For Back Up Use

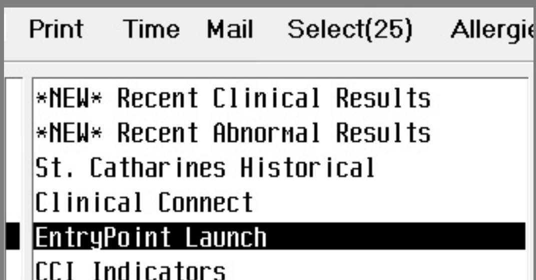
This copy of the Orderset is for Information & BackUp purposes only.

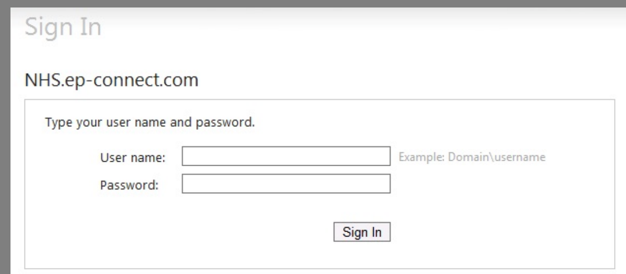
It is intended for use during downtimes.

For daily use, please access the version on EntryPoint

To launch EntryPoint, go to PCI (Patient Care Inquiry) in Meditech. Look for "EntryPoint Launch" and follow the instructions. Log in using your PACS (or Outlook) username and password in lowercase.

Thanks.





niagarahealth
Extraordinary Caring. Every Person. Every Time.

PATIENT INFORMATION

Height ____________ cm Weight ____________ kg

Allergies ____

Emergency Chemical Restraint/Sedation for Violent or Aggressive Mental Health Patient Order Set

		M	K	O
Orders Processed Date (dd/mm/yyyy)	☒ This order expires in 12 hours. Further restraint orders to be obtained from MRP ☒ If de-escalation fails, call Code White or 911 depending on situation and staff/patient safety concerns			
	Vitals			
	☒ Temp, HR, RR, BP, SpO_2 as soon as it is safe to do so			
Time (hhmm)	***Diagnostics***			
	☒ If on atypical antipsychotics, ECG as soon as it is safe to do so. Inform MD if QTc is more than 490ms ☐ CT Head *(complete separate requisition, **usually of little value** unless trauma or other clinical indication)*			
By	***Lab Investigations***			
	☐ Overdose ED Panel *(This should not be used routinely and is to be guided by clinical circumstances)*			
Status	***Medications***			
Processing Reviewed by Status Faxed by	**Antipsychotics **Mainstay except in agitated stimulant overdose, e.g. cocaine or amphetamines**** ☒ Do not administer **OLANZ**apine IM within 1 hour of the most recent IM dose of **LOR**azepam ☐ **OLANZ**apine _________ mg *(usually 2.5 – 10 mg)* ODT, if PO not possible then give IM (**Max dose 20 mg/day**) *(Consider QTc prolongation risk, e.g. concomitant use of atypical antipsychotics, ondansetron, azithromycin)* ☐ May repeat dose 2 hours after first dose if not sedate. If further doses required, inform Physician ☐ haloperidol _________ mg *(usually 5 – 10 mg)* IM *(May be given by slow IV by MD in certain circumstances)* ☐ May repeat dose in 20 - 30 minutes if not sedate. If further doses required, inform Physician **Benzodiazepines **Adjuvant to antipsychotics, used alone in stimulant overdose**** ☒ **LOR**azepam _____ mg SL *(usually 1 – 2 mg),* if SL not possible, give IM ☐ _____________ __________ mg Route: __________ ☒ May repeat Benzodiazepine in 20 – 30 minutes if not sedate. If further doses required, inform MD **EPS/Dystonia Management** ☒ benztropine 1 – 2 mg PO/IM q1h PRN until resolved (maximum 6 mg per 24 hours from all sources)			
	Monitoring			
	☒ Direct observation (1:1) for 30 minutes by a regulated health professional then q15minutes while sedated ☒ Repeat Temp, HR, RR, BP, SpO_2 q4h and PRN once sedate ☒ Regularly assess for side effects and inform MD if deteriorating condition			
	Additional Orders			
	____ ____			

☐ Telephone Order ______________________ ______________ ______________
Ordering Practitioner, Designation Signature Date/Time (dd/mm/yyyy hhmm)

If Telephone Order ______________ ______________ ______________ ☐ Read Back
Ordering Physician Date (dd/mm/yyyy) Time (hhmm)

Rev. 03/2017/V1 ORD204

Chart Copy – Do Not Destroy

PatientOrderSets

niagarahealth
Extraordinary Caring. Every Person. Every Time.

General Information to Aid in the Care of the Severely Agitated and Violent Patient

1. Acuity and Management Principles

- ► Uncontrolled Bizarre or Violent Behavior is a CTAS 1 presentation requiring immediate nurse and physician attendance.
- ► First priority is patient, staff and bystander safety. Then is patient assessment and medical care.
- ► Call Code White or 911 if needed. When de-escalation fails, use physical restraints only as a bridge to effective chemical restraints (see Least Restraint Policy where applicable)
- ► Obtain collateral history, perform focused assessment and review old chart.
- ► Do not leave the patient unattended until behavior is controlled, finger glucose and vital signs are done and a medical assessment is performed in safety.

2. Chemical Restraints/Sedation

- ► Anti-psychotics (classical or novel) and Benzodiazepines are the mainstay of treatment alone or in combination
- ► In primary psychogenic agitation (e.g. mania, schizophrenia), lean towards antipsychotics while in primary medical agitation (e.g. cocaine, amphetamine, ETOH withdrawal, postictal) lean toward benzodiazepines.
- ► Either parenteral and sublingual routes are effective, depending on the situation.
- ► Titrate dosage until desired effect is obtained and a medical assessment can be safely achieved. Consider the following medications alone or in combination:
    - Antipsychotics: (watch for: EPS, QT prolongation, NMS)
        - haloperidol 5 – 10 mg IM/IV, repeat q30minutes until sedate, usual maximum 20 mg per 24 hours
        - olanzapine 2.5 – 10 mg SL/IM, maximum 20 mg per 24 hours
    - Benzodiazepines: (watch for: respiratory depression)
        - lorazepam: 0.5 – 2 mg SL/IM/IV, repeat and titrate
        - midazolam: 2 – 5 mg IM/IV, repeat and titrate
        - diazepam: 5 – 20 mg PO/IV, repeat and titrate most commonly in ETOH withdrawal (consider CIWA and related Order Set)
          (Benzodiazepine dose is only limited by side effects. Some patients with agitated delirium or stimulant OD may require very large doses)
    - Consider adjuvants: Glucose, IV Fluids, diphenhydramine or benztropine as required
- ►There is growing evidence for the use of Intramuscular ketamine in extreme ED or pre-hospital Situations (Dose 5 mg/kg). This drug should be administered under the direct supervision of a physician.

3. Medical Assessment

- ► All cases require detailed medical assessment, which might include an OD panel with or without neuroimaging depending on presentation. Neuroimaging may require procedural sedation (see related policy and forms)
- ► Make sure orders for ongoing sedation, fluids and medical treatment are written
- ► Invoke the Mental Health Act (Form 1) as clinically indicated

4. Disposition

- ► Most patients who don't have a transient medical condition will require admission either for psychiatric or medical assessment and care

5. Suggested Further Reading

- This is not a replacement for clinical knowledge and judgment
- ED Management Of Delirium and Agitation (www.ebmedicine.net/topics.php?paction=dLoadTopic&topic_id=11)
- Roberts: Clinical Procedures in Emergency Medicine, 5th ed., Chapter 71: Physical and Chemical Restraint
- Rosen's Emergency Medicine, 7th ed., Chapter 188: The Combative Patient
- Both Robert's and Rosen's are available through your account at CMA.ca/Clinical Resources/MD Consult