Guideline: Management of Adults with Severe Behavioural Disturbance

Purpose

This guideline has been written to assist in the assessment and management of severely agitated patients in the emergency department

Scope of Use

All EC medical and nursing staff

Guideline

Key Points

1. Protect yourself, staff and patients
   - Call Charge Nurse *3704
   - Call CART (Calming and Restraint Team) consists of: Security, Registrar, Orderlies, Nurses
   - Notify Consultant *3703
   - **If possibility of weapon call the police**
2. Be calm and non-confrontational
3. Move the patient to a low stimulus room (AA23 or AA24)
4. Consider other causes of aggression
   - Organic/medical
   - Psychiatric
   - Drugs & alcohol
5. Take history and do brief exam to identify cause

   (Includes collateral history from the family, accompanying persons, management plan in ED and contact psychiatric services)
6. Attempt verbal de-escalation – Establish rapport with the patient and try to understand patient's concerns eg. pain, anxiety, phobias etc.
7. If danger to self or others the patient will need restraint

   (Includes need to do investigations if concerned re: self-harm or medical cause)
   - Rapid tranquilisation (see drug regime – oral or parenteral)
   - Calming and Restraint Team (CART)

8. Post-sedation monitoring

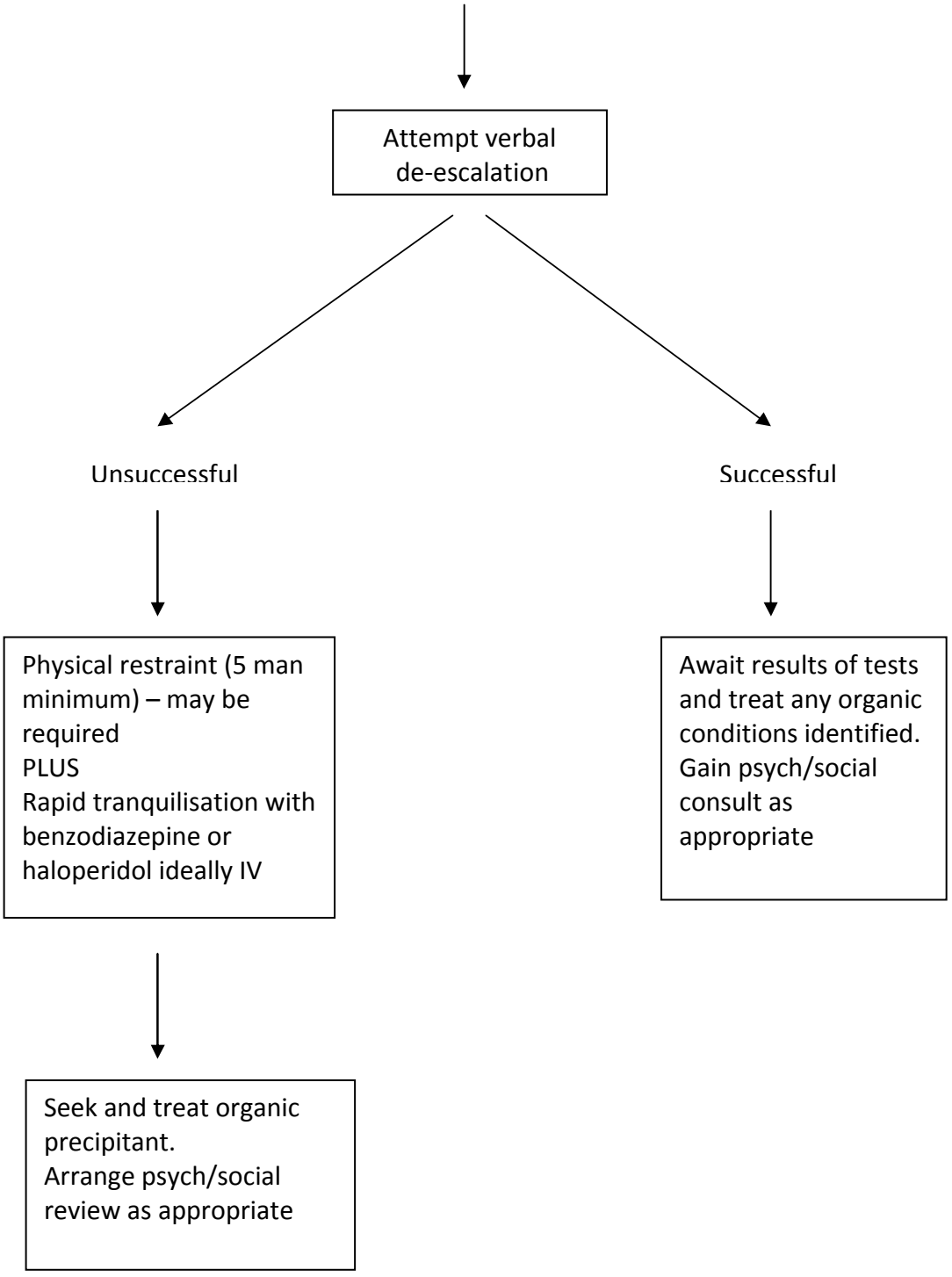
   Mechanical Restraint if extreme risk of safety to self or others.

9. Clear documentation: Full Restraint Use Form, Incident Form and Clinical Notes. If Mechanical Restraint monitoring form.

10. Critical Incident Defusing/Debriefing of staff and later to patient. May be distressing to all who witness it including other patients and family

Flowchart for Management of Severe Behavioural Disturbance

BEHAVIOURALLY DISTURBED
Safety to Staff and Others = Paramount
Treat all in quiet/low stimulus environment
Gain as much history, examination and investigations as possible



The Aggressive Patient

1. Recognise aggression and the potential for aggression

- Be aware of risk factors for aggression
- Be aware of precipitants of aggression
- Be aware of common presentations
- Listen to staff concerns

2. Approaching the patient

- Safe environment
- Remove tie, stethoscope etc
- Avoid sudden gestures, prolonged eye contact. Be calm and confident
- Gather history & mental state exam whilst defusing situation – focus on immediate situation
- Vital signs are important but observation from safe distance sufficient initially
- Do NOT give ultimatums

3. Consider causes of aggression

Psychiatric	Organic
Anxiety Psychosis Antisocial or borderline personality disorder	Neurological Head injury, CVA, post-ictal, encephalitis Drugs and alcohol Intoxication / disinhibiting medications Pain Endocrine Hypoglycaemia Infections Hypoxia Shock any cause

4. Predictors of an ORGANIC cause of violence / agitation

- >40yr
- No history of mental illness

- Disorientation
- Stupor or lethargy
- Visual hallucinations
- Illusions
- Abnormal vital signs

Always consider organic before labelling psychiatric

5. Investigations

- Guided by history and physical exam
- Consider:
    - Bedside – BM glucose, ECG, urinalysis – β-hCG, MC&S, and drug toxicology screen as indicated
    - Bloods – Full Blood Count, U and Es, renal function, TFTs, ethanol, ABG,LP post CT head as indicated
    - Radiology – CXR, CT head as indicated

6. Legal and professional obligations

- Human Rights Act 1993
- Health & Disability Act 1993
- Crimes Act 1961
- Intellectual Disability Act 2001
- Restraint Minimisation and Safe Practice Standards 2001

Mental Health Act

Compulsory Assessment and Treatment Act 1992

Emergency Treatment

Where treatment is a matter or urgency to save the patients life or prevent serious damage to patient's health & it is not possible to obtain consent, emergency treatment can be given

Duty of Care

Management of Severe Behavioural Disturbance

Usually a combination of:

1. Verbal de-escalation/distractions
2. Rapid tranquilisation
3. Calming and Restraint/Mechanical Restraint

A. Verbal De-Escalation

- Allow patient time to express concerns
- Focus on here and now
- May settle if concerns discussed and support offered
- Ascertain cause of behaviour
- Be calm and even
- Offer courtesies – phone, food, regular orientation p/p/time

Encourage the patient to choose help, e.g. "It seems to me things are a bit out of control. Will you let us help you? This medication will help calm things down".

Always be calm. Never be aggressive or threatening in response.

If aggression escalates and violence seems imminent withdraw and mobilise help.

Non-pharmacological management is crucially important to final outcome

B. Rapid tranquilisation

1. Aim of tranquilisation
    - Control dangerous behaviour
    - Facilitate assessment and management
    - Aim is for ROUSABLE SLEEP not unconsciousness
    - May require brief period of physical restraint to administer
    - Brief physical restraint is utilised as part of most acute parenteral sedations for severe behavioural disturbance – so consider concomitant physical restraint

2. Ascertain whether patient has ingested drugs prior to presentation.
    - Exclude pregnancy
    - Ascertain allergy status
3. Encourage the use of oral medications first
4. Patients require appropriate monitoring prior to administration of sedation. Always have resuscitation equipment available

Benzodiazepines usually 1st choice

- More sedating
- Less side effects than anti-psychotics

Anti-psychotics

- Those clearly with psychosis
- Ideally those previously treated with anti-psychotics
- In “Neuroleptic naive” use small doses
- Must have benzodiazepine IV prior to any IV/IM anti-psychotics
- Avoid in drug-induced psychosis & delirium

Table 1. Medication for Sedation in Response to Severe Behavioural Disturbance

Medication		Dose	Notes	Caution
ORAL				
Benzodiazepine	One option: **Lorazepam** Benzodiazepine choice will depend on what drug the clinician is familiar with	2mg titrated	A benzodiazepine is the drug of choice when dealing with patients with known amphetamine/stimulant drug intoxication.	RS depression 20 – 40 min for effect Light-headedness, increasing confusion
Antipsychotic	Haloperidol	2mg – 5mg	Often combined with benzodiazepines	Main complications include loss of consciousness/excessive sedation, cardiovascular problems, seizures, dyskinesias. Check patient medications, can interact with a variety of medications, especially lithium, antidyskinetic agents, antihypertensives, antiepileptics, antidepressants and MAOIs Care in patients with possibility of prolonged QT ***Check MIMs on for precautions, adverse effects and interactions.*** ****Side effects for dystonic reaction – see below***
IVI				
Benzodiazepine	Choice of benzodiazepine will depend on what drug the clinician is familiar with Some options: 1. Midazolam OR 2. Lorazepam	 1 to 2mg aliquots 0.5 to 1 mg aliquots	 Care with dosing above 10 mg total Care with dose escalation – max of 8 mg in 24 hours	Respiratory system depression
Antipsychotic	Haloperidol	2.5 – 10mg	Max 20mg	As above

Treat **dystonia with 1 – 2mg IV of benztropine and 2mg tds for 2/7.*

On occasions the IM route may be required prior to establishing IV access – drugs possibilities here include

- IM lorazepam 2 mg titrated or
- IM haloperidol 5 mg titrated with similar cautions as above

C. Calming and Restraint / Mechanical Restraint

Restraint is the implementation of any forcible control by a service provider that:

- Limits the actions of a patient in circumstances in which the patient is at risk of injury and/or of injuring another person
- Intentionally removes a patient's normal right to freedom

The following steps are intended as a guide for safe restraint:

Step	Action
1	Nominate one person "in charge" of the procedure. One person should talk to the patient to avoid negotiation breakdown, "splitting" and confusion amongst staff
2	Gather sufficient staff (ideally at least five). Assign each person to a specific limb (e.g. right arm) and to the head, one to administer medication
3	As in an arrest situation, a runner/recorder will be required
4	Assemble all necessary equipment and medications before approaching the patient
5	All personnel to remove potentially hazardous articles
6	Approach the patient with the leader talking to the patient and the others right behind or flanking. Explain the situation and what is about to happen, reassuring the patient that it will only be a temporary measure
7	At a pre-arranged signal, each person acquires their designated limb. The patient should be held firmly and gently moved to a lying position if possible
8	One delegated person continues to talk calmly to the patient throughout the process, explaining that the medication is to help calm the situation

Mechanical Restraint will be used in rare circumstances such as:

- In the case of assaultative behaviour where the personal restraint of the patient is prolonged and is causing physical or psychological harm to the individual.
- Patient who is actively self-harming and is at serious risk to themselves and where all other treatment interventions have been tried with little or no success.

A decision to initiate the use of mechanical restraint must be made by the attending doctor in consultation with the consultant who is responsible for the patient (or on-call consultant if out of hours) and with the nursing team.

Always Remember

- Hazardous procedure for staff and patient
- Beware biting, scratching, needle stick injury
- Monitor patients breathing
- Avoid pressure
    - Chest, neck, IV site, abdomen

D. Post-Sedation Care

- Give supplemental oxygen
- Place in left lateral position
- Doctor stay with patient for 10 min after parenteral procedure/until patient maintaining own airway
- Observation: sats/RR/HR/GCS/BP

  E.g.q10min for 30min

  q15min for 30min

  q30min for 60min

  q1hr until wakes

  These can be flexible to avoid waking/irritating patient
- Monitor for extrapyramidal side effects if anti-psychotics used
    - Dystonia, tremor, akathisia
- Reassure patients and families who may have witnessed the procedure – offer a debrief

- When patient alert allow them to express their concerns and explain reason and circumstances for their sedation – offer debriefing

Table 2. Post-Sedation Problems and Management

	PROBLEM	POSSIBLE CAUSE	ACTION
A	Airway obstruction indicated by noisy breathing or stridor ↓ SaO_2 <95%	Occluded relaxed airway Laryngospasm Aspiration Anatomical characteristics such as bull neck, obesity, prominent dentition, dysmorphic features	Supplemental O_2 Airway support: Extend neck, jaw lift Suction Mechanical airway support Get Senior medical help immediately if problem persists Consider benztropine 2mg IVI if laryngospasm
B	↓ resp rate ↓ SaO_2 <95%	Respiratory depression	Supplemental O_2 Vigorous stimulation Airway support Get Senior medical help **Flumazenil 0.1 – 0.2mg** may be titrated **with great caution**, especially for patients who are benzodiazepine dependent or receiving Tricyclic antidepressant medication (risk of seizure)
C	Hypotension	Peripheral vasodilation Adrenergic blockade Dehydration Other medical problems	BP < 100mmHg – close observation BP < 90 mmHg – consider IVI normal saline boluses at 5mL/kg up to 20mL/kg Get Senior medical help immediately if problem persists

E. Documentation and Reporting

Where sedation is used, document:

- The indication for the sedation
- A record of the medications administered
- A record of observations made following the use of IV sedation
- A record that an explanation of the incident is given to the patient and his/her carers if appropriate

F. Critical Defusing / Debriefing – Patient, Staff

References

1. Mental Health for Emergency Departments a reference guideline. NSW Government Action Plan
2. Emergency Medicine. Tintinalli 6th edition

3. Textbook of Adult Emergency Medicine Cameron et al 2nd edition

Associated Documents

Other documents relevant to this guideline are listed below:

NZ Legislation	
CMDHB Clinical Board Policies	
NZ Standards	
Organisational Procedures or Policies	
Other related documents	