

Rapid Tranquillisation (RT) Policy

(Including prescribing, post administration monitoring and remedial measures)

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1 Introduction

The Trust recognises the importance of good practice in preventing and managing aggressive, violent and potentially violent incidents. These can be referred to as a range of behaviours or actions that can result in harm, hurt or injury to self or another person or persons. Individuals with behaviours that challenge should be identified, risk assessed and have an up-to-date and regularly reviewed intervention plan. This will stipulate pro-active and de-escalation techniques that should be utilised to try and prevent the escalation cycle. This can include the pro-active use of oral “as required” (PRN) medication that has been prescribed for the patient.

It is recognised though that severe behavioural disturbance will sometimes occur despite all attempts to prevent it. At these times it may become necessary to use pharmacological interventions alongside physical restraint to maintain the safety and physical health of a patient or others.

In the management of severe behavioural disturbance the administration of medicines using the parenteral route (usually intramuscular), under restraint when necessary, is termed Rapid Tranquillisation (RT).

Rapid tranquillisation should only be used where a patient is highly aroused, agitated, overactive or aggressive, or is making serious threats or gestures towards themselves or others, or is being destructive to their surroundings, when other therapeutic interventions have been ineffective in supporting a reduction in such behaviour.



This policy should be read in conjunction with the [Person Centred Behaviour Support Policy](#).

2 Why we need this policy

2.1 Purpose

The purpose of this policy is to:

- Ensure a standard approach to care, based on the best available evidence;
- Minimise risk related to the use of rapid tranquillisation (RT);
- Advise on best practice in prescribing and administration of medication for RT;
- Provide clarity in relation to staff role and responsibilities;
- Comply with CQC and NHSLA standards, and national (NICE) recommendations

2.2 Objectives

- To ensure good practice in managing aggressive, violent and potentially violent incidents in order to minimise the risk to staff, patients and others;
- To reduce suffering for the patient, to reduce risk of harm to others, to do no harm;
- To ensure all staff are aware of the advice around prescribing, administration and post-administration monitoring relating to the use of RT;

- To reduce the possibility of the patient suffering adverse effects from the administration of RT medication during restraint and heightened emotional disturbances;
- To define parameters for safe and effective use of medication and subsequent aftercare in line with both the:
 - [Procedure for Using the Early Warning Score for the Early Detection and Management of the Deteriorating Patient in CAMHS](#) (CLIN-0098)
 - [Procedure for Using the National Early Warning Score \(NEWS\) 2 for the Early Detection and Management of the Deteriorating Patient in Adults \(aged 16 and above\)](#) (CLIN-0099)

3 Scope

3.1 Who this policy applies to

- All healthcare staff working within in-patient settings where RT may be used

3.2 What is outside the scope of this policy

- The identification, risk assessment and development of intervention plans for patients with behaviours that challenge (this is covered in the [Person-centred Behaviour Support Policy](#))

3.3 Roles and responsibilities

Role	Responsibility
Chief Pharmacist	<ul style="list-style-type: none"> • To ensure the implementation of this policy is monitored and appropriate mandatory training is developed and accessed by relevant staff within their areas of responsibility.
Deputy Chief Pharmacist	<ul style="list-style-type: none"> • To monitor and audit the safe and appropriate usage of medication for rapid tranquillisation
Directors of Operations, Clinical Directors and Associate Clinical Directors	<ul style="list-style-type: none"> • To ensure that managers and Trust staff working in services who use RT are aware of the policy and promote good practice; • To ensure staff attend relevant training as identified within the Staff Development Policy; • To provide support and guidance regarding resources and the consistent application of the policy and future practice recommendations; • To ensure that safe systems are in place to enable medical and nursing staff to work in accordance with the procedures referred to in the policy.
Medicine Management Nurses	<ul style="list-style-type: none"> • To ensure competency based training and assessment packages are developed and available to nursing staff and

	<p>adherence to training is monitored via the Trust Training information system.</p>
Medical staff	<ul style="list-style-type: none"> • To ensure they are familiar with the policy and supporting Trust prescribing guidelines and be responsible for adhering to the procedures referred to in the policy; • To undertake appropriate mandatory training (Royal College of Psychiatry or Trust); • To take responsibility for adhering to the service specific prescribing recommendations in this policy and actions needed in the event of an adverse incident or suspected adverse drug reaction. • To refer to the current Trust guidelines and the electronic British National Formulary (BNF) to check recommended drugs and dosages; • To be aware of their responsibility in relation to first response and the use of remedial measures.
Nursing staff	<ul style="list-style-type: none"> • To ensure they are familiar with the policy and be responsible for adhering to the procedures referred to in the policy; • To ensure mandatory training is undertaken; • To provide support and information to patients, carers and their families with regards to the use of RT; • To adhere to the Trust Medicines Overarching Framework and the Professional Standards for Administration of Medicines in Healthcare Settings; • To ensure they are competent in all the clinical procedures required to implement this policy including first response training and appropriate use of equipment; • To monitor vital signs after the use of RT using the age-appropriate documents: EWS for all persons under the age of 16 and the new National Early Warning Score 2 (NEWS2) guidelines for all persons aged 16 years and over; • To ensure maintenance and monitoring of practice standards and equipment is carried out as recommended.
Clinical pharmacy staff	<ul style="list-style-type: none"> • To ensure medicines for RT are prescribed accurately, unambiguously and comply with legal requirements and good practice standards; • To ensure medicines for RT and medicines to treat adverse effects are available on wards; • To check if patients prescribed RT have received, or may potentially receive “high dose” antipsychotic therapy; • To check if medicines prescribed for RT interact with any regular medication the patient is taking
Heads of Service and Locality Managers	<ul style="list-style-type: none"> • To implement the policy across their areas of responsibility and monitor the competence of nursing staff in applying the procedures referred to in the policy.
Ward/Unit Managers and the nurse in charge of a shift	<ul style="list-style-type: none"> • To ensure the policy and related procedures are adhered to during their span of duty.

- To check that required monitoring is being done following administration of RT.

4 Policy

4.1 What is Rapid Tranquillisation (RT)?

- RT is a **reactive management strategy** and often involves physical intervention.
- RT is the parenteral (intramuscular) administration of medication to calm or sedate an agitated, violent or aggressive patient as quickly as is safely possible; **not** to treat the individual's underlying condition.
- The highly aroused condition of the patient during RT may intensify the effects of medication. The patient's physical health must be monitored after administration, see the [relevant section below](#).



Staff must be aware of the symptoms of respiratory depression, dystonia or cardiovascular compromise and if the patient shows signs of deterioration the Trust [Resuscitation Policy](#) must be followed.

4.2 What is not RT

- Pro-active administration of prescribed oral "as required" (PRN) medication as an intervention within the patient's care plan to **prevent** a violent or aggressive incident;
- Pro-active restraint and administration of intramuscular medication which is documented in a care plan to enable administration of feeds. Specific details should be within the intervention plan and adhere to local requirements (N.B. post-administration monitoring of physical health is still required in this situation)

4.3 Legal considerations



Prior to administering medication for RT, it is essential that the clinician is clear under what legal authority the treatment will be administered. The Mental Health Act and Mental Capacity Act status of the patient must be considered before medication is administered for RT.

4.3.1 Informal patients

Rapid tranquillisation must not be used to treat an informal patient who has the capacity to refuse treatment and who has done so - Code of Practice para 26.99.

RT can be administered to informal patients if they are assessed as having the necessary capacity to consent to it and have, in fact, provided a valid consent. Otherwise legal authority may be provided as follows:

- If they have been assessed as having capacity to consent or refuse treatment and RT is refused, consideration should be given as to whether the criteria for detention under the Mental Health Act are met. Until the Mental Health Act is in place, RT cannot be administered to the capable refusing patient.

- If they are assessed as lacking capacity to consent but are compliant with receiving the treatment then the treatment may be given under the authority of section 5 of the Mental Capacity Act provided the treatment is determined as being in the patient's best interests and there is no refusal in the form of an Advance Decision or an LPA or Deputy. This assessment of capacity and determination of best interests must be clearly documented in the electronic patient record using MCA1 and MCA2
- If the patient is assessed as lacking capacity to refuse or consent to RT and is non-compliant with receiving it, i.e. is objecting to RT either verbally or as indicated by their behaviour, then it is likely, other than in an acute emergency where it is a proportionate response to prevent harm to the person, that authorisation for treatment is beyond the scope of the MCA and consideration should be given as to whether the criteria for detention under the Mental Health Act are met.

4.3.2 Detained patients

If the patient is detained under the Mental Health Act then treatment for mental disorder, including RT, is authorised for patients to whom it applies by Part IV of the Act provided the requirements of Part IV are adhered to.

The MHA does not confer any powers of treatment for mental disorder, including RT, on patients subject to the short terms powers of Sections 4, 135, 136, 5(4), 5(2) or those subject to Section 35.

Where Part IV does apply:

- Treatment can be provided for mental disorder under s63, without the need for certification, provided it is given by or under the direction of the AC in charge of treatment, for up to 3 months from the date medication was first administered for mental disorder during that period of detention. During this time, a capacity assessment should be recorded on MCA1 and consent and capacity status recorded in the MHA case notes the first time that medication for MD is prescribed as per Code of Practice Para 24.41
- After the 3 month period above, treatment for mental disorder must either be certified on Form T2 (where the patient has capacity and consents to the treatment), or on Form T3 (where the patient lacks capacity to consent or refuses to consent)
- RT must be specified on either Form T2 or T3 for authority to administer treatment
- Where the Form T2 does not include RT, the RC may complete a new Form T2 to include RT if the patient has capacity and consents
- Where the Form T3 does not include RT or the patient subject to Form T2 does not have capacity or refuses to consent, then where the criteria are met the RC must use section 62 to authorise RT and complete the appropriate form. If this is likely to be a regular occurrence then the RC should arrange for a SOAD to visit.

The entry made into the patient's electronic care records (e.g. PARIS) should make it clear which authority was used at the time of RT.

Where appropriate, [advance decisions and requests](#) should be put into place to inform the care team of any treatment that a person may have refused in advance or what treatment an individual would prefer to receive and/or whom they wish to be consulted if they become incapacitated as a result of their mental disorder.

4.4 Physical intervention



- All staff likely to be using physical intervention in the clinical management of a disturbed patient **must be competent** as outlined in the [Safe use of Physical Restraint Techniques procedure](#)
- **Physical restraint should not be used for more than 10 minutes without considering RT or seclusion.** RT or seclusion may be used sooner than this if deemed clinically appropriate; conversely, physical restraint may continue without RT or seclusion if the event is resolving, but the need for RT or seclusion must be continuously reconsidered.
- Any restraint required to administer RT should be proportionate and necessary to prevent harm to the patient or others.

4.5 Training requirements

All staff potentially involved in the use of RT should comply with the following mandatory training requirements:

- Medical staff (in services for adults & older people) - RCPsych RT e-learning module
- Medical staff (in CYPS) – CAMHS RT module accessible via the RCPsych website
- Registered Nurses (RNs) – Trust RT e-learning module
- Nursing Associates (NAs) – Trust RT e-learning module
- Non registered practitioners (NRPs) – Trust RT e-learning module
- RNs and NRPs – service specific training in physiological observation and the use of EWS/NEWS2

4.6 Managing risk

Patients who have received RT must have an immediate clinical risk assessment to determine appropriate levels of observation. They will require enhanced physical observations during the period immediately following RT in line with [section 4.9](#) of this policy.



All instances of RT must be reported via the Datix reporting system (currently as part of a “physical intervention” incident) to allow regular monitoring and audit to improve patient safety.

Consideration should always be given to the longer-term risk of iatrogenic harm from using RT

4.7 Working with patients

If using RT for the management of disturbed/violent behaviour:

- Ensure that the patient’s dignity and privacy is maintained at all times.
- Explain the reasons for using the interventions at the earliest opportunity and at appropriate times throughout the process.
- Reassess their care plan and presentation and help them reintegrate at the earliest safe opportunity.
- Provide an opportunity to document their account as part of the debriefing process in line with the [Person-centred Behaviour Support Policy](#)
- Provide an opportunity for the patient to review their intervention plan with staff where appropriate.

4.8 Prescribing and administration of RT



Age group-specific algorithms are attached as appendices and should be referred to whenever considering the use of RT.



Sometimes it is necessary to admit a 16-18 year old onto an adult in-patient ward for care and treatment. In this situation, staff must be aware of the parameters appropriate to the use of rapid tranquilisation in this age group.



For frail older people on adult in-patient wards it may be clinically appropriate to follow the MHSOP algorithm



DO NOT prescribe medication for RT routinely on admission, in anticipation of an event. If an event is highly likely (e.g. admissions to PICU), a single dose may be prescribed in the “once only” section of the inpatient chart to allow nurses to manage the event initially in the absence of a doctor. A doctor MUST attend before a second dose is administered and if it is required, this must also be prescribed in the “once only” section.



RT may be prescribed “as required” for individual patients who have undergone a thorough psychiatric assessment prior to admission which has identified a high risk of disturbed behaviour likely to require restraint and intervention, for example:

- acutely unwell patients transferred from prisons for hospital treatment
- patients with organic mental illness admitted to hospital from their normal care environment

The rationale for “as required” prescribing on admission must be recorded in the electronic patient record

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, if possible, the duty nurse co-ordinator. All prescriptions of RT medication must be reviewed within 72 hours of admission, and regularly thereafter, and discontinued when appropriate to do so



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.



An episode of disturbed behaviour resulting in RT should be seen as an opportunity to review the patient’s regular and PRN medication to improve control of their condition and management of future episodes.

4.8.1 Prescribing considerations

The aim of RT is to achieve a state of calm sufficient to minimise the risk posed to the patient or to others. The prescriber must use medication for RT, particularly in the context of restraint, with caution because of the following risks:

- Loss of consciousness instead of sedation
- Over-sedation with loss of alertness
- Respiratory depression or arrest (loss of airway)
- Cardiovascular complications and collapse
- Seizures

- Adverse effects, for example, neuroleptic malignant syndrome
- Interactions with medication or other substances (prescribed or illicit)
- Underlying coincidental physical disorders, e.g. cardiovascular disease
- Possible damage to patient/clinician relationship
- Specific issues in relation to diagnosis, e.g. symptoms of delirium
- Need for physical restraint during administration
- Needle-stick injuries

General considerations

- Consider all medicines and other substances previously and/or recently taken when deciding to use RT – this includes medicines taken shortly prior to admission
- Clinicians may sometimes decide that use of medication outside the Summary of Product Characteristics (SPC) or BNF parameters is justified. This must be authorised by an ST4 doctor or above. This decision must not be taken lightly nor the risks underestimated. A risk-benefit analysis must be recorded in the case notes and a rationale in the care-plan. Under these circumstances, monitoring of the patient should be more frequent (for frequency see procedure for post administration monitoring), paying particular attention to regular checks of the airway, level of consciousness, pulse, blood pressure, respiratory effort, temperature and hydration.
- Prescribe IM doses of medicines for RT separately to any regular or as required oral doses of the same medicine and consider total amounts prescribed (including regular, as required, IM and oral) to ensure compliance with maximum daily doses.
- Sufficient time should be allowed for a clinical response between doses (see individual algorithms)
- Do not use two drugs of the same class for RT purposes.
- Be aware of any co-existing medical conditions, particular caution should be exercised during RT if these exist. Any respiratory condition should increase the level of concern and vigilance. Any cardiac problem, which may be related to congenital cardiac defects or known conduction problems, should also increase the level of caution during RT. Other known medical conditions may increase the risks during RT and include metabolic disorders, such as Addison's disease.
- Poorly controlled blood glucose levels in diabetic patients may be associated with additional risk when administering RT
- Most psychotropic drugs have the potential to lower blood pressure. In particular, patients on clozapine, quetiapine and olanzapine may be prone to postural hypotension due to alpha-adrenergic effects. Older drugs such as chlorpromazine and tricyclic anti-depressants may also be associated with hypotension. Benzodiazepines tend not to cause marked hypotension but may do when used in combination with antipsychotic drugs such as haloperidol.
- These drugs don't tend to cause hypertension unless the effects are secondary to either obesity, cardiac or renal problems
- Benzodiazepines may cause respiratory depression. This is normally mild unless the patient is concurrently given other psychotropic medication or has recently ingested alcohol or illicit drugs (e.g. opioids). Flumazenil is not available on wards to manage benzodiazepine-induced respiratory depression; emergency services must be called immediately if respiratory arrest occurs.
- It will not always be practicable to adhere rigidly to the prescribing guidelines, particularly with a patient whose needs (or distress) are difficult to manage. At the stage when the relevant algorithm has been followed and resolution is still not achieved, the prescriber

should be guided by his or her own clinical judgment on further pharmacological interventions

- Promethazine is not licensed for RT; please see the NICE evidence summary regarding its unlicensed/off label use in this indication:
<http://www.nice.org.uk/mpc/evidencesummariesunlicensedofflabelmedicines/ESUOM28.jsp>

Antipsychotics

- Baseline ECG monitoring is strongly recommended before prescribing and administering parenteral antipsychotics. If it is not possible to perform an ECG, the reason must be clearly documented in the electronic patient record.
- If a recent ECG has not been performed, consider and document the risks of using an antipsychotic against the potential benefit.
- If there is evidence of cardiovascular disease or a prolonged QTc-interval, avoid IM haloperidol combined with IM promethazine and use IM lorazepam instead.
- Antipsychotics can lower the seizure threshold so caution is advised with patients who have a history of or are at high risk of developing seizures.
- Caution in patients who have never received antipsychotics before. Procyclidine injection should be prescribed and available in case dystonia occurs including oculogyric crises. (Be aware of the symptoms of neuroleptic malignant syndrome [NMS] e.g. rigidity, fever, sweating, confusion, fluctuating consciousness, fluctuating blood pressure, tachycardia, elevated creatine kinase, leucocytosis, altered liver function tests).
- Zuclopenthixol acetate ('Acuphase®') should not be considered as an option for RT due to its delayed onset of action (2 hours), peak effect (12 hours) and prolonged effect (up to 72 hours). It can be considered as a proactive intervention when:
 - The patient is expected to be disturbed / violent over an extended time period;
 - There is documented evidence of repeated doses of RT drugs for violent / aggressive episodes;
 - There is documented evidence of a previous good / timely response;
 - It is cited in an advance directive

Consultant Psychiatrist approval is required before administering zuclopenthixol acetate (Acuphase®). Never give to a patient without previous antipsychotic exposure (antipsychotic naïve). Consult [Trust guidelines](#), and the electronic BNF / manufacturer's SPC for dosage information.

-  N.B oral and IM doses of psychotropics are not always equivalent. Care is needed to not exceed the maximum daily dose when prescribing/administering drugs via more than one route. Please refer to [POMH ready reckoner](#) for guidance on maximum doses. If actual or potential high dose antipsychotic therapy, refer to [HDAT guidelines](#)
-  Special caution should be given when prescribing for individuals who do or may have Dementia with Lewy bodies (DLB) or Parkinson's Disease Dementia.
Avoid use of anti-psychotics in Parkinson's Disease

Age-specific considerations

Elderly patients

- There are no national level consensus guidelines for the use of RT in older people. Physical health co-morbidities are more common and older patients are likely to be on medications in addition to psychiatric medication; hence the risk of drug interactions and side effects is higher.
- Cognitive disturbance is more common which is likely to be exacerbated by psychotropics

used for RT

- Prescribing antipsychotics in older people should consider the balance of risks and benefits in patients with dementia - antipsychotics are associated with a small increase in risk of mortality and increased risk of stroke or transient ischaemic attack.
- Promethazine has significant anticholinergic activity and has also been associated with QT prolongation, particularly relevant if co-administered with haloperidol. It has been shown to potentially precipitate delirium in physically unwell older people and therefore should be avoided in patients who have dementia or delirium.

Children and young people

- Zuclopenthixol acetate is NOT included in ANY form in the BNF for Children. Extreme caution should be exercised when using zuclopenthixol acetate in patients under 15 years of age as they may suffer from severe extra pyramidal side effects even at very low doses. Do not use a test dose greater than 25 mg in patients under 15 years old. Subsequent additional doses should not exceed 50-100 mg per dose.

Drugs / formulations not recommended and/or not suitable for RT

- Zuclopenthixol acetate (Clopixol Acuphase)
- Chlorpromazine (intramuscular is extremely painful and there is a severe risk of severe hypotension)
- Diazepam (to be avoided due to erratic and slow absorption)
- Depot / long-acting antipsychotic injections (slow onset of action and too long acting)

Record-keeping requirements

The risks and benefits of any prescription must be assessed by the prescriber on an individual basis and all prescribing must include a full assessment and history. If it is deemed appropriate to prescribe outside the recommendations specified in the treatment algorithms (appendices 1, 2 and 3), clear justification for doing so must be recorded in the care record with evidence of Consultant Psychiatrist's approval. This should include what has been prescribed and reasons for choice of treatment.

Prescribers must clearly document the indication if prescribing zuclopenthixol acetate for the management of severely disturbed patients.

4.8.2 Administration of medicines for RT

- Never mix two drugs in the same syringe.
- Adhere to requirements for lorazepam injection regarding storage (cold chain) and dilution, dependant on supplier/manufacturer.
- Use a site for IM administration which maintains patient dignity and reduces risk – lorazepam, haloperidol and promethazine may be administered into the deltoid, gluteal or lateral thigh muscle; aripiprazole may be administered into the deltoid or gluteal muscle.

4.9 Post-administration Monitoring



Please refer to:

- [Procedure for Using the Early Warning Score for the Early Detection and Management of the Deteriorating Patient in CAMHS \(CLIN-0098\)](#)
- [Procedure for Using the National Early Warning Score \(NEWS\) 2 for the Early Detection and Management of the Deteriorating Patient in Adults \(aged 16 and above\) \(CLIN-0099\)](#)

to access the relevant monitoring charts and other supporting information.

4.9.1 Age and other considerations

The NEWS should not be used in children (aged <16 years) or in women who are pregnant, because the physiological response to acute illness can be modified in children and by pregnancy. The NEWS may be unreliable in patients with spinal cord injury owing to functional disturbances – use with caution.

Within CAMHS, all children should be clinically assessed on admission by medical staff and a decision made regarding which chart should be used – either EWS (12- 15 years) or NEWS2 (16+) depending on physicality and BMI.

Consideration should be given to age, size and physical presentation with a baseline taken on admission to ensure any changes are noted immediately

4.9.2 EWS/New Early Warning Score 2 (NEWS2)

Both the EWS for under-16s and the NEWS2 for those aged 16 years and above are a combination of six physiological observations

- Respiration rate (R)
- Systolic blood pressure (BP)
- Pulse (P)
- Temperature (T)
- Conscious level (AVPU = alert, voice, pain, unresponsive)
- Oxygen saturations (Sats / SPO2)

Each of the observations generates a score which in turn generates an overall score and this can identify acute illness and shock.

Both scorecards are set to trigger when a patient has abnormal physiology apart from hypertension which is not a clinical emergency unless severe

4.9.3 Monitoring requirements

- Following the administration of RT physiological observations must be taken regularly to allow the monitoring of any physical deterioration. The observations must include temperature, pulse, blood pressure, respiratory rate, oxygen saturation and responsiveness
- It is particularly important to undertake frequent and intensive monitoring of a sedated/non ambulatory patient.
- Observations should be taken every ten minutes for one hour then every hour for a further 3 hours; the scores for individual observations should be recorded, with a total at the end

of each column on the scorecard to identify actions required; these actions should be completed as directed

- If the patient's level of agitation and risk increase due to the regularity of the observations, the nurse may use their clinical judgment as to the frequency of observations following discussion with the prescriber; if so an entry should be made into the electronic records to evidence this
- The patient should continue to be observed for visual signs and symptoms of deterioration and respiration rates must be documented as a minimum
- If the patient refuses to have their physiological observations taken staff should document refusal on the post-RT record template ([appendix 5](#)) and continue to observe for signs and symptoms of deterioration; respiration rates should be recorded on the early warning score chart as a minimum
- When ceasing the monitoring of observations an entry should be made into the electronic records explaining the rationale for discontinuation
- At the end of the monitoring period, scores should be documented in the patient electronic record by pasting the completed Post RT record template ([appendix 5](#)) into a case note

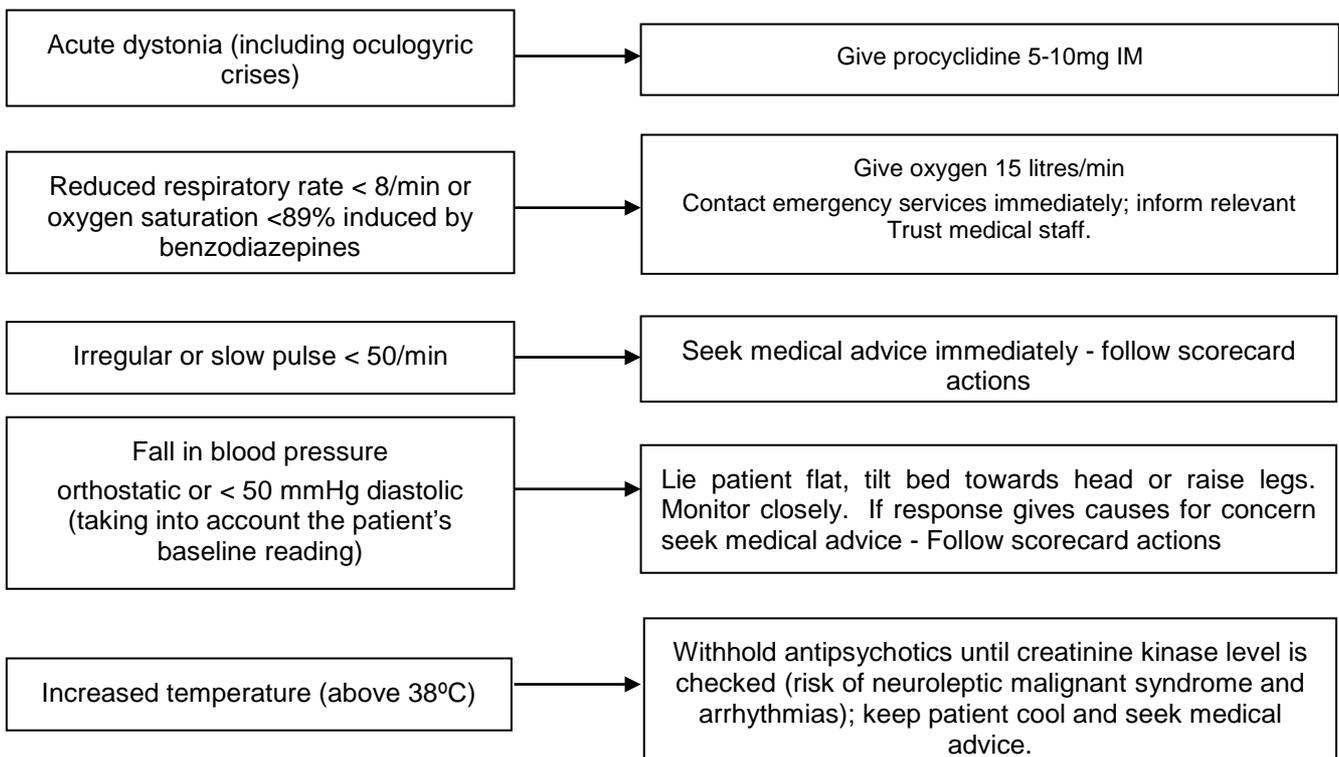
For ease of reference an aide memoir for post RT observations is attached as [appendix 4](#) to print and display.

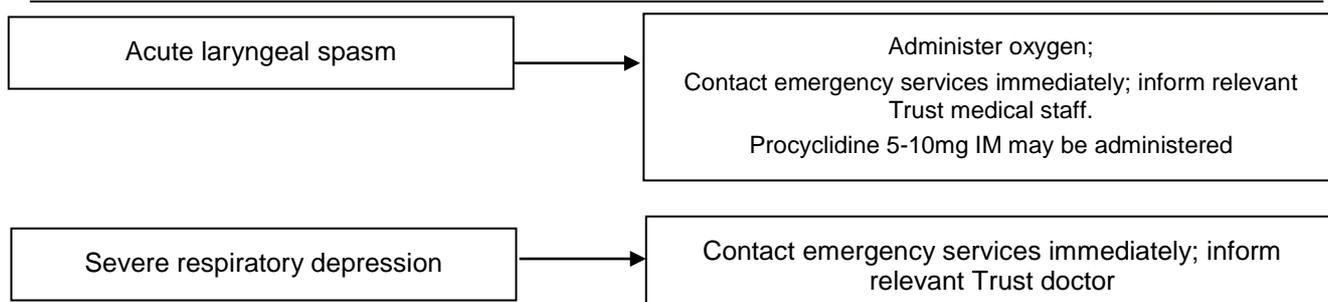
4.9.4 Remedial measures

ECG monitoring of QTc interval is strongly recommended before parenteral antipsychotics are given, especially when higher doses are used. Therefore, it is recommended that an ECG is performed on admission

Physiological observations should be taken as identified above; scores should be monitored and responses as per instructions on the early warning score chart

4.9.5 Interventions





5 Definitions

Term	Definition
Advance Decisions and Advance Requests	<ul style="list-style-type: none"> An Advance Decision is an advance refusal of specific medical treatment to be taken into account and adhered to when the person loses the necessary capacity to make the refusal contemporaneously as defined by the Mental Capacity Act 2005. An Advanced Decision relating to medical treatment for mental disorder may be overruled by Part IV of the Mental Health Act 1983. An Advance Request is a description of what a service user may like to happen in specific circumstances in the future if they lost the necessary capacity to make this clear at the time. Refer to the Code of Practice Mental Health Act 1983 (2008).
Aggression	<ul style="list-style-type: none"> This may be of a verbal nature or a physical act, whereby intentional behaviour leads to harm to the individual, to another person or to the damage of property.
GCS	<ul style="list-style-type: none"> Glasgow Coma Scale
IM	<ul style="list-style-type: none"> Administration of medicine by an intramuscular route – permissible by both nursing and medical staff in TEWV
IV	<ul style="list-style-type: none"> Administration of medicine by an intravenous route – only permissible by medical staff who consider themselves clinically competent
Antipsychotic naive	<ul style="list-style-type: none"> Never having been in receipt of antipsychotic medication
Neuroleptic malignant syndrome (NMS)	<ul style="list-style-type: none"> NMS is caused almost exclusively by the use of antipsychotic medication. Rapid and large increases in dosage, such as RT, can also trigger the development of NMS. Signs and symptoms include muscular rigidity, pyrexia and confusion; sometimes muscle tremors and a sore throat. If NMS occurs, it should be treated as a medical emergency.
Parenteral	<ul style="list-style-type: none"> Administration of medicine by an injectable route.
PRN	<ul style="list-style-type: none"> Pro re nata (PRN) is a Latin phrase meaning "for an unforeseen need or contingency" – in this context it refers to medicines prescribed to be taken "as required", rather than taken regularly
Rapid Tranquillisation	<ul style="list-style-type: none"> RT is the parenteral (intramuscular) administration of medication to calm or sedate an agitated, violent or aggressive patient as quickly as is safely possible; not to treat the individual's underlying condition. RT is a reactive management strategy using medicine to quickly calm an individual to reduce risk to self and/or others; it typically involves physical intervention.
SOAD	<ul style="list-style-type: none"> Second Opinion Appointed Doctor: This is a doctor appointed by the Care Quality Commission in order to review a detained or a

	community patient's treatment where this is required by the Mental Health Act
Violence	<ul style="list-style-type: none"> Any incident where staff, patients or others are abused, threatened or assaulted in circumstances related to their work, involving an explicit or implicit challenge to their safety, well-being or health.

6 Related documents

- [Person-centred Behaviour Support Policy](#)
- Code of Practice, Mental Health Act 1983, (2008)
- [Procedure for Using the Early Warning Score for the Early Detection and Management of the Deteriorating Patient in CAMHS](#) (CLIN-0098)
- [Procedure for Using the National Early Warning Score \(NEWS\) 2 for the Early Detection and Management of the Deteriorating Patient in Adults \(aged 16 and above\)](#) (CLIN-0099)

7 How this policy will be implemented

- This policy will be published on the Trust's intranet and external website.
- Line managers will disseminate this policy to all Trust employees working in in-patient services through a line management briefing.
- The Pharmacy Nursing Team will develop and deliver the mandatory training to nursing staff. The Medical Development Team will ensure appropriate training is accessible and completed by medical staff.
- Training requirements will be included in the Staff Development Policy.

8 How this policy will be audited

- Audit of the use of RT and adherence to parameters will be completed regularly, coordinated by the Trust Clinical Audit and Effectiveness Team in liaison with Service leads and the Pharmacy audit lead.
- Results will be analysed and reported through the Pharmacy audit group, Clinical Effectiveness Group and Drug & Therapeutics Committee
- Actions and recommendations from the audit will be agreed by the Pharmacy Audit Group and approved by the Drug and Therapeutics Committee.

9 Appendices

[Appendix 1 - Algorithm: Guidance for prescribing of RT in adult in-patient services](#)

[Appendix 2 - Algorithm: Guidance for prescribing of RT in C&YPS in-patient services](#)

[Appendix 3 - Algorithm: Guidance for prescribing of RT in MHSOP in-patient services](#)

[Appendix 4 - Aide memoir for post-administration monitoring](#)

[Appendix 5 - Post RT Paris recording template](#)

10 References

- NICE NG10: Violence and aggression: short-term management in mental health, health and community settings (2015)
- NICE NG11: Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges (2015)
- NICE CG178: Psychosis and schizophrenia in adults: treatment and management (2014)
- NICE CG155: Psychosis and schizophrenia in children and young people: recognition and management (2013)
- NICE CG136: Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services (2011)
- NICE ESUOM 28: Rapid tranquillisation in mental health settings: promethazine hydrochloride (2014)
- QS154 Violent and aggressive behaviours in people with mental health problems (2017)
- RCPsych Guidelines on the Short-term Management of Disturbed/Violent Behaviour in Psychiatric In-patient Settings and Emergency Departments (2005)
- RCN Restrictive physical intervention and therapeutic holding for children and young people – guidance for nursing staff (2010)
- Department of Health (2014) Positive and Proactive Care: Reducing the need for restrictive interventions
- Mental Health Act 1983: Code of Practice (2015)
- eBNF & eBNF for Children via [Medicines Complete](#)
- Maudsley Prescribing Guidelines 13th edition (2018)

11 Document control

Next review date:	28 August 2022	
This document replaces:	CLIN-0014-v8 Rapid Tranquillisation Policy	
Lead:	Name	Title
	Richard Morris	Deputy Chief Pharmacist
Members of working party:	Name	Title
	Linda Johnstone	Lead Nurse Medicines Management
	Stephen Davison	Lead Nurse Positive and Safe
	Ann Cranke	Clinical Pharmacist
	Gillian Bell	Clinical Pharmacist
	Ryan Brown	Clinical Audit Facilitator
This document has been agreed and accepted by: (Director)	Name	Title
	Ruth Hill	Chief Operating Officer
This document was approved by:	Name of committee/group	Date
	Drugs & Therapeutics	21 November 2019
This document was ratified by:	Name of committee/group	Date
	Executive Management Team	27 November 2019
An equality analysis was completed on this document on:	General pharmacy EA statement applies	

Change record

Version	Date	Amendment details	Status
7	7 Sep 2016	Reviewed and updated in response to NG10 Violence and aggression: short-term management in mental health, health and community settings (May 2015)	Superseded
7.1	15 Mar 2017	Minor amendment to footnote of Appendix 3	Superseded
7.2	25 Jan 2018	Minor changes to wording to clarify definition of RT in response to audit findings Revision of criteria for acceptable prescribing of RT on admission	Superseded
7.3	24 Jan 2019	Changes around the EWS / NEWS2 including prescriptive times around post RT monitoring and a post RT form to be used within PARIS case note to enable staff to capture all necessary info post RT	Superseded

		Changes to max dose of haloperidol in adult algorithm	
8	28 August 2019	Full review and update. Minor rewording to improve legibility and understanding. Monitoring section updated to reflect new Trust policies (EWS/NEWS)	Superseded
8.1	21 Nov 2019	Appendix.5 Post RT Recordings Template/Required Content for Electronic Patient Record was re-formatted to allow copying into patient record	Ratified

11.1 Appendix 1 – Algorithm: Guidance for prescribing of RT in adult in-patient services (including forensic services)

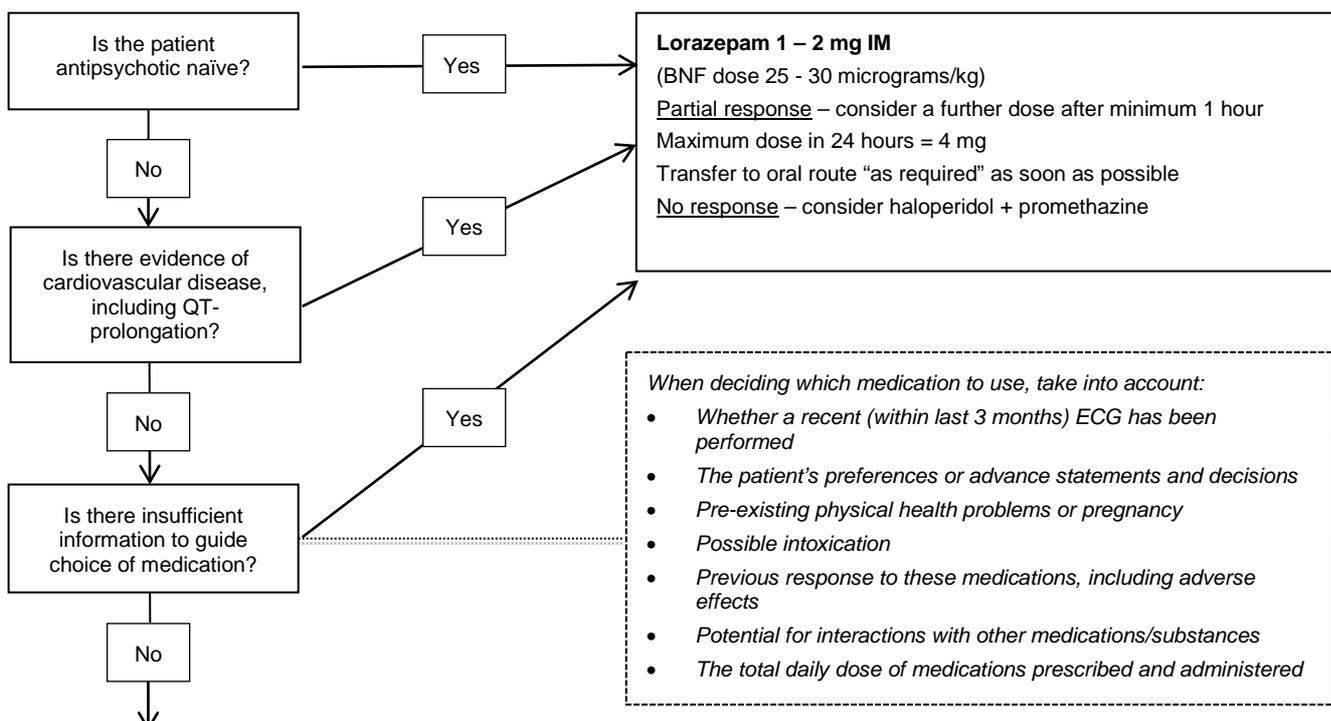
ADULT IN-PATIENT SERVICES INCLUDING FORENSIC SERVICES

This algorithm is for guidance only; consult the BNF for full prescribing information

Try non-drug measures ([Positive approaches to people whose behaviour is described as challenging](#)); exclude physical causes

Rapid Tranquillisation - only use if:

- oral route inappropriate, refused or failed as identified within [Positive approaches to people whose behaviour is described as challenging](#)
- oral route not indicated by previous clinical response
- immediate administration required after risk assessment and involvement of restraint



<p>Haloperidol 3 – 5 mg IM + Promethazine 25 – 50 mg IM</p> <p><u>Partial response</u> – consider a further dose after minimum 1 hour Recommended max.haloperidol dose / 24 hours = 15 mg (BNF max.= 20 mg) Maximum promethazine dose in 24 hours = 100 mg Transfer to oral route “as required” as soon as possible Procyclidine injection should be available to treat dystonic reactions <u>No response</u> – consider lorazepam, if not already used in this episode</p>	OR	<p>Lorazepam 1 - 2 mg IM</p> <p>(BNF dose 25-30 micrograms/kg)</p> <p><u>Partial response</u> – consider a further dose after minimum 1 hour Maximum dose in 24 hours = 4 mg Transfer to oral route “as required” as soon as possible <u>No response</u> – consider haloperidol + promethazine</p>
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Alternatives for IM administration - e.g. for patients who are resistant to lorazepam, or history of EPSEs with haloperidol:

- Promethazine monotherapy – 25 – 50 mg IM, maximum dose in 24 hours = 100 mg
- Aripiprazole - 5.25-15 mg (usual dose 9.75 mg), followed by 5.25-15 mg after 2 hours if required; maximum 3 doses / 30 mg in 24 hours

If at the point of administration of IM medication patient agrees to accept **oral** medication (this is NOT rapid tranquillisation):

<p>Lorazepam 1 – 2 mg ORALLY</p> <p>If partial / no response after 1 hour, administer another dose Maximum dose in 24 hours = 4 mg</p>	<p>If <u>not</u> antipsychotic-naïve, and no evidence of cardiovascular disease (and ECG done), consider giving an antipsychotic with lorazepam, e.g. haloperidol 3 – 5mg, olanzapine 2.5 – 5 mg, or risperidone 1 – 2 mg</p> <p>If partial / no response after 1 hour, administer another dose Maximum dose in 24 hours: Haloperidol = 20 mg, Olanzapine = 20 mg, Risperidone = 16 mg</p>
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11.2 Appendix 2 – Algorithm: Guidance for Prescribing of RT in C&YP Services (12-18 years)

CHILDREN AND YOUNG PEOPLES SERVICES 12-18 YEARS

N.B. Prescribing guidance may fall outside BNF for Children limits. Consideration **MUST** be given to the age and size of the child.

Try non-drug measures ([Positive approaches to people whose behaviour is described as challenging](#)); exclude physical causes

Rapid tranquillisation – only use if:

- oral route inappropriate, refused or failed as identified within [Positive approaches to people whose behaviour is described as challenging](#)
- oral route not indicated by previous clinical response
- immediate administration required after risk assessment and involvement of restraint

Non-psychotic context or unknown illness or antipsychotic-naïve	Known psychotic illness or regular antipsychotic prescribed or known history of antipsychotic use		
<p>Lorazepam 0.5 – 2 mg IM</p> <p><u>Partial response</u> – consider a further dose after minimum 1 hour</p> <p>Maximum dose in 24 hours = 4 mg (including any given orally)</p> <p>Transfer to oral route “as required” as soon as possible</p> <p>In LD consider IM antipsychotic if IM lorazepam previously failed</p>	<p>Lorazepam 0.5 – 2 mg IM</p> <p><u>Partial response</u> – consider a further dose after minimum 1 hour</p> <p>Maximum dose in 24 hours = 4 mg (including any given orally)</p> <p>Transfer to oral route “as required” as soon as possible</p>	PLUS if needed	<p>Haloperidol 1 – 2 mg IM</p> <p><u>Partial response</u> – consider a further dose after minimum 1 hour</p> <p>Maximum dose in 24 hours = 10 mg (including any given orally)</p> <p>Transfer to oral route “as required” as soon as possible</p> <p>If used, ensure procyclidine injection is prescribed and available to treat dystonia</p>

Alternative for IM administration - e.g. for patients who are resistant to lorazepam, or history of EPSEs with haloperidol:

- Promethazine – 10 – 20 mg IM; repeat after 1 hour if necessary; maximum dose in 24 hours = 50mg

If at the point of administration of IM medication patient agrees to accept **oral** medication (this is NOT rapid tranquillisation):

<p><u>ORALLY:</u></p> <p>Diazepam[§] 5 - 10 mg OR</p> <p>Lorazepam[§] * 500 micrograms - 2 mg OR</p> <p>Promethazine 10 - 25 mg</p> <p><u>Partial response</u> – administer a further dose after minimum 1 hour</p> <p>Maximum dose in 24 hours: Diazepam = 20mg Lorazepam = 4mg Promethazine = 50mg</p>	<p><u>ORALLY:</u></p> <p>Diazepam[§] 5 - 10 mg OR</p> <p>Lorazepam* 500 micrograms - 2 mg</p> <p><u>Partial response</u> – administer a further dose after minimum 1 hour</p> <p>Maximum dose in 24 hours: Diazepam = 20mg Lorazepam = 4mg</p>	PLUS	<p><u>ORALLY:</u></p> <p>Haloperidol** 1.5 – 5 mg</p> <p>Olanzapine 2.5 - 5 mg OR</p> <p>Risperidone 1 - 2 mg OR</p> <p><u>Partial response</u> – administer a further dose after minimum 1 hour</p> <p>Maximum dose in 24 hours: Haloperidol = 10 mg Olanzapine = 20 mg Risperidone = 16 mg (Dispersible tablets available for olanzapine & risperidone and liquid available for risperidone)</p>
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NOTES:

After RT vital signs should be monitored using the age-appropriate EWS chart/guidelines

§ Special caution must be exercised when using benzodiazepines where a history of substance misuse/dependence exists

* Lorazepam may be preferable in circumstances where both IM and oral administration are occurring frequently as it is easier to calculate the total dose of benzodiazepines given within a 24hour period.

** avoid unless previously given typical antipsychotics. ECG recommended prior to treatment in all patients.

Developed by Dr Paul Tiffin & Dr Jose Mediavilla
Reviewed July 2019

11.3 Appendix 3 – Algorithm: Guidance for Prescribing of RT in Mental Health Services for Older People

MHSOP SERVICES

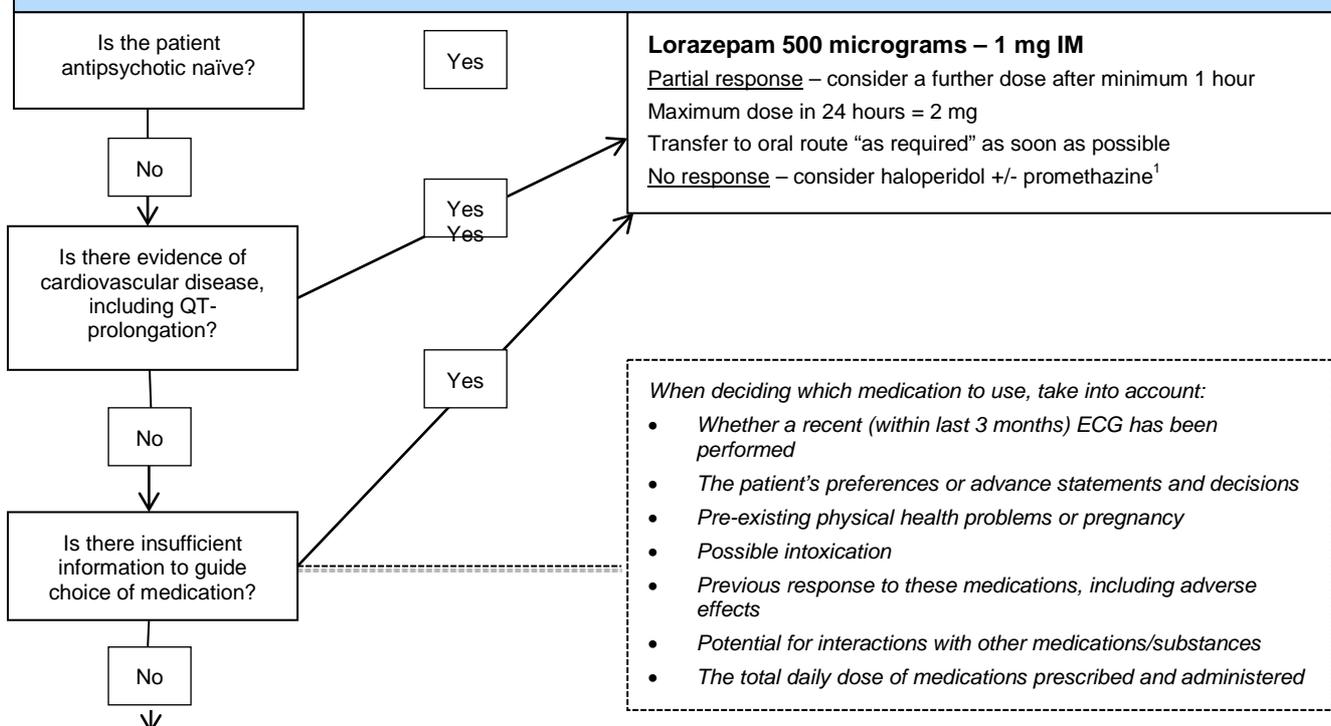
This algorithm is for guidance only; consult the BNF for full prescribing information

Try non-drug measures ([Positive approaches to people whose behaviour is described as challenging](#); [BPSD management algorithm](#))
For patients unknown, frail, or under the influence of alcohol or illicit substances use lower end of dose ranges. For known patients consider what has worked before.

Avoid use of antipsychotics if patient has dementia illness. Do NOT use antipsychotics for patients who are suspected of having Lewy body dementia or Parkinson's disease.

Rapid Tranquillisation - only use if:

- oral route inappropriate, refused or failed as identified within [Positive approaches to people whose behaviour is described as challenging](#)
- oral route not indicated by previous clinical response
- immediate administration required after risk assessment and involvement of restraint



When deciding which medication to use, take into account:

- Whether a recent (within last 3 months) ECG has been performed
- The patient's preferences or advance statements 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/substances
- The total daily dose of medications prescribed and administered

<p>Haloperidol 500 micrograms – 1 mg IM +/- Promethazine¹ 12.5 - 25 mg IM</p> <p><u>Partial response</u> – consider a further dose after minimum 1 hour Maximum haloperidol dose in 24 hours = 2 mg (only to be exceeded with consultant approval) Maximum promethazine dose in 24 hours = 50 mg Transfer to oral route “as required” as soon as possible Procyclidine injection should be available to treat dystonic reactions.</p> <p><u>No response</u> – consider lorazepam, if not already used in this episode</p>	OR	<p>Lorazepam 500 micrograms - 1 mg IM</p> <p><u>Partial response</u> – consider a further dose after minimum 1 hour Maximum dose in 24 hours = 2 mg Transfer to oral route “as required” as soon as possible</p> <p><u>No response</u> – consider haloperidol +/- promethazine¹ Non-psychotic context or unknown illness or antipsychotic naïve</p>
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Alternatives for IM administration - e.g. for patients who are resistant to lorazepam, or history of EPSEs with haloperidol:

- Promethazine¹ monotherapy – 12.5 – 25 mg IM, maximum dose in 24 hours = 50 mg
- Aripiprazole - 5.25 mg, followed by 5.25 mg after 2 hours if required; maximum 3 doses in 24 hours

1. Promethazine – may precipitate delirium; do not use in physically unwell patients; use with extreme caution in patients with dementia or delirium

If at the point of administration of IM medication patient agrees to accept **oral** medication (N.B. this is NOT rapid tranquillisation):

<p>Lorazepam 500 micrograms - 1 mg ORALLY</p> <p>If partial / no response after 1 hour, administer another dose</p> <p>BNF maximum dose in 24 hours = 2 mg (only to be exceeded with Consultant approval)</p>	<p>If <u>not</u> antipsychotic –naïve, and no evidence of cardiovascular disease (and ECG done), consider giving an antipsychotic with lorazepam, e.g. haloperidol 500 micrograms or risperidone 500 micrograms</p> <p>If partial / no response after 1 hour, administer another dose</p> <p>Maximum dose in 24 hours: Haloperidol = 5 mg, Risperidone = 4 mg</p>
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11.4 Appendix 4 – Aide memoir for post-administration monitoring

The following is a simple description of your responsibilities following administration of medication used for RT to ensure the patient is monitored appropriately and you fully adhere to Trust guidance. For specific details please refer to the individual protocols and algorithms for the service you work in.

The reason for recording and monitoring on EWS/NEWS2 is to ensure that any subtle deterioration will be noted and can be acted on in a timely way. Every recording of the physiological observations should be added up and acted on according to the total score by following the instructions on the scorecard. These total scores and responses should be documented in the electronic record at the end of the monitoring period

If the patient received intramuscular medication you must monitor and document observations directly onto the EWS/NEWS2 (i.e. take BP, pulse, temperature, respiration, oxygen saturation levels and CNS/levels of response) every 10 minutes for the first hour and then hourly for a further 3 hours. The results must also be recorded in the electronic patient record within a Physical Healthcare case note. If the patient continues to lie down, observations must continue every half hour until the patient gets up.

If a patient becomes more agitated by having these observations the registered nurse, in liaison with the doctor, may decide to reduce the frequency of observations. If this is agreed, a record of these discussions and assessments must be fully documented in the patient's electronic records to evidence why the EWS/NEWS2 has not been fully completed.

If a patient refuses to have their observations taken this must be documented comprehensively in the electronic records.

Irrespective of whether other physiological observations are completed, respiratory rates need to be monitored and documented on the scorecard at the frequency discussed above – these can be monitored from a distance.

Under no circumstances should 'patient sleeping' be recorded as grounds for not monitoring the physiological observations following RT; **you must monitor and document observations even if the patient is asleep.**

If RT is administered late at night the frequency of monitoring should be adhered to

You **must** document in the care records when you cease to record on EWS/NEWS2 and justify/give reasons why

11.5 Appendix 5: Post RT Recordings Template/Required Content for Electronic Patient Record

Patients name:
Rapid tranquilisations (RT) used:
Serial number of medication:
Site given:

Date of Incident:
Time physical intervention started:
Time physical intervention ended:
Total time physical intervention was used:

Description of Incident, including rationale for use of RT (i.e. was a PBS in place, what de-escalation was tried, patients current medication, patients physical health condition):

If patient restrained, name & position of staff:

Name	Position

Staff full name, base ward and designation:

Name of post RT physical observations lead:

Frequency post administration	10 min	20 min	30 min	40 min	50 min	60 min	120 min	180 min	240 min
Refused									
Pulse									
Respiration rate									
Temperature									
BP									
Oxygen Sats									
Level of Alertness									
Emergence of side effects									
NEWS Score									

Name of Reflection facilitator:
Names of staff debriefed:

All information recorded on this sheet must be recorded within the patients notes on **PARIS** and physical observations in the patients **NEWS** chart. Remember to complete a **DATIX**.

Rapid Reflection Tool - Patients

(Asked immediately following restrictive intervention)

Are you feeling ok and safe?

What can we do to help you feel safe?

Rapid Reflection Tool

(follow up debrief within 24 hours or as soon as possible)

Do you understand why staff needed to use restrictive interventions?

What could we have done to support you better?

Is there anything you would do differently next time?

Offer the opportunity to make a written account

Consider formulation a Positive Behavioural Support Plan (PBS) with patient if one is not already in place already

All information recorded on this sheet must be recorded within the patients notes on **PARIS** and physical observations in the patients **NEWS** chart. Remember to complete a **DATIX**.

Debrief following physical intervention and Rapid tranquilisation

The tool should take no longer than three minutes. All staff involved should take part in the rapid reflection (before returning to their base ward), with one member of staff acting as the reflection facilitator.

It is not a blame process; the outcomes should help lessons to be learnt so that the same incidents are not repeated.

Rapid Reflection Tool - Staff

- **Are we all ok and safe?**

Don't just focus on physical health; consider emotional needs of each other.

- **Is there anything we would do differently next time?**

Remember the thing you can control i.e. more knowledge of the patient, regular rotation of staff.

- **What went well?**

Remember to acknowledge the positive aspect of the support you have offered.

Remember three minutes is not long, do you need to plan a more formal debrief?

Rapid Reflection Tool - Patients

(Asked immediately following restrictive intervention)

- **Are you feeling ok and safe?**

Don't just focus on physical health; consider emotional needs of each other.

- **What can we do to help you feel safe?**

Do not dismiss the response and validate how they are feeling

Questions to be asked within 24 hours (or as soon as possible/appropriate)

- **Do you understand why staff needed to use restrictive interventions?**

This question potentially may lead to an emotional response. You will need to respond to the answer they give and offer reassurance. Do not move on until the patient is ready too.

- **What could we have done to support you better?**

What could staff have done to make you feel better, stop you getting so upset?

- **Is there anything you would do differently next time?**

This is trying to get the patient to think about what they did and to think about any coping strategies they have that they could have been used.

Consider formulating a Positive Behavioural support Plan (PBS) with the patient if one is not in place already

Offer the opportunity to make a written account

11.6 Appendix 6 - Equality Analysis Screening Form

Please note; The Equality Analysis Policy and Equality Analysis Guidance can be found on InTouch on the policies page

Name of Service area, Directorate/Department i.e. substance misuse, corporate, finance etc.	Pharmacy				
Name of responsible person and job title	Richard Morris Deputy Chief Pharmacist				
Name of working party, to include any other individuals, agencies or groups involved in this analysis					
Policy (document/service) name	Rapid Tranquillisation Policy				
Is the area being assessed a...	Policy/Strategy	x	Service/Business plan		Project
	Procedure/Guidance				Code of practice
	Other – Please state				
Geographical area covered	Trustwide				
Aims and objectives	<p>The purpose of this policy is to:</p> <ul style="list-style-type: none"> • Ensure a standard approach to care, based on the best available evidence; • Minimise risk related to the use of rapid tranquillisation (RT); • Advise on best practice in prescribing and administration of medication for RT; • Provide clarity in relation to staff role and responsibilities; • Comply with CQC and NHSLA standards, and national (NICE) recommendations <p><u>Objectives:</u></p> <ul style="list-style-type: none"> • To ensure good practice in managing aggressive, violent and potentially violent incidents in order to minimise the risk to staff, patients and others; • To reduce suffering for the patient, to reduce risk of harm to others, to do no harm; • To ensure all staff are aware of the advice around prescribing, administration and post- 				

	administration monitoring relating to the use of RT; <ul style="list-style-type: none"> • To reduce the possibility of the patient suffering adverse effects from the administration of RT medication during restraint and heightened emotional disturbances; • To define parameters for safe and effective use of medication and subsequent aftercare in line with both the: <ul style="list-style-type: none"> o Procedure for Using the Early Warning Score for the Early Detection and Management of the Deteriorating Patient in CAMHS (CLIN-0098) o Procedure for Using the National Early Warning Score (NEWS) 2 for the Early Detection and Management of the Deteriorating Patient in Adults (aged 16 and above) (CLIN-0099)
Start date of Equality Analysis Screening	6 th June 2019
End date of Equality Analysis Screening	27 th August 2019

You must contact the EDHR team if you identify a negative impact. Please ring Sarah Jay on 0191 3336267/3046

1. Who does the Policy, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan benefit?					
Patients – ensures the use of RT is safe and in line with national guidance (NICE)					
2. Will the Policy, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan impact negatively on any of the protected characteristic groups below?					
Race (including Gypsy and Traveller)	No	Disability (includes physical, learning, mental health, sensory and medical disabilities)	No	Sex (Men, women and gender neutral etc.)	No
Gender reassignment (Transgender and gender identity)	No	Sexual Orientation (Lesbian, Gay, Bisexual and Heterosexual etc.)	No	Age (includes, young people, older people – people of all	No

				ages)	
Religion or Belief (includes faith groups, atheism and philosophical belief's)	No	Pregnancy and Maternity (includes pregnancy, women who are breastfeeding and women on maternity leave)	No	Marriage and Civil Partnership (includes opposite and same sex couples who are married or civil partners)	No
<p>Yes – Please describe anticipated negative impact/s</p> <p>No – Please describe any positive impacts/s</p>					

<p>3. Have you considered other sources of information such as; legislation, codes of practice, best practice, nice guidelines, CQC reports or feedback etc.? If 'No', why not?</p>				Yes	x	No	
<p>Sources of Information:</p> <ul style="list-style-type: none"> • Audit findings • NICE guidance – NG10 • Incident reports • CQC reports • Internal consultation 							
<p>4. Have you engaged or consulted with service users, carers, staff and other stakeholders including people from the following protected groups?: Race, Disability, Gender, Gender reassignment (Trans), Sexual Orientation (LGB), Religion or Belief, Age, Pregnancy and Maternity or Marriage and Civil Partnership</p>							

Yes – Please describe the engagement and involvement that has taken place
There is a service user rep and a carer rep on the Drug & Therapeutics Committee.
No – Please describe future plans that you may have to engage and involve people from different groups

5. As part of this equality analysis have any training needs/service needs been identified?					
No	Please describe the identified training needs/service needs below				
A training need has been identified for;					
Trust staff	No	Service users	No	Contractors or other outside agencies	No
Make sure that you have checked the information and that you are comfortable that additional evidence can provided if you are required to do so					
The completed EA has been signed off by: You the Policy owner/manager: Type name: Richard Morris					Date: 27/8/2019

Your reporting (line) manager:

Type name: Christopher Williams

Date:

27/8/2019

If you need further advice or information on equality analysis, the EDHR team host surgeries to support you in this process, to book on and find out more please call: 0191 3336267/3046