Policy Title:	**Prevention and Management of Behaviour that Communicates Distress in Adults**
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Policy Owner:	Paul Cowans, Specialist Director
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Outcome:	This policy: • Aims to prevent where possible and ensure that patients displaying distressed/ challenging behaviour are managed appropriately • Describes permissible physical interventions
Cross Reference:	HR05 Absence and Sickness Policy H&S03 RIDDOR H&S35 Risk Assessment H&S45 Prevention and Management of Violence at Work OP04 Incident Management, Reporting and Investigation OP06 Safeguarding Children OP08 Safeguarding Adults OP13 Cardio-Pulmonary Resuscitation (CPR) and Other Medical Emergencies OP16 Advance Decisions (including DNACPR) OP17 Advocacy H20 Nutritional Support, Enteral Feeding and Nasogastric Feeding H22 Medicines Management in Hospitals H35 Clinical Risk Assessment and Management H37.1 The Use of Mechanical Restraint and Soft Cuffs H47 Observation & Engagement H97 Searching Patients & Their Belongings H119 Safer Clothing H-SOP09 Algorithm for Rapid Tranquillisation for Adults H-SOP17 Rapid Tranquillisation

EQUALITY AND DIVERSITY STATEMENT

Priory is committed to the fair treatment of all in line with the Equality Act 2010. An equality impact assessment has been completed on this policy to ensure that it can be implemented consistently regardless of any protected characteristics (age, disability, gender identity and expression, marriage or civil partnership, pregnancy or maternity, race, religion or beliefs, sex, sexual orientation), and all will be treated with dignity and respect.

In order to ensure that this policy is relevant and up to date, comments and suggestions for additions or amendments are sought from users of this document. To contribute towards the process of review, email LegalandComplianceHelpdesk@priorygroup.com

PREVENTION & MANAGEMENT BEHAVIOUR THAT COMMUNICATES DISTRESS IN ADULTS

1 SCOPE

1.1 This policy applies to all sites and services across England, Scotland and Wales. Where there are differences in legislation between nations, this will be clearly highlighted.

1.2 This policy is intended for use in Priory Healthcare sites where adults with mental health difficulties are accommodated in a hospital setting.

2 POLICY STATEMENT

2.1 The Hospital will create an environment where colleagues are able to provide high quality care, which emphasises preservation of the patient's rights and dignity. At the same time, the Hospital should have in place procedures that recognise, assess and manage risk. Overall, the emphasis should be on the provision of care within the least restrictive environment. The purpose of this policy is to ensure the maximum protection and safety of adults (our patients), colleagues and visitors.

2.2 Principles:

(a) Every adult deserves to be understood and supported as an individual.
(b) The best interests of all adults, their safety and welfare should underpin any use of restraint.
(c) The risk of harm to all patients and staff should be minimised.
(d) The needs and circumstances of individual patients, including their age, ethnicity, particular vulnerabilities, learning disability, medical condition or impairments, should be considered and balanced with the needs and circumstances of others. Decisions on whether or not to restrain or intervene with an individual affects others, including staff.
(e) A decision to restrain any patient is only taken to assure their safety, dignity and that of all concerned, including other adults present.
(f) Reducing the need for Restraint and Restrictive Intervention (HM government, 2019).

3 INTRODUCTION

3.1 There is occasionally a need for those who care for mentally disordered adults to exercise some degree of physical intervention. This should only be in circumstances where there is a real possibility of harm to the person or to colleagues, the public or others if no action is undertaken as described in Positive & Proactive Care: reducing the need for restrictive interventions (DH 2014). This policy is underpinned by an important principle, i.e. that distressed or challenging behaviour may be prevented using effective preventative and de-escalation interventions.

3.2 It is the right of every adult to be protected from harm. Harm can be minimised within an inpatient context by ensuring that patients receive a high standard of care and treatment. Patients should be individually encouraged to develop coping skills and non-violent means of conflict resolution. Risks should be managed safely, effectively and in a way that protects the safety, dignity and rights of the patient. As such, all measures possible should be taken to protect patients from any form of physical intervention which is unnecessary, inappropriate, excessive or unlawful. The purpose of this policy is to ensure the maximum protection and safety of patients, colleagues and visitors.

3.3 It is essential to recognise that there are a wide range of effective interventions for distressed or challenging behaviour. At one end of the spectrum, there are primary interventions that can be described as preventative or de-escalating (proactive). At the other end of the spectrum, there are reactive interventions that involve the provision of physical restraint. However, it is essential that physical restraint is a last resort. In keeping with Human Rights law, all

interventions must be necessary and proportionate to the risk being posed and be seen as reasonable in the circumstances. Physical intervention is only ever used as a last resort. It is not to be used until all other approaches have failed and/or violence is imminent.

3.4 Priory recognises that it has a duty of care, not only to patients but also to all colleagues who work in Priory Healthcare units.

4 SAFEGUARDING ADULTS

4.1 Priory policies, on the use of physical interventions must be followed and colleagues trained appropriately. 'Guidance in Positive and Proactive Care: Reducing the need for restrictive interventions (DH 2014)' should be followed.

4.2 Unlawful use of force (force that is neither necessary nor proportionate) is considered physical abuse. Whilst the law recognises that the test for necessity is based on the individual instinctive and honestly held believe in the moment, all colleagues have a responsibility to report incidents and practice that they have concerns about so they can be appropriately explored.

4.3 Incident data on physical interventions is monitored at site level and centrally to identify trends and themes.

4.4 The use of restraint should only ever be a last resort. Where restraint has been used, a full record of the incident must be made, carers/parents must be made aware and if serious the appropriate authorities informed (identified in the services Local Safeguarding Procedures). In exceptional cases the appropriate regulatory body should also be advised (CQC, RQIA, CI, HIS, CIW, HIW) by the site/service manager, in consultation with the Managing Director. Incidents involving physical interventions must be captured on Datix, good safeguarding governance requires such incidents to be considered through a safeguarding lens to identify the appropriate resulting actions.

4.5 Concerns about the potential or alleged inappropriate or unlawful use of physical interventions by colleagues must be referred to the Local Authority Designated Officer (LADO) or 'on duty Social Worker' (Wales and Scotland) for advice about whether a subsequent investigation is required. The advice from the LADO/on Duty Social Worker should take precedence over the opinions of RRIT Leads about whether an incident requires further investigation, the opinions of RRIT Leads are normally then captured in any subsequent LADO process/investigation.

5 NICE GUIDANCE

5.1 The National Institute for Health and Clinical Excellence (NICE) issued updated guidance [NG10] on Short Term Managing of Violence and Aggression in Mental Health, Health and Community Settings (May 2015): This guidance provides a comprehensive account of the prevention and management of violence in these settings.

5.2 Positive & Proactive Care: reducing the need for restrictive interventions (DH 2014), identifies that:

(a) All forms of restrictive practice should be reduced over two years.
(b) Restrictive practices should only be used as a last resort in emergency situations.
(c) There is an objective end to prone (face-down) restraint.
(d) Board members should be given frequent briefings on restrictive practice.
(e) An Executive Director is identified to lead on recovery approaches and reducing restrictive practices; and
(f) Providers should produce an annual report on the use of restrictive interventions.

5.3 The Healthcare Division Reducing Restrictive Practice Steering Group (see section 8.4) is responsible for ensuring that legislation, policy and guidance is incorporated into day-to-day working practice.

6 DEFINITIONS OF VIOLENCE AND AGGRESSION

6.1 The NICE Guidelines (2015) state that violence and aggression refer to 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.

7 CAUSES

7.1 It is important to emphasise that distressed/challenging behaviour may have a range of causes, including the mental disorder from which the person suffers. It is also important to emphasise that distressed/challenging behaviour may be caused by oppressive environments in which care takes place and the use of blanket restrictions such as locked doors, lack of access to outdoor space or refreshments, boredom etc. The behaviours of colleagues and other patients can also have a negative impact on how people behave.

7.2 The Safewards model ((Bowers, L 2013) *Safewards: a new model of conflict and containment on psychiatric wards London: Institute of Psychiatry)* takes this a step further and looks at seven domains or originating factors which can impact on people's behaviour if flashpoints arise and how colleagues can intervene to decrease the likelihood of conflict:

Domain/originating factors	Flashpoints	Staff modifiers
Team or Internal Structure: Rules, routines, ideology, custom and practice, etc.	Denial of request; staff demand; limit setting; bad news; ignoring etc.	Carefully and compassionately managing times when colleagues need to ask patients to do something or stop doing something. Teamwork and consistency etc.
Physical environment Door locked, decor, quality of furniture and equipment etc.	Broken furniture and equipment; lack of access to fresh air; lack of quiet areas	Paying attention to repair and decor needs; knowing where patients are and making active choices about allowing privacy or supervising.
Outside hospital Visitors; Relatives & family tensions; Financial concerns etc.	Bad news; home crisis; loss of relationship or accommodation; argument etc.	Colleagues being familiar with stressors outside of hospital; carer/relative involvement; active patient support etc.
The patient community Contagion and discord amongst patients.	Assembly/crowding/ activity; queuing/waiting/noise; colleague/patient turnover/change; bullying/stealing/property damage	Explanation/information; role modelling; education; removal of means; presence etc.
Patient characteristics Symptoms & demography; Paranoia; PD traits; irritability/disinhibition; Abused; Alcohol/drugs; Delusions etc.	Perceived (or real loss) of liberty; acuity/severity etc.	Nursing support and intervention; psycho-educational interventions; pharmacology

Regulatory Framework Legal framework; Appeals; National policy; Hospital policy	Compulsory detention; appeal refusal; enforced treatment etc.	Due process; justice; respect for rights; information giving; support to appeal or complain etc.

8 PREDICTION

8.1 The NICE guidance details a number of variables, which will assist colleagues in predicting distressed and challenging behaviour and also identify individuals who may be prone to the same. These variables may be described under several headings:

(a) Risk factors.
   i. From the patient's personal history.
   ii. Clinical variables.
   iii. Situational variables.

(b) Antecedent behaviours and warning signs.

9 RISK ASSESSMENT

9.1 Frequent and sufficiently detailed risk assessment must be completed in order to manage distressed and challenging behaviour. The process of assessing risk comprises a number of elements, including direct assessment by medical and nursing colleagues – both separately and together, collection of background information and accessing and utilising other sources of information. Risk assessment must be seen as an ongoing process and there should be regular reviews. Risk assessments must lead to a risk management plan, which will be clearly identified in the patient's Health Record. Priory Group also recognises that there is a need to continually assess risks in the environment, as environmental factors often link with patient variables in producing distressed/challenging behaviour. Refer to H35 Clinical Risk Assessment and Management and H&S35 Risk Assessment.

9.2 The risk assessment form (**H&S Form: 33** – Potential Violence Risk Assessment) must be completed by the multidisciplinary team in advance of the opening of a new service and in the event of a very serious incident of violence. The existing assessment should be reviewed on an annual basis by the multidisciplinary team. An example of the risk assessment can be found at: http://prioryintranet/home/default.aspx?oid=645.

9.3 As part of the risk assessment process the multidisciplinary team should take into account all aspects of patient and colleague safety which includes:

(a) The availability and type of alarms.
(b) The physical environment and any required equipment for example bite protective clothing, arm guards and breast plates, Safety Pods.
(c) Staffing levels and the minimum numbers of colleagues with specific training that should be on a shift where physical intervention may be used.

This in turn should be developed into a robust care plan, usually within Keeping Safe.

10 PREVENTION AND REDUCTION

10.1 International literature on seclusion and restraint reduction has identified that recovery-focused care and treatment is essential for achieving a reduction in the use of restrictive interventions carried out against a person's wishes. Recovery means working in partnership with people to improve their clinical outcomes; promoting human rights based approaches; enhancing personal independence and promoting and honouring choices.

10.2 Most distressed/challenging behaviour can be prevented by the use of de-escalation techniques and skilful observation of the patient, which should emphasise the need to engage therapeutically. Refer to H47 Observation and Engagement and to the NICE Guidance which includes recommendations about using observation after positive engagement with the patient has failed.

10.3 A range of whole service approaches can promote therapeutic engagement, avoidance of conflict situations and the safe support of people at times of behavioural crisis such as those shown at 7.2.

10.4 Where a patient is known to present with behaviour that colleagues may find challenging, individualised support plans should be implemented. Following the positive behaviour support approach, care plans should be person-centred, values-based and informed by skilled assessment of the probable reasons why a person presents behaviours of concern (functional analysis). The plan should include any advance statements the patient has made regarding their care and treatment in times of distress and reference where this information is kept.

10.5 The Healthcare Division has in place a divisional Reducing Restrictive Practice Steering Group which meets quarterly and which is attended by divisional and corporate representatives together with training provider representatives. The function of the meeting is to:

(a) Receive and analyse data in respect of physical interventions and restrictive practice.
(b) Agree to the format of any audits to be undertaken and to receive the results of those audits.
(c) Identify ways in which restrictive interventions, including the use of restraint, can be reduced.
(d) Identify restrictive practice reduction targets.
(e) Identify systems in respect of managing and eliminating the use of prone restraint.
(f) Monitoring the specific actions taken by sites.
(g) Consider the nature and content of the staff training programmes.
(h) Facilitate opportunities for cross-divisional learning.
(i) Disseminate relevant guidance and good practice.

11 THE MANAGEMENT OF DISTRESSED/CHALLENGING BEHAVIOUR

11.1 Sometimes, despite all possible use of techniques aimed at prevention, distressed/challenging behaviour may occur. The paramount need in such situations is to keep both the patient and colleagues as safe as possible. As noted above, the interventions used to manage distressed/challenging behaviour should be both necessary and proportionate in the circumstances to be seen as reasonable.

12 PHYSICAL INTERVENTIONS AND THE USE OF PRN MEDICATION

12.1 As the NICE Guidance emphasises:

(a) There are real dangers with physical intervention in any position.
(b) Physical intervention should be avoided if at all possible.
(c) The use of PRN medication should be prescribed and tailored to the individual needs of services users, and used as part of the strategy to de-escalate or prevent situations which potentially lead to violence and aggression. For example, oral lorazepam or promethazine could be considered.
(d) Physical intervention should not be used for prolonged periods and should be brought to an end as soon as possible.
(e) Remember that the force applied must be both necessary and proportionate in the circumstances of the specific situation and applied for the shortest possible time.
(f) Colleagues may continue to employ de-escalation techniques if appropriate, but should be aware that this could be a trigger.
(g) One colleague should assume the lead throughout the process of physical intervention to ensure a coordinated response.
    i. To protect and support the patient's head and neck - NG Feeds Only.
    ii. To ensure the patients airway and breathing are not compromised.
    iii. To ensure the patients vital signs are monitored.
    iv. To lead the team through the process.

(h) The authorisation of the relevant Hospital Director/ Medical Director should be sought before mechanical restraints are used. Colleagues should have received an appropriate level of training in the event that such restraints are used.
(i) The patient's overall physical and psychological wellbeing must be monitored throughout.
(j) Under no circumstances should direct pressure be applied to the neck, thorax, abdomen, back or pelvic area.
(k) To avoid prolonged physical intervention, consider using oral PRN medication or rapid tranquillisation as an alternative.
(l) The application of deliberate pain has no therapeutic value and could only ever be justified for the immediate escape or rescue of colleagues, other patients or others from a life threatening situation.
(m) Techniques intended to inflict pain as a means of control must never be used.
(n) Prone restraint and supine must not be used as a planned intervention. If a restraint results in a prone or supine position, colleagues should disengage as soon as possible and re-engage if necessary. Staff training will reinforce this approach and show alternative techniques to enable colleagues to administer intra-muscular medication. Any prone or supine restraint needs to be reported as part of the incident reporting process and should instigate a Team Incident Review. All incidences of prone restraint use requires a 24 hr report to be submitted. The number of reported prone and supine restraints are monitored centrally and followed up weekly.

12.2 For Eating Disorder Services, in some circumstances, there may be a need for an individual to receive nutrition/hydration via nasogastric feeding tube, NG tube. In exceptional circumstances this may require the specialist care team to restrain an individual in order to ensure the patient receives the nutrition/hydration they require as part of their planned ongoing care. **Appendix 4** contains a protocol which aims to provide guidance for specialist care teams and Priory RRIT trainers when a multi-disciplinary decision is made to use approved restraint techniques in order to provide nutrition/hydration, to a patient, via a NG tube.

13 MECHANICAL RESTRAINT

13.1 Mechanical restraint is a form of restrictive intervention which involves the use of a device to prevent, restrict or subdue the movement of a person's body, or part of the body, for the primary purpose of behavioural control.

13.2 Mechanical restraint should only be used exceptionally, where other forms of restriction cannot be safely employed. It should be used in line with the principle of least restrictive option and should not be an unplanned response to an emergency situation. Mechanical restraint should never be used instead of adequate staffing.

13.3 The use of mechanical restraint should be approved following multi-disciplinary consultation (which should include an IMHA where the patient has one). A quorum of the MDT is required to approve the use of mechanical restraint (Consultant/RN & one other discipline). Provision for the use of mechanical restraint should be recorded as a tertiary strategy in the positive behaviour support plan and/or Keeping Safe care plan. This plan should detail the circumstances which might warrant mechanical restraint, the type of device to be applied, how continued attempts should be made to de-escalate the situation and any special measures that are required to reduce the likelihood of physical or emotional trauma resulting.

13.4 Where the agreed provisions for the use of mechanical restraint in positive behaviour support plans (or equivalent) allow a nurse or other professional to authorise the actual use of mechanical restraint, then that professional should notify, without delay, the responsible clinician or duty doctor (or equivalent).

13.5 Staff applying mechanical restraint devices should have appropriate training in their application and use.

13.6 An individual who is mechanically restrained should remain under continuous observation throughout. It may be necessary for the individual to remain at arm's length.

13.7 The individual should be reviewed by a nurse every 15 minutes for the duration of the period of mechanical restraint.

13.8 The individual should have a medical review by a doctor at least one hour after the beginning of mechanical restraint. Subsequently there should be ongoing medical reviews at least every four hours by a registered medical practitioner. Reviews should be undertaken more frequently if requested by nursing staff. Reviews should ensure that the individual is as comfortable as possible and should include a full evaluation of the patient's physical and mental health condition.

13.9 Procedures should be in place to enable nursing staff to summon a doctor to conduct a medical review ahead of the next scheduled review if they have concerns about the patient's condition.

13.10 The patient's clinical record should provide details of the rationale for the decision to mechanically restrain them, the medical and psychiatric assessment, the patient's condition at the beginning of mechanical restraint, the response to mechanical restraint and the outcomes of the medical reviews.

13.11 There may be circumstances where mechanical restraint devices need to be used on a long-term basis, such as to limit self-injurious frequent and intense behaviour (in which case the requirement for post-incident review does not apply). This will be rare and encountered with small numbers of patients who have severe cognitive impairments, where devices such as arm splints or cushioned helmets may be required to safeguard an individual from the hazardous consequences of their behaviour. In such cases, tertiary strategies within positive behaviour support plans (or equivalent) should aim to provide brief recurrent periods when restraints can be removed. The positive behaviour support plan (or equivalent) may also allow for less frequent medical and nursing reviews provided that the whole MDT, the patient's family, carers and advocates are in agreement.

13.12 Devices used that constitute mechanical restraint:

(a) Emergency Restraint Belt - Will require a written case by the Consultant/MDT (following provisions of 11.3 above have been met, supported by the relevant Clinical Director and to be signed off by the Executive Medical Director.

(b) Mechanical Handcuffs/Softcuffs – See Healthcare Policy H37.1 for guidance concerning applicable services and authorisation required.

14 USE OF SUPPORTIVE INTERVENTIONS

14.1 Small bean bags as a supportive measure may be used by a nurse involved in a physical intervention to ensure the safety and comfort of the patient and staff.

15 SAFER CLOTHING

15.1 The use of safer clothing should be a last resort intervention utilised proportionately in the management of high risk self-harm/potential suicide, particularly where the use of ligatures from removed or torn clothing is severe and or of immediate concern. This intervention should be the least restrictive option available with a view to discontinuing use at the safest and earliest opportunity.

16 POST-INCIDENT PROCEDURES

16.1 An immediate post-incident de-brief should be carried out, including a doctor and a nurse, to identify and address any physical harm to patients or colleagues, ongoing risks and the emotional impact on patients and colleagues, including witnesses. A full and detailed account

of the incident must be recorded in all the patients' health records. An incident report must be completed for all incidents of physical intervention.

16.2 The detail of physical intervention used should be recorded and kept with the incident report and also discussed by the Clinical Governance Committee (or relevant delegated committee such as the Learning Outcomes Group) as part of reviewing incidents monthly (**H Form: 91** Record of De-escalation and Physical Intervention is available for this purpose).

16.3 A doctor or consultant must assess the patient as soon as possible following any incident of physical intervention, and the results of the assessment must be documented in the patient's health record.

16.4 A suitably qualified and experienced colleague will facilitate a de-briefing session with the patient within 24 hours of the incident, being mindful that it is usually not advisable to carry out a debrief until at least 90 minutes following the incident to ensure that levels of arousal have decreased. Support to other patients on the ward and any visitors who witnessed the incident should be given as soon as possible following the incident. The patient will be offered the opportunity to record their experience in writing, to be kept as part of the Health Record (**OP Form: 46D** is available for this purpose). Post incident reviews should include ensuring the patients' psychological and physical wellbeing and give an opportunity to understand what actions colleagues or the patient may have taken to prevent the incident. This should then inform the care plan.

16.5 Where necessary a proportionate investigation will be commissioned by the Hospital Director and relevant others. The findings and lessons learnt from the investigation will be shared with colleagues across the Healthcare Division in a format agreed by the management team.

16.6 Victims of aggression or violence may require additional support and counselling outside of the internal de-brief arrangements. This is a process which should be guided as far as possible to the individual needs of those involved.

16.7 A suitably qualified and experienced colleague should facilitate a de-briefing discussion as soon as possible, for all colleagues involved in the incident to reflect, offer support and guidance to each other and discuss alternative interventions that may have been used. Colleagues should also be encouraged to raise issues as part of Clinical Supervision as a means of obtaining further support.

16.8 The following processes should be applied in the event that colleagues sustain an injury necessitating time off work:
(a) RIDDOR reporting processes should be followed in line with the RIDDOR Policy (H&S03).
(b) Support should be provided to the colleague including maintaining contact with them while they are absent and conducting a return to work interview in line with Attendance Management Policy (HR05).

17 STAFF TRAINING

17.1 All colleagues who work in areas where distressed/challenging behaviour is foreseeable should receive an appropriate level of training. The level of training will be determined by local assessment procedures of colleague and patient risk. New substantively employed colleagues should receive training as promptly as possible and ideally at the point of induction. A check should be made that agency colleagues have received a similar level and type of training to that which is in place at Priory Group. Two types of training are available:
(a) **Breakaway skills training.** This training focuses on providing colleagues with the skills and knowledge necessary to break away/escape from a situation where they are at risk of violence from distressed/challenging behaviour. All colleagues who have patient contact should receive this level of training, as a minimum.

(b) **Reducing Restrictive Intervention Training.** This training will emphasise a wide variety of skills, ranging from skills in predicting distressed/challenging behaviour, de-escalation techniques, positive behavioural support, conflict resolution, through to physical intervention skills, such as those used in management of violence and aggression. The length and content of practical training delivered is determined by a risk assessment based on the acuity of patients at individual sites.
(c) Due to the potential risks involved in any physical interventions, colleagues will be trained in either ILS/BLS/First Aid depending on the individual's role.
(d) Colleagues working in specialist areas with vulnerable patients (physically frail, ASD, LD, BIS) will receive additional training in line with service best practice.

17.2 For guidance on course availability of training see Priory Group Academy, or contact the Priory Group Learning & Development department.

17.3 **Refresher Training** - Priory Group recognises that there is a need for regular updating of knowledge and skills. Employees will attend annual refresher courses. Colleagues should contact the Priory Group Learning & Development department for guidance on the availability of training.

17.4 The Hospital Director and Ward Manager should review those instances where colleagues have failed to complete the training. They should take into account the safety of the staff member, their colleagues and the patients and where necessary take advice from the Human Resources Department as to the next steps to be taken.

18 SEARCHING

18.1 Risk assessment of individual patients may provide cause for carrying out searches. Refer to H97 Searching Patients and Visitors.

19 RAPID TRANQUILLISATION

19.1 NICE defines rapid tranquillisation as the 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. It should not be regarded as a primary treatment technique.

19.2 PRN medication should not be routinely or automatically prescribed. The MDT should develop an individual treatment plan for distressed behaviour, and this should be reviewed regularly.

19.3 Rapid tranquillisation should only be employed:
(a) Once de-escalation and other strategies have failed.
(b) On the basis of the safety and clinical need of the patient. Where possible, advance directives should be taken into account. Rapid tranquillisation should only be undertaken when it is deemed to be a necessary and proportionate response to the risk posed by/to the patient.
(c) In an emergency situation to sedate a patient, rather than as a treatment for their underlying mental health condition. Rapid tranquillisation should use the minimum dose of medication that is required to improve the mental state of a patient to a point where it is possible to manage them without undue risk or distress to themselves or those around them.
(d) Having taken into account the age, size, weight and physical status of the patient.

19.4 In line with the MHA Codes of Practice for England and Wales the following guidance should be followed:
(a) Where a prescription indicates a choice of administration routes for rapid tranquillisation e.g. oral or intramuscular injection), the person prescribing the medication should list

factors which should be considered in deciding which route to use under any reasonably foreseeable circumstances.

(b) Where rapid tranquillisation in the form of an intramuscular injection is needed, it may be helpful for the MDT to consider the most appropriate injection site having taken full account of the need to avoid prone and supine restraint (i.e. where the person is forcibly laid on their front).

(c) Physical restraint may, on occasion, need to be used to administer rapid tranquillisation by intramuscular injection to an unwilling patient, where the patient may lawfully be treated without consent. It must not be used unless there is such legal authority, whether under the Act (see provisions for treatment in chapter 24 of English MHA CoP or Chapter 24 of the Welsh MHA CoP), the MCA or otherwise. Rapid tranquillisation must not be used to treat an informal patient who has the capacity to refuse treatment and who has done so.

(d) The use of restraint to administer treatment in non-emergency circumstances should be avoided wherever possible, but may sometimes be necessary, especially if an emergency situation would be likely to occur if the treatment were not administered. The decision to use restraint should be discussed first with the clinical team and should be properly documented and justified in the patient's notes.

19.5 **Use of Physical Intervention -** Any use of physical intervention to administer IM injections must be planned by the MDT. This includes prescribing the administration site for the IM injection which is the least restrictive option (i.e. Deltoid, Thigh, Gluteal). Staff must use the least restrictive option possible. The hierarchy of physical interventions to administer IM injections is set out below:

1. Wherever possible persuade and gain the patients cooperation and consent
2. RRIT holds in a standing position
3. RRIT hold in a kneeling position
4. Use of Safety Pod
5. RRIT holds in the Supported Recovery Position.

19.5.1 Any physical intervention used should:

(a) Be reasonable, justifiable and proportionate to the risk posed by the patient

(b) Apply the minimum, justifiable level of restriction or force necessary to prevent harm to the patient or others

(c) Be used for only as long as is absolutely necessary

(d) Be carried out in a way that demonstrates respect for the patient's gender, cultural sensitivities and preferences relating to any history of trauma as identified in individuals care plans.

19.6 Following administration of medication for rapid tranquillisation, observation and monitoring of the patient must be carried out. It is recommended by NICE that this is done every hour until there are no further concerns about the physical health of the patient. This monitoring frequency should be increased to at least every 15 minutes if the patient:

(a) Has had a dose above the maximum BNF limit.

(b) Appears to be asleep or sedated.

(c) Has taken illicit drugs or alcohol.

(d) Has a pre-existing physical health problem.

(e) Has experienced any harm as a result of any restrictive intervention.

19.7 NICE recommends that monitoring should include pulse, temperature, respiration rate, alertness/sedation, blood pressure, and level of hydration.

19.8 Oxygen saturation (pulse oximeter) and EPSE's may also be monitored as well as any other observations deemed appropriate.

19.9 NOTE: Patients who receive oral PRN doses should also be monitored for their effect and also any adverse effects as this is standard clinical practice. The rationale and circumstances in

which PRN medication may be used should be clear, and should be included in the care plan for the patient.

19.10 Monitoring charts are available, see **OP Form: 76** National Early Warning Score (NEWS2) and **OP Form: 76B** Modified Early Warning Score – Adopted for Eating Disorder (Marsi Mews). See Appendix 1 on potential problem scenarios and **HSOP17** Rapid Tranquilisation.

19.11 **Training and Equipment** - All medical and registered nursing colleagues using rapid tranquillisation and monitoring of patients post-rapid tranquilisation should be appropriately trained in intermediate life support and be familiar with **OP13** Resuscitation. For guidance on training available, contact People Development.

19.12 Where rapid tranquillisation is used, it is essential that the appropriate equipment is also available. NICE Guidance specifies that "Crash bag should be available within three minutes in healthcare settings where this intervention is used". This equipment should include:

(a) An automatic external defibrillator, a bag valve mask, oxygen, cannulas, fluids, suction and first line resuscitation medications.
(b) Be maintained and checked weekly.

20 DOCTOR'S ATTENDANCE

20.1 NICE Guidance recommends that, a doctor should be immediately available to attend an emergency, if restrictive interventions including rapid tranquillisation might be used. Colleagues should inform the appropriate medical colleagues when restrictive interventions are used and provide reports updating the patient's condition to the responsible doctor. If a doctor is unable to attend an emergency situation, then colleagues must manage the patient until the "999" emergency services attend.

21 LEGAL RESPONSIBILITIES

21.1 All colleagues need to be aware of the legal frameworks that authorise the use of interventions in the prevention and management of distressed/challenging behaviour or violence. The central guidance comes from the Mental Health Act Code of Practice (Chapter 26. The Mental Health Code of Practice and is available via:
https://www.gov.uk/government/publications/code-of-practice-mental-health-act-1983

For Welsh sites refer to the Welsh MHA Code of Practice:

https://gov.wales/topics/health/nhswales/mental-health-services/law/code-of-practice/?lang=en

21.1.1 Site management should ensure colleagues are knowledgeable about the relevant Code of Practice. Guidance around emergency treatment in children and young people in the Children Act (1989) should also be borne in mind. The Code includes oral PRN medication as well as parenteral drugs in its definition of rapid tranquillisation. This is in contrast to NICE Guidance.

21.2 If for any reason there is any departure from the Code of Practice, this should be clearly recorded in the health record and justified as being in the patient's best interests.

22 PATIENT PERSPECTIVES

22.1 Priory Healthcare are committed to providing patients with as much information as possible about the colleagues who care for them, their treatment programme and their rights with regard to consent to treatment, complaints procedures and access to independent help and advocacy (See OP17 Advocacy).

22.2 In the case of patients who are identified at risk of behaviours that communicate distress, they should be given the opportunity to have their needs and wishes recorded in the form of an advanced statement and as part of an individualised behavioural support plan (see OP16 Advance Decisions). This should fit within the context of their overall care and should clearly state what intervention(s) they would and would not wish to receive. The advance decision document should be subject to periodic review.

23 CHOICE OF MEDICATION

23.1 A list of recommended medication can be found at **H-SOP09** Algorithm for Rapid Tranquillisation for Adults. This is based on the NICE guidance and The Maudsley Prescribing Guidelines.

23.2 Recent advice from The Maudsley Prescribing Guidelines (11th edition) does not include Haloperidol as first line treatment in Rapid Tranquillisation. This is because of the risk of prolonged QTc interval, and the manufacturer recommending ECG monitoring during dose increases. However, haloperidol injection has been recommended by NICE as the antipsychotic drug of choice for rapid tranquillisation of adults. Prescribers should make a choice of which drugs to use for rapid tranquillisation based on their clinical assessment of the individual needs of their patient.

23.3 There have been long-term supply problems with Lorazepam injection. Midazolam (Buccal) or Midazolam injection intra-muscular injection has been used as an alternative to Lorazepam.

23.4 The antihistamine Promethazine 25-50mg oral or by intra-muscular injection is an alternative to Benzodiazepines.

24 REFERENCES

24.1 **Legislation**
Mental Health Act 1983
Mental Health (Scotland) Act 1984

24.2 Bowers, L (2013) Safewards: A new model of conflict and containment on psychiatric wards (London: Institute of Psychiatry)
DH (2014) Positive & Proactive Care: reducing the need for restrictive interventions
DH (2015) Mental Health Act 1983: Code of Practice
MIND (2013) Mental Health Crisis Care: Physical restraint in crisis
NICE (2015) Violence and Aggression: Short-term management in mental health, health and community settings (NG10). NICE. London. www.nice.org.uk
The Maudsley Prescribing Guidelines.
Welsh Assembly Government (2016) Mental Health Act 1983 Code of Practice for Wales Review

25 ASSOCIATED FORMS

25.1
H Form: 91 Record of De-escalation and Physical Intervention
H Form: 91A Physical Intervention Competency Checklist for Agency Staff
H Form: 131 Zuclopenthixol Acetate (Clopixol Acuphase): Post-Administration Physical Monitoring
OP Form: 46D Patients Account following Physical Intervention
OP Form: 76 National Early Warning Score (NEWS2)
OP Form: 76B Modified Early Warning Score- Adopted for Eating Disorder (Marsi Mews)

26 EQUALITY IMPACT ASSESSMENT

26.1 **How is the policy likely to affect the promotion of equality and the elimination of discrimination in each of the groups?**

Protected Characteristic (Equality Act 20210)	**Impact** Positive/ Negative/ None	**Reason/ Evidence of Impact**	**Actions Taken** (if impact assessed as Negative)
Age	**P**	In line with current legislation and Human Rights Act	
Disability	**P**	In line with current legislation and Human Rights Act	
Gender re-assignment	**P**	In line with current legislation and Human Rights Act	
Marriage or civil partnership	**N**		
Pregnancy or maternity	**P**	In line with current legislation and Human Rights Act	
Race	**P**	In line with current legislation and Human Rights Act	
Religion or beliefs	**P**	In line with current legislation and Human Rights Act	
Sex	**P**	In line with current legislation and Human Rights Act	
Sexual orientation	**P**	In line with current legislation and Human Rights Act	
Other, please state:			
EIA completed by:			
Name: **Role/Job Title:**	Paul Cowans, Specialist Director		
Date completed:	09.06.2023		

27 APPENDICES

27.1
Appendix 1 Rapid Tranquilisation – Problem Scenarios
Appendix 2 Important Notes on Zuclopenthixol Acetate (Acuphase)
Appendix 3 Medication Time of Onset
Appendix 4 Protocol for the Restraint of Patients Diagnosed with an Eating Disorder Who Require Nutrition via a Nasogastric Tube
Appendix 5 The Use of Physical Interventions That Are Unrecognised or Unapproved (In The Context Of The Priory Group RRI Syllabus) in Regards to Patients Requiring NG Feeding

Appendix 1

RAPID TRANQUILLISATION – PROBLEM SCENARIO

1 Introduction

1.1 The definition of rapid tranquilisation as outlined by the NICE guidelines (2015b) states it is the use of medication by the parenteral route (usually intramuscularly or, exceptionally, intravenously) if oral medication is not possible or appropriate and urgent sedation with medication is needed. It should not be regarded as a primary treatment technique.
Following the joint BAP and NAPICU guidelines (for the clinical management of acute disturbance: de-escalation and rapid tranquilisation), there is more emphasis on the non-medical interventions in the process of managing an acute patient. They state de-escalation as "an explicitly collaborative process involving a range of verbal and non-verbal interventions that aim to reduce agitation and distress, with the purpose of averting aggression or violence".

1.2 Their evidence based consensus led them to create an algorithm for managing acute patients that incorporates "pre-RT" (verbal interventions and oral medication) as well as rapid tranquilisation.

1.3 *This policy aims to incorporate information and guidelines from NICE guidelines, Maudsley prescribing guidelines and joint BAP/NAPICU guidelines.*

2 Duties/Responsibilities

2.1 **Doctor:** to ensure patients' prescription is individualised, not routine and include the details/dose range/frequency of the medication prescribed. The minimum time between doses and the maximum dose to be administered in a specified period must be stated. They must consider medication already prescribed and patients should be monitored (for effects, side effects and necessity of RT) and reviewed weekly in MDT.
NICE Guidance recommends that, a doctor should be immediately available to attend an emergency, if restrictive interventions including rapid tranquillisation might be used.

2.2 **Nurse:** to ensure the RT is indicated, having exhausted other strategies to calm the patient. They must ensure the prescription is followed and that the patient has the appropriate physical observations completed. They must ensure written records including care plans are maintained.

2.3 **Pharmacist:** to ensure prescriptions are checked for potential adverse interactions and that doses are with BNF limits.

2.4 Colleagues should inform the appropriate medical colleagues when restrictive interventions are used and provide reports updating the patient's condition to the responsible doctor. If a doctor is unable to attend an emergency situation, then colleagues must manage the patient until the "999" emergency services attend.

3 Principles as set out in the joint BAP and NAPICU guidelines 2018

1. Multidisciplinary approach: as the aetiology of acute disturbance is complex and heterogeneous, its management warrants a multidisciplinary approach including psychopharmacological, psychological, environmental and social interventions.
2. Effective interventions: interventions should have an evidence base confirming they increase positive outcomes and/or reduce negative outcomes (harm) of acute disturbance in the immediate to short term (from minutes to hours). Strategies should be used to minimise the risk of adverse effects of these interventions such as seeking to prescribe the minimum effective dose and checking for increased risk of side effects.

3. Proportionality of intervention: an intervention has an associated imposed level of restriction on the patient and this restriction should be proportionate (i.e. not excessive) to the acute severity of the clinical risk posed by the acute disturbance. Further, the least restrictive options available should always be considered in the first instance and so RT should generally be used as a last resort only if non-pharmacological and oral pharmacological options have been exhausted.
4. Treatment individualisation/choice: steps should be taken, wherever possible, to ensure that interventions are selected with patient-specific factors (clinical, risk and choice related) as part of the decision-making process. This will include clinical consideration of previous response to specific medication as well as adverse responses and allergies.
5. Treatment optimisation of underlying disorder: interventions should be set in a context of the overarching goal of optimising the treatment of the underlying disorder as this may be partially or wholly causing the acute disturbance.
6. Continuous monitoring/review of: (i) mental/physical health; (ii) risk to self/others; (iii) treatment effectiveness/harm; (iv) patient engagement level. The clinical scenario and associated risks to self/others change with time. Thus, selection of interventions to reduce risk in the immediate or short term needs to reflect this so that the right intervention is used for the right scenario at the right time. Physical health is also important as both acute disturbance and the interventions are associated with physical health consequences. Further, it should be noted that when prescribing in combination some side effects are additive. As a patient-centred approach is at risk of being compromised, the assessment of the patient's level of engagement in seeking positive solutions to reduce harm and improve clinical outcomes should be kept under review.
7. Consideration of modifiers: certain clinical sub-populations merit specific consideration as they may require a modified approach to pre-RT and RT. These include: pregnancy, drugs and alcohol, medically frailty or physically compromised (e.g. dehydrated), psychotropic naivety, patients already prescribed regular psychotropics, learning disability and (extremes of) age.

4 Rapid tranquilisation should only be employed if:

4.1 (a) All other de-escalation techniques have failed
(b) On the basis of the safety and clinical need of the patient. Where possible, advance directives should be taken into account. RT should only should only be undertaken when it is deemed necessary and proportionate to the risk posed by/to the patient.
(c) In an emergency situation to sedate the patient, rather than treatment of the underlying mental health condition. The minimum dose of medication to achieve the required effect is to be used.
(d) Having taken into account the size, weight and physical status of the patient.

5 Post-rapid tranquilisation physical monitoring

5.1 Following administration of medication for rapid tranquillisation, observation and monitoring of the patient must be carried out. It is recommended by NICE that this is done every hour until there are no further concerns about the physical health of the patient. This monitoring frequency should be increased to at least every 15 minutes if the patient:
(a) Has had a dose above the maximum BNF limit.
(b) Appears to be asleep or sedated.
(c) Has taken illicit drugs or alcohol.
(d) Has a pre-existing physical health problem.
(e) Has experienced any harm as a result of any restrictive intervention.

5.2 NICE recommends physical monitoring should include pulse, temperature, respiration rate, alertness/sedation, blood pressure, and level of hydration.

5.3 Monitoring should be determined by a doctor and the nurse in charge. NICE recommends this should include pulse, temperature, respiration rate, alertness/sedation, blood pressure, and level of hydration.

5.4 Oxygen saturation (pulse oximeter) and EPSE's may also be monitored as well as any other observations deemed appropriate.

5.5 NOTE: Patients who receive oral PRN doses should also be monitored for their effect and also any adverse effects as this is standard clinical practice. The rationale and circumstances in which PRN medication may be used should be clear, and should be included in the care plan for the patient.

5.6 Monitoring charts are available, see **OP Form: 76** National Early Warning Score (NEWS2).

6 Training and Equipment

6.1 All medical and registered nursing colleagues using rapid tranquillisation and monitoring of patients' post-rapid tranquilisation should be appropriately trained in intermediate life support and be familiar with OP13 Cardio-Pulmonary Resuscitation (CPR) and Other Medical Emergencies

6.2 Where rapid tranquillisation is used, it is essential that the appropriate equipment is also available. NICE Guidance specifies that "Crash bag should be available within three minutes in healthcare settings where this intervention is used". This equipment should include:

(a) An automatic external defibrillator, a bag valve mask, oxygen, cannulas, fluids, suction and first line resuscitation medications.
(b) Be maintained and checked weekly.

7 Legal responsibilities

7.1 All colleagues need to be aware of the legal frameworks that authorise the use of interventions in the prevention and management of disturbed behaviour or violence. The central guidance comes from the Mental Health Act Code of Practice (Chapter 26. The Mental Health Code of Practice and is available via: https://www.gov.uk/government/publications/code-of-practice-mental-health-act-1983

7.1.1 Site management should ensure colleagues are knowledgeable about the Code of Practice.

7.2 Guidance around emergency treatment in children and young people in the Children Act (1989) should also be borne in mind. The Code includes oral PRN medication as well as parenteral drugs in its definition of rapid tranquillisation. This is in contrast to NICE Guidance.

7.3 If for any reason there is any departure from the Code of Practice, this should be clearly recorded in the health record and justified as being in the patient's best interests.

8 Choice of Medication

8.1 A list of recommended medication is provided with this policy is based on the evidence based joint BAP and NAPICU guidelines 2018:

Pre-RT: Oral, oral-inhaled and buccal:

EFFECTIVE	MAY BE EFFECTIVE	NOT RECOMMENDED
Oral-inhaled loxapine* Not available within Priory	**Oral lorazepam**	**Oral formulations of clonazepam and diazepam are not recommended***
Buccal midazolam Not available within Priory	**Oral promethazine**	**Oral levomepromazine is not recommended***
Oral formulations of aripiprazole, olanzapine and risperidone		
Oral haloperidol*		
Oral quetiapine		

***Oral-inhaled loxapine** is effective although a brief respiratory assessment is required beforehand, as it is contraindicated in patients with asthma or chronic obstructive pulmonary disease, and a short-acting beta-agonist bronchodilator (e.g. salbutamol) should be available. This is currently not used in the Priory Group
Buccal midazolam is effective. This is currently not used in the Priory Group
Oral lorazepam may be effective.
Oral promethazine may be effective.
Oral formulations of aripiprazole, olanzapine and risperidone are effective.
***Oral haloperidol** is effective and a baseline ECG is advised before use due to the risk of QTc prolongation.
Oral quetiapine is effective.
***Oral formulations of clonazepam and diazepam are not recommended** due to lack of evidence for use in RT together with the risk of accumulation with repeated dosing and the resultant risk of cumulative adverse effects.
***Oral levomepromazine is not recommended** due to lack of evidence for use in RT.
Pre-RT pharmacological strategies should be considered before RT.

RT: IM monotherapy:

EFFECTIVE	MAY BE EFFECTIVE	NOT RECOMMENDED
IM lorazepam*	**IM Promethazine**	**IM clonazepam**
IM aripiprazole		**IM diazepam**
IM olanzapine*		**IM midazolam**
		IM haloperidol
		IM levomepromazine

***IM lorazepam** is effective. Parenteral benzodiazepines have safety concerns due the risk of respiratory depression. Thus, wherever they are used, flumazenil must be immediately available (S).
IM promethazine may be effective.
IM aripiprazole is effective.
***IM olanzapine** is effective, but it should only be administered by itself and not concurrently with IM benzodiazepines due to risk of hypotension; thus, there should be an interval of at least 1 hour between the two.
IM clonazepam is not recommended due to a relative lack of supporting evidence for use in RT.
IM diazepam is not recommended due to lack of evidence for use in RT.
IM midazolam is not recommended due to the risk of respiratory depression.
IM haloperidol is not recommended as monotherapy even though it has evidence of effectiveness, and a baseline ECG is advised, as measures need to be in place to offset its adverse effects and especially for the risk of acute dystonia.

IM levomepromazine is not recommended, even though it has some evidence of effectiveness, as there is potential evidence for a risk of cardiovascular adverse effects, especially hypotension.

RT: IM combinations:

EFFECTIVE	NOT RECOMMENDED
*IM promethazine plus IM haloperidol	IM lorazepam plus IM promethazine
*IM lorazepam plus IM haloperidol	

***IM promethazine plus IM haloperidol** is effective and a baseline ECG is advised before haloperidol use due to the risk of QTc prolongation .
***IM lorazepam plus IM haloperidol** is effective and a baseline ECG is advised before haloperidol use due to the risk of QTc prolongation.
Parenteral benzodiazepines have safety concerns due the risk of respiratory depression. Thus, wherever they are used, flumazenil must be immediately available.
IM lorazepam plus IM promethazine is not recommended due to lack of evidence for efficacy for this combination. However, this combination is widely used and can be considered with senior clinicians' advice.

9 Non-response to pre-RT and RT interventions:

9.1 Seeking senior advice, conducting a comprehensive case review and a reviewing the appropriateness of the clinical setting should all be considered.

9.2 **Zuclopenthixol acetate** is not recommended for use as RT as the evidence does not support it, particularly as its onset of action takes several hours. However, after other strategies have failed to achieve a required response, its use may be considered. A baseline ECG is advised before use due to the risk of QTc prolongation. Please see Appendix 2 for further details.

9.3 **ECT** may also be considered when other strategies have failed to achieve a required response, and particularly if the underlying disorder has an evidence base for the use of ECT (e.g. mania) or if there is a history of good response for the individual patient.

Appendix 2

IMPORTANT NOTES ON ZUCLOPENTHIXOL ACETATE (ACUPHASE)

This drug is NOT suitable for use in rapid tranquillisation.

Patients should only receive Acuphase if:
(a) They give informed consent or they are treated under a section of the Mental Health Act (with the exception of Section 5(2) or Section 4).
(b) They are not struggling.
(c) They are not neuroleptic naïve, i.e. they have previously had oral neuroleptics.
(d) Past history of good/timely response
(e) Cited in advanced directives

Zuclopenthixol acetate can be a difficult preparation to use with limited evidence for its value in the management of schizophrenia. The effect of the injection has a significantly delayed onset and relatively long duration of action compared to standard oral treatments.

Zuclopenthixol acetate injection may have a role in the ongoing management of a risk of violence once tranquilisation has been satisfactorily achieved. It is important to consider the pharmacokinetics of other drugs when prescribing Zuclopenthixol acetate injection, including any medication being used for rapid tranquilisation, concomitant oral antipsychotics prescribed or administered and use of any long acting antipsychotic injections. For example, caution is necessary in a service user who has recently received a dose of a depot antipsychotic which has not yet reached peak levels and where the peak of the depot and the peak of the Zuclopenthixol acetate may coincide, the additive effects possibly causing significant toxicity, harm and risk to the individual.

Normally, Zuclopenthixol acetate injection should only be given when it is likely that repeat doses of intramuscular sedatives are unlikely to be necessary.

Zuclopenthixol acetate injection should never be used in:
1. Those who are physically resistant, due to the risk of intravasation and oil embolus during injection. Restraint may be used in order to facilitate administration however this strategy should be carefully risk assessed prior to administration.
2. Those who will accept oral antipsychotics medication
3. Those who are sensitive to extrapyramidal side effects (EPSE)
4. Those with cardiac disease, hepatic or renal impairment
5. In pregnancy

In such instances, follow the prevention and management of disturbed/violent behaviour policy.

Zuclopenthixol acetate injection may be considered as an option when:
1. It is clearly expected that the service user will be remain violent over an extended period of time.
2. A service user has a past history of repeated parenteral administration
3. A service user has a past history of good and timely response to zuclopenthixol acetate

Dosing and pharmacokinetics of Zuclopenthixol acetate injection

- Normally 50 to 150mg.
- May be repeated after a minimum of 24 hours but preferably 48 to 72 hours after the first dose.
- If necessary, further doses may be given at intervals of 48 to 72 hours, up to a maximum of 400mg over a two week period.
- Sedative effects usually begin to be seen two hours after injection and peak between 12 and 36 hours after injection.
- The effects may last for up to 72 hours but complete elimination may take up to seven days. It is therefore important not to given additional treatments that will coincide with high Zuclopenthixol levels.

There is no such thing as a 'course of Acuphase'. One dose may be sufficient to calm the service user and prepare them for other therapeutic interventions. Where repeat doses are given, the service user should be assessed carefully before each administration.

Where Zuclopenthixol acetate injection is administered, the service user should be monitored at regular intervals, beginning at baseline, then two hours, foru hours, six hours, eight hours and 12 hours post-injection. After 12 hours, monitoring should occur approximately every four hours up to 48 hours post-injection. Where a subsequent injection is given within 48 hours, then monitoring for the subsequent injection should replace the original monitoring. A suggested monitoring form is included at the end of this appendix.

All service users should be reviewed after receiving Zuclopenthixol acetate injection. This should include response, service user experience and future preferences as well as plans for ongoing treatment.

Ongoing treatment with oral or long acting injections may be commenced during the period of time after the last injection is given. The summary of the product characteristics for Zuclopenthixol acetate injection gives details of how Zuclopenthixol tablets or long acting injection may be initiated. This may be substituted for another appropriate treatment that the service user agrees to receive in the longer term.

Appendix 3

MEDICATION TIME OF ONSET

It is important to know the time of onset of action for different medications to allow nurses to choose the appropriate medication for the situation at hand. This is particularly helpful in determining at what point the medication should be given and if it will be effective in managing your patient to reduce risk efficiently.

MEDICATION	TIME TO ONSET OF ACTION
Oral inhaled Loxapine	10 minutes
Buccal midazolam	20 minutes
Oral Risperidone	1-2 hours
Oral Haloperidol	1-2 hours
Oral Quetiapine	1-2 hours
Oral Promethazine	2-3 hours
Oral Aripiprazole	3-5 hours
Oral Lorazepam	5-8 hours
Oral Olanzapine	5-8 hours
IM Droperidol	10 minutes
IM Haloperidol	10-20 minutes
IM Olanzapine	15-45 minutes
IM Lorazepam	30-60 minutes
IM Aripiprazole	1-3 hours
IM Promethazine	2-3 hours
IM Zuclopenthixol Acetate	1-2 hours

For all patients, the choice of drug should be guided by:

(a) The patient's preferences or advance statements and decisions.
(b) Pre-existing physical health problems or pregnancy.
(c) Possible intoxication.
(d) Previous response to these medications, including adverse effects.
(e) Potential for interactions with other medications.
(f) The total daily dose of medications prescribed and administered.

General notes:

If there is a partial response to a drug, a further dose should be considered. If there is no response, then the other drug should be given.

Concomitant use of two or more antipsychotics (antipsychotic polypharmacy) should be avoided where possible, on the basis of risk associated with QT prolongation (common to almost all antipsychotics), particularly where the patient's physical state predisposes to cardiac arrhythmia.

Appendix 4

PROTOCOL FOR THE RESTRAINT OF PATIENTS DIAGNOSED WITH AN EATING DISORDER WHO REQUIRE NUTRITION VIA A NASOGASTRIC TUBE

CONTENTS

1 INTRODUCTION

1.1 Any use of restraint for Nasogastric feeding should always be a last resort when best efforts with oral nutrition have failed with resulting deterioration in physical health.

1.1 In some circumstances there may be a need for a patient to receive nutrition/hydration via a nasogastric (NG) feeding tube, NG tube. In exceptional circumstances this may require the specialist care team to restrain a patient in order to ensure the patient receives the nutrition/hydration they require as part of their planned care and treatment.

1.2 This appendix provides guidance for specialist care teams and Priory RRIT trainers when a multi-disciplinary decision is made to use approved restraint techniques in order to provide nutrition/hydration, to a patient, via a NG tube. There is no national guidance available.

2 PHYSICAL HEALTH RISKS

2.1 Patients with eating disorders often have physical health problems which need to be assessed and managed.

3 OSTEOPOROSIS

3.1 A number of patients with eating disorders will have osteoporosis. This can affect both adults and young people. Osteoporosis caused by anorexia nervosa may not be completely reversible, particularly if the illness starts before puberty and continues well into adult life. The longer anorexia nervosa continues and the greater the extent of weight loss, the more fragile the skeleton becomes. Fractures of the spine result in permanent pain, disfigurement and disability.

3.2 Osteoporosis is a progressive bone disease that is characterized by a decrease in bone mass and density which can lead to an increased risk of fracture.

3.3 Hip, vertebral, wrist and rib fractures are common in people who have been diagnosed with or are statistically at risk of developing/having osteoporosis.

3.4 All of the ED patients, adult and adolescent, who have been diagnosed with an eating disorder, should be considered as high risk of having osteoporosis, therefore extra care should be taken when engaging in any restraint as part of their planned care.

4 NG FEEDING UNDER RESTRAINT

4.1 All patients requiring restraint for the purposes of NG feeding should have a RRI individual risk assessment completed in care notes (under risk assessment tab)

4.2 Only nursing/clinical colleagues who have been trained by Priory RRIT instructors may lead a planned restraint for the purposes of NG feeding.

4.3 Only nursing/clinical colleagues who have been trained by Priory RRIT instructors may support the head where required during a planned restraint for the purposes of NG feeding.

4.4 The nursing/clinical colleagues who have been trained by Priory RRIT instructors that are leading a planned restraint for the purposes of NG feeding must discuss the patient RRI risk assessment with staff members (including agency staff) and assess and plan who will perform each role and position during the NG feed.

4.5 Training is delivered emphasising that this is a low level method of management and the least restrictive intervention available should be used.

4.6 No pressure is to be applied and if the team assess that a restraint has become unsafe or unmanageable they are advised to disengage, when safe to do so and then review the intervention plan.

4.7 Throughout the training reasonable force is reiterated and what is proportionate to the amount of harm likely to be suffered by the patient or likely result if the forcible intervention is not made.

4.8 A patient's dignity must be maintained. Careful consideration must be given to the location of restraint feeds.

4.9 Where patients are repeatedly nasogastrically fed under restraint for seven days or more, a second opinion/network review is to be sought and recorded, this will include consideration of how this can be reduced and at what point further reviews will be necessary.

5 SAFETY CONSIDERATIONS

5.1 Due to the potential risks to patients it is recommended site RRIT instructors discuss the use of equipment, such as bean bags and safety pods, during a restraint. Placing pillows between the patient and colleague may reduce the risk of accidental injury to the patient's ribs and hips from the colleague's elbows and arms.

5.2 During a restraint there should never be any direct pressure applied to the patient's joints i.e. across the knee caps.

5.3 If the team assess a restraint has become unsafe or unmanageable they are advised to disengage, when it is safe to do so, and review the current treatment plan.

6 TRAINING

6.1 Only nurses and healthcare assistants who have been trained in RRIT by Priory RRIT instructors may lead a planned restraint for the purposes of NG feeding.

6.2 Agency nursing/care colleagues are not permitted to engage in a planned restraint for NG feeding, unless they have attended a BILD certificated training course and this has been verified via their training records. A nursing/clinical colleague who has been trained by Priory RRIT instructors is required to lead the restraint. This will include reviewing the RRIT plan with the restraint team and allocating staff roles, supporting of the head etc.

7 INSERTION AND MANAGEMENT OF NG TUBE

7.1 The clinical care team/MDT should follow Priory Policy H20.

7.2 **If there are any concerns during the use of restraint to NG feed, the intervention should be terminated. The patient's head must be carefully supported, if required, during the NG feeding process.**

8 SUGGESTED EQUIPMENT

8.1 ***High Backed Sofa*** **-** Specially designed high back chairs/sofa/couch may be used.

Nursing/care colleagues use their shoulders to support the patient against the back of the sofa, which in turn provides support to the patient's spine. When using this sofa/couch with patients who have low BMIs it is recommended pillows/cushions are used to prevent accidental injury from the nursing/care colleague's elbows against the services user's ribs/hips. The high back sofa/couch provides support for the patient's neck and spine whilst sitting up.

8.2 ***Bean Bag –*** RRIT trainers are able to train colleagues to use the beanbag as a method of restraint. This can be used which patients who are not cooperating with NG feeding.

8.3 The patient is surrounded by the bean bag which provides crucial support to the neck and along the spine. The bean bag cushions the patient and gives greater control to the team.

8.4 The colleague restraining the patient's legs is advised to use a pillow/cushion between themselves and the patient's legs to reduce risk of injury.

8.5 Please liaise with your site RRIT instructor for further guidance.

8.6

8.7 ***Safety Pod -*** Safety Pods allow the patient to receive a completely individualised response in terms of head and neck support, spinal alignment and seating angle.

8.8 RRIT trainers are able to train colleagues to use the safety pod as a method of restraint. This can be used with patients who are not are not cooperating with NG feeding

9 DOCUMENTATION REQUIRED POST PHYSICAL INTERVENTION

9.1 All interventions of NG feeding under restraint must be recorded as an incident on Datix under the category NG Intervention.

9.2 Datix enables the capture of a daily record of NG feeding up to five interventions.

10 ACTIONS POST PHYSICAL INTERVENTION

10.1
(a) An incident form is not required if the restraint is part of the patient's planned care. See above. **This only applies to NG feeding.**
(b) Update risk assessment/risk management (if appropriate).
(c) Update care plan, as appropriate.
(d) Colleague to remain with the patient for one hour post meal support.
(e) Nursing colleagues are advised to use a "body map" document in order to record any injuries.
(f) Offer a debrief to all nursing/care colleagues involved in the incident.
(g) Offer a debrief to the patient.
(h) If there have been any concerns during the restraint the patient should be reviewed by the ward doctor.

11 MENTAL HEALTH ACT 1983 (2007 AMENDMENTS)

11.1 Detention under The Mental Health Act 1983 should be considered by the clinical care team/MDT in order to provide required care and intervention whilst providing the patient with a legal frame work which gives them rights.

12 CONSENT

12.1 Consent over 16s - If a patient is to be restrained for naso gastric feeding the MHA must be considered.

12.2 Under 16s - Parental consent can be used to restrain a young person in order to provide naso gastric feeding but if persistent restraint is used the MHA needs to be considered.

13 ADVANCE DECISIONS

13.1 Detailed information about Advanced Decisions is available in OP16: Advance Decisions Policy. This policy applies to persons over the age of 18.

13.2 **It should be noted that:**
3.11 … the powers of the Mental Health Act 1983 take precedence and prevail over Advance Decisions, when it comes to treatment for a mental disorder (as opposed to treatment for a physical disorder). This means that where a patient is subject to compulsory detention under the Mental Health Act, an Advance Decision is not legally binding on decisions about their mental health (e.g. in Eating Disorders units where the patient is refusing any form of nutrition or hydration including ANH).

14 INDEPENDENT ADVOCACY

14.1 Each Priory healthcare site has access to an independent Advocate and/or Independent Mental Health Advocate (IMHA). It is imperative patients are made aware of their rights to speak to an advocate at any point throughout their admission.

15 REFERENCES:

15.1 The National Federation for Personal Safety Ltd.
Medical Emergencies in Eating Disorders: Guidance on Recognition and Management – Royal College of Psychiatrists, May 2022.
The Mental Health Act 1983.

Appendix 5

THE USE OF PHYSICAL INTERVENTIONS THAT ARE UNRECOGNISED OR UNAPPROVED (IN THE CONTEXT OF THE PRIORY GROUP RRI SYLABUS) IN REGARD TO PATIENTS REQUIRING NG FEEDING

1 CONTEXT

1.1 There are occasions when patients require physical intervention in the form of restraint to be NG fed. As in all cases where physical restraint is used, it must fulfil the legal criteria of 'Reasonable Force' as defined in section 3(1) of the Criminal Law Act 1967 in that it must be both 'necessary' and 'proportionate'. In the case of a patient requiring NG feeding, their physically compromised state and our duty of care to ensure their safety clearly fulfils the 'necessity' part of this equation. And, in regard to the 'proportionality', the risk of severe physical issues developing which could, if taken to their ultimate conclusion, result in the patient's death, if the feeds did not take place, clearly fulfil the criteria of a 'proportionate' intervention. In this instance, staff are fully trained in a range of techniques, contained within the Priory Group RRI syllabus, that which will enable them to safely hold a patient while an NG feed is carried out.

1.2 However, there are rare occasions when a patient will become familiar with the techniques employed by the nursing team and will adapt their behaviour to make them difficult to employ or, in some situations, ineffective and unsafe to use. They may also come to the realisation that nursing staff cannot lift or carry them and that if they place themselves in certain positions or locations, staff cannot physically intervene to relocate them.

1.3 Given the inherent risk in any attempt to move someone who has placed themselves in a dangerous position (e.g. on the stairs; on a windowsill; under furniture etc.) this would normally result in the staff withdrawing and re-engaging at a later time. Unfortunately, it has to be recognised that a patient with an eating disorder may be at the point where to not administer the NG feed may place them at greater risk of harm than that posed by physically moving them using an unapproved technique. If this is the case, and the decision is made to use such techniques, then a strict process must be followed which clearly states why the intervention used fulfilled all the criteria as stated above.

1.4 If the above criteria is met then any techniques used that are outside of those taught in the Priory RRI syllabus come under the umbrella term of 'Preclusion'.

1.5 While this guidance has been developed to directly address issues that may arise around NG feeding, it should be noted that 'preclusion' can be used in an emergency situation where recognised RRI techniques have proven ineffective and it is unsafe to simply disengage from the patient, as long as the criteria for 'Reasonable Force' is met. The difference in regard to NG feeding is that this will always be a planned procedure and as such we must ensure that the procedure detailed below has been followed before any intervention that could be deemed as 'preclusion' is used.

2 PRECLUSION

2.1 As detailed above, for any use of force to be deemed lawful, any action taken must be both 'reasonable' and 'proportionate' to the harm that staff are trying to prevent. In extreme situations colleagues might 'preclude' and employ unrecognised or unapproved (in the context of the Priory Group RRI training syllabus) techniques. As long as any actions taken are 'necessary' and 'proportionate' then they will still be considered lawful.

2.2 The RRI training syllabus states:

- A member of staff may be legally justified in the deployment of a physical technique that is outside of the taught skills in the RRI syllabus.
- This may also be in the format of a pre-emptive action.
- Staff must be able to justify any intervention they deploy.
- Any action must meet the legal criteria of 'Reasonable Force'.
- It must be clearly documented.

3 PROCESS

3.1 After it has been decided that 'preclusion' may be necessary, any consequent care plan should be created by the MDT and clearly document the following:

1) The rationale for the decision to use 'preclusion' (i.e. why it is necessary and proportionate).
2) The criteria that must be met before the use of 'preclusion' is adjudged to reach the threshold whereby it becomes 'Necessary' in the context of 'Reasonable Force'. The most common criteria may include, for example:
    - Agreed weight loss over an identified period.
    - The specific levels at which the deterioration in a patient's physical observations need to reach.
    - The number of feeds that have been missed.

    This should not be considered an exhaustive list and any plan where it is decided by the MDT that preclusion may be required will be specific to the individual patient involved.
3) That the criteria, decided above, in regard to the 'necessity' of the intervention is reviewed on a feed by feed basis and that if that criteria is not met, then the use of 'preclusion' is not warranted as the 'necessity' element of 'Reasonable Force' is not fulfilled.
4) The involvement of all appropriate individuals involved in the patient's care and their agreement to the implementation of any plan or, alternatively, any objections they may have and that these have been taken into account in the final decision.
5) That the Senior Management Team (Hospital Director; Deputy Hospital Director; Director of Clinical Services) are aware of the plan and are in agreement with its implementation.
6) That the plan and the rationale behind it will be clearly explained to the patient.

4 ADDITIONAL CONSIDERATIONS

4.1 If the decision is taken that the form of preclusion necessary is for the patient to be lifted and carried to a location where the feed is to take place, then the following need to be considered:

4.1.1 **Staff capabilities** – While the physical weight of the patient may not be an issue when being lifted and carried by staff, it should be recognised that it is highly likely that there will be significant resistance from the patient. When planning the intervention, staff who are physically capable of dealing with such resistance should be selected and briefed as to what to expect.

4.1.2 **Location** – The location of the feed should be as near as possible to the location in which the patient has put themselves. This will reduce the distance to be travelled should the patient have to be carried and so equally reduce the risk of incident should problems occur during transit. Communal areas should not be discounted if they are the nearest location as long as other patients can be relocated to protect the dignity of the patient being fed and to prevent the restraint from upsetting any patients who may witness it.

4.1.3 **Environment** – Staff should take steps to ensure that any corridors that are to be travelled down are clear of obstacles, that doors are open or unlocked, that equipment such as Safety Pods are available and prepared for use and that staff not involved in the process are aware that it is occurring and that they are making sure that other patients are not in the immediate area.

4.1.4 **Safety** - While a robust plan and well prepared and selected staff will give the intervention a high likelihood of success, it must be recognised that there are a number of significant risks involved in moving a patient in this manner. It should always be the Nurse in Charge of the intervention at the time who has the final say as to the safety of any given situation and whether the attempt should continue. If they feel that the risks involved at any particular point during the intervention are too high then they can, and should, make the decision to stop for the safety of all involved, both patient and staff. They should then re-assess the situation and decided whether to re-attempt or abandon the intervention, clearly recording their rationale for doing either.

4.1.5 **Debrief** - A debrief should take place after any intervention that uses 'preclusion' to look at what worked and what didn't, to discuss whether staff still feel that the use of preclusion is needed

and, if it is, what can be done to minimise the risk to all involved (think location etc.) in future interventions?

4.1.6 **Reporting** - In order to ensure transparency in regard to our working outside of taught techniques, in addition to the normal Datix report the following documentation should also be completed. A daily 24 hour notification (OP Form: 46B) must be completed detailing any and all incidents of "preclusion" for each individual Patient for which they are used. In addition, a weekly thematic Team Incident Review (TIR) must be completed to identify any lessons learnt.