Crosstown Clinic: Care for Clients Who Use Alcohol

Site Applicability

Crosstown Clinic

Practice Level

Basic: RN/RPN/LPN

Need to Know

- Alcohol use must be monitored when clients are receiving their diacetylmorphine or HYDROmorphone due to potential adverse reactions (e.g. increased sedation)
- Alcohol use may increase the depressive effects of the client's prescribed dose of diacetylmorphine or HYDROmorphone
- Alcohol use refers to the use of beverage or non-beverage alcohol (e.g. mouthwash, hand sanitizer, rubbing alcohol, etc.)
- Clients who display signs and symptoms of alcohol intoxication (smells of alcohol, change in behaviour, slurred speech, unsteady gait) at the pre-assessment require an assessment by a provider on site or a provider on call UNLESS clients have specific orders to manage their alcohol use as determined by their most responsible provider(MRP)

Equipment and Supplies

- Dynamap

Procedures

Client WITHOUT Specific Alcohol Care Orders

- If a client is suspected of consuming alcohol (e.g. displays signs and symptoms of intoxication or smells of alcohol) during pre-assessment, the following steps should be completed:

1. The Pre/Post nurse discretely asks the client to speak in private.
2. The Pre/Post nurse inquires if the client has been consuming alcohol.
3. If the client confirms they have consumed alcohol, the Pre/Post nurses offers to either connect with a provider about safe dosing OR the client can choose to return at a later time to see if they meet pre-assessment criteria (minimum 1 hour).

Pre assessment is completed by observing the client for the following signs or symptoms:

a. Severely anxious or agitated

b. Dyskinetic

c. Overly sedated (use the POSS scale - **Appendix A**)

d. Slurred speech

e. Smells of alcohol/signs and symptoms of alcohol intoxication

Client Specific Alcohol Care Plan

1. Follow the client specific orders to manage alcohol use as outlined by the provider.

Documentation

- If a client does not meet the pre-assessment criteria, document this on the Opiate Assisted Treatment (OAT) database and in the EMR using the template **ITCI**.
- Document interventions in the Electronic Medical Record using the appropriate typing template for the intervention (e.g. ITCH).

Patient and Family Education

- Clients will be informed of the procedures for alcohol use assessments at clinic intake
- If a client displays signs and symptoms of alcohol consumption during the pre-assessment, advise them of the plan of care.

Related Documents

1. B-00-13-10210 - Crosstown Clinic: Client Flow and Assessment

Appendix

Appendix A – POSS (Pasero Opioid-Induced Sedation Scale)

Appendix A - Modified Pasero Sedation Scale (POSS)

Score	Meaning of Score	
S	Sleep, easy to rouse	**Acceptable**: no action necessary; may increase opioid dose if needed
1	Awake and alert	**Acceptable**: no action necessary
2	Slightly drowsy, easily roused	**Acceptable**: no action necessary
3	Frequently drowsy, rousable, drifts off to sleep during conversation	**Unacceptable:** client does not meet the criteria for pre- or post-assessment and requires further medical assessment/interventions
4	Somnolent, minimal or no response to verbal and physical stimulation	**Unacceptable:** Consider administering naloxone and call 911. Call prescriber for dose adjustment for next visit

Persons/Groups Consulted:

Nursing, Crosstown Clinic

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