Nottinghamshire Healthcare
NHS Foundation Trust

If a Patient Requires Rapid Tranquilisation (RT)

The following practice should be adhered to as per policy (Trust Procedure 14.05 – Use of Medication in Rapid Tranquilisation Policy / RT Training visit: **https://connect/download.cfm?doc=docm93jijm4n12029.pdf&ver=49075)**

Questions before administering Rapid Tranquilisation:

- Has a first line treatment been utilised & encouraged?
- Has the patient a Care/Treatment Plan for RT?
- Has this been discussed and agreed at MDT?
- Have all other attempts to reduce the risks been attempted and documented on RiO?
- Have all options been exhausted such as de-escalation, time-out, seclusion or oral medication.
- A doctor must always be contactable at the time that IM medication for RT is administered but does not necessarily need to be present.

If a patient does not consent:

The provisions of S62 will apply where treatment is immediately necessary to save life, prevent a serious deterioration in the patient's condition, alleviate serious suffering, or is immediately necessary to prevent the patient from behaving violently to himself or others.

Rapid Tranquilisation

- In the first instance: Check the Prescription Card and the consent to treatment.
- Ensure that there are two registered nurses present who have completed face to face or e-learning training on Rapid Tranquilisation.
- Check the prescription, draw up the injection (this needs to be carried out immediately- prior to administration) with both registrants' present.
- Ensure the patient is in a safe and supportive environment where privacy and dignity can be maintained.
- Ensure emergency equipment is readily available.

Within the first hour of administration:

- Physical observations every 15 minutes.
- Record observations on NEWS2.
- Check AVPU and document accordingly.
- Document on RiO.
- Monitor and record any changes.
- Ensure that a doctor is contactable.
- Observe the colour of the patient, any signs of hypoxia (blue colour), pale, clammy?
- Respiratory rate and pattern, any signs of respiratory distress?

Physical Observations to be carried out as per policy:
"Irrespective whether medication used for RT is given as an advanced decision / statement or as part of a restraint, the levels of observation MUST remain the same to ensure patient safety. If a patient has underlying health conditions or is prescribed therapeutic observations this should continue alongside the post RT observations"

- 15-Minute physical observations for the first hour and then hourly until the patient becomes ambulatory.
- Evaluate the patient's observations and response.
- Following consultation with a doctor discontinue observations if appropriate.

IM Medication used for RT:
- Please refer to policy- anything that deviates from guidance should be a documented decision if not already care planned.

Refusal of Physical observations or unsafe to perform them:

- If a patient refused their physical observations or their behaviour and risk is of such a degree that it is unsafe to carry this out. Ensure that respirations and the patient's level of consciousness is inputted (AVPU) onto their NEWS2 chart.
- Document clearly what they are doing e.g., pacing, talking, shouting, disengaged.
- Inform a doctor or the physical healthcare team.
- Repeat the process every 15 minutes attempting to gain compliance.
- Under no circumstances should 'patient sleeping' be recorded as grounds for not monitoring the physical observations following Rapid Tranquilisation. In this situation you must monitor and document RESPIRATIONS.

Rapid Tranquilisation Checklist:

- Has everything been documented on RiO & NEWS2?
- Have you entered YES on the Ulysses IR1 reporting system with an explanation of why RT was required and what action was taken prior, during and following the incident?
- Have you completed the restrictive practice section on RiO?
- Was restraint utilised and if so- identify the staff members with their designation and what part of the body they held?
- What medication was used, the dosage and times.
- Did any injury occur to the patient or staff member?
- In the event of administration under restraint, do staff /patient/patients need a debrief and has this been documented?
- Ensure the incident is discussed in the next ward round- make an entry in the ward diary as a reminder.

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