Behavioural disturbances in older adults

Queensland Ambulance Service: A paramedic perspective

Acknowledgment of Country

"I too would like to begin by acknowledging the Yugambeh people who are the Traditional Owners of the land on which we meet today and pay my respects to Elders past, present and emerging.

I would also like to acknowledge any other Indigenous, Torres Strait Islanders or Australian South Sea Islanders participating in this forum either in person or virtually."

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QAS Purpose

We deliver timely, quality, and appropriate, patient focused ambulance services to the Queensland Community

Strategic Objectives

Caring for Queenslanders
Our Workforce
Health System Integration
Sustainability
Our Systems and Processes

(QAS Strategy 2022-2027)

QAS & RACFs: The Stats

49,182 QLD

8410 or 17.1% are from the Gold Coast

246 (2.9%)

Gold Coast RACFs calling for behavioural disturbances

19 (0.2%)

RACF patients requiring chemical sedation from QAS Paramedics

Allocation of QAS resources

105 Mins

Average transport case interval

14,717.5 Hours

QAS time per year across QLD

105 Days

614.2 full days across QLD

Challenges for patients & paramedics

- Pts can become claustrophobic
- Pts often present with increased confusion and fear during transport
- The ambulance is small – we sit approx. 1 foot away from the patient
  - Increase of exposure to injury by patients who may be scared and become physical.
- Emergency Departments are loud (especially the triage ramp!)
- Communicable disease exposure
- Stretchers are smaller and less comfortable than their normal beds
- Car sickness
- Potential exposure to adverse weather
  - We cannot always park undercover at ED, or at RACFs.

What are paramedics trained and expected to do?

- They are expected to conduct a full assessment post-handover
- They are expected to work collaboratively with the RACF team and any other relevant professionals.

- Expect the following:
  - Paramedics will be looking for a handover with the on-site RN wherever possible
  - Paramedics will ask to call the patients GP and discuss their condition with them
  - Paramedics are encouraged to call RaSS. This is often done pro-actively prior to QAS arrival.

Increased use of Clinical Hub and specialist LARU/Community Paramedics

- The QAS Clinical Hub gives paramedics access to:
- Emergency physicians, mental health nurses and social workers
- They work in collaboration with RaSS and the Gold Coast Hospital PACH.
- Attendance by our specialist LARU/Community Paramedics is designed to work collaboratively with RACF staff
- LARU/Community Paramedics have additional post-graduate specialist paramedic training to support community-based care and health care navigation
- These systems are designed to integrate with the RACF and other key stakeholders

What treatment can we offer an agitated patient?

Differentiating the cause of behavioural disturbances is **important.**

Acute Behavioural Disturbance – *QAS Clinical Practice Guideline 2024*

Paramedics must explore all options to de-escalate dangerous or potentially dangerous behaviour

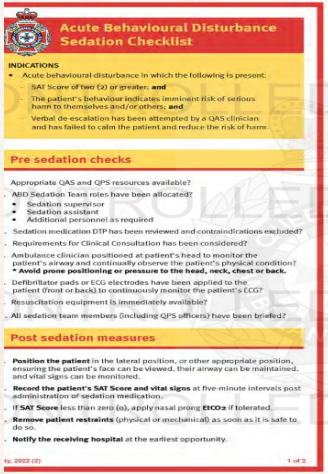
This can often take time

Restraint (physical or chemical) is a last resort and is associated with poorer patient outcomes

QPS are required to be on scene if physical restraint is required

Patient Safety Tools & Checklists

SEDATION ASSESSMENT TOOL[1]		
Score	**Responsiveness**	**Speech**
+3	Combative, violent, out of control	Continual loud outbursts
+2	Very anxious and agitated	Loud outbursts
+1	Anxious/restless	Normal/talkative
0	Awake and calm/cooperative	Speaks normally
-1	Asleep but rouses if name is called	Slurring or prominent slowing
-2	Responds to physical stimulation	Few recognisable words
-3	No response to stimulation	Nil



Acute Behavioural Disturbance Sedation Checklist

INDICATIONS

- Acute behavioural disturbance in which the following is present:
  - SAT Score of two (2) or greater; **and**
  - The patient's behaviour indicates imminent risk of serious harm to themselves and/or others; **and**
  - Verbal de-escalation has been attempted by a QAS clinician and has failed to calm the patient and reduce the risk of harm

Pre sedation checks

- Appropriate QAS and QPS resources available?
- ABD Sedation Team roles have been allocated?
  - Sedation supervisor
  - Sedation assistant
  - Additional personnel as required
- Sedation medication DTP has been reviewed and contraindications excluded?
- Requirements for Clinical Consultation has been considered?
- Ambulance clinicians positioned at patient's head to monitor the patient's airway and continually observe the patient's physical condition? *** Avoid prone positioning or pressure to the head, neck, chest or back.**
- Defibrillator pads or ECG electrodes have been applied to the patient (front or back) to continuously monitor the patient's ECG?
- Resuscitation equipment is immediately available?
- All sedation team members (including QPS officers) have been briefed?

Post sedation measures

- **Position the patient** in the lateral position, or other appropriate position, ensuring the patient's face can be viewed, their airway can be maintained, and vital signs can be monitored.
- **Record the patient's SAT Score and vital signs** at five-minute intervals post administration of sedation medication.
- If **SAT Score** less than zero (0), apply nasal prong **ETCO2** if tolerated.
- **Remove patient restraints** (physical or mechanical) as soon as it is safe to do so.
- **Notify the receiving hospital** at the earliest opportunity.

ABD Sedation Handover

Name: Age:

Estimated body weight (kg):

Presenting history:

Pre-sedation SAT Score:

Suspected ABD cause:

QPS on scene: Yes No

Case discussed with the *QAS Clinical Consultation & Advice Line*:

Yes No Who:

ABD sedation supervisor:

ABD sedation assistant:

SAT Score:	Sedative:	Sedation effectiv	
Dose:	Time:	Yes	No
SAT Score:	Sedative:	Sedation effectiv	
Dose:	Time:	Yes	No
SAT Score:	Sedative:	Sedation effectiv	
Dose:	Time:	Yes	No

Post sedation VSS:

Time:				
SAT Score:				
GCS:				
HR:				
RR:				
SpO2:				
ETCO2:				

Sedation Assessment Tool

Designed to assess level of agitation before and after sedation

QAS Sedation Checklist

Mandatory patient safety tool

Emergency Sedation – *QAS Clinical Practice Procedure*

- High-risk procedure which is conducted post assessment of the patient and scene by the treating paramedics
- Droperidol is the first line ABD sedative used by QAS.
  - 5mg IM or IV dose >65 years of age (Clinical consult required)
  - 10mg IMI or IV dose 16 – 65 years of age
- Ketamine is our second line sedative where two (2) droperidol administrations have been ineffective. Extremely rare in RACFs.
  - Critical Care Paramedics should attend

Future Options for Care

- The QAS will be introducing Olanzapine for patients with a SAT +1.
- This is not currently available to paramedics
- Dose will be 5mg for pts >65 with a repeat dose after 20 minutes.

So where to from here?

Increased clinical support from QAS

Clinical Hub callbacks

Active referral to RaSS prior to ambulance dispatch

LARU/Community Paramedics

Increase use of primary (non-transport) specialist staff to support RACFs

Healthcare Integration

Collaboration with community healthcare partners while on scene (GPs, RaSS, Specialists, NOK)

Transport Ambulances

Delays may be experienced where non-urgent transport is required.

“It is the long history of humankind (and animal kind, too) that those who learned to collaborate and improvise most effectively have prevailed.”

—Charles Darwin