Clinical Practice Procedures: Behavioural disturbances/ Sedation - acute behavioural disturbances

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Purpose: To ensure a consistent procedural approach to Sedation - acute behavioural disturbances

Scope: Applies to all QAS clinical staff.

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Information security: 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.

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Sedation refers to an individual having a reduced awareness of their environment and/or a decreased level of consciousness, which has been drug-induced. In the patient with acute behavioural disturbance (ABD) the aim of sedation is to ensure safety of both the patient and officers, ensuring a safe transfer to medical care and to facilitate assessment and appropriate management of any underlying organic disorders.\[1\]

Psychostimulants are a major drug of concern within Australia with its prevalence continuing to rise along with an increase in the pattern of poly-drug use.\[2,3,4\] Studies in Australia have demonstrated that violent ABD episodes are frequently related to the use of or withdrawal from alcohol and drugs with only 10% of ABD patient aetiologies attributed to a pure psychiatric disturbance.\[5\] Sedation in ABD patients is high risk due to potential interaction with the various pharmacological agents within the patient’s system. Clinicians are to ensure that, when considering sedation for an ABD patient, the procedure can be performed safely, cognisant of all risks.

The SAT is a simple, rapid and useful measure of agitation and sedation in patients with ABD. The purpose of the SAT is to determine the patient’s level of agitation and response to medication administration with resultant level of sedation. A SAT score of +2 or +3 is a good predictor of the need to administer sedation and a SAT is required for all patients with ABD prior to and at regular intervals following sedation medication and should complement the patient’s standard vital sign survey.

<table>
<thead>
<tr>
<th>Score</th>
<th>Responsiveness</th>
<th>Speech</th>
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<tbody>
<tr>
<td>+3</td>
<td>Combative, violent, out of control</td>
<td>Continual loud outbursts</td>
</tr>
<tr>
<td>+2</td>
<td>Very anxious and agitated</td>
<td>Loud outbursts</td>
</tr>
<tr>
<td>+1</td>
<td>Anxious/restless</td>
<td>Normal/talkative</td>
</tr>
<tr>
<td>0</td>
<td>Awake and calm/cooperative</td>
<td>Speaks normally</td>
</tr>
<tr>
<td>-1</td>
<td>Asleep but rouses if name is called</td>
<td>Slurring or prominent slowing</td>
</tr>
<tr>
<td>-2</td>
<td>Responds to physical stimulation</td>
<td>Few recognisable words</td>
</tr>
<tr>
<td>-3</td>
<td>No response to stimulation</td>
<td>Nil</td>
</tr>
</tbody>
</table>
Indications

- Acute behavioural disturbance with a SAT Score \( \geq 2 \), when,
  - verbal de-escalation has failed; and/or
  - the patient presents an imminent risk to themselves or others.

Contraindications

- Patients with current airway compromise where securing the airway will be difficult

Complications

The induction of sedation by the clinician requires CAREFUL ATTENTION to all aspects of risk assessment and close adherence to accepted clinical guidelines.

- The risks associated with sedation include:
  - Potential for unintentional loss of consciousness
  - Depressed airway reflexes
  - Unpredictable responses due to drug effects and/or interactions
  - Depressed cardiovascular system
  - Inadequate analgesia
  - Individual variations in responses and dosage requirements

Procedure

1. Predict Patient Risk Factors

   Patients with a current airway compromise where securing the airway will be difficult are contraindicated for sedation

   - Where possible, establish detailed history
   - Observe/Examine Patient: VSS, RSA, PSA SAT Score
   - Eliminated other factors that precipitate the need for sedation

2. Assemble and Brief Sedation Team

   - Request QPS backup
   - Ensure PPE is utilised
   - Brief the team and allocate team roles
   - Ensure dedicated clinician to adequacy of airway and breathing
   - Brief QPS, including plan, clinical course and complications
   - Consider the environment and bystander reaction
   - Prepare resuscitation equipment
   - Prepare the sedation pharmacology

3. Coordinate Approach to Patient

   - QPS are the first point of contact for patient physical restraint
   - Advocate for patient safety during physical restraint
   - AVOID PRONE POSITIONING AND PRESSURE TO CHEST, HEAD OR NECK
   - When adequate control is gained administer medication
   - Ensure safety of all members of team. Beware needle stick injury
   - Continue sedation according to relevant indication and DTP
   
   BEWARE the patient who states they cannot breath.
   
   High risk of imminent arrest.
4. Post-Sedation Care

- Vigilant VSS monitoring (once appropriate sedation achieved)
  - SpO2
  - EtCO2 (only to be applied when SAT Score < 0)
  - BP
  - ECG
- Avoid unnecessary stimulation of patient
- Repeated SAT score
- Documentation – including ABD Audit Form (required for all patients < 16 years, > 64 years or when ketamine/midazolam was required (following droperidol administration))
- Hospital notification
- Consider EEA

Additional information

- Generally, moderate sedation will be optimal in most situations. Deep sedation is to be avoided as it is unnecessary in the pre-hospital environment. Most, if not all, patients in the pre-hospital setting are not fasted and are therefore at a greater risk of aspiration.
- Restrained patients are at increased risk of further injury and use of restraints, in the context of psychostimulant use, is a risk factor for sudden death. Refer to CPG: The physically restrained patient.
- CCP back-up is to be requested for all ABD patients requiring a 2nd dose of droperidol.