CONSIDER	ANAESTHETIC RISK		
MENTAL HEALTH SAFETY/RISK	**LOW** thin, fit, fasted	**MEDIUM** ASA II - III	**HIGH** old, sick, difficult airway OSA etc
LOW flat, depressed, no Hx violence, low risk suicidal patient "happy" drunk thought disordered but compliant	low risk reassurance mild anxiolytic	restraint monotherapy longer acting agents 1:1 nursing	avoid drugs if possible orientation reassurance 1:1 nursing
MEDIUM intoxicated / disinhibited unpredictable delusional with poor insight anxious +++	sedation needed single agent antipsychotic (+/- benzo)	as above heavier sedation airway adjuncts to hand	airway risk non-pharmacy preferred short acting BDZ tincture of time
HIGH violence /weapons physical threats persecutory delusions around care "big guy" you whom cannot restrain	as above then ketamine sedation or RSI/ETT	as orange but delay until fasted await retrieval?	balance of minimal sedation & own airway vs GA/ETT

Olanzapine - first line oral antipsychotic; wafer 10-20mg oral, rapid onset

Quetiapine - second line oral antipsychotic; mania, behavioural-based agitation or previous use

Haloperidol - 5mg ORAL or 10mg IM to max 50mg; 5-10mg IV up to max 20mg
benztropine 1-2mg IV should be available to treat acute dystonia

Midazolam - IM 5-20mg, IV 0.1-0.2mg/kg in aliquots, IN 0.2mg/kg, ORAL 0.5mg/kg
flumazenil 0.2-0.5mg IV should be available if acute reversal required

Ketamine - PRE-KETAMINE SEDATION ESSENTIAL to MINIMISE DELIRIUM ie : BDZ
IM 5mg/kg, IV 0.5-1.5mg/kg sedation. Ketamine infusion has been used for transport.
Consider antisialogogue adjunct (atropine or glycopyrrolate)

See also : Minh le Cong et al. "*Ketamine sedation for patients with acute agitation and psychiatric illness requiring aeromedical retrieval*" EMJ May 2011 - ketamine sedation used to avoid RSI/ETT of red/black patients in risk matrix above

MINIMUM SEDATION MONITORING - SpO2, ECG, NIBP. Consider ETCO2 via HM. SUPPLEMENTAL **OXYGEN AT ALL TIMES**
RFDS restraints or net, 45 degree head up to maximise SV and minimise aspiration risk. **CHECK BGL!**

LIAISE WITH RETRIEVAL TEAM

RAPID ASSESSMENT ACUTE AGITATION

AIRWAY?
BREATHING?
CIRCULATION
DISABILITY, DRUGS?
ENVIRONMENT, ECG
FULL BLADDER?
GLUCOSE?
HEAD INJURY?

SUGGESTED ALGORITHM

NO IV ACCESS

oral olanzapine 10-20mg stat
and/or
IMI midazolam 5-10mg
and/or
IMI ketamine 4mg/kg

IV ACCESS OBTAINED

IV midazolam 2-5mg
and/or
IV haloperidol 5-10mg
and/or
IV ketamine 1-1.5mg/kg

repeat every 5-10 mins, target RASS 0 to -3

SAFE PSYCH SEDATION MATRIX

RICHMOND AGITATION SEDATION SCALE		
Term	**Description**	**Score**
COMBATIVE	overtly combative, violent, immediate danger to self/others	**+4**
VERY AGITATED	pulls or removes tube(s), catheter(s), aggressive	**+3**
AGITATED	frequent non-purposeful movement, fights ventilator	**+2**
RESTLESS	anxious but movements not aggressive or vigorous	**+1**
ALERT & CALM	Doctor or Nurse	**0**
DROWSY	Not fully alert, but sustained awakening to voice (**eyes open > 10s**)	**-1**
LIGHT SEDATION	briefly awakens with **eye contact to voice < 10s**	**-2**
MODERATE SEDATION	movement or eye opening to voice **but no eye contact**	**-3**
DEEP SEDATION	no response to voice, but **movement or eye opening to physical stimulation**	**-4**
UNROUSABLE	**no response to voice or physical stimulation**	**-5**

Procedure

(i) observe patient - patient is alert, restless, agitated or combative (0 to +4)

(ii) if not alert, state patient's name and say to open eyes and look at speaker
-1 if awakens with sustained eye contact to voice > 10s to voice
-2 if awakens with eye contact to voice < 10s
-3 if moves or opens eyes to voice but no eye contact

(iii) if no response to voice, use physical stimulus (shoulder shake, trapezius squeeze, jaw thrust)
-4 if any movement to physical stimulation
-5 if no response to physical stimulation

TARGET RASS is 0 to -3

AIRWAY EQUIPMENT and MONITORING must be available

1:1 NURSING, 10 minutely obs

LIAISE WITH RETRIEVAL SERVICE

RICHMOND AGITATION SEDATION SCALE