Pennine Care NHS
NHS Foundation Trust

Policy Document Control Page

Title

Title: Rapid Tranquillisation Policy

Version: Version 7

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Supersedes

Supersedes: Version 6

Description of Amendment(s):
Various amendments made throughout the policy, in line with NG10: Violence and Aggression: short-term management in mental health, health and community settings

Originator

Originated By: Karen Maneely

Designation: Chair of Trust-wide Acute Care Forum

Equality Assessment (EA) Process

Equality Relevance Assessment Undertaken by:

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Where policy deemed relevant to equality- YES

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Executive Directors / Local Governance Group Arrangements

Referred for approval by: Chair of Trustwide Acute Care Forum

Date of Referral: 6th May 2016

Approved by: Trustwide Acute Care Forum

Approval Date: 6th May 2016

Date Ratified by Executive Directors: 16th May 2016

Executive Director Lead: Medical Director

Circulation

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Circulated by: Performance and Information

Issued to: An e-copy of this policy is sent to all wards and departments

Policy to be uploaded to the Trust's External Website? YES

Review

Review Date: February 2019

Responsibility of: Karen Maneely

Designation: Chair of Trust-wide Acute Care Forum

This policy is to be disseminated to all relevant staff.

This policy must be posted on the Intranet.

Date Posted: 16th May 2016

1. INTRODUCTION

Pennine Care NHS Foundation Trust is committed to providing the highest standard of care for people with mental health problems. Through its Clinical Governance systems, the Trust will continue to ensure that patient safety is at the centre of this work.

This Policy is one component of the Trust's Strategy for Clinical Risk Management. It is therefore essential that the Policy is viewed within this wider context, and implemented in conjunction with all other relevant Pennine Care Policies.

The Trust recognises that it is sometimes necessary to use pharmacological interventions to maintain the safety and physical health of some service users who are acutely unwell. This can be a distressing experience for service users. It is hoped that this Policy, and continued collaboration with service users, will ensure that Rapid Tranquillisation (RT) is undertaken only when absolutely necessary, and always with utmost respect and sensitivity for the individual.

2. RELATED TRUST POLICIES

- Care Programme Approach Policy – CL3
- Resuscitation Policy – CL9
- Violence Reduction Policy – CO38
- Safer Place to Work Policy – CO31
- Incident Reporting, Policy – CO10
- Consent to Examination or Treatment Policy - CL2
- Prescribing Guidelines for Rapid Tranquillisation
- Seclusion Policy – CL26
- Observation Policy – CL5
- Core and Essential Skills (Mandatory training) Education Policy CO81
- Policy on Treatment of patients subject to the Mental Health Act 1983 – Part 4 and Part 4A CL58
- Medicines Policy CL15

3. AIMS OF THE POLICY

- Provide a standardised approach to physical monitoring and nursing care before, during and following RT.
- To define RT.
- Describe the appropriate skills and competencies for staff undertaking RT in Pennine Care NHS Foundation Trust.
- Provide guidance to staff around evidence based prescribing in RT. (Appendices: Prescribing Guidelines for Rapid Tranquillisation 2012)

4. SCOPE OF THE POLICY

RT should only be undertaken on hospital premises where there is emergency defibrillation equipment, and staff who are trained to use it within the clinical area 24 hour a day.
Therefore this Policy would apply to:

- All inpatients in adult and older people inpatient services
- Patients on the CAMHS Inpatient units (aged between 12 and 18 years old
- All Pennine Care NHS Foundation Trust staff providing direct patient care, in inpatient wards and A&E Departments
- All Agency and Bank Staff working in the above clinical areas

NB: Further guidance should be sought when children under the age of 16 years are temporarily admitted to adult wards, awaiting transfer to a Healthy Young Minds (CAMHS) services[1,2].

5. INTRODUCTION TO RT

5.1 The revised 2015 Mental Health Act (MHA) Code of Practice refers to RT as the use of medication to calm or lightly sedate an individual to reduce the risk of harm to self or others and to reduce agitation and aggression. RT may also be used to manage acute behavioural disturbance, though this should be a very short-term strategy designed solely to reduce immediate risk and is distinct from treating any underlying mental illness.

5.2 RT includes the use of both intramuscular (IM) injections and oral medication. Oral medication should always be considered before any injections. RT should be prescribed in accordance with evidence-based practice guidelines such as those published by NICE and in a manner that is consistent with General Medical Council's good practice in prescribing and managing medicines. It must be in line with legal requirements (in respect of patients subject to the MHA, the rules concerning treatment and emergency treatment powers under the Act please refer to Chapter 24 of the 2015 revised MHA Code of Practice). Where RT in the form of an IM injection is needed, the person prescribing the injection should state the preferred injection site, having taken full account of the need to avoid prone restraint (i.e. where the person is forcibly laid on their front).

5.3 Physical restraint may, on occasion, need to be used to administer RT by IM injection to an unwilling patient, where the patient may lawfully be treated without consent[3]. It must not be used unless there is such legal authority, whether under the Act (see provisions for treatment in chapter 24 of the MHA Code), the Mental Capacity Act (MCA) or otherwise. If the MHA and/or MCA do not apply, the use of force is only justified legally for the purposes of self-defence, the defence of others, prevention of crime, lawful arrest or to protect property and the same statutory and common law provisions apply within health and care services as elsewhere.

5.4 The decision to use restraint should be discussed first with the clinical team and should be properly documented and justified in the patient's notes. Following the administration of RT, the patient's condition and progress should be closely monitored. Subsequent records should indicate the reason for the use of RT and provide a full account of both its efficacy and any adverse effects observed or reported by the patient.

5.5 RT should never be used to manage patients as a substitute for adequate staffing.

5.6 The need for RT requires a careful clinical judgment, based on a risk/ benefit analysis. The use of antipsychotic and benzodiazepine medicines for RT carries a small but serious risk of adverse effects for the patient. This risk can be minimised by good prescribing practices and appropriate nursing care.

5.7 The Department of Health[4] (DoH) have produced documents which set out good standards for use of RT in the management of violence & aggression. Where possible, the advice and recommendation within these documents has been incorporated into this Policy.

5.8 Under the DoH Positive & Proactive guidance: Reducing the Need for Restrictive Interventions, clear definitions of what counts as a restrictive intervention have been put forward, including the use of medication in some circumstances when used in the context of challenging behaviour. The term chemical restraint has been applied and all practitioners who use RT should employ the necessary safeguards and considerations for use when applying this restrictive intervention.

6. RESPONSIBILITIES AND DUTIES

Staff

Medical Practitioners

- Should be familiar with the properties of all psychotropic medicines used in RT
- Must document rational if prescribing above British National Formulary (BNF) limits and out of line with Trust's Medicine Policy (CL15)
- Should check responses to medication during previous episodes of RT where practicable
- Follow prescribing guidelines with regard to RT Policy
- Check case notes for advanced decisions[5]
- Ensure consent to treatment has been checked. Including detained patients and their certificate status under Section 58 where this applies (i.e. T2, T3, or where emergency provisions apply under Section 62 of the MHA)
- Ensure that treatment plan is drawn up, recorded in notes and be available to the multi-disciplinary team
- To ensure monitoring of patient as per Policy, see appendix 1

Senior Nurse in Charge

- Ensure that staff have sufficient competencies and skills in basic life support (BLS) skills and immediate life support (ILS)
- Ensure staff are sufficiently trained in managing violence and aggression as per training needs analysis
- Ensure that there is resuscitation equipment available and is checked daily
- Ensure that staff complete physical observations on patient following RT and document as per policy

All Registered Nurses

- Ensure consent to treatment has been checked. Including detained patients and their certificate status under Section 58 where this applies (i.e. T2, T3, or where emergency provisions apply under Section 62 of the MHA)
- Ensure detained patients' certificates are updated with the additions made to inpatient medicine charts for the treatment if necessary

- Administer RT as per agreed treatment plan
- Contact the Pharmacist if there are any queries regarding prescription
- Ensure prescribing as per RT policy and involvement in Multi-Disciplinary Team (MDT) discussions
- Ensure a drug history has been taken including the consideration of over the counter medicines, and substances that may have been misused (i.e. Alcohol, illicit substances) prior to administration
- Ensure safe and effective use of RT medication taking concomitant medication and other conditions into consideration
- Ensure medicines available on ward before RT plan is implemented
- Ensure they have attended the required training as per training needs analysis and have undertaken CPD appropriate to the post
- Work within own sphere of competency and request second opinion as required
- Carry out physical observations and ensure sufficient monitoring on patient following RT as per policy and are able to identify when further medical intervention is required
- Ensure that all these observations are recorded on relevant Trust approved documentation, (see appendix 1)
- Ensure detained patients certificates are updated with the additions made to inpatient medicine charts for the treatment if necessary

Pharmacists

- Pharmacists will be responsible for ensuring that prescribing is as per policy or that deviations are clinically appropriate and documented
- They will be involved in audit, training and monitoring of the policy Pharmacists and the associated technical staff will be responsible for ensuring stocks of medicines are available on wards as needed
- Pharmacists will be responsible for ensuring they keep up to date with the latest evidence with regards to RT and that they attend all required mandatory training

7. THE INPATIENT ENVIRONMENT

7.1 The Royal College of Psychiatrists[6] highlighted the importance of minimizing environmental factors which might contribute to increased tension and frustration for service users in acute inpatient settings. Improving the environment can have an impact on the incidence of violence and aggression and use of RT[3]. It is important to ensure that the environment is properly adapted for the needs of the acutely ill and

that communication between staff and service users is clear and therapeutic.

7.2 Other factors to be routinely identified, monitored and corrected include:

- Overcrowding
- Lack of privacy
- Lack of activities
- Long waiting times to see staff
- Weak clinical leadership
- Use of orientation aids
- Availability of patient information and literature.

7.3 Improving the inpatient experience is a key target of Acute Care Forums across Pennine Care. Inpatient areas are also working together with Patient Led Assessments of the Care Environment (PLACE) to ensure that improvements are continuous and sustained.

8. THE SERVICE USERS EXPERIENCE

8.1 It is sometimes necessary to undertake RT without the patients consent. Pennine Care recognises that involuntary procedures can be highly distressing or even traumatic for the patient[3].
The Trust is working to increase opportunities for service users to plan how care is provided for them. Information from patient surveys, Patient Advice Liaison service (PALs) and complaints will support to improve the quality of care provided for service users. Where existing service users require the use of RT an advanced statement, behavior support or specific care plan should be in place documenting the service users views and wishes (where possible) as to how they want their challenging behavior de-escalated, supported and where necessary managed. This should include preferences on medication use and route of administration.

8.2 Pennine Care will make every effort to minimize the negative experience of RT. Service user's views and experiences will contribute to developing positive practice, to ensure that RT is always undertaken sensitively and therapeutically.
NICE guidelines encourage that service user experience should be recorded following the event of RT.

9. MULTIDISCIPLINARY WORKING

9.1 RT should be a multidisciplinary intervention, involving the service user, nursing, and medical expertise. There should be discussion about alternative strategies or advance decisions to ensure that RT is used only when absolutely necessary. It should also ensure that RT is planned around the individual needs of the patient.

9.2 The possibility of adverse reactions, side effects and potential interaction with other medications should always be considered, in particular if the patient receives medication for physical disorders, with which the mental health team are unfamiliar. When needed, a pharmacist should be consulted for additional advice and information. During office hours the local mental health pharmacist can be contacted. Outside office hours, an on call pharmacist can be contacted in an emergency, via the Acute Trust.

10. CONSENT & CAPACITY

The Clinical team must always consider the issue of consent and capacity, when using RT.

Where patients are detained their consent and capacity should always be considered in addition to their certification requirements under Part 4 of the Act.

11. TRAINING AND COMPETENCIES FOR USE OF RT

11.1 Staff who use RT should be competent in the assessment and management of service users specifically in this context[3]: All registered health professionals involved in the prescribing, administration or monitoring of RT should;

- Be trained in how to assess and manage potential and actual violence using de-escalation techniques, and engaging the patient in therapeutic observations
- Receive training, and regular updates, in the Management of Violence & Aggression (MVA) training. This is available through the Trust Learning and Development Department; please see Training Needs Analysis (TNA)
- Be able to assess the risks associated with RT, particularly when the service user is highly aroused and may have been misusing drugs or alcohol, be dehydrated or possibly be physically ill

- Understand the cardio-respiratory effects of the acute administration of these drugs and the need to titrate dosage to effect

- Recognise the importance of nursing in the recovery position and maintaining an unobstructed airway. Also of monitoring vital signs and physical health following RT

11.2 "The crash bag (including an automatic external defibrillator, a bag valve mask, oxygen, cannulas, fluids, suction and first-line medications) must be available within 3 minutes in healthcare settings where rapid tranquillisation might be used"[3].

11.3 Pennine Care supports the principles of Good Practice contained in NICE Guidelines for the Management of Violent Behaviour [3] . This recommends that all registered health professionals involved in the prescribing, administration or monitoring of RT should be trained to ILS level. The Trust will work toward achieving this standard as soon as possible, by ensuring that;

- Training and annual updates in ILS skills is mandatory for all qualified staff

- Training in ILS skills is prioritised for senior inpatient nursing staff and medical staff (see Training Needs Analysis).

11.4 All Registered Nurses and Doctors working in inpatient areas are expected to demonstrate competency in the use of RT[1]. Staff's competency in RT is included in the Trusts Medication Competency Assessment Framework (CAF) for Registered Nurses and Core Competencies in Medicines Management for Doctors. The Competency Assessment Framework and Core Competencies for Medicines Management should be completed within three months of commencement in post. The required proforma within the CAF should be filed in the staff member's personal file.

The knowledge & skills required to develop competency are provided through:

- Pre-registration training
- Continuous professional development
- MVA training & updates
- CPR training & updates

11.5 Competency in the use of RT and general medicines safety should be addressed by managers within supervision and appraisal.

11.6 Pennine Care's Core and Essential Skills Policy has information on all mandatory training requirements, including resuscitation and Management of Violence & Aggression.

11.7 Managers will be responsible for supporting staff to attend the required training. Any non-attendance at the required training will be reported to the authorising manager via email by the Learning and Development Department for action and further dates to be arranged to attend training.

11.8 To ensure all RT is carried out legally staff should attend regular legal update training accessed through the Principles of Governance Mental Health Law dates or the Trusts Medical Training Programme.

12. DECISION TO UTILISE RT

12.1 The service user remains distressed despite the clinical team using all the appropriate approaches including de-escalation.

12.2 Extra care should be taken when RT is being considered in the following circumstances;

- When there is a known presence of congenital cardiac conductive abnormalities
- When there is a known presence of certain disorders that may affect metabolism (e.g. hypothermia, hyperthermia, extreme physical exertion)
- Where there is co-prescription of medications that can directly or indirectly lengthen QT intervals on ECG's. Please see prescribing guidelines for RT appendices 3, 4, and 5

12.3 Where any complicating factors are identified or resuscitation equipment is not available for any reason, an immediate risk assessment should be undertaken by the clinical team and medical staff. Where there are concerns about the safest course of action, advice should be sought from the consultant (or the consultant on-call out of hours).

12.4 The multi-disciplinary team should try to ensure that advanced decisions and any complicating factors (as above) are identified and actions agreed prior to the need arising as the situation is often urgent.

12.5 Oral preparation should be offered first. If the oral preparation is declined an IM preparation should be considered. The service user should be given an explanation of the medication, its effects and why it is necessary. In exceptional circumstances the intravenous (IV) route may be considered for RT where staff have received the required training in the administration of IV (this may only apply to medical staff).

12.6 As a further example the requirement to actively physically monitor a service user at the frequency suggested may on occasions be counter-therapeutic, add to the individual's distress and pose significant risks by following the procedure literally. The procedure has therefore been open to variance due to clinical judgement. The critical point is that the practitioner concerned will need to record and be clear why the policy has been varied from on each and every occasion and what steps they have taken to ensure the service user has not deteriorated physically.

12.7 If Acuphase is considered appropriate the BNF should be consulted for dosing instructions.

12.8 NICE Guidelines NG10 Violence and Aggression: short-term management in mental health, health and community settings to be adhered to.

Decision to use RT for a pregnant patient

12.9 The decision to prescribe/utilise RT for a pregnant patient will need to be individually assessed and managed according to the following criteria:

- The stage of the pregnancy
- Previous response to treatment
- A risk benefit analysis in the patient's given presentation

When IM medication is indicated during restraint it should be given whilst the woman is in a semirecumbent position.
Where there has been an incident of restraint and or the patient complains of low back pain following restraint the duty doctor should be contacted to complete an assessment. Staff are also advised to consult other specialist advisors where appropriate i.e Moving and Handling Advisor, MVA Lead, Infection Control Lead.

13. DRUG ADMINISTRATION AND MONITORING

13.1 Regular monitoring of the patients vital signs, blood pressure, pulse, and respirations must be recorded following RT. However there may be occasions where it would not be practical to monitor the patients pulse or blood pressure. Staff must document where deviation from the policy have occurred and at the very minimum staff must observe and record the patients breathing every 15-20 minutes following RT for a period of at least two hours then hourly for the next six hours.

13.2 If any abnormalities are identified by the nurse in-charge they should refer to the care plan and inform the duty doctor immediately.

13.3 If the service user remains distressed after 30 minutes despite the medication, and de-escalation techniques continue to be unsuccessful, the nurse in-charge should inform the duty doctor who may prescribe a

second dose. The service user should be given an explanation why a second dose is necessary.

13.4 Where a second dose is given the duty doctor should ensure that the BNF maximum dose is not exceeded.

13.5 If there is no response to a second dose the duty doctor should seek advice from the consultant (consultant on-call out of hours).

14. DEBRIEFING AND REPORTING FOLLOWING THE USE OF RT

14.1 Following the use of RT a Registered Nurse should ensure that the patient is offered debriefing as soon as practicable. This should constitute an explanation of the decision to use RT, the medication and its effects and a discussion of their experiences. This should be completed in line with the Consent to Examination and Treatment Policy standards.

The service user should also be offered the opportunity to write their experience within their case notes and be supported to do this, a discussion regarding Advance Decisions or Written Statements may be beneficial if the patient has capacity to engage with this at the time. The patient will be asked whether they would like the involvement of an independent body where they are detained this should be the Independent Mental Health Advocacy service in the first instance. If this is the case, the nurse in-charge should ensure that advocacy services are contacted.

14.2 The nurse in-charge should ensure that the use of RT is discussed at the MDT meeting. This meeting should be used to ensure that the appropriate documentation has been completed and any issues relating to the use of RT are discussed and lessons incorporated into practice. Lessons should be shared with Divisional Integrated Governance Forums for wider dissemination (including the Drug's & Therapeutics Committee).

14.4 Therefore frequent monitoring and diligent nursing care is essential during and after RT, for all patients.

15. PROCEDURE FOR RT AND MONITORING VITAL SIGNS & SIDE EFFECTS

15.1 RT and the use of other physical interventions should be considered as the final option, when all non-invasive strategies are unsuccessful or inappropriate. Every effort should be made to de-escalate the situation, and avoid use of RT (See Pennine Care Management of Violence & Aggression Policy).

15.2 Planning RT should be a multidisciplinary intervention. There should be discussion about alternative strategies or advance decisions to ensure that RT is used only when absolutely necessary. It should also ensure that RT is planned around the individual needs of the patient.

15.3 Wherever possible, RT should be planned in advance, and should always take account of the following issues

- Safety of the service user, staff and other service users
- Best interests of the service user
- Privacy & dignity of the service user
- Evidence based prescribing
- Appropriately skilled staff available to undertake monitoring and aftercare
- Legal requirements, Responsible Clinician's are advised to include PRN medication including RT on any statutory certificates completed for the MHA where section 58 applies.

15.4 Each clinical area should ensure that there is immediate access to appropriate resuscitation equipment, and that all staff know where this is located.

"The crash bag (including an automatic external defibrillator, a bag valve mask, oxygen, cannulas, fluids, suction and first-line medications) must be available within three minutes in healthcare settings where RT might be used"[3].

15.5 Resuscitation equipment and drugs, including flumazenil, must be available and easily accessible where RT is used
Antimuscarinic drugs such as procyclidine, which should be available in ward medication stock.

15.6 The medical and nursing team should plan how frequently the patients vital signs are to be monitored, and when this will be reviewed. This should be considered for each patient individually, and will depend on various factors i.e:

- route of administration
- amount of medication received
- level of sedation
- physical health
- age
- potential interactions with other medication or Illicit substances/alcohol, etc.

This should be documented in the patient's notes.

15.7 However all patients receiving RT by parenteral route should have vital signs monitored and documented at a minimum of the following frequency (see fig 1). This may also be appropriate for patients receiving RT by oral route, if they have high or repeated doses, or receive the medication for the first time.

(Fig 1)

Monitoring Vital Signs	On Admission	Before RT	0-2 hour post RT	2– 6 hours post RT
• **Pulse** • **Blood Pressure** • **Respirations** • **Level of Consciousness** • **EPSE**	**Obtain baseline of all vital signs (incl Temp)**	**Check breathing, pulse, A.V.P.U Capillary Refill Test (incl Temp)**	**Every 15 Minutes As a minimum check level of consciousness and respirations**	**Every hour or more often where clinically indicated (incl Temp)**

15.8 Wherever possible, the patient's vital signs should be monitored and recorded before RT is administered. If this is not possible due to the patient refusing, or the urgency of the situation, this should be recorded in the patient's notes. It is therefore especially important that vital signs are obtained and recorded as a routine part of admission procedures, to ensure there is a baseline to refer to.

15.9 Following RT, every effort should be made to monitor vital signs, particularly if the patient appears to be sedated or sleeping. If it is not possible (i.e. patient refusing) or the care team feels that further interventions would distress or antagonise the patient, this should be documented in the patient's notes. At a minimum the patient's level of consciousness and respirations should be monitored every 15 minutes for two hours following RT. After which further observations of the patient's vital signs should be hourly for the next six hours or more often where this is clinically indicated.

15.10 The potential for acute dystonia and oculogyric crisis should be anticipated, particularly if conventional antipsychotics are used. The clinical team should ensure that prescription and administration of anticholinergic is quickly accessible, to minimise the patients discomfort and distress.

15.11 All other vital signs should be monitored to ensure they remain within normal range. The clinical staff should consider what "normal range" is for each individual patient. This should be communicated to all staff and documented as part of the "outline of medical care plan" section of the RT monitoring form (Appendix 1).

15.12 The purpose of monitoring vital signs and side effects is to ensure early detection and intervention if adverse effects occur. **Any deviation**

from normal range or evidence of adverse effects must be reported to the Team or Duty Doctor.

15.13 All monitoring should be recorded on approved Trust documentation, which is easily identifiable within the patient's notes (See Appendix 1).

15.14 Service users should be offered the opportunity to discuss their experiences and should be provided with a clear explanation of the decision to use urgent sedation. This should be documented in their notes. Service users should also be given the opportunity to write their account of their experience of RT, which should be filed in their notes.

15.15 The use of RT should prompt a full review of the service user's care and treatment. This should explore reasons why RT was necessary, and any changes which could reduce need for further RT.

16. SECLUSION & RT

16.1 The use of seclusion for patients receiving RT should be avoided wherever possible[3].

16.2 However if seclusion following RT is judged necessary to manage serious risk of violence, the service user must be placed under constant visual observation.

16.3 Frequent monitoring of vital signs as described in Section 14 should continue.

16.4 Staff should refer to the Trust Seclusion Policy.

17. OBSERVATION

17.1 Monitoring for side effects and vital signs must not be confused with Observation. The patients need for enhanced observation should be assessed and planned separately.

17.2 Supportive observation is a risk management intervention, which is based on clinical risk assessment. This will include potential risk of harm to self or others. Every patient should have their observation needs assessed and reviewed regularly. The level of observation will depend on the degree of potential risk the patient presents in terms of maintaining their own safety and the safety of others. The frequency of observation will be decided by the Multidisciplinary Team, and will be different from the frequency of monitoring following RT, and have a different purpose.

17.3 However the need for RT is often associated with issues of risk and should always prompt a review of the patients Observation needs. The Clinical team should ensure adherence to the Trusts Observation Policy.

18. REPORTING INCIDENTS

18.1 All incidents of restraint, RT and untoward events or adverse outcomes resulting from RT by any route should be recorded using the Trust Incident Reporting procedures.
This should include medication errors, and serious physical complications or adverse effects.

19. AUDIT/MONITORING

19.1 Each incident reported will be reviewed by the weekly Patient Safety Improvement Group (PSIG) to ensure that prescribing guidelines, rules and responsibilities have been adhered to in accordance with the policy and that staff have monitored vital signs following an incident of RT. Any deviation from the policy and/or recommendations arising from the review will result in an action plan to be shared at the Divisional Integrated Governance Groups (DIGG). The DIGG will be responsible for ensuring the actions are implemented and monitor on a monthly basis. The Risk Department will monitor that all actions are completed.

19.2 All non-attendance at the required training will be communicated by email by the Learning and Development to the member of staff's authorising manager for action and further dates to be arranged. The Learning and Development Department will produce a monthly report to Service Line Managers detailing all staff that has completed the required training. In addition a six monthly report will be produced to the Educational Governance Group (EGG) by the Learning and Development Department identifying the numbers of staff that has completed the required training. Where concerns are identified in relation to staff training completion the EGG will develop an action plan that will be shared with the Divisional Integrated Governance Groups. The DIGGs are responsible for monitoring the implementation of any actions required on a monthly basis.

20. REVIEW

Review of this policy will take place two yearly. The Divisional Integrated Governance Groups will review this policy and the Acute Care Forum will approve the policy.

21. REFERENCES

1. National Service Framework for Children: Standards for Hospital Services DoH 2003
2. National Service Framework for Children: Standard 7 Medicines for Children and Young People DoH 2004
3. NICE Guideline NG10: Violence & Aggression The Short-Term Management in mental health, health and community settings (2015)
4. Positive and Proactive Care: reducing the need for restrictive interventions DoH (2014).
5. Meeting Needs and Reducing Stress: Guidance on the Prevention and Management of Clinically Related Challenging Behaviour in NHS Settings – NHS Protect (2014).
6. Technological Appraisal No43. Schizophrenia – Atypical Antipsychotics NICE 2001
7. Schizophrenia: Core Interventions in the Treatment and Management of Schizophrenia in Primary and Secondary Care. NICE 2002.
8. Mental Health Act 1983 Code of Practice (2015)
9. Mental Capacity Act 2005 Code of Practice

22. APPENDICES
Appendix 1

Pennine Care NHS
NHS Foundation Trust

RAPID TRANQUILISATION MONITORING FORM

PATIENT NAME: **HOSPITAL NO**:

ALLERGIES/PHYSICAL PROBLEMS:

BASELINE VITAL SIGNS (if unable to obtain prior to Rapid Tranquillisation, please indicate baseline on admission)

DATE: **BP:** **PULSE:** **RESPS:** **TEMP:** **OTHER:**

MEDICATION GIVEN

DRUG NAME:	DOSE:	ROUTE:	DATE:	TIME GIVEN:

OUTLINE OF MEDICAL & NURSING CARE PLAN: (Include details of vital signs to be monitored. State acceptable / normal range for the patient, and action to be taken if vital signs outside of normal range).

DURATION OF MONITORING: **OR** **PLEASE INDICATE FREQUENCY & DURATION**

☐ **EVERY 15 MINS FOR 1 HOUR**
IF STABLE THEN HOURLY FOR 3 HOURS
IF STABLE THEN 4 HOURLY FOR 8 HOURS
(TOTAL = 12 HOURS)

☐

OTHER INFORMATION (include any actions from above monitoring, observation for EPSE's and any subsequent actions, and diet/fluid intake)

(CONTINUE ON NEXT PAGE)

Form Completed by:..... Designation ....
Signature: Date:

ON COMPLETION A COPY OF THIS FORM SHOULD BE SENT TO RISK DEPARTMENT

RAPID TRANQUILISATION MONITORING FORM (Continuation Sheet)

PATIENT NAME: **HOSPITAL NO:**

CONTINUATION SHEET NO:

DATE	TIME	CONSCIOUSNESS *	BP	PULSE	RESPS	TEMP	OTHER**	SIGNED

*rate consciousness from 1 – 4 (where 1=awake/alert, 2=drowsy, 3=sleepy but rousable, and 4= unrousable)

**Monitoring of Oxygen saturation recommended following Intravenous administration, or if patient appears heavily sedated based on work by G.Flockhart, D.Gilbert (2002)

OTHER INFORMATION (include any actions from above monitoring, observation for EPSE's and any subsequent actions, and diet/fluid intake)

MONITORING DISCONTINUED. (Include date /time. Also rationale and summary of patients physical health/ response to medication)

SIGNED **PRINT NAME** **DATE** **TIME**

ON COMPLETION A COPY OF THIS FORM SHOULD BE SENT TO RISK DEPARTMENT

Appendix 2

USE OF RAPID TRANQUILISATION – ROLES AND RESPONSIBILITIES

Nurse-in-charge

1. Ensure clinical team have tried appropriate de-escalation techniques but service user remains distressed
2. Contact duty doctor

Medical Practitioner

1. Ensure case notes have been checked for advanced decisions and complicating factors
2. Ensure service user has not been using alcohol or opiates.
3. Ensure that consent to treatment (MHA or MCA **(SEE PART 6 AND 10 OF THIS POLICY FOR EXCLUSIONS)** has been checked).

If resuscitation provision is not available, &/or advance decisions are outside normal clinical practice or alcohol/opiate use suspected contact Consultant/Consultant on-call to determine safest course of action

1. Offer oral preparation	2. If declined consider use if intramuscular route	3. In exceptional circumstances intravenous route may be considered
Use minimum effective dose of benzodiazepine,olanzapine or haloperidol: for haloperidol initial prescriber should also consider an anticholinergic	1. Use minimum effective dose of benzodiazepine, olanzapine or haloperidol also consider an anticholinergic. 2. Agree care plan, legal changes to consent and observations with Nurse in Charge of Ward **(Peak levels of medication occur at around 2hrs post dose – this fact needs to be represented in the care plan)**	1. Ensure additional resuscitation equipment is available 2. Agree intravenous route with Consultant/ Consultant on-call 3. Use minimum effective dose of benzodiazepine or 4. Monitor as per IM route (see across)

Registered Nurse

1. State level of consciousness
2. Check for continuous distress after 30 minutes – observe for any signs of compromise to physical integrity
3. Check hourly for 4 hours and 2 hourly for 6 hours.

Registered Nurse

1. Check blood pressure, pulse and respiratory rate every 15 minutes for 1 hour then every hour for 4 hours (1:1 observations if sleeping). Then every 4 hours up to 12 hours.
2. Check for continued distress after 30 minutes

Pharmacist
Will give advice and support in relation to prescribing and administration

Abnormalities	Continued distress	Distress reduced

Registered Nurse

1. Contact duty doctor

Ring 999

1. Prescribe & arrange for the administration of flumazenil if respiratory rate < 10
2. Agree any other action with consultant/ consultant on-call
3. Ensure checks continue as above

Registered Nurse

1. Use appropriate de-escalation techniques and continue checks as above
2. If de-escalation techniques fail to reduce distress contact duty doctor

Doctor

1. Consider second dose of medication. If second dose already given contact consultant (on-call) to determine safest course of action
2. Give explanation of medication and why necessary
3. Ensure BNF maximum dose not exceeded
4. Ensure checks continue as above and review treatment in line with MHA or MCA (see part 6 and 10 of this policy)

Registered Nurse

1. Debrief service user when alert (include opportunity to include written account of their experience in case notes)
2. Discuss at MDT meeting to ensure appropriate Mental Health Act documentation completed (see part 6 and 10 of this policy) and lessons shared with Service Governance Forum

Pennine Care NHS
NHS Foundation Trust

SUMMARISED PRESCRIBING GUIDELINES FOR RAPID TRANQUILISATION IN INPATIENT SERVICES FOR ADULTS 18 – 65 YEARS. Version 5

STEP 1	De-escalation, psychological treatment
STEP 2 Offer **oral** treatment	**lorazepam 1-2mg** or **promethazine 25-50mg** or **quetiapine 100-200mg** or **haloperidol 5mg** - NB SPC for haloperidol recommends ▪ avoid concomitant antipsychotics ▪ a pre-treatment ECG ▪ Maximum dose now 20mg/24 hours
	Oral treatment may be repeated after 45-60 minutes *Go to step 3 if two doses fail or sooner if there is significant risk*
STEP 3 Consider **IM** treatment	**lorazepam 1-2mg** - Have flumazenil to hand in case of respiratory depression or **midazolam 7.5mg** *(if lorazepam is unavailable)* maximum dose 15mg in 24 hours or **promethazine 50mg** or **haloperidol 5mg** - haloperidol should be the last drug considered - Have IM procyclidine to hand in case of acute dystonia - New maximum dose 12mg/24 hours *Repeat after 30-60 minutes if insufficient effect* The use of IM haloperidol and IM promethazine simultaneously is recommended by NICE in NG10 (2015). Consideration may be given to the use of this combination when clinically appropriate
STEP 4	Seek expert advice, from consultant or senior staff

NOTES

Monitoring

1. After IM treatment, or physical restraint, as a minimum, the level of consciousness and the breathing rate should be monitored every 15 minutes up to 2 hours after administration
2. Temperature, pulse, blood pressure and respiratory rate may be monitored as clinically indicated.

Dosage

1. Smaller doses may be needed in persons with low body weight or severe renal impairment. Use with caution in hepatic impairment, respiratory and heart disease.
2. Consult the British National Formulary (BNF) for maximum doses / 24 hours of drugs used.
3. Doses above BNF limits must not be given except where authorised by a consultant or senior prescriber

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Appendix 4
Document Reference
MM 057

SUMMARISED PRESCRIBING GUIDELINES FOR RAPID TRANQUILISATION IN PATIENTS 65 YEARS OF AGE OR OVER. Version 4

STEP 1	De-escalation, psychological treatment
STEP 2 Offer **oral** treatment	**lorazepam 0.5-1mg** - May be repeated after 45-60 mins or **promethazine 10-25mg** - May be repeated after 45-60 mins or **quetiapine 25-50mg** or **haloperidol 0.5-1.5mg** - NB SPC for haloperidol recommends • avoid concomitant antipsychotics • a pre-treatment ECG • Maximum 10mg/24 hours
	Go to step 3 if two doses fail or sooner if there is significant risk
STEP 3 Consider **IM** treatment	**lorazepam 0.5-1mg** - have flumazenil to hand in case of respiratory depression or **midazolam 2.5-5mg** *(if lorazepam is unavailable)* maximum 10mg in 24 hours **or** **promethazine 10-25mg** or **haloperidol 0.5-2.5mg** - haloperidol should be the last drug considered - have IM procyclidine to hand in case of acute dystonia - maximum 6mg/24 hours *May be repeated after 30-60 minutes* The use of IM haloperidol and IM promethazine simultaneously is recommended by NICE in NG10 (2015). Consideration may be given to the use of this combination when clinically appropriate.
STEP 4	Seek expert advice, from consultant or senior staff

NOTES

Monitoring

1. After IM treatment, or physical restraint, as a minimum, the level of consciousness and the breathing rate should be monitored every 15 minutes up to 2 hours after administration
2. Temperature, pulse, blood pressure and respiratory rate may be monitored as clinically indicated.

Dosage

1. Smaller doses may be needed in persons with low body weight or severe renal impairment. Use with caution in hepatic impairment, respiratory and heart disease.
2. Consult the British National Formulary (BNF) for maximum doses / 24 hours of drugs used.
3. Doses above BNF limits must not be given except where authorised by a consultant or senior prescriber

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Appendix 5
Document Reference MM 053

SUMMARISED PRESCRIBING GUIDELINES FOR RAPID TRANQUILISATION FOR PATIENTS ON THE CAMHS IN-PATIENT UNITS AGED BETWEEN 12 to 18 YEARS. Version 4

STEP 2 offer **ORAL** treatment	**Promethazine 25mg-50mg**	Max dose 100mg/24hrs
	or	
	Lorazepam 0.5mg-2mg	Max dose 4mg/24hrs
	or	
	Quetiapine 25mg-50mg	Max dose 750mg/24hrs
	or	
	Haloperidol 1.5mg-5mg	Max dose 20mg/24hrs SPC for haloperidol recommends: - a pre-treatment ECG - avoid concomitant antipsychotics
Oral treatment may be repeated after 45-60 minutes. Seek expert advice, from consultant or senior staff *Go to step 3 if **two** doses fail or <u>sooner</u> if there is significant risk*		
STEP 3 consider **IM** treatment	**Promethazine 25mg-50mg**	Max dose 100mg/24hrs Avoid concomitant haloperidol
	Or	
	Lorazepam 0.5mg-2mg	Max dose 4mg/24hrs - Have flumazenil to hand in case of respiratory depression
	Or	
	Midazolam 0.05-0.15mg/kg (if lorazepam is unavailable)	Dose 0.05-0.15mg/kg Max single dose 7.5mg Max daily dose 15mg/24hrs
	Or	
	Haloperidol 1.5mg-5mg SPC for haloperidol recommends: - a pre-treatment ECG - avoid concomitant antipsychotics - IM procyclidine to hand in case of acute dystonia	**Max dose 12mg/24hrs** - consider lower max daily dose in younger patients Avoid concomitant promethazine <u>Note – Haloperidol should be the last drug considered</u>
STEP 4	*Seek expert advice, from consultant or senior staff*	

NOTES

Monitoring

1. After IM treatment, or physical restraint, as a minimum, the level of consciousness and the breathing rate should be monitored every 15 minutes up to 2 hours after administration
2. Temperature, pulse, blood pressure and respiratory rate may be monitored as clinically indicated.

Dosage

1. Smaller doses may be needed in persons with low body weight or severe renal impairment. Use with caution in hepatic impairment, respiratory and heart disease.
2. Consult the British National Formulary (BNF) for maximum doses / 24 hours of drugs used.
3. Doses above BNF limits must not be given except where authorised by a consultant or senior prescriber

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