Applying a Multidisciplinary Approach to Evaluation and Monitoring of Substance-Related Sedation in Low Threshold Spaces

Michelle Whitaker, RN, CARN; Morgan Younkin, MD, MPH; Samantha Walsh, NP, RN; Caitlin Pollard, MSN, RN; Tehya Johnson, AGPCNP-BC; Max Bernstein, BS; Riley Coleman, CM, Teddie Lindberg, CM

Learning Objectives

1. Learners will summarize key components of the initial multidisciplinary evaluation of a sedated guest including comfortably describing the level of sedation of a guest using the Inova Sedation Scale.

2. Learners will apply the procedures involved in close sedation monitoring and milieu management to typical client case presentations.

3. Learners will use structured decision support tools to demonstrate when a higher level of care is indicated during sedation support.

Boston Health Care for the Homeless Program (BHCHP)

BOSTON HEALTH CARE *for the* HOMELESS PROGRAM
SINCE 1985

www.bhchp.org
@BHCHP

Identifying a Community Need

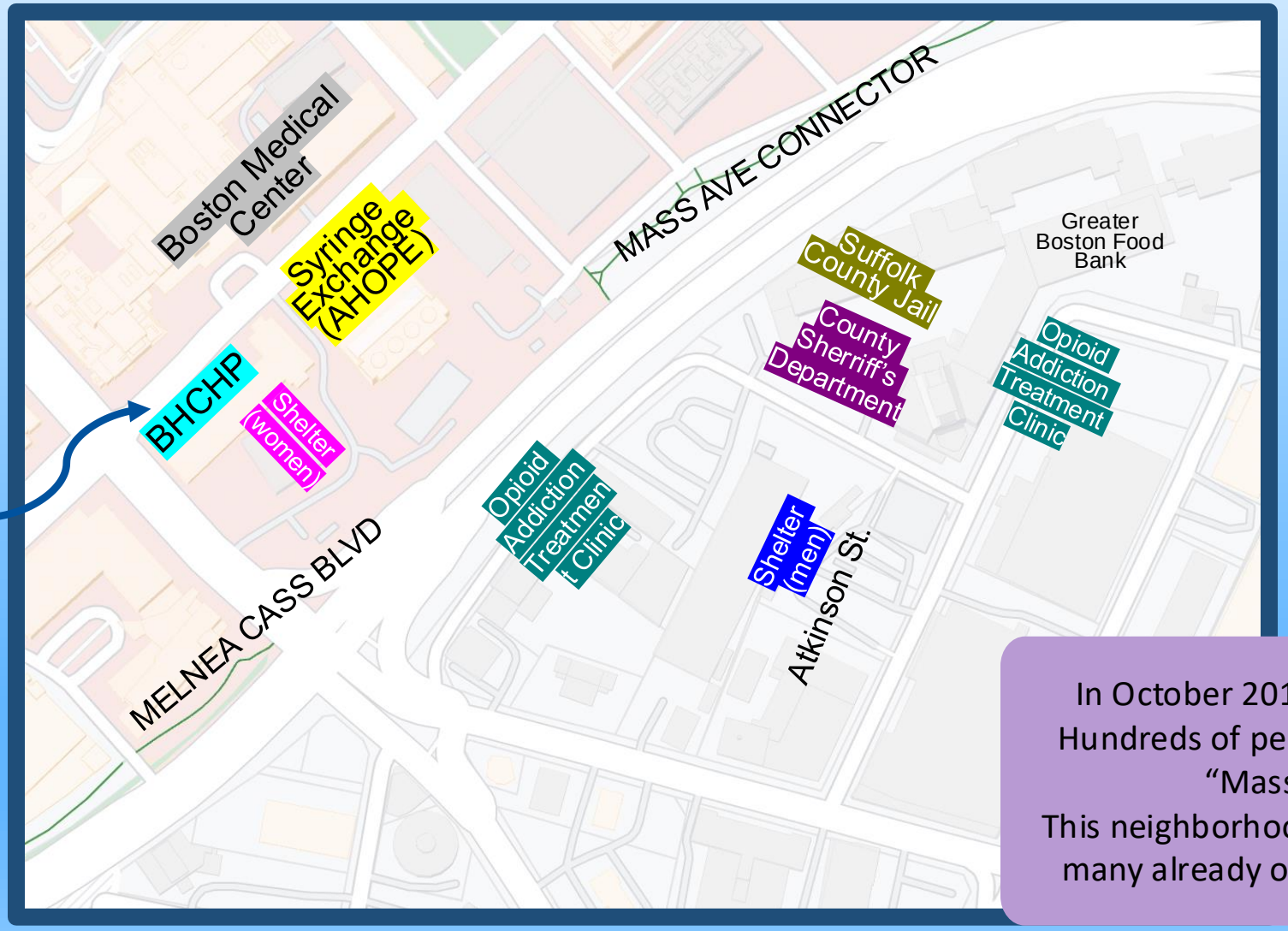
- Drug overdose = leading cause of death for cohort of 28,033 adults seen at BHCHP from 2003 to 2008.[1]
- Opioids implicated in 81% of overdose deaths.[1]
- Overdoses frequently happening in our building.
- Significant existing addictions programming already, but **no dedicated harm reduction services.**


Photo: Boston Globe 2016


Photo: Boston Globe 2016

1. Baggett TP, et al. Mortality among homeless adults in Boston: shifts in causes of death over a 15-year period. JAMA Internal Medicine 2013; 173(3): 189-195.

CONTEXT: Our Neighborhood circa 2016



In October 2014 Long Island closed.
Hundreds of people "resettled" to the "Mass/Cass" area.
This neighborhood was already home to many already overburdened services.

SPOT:
Supportive Place for Observation and Treatment

SUPPORTIVE PLACE FOR OBSERVATION AND TREATMENT

Staffing Model

- **Registered Nurse or Harm Reduction Tech (EMT)**
- **Harm Reduction Specialist**
- On call: rapid response clinician (**MD/NP/PA**)

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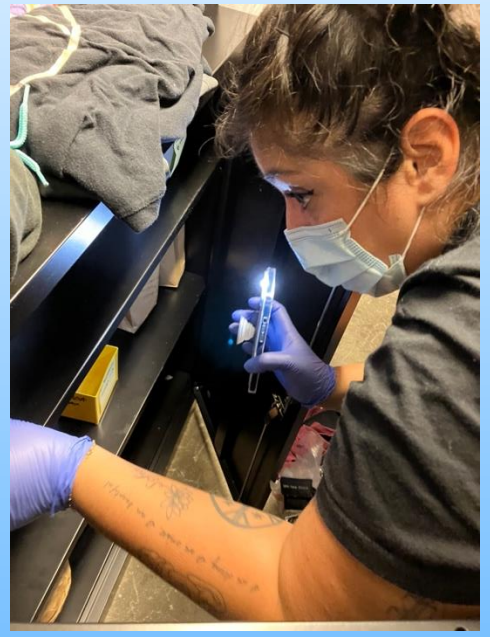
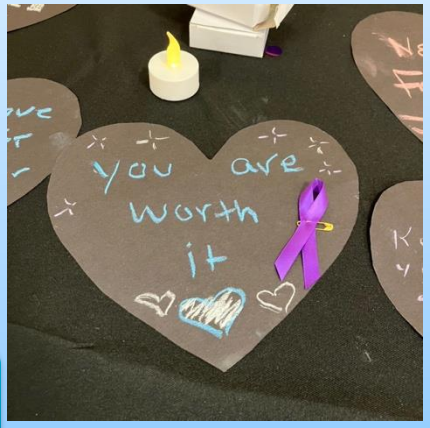
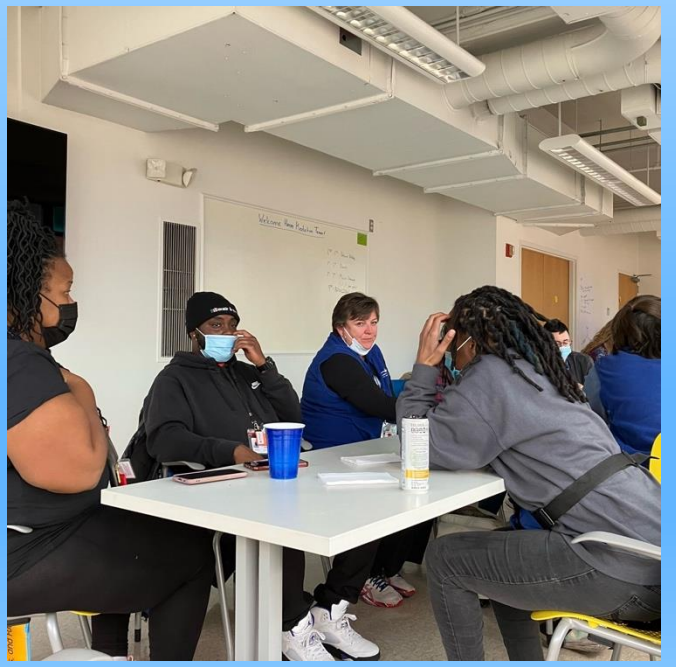
Multi-Disciplinary Approach to Harm Reduction





- Nursing
- Behavioral Health
- Case Management
- EMTs
- MDs/NPs



Overdose Prevention Model Variations

Photo: Boston Globe 2016

SPOT

Peer Support

Helplines & Apps

Medical Monitoring

Overdose Prevention Center

NEVER USE ALONE
1-877-696-1996

Safe Spot
1-800-972-0590

ONPOINT NYC

(ONPOINT NYC)

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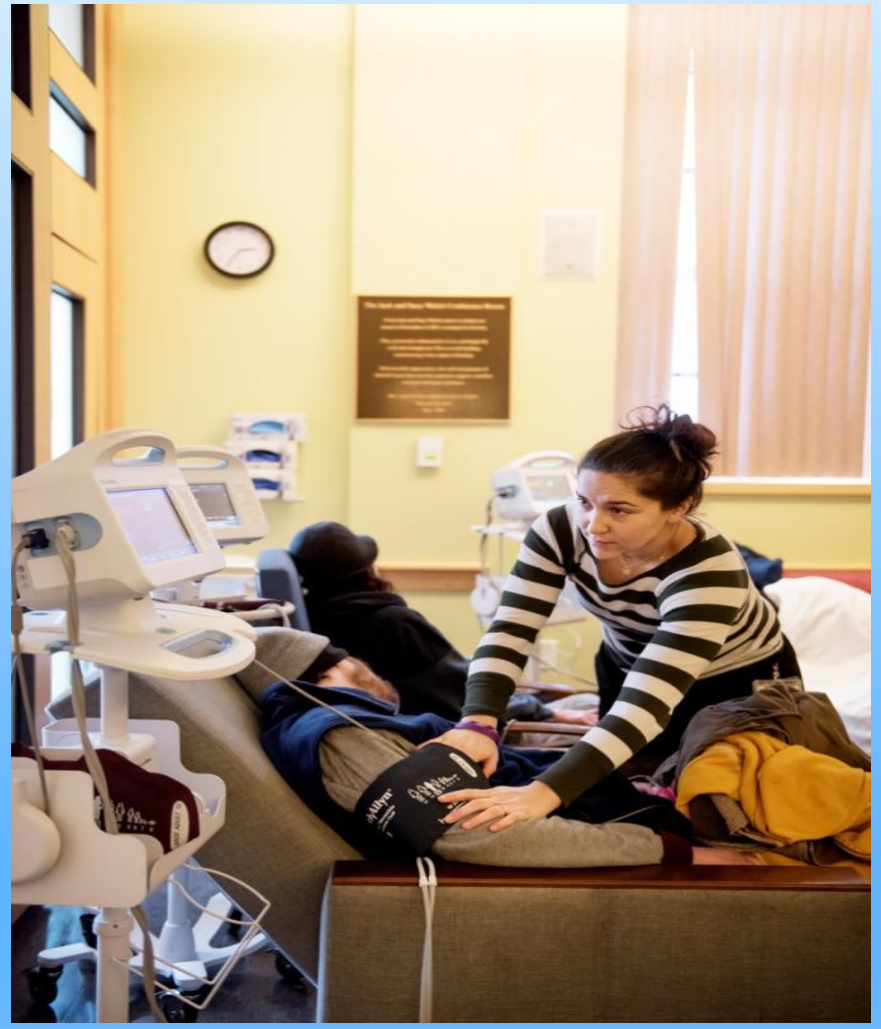
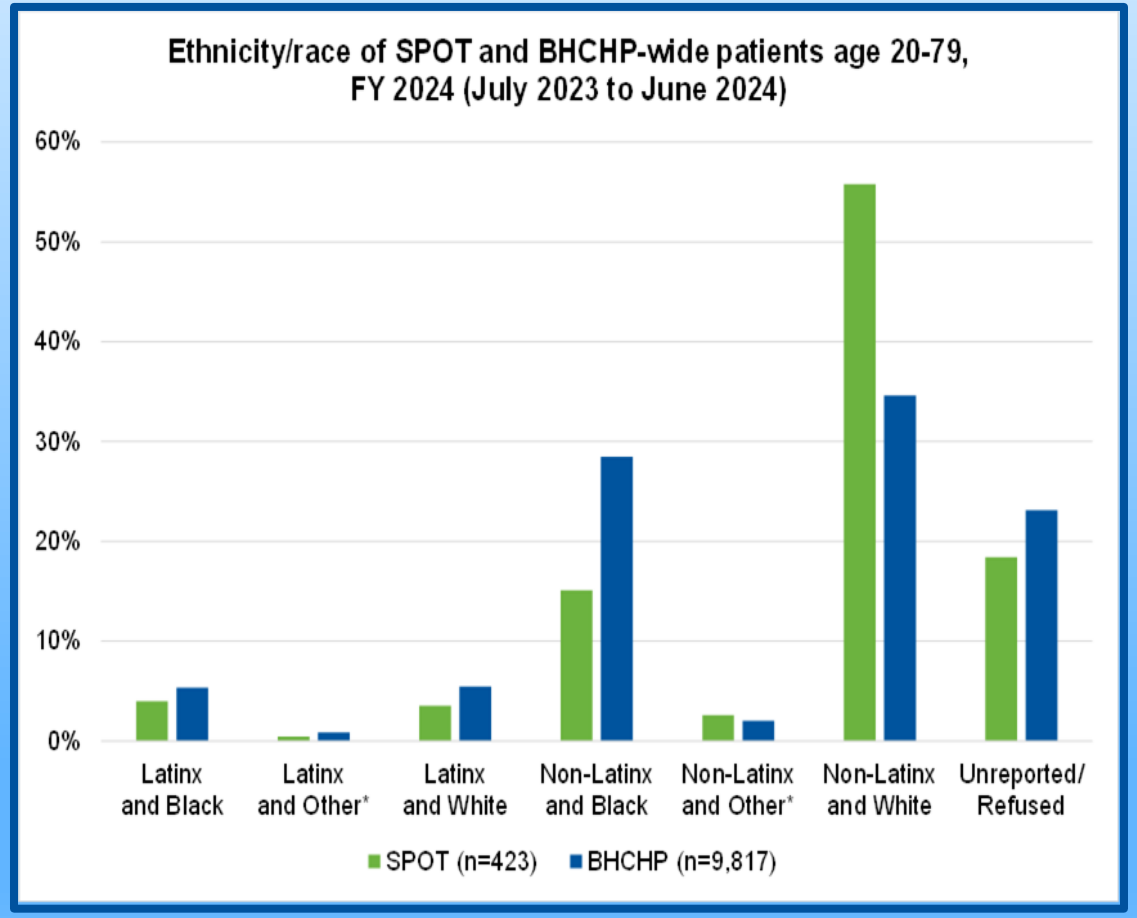
How is SPOT different from an Overdose Prevention Center (OPC)?



- Substances are consumed *prior* to arrival.
- Some participants may come in after a “run” of stimulants and be exhausted, but not sedated.
- Clinician may perform an initial brief assessment including vital signs to determine client safety.
- Vital signs are assessed and documented every 15-30 minutes by the clinician on duty.

Efforts Are Underway to Improve Equity and Diversity



In 2024, SPOT saw fewer Black and Latinx patients compared to the rest of BHCHP.

We saw more men than women in SPOT, but saw more women overall compared to the BHCHP average.

Finally, we see a much younger population in SPOT than the rest of BHCHP. 74% of SPOT guests are in the 20-49 year old range.

Welcome to **SPOT**!

A SPOT participant with founder Dr. Jessie Gaeta. Photo Credit: BHCHP

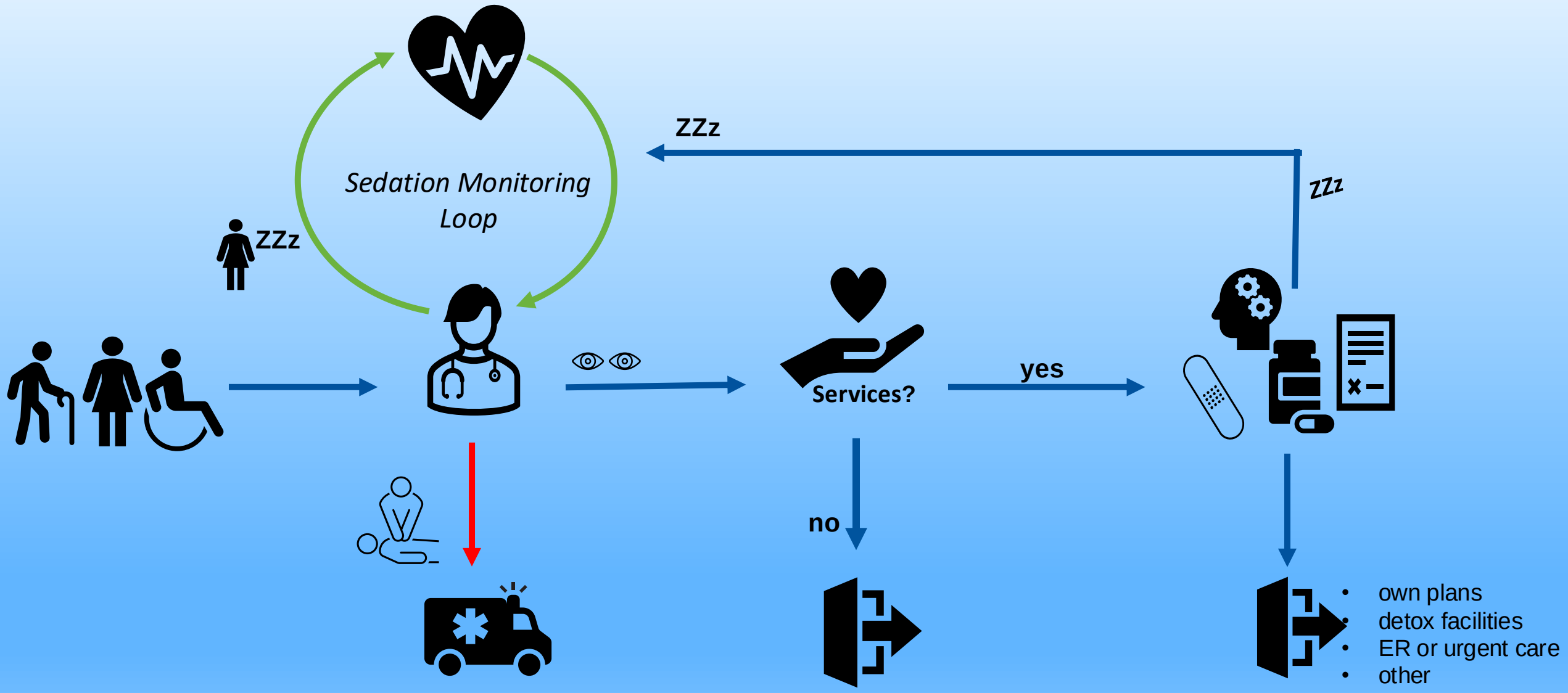
Participants access SPOT through:

1. Self-referral OR

2. Being brought in by someone else:
   - Friend/Peer
   - BHCHP Staff
   - Other (partner org, police, EMS)

Guests arrive in **varying states of sedation,** and not everyone is sedated when they first come to SPOT.

SPOT Guest Flow



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Identifying Initial Sedation Level Using the Inova Sedation Scale (ISS)

S1: Awake and alert

S2: Calm and cooperative

S3: Nodding

Falling asleep mid-task
Defensive

S4: Light Sleeping

Easy to wake
Can communicate once awake

S5: Deep Sleeping

Hard to wake
Difficulty communicating

S6: Unable to Wake

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Initial Brief Assessments

- Altered presentations aren’t always from using substances
- Clinician can make clinical observations or do medical assessments.
- Non-clinical staff may be able to add context, or help take a history from the guest.
- The assessments may be formal or informal.
- This helps them determine whether the guest is stable enough to monitor in this outpatient setting.

GROUP ACTIVITY: Evaluating Sedation

What are some key things are you observing for?

What additional contexts might be helpful?

Are there any assessments you might perform?

What differentials might you consider?

Clinical Assessment Tool Box

- **Sedation Level:** Estimate sedation using ISS (S1-S6)
- **Physical Survey:** Notice any jaundice or icterus, facial or head trauma, abrasions, diaphoresis, concerning skin rashes
- **Neuro/Motor Check:** Abnormal gait, posturing, asymmetric pupils, facial droop, seizure
- **Vital Signs:** RR, Sp02, pulse, blood pressure, temperature
- **Blood Glucose:** Consider when sedation = S5/S6 or if known DM

Taking a Brief History

If the person is S1-S4 they may be able to answer questions themselves.

1. Onset of symptoms (**sudden** onset may indicate stroke for example)
2. Other symptoms preceding sedation (vomiting, recent fall)
3. Recent trauma (assault, car accident, etc)
4. PMH including any neurological diseases or conditions like diabetes
5. Substances used, how recently and route if applicable
6. Prescribed medications

TOP DECIDING FACTORS FOR ER TRANSFER

1. Hypoxia or hypopnea not sufficiently responsive to supplemental oxygen, naloxone, or attempts to arouse. Patients requiring high volumes of oxygen for long periods of time. 15LPM > 10min

2. Temperature ≤ 96°F or ≥ 101°F

3. Posturing or seizure activity

4. BP out of expected range, even in context of use

5. Asymmetrical pupils

6. Evidence of head trauma or extreme bodily injury

7. Jaundice, asterixis (suspected ESLF or encephalopathy)

8. Glucose ≤ 60 (consider glucagon per standing order) or ≥ 400

9. A non-substance related cause of sedation is likely based on history and exam (MI, stroke, concerning rash)

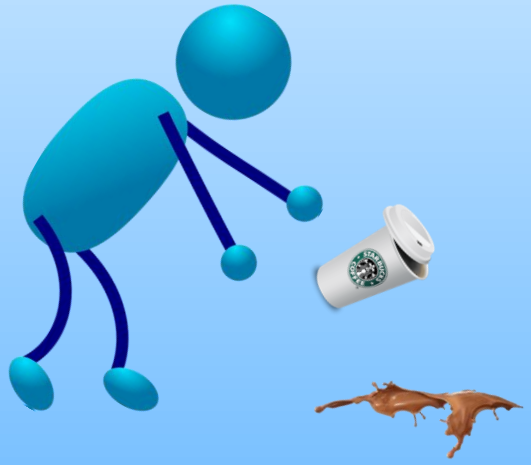
10. Staffing, timing or environment does not allow for close monitoring.

GROUP ACTIVITY: Sedation Scenario

You are working in a low threshold shelter setting and doing safety rounds. You notice a guest holding a coffee but their eyes are half closed.

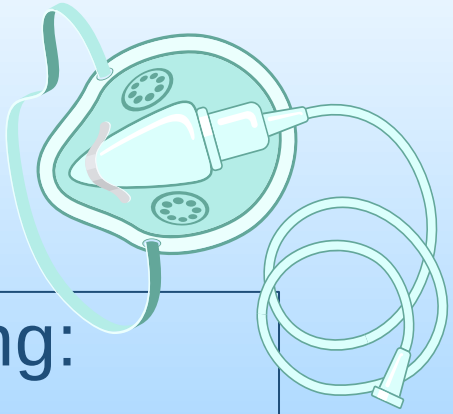
They are bending at the knees and look like they may fall but keep catching themself.

There is a little coffee on the floor where they spilled it.

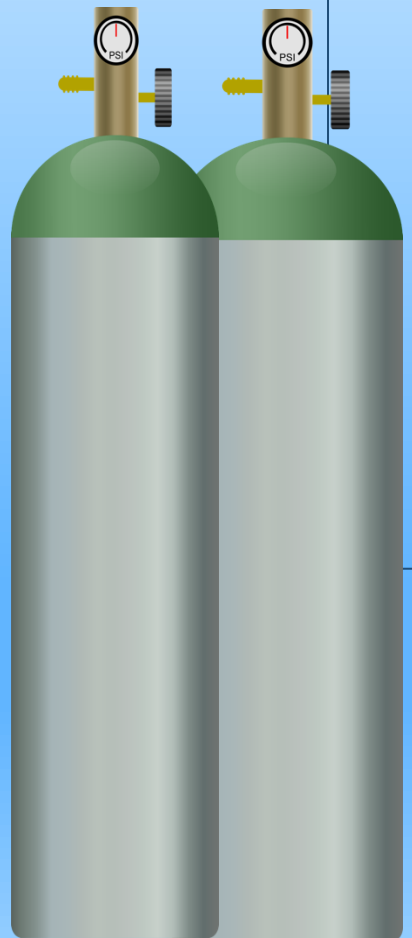


What level of sedation is the guest?
What signs/symptoms are you scanning for?
What is the next move here?

Medical Interventions



We may intervene to prevent a fatal overdose using:



- Oxygen delivery
- Ventilation/Rescue Breathing
- Breathing “Cues”
- Small doses of naloxone (0.5mg-1mg)

OVERDOSE RESPONSE GUIDELINES

1) INITIAL ASSESSMENT: Assess Pulse, RR, and SpO2 to determine sedation stage. *If discrepancy between RR and SpO2, use RR to determine stage.*						
	STAGE 1	**STAGE 2**	**STAGE 3**	**STAGE 4**	**STAGE 5**	**STAGE 6**
Pulse	Yes	Yes	Yes	Yes	Yes	**NO PULSE + OD concern**
RR	>11	8-11	5-7	0-4	0 or Cyanosis or Agonal Breathing	
SpO2 **KeyNote: pulse ox overestimates oxygenation in people with darker skin tones!*	>94%	86-94%	80-85%	70-79%	<70%	
2) RESPONSE:						
Oxygenation and Ventilation	NO	**YES** NC to maintain O2 sat >90%	**YES** NRB + 10-15 LPM	**YES** **BVM + 15 LPM** Ventilation rate q6sec If BVM not available, high quality rescue breaths with barrier		**CPR** Include AED
Naloxone (1st dose[3])	NO. (Consider diff. dx for sedation)	NO … (Consider diff. diagnosis and continue to monitor)	NO… Unless medical[1] or environmental[2] concern, VS or presentation worsening: give 1 mg IN	**2 mg IN initial[3]**	**4 mg IN initial[3]**	**4 mg IN initial[3]**
Call 911?	**Consider if comorbid medical[1] concern or environmental issue[2]**					**Call 911**

[1] Medical emergencies include but are not limited to: seizure, head injury, physical trauma, temp <96°F or > 101°F, hyper or hypoglycemia
[2] Environmental issues include but are not limited to: lack of staffing to provide ongoing oxygenation and ventilation
[3] WAIT 3-5 min before potential additional doses - refer to next chart for guidance on repeat dosing

The Milieu: Creating a Safe and Supportive Space

- Setting the space for success
- Managing the milieu
- HRS contributions to sedation monitoring
- Working through challenges
- End of Day Routine

Non-Clinical Supportive Services

Case Management

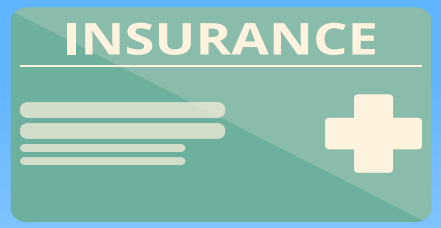
- Treatment program referrals
- State benefits (SNAP/EBT, etc.)
- Letters of support
- Appointment Coordination
- Vital documents
- Health insurance

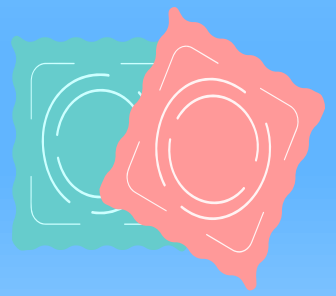
Harm Reduction

- Education and safety promotion
- Material and non-material resources

Milieu Management

- SPOT's "welcoming committee"
- Boundary setting
- Redirection





Break Out Groups: Sedation Scenarios

Interdisciplinary Sedation Monitoring Panel

Please scan for digital copies of our handouts, links to our emails, and a brief survey about this workshop!

Thank you!