# Rapid Tranquilisation Policy and Guidance

**Version: 3**

| Summary: | The aim of the policy is to ensure support, advice and consistency for staff dealing with psychiatric emergencies and to maintain the safety of the service users and others |
| Keywords (minimum of 5): *(To assist policy search engine)* | Rapid tranquilisation, lorazepam, clonazepam, olanzapine, haloperidol, aripiprazole, rapid tranq, tranq |
| Target Audience: | Heads of Professions, Medical Staff, Inpatient nursing staff, Pharmacists. |
| Next Review Date: | September 2019 |
| Approved and ratified by: | Medicines Management Committee | Date of meeting: 6 July 2017 |
| Date issued: | September 2016 |
| Author: | Juliet Wells and Rebecca Henry, Principal Pharmacist |
| Sponsor: | Francis Johnson, Deputy Chief Pharmacist |
Version Control

Change Record

<table>
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<th>Author</th>
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<tr>
<td>Sept 2014</td>
<td>Marion Wetherill</td>
<td>2</td>
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<td>Decrease to maximum dose of haloperidol Appendix 3</td>
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<tr>
<td>July 2015</td>
<td>Louise Hartland</td>
<td>2</td>
<td>10</td>
<td>Updated TNA (Appendix 1)</td>
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<tr>
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<td>Juliet Wells</td>
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<td>Addition of appendix 9 to policy document</td>
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<td>Juliet Wells</td>
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<td>March 2017</td>
<td>Juliet Wells</td>
<td>3</td>
<td></td>
<td>Typos corrected throughout document</td>
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Reviewers/contributors

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Version Reviewed &amp; Date</th>
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</thead>
<tbody>
<tr>
<td>Marion Wetherill</td>
<td>Area Lead Pharmacist</td>
<td>Version 1 August 2012</td>
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<tr>
<td>Rebecca Henry</td>
<td>Principal Pharmacist</td>
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<tr>
<td>Dr Priyanka Pillay</td>
<td>AMH Consultant</td>
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</table>
1. **Introduction**

1.1 NICE defines the risks of rapid tranquillisation and the management of these risks in Clinical Guideline NG10, May 2015 “Violence and aggression: short-term management in mental health, health and community settings.”

1.2 Rapid Tranquilisation (RT) should only be considered once de-escalation and other strategies have failed to calm the patient. The intervention (along with physical intervention and seclusion) should be considered a management strategy and not be regarded as a primary treatment technique. When determining which intervention to employ, clinical need, the safety of service users and others and, where possible, any advance directives should be taken into account. The intervention selected must be a reasonable and proportionate response to the risk posed by the patient at that particular time. The aim of rapid tranquilisation is to achieve a state of calm sufficient to minimise the risk posed to patients or others. The patient should be able to respond to communication throughout the period of rapid tranquilisation.

1.3 The use of rapid tranquilisation is a high risk practice which has to be well managed in order to avoid unnecessary harm. The risks associated with rapid tranquilisation have been identified as

- Over-sedation causing loss of consciousness
- Over-sedation causing loss of alertness
- Loss of airway
- Cardiovascular collapse (problems with arrhythmias, hypotension, sudden death)
- Respiratory depression (Be Aware acute dystonia’s may compromise respiratory rate)
- Interaction with medication (prescribed or illicit including alcohol)
- Damage to the therapeutic relationship
- Underlying coincidental physical disorders

This policy defines the process for managing these risks by ensuring that staff are aware of:

- Training requirements.
- Safe prescribing guidelines
- Safe physical health monitoring guidelines

2. **Scope**

2.1 This policy provides a protocol for the training in, safe prescribing and administration of rapid tranquilisation in Southern Health NHS Foundation Trust to inpatients in adolescent, adult and older people’s services.

2.2 This policy applies to all doctors, mental health practitioners and nurses employed in Southern Health NHS Foundation Trust.

2.3 This policy should be read in conjunction with the Southern Health NHS Foundation Trust Medicines Control, Administration and Prescribing Policy.
3. **Definitions**

3.1 Rapid tranquilisation Use of medication by the parenteral route (usually intramuscular or, exceptionally, intravenous) if oral medication is not possible or appropriate and urgent sedation with medication is needed. (NICE NG10 May 2015)

4. **Duties / Responsibilities**

4.1 **Doctor** - to ensure service users' prescription is individualised, not routine, includes details of what medication to use for rapid tranquilisation, in what dose range and with what frequency. Minimum time between doses and the maximum dose to be administered in a specified period must be stated. Consider medication already prescribed. Patients should be monitored, for effects and side effects and reviewed weekly in MDT and if RT is needed.

4.2 **Nurse in charge** of unit at time of rapid tranquilisation - to ensure:
- the RT is indicated, having exhausted other strategies to calm the patient
- the prescription is followed
- the patient has the appropriate physical observations completed
- written records including care plans are maintained

**MHP**
- to ensure the prescription for oral medication is followed
- to undertake appropriate physical observations
- to maintain written records.

4.3 **Pharmacist** – to ensure prescriptions are checked for potential adverse interactions

4.4 **Medicines Management Committee** – to monitor the use of rapid tranquilisation and discuss audit results. To ensure best practice is carried out and that any incidents relating to rapid tranquilisation are investigated and lesson learned shared.

5. **Prescribing and Administration of rapid tranquilisation**

5.1 Checks must be made to establish if there are any advance directives in place in the event of requiring rapid tranquilisation.

5.2 Oral medication should be offered before parenteral medication as far as possible.

5.3 Oral and intramuscular medication should be prescribed separately in line with Medicines Control, Administration and Prescribing Policy (MCAPP) and an indication of when and in what order to use it recorded on the chart and in the medical notes. If necessary the medical staff, nurses and MHPs should draw up a care plan to give clear instructions on which medicines should be given and when. This care plan should be signed by the doctor.

5.4 Sufficient time should be allowed for clinical response between doses of medication for rapid tranquilisation.

5.5 Medications should never be mixed in the same syringes.

5.6 For algorithm of drug treatment, choice, dose and frequency see Appendix 3 for adolescents, Appendix 4 for adults and older persons

5.7 See Appendices 3, 4 and 5 for monitoring requirement after rapid tranquilisation
Risks Associated with Medicines used in Rapid Tranquilisation

In certain circumstances prescribing outside the trust guidelines may be appropriate. A risk benefit analysis should be recorded in the medical notes and a rationale in the care plan. Where the risk benefit is unclear, consideration should be given to seeking advice from clinicians who are not directly involved in the care of the patient. There are specific risks associated with the different classes of medications that are used in rapid tranquilisation. The specific properties of the individual drugs should be taken into consideration. When combinations are used, risks may be compounded. Staff need to be aware of the following:

For benzodiazepines
- Loss of consciousness
- Respiratory depression or arrests
- Cardiovascular collapse (in patients receiving both clozapine and benzodiazepines)
- Paradoxical increases in aggression.

For antipsychotics
- Loss of consciousness
- Cardiovascular and respiratory complications and collapse (risk of sudden death)
- Seizures
- Subjective experience of restlessness (akathisia)
- Acute muscular rigidity (dystonia)
- Involuntary movements (dyskinesia)
- Neuroleptic malignant syndrome
- Excessive sedation

For antihistamines
- Excessive sedation
- Painful injection
- Additional antimuscarinic effects.
- Hypotension
- Arrhythmias

Extra care should be taken when implementing rapid tranquilisation in the following circumstances:
- The presence of congenital cardiac conduction abnormality
- The concurrent prescription or use of other medication that lengthens QT intervals on ECG both directly and indirectly
- The presence of certain disorders affecting metabolism, such as, stress and extreme emotions, and extreme physical exertion (hypokalaemia, dehydration).

Monitoring required after rapid tranquilisation (appendices 5 and 7)

All observations must be recorded using the Track and Trigger Tool at Appendix 5.

Observations include:
- monitor pulse blood pressure temperature and respiratory rate every 15 minutes for the first hour then hourly until there are no further concerns
- review mental after the first hour state and then depending on clinical status.
- Use fluid monitoring sheet to ensure adequate hydration and do U and Es if clinically appropriate
• Review and record the episode with the patient within 72 hours

5.8 Post Incident Review

• Any incident requiring rapid tranquillisation (or physical intervention) must be recorded. All appropriate staff should be trained to ensure that they are aware of how to correctly record any incident using the appropriate documentation.

• A post incident review should take place as soon as possible and at least within 72 hours of an incident ending. Wherever possible a person not directly involved in the incident should lead the review which should address:

  • What happened during the incident
  • Any trigger factors
  • Each person’s role in the incident
  • Their feeling at the time of the incident, at the review and how they may feel in the near future
  • What can be done to address their concern?
  • Service users should be given the opportunity to document their own account of the intervention. This should be filed in their medical notes.
  • Effectiveness of medications

6 Training Requirements

6.1 The Trust has developed Guidelines for Rapid Tranquillisation which includes prescribing advice, physical health monitoring and management of problems which may arise. To maintain competency in this area, all staff involved in rapid tranquillisation – registered nurses, mental health practitioners and medical staff must receive training on the guidelines.

6.2 Training: AMH, OPMH and Specialised Services only:

Medicines Management – Rapid Tranquillisation: staff are required to undertake training as defined in the TNA (Appendix 1). All qualified nurses, mental health practitioners and medical staff (including on call) who are working in the inpatient units.

6.3 This training should be carried out once every 3 years.

6.4 The course, delivered by e-learning, is described on the Personal Development and Training website. It will include:

  • Understanding of indications, onset of action, dosage regimens, side effects, cautions and contra-indications for drugs used in rapid tranquillisation

6.5 In addition all staff involved in administering or prescribing rapid tranquillisation or monitoring service users to whom parenteral rapid tranquillisation has been administered, should receive ongoing competency training to a minimum of Intermediate Life Support – see Medical Emergencies and Resuscitation Policy.

6.6 All staff involved in an incident requiring the use of rapid tranquillisation (or physical intervention) should be aware of the potential for damage to the service user/professional relationship and should ensure that everything possible is done to avoid any negative impact.

6.7 All staff involved in rapid tranquillisation need to be aware of the legal framework that authorises this intervention. The intervention should be in line with the
guidance contained within the current Mental Health Act code of practice (and the Mental Capacity Act), and any departure from that guidance should be clearly recorded and justified as being in the best interests of the patient.

6.8 Staff who fail to attend relevant medicines management training will be managed in accordance with the Education and Development Policy.

7. Monitoring Compliance

7.1 The process for monitoring compliance with statutory and mandatory training requirements is outlined in the Trust Education and Development Policy.

7.2 The following table outlines how the Trust will monitor compliance with this policy.

<table>
<thead>
<tr>
<th>Monitoring Compliance</th>
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<tbody>
<tr>
<td><strong>Element to be monitored</strong></td>
</tr>
<tr>
<td>Duties / responsibilities</td>
</tr>
<tr>
<td>Prescribing guidelines for rapid tranquilisation</td>
</tr>
<tr>
<td>Documented process for how observations are recorded, including timeframes when patients have received rapid tranquilisation</td>
</tr>
<tr>
<td>Documented process for how the organisation trains staff, in line with the training needs analysis</td>
</tr>
</tbody>
</table>

8 Policy Review

8.1 This policy will be reviewed 3 years from the date of approval or sooner in the event of significant safety issues or changes in practice.
9. **Associated Documents**

- Medicines Control Administration and Prescribing policy (MCAPP)
- Guidelines for the use of Zuclopenthixol acetate (Clopixol Acuphase®)
- Shortage of lorazepam injection memo January 2012
- Medical Emergencies and Resuscitation Policy

10. **Supporting References**

- Maudsley Prescribing Guidelines 12th edition
- NICE NG10
- Bazire Psychotropic Drug Directory
- BNF 70 September 2015
- BNF for Children 2015-2016
Training Needs Analysis

If there are any training implications in your policy, please complete the form below and make an appointment with the LEaD department (Louise Hartland, Quality, Governance and Compliance Manager or Sharon Gomez, Essential Training Lead on 02380 874091) before the policy goes through the Trust policy approval process.

<table>
<thead>
<tr>
<th>Training Programme</th>
<th>Frequency</th>
<th>Course Length</th>
<th>Delivery Method</th>
<th>Facilitators</th>
<th>Recording Attendance</th>
<th>Strategic &amp; Operational Responsibility</th>
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<tr>
<td>Medicines Management – Rapid Tranquilisation</td>
<td>Every 3 years</td>
<td>Face to Face - 1.5 hours</td>
<td>Face to Face</td>
<td>Medicines Management Team</td>
<td>LEaD</td>
<td>Strategic – Medical Director Operational – Chief Pharmacist</td>
</tr>
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| Directorate | Service | Target Audience |
|-------------|---------|-----------------
| MH/LD/TQ21 | Adult Mental Health | Qualified nurses, mental health practitioners and medical staff working in acute in-patient settings including PICU’s who are involved in prescribing, administration and /or monitoring of rapid tranquilisation. All Modern Matrons.
Elmleigh (Elmleigh Inpatients, Elmleigh FM, Elmleigh PICU); Antelope House (Hamtun Ward, Trinity Ward, Saxon Ward & Abbey Ward); Parklands Hospital (Hawthorns Inpatients, Hawthorns MOD & Hawthorns PICU); Melbury Lodge (Kingsley Ward & Mother & Baby Unit). |
| Specialised Services | | Qualified nurses, mental health practitioners and medical staff working in in-patient and Forensic in-patient settings who are involved in prescribing, administration and /or monitoring of rapid tranquilisation.
All qualified nurses who work in the following services;
Leigh House; Ravenswood House (Ashurst, Lyndhurst, Malcolm Faulk, Mary Graham, Meon Valley wards, Clinical Risk & Security and RSU Management); Southfield; Bluebird House (Bluebird Nursing & Security, Hill, Moss & Stewart wards); RSU Medical;
Bluebird House Medical; Southfield Medical. |
| Learning Disabilities | | Qualified nurses and medical staff working in in-patient settings who are involved in prescribing, administration and /or monitoring of rapid tranquilisation.
Westview/Homefarm; Willow Assessment & Treatment Unit; Ashford; Evenlode; The Ridgeway Centre and Inpatient Services Management Oxon; Hampshire Management; Hampshire Intensive Support Team; Soton Intensive Support Team. |
| TQtwentyone | | Not Applicable |
| ISD’s | Older Persons Mental Health | Qualified nurses, mental health practitioners and medical staff working in acute in-patient settings who are involved in prescribing, administration and /or monitoring of rapid tranquilisation.
Gosport War Memorial Hospital (Dryad & Daedalus wards); Melbury Lodge (Stefano Oliveri ward); Parklands Hospital (Beechwood & Elmwood wards); Western Community Hospital (Beaulieu, Berrywood & Minstead wards). |
| ISD’s | Adults | Not Applicable |
| ISD’s | Childrens Services | Not Applicable |
| Corporate | All | Not Applicable |
APPENDIX 2 - Southern Health NHS Foundation Trust: Equality Impact Analysis Screening Tool

Equality Impact Assessment (or ‘Equality Analysis’) is a process of systematically analysing a new or existing policy/practice or service to identify what impact or likely impact it will have on protected groups. It involves using equality information, and the results of engagement with protected groups and others, to understand the actual effect or the potential effect of your functions, policies or decisions. The form is a written record that demonstrates that you have shown due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations with respect to the characteristics protected by equality law.

For guidance and support in completing this form please contact a member of the Equality and Diversity team

<table>
<thead>
<tr>
<th>Name of policy/service/project/plan:</th>
<th>Rapid Tranquilisation: Policy and Guidance for use in Mentally Ill Patients Displaying Acutely Disturbed or Violent Behaviour</th>
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<tr>
<td>Policy Number:</td>
<td>SH CP 48</td>
</tr>
<tr>
<td>Department:</td>
<td>Medicines Management</td>
</tr>
<tr>
<td>Lead officer for assessment:</td>
<td>Marion Wetherill, Area Lead Pharmacist</td>
</tr>
<tr>
<td>Date Assessment Carried Out:</td>
<td>12 June 2012</td>
</tr>
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1. Identify the aims of the policy and how it is implemented.

<table>
<thead>
<tr>
<th>Key questions</th>
<th>Answers / Notes</th>
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<tr>
<td>Briefly describe purpose of the policy including</td>
<td>The aim of the policy is to ensure support, advice and consistency for staff dealing with psychiatric emergencies and to maintain the safety of the service users and others</td>
</tr>
<tr>
<td>• How the policy is delivered and by whom</td>
<td>✓ If employed it should only be considered once de-escalation and other strategies have failed.</td>
</tr>
<tr>
<td>• Intended outcomes</td>
<td>✓ It is normally employed to avoid prolonged physical intervention and when medication is required to calm a psychotic or non-psychotic behavioral disturbance.</td>
</tr>
<tr>
<td></td>
<td>✓ The aim of rapid tranquillisation is to achieve sufficient sedation levels to minimise the risk posed to the patient or others.</td>
</tr>
<tr>
<td></td>
<td>✓ The aim of this policy is to define parameters for safe and effective use of medication, and subsequent after care, as part of an overall clinical risk management plan</td>
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</table>

2. Consideration of available data, research and information

Monitoring data and other information involves using equality information, and the results of engagement with protected groups and others, to understand the actual effect or the potential effect of your functions, policies or decisions. It can help you to identify practical steps to tackle any negative effects or discrimination, to advance equality and to foster good relations.

Please consider the availability of the following as potential sources:

- Demographic data and other statistics, including census findings
- Recent research findings (local and national)
- Results from consultation or engagement you have undertaken
- Service user monitoring data
- Information from relevant groups or agencies, for example trade unions and voluntary/community organisations
- Analysis of records of enquiries about your service, or complaints or compliments about them

Recommendations of external inspections or audit reports

<table>
<thead>
<tr>
<th>Key questions</th>
<th>Data, research and information that you can refer to</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1 What is the equalities profile of the team delivering the service/policy?</td>
<td>This policy applies to all doctors and nurses employed in Southern Health NHS Foundation Trust. The Equality and Diversity team will report on Workforce data on an annual basis.</td>
</tr>
<tr>
<td>2.2 What equalities training have staff received?</td>
<td>All Trust staff have a requirement to undertake Equality and Diversity training as part of Corporate Induction (Respect and Values) and E-Assessment</td>
</tr>
<tr>
<td>2.3 What is the equalities profile of service users?</td>
<td>The Trust Equality and Diversity team report on Trust patient equality data profiling on an annual basis</td>
</tr>
<tr>
<td>2.4 What other data do you have in terms of service users or staff? (E.g. results of customer satisfaction surveys, consultation findings). Are there any gaps?</td>
<td>The Trust is preparing to implement the Equality Delivery System which will allow a robust examination of Trust performance on Equality, Diversity and Human Rights. This will be based on 4 key objectives that include: 1. Better health outcomes for all 2. Improved patient access and experience 3. Empowered, engaged and included staff 4. Inclusive leadership This EqIA screening will consider the impact of Rapid Tranquilisation against the nine protected characteristics.</td>
</tr>
</tbody>
</table>

**Key research:**

1. The NICE guideline on the management of violent behaviour involving psychiatric inpatients conducted a systematic examination of the literature relating to the effectiveness and safety of rapid tranquilisation (NICE, 2005).


**Dignity:** Intramuscular administration of rapid tranquilisation often requires unavoidable securing of the patient by restraint and the removal of clothing to expose the upper outer quadrant of the patient’s buttocks. In effect, a patient is held down while embarrassing areas of their body are exposed. There should be no doubt that the procedure has potentially serious physical and psychological consequences for the patient.

**Location:** People who see rapid tranquilisation, for example other patients and relatives, can find it very distressing. Obviously, it is sometimes necessary to use
<table>
<thead>
<tr>
<th>restraint in an area that is not particularly private, for example when an individual becomes aggressive and attempts to attack a staff member during the course of negotiation, or when a patient’s resistance and aggression are so strong that their relocation to a more private area would be unnecessarily risky. However, every effort should be made to ensure that intramuscular rapid tranquilisation in particular is delivered in a private area of the ward where maximum attention can be paid to the dignity of the patient.</th>
<th>2.5 What internal engagement or consultation has been undertaken as part of this EIA and with whom? What were the results? Service users/carers/Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.6 What external engagement or consultation has been undertaken as part of this EIA and with whom? What were the results? General Public/Commissioners/Local Authority/Voluntary Organisations</td>
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</tr>
<tr>
<td>Positive impact (including examples of what the policy/service has done to promote equality)</td>
<td>Negative Impact</td>
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</table>
| **Age** | In people over the age of 65 years, other health problems are more common compared to adults of working age, they may be:  
- More frail;  
- Have more general medical illnesses;  
- Taking non-psychiatric medication;  
- Often more likely to develop extra pyramidal side effects;  
Suffering from dementia, so more likely to develop increased cognitive impairment with high doses of medication; | Regular monitoring via incident reports to identify any over / under use of rapid tranquillisation  
Reviewed accordingly by the Trust's Medicine Management Group | | |
| Applied to all protected groups:  
The Trust has developed Guidelines for Rapid tranquillisation which includes prescribing advice, physical health monitoring and management of problems which may arise. To maintain competency in this area, all staff involved in rapid tranquillisation – registered nurses, mental health practitioners and medical staff must receive training on the guidelines. | | | |
| **Disability** | The choice between using physical intervention and rapid tranquillisation as a method of managing violent behaviour in those with a learning disability should be part of an overall care plan. | Learning Disability: People with severe learning and communication difficulties may not be able to express discomfort or pain in usual ways. | Staff responsibilities (for de-escalation, rapid tranquillisation, physical intervention and seclusion) should be detailed in the individual care plans of service users with disabilities (this includes service users with physical or sensory) | |
There may be developmental disorders, including autistic spectrum and attention-deficit hyperactivity disorders that frequently coexist with a learning disability.

Sensory impairments must be detected and remedied to minimise the consequent disability, and a specialised and sensitive approach is usually needed. About 30% of people with learning disabilities have significant sight impairment and 40% have significant hearing problems.

The prevalence of these problems increases with age, and professionals should be aware of this as a possible explanation for changes in behaviour and awareness. Sensory disabilities are often associated with challenging behaviour.

Lindsey, M. (2000) Services for people with learning impairment and/or other communication difficulties). (NICE Clinical Guideline 25)
<table>
<thead>
<tr>
<th>Gender Reassignment</th>
<th>This policy should ensure that people are treated with dignity and respect.</th>
<th>No identified negative impacts at this stage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marriage and Civil Partnership</td>
<td>This policy should ensure that people are treated with dignity and respect.</td>
<td>No identified negative impacts at this stage</td>
</tr>
</tbody>
</table>
| **Pregnancy and Maternity** | A pregnant woman requiring rapid tranquilisation should be treated according to the NICE clinical guidelines on the short-term management of disturbed/violent behaviour, schizophrenia and bipolar disorder (see NICE [2005d, 2002, 2006] for details), except that:  
  ● she should not be secluded after rapid tranquilisation  
  ● restraint procedures should be adapted to avoid possible harm to the foetus  
  ● during the perinatal period, the woman's care should be managed in close collaboration with a paediatrician and an anaesthetist. | Special provision should be made for pregnant women in the event that interventions are needed. These should be recorded in the service user's care plan. (NICE Clinical Guideline 25)  
Prescribed medication for physical and/or mental health may need to be changed in the event of pregnancy and breast feeding. |
| Race | Chen et al. (1991) found a significantly higher number of African Caribbean | Regular monitoring via incident reports to identify any over/under use of rapid tranquilisation |
service users were given high dose neuroleptic medication for disturbed/violent behaviour than service users from other ethnic backgrounds (p<0.03). The NICE Clinical Guideline 25 felt that there was insufficient evidence (due to the availability of only one study) to assess whether African Caribbean service users are given rapid tranquillisation more often than service users from other ethnic backgrounds. If this were the case then this would place them at higher risk of physical health complications secondary to the prescribing of high dose antipsychotic medication.


Reviewed accordingly by the Trust’s Medicine Management Group

Where language barriers are seen to be a factor which is preventing a response by the service user to interventions/treatment, this can lead to an escalation of acute behaviour disturbance by the service user. Staff should be mindful of this and seek the support of the interpreting service as soon as possible.
Violence: The Short term management of disturbed/violent behaviour in inpatient psychiatric settings and emergency departments. Feb 2005

Metabolism of medication may vary across different ethnic groups. Where medication is metabolized via cytochrome P450 enzymes, there is ethnic variation as to extent of metabolism e.g. approximately 20% of Asians and 3-5% of Caucasians are poor CYP2C19 metabolisers, around 5-8% Caucasians, 8.5% African-Americans, and 2-10% of Asians are slow metabolisers at CYP2D6, contrasting with up to 29% of North African and Middle Eastern people who are ultra rapid metabolisers at CYP2D6.


There is a concern that
– due to language requirements – those service users who have poor or no English could be more at risk of needing to be rapidly tranquilised. The reason for this is that they may not respond to other methods of treatment due to a need for staff to communicate with them. Whilst this cannot be prevented, services should be mindful of this fact and where possible involve interpreters as soon as possible in the process.

Religion or Belief

This policy should ensure that people are treated with dignity and respect.

Service users from the Muslim faith are exempt from fasting during daylight hours and can also take prescribed medication if there is an urgent clinical need. For service users who do not want to take prescribed medication during daylight hours, the medication regimen will be changed wherever it is possible, safe and appropriate to do so to support this.

Religious jewellery being used to compromise the safety of the patient or others.

A service user in seclusion should keep their clothing and any personal items, including those of religious or cultural significance (such as some items of jewellery), provided this does not compromise their safety or the safety of others.
<table>
<thead>
<tr>
<th>Sex</th>
<th>Every effort should be made to ensure that staff delivering rapid tranquilisation are of the same gender as the patient receiving it.</th>
<th>Males are considered to be at higher risk of dystonic reactions secondary to antipsychotic medication than females.</th>
<th>A summary of recommendations from the NICE guidance on antenatal and postnatal mental health is available on the intranet. Medicine Management staff are always available to give advice on appropriate choice of medication in such circumstances.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sexual Orientation</td>
<td>This policy should ensure that people are treated with dignity and respect.</td>
<td>No identified negative impacts at this stage</td>
<td></td>
</tr>
</tbody>
</table>
Appendix 3

Guideline for the Rapid Tranquilisation (RT) for adolescents <18 years

**Definition:** Use of medication by the parenteral route, if oral medication is not possible or appropriate and urgent sedation with medication is needed. This is a restrictive intervention.

**Rapid Tranquilisation Care Plan and MDT review:**
RT should NOT be routinely prescribed;
- MDT individualised care plan should be developed and documented as soon as possible after admission
- Review weekly in MDT and discuss with senior doctor if used: 1) record whether it has been used or not; including rationale, target symptoms, timescales, triggers, total daily doses, number/reason for missed doses, response & side effects, 2) whether changes are needed in the care plan and prescription, 3) the care plan should be based on accurate, up-to-date and thorough risk assessments, 4) if an Advanced Directive can be used in the future
- Post- incident debrief immediately for the team and later for the service user with review and risk assessment. An incident form MUST be completed.

**De-escalation and Calming Techniques** (NICE, NG10 and 11)
Aim to reduce the use of restrictive interventions through staff training; conflict resolution, positive behaviour technique, in response to comprehensive risk assessments conducted by staff including consideration of service user views and advanced directives

**Prior to Rapid Tranquilisation**
Keep the patient safe and choose the appropriate pathway;
- Consider physical causes and conditions (acute infection, akathisia, alcohol/illicit substance intoxication, frailty, risk of Delirium Tremens, physical co-morbidities)
- Review medicines given in the last 24 hours. If greater than BNF max contact senior doctor. Ensure oral medication has been offered prior to RT.
- Start RT checklist

**Consider IM Lorazepam** (Unlicensed use)
Adjust dose according to weight and age;
- <12 years or <30kg weight 0.5-1mg,
- >12 years 0.5-2mg (max 4mg/24 hours)

Start Physical Health Monitoring and at 1 hour Review Mental State

**Follow up Physical Health Monitoring**

- Consider repeating IM Lorazepam
- Review mental state at 1 hour and continue Physical Health Monitoring

**Consider Haloperidol or Atypical** (unlicensed use);
- Haloperidol – confirm previous antipsychotic use and ECG
- Atypical – antipsychotic naive, evidence of cardiovascular disease/ prolonged QTc/no ECG/ on drugs that can affect QTc, alcohol or illicit drug intoxication

**Haloperidol**
- Consider 1 – 5mg IM Haloperidol
- Consider combining with Promethazine IM
- < 12 years old 5 – 10mg (max 25mg/day)
- > 12 years old 10 – 25 mg (max 100mg/24 hours) to improve tolerability to Haloperidol or Procyclidine oral/IM

Continue Physical Health Monitoring and at 1 hour Review Mental State

- If there is a partial response consider a second dose of Haloperidol in a minimum of 1 hour
- Haloperidol IM max 5mg in 24 hours

**Olanzapine**
- Wait 2 hours after Lorazepam before giving
- Olanzapine 2.5 – 5mg IM
- Do not give with IM Lorazepam
- Consider procyclidine oral/IM (EPEs more common in adolescents)

- If there is a partial response consider a second dose of Olanzapine in 2 hours
- Max 20mg or 3 doses IM in 24 hours, whichever is reached first

If no response arrange urgent team review. Speak to senior doctor

**Zuclopenthixol Acetate is NOT Rapid Tranquilisation**
Physical Health Monitoring after RT

- **What to Record: Track & Trigger Tool**
  - Temperature (T), Blood Pressure (BP), Pulse (P), Respiratory Rate (RR)
  - Level of consciousness (Alert, Vocalise, Pain, Unresponsive)
  - Oxygen saturation

- **When to Record:**
  - Baseline on admission/ prior to RT
  - and then every 15 minutes for the 1st hour
  - then at least hourly until there are no concerns

- **Fluid Balance**
  - Use Fluid Monitoring Sheet to ensure adequate hydration
  - Do U & Es if clinically appropriate
  - Avoid fluid overload

- **What to do if unable to monitor**
  - Must document why you can’t monitor
  - Record what you can monitor; awake, good colour, RR
  - Keep the patient on close visual observation
  - If appears asleep, wake to assess level of consciousness

### Time to peak

<table>
<thead>
<tr>
<th>Injection</th>
<th>Inj cost</th>
<th>Oral</th>
</tr>
</thead>
<tbody>
<tr>
<td>Haloperidol</td>
<td>15 – 60 mins</td>
<td>£2-6 hours</td>
</tr>
<tr>
<td>Lorazepam</td>
<td>60 – 90 mins</td>
<td>£5-8 hours</td>
</tr>
<tr>
<td>Promethazine</td>
<td>2 – 3 hours</td>
<td>£2 – 3 hours</td>
</tr>
<tr>
<td>Aripiprazole</td>
<td>1 – 3 hours</td>
<td>£3 – 5 hours</td>
</tr>
<tr>
<td>Olanzapine</td>
<td>15 – 45 mins</td>
<td>££££ Tabs 5 – 8 hours</td>
</tr>
<tr>
<td>Flumazenil</td>
<td>Response within 3 mins</td>
<td>Peak 6-10 minutes, Duration depends on type &amp; dose of benzodiazepine</td>
</tr>
<tr>
<td>Risperidone</td>
<td>-</td>
<td>1 hour</td>
</tr>
<tr>
<td>Quetiapine</td>
<td>-</td>
<td>1 hour</td>
</tr>
</tbody>
</table>

### Using PRN medication

- Do not prescribe routinely or automatically on admission.
- Tailor medication to individual need, include discussion with patient/family/carer where possible
- Ensure the indication and rationale are clear and in the care plan
- Ensure dose/24 hour is completed and does not exceed BNF limits, particularly in combination. Ensure the time interval between doses is specified
- Only exceed BNF dosing if planned, documented and approved by a senior doctor
- MDT should review PRN at least weekly; if to be continued record rationale. If not used since last review consider stopping

### Management of possible complications of RT which may require urgent medical attention

- **N.B. IV administration by medical staff only**
  - **Problem** Irregular/ Slow Pulse <60/minute
  - **Remedial Measures** Contact Doctor. Consider urgent referral to physicians
  - **Problem** Fall in Blood Pressure orthostatic or <50 mmHg diastolic
  - **Remedial Measures** Contact doctor. Lie patient flat. Raise legs if possible. Monitor closely. May need physician referral
  - **Problem** Acute Dystonia (including oculogyric crisis)
  - **Remedial Measures** Give Procyclidine 5 – 10mg IM (or IV)
  - **Remedial Measures** Review Antipsychotic medication
  - **Problem** Reduced Respiratory Rate
  - **Remedial Measures** Ensure patient is well hydration
  - **Remedial Measures** Continued monitoring of blood gases
  - **Remedial Measures** If necessary contact doctor

### Neuroleptic Malignant Syndrome (NMS)

- Fever, usually above 38°C sometimes hyperpyrexia over 40°C
- Muscle rigidity
- Alteration in consciousness
- Autonomic disturbance – tachycardia, changes in BP, urinary incontinence
- Raised creatinine kinase levels

### Risk Factors:-

- Previous NMS or cerebral compromise
- Catatonia, agitation, overactivity, dehydration
- Rapid tranquillisation, IM therapy, high potency neuroleptics

### STOP ANTI精神病otic IMMEDIATELY

Consult doctor, can be FATAL, may need ITU. Consider urgent referral

### Rapid Tranquilisation during Seclusion

- Ensure the patient is observed WITHIN EYESIGHT by trained staff
- Undertake a risk assessment and consider ending the seclusion when rapid tranquilisation has taken effect

### Pregnancy

- After 20 weeks of pregnancy, women should never be restrained face down
- Pregnancy: ensure perinatal service involved in overall care in patients with psychosis and previous antipsychotic exposure
- Haloperidol 1.5mg – 5mg PO or 2 – 5mg IM may be added to Lorazepam, Repeat as necessary. Same max doses apply.
- After rapid tranquilisation consider medical review of pregnancy

---

**Refer to:-**
NICE NG 10 & 11
Current SPC for the relevant drug

From the Southern Health NHS F Trust website;
Medical emergencies & resuscitation Policy SH CP 30
ECG Policy SH CP
Guidelines for the use of Zuclopenthixol Acetate SH CP 17
Seclusion & long term segregation policy SH CP 107
Appendix 4 - Algorithm Adult

Guideline for the Rapid Tranquilisation (RT) for adults >18 years

**Definition:** Use of medication by the parenteral route, if oral medication is not possible or appropriate and urgent sedation with medication is needed. This is a restrictive intervention.

**Rapid Tranquilisation Care Plan and MDT review:**
- RT should NOT be routinely prescribed;
- MDT individualised care plan should be developed and documented as soon as possible after admission;
- Review weekly in MDT and discuss with senior doctor if used: 1) record whether it has been used or not; including rationale, target symptoms, timescales, triggers, total daily doses, number/reason for missed doses, response & side effects; 2) whether changes are needed in the care plan and prescription; 3) the care plan should be based on accurate, up-to-date and thorough risk assessments; 4) if an Advanced Directive can be used in the future;
- Post-incident debrief immediately for the team and later for the service user with review and risk assessment. An incident form MUST be completed.

**De-escalation and Calming Techniques** (NICE, NG10 and 11)
Aim to reduce the use of restrictive interventions through staff training; conflict resolution, positive behaviour technique, in response to comprehensive risk assessments conducted by staff including consideration of service user views and advanced directives.

**Prior to Rapid Tranquilisation**
Keep the patient safe and choose the appropriate pathway:
- Consider physical causes and conditions (acute infection, akathisia, alcohol/illicit substance intoxication, frailty, risk of Delirium Tremens, conditions (renal, liver, cardiac, respiratory or diabetes);
- Review medicines administered by nursing staff in the last 24 hours. If greater than BNF max contact senior doctor. Ensure oral medication has been offered prior to RT.
- Start RT checklist

**Consider IM Lorazepam**
1 – 2mg IM (max 4mg/24 hours)
(Adults over 65 years and Learning Disability (LD) 500 micrograms to 1mg, Max 2mg in 24 hours)

**Start Physical Health Monitoring and at 1 hour Review Mental State**

- Full response
- Partial response
- No response

**Follow up Physical Health Monitoring**

**Consider repeating IM Lorazepam**
- Review response and tolerability at 1 hour and continue Physical Health Monitoring
- Partial or no response

**Haloperidol**
- Consider 2.5 – 5mg IM Haloperidol
- In LD and adult>65 use lower doses 500micrograms to 1mg (max 2 mg in 24 hours)
- Consider combining with Promethazine IM 25 – 50mg (max 100mg/24 hours) to improve tolerability to Haloperidol (Not in adults>65 or LD)

**Olanzapine**
- Wait 2 hours after Lorazepam before giving Olanzapine 5 – 10mg IM (2.5mg adults>65) unlicensed use
- Do not give with IM Lorazepam

**Continue Physical Health Monitoring and at 1 hour Review Mental State**

- Partial or no response
- Partial or no response

**If there is a partial response consider a second dose of**
- Haloperidol in a minimum of 1 hour
- Haloperidol IM max 12mg in 24 hours

**If there is a partial response consider a second dose of Olanzapine in 2 hours**
- Max 20mg or 3 doses IM in 24 hours, whichever is reached first

**If no response arrange urgent team review. Speak to senior doctor**
**Physical Health Monitoring after RT**

- **What to Record: Track & Trigger Tool**
  - Temperature (T), Blood Pressure (BP), Pulse (P), Respiratory Rate (RR)
  - Level of consciousness (Alert, Vocational, Pain, Unresponsive)
  - Oxygen saturation

- **When to Record:**
  - Baseline on admission/prior to RT
  - and then every 15 minutes for the 1st Hour
  - then at least HOURLY until there are no concerns

- **Fluid Balance**
  - Use Fluid Monitoring Sheet to ensure adequate hydration
  - Do U & Es if clinically appropriate
  - Avoid fluid overload

- **What to do if unable to monitor**
  - Must Document why you can’t monitor
  - Record what you can monitor; awake, good colour, RR
  - Keep the patient on close visual observations
  - If appears asleep, wake to assess level of consciousness

---

**Management of possible complications of RT which may require urgent medical attention**

- **Problem**
  - Irregular/Slow Pulse <60/minute

- **Remedial Measures**
  - Contact Doctor. Consider urgent referral to physicians

- **Fall in Blood Pressure**
  - orthostatic or <50 mmHg diastolic
  - Contact doctor. Lie patient flat. Raise legs if possible. Monitor closely. May need physician referral

- **Acute Dystonia**
  - (including oculogyric crisis)
  - Give procyclidine 5 – 10mg IM (or IV)
  - Review Antipsychotic medication

- **Reduced Respiratory Rate**
  - < 10/minute
  - O₂ sats <95
  - Phone 999 and contact doctor immediately.
  - Give Flumazenil if Benzodiazepine-induced and RR falls below 10/min
  - Initial dose: 200mcg IV over 15 secs – if required level of consciousness not achieved after 60 seconds then:
  - Subsequent dose: 100mcg over 10 seconds, repeated after 60 seconds if necessary
  - Maximum dose: 1mg in 24 hours (one initial dose and eight subsequent doses)

- **Monitor** until RR returns to baseline level.

- **Neuroleptic Malignant Syndrome**

---

**Time to peak**

<table>
<thead>
<tr>
<th>Dose</th>
<th>Injection cost</th>
<th>Oral</th>
</tr>
</thead>
<tbody>
<tr>
<td>Haloperidol</td>
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<td>Aripiprazole</td>
<td>3 hours</td>
<td>£3 – 5 hours</td>
</tr>
<tr>
<td>Olanzapine</td>
<td>15 – 45 mins</td>
<td>£1 – 4 hours</td>
</tr>
<tr>
<td>Risperidone</td>
<td>-</td>
<td>1 hour</td>
</tr>
<tr>
<td>Quetiapine</td>
<td>-</td>
<td>1 hour</td>
</tr>
</tbody>
</table>

**Using PRN medication**

- Do not prescribe routinely or automatically on admission.
- Tailor medication to individual need, include discussion with patient where possible
- Ensure the indication and rationale are clear and in the care plan
- Ensure dose/24 hour is completed and does not exceed BNF limits, particularly in combination. Ensure the time interval between doses is specified
- Only exceed BNF dosing if planned, documented and approved by a senior doctor
- MDT should review pm at least weekly; if to be continued record rationale. If not used since last review consider stopping

---

**Neuroleptic Malignant Syndrome (NMS)**

- Fever, usually above 38°C sometimes hyperpyrexia over 40°C
- Muscle rigidity
- Alteration in consciousness
- Autonomic disturbance – tachycardia, changes in BP, urinary incontinence
- Raised creatinine kinase levels

**Risk Factors:**
- Previous NMS or cerebral compromise
- Catatonia, agitation, over activity, dehydration
- Rapid tranquillisation, IM therapy, high potency neuroleptics
- STOP ANTIPSYCHOTIC IMMEDIATELY
  - Consult doctor, can be FATAL, may need ITU. Consider urgent referral

---

**Rapid Tranquilisation during Seclusion**

- Ensure the patient is observed WITHIN EYESIGHT by trained staff
- Undertake a risk assessment and consider ending the seclusion when rapid tranquillisation has taken effect

---

**Pregnancy**

- After 20 weeks of pregnancy, women should never be restrained face down
- Pregnancy: ensure perinatal service involved in overall care in patients with psychosis and previous antipsychotic exposure
- Haloperidol 1.5mg – 5mg PO or 2 – 5mg IM may be added to Lorazepam, Repeat as necessary. Same max doses apply.
- After rapid tranquillisation consider medical review of pregnancy

---

**Refer to:**
- NICE NG 10 & 11
- Current SPC for the relevant drug
- From the Southern Health NHS foundation Trust website; Medical emergencies & resuscitation Policy SH CP 30
- ECG Policy SH CP
- Guidelines for the use of Zuclopenthixol acetate SH CP 17
- Seclusion & long term segregation policy SH CP 107

---

**Rapid Tranquilisation Policy and Guidance**

Version: 3

August 2016
### Appendix 5 - Physiological Observation Chart

**Adult Track and Trigger Tool**

Patient information hand written or sticker

<table>
<thead>
<tr>
<th>Forename</th>
<th>Surname</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Consultant/GP (in charge of care)</th>
<th>NHS Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ward</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

This is chart number _________ for this admission episode

#### Frequency of observations

This will depend on the patient’s physical condition. It is the responsibility of the nurse in charge of the patient’s care to assess each individual patient and make an appropriate decision about the frequency of observations required, whilst consulting with the appropriate doctor responsible for this patient.

The **minimum frequency for observations of this patient are**, please tick and write name of person confirming decision

<table>
<thead>
<tr>
<th></th>
<th>Hourly</th>
<th>4 hourly</th>
<th>Daily</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weekly</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Stable

- Potential for deterioration
- Acute Deterioration
- Critically Ill

#### Normal observations

- Extra vigilance
- Assess and inform doctor
- Act now

#### Normally physical observations with review according to patients physical condition and observation frequency prescribed for the patient observations

- Inform nurse in charge and act on their recommendations
- Take any appropriate actions as required or prescribed
- Consider increasing frequency of physical observations
- Inform all staff in area if concerned about patient

#### Document actions

- Continually monitor/observe patient
- Document actions

#### Frequency of observations

- Call emergency help as appropriate – (9)999 or Medical Emergency Team as appropriate to location
- Inform nurse in charge
- Take any appropriate actions as required or prescribed
- Continue physical observations every 15 minutes
- Prepare for transfer as appropriate
- Document actions

---

Seek further advice from senior nursing staff or medical staff as appropriate if:

- If you have concerns about the patient’s status based on your clinical judgement
- If patient failing to improve despite optimal treatment plan

---

Rapid Tranquilisation Policy and Guidance

Version: 3

August 2016
<table>
<thead>
<tr>
<th>Date</th>
<th>Time of observations</th>
<th>Initials of staff performing observations</th>
</tr>
</thead>
</table>

### Airway and Breathing

- **Respiration Rate** (breaths per minute):
  - Above 30
  - 25 – 30
  - 21 – 24
  - 16 – 20
  - 8 – 9
  - Less than 8

### Oxygen saturation (%)

- 94 – 100
- 90 – 93
- 85 – 89
- Less than 84

### Circulation

- **Heart Rate** (beats per minute):
  - More than 130
  - 111 – 129
  - 101 – 110
  - 51 – 100
  - 40 – 50
  - Less than 40

- If heart rate is above systolic blood pressure, then this is an amber concern.

### Disability

- **Neurological Observation**
  - Alert: awake and responding
  - Voice: responds to verbal commands or new confusion
  - Pain - new: responds to verbal stimulus – complete neurological observation chart
  - Unresponsive: Unresponsive – must complete neurological observation chart

### New Pain

- None = 1
- Slight = 2
- Moderate = 3: May require treatment alteration or further pain relief, speak to doctor
- Severe = 4: Requires immediate action, call doctor for action

### Blood Sugar

- **BM (mmol/L)**
  - Less than 2
  - Between 3 – 4
  - Between 5 – 9
  - 10 – 19
  - Over 20 or if device reads high

### Temperature

- **Degrees Celsius**
  - Above 41
  - 39 – 40
  - 37.6 – 38.9
  - 36 – 37.5
  - 35.1 – 35.9
  - Less than 35
There is a supply problem with Lorazepam injection resulting in a national shortage. A small supply of unlicensed Lorazepam injection may be available. If this is required please discuss this with your ward pharmacist. As this is an unlicensed supply the consultant must confirm approval for use in the RIO notes and the nurses should enter details of the batch number of injection administered.

The following alternatives should be considered if no stock of Lorazepam injection is available and guidance should be read in conjunction with the Trust Guidelines for Rapid Tranquilisation. Suggested alternatives are:

### Olanzapine IM

as per SHFT Rapid Tranquilisation Guidelines (SH CP 48)

### Promethazine IM

- 25mg- 50mg IM
- Maximum dose 100mg in 24 hours
- Onset of sedation 1-2 hours
- Time to peak plasma concentration 2-3 hours
- Half-life 5-15 hours

### Clonazepam IM (unlicensed use)

- Dose: 500micrograms -2mg
- Maximum dose 4mg in 24 hours (higher doses may be used in exceptional circumstances after discussion with consultant psychiatrist)
- Time to peak concentration 3.1 hours, wait at least 1 hour before repeating Clonazepam.
- Half-life 20-60 hours mean 30 hours – please note the long half-life compared with Lorazepam. There is an accumulation risk with repeated dose.
- Off licence use in rapid tranquilisation. IM route not licensed.
- Clonazepam is a benzodiazepine and should not be given until at least one hour after IM Olanzapine.
- There is little information on the use of Olanzapine IM after Clonazepam IM. Do not give both IM within a 24 hour period without seeking advice from a senior doctor.

<table>
<thead>
<tr>
<th>Pharmacokinetics</th>
<th>Clonazepam IM</th>
<th>Lorazepam IM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time to peak concentration</td>
<td>~3 hours</td>
<td>~1.5 hours</td>
</tr>
<tr>
<td>Elimination half-life</td>
<td>30 hours(range: 20-60 hours)</td>
<td>12-16 hours</td>
</tr>
</tbody>
</table>

Drug charts should be reviewed to take account of the possibility that a ward may have run out in the period between writing and giving, i.e. an option if Lorazepam not available.

Forms T2 and T3 should be reviewed as Clonazepam and Promethazine are in different sections of the BNF and both should be written as individual drugs.
Appendix 7
Rapid Tranquilisation (RT) with IM injection - Monitoring Checklist

Refer to SH CP 48- Rapid Tranquilisation Policy on SHFT website

<table>
<thead>
<tr>
<th>Patients Name:</th>
<th>Date of Birth:</th>
<th>Hospital Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ward:</td>
<td>Consultant:</td>
<td></td>
</tr>
</tbody>
</table>

Pre RT Checklist. All checks must be completed.

1. Check for intoxication with alcohol/illicit substances and/or acute infection Y
2. Non drug approaches considered Y
3. Medication in last 24 hours checked Y
4. Oral medication offered before IM medication. Y
5. Does the time interval between doses follow SHFT rapid tranquillisation guidelines Y N/A
6. If this isn’t the first dose, has the prescribed interval between doses elapsed? Y N/A
7. Repeated RT doses - has junior doctor considered contacting a senior doctor Y N/A

Checklist completed by……………………………………(Trained nurse) Date…/…/…..

Drug(s) administered | Dose(s)
---------------------|------

Date…../…../…… Time………..

Physical health monitoring checklist (Use TRACK and TRIGGER TOOL)
Monitor - Temperature, pulse, blood pressure, oxygen saturation and respiratory rate every 15 minutes for first hour then hourly thereafter until there are no clinical concerns.
If patient is as sleep they should be woken to ensure that they are not unconscious, unless there is a good reason not to. This reason MUST be recorded on Track and Trigger and RiO. As a minimum the respiratory rate and pulse should be recorded.

1. Most recent baseline observations added to Track and Trigger Y
2. Date/times for first hour (every 15 mins) added to Track and Trigger Y
3. Date/times hourly monitoring thereafter added to Track and Trigger Y
4. Fluid chart started (see overleaf) Y

Completed by……………………………………………………..Date…/…/…..

Physical health review at 5 hours

<table>
<thead>
<tr>
<th>Clinical status reviewed</th>
<th>Y</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical health monitoring to continue</td>
<td>Y / N</td>
</tr>
<tr>
<td>Date/times for further monitoring added to Track and Trigger tool</td>
<td>Y N/A</td>
</tr>
<tr>
<td>Completed by……………………………………………………..(trained nurse) Date…/…/…..</td>
<td></td>
</tr>
</tbody>
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Post RT Checklist

1. Incident form completed Y
2. Diary entry for doctor to review need for U and Es blood test at 24 hrs post dose Y
3. Incident added to next MDT template for review/plan Y
4. Incident reviewed with patient within 72 hours and documented on RiO Y/

If no, please state reason……………………………………………………………………..
Completed by……………………………………………………..(trained nurse) Date…/…/…..
<table>
<thead>
<tr>
<th>Date/time</th>
<th>Description of food/fluid</th>
<th>Fluid intake (mls)</th>
<th>Total (mls)</th>
<th>Initials</th>
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