

Guideline Protocol

Intoxicated Patient in the ED

Mode of Arrival Note: Non-emergent procedures can be delayed/ Special Circumstances declined if intoxication impairs patient's ability to 1. BPD, CSP, AST consent or maintain safety. Involuntary Psychiatric Hold 2. Walk in - Suicidal or homicidal ideation, gravely disabled. 3. EMS - Must be sober prior to BH evaluation. Note: Alcohol can mask other causes of altered 4. LifeMed mental status. Use clinical judgment to determine OCS report via reportchildabuse@alaska.gov. need for head imaging. - Discharge to sober adult (guardian or someone designated by guardian). Vitals Violent POC Glucose - Deescalate if able. GCS - Restraint or medication sedation to maintain safety. History Medical Screening Vitals not reassuring Vitals reassuring Hemodynamically unstable Glucose abnormal Glucose normal • GCS <8 Non-ambulatory GCS 13-15 Severe Trauma **Emergent Illness** • GCS 8-13 Ambulatory +Trauma/Illness Medically stable Concern for safety/SI Care per ACLS/ATLS Discharge Statuses Maintain in ED Consider Narcan Consider occult illness/trauma Continuous pulse-oximetry Remand No medical Full evaluation/exam • PC indication • ± Labs, imaging as appropriate · Care of sober adult for admission Treatment Self care if sober Stable or improving Medical indication for admission Transfer to higher level of care when appropriate. Admit to Inpatient once sober.

Common Complications of Acute Alcohol Intoxication

- Hypoglycemia
- Electrolyte abnormality
- Hypothermia
- Occult trauma
- Co-ingestion/intoxication
- Gastritis
- Pancreatitis
- Hepatitis
- Occult infection
- Aspiration
- Exacerbation of chronic illness
- Victim of physical/sexual assault

Alcohol Metabolism

- (Serum Alcohol 80) / (20 to 30) = Time to sobriety
- BRAC x 1000 = Serum Alcohol
- Serum alcohol <80 is considered sober.

This guideline is designed for the general use of most patients but may need to be adapted to meet the special needs of a specific patient as determined by the medical practitioner. Approved by MSEC 3/1/22.

Click here to see the supplemental resources for this guideline. If comments about this guideline, please contact Megan_Young@ykhc.org.

Deescalation Strategies for Adolescents

- If not immediately dangerous, attempt simple, nonrestrictive strategies:
 - Verbal de-escalation.
 - Reduction of environmental stimuli (a quiet room is much better than a loud hallway).
 - Offer basic needs (ex, food, warm blanket).

Medications

Use caution when giving medications to intoxicated patients, as alcohol can intensify sedation effects.

- · Oral vs Intramuscular If the patient is cooperative, offer oral medications first
 - May give the patient sense of some control.
 - Avoid trauma of being physically restrained for IM shot.
 - Many medications are equally effective in oral form
 - If patient is not cooperative, the oral route is not going to be an option.
- Benzodiazepines
 - Lorazepam 0.05-0.1 mg/kg/dose (PO/IM/IV)
 - Midazolam 0.25-0.5 mg/kg/dose PO; 0.2-0.3 mg/kg IN; 0.1-0.15 mg/kg/dose IM
- First Generation Antipsychotics
- Haloperidol 0.5-5 mg PO; 0.05-0.15 mg/kg IM (up to 5 mg/dose)
- Second Generation Antipsychotics
 - Risperidone 0.25-2 mg PO/ODT
 - Olanzapine 2.5-5 mg PO/ODT
- - Diphenhydramine 1 mg/kg/dose (PO/IM)
 - Ketamine

Rapid onset due to high bioavailability (even when given IM)

Safe even in overdose (important when you aren't sure of patient weight) No respiratory depression (rarely, may see laryngospasm)

No QT prolongation issues