.

E. Reporting alleged offences by patients to the police.

The following document focuses on area D above. The other aspects of the reactive approach to the management of violence and aggression (which may include other forms of acute disturbance) in relation to patients are covered in the Trust policies on referral to the police or criminal justice system, PBM and PMVA.

2. PURPOSE

It is the policy of the Trust to ensure that the management of violence and aggression is undertaken in line with locally developed procedures, as detailed above, and subject to regular review and development consistent with best practice and nationally agreed standards this includes the use of RT.

3. SCOPE

This policy applies to all Trust staff, who have a duty to abide by and promote the use of this policy.

4. DUTIES

General Roles, Responsibilities and Accountability

Gloucestershire Health and Care NHS Foundation Trust (GHC) aims to take all reasonable steps to ensure the safety and independence of its patients and service users to make their own decisions about their care and treatment.

In addition, **GHC** will ensure that:

- All employees have access to up to date evidence based policy documents.
- Appropriate training and updates are provided.
- Access to appropriate equipment that complies with safety and maintenance requirements is provided.

Managers and Heads of Service will ensure that:

- All staff are aware of, and have access to policy documents.
- All staff access training and development as appropriate to individual employee needs.
- All staff participate in the appraisal process, including the review of competencies.

Employees (including bank, agency and locum staff) must ensure that they:

- Practice within their level of competency and within the scope of their professional bodies where appropriate.
- Read and adhere to GHC policy
- Identify any areas for skill update or training required.
- Participate in the appraisal process.
- Ensure that all care and consent complies with the Mental Capacity Act (2005).

Drugs and Therapeutics Committee and the Reducing Restrictive Practice Project Group

- This policy and related training will be discussed and approved with the Drugs and Therapeutics Committee and the Reducing Restrictive Practice Project Group.

5. MENTAL CAPACITY ACT COMPLIANCE

Where parts of this document relate to decisions about providing any form of care treatment or accommodation, staff using the document must do the following: -

- Establish if the person able to consent to the care, treatment or accommodation that is proposed? (Consider the 5 principles of the Mental Capacity Act 2005 as outlined in section 1 of the Act. In particular principles 1,2 and 3) Mental Capacity Act 2005 (legislation.gov.uk).
- Where there are concerns that the person may not have mental capacity to make a specific decision, complete and record a formal mental capacity assessment.
- Where it has been evidenced that a person lacks the mental capacity to make a specific decision, complete and record a formal best interest decision making process using the best interest checklist as outlined in section 4 of the Mental Capacity Act 2005 Mental Capacity Act 2005 (legislation.gov.uk).
- Establish if there is an attorney under a relevant and registered Lasting Power of Attorney (LPA) or a deputy appointed by the Court of Protection to make specific decisions on behalf of the person (N.B. they will be the decision maker where a relevant best interest decision is required. The validity of an LPA or a court order can be checked with the Office of the Public Guardian) Office of the Public Guardian - GOV.UK (www.gov.uk).

6. POLICY DETAIL

6.1 Assessment Prior to RT

When deciding which medication to use, especially in the context of physical intervention, take into account:

- The service user's preferences or advance statements and decisions.
- Pre-existing physical health problems or pregnancy (confirm by routine pregnancy testing on admission).
- Possible intoxication and recent substance misuse.
- Previous response to these medications, including adverse effects.
- Potential for interactions with other medications.

- The total daily dose of medications prescribed and administered.

6.2 Aim of RT

The aim of rapid tranquillisation is to calm a person and reduce risk of violence and harm rather than treat any underlying psychiatric conditions. The circumstances in which RT will be commonly used are:

- A person with disturbed mental functioning who: -
    - Is exhibiting behaviour that is destructive, dangerous or aggressive.
    - Is at risk of exhaustion.
    - Needs rapid calming to alleviate immediate and severe distress.

6.3 Definition of Key Terms

Rapid Tranquillisation: Rapid tranquillisation (RT) is the reactive administration of medication (IMI or oral) to manage unanticipated agitation or disturbance with the intended purpose of calming the patient in circumstances where the clinical decision has been reached that receiving the prescribed medication is essential and should be seen as part of a measured and proportionate approach to de-escalation.

PRN Medication (Pro Re Nata 'as needing'): This is medication that is different to RT. This medication forms part of a pro-active approach to assist the patient with a pre-existing illness or condition with the express intention of relieving the symptoms of that condition to support therapeutic engagement, delivery of individualised care, recovery and social inclusion. It is not prescribed or administered with the intention of rapidly calming or tranquilising the patient and it will form part of a therapeutic approach to supporting patient's wellbeing.

NB. Despite the attempts to clarify with these carefully considered definitions, what constitutes RT is ultimately decided by the clinician in front of their patient after they have made their assessment. The importance of reasoned and discussed clinical judgement is key.

De-escalation: refers to 'a set of verbal and non-verbal responses which if used selectively and appropriately, may reduce the level of a person's hostility by reducing anger and in turn the predisposition to violent behaviour.'

Physical Intervention is defined as: Physical contact with a service-user to prevent harm to that service-user or other people. It may be of two broad types, breakaway techniques and restraints:

- **Breakaway techniques**: These are carried out by the person being attacked and are relatively instantaneous in nature. They include for example, techniques designed to remove a grab, hair pull or strangle.

- **Restraints:** These involve holding a service-user with the intent of restricting their movement.

6.4 Before RT

There are a number of interventions that can be useful in diminishing the need for RT. These include: -

- Verbal de-escalation.
- Diversion from the stimulation.
- Removal of the individual from the situation that is causing heightened arousal.

6.5 If RT is Required:

Principles: The preferred RT administration route is oral. This may require a considerable degree of negotiation/de-escalation between staff and patient in order to be clear that agreement to take oral medication cannot be achieved. Although continued attempts at negotiation can escalate a situation to a higher level of disturbance it is mandatory that a significant attempt is made.

6.6 Intramuscular (IM) RT:

IM is a more complex and potentially hazardous mode of administration than oral. It will often require a restraint team who may need to secure the patient while the IM injection is administered, overcoming various degrees of resistance. IM administration of RT is often perceived as a degrading and traumatic experience for the patient and for the staff involved. It is essential that intramuscular administration of RT be considered a sophisticated intervention requiring a high level of organisation and skill. RT would normally be administered in the buttock (dorso-gluteal) if the patient is prone and the thigh (vastus lateralis and rectus femoris) if the patient is supine. Detail around this is discussed in the Prevention and Safe Management of Risk Incidents (including Violent and Aggressive Behaviour) policy (CLP117).

Intravenous RT: this route is not supported in this trust under any circumstances.

6.7 Injection through Clothes:

There is limited evidence to help make the decision on whether or not injecting through clothes causes more harm than good. We acknowledge that other hospitals will regularly inject through clothes if the clinical situation requires, for example in the Accident and Emergency department. Therefore, although we do not advise injecting through clothes routinely there may well be situations in which risk / benefit assessment means that this is undertaken.

6.8 Preparing to give RT:

In some circumstances the need for RT emerges quickly and without warning. In the majority of cases, however, there is time to plan for the delivery of RT. Once all verbal and other interventions have been attempted and the decision for RT has been made the following principles apply:

- A single individual should be responsible for co-ordinating the whole RT team.
- The area of the ward in which the patient will be approached should be decided upon and assessed for its appropriateness. Considerations will include; the privacy of the area, space available, ease of access and exit, the availability of potential weapons and the likelihood that prolonged restraint will be necessary.
- Each member of the RT team should have a clear role with pre-determined methods of communication.
- An individual should be clearly identified to administer the IM medication
- The MERT assessor should be present with the appropriate equipment. The MERT assessor should not be involved in the restraint and should only be occupied to monitor the physical condition of the person being restrained and receiving RT.

6.9 Dignity

It is often unavoidable that the IM administration of RT will require the securing of a patient by means of restraint, during which clothing will be removed to expose the upper outer quadrant of the patient's buttocks or in some circumstances, the quadriceps. Staff should remain aware that in effect, a patient is restrained while embarrassing areas of their body are exposed for the

purposes of the injection.

While RT is often unavoidable, there should be no doubt that the procedure has potentially serious physical and psychological consequences for the patient.

6.10 Gender

As per the Prevention and Safe Management of Risk Incidents policy "Reasonable steps must be taken to work collaboratively with the person. Staff must bear in mind any physical, sensory or communication deficit/difference the person is experiencing and must take this into account when managing the situation. Similarly, cultural and gender issues must positively influence staff response to (potential) violence or challenge."

6.11 Location

It is likely to be distressing for other patients, visitors and relatives to witness RT. Every reasonable effort should therefore be made to ensure that it is delivered in a private area of the ward where maximum attention can be paid to the dignity of the individual. It is accepted however, that there are circumstances that will necessitate the restraint of an individual in areas that are not particularly private. Such circumstances include:

- Where, during the course of negotiation, a patient becomes aggressive and immediately attempts to attack others.
- Where the level of resistance and aggression from a patient is such that their relocation to a private area would involve unnecessary risk.

In these situations, other available staff should move onlookers to another area.

6.12 Legal Framework for giving Rapid Tranquillisation

RT will usually be given under either Part IV of the Mental Health 1983 (as revised) Act for example if they are subject to Sections 2, 3, 37, 48.

Special attention needs to be paid to patients recalled via their CTO but without it being revoked. Unless the CTO is revoked, RT would be given again under the Mental Capacity Act in line with their best interests.

Section 62: in patients whose T3 doesn't allow for further or any RT but they need this due to their presentation. The patient's Responsible Clinician in hours or the oncall consultant needs contacting to discuss the situation. If they authorise RT, they need to document this on EPR then a Section 62 form would need to be completed the following morning and a request for SOAD made the next working day. A patient with a T2 for all their psychotropic medications who requires RT may well need a S62 and a SOAD request for RT if this is a regular occurrence.

However, if the patient is informal or subject to Section 4, 35, 5(2), 5(4) then the Mental Capacity Act in line with their best interests applies.

When giving RT under the Mental Capacity Act it is likely that the clinical expediency for such an intervention will mean that a formal capacity assessment will be difficult to complete. Therefore, clinical judgement will need to be used regarding capacity with careful documentation following administration of RT to illustrate why the patient lacked capacity to consent to the medication in that instance. Furthermore, documentation will need to state that the medication was administered to the patient in their best interests.

6.13 Use of Medication

Prescribing: When prescribing medication for use in rapid tranquillisation, the initial prescription should be as a single dose, and not repeated until the effect of the initial dose has been reviewed.

If RT is prescribed it should be reviewed in the MDT meeting every week as per the trust standard ward round pro forma.

The prescriber should clearly highlight that the medication prescribed is for RT and this medication would not usually form part of a therapeutic treatment plan for a pre-existing condition.

The prescribing and administration of medication to tranquilise the agitated or disturbed patient (RT) is distinctly different from medication prescribed to assist with a pre-existing illness that may support therapeutic engagement, individualised care delivery, recovery and social inclusion.

The Trust has commissioned a specific RT module for ePMA. RT should not be prescribed elsewhere on ePMA.

Verbal Orders: In exceptional circumstances such as where the prescriber cannot attend within a reasonable time or gain access to ePMA, a verbal order for RT can be given under POPAM 2 Prescribing General Instructions 2.20 (section 2). This would require the prescriber to explain the prescription to two registered nurses, or send confirmation via e-mail then prescribe via ePMA at the earliest possibly opportunity.

General Considerations for Use of Medication: Tranquillising a disturbed patient with medication should be considered for use when methods of de-escalation and containment alone have, become ineffective. There are considerable potential hazards; particularly where the patient is unknown to services and their reaction to neuroleptic medication is not predictable. The combination of biochemical changes that are present in an aroused, anxious individual, who may be dehydrated and not in the best of physical health, together with the physiological manifestations of stress, the aftermath of aggression and physical restraint, increase the dangers considerably.

6.14 Electrocardiograms

These can provide useful additional assessment of the risks of administering antipsychotic drugs. Ideally, all patients being admitted to a clinical area where RT including antipsychotics could potentially be used should have an ECG when this is practicable. Attempting to perform an ECG on an agitated uncooperative patient is, however, inadvisable.

On the ECG, a prolonged QT interval is an indicator of increased cardiac risk with antipsychotics. A QT interval which increases following the introduction of an antipsychotic drug is also a risk indicator. However, a normal ECG does not mean that RT with an antipsychotic drug is a low risk procedure.

6.15 Specific Recommended Medications for RT

A range of medications can be used in RT and there is some variation in policies in the UK.

6.16 Use of Medication General Guidance Notes

Benzodiazepines represent the first line of treatment in patients who are unknown to the service,

with sensitivity to antipsychotics, or whose health is of concern. They are relatively safe, in overdose and their effects can be reversed with the antagonist, Flumazenil (if Flumazenil is required it would have to be administered by an emergency paramedic or in the acute Trust's A&E department). Lorazepam is the preferred benzodiazepine in RT due to its quick absorption and short half-life. Of the short-acting neuroleptics, Haloperidol is available orally and in a parenteral preparation, and can be used alone or in conjunction with Promethazine or Lorazepam.

The Trust has recommended the use of Lorazepam, Haloperidol and Promethazine within the format detailed in the Rapid Tranquilisation algorithm.

6.17 Documentation

Following use of RT, the following needs to be documented on RiO:

- The reason for use of RT.
- The legal framework used to give RT.
- The associated use of restraint such as PMVA or PBM.
- Any noted side effects of the medication.
- Rationale and reason for not completing full set of physical observations should be documented.

For DATIX:

- DATIX for the incident that led to the need for RT.

NEWS2 charts:

- NEWS2 documented at least every hour for the first four hours.

6.18 RT Guidance in Children and Young People (below age of 18)

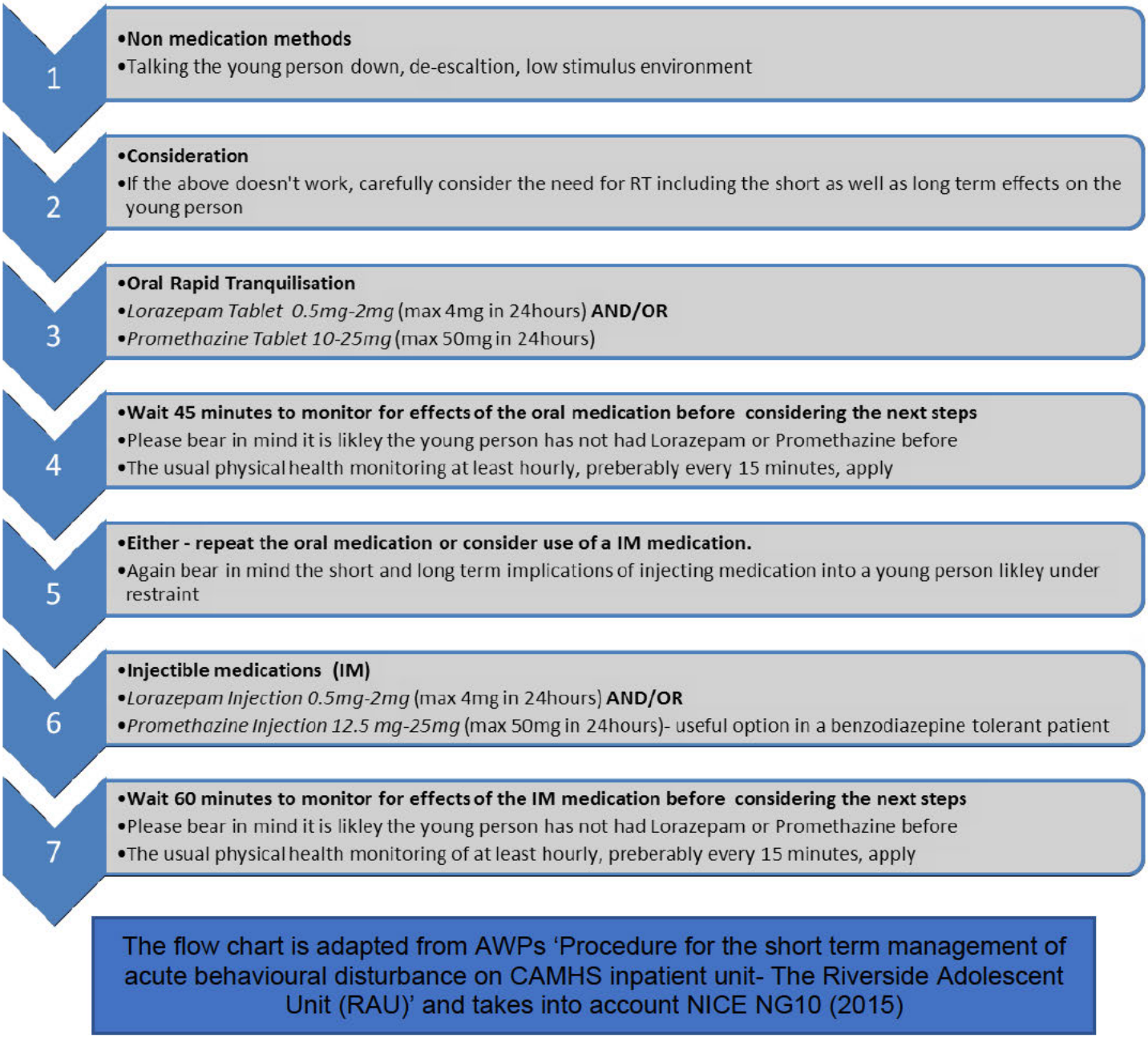
RT for children and young people must always be undertaken after careful consideration. The risk of destabilising the therapeutic relationship with the young person both now but also potentially going forward are very real and must be borne in mind.

Prescription of RT in those under 18 must come from the on-call consultant psychiatrist rather than junior prescribers. There are two main circumstances where consultant psychiatrists on call would be advising on the prescription of medications: -

- **Firstly**, to colleagues in Gloucestershire Hospitals Trust (GHT) when something is needed beyond Lorazepam. In these circumstances it must be noted that advice would be based on your best clinical judgement and responsibility remains with the GHT prescribing prescribers.
- **Secondly**, on the rare occasions when a young person aged 16-17 is admitted to Wotton Lawn for a short period of time. In these circumstances. The junior prescriber would not be expected to prescribe any medications, including RT, without first discussing with the on-call consultant.

Antipsychotics, except for Promethazine (which although an antihistamine, has mild antipsychotic properties) should be avoided in the young person as RT due to risks of side effects which may limit their use in later treatment.

THE CHILD AND ADOLESCENT RAPID TRANQUILISATION ALGORITHM



The flow chart is adapted from AWPs 'Procedure for the short term management of acute behavioural disturbance on CAMHS inpatient unit- The Riverside Adolescent Unit (RAU)' and takes into account NICE NG10 (2015)

6.19 RT Inpatients with a Learning Disability (LD)

Where possible, patients with LD who have a mental illness but can be managed in a generic mental health unit, will be admitted to the appropriate ward and will be subject to standard Trust policies.

Patients admitted to the LD inpatient services will be drawn from a different demographic and will often have a diagnosis of autism, will usually lack capacity and so will be detained under the Mental Health Act. Managing an inpatient with Autism is quite different from managing a patient with a generic mental illness. The RT policy should be considered appropriate for patients with autism or a LD admitted to the generic wards as well as patients who are newly admitted to LD inpatient units.

For those patients that have undergone assessment and are the subject of ongoing treatment,

their behaviour is usually well understood and positive behaviour support (PBS) plans are put in place to manage this appropriately. The commissioners have set a standard that requires these plans to be in place within 28 days. Many patients will arrive in the inpatient setting with a community based PBS plan in place.

PBS plans will look at all aspects of the patient's presentation. How they should be supported when calm, when moving off baseline and then a reactive strategy when they become distressed (usually colour coded (Red Amber Green) and referred to as RAG). As part of the management plan, when patients are moving from amber into red, medication used in RT may be offered. This is usually offered in oral form, but, on occasion may be given by IM injection.

Where an LD patient has a PBS plan and is offered oral medication as part of the reactive strategy, this should not be considered to be RT as it is being used as part of an extensive plan to reduce the likelihood of self-harm or the harm of others. This is prescribed as part of a multidisciplinary team review (MDT) and the use of this and other strategies, including restrictive practices, are reviewed through regular MDT meetings.

The RT policy would therefore apply to those patients who do not yet have a PBS plan or where there is a need to use IM medication as per the policy. The use of medication in this way will be recorded and monitored as RT.

STOMP (Stopping Overmedicating People with Learning Disability and Autistic people) is a national project that aims to reduce the prescribing of psychotropic medications to people with a learning disability or autism or both. People with a learning disability or autistic people are commonly prescribed psychotropic medications and do not have diagnosis that match prescribing decisions.

STOMP aims to focus prescribers into thinking about how to improve quality of life and support the patient to stay well without medications they may not require.

Psychotropic medication may be right for some people and may keep someone safe and well. Prescriber should always think STOMP and how medication should be prescribed for the shortest period of time and how to plan reducing these when they are prescribed. There should be regular review for medications prescribed and close monitoring for potential atypical reactions to prescribed medications.

6.20 Prescribing RT in the Perinatal Period

RT should be avoided during pregnancy where possible. NICE recommend pregnant woman requiring RT should be treated according to the standard clinical guidelines on the short-term management of violence and aggression (Antenatal and postnatal mental health CG192). NICE also recommend that:

- Restraint procedures should be adapted to avoid possible harm to the foetus.
- When choosing an agent for RT in a pregnant woman, an antipsychotic or a benzodiazepine with a short half-life should be considered; if an antipsychotic is used, it should be at the minimum effective dose because of neonatal extrapyramidal symptoms; if a benzodiazepine is used frequently in the third trimester, the risks of floppy baby syndrome should be taken into account.
- During the perinatal period, the woman's care should be managed in close collaboration with a paediatrician, an anaesthetist and obstetrician.

RT should always be discussed with the consultant. As always, offer oral medications first and use the lowest effective dose, with the shortest half-life. Try to avoid polypharmacy – exposing foetus to fewer medications.

The preference is for Lorazepam then consider Promethazine or Haloperidol. A pregnant patient should never be left alone after receiving RT. There should also discussion with Midwives for foetal wellbeing checks after RT (contact maternity at GRH) Physical observations to be recorded on NEWS2 chart (for all physical checks, not just RT). Physical review to include: foetal movements, any PV loss (blood or fluid).

There is an understandable anxiety about prescribing and administering medications perinatally. However, there is a careful risk/benefit decision to be made: -

- Direct effects of RT on the neonate are likely to be minimal.
- The risks associated with use of restraint and any ongoing regular medicines are likely to be more significant.
- Lots of other considerations such as restraint positions.
- There are risks of doing nothing, including not treating the mental illness, on the foetus in the longer term.
- Ongoing consequences of doing nothing through the patient's agitation, could again effect the foetus in the short term.
- The outcome for the foetus in the long term can have a very significant burden for the mother's mental health in the future.
- Our principle duty of care is to the woman and her health (an unborn child has no legal rights until after its birth).

"Lorazepam should not be used during pregnancy, especially during the first and last trimesters, unless in the judgement of the physician such administration is clinically justifiable."

Reference: Lorazepam Macure 4mg/ml solution for injection - Summary of Product Characteristics (SmPC) - (emc) (medicines.org.uk)

Other considerations:

- Consider timing and method of delivery to inform physical restraint e.g. caesarean stitches.
- Consider if breastfeeding or expressing milk
    - Women should be encouraged and facilitated to breastfeed/express if they want to.
    - Clozapine and Lithium: Cannot usually breastfeed.
    - Polypharmacy not necessarily a reason to stop breastfeeding – seek specialist advice from pharmacy.
    - Seek advice from neonatologist if infant premature or has underlying health condition. With recent RT (last few hours) consider discarding milk and expressing again to feed.
- Think about dignity in this patient group. If caring for infant consider risks of maternal over-sedation.

References: -

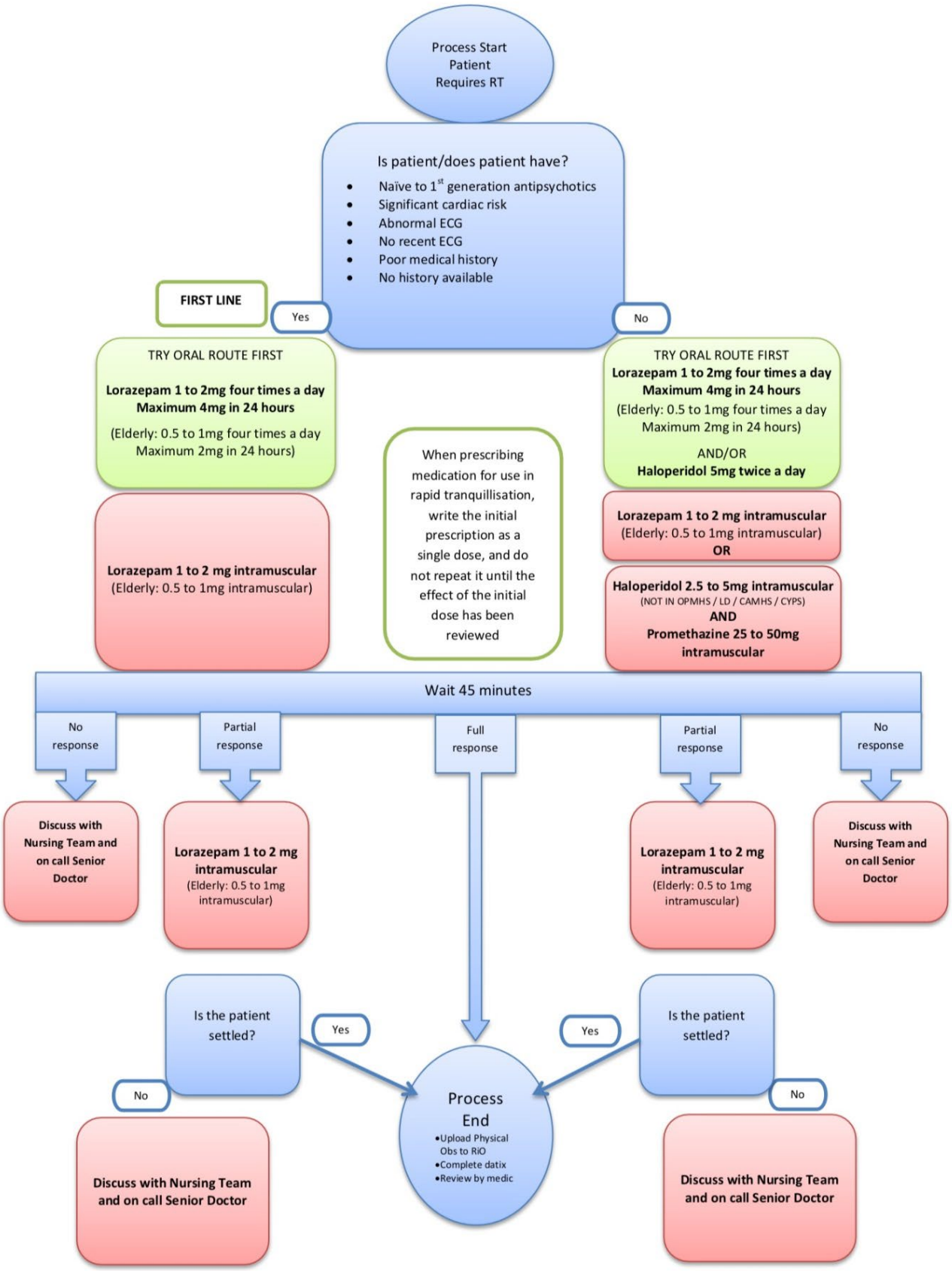
The British Association for Psychopharmacology | BAP Consensus Guidelines (page 2 – guideline

from 2017)

BAP/NAPICU RT guidelines 2018 BAP_Guidelines-RapidTranquillisation.pdf Drugs and Lactation Database (LactMed) - NCBI Bookshelf (nih.gov)

Bumps - best use of medicine in pregnancy (medicinesinpregnancy.org)

THE RAPID TRANQUILISATION ALGORITHM



MEDICATION TO BE USED ONLY **WITH SPECIALIST KNOWLEDGE/ADVICE**
PRESCRIBED AS ONCE ONLY

Any medication used from this list must have the reason for its use recorded in EPR and you must justify clearly why you have moved away from the NICE recommended regime.

Drug	Dose	Max Dose / 24hrs	Pharmacokinetics	Notes
Aripiprazole IM	**9.75mg (5.25–15mg) Repeated after 2 hours**	• Max 3 injections • Max 30mg (inc. oral)	• Onset not reported • Peak 1-3 hours • Half Life 75 hours	• Those receiving IM aripiprazole should be observed for orthostatic hypotension.
Zuclopenthixol Acetate (Acuphase®)	**Not for Rapid Tranquillisation due to delayed onset and long duration of action**			

Medication	Advantages	Disadvantages
Haloperidol/Promethazine	Faster and better tolerated than haloperidol alone. Better with benzo-tolerant patients Awake/calm more likely.	More risk of cardiac or seizure problems

- Decisions about drugs for rapid tranquillisation should be escalated to consultant level.
- In working age adult settings, the main option would be use of Haloperidol 2.5-5mg and Promethazine 25-50mg IM. Patients with an increased risk of seizures would be the main exception to this. Promethazine alone in the elderly: reduce dose until dose-response for individual patient established.
- In learning disability settings Midazolam may be the better option. However, for sites where this is used in rapid tranquillisation a supply of Flumazenil must be available in the ward drug cupboard together with staffing to give it intravenously.
- However, Olanzapine is recommended only for moderate disturbance, and its incompatibility with injectable benzodiazepines introduces other potential risks.

6.21 Medicines that should NOT be used for RT:

Diazepam IM: should not be administered IM due to its erratic pattern of absorption and lack of evidence for use in RT.

Haloperidol IM: should not be administered as monotherapy due to the high incidence of adverse effects.

Midazolam IM: should not be administered due to the risk of respiratory depression.

Lorazepam IM plus promethazine IM: this combination is not recommended due to lack of evidence for efficacy.

Zuclopenthixol Acetate (Clopixol Acuphase®): this cannot be rapid tranquillisation due to its slow onset of action. It may be useful for patients who have responded to other short acting IM antipsychotics if it is anticipated that they will require further frequent doses of IM antipsychotics. 50-150mg IM (maximum 100mg per injection in older adults). Do not administer to antipsychotic naïve patients. Refer to the Trust's guidelines on zuclopenthixol acetate (Clopixol Acuphase®).

6.22 Use of RT in Patients who have been Tasered

RT may be administered after the use of Tasers if indicated, with the usual precautions and monitoring. There is no known adverse link between any relevant medication and the use of Taser, this is in keeping with the knowledge and understanding of how the technology and medications work. Patients who have been tasered should be observed until they have recovered. Physical observations (pulse, BP and respiration rate etc.) should be taken every 10 minutes for the first hour and every 30 minutes thereafter, until they are fully conscious and mobile.

6.23 Physical Monitoring and Assessment after RT

After administration of RT it is necessary to carefully monitor the patients' physical health due to potential complications arising from RT and/or physical interventions. This comprises of three main elements:

1) At least hourly physical health observations using the NEWS2 score system:
    a. If normal after 4 hours this monitoring can be stopped
    b. If abnormal after 4 hours +/- concerns then doctor or advanced Nurse Practitioner (ANP) review is to be requested using SBAR (see appendix 3)
    c. If patient is unconscious and/or concerns regarding physical health, 15 min observations and doctor review
    d. If physical observations meet pre-arrest call criteria then MERT procedure
2) If unable to complete physical monitoring due to the patient's refusal, then non-contact physical health observations guidance
3) Rationale and reason for not completing full set of physical observations should be documented
4) A review by a prescriber if specific concerns are identified such as the side effects indicated below.

If PMVA or PBM techniques have been used as part of the RT then a physical examination will be required within 2 hours after the commencement of the restraint (Prevention and Safe Management of Risk Incidents policy).

This is mandatory for all patients and critical to ensuring patient safety. The appendices list the forms used in this monitoring.

6.24 Management of Specific Side Effects

a) Acute Dystonia: anticholinergic e.g. Procyclidine 5-10mg IM stat. Oral PRN procyclidine should be routinely be prescribed for patients who are also prescribed IM haloperidol.
b) Respiratory Depression: This is diagnosed if the respiratory rate falls below 10 per minute more than 10 minutes after administration. If this occurs as well as calling a MERT, raise the legs, clear the airway, ventilate mechanically and arrange urgent transfer to the general

hospital.

c) Consider Neuroleptic malignant syndrome (NMS).

6.25 Debrief Following RT

Following use of RT debrief should be undertaken in a timely fashion with the patient who received RT, other patients witnessing the events leading to the use of RT or administration/restraint itself as well as all the staff involved in RT.

Debrief provides at least three functions:

a) To rebuild any patient/clinician relationship following RT.
b) To reassure those involved and ensure they have support.
c) To reflect and understand why RT was used and whether a less restrictive option could be used next time in order to avoid further RT.

7. DEFINITIONS

Definitions are included in paragraph 5 – Definitions of Key Terms.

8. PROCESS FOR MONITORING COMPLIANCE

Are the systems or processes in this document monitored in line with national, regional, trust or local requirements?	YES

Monitoring Requirements and Methodology	Frequency	Further Actions
The use of RT will be subject to an annual audit to ensure prescribing is in line with the policy. The audit criteria will include assessing compliance against the following standards: • Duties • Prescribing guidelines with regards to RT. • The use of debrief following the use of RT. • Arrangements for monitoring patients having received RT (including physical health observations).	Annually	It is expected that all documents audited will comply with this guidance. The results of the audit will be presented to the Governance Committee who will be responsible for the development and monitoring of any identified actions within the scope of the audit.

9. INCIDENT AND NEAR MISS REPORTING AND REGULATION 20 DUTY OF CANDOUR REQUIREMENTS

9.1 To support monitoring and learning from harm, staff should utilise the Trust's Incident Reporting System, DATIX. For further guidance, staff and managers should reference the Incident Reporting Policy. For moderate and severe harm, or deaths, related to patient safety incidents, Regulation 20 Duty of Candour must be considered and guidance for staff can be found in the Duty of Candour Policy and Intranet resources. Professional Duty of Candour and the overarching principle of 'being open' should apply to all incidents.

10. TRAINING

Training in this subject area is considered mandatory for all qualified nurses and prescribers working in inpatient areas. This information, along with publicity and booking procedures are managed and published by the Trust's Training Department. Training information is located in the Trust's Training Matrix which can be found on the Training section of the Trusts intranet site. Staff

who are required to undertake this training will have it loaded onto their training profile on the Trust's Learning Management System (Care to learn).

RT training should be undertaken every 2 years or more frequently if there are major policy changes such as to reflect updated NICE guidance.

There is also separate training for Health Care Assistants specifically focused on post-RT physical health monitoring. This training will be mandatory and undertaken every 2 years for HCAs working in the inpatient environment.

Those involved in administering in RT policy should have relevant training PMVA or PBM techniques.

11. REFERENCES

Joint BAP NAPICU evidence-based consensus guidelines for the clinical management of acute disturbance: De-escalation and rapid tranquillisation. (2018)
BAP_Guidelines-RapidTranquillisation.pdf

National Institute of Clinical Excellence (2015): NG10 Violence and aggression: short-term management in mental health, health and community settings. NICE guidelines published: 28 May 2015
Overview | Violence and aggression: short-term management in mental health, health and community settings | Guidance | NICE

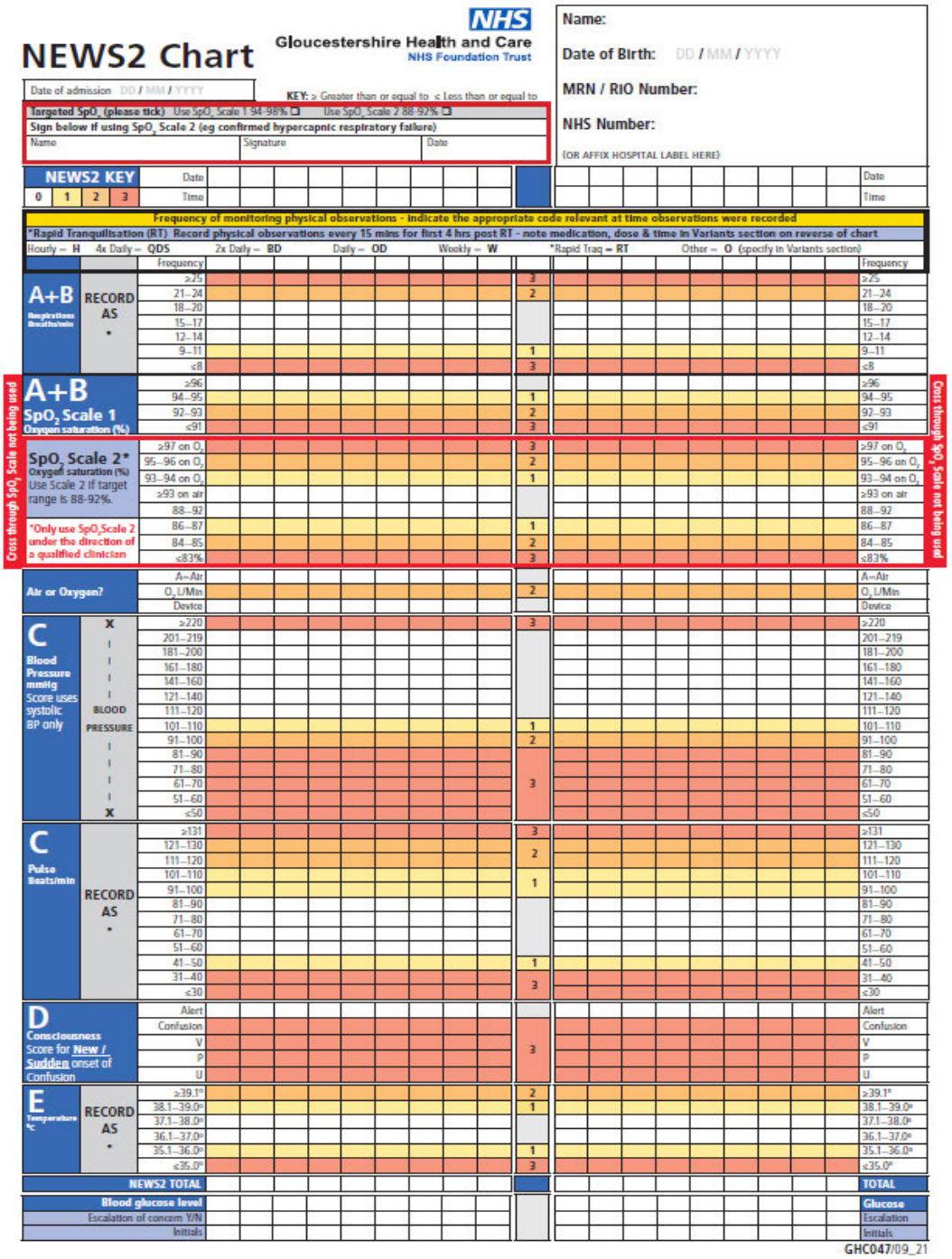
12. ASSOCIATED DOCUMENTS

GHC Prevention and Safe Management of Risk Incidents (including Violent and Aggressive Behaviour) Clinical Policy (CLP117)

Appendix 1 - Post RT Physical Monitoring Protocol

After each episode that rapid tranquillisation is administered physical observations need to be monitored and recorded on NEWS2 chart **hourly as a minimum – it is important to write 'RT' in the Frequency row to indicate these physical observations are for Rapid Tranquilisation.** (see guidance below that will require more regular monitoring).
If normal after 4 hours this monitoring can be stopped.
Physical observations to be recorded include: a) Level of consciousness b) Respiratory rate c) Heart rate d) Oxygen saturation without additional oxygen e) Blood pressure f) Temperature g) Hydration status
If abnormal after 4 hours and/or any concerns within this time a doctor or ANP review is to be requested using SBAR (Situation, Background, Assessment and Recommendation) method.
If patient is sedated, unrousable and/or concerns regarding physical health, physical observations should be recorded every 15 minutes and a **doctor or ANP** is to be requested. **If physical observations meet pre-arrest call criteria then MERT procedures should be activated.**
If unable to complete physical monitoring, the following should be **completed as a minimum** (please also refer to the "non-contact physical health observations guidance when completing NEWScore is not possible" document): a) Level of consciousness b) Respiration rate c) Any concerns regarding airways, breathing, circulation, disability, exposure **Rationale and reason for not completing full set of physical observations should be clearly documented on EPR.**

Appendix 2 – Sample copy of the NEWS2 Chart



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NEWS2 Chart

Name:
Date of Birth: DD / MM / YYYY
MRN / RIO Number:
NHS Number:
(OR AFFIX HOSPITAL LABEL HERE)

Date of admission DD / MM / YYYY

KEY: ≥ Greater than or equal to ≤ Less than or equal to

Targeted SpO_2 (please tick) Use SpO_2 Scale 1 94-98% ☐ Use SpO_2 Scale 2 88-92% ☐

Sign below if using SpO_2 Scale 2 (eg confirmed hypercapnic respiratory failure)

Name	Signature	Date

NEWS2 KEY 0 1 2 3

Date / Time

Frequency of monitoring physical observations - Indicate the appropriate code relevant at time observations were recorded

*Rapid Tranquillisation (RT) Record physical observations every 15 mins for first 4 hrs post RT - note medication, dose & time in Variants section on reverse of chart

Hourly – H 4x Daily – QDS 2x Daily – BD Daily – OD Weekly – W *Rapid Traq – RT Other – O (specify in Variants section)

		Frequency	Score
A+B Respirations Breaths/min	RECORD AS •	≥25	3
		21–24	2
		18–20	
		15–17	
		12–14	
		9–11	1
		≤8	3
A+B SpO_2 Scale 1 Oxygen saturation (%)		≥96	
		94–95	1
		92–93	2
		≤91	3
SpO_2 Scale 2* Oxygen saturation (%) Use Scale 2 if target range is 88-92%.		≥97 on O_2	3
		95–96 on O_2	2
		93–94 on O_2	1
		≥93 on air	
		88–92	
*Only use SpO_2 Scale 2 under the direction of a qualified clinician		86–87	1
		84–85	2
		≤83%	3
Air or Oxygen?		A=Air	
		O_2 L/Min	2
		Device	
C Blood Pressure mmHg Score uses systolic BP only	X	≥220	3
		201–219	
		181–200	
		161–180	
		141–160	
		121–140	
	BLOOD PRESSURE	111–120	
		101–110	1
		91–100	2
		81–90	
		71–80	
		61–70	3
		51–60	
	X	≤50	
C Pulse Beats/min	RECORD AS •	≥131	3
		121–130	2
		111–120	
		101–110	1
		91–100	
		81–90	
		71–80	
		61–70	
		51–60	
		41–50	1
		31–40	3
		≤30	
D Consciousness Score for New / Sudden onset of Confusion		Alert	
		Confusion	3
		V	
		P	
		U	
E Temperature °C	RECORD AS •	≥39.1°	2
		38.1–39.0°	1
		37.1–38.0°	
		36.1–37.0°	
		35.1–36.0°	1
		≤35.0°	3
NEWS2 TOTAL			TOTAL
Blood glucose level			Glucose
Escalation of concern Y/N			Escalation
Initials			Initials

Cross through SpO_2 Scale not being used

Cross through SpO_2 Scale not being used

GHC047/09_21

Appendix 3 - Pre-Arrest Criteria / NEWS2 Triggers

NEWS2 Score	Frequency of monitoring	Clinical response
LOW RISK 0	**Continue with routine monitoring**	Continue routine monitoring and observe for any clinical changes
Total 1-4 *Consider Sepsis*	**Increase frequency of physical observations**	Registered Practitioner to assess patient and to decide if increased frequency of monitoring and/or escalation of care is required. See local guidance Registered Practitioner to discuss with either: Medical Team, Out Of Hours or Rapid Response-Red Team Lead (0300 421 6570). **Use SBARD to handover**
LOW-MEDIUM RISK 3 in single parameter *Consider Sepsis*	**Increase frequency of physical observations to a Minimum 4 hourly** Consider increasing frequecy of physical observations as necessary.	Registered Practitioner to discuss with either: Medical Team, Out Of Hours or Rapid Response-Red Team Lead (0300 421 6570). **Use SBARD to handover**
MEDIUM RISK Total 5-6 Complete Sepsis Screening Tool	**Increase frequency of physical observations to a Minimum 1 hourly** **SEPSIS REG FLAG SIGNS** Slurred speech Extreme shivering/muscle pain Passing no urine (in a day) Severe breathlessness "I feel like I might die" Skin mottled/discoloured Refer to the Sepsis Screening Tool	Registered Practitioner to **immediately** seek urgent medical review/advice. If applicable refer to ReSPECT form. For Rapid Response-Red Team Lead (0300 421 6570) will decide if medical input can be provided in the community SWAST Health Care Professional Line (0300 369 0096) **Use SBARD to handover** Initiate emergency response and call (9)999 if transfer of patient is required
HIGH RISK Total 7 or more	**Continuous monitoring of patient's physical observations** Refer to the Sepsis Screening Tool	Initiate emergency response and call (9)999 for emergency ambulance to transfer patient to nearest acute hospital site. If applicable refer to ReSPECT form. For Rapid Response-Red Team Lead (0300 421 6570) will decide if medical input can be provided in the community SWAST Health Care Professional Line (0300 369 0096) **Use SBARD to handover**

If a decision is made to deviate from the clinical response guidance above,this MUST be documented in the patient's progress notes and care plan with a rationale for the decision.

Nothing in this scheme should prevent a Practitioner making an appropriate response based upon their clinical judgement.

Variants:	Registered Practitioner to detail any variation in specific NEWS2 parameters:

Print name	Signature	Date	Review date
		DD / MM / YYYY	DD / MM / YYYY

SBARD - Situation, Background, Assessment, Recommendation, Decision	
Situation	State name, position and location. patients details, reason for calling
Background	Any recent relevant events, eg: MHA status, date & reason for admission, medical history, medications, investigations/treatments
Assessment	NEWS2 score, ABCDE assessment, clinical concerns
Recommendation	Be specific, explain what you need, make suggestions, clarify expectations
Decision	Record what has been agreed in the patients progress notes

SBARD - Situation, Background, Assessment, Recommendation, Decision Do not hestite to call 999 if the patient is deteriorating or you clinical concerns	
Situation	State name, position and location. patients details, reason for calling
Background	Any recent relevant events, MHA status, date & reason for admission, medical history, medications, investigations/treatments
Assessment	NEWS2 score, ABCDE assessment, clinical concerns
Recommendation	Be specific, explain what you need, make suggestions, clarify expectations
Decision	Record what has been agreed in the patients progress notes on RiO

Appendix 4 - Non-Contact Physical Observations – Please also see Non-Contact Physical Observations Attachment

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Non-Contact Physical Observations

(When it is not possible to use NEWS2 Physical Observation Chart, e.g. during and after restrictive interventions/manual restraint)

Name:	Date of birth:

If any statement from the red box is true, raise the alarm and DO NOT leave the patient

Airway	• Airway obstructed? Silence? Coughing? Swelling? Gurgling? • Risk of vomiting. **Consider moving onto their side into the recovery position and carry out constant observations to prevent choking.**	• Talking (not just moans and groans). • Airway clear.
Breathing	• Noisy or difficult breathing even with an open airway. • Breathing rate is more than 20 breaths per minute. • Breathing rate is less than 12 breaths per minute. **Consider: COPD hypercapnic respiratory failure, asthma, heart failure**	• Breathing is quiet and regular. • Breathing between 12-20 breaths per minute. **Breathing causes no extra effort of difficulty e.g. no wheezing or gurgling.**
Circulation	• Change in ability to mobilise. • Pale or flushed, clamming, sweating, cold, swollen, blue tinge to skin. • Dehydrated and / or malnourished. • Trauma / bleeding.	• Mobility normal. • Presenting as normal. • Warm, pink skin, comfortable presentation.
Disability	• Unresponsive. • Unexpected sleepy/drowsy, confusions, fitting. • Pain, only responds to physical stimulus. **Consider checking all observations including blood glucose level and epilepsy.**	• Alert and orientated. • Responsive to voice responding to voice could indicate a decrease in level of consciousness. • Drinking & eating. • Active.
Exposure		• Monitor and record findings and visual observations using the non-contact physical observations. **Consider additional monitoring for asthma, diabetes, epilepsy, intoxication etc., medication side effects.**

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