# Clinical Rapid Tranquillisation Policy

## Document Control Summary

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<th>Status:</th>
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<td>Replaces v5.1</td>
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<tr>
<td>Version:</td>
<td>v6.0</td>
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<tr>
<td></td>
<td>Date: August 2016</td>
</tr>
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<td>Approved by:</td>
<td>Policy and Procedures Committee</td>
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<td>Date: 15th Sept 2016</td>
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<tr>
<td>Ratified:</td>
<td>Trust Board</td>
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<tr>
<td></td>
<td>Date: 29th Sept 2016</td>
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<tr>
<td>Related Trust Strategy and/or Strategic Aims</td>
<td>CQC Compliance</td>
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<td></td>
<td>Health &amp; Social Care Act 2014 (Regulation 12, Safe Care and Treatment)</td>
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<td></td>
<td>To support the delivery of safe care and treatment, in keeping with national guidance from NICE.</td>
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<tr>
<td>Implementation Date:</td>
<td>September 2016</td>
</tr>
<tr>
<td>Review Date:</td>
<td>September 2017</td>
</tr>
<tr>
<td>Key Words:</td>
<td>Violence, Aggression, Medicine, Intramuscular Injection, Restrictive Intervention, Restraint, Seclusion, Incident, Risk Assessment, Monitoring, Observation, Documentation</td>
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<td>Associated Policy or Standard Operating Procedures</td>
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<td>Assessment and Management of Physical Health Policy</td>
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<td>Care Planning Policy</td>
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<td>Clinical Risk Assessment and Management Policy</td>
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<td>Guidance on the Administration to Adults of Deep Intra-Muscular Injections, Including Depot and Other Long Acting Antipsychotic Injections.</td>
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Safe Nutrition and Hydration of Service Users
Safeguarding Policy
Search Policy
Supportive Observation, Intervention and Engagement of Service Users Policy
SSSFT Formulary
1. Introduction


This policy aims to provide staff with a pathway from the point of a service users’ admission to an inpatient psychiatric unit, for the safe use of rapid tranquillisation in the short-term management of violence and aggression. The policy aims to promote an overall reduction in the number of rapid tranquillisation incidents being administered to service users within SSSFT by:

- Improved anticipation & prevention of violence & aggression (risk assessments, care plans, observation, de-escalation)
- Working in partnership with patients & carers, involving them in decisions about their care & treatment
- Ward & organisational learning from incidents involving restrictive interventions (reflection, feedback, change & improvement in care provided)

2. Purpose

This policy has been developed to support the delivery of safe care and treatment, in keeping with national guidance from NICE. The implementation of this policy will ensure the delivery of safe, evidenced based care to our service users in keeping with CQC standards and the Health & Social Care Act 2014 (Regulation 12, Safe Care and Treatment).

3. Scope

This policy applies to all SSSFT staff involved in the prescription, supply and administration of medication and its subsequent monitoring for the purpose of rapid tranquillisation. This policy applies to all inpatient wards within SSSFT.

4. Risk Assessment and Care Planning to Reduce the Use of Rapid Tranquillisation Following Admission to an Inpatient Psychiatric Ward

Check whether the service user has made an advance decision or advance statement about the use of rapid tranquillisation and take this information into account when making decisions about care.

Do not prescribe ‘when required’ (p.r.n.) medication routinely or automatically on admission (in the context of rapid tranquillisation or de-escalation).

Assess the risk of violence and aggression using a multidisciplinary approach that reflects the care setting, ensuring objectivity.

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

When deciding on levels of observation take into account:

- the service user’s current mental state
- the physical health of the service user
- any prescribed medications and their effects
- suspected or confirmed consumption of illicit substances or alcohol
- the current assessment of risk
- the views of the service user

Record decisions about observation levels in the service user’s clinical records (RiO) and clearly specify the reasons for the observation.

Implement the ‘framework to anticipate violence and aggression in inpatient psychiatric wards’, to identify ways to reduce violence and aggression and the use of rapid tranquillisation.

Consider offering service users with a history of violence or aggression psychological help to develop greater self-control and techniques for self-soothing.

A multidisciplinary team that includes a psychiatrist and a specialist pharmacist in mental health should develop and document an individualised pharmacological strategy for using regular and p.r.n. medication to calm and relax service users who are at risk of violence and aggression as soon as possible after admission to an inpatient psychiatric unit.

The physical health of the service user along with the results of recent physical health checks including blood test and electrocardiogram (ECG) results should be considered when deciding which medication to prescribe. Medication already prescribed to the service user must also be considered; clinically significant interactions, additive side effects and daily doses that exceed the licensed maximum should be avoided where possible.

Historical response to psychotropic medicines should also be taken into consideration, including allergies and adverse drug reactions.

Ensure that the service user understands the main side-effect profiles of the medications recommended for rapid tranquillisation so that they can make an informed choice.

If the service user has not made any advance decisions or statements about the use of rapid tranquillisation and their risk assessment concludes that a de-escalation and rapid tranquillisation management plan is necessary, the service user should be offered the opportunity and encouraged to complete one as soon as possible, as part of the care planning process.

If the service user is being transferred to another care setting or being discharged, share the content of the risk assessment with staff in the relevant agencies or care settings, and with carers.
5. During Admission on an Inpatient Psychiatric Ward

Regularly review risk assessments and risk management plans, addressing the service user and environmental domains within the ‘framework to anticipate violence and aggression in inpatient psychiatric wards’. The regularity of the review should depend on the assessment of the level of risk. Base the care plan on accurate and thorough risk assessments.

The multidisciplinary team should review the pharmacological strategy and the use of 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:

- clarification of target symptoms
- the likely timescale for response to medication
- the total daily dose of medication, prescribed and administered, including p.r.n. medication
- the number of and reason for any missed doses
- therapeutic response
- the emergence of unwanted effects
- any changes made

6. Preventing Violence and Aggression on an Inpatient Psychiatric Ward

In response to the early signs of agitation, irritation, anger and aggression, implement de-escalation techniques such as the use of distraction and methods that promote calming and relaxation

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

- do not prescribe p.r.n. medication routinely
- tailor p.r.n. medication to individual need and include discussion with the service user if possible
- ensure there is clarity about the rationale and circumstances in which p.r.n. medication may be used and that these are included in the care plan
- 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 service users regular dose or their dose for rapid tranquillisation
- only exceed the BNF maximum daily dose (including p.r.n. dose, regular dose and dose for rapid tranquillisation) if this is part of a care plan to achieve an agreed therapeutic goal, documented on RiO and authorised by a Consultant Psychiatrist.
- If a high dose antipsychotic regime is prescribed a ‘High Dose Antipsychotic Monitoring Sheet’ must be completed and signed by the authorising Consultant Psychiatrist
- ensure that the interval between p.r.n. doses is specified
- If Mental Health Act (MHA) consent to treatment paperwork is required, ensure all psychotropic medication prescribed is appropriately authorised. Failure to do so may result in the unlawful administration of medication to a service user.
The multidisciplinary team should review p.r.n. medication at least once a week and, if p.r.n. medication is to be continued, the rationale for its continuation should be documented on RiO. If p.r.n. medication has not been used since the last review, consider stopping it.

7. Using Restrictive Interventions (Including Rapid Tranquilisation) on an Inpatient Psychiatric Ward

Rapid tranquilisation should only be used if there are sufficient numbers of appropriately trained staff available to do so safely in accordance with SSSFT safe staffing levels.

Rapid tranquilisation should only be used if staff trained in immediate life support (or SSSFT approved equivalent) and a doctor trained to use resuscitation equipment are, when needed, available to rapidly attend an emergency situation on the ward.

Rapid tranquilisation should only be used if resuscitation equipment is immediately available. Resuscitation equipment should include an automatic external defibrillator, a bag valve mask, oxygen, cannulas, intravenous fluids, suction and first-line resuscitation medications. Equipment must be maintained and checked every week.

The decision to use rapid tranquilisation must always be in response to a clinical need in order to manage the risk of violence and aggression. In keeping with NG10 it is never the intention to use rapid tranquilisation to punish, inflict pain, suffering or humiliation, or establish dominance. If it is suspected that rapid tranquilisation or other restrictive interventions are being used inappropriately the SSSFT policy for ‘Public Interest Disclosure’ should be followed.

Use rapid tranquilisation only if de-escalation and other preventive strategies, including oral p.r.n. medication, have failed and there is potential for harm to the service user or other people if no action is taken.

Continue to attempt de-escalation throughout rapid tranquilisation.

Ensure that the techniques and methods used to manage the risk, including rapid tranquilisation, to restrict a service user:

- are proportionate to the risk and potential seriousness of harm
- are the least restrictive option to meet the need
- are used for no longer than necessary
- take account of the service user’s preferences, if known and it is possible to do so
- take account of the service user’s physical health, degree of frailty and developmental age

Consider rapid tranquilisation or seclusion as alternatives to prolonged manual restraint (longer than 10 minutes).

Use of restrictive interventions, including rapid tranquilisation, must be undertaken in a manner that complies with the Human Rights Act 1998 and the relevant rights in the European Convention on Human Rights.
Unless a service user is detained under the Mental Health Act 1983 or subject to a deprivation of liberty authorisation or order under the Mental Capacity Act 2005, the use of restrictive interventions, including rapid tranquillisation, must not impose restrictions that amount to a deprivation of liberty.

8. Rapid Tranquillisation

Rapid tranquillisation is a restrictive intervention involving the use of medication by the parenteral route (intramuscular) when oral medication is not possible or appropriate and urgent calming with medication is needed. Such use should always be considered rapid tranquillisation, unless in exceptional circumstances the Consultant Psychiatrist documents an alternative rationale and justifies why it is not a restrictive intervention. Appropriate monitoring of physical health must still be undertaken and documented on RiO.

The decision to prescribe rapid tranquillisation to a service user who has dementia or is physically frail must be authorised by a Consultant Psychiatrist.

When deciding which medication to use for rapid tranquillisation, take into account:

- the service user's preferences or advance statements and decisions
- pre-existing physical health problems or pregnancy
- possible intoxication (alcohol, drug misuse including novel psychoactive substances)
- previous response to these medications, including adverse effects
- potential for interactions with other medications
- the total daily dose of medications prescribed and administered.

If there is insufficient information to guide the choice of medication for rapid tranquillisation, or the service user has not taken antipsychotic medication before, use intramuscular lorazepam.

If there is evidence of cardiovascular disease, including a prolonged QT interval, or no electrocardiogram (ECG) has been carried out, use intramuscular lorazepam.

When prescribing medication for use in rapid tranquillisation, consider writing the initial prescription as a single dose. In exceptional circumstances, for example when the service user has a known relapse presentation requiring repeated episodes of rapid tranquillisation, a p.r.n prescription may be written with a specified number of doses for administration. Prescriptions for multiple doses of rapid tranquillisation should be agreed by the multidisciplinary team or authorised by a Consultant Psychiatrist.

Additional doses of rapid tranquillisation should not be administered to the service user until the full effect of the first dose has been assessed and found to be physically tolerated.

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

If there is no response to intramuscular lorazepam, consider intramuscular haloperidol combined with intramuscular promethazine. Extra-pyramidal side effects (EPSEs) are thought to occur less frequently when haloperidol is administered with promethazine due to its intrinsic anticholinergic properties.
SSSFT recognises that the evidence base upon which the combination of haloperidol and promethazine is based may not be applicable to UK clinical practice and that clinical experience with this combination within SSSFT is limited. Therefore, if clinicians feel that the traditional combination of haloperidol and lorazepam is more appropriate this may be used instead. When prescribing haloperidol in combination with lorazepam consideration should be given to prescribing a p.r.n antimuscarinic agent (e.g. procyclidine) to treat EPSEs should they occur.

The summary of product characteristics for haloperidol recommends a baseline ECG. If an ECG is not available the prescriber should consider the risks and benefits of using this treatment and be able to justify their prescribing decision, as it may be considered an off-licence use. The off license use of haloperidol should be authorised by a Consultant Psychiatrist.

If there is a partial response to intramuscular haloperidol combined with intramuscular promethazine, consider a further dose.

If there is no response to intramuscular haloperidol combined with intramuscular promethazine, consider intramuscular lorazepam if this hasn't been used already during this episode. If intramuscular lorazepam has already been used, arrange an urgent multidisciplinary team meeting to carry out a review and seek a second opinion if needed.

The recommendations made in NG10 do not preclude the use of alternative treatment options. However, their use should be tailored to the individual service user in line with the recommendations for rapid tranquillisation.

The evidence for the use of intramuscular aripiprazole (Abilify) in rapid tranquillisation was insufficient to warrant its inclusion in NG10 but it is a commercially available and licensed product within the UK. Stocks are routinely held in SSSFT dispensaries, emergency cupboards and ward stock lists. It is permitted for use on inpatient wards within SSSFT if it is considered to be the safest and most appropriate treatment option for the service user. Intramuscular aripiprazole can be combined with intramuscular lorazepam if considered clinically appropriate and necessary.

The evidence for the use of intramuscular olanzapine (Zyprexa) in rapid tranquillisation was not considered by the Guideline Development Group for NG10 because the manufacturer of intramuscular olanzapine has withdrawn the product from the UK market. As a result they were unable to make recommendations regarding its use. However, it remains a licensed product in the European Union (EU) and it can be imported for named patient use within SSSFT, if following a multidisciplinary review it is considered to be the most appropriate treatment option for a service user. Intramuscular olanzapine MUST NOT be co-administered with benzodiazepines, hypnotics (e.g. promethazine) or other antipsychotics. These medicines must not be given within 60 minutes of intramuscular olanzapine (pre or post dose). This is due to the increased risk of respiratory depression, hypotension and bradycardia; on rare occasions fatalities have occurred.

If rapid tranquillisation is needed whilst a service user is secluded in a seclusion suite, undertake with caution and be aware of and prepared to address any complications associated with rapid tranquillisation. Ensure the service user is observed within eyesight by
a suitably qualified and trained staff member at all times. Undertake a risk assessment and consider ending the seclusion when rapid tranquillisation has taken effect. Physical health monitoring must be completed.

9. Post Rapid Tranquillisation Monitoring and Documentation

The ‘restrictive practices monitoring form’ (appendix 3) must be completed within the service users RiO record following the administration of rapid tranquillisation. This form is located within the ‘physical health pathway’ on RiO.

It is the responsibility of the nursing team administering rapid tranquillisation to ensure that the appropriate physical health monitoring, observations and documentation are completed.

The following parameters should be monitored and documented when rapid tranquillisation is administered to a service user:

- level of alertness (AVPU)/consciousness
- respiratory rate
- oxygen saturation
- blood pressure
- pulse
- temperature
- AMEWS score
- level of hydration
- emergence of side effects from medication administered, giving consideration to duration of action

Monitoring must be undertaken and documented every 15 minutes when any of the following apply:

- the service user has a pre-existing physical health problem
- the service user has an abnormal ECG or electrolyte levels
- the service user is physically frail, anorexic or obese (body mass index (BMI) is red)
- the service user has dementia
- the service user is pregnant
- the service user has taken illicit drugs or alcohol
- the service user has experienced any harm as a result of any restrictive intervention
- the service user appears to be asleep or is sedated
- the BNF maximum dose of medication administered to the service user has been exceeded (as a single dose or in the last 24 hour period, taking regular and p.r.n medication into consideration)

If none of the above conditions apply and providing there are no concerns about the physical health of the service user, monitoring can be undertaken at hourly intervals.

If the service user is offered but refuses to allow physical health checks to be completed, their refusal should be documented against the relevant parameters and time points within
the ‘restrictive practices monitoring form’ on RiO. The service user’s level of alertness must always be completed.

When making the decision to continue/discontinue monitoring, consideration should be given to the medication administered to the service user, time to onset, time to peak and its duration of action.

Monitoring should continue until there are no further concerns about the service user’s physical health. The service user must be awake, alert and physically well when monitoring is discontinued.

A failure to appropriately monitor a service user after rapid tranquillisation has been administered will constitute a clinical incident.

Nursing staff must exercise their clinical judgement, contacting the duty doctor to rapidly attend the ward if urgent clinical concerns regarding the service user develop and SSSFT policies must be implemented appropriately in regards to medical and psychiatric emergencies and resuscitation.

10. Incident Reporting

An incident is defined as any event that involves the use of a restrictive intervention – restraint, rapid tranquillisation or seclusion (but not observation) – to manage violence or aggression.

A SSSFT incident report should therefore be completed via the Safeguard system each time rapid tranquillisation is administered to a service user.


The incident report number must be documented within the ‘restrictive practices monitoring form’. A pdf copy of the incident report can be printed and uploaded to the patients RiO record.

11. Post Rapid Tranquilisation Review & Support

Multidisciplinary Post Incident Review

After using rapid tranquillisation, and when the risk of harm has been contained, conduct a multidisciplinary post-incident review. As a minimum this should include a doctor and a nurse. This could be at the daily rapid review meeting or multidisciplinary team meeting, but always within 24 hours of the incident occurring and earlier when urgent clinical concerns exist.

Identify ongoing risks and any factors that can be addressed quickly to reduce the likelihood of a further incident and amend risk and care plans accordingly.

Review the service user to identify and address any physical harm caused including adverse effects from medication administered.
Ascertain the level of clinical effectiveness achieved by the intervention.

Review the pharmacological treatment strategy including regular and p.r.n medication, amending accordingly.

The multidisciplinary team must be satisfied that the intervention was clinically effective and did not cause any serious adverse effects before prescribing further doses for administration to the service user.

Ensure that the restrictive practices monitoring form and incident report has been completed.

**Service User Post Incident Support**

Ensure that the service user has the opportunity to discuss the incident in a supportive environment with a member of staff, an advocate or carer.

Offer the service user the opportunity to write their perspective of the event in their clinical records (RiO).

Offer the service user the opportunity to develop or amend their advance statement in relation to rapid tranquilisation.

**Staff Post Incident Support**

Identify and address any physical harm to staff and other witnesses.

Assess the emotional impact of the incident on staff and other witnesses. Offer staff the opportunity to complete the ‘impact of event scale’.

**12. Trust Board**

The trust board should ensure that it receives regular reports from each ward about violent incidents and the use of restrictive interventions (including rapid tranquilisation). Service users' experience of those interventions and the learning gained from incidents should inform the review of policy and training.

Board reports on the public website will include data about incidents of violence and aggression and use of restrictive interventions within each team, ward and service, including reasons for the similarities and differences between services.

**13. Process for Monitoring Compliance and Effectiveness**

Prescribing Observatory for Mental Health, Audit Topic 16a: Rapid Tranquilisation in the context of the pharmacological management of acutely-disturbed behaviour. To be completed 2016/17.

Medicines Incident Review Group.

Medicines Optimisation Committee.
14. References


Summary of Product Characteristics (SPC) via the eMC website: https://www.medicines.org.uk/emc/
Appendix 1
The following terms are defined by NICE as follows:

- **Positive Engagement**
  An intervention that aims to empower service users to actively participate in their care. Rather than 'having things done to' them, service users negotiate the level of engagement that will be most therapeutic.

- **Violence and Aggression**
  A range of behaviours or actions that can result in harm, hurt or injury to another person, regardless of whether the violence or aggression is physically or verbally expressed, physical harm is sustained or the intention is clear.

- **Observation**
  A minimally restrictive intervention of varying intensity in which a member of the healthcare staff observes and maintains contact with a service user to ensure the service user's safety and the safety of others.

- **De-escalation**
  The use of techniques (including verbal and non-verbal communication skills) aimed at defusing anger and averting aggression. P.r.n. medication can be used as part of a de-escalation strategy but p.r.n. medication used alone is not de-escalation.

- **p.r.n (pro re nata)**
  When required. In this guideline, p.r.n. refers to the use of oral medication as part of a strategy to de-escalate or prevent situations that may lead to violence or aggression; it does not refer to p.r.n. medication used on its own for rapid tranquillisation during an episode of violence of aggression.

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

- **Incident**
  Any event that involves the use of a restrictive intervention – restraint, rapid tranquillisation or seclusion (but not observation) – to manage violence or aggression.

- **Manual Restraint**
  A skilled, hands-on method of physical restraint used by trained healthcare professionals to prevent service users from harming themselves, endangering others or compromising the therapeutic environment. Its purpose is to safely immobilise the service user.

- **Mechanical Restraint**
  A method of physical intervention involving the use of authorised equipment, for example handcuffs or restraining belts, applied in a skilled manner by designated healthcare professionals. Its purpose is to safely immobilise or restrict movement of part(s) of the body of the service user.

- **Rapid Tranquillisation**
  Use of medication by the parenteral route, usually intramuscular, when oral medication is not possible or appropriate and urgent calming/relaxation with medication is needed.

- **Seclusion**
  Defined in accordance with the Mental Health Act 1983 Code of Practice: 'the supervised confinement of a patient in a room, which may be locked. Its sole aim is to contain severely disturbed behaviour that is likely to cause harm to others'.

## Appendix 2

### Overview of medicines available for use in rapid tranquilisation in SSSFT: Ref. Martindale via Medicines Completes and individual medicines SPCs.

Please refer to the Summary of Product Characteristics (SPC) via the eMC website for the most up to date information and full prescribing advice: [https://www.medicines.org.uk/emc/](https://www.medicines.org.uk/emc/)

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<th>Pharmacokinetics</th>
<th>Comments</th>
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<td><strong>Single dose</strong>: 0.5-2mg</td>
<td><strong>Minumum Dosing Interval</strong>: 1-2 hours</td>
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<td><strong>IM Haloperidol</strong></td>
<td><strong>Single dose</strong>: 2-5mg</td>
<td><strong>Minimum Dosing Interval</strong>: 4 hours</td>
<td><strong>Max daily dose</strong>: 12mg</td>
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<td><strong>IM Promethazine</strong></td>
<td><strong>Single dose</strong>: 25-50mg</td>
<td><strong>Minimum Dosing Interval</strong>: 2 hours</td>
<td><strong>Max daily dose</strong>: 100mg</td>
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<td><strong>IM Aripiprazole</strong></td>
<td><strong>Single dose</strong>: 9.75mg (5.25-15mg)</td>
<td><strong>Minimum Dosing Interval</strong>: 2 hours</td>
<td><strong>Max daily dose</strong>: 30mg</td>
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<td><strong>IM Olanzapine</strong></td>
<td><strong>Single dose</strong>: 5-10mg</td>
<td><strong>Minimum Dosing Interval</strong>: 2 hours</td>
<td><strong>Max daily dose</strong>: 20mg</td>
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* Dose schedules may need to be reduced for older adults, people with renal or hepatic impairment and people of low BMI, refer to individual medicines SPCs for prescribing advice. Alternatively contact your ward pharmacist or local pharmacy department for advice.
Appendix 3

Restrictive Practices Monitoring Form

Client: TEST, Patient Fred (Miss) - 1000004
Ward: Dummy Ward
MHA Status: Detained

Has an Advance Statement been completed to support the Restrictive Practice? Yes No

Emergency medical equipment must always be available during a Restrictive Intervention:
Oxygen, Pulse Oximeter, First Aid Kit, Ligature Knife, CPR Pocket Mask, Defibrillator, Access to Emergency Drugs

Why was intervention necessary?

ABC

Time physical intervention commenced:

Time physical intervention completed:

Total number of hours/minutes:

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<th>Intervention Type</th>
<th>Name of Staff/Ward</th>
<th>Original Team</th>
<th>Change</th>
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<th>Trained in BLS</th>
<th>Technique Used</th>
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<td>Please Select</td>
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<td>Yes</td>
<td>No</td>
<td>Please Select</td>
<td>Please Select</td>
<td>Add</td>
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Third person is responsible for Head, Neck and airway management

Rapid Tranquilisation

Are staff involved in Rapid Tranquilisation ILS trained? Yes No

Why was RT given?

ABC

Drug given? If other, please specify Dosage (mg) Route of administration Administered by Time Given

<table>
<thead>
<tr>
<th>Drug given?</th>
<th>If other, please specify Dosage (mg)</th>
<th>Route of administration</th>
<th>Administered by</th>
<th>Time Given</th>
</tr>
</thead>
<tbody>
<tr>
<td>Haloperidol</td>
<td></td>
<td>IM</td>
<td></td>
<td>10.07</td>
</tr>
<tr>
<td>Promethazine</td>
<td></td>
<td>IM</td>
<td></td>
<td>10.07</td>
</tr>
</tbody>
</table>

Warning Box (Note any condition, illness, injuries, or risks in Physical Interventions, Seclusion, Mechanical Restraint, or Rapid Tranquilisation use)

ABC

Physical Health Care

Warnings/Risks

Pre-existing physical health problems Yes No
Physically frail, anorexic, or obese (BMI red) Yes No
Has Dementia Yes No
Doses of medication administered above BNF doses Yes No
Taken any illicit drugs or alcohol Yes No
Experienced any harm from the restrictive intervention Yes No
Asleep or sedated Yes No
Abnormal ECG or electrolyte results Yes No
### Time Since Administration

<table>
<thead>
<tr>
<th>Time</th>
<th>Level of Alertness (AVPU)</th>
<th>Respiration Rate</th>
<th>Oxygen Saturation</th>
<th>Blood Pressure (mmHg)</th>
<th>Pulse (bpm)</th>
<th>Temperature (°C)</th>
<th>AMEWS Total</th>
<th>Emergence of Side Effects from RT?</th>
<th>Monitored by</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline</td>
<td>Voice</td>
<td>50</td>
<td>50</td>
<td>50</td>
<td>50</td>
<td>50</td>
<td>0</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

- Level of alertness and respiratory rate must always be documented; a visual estimation of respiratory rate is acceptable.
- Document if observations have been offered/attempted and the patient has refused.
- Document if the patient is asleep and confirm that they are breathing (you do not need to wake them).
- Monitoring must continue until there are no further concerns about the service user’s physical health.
- The service user must be awake, alert and physically well when monitoring is discontinued.
- When making the decision to continue/discontinue monitoring, consideration must be given to the medication administered to the service user, time to onset, time to peak and its duration of action.

### Description of RT Incident

```

```

### ABC

```

```

### Multidisciplinary Post-Incident Review (please specify attendees of review)

```

```

### ABC

```

### Date and Time of Review

15 August 2016 16:09

### Patient Post-Incident Support

```

```

### ABC

```

### Date and Time of Patient Post-Incident Support

15 August 2016 15:09

**Has the patient been offered the opportunity to record their perspective of the incident?**
- Yes ☑ No

**Has the patient been offered the opportunity to develop/amend an advance statement to inform the future use of restrictive practices?**
- Yes ☑ No

[CLICK HERE](#) to view / edit / update / the Advance Statement

### Staff Post-Incident Support

```

```

### ABC

```

### Date and Time of Staff Post-Incident Support

15 August 2016 15:09

**Has the ‘impact of event scale’ been completed by staff involved?**
- Yes ☑ No

[Click here](#) to access ‘impact of event scale’

Save  Clear  Cancel
Appendix 4
Poster for Inpatient Wards/Clinic Rooms

Rapid Tranquillisation (RT) Process

Have other strategies been attempted; such as de-escalation, use of oral PRN medication?

Yes - Rapid Tranquillisation may be used if clinically justified

Consider de-escalation techniques/use of oral PRN

Adhere to Restrictive Practices & Deep Intramuscular Injection policies when administering Rapid Tranquillisation

Undertake physical health monitoring, including:

- Level of alertness (AVPU/consciousness)
- Respiratory rate, oxygen saturation
- Emergence of side effects from medication administered
- Blood pressure & pulse
- Temperature
- Level of hydration

Monitoring must be undertaken and documented every 15 minutes when any of the following apply to the patient:

- There is a pre-existing physical health problem
- Has taken illicit drugs or alcohol
- Is physically frail, anorexic or obese (BMI red)
- Appears to be asleep or is sedated
- Has abnormal ECG or electrolyte results
- Has dementia
- Has experienced harm as a result of any restrictive intervention
- Is pregnant
- The BNF max dose has been exceeded (as a single dose or in the last 24 hours, take into consideration regular and PRN medication)

If none of these apply monitoring can be undertaken at hourly intervals

Complete the ‘Restrictive Practices Monitoring Form’ on RiO including physical observations (located within the physical healthcare pathway)

A patient’s refusal to have their physical health monitored must also be documented

The patient must be awake, alert & physically well when monitoring is discontinued

Complete an incident report via the Safeguard system & upload onto RiO
Document the incident report number in the ‘Restrictive Practices Monitoring Form’

An MDT post incident review must be carried out within 24 hours of the incident (minimum a doctor & a nurse)
Review the patient, the effectiveness of the intervention & the pharmacological treatment plan. Identify any risks that can be addressed quickly to reduce the likelihood of a further incident, amend risk & care plans accordingly.
Document on RiO in the ‘Restrictive Practices Monitoring Form’

Consult with the patient to discuss their preferences & wishes regarding the future management of episodes of acute behavioural disturbance. Offer them the opportunity to complete (or amend) an advance statement.