Rotherham Doncaster and South Humber NHS Foundation Trust

Rapid Tranquilisation Policy

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1. Document summary

1.1 What is rapid tranquillisation?

Rapid tranquillisation means giving medicine to help calm someone quickly when there is an immediate risk that they may seriously harm themselves or another person.

1.2 When can it be used?

It must only be used as a last resort. Staff should first try talking calmly, reducing distress, distraction and other ways of helping the person feel safe.

1.3 What should staff do first?

Staff should explain what is happening and involve the person in decisions whenever possible. They must check the person's health, medicines, allergies, use of alcohol or drugs, and any wishes the person has recorded about their care.

1.4 How is the medicine given?

Medicine by mouth should be offered first when it is safe and suitable. An injection may be used if this does not work or cannot be used. Staff must use the lowest dose that is likely to work and check the effect before giving more.

1.5 What happens afterwards?

Rapid tranquillisation can cause serious side effects. Trained staff must keep the person in sight and check their breathing, alertness and other physical signs. Checks are made every 15 minutes for the first hour and every 30 minutes for the next 3 hours. A doctor must be contacted straight away if there are concerns.

1.6 How will the person be supported?

Staff must protect the person's privacy, dignity and safety. The reason for the medicine, the checks and what happened afterwards must be recorded. The person should be offered a chance to talk about the incident and say what might help if a similar situation happens again.

Important: This Easy Read summary gives the main points only. Staff must use the full policy for clinical guidance, medicine doses and legal requirements.

2. Introduction and aim

The Department of Health published *Positive and Proactive Care: Reducing the Need for Restrictive Interventions* in April 2014. It asks services to provide therapeutic care and reduce restrictive practice.

Restrictive interventions must only be used as a last resort and for the shortest time needed.

The trust is committed to high-quality, person-centred care that protects each patient's dignity and reduces the use of restrictive interventions in inpatient services.

Staff must manage risk in a way that considers the patient's wishes and best interests. Any restrictive practice must be monitored, reviewed and reduced as soon as it is safe to do so.

The trust puts these requirements into practice through its policies and procedures. Assurance is obtained through internal audit and inspection, and external review by the Care Quality Commission.

The chief nursing officer leads this work and chairs the trust's Restrictive Interventions Steering Group.

The trust has six aims for safer care:

- Staff must never deliberately restrain a person in a way that restricts their airway, breathing or circulation. This includes face-down restraint on any surface.
- Restrictive interventions must not deliberately cause pain.
- Any restrictive intervention must be the least restrictive option needed to manage the immediate risk.
- Seclusion may be used only to manage an exceptional emergency that creates a serious safety risk. Staff must follow the trust's seclusion guidance and use only the physical or medical intervention needed to end the emergency.
- Patients, families and carers must be involved in planning, reviewing and evaluating care and support.
- Each patient must have an individual support plan, including a behaviour support plan where needed.

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

- Rapid tranquillisation may be used to reduce an immediate risk of harm, agitation or aggression so that a full assessment can take place. The aim is to calm the patient, not to sedate them so deeply that they cannot understand or respond. It is a short-term safety measure and does not treat the underlying mental illness.
- Use rapid tranquillisation only when de-escalation and other therapeutic approaches have failed or are not appropriate, and the patient is highly aroused, agitated, overactive, aggressive, making serious threats or gestures, or damaging their surroundings.
- Rapid tranquillisation is a way to manage immediate risk, not a first-line treatment. Staff must protect the patient's privacy and dignity throughout, including when deciding who will give the medicine, who will complete physical observations and where the intervention will take place.
- The medicines guidance in this policy reflects the trust medicines management committee's agreed response to NICE guidance. It supports, but does not replace, professional knowledge, clinical judgement and skills.

3. Procedure

3.1 Definitions

Staff often ask how rapid tranquillisation differs from ‘when required’ (PRN) medication.

For this policy, rapid tranquillisation means giving medication to quickly calm a patient or change behaviour that presents an immediate risk of violence or aggression. NICE defines rapid tranquillisation as medication given by injection as part of the response to that risk.

For trust monitoring, rapid tranquillisation also includes oral medication used to manage the same situation. When the trust reports data nationally or to partner organisations, it reports injected medication only, in line with NICE guidance.

PRN medication for behavioural disturbance is medication used as part of a plan to calm a situation or prevent violence or aggression.

Every PRN prescription must clearly state:

- the circumstances in which staff may consider giving the medicine
- how often it may be given and the maximum dose in 24 hours

The prescriber should also:

- include regular medication when checking that the total prescribed dose stays within British National Formulary (BNF) limits
- check that the prescription is covered by the patient’s consent-to-treatment authority when they are detained under the Mental Health Act 1983, including forms T1 to T5 and section 62

For mild agitation, a nurse in charge may decide to give one prescribed PRN dose as part of a de-escalation plan. Staff must record the decision and the outcome in the clinical record.

One PRN dose used in this way is not rapid tranquillisation. If the patient does not improve, their condition worsens or more medication is needed to control agitation or aggression, staff must treat and record this as rapid tranquillisation.

3.2 Prior to the use of rapid tranquillisation

Rapid tranquillisation should only be considered if non-drug treatments have been tried or are felt to be inappropriate:

- Try de-escalation and distraction first.
- Consider other non-drug options, including a safer care setting or transfer to a psychiatric intensive care unit when appropriate.
- Keep the process clear and explain what is happening at each stage.
- Involve the patient in decisions and care planning and record their views and wishes.
- Call a doctor immediately if the patient is acutely disturbed.

- Before medication is given, the doctor must obtain as much information as possible from the patient and other sources. Sedation may make assessment and diagnosis more difficult.
- Make the immediate safety of the patient, staff and others the main priority.
- Consider and manage physical causes of disturbed behaviour, such as low blood glucose, delirium, or alcohol or drug intoxication.
- The aim is to calm the patient, not to make them unconscious. They should remain able to take part in assessment and treatment where possible.
- Ask a senior colleague or consultant for advice if you are unsure.
- Use medication only after assessing the risks and deciding that the risk of not treating is greater than the risk of side effects.
- Tell the patient what medication will be given and why.
- Give the patient the chance to make an informed and voluntary choice whenever possible.
- Use the lowest effective dose.
- Consider any advance statement or advance decision, and the views of carers or advocates, when clinically appropriate. If these views are not followed, record the reason in the clinical record.

3.3 Legal issues

If a patient refuses treatment or cannot give valid consent to treatment for a mental disorder, staff may use reasonable force only when it is necessary in an emergency or the treatment is in the patient's best interests. This applies to informal and detained patients. Staff must follow the Mental Health Units (Use of Force) Policy, the Mental Capacity Act Policy and the Consent Policy.

3.3.1 Mental Capacity Act (MCA) (2005)

Section 5 of the Mental Capacity Act allows necessary care or treatment to be given when staff reasonably believe that a person lacks capacity to consent and the action is in their best interests.

This may include necessary treatment when the person objects, but only if the Act's requirements are met.

Emergency treatment may be needed to save the person's life or prevent serious harm.

Staff are protected from liability only when they reasonably believe that the person lacks capacity and the action is necessary and, in the person's, best interests.

Section 6 limits this protection where restraint is inappropriate or the action deprives the person of their liberty. Any action must follow the Act's principles and be the least restrictive option.

Any action intended to restrain a person who lacks capacity will not attract protection from liability unless the following two conditions are met:

- the person taking action must reasonably believe that restraint is necessary to prevent harm to the person who lacks capacity

- the amount or type of restraint used and the amount of time it lasts must be a proportionate response to the likelihood and seriousness of harm

When staff act under the Mental Capacity Act, they must record the capacity assessment, best-interests decision, reasons for the action and evidence that any restraint was necessary and proportionate.

3.3.2 Common law

Healthcare staff have a duty of care to protect patients and other people from immediate harm. Necessary and proportionate action may be taken to restrain or move a person who lacks capacity when their behaviour creates a serious risk. Common law does not provide authority to deprive a person of their liberty.

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 tranquillisation.

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 either:

- immediately necessary to save the patient's life
- immediately necessary to prevent a serious deterioration of their condition (provided the treatment is not irreversible)
- immediately necessary to alleviate serious suffering by the patient (provided the treatment is not irreversible or hazardous)
- 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 ended.

The responsible clinician must complete the relevant form for section 62, and for full guidance colleagues should refer to the guidelines for nursing colleagues on the use of section 62, see the section 62 procedure for clinical colleagues.

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

3.4 Pharmacological treatments

- Follow the patient's recorded preferences or advance decision to refuse treatment when this is clinically and legally appropriate.
- Keep doses within current BNF limits unless the trust's high-dose protocol applies. A consultant or senior doctor must agree any decision to exceed BNF limits.
- Consider physical illness, allergies, medication already prescribed or given, and the combined total of oral and intramuscular medication. Avoid using more than one medicine from the same drug class where possible.
- If the patient has already received an antipsychotic that day, the total dose should normally remain within the BNF maximum. Consider lorazepam alone when appropriate.
- Consider prescribed medicines, depot treatment, alcohol and other substances because these may change the dose needed and the risk of side effects.
- NICE recommends intramuscular lorazepam or intramuscular haloperidol with promethazine when urgent tranquillisation is needed. See the appendices and NICE NG10.
- Consider lorazepam alone first unless it is unsuitable, for example because of benzodiazepine hypersensitivity, respiratory depression and respiratory weakness.
- Prescribe the first dose as a single dose where possible. Review its effect before repeating it. Start at the lower end of the dose range and use the lowest effective dose for the individual patient.

3.5 Oral medication guidelines

3.5.1 Adults age 18 to 65 years

- Offer oral medication before medicine by injection. Intramuscular antipsychotic medication may act more quickly.
- The following options are supported by the trust:
    - oral lorazepam 1 to 2 mg; repeat after 60 minutes if needed, up to 6 mg in 24 hours
    - oral lorazepam 1 to 2 mg with oral haloperidol 2.5 to 5 mg; repeat after 2 hours if needed, with a maximum haloperidol dose of 20 mg in 24 hours. Note oral and IM haloperidol have different bioavailability lower doses such as 3mg should be considered
    - as an alternative, risperidone 2 mg with lorazepam 2 mg, up to 4 mg of each in 24 hours
    - consider procyclidine 5 mg to reduce the risk of acute dystonia when haloperidol is used for a patient who has not previously taken antipsychotic medication
    - start at the lower end of the dose range and use the lowest effective dose for the individual patient
    - if oral medication is repeatedly refused, medical and nursing staff must jointly decide whether restraint is necessary to give intramuscular medication
    - any physical intervention must protect the patient's dignity and be carried out only by staff trained for their role

3.5.2 Elderly

- Lorazepam 0.5mg, 1mg Max 2mg in 24hours
- Haloperidol 0.5mg, 1mg Max 5mg in 24 hours – note oral and IM haloperidol have different bioavailability and maximum dosing for IM is lower

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

3.6 Intramuscular medication (IM) guidelines

3.6.1 Adults age 18 to 65 years

Consider intramuscular medication only when non-drug measures and oral medication have not worked, or the patient refuses oral medication.
Continue to offer oral medication at each stage. Before prescribing an intramuscular dose, include any oral medication already given when calculating the total dose.

Consider Lorazepam first line in neuroleptic naive patients either:

- For patients who have not previously taken antipsychotic medication, consider intramuscular lorazepam first: 1 to 2 mg, repeated after 60 minutes if needed, up to 6 mg in 24 hours.
- An alternative is intramuscular haloperidol 2.5 to 5 mg with intramuscular promethazine 50 mg. Repeat after 2 hours if needed, up to 20 mg haloperidol or 100 mg promethazine in 24 hours. Be aware that both drugs cause QTc prolongation and promethazine has significant anticholinergic effects.
- Consider intramuscular aripiprazole when an antipsychotic is needed but haloperidol is contraindicated, for example in Lewy body dementia.
- The recommended initial aripiprazole dose is 9.75 mg (1.3 ml) as one intramuscular injection. The effective single-dose range is 5.25 to 15 mg. A lower dose of 5.25 mg (0.7 ml) may be used after considering the patient's condition and any medicine already given.
- A second aripiprazole injection may be given two hours later if clinically needed. Do not give more than three injections or more than 30 mg from all aripiprazole preparations in 24 hours.
- Zuclopenthixol acetate (Acuphase) 50 to 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. The prescribing of Zuclopenthixol acetate should only ever be done by a Consultant or a Specialist doctor.
- Due to its pharmacokinetics, zuclopenthixol acetate (Acuphase) is not suitable for first line use within rapid tranquillisation. It should not be given to struggling patients, or antipsychotic naive 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.

3.6.2 Elderly

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

- Lorazepam 0.5mg, 1mg Max 2mg in 24hours
- Haloperidol 0.5mg, 1mg Max 2mg in 24 hours
- Promethazine 25mg (maximum 50mg in 24-hours)
- 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 such as 2.5mg
- Promethazine has significant anticholinergic properties and may worsen delirium in elderly patients. It can also cause QTc prolongation.
- Lorazepam should be mixed in a 1 to 1 ratio with water for injections before administration and should not be mixed with other injections.
- If IM Haloperidol is used, anticholinergic (for example, Procyclidine 5 to 10mg IM) should also be considered in order to reduce the risk of extrapyramidal symptoms.
- Zuclopenthixol acetate (Acuphase) 50 to 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. The prescribing of Zuclopenthixol acetate should only ever be done by a Consultant or a Specialist doctor.
- Due to its pharmacokinetics, zuclopenthixol acetate (Acuphase) is not suitable for first line use within rapid tranquillisation. It should not be given to struggling patients, or antipsychotic naive 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. This site provides alternatives to the dorsogluteal, with fewer potential complications and a faster absorption rate, it can be accessed without using prone restraint, therefore less risk and more dignified as can be administered through clothing.

3.7 Patient monitoring or observation requirements or use of the early warning score

- Treat rapid tranquillisation as a medical emergency because it can cause serious harm. Protect the patient and other people throughout.
- Staff who monitor the patient must be trained in immediate life support, and emergency equipment must be available. A doctor must be able to attend as soon as possible, ideally within 30 minutes of being called.
- Only staff trained to the level required for their role may use physical restraint. They must follow the trust's violence-reduction and restrictive-intervention guidance.
- Risk is higher if the patient has used alcohol or other drugs, is obese, or has a condition affecting their heart, airway or breathing.

- Keep the patient in constant sight. Complete and record the required physical observations and early warning score on the observation chart and rapid tranquillisation care plan.

The Following observations should be taken every 15 minutes for the first hour, then every 30 minutes for the next 3 hours:

- respiration rate
- level of consciousness AVPU (levels of response AVPU (alert, voice, pain, unresponsive))
- oxygen saturation via pulse oximeter (if clinically indicated and only if safe to do so for both colleagues and patient)
- pulse (if clinically indicated and safe to do so for both colleagues and patient)
- blood pressure (if clinically indicated and only if safe to do so for both colleagues and patient)
- temperature (if clinically indicated and only if safe to do so for both colleagues and patient)

Colleagues 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 colleagues to complete all the above physical monitoring requirements, the reason why is to be recorded and as a minimum colleagues must monitor and record the patient's:

- respiration rate
- level of consciousness. (AVPU)

3.7.1 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 colleagues 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.

3.7.2 Electrocardiogram (ECG) requirements

If using Antipsychotics, where the summary of product characteristics indicates ECG monitoring, (currently haloperidol) 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.

3.8 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 (colleagues 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. If it is not possible to take a blood pressure due to the patient's presentation contact a doctor if a radial pulse can no longer be detected
- Or if colleagues become concerned about the clinical presentation of the patient

If the patient is asleep, a more frequent and intensive monitoring by appropriately trained colleagues 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.

3.9 Action following the use of rapid tranquillisation

- Record the reason for prescribing, the working diagnosis, all medication given and the patient's response in the clinical record.
- Review the patient's risk assessment and update the care plan.
- Arrange multidisciplinary review at the next meeting, or sooner when needed, to agree longer-term management.
- Offer the patient a debrief when they are ready. Record it and offer them the opportunity to add their own account to the clinical record.
- Complete the incident report and rapid tranquillisation care plan.

3.10 Debriefing

3.10.1 Patient

When the patient is ready, discuss their thoughts and feelings about the incident and record the discussion in the rapid tranquillisation care plan. The discussion must cover:

- any triggers that contributed to the incident
- what could be done differently if a similar situation happens again
- how the patient felt about the incident and the care they received

3.10.2 Colleagues

After the incident this will be reviewed in line with the trust reducing restrictive interventions policy.

3.11 Guidance specific to older adults

Apply the same principles used for working-age adults, but take extra care with existing physical illness, prescribed medicines, delirium and the build-up of sedative effects.

- 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.

3.12 Guidance for adolescents

It is recognised that on rare occasions adolescents under the age of 18 are admitted on to an acute ward. See appendix E for guidance

3.13 Guidance specific to pregnant women

If a patient is known or suspected to be pregnant, the consultant psychiatrist responsible for their care must give clear, individual advice about medicines, including any possible use for rapid tranquillisation. The decision must consider the stage of pregnancy and may require advice from the patient's obstetric team. Where medication is needed, consider an antipsychotic or benzodiazepine with a shorter half-life.

3.14 Additional guidance for patients post head injury on neuro rehabilitation ward

Patients recovering from a head injury may be more sensitive to paradoxical reactions from benzodiazepines and movement-related side effects from antipsychotics. For severe agitation, consider oral promethazine or quetiapine. If medicine by injection is needed, consider intramuscular promethazine or aripiprazole. Follow adult monitoring requirements, start at the lower end of the dose range and adjust the dose to the patient.

3.15 Rapid tranquillisation and seclusion

Wherever possible the use of seclusion for patients that have been subject to rapid tranquillisation 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 person
- terminate the episode of seclusion at the earliest opportunity

3.16 Documenting rapid tranquillisation

All incidents of rapid tranquillisation should be documented using the rapid tranquillisation care plan and incident reporting form appendix B. 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).

4. Responsibilities

4.1 Multidisciplinary team

- As soon as possible after admission, the multidisciplinary team must agree and record an individual medication plan for any patient at risk of violence or aggression. The team should include a psychiatrist or consultant physician, where appropriate, and a specialist pharmacist where available. The plan must cover regular and PRN medication used to calm, relax, tranquillise or sedate the patient.

- The team must review the plan and the use of medication at least weekly, and more often if incidents are increasing or restrictive interventions are being considered or used. The review must record the target symptoms, expected response time, total daily dose prescribed and given including PRN medication, missed doses and reasons, clinical response, and any unwanted effects.

If rapid tranquillisation is being used, a senior doctor must regularly review all medication.

4.2 Pharmacist

- Where possible, include a pharmacist when reviewing a patient for whom rapid tranquillisation is being considered.
- The pharmacist must check new prescriptions as part of the review. This check may be completed remotely.

4.3 The person performing the monitoring of the patient's physical observations

Will:

- complete the monitoring required by this policy
- record the patient's physical observations
- record why any required observation could not be completed
- report any concerning change in the patient's physical condition to the nurse, who must contact the doctor
- complete the rapid tranquillisation care plan

4.4 The nurse in charge of the ward

The nurse in charge of the ward at the time of rapid tranquillisation being utilised must be satisfied that:

- de-escalation and other suitable interventions have been tried or considered before rapid tranquillisation
- staff follow the prescription and complete the required physical monitoring
- clinical records, the rapid tranquillisation care plan and the incident report are completed accurately
- any concern about the patient's physical condition is reported promptly to a doctor
- the patient receives a clear explanation and is offered a chance to reflect on the incident; capacity and the need to involve other people must be considered
- the restrictive intervention is reviewed after the incident under the trust's reducing restrictive interventions policy
- the patient's privacy and dignity are protected throughout

4.5 Prescriber

When prescribing under the policy they must:

- confirm that de-escalation and other suitable interventions have been tried or considered
- consider all medication the patient has already received or is prescribed

- state clearly which medicine is to be used, the dose range and frequency, the minimum interval between doses, and the maximum dose allowed in the stated period

4.6 The chief medical officer

The chief medical officer is responsible for,

- acting as lead author and ensuring the policy is reviewed and updated
- identifying risks to the trust from rapid tranquillisation or from failure to follow this policy
- agreeing the content of staff training linked to this policy

4.7 The care group directors

The care group directors are responsible for:

- putting this and related policies into practice across their care group
- monitoring whether staff follow the policies
- making sure clinical teams have suitable resources and training

5. Training

The training needs analysis for this policy is set out in the trust's mandatory and statutory training policy. It explains which staff need training and how often they must complete it.

Rapid tranquillisation training should cover:

- All staff involved in rapid tranquillisation must be trained in immediate life support.
- Prescribers and staff who administer medicines must understand rapid tranquillisation and the properties of benzodiazepines, antipsychotics, antimuscarinics and antihistamines.
- Training must cover the risks of urgent medication, including effects on the heart and breathing. Risk may be higher when a patient is very distressed, has used drugs or alcohol, is dehydrated or may be physically unwell.
- Staff must know how to adjust doses to achieve the required effect safely.
- Staff must be trained to assess and manage actual or potential violence using de-escalation, restraint, seclusion and rapid tranquillisation, in line with their role and training needs.

6. Monitoring Arrangements

6.1 Duties

- How and who by: Clinical audit by Resuscitation officer.
- Reported to: medicines management committee (reports to clinical governance group) divisional governance groups.
- Frequency: Annually.

6.2 Prescribing guidelines for rapid tranquillisation

- How and who by: Clinical audit by Effectiveness team.
- Reported to: medicines management committee (reports to clinical governance group) divisional governance groups.
- Frequency: Annually.

6.3 How observations are recorded, including timeframes, when patients have received rapid tranquillisation

- How and who by: Clinical audit by Modern matrons.
- Reported to: medicines management committee (reports to clinical governance group) divisional governance groups.
- Frequency: Annually.

6.4 How the organisation trains colleagues in line with the training needs analysis

- How and who by: Monitoring of training content and training compliance conjunction with the above by Head of learning and development
- Reported to: Medicines management committee (reports to clinical governance group) divisional governance groups.
- Frequency: Annually.

6.5 Induction training for trainee doctors

- How and who by: Review of induction records by chief medical officer.
- Reported to: Medicines management committee (reports to clinical governance group) divisional governance groups.
- Frequency: Twice or three times a year depending on training grade.

6.6 Local induction of new colleagues within inpatient services

- How and who by: Review of induction records by Modern matrons.
- Reported to: Medicines management committee (reports to clinical governance group) divisional governance groups.
- Frequency: Twice a year.

7. Related documents and associated references

- Safe and secure handling of medicines manual
- Reducing restrictive interventions policy
- Mandatory and statutory training policy
- Resuscitation manual
- Clinical risk assessment and management policy
- Management of a secluded or segregated patient policy
- MCA, Advance statements and advance decisions to refuse treatment
- MHL, Section 62, procedure for clinical staff
- MCA, Mental Capacity Act 2005 policy
- Mental health units (use of force) policy
- NICE (2015) Violence and aggression: short term management in mental health, health and community settings (accessed 11 November 2024) (opens in new window).
- Department of health (2015) code of practice, Mental Health Act 1983 (accessed 11 November 2024) (opens in new window).
- Department of constitutional affairs (2007) code of practice, Mental Capacity Act 2005, the stationery office (accessed 11 November 2024) (opens in new window).
- Mental Health Act, Richard Jones (accessed 11 November 2024) (opens in new window).

- British national formulary (BNF) latest edition (accessed 11 November 2024) (opens in new window).
- Patient Safety Incident Response Framework (August 2022)

8. Appendices

8.1 Appendix A Early warning score system and score chart

- Appendix A Early warning score system and score chart (staff access only) (opens in new window)

8.2 Appendix B Rapid tranquillisation care plan

- Appendix B Rapid tranquillisation care plan (staff access only) (opens in new window)

8.3 Appendix C Rapid tranquillisation for frail or elderly people

8.3.1 When to use

When all other non-pharmacological interventions and de-escalation options have been tried and failed.

8.3.2 Prior to use

- Seek senior advice.
- Assess and establish risk of not doing so is greater than risk of side effects of acute pharmacological intervention.
- Inform patient medication is going to be given and why.
- Refer to rapid tranquillisation care plan, check consent to treatment where appropriate.
- Document authority to administer rapid tranquillisation.

8.3.3 Potential risks

- over sedation causing loss of consciousness
- over sedation causing loss of alertness
- loss of airway
- cardiovascular and respiratory collapse
- interaction with medication (prescribed or illicit)
- damage to therapeutic relationship
- underlying co-incidental physical disorders

8.3.4 Specific risks

Benzodiazepine:

- loss of consciousness
- respiratory depression or arrest
- cardiovascular collapse when receiving both clozapine and benzodiazepines

Antipsychotics:

- loss of consciousness

- cardiovascular or respiratory complications and collapse
- seizures
- akathisia
- dystonia
- dyskinesia
- excessive sedation
- neuroleptic malignant syndrome

Antihistamine:

- excessive sedation
- painful injection
- additional anti-muscarinic effects

8.3.5 Lorazepam

Oral:

- first choice unless contraindicated 0.5 to 1mg (maximum 2mg in 24-hours) can repeat after 60 minutes

Intramuscular medication injection:

- 0.5 to 1mg maximum 2mg in 24-hours including regular can repeat after 60 minutes

Concerns consult senior before administering:

- contraindicated in respiratory depression, marked neuromuscular respiratory weakness

8.3.6 Promethazine

Intramuscular medication injection:

- 12.5 to 25mg (maximum 50mg in 24-hours can repeat after 2 hours

Concerns consult senior before administering:

- significant anti-muscarinic properties, may worsen delirium, heavily sedating

8.3.7 Haloperidol

Oral:

- 0.5 to 1mg (maximum 5mg in 24-hours including any regular prescription), can repeat after 2 hours

Intramuscular medication injection:

- 0.5 to 1mg (maximum 2mg in 24-hours including any regular prescription), can repeat after 2 hours

Concerns consult senior before administering:

- caution in patients with Lewy body dementia and Parkinson’s disease due to extrapyramidal side effects, consider procyclidine if using haloperidol in naive patients

8.3.8 Aripiprazole

Intramuscular medication injection:

- start on 2.5mg and monitor closely, max dose 15.75mg per 24-hours, can repeat after 2 hours

8.3.9 After use

Physical observations:

- AVPU and respiratory rate as minimum if vital signs cannot be measured.

- blood pressure, temperature, respiration rate, level of consciousness, oxygen saturation, pulse if safe and clinically indicated.
- every 15 minutes for the first hour, then every half hour for the next 3 hours
- doctor to attend within 30 minutes
- document, rationale, medication given, response risk assessment, patient preference
- MDT for post event review as soon as possible
- ECG if using antipsychotics at earliest opportunity
- refer to policy for full guidance

8.4 Appendix D Rapid tranquillisation for adult inpatient

8.4.1 When to use

When all other non-pharmacological interventions and de-escalation options have been tried and failed.

8.4.2 Prior to use

- Seek senior advice.
- Assess and establish risk of not doing so is greater than risk of side effects of acute pharmacological intervention.
- Inform patient medication is going to be given and why.
- Refer to rapid tranquillisation care plan, check consent to treatment where appropriate.
- Document authority to administer rapid tranquillisation.

8.4.3 Potential risks

- Over sedation causing loss of consciousness.
- Over sedation causing loss of alertness.
- Loss of airway.
- Cardiovascular and respiratory collapse.
- Interaction with medication (prescribed or illicit).
- Damage to therapeutic relationship.
- Underlying co-incidental physical disorders.

8.4.4 Specific Risks

Benzodiazepine:

- loss of consciousness
- respiratory depression or arrest
- cardiovascular collapse when receiving both clozapine and benzodiazepines

Antipsychotics:

- loss of consciousness
- cardiovascular or respiratory complications and collapse
- seizures
- akathisia
- dystonia
- dyskinesia
- excessive sedation
- neuroleptic malignant syndrome

Antihistamine:

- excessive sedation
- painful injection
- additional anti-muscarinic effects

8.4.5 Lorazepam

Oral:

- first choice unless contraindicated 1 to 2mg (maximum 6mg in 24-hours) can repeat after 60 minutes

Intramuscular medication injection:

- 1 to 2mg maximum 6mg in 24-hours including regular can repeat after 60 minutes

Concerns consult senior before administering

- contraindicated in respiratory depression, marked neuromuscular respiratory weakness

8.4.6 Promethazine

Intramuscular medication injection:

- 25 to 50mg (maximum 100mg in 24-hours can repeat after 2 hours

Concerns consult senior before administering:

- significant anti-muscarinic properties, may worsen delirium, heavily sedating

8.4.7 Haloperidol

Oral

- 2 to 5mg (maximum 20mg in 24-hours including any regular prescription), can repeat after 2 hours

Intramuscular medication injection:

- 2.5 to 5mg (maximum 20mg in 24-hours including any regular prescription), can repeat after 2 hours

Concerns consult senior before administering:

- caution in patients with Lewy body dementia and Parkinson’s disease due to extrapyramidal side effects, consider procyclidine if using haloperidol in naive patients

8.4.8 Aripiprazole

Intramuscular medication injection:

- start on 9.75mg and monitor closely, max dose 30mg in 24-hours, can repeat after 2 hours

8.4.9 After use

Physical observations:

- AVPU and respiratory rate as minimum if vital signs cannot be measured.
- blood pressure, temperature, respiration rate, level of consciousness, oxygen saturation, pulse if safe and clinically indicated.
- every 15 minutes for the first hour, then every half hour for the next 3 hours
- doctor to attend within 30 minutes
- document, rationale, medication given, response risk assessment, patient preference
- MDT for post event review as soon as possible

- ECG if using antipsychotics at earliest opportunity
- refer to policy for full guidance

8.5 Appendix E Rapid tranquillisation for adolescent inpatients

8.5.1 When to use

When all other non-pharmacological interventions and de-escalation options have been tried and failed.

8.5.2 Prior to use

- Seek consultant advice, prescribing to be consultant led.
- Assess and establish risk of not doing so is greater than risk of side effects of acute pharmacological intervention.
- Inform patient medication is going to be given and why:
    - monitoring in line with adults
    - be aware of unlicensed use and dosage regimes and document this in the clinical records
    - adolescents and children are more sensitive to extrapyramidal side effects and more likely to be antipsychotic naive
    - disinhibition is more likely to occur with benzodiazepines in adolescents or children.
      Adolescents and children are more sensitive to extrapyramidal side effects (EPSE)
    - use oral medication first line wherever possible
- Consider age, weight, physiological maturity, and differences in pharmacodynamics and pharmacokinetics.
- Refer to rapid tranquillisation care plan, check consent to treatment where appropriate.
- Document authority to administer rapid tranquillisation.

8.5.3 Potential risks

- Over sedation causing loss of consciousness.
- Over sedation causing loss of alertness.
- Loss of airway.
- Cardiovascular and respiratory collapse.
- Interaction with medication (prescribed or illicit).
- Damage to therapeutic relationship.
- Underlying co-incidental physical disorders.

8.5.4 Specific risks

Benzodiazepine:

- loss of consciousness
- respiratory depression or arrest
- cardiovascular collapse when receiving both clozapine and benzodiazepines

Antipsychotics:

- loss of consciousness
- cardiovascular or respiratory complications and collapse
- seizures

- akathisia
- dystonia
- dyskinesia
- excessive sedation
- neuroleptic malignant syndrome

Antihistamine:

- excessive sedation
- painful injection
- additional anti-muscarinic effects

8.5.5 Lorazepam

Oral:

- first choice unless contraindicated 0.5 to 1mg (maximum 4mg in 24-hours) can repeat after 60 minutes.

Intramuscular medication injection:

- 0.5 to 1mg maximum 4mg in 24-hours including regular can repeat after 60 minutes

Concerns consult senior before administering:

- contraindicated in respiratory depression, marked neuromuscular respiratory weakness

8.5.6 Haloperidol

Oral:

- 1 to 2.5mg (maximum 10mg in 24-hours including any regular prescription), can repeat after 2 hours

Intramuscular medication injection:

- 1 to 2.5mg (maximum 5mg in 24-hours including any regular prescription), can repeat after 2 hours.

Concerns, consult senior before administering:

- consider Procyclidine 2.5m po IM, if using haloperidol in naive patients

8.5.7 After use

Physical observations:

- AVPU and respiratory rate as minimum if vital signs cannot be measured
- blood pressure, temperature, respiration rate, level of consciousness, oxygen saturation, pulse if safe and clinically indicated
- every 15 minutes for the first hour, then every half hour for the next 3 hours
- doctor to attend within 30 minutes
- document, rationale, medication given, response risk assessment, patient preference
- MDT for post event review as soon as possible
- ECG if using antipsychotics at earliest opportunity
- refer to policy for full guidance