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Date: 10th March 2026

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Reception: 0300 123 1535

Dear

Freedom of Information Act Request

I am writing in response to your e-mail of the 25th February 2026. Your request has been processed using the Trust's procedures for the disclosure of information under the Freedom of Information Act (2000).

Requested information:

Can I ask if the Rapid Tranquilisation Policy has been reviewed and if so can I request a copy of the latest one?

Please see Appendix 1 attached.

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	Chief Medical Officer
Authors details	Deputy Director of Medicines and Clinical Effectiveness Principal Clinical Pharmacist Trainee Advanced Nurse Practitioner

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

Approving meeting	Quality Committee	Meeting date	8 th January 2026
Implementation date	8 th January 2026	Review date	31 st January 2029

Trust documents to be read in conjunction with	
1.03	Medicines Policy
1.88	High Dose Antipsychotic Therapy Policy
1.98	Non-formulary/Off-label/Unlicensed Policy
13.24	Medication Monitoring Guidelines
1.62	Physical Health 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
1.55	Policy and Procedure for Advance Statements and Advance Decisions to Refuse Treatment
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 monitoring; clarification of roles and responsibilities. Clarifies the duty of the MDT in deciding to prescribe RT. Added relevant Health and Safety at work legislation to the 'Legal Considerations' section. Added a diagrammatic pathway and associate algorithms to summaries key information. Dialog changed to reflect changes with EPR and current auditing tools used	V2	
Appendices / electronic forms	Added Appendix 3 & 4	1	
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	The training requirements for staff are described in the Trust Training Needs Analysis (TNA). The process for monitoring attendance and compliance with the requirements of the TNA is described in the Trust Learning and Development Policy. A summary of the training requirements can be found below under the training section of the policy.
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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
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External references	
1. British Association for Psychopharmacology & The National Association of Psychiatric Intensive Care Units. (2018). <u>Joint BAP NAPICU Evidence-Based Consensus Guidelines for the Clinical Management of Acute Disturbance: De-Escalation and Rapid Tranquilisation</u>. Journal of Psychopharmacology. Available From: https://www.bap.org.uk/docdetails.php?docID=105. Last accessed 24.07.25. 2. British National Formulary (BNF) [online] Last accessed 24.07.25	

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12. Swift, H, Harrigan P, Cappelleri, C, et al. (2002) **Validation of the behavioral activity rating scale (BARS): A novel measure of activity in agitated patients**. *Journal of Psychiatric Resources* 36: 87–95.
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14. NICE QS154. (2017). **Violent and aggressive behaviours in people with mental health problems**.
15. Galletly C, Castle D, Dark F, et al. (2016). **Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for the management of schizophrenia and related disorders**. *Australian & New Zealand Journal of Psychiatry*. 50:410–472.
16. O'Connor N and Corish J. (2017). **Pharmacological management of acute severe behavioural disturbance: a survey of current protocols**. *Australasian Psychiatry*. ;25:395-398.
17. Garriga M, Pacchiarottia I, Kasper S, et al. (2016). **Assessment and management of agitation in psychiatry**: Expert consensus. *World Journal of Biological Psychiatry* 2016;17:86-128.

Acknowledgements to RT Policies received from other NHS Trusts during this review:

1. Procedure 27: Medicines Procedure: Rapid Tranquilisation. Surrey and Borders Partnership NHS Foundation Trust. Review date: Draft version in progress shared.
2. Clinical Policy: Drug Management of Violence and Aggression: Clinical Guideline and Policy. Derbyshire Healthcare NHS Foundation Trust. Review: date 2022.
3. Rapid Tranquilisation Policy: Acute Medical Treatment of Behavioural Crisis. Leicestershire Partnership NHS Trust. Review date: November 2025.
4. Clinical Protocol CP11: Rapid Tranquilisation: Protocol for the prescribing and administration of injectable drugs for rapid tranquilisation (RT), physical health assessment and monitoring, including prescribing guidelines on the drugs to be used for RT. Devon Partnership NHS Trust. Review date: July 2024.
5. Rapid Tranquilisation Policy (Adults & Older People). Version 8.0. East London NHS Foundation Trust. Review Date: May 2025.
6. CLIN-0014-v8.3: Rapid Tranquilisation (RT) Policy, including prescribing, post administration and remedial measures. Tees, Esk and Wear Valleys NHS Foundation Trust. Review date: March 2024.

Monitoring compliance with the processes outlined within this document	Reducing restrictive practice quarterly and annual reports that feed through CSIG and CEG. Rapid tranquilisation auditing carried out through quality assurance audits, Rapid Tranquilisation audit presented to CEG, competency documentation, supervision notes and PDRs, surveillance etc. Ulysses surveillance and MDT review.
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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) – Marriage and/or Civil Partnership (including heterosexual and same sex marriage) – 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	
	No	
	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	

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

Please tick as appropriate

There is 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 is 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 Trustwide 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.

Violence and aggression: short-term management in mental health, health and community settings, NICE Guideline [NG10].

Joint BAP NAPICU evidence-based consensus guidelines for the clinical management of acute disturbance: De-escalation and rapid tranquillisation.

Any other additional information

Completed by		Date	
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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 tranquillisation (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 content of this clinical policy and procedure is substantially based on [NICE NG10](#) "Violence and aggression: short-term management in mental health, health and community settings" (2014), available at <https://www.nice.org.uk/guidance/ng10> . It is also further informed the Maudsley Prescribing Guidelines in Psychiatry (14th Edition) and the BAP/NAPICU consensus guideline on the clinical management of acute disturbance (2018): https://www.bap.org.uk/pdfs/BAP_Guidelines-RapidTranquillisation.pdf .

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 individual's risk assessment and accompanied by an up-to-date intervention plan. Within seven days of an incident of violence or aggression the intervention plan should be updated to reflect triggers or early warning signs, outline actions to manage future episodes of acute behavioural disturbance and reflect the patient's preferences and wishes for future care.

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 as part of a formulated short-term management strategy to reduce the risk of harm to the service user, other service users and staff, whilst respecting the individual's right to treatment that is neither punitive nor humiliating / degrading. In the management of acute agitation or aggression the administration of medicines using the parental route (usually intramuscular) is termed Rapid Tranquillisation (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 the aforementioned 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 qualified medical and nursing staff employed by North Staffordshire Combined NHS Trust (NSCHT), this includes all healthcare staff contracted or seconded to the Trust who are involved in the prescribing or administration of Rapid Tranquillisation (RT).

This policy applies to service users who are in-patients in the following services:

- Acute Adult Mental Health
- Child and Adolescent Services (applies to children over the age of 12 years of age)
- Learning Disability Services
- Older Persons Services

RT will not be regularly used within Community teams, 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. Glossary of Terms

Tranquillisation	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.
Rapid Tranquillisation	The use of medication by the parenteral route (usually intramuscular or, exceptionally, intravenous) if oral medication is not possible or appropriate and urgent sedation with medication is needed' (NICE NG10), to help calm a person who is extremely distressed and is at risk of harm to themselves, or possibly those around them. Please note that, in line with NICE NG10, <i>the term rapid tranquilisation no longer incorporates the use of oral medicine(s)</i> for the management of agitation or aggression.

Non-urgent Tranquillisation	Tranquilisation using orally administered medicine(s). This should be used in preference to rapid/urgent tranquilisation whenever possible
PRN dose	(Pro re nata/when required) Medicines that are used when required. PRN medication can be used as part of de-escalation but medication used alone is not de-escalation.
Stat dose	Medication prescribed as a single one-off dose
De-escalation	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 - NG10). De-escalation techniques should be used prior to the use of RT.
Restrictive Intervention	Interventions that may infringe a person's human rights and freedom of movement, including rapid tranquillisation
Seclusion	Defined in accordance with the Mental Health Act 1983 Code of Practice: "the supervised containment of a patient in a room, which may be locked. Its sole aim is to contain severely disturbed behaviour that is likely to cause harm to others."
Violence and aggression	A range of behaviours or actions that can result in harm, hurt or injury to another person, regardless of whether the violence or aggression is physically or verbally expressed, physical harm is sustained or the intention is clear (NG10).
Neuroleptic naïve	A person who has not previously been treated with an antipsychotic (neuroleptic).
Dystonia	A neurological movement disorder, presenting as sustained muscle contractions, twisting and repetitive movements or abnormal postures.
Extrapyramidal side Effects (EPSE)	A group of symptoms that can occur in persons taking antipsychotic medications e.g., tremor, akathisia, slurred speech, dystonia, bradykinesia, muscle rigidity.

Advance decision	A written statement made by a person aged 18 or over that is legally binding and conveys a person's decision to refuse specific treatments and interventions in the future.
Advance statement	A written statement that conveys a person's preferences, wishes, beliefs and values about their future treatment and care. An advance statement is not legally binding.
Senior Doctor	A consultant psychiatrist or a specialty doctor in psychiatry
Due regard	Having due regard for advancing equality involves: • Removing or minimising disadvantages suffered by people due to their protected characteristics. • Taking steps to meet the needs of people from protected groups where these are different from the needs of other people. • Encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low.
NEWS2	The National Early Warning Scoring tool was developed by the Royal College of Physicians; it improves the detection and response to clinical deterioration in adult patients and is a key element of patient safety and improving patient outcomes. Observations should be taken and recorded on the NEWS form within EPR
Non-contact Physical Observations	Patients may decline or not engage with contact observations being taken. In this situation observations should be taken and recorded with a non-contact technique and recorded on the non-contact observation form within EPR. The patient must be asked every time observations are due if they will allow contact observations to be taken, non-contact observations should be used as an exception.
PEWS	The Paediatric Early Warning Score tool was collaboratively developed by clinical teams across England to standardise the approach of tracking the deterioration of children in hospital settings.
EPMA	Electronic Prescribing and Administration System.

5. 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'.
- Mental Health Units (Use of Force) Act 2018 which defines "Chemical Restraint" as the use of medication that is intended to prevent, restrict, or subdue movement of any part of the patient's body. This includes the use of rapid tranquillisation (see NICE guideline [NG10], Violence and aggression: short-term management in mental health, health and community settings).
- The Health and Safety at Work Act 1974, which place duties on both employers and employees, and applies to the risk of violence from patients and the public.
- The Management of Health and Safety at Work Regulations 1999, which place specific duties on the employer to ensure suitable arrangements for the effective planning, organisation, control, maintenance and review of health and safety (these duties include ensuring that the risk assessments are undertaken and implemented).

It is also important to ensure that any developing situation, or positive intervention takes into account the individual needs of the patient in relation 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
- gender assignment e.g. (are some members of staff who are restraining of the same sex)
- patients with communication difficulties
- frail / older patients

Procedure Section

6. Roles 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. - To support the positive and safe approach to care and Rapid Tranquillisation and ensure this is only be considered when other non-restrictive interventions have been offered.
The Chief Nursing & Quality Officer and Chief Medical Officer	- 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 within their areas of responsibility.
Clinical Directors and Associate 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. - Ensure that resources are available for the following equipment in any environment where rapid tranquillisation maybe required (including ECG machines, Resuscitation equipment). - 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. - To ensure competency-based training and assessment packages are developed and available to inpatient staff and adherence to training is monitored.
Quality Improvement Leads Nurses	- 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.
All Clinical Staff involved in RT	- To familiarise themselves with this policy - Should be suitably trained and competent to carry out their professional duties and to assess and manage potential

	and actual violence using de-escalation techniques, restraint, seclusion and RT as appropriate. • If involved in physically restraining service users' staff must be proficient in violence and restrictive practices reduction techniques and should have adequate immunisation against hepatitis B. • Should be trained to use and maintain the techniques and equipment required to undertake cardiopulmonary resuscitation. • Have awareness of responsibilities for post RT monitoring on epr • Should ensure that following an emergency restraint and medication a short feedback session is held, and that the patient is debriefed. • Should have understanding of application of the Human Rights Act 1998, the Mental Capacity Act 2005 and the Mental Health Act 1983.
Consultant Psychiatrists	• To understand the policy requirements as it relates to their areas of service and be responsible for the implementation of the policy within their scope of leadership and management. • To liaise with local tutors to identify and support the RT training needs of their junior grade doctors through training programs, supervision, appraisal and the PDP process, and will reflect these in staff training plans. • Review individuals who are being prescribed or have had administered RT at MDT and when clinically appropriate. • Review level of physical health monitoring for those requiring RT and give instruction clearly to the team (verbally and as a written record in EPR) where monitoring may deviate from the Trust guidelines.
Authorised Prescribing staff	• Prioritising attendance to the ward to undertake a full assessment, including consideration of medical and psychiatric differential diagnosis, physical examination and any known advanced directives. • Prioritising attendance to the ward to undertake a full assessment, including consideration of medical and psychiatric differential diagnosis, physical examination and any known advanced directives. • 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.

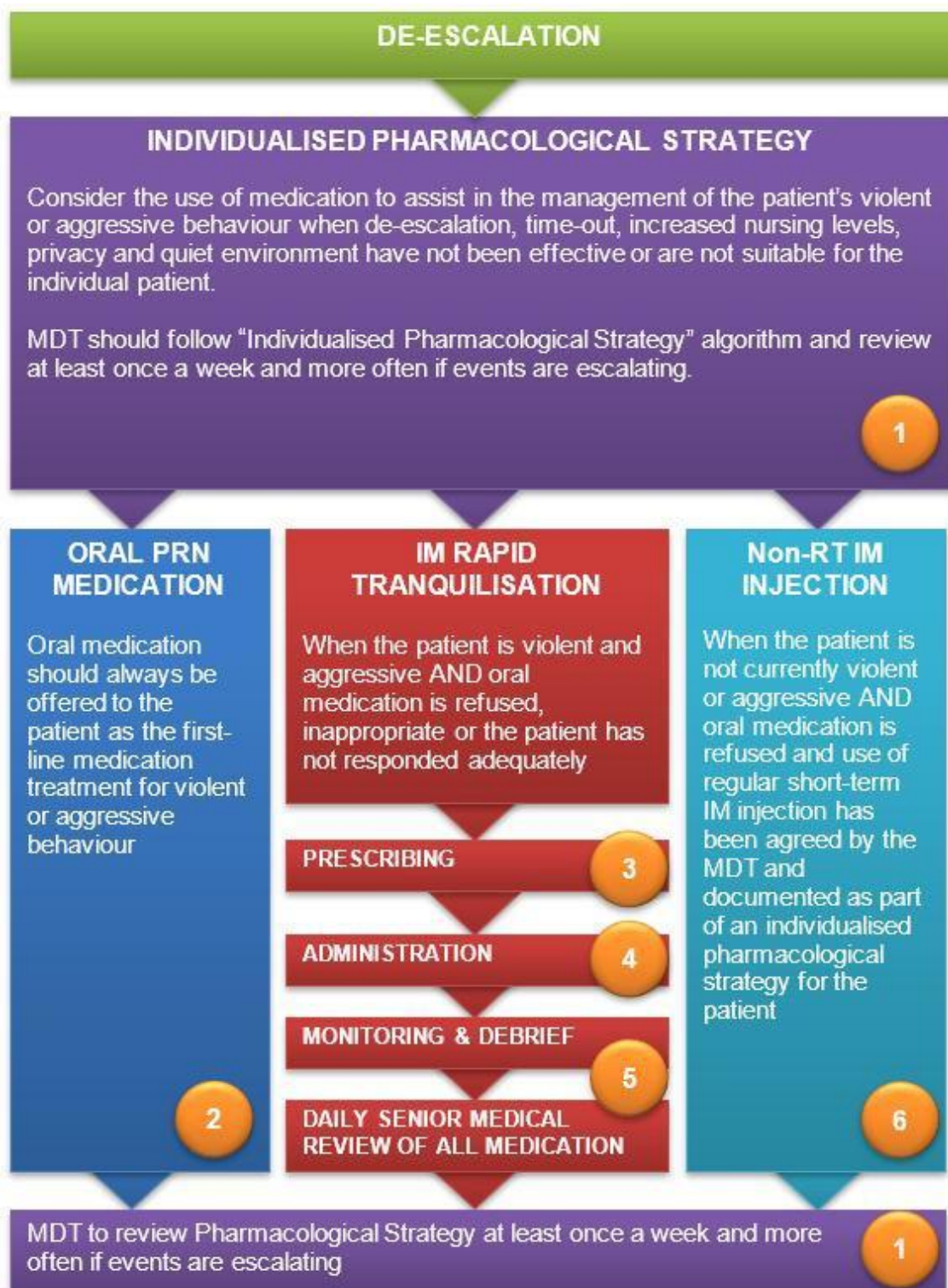
	• When prescribing medication for use in rapid tranquillisation, write the initial prescription as a single dose, and do not repeat it until the effect of the initial dose has been reviewed. • Competently prescribing and administering emergency medication and monitoring for possible side effects associated with rapid tranquillisation medication. • Good prescribing practice which includes: • To conduct a mental state examination, assessment of physical health (including an ECG when possible) • discontinuing any potentially unhelpful medication • simplifying regimens, including therapeutic duplication • agreeing a suitable therapeutic goal e.g., level of sedation/control • giving consideration to previous medicines and response • being aware of the total dose and combination of medications taken in last 24 hours; including illicit drugs • documenting a risk benefit analysis in patients' electronic patient record (EPR) if antipsychotic doses in a 24-hour period will exceed 100% of BNF maximum doses (refer to the Trust's High Dose Antipsychotic Procedure) • consider medical history and risk factors. • Ensuring prescribed treatment is in line with the requirements of the Mental Health Act or Common Law, including the consent to treatment forms where applicable. • Liaising with the nurse in charge to ensure care is coordinated for the safe administration of medication for rapid tranquillisation. • Liaising with the nurse in charge to ensure the treatment plan includes monitoring of the person using our services for side effects or adverse complications. • Liaising with the nurse in charge to ensure post rapid tranquillisation monitoring is completed. • Inform the appropriate consultant of any concerns or complications. • To refer to the most recent British National Formulary (BNF) if unsure of recommended drugs and dosages. • To consider any advance decisions/statements before prescribing. • To ensure rationale for prescribing is documented within the patients' 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 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. • Familiar with the risks associated with treatment. • 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 maintenance and monitoring of practice standards and equipment is carried out as recommended. • To ensure that non-pharmacological (de-escalation) methods are tried first. • Ensure the medication is prescribed and administered according to the medication algorithm. • Ensure the required monitoring and remedial measures are performed according to the procedure below. • Thoroughly document in the individuals EPR a comprehensive account of the circumstances resulting in the need for RT; techniques used, offering of oral medication, subsequent actions and proposed follow-up. • Complete a Ulysses incident form for each time IM medication has been administered. • Arrange an immediate post incident debrief for staff. • Ensure the person using our services has a post incident debrief and an opportunity to write his or her own account of the event in their EPR. Record if this is declined. The person using our services account should be used for reflection by the multidisciplinary team and to document the person using our services' choice for any future events in the person using our services' care plan.
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. • Ensure staff present are able to provide immediate life support, in accordance with the Resuscitation Policy, should the need arise. • Ensure an emergency trolley is readily available within 3 minutes, and contains the equipment listed in the Resuscitation Policy and has been checked in line with the policy. • Ensure staff are familiar with the risks associated with treatment. • Ensure prescribed medication is available including emergency medication for the treatment of possible side effects. • To ensure compliance is audited. • To ensure Quality Improvement Lead Nurses are informed

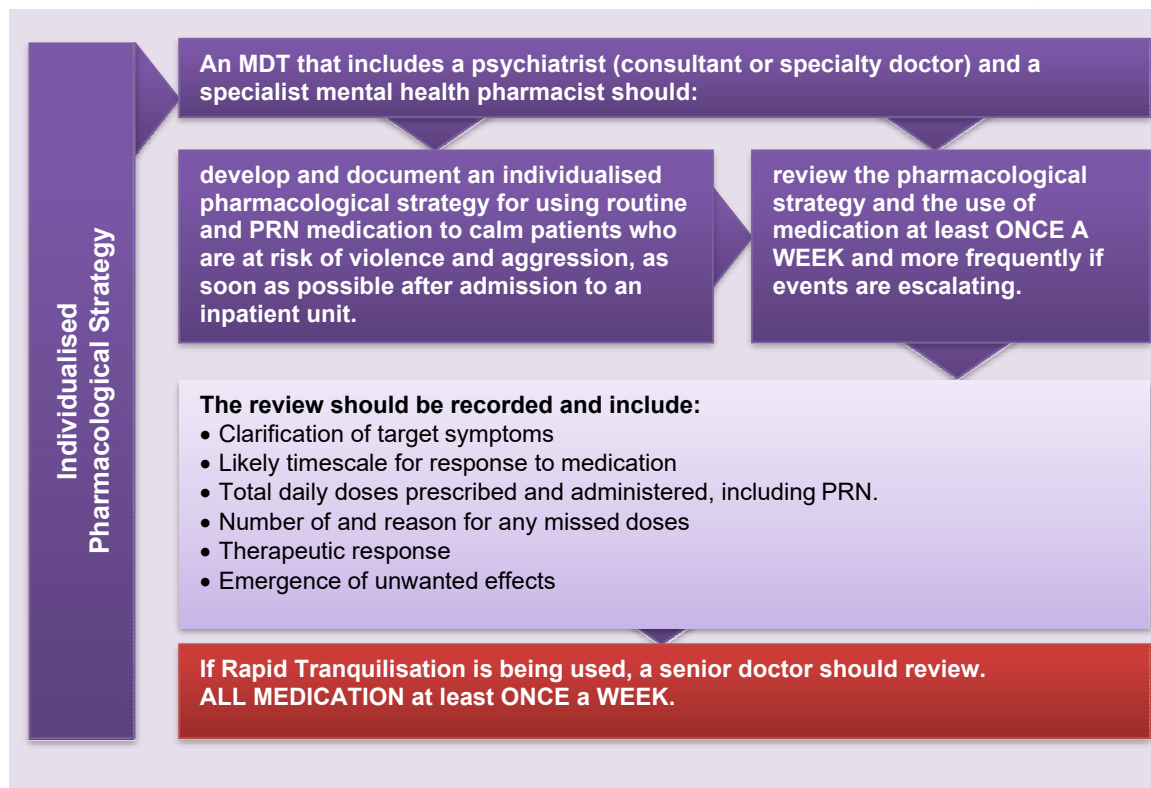
	if the guidelines are not being adhered to appropriately.
Clinical Pharmacy staff	• Working together with the multidisciplinary team and people using our services to develop individualised pharmacological care plans for routine and PRN medication. • Weekly review of individual pharmacological care plans with the multidisciplinary team. • Clinical screening of pre-written prescriptions for RT medication to ensure they are at the right dose, right medicine, right route and right form. • Clinical screening of medication charts for RT to ensure medicines are prescribed as a single stat dose and not repeated until the effect of the initial dose has been reviewed by a medical doctor, and MDT agree as part of care management plan to prescribe as PRN. • Clinically screening prescriptions to identify actual and potential High Dose Antipsychotic treatment (HDAT) and/or above maximum BNF doses of benzodiazepines. • To check that required monitoring is being done following administration of RT. • To check that prescribed medication is included in MHA consent to treatment documents where applicable.
Healthcare Support Workers	• Be suitably trained and competent to assess and manage potential and actual violence using de-escalation techniques, restraint, and seclusion (where appropriate). • Ask nursing colleagues and doctors for advice when necessary. • Must report any concerns around vital signs or changes in the patient's condition after IM RT to a qualified nurse. • Should be trained and competent to use and maintain the technique and equipment required to undertake cardiopulmonary resuscitation.

7. Procedure Flowchart and Algorithms

Pathway: use of medicines in the prevention and management of violence and aggression



Individualised Pharmacological Strategy Algorithm



Prescribing IM injections for a patient with a bleeding disorder or who are prescribed an anticoagulant

Individuals with a bleeding disorder or who are receiving anticoagulant therapy have an increased risk of bleeding and deep muscle haematoma when intramuscular (IM) injections are given.

- It is difficult to quantify the exact risk of developing a haematoma.
- Other options should be considered before any IM injection is prescribed.
- The risks and benefits of giving the IM injection should be discussed and documented; and wherever possible the patient or family should be advised about the risk of haematoma formation following the injection.
- If the patient has a bleeding disorder, consider seeking advice from the clinician who manages their condition before deciding to prescribe medication as an IM injection.
- If the decision is taken to prescribe an IM injection, inform relevant team members of the risk. For steps to minimise the risk, see the "Administration" section below, however prescribers should bear in mind that post-injection measures to minimise risk may be impractical in the case of a physically agitated person.

Oral PRN Prescribing Algorithm

See section 9.2.

Oral PRN
Medication

DO NOT PRESCRIBE PRN ROUTINELY OR AUTOMATICALLY ON ADMISSION

- Ensure there is clarity about the **rationale and circumstances** in which PRN medication may be used and that these are **documented** in the EPR
- Consider any **MHA consent to treatment** issues (T2/T3/S62)
- Tailor PRN medication to **individual need** and include discussion with the patient if possible
- Specify the **minimum interval** between doses
- Specify the **maximum daily dose** and take care that this is not exceeded when combined with regular or other medication
- Only exceed the BNF maximum daily dose if this is planned to achieve a therapeutic goal, is documented and is carried out under **the supervision of a senior doctor**

Trust recommendations for oral PRN medication:

- Oral lorazepam
- Oral promethazine
- Oral risperidone
- Oral olanzapine

BEFORE administering medication prescribed for the management of violence and aggression the nurse must:

- Ensure less-restrictive techniques have been attempted and documented
- Consider physical health issues and whether medical advice is needed
- Review consent issues, particularly if detained under the Mental Health Act
- Review any advance statements and advance decisions
- Consider the effect of any recent medication or the use of alcohol or illicit substances

Document the patient's activity and alertness, 1 hour after administration of oral PRN. **If there are clinical concerns, follow the guidance for monitoring after rapid tranquillisation**

The MDT should review the pharmacological strategy and the use of medication at least **ONCE A WEEK** and more frequently if events are escalating (see above). If multiple doses of PRN medication are being used, consider starting a regular prescription

Rapid Tranquilisation Prescribing Algorithm

PRESCRIBING PROCESS (see section 9.2 & 9.8)

Consider:

- The person's preferences or advance statements or decisions
- Pre-existing physical health problems or pregnancy
- Possible intoxication
- Previous response to medication including adverse effects
- Potential for interaction with other medications or illicit substances
- The total daily dose of medications prescribed and administered
- Any MHA consent to treatment restrictions (T2/T3/S62)
- Bleeding disorders or co-prescribed anticoagulants

- If there is insufficient information to guide the choice of medication, or if the person has not taken antipsychotic medication before, use IM LORAZEPAM.
- If there is evidence of cardiovascular disease, including a prolonged QT interval, or no ECG has been carried out, use IM LORAZEPAM

Write the initial prescription as a "once only" dose and do not repeat it until the effect of the initial dose has been assessed. Document your actions.

Prescribe either:

Lorazepam IM

OR

Haloperidol IM* +
Promethazine IM

Assess response after an appropriate interval

Inadequate/None	Partial	Responded
Consider the alternate treatment above if clinically appropriate	Consider 2 nd dose of same medication	Post-incident debriefs

If neither **IM lorazepam** or a **combination of IM haloperidol and IM promethazine** is effective or suitable then arrange an urgent team meeting to carry out a review and seek a second opinion if needed

PRESCRIBING ADVICE

Medication	IM Dose	Minimum interval	BNF Max. in 24 hours	if elderly, frail or sensitive to medication:	
				Suggested starting dose	Suggested initial max. daily dose
Lorazepam	2mg	1 hour	4mg	0.5-1mg	2mg
Haloperidol with Promethazine hydrochloride	Up to 5mg With Up to 50mg	2 hours	20mg And 50mg	2.5mg With 25mg	5mg and 50mg

*An ECG is recommended before prescribing haloperidol or promethazine.

A senior doctor must document approval for the use of haloperidol in the absence of an ECG

More detailed advice and guidance on other intramuscular medication options is provided in Appendix 1 of the policy.

BEFORE administering medication prescribed for the management of violence and aggression the nurse must:

- Ensure less-restrictive techniques have been attempted and documented
- Consider physical health issues and whether medical advice is needed
- Review consent issues, particularly if detained under the Mental Health Act
- Review any advance statements and advance decisions
- Consider the effect of any recent medication or the use of alcohol or illicit substances

The administration of IM rapid tranquilisation is a **RESTRICTIVE PRACTICE** and must be reported on **Ulysses** on every occasion

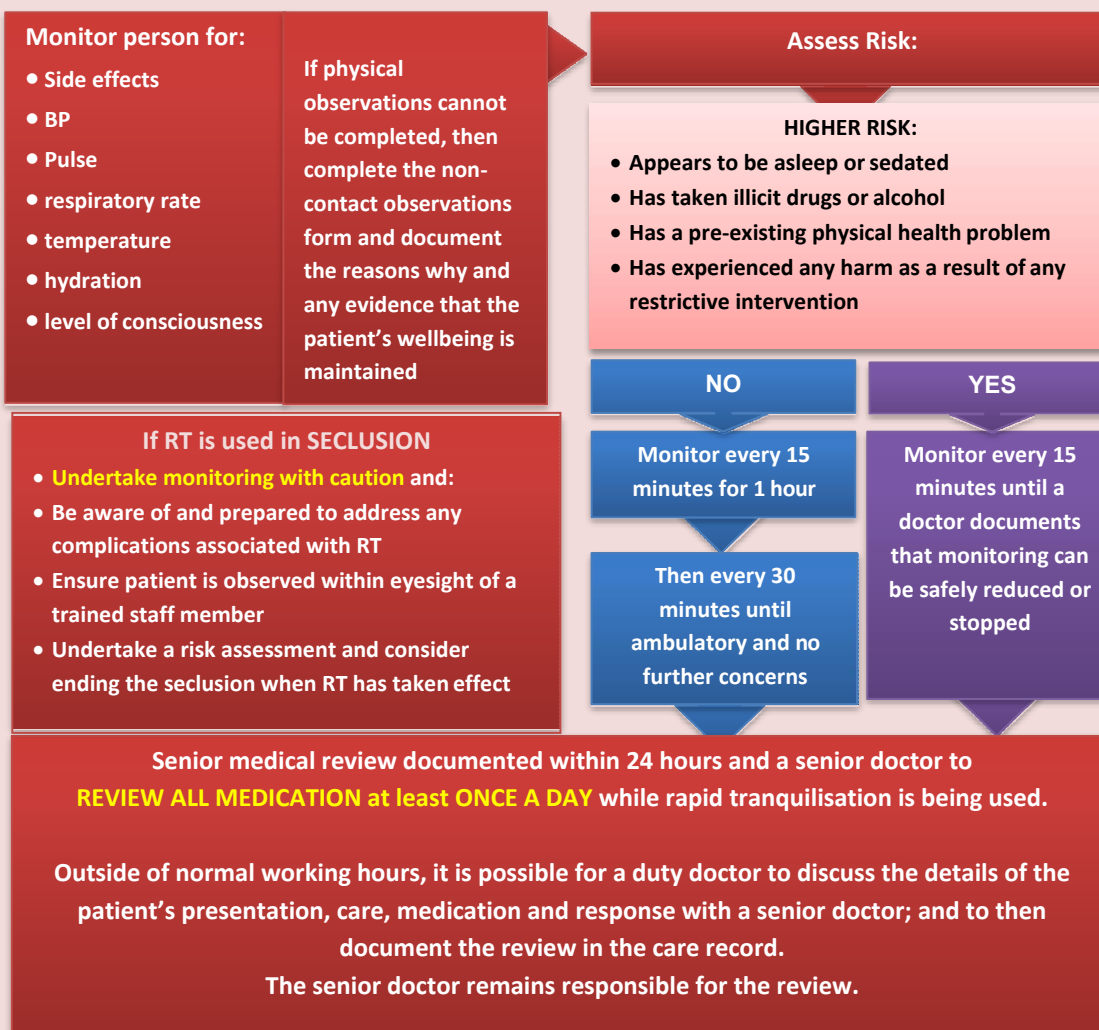
If the patient has a **BLEEDING DISORDER** or is prescribed an **ANTICOAGULANT**

- Apply firm pressure to the injection site for at least 2 minutes after injecting; to aid clotting
- Do **not** rub or massage the injection site

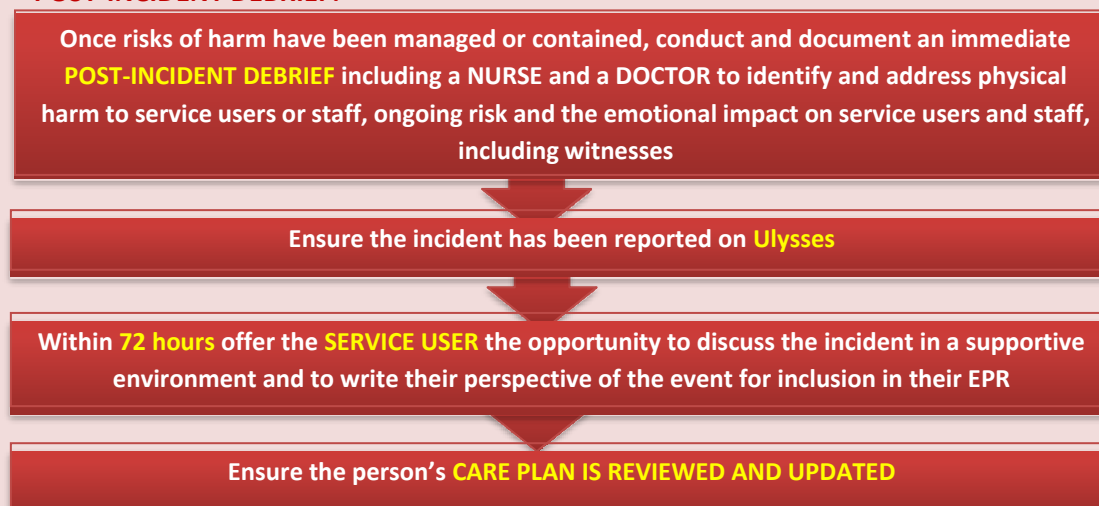
If nursing staff feel that the steps described would be impractical to implement for a particular person, this must be discussed with the prescriber and a risk assessment documented **before** administering the injection.

Rapid Tranquilisation Monitoring and Debrief Algorithm

MONITORING: Rapid tranquilisation monitoring form is within the EPR



POST-INCIDENT DEBRIEF:



Non-RT IM injection algorithm

PRESCRIBING AND REVIEW OF NON-RT SHORT-ACTING IM INJECTIONS:

It will rarely be the case that medication is administered through the IM route as part of plan to maintain routine treatment and prevent aggression, violence or distress.

Non-RT IM medication must be prescribed as part of an individualised pharmacological strategy agreed by an MDT that includes a senior doctor and a specialist pharmacist. The specific reason for favouring IM over oral administration must be documented.

Prescriptions should be regular, or PRN to be used when a regular oral dose is declined by the patient

Consider bleeding disorders or co-prescribed anticoagulants before prescribing an IM injection

Review non-RT IM prescriptions and their rationale at least once a week as part of the documented MDT review of the patient's individualised pharmacological strategy as described in the "Regular and PRN medication algorithm"

POST-INJECTION MONITORING:

Monitor person for:

- Side effects
- BP
- Pulse
- respiratory rate
- temperature
- hydration
- level of consciousness

If physical observations cannot be completed then document the reasons why, complete non-contact observations form and document any evidence that the patient's wellbeing is maintained

Monitor the patient ONE HOUR after administration and repeat monitoring if there are concerns

Document monitoring and any concerns in the patient's care record (EPR)

Do **NOT** complete a Ulysses specifically for this type of administration

The use of non-RT IM medication in the management of violence and aggression will not form part of the audit of IM RT

8. Procedure Statement

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 innertension.
- When determining which interventions to employ, clinical need, safety of service users and others, and where possible advance decisions, should be considered.
- Where appropriate the patient should be offered oral medication (non-urgent tranquilisation) in the first instance as per [Algorithm 2](#). If the patient refuses oral medication but is not currently violent and aggressive follow Non-RT IM Injection [Algorithm 6](#), accompanied by monitoring as outlined in [Algorithm 5](#). However, if the risks associated with violence and aggression are escalating such that, for safety reasons, the intramuscular (IM) route is deemed necessary, then follow [Algorithms 3 and 5](#).

NOTE: Culminative doses of both PRN and IM over the preceding 24 hours must be carefully calculated before administration as failure to do so may lead to an overdosing error.

- The aim of RT is not to treat any underlying illness or disorder. Instead, RT should be used as a short-term 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.
- 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, the duty doctor must be informed that RT has been used as soon as possible.

9.0 Procedure / Process

9.1 Nursing Considerations

Non-Pharmacological Interventions

Nursing staff should ensure that the following measures have been fully utilised before the use of pharmacological interventions. Please refer to the Trust Policy on the use and reduction of restrictive interventions, for further information.

9.1.1. De-escalation

Staff should ensure that a patient-centred approach is taken during de-escalation and should always utilise appropriate defusing techniques. These include:

- Speaking clearly and calmly.
- Avoid reacting to abusive remarks.
- Listening carefully to what is being said.
- Explaining the consequences of continued aggressive/violent behaviour.
- Using open gestures.
- Avoiding confrontational situations.

9.1.2. Physical restraint

Employ physical restraint or 'holding' as little as possible i.e., use restraint only as a last resort, and when necessary. The minimum amount of force necessary should be employed for the shortest amount of time possible when carrying out physical restraint. The force used should only be of a degree proportional to the actual danger or resistance shown by the violent individual. Continue to utilise defusing techniques.

9.1.3. Seclusion

Seclusion may be used as a last resort to prevent injury to others after all other methods of managing violent incidents have been deemed to be ineffective by the nurse in charge of the ward. The seclusion must occur using the approved seclusion suite or a designated side room.

9.2 Legal Considerations - [See section 5 above.](#)

9.3 Risk Assessment and engagement Considerations

Risk assessments

The presence of an accurate and comprehensive current risk assessment as part of a care management plan is central to the prediction and management of future episodes of agitation or disturbance. Please refer to the Trust's 'Clinical Risk Assessment Policy' for further information. The management of the identified risk variables should be clearly documented in the care management plan, as should any discussion with the individual regarding the treatment of such behaviour, especially those discussions relating to pharmacological agents.

Advance Directives and Decisions

Check whether any advance decision to refuse treatment, advance statement or specific management plan is in place that may affect the choice of medication. This should have been documented in the patient's Electronic Patient Record (EPR). See Trust 'Policy and Procedure for Advance Statements and Advance Decisions to Refuse Treatment' for further information on Advance Statements and Advance Decisions.

If an individual has not made any advance decisions or statements about the use of restrictive interventions, encourage them to do so as soon as possible (for example, during admission to an inpatient psychiatric unit). Ensure that individuals understand the main side-effect profiles of the medications recommended in this policy so that they can make an informed choice.

Involvement and engagement

Involve individuals in all decisions about their care and treatment and develop care and risk management plans jointly with them. If an individual is unable or unwilling to participate, offer them the opportunity to review and revise the plans as soon as they are able or willing and, if they agree, involve their carer.

Ensure that individuals understand that during any restrictive intervention their human rights will be respected, and the least restrictive intervention will be used to enable them to exercise their rights (for example, their right to follow religious or cultural practices during restrictive interventions) as much as possible. Identify and reduce any barriers to an individual exercising their rights and, if this is not possible, record the reasons in their notes.

9.4 Assessment of Physical Health

The multidisciplinary team should always refer to the service user's most current physical health assessment or if unavailable, the prescriber should make as thorough a physical health assessment as is possible at the time of prescribing, taking into consideration any known physical health co-morbidities, recent tests/examinations (e.g. U & Es, LFTs, FBC, Urine drug screen, ECG) and the current physical presentation e.g. dehydration, intoxication.

Neuroleptic naivety: A service user's intra-muscular (IM) psychotropic naivety should be considered when choice and dose of oral or parenteral RT medication is made.

9.5 ECG Monitoring

Due to the risk of prolongation of the QTc interval with antipsychotics, ECG and hematological monitoring are also strongly recommended when parenteral antipsychotics are given, especially if using higher doses. On the ECG, a prolonged QT interval is an indicator of increased cardiac risk with antipsychotics. A QT interval which increases following the introduction of an antipsychotic drug is also a risk indicator. However, a normal ECG does not mean that RT with an antipsychotic drug is a low-risk procedure. ECGs can provide useful additional assessment of the risks of administering antipsychotic drugs. Ideally, all patients being admitted to a clinical area where RT including antipsychotics, could potentially be used, should have an ECG when this is practicable. Attempting to perform an ECG on an agitated uncooperative patient is, however, inadvisable.

Hypokalemia, stress, and agitation place the person using our services at risk of cardiac arrhythmias.

See Appendix 3 for information about medications and the effects on QT interval.

9.6 RT Prescribing Considerations - See Algorithm 3.

When prescribing medication for use in rapid tranquilisation, the initial prescription should be as a single dose and not repeated until the effect of the initial dose has been reviewed.

The prescriber should clearly highlight that the medication prescribed is for RT. This medication should not form part of a therapeutic treatment plan for a pre-existing condition.

Prescribers are responsible for the prescribing decision made:

- Prescribing decisions must be documented in the patient's care record including their rationale.
- Decisions must be made in the patient's best interests and take into account the patient's health and known history.
- The policy expects (in line with NG10) that prescribers will use a medicine's summary of product characteristics (SPC) to inform decisions made with individual service users. SPCs can be found on-line at www.medicines.org.uk.
- The guidance within the policy recommends some medicines for indications for which they do not have a UK marketing authorisation (licence). Prescribers should follow relevant professional guidance, taking full responsibility for the decision to use a medication in this manner. For further advice see the Trust's Medicines Code and the General Medical Council's Prescribing Guidance: prescribing unlicensed medications.

9.6.1 Review the patient and their history before prescribing

- Attempt a physical examination – where the patient refuses or resists physical examination this must be clearly documented in the patient's EPR.
- Review the patient's care record with regards to their:
 - General medical history
 - Pre-existing physical health problems or pregnancy
 - Recent investigations, particularly ECG, baseline electrolytes and recent results of urine drug screening (UDS)
 - Previous response to medication, including side effects such as severe extrapyramidal, side effects or antipsychotic naivety, previous response to RT or other methods of managing imminent violence.
 - Other methods of managing violence and aggression that have previously been successful.
 - Current prescription, taking note of recent administration of acute "PRN" and "Once Only" medication.
 - Check baseline NEWS observations.
 - Consent issues and any restrictions due to the Mental Health Act (e.g. T2, T3 or S62 documentation).
 - Relevant advance statements or advance decisions.

9.6.2 When prescribing PRN medication as part of a strategy to de-escalate or prevent situations that may lead to violence and aggression (NICE NG10 1.3.10): (reference Pathway)

- Do not prescribe PRN medication routinely or automatically on admission
- Tailor PRN medication to individual need and include discussion with the patient where possible

- Ensure there is clarity about the rationale and circumstances in which PRN medication may be used and that this is documented in the patients record
- Ensure that the maximum daily dose is specified and does not inadvertently exceed the maximum dose stated in the British National Formulary (BNF) when combined with the patient's standard dose and/or their dose for Rapid Tranquilisation
- Only exceed the BNF maximum daily dose if this is planned to achieve an agreed therapeutic goal, documented and carried out under the direction of a senior doctor
- Ensure the interval between PRN doses is clearly specified
- Ensure the daily maximum of all formulations is clearly specified.

9.6.3 When prescribing intramuscular medication for rapid tranquilisation (NICE NG10 1.4.37 – 1.4.44)

- Write the initial prescription as a single dose and do not repeat it until the effect of the initial dose has been reviewed.
- Use either intramuscular lorazepam on its own or intramuscular haloperidol combined with intramuscular promethazine for rapid tranquilisation in adults.
- When deciding which medication to use take into account:
 - The patient's preference or advance statements and decisions
 - Pre-existing physical health problems or pregnancy
 - Possible intoxication
 - Previous response to these medications, including adverse effects
 - Potential for interaction with other medications
 - The total daily doses of medications prescribed and administered
- If there is insufficient information to guide the choice of medication for rapid tranquilisation, or the service user has not taken antipsychotic medication before, use intramuscular lorazepam.
- If there is evidence of cardiovascular disease, including a prolonged QT interval, or no ECG has been carried out, avoid intramuscular haloperidol combined with intramuscular promethazine and use intramuscular lorazepam instead.
- If there is a partial response to intramuscular lorazepam, consider a further dose.
- If there is no response to intramuscular lorazepam, consider intramuscular haloperidol combined with intramuscular promethazine.
- If there is a partial response to intramuscular haloperidol combined with intramuscular promethazine, consider a further dose.
- If there is no response to intramuscular haloperidol combined with intramuscular promethazine, consider intramuscular lorazepam if this has not been used already during this episode. If intramuscular lorazepam has already been used, arrange an urgent team meeting to carry out a review and seek a second opinion if needed.
- Be guided by the clinical guideline attached to this policy and document any actions taken including the reasons for deviation from the clinical guideline

- Before prescribing haloperidol, check that the patient's cardiac risk including reference to a recent ECG and QTc interval. Where an ECG is not available consider the risks and benefits and be able to justify a decision to prescribe haloperidol, because it may be considered an off-label use.
- Refer to Trust guidance on High Dose Antipsychotic Therapy (HDAT) if prescribing will result in antipsychotics being used individually or in combination in excess of 100% of BNF maximum
- Refer to relevant Trust guidance if medication is to be administered covertly
- Complete mandatory education and training including that on the use of medication in violence and aggression
- Ensure Ulysses is used to record any incidents or use of restrictive practices

9.6.4 Senior Doctor Oversight

Senior doctors include consultant psychiatrists and specialty doctors in psychiatry

In addition to “prescriber” and “doctor” duties:

Senior doctors are responsible for reviewing the prescribing, use and monitoring of medication in their local area of responsibility and for ensuring each patient has an appropriate plan of treatment.

- Review patients who have “rapid tranquilisation” administered within 24 hours and daily while IM administration is required, and ensure this is documented
- Where the senior medic staff for the relevant ward is not available, such as at weekends, a review should be completed by an available senior doctor. The policy does not mandate the attendance of the senior doctor however they are responsible for the effectiveness and quality of the review.
- Review patients prescribed PRN medication for the management of violence and aggression at least once a week as part of an MDT that includes a specialist pharmacist
- Review the prescribing, use and monitoring of medication in their area of responsibility
- Ensure supervised professionals are aware of the expectations of their role

9.7 Treatment Options - See algorithm 3

9.7.1 Factors Influencing treatment option

Additional considerations for a patient with a bleeding disorder or who are prescribed an anticoagulant:

Individuals with a bleeding disorder or who are receiving anticoagulant therapy have an increased risk of bleeding and deep muscle haematoma when intramuscular (IM) injections are given.

- It is difficult to quantify the exact risk of developing a haematoma.
- Other options should be considered before any IM injection is prescribed.
- The risks and benefits of giving the IM injection should be discussed and documented; and wherever possible the patient or family should be advised about the risk of haematoma formation following the injection.
- If the patient has a bleeding disorder, consider seeking advice from the clinician who manages their condition before deciding to prescribe medication as an IM injection.
- If the decision is taken to prescribe an IM injection, inform relevant team members of the risk. For steps to minimise the risk, see the “Administration” section below, however prescribers should bear in mind that post-injection measures to minimise risk may be impractical in the case of a physically agitated person.

9.7.2 Choice of intramuscular antipsychotic (see BNF for dosing information)

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 Appendix 1). When deciding which medication to use, consider:

- 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 using IM Lorazepam.

Haloperidol is best avoided in:

- Patients 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.

During therapy, the need for ECG monitoring (e.g. at dose escalation) should be assessed on an individual basis. Whilst on therapy, the dose should be decreased if the QTc is prolonged, and haloperidol should be discontinued if the QTc exceeds 500ms.

Haloperidol should not be used concomitantly with other QTc prolonging drugs: [see Appendix 1 & 3](#) (these tables below are not exhaustive so please refer to QT Drugs and the current Maudsley Prescribing Guidelines).

- Higher risk of dystonic / EPSE side effects
- Should be used with promethazine (IM) as per NICE and BAP Guidelines.
- Prescribe with procyclidine PO and IM PRN.

Alternatives

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 must 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 in exceptional circumstances on initiation by a consultant psychiatrist with a clear care plan for its use. It requires 48 hours of post administration monitoring due to its prolonged half-life.

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.

9.7.3 Choice of intramuscular benzodiazepine

Intramuscular lorazepam is an established treatment, and its efficacy is supported by NICE and BAP Guidelines. However parenteral administration of midazolam, particularly in higher doses, may cause over-sedation accompanied by respiratory depression.

Prescribing above BNF maximum for lorazepam:

Dose for acute anxiety is 0.025-0.03mg/kg given by IM injection every 6 hours if required.

For a 70kg person, the single dose would be 1.75mg – 2.1mg.

IM diazepam is not recommended for Rapid Tranquillisation

9.7.4 Treatment options for children and young people

Rapid tranquillisation is not encouraged with this age group although on occasions it may be necessary, and this should be discussed as part of the admission process with the parents / carers.

Parents / carers are informed of all actions taken in the event of an incident. The consultant must be involved, and an advance directive should be written in the care plan.

- 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.
- 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.
- It is unusual to use doses over that given in the BNF for young people as there is minimal 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 SOAD.

- 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 authorise 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.
- 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 1983 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).
- Before prescribing RT it is necessary to be aware of potential psychotropic 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.
- 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 a psychotropic 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.
- 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.
- Monitor physical health and emotional impact continuously when undertaking rapid tranquilisation in a child or young person. The NEWS chart should not be used in children (aged <16 years), instead the age-appropriate Paediatric Early Warning Score (PEWS) chart should be used.

Intramuscular haloperidol should not be used in this age group.

9.7.5 RT in patients with a Learning Disability (LD)

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.

Where possible, patients with a LD who have a mental illness but can be managed in a generic mental health unit, will be admitted to the appropriate ward and will be subject to standard Trust policies.

Patients admitted to the LD inpatient services will be drawn from a different demographic and will often have a diagnosis of autism, will usually lack capacity and so will be detained under the Mental Health Act. Managing an inpatient with Autism is quite different from managing a patient with a generic mental illness. The RT policy should be considered appropriate for patients with autism, or a LD admitted to the generic wards as well as patients who are newly admitted to LD inpatient units.

For those patients that have undergone assessment and are the subject of ongoing treatment, their behaviour is usually well understood and positive behaviour support (PBS) plans are put in place to manage this appropriately. Many patients will arrive in the inpatient setting with a community-based PBS plan in place.

PBS or RAID plans will look at all aspects of the patient's presentation. How they should be supported when calm, when moving off baseline and then a reactive strategy when they become distressed (usually colour coded (Red Amber Green) and referred to as RAG). As part of the management plan, when patients are moving from amber into red, medication used in RT may be offered. This is usually offered in oral form, but on occasion may be given by IM injection.

Where an LD patient has a PBS / RAID plan and is offered oral medication as part of the reactive strategy, this should not be considered as RT as it is being used as part of an extensive plan to reduce the likelihood of self-harm or the harm of others. This is prescribed as part of a multidisciplinary team review (MDT) and the use of this and other strategies, including restrictive practices, are reviewed through regular MDT meetings.

The RT policy would therefore apply to those patients who do not yet have a PBS plan or where there is a need to use IM medication as per the policy. The use of medication in this way will be recorded and monitored as RT.

STOMP (Stopping Overmedicating People with Learning Disability and Autistic people) is a national project that aims to reduce the prescribing of psychotropic medications to people with a learning disability or autism or both. People with a learning disability or autistic people are commonly prescribed psychotropic medications and do not have diagnosis that match prescribing decisions.

STOMP aims to focus prescribers into thinking about how to improve quality of life and support the patient to stay well without medications they may not require.

Psychotropic medication may be right for some people and may keep someone safe and

well. Prescriber should always think STOMP and how medication should be prescribed for the shortest period of time and how to plan reducing these medications when they are prescribed. There should be regular review for medications prescribed and close monitoring for potential atypical reactions to prescribed medications.

9.7.6 Treatment options in pregnancy

The safety of psychotropics in pregnancy cannot be clearly established because robust, prospective trials are unethical. Individual decisions are dependent upon an imperfect retrospective database and an assessment of the risks and benefits associated with withdrawal or continuation of drug treatment.

The service user's view of risks and benefits will have paramount importance. Possible effects on the unborn child should be discussed, if possible, with a mother who requires acute or maintenance treatment.

Risks should be weighed up against possible benefits.

RT should be avoided during pregnancy where possible. NICE recommend pregnant woman requiring RT should be treated according to the standard clinical guidelines on the short-term management of violence and aggression (Antenatal and postnatal mental health CG192).

NICE also recommend that:

- Restraint procedures should be adapted to avoid possible harm to the foetus (refer to the Reducing Restrictive Practice Lead/Team for advice).
- When choosing an agent for RT in a pregnant woman, an antipsychotic or a benzodiazepine with a short half-life should be considered; if an antipsychotic is used, it should be at the minimum effective dose because of neonatal extrapyramidal symptoms; if a benzodiazepine is used frequently in the third trimester, the risks of floppy baby syndrome should be taken into account.
- During the perinatal period, the woman's care should be managed in close collaboration with a paediatrician, an anaesthetist and obstetrician.

RT should always be discussed with the consultant. As always, offer oral medications first and use the lowest effective dose, with the shortest half-life. Try to avoid polypharmacy – exposing foetus to fewer medications.

- The preference is for Lorazepam then consider Promethazine or Haloperidol.
- A pregnant patient should never be left alone after receiving RT.
- There should also discussion with Midwives for foetal wellbeing checks after RT (contact maternity at UHNM). Physical observations must be recorded on Modified Early Obstetric Warning Signs (MEOWS) Chart (for all physical checks, not just RT).
- Physical review to include: foetal movements, any PV loss (blood or fluid).

9.7.7 Rapid Tranquilisation in Patients over 65's years of age

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.

- Start with oral medication and remember that in older people lower doses and

slower increases are recommended.

- Risperidone up to 2.5mg 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.
- Where a licensed product is available this should be used in preference to that without a license.

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 be considered and documented in advance e.g. on admission.

- 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.
- Older patients may also have an effectively larger volume of distribution which leads to a longer duration of action, this needs to be considered to avoid accumulation.
- 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 in order to identify any adverse effects.
- All antipsychotics should be avoided where possible in Lewy Body Dementia and Parkinson's Disease.
- All antipsychotics can cause increased cognitive impairment and confusion in patients with dementia.
- If delirium is the suspected cause of the agitation, NICE advocate haloperidol.

9.7.8 Medicines NOT recommended for RT

- IM or oral chlorpromazine: should not be administered due to local irritant effect, if given IM, increased risk of cardiovascular complications, causes hypotensive effects, especially at RT doses, erratically absorbed and effect on QTc intervals suggests it is unsuitable.
- IM diazepam: should not be administered IM due to its erratic pattern of absorption and lack of evidence for use in RT
- IM depot antipsychotics: slow onset of action
- IM midazolam: should not be administered due to the risk of respiratory depression
- IM lorazepam plus IM promethazine: this combination is not recommended due to lack of evidence for efficacy
- IM zuclopenthixol acetate: due to slow onset of action

9.7.9 Routes of Administration

- The Oral Route is the preferred administration route. This may require a considerable degree of negotiation/de-escalation between staff and the individual to be clear that consent is achieved. Excluding LD and CYP this would not be classed as RT.
- The Parenteral Route – the Intramuscular (IM) route is a more complex mode of

administration. It may involve a restraint team who may need to secure the individual while the IM is administered using a Safety Pod. The prone position (lying face-down) should ideally not be used to restrain, (see the Trust's Policy on the use and Reduction of Restrictive Interventions). Whilst the ventrogluteal site is the preferred site for IM administration in rapid tranquillisation it is the judgement of the team at the time of giving the intervention as to which site to be used, subject to risk assessing the licensed route for the drug and the accessibility of the injection site.

- Intravenous (IV) route **IS NOT TO BE USED** in NSCHT.

9.8 Risks associated with Treatment

9.8.1 The specific risks associated with the different classes of medications that are used in rapid tranquillisation should be taken into consideration along with the specific properties of the individual drugs. When combinations are used, risks may be compounded. Staff need to be made aware of the following risks:

Drug Class	Possible adverse effects
Benzodiazepines	Loss of consciousness Respiratory depression or arrest Cardiovascular collapse (in a person using our services receiving both clozapine and benzodiazepines)
Antipsychotics	Loss of consciousness Cardiovascular and respiratory complications and collapse Seizures Subjective experience of restlessness (akathisia) Acute muscular rigidity (dystonia) Involuntary movements (dyskinesia) Neuroleptic malignant syndrome Excessive sedation
Antihistamines	Excessive sedation Painful injection Additional antimuscarinic effects (including dry mouth, constipation, urinary retention, blurred vision, cognitive impairment, tachycardia, sedation etc.)

9.8.2 Additional risk factors

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

- The presence of congenital prolonged QTc syndromes

- The concurrent prescription or use of other medication that lengthens QTc intervals both directly and indirectly
- The presence of certain disorders affecting metabolism, such as hypo-and hyperthermia, stress and extreme emotions, and extreme physical exertion.
- Pre- existing cardiac disease, digoxin, diuretics or hypokalaemia may also increase the risk.
 - The elderly (aged 65 and above) or those who are frail
 - have more general medical illnesses
 - suffering with dementia so more likely to develop increased cognitive impairment with high doses of medication, especially haloperidol and procyclidine.
 - naïve to antipsychotics and/or benzodiazepines

In addition to the advice for adults the following precautions must be taken:

- check for treatable causes of the crisis, and initiate treatment as soon as possible.
- use a quarter to half the initial dose recommended for a normal adult.
- haloperidol can be particularly dangerous in Dementia with Lewy Bodies and should also be avoided if the person using our services is suffering from Parkinson's disease. Lorazepam should be tried instead.
- Pregnant women - special provision should be made for this group. The clinical team should involve the pharmacist and Perinatal Service in forward planning for the person using our services.
- People affected by alcohol and/or substance misuse
- Neurodiversity

9.9 Physical Monitoring and Debrief Post Rapid Tranquillisation – see algorithm 5

9.9.1 Post administration monitoring

- A member of staff, designated by the nurse in charge, should remain with the individual who has received rapid tranquilisation, to monitor for side effects and to record their physical health observations on a NEWS2/PEWS/MEOWS chart or the Visual Observations Form every 15 minutes for the first two hours after administration of the IM medication.
- Medical attention should be sought promptly as per the applicable early warning score escalation tool, or if there are any clinical concerns at any point.
- For individuals who are unconscious or very sedated, they should be nursed in the recovery position and observed continuously, and medical attention sought. The use of pulse oximetry to continually measure oxygen saturation is mandatory.
- After two hours the monitoring frequency must continue as per [Appendix 4](#).
- If it is not possible to obtain measurements of observations (temperature, pulse, BP, respiratory rate, pulse oximetry, hydration level, conscious level), visual observations may be undertaken every 15 minutes, resuming physical observations at the earliest opportunity as above. Staff should visually check respiratory rate and

ease of breathing, skin colour (looking for cyanosis) and check for evidence of dystonia or other significant side effects.

- Where visual observations are used medical attention should be sought promptly should the person demonstrate any “Amber” or “Red” observations, or if there are any clinical concerns.

9.9.2 Managing adverse effects and complications after Rapid Tranquilisation

In line with the Trust Resuscitation policy, if the patient is unconscious, remains over-sedated or is otherwise unwell they must be reviewed by a Doctor. Immediate escalation and review is 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 because 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.

Complication	Symptoms / signs	Management
Acute Dystonia	Severe painful muscular stiffness	Give procyclidine 5-10mg IM up to 30mg in 24 hours. Usually effective in 5-10 minutes but may need 30 minutes for relief
Hypotension	Fall in blood pressure (>30 mmHg orthostatic drop or <50mmHg diastolic)	Lie patient flat and raise legs - tilt bed toward bed. 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	Monitor closely and liaise with general medical team

	irregular pulse	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 waking.

Caution is necessary if combining RT with seclusion and physical intervention. If the service user is secluded, the potential complications of RT should be considered.

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.

10.0 Incident Reporting and Post-Incident Reviews

Incidents regarding the administration of parenteral RT should be reported electronically on Ulysses in accordance with Trust's Incident Management 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
- Any safety intervention holds used and duration

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

10.1 Standards for documentation completed by nursing staff

The clinical record should contain a comprehensive, synchronous account of the circumstances leading up to the use of RT, the outcome and proposed follow up. This post RT monitoring form supports this and the below being documented:

- Timeline of events
- Non-medication de-escalation techniques tried and effects
- Skills used e.g., VRT
- If oral medication was accepted
- Any suspected use of alcohol or illicit substances
- Medication administered: drug, doses, form, number of injections, evidence to support the use of the step wise algorithm
- If IM medication administered: effect on the person using our services
- Evidence for monitoring of side effects
- Post rapid tranquillisation physical health monitoring form should be completed, including NEWS2 or non-contact physical observations. If for any reason it has not been completed the rationale needs to be recorded in EPR.
- Complete Ulysses incident report and record details of incident in EPR.
- Within seven days of the incident, the intervention plan needs to be updated reflecting early warning signs, management plans, and patient preferences for future care.

10.2 Standards for documentation completed by medical staff

The entry in the EPR progress notes should include the following:

- Timeline of your input into the event.
- Details of the person using our services' assessments and observations.
- Details of medication reviewed and prescribed.
- Description of your observations of the RT process and event.
- The person's response to de-escalation techniques tried.
- The person's response to oral medication.
- The person's response to IM medication.
- Post RT physical health monitoring, record of completion and any adverse events.
- Plan for post RT incident review and assessment.

10.3 Post Incident Review

The aim of a post-incident review should be to learn lessons, support staff and people using our services, and encourage the therapeutic relationship between staff, people who use services and their carers.

The post-incident review should occur within 72 hours, exploring the incident, triggers, individual roles, emotional responses, future concerns, and possible solutions. Ideally, it's led by a service user and involves trained staff from outside the ward.

11. 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.

12. Implementation and Monitoring of 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. These are as follows:

12.1 Management of Actual and Potential Aggression (safety intervention training)

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. (Safety Intervention Training).

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.

12.2 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).

12.3 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).

12.4 Physical Health Training –

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

Mandatory training, including in hospital resuscitation.

Appendix 1.

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		
	Oral	Onset: 5 to 8 hrs Peak: 5 to 8 hrs Half-life: 32 to 50 hrs		- Less likely to cause EPSE than haloperidol. - IM administration results in initial maximum plasma concentration 5

Olanzapine	IM	Onset: 15 to 45 mins Peak: 15 to 45 mins Half-life: 30 hrs	- Hypotension - Bradycardia - Syncope	- 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
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 to 14 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	50mg/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.

Appendix 2 - 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.

Appendix 3: Effect of Psychotropic and Non-Psychotropic drugs on QTc.

Table one: Effects of psychotropic drugs on QTc*				
No effect	Low effect	Moderate effect	High effect	Unknown effect
Benzodiazepines Carbamazepine Cariprazine Gabapentin Lamotrigine Lurasidone MAOIs Mirtazapine SSRIs (except citalopram & escitalopram) Reboxetine Valproate Vortioxetine	Aripiprazole Asenapine Clozapine Flupentixol Paliperidone Prochlorperazine Olanzapine Risperidone Sulpiride Venlafaxine Trazodone Lithium	Amisulpride Chlorpromazine Citalopram Haloperidol Levomepromazine Tricyclic Antidepressants Quetiapine	Any intravenous antipsychotic Any drug or combination of drugs used in doses exceeding recommended maximum	Trifluoperazine Zuclopentixol Anticholinergic drugs e.g. Procyclidine
*Medicines available				

Table two: Non-psychotropic drugs associated with QT prolongation ^{1, 4}	
Antimicrobials	erythromycin, clarithromycin, ciprofloxacin, co-trimoxazole, fluconazole, ketoconazole
Antiarrhythmics	sotalol, amiodarone, dronedarone, flecainide, quinidine, disopyramide, procainamide, bretylium
Others	methadone, amantadine, ciclosporin, antimalarials, antiretrovirals, domperidone, lithium, antihistamines, nifedipine, tamoxifen

Further guidance can also be found on the Specialist Pharmacy Service website; 'Identifying risk factors for developing a long QT interval' is available [here](#), which contains safety concerns, risk factors, medicine risk factors, strategies for risk minimisation, and useful resources.

Individual drug interactions can also be checked using the online BNF, [here](#).

Appendix 4: Post Rapid Tranquillisation Physical Health Monitoring – found within EPR

Every 15 minutes for first two hours	For anyone who has had an IM injection for rapid tranquillisation
Continue every 15 mins or at a frequency set by medical staff	If a person using our services observations are not within normal limits after two hours or the person is not alert and ambulatory, medical advice should be sought to determine appropriate ongoing monitoring frequency and agree an action plan. Particular attention should be paid to high-risk groups such as those who: • appear to be asleep or sedated • have taken illicit drugs or alcohol • have a pre-existing physical health problem • have experienced any harm because of the intervention • have been given a dose higher than the BNF maximum The use of pulse oximetry to continually measure oxygen saturation is desirable.
Switch to 60-minute observations	If their observations (temperature, pulse, BP, respiratory rate, pulse oximetry, hydration level, conscious level) are within normal limits after two hours, and the person is alert and ambulatory, standard observations can be undertaken from then on.
Every 60 minutes	Until there are no further concerns about their physical health status *If a person later becomes sedated then monitoring must be recommenced every 15 minutes
Medical attention should be sought promptly as per the escalation tool or if there are any clinical concerns at any point.	
Where visual observations are used medical attention should be sought promptly should the person demonstrate any “Amber” or “Red” observations, or if there are any clinical concerns.	
Occasionally a balance will need to be drawn between provoking further	

assaultive behaviour by imposing observations against the risks of not doing those observations. Any such risk should clearly be documented and regular review implemented.

Rapid tranquilisation monitoring from – as found in EPR.

Name:	NHS Number:	Date and Time of RT
Ward/Unit	Drug, Dose and Route of RT Administered	Prescriber:
Was this a STAT dose or PRN Treatment?	<i>Please provide further details: how long has the patient been an in-patient and have they already had RT during this admission? Does the patient have a diagnosis?</i>	
Has a physical health assessment been completed prior to the administration of RT?	<i>i.e. ECG, U&E's and drug screen. Please provide further details:</i>	

Does the Service user have any Advanced Decisions/Statements?	No ☐	Yes ☐	If so, have they been considered? <i>Please provide additional information</i>

Please enter the rational and the clinical decision making for the administration of RT

Demonstrate that the least restrictive care and treatment options had been exhausted in the first instance, What de-escalation skills were utilised in the first instance? Was any oral medication offered prior to the RT? Who was the most senior doctor or most senior nurse involved in the decisions making to use RT? What was the clinical rational for the administration of RT? What MAPA techniques were utilised?

Please Indicate least restrictive intervention tried in the first instance:

Verbal de-escalation techniques	Radio Button
Non-verbal de-escalation techniques	Radio Button
Oral as required medication offered and administered	Radio Button
Oral as required medication offered however, declined	Radio Button
Low stimulus area	Radio Button
Other	Free Text Box

Post-RT Physical Observations:

What to monitor and Record Within Lorenzo electronic health records:

National Early Warning Score 2 (NEWS) and fluid chart to monitor Temperature, Blood Pressure, Pulse, Respiratory Rate, Oxygen saturation, Level of consciousness (Alert, Vocalise, Pain, Unresponsive), level of hydration and the patient's level of behavioural activation on the 7-point BARS rating scale.

When to monitor and record:

NEWS 2, fluid chart and BARS Rating Scale to be complete 15 minutes post-RT and then every 15 minutes for the 1st Hour then at least HOURLY until there are no concerns

If "hands on" Physical monitoring cannot take place implement NSCHT NON-CONTACT PHYSICAL OBSERVATIONS FORM

Has the NEWS 2, level of hydration and the patients' level of behavioural activation been carried out 15 minutes post rapid tranquilisation 15 minutes post RT?

Yes ☐

What was the time of the 1st set of observations carried out? **00:00**
NEWS 2 TO BE COMPLETE ON LORENZO FORMS

No ☐

Please state why observations could not be carried out:

If it is not possible to complete NEWS 2 utilise NSCHT NON-CONTACT PHYSICAL OBSERVATIONS FORM

--

What is the patient's level of behavioural activation on the 7-point BARS rating scale?

- ☐ 1- *Difficult or unable to rouse*
- ☐ 2 -*Asleep but responds normally to verbal or physical contact*
- ☐ 3 -*Drowsy, appears sedated*
- ☐ 4- *Quiet and awake (normal level of activity)*
- ☐ 5 - *Signs of overt (physical or verbal) activity, calms down with instructions*
- ☐ 6 - *Extremely or continuously active, not requiring restraint*
- ☐ 7 - *violent, requires restraint*

Has the NEWS 2, level of hydration and the patients' level of behavioural activation been carried out 30 minutes post rapid tranquilisation?

If it is not possible to complete NEWS 2 utilise NSCHT NON-CONTACT PHYSICAL OBSERVATIONS FORM

Yes ☐
 What was the time of the 2nd set of observations carried out? **00:00**
NEWS 2 TO BE COMPLETE ON LORENZO FORMS

No ☐
 Please state why observations could not be carried out:

--

What is the patient's level of behavioural activation on the 7-point BARS rating scale 30 minutes post RT?

- ☐ 1- Difficult or unable to rouse
- ☐ 2 -Asleep but responds normally to verbal or physical contact
- ☐ 3 -Drowsy, appears sedated
- ☐ 4- Quiet and awake (normal level of activity)
- ☐ 5 - Signs of overt (physical or verbal) activity, calms down with instructions
- ☐ 6 - Extremely or continuously active, not requiring restraint
- ☐ 7 - violent, requires restraint

Has the NEWS 2, level of hydration and the patients' level of behavioural activation been carried out 45 minutes post rapid tranquilisation? If it is not possible to complete NEWS 2 utilise NSCHT NON-CONTACT PHYSICAL OBSERVATIONS FORM	Yes ☐ What was the time of the 3rd set of observations carried out? 00:00 NEWS 2 TO BE COMPLETE ON LORENZO FORMS No ☐ Please state why observations could not be carried out:
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What is the patient's level of behavioural activation on the 7-point BARS rating scale 45 minutes post RT?

- ☐ 1- *Difficult or unable to rouse*
- ☐ 2 -*Asleep but responds normally to verbal or physical contact*
- ☐ 3 -*Drowsy, appears sedated*
- ☐ 4- *Quiet and awake (normal level of activity)*
- ☐ 5 - *Signs of overt (physical or verbal) activity, calms down with instructions*

Was an on-call Doctor or Nurse Practitioner been contacted to review the physical and mental state of the patient?	No ☐	Yes ☐	If so: Who attended and at what time?
Has a post-rapid tranquilisation debrief been carried out with the Patient?	No ☐	Yes ☐ When was this carried out? 	If not state why? What actions have been taken to ensure debrief is carried out at earliest opportunity?
Has an Incident form been complete and submitted	Yes ☐	Please Provide the incident number 	No ☐ Please state the reason why:

Have family/carers been informed of the RT incident? Yes ☐ No ☐ Please Provide Further Information: ☐ No consent to share Information ☐ Unsuitable hour ☐ No known carer/family member to contact ☐ Other
Rapid Tranquilisation incidents to be discussed within the patients MDT meeting

Has the patients care plan been updated within 7 days following the episode of rapid tranquilisation? Care plan to include actions to be taken to manage any further episodes of acutely disturbed behaviour, referring to the patient's preferences and wishes regarding the management of future episodes. Yes ☐ No ☐
