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| Caring for people displaying acute behavioural disturbance  Clinical guidance supplement |

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1. Guidance production process

## Topic Selection

In 2018, Safer Care Victoria’s (SCV) Emergency Care Clinical Network hosted a strategy day attended by more than 160 clinicians from across the emergency care sector. Attendees at this day identified improving the care of people displaying behaviours of concern as a priority focus area.

We subsequently formed a phase one expert working group to scope and prioritise improvement ideas. After reviewing literature, collecting data and consulting with Victorian healthcare stakeholders, one of the recommendations was to develop statewide evidence-based clinical guidance. The purpose of this guidance is to support person-centred, evidence-based practice and reduce unwarranted variation in care.

### Scope

The guidance is intended for use by emergency care clinicians in Victoria. Table 1 describes the scope of the guidance.

Table : Scope of the clinical guidance

| In scope | Out of scope |
| --- | --- |
| Adult patients (16–65 years of age) | Paediatric patients |
| Urgent care centres | Clear organic cause for acute behavioural disturbance (e.g. dementia, delirium, closed head injury) |
| Emergency departments | Care after discharge or transfer from an emergency department or urgent care centre |
| Transitions of care in and out of emergency departments or urgent care centres | Providing clinical guidance to Victoria Police |
|  | Prehospital care\* |

\* While out of scope, our guidance may be suitable to adapt.

## Expert working group

We formed a phase two expert working group to develop the clinical guidance. The group, listed in   
Table 2, consisted of three healthcare consumer representatives, 13 clinical experts and two SCV staff members.

The Network’s Governance Committee appointed the chair of the expert working group, and all other members were selected through an expression of interest process open for three weeks. Applicants were asked to submit one paragraph outlining why they were interested in being involved and any relevant experience or skills. All expressions of interest were reviewed by SCV staff and final membership of the group was endorsed by the working group chair and the Network clinical lead.

Table : Expert working group membership

| Name | Role | Affiliation |
| --- | --- | --- |
| Thomas Chan (chair) | Emergency Physician Director of Emergency Department | Austin Health |
| Kristy Austin | National Standards Accreditation Lead | Ambulance Victoria |
| Shaun Baxter | Emergency Physician  Retrieval Physician | Alfred Health  Adult Retrieval Victoria |
| Scott Bennetts | Manager, Clinical Practice Guidelines | Ambulance Victoria |
| Simon Craig | Emergency Physician | Monash Health |
| Sim Crawford | Consumer representative | Community |
| Jo Colvin | Emergency Department Alcohol and Other Drug Nurse Practitioner | Latrobe Regional Hospital |
| Dan Crompton | Emergency Physician Director of Emergency Services  Retrieval Physician Director of Education and Training | Bass Coast Health (Wonthaggi Hospital)  Adult Retrieval Victoria |
| John Cunning | Clinical Nurse Specialist (Psychiatry) Associate Director of Nursing | Benalla Health |
| Cathy Daniel | Consultation Liaison Nurse  Coordinator of Postgraduate Mental Health Nursing | Royal Melbourne Hospital  University of Melbourne |
| Claire Doherty | Project Lead, Emergency Care Clinical Network | Safer Care Victoria |
| Daniel Eltringham | Emergency Department Drug and Alcohol Care Coordinator | Bendigo Health |
| Liz Flemming-Judge | Consumer representative | Community |
| James Fowler | Clinical Fellow, Emergency Care Clinical Network | Safer Care Victoria |
| Kate James | Emergency Department Clinical Nurse Specialist | Werribee Mercy Hospital |
| Cristina Roman | Emergency Department Pharmacist | Alfred Health |
| Frances Sanders | Consumer representative | Community |
| Penny Whelan | Emergency Department Nurse Unit Manager | Goulburn Valley Health |

### Healthcare consumer involvement

Healthcare consumers are people, families and carers who are current or potential users of health services. All consumers included in our group have lived experience of behaviours of concern in emergency care settings.

All consumers were offered orientation to SCV and the Network and were reimbursed for their time and travel expenses. To support safe participation, consumers were given access to the Department of Health and Human Services (DHHS) employee assistance program. Consumers were also offered the opportunity to debrief with SCV staff and the working group chair after every meeting.

### Conflicts of interest

Expert working group members were required to declare any conflicts of interest in a formal declaration when joining the group. No relevant conflicts were identified.

## Methodology to produce the guidance

### Production timeline

May 2019–April 2020.

### Decision to endorse, adapt or develop

In line with SCV’s [evidence-based guidance strategy](https://www.bettersafercare.vic.gov.au/reports-and-publications/evidence-based-guidance-a-new-approach-to-sharing-best-practice), we evaluated existing guidance relating to people displaying acute behavioural disturbance for applicability and methodological rigour. Shortlisted guidance was evaluated by at least two expert working group members. High-scoring guidance was evaluated by at least three members, including one consumer representative.

After evaluation we decided to adapt, with permission, the Alfred Health ‘Physical and mechanical restraint: assessment and application guideline’ for our ‘Physical and mechanical restraint and ongoing care while restrained’ section only.

### Search method to review the evidence

We developed the guidance using a basic search strategy involving both a formal and informal approach. Evidence sources included academic literature, legislation, government documents and grey literature.

#### Databases searched

* EbscoHost: Academic Search Complete; Psych and Behavioral Science Collection; SocIndex
* OVID: MEDLINE; PsychInfo
* Scopus
* Cochrane Library
* INFORMIT: Health Collection; CINCH (Australian Institute of Criminology); FAMILY (Australian Institute of Family Studies); Humanities and Social Science Collection; Australian Policy Observatory
* Google Scholar

#### Keywords

Keywords used in the basic search strategy included: acute behavioural disturbance, aggression, agitation, assessment, behaviour of concern, behavioural escalation, best practice, clinical guidance, continuing care, critical care, debrief, de-escalation, difficult behaviour, discharge, distress, emergency, emergency department, framework, guideline, handover, incident, mental health, oncall GP, paramedic, policy, post-discharge, post-incident, post-sedation, prehospital, psychomotor agitation, referral, restraint, risk assessment, sedation, situational crisis, transfer, urgent care and violence.

### Reviewed evidence

A bibliography of evidence the expert working group reviewed is included in Appendix 1. Not all reviewed evidence directly informed our guidance. We graded reviewed evidence according to the levels of evidence described in Table 3. These are based on the National Health and Medical Research Council’s (NHMRC) 2009 levels of evidence and grades for recommendations for developers of guidelines. Note that the definitions for level V and consensus differ from that proposed by the NHMRC. The expert working group decided to introduce these levels of evidence to reflect the importance of lived experiences of care and consensus statements from respected authorities.

Table : Levels of evidence

| Level | Description |
| --- | --- |
| I | Evidence obtained from a systematic review of all relevant randomised controlled trials |
| II | Evidence obtained from at least one properly designed randomised controlled trial |
| III-1 | Evidence obtained from well-designed, pseudo-randomised controlled trials |
| III-2 | Evidence obtained from comparative studies with concurrent controls, including reviews of such studies. Examples include cohort studies, case-control studies, non-randomised experimental trials, interrupted time series with a control group |
| III-3 | Evidence obtained from comparative studies without concurrent controls, including reviews of such studies. Examples include historical control studies, two or more single-arm studies, interrupted time series without a parallel control group |
| IV | Evidence obtained from case series with either post-test or pre-test/post-test outcomes |
| V | Evidence obtained from single descriptive or qualitative studies, including reports of lived experiences of care |
| Consensus | Expert opinions based on respected authorities or reports of expert committees |
| N/A | Evidence that cannot be graded, such as legislation |

Table 4 summarises the levels of evidence for each section of our guidance as an indication of what type of evidence was identified and reviewed.

Table : Level of evidence summary for each guidance section

|  | Level I | Level II | Level III-1 | Level III-2 | Level III-3 | Level IV | Level V | Consensus | N/A |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Assessment | 1 | 0 | 0 | 6 | 2 | 0 | 9 | 18 | 0 |
| Transition from prehospital care | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 1 |
| De-escalation | 5 | 0 | 0 | 0 | 2 | 0 | 7 | 8 | 0 |
| Sedation and ongoing care  post-sedation | 1 | 6 | 0 | 6 | 1 | 4 | 0 | 6 | 0 |
| Physical and mechanical restraint and ongoing care while restrained | 3 | 0 | 0 | 2 | 10 | 1 | 12 | 4 | 0 |
| Transition from the emergency care setting | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 1 |
| After the person has left the emergency care setting | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 4 | 1 |

## Reaching consensus

Consensus was reached among expert working group members through discussion, as summarised by the chair. Where consensus could not be reached on a matter, the chair could choose for it be decided by a simple majority vote, or by referral to the Network’s Governance Committee for determination.

SCV staff members were responsible for the guidance creation process and for preparing the guidance supplement. They did not have casting votes for the purposes of consensus building or decision making in the group.

## Consultation

### Public consultation

We performed a four-week open public consultation on our guidance in February 2020. This was an opportunity for individuals and organisations to have input into the content and structure of the guidance. Feedback was collected through an electronic survey accessible via the SCV website. A public consultation report is included in Appendix 2.

### Targeted consultation

We performed a targeted, face-to-face consultation with the following organisations:

* DHHS mental health branch and lived experience workforce
* DHHS violence in healthcare reference group
* Australian Nursing and Midwifery Federation, Victorian branch
* Victorian Mental Health Complaints Commissioner.

## Review

In line with SCV’s evidence-based guidance strategy, this guidance will be reviewed at least every five years, or more frequently if required, to reflect any changes in evidence and best practice. The latest possible review date is April 2025.

Feedback or changes in practice context in between scheduled revisions may prompt adjustments to the guidance. The decision to update the guidance in between scheduled review cycles will be made by the Network’s Governance Committee in collaboration with previous expert working group members or topic experts as required.

The expert working group identified the following changes in practice context as possible triggers for review or adjustment to the guidance:

* changes to relevant legislation such as the *Mental Health Act 2014*
* sentinel events relating to care recommended in this guidance
* changes to statewide models of care for people displaying behaviours of concern, for example full implementation of the emergency mental health and alcohol and other drug (AOD) hubs.

## Future research priorities

Based on their work producing this guidance, and their experience and knowledge, expert working group members identified the following future research priorities:

* determining the effectiveness of different de-escalation techniques, including when and with what types of people they should be used
* assessing any long-term effects of ketamine administration
* determining the most appropriate population for ketamine administration
* determining specific risks associated with different physical and mechanical restraint techniques, and the best technique to use with different populations
* establishing reliable reporting and auditable measures for the use of restrictive practices in emergency care settings.

2. Governance

## Approval

This guidance was approved by the Network’s Governance Committee and SCV Centres of Clinical Excellence Director in April 2020.

## Funding

No financial support was received to enable the development, publication and dissemination of this guidance.

Appendix 1: Reviewed evidence

Table A: Levels of evidence

|  |  |
| --- | --- |
| Level | Description |
| I | Evidence obtained from a systematic review of all relevant randomised controlled trials |
| II | Evidence obtained from at least one properly designed randomised controlled trial |
| III-1 | Evidence obtained from well-designed, pseudo-randomised controlled trials |
| III-2 | Evidence obtained from comparative studies with concurrent controls, including reviews of such studies. Examples include cohort studies, case-control studies, non-randomised experimental trials, interrupted time series with a control group |
| III-3 | Evidence obtained from comparative studies without concurrent controls, including reviews of such studies. Examples include historical control studies, two or more single-arm studies, interrupted time series without a parallel control group |
| IV | Evidence obtained from case series with either post-test or pre-test/post-test outcomes |
| V | Evidence obtained from single descriptive or qualitative studies, including reports of lived experiences of care |
| Consensus | Expert opinions based on respected authorities or reports of expert committees |
| N/A | Evidence that cannot be graded, such as legislation |

### Assessment

Table A: Level of evidence summary: assessment section

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Level  I | Level  II | Level  III-1 | Level  III-2 | Level  III-3 | Level  IV | Level  V | Consensus | N/A |
| Total number | 1 | 0 | 0 | 6 | 2 | 0 | 9 | 18 | 0 |

Alam A, Rachal J, Tucci VT, Moukaddam N. Emergency department medical clearance of patients with psychiatric or behavioral emergencies, Part 2: Special Psychiatric Populations and Considerations. Psychiatric Clinics of North America [Internet]. 2017 [cited 2019];40(3):425–33.

Calver LA, Stokes B, Isbister GK. Sedation assessment tool to score acute behavioural disturbance in the emergency department. Emergency Medicine Australasia [Internet]. 2011 [cited 2019];23(6):732-40.

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Knott J, Gerdtz M, Dobson S, Daniel C, Graudins A, Mitra B, et al. Restrictive Interventions in Emergency Departments: A Review of Current Clinical Practice [Internet]. Melbourne: Department of Health and Human Services; 2019 [cited 2020]. 29pp. Available from: <https://www2.health.vic.gov.au/about/publications/researchandreports/restrictive-interventions-emergency-departments-review>

Luck L, Jackson D, Usher K. STAMP: components of observable behaviour that indicate potential for patient violence in emergency departments. Journal of Advanced Nursing [Internet]. 2007 [cited 2019];59(1):11–19.

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Ryan CJ, Callaghan S. The impact on clinical practice of the 2015 reforms to the New South Wales Mental Health Act. Australasian Psychiatry [Internet]. 2017 [cited 2019];25(1):43–7.

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Zeller SL, Rhoades RW. Systematic reviews of assessment measures and pharmacologic treatments for agitation. Clinical Therapeutics [Internet]. 2010 [cited 2019];32(3):403–25.

### Transition from prehospital care

Table A: Level of evidence summary: transition from prehospital care section

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Level  I | Level  II | Level  III-1 | Level  III-2 | Level  III-3 | Level  IV | Level  V | Consensus | N/A |
| Total number | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 1 |

Australian Commission on Safety and Quality in Health Care [Internet]. Sydney: ACSQHC; 2017. Communication at clinical handover; 2019 [cited 2019]. Available from: <https://www.safetyandquality.gov.au/standards/nsqhs-standards/communicating-safety-standard/communication-clinical-handover>

Australian Charter of Healthcare Rights [Internet]. 2nd edn. Sydney: ACSQHC; 2019. 1 p. Available from: https://www.safetyandquality.gov.au/your-rights

### De-escalation

Table A: Level of evidence summary: de-escalation section

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Level  I | Level  II | Level  III-1 | Level  III-2 | Level  III-3 | Level  IV | Level V | Consensus | N/A |
| Total number | 5 | 0 | 0 | 0 | 2 | 0 | 7 | 8 | 0 |

D’Ettorre G, Pellicani V, Mazzotta M, Vullo A. Preventing and managing workplace violence against healthcare workers in emergency departments. Acta Bio-Medica: Atenei Parmensis [Internet]. 2018 [cited 2019];89(4–S):28–36.

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### Sedation and ongoing care post-sedation

Table A: Level of evidence summary: sedation and ongoing care post-sedation section

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Level  I | Level  II | Level  III-1 | Level  III-2 | Level  III-3 | Level  IV | Level  V | Consensus | N/A |
| Total number | 1 | 6 | 0 | 6 | 1 | 4 | 0 | 6 | 0 |

ACEM, ANZCA, CICM, RANZCP. Guidelines for safe care for patients sedated in health care facilities for acute behavioural disturbance [Internet]. Melbourne: ANZCA; 2018 [cited 2019]. Available from: http://www.anzca.edu.au/documents/ps63-2018-guidelines-for-safe-care-for-patients-se.pdf

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### Physical and mechanical restraint and ongoing care while restrained

Table A: Level of evidence summary: physical and mechanical restraint and ongoing care while restrained section

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Level  I | Level  II | Level  III-1 | Level  III-2 | Level  III-3 | Level  IV | Level  V | Consensus | N/A |
| Total number | 3 | 0 | 0 | 2 | 10 | 1 | 12 | 4 | 0 |

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### Transition from the emergency care setting

Table A: Level of evidence summary: transition from emergency care setting section

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Level  I | Level  II | Level  III-1 | Level  III-2 | Level  III-3 | Level  IV | Level  V | Consensus | N/A |
| Total number | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 1 |

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### Staff support and case review

Table A: Level of evidence summary: staff support and case review section

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Level  I | Level  II | Level  III-1 | Level  III-2 | Level  III-3 | Level  IV | Level  V | Consensus | N/A |
| Total number | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 4 | 1 |

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Appendix 2: Public consultation report

We asked for your view on Safer Care Victoria’s (SCV) clinical guidance on caring for people displaying acute behavioural disturbance in emergency settings. This new clinical guidance aims to support emergency clinicians to provide person-centred, evidence-based care. With your help we have finalised the guidance, now available at safercare.vic.gov.au

## Purpose

Improving the care of people displaying acute behavioural disturbance is a priority focus area for SCV’s Emergency Care Clinical Network. With the help of experts including clinicians and healthcare consumers we produced some new clinical guidance to support person-centred, evidence-base care.

We invited feedback from the public to help us make sure our guidance was practical, appropriate and useful.

This summary includes public consultation key insights and themes, as well as how public feedback helped us shape the final guidance.

## How we engaged

The draft clinical guidance, visual summary, and supplement outlining our development method and supporting evidence was available for public consultation over a four-week period in February 2020. Feedback was invited through an electronic survey.

We received 68 online contributions through the electronic survey and five direct email submissions.

## who provided feedback

Seventy per cent of responses were from individuals, most of whom were nurses (**Figure 1**). The remaining 30 per cent of responses were from a variety of groups (**Figure 2**).

Figure : What best describes your role?

Figure : What best describes your group?

## 

## what you told us

Your responses to our public consultation questions, key insights and how they shaped the final guidance are summarised in **Table 1**.

There was very positive sentiment towards the wording, language and structure of the guidance. We made only slight adjustments to the wording.

Of 20 respondents who said we had not considered all relevant and important evidence, three provided additional evidence. We reviewed this evidence and it is now included in our bibliography.

Respondents made several suggestions for how the care we recommend could be more appropriate and acceptable. The summary in Table 1 is not exhaustive.

There was also positive sentiment towards our visual summary, and we used this feedback to help us refine the design.

Table : Public consultation question responses and key insights

| Consultation question | Responded yes | What you told us | How this shaped the final guidance |
| --- | --- | --- | --- |
| Is the wording respectful to healthcare consumers, healthcare staff and the public? | 92% | The wording could demonstrate deeper understanding of people with intellectual disabilities such as autism | Adjusted language to reflect that people with intellectual disabilities usually only display acute behavioural disturbance when there is an underlying cause |
| Is the guidance easy to read and understand? | 91% | The structure and language is easy to understand | No significant adjustments to structure or language |
| Has the guidance considered all relevant and important evidence that you know of? | 69% | There are several helpful existing resources you could link to | Added links to DHHS resources on code grey, weapons management and staff support |
| Does the guidance recommend care that you consider appropriate and acceptable? | 77% | * Nicotine withdrawal is a common cause of acute behavioural disturbance * The intent of section 7 is not clear. It does not distinguish between psychological and operational review   You have missed opportunities to integrate with existing health service resources | * Added nicotine withdrawal to Table 3 and emphasised importance of early treatment * Renamed section 7. Restructured section to reflect differences between staff support and case review   Added references to health services’ individual code grey responses and incident management systems |
| Is the visual summary clear and easy to follow? | 89% | The colours make the visual summary hard to use. It is a bit cluttered | Changed the colours.  De-cluttered and refined the design |
| Does the visual summary accurately reflect the contents of the guidance? | 95% | The visual summary could highlight the importance of staff safety and repeated assessment | Added graphic prompts to highlight staff safety and ongoing/repeated assessment |

