Paediatric Rapid Tranquilisation Policy

Department / Service:	Paediatrics
Originator:	Dana Picken
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Target Organisation(s)	Worcestershire Acute Hospitals NHS Trust
Target Departments	Paediatrics
Target staff categories	All staff

Policy Overview:

Provide clarity and direction for rapid treatment and management of acutely disturbed behaviour for under 18 year old children and young people attending Worcestershire Acute Hospitals NHS Trust.

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.

Rapid tranquillisation in this guideline refers to the use of medication by the parenteral route (usually intramuscular or, exceptionally, intravenous) if oral medication is not possible or appropriate and urgent sedation with medication is needed" (NICE NG10).

Acknowledgements:
This guideline is largely drawn from Paediatric Rapid Tranquilisation Policy (2024) - Pier Network Regional Guidelines which has been adopted by Hereford and Worcestershire Health and Care Trust.

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Dec 24	*New document approved*	*Medicines Safety Committee/Paediatric Governance*

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Supporting Documents

Supporting Document 1 Equality Impact Assessment
Supporting Document 2 Financial Risk Assessment

1. Introduction

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

“Rapid tranquillisation (RT) in this guideline refers to the use of medication by the parenteral route (usually intramuscular or, exceptionally, intravenous) if oral medication is not possible or appropriate and urgent sedation with medication is needed” (NICE NG10).

The aim of rapid tranquillisation (RT) is to achieve a state of calm sufficient to minimise the risk posed to patients or others. The patient should be able to respond to communication throughout the period of rapid tranquillisation. Rapid tranquilisation should only be considered appropriate where a patient presents a risk to themselves or others and de-escalation (including the use of ‘when required’ medication where appropriate) and any other appropriate non-restrictive techniques have failed, or the situation cannot be appropriately managed in any other way.

There can be any number of medical reasons for aggressive behaviour and any reversible causes should be investigated and managed appropriately before commencing rapid tranquillisation.

The use of rapid tranquillisation is a high risk practice which has to be well managed in order to avoid unnecessary harm. The risks associated with rapid tranquillisation have been identified as

- Over-sedation causing loss of consciousness
- Over-sedation causing loss of alertness
- Loss of airway
- Cardiovascular collapse (problems with arrhythmias, hypotension, sudden death)
- Respiratory depression (Be aware: acute dystonias may compromise respiratory rate)
- Interaction with medication (prescribed or illicit including alcohol)
- Damage to the therapeutic relationship
- Underlying coincidental physical disorders

Rapid tranquilisation should only take place in clinical areas where resuscitation facilities and equipment is immediately available with appropriately trained staff.

Purpose

The purpose of this guideline is to provide a standardised approach for rapid tranquilisation

2. Scope of this document

This guideline applies to all paediatric patients in Worcestershire Acute Hospitals NHS Trust but not to neonates on neonatal units.

3. Definitions

Rapid tranquillisation (RT) in this guideline refers to the use of medication by the parenteral route (usually intramuscular or, exceptionally, intravenous) if oral medication is not possible or appropriate and urgent sedation with medication is needed” (NICE NG10).

CYP refers to children and young people under the age of 18 years old

4. Recommendations

Children with challenging behaviour may be a danger to themselves, to other children in the hospital and to medical staff. Behaviour that challenges may be due to a variety of causes such as organic

disease, psychosocial problems or alcohol / drug abuse. Acutely disturbed behaviour may arise in the course of almost any medical disorder or its treatment.

Establish a close working relationship with CYP at the earliest opportunity and sensitively monitor changes in their mood or composure that may lead to aggression or violence.

- recognise the early signs of agitation, irritation, anger and aggression
- understand the likely causes of aggression or violence, both generally and for each patient (sometimes it might be because they are not allowed to go out for a cigarette)
- use techniques for distraction and calming, and ways to encourage relaxation recognise the importance of personal space respond to a patients' anger in an appropriate, measured and reasonable way and avoid provocation
- offer the child or young person the opportunity to move away from the situation in which the violence or aggression is occurring, for example to a quiet room or area/parental presence
- aim to build emotional bridges and maintain a therapeutic relationship

Take into account the child or young person's level of physical, intellectual, emotional and psychological maturity. The Mental Capacity Act 2005 applies to young people aged 16 and over. Collaborate with those who have parental responsibility when managing violence and aggression in children and young people. Use safeguarding procedures to ensure the child or young person's safety.

Roles and Responsibilities:

Medical staff are responsible for:

a) prescribing appropriate medicines for RT for patients. All prescribers must comply with the legal framework for medicines, the Medicines Code and the Mental Health Act when performing these duties

b) organising an appropriate physical examination **prior** to prescribing medicines for RT including the arrangement or ordering of laboratory tests, ECGs or other appropriate investigations

c) attending a RT episode as soon as possible

d) medical examinations during RT and for the administration of IV flumazenil, should it be indicated.

Senior Nurses (Band 7 and above) are responsible for

a) ensuring that all nursing staff are aware of the policy and procedure associated with RT

b) ensuring all nursing staff are competent in the administering and monitoring of medicines used in RT, in physical health monitoring and in debrief through a planned programme of training

c) ensuring the availability and functionality of the appropriate medical equipment available to allow the correct monitoring of the young person

d) ensuring the availability of the appropriate medicines for RT and for the emergency management of side effects of RT is available on the ward.

Nurse in Charge or Shift Coordinator is responsible for:

a) leadership and management of an episode of RT administration

b) taking immediate charge of an episode where RT is administered

c) holding responsibility for ensuring the post RT monitoring and debrief is completed effectively

d) ensuring that a DATIX incident report form, and audit form is completed every time a young person is given RT

Registered Nurses (including Nurse Associates) are responsible for:

a) administering oral and where necessary IM medication in accordance with prescriptions for such medication, taking account of policies and procedures within the WAHT Medicines Management Policy and the associated Mental Health Act policy

b) the physical monitoring required during an episode of RT and for recording observations on the NPEWS chart and within clinical records

c) debriefing patients after an episode of RT and for recording any preferences or advanced decisions and making necessary adjustments to the nursing care plan

d) updating the risk assessment after every episode of RT

e) advanced planning (using Positive Behaviour Support if clinically appropriate) is reflected in the individual's care plan when RT is anticipated

f) robust and clearly recorded risk management and contingency planning occurs with multidisciplinary involvement.

Clinical Support Workers will be routinely involved in an episode of RT as instructed by the nurse in charge including physical restraint, physical health monitoring and clinical record keeping, and should be competent to do so.

RT and Physical Frailty

Physically frail young people (e.g. malnourished young people) are more likely to have concurrent medical conditions (such as cardiovascular, respiratory and/ or neurological disorders), and are therefore at a greater risk of experiencing adverse effects of medication used for RT.

A doctor must be in attendance prior to the administration of RT.

RT and Learning Disability/Autism

Young people with learning disabilities may carry an increased risk of certain health complications such as cardiac and respiratory disorders, which must be considered with the use of physical

restraint and RT. There is also a higher rate of under detected visual and hearing problems, and people with learning disabilities may also have an altered threshold to pain.

Any pre-existing physical health conditions and history must be well understood at the point of admission and included in the young person's care plan and risk assessment.

Full consideration should be given for young people with autism as to potential impact of physical restraint and RT and plans for minimising adverse effects of these procedures be included in the risk assessment and Positive Behaviour Support plans. For example, the impact on aspects of the young person's sensory profile and sensitivities.

Young people with diagnoses of learning disabilities and/or autism can be more sensitive to all side effects of medication

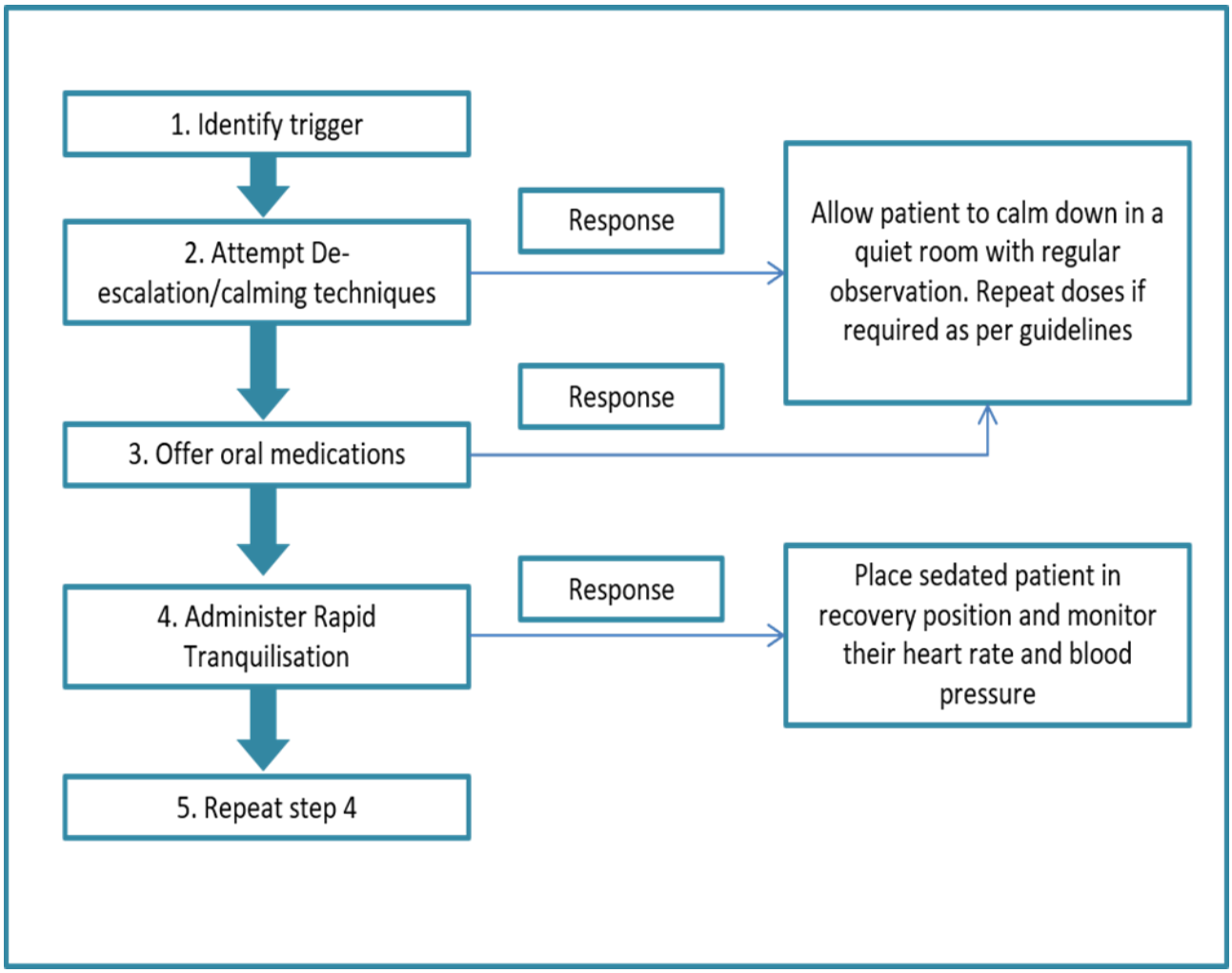
RT and Gender

Consideration and advanced planning should be undertaken with regards to gender and gender identity in the relations to the use of rapid tranquillisation.

All young people must have a co-produced care plan in place which fully highlights all considerations and wishes in relation to gender and gender identity, irrespective of whether or not rapid tranquillisation is used.

Advanced planning and the use of Positive Behaviour Support plans should highlight preferences (and potential limitations) to the young person's gender preferences of the staff involved in rapid tranquillisation, particularly in incidents where physical restraint and declothing (for injection) is implemented.

Summary of Management Flowsheet



Follow up actions:

- Complete pro forma 'De-escalation of challenging behaviours' Appendix 4
- Ward Manager and Matron for the department where rapid tranquilisation has been undertaken is informed 'in hours' and the 'on call site team out of hours'
- Inform patient's next of kin with parental responsibility if not already present or if a 'looked after child' inform Children's Social Care Services.
- Inform the Trust's Integrated Safeguarding Team via the generic trust email.
- If CYP is known to CAMHS (Child and Adolescent Mental Health Service) Inform CAMHS Crisis and Home Treatment Team: whcnhs.camhscrisisandhometreatmentworcs@nhs.net (working weekend hours are: 08.00-20.00). CAMHS Team routinely telephones Riverbank at 09.00 hours each morning.
- Clinical incident recorded via Datix system. Please include the following information:
  - ✓ has been assessed by the CAMHS team
  - ✓ Waiting for Mental Health Act Assessment
  - ✓ Subject to Mental Health Act (MHA). If yes, please specify which Section of the MHA

For out of hours' advice please contact Mental Health Liaison Team (MHLT) based at Worcestershire Royal Hospital Emergency Dept, who provide hour service. The MHLT will contact the CRISIS Team as required.

5. De-escalation Techniques

If a patient becomes agitated or angry, a single staff member should take the primary role in communicating with them. That staff member should assess the situation for safety, seek clarification with the patient and negotiate to resolve the situation in a non-confrontational manner.

Use emotional regulation and self-management techniques to control verbal and non-verbal expressions of anxiety or frustration (for example, body posture and eye contact) when carrying out de-escalation.

Use a designated area or room to reduce emotional arousal or agitation and support the patient to become calm.

6. Oral Treatment Options

Oral medication should be considered first line where de-escalation techniques have been unsuccessful in managing the patient and considered prior to using rapid tranquilisation (parenteral therapy).

Patient 12 years and old and under

If the child is usually on medication, consider an additional dose to help resolve the situation. If this is not appropriate:

- First line – **Lorazepam 0.5 mg – 1 mg PO**
- Second line – **Promethazine hydrochloride 5 – 10 mg PO (max 25 mg / day)**

Consider an antipsychotic if NOT already taking a regular oral or depot anti-psychotic

- **Olanzapine 2.5 mg – 5 mg PO** (Please note that Olanzapine is not licensed for use in children).

Patients 12-18 years old

If the child is usually on medication, consider an additional dose to help resolve the situation. If this is not appropriate:

- First line – **Lorazepam 0.5 mg – 2 mg PO**
- Second line – **Promethazine hydrochloride 10 – 25 mg PO (max 50 mg / day)**

Consider an antipsychotic if NOT already taking a regular oral or depot anti-psychotic

- **Olanzapine 5 mg – 10 mg PO** (Please note that Olanzapine is not licensed for use in children).

7. Rapid Tranquilisation

Rapid tranquilisation should always be viewed as an option of last resort and only considered after any reversible causes have been appropriately treated and de-escalation techniques have been attempted or have been deemed to be inappropriate. The decision to medicate a patient should always be made by a Consultant Paediatrician in hours or Specialist Registrar out of hours. If the young person is under the care of the adult medical team decision should be made by a medical consultant or SpR out of hours. A referral should then be made to a senior member of the CAMHS team (Child and Adolescent Mental Health Service) in hours and liaison with the Mental Health Liaison Team (MHLT)based in the Emergency Department out of hours, who will inform CRISIS team.

Please note this is for information and advice, the teams are unlikely to be able to attend the Department.

For any patient initiated on rapid tranquillisation a RT checklist should be started (see appendices)

- Appendix 1 Rapid Tranquilisation and management of Acutely Disturbed Behaviour
- Appendix 2 RT for paediatric patients under 12 years old
- Appendix 3 RT for paediatric patients 12-18 years old
- Appendix 4 Administration of Short Acting Intramuscular injections for the Management of Acute Disturbance.

Patients 12 years old and under

Intramuscular Treatment

- **Lorazepam 0.5 mg – 1 mg IM**
  - ✓ Ensure Flumazenil is available for benzodiazepine-induced respiratory depression
- **Promethazine hydrochloride 6.25 – 12.5 mg IM**
  - Useful option in benzodiazepine-tolerant patients
- **Olanzapine 2.5 mg – 5 mg IM (IV use unlicensed)**
  - Olanzapine and Lorazepam administration should be separated by at least 1 hour
  - Consider Procyclidine Oral / IM (Note: Extra pyramidal Side Effects are more common in adolescents)
  - Give 5 mg initially (Max 10 mg / 24 hours)

Patients 12-18 years old

Intramuscular Treatment
Lorazepam

- Patients under 30 kg 0.5 – 1 mg IM
- Patients 30 kg or more 0.5 – 2 mg (max 4mg / 24 hours)

If patient has a partial response a second dose may be given at 1 hr. In patients that fail to respond to Lorazepam second-line treatment is with anti-psychotic:

Olanzapine 2.5 mg – 5 mg IM (IV use unlicensed)
Consider use first line, but do not give within 2 hours of Lorazepam.

Consider prescribing with Procyclidine oral / IM to reduce the risk of EPSEs, these are most common in adolescents: 10 mg initially (Max 20 mg / 24 hours)

Haloperidol 1 – 5 mg IM (NOT for IV use)
Consider combining with Promethazine IM 10 – 25 mgs (max 100 mg/ 24 hours)

8. Cautions and Contraindications to Rapid Tranquilisation

Ensure Flumazenil is readily available to reverse benzodiazepine respiratory depression. Flumazenil to be given intravenously 10 micrograms / kg every 1 minute (maximum dose 200 micrograms)

Rapid tranquillisation should always be considered as a restrictive intervention and not routinely prescribed, as treatment is associated with risks. Careful consideration should be given to any pre-existing co-morbidities and current therapy (i.e. those already taking anti-psychotics or other medication known to have similar side effects). The following is a summary of key risks associated with treatment**:**

Antipsychotics

(e.g. olanzapine, haloperidol, risperidone)
The main risks/side effects associated with anti-psychotic use include:

- **Loss of consciousness/Excessive sedation**
- **Cardiovascular toxicity** i.e. tachycardia, arrhythmias, hypotension, QT prolongation and rarely sudden death. Antipsychotics should therefore be avoided in patients with known cardiac problems or ECG abnormalities. The risk is greater with haloperidol.
- **Extrapyramidal Side Effects (EPSEs)** i.e. tremor, rigidity, dystonias (abnormal face and body movements), akathisia (restlessness) and tardive dyskinesia. These occur more commonly with the older “typical” antipsychotics including haloperidol, but can still occur with atypicals (olanzapine, risperidone), particularly in adolescence. Prevention/management is with an anti-muscarinic (procyclidine IM/oral) which can be given simultaneously.
- **Neuroleptic Malignant Syndrome** characterised by temperature dysregulation, fluctuating blood pressure, altered consciousness, autonomic dysfunction (pallor, sweating, urinary incontinence) and raised creatinine kinase. This is a medical emergency and requires urgent referral

Avoid antipsychotics if:

- Known cardiac problems
- Known abnormal ECG parameters – e.g. Prolonged QT interval (especially over 500ms)
- On other medication that can prolong QT or cause pharmacokinetic interactions – e.g. amitriptyline, imipramine, doxepin, citalopram, escitalopram, methadone or anti-arrhythmics e.g. amiodarone, calcium channel blockers.
- Consider simultaneous use of procyclidine with atypical antipsychotics as extra pyramidal side effects are more common in adolescents even when using atypicals.

Pregnancy: Ensure perinatal service is involved.

Benzodiazepines should be avoided in adolescents that are physically unwell/delirious or have significant respiratory impairment e.g. asthma.

Benzodiazepines

(e.g. lorazepam, midazolam)

The main risks/side effects associated with benzodiazepines include:

- Loss of consciousness/Excessive sedation
- Respiratory depression all areas where patients are receiving benzodiazepines should stock flumazenil
- Paradoxical increase in aggression risk is increased in children/adolescence

Antihistamines

(e.g. promethazine)

The main risks/side effects associated with anti-histamines include:

- Excessive sedation
- Enhanced anti-muscarinic effects
- Cardiovascular toxicity i.e. hypotension, arrhythmias

9. Monitoring Requirements

What to Record

- Temperature
- Blood pressure
- Pulse
- Respiratory rate
- Level of consciousness (alert, vocalise, pain, unresponsive
- Oxygen saturation
- Fluid balance – to ensure adequate hydration

When to Record

Monitoring should be carried out:

- Baseline on admission / prior to RT
- Every 15 minutes for the first hour
- Hourly until there are no concerns

What to do if unable to monitor

Where it is not possible to monitor patients this must be documented in the patients notes. Record anything that you can monitor through observation i.e. alertness/awake, pallor, respiratory rate etc. If the patient appears asleep then wake to assess level of consciousness.

10. Post Incident Review

Any incident requiring rapid tranquillisation (or physical intervention) must be contemporaneously recorded. All appropriate staff should be trained to ensure that they are aware of how to correctly record any incident using the 'De-escalation of Challenging Behaviours' pro forma. If insufficient space on the pro forma, documentation should be completed via the patient's medical records.

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?

The Patient should be given the opportunity to document their own account of the intervention. This should be filed in the patient's notes.

Appendix 1:

Rapid Tranquilisation & Management of Acutely Disturbed Behaviour

INDICATIONS

Rapid Tranquilisation should only take place in clinical areas where resuscitation facilities and equipment is immediately available with appropriately trained staff.

Establish a close working relationship with child / young person at the earliest opportunity and sensitively monitor via Mental Health Triage Tool changes in their mood or composure that may lead to aggression or violence

1. Identify trigger

2. Attempt De-escalation / calming techniques

Response → Allow CYP to calm down in a quiet room with regular observation. Repeat dose if required as per guidelines

3. Offer oral medications

Response → Allow CYP to calm down in a quiet room with regular observation. Repeat dose if required as per guidelines

4. Administer Rapid Tranquilisation

Response → Place sedated CYP in recovery position and monitor their NPEWS

5. Repeat step 4

The decision to medicate a patient should be made by a Consultant Paediatrician or if YP is under adult medical team by Medical Consultant in hours and SpR of appropriate team out of hours in liaison with Consultant on call. **NB:** Medical presence is required on the ward when RT is undertaken. Relevant CAMHS or Adult MH team to be informed in hours and CRISIS team / AHMLS out of hours. De-escalation of challenging behaviours pro forma to be completed. Datix to be completed

Rapid Tranquilisation for CYP under 12 years old

Rapid Tranquilisation for YP aged 12-18 years old

Adapted from Paediatric Rapid Tranquilisation Policy, March 2023. (Pier Network Guidelines (Paediatric Innovation, Education and Research Network).

Appendix 2:

Rapid Tranquilisation for CYP UNDER 12 YEARS OLD

Step 1

Identify Triggers

- Keep the CYP safe and choose the appropriate pathway
- Consider physical causes and conditions (acute infection, akathisia, alcohol/illicit substance intoxication, physical co-morbidities, hunger, pain, thirst?
- Consider environmental changes, especially for children with neurodevelopmental conditions.
- Review medicines given in the last 24 hours. If greater than BNFC maximum, contact senior doctor.

Step 2

De-escalation & Calming Techniques

If CYP becomes agitated or angry, a single member of staff should take the primary role in communicating with them and:

- Assess situation for safety
- Negotiate with CYP to resolve the situation in a non-confrontational manner
- Use emotional regulation and self-management techniques to control verbal/non-verbal expression of anxiety / frustration
- Use a designated area/room to reduce emotional arousal / agitation

The decision to medicate a CYP should be made by a Consultant and referral should be made to a senior member of the CAMHS / Mental Health Team

Step 3

Offer Oral Medication

If the CYP is usually on medication, consider an additional dose to help resolve the situation. If this is not appropriate:

- First line **– LORAZEPAM 0.5-1mg PO**
- Second line – **PROMETHAZINE HYDROCHLORIDE 5-10mg PO (max 25mg/day) if Lorazepam is not appropriate.**

Start monitoring Checklist

Step 4

Consider Rapid Tranquilisation where 2 doses of oral treatment have failed or sooner if patient is placing themselves or others at risk

Intramuscular Treatment:

- **LORAZEPAM 0.5 – 1mg IM**

Ensure Flumazenil available for benzodiazepine-induced respiratory depression

- **PROMETHAZINE HYDROCHLORIDE 6.25 – 12.5 mg IM**

Useful option in benzodiazepine--tolerant patients

- **OLANZAPINE 2.5-5mg IM**

- Olanzapine and Lorazepam administration should be separated by at least 1 hour
- Consider Procyclidine Oral / IM (Note: Extra pyramidal Side Effects more common in adolescents):
- Give 5mg initially (Max 10mg/24 h**rs)**

- Start physical health monitoring and at 1 hour review mental state
- Repeat IM dose after 30-60 mins if no response

If no response, arrange urgent team review. Maintain communication with mental health teams.

Adapted from Paediatric Rapid Tranquilisation Policy, March 2023. (Pier Network Guidelines (Paediatric Innovation, Education and Research Network).

Appendix 3

Rapid Tranquilisation for CYP 12 - 18 YEARS OLD

Step 1

Identify Triggers

- Keep the CYP safe and choose the appropriate pathway
- Consider physical causes and conditions (acute infection, akathisia, alcohol/illicit substance intoxication, physical co-morbidities, hunger, pain, thirst)
- Consider environmental changes, especially for CYP with neurodevelopmental conditions.
- Review medicines given in the last 24 hours. If greater than BNFC maximum, contact senior doctor.

Step 2

De-escalation & Calming Techniques

If CYP becomes agitated or angry, a single member of staff should take the primary role in communicating with them and:

- Assess situation for safety
- Negotiate with CYP to resolve the situation in a non-confrontational manner
- Use emotional regulation and self-management techniques to control verbal/non-verbal expression of anxiety / frustration
- Use a designated area/room to reduce emotional arousal / agitation

The decision to medicate a CYP should be made by a Consultant and referral should be made to a senior member of the CAMHS / Mental Health Team

Step 3

Offer Oral Medication

If the CYP is usually on medication, consider an additional dose to help resolve the situation. If this is not appropriate:

- First line – **LORAZEPAM 0.5-2mg PO**
- Second line – **PROMETHAZINE HYDROCHLORIDE 10-25mg PO (max 50mg/day)**

Consider an antipsychotic as first line treatment if severe agitation and / or psychosis thought to be the cause.

- **Olanzapine 5-10mg PO**

Start monitoring Checklist

Step 4

Consider Rapid Tranquilisation where 2 doses of oral treatment have failed or sooner if CYP is placing themselves or others at risk

Intramuscular Treatment:

- **LORAZEPAM 0.5 – 2mg IM –** factors to consider with dosing include weight, lower dose if learning disability and benzodiazepine naive.

Ensure Flumazenil available for benzodiazepine-induced respiratory depression

Partial response

Consider repeating **IM Lorazepam**

No response

Consider Olanzapine (Avoid if known cardiac problems, ECG abnormalities or on other medication known to interact or cause QT prolongation)

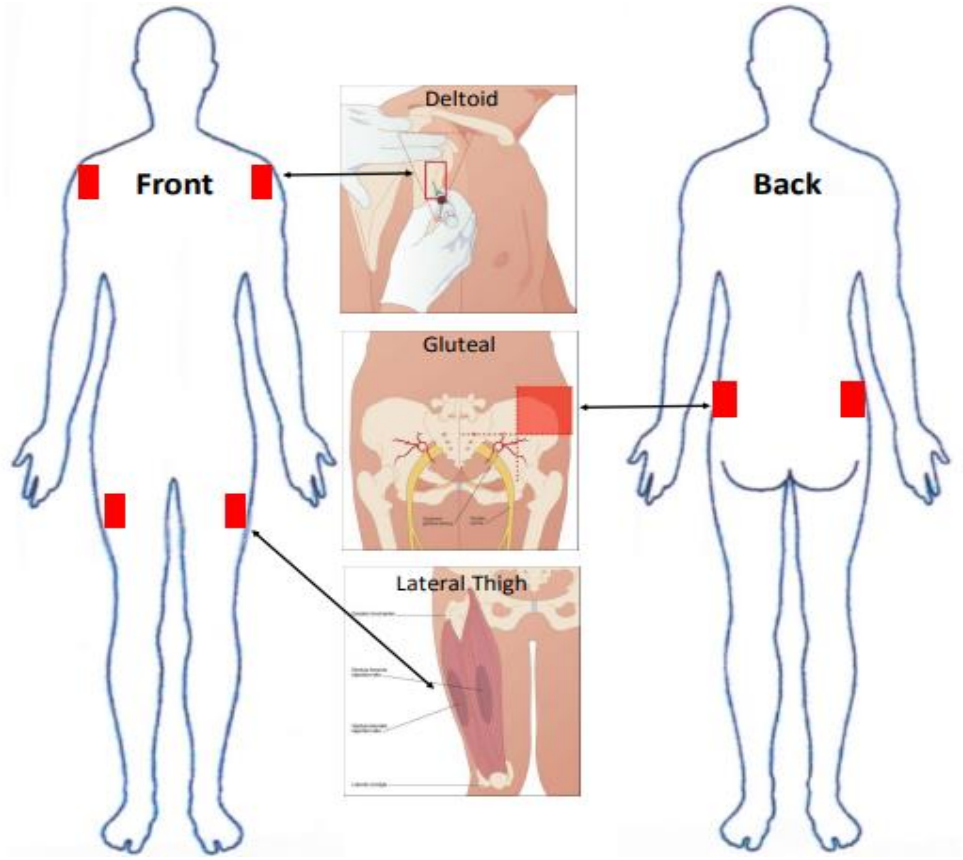
If no response, arrange urgent team review. Maintain communication with mental health teams.

Olanzapine 2.5-5mg IM (IV unlicensed) **DO NOT GIVE WITH IM LORAZEPAM – wait 1 hour after Lorazepam before giving** Consider Procyclidine oral / IM (Note extra pyramidal side effects more common in adolescents) – Give 10mg initially (max 20mg / 24 hours)

Adapted from Paediatric Rapid Tranquilisation Policy, March 2023. (Pier Network Guidelines (Paediatric Innovation, Education and Research Network.

Appendix 4

Administration of Short Acting Intramuscular Injections for the Management of Violence and Aggression



	Anatomical site		
Short Acting Intramuscular Injection RT Medication	**Deltoid**	**Lateral Thigh**	**Gluteal**
Aripiprazole Injection	YES	NO	YES
Haloperidol Injection	YES	YES	YES
Lorazepam Injection	YES	YES	YES
Promethazine Injection	YES	YES	YES
Zuclopenthixol Acetate Injection (Not recommended for RT)	NO	YES	YES

Where practical and time allowing explore with the patient options for administration Site? (Gluteal, Deltoid, Lateral Thigh– See table)

Appendix 5: Side Effects and Management of Side Effects

Complication	Symptoms/signs	Management
Acute dystonia	Severe painful muscular stiffness	Procyclidine 5 to10mg IM stat
Hypotension	Fall in blood pressure (orthostatic or 50mmHg diastolic)	Lie patient flat and raise legs Monitor closely and respond in line with NPEWS thresholds
Neuroleptic Malignant Syndrome (NMS)	Increased temperature, fluctuating blood pressure, muscular rigidity, confusion/altered consciousness	Withhold antipsychotics Monitor closely and respond in line with NPEWS thresholds Liaise with medical team immediately
Arrhythmias	Slow (50/min) or irregular pulse	Monitor closely and respond in line with NPEWS thresholds. Liaise with medical team immediately
Respiratory depression	Reduced respiration rate and reducing consciousness	Give oxygen. If necessary ventilate with a bag valve mask. If respiratory rate drops below 10/min in a patient who has received benzodiazepines give Flumazenil 200 micrograms over 15 seconds. If consciousness is not resumed within 60 seconds give 100 micrograms over 10 seconds Repeat at 60 second intervals Maximum dose 1mg (1000 micrograms) in 24 hours Continue to monitor after respiratory rate returns to normal. Flumazenil has a short duration of action so further doses may be required. CYP may become agitated or anxious on waking

Appendix 6: De-escalation of challenging behaviours

Patient Label

NHS Worcestershire Acute Hospitals NHS Trust

De-escalation of challenging behaviours

Date		Time challenging behaviours started			Time challenging behaviours ended		
Completed by			Print name		Role		
Subject to Mental Health Act?	No	Yes	Section 5(2) (delete n/a section)	Section 2 (delete n/a section)	Expires		
Subject to DoLS	No	Yes	Section 3 (delete n/a section)	Section 5(4) (delete n/a section)			

Challenging behaviours shown: tick those that are applicable – Complete clinical incident form

	Yes		Yes		Yes		Yes	
Ligature Making		Attempting self -strangulation						
Banging head		Sitting down		Standing up		Running at the wall		
Cutting		Arms		Legs		Other (please state where)		
Biting		Arms		Legs		Other (please state where)		
Combative		Family		Other CYP		Staff		
Attempting to abscond		Main door		Fire exit		Playground		
Destructive to property		Please state						
Other behaviours		Please state						

Distraction (TIPP)

	Yes	Effect
Temperature Splash cold water on face		
Intense exercise – star jumps etc		
Paced breathing Breathe in for 3 seconds, hold breath for 3 seconds and breathe out for 5 seconds		
Progressive muscle relaxation Start with the top of the body become aware of muscles in the upper back and ask them to tighten them for 5 seconds and then let go, repeat with muscles in arms, abdomen, back, bottom, thighs, upper legs and calves		
Other: Please state:		

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Patient Label

NHS Worcestershire Acute Hospitals NHS Trust

De-escalation of challenging behaviours

Physical restraint required: Yes / No Least restrain for shortest possible time. Complete a clinical incident form.

Time restraint started: _____ **Time restraint ended:** _____

Staff present – please print names include ward staff, security and RMN as applicable. **Request Doctor to attend.**

Patient position: Sitting / Standing / Lying down – face up, face down (please circle position)

			Arms		Legs		Torso		Other
No.	Name	Role	Left	Right	Left	Right	Front	Back	Please state
1									
2									
3									
4									
5									
6									
7									

If Police were asked to attend please note incident number: _____ / Not applicable

Police Collar Number: _____ and _____ and

Was medication required? YES NO (record NPEWS at 15 min intervals for one hour if IM used, record AVPU if non-compliant – ensure Flumanezil available if IM Lorazepam used)

Medication	Dose	Route	Time	Effect

Patient Label

NHS Worcestershire Acute Hospitals NHS Trust

De-escalation of challenging behaviours

Did patient sustain injuries? Yes No

If yes list injuries, stating self inflicted or result of restraint and consider use of body map. Doctor to review

Site and type of Injury	Cause of Injury	First aid required		Medical intervention required		Comments
		Yes	No	Yes	No	

Did staff sustain injuries? Yes No

Site and type of Injury	Cause of Injury	First aid required		Medical intervention required		Comments
		Yes	No	Yes	No	

Patient Label

NHS
Worcestershire
Acute Hospitals
NHS Trust

De-escalation of challenging behaviours

Debrief with patient completed: YES / NO

Reason not completed: _____

Date		**Time**		**Print Name**		**Role**	
Triggers identified							
Strategies identified that help to de-escalate							
Staff debrief held: Yes / No Date and Time		Clinical Incident Form No:		Form completed by: Name: Sign:		Role	

Monitoring and Compliance

Page/ Section of Key Document	Key control:	Checks to be carried out to confirm compliance with the Policy:	How often the check will be carried out:	Responsible for carrying out the check:	Results of check reported to: *(Responsible for also ensuring actions are developed to address any areas of non-compliance)*	Frequency of reporting:
	WHAT?	**HOW?**	**WHEN?**	**WHO?**	**WHERE?**	**WHEN?**
	Hospital staff awareness of SOP for Rapid Tranquilisation for CYP aged under 18 years old	Staff audit Datix analysis	Annually	Divisional Governance Teams	Divisional Governance Teams CYP Board	Annually

11. Policy Review

This policy will be reviewed every three years or earlier if regulations change by the named individual on the front of the policy and circulated for comment prior to approval by the CYP Trust Board

Dissemination of the document will be as per the Trust Policy for Policies (WAHT-CG-827).

The policies will be available to view on the Trust Key Documents page on the intranet.

12. References

- NICE Clinical Guideline 10 - Violence and aggression: short-term management in mental health, health and community settings.
- Paediatric Rapid Tranquilisation Policy (2024) Pier Network
- Tier 4 Inpatient CAMHS and Forward Thinking Birmingham (FTB) Policy for Rapid Tranquilisation. (2024) Birmingham Women's and Children's Foundation Trust
- Guidelines for the use of Rapid Tranquilisation (2021) Herefordshire and Worcestershire Health and Care Trust.

13. Background

Supporting Document 1 – Equality Impact Assessment form

NHS Worcestershire Acute Hospitals NHS Trust

Herefordshire & Worcestershire STP - Equality Impact Assessment (EIA) Form
Please read EIA guidelines when completing this form

Section 1 - Name of Organisation (please tick)

Herefordshire & Worcestershire STP		Herefordshire Council		Herefordshire CCG	
Worcestershire Acute Hospitals NHS Trust	X	Worcestershire County Council		Worcestershire CCGs	
Worcestershire Health and Care NHS Trust		Wye Valley NHS Trust		Other (please state)	

Name of Lead for Activity	

Details of individuals completing this assessment	**Name**	**Job title**	**e-mail contact**
Date assessment completed			

Section 2

Activity being assessed (e.g. policy/procedure, document, service redesign, policy, strategy etc.)	**Title:** Paediatric Rapid Tranquilisation Policy			
What is the aim, purpose and/or intended outcomes of this Activity?	The Trust recognises that the use of rapid tranquillisation is a significant event for people who use our services and this policy outlines the trust approach to the use of rapid tranquillisation making this as safe as possible.			
Who will be affected by the development & implementation of this	❑	Service User	❑	Staff
	❑	Patient	❑	Communities
	❑	Carers	❑	Other _____

activity?	❑	Visitors	❑	
Is this:	❑ Review of an existing activity ❑ New activity ❑ Planning to withdraw or reduce a service, activity or presence?			
What information and evidence have you reviewed to help inform this assessment? (Please name sources, eg demographic information for patients / services / staff groups affected, complaints etc.	Mental Capacity Act, 2005. The Stationery Office, 2005. Available at: http://www.legislation.gov.uk/ukpga/2005/9/pdfs/ukpga_20050009_en.pdf Department of Health, Mental Health Act 1983: Code of Practice. https://www.gov.uk/government/publications/code-of-practice-mental health-act-1983 Rapid Tranquilisation Guidelines V2 H&W Health and Care NHS Trust Paediatric Rapid Tranquilisation Policy (2024) PIER (Paediatric Innovations, Educations and Research Network Tier 4 Inpatient CAMHS and Forward Thinking Birmingham (FTB) Policy for Rapid Tranquillisation (2024)			
Summary of engagement or consultation undertaken (e.g. who and how have you engaged with, or why do you believe this is not required)				
Summary of relevant findings				

Section 3

Please consider the potential impact of this activity (during development & implementation) on each of the equality groups outlined below. **Please tick one or more impact box below for each Equality Group and explain your rationale**. Please note it is possible for the potential impact to be both positive and negative within the same equality group and this should be recorded. Remember to consider the impact on e.g. staff, public, patients, carers etc. in these equality groups.

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Age	√			MHA/MCA outlines how this policy is delivered in relation to age. Age is considered in relation to medication and its dosing according to age.
Disability		√		Specific section for people with Learning Disabilities and Neurodevelopmental disorders and the need to make adaptations
Gender Reassignment		√		Policy references need for staff to be sensitive to gender but does not discriminate with regard to gender reassignment.
Marriage & Civil Partnerships		√		No clear positive or negative impact of this policy.

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Pregnancy & Maternity		√		No clear positive or negative impact of this policy. Pregnancy needs to be taken into account before initiating RT procedure.
Race including Traveling Communities		√		No reference in this policy. All patients to be treated with the same choices of medication, regardless of race or ethnic group
Religion & Belief		√		Not referred to in this policy. All patients will be treated with the same choices of medication, regardless of religion or belief.
Sex		√		Policy acknowledges gender differences and sensitivities in the 'policy
Sexual Orientation		√		No reference made in this policy. All patients will be treated with the same choices of medication, regardless of sexual orientation
Other Vulnerable and Disadvantaged Groups (e.g. carers; care leavers; homeless; Social/Economic deprivation, travelling communities etc.)		√		
Health Inequalities (any preventable, unfair & unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental & economic conditions within societies)		√		

Section 4

What actions will you take to mitigate any potential negative impacts?	Risk identified	Actions required to reduce / eliminate negative impact	Who will lead on the action?	Timeframe
		.		

How will you monitor these actions?	**The policy will be monitored reports from Datix system.**
When will you review this EIA? (e.g in a service redesign, this EIA should be revisited regularly throughout the design & implementation)	**With policy reviews**

Section 5 - Please read and agree to the following Equality Statement

1. Equality Statement

1.1. All public bodies have a statutory duty under the Equality Act 2010 to set out arrangements to assess and consult on how their policies and functions impact on the 9 protected characteristics: Age; Disability; Gender Reassignment; Marriage & Civil Partnership; Pregnancy & Maternity; Race; Religion & Belief; Sex; Sexual Orientation

1.2. Our Organisations will challenge discrimination, promote equality, respect human rights, and aims to design and implement services, policies and measures that meet the diverse needs of our service, and population, ensuring that none are placed at a disadvantage over others.

1.3. All staff are expected to deliver services and provide services and care in a manner which respects the individuality of service users, patients, carer's etc, and as such treat them and members of the workforce respectfully, paying due regard to the 9 protected characteristics.

Signature of person completing EIA	
Date signed	
Comments:	
Signature of person the Leader Person for this activity	
Date signed	
Comments:	

Supporting Document 2 – Financial Impact Assessment

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

	Title of document:	Yes/No
1.	Does the implementation of this document require any additional Capital resources	No
2.	Does the implementation of this document require additional revenue?	No
3.	Does the implementation of this document require additional manpower	No
4.	Does the implementation of this document release any manpower costs through a change in practice	No
5.	Are there additional staff training costs associated with implementing this document which cannot be delivered through current training programmes or allocated training times for staff?	No
	Other comments:	

If the response to any of the above is yes, please complete a business case and which is signed by your Finance Manager and Directorate Manager for consideration by the Accountable Director before progressing to the relevant committee for approval

Contribution List

This key document has been circulated to the following individuals for consultation;

Designation
Clinical Director (Paediatrics)
Pharmacist
Children's Emergency Department
CAMHS Worcestershire Health and Care Trust

This key document has been circulated to the chair(s) of the following committees / groups for comments;

Committee
Paediatric Governance Committee
Urgent Care Governance Committee
Children's and Young People Board
Medicines Safety Committee