



**NHS Fife  
&  
Fife Council**

**2010**



*Psychiatric Emergency Plan*

The members of the Psychiatric Emergency Plan Review Group would like to thank everyone involved in the consultation and production of this document.

This Psychiatric Emergency Plan has been developed by NHS Fife in partnership with Fife Council, Fife Constabulary and the Scottish Ambulance Service. It will be reviewed in August 2013.



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## Key Abbreviations

2000 Act	<a href="#">Adults with Incapacity (Scotland) Act 2000</a>
2003 Act	<a href="#">Mental Health (Care and Treatment) (Scotland) Act 2003</a>
AMP	Approved Medical Practitioner
CAMH(S)	Child and Adolescent Mental Health (Services)
ECHR	<a href="#">European Convention of Human Rights</a>
EMDC	Emergency Medical Dispatch Centre
GP	General Practitioner
LD	Learning Disability
MH	Mental Health
MHO	Mental Health Officer
PEP	Psychiatric Emergency Plan
RMN	Registered Mental Nurse
RMO	Responsible Medical Officer
RNLD	Registered Nurse Learning Disabilities
SAS	Scottish Ambulance Service
UCS	Unscheduled Care Service

## **Introduction**

This Psychiatric Emergency Plan (PEP)<sup>1</sup> sets out clear and concise guidance for staff who may be involved in the detention of persons under the [Mental Health \(Care and Treatment\) \(Scotland\) Act 2003](#). The guidance is relevant and applicable to all healthcare and local authority staff, police officers, ambulance personnel and various persons and agencies. It addresses their key responsibilities and the procedures that should be followed in an emergency psychiatric situation but it is not intended to replace more detailed information available elsewhere. It is the intention of the authors that this PEP will provide procedural information required both quickly and in a manner that will enable informed decision-making in difficult and urgent circumstances. It must be stressed that it does not replace professional judgement of the situation in question.

The PEP has been written taking account of human rights legislation (the [Human Rights Act 1998](#) and the [ECHR](#)) and the principles set out in section one of the 2003 Act (see [Appendix A](#)). Although not expressly stated, this guidance may be applied to other clinical situations.

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<sup>1</sup> The steering group would like to thank various members of NHS Greater Glasgow and Clyde and NHS Tayside for their cooperation and assistance in the groundwork of this PEP.

## **Detention of Persons from the Community to Hospital**

### ***Where access to private premises is granted***

Where possible, the Short Term Detention Certificate is the preferred order as it affords the person more rights and safeguards. It requires the approval of a Mental Health Officer (MHO) and may only be granted by an Approved Medical Practitioner (AMP). When all other available options have been considered, however, the Emergency Detention Certificate may be the only route to admission to hospital for urgent assessment of a person's mental health.

Any fully registered medical practitioner can grant an emergency detention certificate. The certificate authorises the transportation of a person to hospital, but compulsory admission to hospital is authorised only after the certificate has been handed over to the hospital manager or his/her representative. Copies of the Emergency Detention form (DET1), and of other mental health forms, are available at:

<http://www.scotland.gov.uk/Topics/Health/health/mental-health/mhlaw/mha-Forms> (Adobe Acrobat Reader v 7.0, or later, is required).

The application for emergency detention must include the following statements:

- It is likely that the person has a mental disorder as defined by the 2003 Act (mental illness, learning disability or personality disorder);<sup>2</sup>
- As a result of this mental disorder the person's ability to make decisions regarding his/her medical treatment is significantly impaired;
- It is a matter of urgency to detain the person in hospital to determine what treatment is required;
- If the person were not detained, there would be significant risk to the health, safety or welfare of the person or the safety of others; and
- Granting a Short-Term Detention Certificate would involve an undesirable delay.

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<sup>2</sup> Section 328

The following points should be noted:

- Any fully registered medical practitioner can grant the certificate, e.g. GPs, A & E doctors, physicians, surgeons, etc.
- It is not necessary to specify which hospital the person will be admitted to or the nature of the person's mental disorder; and
- Mental Health Officer (MHO) approval should be sought or a reason why this was not possible must be indicated on the detention form.

**The *detaining medical practitioner* has overall responsibility for organising the safe transfer of the person to hospital.<sup>3</sup>**

***Where access to the premises is denied***

In circumstances where access to a person who may require assessment and treatment is denied, or is likely to be denied, certain procedures are required:

- The 2003 Act places a duty on an MHO to apply to a Sheriff or Justice of the Peace for a warrant to enter the premises;
- The warrant authorises any police officer to open the premises, by force if necessary;
- This allows the MHO and medical practitioner to carry out further enquiries into the person's circumstances and if necessary to make arrangements to remove the person to hospital;
- It is the MHO's duty, as an officer of the local authority, to secure the premises and to ensure that there is no further damage to, or loss of, the person's property.

See overleaf for a summary of the relevant warrants.

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<sup>3</sup> Code of Practice, Volume 2, Chapter 5, §50

**Warrants**

All warrants must be granted by a Sheriff or Justice of the Peace and the applicant (MHO) should appear personally so that s/he can answer any questions.

The following relevant warrants are authorised by the 2003 Act:

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Section 33	Duty on a local authority to make inquiries
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Section 35	Entry to premises
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Section 35	Access to medical records
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Section 292	An authorised person to enter premises to take a patient
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Source: [Maas-Lowit, Newsletter for MHOs in Scotland, Issue 12, 2006, p14](#)

## Detention in Hospital

### **Medical Detention**

When detaining a person in hospital under emergency conditions, any fully registered medical practitioner (not necessarily a psychiatrist) may issue an Emergency Detention Certificate. Where possible, the Short Term Detention is the preferred order as it affords the person more rights and safeguards: It requires the approval of a Mental Health Officer (MHO) and may only be issued by an Approved Medical Practitioner (AMP).

### **Nurses' Power to Detain**

Section 299 empowers certain nurses to detain an informal patient who is already in hospital receiving treatment for a mental disorder, for a limited time in order to have a medical examination. It cannot be used for detaining persons in resource centres or in the home setting and it can only be authorised by Level 1 registered mental health (RMN) and learning disability nurses (RNLD).

First level registered mental health or learning disability nurses are empowered under s299 of the Mental Health (Care and Treatment) (Scotland) Act 2003 to detain an informal patient who is in hospital receiving treatment for a mental disorder. The nurse may detain the person where s/he believes that it is **likely** that the following conditions are met:

- The person has a mental disorder;
- The person is in hospital receiving treatment for that mental disorder;
- It is necessary for the health, safety or welfare of the person **or** for the protection of the safety of any other person; and
- It is necessary to carry out a medical examination.

The holding power may be used where the person is in hospital awaiting an assessment or otherwise and is receiving care, it is not necessary that the person has been formally 'admitted' to the ward, see footnote 4, below.<sup>4</sup>

***Care of the person during detention***

It is the duty of all statutory services to act in the best interests of persons to deliver high quality care and to treat persons with respect and dignity, regardless of the location. The underlying principles of the 2003 Act (see [Appendix A](#)) relating to the care of the person should be observed at all times.

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<sup>4</sup> It is the opinion of the MWC that it is unnecessary for the person to have been formally admitted to hospital as the Act only states that s/he need be *in* hospital and medical treatment can be defined simply as **care** (s299 (1)(a)).

## **Escorting/accompanying a detained person**

After a person has been detained in the community, the detaining medical practitioner is responsible for contacting the duty/on-call junior doctor/local co-ordinator at the admitting hospital. It is the responsibility of the junior doctor/local co-ordinator to obtain the patient's full details from the detaining medical practitioner, including:

- Name, date of birth and home address;
- Address where the person will be located, if different from above;
- Name of the attending MHO;
- Mobile telephone number of the referring medical practitioner;
- Confirmation of whether the police will be required to attend and whether they have been contacted;
- Information about the physical health and medical history of the person;
- Details of any recent medication administered to the person; and
- Full clinical details of the circumstances leading to detention.

The junior doctor/local co-ordinator should liaise directly with nursing staff in the admitting ward and pass on the above details to the nurse-in-charge of the ward<sup>5</sup>. Please note, the admitting ward may not always be the normal admission ward for that sector, but the junior doctor and local co-ordinator should identify a vacant bed through normal procedures. If a patient is to be admitted to an out-of-sector ward, then the patient should be conveyed to that ward directly by the escorting staff.

The junior doctor/local co-ordinator should ensure that the nurse-in-charge of the ward is aware of the following information:

- Confirmation that all required documentation has been completed and the whereabouts of the certificate;

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<sup>5</sup> Local arrangements may apply.

- Confirmation that a person able to identify the detained person will be in attendance;
- All available information obtained from the medical practitioner or MHO required to identify risks associated with the escort of a detained person (see [Appendix B](#) for a sample checklist);
- Confirmation of whether the person is to be admitted directly to a psychiatric or learning disability ward or whether other arrangements apply; and
- Confirmation that the admitting ward has been notified of all relevant details of the expected admission.

The nurse-in-charge of the ward and the local co-ordinator, will identify a **minimum** of two escorts, one of whom normally must be a first level RMN or RNLD; professional judgement and assessment of risk will determine the escort staff requirements.<sup>6</sup> Escorts will be informed of all relevant information. Escorts are normally provided by the sector ward staff, even if the patient is to be admitted out of sector. When identifying escorts, regard should be given, at all times, to the principles of the Act, especially the principle of least restrictive alternative.

A mobile telephone should be provided for the nurse escorts' use. The Transport Arrangements Flowchart on page 16 outlines the transport to hospital process and the responsibilities of the various parties involved.

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<sup>6</sup> In certain circumstances outreach social work personnel may escort patients into hospital.

## **Transport Arrangements**

The medical practitioner attending the patient in the community has a professional obligation to ensure that the least restrictive method of conveying the person to hospital is used, consistent with ensuring that no harm comes either to the person or to others. The following points, where appropriate, should be taken into account:

- Recorded previous history of violence committed by the detained person;
- The detained person's preferences;
- The views of relatives, carers or Named Person;
- The views of other professionals involved in the process or who know the person;
- The medical practitioner's judgement of the person's state of mind and the likelihood of him/her behaving in a violent or dangerous manner; and
- The impact that any particular mode of transport will have on his/her relationship with the community to which s/he will return.

The ambulance service has introduced a service to transport patients who have been detained in the community under an emergency order and who require to be urgently transported to hospital. The service will operate between the hours of **9 AM and 9 PM**. Outwith those hours ordinary arrangements for ordering ambulances will apply; see [Appendix F](#) for contact telephone numbers.

Arrangements for transport to hospital for emergency detention admissions should follow this procedure:

1. The detaining medical practitioner contacts the ward to arrange admission indicating the preferred timeframe of the patient's admission, e.g. "should be in hospital within 2 hours".

2. The nurse in charge of the ward will contact the Ambulance Service Emergency Medical Dispatch Centre (EMDC) and ask for an **URGENT** ambulance to attend at the address where the patient is being held. S/he should inform the ambulance dispatcher that this request is on the authority of the detaining doctor and give the doctor's name.
3. The nurse will ask for the expected time that the ambulance will arrive. If, after determining the circumstances of the case, the nurse believes that the wait is too long then the ambulance request should be upgraded to **EMERGENCY**.
4. In all circumstances the following information should be given to the EMDC:
  - The detained person's name;
  - Address from where the person will be picked up;
  - The person's condition, e.g. whether s/he has been sedated or if there is a medical condition of which the ambulance crew should be made aware;
  - Details of any medication that has been administered, including route and time of administration;
  - An indication of the person's likely attitude to admission, e.g., whether s/he is likely to be violent or distressed;
  - The time by which the ambulance should be at the appointed address;
  - Who will accompany the person;
  - The hospital to which the person is being admitted; and
  - A contact telephone number and name.
5. When the ambulance time of arrival has been agreed, the nurse in charge will telephone the contracted taxi firm to take the nurse escorts to collect the person (see below). Ideally, arrival at the location should be co-ordinated with the arrival of the ambulance in order that delays are kept to a minimum.

6. In certain circumstances it may be necessary to take the patient to an Accident & Emergency Department or other hospital on route. If so, it is anticipated that the ambulance will leave the patient and nurses escorts at the other hospital; when the patient is ready to be taken to the hospital in the detention order, the EMDC should be contacted and a request made for an **URGENT** ambulance, as before.

**Please Note:** Urgent ambulances are not staffed with paramedics, but with drivers and escorts who are trained to give first aid in a medical emergency. If necessary, they will make a decision to take the patient to A&E if they determine that further emergency treatment is required.

***Arranging nurse escort transport***

The senior nurse will telephone the contracted taxi firm to take the nurse escorts to collect the person. Alternatively, the senior nurse may authorise the nurse-in-charge of the admitting ward to arrange a taxi according to local arrangements.

On arrival at the destination, the nurse escorts will enter the premises unless the attending medical practitioner and/or the MHO indicate risks which would suggest otherwise.

The medical practitioner will be required to provide as much of the following information as possible to the Ambulance Service Emergency Medical Dispatch Centre (EMDC), see number 4, above.

It is the responsibility of the medical practitioner to ensure the safe handover of the detained person to Scottish Ambulance Service staff and, whenever possible, the doctor should do so in person. Where this is not possible, the medical practitioner should ensure that all relevant parties are aware of, and able to advise on, the individual's circumstances and needs. The medical practitioner should stress the need for attendance at the earliest opportunity.

**MHOs will NOT use personal vehicles to transport detained persons to hospital.**

In exceptional circumstances a police vehicle may be used to convey a detained person to hospital. The police will only agree to provide transport for persons who have been assessed on private premises where:

- A current assessment of risk indicates a real risk of violence and that it would be unsafe to use an ambulance;
- The police have been informed in advance of the destination of the detained person; and
- Emergency medication has **NOT** been administered.

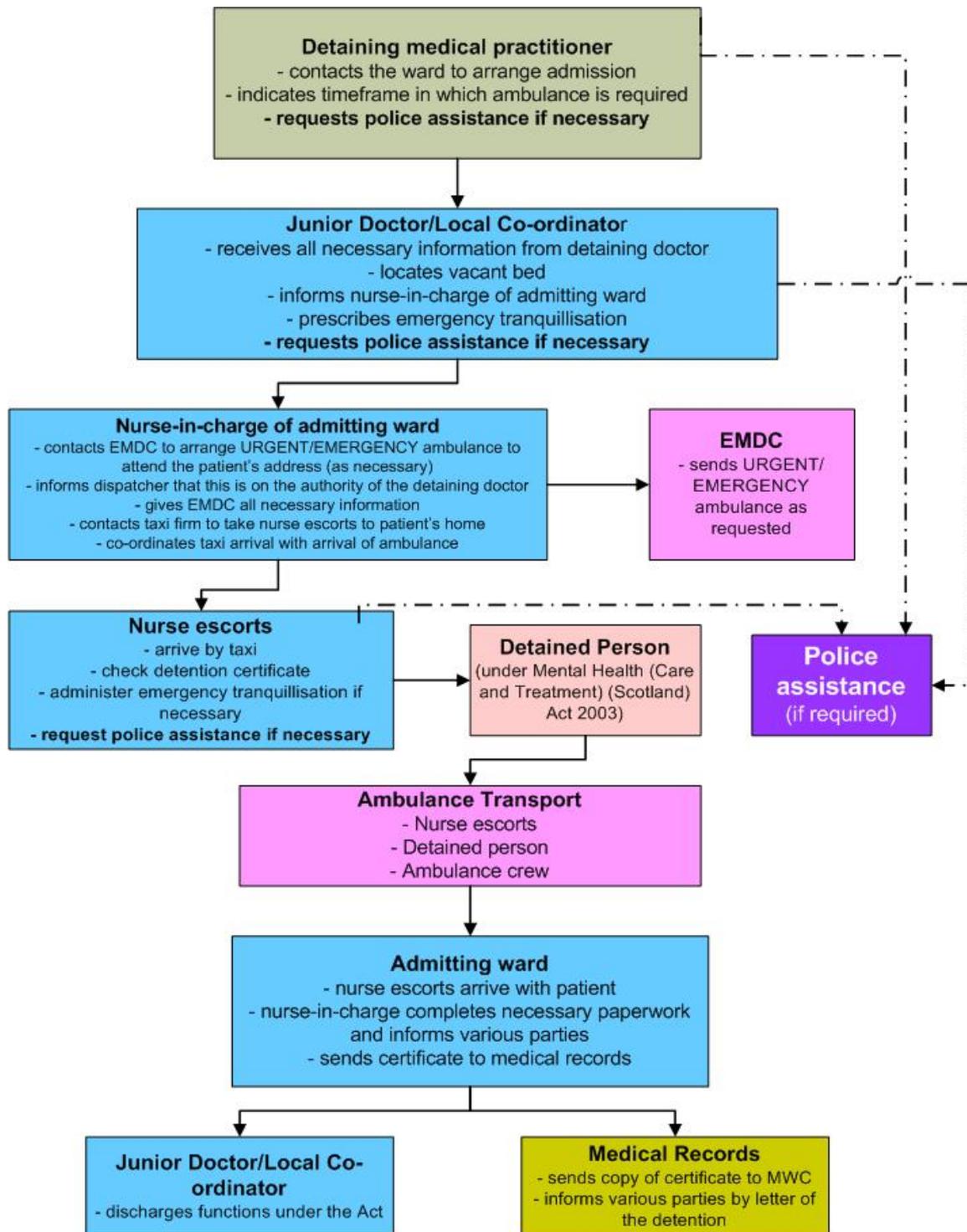
See [Appendix C](#) for guidance on information-sharing.

The admitting ward is responsible for arranging nurse escorts. The nurse in charge of the escort party is responsible for ensuring that the Detention Certificate is in his/her possession, that it is properly completed and within the time-frame, before escorting the person from the location. The sector consultant/senior doctor on call should be contacted if there are any problems with correct completion of detention certificates.

The escort nurse must ensure that the Certificate is handed over to the nurse in charge of the ward on arrival. The nurse in charge of the admitting ward must ensure that the Certificate is delivered as soon as possible to the nominated person responsible for the administration of the Mental Health Act within the locality. This will usually be the local medical records department.

Because of the nature of the situation, emergency detentions can easily become public events. It would therefore be good practice to take all reasonable steps to preserve the privacy and dignity of the individual by ensuring that the transfer and detention proceedings are conducted as discreetly as possible under the circumstances. For example, marked police vehicles and ambulances can be parked within easy reach of, but not necessarily in immediate proximity to the emergency scene. In all cases, persons should try to act in accordance with the principle of “least restrictive alternative”.

**Transport Arrangements Flowchart**



## **Admission to an Acute Hospital**

Occasionally, an individual detained in the community may require immediate treatment for an urgent physical injury or medical disorder, prior to the inpatient psychiatric assessment. This is in order, as under the 2003 Act “the hospital” is not confined to one which solely provides psychiatric care. The person could be detained in an acute hospital and transferred for psychiatric care when appropriate. In such cases, the various services must recognise that the law covering such a situation may be unclear and therefore, no single protocol exists to identify how the situation should be managed. In all situations, the welfare of the individual is paramount and should override any service considerations.

If a general practitioner detains a patient for the purpose of treating a physical disorder in an acute hospital (e.g. acute confusional state due to chest infection), then s/he should liaise with the admitting hospital. The **admitting hospital** would usually then be primarily responsible for all that subsequently happens, i.e. clinical care and ensuring that the requirements of the Act are met. This hospital will also have the main responsibility for providing the nurse escort, but there should be liaison with mental health or learning disability services about the need for a mental health/learning disability nurse. Mental health and learning disability services should be prepared to respond to requests to provide escort nurses in these situations.

Provision of dedicated mental health/learning disability nursing in the acute hospital is sometimes necessary but should be based on needs – patients should not automatically have mental health/learning disability nursing merely because they are detained, if there is no need. There is no statutory requirement to have MH/LD nurses supervising detained patients as a matter of course and it is a matter for the senior escorting nurse, in discussion with the acute hospital clinical staff, to decide whether attendance by mental health or learning disability nurses should continue. Responsibility for providing appropriate nursing care remains with the acute hospital following admission; it should not be considered routine that a detained patient requires a mental

health or learning disability nurse or that the local mental health hospital should provide staff for that purpose.

Detained patients should not be routinely subjected to increased levels of observation; this should be assessed on the needs of the patient and any risks posed.

All detained patients must have an RMO, who must be an AMP. Consequently, if a patient is detained in an acute hospital, members of the clinical team at the acute hospital are responsible for his/her clinical care, but the acute hospital consultant cannot be the RMO. Best practice recommends that while there should be essential good liaison between acute and mental health teams, the RMO has a statutory responsibility to examine the detained patient as soon as is reasonably practicable. Where a patient is detained, it is therefore essential that the acute hospital makes contact with the mental health or learning disability services so that an RMO can be determined. Out-of-hours, this would be the duty consultant; if during working hours, it would be the sector consultant.

If a patient being admitted to a psychiatric/learning disability hospital is medically assessed as requiring urgent medical treatment (e.g. to suture a laceration), that person should be taken to A&E before being admitted to the psychiatric/learning disability hospital.

See [Appendix D](#) for details of the duties of the healthcare professionals concerned.

## **Emergency Medical Treatment in the Community**

The decision to administer urgent medical treatment should be informed by the presence of a level of risk commensurate with the criteria listed at section 243 of the Act rather than as a means of managing a “difficult” person.

The urgent treatment provisions (s243) state that treatment may be given that is necessary to:

- Save the patient’s life;
- Prevent serious deterioration of the patient’s condition;
- Alleviate suffering;
- Prevent harm to the patient or others; or
- Prevent violent or dangerous behaviour

It is important to recognise that the assessment of the likelihood of “serious deterioration” and “serious suffering” is a subjective process. Treatment may be given provided that it is not likely to have unfavourable and irreversible physical and psychological consequences or cause the patient significant physical hazard.

### ***Emergency tranquillisation during nurse escort duty***

Prior to emergency treatment by injection being necessary, consideration should be given to the use of oral preparations. There will be times when emergency treatment is necessary, but can be administered with the agreement of the patient; therefore it would be best practice to make oral preparations available to nurse escorts via the usual prescribing guidelines.

It may be necessary, however, for nurse escorts to administer emergency tranquillisation by injection before or during transfer of the person to hospital. This should be carried out according to the current NHS Fife procedure, *Prescribing, Preparation and Administration of Medication for Emergency Tranquillisation during Nurse Escort Duty (M1-P1-MH)*. The procedure ensures the safe, appropriate and effective use of medicine for emergency

tranquillisation in community patients who have been detained under the terms of the 2003 Act and who are being escorted by a nurse during admission to a psychiatric/learning disability unit within Fife. Completion of the prescription sheet should be in accordance with this procedure and must be done in liaison with the attending medical practitioner. A full copy of the procedure is attached at [Appendix E](#).

## Role of the Police in Detentions

There may be occasions when healthcare staff will be unable to contain a situation within a community establishment or in a person's home. Where there is a **clear threat** to staff, patient, or public safety, they should request the assistance of the police. If the person to be detained is known to potentially pose a risk to themselves or others discussion may be held with the consultant psychiatrist and MHO to arrange police presence prior to the visit should this be required.

In appropriate cases, where the police have been called to an area, control will only pass to the police if the patient is unruly, a crime has been committed, or there is a significant risk to others; otherwise officers will maintain observations in case any of those situations occur. If the authority and responsibility for the control of the incident passes over to the police, staff must be aware that the officers may take whatever action they feel necessary in order to deal safely with the individual concerned and to protect themselves and others. This may include the use of police restraint equipment and techniques. While the incident remains under police control, staff may be called upon to provide information, guidance and/or assistance in respect of the care of patient. Once the situation has been contained, and providing the police are taking no further action, the nursing staff may be able to retake control.

***The police have no power under mental health legislation to remove a person from their place of residence.***

Police Officers have the power to take a person, who is in a public place, to a place of safety. See separate NHS Fife Procedure/Fife Constabulary Standard Operating Procedure for the Removal of a Person from a Public Place to a Place of Safety (Procedure No. R2-9-MH).

## **Identification of Beds for Admission**

When a person has been detained from a community setting, locating a suitable bed is a priority. It is always preferable for the person to be cared for in a hospital within his/her local area, but if this is not possible the nearest available hospital should be the next preferred choice. It is best practice to locate a vacant bed prior to detaining a patient.

### **1. Emergency admissions: mental health**

#### **a) During office hours (9am-5pm)**

The following process should be followed:

- The duty junior doctor/local co-ordinator will liaise with the senior nurse on duty to identify location of vacant beds;
- If there are **no** available beds within the sector, then the junior doctor/local co-ordinator will liaise with his/her colleagues across Fife in a bid to resolve the situation; and
- The junior doctor/local co-ordinator should identify to which ward the patient will be admitted.

#### **b) Out of hours**

The following process should be followed:

- The duty/on-call junior doctor/local co-ordinator and senior nurse should always be contacted, in the first instance, by the medical practitioner in attendance;
- The senior nurse should be aware of bed availability, i.e. vacant or pass beds that may be used;
- If there are no available beds, the duty junior doctor/local co-ordinator/senior nurse should determine the availability of beds across Fife (local arrangements will apply);
- On night duty, the duty junior doctor/local co-ordinator/senior nurse will attempt to resolve any difficulty by liaising with his/her colleagues across the region;

- If at any time agreement cannot be reached, the duty/on-call junior doctor/local co-ordinator will contact the on-call consultant for advice;
- If no beds are available within Fife, the duty consultant will liaise with his/her counterparts in other NHS Boards;
- Transfers outwith Fife will require the involvement of the duty consultant; and
- It is the responsibility of the originating catchment area to provide escorts both within and outside Fife.

## **2. Emergency admissions: learning disability**

There will be **no emergency admissions out of hours** to learning disability beds in south-east Scotland. If a patient with a learning disability requires urgent admission out of hours, then s/he should be admitted to a general psychiatric ward until appropriate alternative arrangements can be made during normal working hours. There will be a consultant psychiatrist on call, out of hours, for telephone advice only.

## **3. Emergency admissions: child and adolescent mental health services**

A key aim of the Fife CAMHS is to prevent admission to specialist CAMH inpatient facilities in cases where viable alternatives to admission are available locally. Where there are concerns, a consultant Child & Adolescent Psychiatrist and the Intensive Therapy Team must be contacted first. Any admissions out of hours must happen locally and admissions to specialist child & adolescent inpatient units can only be negotiated between Fife CAMHS and the Specialist Inpatient Provider.

### ***Emergency admissions fall into three main categories:***

#### **i) Under 12's**

Emergency admissions are extremely rare for this age group and are actively discouraged by Scotland's only psychiatric inpatient unit at Yorkhill Hospital, Glasgow. Out of hours admissions should be made to Fife paediatric inpatient beds and assessed immediately on the following working day by a CAMHS

consultant psychiatrist and the Intensive Therapy Team. Admission to specialist inpatient facilities will then be arranged if necessary.

**ii) 12 to 15-year-olds**

Urgent admissions out of hours should be made to Fife paediatric inpatient beds and assessed on the following working day by a CAMHS consultant psychiatrist and the Intensive Therapy Team. Emergency admissions will be arranged through Fife CAMHS to the adolescent inpatient units in Edinburgh, Dundee or Glasgow if necessary. Referrals to Specialist Child & Adolescent Inpatient units can only be arranged between Fife CAMHS and the Specialist Inpatient Provider.

Risk assessment should be carried out by the admitting medical practitioner and admission arranged to adult inpatient wards if the level of presenting risk is deemed to be unmanageable in a paediatric setting.

CAMHS input will be coordinated by the CAMHS Intensive Therapy Team and a CAMHS Consultant Child & Adolescent Psychiatrist will hold Responsible Medical Officer (RMO) status for all young people admitted to Paediatric Inpatient settings due to issues relating to mental illness.

**iii) 16 to 17-year-olds**

Emergency admissions should be arranged through a Fife CAMHS consultant psychiatrist and the Intensive Therapy Team. If necessary, admission will be made to the nearest (to the patient's home) available adult inpatient admission ward able to offer appropriate accommodation to meet the needs of the young person in question. Ideally this should be a single room. Fife CAMHS Intensive Therapy team should be informed of all admissions on the next working day.

For all emergency admissions, a senior nurse from the Fife CAMHS Intensive Therapy Team will be allocated as a key worker to visit the patient daily. S/he will support nursing staff and start work with the patient and his/her family and carers in planning for discharge, which should take place at the earliest safe

opportunity. Consultant psychiatrists from Fife CAMHS will liaise closely with their colleagues from the adult services in order to ensure that appropriate treatments are offered and to clarify the issue of ongoing medical responsibility for each individual admission. A CAMHS Consultant Child & Adolescent Psychiatrist will hold Responsible Medical Officer (RMO) status for all young people admitted to Adult Mental Health Inpatient settings.

Fife CAMHS staff are available Monday to Friday 9 AM to 5 PM to respond to emergencies but can work flexibly out of hours in order to meet the needs of patients and to support adult wards in response to an admission. This means that nurses will work outwith office hours in a planned way in order to provide interventions that will remove the need for an admission to an inpatient facility. This is dependant upon staff availability, service capacity and whether the patient's presentation is assessed as being manageable outwith a hospital setting by the Intensive Therapy Team. Out of hours, the procedure for admissions of 16 to 17-year-olds will be the same as for adult admissions.

## References

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## **Appendix A: General Principles of the Act**

The table below sets out the Millan principles, these guide the measures proposed in this PEP.

<b>Principle</b>	<b>Brief Description</b>
<b>Non-Discrimination</b>	People with a mental disorder should, wherever possible, retain the same rights and entitlements as those with other health needs.
<b>Equality</b>	All powers under the Act should be exercised without any direct or indirect discrimination on the grounds of physical disability, age, gender, sexual orientation, language, religion or national, ethnic, or social origin.
<b>Respect for Diversity</b>	Service users should receive care, treatment and support in manner that accords respect for their individual qualities, abilities and diverse backgrounds and properly takes into account their age, gender, sexual orientation, ethnic group social cultural and religious background.
<b>Reciprocity</b>	Where society imposes an obligation on an individual to comply with a programme of treatment of care, it should impose a parallel obligation on the health and social care authorities to provide safe and appropriate services, including ongoing care following discharge from compulsion.
<b>Informal Care</b>	Wherever possible, care, treatment and support should be provided to people with mental disorder without the use of compulsory powers.
<b>Participation</b>	Services users should be fully involved, so far as they are able to be, in all aspects of their assessment, care, treatment and support. Their past and present wishes should be taken into account. They should be provided with all information and support necessary to enable them to participate fully. Information should be provided in a way which makes it most likely to be understood.
<b>Respect for Carers</b>	Those who provide care to service users on an informal basis should receive respect for their role and experience, receive appropriate information and advice, and have their views and needs taken into account.
<b>Least Restrictive Alternative</b>	Service users should be provided with any necessary care, treatment and support both in the least invasive manner and the least restrictive manner, in an environment compatible with the delivery of safe and effective care, taking account where appropriate, of the safety of others.
<b>Benefit</b>	Any intervention under the Act should be likely to produce a benefit for the service user that cannot reasonably be achieved other than by intervention.
<b>Child Welfare</b>	The welfare of a child with mental disorder should be paramount in any interventions imposed on the child under the act.

## **Appendix B: Identifying and Managing Risk**

### ***Sample Checklist***

The detention of persons in any setting may leave staff vulnerable to acts of violence or aggression. Areas of potential risk to personal safety can be influenced by a number of factors and all transfers should have any potential risk identified. It is important to attempt to access records at all times.

The following are examples of questions that might be asked of the medical practitioner or MHO in order to identify risks associated with escort of detained persons:

- Is the person known to the service?
- Has the person a history of violence or aggression towards him/herself and/or others?
- Is there any indication of intent to harm at the present time?
- Are any friends, relatives or pets likely to cause problems when the escorts arrive to remove the detained person to hospital?
- Does the person have a history of carrying weapons?
- Are there any weapons on the premises?
- Does the medical practitioner or MHO consider that the situation merits police assistance? If so, have the police been called?
- What medication is the person regularly taking?
- Has the person been sedated? If so, when and what was the medication and route of administration used?
- Does the person appear to be under the influence of alcohol or drugs?

This list is not exhaustive and serves only as an aide memoir for staff proceeding on escort duty. It is important that the senior nurse obtains as much information as possible from the medical practitioner and MHO in order to identify any risks that may be associated with each individual situation before sending nursing staff on escort duty.

***Best practice guidelines on managing a detention interview safely***

Best practice dictates that, in all cases, personnel should refer to their own agency's policies and guidelines, for example, lone workers and personal safety. The following are details that should be considered if the interview is being conducted in a community-based establishment:

- Conduct the interview in an area that is easily accessible to other staff who can be called on for help in the event of an emergency;
- Notify other staff of your whereabouts and the nature of the situation;
- If possible, try to use an interview room fitted with an alarm system and use it to notify other staff should a threatening situation arise;
- Remove obvious hazards from the area being used to conduct the detention interview;
- Balance issues of privacy with environmental safety and observational considerations;
- Consider having another member of staff present during the detention interview; and
- Give the person as much freedom as the situation safely allows and conduct the interview in the least restrictive manner bearing in mind the potential risk the person may pose to him/herself or others.

If the interview is being conducted in a private dwelling setting:

- Respect disagreements with the person over detention decisions and allow for non-confrontational explanations;
- Carry a mobile phone in the community;
- Ensure staff have undertaken appropriate management of aggression training.

## **Appendix C: Information Sharing**

Effective sharing of information and communication is vital during all procedures contained in this PEP; however, information sharing between agencies may raise potential problems in terms of confidentiality. Whilst it is central to the proper care of individuals that appropriate agencies have ready access to vital information, it is equally important that service users and their carers can be confident that personal information will be kept confidential and that their privacy will be respected.

Personal details listed below should be shared with other agencies in order for them to discharge their functions according to their duties of care (this list is not definitive and should be seen as a minimum requirement):

- Name of person;
- Address and contact telephone numbers;
- Date of Birth;
- Named Person's contact details;
- Advance Statement: is there one and where is it?
- Risk Assessment Summary; and
- A brief history of events leading up to the need for detention.

### ***How should information be shared?***

In sharing all appropriate information with other agencies, all involved personnel should ensure that the following guidelines are observed:

- Ensure all sensitive information is kept secure and confidential; and
- Personal details should not be left unattended.

Informed consent to information sharing should ideally be sought from the person, in writing, as part of the assessment process. In emergency situations this may not be possible and guidelines should be followed as far as is practicably possible.

### **Data Protection**

Confidentiality and data protection are linked, in that the unlawful disclosure of personal information would potentially be a breach of the [Data Protection Act 1998](#), which is a criminal offence. The Act provides that the following practices should be observed when dealing with personal data. These are:

- Personal data shall be obtained and processed fairly and lawfully (i.e. normally with the person's consent);
- Data may only be held for one or more specified and lawful purposes;
- Data must be adequate, relevant and not excessive for the purpose;
- Data must be accurate, and if not, must be amended and kept up to date;
- Data must not be kept longer than necessary;
- Personal data must be processed in accordance with the rights of the data subject;
- Data must be secure and there must be no unauthorised access, alteration, disclosure to third parties or accidental loss; and
- Transfer of data outside the European Economic area is restricted.

These points must be followed in conjunction with the [Human Rights Act 1998](#), which applies to all public authorities. It is also unlawful for a public authority to act in a manner inconsistent with the rights set out in the [European Convention on Human Rights](#) (ECHR). [Article 8](#) addresses the right to respect for private and family life, and while this right is not absolute, any breach must:

- Be in accordance with law, particularly in regard to confidentiality;
- Pursue a legitimate aim;
- Be supported by sufficient and relevant reasons; and
- Be proportionate to the risk observed.

A victim of a breach of human rights may pursue legal action up to one year after the alleged breach, accurate recording of procedures taken and information shared and with whom, is therefore crucial.

## Appendix D: Healthcare Professionals' Responsibilities

For the purposes of psychiatric emergency planning, and for this PEP in particular, the following definitions apply:

### ***The duty/on-call junior doctor/local co-ordinator:***

- Person who is responsible for receiving the detention certificate and discharging any immediate functions under the Act; and
- Liaises with the on-call psychiatric consultant to ensure an AMP is available to examine the patient as soon as is practicable after the EDC has been granted.

### ***Nurse in charge of the escort team***

- Takes charge of the escort team;
- Gathers all available information on the situation;
- Prepares the strengths of the team to the risks involved;
- Has medication prescribed and dispensed;
- Decides on the best methods of communication;
- Risk assesses the situation on arrival;
- Administers medication if necessary and appropriate;
- Takes receipt of the [Emergency Detention Certificate](#) (DET1) and checks that it is completed correctly and signed;
- Calls for police assistance if necessary;
- Minimises stress for all concerned.

### **Hospital Managers**

The Act places a responsibility on Hospital Managers to discharge certain functions. As the definition of 'hospital manager' may refer to a variety of roles within the NHS, clarification is required.

**a) The senior nurse on the admitting ward:**

- Informs persons as defined in the DET1 within 12 hours of granting of the certificate;
- Completes relevant sections of the DET1;
- Responsible for ensuring that medical records receive the certificate as promptly as possible; and
- Arranges for the patient to be examined by an AMP as soon as practicable after detention begins.

**NB** Acute hospital management services should make local arrangements with psychiatric and learning disability providers to ensure the availability of AMPs to act as the RMO for such a patient

**b) The Medical Records Officer, for the admitting hospital:**

- Responsible for notifying any body or agency (e.g. Mental Welfare Commission, Social Work Department, etc.) of someone's detention status;
- Completes the final page of the DET1 and sends a copy to the Mental Welfare Commission within 7 days, a copy should also be kept in the patient's case notes;
- Notifies various persons, by letter, within 7 days (see DET1); and
- Where the EDC was granted without MHO consent, informs the local authority for the area where the patient resides/or the area where the hospital is situated, of the detention.

## Appendix E: Emergency Tranquillisation

Subject(M1)	<b>Medication</b>		
Title	<b>PRESCRIBING, PREPARATION AND ADMINISTRATION OF MEDICATION FOR EMERGENCY TRANQUILLISATION DURING NURSE ESCORT DUTY</b>		
Manual	<b>Mental Health – BLUE</b>	Procedure No	<b>M1-P1-MH</b>
Department	Pharmacy	Procedures	<b>All</b>
Author	Rae McKnight	Review	2
Reviewer	Ian Wright	Implementation Date	01-12-99
Status	Approved 04	Last review date	March 2010
Approved by		Next Review date	March 2012
Clinical Pharmacy Manager			
K&L CHP Lead Nurse			

### 1 FUNCTION

- 1.1 To ensure the safe, appropriate and effective use of medicine for the emergency tranquilisation of community patients detained under the terms of The Mental Health (Care and Treatment) (Scotland) Act 2003 and who require nurse escort to effect emergency admission to an NHS Fife inpatient unit.

### 1 LOCATION

- 2.1 NHS Fife Mental Health Service

### 2 RESPONSIBILITY

- 3.1. All practitioners who may be required to, prescribe, prepare and administer medication to patients subject to detention in the community and who require urgent escorted admission from the community to hospital.

### 3 OPERATIONAL SYSTEM

- 4.1 The prescriber must ensure as far as possible that the patient has no physical contra-indication to the use of benzodiazepine and/or antipsychotic medicines.
- 4.2 The prescriber must establish where possible whether any emergency tranquillisation has already been given and by whom including the name of the medication, the dose, the route and the time of administration. This information may influence the choice and timing of any subsequent medication prescribed for this patient.
- 4.3 The prescriber must prescribe medication, which may be required for emergency tranquillisation during escort duty on a medicine kardex in the "Once Only" section. The name of the patient, his / her date of birth and unit number, if known, must be written on the kardex. More than one dose of each drug may be prescribed if considered necessary.
- 4.4 The prescriber must complete a form T4 where medication has been given without consent, but under the authority of section 243, Mental Health (Care and Treatment) (Scotland) Act 2003. The form must be sent to the Mental Health Act Administrator at medical records, who will notify the Mental Welfare Commission within 7 days.
- 4.5 All medication listed in the Management of Acutely Disturbed Adult Patients: Guidelines for Rapid Tranquillisation (M1-G2-MH) may be used with this policy. Particular issues regarding medication are listed below.

#### 4.6 INTRAMUSCULAR LORAZEPAM

**N.B. In the interest of patient care, it has been agreed by Senior Nurse Management that staff can disregard the off label use as specified below, only for this situation**

- 4.6.1 Intramuscular Lorazepam 2mg is recommended as the standard treatment in an average weight adult.
- 4.6.2 **NOTE:** To make the use of Lorazepam practical for use within the scope of this policy, Lorazepam injection for intramuscular use must be prepared immediately before transit to the patient's location by dilution with an equal volume of water for injections or sodium chloride 0.9% for injection. The prepared syringes must be labelled clearly and transported in a suitable transit box. (The prepared injection must then be administered within six hours of preparation). **This would however be regarded as "off label use" see the manufacturers guidance below.**
- 4.6.3 Current manufacturer's advice, following a Medicines and Healthcare products Regulatory Agency (MHRA) review, is that Lorazepam should be prepared immediately before use. The manufacturer states that the

stability of the ampoules and prepared injection is only 20 to 30 minutes at temperatures above 2°C to 8°C.

**N.B. In the interest of patient care, Senior Nurse Management has reviewed and overridden the guidance below, only in this situation**

4.6.4 The NMC guidelines (Standard 14 published 2007 / 2008), state that "Registrants must not prepare substances for injection in advance of their immediate use".

4.6.5 A dose adjustment may be required in underweight, overweight or elderly patients based on the BNF recommended dose of 25-30micrograms per kilogram bodyweight.

4.6.6 Midazolam injection 5mg in 1ml could be used as an alternative to Lorazepam injection if necessary. See appendix 5.4.

**4.7 INTRAMUSCULAR HALOPERIDOL AND INTRAMUSCULAR PROCYCLIDINE**

4.7.1 Haloperidol 5mg (Elderly Patients 2mg) may be prescribed if the patient is known to the prescriber and where the use of benzodiazepines is either contraindicated or the patient does not respond to / tolerate benzodiazepines.

4.7.2 Intramuscular Procyclidine 5mg must also be prescribed in the as required section of the medicine kardex in case the patient experiences a dystonic reaction following the administration of Haloperidol injection.

4.7.3 In some cases both Lorazepam and haloperidol injection will be required. Staff may decide that both should be available depending on the individual circumstances. This would be most likely in the case of patients unknown to the Prescriber / Nurses / other staff involved.

4.7.4 Other medication may be required as outlined in the Management of Acutely Disturbed Adult Patients: Guidelines for Rapid Tranquillisation (M1-G2-MH).

**4.8 PREPARATION OF THE MEDICATION AND TRANSIT**

4.8.1 The syringes with the prescribed medication must be prepared by a registered nurse going on escort duty. Each syringe must be clearly and correctly labelled with the name and strength of the medication using the pre-printed labels provided by Pharmacy Services. The nurse who prepares each syringe must complete the label with the batch number, the time of preparation and his / her initials. The preparation and labelling of the syringes is checked by a second nurse who will

also be going on escort duty. (N.B See NMC Standard 14 and 4.5.2 above).

- 4.8.2 Further supplies of pre-printed labels for identification of each syringe prepared for use during nurse escort duty are available from Pharmacy Services, Pentland House, Lynebank Hospital, Dunfermline, telephone number 01383 565343.
- 4.8.3 Prior to transit, the prepared labelled syringes are placed in the ward transit box (supplied by Pharmacy) reserved for this purpose. The senior nurse on escort duty is responsible for the transit box and its contents at all times.

#### **4.9 PRECAUTIONS FOR ANAPHYLAXIS / HYPERSENSITIVITY TO MEDICATION**

- 4.9.1 Anaphylaxis / hypersensitivity to medication rarely occurs, however, precautions for such an event require that **no** medication be administered by injection until the paramedic staff have arrived and the medicines and equipment required in a medical emergency are readily available.
- 4.9.2 If there is significant risk of self-harm to the patient or physical harm to others before the arrival of the paramedic staff, the senior nurse on escort duty may decide that the administration of medication is essential immediately. In the event of an adverse drug reaction, the emergency services should be called immediately, by dialling 999.
- 4.9.3 Adrenaline (epinephrine) must be available at all times and staff must have received anaphylaxis training. See Operational procedure for the management of anaphylaxis [R2-5](http://intranet.fife.scot.nhs.uk/uploadfiles/publications/R2-5%20Anaphylaxis.doc).  
<http://intranet.fife.scot.nhs.uk/uploadfiles/publications/R2-5%20Anaphylaxis.doc>

#### **4.10 ADMINISTRATION OF MEDICATION**

- 4.10.1 The senior nurse on escort duty determines the requirement for administration of medication by the clinical presentation of the patient and / or the time of any previous medication that may have been given.
- 4.10.2 The nurse on escort duty who prepared the medication normally administers any medication required before or during escort to hospital. The senior nurse on escort duty may delegate this duty to a second nurse on escort duty in an emergency situation.
- 4.10.3 A record of the time of administration and signature of the administering nurse is completed on the kardex immediately or as soon as the clinical situation allows.

- 4.10.4 Any used syringes and needles are disposed of immediately in a small CINBIN for disposal of sharps. (Needs to be labelled “contains mixed pharmaceutical waste and sharps” if ampoules are disposed of in this CINBIN).
- 4.10.5 Any unused medication is returned to the ward for destruction or to be returned to stock. Syringes / needles returned to the ward should be disposed of in the ward CINBIN. The disposal of sharps is the responsibility the senior nurse on escort duty witnessed by a second nurse following the CHP Guidelines. The destruction of unused medication must be documented on the patient’s drug administration sheet. Unused medication can be disposed of in the ward CINBIN, but this should then be labelled “mixed pharmaceutical waste and sharps” for disposal.

#### **4.11 PATIENT MONITORING**

- 4.11.1 Any patient who has received any medication must be kept under constant observation with monitoring for vital signs as outlined in Management of Acutely Disturbed Adult Patients: Guidelines for Rapid Tranquillisation (M1-G2-MH) or more frequently as indicated.

### **5 RISK MANAGEMENT**

- 5.1 The purpose of this procedure is to minimise the risk to patients and staff
- 5.2 Ensuring safe and appropriate prescribing, administration and monitoring of rapid tranquillisation to patients within a community setting.

### **6 RELEVANT DOCUMENTS**

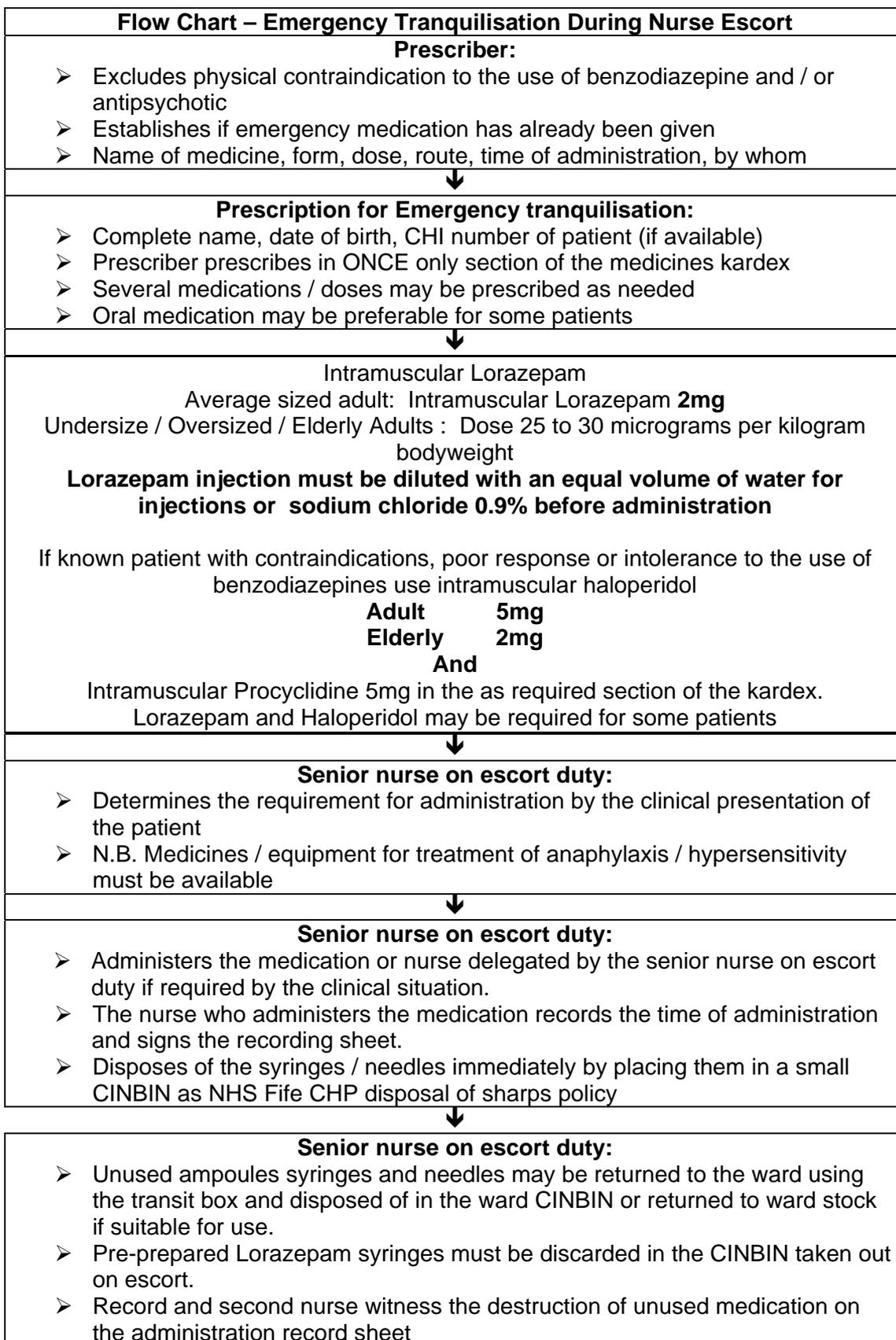
- 6.1 Flow Chart – Emergency Tranquillisation during Nurse Escort Duty
- 6.2 Appendix 5.2: Procedure for Rapid Tranquillisation (Adults 18-65 years)
- 6.3 Appendix 5.3: Procedure for Rapid Tranquillisation (Adults 65 years +)
- 6.4 Appendix 5.4: Prescribing, Preparation and Administration of Midazolam for Emergency Tranquillisation as an alternative to parenteral Lorazepam.

6.5 NHS Fife CHPs Operational procedure for the management of anaphylaxis [R2-5](#)  
<http://intranet.fife.scot.nhs.uk/uploadfiles/publications/R2-5%20Anaphylaxis.doc>

## **7 REFERENCES**

7.1 McALLISTER-WILLIAMS, R. HAMISH; FERRIER, I. NICOL. Rapid tranquillisation: time for a reappraisal of options for parenteral therapy. *B J Psychiatry* 2002; **180**; 485-489.

**Appendix 5.1: Flow Chart – Emergency Tranquilisation during Nurse Escort**



**Appendix 5.2: Procedure for Rapid Tranquillisation (Adults 18-65 years)**

Step	Intervention	
<b>1.</b>	<ul style="list-style-type: none"> <li>• Review the use of non-pharmacological strategies for managing an imminent risk of violence</li> <li>• Review the patients consent to treatment. Is it necessary to use the Mental Health Act?</li> <li>• Review their notes for previous medical history and recent investigations.</li> <li>• Consider physical examination</li> <li>• If necessary review the practice guidelines for the Management of Acutely Disturbed Patients: Guidelines for Rapid Tranquillisation.</li> <li>• Consult with a more senior doctor at any stage if unsure</li> </ul>	
<b>2.</b>	Consider using <b>oral medication</b> . The options are:	
	<p><b>Lorazepam 1 - 2mg (4mg/24hrs)</b></p> <p><b>Haloperidol 5 - 10mg (30mg/24hrs)</b></p> <p><b>Olanzapine 5 - 10mg (20mg/24hrs)</b></p> <p><b>Risperidone 1-2mg (16mg/24hrs)</b></p> <p><b>Quetiapine 100 - 200mg (800mg/24hrs)</b></p>	<p>Lorazepam works quickly, oral antipsychotics will take considerably longer. Therefore there may be some advantage in combining them.</p> <p>If the patient is benzodiazepine tolerant or has respiratory disease, consider using antipsychotics alone.</p> <p>If the patient is established on regular antipsychotics or has cardiovascular disease, consider using benzodiazepines alone.</p> <p>Avoid Haloperidol in neuroleptic naïve patients</p>
	<ul style="list-style-type: none"> <li>• Lorazepam may be repeated after 30 minutes</li> <li>• Doses of oral antipsychotics should not be repeated for at least 45-60 minutes</li> <li>• Doses can be repeated as necessary up to their maximum BNF doses. If two doses fail proceed to step 3.</li> <li>• Monitor the TPR of patients receiving frequent doses of oral sedatives at intervals agreed by the multidisciplinary team until the patient is active again.</li> </ul>	
<b>3.</b>	Consider using <b>intramuscular medication</b> if oral therapy unsuccessful or patient refuses / unable to take oral. The options are:	
	<p><b>Lorazepam 1 - 2mg (4mg/24hrs)*</b> (Dilute 1:1 with water for injections or 0.9% Sodium Chloride)</p> <p><b>Haloperidol 5 - 10mg (18mg/24hrs)</b></p> <p><b>Olanzapine 5 - 10mg (20mg/24hrs)</b></p>	<p>These 3 agents have a similar rate of onset of action. A combination of haloperidol and Lorazepam may have the greatest efficacy.</p> <p>If the patient is benzodiazepine tolerant or has respiratory disease, consider using antipsychotics alone</p> <p>If the patient is established on regular antipsychotics or has cardiovascular disease, consider using benzodiazepines alone</p> <p>Avoid using Haloperidol in neuroleptic naïve patients</p> <p>BNF maximum Lorazepam 4mg/24hrs although in emergency situations it may be necessary to prescribe higher doses.</p> <p><b>Intramuscular Lorazepam should not be given within 1 hour of I.M Olanzapine. Oral Lorazepam should be used with caution.</b></p> <p><b>Refer to MH -G4-MH (08) "Guidance Document on the Use of Intramuscular Olanzapine"</b></p>
	<ul style="list-style-type: none"> <li>• Intramuscular Lorazepam and Haloperidol may be repeated after at least 30 minutes</li> <li>• Intramuscular Olanzapine may be repeated after at least 1 hour</li> <li>• Doses can be repeated at recommended intervals up to their maximum BNF doses</li> <li>• Monitor the TPR of patients receiving any parenteral medication at intervals agreed by the multidisciplinary team until the patient is active again.</li> <li>• I.M. Procyclidine should be available if haloperidol is used due to the possibility of acute dystonic reactions occurring.</li> <li>* If IM Lorazepam is unavailable, See appendix 5.4 Prescribing, Preparation and Administration of Midazolam for Emergency Tranquillisation as an alternative to parenteral Lorazepam.</li> </ul>	
<b>4.</b>	Reconsider non-pharmacological measures and consult a senior colleague if you haven't already	
<b>5.</b>	Pharmacological options following response include:	
	<p><b>Zuclopenthixol acetate (Acuphase) 50 - 150mg. Maximum 400mg/2 weeks and 24hrs between doses</b></p> <p><b>Short reducing course of a long acting benzodiazepine, e.g. Diazepam 5mg tds reduced over 3 days</b></p>	<p>Acuphase may have a role in the ongoing management of a risk of violence once tranquillisation has been satisfactorily achieved. Acuphase should only be given after calming has been achieved, in those situations when it is likely that repeated doses of IM antipsychotics will be necessary</p> <p>May help to prevent a rapid recurrence of disturbance</p>

### Appendix 5.3: Procedure for Rapid Tranquillisation (Adults 65 years +)

Step	Intervention	
<b>1.</b>	<ul style="list-style-type: none"> <li>• Review the use of non-pharmacological strategies for managing an imminent risk of violence</li> <li>• Review the patients consent to treatment. Is it necessary to use the Mental Health Act?</li> <li>• For patients under the Adults with Incapacity Act 2000 ensure there is a Section 47 form completed.</li> <li>• Review their notes for previous medical history and recent investigations.</li> <li>• Consider physical examination</li> <li>• For physically fit patients, and those currently / previously treated with higher doses of antipsychotics, the protocol for younger adults may be more appropriate.</li> <li>• If necessary review the practice guidelines for the Management of Acutely Disturbed Patients: Guidelines for Rapid Tranquillisation.</li> <li>• Consult with a more senior doctor at any stage if unsure</li> </ul>	
<b>2.</b>	Consider using oral medication:	
	<p><b>Lorazepam 500micrograms - 1mg (4mg/24hrs)</b></p>	<p>Lorazepam works quickly, response should be seen within half an hour When using benzodiazepines ensure that the patients respiratory function is not compromised prior to their use e.g. patients with COPD</p>
	<ul style="list-style-type: none"> <li>• Lorazepam may be repeated after 30 minutes</li> <li>• Doses can be repeated as necessary up to their maximum BNF doses</li> <li>• Monitor TPR of patients receiving frequent doses of oral sedatives at intervals agreed by the multidisciplinary team until the patient is active again</li> <li>• If two doses fail proceed to step 3</li> </ul>	
<b>3.</b>	Consider using intramuscular medication if oral therapy unsuccessful or patient refuses / unable to take oral. The options are:	
	<p><b>Lorazepam 500micrograms - 2mg*</b> (Dilute 1:1 with water for injections or 0.9% Sodium Chloride)</p> <p><b>Haloperidol 1 - 5mg (9mg/24hrs)</b></p> <p><b>Olanzapine 2.5 - 5mg (20mg/24hrs)</b></p>	<p>These 3 agents have a similar rate of onset of action. A combination of haloperidol and Lorazepam may have the greatest efficacy. If the patient is benzodiazepine tolerant or has respiratory disease, consider using antipsychotics alone. If the patient is established on regular antipsychotics or has cardiovascular disease, consider using benzodiazepines alone. Avoid using Haloperidol in neuroleptic naïve patients. Olanzapine should be avoided in dementia-related disturbance. BNF maximum Lorazepam 4mg/24hrs although in emergency situations it may be necessary to prescribe higher doses. <b>Intramuscular Lorazepam should not be given within 1 hour of I.M Olanzapine. Oral Lorazepam should be used with caution. Refer to MH -G4-MH (08) "Guidance Document on the Use of Intramuscular Olanzapine"</b></p>
	<ul style="list-style-type: none"> <li>• Intramuscular Lorazepam and Haloperidol may be repeated after at least 30 minutes</li> <li>• Intramuscular Olanzapine may be repeated after <b>at least 2 hours</b></li> <li>• Doses can be repeated at recommended intervals up to their maximum BNF doses</li> <li>• Monitor the TPR of patients receiving any parenteral medication at intervals agreed by the multidisciplinary team until the patient is active again.</li> <li>• I.M. Procyclidine should be available if haloperidol is used due to the possibility of acute dystonic reactions occurring.</li> <li>* <b>If IM Lorazepam is unavailable, See appendix 5.4 Prescribing, Preparation and Administration of Midazolam for Emergency Tranquillisation as an alternative to parenteral Lorazepam.</b></li> </ul>	
<b>4.</b>	Reconsider non-pharmacological measures and consult a senior colleague if you haven't already	
<b>5.</b>	Pharmacological options following response include:	
	<p><b>Zuclopenthixol acetate (Acuphase) 50-100mg. Maximum 400mg/2 weeks and 24hrs between doses</b></p> <p><b>Short reducing course of a long acting benzodiazepine. E.g. Diazepam 2mg tds reduced over 3 days</b></p>	<p>Acuphase may have a role in the ongoing management of a risk of violence once tranquillisation has been satisfactorily achieved Acuphase should only be given after calming has been achieved, in those situations when it is likely that repeated doses of IM antipsychotics will be necessary</p> <p>May help to prevent a rapid recurrence of disturbance</p>

**Appendix 5.4: Prescribing, Preparation and Administration of Midazolam for Emergency Tranquillisation as an alternative to parenteral Lorazepam.**

Indications	Properties of Midazolam	Comparative properties of Lorazepam
<p><b>To be used in Rapid Tranquillisation when IM Lorazepam is unavailable.</b></p> <p>IV Flumazenil should always be available for use when administering IM benzodiazepines</p>	<p>Absorption after IM injection is rapid and complete. Maximum plasma concentrations in 30 minutes Absolute bioavailability is 90%. Metabolised by CYP3A4. Active metabolites exist. Elimination half life 1.5-2.5 hours. Excreted mainly renally.</p> <p><b>Dose 7.5mg (1.5ml of 10mg / 2ml amp) Repeated ONCE after 1 hour if required, up to a maximum of 15mg / 24 hours.</b></p> <p><b><u>How to administer:</u> No Dilution Required. Ampoules contain Midazolam 10mg / 2mL. Draw and administer deep IM.</b></p> <p>A Doctor should be available when administered. Switch to oral Lorazepam at the earliest opportunity. Midazolam cause respiratory depression at higher doses when administered by rapid IV injection.</p> <p><b>Midazolam is in BNF section 15 (not 4) so beware of patients subject to MHA act restrictions. T2 &amp; T3 Forms.</b></p> <p><b>N.B.</b> Midazolam is a schedule 3 Controlled drug. Therefore wards / departments must order it in their controlled drug order books. It does not require recording in the ward / department controlled drug register.</p>	<p>IM injection is readily and completely absorbed. Maximum plasma concentrations in 60-90 minutes. Metabolised by one-step glucorinidation. No active metabolites exist. Elimination half life 12-16 hours.</p> <p>Dose 1-2mg. Repeated at 30 minute intervals if required up to maximum of 4mg / 24hours.</p> <p><b><u>How to administer:</u></b> Dilute 1:1 with WFI or NaCl 0.9% and give IM.</p>

Midazolam IM has been approved by the NHS Fife Drugs and Therapeutics Committee for use in rapid tranquillisation, where a shortage of Lorazepam injection exists. NB Midazolam is not licensed for use in rapid tranquillisation.

## Monitoring

<ul style="list-style-type: none"> <li>• <b>Alertness</b></li> <li>• <b>Temperature</b></li> <li>• <b>Pulse</b></li> <li>• <b>Blood pressure</b></li> <li>• <b>Respiratory rate</b></li> </ul>	<p>every 5 to 10 minutes for 1 hour <b>then</b> every 15 minutes until patient is ambulatory <b>then</b> continue to monitor alertness, mental state and behaviour</p> <p>Restart physical observations if there are any concerns</p>
<p><b>Fluid balance &amp; electrolyte balance</b> should be monitored as clinically indicated</p>	
<p>If a patient is unconscious <b>continuous pulse oximetry</b> is recommended to monitor oxygen levels. The level of alertness should be assessed by attempting to wake a sleeping patient.</p>	

Dosage in elderly patients and those with pre-existing medical conditions

A **2.5mg**, (0.5ml from a 10mg in 2ml ampoule), dose is recommended in the elderly and those patients with pre-existing significant respiratory disease, significant hepatic disease and those patients currently taking opiates (additive respiratory depression may occur), either prescribed or illicit. This dose may be repeated every 30 to 60 minutes with careful monitoring and with monitoring as above. Recommended maximum dose is 15mg in 24 hours. Due to the relatively short half life accumulation is unlikely.

Whenever I.M Midazolam is administered, the patient should be carefully monitored. N.B. Anaesthetists would recommend constant observation until the patient is fully ambulant. The short half life of the drug results in rapid recovery from the sedative effects of the drug and could lead to re-emergence of the agitated state. Oral Lorazepam should be offered if possible prior to further doses of I.M Midazolam being administered to provide a longer clinical effect. The combination of IM Midazolam and oral Lorazepam would be expected to increase the risk of respiratory depression.

## References

British National Formulary 49, March 2005. British Medical Association, Pharmaceutical Press.

Electronic Medicines Compendium, Summary of Product Characteristics for Lorazepam and Midazolam. Via [www.emc.medicines.org.uk](http://www.emc.medicines.org.uk)

TREC Collaborative group, Rapid Tranquillisation for agitated patients in emergency psychiatric rooms: a randomised controlled trial of Midazolam vs. haloperidol and Promethazine. BMJ 2003; 327:708-713.

D Taylor, C Paton and R Kerwin, Taylor and Francis Group, the South London and Maudsley NHS Trust Oxleas NHS Trust 2005-2006 Prescribing Guidelines 8<sup>th</sup> Edition.

Norfolk and Waveney Mental Health Partnership NHS Trust, Interim guidelines on the Administration of IM Midazolam in adults, only in the case of shortage in IM Lorazepam supply

## Appendix F: Contact Numbers

<b>Ambulance Control</b>	Advance Bookings	<b>0131 446 2844</b>
	Urgent	<b>0845 602 3999</b>
<b>Consultant Psychiatrists (LD advice)</b>	Royal Edinburgh Hospital	<b>0131 537 6000</b>
<b>Duty MHO</b>	Mental Health Officer Team Elizabeth House 1a-1b Barclay Court Carberry Road Kirkcaldy KY1 3WE	<b>01592 583652</b>
	Out of hours	<b>08451 550099</b>
<b>Lynebank Hospital</b>	Halbeath Road Dunfermline	<b>01383 623623</b>
<b>Ninewells Hospital</b>	Dundee	<b>01382 660111</b>
<b>Pharmacy Services</b>	Pentland House Lynebank Hospital Dunfermline	<b>01383 565341</b>
<b>Police</b>	Force Contact Centre	<b>0845 600 5702</b>
	Emergency	<b>999</b>
<b>Queen Margaret Hospital</b>	Whitefield Road Dunfermline	<b>01383 623623</b>
<b>Stratheden Hospital</b>	Cupar	<b>01334 652611</b>
<b>Victoria Hospital</b>	Hayfield Road Kirkcaldy	<b>01592 643355</b>
<b>Whyteman's Brae Hospital</b>	Whyteman's Brae Kirkcaldy	<b>01592 643355</b>

## **Notes**

