Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Alcohol Issues in the Acute General Hospital Setting

(Guidelines and Management)

This procedural document supersedes: PAT/T 25 version 4 – Alcohol issues in the Acute General Hospital Setting – Guideline and Management

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Amendment Form

Please record brief details of the changes made alongside the next version number. If the procedural document has been reviewed **without change**, this information will still need to be recorded although the version number will remain the same.

Version	Date Issued	Brief Summary of Changes	Author
Version 5	29 Sept 2021	• Lorazepam reducing regime added • Chlordiazepoxide regime updated • Process flow chart to support staff in utilising the policy	S Bartle
Version 4	5 February 2018	• Revised layout to make document more user friendly • Sec 7.3 changes to Pabrinex Regimen	S Peagram
Version 3	29 October 2014	Revised layout to all sections to make the policy more user friendly. • Section 8 – now includes a greater choice of drug regimens in keeping with NICE guidance. • Section 9 – clear guidance on discharge arrangements for patients undergoing detox across a wide range of scenarios.	S Peagram
Version 2	January 2010	• **Section 1** - Background information updated to include current national, regional and local strategies • **Section 2** - Reference made to the new Trust alcohol screening and care pathway [Appendix 1 and 2] • **Section 4 -** Throughout the general management there are various aspects of treatment and prescribing amendments as advised by Lee Wilson - Consultant Pharmacist. Included in this edition are notes regarding rapid tranquillisation; [supported by Shane Peagram –Drug & Alcohol Liaison Nurse Specialist DR1] also added is Nutritional Management of Alcoholic Liver Disease [submitted by Vera Todorovic - Consultant Dietitian] • **Revised reference** • **Revised Appendices**	V Wood
Version 1	June 2006	New Document	V Wood

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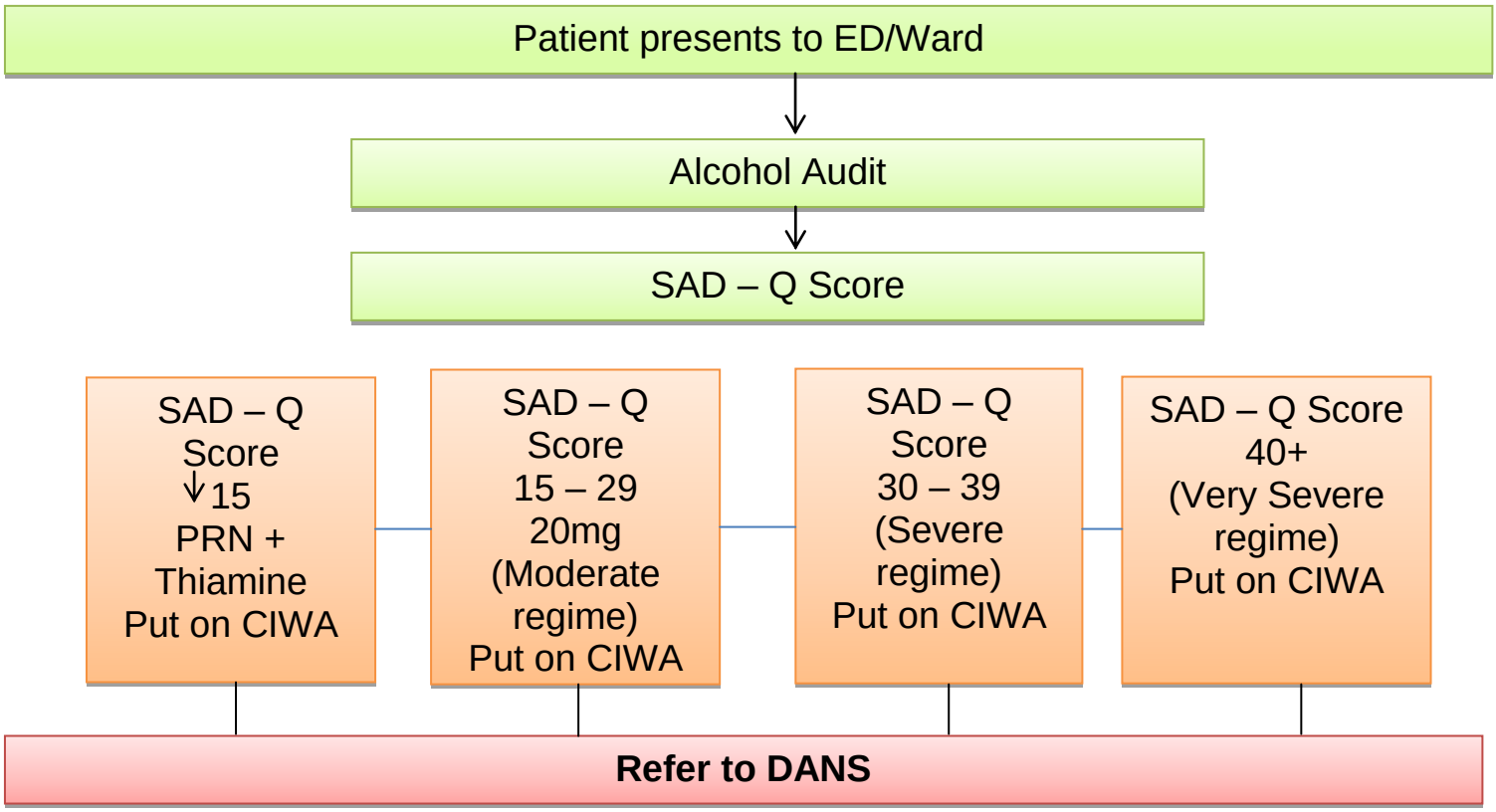
Alcohol Assessment Flow Chart



If patient is jaundiced or has head injury use Lorazepam not Chlordiazepoxide

In JAC type Alcohol and choose regime from above score

Abbreviations

SAD –Q - Severity of Alcohol Dependence Questionnaire

CIWA - Clinical Institute Withdrawal Assessment

DANS - Drug and Alcohol Liaison Nurse Specialist

1. INTRODUCTION

In 2012-13 there were over 1 million hospital admissions related to alcohol, at a cost to the NHS of £3.5 billion per year. (HSCIC 2014)

In 2014 there were 8,697 deaths directly attributable to alcohol, rising to 21,512 where alcohol was a contributing factor, making alcohol the third biggest lifestyle factor for disease and death in the UK. (ONS 2016)

In 2019 7565 deaths were wholly attributable to alcohol, which are 11.8 deaths per 100,000 of the UK population (ONS 2021)

Liver disease is one of the few major causes of premature death that is increasing. Deaths from liver disease have risen by 20% in the last ten years. In England and Wales, 63% of all alcohol related deaths were caused by alcohol related liver disease.

The NHS estimates that 9% of men and 4% of women show signs of alcohol dependence. For every £1 invested in specialist alcohol treatment, £5 is saved on health, welfare and crime.

2. PURPOSE

These guidelines are intended for both medical and nursing staff and act as a resource in the screening and identification of patients at risk of alcohol related harm **AND** the treatment of alcohol dependency.

The main source of evidence used within these guidelines is taken from *NICE (2017) CG100 Alcohol Use Disorders – Diagnosis and clinical management of alcohol – related physical complications*. *NICE (2011) CG115 Alcohol Use Disorders – Diagnosis, assessment and management of harmful drinking and alcohol dependence.* And should be read in conjunction with *NICE (2010) PH24 Alcohol Use Disorders*

3. DUTIES AND RESPONSIBILITIES

3.1 Doctors' responsibilities

The Doctor responsible for the patient will ensure an assessment of alcohol intake [section 8], including risk of alcohol withdrawal and risk of Wernicke's encephalopathy [section 7] is undertaken upon admission and where necessary initiate immediate treatment. [section 6]

Doctors must ensure an adequate risk assessment is carried out as part of the admission / discharge planning process. [Sub-section 9.6]

3.2 Prescribers' responsibilities

The prescriber will ensure a triage assessment [sub-section 8.2] of alcohol intake, risk of alcohol withdrawal and risk of Wernicke's encephalopathy [section 7], is undertaken prior to prescribing.

Prescribers must ensure an adequate risk assessment is carried out as part of the admission / discharge planning process. [Sub- section 9.6]

In the case of Non-Medical prescribers, prescribing will only take place where the prescriber is competent to do so.

3.3 DANS responsibilities

Where the patient's condition allows the Drug and Alcohol Liaison Nurse Specialist (DANS) will carry out a comprehensive assessment of alcohol intake [sub-section 8.3].

The DANS will provide risk assessment as part of discharge planning process. [Sub-section 9.6]

The DANS will provide liaison and referral to community alcohol services.

3.4 Nurses' responsibilities

Where the patient's condition allows nursing staff will routinely screen for alcohol related harm as part of the Combined Risk Screening and Assessment bundle.

Patients receiving detox will be monitored according to the CIWA-AR tool [APPENDIX 1]

Nursing staff will refer to the Drug and Alcohol Liaison Nurse Specialist (DANS).

3.5 Patients' responsibilities

Where their condition allows the patient is expected to engage with the screening and assessment process, providing a true and honest account of their alcohol intake in order to ensure safe and appropriate treatment.

For patients requiring detox there is an expectation that they abstain from alcohol throughout in order to ensure safe treatment.

Patients are encouraged to remain on the ward to ensure optimal treatment.

4. BACKGROUND

The risk of harm from alcohol increases the more you drink, and, the more often you drink.

By helping people to understand the risk of harm associated with their alcohol intake we enable them to make better informed lifestyle choices.

4.1 Alcohol Intake – Current Guidance Amounts

MEN + WOMEN = 14 units / week

These are general guidelines for healthy adults and advice may differ for patients with specific health conditions or taking certain medicines.

4.2 Calculating Risk

The number of units of alcohol consumed per week can be used to identify the level of risk of harm from alcohol.

Risk Level	Men	Women
Lower Risk	<14 units / week	<14 units / week
Increasing Risk	15-49 units / week	15-35 units / week
Higher Risk	50+ units / week	36+ units / week

Screening tools such as AUDIT [APPENDIX 2], Severity of Alcohol Dependence Questionnaire (SADQ)[APPENDIX 3] can be used to provide a more specific level of risk.

Patients drinking at levels that place them in the Higher Risk group may also be at risk of dependency.

4.3 Alcohol dependency

In the UK the NHS estimates 9% of men and 4% of women show signs of alcohol dependence.

The World Health Organisation (WHO) describe Alcohol Dependence as, a cluster of physiological, behavioural and cognitive phenomena in which the use of alcohol takes on a much higher priority for an individual than other behaviours.

Alcohol dependence is categorised by;

- A strong desire or sense of compulsion.
- Difficulty controlling onset, termination or levels of use.
- A physical withdrawal syndrome.
- Evidence of tolerance.
- Neglect of alternative pleasures or interests.
- Persisting despite clear evidence of harmful consequences.

While many patients who experience alcohol dependency are aware of their condition and will inform medical staff others may be unaware or unfamiliar with the effects of dependency.

Assessment tools such as the SADQ can be used to establish the severity of dependence [APPENDIX 3]

5. ALCOHOL WITHDRAWAL SYNDROME

The alcohol withdrawal syndrome occurs when people who are physically dependent on alcohol stop drinking abruptly or rapidly reduce their alcohol consumption.

Acute alcohol withdrawal symptoms can develop within a few hours and can progress rapidly from simple tremors to potentially life threatening seizures or Wernicke's Encephalopathy (see section 5).

Not all drinkers will experience physical withdrawal and those that do present with a wide range of symptoms described across 4 sets [Hall, 1997, Rubino, 1992, Turner, 1989]

5.1 Set 1: Uncomplicated Withdrawal

- Occurring within hours [typically 6-8 hours] of last drink and may develop before the blood / breath alcohol level has fallen to zero.
- Peaks at 10-30 hrs, Subsiding by 40 to 50 hrs [Adinoff 1988, DTB,1991, Hall,1997, Morgan, 1998]
- Tremors, starting in the hands but progressing to the head and trunk as severity worsens.
- Anxiety, restlessness, irritability, depression, insomnia and tiredness
- Anorexia, nausea, and weakness.
- Confusion
- Signs and symptoms of autonomic arousal
    - ❖ Sweating
    - ❖ Tachycardia [100+bpm]
    - ❖ Raised BP
    - ❖ Fever [37-38 C]
    - ❖ Hyperreflexia

5.2 Set 2: Complex Withdrawal - Hallucinosis

- Onset in the majority of cases is within 24 hours of last drink
- Stopping within another 24-48 hours [Turner,1998]
- Both auditory [frequently accusatory or derogatory voices] and visual [bugs crawling on the bed, for example] hallucinations occur in otherwise clear sensorium. [Chick, 2000, Rubino,1992, Turner, 1998]

5.3 Set 3: Complex Withdrawal - Seizures

- Can occur at 6 to 48 hours of alcohol cessation are more likely if there is a previous history of withdrawal fits or epilepsy.
- Rare beyond 48 hours following cessation. [Morgan, 1998]
- They are characterised by major motor seizures that occur during withdrawal in patient who normally have no seizures and have normal EEGs.
- Fits tend to be single, generalised (if focal, suspect head injury) and may occur in bouts.
- 30% of cases are followed by Delirium Tremors (DT).

5.4 Set 4: Complex Withdrawal - Delirium Tremens

Delirium Tremens is the most severe manifestation of alcohol withdrawal. Delirium Tremens occur in only about 5% of patients undergoing alcohol withdrawal but account for the highest morbidity and mortality.

Patients consuming more than 16 units per day (½ to a bottle of spirits per day or equivalent) are particularly at risk.

In addition to the classical symptoms of withdrawal the characteristic symptoms of DT's are:

- Onset can occur 2 to 5 days following cessation.
- Agitation, apprehension, confusion, disorientation, auditory / visual hallucination, insomnia, vomiting, motor incoordination and paranoid delusion.
- Fever is common
- Poor concentration, disorientation and agitation may continue for 1 – 2 weeks post recovery

[Adinoff,1988, Erwin, 1998, CRAG 1991, Morgan, 1998, Rubino,1992]

5.5 Risk Factors for Complex Withdrawal

The risk of Complex Withdrawal developing is greater in patients with associated 'risk factors' such as;

- Concomitant use of other psychotropic drugs, high levels of anxiety, other psychiatric disorders.

- Poor physical health, hypoglycaemia, hypokalaemia [with respiratory alkalosis, hypocalcaemia]
- Fever, sweating, insomnia, tachycardia
- Poor nutritional state

[DTB, 1991, CRAG, 1994, RCP, 2001]

5.6 Protracted Withdrawal

Although not an official diagnosis "*protracted withdrawal"* has been noted in many alcohol dependent patients.

This disorder is characterised by irritability, emotional liability, insomnia and anxiety that persist for weeks to months after alcohol withdrawal. Protracted withdrawal symptoms generally clear spontaneously with prolonged abstinence. [Armstong, 2002]

6. DETOXIFICATION REGIMENS

The mainstay of treatment for alcohol withdrawal is Chlordiazepoxide.

Adequate and timely dosing with Chlordiazepoxide supresses the autonomic arousal associated with acute alcohol withdrawal and usually prevents more complex symptoms from developing.

The patients Liver Function and Renal output need to be taken into account to avoid potential toxicity.

Patients with grossly deranged Liver Function Tests / Decompensation should receive treatment with Lorazepam at equivalent dosage [sub-section 6.9].

Nutritional support with parenteral Pabrinex 2 x pairs TDS is also required to prevent Wernicke's Encephalopathy. [Section 7]

The choice of detox regime is influenced by a number of factors;

- Level of alcohol consumption – daily unit intake.
- Severity of dependence – SADQ [APPENDIX 3]
- Symptom severity – CIWA-AR [APPENDIX 1]

On JAC regimens can be found by entering "alcohol" as the drug you wish to prescribe and choosing from the four following regimens.

6.1 15-30 units/day - Moderate Dependency

Patients who drink **15 – 30 units / day** and are experiencing or report experiencing physical withdrawal symptoms on stopping alcohol

Day 1	Chlordiazepoxide 20mg QDS	Pabrinex 2 x pair TDS
Day 2	Chlordiazepoxide 20mg QDS	Pabrinex 2 x pair TDS
Day 3	Chlordiazepoxide 15mg QDS	Oral Thiamine 100mg TDS
Day 4	Chlordiazepoxide 10mg QDS	Oral Thiamine 100mg TDS
Day 5	Chlordiazepoxide 10mg BD	Oral Thiamine 100mg TDS
Day 6	Chlordiazepoxide 10mg OD	Oral Thiamine 100mg TDS

+ PRN Chlordiazepoxide 30mg in response to CIWA-AR score

NOT SUITABLE FOR PATIENTS WITH ACUTE HEPATIC IMPAIRMENT or DECOMPENSATED ALCOHOL RELATED LIVER DISEASE see [sub-section 6.9].

6.2 30-49 units/day – Severe Dependency

Patients who drink **30 – 49 units / day** and are experiencing or report experiencing physical withdrawal symptoms on stopping alcohol

Day 1	Chlordiazepoxide 30mg QDS	Pabrinex 2 x pairs TDS
Day 2	Chlordiazepoxide 30mg QDS	Pabrinex 2 x pairs TDS
Day 3	Chlordiazepoxide 25mg QDS	Pabrinex 2 x pairs TDS
Day 4	Chlordiazepoxide 20mg QDS	Oral Thiamine 100mg TDS
Day 5	Chlordiazepoxide 15mg QDS	Oral Thiamine 100mg TDS
Day 6	Chlordiazepoxide 10mg QDS	Oral Thiamine 100mg TDS
Day 7	Chlordiazepoxide 10mg BD	Oral Thiamine 100mg TDS
Day 8	Chlordiazepoxide 10mg OD	Oral Thiamine 100mg TDS

+ PRN Chlordiazepoxide 30mg in response to CIWA-AR score

NOT SUITABLE FOR PATIENTS WITH ACUTE HEPATIC IMPAIRMENT or DECOMPENSATED ALCOHOL RELATED LIVER DISEASE see [sub-section 6.9]

6.3 50 – 60 units/day – Very Severe Dependency

Patients who drink **50 – 60+ units / day** and are experiencing or report experiencing physical withdrawal symptoms on stopping alcohol

Day 1	Chlordiazepoxide 45mg QDS	Pabrinex 2 x pairs TDS
Day 2	Chlordiazepoxide 40mg QDS	Pabrinex 2 x pairs TDS
Day 3	Chlordiazepoxide 35mg QDS	Pabrinex 2 x pairs TDS
Day 4	Chlordiazepoxide 30mg QDS	Oral Thiamine 100mg TDS
Day 5	Chlordiazepoxide 25mg QDS	Oral Thiamine 100mg TDS
Day 6	Chlordiazepoxide 20mg QDS	Oral Thiamine 100mg TDS
Day 7	Chlordiazepoxide 15mg QDS	Oral Thiamine 100mg TDS
Day 8	Chlordiazepoxide 10mg QDS	Oral Thiamine 100mg TDS
Day 9	Chlordiazepoxide 10mg BD	Oral Thiamine 100mg TDS
Day 10	Chlordiazepoxide 10mg OD	Oral Thiamine 100mg TDS

+ PRN Chlordiazepoxide 30mg in response to CIWA-AR score

NOT SUITABLE FOR PATIENTS WITH ACUTE HEPATIC IMPAIRMENT or DECOMPENSATED ALCOHOL RELATED LIVER DISEASE see [sub-section 6.9]

6.4 Symptom-Triggered PRN only

Patients who drink **<15 units per day** and are experiencing or report experiencing physical withdrawal symptoms on stopping alcohol.

OR

Patients who report higher levels of alcohol use but where no physical withdrawal symptoms are present despite sufficient time passing since they last drank alcohol that you might reasonably expect to see withdrawal.

PRN Chlordiazepoxide 20 - 30mg in response to CIWA-AR score
Pabrinex 2 x pairs TDS 2 days (6 x doses)

OR

Patients who require closer observation ie Hepatic / Renal impairment where there is a risk of accumulation.

PRN Lorazepam 0.5 – 1mg in response to CIWAR_AR score
Pabrinex 2 x pairs TDS 5 days

6.5 JAC Electronic Prescribing

In order to optimise patient care and minimise the risks associated with under prescribing JAC provides three automated regimens accessed by entering "***ALCOHOL***" as the drug to be prescribed, a choice of three detox regimens is offered:

- **15-30 units/day Moderate Dependency**
- **30-49 units/day Severe Dependency**
- **50-60+ units/day Very Severe Dependency**

By selecting the preferred regimen and clicking **"YES"** on the following confirmation screens the appropriate fixed dose reducing regimen of Chlordiazepoxide, PRN Chlordiazepoxide and Pabrinex is prescribed.

No fixed dose reducing regimen for Lorazepam is available. For patients with impaired hepatic or renal function individualised regimes at equivalent doses will be required. [sub-section 6.9]

6.6 Hallucination

Auditory, visual or tactile hallucinations can develop in patients with an otherwise clear sensorium.

- Severe psychotic symptoms may be managed by the addition of Haloperidol 1 to 5mgs 2-3 times a day.
- Adequate treatment with benzodiazepines to manage the underlying withdrawal is the priority.

6.7 Delirium Tremens

The most severe and potentially life threatening complication of acute alcohol withdrawal characterised by agitation, confusion, disorientation, poor motor coordination, paranoid delusions.

- Oral Lorazepam as the first-line treatment 1– 2 mg in response to CIWAR-AR scores
- If symptoms persist or oral medication is declined, consider parenteral Benzodiazepines
- Titrate IV Lorazepam 0.5mg - 1mgs every 30 minutes in response to CIWAR-AR score **OR** Titrate IV Diazepam emulsion 5mg - 10 mgs every 30 – 60 minutes (at a rate of not more than 5mgs per minute into a large vein) in response to CIWAR-AR.
- Try to avoid IM administration due to unpredictable absorption.

Baseline physical observations prior to IV drug administration to be repeated every 15 mins for the first hour and half hourly for the next four hours. PAT/PS 15 – De-escalation: Principles and Guidance including restraint.

- Nursing staff to complete CIWA-AR scores as directed
- If using more than one type of Benzodiazepine, approximate equivalent doses are as follows:

Chlordiazepoxide 15mg = Diazepam 5mg = Lorazepam 500mcg = Nitrazepam 5mg = Temazepam 10mg

Attention should be paid to the Mental Capacity Act 2005 policy PAT/PA 19 and – De-escalation: Principles and Guidance including restraint. PAT/PS 15.

6.8 Seizures

Seizures can occur 6 – 48 hours after alcohol cessation and are usually self-limiting.

Seizures are more likely in patients with a history of withdrawal seizure or epilepsy.

- Prolonged or recurrent seizures, intravenous Lorazepam [2mgs] is effective.
- There is little or no evidence to support conventional anti-epileptics in either the treatment of prophylaxis of alcohol withdrawal seizures. [Maudsely, 2005].

6.9 Liver Disease

For patients with grossly deranged Liver Function suggestive of acute alcoholic hepatitis or decompensated alcohol related liver disease **Lorazepam is preferred to Chlordiazepoxide**.

- Lorazepam 1mg = Chlordiazepoxide 30mg
- Where there is evidence of hepatic encephalopathy symptom triggered dosing in response to CIWA-AR scores is favoured over fixed dosing regimens.
- Pabrinex 2 x pairs TDS 5 days

LORAZEPAM REGIME FOR ALCOHOL DETOXIFICATION

MODERATE DEPENDENCY

DAY 1	LORAZEPAM 500mcg QDS	PABRINEX 2 PAIRS TDS
DAY 2	LORAZEPAM 500mcg QDS	PABRINEX 2 PAIRS TDS
DAY 3	LORAZEPAM 500mcg TDS	PABRINEX 2 PAIRS TDS
DAY 4	LORAZEPAM 500mcg BD	THIAMINE 100MG TDS
DAY 5	LORAZEPAM 500mcg OD	THIAMINE 100MG TDS

SEVERE DEPENDENCY

DAY 1	LORAZEPAM 1.5MG QDS	PABRINEX 2 PAIRS TDS
DAY 2	LORAZEPAM 1MG QDS	PABRINEX 2 PAIRS TDS
DAY 3	LORAZEPAM 1MG TDS	PABRINEX 2 PAIRS TDS
DAY 4	LORAZEPAM 1MG TDS	THIAMINE 100MG TDS
DAY 5	LORAZEPAM 1MG BD	THIAMINE 100MG TDS
DAY 6	LORAZEPAM 500mcg BD	THIAMINE 100MG TDS
DAY 7	LORAZEPAM 500mcg OD	THIAMINE 100MG TDS

7. WERNICKE'S ENCEPHALOPATHY

An acute life-threatening neurological syndrome, consisting of confusion, apathy, dullness, delirium, nystagmus, hypotension, hypothermia and ataxia.

The most common cause of thiamine deficiency in industrialized countries is alcoholism.

7.1 Background

Thiamine plays a role in metabolizing glucose to produce energy for the brain. An absence of thiamine results in an inadequate supply of energy to the brain.

Frequent alcohol use decreases absorption and increases demand for thiamine, so even in cases where patients are eating a balanced diet thiamine deficiency cannot be excluded.

7.2 Diagnosis

A diagnosis of Wernicke's encephalopathy can be difficult to establish as the triad of classic symptoms is seldom present;

Signs	Incidence
Mental changes	82%
Ataxia	23%
Eye signs	29%
Classic Triad	10%

A high index of suspicion is therefore needed and diagnosis should be based on the presence of any one of following signs [Chick 2000, Cook 2000, Morgan 1998].

- Acute confusion
- Decreases consciousness level including unconsciousness/coma
- Memory disturbance
- Ataxia/unsteadiness
- Ophthalmoplegia
- Nystagmus
- Unexplained hypotension with hypothermia

Mental changes such as confusion, drowsiness, obtundation (slowness of response), pre-coma and coma maybe the only signs of Wernicke's encephalopathy [Cook, 1998].

These mental changes are non-specific and may be attributed to head injury, intoxication or alcohol withdrawal resulting in a missed diagnosis of Wernicke's.

7.3 Treatment

Parenteral Thiamine (Pabrinex) **2 x – pairs** is required where

- the patient is malnourished **OR** has decompensated liver disease

AND

- Attends an emergency department **OR** is admitted to hospital with acute illness

NICE (2014)

Where Wernicke's Encephalopathy is suspected

Parenteral Thiamine (Pabrinex) 2 x pairs – TDS – 5 days min

Followed by

Oral Thiamine 100mg TDS for the duration of inpatient stay.

On discharge those patients with **cognitive impairment or malnourishment** should be maintained on **50mg Once Daily**. Otherwise there is no reason for continued supplementation with B Vitamins

NICE (2014)

8. ASSESSMENT

8.1 General Principles

On admission to an acute hospital patients may be unwell with an array of complex and pressing physical health problems. These problems can be exacerbated by the onset of physical withdrawal from alcohol.

It is therefore necessary to include an alcohol risk assessment (triage assessment) as early as possible in the patient admission process. The extent of the assessment should be sufficient to identify immediate risks without impeding the broader patient assessment.

8.2 Triage Assessment

A triage assessment for alcohol dependency must be completed during medical clerking.

The triage assessment should consider

- Frequency and quantity of alcohol use.
- Evidence of Dependence.
- Need for detoxification
- Any associated risks to self or others
- The presence of any co-morbidity or other factors that may need further specialist assessments or intervention.

The Triage assessment agrees the initial plan, taking into account the service user's preferences and outcomes of any previous treatments. [NTA, 2005]

8.3 Comprehensive Assessment

A comprehensive assessment should assess multiple areas of need, be structured in a clinical interview, use relevant and validated clinical tools, and cover the following areas:

- alcohol consumption, dependence and alcohol-related problems
- co-existing health conditions, including co-existing drug and mental health problems
- cognitive functioning
- risk of harm to self and others
- urgency for treatment
- motivation and readiness to change
- socio-demographic data
- family relationships, social functioning

The Drug and Alcohol nurse specialist OR Substance misuse liaison will undertake the comprehensive assessment.

- **Any child protection issues that might arise during the assessment must be addressed following the appropriate local Area Child Protection Committee guidelines.**

8.4 Examination

Patients who misuse alcohol may appear to be sober and unexceptional upon attendance.

Dependent patients might not yet display classic signs of withdrawal i.e. tremors, vomiting [5] or might never have abstained from alcohol long enough to experience symptoms before.

Symptoms can also be overlooked due to incurrent illness i.e. sweating, pyrexia, tachycardia. [DTB, 1991].

Neurological symptoms associated with acute Thiamine deficiency (Wernicke's Encephalopathy) drowsiness, confusion, ataxia [section 7] can easily be mistaken for intoxication.

8.5 Investigations

TABLE 1 - LABORATORY MARKERS THAT INDICATE ALCOHOL EXCESS [RCP, 2001]

Blood and breath alcohol

- *A raised blood or breath alcohol is firm evidence of recent alcohol consumption. However alcohol is metabolised rapidly and absence of alcohol indicates only that alcohol has not been consumed in the past few hours.*

Erythrocyte Mean Corpuscular Volume [MCV]

- *MCV is raised in many chronic heavy drinkers but may also be raised for other reasons.*

Gamma glutamyl trasferase [GGT]

- *GGT is a liver enzyme raised in a high proportion of chronic heavy drinkers but returns to normal levels after about 5 week's abstinence. It may also be raised in non-alcoholic liver disease and in patients taking enzyme-inducing drugs.*

Aspartate amino transferase [AST]

- *The liver enzyme AST is raise after heavy binge drinking but returns to normal within 48 hours. It may also be raised for other reasons.*

Carbohydrate deficient transferrin [CDT]

- *CDT is raised in some heavy drinkers. It is more specific than AST,GGT, or MCV [Stribler, 1991]*

Whilst laboratory markers may provide supporting evidence for alcohol related harm in patients, none are sensitive or specific enough to be used in isolation. The results need to be supported by an assessment of the patient's alcohol history.

8.6 Nursing Observations

In the general hospital, setting alcohol withdrawal is usually accompanied by a serious acute illness. The signs and symptoms of alcohol withdrawal may not be obvious and the assessment may be difficult.

Repeated nursing observations using valid assessment tools are invaluable in identifying subtle changes in the patient's condition, allowing earlier intervention and management.

CIWA-AR

An adaptation of the Addiction Research Foundation Clinical Institute's *Withdrawal Assessment for Alcohol, Revised* [CIWA-Ar] tool has been formatted for use in acute hospital settings. [APPENDIX 1]

The CIWA-AR tool must be initiated for all patients where alcohol withdrawal is present or suspected.

The CIWA-AR is repeated 4hrly initially and the subsequent frequency is dictated by the total score.

- Less than 10 repeat 4 hourly for 24 hours
- More than 10 repeat 2 hourly
- More than 15 repeat 1 hourly
- STOP once score less than 10 for 48hours

At each assessment interval there is an opportunity to give additional as required medication in response to developing symptoms.

The CIWA-AR score may also be used to decide when to initiate regular treatment for alcohol withdrawal syndrome, but is not the preferred assessment tool.

- Score 15 or more on two occasions
- Score 20 or more on one occasion.

9. DISCHARGE PLANNING

The decision when to discharge patients receiving alcohol detoxification is one that requires careful consideration. Discharge planning should adhere to the Trust guidelines contained within PAT/PA 3 - Discharge of Patients from Hospital Policy.

There are several common scenarios which might arise.

9.1 Self Discharge

- Assess patient capacity
- Assess symptom severity
- Offer referral to Community Alcohol Team
- Give advice that acute withdrawal may return, not to stop alcohol abruptly
- Complete self-discharge paperwork WPR10390A
- NO TAKE HOME DETOX MEDICATION

9.2 Non Compliance with Detox

Despite their good intentions and our best efforts some patients will continue to drink alcohol whilst in hospital receiving detox.

if **MEDICALLY FIT**

- Assess patient capacity
- Assess symptom severity- CIWA-AR
- Offer referral to Community Alcohol Team
- Give advice that - acute withdrawal may return, not to stop alcohol abruptly
- PLANNED DISCHARGE
- NO TAKE HOME MEDICATION

if **MEDICALLY UNFIT**

- Assess patient capacity
- Assess symptoms severity – CIWA-AR
- Advise that combining alcohol with detox medication could result in death.
- Discontinue routine detox medication.
- Prescribe PRN only symptomatic relief of withdrawal symptoms as per CIWA score.
- Continue routine vitamin supplementation i.e. Pabrinex / oral Thiamine

9.3 Patient Declines Detox

- Assess capacity.
- Assess symptom severity- CIWA-AR
- Offer referral to Community Alcohol Team
- Give advice that - acute withdrawal may return, not to stop alcohol abruptly
- Explain benefits and offer oral Thiamine
- PLANNED DISCHARGE
- NO TAKE HOME MEDICATION

9.4 Medically Fit – Detox Complete

- Assess Capacity
- Assess symptom severity
- Oral Thiamine
- Offer referral to Community Alcohol Team

9.5 Medically Fit- Detox Incomplete

Where the patient is *Medically Fit* before the detox is completed a planned discharge with the remaining medication is possible based on an individual risk assessment.

- Assess Capacity
- Assess symptom severity
- Risk Assessment for TTO detox medication
- Oral Thiamine
- Offer referral to Community Alcohol Team

9.6 Risk Assessment for Take home Medication

The Risk Assessment should consider the following:

Suitable	Contra-indication
Simple withdrawal – tremors, sweats	Complex withdrawal – delirium, hallucination, paranoid delusions
Asymptomatic – receiving routine meds	Symptomatic – requiring PRN in past 24hrs
Supported – non drinking family members, spouse	Unsupported – living alone, NFA
Mental health stable	Mental health unstable, Suicidal, admitted with overdose
Non drug user, ex drug user, stable community drug treatment	Chaotic Drug use – heroin , methadone, benzodiazepines
Planning abstinence – choosing to be alcohol free	Controlled drinking – risk mixing alcohol and medication
Absence of Neurological symptoms – completed initial Pabrinex 2 x pairs TDS for 72hrs	Neurological Symptoms – Seizures (whilst receiving Detox) , Wernicke's Encephalopathy

9.7 Maximum Take Home Doses

There is no set Day or Dose at which discharge becomes possible, every patient is different and the decision to discharge should be based on the outcome of a **risk assessment**.

That said it would be unwise to issue an entire detox or majority of detox to take home due to the risk of complex symptoms developing within the first 72 hours.

Once 72 hours have passed and the **risk assessment** is satisfied we can consider discharge.

The discharge letter should contain Clear instructions of day / dose and timing of medication to assist the patient.
Eg.

"*Chlordiazepoxide 15mg QDS (0800/1200/1800/2200hr)*
Chlordiazepoxide 10mg QDS (0800/1200/1800/2200hr)
Chlordiazepoxide 10mg BD (0800/1800hr)
Chlordiazepoxide 10 OD (0800hr)
STOP
DO NOT DRIVE
NOT TO BE TAKEN WITH ALCOHOL"

No PRN doses to be given as Take home.

9.8 Nursing Management

Safe management of acute withdrawal is best achieved through **proactive** rather than reactive management.

- Early identification through screening SAD-Q
- Symptom severity monitoring using CIWAR tool
- Medication choices
- Environmental factors
- Staffing level

The following general measures should be put in place [Ghodse, 2002]:

- Ensure adequate levels of medical and nursing staff
- Treat the patient in a well-lit area away from other patients
- Keep external stimuli, especially noise, to a minimum
- Use a friendly, understanding but firm approach
- Be aware of the possibility of withdrawal fits

Where a patient presents with challenging behaviour i.e. delirium and this represents a risk to the patient or others it may be necessary to intervene in order to maintain patient safety.

Measures to maintain patient safety such as physical restraint or medication should be at a level proportionate to the level of risk in keeping with PAT/PS 15 De-escalation: Principles and Guidance including restraint.

10. TRAINING/ SUPPORT

The training requirements of staff will be identified through a training needs analysis.

Role specific education will be delivered by the service lead or nominated individual.

The Drug and Alcohol Liaison Nurse Specialist services at Doncaster Royal Infirmary provide "in house" training support via Specific Study Days, ward based sessions or on a 1:1 case specific supervision basis.

11. MONITORING COMPLIANCE WITH THE PROCEDURAL DOCUMENT

What is being Monitored	Who will carry out the Monitoring	How often	How Reviewed/ Where Reported to
CIWAR completion	DANS	annual	Emergency care governance group
Detox regimen choices	DANS	annual	Emergency care governance group
Discharge planning	DANS	annual	Emergency care governance group

12. DEFINITIONS

ABV% - Alcohol By Volume
AUDIT – Alcohol Use Disorders Identification Test
BD – Twice daily
CG – Clinical Guideline
CIWA-AR – Clinical Institute Withdrawal Assessment – Alcohol Revised
DANS – Drug and Alcohol Nurse Specialist
EEG - electroencephalogram
DTs – Delirium Tremens
FAST – Fast Alcohol Screening Test
FAST ED – Fast Alcohol Screening Test Emergency Department
IPOC – Integrated Pathway of Care
NICE – National Institute for Clinical Excellence
NTA – National Treatment Agency
OD – Once daily
PAT – Paddington Alcohol Test
PHG – Public Health Guideline
PRN – As the occasion arises
SADQ – Severity of Alcohol Dependence Questionnaire
TDS – Three times daily
QDS – Four times daily

13. EQUALITY IMPACT ASSESSMENT

The Trust aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are disadvantaged over others. Our objectives and responsibilities relating to equality and diversity are outlined within our equality schemes. When considering the needs and assessing the impact of a procedural document any discriminatory factors must be identified.

An Equality Impact Assessment (EIA) has been conducted on this procedural document in line with the principles of the Equality Analysis Policy (CORP/EMP 27) and the Fair Treatment for All Policy (CORP/EMP 4).

The purpose of the EIA is to minimise and if possible remove any disproportionate impact on employees on the grounds of race, sex, disability, age, sexual orientation or religious belief. No detriment was identified. [APPENDIX 4]

14. ASSOCIATED TRUST PROCEDURAL DOCUMENTS

Discharge of Patients from Hospital Policy – PAT/PA 3

Fair Treatment for All Policy – CORP/EMP 4

Equality Analysis Policy – CORP/EMP 27

Mental Capacity Act 2005 – Policy and Guidance including Deprivation of Liberty Safeguarding (DOLs) - PAT/PA 19

Privacy and Dignity Policy - PAT/PA 28

De-escalation: Principles and Guidance including restraint– PAT/PS 15

Non-Medical Prescribing Policy – PAT/MM 11

15. DATA PROTECTION

Any personal data processing associated with this policy will be carried out under 'Current data protection legislation' as in the Data Protection Act 2018 and the UK General Data Protection Regulation (GDPR) 2021.

For further information on data processing carried out by the trust, please refer to our Privacy Notices and other information which you can find on the trust website:
https://www.dbth.nhs.uk/about-us/our-publications/information-governance/

16. REFERENCES

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APPENDIX 1 CLINICAL INSTITUTE WITHDRAWAL ASSESMENT

PAT/T25 V.1

Doncaster and Bassetlaw Hospitals NHS Foundation Trust

ASSESSMENT AND MEASUREMENT (CIWA-AR) OF ALCOHOL WITHDRAWAL

AFFIX LABEL HERE IF AVAILABLE

NHS Number: _____

District Number: _____

Surname: _____

Forename(s): _____

Address: _____

_____

D.o.B.: _____

GUIDELINES

The alcohol withdrawal syndrome may be a continuum from simple tremulous [the most common symptom] with relatively mild signs/symptoms of autonomic overactivity, through hallucinosis in clear sensorium to seizures and, most severely, life-threatening delirium tremens. [Hall 1997, Rubino 1992, Turner 1989]. It is therefore important to recognise complications early and treat them appropriately. The AWS can be grouped into four sets of symptoms:

SET 1: Uncomplicated alcohol withdrawal

- Signs/symptoms occur within hours [typically 6-8 hours] of last drink and may develop before the blood alcohol level has fallen to zero. Commonly peak at 10-30 hours and usually subside by 40 to 50 hours. [Adinoff 1988, DTB 1991, Hall 1997, Morgan 1998].
- Signs and symptoms of autonomic arousal, sweating, tachycardia [100+bpm], raised BP, fever [37-38° C], hyperreflexia.
- Characteristic tremor, starting in the hands but progressing to the head and trunk as severity worsens.
- Anxiety, restlessness, irritability, depression, insomnia and tiredness.
- Anorexia, nausea, and weakness.
- Confusion.

SET 2: Hallucinosis

- Onset in the majority of cases is within 24 hours of last drink, ceasing within another 24-48 hours. [Turner,1998].
- Both auditory [frequently accusatory or derogatory voices] and visual [bugs crawling on the bed, for example] hallucinations occur in otherwise clear sensorium. This is unlike delirium tremens, where the sensorium is diffused and impaired. [Chick 2000, Rubino 1992, Turner 1989].

SET 3: Alcohol-related seizures

- Can occur between 6 and 48 hours of alcohol cessation and are more likely if there is a previous history of withdrawal fits or epilepsy. Fits are rare beyond 48 hours following cessation. [Morgan, 1998].
- They are characterised by major motor seizures that occur during withdrawal in patients who normally have no seizures and have normal EEGs. Fits tend to be single, generalised (if focal, suspect head injury) and may occur in bouts.
- 30% of cases are followed by DTs.

SET 4: Delirium tremens (DTs)

- Delirium tremens [DTs] is the most severe manifestation of alcohol withdrawal. DTs occur in only about 5% of patients undergoing alcohol withdrawal, but account for the highest morbidity and mortality. Onset of DTs is 2 to 5 days [most commonly at 2 to 3 days] following cessation and represents a medical emergency. [Adinoff 1988, Erwin 1998, CRAG 1994, Morgan 1998, Rubino 1992].
- DTs usually occur in heavy drinkers who have withdrawn unexpectedly, have minimised their consumption or have been inadequately treated during withdrawal.
- Patients who consume more than 16 units per day (½ to 1 bottle of spirits per day, or equivalent) are particularly at risk.
- In addition to the classical symptoms of withdrawal the characteristic symptoms of DT's are:
  - (a) Agitation, apprehension, confusion, disorientation in time and place and visual and auditory hallucinations, insomnia, nausea, vomiting, motor inco-ordination and paranoid ideation may be present.
  - (b) Fever is common.
  - (c) Poor concentration, intermittent disorientation and agitation may continue for 1-2 weeks before recovery.

Risk factors for progression to severe withdrawal.

There is a risk of progression to severe withdrawal symptoms and delirium tremens if a patient with mild symptoms also has associated 'risk factors'. [Chick 1989, DTB 1991, CRAG 1994, RCP 2001], e.g.:

- high alcohol intake (>15 units per day in a person of normal build), previous history of severe withdrawal, seizures and/or DTs.
- Concomitant use of other psychotropic drugs, high levels of anxiety, other psychiatric disorders.
- Poor physical health, hypoglycaemia, hypokalaemia [with respiratory alkalosis, hypocalcaemia].
- Fever, sweating, insomnia, tachycardia.

PLEASE NOTE

Any patient suffering alcohol withdrawal has the potential to develop seizures and delirium tremens [DTs]. If DTs are not detected early or managed effectively, there is a high risk of the patient becoming aggressive and violent towards members of staff. Therefore, the risk management plan for patients suffering alcohol withdrawal should reflect this risk element.

ASSESSMENT AND MEASUREMENT (CIWA-AR) OF ALCOHOL WITHDRAWAL

Administration of PRN Medication

- Check the last 24-hour accumulative benzodiazepine dosage in accordance with PAT/T25.v2
- Approximate equivalent dose for (C) Chlordiazepine 15mg: (D) Diazepam 5mg, (L) Lorazepam 500 micrograms, (N) Nitrazepam 5mg, (T) Temazepam 10 mg
- Psychotic symptoms (auditory and visual hallucinations) may be managed by (H) Haloperidol. Please refer to PAT/T25.v2

Dat
Tim

Temperature			
1 37.0 - 37.5°C	2 37.5 - 38.0°C	3 Greater than 38.0°C	
Pulse			
1 90 - 95	2 95 - 100	3 100 - 105	4 105 - 110
5 110 - 120	6 Greater than 120		
Respiration rate (inspirations per minute)			
1 20 - 24	2 Greater than 24		
Blood pressure (diastolic)			
1 95 - 100mmHg	2 100 - 103mmHg	3 103 - 106mmHg	4 106 - 109mmHg
5 109 - 112mmHg	6 Greater than 112mmHg		
Nausea and vomiting (Ask - 'Do you feel sick?' or 'Have you vomited?')			
0 None	2 Nausea, no vomiting	4 Intermittent nausea with dry heaves	6 Nausea, dry heaves, vomiting
Tremor (arms extended, fingers spread)			
0 No tremor	2 Not visible - can be felt fingertip to fingertip	4 Moderate with arms extended	6 Severe, even with arms not extende
Sweating (observation)			
0 No sweat visible	2 Barely perceptible, palms moist	4 Beads of sweat visible	6 Drenching sweats
Tactile disturbances			
0 None		2 Mild itching or pins and needles or numbness	
4 Intermittent tactile hallucinations (for example, bugs crawling)		6 Continuous tactile hallucinations	
Auditory disturbances (loud noises, hearing voices)			
0 None present		2 Mild harshness or ability to frighten (increased sensitivity)	
4 Intermittent auditory hallucinations (appear to hear things that others cannot)		6 Continuous auditory hallucinations (shouting, talking to unseen persons)	
Visual disturbances (photophobia, seeing)			
0 Not present		2 Mild sensitivity (bothered by lights)	
4 Intermittent visual hallucinations (occasionally see things that others cannot)		6 Continuous visual hallucinations (seeing things constantly)	
Hallucinations			
0 None	1 Auditory, tactile or visual only	2 Non-fused auditory or visual	3 Fused auditory and visual
Clouding of sensorium ("What day is this?" or "What is this place?")			
0 Orientated		2 Disorientated for date by no more than two days	
3 Disorientated for date		4 Disorientated for place (re-orientated if necessary)	
Quality of contact			
0 In contact with examiner		2 Seems in contact, but is oblivious to environment	
4 Periodically becomes detached		6 Makes no contact with examiner	
Anxiety ("Do you feel nervous?") (Observation)			
0 No anxiety	2 Appears anxious	4 Moderately anxious or guarded	6 Overt anxiety (equal to panic)
Agitation (Observation)			
0 Normal activity	2 Somewhat more than normal activity	4 Moderately fidgety and restless	6 Pacing or thrashing about constan
Thought disturbances (flight of ideas)			
0 No disturbances		2 Does not have much control over nature of thoughts	
4 Plagued by unpleasant thoughts constantly		6 Thoughts come quickly and in a disconnected fashion	
Convulsions (seizures or fits of any kind)			
0 No	2 Yes		
Headache ("Does it feel like a band around your head?")			
0 Not present	2 Mild	4 Moderately severe	6 Severe
Flushing of face			
0 None	1 Mild	3 Severe	

If the score is less than 10, complete the assessment 4-hourly for first 24 hours.
If the score is greater than 10, complete the assessment 2-hourly.
If the score is greater than 15, complete the assessment hourly.
Treatment is advised if the score is greater than 15 on more than 2 occasions or above 20 once.
Continue the assessment hourly until the score has fallen to less than 10.
Note: If temperature falls below 35°C and/or pulse is less than 60 beats per minute, contact the Medical Team IMMEDIATELY.

ACTION

T
Assessment freque
PRN medication giv
Please c
Amount g
Type g

CIWA-AR – (Clinical Institute Withdrawal Assessment for Alcohol – revised

APPENDIX 2 - AUDIT

	SCORING SYSTEM					
AUDIT	**0**	**1**	**2**	**3**	**4**	**Your Score**
How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times per month	2-4 times per week	4+ times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	1-2	3-4	5-6	7-9	10+	
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	
How often during the last year, have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost 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 monthly	Monthly	Weekly	Daily or almost 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 monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year, have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost 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 monthly	Monthly	Weekly	Daily or almost 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	
SCORING SYSTEM 0 - 7 LOWER RISK, 8 – 15 INCREASING RISK, 16 – 19 HIGHER RISK, 20+ POSSIBLE DEPENDENCE					Your Total Score	

APPENDIX 3 – SEVERITY OF ALCOHOL DEPENDENCE QUESTIONNAIRE

The following questions cover a wide range of topics to do with drinking. Please read each one carefully and answer without thinking too much about the exact meaning.
Answer all questions in relation to your recent drinking

Question	0 Never	1 Sometimes	3 Often	*4* *Nearly always*
Do you find it difficult getting the thought of alcohol out of your mind?				
Is getting drunk more important than your next meal?				
Do you plan your day so you know you will be able to drink?				
Do you start drinking in the morning and continue drinking right through the afternoon into the evening?				
Do you drink as much as you can without considering what you have to do the next day?				
Knowing that many of your problems may be caused by alcohol, do you still drink too much?				
Do you find that once you have had one drink you have to have another?				
Do you need an alcoholic drink to get yourself going in the morning?				
Do you notice a definite tremor in your hands in the morning?				
When you have been drinking, do you go out of your way to avoid people?				
Do you see things and later realise they were not real?				
Do you find that you have gaps in your memory or are unable to remember recent events?				
Do you vomit following a drinking session?				
Do you deliberately control your drinking by giving up for days or weeks at a time?				

Scoring
Scores below 15 indicates Mild Dependency
15-30 indicates Moderate Dependency
30-40 indicates Severe Dependency
40-60 indicates Very Severe Dependency

APPENDIX 4 – EQUALITY IMPACT ASSESSMENT PART 1 INITIAL SCREENING

Service/Function/Policy/ Project/Strategy	Division Executive Directorate and Department	Assessor (s)	New or Existing Service or Policy?	Date of Assessment
Alcohol Issues in the Acute General Hospital Setting - PAT/T 25 v.5	ALL	Sarah Bartle	EXISTING POLICY	8.6.2021

1) Who is responsible for this policy? Drug and Alcohol Nurse Specialist

2) Describe the purpose of the service / function / policy / project/ strategy
The identification and management of persons with alcohol issues whilst inpatients within the hospital setting.

3) Are there any associated objectives? NICE (2010) CG100 Alcohol Use Disorders – Diagnosis and clinical management of alcohol – related physical complications. NICE (2011) CG115 Alcohol Use Disorders – Diagnosis, assessment and management of harmful drinking and alcohol dependence. And should be read in conjunction with NICE (2010) PHG24 Alcohol Use Disorders – preventing the development of hazardous and harmful drinking

4) What factors contribute or detract from achieving intended outcomes? – Staff Compliance with the Policy

5) Does the policy have an impact in terms of age, race, disability, gender, gender reassignment, sexual orientation, marriage/civil partnership, maternity/pregnancy and religion/belief? Details: [see Equality Impact Assessment Guidance] - No

- **If yes, please describe current or planned activities to address the impact** [e.g. Monitoring, consultation] –N/A

6) Is there any scope for new measures which would promote equality? [any actions to be taken] No

7) Are any of the following groups adversely affected by the policy?

Protected Characteristics	Affected?	Impact
a) Age	No	
b) Disability	No	
c) Gender	No	
d) Gender Reassignment	No	
e) Marriage/Civil Partnership	No	
f) Maternity/Pregnancy	No	
g) Race	No	
h) Religion/Belief	No	
i) Sexual Orientation	No	

8) Provide the Equality Rating of the service / function /policy / project / strategy – tick outcome box

Outcome 1 ✓	Outcome 2	Outcome 3	Outcome 4

If you have rated the policy as having an outcome of 2, 3 or 4, it is necessary to carry out a detailed assessment and complete a* **Detailed Equality Analysis form in Appendix 4

Date for next review: June 2024

Checked by: Kate Carville **Date: 8.6.2021**