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

Pre-arrival notification

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

Prepare for arrival

- Assemble a team
- Allocate a care space

Handover

- Use a structured handover tool
- Communicate key information

Seating and ongoing care

- 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: 5–10 mg IM midazolam × 2
- When safety is at extraordinary and immediate risk: 4–5 mg/kg IM ketamine

Safe and vigilant post-sedation care

15-minutely clinical assessment for 1hr, then guided by SAT score

De-escalation

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

Assess the stages of verbal de-escalation

- Get started
- Listen: Work out what the problem is
- Find solutions

Apply principles of de-escalation

- Non-verbal communication
- Verbal communication
- Environment

Physical and mechanical restraint

- 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

Admit to the appropriate specialty and health service

Discharge with referrals and advice

Review the care episode

Communicate review findings and take action

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