

## Rapid Tranquilisation Policy Powys Teaching Health Board Mental Health Directorate

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The latest approved version of this document is online.  
If the review date has passed please contact the Author for advice.

### Version Control

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| 1              | Initial Issue                        | Nov 2019          |
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## ENGAGEMENT & CONSULTATION

### Key Individuals/Groups Involved in Developing this Document

| Role / Designation                            |
|---|
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| Interim Clinical Director Mental Health       |
| Interim Quality and Safety Lead Mental Health |

### Circulated to the following for Consultation

| Date     | Role / Designation                        |
|----------|---|
| 14/08/19 | Head of Pharmacy                          |
| 14/08/19 | Interim Clinical Director Mental Health   |
| 14/08/19 | Consultant Psychiatrists                  |
| 14/08/19 | Assistant Director Mental Health and LD   |
| 14/08/19 | Senior Service Managers                   |
| 14/08/19 | Ward Managers AMI/OAMH                    |
| 14/08/19 | Head of Nursing and Quality               |
| 14/08/19 | Nurse prescribers                         |
| 14/08/19 | Interim Operational Manager Mental Health |

### Evidence Base

**Please list any National Guidelines, Legislation or Health and Care Standards relating to this subject area?**

- NICE guidelines
- Mental Health Measure (2010) Wales
- Mental Health Act (1983)
- Mental Capacity Act (2010)
- All Wales Interim Policy & Procedures for the Protection of Vulnerable Adults (2014)
- NMC The Code for Nurses and Midwives - (NMC 2018)
- Consent to Treatment Policy (2015)
- GMC Standards – Good practice in prescribing and managing medicines and devices March (2013)
- The Human Medicines Regulations (2012)

## **Health and Care Standards**

### Theme 1 Staying healthy

1.1 Health promotion, protection and improvement

### Theme 2 Safe care

2.1 Managing risk and promoting health & safety

2.5 Nutrition and Hydration

2.6 Medicines management

2.7 Safeguarding children & adults at risk

2.9 Medical devices, equipment & diagnostic systems

### Theme 3 Effective care

3.1 Safe & clinically effective care

3.2 Communicating effectively

3.3 Quality improvement, research & innovation

3.4 Information governance & communications technology

3.5 Record keeping

### Theme 4 Dignified care

4.1 Dignified care

4.2 Patient information

### Theme 5 Timely care

5.1 Timely access

### Theme 6 Individual care

6.1 Planning care to promote independence

6.2 Peoples rights

6.3 Listening and Learning From Feedback

### Theme 7 Staff and resources

7.1 Workforce

## **Nursing and Midwifery Strategy**

Theme 1: Caring with humanity, dignity, kindness and compassion

Theme 2: Providing safe, effective, harm-free care.

Theme 3: Listening to patients and improving the way we work, securing a reputation for excellence.

Theme 5: Working with partners for the benefits of patients

## IMPACT ASSESSMENTS

| Equality Impact Assessment Summary   |           |         |              |          |  |
|--|-----------|---------|--------------|----------|--|
|  | No impact | Adverse | Differential | Positive | Statement  |
|  |           |         |              |          | <p>In situations where medication is given without consent, human rights will be covered under the Mental Health Act 1983 (revised 2016)</p> |
| <b>Age</b>   | *         |         |              |          |  |
| <b>Disability</b>  | *         |         |              |          |  |
| <b>Gender</b>  | *         |         |              |          |  |
| <b>Race</b>  | *         |         |              |          |  |
| <b>Religion/ Belief</b>  | *         |         |              |          |  |
| <b>Sexual Orientation</b>  | *         |         |              |          |  |
| <b>Welsh Language</b>  | *         |         |              |          |  |
| <b>Human Rights</b>  |           |         | *            |          |  |
| Risk Assessment Summary  |           |         |              |          |  |
| <p><b>Have you identified any risks arising from the implementation of this policy / procedure / written control document?</b></p> <p>No risks identified</p>  |           |         |              |          |  |
| <p><b>Have you identified any Information Governance issues arising from the implementation of this policy / procedure / written control document?</b></p> <p>No issues identified</p>   |           |         |              |          |  |
| <p><b>Have you identified any training and / or resource implications as a result of implementing this?</b></p> <p>All qualified ward staff will need to be aware of this policy and its contents. This policy has implications for staff to be trained in associated procedures such as Resuscitation</p> |           |         |              |          |  |

## **1. Policy Statement/Introduction**

Powys Teaching Health Board recognises that people with mental health problems admitted to our in-patient units need to have places where they can feel safe and comfortable and have privacy and dignity. It is important that the risk of violence or harm to any person is kept as low as possible. Rapid tranquillisation is when medicines are given to a person who is very agitated or displaying aggressive behaviour to help quickly calm them. This is to reduce any risk to themselves or others, and allow them to receive the care that they need.

## **2. Objective**

Before giving rapid tranquillisation, staff will try to calm the person without using medicines. If this does not work, rapid tranquillisation can be used as a last resort, because the risk to the person or others is too large unless they are given help to calm down. During and after rapid tranquillisation the person will be kept safe, treated with dignity and respect, and a member of staff will tell the person what is happening.

## **3. Definitions**

BLS – Basic Life Support  
BNF – British National Formulary  
CPR – Cardio Pulmonary Resuscitation  
HDAT - High Dose Anti-Psychotic Treatment  
ILS – Immediate Life Support  
IM – Intra muscular  
MDT – Multi Disciplinary Team  
MHA – Mental Health Act (1983 revised 2016)  
NMS – Neuroleptic Malignant Syndrome

## **4. Responsibilities**

### **4.1 Ward/team manager**

To ensure that:

There is a planned programme of training for clinical staff, to include Basic Life Support (BLS), Immediate Life Support (ILS) and managing violence and aggression

- Appropriate medical equipment available on the unit including to allow rapid tranquilisation to be delivered, to monitor the individual where rapid tranquilisation has been used, and to provide CPR in accordance with Powys Teaching Health Board Resuscitation Policy 2014 if required
- Appropriate medication for rapid tranquilisation and for the emergency management of side effects is available on the ward
- Whenever a clinical need for rapid tranquilisation is anticipated and a prescription written in advance, this is reflected in the patient's care and treatment plan and robust risk management and contingency planning is discussed, agreed and clearly recorded by the Multidisciplinary Team (MDT) in the patient's medical record.

- There is a system and procedures in place if CPR is needed in accordance with Powys Teaching Health Board Resuscitation Policy 2014
- Staff complete physical observations on patient following rapid tranquilisation and document as per policy
- All staff are familiar with signs and symptoms of neuroleptic malignant syndrome (NMS)

#### **4.2 All staff prescribing and/or administering rapid tranquilisation**

To ensure that:

- They are trained in the assessment and management of aggression and violence from service users who may present as being behaviourally disturbed and therefore pose a potential risk to themselves or others
- Staff with validated resuscitation skills who can access appropriate resuscitation equipment and support will be available to meet the requirements of this policy
- Consent to treatment has been checked
- Detained patients' certificates are updated with the additions made to inpatient medicines charts for the treatment if necessary
- Administer rapid tranquilisation as per agreed treatment plan (refer to Appendix A and Appendix B)
- Contact the pharmacist if there are any queries regarding prescription
- Medicines are available on the ward before rapid tranquilisation plan is implemented
- They work within own sphere of competency and request a second opinion as required

#### **4.3 Prescribers**

To ensure that:

- They are familiar with the properties of all psychotropic medications used in rapid tranquilisation, in order to individualise treatment
- Inpatient's prescriptions are individualised, not routine and include details of what medication to use for rapid tranquilisations, in what dose range, preferred injection site and with what frequency
- Should check responses to medication during previous episode of rapid tranquilisation where practicable
- Check medical records for advanced decisions
- Minimum time between doses and maximum doses to be administered in a specific time period must be stated
- Medication already prescribed should be taken into consideration
- Patients are to be monitored for effects and side effects and the prescription should be reviewed weekly in MDT and at any other prescribed medication change
- If rapid tranquilisation is utilised, the prescription should be reviewed daily by the doctor in charge

- Ensure consent to treatment has been checked. Any CO2 or CO3 are checked prior to prescription, and if necessary a Section 62 (MHA) 1983 written up prior to prescription and administration
- Ensure that treatment plan is drawn up, recorded in the patient's medical records and available to the multi-disciplinary team
- Must complete a High Dose Anti-Psychotic Treatment (HDAT) form if total prescribed dose of all antipsychotics, including rapid tranquilisation goes above British National Formulary (BNF) limits and document the rationale for using HDAT in the medical records and that monitoring is up to date

#### **4.4 Nurse in charge of unit at time of rapid tranquilisation**

To ensure that:

- Rapid tranquilisation is indicated, all other strategies to calm the patient having been exhausted
- The prescription is followed
- The patient has the appropriate physical observations completed
- Medical records including care plans are maintained
- Legal status is checked
- In the absence of a prescription the on call doctor is contacted and an assessment made as to the appropriateness of rapid tranquilisation, and a prescription is obtained if required
- That all staff have BLS, ILS competencies prior to rapid tranquilisation administration

#### **4.5 Nursing staff administering**

To ensure that:

- The prescription for oral or Intramuscular (IM) medication is followed
- Appropriate physical observations are carried out
- To update the patient's records to reflect the individual assessment, circumstances, and action taken
- To check consent to treatment documentation

#### **4.6 Ward Pharmacist**

To ensure that:

- Prescriptions are checked for potential adverse interactions
- HDAT forms are completed and monitoring is carried out
- Check CO2/CO3 forms are up to date
- Advise nurses and prescribers of medication options according to individual assessment and availability of the medication
- Keep staff up to date with supply issues and suitable alternatives if necessary
- Involved with audit, training and monitoring of the policy

#### **4.7 Decision to use rapid tranquilisation for a pregnant patient**

The decision to prescribe/utilise rapid tranquilisation for a pregnant patient will need to be individually assessed and managed according to the following criteria:

- The stage of the pregnancy
- Previous response to treatment
- A risk benefit analysis in the patient's given presentation using the most up to date information available <https://www.ukmi.nhs.uk>

When IM medication is indicated during restraint it should be given whilst the woman is in a semi recumbent position.

Where there has been an incident of restraint and or the patient complains of low back pain following restraint the duty doctor should be contacted to complete an assessment. Staff are also advised to consult other specialist advisors where appropriate.

#### **5. Monitoring Compliance, Audit & Review**

Powys Teaching Health Board Mental Health wards will audit compliance of this policy after 6 months. The policy will be reviewed three years after implementation or on earlier significant changes or recommendations on medicines used within this policy.

#### **6. References / Bibliography**

NICE guidelines. Violent and aggressive behaviours in people with mental health problems (June 2017)

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

The Human Medicines Regulations (2012)

Mental Health Measure (2010) Wales

Mental Health Act (1983)

Mental Capacity Act (2010)

All Wales Interim Policy & Procedures for the Protection of Vulnerable Adults (2014)

NMC The Code for Nurses and Midwives - (NMC 2018)

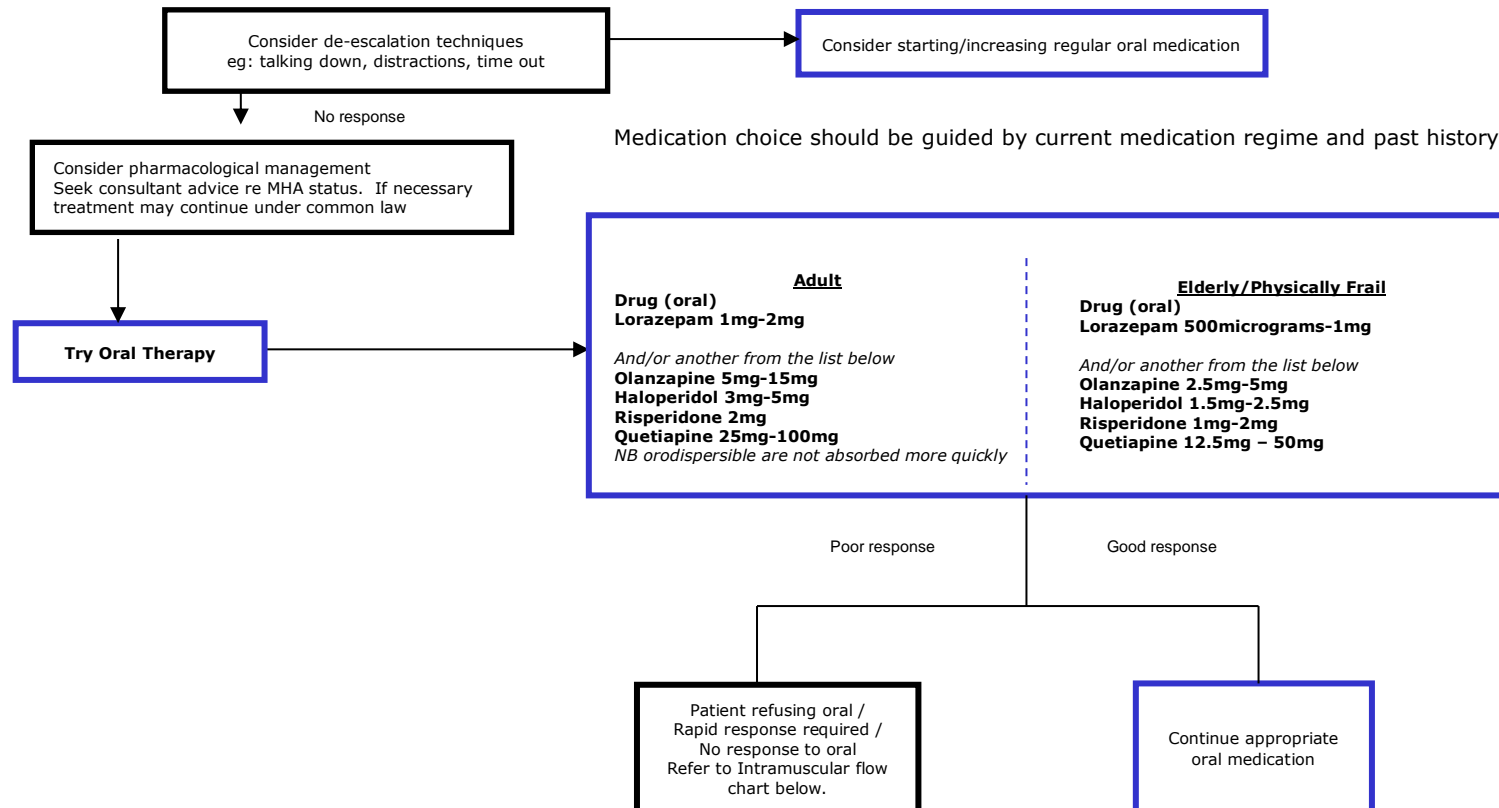
CDP 011 Consent to Treatment Policy (2015)

CDP 004 Resuscitation Policy (2014)

GMC Standards – Good practice in prescribing and managing medicines and devices (2013)

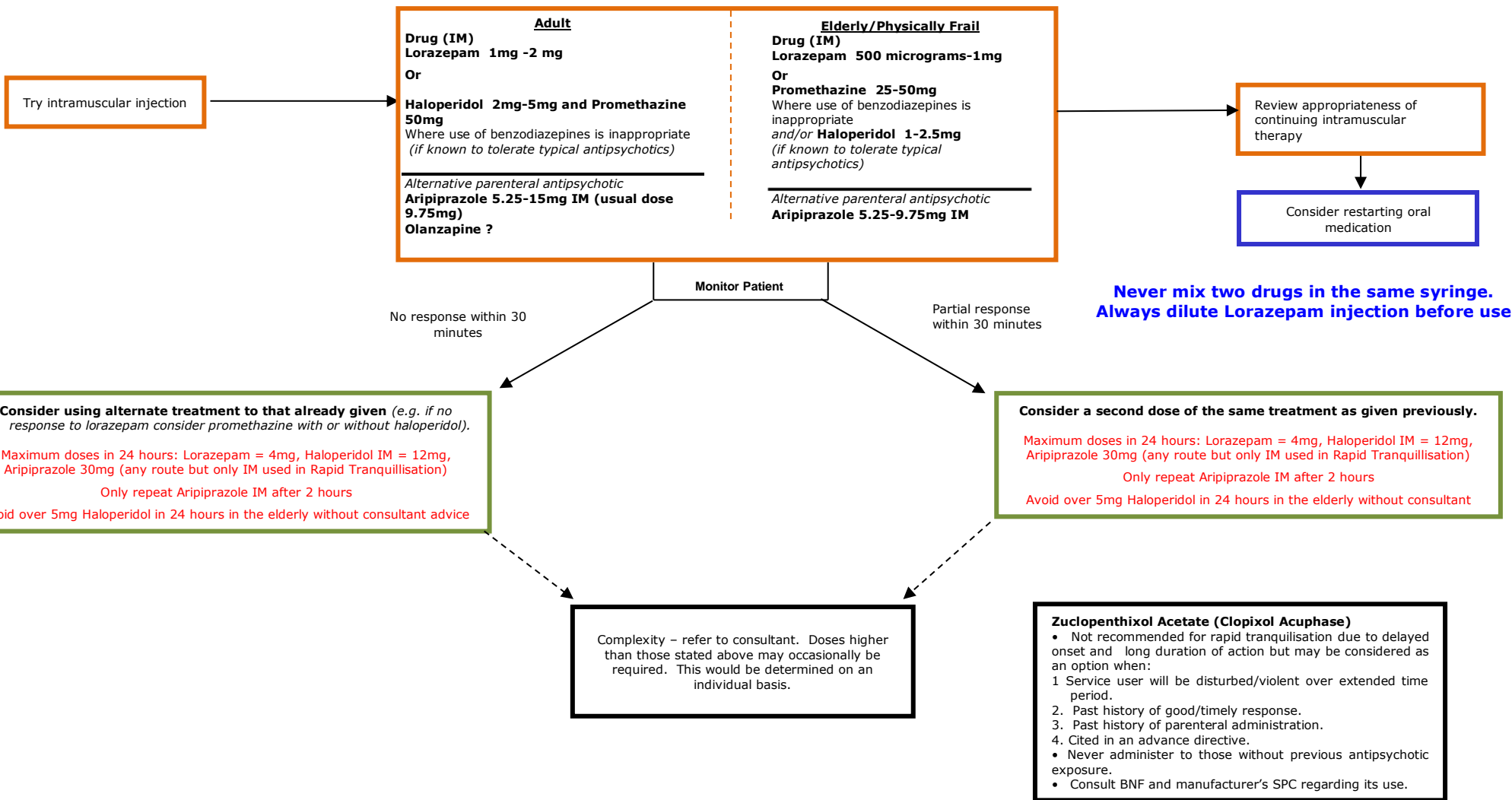
**Rapid Tranquillisation and Monitoring – Oral Medication**

Have access to Procyclidine injection for acute dystonic reactions and Flumazenil for Benzodiazepine induced respiratory depression.  
Have access to emergency resuscitation facilities



**Rapid Tranquillisation and Monitoring – Intramuscular**

Have access to Procyclidine injection for acute dystonic reactions and Flumazenil for Benzodiazepine induced respiratory depression.  
Have access to emergency resuscitation facilities



## Intramuscular (IM) Medication Guidance

| Medicine/Dose  | Route & Preparation            | Pharmacokinetics  | Major Side Effects/<br>Contraindications   | Practice Points   |
|--|--------------------------------|---|--|---|
| <p><b>Lorazepam</b></p> <p><b>Dose</b><br/>Adult 1 - 2mg<br/>Elderly 0.5 -1mg</p> <p><b>Max dose in 24 hours</b><br/>Adult 4mg<br/>(may be higher depending on weight)</p> <p>Elderly 2mg</p>                                      | <p>IM injection<br/>4mg/ml</p> | <p>Onset 20-40 mins<br/>Peak 60-90mins<br/>Half-life 12-16hrs</p> | <p>Respiratory depression</p> <p>Disinhibition<br/>(more likely to occur in those with organic brain disease, including learning difficulties, the under 18s and the over 65s and, perhaps, those with impulse control problems).</p> <p>Avoid in severe hepatic insufficiency</p> | <p>IM absorption is the same as oral absorption, but is more rapid in an active patient.</p> <p><b>The injection should be diluted 1:1 with water for injections or normal saline before administration.</b></p> <p>There is no accumulation of Lorazepam with repeated doses or in impaired liver function.</p> <p>Respiratory depression is readily reversed with the specific antagonist <b>Flumazenil</b>.</p>  |
| <p><b>Haloperidol</b></p> <p><b>IM Dose</b><br/>Adult 2-5mg<br/>Elderly 1-2.5mg</p> <p><b>Max dose in 24 hours</b><br/>IM 12mg<br/>(Oral 20mg)</p> <p>Avoid giving more than 5mg in elderly patients without consultant advice</p> | <p>IM Injection<br/>5mg/ml</p> | <p>IM<br/>Onset 20 mins<br/>Peak 1 hr<br/>Half life 20hrs</p>     | <p>EPSE, hypotension, NMS<br/>Increased QT interval<br/>Arrhythmias<br/>Seizures<br/>Sudden Death</p> <p>Avoid in clinically significant cardiac disorders.<br/>Avoid in Parkinson's disease</p>   | <p>Risk of acute dystonias. Routinely prescribe an antimuscarinic agent such as Procyclidine to use if EPSE develop.</p> <p>Bioavailability of IM and oral formulations differ. This must be taken into account when considering a total 24 hr dose: <b>5mg PO = 3mg IM</b></p> <p>Use SEPARATE LINES on the prescription sheet for each route of administration. .</p> <p>Baseline ECG recommended in all patients, especially the elderly and those with positive family or personal history of cardiac disease or abnormal findings on cardiac clinical examination.</p> |

## Appendix C

| Medicine/Dose  | Route & Preparation              | Pharmacokinetics  | Major Side Effects/<br>Contraindications   | Practice Points  |
|--|----------------------------------|---|--|--|
| <p><b>Aripiprazole</b></p> <p><b>IM Dose</b><br/>5.25mg to 15mg<br/>(usual initial dose<br/>9.75mg)</p> <p><b>Max dose in 24<br/>hours</b> 30mg by any<br/>route<br/><i>Oral not used for RT</i></p> | <p>IM injection<br/>7.5mg/ml</p> | <p>Onset 45mins-2hrs<br/>Peak 1-3hrs</p> <p>Half-life 75 - 146hrs</p> | <p>Not suitable in combination<br/>with other antipsychotics</p> <p>Not likely to cause sedation</p> <p>Orthostatic hypotension</p>  | <p>A second injection may be administered 2 hours after the<br/>first injection.</p> <p>No more than three injections should be given in a 24-<br/>hour period.</p> <p>Aripiprazole IM is licensed for control of agitation and<br/>disturbed behaviour in schizophrenia, but not specifically<br/>recommended by NICE</p>   |
| <p><b>Promethazine</b></p> <p><b>IM Dose</b><br/>25-50mg by deep IM<br/>injection</p> <p><b>Max dose in<br/>24hours</b><br/>100mg.</p>   | <p>IM injection<br/>25mg/ml</p>  | <p>Onset / Peak 1-2hrs<br/>Half-life 7-15hrs</p>                      | <p>Prolonged sedation<br/>Hypotension<br/>Arrhythmias<br/>Antimuscarinic effects</p> <p>Promethazine may lower the<br/>convulsive threshold – care in<br/>patients with epilepsy</p> | <p>Promethazine is recommended by NICE for management<br/>of violence &amp; aggression, but unlicensed for this indication.</p> <p>IM injection must be performed carefully to avoid<br/>inadvertent subcutaneous injection, which could lead to<br/>local necrosis</p> <p>Should be avoided in patients taking monoamine oxidase<br/>inhibitors up to 14 days previously.</p> |

***The following is not used routinely in rapid tranquilisation but has been used in specialist circumstances***

| <b>Medicine/Dose</b>  | <b>Route</b> | <b>Pharmacokinetics</b>   | <b>Major Side Effects</b>  | <b>Practice Points</b>  |
|---|--------------|---|--|---|
| <p><b>Zuclopenthixol Acetate</b></p> <p><b>IM Dose</b><br/>                     Adult 50- 150mg<br/>                     Elderly 50-100mg</p> <p><b>Max dose</b><br/>                     150mg as a single dose<br/>                     400mg over 14 days</p> <p><i>This is not an appropriate drug for use in rapid tranquilisation due to long duration of action.</i></p> | IM           | <p>Onset 2-8hrs<br/>                     Peak 24-36hrs</p> <p>Half-life 60hrs</p> <p>Can be repeated after 2 to 3 days</p> <p>Monitor for 48 hours after each injection</p> | <p>EPSE<br/>                     Sudden death<br/>                     Cardiac arrest<br/>                     Arrhythmias</p> | <p>Give by deep IM injection into the gluteal muscle, taking care not to give into a vein, as it can be fatal.</p> <p>It may occasionally be used as part of a medium term strategy.</p> <p>Never use in pregnancy, in those who are neuroleptic naïve, who are struggling, who are sensitive to EPSE, those with cardiac disease, hepatic or renal impairment.</p> |

Algorithm for prescribing and administration of rapid tranquilisation

Consider service user's preferences or advance statements, pre-existing medical conditions or pregnancy, possible intoxication, previous response to medications, including adverse effects, potential for interaction with other medication, total daily dose of medications prescribed and administered.



If there is evidence of cardiovascular disease, including prolonged QT interval, or no ECG has been carried out - avoid IM haloperidol combined with IM promethazine and use IM lorazepam instead



Where there is insufficient information to guide the choice of medication, or in patients who have not previously taken antipsychotic medication, consider use of lorazepam first line



Offer oral medications first line - avoid the prescribing of more than one antipsychotic where patients are taking regular antipsychotic medication



Consider the use of IM medications second line, if oral therapy is refused or failed, or not indicated by previous clinical response