Leicestershire Partnership NHS Trust

Rapid Tranquillisation Policy

Acute Medical Treatment of Behavioural Crisis

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Type of Policy Clinical

Keywords: Rapid tranquillisation, aggression, behavioural disturbance

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Contents

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Policy on a page

Please note that this is designed to act as a quick reference guide only and is not intended to replace the need to read the full policy. Please include details using the headings below:

Summary and aim

This policy sets out the safe, lawful and least-restrictive use of Rapid Tranquillisation (RT) to manage acute behavioural disturbance when de-escalation and other alternatives have failed. RT is a form of chemical restraint and therefore a restrictive practice under national guidance; it must comply with the Mental Health Units (Use of Force) Act 2018, be necessary, proportionate, and recorded as use of force.

When RT May Be Used

Only when the person is highly agitated, aggressive, overactive or presents immediate risk, and after de-escalation and alternatives have been attempted and documented. Continue attempts at de-escalation throughout

Legal & Ethical Framework

RT must be the least restrictive option and align with the Human Rights Act 1998, Equality Act 2010, and the Use of Force Act 2018 (chemical restraint is use of force; all such episodes must be recorded and reviewed). Restrictive practices must never be punitive, degrading or coercive.

Documentation (Key Requirements)

For every RT episode:

- Incident report (to be completed by the person who administered the RT) (required for MHSDS capture).
- Legal and clinical justification (indication, capacity, consent).
- Medication(s), dose(s), route(s), and rationale; note any deviations from BNF/NICE.
- Alternatives/de-escalation attempted and outcome.
- Physical observations
- Protected characteristics recorded to monitor disproportionality.

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- Post-incident review, patient debrief and offer to create/update an advance statement within 72 hours.

RT vs treatment dose: Medications in this policy are RT (and must be incident-reported) when used to manage acute disturbed behaviour. They are not RT when used solely as treatment (e.g., lorazepam for catatonia, aripiprazole for non-compliance). Physical observations are still required in either case.

Target audience

This guideline applies to all medical, registered nursing and other prescribers employed by LPT, including bank, agency, and locum staff working on Mental Health inpatient areas.

Training

There is a need for training identified within this policy. In accordance with the classification of training outlined in the Trust Learning and Development Strategy, this training has been identified as Role Essential Training.

It is delivered via eLearning at least every 3 years. A record of the event will be recorded on uLearn.

Compliance is monitored in accordance with the Trust's Mandatory Training Policy. The governance group responsible for monitoring the training is the Medicines Management Committee.

Key Roles

The Trust's Responsible Person (Use of Force Act, Section 2) is The Group Chief Nurse, accountable for training, publication, data reporting and governance of use of force.

Key requirements

1. On admission to a mental health ward

On admission, staff should discuss with patients and, where appropriate, their carers, what may happen if they become disturbed or violent and provide them with the opportunity to express their needs and wishes in the likelihood of such an event.

Interpretation services are available for patients if required.
A leaflet for Restrictive practices in available in inpatient areas that describes how staff will care for patients in distress, which covers the use of Rapid Tranquilisation.

2. Prescribing and administering medication

Nurses should administer medication only according to written prescriptions. Instruction by telephone (verbal orders) to administer a drug that has not been

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prescribed previously is not acceptable (Guidelines for the administration of medicines, Nursing and Midwifery Council 2004).
In managing disturbed behaviour, it is essential that nursing and medical staff should present a united and easy to understand format to the patient.
If there is disagreement among staff about whether or not to use RT, more senior staff i.e., line managers / senior medical staff must be consulted to clarify the management plan as quickly as possible.

3. Choice of medication

a. Adults

Administer Lorazepam 1 - 2 mg IM
OR
Promethazine 50mg IM
OR
Aripiprazole 9.75mg IM
OR
Haloperidol 5 mg IM with or without Promethazine 50 mg IM

All IM injections should be administered separately not mixed.
Use Lorazepam monotherapy if:
There is little information available to guide choice of agents
There is a history of cardiovascular disease
An ECG shows prolonged QTc interval
Or if there is no ECG
Haloperidol must not be given without a CURRENT ECG.

b. Older and Frail Adults

Administer Lorazepam 0.5 - 2 mg IM
OR
Promethazine 25mg IM
OR
Aripiprazole 5.25 mg (0.7 ml) IM
OR
Haloperidol 2.5 mg IM with or without Promethazine 25 mg IM
Haloperidol must not be given without a CURRENT ECG

Do not use Haloperidol if there is evidence of Parkinson's disease and/or Lewy Body Dementia)

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c. Children, CAMHs (12 years and over)

Administer Lorazepam 0.5-2 mg IM
OR
Promethazine 25-50mg IM
OR
Haloperidol 5 mg IM with or without Promethazine 25 mg IM
All IM injections should be administered separately not mixed.
Haloperidol must not be given without a CURRENT ECG

Due Regard & Equity

Evidence shows restrictive practices disproportionately affect some groups, including people from ethnic minority backgrounds. Staff must consider individual, cultural and communication needs and document any adjustments made to avoid disproportionate restriction

The Trust will conduct routine analysis of RT incidents to identify and address any disproportionality relating to protected characteristics.

Monitoring and Documentation

After Rapid Tranquillisation,

Person who administered RT to complete eIRF

For the first hour after RT medication is administered the patient must remain in sight at all times.

Monitor:

- side effects
- the service user's pulse,
- blood pressure,
- respiratory rate,
- temperature,
- level of hydration
- and level of consciousness

At least every hour, until there are no further concerns about their physical health status.

Monitor every 15 minutes if the service user is under 18 or if other concerns present.

Document on Brigid/SystmOne

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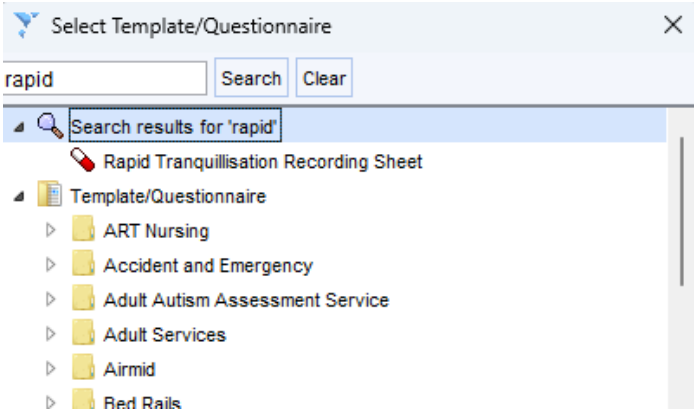
There is a template on SystmOne. This is to be used in preference to the scanning in of paper records

This can be located by searching for the term ‘rapid’ in the search bar on the bottom left or on the Assessments, Template tab



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Introduction and Purpose

Aggressive or severely disturbed behaviour may arise as a consequence of mental disorder and is often the result of complex interactions between a person's internal experiences and their environment. This policy supports a therapeutic, trauma-informed culture, in which relational approaches, collaboration, de-escalation, and psychological safety are prioritised over coercive measures.

In most circumstances, skilled and trained staff are able to reduce agitation, aggression or potential violence through verbal de-escalation, engagement and other non-restrictive interventions. However, there are occasions when these methods are insufficient, and a person's behaviour poses a significant and immediate risk of harm to themselves or others. In such circumstances, rapid tranquillisation (RT) may be required to achieve a state of calm that enables safe assessment and ongoing care.

Rapid tranquillisation is a form of chemical restraint, one of the eight restrictive practices defined within NHS England's *Identifying Restrictive Practice* resource (2025). Its use must therefore comply with national expectations that all restrictive practices are lawful, necessary, proportionate, justified for a legitimate aim, and the least restrictive option available. Restrictive practices must never be used to punish, degrade, coerce, or humiliate.

This policy is aligned with the legal requirements of:

- The Human Rights Act 1998, ensuring that any restriction on liberty, privacy, dignity or autonomy is lawful, justified, and the minimum necessary to maintain safety.
- The Mental Health Units (Use of Force) Act, which requires transparency, accountability, and safe practice whenever force or restrictive interventions are used.
- The Equality Act 2010, which mandates that restrictive practices do not disproportionately impact individuals with protected characteristics, acknowledging national evidence of unequal use.

RT must only be used when a patient is highly aroused, agitated, overactive, aggressive, making serious threats, or behaving in a way that risks significant harm, and only when all other therapeutic and preventive interventions have failed. Staff must continue to attempt de-escalation throughout any restrictive intervention.

All staff involved in administering RT must be appropriately trained in the assessment and management of patients in acute behavioural disturbance. This includes understanding the risks associated with benzodiazepines and antipsychotics, recognising and responding to physical health deterioration, using cardiopulmonary resuscitation equipment, prescribing within therapeutic limits, and administering flumazenil where required.

All of the medications described within this policy (e.g., lorazepam, promethazine, aripiprazole and haloperidol) will be considered rapid tranquillisation when administered for the purpose of managing acute behavioural disturbance (agitation, aggression, overactivity or immediate risk).

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These episodes must be incident-reported. The eIRF is to be completed by the person who administered the RT

Medications will not be considered rapid tranquillisation only when they are administered solely as part of:
• treatment for a diagnosed condition (e.g., lorazepam for catatonia), or
• routine treatment where the purpose is not behavioural control (e.g., aripiprazole for non-compliance with prescribed antipsychotic regimen).

Even in these situations, staff must still carry out physical health observations post-administration, as required for patient safety and wellbeing.

Policy Requirements and Objectives

Use of Rapid Tranquilisation (as with all restrictive practice) is to be used only if de-escalation and other preventive strategies, including as required (PRN). medication, have failed and there is potential for harm to the service user or other people if no action is taken. Continue to attempt de-escalation throughout a restrictive intervention.

RT must only be used when all other preventive and relational approaches have been exhausted. Staff must record the steps taken to avoid restrictive practice, in line with NHS England's requirement for reflective practice and harm reduction.

Do not use restrictive interventions including rapid tranquilisation to punish, inflict pain, suffering or humiliation, or establish dominance.

Staff must apply trauma informed, autism informed and culturally competent approaches at all stages of care, consistent with NHS England's Culture of Care Standards.

Process

1.0 Initial Measures

1.1 Safety

The first step is to ensure safety of the patient, staff and others on the ward. This may involve:

- Making sure that enough staff members are available
- Considering the patient's preferences
- Considering history of adverse reactions to medication
- Considering what worked in the past

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- Removing the patient to a low stimulus environment
- Ensuring availability and easy accessibility of resuscitation equipment. e.g., pulse oximeter and drugs, including flumazenil
- Physical restraint

1.2 **Assessment**

Assess the situation within the multidisciplinary team.

Consider the likely diagnoses, physical illnesses, general physical state e.g.:

- pregnancy
- exhaustion
- dehydration
- recent test results
- current psychiatric and non-psychiatric medication
- alcohol and/or substance misuse

Before RT is considered, staff must assess for environmental contributors (e.g., noise, crowding, overstimulation, blanket restrictions) and apply adjustments wherever possible.

A basic physical examination should be done. If this is not possible at the time, the reason should be documented, and the physical examination done as soon as possible afterwards.

Use caution in patients who are already sedated or using alcohol or illicit drugs. Consider the patient's regular oral and depot medication, as they affect the dose requirements and side effects of the RT medication.

1.3 **Pregnant Patients**

Special Care must be taken when administering RT to a female patient during **any stage** of pregnancy. Additional medical advice may be required due to the possible additional

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complications that may arise. This situation may well require quite complex discussions with relatives / carers.

1.4 **Elderly** and **Frail patients**

In elderly patients consider:

- Dementia
- physical frailty
- delirium

Look for causes of confusion.

1.5 **Non-pharmacological measures**

Always use behavioural approaches and de-escalation techniques, e.g., talking down, distraction, interventions that are outlined within their collaborative care plan or Positive Behaviour Support plan etc. Even when they do not prevent the need for RT, they will help preserve the therapeutic relationship and improve safety.

Before administering any medication, inform the patient that medication needs to be given and that they will have the opportunity to take the medication orally.

2.0 Drugs for Rapid Tranquillisation

Try <u>ORAL</u> therapy

If refused, or the behavioural crisis escalates, begin to follow these guidelines when you have established:

- How to quickly contact a consultant / senior colleague
- The availability of mechanical ventilation / cardiac resuscitation equipment

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ALWAYS discuss with a consultant / senior colleague if there is **ANYTHING** you are unhappy or uncertain about.

Remember that there is always on-call pharmacist support.

After Rapid Tranquillisation,

Person who administered RT to complete eIRF

For the first hour after RT medication is administered the patient must remain in sight at all times.

Monitor:

- side effects
- the service user's pulse
- blood pressure
- respiratory rate
- temperature
- level of hydration
- and level of consciousness

at least every hour until there are no further concerns about their physical health status.

Monitor every 15 minutes if the BNF maximum dose has been exceeded or the service user:

- appears to be asleep or sedated
- has taken illicit drugs or alcohol
- has a pre-existing physical health problem
- has experienced any harm as a result of any restrictive intervention

Planned recording of vital signs may be compromised by the clinical state of the patient.

Monitoring requirements for CAMH patients are different as they can be more sensitive to psychotropics.

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The recording of these signs should be in the **Trust approved monitoring tool: Brigid/Systm1**

If monitoring is not possible, enter:

- Date
- Time
- “Patient uncooperative to monitoring”
- Patient’s conscious level and respiration rate as minimum. onto the Trust approved monitoring tool; Brigid/System 1

Refer to any advance directives that explain the patient’s preference for medication, if clinically appropriate.

RT is used to reduce markedly aggressive or over-aroused behaviour and agitation, rather than to sedate the individual. However, if the patient’s behaviour is very disturbed, it may become necessary to sedate a patient for safety reasons.

Antipsychotic drugs are used in RT for their calming and sedative effects. Their antipsychotic effect usually takes two weeks.

Benzodiazepines reduce arousal and cause sedation at higher doses. They have no antipsychotic effects.

Oral and IM prescriptions should be prescribed separately on EPMA chart.

IV and IM doses generally have 2 - 5 times higher potency than oral doses.

The ward team need to be clear about the level of nursing observations required and plan staffing accordingly.

All episodes of rapid tranquillisation must be recorded as an incident, in line with Section 6 of the Mental Health Units (Use of Force) Act, which requires the recording of every instance of force including chemical restraint. The eIRF is to be completed by the person who administered the RT.

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Reporting ensures accurate Trust submission to the Mental Health Services Data Set (MHSDS) and enables local and national oversight of restrictive practices

A post incident review and patient debrief must take place within 72 hours of the RT episode. Staff must offer the patient the opportunity to create/update an advance statement describing their preferences should behavioural crisis occur in future.

A medical review must occur within 72 hours following any RT episode to evaluate the cause, effectiveness, and future risk reduction strategies.

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3.0 Adults

Lorazepam or Promethazine or Aripiprazole or Haloperidol +/- Promethazine

Administer **Lorazepam 1 - 2mg IM**

OR

Promethazine 50mg IM

OR

Aripiprazole 9.75mg IM

OR

Haloperidol 5 mg IM with or without Promethazine 50 mg IM

All IM injections should be administered separately not mixed.

Use Lorazepam monotherapy if:

- There is little information available to guide choice of agents
- There is a history of cardiovascular disease
- An ECG shows prolonged QTc interval
- Or if there is no ECG

Haloperidol must not be given without a CURRENT ECG Unless the clinical situation constitutes a life-threatening emergency where no safer alternative is available (NICE NG10)

- Dose adjustments should be considered for younger and older patients or those with special requirements
- When using Lorazepam make sure Flumazenil is available in case of benzodiazepine induced respiratory depression
- If there is a partial response to Lorazepam that has been administered, consider a further dose after 2 hours up to a maximum of: 4 mg/24 hours.
- Promethazine IM is a useful option in a benzodiazepine-tolerant patient. It has a slow onset of action but is often an effective sedative.

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- If there has been a partial response to Promethazine this may be repeated after 2 hours up to a maximum of 100mg/24hours
- Note that promethazine may (rarely) cause NMS.
- Aripiprazole may be repeated after 2 hours. Total of three injections in 24hours.
- If there is a partial response to Haloperidol that has been administered, consider a further dose after 1 hour up to a maximum dose of: 20 mg/24hours.
- If there has been no response to the medication that has been administered, use an alternate regime unless contraindicated.

Acute Dystonia

Consider giving IM antimuscarinic medication (i.e. Procyclidine or Benztropine) prophylactically with Haloperidol but remember that this may cause or worsen any confusion present.

At the time of writing **Procyclidine 10mg/2ml solution for injection ampoules have been recently withdrawn from sale**. (Procyclidine tablets and solution remain unaffected). This means that continued usage of this product for the treatment of acute dystonia has become 'unlicensed'.
It was withdrawn due to commercial rather than safety reasons. There are no licensed alternative products for parenteral use.

While residual supplies of Procyclidine injection remain, the Trust endorses the continued use of procyclidine injection for the acute treatment of dystonia associated with antipsychotic use, without the need to complete an unlicensed form.

Unlicensed imports of procyclidine 10mg/2ml solution for injection **cannot** be sourced.

Provision has been made to import another unlicensed product, Benztropine 2mg/2ml injection for this indication. Benztropine mesylate, (although unlicensed in the UK), is an injectable anticholinergic used to manage acute dystonic reactions. However, unlike Procyclidine, it remains licensed and available in other countries. Therefore, there is the option to import supplies.

Benztropine 2mg/2ml injection has been endorsed by the Trust as an option for the acute treatment of dystonia associated with antipsychotic use, without the need to complete an unlicensed form.

Adults

- Administer 1-2mg intramuscularly (IM)
- Administer a repeat dose if there has been no response after 30 minutes (IM)

Maximum daily doses of 4-6mg have been reported

Children

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Use is contraindicated in children under 3 years of age.
Children 3 years and over

- Administer 20-50 micrograms per kg (maximum 2mg) intramuscularly (IM)
- Administer a repeat dose if there has been no response after 30 minutes (IM)

Pharmacokinetics
The IM injection is reported to have a similar onset of action as the IV injection. Therefore, the Trust advocates for IM use only
The duration of action of benztropine may persist for up to 24 to 48 hours following a single 2mg IM injection.

Caution
Consider the cumulative anticholinergic dosing, side effects and maximum doses in people prescribed regular oral procyclidine or trihexyphenidyl who subsequently need 'as required' injectable benztropine.

Specific Patient Populations (ref https://www.ncbi.nlm.nih.gov/books/NBK560633/)
Hepatic impairment: The manufacturer does not publish advice on benztropine in patients with hepatic impairment.
Renal impairment: The manufacturer label does not publish advise on benztropine in patients with renal impairment.
Breastfeeding considerations: According to current literature, the exact effects of benztropine on human breastfeeding are unknown. Furthermore, atropine, which shares structural similarities with benztropine, demonstrates little to no impact on human breastfeeding. However, some studies on antimuscarinic drugs, in general, have shown adverse effects on animal breastfeeding by reducing serum prolactin concentration in experimental animals. As a precautionary measure, it is advisable to contraindicate benztropine during breastfeeding.
Pregnancy considerations: The effect of benztropine during pregnancy and labour is still unknown. Several cases in the literature discuss the impacts of benztropine administration during pregnancy. According to the literature, it is neither indicated nor contraindicated to use benztropine during pregnancy, as more clinical data and research are needed to detect the exact influence of benztropine.

1.6 If there IS a response to RT medication administered

There is a high likelihood of recurrence of the crisis, unless treatment is instituted for the underlying disorder causing the behavioural emergency.

Therefore, consider the following:

- Commence / re-commence oral antipsychotics.

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- Consider (in discussion with colleagues/consultant) giving Zuclopenthixol acetate (Clopixol Acuphase) 50 - 150 mg IM to minimize likelihood of repeat injections.
- Clopixol Acuphase should **NOT** be used for RT.
- Maximum serum concentrations of
- Clopixol Acuphase are usually reached 36 hours after an injection
- Three days after the injection the serum level is about one third of the maximum.

It should only be considered if a patient responds to other short acting parenteral antipsychotics, and it is anticipated that they will require further frequent doses of IM typical antipsychotics.

It is best reserved for people who have had a previous good response to Acuphase.

It should not be given to:

- antipsychotic naïve patients
- elderly patients
- physically struggling patients.
- Clopixol Acuphase should be given only after assessing the response to previously injected drugs:

i.e., 30 - 60 minutes after IM injections:

- Give 50 -150 mg IM and reassess after 24 hours
- Give up to a maximum of 400 mg in 3 days
- Assess patient for dystonia and other extrapyramidal side effects.

Continue to monitor vital signs as above. Pulse oximeter should be available and should be used where appropriate.

Use of Clopixol Acuphase should be incident reported using the Cause Group – Care/Treatment under Restraint – Acuphase/depot administration so the use of Chemical restraint can be monitored by MHSDS. This should be recorded by the person who administered the Clopixol Acuphase.

Acute reversal of benzodiazepine induced unconsciousness requires the use of

Flumazenil:

The initial dose is:

- 200 micrograms IV over 15 seconds.

A further dose of

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- 100 micrograms

Can be given after 60 seconds where necessary and repeated up to a total dose of 1 mg.

Flumazenil must be administered by a doctor or suitably qualified person.

If no doctor is available and there is concern for the patient's safety: please call the crash team on 2222, or where this is not available, call 9999.

1.7 If there is NO response to RT medication administered

If there is a **partial response** to the medication that has been administered, consider a further dose.

If there has been **no response** to the medication that has been administered, use an alternate regime, unless contraindicated.

Other medications may occasionally be used if a response from the above cannot be obtained, but only following discussion with a consultant psychiatrist.

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4.0 Older and Frail Adults

Lorazepam or Promethazine or Aripiprazole or Haloperidol +/- Promethazine

Administer **Lorazepam 0.5-2mg IM**

OR

Promethazine 25mg IM

OR

Aripiprazole 5.25 mg IM

OR

Haloperidol 2.5mg IM with or without Promethazine 25mg IM

All IM injections should be administered separately not mixed.

Use Lorazepam monotherapy if:

- There is little information available to guide choice of agents
- There is a history of cardiovascular disease
- An ECG shows prolonged QTc interval
- Or if there is no ECG

Haloperidol must not be given without a CURRENT ECG

- When using Lorazepam make sure Flumazenil is available in case of benzodiazepine induced respiratory depression
- If there is a partial response to Lorazepam that has been administered, consider a further dose after 2 hours up to a maximum of: 2mg/24 hours.
- Promethazine IM is a useful option in a benzodiazepine-tolerant patient. It has a slow onset of action but is often an effective sedative.

- Promethazine carries a high Anticholinergic Effect on Cognition (AEC) burden (score 3 as a single agent) score of 3+ is associated with increased cognitive impairment and mortality.
- If there has been a partial response to Promethazine this may be repeated after 2 hours up to a maximum of 50mg/24hours
- Note that promethazine may (rarely) cause NMS.
- Aripiprazole may be repeated after 2 hours. Up to a total of 15mg in 24hours.
- Do not use Haloperidol if there is evidence of Parkinson's disease and/or Lewy Body Dementia)
- If there is a partial response to Haloperidol that has been administered, consider a further dose after 1 hour up to a maximum dose of: 20 mg/24hours.
- If there has been no response to the medication that has been administered, use an alternate regime unless contraindicated.

5.0 After Rapid Tranquillisation

After Rapid Tranquillisation,

Person who administered RT to complete eIRF

For the first hour after RT medication is administered the patient must remain in sight at all times.

Monitor:

:

- side effects
- the service user's pulse,
- blood pressure,
- respiratory rate,
- temperature,
- level of hydration
- and level of consciousness

at least every hour until there are no further concerns about their physical health status.

Monitor every 15 minutes if the service user is **under 18 years** or if they:

- appears to be asleep or sedated
- have taken illicit drugs or alcohol
- have a pre-existing physical health problem
- have experienced any harm as a result of any restrictive intervention
- have received doses above BNF maximum

If the patient is asleep or unconscious, it is important to continue monitoring. In addition, monitor oxygen saturation by pulse oximeter. In case of a patient who is unconscious 1:1 observation by competent staff is required.

Consider a fluid chart if their fluid intake is poor, or if the patient appears dehydrated consider a medical review.

Staff will need to check the patient's colour and responsiveness at regular intervals, as both these areas could indicate that the patients' physical health is deteriorating as per section 7

6.0 Patients with Eating Disorders

Anorexia nervosa involves starvation and intense weight loss which not only denies the body of essential nutrients but forces the body to physiologically slow down to conserve energy.

In the early stages of treatment when patients are acutely starved and low in weight, cardiovascular symptoms and objective measures of cardiac impairment are not unusual. Patients can exhibit abnormally slow heart rate (bradycardia) and low blood pressure (the latter often the result of a combination of bradycardia, poor muscle bulk, electrolyte disturbance (impairing contractility) and dehydration.

These factors can individually or in combination contribute to an increased risk of heart failure.

Electrolyte disturbance commonly related to purging behaviours, including self-induced vomiting and laxative misuse can increase the hearts irritability and proneness to arrhythmia.

The literature contains several cases of anorexia nervosa with prolonged QTc interval although it is not clear what risk this presents to patients as a consequence. It is also worth considering issues connected to re-feeding syndrome in particular the possibility of low serum phosphate which can contribute to cardiac failure through reduced muscle contractility.

Incidentally, mitral valve prolapse due to poor muscle bulk (reversible on weight restoration) and pericardial effusion can also be detected more often with echocardiogram than through clinical examination. These last two findings do not necessarily present with clinical symptoms or significant impairment. Clearly consideration needs to be given to medications prescribed in this patient group that may have prolonged QTc interval.

Psychiatric comorbidity is common in patients with anorexia nervosa and thus by extension, so is psychotropic prescribing.

Taking all of this into consideration it seems prudent to consider this group of patients as frail and having a heightened risk of adverse consequences from medications prescribed acutely in the context of RT. A sensible approach might be to start with lower doses and titrate further doses in response to clinical need and close reassessment of the patient especially cardiovascular status.

7.0 Documentation

- An incident report that, ensures inclusion in the Mental Health Services Data Set (MHSDS). (this is to be completed by the person who administered the RT)
- Legal and clinical justification, including indication, assessment of capacity, and whether consent was given.
- Medications administered, including dose, route, and justification for any deviation from BNF/NICE guidance.
- De-escalation measures and alternatives attempted prior to RT.
- Physical health observations recorded using NEWS on Brigid, with non-contact observations AVPU and Respiration Rate as a minimum.
- Any injuries, adverse effects or harm, and staff involved.
- Protected characteristics, to support monitoring for disproportionate use of force.
- Rationale where the policy could not be followed.

If staff cannot obtain observations due to the patient's mental state or staff safety concerns, this must be clearly documented in progress notes, including the reason and actions taken to maintain safety.

Other interventions

Provide explanation, advice, reassurance and support to the patient, their carers and any other persons who may have witnessed the incident.

Transfer the patient for nursing in a Low Stimulus Environment or side room.

Whenever possible establish the patient on regular medication with clear instructions regarding regular review.

If in any doubt, a senior member of staff should be consulted. For doctors this means the Consultant, or the senior doctor on call. For nurses this means the duty manager.

Use of Force Compliance

Rapid tranquillisation (RT) is considered 'chemical restraint' and therefore constitutes 'use of force' under the Mental Health Units (Use of Force) Act 2018.

RT must therefore be:

• lawful, necessary, proportionate and the least restrictive option;

• undertaken in accordance with human rights principles;

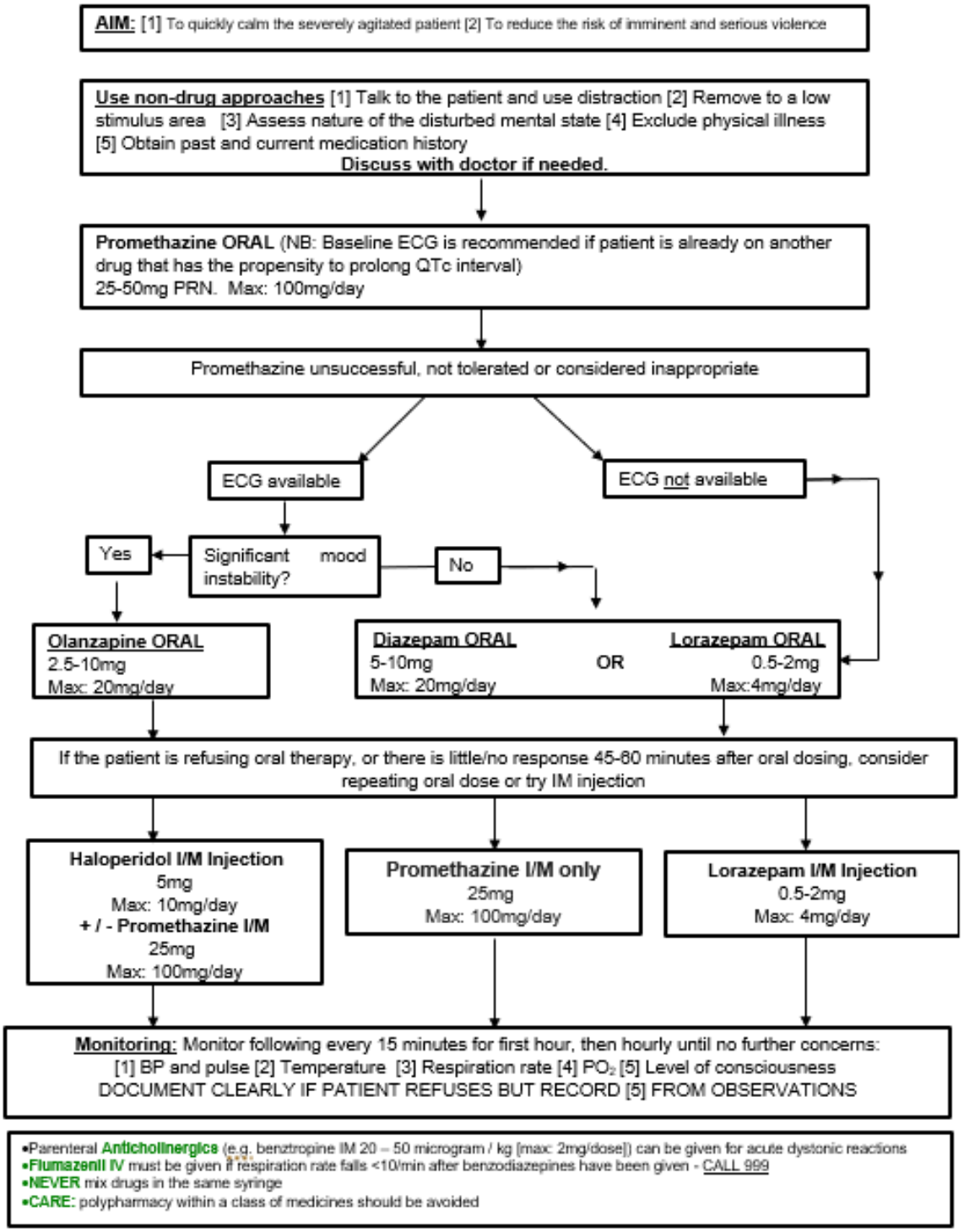
• fully recorded and monitored in line with Sections 5 & 6 of the Act;

• subject to post incident review and governance oversight.

The Trust's designated Responsible Person, as required under Section 2 of the Use of Force Act, is the Group Chief Nurse, delegated to Deputy Director of Nursing & Quality.

They are accountable for ensuring training, reporting, policy publication, data monitoring, and compliance with statutory duties.

8.0 Guidelines for Rapid Control Of Acutely Disturbed Behaviour in Inpatient CAMHs (12 years and over)



Roles and Responsibilities

Prescriber To:

Ensure patient's prescription includes details of what medication to use for RT, in what dose range, and with what frequency
ensure minimum time between doses and the maximum dose to be administered in a specified period must be stated
consider medication already prescribed
complete the Rapid Tranquillisation Recording Sheet - Appendix 1

Nurse who administered RT To:
Complete eIRF
Nurse in charge (of unit at time of RT) To ensure:
the RT is indicated, having exhausted other strategies to calm the patient
the prescription is followed
the patient has the appropriate physical observations completed
written records are maintained - use SystmOne
completion of Review of Rapid Tranquillisation –on SystmOne
Pharmacists To:
ensure prescriptions are checked for potential adverse interactions
Clinicians To:

ensure the prescription for oral medication is followed
undertake appropriate physical observations
maintain written records - Brigid & SystemOne

Ward Sister/Charge Nurse To:
Check after incidents of RT that follow-up is completed by nursing staff. To complete AMAT tool following incidents of RT to ensure that there is consistent governance.
ensure that any incident of RT during the evening/night shift is reported to the morning staff and vice versa.

Consent

Whereas for most LPT policies clinical staff must ensure that consent has been sought and obtained before any care, intervention or treatment is delivered.

The circumstances where a patient may require rapid tranquilisation are such that informed consent is unlikely to be forthcoming.

For patient and/or public safety, patients may be detained under the Mental Health Act (1983). They may then receive medication against their will.

If more than three months have passed since a patient first received medication under the Mental Health Act, then the prescription must be covered by an appropriate consent to treatment form.

This would preferably be a T3 as completed by a Second Opinion Authorised Doctor (SOAD). Or, in an emergency, a C6. (Please note that a T2 form is unlikely to be valid for rapid tranquilisation. As a T2 specifically states that the patient 'Understands the nature, purpose and effect of the treatment and agrees to take it').

Appendix One: Recording Sheet for IM Rapid Tranquillisation

This is recorded here for business continuity purposes. Please use the template available on SystmOne.

Post rapid tranquillisation review for patients

Patient Label

(Write full name until label can be sought)

NHS Leicestershire Partnership NHS Trust

What happened in the incident?
How do you feel about the incident
In your mind, what led to the incident?
What other coping strategies/distraction/calm down methods/activities could we have helped you engage in to prevent this in future?
How do you feel about the way staff involved you during the incident? Is there anything else they could have done differently?

Care plan reviewed?	Yes ☐	No ☐	If not completed, please explain why:	
Risk Assessment updated?	Yes ☐	No ☐	If not completed, please explain why:	
Date			Patient signature	
Staff name			Staff signature	
Charge Nurse/Sister Review			Date:	
Name				
Signature				

Recording Sheet for
IM Rapid Tranquillisation
All parts must be completed

Patient Label

(Write full name until label can be sought)

NHS
Leicestershire Partnership
NHS Trust

Ward		**MHA status**	
Date		**Time of injection**	
Capacity to consent?		**Consent to treatment in place?**	
Staff administering injection: [Print names]			
Medication administered		**Dose**	

A Nurse will ensure that the following duties are carried out	**Time done**
Allocate staff for observations duties	
Contact Ward/Duty Doctor to review patient	
Inform Doctor on arrival of if there are any concerns re: • Medical conditions • Prolonged restraint • Patient has used illicit drugs/alcohol	
Document in electronic patient record that: 1. Patient has been given RT 2. Their response to the medication 3. Their capacity related to this 4. Any concerns from observations taken after RT	
If RT already identified as an intervention in patient's **Care Plan**, evaluate the care plan with its use	
Update the patient's **Care Plan/Risk Assessment** with the use of RT as an intervention if not already identified as one	
Diarise **post RT incident review** for the following day	
Complete an Electronic Incident Reporting Form - eIRF	

Allocated Staff to document:	
All required physical observations by completing **NEWS2** form on **SystmOne**	Side-effects & Level of hydration in patient's **electronic patient record**

CAMHs patients: monitor **every 15 minutes** until no further concerns about patient's physical health status
Adult patients: monitor at least **hourly**, until there are no further concerns about patient's physical health status OR **every 15 minutes** if the patient:

• appears to be asleep or sedated • has taken illicit drugs or alcohol	• has a pre-existing physical health problem • has experienced any harm as a result of any restrictive intervention • has received above BNF doses

If a patient **refuses** to have their **vital signs** measured: **Allocated Staff** to document in **electronic patient record** every **15 minutes** as a minimum: • **AVPU** and • **Respiratory rate**

A = Alert/Awake	**V** = responds to Verbal stimuli	**P** = responds to Pain/Pressure stimuli	**U** = Unresponsive

	Time 1:	Time 4:	Time 7:
	Time 2:	Time 5:	Time 8:
	Time 3:	Time 6:	Time 9:

Post rapid tranquillisation review for patients

Patient Label

(Write full name until label can be sought)

NHS
Leicestershire Partnership
NHS Trust

What happened in the incident?
How do you feel about the incident
In your mind, what led to the incident?
What other coping strategies/distraction/calm down methods/activities could we have helped you engage in to prevent this in future?
How do you feel about the way staff involved you during the incident? Is there anything else they could have done differently?

Care plan reviewed?	Yes ☐	No ☐	If not completed, please explain why:	
Risk Assessment updated?	Yes ☐	No ☐	If not completed, please explain why:	
Date			Patient signature	
Staff name			Staff signature	

Charge Nurse/Sister Review		Date:	
Name			
Signature			

Appendix Two: Definitions

Rapid tranquillisation	The use of injectable medication to control severe mental and behavioural disturbance, including aggression associated with mental illness
Psychoactive substance	A chemical substance that affects the processes of the mind
PRN dose	Medication prescribed for use on an “as required” basis
Stat dose	Medication prescribed as a one-off dose.
Neuroleptic naive	Person who has not previously been treated with an antipsychotic (neuroleptic).
Dystonia	A neurological movement disorder, presenting as sustained muscle contractions, twisting and repetitive movements or abnormal postures.
Extrapyramidal side effects (EPSE)	A group of symptoms that can occur in persons taking antipsychotic medications e.g., tremor, akathisia, slurred speech, dystonia, bradykinesia, muscular rigidity
Due Regard	Having due regard for advancing equality involves: • Removing or minimising disadvantages suffered by people due to their protected characteristics. • Taking steps to meet the needs of people from protected groups where these are different from the needs of other people. • Encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low.
NEWS	National Early Warning Scoring Tool
EPMA	Electronic Prescribing and Administration service
SystemOne	System for electronic recording of patient observations.
Restrictive Practices	Restrictive practices (8 types): Cultural, Surveillance, Blanket restrictions, Mechanical restraint, Physical restraint, Chemical restraint, Psychological restraint, Environmental restraint.
Chemical Restraint	Chemical restraint: Medication used to restrict movement/behaviour (RT is chemical restraint; part of “use of force” under the Act).

Appendix Three: Governance

Version control and summary of changes

Version number	Date	Description of key change
5	June 2026	Full review

Responsibilities

Responsibility	Title
Executive Lead	*Chief Nurse*
Policy Author	*Rachel Carlton*
Advisors	*Members of the Pharmacy Team and MMC*
Policy Expert Group	

Governance

Governance Level	Name
Level 1 Assurance Oversight	Quality & Safety Committee
Level 2 Delivery Group for policy approval and compliance monitoring	MMC Safety Forum

Compliance Measures

KPI (only need 1-2 KPI's per policy)	Where will this be reported and how often
Should describe how you are monitoring what you say you will do in the policy e.g., 100% of nurses will be on the NMC register	Where will this information be reported, what format and how often?
Every RT episode must undergo a post-incident reflective review with staff and (where possible) the patient.	AMAT audit to be completed for all incidents of RT to evidence. These to be reviewed in service line meetings and escalated to Least Restrictive Practice Group within highlight reports with areas of good practice and those for improvement

Training Requirements

All staff involved in preventing, de escalating, administering, or monitoring rapid tranquillisation must receive training in accordance with the Mental Health Units (Use of Force) Act 2018, which requires trauma informed, anti discriminatory and least restrictive practice training.
Staff trained in Safety Interventions will receive:

- Trauma informed care, in line with NHS England's restrictive practice guidance.
- Anti discriminatory and anti bias practice, reflecting national expectations to reduce disproportionate use of force.
- Training in reducing restrictive practice, including alternatives to RT and relational approaches.

Physical health & emergency response training:

- Staff will be trained in the use of physical health monitoring equipment as part of induction.
- All inpatient staff will be trained in the appropriate level of life support, including Immediate Life Support where required, consistent with recent NHS RT policies.

Competency must be maintained through regular refresher training based on current national guidance.
Rapid Tranquillisation e learning:

- All qualified nursing staff will complete RT e learning every three years as part of mandatory training requirement

References

- **Mental Health Units (Use of Force) Act 2018 – Statutory Guidance** (DHSC).
- **Mental Health Units (Use of Force) Act 2018 – GOV.UK overview** (definitions of use of force including chemical restraint).
- **NHS England – Identifying Restrictive Practice (2025)** (eight restrictive practices; culture standards; reduction focus).
- **CQC – Restrictive Practices (Monitoring the MHA 2022/23)** (expectations to reduce, learn, and use least-restrictive approaches).
- **NHS England Digital – Restrictive Intervention reporting / MHSDS** (importance of accurate recording and data quality).
- **Benztropine injection for acute dystonic reactions**
  https://www.sps.nhs.uk/articles/benztropine-injection-for-acute-dystonic-reactions/