



Critical Care Paramedic Programme

Clinical Management Plans

NON-TRAUMATIC AGITATION (INCLUDING ABD)

Introduction

Non-traumatic agitation is frequently encountered by Critical Care Paramedics (CCPs) and has a wide variety of aetiologies. Whilst the agitation itself may not be immediately life threatening, frequently the agitated state prevents the administration of emergency medical treatment and needs to be urgently addressed.

Acute Behavioural Disturbance (ABD, interchangeably known as Excited Delirium) is a rare but serious presentation in the prehospital environment. These patients pose a significant clinical risk to themselves and the health care professionals treating them. The causes of ABD are usually multifactorial but often include mental illness and intoxication with drugs and/or alcohol. The epidemiology in the UK is poorly understood.

This clinical management plan is for use by CCPs within South East Coast Ambulance Service in the context of agitation of a suspected non-traumatic origin, and ABD. It should be used in conjunction with:

- PGD-CCPTBA Ketamine for Severe Agitation (ABD)
- PGD-CCP005 Midazolam Sedation
- CMP Sedation

Initial Approach

As with all incidents, a stepwise approach must be taken to the agitated patient, or patient with suspected ABD. The safety of the rescuer and other healthcare professionals and bystanders remains of the utmost importance. With this in mind, the patient's level of agitation should be assessed using the criteria in Table 1. If the patient is already restrained, best efforts should be made to ascertain their level of agitation prior to restraint.

LEVEL OF AGITATION	DESCRIPTION
Mild	Restless but settles with calm de-escalation and accepts care. Fluctuations in cooperation may exist, but no physical aggression.
Moderate	Agitated and uncooperative. Restless with the potential for physical aggression. De-escalation fails to reduce arousal or acceptance of treatment.
Severe	Agitation with significant physical components including violent behaviour towards people and surroundings. The individual has an inability to engage or comply with instructions and poses a direct risk to self or others. There is also likely to be a degree of physiological derangement, though this may not be captured without monitoring. It is likely to include tachycardia, dysrhythmia, respiratory dysfunction, hyperthermia and underlying metabolic disturbance. <i>**This stage can represent a clear and immediate threat to life and should be treated as a medical emergency**</i>

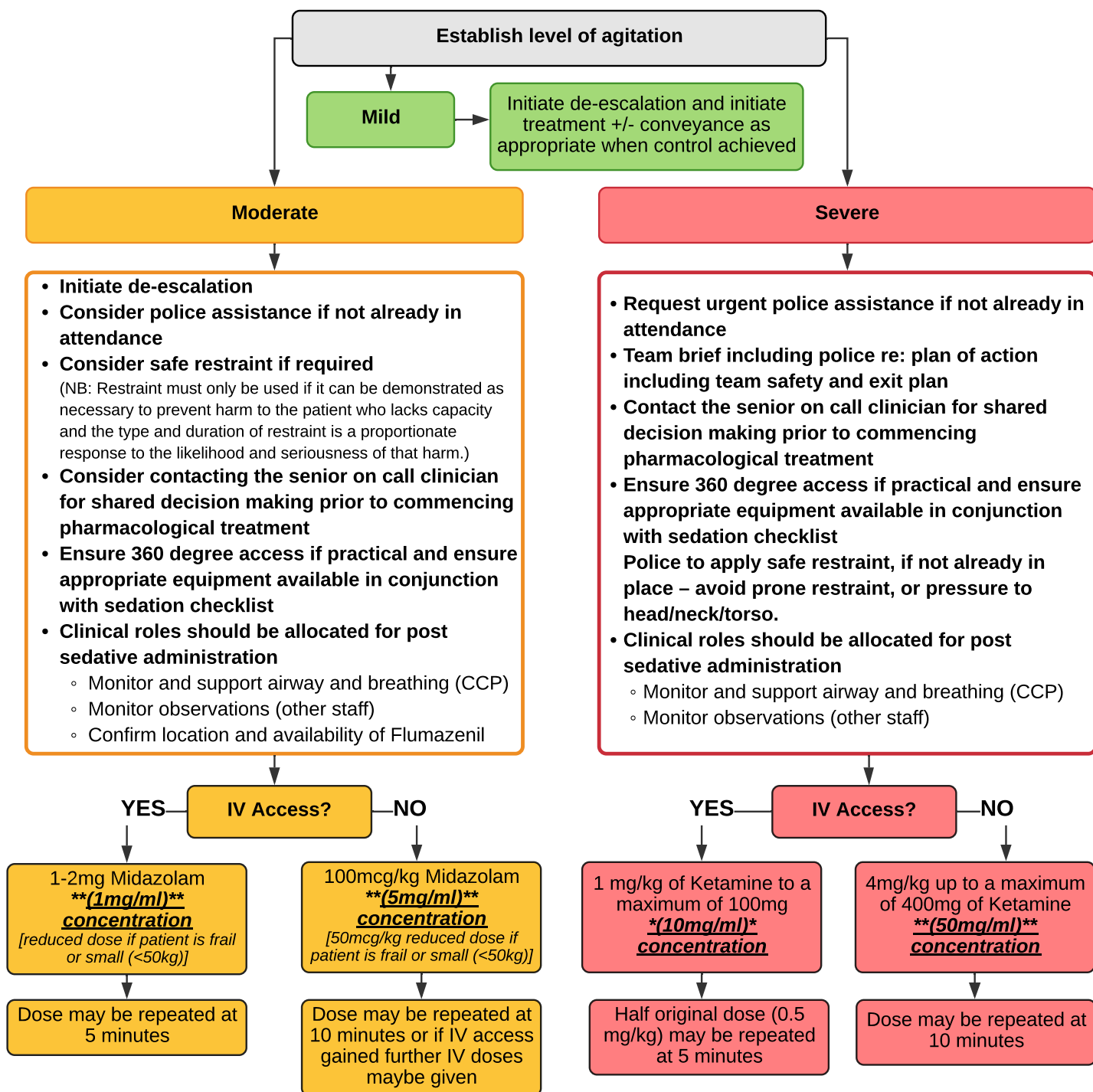
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As soon as control has been achieved

- Optimise patient position (consider lateral positioning)
- Optimise oxygenation – high flow oxygen with NRB or assisted ventilation if required
- Continue safe restraint as required
- Obtain full multi-modality monitoring (ECG, NIBP, SpO2, EtCO2/RR)
- Gain IV access, if not already established, and dispose of any unused IM strength medication.
- Consider contacting the senior on-call clinician regarding ongoing sedation/monitoring needs for transport to hospital, if not discussed in the initial call
- Police to escort during transfer

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Notes

Multi-agent sedation should be avoided – it is generally better to give a higher dose of one agent, than smaller doses of two. However, where the CCP feels multi-agent dosing is necessary, this must be discussed with the senior on-call clinician prior to administration.

All high strength medication must be drawn in to a coloured 2ml syringe and administered via the intramuscular route only. A coloured 2ml syringe must not be used to administer IV medication under any circumstance.

Restraint

Restraint is defined by The Mental Capacity Act 2005 (MCA) as when someone “uses, or threatens to use force to secure the doing of an act which the person resists, OR restricts a person’s liberty whether or not they are resisting”. This may or may not involve the use of force. Restraint does not require the use of physical force, or resistance by the person being restrained, and may include indirect acts of interference for example removing someone’s walking frame to prevent them moving around. (See below for more information on the MCA).

Types of restraint are broadly categorised in the three domains below, these being:

Physical restraint (also known as restrictive physical intervention or safe holding) is defined by the CQC (2018) as any direct physical contact where the intention of the person intervening is to prevent, restrict, or subdue movement of the body, or part of the body of another person.

Mechanical restraint involves ‘the use of a device (e.g. belt or cuff) to prevent, restrict or subdue movement of a person’s body, or part of the body, for the primary purpose of behavioural control’ (CQC, 2018). The use of blanket wraps to restrict movement would also be considered a mechanical restraint.

Chemical Restraint is the use of medication which is prescribed and administered for the purpose of controlling or subduing disturbed/violent behaviour, where it is not prescribed for the treatment of a formally identified physical or mental illness (CQC2018). The deployment of these techniques may inter-relate i.e. physical techniques may be deployed to safely administer medication (chemical restraint). In addition to the Code of Practice Guidance provided by the MCA (below), common and statute law provides additional considerations in the area of restraint as outlined below:

Law

Common Law is created and refined by judges through decisions in courts and other legal proceedings, rather than through legislative statutes. It recognises the entitlement to defend oneself or another from harm

- If you have an honestly held belief that you or another, are in imminent danger, then you may use such force as is reasonable and necessary to avert that danger.
- Necessary and proportionate action may include restrictive physical interventions to restrain or remove a person in order to prevent harm both to the person concerned and to anyone else.

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Criminal Law Act 1967 -Section 3 of the Criminal Law Act 1967 allows such force as is reasonable in the circumstances to prevent crime. Reasonable means:

- Necessary
- Proportionate (ie, the degree of force used must be the minimum required in the circumstances to achieve the objective) otherwise, it is likely that the use of force will be excessive and unlawful.

CONSIDER The use of restraint is a consideration only to be taken when other avenues to resolve the situation have been ineffective or not appropriate to manage the immediate presenting risk. Refer to the RAG rated table above to assist in decision making. In managing an episode of ABD, application of restraint techniques may accelerate both physical and mental deterioration and therefore should only be applied to prevent **immediate serious harm or the preservation of life**. Any **planned restraint** for the administration of medication should be carried out by staff trained in appropriate restraining techniques i.e. the police.

Mental Capacity, Best Interest & DOLS

Many patients that fall within this CMP will be deemed to not have mental capacity, but this must not be assumed and full assessment should be carried out. The trust has a Mental Capacity Assessment Policy which all CCPs should be aware of prior to following this CMP. In addition, the safeguarding team are available to answer any questions surrounding this topic, or to assist with safeguarding supervision.

CCPs following this CMP should be aware of the 5 principles of the Mental Capacity Act:

1. Every adult has the right to make his or her own decisions and must be assumed to have capacity to make them unless it is proved otherwise.
2. A person must be given all practicable help before anyone treats them as not being able to make their own decisions.
3. Just because an individual makes what might be seen as an unwise decision, they should not be treated as lacking capacity to make that decision.
4. Anything done or any decision made on behalf of a person who lacks capacity must be done in their best interests.
5. Anything done for or on behalf of a person who lacks capacity should be the least restrictive of their basic rights and freedoms.

Deprivation of Liberty Safeguards (DoLS) generally apply to patients whose care needs are met in restricted environments e.g. care homes, hospital wards or mental health in-patient facilities. In our daily work SECAMB doesn't deprive people of their liberty.

Documentation

CCPs must ensure the incident is documented in line with trust guidelines, including the use of ePCR and CCPBase. It is envisaged that many of these patients will involve complex mental capacity decisions, so this should also be clearly documented. A 'Best Interest' form will also be needed in many of these cases.

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De-escalation components

Component	Description
Continual risk assessment	Dynamic cycles of micro-assessment are required. These entail continually monitoring the nature/degree of risk including responses to staff efforts.
Self-control techniques	Exposure to aggression can have an impact on staff emotional regulation, which needs to be actively and consciously managed.
Avoidance of provocation	Understanding and seeking to avoid known triggers or otherwise behaving in a way likely to provoke aggression.
Respect patient space	Staff should actively increase the personal space they afford the patient to decrease any perceived threat.
Management of environment	Moving other patients away or suggesting to the patient that the location of interaction is moved to another room or offering a choice of preferred activity
Passive intervention and watchful waiting	Consciously minimising the cognitive load of the patient who may be struggling to sustain emotional regulation whilst actively assessing the situation.
Empathy	Display empathy verbally and non-verbally. Appearing calm is helpful, but an acknowledgment of the patient's distress via mirroring can be helpful.
Reassurance	Fear or shame may underlie overt aggression. Reassuring the patient that they are safe, respected, valued and that nobody will harm them, can be critical.
Respect and avoidance of shame	Shame may trigger aggression in patients and staff. Seeking solutions that allow the patient to retain their dignity is important.
Appropriate use of humour	Changing the emotional dynamic of a situation underpins de-escalation and the appropriate but importantly empathic use of humour may do this.
Identification of	Aggression should be understood as an expression of a need for the patient.
Distraction	Distracting the person by changing the focus of the interaction may reduce
Negotiation	Identifying mutual goals and a shared consensus may consider underlying control issues as root cause of aggression.
Reframing events for patient	Emotions arise from an interpretation of an event that involves judgements about the motivation of others. Cautious exploration of alternative
Non-confrontational limit setting	Explaining the situation calmly, where possible presenting the patient with a choice and avoiding issuing ultimatums.

Sedation Assessment Tool

Score	Responsiveness	Speech
+3	Combative, violent, out of control	Continual loud outbursts
+2	Very anxious and agitated	Loud outburst
+1	Anxious/restless	Normal/talkative
0	Awake and calm/cooperative	Speaks normally
-1	Asleep but rouses if name is called	Slurring or prominent slowing
-2	Responds to physical stimulation	Few recognizable words
-3	No response to stimulation	Nil

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CCP Sedation Checklist - Standard

CHALLENGE	RESPONSE
Oxygen mask on tight	Check
Oxygen cylinder > half full	Check
Spare cylinder next to patient	Check
IV / IO access secured and flushed	Check
IV Fluids connected or 10ml PosiFlush	Check
Monitoring	
BP cycling	Check
Sats probe on	Check
ECG on	Check
EtCO2 on	Check
Airway Equipment	
OPA / NPAs	Check
iGel / LMA	Check
BVM functional and connected to flowing oxygen	Check
Primary Suction ready	Check
Drugs	
Agent 1 (<i>Sedation: e.g. Midazolam / Ketamine</i>)	Check
Agent 2 (<i>Analgesia: e.g. Morphine / Paracetamol</i>)	Check
Rescue drugs available (<i>Naloxone / Flumazenil</i>)	Check
Assistant briefed	Check
Baseline Obs	Check

CCP Sedation Checklist - Immediate

CHALLENGE	RESPONSE
Oxygen	Check
IV / IO access secured	Check
IV Fluids connected or PosiFlush	Check
Monitor on and ready	Check
Airway equipment available	Check
BVM ready	Check
Suction ready	Check
Agent 1 (<i>Sedation</i>) Dose	Check
Agent 2 (<i>Analgesia</i>) Dose	Check
Rescue drugs available	Check
Team briefed	Check

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