

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 · Vital sign abnormalities not attributable to Vitals reassuring Hemodynamically unstable alcohol intoxication alone Glucose normal • GCS <8 Glucose abnormal GCS 13-15 Severe Trauma Non-ambulatory **Emergent Illness** Ambulatory • GCS 8-13 Medically stable • +Trauma/Illness Concern for safety/SI **Discharge Statuses** Care per ACLS/ATLS Maintain in ED Consider Narcan Remand Consider occult illness/trauma Continuous pulse-oximetry No medical • PC Full evaluation/exam indication Care of sober adult ± Labs, imaging as appropriate for admission Self care if clinically sober Treatment or has decision making capacity as determined by provider 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 Clinical Guideline Committee 5/28/24. Click here to see the supplemental resources for this guideline. If comments about this guideline, please contact clinical_guidelines@ykhc.org.

Deescalation Strategies

- 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 2-10 mg PO or IMIV, may repeat IM/IV every 15 min up to 30 mg
- Second Generation Antipsychotics
 - Risperidone 0.25-2 mg PO/ODT
 - Olanzapine 2.5-5 mg PO/ODT
- - Diphenhydramine 25-50mg PO or IM
 - Ketamine 1-2 mg/kg/dose IV or 4-5 mg/kg/dose IM

Rapid onset due to high bioavailability (even when given IM) No QT prolongation issues

Safe even in overdose (important when you aren't sure of patient weight)

No respiratory depression (rarely, may see laryngospasm)