De-escalation Pathway for over 65's lacking capacity

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Step 1: Non-Pharma

Non-pharmacological Measures (remember to involve family in de-escalation techniques and keep them up-to-date with the situation), for example de-escalation, distraction, move to a quiet area, negotiation, review observation levels, consideration of placement and physical review.

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Move to *Step 2* only if:

1. Full clinical assessment carried out **AND**
2. Other options exhausted **AND**
3. Best Interest Assessment completed and documented **AND**
4. Co-existing illness and medicines (prescribed and illicit substances considered) **AND**
5. Pain and urinary retention has been considered as a cause of behavioural changes
6. Resuscitation equipment available within three minutes.

Step 2: Oral Medication (Including covert administrant if required)

Non-Pharma interventions unsuccessful
(RT deemed proportional and necessary).

Skip to Step 3 if patient refuses oral treatment or more rapid response is required.

ORAL Lorazepam 500mcg-1mg **ONCE ONLY** unless contraindicated (wait at least one hour to assess response).

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If requiring a further dose give lorazepam 500mcg-1mg Repeat to a max **Lorazepam 2mg in 24 hours**.
If refusing oral route consider *Covert Medication administration.

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If only partial response,or alternative required consider a dose of oral Haloperidol 500mcg (unless contraindicated i.e. Parkinsons Disease or Lewy Body Dementia). **OR Seek advice from a Senior Doctor**.

Consider cardiac risk if using haloperidol, check recent ECG if possible.

Step 3: Intramuscular Medication

**IM Lorazepam 500mcg-1mg ONCE ONLY (Wait at least one hour to assess response).

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If partial response to first IM dose consider a further dose (Total max Lorazepam by any route is 2mg in 24 hours)
OR alternative ***IM Haloperidol 500mcg-2.5mg ONCE ONLY (Wait at least one hour to assess response.

IF NO RESPONSE SEEK SENIOR DOCTOR ADVICE FOR FURTHER DOSES OR ALTERNATIVE AGENTS.

Monitoring

- Monitor observations every 15 minutes for the first hour, then every 30 minutes for the second hour. Where the patient is not ambulatory at 2 hour monitoring may be instigated depending on the on-going clinical assessment (Consider reducing frequency of observations if causing distress)
- *The covert administration of medicines should only be used as a means of administration, if judged necessary, in accordance with the Mental Capacity Act 2005. Discuss the safety of covert medication administration with a pharmacist
- **Lorazepam injection should be diluted 1:1 with water for injection or 0.9% sodium chloride prior to IM administration
- ***Prescribe PRN IM Procyclidine 2.5-5mg if giving IM Haloperidol for possible acute dystonic reaction
- NEVER mix two drugs in the same syringe
- Benzodiazepines: can cause loss of consciousness; respiratory depression or arrest; and can cause cardiovascular collapse in patients also receiving clozapine. Monitor arterial oxygen saturation and have oxygen ready in case required
- Proceed with extreme caution with doses above recommendations
- Be aware of paradoxical agitation in Lorazepam
- Refer to the Daily Supervision and Engagement Assessment.

If IM medication is administered seek advice from liaison psychiatry (DRI: 07786312690) or 01302 796505 or (BDGH: ext 2590). For patients with PD contact Parkinson's nurse specialist via TRH switch.
Call for Enhanced Care Support (DRI: 07766366556) or (BDGH: 07976361069).

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Pathway Guidance

It is important to note that each step needs to be followed as chemical restraint is only considered once de-escalation and other strategies have failed to calm the patient
This pathway is to be used to keep our patients safe, and can allow medical treatment to be provided to the patient when the patient is displaying challenging behaviour.

De-escalation

To de-escalate a situation there needs to be some understanding of who the person is, and why they behave the way they do

- Has the patient got a This is Me?
- Have you gone through TIME AND SPACE?
- Have you involved family/carers?
- Have you used the Trust Pain Tool for people with communication difficulties?

The Supervision and Engagement Policy have “Talk Down Tips” that support staff through de-escalation

Mental Capacity and Best interests Assessment

Please refer to the Mental Capacity Act Policy regarding Best Interest Assessments and Meetings. The Form MCA2 is found in the MCA Policy.

If harm is imminent it may be necessary to restrain prior to a documented Best Interest meeting and assessment. Staff acting in perceived Best Interest as a one off emergency are protected by common law as long as the action is proportionate

It is not acceptable to repeatedly restrain and it is not used for the convenience of the ward

If it is clear that the patient will need restraint to achieve their clinical management objectives over a prolonged period of time; chemical restraint may prove to be a better option than repeated physical restraint. If prolonged restraint is likely, then it will need to be the least restrictive and application for DOLs completed.

Reporting and Documentation
If IM medication is being administered then the relevant mental health teams need to be informed for review.

Document use of chemical restraint in the patients notes, complete a Datix and consider use of other teams for assistance such as the Enhanced Care Practitioner and the Lead Dementia Nurse.

Use of IM sedation

Chemical restraint should be used only for a person who is agitated, aggressive and is considered a current danger to themselves or others, and when all other therapeutic interventions have failed to contain their behaviour.
It should only ever be delivered in accordance with acknowledged, evidence based best practice guidelines. Prescribers should provide information to those who provide care and support, regarding any physical monitoring that may be required as well as the medication to be used and the route of medication.