

Nursing and Midwifery Management of Drug and Alcohol use in the Delivery of Health Care

Summary This Policy Directive outlines the required practice of registered nurses and midwives when providing health care to all patients admitted to the NSW Health Care system. It is to reduce barriers to engaging patients in treatment, ensuring effective clinical management and improving health outcomes. The Policy is underpinned by the Nursing and Midwifery Guidelines: Responding effectively to people who use alcohol and other drugs.

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NURSING AND MIDWIFERY MANAGEMENT OF ALCOHOL AND DRUG USE IN THE DELIVERY OF HEALTH CARE

POLICY STATEMENT

Nurses and midwives in all NSW Health care settings are to ensure people with drug and alcohol related issues experience person-centred, safe and high-quality intervention and care.

SUMMARY OF POLICY REQUIREMENTS

All care and treatment delivered to people who are experiencing harm from alcohol and other drug use is to be person centred and non-discriminatory

On admission to a health service all patients will undergo an initial screening to identify alcohol and/or drug use and risks as part of all nursing and midwifery care.

The use of drugs and alcohol is to be recorded for all patients so that there is a consistent approach to provision of care and referral of patients to specialist services.

As part of responding to alcohol and/or drug use risks, nurses and midwives are to deliver brief interventions in line with their scope of practice, consult and refer to a specialist treatment provider for comprehensive assessment, as appropriate.

Nurses and midwives need to maintain awareness that patients presenting with risk factors, associated with alcohol and other drug use, also may predispose any child to increased risks to their wellbeing. Where this is identified, appropriate and sensitive questioning must be undertaken in line with NSW Health Policy.

The drug and alcohol goals, and treatment plan must be considered and integrated into their overall holistic health care plan, in collaboration with the patient.

Nurses and Midwives must ensure a patient's drug and alcohol health care needs are integrated into their transfer of care planning process.

At each transition of care, clinical handover must occur to ensure patient safety.

REVISION HISTORY

Version	Approved by	Amendment notes
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December-2007 (PD2007_091)	Director General	Initial Document

ATTACHMENTS

1. Nursing and midwifery management of alcohol and drug use in the delivery of health care: procedures.

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1 BACKGROUND

Substance use is a normal part of many people's lives and although many people drink alcohol or use drugs, not everyone suffers harm to their physical or mental health. Alcohol and other drug related harms affect individuals regardless of race, cultural background, education, religion, gender and age. It is important to recognise that alcohol and other drug use is common, and those who use these substances may be affected by stigma and/or discrimination by others, including healthcare staff.

Assumptions about people who use alcohol and other drugs are often founded on stereotypes. Within the role and scope of nursing and midwifery practice, it is common to come across people who have used substances for a variety of reasons. Substances may be legal (such as nicotine, alcohol, prescription or over-the-counter medications) or illegal (such as methamphetamine, or non-prescription opioids, benzodiazepines or cannabis). In each case, the nurse or midwife must consider the clinical and social implications associated with any substance use that has occurred.

Understanding substance use means identifying the reasons a person may be drinking alcohol or using drugs rather than just focusing on the substance being used. Often, increased hazardous or harmful use is connected to other personal health or psychosocial issues, including a lack of educational opportunities, childhood trauma and housing problems.

Harm reduction is the key policy direction for people when addressing the impact of alcohol and other drug use on their lives. Embedding a health system response to alcohol and other drug use remains a strategic focus. A key strategy to achieve this is raising the skills and awareness of substance use related harms among all generalist health workers. Nurses and midwives are well-placed to deliver harm reduction message as they are often the first point of contact for people who use alcohol or other drugs at hazardous or harmful levels.

Everyone who uses substances does not become dependent. The World Health Organisation (WHO) lexicon of alcohol and drug terms identifies dependence syndrome as '*a cluster of behavioural, cognitive, and physiological phenomena that may develop after repeated substance use*'.¹ These phenomena include:

- a strong desire to take the drug
- impaired control over its use
- persistent use despite harmful consequences
- a higher priority given to drug use than to other activities and obligations
- increased tolerance
- experience of physical withdrawal reaction when drug use is discontinued.

The dependence syndrome may relate to a specific substance (e.g. nicotine, alcohol, diazepam), a class of substances (e.g. opioids), or a wider range of pharmacologically

¹ World Health Organisation, Lexicon of alcohol and drug terms published by the World Health Organization, https://www.who.int/substance_abuse/terminology/who_lexicon/en/

different substances. Dependence also occurs on a continuum from mild to moderate to severe. There may also be different treatment options for patients based on their level of dependence.

Patients who use alcohol and other drugs, particularly at hazardous or harmful levels, are more likely to experience poor health outcomes and have associated mental health conditions, cognitive impairment and physical health issues.

Patients with alcohol and other drug issues may enter hospital:

- in crises as a non-planned admission through the Emergency Department (e.g. overdose, injury or accident, or with medical complications of use)
- in a planned admission for surgery/medical management
- for planned care (e.g. medical complications related to use of substances)
- for pregnancy care or to give birth.

It is critical that nurses and midwives are attuned to risks associated with alcohol and other drug use and the implications that this may have on clinical care. Risk identification consists of assessing a patient's physical and mental health as well as their social risks. The core risks to be considered routinely for patients in alcohol and other drug treatment, regardless of the substances used or the treatment they are receiving, are those related to:

- overdose, including poly-sedative use
- domestic and family violence
- child wellbeing
- complicated withdrawal history including withdrawal seizures and alcohol withdrawal delirium
- recent release from hospital or residential health setting (including residential rehabilitation) or a custodial facility (e.g. prison, remand, police cells) may reduce tolerance and increase risk of overdose.
- current mental health issues including risk of harm to self or others.
- risk of homelessness or eviction.

Nurses and midwives are best placed as health professionals to identify and assess alcohol and other drug use, identify and respond to risks associated with alcohol and other drug (AOD) use, and incorporate AOD considerations into care planning and transfer of care. It is within the role and scope of all nurses and midwives to minimise the harm associated with hazardous substance use.

1.1 About this document

These Procedures outline the minimum requirements and actions of nurses and midwives to recognise harmful use, understand the impact of that use, and support clinical decision-making. There is no requirement for nurses and midwives to become experts in the area of AOD health care. It is critical however that they are supported to

develop the requisite knowledge and skill to identify levels of risk, implications for clinical management and facilitate pathways to appropriate treatment.

The policy and procedures for Nursing and Midwifery management of alcohol and drug use in the delivery of health care provide a framework for practice which will enhance the safety and quality of services delivered to people experiencing harm from substance use.

A Handbook for Nurses and Midwives: Responding effectively to people who use alcohol and other drugs is being developed to underpin the implementation of these procedures. The Handbook can be found on the NSW Health Alcohol and Other Drugs web page <https://www.health.nsw.gov.au/aod/Pages/default.aspx>

NSW Health also has a range of Clinical Guidelines to support the care and management of patients experiencing withdrawal syndromes, presenting with co-morbid mental health and drug and alcohol disorders and management of substance use in pregnancy. These clinical guidelines focus on specific drugs and AOD treatments. More information is available on the NSW Health Policy Distribution System web page <https://www1.health.nsw.gov.au/pds/Pages/pdslanding.aspx>

1.2 Definitions

Domestic violence

Domestic violence is any abusive behaviour used by a person in a relationship to gain and maintain control over their partner or ex-partner. It can include a broad range of behaviour that causes fear and physical and/or psychological harm. If a child or young person is living in a household where there have been incidents of domestic violence, they may be at risk of serious physical and/or psychological harm.

Domestic violence also includes physical, sexual, emotional and psychological abuse.

Emotional abuse (of a child)

Emotional abuse can occur if the behaviour of their parent or caregiver damages the confidence and self-esteem of the child or young person, which often results in serious emotional disturbance or psychological trauma.

Family violence

Family violence is a broader term that refers to violence between family members, as well as violence between intimate partners. The term family violence is the most widely used term to identify the experiences of Indigenous people, because it includes the broad range of marital and kinship relationships in which violence may occur.

Neglect

Neglect is defined as continued failure by a parent or caregiver to provide a child with the basic things needed for his or her proper growth and development, such as food, clothing, shelter, medical and dental care; and adequate supervision.

Overdose

Where a person has taken more of a substance than the recommended therapeutic dose or an amount that exceeds his/her tolerance, whether intentionally or by accident.

Overdose may result in a substantially reduced level of consciousness, seizure, coma or death.

Psychological abuse

Psychological abuse is characterised by a person subjecting or exposing another person to behaviour that may result in psychological trauma, including anxiety, chronic depression, or post-traumatic stress disorder.

Physical abuse

Physical abuse is a *non-accidental* injury or pattern of injuries to a child or young person caused by a parent, caregiver or any other person.

Sexual abuse

Sexual abuse is abusive sexual behaviour by one person upon another. It is often perpetrated using force or by taking advantage of trust.

2 SCREENING FOR THE USE OF ALCOHOL AND OTHER DRUGS

On admission to a health service all patients will undergo an initial screening to identify alcohol and/or drug use and risks as part of all nursing and midwifery care.

Furthermore, patients with identified AOD related risks must be referred for a comprehensive assessment of their alcohol and/or drug use, as required.

Screening and, where indicated, comprehensive assessment, enables a greater understanding of the patient's history of AOD use, and helps to identify any immediate or ongoing health risks (such as whether the patient may experience withdrawal), the types of tools or scales required to monitor the patient's physical and mental health and the pharmacotherapies that may be prescribed for the patient.

All care and treatment delivered to people who are experiencing harm from alcohol and other drug use is to be person centred and non-discriminatory. Consideration must be made for the patient's privacy when discussing any health information or undertaking any assessments.

Screening is integral to ensuring safe and effective nursing and midwifery care. The effects of alcohol and other drugs can mimic or mask serious medical and mental health conditions.

The aim of screening is to determine whether a particular condition is present or if the presentation is due to substances used. Screening is also intended to determine the possibility of harm associated with substance use and the impact this may have on the individual and their episode of care. This includes the risk of physical complications on sudden cessation or impact of acute intoxication.

In addition to noting vital signs, fluid balance and level of consciousness, the nurse or midwife is to screen for the presence of any substance use that may impact clinical care. Identify and document details about the patient's past or current alcohol and other drug use including tobacco use, prescribed medications, non-prescribed pharmaceuticals, and legal and illicit substances.

A positive screen is the trigger for a comprehensive assessment which, if indicated, will inform integrated planning for all treatment.

2.1 Initial Screening

The initial screening of all patients is to be systematic and include consideration of:

- past medical history
- psychosocial issues
- indicators of risk
- physical signs and symptoms
- current mental health status
- pathology results.

It is important to note that no single sign, symptom or pathology test is conclusive evidence of an alcohol or drug-related issue.

As part of the initial screening, all patients are also to undergo preliminary screening for suicide risk, as outlined in the NSW Health Policy *Clinical Care of People Who May Be Suicidal* (PD2016_007).

The suicide risk assessment determines the severity of self-harm, suicidal thoughts or behaviour including identifying any specific plans for suicide, access to means, potential lethality of the chosen method, persistence of ideation, what precautions against discovery were planned, impulsivity and distorted thinking, and details of any previous suicide attempts.

The NSW Health *Mental Health Triage Policy* (PD2012_053) defines and outlines the clinical processes to identify the presenting factors that suggest risk, the appropriate response required, and how to manage call situations including callers who threaten to harm.

2.1.1 Specific screening questions

Initial screening is undertaken to understand the patient's individual circumstances. This includes asking the patient the following questions:

In the last month have you:

- Smoked tobacco or vaped?
- Consumed alcohol on 4 days or more in a week or had 6 or more standard drinks on one occasion?
- Used any recreational drugs?
- Taken medication for pain, anxiety/stress or sleeping problems?
- Used any other substances?

If 'yes' to any of the above, then clarify:

- How frequently have you used the substances you have identified?

- When did you last use this drug, smoke tobacco/vape or drink alcohol?
- How do you take the drug or alcohol? (e.g. drink, inject, snort, smoke, vape)
- Have you ever overdosed or experienced withdrawal symptoms?
- Have you ever attended a drug or alcohol service for treatment for your alcohol or drug use?

The quantities of substance a person is using, or has used prior to seeking clinical care, is to be documented. It is also necessary to ask the patient if they are using more than one drug at a time, as polysubstance use can significantly increase the risk involved. If the patient uses “slang” language to describe their use, clarify with them exactly what they are using.

While many screening tools are available, it is recommended that nurses and midwives first refer to their local guidelines and protocols.

Some tools commonly used include:

- Alcohol Use Disorders Identification Test (AUDIT) (AUDIT-C)
- DASS 21 (Depression, Anxiety, Stress Scales)
- Kessler 10 (K-10)
- Severity of Dependence Scale
- Indigenous Risk Impact Screen (IRIS)
- Substance and Choices Scale (for ages 13-18)
- Mental State Examination
- Fagerstrom Nicotine Tolerance Questionnaire
- Edinburgh Depression Scale
- Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) (Short and long version)
- The CAGE-AID is a four-item questionnaire which assesses alcohol and other drug use. It is easy to administer with good sensitivity and specificity.

The aim of screening is to determine whether a condition is present or if the presentation is due to substances used. A positive screen is a trigger for a referral to an AOD Specialist for a more comprehensive assessment and, if indicated, will inform integrated planning for all treatment.

2.1.2 Quantifying and documenting substance use

Screening of AOD use is to include the quantity of substance used and frequency of use. This must be done to identify whether the level of use may cause harm and whether withdrawal or progression to withdrawal or overdose is imminent.

There is no recommended safe use of nicotine, illicit or non-prescribed illicit substances. The degree of harm associated with these substances is dependent on type of substance used, amount used, frequency of use and general wellbeing.

To reduce the risk of harm from alcohol-related harm, it is recommended that healthy men and women drink no more than 10 standard drinks per week and no more than 4 standard drinks on any one day. The less a person chooses to drink, the lower the risk of alcohol-related harm. For pregnant women, children under the age of 18 and people with co-morbidities or taking sedative medications, not drinking at all is the safest option.

The quantities of substance a person is using, or has used prior to seeking clinical care, is to be documented.

2.1.3 Treatment of an in-patient who is on an Opioid Treatment Program

If the patient is on Opioid Agonist Treatment (Methadone, Naltrexone or Buprenorphine) it is critical that their treatment is maintained if there are no medical contraindications. On admission it is important to:

- Verify the patient's identity
- Contact the authorised prescriber and opioid treatment dosing point
- Confirm type of treatment, date and time of last dose, including any takeaway doses given

If you have difficulties obtaining details of the authorised prescriber for the patient, contact Pharmaceutical Services Branch, NSW Health on (02) 9879 5246 during office hours.

Confirmation of dosage is important as any additional administration of an opioid drug may lead to overdose if the patient has had a recent dose or if an incorrect dose is given.

Patients who are maintained on Buprenorphine will have a diminished response to opioids which may be prescribed for analgesia. Refer to the following documents for more information on:

- *NSW Clinical Guidelines: Treatment of Opioid Dependence (GL2018_018)*
- *Opioid Dependent Persons Admitted to Hospitals in NSW – Management (PD2006_049)*

2.1.4 Brief Intervention

When delivering care, nurses and midwives are to provide information and non-judgmental advice to reduce the risk of harm associated with alcohol and other drug use.

A brief intervention is the process of providing relevant, easy-to-understand information, such as self-help materials or handouts, which may lead a patient to seek further help.

Brief interventions can be done at any time during contact with the patient who is being assessed including, for nurses and midwives, during holistic health assessments and other care processes.

Referral information and relevant contact details for AOD services are also to be provided when appropriate, particularly for treatment-seeking individuals with substance-related problems.

2.1.5 Referral for comprehensive assessment

Following the screening process, any patient identified as using alcohol or drugs at harmful levels is to be referred for a comprehensive assessment.

If the patient is pregnant and, as a result of the screening, has been identified as using alcohol or drugs to any extent, they must also be referred for a comprehensive assessment to a Substance Use in Pregnancy and Parenting Service (SUPPS) or Specialist Alcohol and Other Drug Service.

Comprehensive assessments are to be performed by an alcohol and other drug (AOD) specialist. If there are no AOD specialist services available in your district, consult with:

- Drug and Alcohol Specialist Advice Service (DASAS) – available 24/7
 - Sydney Metropolitan ph. 02 9361 8006
 - Regional & Rural NSW ph. 1800 023 687
- Quitline (for tobacco smoking or nicotine addiction) ph. 13 78 68.

Further referral considerations are to be made based on assessment of the patient, and may include:

- Aboriginal Health Worker and/or Aboriginal Liaison Officer
- Health Language Services or Translation Services for Culturally and Linguistically Diverse patients
- Social worker, mental health or other allied health as appropriate
- Family Referral Service as per local protocols

2.2 Comprehensive assessment

Comprehensive assessment is the first step toward providing an effective package of medical and social care. It builds on initial assessment to further understand the impact of the patient's alcohol and other drug use. It is essential that the outcomes of assessment, including risk monitoring, are integrated into the treatment and care plan.

In addition to initial assessment information, the comprehensive assessment aims to establish:

- The chronology of presenting problems
- The relationship (if any) between them
- Whether the presenting clinical states require independent treatment
- Whether treating one clinical state will help alleviate the other.

Wherever possible, the comprehensive assessment is to be conducted by an alcohol and other drug (AOD) specialist nurse, midwife or addiction medicine specialist. The comprehensive assessment seeks to gain a thorough understanding of the patient's presentation and includes:

- the reason the patient presented to the service;

- all psychoactive substances used in the past 28 days, with attention to consumption in the past 3 days;
- any other AOD treatment the patient is currently participating in;
- if there are any concerns with the patient's social situation, mental health, and physical health and whether they would like any assistance from the treatment service;
- psychological, social, and cultural considerations;
- risks including those relating to the patient's personal characteristics and circumstances, behaviours and the substances used;
- a formulation; and
- an initial treatment plan for management of substance use integrated into the care plan and associated issues.

In gaining this information there is also an opportunity for the specialist to explore with the patient, their strengths and any requirements that they may have to support engagement in treatment.

2.2.1 Comprehensive assessment of women who are pregnant

It is critical that all pregnant women undergo a comprehensive substance use assessment to determine risk of harm to the woman and the fetus. Substance use is associated not only with adverse pregnancy outcomes, but with a cascade of health, legal, social and financial problems that adversely affect the welfare of the mother and child.

Supporting and engaging pregnant women who use substances is a key to providing opportunities to access treatment services and other supports. Stigma is a significant barrier to treatment faced by many pregnant women who use alcohol or other drugs.

In any setting, a pregnant woman who discloses that she uses alcohol or drugs is to be supported by:

- providing confidentiality
- engaging sensitively
- being offered appropriate care, support and referral.

All health staff are to work closely with other care support persons and services involved in the care of the new mother to secure the best possible outcomes for her and the newborn child. Best practice advice regarding the management of alcohol and other drug use during pregnancy, birth and early developmental years of the newborn can be found in the NSW Health Guideline *Guidelines for the Management of Substance Use during Pregnancy Birth and the Postnatal Period* (GL2014_022).

If the pregnant woman is an Aboriginal person then the Aboriginal Health Worker must be included in the care management. Referrals to specific Aboriginal Midwifery and Child and Family Health programs must also be made.

Where the comprehensive assessment is for a pregnant woman, the assessment is to be guided by the NSW Health *SAFE START Strategic Policy* (PD2010_016)

Where available, substance-using pregnant women are to be referred to Substance Use in Pregnancy and Parenting Services (SUPPS) - a specialist AOD treatment service for early and post antenatal care, established in all Districts.

3 INTOXICATION, OVERDOSE AND WITHDRAWAL

3.1 Identifying intoxication

Nurses and midwives must be able to correctly identify and manage intoxication because it complicates assessment and management of other health concerns, even when the intoxication is not life-threatening.

Intoxication can be dangerous because:

- it can mimic or mask serious illness and injury
- it can be life threatening and cause altered physical or mental functions
- psychoactive drugs affect mood, cognition, behaviour and physiological functioning
- aggressive or disruptive behaviour can pose a risk to both the person's safety and that of other visitors, staff and patients (see section 3.3.1.)

3.1.1 Checking for causes other than intoxication

Patients who appear to be intoxicated may be experiencing conditions due to other causes. Nurses and midwives must consider and investigate the possibility of an underlying illness.

Conditions that may mimic intoxication include:

- Infection
- Respiratory disease, hypoxia
- Dehydration
- Delirium
- Heat-related illness
- Head injury (e.g. subdural haematoma)
- Acute psychosis
- Cerebrovascular accident (CVA or stroke) or transient ischaemic attack (TIA)
- Diabetes, hypo or hyperglycaemia
- Epilepsy, postictal confusion
- Drug toxicity (e.g. phenytoin, digoxin)
- Meningitis

- Alcohol and/or benzodiazepine withdrawal
- Wernicke encephalopathy
- Other considerations (and the most common to mimic intoxication) include regularly prescribed medications. Many medications can mimic intoxication in their therapeutic range (e.g. clonidine, opioids, gabapentin, betablockers).

3.2 Managing intoxication

Table 1 (below) outlines the general principles for managing intoxication in a clinical setting. Nurses and midwives are to implement these management approaches when caring for patients who are intoxicated.

If intoxication does not diminish with fall of serum drug levels, the patient must be assessed for other possible causes of their condition. Refer to NSW Health Policy *Recognition and management of patients who are deteriorating* (PD2020_018).

Table 1: General principles for managing intoxication in a clinical setting

PRINCIPLE	MANAGEMENT APPROACH
Immediate physical care	<p>Treat any patient presenting as incoherent, disoriented or drowsy as having a head injury until proven otherwise</p> <p>Take baseline observations: blood pressure, respiratory rate, temperature and pulse</p> <p>Maintain observations half hourly in the acute phase and then 2nd hourly until symptoms stabilise</p> <p>Measure fluid intake and maintain hydration</p> <p>Ensure thorough physical and mental status examination</p> <p>Any patient presenting with seizures are to be assessed for alcohol withdrawal, benzodiazepine withdrawal, or stimulant intoxication, as well as other possible causes.</p> <p>Seizures must be treated, and the patient observed for at least 4 hours post-seizure using the Glasgow Coma Scale (GCS) or the Alert, Verbal, Pain, Unconscious (AVPU) scale.</p> <p>Maintain medication regime as ordered by a medical officer.</p>
Physical care on stabilisation	<p>Maintain observations 4th hourly</p> <p>Further assess for any possibility of withdrawal. Early identification and intervention of withdrawal management can prevent complications that may be life threatening</p> <p>Identify and observe for the effects of more than one substance in the intoxicated person</p> <p>Maintain medication regime as ordered by a medical officer</p>
Environment	<p>Treat in a quiet or low stimulus environment if possible</p> <p>Protect from injury or accidents</p>
Supportive care	<p>Approach the patient in a friendly and respectful manner</p> <p>Be polite, introduce yourself and ask the patient's name</p> <p>Orient the patient to their environment and establish rapport</p> <p>Where possible, postpone questions or procedures that upset the patient</p>

	<p>Provide clear, concrete instructions and if necessary, guide the patient to and from their destination if required</p> <p>If English is not the first language used, engage an interpreter ASAP.</p>
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3.2.1 Managing intoxicated behaviour

Intoxicated behaviour will vary between individuals and the substances behind the intoxication. Table 2 (below) outlines approaches to manage various behaviours arising as a result of intoxication.

Table 2: Management of specific behaviours of intoxicated patients

BEHAVIOUR	MANAGEMENT APPROACH
Anxiety Agitation Panic	<p>Approach the patient in a calm and confident manner</p> <p>Move and speak in an unhurried way</p> <p>Minimise the number of staff attending to the patient</p> <p>Provide a quiet environment to reduce stimulation</p> <p>Reassure the patient frequently</p> <p>Explain interventions</p> <p>Protect the patient from accidental harm (e.g. don't leave them unattended on a trolley)</p>
Confusion Disorientation	<p>Use clear simple communication</p> <p>Provide frequent reality orientation</p> <p>Display some object familiar to the patient, such as his or her own dressing gown or slippers</p> <p>Ensure frequent supervision</p> <p>Accompany the patient to and from places (e.g. bathroom, TV lounge)</p>
Altered perception Hallucinations	<p>Explain perceptual errors and re-orientate the patient</p> <p>Create a simple, uncluttered environment</p> <p>Nurse in well-lit surroundings to avoid perceptual confusion</p> <p>Protect the patient from harm</p>
Anger Aggression	<p>Use space for self-protection (e.g. don't crowd the patient, keep furniture between yourself and the patient if feeling unsafe)</p> <p>Speak in a calm, reassuring way</p> <p>Use the patient's name when speaking to them</p> <p>Do not challenge or threaten the patient by tone of voice, eyes, or body language</p> <p>Let the patient air their feelings, and acknowledge them</p> <p>Determine the source of the patient's anger and if possible, remove it</p> <p>Be flexible within reason</p>

Be aware of workplace policies on managing aggression

3.3 Identifying overdose

Overdose can occur by accident or as a result of deliberate self-harm. A person who has used two or more depressant drugs (e.g. opioids, benzodiazepines and /or alcohol) is at high risk of accidental overdose.

All patients who present with decreased level of consciousness (LOC) must have careful and appropriate monitoring of vital signs and neurological function. The GCS plus vital signs provide the best method of assessment.

These observations must be done on arrival, after checking airway, breathing and circulation and be continued every hour for at least four hours.

Table 3: Assessments for signs of overdose

DRUG TYPE	SIGNS	ASSESS FOR	IMMEDIATE CARE REQUIREMENTS
SEDATIVES / HYPNOTICS	Physical signs	Abnormal pulse (irregular, <60 or >120 beats per minute) Increase or decrease in blood pressure (BP) below 90/60 Breathing difficulties Diminished response to stimuli Seizures	Monitor pulse and BP every 15 mins Monitor respiration/breathing Oxygen Saturation Monitor level of consciousness (LOC) Create a quiet, low-stimuli area if possible
	Mental state	Increasing agitation or sedation Changing mental state (hallucinations, panic or deep depression) Decreasing level of consciousness Increasing disorientation	Observe for behavioural changes Check orientation to time, place and person Monitor LOC Sit with patient, reassure
AMPHETAMINE-TYPE STIMULANTS	Physical signs	Mildly aroused, pacing, still able to talk reasonably. Becoming more vocal Responds to requests Abnormal pulse	Monitor pulse and BP every 15 mins Monitor respiration/breathing Monitor LOC Create a quiet, low-stimuli area if possible
	Mental state	Mildly aroused Moderately aroused, agitated, and becoming more vocal, unreasonable and hostile	Observe for behavioural changes Check orientation to time, place and person Monitor LOC Sit with patient, reassure Nurse in a quiet, low stimulus room

Any patient who presents as incoherent, disoriented or drowsy is to be assessed and treated as having a cerebral event (head injury) until proven otherwise.

3.4 Management of overdose

All NSW Health organisations are to have local guidelines or protocols in place for the management of overdose, consistent with Table 4 below.

Table 4: Management of overdose

ACTIONS	MANAGEMENT
A person who has had a potentially lethal overdose must be assessed immediately.	
Physical care	<p>Do not give food or fluids</p> <p>Place on side (i.e. in the recovery position)</p> <p>Measure and observe the following signs and manage symptoms:</p> <ul style="list-style-type: none"> • BP – monitor for hypo or hypertension • Pulse – monitor for brady or tachycardia, arrhythmia • Temperature – monitor for hypo or hyperthermia • Oxygen Saturation • Fluid balance – commence a fluid balance chart and monitor for oliguria or anuria • Observe for seizures • Observe for vomiting and have suction and resuscitation equipment available
Identify substance(s) and dose	<p>Seek history of ingestion or use of foreign substance</p> <p>Review medical history (e.g. diabetes, epilepsy)</p> <p>Check for recent history of AOD use</p> <p>Check the type and/or combination of substances taken</p> <p>Collect a urine sample as soon as possible to identify the substance used</p> <p>Collect a blood sample:</p> <ul style="list-style-type: none"> • To identify presence of substance(s) • For blood alcohol level or for serum drug levels <p>For assistance with identification, check with:</p> <ul style="list-style-type: none"> • MIMS • NSW Poisons Information Centre – 13 11 26 • Medical staff/ Pharmacist • Manufacturer (if known)

3.5 Withdrawal management

The rationale of withdrawal management is to provide the appropriate level of support for withdrawal to be completed safely. This allows the individual to determine his or her optimal ongoing management strategy. Withdrawal management is not a stand-alone treatment - it is a precursor to treatment.

The objective of effective withdrawal management is immediate and long-term patient safety, not necessarily long-term abstinence. Individual treatment goals following withdrawal will depend on patient circumstances and choice.

Other aims of withdrawal management include minimising withdrawal discomfort, assisting patients to complete withdrawal, identifying and treating any co-existing health conditions, and using the opportunity to link patients into treatment after withdrawal.

Complicated withdrawal may be life threatening due to dehydration, electrolyte imbalance, seizures, alcohol withdrawal delirium or the negative impact of other concurrent disorders including acute infection, cardiac disease or diabetes. Complicated withdrawal may also lead to accidental injury.

Drugs that can result in a medically dangerous withdrawal syndrome are alcohol, benzodiazepines and GHB. Opioids result in a very unpleasant withdrawal syndrome with a range of medical issues. Other drugs which can also result in a withdrawal syndrome include methamphetamines, cocaine, cannabis and nicotine.

The severity of withdrawal depends on the type of drug used, the dose and duration of use. The timing and severity of withdrawal symptoms can differ depending on:

- the person
- the substance(s) used
- duration of use
- past experience of withdrawal
- other psychological or physical conditions (e.g. nutrition, hydration)
- acute or chronic illness.

Early identification and effective management of withdrawal in the early stages can reduce or prevent progression to a complicated withdrawal state.

The *Drug and Alcohol Withdrawal Clinical Practice Guidelines – NSW* (GL2008_011) provide further information on pharmacological and clinical management of specific withdrawal syndromes. This can be found on the NSW Health Policy Distribution System web page.

3.5.1 Identifying Alcohol and Other Drug Withdrawal

Table 5: Signs and symptoms of withdrawal

DRUG	ONSET	DURATION	SIGNS AND SYMPTOMS
Alcohol withdrawal delirium must be treated as a medical emergency			
ALCOHOL	<p>6 - 24 hours after last drink</p> <p><i>Onset may be delayed if benzodiazepines or other sedatives have been recently consumed.</i></p> <p><i>May also occur when blood alcohol is decreasing but not zero.</i></p>	<p>Mild: Usually 2 - 3 days.</p> <p>Severe: May continue up to 10 days</p>	<p>Autonomic overactivity</p> <ul style="list-style-type: none"> Sweating, tachycardia, tremor, fever Hypertension, insomnia <p>Gastrointestinal</p> <ul style="list-style-type: none"> Anorexia, nausea, vomiting, dyspepsia <p>Cognitive / perceptual changes</p> <ul style="list-style-type: none"> Anxiety, vivid dreams, hallucinations, illusions Seizures occur in about 5% of people withdrawing from alcohol. Seizures: <ul style="list-style-type: none"> occur early - usually with 24 hours of the last drink are grand mal in type, i.e. not focal, and usually, although not always, occur as a single episode.
BENZODIAZEPINES	<p>Between 2 - 5 days after last dose</p> <p><i>The onset of withdrawal will depend on the half-life of the benzodiazepine consumed</i></p>	<p>May last up to 28 days</p>	<p>Common</p> <ul style="list-style-type: none"> Anxiety, agitation, insomnia, restlessness Poor concentration, poor memory Depression Muscle tension, aches and pains, twitching <p>Less common</p> <ul style="list-style-type: none"> Nightmares, agoraphobia Feelings of unreality, depersonalisation Panic attacks, nausea, dry retching, decreased appetite, weight loss, sweating, lethargy Increased sensory perception, aches, pains, headaches, palpitations, tremor, blurred vision Increased temperature, ataxia Gastrointestinal unrest and menstrual changes <p>Uncommon (but medically dangerous)</p> <ul style="list-style-type: none"> Confusion, delusions, paranoia, hallucinations Seizures, persistent tinnitus

DRUG	ONSET	DURATION	SIGNS AND SYMPTOMS
OPIOIDS	Short acting opioid (e.g. heroin) 6 - 24 hours after last dose	7 - 10 days	Signs <ul style="list-style-type: none"> Restlessness, yawning, sweating Rhinorrhoea, dilated pupils, piloerection Muscle twitching, restless legs whilst lying down Vomiting, diarrhoea Symptoms <ul style="list-style-type: none"> Anorexia, nausea, abdominal pain Hot and cold flushes Bone, joint and muscle pain, cramps Insomnia and disturbed sleep Intense craving for opioids
	Long acting opioid (e.g. methadone) 36 - 48 hours after last dose	3 - 4 weeks	
	Buprenorphine 3 - 5 days after last dose	Withdrawal may last several weeks	

3.5.2 Alcohol Withdrawal Delirium (previously known as delirium tremens)

Alcohol withdrawal delirium (AWD) must be treated as a medical emergency. AWD is the most serious form of alcohol withdrawal. Patients who are at risk of developing AWD are those who have:

- Been drinking heavily for a long period of time
- A history of alcohol withdrawal or previous episodes of AWD
- Other health problems in addition to alcohol use
- A history of seizure disorder or other brain injury.

The peak period of onset is between two and four days after ceasing alcohol intake. It may or may not be preceded and/or followed by withdrawal seizures and is life threatening. It usually lasts for 72 hours or less.

Treatment is to be directed toward control of any highly aroused states, which may include delusional thoughts and perceptual disturbances and prevention of brain injury, shock, congestive cardiac failure or acute kidney injury. Treatment must be directed to keeping people safe if, and when, those symptoms occur.

3.5.3 Symptoms of Alcohol Withdrawal Delirium

Symptoms of AWD include:

- Dehydration, rapid pulse, hypertension, tachycardia, elevated body temperature, sweating, tremor
- Feelings of severe agitation, panic or even a sense of impending doom
- Clouding of consciousness, delirium, hallucinations (usually only visual or tactile but can be aural. They are often threatening to the patient)

- Changes in heart rate or breathing that are potentially fatal.

Symptoms of AWD are serious, require immediate medical attention, and usually resolve in a few days.

3.5.4 Management of Alcohol Withdrawal Delirium

In patients using more than one substance, the onset and duration of AWD may vary markedly. In addition to general care:

- Ensure easy access to emergency medical equipment
- Pulse, blood pressure and temperature be checked:
 - every 15 minutes for 1 hour, then
 - ½ hourly for 2 hours, then
 - hourly for another 2 hours, then
 - every four hours after that
- Medicate as per medical officer orders and review regularly
- Escalate any deterioration to a medical officer for review as per local protocols.

3.5.5 Monitoring AOD withdrawal

There are range of AOD withdrawal scales that can be used to monitor progression of withdrawal. Some of these include, but may not be limited to:

- Alcohol Withdrawal Scale (AWS)
- Clinical institute Withdrawal Assessment for Alcohol – revised (CIWA-AR)
- Clinical institute Withdrawal Assessment for Benzodiazepines (CIWA-B)
- The Subjective Opiate Withdrawal Scale (SOWS)
- Objective Opioid Withdrawal Scale (OOWS)
- Clinical Opiate Withdrawal Scale (COWS)
- Modified Finnegan's Scale (* used for monitoring Neonatal Withdrawal)

Withdrawal scales are a guide only and do not diagnose withdrawal. As they may not be valid in a range of different settings, it is recommended that the withdrawal scales used are in line with local protocols and policies.

* The Modified Finnegan's Scale is an Opiate Withdrawal Scale for neonates and is not be used to ascertain the impact of withdrawal from all drugs.

3.5.6 Nursing management of withdrawal

Table 6:

PRINCIPLE	MANAGEMENT APPROACH
Immediate physical care	<p>Obtain a clear history of recent substance use</p> <p>Select the appropriate withdrawal scale as per protocol indicated by the person's recent AOD use history</p> <p>Maintain observations:</p> <ul style="list-style-type: none"> • ½ hourly in the acute phase, then • 2nd hourly until symptoms stabilise <p>Maintain hydration – monitor fluid intake (suggest 2-2.5 litres/daily) and nutritional intake.</p> <p>Maintain regular observations until symptoms stabilise</p> <p>Engage AOD specialist clinician in ensuring appropriate medication is being prescribed and dispense accordingly</p> <p>Monitor for deterioration and escalate as per local protocols and NSW Health Policy: <i>Recognition and Management of Patients who are Deteriorating PD2020_018</i></p> <p>ON STABILISATION</p> <p>Maintain observations 4th hourly</p> <p>Further assess for any possibility of withdrawal – early identification and intervention of withdrawal management can prevent complications that may be life threatening</p> <p>Identify and observe for the effects of more than one substance in the intoxicated person</p> <p>Maintain medication regime as ordered by a medical officer</p>
Environment	<p>Treat in a quiet environment, if possible</p> <p>Protect from injury or accidents</p>
Supportive care	<p>Managing anxiety is the key to effectively managing all withdrawal states</p> <p>Frequently reassuring the patient in a non-judgmental manner may decrease the severity of the withdrawal syndrome</p> <p>Orient the patient to their environment and establish rapport</p> <p>If English is not the first language used, engage an interpreter ASAP and be attentive to cultural issues, providing a culturally safe space and responding to individual needs as appropriate.</p>

4 IDENTIFYING AND MANAGING OTHER RISKS

4.1 Risk associated with discharge from a health service or other facility

The period following discharge from a health service is a high-risk time for many patients, including those with substance use issues.

It is important to identify whether a patient has recently been discharged from:

- a hospital or other health setting
- a rehabilitation or detoxification service
- correctional centre (gaol) or other custody setting
- other temporary health or social services setting.

This is particularly important for people with alcohol or other drug issues as a recent admission may have resulted in an interruption or cessation to their substance use. For some patients, discharge from services can be stressful and they may resume their substance use. However, their tolerance to alcohol or drugs may have changed since their last use, putting them at high-risk of intoxication and/or overdose.

It is appropriate to ask the patient whether they have recently been in contact with any other health services to determine whether they have recently been discharged from another setting. If so, contact the discharging service and ask for a copy of their recent discharge letter or plan (with the patient's permission) to assist with assessment and care planning.

4.2 Risk of harm to self or others, or deteriorating mental health

Psychoactive drugs affect cognition, emotions and behaviour. Depending on the substance, they can induce confusion, disorientation, perceptual disturbance, euphoria, agitation, panic, emotional lapses, repetitious behaviour or aggression.

4.2.1 Self-harm

All health staff need to complete a preliminary screening for suicide risk as part of any assessment, as per:

- the NSW Health Policy *Clinical Care of People Who May be Suicidal* (PD2016_007)
- the NSW Health *Mental Health Triage Policy* (PD2012_053)
- local protocols and procedures.

Following assessment of mental state and risk of suicide, referral to specialist mental health clinicians or services may be required.

4.2.2 Aggression or violent behaviour

Under the NSW Health Policy *Principles for Safe Management of Disturbed and/or Aggressive Behaviour and the Use of Restraint* (PD2015_004), all NSW Health organisations are required to have local processes and guidelines on the identification

and management of aggressive or violent behaviour, including how to access help immediately when required.

4.3 Blood-borne viruses or infection

All parts of the health system must support blood-borne virus testing and appropriate follow-up treatment of patients. Screening is to be routinely offered and performed with consent, at the initial assessment interview, during an inpatient / outpatient admission process or first appropriate opportunity.

Testing for hepatitis B, C and HIV is to be offered to people who are most at risk. This group includes people, and partners of people, with the following characteristics:

- have injected drugs
- men who have sex with men
- Aboriginal and/or Torres Strait Islander
- from (or travel to) high-prevalence countries
- had unsterile tattoos, piercings or medical procedures
- identifies as previously or currently engaging as a sex worker
- previously been in custody
- have multiple sex partners, or have recently changed their partner
- pregnant
- have received blood products from overseas, or before 1990 in Australia
- If requested, regardless of the presents/absents of other risk factors

Screening for sexually transmitted infections may also be offered as part of this process, if the patient is sexually active. A referral, with the patient's permission, to a Sexual Health clinic for follow up care may be made, if available.

4.3.1 Hepatitis C

All positive hepatitis C antibody tests are to be confirmed by an HCV RNA test. Repeat hepatitis C screening is to be offered over multiple admissions while there is ongoing risk behaviour.

Oral direct acting antiviral treatments are well tolerated and will cure over 95% of people after a short course of treatment. Treatments are suitable for most people and the majority can be managed in the community. Curing hepatitis C will reduce progression of liver disease, increase overall survival and prevent transmission to others. Guidance on prescribing treatments is available from the Gastroenterological Society of Australia.

4.3.2 Hepatitis B

People with chronic hepatitis B must be referred for specialist follow-up with a gastroenterologist and have their liver function monitored regularly (every 6 months). Treatment is sometimes required. Treatment can manage the effects but is not a cure. People who are not immune to hepatitis B are to be offered vaccination.

4.3.3 HIV

Treatment as Prevention is a HIV prevention strategy where a person living with HIV takes HIV treatment as prescribed to maintain an undetectable viral load, which prevents the HIV being infectious, so the virus cannot be transmitted.

People with a positive HIV test and their clinicians can be supported by the HIV Support Program. The Program offers appropriate linkage to care and treatment, counselling and psychosocial support, and assistance with contacting partners and others at risk. Refer to the following website for further information:

<https://www.health.nsw.gov.au/endinghiv/Pages/support-program.aspx>

5 IDENTIFYING AND MANAGING FAMILY AND SOCIAL NEEDS

5.1 Child wellbeing and child protection

Nurses and midwives need to maintain awareness that patients presenting with risk factors, associated with alcohol and other drug use, also may predispose any child to increased risks to their wellbeing. Where this is identified, appropriate and sensitive questioning must be undertaken in line with the Child Wellbeing and Child Protection Policies and Procedures for NSW Health (PD2013_007).

Maintaining child wellbeing, and being aware of child protection issues, must be part of the assessment process for all nurses and midwives when working with adult patients who are parents or carers of children, or women who may be pregnant. This includes asking all patients if they have a parenting or carer role in relation to a child or young person.

When assessing whether a child or young person may be at risk, nurses and midwives are to consider contextual factors such as:

- The age of the child or young person, (the younger the child and more reliant on the parent, the greater the immediate physical risk)
- Emotional and developmental milestones being met
- Their level of vulnerability
- Impact may include, but not be limited to inconsistent moods, inconsistent behaviour and cognition.

In assessing risk, it is important to:

- Identify household make up
- Understand the number and ages of the children
- Identify other adults in the home
- Talk with the adult patient so that they understand why you may need to talk with others and initiate referrals to other services that can provide support to the patient/client and family
- Monitor risk and escalate concerns to senior managers/clinicians

- Consider opportunities to coordinate delivery of health services to parents/carers with complex needs
- Consider opportunities to share information and collaborate with other health professionals or support services to ensure the safety and wellbeing of a child or young person

The NSW Mandatory Reporter Guide (MRG) supports health workers in their decision-making about reporting the safety, wellbeing and welfare of a child or young person.

Refer to The ChildStory Reporter Community website

<https://reporter.childstory.nsw.gov.au/s/>

Nurses and midwives can also contact the Child Wellbeing Unit (CWU) on 1300 480 420 (8:30am to 5:00pm Monday to Friday) to discuss concerns about *Significant Risk of Harm*. The CWU can assist health workers in planning and determining next steps. The CWU will also provide an accumulative risk report for Health staff.

Nurses and midwives must contact the Family and Community Service Helpline on 132 111 to report an *Imminent Risk of Harm*.

Table 7: How substance use may impact parenting

IMPACT ON THE BRAIN	IMPACT ON THE PERSON	POSSIBLE IMPACT ON PARENTING
Impairing the senses	The parent may experience blurred vision, impaired hearing	Risk of not responding to the needs of the child
Perceptual disturbance	Misunderstanding what is said, impaired reaction time, poor balance, paranoia	Can overreact differently on each day, may not respond, may be suspicious of others in the home or external, may fall and injure child
Motor skills	Impaired coordination, shaking	Not being able to assist child
Judgement	Impaired reason, less caution, self-restraint, change to inhibitions	Can be more impatient, may not identify dangers to child, may display unpredictable behaviours, may not be so aware of child's needs
Accelerate activity or slow down	Fast talking, thinking, can lead to increased frustration or extreme lethargy, tiredness	'Passing out' and not available to supervise the children
Changes in mood	Can cause inconsistent parenting as a result of fluctuating mood swings	Children one day may find the parenting is strict, controlling, or parents are angry and irritated or another day they are permissive or have inattentive parenting styles
Intoxication/withdrawal	Poor supervision	Regular healthy meals not always provided, clothes not washed, less attendance at school, lack of emotional attention

5.1.1 Consumption of methadone or buprenorphine by a child

Methadone and buprenorphine takeaway doses may be inadvertently ingested by a child or deliberately administered to them by a patient or other person. Ingestion of methadone or buprenorphine may be dangerous for children and could be potentially life threatening.

In rare occasions, methadone may be administered in paediatric oncology however this is closely monitored and usually initiated or recommended by treating specialists.

If a child has ingested an unprescribed dose of methadone or buprenorphine by any means, the child is at risk of harm and a report must be made to the Department of Communities and Justice Child Protection Helpline on 132 111.

If an ingestion of an unprescribed dose of methadone or buprenorphine is associated with, or potentially associated with, a child's presentation or admission to hospital, a mandatory notification via a Reportable Incident Brief to the Ministry of Health is required, regardless of the Severity Assessment Code score. This aligns with the direction outlined in the Incident Management Policy (PD2020_020).

Staff must also complete the following actions:

- If the parent or carer is receiving takeaways, contact must be made with the prescriber or pharmacotherapy clinic immediately, to ascertain dosage.
- Notify the prescriber, the Pharmaceutical Regulatory Unit (PRU) and the Centre for Alcohol and Other Drugs of the incident.
- The treating medical officer is to discuss concerns for the child and next steps with the Health CWU and/or the hospital social worker (if available) prior to discharge.

When presented with a suspected opioid ingestion by a child outside the hospital setting:

- Call Emergency '000'
- Assess the level of consciousness and monitor this continuously until the child is in the care of an ambulance or qualified staff
- Refer the child to a hospital emergency department without delay, providing the information available about the amount taken and the time
- Administer oxygen if available
- Consider naloxone administration if the child is showing signs of respiratory depression (document any treatment given).

5.2 Pregnancy and risks to unborn children

Stigma is a significant barrier to treatment faced by many pregnant women who use alcohol or other drugs. It is the responsibility of all health staff to work closely with other services involved in the care of the new mother to secure the best possible outcomes for the mother and her unborn child. Supporting and engaging pregnant women who use substances is a key to providing opportunities to access treatment services and other supports.

Safe Start multidisciplinary case discussion meetings provide the opportunity for consultation and collaboration re the woman's care.

In any setting, a pregnant woman who discloses that she uses alcohol or drugs is to be supported by:

- Providing confidentiality
- Engaging sensitively
- Offering appropriate care, support and referral.

If there are concerns about engaging the mother in treatment, support programs, or what needs to occur to protect newborns in response to identified risks, nurses and midwives are to consult the **NSW Health Child Wellbeing Unit on 1300 480 420 (8:30am to 5:00pm Monday to Friday)** to discuss and determine initial action.

When nurses and midwives consider that an unborn child may be at 'risk of significant harm' due to substance use, they are to report their concerns to the Child Wellbeing Unit or use the [NSW Mandatory Reporter Guide \(MRG\)](https://reporter.childstory.nsw.gov.au/s/) to support decision-making about reporting to the Department of Communities and Justice. Refer to the <https://reporter.childstory.nsw.gov.au/s/>

5.3 Violence (including domestic and family violence)

Responding to domestic and family violence is the responsibility of all staff members of NSW Health. Risk assessment is considered routine clinical practice where domestic violence is identified and is part of an ongoing continuum of care. It is to be revisited and evaluated at subsequent appointments or contacts with a client who has disclosed domestic violence. Risk can change quickly and unpredictably, and therefore must be continuously assessed, monitored and reviewed, as part of a patient's regular contact with their health service.

The NSW Health Policy *Domestic Violence – Identifying and Responding* (PD2006_084) provides a framework for informing domestic violence responses for staff in hospitals and community health services. A core component of the policy is routine screening for domestic violence. This is to be implemented for women attending antenatal and early childhood health services, and women aged 16 years and over attending mental health and AOD services.

5.3.1 Risk assessment for violence

Health workers who have received appropriate training in the dynamics of domestic violence are to conduct risk assessments using a structured tool where it is safe and appropriate to do so. Available tools for use include:

- The Domestic Violence Risk Assessment Screening tool (DVRS)
- The Domestic Violence Safety Assessment Tool (DVSAT).

Health workers who have not received training are to make a referral to a social worker or appropriately trained staff member within the health facility or organisation. It is important to follow-up to ensure the client was able to connect with the referral.

All domestic violence identification, risk assessment and resulting safety planning must consider the safety of any relevant children as a primary concern. Where a nurse or

midwife has reasonable grounds to suspect a child is at risk of harm, they are to follow the procedures outlined under section 5.1 of this Policy.

5.4 Homelessness or risk of eviction

Substance use is likely to be a marker for the presence of other risk factors, including poverty, homelessness and poor social supports.

If the patient is identified as being homeless or at risk of losing their accommodation, the patient is to be offered a referral to a social worker or other relevant social assistance services to potentially assist the patient with their housing.

6 CARE PLANNING

The key principles of care planning include:

- Speaking to the patient, their family or carers and friends (if you have the patient's permission) and ask them what they think should be included in their care plan
- Integrating patient goals and treatment plans into the overall holistic healthcare plan
- Ensuring the care plan is:
 - simple and easy to understand
 - clearly related to the goals of the patient and clinical issues that are to be addressed
 - clear on who is going to do what by when
 - reviewed and able to be measured

Often, practitioner roles and where services are delivered determine the level, nature and detail of care planning that is undertaken. In acute care settings, care plans are more likely to focus on stabilising the patient and managing acute physical needs. They may also focus on referral for further assessment and interventions. Services with a more specialist role may also include psychosocial, accommodation, spiritual and legal needs.

Irrespective of the above, care plans are to be written in plain English and the patient (and their family or carer, where appropriate) must be invited to participate in the development, review and update of their plan, wherever possible.

In units, facilities or organisations where there is an established care planning process, there should be added section(s) or domains that outline strategies and goals to effectively manage and treat any clinical concerns, and to support the patient to reduce any alcohol and other drug-related harms.

Where the facility has access to a Hospital AOD Consultation and Liaison Team or an Addiction Medicine Specialist, the care plan is to include the following elements, where appropriate:

- Goal of consultancy and referral
- Discussion of referral with patient

- Name of person making the referral
- Monitoring of outcomes
- Integration of any new goals identified while patient is in your care
- Implications for follow-up on discharge.

An example care plan is included in the appendices of this document.

6.1 Care coordination

The key elements of care coordination include:

- ensuring care is patient-centred, which involves understanding the patient's perspective and keeping them informed every step of the way.
- identifying physical, alcohol and other drug health-related risks and ensuring treating teams are communicating with the patient, their family and each other on all matters related to their care.
- identifying family and social needs and integrating supports into their treatment plan.
- planning clinical treatment with all care providers, including alcohol and other drug specialist staff and referral agencies.
- communicating any delays to the patient, their family and other staff.

6.2 Transfer of care

Transfer of care involves transferring professional responsibility and accountability for the care of a patient to another professional, or a combination of professionals. The process of transferring within, or between, health services is a vulnerable and high-risk time for patients experiencing harm from AOD use.

People experiencing harms from alcohol or other drug use often have multiple health and social needs. It is therefore essential that the transfer of care for a patient's AOD healthcare needs are integrated into the overall transfer of care planning process.

Patients may be:

- admitted to hospital from an Emergency Department (or other) to a ward setting
- transferred across health services (e.g. ward to ward, general ward to specialist service, inpatient to outpatient, acute to subacute)
- discharged from health service setting with ongoing health care provision from the community (e.g. patient will follow-up with their GP, home-visiting program or referred to non-government AOD specialist service)
- self-discharged or going home with no further health care provision.

6.2.1 Planning transfer of care

It is vital that nurses and midwives incorporate strategies to identify and reduce risks in the patient's care plan from the outset. The information collected needs to be used to involve AOD services and to plan for the patient's transfer of care.

Nurses and midwives must adhere to the:

1. Discharge Planning and Transfer of Care for Consumers of NSW Health Mental Health Services (PD2019_045)
2. Care Coordination: Planning from Admission to Transfer of Care in NSW Public Hospitals (PD2011_015)

Throughout the process of care, it is important to:

- discuss transfer of care goals with the patient
- communicate with the patient and all team members on the plan for treatment and transfer of care
- manage the patient's transfer of care plan
- communicate progress with the patient and/or their family or carer
- coordinate referrals and the transfer of the patient to alternative treatment programs and back to the community.

6.2.2 Referral and liaison for patient transfer

To ensure that care is coordinated, and appropriate referral and follow-up is made, the process is to be delegated to someone who has responsibility for making arrangements and ensuring all referrals have been received and will be actioned by the receiving service.

Some of the services or disciplines that nurses and midwives may engage with during the acute phase may include, but not be limited to:

- AOD Consultation and Liaison team within your facility, if one is available
- AOD Clinical Nurse Consultant or Nurse Practitioner
- Social work teams
- Substance Use in Pregnancy and Parenting Services (SUPPS)
- Mental Health services
- Aboriginal Health teams, if the patient identifies as an Indigenous person
- Interpreter services, if the patient or family or carer's first language is not English
- Domestic and family violence services.

For nurses and midwives working in settings that do not have access to specialist teams or in rural and remote areas in NSW, ongoing consultation with an addiction medicine specialist is available 24 hours a day via the Drug and Alcohol Specialist Advice Service (DASAS).

- Sydney Metropolitan ph. 02 9361 8006
- Regional & Rural NSW ph. 1800 023 687

Additional resources and referral information are also available via the Alcohol and Drug Information Service (ADIS) 24-hour support line 1800 250 015.

6.2.3 Planning transfer of care with the patient

During the admission, and where possible before treatment is ceased, the nurse or midwife is to discuss with the patient (and any support people identified), their plans and the ongoing supports that they will need during and after the transfer is complete.

The focus on progress allows the client to experience feelings of control and success, which may counter common feelings of hopelessness and worthlessness. The plan is also to include a description of any ongoing support from specialist teams, medical interventions or other avenues for community support.

6.2.4 Transfer of care between treating clinicians and service providers

When there is transfer of care between clinicians or healthcare providers, a clinical handover must be provided. Clinical handover is the effective transfer of professional responsibility and accountability for some or all aspects of care for a patient, or group of patients, to another person or professional group on a temporary or permanent basis.

It is recommended that **ISBAR** is used as a communication tool for clinical handover and that clinical handover is documented.

- Introduction
- **S**ituation
- **B**ackground
- **A**ssessment
- **R**ecommendation

Additional information and the ISBAR resource for clinical handover requirements can be found on the Clinical Excellence Commission website www.cec.health.nsw.gov.au

All nurses and midwives are responsible for ensuring that clinical handover is effective and documented. Good clinical handover facilitates safe patient care, good patient experiences and excellent patient outcomes.

6.3 Discharge planning

6.3.1 Liaison and referral to services on discharge

Nurses and midwives must consider additional needs when transferring responsibility and accountability for care. It is important work with the patient and their care givers to identify their needs on discharge, assess their level of risk, interventions required and liaise with appropriate disciplines and services to coordinate care. It is also critical to note any risks that may be ongoing in the care plan, this will ensure that when a discharge plan is formulated that risks are considered throughout the process of transferring care.

Collaborative relationships across care boundaries:

- lead to improved health outcomes
- enhance patient experience
- empower patients and carers to address issues of concern
- strengthen relationships between clinicians and across treatment settings.

Additional services may also include:

- AOD Treatment Services – Assessment, Counselling, Inpatient Withdrawal Management Units, Opioid Treatment Services.
- follow-up services for health conditions (e.g. hepatitis C and mental health)
- home-visiting programs for postnatal care
- Aboriginal medical services or Aboriginal counselling/rehab services
- non-government AOD services
- counselling, psychology or services offering day programs
- homelessness services
- family and community services
- dental services
- other government or non-government community-based services.

6.3.2 Discharge summaries

At the time of discharge from a service, discharge summaries are to be sent to the appropriate stakeholders (e.g. patient, referrer, primary care providers, health or other relevant care providers), as identified in the care plan. Transfer of care must be timely, and discharge summaries completed as soon as practicable.

6.3.3 Unplanned cessation of treatment

There are many reasons why patients may cease treatment prior to completion of their care plan. When this occurs, the patient may be discharging while in withdrawal or be impacted by altered levels of tolerance if they have not used substances for a period. Under these circumstances, the focus is to ensure the patient is safe and knows how to maintain engagement with the health service.

When discharges are unplanned, the patient is to be offered appropriate information and advice to maintain their wellbeing, which may include information on:

- opportunities to re-engage with AOD services, as required (provide relevant contact numbers)
- strategies to manage and reduce health risks or harms with any continued substance use
- access to community and/or specialist support and resources (e.g. local needle and syringe programs locations, hepatitis B and C services)

- for opioid users, provide take-home naloxone.

Where there is concern for the patient's safety, escalate according to local protocols. An active referral to local AOD service for community follow up can also be made.

Patients who use opioid medicines and are at risk of overdose are to be given instruction and offered Naloxone on discharge from services, in line with the NSW Health *Opioid Overdose Response & Take-Home Naloxone (ORTHN)* (PD2019_036) Policy.

The procedures related to the ORTHN Policy must be implemented by trained and credentialed staff of NSW Health.

7 APPENDIX LIST

1. Implementation Checklist
2. Example Care Plan written with SMART goals
3. Example Care Plan

7.1 Implementation Checklist

Organisation / Facility:			
Assessed by:		Date of Assessment:	
Key actions	Not commenced	Partial compliance	Full compliance
The Policy has been distributed through local policy distribution systems and made available via link in local intranet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Notes:			
Information related to the release of the policy and local implementation strategies are communicated and actioned.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Notes:			
All relevant pathways of care have been reviewed to incorporate the requirements of this Policy to ensure safe and effective health care for patients with drug and alcohol related harms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Notes:			
AOD education has been integrated into existing orientation programs and education streams	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Notes:			
An individual has been nominated at a district or network level for ensuring the policy has been implemented across the organisation.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Notes:			
Local protocols have been established and integrated into Quality Management Systems to support and monitor implementation.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Notes:			

7.2 Example Care Plan written with SMART goals

GOAL: Effective management of withdrawal in hospital admitted patient		
	PRINCIPLE	OUTCOME
SPECIFIC	Goal is written in clear language that the patient can understand. It is aligned to a need which has been discussed and identified in collaboration with the patient	Reduce the impact of withdrawal and related harms associated with use throughout admission.
MEASURABLE	Goal is defined in a way that we can measure, i.e. it says who is going to do what, by when	Monitor withdrawal symptoms, using appropriate withdrawal assessment tools (e.g. AWS) Establish regime for management of withdrawal symptoms – regularly review every 2–4 hours
AGREED	Goal is known and agreed with the patient and all care providers	The patient and the multidisciplinary team have been involved in identifying needs and understand the purpose of monitoring and intervention. All treating teams are aware of the plan and apply consistent practice to minimise impact of symptoms in relation to medication, environment and physical care.
REALISTIC	The goal is achievable within the resources, knowledge and time available. <i>Ensure that you are setting goals:</i> <ul style="list-style-type: none"> • for which the resources are available and • that are achievable within the setting you are in. 	Referral to specialist resources are included in the plan, if required. <i>e.g. referral to specialist consultant either via direct referral to AOD Consultation and Liaison team or advice via phone from DASAS.</i> Escalate, if necessary, as per local protocols.
TIME-FRAMED	Defined with enough time to achieve the goal	Review times articulated and adhered to. Plan reviewed at regular intervals, or at patient request.

7.3 Example Care Plan

Below is a hypothetical example of a SMART care plan for a hospitalised patient, “Mark”, who has reported drinking alcohol at a hazardous level on a daily basis.

NEED / GOAL	STRATEGIES & INTERVENTIONS	WHO IS RESPONSIBLE	TARGET DATE	DATE OF REVIEW
<p>Mark reports drinking alcohol at a level which indicates a high risk of withdrawal.</p> <p>The goal is to ensure patient safety and comfort by monitoring and treating any symptoms of withdrawal.</p>	Discuss possibility of withdrawal with Mark and monitor for symptoms alcohol withdrawal by using the AWS on a 2-hourly basis while awake	Nursing staff	Daily	DD/MM/YY (in 48 hrs)
	Encourage Mark to alert for any discomfort, monitor vital signs on a 2-hourly basis and document. Reduce to 4 th hourly when stable	Nursing staff	Daily	DD/MM/YY (in 3 days)
	Administer benzodiazepines in consultation with Mark and medical team	Medical/ nursing staff	Daily	DD/MM/YY (in 5 days)
	Administer thiamine 300mg oral as prescribed	Medical/ nursing staff	Daily	DD/MM/YY (in 5 days)
	Discuss follow-up with Mark and refer with permission to AOD Consultation Liaison team or Clinical Nurse Consultants (CNC)	Nursing staff	Daily	DD/MM/YY (in 5 days)