Keele University Teaching Trust

NHS
North Staffordshire Combined Healthcare NHS Trust

Our Ref: NG/RM/25299
Date: 15th September 2025

Nicola Griffiths
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Dear

Freedom of Information Act Request

I am writing in response to your e-mail of the 20th August 2025**.** Your request has been processed using the Trust's procedures for the disclosure of information under the Freedom of Information Act (2000).

Requested information:

Please can I get a copy of your latest Rapid tranquillisation or management of acute disturbance policy/guidance?

Please see Appendix 1 attached, policy is currently under review.

If you are dissatisfied with the handling of your request, you have the right to ask for an internal review of the management of your request. Internal review requests should be submitted within two months of the date of receipt of the response to your original letter and should be addressed to: Dr Buki Adeyemo, Chief Executive, North Staffordshire Combined Healthcare Trust, Trust Headquarters, Lawton House, Bellringer Road, Trentham, ST4 8HH. If you are not content with the outcome of the internal review, you have the right to apply directly to the Information Commissioner for a decision. The Information Commissioner can be contacted at: Information Commissioner's Office, Wycliffe House, Water Lane, Wilmslow, Cheshire, SK9 5AF.

Yours sincerely

Nicola Griffiths
Deputy Director of Governance

Document level: Trust
Code: 1.27
Issue number: _____

Rapid Tranquilisation Policy

Lead executive	Medical Director
Authors details	Deputy Director of Medicines, and MACE Head of Nursing and Quality Principle Clinical Pharmacist Head of IPC, and Physical Health

Type of document	Policy
Target audience	All inpatient clinical staff
Document purpose	Information

Approving meeting	Quality Committee	Meeting date	5th September 2019
Approving meeting	Trust Board	Meeting date	26th September 2019
Implementation date	26th September 2019	Review date	31st October 2024

Trust documents to be read in conjunction with	
1.03	Medicines Policy
	High Dose Antipsychotic Therapy Policy
	Non-formulary/Off-label/Unlicensed Policy
	Medication Monitoring Policy
1.62	Physical Health Policy
	Restraint Policy
1.80	Resuscitation Policy
1.24	Nutrition and Hydration Policy
5.01	Incident Reporting Policy
5.32	Serious Incident Policy
R01	Policy on the use and Reduction of Restrictive Interventions
1.62b	Neurological Observations SOP
1.35	Observation Policy
1.12a	Safeguarding Policy Statement
R11	Seclusion and Longer-Term Segregation Policy
5.19	Violence and Aggression Policy
1.64	Effective Care Planning
MHA13	Mental Capacity Act Policy

Document change history		Version	Date
What is different?	Review of the definition of rapid tranquilisation; updated the requirements for physical health		2019

	monitoring; clarification of roles and responsibilities.		
Appendices / electronic forms	Total review	1	July 2019
What is the impact of change?	The changes will give staff greater clarity around the principles of RT including definition, assessment, monitoring, escalation, and documentation. Therefore, ensuring the consistent delivery of best of practice.		

Training requirements	As per Trust TNA

Document consultation	
Directorates	Acute and Urgent care Directorate representatives and members of CEG
Corporate services	POST, MACE and CEG
External agencies	

Financial resource implications	None

External references

1. British Association for Psychopharmacology & The National Association of Psychiatric Intensive Care Units. (2018). Joint BAP NAPICU Evidence-Based Consensus Guidelines for the Clinical Management of Acute Disturbance: De-Escalation and Rapid Tranquilization. Journal of Psychopharmacology. Available From: https://www.bap.org.uk/docdetails.php?docID=105. Last Accessed 25/03/2019.
2. Innes, J & Sethi, F. (2013). Current Rapid Tranquilization Documentation in the UK: A Review of Drug Recommended, Their Routes of Administration and Clinical Parameters Influencing Their Use. *Journal of Psychiatric Intensive Care Unit.* 9: 110-118.
3. Lambert, L, Evans, D, &Wood, J. (2003), Patient Injury and Physical Restraint Devices: A Systematic Review. *Journal of Advanced Nursing.* Available From: https://www.academia.edu/29575297/Patient_injury_and_physical_restraint_devices_a_systematic_review. Last Accessed: 1/5/19.
4. Loynes, B, Innes, J & Dye, S. (2013). Assessment of Physical Monitoring Following Raid Tranquilization: A National Survey. *Journal of Psychiatric Intensive Care.* Vol, 9. 2. 85-90.
5. National Institute for Healthcare and Clinical Excellence. (2015). Violence and Aggression: Short-Term Management in Mental Health, Health and Community Settings {NG10}. Available From: https://www.nice.org.uk/guidance/ng10. Last Accessed 1/4/19.
6. Taylor, D, Thomas, B and Young, A. (2018). The Maudsley Prescribing Guidelines in Psychiatry. (2018). 13th Ed. West Sussex: Willey Blackwell.

7. The Resuscitation Council UK. (2006). ABCDE approach. Available from: https://www.resus.org.uk/resuscitation-guidelines/abcde-approach/. Last Accessed;1/5/19.

Monitoring compliance with the processes outlined within this document	Rapid tranquilisation auditing carried out through the inpatient safe matrix, Rapid Tranquilisation audit presented to CEG, competency documentation, supervision notes and PDRs, surveillance etc.

Equality Impact Assessment (EIA) - Initial assessment	**Yes/No**	**Less favourable / More favourable / Mixed impact**
Does this document affect one or more group(s) less or more favorably than another (see list)?		
– **Age** (e.g., consider impact on younger people/ older people)	No	
– **Disability** (remember to consider physical, mental, and sensory impairments)	No	
– **Sex/Gender** (any particular M/F gender impact; also consider impact on those responsible for childcare)	No	
– **Gender identity and gender reassignment** (i.e., impact on people who identify as trans, non-binary or gender fluid)	No	
– **Race / ethnicity / ethnic communities / cultural groups** (include those with foreign language needs, including European countries, Roma/travelling communities)	No	
– **Pregnancy and maternity, including adoption** (i.e., impact during pregnancy and the 12 months after; including for both heterosexual and same sex couples)	No	
– **Sexual Orientation** (impact on people who identify as lesbian, gay or bi – whether stated as 'out' or not)	No	
– **Marriage and/or Civil Partnership** (including heterosexual and same sex marriage)	No	
– **Religion and/or Belief** (includes those with religion and /or belief and those with none)		
– **Other equality groups?** (May include groups like those living in poverty, sex workers, asylum seekers, people with substance misuse issues, prison and (ex) offending population, Roma/travelling communities, and any other groups who may be disadvantaged in some way, who may or may not be part of the groups above equality groups)	No	

If you answered yes to any of the above, please provide details below, including evidence supporting differential experience or impact.	
Enter details here if applicable	
If you have identified potential negative impact: - Can this impact be avoided? - What alternatives are there to achieving the document without the impact? Can the impact be reduced by taking different action?	
Enter details here if applicable	
Do any differences identified above amount to discrimination and the potential for adverse impact in this policy?	No
If YES, could it still be justifiable e.g. on grounds of promoting equality of opportunity for one group? Or any other reason	N/A
Enter details here if applicable	
Where an adverse, negative, or potentially discriminatory impact on one or more equality groups has been identified above, a full EIA should be undertaken. Please refer this to the Diversity and Inclusion Lead, together with any suggestions as to the action required to avoid or reduce this impact. For advice in relation to any aspect of completing the EIA assessment, please contact the Diversity and Inclusion Lead at Diversity@northstaffs.nhs.uk	
Was a full impact assessment required?	No
What is the level of impact?	Low

CONTENTS

1. Introduction

Within North Staffordshire Combined Healthcare NHS Trust (NSCHT) all patients, where possible, will be at the centre of the clinical decision-making process ensuring safety is the priority throughout each intervention. The purpose of this policy is to outline the use of rapid tranquilisation (RT) within the context of the prevention and management of acute agitation or aggression in order to:

- Reduce psychological suffering and self-harm for patients.
- Maintain a safe environment.
- Prevent harm.

2. Background

The Trust recognises the importance of good practice in preventing and managing acute agitation, aggression, and potentially violent incidents. Risk of acute agitation or aggression should be identified through the assessment process and where this risk is identified this should be reflected in the person's risk assessment and accompanied by an up-to-date intervention plan. This intervention plan should identify pro-active primary and secondary strategies and de-escalation techniques that should be utilised to support the person and minimise the risk of escalation.

It is recognised that on occasions acute agitation or aggression may occur despite all attempts to prevent this using de-escalation techniques. It is at these times it may become necessary to use pharmacological interventions to maintain the safety and physical health of an individual. In the management of acute agitation or aggression the administration of medicines using the parental route (usually intramuscular) is termed Rapid Tranquilisation (RT) however it should be noted that RT has a limited evidence base as clinical trials are difficult to conduct.

Moreover, there are a variety of approaches for managing acute agitation or aggression, which should be considered prior to the use of RT. These include de-escalation, distraction techniques, consideration of environment, physical restraint and seclusion. All of these strategies should be considered in each case. Even when RT is used, these alternate treatment strategies should continue to be used alongside RT, as each is likely to augment the effect of the others. The aim of the policy is to:

- Ensure a standard approach to care, based on the best available evidence.
- Minimise risk related to the use of RT.
- Advise on best practice in prescribing of medication for RT.
- Provide clarity in relation to staff roles and responsibilities.
- Comply with CQC and NHSLA standards, and national (NICE) recommendations.

3. Policy Synopsis

This policy applies to all healthcare staff working within in-patient settings where RT may be utilised. The policy is applicable to both Mental Health and Learning Disabilities Services and applies to in-patients over the age of 12.

RT will not be regularly used within Resource Centres, Rehabilitation Units or within Children's Services. However, staff may be faced with extreme emergency situations where the use of RT may be unavoidable. In any event staff must ensure that wherever possible the guidance is fully adhered to.

4. Definitions

De-escalation techniques

De-escalation is the use of techniques (including verbal and non-verbal communication skills) aimed at defusing anger and averting aggression. PRN medication can be used as part of a de-escalation strategy, but PRN medication used alone is not de-escalation (taken from Violence and Aggression Short Term Management in Mental Health and Community Settings - NICE May 2015). De-escalation techniques should be used prior to the use of RT.

Tranquilisation: The administration of medicine(s), orally or parenterally, with the aim of calming or lightly sedating a patient in order to reduce the risk to the patient or others from agitated or aggressive behaviour. The aim is to achieve an optimal reduction in agitation and aggression, thereby allowing a thorough psychiatric evaluation to take place whilst allowing comprehension and response to spoken messages throughout. Tranquilisation should only be used if non-medicine de-escalation has had inadequate effect.

Non-urgent tranquilisation: Tranquilisation using orally administered medicine(s). This should be used in preference to rapid/urgent tranquilisation whenever possible (see below).

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

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

4. Legal Considerations

Staff involved in rapid tranquilisation should be mindful of and take account of the following legal frameworks:

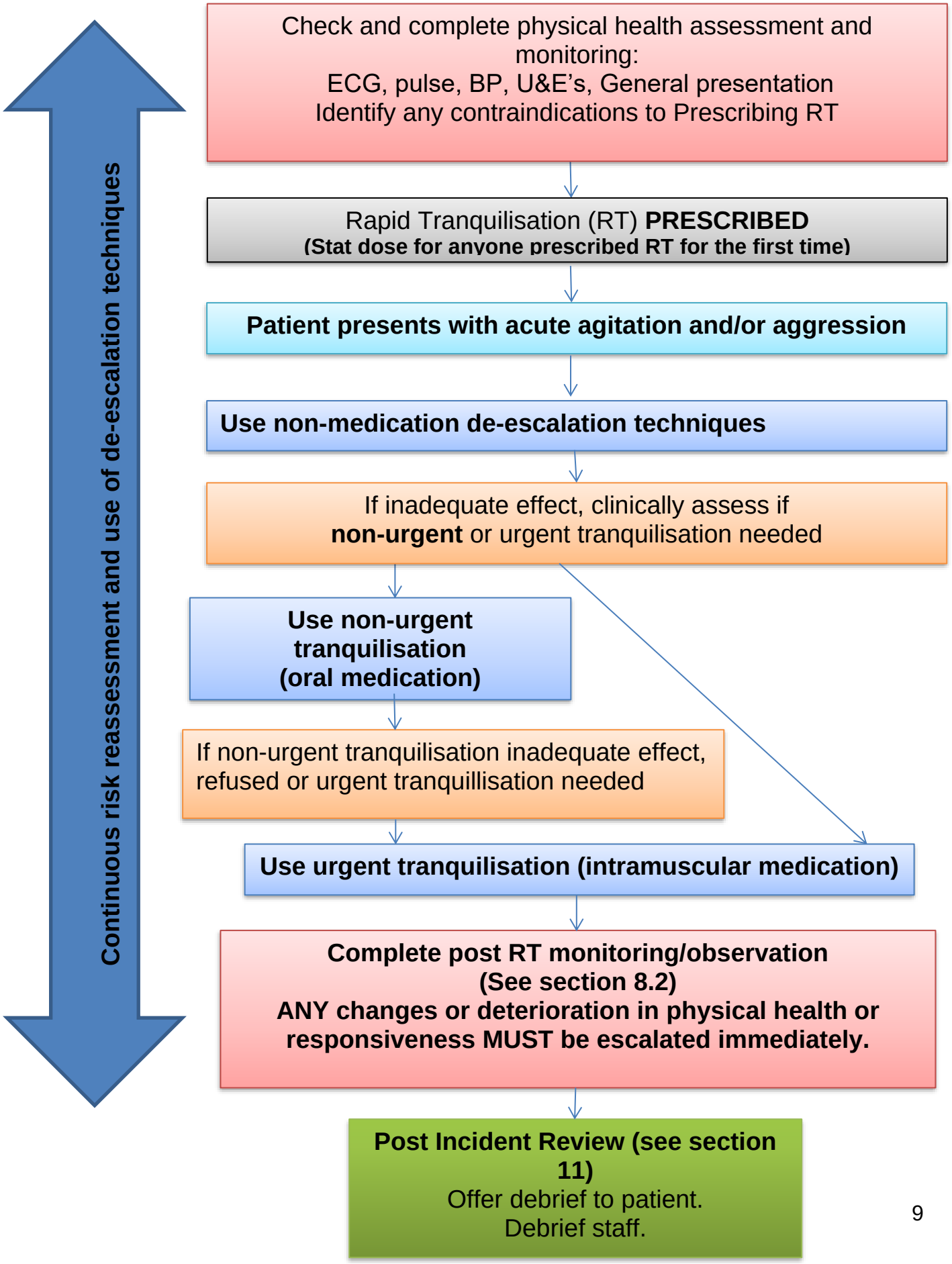
- Relevant sections of the Mental Health Act 1983 and its Code of practice. The principles underlying the common law doctrine of 'necessity', and the requirements of the relevant articles of the European Convention on Human Rights including:
  - Article 2 (right to life)
  - Article 3 (the right to be free from torture or inhuman or degrading treatment or punishment)

- Article 5 (the right to liberty and security of person save in prescribed cases) and
- Article 8 (the right to respect for private and family life), and the principle of 'proportionality'.

It is also important to ensure that any developing situation or positive intervention takes into account the individuals need of patient related to:

- Protected characteristics (age, disability, gender, gender reassignment, race, religion or belief, sex, sexual orientation, marriage or civil partnership, pregnancy, or maternity)
- sensory impairment
- patients with a physical impairment
- patients with a cognitive impairment
- female patients e.g. (are some members of staff who are restraining of the same sex)
- patients with communication difficulties
- frail older patients

5. Rapid Tranquilisation Flowchart



6.0 Circumstances for Appropriate Use of Rapid Tranquilisation

The need for RT requires careful clinical judgement taking into consideration the following:

- Imminence of violence may be suggested by rapidly increasing verbal aggression or anger, perhaps associated with explicit threats of violence, changes or extremes of behavior, and/or outward signs of inner tension.

- When determining which interventions to employ, clinical need, safety of service users and others, and where possible advance decisions, should be taken into account.

- Where appropriate the patient should be offered oral medication (non-urgent tranquilisation) in the first instance. However, if the patient refuses oral medication, or the risks are escalating such that, for safety reasons, the intramuscular (IM) route is deemed necessary, then this route should be used and this RT policy followed.

- The aim of RT is not to treat any underlying illness or disorder. Instead, RT should be used as a management strategy to treat acute agitation or aggression.

- Prescribers should aim to ensure that the degree of sedation arising from RT does not compromise the patient's capacity to understand and respond to what is said to them.

- Although not the overt intention, rapid tranquilisation may lead to deep sedation/anesthesia hence the need for comprehensive monitoring.

- RT is potentially hazardous, and the risk of adverse events is higher if the patient has taken illicit drugs or alcohol. The duty doctor must be informed that RT has been used as soon as possible and be available for a rapid response for 30 minutes after administration of RT as medical support must be available in case of adverse reactions, over-sedation, or the need to administer flumazenil.

- NICE recommends that the doctor should aim to be at the scene within 30 minutes as medical support must be available in case of adverse reactions, over-sedation, or the need to administer flumazenil. Therefore, if RT is to be attempted out of hours the duty doctor should be contacted.

7.0 Physical Health Monitoring

7.1 Physical Monitoring Before Rapid Tranquilisation

The prescriber should:

- Review the patients' clinical record with regard to their general medical history and consider the possibility of a physical examination.
- Check for recent ECG, U&E and urine drug screen results, a previous history for severe extrapyramidal side effects or antipsychotic naivety, previous response to RT or other methods of managing imminent violence.
- Review current prescribed medication and recently administered medication,

taking note of administration of PRN prescriptions.
- Mental Health Act Status - consider if a T2/T3 form is in place which lists medications which can be prescribed. A S62 form completed by the Consultant would be needed if RT medicines not included.
- Check baseline NEWS observations.

7.2 Physical Monitoring Post Rapid Tranquilisation

Following the administration of RT, the following parameters must be monitored and recorded on the NEWS chart:

- Pulse
- Blood pressure
- Respiratory rate
- Temperature
- Level of hydration
- Level of consciousness

If the patient will not allow the complete NEWS parameters to be monitored discrete visual observations must be undertaken and recorder on the Patients Electronic Record (EPR). The following observations must be included:

- Airway
- Breathing
- Circulation
- Disability
- Exposure

This should only occur in exceptional circumstances when the patient is not compliant with the completion of standard NEWS monitoring. The rationale for using the discrete visual observations must be documented within the EPR, and as soon as the patient becomes compliant monitoring should revert to the standard NEWS chart.

NEWS scores will indicate the escalation level required and the required increase in observations and actions required. Staff MUST always escalate any concerns and seek further clinical advice or support as per the action section on the reverse of the NEWS monitoring form.

As a minimum monitor the above:

- Every 15 minutes for the first hour
- Then every hour for a minimum of 4 hours until the NEWS score is normal and the nurse in charge has no further concerns about their physical health status.

If the patient is unconscious, remains over-sedated or is otherwise unwell they must be reviewed by a doctor. Immediate escalation and review are required by the Ward Doctor, if not able to attend immediately then 2222 or the duty response team followed by (9)999.

If the patient remains on the ward following clinical review continue to monitor every 15 minutes if the BNF maximum dose has been exceeded (either with one medicine or when regular and ‘prn’ are combined) or the service user:

- Remains over-sedated
- Has sustained a head injury.
- Has taken illicit drugs or alcohol.
- Has a pre-existing physical health condition.
- Has experienced any harm as a result of any restrictive intervention. A clinical review specifically in relation to the harm sustained must be undertaken and further observations, reviews or intervention determined to reflect the severity of the injury.

After RT a mental health assessment should be undertaken in conjunction with physical health checks.

8.0 Special Circumstances

8.1 Rapid Tranquilisation and Seclusion

Particular caution is necessary if combining RT with seclusion and physical intervention. If the service user is secluded, the potential complications of RT should be taken into account.

The service user may be monitored by discrete visual observation by appropriately trained staff. This should only happen if the patient is too agitated to be closely accompanied by a staff member and the rationale for this decision must be clearly documented within the EPR.

8.2 Rapid Tranquilisation and Physical Intervention

Medicines for RT, particularly in the context of physical intervention should be used with caution due to the increased risk of the following:

- Loss of consciousness
- Sedation with loss of alertness
- Compromised or loss of airway.
- Cardiovascular and respiratory collapse
- Interaction with medicines already prescribed or illicit substances taken (can cause side effects such as akathisia, disinhibition)
- Negative impact on patient-staff relationship
- Underlying pre-existing physical disorder

9.0 Medical Equipment

NICE NG10 stipulates that resuscitation equipment must be available if restrictive interventions, including RT, might be used. This consists of an automatic external defibrillator with monitoring ECG pads, a bag valve mask, oxygen, cannulas, fluids, airways, pulse oximeter, vital signs monitor; suction should be available immediately in clinical areas where RT may be used. The equipment should be maintained and checked in accordance with the Trust Resuscitation policy.

10.0 Medicines for Tranquilisation

10.1 Prescribing Guidelines for Rapid Tranquilisation

This policy describes the use of lorazepam first line and then promethazine and haloperidol second line as RT in line with NICE guidelines (see table 1). When deciding which medication to use, take into account:

- The service user's preferences or advance statements and decisions
- Pre-existing physical health problems or pregnancy
- Any known allergies to medicines
- Possible intoxication or delirium
- Previous response to these medications, including adverse effects.
- Potential for interactions with other medications
- The total daily dose of medications prescribed and administered.

The regular medication prescribed to a patient must always be considered to ensure that RT does not duplicate oral medication. Ideally antipsychotic or benzodiazepine polypharmacy should be avoided. If a combination of antipsychotics takes the patient on to a 'high dose' antipsychotic combination, then the High Dose Antipsychotic Therapy policy must be followed. If there is insufficient information to guide the choice of medication for RT, or the service user has not taken antipsychotic medication before use IM Lorazepam.

Haloperidol is best avoided in those who are naïve to antipsychotics; have a history of severe extra-pyramidal side effects; have a history of cardiovascular disease or an abnormal ECG; or in whom no ECG has yet been taken due to patient refusal or they are too unwell to have an effective ECG reading. IM Lorazepam should be used instead.

Benzodiazepines are best avoided in those with compromised respiratory function.

If there is a partial response to IM Lorazepam, consider a further dose. If there is no response to IM Lorazepam, consider IM haloperidol combined with IM Promethazine.

If there is partial response to IM Haloperidol combined with IM Promethazine, consider a further dose. If there is no response to IM Haloperidol combined with IM Promethazine, consider IM Lorazepam if this hasn't already been used already during this episode. If IM Lorazepam has already been used, arrange an urgent team meeting to carry out a review and seek a second opinion if needed.

In exceptional circumstances such as contra-indications or product manufacturing issues a consultant may decide to prescribe an alternative medication for RT. The rationale for this decision must be clearly documented within the patient's notes and appropriate assessment and monitoring followed as per this policy and the BNF.

Aripiprazole is available as an IM injection licensed for RT in patients with schizophrenia or mania. Olanzapine is available as an IM injection licensed for RT in patients with schizophrenia or mania; however, it is no longer available in the UK and has to be imported as an unlicensed product. Olanzapine IM cannot be given within 1 hour of IM benzodiazepines.

Zuclopentixol acetate injection is not recommended for rapid tranquilisation due to its long onset and duration of action. It is only allowed for use in the Trust on the initiation of a consultant psychiatrist with a clear care plan for its use and requires 48 hours of post administration monitoring due to it prolonged half-life.

When prescribing medication for use in rapid tranquilisation, write the initial prescription as a single 'stat' dose, and do not repeat it until the effect of the initial dose has been reviewed.

It may be necessary to give IM medication through clothing in certain situations. The rationale should be documented in the notes if this occurs.
Note under the Mental Health Act Nurse Associates are not permitted to administer rapid tranquilisation to a patient.

Table 1: Medicines Used for Management of Acute Agitation or Aggression – their properties, cautions and advice notes

Medicine	Route	Pharmacokinetics	Major Adverse effects	Notes
Lorazepam	Oral or IM	Onset 10 to 30 mins Peak 60 to 90 mins Half-life 12 to 16 hrs	- Respiratory Depression - Disinhibition	- IM absorption is as slow as oral absorption but is rapid in an active patient. - The injection should be diluted 50:50 with water for injections pre-injection. - There is no accumulation of lorazepam with repeated doses or in impaired liver function. - Respiratory depression is readily reversed with the specific antagonist flumazenil. - Paradoxical reactions are more likely to occur in those with organic brain disease, including learning disabilities, the under 18s and the over 65s, and perhaps those with impulse control problems. - Do not give IM lorazepam and IM olanzapine within one hour of each other because there is a risk of excessive sedation, cardiorespiratory depression, and death.
Haloperidol	Oral	Onset 1 to 2 hrs Peak 4 (2-6) hrs Half-life 24 (15-37)hrs	- EPSE - Hypotension - NMS - Increased QTc or arrhythmias - Seizures - Sudden death	- The bioavailability of both formulations is different, and this must be taken into account when considering the total dose per 24 hr period. See conversion table 2. - Note risk of acute dystonia and ensure that an appropriate antimuscarinic is available. - The Summary of Product Characteristics (SPC) for haloperidol specifies that a baseline ECG must be carried out prior to treatment. - Before prescribing haloperidol, there must be documentation on Carenotes of either the QT interval from a recent ECG, or the decision to prescribe haloperidol despite absence of an ECG.
	IM	Onset 20 mins Peak 20-40 min Half-life 21(13-36)hrs		
Olanzapine	Oral	Onset 5 to 8 hrs Peak 5 to 8 hrs Half-life 32 to 50 hrs	- Hypotension - Bradycardia - Syncope	- Less likely to cause EPSE than haloperidol. - IM administration results in initial maximum plasma concentration 5 times higher than same dose given orally. - IM lorazepam should not be administered until at least 1 hour after IM olanzapine administration. - No more than 3 injections of IM olanzapine should be given in 24 hours and a minimum of two hours should elapse between each
	IM	Onset 15 to 45 mins Peak 15 to 45 mins Half-life 30 hrs		

Medicine	Route	Pharmacokinetics	Major Adverse effects	Notes
				injection. - Olanzapine IM is intended for short term use, for a maximum of 3 consecutive days.
Promethazine	IM	Onset 20 mins Peak 2 to 8 hrs Half-life 7 to14 hrs	- Prolonged sedation - Seizures - Cardio-respiratory depression - NMS	- ECG recommended (potential for QT interval prolongation) - Use of IM promethazine for rapid tranquilisation is off label. - It has a slow onset of action but is an effective sedative. - Dilution is not required before IM injection. - Smaller doses will be required in severe renal impairment, - Use with caution in hepatic impairment, respiratory disease, and congestive heart failure. - As promethazine is **NOT** a benzodiazepine, flumazenil is not an antidote to reverse its effects.
Zuclopenthixol Acetate (Clopixol Acuphase®)	IM	**Not rapid tranquilisation** Onset 2 to 8 hrs Peak 24 to 36 hrs Half-life 60 hrs	- Sudden death - Cardiac arrest - Arrhythmias - EPSE	- **This is not an appropriate medicine for rapid tranquilisation** - Given by deep IM injection into the gluteal muscle, taking care not to give into a vein, as this can be fatal. - It should not be used in those who are neuroleptic naive, who are struggling, who are sensitive to EPSE, those with cardiac disease, hepatic or renal impairment, or in pregnancy. - Please refer to the latest version of the BNF, SPC, and Maudsley Prescribing Guidelines in Psychiatry when prescribing or administering zuclopenthixol acetate.

Table 2: Haloperidol conversion

	APPROXIMATE EQUIVALENT DOSES (mg)										
Oral Haloperidol	0.5	1	1.5	2.5	4.2	5	7.5	8.3	10	12.5	16.7
IM Haloperidol	0.3	0.6	0.9	1.5	2.5	3	4.5	5	6	7.5	10

Notes:

- The pharmacokinetics of lorazepam is similar whether given orally or parenterally, therefore the only reason to give lorazepam parenterally is if the patient refuses oral.

- It is recognised that clinicians may decide that the use of medication outside of the manufacturer's Summary of Product Characteristics (SPC) is occasionally justified, bearing in mind the overall risks. However, where the regulatory authorities or manufacturer issues a specific warning that this may result in an increased risk of fatality, the medication should only be used strictly in accordance with the current marketing authorisation.

Table 3 - Usual and Maximum Doses

Medication	Usual Dose	Maximum Dose
Lorazepam	0.5-2mg 4-hourly	4mg/24hours
Haloperidol IM	1-10mg 4- hourly	20mg/24hours (IM is more potent than PO)
Haloperidol oral	1-10mg 4-hourly	20mg/24hours
Promethazine	25-50mg	100mg/24hours (off-label)
Aripiprazole IM	9.75mg	30mg/24 hours
Olanzapine IM	5-10mg	20mg/24 hours

The maximum doses given are guidelines only. The dose ranges have been chosen after careful consideration of relevant literature and other guidelines such as the products individual Summary of Product Characteristics (SPC). BNF maximum doses should not be exceeded without careful thought and advice from a Consultant Psychiatrist. The High Dose Antipsychotic Therapy (HDAT) guideline should be followed in this instance.

11.0 Management of Adverse Effects and Complications

Complication	Symptoms / signs	Management
Acute Dystonia	Severe painful muscular stiffness	Procyclidine 5 to 10mg IM
Hypotension	Fall in blood pressure (orthostatic or <50mmHg diastolic)	Lie patient flat and raise legs - tilt bed head down. Complete physical observation chart every 15 minutes and complete actions
Neuroleptic malignant syndrome (see appendix 1)	Increasing temperature, fluctuating blood pressure, muscular rigidity, confusion/ altered consciousness	Withhold antipsychotics. Complete physical observation chart every 15 minutes and complete actions. Consider blood test for creatinine kinase level. Liaise with general medical team and consider transfer to acute medical care
Arrhythmias	Slow (<50/minute) or irregular pulse	Monitor closely and liaise with general medical team immediately
Respiratory Depression	Reducing respiratory rate, reducing consciousness	Complete physical observation chart every 15 minutes and complete actions. If respiratory rate drops below 10/minute in a patient who has received benzodiazepines, then flumazenil should be administered by a doctor: 1) 200 micrograms IV over 15 seconds. 2) If consciousness not resumed within 60 seconds give 100 micrograms over 10 seconds. 3) Repeat at 60 second intervals. Maximum dose 1mg/24 hours. 4) Contact emergency medical services. Continue to monitor after respiratory rate returns to normal. Flumazenil has a short duration of action so further doses may be required. Patients may become agitated or anxious on wakening.

12.0 Incident Reporting and Post-Incident Reviews

Incidents regarding the administration of parenteral RT should be reported electronically on an Incident Form in accordance with Trust Management of Incident policy. The episode of RT should also be documented in the patient's EPR along with the completed NEWS physical observation forms (available on Lorenzo) and any additional monitoring. Information recorded on the incident form should also include:

- The medication prescribed/administered.
- Mental Health Act status

Following the use of RT all staff involved should participate in a staff debrief as soon as possible.

All service users must be offered the opportunity to discuss their experiences and should be provided with a clear explanation of the decision to use RT as opposed to other methods along with any necessary support within 72 hours of the incident. This information may be used to inform amendments to the patient's care plan i.e. how they would like a similar situation to be approached in the future. This discussion should be recorded in their EPR and the service user given an opportunity to record their account of the experience. In doing so, service users should be given the opportunity to be supported by an independent mental health advocacy support worker.

13.0 Guidance on Rapid Tranquilisation in Patient Groups

Special consideration must be given to specific patient groups. It may be necessary to refer to colleagues within other clinical specialties to seek advice such as pediatrics.

13.1 Guidance on Rapid Tranquilisation in Patients over 65's years of age

1. When dealing with acutely disturbed behaviour in older people non-pharmacological measures, such as de-escalation and distraction should always be attempted first. Remember that if passive restraint is required older people have a higher risk of skin damage.
2. Start with oral medication and remember that in older people lower doses and slower increases are recommended.
3. Risperidone up to 2mg twice a day is licensed for the short-term treatment (up to 6 weeks) of persistent aggression in patients with moderate to severe Alzheimer's dementia unresponsive to non-pharmacological approaches and when there is a risk of harm to self or others. Generally, where a licensed product is available this should be used in preference to that without a license.
4. All antipsychotics should be used with caution in older people with dementia, especially those with a history of cerebrovascular disease and only after discussion with relatives. For older people exhibiting greater risk of acute agitation or aggression, potential management strategies including RT should occur in advance of the likelihood of an alert, e.g., on admission.
5. Older patients will absorb medications more slowly and so there will be a slower onset of action, be sure to take this into consideration before repeating doses.

6. Older patients may also have an effectively larger volume of distribution which leads to a longer duration of action, this needs to be considered so as to avoid accumulation.
7. There is a higher incidence of adverse effects in older patients; in particular disinhibition is much more likely with benzodiazepines than in working age patients. Be aware that their risk of falls is greatly increased with any sedating medication, consider revising the level of nursing observations. It is important to ensure that all physical monitoring is carried out as per policy so as to be sure to pick up any adverse effects.
8. All antipsychotics should be avoided if possible, in Lewy Body Dementia and Parkinson's Disease.
9. All antipsychotics can cause increased cognitive impairment and confusion in patients with dementia.
10. If you think a delirium is the cause of the agitation, NICE advocate haloperidol.

13.2 Guidance on Rapid Tranquilisation in Patients under 18s years of age

1. Many drugs are not licensed for use in children and adolescents. Some may be used because over time clinical experience has been built up amongst experts and there is peer support for usage. There is an expectation that in the future drug companies will have to give fuller information on the effects of their drugs on children.
2. Children and adolescents should only be treated with medication (RT) after completing a physical risk assessment and when it has been clearly established that the risks of not treating are greater than the risks of using medication.
3. The weight and pubertal status of the young person needs to be considered in deciding dosages. Over a weight of 40kg dosages up to adult BNF limits may be used. Calculate dosage by weight for those weighing under 40kg.
4. It is unusual to use doses over that given in the BNF for young people as there is no body of evidence to support such usage. In all cases the minimum effective dose of medication should be used. BNF maximum doses should only be exceeded in extreme circumstances and with the advice of a Consultant Child and Adolescent Psychiatrist. Consider involving a SOAD.
5. In the case of young people who are not detained under the mental health act, or who are detained, but under a section of the act which does not authorize treatment, the child/adolescent must be informed that medication is going to be given and must be given the opportunity at any stage to accept oral medication voluntarily. In children/ adolescents who are not Gillick competent, the person with parental responsibility should be informed of the situation and consent sought for such treatment. It is good practice to inform both the child/adolescent and the person with parental responsibility. Rapid tranquilisation can be given in emergency situations under common law, but this should be in exceptional cases only.
6. In the case of young people who are detained under a treatment section of the mental health act, reference must be made to the consent to treatment

documentation (forms T2 or T3). Medication not specifically consented to or authorised by a consent to treatment form can still be given, if necessary, under section 62 of the mental health act 1930 as amended 2007 ('urgent treatment', subsection (d) [treatment] which (not being irreversible or hazardous) is immediately necessary and represents the minimum interference necessary to prevent the patient from behaving violently or being a danger to himself or others).

7. Before prescribing RT, it is necessary to be aware of potential drug naivety, differing pharmacokinetics in children and adolescents, and varying durations of response. Children and adolescents are more sensitive to all side effects of medication, in particular dystonia with antipsychotics and paradoxical excitation with benzodiazepines. Refer to appropriate physical risk assessment documentation whenever possible.
8. The most appropriate medicine for use in RT in children and adolescents is lorazepam; sedating antihistamines may also have a role in specific cases. Medication for naïve young people should be started at low doses which should not be repeated until there has been enough time to assess effect. NICE only recommends lorazepam in under 18s for RT.
9. No parenteral RT medication, even if prescribed on a prn basis, should be given to a child or adolescent without a doctor being informed, ideally prior to administration, but if this is not possible due to the urgency of the situation, then as soon as practical thereafter. Repeated doses should never be given parenterally without medical review.

13.3 USE of Medicines for Tranquilisation in People with a Learning Disability

The policy will apply to learning disability using the appropriate guidance to the age of the patient. Special consideration will need to be given to those with cerebral palsy as they may be at risk of postural deformities and hip dislocation. Additionally, there is a higher rate of undetected visual and hearing problems in the learning disability population and findings suggest that a high proportion of people with learning disabilities have an altered pain threshold. Many also carry an increased risk of certain health complications such as cardiac and respiratory disorders, which contribute to potential hazards associated with restraint. The choice between using physical intervention and rapid tranquilisation as a method of managing violent behaviour in those with a learning disability should be part of an overall care plan.

14.0 Implementation and Monitoring

Training

There are four components to the training that will be required for all staff involved in the administration, prescription, and monitoring of service users to whom RT has been administered. They are as follows:

14.1 Management of Actual and Potential Aggression (MAPA)

All staff whose need is determined by training needs analysis will receive on- going competency training to recognise anger, potential aggression, antecedents, and risk factors of disturbed/violent behaviour.

Training will include methods of anticipating, de-escalating, or coping with

disturbed/violent behaviour. (Management of Actual and Potential aggression – MAPA Training Strategy).

All inpatient staff should receive training to ensure current use of physical intervention, which adheres to approved national standards.

The training needs analysis will be reviewed annually, as a minimum, to identify those staff groups that require on-going professional training in the recognition, prevention and de-escalation of disturbed/violent behaviour and in physical intervention to manage disturbed/violent behaviour.

14.2 Resuscitation

All staff involved in administering or prescribing RT or monitoring service users to whom parenteral rapid tranquilisation has been administered, will receive on-going competency training to a minimum of in–hospital resuscitation (Resuscitation Council UK).

Staff who are involved in physical intervention or seclusion will also be trained to a minimum of Basic Life Support (Resuscitation Council UK).

14.3 Use of Medical Equipment

All staff (Band 5 and above) involved in administering or prescribing RT or monitoring service users to whom parenteral rapid use of pulse oximetry, vital signs monitoring and the use of Automated External Defibrillator with monitoring ECG leads in addition to existing training provision for current Resuscitation Equipment. This training will be undertaken in conjunction with the training provided for all other items of medical equipment that are included in resuscitation equipment. This training will be provided within the in- hospital resuscitation Training (Resuscitation Council UK).

14.4 Physical Health Training

The Trust Physical Health Day training which includes NEWS must also be completed.

15.0 Duties and Responsibilities

Roles	Responsibility
The Chief Executive	• To ensure that an appropriate and adequate infrastructure exists to support the provision of rapid tranquilisation policy amongst staff and patients throughout the organisation.
The Executive Director of Nursing and Quality and Medical Director	• For the strategic and operational management of the rapid tranquilisation policy. • To ensure the implementation of this policy is monitored and appropriate mandatory training is developed and accessed by relevant staff with their areas of responsibility.
Deputy Director of Medicines and MACE	• Monitoring safe and appropriate usage of medication.
Clinical Directors and Associate Clinical Directors	• To ensure that managers and Trust staff working in services who use RT are aware of the policy and promote good practice. • To ensure staff attend relevant training. • Provide support and guidance regarding resources and the consistent application of the policy and future practice recommendations. • To ensure that safe systems are in place to enable medical and nursing staff to work in accordance with the procedures referred to in the policy. • To implement the policy across their areas of responsibility and monitor the competence of nursing staff in applying the procedures referred to in the policy.
Quality Improvement Leads Nurses	• To ensure competency-based training and assessment packages are developed and available to inpatient staff and adherence to training is monitoring via the Trust Training information system. • Ensure within the area of responsibility the application of the rapid tranquilisation policy is adhered to and where necessary , action is taken to ensure compliance. • Monitor compliance of staff with training requirements and inclusion of RT in appraisals.
Authorised Prescribing staff	• To ensure they are familiar with the policy and be responsible for adhering to the procedures referred to in the policy.

	• Undertake appropriate mandatory training (Royal College of Psychiatry or Trust); • Take responsibility for adhering to the service specific prescribing recommendations in this policy and actions to take in the event of an adverse incident or suspected adverse drug reaction. • To assess the patient and ensure a drug history is available, wherever possible, including ascertaining any past allergies and drug reactions from the clinical notes • To conduct a mental state examination, assessment of physical health (including a ECH when possible) and ascertain a history of any physical health conditions before prescribing and administering any medication. • To always refer to the most recent British National Formulary (BNF) to check recommended drugs and dosages. • To consider any advance decisions/statements before prescribing. • To follow the guidance of the Mental Health Act Code of practice in relation to the use of RT and the mental Capacity Act. • To ensure that the nurse in charge is fully aware of any decisions regarding medication. • To ensure rationale for prescribing is documented within the patient's electronic care record; • Must be aware of their responsibility in relation to first response and the use of remedial measures.
Registered Nurses	• To ensure they are familiar with the policy and be responsible for adhering to the procedures referred to in the policy. • To ensure mandatory training is undertaken. • Provide support and information to patients, carers and their families with regards to the use of RT. • Adhere to the Trust Policies and the NMC Medicines Management Standards. • To ensure they are competent in all the clinical procedures required to implement this policy including first response training and appropriate use of equipment.

	• To assess risk and implement the policy when they feel it is appropriate. • To ensure that non-pharmacological (de-escalation) methods are tried first. • Monitor vital signs after the use of RT using the appropriate National Early Warning Score 2 (NEWS) guidelines. • To ensure maintenance and monitoring of practice standards and equipment is carried out as recommended. • To follow the guidance of the Mental Health Act Code of practice in relation to the use of RT and the mental Capacity Act. • To complete all relevant Rapid Tranquilisation documentation.
Clinical Pharmacy staff	• To ensure medicines for RT are prescribed accurately, unambiguously, and compliant with legal requirements and good practice standards. • To ensure medicines for RT and medicines to treat adverse effects are available on wards. • To check if patients prescribed RT have received or may potentially receive “high dose” antipsychotic therapy. • To check if medicines prescribed for RT interact with any regular medication the patient is taking. • To check that required monitoring is being done following administration of RT.
Ward Managers	• To ensure the policy and related procedures are adhered to. • To ensure that adequate training is given to allow staff to safely implement the guidelines. • To ensure compliance is audited. • To ensure Quality Improvement Lead Nurses are informed if the guidelines are not being adhered to appropriately.

Appendix 1 - The Neuroleptic Malignant Syndrome (NMS)

Neuroleptic Malignant Syndrome (NMS)

- Incidence - 0.5% - 1% patients.
- Mortality - (untreated) 20%.
- Onset may be acute or insidious.
- Course may fluctuate.
- May occur out of hospital.

Signs and symptoms

- Fever / Hyperthermia.
- Hypertension / autonomic instability (Fluctuating B.P).
- Tachycardia.
- Sweating.
- Incontinence / retention / obstruction.
- Muscular rigidity (may be confined to head and neck);
- Confusion / agitation.
- Varying degree of unconsciousness.
- Raised white blood cell count.
- Raised creatinine phosphokinase (CK).

Risk factors

- Organic brain disease, dementia, alcoholism.
- Hyperthyroidism.
- Parkinson's' disease.
- Dehydration.
- High dose of antipsychotic medication / recent dose increase.
- History of catatonia.

Treatment

- Withdraw the precipitating medicines immediately- antipsychotics, antidepressants, lithium, promethazine.
- Treat as a medical emergency – arrange emergency transfer to acute medical trust.
- Correct dehydration and hyperpyrexia- rehydrate, use ice packs.
- Control agitation with short-acting benzodiazepines.
- Dopamine antagonists: bromocriptine / dantrolene (can only be administered at acute trust).
- Antimuscarinic agents.
- Propranolol.
- General supportive intervention on a medical ward.

Training Needs Analysis for the policy for the development and management of Trust wide procedural / approved documents

Please tick as appropriate

There **are no** specific training requirements- awareness for relevant staff required, disseminated via appropriate channels. (Do not continue to complete this form-no formal training needs analysis required)	✓
There **are** specific training requirements for staff groups. (Please complete the remainder of the form-formal training needs analysis required-link with learning and development department.	

Staff Group	✓ if appropriate	Frequency	Suggested Delivery Method (traditional/ face to face / e-learning/handout)	Is this included in Trust wide learning programme for this staff group (✓ if yes)
Career Grade Doctor				
Training Grade Doctor				
Locum medical staff				
Inpatient Registered Nurse				
Inpatient Non-registered Nurse				
Community Registered Nurse				
Community Non-Registered Nurse / Care Assistant				
Psychologist / Pharmacist				
Therapist				
Clinical bank staff regular worker				
Clinical bank staff infrequent worker				
Non-clinical patient contact				
Non-clinical non patient contact				

Please give any additional information impacting on identified staff group training needs (if applicable)

Please give the source that has informed the training requirement outlined within the policy i.e. National Confidential Inquiry/NICE guidance etc.

Any other additional information

Completed by		Date	