PSYCHIATRIC EMERGENCY PLAN

GRAMPIAN

SEPTEMBER 2005
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1.0 Introduction

Purpose of document
The Remote and Rural Areas Resource Initiative (RARARI), through a project led by Dr Malcolm Kerr, from Arran, has examined and reported the issues surrounding psychiatric emergencies across remote and rural Scotland. The main recommendation to emerge from the report is that NHS Boards should be responsible for ensuring that a Psychiatric Emergency Plan (PEP), endorsed by all appropriate agencies and professional groups, is in place for each locality. It should include statements on: the skills and competencies required of staff; minimum staffing levels, and clear arrangements on the availability of Mental Health Officers (MHOs). Service users, those who care for them, and those who advocate for them should have a central role in drawing up and endorsing PEPs. NHS Boards must ensure that arrangements for involvement of these groups are made explicit (BID 79, 2002).

The Scottish Executive has responded to the RARARI recommendations through the Code of Practice accompanying the Mental Health (Care & Treatment) (Scotland) Act 2003 (the 2003 Act). It recommends, as good practice, that the relevant local agencies and service providers, who might potentially be involved in psychiatric emergencies, work together to develop and agree on a “Psychiatric Emergency Plan” (PEP). This would allow potential local difficulties to be addressed and contingency procedures put in place before they arise for real. The development and aim of such a plan would be to,

agree procedures that would manage the transfer and detention processes in a manner which minimises distress and disturbance for the person and to ensure as smooth and safe transition as possible from the site of the emergency to the appropriate treatment setting (Draft Code of Practice, Volume 1, 2003: para 56).

The Grampian PEP

The partner agencies in Grampian have agreed to adopt a generic approach and use standardised templates for the production and implementation of PEPs across the NHS Grampian area. This will provide a co-ordinated approach and ensure there is sufficient flexibility to meet local needs
and requirements of the 3 Local Authorities (Aberdeen City, Aberdeenshire and Moray) and all 3 Community Health Partnerships that broadly share similar geographical boundaries.

This PEP sets out clear guidance for staff who may be involved in various functions under the 2003 Act, including detention of persons. The guidance contained therein is applicable to all healthcare and local authority personnel, police officers, ambulance personnel and associated persons and agencies. The PEP has been written with regard to human rights legislation (Human Rights Act 1998) and the principles set out in section one of the 2003 Act and any action undertaken while discharging a function under the Act takes account of these principles.

As a means of comprehensively addressing these issues in a manner which best reflects local circumstances, the professionals involved in drawing up this PEP have included: general practitioners, approved medical practitioners, MHOs, other social workers, social care workers, CPNs, ward nursing staff, independent service providers, police officers, and ambulance personnel. Mental health service users and carers have also been consulted in the preparation of this Plan.

**Monitoring and Review arrangements**

This PEP and attached flow charts are intended to be practical working documents and in accordance with the Act, monitored and reviewed on a regular basis. The RARARI Report requires a process for “Significant Event Analysis” (see APPENDIX 5). This PEP will be used as the baseline for carrying out a review and that initially this will be undertaken by the PEP development group and key findings/problems shared on a Grampian-wide basis via the PEP Lead Officers (see below).

**Lead Officers**

Margaret Christie  
Kevin Dawson  
Janice MacKinnon  
Fiona Palin
2.0 Geographic Profile

Grampian is one of the most prosperous locations in Scotland, and the only part of the UK to have consistently outperformed the growth of the global economy over a period of 20 years. Scottish Enterprise Grampian covers the North East corner of Scotland, including Aberdeenshire and the City of Aberdeen, which has been ranked the UK’s most competitive city after London.

<table>
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<tr>
<th>Area</th>
<th>Overall Population</th>
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</thead>
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<tr>
<td>Aberdeen City</td>
<td>209,270</td>
</tr>
<tr>
<td>Aberdeenshire</td>
<td>227,280</td>
</tr>
<tr>
<td>Moray</td>
<td>86,740</td>
</tr>
</tbody>
</table>
### 3.0 General Principles

The table below sets out the principles contained in the 2003 Act. These principles guide the measures proposed in this PEP.

<table>
<thead>
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<th>PRINCIPLE</th>
<th>BRIEF DESCRIPTION</th>
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<tbody>
<tr>
<td>Non-Discrimination</td>
<td>People with mental disorder should wherever possible retain the same rights and entitlements as those with other health needs.</td>
</tr>
<tr>
<td>Equality</td>
<td>All powers under the act should be exercised without any direct or indirect discrimination on the grounds of physical disability, age, gender, sexual orientation, language, religion or national, ethnic, or social origin.</td>
</tr>
<tr>
<td>Respect for Diversity</td>
<td>Service users should receive care, treatment and support in a manner that accords respect for their individual qualities, abilities and diverse background and properly takes into account their age, gender, sexual orientation, ethnic group social cultural and religious background.</td>
</tr>
<tr>
<td>Reciprocity</td>
<td>Where society imposes an obligation on an individual to comply with a programme of treatment of care, it should impose a parallel obligation on the health and social care authorities to provide safe and appropriate services, including ongoing care following discharge from compulsion.</td>
</tr>
<tr>
<td>Informal Care</td>
<td>Where ever possible care, treatment and support should be provided to people with mental disorder without the use of compulsory powers.</td>
</tr>
<tr>
<td>Participation</td>
<td>Services users should be fully involved so far as they are able to be in all aspects of their assessment, care, treatment and support. Their past and present wishes should be taken into account. They should be provided with all information and support necessary to enable them to participate fully. Information should be provided in a way, which makes it most likely to be understood.</td>
</tr>
<tr>
<td>Respect for Carers</td>
<td>Those who provide care to service users on an informal basis should receive respect for their role and experience, receive appropriate information and advice and have their views and needs taken into account.</td>
</tr>
<tr>
<td>Least Restrictive Alternative</td>
<td>Service users should be provided with any necessary care, treatment and support both in the least invasive manner and the least restrictive manner and environment compatible with the delivery of safe and effective care, taking account where appropriate of the safety of others.</td>
</tr>
<tr>
<td>Benefit</td>
<td>Any intervention under the act should be likely to produce for the service use a benefit that cannot reasonably be achieved other than by intervention.</td>
</tr>
<tr>
<td>Child Welfare</td>
<td>The welfare of a child with mental disorder should be paramount in any interventions imposed on the child under the act.</td>
</tr>
</tbody>
</table>
4.0 Hospital Manager Responsibilities

The Act places a responsibility on Hospital Managers to discharge certain functions. As the definition of ‘hospital manager’ may refer to a variety of roles within the NHS, clarification is required.

For the purposes of psychiatric emergency planning and for this Plan in particular, the following directions apply:

- The Medical Records Officer, for the admitting hospital, is the person responsible for notifying any body or agency (e.g. Mental Welfare Commission, Social Work Department, etc.) of someone’s detention status;

- The Senior Nurse on the admitting ward is responsible for ensuring that the Medical Records Officer receives the certificate as promptly as possible;

- The duty consultant/on-call SHO/senior nurse is the person responsible for receiving detention certificates and discharging any immediate functions under the Act.
5.0 Detention of persons from community to hospital

Where access to private premises is granted (Individual’s home)

Where possible the Short Term Detention Certificate (s44) is the preferred gateway order as it affords the person more rights. It requires the consent of a Mental Health Officer (MHO) and it can only be issued by an AMP. In situations of extreme urgency, the Emergency Detention Certificate (s36) may be the preferred route to detention. It can be granted by any fully registered medical practitioner and where an Approved Medical Practitioner (AMP) and MHO are not immediately available; the Short Term Detention Certificate would be impracticable.

The certificate authorises the transportation of a person to hospital but admission to hospital is authorised only after the certificate has been given to the hospital manager or his/her representative.

The Emergency Detention recommendation does not have to be given on a prescribed form, however, a form does exist for this purpose and it would be good practice to use this form to avoid errors and the possibility of invalid recommendations. The application for emergency detention must include the following statements:-

- That it is likely the person has a mental disorder;
- As a result of this mental disorder the person’s ability to make decisions regarding his/her medical treatment is significantly impaired;
- That it is a matter of urgency to detain the person in hospital to determine what treatment is required;
- That if the person were not detained there would be significant risk to the person and/or others; and
- Granting a short-term detention certificate would involve an undesirable delay.

The following points should be noted:-

- It is not necessary to specify which hospital the person will be admitted to or the nature of the person’s mental disorder;
- Mental Health Officer (MHO) approval should be sought or a reason why this was not possible must be indicated to the Hospital Manager; and
- The nearest relative cannot give consent.

*See flowchart on page 11.*
AT HOME – ACCESS GAINED

REFERRAL FROM FAMILY CARER/SW/CPN/DAY HOSP/LIAISON NURSE → PATIENT GP (IN HOURS) DUTY GP (OUT OF HOURS) → SUSPECT MENTAL DISORDER → CHECK FOR P.E.P. → NO PLAN IN PLACE → PLAN IN PLAN INITIATED → ACTION

EMERGENCY PSYCHIATRIC TEAM

DUTY MHO

NURSING STAFF

AMBULANCE

POLICE

LIAISE RE SHORT-TERM DETENTION/EMERGENCY DETENTION. IF NO SECT.22 APPROVED DOCTOR AVAILABLE OR ALTERNATIVES TO HOSPITAL → DETENTION REQUIRED → LIAISE WITH NURSING STAFF RE TRANSFER OF PATIENT TO WARD 4 OR R.C.H. AMBULANCE SERVICE IF REQUIRED RE TRANSFER

ALTERNATIVE TO HOSPITAL AGREED

Grampian

May 2005

Psychiatric Emergency Plan

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Where access to the premises is denied

In circumstances where access is denied, the 2003 Act places a duty on the Local Authority to make enquiries under s33, but only an MHO can apply to a Sheriff or Justice of the Peace for warrants under s35 (entry and possible assessment) and s293 (removal to a place of safety).

Powers under s292-293 are not powers of access for assessment purposes. Deciding which of these powers to apply will be dictated by the individual circumstances.

Involving the Police:
- Contact should be made with Grampian Police Service Centre 0845-600-5-700
- Consult with the Duty Inspector re course of action
- Duty Inspector to consider contacting Tactical Advisor (TA)
- Risk Assessment will be required
- TA becomes Police OIC at scene until situation is resolved
- Police Support Unit (PSU) may require to be deployed

See flowchart on page 13.
PATIENT AT HOME AND REFUSING ACCESS

GP

INITIAL ASSESSMENT

MD SUSPECTED, FURTHER ASSESSMENT DEEMED NECESSARY AND PATIENT REFUSING ACCESS TO HOME

LIAISE WITH DUTY MHO AND CONSIDER NEED FOR SPECIFIC ACTION UNDER SECT.33

SITUATION URGENT-MHO SECURES APPROPRIATE WARRANT UNDER SECT.35-LIAISES WITH POLICE/MED PRACT. RE DOMICILIARY VISIT

MHO TO ATTEMPT ACCESS (WITH OR WITHOUT POLICE AND/OR MED.PRACT)

MHO TO ATTEMPT ACCESS

NO FURTHER ACTION

HOSPITAL ADMISSION

LIAISE WITH NURSING STAFF RE TRANSFER OF PATIENT TO WARD 4 OR RCH.

AMBULANCE SERVICE IF REQUIRED RE TRANSPORT/TRANSFER ARRANGEMENTS

WARD 4

AMBULANCE

POLICE

May 2005
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Warrants

Under section 33 of the Mental Health Care and Treatment Act, Local Authorities will have a duty to inquire into the case of a person with mental disorder where certain criteria are met - essentially, where they are at risk of harm of some kind. Under sections 34 and 35, Local Authorities will also be able to apply for a range of warrants (such as a warrant to enter premises) to enable them to carry out their inquiries.

Under the new Act, a sheriff or a justice of the peace may, in certain circumstances, grant a warrant authorising someone with the appropriate authority, such as an MHO, to enter specified premises to take a person to a place of safety or into custody (for example, under emergency detention).

In circumstances where access is denied, the 2003 Act gives an MHO a duty to apply to a Sheriff or Justice of the Peace for an entry warrant, for assessment (s35) or access and removal to a place of safety (ss292-293). Powers under ss292-293 are not powers of access for assessment purposes. Deciding which of these powers to apply will be dictated by the individual circumstances.

Detention in a community facility

Due to the varied nature of service delivery, there will be occasions when persons who require detention, will be within community facilities such as day hospitals. As with detention in the community, the preferred gateway order is the Short Term Detention Certificate (s44), but the Emergency Detention Certificate (s36) may be used in circumstances (as noted above) where the use of the Short Term Detention Certificate is impracticable. The mechanism for their use is the same as those described above.

There may be occasions when staff will be unable to contain a situation within a community resource, and if there is a clear threat to staff’s personal safety, they should request the assistance of the police. It may not always be practicable for staff directly involved in the detention interview to
instruct that police assistance is required, and the decision to involve the police may be taken by any member of the team involved in the detention.

In cases of urgency Dial 999 to ensure an immediate Grade 1 response and for all other non-urgent calls ring Grampian Police Service Centre on: 0845 – 600 – 5 - 700
PROCESS IN A PUBLIC PLACE - LOW RISK

**POLICE**

**SUSPECT MENTAL DISORDER**

**CHECK STORM FOR P.E.P.**

**PLAN IN PLACE**

**INITIATE**

**NO PLAN**

**TRANSFER TO A&E FOR ASSESSMENT**

**NO MENTAL DISORDER**

**MENTAL DISORDER PRESENT**

**GP TO LIAISE WITH VIEW TO SHORT-TERM DETENTION/EMERGENCY DETENTION ALTERNATIVES TO HOSPITAL CARE**

**LIAISE WITH NURSING STAFF RE ADMISSION TO WARD 4 OR R.C.H./AMBULANCE IF REQUIRED RE TRANSPORT FOR TRANSFER**

**DUTY GP/LIAISON NURSE**

**MENTAL HEALTH OFFICER**

**DUTY PSYCHIATRIST SECT.22 APPROVED MEDICAL PRACTITIONER**

**NURSING STAFF**

**AMBULANCE**
6.0 Detention in hospital

**Medical Detention in general hospital**

When detaining a person in a general hospital under emergency conditions an Emergency Detention Certificate may be used by any fully registered medical practitioner. It should only be used where the use of the Short Term Detention Certificate is impracticable, for example, when an Approved Medical Practitioner and a Mental Health Officer is not immediately available.

*See flowchart on page 18.*
REQUEST FOR EMERGENCY ASSESSMENT FROM GENERAL HOSPITAL

LIAISON NURSE

INITIAL ASSESSMENT

ADVICE GIVEN

NO M. DISORDER

INITIATE

P.E.P. AVAILABLE

M. DISORDER PRESENT

CHECK FOR P.E.P.

NO P.E.P.

TRANSFER INITIATED

TRANSFER TO HOSPITAL INFORMAL

FURTHER ASSESS RE TRANSFER TO M.H. SERVICES

ASSESS RE SHORT-TERM DETENTION/EMERGENCY DETENTION

DUTY CONSULTANT SECT.22 APPROVED

DOCTOR TO LIAISE WITH M.H.O.

DETENTION REQUIRED

LIAISE WITH NURSING STAFF RE TRANSFER OF PATIENT TO WARD 4 OR R.C.H.

AMBULANCE IF REQUIRED RE TRANSPORT/TRANSFER ARRANGEMENTS

M.H.O.

NURSING STAFF WARD 4

AMBULANCE

POLICE

LIAISON PSYCHIATRIST/DUTY S.H.O./CONSULTANT/SECT.22 DOCTORS
Medical Detention in psychiatric unit

When detaining a person in a psychiatric unit under emergency conditions an Emergency Detention Certificate may be used by any fully registered medical practitioner. It should only be used where the use of the Short Term Detention Certificate is impracticable, for example, when an Approved Medical Practitioner and a Mental Health Officer is not immediately available.

See flowchart on page 20.
HIGH RISK PATIENT IN WARD 4, DR. GRAY'S HOSPITAL

NURSING STAFF

IDENTIFIED PATIENT AS HIGH RISK TO SELF OR

CHECK FOR P.E.P.

PLAN IN PLACE

INFORM POLICE AND REQUEST

ADVISE DUTY PSYCHIATRIST OF CIRCUMSTANCES, ASSESS MEDICATION AND RISK

POLICE

CHECK STORM FOR P.E.P.

PLAN INITIATED

ATTEND WARD 4

MANAGE RISK BY MEANS OF:

- ASSESS FOR DETENTION IF REQUIRED
- USE OF COMMON LAW
- ASSESS WHETHER TRANSFER TO OTHER AREA IS NECESSARY
- ORGANISE APPROPRIATE TRANSPORT IF REQUIRED AND USE OF RESTRAINT / MEDICATION

M.H.O.

DUTY PSYCHIATRIST

DUTY SHO / RMN NURSE PRACTITIONER

AMBULANCE TRANSPORT

NB Restraint : agreed method by nursing staff and police
Medications : to be administered only by nursing staff/medical staff on Ward 4
Use of nurses’ holding power (s299)

The nurses’ holding power can only be used for informal persons in the in-patient setting. It cannot be used for detaining persons in resource centres or in the home setting and it can only be authorised by a first level registered mental health nurse.

It is used to detain a person pending medical examination to determine whether an Emergency Detention Certificate or Short-term detention Certificate should be granted and the following points should be noted:

- The “holding period” lasts for up to 2 hours to allow a medical practitioner to attend;
- A further 1 hour holding period from the time of the medical practitioner arriving now comes into force;
- A written record must be made stating why the person was detained, the time the holding period began and the reasons for detention; and
- Notification must be made to the on-call Mental Health Officer and the Hospital Manager.

Care of an individual during detention

It is incumbent upon all statutory services to act in the best interests of persons to deliver high quality care and to treat persons with respect and dignity at all times. All procedures should be directed towards the best overall interests of the person, being based on the principle of minimum necessary force or action to achieve a desired outcome, and to be carried out in a safe, professional and competent manner. The underlying principles of the Act relating to the care of the person should be observed at all times. A pragmatic approach should also be taken to ensure the smooth running of any function discharged under the Act with good communication being fundamental.
**Involvement of the Police**

The primary role of the Police is to ensure the safety of medical/nursing staff and the public. Police vehicles should not be used to transport patients either to hospital or in the transfer of patients between hospitals.

There may be exceptional circumstances where Police will be required to provide back-up for nursing staff and ambulance crews involved in the transfer of “HIGH RISK” or VIOLENT patients to Royal Cornhill Hospital.

When Police back-up is required for the above, the Duty Doctor should contact Grampian Police Service Centre on: 0845 – 600 – 5- 700 and liaise with the Duty Controller in the Force Control Room who will co-ordinate the control Police response.
7.0 Identifying available beds for admission

When a person has been detained in a community setting, locating a suitable bed is a priority. It is always preferable for the person to be cared for in a hospital within their catchment area, however admission should be to the most appropriate inpatient service suitable for the patient’s needs and it is recognised this may not always be within a patient’s catchment area. If there is a delay in accessing a permanent bed, the person should be moved to the catchment area hospital as a priority, even if this move is temporary until a permanent bed can be found.

Where a person has a Learning Disability and is believed to be suffering from a mental disorder, the admission protocol to psychiatric care would be followed.

Dr Gray’s Hospital, Elgin

During office hours (9am-5pm)
The following process should be followed:

- The duty SHO/Nurse Practitioner will liaise with the Senior Nurse on duty to identify where there are vacant beds;
- If there are no available beds within the sector, then the Consultant/Lead Nurse will liaise with his/her colleagues across Grampian in a bid to resolve the situation; and
- For persons who are being sent outwith their catchment area hospital, the duty SHO/Nurse Practitioner will advise as to which consultant is receiving out of sector admissions.

Royal Cornhill Hospital, Aberdeen

During office hours (9am-5pm)
The following process should be followed:

- Within RCH, the Team Consultant/SHO will identify a bed available within their admitting ward.
- If necessary, a bed will be made available by use of the agreed decanting policy.
Any admissions from out of area, e.g. Shetland or NFA, will be agreed by the Duty Consultant, who will identify an available bed.

**Out of hours (Grampian)**

The following process should be followed:

- The duty/on-call SHO/Nurse Practitioner and Senior Nurse on the ward should always be contacted in the first instance;
- The Senior Nurse/Nurse Practitioner should be aware of bed availability, i.e. vacant or pass beds that can be utilised;
- If there are no available beds, the Senior Nurse should determine the availability of beds on site or across Grampian;
- On night duty, the Senior Nurse will attempt to resolve any difficulty by liaising with his/her colleagues across the region;
- If at any time agreement cannot be reached the duty/on-call SHO will contact their on-call Consultant for advice;
- Transfer to a non-catchment hospital site within Grampian (e.g. Dr Grays to Royal Cornhill) should be agreed by both Duty Consultants;
- If no beds are available within Grampian, the duty consultant will liaise with his/her counterpart in other regions; and
- Transfers outwith/into Grampian will require the involvement of the duty Consultant (Protocol in place including protocol for young people under 18yrs).
8.0 Places of safety

The Act outlines the clear requirements for places of safety to be identified for persons in an emergency situation to go to. It is explicit that Police Stations should not routinely be used for this purpose and this is reaffirmed in the RARARI report. Appropriate places of safety are identified below.

The place of safety under the act means:-

- a hospital
- premises which are used for the purpose of providing a care home service
- other suitable place (other than a police station) the occupier of which is willing temporarily to receive mentally disordered person.

This includes:-

- Accident and Emergency departments
- Psychiatric wards
- Community Mental Health Team Premises
- Registered nursing homes

Place of Safety for Moray will be Pluscarden Clinic, Dr Gray’s Hospital, Elgin and Royal Cornhill Hospital, Aberdeen for Aberdeen City and Aberdeenshire.

Although Police Stations will not be used as places of safety as a matter of routine, there will inevitably be exceptional circumstances when local Police officers judgment based on specific case circumstances) may deem that a Police Station is an appropriate place of safety. Police Officers have the power to take a person, who is in a public place, to a place of safety if:

- They reasonably suspect that a person in a public place has a mental disorder;
- That person requires immediate care or treatment;
- That it is considered in the interest of the person or protection of any other person to move the person to the place of safety;
The removal to a place of safety is to enable:-

- examination by a medical practitioner
- the making of arrangements that the medical practitioner feels necessary (e.g. continued detention in hospital) within 24 hours

It is proposed that Places of Safety are monitored through the PEP to ensure they are working satisfactorily and meet demand.
PROCESS IN A PUBLIC PLACE – IN CUSTODY (HIGH RISK)

PLAN IN PLACE

POLICE

CHECK STORM

NO PEP

ASSESS INITIAL RISK

TRANSFER TO POLICE STATION

CALL GP ASSESS FOR Mental Disorder

DUTY GP

MHO

DUTY PSYCHIATRIST

NURSING STAFF

AMBULANCE

ACTION CRIMINAL PROCESS (IF APPROPRIATE)

NO MENTAL DISORDER

GP to liaise with MHO/duty Psychiatrist re informal Admission Short-term detention or in absence of Section 22 approved doctor Emergency detention

LIAISE WITH NURSING STAFF RE TRANSFER ARRANGEMENTS TO WARD 4 OR ROYAL CORNHILL HOSP AS APPROPRIATE AMBULANCE/IF REQUIRED RE TRANSPORT/TRANSFER ARRANGEMENTS
9.0 Escorting/accompanying a detained person

After a person has been detained in the community, the medical practitioner will be responsible for contacting the duty/on-call SHO or the Emergency Psychiatric Pager Holder (EPPH) at the admitting hospital. The duty/on-call SHO will contact the appropriate duty senior nurse to arrange escort and admission of the detained person. On receipt of the request from the SHO, the senior nurse will obtain full details of the person, including:

- Name;
- Date of birth;
- Home address;
- Advance Statement;
- Address where the person will be located if different from above;
- Mobile telephone number of the referring medical practitioner; and
- Confirmation of whether the police will be required to attend and whether they have been contacted.

In making the escort arrangements the senior nurse should observe the following details:

- Confirm that all required documentation has been completed and will be available to hand over to the nurse escorts;
- Confirm that a person able to identify the person will be in attendance;
- Obtain from the medical practitioner or MHO all information required to identify risks associated with escort of detained persons (see Appendix A for a sample checklist);
- Confirm whether the person is to be admitted directly to a ward or whether other arrangements apply; and
- Ensure that the admitting ward has been notified of all relevant details of the expected admission.

A patient who has been sedated should always be accompanied by a nurse, a doctor or a suitably trained ambulance person experienced in the management of such patients. Only in exceptional
circumstances and when it is evident that the sedated patient is reconciled to the situation, should the ambulance crew be asked to act as the sole escort.
10.0 Arranging transport

The senior nurse will arrange transport (usually hospital transport/ambulance) to take the nurse escorts to collect the person. The senior nurse will also confirm the following details at the time of booking:-

- Pick up point for staff and names of staff to be collected; and
- Destination

The medical practitioner attending the patient in the community has a professional obligation to ensure the most humane and least restrictive method of conveying.

The medical practitioner will be required to provide as much of the following information as possible to the Ambulance Service:

- The detained person's name or other identifying information;
- Address from which the person will be conveyed;
- The person's condition, e.g. whether s/he has been sedated or if there is another medical condition of which the ambulance crew should be aware;
- An indication of the person's likely attitude to admission, e.g., whether s/he is likely to be violent or distressed;
- The time by which the ambulance should be at the appointed address;
- Who will accompany the person;
- The hospital to which the person is being admitted; and
- A contact telephone number and name.

It is the responsibility of the medical practitioner to arrange the conveyance of the patient to hospital. In the majority of cases an ambulance will be required, but under certain circumstances transport may be with a relative or carer in a car or taxi. This may be delegated, depending on various circumstances, to a carer, relative, Named Person or MHO. However, the ultimate responsibility remains with the attending medical practitioner.
Occasionally a police vehicle may be used to convey a detained person to hospital. The police will only agree to provide transport for persons who have been assessed on private premises, where:

- The person is violent or is known to have a history of violence;
- The SAS ambulance crew consider it unsafe to use an ambulance;
- The police have been informed in advance of the destination of the detained person; and
- The person has **NOT** been sedated.

In all cases, persons should try to act in accordance with the Principle of Least Restrictive Alternative.

**Involvement of the Ambulance Service**

If there are overwhelming grounds for predicting admission and for predicting a straightforward admission process without delays, an ambulance may be booked before the assessment is undertaken.

If, despite the best intentions, the ambulance arrives before it is needed, the detaining doctor should ensure that the ambulance crew is kept informed of any developments that may impact on the admission process.

**Medical Emergencies En-route**

In the event that the patient has a medical emergency whilst en route to the booked hospital, the conveying vehicle should divert to the nearest Accident and Emergency department. The crew and escort should then remain with the patient while he or she is assessed by Accident and Emergency staff and until he or she is judged fit to continue the journey. If the patient is assessed as requiring emergency admission, responsibility for the care of the patient will then transfer to the hospital staff who should inform the duty psychiatrist of the patient’s medical status. Details of any such admission must be communicated by the escort to the relevant MHO.
The section remains in force, and the duty consultant psychiatrist at the hospital where the patient is admitted, will be responsible for ensuring a reassessment of the patient when the patient is judged well enough. The admitting hospital’s staff will also be responsible for making any subsequent arrangements for the patient's onward transport to the original hospital, if this is still necessary.
11.0 Emergency Medical Treatment in the Community

There may be situations when the need to administer urgent medical treatment is clear and unequivocal, and a decision to provide urgent treatment will be based on the best professional judgement available under the necessarily difficult circumstances of the case. However, it is important to recognise that the assessment of the likelihood of ‘serious deterioration’ and ‘serious suffering’ is a subjective process. A person who is experiencing symptoms and behaviours as a result of mental disorder can be difficult to manage and may become oppositional or verbally aggressive or abusive. It would be expected that such behavior would not, in itself, be seen as criteria for the giving of urgent medical treatment.

The decision to administer urgent medical treatment will therefore need to be informed by the presence of a level of risk commensurate with the criteria listed at section 243 of the Act rather than as a means of managing a “difficult” person. Good practice would dictate that recourse to the use of sedative medication would be restricted to the exceptional circumstances envisaged in section 243(3) and 243(4) and not as a way of subduing a person who is difficult to manage or is demanding of staff time and attention.

Emergency tranquilisation during nurse escort duty
There may be a need for nurse escorts to administer emergency tranquilisation before or during escort of the person to hospital, this should be carried out according to the NHS Grampian Policy. This policy ensures the safe, appropriate and effective use of medicine for emergency tranquilisation in community patients who have been detained under the terms of the Mental Health (Care and Treatment) (Scotland) Act 2003 and are being escorted by a nurse during admission to a psychiatric unit within Grampian. This policy is attached in APPENDIX 2.
**Transport to hospital**

**GP/Medical Practitioner**
Contact SHO/EPPH to request admission giving all relevant details - Arranges ambulance transport - requests police assistance if necessary

**SHO**
Requests escorts & bed in admitting ward

**Senior Nurse**
Admitting Hospital
Arranges escorts - identifies potential risks - arranges transport for escorts

**Nurse Escorts**
Emergency equipment & sedation - all relevant info

**Escorts via hospital transport/ambulance to premises**

**Detained Person**

**Admitting Ward**
Admits patient - ensure medical records receive certificate ASAP

**SHO**
Receives detention certificate - discharges functions under the MHA - gives certificate to senior nurse

**Medical Records**
Receives certificate - notifies relevant agencies
12.0 Accessing a Mental Health Officer

In Grampian, a 24hr MHO rota is in operation.

**Moray**

The Duty MHO should be accessed via the MHO Rota:

- **Daytime**: 01343 567376 (social work reception)
- **Emergency/Out-of-hours**: 08457 56 56 56

**Aberdeenshire**

- **Daytime:**
  - Monday – Friday: 9.00-5.00 pm, emergencies - community
    - North Aberdeenshire Pager Number: 07699 715266
    - Central Aberdeenshire Pager Number: 07659 106358
    - South Aberdeenshire Pager Number: 07699 714303
  - Monday – Friday: 9.00-5.00 pm, emergencies – hospital
    - Tel: 01224 557638

- **Out of Hours Housing & Social Work Service**: 0845 8400070

**Aberdeen City**

- **Daytime:**
  - Monday – Thursday: 8.30 – 5.00pm, Friday: 8.30 – 4.00pm

Karen Elrick: 01224 557260

Margaret Long: 01224 557734
Fiona Cussick: 01224 557346
Paula Fyfe: 01224 557306
Block A reception: 01224 557299
Main reception: 01224 557201

*Each of these contact points has the current Emergency Duty MHO rota.*

**Out of Hours:** 01224 693936
13.0 Out of Hours/Links with NHS 24

Out of hours telephone numbers:

Moray: 08457 565656

Aberdeenshire: 0845 8400070

Aberdeen City: 01224 693936

NHS 24

NHS 24 currently integrates with A&E departments in Grampian and community out of hours departments and also links up with the Scottish Ambulance Service.

NHS 24 is able to pass clinical summary information to these services either by phone, fax or electronically.

Integration with out of hours services means that NHS 24 fronts all calls from the public to these services.

Links with NHS 24 – Tel: 08454 242424
14.0 Risk assessment/identifying risk

The detention of persons in any setting may leave staff vulnerable to acts of violence or aggression. Areas of potential risk to personal safety can be influenced by a number of factors and all transfers should have any potential risk identified. It is important to attempt to access records at all times.

The following points should always be considered in identifying potential risk, but this list is not exclusive:

- Does the person appear to be under the influence of drink or drugs?
- Do the person and/or his/her family have a history of violence?
- Does the person have a history of carrying weapons?
- Is the person expressing intent to harm you or others?
- Are there signs of anger or frustration?
- Is the person displaying sexually inappropriate behaviour?
- Does the person have a history of dangerous impulsive acts?

Good practice dictates that, in all cases, staff should refer to their own agency’s policies and guidelines on, e.g. lone workers and personal safety. The following examples should be considered if the interview is being conducted in a community-based establishment:

- Conduct the interview in an area that is easily accessible to other staff in the event of an emergency;
- Try to use an interview room that has been fitted with an alarm system and use it to notify other staff should a threatening situation arise;
- Remove obvious hazards from the area being used to conduct the detention interview;
- Balance issues of privacy with environmental, safety and observational considerations;
- Always communicate an intention to detain a person to other staff within the resource centre;
- Consider having another member of staff present during the detention interview; and
The movement of the detained person around the community setting should be restricted as far as is reasonably practicable, bearing in mind the potential risk the person may pose to him or herself or others.

If the interview is being conducted in a private dwelling setting:-

- Respect disagreements with the person over detention decisions and allow for non-confrontational explanations;
- Staff should carry a mobile phone in the community; and
- Staff should ensure that they have received the appropriate management of aggression training.

The Grampian Risk Assessment Tool is attached at APPENDIX 3.
15.0 Advanced Statements

Doctors and other individuals treating someone with a mental disorder have a duty to take into account the individual’s wishes about how they would like to be treated. The new Act means that, individuals with a mental disorder can write down in an advance statement how they would like to be treated if, in the future, they became too unwell to make decisions themselves. This refers specifically to the treatment they would prefer to receive, or not receive for their mental disorder.

To be valid, an advance statement must be in writing, signed, and witnessed according to the following criteria: -

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>At the time of making (or withdrawing) an advance statement, the person must have the capacity of properly intending the wishes specified in it</td>
</tr>
<tr>
<td>2.</td>
<td>The advance statement must be in writing</td>
</tr>
<tr>
<td>3.</td>
<td>It must be subscribed (signed) by the person making it</td>
</tr>
<tr>
<td>4.</td>
<td>The person's subscription of it is witnessed by a person (the &quot;witness&quot; see note 8 below) who signs the statement as a witness to that subscription</td>
</tr>
<tr>
<td>5.</td>
<td>the witness certifies in writing on the document that, in their opinion, the person making the statement has the capacity referred to in 1 above</td>
</tr>
</tbody>
</table>

An advance statement may be withdrawn by the person who made it if-

i. at the time of making it the person has the capacity properly to intend to withdraw the statement; and

ii. it is made by means of a written document which is signed and witnessed in the same way as the original statement.
16.0 Advocacy

The new Act gives every individual with a mental disorder the right of access to independent advocacy and puts duties on Health Boards and Local Authorities to ensure that independent advocacy services are available. The right to access advocacy applies to all mental health service users, not just to people who are subject to powers under the new Act.

**Moray**

Advocacy services in Moray are provided through Advocacy North East (ANE), Elgin Business Centre, Maisondieu Rd, Elgin, Moray.

*Tel: 01343 559649*

**Aberdeenshire**

*Adults, community* - advocacy services are provided through Advocacy North East (ANE), Unit 2, Dalfling Business Centre, Blairdaff, Inverurie.

*Tel: 01467 651605*

*Adults, inpatients, Aberdeen* – Block A, Clerkseat Building., Royal Cornhill Hospital, Cornhill Road, Aberdeen, AB25 2ZH

*Tel: 01224 557912 (internal RCH no: 57912)*

**Aberdeen City**

*Adults, community* – advocacy services are provided through Advocacy Service Aberdeen, Aberdeen Business Centre, Willowbank Road, Aberdeen, AB11 6YG

*Tel: 01224 332314*

Inpatients – Block A, Clerkseat Building, Royal Cornhill Hospital, Cornhill Road, Aberdeen, AB25 2ZH

*Tel: 01224 557912 (internal RCH no: 57912)*
17.0 **Information Sharing**

Effective sharing of information and communication are vital during all procedures contained in this PEP. However, information-sharing between agencies raises problems in terms of an individual’s confidentiality. Whilst it is vital for the proper care of individuals that appropriate agencies have ready access to vital information, it is equally important that service users and their carers can be confident that personal information will be kept confidential and that their privacy will be respected.

Personal details listed below should be shared with other agencies in order for them to discharge their functions according to their duties of care (this list is not definitive and should be seen as a minimum requirement):

- Name of person;
- Address and contact telephone numbers;
- Date of Birth;
- Named Person;
- Risk Assessment Summary; and
- A brief history of events leading up to the need for detention.

**Data Protection**

The Data Protection Act 1998 provides that the following practice should be observed when dealing with personal data. These are:

- Personal data shall be obtained and processed fairly and lawfully (i.e. normally with the person’s consent);
- Data may only be held for one or more specified and lawful purposes;
- Data must be adequate, relevant and not excessive for the purpose;
- Data must be accurate, and if not, must be amended and kept up to date;
- Data must not be kept longer than necessary;
- Personal data must be processed in accordance with the rights of the data subject;
Data must be secure and there must be no unauthorised access, alteration, disclosure to third parties or accidental loss; and
Transfer of data outside the European Economic area is restricted.

These points must be followed in conjunction with the Human Rights Act 1998, which applies to all public authorities. It makes it unlawful for a public authority to act in a manner inconsistent with the rights set out in the European Convention on Human Rights and Fundamental Freedoms. Article 8 covers the right to respect for private and family life, and while this right is not absolute, any breach must:

- Be in accordance with law, particularly in regard to confidentiality;
- Pursue a legitimate aim;
- Be supported by sufficient and relevant reasons; and
- Be proportionate to the risk observed.

Confidentiality and data protection are linked in that the unlawful disclosure of personal information would potentially be a breach of the Data Protection Act 1998, which is a criminal offence. A victim of a breach of human rights may pursue legal action up to one year after the alleged breach, accurate recording of procedures taken and information shared and with whom, is therefore crucial.

Informed consent to information sharing should ideally be sought from the person, in writing, as part of the assessment process. In emergency situations this may not be possible and the above guidelines should be followed as far as is practicably possible in the circumstances.

**How should information be shared?**

All information should be shared on a strictly “need to know” basis and the minimum amount of information needed to complete the task should be shared. All involved personnel should ensure that the following guidelines are observed:

- Ensure all sensitive information is kept secure and confidential whilst in your care;
- All personal details should be not be left unattended;
- When using the telephone ensure that the minimum information required is divulged.
18.0 References

Adults with Incapacity (Scotland) Act 2000

Data Protection Act 1998

European Convention for the Protection of Human Rights and Fundamental Freedoms 1950

Human Rights Act 1998

Mental Health (Care and Treatment) (Scotland) Act 2003

RARARI Bid 79, 2001, Handling and Transfer of Mentally Disturbed Patients, RARARI

Scottish Executive, 2004, Mental Health (Care and Treatment) (Scotland) Act 2003, Draft Code of Practice, Volume 1, Edinburgh: Stationery Office

Appendix 1 – Summary of Roles & Responsibilities

All of those involved in the detention of a patient should work in concert, in a co-operative way, to engender mutual support and to minimise the distress to the patient.

The escort is responsible for:

- Accompanying the patient to hospital;
- Ensuring that detention papers are given to hospital staff;
- Assisting the patient and explaining events to him or her.

The detaining doctor (usually the G.P.) in attendance is responsible for:

- Where possible co-ordinating the time and place of the assessment with the necessary parties;
- Requesting police presence if that is necessary, and supplying the police with details that enable them to assess the level of response that will be necessary to ensure the safety of all concerned;
- Examining the patient, to assess the nature and seriousness of any mental disorder, and to ascertain the need for further assessment or treatment in hospital;
- Ordering the ambulance;
- Ensuring that all parties are briefed before and after the assessment;
- Liaising with others involved in the assessment and making a medical recommendation where appropriate;
- Completing the necessary MH(S)A form;
- Making arrangements for the patient to be escorted if required;
- Handing over forms to the escort;
- Arranging a hospital bed where needed.
**Mental Health Officers are responsible for:**

- Considering the medical assessment, ensuring detention is legal, and making sure that the appropriate forms are correctly completed;
- Ensuring the welfare of the patient, whether detained or not;
- In discussion with, and with consent of, the patient, ensuring that their carer and/or nearest relative has/have been informed;
- Security of property and premises;
- Arranging short term care of any children or pets.

**Scottish Ambulance Service Qualified Ambulance Technicians and Paramedics in Attendance are responsible for:**

- Co-operating with the request of the detaining doctor or MHO over the method and timing of assistance;
- Co-operating with others present at the assessment, including the MHO, doctors and the police;
- Contributing to the care and physical well-being of the patient (and others present) by conducting an assessment of any other relevant or significant illness or injury;
- Making a record of the call to the patient, including information given by the MHO regarding any medication the patient is using;
- Passing information to the hospital on their arrival.

**Grampian Police are responsible for:**

- Sharing relevant information with community care teams in terms of S33 “duty to inquire” into patients living in the community who are suspected of being at risk of neglect, ill-treatment and because of their mental disorder their safety, the safety of other persons or property may be at risk
- Taking details of the call from the detaining doctor or MHO;
- Ensuring that a supervising officer, preferably the duty Inspector, is made aware of the incident;
- Ensuring that where at all possible, an appropriate officer attends at, or participates in, any joint risk assessment and/or briefing;
- Ensuring that an appropriate police presence is allocated to arrive at the requested address, or briefing location, if at all possible at the requested time;
- Taking necessary action, including the use of physical restraint, with a view to effecting the admission in as peaceful a way as possible whilst striving to ensure the safety of all concerned - in doing so, they will liaise with the ambulance crew, the detaining doctor or MHO over the method and timing of assistance, particularly where violence is expected;
- Ensuring Police presence is maintained during initial psychiatric assessment at the "Place of Safety" to protect nursing and medical staff.
- At the conclusion of any such incident, at a supervisory level, discussing with other professionals involved in the incident, any concerns of the police.
RAPID TRANQUILISATION OF DISTURBED PATIENTS IN THE GENERAL HOSPITAL

Co-ordinator: Dr R Goldbeck
Reviewer: Trust Executive Group
Approver: Chief Executive

Signature
Signature
Signature

Identifier: GUHT/POL/2
Review Date: January 2004
Date: 24 January 2002

UNCONTROLLED WHEN PRINTED

VERSION 1
RAPID TRANQUILISATION OF DISTURBED PATIENTS
IN THE GENERAL HOSPITAL

The need for rapid tranquillisation is determined by the underlying cause of the patient's disturbed behaviour, the effectiveness of non-pharmacological approaches as well as consideration of whether the patient requires continued hospitalisation or not. Rapid tranquillisation only constitutes one part in the overall management of disturbed patients which may include other measures such as use of de-escalation methods, restraint, special nursing or occasionally, police involvement.

Rapid tranquillisation should only be administered following an initial assessment of the patient and if other methods of containment have failed or are considered to be inadequate. It is vital that facilities for continuous monitoring of the patient exist if rapid tranquillisation is being considered. Patients must be monitored closely for at least 2 hours following the use of rapid tranquillisation. This may involve special nursing or nursing observations carried out every 5-10 minutes (BP, HR, RR, level of consciousness). The need for further medication has to be determined carefully and titrated against the patient's response. It is vital to try to determine the cause for the patient's disturbed behaviour (unless already known).

Some patients may require physical restraint in order to administer drugs for rapid tranquillisation. In order to carry this out safely for both patient and staff, adequate numbers of staff are required who are trained in methods of physical restraint.

The use of rapid tranquillisation, if administered without or against the patient's expressed will, is governed by common law principles. Detention under the MHA does not authorize such treatment (although provided certain conditions are met, it allows for the retention of a patient in hospital if a mental disorder is suspected).

Medication used for rapid tranquillisation

In the majority of situations, rapid tranquillisation can be achieved with just two groups of drugs, benzodiazepines and neuroleptics. These may be used individually or in combination, depending on the clinical situation. If possible, medication should always initially be offered in oral form. If this is not feasible, parenteral administration should be pursued.

Benzodiazepines

Diazepam

A long-acting drug which has active metabolites. It can be given orally, intravenously (give slowly and titrated to response) but should not be given intramuscularly. If used repeatedly, it may accumulate, especially in patients who have significantly impaired liver function. Usual doses range from 10 to 30 mgs. The total daily dose should not exceed 120 mg/d.
**Lorazepam**

A shorter-acting benzodiazepine which is less likely to accumulate. It can be given orally, intramuscularly or intravenously (give slowly). Usual doses range from 1 to 4 mgs. The total daily dose should not exceed 16 mg/d.

**Neuroleptics**

**Haloperidol**

Haloperidol can be given orally, intramuscularly or intravenously. It is less likely to cause hypotension than Chlorpromazine and less likely than the benzodiazepines to cause oversedation. Usual doses range from 2 to 10 mg. The administration of Haloperidol can lead to acute extra-pyramidal side-effects and in particular, acute dystonia. Acute dystonic reactions should be treated by the intramuscular or intravenous administration of 5-10 mg Procyclidine. The total daily dose of Haloperidol should not exceed 60 mg/d.

**Clinical situations which may necessitate rapid tranquillisation**

**Alcohol intoxication**

Patients who are intoxicated with alcohol can be disruptive and potentially violent. This can significantly interfere with their medical and psychiatric assessment and management. If there is an urgent need for medical or psychiatric treatment and the patient cannot be managed by purely non-pharmacological means, rapid tranquilisation may be required.

- Haloperidol 3-5 mg oral/IM

The initial dose should be followed by a 0.5-1 hour wait before further doses are considered.

**Alcohol withdrawal**

The early recognition of the potential for developing alcohol withdrawal and close monitoring and prompt treatment of such patients is the most important aspect of the management of alcohol withdrawal. This is covered by a separate protocol with which is available throughout the hospital. Patients in established alcohol withdrawal and in particular, patients suffering from delirium tremens can become acutely disturbed and may require initial rapid tranquillisation.

The following is recommended:

- Diazepam 10-40 mg oral or 10-20 mg i.v., repeated every 1-2 hours until patient is adequately sedated
- Lorazepam 1-4 mg oral/i.m./i.v. in patients who have significantly impaired liver function (Lorazepam is shorter acting) or where i.m. administration is the only feasible route
- Haloperidol 5-10 mg oral/i.m./i.v. if the patient remains acutely disturbed following the administration of a benzodiazepine
Once adequate sedation has been achieved, the further use of benzodiazepines is guided by a separate alcohol withdrawal protocol. A common approach would be to prescribe 10-20 mg Diazepam qds which is reduced by daily decrements of 10-20 mg, depending on the patient's individual needs. The use of Chlormethiazole for alcohol withdrawal is no longer recommended.

**Drug intoxication**

As in alcohol intoxication, the same general principles apply. The important aspect is to rule out any other treatable physical or psychiatric cause for the patient's disturbed behaviour. Disturbed behaviour is most often associated with the ingestion of stimulant or hallucinogenic drugs (e.g. ecstasy, LSD, amphetamines, cocaine) but can occasionally also occur in the setting of an overdose with tricyclic antidepressants, carbamazepine or other drugs.

If rapid tranquillisation becomes necessary, the following is suggested:

- Lorazepam 1-4 mg  
  oral/i.m./i.v.
- Haloperidol 5-10 mg  
  oral/i.m./i.v.

In situations where there is concern about potential lowering of the seizure threshold, Lorazepam is preferable. Haloperidol may, however, be used in conjunction with Lorazepam if there is insufficient response to Lorazepam alone.

**Drug withdrawal**

Drug withdrawal, like alcohol withdrawal, can be associated with disturbed or violent behaviour, especially if the patient becomes delirious. Some drug users can be aggressive and demanding in their pursuit of obtaining prescribed drugs and may have a history of habitual use of violence.

If the patient requires further hospitalisation for treatment of an urgent physical problem, the need for temporary maintenance on medication that suppresses withdrawal symptoms should be considered. This area is covered by separate policy/guidelines.

If rapid tranquillisation is required, the following is recommended:

- Lorazepam 1-4 mg oral/i.m./i.v.
- Haloperidol 5-10 mg oral/i.m./i.v if the patient remains acutely disturbed following the administration of a benzodiazepine

**Acute organic confusional states (delirium)**

Acute organic confusional states can result from a large variety of physical conditions or certain drug treatments and are especially common in the elderly. Often, there is no single cause but rather, multifactorial
aetiology. Acute organic confusional states are particularly likely in conditions affecting the CNS, those which result in hypoxia or those which are characterised by systemic infection.

The most important aspect of the management of acute organic confusional states is the recognition and treatment of any underlying reversible physical cause. If tranquilisation is required, the following is recommended:

- **Mild agitation**  - Haloperidol, 0.5-2 mg oral/i.m./i.v.
- **Moderate agitation**  - Haloperidol, 5 mg oral/i.m./i.v.
- **Severe agitation**  - Haloperidol, 10 mg oral/i.m./i.v.

Repeated doses of Haloperidol should be staggered by at least 30 minutes. If the smaller dose does not calm the patient, the next higher dose should be chosen. Haloperidol may be combined with Lorazepam, starting dose 1-2 mg IM/IV. In elderly patients, smaller doses should be used.

**Acute psychosis**

Patients with florid psychotic symptoms secondary to a functional psychiatric disorder (e.g. schizophrenia, mania) may become agitated, aggressive, disturbed and in some instances, even physically violent.

In such situations, psychiatric assistance should always be sought. If rapid tranquilisation is required, the following is suggested:

Lorazepam, 2-4 mg oral/i.m./i.v.

+ Haloperidol, 5 - 10 mg oral/i.m./i.v.

If there is no response after 30 minutes, repeat the above.
The Handbook is intended as a helpful aide memoir not a protocol
Information may be out of date or inappropriate to some situations

RAPID TRANQUILISATION

For rapid control of the acutely disturbed patient – for guidance only
(rigid adherence to the algorithm may not always be appropriate)

IV DRUGS MUST BE GIVEN OVER 2-3 MINUTES. NEVER MIX LORAZEPAM OR DIAZEPAM
WITH OTHER DRUGS IN THE SAME SYRINGE. NEVER GIVE DIAZEPAM

Seek advice from your consultant at any stage if you are in doubt

Consider non-drug measures; talking down, distraction, seclusion.
Try oral therapy

- Give EITHER lorazepam 2mg IM and haloperidol 5-10mg IM
  - Wait 10 minutes
  - OR
  - Diazepam 10mg IV and haloperidol 5-10mg IV
  - Wait 30 minutes

- Repeat above:
- Give EITHER lorazepam 2mg IM and haloperidol 5-10mg IM
  - Wait 10 minutes
  - OR
  - Diazepam 10mg IV and haloperidol 5-10mg IV
  - Wait 30 minutes
  - Repeat to maximum 60mg haloperidol + 60mg diazepam

Consider starting/increasing regular oral medication

- Recomence oral neuroleptics
  - OR
  - Give zuclopenthixol acetate 50-150 mg.
  - Peaks at 24-36 hrs Effective for 72 hrs

- Facilities for mechanical ventilation/cardiac resus must be available. If contact with patient is lost: Monitor as for full anaesthetic using pulse oximeter. Give flumazenil if respiratory rate drops below 10/minute. Use IV route if IM route ineffective after 3 doses.

- Monitor RR, pulse and BP every 5 minutes. Beware of accumulation of BZPs. Use BZPs alone in cardiac disease. NEVER give zuclopenthixol acuphase to a struggling patient or those who are neuroleptic naïve. Procyclidine IM/IV must be available.

- Seek advice from your consultant at any stage if you are in doubt

- Response

- No response
Appendix 3 - Risk Assessment Guidance Note

**Aim:** - The document aims to give support and guidance to assist the risk assessment of individuals under the care of Mental Health Services. This tool outlines the principles of Risk Assessment and should be applied to all patients in contact with Services, although individual parts of the Service should also continue to use relevant further Risk Assessment Forms.

**Background:** - Risk is inevitable in healthcare. NHS Grampian has agreed a strategy to create a culture of risk management that focuses on assessment and prevention rather than reaction and remedy. We aim to show that risk management is considered as an integral part of patient care and decision making, rather than an additional administrative burden. Therefore, in relation to mental health services, this guidance note aims to act as an aide-memoir, giving consistency to the approach taken by clinical professionals, without constraining their professional judgement.

**Context:** - It is normally useful to state whether the assessment is an initial assessment, or part of an ongoing series. Standardised terms therefore would include (1) admission assessment (2) referral assessment (3) review assessment or (4) discharge assessment.

**Specific Considerations:** - There are three broadly accepted headings under which to gain useful risk information, those being (1) History (2) Environment and (3) Current or Present situation. Some general considerations are set out below however there may be others in your judgement.

<table>
<thead>
<tr>
<th>History</th>
<th>Environment</th>
<th>Present / Current</th>
</tr>
</thead>
<tbody>
<tr>
<td>Previous violence;</td>
<td>Poor social support;</td>
<td>Passive / persecutory delusions;</td>
</tr>
<tr>
<td>Previous sexual deviance;</td>
<td>Loss of accommodation;</td>
<td>Command hallucinations;</td>
</tr>
<tr>
<td>Previous sexual offending;</td>
<td>Loss of employment;</td>
<td>Violent fantasies;</td>
</tr>
<tr>
<td>Previous fire-setting / arson;</td>
<td>Current access to potential victim;</td>
<td>Violent sexual fantasies;</td>
</tr>
<tr>
<td>Previous attempted absconsion;</td>
<td>Current access to weapons;</td>
<td>Specific threat to others;</td>
</tr>
<tr>
<td>Previous deliberate self harm;</td>
<td>Current access to alcohol / drugs.</td>
<td>Thoughts of DSH / suicide;</td>
</tr>
<tr>
<td>Previous self neglect;</td>
<td></td>
<td>Thoughts of fire-setting / arson;</td>
</tr>
<tr>
<td>Previous substance abuse;</td>
<td></td>
<td>Likely to attempt absconsion;</td>
</tr>
<tr>
<td>Previous poor compliance; Previous supervision failure; Planning / obtaining / use of weapons; Antisocial personality traits.</td>
<td>Likely to self neglect; Vulnerable to abuse by others; Negative attitudes; Impulsivity; Stress; Use of alcohol or illicit drugs; Poor treatment response; Poor compliance; Lack of insight; Irritability; Agitation; Hostility; Restlessness; Argumentative; Loud / Aggressive.</td>
<td></td>
</tr>
</tbody>
</table>

In every case where a further detailed risk assessment is undertaken, specific attention should be paid to:

(1) persons at risk (2) likelihood or type of harm if possible (3) existing controls that are in place (4) an estimation of the effectiveness of those control and (5) Further control considered necessary to control those risks.
# Appendix 4 – Emergency Contact Numbers

<table>
<thead>
<tr>
<th>Service</th>
<th>Telephone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance</td>
<td>01343 546392 01224 552020</td>
</tr>
<tr>
<td>Grampian Police (Bucksburn call centre)</td>
<td>0845 600-5-700</td>
</tr>
<tr>
<td>MHO Services</td>
<td>Moray: Office Hours: 01343 567376 Out of Hours: 08457 56 56 56</td>
</tr>
<tr>
<td></td>
<td>Aberdeenshire: Office Hours: pager numbers: 07699 715266, 07659 106358, 07699 714303 (community) Out of Hours: 0845 8400070</td>
</tr>
<tr>
<td></td>
<td>Aberdeen City: 01224 557299/557201 Out of Hours: 01224 693936</td>
</tr>
<tr>
<td>Hospital</td>
<td>Dr Grays: 01343 567632 Royal Cornhill: 01224 557638</td>
</tr>
<tr>
<td>Advocacy</td>
<td>Moray: 01343 559649 Aberdeenshire: 01467 651605 Aberdeen City: 01224 332314</td>
</tr>
</tbody>
</table>
SIGNIFICANT EVENT REPORT FORM

This form allows the staff involved in PEP situations to raise problems for analysis and reflection in a non judgmental manner as a means of maintaining service quality, improvement and health governance. It should be used to report problems, near misses or good events and returned to Locality and Central PEP Clinical Governance Lead's for analysis and follow-up. The procedure is to circulate the form around all involved in the significant event for comment before submission.

Date of Event:____________________________ Time of Event:___________________________

Details of person initiating event:-

Name:___________________________________ Designation:______________________________

Address:_________________________________ E-mail:_________________________________

Telephone:_______________________________

SEA Name:

Initiator's description of what happened:

ID No
LL loggec
Who else needs to comment?
(please tick all appropriate)

<table>
<thead>
<tr>
<th>Medical Practitioner</th>
<th>Nurse Escort Team</th>
</tr>
</thead>
<tbody>
<tr>
<td>MHO</td>
<td>Police</td>
</tr>
<tr>
<td>MH Vehicle/Ambulance Staff</td>
<td>Other e.g. Hospital/Community Staff</td>
</tr>
</tbody>
</table>

Initiator’s lessons learned and suggestions for improvement:

Further comments from others involved in event:

Final recommendation from Initiator:
Conclusion by PEP Clinical Governance Lead:-

<table>
<thead>
<tr>
<th>Level of risk category for analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1</td>
</tr>
<tr>
<td>Level 2</td>
</tr>
<tr>
<td>Level 3</td>
</tr>
</tbody>
</table>

Action points For the Joint Local Implementation Group:

LESSONS LEARNED:

Date feedback loop completed to all involved:-

Date for review by PEP Clinical Governance Lead:-
REVIEW OF EVENT

Scheduled Date of Review:__________________  Actual date of review:__________________

Details of person reviewing event:-

Name:___________________________________  Designation:____________________________

Address:_________________________________  E-mail:______________________________

Telephone:______________________________

Review Comments:-

Could this happen again?-

Further review required?  (please give details)  If yes, date of next review:-______________