

PROTOCOL FOR: Detoxification: Care of the Patient Requiring

- POLICY:**
1. All patients are assessed upon admission for substance use history.
 2. When substance abuse is known or suspected, further assessment to identify the potential for withdrawal syndrome and/or delirium tremens will be completed and appropriate interventions instituted.

- DEFINITIONS:**
1. Withdrawal Syndrome: The complex of physical and psychological disturbances observed upon withdrawal of the addicting agent. Severity of the autonomic and psychomotor disturbances varies with the agent, length of addiction, and size of dosage.
 2. Delirium Tremens: Delirium accompanied by constant tremor, fumbling movements of the hands, insomnia, and other physical and neurologic symptoms.

DESIRED PATIENT

- OUTCOMES:**
1. Patient will experience minimal discomfort related to withdrawal syndrome.
 2. Patient will experience minimal or no complications related to detoxification and withdrawal syndrome.
 3. Patient will recognize the signs and symptoms of withdrawal syndrome.

**CLINICAL
ASSESSMENT AND**

- CARE:**
1. The following criteria will be considered when assessing a patient who is experiencing symptoms of and/or at risk for withdrawal.
 - a. Substance Abuse History
 - 1) Type of substance(s) used
 - 2) Amount/route/substance(s) used
 - 3) Frequency/duration of use
 - 4) Date and time of last substance(s) used
 - 5) History of blackouts, seizures and/or delirium tremens
 - b. General signs and symptoms of withdrawal which may include pupil reaction, change in general appearance, nausea, vomiting, abdominal cramping, tremors, ataxia, lacrimation and rhinorrhea. For specific withdrawal symptoms, see attached table.
 - c. Admission lab work ordered initially should assess general health status and liver function. If clinically warranted, additional lab work may be ordered to further assess liver function, GI bleeding, anemia, malnutrition, significant changes in mental status, pregnancy or other substance abuse, i.e., B-HCG (qualitative, urine), Direct and Indirect Bilirubins, Hepatitis B/C Antibody screens, Amylase/Lipase (pain suggestive of pancreatitis), Urine Toxicology (routine for Opiates, Benzodiazepines, Cocaine and Cannabis; indicate if amphetamine-type substances, PCP or other substances are suspected), PPD testing, Ammonia, HIV Testing (consent form required); other tests that may be indicated are: EKG, Chest X-Ray.

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2. Nursing interventions include the following for alcohol detoxification:
 - a. Monitor vital signs and CIWA (for alcohol detoxification) every six hours for 48 hours, then every shift for 24 hours, Routine Unit vital signs thereafter.
 - b. Complete while awake CIWA every:
 - One hour if CIWA > 19
 - Two hours if CIWA = 14-19
 - Four hours if CIWA = 9-13
 - c. Notify MD if:
 - Systolic Blood Pressure > 150
 - Diastolic Blood Pressure > 100
 - Heart Rate > 100
 - Temperature > 100°
 - Respiration Rate > 26 or < 12
 - CIWA > 10
 - Persisting elevation of vital signs in spite of Lorazepam (Ativan) treatment
 - Exhibiting delirium tremens, i.e., symptoms of delirium, visual and or tactile hallucinations
 - Seizure
 - d. Hold Lorazepam (Ativan) if difficulty awakening, unsteady gait or slurred speech
 - e. For opiate detoxification, check Blood Pressure and pulse before each dose of Clonidine Hydrochloride is administered. Hold Clonidine Hydrochloride if Blood Pressure is < 90/60 and Pulse < 55.
 - f. Collaborate with physician for medication management of withdrawal symptoms (use detoxification order sheet for alcohol and or opiate detoxification if indicated).
 - g. Administer scheduled and/or prn meds as ordered to control withdrawal symptoms.
 - h. Monitor intake and output when clinically indicated. Encourage food and nourishing fluids; serve only decaffeinated beverages.
 - i. Maintain patient safety (i.e., 3 side rails up and padded when in bed, assist with ambulation when necessary).
 - j. Monitor level of consciousness and changes in mental status q 4° or more often as needed.
 - k. Reorient as needed.
 - l. Maintain decreased external stimuli (i.e., soft lighting, encourage bed rest and delay involvement in unit activities until appropriate).

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- m. Collaborate with interdisciplinary team regarding plans and expectations for gradual progression/participation in unit routine.
- n. Monitor sleep pattern.

- PATIENT TEACHING:**
1. Explain procedures to allay fears.
 2. Educate patient to the signs and symptoms of withdrawal and importance of reporting these to staff.
 3. Educate regarding use of prn medication for withdrawal signs and symptoms.
 4. Educate regarding detoxification process, including tapering dosage of medications for withdrawal.
 5. Begin initial education regarding abstinence (i.e., support groups, consequences of continued use).

APPROVAL: Nursing Standards Committee

EFFECTIVE DATE: 5/91

REVISION DATES: 5/93, 8/93, 11/94, 10/96, 12/99, 10/00, 10/03, 5/06, 2/07, 8/08