Regional Guideline for the Management of Acutely Disturbed Behaviour (ADB) through the use of Pharmacological De-escalation and Rapid Tranquillisation

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1. Introduction

The recommendations in this regional guideline are based on the NICE NG10 Violence and aggression: short term management in mental health, health and community settings (2015). The guidance also offers guidance on prevention and de-escalation strategies which are not described in NICE NG10 which have been at arrived at after careful consideration of the evidence available. When exercising their clinical decision for the pharmacological management of acute behavioural disturbance, professionals are expected to take this guideline fully into account, alongside the individual needs, preferences and values of their patients. It is not mandatory to apply the recommendations contained herein, and the guideline does not override the responsibility to make decisions appropriate to the circumstances of the individual, in consultation with them and their families and carers or guardian.

This guideline adopts the definition in the British Association for Psychopharmacology / National Association of Psychiatric Intensive Care Units (BAP/NAPICU) guidelines of acute behavioural disturbance being reflective of an acute mental state associated with an underlying mental or physical disorder, symptoms of which range from agitation and distress (which may or may not lead to aggression or violence) to actual aggression or violence that causes harm or injury to another person or damage to property. The violence or aggression can be physical or verbal. Management of acute behavioural disturbance is multifaceted and in addition to medication should incorporate de-escalation techniques and non-pharmacological measures.

All staff should familiarise themselves with the NICE NG10 pathway which serves as a useful summary of the full NICE guideline and outlines other approaches to management of acute behavioural disturbance.

The focus of this guideline is on the pharmacological management in de-escalation and rapid tranquillisation (RT) only; and describes the recommended pharmacological management options that may be used to manage acute behavioural disturbance in patients cared for in Health and Social Care Trusts hospitals across Northern Ireland.

2. Purpose

The purpose of this regional guideline is to ensure a consistent approach to the management of acute behavioural disturbance, whilst maintaining patient safety and minimising risk. The safety and dignity of patients and staff are a priority.

This regional guideline sets out the standards of care that are expected by clinical team members when prescribing medication for the management of acute behavioural disturbance.

3. Scope

This guideline DOES NOT apply to the management of delirium or acute alcohol (including psychoactive substances) withdrawal. The appropriate pathways should be followed.

This guideline is concerned with the prescribing, administration and monitoring of oral PRN, intramuscular and intravenous medication and is intended to support the delivery of appropriate, safe and effective pharmacological de-escalation and RT. The guidance represents expected practice for hospital settings and replaces all previous local RT related guidance or procedures.

This guideline does not provide advice on non-pharmacological strategies for de-escalation and staff should refer to the NICE NG10 guideline for this information.

4. Definitions

Acute behavioural disturbance (ABD) is defined by British association of Psychopharmacology (BAP) as a composite term to include the concepts of 'agitation', 'aggression' and 'violence' in the context of an acute mental state associated with an underlying mental and/or physical disorder.

De-escalation is defined by NICE as the use of techniques (including verbal and non-verbal communication skills) aimed at diffusing anger and averting aggression. PRN medication, given orally, can be used as part of a de-escalation strategy accompanied by non- pharmacological techniques.

Oral PRN (pro re nata) is defined as when needed. In this guideline, PRN. refers to the use of medication as part of a strategy to de-escalate or prevent situations that may lead to violence or aggression; it does not refer to PRN medication used on its own for rapid tranquillisation during an episode of violence of aggression.

Rapid tranquillisation (RT) is defined by NICE as the use of medication by the parenteral route (usually intramuscular (IM) or, exceptionally, intravenous (IV)) if oral medication is not possible or appropriate and urgent sedation with medication is needed.

Violence and aggression is defined as a range of behaviours or actions that can result in harm, hurt or injury to another person. The violence or aggression can be physical or verbal.

For the purposes of this policy and to guide safe prescribing the following are recognised:
Child is defined as a person aged between 6 and 12 years.
Young person is defined as a person aged between 13 and 17 years.
Adult is defined as a person 18 years and older.
Older adults are defined as persons 65 years and over.

Parkinsonian syndrome is defined as including those patients with idiopathic Parkinson's disease, Parkinson's disease dementia and Dementia with Lewy Bodies).

SPC is defined as Summary of Product Characteristics

Senior Doctor is defined a ST4 and above, specialty and associate specialist doctors or consultant, all with experience in the pharmacological management of ABD.

5. Roles and responsibilities

5.1 The Trusts will:

- Ensure that governance arrangements are in place and will include audit procedures that relate to training needs and provision, and the review of untoward incidents.
- Ensure that when the guideline is reviewed and updated that this is supported by local governance arrangements.
- Learn and react appropriately to any untoward incidents and events related to RT.
- Respond or react to any resource implications related to RT.

5.2 It is the responsibility of the relevant service area Directors and Medical Director to ensure implementation of this guidance.

5.3 All staff involved in the RT of patients presenting with ABD should be familiar with the content of this guideline and follow it when it is appropriate to do so.

5.4 Clinicians should use their own clinical judgement in each case and if they decide that a different management approach is clinically indicated then the reasons for this should be clearly documented.

6. Training

6.1 Staff should be trained, to a level appropriate to their role, in how to assess and manage potential and actual violence or aggression using de-escalation techniques, restraint and pharmacological management.

6.2 Appropriate staff should also be trained to Immediate Life Support (ILS) in the maintenance of patient's airways, cardio-pulmonary resuscitation (CPR), the use of defibrillators and the use of pulse oximeters.

6.3 Prescribers and those who administer medicines should be familiar with and have received training in rapid tranquillisation, including: the properties of benzodiazepines; antipsychotics; antimuscarinics and antihistamines, associated risks, including cardio-respiratory effects of the acute administration of the drugs.

6.4 The responsibility to ensure adequate training is undertaken lies with the service area Directors and Medical Director and should extend to include locum, agency and bank staff.

6.5 In addition for members of the Royal College of Psychiatrists, an e-learning module 'rapid tranquillisation of the acutely disturbed patient' may be for available.

7. Overview of the short-term management of ABD

PREDICTION
Risk Assessment
Necessary and Lawful Searches e.g. drugs/weapons
Mental Health Presentation
Behavioural Presentation
Other incidents (especially if escalating)

↓

PREVENTION
De-escalation techniques including oral PRN medication
Observation

↓

INTERVENTIONS FOR CONTINUED MANAGEMENT **Consider, in addition to above, one or more of the following:-**		
Rapid Tranquillisation (RT)	**Seclusion**	**Physical Intervention (PI)**
Use to avoid prolonged physical intervention. Parenteral medication is required to urgently calm acutely disturbed behaviour in a patient with either psychotic or non-psychotic symptoms.	Used to avoid prolonged physical intervention.	Better if patient responds quickly. Can be used to facilitate administration of RT and/or enable RT to take effect.

RELATIVE CONTRA-INDICATED AS AN INTERVENTION		
RT	**Seclusion**	**PI**
Refer to individual medication SPC.	Seclusion should be reviewed after rapid tranquillisation, if given, has taken effect. When other interventions not yet explored.	Prolonged physical intervention.

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COMPLETE DATIX / IR1
POST-INCIDENT REVIEW

8. Key Principles

8.1 Staff should adopt approaches to care that respect patients; independence, choice and human rights.

8.2 A multidisciplinary approach is required to manage harmful or potentially harmful behaviour and should involve the patient and their carers. The focus is towards prediction and prevention of potentially harmful events.

8.3 All staff involved in an incident requiring the use of restrictive practice should be aware of the potential for damage to the patient / professional relationship and ensure that everything possible is done to reduce the impact

8.4 All staff involved in RT need to be aware of the legal framework that authorises this intervention and this should be in line with the guidance contained within the RQIA Guidelines on the use of the Mental Health (Northern Ireland) Order 1986, the Mental Health (Northern Ireland) Order 1986 Code of Practice and the Mental Capacity Act (Northern Ireland) 2016 and its supporting Deprivation of Liberty Safeguards Code of Practice. Any departure from that guidance should be clearly recorded and clinically justified.

8.5 Documentation in patient's notes must demonstrate that administration of a particular medication for RT was justified, reasonable, proportionate and the least restrictive option to meet the need. Any incident requiring restrictive practice (e.g. physical intervention, seclusion or parenteral RT medication) **must** be recorded on the Datix Incident Reporting System.

8.6 Level 1 refers to the use of oral medication. This is indicated for patients where non-pharmacological de-escalation techniques were not adequate to diffuse anger or avert aggression, the patient is accepting of oral medication and there is not an immediate risk of violence or aggression. The NICE guideline clearly states that oral PRN medication on its own is not de-escalation.

8.7 Level 2 refers to rapid tranquillisation. It should only be considered when there is actual or clear risk of imminent violence or aggression where de-escalation and other preventative strategies including oral PRN have been unsuccessful. It is common practice for patients to be prescribed the same PRN medicine to be administered orally or if indicated intramuscularly. If the medication is administered by IM/IV injection this is not de-escalation and must be considered RT.

8.8 Level 3 describes interventions to consider if Level 2 interventions have failed to produce a sufficient response. Level 3 interventions should only be used by or after consultation with a senior doctor.

8.9 Any preference that the patient has expressed when they are well, concerning future treatment should be taken into consideration. These may include preferred treatment choices documented in the multidisciplinary team treatment and care plan known to the patients care coordinator or keyworker e.g. Wellness and Recovery Action Plan (WRAP), advance directives or behaviour support plan. WRAP plans, advance directives and behaviour support plans must be accessible and up to date.

8.10 The patient must be informed about the medications that are prescribed and administered in an emergency, as soon as possible following the administration of the medication. Where consent to share information has been previously given, the family member/carer must be informed about the medications prescribed and administered in an emergency as soon as possible following the administration of a medication.

8.11 Specific to children and adolescent services. All patients must be informed that medication is to be given and given the opportunity at any stage to accept oral medication voluntarily. In children / young people who are not Gillick competent, parent(s)/carer(s) should be informed of the situation and consent sought for treatment, in advance if at all possible. Consideration should be given to inform the child/adolescent and parent(s)/carer(s) that rapid tranquillisation has been necessary.

8.12 Specific to Intellectual disability (ID) Services. All patients must be informed (in a way that best facilitates their understanding) that medication is to be given and given the opportunity to accept oral medication.

8.13 A post-incident de-brief should take place as soon as possible after the incident and, where possible, a post-incident review should take place within 72 hours of an incident ending. (see section 15.1.2)

8.14 Resuscitation facilities must be available within three minutes in all healthcare settings where RT might be used. Suitable equipment must be available and maintained as per local resuscitation guidance.

8.15 Staff must follow local infection control policies relevant to the area at that time.

9. Specific risks of medications in combination with other physical practice interventions

9.1 Patients may occasionally require physical intervention to prevent violence to themselves or others. There are increased risks associated with medications used in combination with physical restraint. Effective drug treatment may be needed to allow assessment and management. Medication should be prescribed following attempts to de-escalate using non-pharmacological approaches and the least restrictive practice that is appropriate to manage any evolving incident.

9.2 Medication for RT, particularly in the context of physical intervention, should be used with caution owing to the following risks:

- loss of consciousness
- sedation with loss of alertness
- loss of airway
- cardiovascular and respiratory collapse
- interaction with medicines already prescribed or illicit substances taken
- possible damage to patient-staff relationship
- underlying coincidental physical disorder

10. Prescribing Principles

The following should be considered when choosing which treatment is appropriate for use, and documented in the patient's clinical notes/ management plan, according to local policy:

- The patients' preferences or advance statements and best interest decisions, where possible.
- Pre-existing physical health conditions.
- Previous response to medication, including adverse effects.
- Potential for interaction with other medications.
- The total daily dose of medication prescribed and administered.
- Whether there is a chance the patient may be pregnant, and whether this has been tested.

10.01 The aim of pharmacological de-escalation/RT is not sedation, but to achieve a state of calm so that there is minimal risk to the patient, staff and others.

10.02 When RT is being administered, a doctor should be available for advice. A junior doctor must be able to contact a senior doctor for advice if required. .

10.03 Medical notes should be reviewed, if available, to see if the patient's response and tolerability to previous medications is known. In addition current and historical physical co-morbidities that may affect drug absorption /distribution /elimination should be considered as well as recent observations and ECG (The NICE Guideline CG 178 Psychosis and schizophrenia in adults: prevention and management recommends that before starting an antipsychotic, an ECG should be offered). Any other relevant information should be taken into consideration when prescribing e.g. exclusion of substance intoxication, organic brain states or injuries, allergy status, history of severe idiosyncratic reaction to the medication or Neuroleptic Malignant Syndrome (NMS) and medication adherence if relevant, and consider any reasons for medication non-adherence or refusal.

10.04 Avoid unnecessary polypharmacy. This may necessitate careful choice of drug in relation to either current treatment or expected maintenance treatment.

10.05 When prescribing oral PRN medication for pharmacological de-escalation or medication for RT, then prescribing should be as per the medicines code, in addition:

- The indication for use MUST be clearly indicated.
- The order in which these are to be used if more than one medication is prescribed for the same indication.
- If two medicines are intended to be given at the same time this should be clearly stated.
- Frequency of administration / minimum interval between doses.
- Maximum dose in 24 hours.

10.06 The inpatient Kardexes MUST be reviewed at least once weekly by the Multidisciplinary team if pharmacological de-escalation or RT is prescribed.

10.07 If RT is being administered, a senior doctor should discuss or review all prescribed medications, at least once a day (this can be done remotely), as part of continuous risk assessment; to ensure changes in the patient's mental and physical state over time are reflected.

10.08 If an inpatient is being transferred between or within another clinical area or Trust, a full medical history, including the patient's response to medications, any adverse effects, should accompany them along with any Wellness and Recovery Action Plan (WRAP), advance directives or behaviour support plan.

10.1. Advice on doses

10.1.1. Prescribe the minimum effective dose and consider tolerability and previous response. For prescribing information for the drugs used in management of ABD, (see Appendix A). Consider lower maximum doses in older adults or the physically frail.

10.1.2. Frequent small doses are safer and more effective than single large doses, but this may lead to a risk of accumulation. Therefore, the medication used should have a short duration of action and the prescriber should bear in mind the pharmacokinetics of the agents used.

10.1.3. Avoid variable doses of oral PRN e.g. lorazepam 1–2mg as this leads to higher doses being administered without review.

10.1.4. Allow sufficient time following administration for therapeutic response before doses are repeated.

10.1.5. In some cases current BNF and SPC dose may be knowingly exceeded under the advice of a senior doctor (e.g. lorazepam >4mg/day), bearing in mind the overall risks.

10.1.6. Promethazine should not be used in patients suffering from CNS depression of any cause or within 14 days of administration of a monoamine oxidase inhibitor.

10.1.7. **High Dose Antipsychotic Monitoring** must be conducted if a patient is receiving more than 100% BNF maximum daily dose of antipsychotics (monotherapy or poly-therapy). Undertake frequent and intensive monitoring post incident including level of consciousness, pulse, blood pressure, respiratory rate, temperature and hydration. The rationale for prescribing high dose antipsychotics **must** be documented in the patents notes.

10.2. Level 1 Oral pharmacological de-escalation

10.2.1. When prescribing oral PRN medication for pharmacological de-escalation take the following points into consideration:

- Do not prescribe oral PRN medication for de-escalation routinely or automatically on admission.
- Individualise oral PRN medication and discuss with the patient if possible.

10.2.2. Lorazepam alone is encouraged as the drug of first choice, particularly in elderly and frail individuals. There is normally a delayed onset of action particularly if the patient has recently ingested food. Once the patient has been calmed, either by de-escalation techniques or use of lorazepam an alternative medication such as an antipsychotic drug may be required for maintenance of the situation. Remember that repeated use of a benzodiazepine may result in tolerance to the effect and this will probably become evident within 7 to 10 days.

10.2.3. If lorazepam is not clinically appropriate for the management of ABD and:

- If a patient is prescribed a regular antipsychotic, consider promethazine. Promethazine has anticholinergic side effects such as dry mouth, blurred vision, urinary retention and constipation. Prescription of promethazine is not recommended in individuals who are cognitively impaired or who are at risk of cognitive impairment, e.g. older and/or frail individuals and patients with dementia or delirium/history of delirium. Promethazine may also prolong the QT interval.
- If a patient is not already taking regular oral or depot antipsychotic oral haloperidol or olanzapine may be used.

10.2.4. When necessary, and in certain clinical circumstances, alternative Level 1 options such as oral risperidone or quetiapine may be considered. For dosing see Appendix A

10.3. Level 2 Rapid Tranquillisation

10.3.1. Intramuscular (IM) administration is recommended and should be used within mental health settings in the vast majority of cases, however intravenous (IV) administration may be considered in the non-mental health settings in certain clinical circumstances but should be avoided in elderly and frail whenever possible.

10.3.2. The recommendations below do not preclude the use of alternative treatment options. However, their use should be tailored to the individual in line with the recommendations for RT.

10.3.3. When prescribing medication for use as RT.

- Do not prescribe for ongoing use
- Prescribe oral and parenteral doses separately – do not use PO/IM abbreviation as these routes are indicated for different reasons.
- Prescribe defined doses as opposed to a dosing range where possible.
- When administering more than one parenteral medicine do not mix medications in the same syringe

10.3.4. The use of parenteral lorazepam alone is supported as the first line option in patients where there is no clear psychotic component to the presentation or where there is insufficient information to guide the choice of medication. Intramuscular (IM) formulations can take in excess of an hour before achieving full effect. Staff should take such delays into account before administering follow-up doses.

10.3.5. If there is a partial response to parenteral lorazepam, consider a further dose.

10.3.6. If there is no response to parenteral lorazepam, consider IM haloperidol combined with IM promethazine. There is some evidence to suggest that promethazine reduces the risk of movement-related side effects associated with haloperidol. If parenteral haloperidol is used, monitor for emergence of EPSEs, especially dystonia and ensure procyclidine is available.

10.3.7. If there is a partial response to IM haloperidol combined with IM promethazine, the full effect of haloperidol may not be apparent for more than 1hour and more than 2hours for promethazine. Consider repeating parenteral haloperidol WITHOUT promethazine if it is less than 2hours since the last injection.

10.3.8. The SPC for haloperidol recommends all patients must have an ECG prior to administration. If an ECG is not available, or there is evidence of cardiovascular disease, the prescriber should consider the risks and benefits of using parenteral haloperidol and be able to justify their prescribing decision, as it is considered an off-label use.

10.3.9. Simultaneous administration of parenteral antipsychotics and parenteral lorazepam may be associated with excessive sedation and cardio respiratory depression. If this combination is deemed necessary then patients must be monitored for excessive sedation and postural hypotension.

10.3.10. Patients taking regular clozapine or olanzapine require care when giving benzodiazepines especially parenteral route as potentially fatal orthostatic and cardio-respiratory dysregulation have been reported. If this combination is considered necessary, it is essential to undertake frequent monitoring of the patient.

10.4. **Level 3: Failure to respond to Level 2 RT**

10.4.1. Different strategies including medicines or combinations not included in NICE NG10. These must be tailored to the individual and might be guided by previous response in similar circumstances. The rationale and outcome must be clearly recorded.

10.5. **Alternative options for RT outside of guidance for Emergency Departments (ED)**

10.5.1. ED will be expected to use these guidelines for the majority of individuals with acute behavioural disturbance secondary to psychiatric states (e.g. psychosis and mania). However it is recognised that within ED only, a cohort of individuals will present with acute behavioural disturbance, secondary to an underlying medical condition, and may need to be treated as per The Royal College of Emergency Medicine (RCEM) guideline – Management of Excited Delirium/Acute Behavioural Disturbance.

10.5.2. Documentation in patient's notes must demonstrate that administration of a particular medication outside the regional guideline for the management of acutely disturbed behaviour though the use of pharmacological de-escalation and rapid tranquillisation was justified, reasonable, proportionate and the least restrictive option to meet the need.

10.5.3. ED staff should be involved in immediate post-incident debrief and NICE recommend that a full mental health assessment should be available within 1 hour of alert from the ED, or as soon as is appropriate.

10.6. **Alternative options for RT outside of guidance for all other acute and mental health settings**

10.6.1. All other areas will be expected to use these guidelines for the majority of individuals. However it is recognised that a small cohort of individuals may need to be treated where IM lorazepam or IM haloperidol + IM promethazine are not considered clinically appropriate, the following may be considered. See Appendix A for dosing.

- Olanzapine IM. **Olanzapine IM MUST NOT be administered within one hour of IM lorazepam**. It is not licensed for use beyond three days
- Aripiprazole IM causes less hypotension than olanzapine, but some sources suggest that it may be less effective.
- Promethazine IM alone: useful for benzodiazepine-tolerant patients.

- In very exceptional circumstances there may be indication to give medication intravenously (IV). The decision to use IV route must only be used following discussion with the consultant or senior doctor who has previous experience of using intravenous (IV) interventions for ADB. Administration may only be undertaken by a practitioner who is fully trained in IV administration, can manage medical emergencies and where resuscitation equipment is available.
- ECT may also be considered, if clinically appropriate.

10.6.2. Documentation in patient's notes must demonstrate that administration of a particular medication outside the regional guideline for the management of acutely disturbed behaviour though the use of pharmacological de-escalation and rapid tranquillisation was justified, reasonable, proportionate and the least restrictive option to meet the need.

11. Drugs NOT recommended for rapid tranquillisation

11.1. The following drugs are **NOT** recommended for rapid tranquillisation:

- Oral and IM chlorpromazine – IM chlorpromazine is painful and can cause severe hypotension. Chlorpromazine **MUST NEVER** be given intravenously.
- IM diazepam – absorption is erratic.
- IM depot antipsychotics- they are not fast acting.
- Zuclopenthixol acetate (Clopixol Acuphase ®) is **not** recommended for routine use in RT due to its slow onset of action.

11.2. Zuclopenthixol acetate (Clopixol Acuphase ®) may be recommended by a consultant Psychiatrist in certain circumstances for behavioural disturbance occurring over an extended time period. This MUST include a multidisciplinary review, including conducting a comprehensive case review, reviewing the appropriateness of the clinical setting for the patient and their treatment. In addition there MUST be at least one of the following:

- Past history of good/timely response.
- An advance directive indicates that it is the treatment of choice and it forms part of the patients overall management plan.
- Past history of repeated parenteral administration required.

11.3. Zuclopenthixol acetate (Clopixol Acuphase ®) **MUST NOT BE USED** on individuals who:

- Are antipsychotic (neuroleptic) naïve i.e. patients without any previous exposure to antipsychotic medication.
- Are sensitive to extrapyramidal side effects.
- Have cardiac disease, hepatic or renal impairment or are pregnant.

12. Precautions for rapid tranquillisation and prescribing in specific patient groups (See Appendices A,B,C,D & E)

12.1. General precautions for prescribing

12.1.1 The dose of medication prescribed should be adjusted and lowered according to bodyweight, and any other co-morbid medical conditions including but not limited to:

- patients with eating disorders
- physical frailty
- any disorders that affect metabolism, including hypothermia, stress, extreme emotional response and post extreme physical exertion
- organic disease
- hepatic or renal impairment

12.1.2 Antipsychotic medication (in particular haloperidol) should be avoided where possible in patients with a parkinsonian syndrome.

12.1.3 Compromised respiratory function – in general avoid benzodiazepines. Where benzodiazepines need to be considered seek advice from senior doctor.

12.1.4 History of epilepsy or at risk of seizures; caution when using antipsychotics – due to risk of lowering of seizure threshold.

12.1.5 Potential interaction with other mediations

12.2 Cardiovascular Safety

12.2.1 The cardiovascular health and risk factors for each patient should be assessed prior to the prescribing of medications for de-escalation and RT.

12.2.2 Antipsychotics as a group are probably associated with an increased risk of QTc prolongation. Normal limits of QTc are less than 440 ms in men and less than 470 ms in women. The risk is dose related and the risks for individual drugs are probably additive when used in combination. Therefore avoid antipsychotic medication if there is known QT / QTc prolongation or conduction abnormalities to avoid potentiation of ventricular arrhythmia or cardiac arrest. Consider risk factors for prolonged QTc interval, such as congenital long QT syndrome, family history of cardiac conduction abnormalities and previous occurrences of medication-mediated QTc prolongation. (see table 1 and 2)

Table 1: Summary of the risk for QTc prolongation for common antipsychotics.

(Adapted from the Maudsley Guideline 13th edition, 2018)

No effect	Low Effect No or average increase <10msec at clinical doses or severe effect only reported following overdose	Moderate Effect Average increase >10msec at clinical doses or ECG officially recommended	High Effect Average increase >20msec	Unknown effect
Brexpiprazole* Cariprazine* Lurasidone	Aripiprazole+ Asenapine Clozapine Flupentixol Fluphenazine Loxapine Perphenazine Prochlorperazine Olanzapine++ Paliperidone Risperidone Sulpiride	Amisulpride** Chlorpromazine Haloperidol Iloperidone Levomepromazine Melperone Quetiapine Ziprasidone	Any intravenous antipsychotic Pimozide Sertindole Any antipsychotic or combination of antipsychotics used in doses exceeding BNF maximum dose	Pipotiazine Trifluoperazine Zuclopenthixol (including Clopicol Acuphase®)

**Limited clinical experience (association with QT prolongation may emerge)*

+ One case of torsades de pointes (TDP) reported; 2 cases of QT prolongation and an association with TDP found in database study. Recent data suggest aripiprazole causes QTc prolongation of around 8ms; it may increase QT dispersion

++Isolated cases of QTc prolongation and has effects on cardiac ion channel, I_{K1}, other data suggest no effect on QTc.

***Torsades de pointes common in overdose, strong association with TDP in clinical doses with Amisulpride*

Table 2: Other psychotropic and non-psychotropic medications associated with prolonged QTc.

(Adapted from the Maudsley Guideline 13th edition, 2018 and crediblemeds)

Antibiotics	Antimalarials	Antiarrthymics	Others
Erythromycin	Chloroquine	Quinidine	Citalopram
Clarthromycin	Mefloquine	Disopyramide	Tricyclic antidepressants
Ampicillin	Quinine	Procainamide	Trazodone
Co-trimoxazole		Sotalol	Lithium
Ciprofloxacin		Amiodarone	Promethazine
Levofloxacin		Bretylium	Methadone
Moxifloxacin			Amantadine
			Cyclosporin
			Diphenydramine
			Hydroxyzine
			Nicardipine
			Tamoxifen

Refer to www.crediblemeds.org for latest and more detailed information.

12.2.3 Haloperidol is contraindicated in clinically significant cardiac disorders. A clinical risk assessment must be carried out before prescribing haloperidol. The SPC for haloperidol recommends that a baseline ECG is performed prior to treatment for all patients and also avoiding the use of concomitant antipsychotics. This may not always be possible in ABD. In such a situation, the prescribing doctor will have to balance the cardiac risks against those arising from the patient's behaviour.

12.2.4 Consider, when applicable:

- The use of lorazepam alone
- To avoid antipsychotics (particularly the use of parenteral haloperidol with IM promethazine).
- The use of any concomitant medication, which may prolong QTc interval.

12.3 **Intellectual Disability (ID)** (See Appendix B and Appendix A)

12.3.1 Patients will be managed as per Appendix B but staff must be familiar with the NICE guidelines for managing challenging behaviour in ID.

12.3.2 The choice between using physical intervention and RT as a method of managing violent behaviour in those with an ID should be part of an overall care plan. RT for patients lacking capacity should be undertaken in adherence with best interest protocol/ guidelines.

12.3.3 People with severe learning and communication difficulties may not be able to express discomfort or pain in usual ways.

12.3.4 Sensory impairments must be detected and remedied to minimise the consequent disability, and a specialised and sensitive approach is usually needed.

12.3.5 Caution should be exhibited for patients with ID particularly if they have conditions like epilepsy, severe ID, genetic disorders or dementia.

12.3.6 If possible avoid using parenteral RT for patients with severe ID or severe autism particularly if it is in the context of non-psychotic challenging behaviour. Benzodiazepines may be preferable to antipsychotics for challenging behaviour wherever possible.

12.4 **Pregnancy and Perinatal Period** (See Appendix B and Appendix A)

12.4.1 Extra care should be taken in prescribing in pregnancy and perinatal period. Pregnant women should be managed in accordance with Appendix B except that:

12.4.2 Specialist advice must be sought on the management of pregnant and perinatal women requiring emergency sedation. Over-sedation has particular risks for these women, particularly if they resume care of their infant. Effects on the foetus through the placenta or to the infant in breastmilk must be considered and appropriate precautions taken.

12.4.3 Pregnant women who are at known risk of relapse and behavioural disturbance should have a clear plan in their notes which should be shared with all relevant statutory professionals and services involved in the female's care.

12.4.4 When choosing a drug for RT, an antipsychotic or a benzodiazepine with a short half-life should be considered: if an antipsychotic is used, it should be at the minimum effective dose because of the potential for neonatal extra pyramidal symptoms: if a benzodiazepine is used, the risks of floppy baby syndrome should be taken into account. Up to date advice on the appropriateness of individual agent must always be sought from pharmacy and using appropriate sources of information such as the British Association for psychopharmacology guidelines www.bap.org.uk . The National Poisons Information Service (NPIS) can also be contacted by telephone: 0344 892 0111 for advice.

12.4.5 Intramuscular injections for RT may be administered in to the gluteal muscle or lateral thigh.

12.4.6 During the perinatal period, the woman's care should be managed in close collaboration with a psychiatrist, a paediatrician, an anaesthetist and a midwife.

12.4.7 A pregnant woman should never be secluded or left alone post rapid tranquillisation.

12.4.8 There should be particular emphasis on keeping the mother hydrated and on the regular monitoring and documentation of temperature, pulse, BP, respiratory rate and oximetry.

12.4.9 Anticholinergics for extrapyramidal side effects of antipsychotics should not be prescribed except for short term use. Instead, adjust the dose and timing of the antipsychotic or switch to another to avoid such side effects.

12.5 **Children and young people under 18 years of age** (See Appendix C and Appendix A)

12.5.1 The NICE Guideline NG10 on violence and aggression states that restrictive interventions (which includes RT) should only be used if all attempts to defuse the situation have failed and the child or young person becomes aggressive or violent. Staff must be familiar with and use the de-escalation techniques outlined in the NICE guideline to avoid having to use a restrictive intervention.

12.5.2 Medication can be given against a children or young persons will, with parental consent i.e. permission from a person with parenteral responsibility under The Children's Act NI and or common law. If repeated medication is required the Mental Health Order NI (1986) should be considered. Children and young people should be informed that a medication is going to be given and always given the opportunity to accept oral medication. Please note that Restraint is defined in the Mental Capacity Act (NI) 2016 Deprivation of Liberty Code of Practice as short, time-bound and reactive to an immediate event, and this may include provision of medication. For any young person requiring high or unusual levels of restraint should seek further advice from Department of Legal Services.

12.5.3 Parents or carers may have the right to stay with the child and young person before, during and after RT takes place. If the parent or carer is adversely affecting the safety and/or the efficacy of the situation, they may however be asked to leave for the benefit of the child or young person – this must be a clinical decision.

12.5.4 Junior doctors should not prescribe RT to children and young people without consultation with a senior doctor/consultant with experience in managing ABD in children and young people, unless *in exceptional circumstances*, where they must discuss directly after with a more senior doctor and record reasons for this occurring.

12.5.5 If initial drug treatment does not work then junior doctors should consider discussion with someone more senior. If a consultant has tried two or three approaches without success then it may be wise to seek a second opinion from a colleague or consult with a psychiatrist who works within the Child and Adolescent Mental Health Service (CAMHS).

12.6 **Older adults or physically frail without dementia** (See Appendix D or Appendix B and Appendix A)

12.6.1 When non-pharmacological measures are insufficient and medication is required, oral medication should always be offered whenever possible. Oral lorazepam, starting at a low dose, is the preferred first line treatment

12.6.2 If lorazepam alone gives an insufficient response or is inappropriate, then a low dose oral antipsychotic may be considered. There is evidence that antipsychotics are associated with increased mortality (probably by increasing the risk of cerebrovascular adverse events) even in people without dementia. A cautious approach is recommended. (See Appendix A). However, agents such as haloperidol, olanzapine, risperidone or quetiapine may be considered. Haloperidol should be avoided if the patient is antipsychotic naive, has a significant cardiac history, has had no recent ECG, or has parkinsonian syndrome. Oral promethazine may not be suitable and is usually not recommended where confusion is a concern.

12.6.3 If oral medication has failed or not possible and a patient requires parenteral medication, lorazepam should be used first line. Parenteral haloperidol may be used if there is confirmed history of previous antipsychotic use, however note contraindications detailed above. This may be in combination with parenteral promethazine, although caution should be taken due to potential for adding to the anticholinergic burden and should be avoided if confusion is present. If previous use of antipsychotics can't be confirmed and lorazepam fails to control the situation, low dose parenteral olanzapine may be given (but not within 1 hour of parenteral lorazepam). Other alternatives include parenteral aripiprazole but this should be after consultation with a senior doctor. (See Appendix A)

12.6.4 In all cases where an antipsychotic or promethazine is felt to be required (either orally or parenteral) it should be under the advice of a senior doctor experienced in the management of ABD in older people/physically frail.

12.7 **People with dementia** (See Appendix E)

12.7.1 Patients with dementia who present with acute behavioural disturbance should be carefully assessed for delirium and treated appropriately. This guideline does not apply to the management of behavioural disturbance in the context of delirium. If delirium is suspected or identified then the appropriate clinical guideline should be followed.

12.7.2 Non-pharmacological interventions should be offered as first-line management unless the patient is severely distressed or there is an

immediate risk of harm to the patient and/or others. Always assess for pain, using a standardised pain scale e.g. Bolton Pain Scale and review the use of analgesics before considering other options. A trial of paracetamol prescribed regularly should be considered for all patients with non-cognitive symptoms of dementia, even when there are no overt symptoms of pain.

12.7.3 If non-pharmacological interventions are ineffective, then lorazepam may be considered. Risperidone is licensed for short-term use for persistent aggression in people with moderate to severe Alzheimer's dementia. If risperidone is not appropriate, and another antipsychotic is required, oral olanzapine may be considered. If on-going use of risperidone or oral olanzapine is considered necessary then the advice of a doctor experienced in the management of dementia should be sought. Oral haloperidol is not recommended, and should only be prescribed in exceptional circumstances under the supervision of a dementia specialist.

12.7.4 Covert administration of oral medication may be suitable in cases where an individual lacks the mental capacity to consent to treatment (see individual Trust guidance regarding same).

12.7.5 People with Alzheimer's disease, vascular dementia or mixed dementias with mild-to-moderate non-cognitive symptoms should not routinely be prescribed antipsychotic drugs because of the possible increased risk of cerebrovascular adverse events and death.

12.7.6 People with Dementia with Lewy Bodies (DLB) with mild-to-moderate non-cognitive symptoms, should not be prescribed antipsychotic drugs, because those with DLB are at particular risk of severe adverse reactions. If an antipsychotic is required for oral de-escalation, low dose oral quetiapine may be useful (outside of product license) due to its low propensity to cause extra-pyramidal side effects. Prescription of antipsychotics in such patients should only be done under the supervision of a senior doctor with experience in DLB.

12.7.7 When parenteral treatment is necessary, parenteral lorazepam or parenteral olanzapine may be used with caution. Only in very exceptional circumstances, when other treatment is impossible, low dose parenteral haloperidol may be used. In these cases, a senior doctor with experience in managing disturbed behaviour in people with dementia should be consulted.

13. Physical Health Monitoring, Side Effect Monitoring and Follow Up after RT (See Appendix F)

13.1 Medical and Nursing Support

13.1.1 When RT has been administrated, nursing staff will contact a doctor to attend the treatment setting as soon as possible when necessary.

13.1.2 If there is deterioration in the patient's physical health or clinical observations, as indicted by a change in the standard observation chart score, then the patient should be escalated for medical review.

13.1.3 The nursing staff and or doctor must also assess the patient's mental state and review the level of psychiatric observations during the post RT period.

13.2 Criteria for monitoring

13.2.1 Physical health and side effect monitoring is essential after an episode of RT (parenteral route).

13.2.2 Routine monitoring is not automatically required after all oral medication, but may be required in certain circumstances, such as:

- It is clinically indicated by the patient's condition.
- The patient was at the point of being administered parenteral rapid tranquillisation but accepted oral medication (individual assessment).
- BNF maximum daily dose of a drug is exceeded in RT.

13.3 Monitoring parameters and frequency of monitoring

13.3.1 Following each episode of RT, or in the circumstances described above for oral medication, the following physical observations should be commenced and recorded on the Trust Standard Observation chart (SOC)/NEWS 2 and the clinical notes:

- Respiratory rate
- SpO_2
- Temperature
- Blood pressure
- Heart rate
- Level of consciousness

13.3.2 After RT, or when clinically necessary with oral medications, carry out the required observations every 15 minutes for the first hour. After one hour, continue observations at least every hour until there are no concerns about the physical health status.

13.3.3 Consider extended or more frequent monitoring in the following circumstances:

- The BNF maximum dose of a medicine has been exceeded.
- The patient appears to be asleep or sedated.
- Concerns about possible illicit drug (including novel substances) or alcohol use.
- Pre-existing physical health problem.
- The patient experienced any harm as a result of a restrictive intervention.

13.4 **Situations where full monitoring and assessment cannot be completed** (See Appendix G)

13.4.1 There may be circumstances when taking a full set of observations according to standard observation charts (SOC) is not possible e.g. patient refuses physiological observation or if they remain too behaviourally disturbed to be approached. In these cases the Non-Contact Physical Health Observations Guidance and Assessment tool should be used to access the patients ABCDE status instead of the Trust standard observation chart. In addition to completing the Non-Contact Physical Health Observations Chart nursing staff should record the following on the Trust SOC chart:

- Respiratory rate.
- Level of consciousness.
- Temperature (using non touch thermometer).
- Pulse oximetry (may be possible if the patient is asleep/ unconscious).

13.4.2 It should be clearly documented on the Trust SOC and in the patient's notes that these are non-contact observations and the reasons for doing so documented in the notes each time they have been carried out. The use of Trust SOC, and calculation of scores, should recommence at the earliest opportunity.

13.4.3 If there is any concern regarding the patient's physical wellbeing such as indicated by a RED status in the Non-Contact Physical Health Observations Guidance and Assessment tool, then the patient MUST be escalated to a doctor and a group of staff who are MAPA trained must enter the room and check the patient's physiological observations. The patient **MUST NOT be left alone.**

13.5 Side Effect Monitoring

13.5.1 For detailed information on the management of complications and side effects associated with RT. (See Appendix F)

13.5.2 RT can be associated with risks to the patient's physical health;

- Inadequate sedation can risk patient exhaustion, dehydration and increases the risk of violence.
- Over sedation can lead to loss of consciousness or reduced alertness.
- Minor injuries and bruising may be present, especially if restraint has been used.
- Prominent side effects of medication can occur; these can be distressing and, unpleasant and include akathisia, dystonia, parkinsonian and hypotension. However side effects may be serious or life threatening and include lowered seizure threshold, respiratory depression or arrest, cardiac arrhythmias and neuroleptic malignant syndrome.

13.5.3 Respiratory depression can be a complication of administration of benzodiazepines. Treatment is with flumazenil, a benzodiazepine antagonist that must be given intravenously. If Flumazenil is being considered on a psychiatric ward, it should be used with input from general physicians whilst transfer of the patient to a medical ward is being sought. See Appendix E for more information on indications for administering flumazenil. Risk of respiratory depression is increased by:

- Underlying respiratory disease.
- Existing compromised respiratory function.
- Co-administration with other medications known to suppress respiratory function e.g. opiates.
- Administration via the parenteral route.
- Administration of higher doses.
- Physical restraint.

13.5.4 Checks for side effects after RT should be recorded in the patient's clinical notes each time they are carried out along with any actions taken to manage these.

13.6 Overall management of patient Electrocardiogram (ECG)

13.6.1 An ECG must be obtained after administration of a parenteral antipsychotic or dosing exceeds BNF maximum daily dose, where possible.

13.6.2 However an ECG is ESSENTIAL after administration of an antipsychotic to a child or young person.

13.6.3 The SPC for Haloperidol injection advise continuous ECG monitoring for repeated intramuscular doses.

13.6.4 Calculate QTc and if an ECG shows any cause for concern then a doctor must be contacted for advice on patient management. Record these observations and any actions in the patient's clinical notes.

14. Recording

14.1 Following administration of oral de-escalation medication

14.1.1 When oral medicines are administered for the management of acutely disturbed behaviour (either as oral PRN in anticipation of the acute disturbed behaviour or upon a prescription written at the time of the event) the following will be recorded in patient's case notes and patient's recovery care plan (where appropriate):

14.1.1.1 The nature of the acutely disturbed behaviour

14.1.1.2 The time course of events from:

- The onset of the behaviour until the offering of oral medicines
- The impact of non-drug strategies
- The acceptance or refusal of oral medicines
- The impact of the administration of oral medicines

14.2 Following administrating of RT

14.2.1 Following administration of RT, in addition to the points mentioned above, the following, should be undertaken and recorded in the patient's case notes and patient's recovery care plan, (where appropriate):

- Physical monitoring completed and documented.
- Prescription chart reviewed re: regular medication.
- Team debrief (see section 15.1.2).
- Handover to clinical team (if out of hours)
- Update risk assessment
- Reassure patient debrief which will include discussion on how to manage further similar incidents.
- Have a member of staff designated to record the course of events.
- Communication with carer.
- A post-incident review may be held within 72 hours.

- Datix is completed after each instance of restrictive practice i.e. rapid tranquillisation.

15. Ongoing Support and Learning

Post incident support and learning has benefits for both patients and staff as they may help minimise the negative impact of an event and help maintain a positive user-staff relationship especially in relation to minimising conflict and crisis events which are likely to lead to the use of restrictive interventions.

15.1 Post incident de-brief

15.1.1 As soon as reasonably practicable, within a supportive environment, provide the opportunity for those involved to debrief and discuss the event, preferably guided by the team leader/incident manager.

- Include involvement of patient and (where agreed by the patient) peer supports and or advocate services and significant others such as family/carer.

15.1.2 During the de-brief process opportunity should be given for:

- The patient to talk about the event from their point of view, when possible.
- Acknowledge the emotional responses to the incident and assess whether there is a need for on-going emotional support including access to counselling services for any trauma experienced.
- Consider any contributing factors to identify any elements that can be addressed quickly to reduce the likelihood of further incidents.
- Staff to reflect on what went well and didn't go so well and what could be done differently.
- Staff to improve primary and secondary preventive approaches including preferences expressed by the patient in how they would like to be managed in future crisis events (advanced statements/directives).
- Support a return to normal patterns of activity.
- Ensure that everyone involved in the patients care, including their carers has been informed of the event, if the patient agrees.
- Complete documentation including DATIX; review and amend risk and care plans accordingly.
- Share any learning with other units as appropriate and address any training needs identified.
- Any concerns or complaints expressed by the patient must be dealt with at the point of service delivery in the first instance immediately and

directly in an attempt to resolve the matter informally, speedily and appropriately in accordance with the Trust's Policy for The Management of Complaints.

15.2 Post incident review

15.2.1 A formal external post-incident review should be undertaken as soon as possible and no later than 72 hours after the incident.

15.2.2 This uses the information from the post-incident debrief, the patients notes and interviews with staff, where relevant, to develop a report which will

- evaluate the physical and emotional impact on everyone involved, including witnesses
- help patients and staff to identify what led to the incident and what could have been done differently
- determine whether alternatives, including less restrictive interventions, were discussed
- determine whether service barriers or constraints make it difficult to avoid the same course of actions in future
- recommend changes to the service's philosophy, policies, care environment, treatment approaches, staff education and training, if appropriate

16. Monitoring and audit

Monitoring and audits will be carried out against the standards set by this guidance as per Table 3. The outcomes of which will be used in conjunction with the local, regional or national learning or feedback. This guidance needs to be reviewed every three years or in the event of a Serious Adverse Incident (SAI).

Table 3 Overview of monitoring and audit

Aspect of compliance or effectiveness being monitored	Method of monitoring	Professional responsible for monitoring	Monitoring frequency	Group or committee who receive findings of reports	Group or individual responsible for completing any actions
Compliance with NICE guidance	Monitoring reports	Medical director	Annually	DTC	Medical director
Prescribing with regard to RT	Audit of kardex for patients receiving RT. POMH-UK audit tool where available	MRP lead (*) POMH lead (*)	Annually As per POMH	Governance fora Chief Executive POMH-Lead	Medical director POMH lead
How physical health observations are recorded, when patients have received RT	Audit of documentation of post RT monitoring	MRP Lead (*)	Annually	Governance fora	Mental Health Director Medical director
Staff have completed training associated with this guidance in line with Trust requirements e.g. MAPA, ILS, NEWS2	Certification of completion of e-learning Or Attendance certificate at Trust learning	Training will monitored in line with Trust statutory and mandatory Training			Relevant director of service

DTC= Drugs & Therapeutics Committee MRP = Minimising Restrictive Practice (*) Mental Health only

17. References

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18. Acknownledgements

Thanks to the membership of the RT subcommittee for their work in pulling together the various Trust guidelines to produce this document.

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Appendix A - Dose information for specific populations (Not applicable to delirium)

Dose ranges highlighted as a guide only: remember to avoid variable dosing on kardex.

Medication	Time to Peak Plasma concentration	Child (6-12 years)	Young person (13 – 17)	Adults (18 +)	Older and Frail People	People with Dementia
Haloperidol oral solution and tablets **If no recent ECG, consider risk/benefits as use may be unlicensed.**	2 – 6 hours (Sedation usually within 30-45 mins)	***Not Applicable***	*Consider risk of acute dystonia especially in the antipsychotic naïve* PO 1mg up to 5mg Max 10mg/24hrs	PO 5mg Max 20mg/24 hours	*Only use first line if there is confirmed history of previous exposure to typical antipsychotics. Start with lower doses:* PO 0.5mg up to 2.5mg (Usual Max 5mg/24hrs.)	***Not recommended.*** *Use only in very exceptional circumstances and under advice of senior doctors with experience in dementia. Consider licensed oral risperidone as an alternative* PO 0.5mg (Max 2mg/24hrs)
Haloperidol injection **If no recent ECG, consider risk/benefits as use may be unlicensed.**	IM 15 – 60 mins (Sedation usually within 30 – 45 mins) IV: 10 mins	***Not Applicable***	***Unlicensed: Only use as part of an individualised care plan.*** *Consider risk of acute dystonia especially in the antipsychotic naïve* IM injection 1mg up to 5mg Max 10mg/24hrs	By IM/IV injection 5mg Max 20mg/24 hours	*Only use first line if there is confirmed history of previous exposure to typical antipsychotics. Start with lower doses* IM 0.5mg up to 2.5mg (Max 5mg/24hrs)	***Not recommended.*** *Use only in very exceptional circumstances and under advice of senior doctors with experience in dementia. Consider licensed oral risperidone as an alternative* IM 0.5mg (Max 2mg/24hrs)
Lorazepam tablets and IM/IV injection	PO/IM 50-90 mins (Sedation usually within 30-45 mins) IV:2-5mins	*Unlicensed but may be justified in some cases* PO or by IM injection 0.5 or 1mg Max:2mg/24hrs	PO or IM injection 0.5mg, 1mg or 2mg Max 4mg/24hrs	PO or IM/IV injection 1mg or 2mg Max 4mg/24 hours	PO or IM injection 0.5mg Max 2mg/24 hours (IV route NOT recommended)	PO or IM injection 0.5mg Max 2mg/24 hours (IV route NOT recommended)
Olanzapine tablets/ orodispersible tablets *(NB orodispersible tablets have no advantage in speed of onset but are harder to spit out/conceal)*	5 – 8 hours	***Not Applicable***	***Not Applicable***	Initially 5mg or 10mg PO Max 20mg/24 hours	*Consider as a second line option.* 2.5mg PO Max 10mg/24hrs.	*Unlicensed but may be justified in some cases.* 2.5mg PO Maximum 5mg//24hours
Promethazine oral solution, tablets & IM injection	Oral 2-3 hours IM 1-2 hours ***IV:NOT recommended***	***Not Applicable***	***Unlicensed: Only use as part of an individualised care plan*** PO or IM injection 10mg to 25mg Max 50mg/24hrs	PO 25mg or 50mg Max 100mg/24 hrs	*Consider appropriateness, if confusion is a concern* PO or IM injection 2.5mg. Max 50mg/24hrs	***Not recommended.*** *Use may be considered in those with compromised respiratory function or sensitive/tolerant to benzodiazepines.* PO or IM injection 12.5mg or 25mg. Max 50mg/ 24hrs

Appendix A - Dose information for specific populations (not applicable to delirium)

Dose ranges highlighted as a guide only: remember to avoid variable dosing on kardex.

Medication	Time to Peak Plasma concentration	Child (6-12 years)	Young person (13 – 17)	Adults (18 +)	Older and Frail People	People with Dementia
Aripiprazole IM injection	1 –3 hours	***Not Applicable***	***Not Applicable***	9.75mg (1.3ml) – Consider lower dose (5.25mg) on basis of clinical status Effective range 5.25 –15mg Max dose 30mg/24hrs by any route	*Effectiveness in over 65's not established. Consider lower doses on basis of clinical status* Consider starting dose 5.25mg Max of TWO injection in 24 hours.	***Not Recommended***
Olanzapine IM injection	15-45 minutes (peak levels up to 5 times that of oral doses)	***Not Applicable***	*Unlicensed but may be justified in some cases under consultant direction.* 2.5mg, 5mg or 10mg IM repeated after 2 hours if needed. Max IM dose is 10mg daily. Max total daily dose by all routes of 20mg not to be exceeded. Max of 3 injections/ 24hrs for 3 days	5 or 10mg IM repeated after 2 hours if needed. Max combined oral/IM dose is 20mg daily NOT to be exceeded. Max of 3 injections/24hrs for 3 days.	*Use may be justified in some cases under consultant direction.* 2.5mg IM repeated after 2 hours if needed. Max combined oral/IM dose is 10mg daily NOT to be exceeded. Max of 3 injections/24hrs for 3 days	***Not recommended.*** *Use only in very exceptional circumstances and under advice of senior doctors with experience in dementia. Consider licensed oral risperidone as an alternative* 2.5mg IM repeated after 2 hours if needed. Max combined oral/IM dose is 5mg daily NOT to be exceeded. Max of 2 injections/24hrs for 3 days
Quetiapine Oral tablets/Solution	1-2 hours	***Not Applicable***	***Not Applicable***	*Unlicensed but may be justified in some cases.* PO 50-100mg (suggested max 200mg/24hours)	*Unlicensed but may be justified in some cases.* PO 12.5mg or 25mg (suggested Max 50mg/24hrs)	*Unlicensed but may be justified in some cases such as Lewy Body Dementia* PO 12.5mg or 25mg (suggested max 50mg/24hrs)
Risperidone tablets / orodispersible tablets/ oral solution	1 -2 hours	***Not Applicable***	20-45kg 0.5mg. Very slow increase to Max 2.5mg >45kg 0.5mg. Very slow increase to Max 3mg	*Unlicensed but may be justified in some cases.* Suggested dose PO 1-2mg BD PRN Max 4mg/24hours	*Consider as a second line option. Unlicensed but may be justified in some cases.* Suggested dose PO 0.25mg once or twice daily PRN. Max 2mg/24hours	In *Alzheimer's Disease* Suggested dose *PO* 0.25mg once or twice daily PRN. Max 2mg/24 hours

Appendix B - Pharmacological management of acute behavioural disturbance (FOR ADULTS 18 YEARS AND OVER)
(Not applicable to delirium, also consider using Appendix D for older adults and frail)

Pharmacological management should be part of an overall management plan that includes appropriate nursing care and de-escalation techniques

LEVEL 1 Accepting oral meds and as part of de-escalation strategy	LEVEL 2 Actual or clear risk of violence or aggression. De-escalation including oral PRN not possible or appropriate	LEVEL 3 Situation rapidly deteriorating or failure to respond to LEVEL 2 interventions
Consider combination of oral lorazepam with an oral antipsychotic if indicated by clinical circumstances. Consider moving to LEVEL 2 if oral therapy is refused or is not indicated by previous clinical response or is not a proportionate response.	Review all medication administered in the last 24 hours – be aware of BNF max doses. Ensure resuscitation equipment and emergency response is readily available within 3 minutes.	If Rapid Tranquillisation (LEVEL 2) is being used, a senior doctor must review all treatment and response every 24 hours. If one round of LEVEL 2 interventions have had insufficient effect a senior doctor should review treatment and consider the following: • The appropriateness of current placement • Age and physical presentation • Check sufficient time has been allowed for response • If there has been a partial response to a LEVEL 2 intervention, consider repeating that intervention • If a LEVEL 2 intervention has had insufficient effect consider offering the alternative LEVEL 2 intervention • Carry out a full review of treatment to date and seek a second opinion if needed. **If LEVEL 2 interventions have had insufficient effect:** **Consider as part of an individualised care plan include:** • Further repeats of LEVEL 2 interventions (do not repeat promethazine if it is < 2hrs since the last injection) • Haloperidol IM combined with Lorazepam IM • Alternative medications (see Section 10) • Zuclopenthixol acetate (Clopixol Acuphase®) (see Section 11)
Consider lower doses in older adults or frail (Appendix A & D)		
Suggested Oral Medication **Lorazepam 1 or 2mg** (Max 4mg/24hrs) **OR** **Promethazine 25 or 50mg** (Max100mg/24hrs) **OR** **Haloperidol 5mg** (max 20mg/24hrs) **OR** **Olanzapine 10mg♦** (♦ Available as an orodisperible product) (Max 20mg/24hr Continue de-escalation strategy. If response is inadequate after 45 minutes, consider repeating oral therapy or moving to LEVEL 2	**Suggested Medication** **Lorazepam IM (or IV)[a] 1 or 2mg [b, c]** (Max 4mg/24hrs) **OR** **Haloperidol IM 5mg** (Max 20mg/24hrs) **Combined with Promethazine IM 25 or 50mg** (Max 100mg/24hrs) If there is continued concern seek advice from a more senior doctor before proceeding further *NOTES* *a. IV in certain clinical settings. NOT recommended in elderly and frail and in mental health settings* *b. IM Lorazepam and IM Olanzapine must not be administered within 1 hour of each other* *c. IV flumazenil must be readily available*	

When deciding which medication to use, consider:	Additional Considerations
• **Oral or parenteral lorazepam is preferred first line if:** o Patient is an older adult or physically frail o There is an uncertain history o Presence of cardiovascular disease o Current illicit drug/alcohol intoxication o Antipsychotic naïve • Antipsychotics and/or promethazine preferred with: o Current regular benzodiazepine use o History of respiratory depression	• Avoid antipsychotics, where possible, in patients with a parkinsonian syndrome (including idiopathic Parkinson's disease Parkinson's disease dementia and Dementia with Lewy Bodies) • Avoid haloperidol in cardiovascular disease or if there has been no recent ECG. • Pre-existing physical health problems (e.g. extra care in patients with eating disorders, physical frailty or comorbidity of any disorders that affect metabolism, including hypothermia, stress, extreme emotional response and post extreme physical exertion) or pregnancy. • Previous response, including adverse effects • Potential for interactions with other medicine • Possible Intoxication • Promethazine is contraindicated in CNS depression and those prescribed a monoamine oxidase inhibitor within the last 14 days. Promethazine may be unsuitable in older adults with confusion due to its anticholinergic effects.

Appendix C Pharmacological management of acute behavioural disturbance (for Children and Young People age 6 to 17 years) (Not applicable to delirium)

Pharmacological management should be part of an overall management plan that includes appropriate nursing care and de-escalation techniques

LEVEL 1 Accepting oral meds and as part of de-escalation strategy	LEVEL 2 Actual or clear risk of violence or aggression. De-escalation including oral PRN not possible or appropriate	LEVEL 3 Situation rapidly deteriorating or failure to respond to Level 2 interventions
Consider combination of oral lorazepam with an oral antipsychotic if indicated by clinical circumstances. Consider moving to LEVEL 2 if oral therapy is refused or is not indicated by previous clinical response or is not a proportionate response. **Suggested Oral Medication** **Children 6-12 years** **Lorazepam 0.5 or 1mg** (Max 2mg/24hrs) **Young People 13-17years** **Lorazepam 0.5mg, 1mg or 2mg** (Max 4mg/24hrs) **OR** **Haloperidol 1mg up to 5 mg★** (max 10mg/24hrs) **OR** **Promethazine 10mg to 25mg** (max 50mg/24hrs) **OR** **Risperidone♦** **20kg-45kg 0.5mg**(Slowly increase to Max 2.5mg/24hrs) **>45kg 0.5mg** (Slowly increase to Max3mg/24 hrs) ♦ Available as an orodispersible product. For both age groups: Continue de-escalation strategy. If response is inadequate after 45 minutes, consider repeating oral therapy or moving to LEVEL 2	Consult a senior doctor/consultant before using IM medication in a child under 12 years of age. Consult a senior doctor/consultant before using IM medication in a young person (13-17 years) unless IM medication is already included in the young person's care plan. Check if an individual care plan recommends an approach not covered in this guideline. Review all medication administered in the last 24 hours – be aware of BNF max doses. Ensure resuscitation equipment and emergency bag is available within 3 minutes. **Suggested IM Medication** **Children 6-12 years** **Lorazepam IM 0.5 or 1mg** (Max 2mg/24hrs) **Young People 13 -17 years** **Lorazepam IM 0.5mg, 1mg or 2mg** (Max 4mg/24hrs) For both age groups: If there is continued concern, seek advice from a more senior doctor/consultant before proceeding	If Rapid Tranquillisation (LEVEL 2) is being used, a senior doctor/consultant must review all treatment and response every 24 hours. If one round of LEVEL 2 interventions have had insufficient effect a senior doctor/consultant should review treatment and consider the following options: • The appropriateness of current placement • Check sufficient time has been allowed for response • If there has been a partial response to lorazepam consider repeating the dose • Carry out a full review and seek a second opinion if needed. **If there has been insufficient response to IM lorazepam:** **Consider as part of an individualised care plan include** (in no particular order) • Further repeats of IM lorazepam • ≥13yrs, Haloperidol IM 1 - 5mg★ (Max 10mg/24hrs) • ≥13yrs, Haloperidol IM combined with lorazepam IM • ≥13yrs, Promethazine IM (10 to 25mg, Max 50mg/24hrs) • ≥13yrs, Olanzapine 2.5mg, 5mg or 10mg (Max 10mg/24hrs IM). **Do not combine** with IM lorazepam and use with caution if IM lorazepam has been given within 1 hour

When deciding which medication to use, consider:	Additional Considerations
• Oral or parenteral lorazepam is preferred first line if: o There is an uncertain history o Presence of cardiovascular disease o Current illicit drug/alcohol intoxication o Antipsychotic naïve • Antipsychotics may be preferred with: o Current regular benzodiazepine use o History of respiratory depression	• Avoid haloperidol in cardiovascular disease or if there has been no recent ECG. • Pre-existing physical health problems (e.g. extra care in patients with eating disorders, physical frailty or comorbidity of any disorders that affect metabolism, including hypothermia, stress, extreme emotional response and post extreme physical exertion) or pregnancy • Previous response, including adverse effects • Potential for interactions with other medicine • Possible Intoxication • Promethazine is contraindicated in CNS depression. ★Dosing for haloperidol should be a fixed dose in the range from 1mg to a max of 5mg. Please consider the available strengths of oral haloperidol 0.5mg, 1.5mg or 5mg to facilitate ease of administration; e.g. 1.5mg is easier to administer than 2mg.

Appendix D - Pharmacological management of acute behavioural disturbance (FOR OLDER and FRAIL ADULTS) (Not applicable to delirium, please also consider using Appendix B)

Pharmacological management should be part of an overall management plan that includes appropriate nursing care and de-escalation techniques

LEVEL 1 Accepting oral meds and as part of de-escalation strategy	LEVEL 2 Actual or clear risk of violence or aggression. De-escalation including oral PRN not possible or appropriate	LEVEL 3 Situation rapidly deteriorating or failure to respond to LEVEL 2 interventions
Consider combination of oral lorazepam with an oral antipsychotic if indicated by clinical circumstances. Consider moving to LEVEL 2 if oral therapy is refused or is not indicated by previous clinical response or is not a proportionate response. **Suggested Oral medications:** ***1st line:*** **Lorazepam 0.5mg** (Max 2mg/24hrs) ***2nd line:*** **Haloperidol 0.5mg-2.5mg★** (Usual Max 5mg/24 hrs) **OR** **Olanzapine 2.5mg** (Max 10mg/24hrs) **OR** **Risperidone 0.25mg** (Max 2mg/24hrs) **OR** **Quetiapine 12.5mg or 25mg** (Max 50mg/24hrs) **OR** **Promethazine 25mg** (Max 50mg/24hrs) Continue de-escalation strategy. If response is inadequate after 45 minutes, consider repeating oral therapy or moving to LEVEL 2	Review all medication administered in the last 24 hours – be aware of BNF max doses. Ensure resuscitation equipment and emergency response is readily available within 3 minutes. **Suggested Medication** ***1st line:*** **Lorazepam IM (or IV)[a] 0.5mg** (Max 2mg/24hrs) [b, c] ***2nd line:*** **Haloperidol IM 0.5mg-2.5mg★** (Max 5mg/24 hours) **Plus or minus** **Promethazine IM 25mg** (Max 50mg/24hours) **OR** **Olanzapine IM 2.5mg** [b] Max 10mg/24hrs [d] (Leave at least 2hrs between injections.) Max of three injections in 24hrs. If there is continued concern seek advice from a more senior doctor before proceeding further ***NOTES*** ***a. IV in certain clinical settings. NOT recommended for elderly and frail and in mental health settings*** *b. Lorazepam and IM Olanzapine must not be administered within 1 hour of each other* *c. IV flumazenil must be readily available* *d. Maximum of 10mg in 24 hours from PO and IM routes combined.*	If Rapid Tranquillisation (LEVEL 2) is being used, a senior doctor must review all treatment and response every 24 hours. If one round of LEVEL 2 interventions have had insufficient effect a senior doctor should review treatment and consider the following: • The appropriateness of current placement • Age and physical presentation • Check sufficient time has been allowed for response • If there has been a partial response to a LEVEL 2 intervention, consider repeating that intervention • If a LEVEL 2 intervention has had insufficient effect consider offering the alternative LEVEL 2 intervention • Carry out a full review of treatment to date and seek a second opinion if needed. **If LEVEL 2 interventions have had insufficient effect:** **Consider as part of an individualised care plan include:** • Further repeats of LEVEL 2 interventions • Alternative medications e.g. **Aripiprazole** (see Section 10 & 12.6)

When deciding which medication to use, consider:	Additional Considerations

• **Oral or parenteral lorazepam is preferred first line if:**
  o There is an uncertain history
  o Presence of cardiovascular disease
  o Current illicit drug/alcohol intoxication
  o Antipsychotic naive
• Antipsychotics are associated with increased mortality
  o Olanzapine, risperidone and quetiapine all unlicensed but use may be justified in some circumstances
  o IM aripiprazole effectiveness in over 65 not established
• Promethazine may increase risk of confusion
	• Avoid antipsychotics, where possible, in patients with a parkinsonian syndrome (including idiopathic Parkinson's disease Parkinson's disease dementia and Dementia with Lewy Bodies)
	• Avoid haloperidol in cardiovascular disease or if there has been no recent ECG
	• Pre-existing physical health problems (e.g. extra care in patients with eating disorders, physical frailty or comorbidity of any disorders that affect metabolism, including hypothermia, stress, extreme emotional response and post extreme physical exertion) or pregnancy.
	• Previous response, including adverse effects and increased risk of falls
	• Potential for interactions with other medicine
	• Possible Intoxication
	★Dosing for haloperidol should be a fixed dose in the range from 1mg to a max of 2.5mg. Please consider the available strengths of oral haloperidol tablets/caps 0.5mg 1.5mg to facilitate ease of administration; e.g. 1.5mg is easier to administer than 2mg.

Appendix E Pharmacological management of acute behavioural disturbance (for PATIENTS WITH DEMENTIA) (Not applicable to delirium)

Pharmacological management should be part of an overall management plan that includes appropriate nursing care and de-escalation techniques

LEVEL 1 Accepting oral meds and as part of de-escalation strategy	LEVEL 2 Actual or clear risk of violence or aggression. De-escalation including oral PRN not possible or appropriate	LEVEL 3 Situation rapidly deteriorating or failure to respond to Level 2 interventions

Only consider combination of oral lorazepam with an oral antipsychotic if indicated by clinical circumstances. Ensure all risks and benefits are fully considered before prescribing antipsychotic drugs.
Avoid antipsychotics in patients who have parkinsonian syndrome (including idiopathic Parkinson's disease Parkinson's disease dementia and Dementia with Lewy Bodies)
Consider moving to LEVEL 2 if oral therapy is refused or is not indicated by previous clinical response or is not a proportionate response.
Suggested Oral medications:
1st line:
Lorazepam 0.5mg
(Max 2mg/24hrs)
 	
2nd line:
Risperidone 0.25mg ♦
(Max 2mg/24hrs)
Oral risperidone licensed for treatment of aggression in Alzheimer's dementia
OR
Olanzapine 2.5mg ♦
(Max 5mg/24hrs)
Olanzapine licensed for agitation and disturbed behaviour in schizophrenia and mania ONLY.
♦ Available as an orodisperible product.
 	
Continue de-escalation strategy. If response is inadequate after 45 minutes, consider repeating oral therapy or moving to LEVEL 2
	Check if an individual care plan recommends an approach not covered in this guideline.
	Review all medication administered within the last 24hrs – be aware of BNF maximum doses.
	Ensure resuscitation equipment and emergency response is readily available within 3 minutes.
	
	Suggested IM medications:
	1st line:
	Lorazepam 0.5mg IM
	(Max 2mg/24hrs)
	(IV flumazenil must be readily available)
	
	OR
	
	Olanzapine*
	2.5mg IM
	(Max 5mg/24hrs)
	*(*Unlicensed, use ONLY in certain clinical circumstances)*
	For Olanzapine, leave at least 2hrs between injections. Max of two injections in 24hrs.
	
	If there is continued concern, seek advice from a more senior doctor before proceeding further.
	
	CAUTION
	• **IM lorazepam and IM olanzapine must not be administered within 1 hour of each other.**
		If Rapid Tranquillisation (LEVEL 2) is being used, a senior doctor must review all treatment and response every 24 hours
		
		If one round of LEVEL 2 interventions have had insufficient effect a senior doctor should review treatment and consider the following options:
		• The appropriateness of current placement
		• Check sufficient time has been allowed for response
		• Carry out a full review and seek a second opinion if needed.
		
		If LEVEL 2 interventions have had insufficient effect:
		Consider as part of an individualised care plan include:
		• Repeat IM injections as per LEVEL 2
		• Use alternative medications not yet tried **in exceptional circumstances only**
		  ○ Haloperidol 0.5mg IM with caution due to known increased risk of cerebrovascular adverse events. Allow sufficient time for response before repeating to maximum of 2mg/24 hrs
		  ○ Promethazine 25mg IM with caution, useful in benzodiazepine tolerant patients or if there has been a known or suspected previous paradoxical reaction to benzodiazepines. Onset of action is slow. Allow 1-2 hours to assess response before repeating to maximum of 50mg/24hrs

When deciding which medication to use, consider:	Additional Considerations
• **Oral or parenteral lorazepam is preferred first line:** • In all cases where an antipsychotic is felt to be required (either orally or parenteral) it should be under the advice of a senior doctor experienced in the management of ABD in dementia and consider antipsychotics only when benefits outweigh risks.	• Avoid antipsychotics, where possible, in patients with a parkinsonian syndrome (including idiopathic Parkinson's disease Parkinson's disease dementia and Dementia with Lewy Bodies) • Avoid haloperidol in cardiovascular disease or if there has been no recent ECG. • Pre-existing physical health problems (e.g. extra care in patients with physical frailty or comorbidity of any disorders that affect metabolism, including hypothermia, stress, extreme emotional response and post extreme physical exertion) • Potential for interactions with other medicine • Possible intoxication • Increased risk of falls • Access pain using a standardised pain scale e.g. Bolton Pain Scale and consider regular analgesia prior to sedative medication

Appendix F — Rapid tranquillisation Monitoring

Following any IM/IV drug administered for RT, or where considered clinically necessary after oral medication, monitor and record as shown below.
Document and record on the Trust Standard Observation Chart (SOC) e.g. NEWS 2 or clinical notes as appropriate.

The Early Warning Score should be calculated from the Trust Standard Observations Chart e.g. NEWS 2 each time and further action taken if indicated

Observations	Monitoring Frequency	General Comments
• Respiratory Rate • SaO2 (if appropriate) • Pulse • Blood Pressure • Temperature • Level of Consciousness • Assess for Side effects • Monitor level of hydration	Every 15 minutes for first hour. After one hour, continue observations at least hourly until there are no further concerns about physical health status. **Action when Observations are not possible** The Non-Contact Physical Health Observations Guidance and Assessment tool (Appendix F) should be used. Record if the patient's mental state or behaviour prevents observations. Complete and record any observations possible, in Trust Standard Observational Chart e.g. NEWS 2.	• Arrange medical review of the patient after administration of IM medication • Protection of the airway is paramount • Ensure adequate levels of hydration are maintained • Consider urgent transfer to an Emergency Department if not already in ED, if condition warrants • Pay particular attention to level of consciousness and blood pressure when IM antipsychotics and IM benzodiazepines are used in combination. • An ECG is recommended when antipsychotics, in particular when haloperidol or higher doses are given. • An ECG is essential after IM antipsychotics are administered to Young People.

Management of side effects and problems that can occur during and after rapid tranquillisation (RT) (and occasionally during and after oral pharmacological de-escalation)

Problem	Remedial Measures
Acute Dystonia (including oculogyric crises, torticollis) *NB. 10% prevalence, more common in young males, neuroleptic naïve, high potency drugs e.g. haloperidol*	Give **procyclidine 5 - 10mg Orally or IM (IV in ED Departments only)** **NOTE** Do not pre-emptively administer procyclidine when IM haloperidol is combined with IM promethazine as the risk of extrapyramidal side effects (EPSE) is significantly reduced by the promethazine. If EPSE do occur after the IM haloperidol/promethazine combination, administer additional procyclidine with caution. Monitor for increased anticholinergic side effects.
Reduced respiratory rate • <10/minute or • Oxygen saturation <92% (Note: COPD patients may have a lower baseline SPO_2)	Give oxygen; ensure patient is not lying face down. If induced by any agent other than a benzodiazepine the patient will require transfer for mechanical ventilation ***If benzodiazepine induced:*** Give flumazenil 200microgram IV over 15 seconds. If desired level of consciousness is not obtained within 60 seconds, a further 100microgram can be injected and repeated at 60 second intervals to a maximum total dose of 1mg (1000microgram) in 24 hours (initial + 8 additional doses). Monitor respiration rate continuously until it returns to baseline level. The effect of flumazenil may wear-off & respiratory depression return – monitoring must continue beyond initial recovery of respiration. Clinicians should be familiar with the use of flumazenil or if being considered on a psychiatric ward, it should be used with input from general clinicians. Additional information is available from Medusa (see local Trust for details), on the treatment of benzodiazepine poisoning and flumazenil should be administered in this context. *Do not use flumazenil if the patient has a history of epilepsy; co-ingested pro-convulsants including tricyclic antidepressant; or in benzodiazepine dependent patients. These patients will require transfer for mechanical ventilation, maintain airway management until transfer .*
Irregular or slow pulse <50 beats/min	**Refer to specialist medical care immediately.**
Fall in blood pressure > 30mmHg drop in systolic BP on standing or diastolic BP <50mmHg	Lie patient flat, raise legs if possible. Monitor closely and seek further medical advice if necessary.
Increased temperature	**Withhold antipsychotics –**risk of NMS or perhaps arrhythmias. Monitor closely, cool the patient, maintain hydration and check muscle creatinine kinase. **Refer to specialist medical care** if continued or other signs of NMS present e.g. sweating, hypertension or fluctuating BP, tachycardia, incontinence (retention/obstruction), muscular rigidity (may be confined to head and neck), confusion, agitation or loss of consciousness.
Akathisia	Review antipsychotic choice, consider propranolol 30-80mg/day prn in 2-3 divided doses (caution with asthma, bradycardia hypotension) or benzodiazepines e.g. diazepam 5-15mg/day prn in divided doses

Appendix G	**Non-Contact Physical Health Observation Guidance and Assessment tool** (adapted from Southern Health NHS Foundation Trust)

Health and Social Care in Northern Ireland

Use addressograph or write in CAPITAL LETTERS

Surname: .....

First names: .....

H&C number: .....

DOB: ..... Check Identity

Circumstances when use of Trust Standard Observations Chart (SOC) is not possible:

When taking a full set of physical observations is ***NOT*** possible or considered to pose significant risk to the patient and/or staff. For example:

- It is not safe to approach the patient
- Approaching the patient may cause significant distress or antagonise the situation
- The patient declines physical observations (the rationale for taking physical observations must be explained to the patient if appropriate)

The use of the non-contact observations assessment tool must be documented on the SOC and a summary for the rationale of this made in the patients progress notes or clinical system

If it is not possible to undertake a full set of physical observations using Trust SOC you should still:

- Record respiratory rate if possible on Trust SOC
- Record Conscious level on Trust SOC
- Note on Trust SOC chart that Non-Contact physical observation assessment tool is being used
- Record in the patients progress notes or in the clinical system, the reason that the Non-Contact physical observation is being used

Use the assessment tool overleaf to record the Non-Contact observations following the ABCDE structure

If any red box statements are true, the patient MUST be escalated to a doctor and a full ABCDE assessment should be undertaken based upon clinical judgement. Medical team/999 must be contacted if required.

Differentiating between unconsciousness and sleep:

- Being asleep is not the same as being unconscious
- If someone is asleep we would expect then to occasionally change position while sleeping and to have a normal complexion for them
- If you are concerned the patient is not sleeping and may be unconscious refer to the Nurse in charge and/or medical team and undertake a full Glasgow Coma Scale (GCS) assessment of conscious level

Non-Contact ABCDE Assessment Tool

Ensure that observations are repeated every 15mins for 1 hours post intramuscular injections

Utilise the ABCDE guidance below to assess the patient and document in the table below	Use addressograph or write in CAPITAL LETTERS
If any RED box statements are true the patient MUST be escalated to an doctor and a full ABCDE assessment should be undertaken. **Medical team/999 MUST be contacted if required.** **DO NOT leave the patient.**	**Surname:** ..... **First names:** ..... **H&C number:** ..... **DOB:** ..... Check Identity

Airway	Talking (not just moan and groans) Airway clear- including when asleep
Breathing	Breathing is quiet and regular Respiratory rate 12-10 breaths per minute
Circulation	Mobility normal for the patient Presenting as normal If asleep, monitor movement Warm skin, normal colour for patient Comfortable presentation
Disability	Alert Drinking and eating as normal Active
Exposure	No signs of injury, bruising, bleeding or rashes.

Airway	Airway obstructed? Silence? Coughing? Swelling? Gurgling? If awake can they speak(not just moans and groans) Risk of vomiting? Consider moving onto their side and carry out constant observations to prevent choking/aspiration if there is a risk of vomiting
Breathing	Noisy or difficult breathing even with open airway Respiratory rate less than 12 or more than 20 breaths per minute Shallow rapid breathing pattern Struggling to breath (using additional muscles and working hard) Abnormal breathing sounds? Stridor? Wheeze? Gurgling? **Consider asthma, COPD, intoxication and has rapid tranquillisation been used?**
Circulation	Change in ability to mobilise Flushed? Pale? Sweaty? Clammy? Mottled? (purplish discolouration to skin) Central cyanosis (blue tinge to lips, tip of nose or ear lobes) Ashen (grey discolouration to skin) Trauma/significant bleeding
Disability	Unresponsive Unexpected sleepiness, drowsiness, confusion or fitting Responsive to voice, pain or unresponsive **Consider diabetes or epilepsy**
Exposure	Abnormal shuffling or unsteady gait Muscle rigidity **THINK NMS** Signs of dehydration: dry cracked lips not passing urine. Signs of physical injury/bleeding/rash Signs of infection: **THINK SEPSIS**

Record of Non-contact Physical Health Observations

If any RED statements are triggered tick relevant ABCDE box below. Document your concerns in the larger box provided (include when and who the patient was escalated to, what support was started, alterations to monitoring and outcomes of review).							Name, Signature and role
Date Time	All green statements (circle if true)	A	B	C	D	E	
Date Time	All green statements (circle if true)	A	B	C	D	E	
Date Time	All green statements (circle if true)	A	B	C	D	E	
Date Time	All green statements (circle if true)	A	B	C	D	E	