SURVIVING SEDATION GUIDELINES 2015

SEDATION FOR ACUTE PSYCHIATRIC AGITATION

RAPID ABCDE ASSESSMENT & CONSIDERATION of MENTAL HEALTH and ANAESTHETIC RISKS

	ANAESTHETIC RISK		
MENTAL HEALTH SAFETY RISK	**LOW RISK** Thin, fit fasted, known easy airway	**MEDIUM RISK** ASA II or III, unfasted or unknown airway	**HIGH RISK** 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 oarenteral 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
Position at 45 degrees head up to maximise SV & minimise aspiration risk

	NO IV ACCESS	IV ACCESS ESTABLISHED
1st line	Olanzapine 10-20mg PO (max 30mg/24hr) +/- Diazepam 10-20 mg	IV Haloperidol or Droperidol 5-10mg (max dose 20mg/24hr)
2nd line	Haloperidol or 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 EMPTYING the 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)

Authorship & Disclaimer : Dr Minh le Cong, Dr Andy Buck, Dr George Douros, Dr Casey Parker, Dr Tim Leeuwenburg. This guideline is meant as consensus recommendations on how to safely manage the acutely agitated patient. It considers psychiatric sedation as a high risk activity requiring assessment of mental health safety and airway/anaesthetic risks. It is based on the clinical expertise and research of the authors.

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Oral meds as combination antipsychotic & benzo to max recommended dose; IM via gluteal (outer upper quadrant), 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

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