Rapid Tranquilisation Policy and Guidelines
(Pharmacological Management of Violence)
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RESTRICTIVE INTERVENTION STATEMENT


The document promotes the development of therapeutic environments, and reducing all forms of restrictive practice so that they are used as a last resort only and then for the shortest possible time.

The Trust is totally committed to providing high quality, person centred care that maintains the dignity of, and respect for our patients, ensuring that restrictive interventions used within inpatient areas are reduced.

All aspects of risk management are to be implemented, taking account of the person’s wishes and best interests, operating within a framework of continual monitoring, reviewing and reducing any necessary restrictive practice.

These frameworks are implemented via Trust level policies and procedures with assurance being derived from internal audits and inspections and external review from Monitor and CQC.

The Trust’s lead for this work is the Deputy Chief Executive/Director of Nursing and Partnerships, Helen Dabbs; who is the Chair of the Trust’s Restrictive Interventions Steering Group.

Six key aims have been identified to ensuring improved care:

- Staff must not deliberately restrain people in a way that impacts on their airway, breathing or circulation, such as face down restrain on any surface, not just on the floor.
- If restrictive intervention is used, it must not include the deliberate application of pain
- If a restrictive intervention has to be used, it must always represent the least restrictive option to meet the immediate need.
- The use of seclusion is permitted under the guidance as detailed in the MHA Code of Practice (2008). However, as the purpose of seclusion is to contain exceptional emergency situations which compromise standards of safety, it is possible that seclusion could be used in relation to a patient who is not subject to detention under the MHA 183. In these circumstances common law powers would be used to seclude the patient, but in using these powers, staff must only use a degree of physical or medical intervention, which is sufficiently enough to bring the emergency to an end.
- People who use services, families and carers must be involved in planning, reviewing and evaluating all aspects of their care and support, and
- Individualised support plans, incorporating behaviour support plans must be implement for all people who use our services.
1. INTRODUCTION

1.1 Rapid Tranquilisation refers to the use of medication to manage acute behavioural disturbance by calming or lightly sedating the patient, to reduce the immediate risk of harm to self and/or others and reduce agitation and aggression. Thereby allowing an opportunity for a thorough psychiatric examination to take place. Prescribers should aim to ensure that the degree of sedation arising from rapid tranquilisation does not compromise the patient’s capacity to understand and respond to what is said to them. This should be a very short-term strategy designed solely to reduce immediate risk and is distinct from treating any underlying mental illness.

1.2 Rapid Tranquilisation should only be used, when other therapeutic interventions (de-escalation and other strategies) have failed, where a patient is highly aroused, agitated, overactive and aggressive, or is making serious threats or gestures towards others, or is being destructive to their surroundings.

1.3 Rapid Tranquilisation should be considered as a management strategy and not a primary treatment technique. Throughout the process of administering rapid tranquilisation regard must be given to maintaining the patient’s privacy and dignity. This will, wherever possible include, the gender of staff administering the medication and caring for the patient i.e. physical observations and the location of the procedure/incident.

1.4 The guidelines on pharmacological treatments contained within this policy have been produced on behalf of the Trust Medicines Management Committee and represent a consensus view of the Committee, in response to the NICE clinical guidelines for the use of rapid tranquilisation.

1.5 The NICE clinical guidelines are recommendations for the care of patients by healthcare professionals and are based on the best available evidence.

1.6 Such guidelines assist the practice of healthcare professionals, but do not replace their knowledge and skills.

2. PURPOSE

2.1 The purpose of this policy is to set out the arrangements for managing the risks associated with rapid tranquilisation, with the aim of reducing and managing risk through clear practice guidelines and standards.

The policy sets out:

- Duties and responsibilities
- Prescribing guidelines for rapid tranquilisation
- How observations are recorded, including timeframes when patients having received rapid tranquilisation
- How the organisation trains staff in line with the training needs analysis
- How the organisation monitors compliance with the policy.
3. **SCOPE**

This policy is applicable to all clinical staff that work within the Inpatient Services of the following Business Divisions:

- Adult Mental Health
- Learning Disabilities
- Older Adults
- Forensic Services
- Substance Misuse

4. **RESPONSIBILITIES, ACCOUNTABILITIES AND DUTIES**

4.1 **The Board of Directors**

The Board of Directors has responsibility for the implementation of this policy and the monitoring of compliance. This responsibility is delegated to the Trust Chief Executive who delegates lead responsibility to the Chief Operating Officer.

4.2 **The Service Directors**

The Service Directors are responsible for:

- The implementation of all policies and procedures which are in place to meet the needs of patients
- Monitoring adherence to this and other related policies
- Adequate resources and training being available to the clinical team

4.3 **The Medical Director**

The Medical Director is responsible for:

- Being the lead author of this policy
- The review and update of the policy contents
- Identifying any risks posed to the Trust by the use of Rapid Tranquilisation, or failure to adequately implement the policy
- Agreeing the content of any training provided to staff in relation to this policy

4.4 **Medicines Management Committee**

Members of the Trust Medicines Management are responsible for:

- Advising on the content of this policy
- Reviewing audit findings and agreeing the contents of any required action plans
4.5 Prescribing Doctor

When prescribing under the policy the doctor must:

- Be satisfied that other interventions have been tried
- Consider what medication the service user is already receiving
- Clearly state on any prescriptions under this policy –
  - Which medication is to be used
  - The dose range and frequency of the medication
  - The minimum time between doses and the maximum dose to be administered within a specified timeframe

4.6 The Nurse in Charge of the Ward

The Nurse in Charge of the ward at the time of rapid tranquilisation being utilised must be satisfied that:

- All attempts have been made to calm the patient utilising interventions other than rapid tranquilisation
- The prescription is followed
- The patient’s physical observations are monitored. Accurate written clinical records are maintained, and the rapid tranquilisation care plan and IR1 completed
- Any concerns about changes in the patient's physical presentation are reported to the Doctor
- The patient is given a full explanation as to why rapid tranquilisation has been used and the patient should be given the opportunity to reflect on the incident, due consideration of capacity should be made and where appropriate others informed.
- Post incident the restrictive practice will be reviewed in line with the Trust restrictive practice policy.
- The patient’s privacy and dignity has been maintained

4.7 The member of staff performing the monitoring of the patient’s Physical Observations will:

- Carry out the monitoring as detailed within the policy
- Record the patient’s physical observations
- Record the reason why, if for any reason all the physical monitoring cannot be completed
- Report to the Nurse who will report to the Doctor any changes in the patient's physical condition which give cause for concern
- Complete the Rapid Tranquilisation care plan

4.8 Pharmacist

- Wherever possible, the pharmacist should be included in the review of a patient for whom rapid tranquilisation is being considered
As part of the review the pharmacist will check prescriptions for potential adverse interactions

4.9 Multi-Disciplinary Team

A multidisciplinary team that includes a psychiatrist and a specialist pharmacist (where available), should develop and document an individualised pharmacological strategy for using routine and p.r.n. medication to calm, relax, tranquillise or sedate patients 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 of medication, prescribed and administered, including p.r.n.
- medication
- the number of and reason for any missed doses
- therapeutic response
- the emergence of unwanted effects.

If rapid tranquilisation is being used, a senior doctor should regularly review all medication.

5. PROCEDURE/IMPLEMENTATION

5.1 Definitions

One question that is often raised by staff is: what is the difference between rapid tranquilisation and the use of PRN (as required medication)?

For the purpose of this policy the following definitions are to be used:

“NICE defines Rapid Tranquilisation as the use of medication, given by injection, to attempt to rapidly calm, or modify the behaviour of a patient to end a period of violence or aggression which may be harmful to the patient or others. It will be prescribed as part of a response to violence or aggression. But should you wish to use oral medication where the patient accepts it this is considered good practice”

For the purposes of the Trust, and monitoring Rapid Tranquilisation includes the use of oral medication to manage these situations, although when feeding data to partner organisations or national bodies only parenteral medication data will be sent in line with NICE guidance.

PRN Medication in the context of behavioural disturbance
“is use of medication as part of a strategy to de-escalate or prevent situations that may lead to violence or aggression;”

Any prescription for PRN medication is to clearly indicate the following:

- Circumstance in which administration of the medication is to be considered
- Both the frequency and maximum dose that can be given within a 24 hour period

The prescriber should also:

- Take into account any regular medication to check the total prescription dose does not exceed BNF limits
- Check that the prescribing does not fall outside of any consent to treatment provisions for patients detained under the MHA 1983 (Forms T1 to T5, S62)

For patients who are showing mild signs of agitation, consideration should be given to the need for a single dose of a prescribed “as required” (PRN) medication to be administered. The use of such a prescription to relieve agitation as part of a de-escalation strategy is at the discretion of the Nurse in charge and must be recorded in the patient’s clinical record. A one-off dose used to manage agitation in this way does not constitute Rapid Tranquilisation but if the situation deteriorates or does not improve and further use of medication for the control of agitation or aggression should be considered, this is then Rapid Tranquilisation, and staff are to adhere to the guidance set out within this policy.

5.2 Prior to the Use of Rapid Tranquilisation

- Rapid Tranquilisation should only be considered if non-drug treatments have been tried or are felt to be inappropriate;
- Verbal de-escalation should be attempted in the first instance.
- Other non-pharmacological interventions should, where possible, also be explored, for example, increasing the level of patient’s setting. This may include transfer to a Psychiatric Intensive Care Unit (PICU).
- The process of rapid tranquilisation should be clear and transparent at all stages.
- Patients should be given the opportunity to participate in decision making and care planning at all stages, and their thoughts and wishes included.
- If a patient is acutely disturbed, then a doctor must be called to attend immediately.
- It is vital that the attending doctor obtains as much history as possible from the patient and other sources before medication is given, as the opportunity to make a diagnosis may be lost if the patient is sedated before an understanding of their mental state is reached.
- The immediate safety of the patient, staff or others is of prime concern.
- Non-psychiatric causes of behavioural disturbance should be considered and managed accordingly, e.g. hypoglycaemia, delirium, and drug/alcohol
intoxication.

- The aim is not to induce sleep or unconsciousness. The patient should be sedated but still ideally be able to participate in further assessment and treatment.
- Staff should always seek advice of a senior colleague/Consultant when unsure.
- Patients should be treated with pharmacological treatments only after an assessment of risk and when it has been established that the risk of not doing so is greater than the risk of side effects of acute pharmacological treatment.
- In all cases the patient should be informed that medication is going to be given and why.
- The patient should be given the opportunity to make an informed choice voluntarily whenever possible. The minimum effective dose of medication should be used.
- If available any advance directives should be given due consideration, along with any carers’ or advocate’s views, and followed, if deemed clinically appropriate. In the event that a decision is made to go against these views, the reason why must be clearly recorded in the patient’s clinical records.

5.3 Legal Issues

If a patient refuses or lacks the capacity to give valid consent to treatment for mental disorders, they may be given treatment using reasonable force if necessary, in an emergency situation or where the treatment is deemed to be in their best interests. This applies to both informal and detained patients. (For further guidance on best interests, staff are to refer to the Mental Capacity Act 2005, Code of Practice).

Patients detained under the Mental Health Act 1983 and subject to Part IV of the Act may in some circumstances be treated against their will regardless of their ability to give consent, or withhold consent.

Section 57 applies to treatment where a second opinion and the patient’s consent is required, and does not apply to rapid tranquilisation.

Section 58 outlines treatment where either the patient’s consent or a second opinion is required. This includes treatment with medication for patients who are subject to the 3 months consent to treatment rules.

If the patient is subject to Section 58 and either has not consented to treatment or the treatment has not been authorised by the Second Opinion Approved Doctor, it may be given if required urgently under Section 62 if it is treatment that is:

- Immediately necessary to save the patient’s life;
  OR
- Immediately necessary to prevent a serious deterioration of their condition (provided the treatment is not irreversible);
OR

- Immediately necessary to alleviate serious suffering by the patient (provided the treatment is not irreversible or hazardous);

OR

- Immediately necessary and represents the minimum interference necessary to prevent the patient from behaving violently or being a danger to themselves or others (provided the treatment is not irreversible or hazardous). See Mental Health Act Code of Practice, 2015.

Section 62 can only be authorised by the patient’s Responsible Clinician and only applies to urgent situations where treatment is immediately necessary. Urgent treatment cannot be continued beyond the point at which the crisis has been brought to an end.

The Responsible Clinician must complete the relevant form for Section 62, and for full guidance staff should refer to the Guidelines for Nursing Staff on the Use of Section 62.

However, even detained patients are subject to the best interest provisions and so treatment could be justified by these provisions.

5.4 Pharmacological Treatments

- Patient preference should be followed where recorded in the care plan or Advance Directive to Refuse Treatment, if clinically appropriate.
- British National Formulary (BNF) doses should normally be followed. When these are exceeded, high dose protocols should be followed.
- In all circumstances, the decision to exceed current BNF limits must be taken in consultation with a Consultant/senior doctor.
- Consideration should be given to concurrent physical problems and/or other medication previously prescribed or administered, drug allergies and combination doses of oral and Intramuscular (IM) medication.
- Polypharmacy within a class of medication (e.g. antipsychotics) should, where at all possible, be avoided.
- If a patient has already received antipsychotics medication that day, then the total dose of antipsychotics should not normally exceed the BNF maximum, and the use of Lorazepam as a single agent should be considered.
- Consideration should be given to any known pre-existing medical illnesses, known legal and illegal substances recently taken (alcohol, amphetamines etc.) and any regularly prescribed oral/depot medication, as this may impact on dose requirements and potential side effects.
- NICE suggest that if urgent tranquilisation is needed then IM Lorazepam or Haloperidol combined with Promethazine be used (see IM guidelines).
- Lorazepam alone should be considered as first-line treatment, unless inappropriate (e.g. Benzodiazepine hypersensitivity, respiratory depression, pregnancy).
- When prescribing medication for use in rapid tranquilisation, consider writing the initial prescription as a single dose, and do not repeat it until the
effect of the initial dose has been reviewed.

5.5 Oral Medication Guidelines
Adults age 18-65

- Oral medication should be offered before parenteral medication.

NOTE: IM antipsychotic medication usually has a faster onset of action.

- The following regimes represent the consensus of the Trusts Medicines Management Committee as appropriate choices of medication:
  - Oral Lorazepam 1-2mg repeated after 45 minutes if required, up to a maximum of 6mg in 24 hours; OR
  - Oral Lorazepam 1-2mg and Oral Haloperidol 5-10mg (haloperidol maximum 20mg in 24 hours) repeat after 45 minutes if required; OR
  - Risperidone 2mg together with Lorazepam 2mg (up to a maximum 4mg of each within 24 hours) may be considered as an alternative;
  - If using Haloperidol in an antipsychotics naïve service user, consider Procyclidine 5mg to prevent acute dystonic reactions.

- If oral medication is repeatedly refused, the decision to restrain a patient in order to administer IM medication should be considered jointly by medical and nursing staff.
- Once the decision has been made to restrain a patient in order to medicate, the physical intervention should be carried out in a manner which safeguards the patient’s dignity.
- Nursing and medical staff involved in restraining the patient should be proficient in physical intervention techniques for managing work related violence.

Elderly
- Lorazepam 0.5mg – 1mg TDS
- Haloperidol 0.5mg – 1mg TDS

Be aware of increased sensitivity to extrapyramidal side effects in patients with Lewy Body dementia and Parkinson’s Disease dementia.

5.6 Intramuscular Medication (IM) Guidelines
(Adults age 18-65)

This should be considered for patients who have not responded to non-drug measures and oral medication, or who are refusing oral medication. In the context of rapid tranquilisation
At all stages patients must be given the option to accept oral medication. When deciding to use IM medication, the prescriber should give due consideration to the amount of any oral medication already administered.

Consider Lorazepam first line in neuroleptic naïve patients
o IM Lorazepam 2mg. Repeat after 30 minutes if necessary, up to a maximum of 10mg in 24 hours;

OR
o IM Haloperidol 5-10mg and IM Promethazine 50mg. Repeat after 30 minutes if necessary up to 12mg Haloperidol/24 hours and/or 100mg Promethazine/24 hours;

OR
o Aripiprazole IM (for patients requiring antipsychotics and Haloperidol would be contraindicated for e.g. Lewy Body dementia

o The recommended initial dose for Aripiprazole solution for injection is 9.75 mg (1.3 ml), administered as a single intramuscular injection. The effective dose range of Aripiprazole solution for injection is 5.25-15 mg as a single injection. A lower dose of 5.25 mg (0.7 ml) may be given, on the basis of individual clinical status, which should also include consideration of medicinal products already administered either for maintenance or acute treatment.

o A second injection may be administered 2 hours after the first injection, on the basis of individual clinical status and no more than three injections should be given in any 24-hour period.

o The maximum daily dose of Aripiprazole is 30 mg (including all formulations of Aripiprazole)"

Elderly

These are suggested doses for frail elderly, individual patient characteristics should be taken into account when considering dose.

- Lorazepam 0.5mg – 1mg TDS
- Haloperidol 0.5mg – 1mg TDS
- Promethazine 25mg (Maximum 100mg in 24hrs)
- The effectiveness of Aripiprazole solution for injection in patients who are 65 years of age or older has not been established. Owing to the greater sensitivity of this population, a lower starting dose should be considered when clinical factors warrant

- Promethazine has significant anticholinergic properties and may worsen delirium in elderly patients.
- Lorazepam should be mixed in a 1:1 ratio with water for injections before administration and should not be mixed with other injections.
- If IM Haloperidol is used, anticholinergic (e.g. Procyclidine 5-10mg IM) should also be considered in order to reduce the risk of extrapyramidal symptoms.
- Zuclopenthixol Acetate (Acuphase) 50-150mg IM should only be considered if a patient has shown transient response to other short acting parenteral antipsychotics, and during the course of the episode they require two or more short acting injections. Or has been agreed as part of an advanced directive.
- Due to its pharmacokinetics, Zuclopenthixol Acetate (Acuphase) is not suitable for first line use within rapid tranquilisation. It should not be given to struggling patients, or antipsychotic naïve patients.
• IM Diazepam should not be used due to pain on injection and an inconsistent rate of absorption.
• IM/ Chlorpromazine should not be used due to the risk of circulatory collapse and pain of injection.

For the purpose of administering rapid tranquillisation medication via intramuscular injection, the ventrogluteal and vastus lateralis should be the preferred injection sites. Both provide alternatives to the dorsogluteal, with fewer potential complications, and both can be accessed without using prone restraint, therefore less risk and more dignified as can be administered through clothing.

5.7 Patient Monitoring/Observation Requirements/ use of the Early Warning Score

• The use of rapid tranquillisation should be viewed as a medical emergency due to the risk associated with its use.
• At all times throughout this procedure the physical safety of the patient and others must be considered.
• Suitable training and emergency equipment must be available to areas where the use of rapid tranquillisation may be required.
• NICE I Guideline 10 states that all staff involved in administering and post-administration observation should be trained in Immediate Life Support (ILS); and a Grab Bag (including defibrillator, Bag-Valve-Mask, suction, and oxygen) must be available WITHIN 3 MINUTES. See Resuscitation Policy.
• A doctor must be able to attend as quickly as possible (ideally within 30 minutes of alert).
• Where physical intervention is also being used, there must be someone available to look after the patient's head. This person should assume the key role with regard to observing for physical distress. In an urgent situation where this is not possible, this responsibility should be clearly delegated. See Policy and proactive care for reducing restrictive interventions.
• At no time during restraint is pressure to be applied to the neck, thorax, abdomen, back or pelvic area.
• Staff must be aware that the risks to the patient are increased if they have taken alcohol or illicit drugs, are obese or if they have a physical condition that may affect cardiopulmonary function.
• Constant visual observation of the patient must be maintained.
• Following the use of rapid tranquillisation, a series of physical observations should be carried out on the patient and recorded using the Early Warning Score (Appendix 1). These are:
  o Respiration rate;
  o Level of consciousness (AVPU)
  o Oxygen saturation via pulse oxymeter (Only if clinically indicated and safe to do so for both staff and patient)
  o Pulse(Only if clinically indicated and safe to do so for both staff and patient)
- Blood pressure; (Only if clinically indicated and safe to do so for both staff and patient)
- Temperature; (Only if clinically indicated safe to do so for both staff and patient)

Staff should also look out for the following:

- Verbal complaints of pain and discomfort;
- Non-verbal clues as to pain or discomfort (especially if communication is identified as difficult).

If for any reason it is not possible for staff to complete all the above physical monitoring requirements, the reason why is to be recorded and as a minimum staff MUST monitor and record the patient's:

- Respiration rate;
- Level of consciousness (AVPU)

These are to be monitored after Rapid tranquillisation has been administered

- every 15 minutes for the first hour,
- every half hour for the next three hours, in line with the Early Warning Score (Appendix 1)

5.7a Patients due for leave or transfer.

Any patient due for leave or transfer within the 4 hour observation period must remain within an area that has the ability to, and accepts responsibility for the physical observations needed, or be accompanied by staff who will continue the observations.

If a patient had planned to go on unescorted leave before the incident that led to rapid tranquillisation the leave must be reviewed, and, if still appropriate delayed until the 4 hour observation period has elapsed and observations have shown no cause for concern.

5.7b ECG requirements.

If using Antipsychotics E.G. Haloperidol, Promethazine an ECG should be performed at the earliest opportunity when;

- A previous ECG showed abnormalities
- The last recorded ECG was over 3 months ago.

The ECG should be reviewed the next working day

If an ECG cannot be performed a note must be made in the rapid tranquillisation care plan as to the reason why.
5.8 Action to Consider if there are Changes to the patient’s Physical Observations

- The Doctor must be contacted immediately if the patient’s:
  - Temperature becomes raised (staff should also withhold the administration of any further antipsychotic medication due to the risk of neuroleptic malignant syndrome);
  - Pulse becomes irregular or falls below 60 per minute;
  - Blood pressure drops below 80mmHg Systolic.
  - Or if staff become concerned about the clinical presentation of the patient

- If the patient is asleep, a more frequent and intensive monitoring by appropriately trained staff is required and should be recorded in the clinical record. Particular attention should be paid to the patient’s respiratory rate, effort, airway and level of consciousness (AVPU). In the event that the patient falls asleep whilst in seclusion, the need to continue the episode of seclusion should be reviewed.

5.9 Action Following the Use of Rapid Tranquilisation

- The reason for prescribing any medication for the acutely disturbed patient must be documented in the clinical record, as well as the working diagnosis.
- Any medication administered and the patient’s response should be recorded in the clinical record.
- The patient’s risk assessment is to be reviewed and their plan of care amended accordingly.
- The patient should be reviewed at the next multidisciplinary meeting or sooner if appropriate for discussion of long term management.
- After the treatment of an acute disturbance, the patient should be debriefed and this should be recorded in the clinical record.
- The patient should be offered the opportunity to write an account in their clinical record (NICE, 2015).
- IR1 and Rapid tranquilisation care plan completed.

5.10 Debriefing

5.10.1 Patient

At a time that is appropriate to the patient their thoughts and feelings regarding the incident should be explored and documented in the rapid tranquilisation care plan. This will include:

- Any identified triggers which led to the incident occurring;
- Could anything be done differently should a similar incident occur;
- A reflection of the service user’s feelings about the incident.
5.10.2 **Staff**

- After the incident this will be reviewed in line with the Trust Restrictive practice policy.

5.11 **Guidance Specific to Older Adults**

- The principles as for adults of working age patients apply but particular care should be given to co-existing medical states and prescribed medication as well as the risk of accumulation of sedatives and the possibility of delirium.
- **NOTE:** MHRA guidance on avoiding Olanzapine and Risperidone in behavioural disturbance in patients with dementia.
- The dose of Haloperidol is a critical factor when determining the likelihood of severe adverse effects
- Benzodiazepines are to be avoided in patients who have significant respiratory impairment.

5.12 **Guidance Specific to Pregnant Women**

For any patient who is known, or suspected to be pregnant the Consultant Psychiatrist in charge of their care and treatment is to give clear guidance in respect of any medication that is to be or can be administered. This will include the potential need for the use of medication for the purpose of rapid tranquillisation. These decisions will need to be determined on a case by case basis taking into account the stage of the pregnancy, and may necessitate advice being sought from the patient’s obstetrician. In such cases it is recommended that antipsychotics or benzodiazepines with shorter half-lives are administered.

5.13 **Rapid Tranquilisation and Seclusion**

Wherever possible the use of seclusion for patients that have been subject to rapid tranquilisation should be avoided. However, in the event that it is felt to be the safest course of action due to the patient presenting a serious risk of violence, the Nurse in charge of the ward must:

- Have the patient monitored within sight by a trained member of staff;
- Terminate the episode of seclusion at the earliest opportunity.

5.14 **Documenting rapid tranquillisation**

All incidents of rapid tranquilisation should be documented using the rapid tranquilisation care plan and IR1 Appendix 2.

This plan will be used in place of the nursing notes and must be used in conjunction with the patients existing TPR chart (all observations must be recorded on the chart itself).
6. TRAINING IMPLICATIONS

The Training Needs Analysis (TNA) for this policy can be found in the Training Needs Analysis document which is part of the Trust’s Mandatory Risk Management Training Policy located under the policy section of the Trust website.

Rapid tranquilisation training should cover:

- All staff involved in rapid tranquilisation to be trained in Immediate Life Support
- Prescribers and those who administer medicines should be familiar with and have received training in rapid tranquilisation, including: the properties of benzodiazepines; antipsychotics; antimuscarinics and antihistamines;
- Associated risks, including cardio-respiratory effects of the acute administration of the drugs, particularly when the service user is highly aroused and may have been misusing drugs; is dehydrated or is possibly physically ill;
- The need to titrate doses to effect.
- Staff must be trained in how to assess and manage potential and actual violence, using de-escalation techniques, restraint, seclusion and rapid tranquilisation.

7. MONITORING ARRANGEMENTS

Compliance with this policy will be monitored as follows:

<table>
<thead>
<tr>
<th>Area for Monitoring</th>
<th>How</th>
<th>Who by</th>
<th>Reported to</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duties</td>
<td>Clinical Audit</td>
<td>Resuscitation Officer, Effectiveness Team, Modern Matrons</td>
<td>Medicines Management Committee (reports to Clinical Governance Group) Divisional Governance Groups</td>
<td>Annually</td>
</tr>
<tr>
<td>Prescribing guidelines for rapid tranquilisation</td>
<td>How observations are recorded, including timeframes, when patients have received rapid tranquilisation.</td>
<td>Monitoring of training content and training compliance in conjunction with the above.</td>
<td>Head of Learning and Development</td>
<td>Medicines Management Committee Divisional Governance Groups</td>
</tr>
<tr>
<td>Induction training</td>
<td>Review of Medical</td>
<td>Medicines Management Committee</td>
<td>Divisional Governance Groups</td>
<td>Twice a year</td>
</tr>
<tr>
<td>Area for Monitoring</td>
<td>How</td>
<td>Who by</td>
<td>Reported to</td>
<td>Frequency</td>
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<td>-------------</td>
<td>-----------</td>
</tr>
<tr>
<td>for Trainee Doctors</td>
<td>induction records</td>
<td>Director</td>
<td>Management Committee Divisional Governance Groups</td>
<td>year</td>
</tr>
<tr>
<td>• Local induction of new staff within inpatient services</td>
<td>Review of induction records</td>
<td>Modern Matrons</td>
<td>Medicines Management Committee Divisional Governance Groups</td>
<td>Twice a year</td>
</tr>
</tbody>
</table>

8. EQUALITY IMPACT ASSESSMENT SCREENING

The completed Equality Impact Assessment for the Protocol for the Protocol for the Safe Transportation of Patients has been published on the Equality and Diversity Web page of the RDaSH Website as follows: EQUALITY AND DIVERSITY IMPACT ASSESSMENT

8.1 Privacy, Dignity, Respect

**Privacy, Dignity and Respect**

The NHS Constitution states that all patients should feel that their privacy and dignity are respected while they are in hospital. High Quality Care for All (2008), Lord Darzi’s review of the NHS, identifies the need to organise care around the individual, ‘not just clinically but in terms of dignity and respect’. As a consequence the Trust is required to articulate its intent to deliver care with privacy and dignity that treats all patients with respect. Therefore, all procedural documents will be considered, if relevant, to reflect the requirement to treat everyone with privacy, dignity and respect, (when appropriate this should also include how same sex accommodation is provided).

<table>
<thead>
<tr>
<th>Indicate how this will be met</th>
</tr>
</thead>
<tbody>
<tr>
<td>There is no requirement for additional consideration to be given with regard to privacy, dignity or respect</td>
</tr>
</tbody>
</table>

8.2 Mental Capacity Act

Central to any aspect of care delivered to adults and young people aged 16 years or over will be the consideration of the individuals capacity to participate in the decision making process. Consequently, no intervention should be carried out without either the individuals informed consent, or the powers included in a legal framework, or by order of the Court.

Therefore, the Trust is required to make sure that all staff working with individuals who use our service are familiar with the provisions within the Mental Capacity Act 2005.

<table>
<thead>
<tr>
<th>Indicate How This Will Be Achieved.</th>
</tr>
</thead>
<tbody>
<tr>
<td>All individuals involved in the implementation of this policy should do so in accordance with the Guiding Principles of the Mental Capacity Act 2005. (Section 1) Where English is not the preferred language of the</td>
</tr>
</tbody>
</table>
Mental Capacity Act. For this reason all procedural documents will be considered, if relevant to reflect the provisions of the Mental Capacity Act 2005 to ensure that the interests of an individual whose capacity is in question can continue to make as many decisions for themselves as possible.

patient/service user, using an interpreting service should enhance the assessment of Mental Capacity.

9. LINKS TO ANY ASSOCIATED DOCUMENTS

- Safe and Secure Handling of Medicines Policy– Clinical Policies, Section 10.
- High Dose Antipsychotic Standards (see Integrated Care Pathway (ICP) for High Dose Antipsychotics).
- Resuscitation policy – Clinical Policies, Section 6.
- Clinical risk assessment and management policy Clinical Policies, Section 6.
- Seclusion policy – Clinical Policies, Section 6.
- Guidelines for Nursing Staff on the Use of Section 62 - Clinical Policies, Section 9 Mental Health Act.
- Guidance for When Injectable Lorazepam Is Not Available [Link]

10. REFERENCES


Mental Health Act, Seventeenth Edition, Richard Jones 2014

British National Formulary (BNF) Latest Edition [Link]
11. APPENDICES

1. THE EARLY WARNING SCORE SYSTEM AND SCORE CHART
2. RAPID TRANQUILISATION CARE PLAN
Appendix 1

EARLY WARNING SCORE

The Early Warning Score (EWS) is an escalation tool used to alert clinical staff to the need to contact a doctor, or emergency services, for patients who give cause for concern because of sudden or deteriorating illness. Within Mental Health and Learning Disabilities In-Patient areas, it is also to be used for patients being observed during or after a period of restraint or rapid tranquilisation.

HOW TO USE THE CHART

Record your observation on the Observation (TPR) chart as normal. Now look up your findings scoring grid and take the score for that column from the top of the column.

FOR EXAMPLE; your patient is alert, flushed and slightly distressed, has a respiratory rate of 22 breaths per minute, a pulse rate of 108 beats per minute, systolic blood pressure is 90 mmHg and his temperature is 38.2 degrees C.

- Alert scores 0
- Respiratory rate scores 1
- Pulse scores 1
- Blood Pressure scores 1
- Temperature scores 1
- **Total score is 4**

Looking at the second part of the chart a score of 4 is greater than 3 but less than 6, so the nurse should call the doctor immediately and increase the frequency of observations to every 30 minutes.

Refusal – a patient has the right to refuse physical contact with staff; this may be due to agitation, confused, fear or lack of understanding. However, physical observations can always be carried out without contact and the minimum of this is central nervous system (CNS - AVPU) and respiratory rate. These physical observations should be recorded on the physical observation chart. Refusal of any other physical observation for example blood pressure should be recorded in the nursing notes with an explanation as to why the patient has refused and a plan for repeating required observations and how this may be undertaken should also be documented. The word refused MUST NOT be recorded on the physical observation chart, as the rational for refusal cannot be documented fully in the small space available.

Baseline – on admission the patients physical observations must be taken, these will become the patients' initial baseline, if the patients physical presentation changes at any time during their stay their baseline observation should be reviewed and if needed a new baseline should be recorded. If this becomes necessary a new sheet should be started and the word NEW should be recorded underneath BASELINE this will communicate changes to the baseline to all staff. If a patient is admitted with a known physical health condition and therefore the baseline scores and triggers on the EWS a normal parameter exception care plan should be devised with the
admitting Doctor. This should state the exceptions for this particular patient and give instructions as to when the patient should be escalated.

The EWS only uses the Systolic blood pressure measurement within its escalation calculations (both the systolic and diastolic measurement should always be recorded on the physical observation chart) as the score is used to note early deterioration in patients to enable a response before a critical illness where ever possible. In these situations the systolic measurement is the measurement that tells us the most about the patient, and the one that will change early enough for a response to be effective. The diastolic measurement is important for day to day health, and should still be noted and acted upon when a patient is unwell; however tends to be slower to change in critical illness and therefore no use from an EARLY warning point of view.

Clinical judgement
The EWS score and track and trigger flow is only a guide, if the Registered Nurse becomes concerned with other aspects of the patient’s condition then further action may well be necessary.

For example:-
Example 1
If the patients’ baseline scores a 3, we take their physical observations and their EWS is now a 4, we need to take into account the reasons behind the initial 3 on admission and any normal parameter exceptions and care plans. A EWS of 3 in any one category needs attention in its own right.

Patient complains of feeling unwell, we take his physical observations
CNS = A - EWS 0 - Baseline = 0
Resps = 22 - EWS 1 - Baseline = 1
Blood Pressure = 98/60 - EWS 1 - Baseline = 1
Pulse = 112 - EWS 2 - Baseline = 1 (baseline pulse = 109)
Sats = 100% - EWS 0 - Baseline = 0
Temp = 37% - EWS 0 - Baseline = 0
Overall EWS = 4 = 3

Example 2
A patient presents as flushed, sweaty skin and in obvious discomfort. He does not allow any physical contact; therefore we can only gain a CNS and respiratory rate reading;
CNS = A - EWS = 0 - Baseline = 0
Resps = 29 - EWS = 1 - Baseline = 0
Overall EWS = 1 = 0

Just looking at the flow chart, an EWS of 1 would state to increase the observations and consider speaking to a Doctor. However, for this patient the increased respiratory rate added to flushing, sweating and pain should lead to a nurse making the decision to speak to a Doctor.

Example 3
Patient complains of being unwell. We take her physical observations.
CNS = A - EWS 0 - Baseline = 0
In this scenario, although the EWS is a 0 this is a considerable change from the patient’s baseline. A negative change in baseline, although the flow chart would not show concern is equally concerning as a positive change in baseline. Therefore this patient needs to be seen by a Doctor.

Decisions are made after physical observations are taken and EWS calculated.

Each physical observation has its own EWS, and if staff are unable to take a full set of physical observations (for any reason - see above) an EWS score must still be calculated no matter how many physical observations have been taken i.e. at the bare minimum we would expect to see CNS and respiratory rate recorded we should still see an EWS calculated score, or lying and standing BP we should still see the EWS calculated for each recording, this can act as a prompt for action to be taken, particularly if the staff are not prompted by the readings alone (a safety net).

**KEY** – a key has been introduced to the chart, this will help staff to see the ‘bigger picture’ you will be able to look back at the last like for like incident and compare, which in turn will aid any decisions that need to be made.

- R  = restraint
- T  = rapid tranquillisation
- U  = unwell
- M  = monitoring
- B  = baseline

How to calculate an Early Warning Score (EWS) and what action is to be taken.

<table>
<thead>
<tr>
<th>SCORE</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pulse</td>
<td>51 - 100</td>
<td>41-50 or 101- 110</td>
<td>111 - 129</td>
<td>≤ 40 or ≥ 130</td>
</tr>
<tr>
<td>Systolic BP</td>
<td>101 - 200</td>
<td>81 - 100</td>
<td>71 - 80 or 201 - 220</td>
<td>≤ 70 or ≥ 221</td>
</tr>
<tr>
<td>Resp rate</td>
<td>9 - 20</td>
<td>21 - 30</td>
<td>31 - 34</td>
<td>≤ 8 or ≥ 35</td>
</tr>
<tr>
<td>Temp</td>
<td>36.1 - 37.9</td>
<td>35.1 - 36 or 38 - 38.5</td>
<td>34 - 35 or 38.6 - 39.9</td>
<td>≤ 33.9 or ≥ 40</td>
</tr>
<tr>
<td>CNS AVPU</td>
<td>ALERT</td>
<td>VOICE</td>
<td>PAIN</td>
<td>UNCONSCIOUS</td>
</tr>
<tr>
<td>O2 Saturation</td>
<td>100% - 95%</td>
<td>94% - 90%</td>
<td>89%-86%</td>
<td>≤ 85%</td>
</tr>
<tr>
<td>SCORE</td>
<td>0</td>
<td>2</td>
<td>3</td>
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</tbody>
</table>
# ESCALATION PROCEDURE

| EWS greater than 0 | Inform registered nurse, suggest repeat observations, and note in file. Use Clinical judgement to decide if further action is required. |
| EWS 1 - 2 | Increase frequency of observations to at least 4 hourly, consider informing Doctor if concerned. |
| EWS 3 in any one category | Contact Doctor for advice, increase frequency of observations to at least hourly. Use clinical judgement as patient may be very poorly. |
| EWS 3 - 5 | Contact Doctor and request urgent visit, or if a possible delay of more than 1 hour call and ambulance unless other advice given by the doctor. Increase observations to at least every 30 minutes. |
| EWS 6 or over | Call Doctor for immediate visit, or if a possible delay of more than 30 minutes call an ambulance unless other advice given by the doctor. Increase observations to at least every 15 minutes. |
## Appendix 2

### PHYSICAL OBSERVATION/EWS CHART

<table>
<thead>
<tr>
<th>Year</th>
<th>Date</th>
<th>Time</th>
<th>Date</th>
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<td>Normal</td>
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### EWS SCORE

<table>
<thead>
<tr>
<th>Score</th>
<th>Pulse</th>
<th>Systolic BP</th>
<th>Respiratory Rate</th>
<th>Temperature</th>
<th>CNS AVPU</th>
<th>O2 Saturation</th>
<th>Score</th>
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<tbody>
<tr>
<td>0</td>
<td>61 - 100</td>
<td>101 - 200</td>
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<td>36.1 - 37.9</td>
<td>100% - 96%</td>
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<td>1</td>
<td>41 - 50 or 101-110</td>
<td>81 - 100</td>
<td>21 - 30</td>
<td>35.1 - 36 or 36.1 - 38.5</td>
<td>ALERT</td>
<td>95-96%</td>
<td>0</td>
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<td>2</td>
<td>111 - 129</td>
<td>71 - 80 or 201 - 220</td>
<td>31 - 34</td>
<td>34 - 35 or 36.6 - 39.9</td>
<td>VOICE</td>
<td>94-90%</td>
<td>1</td>
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<tr>
<td>3</td>
<td>≤ 40 or ≥ 130</td>
<td>≤ 70 or ≥ 221</td>
<td>≤ 50 or 236</td>
<td>≤ 55.9 or ≥ 240</td>
<td>UNCONSCIOUS</td>
<td>89-89%</td>
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<td>85-89%</td>
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**WZT 690**
**RAPID TRANQUILISATION CARE**

**Number ……..**

<table>
<thead>
<tr>
<th>Date Implemented</th>
<th>Implemented By</th>
<th>Signature-</th>
</tr>
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</table>

**What constitutes rapid tranquilisation?**

Rapid tranquilisation is the use of medication, given by injection, to attempt to rapidly calm, or modify the behaviour of a patient to end a period of violence or aggression which may be harmful to the patient or others. It will be prescribed as part of a response to violence or aggression.

**De-escalation Techniques’ Utilised**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
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<tbody>
<tr>
<td></td>
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</table>

If de-escalation techniques not utilised please explain reason why.

**Details of clinical presentation which led to use of rapid tranquilisation.**

**Details of the Medication administered**

<table>
<thead>
<tr>
<th>Drug</th>
<th>Dose</th>
<th>Time</th>
<th>Route</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

If oral medication not administered please state why.

**Early Warning Score must be recorded every 15 minutes for the first hour following administration of rapid tranquilisation.** (As a minimum the respiration rate and level of consciousness (AVPU) is to be recorded and entry made in clinical records as to why full observations can’t be recorded.)

<table>
<thead>
<tr>
<th>Time</th>
<th>Level of consciousness (AVPU)</th>
<th>Respiration rate</th>
<th>O2 sats</th>
<th>Pulse</th>
<th>Temperature</th>
<th>Blood pressure</th>
<th>EWS</th>
<th>Signature</th>
</tr>
</thead>
<tbody>
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</tr>
</tbody>
</table>

Record if safe or clinically indicated

The physical observations above must be documented on patients TPR chart, EWS must be calculated. Time, EWS, and signature to be documented here on this care plan.

**Early Warning Score must be recorded every half hour for the next three hours following administration of rapid tranquilisation.** (As a minimum the respiration rate and level of consciousness (AVPU) is to be recorded and entry made in clinical records as to why full observations can’t be recorded.)

<table>
<thead>
<tr>
<th>Time</th>
<th>Level of consciousness (AVPU)</th>
<th>Respiration rate</th>
<th>O2 sats</th>
<th>Pulse</th>
<th>Temperature</th>
<th>Blood pressure</th>
<th>EWS</th>
<th>Signature</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

Record if safe or clinically indicated

The physical observations above must be documented on patients TPR chart, EWS must be calculated. Time, EWS, and signature to be documented here on this care plan.

**ONLY COMPLETE IF ANTIPSYCHOTIC IS USED**

**Has an ECG been taken in the past 3 months which showed no abnormalities?**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
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</table>

If No: ECG is to be done at the earliest opportunity.

**Date ECG completed.**
If ECG not undertaken please state reason why.

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Evaluation of patient’s clinical response within one hour of administration of rapid tranquilisation.</th>
<th>Signature</th>
</tr>
</thead>
<tbody>
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</table>

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Evaluation of patient’s clinical response within two hours of administration of rapid tranquilisation.</th>
<th>Signature</th>
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<tbody>
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<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Evaluation of patient’s clinical response within three hours of administration of rapid tranquilisation.</th>
<th>Signature</th>
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<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Evaluation of patient’s clinical response within four hours of administration of rapid tranquilisation.</th>
<th>Signature</th>
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<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Record of meeting with patient to discuss their perception of how their clinical presentation was managed and the use of rapid tranquilisation.</th>
<th>Signature</th>
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