

University Hospitals Sussex NHS Foundation Trust

Alcohol Withdrawal Syndrome: Management guidelines for adults

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Chapter 1 Contents

University Hospitals Sussex NHS Foundation Trust	1
1. Guideline summary	4
2. Symptom triggered pharmacological management of Alcohol Withdrawal Syndrome (AWS)	5
3. Introduction	6
4. Scope	6
5. Purpose	6
6. Definitions	6
7. Guideline	7
7.1 Alcohol Withdrawal Syndrome (AWS)	7
7.1.1 Mild to moderate symptoms:	7
7.1.2 Severe symptoms; Seizures, Delirium Tremens & Wernicke's Encephalopathy	7
7.2 Alcohol detoxification	9
7.2.1 Assessment of patients requiring medically assisted alcohol withdrawal	9
7.3 Pharmacological management of alcohol withdrawal syndrome	9
7.3.1 Benzodiazepines	9
7.4 Proton Pump Inhibitors (PPIs) in Acute Alcohol Withdrawal	11
7.5 Alcohol withdrawal syndrome in special patient groups	11
7.5.1 Liver impairment	11
7.5.2 Elderly patients (>75 or >65 with frailty)	11
7.5.3 Respiratory Disease	12
7.5.4 Nil By Mouth (NBM)	12
7.5.5 Dysphagia	12
7.6 Managing detox in patients already on benzodiazepines:	12
7.7 Important additional medical complications	13
7.7.1 Dehydration, electrolyte depletion and malnutrition	13
7.7.2 Hypoglycaemia	13
7.7.3 Alcoholic ketoacidosis	13
7.8 Referral to alcohol misuse services	14
7.9 Discharge	14
7.9.1 Community contact details:	14
Appendices:	15
Appendix A: Indications for hospital admission	15
Appendix B: Recommended assessments for patients requiring alcohol withdrawal	16

Appendix C: Alcohol use disorders identification test consumption (AUDIT C) and full AUDIT questionnaire
Appendix D: Clinical Institute Withdrawal Assessment of Alcohol Scale, Revised (CIWA-Ar)18
Appendix E: Benzodiazepine Prescribing and Monitoring In Low (CIWA-Ar <10) Risk Patients
Appendix F: Benzodiazepine Prescribing and Monitoring In Moderate (CIWA-Ar 10-15) Risk Patients 20
Appendix G: Benzodiazepine Prescribing and Monitoring In High (CIWA-Ar > 15) Risk Patients
Appendix H: Medical Treatment of Aggression, agitation and confusion
Appendix I – Childs Pugh score – to determine liver disease severity
Appendix J: Moderate Risk (CIWA 10-15) Chlordiazepoxide Alcohol Withdrawal Protocol Chart24
Please also complete CIWA-Ar scale (overleaf) for appropriate patient monitoring
Appendix K: High Risk (CIWA >15) Chlordiazepoxide Alcohol Withdrawal Protocol Chart
Please also complete CIWA-Ar scale (overleaf) for appropriate patient monitoring
Appendix L: Moderate Risk (CIWA 10-15) Diazepam Alcohol Withdrawal Protocol Chart
Please also complete CIWA-Ar scale (overleaf) for appropriate patient monitoring
Appendix M: High Risk (CIWA >15) Diazepam Alcohol Withdrawal Protocol Chart
Please also complete CIWA-Ar scale (overleaf) for appropriate patient monitoring
Appendix N: Moderate Risk (CIWA 10-15) Lorazepam Alcohol Withdrawal Protocol Chart
Please also complete CIWA-Ar scale (overleaf) for appropriate patient monitoring
Appendix O: High Risk (CIWA >15) Lorazepam Alcohol Withdrawal Protocol Chart
Please also complete CIWA-Ar scale (overleaf) for appropriate patient monitoring
References

1. Guideline summary

Acute withdrawal syndrome (AWS) is a set of physical and psychological symptoms that most commonly begin within 6-24hours after the last drink however severe symptoms can manifest up to 7 days. In the absence of medical management AWS can be hazardous in those with severe dependence, as it may lead to seizures, delirium tremens and potentially, death.

Detoxification refers to a treatment program designed to help control the medical and physiological complications that may occur after a period of heavy or sustained alcohol use.

Where alcohol dependence or AWS is suspected, in addition to completing a full clinical history, physical and mental state examination, comprehensive alcohol history using SADQ/CIWA-Ar score (appendix B, C and D) and investigations such as FBC, LFTs, INR, BMs are also essential.

2. Symptom triggered pharmacological management of Alcohol Withdrawal Syndrome (AWS)

The aim of detoxification using benzodiazepines is to rapidly control withdrawal symptoms and stabilize the patient. The dose is gradually reduced over 5-7 days, until detox completion. The aim is to keep CIWA score below 10 to treat symptoms comfortably without causing any marked CNS depression. CIWA scoring guidance found in appendix D.

Risk category	Low (CIWA-Ar <10) – Ap. E	Moderate (CIW Ap. F	VA-Ar) 10-15 –	High (CIWA-Ar >15) – Ap. G			
Presentation	 Symptomatic and typical consumption <15 units per day Patients with high risk but non-continuous alcohol use and/or low-level dependence No alcohol on breath test Recent drinking pattern 3-4 days a week only Recent detox with last 2/52 Audit screen <15 Audit C < 8 	 Symptomatic consumption per day Drinking to rwithdrawal s Evidence of withdrawal s No evidence severe withdrawal score complication 	 atic and typical tion 15-30 units Symptomatic and typical consumption > 30 units day History of severe withdrawal, DT, or seizu Signs suggestive of WE CIWA 15+ Multiple substance addiction in particular h benzodiazepine use High level of agitation/aggression High NEWS score 				
Chlordiazepoxide (benzodiazepine of choice) Care in elderly/frail if escalating therapy	Consider 20mg PO hourly PRN (MAX 80mg in 24 hours) There is no need for a fixed dose regimen for this group of patients	30mg PO hourl (MAX 250mg ir AND standard fixed see appendix J	ly PRN n 24 hours) dose regimen –	40mg PO hourly PRN (MAX 250mg in 24 hours) AND standard fixed dose regimen – see appendix K			
Diazepam	<i>Consider</i> 5-10mg PO hourly (MAX 40mg in 24 hours)	10-15mg PO P 100mg/24 hour standard fixed – see appendix	RN (max [.] s) AND dose regimen « L	20mg PO PRN (max 100mg/24 hours) AND standard fixed dose regimen – see appendix M			
Lorazepam	If has signs of encephalopathy please discuss with senior team member before prescribing benzodiazepines <i>Consider</i> 500micrograms PO 2-hourly PRN (max 3mg/24 hours)	If has signs of e please discuss team member l prescribing ber 1mg PO 2-hour 10mg/24 hours fixed dose regi appendix N	encephalopathy with senior before nzodiazepines rly PRN (max) AND standard imen – see	If has signs of encephalopathy please discuss with senior team member before prescribing benzodiazepines 2mg PO 2-hourly PRN (max 10mg/24 hours) AND standard fixed dose regimen – see appendix O			
Pabrinex	Prophylaxis of Wernicke Ence	phalopathy	Signs or	high risk of Wenicke			
	(₩E): Pabrinex 1 pair IV ONCE a day	r for 3-5 days	Encephalopat Pabrinex 2 pai days then If no response Clinical respon days OR until c	ny: irs IV THREE times daily for 2 – discontinue se - <u>1 pair IV OD for a further 5</u> linical improvement ceases			
Oral vitamins	Thiamine 100mg PO TDS		·	·			
Prescribe <u>after</u> completion of Pabrinex	If at risk of malnutrition: ad use disorder, AUD)	ld Multivitamins	s 2 tablets PO C	DD (note: high risk in alcohol			
	Duration of 6 weeks, to be re May be continued indefinitely nutritional state. NOT FOR ALCOHOL WITH	viewed by GP. if heavy drinki	ng continues or	concerns regarding			

Please refer to the full guideline for more information

Vitamin B Co-Strong ONE tablet PO TDS for 10 days only

3. Introduction

Alcohol dependence affects 4% of people aged between 16-65yrs in England. In addition, over 24% of the English population consumes alcohol in a way that is potentially harmful to their health.

Acute alcohol withdrawal in the absence of medical management can be hazardous in those with severe dependence, as it may lead to seizures, delirium tremens and potentially, death.

Most alcohol detoxifications occur in community by the local treatment provider, Change Grow Live (CGL), either at home or in specialist units. However, there are individuals who do not fit the criteria for detox in the community. These patients require detox within hospital where complications can be managed. Nevertheless, it is important to establish communication with community services to ensure seamless transfer of care when patients are discharged.

These tend to be unplanned admissions with a concurrent illness, or with alcohol-related illnesses such as decompensated liver disease.

The AWS management guidelines were developed as failure to identify and manage complications of alcohol withdrawal can lead to long term complications or loss of life.

4. Scope

These guidelines are intended for use within the Trust to aid all staff with individuals aged 16 years and over admitted to hospital or A&E. It does not specifically look at women who are pregnant, children younger than 16 years old or people with physical or mental health conditions caused by alcohol use, other than those described below.

5. Purpose

The goal of this guideline is to minimize morbidity, mortality and patient distress by:

- Promoting early identification of alcohol use disorders (AUDs) in all hospital attendees.
- Promote identification and assess need for intervention in groups at high risk of serious complications.
- Facilitation of prompt initiation of medical management for alcohol-related conditions.
- Aiding appropriate pharmaceutical management of alcohol withdrawal syndrome and its complications.

6. Definitions

AA – Alcoholics anonymous Alcohol dependence – craving, tolerance, a preoccupation with alcohol and continued drinking despite harmful consequences APQ – Alcohol problems questionnaire ARBD – Alcohol Related Brain Damage AUDs – Alcohol use disorders AUDIT-C: Alcohol Use Disorders Identification Test, consumption AWS – Alcohol Withdrawal Syndrome BZD – Benzodiazepine CDZ – Chlordiazepoxide CIWA-Ar: Clinical Institute Withdrawal Assessment of Alcohol Scale, revised CP-C: Child-Pugh Score for Cirrhosis Mortality Harmful drinking (high risk drinking) – pattern of alcohol consumption causing health problems directly related to alcohol LDQ – Leeds Dependence Questionnaire MMSE – Mini Mental State Examination SADQ – Severity of Alcohol Dependence Questionnaire WE – Wernicke encephalopathy

7. Guideline

7.1 Alcohol Withdrawal Syndrome (AWS)

AWS is a set of physical and psychological symptoms that occur following a reduction in alcohol intake after a period of excessive use. Symptoms are variable in onset, severity, and presentation.

AWS <u>most commonly</u> begins within 6-8hours of an abrupt reduction in alcohol intake and can peak between 10-30hours since last drink and lasts from 3-7 days.

Patients that require admission are provided in appendix A.

Recommended assessments for patients with (suspected) AWS are provided in in appendix B.

7.1.1 Mild to moderate symptoms:

- Nausea, vomiting, diarrhoea
- Tremors in hands, arms, legs, sometimes trunk and neck
- Hyperactivity, anxiety, agitation medical treatment recommendations found in appendix H.
- Muscle pain
- Sweating
- Insomnia, restlessness
- Autonomic disturbances (tachycardia, hypertension, pyrexia)

7.1.2 Severe symptoms; Seizures, Delirium Tremens & Wernicke's Encephalopathy

AWS has three severe, life threatening complications which are described briefly below:

a. Seizures

Alcohol related seizures usually occur within the first 12hours of cessation or significant reducing of intake. Seizures are rare beyond 48hours after last alcoholic drink.

Patients that have suffered a seizure should be admitted to CDU for observation for 12-24 hours. For isolated seizures, continue regimen ensuring patient has received adequate BZD dosing, which may need increasing

Predisposing factors include; history of epilepsy, hypoglycaemia, electrolyte disturbances such as, hypocalcaemia and hypomagnesaemia.

Management of alcohol withdrawal seizures

- First line: **Iorazepam 4mg IV bolus** into a large vein as per UHS Trust protocols
- Second line: diazepam 10mg IV bolus <u>OR</u> diazepam 10mg rectally
 Please note, diazepam injection is contraindicated in severe liver impairment.
- If seizures are prolonged, give second dose after 10minutes, then follow Trust protocols
- In seizures are protonged, give <u>second dose arter rominates</u>, men rollow trust protocols
 <u>https://viewer.microguide.global/guide/1000000244#content,12de1a7a-118a-459e-99bc-a6f75e39c59b</u>
- Call MET team on 2222 if two or more doses are required and seek senior medical advice and support
- <u>DO NOT</u> use phenytoin to treat alcohol withdrawal seizures
- Ensure appropriate supervision and monitoring whilst patient at risk of seizures
- It is **vital to avoid over or under sedation** as this can cause: DTs, aspiration pneumonia, hypotension and paradoxical hostility and agitation.

b. Delirium Tremens (DTs)

- DT is a medical emergency and carries a high mortality rate of 15-20% if inappropriately managed.
- It occurs in less than 5% of patients during alcohol withdrawal and can last 3-5 days.
- Onset of symptoms is usually 24-72hours after alcohol cessation of reduced intake, symptoms include: Severe tremor, delusions, tachycardia, pyrexia, visual and auditory hallucinations,

confusion and disorientation, clouding of consciousness

• If agitation is severe, please refer to appendix H for treatment algorithm.

c. Wernicke's Encephalopathy (WE)

- All patients with hazardous or dependent alcohol use will be at risk of WE because of malnutrition or comorbid ALD. WE is an acute neuropsychiatric disorder resulting from thiamine deficiency which develops rapidly or sub-acutely over a number of days
- Inappropriate management is associated with:
- Estimated 20% mortality risk
- Approximately 80% of survivors develop Korsakoff's syndrome
- 85% risk of permanent brain damage (ARBD)
- WE is initially reversible with high dose parenteral vitamin B (Pabrinex) so treatment should be initiated immediately in those with risk factors. WE is a medical emergency, therefore a low index of suspicion of diagnosis and commencement of treatment is recommended.

Management of WE

Prophylaxis	Low risk of developing Wernicke's encephalopathy	Pabrinex 1 pair IV ONCE a day for 3-5 days	Plus for all patients start the following <i>after</i> completion of
Treatment	Signs of Wernicke's encephalopathy (ataxia, opthalmoplegia, loss	Pabrinex 2 pairs IV THREE times daily for 2 days then	parenteral vitamin replacement (Pabrinex):
	of memory, confusion)	If no response – discontinue	Thiamine 100mg orally THREE times a
	OR	Clinical response - <u>1 pair IV</u> <u>OD for a further 5 days</u> OR	day
	HIGH risk of development of	until clinical improvement	
	Wernicke's encephalopathy	ceases	
	(hypotension, hypothermia,		
	malnourished,		
	nypergiycaemia)		

To avoid risk of refeeding, parenteral treatment should always be given before IV glucose therapy concerns about nutritional state

Other vitamin supplementation for WE

- If at risk of malnutrition add Multivitamins orally TWO tablets daily
 If at risk of re-feeding syndrome, prescribe Vitamin B Compound Strong one tablet orally three
 times daily for 10 days ONLY. Due to a lack of evidence on their efficacy and safety, vitamin B
 complex preparations (vitamin B compound and vitamin B compound strong tablets) should NOT
 be prescribed for prevention of WE in alcoholism.
- Oral thiamine and multivitamins can be discontinued after 6 weeks if abstinent and well-nourished but should continue indefinitely if heavy drinking continues or
- Refeeding guidelines available at: <u>https://nww.bsuh.nhs.uk/clinical/teams-and-</u> <u>departments/pharmacy/prescribing-guidelines/9-nutrition-iv-fluids-and-blood/92-refeeding-</u> <u>syndrome-guidelines-for-adults/</u>

7.2 Alcohol detoxification

Detoxification refers to a treatment program designed to help control the medical and physiological complications that may occur after a period of heavy or sustained alcohol use.

It is important to note, individuals who have experienced repeated alcohol detoxifications have an increased likelihood of experiencing severe withdrawal symptoms such as seizures, DTs or WE.

7.2.1 Assessment of patients requiring medically assisted alcohol withdrawal

For those in acute alcohol withdrawal with, or who are assessed to be at high risk of developing, alcohol related seizures or DTs (as per appendix A), offer admission to hospital for medically assisted alcohol withdrawal. Those with milder withdrawal (so lower risk) may only need 'as required' benzodiazepine.

Many dependent patients manage their alcohol withdrawal symptoms everyday with continued alcohol use and it is often appropriate for them to continue doing so until seen in community. They can then be formally assessed to determine the best course of treatment for their alcohol dependence.

Consider a lower threshold for inpatient assisted withdrawal in vulnerable groups, for example, homelessness, older people with frailty and those with cognitive impairment or learning disability.

For those attending A&E who do not require hospital admission it may be appropriate to give a stat dose of chlordiazepoxide (OR diazepam in A&E) and Pabrinex, depending on their CIWA score, to prevent withdrawal symptoms.

Where alcohol dependence or AWS is suspected, in addition to completing a full clinical history, physical examination and mental state examination, a comprehensive alcohol history and investigations are also essential (see appendix B).

7.3 Pharmacological management of alcohol withdrawal syndrome

For alcohol withdrawal protocols need to determine if low, moderate or high risk (see appendices E-G) and then select appropriate benzodiazepine. Withdrawal protocol charts found in appendices J-O and on appropriate selection should be printed and added to patient's end of bed folder.

Benzodiazepine	Rationale
Chlordiazepoxide	More gradual onset
	Long half-life
1st choice	Less risk of rebound symptoms
Diazepam	Alternative in A&E
	Use when patients are unlikely to be admitted to hospital
	However
	Higher abuse potential
	Greater risk of accumulation
Lorazepam	Short acting
	Consider when accumulation should be avoided
	For example:
	Later stage COPD
	Elderly/ frail
	Decompensated liver disease
	*These patients may not be able to metabolise long-acting drugs. Start with
	reduced benzodiazepine doses and monitor liver function closely.

The aim of detoxification using benzodiazepines is to rapidly control withdrawal symptoms and stabilize the Approved by MGC UHS April 2023

patient. The dose is gradually reduced over 5-7 days, until detox completion. The aim is to keep CIWA score below 10 to treat symptoms comfortably without causing any marked CNS depression.

The preferred medication to assist withdrawal is a benzodiazepine:

It is **vital to avoid over or under sedation** as this can cause; DTs, aspiration pneumonia, hypotension and paradoxical hostility and agitation.

Dose equivalence of chlordiazepoxide, diazepam and diazepam:

The table below is guidelines only.

Chlordiazepoxide	Diazepam	Lorazepam
12.5mg	5mg	500microgram

NB Inter-patient variability and differing half-lives mean these figures can never be exact. They should be interpreted using clinical and pharmaceutical knowledge.

Initial treatment/deciding when to give first dose of benzodiazepine

- Ideally 6-8hours after last drink
- Breath ethanol level should be falling
- The higher the alcohol dependency, the earlier withdrawal symptoms may present.
- If the individual is still highly intoxicated and experiencing withdrawal symptoms, discuss with senior physician and use with caution and close monitoring

It is better to give medication before withdrawal symptoms become significant or before investigations results are available. Prolonging treatment initiation can result in withdrawal symptoms becoming difficult to manage or development of severe complications.

It is important to note that use of benzodiazepine sedation whilst the patient is still intoxicated can lead to respiratory depression.

Along with guidelines below, please use professional clinical judgment.

Omitting doses

- Assess CIWA-Ar score (Appendix D) before giving any fixed or PRN dosing
- If CIWA-Ar below 10 and the individual is hard to rouse, consider omitting dose and monitoring NEWS and GCS
- Be aware of respiratory depression monitor pulse, respiratory rate and oximetry
- If individual only responsive to painful stimuli, alert outreach and/or on-call medical staff
- If suspicion of over sedation, omit dose
- Once individual more alert, consider breath alcohol test

UHS uses two regimens; symptom triggered regimen or fixed dose regimen.

Symptom triggered regimen

- Whilst in hospital, NICE recommend a symptom triggered regimen for individuals requiring alcohol detoxification/ in acute alcohol withdrawal.
- A symptom triggered approach involves tailoring the drug regimen according to the severity of withdrawal and any complications. The patient is monitored on a regular basis and pharmacotherapy only continued for as long as withdrawal symptoms are present.
- All staff should be competent in monitoring symptoms effectively and there should be sufficient resource to allow frequent and safe monitoring.

• The CIWA-Ar symptom triggered protocol (Appendix D) is a validated tool which can be used to tailor treatment to the individual and reduce overall time for detoxification and requirement for medication.

Only for use in A&E, AAU, Level 9a and HDU/ITU. These wards have appropriate nursing expertise to safely monitor patients.

Fixed dose regimen

All other areas must use a fixed dose regimen

Use of higher chlordiazepoxide doses in severe dependency

- Generally more effective to increase the dose of chlordiazepoxide than to add another medication
- In severe AWS, higher than BNF recommended doses of chlordiazepoxide may be required (extremely close monitoring is required and **must** be authorized by a senior physician)
- Ensure adequate supervision, individual may need 1:1 nursing until stable
- Consider increased night-time dose if symptoms become more severe at night as first line.
- Zopiclone 3.75-7.5mg ON PRN can be added second line.
- Gradually reduce chlordiazepoxide dose over 7-10 days to avoid alcohol withdrawal recurring
- Withdrawal regimens may last longer (2-3weeks) depending on severity of dependence or history of DTs.
- If patients do not respond well to higher chlordiazepoxide doses and CIWA remains high/ uncontrolled, consider alternative benzodiazepine, for example, switching to lorazepam.

7.4 Proton Pump Inhibitors (PPIs) in Acute Alcohol Withdrawal

- PPIs are **not** routinely recommended for patients requiring alcohol detox
- There is some evidence that use of PPIs in cirrhosis (especially if decompensated cirrhosis) may increase the risk of spontaneous bacterial peritonitis (SBP) and hepatic encephalopathy (HE).
- PPI usage should be based on gastrointestinal bleeding risk or in the immediate post-variceal banding phase to address post-banding ulcers. In such instances, usually a short duration of PPI is recommended based on clinical need.

7.5 Alcohol withdrawal syndrome in special patient groups

7.5.1 Liver impairment

- In patients with advanced liver cirrhosis, benzodiazepines may have a prolonged half-life. This may lead to marked and longer lasting over-sedation.
- The severity of cirrhosis can be assessed using the Childs-Pugh score (CPS) (see appendix I). Severity is graded on a scale from A, indicating well compensated cirrhosis, to C, indicating advanced cirrhosis.
- In patients with advanced cirrhosis (CPS C), chlordiazepoxide should be avoided.
- Lorazepam is less likely to accumulate and should be used in preference –appendices N and O.
- At first presentation in individuals where no biochemical data is available to guide hepatic functional assessment, the presence of large volumes of ascites and/or visibly detectable jaundice, it should be assumed they have severely impaired liver function.
- Lorazepam should be prescribed until investigations are available.

7.5.2 Elderly patients (>75 or >65 with frailty)

Elderly patients are particularly vulnerable to complications of over sedation of benzodiazepines such as

falls and aspiration pneumonia. This is due to a reduced capacity to metabolise and eliminate benzodiazepines.

 General principles to compensate for these factors are to reduce benzodiazepine doses by half and titrate according to response. Dosage intervals can also be increased if necessary and response reviewed regularly. Consider lorazepam if there is a perceived risk of accumulation – appendices N and O.

7.5.3 Respiratory Disease

Benzodiazepines may cause respiratory depression and increase risk of hypercapnoea.

In patients with COPD or severe asthma consider low dose chlordiazepoxide with symptom triggered PRN doses and more regular CIWA monitoring.

7.5.4 Nil By Mouth (NBM)

- Give regime as directed with up to 10ml of water if the patient is only NBM for a procedure or operation
- Detox with IV diazepam or lorazepam should <u>only</u> be used after discussion with a senior clinician, which may require HDU for safe monitoring.
- <u>NB:</u> Diazepam injection is contraindicated in severe liver impairment
- Diazepam IV 10mg can be given slowly into a large vein over 10minutes (MAXIMUM 4hourly in HDU)
- Absorption rate from IM diazepam may be variable and should **only** be considered if IV administration is not possible
- Do NOT use lorazepam IV with olanzapine

7.5.5 Dysphagia

Please discuss with the ward pharmacist. There are several options, however the suitability of each depends on patient specific factors.

Drug	Administration	Cost
Chlordiazepoxide	Open capsules and disperse contents in up to 10ml water	£2.16 per 100 tablets
	Can be given via enteral tubes	
Diazepam	Liquid can be given via enteral tubes Dilute with water to reduce viscosity	£30 per 100ml bottle
Lorazepam	Tablets can be given sublingually Tablets will disperse in water	£5.35 per 100 tablets

7.6 Managing detox in patients already on benzodiazepines:

- Patients already prescribed or taking illicit benzodiazepines, for example temazepam or regular diazepam prior to admission, should be continued on their normal dose in addition to the chlordiazepoxide reducing regime.
- Calculate the initial daily dose based on the requirements for alcohol withdrawal <u>plus</u> the equivalent regularly used daily dose of benzodiazepine.
- Benzodiazepine dependence or tolerance may have an impact on the required doses of chlordiazepoxide needed to control alcohol withdrawal symptoms.

7.7 Important additional medical complications

7.7.1 Dehydration, electrolyte depletion and malnutrition

- Both are likely in those who are withdrawing from prolonged alcohol binges
- These may represent an indication for admission, independent of AWS severity
- The degree of dehydration and electrolyte deficiency may be profound and require substantial replacement (particularly Mg, K+ and phosphate)
- Hypomagnesaemia is particularly significant and should be treated as it decreases seizure threshold and reduces thiamine absorption. Failure to replace magnesium may make treatment of hypokalaemia refractory.
- Dehydration and volume depletion increases autonomic activity and contributes to the physiological challenge posed by AWS.
- Crystalloid fluids containing potassium at standard maintenance rates are required if the patient is sedated and cannot ingest sufficient oral intake.
- Intravenous fluids may initially need to be given at an accelerated rate (N.B. monitor for ascites and pulmonary oedema) according to haemodynamic compromise and volume status, with consideration for common concurrent illnesses, such as advanced cardiac or liver disease.
- Sodium chloride 0.9% should be given initially for fluid and electrolyte repletion.
- <u>Glucose 5% should be reserved until haemodynamically stable and 30minutes after IV</u> thiamine (Pabrinex) has been given.
- Most patients with AUD have poor nutrition status and hence referral to dietician is essential.

7.7.2 Hypoglycaemia

• IV thiamine (Pabrinex) should always be given approximately 30minutes before glucose administration.

7.7.3 Alcoholic ketoacidosis

- Form of starvation ketosis due to carbohydrate depletion.
- Contributes to the illness and physiological instability.
- Low pH with raised capillary ketones.
- Call outreach nurses and doctor.
- Treat 30minutes after initial high dose Pabrinex with 5% glucose and 0.9% NaCl (plus potassium supplementation as necessary)

7.8 Referral to alcohol misuse services

- This is an important step to support the patient maintaining alcohol abstinence.
- This can be done at any time during admission and/or post -discharge (e.g as part of outpatient follow-up).
- This can be completed for patients living in and outside of area as the team will triage appropriately.
- Please complete referral form found on Panda 'CGL Drug and Alcohol liaison team' (found under 'Referrals' tab) please note, additional contact details for the service can be also found on the referral form.
- If further support is needed while team responds, information can be found: <u>Brighton and Hove Recovery Service | Change Grow Live</u> <u>Drug & Alcohol Wellbeing Network - West Sussex | Change Grow Live</u> <u>Drugs - STAR Drugs and Alcohol Service - East Sussex (changegrowlive.org)</u>

7.9 Discharge

- Nurse led discharge may proceed over weekends, provided a consultant plan is in place and documented in the medical notes.
- All inpatients should be prescribed oral thiamine which can be discontinued after 6 weeks if abstinent and well-nourished but should continue indefinitely if heavy drinking continues or concerns about nutritional state.

Consider/include instructions for GP to consider oral thiamine and multivitamins for all other patients (e.g.: patients in emergency department not admitted to a ward).

- Patients must NOT be discharged on chlordiazepoxide
- Provide advice to **all** patients about contacting local alcohol services (see below) or GP regarding further support post discharge.
- If a patient wishes to self-discharge, their mental capacity, as per the Mental Capacity Act 2005, must be established. Where patients are deemed to have capacity, the UHS Trust policy must be adhered to. <u>Please document accordingly</u>.
- If advising patients about continued drinking on discharge, give clear information on reducing consumption slowly rather than abruptly stopping due to the possibility of resulting seizures or DTs. <u>Ensure to document in medical notes.</u>

7.9.1 Community contact details:

- Change Grow Live (CGL) 01273 731 900
- East Sussex drug and alcohol recovery service (STAR) 0300 303 8160
- Alcoholics Anonymous (AA) 01273 203 343
- West Sussex (Crawley, Worthing, Chichester, Bognor, Haywards Heath) 0330 128 1113 or email WestSussex.Firststep@cgl.org.uk
- East Sussex (Eastbourne and Hastings) 0300 3038160 or email EastSussex.Firststep@cgl.org.uk
- East Kent (Ashford, Canterbury, Dover, Folkestone and Hythe, Swale and Thanet) 03001231186 or visit the Forward Trust website <u>https://www.forwardtrust.org.uk/</u>
- West Kent (Dartford, Gravesham and Swanley, Maidstone, Sevenoaks, Tunbridge Wells and Tonbridge and Malling) - 03301281113 or email <u>WestKent.FirstStep@cgl.org.uk</u> or visit the Change Grow Live website <u>https://www.changegrowlive.org/westkent</u>
- Surrey 03002225932 or email <u>rxx.iaccess@nhs.net</u>

Appendices:

Appendix A: Indications for hospital admission

Absolute indications for urgent hospital admission	Severe tremor, hallucinations and autonomic disturbances (may represent DT's) Confusion associated with ataxia, nystagmus, hypotension and hypothermia (may represent WE) Suicide risk (requires urgent referral to mental health) Decompensated liver disease Alcoholic hepatitis Recent withdrawal seizures Large GI or PR bleeding (suggestive of ulcer or varices)
Relative indications for urgent hospital admission	Persistent vomiting or diarrhoea that limits the individuals normal alcohol intake Signs of malnutrition (BMI <18.5 or significant weight loss) – increased risk of WE History of seizure or DTs during previous alcohol withdrawal Nil by mouth or inability to swallow History of epilepsy and/or poor compliance with epilepsy medication Significant benzodiazepine or other recreational drug use/dependence/withdrawal Electrolyte abnormalities that may lower the seizure threshold, for example, hypokalaemia or hypomagnesaemia Pregnancy
Patients that may not require inpatient alcohol detoxification	Binge or periodic drinkers whose last heavy use was over 72hours ago Patients with high risk but non-continuous alcohol use (low dependence) No alcohol on breath test 3-4 day per week drinking pattern only Recent detox in the last two weeks Consumption under 15units per day Full AUDIT < 15 (Appendix C) AUDIT C <8

Appendix B: Recommended assessments for patients requiring alcohol withdrawal

Comprehensive alcohol history

- AUDIT-C or full AUDIT score
- Units consumed per drinking day
- Date and time of first drink
- Drinking pattern
- Dependence (SADQ)
- Mild/low risk dependence SADQ 15 or less
- Moderate dependence SADQ 15-30
- Severe/high risk dependence SADQ over 30
- History of fits
- Medication
- History of complications of alcohol use (for example liver disease, GI bleed, malnutrition, peripheral neuropathy)
- Previous detox and withdrawal symptoms
- Symptoms indicative of physical dependence
- Morning drinking
- Tolerance and relief drinking
- Concurrent illicit drug use (for example, stimulants)
- Benzodiazepine use/dependence (including illicit use)
- Social circumstances (please raise child safeguarding if main carer for or around children)
- Involvement with treatment services
- History of domestic violence

Investigations

- Full blood count
- Urea and electrolytes
- Calcium, phosphate, magnesium
- Liver function tests (with albumin and GGT)
- INR
- Glucose
- Breath alcohol

Appendix C: Alcohol use disorders identification test consumption (AUDIT C) and full AUDIT questionnaire

This alcohol harm assessment tool consists of consumption questions from the full AUDIT screening tool. If you have a score of five or more, complete the remaining alcohol harm questions below to obtain a full AUDIT score.

Scoring:

- 0 to 7 indicates low risk
- 8 to 15 indicates increasing risk
- 16 to 19 indicates higher risk
- 20 or more indicates possible dependence

Questions		Scoring system					
		1	2	3	4	score	
How often do you have a drink containing alcohol?	Never	Monthly or less	2 to 4 times per month	2 to 3 times per week	4 or more times per week		
How many units of alcohol do you drink on a typical day when you are drinking?	0 to 2	3 to 4	5 to 6	7 to 9	10 or more		
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily		

AUDIT C score

Remaining AUDIT assessment questions

Questions		Scoring system				
		1	2	3	4	e
How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthl Y	Monthl Y	Weekl y	Daily or almos t daily	
How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthl y	Monthl Y	Weekl y	Daily or almos t daily	
How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthl y	Monthl Y	Weekl Y	Daily or almos t daily	
How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthl Y	Monthl Y	Weekl Y	Daily or almos t daily	
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthl Y	Monthl Y	Weekl Y	Daily or almos t daily	
Have you or somebody else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	

Appendix D: Clinical Institute Withdrawal Assessment of Alcohol Scale, Revised (CIWA-Ar)

The CIWA-Ar scale is a validated 10-item assessment tool which quantifies the severity of an individual's alcohol withdrawal symptoms. As such, CIWA-Ar provides guidance on monitoring and benzodiazepine dosage throughout withdrawal.

Attach to the drug chart and re-check every 4 hours unless CIWA-Ar is worsening, then increase monitoring until patient is stable

Nausea & Vomiting	Tremor					
Ask "Do you feel sick to your stomach? Have you	Arms extended and fingers spread apart. Observation.					
vomited?" Observation.	0. No tremor					
0. No nausea and no vomiting	 Not visible, but can be felt fingertip to fingertip 					
1. Mild nausea with no vomiting	2.					
2.	3. 4. Madarata with patient's arms extended					
 Intermittent nausea with dry heaves 	5					
5.	6.					
6.	Severe, even with arms not extended					
Constant nausea, frequent dry heaves and vomiting						
Paroxysmal sweats	Anxiety					
Observation.	Ask "Do you feel nervous?" Observation.					
0. No sweat visible	0. No anxiety, at ease					
 Barely perceptible, palms moist 	1. Mildly anxious					
2.	2.					
 Beads of sweat obvious on forehead 	 Moderately anxious, or guarded, so anxiety is inferred 					
5.	5.					
6.	6.					
7. Drenching sweats	 Equivalent to acute panic states seen in severe delirium or acute achizophropia reactions. 					
Agitation	Tactile disturbances					
Observation	Ack "Have you any itching, pine and peodles					
	sensations, any burning, any numbress or do you feel					
0. Normal activity 1. Somewhat more than normal activity	bugs crawling under your skin?" Observation.					
2.	0 None					
3.	 Very mild itching, pins & needles, burning or numbness 					
Moderately fidgety and restless	2. Mild itching, pins & needles, burning or numbness					
5.	 Moderate itching, pins & needles, burning or numbness 					
 Paces back and forth during most of the interview or 	Moderately severe nallucinations Severe hallucinations					
constantly thrashes about	6. Extremely severe hallucinations					
	7. Continuous hallucinations					
Auditory disturbances	Visual disturbances					
Ask "Are you more aware of sounds around you?	Ask "Does he light appear to be too bright? Is colour					
Are they harsh? Do they frighten you? Are you hearing aputhing that is disturbing you? Are you	different? Does it hurt your eyes? Are you seeing					
hearing anything that is disturbing you? Are you bearing things you know are not there?"	vou know are not there?" Observation					
Observation.						
0 Not present	0. Not present					
1. Very mild harshness or ability to frighten	2. Mild sensitivity					
2. Mild harshness or ability to frighten	3. Moderate sensitivity					
3. Moderate harshness or ability to frighten	Moderately severe hallucinations					
Moderately severe hallucinations Severe hallucinations	5. Severe hallucinations					
6. Extremely severe hallucinations	6. Extremely severe hallucinations 7. Continuous hallucinations					
7. Continuous hallucinations						
Headache, fullness in head	Orientation & Clouding of sensorium					
Ask "Does your head feel different? Does it feel like	Ask "What day is this? Where are you? Who am I?"					
there is a band around your head? Do not rate for	0 Orientated and can do serial additions					
dizziness and light-headedness. Otherwise, rate	 Cannot do serial additions or is uncertain about the date 					
severity.	2. Disorientated for date by no more than 2 calendar days					
0. Not present	 Disorientated for date by more than 2 calendar days 					
1. Very mild	 Usorientated for place and/or person 					
2. Milu 3. Moderate						
4. Moderately severe	I otal CIWA-Ar Score/67					
5. Severe	(Max possible score is 67) Pater's Name:					
6. Very severe	Date: / / Time (04hr)					
1. Examinity develo	Date// Time (2411):					

Appendix E: Benzodiazepine Prescribing and Monitoring In Low (CIWA-Ar <10) Risk Patients

There is no need for a fixed dose standard benzodiazepine regimen for this group of patients however please remember if an inpatient, to prescribe Pabrinex 1 pair IV ONCE a day for 3-5 days alongside PRN benzodiazepine

If using diazepam, for older/ frail people, consider starting at lower doses of diazepam.



Appendix F: Benzodiazepine Prescribing and Monitoring In Moderate (CIWA-Ar 10-15) Risk Patients

To be used in addition to appropriate benzodiazepine standard fixed dose regimen chart/protocol (chlordiazepoxide - appendix J, diazepam - appendix L, lorazepam - appendix N) If using diazepam, for older/ frail people, consider starting at lower doses of diazepam.



Appendix G: Benzodiazepine Prescribing and Monitoring In High (CIWA-Ar > 15) Risk Patients

To be used in addition to appropriate benzodiazepine standard fixed dose regimen chart/protocol (chlordiazepoxide - appendix K, diazepam - appendix M, lorazepam - appendix O).

If using diazepam, for older/ frail people, consider starting at lower doses of diazepam.



Appendix H: Medical Treatment of Aggression, agitation and confusion

- During acute AWS, there may be circumstances where a patient becomes a risk to themselves, staff, other patients and/or visitors; please consider the safety of all of these.
 - Alert security if required. Patient's may need 1:1 care and may potentially require formal Deprivation of Liberty Safeguards (DOLS).
- If the patient is not responding to benzodiazepines, the receptor sites may be saturated and therefore further doses will not increase sedation and can lead to paradoxical agitation**. In this case, please use haloperidol.
 - NB: antipsychotic therapy should not routinely be used.
 - **Signs of paradoxical effects: talkativeness, excitement, increased aggression and being antisocial behaviour



Appendix I – Childs Pugh score – to determine liver disease severity

Parameter	Score					
	1	2	3			
Ascites	None	Mild	Moderate or			
			severe			
Encephalopathy (grade)	None	1-2	3-4			
Bilirubin (micromol/L)	<35	35-50 >50				
OR						
Bilirubin in Primary Biliary Cirrhosis (micromol/L)	<70	70-170	>170			
Albumin (g/L)	>35	28-35	<28			
INR	<1.7	1.8-2.3	>2.3			

Child- Pugh grade	Child- Pugh score		1 year survival	5 year survival	10 year survival
Α	5-6	Indicates a well-functioning liver	84%	44%	27%
В	7-9	Indicates significant functional compromise	62%	20%	10%
С	10-15	Indicates decompensation of the liver	42%	21%	0%

The Child-Pugh score should be periodically reassessed as the patient's clinical condition may improve or deteriorate with time.

Reference: Specialist Pharmacy Service (SPS), October 2020. What is the Child-Pugh score? Prepared by UK Medicines Information (UKMi) <u>UKMI_QA_What_is_the_Child-</u> <u>Pugh_score_update_October_2020.pdf (sps.nhs.uk)</u>

Appendix J: Moderate Risk (CIWA 10-15) <u>Chlordiazepoxide</u> Alcohol Withdrawal Protocol Chart



Patient:

Hospital No.:

Consultant:

Ward:

Attach to standard inpatient drug chart/patient folder

DRUG (APPRO	OVED	Dose	Additional information	Date						
NAME)			-							
Chlordiazepo	xide	30mg		Day No	1	2	3	4	5	6
Prescribers name	Start date	Route		0800		Х	Х	Х	Х	Х
		PO		1200		Х	Х	Х	Х	Х
Signature	Bleep number	Frequency	Pharmacy	1600		Х	Х	Х	Х	Х
		variable		2200		Х	Х	Х	Х	Х
DRUG (APPRO NAME)	OVED	Dose	Additional information	Date						
Chlordiazepo	xide	20mg		Day No	1	2	3	4	5	6
Prescribers name	Start date	Route		0800	Х		Х	Х	Х	Х
		PO		1200	Х		Х	Х	Х	Х
Signature	Bleep number	Frequency	Pharmacy	1600	Х		Х	Х	Х	Х
		variable		2200	Х		Х	Х	Х	Х
DRUG (APPRO NAME)	OVED	Dose	Additional information	Date						
Chlordiazepo	xide	15mg		Day No	1	2	3	4	5	6
Prescribers name	Start date	Route		0800	Х	Х		Х	Х	Х
		PO		1200	Х	Х		Х	Х	Х
Signature	Bleep number	Frequency	Pharmacy	1600	Х	Х		Х	Х	Х
		variable		2200	Х	Х		Х	Х	Х
DRUG (APPRO NAME)	OVED	Dose	Additional information	Date						
Chlordiazepo	xide	10mg		Day No	1	2	3	4	5	6
Prescribers name	Start date	Route		0800	Х	Х	Х			Х
		PO		1200	Х	Х	Х	Х	Х	Х
Signature	Bleep number	Frequency	Pharmacy	1600	Х	Х	Х		Х	Х
		variable		2200	Х	Х	Х			
Clinical I	Pabr response - <u>1</u>	inex 2 pair If pair IV OD	s IV THREE times no response – dis for a further 5 day	s daily for 2 continue <u>s</u> OR until	2 days	s ther al imp	n rovem	ent ce	ases	

Please also complete CIWA-Ar scale (overleaf) for appropriate patient monitoring.

Clinical Institute Withdrawal Assessment of Alcohol (CIWA-Ar) Scale

The CIWA-Ar scale is a validated 10-item assessment tool which quantifies the severity of an individual's alcohol withdrawal symptoms. As such, CIWA-Ar provides guidance on monitoring and benzodiazepine dosage throughout withdrawal.

Attach to the drug chart and re-check every 4 hours unless CIWA-Ar is worsening, then increase monitoring until patient is stable

Nausea & Vomiting	Tremor				
Ask "Do you feel sick to your stomach? Have you	Arms extended and fingers spread apart. Observation.				
vomited?" Observation.	0. No tremor				
0. No nausea and no vomiting	 Not visible, but can be felt fingertip to fingertip 				
2.	3.				
3.	Moderate, with patient's arms extended				
 Intermittent nausea with dry heaves 	5.				
6.	 Severe, even with arms not extended 				
7. Constant nausea, frequent dry heaves and vomiting					
Paroxysmal sweats	Anxiety				
Observation.	Ask "Do you feel nervous?" Observation.				
0. No sweat visible	0. No anxiety, at ease				
1. Barely perceptible, palms moist	1. Mildly anxious				
3.	3.				
Beads of sweat obvious on forehead	4. Moderately anxious, or guarded, so anxiety is inferred				
5.	5.				
7. Drenching sweats	 Equivalent to acute panic states seen in severe delirium 				
	or acute schizophrenic reactions.				
Agitation	Tactile disturbances				
Observation.	Ask "Have you any itching, pins and needles				
0. Normal activity	bugs crawling under your skin?" Observation.				
Somewhat more than normal activity	0 None				
3.	 Very mild itching, pins & needles, burning or numbness 				
 Moderately fidgety and restless 	2. Mild itching, pins & needles, burning or numbness				
5.	Moderate itching, pins & needles, burning or numbress Moderately severe ballucinations				
7. Paces back and forth during most of the interview or	5. Severe hallucinations				
constantly thrashes about	6. Extremely severe hallucinations				
Auditory disturbances	7. Continuous hallucinations				
Ask "Are you more aware of sounds around you?	Ask "Does he light appear to be too bright? Is colour				
Are they harsh? Do they frighten you? Are you	different? Does it hurt your eyes? Are you seeing				
hearing anything that is disturbing you? Are you	anything that is disturbing you? Are you seeing things				
Deservation	you know are not there?" Observation.				
	0. Not present				
1. Very mild harshness or ability to frighten	2 Mild sensitivity				
2. Mild harshness or ability to frighten	3. Moderate sensitivity				
3. Moderate harshness or ability to frighten	4. Moderately severe hallucinations				
5. Severe hallucinations	5. Severe hallucinations				
Extremely severe hallucinations	7. Continuous hallucinations				
7. Continuous hallucinations	Orientation & Clauding of concerium				
Headache, fullness in head	Orientation & Clouding of Sensorium				
Ask "Does your head feel different? Does it feel like	Ask "What day is this? Where are you? Who am I?"				
dizziness and light-headedness. Otherwise, rate	0. Orientated and can do serial additions				
severity.	Cannot do serial additions or is uncertain about the date Disorientated for date by no more than 2 calendar days				
0. Not present	 Disorientated for date by more than 2 calendar days 				
1. Very mild	Disorientated for place and/or person				
2. Mild 3. Moderate					
4. Moderately severe	Total CIWA-Ar Score/67				
5. Severe	(Max possible score is 67)				
6. Very severe	Date: / / Time (24br)				
r. Extending severe	Date//				

Appendix K: High Risk (CIWA >15) <u>Chlordiazepoxide</u> Alcohol Withdrawal Protocol Chart



Patient:

Hospital No.:

Consultant:

Ward:

Attach to standard inpatient drug chart/patient folder

DRUG (APPI	ROVED	Dose	Additional	Date								
NAME)	NAME)		information									
Chlordiazep	oxide	40mg		Day No	1	2	3	4	5	6	7	8
Prescribers	Start date	Route		0800			Х	Х	Х	Х	Х	Х
name		PO		1200		Х	Х	Х	Х	Х	Х	Х
Signature	Bleep	Frequency	Pharmacy	1600		Х	Х	Х	Х	Х	Х	Х
	number	variable		2200			Х	Х	Х	Х	Х	Х
DRUG (APPI NAME)	ROVED	Dose	Additional information	Date								
Chlordiazep	oxide	20mg		Day No	1	2	3	4	5	6	7	8
Prescribers	Start date	Route		0800	Х	Х		Х	Х	Х	Х	Х
name		PO		1200	Х			Х	Х	Х	Х	Х
Signature	Bleep	Frequency	Pharmacy	1600	Х			Х	Х	Х	Х	Х
	number	variable		2200	Х	Х		Х	Х	Х	Х	Х
DRUG (APPI NAME)	ROVED	Dose	Additional information	Date								
Chlordiazep	oxide	15mg		Day No	1	2	3	4	5	6	7	8
Prescribers	Start date	Route		0800	Х	Х	Х		Х	Х	Х	Х
name		PO		1200	Х	Х	Х		Х	Х	Х	Х
Signature	Bleep	Frequency	Pharmacy	1600	Х	Х	Х		Х	Х	Х	Х
	number	variable		2200	Х	Х	Х		Х	Х	Х	Х
DRUG (APPI NAME)	ROVED	Dose	Additional information	Date								
Chlordiazep	oxide	10mg		Day No	1	2	3	4	5	6	7	8
Prescribers	Start date	Route		0800	Х	Х	Х	Х				Х
name		PO		1200	Х	Х	Х	Х		Х	Х	Х
Signature	Bleep	Frequency	Pharmacy	1600	Х	Х	Х	Х			Х	Х
	number	variable		2200	Х	Х	Х	Х				
Pabr	inex 2 pair	s IV THREE	times daily for	2 days the	en If i	no re	spon	se – o	disco	ntinu	e	
Clinica	l response	- <u>1 pair IV O</u>	<u>D for a further</u>	<u>5 days</u> OR ı	until	clinica	al imp	orove	ment	t cea	ses	

Please also complete CIWA-Ar scale (overleaf) for appropriate patient monitoring.

Clinical Institute Withdrawal Assessment of Alcohol (CIWA-Ar) Scale

The CIWA-Ar scale is a validated 10-item assessment tool which quantifies the severity of an individual's alcohol withdrawal symptoms. As such, CIWA-Ar provides guidance on monitoring and benzodiazepine dosage throughout withdrawal.

Attach to the drug chart and re-check every 4 hours unless CIWA-Ar is worsening, then increase monitoring until patient is stable

Nausea & Vomiting	Tremor				
Ask "Do you feel sick to your stomach? Have you	Arms extended and fingers spread apart. Observation.				
vomited?" Observation.	0 No tremor				
0. No nausea and no vomiting	 Not visible, but can be felt fingertip to fingertip 				
 Mild nausea with no vomiting 	2.				
2.	3. 4. Moderate with patient's arms extended				
Intermittent nausea with dry beaves	5				
5.	6.				
6.	Severe, even with arms not extended				
Constant nausea, frequent dry heaves and vomiting					
Paroxysmal sweats	Anxiety				
Observation.	Ask "Do you feel nervous?" Observation.				
0. No sweat visible	0. No anxiety, at ease				
1. Barely perceptible, palms moist	1. Mildly anxious				
2.	2.				
 Beads of sweat obvious on forehead 	 Moderately anxious, or guarded, so anxiety is inferred 				
5.	5.				
6. 7. Desetis	6.				
7. Drenching sweats	 Equivalent to acute panic states seen in severe delinum or acute schizophrenic reactions 				
Agitation	Tactile disturbances				
Observation	Ask "Have you any itching, pins and needles				
	sensations, any burning, any numbness or do you feel				
Normal activity Somewhat more than normal activity	bugs crawling under your skin?" Observation.				
2.	0. None				
3.	1. Very mild itching, pins & needles, burning or numbness				
4. Moderately fidgety and restless	 Mild itching, pins & needles, burning or numbness 				
5.	Moderate ltcning, pins & needles, burning or numbress Moderately severe ballucinations				
7. Paces back and forth during most of the interview or	5. Severe hallucinations				
constantly thrashes about	Extremely severe hallucinations				
Auditory disturbances	7. Continuous hallucinations				
Addition y disturbances	Visual disturbances				
Ask "Are you more aware of sounds around you? Are they harsh? Do they frighten you? Are you	Ask "Does ne light appear to be too bright? Is colour different? Does it hurt your eves? Are you seeing				
hearing anything that is disturbing you? Are you	anything that is disturbing you? Are you seeing things				
hearing things you know are not there?"	you know are not there?" Observation.				
Observation.	0. Not present				
0. Not present	1. Very mild sensitivity				
 Very mild harshness or ability to frighten 	2. Mild sensitivity				
Mild harshness or ability to frighten Moderate barshness or ability to frighten	3. Moderate sensitivity				
4. Moderately severe hallucinations	Severe hallucinations				
5. Severe hallucinations	6. Extremely severe hallucinations				
6. Extremely severe hallucinations	7. Continuous hallucinations				
Headache fullness in head	Orientation & Clouding of sensorium				
riedudene, ruiness in neau	Chemation & Clouding of Sensorium				
Ask "Does your head feel different? Does it feel like	Ask "What day is this? Where are you? Who am I?"				
there is a band around your head? Do not rate for dizziness and light-beadedness. Otherwise, rate	Orientated and can do serial additions				
severity.	1. Cannot do serial additions or is uncertain about the date				
0 Not present	3. Disorientated for date by more than 2 calendar days				
1. Very mild	 Disorientated for place and/or person 				
2. Mild					
3. Moderate	Total CIWA-Ar Score /67				
Moderately severe Severe	(Max possible score is 67)				
6. Very severe	Rater's Name:				
7. Extremely severe	Date: _ / _ / Time (24hr) _ : _				
1					

Appendix L: Moderate Risk (CIWA 10-15) <u>Diazepam</u> Alcohol Withdrawal Protocol Chart

Is this the correct chart:		
Likely to get admitted, no		Use alcohol withdrawal
liver		protocol chart
Unlikely to be admitted/pt	1	Use alcohol withdrawal
Later stage COPD, elderly /	-	Use alcohol withdrawal
frail or decompensated/CP-C		LORAZEPAM protocol
liver disease		chart

Patient: Hospital No.: Consultant: Ward:

Attach to standard inpatient drug chart/patient folder

DRUG (APPRC	DVED	Dose	Additional information	Date						
NAME)										
Diazepam		15mg		Day No	1	2	3	4	5	6
Prescribers name	Start date	Route		0800		Х	Х	Х	Х	Х
		PO		1200		Х	Х	Х	Х	Х
Signature	Bleep number	Frequency	Pharmacy	1600		Х	Х	Х	Х	Х
		variable		2200		Х	Х	Х	Х	Х
DRUG (APPRC	DVED	Dose	Additional information	Date						
NAME)										
Diazepam		10mg		Day No	1	2	3	4	5	6
Prescribers name	Start date	Route		0800	Х			Х	Х	Х
		PO		1200	Х			Х	Х	Х
Signature	Bleep number	Frequency	Pharmacy	1600	Х			Х	Х	Х
		variable		2200	Х			Х	Х	Х
DRUG (APPRC	VED	Dose	Additional information	Date						
NAME)										
Diazepam		5mg		Day No	1	2	3	4	5	6
Prescribers name	Start date	Route		0800	Х	Х	Х			Х
		PO		1200	Х	Х	Х	Х	Х	Х
Signature	Bleep number	Frequency	Pharmacy	1600	Х	Х	Х		Х	Х
		variable		2200	Х	Х	Х			
	Pabrinex 2 pairs IV THREE times daily for 2 days then									
		lf	no response - dis	continue						
Clinical r	esponse - <u>1</u>	pair IV OD	for a further 5 day	<u>s</u> OR until	clinica	al imp	rovem	ent ce	eases	

Please also complete CIWA-Ar scale (overleaf) for appropriate patient monitoring.

Clinical Institute Withdrawal Assessment of Alcohol (CIWA-Ar) Scale

The CIWA-Ar scale is a validated 10-item assessment tool which quantifies the severity of an individual's alcohol withdrawal symptoms. As such, CIWA-Ar provides guidance on monitoring and benzodiazepine dosage throughout withdrawal.

Attach to the drug chart and re-check every 4 hours unless CIWA-Ar is worsening, then increase monitoring until patient is stable

Nausea & Vomiting	Tremor				
Ask "Do you feel sick to your stomach? Have you	Arms extended and fingers spread apart. Observation.				
vomited?" Observation.	0 No tremor				
0. No nausea and no vomiting	 Not visible, but can be felt fingertip to fingertip 				
 Mild nausea with no vomiting 	2.				
2.	3. 4. Moderate with patient's arms extended				
Intermittent nausea with dry beaves	5				
5.	6.				
6.	Severe, even with arms not extended				
Constant nausea, frequent dry heaves and vomiting					
Paroxysmal sweats	Anxiety				
Observation.	Ask "Do you feel nervous?" Observation.				
0. No sweat visible	0. No anxiety, at ease				
1. Barely perceptible, palms moist	1. Mildly anxious				
2.	2.				
 Beads of sweat obvious on forehead 	 Moderately anxious, or guarded, so anxiety is inferred 				
5.	5.				
6. 7. Desetis	6.				
7. Drenching sweats	 Equivalent to acute panic states seen in severe delinum or acute schizophrenic reactions 				
Agitation	Tactile disturbances				
Observation	Ask "Have you any itching, pins and needles				
	sensations, any burning, any numbness or do you feel				
Normal activity Somewhat more than normal activity	bugs crawling under your skin?" Observation.				
2.	0. None				
3.	1. Very mild itching, pins & needles, burning or numbness				
4. Moderately fidgety and restless	 Mild itching, pins & needles, burning or numbness 				
5.	Moderate ltcning, pins & needles, burning or numbress Moderately severe ballucinations				
7. Paces back and forth during most of the interview or	5. Severe hallucinations				
constantly thrashes about	Extremely severe hallucinations				
Auditory disturbances	7. Continuous hallucinations				
Addition y disturbances	Visual disturbances				
Ask "Are you more aware of sounds around you? Are they harsh? Do they frighten you? Are you	Ask "Does ne light appear to be too bright? Is colour different? Does it hurt your eves? Are you seeing				
hearing anything that is disturbing you? Are you	anything that is disturbing you? Are you seeing things				
hearing things you know are not there?"	you know are not there?" Observation.				
Observation.	0. Not present				
0. Not present	1. Very mild sensitivity				
 Very mild harshness or ability to frighten 	2. Mild sensitivity				
Mild harshness or ability to frighten Moderate barshness or ability to frighten	3. Moderate sensitivity				
4. Moderately severe hallucinations	Severe hallucinations				
5. Severe hallucinations	6. Extremely severe hallucinations				
6. Extremely severe hallucinations	7. Continuous hallucinations				
Headache fullness in head	Orientation & Clouding of sensorium				
riedudene, ruiness in neau	Chemation & Clouding of Sensorium				
Ask "Does your head feel different? Does it feel like	Ask "What day is this? Where are you? Who am I?"				
there is a band around your head? Do not rate for dizziness and light-beadedness. Otherwise, rate	Orientated and can do serial additions				
severity.	1. Cannot do serial additions or is uncertain about the date				
0 Not present	3. Disorientated for date by more than 2 calendar days				
1. Very mild	 Disorientated for place and/or person 				
2. Mild					
3. Moderate	Total CIWA-Ar Score /67				
Moderately severe Severe	(Max possible score is 67)				
6. Very severe	Rater's Name:				
7. Extremely severe	Date: _ / _ / Time (24hr) _ : _				
1					

Appendix M: High Risk (CIWA >15) <u>Diazepam</u> Alcohol Withdrawal Protocol Chart

Is this the correct chart:		
Likely to get admitted, no COPD, not elderly/frail, healthy liver		Use alcohol withdrawal CHLORDIAZEPOXIDE protocol chart
Unlikely to be admitted/pt staying in A&E		Use alcohol withdrawal DIAZEPAM protocol chart
Later stage COPD, elderly / frail or decompensated/CP-C liver disease	\Rightarrow	Use alcohol withdrawal LORAZEPAM protocol chart

Patient: Hospital No.: Consultant: Ward:

Attach to standard inpatient drug chart/patient folder

DRUG (APPROVED NAME)		Dose	Additional information	Date								
Diazepam		20mg		Day No	1	2	3	4	5	6	7	8
Prescribers name	Start date	Route		0800			Х	Х	Х	Х	Х	Х
		PO		1200		Х	Х	Х	Х	Х	Х	Х
Signature	Bleep number	Frequency	Pharmacy	1600		Х	Х	Х	Х	Х	Х	Х
		variable		2200			Х	Х	Х	Х	Х	Х
DRUG (APP	ROVED NAME)	Dose	Additional	Date								
Diazepam		15mg	information	Day No	1	2	3	4	5	6	7	8
Prescribers name	Start date	Route		0800	Х	Х		Х	Х	Х	Х	Х
		PO		1200	Х			Х	Х	Х	Х	Х
Signature	Bleep number	Frequency	Pharmacy	1600	Х			Х	Х	Х	Х	Х
		variable		2200	Х	Х		Х	Х	Х	Х	Х
DRUG (APPROVED NAME)		Dose	Additional information	Date								
Diazepam		10mg		Day No	1	2	3	4	5	6	7	8
Prescribers name Start date		Route		0800	Х	Х	Х		Х	Х	Х	Х
		PO		1200	Х	Х	Х		Х	Х	Х	Х
Signature	Bleep number	Frequency	Pharmacy	1600	Х	Х	Х		Х	Х	Х	Х
		variable		2200	Х	Х	Х		Х	Х	Х	Х
DRUG (APP	ROVED NAME)	Dose	Additional	Date								
Diazepam		5mg	information	Day No	1	2	3	4	5	6	7	8
Prescribers name	Start date	Route		0800	Х	Х	Х	Х				Х
		PO		1200	Х	Х	Х	Х		Х	Х	Х
Signature	Bleep number	Frequency	Pharmacy	1600	Х	Х	Х	Х			Х	Х
		variable	2200	Х	Х	Х	Х					
Pabrinex 2 pairs IV THREE times daily for 2 days then												
	If no response – discontinue											
Clinical response - <u>1 pair IV OD for a further 5 days</u> OR until clinical improvement ceases												

Please also complete CIWA-Ar scale (overleaf) for appropriate patient monitoring.

Clinical Institute Withdrawal Assessment of Alcohol (CIWA-Ar) Scale

The CIWA-Ar scale is a validated 10-item assessment tool which quantifies the severity of an individual's alcohol withdrawal symptoms. As such, CIWA-Ar provides guidance on monitoring and benzodiazepine dosage throughout withdrawal.

Attach to the drug chart and re-check every 4 hours unless CIWA-Ar is worsening, then increase monitoring until patient is stable

Ask "Do you feel sick to your stomach? Have you vomited?" Observation. Arms extended and fingers spread apart. Observation. 0. No nauses and no vorniting 1. Not visible, but can be felt fingertip to fingertip 1. Mid nauses with no vorniting 2. 3. 4. Intermittent nauses with dry heaves 6. 6. 7. Constant nauses, frequent dry heaves and vorniting 7. Severe, even with arms not extended 7. Constant nauses, frequent dry heaves and vorniting 7. Severe, even with arms not extended 7. Constant nauses, frequent dry heaves and vorniting 7. Severe, even with arms not extended 8. Beads of sweat visible 0. No arxiety: a tease 1. Midly anxious 7. Derenching sweats 7. Equivalent to acute panic states seen in severe delirium or acute schizophrenic reactions. 3. 8. Moderately fidgety and resitess 6. 6. 7. Paces back and forth during most of the interview or constantly thrashes about 7. Nornel 7. Paces back and forth during most of the interview or constantly thrashes or ability to frighten you? Are you seeing thirds, pins & filedite, burning or numbness 8. 9. Notereent 9. Not present 9. Notereent 1. Very mild tarshness or ability to frighten you? Are you seeing thirds you Are you seeing thirds you have are thea? 9.	Nausea & Vomiting	Tremor						
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	vomited?" Observation.	0. No tremor						
	0. No nausea and no vomiting	 Not visible, but can be felt fingertip to fingertip 						
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	3.	 Moderate, with patient's arms extended 						
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Observation. 0. Not present 0. Not present 1. Very mild harshness or ability to frighten 1. Wery mild harshness or ability to frighten 2. Mild sensitivity 2. Mild harshness or ability to frighten 3. Moderate harshness or ability to frighten 3. Moderate harshness or ability to frighten 4. Moderately severe hallucinations 5. Severe hallucinations 5. Severe hallucinations 6. Extremely severe hallucinations 6. Extremely severe hallucinations 7. Continuous hallucinations 7. Continuous hallucinations 8. Extremely severe hallucinations 7. Continuous hallucinations 9. Not present 0. Orientated and can do serial additions 1. Very mild 2. Mild 0. Not present 0. Orientated for date by no more than 2 calendar days 1. Very mild 2. Mild 3. Moderate 4. Moderately severe 4. Moderately severe 4. Moderately severe 4. Moderately severe 6. Extremely severe 1. Very mild 2. Mild 3. Moderate 4. Moderately severe 4. Moderately severe 6. Disorientated for place and/or person 7. Cotal CIWA-Ar Score /67	hearing things you know are not there?"	you know are not there?" Observation.						
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 Very mild narshness or ability to frighten Moderate harshness or ability to frighten Moderate harshness or ability to frighten Moderately severe hallucinations Severe hallucinations Extremely severe hallucinations Extremely severe hallucinations Extremely severe hallucinations Continuous hallucinations Extremely severe hallucinations Continuous hallucinations Continuous hallucinations Extremely severe hallucinations Continuous hallucinations C	0. Not present	1. Very mild sensitivity						
 Moderate harshness or ability to frighten Moderately severe hallucinations Severe hallucinations Extremely severe hallucinations Extremely severe hallucinations Continuous hallucinations Continuous	Very mild harshness or ability to frighten Mild harshness or ability to frighten	2. Mild sensitivity 3. Moderate sensitivity						
 4. Moderately severe hallucinations 5. Severe hallucinations 6. Extremely severe hallucinations 7. Continuous hallucinations 8. Extremely severe hallucinations 9. Orientated or a can do serial additions 1. Cannot do serial additions or is uncertain about the date 2. Disorientated for date by no more than 2 calendar days 3. Disorientated for place and/or person 7. Cotal CIWA-Ar Score [3. Moderate harshness or ability to frighten	4. Moderately severe hallucinations						
5. Extremely severe hallucinations 6. Extremely severe hallucinations 7. Continuous hallucinations 8. Whet day is this? Where are you? Who am I?" 0. Orientated and can do serial additions 1. Cannot do serial additions or is uncertain about the date 2. Mild 3. Moderate 4. Moderately severe 7. Contai CIWA-Ar Score (Max possible score is 67)	Moderately severe hallucinations Severe hallucinations	5. Severe hallucinations						
7. Continuous hallucinations 7. Continuous hallucinations Headache, fullness in head Orientation & Clouding of sensorium Ask "Does your head feel different? Does it feel like there is a band around your head? Do not rate for dizziness and light-headedness. Otherwise, rate severity. Orientation & Clouding of sensorium 0. Not present Ask "What day is this? Where are you? Who am I?" 0. Not present Cannot do serial additions or is uncertain about the date 2. Mild Disorientated for date by more than 2 calendar days 3. Moderate Disorientated for place and/or person 4. Moderately severe Total CIWA-Ar Score (Max possible score is 67)	6. Extremely severe hallucinations	6. Extremely severe hallucinations						
Headache, fullness in head Orientation & Clouding of sensorium Ask "Does your head feel different? Does it feel like there is a band around your head? Do not rate for dizziness and light-headedness. Otherwise, rate severity. Ask "What day is this? Where are you? Who am I?" 0. Not present 0. Not present 1. Cannot do serial additions or is uncertain about the date 2. Mild 3. Moderate Disorientated for date by more than 2 calendar days 4. Moderately severe Cotal CIWA-Ar Score (Max possible score is 67)	7. Continuous hallucinations							
Ask "Does your head feel different? Does it feel like there is a band around your head? Do not rate for dizziness and light-headedness. Otherwise, rate severity. Ask "What day is this? Where are you? Who am I?" 0. Not present 0. Not present 1. Very mild 2. Mild 3. Moderate 4. Moderately severe 4. Moderately severe Content CIUMA-Ar Score ////////////////////////////////////	Headache, fullness in head	Orientation & Clouding of sensorium						
there is a band around your head? Do not rate for dizziness and light-headedness. Otherwise, rate severity. 0. Orientated and can do serial additions 0. Not present 1. Very mild 2. Mild 3. Moderate 4. Moderately severe Content of the present 5. Not present 1. Very mild 6. Moderate 1. Very mild 7. Not present 1. Very mild 8. Moderate 1. Very mild 9. Moderate	Ask "Does your head feel different? Does it feel like	Ask "What day is this? Where are you? Who am I?"						
dizziness and light-headedness. Otherwise, rate severity. 1. Cannot do serial additions or is uncertain about the date 2. Disorientated for date by no more than 2 calendar days 3. Disorientated for date by more than 2 calendar days 4. Disorientated for date by more than 2 calendar days 4. Disorientated for place and/or person 1. Very mild 2. Mild 3. Moderate Total CIWA-Ar Score []/67 4. Moderately severe (Max possible score is 67)	there is a band around your head? Do not rate for	0. Orientated and can do serial additions						
2. Disorientated for date by no more than 2 calendar days 3. Disorientated for date by more than 2 calendar days 3. Disorientated for date by more than 2 calendar days 4. Disorientated for date by more than 2 calendar days 4. Disorientated for date by more than 2 calendar days 4. Disorientated for date by more than 2 calendar days 4. Disorientated for date by more than 2 calendar days 4. Disorientated for date by more than 2 calendar days 4. Disorientated for date by more than 2 calendar days 4. Disorientated for date by more than 2 calendar days 4. Disorientated for date by more than 2 calendar days 4. Disorientated for date by more than 2 calendar days 4. Disorientated for date by more than 2 calendar days 4. Disorientated for date by more than 2 calendar days 4. Disorientated for date by more than 2 calendar days 4. Disorientated for date by more than 2 calendar days 4. Disorientated for date by more than 2 calendar days 4. Disorientated for place and/or person 4. Moderately severe	dizziness and light-headedness. Otherwise, rate	1. Cannot do serial additions or is uncertain about the date						
0. Not present 5. Disordentated for date by indicating 2 calculated days 1. Very mild 4. Disordentated for place and/or person 2. Mild Total CIWA-Ar Score/67 4. Moderately severe (Max possible score is 67)	Seventy.	 Disorientated for date by no more than 2 calendar days Disorientated for date by more than 2 calendar days 						
2. Mild 3. Moderate 4. Moderately severe (Max possible score is 67) (Max possible score is 67)	0. Not present 1. Very mild	4. Disorientated for place and/or person						
3. Moderate 4. Moderately severe //67 (Max possible score is 67)	2. Mild							
4. moderatery severe (Max possible score is 67)	3. Moderate	Total CIWA-Ar Score /67						
5. Severe	Moderatery severe Severe	(Max possible score is 67)						
6. Very severe Rater's Name:	6. Very severe	Rater's Name:						
7. Extremely severe Date: _ / _ / Time (24hr) _ :	7. Extremely severe	Date:// Time (24hr):						

Appendix N: Moderate Risk (CIWA 10-15) Lorazepam Alcohol Withdrawal Protocol Chart

Is this the correct chart:		Detient
Likely to get admitted, no	Use alcohol withdrawal	Patient
COPD, not elderly/frail, healthy	CHLORDIAZEPOXIDE	Hospita
liver	protocol chart	
Unlikely to be admitted/pt	Use alcohol withdrawal	Consul
staying in A&E	DIAZEPAM protocol chart	Ward
		vvaru.
Later stage COPD, elderly /	Use alcohol withdrawal	
frail or decompensated/CP-C	LORAZEPAM protocol	
liver disease	 chart	

al No.:

ant:

Attach to standard inpatient drug chart/patient folder

DRUG (APPROVED NAME)		Dose	Additional	Date						
Lorazepam		1mg	Information	Day No	1	2	3	4	5	6
Prescribers name	Start date	Route		0800			Х	Х	Х	Х
		PO		1200			Х	Х	Х	Х
Signature	Bleep number	Frequency	Pharmacy	1600			Х	Х	Х	Х
		variable		2200			Х	Х	Х	Х
DRUG (APPROVED NAME)		Dose	Additional information	Date						
Lorazepam		500micrograms		Day No	1	2	3	4	5	6
Prescribers name	Start date	Route		0800	Х	Х				Х
		PO		1200	Х	Х		Х	Х	Х
Signature	Bleep number	Frequency	Pharmacy	1600	Х	Х			Х	Х
	varia	variable		2200	Х	Х				
Pabrinex 2 pairs IV THREE times daily for 2 days then										
If no response – discontinue										
Clinical	Clinical response - 1 pair IV OD for a further 5 days OR until clinical improvement ceases									

Please also complete CIWA-Ar scale (overleaf) for appropriate patient monitoring.

Clinical Institute Withdrawal Assessment of Alcohol (CIWA-Ar) Scale

The CIWA-Ar scale is a validated 10-item assessment tool which quantifies the severity of an individual's alcohol withdrawal symptoms. As such, CIWA-Ar provides guidance on monitoring and benzodiazepine dosage throughout withdrawal.

Attach to the drug chart and re-check every 4 hours unless CIWA-Ar is worsening, then increase monitoring until patient is stable

Nausea & Vomiting	Tremor						
Ask "Do you feel sick to your stomach? Have you	Arms extended and fingers spread apart. Observation.						
vomited?" Observation.	0. No tremor						
0. No nausea and no vomiting	 Not visible, but can be felt fingertip to fingertip 						
 Mild nausea with no vomiting 	2.						
2.	3. 4. Moderate with patient's arms extended						
Intermittent nausea with dry beaves	5						
5.	6.						
6.	Severe, even with arms not extended						
Constant nausea, frequent dry heaves and vomiting							
Paroxysmal sweats	Anxiety						
Observation.	Ask "Do you feel nervous?" Observation.						
0. No sweat visible	0. No anxiety, at ease						
1. Barely perceptible, palms moist	1. Mildly anxious						
2.	2.						
 Beads of sweat obvious on forehead 	 Moderately anxious, or guarded, so anxiety is inferred 						
5.	5.						
6. 7. Desetis	6.						
7. Drenching sweats	 Equivalent to acute panic states seen in severe delinum or acute schizophrenic reactions 						
Agitation	Tactile disturbances						
Observation.	Ask "Have you any itching, pins and needles						
0 Normal activity	sensations, any burning, any numbness or do you feel						
1. Somewhat more than normal activity	bugs crawling under your skin?" Observation.						
2.	0. None						
3.	1. Very mild itching, pins & needles, burning or numbness						
4. Moderately fidgety and restless	 Mild itching, pins & needles, burning or numbness 						
5.	Moderate ltcning, pins & needles, burning or numbress Moderately severe ballucinations						
7. Paces back and forth during most of the interview or	5. Severe hallucinations						
constantly thrashes about	Extremely severe hallucinations						
Auditory disturbances	7. Continuous hallucinations						
Auditory disturbances	Visual disturbances						
Ask "Are you more aware of sounds around you? Are they harsh? Do they frighten you? Are you	Ask "Does ne light appear to be too bright? Is colour different? Does it hurt your eves? Are you seeing						
hearing anything that is disturbing you? Are you	anything that is disturbing you? Are you seeing things						
hearing things you know are not there?"	you know are not there?" Observation.						
Observation.	0 Not present						
0. Not present	1. Very mild sensitivity						
 Very mild harshness or ability to frighten 	2. Mild sensitivity						
Mild harshness or ability to frighten Moderate barshness or ability to frighten	3. Moderate sensitivity						
4. Moderately severe hallucinations	wooderately severe nallucinations Severe hallucinations						
5. Severe hallucinations	6. Extremely severe hallucinations						
6. Extremely severe hallucinations	7. Continuous hallucinations						
7. Continuous hallucinations	Orientation & Clouding of concerium						
Headache, ruiness in head	Orientation & Clouding of Sensorium						
Ask "Does your head feel different? Does it feel like	Ask "What day is this? Where are you? Who am I?"						
there is a band around your head? Do not rate for distinges and light boadedness. Otherwise, rate	0. Orientated and can do serial additions						
severity.	 Cannot do serial additions or is uncertain about the date Displayed for data based on the series of th						
0 Not among t	Disorrentated for date by no more than 2 calendar days Disorrentated for date by more than 2 calendar days						
1. Very mild	 Disorientated for place and/or person 						
2. Mild							
3. Moderate	Total CIWA-Ar Score /67						
4. Moderately severe	(Max possible score is 67)						
6. Very severe	Rater's Name:						
7. Extremely severe	Date:// Time (24hr):						

Appendix O: High Risk (CIWA >15) Lorazepam Alcohol Withdrawal Protocol Chart

Is this the correct chart:		
Likely to get admitted, no COPD, not elderly/frail, healthy liver		Use alcohol withdrawal CHLORDIAZEPOXIDE protocol chart
Unlikely to be admitted/pt staying in A&E	\Rightarrow	Use alcohol withdrawal DIAZEPAM protocol chart
Later stage COPD, elderly / frail or decompensated/CP-C liver disease		Use alcohol withdrawal LORAZEPAM protocol chart

Patient: Hospital No.:

Consultant:

Ward:

Attach to standard inpatient drug chart/patient folder

DRUG (AP	PROVED	Dose	Additional	Date							
NAME)			mormation								
Lorazepan	า	2mg		Day No	1	2	3	4	5	6	7
Prescribers nan	ne Start date	Route		0800		Х	Х	Х	Х	Х	Х
		PO		1200		Х	Х	Х	Х	Х	Х
Signature	Bleep number	Frequency	Pharmacy	1600		Х	Х	Х	Х	Х	Х
		variable		2200		Х	Х	Х	Х	Х	Х
DRUG (AP NAME)	PROVED	Dose	Additional information	Date							
Lorazepan	า	1.5mg		Day No	1	2	3	4	5	6	7
Prescribers nan	ne Start date	Route		0800	Х		Х	Х	Х	Х	Х
		PO		1200	Х		Х	Х	Х	Х	Х
Signature	Bleep number	Frequency	Pharmacy	1600	Х		Х	Х	Х	Х	Х
		variable		2200	Х		Х	Х	Х	Х	Х
DRUG (APPROVED NAME)		Dose	Additional information	Date							
Lorazepan	า	1mg		Day No	1	2	3	4	5	6	7
Prescribers nan	ne Start date	Route		0800	Х	Х				Х	Х
		PO		1200	Х	Х		Х	Х	Х	Х
Signature	Bleep number	Frequency	Pharmacy	1600	Х	Х			Х	Х	Х
		variable		2200	Х	Х				Х	Х
DRUG (AP NAME)	PROVED	Dose	Additional information	Date							
Lorazepan	า	500 micrograms		Day No	1	2	3	4	5	6	7
Prescribers nar	ne Start date	Route	1	0800	Х	Х	Х	Х	Х		Х
		PO		1200	Х	Х	Х	Х	Х	Х	Х
Signature	Bleep number	Frequency	Pharmacy	1600	Х	Х	Х	Х	Х		Х
		variable		2200	Х	Х	Х	Х	Х		
		Pabrinex 2 pairs IV	/ THREE tim	nes daily fo	or 2 da	ays th	en				
		lf no	response – d	discontinue)						
CI	Clinical response - <u>1 pair IV OD for a further 5 days</u> OR until clinical improvement ceases										

Please also complete CIWA-Ar scale (overleaf) for appropriate patient monitoring.

Clinical Institute Withdrawal Assessment of Alcohol (CIWA-Ar) Scale

The CIWA-Ar scale is a validated 10-item assessment tool which quantifies the severity of an individual's alcohol withdrawal symptoms. As such, CIWA-Ar provides guidance on monitoring and benzodiazepine dosage throughout withdrawal.

Attach to the drug chart and re-check every 4 hours unless CIWA-Ar is worsening, then increase monitoring until patient is stable

Nausea & Vomiting	Tremor						
Ask "Do you feel sick to your stomach? Have you	Arms extended and fingers spread apart. Observation.						
vomited?" Observation.	0. No tremor						
No nausea and no vomiting Mild nausea with no vomiting	 Not visible, but can be felt fingertip to fingertip 						
2.	3.						
3.	Moderate, with patient's arms extended						
 Intermittent nausea with dry heaves 	5.						
6.	 Severe, even with arms not extended 						
7. Constant nausea, frequent dry heaves and vomiting							
Paroxysmal sweats	Anxiety						
Observation.	Ask "Do you feel nervous?" Observation.						
0. No sweat visible	0. No anxiety, at ease						
 Barely perceptible, palms moist 	1. Mildly anxious						
2.	2.						
 Beads of sweat obvious on forehead 	 Moderately anxious, or guarded, so anxiety is inferred 						
5.	5.						
6. Z Drenching sweats	 Equivalent to acute panic states seen in severe delirium. 						
7. Dienching sweats	or acute schizophrenic reactions.						
Agitation	Tactile disturbances						
Observation.	Ask "Have you any itching, pins and needles						
0. Normal activity	sensations, any burning, any numbness or do you feel						
 Somewhat more than normal activity 	bugs crawling under your skin?" Observation.						
2.	0. None						
Moderately fidgety and restless	 very mild itcning, pins & needles, burning or numbress Mild itching, pins & needles, burning or numbress 						
5.	3. Moderate itching, pins & needles, burning or numbness						
6. 7 Pages back and forth during most of the intension or	4. Moderately severe hallucinations						
constantly thrashes about	Severe nationations Extremely severe hallucinations						
	7. Continuous hallucinations						
Auditory disturbances	Visual disturbances						
Ask "Are you more aware of sounds around you?	Ask "Does he light appear to be too bright? Is colour						
Are they harsh? Do they frighten you? Are you bearing apything that is disturbing you? Are you	different? Does it hurt your eyes? Are you seeing						
hearing things you know are not there?"	vou know are not there?" Observation.						
Observation.	0 Not present						
0. Not present	1. Very mild sensitivity						
1. Very mild harshness or ability to frighten	2. Mild sensitivity						
Mild harshness or ability to frighten Moderate barshness or ability to frighten	3. Moderate sensitivity						
4. Moderately severe hallucinations	Moderately severe nallucinations Severe hallucinations						
5. Severe hallucinations	6. Extremely severe hallucinations						
6. Extremely severe hallucinations	Continuous hallucinations						
Headache, fullness in head	Orientation & Clouding of sensorium						
Ask "Doos your bood fool different? Doos it fool like	Ask "What day is this? Where are you? Who am 12"						
there is a band around your head? Do not rate for	Ask what day is ansi where are your who an it						
dizziness and light-headedness. Otherwise, rate	 Orientated and can do serial additions Cannot do serial additions or is uncertain about the date 						
severity.	2. Disorientated for date by no more than 2 calendar days						
0. Not present	3. Disorientated for date by more than 2 calendar days						
1. Very mild	4. Disorientated for place and/or person						
2. Mild 3. Moderate	Total OWNA As Same						
4. Moderately severe	I otal CIWA-Ar Score/67						
5. Severe	(Max possible score is 67) Rater's Name:						
 very severe Extremely severe 	Date: / / Time (24br)						

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