journey to change

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

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Rapid Tranquillisation (RT) Policy (including prescribing, post administration monitoring and remedial measures)

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Contents

1 Introduction

The Trust recognises the importance of good practice in preventing and managing aggressive, violent and potentially violent incidents. These can be referred to as a range of behaviours or actions that can result in harm, hurt or injury to self or another person or persons. Individuals with behaviours that challenge should be identified; risks assessed and have an up-to-date and regularly reviewed intervention plan. This will stipulate pro-active and de-escalation techniques that should be utilised to try and prevent the escalation cycle. This can include the pro-active use of oral "as required" (PRN) medication that has been prescribed for the patient.

It is recognised though that severe behavioural disturbance will sometimes occur despite all attempts to prevent it. At these times it may become necessary to use pharmacological interventions alongside physical restraint to maintain the safety and physical health of a patient or others.

In the management of severe behavioural disturbance, the administration of medicines using the parenteral route (usually intramuscular), under restraint when necessary, is termed Rapid tranquillisation (RT).

Rapid tranquillisation should only be used where a patient is highly aroused, agitated, overactive or aggressive, or is making serious threats or gestures towards themselves or others, or is being destructive to their surroundings, when other therapeutic interventions have been ineffective in supporting a reduction in such behaviour.

This policy should be read in conjunction with the Supporting Behaviours that Challenge Policy.

This policy is critical to the delivery of OJTC and our ambition to co-create safe and personalised care that improves the lives of people with mental health needs, a learning disability or autism. It helps us deliver our three strategic goals as follows:

- **To co-create a great experience for our patients, carers and families by supporting:**
  - **Access** to the care that is right for you – e.g. prescribing considerations (section 4.7.1), guidance for prescribing RT on in-patient units (appendix 1)
  - **Support** to achieve your goals – e.g. post-RT recording template (appendix 3)
  - **Choice** and control – e.g. legal considerations (section 4.3), working with patients (section 4.6)

2 Why we need this policy

2.1 Purpose

The purpose of this policy is to:

- Ensure a standard approach to care, based on the best available evidence.

- Minimise risk related to the use of rapid tranquillisation (RT).
- Advise on best practice in prescribing and administration of medication for RT.
- Provide clarity in relation to staff role and responsibilities.
- Comply with CQC and NHSLA standards, and national (NICE) recommendations.

2.2 Objectives

- To ensure good practice in managing aggressive, violent and potentially violent incidents in order to minimise the risk to staff, patients and others.
- To reduce suffering for the patient, to reduce risk of harm to others, to do no harm.
- To ensure all staff are aware of the advice around prescribing, administration and post-administration monitoring relating to the use of RT.
- To reduce the possibility of the patient suffering adverse effects from the administration of RT medication during restraint and heightened emotional disturbances.
- To define parameters for safe and effective use of medication and subsequent aftercare in line with:

  • Procedure for Using the National Early Warning Score (NEWS) 2 for the Early Detection and Management of the Deteriorating Patient in Adults (aged 16 and above) (CLIN-0099)

3 Scope

The identification, risk assessment and development of intervention plans for patients with behaviours that challenge (this is covered in the Supporting Behaviours that Challenge Policy)

3.1 Who this policy applies to

All healthcare staff working within in-patient settings where RT may be used

- This policy has been subject to Trustwide consultation to seek the views of staff who might be affected by it.
- This policy aligns to all three of the Trust values, so that people affected are treated with compassion, respect, responsibility.

3.2 Roles and responsibilities

Role	Responsibility
Chief Pharmacist	• To ensure the implementation of this policy is monitored and appropriate mandatory training is developed and accessed by relevant staff within their areas of responsibility.
Deputy Chief Pharmacist	• To monitor and audit the safe and appropriate usage of medication for rapid tranquillisation
Directors of Operations, Clinical Directors, Associate Medical Directors and Lead Psychiatrists	• To ensure that managers and Trust staff working in services who use RT are aware of the policy and promote good practice. • To ensure staff attend relevant training as identified within the Staff Development Policy; • To provide support and guidance regarding resources and the consistent application of the policy and future practice recommendations. • To ensure that safe systems are in place to enable medical and nursing staff to work in accordance with the procedures referred to in the policy.
Medicine Management Nurses	• To ensure competency-based training and assessment packages are developed and available to nursing staff and adherence to training is monitored via the Trust Training information system.
Medical staff	• To ensure they are familiar with the policy and supporting Trust prescribing guidelines and be responsible for adhering to the procedures referred to in the policy. • To undertake appropriate mandatory training (Royal College of Psychiatry or Trust). • To take responsibility for adhering to the service specific prescribing recommendations in this policy and actions needed in the event of an adverse incident or suspected adverse drug reaction. • To refer to the current Trust guidelines and the electronic British National Formulary (BNF) to check recommended drugs and dosages. • To be aware of their responsibility in relation to first response and the use of remedial measures.

Nursing staff	• To ensure they are familiar with the policy and be responsible for adhering to the procedures referred to in the policy; • To ensure mandatory training is undertaken; • To provide support and information to patients, carers and their families with regards to the use of RT; • To adhere to the Trust Medicines Overarching Framework and the Professional Standards for Administration of Medicines in Healthcare Settings; • To ensure they are competent in all the clinical procedures required to implement this policy including first response training and appropriate use of equipment. • To monitor vital signs after the use of RT using National Early Warning Score 2 (NEWS2) guidelines for all persons aged 18 years and over. • To ensure maintenance and monitoring of practice standards and equipment is carried out as recommended.
Clinical pharmacy staff	• To ensure medicines for RT are prescribed accurately, unambiguously and comply with legal requirements and good practice standards. • To ensure medicines for RT and medicines to treat adverse effects are available on wards. • To check if patients prescribed RT have received or may potentially receive “high dose” antipsychotic therapy. • To check if medicines prescribed for RT interact with any regular medication the patient is taking
Heads of Service and Locality Managers	• To implement the policy across their areas of responsibility and monitor the competence of nursing staff in applying the procedures referred to in the policy.
Ward/Unit Managers and the nurse in charge of a shift	• To ensure the policy and related procedures are adhered to during their span of duty. • To check that required monitoring is being done following administration of RT.

4 Policy

4.1 What is Rapid Tranquillisation (RT)?

- RT is a **reactive management strategy** and often involves physical intervention.

- RT is the parenteral (intramuscular) administration of medication to calm or sedate an agitated, violent or aggressive patient as quickly as is safely possible; **not** to treat the individual's underlying condition.
- The highly aroused condition of the patient during RT may intensify the effects of medication. The patient's physical health must be monitored after administration, see the relevant section below.

> Staff **must** be aware of the symptoms of respiratory depression, dystonia or cardiovascular compromise and if the patient shows signs of deterioration the Trust Resuscitation Policy must be followed.

4.2 What is not RT?

- Pro-active administration of prescribed oral "as required" (PRN) medication as an intervention within the patient's care plan to **prevent** a violent or aggressive incident;
- Pro-active restraint and administration of intramuscular medication which is documented in a care plan to enable administration of feeds. Specific details should be within the intervention plan and adhere to local requirements (N.B. post-administration monitoring of physical health is still required in this situation)

4.3 Legal considerations

> Prior to administering medication for RT, it is essential that the clinician is clear under what legal authority the treatment will be administered. The Mental Health Act and Mental Capacity Act status of the patient must be considered before medication is administered for RT.

4.3.1 Informal patients

Rapid tranquillisation must not be used to treat an informal patient who has the capacity to refuse treatment and who has done so - Code of Practice para 26.99.

RT can be administered to informal patients if they are assessed as having the necessary capacity to consent to it and have, in fact, provided a valid consent. Otherwise, legal authority may be provided as follows:

- If they have been assessed as having capacity to consent or refuse treatment and RT is refused, consideration should be given as to whether the criteria for detention under the Mental Health Act are met. Until the Mental Health Act is in place, RT cannot be administered to the capable refusing patient.
- If they are assessed as lacking capacity to consent but are compliant with receiving the treatment, then the treatment may be given under the authority of section 5 of the Mental Capacity Act provided the treatment is determined as being in the patient's best interests and there is no refusal in the form of an Advance Decision or an LPA or Deputy. This assessment of capacity and determination of best interests must be clearly documented in the electronic patient record using MCA1 and MCA2

- If the patient is assessed as lacking capacity to refuse or consent to RT and is non-compliant with receiving it, i.e. is objecting to RT either verbally or as indicated by their behaviour, then it is likely, other than in an acute emergency where it is a proportionate response to prevent harm to the person, that authorisation for treatment is beyond the scope of the MCA and consideration should be given as to whether the criteria for detention under the Mental Health Act are met.

4.3.2 Detained patients

If the patient is detained under the Mental Health Act, then treatment for mental disorder, including RT, is authorised for patients to whom it applies by Part IV of the Act provided the requirements of Part IV are adhered to.

The MHA does not confer any powers of treatment for mental disorder, including RT, on patients subject to the short terms powers of Sections 4, 135, 136, 5(4), 5(2) or those subject to Section 35. For guidance on the use of RT in health-based places of safety, see the Prescribing and Administration of Medication in Section 136 suites procedure

Where Part IV does apply, please see paragraph 4.3.1 regarding informal patients lacking capacity:

- Treatment can be provided for mental disorder under s62 without the need for certification, provided it is given by or under the direction of the AC in charge of treatment, for up to 3 months from the date medication was first administered for mental disorder during that period of detention. During this time, a capacity assessment should be recorded on MCA1and consent and capacity status recorded in the MHA case notes the first time that medication for Mental disorder is prescribed as per Code of Practice Para 24.41
- After the 3-month period above, treatment for mental disorder must either be certified on Form T2 (where the patient has capacity and consents to the treatment), or on Form T3 (where the patient lacks capacity to consent or refuses to consent)
- RT must be specified on either Form T2 or T3 for authority to administer treatment.
    - Where the Form T2 does not include RT, the RC may complete a new Form T2 to include RT if the patient has capacity and consents.
    - Where the Form T3 does not include RT or the patient subject to Form T2 does not have capacity or refuses to consent, then where the criteria are met the RC must use section 62 to authorise RT and complete the appropriate form. If this is likely to be a regular occurrence, then the RC should arrange for a SOAD to visit.

The entry made into the patient's electronic care records should make it clear which authority was used at the time of RT.

Where appropriate, advance decisions and statements should be put into place to inform the care team of any treatment that a person may have refused in advance (e.g. scientologists who do not wish to receive psychotropic medication) or what treatment an

individual would prefer to receive and/or whom they wish to be consulted if they become incapacitated as a result of their mental disorder.

4.4 Physical Intervention

All staff likely to be using physical intervention in the clinical management of a disturbed patient **must be competent** as outlined in the Safe use of Physical Restraint Techniques procedure

Physical restraint should not be used for more than 10 minutes without considering RT or seclusion. RT or seclusion may be used sooner than this if deemed clinically appropriate; conversely, physical restraint may continue without RT or seclusion if the event is resolving, but the need for RT or seclusion must be continuously reconsidered.

Any restraint required to administer RT should be proportionate and necessary to prevent harm to the patient or others.

4.5 Managing risk

Following administration of RT patients require enhanced observations in line with section 4.8 of this policy.

All instances of RT must be reported via the Trust safety event reporting system (currently as part of a "physical intervention" incident) to allow regular monitoring and audit to improve patient safety.

4.6 Working with patients

If using RT for the management of disturbed/violent behaviour:

- Ensure that the patient's dignity and privacy is maintained at all times. Always consider the deltoid route of administration as the preferred option. Consider the potential impact of the gender of staff involved in restraint and administration of RT to patients with certain protected characteristics.
- Explain the reasons for using the interventions at the earliest opportunity and at appropriate times throughout the process.
- Reassess their care plan and presentation and help them reintegrate at the earliest safe opportunity.
- Provide an opportunity to document their account as part of the debriefing process in line with the Supporting Behaviours that Challenge Policy
- Provide an opportunity for the patient to review their intervention plan with staff when appropriate.

4.7 Prescribing and administration of RT

⚠	Guidance and practical advice is available in appendix 1 and should be referred to whenever considering the use of RT.
❗	Similarly, for frail older or underweight people on adult in-patient wards consider guidance in appendix 1 relating to frail/elderly people
❗	DO NOT prescribe medication for RT routinely on admission, in anticipation of an event. If an event is highly likely (e.g. admissions to PICU), a RT dose may be prescribed to allow nurses to manage the event initially in the absence of a doctor (on the electronic prescribing system this is done as a "when required" prescription). A doctor MUST attend before a second dose is administered.
❗	RT may be prescribed "as required" for individual patients who have undergone a thorough psychiatric assessment prior to admission which has identified a high risk of disturbed behaviour likely to require restraint and intervention, for example: • acutely unwell patients transferred from prisons for hospital treatment. • patients with organic mental illness admitted to hospital from their normal care environment. • individuals presenting with suspected or confirmed drug induced psychosis. The rationale for "as required" prescribing on admission must be recorded in the electronic patient record. All prescriptions of RT medication must be reviewed within 72 hours of admission, and regularly thereafter, and discontinued when appropriate to do so
❗	After an RT event, an assessment should be made as to whether on-going "as required" IM medication needs to be prescribed for further events, bearing in mind the patient's consent and MHA status.
❗	An episode of disturbed behaviour resulting in RT should be seen as an opportunity to review the patient's regular and PRN medication to improve control of their condition and management of future episodes.

4.7.1 Prescribing considerations

The aim of RT is to achieve a state of calm sufficient to minimise the risk posed to the patient or to others. The prescriber must use medication for RT, particularly in the context of restraint, with caution because of the following risks:

- Loss of consciousness instead of sedation
- Over-sedation with loss of alertness
- Respiratory depression or arrest (loss of airway)
- Cardiovascular complications and collapse
- Seizures
- Adverse effects, for example, neuroleptic malignant syndrome
- Interactions with medication or other substances (prescribed or illicit)
- Underlying coincidental physical disorders, e.g. cardiovascular disease
- Possible damage to patient/clinician relationship
- Specific issues in relation to diagnosis, e.g. symptoms of delirium
- Need for physical restraint during administration.
- Needle-stick injuries

4.7.1.1 General considerations

- Pregnancy – see advice and recommendations in appendix 1
- Consider all medicines and other substances previously and/or recently taken when deciding to use RT and which options to use, particularly if intoxicated – this includes medicines taken shortly prior to admission.
- Clinicians may sometimes decide that use of medication outside the Summary of Product Characteristics (SPC) or BNF parameters is justified. This must be authorised by an ST4 doctor or above. This decision must not be taken lightly, nor the risks underestimated. A risk-benefit analysis must be recorded in the case notes and a rationale in the care-plan. Under these circumstances, monitoring of the patient should be more frequent (for frequency, see procedure for post administration monitoring), paying particular attention to regular checks of the airway, level of consciousness, pulse, blood pressure, respiratory effort, temperature and hydration.
- Prescribe IM doses of medicines for RT separately to any regular or as required oral doses of the same medicine and consider total amounts prescribed (including regular, as required, IM and oral) to ensure compliance with maximum daily doses.
- Sufficient time should be allowed for a clinical response between doses (see appendix 1). Refer to the Choice & Medication handy chart on Acute Disturbance for information about the onset of action, peak effect and duration of effect of treatments used
- Do not use two drugs of the same class for RT purposes.
- Be aware of any co-existing medical conditions, particular caution should be exercised during RT if these exist. Any respiratory condition should increase the level of concern and vigilance. Any cardiac problem, which may be related to congenital cardiac defects or known conduction problems, should also increase the level of caution during

RT. Other known medical conditions may increase the risks during RT and include metabolic disorders, such as Addison's disease.

- Poorly controlled blood glucose levels in diabetic patients may be associated with additional risk when administering RT
- Most psychotropic drugs have the potential to lower blood pressure. In particular, patients on clozapine, quetiapine and olanzapine may be prone to postural hypotension due to alpha-adrenergic effects. Older drugs such as chlorpromazine and tricyclic anti-depressants may also be associated with hypotension. Benzodiazepines tend not to cause marked hypotension but may do when used in combination with antipsychotic drugs such as haloperidol.
- These drugs don't tend to cause hypertension unless the effects are secondary to either obesity, cardiac or renal problems.
- Benzodiazepines may cause respiratory depression. This is normally mild unless the patient is concurrently given other psychotropic medication or has recently ingested alcohol or illicit drugs (e.g. opioids). **Flumazenil is not available on wards to manage benzodiazepine-induced respiratory depression; emergency services must be called immediately if respiratory arrest occurs.**
- It will not always be practicable to adhere rigidly to the prescribing guidelines, particularly with a patient whose needs (or distress) are difficult to manage. At the stage when the relevant guidance has been followed and resolution is still not achieved, the prescriber should be guided by their own clinical judgment on further pharmacological interventions; consideration should be given to consultation with a more senior clinician if appropriate at this time.
- Promethazine is not licensed for RT; please see the NICE evidence summary regarding its unlicensed/off label use in this indication

4.7.1.2 Antipsychotics

- Baseline ECG monitoring is strongly recommended before prescribing and administering parenteral antipsychotics. If it is not possible to perform an ECG, the reason must be clearly documented in the electronic patient record.
- If a recent ECG has not been performed, consider, and document the risks of using an antipsychotic against the potential benefit.
- If there is evidence of cardiovascular disease or a prolonged QTc-interval, avoid IM haloperidol combined with IM promethazine. IM lorazepam should be used instead. IM olanzapine (+ promethazine) may be considered if lorazepam is contra-indicated or ineffective, but also presents a risk of QT-prolongation.

Simultaneous injection of IM olanzapine and IM lorazepam is not recommended due to the potential for excessive sedation, cardiorespiratory depression and in very rare cases, death. If the patient is considered to need IM lorazepam this **should not be given until at least one hour after IM olanzapine administration**.

If the patient has received IM lorazepam, IM olanzapine administration should only be considered after careful evaluation of clinical status and the patient should be closely monitored for excessive sedation and cardiorespiratory depression.

- Antipsychotics can lower the seizure threshold, so caution is advised with patients who have a history of or are at high risk of developing seizures.

- Caution in patients who have never received antipsychotics before (antipsychotic-naïve), lower doses should always be considered in these cases. Procyclidine injection should be prescribed and available in case dystonia occurs including oculogyric crises. (Be aware of the symptoms of neuroleptic malignant syndrome [NMS] e.g. rigidity, fever, sweating, confusion, fluctuating consciousness, fluctuating blood pressure, tachycardia, elevated creatine kinase, leucocytosis, altered liver function tests).

- Zuclopenthixol acetate ('Acuphase®') should not be considered as an option for RT due to its delayed onset of action (2 hours), peak effect (12 hours) and prolonged effect (up to 72 hours). It can be considered as a proactive intervention when the following apply:

    - The patient is expected to be disturbed / violent over an extended time period.
    - There is documented evidence of repeated doses of RT drugs for violent / aggressive episodes.
    - There is documented evidence of a previous good / timely response.
    - It is cited in an advance directive.

  Consultant Psychiatrist approval is required before administering zuclopenthixol acetate (Acuphase®). Never give to a patient without previous antipsychotic exposure (antipsychotic naïve). Not to be considered for patients under 18 years of age on AMH wards. Consult Trust guidelines, and the electronic BNF / manufacturer's SPC for dosage information.

Oral and IM doses of psychotropics are not always equivalent. Care is needed to not exceed the maximum daily dose when prescribing/administering drugs via more than one route. Please refer to POMH ready reckoner for guidance on maximum doses. If actual or potential high dose antipsychotic therapy, refer to HDAT guidelines

4.7.1.3 Patient-specific considerations

Elderly / Frail / Underweight patients

- There are no national level consensus guidelines for the use of RT in older, frail or low bodyweight people. Physical health co-morbidities are more common and older patients are likely to be on medications in addition to psychiatric medication; hence the risk of drug interactions and side effects is higher.
- Cognitive disturbance is more common which is likely to be exacerbated by psychotropics used for RT.
- Prescribing antipsychotics in older people should consider the balance of risks and benefits in patients with dementia - antipsychotics are associated with a small increase in risk of mortality and increased risk of stroke or transient ischaemic attack.
- Promethazine has significant anticholinergic activity and has also been associated with QT prolongation, particularly relevant if co-administered with haloperidol. It has been shown to potentially precipitate delirium in physically unwell older people and therefore should be avoided in patients who have dementia or delirium, extreme caution should be exercised.

4.7.1.4 Drugs / formulations not recommended and/or not suitable for RT

- Zuclopenthixol acetate injection (Clopixol Acuphase)
- Chlorpromazine injection (intramuscular is extremely painful and there is a severe risk of severe hypotension)
- Diazepam injection (to be avoided due to erratic and slow absorption)
- Depot / long-acting antipsychotic injections (slow onset of action and too long acting)
- Midazolam – IM injection (other than exceptional circumstances when lorazepam injection is not available due to supply disruption – pre-approved indication in Trust off-label guidelines)

4.7.1.5 Record-keeping requirements

The risks and benefits of any prescription must be assessed by the prescriber on an individual basis and all prescribing must include a full assessment and history. If it is deemed appropriate to prescribe outside the recommendations specified in appendix 1, clear justification for doing so must be recorded in the care record with evidence of Consultant Psychiatrist's approval. This should include what has been prescribed and reasons for choice of treatment.

Prescribers must clearly document the indication if prescribing zuclopenthixol acetate for the management of severely disturbed patients.

4.7.2 Administration of medicines for RT

- Never mix two drugs in the same syringe.
- Adhere to requirements for lorazepam injection regarding storage (cold chain) and dilution, dependant on supplier/manufacturer.

- Use a site for IM administration which maintains patient dignity and reduces risk – lorazepam, haloperidol, olanzapine and promethazine may be administered into the deltoid, gluteal or lateral thigh muscle; aripiprazole may be administered into the deltoid or gluteal muscle.

4.8 Post-administration

Please refer to:
Procedure for Using the National Early Warning Score (NEWS) 2 for the Early Detection and Management of the Deteriorating Patient in Adults (aged 16 and above) (CLIN-0099)

To access the relevant monitoring charts and other supporting information.

All post administration recordings **must** be recorded in the electronic patient record within an activity note under the physical health tab.

- After any event involving RT there must be a multidisciplinary review to assess patient status and review the ongoing management plan

4.8.1 Age and other considerations

- The NEWS should not be used in patients who are pregnant, because the physiological response to acute illness can be modified by pregnancy. The NEWS may be unreliable in patients with spinal cord injury owing to functional disturbances – use with caution.
- Consideration should be given to age, size and physical presentation with a baseline taken on admission to ensure any changes are noted immediately.

4.8.2 New Early Warning Score 2 (NEWS2)

NEWS2 is a combination of six physiological observations:

- Respiration rate (R)
- Systolic blood pressure (BP)
- Pulse (P)
- Temperature (T)
- Conscious level (AVPU = alert, voice, pain, unresponsive)
- Oxygen saturations (Sats / SPO2)

Each of the observations generates a score which in turn generates an overall score and this can identify acute illness and shock.

Both scorecards are set to trigger when a patient has abnormal physiology apart from hypertension which is not a clinical emergency unless severe

4.8.3 Monitoring requirements

- Following the administration of RT **physical** observations must be taken regularly to allow the monitoring of any physical deterioration. The observations must include temperature, pulse, blood pressure, respiratory rate, oxygen saturation and responsiveness.
- Observations should be taken every ten minutes for one hour then every hour for a further 3 hours; the scores for individual observations should be recorded, with a total at the end of each column on the scorecard to identify actions required; these actions should be completed as directed.
- If the patient's level of agitation and risk increase due to the regularity of the observations, the nurse may use their clinical judgment to amend the frequency of observations.
- The patient should continue to be observed for visual signs and symptoms of deterioration and respiration rates must be documented as a minimum.
- If the patient refuses to have their physical observations taken staff should document refusal on the post-RT record template (appendix 3) and continue to observe for signs and symptoms of deterioration; respiration rates should be recorded on the early warning score chart as a minimum.
- At the end of the monitoring period, scores should be documented in the patient electronic record by pasting the completed Post RT record template (appendix 3) into a case note.

For ease of reference an aide memoir for post RT observations is attached as appendix 2 to print and display.

4.8.4 Remedial measures

ECG monitoring of QTc interval is strongly recommended before parenteral antipsychotics are given. Therefore, it is recommended that an ECG is performed on admission in case parenteral administration is required during the admission

Physical observations should be taken as per 4.9.2

4.8.5 Interventions

Reaction / Observation	Recommended intervention
Acute dystonia (including oculogyric crises)	Give procyclidine 10mg IM, can be repeated after 30 minutes
Reduced respiratory rate < 8/min or oxygen saturation <89% induced by benzodiazepines	Follow NEWS2 scorecard actions Give oxygen 15 litres/min Consider principles of ILS Contact emergency services immediately; inform relevant Trust medical staff.
Irregular or slow pulse < 50/min	Seek medical advice immediately - follow scorecard actions
Fall in blood pressure orthostatic or < 50 mmHg diastolic (taking into account the patient's baseline reading)	Lie patient flat, tilt bed towards head or raise legs. Monitor closely. If response gives causes for concern seek medical advice - Follow NEWS2 scorecard actions
Increased temperature (above 38ºC)	Immediately seek medical advice - withhold antipsychotics until creatinine kinase level is checked (risk of neuroleptic malignant syndrome and arrhythmias); keep patient cool.
Acute laryngeal spasm	Administer oxygen; Contact emergency services immediately; inform relevant Trust medical staff. Procyclidine 10mg IM should be administered
Severe respiratory depression	Contact emergency services immediately; inform relevant Trust doctor

5 Definitions

Term	Definition
Advance Decisions and Advance Requests	• An Advance Decision is an advance refusal of specific medical treatment to be taken into account and adhered to when the person loses the necessary capacity to make the refusal contemporaneously as defined by the Mental Capacity Act 2005. • An Advanced Decision relating to medical treatment for mental disorder may be overruled by Part IV of the Mental Health Act 1983. An Advance Request is a description of what a service user may like to happen in specific circumstances in the future if they lost the necessary capacity to make this clear at the time. Refer to the Code of Practice Mental Health Act 1983 (2008).
Aggression	This may be of a verbal nature or a physical act, whereby intentional behaviour leads to harm to the individual, to another person or to the damage of property.
Antipsychotic naïve	Never having been in receipt of antipsychotic medication
Aroused	In a state of heightened emotion or response to stimuli
Disturbed	Normal pattern of behaviour or functioning disrupted
GCS	Glasgow Coma Scale
IM	Administration of medicine by an intramuscular route – permissible by both nursing and medical staff in TEWV
IV	Administration of medicine by an intravenous route – not supported in TEWV
Neuroleptic malignant syndrome (NMS)	NMS is caused almost exclusively by the use of antipsychotic medication. Rapid and large increases in dosage, such as RT, can also trigger the development of NMS. Signs and symptoms include muscular rigidity, pyrexia and confusion; sometimes muscle tremors and a sore throat. If NMS occurs, it should be treated as a medical emergency.
Parenteral	Administration of medicine by an injectable route.
PRN	Pro re nata (PRN) is a Latin phrase meaning "for an unforeseen need or contingency" – in this context it refers

	to medicines prescribed to be taken "as required", rather than taken regularly
Rapid Tranquillisation (RT)	• RT is the parenteral (intramuscular) administration of medication to calm or sedate an agitated, violent or aggressive patient as quickly as is safely possible; **not** to treat the individual's underlying condition. • RT is a reactive management strategy using medicine to quickly calm an individual to reduce risk to self and/or others; it typically involves physical intervention.
SOAD	Second Opinion Appointed Doctor: This is a doctor appointed by the Care Quality Commission in order to review a detained or a community patient's treatment where this is required by the Mental Health Act
Violence	Any incident where staff, patients or others are abused, threatened or assaulted in circumstances related to their work, involving an explicit or implicit challenge to their safety, well-being or health.

6 Related documents

- Supporting Behaviours that Challenge Policy
- Code of Practice, Mental Health Act 1983, (2008)
- Procedure for Using the National Early Warning Score (NEWS) 2 for the Early Detection and Management of the Deteriorating Patient in Adults (aged 16 and above) (CLIN-0099)
- Consent to Examination or Treatment Policy

7 How this policy will be implemented

- This policy will be published on the Trust's intranet and external website.
- Line managers will disseminate this policy to all Trust employees working in in-patient services through a line management briefing.
- The Pharmacy Nursing Team will develop and deliver the mandatory training to nursing staff. The Medical Development Team will ensure appropriate training is accessible and completed by medical staff.
- Training requirements will be included in the Staff Development Policy.

8 How this policy will be audited

Audit of the use of RT and adherence to parameters will be completed regularly, coordinated by the Trust Clinical Audit & Effectiveness Team in liaison with Service leads and the Pharmacy audit lead.

Results will be analysed and reported through the Trustwide Clinical Audit sub-group, Clinical Effectiveness Group and Drug & Therapeutics Committee

Actions and recommendations from the audit will be agreed by the Trustwide Clinical Audit sub-group and approved by the Drug and Therapeutics Committee.

8.1 Training needs analysis

All staff potentially involved in the use of RT should comply with the following mandatory training requirements:

Staff/Professional Group	Type of Training	Duration	Frequency of Training
Medical staff (in services for adults & older people) Pharmacists	RCPsych RT e-learning module or Trust RT e-learning module for medics (when available)	1-2 hours	Every 3 years
Medical staff (in CYPS)	CAMHS RT module accessible via the RCPsych website	1-2 hours	Every 3 years
Registered Nurses (RNs) Nursing Associates (NAs) Pharmacy Technicians Non-registered Practitioners (NRPs)	Trust RT e-learning module for nurses	1 hour	Every 3 years
Registered Nurses (RNs) Non-registered Practitioners (NRPs)	Service specific training in physical observation and the use of NEWS2	30-60 mins	Once only

9 How the implementation of this policy will be monitored

Number	Auditable Standard/Key Performance Indicators	Frequency/Method/Person Responsible	Where results and any Associate Action Plan will be reported to, implemented and monitored; (this will usually be via the relevant Governance Group).
1	Number of incident reports of violence and aggression involving restraint and administration of RT	Continuous by Medication Safety Team, with monthly reporting	Trustwide Medicines Management Group, with escalation to CG QAIGs as necessary
2	Completion of post-event physical health monitoring	Trustwide audit, led by Trust Pharmacy Team	Trustwide Clinical Audit Sub-group Drug & Therapeutics Committee

10 References

- NICE NG10: Violence and aggression: short-term management in mental health, health and community settings (2015)
- NICE NG11: Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges (2015)
- NICE CG178: Psychosis and schizophrenia in adults: treatment and management (2014)
- NICE CG155: Psychosis and schizophrenia in children and young people: recognition and management (2013)
- NICE CG136: Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services (2011)
- NICE ESUOM 28: Rapid tranquillisation in mental health settings: promethazine hydrochloride (2014)
- QS154 Violent and aggressive behaviours in people with mental health problems (2017)
- RCPsych Guidelines on the Short-term Management of Disturbed/Violent Behaviour in Psychiatric In-patient Settings and Emergency Departments (2005)
- RCN Restrictive physical intervention and therapeutic holding for children and young people – guidance for nursing staff (2010)
- Department of Health (2014) Positive and Proactive Care: Reducing the need for restrictive interventions
- Mental Health Act 1983: Code of Practice (2015)
- eBNF & eBNF for Children via Medicines Complete
- Maudsley Prescribing Guidelines 14th edition (2021)

11 Document control (external)

To be recorded on the policy register by Policy Coordinator

Required information type	Information
Date of approval	21 February 2024
Next review date	21 February 2027
This document replaces	CLIN-0014-v8.3 Rapid Tranquillisation Policy
This document was approved by	Drug & Therapeutic Committee
This document was approved	25 January 2024
This document was ratified by	Management Group
This document was ratified	21 February 2024
An equality analysis was completed on this policy on	03 January 2024
Document type	Public
FOI Clause (Private documents only)	n/a

Change record

Version	Date	Amendment details	Status
7	7 Sep 2016	Reviewed and updated in response to NG10 Violence and aggression: short-term management in mental health, health and community settings (May 2015)	Superseded
7.1	15 Mar 2017	Minor amendment to footnote of Appendix 3	Superseded
7.2	25 Jan 2018	Minor changes to wording to clarify definition of RT in response to audit findings Revision of criteria for acceptable prescribing of RT on admission	Superseded
7.3	24 Jan 2019	Changes around the EWS / NEWS2 including prescriptive times around post RT monitoring and a post RT form to be used within PARIS case note to enable staff to capture all necessary info post RT Changes to max dose of haloperidol in adult algorithm	Superseded
8	28 August 2019	Full review and update. Minor rewording to improve legibility and understanding. Monitoring section updated to reflect new Trust policies (EWS/NEWS)	Superseded

8.1	21 Nov 2019	Appendix.5 Post RT Recordings Template/Required Content for Electronic Patient Record was re-formatted to allow copying into patient record	Superseded
8.2	24 Sep 2020	Changes to section 4.9 and appendix 4 to include recording advice. Formatting changes made. NB – Due to the delay between approval by D&T and ratification by SLG – this document was ratified on 07 April 2021 and published on the 13 April 2021.	Superseded
8.2	Nov 2022	Review date extended to 01 June 2023	Superseded
8.2	Feb 2023	Review date extended to 01 June 2023	Superseded
8.2	July 2023	Review date extended to 01 June 2023	Superseded
8.3	18 Aug 2023	Error corrected in appendix 3 (MHSOP algorithm) – following text removed from lower lorazepam IM information box: “Non-psychotic context or unknown illness or antipsychotic naïve” – had been incorrectly copied from CYPS algorithm	Superseded
8.3	18 Oct 2023	Received formal retrospective ratification from Management Group	Superseded
8.3	26 Oct 2023	Review date extended till 31 March 2024	Superseded
9	21 Feb 2024	Full review and update. Separate age-related treatment algorithms rationalised into single algorithm with guidance for special patient groups. Olanzapine injection incorporated to policy and algorithm following formulary approval. References to under 18s removed. Once only prescription updated to reflect EPMA.	Published

Appendices

Appendix 1 – Guidance for Prescribing RT on in-patient units

This appendix is a visually accessible layout of complex prescribing information – a more screen-readable, accessible version is available on request

- Try non-drug measures (Supporting Behaviours that Challenge Policy)
- Exclude physical causes.

Rapid Tranquillisation - only use if:

- Oral route inappropriate, refused or failed (after an adequate dose and/or opportunity to take effect) as identified within Supporting Behaviours that Challenge Policy
- Oral route not indicated by previous clinical response.

General Factors to consider when selecting which medication to use:

- Whether a recent (in last 3 months) ECG has been performed.
- The patient's preferences or advance statements and decisions.
- Pre-existing physical health problems – for frail adults, follow the guidance for "frail / elderly" patients
- The possibility of pregnancy
- Possible intoxication with alcohol or illicit substances – use lower end of dose ranges. Special caution if using benzodiazepines where a history of substance misuse/dependence exists
- Previous responses to these medications, including adverse effects and what has worked before.
- Use lower end of dose ranges in frail patients and those who have not taken the prescribed medication before.
- Potential for interactions with other medications/substances (particularly combined prolongation of QT interval)
- The total daily dose of medications prescribed and administered.
- Co-prescribe PRN procyclidine for potential dystonic reactions if haloperidol is prescribed.

Refer to the Choice & Medication handy chart on Acute Disturbance for information about the onset of action, peak effect and duration of effect of medications used

Additional advice for specific patient groups:

People with a Learning Disability and/or Autistic Spectrum Disorder	Pregnancy	Frail / elderly
• Always try oral medication first if possible. • Rapid tranquillisation should be a last resort as issues such as sensory preference difficulties, environment and physical health problems can occur. • Consideration should be given to using lower doses due to increased sensitivity to adverse effects in this population. • Antipsychotics can and promethazine may lower seizure threshold (increased comorbidity of epilepsy in this population). • Be aware of communication difficulties.	• Do not seclude a pregnant patient following RT. • Choose drug with shortest half-life to avoid accumulation e.g. promethazine or lorazepam • Use lowest effective dose. • May be problematic if RT given immediately before delivery. • Adapt restraint procedures to avoid possible harm to the foetus e.g. restrain on bean bag - seek specialist advice. • During the perinatal period, the patient's care should be managed in close collaboration with an obstetrician.	• More susceptible to anticholinergic side effects of antipsychotics & promethazine. • Avoid use of antipsychotics if patient has dementia illness. • Do NOT use antipsychotics for patients who are suspected of having Lewy body dementia or Parkinson's disease. • Promethazine may precipitate delirium, do not use in physically unwell patients; use with extreme caution in patients with dementia or delirium.

Do **ALL** of the following apply?:

- The patient has previously received an antipsychotic
- The patient does not have cardiovascular disease or signs/symptoms of QTc prolongation?
- There is sufficient information available to guide medication choice

NO

**retained risk of QT-prolongation*

	Adult	Frail / Elderly
Drug & IM Dose: If partial response, consider a further dose after min. 1 hour	**Lorazepam 1-2 mg**	**Lorazepam 500 micrograms - 1 mg**
Max. dose in 24 hours (Oral + IM):	4 mg	2 mg
If no response to lorazepam, or otherwise excluded, consider IM:	Olanzapine* + Promethazine (see doses below)	Promethazine +/- Haloperidol (only if no CVD/QTc prolongation)
Transfer to oral route "as required" as soon as possible.		
If at the point of administration of IM medication the patient agrees to accept oral medication, this is no longer RT & the dose advice on the next page should be followed		

YES

	Adult					Frail / Elderly				
Drug & IM Dose: If partial response, consider a further dose after minimum 1 hour	Haloperidol 3-5 mg	**AND**	Promethazine 25-50 mg	**OR**	Lorazepam 1-2 mg	Haloperidol 500 microgram – 1 mg	**+/-**	Promethazine 12.5-25 mg	**OR**	Lorazepam 500 micrograms – 1 mg
Maximum Dose in 24 hours (oral + IM):	15 mg (20 mg BNF)		100 mg		4 mg	2 mg (only to be exceeded with consultant authorisation)		50 mg		2 mg
If no response:	Consider lorazepam, if not already used in this episode				Consider Haloperidol + promethazine	Consider lorazepam, if not already used in this episode				Consider Haloperidol +/- promethazine
IM Alternatives e.g. for patients who are resistant to lorazepam, or history of EPSEs with haloperidol:	• **Promethazine** monotherapy – 25 – 50 mg IM, maximum dose in 24 hours = 100 mg (caution in QT-interval prolongation) • **Aripiprazole** - 5.25-15 mg (usual dose 9.75 mg), followed by 5.25-15 mg after 2 hours if required; maximum 3 doses / 30 mg in 24 hours. • **Olanzapine** (not within 1 hour of lorazepam) – 10 mg, repeated after 2 hours, max. 3 injections / 20 mg in 24 hours					• **Promethazine** monotherapy – 12.5 – 25 mg IM, maximum dose in 24 hours = 50 mg (caution in QT-interval prolongation) **Aripiprazole** - 5.25 mg, followed by 5.25 mg after 2 hours if required: maximum 3 doses in 24 hours.				
Transfer to oral route "as required" as soon as possible.										
If at the point of administration of IM medication the patient agrees to accept oral medication, this is no longer RT & the dose advice on the next page should be followed										

		Adult	Frail / Elderly
ORAL Alternative to Lorazepam IM **Please note:** Onset of action/time to peak levels for ORAL lorazepam similar to IM.	Drug & oral dose:	**Lorazepam** 1 – 2 mg	**Lorazepam** 500 micrograms – 1 mg
	Maximum dose / 24 hours (Oral + IM):	**4 mg**	**2 mg** (only to be exceeded with consultant authorisation)
	Alternative to oral lorazepam monotherapy:		
	Maximum dose / 24 hours (Oral + IM):		
If not antipsychotic-naïve, and no evidence of cardiovascular disease (and ECG done), consider adding **ONE** of these **ORAL antipsychotics with lorazepam**: Consider orodispersible or liquid preparations where available to improve adherence.	Drug & oral dose:	**Haloperidol** 3 – 5 mg	**Haloperidol** 500 micrograms
	Maximum dose / 24 hours (Oral + IM):	**20 mg**	**5 mg**
	Drug & oral dose:	**Olanzapine** 2.5 - 5 mg	
	Maximum dose / 24 hours (Oral + IM):	**20 mg**	
	Drug & oral dose:	**Risperidone** 1 - 2 mg	**Risperidone** 500 micrograms
	Maximum dose / 24 hours (Oral + IM):	**16 mg**	**4 mg** (2 mg in dementia)
If partial or no response, administer another dose after one hour			

Appendix 2 – Aide memoir for post-administration monitoring and recording advice

The following is a simple description of your responsibilities following administration of medication used for RT to ensure the patient is monitored appropriately and you fully adhere to Trust guidance. For specific details please refer to the individual protocols and algorithms for the service you work in.

The reason for recording and monitoring on NEWS2 is to ensure that any subtle deterioration will be noted and can be acted on in a timely way. Every recording of the physical observations should be added up and acted on according to the total score by following the instructions on the scorecard. These total scores and responses should be documented in the electronic record in the activity note under physical health tab at the end of the monitoring period

If the patient received intramuscular medication you must monitor and document observations directly onto the NEWS2 (i.e. take BP, pulse, temperature, respiration, oxygen saturation levels and CNS/levels of response) every 10 minutes for the first hour and then hourly for a further 3 hours. The results must also be recorded in the electronic patient record. If the patient continues to lie down, observations must continue every half hour until the patient gets up.

If a patient becomes more agitated by having these observations the registered nurse, in liaison with the doctor, may decide to reduce the frequency of observations. If this is agreed, a record of these discussions and assessments must be fully documented in the patient's electronic records to evidence why the NEWS2 has not been fully completed.

If a patient refuses to have their observations taken this must be documented comprehensively in the electronic records.

Irrespective of whether other physical observations are completed, respiratory rates need to be monitored and documented on the scorecard at the frequency discussed above – these can be monitored from a distance.

Under no circumstances should 'patient sleeping' be recorded as grounds for not monitoring the physical observations following RT; **you must monitor and document observations even if the patient is asleep.**

If RT is administered late at night the frequency of monitoring should be adhered to

You **must** document in the care records when you cease to record on NEWS2 and justify/give reasons why.

Appendix 3 - Post RT Recording Template / Required Content for Electronic Patient Record

Patients name: Rapid tranquilisations (RT) used: Serial number of medication: Site given:	Date of Incident: Time physical intervention started: Time physical intervention ended: Total time physical intervention was used:

Description of Incident, including rationale for use of RT (i.e. was a PBS in place, what de-escalation was tried, patients current medication, patients physical health condition):

If patient restrained, name & position of staff:	
Name	**Position**

Staff full name, base ward and designation:

Name of post RT physical observations lead:

Frequency post administration	**10 min**	**20 min**	**30 min**	**40 min**	**50 min**	**60 min**	**120 min**	**180 min**	**240 min**
Refused									
Pulse									
Respiration rate (even if rest refused)									
Temperature									
BP									
Oxygen Sats									
Level of Alertness (even if rest refused)									
Emergence of side effects									
NEWS Score									

If refused add "**R**" to the relevant box. Highlighted observations should be attempted at a distance even if refusing others.

Name of Reflection facilitator:

Names of staff debriefed:

Rapid Reflection Tool - *Patients*

(Asked immediately following restrictive intervention)
Are you feeling OK and safe?
What can we do to help you feel safe?

Rapid reflection Tool
(follow-up debrief within 24 hours or as soon as possible

Do you understand why staff needed to use restrictive interventions?
What could we have done to support you better?
Is there anything you would do differently next time?
Offer the opportunity to make a written account **Consider a formulation a Positive Behavioural Support Plan (PBS) with patient if one is not already in place already**

All information recorded on this sheet must be recorded within the patient's notes on the **Electronic Patient Record** and physical observations in the patients **NEWS** chart Remember to complete an **Incident Reporting Form**

Debrief following physical intervention and Rapid tranquilisation

The tool should take no longer than three minutes. All staff involved should take part in the rapid reflection (before returning to their base ward), with one member of staff acting as the reflection facilitator.
It is not a blame process; the outcomes should help lessons to be learnt so that the same incidents are not repeated.

Rapid Reflection Tool - *Staff*

- **Are we all ok and safe?**

Don't just focus on physical health; consider emotional needs of each other.

- **Is there anything we would do differently next time?**

Remember the thing you can control i.e. more knowledge of the patient, regular rotation of staff.

- **What went well?**

Remember to acknowledge the positive aspect of the support you have offered.

Remember three minutes is not long, do you need to plan a more formal debrief?

Rapid Reflection Tool - *Patients*

(Asked immediately following restrictive intervention)

- **Are you feeling ok and safe?**
  Don't just focus on physical health; consider emotional needs of each other.

- **What can we do to help you feel safe?**
  Do not dismiss the response and validate how they are feeling
  Questions to be asked within 24 hours (or as soon as possible/appropriate)

- **Do you understand why staff needed to use restrictive interventions?**
  This question potentially may lead to an emotional response. You will need to respond to the answer they give and offer reassurance. Do not move on until the patient is ready too.

- **What could we have done to support you better?**
  What could staff have done to make you feel better, stop you getting so upset?

- **Is there anything you would do differently next time?**
  This is trying to get the patient to think about what they did and to think about any coping strategies they have that they could have been used.

Consider formulating a Positive Behavioural support Plan (PBS) with the patient if one is not in place already

Offer the opportunity to make a written account

Appendix 1 - Equality Impact Assessment Screening Form

Please note: The Equality Impact Assessment Policy and Equality Impact Assessment Guidance can be found on the policy pages of the intranet

Section 1	Scope
Name of service area/directorate/department	Pharmacy
Title	Rapid Tranquilisation Policy
Type	Policy
Geographical area covered	Trustwide
Aims and objectives	**Purpose** The purpose of this policy is to: • Ensure a standard approach to care, based on the best available evidence. • Minimise risk related to the use of rapid tranquillisation (RT). • Advise on best practice in prescribing and administration of medication for RT. • Provide clarity in relation to staff role and responsibilities. • Comply with CQC and NHSLA standards, and national (NICE) recommendations. **Objectives** • To ensure good practice in managing aggressive, violent and potentially violent incidents in order to minimise the risk to staff, patients and others. • To reduce suffering for the patient, to reduce risk of harm to others, to do no harm. • To ensure all staff are aware of the advice around prescribing, administration and post-administration monitoring relating to the use of RT. • To reduce the possibility of the patient suffering adverse effects from the administration of RT medication during restraint and heightened emotional disturbances. • To define parameters for safe and effective use of medication and subsequent aftercare in line with the Procedure for Using the National Early Warning Score (NEWS) 2 for the Early Detection and Management of the Deteriorating Patient in Adults (aged 16 and above) (CLIN-0099)
Start date of Equality Analysis Screening	03 January 2024
End date of Equality Analysis Screening	25 January 2024 (approval at D&T committee)

Section 2	Impacts
Who does the Policy, Procedure, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan benefit?	Patients
Will the Policy, Procedure, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan impact negatively on any of the protected characteristic groups? Are there any Human Rights implications?	• **Race** (including Gypsy and Traveller) **NO** • **Disability** (includes physical, learning, mental health, sensory and medical disabilities) **NO** • **Sex** (Men and women) **NO** • **Gender reassignment** (Transgender and gender identity) **NO** • **Sexual Orientation** (Lesbian, Gay, Bisexual, Heterosexual, Pansexual and Asexual etc.) **NO** • **Age** (includes, young people, older people – people of all ages) **NO** • **Religion or Belief** (includes faith groups, atheism and philosophical beliefs) **NO** • **Pregnancy and Maternity** (includes pregnancy, women / people who are breastfeeding, women / people accessing perinatal services, women / people on maternity leave) **YES** • **Marriage and Civil Partnership** (includes opposite and same sex couples who are married or civil partners) **NO** • **Armed Forces** (includes serving armed forces personnel, reservists, veterans and their families) **NO** • **Human Rights Implications NO** (Human Rights - easy read)
Describe any negative impacts / Human Rights Implications	It is possible that RT may be administered to a pregnant patient without knowledge of their pregnancy. While this presents a small risk to the foetus, it is likely to be outweighed by the benefits of reducing risk of potential physical harm from the patient being in an agitated state
Describe any positive impacts / Human Rights Implications	Policy includes advice and guidance for special patient groups, i.e. younger, older/frail, pregnant and those with LD/ASD

Section 3	Research and involvement
What sources of information have you considered? (e.g. legislation, codes of practice, best practice, nice guidelines, CQC reports or feedback etc.)	Previous version of policy NICE guidelines MHA/MCA Audit findings
Have you engaged or consulted with service users, carers, staff and other stakeholders including people from the protected groups?	Yes
If you answered Yes above, describe the engagement and involvement that has taken place	Policy has been open to Trustwide consultation (all staff)
If you answered No above, describe future plans that you may have to engage and involve people from different groups	

Section 4	Training needs
As part of this equality impact assessment have any training needs/service needs been identified?	No new training needs
Describe any training needs for Trust staff	As detailed in section 8.1
Describe any training needs for patients	None
Describe any training needs for contractors or other outside agencies	None

Check the information you have provided and ensure additional evidence can be provided if asked.

Appendix 7 – Approval checklist

To be completed by lead and attached to any document which guides practice when submitted to the appropriate committee/group for consideration and approval.

Title of document being reviewed:	Yes / No / Not applicable	Comments
1. Title		
Is the title clear and unambiguous?	Yes	
Is it clear whether the document is a guideline, policy, protocol or standard?	Yes	
2. Rationale		
Are reasons for development of the document stated?	Yes	
3. Development Process		
Are people involved in the development identified?	Yes	
Has relevant expertise has been sought/used?	Yes	
Is there evidence of consultation with stakeholders and users?	Yes	Subject to Trustwide consultation
Have any related documents or documents that are impacted by this change been identified and updated?	Yes	
4. Content		
Is the objective of the document clear?	Yes	
Is the target population clear and unambiguous?	Yes	
Are the intended outcomes described?	Yes	
Are the statements clear and unambiguous?	Yes	
5. Evidence Base		
Is the type of evidence to support the document identified explicitly?	Yes	
Are key references cited?	Yes	
Are supporting documents referenced?	Yes	
6. Training		
Have training needs been considered?	Yes	
Are training needs included in the document?	Yes	
7. Implementation and monitoring		

Does the document identify how it will be implemented and monitored?	Yes	
8. Equality analysis		
Has an equality analysis been completed for the document?	Yes	Commenced 3/1/24
Have Equality and Diversity reviewed and approved the equality analysis?	Yes	Abigail Holder 4/1/24
9. Approval		
Does the document identify which committee/group will approve it?	Yes	D&T committee, then Executive Management Group
10. Publication		
Has the policy been reviewed for harm?	Yes	No harm
Does the document identify whether it is private or public?	Yes	Public
If private, does the document identify which clause of the Freedom of Information Act 2000 applies?	n/a	
11. Accessibility (See intranet accessibility page for more information)		
Have you run the Microsoft Word Accessibility Checker? (Under the review tab, 'check accessibility'. You must remove all errors)	Yes	
Do all pictures and tables have meaningful alternative text?	N/A	No pictures in body of policy
Do all hyperlinks have a meaningful description? (do not use something generic like 'click here')	Yes	