Australian and New Zealand College of Anaesthetists (ANZCA)

Guidelines for Safe Care for Patients Sedated in Health Care Facilities for Acute Behavioural Disturbance

Background paper

1. INTRODUCTION

Sedation is on occasion required to manage patients with acute behavioural disturbance (ABD). Such patients present to a range of hospitals whose facilities vary significantly. The availability of equipment, staff and facilities may differ between major tertiary hospitals, small regional/remote hospitals, and private institutions.

A range of health practitioners from different disciplines may be involved in the management including psychiatry, emergency medicine, intensive care, anaesthesia, nursing and other related health practitioners.

The level of sedation required in the management of ABD may range from orally administered conscious sedation/anxiolysis to parenterally administered deeper sedation. The progression from conscious sedation and deep sedation through to anaesthesia may be rapid and unpredictable. Inadvertent deep sedation carries significant risks and requires the necessary skills to be able to manage unconscious patients including monitoring of relevant physiological variables.

The guidelines were developed to address the specific circumstances and needs of patients with ABD and the practitioners and organisations caring for them. While it is appreciated that implementing some of the recommendations may prove challenging in some facilities it was agreed that they are aspirational and consequently should be included.

2. BACKGROUND

Patients being sedated for ABD may require the services of a range of physicians depending on their state of agitation, location of presentation, and the level of sedation required or inadvertently achieved. While emergency departments are common locations for such patients to present, they may arrive at psychiatric facilities in either major central hospitals or small regional centres. The accompanying guidelines acknowledge the individual needs and limitations of the range of facilities and the practitioners involved yet strive to ensure patient safety irrespective of those differences.

3. DISCUSSION

The definition of ABD (see 4.1 of PS63) concludes with a statement that the behaviour is considered often not to be under the voluntary or legally competent control of the individual. However, this has been questioned as it is proposed that it cannot be globally said that the behaviour is never voluntary. It is possible for a patient to be incompetent but acting voluntarily. As this matter was flagged it is included for information in this background document.

A number of issues were raised and considered during the development of the accompanying guidelines. The recommendations contained within them are emphasised below:

- The reasons for ABD are often multi-factorial and where possible, a good behavioural, psychological, and environment assessment (including family/whanau, caregiver, and appropriate cultural input) should occur.
- It is recommended that wherever possible, behavioural and environmental strategies are attempted prior to sedation. In some settings such strategies are commonly employed with resultant decreased need for pharmacotherapy. This is particularly relevant in vulnerable patient groups who are more likely to experience adverse effects from sedation.
- As a general principle it is recommended that the least harmful and least restrictive approach to ABD should be attempted at all times. This includes communication, environment, oral medications prior to restraint and parenteral routes of administration of sedation, a stepped approach with oral medication as the usual first line approach, intramuscular injection as the usual second line approach and intravenous injections reserved for severe ABD where these safer modes have failed or are likely to fail to resolve the behavioural disturbance. With rapid escalation of behavioural disturbance or inability to reason with the patient, such as may arise in Emergency Departments, this stepped approach may not be feasible.
- Participating colleges may wish to develop additional guidelines or protocols specific to their environments that elaborate or expand on the accompanying guidelines. Fellows of those colleges should be guided by their parent college guidelines in conjunction with the accompanying guidelines.
- Patients with ABD, being managed in some psychiatric units, may be stable or showing signs of early deterioration. It has been normal practice for nurses in those units to administer prn sedation in accordance with medical practitioner prescriptions and under their supervision. It is acknowledged that the prescribing/supervising medical practitioner retains responsibility as the nursing staff are acting under the delegation of medical staff. Nevertheless, there needs to be an ongoing process involving both medical and nursing staff that facilitates documentation of observations, which if they fall outside the limits, results in appropriate escalation to the immediate attention of the medical staff.

3.1 Aims and risks of sedation for ABD

The occasional need for restraint poses risks to the patient, especially in the prone position. The adoption of this position may be associated with risks of serious sequelae including depression of ventilation, asphyxia, musculoskeletal injuries, and occasionally cardiac arrest of unknown aetiology that is unresponsive to resuscitation and resulting in death. Safe patient positioning once adequate sedation has been achieved is important as is the release of restraint as a matter of urgency.

3.2 Assessment and consent

Patients with ABD presenting to mental health facilities may be new to the facility or they may have previously visited the facility. Access to patient histories and ability to obtain relevant histories may be limited and dependent on the patient's ability to provide information and their level of co-operation.

Given the need to proceed rapidly in some circumstances, assessments may be necessarily limited, however, every effort should be made to complete as

comprehensive an assessment as is feasible. This may involve obtaining information from the patient, relatives/whanau, caregivers, accompanying friends, or ambulance/police.

Likewise, obtaining consent may be limited or even impossible should the patient's behaviour state preclude them from giving consent. Furthermore, treating ABD is very different from performing a surgical procedure and the demand for consent differs.

In patients that have not been adequately fasted and there is a need to proceed rapidly with sedation the decision to progress involves assessing risks and benefits.

3.3 Spectrum of facilities

Small psychiatric facilities and small regional centres have limited resources. However, patients presenting with ABD may need to be sedated in these facilities, which should therefore meet the minimum standards for resuscitation equipment and trained staff. Such facilities must have an escalation protocol that can access higher levels of care and can institute rapid transport to a larger centre.

Emergency Departments tend to have acute care facilities and the ability to mobilise medical practitioners. Hospitals with intensive care units can offer a higher level of critical care that may be necessary in some instances.

3.4 Monitoring

Monitoring and observation of sedated patients is essential. While application of monitors in the cooperative patient can be achieved prior to administration of sedation it may be impossible to achieve in the severely disturbed patient. Moreover, monitoring equipment may be used as a weapon, or damaged by such patients. Consequently, monitoring should commence as soon as it is clinically feasible.

It is recognised that some small private facilities may not have oximeters or capnographs, or even ECGs. However, these must be available for all patients, where clinically indicated, and will be determined by the state of the patient and the level of sedation required.

The use of sedation scales is encouraged, and examples are provided in Appendix 3 of the accompanying guidelines.

3.5 Staffing levels and experience

Given that the presentation of ABD can range from mild and cooperative, to severe and presenting a threat to themselves and others, the number of staff required will to some extent be determined by the severity of the behavioural disturbance. Where restraint is required it is common for five staff to be in attendance. However, it was agreed that to safely manage patients to be sedated there must be a minimum of three people.

Reference to ANZCA professional documents PS08 *Statement on the Assistant to the Anaesthetist*, and PS09 *Guidelines on Sedation and/or Analgesia for Diagnostic and Interventional Medical, Dental or Surgical Procedures* was made to determine the training and experience required of staff involved in the safe care of

patients sedated for ABD. This was in the context that these patients are not requiring surgical or interventional procedures and often present as emergencies.

Management of patients requiring sedation for ABD may require a multidisciplinary team approach involving a range of medical specialists. In the Emergency Department team setting this would normally involve ED medical and nursing staff, security or equivalent staff, and often also psychiatric liaison services.

Medical specialists involved in caring for patients with ABD should refer also to any guidance developed by their medical college that is specific to their clinical context. Given the range of specialists and facilities involved in managing ABD specific protocols may be developed and may vary. The accompanying guidelines are not intended to fulfil this purpose, but rather to provide recommendations that enhance the safety of patients sedated for ABD, as well as those caring for them.

4. SUMMARY

Pursuant to the development and publication of PS09 it was recognised that the guidelines did not address patients sedated for ABD as they were not undergoing sedation for the purpose of interventional or surgical procedures. Psychiatrists were concerned that the care for patients sedated to manage their ABD was substandard.

It was agreed that the accompanying guidelines would not become a protocol for sedating patients with ABD, as there were many clinical protocols, and that the guidelines should not be prescriptive clinical guidelines. Instead, the intent was to ensure that patients that had to be sedated were subsequently safely managed and cared for.

In developing the accompanying guidelines, it was recognised that the specialties involved in caring for patients with ABD include psychiatry, emergency medicine, intensive care medicine, and anaesthesia. All four colleges were invited to collaborate on creating a co-badged document with the aim of developing recommendations applicable to caring for all patients sedated for ABD.

5. DOCUMENT DEVELOPMENT

In accordance with a Memorandum of Understanding between the colleges, a joint colleges document development group was established consisting of the following representatives from the Australasian College for Emergency Medicine (ACEM), ANZCA (including the Chair), the College of Intensive Care Medicine (CICM) and the Royal Australian and New Zealand College of Psychiatrists (RANZCP):

- Associate Professor Jonathan Knott, ACEM.
- Professor Andis Graudins, ACEM.
- Dr Peter Roessler, ANZCA, Director of Professional Affairs (Professional Documents) – Chair.
- Dr Joanna Sutherland, ANZCA.
- Dr Martin Minehan, ANZCA.
- Associate Professor John Botha, CICM.
- Dr Himangsu Gangopadhyay, CICM (to August 2015).
- Dr Jason McClure, CICM (from August 2015).
- Dr John Corish, RANZCP.
- Dr Nick O'Connor, RANZCP.
- Dr Michael Paton, RANZCP.
- Professor John Tiller, RANZCP.

In addition, the following internal stakeholders were consulted:

- ANZCA Safety and Quality Committee.
- ANZCA regional and national committees.
- Faculty of Pain Medicine Board and regional committees.
- ANZCA Trainee Committee.
- Relevant Special Interest Groups (SIGs).

RELATED ANZCA DOCUMENTS

PS01 Recommendations on Essential Training for Rural General Practitioners in Australia Proposing to Administer Anaesthesia

PS02 Statement on Credentialing and Defining the Scope of Clinical Practice in Anaesthesia

PS04 Recommendations for the Post-Anaesthesia Recovery Room

PS06 The Anaesthesia Record. Recommendations on the Recording of an Episode of Anaesthesia Care

PS07 Guidelines for the Pre-Anaesthesia Consultation

PS08 Statement on the Assistant for the Anaesthetist

PS09 Guidelines on Sedation and/or Analgesia for Diagnostic and Interventional Medical, Dental or Surgical Procedures.

PS15 Recommendations for the Perioperative Care of Patients Selected for Day Care Surgery

PS16 Statement on the Standards of Practice of a Specialist Anaesthetist

PS18 Guidelines on Monitoring During Anaesthesia

PS26 Guidelines on Consent for Anaesthesia or Sedation

PS55 Recommendations on Minimum Facilities for Safe Administration of Anaesthesia in Operating Suites and Other Anaesthetising Locations

PS63 Guidelines on the Management of Patients Sedated for Acute Behavioural Disturbance

FURTHER READING

American College of Radiology. ACR-SIR practice guideline for sedation/analgesia. Reston: American College of Radiology, 2010. From: http://www.acr.org/~/media/F194CBB800AB43048B997A75938AB482.pdf Accessed 31 July 2014.

American Society of Anesthesiologists. Statement on granting privileges for administration of moderate sedation to practitioners who are not anaesthesia professionals. Schaumburg: American Society of Anesthesiologists, 2011. From: https://www.asahq.org/For-Members/Standards-Guidelines-and-Statements.aspx Accessed 31 July 2014.

American Society of Anesthesiologists Task Force on Sedation and Analgesia by Non-Anesthesiologists. Practice guidelines for sedation and analgesia by non-anesthesiologists. Anesthesiology 2002;96(4):1004-17.

Cravero JP, Blike GT. Review of pediatric sedation. Anesth Analg 2004;99(5):1355-64.

Dental Board of Australia. Registration standard for endorsement in relation to conscious sedation. Melbourne: Dental Board of Australia, 2010. From: http://www.dentalboard.gov.au/Registration/Conscious-Sedation.aspx Accessed 31 July 2014.

Hohl CM, Sadatsafavi M, Nosyk B, Anis AH. Safety and clinical effectiveness of midazolam versus propofol for procedural sedation in the emergency department: a systematic review. Acad Emerg Med 2008;15(1):1-8.

Hosey MT. UK National Clinical Guidelines in Paediatric Dentistry. Managing anxious children: the use of conscious sedation in paediatric dentistry. Int J Paediatr Dent 2002;12(5):359-72.

Medical Board of Australia. Guidelines and conscious sedation. In: Medical Board of Australia. Update. Issue 3. Melbourne: Medical Board of Australia, December 2011. From: http://www.medicalboard.gov.au/News/2011-12-16-Newsletter-from-the-Medical-Board.aspx Accessed 31 July 2014.

Miner JR, Burton JH. Clinical practice advisory: Emergency department procedural sedation with propofol. Ann Emerg Med 2007;50(2):182-7.

Vargo JJ, Ahmad AS, Aslanian HR, Buscaglia JM, Das AM, Desilets DJ, et al. Training in patient monitoring and sedation and analgesia. Gastrointest Endosc 2007;66(1):7-10.

Professional documents of the Australian and New Zealand College of Anaesthetists (ANZCA) are intended to apply wherever anaesthesia is administered and perioperative medicine practised within Australia and New Zealand. It is the responsibility of each practitioner to have express regard to the particular circumstances of each case, and the application of these ANZCA documents in each case. It is recognised that there may be exceptional situations (for example, some emergencies) in which the interests of patients override the requirement for compliance with some or all of these ANZCA documents. Each document is prepared in the context of the entire body of the College's professional documents, and should be interpreted in this way.

ANZCA professional documents are reviewed from time to time, and it is the responsibility of each practitioner to ensure that he or she has obtained the current version which is available from the College website (www.anzca.edu.au). The professional documents have been prepared having regard to the information available at the time of their preparation, and practitioners should therefore take into account any information that may have been published or has become available subsequently.

Whilst ANZCA endeavours to ensure that its professional documents are as current as possible at the time of their preparation, it takes no responsibility for matters arising from changed circumstances or information or material which may have become available subsequently.

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