Clinical Practice Guidelines: Behavioural disturbances/
Acute behavioural disturbance

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<th>Date</th>
<th>October, 2017</th>
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<td>Purpose</td>
<td>To ensure consistent management of patients with Acute behavioural disturbances.</td>
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<td>Scope</td>
<td>Applies to all QAS clinical staff.</td>
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<tr>
<td>Review date</td>
<td>October, 2020</td>
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<tr>
<td>Information security</td>
<td>This document has been security classified using the Queensland Government Information Security Classification Framework (QGISCF) as UNCLASSIFIED and will be managed according to the requirements of the QGISF.</td>
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Acute behavioural disturbance

Patients presenting with Acute Behavioural Disturbances (ABD) pose significant clinical risk to themselves and the health care professionals treating them. The causes of are usually multifactorial and include mental illness, intoxication with drugs and/or alcohol and organic illnesses such as hypoglycaemia.

**ABD can be classified into four general categories:**

- **Psychiatric disorders** – schizophrenia, bipolar, PTSD, psychosis
- **Substance related** – psychostimulants, cocaine, ketamine, LSD, cannabis, alcohol
- **Organic disorders** – hypoglycaemia, sepsis, hypoxia, head injury, dementia
- **Situational** – grief, overwhelming stress

Common ABD presentations include: panic, agitation, anxiety, delusions, hallucinations, or thought disorders. The primary management of ABD should always focus on de-escalation of the situation and the correction of underlying organic aetiologies. An individual with ABD can be impulsive, unpredictable and a risk to themselves or others and so may require emergent management and treatment. Assessing for the cause of the ABD may sometimes only occur after immediate management of the behavioural disturbance.[1-4]

**The main principles, where possible, when managing ABD patients are:**

| S | Safety: POP threat assessment, constantly reassess the safety of the patient, paramedics and others |
| A | Aggression: be aware of the common triggers of aggression and violence |
| F | Fix: Underlying organic illness, Focus on de-escalation strategies |
| E | Evaluate the patient: VSS, PSA, RSA, NSA, SAT score, SAMPLE |
| T | Tactical communication: active listening, empathy, rapport, influence, behaviour change |
| Y | Yes I have the right resources: including QPS, CCP, other QAS resources |

**Triggers of sudden aggression include:**

1. **Life or limb:** basic question of self defence against a perceived threat
2. **Insult:** either verbal or physical
3. **Family:** our instincts tell us to protect our nearest and dearest
4. **Environment:** when someone encroaches in your personal space
5. **Mates:** aggressive behaviour can be perceived as attractive
6. **Order:** anyone who threatens to disrupt an established system of rules
7. **Resources:** such as money or valuables
8. **Tribe:** we tend to defend those with whom we identify
9. **Stopped:** when you feel ‘stopped’ or obstructed by a situation or person.
**Additional information**

**Strategies for de-escalation**

1. Approach the situation with the right attitude and maintain your self-control
2. Non-aggression – ensure that you communicate non-aggression with your voice and body language
3. Match energy levels – respond appropriately, and use ‘voices for occasion’
4. Empathise and listen actively – empathy can help to defuse a conflict situation
5. Focus on the issue at hand – Help the patient focus on how to solve their problem

**Clues increasing likelihood or organic aetiology**

- > 40 years of age with first presentation psychosis or altered mental state
- Disorientation/ ALOC
- Altered vital signs
- Visual, tactile or olfactory hallucinations
- Sudden onset
- Fluctuating conscious state

**Documentation and reporting**

Accurate and timely recording of information related to sedation of the acute behavioural disturbance patient is essential and should include:

- **Sedation Assessment Score** – SAT score for ABD patients must be recorded on initial presentation and throughout patient reassessment
- **Consent** – document patient capacity for appropriate decision making (i.e. delirium, drug or alcohol intoxication, risk to themselves or others)

**Indication for sedation** – consider including what de-escalation techniques were undertaken prior to sedation (i.e. verbal and non-verbal techniques)

**Physical restraint** – document why utilisation of restraint was required (i.e. risk of absconding, patient risk), form of restraint (i.e. handcuffs, physical), potential risks of using restraints (i.e. restricted breathing, metabolic disturbance, risk to staff or others), duration of restraint

**Medications administered** – document rationale for any medications administered and any complications

**Observations and assessments undertaken** – include patient positioning during and after sedation (i.e. supine, lateral) and frequency of observations pre and post sedation (i.e. visual and physical)

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**Diagram:**

- CPG: Paramedic Safety
- CPG: Standard Cares
- Is it safe to proceed?
- Y
- Consider:
- QAS CCP Back-up
- QAS supervisor assistance
- N
- Manage as per:
- CPG: The Physically restrained patient
- CPP: Sedation – ABD
- CPP: Emergency Examination Authority
- Consider:
- Droperidol
- Ketamine

**Note:** Officers are only to perform procedures for which they have received specific training and authorisation by the QAS.