Agenda Item 13ii
Executive Team Meeting
17th February 2009

SOUTH ESSEX PARTNERSHIP NHS FOUNDATION TRUST

Update of CLP and CLPG 52 Rapid Tranquillisation

PURPOSE OF REPORT

To update the Executive Team on the changes made to the Rapid Tranquillisation policy and procedural guidelines CLP 52 and CLPG52,

EXECUTIVE SUMMARY

The Rapid Tranquillisation policy and procedural guidelines have been updated to include procedures that are suitable for use in child and adolescent services.

Specific changes to the procedures include:

- the inclusion of a treatment algorithm for CAMHS
- a statement that Rapid tranquillisation is now taught in the medicines management training.
- a recommendation that a baseline ECG is carried out for all patients prescribed Haloperidol.
- parental consent to be considered in addition to advance directives for CAMHS patients.
- BNF for children added to the list of reference sources.
- aripiprazole injection included in the adult guidance for Forensic and secure services only.

ASSURANCE

The changes are necessary to ensure safe practice regarding rapid tranquillisation for the new inpatient CAMHS service.

The changes to the Policy and Procedures were considered and agreed by the Drugs and Therapeutics Committee (D&TC) on 15th January and the Trust Advisory Nursing Group (TANG) on 6th February. The relevant sections of the Formulary and Prescribing Guidelines have been updated accordingly, and were considered by the D&TC at the same time.

RECOMMENDATION

The Executive Team are advised to approve the amendments to CLP and CLPG 52.

ACTION REQUIRED:

The Executive Team is asked to approve the amendments to CLP and CLPG 52

Report prepared by

Cathy Willan
Lead Pharmacist

On behalf of

Oliver Shanley
Director of Integrated Governance and Executive Nurse

SOUTH ESSEX PARTNERSHIP NHS FOUNDATION TRUST

POLICY FOR RAPID TRANQUILISATION (RT)

Assurance Statement

This policy aims to ensure that staff are provided with current information and underlying principles considered by the Trust to be essential regarding Rapid Tranquilisation (RT).

The principles contained within this policy and associated documents will aim to ensure that open communication and respect are the fundamental elements of management of violence and aggression.

1.0 Introduction

1.1 The Trust believes that preventative strategies and measures such as engagement and the development of therapeutic relationships based upon respect are basic elements underpinning RT.

1.2 This policy and its associated procedure sets out the principles and procedures through which RT will be managed within the Trust

1.3 This takes into account National Institute of Clinical Excellence (NICE), 2002 guidelines on core interventions in primary and secondary care - Schizophrenia, NICE guidelines 2005, regarding Violence and The Independent Inquiry into the Death of David Bennett, 2003.

1.4 This policy must be used in conjunction with The Procedure for Rapid Tranquilisation.

The Prevention and management of Violence and Aggression (CLP25) should be referred to as it contains detailed guidance on general preventative measures, primary de-escalation interventions and managing the 'last resort' of restraint

2.0 Scope

2.1 This policy applies to all employees (permanent or temporary) of the Trust. Only qualified nursing staff and Doctors are authorised to administer/prescribe RT

2.2 RT will only be used on Heath Close within the Learning Disabilities Service, ~~and~~ adult acute wards, PICU and forensic in-patient wards within the Mental Health Service *and the inpatient CAMHS unit at Rochford.*

2.3 This policy document compliments all professional or ethical rules, guidelines and codes of professional conduct as detailed above.

2.4 This policy must be read in conjunction with CLP6 Advanced Directives, CLP14 Policy for Cardio-Pulmonary Resuscitation (CPR), CLPG25 Prevention and Management of Violence and Aggression, CLP40 Time Out, CLP41 Seclusion & the Formulary and Prescribing Guidelines (Rapid Tranquilization section 7)[3.]

3.0 Definition

3.1 All medication given in the urgent management of severely disturbed/violent behavior should be considered as part of rapid tranquillization (including pro re nata (PRN) medication taken from an agreed rapid tranquillisation protocol or as part of an advance directive).[1]

4.0 Aims

4.1 The service user should be able to respond to communication throughout the period of rapid tranquillisation. The aim of Rapid Tranquillisation is to achieve a state of calm sufficient to minimise the risk posed to the service user or to others.[1]

4.2 Deep sedation/sleep is not considered a desirable endpoint for rapid tranquillization. A state of calm is preferred, with the service user remaining conscious where possible.[1]

4.3 To allow the patient to participate in further assessment and treatment.

5.0 Implementation

5.1 This policy will be made available across the organisation via the trust intranet

5.2 All incidents of RT must be reported as per Trust policies RM06 Accident/Incidents Policy and CP3 Serious Untoward Incident (SUI) Policy

5.3 The Trust is committed to safeguarding all patients, visitors and staff and will therefore undertake pre-appointment screening of staff in posts requiring physical or verbal contact with all patients via the Criminal Records Bureau (HSC 2002/008). The Director of Human Resources is accountable to ensure this is actioned

6.0 Training

6.1 Training requirements and the monitoring of training needs are detailed within the Training Needs Analysis within the RT Procedure, CLPG 52.

7.0 Pharmacological Agents Used in RT

7.1 The Trusts' Formulary and Prescribing Guidelines[5] should be referred to or detailed guidance on drugs used in RT covering

- remedial measures
- guidelines for the use of Flumazenil
- guidelines for the use of Clopixol Acuphase
- times to max plasma concentration and half life
- licensed indications

8.0 Monitoring

8.1 Each Individual Qualified Practitioner together with Ward Manager/Charge Nurse is responsible for ensuring that the appropriate procedure is followed and documentation is completed as set out with the Procedural Guideline.

8.2 In all areas especially where there is a high experience of Rapid Tranquilisation the relevant Ward Manager/Charge Nurse is responsible for the following :

- Monitoring the implementation of this policy and procedure
- Maintaining records of monitoring.
- Ensuring any actions are completed if necessary and following this present results to the Clinical Lead Manager.

8.3 The Trust Clinical Audit Department will co-ordinate an annual audit of Rapid Tranquilisation procedures, which will include as a minimum audit of prescribing and monitoring of service users following rapid tranquilisation. The results will be presented to Trust Advisory Nursing Group (TANG) and Clinical Advisory Group (CAG) for review and identification of any actions required.

9.0 Policy Review

9.1 The Director of Integrated Governance and Executive Nurse will be responsible for overall monitoring and review together with the Risk Manager

9.2 This policy will be reviewed every 3 years taking into account emerging national guidance, local audit recommendations and lessons learnt from reports, enquiries and positive practice initiatives.

9.3 Any amendments to this policy will be submitted to the following for consideration and endorsement prior to being ratified

- Clinical Risk Management Group

- Risk Management Committee
- PMVA Lead Trainer
- Trust Advisory and Nursing Group (TANG)
- Drugs and Therapeutic Committee
- Clinical advisory group (CAG)
- Operational service Board

9.4 This policy will be monitored for its effectiveness through the Integrated Governance Department

10.0 Associated Documents

- Violence - the short term management of disturbed/violent behaviour in in-patient psychiatric settings and emergency departments NICE 2005
- Schizophrenia- Full National Guidelines on core interventions in primary and secondary care". NICE, 2003
- The Independent Inquiry into the Death of David Bennett, 2003
- The Maudsley 2005 Prescribing Guidelines 8th Edition
- Code of Practice to the Mental Health Act 1983 (revised 1999**)**
- Formulary and Prescribing Guidelines 1st edition SEPT 2005
- CLP6 Advanced Directives Policy
- CLP14 CPR Policy
- CLPG25 Prevention and Management of Violence and Aggression (PMVA) Policy
- Royal College of Psychiatrist Occasional Paper OP41, "Management of Imminent Violence" 1998
- CLP40 Time Out Policy
- CLP41 Seclusion Policy
- The Formulary and Prescribing Guidelines
- RM06 Accident/Incidents Policy
- CP3 Serious Untoward Incident (SUI) Policy
- Criminal Records Bureau (HSC 2002/008)

11.0 Policy Reference Information

1. Violence -the short term management of disturbed/violent behaviour in in-patient psychiatric settings and emergency departments NICE 2005

2. From section 1.5 "Schizophrenia- Full National Guidelines on core interventions in primary and secondary care". NICE, 2003

3. Formulary and Prescribing Guidelines 1st edition SEPT 2005

4. Independent Enquiry into the Death of David Bennett, December 2003

Clinical Policy No:	CLP52
Implementation Date:	11.10.2006
Last Review Date:	05.11.2007
Amendment Date(s):	05.11.2007, 12.11.2007
Next Review Date:	01.12.2010
Date Approved by the Executive Team:	12.11.2007
Date Ratified by Board of Directors:	Chairs Action Taken November 2007

The Director responsible for monitoring this policy is

The Director of Integrated Governance and Executive Nurse

SOUTH ESSEX PARTNERSHIP NHS FOUNDATION TRUST

PROCEDURE FOR RAPID TRANQUILISATION (RT)

Assurance Statement

These procedural guidelines aim to ensure that staff are provided with current information and underlying principles considered by the Trust to be essential regarding Rapid Tranquilisation *both in adult and child and adolescent services.*

The principles contained within this procedure and associated documents will aim to ensure that open communication and respect are the fundamental elements of management of violence and aggression

1.0 Introduction

1.1 This procedure should be read in conjunction with the Rapid Tranquillisation Policy.

2.0 Responsibilities

2.1 **The Director of Integrated Governance and Executive Nurse will ensure**

- Policy and procedures are embedded into clinical practice as well as Best practice Framework and in ensuring these are updated regularly.
- Ensure the identification and implementation of training educational needs arising from any relevant documentation.

2.2 **Directors and Senior Management will**

- Monitor the implementation of this policy via clinical audit and supervision.
- Ensure that Trust Risk Management Teams are appropriately notified on all incidents.
- Be able to evidence that SEPT policies have been followed.

2.3 **Lead Trainers for PMVA, Medicines Management and Enhanced Emergency Skills will**

- Ensure that any changes in professional knowledge and practice is regularly discussed and updated
- Ensure that all Trust Teams are appropriately notified of all current information on practice
- Ensure Training is delivered and monitored with records continually updated

- Encourage staff to take any issues related to RT to clinical supervision

2.4 **Managers and other Persons in Charge**

- Ensure the procedures and principles detailed within this policy are followed, to meet with all relevant guidance
- Ensure that all patient safety incidents are recorded on the Adverse Incident Report form and where necessary on the Serious Untoward Incident Report form following Trust *Policy CP3 Adverse Incidents including Serious untoward incidents.*
- Ensure staff receive appropriate and correct training as per Trust policy
- Ensure any Advance Directives are considered and used if appropriate
- Monitoring the use of RT is an essential part of managing a clinical area. Managers will collate reports to relevant forums ensuring individual instances are objectively reviewed and audit is undertaken
- Ensure that patients who have received RT are supervised/monitored by qualified nursing staff
- Ensure issues related to RT are discussed in clinical supervision

2.5 **Individual Staff**

- Must adhere to SEPT policy and guidelines.
- Undertake appropriate and approved training as above.

3.0 Training

3.1 Training must promote a philosophy which values engagement and respect together with working collaboratively with patients and other professionals.

3.2 Diversity of culture, race, gender, age and disability must be respected.

3.3 All managers and clinical staff, however senior or junior, should receive mandatory training in all aspects of cultural competency, awareness and sensitivity. This should include training to tackle overt and covert racism and institutional racism[6]

3.4 Staff who come into contact with patients must appreciate the complexities of human behaviour regarding the management of violence and aggression including precipitating factors and trigger factors[1]

3.5 Training in the use and dangers of rapid tranquillisation is as essential as training in de-escalation and restraint. Health professionals should be as familiar with the properties of benzodiazepines as they are with those of antipsychotic[2]

3.6 Staff should attend the relevant training course (see section 3.11) so that they can anticipate possible violence and to de-escalate the situation at the earliest opportunity, and physical means of restraint or seclusion should be resorted to 'only after the failure of attempts to promote full participation in self-care[2]

3.7 Qualified nurses and Doctors who use rapid tranquillisation should be trained in the assessment and management of service users specifically in this context: this should include assessing and managing the risks of drugs (benzodiazepines and anti-psychotics), using and maintaining the techniques and equipment needed for cardiopulmonary resuscitation, prescribing within therapeutic limits and using flumazenil (benzodiazepine antagonist)[2]

3.8 Health professionals should be able to assess the risks associated with rapid tranquillisation, particularly when the service user is highly aroused and may have been misusing drugs or alcohol, be dehydrated or possibly be physically ill

3.9 Health professionals should undertake annual retraining in cardio-pulmonary resuscitation techniques as per Trust Policy Cardio-pulmonary resuscitation policy CLP 14.

3.10 All qualified in-patient nursing staff should be familiar with, and trained in Cardio-Pulmonary Resuscitation (CPR) and in the maintenance and use of resuscitation equipment; this is a fundamental requirement as an anaesthetist or experienced 'crash team' may not be available[2.]

3.11 A training needs analysis has been undertaken to identify which staff require what level of training to ensure training needs outlined above are met, please see table below for all relevant training. All Qualified staff from the work areas listed in the training needs analysis will be expected to undertake training—relevant to the use of rapid tranquillisation as part of their mandatory training. Training in rapid tranqullisation forms part of the Prevention and Management of Violence and Aggression course.

Mandatory Training	**Update Interval**	**Staff Category**	**Delivery Method**
PREVENTION/ MANAGEMENT OF VIOLENCE AND AGGRESSION ETHICAL CARE Includes: • Breakaways • Restraint • C.P.R. Update • SMS	Annual 6 day initial 2/3Day update dependant on SMS status	Acute admissions (Adult), Acute/Challenging Behaviour, Learning Disabilities, PICU, Low + medium Secure Forensic. Any other area where a risk assessment shows	Direct

• Anticipating, de-escalating and coping with disturbed/violent behaviour		it is required	
CPR	Annual	All qualified in patient staff	Direct

Core Practice	Update Interval	Staff Category	Delivery Method
Enhanced Emergency Care	Annual	All qualified in patient staff	Direct
CPR	Annual	All unqualified in patient staff & all grades of community staff that have work directly with Service Users	Direct
Medicines Management	*Annual*	*All qualified in patient staff*	*Direct*

3.12 This training guidance should be read in conjunction with the Induction/Mandatory training policy HR21, Prevention and Management of Violence and Aggression Policy CLP 25, Cardio-pulmonary resuscitation policy CLP 14 and Medicine Management Policy CLP13.

3.13 Staff who are booked onto mandatory/core practice training that do not attend will receive a letter from the information department informing them of their non-attendance, which will be copied to the appropriate Line Manager. Non-attendees will be automatically re-booked onto another course by the information department.

3.14 Monthly mapping reports will also be sent to operational managers and directors identifying which of their staff are up-to-date with their training and when they are approaching update deadlines. Non-attendance of courses will also be recorded. It is the line managers responsibility to ensure all their staff have attended appropriate training as identified in the trust training needs analysis.

3.15 The Workforce Development and Training Department will report monthly on compliance levels for mandatory/core practice training to the Trust Executive Team, Workforce and Business Support Service Board and Risk Management Committee. Compliance for all Mandatory/Core Practice training fields is set at a minimum of 75%. The trust has an agreed target figure that is adjusted to account for sickness/absence, maternity leave etc.

4.0 Principles

4.1 The psychiatrist and multidisciplinary team should, at the earliest opportunity, undertake a full assessment, including consideration of the medical and psychiatric differential diagnoses. Attention to be given to advance directives *or parental consent* if appropriate[2].

4.2 The dose of antipsychotic medication must be individualised for each patient. The prescription will depend on several factors, i.e. age, associated physical disorders and other current medication prescribed.

4.3 The service users who participated in the Royal College of Psychiatrists Research Unit's discussion groups reported that when they behaved violently, medication was their preferred option compared with seclusion or prolonged physical restraint[3]

4.4 Note that RT is often viewed as punitive by patients[4]

4.5 Plans for the management of individual patients should ideally be made in advance. The aim is to prevent disturbed behaviour and reduce the risk of violence. Nursing interventions (de-escalation, time out), increased nursing levels, transfer of the patient to a PICU and pharmacological management are options that may be employed[4]

4.6 In some instances service users may express a particular preference through Advance Directives regarding the medication they wish to be considered, or other strategies to be utilised in managing their aggression. These directives will be respected, although health and safety considerations may determine that other methods of a treatment are used

4.7 Drugs, particularly in the context of restraint, should be used with caution because of the following risks[2]:

- loss of consciousness
- over-sedation with loss of alertness
- cardiovascular and respiratory complications and collapse
- seizures
- akathisia which can worsen the aggression
- possible damage to the therapeutic partnership between patient and clinician
- specific issues in relation to diagnosis

4.8 Resuscitation equipments, including flumazenil, must be available and easily accessible[2]

4.9 Because of the serious risk to patients life NICE recommends that service users who are heavily sedated or using illicit drugs or alcohol should not be secluded[2]. There may be exceptional circumstances were this is necessary. In these rare instances an increased level of observations must be maintained because of the risk of sudden collapse/death such as level 3 (maintaining the service user within

eyesight) as per trust policy CLP 8 Engagement and Formal Observation Policy.

4.10 If a patient is secluded, the potential complications of rapid tranquillisation should be taken particularly seriously[2], level 3 observations must be maintained by a qualified nurse at least until clinical monitoring of patients vital signs is possible

4.11 Violent behaviour can be managed without the prescription of unusually high doses or "drug cocktails". The minimum effective dose should be used and the BNF *and BNF for Children* recommendations for the maximum doses should be adhered to unless exceptional circumstances arise[2]

4.12 If high dose antipsychotic are used the form "Authority for High Dose Antipsychotic Treatment (HDT) should be completed and the guidance in the Formulary and Prescribing Guidelines should be followed

4.13 Clinicians should be aware that absorption from intramuscular administration (I/M) can occur far more rapidly when a service user is agitated, excited or physically overactive[1]

4.14 Health professionals should be able to assess the risks associated with rapid tranquillisation, particularly when the service user is highly aroused and may have been misusing drugs or alcohol, be dehydrated or possibly be physically ill[2]

4.15 The requirement for enforced IM medication in informal patients should prompt a consideration of the need to assess the implementation of the Mental Health Act[4]

4.16 All staff need to be aware of the legal framework that authorises the use of rapid tranquillisation, physical intervention and seclusion. The guidance of the Mental Health Act Code of Practice (chapter 19) should be followed, with any departures from that guidance clearly recorded and justified as being in the service user's best interest[1]

5.0 Route of Drug Administration

5.1 Oral medication should be offered before parenteral medication[2]

5.2 If parenteral treatment proves necessary, the intramuscular route is preferred over the intravenous one[2]

5.3 Intravenous administration should only be used in exceptional circumstances and this decision should be made by the consultant and not by junior medical staff.[2]

5.4 In pharmaceutical practice it is stated that if combinations of intramuscular (i/m) injections are used they should not be mixed together in the same syringe[1]

6.0 Pharmacological Agents Used in RT

6.1 The Trusts' Formulary and Prescribing Guidelines[5] should be referred to for detailed guidance on drugs used in RT covering

- remedial measures
- guidelines for the use of Flumazenil
- guidelines for the use of Clopixol Acuphase
- times to max plasma concentration and half life
- licensed indications

6.2 Where the behavioural disturbance occurs in a non-psychotic context, then it is preferable to initially use oral lorazepam alone or intramuscularly if necessary[1]

6.3 When there is behaviour disturbance in the context of psychosis, to achieve early onset of calming/sedation or to lower the dose of antipsychotic, an oral antipsychotic e.g. haloperidol, olanzapine, risperidone, should be considered in the first instance[1]

6.4 Olanzapine or Risperidone should not be used for the management of disturbed/violent behaviour in service users with dementia due to the increased risk of stroke and death[1]

6.5 The intramuscular (IM) preparations recommended are lorazepam, haloperidol and olanzapine[2] . *Aripiprazole may be used by forensic and secure services.*

6.6 Wherever possible, a single agent is preferred to a combination[2]

6.7 Olanzapine i/m should not be used 1 hour either side of lorazepam as there have been deaths reported with this combination.

6.8 *A Baseline ECG is recommended in all patients who receive or are likely to receive Haloperidol.*

6.9 When rapid tranquillisation is urgently needed, a combination of IM haloperidol and IM lorazepam should be considered[2]

6.10 Sufficient time should be allowed for clinical response between IM doses of medication for RT[1]

6.11 IM diazepam and IM chlorpromazine should not be used in rapid tranquilisation[2]

6.12 When using I/M haloperidol (or any other conventional antipsychotic) as a means of managing disturbed/violent behaviour, an antimuscarinic agent, such as procyclidine or benzatropine, should be immediately available to reduce the risk of dystonia and other extrapyramidal side effects, and should be given orally, intramuscularly or intravenously as per manufacturer's recommendations[1]

6.13 The use of two drugs of the same class for the purpose of rapid tranquillisation should not occur[1]

6.14 Health professionals should understand the cardio-respiratory effects of the acute administration of these drugs and the need to titrate dosage to effect[2]

6.15 There is a risk of respiratory depression when benzodiazepines are given in high doses or when used in combination with other hypnosedatives, including alcohol and some illicit drugs[1]

7.0 Clinical Monitoring of Patients Vital Signs

7.1 Patients should not be left unattended. Vital signs must be monitored after parenteral treatment is administered by qualified nurse. Blood pressure, pulse, temperature, respiratory rate and oxypulsemeter as well as any change in skin colour (i.e. cyanosis) should be recorded at regular intervals, as agreed by the multidisciplinary team based on consideration of the patient's history, until the patient becomes active again. The patient's level of hydration should also be assessed[2]

7.2 If it is not possible to physically monitor vital signs, for example if the patient refuses, or it is risk assessed as being too hazardous to attempt, this must be recorded in Appendix 2. Visual observations must be maintained including respiratory rate and skin colour and these must be recorded.

7.3 If the patient appears to be or is asleep, more intensive monitoring is required. The same applies to patients where intravenous administration of medication has taken place, BNF limits exceeded, where such patients have used alcohol or illicit drugs or have a relevant medical disorder or concurrently take other medication[2]

7.4 Monitoring of vital signs will be recorded on a standardised recording form (Appendix 2). This form should also be used to record where it has not been possible to monitor vital signs along with the reasons why

7.5 Health professionals should understand the importance of maintaining an unobstructed airway[2]

7.6 Health professionals should recognise the importance of nursing, in the recovery position, people who have received these drugs and also

of monitoring pulse, blood pressure, respiration and oxygen saturation levels[2]

7.7 Monitoring RT for children and adolescents after RT is the same as in adults[4]

7.8 It is good practice to monitor service users' vital signs after administering PRN medications.

8.0 Following Incidents of RT

8.1 All use of medication determined to be RT must be reported on an accident /incident report form and as an SUI if necessary following the relevant policy's guidance. A copy of a completed Appendix 2 should be attached to the report.

8.2 A full written account of the incident must be made as soon a possible in the nursing notes detailing why RT was necessary. This should include an outline of the context i.e. precipitants, victim, weapon, severity, actions taken, outcome, subsequent revisions to management plan. The completed Appendix 2 should be filed in the nursing notes to enhance the account.

8.3 With growing awareness that involuntary procedures produce traumatic reaction in service users, following the use of rapid tranquillisation, service users should be offered the opportunity to discuss their experiences and should be provided with a clear explanation of the decision to use urgent sedation. This should be documented in their notes[2]

8.4 Service users should be given the opportunity to write their account of their experience of RT in their notes[2]

8.5 Following an incident the person in charge at the time, with support from the Consultant Prectitioner/Clinical Risk Management Team will ensure that Trust Policy CP3 Serious Untoward Incident (SUI), RM06 Accident/Incidents Policy and CLP 28 Clinical Risk Assessment and Management is carried out this may include:

- Diffusing/Debriefing (informal /formal as appropriate)
- A multi-disciplinary clinical case review and audit
- Completion of accident and incident reporting documents
- Consideration must be given to assessment regarding possible increase in observation status
- Consideration must be given to nursing within a more secure environment e.g. transfer to PICU
- Further investigation if necessary as per Trust Policies

8.6 To manage the risks associated with Rapid Tranquilisation the Clinical Audit Department will complete an annual audit which include the following elements:

- Arrangements for monitoring physical health signs of individual service users as set out within guidelines
- Completion of relevant documentation
- Use of Prescribing guidelines

9.0 Associated Documents

- Violence - the short term management of disturbed/violent behaviour in in-patient psychiatric settings and emergency departments NICE 2005
- Schizophrenia- Full National Guidelines on core interventions in primary and secondary care". NICE, 2003
- The Independent Inquiry into the Death of David Bennett, 2003
- The Maudsley 2005 Prescribing Guidelines 8th Edition
- Code of Practice to the Mental Health Act 1983 (revised 1999**)**
- Formulary and Prescribing Guidelines 1st edition SEPT 2005
- CLP6 Advanced Directives Policy
- CLP14 CPR Policy
- CLPG25 Prevention and Management of Violence and Aggression (PMVA) Policy
- Royal College of Psychiatrist Occasional Paper OP41, "Management of Imminent Violence" 1998
- CLP40 Time Out Policy
- CLP41 Seclusion Policy
- The Formulary and Prescribing Guidelines
- RM06 Accident/Incidents Policy
- CP3 Serious Untoward Incident (SUI) Policy
- Criminal Records Bureau (HSC 2002/008)

10.0 Appendices

1. Management of Acutely Disturbed Patients Algorithm with boxed text guidance

2. Standardised form for Recording Vital Signs Monitoring Rapid Tranquilisation

References;

1. Violence -the short term management of disturbed/violent behaviour in in-patient psychiatric settings and emergency departments NICE 2005

2. From section 1.5 “Schizophrenia- Full National Guidelines on core interventions in primary and secondary care”. NICE, 2003

3. Royal College of Psychiatrist Occasional Paper OP41, “Management of Imminent Violence “1998

4. The Maudsley 2005 Prescribing Guidelines 8th Edition

5. Formulary and Prescribing Guidelines

6. Independent Enquiry into the Death of David Bennett, December 2003

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Next Review Date:	01.12.2010
Date Approved by the Executive Team:	12.11.2007, 17.02.09
Date Ratified by Board of Directors:	Chairs Action Taken November 2007 25.02.09

The Director responsible for monitoring this policy is

The Director of Integrated Governance and Executive Nurse

APPENDIX 1

MANAGEMENT OF ACUTELY DISTURBED PATIENTS (ADULTS)

CONSIDER NON DRUG MEASURES
Talking down, time out, seclusion

If unsuccessful or inappropriate

LEVEL 1
Disturbed but accepting oral medication

- Nurse in quiet area
- Ongoing verbal de-escalation
- Food & fluid to be provided
- Review current medication
- Decide whether additional medication required:

Lorazepam (1-2mg)
(Max 4mg/24 hours)
Can be repeated after 1 hour

OR

Haloperidol (5-10mg)
(Max 30mg po, 18mg im in 24 hours)
Can be repeated after one hour
Ensure cardiac status of patient is known preferably having had a previous ECG

OR

Risperidone (2mg)
Can be repeated after 2 hours

OR

Olanzapine (10mg)
Can be repeated after 2 hours

LEVEL 2
Disturbed but refusing oral medication (includes violence to self or others)

- Review all medication prescribed within the last 24 hours (BNF limits side effects)
- RMO's opinion may have to be sought
- Medication to be used:

Lorazepam (1-2mg) IM
(Max 4mg/24 hours)
Sedation in 30-45 minutes, peaks 1-3 hours, lasts 4-6 hours
[Promethazine (50mg) IM
Is an alternative in benzodiazepine-tolerant patients]

Haloperidol (5mg) IM
(Max 18mg/24 hours)
Sedation in 10 mins, peaks in 15-60 mins.
Half life 10-36 hours. Used singularly or in combination with Lorazepam
Ensure cardiac status of patient is known preferably having had a previous ECG

Olanzapine (5-10mg) as monotherapy IM
Peaks in 15-45 mins
Do not repeat within 2 hours; max 3 injections in 24 hours
Do not use Lorazepam within an hour of administering olanzapine IM

LEVEL 3

- RMO's direct involvement mandatory
- Consult on-call pharmacist

Second opinion from another consultant

- Promethazine 50mg IM
- Diazepam 10mg IV over at least 5 mins: Can be repeated up to 3 times if insufficient effect. Midazolam IM can be used as an alternative

Avoid Diazepam if ECT is being considered

MANAGEMENT OF ACUTELY DISTURBED PATIENTS (CHILDREN & ADOLESCENTS)

CONSIDER NON DRUG MEASURES
Talking down, time out, seclusion

If unsuccessful or inappropriate

LEVEL 1
Disturbed but accepting oral medication

- Nurse in quiet area
- Ongoing verbal de-escalation
- Food & fluid to be provided
- Review current medication
- Decide whether additional medication required:

If patient unkown to services initially treat with Lorazepam and avoid antipsychotics if possible

Lorazepam (1-2mg) (Over 12 years (Max 4mg/24 hours)
Lorazepam (0.5-1mg) (Under 12 years (Max 2mg/24 hours)
Can be repeated after 1 hour

OR

Promethazine (25-50mg) (Over 12 years
Promethazine (10-25mg) (Under 12 years
Can be repeated after 1 hour

OR

Haloperidol (1-5mg) Over 12 Years (Max 15mg in 24 hours)
Haloperidol (0.5-3mg) Under 12 Years (Max 10mg in 24 hours)
Ensure cardiac status of patient is known preferably having had a previous ECG

Can be repeated after one hour

OR

Risperidone (1-2mg) over 12 years
Risperidone (0.5-1mg) under 12 years

Can be repeated after 2 hours

OR

Olanzapine (10mg) over 12 years
Olanzapine (5-10mg) under 12 years

Can be repeated after 2 hours

OR

Quetiapine (25-50mg) over 12 years
Quetiapine (12.5-25mg) under 12 years

Can be repeated after 2 hours

LEVEL 2
Disturbed but refusing oral medication (includes violence to self or others)

- Review all medication prescribed within the last 24 hours (BNF limits/ side effects)
- RMO's opinion may have to be sought
- Medication to be used:

If patient unkown to services initially treat with Lorazepam and avoid antipsychotics if possible

Lorazepam (1-2mg) IM Over 12 years (Max 4mg/24 hours)
Lorazepam (0.5-1mg) (Under 12 years (Max 2mg/24 hours)

Sedation in 30-45 minutes, peaks 1-3 hours, lasts 4-6 hours

Promethazine (25-50mg) IM over 12 years
Promethazine (12.5-25mg) IM under 12 years

Haloperidol (1-5mg) IM over 12 years (Max 15mg/24 hours)
Haloperidol (0.5-3mg) IM under 12 years (Max 10mg/24 hours)

Sedation in 10 mins, peaks in 15-60 mins.
Half life 10-36 hours. Used singularly or in combination with Lorazepam
Ensure cardiac status of patient is known preferably having had a previous ECG
When administering Haloperidol consider also administering procyclidine 1.25-2.5mg.

Olanzapine (5-10mg) IM over 12 years

Peaks in 15-45 mins
Do not repeat within 2 hours; max 3 injections in 24 hours
Do not use Lorazepam within an hour of administering olanzapine IM

Rapid Tranquillisation – Monitoring
After any parenteral drug administration monitor as follows: • **Temperature** • **Pulse** • **Blood Pressure** • **Respiratory Rate** • **Level of Hydration** Every 5-10 minutes for one hour, then half-hourly until patient is ambulatory. If the patient is asleep or **unconscious**, the use of pulse oximetry to continuously measure oxygen saturation is desirable. A nurse should remain with the patient until they are ambulatory again. ECG and haematological monitoring are also strongly recommended when parenteral antipsychotics are given, especially when higher doses are used. Hypokalaemia, stress and agitation place the patient at risk of cardiac arrhythmias.

Remedial Measures in Rapid Tranquillisation	
Problem	**Remedial Measures**
Acute dystonia (including oculogyric crises)	Give **procyclidine** 5-10mg IM or IV or **benzatropine** 1-2mg IM *Procyclidine 1.25 -2.5mg in Children*
Reduced respiratory rate (<10/min) Or oxygen saturation (<90%)	Give oxygen; raise legs; ensure patient is not lying face down. Give **cuphasel** if benzodiazepine-induced respiratory depression suspected (see protocol). If induced by any other sedative agent: **Ventilate mechanically**.
Irregular or slow (<50/min) **pulse**	**Refer** to specialist medical care immediately.
Fall in blood pressure (>30mmHg orthostatic drop or <50mmHg diastolic)	**Lie patient flat**, tilt bed towards head. Monitor closely.
Increased temperature	**Withhold antipsychotics:** (risk of NMS and perhaps arrhythmias). Check creatinine kinase urgently

Guidelines for the Use of Flumazenil	
Indication for use	If, after the administration of lorazepam, respiratory rate falls below 10/minute.
Contra-indications	Patients with epilepsy who have been receiving long-term benzodiazepines.
Caution	Dose should be carefully titrated in hepatic impairment
Dose and route of administration	**Initial:** 200 mcg **intravenously** over 15 seconds (*10 mcg /kg max single dose 200 mcg in children under 12)* - if required level of consciousness not achieved after 60 seconds then, **Subsequent dose:** 100 mcg over 10 seconds
Time before dose can be repeated	**60 seconds**
Maximum dose	1 mg in 24 hours *(40mcg/kg under 12 years* (one initial dose and eight subsequent doses).
Side effects	Patients may become agitated, anxious or fearful on awakening. Seizures may occur in regular benzodiazepine users.
Management	Side effects usually subside
Monitoring • **What to monitor?** • **How often?**	Respiratory rate Continuously until respiratory rate returns to baseline level. Flumazenil has a short half life (much shorter than diazepam) and respiratory function may recover then deteriorate again. ***Note: If respiratory rate does not return to normal or patient is not alert after initial doses given then assume sedation due to some other cause.***

Guidelines for the Use of Clopixol Acuphase (zuclopenthixol acetate)

Acuphase should only be used after an acutely psychotic patient has required repeated injections of short-acting antipsychotic drugs such as haloperidol, olanzapine or ziprasidone, or sedative drugs such as lorazepam.

Acuphase should only be given when enough time has elapsed to assess the full response to previously injected drugs: allow 15 minutes after IV injections; 60 minutes after IM.

*Acuphase should **never** be administered:*

- In an attempt to "hasten" the antipsychotic effect of any other antipsychotic therapy
- For rapid tranquillisation
- At the same time as other parenteral antipsychotics or benzodiazepines
- At the same time as depot medication
- As a "test dose" for zuclopenthixol
- To a patient who is physically resistive (risk of intravasation and oil embolus).

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

- Patients who accept oral medication
- Patients who are neuroleptic-naïve
- *Patients who are less than 12 years old.*
- Patients who are sensitive to EPSE
- Patients who are unconscious
- Patients who are pregnant
- Those with hepatitis or renal impairment
- Those with cardiac disease

Onset and duration of action

Sedative effects usually begin to be seen 2 hours after injection and peak after 12 hours. The effects may last for up to 72 hours. Note: Acuphase has no place in rapid tranquillisation: *its action is not rapid.*

Dose

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

Injections should be spaced at least 24 hours apart.

Note: Zuclopenthixol acetate is widely misused as a sort of "chemical straightjacket". In reality, it is a potentially toxic preparation with very little published information to support its use. It is perhaps best reserved for those few patients who have a prior history of good response to Acuphase.

Reference: The South London and Maudsley NHS Trust. 2007 Prescribing Guidelines. 9th Edition. BNF for Chuldren 2008

APPENDIX 2

Rapid Tranquilization- Physical Monitoring Form	**Sheet number**

1. Record temp, pulse, BP, resp, & level of hydration every 5-10 minutes for 1 hour, then ½ hourly until the patient is ambulatory*
2. If the patient is unconscious, the use of pulse oximetry to continuously measure oxygen saturation is desirable. A nurse should remain with the patient until they are ambulatory again
3. ECG & haematological monitoring are also strongly recommended when parenteral antipsychotics are given, especially when higher doses are used. Hypokalaemia, stress & agitation place the patient at risk of cardiac arrythmias

Name of Patient		DOB	
Unit No		Ward	

Date & Time RT was administered		Date & Time physical monitoring was stopped	

Date & time																		
Temp																		
BP																		
Pulse																		
Resp																		
Level of hydration																		
Pulse oximetry (if used)																		
Skin Colour																		

Full monitoring of vital signs was not carried out because:
