# Managing acute intoxication / Drug affected patients in the ED

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# Presentation sequence

## Intro

## David

- Initial approach
- De-escalation
- Safety in resource poor environment

## Neralie

- How to convince the patient who wants to go to stay +/- take medication
- Restraint options – section 56

## Bob

- Overview of acute ethanol, GHB, opioid, amphetamine intoxication management
- Drugs that help to manage things
- Airway management in intoxication

# The problem

Patients with agitated behaviour or severe intoxication with recreational substances

What we will not cover

- Chronic alcohol/drug use management
- Poisoning with deliberate self harm
- Non drug/alcohol related agitation

# Extent of the problem

7% of the population have an alcohol use disorder

At least

- 4.5% of the population use cocaine
- 1.4% of the population use amphetamines
- GHB use unknown – somewhere in between?

RAH ED

- 6 Code blacks/day
- Most with a drug/alcohol related component
- Attempted staff assault every second day

EFHLHN

- 1 Code black every 10 days in acute services
- Frequency probably under reported
- Severity not specified

# Extent of the problem

SA EDs

- 30,000 DNWs/year
- 10,000 DAMA/year

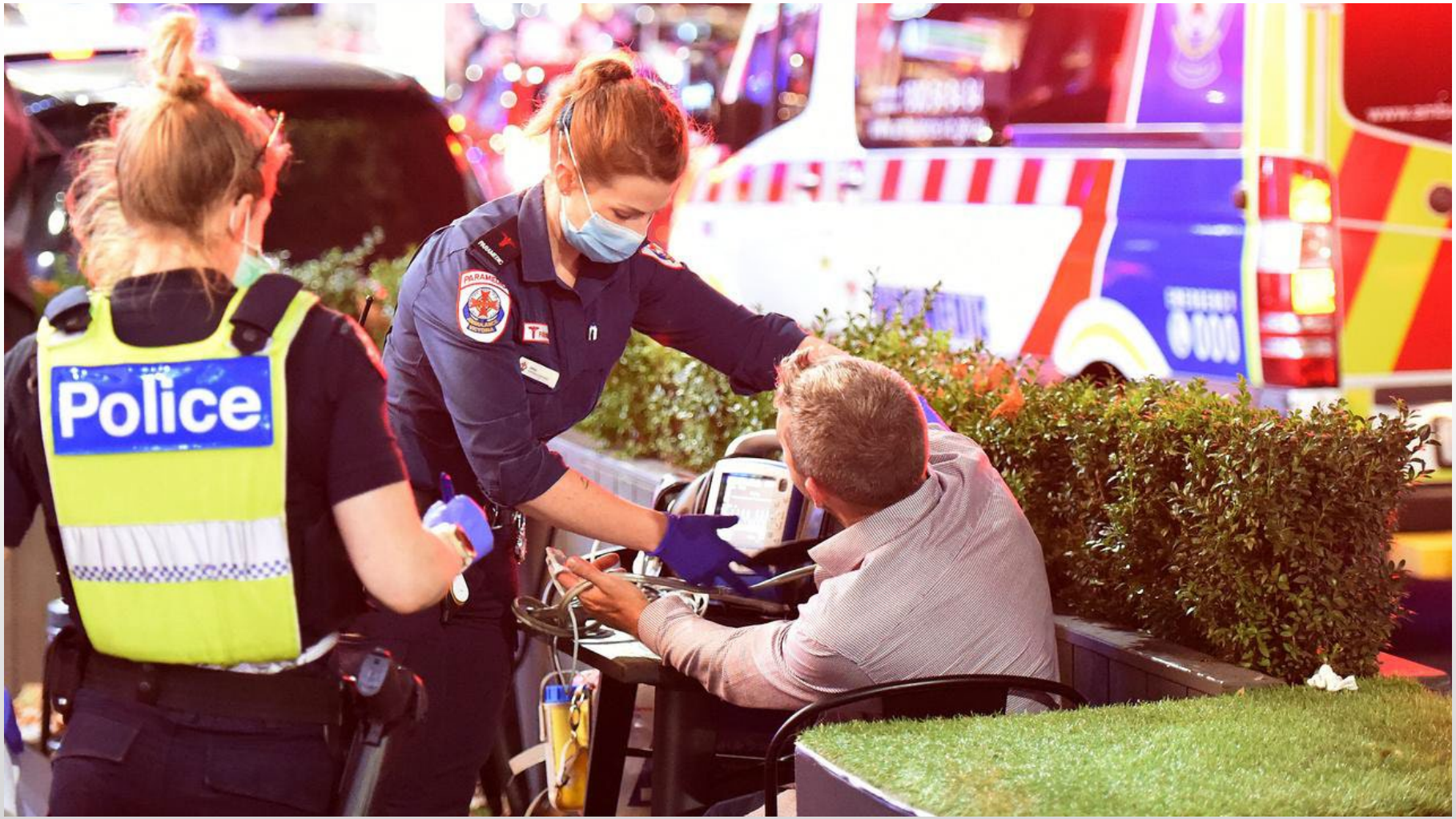
RAH ED

- 5000 DNWs
- 1500 DAMA

Many involve intoxication and trauma

Serious adverse events are rare following self-discharge.

# Prehospital Management: Ensure Safety



# Prehospital Management: De-escalation

1. Manage the scene
   - Ensure personal safety
   - Remove “agitators”
   - Move to another location

2. Establish rapport
   - Take time to listen
   - Acknowledge problem
   - Don’t judge

3. Escalate management prn

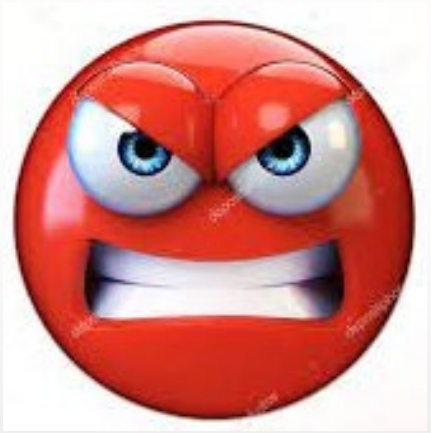
# Prehospital Management: Causes of Agitation

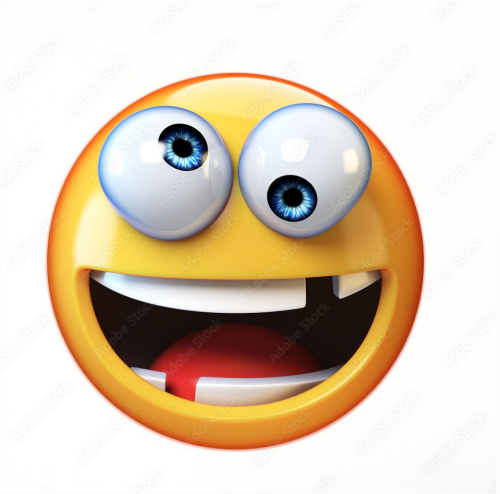
Primary Psychosis

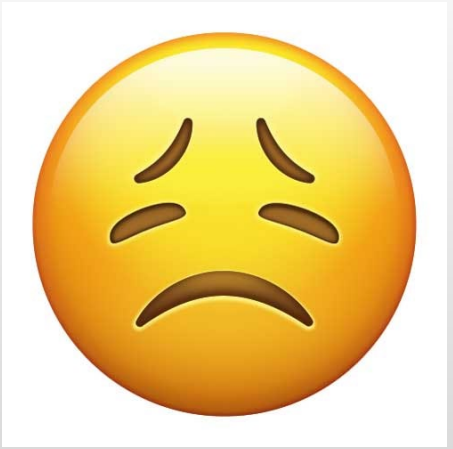
Medical disorders

Drug toxicity / withdrawal

Situational crisis







# Prehospital Management: Legislation

SA Mental Health Act (Sect 56) “Care and Control”

Vs

Consent to Medical Treatment and Palliative Care Act (Sect 14)

# Prehospital Management: Restraint

Principle

- Use least restrictive option

Physical

- SAAS / SAPOL / restraint net

Chemical

- Lorazepam
- Midazolam
- Droperidol
- Ketamine*

# Nursing Considerations

**Environment / Situation specific**

We acknowledge the low resource environments in which you all work can be very challenging

Personal safety must come before everything else

# Nursing Considerations

**Rapport Building / De-escalation**

- Introduce self & desire to help
- Offer courtesies
- Manner is important
- Listen
- Validate
- Explain clinician's wishes / reasoning
  - Why oral medication
  - Why remain in hospital

# Nursing Considerations

**Thorough history and exam**

- Undress when possible
- Full vital signs / GCS / BGL / temperature
- Beware assumptions of intoxication only – are they hiding something?

**Ongoing management**

- Frequency of observations / level of monitoring
- Location of patient in hospital
- Maintenance of appropriate sedation
- Definitive care / disposition?

# Nursing Considerations

**Need help?**

Senior nursing staff

Police

Medical Officer(s)

Sedation guidelines

VCS

MedSTAR

Poisons (toxicology if required)

# Assessing sedation in intoxication

GCS not particularly good

GCS is

- **Best** response
- With **persistent** stimulation

Severe sedation rarely needs intubation in intoxication

# Ethanol

- Coma
  - Rare at BAL < 0.2%
  - Rarely lasts more than 2 hours
- Usually higher risk to themselves than others aggressive
- Nothing speeds sobering up

# GHB (and precursors)

- Sedation
  - Can be profound (GCS 3)
  - Often variable over short periods of time
- Nearly always can be managed without intubation if a single agent ingestion.
- Late deterioration can occur with ethanol co-ingestion
  - Loss of competitive inhibition of GHB precursors
- Usually go home in a few hours

# Opioids

Reduced RR the hallmark feature – more reliable than pupils

Initial small doses of naloxone (40microg) used to prevent acute withdrawal

Double the dose every 5-10 min if no response

Once RR 12, can usually be left alone

Route of toxicity

- IV - more naloxone unlikely to be needed
- Oral – more naloxone likely
- Multiple routes of ingestion common – look for the patch....

# Amphetamines/other stimulants

Highest risk to staff

Paranoia the biggest problem

De-escalation more likely to fail

Droperidol for psychotic features

Midazolam/lorazepam/clonazepam for agitation

Never restrain face down

Be prepared for the post meth ‘downer’ and prolonged sedation

# Drugs to take control

Droperidol/olanzapine

IM route safest – if won't take it orally

Risk of prolonged QTc overstated

10mg usual adult dose

Takes 15min to work IM

Be aware of dystonias (usually the next morning)

# Benzodiazepines

Lorazepam 2mg orally

Clonazepam 0.25mg IM

Midazolam 5mg IM/IV

Well tolerated

# Ketamine

Sometimes used for secondary transport

Some short term anti-depressant effect

Hallucinations/emergence phenomena – especially if used alone

I don't use this as an initial sedating agent

# Airway management

- Intubation rarely required
- Intubation for GCS < 8 (e.g. in trauma) not applicable in poisoning
  - Hypoventilation is well tolerated and not harmful
  - Protective airway reflexes usually retained
- Coma position
- NPA
- Oxygen
- Observation