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Royal Cornwall Hospitals NHS Trust

Rapid Tranquillisation Policy

V5.0

June 2023

Summary

RAPID TRANQUILLISATION IN ADULT PATIENTS

Use non-pharmacological/de-esculation strategies first and throughout.

Review patient: Where possible review physical and mental state, medical history, drug history, blood results, ECG. Ascertain response to previous benzodiazepine/antipsychotic.

Review risk: risk of giving medication versus risk of not giving medication.

LOW RISK	HIGH RISK PATIENTS **FRAIL/ELDERLY/ORGANIC BRAIN DISEASE/LEARNING DISABILITIES** (list not exhaustive).
STEP 1: Offer oral lorazepam 1mg-2mg (if oral refused IM lorazepam 1mg-2mg)	**STEP 1**: Offer oral lorazepam 0.5mg-1mg (if oral refused IM lorazepam 0.5mg-1mg)

Observe every 15 mins

STEP 2: Review after 30 minutes> If required, repeat lorazepam 1-2mg after 30 minutes.	**STEP 2**: Review after 30 minutes. If required, repeat lorazepam 0.5mg-1mg after 30 minutes.

If the response to Lorazepam is inadequate consider Haloperidol oral/IM.

Ensure Procyclidine 5mg IM is available.

USE WITH CAUTION refer to 6.14 of "Guideline for the use of medication to manage acutely disturbed or violent behaviour in adult patients of RCHT (Rapid Tranquillisation)"

Consider Haloperidol 5mg	Consider Haloperidol 0.5-5mg

Observe every 15mins

STEP 3: Review after 30 minutes

If sedation ineffective, senior medical review is required in conjunction with critical care.

Responsibilities:

Ensure physical observations recorded on NEWS chart.

Full documentation of episode and debrief.

Doctors are responsible for medicating, review and communicating frequency of observations.

*In the event of a medication shortage please see section 6.11 of the 'Guideline for the use of medication to manage acutely disturbed or violent behaviour in adult patients of RCHT (Rapid Tranquillisation)'

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Data Protection Act 2018 (General Data Protection Regulation – GDPR) Legislation

The Trust has a duty under the Data Protection Act 2018 and General Data Protection Regulations 2016/679 to ensure that there is a valid legal basis to process personal and sensitive data. The legal basis for processing must be identified and documented before the processing begins. In many cases we may need consent; this must be explicit, informed, and documented. We cannot rely on opt out, it must be opt in.

Data Protection Act 2018 and General Data Protection Regulations 2016/679 is applicable to all staff; this includes those working as contractors and providers of services.

For more information about your obligations under the Data Protection Act 2018 and General Data Protection Regulations 2016/679 please see the Information Use Framework Policy or contact the Information Governance Team

Royal Cornwall Hospital Trust rch-tr.infogov@nhs.net

1. Introduction

1.1. These guidelines offer information and advice for staff managing acutely disturbed or violent behaviour in adult patients under the care of RCHT. They should be used with due regard to the individual situation and the patient's needs and wishes.

1.2. Medication should not be the first approach to managing acutely disturbed behaviour. Other approaches for managing a high risk of harm to self or others should include engagement, distraction, de-escalation, moving the patient to a low stimulus area, or restraint.

1.3. The management strategy should be determined by the severity of the acute disturbance, risks to the patient and others, and known individual patient factors. If the risks are high and imminent, and particularly if other methods have failed, the use of short-acting medication may be indicated. Other strategies should continue even if medication is used.

1.4. Caution should be taken with older patients, particularly those with organic brain disease such as Parkinson's or Lewy Body dementia as they are particularly sensitive to the side effects of medication. Patients with dementia are at increased risk of cerebrovascular events with antipsychotics.

1.5. The advice on medication and doses is not specifically intended for the management of adolescents or people with learning disabilities, who generally require lower doses and are more sensitive to side effects.

1.6. National guidance is available in NICE Clinical Guideline 25, 'Violence: the short-term management of disturbed/violent behaviour in psychiatric in-patient settings and emergency departments'. February 2005.

1.7. Under the Health and Safety at Work Act 1974, and the Management of Health and Safety at Work Regulations 1999, employers have a duty to ensure the health, safety and welfare of their staff. The use of this policy will apply to the statutory requirements of Health and Safety legislation and will bolster the existing Trust policy and legal duties to protect staff, as far as is reasonably practicable, from the effects of violent behaviour in the workplace.

1.8. This version supersedes any previous versions of this document.

2. Purpose of this Policy/Procedure

2.1. The aim of using medication to manage acutely disturbed behaviour is to calm the patient quickly but safely in order to reduce imminent risks, but without over sedation. Sedation is not the primary aim but some sedation may result and may be beneficial to the patient.

2.2. The use of medication to manage acutely disturbed behaviour must be seen as a very short-term strategy and is distinct from treating any underlying physical or mental illness.

3. Scope

This policy applies to all full and part-time employees of the Trust who provide services to the Trust including agency staff.

4. Definitions / Glossary

4.1. Rapid tranquillisation is the use of medication to reduce the risk of harm to self or others.

4.2. For the purposes of this policy, an adult is defined as a person aged 16years or older.

5. Ownership and Responsibilities

5.1. Chief Executive.

The Trust's Chief Executive through the Chief Operating Officer/Medical Director has overall responsibility to have processes in place to:

- Ensure that staff are aware of this policy and adhere to its requirements.
- Ensure that appropriate resources exist to meet the requirements of this policy.

5.2. Executive Directors.

The Executive Directors are responsible for ensuring that all operational managers in their area are aware of this policy, understand its requirements and support its implementation with relevant staff.

5.3. Associate Medical Director/Consultants.

The Associate Medical Director and Consultants are responsible for ensuring procedures are understood and carried out by medical staff involved in the implementation of this policy.

5.4. Ward/Unit Managers.

Ward/Unit Managers are responsible for implementing the policy with their immediate staff and ensuring that staff undertake the duties prescribed in this policy.

5.5. Members of Clinical Teams.

Clinical team members have responsibility to comply with the requirements of this, and associated policies. These guidelines should be read and understood by all staff working in the Trust before they take up clinical duties. All staff who might be involved in using medication to manage acutely disturbed behaviour are trained in:

- These and related Trust guidelines.

- Risk management.
- The principles of rapid tranquillisation with the risks involved, the medications used, how to prescribe (when appropriate) and administer the medications.
- How to monitor for the effects of medication and how to deal with adverse effects.
- Personal safety, de-escalation and holding or restraining techniques.

6. Standards and Practice

6.1. Indications for considering medication.

6.1.1. Medication should be considered only if less restrictive strategies have failed unless it is an appropriate patient preference.

6.1.2. Next Medication should be considered if:

- There is a high and imminent risk of dangerous behaviour that will be a risk to the patient or others.
- If the patient is severely distressed or at risk of exhaustion.

6.2. Medical Review.

6.2.1. Medication should only be prescribed and administered after an assessment by a senior member of medical staff.

6.2.2. This review should be based on the relevant information at the time; it is recognised that on occasions this information may be limited.

6.2.3. Review the patient's:

- Medical history and current physical state.
- Current medication and past responses to medication.
- Medical history and examination.

6.2.4. The review of the patient's physical and mental state, the rationale for using medication, the patient's response to medication, and any adverse effects should be fully documented in the patient's medical notes.

6.2.5. It is recognised that it may not be possible to check base-line observations or carry out a physical examination. This should be documented in the patient's medical notes.

6.3. Choice of Medication.

6.3.1. Oral administration is the preferred route.

6.3.2. Oral medication can be given covertly with due regard to the Mental Capacity Act and/or Mental Health Act.

6.3.3. Lorazepam is the first-line for management of acutely disturbed behaviour unless the patient has respiratory impairment or is highly intolerant of Benzodiazepines.

6.3.4. Haloperidol may be used where Benzodiazepines are contraindicated, or where Lorazepam is ineffective. Avoid Haloperidol if the patient has; had Neuroleptic Malignant Syndrome (NMS), acute dystonia or severe Extrapyramidal Side Effects (EPSE), significant cardiac disease or prolonged QT interval, acute alcohol withdrawal, Parkinson's Disease or Dementia with Lewy Bodies. Use with caution in patients with epilepsy. Where possible before the use of Haloperidol patients should have an ECG.

6.4. Drug Doses.

6.4.1. Prescribing the initial dose of rapid tranquillisation 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.

6.4.2. Use the lowest dose which is likely to be effective in calming the patient. Note that frail, elderly, or patients with learning disabilities require lower doses.

6.4.3. Prescribers must aim to avoid polyprescribing and total doses must not exceed BNF maximum. If maximum recommended doses have been used and the patient's condition has not been adequately treated, senior review/ITU review should be sought.

6.4.4. **CAUTION**: Older patients, particularly those with organic brain disease such as:

Parkinson's or Lewy Body dementia are particularly sensitive to the side effects of medication. Patients with dementia are at increased risk of cerebrovascular events with antipsychotics. Use 50% lower doses and always use Lorazepam as first line treatment and actively monitor for side effects.

6.5. Preparation for IM Medication.

6.5.1. One clinician must take responsibility for coordinating the intervention. Non- pharmacological strategies to calm the patient must continue throughout. Due consideration must be given for the patient's views or preferences for management. As far as possible staff must preserve the patient's dignity and privacy. The administration of sedative medication against a persons' wishes is potentially hazardous. The risks of administering IM medication must be judged against the risks of not proceeding.

6.5.2. When restraint is required security staff should be requested to support. A member of staff who knows the patient will be required to the patient and monitor the physical health and wellbeing of the person until the situation has de-escalated to a more minimal level of intervention.

6.5.3. A range of restraint techniques may be used but the level of force applied must be justifiable, appropriate, reasonable and proportionate to the specific situation and applied for the minimum amount of time.

Please refer to the RCHT Restrictive Practice Policy.

6.5.4. Resuscitation and monitoring equipment, and Flumazenil and Procyclidine injections, must be readily available. Ideally physical monitoring should be attempted before IM injection, but it is recognised it is not always safe to do so. Additional monitoring should be undertaken as soon as possible after IM administration.

6.6. After IM Medication.

6.6.1. The patient must be visually observed and physically monitored by suitably trained staff, until fully alert and ambulatory. Patients who are sedated should not be left alone, refer to the RCHT Enhanced Care and Meaningful Activities Policy.

6.6.2. A medical review must be requested immediately if a patient's NEWS score deteriorates or if the patient remains a risk to themselves or others despite the use of Rapid Tranquillisation.

6.6.3. The use of Rapid Tranquillisation should be recorded in the patient's medical notes. You must state what was administered and the reasons why. Where possible detail the patients' response to the medication.

6.6.4. The administration of IM medication against a person's wishes can be traumatic for all concerned. Those involved in, or observing, or aware of the episode, should be offered support and explanations afterwards.

6.6.5. When sufficiently calm to engage in discussion, the patient should be given the opportunity to talk to a member of staff and helped to understand what happened and why and how similar circumstances could be managed in the future. This discussion should be clearly documented in the patient's notes and a 'management of clinically related challenging behaviour care plan should be commenced.

6.6.6. The staff involved should review the episode to discuss what happened, any trigger factors, each person's role in the episode and how they feel about it. Ongoing support should be available.

6.6.7. Adverse incidents resulting in or relating to rapid tranquillisation must be reported on the RCHT incident reporting system DATIX.

6.7. Physical Monitoring after rapid tranquillisation with IM medication.

Active monitoring and recording of the patient's physical state is essential, especially after IM medication. Use the NEWS observation chart to record observations according to the table on the next page.

Patient Status	Physical Observations	Frequency
Co-operative with physical observations.	Pulse, Blood Pressure, Respiratory Rate, Level of consciousness, oxygen saturation.	Every 15 mins for 1st hour, then if observations are normal, every hour until fully alert and ambulatory.
Uncooperative with physical observations, high risk of further disturbed behaviour.	Visual observation of respiration, pallor, mobility, rigidity, sweating, pupil size, vomiting.	Every 15 mins until patient is cooperative, then as above.
Asleep	Visual observation of respiration, pallor, mobility, rigidity, sweating, pupil size, vomiting. Pulse and blood pressure if patient allows.	Every 15 mins for 1st hour, then if observations are normal, every hour until fully alert and ambulatory.
Unrousable	Place in recovery position. Full set of pulse, blood pressure, oxygen saturations and respiratory rate. Immediate medical review.	Remain with patient. Continuous pulse oximetry.

6.8. Management of complications of medication

Problem	Management
Respiratory depression (RR<10/min).	Full monitoring of cardiovascular and respiratory function. Administer oxygen to achieve a target saturation of 94-98% for most patients but aim for 88-92% for those at risk of hypercapnoeic respiratory failure. If unable to maintain oxygen saturations, consider iv Flumazenil 200mcg over 15 secs and reassess. Further doses of 100mcg every 60secs may be given to a maximum dose of 1000mcg (1mg) in 24hrs.
Hypotension (systolic BP< 90mmHg)	Monitor cardiovascular and respiratory function closely. Lie patient flat or head down if possible.
Bradycardia (HR<50bpm)	Full cardiovascular and respiratory monitoring. Seek immediate medical advice
Seizure	Rectal Diazepam 10-20mg. Seek immediate medical advice
Over sedation	Full monitoring of respiratory and cardiovascular function closely until fully alert and ambulant. If GCS<8 call for immediate medical support.
Acute dystonia, oculogyric crisis, laryngospasm	5-10mg IM Procyclidine immediately. Repeat after 20 mins if necessary

Problem	Management
Suspected neuroleptic malignant syndrome (NMS) Raised temp. Rigidity Tachycardia Labile BP. Confusion and agitation Raised CK.	Stop all antipsychotics immediately Cool the patient. Immediate senior medical review IV fluids.0

6.9. In the event of medication shortages.

In the event of a medication shortage the On Call pharmacist should be called to confirm the shortage.

6.9.1. If Lorazepam is unavailable Diazepam can be used as an alternative. Diazepam doses should be 5-10mg for low-risk patients or 2.5 or 5mg for high-risk patients.

6.9.2. Olanzapine can be used in adults of working age, as an alternative for Haloperidol. Olanzapine doses should be 5-10mg. Olanzapine must NOT be given within 30 minutes of a benzodiazepine. Do not use in high-risk patients.

6.9.3. Olanzapine is a second-generation anti-psychotic medication licensed for rapid tranquilisation in patients with schizophrenia. Where patients are intolerant of haloperidol or it is contraindicated, it can be used with caution, if necessary.

6.10. Legal Considerations.

6.10.1. A patient's consent to treatment must be sought where practicable to do so.

6.10.2. If acting without a patient's consent it must be demonstrated that the treatment is in the patient's best interests and represents the least restrictive option to save the patient's life or prevent serious harm to the patient or others or a deterioration to the patient's health. Staff must be familiar with the RCHT Mental Capacity Policy, principles of the Mental Capacity Act (section 1 MCA 2005), the doctrine of common law and the guidance in the Mental Health Act and Mental Capacity Act Codes of Practice.

6.10.3. A patient, who presents a significant risk to their own health, their own safety, or the safety of others because of or disturbed behaviour, can be given rapid tranquillisation under common law to calm the patient and reduce the risk of harm. Detailed reasons for the administration of medication without the patient's consent must be clearly documented in the patients' notes.

7. Dissemination and Implementation

This policy should be implemented and disseminated through the organisation immediately following ratification and will be published on the organisations intranet site (document library). Access to this document is open to all.

8. Monitoring compliance and effectiveness

Information Category	Detail of process and methodology for monitoring compliance
Element to be monitored	Adverse events relating to the use of rapid tranquillisation
Lead	Pharmacist- medication safety lead
Tool	All adverse events to be reported on DATIX
Frequency	As adverse events occur
Reporting arrangements	Adverse incidents, trends, exceptions and outcomes will be reported to the Safeguarding Adults Operational Group and the Medication Incident Group who will onward report to the Divisional Quality Group along with recommendations and action plans where deficiencies have been identified.
Acting on recommendations and Lead(s)	Where the report indicates sub optimal performance the Chair of SAOG will nominate a group member to produce an action plan. The SAOG will be responsible for monitoring progress and will undertake subsequent recommendations and further action planning for all deficiencies identified within agreed timeframes.
Change in practice and lessons to be shared	Required changes to practice identified will be documented in the action plan outcomes. The membership of the SAOG will identify a lead to take each change forward across divisions as appropriate. Lessons will be shared with all relevant parties.

9. Updating and Review

6.6. This process is managed via the document library; review will be three yearly unless best practice dictates otherwise.

6.7. Revisions can be made ahead of the review date when the procedural document requires updating. Where the revisions are significant and the overall policy is changed, the author should ensure the revised document is taken through the standard consultation, approval and dissemination processes.

6.8. Any revision activity is to be recorded in the Version Control Table as part of the document control process.

10. Equality and Diversity

10.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the Equality Diversity And Inclusion Policy or the Equality and Diversity website.

10.2. Equality Impact Assessment

The Initial Equality Impact Assessment Screening Form is at Appendix 2.

Appendix 1. Governance Information

Information Category	Detailed Information
Document Title:	Rapid Tranquillisation Policy V5.0
This document replaces (exact title of previous version):	Guidelines for the use of medication to manage acutely disturbed or violent behaviour in adult patients of RCHT (Rapid Tranquillisation Policy) V4.0
Date Issued / Approved:	May 2023
Date Valid From:	June 2023
Date Valid To:	June 2026
Author / Owner:	Dr Pollard, Safeguarding Doctor
Contact details:	01872 253219
Brief summary of contents:	A guideline on the role of medication and factors to be considered when prescribing for, or in anticipation of, the management of acutely disturbed behaviour. Information and advice on appropriate medications, their potential adverse effects and management, physical monitoring of patients and record keeping.
Suggested Keywords:	Rapid tranquillisation; Disturbed behaviour; Violent behaviour; Lorazepam; Haloperidol; Sedation; Challenging.
Target Audience:	**RCHT:** Yes **CFT:** No **CIOS ICB:** No
Executive Director responsible for Policy:	Chief Medical Officer
Approval route for consultation and ratification:	Safeguarding Adults Operational Group Rapid Tranquillisation working group
Manager confirming approval processes:	Nigel D'Arcy (interim)

Information Category	Detailed Information
Name of Governance Lead confirming consultation and ratification:	Paul Evangelista
Links to key external standards:	CQC Outcome 7, NHLSA Standard 4- criterion 8
Related Documents:	NICE Guideline 25(2005): The short term management of disturbed/violent behaviour in psychiatric in-patient settings and emergency departments RCHT policy: Management of Violence and Aggression (2009) RCHT policy: Enhanced Care and Meaningful Activities RCHT policy: Mental Capacity Act (2010) RCHT Mental Health Act 1983 and Mental Health Amendment Act 2007 Procedures Guidelines and Information RCHT Deprivation of Liberty Safeguards Policy Guideline for the Diagnosis and Management of Delirium v.3 Alcohol detoxification and chlordiazepoxide (CDZ) administration guidelines
Training Need Identified:	Yes. Refer to the training needs analysis
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet and Intranet
Document Library Folder/Sub Folder:	Clinical / Dementia and Eldercare

Version Control Table

Date	Version Number	Summary of Changes	Changes Made by
25 March 2011	V1.0	Final amendments approved; EIA Completed; document published	Lerryn Hogg Divisional Quality Facilitator
03 Dec 2013	V2.0	Complete review and amendments made	Dr Gabrielle Lockwood Lerryn Hogg –

Date	Version Number	Summary of Changes	Changes Made by
			Specialist Nurse for Mental Health and Wellbeing
May 2017	V3.0	Complete review and amendments made	Dr Pollard – Safeguarding Doctor Lerryn Hogg – Manager LD, Autism, MH and MCA
June 2020	V4.0	Complete review and no changes to content required. Transposed to latest Trust template.	Dr Pollard – Safeguarding Doctor
June 2023	V5.0	Complete review and no changes to content required. Transposed to latest Trust template.	Dr Pollard – Safeguarding Doctor

All or part of this document can be released under the Freedom of Information Act 2000

All Policies, Strategies and Operating Procedures, including Business Plans, are to be kept for the lifetime of the organisation plus 6 years.

This document is only valid on the day of printing.

Controlled Document

This document has been created following the Royal Cornwall Hospitals NHS Trust The Policy on Policies (Development and Management of Knowledge Procedural and Web Documents Policy). It should not be altered in any way without the express permission of the author or their Line Manager.

Appendix 2. Equality Impact Assessment

Section 1: Equality Impact Assessment (EIA) Form

The EIA process allows the Trust to identify where a policy or service may have a negative impact on an individual or particular group of people.

For guidance please refer to the Equality Impact Assessment Policy (available from the document library) or contact the Equality, Diversity, and Inclusion Team rcht.inclusion@nhs.net

Information Category	Detailed Information
Name of the strategy / policy / proposal / service function to be assessed:	Rapid Tranquillisation Policy V5.0
Department and Service Area:	Emergency Department
Is this a new or existing document?	Existing
Name of individual completing EIA (Should be completed by an individual with a good understanding of the Service/Policy):	Dr Neil Pollard- Eldercare Consultant
Contact details:	01872 252446

Information Category	Detailed Information
1. Policy Aim - Who is the Policy aimed at? (The Policy is the Strategy, Policy, Proposal or Service Change to be assessed)	The aim of using medication to manage acutely disturbed behaviour is to calm the patient quickly but safely in order to reduce imminent risks, but without over sedation. Sedation is not the primary aim but some sedation may result and may be beneficial to the patient.
2. Policy Objectives	Information and advice on appropriate medications, their potential adverse effects and management, physical monitoring of patients and record keeping.
3. Policy Intended Outcomes	To offer a guideline on the role of medication and factors to be considered when prescribing for, or in anticipation of, the management of acutely disturbed behaviour. To ensure that prescribing and medicating is carried out safely in order to reduce imminent risks, but without over sedation.

Information Category	Detailed Information
4. How will you measure each outcome?	Monitoring of compliance with this policy will be conducted via DATIX reporting. Adverse incidents, trends, exceptions and outcomes will be reported to the Safeguarding Adults Operational Group and the Medication Incident Group who will onward report to the Divisional Quality Group along with recommendations and action plans where deficiencies have been identified.
5. Who is intended to benefit from the policy?	All patients who require rapid tranquillisation. All staff who are prescribing for, medicating or monitoring a patient who has received rapid tranquillisation.
6a. Who did you consult with? (Please select Yes or No for each category)	• Workforce: Yes • Patients/ visitors: No • Local groups/ system partners: No • External organisations: No • Other: No
6b. Please list the individuals/groups who have been consulted about this policy.	**Please record specific names of individuals/ groups:** Safeguarding Adults Operational Group Pharmacy Clinicians (Medical and Nursing) Psychiatric Liaison
6c. What was the outcome of the consultation?	Agreed
6d. Have you used any of the following to assist your assessment?	**National or local statistics, audits, activity reports, process maps, complaints, staff or patient surveys:** No

7. The Impact

Following consultation with key groups, has a negative impact been identified for any protected characteristic? Please note that a rationale is required for each one.

Where a negative impact is identified without rationale, the key groups will need to be consulted again.

Protected Characteristic	(Yes or No)	Rationale
Age	No	
Sex (male or female)	No	
Gender reassignment (Transgender, non-binary, gender fluid etc.)	No	

Protected Characteristic	(Yes or No)	Rationale
Race	No	
Disability (e.g. physical or cognitive impairment, mental health, long term conditions etc.)	No	
Religion or belief	No	
Marriage and civil partnership	No	
Pregnancy and maternity	No	
Sexual orientation (e.g. gay, straight, bisexual, lesbian etc.)	No	

A robust rationale must be in place for all protected characteristics. If a negative impact has been identified, please complete section 2. If no negative impact has been identified and if this is not a major service change, you can end the assessment here.

I am confident that section 2 of this EIA does not need completing as there are no highlighted risks of negative impact occurring because of this policy.

Name of person confirming result of initial impact assessment: Dr Neil Pollard, Eldercare Consultant

If a negative impact has been identified above OR this is a major service change, you will need to complete section 2 of the EIA form available here:
Section 2. Full Equality Analysis