National Institute for
Health and Clinical Excellence

Violence

The short-term management of disturbed/violent behaviour in in-patient psychiatric settings and emergency departments

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Key priorities for implementation

The following recommendations have been identified as priorities for implementation.

Prediction

- Measures to reduce disturbed/violent behaviour need to be based on comprehensive risk assessment and risk management. Therefore, mental health service providers should ensure that there is a full risk management strategy for all their services.

Training

- All service providers should have a policy for training employees and staff-in-training in relation to the short-term management of disturbed/violent behaviour. This policy should 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.
- All staff whose need is determined by risk assessment should receive ongoing competency training to recognise anger, potential aggression, antecedents and risk factors of disturbed/violent behaviour, and to monitor their own verbal and non-verbal behaviour. Training should include methods of anticipating, de-escalating or coping with disturbed/violent behaviour.
- All staff involved in administering or prescribing rapid tranquillisation, or monitoring service users to whom parenteral rapid tranquillisation has been administered, should receive ongoing competency training to a minimum of Immediate Life Support (ILS – Resuscitation Council UK) (covers airway, cardio-pulmonary resuscitation [CPR] and use of defibrillators).
- Staff who employ physical intervention or seclusion should as a minimum be trained to Basic Life Support (BLS – Resuscitation Council UK).

Commentary

No studies were identified that specifically addressed the issues described in the five key priorities above (the extent to which risk assessment and risk management reduce the risk of disturbed/violent behaviour; the effectiveness of policies on training or training itself in relation to the management of disturbed/violent behaviour; or training in relation to resuscitation in psychiatric settings). The Guideline Development Group carefully considered the available evidence and used formal consensus techniques to extrapolate and develop these

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recommendations. In the opinion of the Group the fulfilment of the last two recommendations above constitutes a duty of care. (See also the Legal preface *.)*

Working with service users

- Service users should have access to information about the following in a suitable format:
    - which staff member has been assigned to them and how and when they can be contacted
    - why they have been admitted (and if detained, the reason for detention, the powers used and their extent, and rights of 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 disturbed/violent.

This information needs to be provided at each admission, repeated as necessary and recorded in the notes.

Commentary

Although no studies were identified that specifically addressed the issue of information provision for service users, the Guideline Development Group viewed this as an important issue requiring guidance. The Group maintain it is a legal right that detained service users are given this information and that this information should be viewed as a right for all service users. (See also the Legal preface *.)*

- Service users identified to be at risk of disturbed/violent behaviour should be given the opportunity to have their needs and wishes recorded in the form of an advance directive. This should fit within the context of their overall care and should clearly state what intervention(s) they would and would not wish to receive. This document should be subject to periodic review.

Commentary

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Although no studies were identified that specifically addressed the issue of advance directives, the Guideline Development Group (in particular those with personal experience of the issue) felt that it was important for service users to be able to have input into their care. The Group did not consider that discussing these issues with appropriate service users would cause unnecessary anxiety. The Group used formal consensus techniques to develop this recommendation.

Rapid tranquillisation, physical intervention and seclusion

- Rapid tranquillisation, physical intervention and seclusion should only be considered once de-escalation and other strategies have failed to calm the service user. These interventions are management strategies and are not regarded as primary treatment techniques. When determining which 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.

Commentary

There is a lack of evidence relating to the effectiveness of these three interventions, particularly for physical intervention and seclusion. The Guideline Development Group therefore felt the need to stress caution when implementing these interventions, and used formal consensus techniques to derive this recommendation. (See also the Legal preface *.)*

Physical intervention

- During physical intervention one team member should be responsible for protecting and supporting the head and neck, where required. The team member who is responsible for supporting the head and neck should take responsibility for leading the team through the physical intervention process, and for ensuring that the airway and breathing are not compromised and that vital signs are monitored.

Commentary

There is limited evidence in this area. However, a number of high profile inquiries, most recently, the inquiry into the death of David Bennett, have stressed the need for staff to protect a service user's head and airway during the physical intervention process. The inquest suggests that failure to do so, and the application of pressure to certain parts of the body, may endanger the

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life of the service user. The focus groups conducted for this guideline also heard reports from participants who described finding it difficult to breathe during physical intervention due to their head not being sufficiently supported. After consultation with experts, including trainers, the Guideline Development Group used formal consensus techniques to develop recommendations in this area. The Group consider the protection of the head when appropriate to constitute a duty of care. (See also the Legal preface *.)*

- A number of physical skills may be used in the management of a disturbed/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.
  - Every effort should be made to utilise skills and techniques that do not use the deliberate application of pain.
  - The deliberate application of pain has no therapeutic value and could only be justified for the immediate rescue of staff, service users and/or others.

Commentary

There is limited evidence in this area. A great deal of discussion took place in the course of the development of the guideline concerning this issue. To ensure a balanced representation at guideline development meetings, experts holding differing perspectives were invited to give presentations. Using formal consensus techniques the Guideline Development Group derived a recommendation which restricts the use of pain to the immediate rescue of staff, service users or others.

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Introduction

Disturbed or violent behaviour by an individual in an adult in-patient 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 trusts was more than three times the average for all trusts (the data include learning disability trusts which are outside the scope of this guideline).

This guideline discusses the short-term management **(72 hours)** of disturbed/violent behaviour in adult psychiatric settings and in service users attending emergency departments for mental health assessments. The guidance applies to all adults aged 16 years and older.

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
- searching
- de-escalation techniques
- observation
- physical intervention
- seclusion
- rapid tranquillisation
- post-incident reviews
- emergency departments.

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Legal preface

This guideline makes recommendations about the short-term management of disturbed/violent behaviour in adult psychiatric in-patient settings and when service users present for mental health assessment in emergency departments. This takes place within a multi-faceted legal framework, compliance with which is a core measure of quality and good practice. For example, the management of disturbed/violent behaviour frequently involves interventions to which an individual does not – or cannot – consent. It is especially important that such interventions are in accordance with best practice.

Failure to act in accordance with the guideline may not only be a failure to act in accordance with best practice, but in some circumstances may have legal consequences. For example, any intervention required to manage disturbed behaviour must be a reasonable and proportionate response to the risk it seeks to address.

The service should ensure access to competent legal advice when required in relation to the management of disturbed/violent behaviour.

The law provides the authority to respond to disturbed/violent behaviour in some circumstances, and it sets out considerations that are extremely important when service providers have to decide what action they may take. The contribution of the law to the management of disturbed/violent behaviour should be recognised as positive and facilitative.

All those involved in the short-term management of disturbed/violent behaviour in psychiatric in-patient settings and emergency departments should:

- be familiar with, in particular:
- the relevant sections of the Mental Health Act 1983 and its Code of Practice
- the principles underlying the common law doctrine of 'necessity', and
- the requirements of the relevant articles of the European Convention on Human Rights, including Article 2 (right to life) and Article 3 (the right to be free from torture or inhuman or degrading treatment or punishment), Article 5 (the right to liberty and security of person save in prescribed cases) and Article 8 (the right to respect for private and family life), and the principle of 'proportionality'

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- the Health and Safety at Work Act 1974, which place duties on both employers and employees, and applies to the risk of violence from patients and the public
- the Management of Health and Safety at Work Regulations 1992, which place specific duties on the employer to ensure suitable arrangements for the effective planning, organisation, control, maintenance and review of health and safety (these duties include ensuring that the risk assessments are undertaken and implemented)
- receive regular training on the legal aspects of the management of disturbed/violent behaviour
- ensure that a comprehensive record is made of any intervention necessary to manage an individual's disturbed/violent behaviour, including full documentation of the reason for any clinical decision
- ensure or contribute to ensuring that all aspects of the management of disturbed/violent behaviour are monitored on a regular basis, and that any consequential remedial action is drawn to the attention of those responsible for implementing it
- be aware of the obligations owed to a service user while his/her disturbed/violent behaviour is being managed, and of parallel obligations to other service users affected by the disturbed/violent behaviour, to members of staff, and to any visitors
- ensure or contribute to ensuring that any service user who has exhibited disturbed/violent behaviour should not be the subject of punitive action by those charged with providing him/her with care and treatment, and that where the disturbed/violent behaviour is thought to warrant criminal sanction, it is drawn to the attention of the proper authority.

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1 Guidance

1.1 Environment (in-patient psychiatric settings)

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

Safety and security

1.1.1.1 When staff are engaged in the short-term management of disturbed/violent behaviour, every effort should be made to manage the service user in an open care setting.

1.1.1.2 All services should provide a designated area or room that staff may consider using, with the service user's agreement, specifically for the purpose of reducing arousal and/or agitation. In services where seclusion is practised, this area should be in addition to a seclusion room (see recommendation 1.1.1.3).

1.1.1.3 In services in which seclusion is practised there should be a designated seclusion room fit for purpose. This room should allow clear observation, be well insulated and ventilated, have access to toilet/washing facilities and be able to withstand attack/damage.

1.1.1.4 Secure, lockable access to a service user's room, bathroom and toilet area is required, with external staff override.

1.1.1.5 The internal design of the ward should be arranged to facilitate observation, and sight lines should be unimpeded (for example, not obstructed by the opening of doors). Measures should be taken to address blind spots within the facility, including consideration of the use of CCTV and parabolic mirrors.

1.1.1.6 Facilities should ensure routes of safe entry and exit in the event of an emergency related to disturbed/violent behaviour.

1.1.1.7 There should be a separate area to receive service users with police escorts.

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Activities and external areas

1.1.1.8 The environment should take into account the service user's needs.

- 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 disturbed/violent behaviour.
- Service users should have single sex toilets, washing facilities, day areas and sleeping accommodation.
- There should be a space set aside for prayer and quiet reflection.

1.1.1.9 There should be daily opportunities for service users to engage in physical exercise, group interaction, therapy and recreation.

1.1.1.10 There should be access to the day room at night for service users who cannot sleep.

1.1.1.11 Service users should be able to have easy access to fresh air and natural daylight.

1.1.1.12 Where practicable, access to an external area should be via the unit and where necessary, appropriate standards of fencing should be provided.

Service user concerns

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

- safety
- privacy
- dignity
- gender- and cultural-sensitivity
- sufficient physical space

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- social and spiritual expression.

1.1.1.14 Where possible, service users should have privacy when making phone calls, receiving guests, and talking to a staff member.

1.1.1.15 Facilities should have adequate means of controlling light, temperature, ventilation and noise.

1.1.1.16 Internal smoking areas/rooms should have powerful ventilation and be fitted with a smoke-stop door(s).

1.1.1.17 All areas should look and smell clean.

1.1.1.18 Suitable access facilities are needed for people who have problems with mobility, orientation, visual or hearing impairment or other special needs.

Alarms

1.1.1.19 Each service should 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 should be disseminated, and staff made familiar with its contents.

1.1.1.20 Comprehensive risk assessment of the clinical environment should be used to determine whether supplementary personal alarms should be issued to individual staff members and vulnerable service users.

1.1.1.21 Collective responses to alarm calls should be agreed before incidents occur. These should be consistently applied and rehearsed.

1.1.1.22 Furniture should be arranged so that alarms can be reached and doors are not obstructed.

1.1.1.23 Alarms should be accessible in interview rooms, reception areas and other areas where one service user and one staff member work together.

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1.1.1.24 All alarms (for example, panic buttons and personal alarms) should be well maintained and checked regularly.

Clinical environment

1.1.1.25 There should be a regular and comprehensive general risk assessment to ensure the safety of the clinical environment.

1.1.1.26 Bed occupancy should be decided at a local level and this level should not be exceeded, because overcrowding leads to tension, frustration and overstretched staff.

1.1.1.27 There should be a stable and consistent in-patient team, as high staff turnover and overuse of short-term bank, locum and agency healthcare staff may create an unsafe environment.

Interagency working

1.1.1.28 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. Such policies should set out what constitutes an emergency requiring police intervention.

1.2 Prediction

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

Policy

1.2.1.1 Measures to reduce disturbed/violent behaviour need to be based on comprehensive risk assessment and risk management. Therefore, mental health service providers should ensure that there is a full risk management strategy for all their services.

Risk assessment

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1.2.1.2 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 trigger factors, early warning signs of disturbed/violent behaviour and other vulnerabilities, and the management of these. Sensitive and timely feedback should complete this process.

1.2.1.3 Risk assessment should be used to establish whether a care plan should include specific interventions for the short-term management of disturbed/violent behaviour.

1.2.1.4 When assessing for risk of disturbed/violent behaviour, care needs to be taken not to make negative assumptions based on ethnicity. Staff members should be aware 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.

1.2.1.5 All staff should be aware of the following factors that may provoke disturbed/violent behaviour:

- attitudinal
- situational
- organisational
- environmental.

1.2.1.6 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.

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

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1.2.1.8 The approach to risk assessment should be multidisciplinary and reflective of the care setting in which it is undertaken. The findings of the risk assessment should be communicated across relevant agencies and care settings, in accordance with the law relating to patient confidentiality.

Antecedents and warning signs

1.2.1.9 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 should be considered on an individual basis.

- 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.
- Discontentment, refusal to communicate, withdrawal, 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 disturbed/violent episodes.
- Reporting anger or violent feelings.
- Blocking escape routes.

Risk factors

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Certain factors can indicate an increase risk of physically violent behaviour. The following lists are not intended to be exhaustive and these risk factors should be considered on an individual basis.

1.2.1.10 Demographic or personal history should be taken into account when assessing the risk of disturbed/violent behaviour, including the following features.

- History of disturbed/violent behaviour.
- History of misuse of substances or alcohol.
- Carers reporting service user's previous anger or violent feelings.
- Previous expression of intent to harm others.
- Evidence of rootlessness or 'social restlessness'.
- Previous use of weapons.
- Previous dangerous impulsive acts.
- Denial of previous established 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.
- One or more of the above in combination with any of the following:
  - cruelty to animals
  - reckless driving.
  - history of bed wetting
  - loss of a parent before the age of 8 years.

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1.2.1.11 Clinical variables should be taken into account when assessing the risk of disturbed/violent behaviour, including the following features.

- Misuse of substances and/or alcohol.
- Drug effects (disinhibition, akathisia).
- Active symptoms of schizophrenia or mania, in particular
  - delusions or hallucinations focused on a particular person
  - command hallucinations
  - 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.
- Organic dysfunction.

1.2.1.12 Situational variables should be taken into account when assessing the risk of disturbed/violent behaviour, including the following features.

- Extent of social support.
- Immediate availability of a potential weapon.
- Relationship to potential victim (for example, difficulties in relationship are known).
- Access to potential victim.
- Limit setting (for example, staff members setting parameters for activities, choices etc.).
- Staff attitudes.

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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 disturbed/violent behaviour safeguards both staff and service users. Training that highlights awareness of racial, cultural, social and religious/spiritual needs, and gender differences, along with other special concerns, also mitigates against disturbed/violent behaviour. Such training should be properly audited to ensure its effectiveness.

Policy

1.3.1.1 All service providers should have a policy for training employees and staff-in-training in relation to the short-term management of disturbed/violent behaviour. This policy should 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.

1.3.1.2 All service providers should specify who the training provider is and ensure consistency in terms of training and refresher courses.

1.3.1.3 Training relating to the management of disturbed/violent behaviour should be subject to approved national standards.[1]

1.3.1.4 If participants on training courses demonstrate inappropriate attitudes then trainers should pass this information onto the relevant line manager for appropriate action.

Specific staff training needs

1.3.1.5 There should be an ongoing programme of training for all staff in racial, cultural, spiritual, social and special needs 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.

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

1.3.1.7 Staff members responsible for carrying out observation and engagement should receive ongoing competency training in observation so that they are equipped with the skills and confidence to engage with service users.

1.3.1.8 All staff involved in administering or prescribing rapid tranquillisation, or monitoring service users to whom parenteral rapid tranquillisation has been administered, should receive ongoing competency training to a minimum of Immediate Life Support (ILS – Resuscitation Council UK) (covers airway, cardio-pulmonary resuscitation [CPR] and use of defibrillators).

1.3.1.9 Staff who employ physical intervention or seclusion should as a minimum be trained to Basic Life Support (BLS – Resuscitation Council UK).

1.3.1.10 All staff whose level of need is determined by risk assessment should receive training to ensure current competency in the use of physical intervention which should adhere to approved national standards.[1]

1.3.1.11 Service providers should ensure that staff's capability to undertake physical intervention and physical intervention training courses is assessed.

1.3.1.12 All staff whose level of need is determined by risk assessment should receive ongoing competency training in the use of seclusion. Training should include appropriate monitoring arrangements for service users placed in seclusion.

1.3.1.13 All staff involved in rapid tranquillisation should be trained in the use of pulse oximeters.

1.3.1.14 Prescribers and those who administer medicines should be familiar with and have received training in rapid tranquillisation, including:

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- the properties of benzodiazepines; their antagonist, flumazenil; antipsychotics; antimuscarinics; and antihistamines
- the risks associated with rapid tranquillisation, including cardio-respiratory effects of the acute administration of these drugs, particularly when the service user is highly aroused and may have been misusing drugs; is dehydrated or possibly physically ill
- the need to titrate doses to effect.

1.3.1.15 All staff involved in undertaking of searches should receive appropriate instruction which is repeated and regularly updated.

Incident recording

1.3.1.16 Training should be given to all appropriate staff to ensure that they are aware of how to correctly record any incident using the appropriate local templates.

Refresher courses

1.3.1.17 Services should review their training strategy annually to identify those staff groups that require ongoing professional training in the recognition, prevention and de-escalation of disturbed/violent behaviour and in physical intervention to manage disturbed/violent behaviour.

Evaluating training

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

1.3.1.19 Independent bodies/service user groups should, if possible, be involved in evaluating the effectiveness of training.

Service user training/involvement in training

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1.3.1.20 Service users and/or service user groups should have the opportunity to become actively involved in training and setting the training agenda, for example groups with potential vulnerabilities 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
- female service users
- service users with communication difficulties.

1.4 Working with service users

There is a growing acceptance that service users in adult psychiatric in-patient settings ought to be involved in their care, as far as possible. This extends to the short-term management of disturbed/violent behaviour 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 recommendations and good practice points that follow also address the needs that arise from diversity (cultural, social, religious/spiritual and gender-related needs) and physical needs in the context of the short-term management of disturbed/violent behaviour. It is important that service users should not be treated less favourably on the basis of their culture, gender, diagnosis, sexual orientation, disability, ethnicity or religious/spiritual beliefs.

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 may happen to them in the event that they become disturbed/violent will help prevent unnecessary aggravation.

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1.4.1.1 All service users, regardless of culture, gender, diagnosis, sexual orientation, disability, ethnicity or religious/spiritual beliefs should be treated with dignity and respect.

1.4.1.2 Service users should have access to information about the following in a suitable format:

- which staff member has been assigned to them and how and when they can be contacted
- why they have been admitted (and if detained, the reason for detention, the powers used and their extent, and rights of 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 disturbed/violent.

This information needs to be provided at each admission, repeated as necessary and recorded in the notes.

1.4.1.3 An effective and fair complaints procedure should be put in place.

1.4.1.4 Where at all possible, service users should have a choice of key worker.

1.4.1.5 Service users identified to be at risk of disturbed/violent behaviour should be given the opportunity to have their needs and wishes recorded in the form of an advance directive. This should fit within the context of their overall care and should clearly state what intervention(s) they would and would not wish to receive. This document should be subject to periodic review.

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1.4.1.6 During the staff/service user risk assessment interview, where a risk of disturbed/violent behaviour is discussed or identified as a possibility, intervention and management strategies (and the service user's preferences regarding these) should be recorded in the service user's care plan and healthcare record. Efforts should be made to ascertain the service user's own views about their trigger factors, early warning signs of disturbed/violent behaviour and other vulnerabilities, and the management of these. The service user should be given a copy of the care plan and, subject to their agreement, a copy should be given to their carer.

1.4.1.7 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 the service user's physical needs.

1.4.1.8 Following any intervention for the short-term management of disturbed/violent behaviour, every opportunity should be taken to establish whether the service user understands why this has happened. Where possible, this should be carried out by a staff member not directly involved in the intervention. This should be documented in the service user's notes.

1.4.1.9 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.

1.4.1.10 All services should have a policy for preventing and dealing with all forms of harassment and abuse. Notification of this policy should be disseminated to all staff and displayed prominently in all clinical and public areas.

1.4.1.11 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 policies of the service.

1.4.1.12 During the administration or supply of medicines to service users, confidentiality should be ensured.

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1.4.1.13 Prescribers should be available for and responsive to requests from the service user for medication review.

1.4.1.14 Staff should be encouraged to talk to service users from diverse backgrounds, including those with special needs, about their experiences and to offer them support and understanding, especially if their experience has been negative.

Pregnant women

1.4.1.15 Special provision should be made for pregnant women in the event that interventions for the short-term management of disturbed/violent behaviour are needed. These should be recorded in the service user's care plan.

Black and minority ethnic service users

See also recommendation 1.2.2.3

1.4.1.16 Services must identify a board member to take specific responsibility for all matters relating to equality and diversity. Responsibilities must include the nature and adequacy of service provision in relation to the short-term management of disturbed/violent behaviour, training on all matters relating to equality and diversity, monitoring service usage by ethnicity and consultation with local Black and minority ethnic groups.

Service users with disabilities

1.4.1.17 Each service should have a policy that outlines the procedures for dealing with service users who have disabilities, including those with physical or sensory impairment and/or other communication difficulties.

1.4.1.18 Individual care plans should detail staff responsibilities for de-escalation, rapid tranquillisation, physical intervention and seclusion of service users who have disabilities, including those with physical or sensory impairment and/or other communication difficulties.

Managing the risk of HIV or other infectious diseases

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Policy

1.4.1.19 Services should have policies in place, developed in conjunction with the Trust infection control officer or relevant officer in the service, 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.

1.4.1.20 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 or relevant officer in the service should be sought.

Confidentiality issues

1.4.1.21 Service users 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 a manner that puts others at risk. Legal and ethical advice should be sought in these circumstances.

1.4.1.22 If any service user or staff member has sustained any injury during the management of disturbed/violent behaviour where blood has been spilt or the skin has been broken, or there has been direct contact with bodily fluids (all bodily fluids should be treated as potentially infectious), the local infection control policy should be followed.

1.5 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 should be undertaken by appropriately trained staff.

See also recommendation 1.3.2.11 (Training)

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Policy

1.5.1.1 All facilities should have an operational policy on the searching of service users, their belongings and 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.

1.5.1.2 The searching 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.

1.5.1.3 Post-search support for all those involved should be provided.

1.5.1.4 The searching policy should 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.

1.5.1.5 The searching policy should 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; and staff and visitors.

1.5.1.6 The searching policy should also extend to the routine and random searching of detained service users, 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.

Carrying out searches

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1.5.1.7 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.

1.5.1.8 All searches should be undertaken with due regard to the service user's dignity and privacy and by a member(s) of staff of the same sex.

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

1.5.1.10 The searching policy should make provision for the following:

- service users, staff and visitors should be informed that there is a policy on searching
- the consent of the person it is proposed to search should always be sought
- the person being searched should be kept informed of what is happening and why
- a comprehensive record of every search should be made, including its justification
- any consequent risk assessment and risk management should be placed in the appropriate records.

1.5.1.11 Following every search undertaken where consent has been withheld there should be a post-incident review that includes an advocacy service or hospital managers visiting the service user who has been searched.

1.5.1.12 The exercise of powers of search should be audited regularly and the outcomes reported regularly to the Trust Board or appropriate body.

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1.6 De-escalation techniques

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 situation. Action plans should be developed at a local level that detail how to call for help in an emergency.

See also recommendation 1.1.1.2 (Environment) and recommendation 1.3.2.2 (Training)

General

1.6.1.1 A service user's anger needs to be treated with an appropriate, measured and reasonable response. De-escalation techniques should be employed prior to other interventions being used.

1.6.1.2 Staff should accept that in a crisis situation they are responsible for avoiding provocation. It is not realistic to expect the person exhibiting disturbed/violent behaviour to simply calm down.

1.6.1.3 Staff should learn to recognise what generally and specifically upsets and calms people. This will involve listening to individual service user's and carer's reports of what upsets the service user, and this should be reflected in the service user's care plan.

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

1.6.1.5 Where possible and appropriate, service users should be encouraged to recognise their own trigger factors, early warning signs of disturbed/violent behaviour, and other vulnerabilities. This information should be included in care plans and a copy given to the service user. Service users should also be encouraged to discuss and negotiate their wishes should they become agitated.

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1.6.1.6 Where de-escalation techniques fail to sufficiently calm a situation or service user, staff should remember that verbal de-escalation is an ongoing element of the management of an escalating individual. Verbal de-escalation is supported but not replaced by appropriate physical intervention.

De-escalation techniques

1.6.1.7 One staff member should assume control of a potentially disturbed/violent situation.

1.6.1.8 The staff member who has taken control should:

- consider which de-escalation techniques are appropriate for the situation
- manage others in the environment, for example removing other service users from the area, enlisting the help of colleagues and creating space
- explain to the service user and others in the immediate vicinity what they intend to do
- give clear, brief, assertive instructions
- move towards a safe place and avoid being trapped in a corner.

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

- attempting to establish a rapport and emphasising cooperation
- offering and negotiating realistic options and avoiding threats
- asking open questions and inquiring about the reason for the service user's anger, for example '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, and not being patronising or minimising service user concerns.

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1.6.1.10 The staff member who has taken control should ensure that their own non-verbal communication is non-threatening and not provocative. This will involve:

- paying attention to non-verbal cues, such as eye contact and allowing greater body space than normal
- adopting a non-threatening but safe posture
- appearing calm, self-controlled and confident without being dismissive or over-bearing.

1.6.1.11 Where there are potential weapons the disturbed/violent person should be relocated to a safer environment, where at all possible.

1.6.1.12 Where weapons are involved a staff member should ask for the weapon to be placed in a neutral location rather than handed over.

1.6.1.13 Staff should consider asking the service user to make use of the designated area or room specifically for the purpose of reducing arousal and/or agitation to help them calm down. In services where seclusion is practised, the seclusion room should not routinely be used for this purpose (see recommendation 1.1.1.2).

1.7 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 user and a staff member, which is meaningful, grounded in trust, and therapeutic for the service user.[2] Observation is an intervention that is used both for the short-term management of disturbed/violent behaviour 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. The terminology covers both uses of observation.

See also recommendation 1.3.2.3 (Training)

Policy

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1.7.1.1 Each service should have a policy on observation and engagement that adheres to contemporary NICE terminology and definitions. This policy should include:

- who can instigate observation above a general level
- who can increase or decrease the level of observation
- who should review the level of observation
- when reviews should take place (at least every shift)
- how service users' 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.

Definitions of levels of observation

1.7.1.2 The observation terminology used in this guideline should be adopted across England and Wales to ensure consistency of use.

1.7.1.3 *General observation* is the minimum acceptable level of observation for all in-patients. 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 assessment 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.

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1.7.1.4 *Intermittent observation* means that the service user's location should 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.

1.7.1.5 *Within eyesight* means 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 themselves or others should be removed. It is required when the service user could, at any time, make an attempt to harm themselves or others. 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.

1.7.1.6 *Within arms length* is needed for service users at the highest levels of risk of harming themselves or others, who should 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.

Possible antecedentsor warning signs that observation is required

1.7.1.7 In addition to the antecedents that indicate disturbed/violent behaviour (see recommendation 1.2.3.1), observation above a general level should be considered if any of the following are present:

- history of previous suicide attempts, self-harm or attacks on others
- hallucinations, particularly voices suggesting harm to self or others

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- 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 override 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.

Carrying out observation

1.7.1.8 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.

1.7.1.9 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.

1.7.1.10 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.

1.7.1.11 All decisions about the specific level of observation should take into account:

- the service user's current mental state
- any prescribed medications and their effects
- the current assessment of risk
- the views of the service user as far as possible.

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1.7.1.12 When making decisions about observation levels, clear directions should be recorded that specify:

- the name/title of the persons who will be responsible for carrying out the review
- the timing of the review.

1.7.1.13 Observation skills should be used to recognise, prevent and therapeutically manage disturbed/violent behaviour. Specific observation tasks should be undertaken by registered nurses, who may delegate to competent persons.

1.7.1.14 Nurses and other staff undertaking observation:

- should take an active role in engaging positively with the service user
- should be appropriately briefed about the service user's history, background, specific risk factors and particular needs
- should be familiar with the ward, the ward policy for emergency procedures and potential risks in the environment
- should be able to increase or decrease the level of engagement with the service user as the level of observation changes
- should be approachable, listen to the service user, know when self-disclosure and the therapeutic use of silence are appropriate and be able to convey to the service user that they are valued.

1.7.1.15 An individual staff member should not undertake a continuous period of observation above the general level for longer than 2 hours.

1.7.1.16 The service user's psychiatrist/on-call doctor should be informed of any decisions concerning observation above the general level as soon as possible.

1.7.1.17 A nominated hospital manager should be made aware when observation above the general level is implemented so that adequate numbers and grades of staff can be made available for future shifts.

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1.7.1.18 Staff members should be aware that service users sometimes find observation provocative, and that it can lead to feelings of isolation and even dehumanisation.

Service user needs

1.7.1.19 The service user should be provided with information about why they are under observation, the aims of observation and how long it is likely to be maintained.

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

1.7.1.21 Although difficult, where possible, the handover from one nurse or staff member to another should involve the service user so that they are aware of what is being said about them.

1.8 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 intervention, rapid tranquillisation and seclusion to manage the incident. All such interventions should only be considered once de-escalation techniques have been tried and have not succeeded in calming the service user.

The choice of intervention(s) will depend on a number of factors, but should be guided primarily by:

- service user preference (if known)
- the clinical needs of, and risks to, the service user
- obligations to other service users affected by the disturbed/violent behaviour
- the protection of staff, service users and visitors
- the facilities available within the particular setting.

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The intervention selected must amount to a proportionate and reasonable response to the risk posed. This section should be read alongside the Mental Health Act Code of Practice.

Overarching recommendations

See also recommendations 1.3.2.4 and 1.3.2.5 (Training); 1.9.1.1 and 1.9.1.2 (Incident reporting)

1.8.1.1 Rapid tranquillisation, physical intervention and seclusion should only be considered once de-escalation and other strategies have failed to calm the service user. These interventions are management strategies and are not regarded as primary treatment techniques. When determining which 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.

Equipment

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

Personnel

1.8.1.3 At all times, a doctor should be quickly[3] available to attend an alert by staff members when rapid tranquillisation, physical intervention and/or seclusion are implemented.

Legal concerns

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1.8.1.4 All staff need to be aware of the legal framework that authorises the use of rapid tranquillisation, physical intervention and seclusion. The guidance of the Mental Health Act Code of Practice (chapter 19) should be followed, with any departures from that guidance clearly recorded and justified as being in the service user's best interest.

Service user concerns

1.8.1.5 When using interventions such as rapid tranquillisation, physical intervention or seclusion, steps should be taken to try to ensure that the service user does not feel humiliated (such as respecting a service user's need for dignity and privacy commensurate with the needs of administering the intervention).

1.8.1.6 The reasons for using rapid tranquillisation, physical intervention or seclusion should be explained to the service user at the earliest opportunity.

1.8.1.7 After the use of rapid tranquillisation, physical intervention 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.

1.8.1.8 Service users should be given the opportunity to document their account of the intervention in their notes.

Physical intervention

See also recommendation 1.3.2.6 (Training)

Carrying out physical intervention

1.8.1.9 During physical intervention, staff should continue to employ de-escalation techniques.

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1.8.1.10 There are real dangers with continuous physical intervention in any position. Physical intervention should be avoided if at all possible, should not be 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 tranquillisation or seclusion (where available), should be considered.

1.8.1.11 During physical intervention, one team member should be responsible for protecting and supporting the head and neck, where required. The team member who is responsible for supporting the head and neck should take responsibility for leading the team through the physical intervention process, and for ensuring that the airway and breathing are not compromised and that vital signs are monitored.

1.8.1.12 During physical intervention, under no circumstances should direct 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.

1.8.1.13 A number of physical skills may be used in the management of a disturbed/ 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.
- Every effort should be made to utilise skills and techniques that do not use the deliberate application of pain.
- The deliberate application of pain has no therapeutic value and could only be justified for the immediate rescue of staff, service users and/or others.

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1.8.1.14 Mechanical restraints are not a first-line response or standard means of managing disturbed/violent behaviour in acute mental health care settings. In the event that they are used, it must be a justifiable, reasonable and proportionate response to the risk posed by the service user, and only after a multidisciplinary review has taken place. Legal, independent expert medical and ethical advice should be sought and documented.

Seclusion

See also recommendations 1.1.1.3 (Environment **) and 1.3.2.8 (** Training **)**

Carrying out seclusion

1.8.1.15 The use of seclusion should be recorded in accordance with the guidance in the Mental Health Act Code of Practice.

1.8.1.16 Seclusion should be for the shortest time possible and should be reviewed at least every 2 hours and in accordance with the guidance in the Mental Health Act Code of Practice. The service user should be made aware that reviews will take place at least every 2 hours.

1.8.1.17 If seclusion is used, an observation schedule should be specified.

1.8.1.18 A service user in seclusion should retain their clothing, as long as it does not compromise their safety and the safety of others.

1.8.1.19 Service users in seclusion should be allowed to keep personal items including those 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.

Rapid tranquillisation and seclusion

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

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- If the service user is secluded, the potential complications of rapid tranquillisation should be taken particularly seriously.
- The service user should be monitored by 'within eyesight' observation by an appropriately trained individual.
- Once rapid tranquillisation has taken effect, seclusion should be terminated.

Rapid tranquillisation

See also recommendations 1.3.2.4, 1.3.2.9 and 1.3.2.10 (Training)

1.8.1.21 Medication for rapid tranquillisation, particularly in the context of physical intervention, should 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 (can cause side effects such as akathisia, disinhibition)
- possible damage to patient–staff relationship
- underlying coincidental physical disorders.

Policy

1.8.1.22 Local protocols should be produced that cover all aspects of rapid tranquillisation. Such protocols should be in accordance with legal requirements (especially in respect of detained patients, the consent to treatment, and the emergency treatment powers and duties under the Mental Health Act), and relevant NICE guidance, and should be subject to review.

Risks associated with rapid tranquillisation

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1.8.1.23 There are specific risks associated with the different classes of medications that are used in rapid tranquillisation. The specific properties of the individual drugs should be taken into consideration. When combinations are used, risks may be compounded. Staff need to be aware of the following.

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

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1.8.1.24 Extra care should 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.

Carrying out rapid tranquillisation

1.8.1.25 The service user should be able to respond to communication 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 or to others.

1.8.1.26 When a service user is transferred between units, a full medication history, including the service user's response to medications, any adverse effects, and an advance directive should accompany them. Where possible, the service user's account of their experience of rapid tranquillisation should also be included. On discharge, all such information should be filed in their healthcare record and be subject to regular review.

Oral therapy for rapid tranquillisation

1.8.1.27 Oral medication should be offered before parenteral medication as far as possible.

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

1.8.1.29 Oral and intramuscular medications should be prescribed separately and the abbreviation of o/i/m should not be used.

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1.8.1.30 When the behavioural disturbance occurs in a non-psychotic context it is preferable to initially use oral lorazepam alone, or intramuscularly if necessary.

1.8.1.31 When the behavioural disturbance occurs in the context of psychosis, to achieve early onset of calming/sedation, or to achieve a lower dose of antipsychotic, an oral antipsychotic in combination with oral lorazepam, should be considered in the first instance. (See chart for rapid tranquillisation at end of section.)

1.8.1.32 The Medicines and Healthcare products Regulatory Agency (MHRA) has warned against the use of risperidone or olanzapine in the treatment of behavioural symptoms of dementia, due to increased risk of stroke and death.

1.8.1.33 Sufficient time should be allowed for clinical response between oral doses of medication for rapid tranquillisation. (See chart for rapid tranquillisation at end of section.)

Parenteral therapy for rapid tranquillisation

1.8.1.34 If parenteral treatment proves necessary, the intramuscular route (i/m) is preferred over intravenous (i/v) from a safety point of view. The service user should be transferred to oral routes of administration at the earliest opportunity.

1.8.1.35 Where rapid tranquillisation through oral therapy is refused, is not indicated by previous clinical response, is not a proportionate response, or is ineffective, a combination of an intramuscular antipsychotic and an intramuscular benzodiazepine (i/m haloperidol and i/m lorazepam) is recommended.

1.8.1.36 In the event of moderate disturbance in service users with psychosis, i/m olanzapine[4] may also be considered. Intramuscular lorazepam should not be given within 1 hour of i/m olanzapine. Oral lorazepam should be used with caution.

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1.8.1.37 There is not sufficient evidence that the safety of the combination of i/m haloperidol with i/m promethazine, or the safety of i/m midazolam alone has been sufficiently demonstrated in the UK. However, it has been shown to be effective and relatively safe elsewhere. The Guideline Development Group is therefore not able to recommend either for routine psychiatric practice in the UK.

1.8.1.38 Sufficient time should be allowed for clinical response between intramuscular (i/m) doses of medications for rapid tranquillisation. (See chart for rapid tranquillisation at end of section.)

1.8.1.39 The use of two drugs of the same class for the purpose of rapid tranquillisation should not occur.

1.8.1.40 Medications should never be mixed in the same syringe.

1.8.1.41 When using i/m haloperidol as a means of managing disturbed/violent 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 intramuscularly or intravenously as per manufacturer's recommendations.

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

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

1.8.1.44 If intravenous medication is used the service user should never be left unattended. Intravenous administration should never occur without full access to the full support and resuscitation as outlined in recommendations 1.3.2.4 and 1.8.1.2.

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1.8.1.45 In very exceptional circumstances, which should be specified and recorded, i/m haloperidol in combination with i/m promethazine, or i/m midazolam alone may be considered as an alternative to intravenous administration of benzodiazepines or haloperidol. This decision should not be made by junior staff without discussion with the senior on-call psychiatrist.

Medications not normally used for rapid tranquillisation

1.8.1.46 Zuclopenthixol acetate injection[5] is not recommended for rapid tranquillisation due to long onset and duration of action. However, zuclopenthixol acetate injection may be considered as an option for rapid tranquillisation when:

- it is clearly expected that the service user will be disturbed/violent over an extended period of time
- a service user has a past history of good and timely response to zuclopenthixol acetate injection
- a service user has a past history of repeated parenteral administration
- 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 *British National Formulary* and manufacturer's Summary of Product Characteristics (SPC) should be consulted regarding its use.

Medications not recommended for rapid tranquillisation

1.8.1.47 The following medications are not recommended for rapid tranquillisation.

- Intramuscular or oral chlorpromazine or oral (a local irritant if given intramuscularly; risk of cardiovascular complications; causes hypotension due to α-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).
- Intramuscular diazepam.

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- Thioridazine.
- Intramuscular depot antipsychotics.
- Olanzapine or risperidone should not be used for the management of disturbed/ violent behaviour in service users with dementia.

Doses for rapid tranquillisation

It is recognised that clinicians may decide that the use of medication outside of the SPC is occasionally justified, bearing in mind the overall risks. However, where the regulatory authorities or manufacturer issues a specific warning that this may result in an increased risk of fatality, the medication should only be used strictly in accordance with the current marketing authorisation.

1.8.1.48 When using rapid tranquillisation there may be certain circumstances in which the current *BNF* uses and limits and manufacturer's SPC may be knowingly exceeded (for example, for lorazepam). This decision should not be taken lightly and the risks should not be underestimated. A risk–benefit analysis should be recorded in the case notes and a rationale should be recorded in the care plan. Where the risk–benefit is unclear, advice may be sought from clinicians not directly involved in the service user's care.

1.8.1.49 If current *BNF* or SPC 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.

1.8.1.50 In all circumstances of rapid tranquillisation, the prescriber and medication administrator should pay attention to:

- the total dose of medication prescribed
- arrangements for review
- issues of consent, *BNF* and SPC requirements and physical and mental status of the service user.

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1.8.1.51 The dose of antipsychotic medication should be individualised for each service user. This will be dependent on several factors including the service user's age (older service users generally require lower doses); concomitant physical disorders (such as renal, hepatic, cardiovascular, or neurological); and concomitant medication.

1.8.1.52 A specialist mental health pharmacist should be a member of the multidisciplinary team in all circumstances where rapid tranquillisation is used. These pharmacists have a responsibility to monitor and ensure safe and appropriate usage of medication.

Care after rapid tranquillisation

1.8.1.53 After rapid tranquillisation is administered, vital signs should be monitored and pulse oximeters should be available. Blood pressure, pulse, temperature, respiratory rate and hydration should be recorded regularly, at intervals agreed by a multidisciplinary team, until the service user becomes active again.

1.8.1.54 In the following circumstances, more frequent and intensive monitoring by appropriately trained staff is required and should be recorded in the care plan. Particular attention should 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 the *BNF* limit or SPC 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.

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1.8.1.55 If verbal responsiveness is lost as a consequence of administration of medication, a level of care identical to that needed for general anaesthesia should be given.

Chart for rapid tranquillisation

Medication	Time to max plasma concentration	Approx plasma half-life	Licensed indications as at August 2004 (see current Summary of Product Characteristics [SPC])	Notes
Haloperidol injection (SPC)	15–60 min (SPC and Itox)	10–36h	• 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	

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Haloperidol oral solution (SPC)	2–6h (Itox)	10–36h	• Schizophrenia and other psychoses • Short-term adjunctive management of psychomotor agitation, excitement, violent 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 tablets (SPC)	2–6 h (Itox)	1–36h	• Schizophrenia and other psychoses • Short-term adjunctive management of psychomotor agitation, excitement, violent 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	

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Lorazepam injection (SPC)	60–90 min	12–16h	• 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	
Lorazepam tablets (SPC)	2h	12h	• 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	

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Olanzapine dispersable tablets (SPC)	5–8h	32–50h	• Treatment of schizophrenia • Maintaining the clinical improvement during continuation therapy in patients who have shown an initial treatment response • Treatment of moderate to severe manic episode • In patients whose manic episode has responded to olanzapine treatment, olanzapine is indicated for the prevention of recurrence in patients with bipolar disorder	• Not approved for the treatment of dementia-related psychosis and/or behavioural disturbances

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Olanzapine injection (SPC)	15–45 min	32–50h	• 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 Olanzapine Powder for Solution for Injection should be discontinued, and the use of oral olanzapine should be initiated, as soon as clinically appropriate	• The manufacturer has issued a warning that use outside of the details contained within the SPC may increase the risk of fatality • i/m 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

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Olanzapine tablets (SPC)	5–8h	32–50h	• Treatment of schizophrenia • Maintaining the clinical improvement during continuation therapy in patients who have shown an initial treatment response • Treatment of moderate to severe manic episode • In patients whose manic episode has responded to olanzapine treatment, olanzapine is indicated for the prevention of recurrence in patients with bipolar disorder	• Not approved for the treatment of dementia-related psychosis and/or behavioural disturbances
Risperidone dispersable tablets (SPC)	1–2h	24h	• 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	• Not licensed for the treatment of behavioural symptoms of dementia

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Risperidone liquid (SPC)	1–2h	24h	• 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	• Not licensed for the treatment of behavioural symptoms of dementia
Risperidone tablets (SPC)	1–2h	24h	• 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	• Not licensed for the treatment of behavioural symptoms of dementia

1.9 Incident reporting and post-incident reviews following rapid tranquillisation, physical intervention and seclusion

See also recommendation 1.3.3.1 (Training)

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Incident reporting

1.9.1.1 Any incident requiring rapid tranquillisation, physical intervention or seclusion should be recorded contemporaneously, using a local template.

1.9.1.2 Incidents of physical assault should be reported to the NHS Security Management Service (SMS) as per Secretary of State directives November 2003.

Post-incident reviews

1.9.1.3 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.

1.9.1.4 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:

- 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 (SMS).

1.9.1.5 The aim of a post-incident review should be to seek to learn lessons, support staff and service users, and encourage the therapeutic relationship between staff, service users and their carers.

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1.9.1.6 The post-incident review should address what happened during the incident, any trigger factors, each person's role in the incident, how they felt during the incident, how they feel at the time of the review, how they may feel in the near future, and what can be done to address their concerns. If possible, a person not directly involved in the incident should lead the review.

1.9.1.7 Appropriate support, including ongoing individual post-incident review sessions, should be available as required.

1.9.1.8 One-off post-incident review sessions have been shown to be unhelpful and should not be undertaken.

1.9.1.9 Consequential sick leave and the return to work should be monitored and positively and carefully managed to ensure that staff are supported.

1.9.1.10 Consequential sick leave should be audited to identify trends within the organisation to inform future strategy and training in relation to the management of disturbed/violent behaviour.

1.10 Emergency departments

Service users will often attend and be admitted to psychiatric in-patient services through emergency departments. The following section applies specifically to emergency department staff when caring for service users requiring mental health assessments. Recommendations in sections 1.2, 1.3, 1.4, 1.5, 1.6, 1.8 (except 1.8.3) and 1.9 also apply.

Training

1.10.1.1 In addition to ongoing competency training in the management of disturbed/ violent behaviour, appropriate staff groups in emergency departments should receive training in the recognition of acute mental illness and awareness of organic differential diagnoses. Service user involvement should be encouraged.

Risk

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1.10.1.2 Emergency units should have a system in place to alert staff to patients known by the unit to pose a risk of disturbed/violent behaviour, 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.

Mental health assessments

1.10.1.3 On making an initial assessment, if staff working in emergency departments decide a mental health assessment is required, they should seek specialist advice from the relevant mental health professional.

Environment

1.10.1.4 Every emergency department should have at least one designated interview room for mental health assessments. Larger 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 emergency department receiving area.

1.10.1.5 The designated interview room(s) should be made available on a priority basis for mental health assessments. It should be of a sufficient size to comfortably accommodate six seated persons, be fitted with an emergency call system, an outward opening door, and a window for observation, have reasonable ventilation, contain soft furnishings and be clear of potential weapons.

1.10.1.6 Staff interviewing a patient in the designated interview room should always inform a senior member of the emergency nursing staff before commencing the interview.

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

Personnel

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1.10.1.8 Every emergency department should have access to an identified consultant psychiatrist for liaison with providers of local mental health services.

1.10.1.9 Appropriate psychiatric assessment should be available within 1 hour of alert from the emergency department, at all times.

1.10.1.10 In addition to a mental health liaison team, there should be at least one registered mental nurse working with every emergency department. Larger emergency departments (more than 75,000 attendances a year) may require more.

1.10.1.11 Emergency departments should be encouraged to employ registered mental nurses.

Rapid tranquillisation

1.10.1.12 The decision to use rapid tranquillisation in an emergency setting should be taken by a senior medical member of staff, where at all possible.

1.10.1.13 Mental health staff should be contacted at the first available opportunity after the administration of rapid tranquillisation.

1.10.1.14 If rapid tranquillisation is considered necessary, prior to formal diagnosis and 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), lorazepam should be considered as the first-line drug of choice. Where there is a confirmed history of previous significant antipsychotic exposure, and response, haloperidol in combination with lorazepam is sometimes used.

Communication provision

1.10.1.15 For patients whose preferred language is not English, interpreting services should be provided. Provision should also be made for patients who have communication difficulties who may need additional support, for example, visual aids, simplified language, or an interpreter who can sign.

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[1] The NHS Security Management Service (SMS) is developing a training curriculum for the management of violence. The National Institute for Mental Health in England (NIMHE) is drawing up an accreditation scheme for trainers. The work is due for completion in 2005.

[2] United Kingdom Central Council for Nursing, Midwifery and Health Visiting(2002) *The Recognition, Prevention and Therapeutic Management of Violence in Mental Health Care*. London.

[3] The Bennett report recommended that a doctor should be available within 20 minutes. The Guideline Development Group considers quick attendance to mean within 30 minutes of an alert.

[4] The manufacturer has issued a warning that use outside of the details contained within the Summary of Product Characteristics may increase the risk of fatality.

[5] This is commonly known as 'acuphase' by staff and service users.

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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.

The scope of the guideline is the short-term management of disturbed/violent behaviour in adult psychiatric in-patient settings and emergency departments. The guideline covers all adult psychiatric in-patient settings and assessment in emergency departments. For the purposes of this guideline, adult is defined as aged 16 years and older and short-term is defined as 72 hours.

The guideline covers the following interventions: prediction and risk assessment, de-escalation techniques, observation, physical intervention, seclusion, and rapid tranquillisation. It also deals with training in these interventions.

In addition, the guideline examines factors in the in-patient environment which relate to the short-term management of disturbed/violent behaviour and 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 emergency departments.

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3 Implementation in the NHS

3.1 Resource implications

Local health communities should review their existing practice for the short-term management of disturbed/violent behaviour in psychiatric in-patient settings and emergency departments against this guideline. 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 service users that the implementation 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.

Information on the cost impact of this guideline in England is available on the NICE website and includes a template that local communities can use.

3.2 General

This guideline should be used in conjunction with the NICE guideline on schizophrenia (see Section 6) and the Commission for Health Improvement audit material created by the Royal College of Psychiatrists (2004).

3.3 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.

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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).

- Prospective cohort studies are required to identify antecedents of disturbed/violent behaviour in adult psychiatric in-patient settings.
- 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 intervention used for the short-term management of disturbed/violent behaviour in adult psychiatric in-patient settings and in emergency departments:
  - effectiveness
  - ethical, legal and safety aspects
  - role within the range of physical interventions taught to staff
  - staff and service user perceptions.
- 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 in-patient settings and in emergency settings:
  - effectiveness
  - ethical, legal and safety aspects
  - role within the range of physical interventions taught to staff
  - staff and service user perceptions.

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- 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 intervention and seclusion for the short-term management of disturbed/violent behaviour in adult psychiatric in-patient settings and in emergency settings.
- Clinical trials and longitudinal cohort studies should be conducted in large, well-designed randomised controlled studies with adult psychiatric in-patients (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 pro re nata regimes (including atypical and antipsychotics), and assess the long-term side effects.
- 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 should assess the short-term and long-term effectiveness of the training programme in psychiatric in-patient settings and assess the safety of the techniques used in these training packages for both staff and service users.
- Prospective cohort studies are needed to develop valid and reliable prediction tools for use in psychiatric in-patient 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.
- Controlled before-and-after studies that examine whether observation and/or de-escalation techniques minimise the need for seclusion, interventions or rapid tranquillisation are needed.

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5 Other versions of this guideline

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 *Violence: the short-term management of disturbed/violent behaviour in psychiatric in-patient settings and emergency departments is* published by the National Collaborating Centre for Nursing and Supportive Care; it is available from the NICE website.

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

There is more information about how NICE clinical guidelines are developed on the NICE website. A booklet, 'How NICE clinical guidelines are developed: an overview for stakeholders, the public and the NHS' is available.

Information for the public

A version of this guideline for service users, their advocates and carers, and for the public is available from the NICE website. This is a good starting point for explaining to patients the kind of care they can expect.

Quick reference guide

A quick reference guide for healthcare professionals is also available from the NICE website.

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6 Related NICE guidance

The Institute has issued the following related guidance:

- National Institute for Clinical Excellence (2003) Core interventions in the treatment and management of schizophrenia in primary and secondary care. *NICE Clinical Guideline* No. 1. [Replaced by NICE clinical guideline 82]

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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.

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Appendix A: Grading scheme

The recommendations in this guideline were graded according to the quality of the evidence they were based on. The gradings are available in the full guideline and are not shown in this web version.

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Appendix B: The Guideline Development Group

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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

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Appendix D: Technical detail on the criteria for audit

The full guideline contains the technical detail on the criteria for audit.

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Appendix E Glossary

This glossary contains selected terms only. Please see the full guideline for the full general glossary

Advance directive: a document that contains the instructions of a person with mental health problems 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 behaviourally or verbally expressed and regardless of whether physical harm is sustained.

Antecedents: warning signs that indicate that a service user is escalating towards a violent act.

Basic Life Support: the maintenance of an airway and the support of breathing and the circulation without using equipment other than a simple airway device or protective shield.

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.

Calming: the reduction of anxiety.

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).

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Disturbed behaviour: to be experiencing emotions and exhibiting behaviours that deviate from the accepted norm as a result of mental ill-health.

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

Environment: the physical and therapeutic external conditions or surroundings.

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

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).

Immediate Life Support: Basic life support and safe defibrillation (manual and/or automatic external defibrillator).

Mechanical restraint : a method of physical intervention 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 (1985) Minorities. In Bernhardt R et al. editors. Encyclopedia of Public International Law. Amsterdam: Elsevier, vol.8, p.385.)

Observation: a two-way relationship, established between a service user 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.

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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.

Post-incident review: A review carried out within 72 hours of an incident, by someone independent of the incident, to determine antecedents, consequences and future positive action without apportioning blame.

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

Psychiatric in-patient settings: any care setting in which psychiatric treatment is given to in-patients.

QT interval: the period in the cardiac cycle between depolarisation (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.

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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 S, Gray R, Parkes J, Gournay K. (2002) The Recognition, Prevention and Therapeutic Management of Violence in Acute In-PatientPsychiatry: A Literature Review and Evidence-Based Recommendations for Good Practice, prepared for the United Kingdom Central Council for Nursing, Midwifery and Health Visiting. London). 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, and cultural or gender issues.

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About this guideline

NICE clinical guidelines are recommendations about the treatment and care of people with specific diseases and conditions in the NHS in England and Wales.

The guideline was developed by the National Collaborating Centre for Nursing and Supportive Care. The Collaborating Centre worked with a group of healthcare professionals (including consultants, GPs and nurses), patients and carers, and technical staff, who reviewed the evidence and drafted the recommendations. The recommendations were finalised after public consultation.

The methods and processes for developing NICE clinical guidelines are described in The guidelines manual.

The recommendations in this guideline were graded according to the quality of the evidence they were based on. The gradings are available in the NICE guideline and are not shown in this web version.

We have produced a summary for patients and carers. Tools to help you put the guideline into practice and information about the evidence it is based on are also available.

Changes since publication

February 2012: minor maintenance

Your responsibility

This guidance represents the view of NICE, which was arrived at after careful consideration of the evidence available. Healthcare professionals are expected to take it fully into account when exercising their clinical judgement. However, the guidance does not override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer, and informed by the summary of product characteristics of any drugs they are considering.

Implementation of this guidance is the responsibility of local commissioners and/or providers. Commissioners and providers are reminded that it is their responsibility to implement the

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guidance, in their local context, in light of their duties to avoid unlawful discrimination and to have regard to promoting equality of opportunity. Nothing in this guidance should be interpreted in a way that would be inconsistent with compliance with those duties.

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