Charity reg. No. 228636

National Audit of Violence

Module 3b – Case note/drug chart audit on the use of rapid tranquillisation

Older people's services

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Contents

Section	Page
Background	2
Methods	2
Glossary of terms	5
Section 1: Carrying out rapid tranquillisation	6
Section 2: The use of oral medication	8
Section 3: The use of covert medication	9
Section 4: The use of intramuscular medication	11
Section 5: Care after rapid tranquillisation if the patient became inactive	13
Section 6: Aftercare and support	15

Background

The bulk of the questions within the audit tool are based upon the rapid tranquillisation section of the NICE Guideline: Violence – the short term management of disturbed/violent in in-patient psychiatric settings and emergency departments (2005). However, as the scope for the guideline specifically **excluded** services for people with dementia, the audit tool for 'older people's services' was briefer than the 'working age adults' equivalent. An additional section on the use of covert medication was added to reflect management practices in older people's services; the standards for this section were drawn both from the Royal College of Psychiatrists' guidance 'College Statement on Covert Administration of Medicines (2004), and from the NAV Steering Group.

The results for 'working age adult services' have been reported separately.

Key findings from national results for older people's services

The sampling methods for the audit, the relatively small number cases audited, and the often high levels of missing data mean that the national results have to be interpreted with caution. However, the data would seem to indicate the following:

- Rapid tranquillisation is being used in many services for older adults with mental illness
- BNF doses were not being exceeded
- Oral medication was being used more frequently than either intramuscular or covert medication
- Usage of covert medication appeared rarer than intramuscular medication
- In the minority of cases when covert medication was used: capacity was usually assessed; carers were consulted; the medication was always reviewed regularly, and only included essential items
- With intramuscular medication, only one drug of the same class was generally used
- Vital signs were **inadequately** monitored in circumstances where they should be, due to failure to agree monitoring schedules
- More attention was paid to assessing conscious level than airway or respiration
- Patients were not given adequate opportunities to discuss or write about the incidents

What happens next?

Local teams are encouraged to review their findings, relative to the national findings and determine whether there is any relevant action required. The Healthcare Commission requires that all participating wards compile and submit an action plan that details the positive improvements that you will be taking forward, based on your local findings from the audit. This action planning is being supported through the Feedback Events.

Methods

Sampling

All wards were encouraged to take part in this part of the audit programme, although it was anticipated many wards would be unable to take part due to lack of cases. In recognition of the fact that the levels of usage of rapid tranquillisation varied considerably between subject wards, the sampling and audit methods were suitably flexible[1].

[1] During the Introductory Workshops that preceded data collection, the Audit Team consulted with local teams to determine an appropriate methodology for this module of the audit.

A three-stage process was recommended: firstly, a census week was used to identify potential cases that might be audited; secondly, the audit sample was identified; finally, the case notes were audited against the audit checklist.

1. **Census week:** local project teams were asked to specify one week and, during this week, the Ward Manager was asked to ensure that a numbered list was compiled of all instances where a patient had received rapid tranquillisation (it was suggested that this task could be delegated to another member of the nursing team or the ward clerk, or could be compiled by the team at each handover).
2. **Sampling:** at the end of the week, teams were instructed to work through the numbered list and draw a sample from the odd numbers of a minimum of 5 and a maximum of 15 separate instances[2].
3. **Audit of case notes/drug charts:** the following suggestions were made to local teams about who should carry out the actual audit.

    - a Senior Nurse
    - an SHO or SpR
    - a Pharmacist
    - a member of the Clinical Governance/Clinical Audit Team

Submission of data

Local teams collected their data using a simple template. This data was then entered via a web-link. The data collection period began on 9 October 2006 and continued until 9 March 2007[3].

Data presentation

This report includes **the national findings for older people's services**. Nationally, data was submitted on behalf of the following:

- 37 trusts;
- 43 wards;
- 195 individual incidents.

[2] If, at the end of the census week, teams had insufficient instances to include in the audit, wards were given two options: continue collecting the list for one (or more) additional weeks; include all instances in the sample.
[3] The original deadline of 28 February 2007 was extended at the request of many of the participating wards.

NOTES

- **Where the actual number of responses was zero**, Excel was unable to calculate a corresponding percentage and the symbol - will appear, e.g.:

	Yes		No	
	n	%	n	%
Local	0	-	0	-
National	35	27%	94	73%

- **Percentages are presented without decimal points** (e.g. 56%, rather than 56.4%), resulting in some 'rounding up' of scores, meaning that sometimes total scores will appear to be 99% or 101%.

- **Good practice** has been highlighted in **green** on the graphs. Areas of concern have been highlighted in **red**.

- **Only wards who entered the required minimum of 5 cases have received a local report that compares their results with the national figures.**

Glossary of terms

This glossary was adapted from the NICE Guideline, 2005.

Parenteral: method of administering medication or nutrition other than via the digestive tract, such as intravenous, subcutaneous or intramuscular.

Patient: the term 'patient' is used, rather than 'service user' in this document and associated audit tools and guidance (except when text is quoted directly from the NICE guideline).

Rapid tranquillisation: the use of medication to calm/lightly sedate the patient, 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 patient, rapid tranquillisation may lead to deep sedation/anaesthesia.

Section 1: Carrying out rapid tranquillisation

NOTE
This section of the audit was completed by ALL respondents. The total number of cases audited by services for older people was 195 (n=195), however, the total figures in some charts do not add up to the expected number due to missing data.

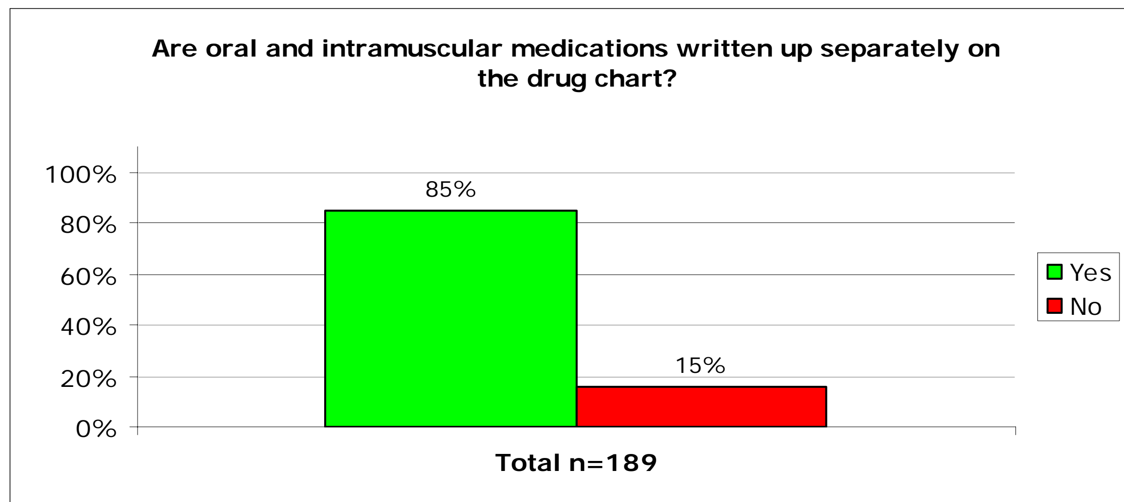
1.8.4.7 **Guideline recommendation**
Oral medication should be offered before parenteral medication as far as possible.

1.8.4.14 **Guideline recommendation**
If parenteral treatment proves necessary, the intramuscular route is preferred over intravenous from a safety point of view.

Which route of administration was used?

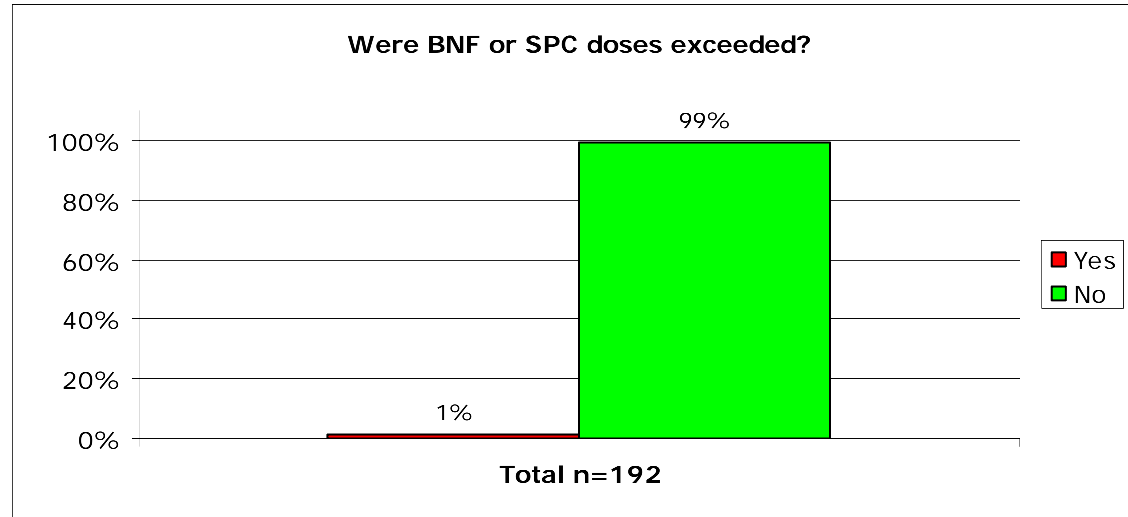
Oral	Covert	Intramuscular	Oral and Intramuscular	Total n
%	%	%	%	
79%	5%	11%	4%	195

1.8.4.9 **Guideline recommendation**
Oral and intramuscular medications should be prescribed separately and the abbreviation of o/i/m should not be used.



Prescribing levels

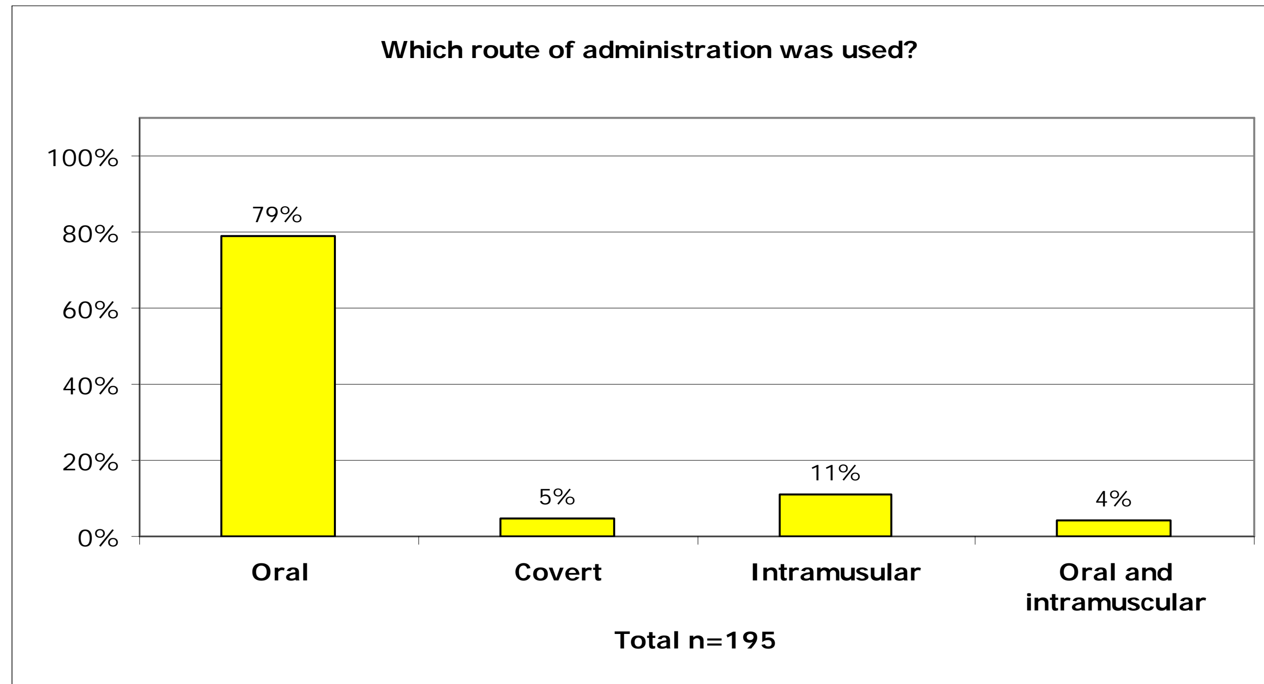
1.8.4.28	**Guideline recommendation** *When using rapid tranquillisation there may be certain circumstances in which the current BNF uses and limits and manufacturer's SPC may be knowingly exceeded. A risk–benefit analysis should be recorded in the case notes and a rationale should be recorded in the care plan.*



There was only **one case** where BNF or SPC does were exceeded. In this case a risk benefit analysis **was not** recorded in the notes but the rationale **was** recorded in the care plan.

Section 2: The use of oral medication

1.8.4.7	**Guideline recommendation** *Oral medication should be offered before parenteral medication as far as possible.*



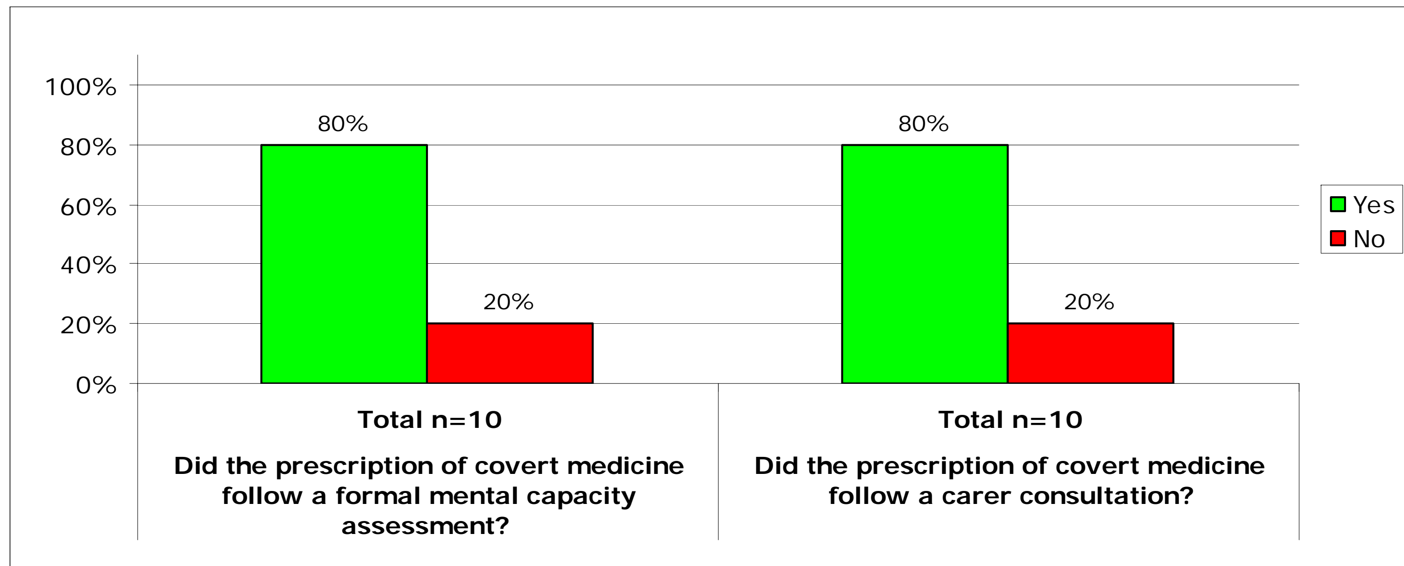
Section 3: The use of covert medication

NOTE: the respondent group for this section includes cases where covert rapid tranquillisation was administered. The total number of respondents was 10 (n=10).

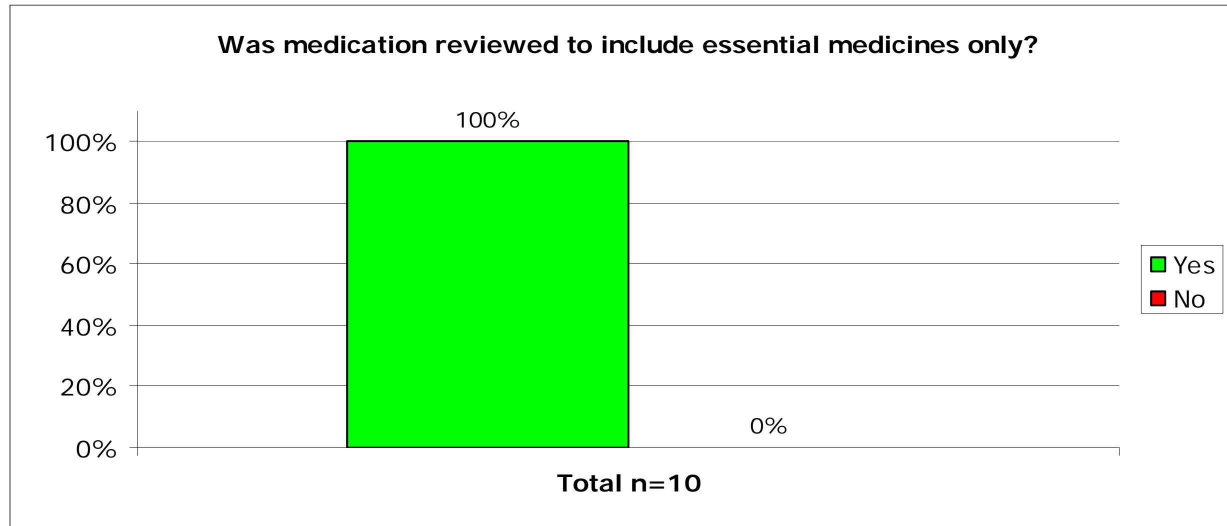
Recommendation
A record of the reasons for presuming mental incapacity (including at the time medication is administered) should be made in the clinical notes. Incapacity should be assessed as per the BMA guidelines

Recommendation
The proposed treatment plan should be discussed with a relative, carer or nominated representative unless it is clear that the patient would not have wished this.

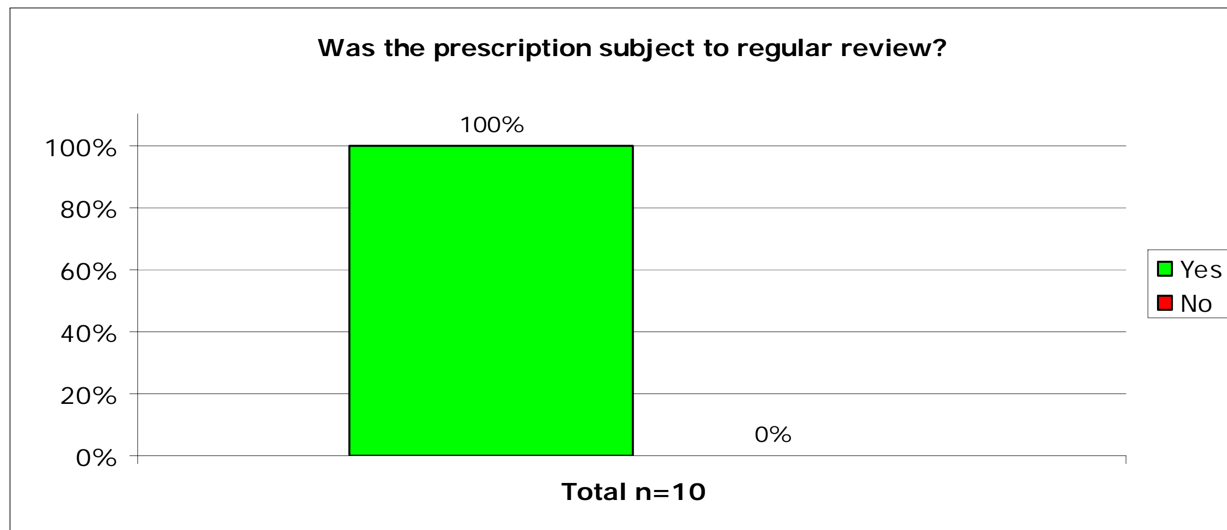
Royal College of Psychiatrists' Statement on Covert Administration of Medicines (2004)



Recommendation
Medication should be reviewed regularly to ensure inclusion of essential medicines only
NAV Steering Group (2006)



Recommendation
The treatment plan should normally be subject to weekly review initially and if the requirement for covert medication does persist, full reviews at less frequent intervals should take place.
Royal College of Psychiatrists' Statement on Covert Administration of Medicines (2004)



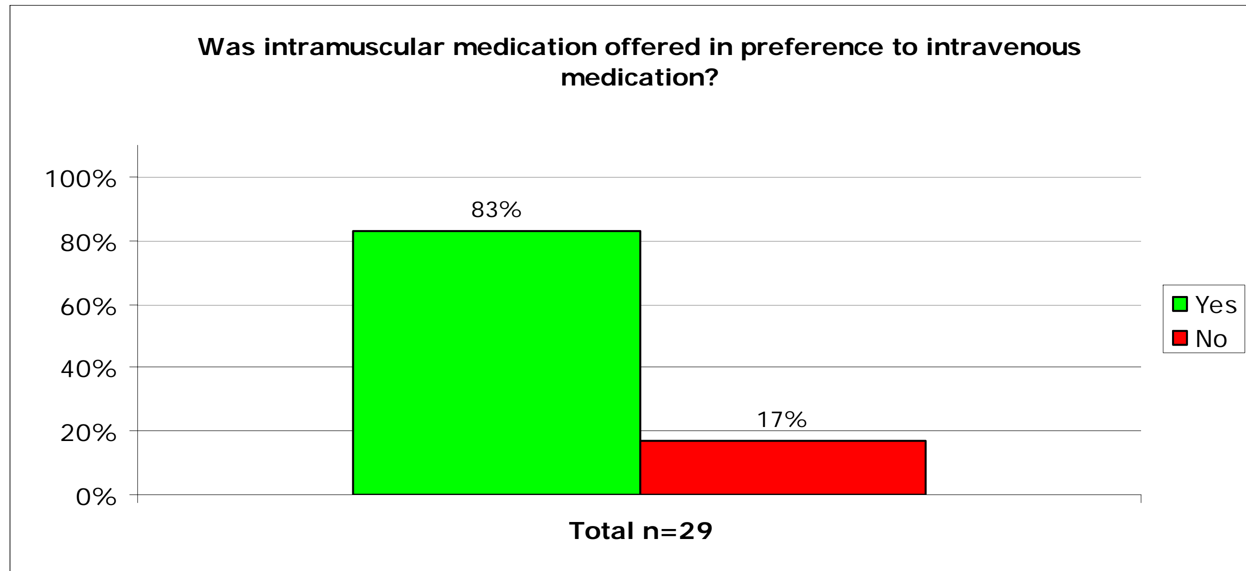
Section 4: the use of intramuscular medication

NOTE: the respondent group for this section included:

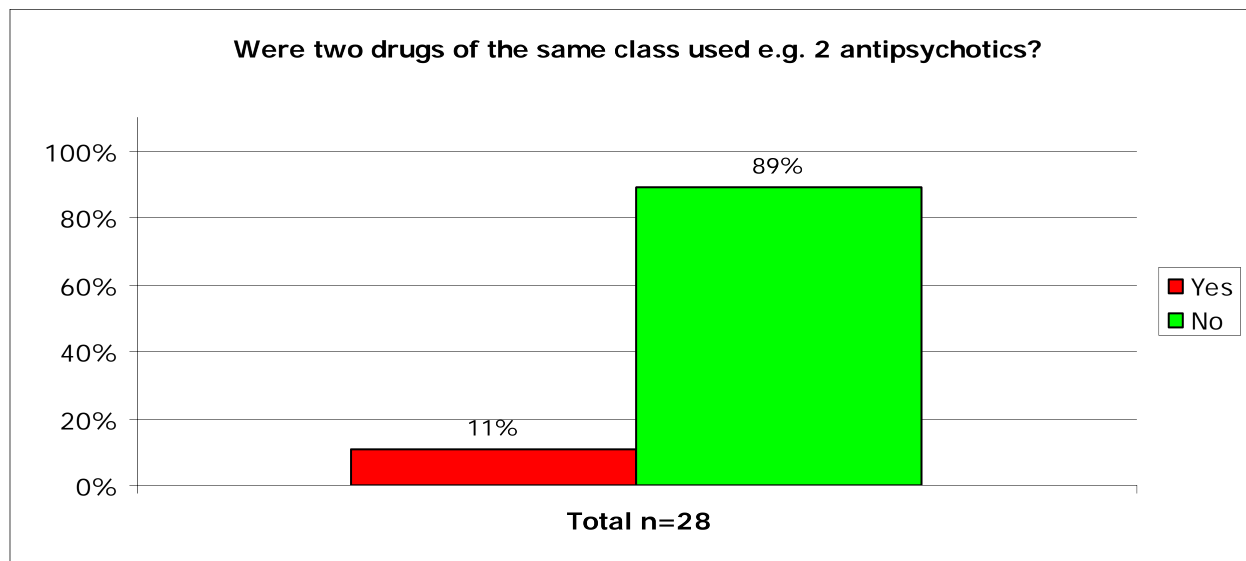
- cases where ONLY intramuscular rapid tranquillisation was administered;
- cases where oral AND intramuscular rapid tranquillisation were administered.

The total number of respondents was 30 (n=30), however, the total figures in some charts do not add up to the expected number due to missing data.

1.8.4.14	**Guideline recommendation**
	If parenteral treatment proves necessary, the intramuscular route (i/m) is preferred over intravenous (i/v) from a safety point of view.



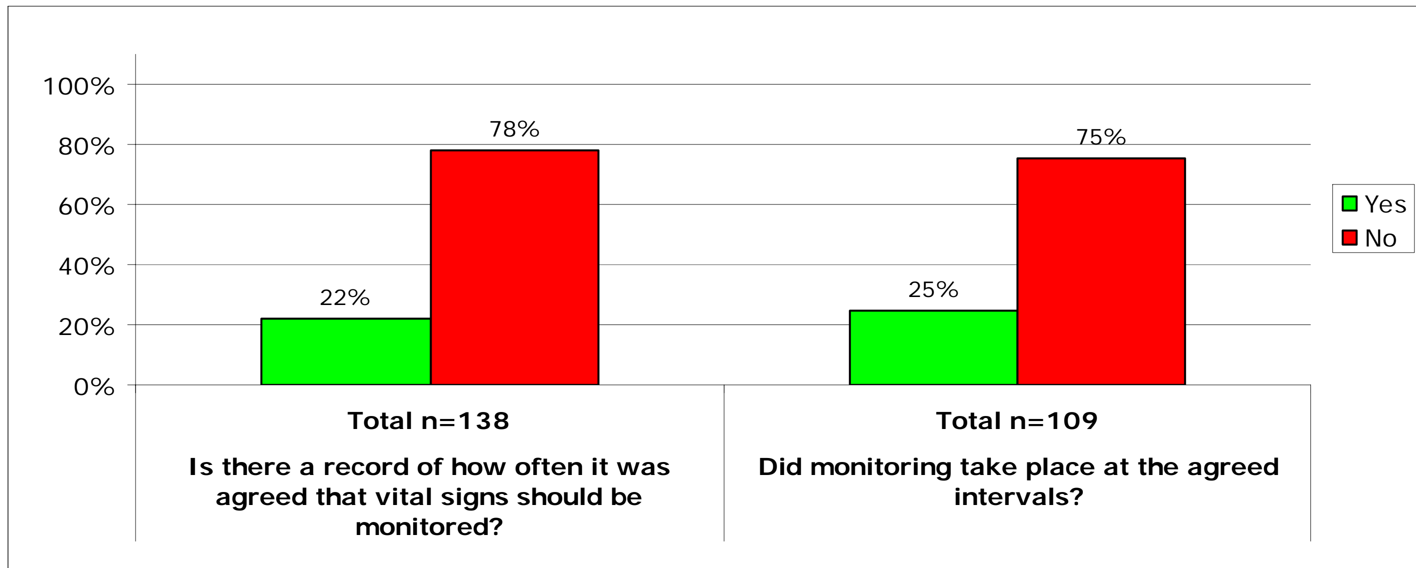
1.8.4.19	**Guideline recommendation** *The use of two drugs of the same class for the purpose of rapid tranquillisation should not occur.*



Section 5: Care after rapid tranquillisation if the patient became inactive

NOTE
This section of the audit was completed by ALL respondents. The total number of respondents was 195 (n= 195), however, the total figures in some tables/charts do not add up to the expected number due to missing data.

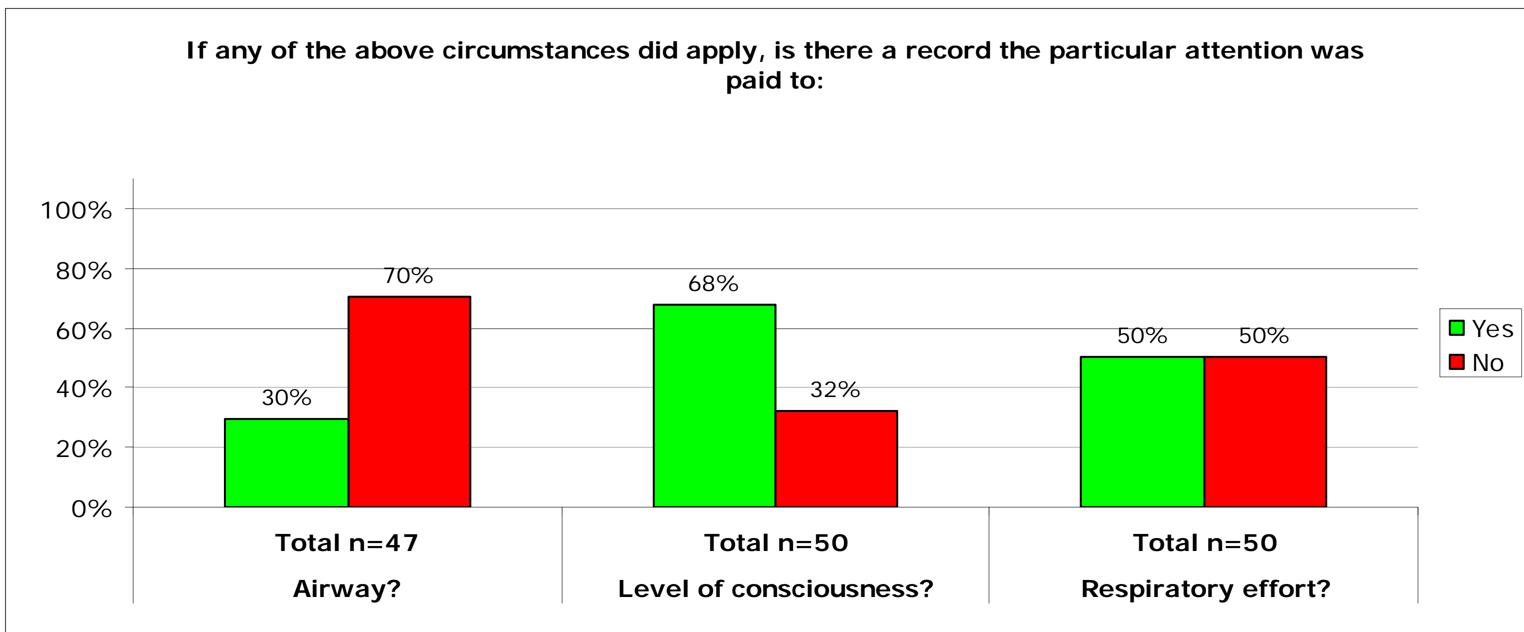
1.8.4.33	**Guideline recommendation**
	After rapid tranquillisation is administered, vital signs should be monitored and pulse oximeters should be available. Blood pressure, pulse, temperature, respiratory rate and hydration should be recorded regularly, at intervals agreed by a multidisciplinary team,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



1.8.4.34	**Guideline recommendation**
	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.*

Did any of the above circumstances apply?

Yes	No	Total n
%	%	
32%	68%	163



Section 6: Aftercare and support

NOTE
This section of the audit was completed by ALL respondents. The total number of respondents was 195 (n= 195), however, the total figures in some charts do not add up to the expected number due to missing data.

1.8.1.8	**Guideline recommendation** *After the use of rapid tranquillisation, service users should be given the opportunity to document their account of the intervention in their notes.*