

NHS Kent & Medway

De-escalation and Rapid Tranquillisation Guideline for Adults (including over 65 years) in Acute Hospital Settings

Version:	1.5
Ratified by:	Kent & Medway Clinical Cabinet
Date ratified:	August 2025
Name of originator/author:	Adam Kasperek
Director responsible for implementation:	Medical Director of Respective Trust
Date issued:	May 2022
Review date:	August 2027
Target audience:	Healthcare staff in Secondary Care (non-psychiatric care settings)

Version Control Schedule

Version	Date	Author	Status	Comment
1	February, 2022	Adam Kasperek	Psychiatry Liaison Consultant	Result consultation based on Maidstone & Tunbridge Wells guideline in Kent & Medway June to December 2021
1.1.	February 2022	Michaela Heath	Administrator	Various formatting changes to K&M format
1.2	March 2022	MH/AK/JR/MLJ	Changes during Committee approval process	Feedback JPC, specifics of alcohol withdrawal out of license use best removed. Submitted to Clinical Cabinet
1.3	April 2022	Michaela Heath	Administrator	Inclusion of all persons who had engagement with the development, consultation and ratification tabled on pages 2, 3 and 4.
1.3a	May 2022	MLJ	Final	Comments to clarify wording identified during approval process.
1.4	June 2024	Von-de-viel Nettey, Jagdip	Draft	4.5 – additional information and guidance around post-administration

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		Bahia, Adam Kasperek		monitoring.
1.5	May 2025	Dr Rucha Phutane, Lauren Julie-Rusz, Dr Adam Kasperek	Final	Revised section is in 4.5 rather than 4.3 and added in the behaviour scales. Appendix 4 and 5 added.

Development, Consultation and Ratification Schedule

Provider Organisation	Speciality	Comments received
EKHUFT	Dr Mandy Small, Specialty Doctor in Emergency Department.	Asked to make additions with consideration for older population (ie. Aripiprazole).
	Eno-Abasi Ente, Advanced Clinical Pharmacist.	
	Syed Gilani, Consultant Emergency Medicine.	
	Dr Jinny McDonald, Team Specialist Pyschiatric Doctor.	
	Dr Sura Albayati, Consultant Geriatrician 06/09/2021.	Approval comments incorporated in the draft version.
	Dr Georgina Scarlet, A&E Consultant 21/10/2021.	
	Dr Wayne Kissoon, A&E Consultant (verbal Sept 2021).	
	Dr Andrew Mortimer, Clinical Director Emergency and Urgent Care 22/10/2021.	
	Dr Christopher Parokkaran, Consultant Acute Physician 14/09/2021.	
	Dr Sunil Lobo, Lead Acute Physician Sept 2021.	
	Dr Michail Kaklamanos, Site Lead Consultant Frailty 21/10/2021.	
	Dr Paula McAvinia, Site Lead Consultant Frailty 08/09/2021.	
	Dr Mustafizur Khan, ST3 Medicine 14/09/2021.	
	Dr Terry Collingwood, Anaesthetist Trainee 14/09/2021.	
	Dr Michael Jackson, Consultant Pharmacist 22/10/2021.	
	QEQM ED /Pharmacy including Dr. M L Jenkinson Consultant Physician Lead Clinician, Drugs & Therapeutics since 2021	Asked to reference advice with regards to IV medication as apparently used more frequently in this locality.
ITU – (2019)	Second draft reviewed and commented on.	
Samantha Gradwell, Deputy Director of Quality Governance 4/5/2022	Comments on wording wrt pregnancy and children for clarification	
DVH	KMPT Liaison – Dr Fareedoon Ahmed (2020) and Pharmacy -Von-De-viel 13/10/2021 Vilma Gilis (2019) Jagdip Bahia, Chief Pharmacist KMPT (14/10/2021)	Plan to pass KMPT-wide once agreed in MTW/ EKHUFT. Noted delays and current web link to KMPT policy. Correction on dosing/timings match KMPT chemical restraint policy.

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Provider Organisation	Speciality	Comments received
DVH	Dr Carlo Berti, Consultant Psychiatrist K&M PT 08/10/2021.	Detailed comments.
	Jagdip Bahia, Chief Pharmacist KMPT 18/10/2021.	
	Julia Scott Simon Wan 12/10/2021.	Detailed comments.
MTW	Dr Paul Blaker, Gastro/Specialty Clinical Director 2019	Formatting comments. Stated happy to review again once in final draft.
	Dr Nisha Krishnan, Gynaecology Consultant	Promethazine for pregnant ladies. No other concerns.
	ITU/A&E – Dr Emma Townsend and Dr Jinny McDonald (2018)	Felt document was too broad, should only advise lorazepam and have exclusion conditions (e.g. alcohol, dementia, delirium, pregnancy) instead of modifying factors advice.
	AMU Consultants and trainees (2019-2022) including Bhavika Patel (14/4/21	No Feedback.
	Jane Caisley Formulary Support Pharmacist (Sept-Nov 2021) Amanda Le Page ITU formulary 21/01/2021	Formatting requests
	Mildred Johnson, Clinical Director of Pharmacy & Medicines Optimisation 11/10/2021.	Confirmed received by DTMMC meeting.
	Junior Doctor help with second draft by Dr Stefan Sleiman (19/10/2019)	Made document reader friendly, formatted tables.
MFT	Dr Katina, Liaison Damaskinidou along with discussion with Dr. M L Jenkinson who has links in the area.	Pharmacy plan to pass once agreed in MTW/EKHUFT.
	Reshma Chhana, Lead Pharmacist for Frailty and Elderly Medicine 25/10/2021.	Noted additional risks and wondered if more special case flowcharts would be helpful and forwarded a four different pathway solution.
	Steve Cook, Director of Pharmacy 10/11/2021.	Positive comments received.
	Dr Godwin K Simon, Consultant Physician Acute Medicine Diabetes and Endocrinology.	Clinicians keen to have approved.
	Dr Brendan Conway, A&E Lead Consultant 10/11/2021.	Confirmed it would be noted at Sedation Steering group on 26th November 2021 chaired by Dr Verma.
	Mr Caris Grimes, Consultant Colorectal Surgeon and Associate Medical Director for Patient Safety 10/11/2021.	
	Dr Sonia Verma, Consultant Anaesthetist and Lead Sedation Steering Group 10/11/2021.	

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CCG/Primary care colleagues		Comments received
EK		
WK	CCG/Pharmacy meeting in March	Had positive perspective to the effort but wished to assure wide review of the protocol.
M&S		
DGS		

Development, Consultation and Ratification Schedule

Name and Title of Individual	Date Consulted
Created by Adam Kasperek, Psychiatry Liaison Consultant	15 th November, 2020
Consultation process all four K&M Acute Trusts and Partnership Trusts	October to November 2021
Michael Jenkinson, Lead Clinician Drugs & Therapeutics during consultation process	2 nd February, 2022
Jag Bahia, Chief Pharmacist Kent & Medway Partnership Trust Chief Pharmacist	2 nd February 2022

Name of Committee	Date Reviewed
Joint Formulary Group (JFG)	22 nd February 2022
Joint Prescribing Committee (JPC)	9 th March 2022
Kent and Medway Medicines Optimisation Committee (KMMOC)	N/A
Clinical Cabinet (CC)	7 th April 2022 & 5 th May 2022

Identified Risks and Risk Management Action	Date
None	

Resource Implications and Finance Approval	Date
None	

Public and Patient Engagement Considerations	Date
None needed	

Links to other policies and/or procedures	Date

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1. Introduction, Background and Purpose

This is a guideline to support staff de-escalating and managing patients who are acutely disturbed with pharmacological rapid Tranquillisation. It is reviewed every two years to assure it complements information found in NICE guidelines, BNF and EMC SPC (<http://www.medicines.org.uk/emc> if you require further information). You may deviate from this guideline when you have appropriately documented clinical indications, as exemplified with modifiers. If you require support, consult with the senior Anaesthetic, Psychiatric or Pharmacy Specialists.

2. Definitions

- 2.1. **Rapid Tranquillisation** - Use of medication by the parenteral route (usually intramuscular or, exceptionally, intravenous) if oral medication is not possible or appropriate and urgent sedation with medication is needed (NICE NG10)¹. The goal of Rapid Tranquillisation is to achieve a state of calmness without sedation, sleep or unconsciousness, thereby reducing the risk to self and/or others while maintaining the ability of the patient to respond to communication. It is often used in the circumstances of chemical or pharmacological restraint.
- 2.2. **Chemical or Pharmacological Restraint**- the administration of sedative medication by injection that is not standard treatment, in response to behaviour that causes harm to the person or others².
- 2.3. **Best Interests** -If a person has been assessed as lacking capacity then any action taken, or any decision made for, or on behalf of that person, must be made in his or her best interests³.
- 2.4. **Capacity**- Having mental capacity means that a person is able to make his or her own decisions about a particular matter at the time the decision needs to be made³.
- 2.5. **De-escalation**- The use of techniques (including verbal and non-verbal communication skills) aimed at preventing potential or actual behaviours of anger and aggression. PRN medication can be used as part of a de-escalation strategy, but PRN medication used alone is NOT de-escalation. De-escalation techniques can include verbal strategies, such as maintaining a calm tone of voice and not shouting or verbally threatening the person; and non-verbal techniques, including an awareness of self, body stance, eye contact and personal safety. (Spencer & Johnson, 2016)⁴. Effective de-escalation approaches are personalised and include openness, honesty, support, self-awareness, coherent communication, non-judgemental approaches and confidence. They have the aim of preventing escalation and supporting the person to be calm.
- 2.6. **Deprivation of Liberty Safeguards (DoLS)**- is a framework to protect those who may lack the capacity to consent to the arrangements made for their treatment

or care where levels of restriction or restraint used in delivering of that care are so extensive as to be depriving the person of their liberty. Deprivation of liberty occurs

when the person is 'under continuous supervision and control and is not free to leave'. DoLS must be applied for if the person is trying to leave, lacks capacity and requires restraint. A large number of these people will be those with significant learning disabilities, or older people who have dementia, delirium or similar disability.⁵

- 2.7. **Duty of Care**- The Governments best practice guidance, Independent Choice and Risk (2007)⁶ states 'Duty of Care' as, 'an obligation placed on an individual requiring that they exercise a reasonable standard of care whilst doing something (or possibly omitting to do something) that could cause harm to others. Exercising 'duty of care' to a person cannot be used to justify restrictive practice except where a person has capacity and gives consent to the practice or where the practice is sanctioned under the Mental Health Act or Mental Capacity Act.
- 2.8. **Enhanced Observations** previously known as (1-2-1 or specialling) is an integral part of a management plan and ensures the safe and sensitive monitoring of the patients physical and psychological well-being including their (conduct and mental health) whilst fostering therapeutic relationships. Through effective monitoring, staff are able to identify changes in a patient's condition and well-being and facilitate a rapid and appropriate response should that conditions deteriorate.
- 2.9. **Restrictive Practices** - a range of activities that involve 'making someone do something they do not want to do or by stopping someone do something they do want to do'. Restrictive practice can be obvious and easily recognised or sometimes may be more subtle; they may be planned or used as a response to an unforeseen emergency. Examples of restrictive practice include the use of observation levels (SMaRT tool and Enhanced Observation Policy), restraining an aggressive patient, locking toxic cleaning chemicals out of harm's way or rapid Tranquillisation. Restrictive physical intervention is increasingly replacing the term "physical restraint". It is described as "any method which involves some degree of direct force to try and limit or restrict movement" (Restraint Reduction Network 2019)⁷. This intervention must though be necessary, proportionate, and justifiable and only used to prevent serious harm.
- 2.10. **Minimal sedation** (anxiolysis) – a state during which patients respond normally to verbal command or can be woken up to full consciousness by minimal stimuli. Although cognitive function and coordination may be impaired, ventilation and cardiovascular functions are unaffected.
- 2.11. **Moderate sedation** –depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. (Reflex withdrawal from a painful stimulus is not considered a purposeful response.) No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.
- 2.12. **Deep sedation/analgesia** – depression of consciousness during which

patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function is impaired. Patients require assistance in maintaining a patent airway and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.

- 2.13. **Conscious sedation** - “a technique in which the use of a drug or drugs produces a state of depression of the central nervous system enabling treatment to be carried out, but during which verbal contact with the patient is maintained throughout the period of sedation. The drug and techniques used to provide conscious sedation should carry a margin of safety, wide enough to render loss of consciousness unlikely” (Skelly, A.M. 1996)⁸. This consideration should also include situations where such sedation is a predictable property of a given drug even though it may be administered for another purpose.
- 2.14. **Hyper-adrenergic autonomic dysfunction** is a state of excessive stimulation of the adrenergic nervous system only usually presenting in clinical practice after use of certain recreational substances.⁹

3. Scope

- 3.1. The purpose of this guideline is to describe good practice related to de-escalation and rapid tranquillisation for adults for both planned and emergency interventions, in acute secondary care settings. It is likely to also provide a useful framework in other community settings such as community hospitals by ensuring that where used, a baseline reference exists that complies with relevant legislation and guidance.

The guidance applies to adults (people aged 18 and over). It does not apply to children and young persons (up to their 18th birthday).

4. Guidance

4.1. Fundamental Principles during De-escalation

There are many causes for agitation on a ward. A multidisciplinary approach is necessary in order to establish effective interventions. At times of aggression, there may be a need for continuous monitoring and review of the patient’s mental/physical health, risks to self or others, treatment effectiveness or harm, and engagement level. Interventions may come from behavioural observations, general/physical observations, behavioural charts, Clinical Institute Withdrawal Assessment for Alcohol (CIA, NICE NG 100¹⁰) scoring or clinical assessments.

When determining which interventions to employ, clinical need, safety, and where possible, advance directives must be taken into account. Rapid tranquillisation should not be used as a primary treatment technique as it is a high-risk practice which needs to be well managed to avoid unnecessary harm.

The intervention selected must be necessary and proportionate, in the patients' best interest and be the least restrictive response to the clinical risks posed by the patient in line with the Mental Capacity Act. If the patient is not consenting to the intervention, a mental capacity assessment **must** be carried out and documented in the patient notes alongside the reasoning behind the actions taken.

Staff must consider modifiers when deciding a treatment plan. Generic advice has been provided; however, staff should request specialty advice when they are working outside of their competence. Patients with clinical modifiers - such as pregnancy, drugs and alcohol, frailty/physical compromise, psychotropic naivety, co-prescribed psychotropic medications, learning disabilities and extremes of age - are discussed further in section 7 and may require specialist input.

4.2. Pre-Rapid Tranquillisation De-escalation

Before administering medication, please consider patient support techniques and passive interventions including but not limited to: self-control, environment management, watchful waiting, empathy, reassurance, shame avoidance, appropriate humour, distraction, negotiation, reframing events, non-conformational limit setting, patient need identification, and respecting patient space so as not to provoke them (see Appendix 3 **De-escalation strategies**).

4.3. Pre-Rapid Tranquillisation (Oral Administration)

In all cases, oral medication should be considered before intramuscular (IM) injections. Please consult with (section 4.5) 'Post sedation monitoring' between doses and consider (section 4.6) 'Modifiers' and (Appendix 2) 'Pharmacological methods' if you need examples of when to deviate from standard treatment. When initiating any medication, please ensure that senior- clinicians are involved.

The below should be done with a behaviour chart to monitor effects.

It is worth noting that some populations may require a different plan. Learning disability patients, for example have a higher risk of paradoxical agitation, older people are at risk of falls or overdosing, and patients chronically taking alcohol or GBL/GHL (gamma butyrolactone) may have a significant tolerance to benzodiazepines. Acute alcohol intoxication may increase sensitivity to benzodiazepines. In cases where you vary from advice you should clearly identify your rationale for doing so. Benzodiazepines should be first line unless there are modifiers or clinical reasons to do otherwise. They should not be mixed with other benzodiazepines or prescribed more frequently than hourly unless the prescribing clinician has the competence to do so (see 4.5).

A patient should only be administered one type of benzodiazepine in a 24-hour period, with the choice of agent based on availability, route and duration of action required. Possible agents include:

First line (oral):

Lorazepam 1-2 mg (0.5 - 1mg in elderly) orally three times a day initially, up to a maximum of 4mg (Maximum of 2mg in those over 75 years or frail and over 65 years or debilitated) in daily divided doses with clinical monitoring (section 5). If alcohol withdrawal suspected after assessment complete manage according to alcohol withdrawal specific protocols which may allow out of license use.

Alternative when above preparations are unavailable with pharmacy temporary shortage protocol/senior clinician or pharmacist agreement

Clonazepam 0.5-2 mg orally QDS up to a maximum of 8mg (4mg in elderly) or Diazepam 5mg orally initially (2mg in elderly), up to a maximum of 30mg (15mg in elderly) in daily divided doses with clinical monitoring/consultant input); or such other medications to be given orally within BNF recommended maximum doses as used in sedation but not usually in pre-rapid Tranquillisation. When prescribing long acting oral benzodiazepines such as diazepam and clonazepam you need to take into consideration the accumulative effects with repeated dosing particularly in patients with hepatic impairment.

Second line:

Promethazine orally should be used second line at a dose of 25-50mg (25mg in elderly) up to twice a day to a maximum of 100mg (50mg in elderly) it is the **first line of choice in pregnancy**, and the behavioural response should be monitored and documented

With or without: Haloperidol orally 5mg (2.5mg in elderly with a maximum dose 20mg /24 hour and maximum 10mg/24 hours in elderly. It should be used with caution due to its cardiovascular risk and should only be administered with Consultant involvement. An ECG should be performed before administration to monitor for increased QTc interval. If there is evidence of cardiovascular disease, including prolonged QT interval, avoid intramuscular haloperidol. If the ECG is normal, haloperidol can be used in conjunction with promethazine. Behavioural chart or the Riker Sedation-Agitation Scale (see appendix 1) should be used. All medications to be given within BNF recommended maximum doses.

if requiring more than one day of oral medication, discuss the case with senior/consultant on-call. If no ECG is available you can discuss alternatives including Aripiprazole with liaison / on-call consultant.

4.4. Rapid Tranquillisation (Intramuscular Administration) See Appendix 4 (For over 65s) and Appendix 5 (For 18-65 years) for flow charts.

Management of reversible organic causes including delirium and substance withdrawal (alcohol or opiate) with specialist advice, where appropriate, should be attempted before rapid tranquillisation. Also, when initiating any medication, ensure that senior doctors are involved.

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It is imperative that a Mental Capacity Assessment be carried out and documented prior to administering rapid tranquillisation and that staff are able to monitor post injection

Practitioners administering rapid tranquillisation must be aware of the associated risks. There must be a clinician able to manage these complications and must be immediately available if required.

Risks Include:

- Loss of consciousness
- Loss of airway or ability to protect airway
- Respiratory insufficiency or arrest
- Cardiovascular collapse
- Arrhythmias in those with underlying prolonged QTc interval
- Interaction with other drugs already taken, whether prescribed or illicit
- Worsening of underlying physical conditions such as COPD
- Damage to patient-staff relationship

Prescribers and those administering medicines with the aim of rapid tranquillisation should be familiar with, and competent in the practice of rapid tranquillisation, including:

- The properties of benzodiazepines, their antagonist flumazenil, antipsychotics and antihistamines
- The risks associated with rapid tranquillization, including cardiovascular/respiratory effects, particularly when the patient is highly agitated/aroused and may have been using drugs and/or is dehydrated or physically ill
- The need to titrate doses and to allow a sufficient time between doses in order to allow the drug to take effect.

There are specific risks associated with different groups of drugs. These may be compounded when multiple agents within any particular group are administered and this should be avoided.

Rapid tranquillisation and physical intervention should only be considered once de-escalation and other strategies have failed, and when there is an imminent risk of harm to the patient or others, including other patients, staff and members of the public.

The aim of rapid tranquillisation is to achieve a state of calm sufficient to minimise the above risks. As prescribing is exceptional it should be documented as single/stat doses. **Prescribing the initial dose of rapid tranquillisation as a single dose will also ensure that any subsequent treatment options can be individualised, taking account of both response and any emergent adverse effects of the initial treatment choice**

First line-

Lorazepam 1-2mg (0.5 – 1mg in elderly) up to QDS IM (Up to maximum total dose in 24-hour period of 4mg (2mg in those over 75 years or frail and over 65 years or debilitated) by any route

Second line-

Promethazine 25mg-50mg (25mg in elderly) QDS IM (Up to a maximum total dose in 24-hour period of 100mg (50mg in elderly))

With or without-

Haloperidol 2-5mg (0.5-1 mg in elderly) IM. Increasing to maximum 5mg IM (2.5mg in elderly) BD (to a maximum by any route in a 24-hour period of 12mg a day in adults (6mg in elderly). Ideally give with Promethazine, due to evidence that it reduces dystonic reactions unless indication not to do so in which case consider Lorazepam in doses as above addition if indicated.

If there is evidence of cardiovascular disease, if there is no recent ECG, or if the patient has not had antipsychotic medication in the past then AVOID Haloperidol.

Use separate syringes but can be given on same side

If a patient is not responding to the above interventions after 60 minutes, review medication or if requiring more than one day of IM medication, discuss the case with either ITU or the Liaison Psychiatry consultant on-call.

If IM is insufficient and IV is considered, a doctor experienced in airway management must be available and staff inexperienced in this must consult the anaesthetist on-call regarding further treatment.

4.5. Post Sedation Monitoring

Patients receiving Rapid Tranquillisation should be directly monitored on a 1:1 basis by appropriate nursing staff or RMN (Registered Mental Health Nurse).

After the administration of oral medication, monitor side effects and temperature, pulse, BP, respiratory rate, level of hydration and level of consciousness 1 hour after administration and repeat until there are no concerns about their physical health status (see Appendix 1 for monitoring chart).

After the administration of intramuscular medication, pulse, CO₂ (if available), blood pressure, respiratory rate, temperature, level of hydration, level of consciousness and oxygen saturations should be measured every 15 minutes for the first hour and then at minimum hourly until the patient is ambulatory (see Appendix 1 for monitoring chart).

Continue to monitor vital signs after 1 hour if the patient is scoring 1 or above on the NEWS2 chart OR you have concerns about their clinical presentation. Therapeutic observations should be reviewed and increased to support the ongoing monitoring for signs of a

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deteriorating patient.

If a patient has a compromised airway, contact a resident anaesthetist as intubation requires their support. When a patient is unconscious, staff should be continually monitoring for positional asphyxiation and withholding medication if a patient is over sedated.

With antipsychotics, monitor for signs of extrapyramidal side effects particularly laryngeal dystonia.

If the patient refuses to have their physiological observations taken, staff should document refusal in the patient's notes and continue to observe for signs and symptoms of deterioration and respiration rate and level of consciousness should be recorded on the early warning score chart as a minimum.

If nursing staff assess that the patient is asleep rather than unconscious and wish to defer neurological observations, they must first seek approval from the ward doctor or the senior emergency department doctor. Observations may only be deferred following this approval.

4.6. Special cases/modifiers

4.61 Elderly

Patients aged over 65 or those who are particularly physically frail are more sensitive to the effects and side effects of medication. Rapid tranquillisation in this group carries a higher risk than in the general population.

Things to consider in the above population:

- Usage of half the normal adult dose
- Comorbidities which may also further increase the likelihood of adverse effects/effects of the medication (e.g. kidney disease)
- 1:1 nursing is essential and special consideration should be given to the added risks of falls and worsening of confusion

Certain patients with dementia may be at a greater risk of stroke if given certain antipsychotics, e.g. risperidone, olanzapine and others, so these medications should be avoided where possible.

Antipsychotics should **not** be given to patients with Parkinson's disease / Lewy Body Dementia without clear rationale as symptoms of the disease may be worsened.

Pregnancy

The potential harm to the mother and foetus must be balanced against the risks posed by the mother's agitated state.

There is very little data on the safety of rapid tranquillisation in pregnancy. Promethazine should be the first line drug used in this Trust.

Before administering rapid tranquillisation in a pregnant woman, up to date information on the risks of teratogenesis must be consulted, particularly in the first trimester when the risk is greatest. Senior obstetric/pharmacist/psychiatrist advice should be sought wherever possible because physiological changes mean that medication requirements may be different in pregnancy. In order to limit potential effects on the neonate an agent that poses a shorter half-life should be favoured.

Breast feeding

Promethazine is considered compatible with breastfeeding. If possible, time breast-feeding in order to avoid peak drug levels, and bear in mind the risk of sedation/extrapyramidal symptoms in the infant.

Children and young persons (under 18)

This patient cohort is not covered by these guidelines. Sedation of under-16 year olds is specifically NOT covered in the scope of this guideline. Please speak with a paediatric specialist in these cases. Sedation in those over 16 years is likely to have similar dosing to these guidelines

Recreational drug toxicity

Both acute recreational drug toxicity and withdrawal may be associated with significant agitation that puts the patient and others at risk of harm and requires appropriate sedation. Alcohol misuse requires adherence to specific protocols that are complimentary to this guidance.

In addition to managing the agitation it is important that a thorough clinical assessment is undertaken to determine whether there are other features of acute drug toxicity that require treatment.

For specific advice about the above special cases/modifiers, contact Toxbase/NPIS.

Acute Behavioural Disturbance (ABD) in the Emergency Department

The principles outlined above apply. Where there are signs of hyper-adrenergic autonomic dysfunction, sedation may have to be by the intravenous route to achieve the aims of early and aggressive management of hyperthermia and acidosis, allow diagnosis and monitoring such as for rhabdomyolysis and disseminated intravascular coagulation (DIC) and to minimise the risk of cardiovascular collapse and sudden death.

Intravenous (IV) administration is generally not used on wards outside of ITU or A&E due to its need for continuous monitoring and specialist skills managing airways including

intubation. Where intravenous use occurs, the lowest effective dose should be considered (e.g. 0.5mg lorazepam) and senior doctor with airway skills/anaesthetist on-call to be aware. Practice should be consistent with those used in conscious sedation.

If the exceptional IV route has to be used it must be documented with justification in the medical records. The intravenous use of lorazepam to treat delirium or for procedural sedation should start at 0.5mg. However, the license dose for acute anxiety in adults is 0.025-0.03 mg/kg (1.75-2.1 mg for an average of 70kg man) repeated up to 6 hourly. A total 24 hours dose by all routes of more than 4mg in young adults and 2mg in those over 75 years or frail and over 65 years or debilitated should not be exceeded. If alcohol withdrawal suspected after assessment complete manage according to alcohol withdrawal specific protocols which may allow out of license use.

The intravenous use of diazepam or midazolam in rapid Tranquillisation is not recommended due to risk associated with these products in this indication. Intravenous use of haloperidol is not recommended due to risks associated with this indication. In other indications the initial starting dose for intravenous haloperidol administration is 0.5mg stat under continuous ECG monitoring.

5. Consultation and Approval

- 5.1. This guideline has been subject to consultation (see page 1) and approved by the Joint Prescribing Committee.
- 5.2. This guideline will be ratified by the Clinical Cabinet

6. Review and Revision Arrangements

- 6.1. This guideline should be subject to review at least every 2 years.

7. Training

- 7.1. The focus of training for all staff should be on alternatives to restraint, restrictive interventions or holding (RRN 2019). Staff should be trained on the use of proactive and preventative strategies such as positive behaviour support, information provision, preparation, distraction, de-escalation and the appropriate use of medications.
- 7.2. Training should emphasise that clinical holding, restrictive physical interventions and restraint should only be used as a last resort after careful consideration of a person's rights and with a clear rationale that the use of any intervention is appropriate and represents the least restrictive option.
- 7.3. Training provided should be documented as per organizational training needs analysis and evident in the individual staff members personal records.

8. Document Control including Archiving Arrangements

- 8.1. This guideline will be uploaded to the CCGs policy management systems.

9. Monitoring

- 9.1 This guideline will be monitored consistent with NHS organizational policies that

cover the use of sedation and restraint.

- 9.2 When adopted by an organization it is expected arrangements would be in place for it to be audited consistent with such policies and the organizations assurance mechanisms for updates of clinical guidelines and risk monitoring.

10. Equality and Diversity Assessment

See separate document with CCG/individual Trust formatted analysis to be inserted.

11. References and Associated Documents

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1. Violence and aggression: short-term management in mental health, health and community settings. NICE NG10 2015 <https://www.nice.org.uk/guidance/ng10>
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4. Spencer S, Johnson P. De-escalation techniques for managing aggression (protocol) [Cochrane Database of Systematic Reviews](#) 2016
5. Liberty Protection Safeguards(2021) ([link](#)) : The Stationary Office, London
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7. Restraint Reduction Network (2019) Training standards; Ethical training standards to protect human rights and minimise restrictive practices. BILD publications, Birmingham
8. Skelly, A.M. Analgesia and sedation; in Watkinson, A. & Adam, A. (Eds) *Interventional Radiology*. Oxford: Radcliffe Medical Press, 1996: pp3-11
9. [The Royal College of Emergency Medicine Best Practice Guideline Guidelines for the Management of Excited Delirium / Acute Behavioural Disturbance \(ABD\)](#) May 2016

10. NICE CG100 Alcohol-use disorders: diagnosis and management of physical complications 2017
11. Brief guide: restraint (physical and mechanical). Care Quality Commission (2018). https://www.cqc.org.uk/sites/default/files/20180322_900803_briefguide-restraint_physical_mechanical_v1.pdf
12. Care Quality Commission, fundamental standards 2014.
13. Mental Health Act 1983 (revised 2007). London_ <https://www.gov.uk/government/publications/mental-health-act-1983-reference-guide>

12. Appendices

Appendix 1: Physical Health/Behavioural Monitoring Flow Chart

Time & Date of Administration:								
Time post injection	+15mins	+30mins	+45mins	+60mins	+1.5 hours	+2 hours	+2.5 hours	+3 hours
Respiration Rate								
CO ₂ (if available)								
Awake								
Verbal								
Pain								
Unconscious								
Pulse/ Blood Pressure								
Temperature								
SATS								
Hydration								
Agitation 1 – 7 (refer to Riker Sedation-Agitation Scale)								

Title: De-escalation and Rapid Tranquillisation Guideline for Adults (including over 65s)

Approved by: IMOC

Ratified Date: August 2025

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Version: KMPT/MTWT/EKHUFT version 1.5

<p>Behaviour (ABC)</p> <p>Antecedent: What specific activity or event occurred before the challenging behaviour</p>								
<p>Behaviour: What specifically did the person do or say?</p>								
<p>Consequence: What happened after or as a result of the challenging behaviour?</p>								

Riker Sedation-Agitation Scale

Score	Description	Explanation
7	Dangerous agitation	Tries to remove monitors and devices or climb out of bed; tosses and turns; lashes out at staff
6	Very agitated	Remains restless despite frequent verbal reassurance; bites endotracheal tube; requires restraint
5	Agitated	Anxious or restless; attempts to move; calms down with reassurance
4	Calm and cooperative	Calm; easy to arouse; able to follow instructions
3	Sedated	Difficult to awaken; responds to verbal prompts or gentle shaking but drifts off again
2	Very sedated	Incommunicative; responds to physical stimuli but not verbal instructions; may move spontaneously
1	Unarousable	Incommunicative; little or no response to painful stimuli

Appendix 2: Pharmacological Background

The aim of rapid tranquillisation is to manage high risks of imminent violence in order to achieve a state of calm sufficient to minimise the risk posed to the patient and to others including other patients, staff and members of the public.

The patient should be able to respond to communication throughout the period in which they are under the influence of the drugs used.

Medication

Risks may be compounded if used in combination or with significant renal or hepatic impairment

Benzodiazepines

- Loss of consciousness
- Loss of airway/airway reflexes
- Respiratory depression/arrest
- Cardiovascular collapse
 - Particularly in combination with clozapine or olanzapine

Antipsychotics

- Excessive sedation
- Cardiovascular and respiratory collapse
- Arrhythmias
- Dystonia/dyskinesia
- Neuroleptic malignant syndrome
- Seizures
- Akathisia

Antihistamines

- Excessive sedation
- Antimuscarinic effects

Extra care should be taken when administering rapid tranquillisation under the following circumstances:

- Prolonged QTc interval
- Disorders affecting metabolism such as: hypo or hyperthermia, stress/extreme emotions or physical exertion as may be seen in acute psychosis or stimulant drug ingestion
- Extremes of age
- Physical frailty

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General Points

- Rapid Tranquilization should be given as a STAT, not a regular, reviewed by clinician before administration
- Oral medication should be offered before parenteral
- Different routes should be prescribed separately, not as “O/IM”
- Sufficient time should be allowed between doses of rapid tranquillisation to allow for observation of clinical response
- The use of two drugs from the same class should be avoided
- Medications should NEVER be mixed in the same syringe
- If moderate or deep sedation occurs as a result of rapid tranquillisation the management should be consistent with conscious sedation policy

REMEDIAL MEASURES

A decreased respiratory rate due to a benzodiazepine may be reversed in an emergency by flumazenil. **If administration of this drug is considered, or needed senior medical review is a must.**

In many cases it may be safer to support respiration with stimulation / basic valve mask ventilation than to administer flumazenil. The half-life of flumazenil may be less than that of the benzodiazepine causing the respiratory depression, creating a risk of rebound respiratory depression. There may be also rebound recurrence of agitation/disturbed behaviour. **Flumazenil must not be given in patients taking benzodiazepines regularly, or in cases of suspected mixed overdose**, as seizures can occur which can then be extremely difficult to treat.

If a rise in temperature follows antipsychotic medication and Neuroleptic Malignant Syndrome is suspected the antipsychotic should be stopped and senior medical review sought.

Hyperthermia in the context of recreational drug use may indicate Serotonin Syndrome. In this situation consult Toxbase/NPIS and consider active cooling measures, benzodiazepines and cyproheptadine.

Acute dystonic/oculogyric crises should be treated with 5-10mg of IM/IV procyclidine.

Appendix 3: De-escalation strategies

Prevention of violent or aggressive outbursts is better than intervention and therefore staff are encouraged to develop their awareness of the potential causes of aggressive or violent incidents in their own working environment and take steps to prevent these circumstances arising. Members of staff should avoid placing themselves in situations of unnecessary risk during the management of incidents.

Staff should utilise appropriate defusing techniques at all times. These are:

- Speaking clearly and calmly
- Avoid reacting to abusive remarks
- Listening carefully to what is being said
- Explaining the consequences of continued aggressive or violent behaviour
- Using open gestures
- Avoiding confrontational situations where possible

Staff should be able to recognise the early signs of agitation, irritation, anger, and aggression. They should be able to understand the likely causes of aggression or violence, both generally and for each service user. Staff should use techniques for distraction and calming, and ways to encourage relaxation. Everyone needs to recognise the importance of personal space and be able to respond to an individual's anger in an appropriate, measured, and reasonable way to avoid provocation.

- **Environmental management**

Moving other patients or relatives away from the situation can be helpful. Suggesting to the patient that the location of the interaction is moved to another room or offering a choice of preferred activity that the patient finds soothing can modify the level of stimulation. If there is a particular stressor that can be removed safely and is appropriate to do so, then this should be done.

- **Avoidance of provocation**

Understanding and seeking to avoid known triggers or otherwise behaving in a way likely to provoke aggression. Staff should aim to recognise early signs of agitation, irritation, anger and aggression, both generally and for each individual. If possible and appropriate this could be in conjunction with discussions with the family about what causes the individual's agitation. The commencement of a behavioural chart can also help identify triggers for individuals. Multi-disciplinary team discussions are helpful in discussing how the individual is best managed and what they have responded well to.

Much of our communication is nonverbal. Staff should be aware of how their posture or hand gestures may be perceived by others. Standing over a seated patient or standing squared up to someone can cause tensions to rise as people feel out of control of their situation. Smaller examples such as eye rolling and tutting can also frustrate individuals who may feel they are not being listened to.

- **Continual risk assessment**

Dynamic cycles of micro-assessment are required. This entails continually monitoring the nature/degree of risk including responses to staff efforts. Behavioural charts and good communication are key at this step.

- **Watchful waiting**

Consciously minimising the cognitive load of the patient who may be struggling to sustain emotional regulation whilst actively assessing the situation.

- **Empathy**

Display empathy verbally and non-verbally. Appearing calm is helpful, but an acknowledgment of the patient's distress via mirroring can be helpful. Building a working relationship with individuals as soon as possible results in better outcomes when managing agitation and anger.

- **Reassurance**

Consciously minimising the cognitive load of the patient who may be struggling to sustain emotional regulation whilst actively assessing the situation.

- **Shame avoidance**

Fear or shame may underlie overt aggression. Reassuring the patient that they are safe, respected, valued and that nobody will harm them, can be critical. Shame may trigger aggression in patients and staff. Seeking solutions that allow the patient to retain their dignity is important.

- **Appropriate humour**

Changing the emotional dynamic of a situation underpins de-escalation and the appropriate but importantly empathic use of humour may do this.

- **Distraction**

Distracting the person by changing the focus of the interaction may reduce their distress and decrease their arousal. Suggesting an activity that they enjoy can help or perhaps phoning a loved one.

- **Negotiation**

Identifying mutual goals and a shared consensus may help you reach an agreement with the individual on how to move on.

- **Reframing events**

Emotions arise from an interpretation of an event that involves judgements about the motivation of others. Cautious exploration of alternative interpretations may prove helpful. If the individual has a specific grievance with one person, if possible, this person should be removed from the situation until it has calmed. One member of staff should lead the

discussion with the individual as too many people becoming involved can over stimulate and lead to misunderstandings and more conflict.

- **Non-confrontational limit setting**

Explaining the situation calmly, where possible presenting the patient with a choice and avoiding issuing ultimatums.

- **Patient need identification**

Aggression should be understood as an expression of a need for the patient. Identifying and resolving that need may help avert violence.

Involve service users in all decisions about their care and treatment, to develop care and risk management plans jointly with them. If a service user is unable or unwilling to participate, offer them the opportunity to review and revise the plans as soon as they are able or willing and, if they agree, involve their carer.

- **Respecting patient space**

Staff should actively increase the personal space they afford the patient to decrease any perceived threat. At times it may be appropriate to encourage the individual into a quieter area where they can discuss their grievance without an audience. However, staff should try to not become isolated.

- **Advance statements**

The presence of an accurate and comprehensive current risk assessment as part of a care plan is central to the prediction and management of future episodes of agitation or disturbance. The management of the identified risk variables should be clearly documented in the care plan, as should any discussion with the individual regarding the treatment of such behaviour, especially those discussions with regard to pharmacological agents. A copy of an advance statement should be given to the individual.

- **Positive engagement**

An intervention that aims to empower service users to actively participate in their care. Rather than 'having things done to' them, service users negotiate the level of engagement that will be most therapeutic. Encouraging an individual to recognise their own triggers and early warning signs can help open up the discussion when they start to become agitated.

- **Self-control**

Exposure to aggression, especially over a period of time, can have an impact on staff's emotional regulation. This needs to be actively and consciously managed and staff supported. Multidisciplinary team discussion should be promoted to manage difficult situations. Debriefing is a valuable tool after an incident is important to allow staff to discuss the situation and any learning that can be taken from it. Debriefing should be a supportive environment and should not be about attributing blame.

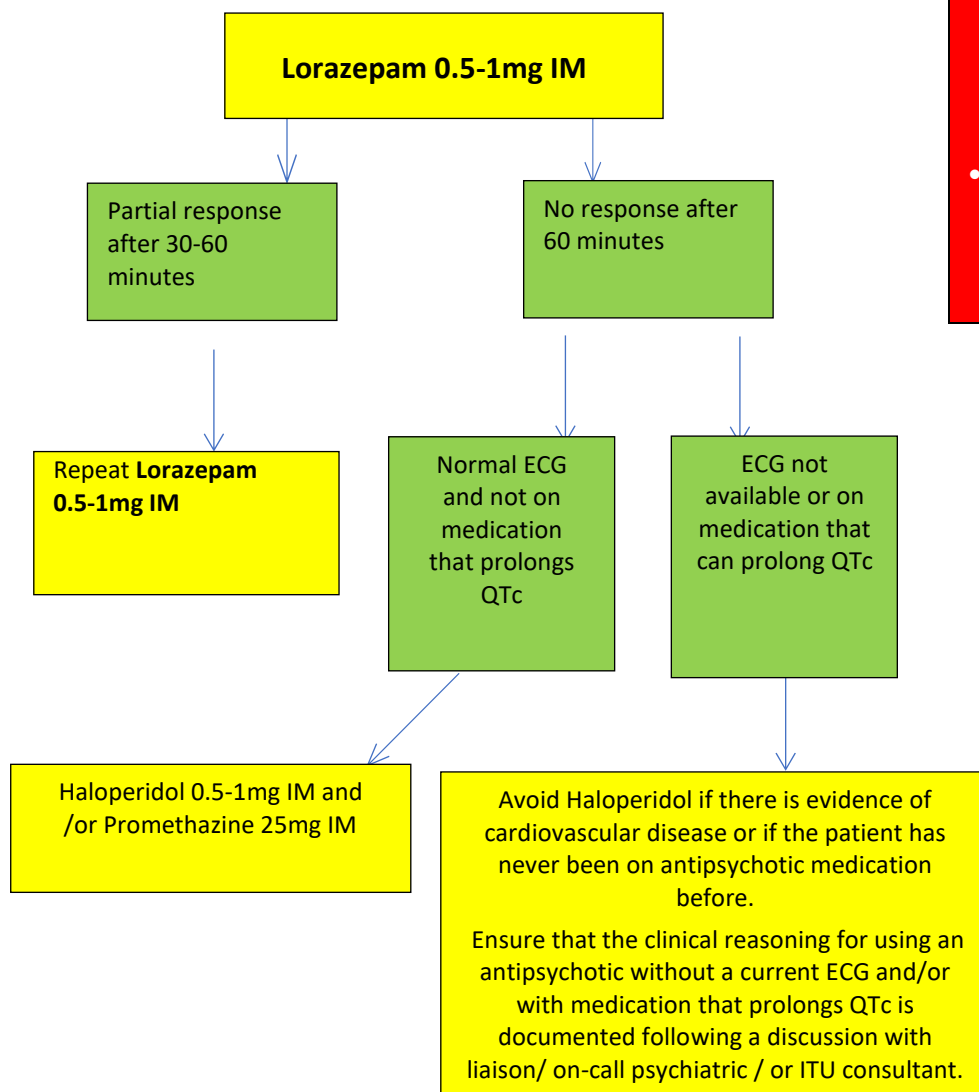
Appendix 4: Rapid Tranquillisation in Older Adults (typically over 65 years – can be adapted)

STEP 1 (BEFORE CONSIDERING THE USE OF MEDICATION)

Non-pharmacological measures; consider and address causes; verbal de-escalation; optimise environment.

>The Psychiatric Liaison Service (LPS) should be contacted to provide early assessment and advice.

IF NON-PHARMACOLOGICAL MEASURES FAIL, FOLLOW THE FLOW CHART BELOW



CAUTION!

- This guideline/algorithm is **ONLY** for rapid sedation of adults with acutely disturbed behaviour which is posing a risk to patient/others.
- It is **NOT** intended for use in the general management of confusion/agitation in the elderly/dementia or to guide sedation for procedures such as CT scanning/cannulation where there is no immediate significant risk to the patient.
- The IV route should only be used with anaesthetic support or a clinician competent in airway management, with monitoring and resuscitation facilities available.

ADVERSE REACTIONS

Benzodiazepine induced respiratory depression:

Flumazenil:200 micrograms IV over 15 seconds. Repeat 100 micrograms at 60 second intervals. Max 1mg

Antipsychotic induced acute dystonia:

Prochlorperazine 5 mg IM. Repeat after 20 minutes if required. Max 10mg/24hrs

RAPID TRANQUILLISATION

MAXIMUM DOSES:

Lorazepam 2mg/24 hrs
Haloperidol 6mg/24hrs
Promethazine 50mg/24hrs

Urgent senior advice should be sought if:

- Two doses of medication have been given and response is inadequate.
- Patient previously responded to RT, but situation is deteriorating and repeat medication is being considered.
- Situation is escalating, and concern has been raised by any member of staff.
- Respiratory depression - Fast bleep Anaesthetic Registrar.

Contact:

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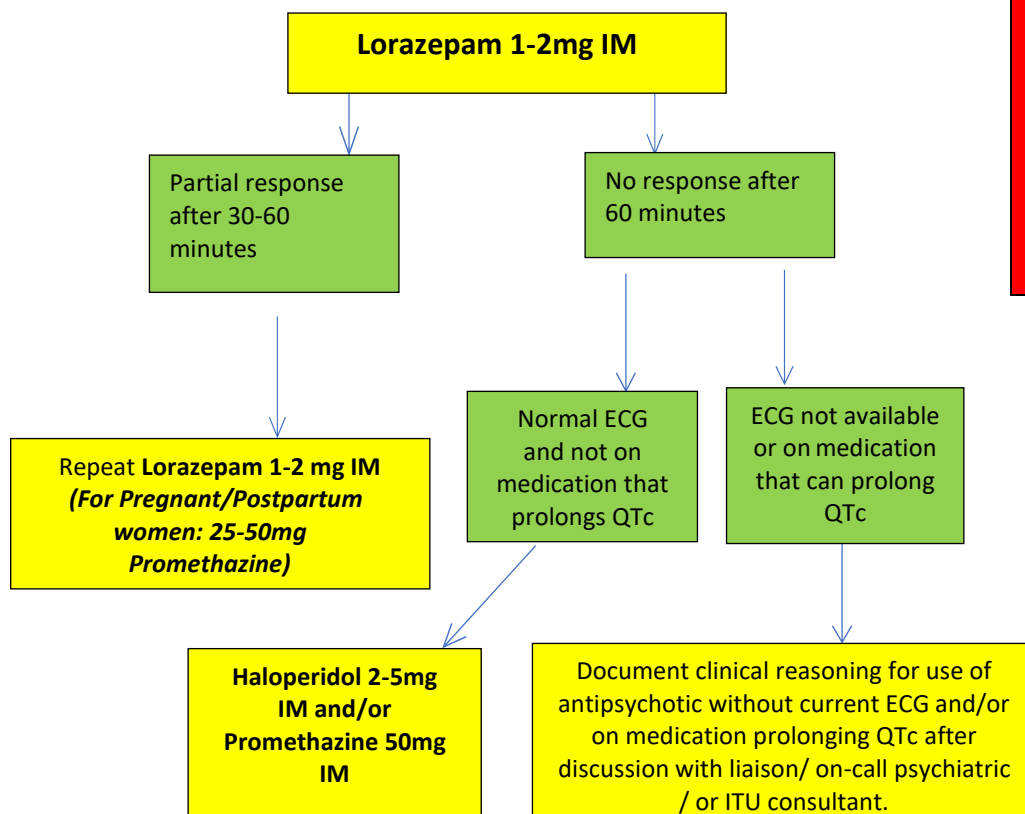
Appendix 5: Rapid Tranquillisation in Adults (typically 18 to 65 years – can be adapted)

STEP 1 (BEFORE CONSIDERING THE USE OF MEDICATION)

Non-pharmacological measures; consider and address causes; verbal de-escalation; optimise environment.

>The Psychiatric Liaison Service (LPS) should be contacted to provide early assessment and advice.

IF NON-PHARMACOLOGICAL MEASURES FAIL, FOLLOW THE FLOW CHART BELOW



CAUTION!

- This guideline/algorithm is **ONLY** for rapid sedation of adults with acutely disturbed behaviour which is posing a risk to patient/others.
- It is **NOT** intended for use in the general management of confusion/agitation in the elderly/dementia or to guide sedation for procedures such as CT scanning/cannulation where there is no immediate significant risk to the patient.
- The IV route should only be used with anaesthetic support or a clinician competent in airway management, with monitoring and resuscitation facilities available.

ADVERSE REACTIONS

Benzodiazepine induced respiratory depression:

Flumazenil: 200 micrograms IV over 15 seconds. Repeat 100micrograms at 60 second intervals. Max 1mg

Antipsychotic induced acute dystonia:

Prochlorperazine 5-10 mg IM. Repeat after 20 minutes if required. Max 20mg/24hrs

PRESCRIBING ADVICE FOR PREGNANT OR POSTPARTUM WOMEN

- Choice of medication should consider risks to mother and (unborn) child.
- Use minimum effective doses.
- Consider using promethazine first line over lorazepam due to risk of Floppy Baby Syndrome.
- Never leave a pregnant woman alone after RT.
- Do not exceed a total dose of 100mg/24h Promethazine (PO and IM)

RAPID TRANQUILLISATION

MAXIMUM DOSES:

Lorazepam 4mg/24 hrs
Haloperidol 12mg/24hrs
Promethazine 100mg/24hrs

Urgent senior advice should be sought if:

- Two doses of medication have been given and response is inadequate.
- Patient previously responded to RT, but situation is deteriorating and repeat medication is being considered.
- Situation is escalating, and concern has been raised by any member of staff.
- Respiratory depression - Fast bleep Anaesthetic Registrar.

Contact:

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Appendix 6: Rapid Tranquillisation (can be adapted)

Commence continuous monitoring as early as possible. To include Capacity assessment baseline set of observations- HR, BP, RR, O₂ saturation, temperature and if possible, ECG. All interventions must be proportionate and reasonable response to the risk posed by the service-user. Always try de-escalation techniques (Appendix 3) before medication. Prescribe the initial dose as a single dose so subsequent treatment can be individualised

Lorazepam 1-2mg (Elderly 0.5-1mg) IM
 Mix 1:1 with water prior to use Ensure Flumazenil available

Promethazine 25-50mg (Elderly 25mg) IM and/or Haloperidol 2-5mg (Elderly 0.5-1mg) IM
 Ensure IM Procyclidine available
 If there is evidence of cardiovascular disease or if there is no recent ECG, if the patient has had not had antipsychotic medication in the past then AVOID Haloperidol. Use separate syringes but can be given on same side

If partial response, repeat after a minimum of 30-60 minutes.

If response is still inadequate or situation is escalating, then call for senior help and anaesthetic support. Perform a Capacity assessment, and ensure that ward consultant, Anaesthetics and site co-ordinators are aware. (Or critical care outreach)
 If there are Psychiatric concerns or alternatives to haloperidol are required then please contact Liaison Psychiatry.
 Treating Consultant to document rationale if exceeding BNF max.

Continue hourly obs. Increase to 15 minutes if patient is:
 -Asleep or sedated
 -Has taken illicit drugs/alcohol
 -Has pre-existing physical health problems
 -Has had more than max. recommended daily doses of medication

Contacts

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