

RAPID TRANQUILLISATION POLICY

**This policy relates specifically to mental health staff
working in Somerset Partnership**

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Applies to:	All mental health inpatient registered nurses and doctors

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DOCUMENT CONTROL

Reference	Version	Status	Author
MAR16/RT	9	Final	Medical Director
<p>Amendments This document replaces Guidelines for Rapid Tranquillisation Version 4.0 Sep 2010 and all previous versions. Version 4.0 was amended in line with the NHSLA Risk Management Standards 2012-2013. Amendments have been made through the guidance to reflect improvements and changes in clinical practice regarding choice of medication for rapid tranquillisation and also monitoring requirements. Changes were made (V5.1) following recommendation made in a clinical re-audit of RT (2014) and also (V5.2) following NICE Violence Guidance (2015). Change to wording of paragraph 5.3.5 to include instructions for electronic prescribing (Mar 17). Updated Appendix A: Additional advice for elderly patients and Lorazepam dose (Dec 17). Changes made to prescribing of RT as STAT doses only rather than PRN now that this facility is available in electronic prescribing. This brings us in line with national guidance which explicitly states that RT should NOT be prescribed on a PRN basis (March 2018)</p>			
<p>Document objectives: This policy is intended to assist clinical staff in carrying out Rapid Tranquillisation in adult and older people's inpatient units both effectively and safely. Rapid Tranquillisation in children and young people requires direct involvement of a Child and Adolescent Consultant Psychiatrist.</p>			
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CONTENTS

Section	Summary of Section	Page
Doc	Document Control	2
Cont	Contents	3
1	Introduction	4
2	Purpose & Rationale	5
3	Duties and Responsibilities	6
4	Definitions	6
5	The Policy	7
	5.1 <i>Environmental issues</i>	7
	5.2 <i>Legal issues</i>	7
	5.3 <i>Assessment</i>	8
	5.4 <i>Administration of Rapid Tranquillisation</i>	11
	5.5 <i>After Rapid Tranquillisation</i>	16
6	Untoward Event Reporting	17
7	Training Requirements	17
8	Monitoring Compliance and Effectiveness	18
9	References, Acknowledgements and Associated documents	18
10	Appendices	19
Appendix A	Rapid Tranquillisation Algorithm	20
Appendix B	Checklist for Medical Staff	21
Appendix C	Clinical Audit Standards	22

1. INTRODUCTION

- 1.1 This policy is primarily intended to assist doctors in training and nursing staff in the care of adults and older people in acute mental health inpatient units. It will be used in training and induction programmes for doctors in training. The use of rapid tranquillisation in children and young people is an individual clinical decision and requires the involvement of a Child and Adolescent Consultant Psychiatrist.
- 1.2 **For the purposes of this policy rapid tranquillisation (RT) is defined as the parenteral administration of tranquillising drugs, if oral medication is not possible or appropriate, with the aim of obtaining a state of calm as soon as possible in an acutely disturbed or violent patient.**
- 1.3 RT is very much a treatment of last resort and should be used when all other approaches fail (NICE Violence Guideline 2015 & NICE Schizophrenia Guideline 2014). RT should only be used for the control of seriously aggressive behaviour when the patient or others are at serious risk of significant harm. Emphasis should be on the prevention of RT by adequate attention to the recognition of risk factors for violent behaviour (including clinical predictors, environmental factors and antecedent/warning signs), attention to cultural issues and the use of appropriate skilled assessment and interventions such as de-escalation techniques.
- 1.4 RT will frequently be used alongside physical restraint techniques and will occasionally be used alongside seclusion. Please refer to 'Prevention and Management of Violence and Aggression (PMVA) Policy' and 'Proactive Care Policy'. These can be found on the intranet (on the home page click on 'Policies and Procedures').
- 1.5 The decision to use RT should always involve: (a) joint medical and nursing discussion and (b) clinical assessment including physical and psychiatric examination with perusal of the clinical notes and the Medication Administration Record (MAR). RT should always be followed by close psychiatric and physical observation of the patient. This policy summarises good practice in clinical assessment and monitoring.
- 1.6 It is important to pre-empt and anticipate problems both to prevent the need for RT and also to ensure that appropriate physical and psychiatric assessment can take place thoroughly prior to an emergency situation. It is therefore recommended that joint medical and nursing discussion and full assessment takes place electively wherever possible and certainly when drugs for RT are prescribed.
- 1.7 When drugs for RT are prescribed there should be full documentation in the clinical notes that adequate assessment encompassing the scope of this policy (see below) has taken place. This is particularly important in inpatients units where first line out of hours medical cover is provided by primary care services. Prescriptions for RT drugs should be rewritten every 7 days.
- 1.8 In units with out of hours medical cover provided by primary care services, if nursing staff feel RT is urgently required out of hours and there is no valid prescription, they should seek advice from the Approved Clinician on the consultant out of hours rota to ensure that there is a joint medical and nursing

discussion encompassing the scope of assessment recommended in the policy and they should also contact the out of hours GP responsible for attending the unit. A doctor should be available to attend an alert as soon as possible and ideally within 30 minutes when RT is required.

- 1.9 RT should not proceed unless appropriately trained staff are present in adequate numbers to control the immediate situation and to maintain control until RT is effective.
- 1.10 When administering rapid tranquillisation, staff must be sensitive to the patient's protected characteristics and culture at all times and the potential effect these may have. The reasons for administering must be fully explained to the patient in a way that can be easily understood and it may be necessary to employ a translator for this purpose. (see Interpreting and Translation Services Policy). Any written information given to the patient must also be in an easily understood format.

2. PURPOSE & RATIONALE

- 2.1 The policy is primarily intended to assist doctors in training, other medical staff and also nursing staff in the care of adults and older people in acute inpatient units. It applies to both permanent staff and temporary staff.
- 2.2 The purpose of the policy is to ensure that best practice, as recommended by NICE (Schizophrenia Guideline 2014; Violence Guideline 2015) and the Royal College of Psychiatrists, is incorporated into clinical care within the Trust.

3. DUTIES AND RESPONSIBILITIES

- 3.1 Duties in respect of the requirements of this document are as follows
 - The **Trust Board** has overall responsibility for procedural documents and delegates responsibility as appropriate
 - The **Lead Director** is the Medical Director. The **Author** is the Medical Director and he will be responsible for producing written drafts of the document and for consulting with others and amending the draft as appropriate. The document will be reviewed at least every three years or sooner if there is a major change to law, legislation or circumstances arise which have significant impact on this document.
 - **Heads of Division** Responsibility for implementing the policy is devolved to Heads of Division.
 - The Head of **Corporate Governance** has responsibility for holding the central database of procedural documents, including this guidance, and for providing quarterly reports to each Governance Group highlighting which policies are due for review. The Corporate Governance Team also has responsibility for dissemination of the final document and archiving old versions.

- **All Medical, pharmacy and inpatient nursing staff** including temporary staff are individually responsible for their actions including complying with this policy.
- The Improving Quality in Inpatient Services **Best Practice Group** has responsibility for undertaking audit and signing off key recommendations and is overseen by the **Medical Audit Group**.
- The **CSCE** is a subgroup of the Clinical Governance Group and will escalate areas of concern to the **Clinical Governance Group**.

4. DEFINITIONS

Advance decision: A written statement made by a person aged 18 years or over that is legally binding and conveys a person's decision to refuse specific treatments and interventions in the future.

Advance statement: A written statement that conveys a person's preferences, wishes, beliefs and values about their future treatment and care. An advance statement is not legally binding.

De-escalation: The use of techniques (including verbal and non-verbal communication skills) aimed at defusing anger and averting aggression. PRN medication can be used as part of a de-escalation strategy but PRN medication used alone is not de-escalation.

PRN (pro re nata): When needed. In this policy, PRN refers to the use of medication as part of a strategy to de-escalate or prevent situations that may lead to violence or aggression. It does not refer to PRN medication used on its own for rapid tranquillisation during an episode of violence or aggression.

Rapid tranquillisation (RT): The parenteral administration of tranquillising drugs, if oral medication is not possible or appropriate, with the aim of obtaining a state of calm as soon as possible in an acutely disturbed or violent patient.

Seclusion: Defined in accordance with the Mental Health Act 1983 Code of Practice: 'the supervised confinement of a patient in a room, which may be locked. Its sole aim is to contain severely disturbed behaviour that is likely to cause harm to others'.

Violence and aggression: A range of behaviours or actions that can result in harm, hurt or injury to another person, regardless of whether the violence or aggression is physically or verbally expressed, physical harm is sustained or the intention is clear.

5. THE POLICY

5.1 Environmental issues

5.1.1 The Trust has a responsibility to ensure that the environment in clinical areas is appropriate for the needs of the acutely ill. In acute units, factors that are associated with an increased risk of violence include overcrowding, lack of privacy, lack of activity, long waiting times to see staff, poor communication between patients and staff and weak clinical leadership (NICE Schizophrenia Guideline 2014; Violence Guideline 2015).

5.1.2 Inpatients should have access to information about the following in a suitable format:

- which member of staff has been assigned to them and how and when they can be contacted
- why they have been admitted (and if detained, the reason for detention, the powers used and their extent, and rights of appeal)
- what their rights are with regard to consent to treatments, complaints procedures, and access to independent help and advocacy and also what may happen if they become disturbed/violent.

This information should be provided at each admission, repeated as necessary and recorded in the notes.

5.1.3 In the majority of cases of behavioural disturbance rapid tranquillisation is not necessary and should not be resorted to routinely. If drugs are required consideration should always be given to offering an oral preparation first, preferably as a liquid or soluble preparation.

5.2 Legal Issues

5.2.1 RT should be humane, ethical, legal and clinically effective. All clinicians should consider the legal framework within which RT is used and document issues related to consent and the patient's capacity to consent to treatment. The primary consideration in an emergency situation involving violence is the safety of all concerned. In these circumstances, emergency treatment decisions of voluntary patients (those who have capacity and have accepted admission to the ward), informal patients (those without capacity who have been admitted without use of the Mental Health Act (MHA)) or patients subject to sections 5(4), 5(2), 4, 35, 135 or 136 of the MHA, should include a consideration of the patient's capacity to consent or refuse the treatment, but there should not be a delay in providing necessary treatment if any delay would compromise the safety of the patient or others.

5.2.2 Where capacity is absent, treatment may be provided in the patient's best interests under the provisions of the Mental Capacity Act 2005 (MCA). The provisions of the

MCA and its Code of Practice ('Consent and Capacity to Consent to Examination and/or Treatment' Policy) should be followed, although the nature of the emergency may preclude an immediate detailed following of the Code of Practice (see 'emergency procedures' in the Trust's policy). Any intervention required to manage the disturbed behaviour must be a reasonable and proportionate response to the risks it seeks to address.

- 5.2.3 Consideration should be given to advance decisions in the care plan. All service users aged 18 or over, identified to be at risk of receiving RT should be given opportunity to have their right to refuse treatment documented in an advance decision, or their treatment preferences recorded as an advance statement. Patients with capacity who choose to make an advance decision refusing treatment should be made aware that if urgent medical treatment is thought necessary, it can be given under either section 2 or 3 of the MHA.
- 5.2.4 Part 4 of the MHA gives authority to provide compulsory medical treatment for mental disorder, including urgent treatment, to patients detained under sections 2, 3, 36 and 37 and also to those subject to a Community Treatment Order after recall to hospital. These patients, to whom Part IV applies, are not subject to the provisions of the MCA for treatment of their mental disorder. Section 58 applies to these patients if three months or more have elapsed since medication for mental disorder was first given to the patient during an unbroken period of compulsion; these patients cannot be given medication for mental disorder unless the Responsible Clinician or a Second Opinion Appointed Doctor (SOAD) has authorised the treatment and certified that they have capacity and are consenting (Form T2) or a SOAD has authorised the treatment and certified that they are not capable and / or not consenting (Form T3). However if treatment is immediately necessary in the opinion of the Responsible Clinician it can be given compulsorily under the provisions of section 62 in patients who are not capable and / or not consenting. For the purposes of RT this means that there are powers to administer medication compulsorily in the first 3 months of detention but after that period the MHA only allows compulsory treatment if this has been authorised under section 62 or by a Form T2 or Form T3. Doctors in training and nursing staff should be aware of the legal framework under which RT is being given and seek advice from a consultant if they are in any doubt.
- 5.2.5 The MHA does not give authority to provide compulsory medical treatment to patients detained under Sections 5(4), 5(2), 4, 35, 135 or 136 nor patients subject to a Community Treatment Order that have not been recalled to hospital (see 5.2.1 and 5.2.2 above).

5.3 Assessment

- 5.3.1 Doctors and nursing staff may be under pressure to act quickly to prescribe and administer medication. However, it is important that prior to RT there is:
- (a) discussion between nursing and medical staff
 - (b) perusal of the casenotes and the Medication Administration Record (MAR)
 - (c) a mental state examination (which can be brief in an emergency situation) and
 - (d) a physical examination with at least assessment of vital signs whenever practical. It is preferable for this assessment to take place on an elective basis rather than in an emergency situation and for this to be fully documented in the

psychiatric casenotes; certainly this assessment should take place whenever drugs for RT are prescribed.

- 5.3.2 The need for RT should be anticipated and preventative measures put in place when indicated. Assessment should take into account previous violent or aggressive behaviour and this is a factor predicting future risk. Do not make assumptions based on culture, religion or ethnicity and ensure that risk assessments are objective. Involve the patient in the risk assessment including asking about factors that might lead to aggression, how this might be prevented and measures that have worked effectively in the past. Ensure risk assessments and management plans are regularly reviewed with the frequency of review determined by the level of risk.
- 5.3.3 If rapid tranquillisation is being used, a psychiatrist on the specialist register will review all medication at least once a day. This can be a face to face assessment or alternatively a telephone discussion involving a senior doctor.
- 5.3.4 Check the age of the patient: **Patients less than 16 years**
Do not administer RT without discussion with a Child and Adolescent Consultant Psychiatrist. If approved, use intramuscular lorazepam for RT and adjust the dose according to their age and weight.
- 5.3.5 Do not administer RT to frail elderly patients without discussion with an Old Age consultant psychiatrist.
- 5.3.6 Do not administer RT to pregnant women without discussion with a Consultant with appropriate specialist knowledge (see 5.4.31)
- 5.3.7 Oral and intramuscular (IM) medication must be prescribed separately and the abbreviation 'O / IM' must not be used.
- 5.3.8 Medication for RT must be written up as a single dose and must not be repeated until the effect of the initial dose has been reviewed by a prescriber with appropriate specialist knowledge. Single dose prescriptions used in RT must be prescribed using the single (STAT) dose section in the electronic prescribing module or the STAT section of a paper MAR chart if e-prescribing is not available.
- 5.3.9 Prescriptions for STAT doses can be valid for up to a maximum of 7 days. However, duration of validity of RT STAT prescriptions should be for the minimum appropriate period. Although a maximum of 7 days is permitted, it does not mean a shorter period of validity should not be specified when clinically appropriate.
- 5.3.10 RT must not be prescribed as PRN medication.
- 5.3.11 Organic Factors Behavioural emergencies may flow from a wide range of underlying organic diagnoses (see Table 1 below). Whilst a degree of uncertainty is inevitable in the emergency situation one should always attempt to formulate a provisional diagnosis carefully considering organic disorders as a possible cause of disturbed behaviour.

Table 1.

Metabolic and endocrine	Hypoxia, hypoglycaemia, hypercalcaemia, liver failure, renal failure, thyroid disease, cortisol excess, pancreatitis, fever.
Mechanical	Brain contusion.
Infections	Meningitis, encephalitis.
Vascular	Thromboembolic stroke, brain haemorrhage, subarachnoid haemorrhage, subdural haematoma.
Nutritional	Thiamine deficiency.
Drug	Alcohol (including withdrawal syndrome), amphetamine and other stimulants, corticosteroids, dopamine agonists.
Paroxysmal	Postictal states, partial epilepsy.
Neoplastic	Brain tumour (primary or secondary).

5.3.12 Medical History Enquiries should be made into the existence of medical problems that might:-

- (a) produce an organic syndrome causing the behavioural disturbance
or
- (b) affect the safety of RT (for example cardiac disease or respiratory depression, the latter being particularly relevant when lorazepam is used).

5.3.13 Wherever practical a 12 lead ECG should be conducted in all patients prescribed antipsychotics and at risk of RT (Royal College Consensus Statement 2006). ECG recording is impossible under circumstances of RT itself and should therefore be undertaken electively wherever possible (for example, on admission or within the first 24 hours of admission). ECGs should be examined for evidence of abnormal rhythm, ischaemic heart disease, left ventricular hypertrophy, repolarisation abnormalities and QT_c prolongation. If no ECG is available it is prudent to avoid high doses of antipsychotics, particularly parenteral antipsychotics.

5.3.14 Drug History The toxic effects of drugs as well as drug withdrawal can be significant factors in behavioural emergencies. A drug history allows consideration of any potential interactions. One should consider the hazards of drug combinations in the RT situation when one drug may inhibit the metabolism of the other leading to an unexpected rise in plasma concentration. Whenever the diagnosis seems uncertain or substance use is suspected a urine sample to screen for drugs of abuse should be obtained at the first opportunity, even though the resulting information may not be available until some time later.

- 5.3.15 Some psychiatric drugs may cause an increase in haloperidol plasma levels (SSRIs including fluoxetine, fluvoxamine and sertraline, venlafaxine, chlorpromazine, promethazine and buspirone). Tricyclic antidepressants, antihistamines and diuretics can all predispose to cardiac arrhythmia, dehydration and / or electrolyte disturbance and hence can increase the risk associated with RT. Valproate can reduce the clearance of lorazepam by 20 – 40%.
- 5.3.16 Mental State The mental state examination should focus on identifying any acute organic syndrome. Disorientation, impaired or varying conscious level and visual hallucinations are primary identifying features.
- 5.3.17 Physical Examination A brief physical examination, even in the restrained patient, should be considered whilst vital signs should be obtained at an early stage and then rechecked and recorded during the course of treatment. The possibility of head injury should always be considered. Although a systematic neurological examination is unlikely to be possible, the movement of the extremities, facial and ocular muscles and pupillary function should be noted at least.

5.4 Administration of Rapid Tranquillisation

- 5.4.1 Oral medication should be offered before parenteral medication as far as possible. Medication for RT should be used with caution because of the risks of loss of consciousness, loss of airway, cardiovascular and respiratory arrest, seizures, extrapyramidal signs (akathisia, dystonia, neuroleptic malignant syndrome), interaction with prescribed or illicit drugs and because of possible underlying physical disorders which might increase the risk of complications. A crash bag (including an automatic defibrillator, a bag valve mask, oxygen, cannulas, fluids, suction and first line resuscitation drugs) should be available within 3 minutes wherever RT might be used. This equipment should be maintained and checked weekly (NICE Violence Guideline 2015).
- 5.4.2 Somerset Partnership mental health inpatient nurses are trained in immediate life support and in using resuscitation equipment including Automated External Defibrillators. The Trust does not operate a cardiac arrest team and medical staff are not always available on site. Therefore the Ambulance Service must be called using the 999 number once a clinical emergency has been confirmed. If Cardiopulmonary Resuscitation is commenced it should continue until the paramedics arrive or the patient shows signs of regaining consciousness.
- 5.4.3 Doctors in training and nursing staff should routinely prescribe and administer medication according to the accompanying algorithm (Appendix A). Do not prescribe alternative medications unless advised for specific clinical reasons by a psychiatrist on the Specialist Register.
- 5.4.4 The preferred options for RT are either intramuscular lorazepam or a combination of intramuscular haloperidol and intramuscular promethazine (NICE Violence Guideline 2015).
- 5.4.5 When deciding which medication to use, take into account patient preference, medical history, pregnancy, possible intoxication, previous response including

adverse effects, potential for interaction with other medications and the total daily dose of medications prescribed and administered.

- 5.4.6 Adjust the dose of RT drug according to age and general frailty. The elderly are particularly susceptible to extrapyramidal side effects and other risks of RT; do not administer RT to frail elderly patients without first seeking advice from a psychiatrist on the Specialist Register. Antipsychotics should be avoided in cases where Lewy body dementia is suspected. Particular caution is required in the presence of concurrent prescription of drugs that lengthen QTc interval or congenital QTc prolongation.
- 5.4.7 Evidence in some randomised controlled trials suggests the combination of haloperidol and promethazine may be more effective in inducing calm or sedation than haloperidol alone and that it may cause less acute dystonia, because of the anticholinergic properties of promethazine. The combination is likely to increase some risks of rapid tranquillisation including excessive sedation, respiratory depression and cardiac risks, compared to the use of haloperidol alone.
- 5.4.8 If there is insufficient information to guide the choice of medication for rapid tranquillisation, or the patient has not taken antipsychotics before, use intramuscular lorazepam.
- 5.4.9 If there is a partial but inadequate response to intramuscular lorazepam, consider a further dose.
- 5.4.10 If there is no response to intramuscular lorazepam, consider intramuscular haloperidol combined with intramuscular promethazine. However, the co-administration of haloperidol and lorazepam in combination is not recommended.
- 5.4.11 If there is a partial but inadequate response to intramuscular haloperidol combined with intramuscular promethazine, consider a further dose.
- 5.4.12 If there is no response to intramuscular haloperidol combined with intramuscular promethazine, consider intramuscular lorazepam if this has not already been used.
- 5.4.13 If these options have been exhausted seek advice from a psychiatrist on the Specialist Register.
- 5.4.14 When prescribing for RT, write the initial prescription as a single (STAT) dose and do not repeat it until the effect of the initial dose has been reviewed.
- 5.4.15 Haloperidol was previously a first line drug for RT but is less well tolerated than lorazepam with a higher incidence of extra-pyramidal and other side effects.
- 5.4.16 Lorazepam is particularly useful in cases where there is no known psychiatric history and in drug-naïve patients, especially those with no prior exposure to antipsychotics or where there are no psychotic symptoms present. Also use lorazepam for most people over the age of 60 or in people with medical risk factors especially a history of cardiac disease or neuroleptic malignant syndrome. Lorazepam should be avoided in patients with respiratory depression. Never mix

lorazepam with other drugs in the same syringe. For intramuscular injection dilute lorazepam with an equal volume of physiological saline or water for injection.

- 5.4.17 The Summary of Product Characteristics for haloperidol injection states that a baseline ECG is recommended prior to treatment in all patients, especially in the elderly and especially in patients with a positive personal or family history of cardiac disease or abnormal findings on clinical cardiac examination. If no ECG has been taken electively and no ECG is available in the RT situation and / or there is evidence of cardiovascular disease (including QTc prolongation) it is prudent to avoid the use of parenteral haloperidol if there are other reasonable alternatives. However, there may be some situations where the balance of risk to the patient or to others justifies use of haloperidol (i.e. the risk associated with inadequate tranquillisation outweighs the risk of an adverse event due to side effects). This is an individual clinical decision and the age of the patient, cardiac risk factors etc. will need to be taken into account. However, use of haloperidol injection under these circumstances is off license (i.e. falls outside of the Summary of Product Characteristics).
- 5.4.18 Promethazine has an indication for sedation but not specifically for rapid tranquillisation. It also has a slower onset of action than other alternatives. It enhances anticholinergic or sedative effects of other drugs including tricyclic antidepressants. The Summary of Product Characteristics for promethazine states that it is contraindicated in people with central nervous system depression or patients that have taken monoamine oxidase inhibitors in the last 14 days. Caution is advised in respiratory disease, severe coronary artery disease and narrow angle glaucoma.
- 5.4.19 In cases where intramuscular haloperidol is used an antimuscarinic should be immediately available to reduce the risk of acute dystonia (NICE Violence Guideline 2015). Acute dystonia has been reported in up to 30% of RT and may occur unexpectedly in the days that follow. Procyclidine IM 5-10 mg should be administered for acute dystonia and can be repeated if necessary after 20 minutes.
- 5.4.20 Consider haloperidol in patients regularly using prescribed or illicit benzodiazepines.
- 5.4.21 Doctors in training should not prescribe drugs other than those in the RT algorithm (Appendix A) for RT without seeking advice from a psychiatrist on the Specialist Register. Intramuscular diazepam and chlorpromazine are not recommended for use in RT. The manufacturers of Olanzapine have withdrawn the product from the UK market and its use in RT is no longer recommended (NICE Violence Guideline 2015).
- 5.4.22 Zuclopenthixol acetate (clopixol acuphase) is not recommended for RT because of long lag to onset and long duration of action. However it may be considered as an option in patients who are well known to the service and whose relapse signature suggests repeated short acting neuroleptic injections are likely to be required because of the likelihood of disturbed behaviour over a prolonged period of time. Avoid the use of zuclopenthixol acetate in drug-naïve, comatose or pregnant patients and any patient who is violently resisting whilst in restraint, or

where there is a history of liver, renal or cardiac disease or severe extrapyramidal side effects.

- 5.4.23 Violent behaviour can virtually always be managed without the use of high doses or 'drug cocktails'. The minimum effective dose should be used. BNF advisory dose limits should be adhered to except in exceptional circumstances. A decision to raise the dose of antipsychotics or benzodiazepines above the recommended BNF upper limit should only be taken by a psychiatrist on the Specialist Register. This applies to BNF maximum doses of individual drugs and cumulative doses arising from drug combinations. Careful watch should be kept on the total percentage of BNF maximum arising from drug combinations of all regular and PRN medication, as well as any STAT doses of medication specifically prescribed for RT.
- 5.4.24 If IM medication is used the patient should subsequently be observed continuously within eyesight. At the outset of the incident ensure that a record is kept on the RIO Rapid Tranquillisation Monitoring Chart to log level of consciousness, airway, respiratory rate, oxygen saturation, pulse and blood pressure as indicated on monitoring record. This form is located in the RIO patient record and is accessed from a link within the Physical Intervention Form De-escalation Pathway (Assessments Menu > Physical Restraint > Physical Intervention Form De-escalation Pathway). The nurse administering RT medication is responsible for ensuring the Rapid Tranquillisation Monitoring Chart is completed. This chart will provide the basis for future RT audit. It is accepted that in practice it is not always possible to measure all the desired parameters in an uncooperative patient. However, if it is not possible to assess vital signs the minimal acceptable assessment is of level of consciousness (AVPU: Alert, Responds to Vocal Stimuli, Responds to Pain, Unresponsive to All Stimuli), breathing (including respiratory rate) and confirmation of an adequate airway (Patent, Threatened, Partial Obstruction or Complete Obstruction) as this can be achieved for an uncooperative patient. A pulse oximeter should always be available.
- 5.4.25 Benzodiazepines are contraindicated in pulmonary insufficiency and when used Flumazenil should be available in case of respiratory depression. After RT, if the respiratory rate is falling progressively and is below 14 breaths per minute on routine observations then nursing staff should seek medical advice as soon as this is apparent and should consider the administration of oxygen. If the oxygen saturation falls to 90% or less and / or the respiratory rate falls below 10 breaths per minute then administer oxygen at 15 L/min through a high-concentration reservoir mask and dial 999 for a paramedic to attend urgently. If respiratory insufficiency is due to benzodiazepines give Flumazenil as an initial dose of 200 micrograms IV over 15 seconds, then 100 micrograms at 60 second intervals if required (maximum total dosage of 1mg in 24 hours). Flumazenil has a half life of 50 minutes which is significantly shorter than most benzodiazepines; observe the patient for relapse over the following 24 hours. For more information see Medical Emergencies Management Policy (Non Cardiac Arrest).
- 5.4.26 It is of paramount importance to recognise the deteriorating patient and to minimise any risk of respiratory and cardiac arrest. This is achieved by assessing level of consciousness, airway and vital signs. Medical and / or paramedic assistance is required if the airway is threatened or obstructed, if the patient does

not respond to verbal stimuli, if respiratory rate fall progressively and in particular if less than or equal to 10 breathes a minute, if oxygen saturation is falling especially if 90% or less, if pulse is less than 50 / minute and if the systolic blood pressure is less than 90mmHg. If the patient becomes unconscious, unresponsive to painful stimuli and is not breathing normally then commence cardiopulmonary resuscitation after treating any airway obstruction and administering oxygen.

- 5.4.27 In cases of increased temperature or deteriorating mental state with confusion consider neuroleptic malignant syndrome if antipsychotics have been administered. Withhold all antipsychotics and take blood for white cell count and CPK as soon as practicable.
- 5.4.28 Should a patient require transfer to a psychiatric ward on another hospital site after RT there should be cardiovascular and respiratory stability for at least 45 minutes after the last drug has been administered. A suitably trained member of staff (see training standards in Section 7 below) should accompany the patient. For transfer between open wards patients should be calm and must be accompanied by staff. If there is a need to transfer urgently from an open ward to a PICU because of ongoing aggression there should be a joint medical and nursing risk assessment in order to consider the most suitable and safe transport and escort arrangements.
- 5.4.29 The use of seclusion with RT is not absolutely contraindicated but if seclusion is used the potential complications and risks should be taken particularly seriously and the service user should be monitored 'within eyesight' (this includes monitoring via remote surveillance by non-recordable television monitor). Subject to risk assessment, taking into account all potential risks, aim to terminate seclusion as soon as RT has taken effect. Heavily sedated patients should not be secluded.
- 5.4.30 Adequate restraint of the patient, if required, is crucial before IM drugs are administered. However, restraint of any individual should be used only where de-escalation and use of oral medication are insufficient, and should always be used in conjunction with further efforts at de-escalation. Its only purpose is to take control of immediately dangerous behaviour, where the risk of not physically intervening is unacceptable. Where restraint is utilised staff must always use the least restrictive method available and endeavour to return full control to the individual as soon as it is practically safe to do so. This philosophy is relevant to all restraint but especially with pregnant women, where not only has the client's safety and well being to be considered but also that of the unborn child.
- 5.4.31 A pregnant woman requiring rapid tranquillisation:-
- (a) should not be secluded after rapid tranquillisation as this compromises observation
 - (b) restraint procedures should be adapted to avoid possible harm to the foetus
 - (c) if an antipsychotic is used, it should be at the minimum effective dose because of neonatal extrapyramidal symptoms
 - (d) if a benzodiazepine is used, the risks of floppy baby syndrome should be taken into account
 - (e) during the perinatal period, the woman's care should be managed in close collaboration with a paediatrician and an anaesthetist.

5.4.32 Restraint procedures in pregnant women can be adapted as follows:

- (a) If possible avoid going to the floor and maintain in a seated position. Although it is usual, during seated de-escalation, to have the restrained individuals' head bent forward until the restraining staff have immobilised the legs, this must not be used with pregnant women, as this will cause pressure on the abdomen. This will increase the risk of kicking by the client and staff should be aware of this risk and take appropriate measures to avoid being kicked by increasing the distance of the head person and standing out to the side of the patient.
- (b) Continue verbal de-escalation throughout.
- (c) Maintain any physical intervention for the shortest time possible.
- (d) If the patient goes to the floor never hold in a prone (face down) position as this poses risks to the mother and baby and immediately assist to supine (face up).
- (e) From a supine position assist the patient to a semi-recumbent position at the earliest opportunity (a position in which the body is half lying / half sitting) as prolonged restraint in the supine position can result in supine hypotension (a temporary condition where arterial blood pressure is abnormally low) and / or pressure on the patient's aorta and vena cava leading to foetal distress and physical complications in the patient. In addition to usual monitoring of physical status there should be monitoring for supine hypotension.
- (f) Intramuscular medication should be given whilst the patient is in a semi recumbent position.
- (g) Once semi recumbent move from side to side alternately.
- (h) The patient should not be stood from a semi-recumbent position by the team and seated de-escalation should take place allowing the team to withdraw. The patient can then be allowed to stand in her own time.
- (i) Within the 24 hours after rapid tranquillisation the patient and unborn baby should be monitored for signs of foetal distress or complications of pregnancy (i.e. bleeding, discharge, contractions).

5.5 After Rapid Tranquillisation

5.5.1 Clinical monitoring and monitoring of vital signs should be conducted according to the Rapid Tranquillisation Monitoring Chart – see 5.4.24 above. U&Es are recommended after parenteral antipsychotics are given (and ECG if practical) especially with higher doses (hypokalaemia, agitation and stress place the patient at increased risk of arrhythmia). A Venous Thromboembolism (VTE) assessment should be routinely completed and recorded on RIO after RT taking into account additional risk factors for pulmonary embolus e.g. dehydration and reduced mobility. Where a patient is heavily sedated following RT special attention should be paid to ensuring that he / she does not remain in one position for any length of time; this is to prevent physical complications such as radial nerve paralysis and nursing staff should ensure that they turn such patients regularly.

5.5.2 A record should be made in the case notes and / or the RIO Rapid Tranquillisation Monitoring Chart of the reasons for using RT, any issues relating to consent / legal framework, any diagnostic conclusions, medical hazards, drugs given and outcome.

- 5.5.3 Patients should be offered the opportunity to discuss their experiences and should be provided with a clear explanation of the reasons behind the decision to use RT. This should be documented in their notes. They should be given the opportunity to write their account of their experience of RT in the notes. Any other patients who may have seen or heard the incident should also be offered the opportunity to discuss it.

6. UNTOWARD EVENT REPORTING

- 6.1 All incidents of violence and aggression associated with RT should be reported as an untoward event in accordance with the Trust's Untoward Event Reporting policy. In addition, medication errors and serious physical complications or adverse effects from RT should also be reported.
- 6.2 Staff should record the untoward event by accessing the DATIX electronic form on the intranet, click: On the Home Page click on Untoward Event Reporting Form and Medical Devices Register, then DATIX Untoward Event Report form.
- 6.3 DATIX Incidents of RT will be monitored on a 6 monthly basis by the Medicines Oversight Group.

7. TRAINING REQUIREMENTS

- 7.1 The Trust mandatory training requirements state that all doctors and registered nurses working in mental health inpatient wards (where restraint and rapid tranquillisation is used) are required to maintain skills at Immediate Life Support level with an annual refresher. Basic Life Support is mandatory for allied health professionals and non-professionally qualified staff working on mental health inpatient wards (NICE Violence Guidelines, 2015; Resuscitation Policy).
- 7.2 The Trust has a responsibility to ensure that medical and nursing staff in inpatient units are trained in Prevention and Management of Violence and Aggression (PMVA) which includes measures to prevent aggression and violence and that emphasise the importance of person-centred values, clear communication (to prevent frustration and misunderstanding), anticipation of potential violence, the relationship between mental illness and risk of violence, and also de-escalation techniques. Nursing staff in acute inpatient settings should receive appropriate training in safe techniques for physical restraint and follow the recommendations in NICE Violence Guidelines, 2015). Staff working with children and young people will be trained in modified PVMA and restraint techniques relevant to that group of patients.
- 7.3 Staff involved in administering or prescribing RT, or monitoring service users to whom parenteral RT has been administered should receive ongoing training in managing the risks of drugs including prescribing within therapeutic limits, monitoring requirements including the use of pulse oximeters, using flumazenil and cardiopulmonary resuscitation to a minimum standard of Immediate Life Support as defined by the Resuscitation Council UK. All staff that employ physical interventions or seclusion should be trained at least to Basic Life Support level. Staff should also receive regular training in the legal aspects of the management

of violent behaviour and in the skills necessary to undertake a post-incident debrief. (NICE Schizophrenia Guideline 2014; Violence Guideline 2015).

- 7.4 For further training detail please refer to the Training Needs Analysis Matrix, the Learning and Development and Mandatory Training Policy and the Training Prospectus accessible on the Trust Intranet within Learning & Development. Mandatory training requirements relevant to this policy include Rapid Tranquillisation e learning, Prevention and Management of Violence and Aggression and Immediate Life Support training.

8. MONITORING COMPLIANCE AND EFFECTIVENESS

- 8.1 The Medicines Oversight Group will oversee compliance and will monitor RT incidents on a 6 monthly basis. This is a subgroup of the Clinical Governance Group and reports regularly according to a specified annual timetable.
- 8.2 Audit of this policy is incorporated into the Trust Clinical Audit plan and appropriately prioritised according to an agreed system for determining the frequency of audit. The responsibility for undertaking audit and signing off key recommendations is held by the Improving Quality in Inpatient Services Best Practice Group and is overseen by the Medical Audit Group. The Trust has developed Clinical Audit Standards for RT (Appendix C).
- 8.3 Complaints which are relevant to RT are reviewed and amendments made to this policy as appropriate.

9. REFERENCES, ACKNOWLEDGEMENTS AND ASSOCIATED DOCUMENTS

9.1 References

Relevant National Requirements

NHSLA Risk Management Standards 2012-2013 for NHS Providers of Acute, Community or Mental Health and Learning Disabilities Services and Non-NHS Providers of NHS Care

National Institute for Health and Clinical Excellence. (2014). Guideline 178 Psychosis and Schizophrenia in Adults: Treatment and Management.

National Institute for Health and Clinical Excellence. (2015). Guideline 10 Violence and Aggression: Short Term Management in Mental Health, Health and Community

National Institute for Health and Clinical Excellence. (2007). Clinical Guideline 45 Antenatal and Post Natal Mental Health. Clinical Management and Service Guidance.

Royal College of Psychiatrists Consensus Statement on the Use of High Dose Antipsychotics. Council Report CR138 (May 2006)

The Maudsley Prescribing Guidelines in Psychiatry. 12th Edition (2015)

Summary of Product Characteristics: Haloperidol Injection BP 5mg/ml.
www.medicines.org.uk

Summary of Product Characteristics: Ativan Injection. www.medicines.org.uk

Summary of Product Characteristics: Phergan Injection. www.medicines.org.uk

9.2 **Cross reference to other procedural documents**

Consent & Capacity to Consent to Treatment Policy

Counter Fraud Policy

Interpreting and Translation Services Policy

Learning Development and Mandatory Training Policy

Mandatory Training Matrix (Training Needs Analysis)

Medical Emergencies Management Policy (Non Cardiac Arrest)

Observation (Safety and Engagement) Policy

Patient Advice and Liaison Service (PALS) & Complaints Policy and Process

Prevention and Management of Violence and Aggression (PVMA) Policy

Privacy, Dignity and Respect Policy

Proactive Care Policy

Record Keeping and Record Management Policy

Resuscitation Policy

Untoward Event Reporting Policy and Procedure

All current policies and procedures are accessible in the policy section of the public website (on the home page, click on 'Policies and Procedures'). Trust Guidance is accessible to staff on the Trust Intranet.

Relevant Objective within Trust Strategy

Trust Service Development Plans:

To further improve the quality and efficient use of the Trust's estate in order to deliver privacy and dignity, patient safety and effective infection control.

To further improve the mental health and wellbeing of people living in Somerset, ensuring that more people with mental health problems regain the fullest quality of life in line with the national mental health strategy.

10. APPENDICES

For the avoidance of any doubt the appendices in this procedural document are to constitute part of the body of this procedural document and shall be treated as such.

Appendix A Rapid Tranquillisation Algorithm

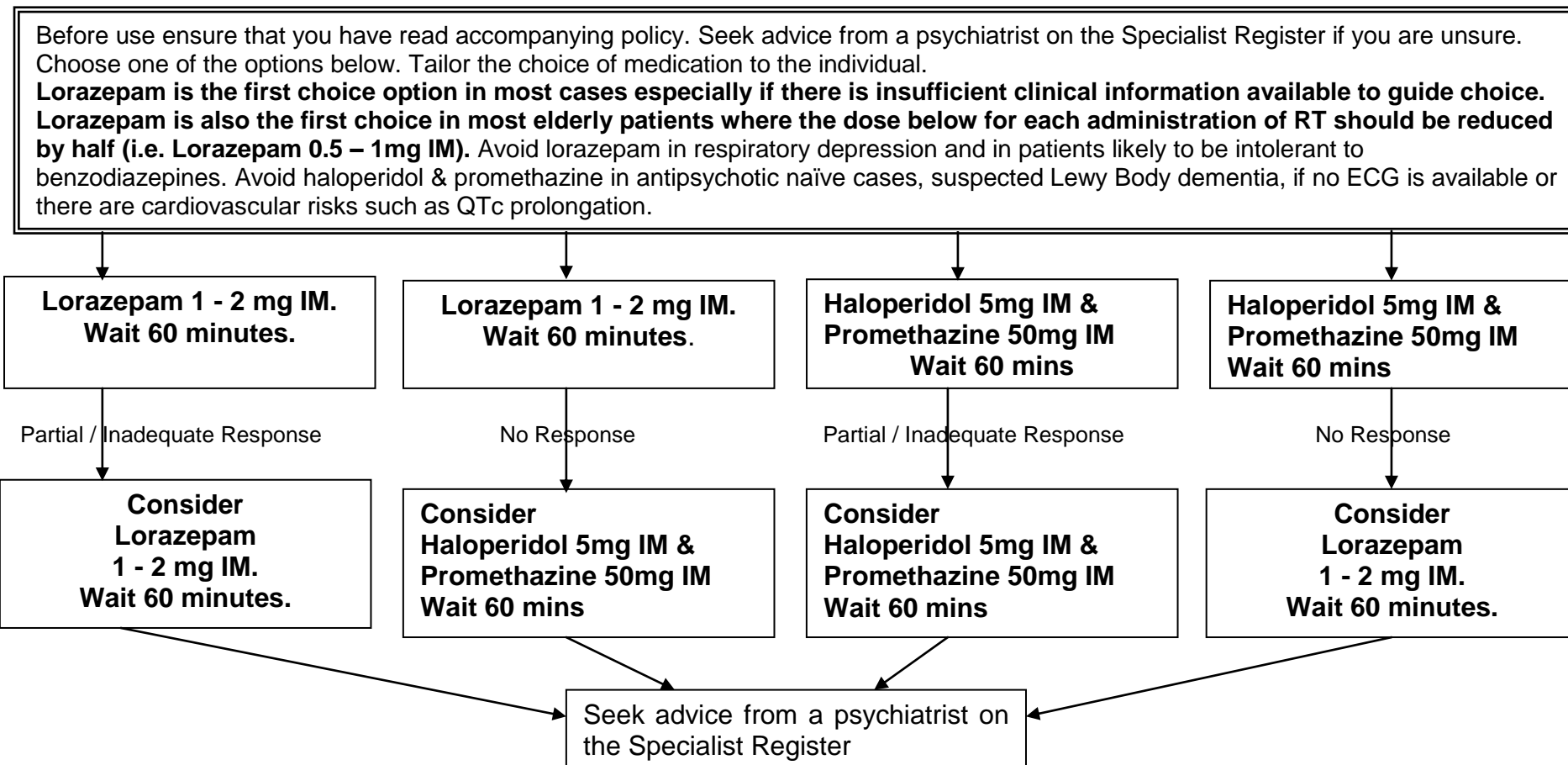
Appendix B Checklist for Medical Staff

Appendix C Clinical Audit Standards

RAPID TRANQUILLISATION ALGORITHM

Rapid tranquillisation is defined as the parenteral administration of tranquillising drugs, if oral medication is not possible or appropriate, with the aim of obtaining a state of calm as soon as possible in an acutely disturbed or violent patient. It is a treatment of last resort and should be used when the patient and others are at risk of significant harm.

If drugs are required consideration should always be given to offering an oral preparation first, preferably as a liquid or soluble preparation.



Never mix Lorazepam with other drugs in the same syringe. For IM injection dilute Lorazepam with an equal volume of physiological saline or water for injection. Have flumazenil to hand in case of benzodiazepine induced respiratory depression. When parenteral haloperidol is administered, it is good practice to prescribe an antimuscarinic drug.

RAPID TRANQUILLISATION CHECK LIST FOR MEDICAL STAFF

Rapid tranquillisation (RT) is defined as the parenteral administration of tranquillising drugs with aim of obtaining a state of calm as soon as possible in an acutely disturbed or violent patient. It is a treatment of last resort and should be used when the patient and others are at risk of significant harm.

You may be under pressure to act quickly to administer medication. However, it is important that prior to RT you: (a) consult with nursing staff, (b) peruse the casenotes and Medication Administration Record (MAR), (c) perform at least a brief mental state examination and (d) perform a physical examination with at least an assessment of vital signs whenever practical.

Attend to the following items:

- (a) check mental health act status (casenotes). Be clear about the legal framework within which RT is being administered.
- (b) check the age of the patient. Do not administer RT to patients under 16 years without discussion with consultant. Do not administer RT to frail elderly patients or pregnant women without first seeking advice from a psychiatrist or the Specialist Register.
- (c) exclude medical contraindications to RT, for example cardiac disease or respiratory depression (casenotes, physical examination). If no ECG avoid haloperidol especially high dose prescriptions (i.e. where combined doses are above B.N.F. advisory dose limits). Promethazine is contraindicated in patients who have taken monoamine oxidase inhibitors in the last 14 days.
- (d) reach a provisional diagnosis carefully considering organic disorders as a possible cause of disturbed behaviour (casenotes, mental state, physical examination)
- (e) no doctor in training should exceed B.N.F. doses (either for single dose or over 24 hours) without discussing with a psychiatrist on the Specialist Register (drug card)
- (f) ensure facilities for basic CPR and also oxygen and flumazenil are available
- (g) follow the RT Algorithm for guidance on preparation, dosage and route of administration
- (h) ensure level of consciousness, airway and vital signs are recorded by nursing staff on the Rapid Tranquillisation Monitoring Chart; document reasons why these are not recorded if it is not practical to do so.
- (i) ensure VTE assessment is completed and documented on RIO post RT administration
- (j) do not transfer patient to a ward on another hospital site post RT until calm and vital signs stable for at least 45 minutes; do not use seclusion in heavily sedated patients.
- (k) after RT record in casenotes the above process and the outcome.

RAPID TRANQUILLISATION CLINICAL AUDIT STANDARDS
Derived from Trust Rapid Tranquillisation Policy and
NICE Guidance CG82 for Schizophrenia
07/01/2016

Service area(s) to which standards apply:

MH Inpatient (CAMHS)		Community CAMHS		CH Specialist Services	
MH Inpatient (Adult)	X	C & YP Integrated Therapy		MH Specialist Services	
MH Inpatient (Older)	X	School Nursing		MH Community Adult	
MH Rehab & Recovery	X	Health Visitors		MH Community Older	
Community Hospital		CH Rehab		Learning Disabilities	
MIU		Musculo-Skeletal		District Nurses	

Standard		Compliance	Exceptions	Definitions <i>(e.g. any interpretations, directions, or instructions on where/how to find information, plus relevant service where applicable)</i>
1	Equipment and resources. Resuscitation equipment and drugs, including flumazenil, should be available where rapid tranquillisation is used.	100%	None	None
2	Dosage of tranquillising medication. The BNF recommendations for the maximum dose of medication should be adhered to unless exceptional circumstances arise.	100%	Exceptional circumstances require authorisation from the consultant responsible for the patients care.	The daily dose as a percentage of the BNF maximum dose is calculated for each antipsychotic and the percentages added to give the total.
3	Use of seclusion in patients who have received rapid tranquillisation. Service users who are heavily sedated should not be secluded.	100%	None	Instances of seclusion after rapid tranquillisation should be recorded and level of consciousness monitored.
4	Preference for oral medication for rapid tranquillisation. Oral medication should be offered before parenteral medication.	100%	When urgent tranquillisation is needed because the patient and others are at immediate and serious risk of significant harm.	The notes should demonstrate that oral medication was offered unless there is clear justification documented.
5	Preference for intramuscular over intravenous route of administration where parenteral treatment required. If parenteral treatment proves necessary then use the intramuscular route.	100%	None	None

Standard		Compliance	Exceptions	Definitions <i>(e.g. any interpretations, directions, or instructions on where/how to find information, plus relevant service where applicable)</i>
6	Drugs should be prescribed according to the RT Policy algorithm	100%	On advice from a psychiatrist on the Specialist register.	Where parenteral agents are used for rapid tranquillisation the first line drugs in all cases should be lorazepam or a combination of haloperidol and promethazine. If other agents are used (for example clopixol acuphase) this must be documented as authorised by a psychiatrist on the specialist register.
7	Monitoring after rapid tranquillisation. A patient who has received parenteral medication during rapid tranquillisation should have baseline recordings, repeated at regular intervals, for level of consciousness, airway, respiratory rate, pulse, blood pressure, oxygen saturation and temperature.	100%	Where to carry out such procedures would cause further agitation and increase the possible risk to either the individual or others. However level of consciousness, airway and breathing can be monitored even in an uncooperative patient and should always be monitored.	The notes contain a record of the individual's level of consciousness, airway, respiratory rate, pulse, blood pressure, oxygen saturation and temperature, monitored at the specified time intervals. Where baseline observations are not carried out, the reasons for this are recorded. The Rapid Tranquillisation Monitoring Chart should be used to record monitoring after RT.
8	Transfer after parenteral rapid tranquillisation. Service users should not be transferred to a psychiatric ward on another hospital site until there is cardiovascular and respiratory stability for at least 45 minutes after the last drug has been administered.	100%	Transfers can occur between wards on the same hospital site (for example from Pyrland Ward to Holford Ward),	None

Standard		Compliance	Exceptions	Definitions <i>(e.g. any interpretations, directions, or instructions on where/how to find information, plus relevant service where applicable)</i>
9	Service users should not be transferred if heavily sedated. They should not be transferred until calm and should be accompanied by staff.	100%	If there is a need to transfer urgently from an open ward to a PICU because of ongoing aggression there should be a joint medical and nursing assessment in order to consider the most suitable transport and escort arrangements.	None
10	Debriefing after rapid tranquillisation. Patients who receive rapid tranquillisation should be debriefed and offered the opportunity to write their account in their record.	100%	Patients who decline to be debriefed and/or to add a comment in their record. Patients unable to participate (e.g. lacking capacity)	A debrief is a face to face discussion in which information is provided to the patient about the RT incident and in which the patient is invited to give their views on the events leading up to the incident and the impact on them of the RT incident. A record must be made of the discussion in the notes. Reasons for any exception must be fully documented.
11	A Venous Thromboembolism (VTE) assessment should be routinely completed and recorded, taking into account additional risk factors for pulmonary embolus e.g. dehydration and reduced mobility.	100%	None	Update Core assessment in RiO. If there is a positive answer to any question in the VTE assessment, then the Department of Health risk assessment for VTE should also be completed
12	Use of advance decisions/statements. Advance decisions and advance statements should be developed collaboratively with people with schizophrenia, especially if their illness is severe and they have been treated under the MHA. Record the decisions and	100%	The individual with schizophrenia who is not able to participate in an informed discussion with the clinician responsible for treatment at the time and an	The clinical record contains an advance decision/statement that describes preferred treatment choices in the event of the individual experiencing an acute episode of illness. Also to be recorded as an Alert within RiO. Copies are given to the service user, and to the carer (subject to an agreement with the

Standard		Compliance	Exceptions	Definitions <i>(e.g. any interpretations, directions, or instructions on where/how to find information, plus relevant service where applicable)</i>
	statements in the care plan, or reference to an uploaded document.		advocate or carer is not available.	service user).
13	Implementation of advance decisions and statements. Advance decisions and statements are honoured in accordance with the Mental Capacity Act	100%	No advance decision/statement has been made. Where the decision/statement is overridden by the MHA	
14	Consent and Capacity Where rapid tranquillisation is indicated in a voluntary or informal patient there should be an assessment of capacity to consent or refuse the treatment.	100%	Where the nature of the emergency may preclude an immediate detailed following of the code of practice.	There should not be a delay in providing the necessary treatment if this would compromise the safety of the patient or others. The provisions of the MCA and its code of practice should be followed but the nature of the emergency may preclude an immediate detailed following of the code of practice.
15				