Policy:

MD 011 - Rapid Tranquillisation Policy and Guidelines for Inpatient Wards

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Policy Owner	Chief Pharmacist
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Summary of policy
This policy advises on the pharmacological management of acute agitation or aggression within inpatient units inpatient units at SHSC. It covers assessment, documentation, treatment, monitoring and follow up in relation to these pharmacological approaches. The policy included algorithms and guidance for treatment in LD, adults 18 to 65 and for service users over 65 years of age.

Target audience	All in service user areas where RT is likely to be used

Keywords	Rapid, tranquillisation, inpatient, in-patient, ward

Storage & Version Control
Policy version and advice on document history, availability and storage
This is version 7 of this policy and replaces version 6.2
This version was reviewed and updated as part of an on-going policy document review process.

This policy will be available to all staff via the Sheffield Health & Social Care NHS Foundation Trust Intranet and on the Trust's website. The previous version will be removed from the Intranet and Trust website and archived. Word and pdf copies of the current and the previous version of this policy are available via the Director of Corporate Governance.

Any printed copies of the previous version (V6.2) should be destroyed and if a hard copy is required, it should be replaced with this version.
Changes: Removal of flumazenil. Update regards NEWS2 and fluid charts. Legal section updated.

Version Control and Amendment Log

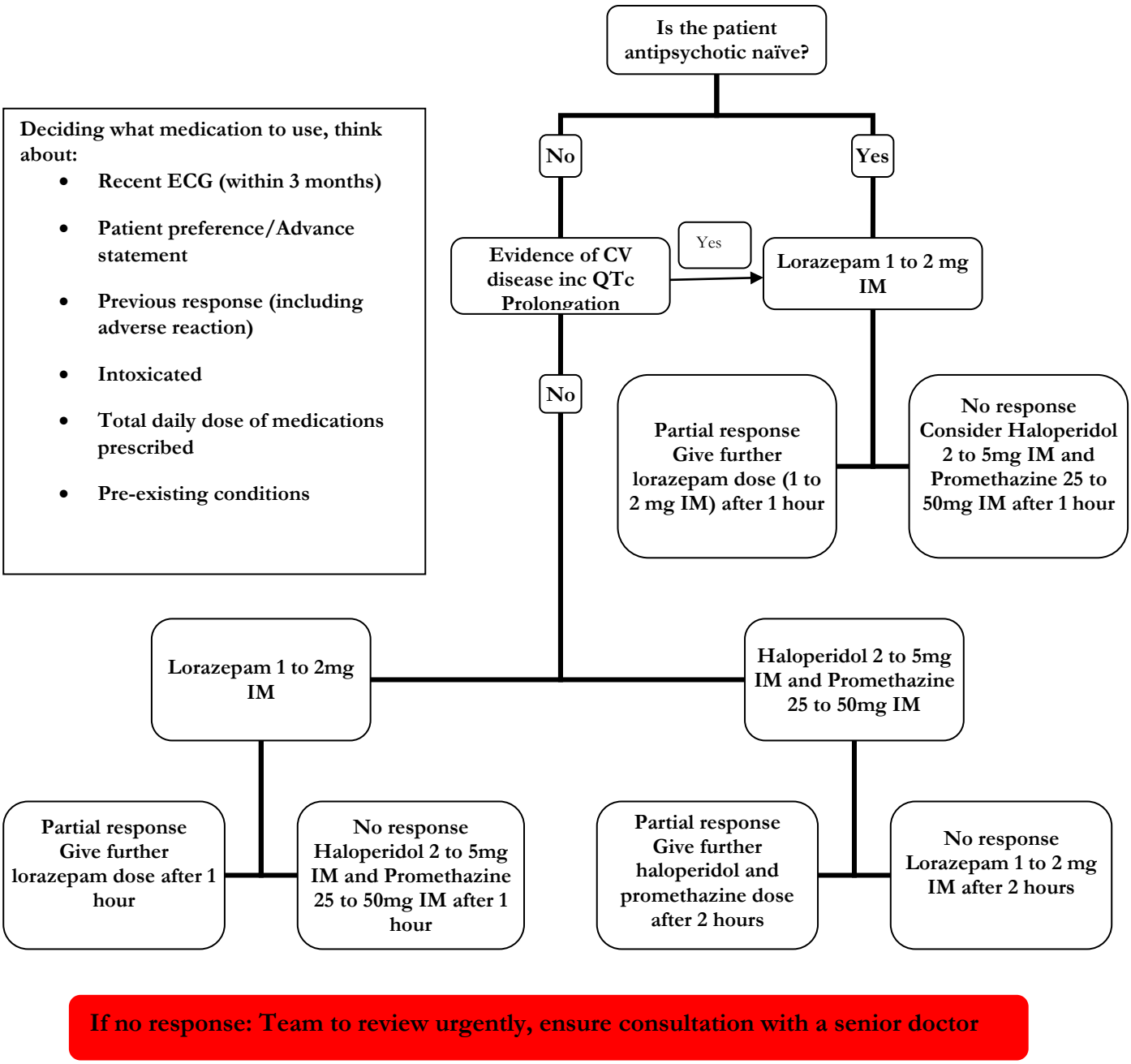
Version No.	Type of Change	Date	Description of change(s)
1	Policy creation	Oct 2006	Previous guidance in operation updated to policy status in line with NICE
2	Review on expiry of policy	Dec 2008	
3	Review on expiry of policy	Feb 2010	
4	Review on expiry of policy	Sept 2012	
5	Review on expiry of policy and updated NICE guidance	Oct 2016	Reviewed in line with updated NICE violence guidelines.
6	Review on expiry of policy	June 2022	
6.1	Clarity on information	October 2020	Amendment in flow diagram, information on administration, further information on olanzapine and aripiprazole use within RT. Addition of LD section.
6.2	Updated information	June 2022	Inclusion of information on clonazepam as oral therapy Clarification on prescribing on the EPMA system (single dose PRN) Information on maximum volumes of injection sites More information on injection sites Inclusion of information relation to Careplans Consideration of Trauma informed care with RT Out of hours /weekend prescribing Inclusion of information after an RT event, an assessment should be made as to whether “as required” IM medication needs to be prescribed for further events, bearing in mind the patient’s consent and MHA status. Clarity on use of fluid monitoring charts for hydration recording
7	Review of expiry of policy, Removal of information, Update of information	July 2023	Removal of flumazenil including appendix as no longer in emergency boxes (following approval in Resus Team and MOC), Fluid chart information updated further, removal of the term AVPU and switch to all monitoring as NEWS2. MHA updated with practice.

Contents

Flowchart

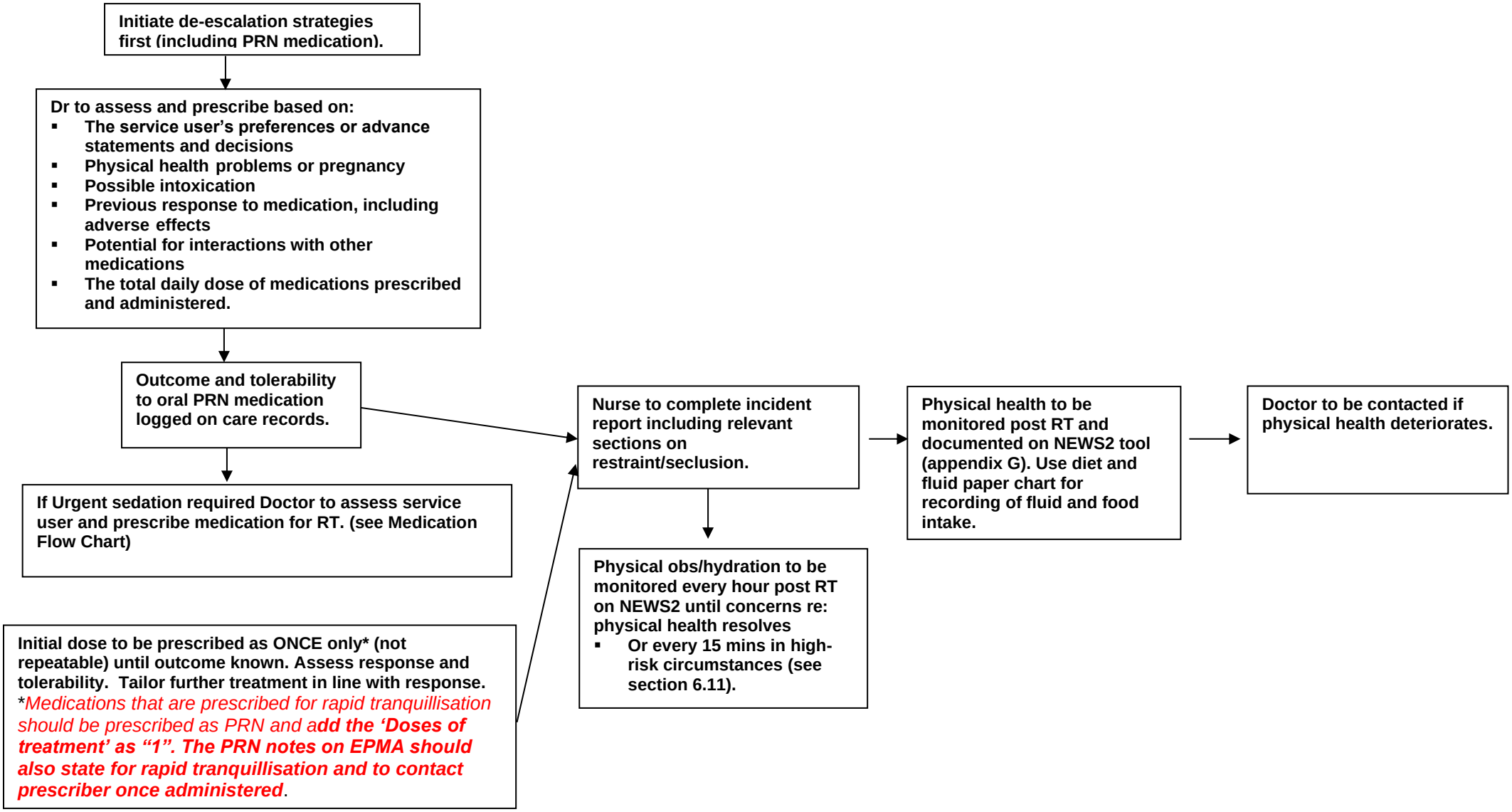
Adult (18-65 years) Rapid Tranquillisation Medication flow diagram

Note: Medications that are prescribed for rapid tranquillisation should be prescribed as PRN on the electronic prescribing and medicines administration (EPMA) system and ***add the 'Doses of treatment' as "1". The PRN notes on EPMA should also state for rapid tranquillisation and to contact prescriber once administered***.



If no response: Team to review urgently, ensure consultation with a senior doctor

Flowchart – Rapid Tranquillisation Algorithm



Summary: medication for rapid tranquillisation adults (18 to 65yrs)

Medication	Time to peak plasma concentration	Dose	Approx. plasma half-life	Notes
Lorazepam injection (SPC)	60 to 90 min	**1 to 2mg** Dose can be repeated after 1 hour up to 4mg in 24 hours	12 to 16 hours	**If there is insufficient information to guide the choice of medication for rapid tranquillisation, or the service user has not taken antipsychotic medication before, intramuscular lorazepam is generally first line.** **Exceptionally and with documented rationale up to 6mg in 24 hours maybe used.**
Promethazine injection	2 to 3 hours	**25 to 50mg** Dose can be repeated after 2 hours Max dose 100mg in 24 hours	5 to 14 hours	**NICE recommend intramuscular promethazine combined with intramuscular haloperidol.** **When IM haloperidol is combined with IM promethazine there is some suggestion that risk of movement-related side effects may be reduced**
Haloperidol injection (SPC)	15 to 60 min	**2 to 5mg** Dose can be repeated after 2 hours Max dose 12mg in 24 hours	10 to 36 hours	**A baseline ECG is recommended before intramuscular dosing.** **Haloperidol should be avoided if there is any evidence of or significant risk factors for cardiovascular disease.** **If an ECG has not been obtained prior to administering intramuscular haloperidol, an ECG should be carried out at the earliest opportunity.** ***The BNF states a maximum dose of 20mg for oral and intramuscular haloperidol in 24 hours.*** ***However oral and intramuscular doses are not bioequivalent (5mg oral equates to 3mg intramuscular).*** ***SHSC recommends a maximum dose of 12mg in 24 hours.*** **Post-rapid tranquillisation service users should be closely monitored for side effects, particularly extrapyramidal side effects (parkinsonism, acute dystonia etc.). Procyclidine oral/IM should be available if required. Procyclidine injection should be prescribed and available in case dystonia occurs including oculogyric crises**

1. Introduction

The management of disturbed and potentially dangerous behaviour, with due regard for the safety and dignity of service users and safety of staff, is an important part of the daily work of the Sheffield Health and Social Care NHS Trust. In addition to environmental, physical and psychological management, the appropriate use of medication may be required. Other non-pharmacological interventions, including de-escalation should always be considered. Restrictive interventions including rapid tranquillisation should only be used in a way that respects human rights (Mental Health Act 1983 Code of Practice (MHACoP) 2015 (26.2)).

This policy covers the use of medication for rapid tranquillisation. The decision to prescribe/administer medication urgently or against the will of the individual should be based on decisions made in line with current legislation:

- Mental Health Act (1983)
- Mental Capacity Act (2005)

Drug treatment that is not urgent requires informed consent or administration under the relevant sections of the Mental Health Act (1983). The aim of rapid tranquillisation is not to treat the underlying psychiatric condition and is not to induce sleep or unconsciousness. The service user should be sedated but still be able to participate in further assessment and treatment.

Rapid tranquillisation in this policy refers to the use of medication by the parenteral route (usually intramuscular or, exceptionally, intravenous) and when urgent sedation with medication is needed. A broader definition is captured in section 3 – but for the purposes of the policy RT refers to the use of medication via the injectable routes.

The process of prescribing and administration RT should be clear and transparent. Service users should be encouraged to participate in post incident reviews, and staff should record service user's preferences as part of their advanced statements or careplans.

2. Scope

The guidance within this policy applies to all staff who advise, prescribe or administer medication for the control of disturbed behaviour. It may impact on any service user being treated as an inpatient.

This guidance does not cover the non-pharmacological related management of disturbed or challenging behaviour.

3. Purpose

During an acute illness, some service users can become behaviourally disturbed to the extent that they or others may be at risk of harm. The use of medication as rapid tranquillisation is risky and may be distressing for service users.
People with mental health problems are at increased risk of coronary heart disease, cerebrovascular disease, diabetes, epilepsy and respiratory disease; all of which can be exacerbated by the effects of manual restrain and RT.
RT should be used in a way that ensures the safety of service users. Monitoring physical health during and after manual restraint/RT is paramount

This policy is based on NICE Guidance: NG10 Violence and aggression: short-term management in mental health, health and community settings (NICE 2015). This policy will ensure that the standards set down by these NICE guidelines are met within the Trust.

The purpose of this policy is to ensure the safe and appropriate use of RT within the Trust.

4. Definitions

Rapid tranquillisation (RT) – In this policy, RT, refers to 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.

Rapid tranquillisation refers to the use of medication to calm or lightly sedate an individual to reduce the risk of harm to self or others and to reduce agitation and aggression.
(Note: It is NOT RT when IM is administered as part of the care plan when regular oral antipsychotic or benzodiazepines are refused. The monitoring post administration though would still be exactly the same).

PRN (when required medication) Within this policy PRN refers to the use of medication as part of a strategy to de-escalate or prevent situations that may lead to violence or aggression. The use of oral medication (PRN) may be considered as part of a strategy to de-escalate or prevent situations that may lead to violence and aggression.

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

Advance statement - A written statement that conveys a person's preferences, wishes, beliefs and values about their future treatment and care. An advance statement is not legally binding.

Careplan – A written document that helps the MDT organise aspects of service users care according to a timeline. It's also a tool for them to think critically and holistically in a way that supports the service users physical, psychological, social, and spiritual care.

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

5. Details of policy

This policy advises on the pharmacological management of acute agitation or aggression within inpatient units inpatient units at SHSC. It covers assessment, documentation, treatment, monitoring and follow up in relation to these pharmacological approaches. The policy included algorithms and guidance for treatment in LD, adults 18 to 65 and for service users over 65 years of age**.**

6. Duties

All staff

When dealing with medicines, all staff should follow the relevant SHSCT medicines related policies, procedures and where applicable their own professional body's code of practice. This will also apply to all staff employed by the Trust, or any staff working or seconded to work within the Trust. Staff must act within the scope of their own competencies and professional standards.

Any health care professional choosing to deviate from these standards will be expected to do so knowingly and be able to justify their course of action to their peers. Adherence to these standards should be the norm.

- All staff that have any involvement with medicines are expected to work within their own sphere of competencies.
- All staff should be aware of and have access to medicines management / medicine optimisation policies and procedures.

Clinical guidelines are recommendations for the care of individuals by healthcare professionals that are based on the best available evidence. Guidelines assist the practice of healthcare professionals, but do not replace their knowledge and skills.

All staff that are likely to become involved in the use of medicines as part of this policy should ensure that they are familiar with the drugs used, the dose ranges and any relative – or absolute contraindications.

Managers

- To ensure their staff attend relevant mandatory training courses associated with this policy
- To ensure their staff have access to all the current Trust policies and procedures relating to medicines.
- To support staff through the appraisal process and training required to ensure they are working within their medicine related competencies.

Pharmacists

To participate in and support the processes of medicines management throughout the Trust and across organisational boundaries. This will include providing advice to all SHSCT staff including cultural & adaptations for service users with special needs.

Chief Pharmacist

Responsible for medicines management/medicines optimisation throughout the Trust. This does not alter the professional responsibilities or duty of care of any other healthcare professional when dealing with medicines.

Medicines Optimisation Committee

To provide multidisciplinary advice, guidance and where necessary assurance on medicines management (medicines optimisation) throughout the Trust.

Medicines Safety Group

To support the medicines safety officer and improve the quality and learning from medicines related incidents in order to prevent harm.

CD Accountable officer

To protect the service users and the wider public from harm associated with controlled drugs prescribed by relevant people.
To provide assurance that sound systems of governance relating to controlled drugs are in operation throughout the Trust.
To share information in order to prevent harm from controlled drugs by relevant people.

Trust Board

The Trust is expected to make sufficient resources available to enable the accountable officer to discharge his/her responsibilities as accountable officer for the Trust (relates to drugs controlled under the Misuse of Drugs Act). The Trust board must also be assured of medicines optimisation processes within the Trust.

7. Procedure

7.1 General

- Always seek advice of a senior colleague/consultant when unsure.
- Service users should only receive RT after an assessment of risk and when it has been established that the risk of not doing so is greater than the risks of the intervention (i.e. a proportionate response).
- The immediate safety of the service user, staff or others is of prime concern. RT should not be used for the sole purpose of protecting property.
- RT should only be considered if de-escalation strategies (including oral PRN medications) have been attempted - or there is a clear, agreed and planned rationale for the use of RT as a first line intervention for example in an emergency situation or where de-escalation has historically not been possible.

- Other non-pharmacological interventions that should be considered are for example increasing the level of alternative activity to provide distraction, providing 1:1 time which may also be achieved through increasing the engagement observations of the service user, understanding and implementing the service user's safety or crisis plan, increasing the level of staffing, reducing the sensory demands on the service user and consider changing the service users setting. Consideration of seclusion should only be considered as a last resort - noting this may not be immediately available.
- It is vital that the assessing doctor obtains as much history as possible from the service user and other sources before medication is prescribed or administered, as the opportunity to make a diagnosis may be lost if the service user is sedated before an understanding of their mental state is reached.
- Non-psychiatric causes of behavioural disturbance should be considered and managed accordingly e.g. hypoglycaemia, delirium, and drug / alcohol intoxication.
- The service user should be informed that RT is going to be administered and why (this should be clearly documented in the clinical notes).
- If possible, the service user should be given the opportunity to make an informed choice by way of an advance statement/careplan if they are admitted to an in-service user unit and RT is considered to be possible at some stage of their admission.
- The dose of medication prescribed and administered should be individualised.
- Preferred intramuscular injection site is usually the gluteal muscle.

7.2 Prevention of violence and aggression

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

- A multidisciplinary team (MDT) should develop and document an individualised pharmacological strategy for using routine and PRN medication to calm, relax, tranquillise or sedate service users who are at risk of violence and aggression as soon as possible after admission to an inpatient psychiatric unit.
- PRN medication should not routinely or automatically be prescribed on admission.
- PRN medication should be tailored to an individual needs (this should include discussion with the service user if possible).
- When multiple PRN medications are prescribed for the same indication, ensure there is clarity about the rationale and the circumstance in which each PRN medication may be used and this is clearly stated in the care plan.
- The multidisciplinary team should review the pharmacological strategy and the use of medication for the prevention and/or management of violence at least once a week and more frequently if events are escalating and restrictive interventions are being planned or used.
- Out of hours - The above applies with the nurse in charge and the on-call doctor being considered the MDT. In the event of not being able to discuss with a doctor in a timely way then escalation to the next level of doctor should occur. This includes the registrar and the On-call Consultant.

Medication choice for prevention of violence (oral therapy as part of de-escalation strategy)

Adult doses
Lorazepam 1mg to 2mg orally PRN up to 4mg in 24hrs.
BNF maximum dose 4mg in 24 hours. However, Trust policy recognises higher doses may sometimes be required up to 6mg in 24hrs.

If lorazepam is ineffective consider alternatives e.g. oral promethazine 25mg to 50mg 2hrly up to 100mg in 24hrs, haloperidol 2mg to 5mg 2hrly up to 20mg in 24hrs.

Clonazepam information
Clonazepam has also been used as a strategy for non-urgent tranquillisation (oral). It could be considered after oral lorazepam has been used up to 6mg daily dose and not effective in managing agitation.

- *Note: It is not licensed for agitation*.
- **(Clonazepam 250micrograms is approximately equivalent to diazepam 5mg;**
- **Lorazepam 500 micrograms is approximately equivalent to diazepam 5mg)**
- **Half-life 20 to 60 hours** and active metabolites, so multiple dosing is associated with a risk of accumulation and thus a risk of cumulative adverse effects
- **Note: the potency and long half-life**
- Max adult daily dose - 8mg

Oral clonazepam has no evidence of effectiveness as monotherapy in RT and it is associated with the risk of accumulation with repeated dosing and the resultant risk of cumulative adverse effects and therefore not recommended (BAP Guidelines 2018)

Adolescents (particularly those who are antipsychotic naive) and the elderly are likely to be more sensitive to the side effects of the medication.
Doses appropriate to the age group should be prescribed (see section 6.5 and Section 6.6 respectively).

7.3 Rapid Tranquillisation (injectable treatment)

Medication Choice
When deciding which medication to use, take into account:
- The service user's preferences or advance statements/careplan and decisions
- Pre-existing physical health problems or pregnancy
- Possible intoxication
- Previous response to these medications, including adverse effects
- Potential for interactions with other medications
- The total daily dose of medications prescribed and administered.
- Fear of injections
- Trauma

In the absence of specific treatment choices above – follow the treatment guidelines below.

If rapid tranquillisation is being used, a senior doctor should review all medication at least once a day. The service user's care plan should be discussed in the next multidisciplinary meeting or sooner if appropriate for discussion of long-term management.

The review should be recorded and include:
- Clarification of target symptoms
- The likely timescale for response to medication
- The total daily dose of medication, prescribed and administered, including PRN medication
- The number of and reason for any missed doses
- Therapeutic response
- The emergence of unwanted effects.
- After an episode of disturbed behaviour, the service user should still be assessed and the treatment plan reviewed to check if suitable to manage any further episodes.

Intramuscular haloperidol should be avoided in the absence of a baseline ECG.
If there is evidence of QTc prolongation, cardiovascular disease, electrolyte abnormalities or the service user is known to be prescribed other medications that can cause QTc prolongation, intramuscular haloperidol should be avoided and intramuscular lorazepam used instead.

Maximum daily dose must be clearly stated on the prescription and does not inadvertently exceed the maximum daily dose stated in the British National Formulary (BNF) when combined with the person's regular dose, PRN dose and dose for rapid tranquillisation.
The combined total dose of antipsychotic (i.e. haloperidol + one or more additional antipsychotic) should not exceed 100% BNF maximum limits.

Only exceed the BNF maximum recommended doses (including combined PRN dose, the standard dose and dose for rapid tranquillisation) if this is planned to achieve an agreed therapeutic goal, documented and carried out under the direction of the responsible clinician (RC).
Service users are at greater risk of developing side effects and complications, additional monitoring is required when exceeding BNF maximum doses, see section 6.9.

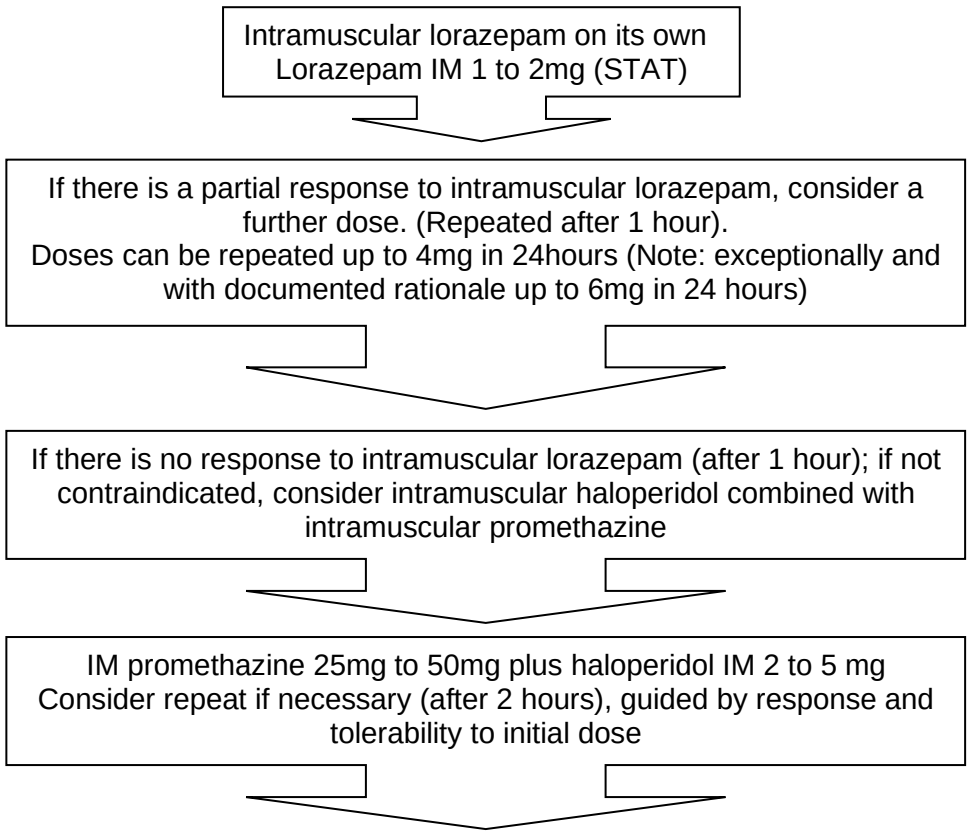
Seclusion
Be aware of and be prepared to address any complications associated with rapid tranquillisation by

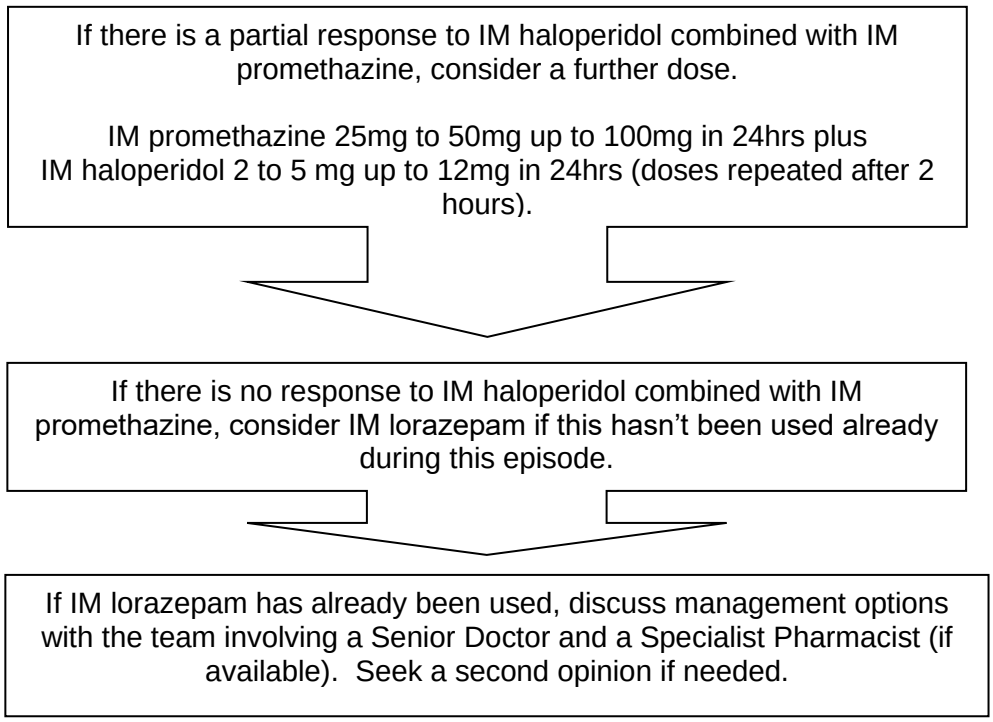
- ensuring the service user is observed within eyesight by a nominated/identified staff member, paying particular attention to physical health monitoring and the offer of regular fluids
- undertaking a risk assessment and consider ending the seclusion when rapid tranquillisation has taken effect.

7.4 Adults (service users aged 18 to 65 years old)

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

When prescribing medication for use in rapid tranquillisation, write the initial prescription as a single dose to manage an episode of violence. This should not be repeated until the effect of the initial dose has been reviewed. A doctor MUST attend before a second dose is administered and if it is required.
After an RT event, an assessment should be made as to whether “as required” IM medication needs to be prescribed for further events, bearing in mind the patient’s consent and MHA status. The prescription should be written in a way to ensure that repeat doses are not given without appropriate review and medical input. Out of hours or in the absence of medical staff on the ward (e.g. over a weekend), the administration of second and subsequent doses of RT must be discussed with the duty doctor on-call and, and the lead nurse on the ward. It is suggested that where possible the Dr attends the ward to assess the service users along with the clinical team to make a plan for the remainder of the out of hours period until the routine ward MDT can review.





On the EPMA system prescribe the initial dose as a PRN one off as below:
Add the 'Doses of treatment' as "1". The PRN notes on EPMA should also state for rapid tranquillisation and to contact prescriber once administered.

7.5 Administration Guidelines

The Intramuscular Route
The intramuscular route delivers medication into a well-perfused muscle. The vascularity of the muscle tissue aids the rapid absorption of medication. This provides a rapid systemic action.
Needles should be long enough to penetrate the muscle. For intramuscular injections the most common sizes used in adults are 21 gauge (green) and 23 gauge (blue) with a length of 25mm (1 inch) or 38mm (1½ inches) long, length used should be based on an individual service user assessment. If a service user has a lot of adipose tissue, a longer needle should be used.
Intramuscular injections should be given at a 90-degree angle to ensure the needle enters into the muscle and reduces pain. Following insertion of the needle, aspiration should be performed to ensure a blood vessel is not being penetrated. In the event of blood being aspirated the procedure should be started again with a new safer sharp needle.
Intramuscular injections usually require the removal of some clothing to access the appropriate injection site.

Rapid tranquillisation medication is not emergency lifesaving medication and should not be administered through clothing.

Infection Prevention and Control considerations

- Hypodermic needles are sterile and therefore if being inserted through clothing there is the possibility of clothing fibres or contamination being entered into the skin (it is no longer a sterile procedure)
- The qualified member of staff administering the injection cannot visualise the injection site prior to administration, during or site observation following administration
- Skin should be visibly clean prior to an injection – visual check prior to administration unable to be performed if wearing clothing
- Clothing may blunt/damage the needle
- Injecting through clothing means the qualified member of staff is unable to stabilise the injection site ready for injecting
- The full depth of the needle won't penetrate the skin due to the fabric being in the way

Note:
It is best practice for ONE nurse to carry out the whole procedure for an individual supported by a colleague to assist in checking that the medication is correct

Rapid tranquillisation medication should be administered via the following IM routes using appropriate injection technique.

Medication	Considered site of administration
Haloperidol	Dorsogluteal/Ventrogluteal
Lorazepam	Dorsogluteal/Ventrogluteal
Promethazine	Dorsogluteal/Ventrogluteal

On occasions the lateral thigh (Vastus lateralis) may be considered for IM injection but this site is not custom and practice. Administration to this site is painful. Using this site would need an MDT decision with appropriate reasons for this route and recorded in the collaborative care plan.

Note: Deltoid administration is rare in RT as administration requires a stationary arm for correct injection technique. If considered appropriate, it should only be used for the shortest possible time whilst maintaining the appropriate physical health monitoring checks.

Recommended maximum volumes of fluid for each muscle group
Dorsogluteal 4ml
Ventrogluteal 4ml
Vastus Lateralis 5ml
Deltoid 2ml

Dilution information

Lorazepam should be mixed 1:1 with water for injection before injecting. The following table provides injection volumes for delivering various doses of lorazepam once diluted.

Dose of lorazepam required	Volume of undiluted (lorazepam (4mg/mL)	Volume of Water from injection
0.5mg	0.125mL	0.125mL
1.0mg	0.25mL	0.25mL
2.0mg	0.5mL	0.5mL

Trauma informed care
A trauma-informed approach to healthcare aims to provide an environment where a person who has experienced trauma feels safe and can develop trust. This should part of the consideration when rapid tranquillisation is being considered.

7.6 Special Treatment Groups - Older Adults

The doses of medication required in the older adult group will be less than those required for the general adult population.

Similar principles as for adult service users should be applied. Particular care should be given to co-existing medical states and prescribed medication, the risk of accumulation of sedatives and the possibility of delirium. Non-pharmacological factors must always be considered.

For acute behavioural disturbances in the elderly when urgent sedation is required to prevent injury or harm consider first line:

- Lorazepam 500micrograms to 1mg IM should be used and repeated not more frequently than every 1 hours (maximum 2 mg in 24 hours).

An initial single dose should be prescribed to allow assessment of response or side effects. Further prescriptions should be considered after assessing the response to initial dose. High doses of benzodiazepines can cause respiratory depression and should be avoided in service users who have significant respiratory impairment.

If IM lorazepam is ineffective and RT is necessary and not contraindicated consider:

- Promethazine IM 12.5mg plus haloperidol IM 500micrgrams to - 1mg.
  Repeat if necessary, according to response and tolerability no more frequently than every 2 hours (promethazine maximum 50mg in 24 hours. Haloperidol maximum 5mg in 24 hours).

Doses prescribed above this regimen should be discussed with a senior doctor and the rationale documented in the service users records.

The dose of haloperidol is a critical factor when determining the likelihood of severe adverse effects. If haloperidol is not tolerated or inappropriate discuss alternative options with the Consultant Psychiatrist and specialist SHSC pharmacist.

The use of antipsychotics is cautioned in elderly service users with dementia. An increased risk of stroke has been implicated with all antipsychotics. The balance of risks and benefit should be considered before prescribing antipsychotic drugs for elderly service users. Antipsychotics should therefore, only be prescribed for use in service users when the use is considered a proportionate response to the risks – https://www.nice.org.uk/guidance/ng97

Promethazine has anticholinergic effect such as dry mouth, blurred vision, urinary retention and constipation. Cognition can also be impaired. Particular care should also be taken in those service users with dementia or learning disability.

7.7 Special Treatment Groups - Learning Disability

The doses of medication required in learning disability group will be less than those required for the general adult population.

Similar principles as for adult service users should be applied. Non-pharmacological factors must always be considered.

Disinhibition is more likely to occur in organic brain disease including learning disabilities. For acute behavioural disturbances in learning disability when urgent sedation is required to prevent injury or harm consider first line:

- Lorazepam 500micrograms to 1mg IM should be used and repeated not more frequently than every 1 hours (maximum 2 mg in 24 hours).

If IM lorazepam is ineffective and RT is necessary and not contraindicated consider:

- Promethazine IM 12.5mg plus haloperidol IM 3-5mg. Repeat if necessary according to response and tolerability no more frequently than every 2 hours (promethazine maximum 50mg in 24 hours. Haloperidol maximum 12mg in 24 hours).

Promethazine has anticholinergic effect such as dry mouth, blurred vision, urinary retention and constipation. Cognition can also be impaired. Particular care should also be taken in those service users with dementia or learning disability.

Olanzapine IM is also another option (only after >1-hour post lorazepam IM). Dose 5 -10mg (max 10mg/24 hours) see section 6.9 for further information.

7.8 Special Treatment Group - Adolescent service users

In practice this only refers to adolescent service users aged 16 or 17 who may be admitted to adult acute wards if they are unable to access adolescent services.

Prior to starting drug treatment it is very important to exclude non-psychiatric causes such as organic disease, psychological disturbance e.g. anger and anxiety, intoxication or withdrawal states.

In all cases the minimum effective dose of medication should be used. BNF maximum doses should only be exceeded in extreme circumstances and with the advice of a Consultant Child & Adolescent Psychiatrist.

Oral medication as part of a de-escalation
The drugs used in adolescents should follow the guidance as for the adult service users however, lower doses may be needed.

For Rapid Tranquillisation:
Lorazepam 1mg to 2mg repeated after 1hr if required, up to a maximum of 4mg in 24 hours. (Treatment recommended by NICE)
If ineffective or unsuccessful consider promethazine 25 to 50mg 2hrly up to maximum of 100mg daily and haloperidol 2 to 5mg (maximum daily dose 12mg) repeat after 2hr if required. (Note – Off-label use)

7.9 Zuclopenthixol acetate (Acuphase)

Acuphase /Zuclopenthixol acetate is not suitable for rapid tranquillisation and should not be used for acutely disturbed service users.
Please see SHSC Guidelines: Use of zuclopenthixol acetate injection (Clopixol Acuphase®) for further guidance.

7.10 Olanzapine IM

Olanzapine IM is an option that can be considered for a service users if haloperidol is contra-indicated and lorazepam is not suitable or effective. This must be agreed by a senior doctor, and a senior pharmacist. Olanzapine IM is unlicensed in the UK. A dose of 5 -10mg is recommended max dose is 20mg, minimum 2 hours between doses. For older adults, a starting dose of 2.5mg, max 10mg. Maximum 3 doses per 24 hours and up to a maximum 3 consecutive days only. Onset of action is 15-30minutes.

Monitoring is the same as discussed in section 6.11.

Lorazepam IM cannot be prescribed alongside olanzapine IM due to the increased risk of respiratory depression. If oral lorazepam is required, it must be administered 1 hour before or after administration of olanzapine IM.

Promethazine IM should also not be given at the same time as olanzapine IM.

7.11 Aripiprazole IM

Aripiprazole IM is not recommended in rapid tranquillisation in the Trust. The reason for this is it is not recommended by NICE. Aripiprazole is a dopamine 2 partial agonist. Evidence shows IM aripiprazole can cause increased agitation initially.

7.12 Monitoring

After rapid tranquillisation, the service user should be monitored. The response to medication and any emergent side effects documented in care records along with the physical health observations (contact or non-contact if refuses/not safe to do so)
Ensure the service user is observed within eyesight by an appropriately skilled staff member post RT.

The following physical health observations should be monitored and recorded every hour (using NEWS2) until there are no concerns about their physical health status (physical observations within range or agreed with a doctor).

Pulse
Blood pressure
Respiratory rate/O2 saturation
Temperature
Level of hydration – e.g. Fluids offered, consumed and recorded on a fluid balance chart
Level of consciousness

In high-risk circumstance monitoring should be increase to every 15 minutes – this includes situations where:

- BNF maximum dose has been exceeded
- The service user appears to be asleep or sedated or has taken illicit drugs or alcohol
- The service user has a pre-existing physical health problem or has experienced any harm as a result of any restrictive intervention.

Physical Health observations/ monitoring should be documented on the Trust agreed national early warning scoring tool (NEWS2) (Appendix C)- this includes contact and non-contact observations. Hydration and fluid offer/intake should be recorded on a diet and fluid paper balance chart.
Post administration clinical response and side effects should be documented in the service users Medical care records.

If monitoring of vital stats is not possible the service user should be monitored closely via the ABCDE assessment system (covered in the basic and immediate life support training).

(A) AIRWAY	Is the airway clear? Is the person able to speak – if so their airway is clear. Is the breathing noisy – coming from the throat?
(B) Breathing	Can you see the chest rising? Can you see if rising equally? Is breathing noisy – coming from the chest? Count the patients respiratory rate
(C) Circulation	Can pulse oximetry be used? Has the person's colour changed – blue lips or fingertips? Monitor the service user's temperature.
(D) Disability	(ACVPU) Alert, responds to Voice, responds to Pain and Unresponsive.

Any abnormalities or concerns identified during the physical observations or rapid deterioration in physical presentation should be discussed with a doctor urgently and/or an ambulance called if the doctor will be delayed attending.

A baseline ECG is recommended before intramuscular dosing of haloperidol.
If an ECG has not been obtained prior to administering intramuscular haloperidol, an ECG should be carried out at the earliest opportunity. The risks and benefits of using haloperidol without an ECG should be considered on a case-by-case basis.
Its use without a prior ECG is off label. – Summary of Products Characteristics (SPC) states - A baseline ECG is recommended before intramuscular dosing. During therapy, the need for ECG monitoring for QTc interval prolongation and for ventricular arrhythmias must be assessed in all service users, but continuous ECG monitoring is recommended for repeated intramuscular doses.

Staff should have access to resuscitation equipment including: an automatic external defibrillator, a bag valve mask, oxygen, cannulas, suction and first-line resuscitation medications (Refer to the Trust resuscitation Policy).
Ward staff should check equipment and emergency boxes on a weekly basis.
In addition, pharmacy staff will also check the emergency boxes during the ward top up process.
Opened or out of date emergency trays need to be re-ordered from pharmacy as soon as possible.

Staff should be trained in immediate life support and a doctor trained to use resuscitation equipment should be immediately available to attend an emergency if restrictive interventions might be used.

If the service users respiratory rate drops below 10/min due to benzodiazepine administration staff should call an ambulance immediately and maintain airway.

Resuscitation equipment and medicationmust be available and easily accessible to all staff likely to use medication to manage behavioural disturbance. Staff should be familiar with their use.

If the service user, is in seclusion and falls asleep then seclusion should be considered to end, following a risk assessment and review by the MDT, and the service users vital signs monitored more closely.

7.13 Incident Review

After using RT and when the risks of harm have been contained, conduct an immediate post-incident debrief, including a nurse and a doctor, to identify and address physical harm to service users or staff, ongoing risks and the emotional impact on service users and staff, including witnesses. Note: Trust guidance on timing of post incident review and support
This should review the factors that contributed to an incident that led to the use of RT so that any factors can be addressed quickly to reduce the likelihood of a further incident.
The care plan should be amended accordingly.

The service user involved should have the opportunity to discuss the incident in a supportive environment with a member of staff or an advocate or carer. Offer the service user the opportunity to write their perspective of the event in their clinical notes or by other means.

As the administration of parenteral medication under restraint is a restrictive practice an incident form should be completed. One incident form can be completed to capture the events leading to the need for RT which may or may not include restraint and/or seclusion. The RT tick box should be indicated, and the details of the medication administered. It should include alternatives and options offered or tried and the rationale for administering RT. The immediate actions should note the physical health monitoring and offer of fluids following the administration. All physical observations should be recorded on NEWS2, fluids should be clearly documented on the paper diet and fluid charts.

7.14 Legal Aspects – Treatment of those detained under the Mental Health Act 1983 (MHA)

The law in relation to the treatment of those who are detained under the Mental Health Act (MHA) can be complex at times, and different rules and requirements may apply depending upon a person's mental capacity, the type of treatment proposed, and which section of the Act a person is subject to. This specific section provides an outline regarding the MHA treatment rules and the following patients:

- Patients who are liable to be detained under the MHA (but not those subject to s4, s5, s35, s135, s136, patients detained temporarily in a place of safety under s37 or 45A pending admission to the hospital named in the order, restricted patients who have been conditionally discharged (unless recalled to hospital)).

- Patients subject to a Community Treatment Order and who have been recalled to hospital/CTO revoked.

This section also does not cover the treatment provisions related to ECT (and medicines associated with ECT), neurosurgery for mental disorder, or the surgical implants of hormones to reduce male sex drive.
The arrangements for the administration of medical treatment in order to treat the mental disorder of patients detained under the MHA are described under Parts 4 and 4A of the Act. The arrangements apply only to medical treatment the purpose of which is to alleviate, or prevent a worsening of, the disorder or one or more of its symptoms or manifestations.
The definition of what constitutes medical treatment is broad. It includes nursing, psychological intervention, mental health habilitation and rehabilitation, as well as care.

Medical treatment in respect of physical disorders which are unrelated to the mental disorder are not covered by the MHA. Treatment for physical health problems which are part of, or are ancillary to, the treatment of mental disorder may however be covered under the MHA.
For patients detained under longer-term sections (e.g. sections 2, 3, and 37), sections 58 and 63 MHA 1983 allows the administration of treatment, of the mental disorder, to be given (without consent if necessary) during the first three months of the treatment's commencement. This treatment must, however, be given by, or under the direction of, the Approved Clinician who is in charge of the treatment.

Despite consent not being necessary during the initial three-month period, efforts should always be made to obtain a patient's freely given permission when giving treatment.
Similarly, the views and wishes of patients should still be obtained and taken into account when determining the most appropriate treatment for a patient. An assessment of the patient's mental capacity should also be recorded on the patient's Electronic Patient Record (this currently being on a CAT2 form).

The 3-month period, referred to above, is a single continuous period occurring once in any period of detention; the 3-month period is not repeated if a patient subject to a Community Treatment Order has the order revoked.
At the end of the 3-month period, non-urgent medical treatment may be lawfully administered only if the correct section 58 certificate (T2 or T3) is in place.
The Responsible Clinician must assess the patient's capacity to consent to the medical treatment prior to the expiry of the 3-month period and complete the appropriate form on the Electronic Patient Record (currently CAT3) in order to determine what is then required. Patients will fall into 2 categories:

1 - Section 58 (3a) – Patients who have capacity and consent to the prescribed treatment – Form T2.
The Responsible Clinician must:

- Undertake an assessment of the patient's mental capacity to establish whether they are able to consent, or otherwise, to the proposed medical treatment.

- Obtain the patient's wishes and preferences regarding their treatment.

- Assist the patient to understand the proposed treatment plan and, where possible, obtain the patient's consent to continuing the medical treatment.

- Record the mental capacity assessment and discussion in the Electronic Patient Record

- If the patient consents to continued treatment, complete a Form T2

NB Certificates remain valid until there is a permanent change of Responsible Clinician (RC), or there is any addition to the treatment plan. Any new medicine prescribed must appear on the certificate. Certificates are no longer valid if the patient loses mental capacity about the treatment they had consented to.
Before any changes are made to T2 certification, the patient's mental capacity should be reviewed and again documented. This is to ensure an ability to understand and consent to treatment remains for any new treatment.
A patient with mental capacity can withdraw consent at any time; it is unlawful to administer medication under Form T2 if consent has been withdrawn, or if the

patient has lost mental capacity about the treatment on the T2. A Form T3 (or Section 62 if urgent treatment is needed and the grounds under s62 are met)) is required in order to proceed.
It is unlawful to administer a medication which is not detailed on the Form T2

2- Section 58 (3b) – Patients who lack capacity to consent to the prescribed treatment, or who have capacity but refuse – Form T3.

The Responsible Clinician must:

- Complete and document their assessment of mental capacity.
- Request a Second Opinion Appointed Doctor (SOAD) visit from the Care Quality Commission (CQC) via the CQC portal.
- If the SOAD agrees with the Responsible Clinician that it is appropriate for the treatment to be given, the SOAD will complete a Form T3.

NB Certificates remain valid until there is any addition to the treatment plan, even if there has been a change of RC. If the Responsible Clinician wishes to make changes to the treatment plan beyond that listed on the T3, then either a Form T2 should be completed (if the patient has capacity and is consenting) or if the patient is not consenting or is not able to consent a Section 62 completed for emergency treatment.
It is unlawful to administer a medication which is not detailed on the Form T3
It is possible that some patients may have a T2 certificate for some treatment, but a T3 certificate for others.
The Trust has a system in place to remind the Responsible Clinician (RC) before the expiry of the 3-month period. The Mental Health Act office informs the Responsible Clinician and Pharmacy - 3 weeks before consent is needed to continue treatment via electronic communication.
This is followed up by a phone call if documented consent is not received 1 week prior to the end of the 3-month period.
Nurses must not administer medicines to patients detained under the Mental Health Act 1983 after the 3-month period without first ensuring that a valid Form T2 or T3 indicates that the treatment can lawfully be given.

<u>Urgent Treatment</u>

Section 57 (treatment requiring both consent and a second opinion) and section 58 (treatment which requires consent or a second opinion) does not apply to any treatment which:

- Is immediately necessary to save a patient's life; or
- (Not being irreversible) is immediately necessary to prevent a serious deterioration of his condition; or
- (Not being irreversible or hazardous) is immediately necessary to alleviate serious suffering by the patient; or
- (Not being irreversible or hazardous) is immediately necessary and represents the minimum interference necessary to prevent the patient from behaving violently or being a danger to themself or to others.

The Code of Practice emphasises that the administration of treatment using s62 can only be used for as long as it remains immediately necessary. As soon as treatment is no longer immediately necessary, the usual treatment rules will apply.

A section 62 urgent treatment form must always be completed if treatment is given under this part of the Act. Once completed, it must be sent to the Mental Health Act office.

Relying upon section 62 for routine treatment purposes is both not acceptable and likely to be unlawful.

Community Treatment Order (CTO) patients who are not recalled or revoked
Where a patient subject to a CTO consents to medication it must be certified by the RC on Form CTO 12. The RC should also complete a CAT4 assessment on the patient's electronic record.

If the patient lacks capacity to consent, medication can only be given if approved by a SOAD on a 'part 4A certificate' - Form CTO11. There are exemptions where a certificate for medication is not required:
1) during the period of one month starting with the day on which the patient became a CTO patient or
2) if less than three months has passed since the patient was first administered medication during an unbroken period of detention and CTO.
CTO patients who are recalled to hospital or whose CTO has just been revoked

Medication can be administered under the following circumstances:

The SOAD certificate (CTO 11) includes the appropriate medication in the section for medication to be used on recall; or

CTO began less than 1 month ago; or

It is less than 3 months since medicine was first administered in this period of detention – Sec 58 (1b); or

A form T2 or T3 is put in place (as appropriate)

The treatment is immediately necessary - Sec 62 (as above)
Staff should be aware of the relevant sections of the Code of Practice – Mental Health Act 2005.

8. Development, Consultation and Approval

- This is a minor update on an approved policy taking into account changes in practice and feedback from doctors and NMP's relating to RT
- Consideration of the Use of Force Act policy and information for service users which has included significant consultation with those with lived experience of RP and RT
- Trauma informed care
- Head of Mental Health Legislation review the legal aspects of the policy
- Interim Resuscitation Lead for SHSC
- Medicines Optimisation Committee 11/07/2022

Review July 2024

Minor amendments June 2022
Included information on clonazepam to aid better prescribing
Added information relating to single dose prescribing on the EPMA system

Minor Amendments February 2021
Amendment in flow diagram, information on administration, further information on olanzapine and aripiprazole use within RT. Addition of Learning Disability (LD) section. Consultation with LD Pharmacist – Winola Chio, and Catriona Murray (Consultant Psychiatrist)

Minor amendments October 2020.
Amended flow chart. Additional information regards administration details, including not to administer via the lateral thigh and not through clothing.
Minor amendments May and June 2019

Notification of maximum dose of lorazepam as 4mg in 24 hours and administration above this should be in exceptional circumstances and rationale recorded in the patients' medical records.
Removal of zuclopenthixol acetate (Acuphase) information and signposting to Acuphase guidelines
Review of formatting and minor typographical errors
Maximum dose of IM haloperidol kept at 12mg due bioavailability as compared to oral therapy (Note BNF. Daily maximum dose is given parity with oral at 20mg in 24 hours)
Administration of flumazenil only by doctors competent to do so.

First updated draft generated Feb 2016
Chief Pharmacist Review – Minor amendment to reflect NICE guidance NG10
SHSC Pharmacists review

- recommended greater emphasis on the need for dose optimisation before switching treatments. (L Scott)
- S Kirby sought clarification of dosing for older adults and adolescents.

Submitted to Restricted interventions group for comment August 2016.

Older Adult Psychiatrists recommended lower initial doses of promethazine IM. Doses reduced to 12.5mg. Dr Atter requested clarification of the term "concern" re: monitoring. This was considered a subjective term. Policy updated – "concern" removed and clearer guidance added.

This policy has been updated in line with NICE clinical guidelines for the management of violence and aggression in mental health settings (2015) (NG10).
(https://www.nice.org.uk/guidance/ng10/resources/violence-and-aggression-shortterm-management-in-mental-health-health-and-community-settings-1837264712389)

Updated details

- Definition -Rapid tranquillisation 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.
- Oral medication (PRN) is an option to be used as part of strategies to de-escalate or prevent situations that may lead to violence.
- Flow chart – easy read/algorithm added.
- Links to Aggression and Violence: Respectful Response and Reduction Policy and Seclusion and Longer-Term Segregation added
- Moderate disturbance/aripiprazole IM removed.
- Duties – reference to KSF processes removed. Support through training added.
- Electronic incident report form and restraint form added.
- Physical health monitoring form added (post RT/restraint)
- Reference to physical health policy / Early warning score.
- Physical health monitoring – updated in line with NICE NG10 guidance. Process of checking physical health equipment every week
- Old Appendix E removed – IM midazolam removed.
- Treatment guidelines updated – Service user choice/advance statement or previous good outcome first line consideration. IM lorazepam as first option if service user unknown. IM Promethazine combined with IM haloperidol as alternative. IM haloperidol alone or in combination with IM lorazepam not first line consideration.
- Initial management of violence. Prescribe RT as a single dose, which should not be repeated until the outcome of the initial dose has been reviewed.
- Review of RT by Senior Doctor daily if RT continued.
- Medical Director details updated.

Verified by Medicines Management Committee on 9 September 2016.

31st Oct 2016 – Emphasis was added in the introduction section to capture the change of the definition for Rapid Tranquillisation within the policy (use of injectable medicines).
Broader definition of Rapid Tranquillisation added to include the use of medicines for the

purpose of de-escalation (Mental Health Act Code of Practice 2015). Added to definitions section.
Interim Chief Pharmacist details updated.

Added to general points (6.1)

- Preferred intramuscular injection site is usually the gluteal muscle.

9. Audit, monitoring and review

The prescribing and use of drugs for rapid tranquillisation (RT) is routinely monitored by Pharmacists working in individual teams (where available). Where pharmacists are not part of teams where rapid tranquillisation is used, these issues should be monitored through each team's governance framework.

The Trust wide weekly review of restrictive practice will include all incidents of RT reported through the Trust incident system. The Trust will participate in the POMH topic on RT (Topic 16a).

Monitoring Compliance Template

Minimum Requirement	Process for Monitoring	Responsible Individual/ group/ committee	Frequency of Monitoring	Review of Results process (e.g. who does this?)	Responsible Individual/group/ committee for action plan development	Responsible Individual/group/ committee for action plan monitoring and implementation
Duties	*Exception reporting through incident review plus individual appraisal process*	*Serious incidents reviewed as part of Trust SUI system. For individuals relevant line manager*	Ongoing	Incident Review Panel	In line with incident policy https://jarvis.shsc.nhs.uk/documents/incident-management-including-serious-incidents-policy-and-procedure-md-023-v6-dec-2021 for individuals line management responsibility	Governance group & line management for individuals
Prescribing guidelines for rapid tranquillisation	In addition to exception reporting through incident review (RT) is routinely monitored by Pharmacists working in individual teams (where available) as well as the wider MDT Where pharmacists are not part of teams where rapid tranquillisation is used, these issues should be monitored through each team's governance framework Audits including POMH high dose & combination as well as ad-hoc audits from staff	Prescribers responsible for prescribing in line with Trust policy for RT	Ongoing	Outcomes of ad hoc audits & POMH high dose & Combination presented to Medicines Optimisation Committee Weekly audits of RT produced by governance officer on ward and reviewed by Restrictive practices group; Tendable	Chief Pharmacist supported by pharmacy team. Clinical directors and Heads of Nursing	Directorates
How Observations are recorded including timeframes when service users have received rapid tranquillisation	In line with NICE guidance (violence) and NEWS2 tool. .	Risk dept	On receipt of monitoring form	Risk dept	Risk dept. with directorates	Directorates monitoring process
How the organisation trains staff in line with the training needs analysis	Attendance at pharmacy training events – Online training also available	Directorate line management structure to ensure attendance at training events	On-going – Post incident review also captures details of staff medicines related training	Expectation that training is covered as part of clinical supervision and post incident debrief.	Through directorates supported by directorate pharmacists and training dept.	Directorates supported by pharmacists and training dept.

The policy will be reviewed in March 2024 (i.e. before July 2024), unless any changes are made sooner in line with changes to national guidance.

10. Implementation plan

Implementation should be through directorate governance systems and supported by pharmacists in clinical teams where available.

Action / Task	Responsible Person	Deadline	Progress update
New policy to be uploaded onto the Intranet and Trust website.	Director of Corporate Governance	Within 5 working days of finalisation	
A communication will be issued to all staff via the Communication Digest immediately following publication.	Director of Corporate Governance	Within 5 working days of issue	
A communication will be sent to Education, Training and Development to review training provision.	Director of pharmacy services	Within 5 working days of issue	
Meds optimisation training and RT to cover key areas within policy	Chief Pharmacists and Heads of Nursing.	Within 10 working days of issue	

11. Dissemination, storage and archiving (Control)

The policy should be disseminated through the Trust clinical governance structures, supported where possible by pharmacists within clinical teams and if available the directorate lead pharmacists.

The policy will be available for all staff on the Trust Intranet via the Rapid Tranquillisation guidelines policy link and the Pharmacy site.

RT policy version 6.1 will be archived in Pharmacy.
Reference to the policy will be included in the Junior Doctor Induction process and mandatory RT training sessions.
Dissemination of the policy will be through the mandatory training sessions on pharmacological aspects of rapid tranquillisation and any relevant learning from incidents processes.

Version	Date on website (intranet and internet)	Date of "all SHSC staff" email	Any other promotion/ dissemination (include dates)
1.0	Oct 2006		
2.0	Dec 2008		
3.2	Feb 2010		
4.0	Sept 2012		
5.0	Nov 2016	Nov 2016 via Communications Digest	
6.0			
6.1	April 2021		
6.2	July 2022		
7	August 2023		

12. Training and other resource implications

All staff will be trained in accordance with the requirements as set out in the Trust's Training Needs Analysis.

- Before newly qualified nursing staff can administer medication for rapid tranquillisation they should receive training in Rapid Tranquillisation as part of their induction process and mandatory training
- All qualified nursing staff who administer medication for rapid tranquillisation should have regular appropriate training and should be updated no less frequently than every 3 years.
- It is the responsibility of the ward manager to ensure that staff have received the relevant training and are deemed competent in the Rapid Tranquillisation process.

All prescribers should have regular appropriate training if likely to prescribe medication for rapid tranquillisation. This training should be updated no less frequently than every 3 years.

The details of the policy will be included in the Junior Doctor Induction process and the training sessions on the pharmacological aspects of Rapid Tranquillisation.
The administration of flumazenil requires staff (doctors) to be competent to administer this drug through the IV route.

Not covered in this policy
Staff must be trained in how to assess and manage potential and actual violence, using de-escalation techniques, restraint, seclusion and rapid tranquillisation. Refer to:

- Use of Force Policy.
- Seclusion and Segregation policy
- Observations of inpatients policy
- Staff must be trained to use and maintain the techniques and equipment required to undertake cardiopulmonary resuscitation (refer to Resuscitation Policy).

13. Links to Other Policies, Standards (Associated Documents)

Use of Force policy
Practice Guidance for the Implementation of the Mental Capacity Act 2005
Mental Capacity Act Deprivation of Liberty Safeguards (DoLS)
Medicines Optimisation Policy

Mental Health Act (1983)
Resuscitation Policy
Incident Management (Including Serious Incidents) Policy and Procedure
Observation of Inpatients Policy
Physical Health Policy
Seclusion and segregation Policy

Any links to other policies/documents that become out of date or inoperative should be to the Chief Pharmacist.

In situations where access to a key document of reference is lost staff should contact SHSC Pharmacy, or their line manager for advice.

14. Contact Details

Title	Name	Phone	Email
Chief Pharmacist	Abiola Allinson	0114 271 8630	Abiola.allinson@shsc.nhs.uk

15. References

NICE: NG10 Violence and aggression: short-term management in mental health, health and community settings (May 2015)

British National Formulary (https://bnf.nice.org.uk/)

British National Formulary for Children (https://bnfc.nice.org.uk/)

PhVWP Assessment report - Antipsychotics and cerebrovascular accident (Sept 2005)

Antipsychotics- https://www.gov.uk/search/all?keywords=antipsychotics&order=relevance accessed June 2022

Joint BAP NAPICU evidence-based consensus guidelines for the clinical management of acute disturbance: De-escalation and rapid tranquillisation 2018 (https://www.bap.org.uk/pdfs/BAP_Guidelines-RapidTranquillisation.pdf)

Department of Health (2015) Mental Health Act 1983: Code of Practice. London; The Stationery Office). Available at: https://www.gov.uk/government/publications/code-of-practice-mental-health-act-1983. Last accessed in June 2022.

Appendix A

Equality Impact Assessment Process and Record for Written Policies

Stage 1 – **Relevance** - Is the policy potentially relevant to equality i.e. will this policy potentially impact on staff, patients or the public? This should be considered as part of the Case of Need for new policies.

NO – No further action is required – please sign and date the following statement. **I confirm that this policy does not impact on staff, patients or the public.**	***I confirm that this policy does not impact on staff, patients or the public.*** Name/Date: Abiola Allinson 04/07/23	**YES,** Go to **Stage 2**

Stage 2 Policy Screening and Drafting Policy - Public authorities are legally required to have 'due regard' to eliminating discrimination, advancing equal opportunity and fostering good relations in relation to people who share certain 'protected characteristics' and those that do not. The following table should be used to consider this and inform changes to the policy (indicate yes/no/ don't know and note reasons). Please see the SHSC Guidance and Flow Chart.

Stage 3 – **Policy Revision** - Make amendments to the policy or identify any remedial action required and record any action planned in the policy implementation plan section

SCREENING RECORD	Does any aspect of this policy or potentially discriminate against this group?	Can equality of opportunity for this group be improved through this policy or changes to this policy?	Can this policy be amended so that it works to enhance relations between people in this group and people not in this group?
Age	**No**	**n/a**	**n/a**
Disability	**No**	**n/a**	**n/a**
Gender Reassignment	**No**	**n/a**	**n/a**
Pregnancy and Maternity	**No**	**n/a**	**n/a**

Race	**No**	**n/a**	**n/a**
Religion or Belief	**No**	**n/a**	**n/a**
Sex	**No**	**n/a**	**n/a**
Sexual Orientation	**No**	**n/a**	**n/a**
Marriage or Civil Partnership	**No**		

Please delete as appropriate: - Policy Amended / Action Identified (see Implementation Plan) / no changes made.

Impact Assessment Completed by:
Name /Date Abiola Allinson 4/07/23

Appendix B

Review/New Policy Checklist

This checklist to be used as part of the development or review of a policy and presented to the Policy Governance Group (PGG) with the revised policy.

		Tick to confirm
	Engagement	
1.	Is the Executive Lead sighted on the development/review of the policy?	Y
2.	Is the local Policy Champion member sighted on the development/review of the policy?	Y
	Development and Consultation	
3.	If the policy is a new policy, has the development of the policy been approved through the Case for Need approval process?	N
4.	Is there evidence of consultation with all relevant services, partners and other relevant bodies?	Y
5.	Has the policy been discussed and agreed by the local governance groups?	Y
6.	Have any relevant recommendations from Internal Audit or other relevant bodies been taken into account in preparing the policy?	N/A
	Template Compliance	
7.	Has the version control/storage section been updated?	Y
8.	Is the policy title clear and unambiguous?	Y
9.	Is the policy in Arial font 12?	Y
10.	Have page numbers been inserted?	Y
11.	Has the policy been quality checked for spelling errors, links, accuracy?	Y
	Policy Content	
12.	Is the purpose of the policy clear?	Y
13.	Does the policy comply with requirements of the CQC or other relevant bodies? (where appropriate)	Y
14.	Does the policy reflect changes as a result of lessons identified from incidents, complaints, near misses, etc?	N/A
15.	Where appropriate, does the policy contain a list of definitions of terms used?	Y
16.	Does the policy include any references to other associated policies and key documents?	Y
17.	Has the EIA Form been completed (Appendix 1)?	N
	Dissemination, Implementation, Review and Audit Compliance	
18.	Does the dissemination plan identify how the policy will be implemented?	Y
19.	Does the dissemination plan include the necessary training/support to ensure compliance?	Y
20.	Is there a plan to i. review ii. audit compliance with the document?	 Y Y
21.	Is the review date identified, and is it appropriate and justifiable?	Y

Appendix C

For physical health monitoring:
All physical health monitoring observations should be recorded on the Trust agreed early warning scoring tool (NEWS2) available on the wards and in the physical health policy. Monitoring information for fluids should be completed on paper diet and fluid monitoring charts and the completed forms uploaded on to the EPR.