Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Pharmacological Management of Patients Experiencing Psychiatric Emergencies/ Behavioural Disturbance Policy (Rapid Tranquilisation)

This policy does not apply to Emergency Departments, ED Colleagues should refer to Royal College of Emergency Medicine (RCEM):
Acute Behavioural Disturbance in Emergency Departments (2023)

This is a new procedural document

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Amendment Form

Please record brief details of the changes made alongside the next version number. If the procedural document has been reviewed **without change**, this information will still need to be recorded although the version number will remain the same.

Version	Date Issued	Brief Summary of Changes	Author
Version 1		New Policy. This is a new procedural document, please read in full.	Aileen Knowles, Named Practitioner for Safety in Caring written in consultation with RDaSH Pharmacy & Psychiatrist, STH Pharmacy, DBTH Pharmacy, ED & Ward based Medical Dr's.

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Summary of Rapid Tranquilisation Process

Initiate de-escalation, primary, strategies. Initiate Secondary strategies if de-escalation ineffective in reducing signs of distress (including PRN medication).

Dr to assess and prescribe based on:

- The Patients preferences or advance statements and decisions
- Physical health problems or pregnancy
- Possible intoxication
- Previous response to medication, including adverse effects
- Potential for interactions with other medications

Outcome and tolerability to oral PRN medication documented in care records.

If urgent sedation required, Doctor to assess patient and prescribe medication for Rapid Tranquilisation (RT) via Intra Muscular Injection if appropriate

Initial dose to be prescribed as once only (not repeatable) until outcome known. Assess response and tolerability. Tailor further treatment in line with response.

Further doses prescribed after a medical review. (Dose optimisation to be undertaken before switching treatment).

Post RT Vital Signs & hydration to be monitored and recorded:

- **Every 15mins for first hour**
- **Every 30 minutes for following 3 hours**

If physical health deteriorates escalate to Doctor.

Datix MUST be completed following RT and include clear documentation of de-escalation attempted, clinical holds/restraint used during administration.

1 INTRODUCTION

Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust (DBTH) recognises the importance of good practice in reducing and managing experiences of high levels of patients' distress, preventing and managing aggressive, violent and potentially violent situations. These can be referred to as a range of behaviours or actions that can result in harm, hurt or injury to self and/or others with due regard for the safety and dignity of both patients and staff.

Individuals experiencing distress that may be communicated through behaviours of concern should be identified; risks assessed and where possible have an up-to-date and regularly reviewed intervention plan.

A recorded intervention plan will specify pro-active and de-escalation techniques that should be utilised to try and prevent the escalation cycle. This can include the pro-active use of oral "as required" (PRN) medication that has been prescribed for the patient.

It is recognised though that severe behavioural disturbance will sometimes occur despite all attempts to prevent it. At these times it may become necessary to use pharmacological interventions alongside physical restraint to maintain the safety and physical health of a patient or others.

In the management of severe behavioural disturbance the administration of medicines using the parenteral route (usually intramuscular), under restraint when necessary, is termed Rapid Tranquillisation (RT).

When a patient is presenting highly aroused, agitated, overactive or aggressive, rapid tranquillisation should only be used:

- When non-pharmacological, therapeutic, de-escalation interventions have been ineffective in supporting a reduction in the level of distress being experienced and the resulting behaviour.
- If the patients continued level of distress is resulting in them making serious threats of harm to self and/or others

or

- The patients continued level of distress is resulting in them being destructive to their surroundings which would cause harm to themselves and/or others within the environment.

This policy covers the use of medications for rapid tranquilisation (usually via intramuscular administration).

In addition to de-escalation techniques and environmental management the appropriate use of medication may be required. Drug treatment that is not urgent requires either informed consent or administration under an appropriate legal framework such as Mental Capacity Act (2005) or Mental Health Act (1983). Restrictive interventions, including rapid

tranquillisation, should only be used in a way that respects human rights and when other none pharmacological approaches have been attempted and proved unsuccessful.

The decision to prescribe and administer medication to support de-escalation of psychiatric distress or against the will of the individual should be based on decisions made in line with current legislation:

- Mental Health Act (1983)
- Mental Capacity Act (2005)

This policy is based on NICE Guidance: NG10 Violence and aggression: short-term management in mental health, health and community settings (NICE 2015).

2 PURPOSE

This policy aims to support staff in the identification of need, and appropriate use of rapid tranquilisation medication if a patient in receipt of care experiences such distress that has not been able to be resolved using proactive de-escalation techniques and prescribed oral PRN medication.

Refer to the Enhanced Care Policy and De-escalation, Including Clinical Holding and Restraint Policy for providing supportive care to patients who present with Behaviours of Concern whilst receiving hospital care for further support around de-escalation.

3 DUTIES AND RESPONSIBILITIES

When dealing with medicines, all staff should follow the relevant DBTH medicines related policies, procedures and where applicable their own professional body's code of practice. This applies to all staff employed by the Trust or any staff working or seconded to work within the Trust.

Staff must act within the scope of their own competencies and professional standards. All staff that are likely to become involved in the use of medicines as part of this policy should ensure that they are familiar with the drugs used, the dose ranges, cautions, interactions and any relative/ absolute contraindications.

Clinical guidelines are recommendations for the care of individuals by healthcare professionals that are based on the best available evidence. Guidelines assist the practice of healthcare professionals, but do not replace their knowledge and skills.

3.1 All Staff

Work to avoid the use of force and restrictive interventions as far as is reasonably possible. Treat service users with compassion and with dignity and respect. At all times interact with service users in a manner that helps to de-escalate the situation rather than escalate it.

3.2 Prescribers

Ensure that where appropriate regular treatment and/or PRN medication are initiated as soon as possible after admission to treat acute mental illness, behaviour disturbance to reduce symptoms, and reduce the need for any parenteral medication to be given, and that treatment is discussed with and explained to the patient and, with consent, their carer or carers.

Ensure that the choice of medication for rapid tranquilisation is clinically appropriate and lawful, including taking full consideration of the patient's physical health, mental health, and current legal status.

Ensure that prescriptions are clear, unambiguous and complete.

Review prescriptions for rapid tranquilisation at least once a week, and document this review in the patient's notes.

If medication for rapid tranquilisation is administered, review the prescription at the next Multi-disciplinary (MDT) review. The Duty Doctor or other appropriately qualified prescriber can also be requested to review the prescription at any time, and a senior review can also take place at any time via the on-call system.

Ensure that patients are monitored for side effects and the therapeutic effect of medicines administered.

3.3 Registered Nurses

Be proactive when a patient is clearly distressed or agitated and not ignore such situations and allow them to escalate. Engagement, de-escalation, offering help and emotional support MUST always be the first choice of interventions.

Ensure that rapid tranquilisation is only used as a last resort:

- After other, non-pharmacological methods of de-escalation and diffusion have been tried.
- When none-pharmacological approaches have been unsuccessful offer of oral medication.
- Parenteral medication is only administered when it is legally appropriate to do so and any use of force is reasonable, justified and proportionate and compliant with the law and the patient's human rights.

When making decisions about the administration of medication, ensure that full consideration is given to the likely effects of the medication in light of the patient's current physical and mental health. Consideration should be given both to the intended therapeutic effects and the possible side effects of the medication.

Ensure that medication is drawn up and administered correctly in accordance with the prescription and that any administration is signed for and recorded. All medication drawn up for injection should be checked by another Registered Nurse or Registered Nursing Associate who is post-preceptorship.

Ensure that the administration of any medication given under restrictive physical intervention is co-ordinated, managed and carried out safely, using staff who are appropriately trained in restrictive physical intervention and Basic or Immediate Life Support, with pre and post-debrief and oversight of the process.

Ensure that any administration of medication by injection and use of holding skills follow all Infection Prevention and Control guidance.

Ensure that all post-RT physical health monitoring and eyesight observation of the patient is carried out as set out in this policy. Monitor the patient for side effects and desired effects following the administration of medication.

Ensure that all episodes of rapid tranquilisation and post-administration monitoring and observations are documented appropriately. Ensure that an incident reporting form is completed.

Ensure that any physical health concerns about the patient are escalated to medical or senior colleagues and handed over using SBARD.

Ensure that a debrief takes place with the patient as soon as it is safe to do so, and that this is documented.

3.4 Registered Nursing Associates

Are not permitted to administer rapid tranquilisation.

Are permitted to undertake the second check of IM medicines alongside the Registered Nurse. Both members of staff must be post-preceptorship.

3.5 Pharmacists

Check medicines are prescribed at the right dose and route, and are appropriate considering the patients' current physical and mental state, and other pharmacological treatments, including possible drug interactions.

3.6 Nurse Managers

Clinical Nurse Managers and Matrons must ensure that there are systems in place on every ward to check and monitor the provision of emergency resuscitation equipment and oxygen, and that staff are up to date for restrictive physical interventions (RRI) Training and either Basic Life Support or Immediate Life Support.

Heads of Nursing and Matrons are responsible for ensuring that there is a culture of learning around the use of rapid tranquilisation and restrictive interventions to ensure that steps can be taken to reduce their use.

Heads of Nursing and Matrons should regularly audit and check that post-RT physical health monitoring and eyesight observation of the patient has been carried out as required.

The above audit and assurance process should be reported to through the appropriate Clinical Governance process.

3.7 Chief Executive

Has the overall responsibility to ensure that the policy is implemented, by delegating duties as outlined above and ensuring the policy is updated.

3.8 Directors

Both the respective Directorate Management Team and the Director of Nursing should provide overall oversight of the audit and monitoring process and take appropriate action if compliance is not being met.

The respective Directorate Management Team should have overall responsibility for monitoring the effectiveness of change ideas being tested to reduce the use of restrictive interventions, with regular reporting and review of progress.

4 PROCEDURE

- Patients should only receive RT after an assessment of risk and when it has been established that the risk of not doing so is greater than the risks of the intervention (i.e. a proportionate response).
- RT should only be considered if de-escalation strategies and oral PRN medications have been tried and been ineffective - or felt to be inappropriate.
- Other non-pharmacological interventions MUST be considered, for example increasing the level of observations of the Patient, increasing the level of staffing, changing the environment.
- Non-psychiatric causes of behavioural disturbance should be considered and managed accordingly e.g. hypoglycaemia, delirium, and drug / alcohol intoxication.

- If possible the patient should be given the opportunity to make an informed choice by way of an advance statement.
- The patient should be informed that RT is going to be administered and why (this should be clearly documented in the clinical record). If the patient lacks capacity to consent to treatment, RT can be given, providing in the best interests of the patient, under the Mental Capacity Act.
- The dose of medication prescribed and administered should be individualised and based on assessment by attending Doctor.

4.1 Prevention of distress presenting in violence and aggression – PRN medication

When prescribing oral PRN medication as part of a strategy to de-escalate or prevent situations that may lead to violence and aggression:

- PRN medication should be tailored to an individual need (this should include discussion with the patient if possible) and should not routinely or automatically be prescribed on admission.
- Ensure there is clarity about the rationale and circumstances in which PRN medication may be used and that these are included in the care plan and on Electronic Prescribing.
- Ensure that the maximum daily dose is specified and does not inadvertently exceed the maximum daily dose stated in the British National Formulary (BNF) when combined with the person's standard dose or their dose for RT.
- Only exceed the BNF maximum daily dose (including P.R.N. dose, the standard dose and dose for rapid tranquillisation) if this is planned to achieve an agreed therapeutic goal, documented and carried out under the direction of a senior doctor.
- Ensure that the interval between P.R.N. doses is specified.

4.2 Rapid tranquilisation

Prescribing should be done in accordance with the Trust's medicines code standards.

Prior to administering medication for RT it is essential that the clinician is clear under which legal framework the treatment will be administered. The Mental Health Act and Mental Capacity Act status of the patient MUST be considered before medication is administered for RT.

Rapid tranquillisation medication is not emergency lifesaving medication and should not be administered through clothing.

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.

If a second rapid tranquilisation dose is required, the prescribing clinician should discuss with a senior colleague.

Rapid tranquillisation medication should be administered via the following IM routes using appropriate injection technique.

The following are considered safe sites for IM injection:

- Dorsogluteal Muscle (buttocks)
- Deltoid Muscle (upper arm muscle)
- Vastus Lateralis Muscle (thigh)
- Ventrogluteal Muscle (hip)

The deltoid muscle can safely be used for IM administration in situations where the patient is not struggling, as it requires the arm to be stationary to enable correct and safe injecting technique. The deltoid is a relatively small muscle and precision is needed. There are currently no holding skills recommended or taught to enable safe administration of IM injection via the deltoid muscle in situations where the service user is unable to keep their arm still.

The recommended maximum volumes of fluid for each muscle group are as follows:

- Dorsogluteal 4ml
- Deltoid 2ml
- Vastus Lateralis 5ml
- Ventrogluteal 4ml

Medication	**Considered site of administration**
Lorazepam	Dorsogluteal/Ventrogluteal/Deltoid/Vastus Lateralis
Haloperidol	Dorsogluteal/Ventrogluteal/Deltoid/Vastus Lateralis
Promethazine	Dorsogluteal/Ventrogluteal/Deltoid/Vastus Lateralis

NICE guideline [NG10] (2015)

See Appendix 4 for Injection Site Images for information.

On occasions the lateral thigh (Vastus lateralis) may be considered for IM injection but this site is not custom and practice. Administration to this site is painful. Using this site would need an MDT decision with appropriate reasons for this route and recorded in the care plan.

When deciding which medication to use the professional should take into account:

- The patients preferences, advance statements and decisions.
- Pre-existing physical health problems, intoxication or pregnancy.
- Previous response to these medications, if known, including adverse effects.
- Potential for interactions with other medications.
- The total daily dose of medications prescribed and administered.

If rapid tranquillisation is being used a senior doctor should review all medication at least once a day and monitor the appropriateness of the medication.

The review should be recorded and include:

- Clarification of target symptoms and intended therapeutic response.
- The total daily dose of medication, prescribed and administered, including PRN medication.
- The number of and reason for any missed doses.
- The emergence of unwanted effects.
- Ensure that the maximum daily dose is specified and does not exceed the maximum daily dose stated in the British national formulary (BNF) when combined with the person's standard dose or their dose for rapid tranquilisation.
- After an episode of hostility the patient should still be assessed and the treatment plan reviewed to check if suitable to manage any further episodes of distress, hostility/violence.

Resuscitation facilities must be available before treatment is commenced.

Note that the cautions and adverse effects listed are not exhaustive; refer to the British National Formulary (BNF) or Summary of Product Characteristics (SPC) or other reputable sources of information as appropriate.

4.3 Lorazepam

Lorazepam is a benzodiazepine with anxiolytic, sedative, hypnotic, anticonvulsant and muscle relaxant properties. Benzodiazepines bind to the gamma-aminobutyric acid (GABA)-benzodiazepine receptor complex without displacing GABA. Binding to the specific attachment site improves GABA's attraction to its own receptor site on the GABA-benzodiazepine receptor complex.

Cautions

- Avoid in patients with myasthenia gravis, acute pulmonary insufficiency and sleep apnoea syndrome.

- Can cause significant respiratory depression – use lower doses in patients with limited pulmonary reserve or compromised respiratory function e.g. elderly, Chronic Obstructive Pulmonary Disease, pneumonia.

- Can cause excess sedation in particular when combined with other central nervous system depressants.

Potential adverse effects: Respiratory depression, excess sedation, unmasking of pre-existing undiagnosed depression.

Flumazenil can be used to reverse the central effects of benzodiazepines, see Appendix 1

4.4 Haloperidol

Haloperidol is a "typical" (butyrophenone) antipsychotic with predominantly dopamine antagonist activity.

A baseline ECG is recommended before intramuscular dosing. During therapy, the need for ECG monitoring for QTc interval prolongation and for ventricular arrhythmias must be assessed in all patients, but continuous ECG monitoring is recommended for repeated intramuscular doses.

Cautions

- Avoid in patients with Parkinson's disease.
- Avoid in known QTc interval prolongation or congenital long QT syndrome.
- Avoid in patients with significant risks for QTc prolongation *e.g.* recent acute myocardial infarction, uncompensated heart failure, history of ventricular arrhythmia or torsades de pointes and uncorrected hypokalaemia.
- Haloperidol should not be used concomitantly with other QTc prolonging drugs (*e.g.* amiodarone, sotalol, erythromycin, clarithromycin.
- Discontinue haloperidol if extrapyramidal side effects (consider procyclidine therapy) or signs of Neuroleptic Malignant Syndrome (NMS) or QTc prolongation occur.
    - Evidence of Extrapyramidal side effects (EPSEs) include: Akathisia (inner restlessness), Dyskinesia (twitches – usually in the face), Oculogyric Crisis (unusual eye movements) and Parkinsonism (e.g. tremor or stiffness).

For adult patients consider Procyclidine 5mg IM (2.5mg for older adults), repeated once after 30 minutes if necessary. If further doses of procyclidine are deemed necessary, the following can be prescribed:

- **Adults** - 5mg TDS (IM/oral) total maximum 15mg in 24hours.
- **Elderly (Older adults)** - 2.5mg TDS (IM/oral) total maximum 7.5mg in 24hours.

- Evidence of Neuroleptic Malignant Syndrome (NMS) include: fever, altered consciousness levels, sweating, muscle rigidity and autonomic instability

4.5 Promethazine

Promethazine is a potent, long acting, antihistamine with additional anti-emetic central sedative and anti-cholinergic properties.

Cautions/Contraindications

- Promethazine should not be used in patients in coma or suffering from CNS depression of any cause.

- Promethazine should be avoided in patients taking monoamine oxidase inhibitors (e.g. Moclobemide, Tranylcypromine, Phenelzine and Isocarboxazid) up to 14 days previously.
- Promethazine may thicken or dry lung secretions and impair expectoration. It should therefore be used with caution in patients with asthma, bronchitis or bronchiectasis.
- Use with care in patients with severe coronary artery disease, narrow angle glaucoma, epilepsy or hepatic and renal insufficiency.
- Intramuscular injection must also be performed carefully to avoid inadvertent subcutaneous injection, which could lead to local necrosis.

Adverse effects
Dizziness, restlessness, headaches, nightmares, tiredness, and disorientation.
Anticholinergic side effects such as blurred vision, dry mouth and urinary retention occur occasionally.

4.6 Pharmacokinetic Information

Medication (Intramuscular)	Peak effect	Half life
Lorazepam	60-90 minutes	12- 16 hours
Haloperidol	20-40 minutes	13-36 hours
Promethazine	2-3 hours	5-14 hours

4.7 High Doses

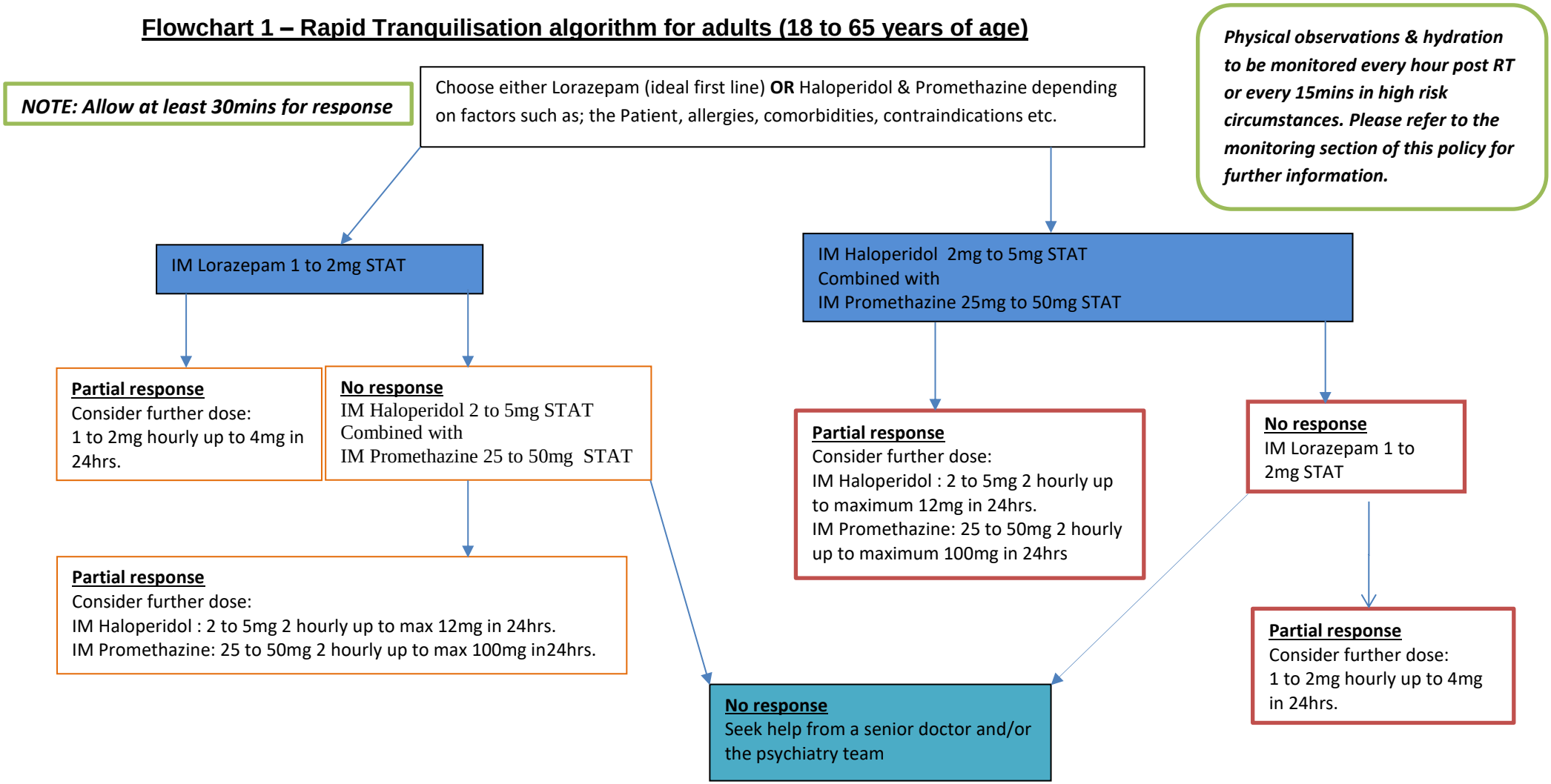
Doses higher than described in this policy or more than the BNF maximums may sometimes be required after consultation with the Psychiatry Team with clear documentation of the rationale in the patients' notes.

4.8 Adults 18 to 65 years of age

If there is insufficient information to guide the choice of medication for rapid tranquillisation or the patient has not taken antipsychotic medication before or there is evidence of cardiovascular disease, including a prolonged QT interval, or no electrocardiogram has been carried out, avoid intramuscular Haloperidol combined with intramuscular Promethazine and use intramuscular Lorazepam instead.

See Flowchart 1 below for RT algorithm for adults (18 to 65 years of age).

Flowchart 1 – Rapid Tranquilisation algorithm for adults (18 to 65 years of age)



4.9 Elderly (Older Adults) – over 65 years of age

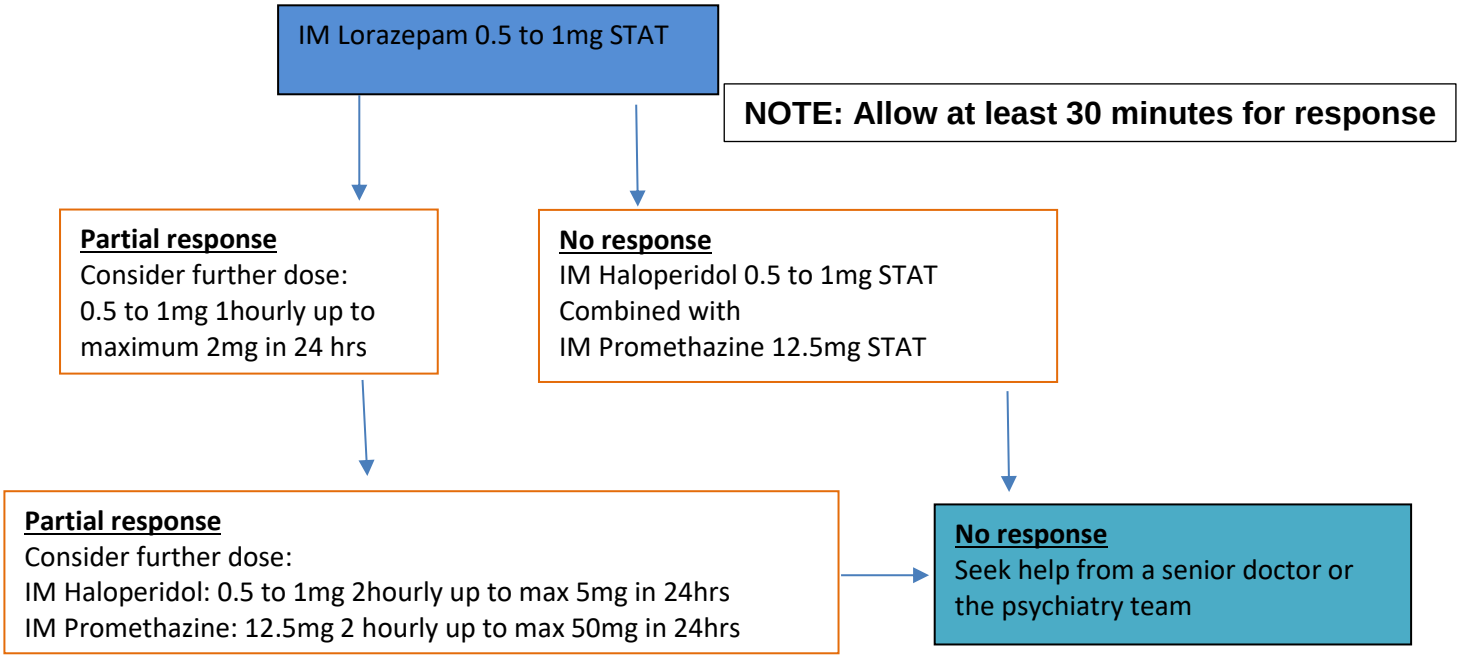
The doses of medication required in the older adult group will be less than those required for the general adult population. Particular care should be given to co-existing medical states (co-morbidities) and prescribed medications, the risk of accumulation of sedatives and the possibility of delirium.

The use of antipsychotics is cautioned in elderly patients with dementia as an increased risk of stroke has been implicated with all antipsychotics. As a result, antipsychotics should only be prescribed for use in patients when the use is considered a proportionate response to the risks.

Lorezepam is associated with increased risk of delirium and falls, therefore where possible its use should be for short term only. Antipsychotics, specifically haloperidol, are more likely to be effective where delirium is suspected.

For acute behavioural disturbances in the elderly when urgent sedation is required to prevent injury or harm to self and/or other use algorithm 2 below.

Algorithm 2 - Rapid Tranquilisation for older adults (over 65 years of age)



***Haloperidol should not be prescribed for patients with Parkinsons Disease or Lewybody Dementia**

***Promethazine, as a result of anticholinergic effects, may worsen delirium and increase likelihood of falling.**

Physical observations/hydration to be monitored every hour post RT or every 15mins in high risk circumstances. Please refer to the monitoring section of this policy for further information.

4.10 Special Treatment Groups – People with Learning Disability

The doses of medication required for people with learning disability will be less than those required for the general adult population.

Similar principles as for older adults should be applied. Non-pharmacological factors must always be used as first option when people are experiencing increased level of distress.

Disinhibition is more likely to occur in organic brain disease including learning disabilities.

For acute behavioural disturbances in people with learning disability when urgent sedation is required to prevent injury or harm to self and/or others consider first line:

- Lorazepam 500micrograms to 1mg IM should be used and repeated not more frequently than every 1 hour (maximum 2 mg in 24 hours).

- If IM Lorazepam is ineffective and RT continues to be necessary and not contraindicated consider Promethazine IM 12.5mg plus haloperidol IM 3-5mg repeat if necessary according to response and tolerability no more frequently than every 2 hours (promethazine maximum 50mg in 24 hours, Haloperidol maximum 12mg in 24 hours).

4.11 Adolescents – 16 – 17 years of age

Prior to starting drug treatment it is very important to exclude non-psychiatric causes such as organic disease, psychological disturbance e.g. anger and anxiety, intoxication or withdrawal status.

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 & Adolescent Psychiatrist via CAMHS.

- Use intramuscular Lorazepam for rapid tranquillisation as first line treatment.

- If there is only a partial response, check the dose again according to the age and weight and consider a further dose.

- Lorazepam 1mg to 2mg repeated after 1hr if required, up to a maximum of 4mg in 24 hours.

- If ineffective or unsuccessful consider promethazine 25mg to 50mg 2hrly up to maximum of 100mg daily and haloperidol 2mg to 5mg (maximum daily dose 12mg) repeat after 2 hours if required. (Note – Off-label use)

4.12 Clinical Holding/Physical Restraint

This information applies for patients of all ages.

All staff likely to be using physical intervention in the clinical management of a disturbed patient must be competent to do so.

Physical restraint should not be used for more than 10 minutes without considering pharmacological intervention of rapid tranquilisation. RT may be used sooner than this if deemed clinically appropriate. Conversely physical restraint may continue without RT if the event is resolving however the need for RT must be continuously reconsidered as part of the de-escalation of increased distress.

Any restraint required to administer RT MUST be proportionate and necessary to prevent harm to the patient and/or others.

Refer to: ***De-Escalation, including Clinical Holding and Restraint Policy – Adult***
De-escalation, including Clinical Holding and Restraint Policy – Children and Young People

4.13 Post Rapid Tranquilisation Monitoring

After rapid tranquillisation the patient should be monitored and the response to medication and any side effects documented in care records.

Pulse, **blood pressure**, **respiratory rate**, **temperature**, **level of consciousness** and **level of hydration** should be monitored and recorded every hour until there are no concerns about their physical health status. Monitor every 15 minutes if the BNF maximum dose has been exceeded or the service user:

- appears to be asleep or sedated
- has taken illicit drugs or alcohol
- has a pre-existing physical health condition
- has experienced any harm as a result of any restrictive intervention

4.14 Post Incident Debrief

After using a restrictive intervention, and when the risks of harm have been reduced/contained, conduct an immediate post-incident debrief (hot debrief), including a nurse and a doctor involved in the intervention, to identify any learning, any physical harm to patient or staff, ongoing safety concerns and the emotional impact on patients and staff,

including witnesses. Ensure Patient is offered a debrief conversation if appropriate to their needs.
Professional Nurse Advocate Restorative Clinical Supervision (RCS) or Restorative Debrief may also be of benefit to staff, both directly and indirectly involved in the intervention. These PNA interventions provide an opportunity to take some time to explore feelings, issues, events or interventions. Enabling colleagues to understand and process thoughts and feelings allowing exploration of different perspectives and inform decision making, including planning actions.

4.13 Legal Frameworks

PATIENTS LACKING CAPACITY
Sometimes it will be necessary to provide care and treatment to patients who lack the capacity to make decisions related to the content of this policy. In these instances staff must treat the patient in accordance with the Mental Capacity Act 2005 (MCA 2005).

- A person lacking capacity should not be treated in a manner which can be seen as discriminatory.
- Any act done for, or any decision made on behalf of a patient who lacks capacity must be done, or made, in the persons Best Interest.
- Further information can be found in the MCA policy, and the Code of Practice, both available on the Extranet.

There is no single definition of Best Interest. Best Interest is *determined on an individual basis. All factors relevant to the decision must be taken into account, family and friends should be consulted, and the decision should be in the Best interest of the individual. Please see S5 of the MCA code of practice for further information.*

Where there is reason to doubt a person's capacity to consent, prior to performing any treatment (other than immediate lifesaving treatment, Doctrine of Necessity) or delivering any care, an assessment of capacity MUST be undertaken.

Where a person has been assessed as lacking capacity to consent to treatment or make a specific decision at the time the decision needs to be made (time and decision specific), any actions taken or decisions made on behalf of that person, must be evidenced to be in their best interests and recorded in the patient record.

4.14 Mental Capacity Act (MCA)

Section 5 of MCA authorises the clinician to act or treat so long as:

- The principles of MCA have been observed
- "reasonable steps" have been made to ascertain decision-making capacity and the assessment has led to a "reasonable belief" that the person lacks capacity
- The action taken is in the best interest of the person

Restraint is permitted if:

- The purpose is to prevent harm to the person e.g. harm to welfare or the vulnerable
- The restraint used is proportionate to the likelihood and seriousness of the harm

Limitations of Section 5:

- Anything that conflicts with a decision made with a valid and applicable power of attorney
- Depriving a person of their liberty
- Restraint that is not proportional to the likelihood of the harm to the person

4.14 Mental Health Act (MHA)

Patients can be held on a ward under section 5(2) of the MHA to allow an assessment to be performed. Under this power the patient can be restrained but not treated. Any treatment requires either the service user's consent (if they have capacity) or given under the MCA. Refer to Mental Capacity Act 2005 and Deprivation of Liberty Safeguards Policy for more information.

5 TRAINING/SUPPORT

Staff must be trained in how to identify changes in patient presentation and respond in a proactive way to reduce the likelihood of Patients becoming increasingly distressed which may result in behaviours of concern posing a risk to self and/or others. This training includes assessment and management of potential and actual behaviours of concern, using de-escalation techniques, clinical holding and restraint (as the last resort)

Rapid Tranquillisation training should cover:

- All staff involved in rapid Tranquillisation to be trained in Immediate Life Support (ILS)
- Prescribers and those who administer medicines should be familiar with and have received training in Rapid Tranquillisation, including:
    - The properties of benzodiazepines; antipsychotics; antimuscarinics and antihistamines.
- Associated risks, including cardio-respiratory effects of the acute administration of the drugs, particularly when the patient is highly aroused and may have been misusing drugs; is dehydrated or is possibly physically ill.
- The need to titrate doses to affect.

Please note: The Standard Training Needs Analysis (TNA) – The training requirements of staff will be identified through a training needs analysis. Role specific education will be delivered by the service lead.

6 MONITORING COMPLIANCE WITH THE PROCEDURAL DOCUMENT

What is being Monitored	Who will carry out the Monitoring	How often	How Reviewed/ Where Reported to
Frequency & circumstances of prescription and administration of Rapid Tranquilisation	Person Centred Care Practitioner Named Practitioner for Safety in Caring	Weekly	Datix/Incident Reports Wellsky Prescription Reported to Patient Safety Review group
Appropriateness of prescription	Pharmacy	Weekly	Prescription
Appropriate legal framework	Safeguarding	Weekly	Datix/Incident Reports MCA/DoLS documentation Reported to Safeguarding Committee

7 DEFINITIONS

Advance statement - a written statement that conveys a person's preferences, wishes, beliefs and values about their future treatment and care.

De-escalation - use of techniques (including verbal and non-verbal communication skills) aimed at reducing the distress that a patient is experiencing and the outward presentation of anger and averting aggression.
P.R.N. medication can be used as part of a de-escalation strategy however P.R.N. medication used in isolation is not de-escalation.

Incident - Any event that involves the use of a restrictive intervention – such as 1:1 constant supervision, restraint (physical, chemical or mechanical) – to manage support a patient in distress with outward presentation of violence or aggression.

PRN (as needed medication) – refers to the use of medication as part of a strategy to de-escalate or prevent situations that may lead to physical harm to self and/or others. The use of oral medication (PRN) may be considered prior to using IM medications.

Rapid tranquilisation (RT) – refers to the use of medication, usually intramuscular (IM), to calm/lightly sedate a patient in order to reduce the risk of harm to self and/or others, in addition to reducing the patients distress, agitation and/or aggression. Rapid tranquilisation should be considered if oral medication is not possible, not appropriate or/and urgent sedation with medication is needed.

Restrictive interventions - Interventions that may infringe a person's human rights and freedom of movement, including observation, seclusion, manual restraint, mechanical restraint and rapid tranquillisation.

Violence and aggression - a range of behaviours or actions that can result in physical and/or psychological harm 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.

8 EQUALITY IMPACT ASSESSMENT

The Trust aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are disadvantaged over others. Our objectives and responsibilities relating to equality and diversity are outlined within our equality schemes. When considering the needs and assessing the impact of a procedural document any discriminatory factors must be identified.

An Equality Impact Assessment (EIA) has been conducted on this procedural document in line with the principles of the Equality Analysis Policy (CORP/EMP 27) and the Fair Treatment For All Policy (CORP/EMP 4).

The purpose of the EIA is to minimise and if possible remove any disproportionate impact on employees on the grounds of race, sex, disability, age, sexual orientation or religious belief. No detriment was identified. (See Appendix 5)

9 ASSOCIATED TRUST PROCEDURAL DOCUMENTS

Mental Capacity Act 2005 Policy and Guidance, including Deprivation of Liberty Safeguards (DoLS) – PAT/PA 19
De-escalation: Principles and Guidance: Clinical Holding & Restrictive Physical Interventions PAT/PS 15 v.8
Safeguarding Adults – PAT/PS 8
Safeguarding Children – PAT/PS 10
Aggressive and Violent Behaviour towards Staff – CORP/HSFS 5
Arrangement for the Provision of Care to Individuals who are Violent or Abusive (Age 18 or Over) – PAT/PA 6
Privacy and Dignity Policy – PAT/PA 28
Fair Treatment for All Policy – CORP/EMP 4
Equality Analysis Policy – CORP/PAT 27
Enhanced Patient Supervision and Engagement Policy - PAT/PS 20
Resuscitation-Policy – PAT/EC1
Use of Force Policy - PAT/PS 25
Alcohol Issues in the Acute General Hospital Setting (Guidelines and Management) - PAT/T 25
Drug Misuse Management in the Acute Hospital Setting – Guidelines – PAT/T 21

10 DATA PROTECTION

Any personal data processing associated with this policy will be carried out under 'Current data protection legislation' as in the Data Protection Act 2018 and the UK General Data Protection Regulation (GDPR) 2021.

For further information on data processing carried out by the trust, please refer to our Privacy Notices and other information which you can find on the trust website: https://www.dbth.nhs.uk/about-us/our-publications/information-governance/

11 REFERENCES

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APPENDIX 1 – REFERRAL PATHWAY TO LIAISON PSYCHIATRY SERVICE

Mental Health
poster for hospital lia

APPENDIX 2 – SUMMARY OF RAPID TRANQUILISATION PROCESS

De-escalation strategies, primary and secondary including prescribed oral PRN medication been initiated and been ineffective.

If urgent sedation required, doctor to assess service user and prescribe medication for RT

Outcome and tolerability to oral PRN medication logged on care records, if PRN accepted.

Dr to assess and prescribe based on:

- The service user's preferences or advance statements and decisions
- Physical health problems or pregnancy
- Possible intoxication
- Previous response to medication, including adverse effects
- Potential for interactions with other medications

Initial dose to be prescribed as once only (not repeatable) until outcome known. Assess response and tolerability. Tailor further treatment in line with response.

Further doses prescribed after a medical review. (Dose optimisation to be undertaken before switching treatment).

Vital Signs/Physical Health & Hydration to be monitored every hour post RT

- Or every 15mins in high risk circumstances (until concerns re: physical health resolves).

Doctors to be contacted if physical health deteriorates.

Datix incident report, including relevant sections on clinical holding/ restraint MUST be completed post incident.

APPENDIX 3 – POST RAPID TRANQUILISATION CARE PLAN

Please affix patient Identification label

Post Rapid Tranquilisation Care Plan

Date Implemented:	**Implemented by:**	**Signature:**

What constitutes rapid Tranquilisation?

Rapid tranquilisation is the use of medicine to help calm a person who is extremely distressed and is at risk of harm to themselves and/or others. This is only normally used when other methods of de-escalation have been unsuccessful. Rapid tranquilisation medication will only be prescribed as part of a response to otherwise unmanageable episodes of distress with associated risk factors including behaviours of concern, physical violence and aggression.

De-escalation Techniques' Used/attempted

Yes	**No**	If de-escalation techniques not attempted or used please explain reason why.

Details of clinical presentation which led to use of Rapid Tranquilisation.

Details of the Medication administered	Drug	Dose	Time
If oral medication not administered, please state why.			

Early Warning Score must be recorded every 15 minutes for the first hour following administration of Rapid Tranquilisation. (As a minimum the **respirations** and level of **consciousness (AVPU)** is to be recorded and entry made in clinical records as to why full observations can't be recorded)								
Time	Level of consciousness (AVPU)	Respiration rate	O2 sats	Pulse	Temperature	Blood pressure	NEWS	Initials
			Record if safe or clinically indicated					
	The physical observations above must be documented on patients TPR chart, NEWS must be calculated. Time, NEWS, and signature to be documented here on this care plan.							

Early Warning Score must be recorded every half hour for the next three hours following administration of rapid Tranquillisation. (As a minimum the **respirations** and level of **consciousness (AVPU)** is to be recorded and entry made in clinical records as to why full observations can't be recorded)								
Time	Level of consciousness (AVPU)	Respiration rate	O2 sats	Pulse	Temperature	Blood pressure	EWS	Signature
			Record if safe or clinically indicated					
	The physical observations above must be documented on patients TPR chart, NEWS must be calculated. Time, NEWS, and signature to be documented here on this care plan.							

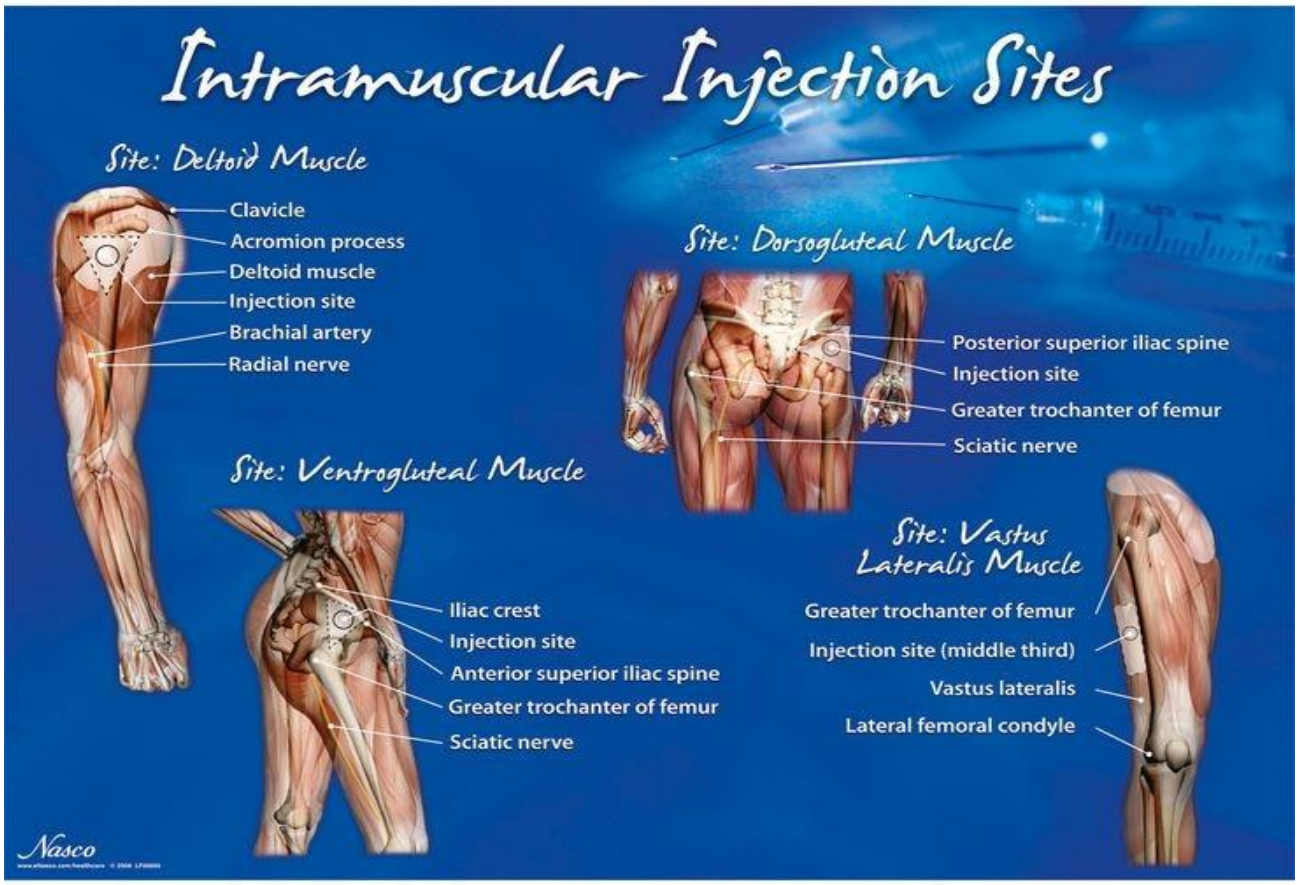
ONLY COMPLETE IF ANTIPSYCHOTIC IS USED **Has an ECG been taken in the past 3 months which showed no abnormalities?**			
Yes	**No**	If **No:** ECG is to be done at the earliest opportunity.	**Date ECG completed.**
		If ECG not undertaken, please state reason why.	

Date Time	Evaluation of patient's clinical response within one hour of administration of Rapid Tranquilisation.	Signature

Date Time	Evaluation of patient's clinical response within two hours of administration of Rapid Tranquilisation.	Signature

Date Time	Evaluation of patient's clinical response within three hours of administration of Rapid Tranquilisation.	Signature
Date Time	Evaluation of patient's clinical response within four hours of administration of Rapid Tranquilisation.	Signature
Date Time	Record of meeting with patient to discuss their perception of how their clinical presentation was managed and the use of Rapid Tranquilisation.	Signature

APPENDIX 4 – INTRAMUSCULAR INJECTION SITES



APPENDIX 5 – REDUCING RESTRICTIVE INTERVENTIONS ESCALATION PATHWAY/RESPONSE

Behaviours of concern where proactive de-escalation intervention is not having a positive impact on the patients' level of distress, **MUST** be escalated to RRIescalation@nhs.net

This escalation process DOES NOT replace referral to MHL/CAMHS/DANS services

If Rapid Tranquilisation has been used – with or without consent- due to escalation of behaviour of concern this MUST be escalated RRIescalation@nhs.net

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Week days: Triaged within 24 hours of receipt.

Weekends: Triaged within 72 hours

↓

Allocation for follow-up by appropriate specialist:

i.e. patient experiencing BPSD/complex delirium – Person Centred Care Practitioner. Person presenting with behaviour of concern linked to Mental Illness, Autism, under 65 years of age with increased confusion, fluctuating capacity to consent, continued suicidal ideation – Named Practitioner for Safety in Caring.

Alcohol/Substance misuse – DANS & Named Practitioner for Safety in caring

↓

Review of potential cause of presenting behaviour, monitoring and current plans around prevention of escalation, de-escalation, restrictive interventions (MCA & DoLS)

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MDT/Safety Huddle – Multi-professional including IMCA/NoK as soon as possible.

↓

Specific support plan formulation, incorporating physical health treatment plan where appropriate.

↓

Schedule frequency of MDT review to be agreed, dependent on complexity of patient need.

APPENDIX 6 - EQUALITY IMPACT ASSESSMENT PART 1 INITIAL SCREENING

Service/Function/Policy/Project/ Strategy	Division	Assessor (s)	New or Existing Service or Policy?	Date of Assessment
Policy	Corporate Nursing	Aileen Knowles	New	1 July 2024

1) Who is responsible for this policy? Corporate Nursing

2) Describe the purpose of the service / function / policy / project/ strategy? Trust Wide Policy/Guidance. Improve patient safety standards & Reporting around use of Rapid Tranquilisation

3) Are there any associated objectives? Legislation, targets national expectation, standards:

4) What factors contribute or detract from achieving intended outcomes? –

5) Does the policy have an impact in terms of age, race, disability, gender, gender reassignment, sexual orientation, marriage/civil partnership, maternity/pregnancy and religion/belief? Details: [see Equality Impact Assessment Guidance] -

- **If yes, please describe current or planned activities to address the impact** [e.g. Monitoring, consultation] –

6) Is there any scope for new measures which would promote equality? [any actions to be taken]

7) Are any of the following groups adversely affected by the policy?

Protected Characteristics	Affected?	Impact
a) Age	N	
b) Disability	N	
c) Gender	N	
d) Gender Reassignment	N	
e) Marriage/Civil Partnership	N	
f) Maternity/Pregnancy	N	
g) Race	N	
h) Religion/Belief	N	
i) Sexual Orientation	N	

8) Provide the Equality Rating of the service / function /policy / project / strategy – tick (✓) outcome box

Outcome 1 ✓	Outcome 2	Outcome 3	Outcome 4

If you have rated the policy as having an outcome of 2, 3 or 4, it is necessary to carry out a detailed assessment and complete a* **Detailed Equality Analysis form – see CORP/EMP 27.

Date for next review: **July 2027**

Checked by: **Marie Hardacre** **Date:** **31 July 2024**