Care of the Patient with Presentation related to the use of Drugs and / or Alcohol in the Waiting Room
Drug and Alcohol Presentations

- Identify common symptoms of Drug and Alcohol intoxication and withdrawal
- Assessment criteria specific to the drug and alcohol population
- List skills to monitor the patient in the waiting room
  - How do drugs and alcohol affect the management of the patient awaiting care?
  - Common presentations to ED involving Drugs or Alcohol.
  - Challenges faced by the CIN
Background

• Patients usually present to the Emergency Department for reasons secondary to their drug and alcohol problem.

• They can be intoxicated on arrival or enter withdrawal while waiting for medical treatment

Some common presentations are:

- Behavioural disturbances
- Collapse/altered LOC
- Trauma/assault

This can be a challenge at Triage and in the Waiting Room.

The role of the CIN is to monitor patients and ensure they, and others, are safe in the waiting room.
Common Signs and Symptoms

Alcohol

- S&S of use:
  - loss of inhibition, exuberance, slurred speech, argumentative, over friendly, stumbling, alcohol smell, drowsiness, aggression

- Symptoms of withdrawal:
  - sweat, tremor, hallucination, seizures, delirium

- Escalate care if:
  - decrease in GCS; perceptual disturbances, hallucinations, seizure
Benzodiazepams

Signs of use: sleepiness, disinhibition, confusion, slurred speech, lack of coordination, drowsiness, headache, confusion, ataxia, dazed look

• Symptoms of withdrawal: nervousness, tremors, seizures
• Escalate care if: change in GCS, seizure, safety concerns

Rowies, moggies, downers, sleepers, tummies, serries, pills
Opioids

- Signs of use: emotional detachment, pain relief, comfort, euphoria, pinpoint pupils, drowsy, ‘nods off’, itchig, constricted pupils
- Symptoms of withdrawal: nausea, pain, cramps, diarrhoea, irritability, dilated pupils, extreme agitations
- Escalate care if: change in GCS, signs of withdrawal

Heroin, H, shit, smack, horse, harry, white, skag, junk, slow, rock
Marijuana, grass, pot, shit, ganja, mull, hash, durry, green, dope, cone
Amphetamines

- Signs of use: dilated pupils, increased energy, loss of appetite, hyperactive, very talkative, may be aggressive, hallucinations, drug induced psychosis, depression, and suicidal ideation, exacerbation of mental illness.

- Symptoms of withdrawal: nervousness, tremors, seizures

- Escalate care if: Change in GCS; A change in demeanour to include increased aggression, agitation, restlessness, seizure

Speed, goey, whiz, uppers, oxblood, point, crystal meth, ice, shabu and cocaine, ecstasy

Note: Ectasy can
BEHAVIOURAL DISTURBANCE
BEHAVIOURAL DISTURBANCE

• Can be physical or psychological
• Can be brought on by intoxication or withdrawal from a substance
• Can be caused by mental health issues brought on by substance dependence e.g. drug induced psychosis
BEHAVIOURAL DISTURBANCE

PSYCHOLOGICAL:
- Anger/Aggression
- Emotional distress
- Paranoia/Agitation
- Euphoria/Inhibition
- Hallucinations (visual/audible)
- Rapid mood swings

PHYSICAL:
- Profuse sweating
- Tremors
- Hyperactivity
- Unco-ordination
- Uncontrolled movement
IMPLICATIONS

ARE THEY SAFE TO WAIT?

• Alone or accompanied?
• Is the patient lucid?
• Is the patient a flight risk?
• Safety of patient, public or staff
• Is there evidence of injuries / co-morbidities / deterioration (including withdrawal symptoms)
TRAUMA/ASSAULT
TRAUMA / ASSAULT

- Drugs and alcohol are involved in a large number of trauma/assault presentations to ED
- Can be combined with altered behaviours
- Can present with ‘friends’ who are also intoxicated
- Can lead to challenging behaviour at triage and in the waiting room
- Combined Head Injury and Alcohol Intoxication is particularly challenging.
  - Management should be for head injury.
TRAUMA / ASSAULT

- Try to keep the situation calm
- Don’t make assumptions
- Consider the ‘worst possible outcome’
- Manage according to the patients needs, not the needs of the department
Identify Risks

- To the patient
- To staff
- To others in the waiting room
Document

• Vital Signs
• Alcohol/opiate scales
• General appearance
• Physical and mental state
• Refer (if applicable)
Tools of Assessment

- Alcohol withdrawal scale
- Opioid Withdrawal scale
- Cannabis withdrawal scale
- NSW Health Guidelines
Tips for the waiting room

• Communicate
  – With patients
  – With family
  – Front of house i.e. triage staff
  – NUM / CNUM / TL

• Maintain privacy and confidentiality

• Manage early signs of withdrawal and escalate care as required
Any patient who presents as incoherent, disoriented or drowsy should be treated as a head injury until proven otherwise.

Consider suicide risk / overdose

Consider child protection and domestic violence issues

Consider polypharmacy abuse / overdose including paracetamol.

Any patient who presents as incoherent, disoriented or drowsy should be treated as a head injury until proven otherwise.

Consider suicide risk, does the patient have access to drugs that may result in a potentially lethal or harmful overdose.

Consider children protection and domestic violence issues. DoCs notification is mandatory if a parent makes a suicide attempt with potentially lethal drugs or presents as an overdose intentional or unintentional.

Be alert to the risk of polypharmacy abuse / overdose including paracetamol. Any suspicion of paracetamol overdose should be treated as such until proven otherwise. A paracetamol level should be obtained 4 hours after a suspicion of acute paracetamol overdose.
Case Scenario 1

- Con is a 24 year old man who has presented requesting to “see a Doctor immediately” because of problems which he will not discuss with anybody else. He appears tense and agitated and was banging his fist on the triage desk. He appears dirty, unkempt and smells of alcohol.

- He has been triaged to the waiting room where he is currently seated, but appears agitated. He is cooperative when you introduce yourself and explain you want to ask him some further questions and check his vital signs.
Discuss the CINs concerns about assessment of this patient / would you take them to a CIN room? What precautions need to be in place?

As the educator you could add further elements into this scenario to guide decision making / action and discussion – e.g.

1) The patient’s behaviour suddenly escalates
2) The patient is suicidal
3) The patient has abdo pain
4) The patient is withdrawing from drugs or alcohol
5) The triage decision – and how this could be discussed with the triage nurse
Case Scenario 2

• Mark is a 24 yr old male who has presented to triage with a painful R hand. He is accompanied by 5 friends and all appear to be intoxicated. Mark has pain over his 5th MCP with no bruising and minimal swelling, he states he ‘punched something.’ He is not in distress but is anxious to be treated ASAP.

• He has been allocated a triage category 5 and is in the waiting room.
Discuss the care needs of the patient

Encourage the use of communication tools discussed in the communicating in difficult circumstances section of the CIN education

What actions could the CIN take to reduce the risk of escalating behaviours in the waiting room?
Summary

• Recognise red flags
• Never assume
• Consider the risks for the patient and others
• Patients need ongoing assessment to monitor deterioration, overdose or withdrawal
Acknowledgement

References


- Images downloaded and used courtesy of Google Images

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