Brief guide: Rapid tranquilisation (by the parenteral route) in children (aged 12 and under) and young people (aged 13 to 17) in mental health

Context and policy position

NICE defines rapid tranquilisation (RT) as 'use of medication by the parenteral route (usually intramuscular or, exceptionally, intravenous) if de-escalation techniques and/or oral medication are not possible or appropriate and urgent sedation with medication is needed'. Clinicians using RT must both monitor the patient's physical health and be prepared to manage medical emergencies that might arise.

If a clinician considers it necessary to use RT, NICE[1] recommends:

- Use intramuscular lorazepam for rapid tranquillisation in a child or young person and adjust the dose according to their age and weight.
- If there is only a partial response to intramuscular lorazepam, check the dose again according to the child or young person's age and weight and consider a further dose.

Evidence required (drawn from NICE[1] guidance)

Policy

Is there a policy on the use of RT for children and young people specifically that includes prescribing, administering, physical health monitoring and the management of problems including resuscitation? Can staff who might need to refer to the policy access it?

Training

Have staff involved in administering or monitoring RT been trained in:

- the relevant sections of the hospital policy for rapid tranquilisation in children and young people,
- the Children Act 1989 and 2004, the Mental Health Act 1983, the Mental Capacity Act 2005, the Human Rights Act 1998. the United Nations Convention on the Rights of the Child.
- de-escalation techniques suitable for children and young people, using calming techniques and distraction.
- intermediate life support training?

The training programme should be designed specifically for staff working with children and young people.

Mental Health Act

Is the appropriate legal authority in place regarding consent to treatment e.g. T3 treatment authorisation? If urgent treatment under section 62 has been used, has it been properly documented and is there adequate explanation of how the strict tests in the Act are applicable?

See brief guide to capacity and competence to consent - BG004 capacity and consent under 18s.

Care planning

Do patients who might be subject to RT have an individual plan? Is this reviewed at least weekly? If RT is being used, does a senior doctor review all medication at least once a day? If under 16, are family or carers given information and support to help the child or young person to make decisions about their treatment. Does information given to young people/carers include the use of medicines for indications for which they do not have UK marketing authorisation. Does the plan record:

- the target symptoms?
- the total daily dose of medication prescribed and administered, including prn?
- therapeutic response and the emergence of unwanted effect?
- informed consent being obtained and documented with the prescribers' use of unlicensed medicines?

Prescribing

Is medication used for RT prescribed as a once-only dose until the effect of the initial dose has been reviewed? Is prescribing in accordance with trust policy and evidence based practice?

Monitoring

Following RT do staff monitor: side effects, pulse, blood pressure, respiratory rate, temperature, level of hydration and level of consciousness every 15 minutes until the patient is ambulatory and there are no further concerns? If full monitoring is impractical, do staff document reasons why and ensure a minimum observation of respiration and level of consciousness?

Also, staff should document psychiatric observations every 15 minutes and monitor the emotional impact of RT on the patient. Staff should offer the patient a 'debrief' once the crisis has abated, to explain and explore impact and any future plans.

Equipment

Does the provider have the equipment and medication to manage medical emergencies arising from RT and are staff trained to use the equipment[2]?

Reporting

Under '**Use of restrictive interventions**' in the '**Safe**' section of the evidence appendix, record your findings on the extent to which staff followed NICE guidance when using rapid tranquilisation.

Information about the quality of the provider's policy on RT, the training provided to staff in RT and the quality of care planning related to RT will also contribute to judgements about the key questions Effective and Well led.

Link to regulations

Failure to comply with guidance and legislation in this area would usually fall under:
Regulation 12 – Safe Care and Treatment
Regulation 11– Need for Consent.

[1] Nice guidelines NG10 March 2015-Violence and aggression: short-term management in mental health, health and community settings

[2] Resuscitation council UK Quality standards for cardiopulmonary resuscitation practice and training.