

Guidelines for Managing Intoxication on In-Patient Wards

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**Guideline for Managing Intoxication on In-Patient Wards**

# 1 Introduction

1.1 This guideline has been produced to support in-patient staff to recognise, assess and provide immediate clinical management to people who are acutely intoxicated with alcohol and illicit substances including New Psychoactive Substances (NPS), previously known as legal highs, and Cannabidiols.

This guideline should be read in conjunction with the following ELFT policies and protocols which are available on the intranet:

#### Prescribing Guidelines Specialist Addiction Services

* + 1. Physical healthcare policy (clinical guide how to treat opiate and other illicit drug users)
    2. Vital signs policy: National Early Warning Score (N.E.W.S) for the detection and care of the deteriorating patient
    3. Resuscitation policy
    4. Admission and discharge policy for mental health services
    5. Rapid Tranquillisation Policy for Adults and Older People
    6. Place of Safety Policy
    7. Local Protocol for the Management of S136 MHA 1983

# 2 Scope

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2.1 This guideline applies to all adults in all directorates admitted to ELFT in-patient wards, and all adult service users brought to the S136 suite for assessment only

# 3 Acute Intoxication

3.1 Acute intoxication can be life threatening. It will pass. It is a transient condition. However, it may be life threatening and must never be ignored. Never “wait, until they sober-up”. A patient may be in overdose, where the respiratory system is in the process of shutting down. A patient may vomit and choke to death.

3.2 Acute intoxication may be related to the amount of substances someone has taken. Or, where underlying health conditions produces a disproportionate severe intoxicating (like renal or liver impairment).

3.3 It is a condition that requires clinical management.

# 4 Recognising Acute Intoxication

**4.1**  **Admission. Initial assessment**

All patients admitted to in-patient mental health units will be assessed for alcohol and substance use as part of the admission process. It is important to take a good history, including history of overdose (accident or intention), and is good practice to include baseline urine drug screening.

Patients with a known history, or disclosed history, of alcohol or substance misuse are to be managed under ELFT Dual Diagnosis Pathways, including alerting community substance misuse teams in good time prior to discharge, and to enable a joined up discharge plan.

Alcohol/drug misuse is always reflected in care plan and risk assessments. This may include the possibility of intoxication whilst an in-patient

4.1.2 For service users who have been known to take drugs or alcohol throughout their admission an ongoing assessment needs to occur. Increased risk maybe indicated when there is suspected drug availability on the ward, visits from friends or family who are suspected to be bringing in drugs or increased periods of leave.

**4.2 Assessment of suspected intoxication**

**4.2.1 Alcohol**

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| **Quick checklist ALCOHOL** |  |
| **Signs and symptoms** | **Behaviours** |
| Smelling of alcohol | Disinhibition |
| Loss of coordination: stumbling or swaying | Argumentativeness |
| Flushing of the face | Lability of mood |
| Bloodshot eyes | Impaired attention |
| Louder speech than usual | Impaired judgement |
| Slurred speech | Interference with personal functioning |
| Damp or clammy skin | Aggression or depression, crying |
| Drowsiness | Mood swings |
| Possible Medical Emergency.   * Loss of consciousness * Shallow breathing * Blue skin or lips | Overdose outcome:  Alcohol poisoning is caused by drinking large quantities of alcohol in a short period of time. Very high levels of alcohol in the body can shutdown critical areas of the brain that control breathing, heart rate, and body temperature, resulting in death. |

**4.2.2 Depressants (e.g. heroin, methadone, pain medication,**

**Benzodiazepines)**

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| **Quick checklist OPIATES/OPIOIDS** |  |
| **Signs and symptoms** | **Behaviours** |
| Drowsiness | Impaired attention |
| Loss of coordination: stumbling or swaying | Impaired judgement |
| Pinned pupils | Apathy |
| Slurred speech | Withdrawn |
| Low pulse | Tired |
| Losing consciousness |  |
| Possible Medical Emergency.  May lead to death   * Shallow breathing * Blue skin or lips * Confusion * Small pupils * Loss of consciousness | Overdose outcome:  Depressants that affect the central nervous system lower blood pressure and body temperature, and slow the heart rate and breathing. When used to excess it lead to respiratory failure, overdose, coma, and death. |

**4.2.3 STIMULANTS (e.g. cocaine, crack, some new psychoactive substances)**

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| **Quick checklist STIMULANTS** |  |
| **Signs and symptoms** | **Behaviours** |
| Increased energy and alertness | Increased body temperature |
| Euphoria | Increased pulse |
| Paranoia | Increased blood pressure |
| Panic | Dry mouth |
| Anxiety | Faster breathing |
| Feeling indestructible | Large dilated pupils |
| Pseudo-hallucinations | Seizures |
| Possible Medical Emergency:   * Chest pain or laboured breathing * Extreme sweating * Increased blood pressure * Rapid heart rate or palpitations * Anger, Confusion * Paranoia, Delirium * Blurred vision or vision loss * Nausea, diarrhoea, or vomiting * Seizures or convulsions * Loss of consciousness | Overdose outcome:  Stimulants cause the heart rate to increase, which can result in heart problems. Elevated blood pressure is also common. When used to excess it can result in loss of vital functions, respiratory failure, cardiac arrest, coma, death. |

* + 1. **NEW PSYCHOACTIVE SUBSTANCES NPS’s (e.g. spice, synthetic cannabinoids, novel benzodiazepines, novel stimulants all available easily online)**

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| **Quick checklist NPS** |  |
| **Signs and symptoms** | **Behaviours** |
| NPS’s can present like STIMULANTS or DEPRESSANTS.  It depends on the NPS | NPS’s can present like STIMULANTS or DEPRESSANTS.  It depends on the NPS |
| Possible Medical Emergency: see above  STIMULANTS and DEPRESSANTS | Overdose outcome:  see above STIMULANTS and DEPRESSANTS |

**4.2.5 Suspicion and detection of use**

a) Observation: change in behaviour, new behaviour, disinhibited behaviour

1. Ask the patient if they have used in a non-confrontational manner
2. If the patient says yes, ask

* which drug or alcohol
* how much
* how (oral, injected, smoke)
* what time did they use
* did they use alone or with someone else

1. Isolate the patient from other patients, but do not leave them alone
2. If the patient agrees seek clarity

* take observations using News 2, in addition assess level of confusion, disorientation
* drug screen
* breathalyse

1. Check when last medications were given, consider overdose possibilities (e.g. if the patient has used depressants, were they also given depressants on the ward within the last 2hours)
2. Inform a senior team member and the DSN out of hours, Contact the ward doctor or on call doctor to agree an onward management plan
3. Onward assessment should include review of medical and psychiatric history to identify additional risk factors that may cause overdose: e.g. liver or renal problems or low tolerance through periods of abstinence
4. Review Quick Checklist above – familiarise yourself and the team with what a medical emergency looks like

# Management of Acute Intoxication

5.1 The primary goal is to ensure the patients safety, and the safety of other patients and staff.

5.2 The team need to monitor what is happening and plan for the potential physical health deterioration. The level of intoxication is on a continuum from mild - to - life threatening.

5.3 Inform the patient that continued monitoring for their safety and the safety of others is required.

5.4 General principles when managing intoxication include:

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| * Maintain a calm, professional, non-judgemental attitude * Orientate and establish rapport * Any Allocated work need to be briefed on the potential physical health deterioration risk and the escalation points. * Pace the interaction to the level of cognitive impairment * Stop and go style of interaction whereby you stop positive interaction at the point of unwanted behaviour, inform the patient this behaviour is not acceptable, and then return to the friendly positive interaction * Work together. Tell the service user what they need to do, what you need to do, and how you might both get to where you need to be |

5.5 One to one eyesight observations must commence at point of assessment and should not be reduced until agreed by the medical team. One to one observations need to include life signs observations using News 2.

**5.6**  **Indications for routine monitoring**

5.6.1 If the baseline total NEW 2. Score is zero initiate physical health monitoring monitoring every 15 minutes initially. If physical observations are refused, then one to one observation should continue.

5.6.2 Levels of acute confusion and disorientation must be assessed and if there is worsening levels this alone would indicate the need for escalation and possible medical intervention.

5.6.3 Consider decreasing the frequency in consultation with the ward or duty doctor when the service user’s observations have been stable for 2 hours.

**5.7 Identification of the need for medical assistance**

5.7.1 If Total NEW 2 score is 1-4 inform a registered nurse who must assess the patient and decide if increased frequency of monitoring, clinical escalation and medical assistance is required. One to one observation must remain or commence until this is done.

5.7.2 Registered nurse to urgently call medical staff (Duty Doctor) and Duty Senior Nurse (DSN) and commence protocol for the Management of Medical Emergencies if:

* Total NEW 2 score is 5 or more
* NEW 2. score is 3 in any one parameter (red section of the chart)

5.7.3 Consider action to improve the patient’s physical condition including positioning and oxygen

5.7.4 The assessing doctor should complete a physical and mental health assessment, including neurological examination to rule out injuries resulting from intoxication, exclude other underlying medical causes and the complications of chronic alcohol abuse if the service user consents.

5.7.5 The service users care plan must be reviewed and a joint decision between the assessing doctor and the nursing team reached about the continuing management plan, frequency of monitoring arrangements and whether an ambulance should be called. This plan must be documented in the service users RiO progress notes.

**5.8 Identification of a medical emergency**

5.8.1 Immediately Follow your local protocol for the Management of Medical Emergencies in the following circumstances:

* The NEWS Total score is 7 or more
* Respirations are noisy, shallow or less than 8 breaths per minute 9
* The level of consciousness as assessed by the NEW 2 indicated the person is unresponsive, (also commonly referred to as unconscious) and service user does not make any eye, voice or motor response to voice or pain.
* The service user is experiencing a seizure

5.8.2 Initiate continuous monitoring of vital signs

5.8.3 Consider action to improve the patient’s physical condition such as positioning and oxygen

5.8.4 Registered nurse to stay with the patient

5.8.5 Response team including the Dr to prepare for medical emergency

5.8.5 Call an ambulance 999 or 2222 (City and Hackney centre for mental health only)

# 6 Naloxone

6.1 Naloxone is a competitive agonist to opioid drugs and is used in the treatment of opioid overdose.

6.2 It can reverse opiate/opioid overdose. It is an essential bit of kit and is very easy to use.

6.3 Naloxone will reverse opioid induced respiratory depression and can be life-saving. It was added to the list of injectable medicines that may be legally used by anyone for the purpose of saving a life in an emergency.

**6.4 Administration of Naloxone**

6.4.1 If a patient has lost consciousness, and you are fairly certain opiates/opioids have been used

* Call 999 and follow local protocol for the Management of Medical Emergencies
* Commence high flow oxygen
* Consider action to improve the patient’s physical condition including positioning (e.g. recovery position)
* Administer intramuscular naloxone which is available in the emergency bag if the respiratory rate is less than 8 breaths per minute
* If there is no improvement within 10 seconds, give a second dose.
* You can give all 5 doses if needed

6.5 The patient must always be transferred to Accident and Emergency even if they respond well to the Naloxone.

# Monitoring the Sleeping Patient

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* 1. Intoxicated patients who fall asleep are at risk:

7.1.1 changes in respiration going unnoticed

* + 1. risk of aspiration due to vomiting
    2. a compromised airway can be mistaken for normal snoring
    3. responsiveness cannot be checked unless you wake the patient

7.2 Tell the patient that monitoring their level of consciousness using the Alert Voice Pain Unresponsive (AVPU) scale is important so that, if they go to sleep, they will need to be woken up as dictated by the monitoring requirements agreed. The observing nurse must observe breathing throughout and escalate any deviation from normal respiratory rate (respiratory rate of 12-20 breaths per minute). Respiratory challenges can be characterised by snoring and the observing nurse needs to undertake a full assessment of breathing in these cases and escalate any concerns.

# Managing Prescribed Medication

8.1 Omit prescribed medication if the service user is intoxicated with alcohol or other substances until the next dose, or until the service user is no longer showing signs and symptoms of acute intoxication.

8.2 Seek medical advice if you think that there is a potential contraindication to omitting prescribed medication and consider seeking additional advice from the pharmacy department or on call pharmacist.

8.3 Do not stop established carbamazepine, rifampicin or ritonavir treatment in a patient who is prescribed methadone without reviewing the methadone dose with a doctor or pharmacist because these medications lower the levels of methadone and can lead to toxicity if they are withdrawn.

# 9 Prescribing during Acute Intoxication

9.1 Non-pharmacological interventions should be explored where possible

9.2 If a pharmacological intervention is necessary, follow the ELFT Rapid Tranquillisation Policy for Adults and Older People.

* 1. Avoid benzodiazepines which may worsen respiratory depression

# 10 Intoxicated Patient in Seclusion

10.1 Where the risk of harm to others is high, seclusion of the intoxicated patient may be required. Where possible this should be avoided as it makes the observation of physical health more challenging.

10.2 Where available, physical health should be constantly monitored using the Oxehealth monitoring system. This does not negate the observing staff responsibility to carry out continuous eyesight observations and escalate any cause for concern. Signs of life in relation to movement, breathing, and levels of alertness need to be constantly monitored. Any deviation from the 0 News 2 score, or inability to assess signs of life will necessitate for the Rapid Response Team to safely enter and undertake News 2 observations or if non-compliant with observations assess breathing and levels of alertness (please refer to the Seclusion Policy). Any concerns must be escalated to the duty senior nurse and Doctor for onward management plan.

# 11 Documentation & Communication

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11.1 Records of the incident – including monitoring, treatment. A datix incident form must be completed if indicated. Review the patient’s care and management plan. Follow ELFT Dual Diagnosis Policy – ensure robust follow up by drug and alcohol services on discharge. If Naloxone was used on the ward, hand the patient a naloxone kit on discharge, and show them how to use it.