# Opioid Use Disorder: Tools for the Emergency Department

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Module Four

APPROVAL STATEMENT: The New Mexico Hospital Association Approved Provider Unit is approved as a provider of Nursing Continuing Professional Development by New Mexico Nurses Association CNE Accredited Approver Unit, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation.

**Immediate Learning Outcome:** 100% of participants acknowledge a better understanding of caring for people with opioid use disorder by changing the culture in the emergency department setting through education of the disease process, identification of words that decrease the stigma of persons with OUD, positive body language, and decreasing withdrawal symptoms and craving.

- Criteria for successful completion: You may receive partial credit dependent on number of webinar sessions attended. You must view an entire session and submit a completed evaluation and attestation for all sessions viewed via Survey Monkey in order to earn up to 4.7 contact hours of approved Nursing Continuing Professional Development/Education and a certificate of completion.
- Conflicts of interest with commercial entities – NONE.
- Joint Providership – NA
- Commercial Support - NONE
- Planners/presenters of this NCPD activity have no conflicts of interest

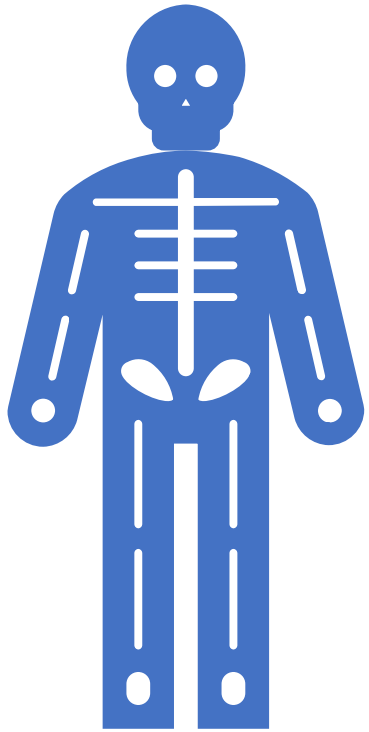
Evaluation link: https://www.surveymonkey.com/r/WEBINAR_OPIOID_ED

**Enduring material: expiration date October 31, 2020**

# Learning Objectives

- Upon completion of this module, participates will be able to:

- Identify some of the various screening tools used for OUD
- Be able to use a readiness and confidence ruler at the bedside



# Pre-Test

- 1.) The acronym SBIRT stands for Screening-Brief Intervention and _____.
- 2.) The Drug Abuse Screening Tool (DAST)-10 has _____(number) items.
- 3.)True or False  A Clinical Opiate Withdrawal Scale is only used in the initial patient interview.

# Pre-Test Answers

1.) SBIRT stands for: Screening-Brief ***Intervention-Referral to Treatment***

2.) The DAST-10 has ***10*** screening elements

3.) ***FALSE*** A COWS is used at the initial assessment and throughout the visit.

# Screening-Brief Intervention-Referral to Treatment **SBIRT**

- SBIRT is a comprehensive, integrated, public health approach for early identification and intervention
- Quick, easy way to identify and intervene with patients whose patterns of use put them at risk for, or already have, substance-related health problems
- Most patients will screen negative (75-85%) Will take about 1-2 minutes to ask 3-4 simple questions
- The remaining 15-25% of patients will require the full screen and brief intervention. Will take 5-20 minutes to complete

# SBIRT: Did you know?

- All use of illegal drugs or misuse of prescription drugs is considered unhealthy use
- Unhealthy drug use is among the most common cause of ***preventable*** morbidity and mortality
- Unhealthy drug use can complicate existing chronic conditions such as diabetes, hypertension, cardiovascular disease and/or mental health disorders
- Research has shown that large numbers of people whose patterns of use put them at-risk for developing drug problems can be identified through screening

# SBIRT Step One: Single Item Drug Screen

## Single-Item Drug Screen

- How many times in the past year have you used an illegal drug or used a prescription medication for non-medical reasons? (If asked what “nonmedical” reasons means you can say because of the experience or feeling the drug caused.)

## Scoring

- Greater than or equal to 1 is POSITIVE Assess using the DAST-10 Patient has at least RISKY drug use
- NEGATIVE screening, reinforce their healthy decisions

# SBIRT: Screening Step Two DAST-10

| ***The DAST-10 survey: These questions refer to the past 12 months. One point is awarded for each "Yes" answer.*** | |
|---|---|
| 1. Have you used drugs other than those required for medical reasons? | Yes / No |
| 2. Do you abuse more than one drug at a time? | Yes / No |
| 3. Are you unable to stop using drugs when you want to? | Yes / No |
| 4. Have you ever had blackouts or flashbacks as a result of drug use? | Yes / No |
| 5. Do you ever feel bad or guilty about your drug use? | Yes / No |
| 6. Does your spouse (or parents) ever complain about your involvement with drugs? | Yes / No |
| 7. Have you neglected your family because of your use of drugs? | Yes / No |
| 8. Have you engaged in illegal activities in order to obtain drugs? | Yes / No |
| 9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs? | Yes / No |
| 10. Have you ever had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding)? | Yes / No |

# SBIRT: DAST-10 SCORING

| | |
|---|---|
| Score | Score less than 3 (Women & Men)= RISKY USE |
| Score | Score greater than or equal to 3 (Women & Men) =Further Diagnostic EVALUATION &REFERRAL<br>• Go to Step #3 to perform a Brief Intervention |

# SBIRT: Step #3 Brief Intervention

| Brief Intervention Steps | Dialogue/Procedures |
|---|---|
| Understand the patient's views of use<br>• Develop discrepancy between patient's goals and values and actual behavior | Ask pros and Cons<br>Summarize Pros and Cons |
| Give Information/Feedback<br>• Ask permission to give feedback<br>• Use reflective listening | Review health risks |
| Enhance Motivation to change<br>• Ask Readiness and Confidence Scales | Readiness Scale<br>Confidence Scale |
| Give advice and negotiate goal | Give advice<br>Negotiate Goal |
| Close: Thank patient | |

# Readiness and Confidence Scales

National Screening, Brief Intervention & Referral to Treatment
ATTC Addiction Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration

## Confidence Ruler

- On a scale of 1-10 how confident are you that you could change your drinking, drug use, substance use?
- Why not a lower number?
- Why would it take to move it to a higher number?

1 2 3 4 5 6 7 8 9 10

CONFIDENCE

60

National Screening, Brief Intervention & Referral to Treatment
ATTC Addiction Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration

## Readiness Ruler

- On a scale of 1-10 how ready are you to make a change in your drinking, drug use, substance use?
- Why not a lower number?
- Why would it take to move it to a higher number?

1 2 3 4 5 6 7 8 9 10

READINESS

59

# SBIRT: Step #4 Referral to Treatment
## Common Treatment Modalities

| Service | Description |
|---|---|
| **Outpatient Counseling** | Individual or group counseling |
| **Acute Treatment Services** | For patients requiring medical intervention to manage withdrawal |
| **Clinical Stabilization Services** | Patients completed detoxification or do not require medically supervised care but require a period of intense residential counseling and time to plan next step |
| **Narcotics Anonymous** | Peer-based support. |

# ENA March 2019 Volume 45 Number 2, pgs. 178-184

- Screening, Brief Intervention, and Referral to Treatment by Emergency Nurses: A Review of the Literature
- Conclusion: “Implementation of SBIRT has the potential to change the conversations…”

# Clinical Opiate Withdrawal Scale

- Common method of assessing opiate withdrawal levels in patients who are in a residential treatment setting as well as in those who are being monitored for medication assisted opiate addiction treatment
- Method of recording scores for various symptoms of opiate withdrawal on a scale that ranges between 0 and 5. The sum of the numbers determines the level of opiate withdrawal and in a healthcare, setting would also determine the next course of action for treatment
- The symptoms of opiate withdrawal that are measured using the clinical opiate withdrawal scale must be solely related to the withdrawal itself and not to some other event or condition
- Eleven items are measured or assessed using the COWS method. This is a clinician-administered assessment that is not recommended to be performed by anyone who is not educated on the use of this method of assessment

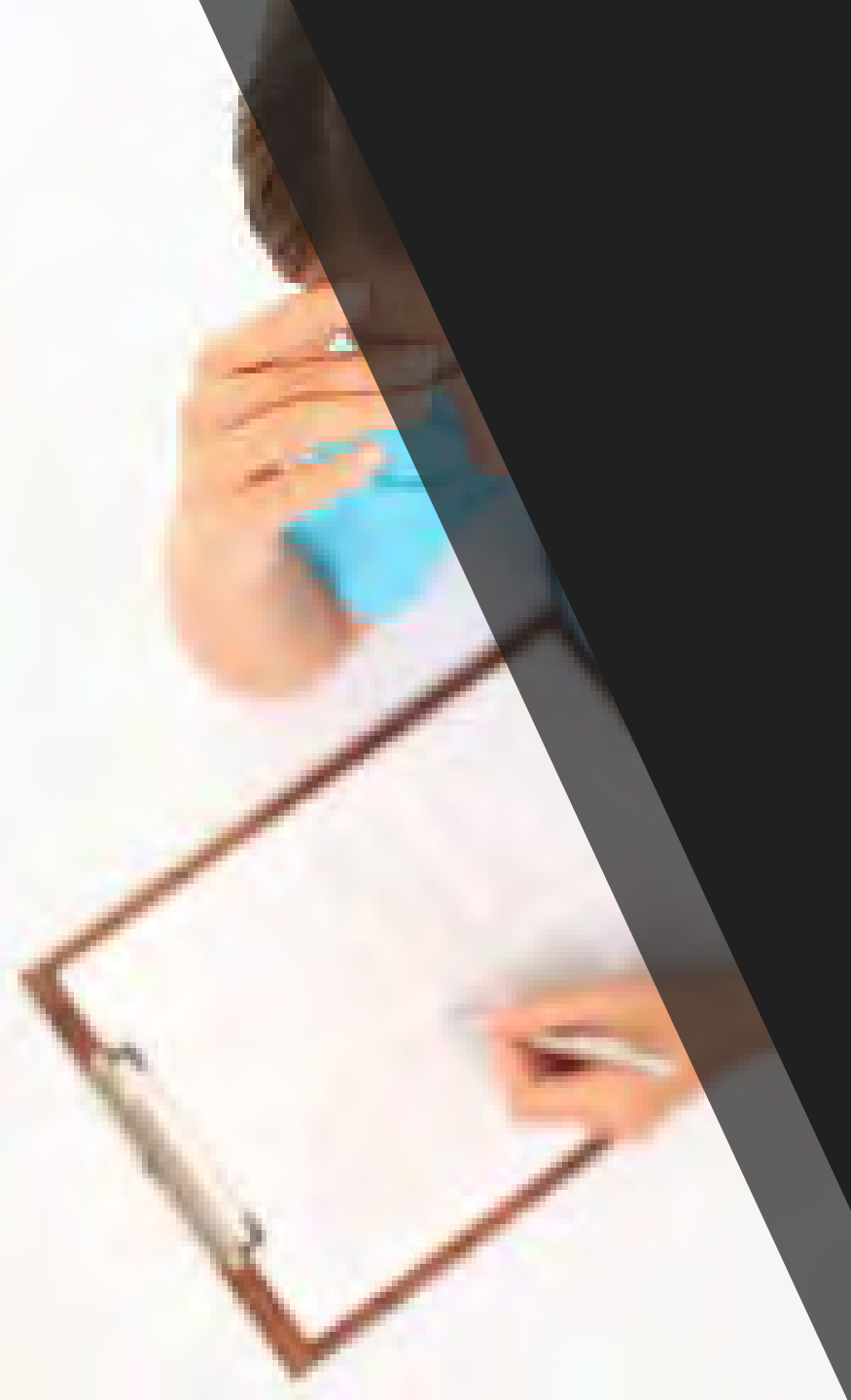
# Clinical Opiate Withdrawal Scale (COWS)

## COWS Clinical Opiate Withdrawal Scale

Wesson & Ling, J Psychoactive Drugs. 2003 Apr-Jun;35(2):253-9.

| | |
|---|---|
| Resting Pulse Rate: _____beats/minute<br>*Measured after patient is sitting or lying for one minute*<br>0 Pulse rate 80 or below<br>1 Pulse rate 81-100<br>2 Pulse rate 101-120<br>4 Pulse rate greater than 120 | GI Upset: *over last 1/2 hour*<br>0 No GI symptoms<br>1 Stomach cramps<br>2 Nausea or loose stool<br>3 Vomiting or diarrhea<br>5 Multiple episodes of diarrhea or vomiting |
| Sweating: *over past 1/2 hour not accounted for by room temperature or patient activity.*<br>0 No report of chills or flushing<br>1 Subjective report of chills or flushing<br>2 Flushed or observable moistness on face<br>3 Beads of sweat *on* brow or face<br>4 Sweat streaming off face | Tremor *observation of outstretched hands*<br>0 No tremor<br>1 Tremor can be felt, but not observed<br>2 Slight tremor observable<br>4 Gross tremor or muscle twitching |
| Restlessness *Observation during assessment*<br>0 Able to sit still<br>1 Reports difficulty sitting still, but is able to do so<br>3 Frequent shifting or extraneous movements of legs/arms<br>5 Unable to sit still for more than a few seconds | Yawning *Observation during assessment*<br>0 No yawning<br>1 Yawning once or twice during assessment<br>2 Yawning three or more times during assessment<br>4 Yawning several times/minute |
| Pupil size<br>0 Pupils pinned or normal size for room light<br>1 Pupils possibly larger than normal for room light<br>2 Pupils moderately dilated<br>5 Pupils so dilated that only the rim of the iris is visible | Anxiety or irritability<br>0 None<br>1 Patient reports increasing irritability or anxiousness<br>2 Patient obviously irritable anxious<br>4 Patient so irritable or anxious that participation in the assessment is difficult |
| Bone or Joint aches *If patient was having pain previously, only the additional component attributed to opiates withdrawal is scored*<br>0 Not present<br>1 Mild diffuse discomfort<br>2 Patient reports severe diffuse aching of joints/ muscles<br>4 Patient is rubbing joints or muscles and is unable to sit still because of discomfort | Gooseflesh skin<br>0 Skin is smooth<br>3 Piloerrection of skin can be felt or hairs standing up on arms<br>5 Prominent piloerrection |
| Runny nose or tearing *Not accounted for by cold symptoms or allergies*<br>0 Not present<br>1 Nasal stuffiness or unusually moist eyes<br>2 Nose running or tearing<br>4 Nose constantly running or tears streaming down cheeks | Total Score _____<br>The total score is the sum of all 11 items<br>Initials of person completing Assessment:_____ |

Score: 5-12 mild; 13-24 moderate; 25-36 moderately severe; more than 36 = severe withdrawal



# The CAGE or CAGE-AID

The CAGE or CAGE-AID should be preceded by these two questions:

1. Do you drink alcohol? 2. Have you ever experimented with drugs?

**If the patient has experimented with drugs, ask the CAGE-AID questions. If the patient only drinks alcohol, ask the CAGE questions.**

# CAGE-AID

## CAGE-AID

1. Have you ever felt you should **cut down** on your drinking or drug use?
2. Have people **annoyed** you by criticizing your drinking or drug use?
3. Have you ever felt bad or **guilty** about your drinking or drug use?
4. Have you ever had a drink or used drugs first thing in the morning **(eye opener)** to steady your nerves or to get rid of a hangover?

"0" for no and "1" for yes. A score of 1 or above accurately detects 91% of alcohol users and 92% of drug users. A score of 2 or greater is considered clinically significant.

Hinkin, 2001, Buschsbaum et. al., 1992; Booth, et. al., 1998



# Useful skills to try during conversation: *The OARS acronym*

- **Open ended questions:**
- “What are the good things about your substance use?”
- “Tell me about the not so good things.”
- **Affirmation:**
- “Thanks for talking with me.”
- I can see that you are a really strong person.”
- **Reflective listening:**
- “You are feeling uncomfortable talking about this.”
- “You are angry because people nag you about your drug use.”
- **Summarize:**
- “So you really enjoy using drugs at parties and you don’t think you use any more than your friends.”
- **Eliciting change talk:**
- “What worries you about your use of drugs?”

# ENA Connection

- ENA's Opioid Bundle-Combat the crisis
  - Access to all ENA's Opioid Education
    - On-line CE courses
    - Published articles
    - Downloadable Opioid Toolkit
    - Opioid related presentations from 2018 Emergency Nursing Conference
    - Signage that can be posted in the hospital with quick tips how to identify an opioid overdose and how to save the patient's life
    - Much more..

    - Find more information at ena.org/opioid

# Other Useful Tools

## Opiate Abuse Rating Scales

- COWS *Clinical Opiate Withdrawal Score*
  - Clinician administered
  - 11 clinical **withdrawal symptom** rating scale
- OOWS *Objective Opiate Withdrawal Score*
  - Clinician administered
  - Yes/no responses to 13 **withdrawal symptoms**
- SOWS *Subjective Opiate Withdrawal Score*
  - Self-reported
  - 16 Questions rated 0-4 related to **withdrawal symptoms**
- VAS *Visual Analog Scale*
  - Self-reported
  - Quantify **craving for opioids** from 0 to 100

# So many tools, so little time

- Lead with presence
- Listen completely
- Come from a place of curiosity and care
- Focus on what matters
- Pause; Remember the option to stay silent
- Be Kind

# Summary

- Many tools exist to assist healthcare providers with screening and intervention at the bedside. Some of these tools include COWS, CAGE-AID.  Many, many more are out there.  Be open to try some or develop your own
- SBIRT is a Comprehensive, **integrated** public health approach for early identification and intervention.
  - Remember: Single-Item Drug Screen, DAST-10, various treatment possibilities
- OARS stands for: Open Ended Questions, Affirmation, Reflective Listening, Summarize, Elicit change Talk
- Practice using tools—it is the only way to become competent

# POST TEST

1.) The use of the Clinical Opiate Withdrawal Scale (COWS) is/is not useful in determining withdrawal after the initial assessment.

2.) TRUE or FALSE. Summarizing a conversation with a patient means you remind the patient of what you discussed.

3.) TRUE or FALSE. The “C” in CAGE-AID stands for “cut down”.

# Post Test Answers

- 1.) The COWS is useful for both the initial assessment of withdrawal and after administering treatment

- 2.) TRUE. Summarizing the conversation with a patient is part of the OARS acronym

- 3.) The “C” does stand for cut down.  “Have you ever felt you should “***cut down***” on your drinking or drug use?”

# References


- https://attcnetwork.org/regcenters/productDocs/21/National%20SBIRT%20TOT%20ATTC%204%20Hour%20Curriculum.pptx. Retrieved on September 04, 2019.
- https://www.masbirt.org/sites/www.masbirt.org/files/document/toolkit.pdf. Retrieved on October 01, 2019.
- https://opiate.com/withdrawal/using-the-clinical-opiate-withdrawal-scale-to-assess-opiate-withdrawals. Retrieved on October 01, 2019.

# Thank You

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