Short-term management of disturbed/violent behaviour in psychiatric in-patient settings and accident and emergency settings

NICE guideline

Draft for second consultation, July 2004

If you wish to comment on the recommendations, please make your comments on the full version of the draft guideline.
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Key priorities for implementation

The following have been identified as priorities for implementation.

- Measures to reduce violence need to be based on comprehensive risk assessment and risk management. Therefore, mental health service providers must ensure that a full risk management strategy is introduced for all their services. [D]

- Where possible (in the form of an advance directive) intervention strategies for the management of disturbed/violent behaviour should be negotiated with all service users at the point of admission to in-patient facilities or as soon as possible thereafter. These strategies must be documented in the service users care plan and healthcare records. Subject to agreement from the service user, a copy should also be given to their carer. [D]

- Trusts must identify a board member to take responsibility for diversity and ethnic issues. Responsibilities must include the nature and adequacy of service provision in relation to the short-term management of disturbed/violent behaviour, training on cultural difference, monitoring service usage by ethnicity, consultation with local Black and minority ethnic groups and achieving targets set in advance on a year-to-year basis. [D]

- All service providers must have a policy for training employees and staff in training in relation to the short-term management of violence. It must specify who will receive what level of training (based on risk assessment), how often they will be trained and also outline the techniques in which they will be trained. [D]

- All those involved in the administration, prescribing and monitoring of a service user receiving parenteral rapid tranquillisation or who employ physical interventions or seclusion must receive mandatory training to a minimum of Intermediate Life Support (ILS – Resuscitation Council UK)
(covers airway, cardio-pulmonary resuscitation (CPR) and use of defibrillators).

The crash bag (including an automatic external defibrillator, a bag valve mask, oxygen, cannulas, fluids, suction and first-line medications) must be available within 3 minutes in healthcare settings where rapid tranquillisation, physical interventions and seclusion might be used. This equipment should be maintained and checked weekly. [D]

- Service users and/or service user groups should have the opportunity to become actively involved in training and setting the training agenda, for example vulnerable groups such as: [D]
  - service users with sensory impairment
  - Black and minority ethnic service users
  - service users with physical impairment
  - service users with cognitive impairment
  - women service users.

- All staff whose need is determined by risk assessment must receive ongoing mandatory training to recognise anger, potential aggression, antecedents and risk factors of violence and to monitor their own verbal and non-verbal behaviour. Training should include methods of anticipating, de-escalating or coping with violent behaviour. [D]

- Rapid tranquillisation, physical interventions and seclusion should only be considered once de-escalation and other strategies have failed to calm the service user. They should never be used as punishment. When determining which of these interventions to employ, clinical need, safety of the service user and others and, where possible, advance directives should be taken into account.

  The intervention selected must be a reasonable and proportionate response to the risk posed by the service user. [D]

- During physical restraint one team member must be responsible for protecting and supporting the head and neck at all times. The team
member who is responsible for supporting the head should take responsibility for leading the team through the restraint process, and for ensuring that the airway and breathing are not compromised and that vital signs are monitored. [D]

• A number of physical skills may be used in the management of a violent incident: [D]
  
  - The level of force applied must be justifiable, appropriate, reasonable and proportionate to a specific situation and should be applied for the minimum possible amount of time.
  
  - Certain techniques use the deliberate application of pain. However, every effort must be made to utilise skills and techniques that do not rely upon the deliberated application of pain, which is only permitted in exceptional circumstances and when other techniques have been tried and proved unsuccessful.
  
  - It should be noted that the application of pain may lead to a worsening of an already highly charged situation and so should be avoided unless absolutely necessary.

• All facilities must have an operational policy on the searching of service users, their belongings, the environment in which they live and also the searching of visitors. Where necessary the policy should refer to related policies such as those for substance misuse and police liaison. [D]

• The searching policy should be in place in order to ensure the creation and maintenance of a safe and therapeutic environment for service users, staff and visitors. [D]
The following guidance is evidence based. The grading scheme used for the recommendations (A, B, C, D or good practice point [(D) GPP]) is described in Appendix A; a summary of the evidence on which the guidance is based is provided in the full guideline (see Section 5).

1 Guidance

In March 2002, the National Collaborating Centre for Nursing and Supportive Care (NCC-NSC) was commissioned by NICE to develop cost and clinically effective guidelines on the short-term management of violence in psychiatric in-patient settings.

Disturbed or violent behaviour by an individual in an adult inpatient psychiatric setting poses a serious risk to that individual, other service users and staff. In 1998/99 an NHS Executive survey found that there were approximately 65,000 violent incidents against staff across the NHS. The average number of incidents in mental health/learning disability trusts was more than three times the average for all trusts.

This guideline discusses the short-term management (72 hours) of disturbed/violent behaviour in adult psychiatric settings. The guidance applies to all adults between the ages of 16-65.

The following interventions and related topics are covered in this guideline:

- environment, organisation and alarm systems
- prediction: antecedents, warning signs and risk assessment
- training
- service user perspectives, including those relating to ethnicity, gender and other special concerns
- de-escalation techniques
- observation
- physical interventions
- seclusion

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• rapid tranquillisation
• post-incident reviews
• accident and emergency departments.

Environment
The physical and therapeutic environment can have a strong, mitigating effect on the short-term management of disturbed/violent behaviour. The following recommendations include the minimum requirements that should be expected within psychiatric facilities:

Safety and security
1.1.1 When staff are engaged in the short-term management of violence, every effort should be made to manage the service user in an open care setting. [D]

1.1.2 Services in which seclusion is practiced must have a designated room fit for purpose. This room must allow clear observation, be well insulated, have access to toilet/washing facilities and be able to withstand attack/damage. [D]

1.1.3 A safe designated area or room specifically for the purpose of reducing arousal and/or agitation should be provided in addition to a seclusion room. [D]

1.1.4 Secure lockable access to a service user’s room, bathroom and toilet area is required, with external staff override. [D]GPP

1.1.5 The internal design of the ward must be arranged to facilitate observation and sight lines must be unimpeded (for example, not obstructed by opening of doors). Measures must be taken to address blind spots within the facility. [D]

1.1.6 Facilities must ensure routes of safe entry and exit in the event of a violence-related emergency. [D]GPP

1.1.7 All exits and entrances should be within the sight of staff. [D]GPP

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1.1.8 Consideration should be given to the use of CCTV and parabolic mirrors (in areas such as corridors, staircases, reception). [D]GPP

1.1.9 There should be a separate area to receive service users with police escorts. [D]GPP

Activities and external areas

1.1.10

- Services should be able accommodate service users’ needs for engaging in activities and individual choice – there should be an activity room and a dayroom with a television, as boredom can lead to violent behaviour.

- Service users must have single sex toilets, sleeping accommodation, day areas and washing facilities.

- There should also be a space set aside for prayer and quiet reflection. [D]

1.1.11 There must be regular opportunities for service users to engage in physical exercise, group interaction, therapy and recreation. [D]GPP

1.1.12 Service users must be able to have easy access to fresh air and natural daylight. [D]

1.1.13 Where practicable, access to an external area should be via the unit and appropriate standards of fencing should be provided. [D]GPP

Service user concerns

1.1.14 The environment should take into account service user needs for:

- safety
- privacy
- dignity
- gender- and cultural-sensitivity
• sufficient physical space
• social and spiritual expression. [D]

1.1.15 Where possible, service users should have privacy when making phone calls, receiving guests, and talking to a staff member. [D]GPP

1.1.16 Facilities must have adequate means of controlling light, temperature, ventilation and noise. [D]GPP

1.1.17 Internal smoking areas/rooms must have powerful ventilation and be fitted with a smoke-stop door(s). [D]GPP

1.1.18 All areas should look and smell clean. [D]GPP

1.1.19 Bed occupancy should be decided at a local level and this level should not be exceeded, since overcrowding leads to tension, frustration and overstretched staff. [D]GPP

1.1.20 Suitable access facilities are needed for people who have problems with mobility, orientation, visual or hearing impairment or other special needs. [D]GPP

1.1.21 There should be access to the day room at night for those who cannot sleep. [D]GPP

Alarms

1.1.22 Each service must have a local policy on alarms and determine the need for alarms according to a comprehensive risk assessment of the clinical environment, service users and staff. The policy must be disseminated and staff made familiar with its contents. [D]

1.1.23 Collective responses to alarm calls should be agreed before incidents occur, consistently applied and rehearsed. [D]GPP

1.1.24 Furniture must be arranged so that alarms can be reached and doors are not obstructed. [D]GPP
1.1.25 Alarms must be accessible in interview rooms, and in reception areas and any other areas where one service user and one clinician work together. [D]GPP

1.1.26 All alarms (for example panic buttons, personal alarms) must be well maintained and checked regularly. [D]GPP

1.1.27 Comprehensive risk assessment of the clinical environment must be used to determine whether supplementary personal alarms should be issued to individual staff members and vulnerable service users. [D]GPP

**Staffing requirements**

1.1.28 Adequate staff and service user ratios are essential to ensure a safe clinical environment. [D]GPP

1.1.29 There should be a stable and consistent inpatient team, as high staff turnover and overuse of short-term bank, locum and agency healthcare staff may create an unsafe environment. [D]GPP

**Interagency working**

1.1.30 Local protocols should be developed to ensure that the police and staff are aware of the procedures and ascribed roles in an emergency, in order to prevent misunderstanding between different agencies. [D]GPP

**1.2 Prediction**

Violence can never be predicted with 100% accuracy. However, this does not mean that risk assessment should not be carried out.

**Policy**

1.2.1 Measures to reduce violence need to be based on comprehensive risk assessment and risk management. Therefore, mental health service
Risk assessment

1.2.2 Risk assessment should include a structured and sensitive interview with the service user and, where appropriate, carers. Efforts should be made to ascertain the service user’s own views about their antecedents to violence, warning signs and management of these feelings. [DGPP]

1.2.3 Risk assessment should be used to establish whether a care plan needs to include specific interventions for the short-term management of violence. [DGPP]

1.2.4 When assessing for risk of violence care needs to be taken not to make negative assumptions based on ethnicity. There should be awareness that cultural mores may manifest as unfamiliar behaviour that could be misinterpreted as being aggressive. The assessment of risk should be objective, with consideration being given to the degree to which the perceived risk can be verified. [DGPP]

1.2.5 All staff must be aware of any of the following factors that may provoke violent behaviour:

- attitudinal
- situational
- organisational
- environmental. [DGPP]

1.2.6 Actuarial tools and structured clinical judgement should be used in a consistent way to assist in risk assessment, although no ‘gold standard’ tool can be recommended. [C]

1.2.7 Since the components of risk are dynamic and may change according to circumstance, risk assessment (environment and service user)
must be ongoing and care plans must be based on an accurate and thorough risk assessment. [D]

1.2.8

- The approach to risk assessment must be multidisciplinary and reflective of the care setting in which it is undertaken.
- The findings of the risk assessment must be communicated across relevant agencies and care settings. [D]

Antecedents and warning signs

Certain features can serve as warning signs to indicate that a service user may be escalating towards physically violent behaviour. The following list is not intended to be exhaustive and these warning signs must be weighed on an individual basis.

1.2.9

- Facial expressions tense and angry.
- Increased or prolonged restlessness, body tension, pacing.
- General over-arousal of body systems (increased breathing and heart rate, muscle twitching, dilating pupils).
- Increased volume of speech, erratic movements.
- Prolonged eye contact.
- Discontented, refusal to communicate, withdrawn, fear, irritation.
- Thought processes unclear, poor concentration.
- Delusions or hallucinations with violent content.
- Verbal threats or gestures.
- Replicating, or behaviour similar to that which preceded earlier violent episodes.
- Reporting anger or violent feelings.
- Blocking escape routes.
Risk factors

Certain factors can indicate an increase risk of physically violent behaviour. The following list is not intended to be exhaustive and these risk factors must be weighed on an individual basis.

1.2.10 Demographic or personal history

- History of violence.
- Previous expression of intent to harm others.
- Evidence of rootlessness or ‘social restlessness’.
- Previous use of weapons.
- Previous dangerous impulsive acts.
- Denial of previous dangerous acts.
- Severity of previous acts.
- Known personal trigger factors.
- Verbal threat of violence.
- Evidence of recent severe stress, particularly loss event or the threat of loss.
- History of bed wetting, cruelty to animals, reckless driving, loss of a parent before the age of 8 years.

1.2.11 Clinical variables

- Misuse of substances and/or alcohol.
- Active symptoms of schizophrenia or mania, in particular if:
  - delusions or hallucinations are focused on a particular person
  - preoccupation with violent fantasy
  - delusions of control (especially with violent theme)
  - agitation, excitement, overt hostility or suspiciousness.
- Poor collaboration with suggested treatments.
- Antisocial, explosive or impulsive personality traits or disorder.
1.2.12 Situational variables

- Extent of social support.
- Immediate availability of a potential weapon.
- Relationship to potential victim.
- Access to potential victim.
- Limit setting.
- Staff attitudes.

1.3 Training

Staff need to have the appropriate skills to manage disturbed/violent behaviour in psychiatric inpatient settings. Training in the interventions used for the short-term management of violence safeguards both staff and service users. Training that highlights awareness of racial, cultural, social, religious/spiritual, and gender, along with other special concerns, also mitigates against violent behaviour. Such training must be properly audited to ensure its effectiveness.

Policy

1.3.1 All service providers must have a policy for training employees and staff-in-training in relation to the short-term management of violence. It must specify who will receive what level of training (based on risk assessment), how often they will be trained and also outline the techniques in which they will be trained.

1.3.2

- All service providers must specify who the training provider is and ensure consistency in terms of training and refresher courses.
- In 2005, training relating to the management of violence should be subject to the national accreditation and regulation scheme.

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being set up by the National Institute for Mental Health in England (NIMHE) and the Security Management Service (SMS) when this comes into force. [D]

1.3.3 Both training and auditing should be in accordance with the current principles being developed by NIMHE and SMS. [D]

1.3.4 If participants on training courses demonstrate inappropriate attitudes then trainers must pass this information onto the relevant line manager for appropriate action. [D]

Specific staff training needs

1.3.5

- There should be an ongoing programme of training for all staff in racial, cultural, spiritual and social issues to ensure that staff are aware of and know how to work with diverse populations and do not perpetuate stereotypes.

- Such courses should also cover any special populations, such as migrant populations and asylum seekers, that are relevant to the locality. [D]

1.3.6 All staff whose need is determined by risk assessment must receive ongoing mandatory training to recognise anger, potential aggression, antecedents and risk factors of violence and to monitor their own verbal and non-verbal behaviour. Training should include methods of anticipating, de-escalating or coping with violent behaviour. [D]

1.3.7 Healthcare staff responsible for carrying out observation must receive ongoing mandatory training in observation so that they are equipped with the skills and confidence to engage with service users. [D]

1.3.8

- All those involved in the administration, prescribing, and monitoring of a service user receiving parenteral rapid
tranquillisation or who employ physical interventions or seclusion must receive mandatory training to a minimum of Intermediate Life Support (ILS – Resuscitation Council UK) (covers airway, cardio-pulmonary resuscitation (CPR) and use of defibrillators).

- The crash bag (including an automatic external defibrillator, a bag valve mask, oxygen, cannulas, fluids, suction and first-line medications) must be available within 3 minutes in healthcare settings where rapid tranquillisation, physical interventions and seclusion might be used. This equipment should be maintained and checked weekly.[D]

1.3.9 All staff whose level of need is determined by risk assessment must receive mandatory training in the use of physical interventions. A core module of physical interventions is being developed by NIMHE and SMS. This module should be followed once it comes into effect in 2005.[D]

1.3.10 All staff whose level of need is determined by risk assessment must receive mandatory training in the use of seclusion. Training must include appropriate monitoring arrangements for service users placed in seclusion. [D]

1.3.11 All staff involved in rapid tranquillisation must be trained in the use of pulse oximeters. [D]

1.3.12 Prescribers of medicines must be familiar with and must have received training in all aspects of rapid tranquillisation, including:

- the properties of benzodiazepines and their antagonists (flumazenil), anti-psychotics, antimuscarinics and antihistamines
- the risks associated with rapid tranquillisation, particularly when the service user is highly aroused and may have been misusing drugs, be dehydrated or possibly physically ill
cardio-respiratory effects of the acute administration of these drugs

the need to titrate doses to effect. [D]

1.3.13 Service providers should ensure that staff’s capability to undertake physical interventions and physical interventions training courses is assessed. [D]GPP

Incident recording

1.3.14 Templates for incident recording were issued by SMS in November 2003. Mandatory training must be given to all appropriate staff to ensure that they are aware of how to correctly record an incident using the appropriate nationally recognised templates. [D]

Refresher courses

1.3.15 Services must review their training strategy annually through audit to identify those staff groups that required on-going professional training in the recognition, prevention and de-escalation of disturbed/violent behaviour and in physical interventions training to manage disturbed/violent behaviour. [D]

Auditing training

1.3.16

All such training must be audited, including training in racial, cultural, religious/spiritual and gender issues, along with training that focuses on other special service user concerns.

Independent bodies/service user groups should, if possible, be involved in auditing the effectiveness of training.[D]
Service user training/involvement in training

1.3.17 Service users and/or service user groups should have the opportunity to become actively involved in training and setting the training agenda, for example vulnerable groups such as:

- service users with a sensory impairment
- Black and minority ethnic service users
- service users with a physical impairment
- service users with a cognitive impairment
- women service users.

1.4 Working with service users (from diverse backgrounds)

There is a growing acceptance that service users in adult psychiatric inpatient settings ought to be involved in their care as far as possible. This extends to the short-term management of violence where service user input can be made through measures such as advance directives. Listening to service users' views and taking them seriously is now also regarded as an important factor in the short-term management of disturbed/violent behaviour. Service users may also have physical needs that need to be taken into account when using the interventions discussed in this guideline.

The following recommendations and good practice points focus specifically on the needs that arise from diversity (cultural, social, spiritual and gender-related needs) and physical needs in the context of the short-term management of disturbed/violent behaviour since it is important that service users should not be treated less favourably on the basis of their gender, race, diagnosis, religious/spiritual practices, or disability. However, many of these recommendations and good practice points apply to all service users.
Creating a feeling of safety and understanding

Preventing disturbed/violent behaviour is a priority. Providing relevant information so that service users feel safe and understand what is and may happen to them in the event that they are violent will help prevent unnecessary aggravation.

1.4.1 Service users must have access to suitable information about the following in their preferred language:

- which staff member has been assigned to them and how and when they can be contacted
- why they have been admitted (and if on a section, why they have been sectioned, type of section, maximum length of detention, right to appeal)
- what their rights are with regard to consent to treatments, complaints procedures, and access to independent help and advocacy
- what may happen if they become aggressive/violent.

This information needs to be provided at each admission. [D]

1.4.2 An effective and fair complaints procedure must be put in place. [D]GPP

1.4.3 Where at all possible, service users should have a choice of key worker. [D]GPP

1.4.4 Where possible (in the form of an advance directive) intervention strategies for the management of disturbed/violent behaviour should be negotiated with all service users at the point of admission to inpatient facilities or as soon as possible thereafter. These strategies must be documented in the service user’s care plan and healthcare records. Subject to agreement from the service user, a copy should also be given to their carer. [D]
1.4.5 The physical needs of the service user should be assessed on admission or as soon as possible thereafter and then regularly reassessed. The care plan should reflect physical needs. [DGPP]

1.4.6 Following any intervention for the short-term management of disturbed/violent behaviour, every effort should be made to establish whether the service user understands why this has happened. These efforts must be documented in the service user’s notes. [D]

1.4.7 Staff should take time to listen to service users, including those from diverse backgrounds, (taking into account that this may take longer when using interpreters), so that therapeutic relationships can be established. [DGPP]

1.4.8 All trusts must have a policy for preventing and dealing with all forms of harassment and abuse. Notification to the effect should be disseminated to all staff and displayed prominently in all clinical and public areas. [D]

1.4.9 In the event of any form of alleged abuse, the matter should be dealt with by staff as soon as is practicable in accordance with relevant trust policies. [DGPP]

1.4.10 All service users, regardless of culture, gender, diagnosis, sexual orientation or religious/spiritual beliefs should be treated with dignity and respect. [D]

1.4.11 During the administration or supply of medicines to service users confidentiality should be ensured. [DGPP]

1.4.12 Prescribers should be available and responsive to requests for medication review. [DGPP]

1.4.13 Special provision should be made for pregnant women in the event that interventions of the short-term management of violence are needed. These should be recorded in the service user’s care plan. [DGPP]
**Black and minority ethnic service users**
There is growing concern that Black service users, particularly those from African–Caribbean communities are sometimes adversely affected by negative stereotyping in which they are perceived as more dangerous than other service users, which causes staff to use interventions such as rapid tranquillisation, restraint or seclusion before less coercive measures have been tried.

1.4.14 Trusts must identify a board member to take specific responsibility for diversity and ethnic issues. Responsibilities must include the nature and adequacy of service provision in relation to the short-term management of disturbed/violent behaviour, training on cultural difference, monitoring service usage by ethnicity, consultation with local Black and minority ethnic groups, and achieving targets set in advance on a year-to-year basis. [D]

**Service users with physical disabilities**

1.4.15 Each service must have a policy that outlines the procedures for dealing with service users who have disabilities, including those with physical or sensory impairment. [D]GPP

1.4.16 Individual care plans should detail staff responsibilities for de-escalating, use of rapid tranquillisation, restraining and seclusion of service users who have disabilities, including those with physical or sensory impairment. [D]GPP

**Service users with HIV or other sexually transmitted diseases**

*Policy*

1.4.17 Services must have policies in place, developed in conjunction with the Trust infection control officer, that outline the reasonable steps that can be taken to safeguard staff and other service users if a service user who has HIV, hepatitis or other infectious or contagious diseases is acting in a manner that may endanger others [D]GPP

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1.4.18 If staff are aware that a service user has HIV, hepatitis or other infectious or contagious diseases, the advice of the Trust infection control officer should be sought. [D]GPP

Confidentiality issues

1.4.19

- Patients are owed important obligations of confidentiality but these are not absolute. In certain circumstances they may be breached to safeguard others:
  - This is particularly relevant where a service user has HIV, hepatitis or other infectious or contagious diseases, and is acting in manner that puts others at risk.
- Legal and ethical advice should be sought in these circumstances. [D]GPP

1.4.19 If any person has sustained any injury during restraint where blood has been spilt or the skin has been broken or there has been direct contact with bodily fluids, the local infection control policy should be followed. [D]GPP

1.5 De-escalation techniques

Action plans should be developed at a local level, which detail how to call for help in an emergency. De-escalation involves the use of techniques that calm down an escalating situation or service user, therefore, action plans should stress that de-escalation should be employed early on in any escalating process.

Environment

1.5.1 A safe designated area or room specifically for the purpose of reducing arousal and/or agitation should be provided in addition to a seclusion room. [D]
Training

1.5.2 All staff whose need is determined by risk assessment must receive ongoing mandatory training to recognise anger, potential aggression, antecedents and risk factors of violence and to monitor their own verbal and non-verbal behaviour. Training should include methods of anticipating, de-escalating or coping with violent behaviour. [D]

General

1.5.3 Service user anger needs to be treated with an appropriate, measured and reasonable response. Where at all possible, de-escalation skills need to be employed prior to other interventions being used. [D]GPP

1.5.4 Staff should accept that in a crisis situation they are responsible for avoiding provocation. It is not realistic to expect the disturbed/violent person to simply calm down. [D]GPP

1.5.5 Staff should learn to recognise what generally upsets and calms people and they should also make themselves aware of what specific things upset and calm those in the service user. This will involve listening to individual service user's reports of what upsets them and this must be reflected in service users’ care plans. [D]GPP

1.5.6 Staff should be aware of, and learn to monitor and control, their own verbal and non-verbal behaviour, such as body posture, eye contact etc. [D]GPP

1.5.7 Where possible, service users should be encouraged to recognise the early warning signs of violence within themselves. This should be included in care plans and a copy given to the service user. They should also be encouraged to discuss and negotiate their wishes should they become agitated. [D]GPP

1.5.8 Where de-escalation techniques fail to sufficiently calm a situation/service user, staff should remember that verbal de-escalation is an ongoing element of the management of an escalating individual.
De-escalation techniques

1.5.9 One staff member should assume control of the situation. [D]GPP

1.5.10 The staff member who assumes control should explain to the service user and others in the immediate vicinity what they intend to do. This will involve:

- managing others in the environment, for example removing other service users from the area, enlisting the help of colleagues, suggesting to the aggressor that he/she moves to another area, creating space and making sure that the service user feels that they have options
- giving clear, brief, assertive instructions, negotiating options and avoiding threats
- moving towards a safe place and avoiding being trapped in a corner. [D]GPP

1.5.11 The staff member who assumes control should ask for facts about the problem and encourage reasoning. This will involve:

- offering realistic options
- encouraging reasoning by use of open questions and inquiring about the reason for the service user’s anger
- asking questions about the facts rather than the feelings to assist in de-escalation, such as ‘What has caused you to feel upset/angry?’
- showing concern and attentiveness through non-verbal and verbal responses
- listening carefully and showing empathy, acknowledging any grievances, concerns or frustrations. Not being patronising or minimising service user concerns. [D]GPP
1.5.12 The staff member who assumes control should ensure that their own non-verbal communication is non-threatening. This will involve:

- considering which de-escalation techniques are appropriate for the situation
- paying attention to non-verbal cues, such as eye contact. Allowing greater body space than normal
- adopting a non-threatening but safe posture
- avoiding provocative non-verbal behaviours
- attempting to establish rapport and emphasising cooperation
- appearing calm, self controlled and confident without being dismissive or over-bearing. [D]GPP

1.5.13 Where weapons are involved the staff member who assumes control should ask for the weapon to be placed in a neutral location rather than handed over. [D]GPP

1.5.14 Where there are potential weapons the aggressor should be relocated to a safer environment, where at all possible. [D]GPP

1.5.15 Staff should consider asking the service user to make use of a safe area or room specifically designed for the purpose of reducing arousal and/or agitation to help them calm down. The seclusion room should not routinely be used for this purpose. [D]GPP

1.6 **Observation and engagement**

The primary aim of observation should be to engage positively with the service user. This involves a two-way relationship, established between a service users and a nurse, which is meaningful, grounded in trust, and therapeutic for the service user (UKCC, 2002). Observation is an intervention that is used for both the short-term management of violence and to prevent self-harm. The recommendations and good practice points below are specifically directed towards the use of observation as an intervention for the short-term management of disturbed/violent behaviour. However, many are
also applicable where observation is used to prevent self-harm. Terminology covers both uses of observation.

Policy
1.6.1 Each service must have a policy on observation and engagement (reflecting the needs of specialist facilities) that adheres to contemporary NICE terminology and definitions. The risk levels that a service user poses must be reviewed every shift. This policy must include:

- who can instigate observation
- who can increase or decrease observation level
- who must review level of observation
- when reviews must take place
- how service user perspectives will be taken into account
- a process through which a review by a full clinical team will take place if observation above a general level continues for more than 1 week.

Training
1.6.2 Healthcare staff responsible for carrying out observation must receive ongoing mandatory training in observation so that they are equipped with the skills and confidence to engage with service users.

Definitions of levels of observation
1.6.3 The terminology outlined in the current guideline must be adopted across England and Wales so that there is consistent observation terminology.

1.6.4 General observation is the minimum acceptable level of observation for all inpatients. The location of all service users should be known to staff, but not all service users need to be kept within sight. At least once a shift a nurse should set aside dedicated time to assess the
mental state of the service user and engage positively with the service user. The aim of this should be to develop a positive, caring and therapeutic relationship with the service user. This interview should always include an evaluation of the service user's moods and behaviours associated with risks of disturbed/violent behaviour, and these should be recorded in the notes. [D]GPP

1.6.5 Intermittent observation means that the service user's location must be checked every 15 to 30 minutes (exact times to be specified in the notes). Checks need to be carried out sensitively in order to cause as little intrusion as possible. However, this check should also be seen in terms of positive engagement with the service user. This level is appropriate when service users are potentially, but not immediately, at risk of disturbed/violent behaviour. Service users who have previously been at risk of harming themselves or others, but who are in a process of recovery, require intermittent observation. [D]GPP

1.6.6 Within eyesight is required when the service user could, at any time, make an attempt to harm themselves or others. The service user should be kept within eyesight and accessible at all times, by day and by night and, if deemed necessary, any tools or instruments that could be used to harm self or others should be removed. It may be necessary to search the service user and their belongings, while having due regard for the service user's legal rights and conducting the search in a sensitive way. Positive engagement with the service user is an essential aspect of this level of observation. [D]GPP

1.6.7 Within arms length Service users at the highest levels of risk of harming themselves or others, may need to be supervised in close proximity. On specified occasions more than one member of staff may be necessary. Issues of privacy, dignity and the consideration of gender in allocating staff, and the environmental dangers need to be discussed and incorporated into the care plan. Positive engagement with the service user is an essential aspect of this level of observation. [D]GPP
1.6.8 Possible antecedents or warning signs that observation is required

In addition to the antecedents that indicate disturbed/violent behaviour, the following indicate that observation above a general level may be required:

- history of previous suicide attempts, self-harming or attacks on others
- hallucinations, particularly voices suggesting harm to self or others
- paranoid ideas where the service user believes that other people pose a threat
- thoughts or ideas that the service user has about harming themselves or others
- threat control over-ride symptoms
- past or current problems with drugs or alcohol
- recent loss
- poor adherence to medication programmes or non-compliance with medication programmes
- marked changes in behaviour or medication
- known risk indicators. [D]GPP

Carrying out observation

1.6.9 Designated levels of observation should only be implemented after positive engagement with the service user has failed to dissipate the potential for disturbed/violent behaviour. [D]GPP

1.6.10 The least intrusive level of observation that is appropriate to the situation should always be adopted so that due sensitivity is given to a service user's dignity and privacy whilst maintaining the safety of those around them. [D]GPP

1.6.11 Decisions about observation levels should be recorded by both medical and nursing entries in the service user's notes. The reasons for using observation should be clearly specified. [D]GPP

The short-term management of disturbed/violent behaviour in psychiatric in-patient settings and accident and emergency settings: NICE Guideline (draft)
1.6.12 Decisions regarding the specific level of observation implemented, clear directions regarding therapeutic approach, timing of next review, and name/title of person who will be responsible for carrying out review should take into account current mental state, prescribed medications and their effects, and current assessment of risk. The views of the service user should be taken into account as far as possible. [D]GPP

1.6.13 Observation skills may be used to recognise, prevent and therapeutically manage violence. Specific observation tasks are primarily undertaken by registered nurses, who may delegate to competent persons while retaining overall responsibility and accountability. [D].

1.6.14 Each staff member responsible for observation should take an active role in engaging positively with the service user by knowing their history, risk factors, early warning signs and likes and dislikes.

1.6.15 An individual staff member must not undertake a continuous period of observation for longer than 2 hours. [D]

1.6.16 The service user's psychiatrist/on-call doctor should be informed of any decisions concerning observation as soon as possible. GPP[D]

1.6.17 A nominated hospital manager should be made aware when observation is implemented so that adequate numbers and grades of staff can be made available for future shifts. [D]GPP

**Observation skills**

1.6.18 Nurses and other staff responsible for carrying out observation:

- must be appropriately briefed about the service user, including their history, background, specific risk factors and particular needs [D]GPP
• should be familiar with the ward, the ward policy for emergency procedures and potential risks in the environment [D]GPP

• must be able to increase or decrease the level of engagement with the service user as the level of observation increases [D]GPP

• should be approachable, listen to the service user, know when self-disclosure and the therapeutic use of silence are appropriate and be able convey to the service user that they are valued. [D]GPP

1.6.19 Healthcare professionals should be aware that service users sometimes find observation provocative, and that it can lead to feelings of isolation and even dehumanisation. [D]GPP

Service user needs and responses

1.6.20 The service user is entitled to information about why they are under observation, the aims of observation and how long it is likely to be maintained. For some service users a written contract stating the roles and expectations of staff and service user might have some therapeutic potential. [D]GPP

1.6.21 The aims and level of observation should, where appropriate, be communicated with the service user's approval to the nearest relative, friend or carer. [D]GPP

1.6.22 Although difficult, where possible the handover from one nurse or healthcare professional to another should involve the service user so that they are aware of what is being said about them. [D]GPP

1.7 1.7 Other interventions

Where de-escalation techniques have failed to calm a service user, it may be necessary to make use of additional interventions, such as physical interventions, rapid tranquillisation and seclusion. All such interventions

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should only be used once de-escalation techniques have been tried and have not succeeded in calming the service user. The choice of intervention must be guided by clinical need and the obligations owed to the service-user, other service users affected by the disturbed/violent behaviour and to members of staff and any visitors. The intervention selected must amount to a proportionate and reasonable response to the risk posed.

1.7.1

- Rapid tranquillisation, physical interventions and seclusion should only be considered once de-escalation and other strategies have failed to calm the service user. They should never be used as punishment. When determining which of these interventions to employ, clinical need, safety of service users and others, and, where possible, advance directives should be taken into account.

- The intervention selected must be a reasonable and proportionate response to the risk posed by the service user.

Personnel

1.7.2 A medical officer should be available to attend at all times within half an hour of an alert by healthcare staff when rapid tranquillisation, physical interventions and/or seclusion are implemented, throughout the 24 hours, 7 days a week. [D]

Incident reporting

1.7.3 Any incident requiring parenteral rapid tranquillisation, physical restraint or seclusion should be recorded contemporaneously, using a national template that is available from the SMS. [D]
Legal concerns

1.7.4 All staff need to be aware of the legal framework that authorises the use of rapid tranquillisation, physical interventions and seclusion. If seclusion is considered as an alternative strategy to physical interventions, when managing actual violence, then the guidance on seclusion in the current Mental Health Act Code of Practice must be followed. [D]GPP

1.7.5 The service should provide easy access to competent legal advice in relation to the management of any contentious aspect of disturbed/violent behaviour. [D]GPP

Service user concerns

1.7.6 When using interventions such as restraint, rapid tranquillisation or seclusion, steps must be taken to try to ensure that the service user does not feel humiliated. [D]GPP

1.7.7 The reasons for using rapid tranquillisation, physical interventions or seclusion should be explained to the service user at the earliest opportunity. [D]GPP

1.7.8 After the use of rapid tranquillisation, physical interventions or seclusion, the service user's care plan should be reassessed and the service user should be helped to reintegrate into the ward milieu at the earliest safe opportunity. [D]GPP

1.7.9 Service users should be given the opportunity to write up their account of the intervention in their notes. [D]GPP

1.8 Physical Interventions

Training

1.8.1
• All those involved in the administration, prescribing, and monitoring of service users receiving parenteral rapid tranquilisation or who employ physical interventions or seclusion must receive mandatory training to a minimum of Intermediate Life Support (ILS – Resuscitation Council UK) (covers airway, cardio-pulmonary resuscitation (CPR) and use of defibrillators).

• The crash bag (including an automatic external defibrillator, a bag valve mask, oxygen, cannulas, fluids, suction and first-line medications) must be available within 3 minutes in healthcare settings where rapid tranquilisation, physical interventions and seclusion might be used. This equipment should be maintained and checked weekly. [D]

1.8.2 All staff whose level of need is determined by risk assessment must receive mandatory training in the use of physical interventions. A core module of physical interventions is being developed by NIMHE and SMS. This module should be followed once it comes into effect in 2005. [D]

Carrying out physical interventions

1.8.3 During physical interventions, de-escalation techniques should continue to be employed. [D]

1.8.4 There are real dangers with continuous physical interventions in any position. Physical interventions should be avoided if at all possible, not used for prolonged periods, and should be brought to an end at the earliest opportunity. To avoid prolonged physical intervention an alternative strategy, such as rapid tranquilisation or seclusion, should be considered. [D]

1.8.5 During physical restraint one team member must be responsible for protecting and supporting the head and neck at all times. The team member who is responsible for supporting the head and neck should...
take responsibility for leading the team through the restraint process, and for ensuring that the airway and breathing are not compromised and that vital signs are monitored. \[D\]

1.8.6 During physical interventions, under no circumstances should pressure be applied to the neck, thorax, abdomen, back or pelvic area. The overall physical and psychological well-being of the service user should be continuously monitored throughout the process. \[D\]

1.8.7 A number of physical skills may be used in the management of a violent incident:

- The level of force applied must be justifiable, appropriate, reasonable and proportionate to a specific situation and should be applied for the minimum possible amount of time.
- Certain techniques use the deliberate application of pain. However, every effort must be made to utilise skills and techniques that do not rely upon the deliberate application of pain, which is only permitted in exceptional circumstances and when other techniques have been tried and proved unsuccessful.
- It should be noted that the application of pain may lead to a worsening of an already highly charged situation and so should be avoided unless absolutely necessary.\[D\]

1.8.8 If the need to 'breakaway', or to rescue another staff member/service user arises, the deliberate application of pain may be required. This should be for a minimal period to bring them to a point of manageable control. The use of pain in this circumstance is only permitted for protection of staff and service users and has no therapeutic value. Staff must make every effort to de-escalate the situation. \[D\]

1.8.9

- Mechanical restraints are not a standard means of managing violence in acute mental health care settings.

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• In the event that they are used (for example very exceptionally in high security hospitals) it must be a justifiable, reasonable and proportionate response to the risk posed by the service user and once all other interventions have been exhausted, and only after a multidisciplinary review has taken place.

• Legal, independent expert medical and ethical advice must be sought and documented. trastuzumab [D]

1.9 Seclusion

Environment

1.9.1 Services in which seclusion is practised must have a designated room fit for purpose. This room must allow clear observation, be well insulated, have access to toilet/washing facilities and be able to withstand attack/damage. [D]

Training

1.9.2

• All those involved in the administration, prescribing, and monitoring of a service user receiving parenteral rapid tranquillisation or who employ physical interventions or seclusion must receive mandatory training to a minimum of Intermediate Life Support (ILS – Resuscitation Council UK) (covers airway, cardio-pulmonary resuscitation (CPR) and use of defibrillators).

• The crash bag (including an automatic external defibrillator, a bag valve mask, oxygen, cannulas, fluids, suction and first-line drugs) must be available within 3 minutes in healthcare settings where rapid tranquillisation, physical interventions and seclusion might be used. This equipment should be maintained and checked regularly. [D]
1.9.3 All staff whose need is determined by risk assessment must receive mandatory training in the use of seclusion. Training must include appropriate monitoring arrangements for service users placed in seclusion. [D]

Carrying out seclusion

1.9.4 Seclusion should be for the shortest time possible and should be reviewed at least every 2 hours. The service user should be made aware that reviews will take place at least every 2 hours. [D]

1.9.5 If seclusion is used, an observation schedule must be specified. [D]GPP

1.9.6 A service user's clothes should never be removed when they are secluded (as long as it does not compromise their safety and the safety of others). [D]GPP

1.9.7 Service users in seclusion should be allowed to keep personal items of religious or cultural significance (such as some items of jewellery) as long as they do not compromise their safety or the safety of others. [D]GPP

Rapid tranquillisation and seclusion

1.9.8 The use of seclusion with rapid tranquillisation is not absolutely contraindicated for rapid tranquillisation. However, the following advice must be carefully considered and followed.

- If the service user is secluded, the potential complications of rapid tranquillisation should be taken particularly seriously.
- The service user should be monitored by constant eye sight observation by an appropriately trained individual.
- Once rapid tranquillisation has taken effect, seclusion should be terminated. [D]GPP
1.10 Rapid tranquillisation

Medication, skilfully given (in the context of good clinical care and milieu), can safely and effectively be used to manage disturbed/violent behaviour.

Medication for rapid tranquillisation, particularly in the context of physical interventions, must be used with caution owing to the following risks:

- loss of consciousness instead of tranquillisation
- sedation with loss of alertness
- loss of airway
- cardiovascular and respiratory collapse
- interaction with medicines already prescribed or illicit substances taken (such as akathisia, disinhibition)
- possible damage to patient-clinician relationship
- underlying coincidental physical disorders.

Policy

1.10.1 Local protocols must be produced that cover all aspects of rapid tranquillisation. Such protocols must be in accordance with relevant NICE guidance and guidelines and subject to review.

Training

1.10.2

- All those involved in the administration, prescribing or monitoring of service users receiving parenteral rapid tranquillisation or who employ physical interventions or seclusion must receive mandatory training to a minimum of Intermediate Life Support (ILS-Resuscitation Council UK) (covers airway, cardio-pulmonary resuscitation (CPR) and use of defibrillators).

- The crash bag (including an automatic external defibrillator, a bag valve mask, oxygen, cannulas, fluids, suction and first-line medications) must be available within 3 minutes in healthcare
settings where rapid tranquillisation, physical interventions and seclusion might be used. This equipment should be maintained and checked weekly.

1.10.3 All staff involved in rapid tranquillisation must be trained in the use of pulse oximeters. [D]

1.10.4 Prescribers of medicines must be familiar with and have received training in all aspects of rapid tranquillisation, including:

- the properties of benzodiazepines and their antagonists (flumazenil), anti-psychotics, antimuscarinics and antihistamines
- the risks associated with rapid tranquillisation, particularly when the service user is highly aroused and may have been misusing drugs, be dehydrated or possibly physically ill
- cardio-respiratory effects of the acute administration of these drugs
- the need to titrate doses to effect. [D]

Risks associated with rapid tranquillisation

1.10.5 There are specific risks associated with the different classes of medications that are used in rapid tranquillisation. When combinations are used, risks may be compounded. These include: [D]GPP

For benzodiazepines

- Loss of consciousness.
- Respiratory depression or arrest.
- Cardiovascular collapse (in service users receiving both clozapine and benzodiazepines).

For antipsychotics

- Loss of consciousness.
• Cardiovascular and respiratory complications and collapse.

• Seizures.

• Subjective experience of restlessness (akathisia).

• Acute muscular rigidity (dystonia).

• Involuntary movements (dyskinesia).

• Neuroleptic malignant syndrome.

• Excessive sedation.

For antihistamines

• Excessive sedation.

• Painful injection.

• Additional antimuscarinic effects.

Circumstances for special care

1.10.6 Extreme care needs to be taken when implementing rapid tranquillisation in the following circumstances:

• the presence of congenital prolonged QTc syndromes

• the concurrent prescription or use of other medication that lengthens QTc intervals both directly and indirectly

• the presence of certain disorders affecting metabolism, such as hypo- and hyperthermia, stress and extreme emotions, and extreme physical exertion. [D]

1.10.7 Risk-benefit analysis must be undertaken in cases where service users are pregnant, as there is insufficient evidence on the safety of rapid tranquillisation in pregnancy. [D]GPP

Carrying out rapid tranquillisation
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1.10.8 The service user should be able to respond to spoken messages throughout the period of rapid tranquillisation. The aim of rapid tranquillisation is to achieve a state of calm sufficient to minimise the risk posed to the service user themselves or to others. [D]

1.10.9 When a service user is transferred between units a full medication history, response, adverse effects, advance directive and, where possible, the service user’s account of their experience of rapid tranquillisation should accompany them. On discharge, all such information should be filed in their healthcare record. GPP[D]

Oral therapy for rapid tranquillisation

1.10.10 Oral medication should be offered before parenteral medication as far as possible.[D]

1.10.11 All medication given in the short-term management of disturbed/violent behaviour should be considered as part of rapid tranquillisation (including PRN taken from an agreed rapid tranquillisation protocol or as part of an advance directive).[D]

1.10.12 Oral and intramuscular medications should be prescribed separately and the abbreviation of O/IM should not be used.[D]

1.10.13 Where the behavioural disturbance occurs in a non-psychotic context then it is preferable to initially use oral lorazepam alone, or intramuscularly if necessary.[B]

1.10.14 When there is behaviour disturbance in the context of psychosis, to achieve early onset of calming/sedation, or to lower dose of antipsychotic, an oral antipsychotic (haloperidol/olanzapine/risperidone) in combination with oral lorazepam, should be considered in the first instance. The MHRA have warned against the use of risperidone or olanzapine in the treatment of behavioural symptoms of dementia, due to increased risk of stroke and death. [B]
1.10.15 Sufficient time should be allowed for clinical response between oral doses. (See chart for rapid tranquillisation at end of section.) [B]

**Parenteral therapy for rapid tranquillisation**

1.10.16 If parenteral treatment proves necessary, the intramuscular route is preferred over intravenous from a safety point of view. [D]

1.10.17 Where rapid tranquillisation through oral therapy has repeatedly failed, is refused, is not indicated by previous clinical response or is not a proportionate response, a combination of an intramuscular antipsychotic and an intramuscular benzodiazepine (IM haloperidol and IM lorazepam) is recommended. [B]

1.10.18 In the event of moderate disturbance in service users with psychosis, IM olanzapine may also be considered. IM lorazepam must not be given within one hour of IM olanzapine. Oral lorazepam should be used with caution. [B]

1.10.19 There is not sufficient evidence that the safety of the combination of haloperidol IM with promethazine IM or of midazolam IM has been sufficiently demonstrated to be able to recommend either for routine psychiatric practice in the UK population. [B]

1.10.20 Sufficient time should be allowed for clinical response between IM doses. (See chart for rapid tranquillisation at end of section.) [B]

1.10.21 Using two drugs of the same class for the purpose of rapid tranquillisation is unacceptable. [D]

1.10.22 Medications should never be mixed in the same syringe. [D] GPP

1.10.23 When using IM haloperidol as a means of managing disturbed behaviour, an antimuscarinic agent such as procyclidine or benzatropine should be immediately available to reduce the risk of dystonia and other extrapyramidal side effects, and should be given IM or IV as per manufacturer’s recommendations. [D]
1.10.24

- Intravenous administration of benzodiazepines or haloperidol should not normally be used except in very exceptional circumstances, which must be specified and recorded. This decision must not be made by junior medical staff in isolation.

- However, if immediate tranquillisation is essential then intravenous administration may be necessary. If it is used staff must be appropriately trained to recognise symptoms of respiratory depression, dystonia or cardiovascular compromise (such as palpitations, significant changes in blood pressure, collapse).

- If intravenous medication is used the service user must never be left unattended. Intravenous administration must never occur without full access to the full support and resuscitation as outlined in Recommendation 1.10.2 [D]

1.10.25 In very exceptional circumstances, which must be specified and recorded, haloperidol IM with promethazine IM or midazolam IM may be considered as an alternative to intravenous administration of benzodiazepines or haloperidol. This decision must not be made by junior staff in isolation. [D]

Medications not normally used for rapid tranquillisation

1.10.26

- Zuclopenthixol acetate (clopixol, acuphase), is not recommended for rapid tranquillisation due to long onset and duration of action.

- However, zuclopenthixol acetate(clopixol, acuphase) may be considered as an option:
- when it is clearly expected that the service user will be disturbed over an extended period of time
- when a service user has a past history of good and timely response to zuclopenthixol acetate (clopixol, acuphase).
- when a service user has a past history of repeated parenteral administration.
- when an advance directive has been made indicating that this is a treatment of choice.

- It should never be administered to those without any previous exposure to antipsychotic medication.

- The \textit{BNF} and manufacturer’s SPC must be consulted regarding its use.  [B]

\textbf{Drugs not recommended for rapid tranquillisation}

1.10.27 The following drugs are not recommended for rapid tranquillisation.

- Chlorpromazine IM or oral – a local irritant if given intramuscularly; risk of cardiovascular complications; causes hypotension due to \(\alpha\)-adrenergic receptor blocking effects, especially in the doses required for rapid tranquillisation; is erratically absorbed; its effect on QTc intervals suggests that it is unsuitable for use in rapid tranquillisation.  [C]
- Diazepam IM  [C]
- Thioridazine  [C]
- IM depot anti-psychotics  [D]
- Olanzapine and risperidone should not be used for the management of disturbed behaviour in service users with dementia.  [C]

\textbf{Doses for rapid tranquillisation}

1.10.28

- When using rapid tranquillisation there may be certain circumstances in which the current \textit{BNF} uses and limits and
manufacturers licence may be knowingly exceeded (for example for lorazepam). The rationale must be recorded in the care plan.

- If current BNF doses are exceeded it is particularly important that frequent and intensive monitoring of a calmed service user is undertaken, with particular attention to regular checks of airway, level of consciousness, pulse, blood pressure, respiratory effort, temperature and hydration. [D]

1.10.29

- The total dose of medication prescribed for an acutely disturbed service user must be reviewed:
  - regularly by the responsible consultant or nominated deputy in conjunction with the multidisciplinary team
  - at least every 24 hours (or more often in a rapidly changing situation)
  - paying particular attention to issues of consent, BNF requirements and physical and mental status.

- In all circumstances of rapid tranquillisation, the prescriber and medication administrator must pay attention to issues of consent, BNF requirements and physical and mental status of the service user. [D]

1.10.30

- The dose of antipsychotic medication should be individualised for each service user. [D]GPP

- This will be dependant on several factors including their age; older service users generally require lower doses, those with concomitant physical disorders. (such as renal, hepatic, cardiovascular, or neurological) and concurrent medication. [D]GPP
A specialist mental health pharmacist must be a member of the multidisciplinary team in all circumstances where rapid tranquillisation occurs.

These pharmacists have a responsibility to monitor and ensure safe and appropriate usage of medication. [D]

Care after rapid tranquillisation

After parenteral treatment is administered, vital signs must be monitored and pulse oximeters must be available. Blood pressure, pulse, temperature, respiratory rate and hydration must be recorded regularly, at intervals agreed by a multidisciplinary team, until the service user becomes active again. [D]

In the following circumstances more frequent and intensive monitoring by appropriately trained staff is required and must be recorded in the care plan. Particular attention must be paid to the service user’s respiratory effort, airway, and level of consciousness:

- if the service user appears to be or is asleep/sedated
- if intravenous administration has taken place
- if BNF limit is exceeded
- in high-risk situations
- where the service user has been using illicit substances or alcohol.
- where the service user has a relevant medical disorder or concurrently prescribed medication. [D]
1.10.33 If verbal responsiveness is lost as a consequence of medication administration the patient requires a level of care identical to that needed for general anaesthesia. [D]

### Chart for rapid tranquillisation

<table>
<thead>
<tr>
<th>Medication</th>
<th>Time to maximum plasma concentration</th>
<th>Approximate plasma half life</th>
<th>Licenced indications</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Olanzapine tablets (spc)</td>
<td>5-8 hours</td>
<td>32-50 hours</td>
<td>• treatment of schizophrenia.</td>
<td>not approved for the treatment of dementia-related psychosis and/or behavioural disturbances.</td>
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<td></td>
<td></td>
<td></td>
<td>• maintaining the clinical improvement during continuation therapy in patients who have shown an initial treatment response.</td>
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<td></td>
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<td></td>
<td>• treatment of moderate to severe manic episode.</td>
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<td></td>
<td></td>
<td></td>
<td>• In patients whose manic episode has responded to olanzapine treatment, olanzapine is indicated for the prevention of recurrence in patients with bipolar disorder</td>
<td></td>
</tr>
<tr>
<td>Olanzapine dispersable tablets (spc)</td>
<td>5-8 hours</td>
<td>32-50 hours</td>
<td>• treatment of schizophrenia.</td>
<td>not approved for the treatment of dementia-related psychosis and/or behavioural disturbances.</td>
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<td></td>
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<td></td>
<td>• maintaining the clinical improvement during continuation therapy in patients who have shown an initial treatment response.</td>
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<td>• In patients whose manic episode has responded to olanzapine treatment, olanzapine is indicated for the prevention of recurrence in patients with bipolar disorder</td>
<td></td>
</tr>
<tr>
<td>Olanzapine injection (spc)</td>
<td>15-45 mins</td>
<td>32-50 hours</td>
<td>• Indicated for the rapid control of agitation and disturbed behaviours in patients with schizophrenia or manic episode, when oral therapy is not appropriate. Treatment with Zyprexa Powder for Solution for Injection should be discontinued, and the use of oral olanzapine should be initiated, as soon as clinically appropriate.</td>
<td>IM olanzapine may produce a 5 fold increase in plasma concentration vs the same dose given by the oral route. not approved for the treatment of dementia-related psychosis and/or behavioural disturbances.</td>
</tr>
<tr>
<td>Risperidone tablets (spc)</td>
<td></td>
<td></td>
<td>• the treatment of acute and chronic schizophrenic psychoses, and other psychotic conditions, in which positive or negative symptoms are prominent.</td>
<td>not licensed for the treatment of behavioural symptoms of dementia.</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>• maintaining the clinical improvement during continuation</td>
<td></td>
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<tr>
<td>Drug</td>
<td>Duration</td>
<td>Duration</td>
<td>Indications</td>
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</tr>
</tbody>
</table>
| Risperidone dispersible tablets (spc)     | 1-2 hours| 24 hours | • the treatment of acute and chronic schizophrenic psychoses, and other psychotic conditions, in which positive or negative symptoms are prominent  
• maintaining the clinical improvement during continuation therapy in patients who have shown an initial treatment response.  
• treatment of mania in bipolar disorder. |
| Risperidone liquid (spc)                   | 1-2 hours| 24 hours | • the treatment of acute and chronic schizophrenic psychoses, and other psychotic conditions, in which positive or negative symptoms are prominent  
• maintaining the clinical improvement during continuation therapy in patients who have shown an initial treatment response.  
• treatment of mania in bipolar disorder. |
| Haloperidol tablets (www.intox.org/databank/documents/psych/haloperi/ukpid24.htm) | 3-6 hours| 1-36 hours| • schizophrenia and other psychoses  
• short-term adjunctive management of psychomotor agitation, excitement, olent or dangerously impulsive behaviour, mental or behavioural, disorders especially when associated with hyperactivity and aggression, short-term adjunctive management of severe anxiety, restlessness and agitation in the elderly, intractable hiccup, nausea and vomiting, Gilles de la Tourette syndrome and severe tics. |
| Haloperidol oral solution  
www.intox.org/databank/documents/psych/haloperi/ukpid24.htm) | 3-6 hours| 10-36 hours| • schizophrenia and other psychoses  
• short-term adjunctive management of psychomotor agitation, excitement, olent or dangerously impulsive behaviour, mental or behavioural, disorders especially when associated with hyperactivity and aggression, short-term adjunctive management of severe anxiety, restlessness and agitation in the elderly, intractable hiccup, nausea and vomiting, Gilles de la Tourette syndrome and severe tics. |
| Haloperidol injection  
(spcc and www.intox.org/databank/documents/psych/haloperi/ukpid24.htm) | 15-60 mins| 10-36 hours| • schizophrenia: treatment of symptoms and prevention of relapse  
• other psychoses; especially paranoid  
• mania and hypomania  
• mental or behavioural problems |
such as aggression, hyperactivity and self-mutilation in the mentally retarded and in patients with organic brain damage
- as an adjunct to short term management of moderate to severe psychomotor agitation, excitement, violent or dangerously impulsive behaviour
- nausea and vomiting

| Lorazepam tablets (spc) | 2 hours | 12 hours | • short term treatment of moderate and severe anxiety.
• short term treatment of anxiety in psychosomatic, organic and psychotic illness.
• short term treatment of insomnia associated with anxiety.
• premedication before operative dentistry and general surgery. |

| Lorazepam injection (spc) | 60-90 mins | 12-16 hours | • preoperative medication or premedication for uncomfortable or prolonged investigations.
• the treatment of acute anxiety states, acute excitement or acute mania
• the control of status epilepticus. |

1.11 Incident reporting and post-incident reviews following rapid tranquillisation, physical interventions and seclusion

Incident reporting

1.11.1 Any incident requiring rapid tranquillisation, physical restraint or seclusion should be recorded contemporaneously, using a national template that is available from SMS. [D]

1.11.2 Templates for incident recording were issued by SMS in November 2003. Mandatory training must be given to all appropriate staff to ensure that they are aware of how to correctly record an incident using these appropriate nationally recognised templates. [D]
Post-incident reviews

1.11.3 A post-incident review should take place as soon after the incident as possible, but in any event within 72 hours of the incident ending. [D]GPP

1.11.4 Mental health service providers should have systems in place with appropriately skilled staff to ensure that a range of options of post-incident support and review mechanisms are available and take place within a culture of learning lessons. The following groups should be considered: [D]GPP

- Staff involved in the incidents
- Service users
- Carers and family where appropriate
- Other service users who witnessed the incident
- Visitors who witnessed the incident
- Independent advocates
- Local Security Management Specialist (LMS).

1.11.5 The aim of the review must be to seek to learn lessons and support staff, and encourage the therapeutic relationship between staff, service users and their carers. [D]GPP

1.11.6 The post-incident review should address what happened, any trigger factors, each person's role in the incident, how they felt during the incident, how they feel now, how they may feel in a few days, what can be done about it. [D]GPP

1.11.7 Appropriate support, including ongoing individual post-incident debriefing sessions, should be available as required. [D]GPP
1.11.8 One-off post-incident debriefing sessions have been shown to be unhelpful and should not be undertaken. [B]

1.11.9 Consequential sick leave and the return to work must be monitored and positively and carefully managed to ensure that staff are supported. [D]GPP

1.11.10 Consequential sick leave must be audited to identify trends within the organisation to inform future strategy and training in relation to the management of disturbed/violent behaviour. [D]GPP

1.12 Accident and emergency

In addition to the recommendations and good practice points that are contained within this guideline, the following good practice points relate specifically to accident and emergency settings.

Training

1.12.1 In addition to mandatory training in the management of violence, appropriate staff groups in accident and emergency departments must receive training in the recognition of acute mental illness and awareness of organic differential diagnoses. Service user involvement should be encouraged.[D]

Risk

1.12.2

- Accident and emergency units should have a system in place to alert staff to patients known by the unit to pose a risk of violence, so that steps can be taken to minimise risks to staff and other patients.

- The system should be reviewed at reasonable intervals to avoid stigmatisation. [D]GPP
Environment

1.12.3 Every accident and emergency department must have at least one designated interview room for mental health assessments. Larger accident and emergency departments (more than 75,000 attendances a year) may require additional rooms. The room(s) should be close to or part of the main accident and emergency receiving area. [D]GPP

1.12.4 These rooms must be made available on a priority basis for mental health assessments, be of a sufficient size to comfortably accommodate six seated persons, be fitted with an emergency call system, with an outward opening door, a window for observation, reasonable ventilation, have soft furnishings and be clear of weapons or potential weapons. [D]GPP

1.12.5 Staff interviewing a patient in this room should always inform a senior member of the accident and emergency nursing staff before commencing the interview. [D]GPP

1.12.6 Ordinarily a chaperone should be present, and interviews without chaperones should only proceed after discussion with relevant staff. Where a staff member is alone, 5-minute checks via the interview room window should occur whilst the interview is taking place. [D]GPP

Personnel

1.12.7 Every accident and emergency department must have access to an identified consultant psychiatrist for liaison with providers of local mental health services. [D]GPP

1.12.8 The attendance of a suitably experienced psychiatrist is needed within 1 hour of alert from the accident and emergency department, at all times. [D]

1.12.9 There should be at least one registered mental nurse working with every accident and emergency department. Larger accident and
emergency departments (more than 75,000 attendances a year) may require more. [D]GPP

1.12.10 Accident and emergency departments should be encouraged to employ registered mental nurses. [D]GPP

Rapid tranquillisation

1.12.11 The decision to use rapid tranquillisation should be taken by a senior medical member of staff, where at all possible. [D]GPP

1.12.12 Mental health staff should be contacted at the first available opportunity. [D]GPP

1.12.13 Prior to formal diagnosis, lorazepam is the preferred choice where there is any uncertainty about previous medical history, including history of cardiovascular disease, uncertainty regarding current medication, or possibility of current illicit drug / alcohol intoxication. [D]GPP

1.12.14 Where there is a confirmed history of previous significant antipsychotic exposure, and response, haloperidol alone or in combination with lorazepam are frequently used alternatives. [D]GPP

Where English is not the first language

1.12.15 For patients whose preferred language is not English, interpreting services should be provided. Provision should also be made for patients who are deaf who will need an interpreter who can sign. [D]GPP

Intoxication and substance misuse

For detailed information on the care of patients who present with alcohol related problems and substance misuse please refer to CR118 Psychiatric Services in Accident and Emergency Departments, Royal College of Psychiatrists (London, 2004).

The short-term management of disturbed/violent behaviour in psychiatric in-patient settings and accident and emergency settings: NICE Guideline (draft) July 2004
1.13 Searching

The undertaking of necessary and lawful searches of both service users and visitors can make an important contribution to the effective management of disturbed/violent behaviour in psychiatric in-patient settings. Unlawful, insensitive and unnecessary searches can also exacerbate disturbed/violent behaviour. Searches are the responsibility of nursing staff save in exceptional circumstances where the assistance of others, including the police, may be sought.

1.13.1

- All facilities must have an operational policy on the searching of service users, their belongings, the environment in which they are accommodated and also the searching of visitors. Where necessary the policy should refer to related policies such as those for substance misuse and police liaison.

- The searching policy should be in place in order to ensure the creation and maintenance of a safe and therapeutic environment for service users, staff and visitors. [D]

1.13.2

- The policy should address all aspects of personal through to environmental searching from the decision to initiate a search through to the storage, return or other disposal (including the lawful disposal of any items such as firearms and illicit drugs) of items found.

- Post-search support for all those involved should be provided. [D]

1.13.3
• The policy must set out, in terms that can easily be understood by all those with responsibilities under the policy, the legal grounds for undertaking searches in the absence of consent.

• In doing so, it must specifically address the searching of service users detained under the Mental Health Act; informal service users without capacity to consent at the time of the search; informal service users with capacity to do so; staff and visitors. [D]

• The policy should also extend to the routine and random searching of detained service users without cause, where it is proposed to do so because there is a pressing social need to do so (for example there is a chronic substance abuse problem on the ward) and undertaking such searches is a proportionate response to that need. [D]

1.13.4 The level of intrusiveness of any personal search undertaken must be a reasonable and proportionate response to the reason for the search. Ordinarily rub-down or personal searching should be provided for in the policy, together with procedures for their authorisation in the absence of consent. [D]

1.13.5 All searches must be undertaken with due regard to the service user's dignity and privacy and by members of staff of the same sex. [D]

1.13.6 The policy must provide for the circumstance in which a service user physically resists being searched. In this event a multidisciplinary decision must be made as to the need to carry out a search using physical intervention. If a decision is made not to proceed then the policy must set out the options available to deal with the situation. [D]

1.13.7

• Service users, staff and visitors must be informed that there is a policy on searching.
The consent of the person it is proposed to search must always be sought.

The person being searched must be kept informed of what is happening and why.

A comprehensive record of every search must be made, including its justification.

Any consequent risk assessment and risk management must be placed in the appropriate records. [D]

1.13.8 Following every search undertaken where consent has been withheld there must be a post incident review that includes advocacy service or hospital managers visiting the service user who has been searched. [D]

1.13.9 The exercise of powers of search should be audited regularly and the outcomes reported from time to time to the Trust Board. [D]

1.13.10 All staff involved in the undertaking of searches must receive appropriate training and refresher courses. [D]

2 Notes on the scope of the guidance

All NICE guidelines are developed in accordance with a scope document that defines what the guideline will and will not cover. The scope of this guideline was established at the start of the development of this guideline, following a period of consultation; it is available from www.nice.org.uk/page.aspx?o=29571

The scope of the guideline is the short-term management of disturbed/violent behaviour in adult psychiatric in-patient settings. The guideline covers all adult psychiatric in-patient settings. For the purposes of this guideline, adult was defined as 18 years and older, short-term was defined as 72 hours.
The guideline covers the following interventions: prediction and risk assessment, de-escalation techniques, observation, physical interventions, seclusion, rapid tranquillisation. It also deals with training in these interventions.

In addition, the guideline examine factors in the in-patient environment which relate to the short-term management of disturbed/violent behaviour, service user perspectives on measures for the short-term management of violence, as well as exploring how ethnicity, gender and other special concerns need to be taken into consideration when applying the interventions discussed in the guideline.

Finally, the guideline considers the use of these interventions and related issues in accident and emergency settings.

3 Implementation in the NHS

3.1 In general

Local health communities should review their existing practice for the short-term management of disturbed/violent behaviour in psychiatric inpatient settings against this guideline as they develop their Local Delivery Plans. The review should consider the resources required to implement the recommendations set out in Section 1, the people and processes involved and the timeline over which full implementation is envisaged. It is in the interests of patients that the implementation timeline is as rapid as possible.

Relevant local clinical guidelines, care pathways and protocols should be reviewed in the light of this guidance and revised accordingly.

This guideline should be used in conjunction with the NICE schizophrenia guideline (2003) and the CHI audit material created by the Royal College of Psychiatrists (2004).
3.2 Audit

Suggested audit criteria are listed in Appendix D. These can be used as the basis for local clinical audit, at the discretion of those in practice.

4 Research recommendations

The following research recommendations have been identified for this NICE guideline, not as the most important research recommendations, but as those that are most representative of the full range of recommendations. All of the recommendations for research should consider the importance of including study-level variables relating to gender, ethnicity and those with special concerns. The Guideline Development Group’s full set of research recommendations is detailed in the full guideline produced by the National Collaborating Centre for Nursing and Supportive Care (NCC-NSC) (see Section 5).

4.1 Prospective cohort studies are required to identify antecedents of disturbed/violent behaviour in adult psychiatric inpatient settings.

4.2 Before and after studies, surveys, cross-sectional studies and cohort studies should be undertaken to establish the following in relation to the deliberate application of pain in physical interventions used for the short-term management of disturbed/violent behaviour in adult psychiatric inpatient settings and in accident and emergency settings:

- effectiveness
- ethical and legal and safety aspects
- role within range of physical interventions taught to staff
- staff and service user perceptions.
4.3 Before and after studies, surveys, cross-sectional studies and cohort studies should be undertaken to investigate the following aspects of mechanical restraints for the short-term management of disturbed/violent behaviour in adult psychiatric inpatient settings and in accident and emergency settings:

- effectiveness
- ethical and legal and safety aspects
- role within range of physical interventions taught to staff
- staff and service user perceptions
4.4 Qualitative and survey research is needed to examine service users’ (including Black and minority ethnic groups) views on the antecedents and risk factors of disturbed/violent behaviour, and the use of observation, de-escalation techniques, physical interventions and seclusion for the short-term management of disturbed/violent behaviour in adult psychiatric inpatient settings and in accident and emergency settings.

4.5 Clinical trials and longitudinal cohort studies should be conducted in large, well-designed randomised controlled studies with adult psychiatric inpatients (including Black and minority ethnic groups) that compare the utility, acceptability, safety and desirable endpoints of available medicines and their dosages for rapid tranquillisation and PRN regimes (including atypical and antipsychotics), and assess the long-term side effects.

4.6 Controlled before and after studies are needed to evaluate the major training programmes identified by the National Institute for Mental Health in England (NIMHE) and the NHS Security Management Service (SMS). These studies must assess the short-term and long-term effectiveness of the training programme in psychiatric inpatient settings and assess the safety of the techniques used in these training packages for both staff and service users.

4.7 Prospective cohort studies are needed to develop valid and reliable prediction tools for use in psychiatric inpatient settings appropriate for use in the UK which:

- may predict the imminent onset of disturbed behaviour
- confirm the predictive validity of key risk factors and assist clinical judgment in risk prediction.
4.8 Controlled before and after studies that examine whether observation and/or de-escalation techniques minimise the need for seclusion, restraint or rapid tranquillisation are needed.

4.9 National audit data collections are required on the incidence of sudden death among psychiatric service users (including ethnicity, age and gender) receiving rapid tranquillisation and on death/morbidity associated with restraint and seclusion.

5 Full guideline

The National Institute for Clinical Excellence commissioned the development of this guidance from the National Collaborating Centre for Nursing and Supportive Care (NCC-NSC). The Centre established a Guideline Development Group, which reviewed the evidence and developed the recommendations. The full guideline, *The Short-term Management of Disturbed/Violent Behaviour in Psychiatric In-Patient Settings*, is published by the National Collaborating Centre for Nursing and Supportive Care (NCC-NSC); it is available on the NICE website (www.nice.org.uk) and on the website of the National Electronic Library for Health (www.nelh.nhs.uk).

[Note: these details will apply to the published full guideline.]

The members of the Guideline Development Group are listed in Appendix B. Information about the independent Guideline Review Panel is given in Appendix C.

The booklet *The Guideline Development Process – An Overview for Stakeholders, the Public and the NHS* has more information about the Institute’s guideline development process. It is available from the Institute’s website and copies can also be ordered by telephoning 0870 1555 455 (quote reference N0472).
6 Related NICE guidance

The Institute has issued the following related guidance:


7 Review date

The process of reviewing the evidence is expected to begin 4 years after the date of issue of this guideline. Reviewing may begin earlier than 4 years if significant evidence that affects the guideline recommendations is identified sooner. The updated guideline will be available within 2 years of the start of the review process.

A version of this guideline for service users and carers is available from the NICE website ([www.nice.org.uk](http://www.nice.org.uk)) or from NHS Response Line (telephone 0870 1555 455 and quote reference number N0XXX for an English version and N0XXX for a version in English and Welsh).
Appendix A: Grading scheme

The grading scheme and hierarchy of evidence used in this guideline (see Table) is taken from the NICE Technical Manual (2004).

Grading of recommendations

A

1++, At least one meta-analysis, systematic review or RCT rated as directly applicable to the target population, or
A systematic review of RCTs or a body of evidence consisting principally of studies rated as 1+, directly applicable to the target population and demonstrating overall consistency of results.
Evidence drawn from a NICE technology appraisal.

B

A body of evidence including studies rated as 2++, directly applicable to the target population and demonstrating overall consistency of results, or
Extrapolated evidence from studies rated as 1++ or 1+.

C

A body of evidence including studies rated as 2+, directly applicable to the target population and demonstrating overall consistency of results, or
Extrapolated evidence from studies rated as 2++.

D

Evidence level 3 or 4, or
Formal consensus.

D (GPP)

A good practice point (GPP) is a recommendation for best practice based on the experience of the Guideline Development Group.

Classification of evidence

<table>
<thead>
<tr>
<th>Level of evidence</th>
<th>Type of evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>1++</td>
<td>High quality meta-analyses, systematic review of RCTs, or RCTs with a very low risk of bias</td>
</tr>
</tbody>
</table>
1+ Well conducted meta-analyses, systematic reviews of RCTs, or RCTs with a low risk of bias

1- Meta-analyses, systematic review of RCTs, or RCTs with a high risk of bias*

2++ High quality systematic reviews of case-control or cohort studies. High quality case-control or cohort studies with a very low risk of confounding, bias or chance and a high probability that the relationship is causal.

2+ Well conducted case-control or cohort studies with a low risk of confounding, bias or chance and a moderate probability that the relationship is causal.

2- Case-control or cohort studies with a high risk of confounding, bias or chance and a significant risk that the relationship is not causal.*

3 Non-analytic studies (for example, case reports, case series).

4 Expert opinion, formal consensus.

*Studies with a level of evidence ‘-’ should not be used as a basis for making a recommendation.
Appendix B: The Guideline Development Group

[titles and job descriptions to be added after consultation]

William Bingley
University of Central Lancashire

Tony Bleetman
British Association for Accident & Emergency Medicine

Jackie Chandler
NCC-NSC, Research Assistant

Frank Corr
Royal College of Nursing

Jane Cronin-Davis
Clinical Effectiveness Forum for Allied Health Professionals

Donna-Maria Fraher
Independent Service User Consultant

Phil Hardy
Institute of Conflict Management

Sophie Jones
National Voices Forum

Kevin Gournay
Institute of Psychiatry (Group Leader)

Edwin Gwenzi
Institute of Psychiatry

Sue Johnston
Royal College of Psychiatrists
DRAFT FOR SECOND CONSULTATION

Louise Nelstrop
NCC-NSC Project Manager

Stephen Pereira
National Association of Psychiatric Intensive Care Units

Peter Pratt
Royal Pharmaceutical Society of Great Britain

Rick Tucker
Nursing & Midwifery Council

Aki Tsuchiya
Health Economist, SchAAR
Appendix C: The Guideline Review Panel

The Guideline Review Panel is an independent panel that oversees the development of the guideline and takes responsibility for monitoring its quality. The Panel includes experts on guideline methodology, health professionals and people with experience of the issues affecting patients and carers. The members of the Guideline Review Panel were as follows.

**Mrs Judy Mead (CHAIR)**  
Head of Clinical Effectiveness, Chartered Society of Physiotherapy

**Mrs Joyce Cormie**  
Consumer Representative

**Mrs Gill Hek**  
Reader in Nursing Research, University of the West of England, Bristol

**Ms Karen Cowley**  
Practice Development Nurse, York Health Services NHS Trust

**Mrs Jill Freer**  
Head of Clinical Governance and Quality Development, Leicestershire, Northamptonshire and Rutland Strategic Health Authority

**Miss Amanda Wilde**  
Reimbursement & Outcomes Manager, ConvaTec Ltd
Appendix D: Technical detail on the criteria for audit

The Royal College of Psychiatrists – on behalf of CHI – have developed audit material, most of which could be used at a local level. The audit criteria here are based on those criteria.

There are a wide variety of areas which need to be incorporated in audit relating to the short-term management of violence in psychiatric in-patient settings. The following objectives provide an example of one area, environment, and is taken from the CHI audit tool on the environment. This structure could also be applied to other areas as listed in the audit criteria table below.

**Possible objectives for an audit**

- To ensure that the environment is safe and helps prevent disturbed/violent behaviour.

**People that could be included in an audit and time period for selection**

- Staff who work or have close associations with the ward/unit being audited.

- People who do not have direct links with the ward/unit, for example service user representatives; community health centre members in Wales and patient forums in England; staff from other areas involved in the care pathway.

**Measures that could be used as a basis for an audit**

These audit criteria were devised by the Healthcare Commission audit team at the Royal College of Psychiatrists, who are currently undertaking a national audit on the short-term management of disturbed/violent behaviour in psychiatric in-patient settings. They represent the key audit criteria that
correspond to the areas covered by these guidelines. NICE and the Healthcare Commission have worked closely to ensure consistency.
<table>
<thead>
<tr>
<th>Criterion</th>
<th>Standard</th>
<th>Exception</th>
<th>Definition of terms</th>
</tr>
</thead>
</table>
| Environment | 1. All areas look friendly.  
2. There is a perception of space and overcrowding is avoided.  
3. Sight-lines are unimpeded so that people can see what is happening on different parts of the ward/unit.  
4. The day rooms are open at night for people who cannot sleep.  
5. There is access to external space.  
6. Adequate private spaces are provided for interactions, that is conversations; phone calls; meeting visitors; interviews with staff. | 100% | None | Refer to recommendations 1.1.1-1.1.6 |
7. Single bedrooms are provided.
8. Women-only spaces have been provided.

<table>
<thead>
<tr>
<th>Predication/ risk assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. There is an effective plan to manage risk of violence for each patient at high risk.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>De-escalation techniques</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Staff should be able to summon help easily where de-escalation techniques have failed to calm the service user.</td>
</tr>
<tr>
<td>2. All staff should be aware of other interventions to be used as detailed in the service user's risk assessment/advance directives.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Observation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Nurses carrying out observation have received training in</td>
</tr>
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</table>

observation and have been well-briefed about the service user and are familiar with the ward.

<table>
<thead>
<tr>
<th>Physical interventions</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>1. All staff responsible for applying physical interventions have received training in those interventions.</td>
<td>100%</td>
<td>None</td>
<td>Refer to recommendations 1.7.1-1.7.13</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Seclusion</th>
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</thead>
<tbody>
<tr>
<td>1. During seclusion the following appropriate measures have been implemented:</td>
<td>100%</td>
<td>None</td>
<td>Refer to recommendations 1.8.1-1.8.8</td>
</tr>
<tr>
<td>a) a doctor is present within the first few minutes of seclusion</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b) a nurse is in sight or sound throughout (and present if the service user is sedated)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c) the service user is able to call for assistance</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
d) the service user has kept her/his clothing.
e) seclusion is used for the shortest period possible.

Rapid tranquillisation

<table>
<thead>
<tr>
<th>1. The appropriate precautions were taken prior to the administration of medication:</th>
<th>100%</th>
<th>None</th>
<th>Refer to recommendations 1.9.1-1.9.24</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) A history/mental state examination</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b) A physical examination (if possible)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c) Establishment of a provisional diagnosis and legal status</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d) A multidisciplinary discussion as to whether rapid tranquillisation is safe and appropriate.</td>
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</tbody>
</table>
### Audit of service users

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td>1.</td>
<td>Dignity is maintained.</td>
<td>100%</td>
</tr>
<tr>
<td>2.</td>
<td>Service user is asked if they are satisfied with the choice of therapies and activities available.</td>
<td>None</td>
</tr>
<tr>
<td>3.</td>
<td>The service user is able to speak to staff when needed, for example, if concerned or upset.</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Service user is asked if they are satisfied with involvement in decisions about care and support is recorded.</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>Service user is made to feel safe during their stay.</td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>Service user has been advised on what to do if they see or hear about a violent incident and know how to summon help.</td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>Service users are asked if staff dealt well with threatening or violent incidents.</td>
<td>Refer to recommendations 1.4.1-1.4.5 and 1.4.14</td>
</tr>
</tbody>
</table>
violent behaviour between service users.

### Audit of staff

| 1. The numbers, skills, experience, and qualifications of the staff on each unit are appropriate to the resident population. | 100% |
| 2. Training was received in relation to the prevention or management of violence prior to working on wards/units. | None |
| 3. Staff satisfaction is measured regarding support received from other staff on the ward/unit. | |
| 4. Staff have the opportunity to report when personally attacked, threatened, or made to feel unsafe. | |
| 5. Staff are asked if other staff dealt | Refer to recommendations 1.3.1-1.3.15 |

The short-term management of disturbed/violent behaviour in psychiatric in-patient settings and accident and emergency settings: NICE Guideline (draft) July 2004
well with threatening and violent behaviour towards staff from service users.
**Calculation of compliance**

Compliance (%) with each measure described in the table above is calculated as follows.

\[
\text{Number of patients whose care is consistent with the criterion} \\
\text{plus number of patients who meet any exception listed} \\
\times 100 \\
\text{Number of patients to whom the measure applies}
\]

Clinicians should review the findings of measurement, identify whether practice can be improved, agree on a plan to achieve any desired improvement and repeat the measurement of actual practice to confirm that the desired improvement is being achieved.
Appendix E: The algorithms

**Working with service users with diverse needs**

Listening to service users’ views and taking them seriously is regarded as an important factor in the short-term management of disturbed/ aggressive/ violent behaviour.

All service users, regardless of culture, gender, diagnosis, sexual orientation or religious/spiritual beliefs must be treated with dignity and respect.
The following are key recommendations and good practice points for working effectively with service users generally and especially with those who have diverse needs.

<table>
<thead>
<tr>
<th>Information</th>
<th>Engagement</th>
</tr>
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<tbody>
<tr>
<td>Providing relevant information at each admission (see list below) so that service users feel safe, thus helping them to understand what is happening to them and what may happen to them in the event that they become aggressive/ violent will help prevent unnecessary aggravation.</td>
<td>Where at all possible, service users should have a choice of key worker.</td>
</tr>
<tr>
<td>- name of key worker, how &amp; when to contact</td>
<td>Risk assessment should include an interview with the service user and where appropriate carers. Efforts should be made to ascertain the service user’s own views about their warning signs and preferred strategies for the management of their feelings should they become frightened, angry, frustrated or aggressive.</td>
</tr>
<tr>
<td>Information</td>
<td>Engagement</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>reason for admission (and if on a section, why, type of section, maximum length of detention, right to appeal)</td>
<td>The service user may wish to draw up an advance directive.</td>
</tr>
<tr>
<td>rights with regards to treatments, complaints procedures, access to independent help and advocacy</td>
<td>Special provision must be made for pregnant women in the event that interventions for the short-term management of aggressive/violent behaviour are needed.</td>
</tr>
<tr>
<td>details about the ward and its procedures</td>
<td>These strategies must be documented in the service user’s care plan and healthcare records. Subject to agreement from the service user, a copy should also be given to their carer.</td>
</tr>
<tr>
<td>who to turn to if feeling angry, frightened or frustrated</td>
<td>Following any intervention for the short-term management of aggressive/violent behaviour, every effort must be made to establish whether the service user understands why this has happened. These efforts must be documented in the service user’s notes.</td>
</tr>
<tr>
<td>what may happen if they become aggressive/violent</td>
<td></td>
</tr>
</tbody>
</table>

All Trusts must have a policy for preventing and dealing with all forms of harassment and abuse.

In the event of any form of abuse, the matter should be dealt with by nursing staff as soon as is practicable.
<table>
<thead>
<tr>
<th>There is growing concern that service users from Black and minority ethnic groups, particularly those from Black African and Black Caribbean communities are sometimes adversely affected by negative stereotyping in which they are perceived to be more dangerous than other service users. This may cause staff to use interventions such as restraint, seclusion or rapid tranquillisation before more therapeutic interventions such as de-escalation, distraction or discussion have been tried.</th>
<th>Trusts must identify a board member to take responsibility for diversity and ethnic issues. Responsibilities must include the nature and adequacy of service provision in relation to the short-term management of aggressive/violent behaviour, training on cultural difference, and consultation with local Black and minority ethnic groups.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff should be encouraged to spend time talking with service users, including those from Black and minority ethnic backgrounds so that therapeutic relationships can be established.</td>
<td>Staff should be encouraged to talk to Black and ethnic service users about their experiences and offer them support and understanding, especially if their experiences have been negative.</td>
</tr>
<tr>
<td>Trusts should have a policy that outlines the procedures for dealing with service users who have disabilities.</td>
<td>Individual care plans should detail staff responsibilities for de-escalating, use of rapid tranquillisation, restraining and seclusion of service users who have disabilities.</td>
</tr>
</tbody>
</table>
**Observation (engagement)**

**Aim:** Observation is a skilled nursing intervention that involves therapeutic engagement which aims to empower the patient to actively participate in their care. Rather than "having things done to them i.e. Observations" the patient negotiates the level of engagement that will be most therapeutic.

Every service must have policy on observation that outlines:
- who can instigate observation
- who can increase/decrease the level of observation
- who must review observation level
- when reviews should take place
- how service user views will be taken into account
- the process of review (by a full clinical team) that will take place if observation lasts longer than one week
DRAFT FOR FIRST CONSULTATION

Determining level needed

Level of observation

What observation involves

1. location of service user known to staff at all times
2. Nurse sets aside dedicated time once a shift for positive engagement with service user

GENERAL OBSERVATION

If positive engagement with the service user fails to dissipate potential disturbed/violent behaviour

INTERMITTENT OBSERVATION

2. Potential of disturbed/violent behaviour but no immediate risk

1. service user checked every 15-30mins
2. Observer is sensitive to minimise intrusion and enters into positive engagement with service user.

Short-term Management of Disturbed/Violent Behaviour in Psychiatric In-patient Settings and Accident and Emergency Settings: NICE guideline (June, 2004) Page 84 of 101
1. Service user is in eye sight at all times
2. Possible weapons are removed
3. Searching may be necessary with due regards to service user’s legal rights
4. Positive engagement with the service user is essential

3. Service user could at any time make an attempt to harm others or self

1. Service user is in very close proximity
2. Observer must attempt to maintain privacy, dignity, and have consideration for gender issues when allocating staff
3. Environmental dangers must be discussed and incorporated into care plan
4. Positive engagement with the service user is essential

4. Highest level of harming others or self
Principles of Practice

1. Listen to service user views about level of engagement and incorporate these into the decision making process about level of observation/engagement.
2. Use the least intrusive level of observation possible.
3. Give service user information about why they are being observed, the aim of observation and how long it is likely to last.
4. Record the level of observation in the medical and nursing notes.
5. Ensure that staff carrying out observation are properly trained and know the service user’s history, likes and dislikes, risk factors and early warning signs.
6. When carrying out observation, staff do so with sensitivity to the dignity and need for privacy of the service user.
7. No staff member should carry out continuous observation for more than 2 hours.
8. The service user should be involved in the handover from one observer to another if at all possible.
**Physical interventions**

If a disturbed/violent situation arises and de-escalation techniques have failed to calm the service user it may also be necessary to make use of physical interventions.

**How to carry out physical intervention**

1. Staff should keep trying to calm the situation down through positive engagement with the service user.
2. Physical interventions should only be carried out by trained staff.
3. During physical interventions one member of staff must support and protect the head and neck. They must check that the service user’s airway and breathing are not compromised and monitor vital signs. This member must guide the rest of the team through the physical intervention.
4. The psychological well-being of the service user should be monitored throughout the process.
5. Staff must remember that the level of force must be justifiable, reasonable, appropriate and proportionate.
6. Physical interventions should be used for the shortest time possible. Because of the real dangers of prolonged restraint alternative strategies such as seclusion or rapid tranquillisation should be considered.

**In exceptional circumstances**

- When other techniques have failed it be necessary to used the deliberate application of pain.
- The deliberate application of pain may also be necessary to ‘breakaway’ from a situation or to rescue other staff or service users.

**What not to do**

- Under no circumstances should pressure be applied to the neck, abdomen, back or pelvic area during physical restraint.
After physical interventions

Once the violent incident has been resolved a post incident review should take place. The post incident review should:

- take place as close in time to the incident as possible, but at least within 72hrs.
- consider including all those who were involved in or witnessed the incident.
Seclusion

If a disturbed incident arises and de-escalation techniques have failed to calm the service user, it may also be necessary to make use of seclusion.

Seclusion must be practised in a designated room fit for purpose. The room must have clear observation, be well insulated, have access to toilet/washing facilities and be able to withstand attack/damage.

How to carry out seclusion

1. Those carrying out seclusion must be appropriately trained.
2. The service users’ clothes should not be removed.
3. The service user should be allowed to keep items of cultural/religious significance as long as they don’t compromise the safety of the service user or others.
4. An observation schedule must be specified.
5. Seclusion should be for the shortest time possible and must be reviewed every at least 2 hours.
6. The service user should be made aware that their seclusion will be reviewed at least every 2 hours.

Seclusion and rapid tranquillisation

If a service user is secluded, rapid tranquillisation is not absolutely contraindicated.

However staff should be aware of the complications that can arise from rapid tranquillisation.

The service user should be kept ‘within eye sight’ observation.

Once rapid tranquillisation has taken effect, seclusion should be terminated.

After seclusion

Once the violent incident has been resolved a post incident review should take place.

The post incident review should:
- take place as close in time to the incident as possible, but at least within 72 hours.
- consider including all those who were involved in or witnessed the incident.
Tranquilisation of agitated patients considered likely to be
due to a psychiatric cause for accident and emergency
departments.

This is given as an example of a sedation guideline. It applies to adults, and should not be used for young people.

**CONSIDER NON-DRUG APPROACHES**

Try talking to the patient, use of distraction, seclusion etc.
Seek advice from staff of the intensive care ward

No history of antipsychotics or history unknown; cardiac disease; current illicit drug intoxication

Confirmed history of significant typical antipsychotic exposure (i.e. not just PRN)

**Consider oral therapy**

lorazepam

Oral unsuccessful, or an effect is required within 30 minutes

**Consider injection**

lorazepam intra-muscular (I/M)

Continue talking and using non-drug approaches

Wait 30 minutes.
Repeat lorazepam injection if necessary.

**Consider oral therapy**

lorazepam and/or haloperidol

**Consider injection**

lorazepam I/M or haloperidol I/M.
In extreme cases, consider combination of both** (via separate syringes)

Wait 30 minutes.
Repeat injection(s) if necessary.
(N.B. BNF maximum 18 mg per day for I/M haloperidol)
Continue talking and using non-drug approaches

**If no response to second injection, seek advice from more experienced doctor**
(treatment options can also be discussed with the pharmacy)

**NOTES**

**Emergency resuscitation equipment, procyclidine injection & flumazenil injection must be available before treatment**

- Monitoring of the patient’s vital signs **must be performed & recorded** according to the guidelines overleaf after any injection is given.

- **Combination treatment may be considered on the basis of either previous knowledge of the patient that predicts poor response to a single agent, or if the level of arousal of the patient is such that forced restraint is required and will be very difficult to repeat in 30 minutes time**

- Procyclidine injection 5-10 mg can be given by IV or IM injection for acute dystonic or parkinsonian reactions.

- Flumazenil (a benzodiazepine antagonist) must be given if the respiration rate falls to less than 10 per minute after lorazepam has been used (see panel below)

  **Give flumazenil 200 microgram IV over 15 seconds. If desired level of consciousness is not obtained within 60 seconds, a further 100 microgram can be injected and repeated at 60 second intervals to a maximum total dose of 1 mg (1000 microgram) in 24 hours (initial + 8 additional doses). Monitor respiration rate continuously until it returns to baseline level.**

  **N.B.** the effect of flumazenil may wear off & respiratory depression can return – monitoring must therefore continue beyond initial recovery of respiratory function.

- Zuclopenthixol acetate (Clopixol Acuphase) injection is not quick-acting and **should not be prescribed for rapid tranquillisation.**
Appendix G Abbreviations and general glossary

Abbreviations

Technical terms
A&E  Accident and emergency
ABS  Agitated Behaviour Scale (Corrigan, 1989)
AED  Automated external defibrillators
ARP  Aggression Risk Profile (Kay et al., 1987)
BARS  Behavioural Activity Rating Scale (Swift et al, 1998)
BARS  Barnes Akathisia Rating Scale (Barnes, 1989)
BPRS  Brief Psychiatric Ratings Scale (Overall & Gorham, 1962)
BVC  Brøset Violence Checklist (Almvik, 1996)
CGI  Clinical Global Impressions Scale (Guy & Bonato, 1970)
CGI-I  Clinical Global Impression of Improvement - subscale of CGI (Guy & Bonato, 1970)
CGI-S  Clinical Global Impressions Severity of Illness Scale - subscale of CGI (Guy & Bonato, 1970)
EAQ  Environment Assessment Questionnaire (Lanza, 1996)
EPS  Extrapyramidal symptoms
GCI  Global Clinical Impressions Scale
GDG  Guideline development group
HCR-20  Historical/Clinical/Risk – 20-item scale, version 2 (Webster et al., 1997)
IFP  Information for the Public version
ILS  Intermediate Life Support
LMS  Local security management specialist
MBPRS  Modified Brief Psychiatric Ratings Scale (Tariot et al, 1993)
MMSE  Mini Mental State Examination (Folstein et al., 1975)
MOAS  Modified Overt Aggression Scale (Kay et al., 1988)
NOSIE-30  Nurses Observation Scale for Inpatient Evaluation (Honigfeld, et al 1966)
OAS        Overt Agitation Scale (Yudofsky, 1997)
PANSS      Positive and Negative Syndrome Scale (Kay et al., 1987)
PANSS-EC   Positive and Negative Syndrome Scale Exited Component - subscale of PANSS (Kay et al, 1987)
PICU       Psychiatric intensive care unit
PCF        Patient Characteristic Form b (Lanza, 1996)
PCL:SV     Psychopathy Checklist: Screening Version (Hart et al., 1995)
PRN        Pro-re-nata medication
QNS        Quantified Neurological Scale (Convit et al., 1994)
RAPP       Routine assessment of patient progress (Ehmann et al., 1995)
RCT        Randomised controlled trial
RSU        Regional secure unit
SOAS       Staff Observation Aggression Scale (Palmestierna & Wistedt, 1987)
SOAS-E     Extended Staff Observation Aggression Scale (Hallenstinsen et al, 1998)
SOAS-R     Staff Observation Aggression Scale Revised (Nijman et al., 1999)
TSRS       Target Symptom Rating Scale (Barber et al, 2002)
VAS        Visual analogue scale
VRAG       Violence Risk Appraisal Guide (Harris et al., 1993; Webster et al., 1994)

Organisations
BNF        British National Formulary
DH         Department of Health
MHRA       Medicines and Healthcare Products Regulatory Agency (formerly Medical Devices Agency)
NCC-NSC    National Collaborating Centre for Nursing and Supportive Care
NICE       National Institute for Clinical Excellence
NIMHE      National Institute for Mental Health in England
NMC        Nursing and Midwifery Council (formerly the United Kingdom Central Council for Nurses, Midwives and Health Visitors)

Short-term Management of Disturbed/Violent Behaviour in Psychiatric Inpatient Settings and Accident and Emergency Settings: NICE guideline (June, 2004)
Select Glossary (see full guideline for full general glossary)

**Accident and emergency settings**: any care setting designed to provide emergency treatment and care.

**Acute Care Setting**: short-term (approximately 30 days) in-patient care or emergency services or other 24 hour urgent care setting.

**Admission unit**: unit into which a service user is admitted either directly from A&E or from ambulance services.

**Advance directive**: a document that contains the instructions of a person with mental illness setting out their requests in the event of a relapse, an incident of disturbed/violent behaviour etc. It sets out the treatment that they do not want to receive and any treatment preferences that they may have in the event that they become violent. It also contains people who they wish to be contacted and any other personal arrangement that they wish to be made.

**African Caribbean**: of or pertaining to both Africa and the Caribbean; used to designate the culture, way of life, etc … of those people of Black African descent who are, or whose immediate forebears were, inhabitants of the Caribbean (West Indies). (from Oxford English Dictionary Online).

**Aggression**: a disposition, a willingness to inflict harm, regardless of whether this is behaviorally or verbally expressed and regardless of whether physical harm is sustained.
**Antecedents**: warning signs which indicate that a service user is escalating towards a violent act.

**Black**: those members of the ethnic minority groups who are differentiated by their skin colour or physical appearance, and may therefore feel some solidarity with one another by reason of past or current experience, but who may have many different cultural traditions and values.

**Breakaway**: a set of physical skills to help separate or breakaway from an aggressor in a safe manner. They do not involve the use of restraint.

**Calming**: reduction of anxiety.

**David Bennett inquiry**: public inquiry into the death of David Bennett, a 38 year old Black man who died while being restrained in a medium secure unit in 1998.

**De-escalation**: a complex range of skills designed to abort the assault cycle during the escalation phase, these include both verbal and non-verbal communication skills (*The Prevention and Management of Aggression: A Good Practice Statement*, The Scottish Office, 1996).

**Environment**: the physical and therapeutic external conditions or surroundings.

**Exceptional circumstances**: circumstances that can not reasonably be foreseen and as a consequence cannot be planned for.

**Forensic services**: Mental health services based on authority derived from judicial actions.

**Gender**: Those characteristics of women and men that are socially determined, as opposed to 'sex' which is biologically determined. (*Mainstreaming Gender and Women’s Mental Health Implementation Guide*, 2003).
Good practice point: a recommendation for good practice based on the experience of the guideline development group.

Guideline recommendation: a systematically developed statement that is derived from the best available research evidence, using predetermined and systematic methods to identify and evaluate evidence relating to the specific condition in question.

Low secure units: low secure units deliver intensive, comprehensive, multidisciplinary treatment and care by qualified staff for patients who demonstrate disturbed behaviour in the context of a serious mental disorder and who require the provision of security (Department of Health, Mental Health Policy Implementation Guide, 2002).

Mechanical restraint: a method of physical restraint involving the use of authorised equipment applied in a skilled manner by designated healthcare professionals. Its purpose is to safely immobilise or restrict movement of part/s of the body of the individual concerned.

Minority ethnic group: a group which is numerically inferior to the rest of the population in a State, and in a non-dominant position, whose members possess ethnic, religious or linguistic characteristics which differ from those of the rest of the population and who, if only implicitly, maintain a sense of solidarity towards preserving their culture, traditions, religion or language. (F. Captorti, ‘Minorities’, in R. Bernhardt et al. eds., Encyclopedia of Public International Law, Elsevier (Amsterdam, 1985), vol.8, p.385.)

Observation: a two-way relationship, established between a service users and a nurse, which is meaningful, grounded in trust, and therapeutic for the service user (UKCC, 2002).

Physical intervention: a skilled, hands-on method of physical restraint involving trained designated healthcare professionals to prevent individuals from harming themselves, endangering others or seriously compromising the therapeutic environment. Its purpose is to safely immobilise the individual concerned.

Short-term Management of Disturbed/Violent Behaviour in Psychiatric In-patient Settings and Accident and Emergency Settings: NICE guideline (June, 2004)
PICU (psychiatric intensive care unit): psychiatric intensive care is for patients compulsorily detained usually in secure conditions, who are in an acutely disturbed phase of a serious mental disorder (Department of Health, Mental Health Policy Implementation Guide, 2002).

Positive/therapeutic engagement: may be defined as a skilled nursing intervention that aims to empower the patient to actively participate in their care. Rather than ‘having things done to’ him or her the patient negotiates the level of engagement that will be most therapeutic.

PRN (Pro-re-nata): medication that may be used as the occasion arises.

Psychiatric inpatient settings: any care setting in which psychiatric treatment is given to inpatients.

Psychosocial interventions: the term is used to refer to a range of social, educational, occupational, behavioural, and cognitive interventions. Within the short-term management of disturbed/violent behaviour, the two main psychosocial interventions are de-escalation and observation.

QTc interval: the period in the cardiac cycle between depolarization (causing contraction) and repolarisation of the heart muscle. Some drugs prolong this interval. This can lead to the development of arrhythmias (abnormal electrical activity in the heart) that may cause cardiovascular collapse and death.

Rapid tranquillisation: the use of medication to calm/lightly sedate the service user, reduce the risk to self and/or others and achieve an optimal reduction in agitation and aggression thereby allowing a thorough psychiatric evaluation to take place and allowing comprehension and response to spoken messages throughout the intervention. Although not the overt intention, it is recognised that in attempting to calm/lightly sedate the service user, rapid tranquillisation may lead to deep sedation/anaesthesia.

Respiratory effect: the changes in thoracic or abdominal circumference that occur as the subject breathes
Seclusion: the supervised confinement of a patient in a room, which may be locked to protect others from significant harm. Its sole aim is to contain severely disturbed behaviour that is likely to cause harm to others. Seclusion should be used as a last resort; for the shortest possible time. Seclusion should not be used as a punishment or threat; as part of a treatment programme; because of shortage of staff; or where there is any risk of suicide or self-harm. Seclusion of an informal patient should be taken as an indicator of the need to consider formal detention.

Threat control override symptoms: a combination of feeling threatened and losing the sense of internal control of our own thoughts and actions. This cluster of symptoms tends to be most related to an increased risk of violent behaviour toward others.

Violence: the use of physical force which is intended to hurt or injure another person (Wright, 2002).

Vulnerability: specific factors that relate to the likelihood of an individual being victimised, taken advantage of or exploited by others. Vulnerable individuals may be subject to verbal abuse or harassment, physical or sexual abuse or intimidation, coercion into unwanted acts and bullying. Assessment of vulnerability may include consideration of mental state, physical/physiological conditions, psychological or social problems, cultural or gender issues.