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Disruptive Patient 3: Withdrawal

Instructor Information

Patient Name: Rolando Jones
Simulation Developer(s): Debra A. Mosley
Scenario Purpose:

- To safely and effectively manage care for the disruptive patient experiencing withdrawal

Learner(s):

- **Registered Nurses (RN), Licensed Practical Nurses (LPN), Unlicensed Assistive Personnel (UAP)**
- **Others as desired, depending on facility protocols**
- **Recommend no more than 6 learners (3 of which can be observers)**

Time Requirements:

- **Setup:** 5 minutes
- **Scenario:** 25 minutes
- **Debrief:** 25 Minutes
- **Reset/Breakdown:** 5 minutes

Confederate(s):

- **Significant Other**
- **Assistance (security, police, social worker, mental health professional, or other assistive personnel as desired)**
- **Standardized patient**

Scenario Prologue:

- **The patient is a 49 year old male who presents for an unknown reason after driving two hours. He is accompanied by his significant other.**
- **The simulation begins when the learners meet the patient in the room – patient is sitting on the exam table**

Patient information:

- ***General:*** Agitated
- ***Weight/Height:*** 113.6kg (250lbs) 182.9 cm (72in)
- ***Vital Signs:*** BP 160/80, Temp 97, HR 120, RR 24, O2 Sat 96%
- ***Pain:*** 6/10 In the lower extremities
- ***Neurological:*** Numbness and pain in bilateral lower extremities
- ***Respiratory:*** Lungs clear, dyspneic, tachypneic
- ***Cardiac:*** Tachycardiac
- ***Gastrointestinal:*** Unremarkable
- ***Genitourinary:*** Unremarkable
- ***Musculoskeletal:*** Gait unsteady
- ***Skin:*** Diaphoretic
- ***Past Medical History:*** Post Traumatic Stress Disorder (PTSD), type 2 diabetes, chronic obstructive pulmonary disease (COPD), arthritis, diabetic neuropathy, 30 year one pack per day smoking history, and he drinks "a few beers a day"
  - ***Past Surgical History:*** Appendectomy and bilateral lower extremity shrapnel removal

Medications:

- Metformin 500 mg three times daily with meals
- Lorazepam 2 mg every 8 hours
- Albuterol/Ipratropium inhaler 2 puffs four times a day
- Gabapentin 300 mg three times daily

Allergies:

- No known drug allergies (NKDA)
- Allergic to dairy products

Confederate

Change in Physiology

Disclaimer: All names used in scenario are fictious and used for examples only.

Learning Objectives

Patient Name: Rolando Jones
Simulation Developer(s): Debra A. Mosley
Scenario Purpose:

- To safely and effectively manage care for the disruptive patient experiencing withdrawal

Pre-Session Activities:

- Complete training on managing the disruptive patient experiencing withdrawal
- Review policies and protocols on managing the disruptive patient experiencing withdrawal

Potential Systems Explored:

- What are examples of de-escalation techniques intended for use on disruptive patients experiencing withdrawal?
- What standardized protocols currently exist to establish safety for the patient experiencing withdrawal?
- What assessment tools are available to assess withdrawal symptoms for alcohol, benzodiazepines, opiods, etc.?
- Which signs and symptoms of withdrawal are prone to subjective misinterpretation and why?
- What facility specific documentation is required at your facility?
- What risk factors, contraindications, and complications are important to consider when caring for the disruptive patient experiencing withdrawal?

Scenario Specific Learning Objectives (Knowledge, Skills, and Attitudes = K/S/A):
**The learner(s) will demonstrate ICARE principles throughout the scenario.
Learning Objective 1: Establish safety when managing care for the disruptive patient experiencing withdrawal

a. ***S***- *Implement PMDB de-escalation principles to establish safety*
   A- *Maintain a calm, neutral tone of voice*
b. ***K***- *Apply knowledge of PMDB principles placing safety as the first priority*
   S- *Utilize de-escalation techniques to establish a safe patient environment*
   A- *Avoid use of condescending tone of voice and maintain non-threatening body language*

Learning Objective 2: Perform an assessment on a patient exhibiting signs and symptoms of alcohol withdrawal utilizing facility specific assessment tool

a. ***K***- *Recognize signs and symptoms of withdrawal*
   S- *Assess the patient's signs and symptoms using the CIWA-Ar scale or facility specific alcohol withdrawal evaluation tool*

Learning Objective 3: Implement symptom based withdrawal protocol

a. ***S***- *Implement facility specific disruptive patient withdrawal protocol*
   A- *Demonstrate confidence when initiating withdrawal protocol*

Learning Objective 4: Utilize effective communication when caring for the disruptive patient experiencing withdrawal

a. ***S***- *Obtain assistance per facility protocol*
b. ***K***- *State interdisciplinary resources available (physicians, mental health, VA police, social work, etc.) to manage the disruptive patient experiencing withdrawal*
   S- *Perform facility ISBAR communication*
c. ***S***- *Complete facility specific documentation*

Debriefing Overview:

- Ask the learner(s) how they feel after the scenario
- Have the learner(s) provide a summary of the scenario from a healthcare provider/clinical reasoning point of view
- Discuss the scenario and ask the learners what the main issues were from their perspective
- Ask what was managed well and why.
- Ask what they would want to change and why.

- For areas requiring direct feedback, provide relevant knowledge by stating "I noticed you *[behavior]…"* Suggest the behavior they might want to portray next time and provide a rationale. "Can you share with us?"
- Indicate closing of the debriefing but provide learners with an opportunity to voice one or two take-aways that will help them in future practice
- Lastly, ask for any outstanding issues before closing the debrief

Critical Actions/Debriefing Points:

1. Implement PMDB de-escalation techniques to establish a safe environment
2. Initiate/delegate request for assistance
3. Correlate tremors with alcohol withdrawal
4. Recognize the patient feeling like bugs are crawling on him as a tactile disturbance
5. Perform an alcohol withdrawal assessment
6. Recognize the patient is experiencing moderate withdrawal
7. Initiate facility specific alcohol detox protocol
8. Provide the patient with alcohol withdrawal information including a potential plan that may include a sedative
9. Prepare to administer sedative per detox protocol
10. Perform ISBAR communication
11. Complete facility specific documentation

Simulation Set-Up

(Standardized Patient)

Patient Name: Rolando Jones
Simulation Developer(s): Debra A. Mosley
Room Set-up:

- Set up like a reception area kiosk (Outpatient)
- Set up like a hospital nurses station (Inpatient)
- The patient is accompanied by his significant other
- The patient is diaphoretic and demonstrating tremors

Patient Preparation:

- The patient is wearing street clothes
- The patient is diaphoretic and has perspiration under his arm pits
- Ensure orders are printed and in a sealed envelope.

Have the following equipment/supplies available:

- Telephone
- *Label on phone for notifying emergency mental health team response (depending on facility)
- *Label on keyboard for notifying emergency mental health team response (depending on facility)
- *Emergency alarm for notifying emergency mental health team response (depending on facility)
- Keyboard and computer monitor (non-functioning; optional)
- Gloves
- Hand sanitizer
- Blood pressure cuff
- Stethoscope

Medications:

- Diazepam 5 mg tablet
  **Calibration will be required if using radiofrequency identification (RFID)

Note: 5.8 Simpad software update is required to load scenarios
(http://cdn.laerdal.com/downloads/f4343/simpad-upgrade.vs2
Scenarios may be used with Laerdal or LLEAP software

Scenario Supplements:

- Confederate scripts
- Confederate and learner name tags
- Patient identification band
- Orders
- CIWA-Ar withdrawal assessment tool
- PMBD GAINS mnemonic supplement
- Symptom based detox protocol example
- Code Orange Button picture
- ZZ test patient/Demo patient in CPRS (if desired)

Simulations for Clinical Excellence in Nursing Services

Disruptive Patient 3: Withdrawal

Flowchart

Initial State:
- Mental Status: Tense, agitated
- Sp02: 96%
- BP: 160/80
- HR: 120
- RR: 24 Labored
- Pain level: 6/10 lower extremities
- Skin: Diaphoretic

- **The patient is a 49 year old male who presents for an unknown reason after driving two hours. He is accompanied by his significant other.**

- ***The patient states "I don't know why I'm here. All I know is I received this paper in the mail and drove two hours to get here! You figure it out!"***
- ***The patient's will hand the learner an envelope while demonstrating moderate tremors***
- ***Explains the purpose of the visit once they are able to view the contents of the envelope***

Patient Status Change
- Mental status: **The patient becomes increasingly agitated**

- ***The patient states "I feel like I got bugs crawling all over me!"***
- ***The significant other states "Please try to calm down, you are making a scene."***
- ***The patient clenches his fists towards his significant other stating "Shut up!!!!"***
- ***Implements Prevention and Management of Disruptive Behavior (PMDB) de-escalation techniques to establish a safe environment***
- ***Initiates/delegates request for assistance***

- ***Correlates tremors with alcohol withdrawal***
- ***Keeps the patient informed of plan of care***
- ***Performs facility specific alcohol withdrawal assessment***
- ***Recognizes patient is experiencing moderate withdrawal symptoms***

- ***Initiates facility specific detox protocol***
- ***The patient will begin to calm down stating "I really do need to stop drinking. I feel so uptight though. What can be causing this?"***
- ***Provides the patient with information regarding alcohol withdrawal as well as potential plan of care that may include a sedative***
- ***Prepares to administer sedative per detox protocol***

***Assistance* Arrives**
- ***Performs ISBAR communication***
- ***Completes facility specific documentation***

Did not follow PMDB Principles
- **Team member(s) remain isolated in the room with the patient**
- **The door is closed**

Patient Status Change
- Mental status: **The patient clenches his fists and threatens to physically injure all individuals present during the scenario**

Critical Actions/Debriefing Points:
1. Implement PMDB de-escalation techniques to establish a safe environment
2. Initiate/delegate request for assistance
3. Correlate tremors with alcohol withdrawal
4. Recognize the patient feeling like bugs are crawling on him as a tactile disturbance
5. Perform an alcohol withdrawal assessment
6. Recognize patient is experiencing moderate withdrawal
7. Initiate facility specific alcohol detox protocol
8. Provide the patient with alcohol withdrawal information including a potential plan that may include a sedative
9. Prepare to administer sedative per detox protocol
10. Perform ISBAR communication
11. Complete facility specific documentation

Confederate

Change in physiology

Red border incorrect action

Supplements

Confederate Scripts

Confederate Name Tags

Patient Identification Band

Orders

CIWA-Ar Withdrawal Assessment Tool

Symptom Based Detox Protocol Example

Code Orange Button (Call for Assistance)

Confederate Scripts

Rolando Jones: Standardized Patient

Medical/Surgical History: PTSD, type 2 diabetes, COPD, arthritis, diabetic neuropathy, 30 year one pack per day smoking history, and he drinks "a few beers a day." Appendectomy and lower extremity shrapnel removal
Medications: Metformin 500 mg three times daily with meals, Lorazepam 2 mg every 8 hours, Albuterol/Ipratropium inhaler 2 puffs four times a day, Gabapentin 300 mg three time a day
Allergies: NKDA; Allergic to dairy products

- The patient states "I don't know why I'm here. All I know is I received this paper in the mail and drove two hours to get here! You figure it out!"
- The patient's will hand the learner an envelope while demonstrating moderate tremors
- The patient states "I feel like I got bugs crawling all over me!"
- The significant other states "Please try to calm down, you are making a scene."
- The patient clenches his fists towards his significant other stating "Shut up!!!!"
- PMDB de-escalation techniques will be utilized
- Alcohol withdrawal assessment will be performed
- Detox protocol will be initiated
- The patient will begin to calm down stating "I really do need to stop drinking. I feel so uptight though. What can be causing this?"
- Assistance will arrive
- ISBAR will be provided
- Scenario will end

Significant Other

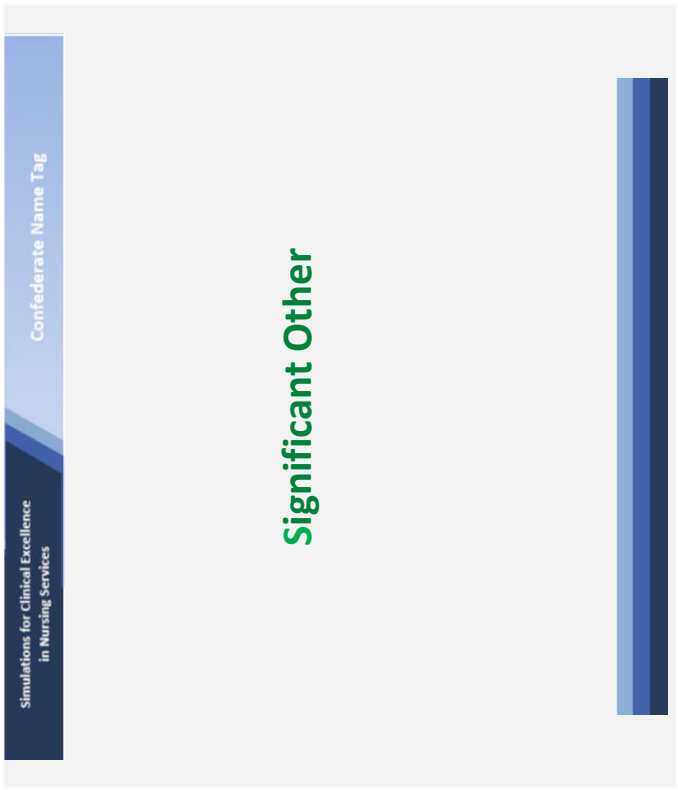
- The patient states "I feel like I got bugs crawling all over me!"
- The significant other states "Please try to calm down, you are making a scene."

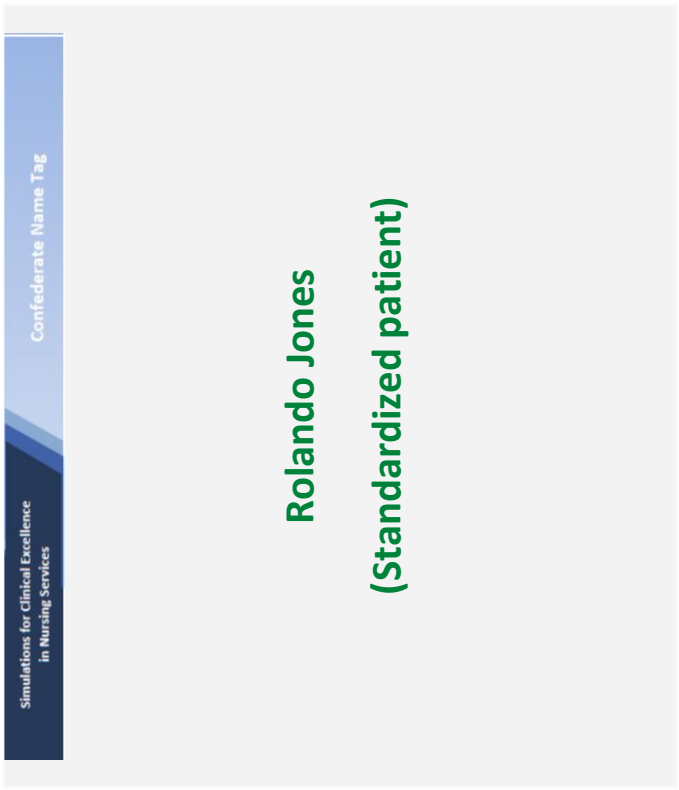
Assistance

(Security, police, social worker, mental health professional, or other assistive personnel)

- Assistance arrives after alcohol withdrawal assessment has been completed
- ISBAR will be provided
- Scenario will end

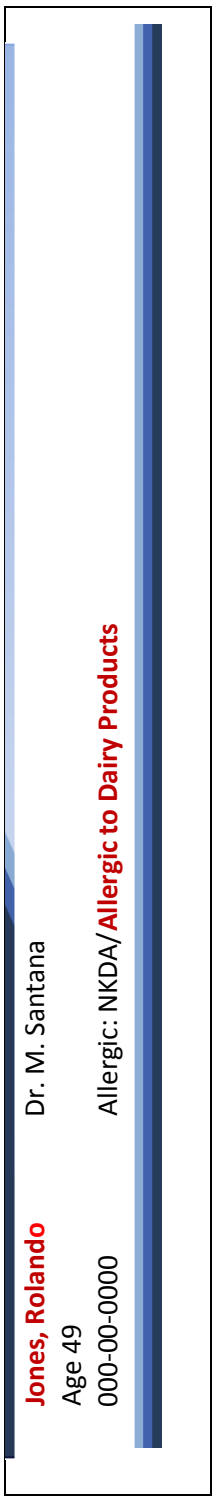
Confederate Name Tags





Additional ASSISTANCE tags may be made prn

Patient Identification Band



Orders

Patient Information

Jones, Rolando
Dr. M. Santana
Age: 49
Social Security #: 000-00-0000
Allergies: **Dairy products**
Weight: 113.6kg (250lbs)
Height: 182.9 cm (72in); BMI 33.9

Admit to	Medical Surgical unit
Diagnosis	Alcohol Withdrawal Syndrome
IV Therapy	Saline Lock
Medications (routine)	Metformin 500 mg three times daily with meals Albuterol/Ipratropium inhaler 2 puffs four times a day Gabapentin 300 mg three times a day
Medications (prn)	Per symptom-based alcohol withdrawal protocol
Diagnostics	Electrolyte profile in the morning
Fingerstick Blood Sugar	Per symptom-based alcohol withdrawal protocol
Code Status	Full code
Miscellaneous Orders	Symptom-based alcohol withdrawal protocol

DO NOT WRITE IN THIS SPACE

Addiction Research Foundation Clinical Institute Withdrawal Assessment for Alcohol, revised (CIWA-Ar)

Pulse or heart rate, taken for one minute: _____ **Blood Pressure: _____** Maximum Possible Score (67)

Total CIWA-Ar Score: _____

NAUSEA AND VOMITING—Ask *"Do you feel sick to your stomach? Have you vomited?"* Observation.
0 no nausea and no vomiting
1 mild nausea with no vomiting
2
3
4 intermittent nausea with dry heaves
5
6
7 constant nausea, frequent dry heaves and vomiting

Rating

TREMOR—Arms extended and fingers spread apart. Observation.
0 no tremor
1 not visible, but can be felt fingertip to fingertip
2
3
4 moderate, with patient's arms extended
5
6
7 severe, even with arms not extended

Rating

PAROXYSMAL SWEATS—Observation.
0 no sweat visible
1 barely perceptible sweating, palms moist
2
3
4 beads of sweat obvious on forehead
5
6
7 drenching sweats

Rating

ANXIETY—Ask *"Do you feel nervous?"* Observation.
0 no anxiety, at ease
1 mildly anxious
2
3
4 moderately anxious, or guarded, so anxiety is inferred
5
6
7 equivalent to acute panic states as seen in severe delirium or acute schizophrenic reactions

Rating

AGITATION—Observation.
0 normal activity
1 somewhat more than normal activity
2
3
4 moderately fidgety and restless
5
6
7 paces back and forth during most of the interview, or constantly thrashes about

Rating

TACTILE DISTURBANCES-Ask *"Have you any itching, pins and needles sensations, any burning, any numbness or do you feel bugs crawling on or under your skin?"* Observation.
0 none
1 very mild itching, pins and needles, burning or numbness
2 mild itching, pins and needles, burning or numbness
3 moderate itching, pins and needles, burning or numbness
4 moderately severe hallucinations
5 severe hallucinations
6 extremely severe hallucinations
7 continuous hallucinations

Rating

AUDITORY DISTURBANCES—Ask *"Are you more aware of sounds around you? Are they harsh? Do they frighten you? Are you hearing anything that is disturbing to you? Are you hearing things you know are not there?"* Observation.
0 not present
1 very mild harshness or ability to frighten
2 mild harshness or ability to frighten
3 moderate harshness or ability to frighten
4 moderately severe hallucinations
5 severe hallucinations
6 extremely severe hallucinations
7 continuous hallucinations

Rating

VISUAL DISTURBANCES—Ask *"Does the light appear to be too bright? Is its color different? Does it hurt your eyes? Are you seeing anything that is disturbing to you? Are you seeing things you know are not there?"* Observation.
0 not present
1 very mild sensitivity
2 mild sensitivity
3 moderate sensitivity
4 moderately severe hallucinations
5 severe hallucinations
6 extremely severe hallucinations
7 continuous hallucinations

Rating

HEADACHE, FULLNESS IN HEAD—Ask *"Does your head feel different? Does it feel like there is a band around your head?"* Do not rate for dizziness or lightheadedness. Otherwise, rate severity.
0 not present
1 very mild
2 mild
3 moderate
4 moderately severe
5 severe
6 very severe
7 extremely severe

Rating

ORIENTATION AND CLOUDING OF SENSORIUM—Ask *"What day is this? Where are you? Who am I?"*
0 oriented and can do serial additions
1 cannot do serial additions or is uncertain about date
2 disoriented for date by no more than 2 calendar days
3 disoriented for date by more than 2 calendar days
4 disoriented for place and/or person

Rating

Symptom Based Detox Protocol Example

Symptom - based alcohol withdrawal protocol

Step 1: Does patient have history of alcohol use?

Yes ↓

Step 2: Does patient have any of the following (MD to evaluate)?

- Current intoxication? If intoxicated, re-assess every 4 hours, and proceed with protocol when clinically appropriate
- Suspected overdose of CNS depressants prior to admission? Do not use this protocol
- Mechanical ventilation? Should have separate sedation orders with RASS score parameters

No ↓

Step 3: Does patient have a *documented* history of alcohol related seizures and/or delirium tremens?

No ↓ Yes → MD to order diazepam 10mg by mouth every 4 hours x 3 doses while proceeding with symptom - based alcohol protocol (Step 4)

Step 4: Initiate symptom based alcohol protocol. ***Note doses depend on CIWA - Ar score***

CIWA - Ar Score	Orders		
	Choose Protocol		
-	□ **Diazepam protocol** *Preferred in most patients	**Or**	□ **Lorazepam protocol** *Preferred choice if significant liver disease
0 – 7 (absent/minimal withdrawal)	Give NO medicine. **Repeat CIWA q4h x 24h, then q12h x 72h, then discontinue checking CIWA**		
8 – 15 (mild – moderate withdrawal)	Diazepam 5mg po q1h as needed **Repeat CIWA in 1 hour to assess effectiveness of prn medication**	**Or**	Lorazepam 1mg po q1h as needed **Repeat CIWA in 1 hour to assess effectiveness of prn medication**
	Note: If patient requires 2 or more 'every hour' doses of medication, contact MD after assessing prn effectiveness (prior to administering 3rd dose)		
>15 (severe withdrawal)	Diazepam 10 mg po q1h as needed **Repeat CIWA in 1 hour to assess effectiveness of prn medication**	**Or**	Lorazepam 2 mg po q1h as needed **Repeat CIWA in 1 hour to assess effectiveness of prn medication**
	Note: If patient requires 2 or more 'every hour' doses of medication, contact MD after assessing prn effectiveness (prior to administering 3rd dose)		

CIWA-Ar = Clinical Institute Withdrawal Assessment for Alcohol – Revised scale

Nursing orders:

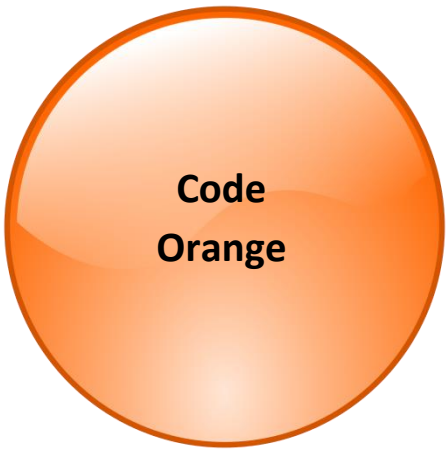
1. Complete baseline CIWA then follow the protocol for vital sign frequency and to assess the patient's need for symptom based treatment
2. If patient is sleeping, do not wake the patient up to give diazepam/lorazepam or assess the patient's CIWA score; Assess the CIWA score when patient awakens
3. If patient requires 2 or more 'every hour' doses of medication, contact MD after assessing prn effectiveness (prior to administering 3rd dose)
4. If after diazepam/lorazepam dose, CIWA score remains unchanged or increases, contact MD
5. Notify MD for: Temp > 101°F, SBP > 160 mmHg, SBP < 90 mmHg, HR > 120, HR < 60, RR > 24, RR < 10, CIWA > 20, increase in CIWA score of > 10, altered mental status, seizures

↓

Step 5: MD to order ancillary meds as appropriate: * Nutrition: Thiamine, folic acid, multivitamins * Nausea/vomiting: Ondansetron

Code Orange Button

(Call for Assistance)



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