## Rapid Tranquilisation Policy

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Appendix: Clinical Guidelines.
1. Purpose

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. It is hoped that this Policy and continued collaboration with service users, will ensure that Rapid Tranquillisation is undertaken only when necessary, and always with utmost respect and sensitivity for the individual.

The use of Rapid Tranquillisation is a high-risk practice which has to be well managed to avoid unnecessary harm, so Rapid Tranquillisation, along with de-escalation and physical interventions, should be seen as a management strategy and is not regarded as a primary treatment technique.

The aim of this document is to ensure that rapid tranquillisation is used safely and effectively within Lincolnshire Partnership NHS Foundation Trust (the Trust). It establishes a framework for:

- Ensuring the decision to use rapid tranquillisation is made with due consideration.
- Ensuring rapid tranquillisation is used safely, effectively and appropriately.
- Ensuring the use of rapid tranquillisation is reflected on and learnt from by staff and service users.

The Trust acknowledges that the medications described in this policy will be needed for the treatment of service users that are not exhibiting symptoms of aggression. However, where medication, including PRN, is used specifically to promote a reduction in agitation and aggressive behaviour, the guidance outlined within this policy, particularly in relation to the physical aftercare of the service user, should be followed.

All staff should be aware of the clinical implications and monitoring requirements when prescribing, dispensing or administering any medication.

This policy should be read in conjunction with other Trust policies, procedures and programmes of work including:

- Medicines Management Policy (OPR17)
- Seclusion Policy (OPR13)
- Identification, Treatment & Management of Challenging Behaviour and Violence Policy (OPR29)
- Policy for the Safe and Supportive Observation of Patients (OPR05)
- Mental Capacity Act Policy (MEN65)
- Induction and Mandatory Training Policy (PER/25)
2. Background

During an acute episode of illness some service users can become behaviourally disturbed and may need help to calm down. The engagement of skilled health care staff who can listen and respond to the needs and anxieties of service users will help to alleviate personal distress. Occasionally however when a service user has become violent or aggressive, the use of quick acting drugs may assist in this process.

National guidelines for the use of rapid tranquillisation form part of the clinical guideline for the short-term management of violence (CG25, NICE, 2005) as well as being covered in the clinical guideline for the treatment of schizophrenia (CG82, NICE, 2009)

Rapid tranquillisation is defined as:-

“The use of medication to calm/lightly sedate the service user, reduce the risk to self and/or others and achieve an optimal reduction in agitation and aggression, thereby allowing a thorough psychiatric evaluation to take place and allowing comprehension and response to spoken messages throughout the intervention. Although not an overt intention, it is recognised that in attempting to calm/lightly sedate the service user, rapid tranquillisation may lead to deep sedation/anaesthesia.”

Where possible, the advice and recommendations from these documents has been incorporated into this policy. These documents can be viewed on-line:

www.nice.org.uk/CG25
www.nice.org.uk/CG82

Rapid Tranquillisation (RT) should only be considered once de-escalation techniques have failed to calm the service user. The RT intervention (along with de-escalation, physical intervention and seclusion) should be considered a management strategy and is not to be regarded as a primary management technique. When determining which intervention to employ clinical need, the safety of service users and others, and where possible any advance statements should be taken into account. It must also be noted that the intervention used must be reasonable and proportionate to the risk posed by the service user at that particular time.

The aim of rapid tranquillisation is to achieve a state of calm sufficient to minimise the risk posed to the service user or others. An optimal response would be a reduction in agitation or aggression without sedation, enabling the service user to participate in further assessment and treatment. Ideally the drug should have a rapid onset of action, low level side effects, and be have a short duration of action.

This policy has been reviewed and finalised by the Trust's Medicines Safe Practice Group and the Medicines Management Committee.

3. Scope of this policy

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 Trust policies.
Rapid Tranquillisation must only be undertaken on hospital premises where there is emergency defibrillation equipment, and there are staff trained to use them within the clinical area 24 hours a day.

This policy applies to:

- Adult in-patients, including people in learning disability adult services (see Appendix for prescribing guidelines).
- All in-patients in older people services (See Appendix for prescribing guidelines).
- All in-patients in Children and Family Services (CAFS) aged 12 - 18 yrs (see Appendix for prescribing guidelines).

The policy will be amended to reflect any subsequent briefs or direction from the Department of Health or the National Institute for Clinical Excellence (NICE).

4. Duties and responsibilities

4.1 The Chief Executive

- Is responsible for the implementation of this policy

4.2 The Medical Director

- Is responsible for ensuring that all medical staff are aware of and operate within the policy, including training requirements

4.3 The Director of Nursing and Strategy

- Is responsible for ensuring mechanisms exist to ensure nursing and allied health professionals within all services are aware of and comply with the requirements of the rapid tranquillisation policy including training requirements and performance measures

4.4 Service Managers

- Are responsible for ensuring that all managed staff with involvement in RT are aware of and comply with the requirements of the policy, including training requirements and performance measures

4.5 Chief Pharmacist

- Is responsible for being the lead author for the RT policy, including its associated prescribing and monitoring guidelines, and ensuring that the document is reviewed with appropriate frequency
- Is responsible for identifying any risks posed to the Trust by the use of RT or the failure to adequately implement the policy

4.6 Medicines Management Committee is required to
Provide advice on the content of the policy, including associated prescribing and monitoring guidelines, to the Chief Pharmacist to ensure it meets standards of good practice for medical and nursing care

Review reported trends of clinical incidents associated with RT and advice on actions to reduce risk to each service and to the Trust as a whole

4.7 **Pharmacy Department**

Clinical Pharmacists will monitor prescribing as per policy and guideline, assess the clinical appropriateness of any deviations and provide feedback to multidisciplinary teams

Pharmacy staff will support the Learning and Development Centre in devising and revising suitable training materials.

Pharmacy staff will review this Policy as deemed necessary

Pharmacy staff will support the audit of rapid tranquillisation practice and the reporting of audit results as detailed in section 17 of this policy

4.8 **The Unit/Ward Manager is required to**

Ensure that all staff are aware of this policy.

Ensure that staff have access to training to enable them to safely implement these guidelines.

Inform Senior Management if the guidelines are not being used appropriately.

4.9 **The Nurse in Charge is required to**

Be fully aware of the contents of this policy and supporting policies and guidance before an incident arises.

Assess risk and implement the policy when they feel appropriate.

Ensure that non-pharmacological methods are tried first

Ensure that the incident is fully recorded, including the physical monitoring and aftercare of the service user.

Ensure the correct monitoring of the service user is carried out by competently trained staff in the use of physical observations.

Ensure that any untoward signs/symptoms or any other cause for concern are reported promptly.

Continue to use de-escalation techniques throughout if appropriate.

4.10 **The Prescriber is required to**

Be familiar with the policy.
Be quickly available when alerted by nursing staff to support the team in the clinical management of the service user, when rapid tranquillisation, physical intervention and/or seclusion are implemented.

Assess the service user and take a drug history where possible, including allergies and adverse drug reactions.

Carry out a mental state examination, where practical before prescribing and administering any medication.

Consider any advanced statements before prescribing.

Follow the guidance of the Mental Health Act 1983 and the Code of Practice (2008) in relation to the use of rapid tranquillisation.

Complete all relevant documentation, highlighting any omissions/deviation from the policy.

Discuss with the nurse in charge in respect to any decisions regarding the administration of regular medication.

Ensure that the service users’ medication chart is amended to reflect the administration of ‘Rapid Tranquillisation.’

4.11 **Learning and Development Centre**

Will provide suitable training material and keep records of training.

Will provide reports on RT training numbers to relevant managers as detailed in section 17 of this policy

5. **Equipment**

Resuscitation equipment should be available within 3 minutes in healthcare settings where rapid tranquillisation is going to be used.

All equipment must be maintained and checked weekly and a recorded log kept of this.

6. **Decision to utilise rapid tranquillisation**

When a service user is distressed, appropriate non-drug measures should be taken to de-escalate the distress.

**“PRN” medication**

If a service user shows early, mild signs of agitation, then the clinical team may consider the use of a single, oral dose of an “as required” (PRN) medication if appropriate, as part of a de-escalation strategy. Such prescriptions should be pre-written as part of a management plan for a service user with a known history of agitation or aggression, taking due account of the service user’s history, physical health, any advance decision/statements and prescribing guidance provided in this Policy. The plan should also specify any post-administration monitoring of the service user that the prescriber considers necessary.
This administration of medication to relieve agitation as part of a de-escalation strategy must be recorded as such in the service user’s notes on each occasion.

If oral PRN medication is not prescribed, unavailable, considered unsuitable for the service user or proves insufficiently effective then the duty doctor should be called by the nurse in charge of the clinical area. Further use of medication for the control of agitation or aggression should be considered Rapid Tranquillisation.

The doctor should:

Check whether any advance decision to refuse treatment or advance statement is in place that may affect the choice of medication

Check if there is any management plan in place for the use of RT in the specific service user

Review the service users’ notes with regard to his/her general medical history and consider the possibility of a physical examination

Check recent ECG, blood and urine drug screen results; check for a previous history of severe extra-pyramidal effects, previous response to Rapid Tranquillisation or other methods of managing imminent violence.

Review current prescribed medication and recently administered medication, taking note of administration of PRN medication

If prescribing rapid tranquillisation, do so in the appropriate sections of the prescription chart so that nurses can clearly identify when they are administering medicines for rapid tranquilisation, and undertake appropriate monitoring

Take care to ensure that high doses do not accidentally occur through the use of PRN medication given in combination with regular medication

Ensure that oral and intramuscular medications are prescribed separately

Extra care should be taken when implementing rapid tranquilisation in the following circumstances:

Where there is a known presence of congenital cardiac conductive abnormalities.

Where 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 the QTc interval

Where antipsychotic drugs are prescribed for an antipsychotic naïve service user

Where an intramuscular injection is to be administered to a service user who is struggling or highly aroused; increased blood flow will increase the rate of absorption of the administered dose and a lower dose may need to be prescribed.
When the duty doctor has established that it is safe and appropriate to utilise rapid tranquillisation a suitable drug, preparation and dose should be prescribed. Oral preparations should be used where possible.

7. Administering rapid tranquillisation

If an intramuscular injection is to be used, the service user should receive an explanation of the medication, its effects and why the intramuscular route may be considered necessary for rapid tranquillisation.

If intramuscular benzodiazepines are to be administered then staff must ensure that a supply of flumazenil is available in the clinical area.

If both olanzapine and a benzodiazepine are prescribed for intramuscular use, they must not be administered within 1 hour of each other.

If rapid tranquillisation is administered out of hours, then the on call doctor must be alerted.

When administering rapid tranquillisation, steps must be taken to try to ensure that such administration has the least impact on privacy and dignity as possible and particular attention should be made in respect of gender issues.

Following the administration of RT, appropriate recording must occur on the prescription chart and in the service user’s notes. Current in-patient prescription charts include specific tick-boxes for PRN (as required) and STAT (once only) prescriptions to indicate when administration of a medicine has been for the purpose of RT.

8. Physical care of the service user during and after rapid tranquillisation

The purpose of monitoring vital signs and side effects is to ensure early detection and intervention if adverse effects occur. Any deviation from normal values or evidence of adverse effects should be reported to the Team or Duty Doctor. The frequency of monitoring should be agreed between the nursing staff and doctor and should normally follow the current monitoring guidelines (see Appendix).

The doctor should remain on, or be contactable by and available to, the ward after intramuscular rapid tranquillisation has been administered until it is clinically and medically safe to leave the service user in the sole care of nursing staff.

The doctor should agree a care plan with the nurse in charge of the ward detailing any actions that must be taken in the case of any change to the service users’ clinical stability. The doctor should make an entry into the clinical notes to this affect.

If any abnormalities are identified by the nurse in-charge following the doctor leaving the ward/clinical area they should refer to the care plan and inform the duty doctor immediately.

Physiological observations should be monitored as per guidelines or as agreed with the prescriber and the frequency should be increased if abnormal physiology is detected.
9. Service users unable to be monitored

The requirement to physically monitor a service user as described in the RT Clinical Guideline may on occasions be counter-therapeutic, add to the individuals’ distress or pose significant risks. The critical point is that the practitioner concerned will need to record and be very clear as to why the deviation from the guideline has occurred and what steps they have taken to ensure the service user remains physically well.

10. Post rapid tranquillisation

Risk assessment and treatment plans must be reviewed following rapid tranquillisation including the use of oral PRN medication to manage agitation unresponsive to de-escalation.

Review causes of violence, diagnosis and consider ongoing management. This is likely to require a review of continuing pharmacological treatment. RT provides a short-term strategy for managing a high risk of imminent violence.

Medium and longer-term measures should be considered at an early stage with the aim of avoiding repeated RT. The diagnosis and its relationship to violence should be considered. Regular treatment should be reviewed.

The service user's care plan should be reassessed and the service user helped to reintegrate in to the ward.

Where this intervention is applied, there must be a Mental Health Act assessment carried out as soon as possible.

11. Rapid tranquillisation and seclusion

The use of seclusion, for patients receiving rapid tranquillisation should be avoided wherever possible.

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

The following advice should be carefully considered and followed in conjunction with the service users management care plan:

If the Service User is secluded, the potential complications of rapid tranquillisation should be taken particularly seriously

The service user should be monitored within ‘eye sight’ observation by a suitably trained individual as agreed by nurse in charge of the ward/unit.

Once Rapid tranquillisation has taken affect, seclusion should be terminated as soon as reasonably possible.
12. Debriefing and reporting following the use of rapid tranquillisation

After the use of rapid tranquillisation, physical interventions or seclusion, the service user’s care plan should be reassessed and the service user should be helped to reintegrate into the ward environment at the earliest safe opportunity.

Following the use of rapid tranquillisation the nurse in charge should ensure that the service user is offered debriefing as soon as is practicable. This should include an explanation of the decision to use rapid tranquillisation.

The service user should be given the opportunity to write their experiences in their care plan. This may necessitate the assistance of advocates and relatives. The written account will be filed in the service users care record. Service users will be engaged in discussion with staff to learn and share lessons.

A post incident Review should take place as soon as possible and at least within 72 hours of the incident ending. Wherever possible a person not directly involved in the incident should lead the review which should address:

- What happened during the incident?
- Any trigger factors
- Each person’s role in the incident
- Their feelings at the time of the incident, at the review and how they may feel in the near future
- What can be done to address their concerns?

13. Zuclopenthixol Acetate (Clopixol Acuphase)

The use of zuclopenthixol acetate does not constitute RT due to the slow onset and prolonged action of this drug.

The use of zuclopenthixol acetate may be considered in a management plan for services users with psychotic or manic illness who fail to respond to repeated RT or have a history of successful response to the drug. It should only be prescribed on the instructions of a consultant.

If zuclopenthixol acetate is considered appropriate, the BNF and the Summary of Product Characteristics (available from [www.medicines.org.uk](http://www.medicines.org.uk)) should be consulted for dosing instructions.

Zuclopenthixol acetate must only be prescribed in the “once-only” section of the prescription chart.

A full MDT review should be conducted as a consequence of the administration of zuclopenthixol acetate.

Care must be taken not to confuse zuclopenthixol acetate with zuclopenthixol decanoate as the latter is a long-acting depot preparation.
14. Legality issues

Rapid tranquillisation is undertaken by health care professionals as a clinical necessity. Health professionals must remain aware of their legal responsibilities and the need to be able to justify their actions.

The National Institute of Clinical Excellence recommended that staff be familiar with in particular:

- The relevant sections of the Mental Health Act 1983 (as amended by the Mental Health Act 2007) and the Mental Health Act Code of Practice (2008)
- Mental Capacity Act 2005 (MCA 2005)
- The requirements of the relevant articles of the European Convention on Human Rights

In the case where an informal service user requires medication to assist them to manage their levels of distress, a dynamic risk assessment must take place as to the need for this intervention, whether the intervention meets the tenets of justifiability (reasonable, proportionate and necessity) and as to whether the service user is medically fit for this intervention to be carried out.

15. Capacity to consent

The principles of the Mental Capacity Act 2005 (MCA 2005) must be followed in relation to consent to treatment.

Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person’s rights and freedom of action.

The assessment of the individual’s ‘capacity to consent’ should be taken by the staff team who carry out the intervention required to manage the situation and clearly documented.

Whether the person has the capacity to consent is incident specific and time specific, this means there may be parts of treatment a person may have capacity to consent to; and at times they may have capacity to consent. An assessment may draw upon the expertise of other healthcare professionals, family, carers and advocates who are close to that person.

The assessment should follow the 2 stage test as outlined in the MCA 2005.

16. Consultation, Approval and Ratification Process

This policy will be consulted upon in line with COR11. The policy will be approved and ratified as outlined in COR11.
17. Review and Revision Arrangements including Version Control

This policy will be reviewed every 3 years or more frequently as required. Corporate & Legal Services will maintain a version control log, in accordance with COR11.

18. Dissemination Training and Implementation

This policy will be disseminated in line with COR11.

It will be implemented by staff through supervisory arrangements with their line manager.

The LPFT pharmacy services will ensure that the document and training package are available on the LPFT medicines management pages of the intranet. Pharmacy services will also inform staff through the Medicines Matters newsletter and Trust weekly word.

Staff involved in the prescribing and administration of rapid tranquillisation are expected to demonstrate a competency with regard to safeguarding themselves and those under their supervision from the risks posed by rapid tranquillisation.

To ensure that staff are appropriately supported to meet this, LPFT Learning and Development Centre in conjunction with the Pharmacy Department, offers a training programme to support this policy.

This training is available to all qualified staff and should be refreshed EVERY TWO YEARS.

The organisation will provide sufficient and appropriate training for each of the main staff groups as outlined within the Trust Mandatory Training Matrix (Induction and Mandatory Training Policy PER/25)

In line with NICE CG25, all staff involved in the prescribing, administration and management of rapid tranquillisation should be competent to a minimum standard of Immediate Life Support (ILS – Resuscitation Council UK)(covers airway, cardio-pulmonary resuscitation [CPR] and use of defibrillators). Staff involved in rapid tranquillisation should have training in the use of pulse oximeters.

Staff responsible for carrying out physical observations of patients, under the supervision of a registered nurse must have up to date knowledge in Basic Life Support (BLS)

Staff must be trained in how to assess and manage potential and actual violence, using de-escalation techniques, restraint, seclusion and rapid tranquillisation. This is available through the Trust’s Learning and Development Centre.

All staff involved in rapid tranquillisation need to be aware of the legal framework that authorises this intervention.

Additional clinical pharmacy advice and support is available from the Trust’s pharmacy department.
19. Policy Control including Archiving Arrangements

Corporate & Legal Services will retain a copy of this policy for a minimum of 10 years in line with the recommendations contained within ‘Records Management: NHS Code of Practice’ (2006).
## 20. Monitoring compliance and effectiveness

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**Notes:**
- Learning and Development Centre
- Risk Management Department
- Pharmacy Department
- Divisional Management Team (action)
- CPP Committee (monitoring and approval)
Appendix: Clinical Guidelines.

These guidelines reflect current opinion on the most appropriate drugs and doses to be used in rapid tranquillisation as well as the current consensus view of the appropriate level of monitoring of the service user during and after rapid tranquillisation. A further guideline is provided to advice on the appropriate action to be taken to manage serious side-effects of RT medication.
Guidelines for use of Rapid Tranquilisation in Adults (18-65 years)
(for frail service users or those with a learning disability, the algorithm for older adults may be appropriate)

Nurse-in-charge
Ensure clinical team have tried appropriate de-escalation techniques but if service user remains distressed then contact duty doctor

Duty Doctor
- Agree appropriateness of rapid tranquillisation
- Agree suitable therapeutic goal (e.g. level of sedation/control) with team
- Ensure case notes have been checked for advanced decisions and complicating factors.
- Ensure service user has not been using alcohol or opiates.
- Ensure service user given an explanation of the medication and why it is necessary.

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

In exceptional circumstances intravenous route may be considered,
- It is strongly recommended that use of the intravenous route is agreed with Consultant/Consultant-on-call
- Ensure appropriate resuscitation equipment is available
- Use minimum effective dose of lorazepam, or haloperidol (also consider an anticholinergic)

Psychotic context: Use antipsychotics with caution if medication history unknown or antipsychotic naïve or cardiac disease present:
- Lorazepam 2mg
  - and/or
  - Haloperidol 5-10mg up to 30mg/day
  - Risperidone 2mg up to 8mg/day
  - Olanzapine 5-10mg up to 20mg/day
  (If haloperidol is used, consider an anticholinergic).

Offer oral preparation. Allow sufficient time for clinical response
Lorazepam 1-2mg up to 4mg/day. Allow at least 30-60 minutes between doses to assess clinical effect

Oral Procyclidine 2.5-5mg up to 3 times or parenteral 5-10mg Procyclidine for acute dystonia.
- For IM Haloperidol, SPC request record of ECG,
- Oral combination of an antipsychotic and benzodiazepines may reduce need for injection.
- Do not repeat IM Olanzapine within 2 hours

Aripiprazole should only be used in service users not already taking antipsychotics. Only the intramuscular preparation is licensed for control of agitation of disturbed behaviour (in schizophrenia)

Duty Doctor
- Consider additional dose of medication. If maximum dose already given contact consultant (on-call) to determine safest course of action. Allow sufficient time for clinical response between doses.
- Give explanation of medication and why necessary
- Ensure BNF maximum dose not exceeded
- Ensure checks continue as above

If unsuccessful or declined use I/M route. Caution if using restraint.
I/M Lorazepam 1-2mg up to 4mg/day (dilute before administration)
I/M Midazolam considered in some cases of Learning Disability

I/M Lorazepam 1-2mg up to 4mg/day. (dilute before administration) and/or
- I/M Haloperidol 5-10mg up to 18mg/day
- I/M Olanzapine 5-10mg up to 20mg/day (not to be given within 1 hour of I/M benzodiazepines)
- I/M Aripiprazole 5.25-15mg, can repeat after 2 hours up to 3 times in 24 hours

Nurse-in-charge
Check blood pressure, pulse and respiratory rate according to team decisions based on guidelines for monitoring (1:1 observations if sleeping) Allow sufficient time for clinical response between doses. Monitor and record vital signs.

Abnormalities
Contact duty doctor

Duty Doctor
- Administer I/V flumazenil if respiratory rate <10
  (See Appendix 1)
- Agree any other action with consultant or senior doctor on-call
- Dial 999 if uncontrollable

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

If unsuccessful or declined use I/M route. Caution if using restraint.
I/M Lorazepam 1-2mg up to 4mg/day (dilute before administration)
I/M Midazolam considered in some cases of Learning Disability

I/M Lorazepam 1-2mg up to 4mg/day. (dilute before administration) and/or
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- I/M Olanzapine 5-10mg up to 20mg/day (not to be given within 1 hour of I/M benzodiazepines)
- I/M Aripiprazole 5.25-15mg, can repeat after 2 hours up to 3 times in 24 hours

Continued distress
Continue to use appropriate de-escalation techniques and continue checks as above. If de-escalation techniques fail to reduce distress contact duty doctor

Duty Doctor
Consider additional dose of medication. If maximum dose already given contact consultant (on-call) to determine safest course of action. Allow sufficient time for clinical response between doses.
Give explanation of medication and why necessary
Ensure BNF maximum dose not exceeded
Ensure checks continue as above

Distress reduced
Transfer to oral route at earliest opportunity.
Debrief service user when alert (include opportunity to include written account of their experience in case notes)
Discuss at MDT meeting to ensure appropriate Mental Capacity Act documentation completed and lessons shared with staff
Nurse-in-charge
Ensure clinical team have tried appropriate de-escalation techniques but if service user remains distressed then contact duty doctor or refer to care plan

Duty Doctor
- Agree appropriateness of rapid tranquilisation
- Agree suitable therapeutic goal (e.g. level of sedation/control) with team
- Ensure case notes have been checked for advanced decisions and complicating factors.
- Ensure service user has not been using alcohol or opiates.
- Ensure service user given an explanation of the medication and why it is necessary.

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

In exceptional circumstances intravenous route may be considered,
- It is strongly recommended that use of the intravenous route is agreed with Consultant/Consultant-on-call
- Ensure appropriate resuscitation equipment is available
- Use minimum effective dose of lorazepam, or haloperidol (also consider an anticholinergic)

Offer oral preparation. Allow sufficient time for clinical response

Lorazepam 0.5 - 1mg up to 4mg/day. Allow at least 30-60 minutes to assess clinical effect

Psychotic context:
Exclude Dementia with Lewy Bodies (DLB)
Use antipsychotics with caution if medication history unknown or antipsychotic naïve or cardiac disease present:
- Lorazepam 0.5 - 1mg up to 4mg/day and/or
- Haloperidol 0.5 - 2mg up to 15mg/day
- Risperidone 0.5 - 1mg up to 2mg/day
- Olanzapine 2.5 – 5mg up to 10mg/day
(If haloperidol is used, consider an anticholinergic).

Duty Doctor
- Administer I/V flumazenil if respiratory rate <10 (See Appendix 1)
- Agree any other action with consultant or senior doctor on-call
- Dial 999 if uncontrollable

If unsuccessful or declined consider I/M route only in cases of extreme emergency. Consultant approval required. Caution if using restraint.

I/M Lorazepam 0.5 - 2mg up to 4mg/day (dilute before administration)
(IM Midazolam considered in some cases of Learning Disability)

I/M Lorazepam 2mg up to 4mg/day, (dilute before administration) and/or
- I/M Haloperidol 0.5 - 1mg up to 9mg/day
- I/M Olanzapine 5mg up to 10mg/day (not to be given within 1 hour of I/M benzodiazepines)
- I/M Aripiprazole 5.25-15mg, can repeat after 2 hours up to 3 times in 24 hours

Aripiprazole should only be used in service users not already taking antipsychotics. Only the intramuscular preparation is licensed for control of agitation of disturbed behaviour (in schizophrenia). Experience in the elderly is limited and low doses are recommended

Psychotic context:
Exclude Dementia with Lewy Bodies (DLB)
Use antipsychotics with caution if medication history unknown or antipsychotic naïve or cardiac disease present:
- Lorazepam 0.5 - 1mg up to 4mg/day and/or
- Haloperidol 0.5 - 2mg up to 15mg/day
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Aripiprazole should only be used in service users not already taking antipsychotics. Only the intramuscular preparation is licensed for control of agitation of disturbed behaviour (in schizophrenia). Experience in the elderly is limited and low doses are recommended

Nurse-in-charge
Check blood pressure, pulse and respiratory rate according to team decisions based on guidelines for monitoring (1:1 observations if sleeping) Allow sufficient time for clinical response between doses. Monitor and record vital signs.

Abnormalities
Contact duty doctor

Continued distress
Continue to use appropriate de-escalation techniques and continue checks as above. If de-escalation techniques fail to reduce distress contact duty doctor

Duty Doctor
Consider additional dose of medication. If maximum dose already given contact consultant (on-call) to determine safest course of action. Allow sufficient time for clinical response between doses.
- Give explanation of medication and why necessary
- Ensure BNF maximum dose not exceeded
- Ensure checks continue as above

Duty Doctor
Consider additional dose of medication. If maximum dose already given contact consultant (on-call) to determine safest course of action. Allow sufficient time for clinical response between doses.
- Give explanation of medication and why necessary
- Ensure BNF maximum dose not exceeded
- Ensure checks continue as above

Distress reduced
Transfer to oral route at earliest opportunity.
- Debrief service user when alert (include opportunity to include written account of their experience in case notes)
- Discuss at MDT meeting to ensure appropriate Mental Capacity Act documentation completed and lessons shared with staff

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- Debrief service user when alert (include opportunity to include written account of their experience in case notes)
- Discuss at MDT meeting to ensure appropriate Mental Capacity Act documentation completed and lessons shared with staff
Guidelines for use of Rapid Tranquillisation in Adolescents (12-18 years)

Nurse-in-charge

Ensure clinical team have tried appropriate de-escalation techniques but if service user remains distressed then contact duty doctor or refer to care plan.

Duty Doctor

- Agree appropriateness of rapid tranquillisation
- Agree suitable therapeutic goal (e.g. level of sedation/control) with team
- Ensure case notes have been checked for advanced decisions and complicating factors.
- Ensure service user has not been using alcohol or opiates.
- Ensure service user given an explanation of the medication and why it is necessary.

Offer oral preparation. Allow sufficient time for clinical response

Lorazepam 0.5 - 2mg up to 4mg/day. Allow at least 30-60 minutes to assess clinical effect.

Psychotic context:
Use antipsychotics with caution if medication history unknown or antipsychotic naïve or cardiac disease present:
- Lorazepam 1-2mg every 4 hours up to 4mg/day
- Haloperidol 1-5mg up to 15mg/day
- Risperidone 0.5-1mg up to 4mg/day
- Olanzapine 5mg once in 24 hours (If haloperidol is used, consider an anticholinergic).

If unsuccessful or declined use I/M route. Caution if using restraint.

- 1M Lorazepam 1-2mg up to 4mg/day (dilute before administration)
- (IM Midazolam considered in some cases of Learning Disability)

- 1M Lorazepam 1-2mg up to 4mg/day (dilute before administration) and/or
  - 1M Haloperidol 1-5mg up to 10mg/day
  - 1M Olanzapine 5mg up to 20mg/day (not to be given within 1 hour of I/M benzodiazepines)

Nurse-in-charge

Check blood pressure, pulse and respiratory rate according to team decisions based on guidelines for monitoring (1:1 observations if sleeping) Allow sufficient time for clinical response between doses. Monitor and record vital signs.

Abnormalities

- Contact duty doctor

Continued distress

- Continue to use appropriate de-escalation techniques and continue checks as above. If de-escalation techniques fail to reduce distress contact duty doctor

Distress reduced

- Transfer to oral route at earliest opportunity.
- Debrief service user when alert (include opportunity to include written account of their experience in case notes)
- Discuss at MDT meeting to ensure appropriate Mental Capacity Act documentation completed and lessons shared with staff

Duty Doctor

- Administer I/V flumazenil if respiratory rate <10 (See Appendix 1)
- Agree any other action with consultant or senior doctor on-call
- Dial 999 if uncontrollable

Duty Doctor

- Consider additional dose of medication. If maximum dose already given contact consultant (on-call) to determine safest course of action. Allow sufficient time for clinical response between doses.
- Give explanation of medication and why necessary
- Ensure BNF maximum dose not exceeded
- Ensure checks continue as above
Guidelines for the monitoring of service users undergoing Rapid Tranquillisation

Vital signs to measure

| • Pulse               | • Level of consciousness   |
|• Blood Pressure      | • Oxygen saturation level   |
|• Respirations        | • Body temperature         |

It is recommended that vital signs be recorded using a “Track & Trigger” chart to aid the identification of results that are beyond “normal” values

Recommended frequency of measurement

<table>
<thead>
<tr>
<th>On admission</th>
<th>Obtain measurements of all vital signs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Before RT</td>
<td>Check all vital signs</td>
</tr>
<tr>
<td>0-1 hours after RT</td>
<td>Check all vital signs every 15 minutes</td>
</tr>
<tr>
<td>1-4 hours after RT</td>
<td>Check all vital signs every 60 minutes</td>
</tr>
<tr>
<td>4-12 hours after RT</td>
<td>Check all vital signs every 4 hours</td>
</tr>
</tbody>
</table>

Notes

- Fluid balance should be monitored as clinically indicated
- ECG monitoring is recommended whenever intramuscular antipsychotics have been given beyond BNF limits and may be advised for some antipsychotics at lower doses
- Service users should be monitored for extra-pyramidal side-effects (EPSEs) following administration of antipsychotics
- If the service user is unrouseable, call ambulance and doctor
## Guidelines for the management of serious side-effects of Rapid Tranquillisation

<table>
<thead>
<tr>
<th>Complication</th>
<th>Symptoms/signs</th>
<th>Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute dystonia</td>
<td>Severe painful muscular stiffness</td>
<td>Procyclidine 5-10 mgs i/m</td>
</tr>
<tr>
<td>Hypotension</td>
<td>Fall in blood pressure (orthostatic or &lt;50mmHg diastolic)</td>
<td>Lie service user flat and raise legs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Monitor closely</td>
</tr>
<tr>
<td>Neuroleptic malignant syndrome</td>
<td>Increasing temperature, fluctuating blood pressure, muscular rigidity, confusion/ altered consciousness</td>
<td>Withhold antipsychotics</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Monitor closely, consider CPK level</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Liaise with general medical team immediately</td>
</tr>
<tr>
<td>Arrhythmias</td>
<td>Slow (&lt;50/minute) or irregular pulse</td>
<td>Monitor closely and liaise with general medical team immediately</td>
</tr>
<tr>
<td>Respiratory depression</td>
<td>Reducing respiratory rate, reducing consciousness</td>
<td>If respiratory rate drops below 10/minute in a service user who has received benzodiazepines, give flumazenil (caution in epilepsy):</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1. 200microgram i/v over 15 seconds</td>
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<tr>
<td></td>
<td></td>
<td>2. if consciousness not resumed within 60 seconds give 100microgram over 10 seconds</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. repeat at 60 second intervals. Maximum dose 1mg in 24 hours</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Liaise with general medical team.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Continue to monitor after respiratory rate returns to normal. Flumazenil has a shorter duration of action than many benzodiazepines therefore there is a risk that patients may become re-sedated. Further doses of Flumazenil may be required. Patients may become agitated or anxious on wakening</td>
</tr>
</tbody>
</table>

N.B Elderly doses are the same.
## INITIAL EQUALITY IMPACT ASSESSMENT

### STAGE 1 - Screening to establish if the proposed function has any relevance to any equality issue and/or minority group

<table>
<thead>
<tr>
<th>Directorate: Corporate</th>
<th>Function to be Assessed: Rapid Tranquilisation</th>
<th>Existing or New Function: Existing</th>
<th>Assessment Date: July 2009</th>
</tr>
</thead>
</table>

1. Briefly describe the aims, objectives and purpose of the function:

   To ensure that the use of rapid tranquillisation (RT) is made with due consideration, safety, effectively & appropriately and that following any episode of RT there is the correct monitoring of the service user and a debrief of all parties is undertaken to ensure any lessons learnt are undertaken.

2. Who is intended to benefit from this function, and in what way?

   Clinical staff by outlining the processes involved prior to, during and after any requirement to use medication for RT; the service user by reducing the period of potential harm due to aggression or violence.

3. What outcomes are wanted from this function?

   The correct identification for the use of RT; the safe delivery of RT; and the appropriate follow up to any service user requiring this method to manage violence.

4. What factors/forces could/ contribute/ detract from these outcomes?

   The lack of knowledge of clinical staff around the subject of safe RT management.

5. Who are the main stakeholders in relation to the function?

   Service users as the recipient of any RT management and clinical staff from the aspect of administering and monitoring the RT episode.

6. Who implements the function, and who is responsible?

   Clinical staff in the ward environment.
7. Are there concerns that the function has a differential impact on the following groups and what existing evidence (either presumed or otherwise) do you have for this?

<table>
<thead>
<tr>
<th></th>
<th>Y</th>
<th>N</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Race</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Disability</td>
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<td>No</td>
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<tr>
<td>Age</td>
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<td>No</td>
</tr>
<tr>
<td>Gender</td>
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<td>No</td>
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<td>Religion or Belief</td>
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<td></td>
<td>No</td>
</tr>
<tr>
<td>Sexuality</td>
<td></td>
<td></td>
<td>No</td>
</tr>
</tbody>
</table>

If the answer to question 7 is 'YES', a partial EIA must be completed.

Should the function proceed to a partial impact assessment? No

If no, please state date of next review: August 2011 Date on which partial impact assessment to be completed by: N/A

I understand the impact assessment of this function is a statutory obligation and that, as owners of this function, we take responsibility for the completion and quality of this process.

Signed (Assessor) ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~Date: 16/07/09

Print Name: Richard Lewis

Signed (Section Head) ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~Date: 14/02/01

Print Name: Susan Lugg