Health
Justice Health &
Forensic Mental Health Network

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Emergency Sedation

Forensic Hospital and Long Bay Hospital Mental Health Unit

Policy Number 1.441

Policy Function Continuum of Care

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Summary The policy provides guidelines to Justice Health and Forensic Mental Health Network Staff regarding the administration and use of emergency sedation in the Forensic Hospital and Long Bay Hospital Mental Health Unit.

Responsible Officer ED Clinical Operations

Applicable Sites

- ☐ Administration Centres
- ☐ Community Sites (e.g. Court Liaison Service, Community Integration Team, etc.)
- ☐ Health Centres (Adult Correctional Centres or Police Cells)
- ☐ Health Centres (Juvenile Justice Centres)
- ☒ Long Bay Hospital
- ☒ Forensic Hospital

Previous Issue(s) Policy 1.441 (June 2017)

Previously issued under the terminology "rapid tranquilisation" (now replaced with the term "emergency sedation") within Policy 1.180 Enforced Medication and Rapid Tranquilisation - Forensic Hospital and Long Bay Hospital Mental Health Unit (Nov 2012, Sep 2010).

Change Summary

- *Clarification of differences in setting and patient cohort between the Forensic Hospital, Long Bay Hospital Mental Health Unit and other external facilities such as emergency department or community mental health units where emergency sedation is administered*
- *Increased choice of parenteral sedation agents to maximise efficacy and minimise risk in individual patients*
- *Increase in senior medical staff decisional input into use of midazolam when indicated*

TRIM Reference POLJH/1441

Authorised by Chief Executive, Justice Health & Forensic Mental Health Network

1. Preface

'Emergency sedation' (ES) is defined in this policy document as 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 ES 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 (IMI) route, it is usually enforced, rather than after obtaining the full, informed consent of the patient.

Patients should be afforded the opportunity to be involved in their ongoing care planning, whenever appropriate. This must be documented in the patient's care plan. Those requiring ES 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.

ES 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, 'time out' and physical separation from other patients, as well as strategies of 'last resort' such as physical restraint and seclusion. Refer to Ministry of Health PD2012_035 *Aggression, Seclusion & Restraint in Mental Health Facilities in NSW*. 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.

The specific environments of the Forensic Hospital (FH) and the Long Bay Hospital Mental Health Unit (MHU) are unique as compared with other mental health facilities and emergency departments available within NSW and are also distinct from one another. The application and utilisation of ES within these two facilities is likely to differ, and requires different approaches and precautions.

2. Policy Content

2.1 Mandatory Requirements

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

- It must only ever 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 JH&FMHN are the FH and Long Bay Hospital (LBH). In practice, for the purposes of the use of emergency sedation, the latter facility is limited to the MHU. This is because, as a matter of policy and clinical practice, only the MHU has the capacity in LBH to manage the prescription and administration of emergency sedation. Admission practices to LBH are accordingly tailored to this specific requirement. Patients in the Aged Care Rehabilitation Unit (ACRU) must be lawfully transferred to the MHU if deemed to require emergency sedation.
- When the need for future episodes of ES 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 ES 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 ES. This must be checked prior to the administration of any ES 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.
- Where a patient is subject to a restrictive intervention such as ES, this must only occur after less restrictive interventions have been considered and deemed ineffective or inappropriate. Even where ES has been required previously, a less restrictive intervention must always be considered first before repeating this intervention.
- 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 ES must be made by the medical officers in consultation with multidisciplinary health staff. It must not be determined by other parties, including CSNSW staff. The purpose of ES must always be clearly defined and documented, and it must include a clear therapeutic 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.

All patients detained in the FH, and most patients detained in LBH, 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."

2.2 Implementation - Roles & Responsibilities

Clinical Director Forensic and Long Bay Hospitals (CDFLBH) is the 'medical superintendent' of the FH and LBH for the purposes of the *MH Act* and the *MHFP Act* and is responsible for ensuring that all medical staff comply with this policy.

Nurse Managers/Nursing Unit Managers (NM/NUM) are responsible for ensuring that all nursing staff comply with this policy.

All clinical staff are responsible for compliance with this policy.

3. Procedure Content

3.1 Forensic Hospital

3.1.1 Characteristics of the Patient Cohort

All patients admitted to the FH will either be transferred from a custodial setting (adult or juvenile) or, in a small number of cases, from another mental health facility (general or forensic facility). There are no admissions that present 'direct from the community' via a brief assessment in an Emergency Department.

The consequences of this, in relation to the characteristics of the patients within the FH, are the following:

- They have generally received a thorough psychiatric assessment prior to their admission, in many cases multiple comprehensive assessments.
- In most cases they have been on psychotropic medication(s) for considerable periods prior to admission.
- In most cases, ongoing symptoms of mental illness are those that are chronic and resistant to treatment rather than acute and florid.
- In many cases, patients are prescribed high doses of a regular antipsychotic medication, and sometimes two or more antipsychotic medications.
- In almost all cases they will NOT be acutely affected by variable quantities of unprescribed substances (e.g. cannabis, methamphetamines, alcohol).

Adolescent patients in the FH differ from the adult patients in a number of respects. They are usually aged 13 to 21 years old. Most are correctional patients; they are usually in their first episode of mental illness and their hepatic metabolism is generally more efficient than is the case with adults. Adolescent patients are more likely to have NOT received any psychotropic medications previously.

It is within this broad context that the use of ES, and the additional immediate benefits of oral or IMI psychotropic medication, need to be considered.

It is likely that patients within the FH identified as requiring ES will possess particular clinical characteristics that place them at ongoing risk of further episodes of ES throughout their admission. Hence ES is likely to be used for a small number of patients, recurrently throughout an often lengthy admission, as opposed to Intensive Psychiatric Care Units (IPCU) or acute mental health units where it is typically used at high frequency early in the course of admission for a significant proportion of admissions, followed by a rapid reduction in the frequency of usage after the initial phase of illness has settled.

As patients are often already on antipsychotic medications, the use of additional antipsychotic medications for ES may have more limited benefit and carry greater risks, such as polypharmacy than in populations not taking antipsychotic medication.

The utility of a medication strategy such as repeated doses of zuclopenthixol acetate has yet to be proven in a setting such as the FH, where the clinical characteristics of patients differ from other settings (such as IPCU) where it may be used more frequently.

3.1.2 Environmental Limitations

The FH is a 'stand-alone' health facility, with no co-located general hospital or onsite clinicians with specialised skills in emergency or intensive care medicine. The nursing and medical clinicians who work in the FH have high level skills in forensic mental health, but only generalist skills in areas such as internal medicine and resuscitation.

As a consequence of these limitations, the use of the intravenous route (IVI) of emergency sedation is not permitted within the FH. Oral and IMI routes of medication administration may be prescribed within established practice guidelines (see below).

3.2 Long Bay Hospital Mental Health Unit

3.2.1 Characteristics of the Patient Cohort

Unlike the FH, most patients admitted to the MHU are transferred from a custodial setting, and are adult patients. The period during which each patient has been detained in custody prior to transfer will vary considerably, but in some cases may be relatively brief.

This increases the likelihood that newly admitted patients to the MHU will be experiencing features of an acute mental illness, and will be either 'drug naïve', non-adherent or relatively under-treated with psychotropic medication. For these reasons, it makes this patient cohort more similar to patients admitted to a general hospital MHU, than the patients admitted to the FH.

3.2.2 Environmental Limitations

Similar to the FH, 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.

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 ES in this setting.

Within the MHU, G ward has access to 5 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 utilized for patients who are demonstrating acute psychotic and complex behaviours, or for patients requiring ES with a period of increased observations.

As there may be limited physical access to a patient due to security management procedures of CSNSW, ES must only be used where access to the patient can be guaranteed for the purpose of administration and monitoring. For this reason, 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.

3.3 Zuclopenthixol Acetate (Acuphase) - NOT to be used in Emergency Sedation in the Forensic Hospital and Long Bay Hospital Mental Health Unit

Zuclopenthixol acetate should never be used as ES, given that the onset of effect is too slow.

3.4 Risks Associated with Emergency Sedation

There are specific risks associated with the different classes of medications that are used in ES. 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 ES. 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, droperidol, olanzapine
    - reduced level of consciousness
    - cardiovascular and respiratory complications and collapse
    - reduced seizure threshold
    - akathisia
    - dystonia (especially laryngeal dystonia)
    - dyskinesia
- Promethazine
    - Paradoxical stimulation

3.5 Oral Therapy

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

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

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

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).

Where oral and intramuscular medications are written on the same medication chart, they must be prescribed as distinct, individual medications. The abbreviation of PO/IM, as a single prescribed medication, must not be used under any circumstances.

3.6 Parenteral Therapy for Emergency Sedation

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

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).

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).

Anticholinergic medications, for example, benztropine, should be immediately available to reduce the risk of acute dystonias. 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.

3.7 Pro Re Nata (PRN) Medication

ES, whether administered as oral or IMI medication, should not be charted as a 'routine' medication for regular administration. In other words, it will be charted either as a 'PRN' medication in the Forensic Hospital only, or as a "once only" or 'stat' order on the **National Inpatient Medication Chart.** Midazolam can be given as a once-only or 'stat/statim' dose after medical review and consultant psychiatrist discussion.

3.7.1 Standing PRN Order

For certain patients, it may be appropriate to anticipate the need for future use of ES, by including a 'standing PRN order'. This may be based on their past requirement for ES, 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 FH (i.e. Austinmer Women's Unit, Austinmer Adolescent Unit, Bronte Male Unit) and the MHU 'G ward'. The PRN chart should be reviewed at a minimum weekly during the MDT meeting.

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

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. Lorazepam 1mg oral/Olanzapine 10mg IMI).

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.

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 ES should be avoided. The clinical rationale for prescribing PRN medication for a particular patient should be discussed with a psychiatrist.

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.

3.7.2 Ad hoc or Statim Order

On occasion, patients in the FH or the MHU may be assessed as requiring ES who do not have a standing PRN order for oral or IMI medication. This may occur because they have had a long period of clinical stability without any anticipated need for ES (i.e. a patient on Clovelly, Dee Why or Elouera units) or simply because no order exists in the relevant medication chart.

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.

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 ES, in conjunction with the patient's allocated nurse.

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' ES 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 in consultation with the treating or consultant psychiatrist on the Back Up Roster.**

3.8 Doses for Emergency Sedation

The dose of medication for ES should be individualized 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.

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.

3.9 Circumstances for Special Care (extra care)

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.

3.10 Emergency Sedation in Older People

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

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.

As ES 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.

3.11 Physical Monitoring

3.11.1 Before Emergency Sedation

Before prescribing for ES, 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 emergency 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 ES 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.

3.11.2 After Emergency Sedation

The medical officer prescribing ES must specify the required frequency of observations both verbally and by documenting in the patient's health record and should include visual observation and subsequent ongoing observation requirements. Nursing staff may increase the frequency of observations where clinically indicated, but cannot reduce the frequency without further review by the medical officer.

After ES is administered:

- vital signs including oxygen saturation must be monitored
- pulse oximeters must be available
- 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

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.

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 Manager of Security at LBH.

Any observation obtained must be recorded in the patient's Standard Adult General Observation (SAGO) Chart.

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

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

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

3.11.2.2 Forensic Hospital

In the event of a medical emergency/code blue, such as:

Airway:

- **Difficulty breathing**

Breathing:

- **RR < 8 or > 30 per min**
- **SpO2 < 90% despite O2 6L via Hudson Mask**

Circulation:

- **HR < 50 or > 130 per min**
- **Systolic BP < 90 mmHg**
- **Chest pain – new or unrelenting chest pain**
- **Acute change in level of consciousness**
- **Seizure**

Clinical staff should refer to the *Australian Resuscitation Council Guidelines*. The treating or on duty/on call registrar must be immediately notified of the deterioration in patient observations. CPR should be commenced where necessary and the NSW Ambulance Service contacted.

It is imperative that the following must be available and immediately accessible when delivering ES:

- suction
- airway equipment of appropriate size
- means of positive-pressure ventilation
- intravenous equipment
- a defibrillator in the same vicinity as the airway bag.

Airway management and AED equipment are available in the medication room and are checked on every night shift.

3.11.2.3 Long Bay Hospital MHU

When a patient is placed on increased observation within the MHU following ES:

1. If a patient requires increased over usual physical observations, 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.
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 by contacting the gate to have it announced. 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 nominated medical emergency team leader (MERTL) will attend and coordinate the incident until the NSW ambulance arrives, where required nursing staff will complete the MH emergency leave form (JUS 200.085 - Request for unplanned transfer for healthcare) and seek approval from the delegate or nominated delegate. CSNSW officers are responsible for coordinating and managing the escort of the patient.

Guide for Emergency Sedation

Note: A Medical officer (MO) can be either a psychiatrist or psychiatry registrar.

1. Exhaust de-escalation techniques, i.e. engagement and verbal de-escalation, distraction, quiet/low stimulus environment
2. Patient does not respond to de-escalation techniques and risk of harm from behavioural disturbance persists.
3. Consult MO, and offer oral pharmacotherapy (see below)
4. Patient refuses oral medication and risk of harm from behavioural disturbance persists, consult MO
5. Consult MO, and administer injectable IMI pharmacotherapy (see below)
6. Monitor patient
7. If risk of harm due to behavioural disturbance persists, consult psychiatrist and consider repeating the above steps.

Medication (oral)

Adult

Diazepam 5-20mg

or

Olanzapine 5-10mg

or

Lorazepam 1-2mg

Adolescents

Olanzapine (first line) (dose administered as clinically indicated)

Diazepam (second line) (dose administered as clinically indicated)

Medication (IMI)

Adult

Droperidol 5-10mg (Maximum 20mg daily)

or

Promethazine 25-50mg

or

Olanzapine 5-10mg – (Maximum 20mg daily)

or

Haloperidol 2-5mg (if known to tolerate typical antipsychotics)

or

Lorazepam 2-4mg

Use midazolam 5-10mg as second line

Adolescents

Use benzodiazepines as second line agents only (dose administered as clinically indicated)

4. Definitions

Must

Indicates a mandatory action to be complied with.

Should

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

5. Legislation and Related Documents

Legislation	*Mental Health Act 2007* *Mental Health (Forensic Provisions) Act 1990*
NSW Ministry of Health Policy Directives, and Guidelines	PD2016_058 *User-Applied Labelling of Injectable Medicines, Fluids and Lines* GL2015_007 *Management of patients with Acute Severe Behavioural Disturbance in Emergency Departments*
JH&FMHN Policies & Procedures	5.005 *Alarm, Pager and Two-Way Radio Use and Management – Forensic Hospital.* 5.070 *Infection Prevention and Control* *Justice Health and Forensic Mental Health Network Psychotropic Medications – Guidelines for Prescribing and Monitoring Use Within Custodial and Forensic Mental Health Settings 2018.* *Justice Health and Forensic Mental Health Network Medication Guidelines 2018* *National Standard for User-applied Labelling of Injectable Medicines, Fluids and Lines*, Australian Commission on Safety and Quality in Health Care 2015.
Clinical Practice Guidelines	*Acute Sedation Guideline for Mental Health Inpatient Units,* Mental Health Services, Sydney Local Health Network, November 2017.*The Maudsley Prescribing Guidelines*. 13th Edition 2018 *Huf G, Alexander J, Gandhi P, Allen MH. Haloperidol plus promethazine for*

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