Rapid Tranquillisation

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5	March 2021	Deputy Chief Pharmacist	Mental Health Medicines Sub group & Medicines Management Group	Discussed in March meeting Section 8 – training updated and signed of my chairs approval

With acknowledgement to Southern Health & Sussex Partnership Rapid Tranquillisation guidelines.

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1. Definition

NICE defines the risks of rapid tranquillisation and the management of these risks in Clinical Guideline NG10, May 2015 'Violence and Aggression: short-term management in mental health, health and community settings'.

Rapid tranquilisation is the use of medication by the parenteral route (usually intramuscular or, exceptionally, intravenous) if oral medication is not possible or appropriate and urgent sedation with medication is needed.' (NICE NG10 May 2015)

2. Introduction

Rapid tranquilisation should only be considered when all attempts at de-escalation have been exhausted. There should be a graduated response to the administration of rapid tranquilisation and physical intervention, and this should not be regarded as a primary treatment technique.

The intervention selected must be a reasonable and proportionate response to the risk posed by the patient at that particular time. Where appropriate, IM medications are able to be administered through clothing via the vastus lateralis site and rectus femoris (thigh sites), enabling least restrictive physical interventions. Clinical need, the safety of patients and others and, where possible, any advance directives should be taken into account.

The aim of rapid tranquilisation is to achieve a state of calm sufficient to minimise the risk posed to themselves and others. The patient should be able to respond to communication throughout the period of rapid tranquilisation.

The use of rapid tranquilisation is a high risk practice which has to be well managed in order to avoid unnecessary harm.

This guideline defines the process for managing these risks by ensuring that staff are aware of:

- Training requirements
- Safe prescribing guidelines
- Safe physical health monitoring guidelines

3. Scope

The guideline applies to all staff employed by Solent NHS Trust.

This guideline provides a protocol for the training in, safe prescribing and administration of rapid tranquilisation in Solent NHS Trust to inpatients in adult and older people's services.

This guideline applies to all doctors, mental health practitioners and nurses employed in Solent NHS Trust.

4. Associated Documents

This guideline should be read in conjunction with the following Solent NHS Trust policies and guidelines

Medicines Policy MMT003

http://intranet.solent.nhs.uk/DocumentCentre/PublishedPolicies/MMT003%20Medicines%20Policy%20V10.pdf

Resuscitation & Deteriorating Patient Policy CLS19

http://intranet.solent.nhs.uk/DocumentCentre/PublishedPolicies/CLS19%20Deterioration%20and%20Resuscitating%20Patient%20Policy%20v1.pdf#search=resuscitation%20policy

Learning and Development policy LD01

http://intranet.solent.nhs.uk/DocumentCentre/PublishedPolicies/LD01%20-%20Learning%20and%20Development%20Policy.pdf#search=learning%20and%20development

Antipsychotic guideline MMT013

http://intranet.solent.nhs.uk/ServiceLines/PharmacyMedicineMan/TeamDocument/Antipsychotic%20guidelines.pdf

Seclusion and Long-Term Segregation Policy

http://intranet.solent.nhs.uk/DocumentCentre/PublishedPolicies/CLS11%20Seclusion%20and%20Long%20Term%20Segregation%20Policy%20V9%20(previously%20Policy%20for%20Use%20of%20the%20Seclusion%20Suite%20within%20Maple%20Ward).pdf#search=seclusion%20policy

5. Guideline for the Rapid Tranquilisation of Adults > 18years (plus OPMH)

Considerations prior to prescribing/administering parenteral RT:

- **CHECK** for an Advanced Directive. MDT individualised Care Plan should be documented as soon as possible post admission where patient preferences and decisions should be considered.
- **ATTEMPTS** at de-escalation should be exhausted before RT e.g. verbal de-escalation, conflict resolution, positive behavior
- **REVIEW** patient and past 24 hours of medication to ensure it is safe to proceed with RT (max doses). If contraindications or cautions identified or attempting greater than BNF max contact senior doctor.
- **EXCLUDE** physical deterioration (review NEWS-2 scores), illicit substance use or medication side effects as cause of agitation
- **OFFER** Oral Lorazepam or Oral Promethazine and/or Oral Antipsychotic before parenteral RT. Patients may wish to revert to ORAL after initial RT administration if further medication warranted so review before subsequent doses.

Decision to proceed with RT confirmed & documented: Complete checklist (appendix 3) & BEGIN NEWS2

Step 1: LORAZEPAM or PROMETHAZINE

- **LORAZEPAM IM 1mg to 2mg** (max 4mg/24hrs) – onset ~30mins **(>65 years/ Learning Disability 500mcg to 1mg, Max 2mg/24hrs)**
- **PROMETHAZINE IM 25mg to 50mg** (max 100mg/24hrs), in benzodiazepine intolerant/contraindicated patients or shortage – onset ~ 60mins **(>65 years/ Learning Disability 12.5mg to 25mg, Max 50mg/24hrs)**

Continue NEWS2, review Mental State at 1hr or sooner if required

Step 2: PARTIAL or NO/INSUFFICIENT RESPONSE

- **Partial response**
  Consider repeating IM Lorazepam or IM Promethazine (if not accepting oral) – usually not less than 1 hour after initial dose.

- **No/Insufficient response**

*Consider **an** Atypical (Olanzapine or Aripiprazole) in antipsychotic naive, evidence of cardiovascular disease/ prolonged QTc/no ECG/ on drugs that can affect QTc, alcohol or illicit drug intoxication **or** a Typical (Haloperidol - confirm previous antipsychotic use, a normal ECG is essential. Only with IM procyclidine.)* Where no electrocardiogram has been carried out, avoid intramuscular haloperidol, use IM lorazepam or IM olanzapine if an antipsychotic is deemed necessary.

- **HALOPERIDOL IM 2mg to 5mg** -max 12mg/24hrs. **(>65yrs/ Learning Disability 1mg to 2.5mg, max 5mg/24hrs)** onset ~30mins
- **OLANZAPINE IM 5mg to 10mg (>65yrs 2.5mg-5mg)** - max 20mg or 3 injs/24hrs - NEVER WITH IM BENZODIAZEPINE (lorazepam) Wait ≥ 2hrs onset 30mins
- **ARIPIPRAZOLE IM - Initial dose 9.75mg (1.3ml). 5.25mg (0.7ml) to 9.75mg -** max 30mg/24hrs. onset ~30mins. Limited evidence in > **65yrs (5.25mg initial and subsequent**). Consider drug interactions

Continue NEWS2, review Mental State at 1hr or sooner if required

Step 3: PARTIAL or NO/INSUFFICIENT RESPONSE

- **Partial response**
  Consider repeating (if not accepting oral) – usually not less than 2 hours after step 2

- **No/Insufficient response**
  Consult senior clinician

Zuclopenthixol Acetate (Acuphase) is NOT Rapid Tranquilisation

Advice from a senior clinician must be sought before use (See Appendix 1)

Considerations once RT has commenced

1. Pharmacokinetics vary between drugs and therefore a previously ambulatory patient may become unwell. E.g. Promethazine has a delayed action compared to Haloperidol. When administered concurrently a patient who may initially appear well may become further sedate over time (although show fewer EPSE)
2. Read information provided on the subsequent pages of this document so you have an understanding of the pharmacokinetics/pharmacodynamics of the drugs and how/when they are likely to work and also how to manage any unintended adverse events
3. Review the ongoing need for parenteral administration. If required, consider using oral when possible.
4. If the desired response is not achieved seek senior advice for guidance

Physical Health Monitoring after RT

- **What to Record: NEWS 2 tool**
  Respiratory rate, oxygen saturations, air or oxygen, blood pressure, pulse, ACVPU (alert, new confusion, responsive to voice, pain or unresponsive, temperature
- **When to Record**;
  Baseline on admission/ prior to RT
  and then every 15 minutes for the 1st Hour
  then at least HOURLY until there are no concerns
- **Fluid Balance**
  Use Fluid Monitoring Sheet to ensure adequate hydration
  Do U & Es if clinically appropriate
  Avoid fluid overload
- **What to do if unable to monitor**
  Must Document why you can't monitor on NEWS 2 .Use Non-Contact Physical Health Observations Guidance & Assessment tool. Record Respiratory rate and ACVPU on NEWS 2

Time to peak:

	Injection	IM Duration	Oral
Haloperidol	15 – 60 mins	4 – 6 hours	2- 6 hours
Lorazepam	60 – 90 mins	4 -8 hours	2 hours
Promethazine	1 – 3 hours	unknown	2 – 3 hours
Aripiprazole	1 – 3 hours	24 hours	3 – 5 hours
Olanzapine	15 – 45 mins	6 – 8 hours	Both tabs & orodispersable 5 – 8 hours
Flumazenil IV (benzo rescue)	Response within 3 mins. Peak 6-10 minutes	Duration depends on type & dose of benzodiazepine	n/a

Using PRN medication

- Do not prescribe routinely or automatically on admission.
- Tailor medication to individual need, include discussion with patient where possible
- Ensure the indication and rationale are clear and in the care plan
- Ensure dose/24 hour is completed and does not exceed BNF limits, particularly in combination. Ensure the time interval between doses is specified
- Only exceed BNF dosing if planned, documented and approved by a senior doctor
- MDT should review prn at least weekly; if to be continued record rationale. If not used since last review consider stopping

Management of possible complications of RT which may require urgent medical attention

N.B. IV administration by medical staff only

Problem	Remedial Measures
Irregular/ Slow Pulse <60/minute	Contact Doctor. Consider urgent referral to physicians
Fall in Blood Pressure orthostatic or <50 mmHg diastolic	Contact doctor. Lie patient flat. Raise legs if possible. Monitor closely. May need physician referral
Acute Dystonia (including oculogyric crisis)	Give procyclidine 5 – 10mg IM (or IV) Review Antipsychotic medication
Reduced Respiratory Rate < 10/minute O_2 sats <95	Phone 2222 and contact doctor immediately. Give **Flumazenil** if Benzodiazepine-induced and RR falls below 10/min **Initial dose**: 200mcg **IV** over 15 secs – if required level of consciousness not achieved after 60 seconds then: **Subsequent dose**: 100mcg over 10 seconds, repeated after 60 seconds if necessary **Maximum dose**: 1mg in 24 hours (one initial dose and eight subsequent doses) **Monitor** until RR returns to baseline level. Very rarely seizures may occur after flumazenil particularly after long term treatment with Benzodiazepine If induced by other agent patient will require mechanical ventilation– arrange transfer to ITU immediately
Increase in Temperature >38°C	Consider **Neuroleptic Malignant Syndrome** (see below)

Neuroleptic Malignant Syndrome (NMS)

- Fever, usually above 38°C sometimes hyperpyrexia over 40°C
- Muscle rigidity
- Alteration in consciousness
- Autonomic disturbance – tachycardia, changes in BP, urinary incontinence
- Raised creatine kinase and/or LFTs levels

Risk Factors:Previous NMS or cerebral compromise

- Catatonia, agitation, over activity, dehydration
- Rapid tranquilisation, IM therapy, high potency neuroleptics

STOP ANTIPSYCHOTIC IMMEDIATELY Consult doctor, can be FATAL, may need ITU.
Consider urgent referral

Rapid Tranquilisation during Seclusion

- Ensure the patient is observed WITHIN EYESIGHT by trained staff
- Undertake a risk assessment and consider ending the seclusion when rapid tranquilisation has taken effect

6. Responsibilities

6.1 Doctor

- Patient's prescription is individualised, not routine, includes details of what medication to use for rapid tranquilisation, in what dose range and with what frequency.
- that the minimum time between doses and the maximum dose to be administered in a specified period is stated.
- that medication already prescribed is considered.
- that patients are monitored, for positive and adverse effects, reviewed weekly in MDT and sooner in the event that RT is required.

Pharmacological interventions should be aimed at achieving maximum efficacy through regular timed dosing, without the necessity to resort to prn. This is of particular relevance in circumstances when patients are in receipt of repeated rapid tranquilisation. In situations where there are difficulties achieving this stability advice should be sought from a pharmacist to review and further inform continued prescribing rationale.

6.2 Nurse in charge of unit at the time of rapid tranquilisation, is to ensure:

- the RT is indicated, having exhausted all other strategies to calm the patient
- the prescription and this Guidance are followed.
- the patient has the appropriate physical observations completed using NEWS 2, Non-contact Physical Health Observations form.
- The written records including care plans are developed and reviewed, which should include any advance directives.
- that an incident form is raised on Ulysses for each RT event. In the event that RT has been required on three or more occasions a separate incident form should be completed to initiate review at IMA panel.

6.3 Nurse/Nursing Associate/MHP:

- to ensure the prescription for oral medication is followed
- to undertake appropriate physical observations
- to maintain written records.

6.4 Pharmacist – to ensure:

- prescriptions are checked for potential adverse interactions
- that advice from this guidance is followed, and highlight where not
- that the MDT is supported with review of medicines for the patient.

6.5 Medicines Management SubCommittee – to ensure that:

- the use of rapid tranquilisation is monitored and discuss audit results and actions there on.
- best practice is carried out and that any incidents relating to rapid tranquilisation are investigated and lesson learned shared.

7. Prescribing and Administration of Rapid Tranquilisation

7.1 Oral medication should be offered before parenteral medication as far as possible.

7.2 For algorithm of drug treatment, choice, dose and frequency (see pages 5 – 6)

See Appendix 3, RT check list for monitoring requirement after rapid tranquilisation

7.3 High Doses

In certain circumstances, current British National Formulary (BNF) doses and limits, and the manufacturers Summary of Product Characteristics (SmPC), may be knowingly exceeded e.g in the case of lorazepam. This decision should not be taken lightly, or the risk underestimated, and a risk benefit analysis should be carried out and a clear rationale should be documented. The High dose SOP should be followed, and the high dose should be recorded in SystmOne using the High Dose Antipsychotic form. The High Dose Antipsychotic treatment summary should be referred to which is located in appendix 6 of the Antipsychotic guidelines.

http://intranet.solent.nhs.uk/ServiceLines/PharmacyMedicineMan/TeamDocument/Antipsychotic%20guidelines.pdf

All patients receiving antipsychotics should have an ECG regularly, in line with the trusts antipsychotic monitoring policy. High stress levels, restraint, agitation, and hypokalaemia all place the patient at high risk of developing cardiac arrhythmias. ECG's need to be less than 3 months old to be considered appropriate for use assuming there have been no significant cardiac changes since the ECG was obtained.

7.4 Risks Associated with Medicines used in Rapid Tranquilisation

In certain circumstances prescribing outside the trust guidelines may be appropriate. A risk benefit analysis should be recorded in the medical notes and a rationale in the care plan. The decision should be made with a senior doctor.

When combinations are used, risks may be compounded. Staff need to be aware of the following:

For benzodiazepines

- Loss of consciousness
- Respiratory depression or arrests
- Cardiovascular collapse (in patients receiving both clozapine and benzodiazepines)
- Paradoxical increases in aggression.

For antipsychotics

- Loss of consciousness
- Cardiovascular and respiratory complications and collapse (risk of sudden death)
- Seizures
- Subjective experience of restlessness (akathisia)
- Acute muscular rigidity (dystonia)
- Involuntary movements (dyskinesia)
- Neuroleptic malignant syndrome
- Excessive sedation
- Nausea and vomiting

For antihistamines

- Excessive sedation
- Painful injection
- Additional antimuscarinic effects.
- Hypotension
- Arrhythmias

Extra care should be taken when implementing rapid tranquilisation in the following circumstances:

- The presence of congenital cardiac conduction abnormality
- When the concurrent prescription(s), or use of other medication, lengthen QTc intervals
- The presence of certain disorders affecting metabolism, such as, stress and extreme emotions, and extreme physical exertion (hypokalaemia, dehydration).

7.5 Physical monitoring required after rapid tranquilisation (Appendix 3)

All observations must be recorded using NEWS 2

Observations include:

- All physical observations as per NEWS 2 every 15 minutes for the first hour then hourly until there are no further clinical concerns
- Use fluid monitoring sheet to ensure adequate hydration and do U&E`s if clinically appropriate.

If unable to carry out observations:
The Non-Contact Physical Health Observations Guidance and Assessment Framework (Appendix 4) should be used.

The decision to use this tool instead of the NEWS 2 tool is a Registered Nurse decision on a case by case basis. Respiratory rate and ACVPU (Alert, new Confusion, Voice, Pain, Unresponsive) should still be recorded and documented in the NEWS 2 chart as per guidance outlined on the front of the tool. Refer to the Trust Seclusion and Long-term Segregation Policy.

7.6 Post Incident Review

- Any incident requiring rapid tranquilisation (or physical intervention) must be recorded in medical notes and on Ulysses

- A post incident review should take place as soon as possible and at least within 72 hours of an incident ending. Wherever possible a person not directly involved in the incident should lead the review which should address:

    - What happened during the incident
    - Any trigger factors
    - Each person's role in the incident
    - Their feeling at the time of the incident, at the review and how they may feel in the near future
    - What can be done to address their concern?

- Patients and/or carers should be given the opportunity to document their own account of the intervention. This should be filed in their medical notes.
- Effectiveness of medications and side effects, with support of a pharmacist
- Review Care Plan and consider development of an Advance Directive if not already in place

8. Training Requirements

8.1 Training should be carried out once every 3 years.

8.2 This training programme is under review but currently is via an e-learning package which is available on ESR it is called Rapid Tranquilisation 15330697.

8.3 All staff involved in administering or prescribing rapid tranquilisation or monitoring patients to whom parenteral rapid tranquilisation has been administered, should receive ongoing competency training in Adult DART. The NICE guidelines for rapid tranquilisation state that staff must be trained to provide immediate life support which is supported by the current DART course that Solent provide.

8.4 All staff involved in an incident requiring the use of rapid tranquilisation (or physical intervention) should be aware of the potential for damage to the patient/professional relationship and should ensure that everything possible is done to avoid any negative impact.

8.5 All staff involved in rapid tranquilisation need to be aware of the legal framework that authorises this intervention. The intervention should be in line with the guidance contained within the current Mental Health Act code of practice (and the Mental Capacity Act), and any departure from that guidance should be clearly recorded and justified as being in the best interests of the patient.

9. Monitoring Compliance

The following table outlines how the Trust will monitor compliance with this guideline.

Monitoring Compliance				
Element to be monitored	**Lead**	**Tool**	**Frequency**	**Reporting arrangements**
Duties / responsibilities	Chief Pharmacist	Rapid tranquilisation audit tool	After each rapid tranquilisation – summary report annually	MH Medicines Sub Committee
Prescribing guidelines for rapid tranquilisation	Chief Pharmacist	Rapid tranquilisation audit tool	After each rapid tranquilisation – summary report annually	MH Medicines Sub Committee

Documented process for how observations are recorded, including timeframes when patients have received rapid tranquilisation	Chief Pharmacist	Rapid tranquilisation audit tool	After each rapid tranquilisation – summary report annually	MH Medicines Sub Committee
Documented process for how the organisation trains staff, in line with the training needs analysis	The process for monitoring compliance with statutory and mandatory training requirements is outlined in the Trust Learning and Development Policy.			

10. Supporting References

- Maudsley Prescribing Guidelines 13th edition
- NICE NG10 and 11
- Bazire Psychotropic Drug Directory 2018
- BAP NAPICU Guidelines: Joint BAP NAPICU evidence-based consensus guidelines for the clinical management of acute disturbance: De-escalation and rapid tranquillisation. Patel, MX et al. J. of Psychopharm; 2018, 1-40
- Current adults' or childrens' BNF or eBNF, including Appendix 1 Table 9
- Current SPC

11. Appendix 1: Zuclopenthixol acetate (Acuphase®) Prescribing information

Should **only** be prescribed;

- on the recommendation of a senior psychiatrist, after assessment
- for short term management of acute psychosis and mania
- if the patient is refusing oral medication and requires repeated injections (allowing adequate time to see the effects of previous medications)
- reduce the dose in renal/ hepatic impairment. In renal/hepatic failure half the dose and consider serum-level monitoring.

Should **never** be prescribed;

- for rapid tranquilisation,
- if the patient is neuroleptic naïve,
- if the patient is accepting oral medications,
- if the patient has suffered EPSEs/ movement disorders previously,
- if the patient is unconscious,
- if the patient has medical conditions including; being pregnant, suffering from neurological disease (e.g. epilepsy, Parkinson's disease), or cardiovascular disease.

Should **never** be administered to;

- hasten the antipsychotic effect of other antipsychotics,
- for rapid tranquilisation,
- at the same time as other IM medication (antipsychotics or benzodiazepines).

Administration information for Zuclopenthixol acetate (Acuphase®)

- The sedative effects usually begin after 2 hours, peak around 36 hours, and last for up to 72 hours. A second dose may be given after 2 to 3 days.
- Maximum of 4 injections and 400mg in any two week period.
- Dose should be reduced to 25-50mg in the elderly and those with unknown tolerability.
- Review and withhold other antipsychotics for the duration of action.
- Zuclopenthixol Decanoate, the depot, may be administered at 200 to 400mg with the last dose of Acuphase®.

Post injection monitoring

After every dose administered:

- Record temperature, pulse, respiratory rate and blood pressure every 4 hours for 72 hours using the track and trigger tool.
- If unable to take observation, document reasons and evidence the patient is safe e.g. respiratory rate, activity, pallor on SystmOne.
- Assess efficacy and side effects before considering additional doses.
- Consider withholding other antipsychotics for duration of action.
- Use a Food and Fluid chart to ensure adequate hydration.

SPC zuclopenthixol

12. Appendix 2 Rapid Tranquilisation (RT) Quick Reference to Calculations for intramuscular (IM) injections

Lorazepam (Ativan®)

- **Before administration lorazepam should be diluted**
- **Add 1 ml of water for injection to the ampoule containing lorazepam 4 mg in 1 ml**
- **Ativan comes in a 2ml ampoule to facilitate dilution**
- **Final concentration is 4 mg in 2 ml (2mg in 1ml)**
- **Draw up the required volume as per the table below.**

Dose	Volume of liquid required
0.5 mg	0.25 ml
1 mg	0.5 ml
2 mg	1 ml

Olanzapine (Zyprexa®)

Before administration mix:

- **ONE vial of olanzapine with 2.1 ml of water for injection.**
- **Final concentration is 10 mg in 2 ml**
- **Actual contents are 11mg in 2.2ml**

Dose	Volume of liquid required
2.5 mg	0.5 ml
5 mg	1 ml
7.5 mg	1.5 ml
10 mg	2 ml

Haloperidol **(concentration of ampoule = 5 mg in 1 ml)**

Dose	Volume of liquid required
500micrograms	0.1ml
1mg	0.2ml
2 mg	0.4 ml
3 mg	0.6 ml
4 mg	0.8 ml
5 mg	1 ml

Aripiprazole (Abilify®) **(concentration of vial = 7.5mg in 1ml)**

Dose	Volume of liquid required
5.25mg	0.7ml
9.75mg	1.3ml
15mg	2ml

13. Appendix 3 Rapid Tranquillisation (RT) with IM Injection – Monitoring Checklist

Refer to Solent NHS Trust Rapid Tranquillisation Guidelines on Trust website

NAME: **NHS NUMBER:** **DOB:** *(AFFIX LABEL HERE)*	**WARD:** MHA STATUS: CONSULTANT:

Pre RT Checklist: All checks must be completed

1. Check for intoxication with alcohol/illicit substances and/or acute infection **Y**
2. Non drug approaches considered **Y**
3. Medication in last 24 hours considered **Y**
4. Oral medication offered before IM injection **Y**
5. Does the time interval between doses follow Solent NHS Trust Rapid Tranquilisation Guidelines **Y N/A**
6. If this isn't the first dose, has the prescribed interval between doses elapsed? **Y N/A**
7. Repeated RT doses – has the junior doctor considered contacting a senior doctor **Y N/A**

Checklist completed by **:……*(Registered Nurse*)** Date**:…. /…./….**

Drug(s) Administered	Dose	Date	Time

Physical Health Monitoring Checklist

Monitor:- Temperature, Pulse, Blood Pressure, Respiratory Rate, Oxygen Saturation and level of consciousness every 15 minutes for the first hour then hourly until there are no concerns. If a patient is asleep they should be woken, unless there is a good reason not to. This reason must be recorded on the NEWS on this form and on Systm One. Respiratory rate and pulse should be recorded, as a minimum.

Time	BP	Pulse	Temp.	Sats	Resps	Alert (Y/N)	Omissions/ Variances	Sign
Most Recent obs.								
15 mins								
30 mins								
45 mins								
60 mins								
Continue monitoring **Y/N**				Signature of Registered Nurse				
2 Hours								

Continue monitoring **Y/N**			Signature of Registered Nurse					
3 Hours								
Continue monitoring **Y/N**			Signature of Registered Nurse					
4 Hours								
Continue monitoring **Y/N**			Signature of Registered Nurse					
5 Hours								

ALL OBSERVATIONS TO BE RECORDED ON NEWS CHART

Post RT Checklist

1. Incident form completed **Y**
2. Incident number:_____
3. Diary entry for doctor to review need for U&Es blood test at 24 hours post dose **Y**
4. Incident added to next MDT template for review/plan **Y**
5. Incident review/debrief completed with patient, doctor and nurse within **72** hours and documented on System One **Y/N**

   If No, please state reason_____

   _____
6. Behavioural care plan made with the patient within **1 week** of rapid tranquilisation **Y/N**

   If no, please state reason_____

   _____

Checklist completed by:…….. Date:…./…./….

14.Appendix 4 Non-Contact Physical Health Observation Tool

NHS Solent NHS Trust

NON-CONTACT PHYSICAL HEALTH OBSERVATIONS TOOL

IF A RED BOX STATEMENT IS TRUE: IMMEDIATELY ESCALATE. DO NOT LEAVE THE PATIENT. DEPENDING ON OUTCOME: CONTACT MEDICAL TEAM USING SBAR OR EMERGENCY AMBULANCE

Document assessment on reverse of this form and also in patients electronic record

Airway clear? • If awake, can they speak? (Not just moans and groans)	**AIRWAY**	• Airway obstructed? Silence? Coughing? Stridor? *(Suggestive of possible swelling)* Gurgling? Wheezing? Snoring? *(Consider: opening airway, back blows, abdominal thrusts, oral suction)* • Is airway unsafe? (Especially if asleep or resting) Are they at risk of vomiting? *(Consider: moving onto their side and carry out constant observations to prevent choking / aspiration)*
Breathing is quiet and regular? • Breathing 12 - 20 respirations per min? • Breathing causes no extra effort or difficulty? • No abnormal breath sounds?	**BREATHING**	• Noisy? Irregular? Shallow? Rapid? Malodourous/unpleasant odour (E.g. pear drops)? • Difficulty breathing, even with open airway? • Rate: more than 20 breaths per min? Or less than 12 breaths per min? *(Consider: COPD, asthma, heart failure, chest infection? Acute illness? Recent rapid tranquilisation? Or restraint? Need for emergency oxygen? Assisted ventilations with bag & valve mask?)*
Warm, comfortable presentation? • Well perfused skin? • "Normal" complexion for them? • Pink mucous membranes inside the mouth? (If easily visible) • If asleep, monitor movement	**CIRCULATION**	• Obvious trauma? Bleeding? Physiological shock? Dehydrated / Malnourished? • Skin: Flushed? Clammy? Sweating? Cold? Pale? Swollen? Ashen (grey)? Mottled (purplish discoloration)? Swollen? Cyanosed (blue tinge, or discoloration of lips, nail beds, tip of nose or ear lobes)? Blue grey tinge to mucous membranes inside the mouth (Dark skin best seen in inner eye lids and lips)? Pallor: white/light coloured skin = skin takes on white hue, especially on face, inside of lips, eyelids & nail beds? Brown skin = yellow/red. Black skin = ashen grey.
Alert? • Responsive to voice? • No other physical health concerns?	**DISABILITY**	• AVPU assessment = Unresponsive? Only responds to verbal or physical stimulus? • Orientation - New or unexplained: Confusion? Disorientation? Sleepy? Drowsy? Fitting? *(Consider: overdose, epilepsy & blood glucose level)* • Temperature: If able to touch - is skin Hot? Cold? Clammy? • Other physical health concern requiring additional interventions / monitoring e.g. Asthma? Diabetes? Epilepsy? Intoxication? Drug / Medication side effects?
Active, walking, steady gait, resting / sleeping NOT unconscious? *(See note on reverse)* • Eating and Drinking? • Presenting as "Normal" for them? • No Patient, Carer, Health / Social Care / Professional concerns	**EXPOSURE**	• Change in ability to mobilise? Inability to stand unaided? • Muscle rigidity? Change in their ability to mobilise? (E.g. weakness in any limbs?) • Not eating & drinking? Signs of dehydration? (Dry cracked lips? Not passing urine?) • Increased: thirst (polydipsia)? And urination (polyuria)? • Signs of Physical Injury / bleeding / bruising / rash / self-harm? • Signs of Infection – Think: Could this Be Sepsis? (Check Sepsis Screening Tool) • Patient, Carer, Health / Social / Professional concerns? (Use clinical judgement

Patient Name DOB NHS No												Please If ANY "RED" statements are triggered overleaf, tick relevant A, B, C, D or E box below Note your concerns to red trigger in larger box provided (Include escalations, support, monitoring & outcomes)	Name, Signature & Role
Date: Time:		A	B	C	D	E	A	B	C	D	E		
Date: Time:		A	B	C	D	E	A	B	C	D	E		
Date: Time:		A	B	C	D	E	A	B	C	D	E		
Date: Time:		A	B	C	D	E	A	B	C	D	E		
Date: Time:		A	B	C	D	E	A	B	C	D	E		
Date: Time:		A	B	C	D	E	A	B	C	D	E		
Date: Time:		A	B	C	D	E	A	B	C	D	E		
Date: Time:		A	B	C	D	E	A	B	C	D	E		

Important Notes: NEWS (contact physical health observations) is always preferred, in conjunction with an ABCDE assessment. The decision to use only this Non-Contact Physical Health Guidance & Assessment Framework tool is a Registered Nurse decision, on a case by case basis and should be determined each time physical health observations are required. This tool aids assessment, but Registered Nurses should always act on their best professional clinical judgement too. NB: Circumstances why non-contact PHO rather than full NEWS should be summarised on the NEWS chart along with RR and AVPU.

Differentiating between unconsciousness and sleep: Being asleep is not the same as being unconscious. If someone is asleep we would expect them to occasionally change position while sleeping and for them to have a "normal" complexion for them. If you are at all concerned that the patient is not sleeping, and may be unconscious escalate / evoke full AVPU assessment of consciousness immediately.