Kent and Medway
NHS and Social Care Partnership Trust

Rapid Tranquilisation Policy and Guidance

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DOCUMENT TRACKING SHEET

Rapid Tranquilisation Policy and Guidance

Version	Status	Date	Issued to/approved by	Comments
0.1	Draft	May 2019		
1.0	Final	October 2019	Trust Wide Patient Safety and Mortality Review Group	Ratified
1.1	Draft	August 2021	Drug and Therapeutic committee	Approved
2.0	Final	October 2021	Trust Wide Patient Safety and Mortality Review Group	Ratified
3.0	Final	July 2023	Trust Wide Patient Safety and Mortality Review Group	Ratified

REFERENCES

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Department of Health (2015) Mental Health Act 1983: Code of Practice.
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Equality Act 2010
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National Institute for Clinical Excellence (2015) Violence and aggression: short-term management in mental health, health and community settings. https://www.nice.org.uk/guidance/ng10
National Institute for Clinical Excellence (2015) Treating severe mental illness in pregnancy and the postnatal period. https://www.nice.org.uk/guidance/cg192/chapter/1-recommendations#treating-specific-mental-health-problems-in-pregnancy-and-the-postnatal-period
National Institute for Mental Health in England (2003) Inside-Outside: Improving Mental Health Services for Black and Minority Ethnic Communities in England

RELATED POLICIES/PROCEDURES/PROTOCOLS/FORMS/LEAFLETS

	Reference
Clinical Risk Assessment Policy	KMPT.CliG.009
Kent and Medway CPA Policy and Procedures	KMPT.CliG.001
Supporting Staff policy	KMPT.HR.044

Management of Incidents including the Management of SIs	KMPT CorG.017
Dignity at Work policy	KMPT.HR.001
Lone Working Policy	KMPT.CorG.024
Stress Policy	KMPT.HR.017
Segregation Seclusion Policy	KMPT.CliG.065
Safeguarding Vulnerable adults Policy	KMPT.CliG.006
First Aid at Work and Resuscitation Policy	KMPT.CliG.010
Joint Working Agreement between Kent Police and Kent Health Bodies	KMPT.CliG.006
Promoting Safe Services Policy	KMPT.CorG.013
Post incident and immediate support policy	KMPT.CliG.159

SUMMARY OF CHANGES

Date	Author	Page	Changes (brief summary)
May 2019	Chief Pharmacist		Rapid tranquilisation section removed from the Prevention and Management of Violence and Aggression and Rapid Tranquilisation Policy and Guidance (now titled the Promoting Safe Services Policy KMPT.Corg.013) and formatted as a separate document.
July 2021	Deputy Chief Pharmacist	9	Addition of guidance on rapid tranquilisation in pregnancy.
July 2021	Deputy Chief Pharmacist	20	Inclusion or rapid tranquilisation monitoring form.
May 2023	Chief Pharmacist	3	All incidents of the use of rapid tranquilisation must be reported via the InPhase electronic system within 24 hours of occurrence.
May 2023	Chief Pharmacist	5	Updated 4.2.5: Rapid tranquilisation should only be considered when all other techniques of calming or managing the patient have failed to reduce the level of risk, or when the extreme nature of the incident requires a rapid response. Consideration also needs to be given to increasing therapeutic observations based on risk and the needs of the patient.
May 2023	Deputy Chief Pharmacist	9	New point 5.5.1 Physical health monitoring is a mandatory requirement after the administration of both oral and IM sedative medication regardless of the indication for use.
May 2023	Deputy Chief Pharmacist	9	Updated 5.5.4: If intra-muscular rapid tranquilisation has been used monitor side effects and the service user's pulse, blood pressure, respiratory rate, temperature, level of hydration and level of consciousness at least every 15 minutes for at least one hour, then continue to monitor vital signs after 1 hours if the service user is scoring 1 or above on the NEWS2 chart/e-observations if there are concerns about their clinical presentation.
May 2023	Chief Pharmacist	10	New 5.5.5: If the patient refuses to have their physiological observations taken, staff should document refusal in the RiO progress notes and continue to observe for signs and symptoms of deterioration and respiration rates should be recorded on the early warning score chart as a minimum.
May 2023	Chief Pharmacist	13	Updated section 12: Monitoring compliance and effectiveness of the policy.
May 2023	Deputy Chief Pharmacist	16	New appendix B on how to record use of RT medication and observations on RiO.
May 2023	Deputy Chief Pharmacist	18	Appendix D updated: Rapid tranquilisation in an acutely disturbed adult.
May 2023	Chief Pharmacist	20	Appendix G updated with remedial measures in rapid tranquilisation particularly on how to manage Neuroleptic Malignant Syndrome.
May 2023	Chief Pharmacist	22	New Appendix I on how to use flumazenil.
June 2023	Deputy Chief Pharmacist	10	Updates to the general principles of management of RT in pregnancy and postpartum including additional advice on prescribing of medication.

June 2023	Chief Pharmacist	19	New appendix E: Rapid tranquilisation in pregnancy and postpartum guidance

CONTENTS

1 EMPLOYER'S DUTIES

1.1 Healthcare organisations have an obligation to ensure treatments are safe and effective and that the NICE guidelines have been considered. They should ensure their staff receive appropriate training. This section aims to help staff understand their responsibilities and accountabilities, it is not exhaustive and professionals must also consider their own Codes of Practice.

1.2 The Trust Board

1.2.1 Will ensure that Governance arrangements are in place and will include audit procedures that relate to training needs and provision, and the review of untoward incidents.

1.2.2 Will ensure that that the policy is reviewed and updated to support Governance arrangements.

1.2.3 Will ensure that the policy is current and based on national guidance.

1.2.4 Will learn and react appropriately to any untoward incidents and events related to rapid tranquilisation (RT).

1.2.5 Will respond or react to any resource implications related to RT.

1.3 Executive Director of Nursing and Governance

1.3.1 Will provide or facilitate the provision of training required to support the clinical principles of this policy.

1.3.2 Ensure monitoring is undertaken in-line with Trust policy.

1.4 Trust Wide Health Safety Reporting Group

1.4.1 Ensure compliance with Health and Safety law, including (RIDDOR) 2010 specifically include those serious injuries sustained by staff as a result of violence.

1.4.2 Have responsibility and the authority to oversee and receive reports from The Violence, Restraint and Seclusion Monitoring group.

1.4.3 Ensure that there are suitable arrangements in place within directorates/care groups to meet their training in PSTS requirements and demonstrate compliance with CQC 5 Key Standards.

1.5 Promoting Safe Service Monitoring Group

1.5.1 Will undertake regular and systematic audit of all activities clinical and non-clinical to identify, and where possible eliminate or minimise risk.

1.5.2 This Group will have a senior representative from PSS, Corporate Nursing, Health and Safety, Care Groups and Safeguarding.

1.5.3 The Group will consider themes and trends and ensure these are taken to the Learning from Experience Group and picked up in supervision if needed in the Care Groups.

1.6 Chief Pharmacist Duties

1.6.1 Ensures that Trust policy is based on current NICE guidelines and standards in relation to rapid tranquilisation

1.6.2 Defines the levels of training required by staff across the Trust

1.6.3 Ensures that a system of clinical audit of rapid tranquilisation is carried out to monitor compliance with this policy

1.6.4 Provides professional advice to the Trust wide Patient Safety Group through membership and attendance at meetings.

1.6.5 Ensures this policy is reviewed and updated in response to changes in recommended Guidelines.

1.7 **Complaints Manager**

1.7.1 Ensures that the PSTS Training Manager/ Senior Practitioner is involved in reviewing complaints regarding the use of physical intervention skills, seclusion or any issues of conflict management.

1.7.2 Feeds back outcomes from complaints to ensure lessons can be learnt.

1.8 **Head of Learning and Development**

1.8.1 Ensure staff induction and training programmes take full account of all hazards and risks, clinical and non-clinical, likely to be encountered in the workplace and provide safe systems of work based upon evidence-based practice where available.

1.8.2 Reviews corporate, directorate and care group mandatory and statutory training requirements, and reports on compliance.

2 EMPLOYEE'S DUTIES

2.1 Will read and understand the policy and guidance. Will complete and pass e-learning module.

2.2 Staff administering RT will comply with the requirements of the policy. It is the responsibility of individual nurses administering RT to ensure post-RT monitoring is undertaken and recorded. See appendix B on how to record use of RT medication and observations on RiO

2.3 Will identify their own training needs in relation to RT through the appraisal process, with reference to the Trust essential training policy.

2.4 Will only carry out RT procedures that they have been trained and assessed as competent to do. All staff have a responsibility and are expected to attend relevant theoretical and practical training and development opportunities in order to gain the necessary competencies associated with the professional management of a violent or potentially violent incident in accordance with Trust policy and other locally determined procedures.

2.5 Those registered nurses who are involved in administration of rapid tranquilisation must undertake Immediate Life Support training yearly.

3 COMMUNICATION AND RECORD KEEPING

3.1 All staff must be aware of the systems and procedures in place for summoning assistance when required.

3.2 All incidents of the use of rapid tranquilisation must be reported via the InPhase electronic system within 24 hours of occurrence.

3.3 It is the responsibility of all staff to report and record actual or potential incidents using the appropriate reporting documentation. Following incident investigations, it is the responsibility

of Managers to report to the individual(s) and or staff groups concerned their findings and recommendations to prevent further incidents from arising.

3.4 Information for patients, visitors and carers with regard to the Trust's position on violence is available

4 RAPID TRANQUILISATION OR CHEMICAL RESTRAINT

4.1 Using oral PRN (pro re nata) medication

PRN in this policy refers to the use of oral medication as part of a strategy to prevent situations that may lead to violence or aggression or to treat a formally identified physical or mental illness. It does not refer to oral medication used on its own for rapid tranquilisation during an episode of violence or aggression (this is described in section 4.2).

4.1.1 If a patient is admitted outside of normal working hours the clerking doctor may prescribe oral lorazepam or promethazine PRN ONLY IF CLINICALLY INDICATED until the patient can be reviewed by a multi-disciplinary team

4.1.2 A multi-disciplinary team that includes a psychiatrist should develop and document an individualised pharmacological strategy for using routine and PRN medication to calm, relax, tranquillise or sedate service users who are at risk of violence and aggression as soon as possible after admission to an inpatient psychiatric unit.

4.1.3 If a specialist pharmacist was not present in the multi-disciplinary team meeting then their agreement with the strategy or further discussion should take place as soon as possible.

4.1.4 N.B 4.1.1 – 4.1.3 Are a variation on NICE NG10 to allow for the safety of staff and clients admitted outside of normal working hours.

4.1.5 The multi-disciplinary team should review the pharmacological strategy and the use of oral PRN medication at least once a week and more frequently if events are escalating and restrictive interventions are being planned or used. The review should be recorded and include:

a) Clarification of target symptoms

b) The likely timescale for response to medication

c) The total daily dose of medication, prescribed and administered, including regular and PRN medication that is being used for tranquilisation / sedation

d) The number of and reason for any missed doses of regular medication

e) Therapeutic response

f) The emergence of unwanted effects.

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

a) Do not prescribe PRN medication routinely or automatically on admission unless this is outside of working hours and clinically indicated. Such a prescription must be reviewed ASAP by a multi-disciplinary team

b) Tailor PRN medication to individual need and include discussion with the service user if possible

c) 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

d) Ensure that the maximum daily dose is specified and does not inadvertently exceed the maximum daily dose stated in the BNF when combined with the person's standard dose or their dose for rapid tranquilisation

e) Only exceed BNF maximum daily dose (including PRN dose, the regular dose and dose for rapid tranquilisation) if this is planned to achieve an agreed therapeutic goal, documented, and carried out under the direction of a senior doctor

f) Ensure the interval between PRN doses is specified.

4.1.7 The multidisciplinary team should review PRN medication at least once a week and, if PRN medication is to be continued, the rationale for its continuation should be included in the review. If PRN medication has not been used since the last review, consider stopping it.

4.1.8 When oral PRN medications are given as part of a strategy to de-escalate or prevent situations that may lead to violence or aggression the following observations should be made: Monitor side effects and temperature, Pulse, BP, respiratory rate, level of hydration and level of consciousness 1 hour after administration and repeat until there are no concerns about their physical health status

This should be documented on a NEWS2 chart/e-observations.

4.2 Rapid Tranquilisation

4.2.1 Rapid tranquilisation for the purposes of this policy (and as defined in NICE CG10 and NHS England, Mental Health Data Set) refers to the administration of sedative medication by injection or orally as a restrictive intervention.

4.2.2 Restrictive intervention is defined as

(1) 'Planned or reactive acts on the part of other person(s) that restrict an individual's movement, liberty and/or freedom to act independently in order to:
- take immediate control of a dangerous situation where there is a real possibility of harm to the person or others if no action is undertaken;
and
(2) end or reduce significantly the danger to the person or others;
and
(3) contain or limit the person's freedom

4.2.3 Chemical restraint or rapid tranquilisation is defined as the use of medication which is prescribed, and administered (whether orally or by injection) for the purpose of controlling or subduing disturbed/violent behaviour, where it is not prescribed for the treatment of a formally identified physical or mental illness. It must fit the criteria defined in 4.2.2

4.2.4 Rapid tranquilisation is to be used when disturbed or violent behaviour by an individual in an inpatient setting poses a serious risk to that individual, other service users and staff. The aim is to achieve a state of calm sufficient to minimise the risk posed to the service user or to others.

4.2.5 Rapid tranquilisation should only be considered when all other techniques of calming or managing the patient have failed to reduce the level of risk, or when the extreme nature of the incident requires a rapid response. Consideration also needs to be given to increasing therapeutic observations based on risk and needs of the patient. Refer to the Promoting Safe Services Policy.

4.2.6 Although a number of effective agents are available for sedation, there is no evidence showing clear superiority for any one agent. Therefore, individualised treatment needs to be emphasised, considering the service user's view, pre-existing physical health problems, previous response to medications including adverse effects, the potential

for interactions with other medications, and the total daily dose of medications prescribed and administered.

4.2.7 Oral medication can include promethazine or lorazepam and should be prescribed as a single dose.

4.2.8 Intramuscular lorazepam is recommended for service users who have not taken antipsychotic medication before because it is an effective intervention that is likely to be acceptable to the majority of service users. Prescribing the initial dose of rapid tranquilisation as a single dose will ensure that any subsequent treatment options can be individualised, taking account of both response and any emergent adverse effects of the initial treatment choice.

4.2.9 Medication for rapid tranquilisation must be used with caution because of the following risks:

a) Loss of consciousness

b) Sedation with loss of alertness

c) Loss of airway

d) Cardiovascular and respiratory collapse

e) Interaction with medicines already prescribed, or illicit substances taken

f) Possible damage to patient-staff relationships

g) Underlying coincidental physical disorders

4.2.10 There are specific risks with different classes of medication. Risks may be compounded if used in combination.

a) Benzodiazepines: Loss of consciousness, respiratory depression or arrest;

b) Cardiovascular collapse when receiving both clozapine and benzodiazepine.

c) Antipsychotics: loss of consciousness, cardiovascular/respiratory complications and collapse; seizures; akathisia; dystonia; dyskinesia; neuroleptic malignant syndrome; excessive sedation.

d) Antihistamines: excessive sedation; painful injection; additional antimuscarinic effects.

4.2.11 When prescribing medication for use in rapid tranquilisation, write the initial prescription as a single dose, and do not repeat it until the effect of the initial dose has been reviewed. The reason for prescribing must be documented in the patient's notes

a) Do not prescribe intra-muscular rapid tranquilisation medication routinely or automatically on admission unless this is outside of working hours and clinically indicated. Such a prescription must be reviewed asap by a multi-disciplinary team

b) Tailor intramuscular rapid tranquilisation medication to individual need and include discussion with the service user if possible

c) Ensure there is clarity about the rationale and circumstances in which rapid tranquilisation medication may be used and that these are included in the nursing care plan

4.2.12 Use either intramuscular lorazepam on its own or intramuscular olanzapine on its own or intramuscular haloperidol combined with intramuscular promethazine for rapid tranquilisation in adults. It is important that olanzapine is only prescribed with Consultant authorisation. When deciding which medication to use, consider:

a) The service user's preferences or advance statements

b) Any contra-indications, warnings or precautions necessary. Patients with any co-existing physical illness, including poor liver, renal or cardiac function, should have drug and dose adjusted accordingly. Care should be exercised in patients with a history of or risk factors for, seizures.

c) Care should be exercised in patients who are or may be pregnant, or who are breast feeding. Where possible advice must be sought from the pharmacist in advance of a potential incident. As the frequency of rapid tranquilisation of this client group is quite low this should always be actively considered so that in the eventuality of an emergency situation there is enough information on which to base prescribing decisions.

d) Possible intoxication

e) Previous response to these medications, including adverse effects

f) Potential for interactions with other medications

g) The total daily dose of medications prescribed and administered

4.2.13 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.

4.2.14 If there is evidence of cardiovascular disease, including prolonged QT interval, or no ECG has been carried out, avoid intramuscular haloperidol combined with promethazine and use intramuscular lorazepam or olanzapine instead.

4.2.15 If there is partial response to intramuscular lorazepam, consider a further dose.

4.2.16 If there is no response to intramuscular lorazepam, consider intramuscular haloperidol combined with intramuscular promethazine or intramuscular olanzapine on its own.

4.2.17 If there is a partial response to intramuscular haloperidol combined with intramuscular promethazine, or olanzapine on its own, consider a further dose.

4.2.18 If there is no response to intramuscular haloperidol combined with intramuscular promethazine (or olanzapine) consider intramuscular lorazepam if this hasn't 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. Do not combine haloperidol and olanzapine in the same rapid tranquilisation episode.

4.2.19 After rapid tranquilisation the client should be observed and monitored as stated in section 5.5.

4.2.20 Resuscitation equipment must be available within 3 minutes in all healthcare settings where rapid tranquilisation might be used. This equipment should include:

a) Automatic external defibrillator

b) Bag Valve Mask

c) Oxygen

d) Suction

e) Pulse Oximeters

f) (a) (d) and (e) to be checked daily and records kept.

4.3 **Alternative treatment options**

4.3.1 These recommendations do not preclude the use of alternative treatment options. However, the use of alternative treatments should be tailored to the individual in line

with the recommendations for rapid tranquilisation and the rationale for using a medication that is not recommended above must be clearly documented in the patient's notes, with agreement from a multi-disciplinary team, prior to a prescription being written.

4.4 **Rapid tranquilisation during seclusion**

4.4.1 If rapid tranquilisation is needed while a service user is secluded, undertake with caution, following the above recommendations and

a) Be aware of and prepared to address any complications associated with rapid tranquilisation

b) Ensure the service user is observed within eyesight by a trained staff member with Immediate Life Support Skills for first 30 minutes.

c) Undertake a risk assessment and consider ending the seclusion when rapid tranquilisation has taken effect.

4.5 **Immediate Post incident debrief**

4.5.1 Following an incident involving the use of rapid tranquilisation, once the risks of harm have been contained, it is good practice for an immediate post-incident review to take place, where practical, including a doctor and a nurse, to identify factors that can be addressed to reduce the likelihood of a further incident and amend risk and care plans accordingly.

4.5.2 Ensure that the service user involved has the opportunity to discuss the incident in a supportive environment with a member of staff or advocate. If the service user takes up the offer, this should be recorded in the clinical record. See appendix B

4.6 **Formal Post incident review**

Where possible and practical, it is good practice for a formal external post-incident review to take place within 72 hours after an incident involving rapid tranquilisation. The group undertaking the review should ensure that the review:

4.6.1 Is led by a service user and includes staff from outside the ward where the incident took place, all of whom are trained to undertake investigations that aim to help staff learn and improve rather than assign blame

4.6.2 Uses information recorded in the immediate post-incident debrief and the service user's notes related to the incident

4.6.3 Includes interviews with staff, the service user involved and any witnesses

4.6.4 Evaluates the physical and emotional impact on everyone involved, helps service users and staff to identify what led to the incident and what could have been done differently

4.6.5 Determines whether alternatives to rapid tranquilisation were discussed

4.6.6 Recommends change to philosophy, policies, care environment, treatment approaches, education and training, if appropriate

4.6.7 The group undertaking the review should provide a report to the ward where the incident took place.

4.7 Within a week the patient's written care plan should address the management of episodes of disturbed behaviour and acknowledge his/her preferences and wishes should they become behaviourally disturbed again.

5 MONITORING OF RAPID TRANQUILISATION

Following any rapid tranquilisation, the monitoring forms MUST be completed on RiO. Failure to report can leave the staff and or patients, visitors and carers at risk.

5.1 Staff and Patient Support

5.1.1 Following an incident of violence appropriate after-care will be provided for affected staff and patients, visitors and carers through the immediate line management who will involve other personnel as appropriate.

5.1.2 It is important to consider informing next of kin, family member or carer of staff or patient who have been involved in the incident before any press involvement.

5.1.3 Staff should work with the Patient to review and amend their Positive Behaviour Support Care Plans

5.2 Immediate Support

5.2.1 Ensure all staff and patients are safe. Arrange that physical care is given as required. Ensure all staff and patients have the opportunity to talk through their experiences. Provision should be given for further and ongoing support.

5.2.2 Arrange for Incident Debriefing to take place (48-72 hours after incident)

5.3 Follow Up

5.3.1 Appropriate support must be offered to all those who have been directly or indirectly affected by the incident.

5.3.2 Access to support is available for staff, see staff handbook

5.3.3 It may be necessary to access other professionals to provide ongoing support to patients, visitors and carers including the Safeguarding team

5.4 Additional Action to be taken following an Incident

5.4.1 To notify the Police that a violent incident/ crime has occurred.

a) For a level 4 or 5 (SI reportable) i.e. broken bones, skin and/or blood) call 999

b) For level 3 or below report through the 101.

5.4.2 The Local Security Manager Specialists (LSMS's) should be informed of the incident by the member of staff affected by the incident, the ward manager or nurse in charge.

5.4.3 That the Incident is reported through the InPhase system.

5.4.4 Ensure witness statements are taken within 48 hours.

5.4.5 The nurse in charge at the time must make and document an assessment:

a) Of the patient’s capacity at the time of the incident.

b) Complete a Police Capacity Assessment Form.

c) A current and updated risk assessment for the police.

d) He or she should then arrange for assessment of the patient/patient by a consultant within 24-48 hours.

5.4.6 An Advocate may need to be appointed to act on behalf of the assaulted victim (to act on their behalf and to keep them informed of proceedings)

5.4.7 The situation should be discussed with the wider multi-disciplinary team in relation to safeguarding and DoLS and any appropriate assessments made, please refer to the Safeguarding Vulnerable adult's policy.

Remember:

5.4.8 Other staff and patients, carers and visitors may experience a reaction to the incident. They may require support and guidance in addition to training to help them manage future situations effectively. Involving all staff in any review of departmental risk assessments and safety procedures soon after the incident and periodically thereafter will help to allay any anxieties staff groups may feel in relation to particular incidents.

5.4.9 The Trust will support police prosecution of individuals committing any acts of violence against staff and patients, visitors and carers.

5.4.10 The Trust will support private prosecution of individuals where appropriate and subject to favourable legal advice.

5.4.11 The member of staff and/or patient assaulted must make a statement to the police if they wish a prosecution to be pursued with any chance of success.

5.4.12 Additional support and advice can be obtained through the Trust's Legal Department.

5.5 **Client observation (as soon as possible following interventions**)

5.5.1 Following oral or intra-muscular rapid tranquilisation the mental and behavioural state (behaviourally disturbed/agitated, asleep or awake, impairment of consciousness) of the patient should be monitored at least every hour until there are no further concerns.

5.5.2 If oral rapid tranquilisation is given the following observations should be made: Monitor side effects and temperature, Pulse, BP, respiratory rate, level of hydration and level of consciousness 1 hour after administration and repeat until there are no concerns about their physical health status

This should be documented on a NEWS2 chart/e-observations

5.5.3 If intra-muscular rapid tranquilisation has been used monitor side effects and the service user's pulse, blood pressure, respiratory rate, temperature, level of hydration and level of consciousness at least every 15 minutes for at least one hour, then continue to monitor vital signs after 1 hours if the service user is scoring 1 or above on the NEWS2 chart/e-observations if there are concerns about their clinical presentation.

Add pulse oximetry to the observations if the BNF maximum dose has been exceeded or the service user:

a) Appears to be asleep or sedated

b) Has taken illicit drugs or alcohol

c) Has a pre-existing physical health problem

d) Has experienced any harm as a result of any restrictive intervention

If the service user is non-responsive, unconscious or unarousable, this is a medical emergency. The alarm should be raised, call 999 and contact the medical team or duty doctor out of hours immediately. If the service user is severely physically unwell or there are concerns regarding clinical presentation, seek medical advice immediately.

5.5.4 Monitor continuously and document the observations on a NEWS2 chart/e-observations.'If the patient refuses to have their physiological observations taken, staff should document refusal in the RiO progress notes and continue to observe for signs and symptoms of deterioration and respiration rate and level of consciousness should be recorded on the early warning score chart as a minimum. For oral rapid tranquillisation this should be minimum 1 hour after administration and for intramuscular rapid tranquilisation minimum every 15 minutes for 1 hour. Continue to monitor vital signs after 1 hour if the service user is scoring 1 or above on the NEWS2 chart/e-observations OR you have concerns about their clinical presentation. Therapeutic observations should be reviewed and increased to support the ongoing monitoring for signs of a deteriorating patient.

6 RAPID TRANQUILISATION IN PREGNANCY AND POSTPARTUM

In addition to the guidance outlined in this policy, the following principles apply when using rapid tranquilisation (RT) for a pregnant service user.

6.1 General principles of management

6.1.1 The aim of rapid tranquilisation in pregnancy is to avoid prolonged physical intervention, prevent or reduce harm to the pregnant service user physically and psychologically and prevent harm to others including the unborn child.

6.1.2 When a service user is known to be pregnant, a care plan including the medication to be used in the event of rapid tranquilisation should be written and shared with all the necessary healthcare professionals that will be involved in their care.

6.1.3 The treatment algorithm remains the same for pregnant service users as detailed in Appendix D. In addition, the principles in Appendix E should be followed when using rapid tranquilisation in a pregnant or postpartum service user.

6.1.4 The choice of medication to be prescribed and administered should be made on an individual basis considering the risks to both the mother and unborn child.

6.1.5 Minimum effective doses should be used because of possible neonatal extrapyramidal symptoms with antipsychotics and floppy baby syndrome with benzodiazepines.

6.1.6 Whenever possible, consider using promethazine first line over lorazepam due to the risk of floppy baby syndrome associated with benzodiazepines.

6.1.7 If antipsychotic medication is used repeatedly close to delivery, this should be documented in the case records so that a neonatologist can check the baby postpartum due to the risk of neonatal abstinence syndrome.

6.1.8 Restraint procedures should only be used as a last resort and should be adapted to avoid possible harm to the unborn child and the mother. On no occasion should the mother be held on her front during restraint.

6.1.9 Any ward/unit that has a pregnant service user on admission should have access to beanbags for use during the administration of RT.

6.1.10 If RT is administered to a pregnant service user on an acute ward, consideration should be given to ensuring that a community midwife review is undertaken where possible.

6.1.11 A pregnant service user should never be secluded after the administration of RT.

6.1.12 A referral should be made to the local acute hospital's A&E department if there are any concerns regarding the unborn child following RT.

6.1.13 During the perinatal period, the service user's care should be managed in close collaboration with the obstetrician and an anaesthetist.

6.1.14 In the post-natal period, care should be taken if a woman has had a Caesarean section in relation to restraint and wound care.

6.1.15 If a mother is breastfeeding, the baby should be observed for sedation after the administration of RT.

6.1.16 All interventions that have taken place during RT should be documented in the service user's notes and communicated verbally in any handover to all the professionals involved including psychiatry, the midwife and paediatrics.

7 IMPLEMENTATION INCLUDING TRAINING AND AWARENESS

7.1 The Trust provides compulsory training in accordance with National and Local policy and guidelines (See Trust Learning and Development Training Prospectus for details of courses).

7.2 Set out below is the training needs analysis for all staff groups identifying which members of staff require training and the level they require.

7.3 **The aim of the training is to:**

7.3.1 Ensure all staff are aware of their duties/roles and responsibilities to enable them to implement the policy.

PACKAGE	WHO AIMED AT	CONTENT'S	DURATION/VENUE	UPDATE'S
Rapid Tranquilisation	Doctor's Registered Nurses	• Introduction • Rapid tranquilisation adults • Rapid tranquilisation older adults • Types of medication Risk of medication • Physical Monitoring • Remedial Measures • Special Groups	e-Learning	Yearly

8 STAKEHOLDER, CARER AND USER INVOLVEMENT

8.1 **Key Individuals:**

Promoting Safer Therapeutic Services Training Manager/ Senior Practitioner

8.2 **Groups:**

c) Trust Wide Health and Safety Group	d) Risk Management Domain Group
e) KMPT and CFSMS information Sharing Group	f) Local Faith Groups
g) Violence, Restraint, Seclusion Monitoring Group.	

8.3 **Disciplines:**

a) All staff through consultation with representatives	b) Via Clinical Governance Group

8.4 **Carers/Users and Associated groups:**

a) Via consultation and monitoring group	b) Via Clinical Governance Group

Stakeholders will be informed of any changes via consultation, monitoring Group and Health and Safety Group.

9 EQUALITY IMPACT ASSESSMENT

9.1 The Equality Act 2010 places a statutory duty on public bodies to have due regard in the exercise of their functions and to assess the impact of its policies/strategies on protected groups. The duty also requires public bodies to consider how the decisions they make, and the services they deliver, affect people who share equality protected characteristics and those who do not. In KMPT the culture of Equality Impact Assessment will be pursued in order to provide assurance that the Trust has carefully considered any potential negative outcomes that can occur before implementation. The Trust will monitor the implementation of the various functions/policies and refresh them in a timely manner in order to incorporate any positive changes.

10 HUMAN RIGHTS

10.1 The Human Rights Act 1998 sets out fundamental provisions with respect to the protection of individual human rights. These include maintaining dignity, ensuring confidentiality and protecting individuals from abuse of various kinds. Employees and volunteers of the Trust must ensure that the trust does not breech the human rights of any individual the trust comes into contact with.

11 KEY PERFORMANCE INDICATORS

11.1 Reduce the number of aggressive and violent incidences to staff, carers, services users and visitors.

11.2 Reduce staff sickness caused by assault or injury.

11.3 To ensure all staff are trained in how to deal with aggressive and violent Incidents.

11.4 That the Trust has a clear understanding of its role and responsibilities.

11.5 That staff have a clear understanding of their role and responsibilities.

11.6 That all Trust staff will have a clear understanding of support as it relates to staff, carers, services users and visitors.

11.7 To reduce the use of prone restraint to those situations where it is the patients own choice of position due to past trauma or situations where the patient over powers the team accurate and complete recording of all incidents

12 MONITORING COMPLIANCE WITH AND EFFECTIVENESS OF THIS DOCUMENT

What will be monitored	How will it be monitored	Who will monitor	Frequency	Evidence to demonstrate monitoring	Action to be taken in event of non-compliance
Effectiveness of the policy and ability of staff to apply it in practice.	During working hours escalation of Rapid Tranquilisation incidents to ward managers matrons Out of hours escalation to Clinical Leads and Forensic On-Call Manager Observation of trends and review of RT prescribing and administration reported by the Medicine Safety Officer to matrons every 4 weeks to enable them to produce reports to patient safety meetings	Matrons / Governance leads within each directorate	Bi-monthly meetings and reporting to Trust wide Patient Safety and Mortality Group and monthly meetings and reporting to Integrated Quality & Performance Review (IQPR) Group	Minutes and reports from Directorate Patient Safety Meetings, Trust wide Patient Safety and Mortality Group, Integrated Quality & Performance Review (IQPR) Group	A lead member of the clinical team will be identified to take each change forward where appropriate and lessons will be shared with all the relevant stakeholders.
Processes and duties for undertaking prevention & management of violence and aggression risk assessments are adhered to.	Review of PSS incidents related to the use of physical force via InPhase	PSS Manager	1. Bimonthly 2. Bimonthly 3. Monthly	1. Reports to Promoting Safe Services group 2. Reports to Trust wide H&S group 3. Monthly reports to directorates	Required changes to practice will be identified and actioned within a specific time frame. A lead member of the clinical team will be identified to take each change forward where appropriate and lessons will be shared with all the relevant stakeholders

					through the PSS training team.
Risk assessments are shared to protect staff and patients from violence and aggression	Review of PSS monitoring forms on InPhase	PSS Manager	Monthly	Reports to directorates	A lead member of the clinical team will work with the PSS training team to share learning with relevant stakeholders.
Appropriate Staff undertake e-learning Rapid Tranquilisation training	Training stats	Learning & Development team	Monthly	Training reports to directorates	Line managers will ensure that staff complete training course and report to directorates.
Processes and duties on prescribing guidelines for Rapid Tranquilisation and documenting observations carried out after rapid tranquilisation are adhered to	Monthly BI report discussed bi-monthly at Medicines Safety Group	Medicines Safety Officer via Medicines Safety Group	Bi-monthly meetings of Medicines Safety Group reported to Drug & Therapeutics Group	Drug and Therapeutic Group minutes	Required changes to practice will be identified and reported to the Medicines Safety Group. A lead member of the clinical team will be identified to take each change forward where appropriate and lessons will be shared with all the relevant stakeholders

APPENDIX A ABBREVIATIONS AND DEFINITIONS

Abbreviation	Meaning
BNF	British National Formulary
CQC	Care Quality Commission
DoH	Department of Health
HSWA	Health and Safety at Work Act
KMPT	Kent and Medway Partnership Trust
LSMS	Local Security Management Specialist
MHSWR	Management of Health and Safety at Work Regulations.
NIMHE	National Institute for Mental Health in England
NMS	Neuroleptic Malignant Syndrome
PSS	Promoting Safe Services
RIDDOR	Reporting of Injuries, Disease and Dangerous Occurrences Regulations.
RT	Rapid Tranquilisation
SMS	Security Management Services.
SPC	Summary of Product Characteristics
PSSMG	Promoting Safe Services Monitoring Group

APPENDIX B HOW TO RECORD USE OF RAPID TRANQUILISATION MEDICATION ON RIO

Guidance sheet:

How to record use of rapid tranquilisation medication on Rio

NHS
Kent and Medway
NHS and Social Care Partnership Trust

Version 2

Complete a **rapid tranquilisation form** every time intramuscular medication (IM) and/or oral medication is administered for rapid tranquilisation.

1

The forms are located under Inpatient Management:

- Inpatient Management
  - Admission
  - Discharge
  - Delayed Discharge
  - Pre Discharge Planning
  - Admission History
  - Leave & AWOL History
  - 836/Place of Safety
  - Long-term Segregation
  - **Rapid Tranquilisation**
  - Seclusion

2

Rapid Tranquilisation - Medication & Observations

Use this form to record:

- medications given
- general observations

3

Rapid Tranquilisation - Immediate Debrief

Use this form to record:

- details of those present for the immediate debrief
- actions taken to reduce the likelihood of a further incident
- a record of discussions with the patient
- the post-incident review date

4

NEWS2 Scores during Rapid Tranquilisation period

NEWS2 scores will populate here from eObs once the 1st form is completed.

If administering RT to a pregnant or postpartum service user, you must ensure all information is correctly recorded as set out in the dedicated Guidance Sheet.

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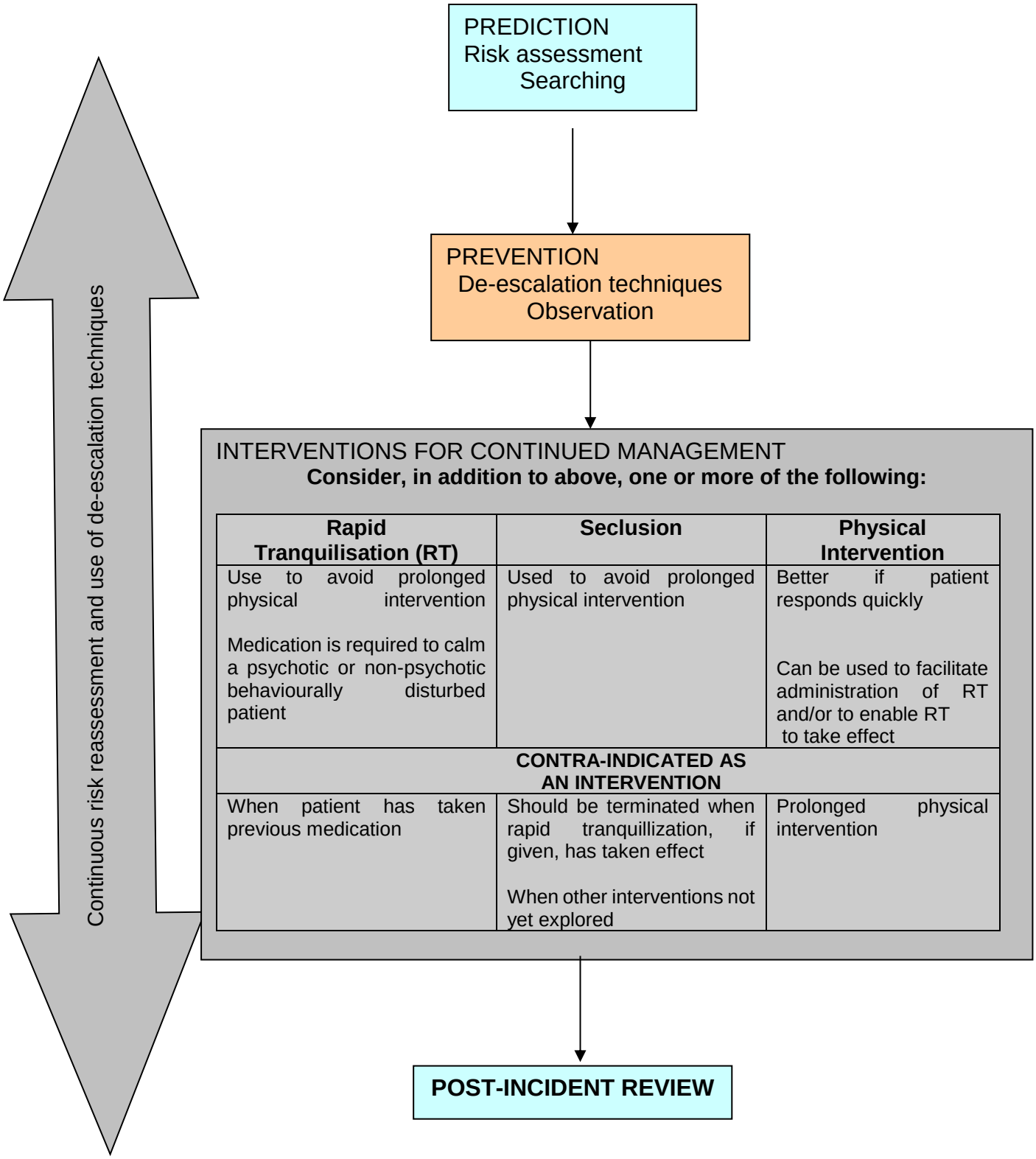
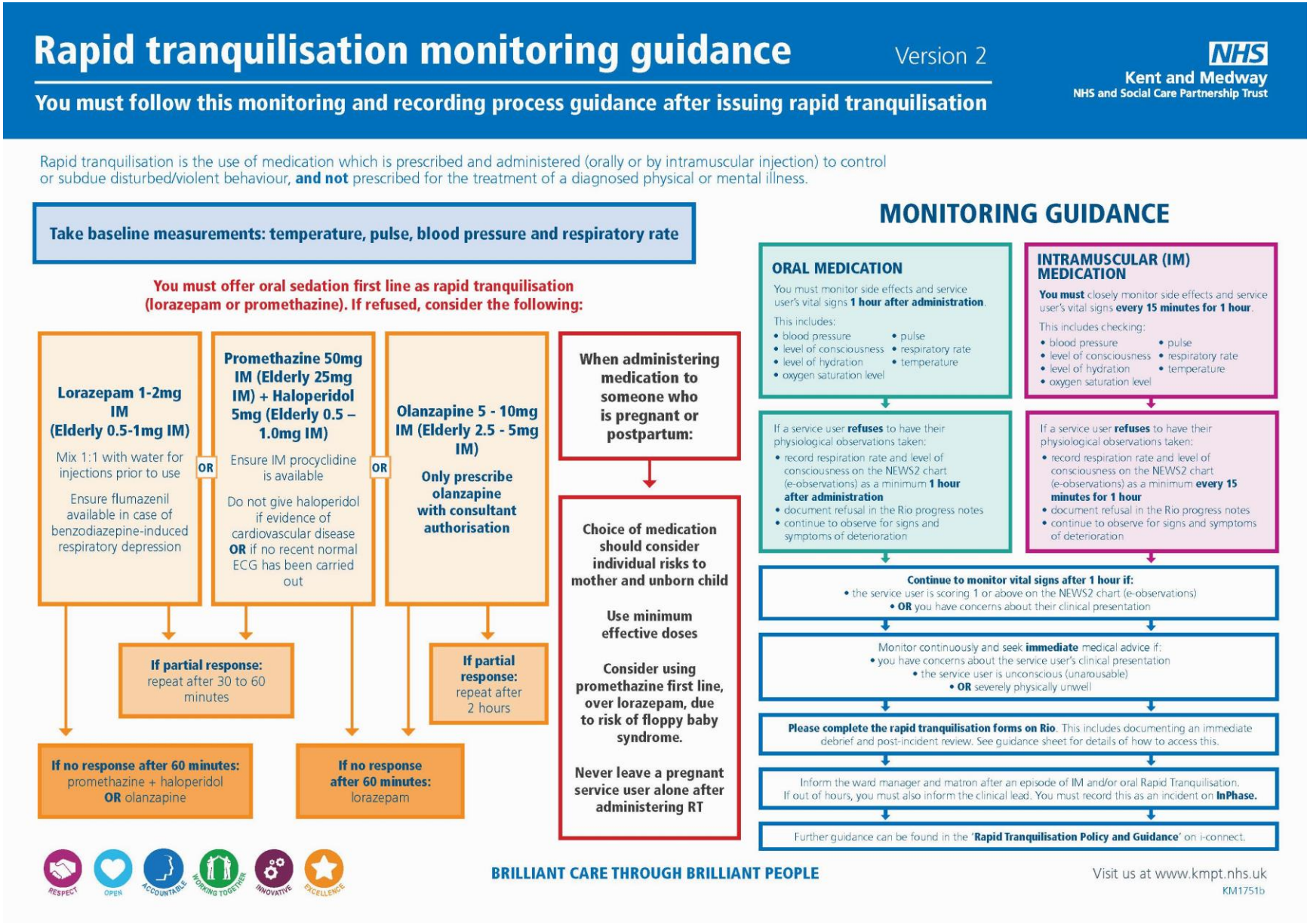
KM1751c

APPENDIX C OVERVIEW OF THE SHORT-TERM MANAGEMENT OF DISTURBED / VIOLENT BEHAVIOUR



APPENDIX D RAPID TRANQUILISATION IN AN ACUTELY DISTURBED ADULT



APPENDIX E RAPID TRANQUILISATION IN PREGNANCY AND POSTPARTUM GUIDANCE

NHS
Kent and Medway
NHS and Social Care Partnership Trust

Guidance sheet:
Rapid tranquilisation in pregnancy and postpartum

In addition to our general guidance policy, the following principles apply when using rapid tranquilisation (RT) for a pregnant or postpartum service user.

1 Care plans

A care plan, including the medication to be used in the event of RT, **must be in place** and shared with all the those who will be involved in a service user's care.

Medication decisions **must consider potential individual risks** to both the mother and unborn child.

During the perinatal period, the service user's care should **be managed in close collaboration with the obstetrician and an anaesthetist**.

2 Restraint

Restraint procedures **should only be used as a last resort** and should be adapted to avoid possible harm to the unborn child and the mother.

On **no occasion should the mother be held on her front** during restraint. Bean bags should also be available for use during the administration of RT.

If a service user has had a **Caesarean section, extra care** must be taken in relation to restraint and wound care.

3 Monitoring post RT

A pregnant service user should **never be secluded** after the administration of RT.

If there are any concerns about the unborn child after RT the service user must **immediately be referred** to the local acute hospital's A&E department.

If a mother is breastfeeding, the **baby should be observed for sedation** after the administration of RT.

4 Recording information about RT

If antipsychotic medication is used repeatedly close to delivery, **this must be recorded on the service user's Rio notes** so a neonatologist can check the baby postpartum.

All interventions during RT **must be documented** in the service user's Rio notes.

Intervention during RT **must also be verbally communicated** in any handover to other professionals - including psychiatry, the midwife and paediatrics.

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KM1751d

APPENDIX F GUIDELINES FOR THE USE OF CLOPIXOL ACUPHASE

Clopixol Acuphase (zuclopentixol acetate) is **NOT** recommended for rapid tranquilisation due to its long onset and duration of action. It may be considered as an option when:

- patient will be disturbed/violent over an extended time period
- past history of good/timely response
- past history of repeated parenteral administration
- cited in an advance directive

Acuphase should NEVER be administered:

- In an attempt to "hasten" the antipsychotic effect of other antipsychotic therapy
- At the same time as, other parenteral antipsychotics or benzodiazepines (may lead to over sedation which is difficult to reverse)
- As a test dose for zuclopentixol decanoate depot injection
- To a patient who is physically resistant (risk of intravasation and oil embolus)

Acuphase should never be used for, or in, the following:

- Patients who accept oral medication
- Patients who are neuroleptic naïve
- Patients who are sensitive to EPSE
- Patients who are unconscious
- Patients who are pregnant
- Patients with hepatic or renal impairment
- Patients with cardiac disease

Onset and duration of action

Sedative effects usually begin to be seen after 2 hours. The effects may last for up to 72 hours. **Note: Acuphase has no place in rapid tranquilisation; its action is not rapid.**

Dose

Acuphase should be given in a dose of 50-150mg, up to a maximum of 400mg over a 2-week period. This maximum duration ensures that a treatment plan is put in place. It does not indicate that there are known harmful effects from a more prolonged administration, although such use should be very exceptional. There is no such thing as a course of Acuphase. The patient should be assessed before each administration.

Injections should be spaced at least 24 hours apart

See Trust Clopixol Acuphase guidance for monitoring and The Maudsley Prescribing Guidelines 14th Edition

APPENDIX G REMEDIAL MEASURES IN RAPID TRANQUILISATION

PROBLEM	REMEDIAL MEASURE
Acute dystonia (including oculogyric crisis) and parkinsonism (see also below)	Procyclidine 5 – 10 mg IM (repeat after 20 minutes if necessary) (repeat after 10 minutes if necessary) Older adults: 2.5 – 5mg
Reduced respiratory rate (<10/min) or oxygen saturation (<90%)	Give oxygen, raise legs, ensure patient is not lying face down Flumazenil (a benzodiazepine antagonist) may be given if benzodiazepine-induced respiratory depression. Flumazenil may only be administered by a DOCTOR only who, in their professional opinion are competent to use it safely. There is no expectation for other medical staff of any grade or any other clinician to use it. There are risks associated with the use of flumazenil it should only be used in life threatening situations. See flow chart below in Appendix H and I for Flumazenil guidelines and on how to use Flumazenil. If induced by any other sedative agent transfer to a medical bed and ventilate immediately.
Irregular or slow (<50/min) **pulse**	Refer to specialist medical care immediately
Fall in blood pressure (>30mmHg orthostatic drop or <50mmHg diastolic)	Have patient lie flat, tilt bed towards head. Monitor closely
Increased temperature or marked muscular rigidity (risk of Neuroleptic Malignant Syndrome and perhaps arrhythmias)	• Withhold antipsychotics • Monitor closely - send bloods for creatinine kinase urgently • Cool the person • Seek urgent medical advice immediately AND refer to ITU if continued or any other signs of NMS, such as sweating, hypertension or fluctuating BP, tachycardia, incontinence/retention/obstruction, muscular rigidity (may be confined to head and neck) or confusion, agitation/altered consciousness.

APPENDIX H GUIDELINES FOR THE USE OF FLUMAZENIL

Indications for use	If, after the administration of lorazepam (or another benzodiazepine) respiratory rate falls below 10/minute
Contraindications	Patients with epilepsy who have been receiving long-term benzodiazepines
Caution	Dose should be carefully titrated in hepatic impairment
Dose and route of administration	Initial: 200microgram intravenously over 15 seconds – if required level of consciousness not achieved after 60 seconds, then subsequent dose: 100microgram over 10 seconds
Time before dose can be repeated	60 seconds
Maximum dose	1mg in 24 hours (one initial dose and eight subsequent doses)
Side effects	Patients may become agitated, anxious or fearful on awakening. Seizures may occur in regular benzodiazepine users
Monitoring	Side effects usually subside
What to monitor	Respiratory rate continuously until rate returns to baseline level. Flumazenil has a short half-life and respiratory function may recover and then deteriorate again. **If respiratory rate does not return to normal or patient is not alert after initial doses given, assume that sedation is due to some other cause**

APPENDIX I HOW TO USE FLUMAZENIL

Flowchart describing the use of IV (intravenous) flumazenil in the event of respiratory depression associated with benzodiazepines given as part of the rapid tranquilisation protocol:

To only be administered by a DOCTOR who, in their professional opinion, are competent to use it safely. There is no expectation for other medical staff of any grade or any other clinician to use it.

There are risks associated with the use of flumazenil it should only be used in life threatening situations.

If, after the administration of benzodiazepines, the individual appears to go into respiratory depression and respiration falls below 10 /minute:

Call the emergency services.
give Flumazenil 200micrograms i/v over 15 seconds

↓

If required level of consciousness is not obtained, after 60 seconds, give another Flumazenil 100micrograms IV over 10 seconds

↓

Repeat process until consciousness is achieved (maximum of 7 further cycles, i.e. a maximum dose of Flumazenil of 1mg/24 hours)

Notes

- This is only part of the initial stage of managing respiratory depression induced by benzodiazepines. **The individual must be transferred immediately to an acute medical hospital for further treatment.**
- A pulse oximeter should be used to gauge whether Flumazenil should be used. Consider using oxygen and bagging the individual if required.
- The duration of action of flumazenil (half-life 52 minutes, duration of action 1-2 hours) is much shorter than the benzodiazepines; therefore, the respiratory function may recover and then deteriorate again.
- Flumazenil may precipitate:
  - a withdrawal syndrome in benzodiazepine-dependent individuals
  - convulsions in epileptics
  - arrhythmias in people who have taken cardiotoxic drugs.
- Do **NOT** give flumazenil for mixed overdoses particularly combined tricyclic antidepressant and benzodiazepine overdosage as convulsions and cardiac arrest may be precipitated.
- Flum azenil should be used with caution in people with a history of seizures, head injury, hepatic impairment or chronic benzodiazepine use.

The aim of this sheet is to provide basic information to facilitate the safe use of flumazenil in an emergency situation. Please refer to the products SPC for more detailed information.