GUIDELINES FOR THE MANAGEMENT OF ACUTELY DISTURBED PATIENTS & THE USE OF RAPID TRANQUILISATION (RT)
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Part one

Background
**Guidelines for the Management of Acutely Disturbed Patients**

These guidelines should be read in conjunction with the following complementary guidance which is available on the HUMBER NHS FOUNDATION Trust Intranet: -

- **Advance Directives**
- Debriefing
- Control and Restraint
- Rapid Tranquillisation
- Observation Policy
- Seclusion / time out
- Mental Health Act
- Mental Capacity Act
- Treatment of Drug / Alcohol withdrawal (in review)
- Procedures for the Safe and Secure Handling of Medicines
- CPR – Resuscitation Policy
- Search
- Serious Untoward Incident reporting

**Introduction**

Acute behavioural disturbance in psychiatric patients may require urgent treatment. This may result from psychotic symptoms, such as persecutory delusions or command hallucinations or alternatively from non – psychotic symptoms such as high levels of anxiety (Atakan and Davies 1997)

The Royal College of Psychiatrists guidelines on the Management of Imminent Violence (1998) identifies that environmental factors may play an important role in increasing the potential for violence and aggression, including:
- Overcrowding
- Lack of privacy
- Lack of activities
- Long waiting times to see staff

The short term management of disturbed (violent) behaviour in psychiatric in patient settings. NICE Guidelines February 2005 recommends:-

- Short term management – up to 72 hours
- Measures to reduce violence need to be based on comprehensive risk assessment and risk management.
- Risk assessment must be ongoing and care plans based on an accurate and thorough risk assessment.
- Actional tools and structured clinical judgement must be used in a consistent way to assist in risk assessment.
- Risk assessment must be multidisciplinary and reflective of the care setting.
- Risk factors must be communicated across care settings.
- Risk assessment should include an interview with the patient and where appropriate with carers.
- Care needs to be taken not to make negative assumptions based on ethnicity. There should be awareness that different cultures may express behaviour that is familiar to
that culture but unfamiliar to others and could be interpreted as being aggressive. National evidence demonstrates that BME groups are more likely to be treated with RT.

The clinical management of acutely disturbed patients involves elements including risk assessment to try to prevent the escalation of disturbed behaviour, “talking down” patients, containment and minimisation of risk to others. Where appropriate if English is not the individuals first language staff should endeavour to find an interpreter. Consideration will be given to individual needs and requirements regarding language, culture and secondary disability.

If non-pharmacological methods have failed to resolve the situation and oral medication is not an option then rapid tranquillisation with intramuscular or intravenous anti-psychotics, benzodiazepines or other sedative drugs may be indicated.

Scope

- Rapid Tranquillisation must only be undertaken on hospital premises where there is emergency defibrillation equipment, and there are staff trained to use them within the clinical area 24 hours a day.
- The guidelines apply to all patients admitted to adult inpatient services aged over 18 years old.
- It is recognised that on rare occasions, this policy will be applied to older adolescents (aged 17 to 18) when they are admitted to adult inpatient units.
General Principles for the Management of Disturbed Behaviour

1. Where possible (in the form of an advanced directive) intervention strategies for the management of disturbed / violent behaviour should be negotiated with all patients at the point of admission to inpatient strategies. These strategies must be documented in the patients care plan and healthcare records, subject to agreement from the patient. A copy should also be given to their carer (NICE guideline CG25). Consideration will be given to individual needs and requirements regarding language, culture and secondary disability.

2. The initial response should be to provide structure, reduce stimulation and try to verbally reassure and calm the person (Osser and Sigadel, 2001).

3. Early intervention is desirable as disturbed behaviour can be calmed down by the use of de-escalation also described as ‘defusing’ or ‘talking down’. These techniques are defined as a set of verbal and non-verbal responses, which if used selectively and appropriately reduce the level of a person’s hostility by reducing anger and the predisposition to assaultative behaviour (Leadbetter and Paterson 1995).

4. Continuous observation may also be a useful method for managing patients representing an acute risk (see trust observation policy). Shugar and Rehaluk (1990) evaluated continuous observation and found brief episodes of observations for less that 72 hours can be effective and practical. Clinical review should take place if more than 72 hours of observation are required.

5. Behavioural interventions may also be useful with the aggressive patient (Corrigan et al 1993). These may include:
   - Diversional activity
   - Use of a safe designated area or room specifically for the purpose of reducing arousal and / or agitation (NICE CG 25 Feb 2005).
   - Use of a low stimulus environment, where staff support and counsel a patient for short periods (15mins) in a specifically allocated quiet area (Hyde and Harrower – Wilson 1994).
   - Self controlled ‘timeout’ – (see Trust Policy and Mental Health Act Code of Practice, Department of Health and Welsh Office 1993). Patients undergo short-term removal for a few minutes from over stimulating situations, the emphasis being on their control over the process, with the patient’s agreement and understanding of their care plan.

6. Physical means of restraint may be necessary. This should only ever be considered after the failure of attempts to promote full participation in self-care as described above. The most important criterion for its use is that control and restraint must be performed by staff who are fully trained to apply it in a safe, rapid and effective manner. It is also recommended that at least 3 members of staff trained to these standards are available – (Royal College of Psychiatrists 1998) – See HUMBER NHS FOUNDATION Trust policy.

7. Seclusion should only ever be considered as an emergency short-term measure to contain or deal with a situation when all other psychological, behavioural and pharmacological approaches have failed or are inappropriate. It differs from restraint in
that all social contact and interaction is removed. The Mental Health Act Code of Practice defines seclusion as ‘supervised confinement of a patient alone in a room which may be locked for the protection of others from significant harm’ (Department of Health and Welsh Office 1999) – See HUMBER NHS FOUNDATION Trust Policy.

8 In some cases police assistance may be needed. The police must always be called if the patient is armed with any kind of weapon, as only the police should attempt to disarm the patient.

9 In some cases where individuals are acutely disturbed and a risk to themselves or others emergency medication is required – see guidelines re rapid tranquillisation.

10 The situation will be managed by the nurse in charge of the unit. As soon as the situation gives rise for concern the unit / on call doctor should be contacted to attend the unit immediately.

11 The senior nurse and operational services manager / on call manager must be informed immediately where the situation is considered to put patient and / or staff at risk and where there are implications for needing support such as extra staff, debriefing and related resources.

12 Where a patient’s presentation requires additional intervention, transfer to an environment where Rapid Tranquillisation interventions can occur may need to be considered.

13 Transfer should only occur when the patient is detained under the Mental Health Act (1983).

14 Transfer of the patient should not occur by Car. There should always be a nurse escort for the patient.

15 If the patient is likely to be violent or dangerous the Police should be asked to assist in the conveyance, where possible an ambulance should be used otherwise a Police vehicle “suitable for conveying such a patient should be used” (M.H.A 1983 – Code of Practice D.O.H.1999)
Clinical Indications for the Use of Rapid Tranquillisation

Definition

Rapid Tranquillisation means the use of drug treatments to achieve rapid, short term behavioural control of extreme agitation, aggression and potentially violent behaviour that places the individual and those around them at risk of physical harm (Broadstock, 2001).

Aim

The aim of drug treatment in such circumstances is to calm the person / achieve sedation sufficient to minimise the risk posed to the person themselves or to others, rather than treat the underlying psychiatric condition. The individual should be able to respond to spoken messages throughout the period of sedation (Royal College of Psychiatrists 1999).

As required (PRN) V Rapid Tranquillisation

There is a clear distinction between Rapid Tranquillisation which is a planned intervention of consistent treatment with a specific aim to calm the patient and achieve sedation which is sufficient to minimise the risk posed to themselves or others. It is likely to last for several hours or even days however, PRN treatment, is usually based on sudden acute clinical need and may follow an unpredictable treatment course. In this acute clinical situation the accumulative doses of PRN and regularly prescribed medication may exceed British National Formulary dose ranges and induce inappropriate side effects in combination. It is advisable therefore in the acute clinical situation that following PRN treatment of antipsychotics e.g. Haloperidol and / or Benzodiazepines e.g. Lorazepam that the patient response to treatment is regularly and systematically reviewed in order to make an informed assessment regarding future indication for RT.

The clinical decision to implement RT will be based on the following criteria:

- Has review of patient’s current management plan taken place? (See flow chart in clinical guidelines).
- Review unsuccessful RT required.
- Are there enough staff on the unit.
- Are staff trained as recommended in the guidelines.
- Is emergency equipment available / accessible?
- Is Flumazenil available / accessible?

If any of the above criteria is not met transfer to unit who meets the criteria must be considered. (See flow chart).
Management Pathway

Patient presents as acutely disturbed.

Review current management plan
- Current prescription / use of PRN
- Increase in regular medication
- Increase in obs levels
- Increase in staff resource
- Removal to low stimulus environment
- Mental Health Act Status

Does patient require RT?

NO
- Review of management plan successful

YES
- Is unit equipped to implement RT policy?
  - I.e. Are staff trained in C & R, CPR and RT administration and monitoring?
  - Does unit carry emergency equipment?
  - Are there enough staff available to implement policy?

NO
- Contact identified RT Resourced units
  - Describe patient presentation, risks and current management.
  - If appropriate arrange transfer via police assistance if necessary

YES
- Implement medical and nursing guidelines for administration of RT.
General Principles/Implementation points for Rapid Tranquillisation

The below points are adapted from the Royal College of Psychiatrists clinical practice guidelines on the management of imminent violence 1998, NICE Clinical Guideline – Schizophrenia Core interventions in Treatment and management of Schizophrenia in primary and secondary care – CG 82 March-09 and the short term management of disturbed (violent) behaviour in psychiatric inpatient settings (NICE CG 25 Feb-05)

Expected standards of good practice to be achieved.

- Be aware of General Principles / Implementation points before incidents arise.
- The most senior nurse on duty will take the lead with regards to the management of the situation and must be kept informed.
- A medical officer should be available at all times within ½ hour of an alert by staff.
- Take a history, from the patient and those who know the patient. And where possible collect information from previous contact with services. Consideration will be given to individual needs and requirements regarding language, culture and secondary disability.
- Complete a mental state examination and a physical examination. Information from previous examinations should be made available. Consideration must be given to cultural and gender needs of each individual e.g. same sex chaperone. Information from previous examinations should be made available and whether there is cultural and religious information that should be taken account of e.g. fasting.
- Consider age, previous history of adverse reactions to certain medications, drug interactions, concurrent medication, illicit drug use, signs of organic brain disorder and patient preferences e.g. Advance Directives.
- Establish a provisional diagnosis: is mental disorder present or likely?
- At the earliest opportunity, a full assessment including consideration of the medical and psychiatric differential diagnosis, should be undertaken in conjunction with the multi disciplinary team and a discussion as to whether or not emergency medication / rapid tranquillisation should continue as an intervention
- Consider legal status and follow correct procedure (See Mental Health Act 1983 and Department of Health Welsh Office Code of Practice 1999).
- Oral medication should be offered before parenteral use See: Clinical Pathway for Medical Staff in the Management of Acutely Disturbed Patients.
- The total dose of medication prescribed must be reviewed at least every 24 hours by the responsible consultant or nominated deputy in conjunction with the multi disciplinary team.
• The multi disciplinary team should include a specialist mental health pharmacist.
Risks associated with Rapid Tranquillisation

Taken from the Royal College of Psychiatrists guideline on the Management of Imminent Violence (1998), NICE Clinical Guideline –Schizophrenia Core intervention in Treatment and management of Schizophrenia in primary and secondary care – NICE CG 82 Mar-09 and the short term management of disturbed (violent) behaviour in psychiatric inpatient settings (NICE CG 25 Feb-05)

Staff should be aware of the following risks

- Inadequate sedation can risk patient exhaustion, dehydration and increases the risk of violence.
- Over sedation can lead to loss of consciousness or reduced alertness.
- Minor injuries and bruising may be present, especially if restraint has been used.
- Prominent side effects with medication such as akathisia, Parkinsonian side effects, lowered seizure threshold, respiratory depression or arrest, hypotension and cardiac complications, neuroleptic malignant syndrome.
- Possible damage to the patient – clinician relationship.
- Damage to the patient’s future concordance with maintenance treatment.
- Warnings concerning the complications of rapid tranquillisation should be taken particularly seriously if the individual is in seclusion. Due to the serious risk to life patients who are heavily sedated or using drugs or alcohol should not be secluded.
- Careful monitoring of the patient’s mental and physical observations is paramount. Tranquillisation should be immediately stopped and emergency medical attention called if: -
  - Respiratory rate falls below 10 breaths per minute
  - Pulse rate increases rapidly
  - Cyanosis develops
  - Systolic blood pressure falls to less than 80
Part two
Nursing Guidelines
Clinical Pathway for Nurses- Management of Acutely Disturbed Patients

1. The senior nurse on duty will take the lead with regards to the management of the situation and must be kept informed of any changes.

2. Plans for the management of individual patients who are acutely disturbed should normally be made in advance and in discussion with the multi-disciplinary team. Consideration will be given to individual needs and requirements regarding language, culture and secondary disability.

3. Consider de-escalation techniques e.g. “talking down” the patient. Attempt to verbally reassure and calm the patient. Where appropriate if English is not the individuals first language staff should endeavour to find an interpreter. Consideration will be given to individual needs and requirements regarding language, culture and secondary disability.

4. Consider behavioural interventions: -
   - Diversional Activities
   - Time out
   - Use of low stimulus environment

5. Review level of supportive observation and the possible need for extra staff resources. Consider Patients Status under the Mental Health Act (1983).

6. As soon as the client behaviour gives rise for concern, contact the unit / on call doctor and request immediate attendance – ensure past clinical information regarding the patient is available.

7. Inform the Senior Nurse and Operational Service Manager / On Call Manager of the situation and possible implications for extra support and resources.

8. Ensure emergency resuscitation equipment and drugs are available and easily accessible.

9. Offer Prescribed oral medication in accordance with the medical guidelines

10. If oral medication refused, I/M medication must be considered

11. Information on medications containing animal production and their alternatives can be sought from Trust Pharmacy

12. Ensure calculation of concurrent medication administered is taken into consideration when doctors are prescribing emergency medication and or rapid tranquillisation.

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1 Velotab and quicklet formulations contain bovine gelatine which may have implications for certain individuals who do not consume such animal products or beef on the grounds of belief

2 Where there are religious requirements for an individual to fast these should be taken into consideration
13. Note dose variances between oral and IM routes

14. Intramuscular injections should be given in the upper outer quadrant of the buttock. The site should be alternated for repeated injections and Z tracking method to be employed

15. Further information on drugs in section under recommended drug & dose. The patient should be observed closely at all times. Blood Pressure, Pulse and respirations should be taken and monitored every 15 minutes following intramuscular injections and oral medication unless otherwise is stated. Complete relevant observations documentation – medical review should take place following the first hour. It is the doctor’s responsibility to decide whether observations can be discontinued or to specify what further observations are required.

16. If respiratory rate falls below 10 breaths per minute, treat as a medical emergency.

**Dial 999 and transfer to the A & E department in the absence of medical direction.**

17. Physical restraint may be necessary if behaviour is escalating. Refer to HUMBER NHS FOUNDATION TRUST Violence and Aggression policy guidelines.

18. If behaviour continues to escalate police assistance must be considered. The police must be called if the patient is armed or that the patient is suspected to be armed with any kind of weapon. Only the police should attempt to disarm a patient.

19. Document the incident clearly and fully. Outline the context i.e. Precipitants, victim, weapon, severity, actions taken, outcome and subsequent revisions to the management plan. Demonstrate the decision process and rationale for final actions taken.

20. Contact the patients Consultant / RMO / On Call Consultant and inform of the incident requesting urgent medical review which must be done within 24 hours of the incident.

21. Ensure privacy, dignity and safety is considered at all times. Consider patient preference.

22. Consider the appropriateness of visitors at this point. Inform relatives / carers of the situation with the patients consent.

23. The patient to be offered the opportunity to discuss their experience and be provided with a clear explanation of the decision to use emergency medication. This should be documented in the patient’s notes.

24. Nursing staff involved must be given the opportunity to reflect on the situation and be offered debriefing.- (See trust policy)

25. The use of seclusion should only ever be considered as an emergency measure and when all other approaches have failed.
**MANAGEMENT OF ACUTELY DISTURBED PATIENTS (NURSING GUIDELINES)**

**Most senior Nurse on duty to take the lead**

**Consider Non drug measures**
- "talking down", low stimulus environment, "time-out", distraction

**Review level of supportive obs & possible need for extra staff resource**

**Unsuccessful/inappropriate**

**Ensure emergency resus equipment & drugs (including flumazenil) are available & easily accessible**

**Ensure past clinical information is available**

**As soon as situation gives rise for concern contact unit/on call doctor. Inform senior Nurse & OSM/on call manager.**

**Offer prescribed oral meds – (see medical guidelines)**

**Begin observations: BP, Pulse & Respiration.**

**Oral / IM medication: every 15mins for 1 hour or more frequently if indicated. After 1st hour, medical review of observations to take place.**

**Remember:- Dose equivalents for oral & I/M for calculation of concurrent meds.**

**Take care when injecting I/M into a struggling patient, bolus injection may result**

**I/M injections to be given in the upper outer quadrant of the buttock - site rotated for repeated injections**

**If respirations fall below 10 per min – ensure Flumazenil is available (see medical guidelines)**

**Treat as medical emergency – Dial 999 Transfer to A & E in the absence of medical direction**

**Document incident, actions taken & outcomes**

**Contact patients consultant/on call consultant. Inform of incident and request 24 hour medical review**

**Inform relatives/carers with patients consent**

**Offer the opportunity to discuss experience when calm. Give clear explanation of the decision to use emergency meds. Document in patient’s notes.**

**Organise reflective practice meeting & debriefing for Nursing Staff involved**

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**Nursing Care Guidelines following emergency medication / RT**

1. A named nurse should be designated by the nurse in charge of the ward to observe the patient for the first hours after the administration of medication on an emergency basis and he/she be relieved of all other duties.

If medication is administered to the patient either orally or I/M, the designated nurse will record at 15 min intervals for one hour the patient’s pulse, blood pressure, respiratory rate and level of consciousness. More frequent observations may be indicated e.g. every 5 mins.

If the patient is asleep and unconscious the use of pulse oximeter to continuously measure oxygen saturation is desirable. A nurse should remain with the patient until they are ambulatory again.

- If I/M medication is prescribed DO NOT MIX IN SAME SYRINGE
- If Haloperidol is administered temperature to be taken hourly for 3 hours.

Ensure patient Privacy, dignity & safety. Consider patient preference

- Baseline ECG recommended prior to treatment in all patients, especially in the elderly and patients with a positive personal or family history of cardiac disease or abnormal findings on cardiac clinical examination.

- During therapy, the need for ECG monitoring (e.g. at dose escalation) should be assessed on an individual basis.

- Document incident, actions taken & outcomes

- Inform relatives/carers with patients consent

- Offer the opportunity to discuss experience when calm. Give clear explanation of the decision to use emergency meds. Document in patient’s notes.

**Post incident debriefing & reflective practice for Nursing Staff involved**

- **Consider Non drug measures**
- "talking down", low stimulus environment, "time-out", distraction

- **Begin observations: BP, Pulse & Respiration.**

- **Oral / IM medication: every 15mins for 1 hour or more frequently if indicated. After 1st hour, medical review of observations to take place.**

- **Ensure emergency resus equipment & drugs (including flumazenil) are available & easily accessible**

- **Ensure past clinical information is available**

- **As soon as situation gives rise for concern contact unit/on call doctor. Inform senior Nurse & OSM/on call manager.**

- **Offer prescribed oral meds – (see medical guidelines)**

- **Begin observations: BP, Pulse & Respiration.**

- **Oral / IM medication: every 15mins for 1 hour or more frequently if indicated. After 1st hour, medical review of observations to take place.**

- **Remember:- Dose equivalents for oral & I/M for calculation of concurrent meds.**

- **Take care when injecting I/M into a struggling patient, bolus injection may result**

- **I/M injections to be given in the upper outer quadrant of the buttock - site rotated for repeated injections**

- **If respirations fall below 10 per min – ensure Flumazenil is available (see medical guidelines)**

- **Treat as medical emergency – Dial 999 Transfer to A & E in the absence of medical direction**

- **Document incident, actions taken & outcomes**

- **Contact patients consultant/on call consultant. Inform of incident and request 24 hour medical review**

- **Inform relatives/carers with patients consent**

- **Offer the opportunity to discuss experience when calm. Give clear explanation of the decision to use emergency meds. Document in patient’s notes.**
2 Awake and calm.
3 Asleep but rousable.
4 Asleep and unrousable.

Patients at conscious level 1 who are uncooperative do not need to have physical observations carried out as this may aggravate the situation. However if the patient’s conscious level changes the observations must be instituted as above.

7 Observations should be recorded on the relevant record of nursing care. (see appendix 4 and 5). This includes details of drug and emergency medication dosage. Nursing actions also to be documented and any changes recorded e.g. from I/M to oral medication.

8 A doctor should be contacted if at any stage the patient’s observations become abnormal or if the conscious level descends to level 4. If respirations fall below 10 per min treat as a medical emergency, dial 999 and transfer to A& E Department in the absence of medical direction.

9 Patients should not be placed in seclusion following emergency administration of medication. If seclusion is necessary and the patient’s conscious level drops to level 2 while in seclusion the need for seclusion should be reviewed immediately and if it drops to level 3 seclusion should be terminated.

10 At the end of the first hour following administration of medication a medical review must take place. It is the doctor’s responsibility to decide whether observations can be discontinued or to specify what further observations are needed. Until this review is completed observations to be continued every 30 minutes.

11 Following the initial medical review the patient should be reviewed again every 6 hours for 24 hours.

12 Consultant or nominated deputy to be contacted and informed of the situation. Request for full medical review within 24 hours to be made.
### Record of Nursing Care during emergency medication / RT

<table>
<thead>
<tr>
<th>Patients name:</th>
<th>Date:</th>
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<tbody>
<tr>
<td>Date of Birth:</td>
<td>Time</td>
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<tr>
<td>NHS No:</td>
<td>Drug and dosage:</td>
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<tr>
<td>Time doctor contacted</td>
<td>Route: oral, I/M or I/V</td>
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**Known physical complaints**

**Patients approx weight:**

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<thead>
<tr>
<th>Time Every 15 min</th>
<th>Pulse</th>
<th>BP</th>
<th>Resps</th>
<th>Temp</th>
<th>SATS</th>
<th>CL level</th>
<th>Comments Change of dose and route to be recorded</th>
<th>Nurse Sign</th>
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**Medical Review**

**Time:**

**Signature:**

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**CL = Consciousness Levels**

1 – Awake and active
2 – Awake and calm
3 – Asleep but rousable (some response to intervention)
4 – Asleep but unrousable (no response to intervention)
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<thead>
<tr>
<th>Patients name</th>
<th>DOB:</th>
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<td>Time Please state</td>
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Part Three
Medical guidelines
Clinical Pathway for Medical Staff-Management of Acutely Disturbed Patients.

1. Be aware of procedures before incidents happen.

2. Respond promptly to requests for medical attendance – must arrive on the unit within 30 minutes.

3. Take a history where possible collect information from the patient and those who know the patient. Consideration will be given to individual needs and requirements regarding language, culture and secondary disability.

4. Do a mental state examination and a physical examination if possible. Information from previous examinations should be made available. Consideration must be given to cultural and gender needs of each individual e.g. same sex chaperone. Information from previous examinations should be made available and whether there is cultural and religious information that should be taken account of e.g. fasting.

5. Establish a provisional diagnosis: is mental disorder present or likely?

6. Establish legal status and follow correct procedures (see Mental health Act 1983 and Department of Health and Welsh Office code of Practice 1993)

7. Conduct a multi disciplinary discussion as to whether or not emergency medication / rapid tranquillisation is safe and appropriate.

8. Consider age, previous history of adverse reactions to certain medication, drug interactions, concurrent medication, illicit drug use, signs of organic brain disorder and patient preferences.

9. Oral medication should be offered before parenteral use. If there is no medical history of anti psychotics or unknown medical history, history of heart disease or current illicit drug intoxication consider oral lorazepam, olanzapine velotabs or risperidone quicklets. If there is confirmed history of significant typical anti – psychotic exposure haloperidol may also be considered. Note for elderly / frail patients, lower doses should be used.

10. The balance of risks and benefit should be considered before prescribing antipsychotic drugs for elderly patients. For recommended dosages always refer to most current British National Formulary and trust pharmacy intranet site.

11. Use the minimum effective dose to achieve tranquillisation. Remember the aim is to achieve ‘calmness’ in the patient not sedation to the point of being unrousable.

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3 Where there are religious requirements for an individual to fast these should be taken into consideration if it is in the patients best interests to do so. Advice can be sought from an Imam if appropriate

4 Velotab and quicklet formulations contain bovine gelatine which may have implications for certain individuals who do not consume such animal products or beef on the grounds of belief. Conventional tablets are available as an alternative if appropriate.
12 If parenteral treatment proves necessary, the intramuscular route is to be preferred over intravenous from a safety point of view. Intravenous administration should only be used in exceptional circumstances and preferably avoided in the elderly.

13 Where behaviour disturbance occurs in a non-psychiatric context then it is preferable to use lorazepam alone, either orally or intramuscularly.

14 Consider reviewing the patients legal status, consulting a senior colleague, starting / increasing regular anti psychotics (within optimal dosage range).

15 Consider dose equivalents for medication prescribed when given orally or intramuscularly. Also ensure calculation of cumulative dosages of concurrent medication of the same class when prescribing emergency medication / rapid tranquilisation.

16 Consider I/M lorazepam / I/M olanzapine or I/M haloperidol. If no response wait 30 minutes and repeat to a maximum of 3 times. When using Olanzapine in conjunction with lorazepam it is recommended that olanzapine is given first with a 60 mins time interval prior to then giving lorazepam. Always refer to most recent British National Formulary and trust pharmacy intranet site to check recommended dosages.

17 Higher doses than those recommended may be required. In such cases senior advice should be sought. The rational must be recorded in the patients care plan.

18 When using I/M haloperidol (or any other I/ M conventional antipsychotic) as a means of behavioural control, an anticholinergic agent (e.g. procyclidine) should be given to reduce the risk of dystonia and other extra pyramidal side effects.

19 Observations (blood pressure, pulse and respiration rate) following both I/M and oral medication should be made every 15mins unless more frequent observation is indicated.

20 At the end of the first hour following administration of medication a medical review must take place. It is the doctor’s responsibility to decide whether observations can be discontinued or to specify what further observations are needed. Following this review the patient should be reviewed again every 6 hours for 24 hours. Document reviews.

21 After treatment with benzodiazepines, if respiratory rate falls below 10 breaths per minute benzodiazepine antagonist flumazenil 200mcg must be given I/V over 15 seconds then 100mcg repeated every 60 seconds until cleared level of consciousness is obtained. Please note: flumazenil has a short half-life and respiratory function once recovered may deteriorate again. Seizures can occur.

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5 Baseline ECG is recommended prior to treatment in all patients, especially in the elderly and patients with a positive personal or family history of cardiac disease or abnormal findings on cardiac clinical examination. During therapy, the need for ECG monitoring (e.g. at dose escalation) should be assessed on an individual basis.
Treat situation as a medical emergency and transfer to A & E department. Always refer to most recent British National Formulary and trust pharmacy intranet site to check recommended dosages.

22 If disturbance continues – consult senior colleagues; consider diazepam I/ V and / or haloperidol I/V. Do not give I/V sedation to elderly patients in the absence of resuscitation equipment and staff trained to use, including defibrillator. Diazemuls should be used to avoid injection site reactions. For recommended dosages always refer to current British National Formulary and trust pharmacy intranet site.

23 Never use drugs you are unfamiliar with – seek advice and support – refer to policy document.

24 Following a period of RT the need for continued treatment should be reviewed. Benzodiazepines should be reduced and discontinued where possible and the continued need for antipsychotic should be considered. Further guidance on the use of these agents and the selection of antipsychotic can be sought from the Trust Medicines Management Tool for Atypical Antipsychotics.

25 Document fully the incident, actions and outcomes.

TAKE NOTE:

- I/M diazepam should NOT be used (absorption slow and unpredictable).
- I/M chlorpromazine should not be used as it crystallises in tissues and is pro-arrhythmogenic.
- Zuclopenthixol acetate is not generally recommended because its onset and length of action cannot always be predicted. For this reason it should never be given to highly aroused, struggling patients because of potential adverse effects on the myocardium. In addition because the drug may have an onset of action between 20mins and 3 hours after administration it limits the safe use of further medication.

However Zuclopenthixol Acetate may ONLY be considered as an option:

- When it is clearly expected that the patient will be disturbed over an extended period of time.
- When the patient has a past history of repeated parenteral administration.
- When an advance directive has been made indicating that this is a treatment of choice.
- The British National Formulary and manufacturers SPC must be consulted regarding its use.
Note – Please ensure you check recommended doses with British National Formulary recommendations and trust pharmacy intranet site.

Perform mental state and physical exam if possible


Take a history

Unsuccessful/inappropriate

Offer oral therapy – Consider Olanzapine Velotabs or Risperidone Quicklets + / - Lorazepam

Oral – unsuccessful after an hour review and repeat Olanzapine Velotabs or Risperidone Quicklets if full dose not already given

Unsuccessful – patient refuses oral medication

Consider I/M Lorazepam (sedation in 30 – 45 mins, peak in 1 – 3 hrs, lasts 4 – 6 hrs). + / - I/M Olanzapine or I/M Haloperidol (sedation in 10mins, peaks in 20 mins. NB half-life 12 – 35 hrs – can accumulate)

When using Olanzapine & Lorazepam give Olanzapine first then wait 60 mins prior to giving Lorazepam

No response – wait 30 mins and repeat, maximum 3 times.

Seek senior advice from consultant and / or pharmacist

Consider Diazepam IV (as Diazemuls) + / - Haloperidol I/V over 5 – 10 minutes

Document incident fully. Actions taken and outcome.

Note: Elderly and physical ill / frail patients require lower doses – between a ¼ and ½ of the standard adult dose

Remember – different dose equivalences for oral and I/M when calculating concurrent doses.

Aim to calm the patient, not sedate into unconsciousness

If respirations fall below 10 per min Give flumazenil 200mcg I/V over 15 seconds then100mcg repeated every 60 secs until desire level of consciousness is obtained. Flumazenil has a short half-life – respiratory function once recovered may deteriorate. Seizures can occur. Treat as a medical emergency and transfer to A & E

When using I/M Haloperidol consider using anticholinergic agent e.g. Procyclidine

Never use drugs you are unfamiliar with – seek additional advice.
## Guidelines for the Use of Flumazenil

<table>
<thead>
<tr>
<th>Indication for Use</th>
<th>If after the administration of Lorazepam or Diazepam respiratory rate falls below 10 / minute.</th>
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<tr>
<td>Contraindications</td>
<td>Patients with Epilepsy who have been receiving long term Benzodiazepines</td>
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<tr>
<td>Dose and route of administration</td>
<td>Initial: 200mcg intravenously over 15 seconds – if required level of consciousness not achieved after 60 seconds then subsequent dose 100mcg over 10 seconds</td>
</tr>
<tr>
<td>Time before dose can be repeated</td>
<td>60 seconds</td>
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<td>Maximum dose</td>
<td>1mg in 24 hours (One initial dose and eight subsequent doses)</td>
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<tr>
<td>Side Effects</td>
<td>Patients may become agitated, anxious or fearful on awakening. Seizures may occur in regular benzodiazepine users.</td>
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<tr>
<td>Management</td>
<td>Side effects usually subside</td>
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<tr>
<td>Monitoring</td>
<td></td>
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<tr>
<td>What to monitor?</td>
<td>Respiratory rate</td>
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</table>
| How often          | Continuously until respiratory rate returns to baseline level. Flumazenil has a short half-life (much shorter that Diazepam) and respiratory function may recover then deteriorate again.  
NOTE – If respiratory rate does not return to normal or the patient is not alert after initial doses them assume sedation due to some other cause.
Recommended Drugs and Doses

The benefit of reducing the risk of harm to the individual or others must be balanced against the risk of adverse effects associated with such drug regimens. In a survey of around 100 incidents of rapid tranquillisation, Pilowsky et al (1992) found few adverse events, although those reported were potentially serious cardiovascular and cardio respiratory events. The cardiovascular effects of antipsychotics in such situations have become a source of growing concern. Osser & Siagdel (2001) recommend that Chlorpromazine is avoided because of its greater risk of hypotension. An increased risk of QT interval prolongation has been reported with several antipsychotic drugs (Royal College of Psychiatrists 1997). Partly on the basis that QTc prolongation may be a marker of risk arrhythmia, the use of Thioridizine has been restricted in the UK since the end of 2000 and would not be appropriate for rapid tranquillisation. (Core Interventions in the treatment and management of Schizophrenia in Primary and secondary care NICE CG 82 Mar-09)

NOTE: lower doses in elderly / frail and consider use of Risperidone as an alternative to Haloperidol.

Prior to prescribing staff are advised to consult the latest British National Formulary and / or contact a pharmacist for further advice if necessary.

Risperidone Quicklets

- Atypical antipsychotic associated with a low incidence of EPS at low dose
- As the dose increases it has the potential to produce dose dependent EPS

Olanzapine Velotabs

- This atypical antipsychotic may be better tolerated than other antipsychotics; extrapyramidal symptoms and prolactin elevation may be less frequent than with older antipsychotics.
- Long term use may me associated with significant weight gain
- For rapid control of behavioural agitation the use of Lorazepam as an adjunct can be useful. Recommended that period of 60 mins is given prior to use of Lorazepam following use of Olanzapine.

Haloperidol

- Haloperidol is most commonly used in rapid tranquillisation, not only has it’s use in rapid tranquillisation been best evaluated; it also has a good safety record. In fact, haloperidol has been used to treat critically ill, confused patients on medical and surgical wards (Adams 1988). The cardio respiratory safety of haloperidol has been established, even in the coronary care unit (Tesar et al 1985).

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6 Velotab and quicklet formulations contain bovine gelatine which may have implications for certain individuals who do not consume such animal products or beef on the grounds of belief e.g. Muslims (non-Halal), Hindus and Vegetarians
• Haloperidol is long acting and so its use may avoid the need for frequent dosing. There is also little risk of hypotension.

• There is a risk of dystonia with high doses especially in young males. If high doses of haloperidol are prescribed consider adding procyclidine 5 mg i.m. stat. Should be given to reduce the risk of dystonia and other extra pyramidal side effects.

• The use of lorazepam as an adjunct is recommended, as it tends to lower the dose of haloperidol required.

• When IM haloperidol is used baseline ECG is recommended prior to treatment in all patients, especially in the elderly and patients with a positive personal or family history of cardiac disease or abnormal findings on cardiac clinical examination. During therapy, the need for ECG monitoring (e.g. at dose escalation) should be assessed on an individual basis.

Lorazepam

• Lorazepam has a short half-life 8-24 hours. It is useful in increasing sedation when given as an adjunct to antipsychotics. It tends to decrease the amount of antipsychotic required.

• Do not mix with other drugs in the same syringe. Dilute lorazepam with equal volume of water for injection.

• Lorazepam should be avoided in people with chronic respiratory disease or respiratory failure.

• Because of risk of addiction give stat doses if possible. Regular and prn prescriptions should be a team decision and need regular review.

Flumazenil

The most serious complication in the use of benzodiazepines is respiratory depression due to sedation. Respiratory depression can be reversed by the use of the benzodiazepine antagonist flumazenil. Flumazenil is not an easy drug to use e.g. must be given IV, the half-life is short compared to the benzodiazepines and repeated doses may be required. Flumazenil may also precipitate withdrawal seizures in those with significant prior exposure to benzodiazepines.

Flumazenil must be given if the respiration rate falls below 10 per min. 200 micrograms given IV over 15 seconds then 100micrograms repeated every 60 seconds until desired level of consciousness is obtained. Always check recommended dosage with most recent British National Formulary and trust pharmacy intranet site.

If resps fall below 10 per min nursing staff must treat as a medical emergency, dial 999 and transfer to A & E department in the absence of medical direction.
**Other drugs for consideration**

**Zuclopenthixol acetate (acuphase)**

- Should not be used in anti-psychotic naïve individuals.

- Zuclopenthixol acetate should never be given to a highly aroused, struggling patient because of potential side effects on the myocardium.

- Consider as an adjunct if: the patient is not anti-psychotic naive, is not receiving adequate regular antipsychotics, and has a history of previous psychotic disturbed behaviour.

- Zuclopenthixol acetate has a longer duration of action (2-3 days). It is useful in patients who are not settling on shorter acting antipsychotics and to avoid repeated injections. However, it is not quick acting and should not be prescribed for rapid tranquillisation.

- If maintenance treatment is necessary, change to an oral anti-psychotic 2-3 days after the last injection or to a longer acting antipsychotic depot injection given concomitantly with the last injection of Zuclopenthixol acetate.

**Diazepam**

- Diazepam should never be given intramuscular injection. due to its prolonged and erratic absorption.

- When given by intravenous injection the emulsion formulation (Diazemuls®) should be used to avoid the risk of venous thromboembolism

**Doses**

Always check recommended dosage with most recent British National Formulary and trust pharmacy intranet site.

**Special Circumstances to consider**

NB – Prior to prescribing medical staff are advised to refer to the latest British National Formulary and / or a pharmacist for confirmation of drug – drug interactions. Refer to www.emc.medicines.org.uk for further information.

**Benzodiazepines and disinhibition**

- Benzodiazepines may cause paradoxical disinhibition or aggressive outbursts.

- These are more likely with high doses of high potency drugs used parenterally.
• Paradoxical reactions are rare in the general population but seen more frequently in people with impulse control damage and in the very young or very old.

• Usually occur in response to (very mild) provocation, the very nature of which is not always obvious to others.

• Is recognised by others but not by the sufferer.

**Special situations**

**Bipolar Patients**

Patients with BAD are sensitive to the EPS of antipsychotics. Further advice can be sought from the Trust prescribing guidelines

**Organic brain syndromes**

When disturbed behaviour is present, physical examination is difficult. However, a diagnosis of organic brain syndrome should be considered especially in the presence of altered level of consciousness and visual, tactile or olfactory hallucinations. Diagnosis and treatment of the underlying condition is essential.

Haloperidol may be prescribed with caution. For recommended dosages always refer to current British National Formulary and trust pharmacy intranet site.

**Drug intoxication**

If this is suspected attempt to get a specimen of urine not blood for a drug screen. Treatment is as for other disturbed behaviour except in the case of LSD intoxication. It has been shown that antipsychotics can aggravate this condition. If there is a history of very recent LSD use give diazepam 20mg orally stat with a further dose of diazepam 10mg after 4-6 hours if not settling. Alternatively, i.m. Lorazepam may be used if the patient is uncooperative.

**Alcohol intoxication**

Medication should be avoided in this situation due to the potential for serious interaction of all tranquillising agents with alcohol.

**Acute alcohol withdrawal**

Disturbed behaviour in any setting may be exacerbated by alcohol withdrawal syndrome or may be the consequence of delirium tremens. The latter is a medical emergency and if suspected should be treated promptly following senior psychiatric and medical advice.
Any patient with suspected alcohol withdrawal syndrome should be fully assessed and treated appropriately in accordance with the Trust Guidelines for the Management of Alcohol Problems on Psychiatric Wards.

Severe alcohol withdrawal including delirium tremens may be precipitated by head injury, dehydration or physical illness such as infection. These should be identified and treated as appropriate. Electrolyte abnormalities are common. The development of withdrawal seizures greatly increases the risk of developing delirium tremens. Delirium tremens should be treated with increased doses of Chlordiazepoxide, parenteral Thiamine and possibly anti-convulsants.

**Parkinson’s Disease**

The use of typical antipsychotics should be avoided in people with Parkinson’s disease or cortical lewy body disease. Diazepam orally or lorazepam should be the drugs of choice. For recommended dosages always refer to current British National Formulary and trust pharmacy intranet site.

**Elderly**

If there is a sudden onset of disturbed behaviour in an elderly patient, a diagnosis of an acute organic brain syndrome is a possibility. If possible identify the underlying cause of this and treat it. Small doses of antipsychotics can be used for the disturbed behaviour. For recommended dosages always refer to current British National Formulary and trust pharmacy intranet site.

**Pregnancy & Lactation**

Refer to Humber NHS Foundation Trust Policy or seek further advice from Trust Pharmacy Department.
Appendix one

Mandatory training and equipment
Mandatory training in the use of rapid tranquillisation.

Ref-The short term management of disturbed (Violent) behaviour in psychiatric inpatient settings- NICE CG 25 Feb-05.

- Staff need to be trained to anticipate possible violence and to de-escalate the situation at the earliest opportunity and physical means of restraint or seclusion should be resorted to only after failure of attempts to promote full participation in self care.
- Training in the use and the dangers of rapid tranquillisation is as essential as training for de-escalation and restraint. Doctors and nurses should be familiar with the properties and possible risks and side effects of benzodiazepine and anti psychotics.

Medical and nursing staff from the identified areas in the trust that use parenteral rapid tranquillisation will:
- Be able to assess the risks associated with rapid tranquillisation, particularly when the patient is highly aroused and may have been misusing drugs, be dehydrated or possibly be physically ill.
- Understand the cardio- respiratory effects of the acute administration, where appropriate, of these drugs and the need to titrate dosage to effect.
- Recognise the importance of nursing, in the recovery position, patients who have received these drugs and also monitoring of pulse, blood pressure and respiration.
- Be familiar with and trained in the use of resuscitation equipment, this is essential as an anaesthetist or experienced crash team may not be available on site.
- Be familiar with the Trust procedure used in a medical emergency.
- Be trained in the use of pulse oximeters.
- Undertake annual training in resuscitation techniques.
- Understand the importance of maintaining an unobstructed airway.
- Use and administration of Flumazenil.

The Trust has an approved policy for rapid tranquillisation. As part of the policy, there is a formal requirement for all staff involved in the use and practice of rapid tranquillisation to be trained and competent in its application. The policy clearly states that this is a planned clinical intervention. Any decision to introduce the regime of rapid tranquillisation needs careful consideration by the multi- disciplinary team and the formulation of a care plan allowing for appropriate care, treatment and observation levels to be maintained.

All qualified registered mental health nurses working in areas who may be required to administer rapid tranquillisation must include as part of their mandatory training:
- Immediate life support, including the use of oxygen, suction, defibrillation and anaphylaxis.
- Care group specific training in violence and aggression
- Safe and secure handling of medicines training
- Demonstrate competence in the use of pulse oximeters.(Training given via immediate life support training).
- Awareness and familiarity with the trust policy on rapid tranquillisation.
Refresher training covering all the above areas should be undertaken every twelve months.

All medical staff must include as part of their mandatory training:

- Awareness and familiarisation of the trust’s policy on rapid tranquillisation.
- Familiarisation of the trust’s policy on the management of violence and aggression.
- Minimum of level one training in the management of violence and aggression (de-escalation and breakaway techniques).
- Knowledge in regards to medication management to include indications for the use of rapid tranquillisation, drugs recommended for use in rapid tranquillisation, the need to titrate dosage to effect, risks associated with rapid tranquillisation and the use and administration of Flumazenil.
- Immediate life support training, including the use of oxygen, suction, defibrillation and anaphylaxis.

Refresher training covering all the above areas should be undertaken every twelve months.

Currently all new doctors who join the Trust will undertake as part of their induction training an awareness session on rapid tranquillisation and familiarise themselves with the trust policy.

A full training session on rapid tranquillisation and immediate life support will occur on a six monthly basis as part of the junior doctor’s training timetable. It is an expectation that all doctors who may be required to use rapid tranquillisation will attend this training session in order to update skills and meet mandatory training requirements.

Recommended list of equipment:

Access to automated external defibrillator or access to general hospital “crash team”

Disposable adult bag and valve mask

Resuscitation pocket masks (10)

Non breathing mask (appropriate to patient group)

Oropharangeal airways (various sizes appropriate to patient group)

Suction equipment (manual or electric)

Oxygen cylinder with multi flow pin index regulator

Tourniquet

Disposable thermometer

Sphygmomanometer

Stethoscope

Pulse oximeter

The above equipment to be audited on a monthly basis by the unit manager.

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Reviewed Sep 2010
For review: Sep 2012
Appendix Two

References
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