Pennine Care
NHS Foundation Trust

DOCUMENT CONTROL	
Title:	Short Term Management of Acutely Distressed Patients and Rapid Tranquillisation
Version:	8
Reference Number:	CL014

Scope:

This policy applies 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.

Purpose:

The purpose of this document is to:

- Define the short term management of acutely distressed patients on inpatient wards
- Incorporate the updated NICE definition of Rapid Tranquilisation (RT) as the use of parenteral medication
- Provide a standardised approach to physical health monitoring and nursing care before, during and following intervention
- Outline responsibilities and duties of staff undertaking short term management of acutely distressed patients in Pennine Care NHS Foundation Trust
- Provide guidance to staff around evidence based prescribing in short term management of acutely distressed patients
- Describe the appropriate skills/competencies for staff in non-pharmaceuticals interventions.

Requirement for Policy

Keywords:

Rapid tranq, tranquillisation, violence and aggression, distressed

Supersedes:

Version 7

Description of Amendment(s):	
Comprehensive review / amendments made throughout the policy, in line with NG10: Violence and Aggression: short-term management in mental health, health and community settings	
Owner:	
Karen Maneely, Chair of Trust Acute Care Forum	
Individual(s) & group(s) involved in the Development:	
This document has been developed in collaboration with the following interested parties: • Multidisciplinary Acute Care Task and Finish Group	
Individual(s) & group(s) involved in the Consultation:	
The document has been circulated for consultation and comments have been taken into consideration and the document amended accordingly: • Acute Care Forum	
Equality Impact Analysis:	
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Review:	
Next review date: **Responsibility of:**	01st March 2021 Chair of Trust Acute Care Forum
Other Trust documentation to which this policy relates (and when appropriate should be read in conjunction with):	
CL003	Care Programme Approach Policy
CL009	Resuscitation Policy
CO038	Violence Reduction Policy
CO031	Security Policy
CO010	Incident Reporting, Management and Investigation Policy
CL002	Consent to Examination or Treatment Policy
MM053/55/57	Prescribing Guidelines for Short Term Management of Acutely Distressed Patients
CL026	Seclusion, Time Out and Other Restriction of Patient Movement Policy
CL05	Observation & Engagement Policy
CO081	Core and Essential Skills (Mandatory Training) Education Policy
CL058	Policy on Treatment of Patients Subject to the Mental Health Act 1983: Part 4 and Part 4A
CL015	Medicines Policy
Policy Associated Documents:	
TAD_CL014_01	Monitoring Form for short term management acutely distressed patients
TAD_CL014_02	Summarised prescribing guidelines for the acute agitation and distressed in adults 18-65 years
TAD_CL014_03	Summarised prescribing guidelines for the acute agitation and distress in HYM aged 12-18 years
TAD_CL014_04	Summarised prescribing guidelines for acute agitation and distress in patients 65 years and over
TAD_CL014_05	Medicines used for management of acute agitation or aggression - their properties, cautions and advice notes
Other external documentation/resources to which this policy relates:	
NICE QS154	Violent and aggressive behaviours in people with mental health problems
NICE CG155	Psychosis and schizophrenia in children and young people: recognition and management

NICE NG10	Violence & Aggression in Short Term Management in Mental Health, Health and Community settings
NICE CG178	Psychosis and Schizophrenia in Adults; prevention and management
CQC Regulations **This policy supports the following CQC regulations:**	

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1. INTRODUCTION

Any restrictive intervention, including RT, should be used minimally and as a last resort, as outlined in NICE NG10 Violence and Aggression: short term management in mental health, health and community settings[1] and the Mental Health Act Code of Practice (2015)[2]. The management of acutely distressed patients should be seen in the context of a restrictive hierarchy of interventions, as outlined by the Department of Health in Positive and Proactive Care Proactive Care 2014[3] starting with "green" approaches such as Safeward techniques, moving onto "amber" approaches, before using the most restrictive "red" interventions such as planned restraint and/or RT.

Where RT, defined by NICE as the use of parenteral medication, has been agreed as the safest clinically reasoned approach, it is still expected that de-escalation skills and alternative approaches, including oral medication, are employed. The decision to use physical restraint should be discussed first with the clinical team and should be documented and justified in the patient's notes. Following the administration of RT, the patient's condition and progress should be closely monitored. Records should indicate the reason for the RT use and provide a full account of both its efficacy, monitoring, and any adverse effects observed or reported by the patient.

2. PURPOSE

The purpose of this document is to:

- Define the short term management of acutely distressed patients on inpatient wards
- Incorporate the updated NICE definition of Rapid Tranquilisation (RT) as the use of parenteral medication
- Provide a standardised approach to physical health monitoring and nursing care before, during and following intervention
- Outline responsibilities and duties of staff undertaking short term management of acutely distressed patients in Pennine Care NHS Foundation Trust
- Provide guidance to staff around evidence based prescribing in short term management of acutely distressed patients
- Describe the appropriate skills/competencies for staff in non-pharmaceuticals interventions.

3. RESPONSIBILITIES, ACCOUNTABILITIES AND DUTIES

Medical Practitioners

- Should be familiar with the properties of all psychotropic medicines used in short term management of agitation and distress

- Should develop and document individualised pharmacological strategies for patients and follow RT prescribing guidelines (section 12)
- Must be aware when medicines use is 'off-label' (outside product licence)
- Must document rationale if prescribing above British National Formulary (BNF) limits or out-with Trust's Medicine Policy (CL015)
- Should review RT medication daily and review monitoring (NICE NG10)
- Must check Consent to Treatment where this applies (i.e. T2, T3, Section 62 MHA), and to check advanced decisions[4]
- Ensure that treatment plan is drawn up, recorded in notes and be discussed with and available to the multi-disciplinary team (MDT)

Senior Nurse in Charge

- Ensure that all staff, including bank and agency, are competent 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 (TNA)
- Ensure resuscitation equipment is available and checked daily
- Ensure that staff complete physical observations following RT and document as per policy

Registered Nurses

- Attend the required training and maintain competency in BLS, ILS, MVA, have reviewed their Training Needs Analysis, and have undertaken Continuing Professional Development
- Work within own sphere of competency and request second opinion as required
- Ensure consent to treatment form has been checked i.e. T2, T3, or where emergency provisions apply under Section 62 MHA)
- Ensure prescribing as per RT policy and involvement 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 medicines available on ward before RT plan is implemented
- Ensure safe and effective use of medication, considering co-morbidities and regular medications, checking with pharmacist if necessary
- Administer RT as per agreed treatment plan

- Carry out physical health observations and ensure sufficient monitoring as per policy and identify when further medical intervention is required
- Ensure that all these observations are recorded on relevant Trust approved documentation (TAD_CL014_01)

Pharmacists

- Ensure that prescribing follows the Trust policy and that any deviations are clinically appropriate and recorded along with treatment rationale
- Assist in the development and documentation of individualised pharmacological strategies for patients
- Involvement in induction training of medical staff
- Ensuring stocks of medicines are available on wards as required (via pharmacy technicians as necessary)
- Ensure they are up to date and attend mandatory training.

4. DEFINITIONS

Advance Decision: A written statement made by a person aged 18 or over that is legally binding (if valid and applicable) and conveys a person's informed decision to refuse specific medical/healthcare treatments in the future in case the person loses the capacity to make these decisions. An advance decision refusing treatment for mental disorder may be overridden under certain sections of the Mental Health Act (1983).

Advance Statement: A written statement that conveys a person's preferences, wishes, beliefs and values about their future treatment and care. It is not legally binding but must be taken into account by decision makers.

De-escalation: The use of skills and techniques, verbal or non-verbal, which aim to defuse anger and aggression.

Incident: Any event that involves the use of a restrictive intervention – restraint, rapid tranquillisation or seclusion (bit not observation) – to manage violence or aggression.

Oral Treatment/Non-Urgent Tranquillisation: The use of orally administered medication, which should be used in preference to rapid tranquillisation (IM) whenever possible, with the aim of calming or lightly sedating a patient in order to reduce the risk to the patient or others.

PRN (pro re nata) Medication: Medicines that are used when required. PRN medication can be used as part of de-escalation but medication used alone is not de-escalation.

Rapid Tranquillisation (RT): Tranquillisation using parenterally administered medicine(s). This should only be used if oral treatment is not possible (e.g. due to patient refusal), not appropriate (i.e. urgent need) or has inadequate effect. In line with NICE NG10, **the term rapid tranquillisation no longer incorporates the use of oral medicine(s) for the management of agitation or aggression.**

Restrictive Interventions: Interventions that may infringe a person's human rights and freedom of movement, including rapid tranquillisation, physical restraint, and seclusion.

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

5. THE IN-PATIENT ENVIRONMENT

The Royal College of Psychiatrists highlighted the importance of minimizing environmental factors which might contribute to increased tension and frustration for service users in acute inpatient settings[5]. NICE NG 10 also states that improving the environment can have an impact on the incidence of violence and aggression and use of RT. Ward areas therefore must adapted for the needs of the acutely ill, with clear and therapeutic communication between staff and service users. Factors that should be identified monitored and corrected:

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

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

6. THE SERVICE USERS EXPERIENCE

Pennine Care recognises that involuntary procedures can be highly distressing or even traumatic for the patient and will make every effort to minimize the negative experience. 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 improve the quality of care provided. As per NICE guidelines, service user's views and experiences will be recorded to help develop positive practice and ensure that interventions are always undertaken sensitively and therapeutically.

Where the use of RT is anticipated, an advanced statement or a specific care plan should be in place where possible, documenting patients views and wishes on de-escalation support and management and medication preferences. Note it may be necessary to administer IM medication without the patients' consent.

7. CONSENT & CAPACITY

The Clinical team must always consider the issue of consent and capacity when considering the management of acutely distressed patients. Where patients are detained their consent and capacity should always be considered in addition to their certification requirements under Part 4 of the Act.

8. SECLUSION AND RESTRAINT

The use of seclusion for patients should be avoided wherever possible however if it is judged necessary to manage serious risk of violence, the service user must be placed under constant visual observation. Frequent monitoring of vital signs should continue. Refer to the Trust Seclusion Policy.

The Trust, in line with national guidance, is trying to reduce the use of prone (face down) restraint, however, as stipulated in the NICE NG10 Guidance, it may be used briefly for RT intramuscular injections. It should not exceed 5 minutes in that position and must be recorded on the Trust Incident Safeguard system as “Prone Restraint for the Purpose of Medication Administration” The techniques are taught as part of the MVA 4 Training Course, along with the knee roll from the supine or seated position to expose the buttock area for administration access.

Generally, physical restraint must not be used unless there is such legal authority, whether under the Act (see provisions for treatment chapter 24 of the MHA Code2), the Mental Capacity Act (MCA6) 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. The same statutory and common law provisions apply within health and care services as elsewhere.

9. MULTIDISCIPLINARY WORKING AND DECISION TO USE RT

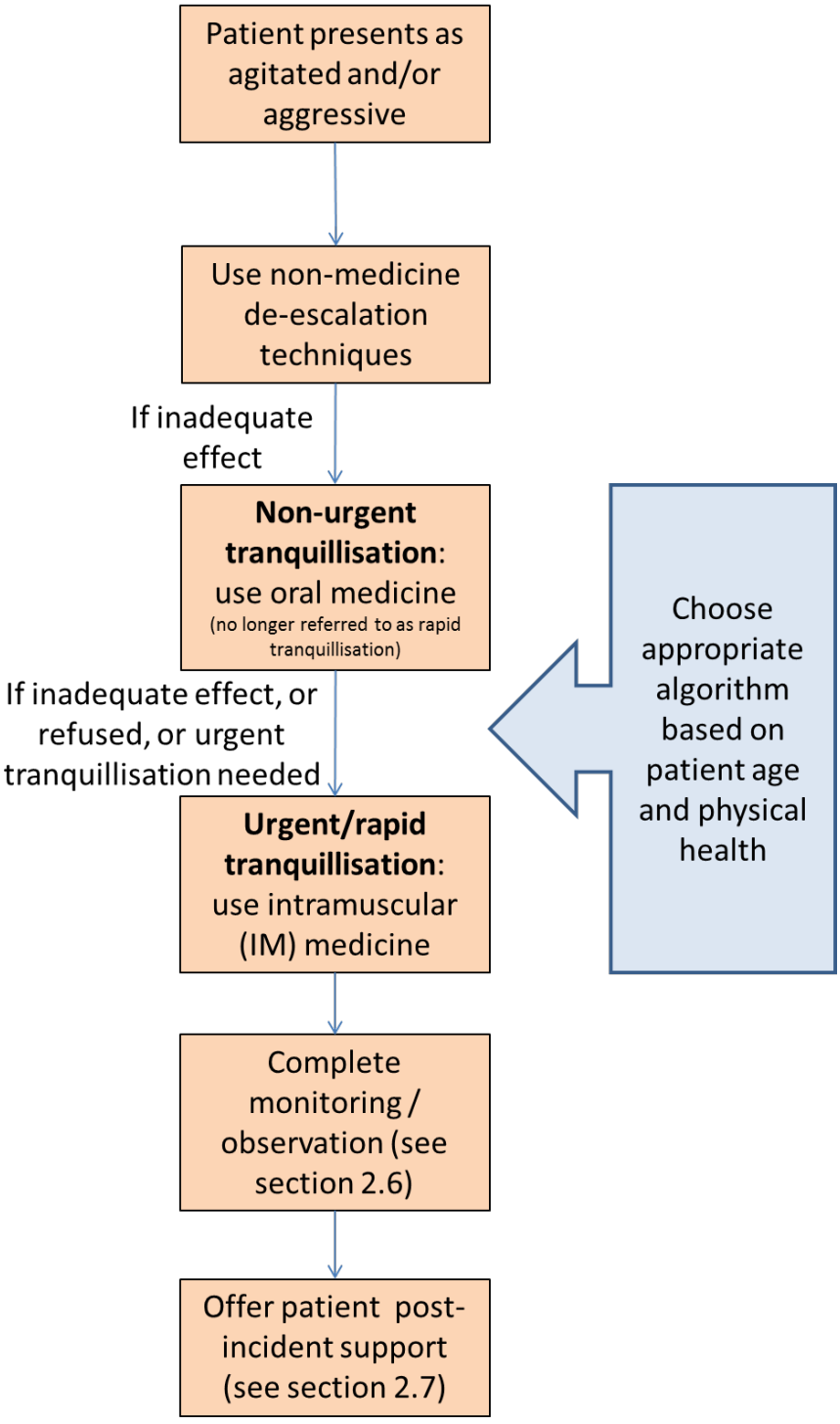
The approach to the short term management of acutely distressed patients and the use of RT is a multidisciplinary intervention. The service user as well as nursing, medical and pharmacy staff should be involved in decision making, advance decisions taken into consideration, and interventions be planned around the individual’s needs. De-escalation must be attempted first (see MVA Policy) and the use of physical interventions/RT should be considered when all non-invasive strategies are unsuccessful or inappropriate. Therefore RT should be used only when absolutely necessary and planned in advance.

Consider:

- Safety of the service user, staff and other service users
- Best interests of the service user
- Privacy & dignity of the service use
- Evidence based prescribing
- Appropriately skilled staff available to undertake monitoring and aftercare

- Legal requirements: Responsible Clinicians are advised to include PRN medication including RT on any statutory certificates completed for the MHA where section 58 applies
- Immediate access to appropriate resuscitation equipment (see Section 13)

Figure 1: Decision to use RT flowchart[7]



10. TRAINING AND COMPETENCIES

Staff should be competent in the assessment and management of acutely distressed patients, including the use of RT. All registered health professionals involved in the prescribing, administration or monitoring of patients should:

Competencies

- Be able to recognise early warning signs of acute distress and agitation, intervene and engage with the patient
- Be able to assess and manage potential and actual violence using de-escalation techniques and engage the patient in therapeutic observations
- Be able to assess the risks associated with medication, particularly when the service user is highly aroused and may have been misusing drugs or alcohol, be dehydrated or possible be physically ill
- Understand the cardio-respiratory effects of the acute administration of medication and the need to titrate dosage to the effect
- Be able to monitor physical health observations, including identifying signs and symptoms of a physically deteriorating patient
- Recognise the importance of nursing in the recovery position and maintaining an unobstructed airway
- All registered and nurses and doctors working in inpatient areas are expected to demonstrate competency in RT: understand RT as the use of parenteral medication and be competent in administration, monitoring vital signs and physical health
- Complete a Competency Assessment Framework (CAF) for nurses and Core Competencies in Medicines Management for medical staff within 3 months of commencement. The required proforma should be filed in the staff member's personal file
- Competency in the use of RT and general medicines safety should be addressed by managers within supervision and appraisal

Training

- Refer to Training Needs Analysis (TNA) VIA Pennine Care's Core and Essential Skills Policy which has information on all mandatory training requirements, including resuscitation and Management of Violence & Aggression (PMVA)
- Receive ILS training and annual updates – prioritised for senior inpatient nursing staff and medical staff (The Trust will work toward achieving this standard as soon as possible)
- Attend regular updated legal training accessed through the Principles of Governance Mental Health Law dates/the Medical Training Programme
- Keep up to date with updates in the subject via CPD

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. PRESCRIBING GUIDELINES

NICE NG10 states that a multidisciplinary team that includes a psychiatrist and a specialist pharmacist should develop and document an individualised pharmacological strategy for using routine and prn medication to calm, relax, tranquillise or sedate service users who are at risk of violence and aggression as soon as possible after admission to an inpatient psychiatric unit.

The multidisciplinary team should review the pharmacological strategy and the use of medication at least once a week and more frequently if events are escalating and restrictive interventions are being planned or used. The review should be recorded and include:

- Clarification of target symptoms
- The likely timescale for response to medication
- The total daily dose prescribed and administered, including p.r.n.
- The number and reason for any missed doses
- Therapeutic response
- The emergence of unwanted effects

The choice of medications is outlined in the summarised prescribing guidelines for the treatment of acute agitation and distress in TAD_CL014_02 – TAD_CL014_04 for inpatients:

- Adults (TAD_CL014_02)
- Healthy Young Minds (TAD_CL014_03)
- Older People (TAD_CL014_04)

As per NICE guidelines, this guideline recommends some medicines for indications for which they do not have a UK marketing authorisation. Details of the medications are listed in Table 1.

NB: The use of IM zuclopentixol acetate is not considered as rapid tranquillisation although it may in some circumstances be administered at the same time, and both requiring monitoring of observations. Refer to MM106 Guidelines for the use of zuclopentixol acetate for adult inpatients.

Circumstances for special care when prescribing include:

- When there is a known presence of certain disorders that may affect metabolism (e.g. hypothermia, hyperthermia, extreme physical exertion)
- When there is a known presence of congenital cardiac conductive abnormalities and elevated QT.
- Where there is co-prescription of medications that can directly or indirectly lengthen QT intervals
- Patients who are prescribed anticoagulant therapy or who have a bleeding disorder – to reduce the risk of haematoma formation:
  - Apply firm pressure to the injection site for at least 2 minutes after injecting; to aid coagulation
  - Do not rub or massage the injection site

Prescribing in Special Patient Groups

Pregnant Patients

- The decision to prescribe/utilise medication will need to be assessed according to:
  - 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 semi-recumbent position
- Seclusion post IM medication should not occur
- 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
- Staff are also advised to consult other specialist advisors where appropriate i.e. Moving and Handling Advisor, Mother and Baby Unit

Patients with Learning Difficulties

- An overall care plan should be devised referencing the method of managing acute agitation and distress
- Patients may have an altered pain threshold as well as potentially undetected hearing or visual problems
- Patients with Cerebral Palsy may be at risk of postural deformities and hip dislocation so special consideration is required
- Restraint can pose hazards in patients with associated cardiac and respiratory disorders

Younger People

- They are more likely to be antipsychotic naïve and sensitive to EPSE
- They have an increased risk of acute dystonic reaction and laryngeal spasm, additionally a single dose of antipsychotic can lead to Neuromuscular Malignant Syndrome (NMS)
- There is a higher incidence of disinhibition or paradoxical reactions with benzodiazepines in younger patients compared with adults.
- Prescribing is generally off-label
- In younger patients who are not Gillick competent, parents or carers should be informed (along with the child), and consent sought

The following additional precautions must be taken:

- If behavioural disturbance is not psychotic in nature, in absence of a care plan stating otherwise, lorazepam or promethazine are preferred agents
- Note benzodiazepines should be avoided in patients with epilepsy, respiratory impairment or physically unwell
- If haloperidol is used, consider prophylactic procyclidine
- Older, higher body mass adolescents or those treated with antipsychotics previously may require use of the adult algorithm – monitor effects carefully

- One to one observation is required throughout the period of RT due to medicine response profiles in younger patients

Older People

- May be frailer, have more medical illnesses, be taking more physical health medication and be more likely to develop EPSE than adult patients
- Are more likely to be naïve to benzodiazepines/antipsychotics
- Are more susceptible to postural hypotension, and hyper-or hypothermia in hot or cold weather
- Higher medication doses can cause cognitive impairment in dementia

The following additional precautions must be taken:

- Doses should be reduced (half of adult dose or less) taking into account weight, co-morbidity and other medication
- Lorazepam is the drug of choice, particularly in patients with dementing illness (NB caution in patients with respiratory disease)
- The use of antipsychotics must be discussed with the consultant and a risk benefit analysis considered along with the symptom severity
- Avoid haloperidol in Lewy Body Dementia and Parkinson's disease
- In dementia, haloperidol and procyclidine can cause cognitive impairment; antipsychotics are associated with increased risk of stroke/TIA

12. MONITORING VITAL SIGNS & SIDE EFFECTS

It is important that vital signs are obtained and recorded as a routine part of admission procedure and before RT is administered where possible.

The clinical staff should consider what "normal range" is for each individual patient and this should be communicated to all staff and documented as part of the "outline of medical care plan" section of the RT monitoring form – TAD_014_01.

If a record of vital signs is not possible prior to RT due to the patient refusing, or due to the urgency of the situation, this should be recorded in the patient's notes.

The purpose of monitoring vital signs and side effects is to ensure early detection and intervention if adverse effects occur following RT. The nursing and medical teams should consider each patient individually, reviewing:

- Route of administration
- Amount of medication received
- Level of sedation
- Physical health
- Age
- Interactions with other medication, illicit substances/alcohol

Figure 2 lists the minimum frequency for monitoring the patient's vital signs, blood pressure, pulse, and respirations recorded following RT. All monitoring should be recorded on approved Trust monitoring form, easily identifiable within the patient's notes.

Fig 2: RT Monitoring parameters

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)

Any deviation from normal range and/or adverse effects must be reported to the medical team

- **Monitoring issues post RT:** On occasion it may not be practical to monitor pulse or blood pressure following RT (e.g. the team feels that further interventions would distress or antagonise the patient). As a minimum staff must document, observe and record levels of consciousness and respirations every 15-20 minutes for at least 2 hours then hourly for the next 6 hours (more often where clinically indicated)
- **Non-response:** If the service user remains distressed after 30 minutes despite medication, and de-escalation techniques continue to be unsuccessful, the nurse should inform the duty doctor who may prescribe a second dose within BNF limits. The service user should be given an explanation and if no further response should discuss with consultant.
- **Side effects:** The potential for acute dystonia and oculogyric crisis should be anticipated, particularly if conventional antipsychotics are used. The clinical should ensure that prescription and administration of anticholinergic is quickly accessible to minimise discomfort and distress.
- **Resuscitation equipment:** Immediate access required and the location known to all staff. NICE stipulate the crash bag must be available within 3 minutes in healthcare settings where RT might be used. Flumazenil and procyclidine IM should also be available.
- **Oral medication:** Monitoring vital signs may be deemed necessary if:
  - High repeated doses have been administered
  - Medication is prescribed to patient for the first time
  - Patient is heavily sedated
  - Patient has recently abused drugs or alcohol
  - Patient has had a history of respiratory depression

13. OBSERVATION

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.

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.

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.

14. DEBRIEFING AND REPORTING 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 used 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 and support to write about their experience within the case notes. A discussion regarding Advance Decisions or Written Statements may also be beneficial if the patient has capacity to engage with this staff at the time.

The patient will be asked whether they would like the involvement of an independent body i.e. the Independent Mental Health Advocacy service in the first instance for detained patients. If this is the case, the nurse in-charge should ensure that advocacy services are contacted.

The nurse in-charge should ensure that the use of IM medication 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 Drugs & Therapeutics Committee).

15. REPORTING, AUDIT AND REVIEW

All incidents of restraint, IM medication and untoward events or adverse outcomes resulting from IM medication should be reported using the Trust Incident Reporting

procedures. Medication errors, and serious physical complications or adverse effect should also be reported.

Monitoring and audit of this policy will take place as part of the clinical audit programme, shared across the organisation and use as a tool for as continuous learning. Review of this policy will take place every two years. The Divisional Integrated Governance Groups will review this policy and the Acute Care Forum will approved the policy.

16. EQUALITY IMPACT ANALYSIS

As part of its development, this document was analysed to consider and address any detrimental impact the policy may have on individuals and or groups protected by the Equality Act 2010. This analysis has been undertaken and recorded using the Trust's analysis tool, and appropriate measures will be taken to remove barriers and advance equality of opportunity in the delivery of this policy.

17. FREEDOM OF INFORMATION EXEMPTION ASSESSMENT

Under the Freedom of Information Act (2000) we are obliged to publish our policies on the Trust's website, unless an exemption from disclosure applies. As part of its development, this policy was assessed to establish if it was suitable for publication under this legislation. The assessment aims to establish if disclosure of the policy could cause prejudice or harm to the Trust, or its staff, patients, or partners. This assessment has been undertaken using the Trust's Freedom of Information Exemption Guide, and will be reviewed upon each policy review.

18. INFORMATION GOVERNANCE ASSESSMENT

This Policy has been analysed to ensure it is compliant with relevant information law and standards as in place at the time of approval, and are consistent with the Trust's interpretation and implementation of information governance components such as data protection, confidentiality, consent, information risk, and records management.

Compliance will be reviewed against any changes to legislation / standards or at the next review of this document.

19. SAFEGUARDING

All staff have a responsibility to promote the welfare of any child, young person or vulnerable adult they come into contact with and in cases where there are safeguarding concerns, to act upon them and protect the individual from harm.

All staff should refer any safeguarding issues to their manager and escalate accordingly in line with the Trust Safeguarding Families Policy and Local Safeguarding Children/Adult Board processes.

20. MONITORING

The effective application of this policy, including adherence to any standards identified within will be subject to monitoring using an appropriate methodology and design, such as clinical audit.

Monitoring will take place on a biannual basis and will be reportable to the Quality Group via the Clinical Effectiveness and Quality Improvement Team.

21. REVIEW

This policy will be reviewed three-yearly unless there is a need to do so prior to this; e.g. change in national guidance.

22. REFERENCES

1. NICE Guideline NG10: Violence & Aggression: The Short-Term Management in Mental Health, Health and Community Settings (2015)
2. Mental Health Act 1983 Code of Practice (2015)
3. Positive and Proactive Care: Reducing the need for restrictive interventions DOH (2014)
4. Meeting Needs and Reducing Stress: Guidance on the Prevention and Management of Clinically Related Challenging Behaviour in NHS Settings – NHS Protect (2014)
5. NICE Clinical Guideline CG178: Psychosis and Schizophrenia Management, March 2009. Accessed 6/10/2017
6. Mental Capacity Act 2005 Code of Practice
7. Cheshire and Wirral Partnership NHS Foundation Trust. Rapid Tranquillisation Policy. Issue 9, March 2017