NHS Grampian

NHS Grampian Staff Guidance On The Use Of Emergency Sedation During The Escort Of Adult Patients, Detained Under the Mental Health (Care and Treatment) (Scotland) Act 2003, to NHS Grampian In-Patient Facilities

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	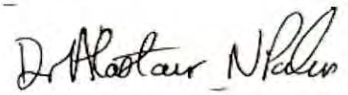	

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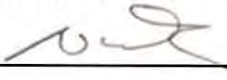
This document has been endorsed by the Medical Director of NHS Grampian

Signature: 

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Title:	NHS Grampian Staff Guidance On The Use Of Emergency Sedation During The Escort Of Adult Patients Detained Under the Mental Health (Care and Treatment) (Scotland) Act 2003 To NHS Grampian In-Patient Facilities
Unique Identifier:	NHSG/Guid/EmSedEsc/MGPG1270
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Document application:	NHS Grampian
Purpose/description:	This guidance has been developed to provide GPs, other detaining doctors and members of the escort team with advice on the treatment of adult patients detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 who require to be medicated in order to achieve a safe transfer to NHS Grampian In-Patient Facilities
Group/Individual responsible for this document:	Psychiatric Emergency Plan (PEP) Steering Group Mental Health Operational Medicines Management Group
Policy statement:	It is the responsibility of individual healthcare professionals and their line managers to ensure that they work with the

terms laid down in this guidance and to ensure that staff are working to the most up to date guidance. By doing so, the quality of the services offered will be maintained, and the chances of staff making erroneous decisions which may affect patient, staff or visitor safety and comfort will be reduced. Supervisory staff at all levels must ensure that healthcare professionals using this guidance act within their own level of competence.

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Responsibilities for implementation:

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Departmental:	Line Managers, GP Practices
Area:	Line Managers

Review: This policy will be reviewed in three years or sooner if current treatment recommendations change

Responsibilities for review of this document:

Lead Author/Coordinator: Principal Pharmacist Mental Health and Learning Disability Services

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Revision History:

Revision Date	Previous Revision Date	Summary of Changes (Descriptive summary of the changes made)	Changes Marked* (Identify page numbers and section heading)
Mar 2022	Dec 2018	General Information – 'drug kardex' replaced by 'Prescription and Administration Record (PAR)'	P2 – General Information
		Medicines rationalised. Promethazine 25mg tablets and Aripiprazole 10mg tablets removed.	P3 - Medicines
		'The clinical responsibility for the patient remains with the attending doctor detaining the patient until the ambulance arrives.' The following added 'Thereafter care transfers to the ambulance staff and escort team.'	P3
		'Antipsychotic naïve patients' changed to ' Patients never previously prescribed antipsychotic medication'	P5 – Choice of medication
		Algorithm – Promethazine dose adjusted to 20 – 50mg to reflect 10mg tablet strength.	P8 - Algorithm
		Algorithm – 'Accepts oral medication Repeat after one hour, if necessary' changed to 'Accepts oral medication Repeat after one hour, if necessary & assessed need outweighs risk'	P8 - Algorithm
		Table 1 Emergency Sedation: Physical Monitoring – Updated in line with current Maudsley Guidelines 2021.	P9 – Table 1
		References – Updated. Maudsley Prescribing Guidelines 14th Edition 2021, Wiley Blackwell added.	P12 - References
		Consultation - Updated	P12 - Consultation

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NHS Grampian Staff Guidance On The Use Of Emergency Sedation During The Escort Of Adult Patients, Detained Under the Mental Health (Care and Treatment) (Scotland) Act 2003, To NHS Grampian In-Patient Facilities

1. Scope

This guidance has been developed to provide GPs, other detaining doctors and members of the escort team with advice on the treatment of adult patients, detained under the Mental Health (Care and Treatment) (Scotland) Act 2003, who require to be medicated in order to achieve a safe transfer to NHS Grampian in-patient facilities. It should be stressed that this is only guidance and GPs and others may wish to use alternative medications with which they are familiar.

Registered mental health/learning disabilities nurses should escort detained patients to hospital. However exceptions to this are where patients may be admitted to dementia assessment units within community hospitals in Aberdeenshire and Moray. These patients may be escorted by registered nursing staff working within these units, who are not registered mental health/learning disabilities nurses, but who have the necessary experience and training to manage presenting behaviours and administer psychotropic medications safely.

When patients detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 are to be admitted from the community to a non-psychiatric setting, the escort team and necessary medication will be provided by the relevant psychiatric service.

2. General Information

For patients who have been detained, the escort team arrive with a supply of medicines, which may be used if emergency sedation is required, and a blank Prescription and Administration Record (PAR). The escort team will include registered mental health/learning disabilities nurses (apart from exceptions noted in point 1 above) but **will not routinely include a doctor** and therefore the attending doctor detaining the patient must prescribe any medication to be administered in the once only medicines section of the PAR (except for adrenaline see note below).

Note: Adrenaline Injection for use by parenteral administration is exempt from Patient Group Direction (PGD), prescription or Patient Specific Direction (PSD) when administered for the purpose of saving a life in an emergency.

Medication carried by the escort team (refer to drug treatment algorithm for further details):

- Lorazepam Tablets 1mg
- Promethazine Tablets 10mg
- Promethazine Injection 25mg/mL
- *Aripiprazole Tablets 5mg
- *Aripiprazole Short Acting IM Injection 7.5mg/mL
- Procyclidine Injection 10mg/2mL
- Adrenaline (epinephrine) injection 1:1000 (1mg/mL ampoule) (for physiological reversal of the immediate symptoms of hypersensitivity and anaphylaxis such as laryngeal oedema, hypotension and bronchoconstriction).

***Aripiprazole** dosage adjustments needed if co-prescribed with potent inducers or inhibitors of CYP3A4 or CYP2D6 (see Table 3).

Note: For anatomical sites for intramuscular injection see Table 4.

It may be a period of time before the escort team arrives and as such the doctor detaining the patient may feel it necessary to medicate the patient beforehand – if this occurs a list of all medication administered prior to the arrival of the escort team must be given in writing to the escort team at the point of transfer.

In cases where emergency sedation has been used the patient must be transferred to hospital by ambulance. The Code of Practice to the Mental Health (Care and Treatment) (Scotland) Act 2003 states, "It would be expected that responsibility for organising the patient's transfer to hospital would be assumed by the medical practitioner who granted the emergency detention certificate. Where the medical practitioner is unable to organise the patient's transfer him/herself, he/she should take all reasonable steps to ensure that the transfer and admission to hospital is taken care of by a third party. This is likely to be the Ambulance Service, a psychiatric nurse or other mental health professional".

The clinical responsibility for the patient remains with the attending doctor detaining the patient until the ambulance arrives. Thereafter care transfers to the ambulance staff and escort team.

Note: Medical treatment cannot be given by force using the Mental Health (Care and Treatment) (Scotland) Act 2003 to a patient whose detention in hospital has not been authorised under the Act. If medication is needed it can be given under the common law doctrine of necessity but the attending doctor must make a record of why it was urgently necessary. If this is not recorded, it could be construed as an assault. Treatment given under the common law doctrine of necessity must be immediately required to save a person's life or to improve or stop deterioration in his or her mental or physical health.

If the doctor detaining the patient has any doubts or concerns about the patient's safe transfer, they should contact the hospital doctor involved with co-ordinating the patient's admission, or the duty consultant at either Royal Cornhill Hospital or Ward 4 Dr Gray's Hospital.

3. Use of Emergency Sedation

Emergency sedation should only be used when it is necessary and when appropriate psychological and behavioural approaches have failed to de-escalate acutely disturbed behaviour. It is essentially a treatment of last resort.

The aim of emergency sedation is to calm the patient and reduce the risk of violence and harm, rather than treat the underlying psychiatric condition. An optimal response would be a reduction in agitation or aggression without sedation, allowing the patient to participate in further assessment and treatment. Ideally the medicine should have a rapid onset of action and a low level of side-effects.

Patients should only be treated with medicines for emergency sedation after an assessment has established that the risk of not doing so is greater than the risk of acute pharmacological treatment.

Before emergency sedation is prescribed, the prescribing doctor should:

- Assess the risk to patient and others
- Consider causes for disturbed behaviour, including an assessment of the patient's physical state to determine any possible precipitants, make a diagnosis and treat accordingly.
- Consider patient's medical and psychiatric history including previous response to emergency sedation or other methods of managing imminent violence.
- Review currently prescribed medication including any 'as required' medication recently administered.
- Assess patient for use of illegal drugs or alcohol.
- Consider any advance directive patient may have made or current treatment plan if detained under the Mental Health (Care and Treatment) (Scotland) Act 2003.

Staff involved in the prescribing and administration of emergency sedation must be adequately trained in:

- The recognition and management of violent/disturbed behaviour.
- Knowledge of drugs used for emergency sedation, their side-effects and risks.
- Up to date knowledge of the legislation relating to the prescribing and administration of emergency sedation.
- Cardiopulmonary resuscitation.
- The administration of adrenaline (epinephrine) in cases of suspected anaphylactic/anaphylactoid reactions.

If restraint is required in order to administer intramuscular medication then a member of the escort team should take responsibility for protecting and supporting the head and neck and for ensuring that the airway and breathing are not compromised and that colour and respiration are constantly monitored until restraint ceases.

4. Principles of Drug Treatment

(Refer to accompanying Treatment Algorithm and Tables 1, 2, 3 and 4)

A risk benefit analysis should be undertaken by the doctor detaining the patient to determine the appropriate medication and dose for the patient. This should include assessing the precautions to prescribing emergency sedation on an individual patient basis.

Oral medication should be offered before intramuscular (IM) medication.

The minimum effective dose should be used. Always give time for the drug to work.

Time to peak effect:

- Oral Lorazepam 2 hours
- Oral Promethazine 2 - 3 hours
- Oral Aripiprazole 3 - 5 hours
- IM Promethazine 1 - 2 hours
- IM Aripiprazole 1 - 3 hours

The maximum daily dose of all prescribed drugs should be carefully observed. If it is necessary to exceed these, the reasons for doing so should be recorded in the case notes. **Note:** Include any regular and 'as required' medication the patient is prescribed.

The concomitant use of two or more antipsychotics should be avoided if possible on the basis of risk associated with QT prolongation. This is a particularly important consideration in rapid tranquillisation where the patient's physical state predisposes to cardiac arrhythmia.

Choice of medication:

- **Patients never previously prescribed antipsychotic medication**
  - Use lower doses.
- **Non-psychotic context**
  - Use lorazepam or promethazine.
- **Compromised respiratory function**
  - Avoid lorazepam.
  - Caution with promethazine as may thicken or dry lung secretions and impair expectoration.
- **Organic disease**
  - Use lower doses.
  - In patients with suspected or confirmed Lewy Body dementia avoid the use of antipsychotics.
  - Caution with aripiprazole in patients with Parkinson's disease.

- Avoid antipsychotics in cerebrovascular disease, including vascular dementia.

- **Alcohol withdrawal/risk of seizures**
  - Caution when using aripiprazole or promethazine as lower seizure threshold.

- **Cardiovascular disease**
  - Use lorazepam.
  - Caution with aripiprazole.
  - Caution with promethazine due to hypotension.
  - Consider any concomitant medication, which may prolong QTc interval.

- **Frail and elderly patients**
  - Use lower doses.
  - Caution with promethazine due to anticholinergic side-effects.
  - Only use oral route medication except in extreme emergencies.

- **Hepatic or renal impairment**
  - Lower doses may be needed due to reduced clearance.
  - See medicine specific prescribing information.

- **Pregnancy**
  - Specialist advice must be sought on the management of pregnant women requiring emergency sedation.
  - The risks and benefits of treatment should be considered on a case by case basis.

- **Comorbid substance misuse**
  - In patients who are benzodiazepine-tolerant consider use of promethazine.
  - Care if on methadone due to increased risk of QTc prolongation.

Patients should be closely monitored following parenteral emergency sedation (refer to Table 1). Having administered parenteral emergency sedation to a patient it is important that the patency of the airway is always maintained.

Always have procyclidine injection available to reverse an acute dystonic reaction if administering aripiprazole (refer to Table 2).

Mixing medicines in the same syringe is hazardous, constitutes an unlicensed product, and should **NEVER** be undertaken.

A post incident review should take place as soon as possible after the event.

Note: The National Institute for Health and Care Excellence (NICE) Guideline 10 Violence and Aggression: Short-term management in mental health, health and community settings, May 2015 states that resuscitation equipment should be readily available if parenteral administration used. However, in a community setting this may not always be possible and the attending doctor must assess the clinical risk associated with prescribing emergency sedation.

5. Involvement of Police Scotland (North)

Where restraint is required for the administration of emergency sedation all healthcare professionals involved must be aware of the following information provided by Police Scotland North:

- Nowhere in the Mental Health (Care and Treatment) (Scotland) Act 2003 does it give the power to the Police to restrain a patient whilst medication is administered. In fact, the Lord Advocate has previously issued guidance to the effect that this is unlawful and may be considered assault. However, where the Police are called in support of mental health services who are attempting to detain a patient under the provisions of the Act and that patient presents a clear and present risk to the safety of the public, the Mental Health Officers, the Police Officers concerned or indeed to themselves, then it is lawful to use common law powers to restrain that person to prevent the risk of injury or damage.

- The following position was detailed in 2003 in a Chief Constable's Memorandum 'Whilst nothing will prevent an Officer restraining anyone who is committing an offence, in the meantime, with immediate effect, when an Officer is faced with circumstances whereby restraint is required to administer medication to a violent or disturbed patient, that Officer shall not become involved in any form of physical restraint of the individual'. Since the inception of Police Scotland, the Police and Federation position and legal opinion has remained unchanged.

- What is clear is that the Police Officers must be in a position to risk assess each situation based on the individual circumstances including any intelligence, previous history, the physical capability of the patient concerned, the existence of a medical action plan for that individual and, not least, the advice and professional opinion of the Mental Health Officers at the location.

Treatment Algorithm for Emergency Sedation
For Use in the Community Setting During the Escort of Adult Patients, Detained Under the Mental Health (Care and Treatment) (Scotland) Act 2003, To NHS Grampian In-Patient Facilities

The following is for guidance only and may not be appropriate in all circumstances. Discussion with senior medical staff is recommended at any stage. This algorithm must only be used in conjunction with the accompanying escort guidance.

IMPORTANT NOTES

- Medication must be prescribed by the attending physician.
- Use minimum effective dose.
- **^Promethazine** is a useful option instead of lorazepam in benzodiazepine tolerant patients. Note unlicensed use.
- ***Aripiprazole**
  - Dosage adjustments needed if co-prescribed with potent inducers or inhibitors of CYP3A4 or CYP2D6 (see Table 3)
  - IM licensed for rapid control of agitation and disturbed behaviour in schizophrenia or mania.
- In non-psychotic context use lorazepam or promethazine.
- If history of cardiac disease use lorazepam. Caution with promethazine and aripiprazole. Consider any concomitant medication which may prolong QTc.
- Avoid aripiprazole in patients with Lewy Body dementia.
- Use aripiprazole with caution in Parkinson's disease.
- Avoid lorazepam in patients with compromised respiratory function. Caution with promethazine.
- Frail / elderly – use lower doses. Caution with promethazine due to anticholinergic side-effects.
- Comorbid substance misuse - Care if on methadone due to increased risk of QTc prolongation.
- Include both oral & IM doses when calculating total amount of a drug given.
- Vital signs must be monitored after parenteral administration (refer to Table 1).
- Procyclidine 5 – 10mg (2.5 – 5mg in frail/elderly) IM / IV can be given for acute dystonia repeated if necessary after 20minutes (maximum 20mg daily; consider lower maximum in frail/elderly).

Assess situation using all information available. Reach working diagnosis taking into account current medication, mental state, drug misuse. Use non-drug measures: talking down, distraction etc.

If unsuccessful consider medication

Oral Medication

LORAZEPAM 1 - 2mg (500micrograms - 2mg in the frail / elderly)
Maximum oral daily dose 4mg (frail / elderly 2mg)
OR
^PROMETHAZINE 20 – 50mg (consider lower dose in frail / elderly)
Maximum oral daily dose 60mg (consider lower maximum in frail / elderly)
OR
***ARIPIPRAZOLE 10mg (consider lower dose 5mg in frail / elderly)**
Maximum oral daily dose 30mg (consider lower maximum in frail / elderly)

No response or patient refuses (consider medico – legal issues)
or rapid effect is essential due to serious risk from prolonged restraint

Accepts oral medication
Repeat after one hour, if necessary & assessed need outweighs risk

Intramuscular (IM) medication

^PROMETHAZINE 25 – 50mg IM (consider lower dose in frail / elderly)
Maximum 100mg/24 hours (consider lower maximum in frail / elderly)
OR
***ARIPIPRAZOLE 9.75mg (1.3mL) IM (consider lower dose 5.25mg (0.7mL) in frail / elderly)**
Maximum 3 injections daily
Maximum 30mg/24 hours (oral & IM combined)

IF NO RESPONSE AFTER
1-2 HOURS (if using Promethazine)
OR 2 HOURS (if using Aripiprazole)
SEEK ADVICE FROM SENIOR MEDICAL STAFF

Table 1: Emergency Sedation: Physical Monitoring.

After any **parenteral** drug administration, monitor the following every 15 minutes for one hour and then hourly until ambulatory:

- Temperature
- Pulse
- Blood Pressure
- Respiratory rate

Patients who refuse to have vital signs monitored, or who remain too behaviourally disturbed, should be observed for signs/symptoms of pyrexia, hypoxia, hypotension, over-sedation and general physical well-being.

If the patient is asleep or unconscious a pulse oximeter should be used to continuously measure oxygen saturation. A nurse should remain with the patient until they are ambulatory again.

Table 2: Side-effects of drugs used in emergency sedation and their management

Side-Effects	Management
Acute dystonia (including oculogyric crisis)	Give procyclidine 5 -10mg (2.5 – 5mg in frail/elderly IM or IV repeated if necessary after 20minutes (maximum 20mg/day; consider lower maximum in frail/elderly).
Reduced respiratory rate (<10/min) or oxygen saturation (<90%)	Give oxygen; raise legs; ensure patient is not lying face down. Ventilate mechanically with a bag and mask and refer immediately to specialist medical care.
Irregular or slow (<50/min) pulse	Refer to specialist medical care immediately.
Fall in blood pressure (> 30mmHg orthostatic drop or < 50mmHg diastolic).	Lie patient flat, raise legs if possible. Monitor closely.
Increased temperature and/or marked rigidity. (Risk of Neuroleptic Malignant Syndrome (NMS) and perhaps arrhythmias).	Withhold any antipsychotics. Monitor closely for any other signs of Neuroleptic Malignant Syndrome such as sweating, hypertension, fluctuating blood pressure, tachycardia, urinary incontinence, retention or obstruction, muscle rigidity, confusion, agitation or altered consciousness. If Neuroleptic Malignant Syndrome suspected refer to specialist medical care immediately.
Hypersensitivity and anaphylaxis such as laryngeal oedema, hypotension and bronchoconstriction.	For physiological reversal of the immediate symptoms: **Adults** - 500micrograms (0.5mL) of Adrenaline (Epinephrine) 1:1000 (1mg/mL) **Route** - Intramuscular (IM) injection. The best site for IM injection is the anterolateral aspect of the middle third of the thigh. **Frequency** - The same dose can be repeated as necessary at intervals of 5 minutes according to the patient's blood pressure, pulse and respiratory function. **Total dose** - The dose as detailed above can be repeated at intervals of 5 minutes until the patient improves or emergency medical services/ambulance has arrived.

Table 3: Strong inhibitors and inducers of CYP2D6 and CYP3A4

(**Note:** This list is not exhaustive – consult BNF or product literature)

Strong inhibitors of CYP2D6	**Strong Inhibitors of CYP3A4**	**Aripiprazole dose adjustment**
Fluoxetine	Ketoconazole	Half dose
Paroxetine	Itraconazole	
Quinidine	HIV Protease inhibitors	
Strong inducers of CYP3A4		Double dose
Carbamazepine	Phenytoin	
St John's Wort	Phenobarbital	
Rifampicin	Primidone	
Rifabutin	Efavirenz	
Nevirapine		

Table 4: Anatomical sites for intramuscular injection

Anatomical Site			
Short acting intramuscular injection	**Deltoid** (maximum volume = 2mL)	**Lateral Thigh**	**Gluteal**
Aripiprazole injection	YES	YES	YES
Promethazine injection	YES	YES	YES

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Consultation

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