Justice Health and
Forensic Mental Health Network

Justice Health NSW Procedure

Acute Sedation – Mental Health Unit, Long Bay Hospital

Issue Date: 24 June 2024

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Acute Sedation – Mental Health Unit, Long Bay Hospital

Procedure Number	6.157
Procedure Function	Continuum of Care
Issue Date	24 June 2024
Next Review Date	24 June 2027
Risk Rating	High
Summary	This procedure is intended to provide guidance to staff in relation to medication administration prior to, during and following the administration of acute sedation in the Mental Health Unit, Long Bay Hospital (MHU LBH).
Responsible Officer	Nurse Unit Manager 2, Mental Health Unit, Long Bay Hospital
Applies to	☐ Administration Centres ☐ Community Sites and programs ☐ Health Centres - Adult Correctional Centres or Police Cells ☐ Health Centres - Youth Justice Centres ☒ Long Bay Hospital ☐ Forensic Hospital
CM Reference	PROJH/6157
Change summary	Previous version as a policy. Updated medication list and exclusive procedure in the MHU, LBH.
Authorised by	Service Director, Custodial Mental Health

Revision History

#	Issue Date	Number and Name	Change Summary
1	June 2024	Acute Sedation – Mental Health Unit, Long Bay Hospital	New Procedure to replace policy Updated medication list and exclusive procedures in the MHU, LBH.

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2. Preface

Acute sedation' (AS) is defined in this procedure is the use of a pharmacological intervention, comprising one or more psychotropic agents given via a range of different routes of administration, for the purpose of managing, in the immediate to short term, behaviours that arise from a mental condition and may pose a risk to the safety of the patient themselves, other patients, visitors or staff.

Key attributes that distinguish AS from other sorts of pharmacological intervention, include the following:

1. It is an 'unplanned intervention' and the medications administered are therefore in addition to (or sometimes instead of) routinely prescribed medications.
2. The decisions about which medications to administer, at what dose, and via which route are made by the relevant medical officer (in consultation with their supervisor, as relevant), in conjunction with treating nursing staff, close in time to the episode of sedation.
3. The expected time scale of the effect of medication on the patient is minutes to hours, as opposed to days to weeks. Hence the need for close monitoring of physical observations is substantially heightened.
4. In the case of medication administered via the intra-muscular injection (IMI) route, it is usually enforced, rather than after obtaining the full, informed consent of the patient.

Acute sedation should be considered as part of a suite of options available to the clinical team to manage the aggression and agitation posed by a patient. Other strategies include de-arousal and de-escalation techniques, and physical separation from other patients, as well as strategies of 'last resort' such as physical and mechanical restraint and seclusion. Refer to Ministry of Health PD2020_004 Seclusion and Restraint in NSW Health Settings and 6.153 Enforced Medication, Seclusion and Restraint - Long Bay Hospital Mental Health Unit, and JH-CS 1.02 LOP Enforced Medication Mental Health Unit Long Bay Hospital. These interventions are best considered as interim management strategies rather than primary treatment techniques. When determining which interventions to employ - clinical need, the safety of patients and others, and, where possible, any advance directives initiated by the patient should be taken into account. The intervention selected must be a reasonable and proportionate response to the clinical presentation and risks posed by the patient.

This procedure applies to:

- Correctional and forensic patients under the Mental Health and Cognitive Impairment Forensic Provisions Act (MHCIFPA) in the Mental Health Unit, Long Bay Hospital.

3. Procedure Content

3.1 Mandatory Requirements

3.1.1 Key principles that must be adhered to in relation to the administration of AS within Justice Health and Forensic Mental Health Network (the Network) include the following:

- AS given as an enforced medication must only take place within a declared mental health facility, where it is lawfully permitted to enforce the use of psychotropic medication for therapeutic purposes as described above for persons detained in accordance with mental health legislation.
- The declared mental health facilities within Justice Health NSW are the Forensic Hospital and Long Bay Hospital (LBH). In practice, for the purposes of the use of acute sedation as an enforced medication, the latter facility is limited to the Mental Health Unit, G ward. This is because, as a matter of clinical practice, only the MHU has the capacity in LBH to manage the prescription and administration of

acute sedation as an enforced treatment. Admission practices to LBH are accordingly tailored to this specific requirement. Patients in the Aged Care Rehabilitation Unit (ACRU) or the Medical Subacute Unit (MSU) must be lawfully transferred to the MHU if deemed to require acute sedation.

- Where a patient is subject to a restrictive intervention such as acute sedation, this must only occur after less restrictive interventions have been considered and deemed ineffective or inappropriate. Even where AS has been required previously, a less restrictive intervention must always be considered first before repeating this intervention.
- When the need for future episodes of acute sedation of an individual patient can be anticipated, and medication requirements can be rationally and carefully considered, they must be 'planned in advance' by the treating team, by way of a standing PRN order. However, the decision to administer AS must always be based on clinical judgment exercised at the time of administration, utilising the most senior nursing and medical expertise practically available to assist with making the decision.
- The treating team providing care to the patient must note within a patient's health record whether an 'advance directive' is in place that may guide decisions relating to acute sedation. This must be checked prior to the administration of any AS wherever possible. Where no such 'advance directive' is in place, the patient should be encouraged and supported to develop one where they are capable of so doing.
- All treatment decisions, administrations of medication, the consideration of less restrictive interventions and discussions with patients about their treatment must be documented in the patient's health record to inform future care.
- The decision to prescribe acute sedation must be made by the medical officers in consultation with other Justice Health NSW staff. It must not be determined by other parties, including CSNSW staff. The purpose of AS must always be clearly defined and documented, and it must include a clear rationale. It must never be used primarily as an aid to restraining a patient, or to facilitate an operational task that is being undertaken by CSNSW.
- The medical officer must review the patient's medication history prior to prescribing acute sedation, to ensure that medications considered have not previously been discontinued due to reasons that could otherwise compromise the physical health and wellbeing of the patient if administered.
- Some patients detained in LBH MHU, are 'involuntary', as defined by the Mental Health Act 2007 (MH Act) and the Mental Health (Forensic Provisions) Act 1990 (MHFP Act). The legal authority to administer medication to involuntary patients without their consent is set out in section 84 of the MH Act, which provides that: *"an authorised medical officer of a mental health facility may, subject to this Act and the Mental Health (Forensic Provisions) Act 1990, give, or authorise the giving of, any treatment (including any medication) the officer thinks fit to an involuntary patient or assessable person detained in the facility in accordance with this Act or that Act."*

3.2 Acute Sedation

3.2.1 Key attributes that distinguish AS from other sorts of pharmacological intervention, include the following:

- It is an 'unplanned intervention' and the medications administered are therefore in addition to (or sometimes instead of) routinely prescribed medications.
- The decisions about which medications to administer, at what dose, and via which route are made by the relevant psychiatric registrar/resident (in consultation with a psychiatrist) or directly by a psychiatrist in conjunction with nursing staff, close in time to the episode of sedation.

- The expected time scale of the effect of medication on the patient is minutes to hours, as opposed to days to weeks. Hence the need for close monitoring of physical observations is substantially heightened.
- In the case of medication administered via the intra-muscular injection (IMI) route, it is usually enforced, rather than after obtaining the full, informed consent of the patient.

3.2.2 Patients should be afforded the opportunity to be involved in their ongoing care planning, whenever possible. This must be documented in the patient's MDT care plan in JHeHS. Those requiring acute sedation should not be excluded from this process. Where it is not possible to discuss these issues with a patient prior to the administration of medication, then this should be discussed with them at the earliest opportunity following the intervention.

3.2.3 When determining which interventions to employ - clinical need, the safety of patients and others, and, where possible, any advance directives initiated by the patient should be considered. The intervention selected must be a reasonable and proportionate response to the clinical presentation and risks posed by the patient.

3.3 Environmental Limitations

3.3.1 The MHU has no co-located general hospital. The MHU itself is a correctional facility with embedded health services rather than a hospital in its true sense. Therefore, the use of IVI medication is not permitted within the MHU.

3.3.2 Furthermore, the fact that Corrective Services NSW (CSNSW) officers manage the security of the facility, including all patient movements and restrictive practices pertaining to patients within the unit, must be taken into account when considering the use of AS in this setting.

3.3.3 Within the MHU, G ward has access to 10 camera cells. These are monitored by CSNSW and are typically for patients who have a recent history of self-harming behaviours and/or current suicidal ideation. They can also be utilised for patients who are demonstrating acute psychotic and complex behaviours, or for patients requiring acute sedation with a period of increased observations.

3.3.4 The treating team needs to liaise with CSNSW prior to acute sedation administration to ensure that access to the patient can be maintained to complete all necessary physical and mental health monitoring in a timely manner,

3.3.5 For this reason, lorazepam and midazolam IMI is not to be charted as a PRN medication and can only be used when review by a medical officer occurs and discussed with and approved by a consultant psychiatrist.

3.4 Guide for Acute Sedation

3.4.1 Exhaust de-escalation techniques, i.e., engagement and verbal de-escalation, distraction, quiet/low stimulus environment.

3.4.2 Patient does not respond to de-escalation techniques and risk of harm from behavioural disturbance persists.

3.4.3 Should consult MO, and offer oral pharmacotherapy (see below)

3.4.4 Patient refuses oral medication and risk of harm from behavioural disturbance persists, consult MO

3.4.5 Consult MO, and administer injectable IMI pharmacotherapy (see below)

3.4.6 Monitor patient, this monitoring should include the MO

3.4.7 If risk of harm due to behavioural disturbance persists, consult psychiatrist and consider repeating the above steps.

3.4.8 **Medication (Oral)**
Diazepam 5-20mg or
Olanzapine 5-10mg or

3.4.9 **Medication (Injectable)**
Promethazine 25-50mg or
Olanzapine 5-10mg – (Maximum 20mg daily)
or
Haloperidol 2-5mg (if known to tolerate typical antipsychotics) or

Use midazolam 5-10mg as second line.

3.4.10 For more information on medications and potential interactions and recommendations, see MIMS.

3.4.11 Zuclopenthixol Acetate (Acuphase) is **NOT to be used as Acute Sedation in the Long Bay Hospital Mental Health Unit.** Zuclopenthixol acetate should never be used as acute sedation, given that the onset of effect is too slow.

3.5 Risks Associated with Acute Sedation

3.5.1 There are specific risks associated with the different classes of medications that are used in acute sedation. The specific properties of the individual medicines should be taken into consideration when combinations are used as risks may be compounded. The patient's current medication must also be considered in the decision to administer AS. Staff must be aware of the following:

- Benzodiazepines, for example, diazepam, midazolam, and lorazepam:
  - reduced level of consciousness
  - may lead to respiratory depression or arrest
  - may reduce blood pressure.
- Antipsychotics, for example, haloperidol, olanzapine
  - reduced level of consciousness
  - cardiovascular and respiratory complications and collapse
  - reduced seizure threshold
  - akathisia
  - dystonia (especially laryngeal dystonia)
  - dyskinesia
- Promethazine
  - Paradoxical stimulation
- Simultaneous IMI administration of olanzapine (Zyprexa IM) and parenteral benzodiazepines is not recommended.
  - potential for excessive sedation
  - cardiorespiratory depression
  - In very rare cases, death (see Product Information, Special Warnings and Precautions for Use)

3.6 Oral Therapy

3.6.1 Oral therapy should be offered as first line treatment where it is safe and appropriate to do so.

3.6.2 Benzodiazepines and antipsychotics can be used separately or concurrently when administered by the oral route.

3.6.3 Oral acute sedation may involve additional PRN doses of a regular prescribed medication, or an alternative PRN medication.

3.6.4 It is important to allow sufficient time for clinical response between oral doses of medication, to avoid cumulative dosing side effects (e.g., excess sedation or ataxia).

3.7 Parenteral Therapy for Acute Sedation

3.7.1 If oral treatment has been ineffective or refused and parenteral treatment is required, the intramuscular route (IMI) is the only option that is considered safe and appropriate for use within the MHU. The administration of AS via the intravenous (IV) route must not be used in these settings.

3.7.2 It is important to allow sufficient time for clinical response between intramuscular (IM) doses of medications, to avoid cumulative dosing side effects (e.g. excess sedation or ataxia).

3.7.3 Different medications must never be mixed within the same syringe. (Refer to National Standard for User- applied Labelling of Injectable Medicines, Fluids and Lines, Australian Commission on Safety and Quality in Health Care 2015).

3.7.4 Anticholinergic medications, for example, benztropine, should be immediately available to reduce the risk of acute dystonia. The decision as to whether to

administer benztropine concurrently with IMI antipsychotic medication, as a prophylaxis against dystonia, should not be routine but should rather be based on an individual patient's identified risks.

3.8 Pro Re Nata (PRN) Medication

3.8.1 AS, whether administered as oral or IMI medication, should not be charted as a 'routine' medication for regular administration in eMeds in JHeHS. In other words, it will be charted either as a 'PRN' medication, or as a "once only" or 'stat' order on the eMeds chart. Midazolam and lorazepam can be given as a once-only or 'stat/statim' dose after medical review and consultant psychiatrist discussion.

3.9 Standing PRN Order

3.9.1 For certain patients, it may be appropriate to anticipate the need for future use of AS, by including a 'standing PRN order'. This may be based on their past requirement for AS, or on their clinical assessment at the time of, or following, admission. This is likely to be limited to patients detained in the acute admission units of the MHU 'G ward'. The PRN chart on eMeds in JHeHS should be reviewed at a minimum weekly during the MDT meeting.

3.9.2 Each 'standing PRN order' should be individualised for the specific patient, including the following parameters:

- the route(s) of administration
- the specific medication(s) prescribed.
- the available dose
- range
- the frequency of administration
- the maximum daily dose
- indications for use
- date of review of standing PRN order

3.9.3 Whilst it is likely that a small number of medications will be utilised frequently, within a relatively narrow dose range, it is not appropriate to apply a 'standard' PRN order indiscriminately to all patients admitted to a particular unit (e.g., Olanzapine 10mg (oral).

3.9.4 In prescribing PRN medication, consideration needs to be given to a range of factors including, but not limited to:

- patient age and sex
- concurrent medical conditions, including renal and hepatic impairment.
- past exposure and response to medications, including adverse effects.
- current clinical symptoms and risk
- alternative non-pharmacological strategies being utilised to manage aggression and agitation.
- review of the patient's medication management plan.

3.9.5 If the patient is already prescribed a regular antipsychotic medication, the prescription of a second (alternative) antipsychotic medication as PRN medication should be avoided, wherever possible. The use of high dose antipsychotic medication for AS should be avoided. The clinical rationale for prescribing PRN medication for a particular patient should be discussed with a psychiatrist.

3.9.6 In circumstances where PRN injectable (IMI) medication is required, nursing staff should contact the relevant registrar immediately. Wherever possible, nursing staff should attempt to contact the registrar or consultant psychiatrist prior to the administration of IMI medication, or on occasions where it is not practical or possible, immediately following the administration of IMI medication.

3.9.7 In the MHU, CSNSW and Justice Health staff would commence a risk briefing and plan for the Joint Planned Intervention. Refer to 6.153 Enforced Medication, Seclusion and Restraint - Long Bay Hospital Mental Health Unit and Joint Planned Interventions by Justice Health and Forensic Mental Health Network (the Network) and Corrective Services NSW (CSNSW) at Long Bay Hospital (LBH).

3.9.8 For more information on medications and potential interactions and recommendations, see MIMS.

3.10 Ad hoc or Statim Order

3.10.1 On occasion, patients may be assessed as requiring AS who do not have a standing PRN order for oral or IMI medication. This may occur because they have had a period of clinical stability without any anticipated need for AS or simply because no order exists in the relevant medication chart in eMeds in JHeHS.

3.10.2 The nursing staff must contact the relevant registrar (either the treating or the duty/afterhours registrar) to assess the patient and/or provide an order for PRN medication as considered appropriate.

3.10.3 Wherever possible, the relevant registrar must attempt in such situations to assess the patient 'face to face' to determine the clinical risk and the need for the use of AS, in conjunction with the patient's allocated nurse.

3.10.4 In such circumstances, the most clinically appropriate action is for the relevant registrar to provide prompt advice remotely (by phone) and, if considered appropriate, a phone order given directly to the treating nursing staff, for the administration of 'stat' AS medication, prior to subsequent review of the patient. At this point, a more definitive management plan, including a standing PRN order, may be instituted. **This should be done where possible in consultation with the treating consultant Psychiatrist alternatively if unavailable discussed with the consultant Psychiatrist on the on-call roster**.

3.11 Doses for Emergency Sedation

3.11.1 The dose of medication for AS should be individualised for each patient with reference to published guidelines and product prescribing information. A risk-benefit analysis should be recorded in the patient's health record and a rationale should be recorded. Important regular checks of airway, level of consciousness, pulse, blood pressure, respiratory effort, temperature, and hydration should be undertaken and recorded on the patient's Standard Adult General Observation (SAGO) chart.

3.11.2 The dose of antipsychotic medication should be individualised for each patient. This will be dependent on several factors including:

- the patient's age (younger and older patients generally require lower doses).
- co-existing physical disorders, such as renal, hepatic, cardiovascular, or neurological.
- concomitant medication.

3.12 Circumstances for Special Care (extra care)

3.12.1 Extra precautions should be considered in the following circumstances:

- The presence of prolonged QTc syndromes
- The concurrent prescription or use of other medication that may lengthen QTc interval.
- Where the physical health status of the patient may be compromised, for example, physical exhaustion, respiratory distress, hypo, or hyperthermia.

3.13 Acute Sedation in Older People

3.13.1 Older people and other groups (e.g., persons with a cognitive impairment) may require smaller doses of medication.

3.13.2 Points to consider:

- check for underlying medical causes of agitation and initiate appropriate treatment.
- metabolism of medications may be altered compared to younger adults.
- physical frailty more likely
- more likely to have pre-existing general medical illnesses (check medical history up to date)
- more likely to be prescribed additional non-psychiatric medication.

- more likely to develop extra pyramidal side effects.
- if suffering from known cognitive disorder, more likely to develop increased cognitive impairment with equivalent doses of medication compared to those without a cognitive disorder.
- may be naïve to antipsychotics and/or benzodiazepines.

3.13.3 As AS of older patients is an infrequent event, it is advisable to contact the patient's consultant psychiatrist or the on-call consultant in relation to their medication management.

3.14 Physical Monitoring

Before Acute Sedation

3.14.1 Before prescribing for AS, the prescribing medical officer should, wherever possible:

- review the patient's health record with regard to his/her general medical history and make observations as to the patient's physical status in the health record as the patient is unlikely to be cooperative with a physical examination.
- consider previously expressed preferences of the patient regarding acute sedation.
- check for recent ECG, U&Es and urine drug screen results.
- consider any previous history of severe extrapyramidal effects.
- consider the previous response to AS or other methods of managing imminent violence.
- review current prescribed medication and recently administered medication, taking note of administration of PRN medications.
- obtain baseline measurements of temperature, blood pressure, pulse rate, respiratory rate and the level of consciousness where it is safe to do so. Observations of the patient's respiratory rate must be measured and documented. Sedation should not be administered to patients with a reduced level of consciousness.
- ensure that emergency resuscitation equipment is available before treatment is given.
- ensure that the patient is continually monitored in line with the Justice Health NSW Policy 1.319 Patient Engagement and Observation – Forensic Hospital and Long Bay Hospital Mental Health Unit and NSW Health policy PD2017_025 Engagement and Observation in Mental Health Inpatient Units.

After Acute Sedation

3.14.2 After AS is administered:

- vital signs including oxygen saturation must be monitored where possible using a pulse oximeter.
- alertness, blood pressure, pulse, temperature, respiratory rate and hydration must be recorded regularly until the patient becomes active again.
- Visual observation of the patient must be maintained.

3.14.3 These parameters should be recorded every 10 minutes for 1 hour then half hourly until the patient is ambulatory. Some vital signs may be difficult to monitor if a patient remains agitated or aggressive. Problems in this regard should be clearly documented and discussed with the prescriber and the clinical team. It is particularly important to ensure that wellbeing is maintained if the patient is asleep or appears to be asleep and that the monitoring of vital signs, including saturation levels, continues. These observations must be completed by health staff.

3.14.4 If vital signs are unable to be monitored as a result of the security restrictions imposed by CSNSW on the MHU this should be discussed urgently with the CSNSW Functional Manager at LBH.

3.14.5 Any observation obtained must be recorded in the patient's SAGO Chart.

3.14.6 Pulse oximetry must be attended in heavily sedated patients. Patients should remain monitored until they are able to maintain oxygen saturation greater than 90%.

3.14.7 Continuation of frequent monitoring is required in the following circumstances and should be recorded in the care plan:
- the patient is difficult to rouse.
- the patient has a concomitant medical condition that may increase the risk of an adverse event occurring.
- the patient has been, or is suspected of, using illicit substances.

3.14.8 All treatment and care must be immediately recorded in the patient health record.

3.15 Medical emergency

3.15.1 If a patient becomes non communitive or is unable to be aroused from the cell door then nursing staff are to inform CSNSW staff immediately. Nursing staff are unable to gain direct access to a patient's cell due to security measures. As a result, CSNSW staff will be requested to open the cell door to enable nursing staff to complete physical observations including, where necessary, further ascertainment of the consciousness of a patient.

3.15.2 If the patient is not responding, but breathing, then the treating or after-hours psychiatry registrar is to be notified immediately. If the patient is not breathing then a "Code Blue" is activated by either CSNSW or nursing staff announcing, "Code Blue, Code Blue" and the location over the two-way radio. The MET Leaders/s will attend the announced Code Blue location as per Long Bay Hospital Medical Emergency Response Procedure (Code Blue).

3.15.3 If required, nursing staff are to request an ambulance via 000, then immediately notify the CSNSW officers on site, in order that staff at the CSNSW gate can be notified of its pending arrival. The MET Leader will coordinate the incident until the NSW Ambulance arrives, where required nursing staff will complete the mental health emergency leave form (JUS 200.085 - Request for unplanned transfer for healthcare) and seek approval. Approval should be sought from the medical superintendent or nominated delegate in their absence being the deputy medical superintendent or in their absence the consultant Psychiatrist on the back up roster. CSNSW officers are responsible for coordinating and managing the escort of the patient.

3.15.4 In the event of a medical emergency/code blue, clinical staff should refer to the Emergency Response Guidelines (Adult), Australian Resuscitation Council Guidelines, and 6.070 Procedure Code Blue (Medical Emergencies) - Management.

4. Definitions

Acute Sedation

The use of a pharmacological intervention, comprising one or more psychotropic agents given via a range of different routes of administration, for the purpose of managing, in the immediate to short term, behaviours that arise from a mental condition and may pose a risk to the safety of the patient themselves, other patients, visitors or staff.

Must

Indicates a mandatory action to be complied with.

Patient Health Record

A hybrid record of paper-based and electronic information pertaining to the health of the patient.

Should

Indicates a recommended action to be complied with unless there are sound reasons for taking a different course of action.

5. Related documents

Legislations	*Mental Health Act 2007* (NSW) Mental Health and Cognitive Impairment Forensic Provisions Act 2020 (NSW) *Mental Health and Cognitive Impairment Forensic Provisions Regulation 2021* (NSW)
Justice Health NSW Policies, Guidelines and Procedures	1.174 *End of Life Care and Decision Making* 1.220 *Use of Physical Restraint on Patients in Custody* 1.319 *Patient Engagement and Observation – Forensic Hospital and Long Bay Hospital Mental Health Unit* 5.070 *Infection Prevention and Control* 6.049 *Medication Guidelines* 6.051 *Guidelines for Psychotropic Medications* 6.070 *Procedure Code Blue (Medical Emergencies) - Management* 9.020 Code Black (Psychiatric Emergency, Armed Hold-Up, Hostage) – Management. Emergency Response Guidelines (Adult) Joint Planned Interventions by Justice Health and Forensic Mental Health Network (the Network) and Corrective Services NSW (CSNSW) at Long Bay Hospital (LBH)
Justice Health NSW Forms	
NSW Health Policy Directives and Guidelines	Management of Withdrawal from Alcohol and Other Drugs Clinical Guidance PD2017_025 Engagement and Observation in Mental Health Inpatient Units PD2020_004 *Seclusion and Restraint in NSW Health Settings*
Other documents and resources	Australian Resuscitation Council Guidelines National Standard for User- applied Labelling of Injectable Medicines, Fluids and Lines, Australian Commission on Safety and Quality in Health Care 2015. *Australian Commission on Safety and Quality in Health Care*

	SESLHDPR/595 *Emergency Sedation Procedure – Acute Inpatient Mental Health Units*