PAEDIATRIC ACUTE CARE GUIDELINE	
Behavioural Problems	
Scope (Staff):	All Emergency Department Clinicians
Scope (Area):	Emergency Department

This document should be read in conjunction with this DISCLAIMER
http://kidshealthwa.com/about/disclaimer/

Behavioural Problems

Background

Aims:

- The focus is safety - to prevent the patient from causing damage to themselves, their family, ED staff or the Emergency Department environment
- Prevent disruption to the rest of ED workflow
- Use minimum intervention or force

Actions:

- If there is an immediate risk of physical harm to staff or patients then a **code black** should be called at once (phone 55 and state "Code Black" and your location). This summons immediate attendance of security staff to assist.
- You can also call the PMH Security Department directly on ext 6444 to request their support with aggressive patients
- Your own safety, and the safety of other staff, patients and visitors comes first

ED Staff Should:

- Recognise signs of increasing agitation
- Attempt to avert the event before it deteriorates - respond to these patients as a priority
    - Verbal escalation, posturing and threats usually precede actual physical violence
- Involve the Senior ED Doctor and Senior ED Nursing staff early
- Discuss with the patient or family their concerns and expectations and involve them in the process
- Prepare staff and an area to deal with the expected problem

- Involve the Psychiatric Team (Psychiatric Liaison Nurse or Psychiatric Registrar)
- Ask for Security Staff assistance when required (ext 6444)

De-Escalation:

- Isolate the child - this is to protect themselves, other staff and equipment, and to minimise disruption to the rest of the ED
- The ED **Behavioural Assessment Room** (near the ambulance entrance) can be used for this purpose
- Please ensure that the back door is locked before bringing the patient in, and remove any furniture and objects that could be damaged or used as a weapon (you can leave two chairs, or a mattress and pillow)
- This room can give you a safe space and the time to deal with the situation
- Speak in a calm, non threatening but confident and assertive voice
- Listen actively to the patient
- Offer support - a drink, food, use of a telephone
- Negotiation and attempting to find a solution in a non-threatening manner can refocus the aggressor
- Avoid any language which may further increase the patient's aggression
- Avoid sudden movements, prolonged eye contact and intimidating body language
- Maintain a safe distance between yourself and the patient, and always be aware of where the exit is
- Reorient the aggressor to the facts of the current situation
    - They are in a children's hospital - there are small babies and sick children around them
    - PMH has a zero tolerance for aggression
    - Inappropriate behaviour will not be tolerated
- Ensure adequate staff are present and that Security are on their way
- If verbal de-escalation is unsuccessful, then you move to physical restraint or chemical sedation

Police:

- If police have brought in a patient in handcuffs, they should be removed as soon as an initial assessment is done (and it is deemed safe to do so)
- The police must remain with the patient until an initial management plan is decided

Assessment

- You should make an assessment of whether the current behavioural issue could be due to:
    - Delirium from an underlying medical problem
    - Substance intoxication (e.g. alcohol, prescription or illicit drugs)
    - Behavioural issues
    - Psychiatric disorder

- Attempt to determine the trigger for the current event
- Get as much collateral information as you can from family members present, police and ambulance officers

Management

- Doctors can use the principle of "duty of care" or the relevant mental health care act when giving treatment without consent, however it should be ethical and professional at all times
- Careful documentation is vital in these situations - giving the rationale for the treatment, and that the patient lacked decision making capacity

Initial Management

- Always try to de-escalate the situation by talking to the aggressor first
- If this is unsuccessful, then move to physical restraint or chemical sedation
- Oral sedation is the first line option for chemical sedation - ask the patient if they will take some medication to help calm them
- Parenteral sedation options - IM is usually safer in the first instance in aggressive patients
- Once the risk to staff has been reduced, an IV cannula can be inserted for ongoing IV sedation if required
- IV sedation is very effective - rapid onset, allows titration of the dosage, and shorter duration of action
- Move a violent or aggressive patient to the ED Behavioural Assessment Room immediately to ensure safety for the patient and staff
- Agitated or aggressive patients need 1:1 nursing observation whilst in the Behavioural Assessment Room

Further Management

Physical Restraint:

- The decision to physically restrain a patient is made after consideration of the appropriateness of this action - under psychiatric grounds (e.g. mental health care act), or under duty of care
- The Senior ED Doctor should always be involved in this decision process
- The patient should be restrained in the supine position (not prone)
- Physical restraint must be coordinated with 6 staff to do the job safely and with minimum force
    - 1 person per limb
    - 1 person for the head
    - 1 person (usually ED Doctor) to administer sedatives and insert an IVC
- Other combinations may be decided on a case by case basis, and the Senior ED Doctor must be involved in the decision process

Monitoring After Sedation:

- All patients who are sedated should be nursed in Section 1, and have 1:1 nursing
- The patient should have cardiac monitoring attached and O_2 saturation probe
- Document the level of sedation with the observations
- The patient should have hourly medical reviews by the ED Doctor

Documentation:

- The event must be well documented including
  - Use of physical restraint
  - Drugs given, the rationale for their use, times given
  - That the patient lacked decision making capacity
- A treatment plan should be done in consultation with the Psychiatric Team

Use of the ED Behavioural Assessment Room:

- Can be used for agitated or aggressive patients with behavioural or psychiatric issues
- An aggressive patient should be immediately moved to the room for ongoing assessment
- It is a safe, contained environment where you can attempt to de-escalate an agitated patient by talking to them
- Whilst in the room, the patient must have 1:1 nursing and be under **continuous visual observation**
- The room is only to be used with **non sedated** patients - once sedation is given successfully, the patient must be moved to Section 1 so that monitoring can be attached
- Patients should not be kept in this room for a long period of time (maximum 30 minutes)

Medications

Oral Sedation
• Lorazepam 0.05 mg/kg (max 2mg per dose) and/or • Olanzapine wafers 0.1 mg/kg (max 5mg per dose) or • Quetiapine 0.1 - 1 mg/kg (max 50mg per dose) • Give oral medications 30 - 60 minutes to work before attempting more sedation, it is usually more effective to move to intramuscular or intravenous medications rather than continuing with the oral route
Intramuscular Sedation
• Used when oral sedation is refused or greater sedative effects required due to the clinical situation • Olanzapine 0.1mg/kg (max 5mg per dose) or • Midazolam 0.1 - 0.15 mg/kg (max 10mg per dose) • Review intramuscular sedation after 30 minutes to assess efficacy before attempting more sedation, continue physical restraint until sedative effect is achieved
Intravenous Sedation
• Midazolam 0.1 - 0.15 mg/kg (max 10mg per dose) • This drug works rapidly, you can titrate to the clinical response and repeat doses after 5 minutes

Medication Side Effects
• For most of the above sedative drugs, respiratory depression, airway compromise and hypotension are side effects to watch for • Over-sedation: reverse benzodiazepines with Flumazenil • Paradoxical reactions: increased agitation and anxiety (particularly with benzodiazepines) • Olanzapine can lead to extrapyramidal reactions (dystonia, dyskinesia, oculogyric crisis)

Adverse Events

Treatment for	Dose and Frequency
Lorazepam or Midazolam overdose	Flumazenil • IV dose: 5microgram/kg repeated ◦ Every 60 seconds to a total of 40 micrograms/kg then 2-10 microgram/kg/hour infusion
Extrapyramidal Side Effects (EPSE)	Benztropine • Oral dose: 20-50 microgram/kg 12-24 hourly • IV, IM dose: 20 microgram/kg/dose stat • May repeat after 15 minutes

Discharge Criteria

- A plan for discharge from the ED to an appropriate facility or location in the hospital for ongoing treatment must be expedited
- Options can include admission to the Psychiatric Ward at PMH, admission to a medical ward, consideration of PICU if very sedated, or transfer to the Bentley Adolescent Psychiatric Unit

Nursing

Routine nursing care.

References

1. WA Health, Child and Adolescent Health Service Pharmacy Manual. Arousal and Agitation Drug Management July 2014

This document can be made available in alternative formats on request for a person with a disability.

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