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COVER SHEET

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FORMER REFERENCE(S) | EMERGENCY SEDATION POLICY – ACUTE INPATIENT PSYCHIATRY UNITS 2007/08
EXECUTIVE SPONSOR or EXECUTIVE CLINICAL SPONSOR | Area Director Mental Health Drug and Alcohol
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KEY TERMS | Emergency sedation
Acute inpatient psychiatry
SUMMARY | This policy provides clear guidance around the use of emergency sedation for all staff members involved in the assessment and treatment within the acute inpatient setting.
The age group of patients covered by this policy is adults aged 18 and above and there is a specific section covering the population aged 65 and over.

COMPLIANCE WITH THIS DOCUMENT IS MANDATORY
Feedback about this document can be sent to areapolicy@sesiahs.health.nsw.gov.au
1. POLICY STATEMENT
The Area Mental Health Program is a clinical stream within the organisational structure of South Eastern Sydney and Illawarra Area Health Service. This policy has been developed to ensure consistent and safe practice in the planning, management and review of inpatients receiving emergency sedation across the Mental Health Program. This policy is consistent with the Mental Health Act 2007 (NSW) and the National Standards for Mental Health Services.

1.2 Policy Development
This policy has been developed by the Area Mental Health Office, in consultation with the Mental Health Executive from each site/service. The guidelines included have been arrived at through consensus involving a wide range of senior psychiatrists from across the Area Mental Health Program.

2. AIMS
This policy provides clear guidance around the safe use of emergency sedation within the acute inpatient environment.

3. TARGET AUDIENCE
This policy is for all mental health staff members who are involved in the assessment and treatment of consumers admitted to acute inpatient facilities.

4. RESPONSIBILITIES
It is the responsibility of the Area Mental Health Office to circulate this policy to the Directors/Managers of each site/service, and to have the Policy published on the Area Intranet. It is the responsibility of each site/service Director/Manager to ensure that the Policy is circulated and implemented locally.

5. DEFINITIONS
Emergency sedation – the administration of pharmacological agents (specifically benzodiazepines and/or antipsychotics) in an immediate timeframe for the purpose of managing acute behavioural disturbance in a patient suffering from a known or suspected psychiatric illness, and where that behaviour puts them or others at immediate risk of serious harm, and which is unable to be contained by other means.

Acute adult inpatient psychiatry unit – a facility whose specific purpose is to admit for assessment and treatment patients aged 18 years and over with a known or suspected psychiatric illness. Such units will be gazetted under the Mental Health Act.

Exclusions: this policy is not specifically designed for the management of emergency sedation:
- In Emergency Department settings
- In general hospital wards
- In community health centres
- In child and adolescent acute inpatient units or other facilities managing children or adolescents

Many of the principles outlined in this policy will be applicable to these settings. However, the guidelines will need to be specifically customised for each specific setting.

The age group covered by this policy is adults aged 18 and above. There is a specific section covering the population aged 65 and over. Whilst the guidelines are not intended for use in adolescents, it may be
applied to adolescents between the ages of 16 – 17 who are admitted to acute adult inpatient units, if considered clinically appropriate.

6. POLICY COMPONENTS

6.1 Guiding Principles

6.1.1 The use of emergency sedation in acute adult inpatient units is guided by the primary concern of providing safe care to patients who are agitated, aggressive or disorganised, as well as maintaining a safe environment for other patients, visitors and staff. The decision to proceed with emergency sedation is made on clinical grounds only, and is authorised by appropriately trained medical and/or nursing staff, depending on the type of intervention being ordered.

6.1.2 The general principle of utilising the least coercive method of sedation, and in the lowest appropriate doses, should be adhered to. The following guidelines provide specific advice on the most appropriate pharmacological interventions to use in the acute inpatient setting, with the margin of safety being greatest with oral and diminishing through intramuscular to intravenous.

6.1.3 The purpose of acute parenteral sedation is to make the patient drowsy but rousable. The procedure is not intended to render the patient unconscious.

6.1.4 Before proceeding to emergency sedation for an acutely disturbed inpatient, there are a number of key issues to consider:

- Is the acutely disturbed behaviour related to the underlying psychiatric disorder (i.e. psychosis or affective disturbance) or may it be caused by a delirium? (e.g. intercurrent medical conditions, head injury, substance misuse, or toxicity from prescribed medications). If delirium is suspected, commence appropriate examination and investigations and do not proceed to emergency sedation using these guidelines. *The assessment and management of delirium is discussed in a separate document.*

- Pregnancy, significant pulmonary disease and intoxication are *relative contraindications* to the use of emergency sedation.

- Have alternative strategies to sedation been attempted? E.g. verbal de-escalation and distraction, seclusion (*refer to policy on use of seclusion*)

- Ideally, violence, aggression or self-harm should be anticipated and alternative management strategies utilised. Medication should always be used in conjunction with psychological and behavioural strategies.

6.2 GENERIC REQUIREMENTS

6.2.1 Legal Considerations

In most situations the client will be sedated while an involuntary client under the Mental Health Act, although on occasion informal clients under the Act may give informed consent to the procedure.

Every attempt to verbally de-escalate the situation should be made and the use of oral medication considered prior to initiating emergency sedation. If emergency sedation is selected as the best treatment option then an attempt to discuss this plan with the patient and to explain the reasons why emergency sedation is necessary should be made. The need for sedation will typically follow a period of deteriorating behaviour and a failure of more conservative measures.

Certain provisions of the Mental Health Act need to be borne in mind including that clients should not be given dosages of medication that are excessive or inappropriate (Section 198) or which would interfere
For adult patients (aged 18 – 64) the following guidelines apply:

6.2.2 Oral Medication

First offer oral medication. Choice of tablet, wafer or syrup is to be at the discretion of the nursing staff unless specifically prescribed.

Oral medication can be ordered by a medical officer, in advance of a patient actually requiring emergency sedation, as a ‘PRN’ order. This can then be administered by appropriately trained nursing staff without requiring concurrent authorisation. Standing PRN orders should be reviewed on a regular basis by the treating team and maximum doses per day clearly outlined.

1st line treatments:
- **diazepam** - up to 20 mg initially, repeated every 2 to 6 hours, to a maximum of 120 mg per 24 hours
- **lorazepam** - between 2 – 6 mg initially, repeat every 2 to 6 hours, maximum of 15 mg per 24 hours
- **+/− risperidone** - up to 2 mg initially up to a maximum of 6 mg per 24 hours

2nd line treatments:
- **clonazepam** - up to 4 mg initially, to a maximum of 12 mg per 24 hours
- **+/− chlorpromazine** – between 50 – 200 mg initially, up to a maximum of 600 per 24 hours
- **+/− olanzapine** - initially 5 –10 mg up to maximum of 30 mg per 24 hours
- **+/− quetiapine** – initially 50 – 100 mg up to a maximum of 400 mg per 24 hours

6.2.3 IMI Medications

IMI medication can be ordered by a medical officer, in advance of a patient actually requiring emergency sedation, as a ‘PRN’ order. This can then be administered by appropriately trained nursing staff without requiring concurrent authorisation. However, if a patient is requiring repeated IMI sedation over a short period of time, nursing staff should contact the relevant medical staff member to discuss ongoing management.

Standing PRN orders should be reviewed on a regular basis by the treating team and maximum doses per day clearly outlined.

**Acuphase is the exception to the above.** It should never be ordered by a medical officer in advance. Acuphase can be prescribed by a registrar but must be AUTHOURISED by a consultant psychiatrist at the time it is to be administered.

**Benzodiazepines:**
- **Lorazepam** – (but not to be given within 30 minutes of olanzapine). A dose of 1-2mg at half-to-one-hourly intervals up to a daily maximum of 8mg. Where it is available, this is the preferred benzodiazepine for acute IMI use.
- **Midazolam** (but not to be given within 30 minutes of IMI olanzapine). Dosage 5 – 10 mg initially, may be titrated to response every 20 minutes to a maximum of 20 mg per sedation event. This can be repeated every 4 – 6 hours, up to maximum of 40 mg per day. Due to its very short half-life, the usefulness of midazolam may be limited in patients who are acutely disturbed over an extended period.
**Antipsychotics:**

- **1st line:** olanzapine (10 mg per dose, maximum 3 doses (30 mg) in 24 hours. olanzapine should not be given within 30 minutes of IMI midazolam).
- **2nd line:** haloperidol (usually in conjunction with midazolam).

**NB.** Droperidol is **NOT** recommended due to its effect on prolonging the QT interval.

**Acuphase** can be used in the following situations:

- where the patient has had prior exposure to Acuphase OR
- where other IMI antipsychotics have failed or have been inadequate AND
- there is a clear diagnosis of a psychotic disorder AND
- there is a commitment to an admission of at least 72 hours

Augmentation with benzodiazepines:

- orals preferred
- if using IMI, can use midazolam concurrently. Clonazepam is preferred if repeat administration is required (orals >> IMI)

  - **The use of concurrent olanzapine IMI with Acuphase is NOT recommended.**
  - There is no need to withhold atypical oral antipsychotics during period of Acuphase treatment, only typical oral antipsychotics.
  - Each Acuphase dose should be authorised by a consultant psychiatrist.
  - Acuphase should NOT be given to the neuroleptic naïve patient
  - The maximum dose is 150 mg per administration, and 450 mg over 72 hours.
  - Close monitoring of the patient for the presence of extra-pyramidal side effects (EPSEs) and postural hypotension.

6.2.4 **Intravenous Medications**

Intravenous medications should never be ordered by a medical officer in advance, but should be ordered at the time it is to be administered. These should only be administered by an appropriately trained medical officer.

- **Diazepam** is the only recommended benzodiazepine in the inpatient setting. Midazolam is **NOT** recommended.
- **Haloperidol** is the only recommended antipsychotic in the inpatient setting.
- **Droperidol** is **NOT** recommended.

Diazepam is to be used as the first option for IV sedation. If adequate sedation is not achieved with diazepam in doses up to 60mg then haloperidol can also be administered in a single bolus dose (between 10-20 mg)
The diazepam dose will need to be titrated appropriately, but should not exceed 120 mg per episode.

A normal saline flush is to be given between titration of every 5mg bolus dose of diazepam above the initial bolus, to minimise risk of over-sedation.

It is noted that registrars require specific training and supervision in administering IVI sedation. As this is becoming a rarer event in inpatient units, ‘on the job’ training is unlikely to be sufficient for this purpose. Specific teaching on the rationale for and method of administering IVI sedation should be provided to all junior and new registrars as part of their orientation to the Mental Health Program.

6.2.5 For Older Persons (65 and above) as well as Medically Compromised Patients the following amendments to the above guidelines should be noted:

Oral medication

1st line treatments:
- lorazepam - between 1 – 2 mg initially, repeat every 4 to 6 hours, maximum of 6 mg per 24 hours
- +/- risperidone - up to 1 mg initially up to a maximum of 3 mg per 24 hours

2nd line treatments:
- diazepam - up to 10 mg initially, to a maximum of 20 mg per 24 hours
- +/- olanzapine - initially 2.5 - 5 mg up to maximum of 10 mg per 24 hours
- +/- quetiapine – initially 25 - 50 mg up to a maximum of 200 mg per 24 hours

IMI medication

- lorazepam 0.5-1mg, repeated after 1-2 hours if needed, to a maximum of 4mg in 24 hours
- midazolam 2mg

Neither lorazepam or midazolam are to be given within 30 minutes of IMI olanzapine AND usage of these medications requires monitoring for respiratory depression.

Antipsychotics

1st line: olanzapine (2.5 mg per dose, maximum 7.5mg per 24 hours)
2nd line: haloperidol (1mg, usually in conjunction with midazolam. Maximum dose 3 mg per 24 hours).

NB. Haloperidol should NOT be used in patients with a parkinsonian syndrome including Parkinson's disease and Lewy Body Dementia.

There is NO PUBLISHED DATA on the use of Zuclopenthixol Acuphase in the elderly so it should be prescribed with extreme caution, particularly bearing in mind the risk of EPSEs.

Acuphase should NOT be used in the medically compromised patient.

Intravenous medication

NOT recommended in the elderly, or in the medically compromised patient, due to the significant risk of respiratory depression.

6.3.1 Intramuscular Rapid Tranquillisation Procedure

- Ensure the patient is safely restrained, with a 3-5 person technique. Precautions against biting and spitting should be taken (including goggles, gloves).
Whenever possible, prior to the procedure, the senior nurse of the shift will inform staff of their roles during the procedure to ensure clarity concerning preparation of medication, preparation of the area and designated staff to remain with the patient.

First dosing should be at the lower end of the range, to assess tolerance of the patient to the medication.

Repeat IMI can be given 30 to 45 minutes after the first injection, if no significant effect is observed. If no or limited response after two IMIs, seek consultation with a psychiatrist / psychiatry registrar and consider IVI sedation.

### Intravenous Rapid Tranquillisation Procedure

- IVI tranquillisation should be a step-wise procedure, with an immediate post-injection end-point of a sleeping, but rousable, patient.
- Ensure that all staff are aware and protected against risk behaviour (goggles, gloves), and there is an absence of items that have the potential to be used as weapons (pens, ties etc).
- Ensure the patient is safely restrained, with a 3-5-person technique. Precautions against biting and spitting should be taken. However the patients face and airway must not be obscured or obstructed in anyway to reduce such risks.

**Step 1.** Obtain access to a large antecubital fossa vein, using a large gauge cannula. Inject Diazepam slowly at a rate of 5mg per minute; titrate against respiratory rate and level of consciousness, up to maximum limit of medication. Do not exceed maximum limit of medication before further consultation.

**Step 2.** If the patient is psychotic, consider giving the antipsychotic medication together with the Diazepam. Incremental boluses should be given up to the maximum dose per event. If acute dystonia is observed give anticholinergics as necessary. A 5ml normal saline flush between each incremental dose and drug is recommended.

**Step 3.** If further sedation is required, after maximum doses of sedation (as in step 1) and antipsychotics (as in step 2), consult with a Psychiatrist before proceeding to give further doses of medication.

In practice higher doses are rarely required.

### Monitoring

**After IMI sedation,** blood pressure, pulse rate, level of unconsciousness and respirations must be monitored every fifteen minutes for thirty minutes. If monitoring of blood pressure is likely to disturb the client, monitor only the pulse and respirations. However always monitor the blood pressure prior to administering a second intramuscular injection.

The airway should be checked with the client in the coma position. The airway may need to be assisted with chin-lift forward or jaw thrust manoeuvre or an oropharyngeal airway, if there is any evidence of obstruction. Medical assistance should be sought if needed.

Pulse oximetry must be used to monitor oxygen saturation. If oxygen saturation levels are <95% supplemental oxygen therapy is to be given at 6L/min (unless clinically contraindicated).

Risk assessment for pressure ulcers is recommended where immobility is present for an extended period and appropriate preventative strategies employed.
**Post-sedation Monitoring**

- The Medical Officer is to remain with the patient for 10 minutes or until the patient is able to maintain their own airway.

Observations such as BP, pulse, respirations and oxygen saturation are to be monitored at the following recommended frequency:
  - Every 10 minutes for 30 minutes
  - Every 15 minutes for 30 minutes
  - Every 30 minutes for 60 minutes
  - Then hourly for 4 hours or until the patient is awake

The patient will be classified as Care Level 1 for at least one hour after IV sedation, or in accordance with their condition.

An appropriately equipped emergency trolley should be in close proximity. This should include an air-viva bag, oxygen and airway.

Clients should be monitored for early signs of acute dystonia with parenteral benztropine 2mg administered if required.

Risk assessment for pressure ulcers is recommended where immobility is present for an extended period and appropriate preventative strategies employed.

The medical officer will be immediately notified of deterioration in observations.

Observation of the client following IV sedation should be continuous for 1 hour, with a registered nurse always in attendance. The risks of respiratory depression, hypotension and laryngeal spasm cannot be adequately assessed by periodic observation.

Longer observation may be considered in the presence of possible organic causation or observed side effects (e.g., hypotension, bradycardia, desaturation, and extra pyramidal side effects).

The medical officer will undertake a physical examination of the patient after the first hour (if possible) and will determine the level and frequency of further observations.

Flumazenil (a benzodiazepine antagonist) should also be available (0.2mg - 1mg IVI titrated against clinical response) when benzodiazepine reversal is required. This has been associated with seizures in the benzodiazepine dependent client, as well as ventricular tachyarrhythmias. Physician support is warranted if flumazenil is considered. If considering use of Flumazenil the on-duty Medical or ICU Registrar is to be contacted for consultation and assistance. Respiratory support of the patient is to be continued until consultation and treatment commences.

Consideration should be given to intravenous re-hydration in the presence of dehydration or if oral intake has been poor as a result of mental illness. Dehydration is a risk factor for neuroleptic malignant syndrome.
6.4 DEBREIFING
Debriefing should be offered to the patient, co-patients, family, friends, visitors and staff, where appropriate. Arranging the debriefing is the joint responsibility of the doctor who authorised the sedation and the Shift Coordinator, and may occur when emergency sedation using IMI or IVI medications has occurred.

7. QUALITY IMPROVEMENT
Use of emergency sedation and rapid tranquillisation will be monitored through incident management systems, documentation audits, regular review of IV sedation, seclusion and restraint registers and reported to Area and Network MH Quality, Safety & Service Evaluation Committees.

8. DOCUMENTATION
Rapid Tranquillisation Episodes
All episodes of Rapid Tranquillisation must be recorded in an IV Sedation Register (to comply with Section 199 of the Mental Health Act 1990: Administration of drugs in hospitals). This register must be available for Official Visitor inspection.

An episode of Rapid Sedation must also be documented in the patient’s progress notes in the Medical Record File.

Documentation in the patient's progress notes should record:

- The indication
- Events preceding the sedation including de-escalation/interventions applied
- A record of observations
- Whether sedation was used with seclusion and/or restraint
- A record of debriefing
- Detailed alternate management plan to decrease recurring disturbed behaviour (when there has been repeated sedation)
- A review of the Care Plan
- Risk assessment for pressure ulcers is recommended where immobility is present for an extended period and appropriate preventative strategies employed.

Documentation in the Intravenous Sedation Register must record:

- Name of patient
- Date of birth
- MRN or address
- Date of administration
- Date of admission
- Legal status of patient
- Reason for use of sedation
- Medications used, with dosages
- Whether sedation was used with seclusion and/or restraint
- Details of any complications experienced
- Name of nurse recording observations
- Name of medical officer authorising sedation
- Diagnosis
If any form of physical restraint was used during the procedure, the Restraint Register will be completed by a RN and signed by the treating medical officer.

If seclusion has been used, the Seclusion Register will be completed as per the Seclusion Policy.

The patient's care level and observation is to be documented in the medical record progress notes and the care level observation form. Physical observations are to be recorded on the facility observation chart(s).

9. REFERENCES
Local emergency sedation / rapid tranquillisation policies used at Sutherland, St George, Prince of Wales, Illawarra and St Vincent's MHS.
SESIH MHS Clinical Risk Assessment & Management, 2006/05
SESIH MHS Patient Care Levels, 2006/01
SESIH MHS Seclusion Policy, 2006/04
SESIH MH Interpersonal Prevention and Management of Aggression Guidelines, 2007
SESIH MHS Physical Health Care Policy (in draft)
SESIH MHS Assessment & Management of Delirium Guidelines (in draft)
SESIH Medication Management: Drugs – Schedule 4 Appendix D – Balance Checks, PD 106
NSW Health, Patient Matters Manual for Health Service Areas, Chapter 13
NSW Health, Mental Health for Emergency Departments: A reference guide, 2001
NSW Mental Health Act, 2007
NSW Centre for Mental Health, Mental Health for Emergency Departments – A reference guide 2002
http://sesiweb/AMH/Projects_Strategic_Planning/Risk_Management/Pressure_ulcers.asp

10. REVISION & APPROVAL HISTORY

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<tr>
<th>Date</th>
<th>Revision No.</th>
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<td>1</td>
<td>Endorsed by AMH Executive</td>
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<tr>
<td>09/2008</td>
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<td>Policy reviewed and revised</td>
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<td>3</td>
<td>Pressure ulcer care added. Revised document endorsed by AMH Executive</td>
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