Rapid Tranquilisation Guidance for Emergency Department and Observation Ward

To be used ONLY in the Emergency Department and Observation Ward by ED Doctors

Introduction

This is a summary guidance document based on the Avon and Wiltshire Mental Health Partnership Rapid Tranquilisation Policy and follows the principles of NICE Guidance CG25 – "Short Term Management of Disturbed/Violent Behaviour in Psychiatric In-Patient Settings and Emergency Departments, 2005". This has been updated in 2015 to NG10.

Rapid Tranquilisation, physical interventions and seclusion should **ONLY** be considered once de-escalation strategies have failed to calm the service user. The following factors should be taken into account and documented when determining which intervention to employ

- Clinical Need
- Safety of the Service User
- Safety of others
- Advance Decision

In addition the intervention must be **Reasonable and Proportionate** for the management of service users exhibiting disturbed or violent behaviour.

Rapid Tranquilisation aims to quickly calm a service user down and reduce the risk of further violence or harm to themselves or others **NOT** to treat underlying mental illness.

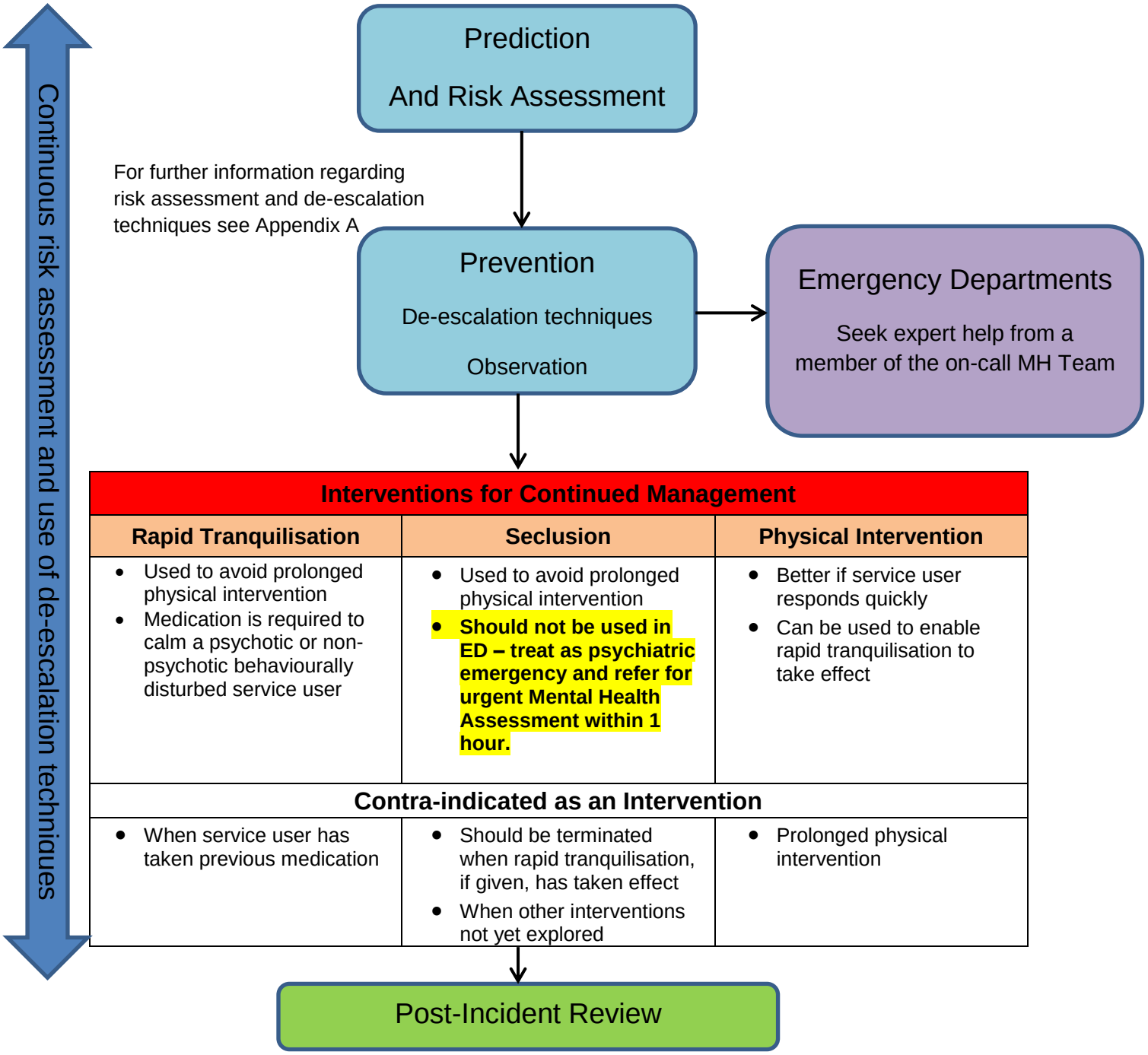
The aim is **NOT** to induce sleep or unconsciousness but to promote a calmer state to facilitate further assessment and/or treatment.

Rapid Tranquilisation must only be employed when it has been established that the risk of not doing so is greater that the risk of acute pharmacological treatment. There are serious adverse reactions associated with Rapid Tranquilisation especially in combination with biochemical changes present in aroused, anxious individuals, who may be dehydrated and not in best physical health

Decision to Use Rapid Tranquilisation

Should only be used when appropriate psychological and behavioural approaches have failed to de-escalate acutely disturbed behaviour. **It is a treatment of last resort.**

Management of disturbed and violent behaviour should follow the principles as stated in NICE Guidance NG10 as below.



Procedure for Rapid Tranquilisation in Adults

Pre-Rapid Tranquilisation

De-escalation Techniques

- Eliminate antagonising factors
- Move to safe, low-stimulus environment and oral medication offered

Clinician to undertake history/physical and mental state examination

- Working Diagnosis
- Physical state and past medical history – **cardiovascular disease esp. prolonged QTc**, epilepsy, alcohol/drug use, respiratory disease, diabetes and organic brain impairment
- Hepatitis and HIV serology
- Current medication and "as required" in last 24 hours
- Previous responses to medications, especially anti-psychotics
- Previous management when disturbed and previous tranquilisation

Rapid Tranquilisation

- A Control and Restraint Team should be assembled and the service user safely restrained in a secure environment
- Resuscitation equipment present and IV Flumazenil (200mcg IV then 100mcg prn up to maximum of 1mg) and Procyclidine (5-10mg IV/IM) readily available
- See below for detailed guidance regarding prescribing.

Post-Rapid Tranquilisation

- Clinician to complete physical examination and arrange basic investigations
- Nursing staff to record vital signs on NEWS Physical Observation Chart
- Vital signs and GCS every 15 mins for first hour then half-hourly until ambulatory
- If asleep or unconscious continuous use of pulse oximetry
- ECG monitoring and bloods strongly recommended if parenteral antipsychotics given
- **Adverse Effects**
    - Acute Dystonia – Procylidine 5-10mg IM
    - Reduced Respiratory Rate – O2, raise legs. If given benzodiazepine then Flumazenil 200mcg IV
    - Drop in BP – Lie flat, head down tilt on bed. IV fluid if persists
    - Raised temperature – withhold anti-psychotic, check CK urgently, Medical/ITU referral - ?Neuroleptic Malignant Syndrome

Prescribing Guidelines for Short Term Management of Acute Behavioural Disturbances in Adult Inpatient Settings

Checklist for All Steps

- Review notes and drug chart
- Physical examination: Assess:
  - Hydration
  - Blood Pressure
  - Pulse
  - Temperature
  - Abnormal movements
  - Evidence of intoxication/illicit drugs

Step 1: Non-pharmacological measures

De-escalation e.g. Amenable to talking down, providing privacy, time out and other techniques.. **See Appendix A**

(If responding do **not** proceed to Step 2).

Always: Check for advance directions from the service user;

Refer to current BNF and SPC for prescribing information or contact pharmacy for advice – contact details on pharmacy page

Step 2: Oral medication

Accepting if oral medication offered. (If responding do **not** proceed to Step 3).

Lorazepam 1mg to 2mg initially – repeat after 45 to 60 minutes usual max is 4mg in 24 hours

An oral antipsychotic is an option for those not already taking a regular oral or depot antipsychotic e.g. olanzapine 10mg or risperidone 1 to 2mg or *[1]haloperidol 2.5 to 5mg – repeat once after 2 hours if needed. Check ECG

Checklist for Step 2

Monitor temperature, pulse, blood pressure and respiratory rate after one hour and then at half hourly intervals until ambulatory, where possible.

- Access to procyclidine IM for acute dystonias

Step 3: Consider Short Acting IM medication

Refusing oral medication or if two doses fail (from step 2) or sooner if patient is placing themselves or others at risk.

Treatment options for IM route:

Lorazepam 1-2mg IM
***Promethazine 50mg IM**
IM promethazine is a useful option in a benzodiazepine-tolerant patient. .Max dose in 24 hours is 100mg – allow 1 to 2 hours after initial injection to assess response. Avoid IM benzodiazepines (e.g. lorazepam) within 1 hour of promethazine.
Haloperidol 5mg – incidence of acute dystonias is high; consider combining with IM promethazine or lorazepam and ensure IM procyclidine is at hand.
Pre-treatment ECG is advised

Review after 30 - 60 minutes . Observe recommended times between injections

Checklist for Step 3

Monitor temperature, pulse, blood pressure and respiratory rate every 15 minutes for the first hour and then at half hourly intervals until ambulatory.

- Access to oxygen or mechanical ventilation.
- Access to flumazenil IV and procyclidine IM.
- Ideally a recent ECG if high doses or haloperidol indicated.

Consider reduced doses in:

- Older people – See **Appendix B** for Treatment Guidance
- Patients with low body weight
- Patients with dehydration
- Patients with no previous exposure to antipsychotic medications.

Documentation and Reporting

Although rapid tranquilisation is not considered to be an incident in its own right, it is considered to be an intervention only undertaken in response to an incident. Therefore the incident prompting tranquilisation always needs reporting via the IR1 system.

There needs to be clear documentation in the medical notes of the patient regarding the details of the behaviour leading to rapid tranquilisation. In addition a clear indication of which strategies were employed to de-escalate the situation and the reasoning which led to the decision to rapidly tranquilise the patient. A risk assessment of the safety of this strategy should also be documented including the patient's previous medical history, physical examination as able and usual medications.

Appendix A

Predictors and Risk Assessement

Demographic or Personal History

- History of disturbed/violent behaviour
- History of misuse of drugs/alcohol
- Carers reporting previous anger or violent feelings
- Previous expression of intent to harm others
- Evidence of rootlessness or “social restlessness”
- Previous use of weapons
- Previous dangerous impulsive acts
- Denial of previous established dangerous acts
- Severity of previous acts

- Known personal trigger factors
- Verbal threat of violence
- Evidence of recent severe stress, particularly a loss event or threat of loss
- One or more of the above in combination with any of the following
    - Cruelty to animals
    - Reckless driving
    - Loss of a parent before the age of 8 years

Clinical Variables

- Misuse of substances and/or alcohol
- Drug effects
- Active symptoms of schizophrenia or mania in particular
    - Delusions or hallucinations focused on a particular person
    - Command hallucinations
    - Preoccupation with violent fantasy
    - Delusions of control
    - Agitation, excitement, overt hostility or suspiciousness

- Poor collaboration with suggested treatments
- Antisocial, explosive or impulsive personality traits or disorder
- Organic Dysfunction

Situational Variables

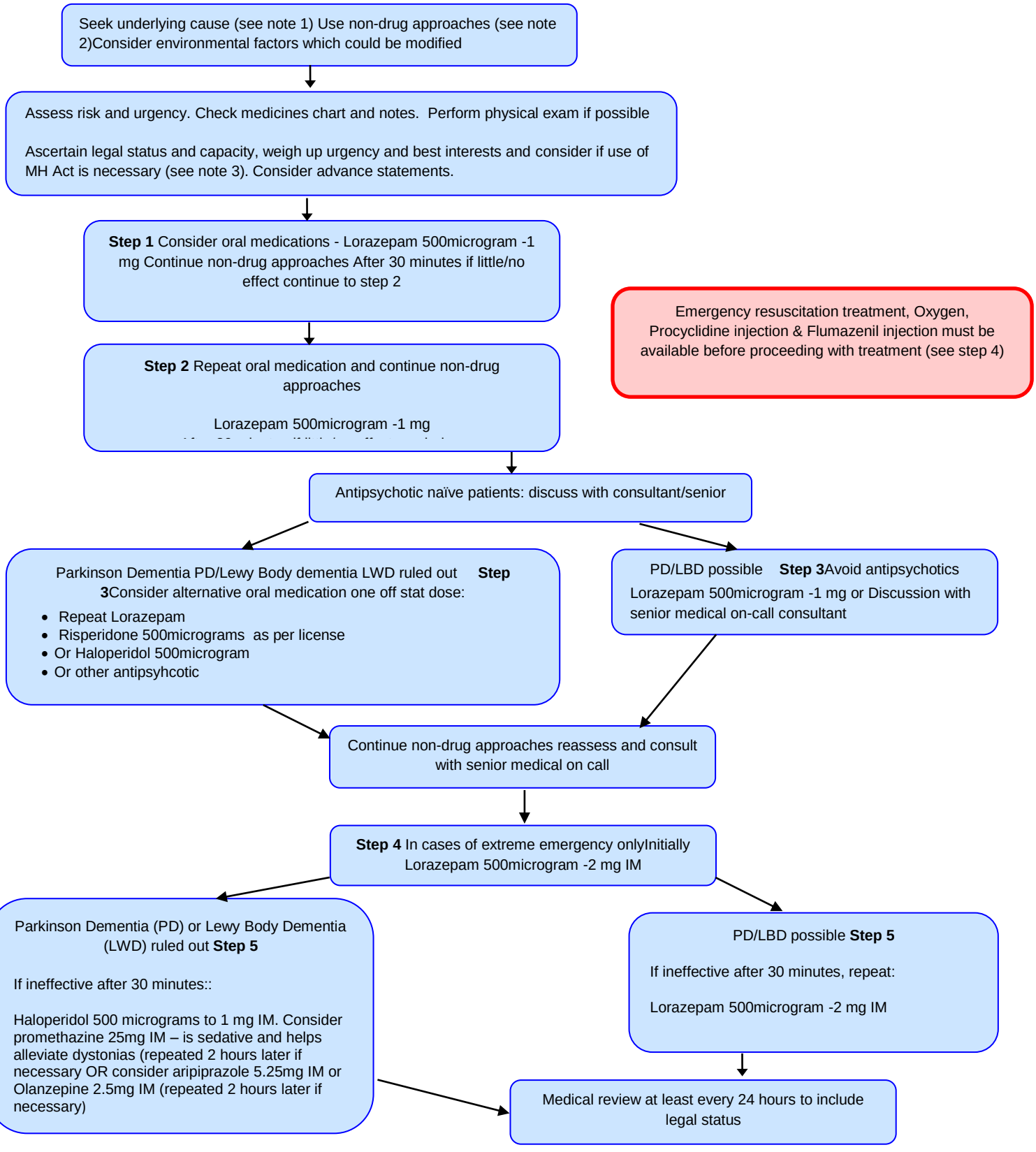
- Extent of social support
- Immediate availability of a weapon
- Relationship to potential victim

- Access to potential victim
- Limit setting
- Staff attitudes

De-escalation Strategies

- One person in control and leading the situation
- Managing others in the area
  - Moving other service users/staff away
  - Moving to as safe area
- Explain what you are doing
- Use brief and clear instructions
- Ask for facts and encourage reasoning
- Non-confrontational approach
- Show concern and attentiveness
- Use of open questions

Appendix B Guidance for Immediate Treatment of Aggression in Older Frail Patients



PD/LBD possible **Step 5**