

CAMHS Rapid Tranquillisation Guidelines

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| Services | Applicable |
| Trust wide | x |
| Mental Health and LD |  |
| Community Health Services |  |

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| Version 8.0 and 9.0 | Dec 2020/ Jan 2021 | Format changes  Expansion of QTc section: reference to RISQ-PATH study and  Credible meds  Update of QT psychotropic and non-psychotropic section  Addition of short section on neuroleptic malignant syndrome |
| 7.0 | September 2020 | Removal of treatment flow chart  NICE guidance incorporated  Removal of oral columns from medication tables  Medication table updated to reflect child/adolescent license  Reference to adult doses in medication table  Expansion of consultant, medical and pharmacist responsibilities section  Initial assessment: new section  Re-written non- pharmacological interventions  Restrictive interventions: new section  Re-written pharmacological interventions  Training section updated: NICE  Statements added to highlight unlicensed status of medications  Reference to BAP NAPICU guidance |
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| 4.0-5.1 | January 2017 | Content page  Prescriber section expanded to- Consultant and Medical team  Section expanded for children/ adolescents detained under the mental health act  Section included in ‘general notes’ to consider any physical illness/ neurocognitive deficits when choosing medication  Updated Physical Health Monitoring Forms:  COAST: 5-12 year old  PEWS: 13-18 year old |
| 3.0 | October 2014 | Zuclopenthixol acetate moved to ‘Medicines  Not Recommended for RT’. Midazolam included for IM RT use. Olanzapine included for PO RT use.  Maximum IM dose of Haloperidol amended. Appendix 1 flowchart reviewed.  Updated RT monitoring chart included. |
| 2.1 | August 2011 | Medications reviewed  IM haloperidol dose changed |
| 2.0 | January 2008 | Changed to include RT for <12years Title changed  Altered doses for RT to include <12years  Medications reviewed Monitoring reviewed  Richmond Agitation Sedation Scale added Restraint policy mentioned  QT prolongation causing medications included Training, & audit included  Consent issues highlighted |
| 1.0 | Sept 2005 | Repeated references to the fact that the guidelines are for 12-18 year olds throughout the document.  Include the use of the Mental Health Act, particularly in the case of 16-18 year olds.  If oxygen sats fall below 90%, remedial action should state, “seek urgent medical review”. Approved by Medicines Committee Sept 2005 |

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# Guidelines for the Management of Acutely Disturbed Children & Adolescents (Aged 6 - 17 years)

1. **Aims**

The aim of rapid tranquillisation (RT) is:

* To quickly and safely calm a patient who is severely agitated and/ or physically aggressive
* To quickly reduce the risk of imminent and serious physical aggression to self and/or others, rather than treat the underlying psychiatric condition.
* To not induce sleep or unconsciousness. The child/adolescent should be sedated but still able to participate in further assessment and treatment.
* To avoid un-necessary and prolonged physical restraint which can potentially be physically harmful to the patient and staff involved in the restraint.

Rapid tranquillisation (RT) is a management strategy and is not the primary treatment. If administered:

It should be considered once de-escalation, psychological and behavioural strategies have been tried, but produce limited benefit.

There should be consideration regarding the level of risk of harm to self and/ or others including patients and staff if RT is not given.

* There should be a clear clinical need.
* Check if an advance directive is in place. Advance directives should be taken into account when making decisions on which interventions to use.
* The intervention selected must be reasonable and proportionate to the level of risk.
* Check the suitability of using RT medication alongside regular and ‘as required’ medication already prescribed.
* Check the total % antipsychotic medication prescribed prior to prescribing and administering RT medication. If the total % of all antipsychotics prescribed (regular, PRN and RT) exceed 100%, the High Dose Antipsychotic Policy must be implemented.

These guidelines are intended for:

* Children & adolescents anywhere within the East London NHS
* Foundation Trust.
* Children & adolescents from 6 to 17 years of age.
* This policy *must* be read in conjunction with the policy on the use of Physical Holding Skills.
* If applicable, refer to the Trust High Dose Antipsychotic Medication policy.
* If applicable, refer to the Trust Seclusion policy.

# Duties

**2.1 Operational duties**

**Consultant:**

* Overall responsibility of using RT medication lies with the consultant.
* Overall responsibility of ensuring review and monitoring of RT medication lies with the consultant.
* Ensure appropriate debrief is provided for staff, young person and families.
* Ensure the treatment plan and/ or the rationale to use RT is clearly documented in the clinical notes and communicated to the appropriate teams/ professionals.
* Overall responsibility for assessment, decision and to prescribe RT for a young person in seclusion lies with the consultant (please refer to Seclusion policy for detailed information).

**Medical team:**

* Ensure the medication is prescribed specifically and clearly for RT.
* Prescribing the right drug, right dose, right route, and frequency and maximum specified for a 24 hour period.
* Reviewing the prescription daily and/ or at the most once weekly.
* Ensuring patients are monitored for potential side effects from medicines administered.
* Medical review of patient post RT medication, including the RT physical health monitoring chart.
* Where a young person is in seclusion, complete medication review as per monitoring standards provided in the Trust Seclusion policy.
* Ensure there is clear documentation for the rationale to use RT in the patient notes, as well as documentation of post RT reviews.
* Follow up and/ or action any concerns highlighted from the post RT review and/ or RTphysical health monitoring chart.

**Nursing staff are accountable for:**

* The safe administration of medicines, according to the 10Rs (see the Trust [Medicines Policy](http://elcmhtintranet/pharmacypols.html)).
* The selection and administration of the right medicine at the right dose and the right route, as prescribed for the purpose of RT.
* Record on the prescription chart to indicate administration of the medicine.
* Documentation of administration in the patient case notes and completion of an incident report form.
* Completion of post rapid tranquillisation monitoring, including monitoring for potential side effects.
* Where a young person is in seclusion, complete post RT monitoring as per this guideline and any additional physical health monitoring as stipulated in the Seclusion policy.
* Contact the Doctor if any concerns following RT medication and/ or post RT monitoring.
* Ensure appropriate debrief is provided for staff, young person and families.

**Pharmacists:**

* Advice on appropriate medication, taking into consideration the patient’s presentation, current medication and as per the RT policy.
* Ensure safe use of RT medication.
* Clinically review all medication to ensure RT medication is suitable for use.
* In case of antipsychotic RT medication, if total antipsychotic therapy (regular, PRN and RT) is over 100% BNF maximum, ensure High Dose Monitoring is in place (refer to HDAT policy for further guidance).
* Ensure the prescription for medicines for rapid tranquillisation are the right
* dose, right medicine and right route.
* Ensuring appropriate prescribing of medicines.
* Ensuring appropriate subsequent monitoring of potential side effects of
* medicines administered.
* Ensuring RT medication is reviewed daily and/ or at the most once weekly.
* Document clearly in the patient notes any recommendations/ interventions with regards to RT medication and/ or monitoring.

# 2.2 Strategic duties

Responsibilities lie with the Chief Pharmacist, Medical Director and Director for Nursing. As well as the inpatient Associate clinical director and service manager for inpatient child and adolescent services.

# 3.0 Principle of restrictive intervention

If a child/adolescent is acutely disturbed, then the patients’ responsible clinician should be called to attend immediately. It is vital the responsible clinician obtains as much history as possible from the patient and the multidisplinary team before medication is given. In reaching a decision to use rapid tranquillisation, the responsible clinician, nursing staff/ and or clinical pharmacist should be involved.

The responsible clinician should undertake a risk assessment of the situation,considering the risks to the child/adolescent, other patients and staff.

Before drugs are administered for rapid tranquillisation, it is very important to exclude non-psychiatric causes such as organic disease, psychological disturbance e.g. anger and anxiety, intoxication or withdrawal states.

Children/adolescents should only be treated with the following medicines after completing a comprehensive risk assessment and when it has been established that the risk of not doing so is greater than the risk of acute pharmacological treatment.

**4.0 Consent**

At the point of any admission, the appropriate or relevant local consent form should be completed by the child/adolescent and/or parent(s)/carer(s).

In all cases the child/adolescent must be informed that RT medication may potentially be given if deemed clinically appropriate. The young person must be given the opportunity at any stage to accept medication voluntarily.

In children/adolescents who are not competent to make a clinical decision about medication, where possible parent(s)/carer(s) should be informed of the situation and consent sought for such treatment. It is good practice to inform both the child/adolescent and their parents/carers.

Where possible, parents and/or carers have the right to stay with the child/adolescent before, during and after rapid tranquillisation takes place. If the parent or carer is adversely affecting the safety and/or the efficacy of the situation, parents may be asked to leave for the benefit of the child/adolescent – this must be a clinical decision.

Children and/ or adolescents detained under the mental health act (section 2/ section 3) can be administered RT medication. However, it is important to ensure a current competency/ capacity assessment is in place. Where a treatment order form is in place (T2/T3) ensure the RT medication and/ or category of medication is listed on the T2/T3 form. In the event it is not, the responsible clinician must complete a Form 62 (urgent treatment form) prior to administration of RT medication.

# 5.0 Documentation and feedback

# The reason for prescribing any medication for the acutely disturbed child/adolescent should be documented on the medication chart, in the medical notes, as well as the working diagnosis.

# Any medication administered and the patient’s response should be recorded.

# Following administration of RT medication as part of the restraint, staff involved should have a de-brief to reflect on the incident.

# The young person involved should also be offered the opportunity to have a de-brief of events leading up to the incident, including the incident itself. Staff should provide the young person with an explanation of why certain measures were taken i.e. physical holding and use of RT medication.

# The young person should be provided with support and reassurance and given the chance to talk about their experiences of the RT medication and restraint. The young person can describe their experiences, either in writing or verbally, this should be recorded in their notes.

# If a family member and/ or carer were present during the restraint and the administration of RT medication, staff should provide the family member/ carer with the opportunity to debrief and reflect on the incident with staff support.

# If family member and/ or carer was not present. Ward staff should inform the family of the restraint and RT medication as soon as possible to do so. This conversation should include a discussion of the rationale for restraint and RT medication.

# An incident form must be completed. Appropriate entries into the young person’s case notes must be completed with regards to the events leading up to the incident, the incident itself and documentation of any restraint and use of RT medication. The case note entry should include any feedback/ reflection from the young person and if applicable family member and/ or carer.

**6.0 Non-pharmacological interventions**

Assess and treat any underlying mental health problems in line with relevant NICE guidelines, including those on [antisocial behaviour and conduct disorders in children and young people](http://www.nice.org.uk/guidance/cg158), [attention deficit hyperactivity disorder](http://www.nice.org.uk/guidance/cg72), [psychosis and schizophrenia in children and young people](http://www.nice.org.uk/guidance/cg155), [autism diagnosis in children and young people](http://www.nice.org.uk/guidance/cg128) and [autism](http://www.nice.org.uk/guidance/cg170).

Identify any history of aggression or aggression trigger factors, including experience of abuse or trauma and previous response to management of violence or aggression.

Identify cognitive, language, communication and cultural factors that may increase the risk of violence or aggression in a child or young person.

Consider offering children and young people with a history of violence or aggression psychological help to develop greater self‑control and techniques for self‑soothing.

Offer support and age-appropriate interventions (including parent training programmes) in line with the NICE guideline on [antisocial behaviour and conduct disorders in children and young people](http://www.nice.org.uk/guidance/cg158) to parents of children and young people whose behaviour is violent or aggressive.

Staff should be trained in how to assess and manage potential and actual violence using de-escalation techniques, restraint, seclusion and rapid tranquilisation. Staff should also be trained to use and maintain the techniques and equipment required to undertake cardiopulmonary resuscitation.

Intervention should take the form of using the appropriate psychological, behavioural and pharmacological strategies as per the patient’s care-plan. If this fails, seclusion maybe considered (therefore this document should be read in conjunction with the Trust’s seclusion policy).

Other non-pharmacological interventions should, where possible, also be explored, for example increasing the level of observations of the patient, increasing the level of staffing, engaging in a low stimulus environment and/ or activities, considering changing the child/adolescent’s setting, this may include transfer to a Psychiatric ICU.

# 7.0 Pharmacological interventions/ treatments

# *Based on the current NICE guidance below it is important to highlight that the decision to prescribe and/use RT ultimately lies with the responsible consultant.*

NICE guidelines (NG10) recommend using intramuscular lorazepam for [rapid tranquillisation](https://www.nice.org.uk/guidance/ng10/chapter/recommendations#terms-used-in-this-guideline) in a child or young person and adjust the dose according to their age and weight[15).

If there is only a partial response to intramuscular lorazepam, check the dose again according to the child or young person's age and weight and consider a further dose.

Monitor physical health and emotional impact continuously when undertaking rapid tranquillisation in a child or young person.

# Given the current NICE guidance there is no treatment algorithm included with this guidance. There is currently limited evidence providing a clear direction and/ or stepped approach to the use of medication for the purpose of RT.

# To ensure best practice is followed when considering medication:

In all cases the minimum effective dose of medication should be used. BNF maximum doses should only be exceeded in extreme circumstances and under the advice and direction of the Consultant Child & Adolescent Psychiatrist (Please refer to the Trust High Dose Monitoring policy for further guidance).

Oral medication should be offered before parenteral (usually intramuscular) treatment is administered.

If oral medication is repetitively refused, the decision to medicate a patient via the IM route must be taken as part of a multi-disciplinary decision, involving nursing, medical, clinical pharmacist and/ or other key professionals involved in the care of the young person.

Nursing and medical staff involved in physically restraining the patient must be proficient in “Control & Restraint” techniques and should have immunisation against hepatitis B.

Polypharmacy within a class of medication (e.g. antipsychotics) should, where at all possible, should be avoided.

Consideration should be given to any co-existing medical illnesses, physical conditions, neurodevelopmental/ cognitive impairments, as these may have impact on the choice of medication and potential side effects.

Consideration should be given to any regularly prescribed medication *as these* *may impact on dose requirements and potential side effects*, for example:

* Oral antipsychotics:
* Consider total dose for regular and “prn”
* Include depot antipsychotics
* Oral benzodiazepines (avoid if possible)
* Consider benzodiazepines already prescribed for regular administration (additional PRN doses may have little effect)
* Substance misuse or alcohol intoxication

Consideration should be given to past experiences with medication as this may influence medication choices.

Medication for rapid tranquillisation should not be administered if the appropriate monitoring equipment is not available.

Where possible, ensure a baseline ECG has been obtained for the young person. Review of ECG should be essential prior to IM administration.

Where IM medication is given without the young person having a baseline ECG, the rationale should be clearly documented in the clinical notes.

Young people with a diagnosed learning disability are more susceptible to the effects of medication; a ‘start low, go slow’ approach should be adopted.

Young people with emotional dysregulation difficulties should not routinely be prescribed antipsychotics.

Sensory profiling and non-pharmacological methods of managing acutely disturbed behavior should form the basis of the care plan.

# 8.0 Advance Directives

Where a child/adolescent’s preference in medication (to be used in the event of an acute episode of illness) is documented in their care plans, this preference should be adhered to if clinically appropriate. The nursing team should ensure the advance directive is available to view in the patient’s case notes. The clinical team should be aware of the individual’s advance directive, and a record should be included in the care-plan.

# 9.0 Drugs used in Rapid Tranquillisation

# The table below provides an overview of the medication available for use as rapid tranquillisation to assist in the decision making process.

# The information for the medication is condensed from the Summary Of Product Characteristics (SPC), BNF (current online version 2020) and the Joint BAP NAPICU Consensus Guidance (2018).

# If required, for comprehensive direction, please refer to the above sources and seek advice from the CAMHS clinical pharmacist/ pharmacy service.

**Short Acting IM Antipsychotics**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Drug** | **Formulation** | **Dose (adults)** | **Pharmacokinetics** | **Major side effects/ Risks** | **Notes** |
| Haloperidol | 5mg/ml solution for injection | 5mg IM  Can be repeated hourly if needed  Majority adults 15mg/24hrs sufficient  **Oral children/**  **adolescents:**  **max 5mg/24hrs** | Peak concentration = 20-30 minutes  t½ 21 hours | EPSE  Hypotension NMS  Increased QTC, Arrhythmias Seizures  Sudden death | IM not licensed for use in children/adolescents  Note risk of acute dystonias and ensure that an appropriate antimuscarinic is prescribed.  If **oral** haloperidol used, consider  administering oral procyclidine 1.25mg (<14years) to 2.5mg (>14years)  If **IM** haloperidol is used,  consider administering IM procyclidine 2.5mg-5mg to reduce risk of EPSE, especially in:  Those with a propensity to extrapyramidal side effects  Unknown patients  Antipsychotic naïve patients  Caution if using a typical antipsychotic (e.g. haloperidol) in an unknown or antipsychotic naïve child/adolescent, as extrapyramidal symptoms (EPS) may be even more frequent and severe in children than adults. Consider using lorazepam alone or a low dose of haloperidol (0.5mg-2mg).  Not recommended for IV use because of the risk of arrhythmias.  **NB: ECG Essential** |
| Aripiprazole | Aripiprazole 7.5 mg/mL solution for injection  Each mL contains 7.5 mg of aripiprazole.  Each vial contains 9.75 mg aripiprazole | Adults= 5.25 mg to 15 mg as a single injection.  A lower dose of 5.25 mg (0.7 mL) may be given, on the basis of individual clinical status  **Oral child/adolescent:**  **Depending on indication: 10- 30mg/24hrs** | Median time to peak concentration = 1- 3 hour  t ½= 75 hours | The most commonly reported adverse reactions in placebo-controlled trials were nausea, dizziness and somnolence each occurring in more than 3 % of patients treated with aripiprazole solution for injection. | **IM not licensed for use in children/adolescents**  The recommended initial dose for Aripiprazole solution for injection is 9.75 mg (1.3 mL), administered as a single intramuscular injection.  .  A second injection may be administered 2 hours after the first injection, on the basis of individual clinical status and no more than three injections should be given in any 24-hour period.  The maximum daily dose of aripiprazole is 30 mg |
| Olanzapine | 10mg powder in ampoule  Requires reconstitution for administration | 5-10mg BNF max  20mg/24 hrs  **Oral max in children/adolescents:**  **20mg/24hrs** | Peak concentration = 15-45 minutes  t½ 30 hours | Hypotension Bradycardia Syncope  Sedation  QT prolongation  Dyslipidaemia | **IM not licensed for use in children/adolescents**  Maximum 3 injections daily for 3 days.  Maximum daily combined oral and parenteral route = 20mg/24hrs  One/ more of the following factors may result in slower metabolism- female gender, elderly, for non-smoker consider lower initial dose and more gradual dose increase.  Less likely to cause EPSE than haloperidol.  IM administration results in initial maximum plasma concentration  5× higher than same dose given orally.  **Benzodiazepines should not be given within 1 hour of IM olanzapine** |

**General notes related to short acting antipsychotics:**

* When using anticholinergics attention should be paid to the total anticholinergic effect of all medicines being used. In particular, caution should be taken if using promethazine concurrently with procyclidine due to the increased anticholinergic effects.
* **RISKS**: Loss of consciousness, cardiovascular and respiratory complications and collapse (i.e. QT prolongation), seizures, akathisia, dystonia, dyskinesia, neuroleptic malignant syndrome, excessive sedation.

# Benzodiazepines

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Drug | Formulation | Dose | Pharmacokinetic | Major side effects | Notes |
| Lorazepam | Ativan 4mg/ml injection (stored in fridge)  Requires mixing with sterile water. Always check the product leaflet to determine lorazepam: water ratio | Indications child/  adolescent  Premedication  12-17 years: 1-4mg  status epilepticus/febrile convulsions/ convulsions caused by poisoning  12-17 years: 4mg | Peak 60-90 mins  t½ 12-16 hours | Loss of consciousnessrespiratory depression or arrest, cardio- vascular collapse, disinhibition | Oral and IM not licensed for use in children/adolescents  *NB: NEVER mix haloperidol and lorazepam in the same syringe*  Requires mixing with sterile water before administration. Always check the product leaflet to determine lorazepam: water ratio  Administration can be repeated after 30 minutes if necessary  Oral lorazepam 1mg = oral diazepam 10mg. Lower doses of lorazepam, 0.5 – 1mg should be administered and repeated if necessary. The maximum oral dose of lorazepam is 4mg a day in adults, at times doses higher than this may be required, in such circumstances advice should be sought from senior medical staff.  A wide therapeutic index & respiratory depression is readily reversed with the specific antagonist flumazenil  Benzodiazepines should not be given within 1 hour of IM olanzapine  Disinhibition is more likely to occur in those with organic brain disease, including learning disabilities, under 18s and perhaps those with impulse control problems  *NB: Oral lorazepam 1mg = oral diazepam 10mg*  Avoid *benzodiazepines* in children/adolescents who are physically unwell, delirious or who have significant respiratory impairment. Use benzodiazepines in preference to antipsychotics in patients with cardiac disease, as these are safer, but beware of accumulation. |

**Flumazenil**

Flumazenil should be given if respiratory rate drops below 10/min due to the sedative effects of benzodiazepines. Repeated doses may be required as it is short acting, see table of monitoring and management of side effects to RT. Flumazenil is best avoided in patients with epilepsy – start mechanical ventilation instead.

# Antihistamines

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Drug** | **Formulations** | **Dose** | **Pharmacokinetics** | **Major side effects/ Risks** | **Notes** |
| Promethazine | 25mg/ml solution for injection | Oral child/  adolescent  Sedation:  10-17 years:  25-50mg | Onset 1-2 hours  t½ 7-15 hours | Prolonged sedation, Seizures, Cardio- respiratory depression, Painful Injection, Additional anti- cholinergic effects | Not licensed for use in children.  Limited evidence for efficacy.  May be considered as an alternative sedative agent in those who are antipsychotic naïve, who have been administered the maximum dose of medication or who are benzodiazepine tolerant.  Should be used with advice from SpR or Consultant. |

**10.0 Medicines not recommended for Rapid Tranquillisation**

**Please note: The medication summarised below are not licensed for the management of aggression/ violence in children and adolescents.**

**10.1 IM or PO chlorpromazine**

Local irritant if given IM.

Risk of cardiovascular complications.

Causes hypotensive effects, especially at RT doses.

Erratically absorbed.

Effect on QTc intervals suggests it is unsuitable.

**10.2 IM diazepam**

The IM use of diazepam injection can lead to a rise in serum creatinine phosphokinase activity, with a maximum level occurring between 12 and 24 hours after injection. This fact should be taken into account in the differential diagnosis of myocardial infarction.

The absorption from IM injection of diazepam may be variable, particularly for the gluteal muscles. This route of administration should only be used if IV administration is not possible.

Diazepam Injection BP contains propylene glycol. There have been rare reports of propylene glycol toxicity (e.g. increased anion gap, metabolic acidosis, hyperosmolality, renal impairment) with the potential for organ system failure and circulatory shock, in patients treated with continuous infusions of diazepam.

Central nervous system toxicity, including seizures, as well as unresponsiveness, tachypnoea, tachycardia and diaphoresis have also been associated with propylene glycol toxicity. Symptoms may be more likely to develop in patients with renal or hepatic impairment and in paediatric patients (SPC)

**10.3 Zuclopenthixol acetate (Clopixol Acuphase™)**

Zuclopenthixol acetate is an intramuscular injection which is indicated for the initial treatment of acute psychoses including mania and exacerbation of chronic psychoses, particularly where a duration of effect of 2-3 days is desirable.

The usual dosage is 50-150 mg (1-3 ml), repeated if necessary after 2 or 3 days. Some patients may need an additional injection between 1 and 2 days after the first injection (SPC).

Clopixol-Acuphase is not intended for long-term use and duration of treatment should not be more than two weeks. The maximum accumulated dosage should not exceed 400 mg and the number of injections should not exceed four (SPC).

* It is not an appropriate drug for use in RT as the onset of action does not occur for at least 2 hours.
* It may be considered as part of a medium term strategy if:
* The responsible clinician has made a reviewed and deemed it is clinically appropriate.
* A patient does not adequately respond to other short acting IM antipsychotics and it is anticipated that they will require further doses of IM antipsychotics.
* Where a patient has shown limited response to frequent oral and IM antipsychotic medication
* To reduce the risk to the patient and/ others from frequent use of RT medication and physical restraints
* It should never be used in those who are neuroleptic naive, who are struggling, who are sensitive to EPSE, those with cardiac disease, hepatic or renal impairment or in pregnancy.

# 11.0 Medicines which may prolong the QT interval

# The impact on QTc is categorized according to the Bazett’s correction formula (Maudsley 13ED). ‘No effect’ refers to those medication where QTc prolongation has not been reported at therapeutic doses or in overdose. ‘Low effect’ medication are those where QTc prolongation has been reported following an overdose or where only small average increases have been observed (<10ms) at clinical doses/ ‘Moderate effect’ medication refer to those medication which have been noted to increase QTc by approximately >10ms at clinical doses or where ECG monitoring is recommended. ‘High effect’ psychotropics are those where QTc prologation has been observed at >20ms at usual clinical doses.

# For further information, the clinician can refer to the RISQ-PATH study which provides a scoring system of QT prolongation (to above normal ranges) in any patient. The RISQ-PATH method uses the CredibleMeds system which can be accessed online by healthcare professionals.

# 11.1 Psychotropics

The QT prolongation effect is dose dependent therefore any antipsychotic used above recommended doses should be considered as an increased risk.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| No effect | Low effect | Moderate effect | High effect | Unknown effect |
| Brexpiprazole | Aripiprazole | Amisulpride | Any IV antipsychotic | Pipotiazine |
| Cariprazine | Asenapine | Chlorpromazine | Pimozide | Trifluperazine |
| Lurasidone | Clozapine | Haloperidol | Sertindole | Zuclopentixol |
|  | Flupentixol | Iloperidone | Any drug/ combination of drugs used in doses exceeding recommended maximum |  |
|  | Fluphenazine | Levomepromazine |  |  |
|  | Loxapine | Melperone |  |  |
|  | Perphenazine | Quetipaine |  |  |
|  | Prochloperazine | Ziprasidone |  |  |
|  | Olanzapine | Tricyclic antidepressant |  |  |
|  | Paliperidone | Methadone |  |  |
|  | Risperidone | Bupernorphine |  |  |
|  | Sulpiride |  |  |  |

**11. 2 Non-Psychotropics associated with QT prolongation**

|  |  |
| --- | --- |
| **Drug class** | **Drug** |
| **Antibiotics** | Erythromycin |
| Clarithromycin |
| Ampicillin |
| Co-trimoxazole |
| Pentamidine |
| Some quinolones affect QTc- see manufacturer’s information |
| **Antimalarials** | Chloroquine |
| Mefloquine |
| Quinine |
| **Antiarrhythmics** | Qunidine |
| Disopyramide |
| Procainamide |
| Sotalol |
| Amiodarone |
| Bretylium |
| **Others** | Amantadine |
| Cyclosporin |
| Diphenhydramine |
| Hydroxyzine |
| Methadone |
| Nicardipine |
| Tamoxifen |

**12.0 Monitoring and management of side effects**

**Before prescribing** for RT, the prescriber should:

Scrutinise the child/adolescent’s notes with regard to his/her general medical history and consider the possibility of a physical examination.

Check for recent ECG, U&Es and urine drug screen results, a previous

history of severe extrapyramidal effects, previous response to rapid tranquillisation or other methods of managing imminent violence.

Review current prescribed medication and recently administered

medication, taking note of administrations of prn medications.

# During rapid tranquillisation:

Every effort must be made to obtain (prior to the administration of

medications) **baseline** measurements of:

Temperature

Blood pressure

Pulse rate

Respiratory rate

Level of consciousness

# Neuroleptic Malignant Syndrome (NMS)

# Although, monitoring of NMS is not part of the core post RT monitoring. It is recommended where high doses and/ or frequent IM psychotropic medication is given to monitor for NMS in children/ adolescents.

# A number of the risk factors associated with NMS apply to the child/ adolescent population on an inpatient ward:

# High potency FGAs

# Recent/ rapid dose increases

# Rapid dose reduction

# Abrupt withdrawal of anticholinergic agents

# Antipsychotic polypharmacy

# Pychosis

# Organic

# Brain disease

# Psychomotor agitation

# Mental/ cognitive disability

# Male gender

# Younger age

# Agitation and dehydration

# NMS is an acute disorder of thermoregulation neuromotor control. Symptoms usually associated with NMS are:

# Muscular rigidity, hyperthermia, altered conscience and autonomic dysfunction

# Fever, diaphoresis, confusion, fluctuating blood pressure

# Elevated CK, leucocytes, altered liver function tests

# Treatment

# Within and inpatient MH ward setting the following is recommended:

# Withdraw all antipsychotic medication

# Monitor physical health observations- if NMS is picked up during RT monitoring to continue RT monitor until young person is seen by a Dr

# Urgent medical and consultant review

# ECG and bloods

# Possible admission to the acute ward

# Rehydration- ensure adequate food and fluid intake

# See below for table of monitoring and management of side effects to RT

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Measure** | **Drugs** | **Frequency** | **Problem** | **Action if problem** |
| Respiratory  Rate | Lorazepam  Diazepam | Every 15 mins  (unless stated otherwise) for first hour, then every 30mins for next 4 hours.  If patient is unconscious monitor every 5 mins. | Reduced  respiratory rate < 10/min | Give flumazenil but only if  benzodiazepine-induced  **Guidelines for the use of flumazenil: *Initially***: 200mcg IV over 15 seconds – if required level of consciousness not achieved after 60 seconds then: ***Subsequent does:*** 100mcg over 10 seconds, repeated after 60 seconds if necessary.  ***Maximum dose:*** 1mg in 24 hours (one initial dose and eight subsequent doses) Monitor respiration until rate returns to baseline.  If induced by other agent patient will require mechanical ventilation – arrange transfer to ITU immediately |
| Oxygen saturation | Lorazepam Diazepam | Every 15 mins (unless stated  otherwise) for first hour, then every 30mins for next 4 hrs  If patient  unconscious, monitor continuously | Should not fall below  90% (normal  sats 95-  100%) | Seek urgent medical review  **NB: A pulse oximeter is required for**  **monitoring oxygen saturation** |
| Blood  pressure | Lorazepam  Diazepam Haloperidol Olanzapine Risperidone | Every 15 mins  (unless stated otherwise) for first hour, then every 30mins for next 4 hrs | Orthostatic or  diastolic < 50mm Hg | Lie patient flat, raise legs if possible.  Monitor closely Seek medical advice |
| Pulse | Haloperidol  Olanzapine Risperidone | Every 15 mins  (unless stated otherwise) for first hour, then every 30mins for next 4 hrs | Irregular or  slow (<50/min) pulse | Refer to specialist care immediately.  ECG essential. |
| Temperature | Haloperidol  Olanzapine Risperidone | Every 15 mins  (unless stated otherwise) for first hour, then every 30mins for next 4 hrs | Increased  temp > 38°C | Withhold antipsychotics – risk of NMS and  perhaps arrhythmias:  monitor closely  cool patient  check CPK, BP, FBC, U&Es, MSU  Refer to medical team if continued signs of NMSSweating, hypertension or fluctuatingBP, tachycardia, muscular rigidity, confusion, agitation, altered consciousness. |
| Observe for  acute dystonias, Inc. oculogyric crisis | Haloperidol  Olanzapine Risperidone | Every 15 mins  (unless stated otherwise) for first hour, then every 30mins for next 4 hrs | Severe,  painful muscle stiffness | Procyclidine can be given at same time as  haloperidol for prophylaxis of EPSE (see doses above) |
| Hydration | Lorazepam Diazepam  Haloperidol Olanzapine Risperidone | Every 15 mins (unless stated  otherwise) for first hour, then every 30mins for next 4 hrs | Signs of dehydration | Rehydrate  Fluid and electrolyte balance should monitored if clinically indicated Monitor using fluid chart if appropriate |

***See Appendix 2 and 3 for physical monitoring charts to be completed***

**13.0 Monitoring of Efficacy**

In the interest of individualizing treatments for rapid tranquillisation in individual patients, the Richmond Agitation Sedation Scale tool (appendix 3) should be used to monitor state of arousal *before*, *during* and *after* giving medication for rapid tranquillisation.

# 14.0 Ethnic Origin

There is conflicting evidence as to whether the patient’s ethnic origin gives rise to any differences in response to antipsychotic medication; each case should be dealt with on an individual basis.

*NICE recommendations (staff training) (NG10)*

Child and adolescent mental health services (CAMHS) should ensure that staff are trained in the management of [violence and aggression](https://www.nice.org.uk/guidance/ng10/chapter/recommendations#terms-used-in-this-guideline) using a training programme designed specifically for staff working with [children](https://www.nice.org.uk/guidance/ng10/chapter/recommendations#terms-used-in-this-guideline) and [young people](https://www.nice.org.uk/guidance/ng10/chapter/recommendations#terms-used-in-this-guideline). Training programmes should include the use of psychosocial methods to avoid or minimise [restrictive interventions](https://www.nice.org.uk/guidance/ng10/chapter/recommendations#terms-used-in-this-guideline) whenever possible. Staff who might undertake restrictive interventions should be trained:

in the use of these interventions in these age groups

to adapt the [manual restraint](https://www.nice.org.uk/guidance/ng10/chapter/recommendations#terms-used-in-this-guideline) techniques for adults in recommendations adjusting them according to the child or young person's height, weight and physical strength

in the use of resuscitation equipment in children and young people.

CAMHS should have a clear and consistently enforced policy about managing antisocial behaviour and ensure that staff are trained in psychosocial and behavioural techniques for managing the behaviour.

CAMHS staff should be familiar with the Children Act 1989 and 2004 and the Mental Health Act 1983, as well as the Mental Capacity Act 2005 and the Human Rights Act 1998. They should also be aware of the United Nations Convention on the Rights of the Child.

# 15.0 Training

As a result of medication incidents analysed by the trust medicines safety group and audit results relating to the use of high-dose antipsychotics, the expectation of the trust is;

For all medical staff (nurses, doctors and pharmacists) working on in-patient wards for Children and Adolescents and Accident and Emergency Departments to be trained at induction and then every 3 years.

For all non-medical staff that handle medicines (Occupational Therapists, Social Workers, Support workers, Social Therapists, and Psychologists) working on in-patient Children and Adolescent wards and Accident and Emergency Departments to have an awareness around rapid tranquillisation on induction.

Training around the use of medicines for rapid tranquillisation and subsequent monitoring of side effects and desired effects will occur during induction of all new medical staff. This will be during the regular “Medicines Safety” slot.

All new staff will also have to work through and pass the e-learning programme on “Safe Administration of Medicines” before administering medicines. This training programme is based on the 10Rs of administration of medicines and will be linked to the Medicines Policy. Staff members will be asked to read and understand the Medicines Policy.

Local training is delivered by pharmacy staff as and when it is needed.

# 16.0 Monitoring of Rapid Tranquillisation Guidelines

**Audit**

Audit is done in a variety of ways including local POM UK audits for high dose and combination antipsychotics.

The mandatory administration audit tool includes data collection on whether ‘PRN’ medication and/or medication and monitoring has been completed for Rapid Tranquillisation (Please refer to the PRN Psychotropic Guidelines for further information).

The mandatory prescribing audit tool collects information on high dose antipsychotic prescribing and whether monitoring has been completed in relation to high dose prescribing.

All medicine incidents are reviewed by the trust Medicines Safety Group and systems errors identified.

# Review

Prescribing of medication for RT should be reviewed regularly. Daily in cases of active use and at least once weekly in all other cases. All medication prescribed should be regularly reviewed by the consultant, medical team and the appropriate clinical pharmacist/ pharmacy service.

# 17.0 Incident Reporting

An incident form must be completed where rapid tranquillisation medication have been administered. This applies to all intramuscular medication, including Zuclopenthixol acetate (Acuphase)

The rate of incidents relating to rapid tranquilisation are monitored via the trust Medicines Safety Group. Learning is shared across the Trust through the Medicines Safety Newsletters and reports to the Clinical Risk Group and Medicines Committee.

**18.0 Implementation**

**Dissemination**

This guideline will be distributed electronically to all medical and nursing staff belonging to ELFT CAMHS directorate, and any other relevant clinical staff. The guideline will also be available on the Trust intranet.

# 19.0 Training

All relevant staff must have read these guidelines and had training on the guidelines at induction and a refresher every 2 years thereafter, and whenever the guidelines are next updated. All new clinical staff to the trust will have the training on induction.

Training and Education select all staff expected by the trust (as detailed above) to attend training at induction.

The attendance of staff at induction is monitored by the Training and Education Department. Those staff that do not attend are recalled at a later date. If absence is repeated, the manager is contacted by Training and Education and attendance is ensured at a later date.

The e-learning package around the “Safe Administration of Medicines” includes a management system for evidence. An electronic record of all staff that have completed the package is available to all managers. This package has been available from February 2009 onwards.

Records of attendance at training will be stored centrally.

|  |  |  |
| --- | --- | --- |
| **Staff Group** | **Read Guidelines** | **Training Session** |
| CAMHS SHO/ FY2/  FT1,2&3 | M | M |
| In-patient CAMHS  Consultants | M | M |
| Other CAMHS consultants | M | D |
| In-patient CAMHS nursing staff | M | M |
| Other CAMHS nursing staff | M | D |
| CAMHS Modern matrons,  ward managers | M | M |
| Pharmacists | M | M |

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# ACKNOWLEDGEMENTS

The original guidelines were adapted from:

Maudsley Prescribing Guidelines- 12th Edition

Central North West London Mental Health Trust

Norfolk Mental Health Trust

South West London and St George’s Mental Health NHS Trust, Guidelines for Rapid Tranquillisation (for young

people aged 6 – 17 years) DRAFT, Andrew Fuller, 2003. CHIPSIG Children’s Special Interest Group

Bradford District Care Trust

Appendix 1: Richmond Agitation Sedation Scale (RASS)

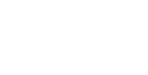
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| --- | --- | --- |
| **Score** | **Term** | **Description** |
| + 4 | Combatative | Overtly combative, violent, immediate danger to staff |
| + 3 | Very Agitated | Pulls or removes tube(s) or catheter(s), aggressive |
| + 2 | Agitated | Frequent non-purposeful movement, fights ventilator |
| + 1 | Restless | Anxious but movements not aggressive vigorous |
| 0 | Alert and Calm |  |
| - 1 | Drowsy | Not fully alert, but has sustained awakening (eye  opening/eye contact) to voice **(<10 seconds)** |
| - 2 | Light Sedation | Briefly awakens with eye contact to *voice* **(<10 seconds)** |
| - 3 | Moderate Sedation | Movement or eye opening to *voice* **(but no eye contact)** |
| - 4 | Deep Sedation | No response to voice, but movement or eye opening to  *physical* stimulation |
| - 5 | Unarousable | No response to *voice* or *physical* stimulation |

# Procedure for RASS Assessment

|  |  |  |
| --- | --- | --- |
| Category |  | Score 0 to +4 |
| 1 | Observe patient   1. Patient is alert, restless, agitated | (score 0 to +4) |
| 2 | If not alert, state patient’s name and say to open eyes and look at speaker   1. Patient awakens with sustained eye opening and eye contact 2. Patient awakens with eye opening and eye contact, but not sustained 3. Patient has any movement in response to voice but no eye contact | 1. (score- 1) 2. (score -2) 3. (score -3) |
| 3 | When no response to verbal stimulation, physically stimulate patient by shaking shoulder and/or rubbing sternum   1. Patient has any movement to physical stimulation 2. Patient has no response to any stimulation | 1. (score- 4) 2. (score- 5) |

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******Appendix 2: SCHOOLAGE (5-12 years)**



Patient details

Name DOB

Hosp No

**CHILDREN’S**

**UNIT**

**COAST: CHILDREN’s UNIT**

**C**HILDREN’s **O**BSERVATION **A**ND **S**EVERITY **T**OOL **page 25**

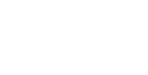
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| **SOUTH COAST CHILDREN’s EARLY WARNING SCORE: CHILDREN’S UNIT** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Temperature  (°C) |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| Heart Rate (number) | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | 70  60  50  40  30  20  10 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| **R**esp **R**ate  (bpm)  (over 1 minute) |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| Resp Rate (number) | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Receiving O2** (L/min) | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| O2 saturations (%) | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **R**esp. **Mod/Severe** | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **D**istress None/Mild | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **C**onscious Normal | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **L**evel **Decreased** | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| GCS\* | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Pain Score\* | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **TOTAL COAST SCORE** | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Number of shaded boxes | |
| Observer’s initials | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **ACTIONS**  NB: Scores ≥3 should be recorded overleaf | | **0-1** | Continue normal observations. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **2** | Nurse in Charge review. Hourly observations. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **3** | Nurse in Charge & Doctor to review patient. Half hourly observations. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **4** | Nurse in Charge & SpR to review patient. Consider informing Consultant. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **5-6** | Nurse in Charge & Senior Doctor to see immediately. If airway compromise, call ITU Registrar immediately. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

\*nb: BP, GCS and Pain Score values do not contribute to the overall COAST Score.

Page 25Dr Julian Sandell, Jan 2015. Adapted from the NHS Institute for Innovation & Improvement PEWS Scoring system.

****

**SCHOOLAGE (5-12 years) page 26**



Patient details

Name DOB

Hosp No

**CHILDREN’S**

**UNIT**

**COAST: CHILDREN’s UNIT**

**C**HILDREN’s **O**BSERVATION **A**ND **S**EVERITY **T**OOL

**Instructions:**

* The Paediatric COAST tool i) seeks to identify the abnormal physiological findings seen during serious childhood illnesses and ii) offers a method to interpret such physiological derangements with clearly defined actions, ensuring that suitably experienced staff are involved with the care of the sickest children.
* The COAST tool does **not** replace clinical experience and acumen and should **not** be relied upon for such purposes.
* 6 clinical parameters are assessed and recorded as part of the child’s routine clinical observations, providing a COAST score between 0-6. (Higher COAST scores are seen in sicker children).
* Detailed Actions are described according to increasing COAST Score.
* Some children with complex medical needs e.g. cyanotic heart disease, may require modification to their trigger thresholds/action plan – this should follow discussion with senior colleagues.
* Any COAST score of **3 or above** should be recorded below with details of any subsequent action initiated.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Record details when COAST ≥ 3** | | | **Record time of review and plan** | | |
| **Date** | **Time** | **COAST score** | **Time** | **Plan** | **Print name** |
| **e.g. 1/1/11** | **09:00** | **5** | **09:15** | **Seen immediately by Paed SpR** | **SN F Morton** |
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* **If at any time additional help is required, call for help - regardless of the COAST score!**
* Following a COAST assessment, senior help may be required.

The **SBAR** communication tool (**S**ituation, **B**ackground, **A**ssessment, **R**ecommendations) is a helpful mnemonic that can be used to describe a child’s clinical condition to a colleague.

|  |  |
| --- | --- |
|  | Situation:  I am (name), a nurse on ward (X). I am calling about (child X)  I am calling because I am concerned that… (e.g. BP is low/high, pulse is XXX, temperature is XX, COAST Score is XX). |
|  | Background:  Child (X) was admitted on (XX date) with (e.g. respiratory infection). They have had (X operation/procedure/ investigation). Child (X)’s condition has changed in the last (XX mins). Their last set of observations were (XXX). The child’s normal condition is… (e.g. alert/drowsy/confused, pain free). |
|  | Assessment:  I think the problem is (XXX) and I have… (e.g. given O2 /analgesia, stopped the infusion), OR I am not sure what the problem is but child (X) is deteriorating,  OR I don’t know what’s wrong but I am really worried. |
|  | Recommendation:  I need you to… Come to see the child in the next (XX mins) AND  Is there anything I need to do in the meantime? (e.g. stop the fluid/repeat observations). |

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**Total  
PEWS**

0-2

3-4

5-6

**PTO**

For Action

**PTO**

For Action

**Total PEWS** = Number of entries of shaded boxes

5

X

X



Name

Date of Birth

NHS Number

Consultant

Ward Weight

**Appendix 3: PEWS Form**

**13 - 18 Years**

**EXAMPLE**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| Conscious Level | Normal |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Decreased |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

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| Heart Rate & Blood Pressure |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| Heart Rate (Number) | | | 110 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

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| O2 Saturation % | 95 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Receiving O2 l/min | 2 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

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| Respiratory  Distress | Severe/Mod |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Mild/None |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

50

40

30

20

10

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| Respiratory Rate (Over 1 minute) |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| a | | | | | | | | | | | | | | | | | | | |
| Respiratory Rate (number) | | 35 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

180

170

160

150

140

130

120

110

100

90

80

70

60

50

40

30

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| Doctor/Nurse/Family concern? |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

40

39

38

37

36

35

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| Temperature °C |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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|  | | | | | | | | | | | | | | | | | | | |
| Temperature (Number) | | 38 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

Frequency of obs

Every

hourly

C

B

A

*BP NOT used to calculate PEWS*

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Date | 30/11 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Time | 18:00 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Initial | SNM |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

page 28

Nurse in charge & Consultant  
MUST review

Nurse in charge & Doctor  
MUST review

Nurse in charge & Doctor MUST review & inform Consultant



Name

Date of Birth

NHS Number

Consultant

Ward

**PEWS Form**

**13 - 18 Years**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Record Call When PEWS 3 Or More** | | | | **Record Time of Review, Who by & Plan** | | |
| **Date** | **Time** | **PEWS** | **Print Name** (nurse) | **Time** | **Plan** | **Print Name** |
| **01/01/12** | **09:00** | **5** | **SN Morton** | **09:15** | **ED consultant called Anaesthetic review** | **Sister JACKS** |
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and Improvement 2012

6

5

1

0

2

3

4

Nurse in charge MUST review

Continue monitoring

|  |  |
| --- | --- |
| S | **Situation:**  *I am (name), a nurse on ward (X)*  *I am calling about (child X)*  *I am calling because I am concerned that…*  *(e.g. BP is low/high, pulse is XXX*  *temperature is XX, Early Warning Score is XX)* |
| B | **Background:**  *Child (X) was admitted on (XX date) with*  *(e.g. respiratory infection)*  *They have had (X operation/procedure/investigation)*  *Child (X)’s condition has changed in the last (XX mins)*  *Their last set of obs were (XXX)*  *The child’s normal condition is…*  *(e.g. alert/drowsy/confused, pain free)* |
| A | **Assessment:**  *I think the problem is (XXX)*  *and I have…*  *(e.g. given O2 /analgesia, stopped the infusion)*  *OR*  *I am not sure what the problem is but child (X)*  *is deteriorating*  *OR*  *I don’t know what’s wrong but I am really worried* |
| R | **Recommendation:**  *I need you to…*  *Come to see the child in the next (XX mins)*  *AND*  *Is there anything I need to do in the meantime?*  *(e.g. stop the fluid/repeat the obs)* |
| Download SBAR prompt cards and pads at  **www.institute.nhs.uk/SBAR** | |

**Remember:** If you feel you need more help at any time, call for help – regardless of PEW Score

**PEWS** Escalation Aid

Download documents to use or eerdit at

[**www.institute.nhs.uk/PEWScharts**](http://www.institute.nhs.uk/PEWScharts)

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