Safer Care Victoria

Caring for people displaying acute behavioural disturbance in emergency settings

A3 visual summary to be used with Safer Care Victoria's clinical guidance *Caring for people displaying acute behavioural disturbance*

Maintain safety for all: Know when and how to call for help

Ongoing and repeat assessment: When the situation changes or with new information. Identify how to best support the person

Assessment
pages 4–6

Consider past experiences and individual needs of the person

Optimise assessment environment
- A safe space with minimal distractions
- Use a BAR if available, or high-acuity space
- Know when to call for help

Initial assessment
- Seek information from many sources
- Assess underlying cause, consider 'red flag indicators'
- Use the SAT and STAMP framework

Transition from prehospital care
page 7–8

Pre-arrival notification

Prepare for arrival
- Assemble a team
- Allocate a care space
- Discuss possible support and de-escalation strategies

Handover
- Use a structured handover tool
- Communicate key information

De-escalation
pages 9–10

- Consider the impact of gender identity, cultural identity, language, trauma history and individual needs
- Assign **one** staff member as the lead communicator

Apply principles of de-escalation
- Non-verbal communication
- Verbal communication
- Environment

Follow the stages of verbal de-escalation
- Get started
- Listen. Work out what the problem is
- Find solutions

Sedation and ongoing care
pages 11–14

- Consider less restrictive options and legal requirements
- Aim for the person to be **drowsy but rousable** with a SAT score of –1 or 0

Oral sedation
5-20 mg diazepam and/or 5–10 mg olanzapine

Parenteral sedation
- For most people: 5–10 mg IM droperidol × 2
- For people with psychostimulant toxicity or alcohol withdrawal consider adding: 5–10 mg IM midazolam × 2
- When safety is at extraordinary and immediate risk consider as first line or rescue therapy: 4–5 mg/kg IM ketamine

Safe and vigilant post-sedation care
15-minutely clinical assessment for 1hr, then guided by SAT score

Physical and mechanical restraint
pages 15–18

- Not a therapeutic intervention; always a **last resort**
- Consider legal requirements
- Always for the shortest time possible

Optimise safety for all
- Assemble a team
- Consider individual needs of the person
- Use the safest techniques possible
- Assign **one clinical staff member** to monitor the person's vital signs, head, neck, airway and chest

Preserve dignity and maintain safety
- Document a clinical assessment every 15 minutes
- **Continuously** observe. Offer food, water, toilet, etc.
- Stop restraint as soon as no longer required to prevent serious and imminent harm
- Perform a post-restraint assessment. Offer counselling

Transition from emergency care
pages 19–21

Offer the person options for feedback and debrief

Admit to the appropriate specialty and health service

Discharge with referrals and advice

Staff support and case review
page 22

Consider psychological support for staff

Review the care episode
Communicate review findings and take action

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