



# Sedation for Mental Health Patients Awaiting Aeromedical Transfer Guideline

## 1. Background

This guideline has been developed to minimise the risk of adverse events related to the use of prolonged sedation for adult mental health patients in the WA Country Health Service (WACHS) who are awaiting transfer for specialist treatment.

The medication options are designed to be simple to improve practicality of use and likely availability of medications within WACHS sites. It is designed for adults and should not be used for children. For paediatric patients, it is recommended to contact the consulting emergency department physician at Princess Margaret Hospital or Acute Response Team (ART)

This guideline is to be read in conjunction with:

- WACHS [Assessment, Admission, Treatment and Discharge of Mental Health Patients in Emergency Departments and General Wards Policy](#)
- WACHS [Assessment, Admission, Treatment and Discharge of Mental Health Patients in Emergency Department and General Wards Guideline](#)
- Operational Circular [OP 1821/04 Prevention of Workplace Aggression and Violence Policy and Guidelines](#)
- Operational Circular [OP 1821/04 WA Prevention of Workplace Aggression and Violence](#)
- WACHS [Assessment and Management of Interhospital Patient Transfers Policy](#)
- WACHS [Clinical Escalation Including Code Blue Medical Emergency Response \(MER\) Policy](#)
- WACHS [Clinical Observations and Assessments Clinical Practice Standard \(physiological, neurovascular, neurological and fluid balance\)](#)
- WACHS [Restraint and Seclusion Minimisation Clinical Practice Standard](#)
- WACHS [Bladder Management - Catheter Clinical Practice Standard](#)
- Operational Directive [OD 0501/14 Clinical Deterioration Policy](#)
- WACHS [Medication Administration Policy](#)
- Operational Directive [OD 0657/16 Consent to Treatment Policy](#)
- [MR521 WACHS Falls Risk Management Tool \(FRMT\)](#)
- WACHS [Venous Thromboembolism Prevention Clinical Practice Standard](#)
- Department of Health [Guidelines for the Management of nicotine withdrawal and cessation support in nicotine dependent patients](#)
- WACHS [Alcohol and Tobacco Brief Intervention Policy](#)
- WACHS [Administration of the Alcohol and Tobacco Screening Tool and Brief Intervention Procedure](#)

## 2. Guideline

This sedation guideline aims to provide guidance in:

- the safe use of sedative medication and to minimise the risks of harm to the patient that could result from drug treatment
- the emergency use of sedative medication in the anti-psychotic naïve referred patient who is awaiting transfer to an authorised psychiatric hospital under the [Mental Health Act 2014](#) (WA)
- the management of those patients who are already on significant doses of benzodiazepines or antipsychotics; adjustments and/or discussion with a consultant psychiatrist and/or anaesthetist may be required.

### 2.1 Principles

- **Medical assessment, including physical and neurological examination, to exclude underlying organic conditions is to be undertaken within 24 hours.**
- Sedation is only to be used where other psychological and behavioural approaches have failed to de-escalate the disturbed behaviour.
- Optimum level of sedation produces effect of rousable drowsiness i.e. patient sleepy, but rousable when spoken to at normal volume. Recommend using the [MR12A WACHS Sedation Assessment Tool](#) as a means of communicating level of sedation with clinicians – see [Appendix 2](#).
- Patient care will be optimised by compliance with the following policy and guidelines:
  - [Assessment, Admission, Treatment and Discharge of Mental Health Patients in Emergency Departments and General Wards Policy](#)
  - [Assessment, Admission, Treatment and Discharge of Mental Health Patients in Emergency Departments and General Wards Guideline](#)
- Oral administration of sedative medications is to be used before parenteral administration, wherever possible. Where available, alternatives such as syrups or wafers may be used in preference to tablets to aid compliance.
- Intravenous sedation is to be administered with caution. If Midazolam is used for initial sedation, this should be replaced with a longer acting benzodiazepine as soon as clinically possible.
  - An adequate therapeutic dose is to be used to quickly achieve the required level of sedation. Repeated sub-therapeutic doses are undesirable and may lead to a greater total dose of medication.
  - Lower doses are to be used in patients who are dehydrated, intoxicated with drugs or alcohol, medically compromised or elderly.
  - Prescribers are to be aware that a sudden unexpectedly large sedative effect sometimes occurs as a result of non-linear pharmacokinetics of administered drug(s). This effect occurs more often in patients who are frail, have low body fat, or have renal disease.
  - **The advice of the Duty Medical Officer/ Fellow of the Australasian College for Emergency Medicine (FACEM) on call is to be sought if a patient is not adequately sedated after receiving a maximum dose.**

Treatment of the underlying psychiatric disorder is to be instituted from the outset, where appropriate.

- Care is to be taken with antipsychotic-naïve patients, elderly, and those with pre-existing brain damage or impulse control problems: they may respond to smaller doses of drugs, be more sensitive to side-effects, and require more monitoring and observation.
- Use of two or more antipsychotics is generally to be avoided as it increases the risk of QT prolongation, particularly in patients predisposed to cardiac arrhythmias.
- Sedation is usually a temporary measure while awaiting transport to an Authorised Hospital and may be necessary as part of a [Form 4A Authorisation for Transport Order](#).

**Note:**

- It is to be noted that this guideline does not serve as a substitute for the safe and timely transfer of a referred patient to an authorised hospital and speedy transfer is of primary importance in avoiding adverse outcomes. This is particularly so in individuals who seem to develop tachyphylaxis to sedative medication or appear to not respond to maximal doses of sedating medication.
- Clinicians should consider seeking advice from existing services (e.g. Regional on-call Psychiatrist if available, or RuralLink on-call Psychiatrist, or Emergency Telehealth Service).
- If transport providers are unable to provide timely transfer (within 24 hours), escalation and communication in relation to the transport situation must be made to the Senior Medical Officer and Regional Medical Director.
- Where delay in transfer results in adverse outcome for the patient it is to be documented as a trackable event.
- Referred patients and/or families are to be informed, where appropriate, as to the expected time of transport to an authorised facility and the need for intravenous lines, indwelling catheters etc. being inserted where clinically indicated. Attempts should be made to obtain informed consent where possible and clinically appropriate.
- Where airway management becomes a priority as a result of ongoing agitation as a side effect of sedative medication or other reasons (such as an anatomical problem with the airway or comorbid conditions such as sleep apnoea), the decision to protect the airway through intubation is to be made in consultation with a FACEM/ED/Royal Flying Doctor Service (RFDS) medical officer on call, and this decision documented in the patient health record.
- The legal status of those sedated to protect their safety and/or that of others need to be recorded explicitly in the notes. There should be a clear documentation of whether a patient is competent to accept or decline treatment. The basis of incapacity should also be expressly stated e.g. alcohol intoxication, psychotic episode, severe depression etc.
- A patient may be sedated under duty of care in order to protect their safety and wellbeing. If treatment is provided under duty of care there is no form but a note should be made in the medical record of what and how the treatment was provided.
- Where a patient is referred for assessment under the MHA, and they refuse or are unable to consent to treatment because of their mental state, Emergency Psychiatric Treatment (EPT) may be initiated to save the person's life or prevent the person behaving in a way that is likely to result in serious physical injury to self or others. In those circumstances, a [Form 9A Record of Emergency Psychiatric Treatment](#) must be completed, a copy kept on the patient health record and a copy forwarded to the Office of Chief Psychiatrist (OCP). EPT does not apply to the provision of seclusion or restraint.

## 2.2 Contraindications / Precautions

Sedation must be used with extreme caution, taking into consideration all of the circumstances and risks, including:

- upper airway abnormalities which may cause obstruction (including patients with stridor, obstructive sleep apnoea syndrome, facial/neck abnormalities, syndromes with craniofacial abnormalities e.g. micrognathia, Apert's syndrome, Pierre Robin)
- abnormalities of the respiratory centre e.g. brainstem tumours, mitochondrial disorders, central hypoventilation
- significant cardiac disease (discuss with senior colleague first)
- patients with reduced sensitivity to CO<sub>2</sub> retention e.g. chronic lung disease, neuromuscular disorders
- significant renal or hepatic dysfunction (discuss with senior colleague first)
- raised intracranial pressure
- severe obesity
- patients with neurological disorders placing them at high risk of aspiration of gastric contents e.g. severe Cerebral Palsy with pseudobulbar palsy, or history of recurrent aspiration, some neuromuscular disorders.

## 2.3 Patient Safety

Sedation is only to be considered in environments where the patient can be safely cared for. Sedation is only to occur where there is access to appropriate staff, resuscitation equipment, and reversal agents to manage potential adverse outcomes. Where possible prior to sedation, a history should be taken to check for past allergies and when the person last ate or drank.

The decision to initiate sedation is to be made concurrently with the availability of suitably competent clinical staff to undertake one to one patient care.

If physical restraint is required to initiate sedation, sufficient numbers of appropriately trained staff will be required, otherwise police assistance will be required to restrain the patient. The use of mechanical restraint should be avoided if at all possible. Refer to WACHS [Restraint and Seclusion Minimisation Clinical Practice Standard](#).

In small sites where resources do not allow the safe care of sedated patients, early transfer to a larger regional centre prior to definitive transfer to the Authorised Hospital is recommended. This requires consultation with the Senior Medical Officer and Coordinator of Nursing.

## 2.4 Required Staffing

Medical staff appropriately credentialed to initiate sedation and to monitor the ongoing care of the patient including capacity to undertake advanced airway management. Registered Nurse (RN) with current Advanced Life Support competency to be continuously responsible for, the observation of the patient's vital signs, airway patency, adequacy of ventilation, heart rate, blood pressure, and level of sedation for all of the sedation period. This RN must be available to provide one to one care for the duration of the sedation period.

## 2.5 Equipment

In any circumstance where a patient may be sedated, the following emergency resuscitation equipment and medication with all age-appropriate equipment must be available, including:

- functioning suction apparatus with Yankauer sucker attached
- oxygen and appropriate masks
- self-inflating bag and mask with ready access to a range of equipment for advanced airway management
- pulse oximeter and non-invasive end tidal CO<sub>2</sub> monitor
- continuous electrocardiograph monitor
- non-invasive blood pressure monitoring equipment
- intravenous equipment and fluids
- reversal drug agents such as Flumazenil for benzodiazepines
- access to a Medical Emergency Response (MER) Team, or identified MER responders (as per sited Adult and Maternity Observation and Response Escalation and Medical Emergency Response document).

## 2.6 Nursing Practice Standards

- The complexity of nursing care requires the ongoing assessment, monitoring and intervention by an RN. Responsibility cannot be delegated to an enrolled nurse, midwife or unregulated health care worker. Midwives will qualify where they are both an RN and an RM.
- Where an appropriate RN is not available, escalation and communication in relation to the staffing situation must be made to the Nurse Unit Manager (NUM).
- Where possible, prior to sedation, the RN is to explain to the patient and/or carer the purpose of the administration of the sedative agent and subsequent monitoring, this is not the consent to treatment. (See medical standards of care.)
- Nursing staff must be Advanced Life Support competent which include advanced airway skills i.e. administration of oxygen and use of bag-and-mask supported ventilation.
- At the earliest available opportunity:
  - an IV cannula is to be inserted either by an appropriately competent RN or the treating medical practitioner
- To minimise the risk of aspiration of gastric contents, the patient is to be **nil by mouth** for the duration of the sedation period.
- Patient assessment is to include documentation and observation of:
  - Level of alertness/sedation (SAT see MR12A [Appendix 2](#)) and Glasgow Coma Score (GCS)
  - Respiratory rate, pulse oximetry and end-tidal CO<sub>2</sub>
  - Continuous cardiac rhythm and pulse rate
  - Blood Pressure (BP)
  - Evidence of extra-pyramidal side effects (EPSE) for anti-psychotic administration.

- Frequency of observation:
  - Initial, then ten minutely for the first 30 minutes, then:
    - every 15 minutes for the next hour; then
    - every 30 minutes for the next hour; and then
    - every hour thereafter until the patient is ambulatory
  - Four hourly:
    - temperature
    - bedside blood sugar level (BSL)
    - urine output and fluid balance
- Bladder scan if patient has not passed urine every 4 hours, and if volumes >500ml
- IDC insertion if patient is unable to void.
- Refer to the WACHS [Clinical Observations and Assessments Clinical Practice Standard \(physiological, neurovascular, neurological and fluid balance\)](#)
- Patient observations are to be documented on the Adult Observation and Response Chart MR 140a.

**Note: Frequency must be increased and clinical escalation of care as per site Adult and Maternity Observation and Response Escalation and Medical Emergency Response document.**

- Consideration of an indwelling urinary catheter (IDC) will need to be balanced with risk of agitation from the IDC and priority of assessment of accurate patient hydration / renal function. Refer to bladder scanning in WACHS [Bladder Management Catheter Clinical Practice Standard](#).
- Consider leaving this out until definitive transfer. It is recommended that indwelling catheters are not inserted on a routine basis prior to transfer, particularly in Indigenous patients
  - Attempts are to be made to inform the patient and/or family where appropriate, and obtain informed consent where possible, as to the reason for insertion of indwelling catheter.
- Nursing handover is to occur at the bedside using the iSoBAR format.
- Patient is also to be assessed for risk of:
  - Falls prevention - refer to the WACHS [Falls Prevention and Management Clinical Practice Standard](#).
  - Pressure injury prevention and management.
  - Venous thromboembolus - to reduce the risks of Deep Vein Thrombosis / Pulmonary Embolism from prolonged immobilisation, consider the use of TED Stockings and subcutaneous Heparin according to the level of risk. Refer to the WACHS [Venous Thromboembolism Prevention Clinical Practice Standard](#).
  - Nicotine, alcohol or other drug withdrawal as indicated by assessment of the patient's presentation. Refer to the Department of Health [Guidelines for the Management of nicotine withdrawal and cessation support in nicotine dependent patients](#) and WACHS [Alcohol and Tobacco Brief Intervention Policy](#) (June 2010).



- Risk assessment is to occur according to risk tools.
  - [MR521 WACHS Falls Risk Management Tool \(FRMT\)](#).
  - [WACHS Administration of the Alcohol and Tobacco Screening Tool and Brief Intervention Procedure](#) (September 2011).  
(Use VTE/DVT Risk Assessment Tool.)

Appropriate nursing intervention is to be initiated according to the risk identified.

- The patient is to be nursed in the lateral position, with the head of bed flat to allow oral secretions to drain.
- If two or more antipsychotic medications are administered, a 12 lead ECG is to be performed, for measurement of QT interval, if requested by the medical practitioner. If prolonged QT interval is determined, the patient should be considered for monitoring via defibrillator pads.

### 2.7 Medical Standards of Practice

- Medical practitioners responsible for the prescription and administration of sedative drugs must be competent in their use and be aware of the potential risks of sedative drugs:
  - Airway obstruction
  - Respiratory depression
  - Aspiration
  - Excessive sedation
  - Profound hypotension
  - Laryngospasm
  - Extrapyrimal Side Effects (EPSEs): dystonic and involuntary muscle movements
  - Cardiac arrhythmias (QT interval prolongation)
- Medical staff should be familiar with the pharmacology of the sedative agents they will be prescribing, their adverse effect profiles, and the use of appropriate antagonist agents.
- Where possible, prior to sedation, the Medical practitioner is to obtain consent and explain to the patient and/or carer the purpose of the administration of the sedative agent and subsequent monitoring (see [Operational Directive OD 0657/16 Consent to Treatment Policy](#)).
- Consent to treatment under the MHA14 Part 5 Div 1 section 13 - 20
- All medical staff present must be able to initiate resuscitation procedures, including advanced airway management.
- The Medical Practitioner (GP or consultant) must document any modifications to the parameters of the patient's vital signs on the Adult Observation and Response Chart MR 140a. Refer to WACHS [Clinical Escalation Including Code Blue Medical Emergency Response \(MER\) Policy](#) and WACHS [Clinical Observations and Assessments Clinical Practice Standard \(physiological, neurovascular, neurological and fluid balance\)](#).
- Measurement of QT interval for patients prescribed two or more anti-psychotic medications (seek advice when QTc > 450ms in men and > 470ms in women).
- Consider prescription of Benztropine, up to 2mg once to twice daily for prophylaxis or treatment of EPSE.
- Consider use of Flumazenil only under senior clinician advice, and not in the case of polysubstance overdose.

## 2.8 Initial Sedation Options

Please note that the following list is to be considered a starting point for sedative medications and that the number of options has been deliberately kept to a minimum to allow clinicians to gain confidence in the use of a simple regimen. Other medications may be used upon advice of the Consultant Psychiatrist.

### Oral

- **Olanzapine** (wafers if possible) 5 to 10 mg repeat dose if required in two to four hours  
Maximum 30mg/ 24 hours (suggest regular dose of 5-10mg BD)  
Side-effects: Orthostatic hypotension, dizziness.
- **Clonazepam** 1-2mg repeat dose if required in 60 minutes  
Maximum 6 to 8mg/ 24 hours (suggest regular dose of 1-2 mg BD)  
Side-effects: Drowsiness or somnolence (50%), ataxia (30%), behaviour problems (25%), hypersalivation (10%), fatigue (8%), muscle weakness (5%) and vertigo (5%).

### Intramuscular

- **Clonazepam** 1-2mg 30 minutes repeat dose if required in 30 minutes  
Maximum 8mg/ 24 hours  
Side-effects: Cardio-respiratory depression / arrest potential
- **Droperidol** 2.5-5mg repeat dose if required in 30 minutes  
Maximum 20mg/24 hours  
Side-effects: Extrapyramidal reactions, Akathisia, Dystonia, Parkinsonian effects
- **Midazolam** 2.5 mg to 5 mg repeat dose if required in 30 minutes  
Maximum 20mg per event recommended. If dose of 20mg exceeded, then consider institution of longer acting benzodiazepine  
Side-effects: Respiratory depression, hypotension.

### Intravenous

- **Clonazepam** 1-2mg repeat dose if required in 30 minutes  
Maximum 8mg/24 hours (suggest regular dose of 1-2 mg BD)  
Side-effects: Cardio-respiratory depression/arrest potential
- **Droperidol** 2.5-5mg repeat dose only if benzodiazepine titration is ineffective, avoid in neuroleptic naïve (suggest regular dose of 5-10mg BD)  
Maximum 20mg/ 24 hours  
Side-effects: Extrapyramidal reactions, Akathisia, Dystonia, Parkinsonian effects
- **Midazolam** 2.5 mg to 5 mg repeat dose if required in 5 - 10 minutes  
If dose of 20mg exceeded, then consider institution of longer acting benzodiazepine.  
Side-effects: Risk of respiratory depression and unpredictability of effect would suggest that Midazolam should be used as first line only to achieve rapid sedative effect and ongoing benzodiazepine choice should be longer acting alternatives i.e. Clonazepam.

**Alternatively, where the hospital does not stock Clonazepam, use Diazepam 10 - 20mg repeat dose up to four times per day, with a maximum of 80 mg / 24 hours.**



## Other Treatments

### To reduce the risk of aspiration pneumonitis:

Nil by Mouth (NBM) with IV fluids, commensurate with the patient's hydration status, must be applied when sedation is being considered or commences.

- Check potassium level daily if on IV fluid therapy replacement.
- Keep NBM until inter hospital transfer occurs unless otherwise assessed by the medical practitioner as being alert and able to manage diet without risk of aspiration.
- Consider:
  - Metoclopramide 10 mg IVI and repeat dose every six hours
  - Ranitidine 50 mg IVI and repeat dose every six hours.
- Nurse in lateral position with bed flat to allow oral secretions to drain.

To reduce the risk of agitation from nicotine withdrawal, consider the application of a nicotine patch 14 milligram topically every 24 hours.

## 2.9 Bodily Restraint

- **Restraint under the MHA 14 is only to be initiated in an authorised place (MH inpatient units) otherwise restraint occurs under duty of care or through the provisions of Emergency Psychiatric Treatment (EPT).** Services should 'prevent, reduce and ultimately eliminate the use of restraint...' (WACHS [Restraint and Seclusion Minimisation Clinical Practice Standard](#)) This is in accord with widespread recognition that restraint is non-therapeutic, and has significant professional and legal implications for staff. It should only be employed 'when it is the only means available to prevent immediate or imminent harm to the patient or others'.
- Unless any WACHS Emergency Department or site can fully address the necessary training, staffing and governance procedures to meet the principles of restraint minimisation, the use of mechanical restraint should not occur. Keep clear and detailed notes in the medical record at all times as to why a clinical decision to restrain was made and who it was made by (DMO/SMO).

If restraint is conducted prior to EPT, complete the [Form 9A Record of Emergency Psychiatric Treatment](#) and file in the patient health record. Forward a copy (see attached flowchart) to the:

- Office of Chief Psychiatrist
- Regional Clinical Director or delegate, Mental Health Service
- Regional Medical Director
- the patient as soon as practicable.

Discuss the decision with medical colleagues – Rural Link, Community Mental Health Service, RFDS or Psychiatrist – at the earliest opportunity.

- Once mechanical restraint is deployed a minimum level of constant nursing observation (including regular vital signs) is to be ordered and maintained (i.e. deployment of mechanical restraint actually puts even greater onus of responsibility on staff, especially as the patient is also likely to be receiving sedative medication) as per nursing practice standards 2.6. Nurse special should be instituted if not already done.

- Neurovascular Observation chart and VTE/DVT Risk Assessment chart.)
- There is to be regular medical review. Follow the schedule of medical review as stated in the MHA (**every half hour by medical practitioner**), or more regularly.
- At such times of review, consideration is to be given for discontinuing restraint, and the reasons for continuing restraint are to be clearly noted.
- If the person remains restrained for more than 6 hours, a psychiatrist must review the use of bodily restraint on the person and make a record of the results of the review using this form.
- If it is not possible for such frequent medical reviews, there is to be a minimum of eight hourly medical review in a 24 hour period regarding the need to continue mechanical restraint, and this is to be documented in the patient health record.
  - If in authorised hospital, then procedure must conform to requirements under the Act which are 30 minutes reviews and extensions and a nurse (mental Health Practitioner) with the patient at all times.

### 3. Definitions

<b>Clinical Staff</b>	Refers to credentialed medical practitioners, registered nurses and nurse practitioners. Enrolled nurses can play a minimal role
<b>Chief Psychiatrist</b>	Is responsible for overseeing the standards of treatment and care of all involuntary and voluntary patients of a mental health service, mentally impaired accused persons detained in an authorised hospital and those referred under the MHA 2014 for an examination by a psychiatrist (s.508).
<b>Authorised hospital</b>	An authorised hospital is: <ul style="list-style-type: none"> <li>a) a public hospital, or part of a public hospital, in respect of which an order is in force under section 542</li> <li>b) a private hospital the licence of which is endorsed under the <i>Hospitals and Health Services Act 1927</i> (s.541).</li> </ul>
<b>Mental illness</b>	A condition that is characterised by a disturbance of thought, mood, decisions, perception, orientation or memory and impairs (temporarily or permanently) the person's judgement or behaviour.
<b>Mental Health Tribunal (MHT)</b>	An independent review body established under the Act. The Board's primary statutory role is to review involuntary patients, in accordance with the Act (s.380).

<p><b>Authorised Mental Health Practitioner (AMHP)</b></p>	<p>The Chief Psychiatrist may, by order published in the Gazette, designate a mental health practitioner as an authorised mental health practitioner if satisfied that the practitioner has the qualifications, training and experience appropriate for performing the functions of an authorised mental health practitioner under this Act (s.539).</p>
<p><b>Voluntary patient</b></p>	<p>A person to whom treatment is being, or is proposed to be, provided by a mental health service but who is not:</p> <ul style="list-style-type: none"> <li>a) an involuntary patient</li> <li>b) a mentally impaired accused required under the Mentally Impaired Accused Act to be detained at an authorised hospital.</li> </ul>
<p><b>Involuntary patient</b></p>	<p>A person who is under an involuntary inpatient treatment order or an involuntary community (outpatient) treatment order (s.21).</p>
<p><b>Referral for examination MHA 14 (s.29)</b></p>	<p>A medical practitioner or AMHP can refer a person for examination by a psychiatrist if he/she expects on reasonable grounds that that person should be made an involuntary patient. <a href="#">Form 1A - Referral for Examination by Psychiatrist</a></p>
<p><b>Transport to an Authorised Hospital MHA 14 (s.29,63,67,92,112,129,133,148,152,154)</b></p>	<p>To transport the person referred to an authorised hospital or any Other Place for examination, the referrer must make a clinical judgement as to whether the condition of the person is such that assistance with transport is required. If the condition of the person is such that police assistance is required to take the person to the examination, and where no suitable alternative is available, the referrer can make a written <a href="#">Form 4A - Authorisation for Transport Order</a> and <a href="#">Form 4B - Extension of Transport Order</a>, if necessary.</p>
<p><b>Emergency Psychiatric Treatment (EPT) (s 202)</b></p>	<p>EPT is treatment that is necessary to give to a person to save a person's life or prevent a person from behaving in a way that can be expected to result in serious physical harm to the person or others.</p> <p><b>EPT can be given to a person regardless of that person's status under the MHA, informed consent is not required and a record of treatment provided must be filed in accordance with (s202) MHA14.</b></p>
<p><b>Physical restraint</b></p>	<p>Physical restraint is defined under MHA14 in section (227(2)).Physical restraint may be required to enable treatment, but is not considered a treatment in itself. Duty of care provides for the use of physical restraint in non-authorised settings.</p>
<p><b>Mechanical bodily restraint</b></p>	<p>Restraint by mechanical means to prevent the patient from moving his or her body or limbs. Mechanical restraint is defined under MHA14 in section (227(4)).</p>

## 4. Roles and Responsibilities

- 4.1 **Registered Nurse (RN) and registered Midwife – Current registration with APHRA.** Nursing staff must be Advanced Life Support competent which includes advanced airway skills i.e. administration of oxygen and use of bag-and-mask supported ventilation.
- 4.2 **Nurse Practitioner (NP)** is a registered nurse educated and authorised to function autonomously and collaboratively in an advanced and extended clinical role. The scope of practice of the NP is determined by the context in which the NP is authorised to practice. NPs must have current Advanced Life support competence.
- 4.3 **Medical Practitioner:** Refers to a person registered with the WA Medical Board and who is required to practice according to the [Health Practitioner Regulation National Law \(WA\) Act 2010](#), who have current Advanced Life support competence or are credentialed to provide advanced airway management.
- 4.4 **Line / Discipline Managers** are to ensure appropriate staff have achieved competency to perform advanced life support via Capabiliti LMS and medical practitioners are credentialed to provide advanced airway management.

## 5. Evaluation

Audit results are to be reported locally through the regional clinical governance committees and used to identify areas for improvement. In addition, the area Clinical Governance Patient Safety Committee and/or Clinical Risk Review Committee may request results be tabled for review and improvement recommendations to be made.

Number of WACHS intranet views by staff via [HealthPoint Policies](#) available through the WACHS Policy Unit.

## 6. Standards

[National Safety and Quality Health Care Standards](#) (First edition): 4.1.1, 4.1.2

[National Safety and Quality Healthcare Standards](#) (Second edition 2017): 4.3, 4.10

[National Standards for Mental Health Services](#) - 1.3, 1.4, 2.4, 2.5, 6.3, 6.8, 10.5.10

## 7. Legislation

[Mental Health Act 2014](#) (WA)

[Health Practitioner Regulation National Law \(WA\) Act 2010](#)

## 8. References

Taylor, D., Paton, C., and Kirwin, R. 2007. *The Maudsley Prescribing Guidelines*. 9<sup>th</sup> Edition. CRC Press, London, UK.

2003. The Prince Charles Hospital and Health Service District Rapid Tranquillisation Guideline, unpublished.

[Mental Health Act 2014 \(WA\)](#)

[Clinician's Guide to the Mental Health Act 2014 Edition 3, November 2015](#)

[WA Nurses and Midwives Registration Board](#)

[WACHS Sedation Process for Mental Health Patients Flowchart](#)

## 9. Related Forms

[MR12A WACHS Sedation Assessment Tool \(SAT\)](#)

[MR521 WACHS Falls Risk Management Tool \(FRMT\)](#)

## 10. Related Policy Documents

[WACHS Sedation Process for Mental Health Patients Flowchart](#)

[WACHS Assessment, Admission, Treatment and Discharge of Mental Health Patients in Emergency Departments and General Wards Policy](#)

[WACHS Assessment, Admission, Treatment and Discharge of Mental Health Patients in Emergency Department and General Wards Guideline](#)

[WACHS Assessment and Management of Interhospital Patient Transfers Policy](#)

[WACHS Assessment and Management of Interhospital Patient Transfers Policy](#)

[WACHS Administration of the Alcohol and Tobacco Screening Tool and Brief Intervention Procedure](#)

[WACHS Alcohol and Tobacco Brief Intervention Policy](#)

[WACHS Bladder Management - Catheter Clinical Practice Standard](#)

[WACHS Clinical Observations and Assessments Clinical Practice Standard \(physiological, neurovascular, neurological and fluid balance\)](#)

[WACHS Clinical Escalation of Acute Physiological Deterioration including Medical Emergency Response \(MER\) Policy](#)

[WACHS Clinical Observations and Assessments Clinical Practice Standard \(physiological, neurovascular, neurological and fluid balance\)](#)

[WACHS Medication Administration Policy](#)

[WACHS Restraint and Seclusion Minimisation Clinical Practice Standard](#)

[WACHS Venous Thromboembolism Prevention Clinical Practice Standard](#)

## 11. WA Health Policy Framework

[Mental Health Policy Framework](#)

## 12. Appendices

**Appendix 1:** [Sedation Process for Mental Health Patients Flowchart](#)

**Appendix 2:** [MR12A WACHS Sedation Assessment Tool \(SAT\) sample only](#)

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

<b>Contact:</b>	Area Director Clinical Services WACHS Adult & Older Adult Mental Health (R. Main)		
<b>Directorate:</b>	Mental Health	<b>TRIM Record #</b>	ED-CO-14-5541
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# Appendix 2 WACHS Sedation Assessment Tool (SAT)

Hospital / Health Service: \_\_\_\_\_ Ward / Dept: \_\_\_\_\_  
 Consultant: \_\_\_\_\_ RMO / Registrar: \_\_\_\_\_

Surname		UMRN / MRN	
Given Name		DOB	Gender
Address		Post Code	
Telephone			

Intervention Letter (IL) – enter below (see instructions over page)										Date:										Form Number:									
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IL																													
RN/EN Initial																													
Companion Initial																													
Score:	Examples:		Action / Intervention:		Score:	Examples:		Action / Intervention:																					
4	Violent, unable to be de-escalated, poses a risk to staff or other patients. Absconding and at imminent risk to staff / others		<b>Code Black</b>		-1	Reduced emotional reactivity (decreased mood / cognitive function)		Non-pharmacological management Consider triggers (e.g. lack of sleep / single room, lack of activity) <b>Routine team review</b>																					
3	Agitated, pacing, not able to be redirected, appears very distressed, resistant to care, refuses medication, attempting to get out of restraints or to leave ward / hospital, verbally aggressive (yelling / swearing / threatening)		<b>Urgent clinical review</b> Non-pharmacological management (e.g. blood tests / root cause) Adjust regular / prn medications Consider prn sedation		-2	Drowsy but easily rousable		<b>Routine team review</b> Observations																					
2	Wandering, plucking at clothes, distressed / crying out but settles with reassurance, pulling at lines / tubes / dressings, trying to get out of bed		<b>Routine team review</b> Non-pharmacological management Review regular prn / medications Consider increasing frequency of observations		-3	Drowsy, difficult to rouse, difficulty staying awake. Avoiding eye contact / interaction		<b>Urgent clinical review</b> Omit sedative medications + medical review needed Observations / blood glucose																					
1	Mildly agitated or distressed, settles with reassurance. Restless / fidgety / jumpy		<b>Non-pharmacological management</b> If delirium – root cause, e.g. U / A, MSU, pain score		-4	Unconscious, unable to wake patient		<b>Medical Emergency Team (MET)</b>																					
0	Alert, calm, may be mildly confused and needs orientation OR asleep. Compliant with care		<b>Non-pharmacological management</b> as appropriate		<b>Sedated</b>	Patient sedated as per MO instructions		Nurse must be experienced in patient assessment. Maintain airway / breathing. Assess and document depth of sedation using rousability score, and perform / document observations 10 minutely for a minimum of 30 mins from when IV sedation was last administered. <b>Refer to Procedural Sedation CPS</b>																					
<ol style="list-style-type: none"> <li>Patients need to be scored at a minimum every hour. Document the exact time of observation</li> <li>Place a "+" in the area the patient is scoring / an "X" if the patient is asleep / an "S" if sedated</li> <li>Document interventions by letter at the appropriate time and record actual intervention on page 2</li> <li>Patients do not have to exhibit all the behaviours applicable to a particular score</li> <li>Initial for each action / intervention (both RN and companion - see over page)</li> </ol>					<b>Rousability Score</b> 0 = none (awake, alert) 1 = mild, occasionally drowsy 2 = moderate = frequently drowsy (rousable to voice) 3 = difficult to rouse (rousable to pain / stimulus) 4 = unconscious / unrousable																								

MR 12A WACHS SEDATION TOOL (SAT)



# WACHS Sedation for Mental Health Patients Awaiting Aeromedical Transfer Guideline

## Actions / interventions associated with Sedation Assessment signs

- An Intervention Letter (IL) is only to be used by the RN / EN who has signed for that action / intervention and is only valid for that shift. The Nurse allocated to care for this patient must initial the box following discussion with the companion - **NOT the companion, as this is a clinical assessment**. It also ensures the RN / EN is performing a minimum of hourly assessments on the patient, and related interventions.
- If any action / intervention changes AT ALL, a new letter must be used to indicate that same nurse's different actions / interventions
- If ANOTHER nurse assesses the patient, a NEW letter must be used even if the action / intervention is unchanged, as this nurse's signature confirms his / her OWN actions

IL	Action / Intervention	Print Name	Signature
A			
B			
C			
D			
E			
F			
G			
H			
I			
J			
K			
L			

If you administer an action / intervention, Record the IL on the Sedation Assessment over the page in the appropriate time column.

Staff Performing Special – i.e. companion name / signature / designation to be completed EACH shift **(Note: RN / EN supervising the companion must also complete EACH shift)**

Print Name	Initial	Signature	Desig.

Print Name	Initial	Signature	Desig.