

SURVIVING SEDATION GUIDELINES 2015

SEDATION FOR ACUTE PSYCHIATRIC AGITATION

RAPID ABCDE ASSESSMENT & CONSIDERATION of MENTAL HEALTH and ANAESTHETIC RISKS

MENTAL HEALTH SAFETY RISK	ANAESTHETIC RISK		
	LOW RISK	MEDIUM RISK	HIGH RISK
	Thin, fit fasted, known easy airway	ASA II or III, unfasted or unknown airway	ASA IV, old, sick, obese, OSA, COPD, difficult airway etc
LOW RISK flat affect, low suicide risk, thought disordered with insight	Low risk verbal reassurance, safe disposition plan	Safe disposition plan No physical restraint parenteral drugs with oral monotherapy	Try to avoid pharmacotherapy. Reassure & orientate Enlist family & carers
MEDIUM RISK intoxicated, disinhibited, no insight, unpredictable	if sedation required, aim for minimal dose SAT 0 to -1	Aim for sedation SAT 0 titrate monotherapy have airway kit ready	Aim for SAT 0 to +1 using short-acting agents Airway ready for RSI
HIGH RISK known forensic history, weapons, agitated, aggression	Consider rapid 'takedown' if unsafe Be ready for advanced airway management	Sedation to occur in fully monitored area with all airway equipment & monitoring, RSI ready	Difficult scenario - ketamine may be best option with plan to RSI if required. Physical restraints if safe

Use only approved restraints - preferably one staff member per limb & head

	NO IV ACCESS	IV ACCESS ESTABLISHED
1st line	Olanzapine wafer 10-20mg PO (max 30mg/24hr) +/- Diazepam 10-20 mg	IV Droperidol 5-10mg (max dose 20mg/24hr)
2nd line	Droperidol 10mg IM	IV ketamine 1-1.5 mg/kg to SAT
3rd line	Ketamine 4mg/kg IM	Consider RSI ONLY if absolutely necessary

RAPID ASSESSMENT

Look for & Treat reversible causes of AIRWAY, BREATHING, CIRCULATION, DISABILITY
Provide low stimulus & calm ENVIRONMENT

Look for & exclude OD or Toxidromes

Consider EMPTY BLADDER & NICOTINE REPLACEMENT

Check ECG & BGL on agitated patients ASAP

MONITORING

Proceed as for PROCEDURAL SEDATION

Suction, Oxygen, Basic & Advanced Airway (inc Difficult Airway) Equipment available

Establish an Airway Plan and Team Brief

Monitor BP, HR, SpO2, ETCO2, RR
PROVIDE SUPPLEMENTAL OXYGEN

Use a SEDATION ASSESSMENT TOOL (SAT)
TARGET THE TREATMENT TO SAT score (see overleaf)

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Oral meds as combination antipsychotic & benzo to max recommended dose; IM given via gluteal (outer quadrant) or lateral thigh or deltoid
Give IV drugs to large vein - mid forearm preferred as ante-cubital can kink & prevent drug administration. Secure IVs to prevent removal.

NB: Ketamine infusion has been adopted by some retrieval services to facilitate transfer of agitated patients and minimise risks of intubation and ventilation - commence only after discussion with retrieval service & appropriate initial loading

SEDATION ASSESSMENT TOOL (SAT)

SAT	Responsiveness	Speech
3	combative, violent, out of control	continual loud outbursts
+2	very anxious & agitated	loud outbursts
+1	anxious or restless	normal, talkative
0	awake & calm, cooperative	normal
-1	asleep, rouses to voice	slurring or marked slowing
-2	responds to physical stimulation	few recognisable words
-3	no response to stimulation	nil

GENERAL PRINCIPLES

Select one sedative (benzo) and one antipsychotic agent and titrate these to a targeted SAT
Avoid switching agents/classes as unpredictable
Use longer acting agents where possible, to avoid the roller coaster effect of agitation/over-sedation

If using RAPID TAKEDOWN agents, be prepared to MANAGE THE AIRWAY inc. RSI & CICO

Assessment should occur in a designated safe area of hospital (available exits & duress alarms)
Assess situation and patient including airway, anaesthesia and risk to self and others

Administer medications with patient supine, one staff member to each limb and one to give drugs
AVOID PRONE RESTRAINT