



Government of **Western Australia**
Department of **Health**

COVID-19 Guideline for management of acute behavioural disturbance

Version 4.1

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1 Introduction

1.1 Scope

- This guideline addresses the safe care and management of consumers presenting with psychological distress and acute behavioural disturbance who are COVID-19 positive, symptomatic and/or close contacts (see section 1.4, COVID-19 infection status).
- Behaviours within scope of this guideline are aggression, acute behavioural disturbance, and agitation.
- This guideline:
 - Is of particular relevance to inpatient mental health units and emergency departments, but the principles can be applied in other health settings such as general medical wards, alcohol and other drug services and community settings.
 - Does not seek to replace or duplicate existing guidance about the management of acute behavioural disturbance.

1.2 General principles

- In a COVID-19 context, all the elements of good practice apply, with an emphasis on prevention, de-escalation, and least restrictive practice.
- Always provide person centred¹, recovery oriented², trauma informed³, family inclusive⁴, gender- and sexuality-sensitive, and culturally appropriate care⁵.
- Consumers, family members, carers and staff may experience heightened distress in the context of the COVID-19 pandemic. Care should be taken to minimise inadvertent exacerbation of psychological distress.
- Health services should ensure the provision of equitable and culturally safe health care for Aboriginal consumers and their families.⁶
- Adapt strategies to the particular needs of diverse and specific populations (including but not limited to people from culturally and linguistically diverse backgrounds, older adults, children and youth, and people with cognitive impairment).

¹ Available from: <https://www.safetyandquality.gov.au/our-work/partnering-consumers/person-centred-care>

² Available from: <https://www1.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-n-recovfra>

³ Available from: <https://mhcc.org.au/publication/trauma-informed-care-and-practice-ticp/>

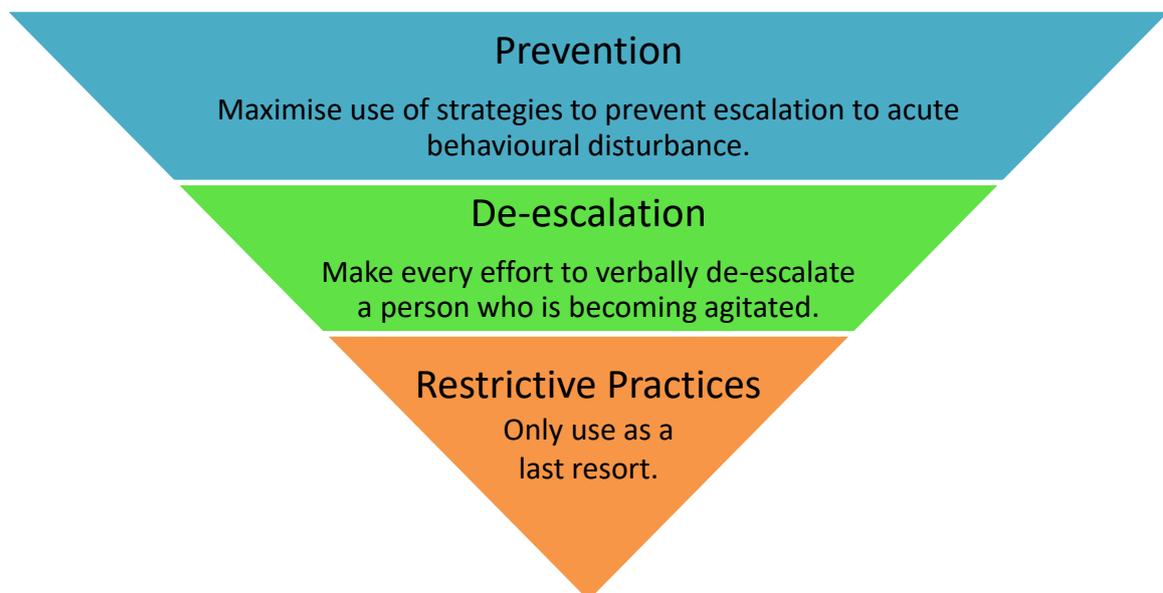
⁴ Available from: <https://www.wa.gov.au/organisation/departments-of-communities/carers-recognition-act-2004>

⁵ Available from: <https://www1.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-n-servst10>

⁶ See Aboriginal ethical position statement. Available from: <https://ww2.health.wa.gov.au/-/media/Files/Corporate/general-documents/Infectious-diseases/PDF/Coronavirus/COVID-19-Aboriginal-Ethical-Position-Statement.ashx>

- Prioritise preventative strategies to:
 - Reduce the risk of acute behavioural disturbance.
 - Minimise the risk of COVID-19 transmission.
 - Minimise the risk of avoidable physical health deterioration, particularly in those at risk of respiratory depression.
 - Minimise physical and psychological trauma to consumers, families, carers, and staff (see Figure 1).
- The use of restrictive practices should be a last resort (see Figure 1).
- Always follow infection control protocols, guidance and directions to minimise the spread of COVID-19.

Figure 1: Hierarchy of strategies for managing acute behavioural disturbance in consumers with suspected or confirmed COVID-19.



1.3 Assumptions

- This guideline is based on the assumptions that health services:
 - Have developed and implemented local COVID-19 pandemic response plans.
 - Have policies and procedures for the management of aggression, and staff are appropriately trained in the prevention and management of aggression in their clinical setting.

1.4 COVID-19 infection status

- This guideline applies to the assessment and treatment of consumers who are COVID-19 positive cases, symptomatic and/or close contacts.⁷
- The *Coronavirus Disease 2019 (COVID-19) CDNA National Guidelines for Public Health Units*⁸, as amended from time to time, provides case definitions for confirmed and probable COVID-19 infection status.
- Those who do not have a current diagnosis of COVID-19, have no symptoms suggestive of COVID-19 and who have no recent travel history or exposure to a known case are considered to be at a low-risk for being a positive COVID-19 case.
- All services should identify consumers considered to be a COVID-19 positive case and/or close contact by asking screening questions about being a close contact of a known case, influenza-like symptoms, gastroenteritis symptoms and whether they have been tested for COVID-19 to plan their safe management. For those with chronic respiratory conditions, ask about an acute deterioration in chronic symptoms or the recent appearance of new influenza-like symptoms.

⁷ Available from: <https://www1.health.gov.au/internet/main/publishing.nsf/Content/cdna-song-novel-coronavirus.htm>

⁸ Ibid.

2 Legislation and policy

This guideline should be used in conjunction with:

- The *Mental Health Act 2014* and related documents, particularly The Chief Psychiatrist's Standards for Clinical Care.⁹
- The *Public Health Act 2016* and the *Emergency Management Act 2005* and directions issued under these Acts relating to COVID-19.¹⁰
- The *Carers Recognition Act 2004*.¹¹
- Mandatory national or WA Health system-wide policies, particularly:
 - *Coronavirus Disease – 2019 (COVID-19) Infection Prevention and Control in Western Australian Healthcare Facilities*¹²
 - *Recognising and Responding to Acute Deterioration Policy*.¹³
 - *Identification and Use of Personal Protective Equipment in the Clinical Setting Policy*¹⁴
 - *Clinical Care of People with Mental Health Problems Who May Be at Risk of Becoming Violent or Aggressive Policy*.¹⁵
- Health Service Provider and local health service policies and protocols.

⁹ Available from: <https://www.chiefpsychiatrist.wa.gov.au/standards-guidelines/chief-psychiatrists-standards-for-clinical-care/>

¹⁰ Available from: <https://www.wa.gov.au/government/document-collections/covid-19-coronavirus-state-of-emergency-declarations#western-australia-declaration-of-state-of-emergency-and-public-health-emergency>

¹¹ Available from: https://www.legislation.wa.gov.au/legislation/statutes.nsf/law_a9247.html

¹² Available from: https://ww2.health.wa.gov.au/~/_media/Corp/Documents/Health-for/Infectious-disease/COVID19/COVID19-Infection-Prevention-and-Control-in-Hospitals.pdf

¹³ Available from: <https://ww2.health.wa.gov.au/About-us/Policy-frameworks/Clinical-Governance-Safety-and-Quality/Mandatory-requirements/Recognising-and-Responding-to-Acute-Deterioration-Policy>

¹⁴ Available from: <https://ww2.health.wa.gov.au/About-us/Policy-frameworks/Public-Health/Mandatory-requirements/Communicable-Disease-Control/Infection-Prevention-and-Control/Identification-and-Use-of-Personal-Protective-Equipment-in-the-Clinical-Setting-Policy>

¹⁵ Available from: <https://ww2.health.wa.gov.au/About-us/Policy-frameworks/Mental-Health/Mandatory-requirements/Clinical-Care-of-People-With-Mental-Health-Problems>

2.1 Mental Health Act 2014

The *Mental Health Act 2014* remains in effect during the COVID-19 pandemic; and there is a continuing requirement to comply with its provisions and associated protocols and reporting requirements.

The *Mental Health Act 2014* should not be used for the purpose of detaining or keeping individuals isolated for infection control.

For queries about applying the *Mental Health Act 2014*, call the Office of the Chief Psychiatrist from 08:30 to 16:30 Monday to Friday on 08 6553 0000.

- If someone is believed to meet the established *Mental Health Act 2014* criteria for an involuntary treatment order, then the *Mental Health Act 2014* is relevant.
- Mental health services need to identify strategies to observe infection prevention and control requirements while also adhering to the provisions of the *Mental Health Act 2014*. This includes, but is not limited to:
 - Delivering care in accordance with the Charter of Mental Health Care Principles (*Mental Health Act 2014*, Part 4, Schedule 1).
 - Including families and carers in treatment, support and discharge planning.
 - For Aboriginal consumers, collaborating with an Aboriginal Mental Health Worker and significant members of the person's community.
 - Using seclusion and restraint only as a last resort and only in accordance with the *Mental Health Act 2014* - note that it is the State and Federal Government policy position that mental health services should be working towards elimination of restrictive practices.
- The *Mental Health Act 2014* cannot be used to provide physical health care against an individual's wishes - there is a rare exception when an individual meets the extremely strict criteria for s242 *Mental Health Act 2014*.
- The *Mental Health Act 2014* cannot be used to force an individual to take a COVID test against their wishes.
- The *Mental Health Act 2014* cannot be used as a vehicle purely to force compliance with the *Public Health Act 2016*.

2.2 Public Health Act 2016

- The *Public Health Act 2016* was used to prevent the spread of COVID-19.¹⁶
- Western Australia's State of Emergency and the Public Health State of Emergency came to an end on 4 November 2022. There are currently no Public Health Declarations or Directions in place relating to COVID-19. A Temporary COVID-19 Declaration can be made by the State Emergency Coordinator if COVID-19 escalates and public health and social measures are needed to protect the community.
- People must obey Public Health Directions despite the provisions of any other written law (e.g. the *Mental Health Act 2014*) but this does not negate or override the whole of the other Act. The *Mental Health Act 2014* still otherwise applies.

¹⁶ Available from: https://www.legislation.wa.gov.au/legislation/statutes.nsf/main_mrtitle_13791_homepage.html

3 Training and preparation

3.1 Training

- Ensure that all staff are up to date in completing training in:
 - Trauma-informed care and practice.
 - Preventing and managing aggression.
 - Basic life support and defibrillation.
 - Donning and doffing Personal Protective Equipment (PPE) including Particulate Filter Respirator (PFR) fit-checking.
- Staff should regularly practice scenarios relevant to the local healthcare context to ensure that they are confident in optimising the safe delivery of care to consumers deemed to be COVID-19 positive, symptomatic and/or a close contact, including:
 - Donning and doffing PPE including fit-checking PFR masks.
 - De-escalation while wearing PPE.
 - Restraint while wearing PPE.
 - Responding to a medical emergency while wearing PPE.

3.2 Preparation

- Staff should undergo annual fit-testing to ensure the most effective PFR is used for that individual.
- Services should develop clear plans for managing an episode of acute behavioural disturbance safely without exposing large numbers of staff, consumers and visitors to COVID-19.¹⁷
 - Ensure security staff can access areas in a timely way if doors are closed to create isolation areas.
 - Ensure that staff arriving to respond to an incident receive clear handover information about risks and plans to manage the situation.
 - Identify a suitable space for clinical and security staff to safely don (including fit-check PFR) PPE in a timely way.
 - Keep the number of staff responding to a safe minimum.
 - Establish protocols to minimise the risk of clinical staff without PPE responding to duress alarms in potentially contaminated areas.
 - Ensure consumers in self-isolation can be evacuated safely.
 - Establish a plan to facilitate entry of external emergency services (police, fire and rescue) into areas with risk of COVID-19 exposure.¹⁸

¹⁷ Lightfoot, J., Harris, D., & Haustead, D. (2020). The challenge of managing patients with COVID-19 and acute behavioural disturbances. *Emergency Medicine Australasia*. Available from: <https://onlinelibrary.wiley.com/doi/10.1111/1742-6723.13522> (copy and paste link to web browser).

¹⁸ Ibid.

4 Prevention and early intervention strategies

This section outlines strategies for prevention of acute behavioural disturbance and early intervention to prevent further escalation while maintaining infection prevention and control.

4.1 Environment

- Consider the most appropriate environment for a consumer to minimise infection risk and agitation, especially if they need to spend a long time in isolation. For example, where available, provide access to an activity area, courtyard, window, or space to pace around.
- Identify creative ways to adapt the environment safely to consumers' needs within the constraints of infection control in your setting.
- Develop creative strategies for managing consumers who cannot, or will not, isolate (e.g. provide access to an appropriate area or room).
- Make provisions for the isolation needs of consumers who need to pace (e.g. due to akathisia) and cannot be kept in their room.
- If access to an outdoor area is constrained due to physical distancing and isolation requirements, prioritise activity options in-situ.
- Processes for transferring consumers who are COVID-19 positive, symptomatic or a close contact should be set in place in advance so that receiving services can plan for their safe receipt and admission in an appropriate environment.

4.2 Information and communication

- Make every effort to assist consumers, carers and families to understand, comply with, and cope with COVID-19 infection prevention and control measures.
 - Discuss the rationale for strategies to manage COVID-19 infection risk (e.g. isolation, social distancing and PPE).
 - Address concerns and clearly identify a point of contact for queries.
- Recognise that some consumers may find it difficult or confronting to communicate with staff who are wearing PPE.
 - Staff wearing face masks and eye protection are more difficult to recognise, and their non-verbal facial expressions are hidden.
 - Masks may make speech difficult to understand. People with hearing impairment will be unable to lip read if someone is wearing a mask.
- **Consider strategies to support communication while wearing PPE:**
 - Remind consumers, carers and family members of the reason for PPE.
 - Display names and photographs of staff on duty and provide staff with large print name tags or stickers.

- Staff wearing PPE, particularly masks, should make every effort to introduce themselves, speak clearly and slowly, and check that the consumer has understood what they have said.
- Orient consumers, carers and families to the roles of staff providing their care.
- Provide information regarding COVID-19 in a variety of accessible formats.
 - Use easy read guidelines for people with cognitive impairment.¹⁹
 - Provide translated resources for people from culturally and linguistically diverse backgrounds.^{20,21}
- The Australian Commission on Safety and Quality in Health Care has produced a COVID-19 guideline to support safe, high quality care for people with cognitive impairment.²²
- The *WA Health System Language Services Policy*²³ and the *COVID-19 Use of Interpreters Guideline*²⁴ may apply.
 - For consumers who cannot communicate effectively in English (including people who use Auslan).
 - For Aboriginal people whose first language is not English.

4.3 Engaging carers, family and friends

- Infection control constraints can present challenges for engaging families and carers. However, they are critical to supporting consumers' mental well-being by reducing isolation and advocating for consumers' needs. This can help minimise risk of escalation to acute behavioural disturbance.
- Identify ways to ensure carers, family and friends remain engaged in the assessment, treatment and support of consumers in accordance with isolation requirements and relevant service-specific policies. For example, provide consumers with access to a mobile device and internet connection in a protective case that can be cleaned and disinfected once the episode of care is complete.
- See section 7.1 for Aboriginal people and section 7.2 for children and youth.
- For LGBTIQ+ people, identify a person's nominated carer/next of kin; and ensure that same-sex partners are engaged and supported.

¹⁹ Available from: <https://www.communities.wa.gov.au/coronavirus-covid-19/disability-services-covid-19/>.

²⁰ Available from: https://www.healthywa.wa.gov.au/Articles/A_E/Coronavirus/Coronavirus-translated-resources

²¹ Available from: <https://www.health.gov.au/resources/translated>

²² Available from: <https://www.safetyandquality.gov.au/our-work/cognitive-impairment/cognitive-impairment-and-covid-19>

²³ Available from: <https://ww2.health.wa.gov.au/About-us/Policy-frameworks/Communications/mandatory/WA-Health-System-Language-Services-Policy>

²⁴ Available from: <https://ww2.health.wa.gov.au/-/media/Files/Corporate/general-documents/Infectious-diseases/PDF/Coronavirus/COVID-19-Interpreter-guidelines.pdf>

4.4 Individualised care and safety planning

Figure 2: Elements of a safety plan for minimising escalation to acute behavioural disturbance

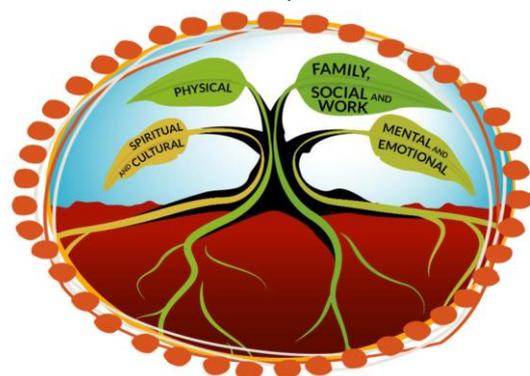


- Prioritise the development and implementation of individualised Safety Plans that incorporate the infection control considerations (see Figure 2) for the prevention, de-escalation and management of psychological distress and acute behavioural disturbance.
- Work proactively with the consumer, carer and family to identify existing triggers and management strategies.

For Aboriginal people, ensure the Safety Plan considers culture and community. The Stay Strong Plan provides an appropriate framework (see Figure 3).²⁵

- Staff should hand over information regarding individualised Safety Plans at transitions in care (e.g. shift change, transfer and discharge).

Figure 3: The Grow Strong Tree from the Stay Strong Plan represents the foundations of mental health; the Spiritual, Physical, Family, Social and Work, and Mental and Emotional components of our lives.



²⁵ Available from: https://www.menzies.edu.au/page/Research/Indigenous_Health/Mental_health_and_wellbeing/

4.5 Prevention and early intervention strategies

- Where possible, avoid or reduce known precipitants for acute behavioural disturbance.
- Identify and proactively manage or treat direct causes of psychological distress and acute behavioural disturbance (e.g. delirium, isolation, bereavement, lack of face to face visits, alcohol or other drug withdrawal, boredom, and denial of leave).
- The increased occurrence of delirium in older adults may increase the risk of acute behavioural disturbance and should be considered when developing care plans (see section 4.8).
- Recognise that Aboriginal people may present with cultural phenomena that may be confused with symptoms of delirium, psychosis or intoxication/withdrawal. It is important to clarify this as the cause will inform appropriate management (see section 7, Aboriginal people).
- Maximise consumers' ability to apply self-directed activities for coping with isolation and physical distancing requirements *and* minimising risk of acute behavioural disturbance. For example, provide resource packs (items should be disposable or able to be cleaned and disinfected) to support:
 - Self-directed activities (e.g. books, art materials and music).
 - Access to a mobile device and internet connection in a protective case that can be cleaned and disinfected.
 - Meditation.
 - Sensory modulation.
- For mental health units, encourage engagement with and access to Mental Health Advocates and peer support workers to facilitate consumers in applying self-directed strategies aimed at maintaining mental well-being and minimising psychological distress.
- Staff may need to liaise with the Public Trustee and/or Public Advocate for consumers under a guardianship or administration order.

4.6 De-escalation

- De-escalation is a particularly important strategy for managing acute behavioural disturbance to minimise the risk of COVID-19 transmission.
- All usual strategies apply (see Appendix B), paying particular attention to clear communication (see section 4.2).²⁶

²⁶ Ten domains of de-escalation adapted from: <https://mhphds-healthpoint.hdwa.health.wa.gov.au/directory/Education/Pages/Take-5.aspx>; and Richmond, J et al. (2012). *Verbal De-escalation of the Agitated Patient: Consensus Statement of the American Association for Emergency Psychiatry Project BETA De-escalation Workgroup*. The western journal of emergency medicine. 13. 17-25. 10.5811/westjem.2011.9.6864.

4.7 Managing co-occurring alcohol and other drug use

- Alcohol and other drug intoxication or withdrawal may contribute to acute behavioural disturbance.
- History from the consumer, carer and family will assist in determining whether alcohol or other drug use plays a part in the consumer's presentation.
- Screen for nicotine dependence as early as possible on admission and provide consumers with access to nicotine withdrawal management if needed.²⁷
- Identify and ensure continuity of opioid substitution treatment where required. Further collateral information may be obtained from the following:
 - For Medicines and Poisons Regulation Branch, call 08 9222 6883.²⁸
 - For Community Pharmacotherapy Program, call 08 9219 1913.²⁹
- If local clinical advice is not available, clinical advice for health professionals on management of all issues relating to alcohol and other drug use is available from experienced addiction medicine specialists from 08:00 to 20:00 hrs Monday to Friday through the Drug and Alcohol Clinical Advisory Service (DACAS) by calling 08 6553 0520.³⁰



²⁷ Available from: <https://ww2.health.wa.gov.au/~media/Corp/Policy-Frameworks/Public-Health/Smoke-Free-Policy/Supporting/Guidelines-for-the-implementation-of-the-Smoke-Free-Policy.pdf>

²⁸ Available from: https://ww2.health.wa.gov.au/Articles/N_R/Opioid-substitution-treatment

²⁹ Available from: <https://www.mhc.wa.gov.au/about-us/our-services/community-pharmacotherapy-program/>

³⁰ Available from: <https://www.mhc.wa.gov.au/about-us/our-services/drug-and-alcohol-clinical-advisory-service/>

4.8 Recognising and managing delirium

- Delirium is common in the context of COVID-19 and may be a symptom at initial presentation and/or during management.³¹
- Delirium may present as agitated, disturbed behaviour and is therefore important to recognise.
- Prevention and screening are the most effective ways to manage delirium.
 - Identify consumers at increased risk.
 - Screen for and detect delirium. The 4AT is a useful rapid clinical test for delirium (see Appendix A).³²
 - Monitor for and assess potential causes of delirium. PInCH ME is a useful mnemonic (see Figure 4).³³
- Carers and family can play a pivotal role in preventing delirium by reducing isolation, providing daytime stimulation to maintain sleep wake cycles, and advocating for consumer needs.³⁴ This may need to be facilitated by audio-visual means.
- Maximise orientation and reduce isolation. The 3Rs is a useful mnemonic:
 - Verbally **REASSURE**.
 - Use a loud, clear, slow voice to offset the communication challenges of using PPE/mask (see section 4.2).
 - Avoid confrontation.
 - **REORIENTATE** the consumer with each interaction.
 - Facilitate frequent videoconferencing with carer, family and friends.
 - Minimise sensory deprivation by making sure consumers are using any visual or hearing aids they may require.
 - Check understanding and **REPEAT INFORMATION** as needed to aid retention and recall.³⁵
- Maintain a low level of sensory stimulation – soft sound and lighting.

³¹ British Geriatrics Society. *Coronavirus: Managing delirium in confirmed and suspected cases*. 25 March 2020. Downloaded 13 May 2020 from: <https://www.bgs.org.uk/resources/coronavirus-managing-delirium-in-confirmed-and-suspected-cases>

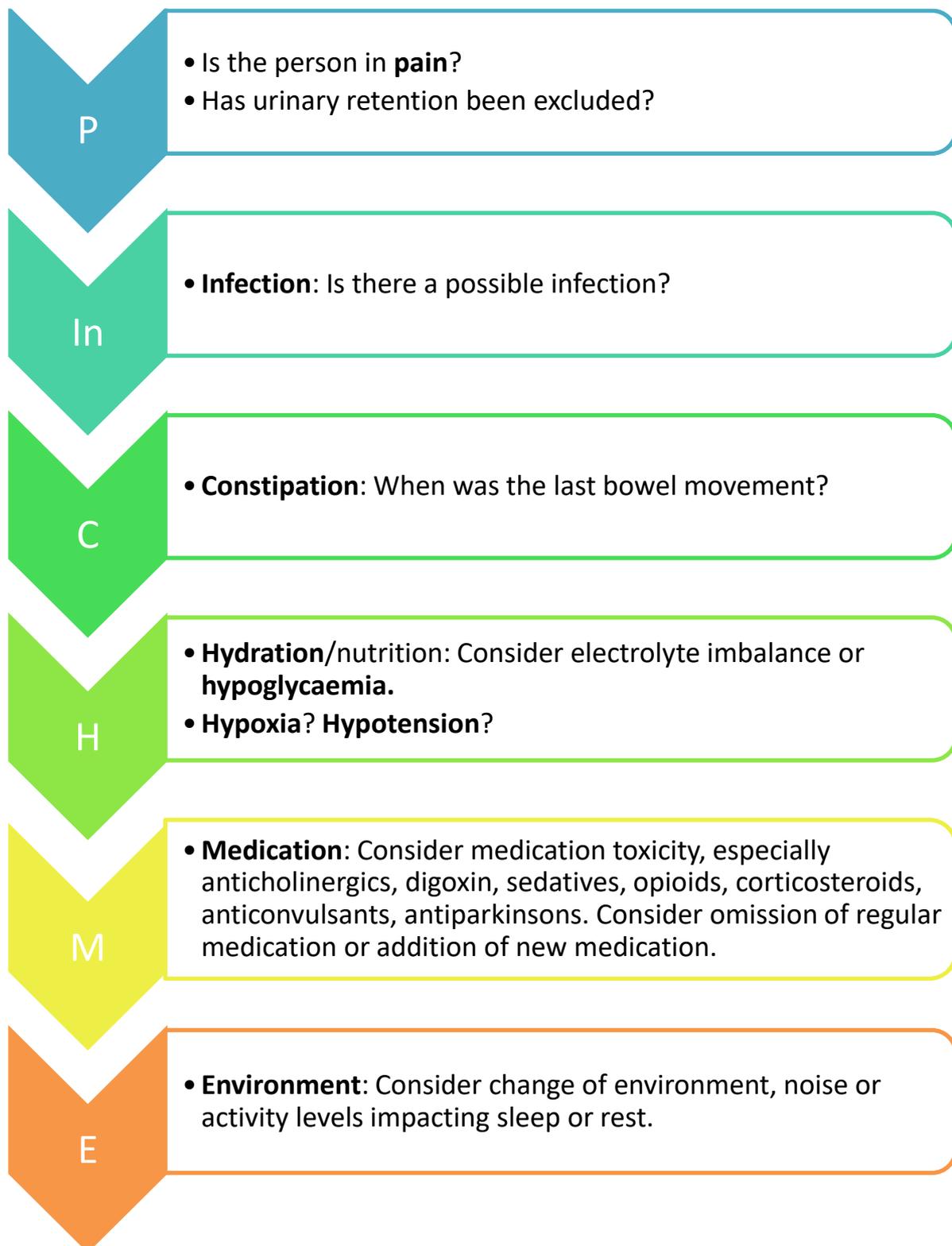
³² Meagher D et al. Developing a guidance resource for managing delirium in patients with COVID-19. *Irish Journal of Medicine*. DOI: 10.1017/ipm.2020.71. Downloaded 16 June 2020 from: <https://www.cambridge.org/core/journals/irish-journal-of-psychological-medicine/article/developing-a-guidance-resource-for-managing-delirium-in-patients-with-covid19/BED399A6E1E82231E2501176FB6A2F96>

³³ Available from: https://ww2.health.wa.gov.au/~/_/media/Files/Corporate/general-documents/End-of-Life/Goals-of-Care/PDF/Management-tips-for-suspected-delirium-in-patients.pdf

³⁴ LaHue SC et al. *Collaborative Delirium Prevention in the Age of COVID-19*. *J Am Geriatr Soc*. 2020 May; 68(5): 947–949. Published online 2020 May 17. Downloaded 12 June 2020 from: <https://onlinelibrary.wiley.com/doi/abs/10.1111/jgs.16480> (copy and paste link to web browser)

³⁵ Ibid.

Figure 4: PInCH ME assessment of potential causes of delirium³⁶.



³⁶ Meagher D et al. Developing a guidance resource for managing delirium in patients with COVID-19. Irish Journal of Medicine. DOI: 10.1017/ipm.2020.71. Downloaded 16 June 2020 from: <https://www.cambridge.org/core/journals/irish-journal-of-psychological-medicine/article/developing-a-guidance-resource-for-managing-delirium-in-patients-with-covid19/BED399A6E1E82231E2501176FB6A2F96>

5 Use of medications for managing acute behavioural disturbance

- Always consider non-pharmacological behavioural management options first.
- When considering pharmacological treatment, work in accordance with the relevant national, statewide and local policies and guidelines.³⁷ Consumers with COVID-19 are more **vulnerable to respiratory depression and cardiac effects and may experience rapid clinical deterioration**. Notably, they may exhibit few or no signs of hypoxia even with low oxygen saturation levels.^{38,39}
- General principles of pharmacological treatment are:
 - **Short acting medication**

Consider short acting medication as a consumer's physical health condition may rapidly deteriorate.⁴⁰
 - **Oral medication is preferred**

Where possible, oral medication is preferred and should be offered as the first choice; as parenteral medication is more likely to cause dose related side effects such as respiratory depression, postural hypotension, QTc prolongation and extrapyramidal side effects.⁴¹
 - **Start low, go slow**

With older adults and people who may be delirious or physically unwell, use the principle of start low, go slow. Begin with a low dose and titrate up slowly while monitoring closely for falls risk, sedation, cardiac and respiratory complications.
 - **Monitor observations and response (vital signs) (see 5.4)**
- Use local **Child and Adolescent Guidelines** for medications if required. The following three sections should be read in conjunction with the Child and Adolescent Health Service *Arousal and Agitation Drug Management* Guideline.⁴²
- The current physical health of the consumer is the key factor in decision-making regarding pharmacological treatment (see Figure 5).

³⁷ Such as *Joint Guideline for Safe Care for Patients Sedated in Health Care Facilities for Acute Behavioural Disturbance* (available from: <https://acem.org.au/getmedia/b8593544-9f62-4e91-bcb6-e5b45defb9ea/G637-2018-Guidelines-for-Safe-Care-for-Patients-Sedated-in-Health-Care-Facilities-for-Acute-Behavioural-Disturbance-republished>) and the *Statewide Medicines Formulary Policy* (available from: <https://ww2.health.wa.gov.au/About-us/Policy-frameworks/Clinical-Governance-Safety-and-Quality/Mandatory-requirements/Statewide-Medicines-Formulary-Policy>)

³⁸ Ottestad W, Seim M & Maehlen JO. *COVID-19 with silent hypoxemia*. Tidsskr Nor Legeforen. 21 April 2020. Downloaded 12 June 2020 from: <https://tidsskriftet.no/en/2020/04/kort-kasuistikk/covid-19-silent-hypoxemia>

³⁹ Ottestad W & Sovik S. *COVID-19 patients with respiratory failure: what can we learn from aviation medicine?* British Journal of Anaesthesia. Article in press. Downloaded 12 June 2020 from: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7165289/pdf/main.pdf>

⁴⁰ Ibid.

⁴¹ Ibid.

⁴² Available from: <https://healthpoint.hdwa.health.wa.gov.au/policies/Policies/CAHS/PCH.PHARM.ArousalAndAgitationDrugManagement.pdf>

5.1 Benzodiazepines

- Where a consumer has compromised respiratory function avoid benzodiazepines if possible (see Figure 5).
- If benzodiazepines are to be used, lorazepam is the preferred benzodiazepine as it has a short half-life and no active metabolites (oral medication is first choice).
- Ensure immediate access to flumazenil is available if benzodiazepines are given.⁴³
- If benzodiazepines are used, carefully monitor respiratory function and oxygen saturation levels.
- Simultaneous injections of intramuscular olanzapine and parenteral benzodiazepines can result in excessive sedation and cardiorespiratory depression; so, they must be given at least one hour apart.
- Note that benzodiazepines may be appropriate in people who are already receiving end of life palliative care for severe respiratory distress.⁴⁴

5.2 Antipsychotics

- In the context of COVID-19, cardiac effects are an important concern in the choice of antipsychotic (see Figure 5).
- In addition, it is preferable to choose an antipsychotic medication with a low propensity to cause respiratory depression (see Figure 5).
- Olanzapine has a favourable profile compared with risperidone and quetiapine.⁴⁵ It is for prescription under the direction of a Consultant Psychiatrist for acute agitation and arousal.
- Droperidol is the preferred and recommended intramuscular antipsychotic medication to use. Haloperidol carries more risk with QTc prolongation than Droperidol.
- Monitor cardiac function in particular to rule out QTc prolongation with a baseline ECG.
- Monitor for extrapyramidal side effects – particularly dystonic reactions involving the airway. A parenteral anticholinergic e.g. Benztropine should be administered in this instance.
- Consumers with delirium and older adults may be particularly sensitive to adverse effects from psychotropic medication.
- Febrile patients may have their seizure thresholds altered by antipsychotics. Patients with history of seizures may have their seizure thresholds altered by

⁴³ Ibid.

⁴⁴ See https://ww2.health.wa.gov.au/Articles/A_E/Clinical-resources-for-End-of-Life-and-Palliative-Care-in-the-COVID19-environment

⁴⁵ Meagher D et al. Developing a guidance resource for managing delirium in patients with COVID-19. Irish Journal of Psychological Medicine, 1-16. <http://dx.doi.org/10.1017/ipm.2020.71>

antipsychotics. Non-febrile patients with no history of seizures may have seizure thresholds altered by antipsychotics.⁴⁶

- Avoid long-acting formulations like zuclopenthixol acetate.

5.3 Interactions between psychotropic medication and antiviral agents

- Staff should consider any actual and potential drug interactions with medication prescribed to treat respiratory symptoms and/or COVID-19 (e.g. antivirals).
- Staff should use usual processes to identify medication interactions (e.g. Liverpool University, MIMS, Micromedex etc) and specialist pharmacist advice.
- Common interactions via CYP enzyme pathways can result in unpredictable drug levels and increased risk of adverse events.
- Olanzapine has a favourable profile in relation to interactions with oral COVID-19 antiviral therapies. Haloperidol, risperidone and quetiapine increase the potential of adverse effects of many antiviral agents. Stop and replace haloperidol if possible. Specialist prescriber or pharmacist consultation is recommended because of potential for effects on cardiac conduction.^{47,48}

WA Health has issued guidance for [oral COVID-19 antiviral medications in relation to drug interactions](#) mentioned in this document.

What prescribers and pharmacists need to know

- [Molnupiravir \(Lagevrio®\) – what prescribers and pharmacists need to know \(PDF 301KB\)](#)
- [Nirmatrelvir + Ritonavir \(Paxlovid®\) – what prescribers and pharmacists need to know \(PDF 287KB\)](#)

Hospital guidelines

- [WA Health guidelines for use of Molnupiravir \(Lagevrio®\) for COVID-19 \(PDF 197KB\)](#)
- [WA Health guidelines for use of Nirmatrelvir + Ritonavir \(PDF 540KB\)](#)
- [WA Health guidelines for use of Sotrovimab for COVID-19 \(PDF 322KB\)](#)

⁴⁶ Dix R, Tunnicliffe T and Thomas S (Eds). *Managing acute disturbance in the context of COVID-19*. National Association of Psychiatric Intensive Care and Low Secure Units. Revised 11 May 2020. Downloaded 13 May 2020 from: https://napicu.org.uk/wp-content/uploads/2020/12/NAPICU-Guidance_rev5_15_Dec.pdf

⁴⁷ Meagher D et al. Developing a guidance resource for managing delirium in patients with COVID-19. *Irish Journal of Psychological Medicine*, 1-16. <http://dx.doi.org/10.1017/ipm.2020.71>

⁴⁸ University of Liverpool COVID-19 Drug Interaction Checker. Available from: <https://www.covid19-druginteractions.org/>

5.4 Physical health monitoring

- It is essential to **check and continually monitor vital signs, particularly respiration, oxygen saturation levels and level of consciousness**, when using pharmacological treatment.⁴⁹
- Use of pulse oximetry provides rapid detection of desaturation.
- Monitors should be applied as soon as practicable; however, it is recognised that this may need to be delayed until consumer co-operation is achieved.
- Monitoring must always be used in conjunction with careful clinical observation, as there are circumstances in which equipment may not detect clinical deterioration.⁵⁰
- Monitoring equipment could be used for self-harm or as a weapon and consequently requires appropriate care and storage when not in use.
- Equipment should be cleaned in line with infection control recommendations.
- Staffing must include trained practitioners with the ability to recognise and manage an obstructed airway and maintain oxygenation, ventilation and cardiovascular support if required.
- Staff must have knowledge of and access to rescue medications to reverse medication induced side effects (e.g. Benzatropine for extrapyramidal side effects, flumazenil for benzodiazepine associated respiratory depression).
- If someone has respiratory insufficiency they should be managed in close collaboration with the respiratory team who may need to have the intubation team on standby.
- If the consumer is sedated they must be closely monitored for clinical deterioration, and care escalated as per recognising and responding to acute deterioration protocols.
- If a consumer with symptoms of respiratory deficiency with COVID-19 is sedated to control behaviour and becomes hypoxic, they may need oxygen via high flow humidified nasal cannula.
- If sedation results in Type 2 respiratory failure, then intubation will be required.

⁴⁹ ACEM, ANZCA, CICM & RANZCP *Joint Guideline for Safe Care for Patients Sedated in Health Care Facilities for Acute Behavioural Disturbance*. Available from: <https://acem.org.au/getmedia/b8593544-9f62-4e91-bcb6-e5b45defb9ea/G637-2018-Guidelines-for-Safe-Care-for-Patients-Sedated-in-Health-Care-Facilities-for-Acute-Behavioural-Disturbance-republished>

⁵⁰ Ibid.

Figure 5: Recommendations for medication management of acute behavioural disturbance in adult consumers

CONSUMER SCENARIO	USE	AVOID
COVID-19 positive or symptomatic	Local health service acute sedation guidelines	AVOID WHERE POSSIBLE use of the following options due to risk of respiratory depression or excessive sedation: <ul style="list-style-type: none"> • Promethazine • Benzodiazepines • Chlorpromazine • Zuclopenthixol acetate
Close contacts, asymptomatic and COVID-19 status unknown	Local health service acute sedation guidelines	AVOID WHERE POSSIBLE use of the following options due to risk of respiratory depression or excessive sedation: <ul style="list-style-type: none"> • Benzodiazepine use should be minimised. If necessary, use a short acting option e.g., lorazepam. Avoid use of long-acting agents clonazepam or diazepam. • Chlorpromazine • Zuclopenthixol acetate
No recent exposure to a positive case and no symptoms and COVID-19 status unknown	Local health service acute sedation guidelines	

6 Managing an acute behavioural incident

- Stay safe. In a high-risk situation, know you have the choice to retreat to a place of safety and consult with colleagues to plan a management strategy.
- Be aware that shouting and spitting increase the risk of COVID-19 transmission.
- Medication, restraint and seclusion carry particular risks in the COVID-19 context. Clinical decisions will depend on a case-by-case assessment of the risks and benefits of different courses of action.
- Clinical documentation should include the following:
 - The rationale for the chosen action.
 - The name of the person who made the decision.
 - The name of the person notified and/or to whom the decision was escalated.

People with COVID-19 infection can experience rapid clinical deterioration.

People with COVID-19 are more vulnerable to respiratory depression and cardiac effects.

Restrictive practices should only be used as a last resort.

Monitor vital signs closely for any indication of clinical deterioration for the duration of the intervention used.

6.1 PPE and infection control considerations

- Refer to the system-wide mandatory *Identification and Use of Personal Protective Equipment in the Clinical Setting Policy* and the associated [related document](#).⁵¹
- Staff providing care to patients who are COVID-19 positive, symptomatic and/or a close contact must wear a fit tested particulate filter respirator (PFR), protective eyewear, gown and gloves.
- Plastic aprons are not recommended for use when applying restraint in consumers with suspect or confirmed COVID-19. Scenario training in WA and experience in other countries shows they can be easily ripped and may become a hazard.
- Donning and doffing areas should be clearly identified. Any person entering the patient room or designated isolation area is to don PPE prior to entry to

⁵¹ Available from: <https://ww2.health.wa.gov.au/About-us/Policy-frameworks/Public-Health/Mandatory-requirements/Communicable-Disease-Control/Infection-Prevention-and-Control/Identification-and-Use-of-Personal-Protective-Equipment-in-the-Clinical-Setting-Policy>

the room or isolation area. Non-essential personnel are not to enter these rooms or designated isolation areas.

- Clear signage indicating the appropriate transmission-based precautions and required PPE is to be placed at the entrance of the patient room or in a prominent position at the entry to the designated isolation area or zone.
- In an emergency, a mask and eye protection are the most important PPE.
- All staff should be trained in donning and doffing PPE. Consider having a small team who are expert in donning and doffing PPE, or who always wear PPE while on duty, who are ready to respond if physical restraint is necessary. If physical restraint is necessary, rotate staff and change PPE once restraint has been carried out.
- Develop a local strategy for how to respond if PPE is breached while applying physical restraint or while providing patient care. A staff log should be maintained of all staff entering the room of a COVID-19 positive, symptomatic and/or close contact patient to allow for monitoring of potential IPC breaches and contact tracing.
- When possible, patients are to wear a surgical mask, and if on oxygen therapy transitioned to nasal prongs if their condition allows, during inter and intra hospital transfers

The WA health system's mandatory policies on infection prevention and control and PPE are being updated regularly.

Mandatory policy:

<https://ww2.health.wa.gov.au/About-us/Policy-frameworks/Public-Health/Mandatory-requirements/Communicable-Disease-Control/Infection-Prevention-and-Control/Identification-and-Use-of-Personal-Protective-Equipment-in-the-Clinical-Setting-Policy>

For other updates visit COVID-19 Information for Health Professionals:

https://ww2.health.wa.gov.au/Articles/A_E/Coronavirus/COVID19-information-for-health-professionals

6.2 Restrictive practices

6.2.1 Restraint

- Physical or mechanical restraint should only be applied in an authorised mental health unit as defined in the *Mental Health Act 2014* or in a non-authorised setting under the doctrine of necessity.
- Prone restraint carries a high risk of asphyxiation, especially in people already at risk of respiratory depression and must be avoided in people who are COVID-19 positive, symptomatic and/or a close contact.

APPLY THE FOLLOWING PRECAUTIONS WHEN USING RESTRAINT

In consumers who are COVID-19 positive, symptomatic and/or a close contact, physical restraint should be used for the minimum possible duration.

Avoid prone restraint.

People with COVID-19 infection are at risk of respiratory depression, cardiac effects and rapid clinical deterioration.

Closely monitor vital signs, particularly respiration and oxygen saturation, for any signs of clinical deterioration during and after restraint.

- The usual requirements apply for documenting and reporting restraint applied under the *Mental Health Act 2014* in an authorised mental health unit.
- Mechanical restraints must be thoroughly cleaned and disinfected between uses or laundered.
- Review incidents of restrictive practices to identify areas for improvement for the safe management of any future events.
- This guidance does not provide authority for consumers presenting with risk of COVID-19 infection to self or others to be restrained for this risk alone.

6.2.2 Seclusion

- A clear distinction should be maintained in terminology, documentation and clinical practice between:
 - **Seclusion** in an authorised mental health unit as defined in the *Mental Health Act 2014* or seclusion in a non-authorised setting under the doctrine of necessity, and
 - **Isolation** for infection control purposes in any setting in accordance with the system-wide mandatory *Identification and Use of Personal*

Protective Equipment in the Clinical Setting Policy and the associated [related document](#).⁵²

- Every effort should be made to ensure that mental health consumers understand the difference between isolation for infection prevention and control purposes and seclusion under the *Mental Health Act 2014*.
- The usual requirements apply for documenting and reporting seclusion applied under the *Mental Health Act 2014* in an authorised mental health unit.
- This guidance does not provide authority for consumers presenting with risk of COVID-19 infection to self or others to be secluded for this risk alone.

APPLY THE FOLLOWING PRECAUTIONS WHEN USING SECLUSION

People with COVID-19 infection are at risk of respiratory depression, cardiac effects and rapid clinical deterioration.

Closely monitor vital signs, particularly respiration and oxygen saturation, for any signs of clinical deterioration during seclusion.

Clearly document that observations are for the purpose of vital sign monitoring; and stipulate the type and frequency of observations.

⁵² Available from: <https://ww2.health.wa.gov.au/About-us/Policy-frameworks/Public-Health/Mandatory-requirements/Communicable-Disease-Control/Infection-Prevention-and-Control/Identification-and-Use-of-Personal-Protective-Equipment-in-the-Clinical-Setting-Policy>

7 Aboriginal people

- Identifying Aboriginal people is critical to implementing culturally safe care.
 - All health service providers are required to establish processes to accurately identify and record Aboriginal status. These processes should ensure that all people, regardless of appearance and across all service areas, are asked whether they identify as being of Aboriginal and/or Torres Strait Islander origin.
 - This information should be routinely recorded in information systems and should be consistent across administrative and clinical information systems.
 - The guideline, *How to identify Aboriginal and Torres Strait Islander Clients*⁵³, outlines best practice with regards to this process.
- Providing a culturally safe health care environment can prevent escalation to acute behavioural disturbance. Strategies for achieving this include:
 - Liaising with the health or mental health service in the relevant health region to ensure the appropriateness of response.
 - Engaging with an Aboriginal Liaison Officer (ALO), Aboriginal Mental Health Liaison Officer (AMHLO), and/or Aboriginal Mental Health Worker (AMHW) to help guide and implement culturally safe care.
 - Consulting with staff in the region in which the consumer resides to seek advice about local cultural and community considerations.
 - Making every effort to engage with a carer, family, elder, community member and/or traditional healer from the consumer's region of residence to help maintain connection to community and culture.
- Be aware that Aboriginal people may be experiencing grief and loss with associated psychological distress. This may be of particular relevance in the context of the COVID-19 pandemic.
- Engage with an ALO, AMHLO or AMHW who can:
 - Support the consumer during assessment and treatment.
 - Alleviate the consumer's concerns about family members' welfare while they are in isolation.
 - Support carers and family to access appropriate support services.
- Ensure carers and family have access to appropriate communications equipment to facilitate maintaining contact with the consumer. This may entail providing regular access to a mobile device (e.g. tablet or smart phone) and SIM/internet connection for the duration of the episode of care.

⁵³ Available from: <https://ww2.health.wa.gov.au/-/media/Files/Corporate/general-documents/Infectious-diseases/PDF/Coronavirus/COVID19-Collecting-identity-data-Aboriginal-ATSI-people.pdf>

- Explain COVID-19 and related treatment and infection control strategies and PPE to the consumer, carer, family, elder, community member and/or traditional healer.
 - Consider potential language barriers, particularly for Aboriginal people whose first language is not English, and engage an interpreter as needed (see section 4.2).
 - Do not assume providing written information is adequate, due to possible language barriers and low literacy.
 - Provide education to those collaborating in delivering treatment.
- Aboriginal COVID-19 resources:
 - Australian Government advice for Aboriginal people and remote communities.⁵⁴
 - WA Health COVID-19 guidance for the Aboriginal sector.⁵⁵
 - WA Health COVID-19 guidance for Aboriginal people and communities.⁵⁶
 - Aboriginal Health Council WA COVID-19 resources.⁵⁷

⁵⁴ Available from: <https://www.health.gov.au/news/health-alerts/novel-coronavirus-2019-ncov-health-alert/advice-for-people-at-risk-of-coronavirus-covid-19/coronavirus-covid-19-advice-for-aboriginal-and-torres-strait-islander-peoples-and-remote-communities>.

⁵⁵ Available from: https://ww2.health.wa.gov.au/articles/a_e/coronavirus.

⁵⁶ Available from: https://healthywa.wa.gov.au/Articles/A_E/Coronavirus/Coronavirus-information-for-Aboriginal-people.

⁵⁷ Available from: <https://www.ahcwa.org.au/coronavirus-updates>

8 Children and youth

- Make every effort to enable carers and family to maintain contact with the consumer for the duration of the episode of care.
- Explain COVID-19 and related treatment and infection control strategies and PPE to the consumer, carer and family.
 - Consider the young person’s literacy level and ability to comprehend.
 - Do not assume providing written information is adequate.
 - Provide education to those collaborating in delivering treatment.
- Child and Adolescent Health Service (CAHS) COVID-19 resources:
 - Information for health professionals regarding paediatric consumers who are COVID-19 positive, symptomatic and/or close contacts.⁵⁸
 - Coronavirus information for CAHS consumers and families.⁵⁹
 - Coronavirus information for children and young people.⁶⁰

⁵⁸ Available from: <https://pch.health.wa.gov.au/~media/Files/Hospitals/PCH/General-documents/Health-professionals/Clinical-Practice-Guidelines/Clinical-Care-for-Paediatric-Patients-During-the-COVID-19-Pandemic.pdf>

⁵⁹ Available from: <https://www.caHS.health.wa.gov.au/News/2020/03/Coronavirus>

⁶⁰ Available from: <https://www.cryp.wa.gov.au/info-for-children-and-young-people/>

9 Older adults

- Older adults who are COVID-19 positive, are at significant risk of developing psychological, psychiatric or behavioural issues.
- Wherever possible, consider and use non-pharmacological approaches to prevent delirium and manage behaviour (see sections 4 and 5).
- COVID-19 is associated with a markedly increased rate of mortality and morbidity for older adults, especially those with significant co-morbidities, which means they and their families are more likely to be anxious about adverse outcomes and to socially isolate.
- Behavioural disturbance in older adults is usually related to dementia, delirium or psychiatric illness and can frequently be of multifactorial aetiology; and, therefore, requires a multimodal approach to assessment and management.
- Older adults are more likely to suffer pre-existing conditions, such as dementia or cognitive impairment, which increase the risk of agitated behaviour and Behavioural and Psychological Symptoms of Dementia (BPSD); especially when combined with risk of superimposed delirium.
- Older adults are at increased risk of developing delirium, particularly if they have pre-existing cognitive decline, other medical co-morbidities, and/or sensory deficits.
 - COVID-19 may cause neurological disturbance which leads to delirium and behavioural disturbance via a range of pathways including direct central nervous system infection, reduced blood-brain barrier integrity, retrograde neuronal transport, hypoxic damage, vascular mechanisms and neuroinflammatory responses.
 - Patients in isolation, requiring mechanical ventilation, with reduced sensory input and mobilisation are more prone to developing delirium.⁶¹
 - First line management of BPSD and delirium should consider non-pharmacological approaches and should follow best practice guidelines, wherever possible. These may need to be modified to minimise the risk of COVID-19 transmission (see section 4.8).
- If non-pharmacological options are limited, then pharmacological options may be required to minimise risk to self and others (including COVID-19 infection).
- Older adult COVID-19 resources:
 - Providing safe hospital care for people with cognitive impairment during COVID-19 fact sheet.⁶²

⁶¹ Kotfis K, Williams Roberson S, Wilson JE, Dabrowski W, Pun BT, Ely EW. COVID-19: ICU delirium management during SARS-CoV-2 pandemic. *Crit Care*. 2020;24(1):176. Published 2020 Apr 28. doi:10.1186/s13054-020-02882-x.

⁶² Available from: <https://www.safetyandquality.gov.au/publications-and-resources/resource-library/safe-hospital-care-people-cognitive-impairment-during-covid-19-fact-sheet-clinicians>

- Advice for older people at risk of COVID-19.⁶³
- Key documents related to the care of the older person during COVID-19.⁶⁴

⁶³ Available from: <https://www.health.gov.au/news/health-alerts/novel-coronavirus-2019-ncov-health-alert/advice-for-people-at-risk-of-coronavirus-covid-19/coronavirus-covid-19-advice-for-older-people>

⁶⁴ Available from: https://ww2.health.wa.gov.au/Articles/A_E/Coronavirus/COVID19-information-for-Aged-Care-and-Community-Care-Providers

Appendix A: 4AT Assessment test for delirium and cognitive impairment

- The 4AT is a brief screening tool designed for rapid initial assessment of delirium and cognitive impairment in clinical practice (see Table 1).⁶⁵

Table 1: 4AT Assessment test for delirium and cognitive impairment.

1. Alertness			
<i>This includes patients who may be markedly drowsy (e.g. difficult to rouse and/or obviously sleepy during assessment) or agitated/hyperactive. Observe the patient. If asleep, attempt to wake with speech or gentle touch on shoulder. Ask the patient to state their name and address to assist rating.</i>			
Normal (fully alert, but not agitated, throughout assessment)			<input type="checkbox"/> 0
Mild sleepiness for <10 seconds after waking, then normal			<input type="checkbox"/> 0
Clearly abnormal			<input type="checkbox"/> 4
2. AMT4 (Abbreviated Mental Test 4)			
<i>Age, date of birth, place (name of the hospital or building), current year.</i>			
No mistakes			<input type="checkbox"/> 0
1 mistake			<input type="checkbox"/> 1
2 or more mistakes/untestable			<input type="checkbox"/> 2
3. Attention			
<i>Ask the patient: "Please tell me the months of the year in backwards order, starting at December." To assist initial understanding one prompt of "what is the month before December?" is permitted.</i>			
Achieves 7 months or more correctly			<input type="checkbox"/> 0
Starts but scores <7 months / refuses to start			<input type="checkbox"/> 1
Untestable (cannot start because unwell, drowsy, inattentive)			<input type="checkbox"/> 2
4. Acute change or fluctuating course			
<i>Evidence of significant change or fluctuation in: alertness, cognition, other mental function (e.g. paranoia, hallucinations) arising over the last 2 weeks and still evident in last 24 hours.</i>			
No			<input type="checkbox"/> 0
Yes			<input type="checkbox"/> 4
4 or more	Possible delirium +/- cognitive impairment		TOTAL 4AT SCORE
1-3	Possible cognitive impairment		
0	Delirium or severe cognitive impairment unlikely (but delirium still possible if information for item 4 is incomplete).		

⁶⁵ MacLulich A, Ryan T & Cash H. *The 4AT Rapid Clinical Test for Delirium*. Available from: <https://www.the4at.com/>

Test items

- **Alertness:** An altered level of alertness is very likely to be delirium in general hospital settings. If the patient shows significant altered alertness during the bedside assessment, score 4 for this item.
- **AMT4 (Abbreviated Mental Test - 4):** This score can be extracted from items in the AMT10 if the latter is done immediately before.
- **Months of the Year Backwards:** This item uses the Months of the Year Backwards screening method.⁶⁶
- **Acute Change or Fluctuating Course:** Fluctuation can occur without delirium in some cases of dementia, but marked fluctuation usually indicates delirium. To help elicit any hallucinations and/or paranoid thoughts ask the patient questions such as, “Are you concerned about anything going on here?”; “Do you feel frightened by anything or anyone?”; “Have you been seeing or hearing anything unusual?”

Administration

- The tester should take account of communication difficulties (hearing impairment, dysphasia, lack of common language) when carrying out the test and interpreting the score.
- Items 1-3 are rated *solely on observation of the patient at the time of assessment*.
- Item 4 requires information from one or more source(s). For example:
 - The tester’s own knowledge of the patient.
 - Other staff who know the patient (e.g. ward nurses).
 - GP letter and/or case notes.
 - Carers.

Scoring and interpretation

- A score of 4 or more *suggests* delirium but is not diagnostic. More detailed assessment of mental status may be required to reach a diagnosis.
- A score of 1-3 suggests cognitive impairment and more detailed cognitive testing and informant history-taking are required.
- A score of 0 does not definitively exclude delirium or cognitive impairment. More detailed testing may be required depending on the clinical context.

⁶⁶ O'Regan NA, Ryan DJ, Boland E, et al Attention! A good bedside test for delirium? Journal of Neurology, Neurosurgery & Psychiatry 2014;85:1122-1131. Downloaded 12 June 2020 from: <https://jnnp.bmj.com/content/85/10/1122>

Appendix B: Ten domains of de-escalation

- Figure 6 lists the ten domains of de-escalation that are commonly applied.⁶⁷
- The North Metropolitan Health Service *De-escalation and crisis communication* Take 5 training provides a brief overview of key considerations in relation to de-escalation.⁶⁸

Figure 6: Ten domains of de-escalation.

Respect personal space.	When approaching the agitated patient, maintain at least 2 arm's lengths of distance between you and the patient.
Do NOT be provocative.	Demonstrate by body language that you want to listen, and that you want everyone to be safe.
Establish verbal contact.	Designate one clinician to talk with the person. Multiple people can be confusing.
Be concise and clear.	Use short sentences and simple words. Give the person time to process and respond.
Identify feelings, needs and wants.	Ask the person what they want, whether or not this can be met. Actively listen. Show you are paying attention and check that you understand what the person is saying.
Actively listen	Listen closely and with genuine attention to what the individual is saying.
Agree, or agree to disagree.	Agree with the truth; agree in principle; agree with the odds; or agree to disagree.
Set limits.	Be clear about expectations. Tell the person about acceptable (and unacceptable) behaviours in a clear, matter-of-fact way and not as a threat.
Offer choices and optimism.	Offer realistic choices that provide constructive alternatives to violence; and realistic reassurance that they are safe and that things will improve.
Debrief/support all involved.	Staff reflect on what went well and what could be improved. Staff restore rapport with the person, and identify with them what works to help them stay in control when very upset.

⁶⁷ Ten domains of de-escalation adapted from: <https://mhphds-healthpoint.hdwa.health.wa.gov.au/directory/Education/Pages/Take-5.aspx>; and Richmond, J et al. (2012). *Verbal De-escalation of the Agitated Patient: Consensus Statement of the American Association for Emergency Psychiatry Project BETA De-escalation Workgroup*. The western journal of emergency medicine. 13. 17-25. 10.5811/westjem.2011.9.6864.

⁶⁸ Available from: <https://mhphds-healthpoint.hdwa.health.wa.gov.au/directory/Education/Pages/Take-5.aspx>

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- Acute Behavioural Disturbance Guidelines Working Group;
- COVID-19 Mental Health Clinical Leads Group;
- Infection Prevention and Control Clinical Advisory Group;
- COVID-19 Mental Health Working Group;
- Mental Health Pharmacy Service.

Version Control

Revision History

Version	Date	Summary of Changes	Author/Role
1.0	02/07/2020	Initial version	SHICC Health Operations Mental Health
2.0	31/08/2020	Section 6.1 PPE and infection control considerations, updated to reflect changes to mandatory policy on PPE, issued 24 August 2020	SHICC Health Operations Mental Health
3.0	11/03/2022	Section 1.4 COVID-19 infection status updated to reflect latest CDNA SoNG; added link to COVID-19 Infection Prevention and Control in Western Australian Healthcare Facilities; Section 5.5 use of medications updated based on current pharmacological advice Section; 6.1 PPE and infection control considerations updated to reflect changes to mandatory policy on PPE; Section 6.2.1 addition of disinfecting or laundering mechanical restraints. Links updated throughout document.	Mental Health Projects SHICC Health Operations COVID-19 Mental Health Working Group WA Psychotropic Medication Group WA Therapeutic Advisory Group
3.1	02/05/2022	Title change and review by SHICC Public Health Cell	SHICC Public Health Operations SHICC Public Health Advice and Biosecurity
3.2	16/06/2022	Terminology changes and review	SHICC Health Operations and Mental Health Working Group
4.1	16/01/2023	Whole document reviewed and changes made to reflect the end of the State of Emergency and Public	Mental Health Unit, Patient Safety and Clinical Quality,

		Health State of Emergency in WA and revocation of related Public Health Directions. Links updated throughout the document.	Clinical Excellence Division.
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