EMERGENCY ACTION CARD

This guideline should be used to guide the management of patients admitted to critical care displaying features of acute behavioural disturbance where safety to themselves or others has been deemed compromised. It is not intended for the management of patients with severe encephalopathy related to confirmed or suspected fulminant hepatic failure or TCA overdose – where RSI is the recommended immediate course of action.

Step 1: Patient Assessment

- ☐ Episodes of suspected V&A must be promptly assessed by a senior doctor
- ☐ In emergencies, a response team can be summoned by calling 2222, in **RIE** state

  'Group 9 to [patient location in critical care]'

- ☐ The senior doctor on duty must ascertain the following:
  - The patient lacks capacity
  - The patient represents significant danger to themselves or others.

Step 2: De-Escalation

- ☐ Verbal de-escalation measures as per NHS Lothian V&A training
- ☐ Consideration of triggering situations (loud noises, lighting, pain, delirium) and their mitigation
- ☐ The use of exclusion/patient isolation if possible should be considered
- ☐ Ensuring a safe environment, removal of all unnecessary objects from bedspace
- ☐ Patient and staff safety is paramount – if verbal de-escalation measures are failing **do not persevere.**
- ☐ Do you need to contact on site Security and or Police (strongly encouraged)
  - ☐ CALL RIE 23999 WGH 33920 SJH 52084 (Security) All sites 9999 (Police)

Step 3: Preparation for Rapid Tranquilisation

- ☐ Senior doctor (registrar/consultant) with airway experience and senior nurse must be present.
- ☐ In emergencies the senior doctor can continue but the Consultant must be notified
- ☐ Oxygen and high flow reservoir mask or C-circuit immediately ready and connected to O2 supply.
- ☐ Monitoring equipment primed for use (ECG, pulse oximeter, NIBP, ETCO2 minimum)
- ☐ Airway trolley prepared and readily accessible.
- ☐ Short safety brief, plan for responsibilities, do you have adequate staff present?

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Step 4: Rapid Tranquilisation Procedure, in ICU ONLY

- If there is reliable intravenous access the following drug choice is recommended:
  - **Ketamine 2mg/kg IV**

  or
  - **Droperidol 5-10mg IV (repeated up to 20mg, may be within 15mins)**
  - **Midazolam 5-10mg IV (may also be used with droperidol), up to 30mg**
  - **Consider reduced/half dose of Droperidol and Midazolam in those >65yrs**
- If there is **no** reliable IV access, this should not be attempted in the agitated patient and IM medicines administration should be first line:
  - **Ketamine 4mg/kg IM**
  - Or **Droperidol 5-10mg IM (dosing as IV)**

Step 5: Post Rapid Tranquilisation Ongoing Care

- Commence monitoring immediately if not already done.
- Establish and secure intravenous access if not already done.
- Maintain sedation with IV bolus medication until definitive management plan agreed, documented and in place (**PRN only medication NOT adequate in this situation**)
- Is this drug or alcohol withdrawal consider longer acting benzodiazepine (Diazepam)
- Obtain routine bloods to include blood gas and CK and correct any electrolyte/glucose/acid-base abnormality.
- If considered to be related to an acute psychosis or long-standing psychiatric illness can consider drug management with:
  - **Olanzapine 10mg IM**
- If psychiatric concerns early discussion advised, may include use of Zuclopenthixol(Acuphase)

Step 6: Documentation & Team After-Care

- Document the indication for rapid tranquilisation and any attempts at de-escalation
- Document your mental capacity assessment, **AWI / Emergency Detention Certificate**
- Guidance is available from the FICM LEPU Midnight Law series and on FAQs about AWI on department intranet. (www.critcare.net)
- Ensure all team members are safe and uninjured, arrange DATIX submission.
- Debrief to be discussed and arranged for all staff involved.