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Symptom-Triggered Alcohol Detoxification in C&V UHB Hospitals - Guideline

Introduction and Aim
This document sets out the usual way to conduct an alcohol detoxification in an inpatient setting through the UHB.

Objective
To standardise alcohol detoxification practice in hospital settings – in line with NICE CG100

Scope
This guideline applies to the usual management of alcohol detoxification in all Cardiff and Vale UHB inpatient settings. Rationale for divergence from this guideline should be documented in patient records.

Equality Impact Assessment	An Equality Impact Assessment has not been completed.
Documents to read alongside this Procedure	Guideline for the care of substance using women and their babies *http://www.wales.nhs.uk/sitesplus/documents/864/Acute%20Pain%20Guidlines%20Adult.p df* Management of patients/visitors in possession of alcohol or unprescribed/ illegal substances policy & procedure *http://www.cardiffandvaleuhb.wales.nhs.uk/opendoc/210821* *Nice CG 100 guidelines* *https://www.nice.org.uk/guidance/CG100/chapter/1-Guidance*
Approved by	Corporate Medicines Management
Accountable Executive or Clinical Board Director	Executive Medical Director
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Disclaimer

If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the Governance Directorate.

Summary of reviews/amendments

Version Number	Date of Review Approved	Date Published	Summary of Amendments
2	19/02/2016	12/07/2016	Follows new format for UHB documents Now has one page flowchart in appendices Covers hospital settings other than UHL and UHW Section on alcohol withdrawal seizures Section on discharge
3	01/04/2022	01/04/2022	Follows new format for UHB documents Now has one page flowchart in appendices Covers hospital settings other than UHL and UHW

Symptom-Triggered Alcohol Detoxification

Introduction

This method of detoxification is an alternative to fixed-dose treatment strategy and should be used only when training has been completed by nursing and medical staff. It is of potential benefit as the duration of detoxification is reduced although there is a requirement for more monitoring of withdrawal symptoms (NICE, 2010)

With this method patients with overt or suspected alcohol withdrawal are objectively assessed for presence of significant withdrawal at regular intervals. Severity of withdrawal is assessed using a standardised scale – The CIWA-Ar (Sullivan et al, 1989).

If found to have significant alcohol withdrawal, the patient is given a stat dose of diazepam 20mg. This procedure of standardised assessment and treatment is repeated every ninety minutes until the patient is no longer in withdrawal and detoxification is complete

Inclusion Criteria

Alcohol-dependent adult patients requiring treatment of withdrawal

Patients with a history of previous alcohol-withdrawal seizures or delirium tremens

Exclusion Criteria

Patients with severe liver impairment or other major physical illness. Medical assessment must be sought prior to initiation of CIWA-Ar in cases of severe liver impairment as metabolism of diazepam and its metabolites maybe dramatically slowed

When to initiate the scale

The patient reports alcohol withdrawal symptoms or shows signs of alcohol withdrawal.

The patient's history indicates a likelihood of withdrawal reaction:

1) drinking large amounts of alcohol over a long period of time
2) history of withdrawal symptoms
3) last drink within the past 12 hours.

If such a history is not evident, observe informally for signs of withdrawal as people may deny dependent drinking.

How to use the CIWA-Ar scale

The prescribing practitioner should prescribe diazepam 20mg to be given for CIWA-Ar scores of 11 or more. All other sedative hypnotics already prescribed for the patient should continue to be prescribed at the same doses and times, on a regular basis in the "regular medication" section of the prescription sheet.

Take the scale with you when assessing the patient. Ask each question as it appears on the CIWA-Ar and assign a score to each item. Speak slowly and clearly and reword questions, if necessary.

Adjust the score based on the subjective and objective signs and symptoms. Add up the number of points and assign a total score.

Take the vital signs. These are not factored into the overall scoring but they provide important clinical information. Slight elevation of these signs is common. Please record Vital Signs and Neurological Observations separately every 90 minutes

Medical review at 200mg or every 24 hours should be noted on the 'as required' section of the prescription sheet.

What to do next

If CIWA-Ar score is 11 or over administer Diazepam 20mg po stat

If the CIWA-Ar score is under 11 do not administer medication

After 90 minutes, reassess symptoms of withdrawal, using the CIWA-Ar again. If CIWA-Ar score is 11 or over administer diazepam 20mg po stat. Patient can be reassessed sooner than 90 minutes if previous score was below 11 and symptoms have worsened.

Repeat the process <u>every</u> 90 minutes until CIWA-Ar score is under 11 on 3 consecutive occasions. At this point formal detoxification is complete and CIWA-Ar assessments may be stopped.

Continue then to monitor informally including monitoring vital signs and neurological observations to ensure there is no re-emergence of symptoms.

If the patient is asleep (usually at night) at the time of their scheduled CIWA-Ar then the CIWA-Ar should be suspended and their respiratory rate should be checked and noted. The patient should be returned to every 90 minutes and their respiratory rate rechecked and noted. On waking, the CIWA-Ar should resume until three consecutive CIWA-Ar scores have fallen below 11.

What to expect generally

Expect that a significant minority of patients will not require diazepam at all as CIWA-Ar score will be under 11 from the outset. Expect a median duration of detoxification of 8 hours.

What if CIWA-Ar score remains above 11 after 24 hours?

Some patients may remain symptomatic despite prolonged (i.e. >24 hours) CIWA-Ar monitoring and Benzodiazepine treatment. In such cases, the diagnosis of Alcohol Withdrawal should be medically reviewed. Look for other causes (i.e. benzodiazepine dependence, drug seeking behaviour, organic agitation as part of delirium or other cause). Discontinue detoxification, consider other drug treatment strategies and if necessary investigate further.

Seizures

Alcohol is a common cause of epileptic seizures. Well managed alcohol detoxification reduces, but does not completely prevent alcohol withdrawal seizures. Episodes are usually

experienced as a single tonic clonic seizure. Management is as per NICE CG137, the guidance describing when active treatment is required. Secondary prevention of further seizures (risk between 13-24%) is recommended: give diazepam 20mg orally and restart or continue CIWA-Ar scored alcohol withdrawal detoxification procedure.

Remember Pabrinex

Wernicke-Korsakoff Syndrome (WKS) is a neurological syndrome of Vitamin B deficiency that may have serious sequelae.

Prophylaxis against Wernicke-Korsakoff Syndrome should be given to all alcohol dependent patients as follows: Pabrinex (Ampoules I & II) I.V. two pairs three times daily for 3 days. Pabrinex should be diluted in 100ml saline infused over 30 minutes.

In patients with signs of possible WKS, (i.e. acute delirium, ataxia, gaze palsy), give 2 pairs of Pabrinex (Ampoules I & II) I.V. three times daily and continue beyond three days for as long as symptoms are improving.

When to refer for assistance?

If symptoms continue for longer than 24 hours please refer for medical review. For repeat attendees please refer to Substance Misuse Liaison Nursing Team.
For those wanting assistance with changing drinking behaviours please refer to Substance Misuse Liaison Nursing Team.

For referrals the following information is required by telephone to internal extension: 44901.
Patients – Name, Hospital number/Date of Birth, Ward, Referral details.

The Substance Misuse Nursing Team covers only the acute settings in University Hospital Llandough and University Hospital of Wales. Advice in mental health settings can be sought from Pinwydd (Pine) Ward, Hafan Y Coed Hospital (see useful contacts) or through E-DAS (Entry to Drug and Alcohol Services) for Cardiff & Vale TEL: 0300 300 7000 for potential community assessment / treatment referrals if discharged from acute setting.

Discharge

Ideally any patient commencing a symptom triggered alcohol detoxification as an inpatient should be allowed to complete it (adjudged to be three consecutive CIWA-Ar scores under 11).

If discharging a patient part way through an alcohol detoxification, the rationale for discharge should be explained in the patient record.

Thiamine 100mg TDS should be include in TTH and advice to GP.

Training

Please approach your ward manager / clinical lead to arrange CIWA-Ar training and ensure that you update training annually.

Appendix 1

CLINICAL INSTITUTE WITHDRAWAL ASSESSMENT FOR ALCOHOL (CIWA-Ar) (Sullivan et al.,1989)

Patient_____Date _____ Time_____Pulse ___ (for one min.)

NAUSEA AND VOMITING – Ask "Do you feel sick to your stomach? Have you vomited?" Observation	TACTILE DISTURBANCES – Ask "Have you any itching, pins and needles, any burning, or numbness or do you feel bugs crawling under your skin?"
0 No nausea **1** Mild nausea with no vomiting **2** **3** **4** Intermittent nausea with dry heaves **5** **6** **7** constant nausea, frequent dry heaves and vomiting	**0** None **1** Very mild itching, pins and needles, burning or numbness **2** Mild itching, pins and needles, burning or numbness **3** Moderate itching, pins and needles, burning or numbness **4** Moderately severe hallucinations **5** Severe hallucinations **6** Extremely severe hallucinations **7** Continuous hallucinations
TREMOR – arms extended and fingers spread apart. Observation	AUDITORY DISTURBANCES – Ask " Are you more aware of sounds around you? Are they harsh? Do the frighten you?
0 No tremor **1** Not visible, but can be felt fingertip to fingertip **2** **3** **4** Moderate, with patient's arms extended **5** **6** **7** severe, even with arms not extended	**0** Not present **1** Very mild sensitivity **2** Mild harshness or ability to frighten **3** Moderate harshness or ability to frighten **4** Moderately severe hallucinations **5** Severe hallucinations **6** Extremely severe hallucinations **7** Continuous hallucinations
PAROXYSMAL SWEATS –Observation	VISUAL DISTURBANCES – Ask "Does the light appear to be too bright? Is its colour different? Does it hurt your eyes? Are you seeing anything that is disturbing to you? Are you seeing things that you know are not there? Observation
0 No sweat visible **1** Barely perceptible sweating, palms moist **2** **3** **4** Beads of sweat obvious on forehead **5** **6** **7** Equivalent to acute panic states as seen in severe delirium or acute schizophrenic reactions	**0** Not present **1** Very mild sensitivity **2** Mild sensitivity **3** Moderate sensitivity **4** Moderately severe hallucinations **5** Severe hallucinations **6** Extremely severe hallucinations **7** Continuous hallucinations
ANXIETY – Ask "Do you feel nervous?" Observation	HEADACHE, FULLNESS IN HEAD – Ask "Does your head feel different/ Does it feel like there is a band around our head?" Do not rate for dizziness or light-headedness. Otherwise rate severity
0 No anxiety **1** Mildly anxious **2** **3** **4** Moderately anxious, or guarded so anxiety is inferred **5** **6** **7** Equivalent to acute panic states as seen in severe delirium or acute schizophrenic reactions	**0** Not present **1** very mild **2** mild **3** moderate **4** moderately severe **5** severe **6** very severe **7** extremely severe
AGITATION – Observation	ORIENTATION AND CLOUDING OF SENSORIUM – Ask "What day is this/ Where are you? Who am I?"
0 Normal activity **1** Somewhat more than normal activity **2** **3** **4** Moderately fidgety and restless **5** **6** **7** Paces back and forth during most of the interview, or constantly thrashes out	**0** Orientated and can do serial additions **1** Cannot do serial additions or is uncertain about date **2** Disorientated for date by no more than two calendar days **3** Disorientated for date by more than two calendar days **4** Disorientated for place and/or person

Appendix 2

'Symptom Triggered Therapy' Alcohol Detoxification Monitoring - form

Name_____NHS No. _____ Date _____

SYMPTOMS								
Date /Time (Sign)								
1. Nausea								
2. Tremor								
3. Sweats								
4. Anxiety								
5. Agitation								
6. Tactile								
7. Auditory								
8. Visual								
9. Headache								
10. Orientation								

Total								

Appendix 3

Symptom Triggered Alcohol Detoxification

NHS WALES GIG CYMRU | Bwrdd Iechyd Prifysgol Caerdydd a'r Fro | Cardiff and Vale University Health Board

ON ADMISSION:

The following information may indicate likelihood of alcohol withdrawal reaction:

1. drinking large amounts of alcohol over a long period of time
2. past history of withdrawal symptoms
3. last drink within the past 12 hours.

If withdrawal expected prescribe as follows:

Write "diazepam 20mg for CIWA-Ar scores of 11 or more" on PRN side of chart

oral thiamine 100mg tds

Signs of WKS ? — NO / YES

Score CIWA-Ar every 90 mins

Pabrinex: 2 pairs of amps tds as long as improvement continues (IM or slow IV infusion over 30 mins)

CIWA-Ar Score 11 or more ? — NO / YES

three consecutive Scores below 11? — NO / YES

Pabrinex: 1 pair of amps bd (IM or slow IV infusion over 30 mins) for three days

Administer diazepam 20mg orally

STOP detox & consider referral to SM liaison team*

Maintain on oral thiamine 100mg tds and include on TTH

More than 200mg diazepam given, and / or still scoring after 24 hours ? — NO / YES

Medical review:
1. Decision to continue or suspend CIWA detox
2. if continuing specify next medical review
3. if complex detox consider SM liaison input?

Seizures in Alcohol detoxification

Usually experienced as a single tonic clonic seizure.

Manage prolonged seizure or status epilepticus as per NICE CG137

Post seizure, administer single dose of diazepam 20mg (as shown in flowchart) and continue / restart CIWA-ar scoring.

Acronyms:
CIWA-Ar –Clinical Institute Withdrawal Assessment – Alcohol Revised
WKS – Wernicke Korsakoffs Syndrome
(consider if ANY of acute delirium, ataxia, gaze palsy)
TTH – to take home (discharge medication)
IM – intramuscular IV – intravenous

* **Substance Misuse (SM) liaison contacts**
For:
Mental health patients: – contact Pinwydd 24830
Patients in other areas: – contact 44901

References

Sullivan, J.T., Sykora, K., Schneiderman, J., Naranjo, C.A. & Sellers, E.M. (1989). Assessment of alcohol withdrawal: The revised Clinical Institute Withdrawal Assessment for Alcohol scale (CIWA-AR). *British Journal of Addiction, 84,* 1353-1357.

National Institute of Clinical Excellence (2010) Alcohol-use disorders: Diagnosis and clinical management of alcohol-related physical complications. NICE clinical guidance 100. Available at www.nice.org.uk/cg100 [NICE guideline]

National Institute of Clinical Excellence (2012) The epilepsies: the diagnosis and management of the epilepsies in adults and children in primary and secondary care. NICE clinical guidance 137. Available at www.nice.org.uk/cg137 [NICE guideline]

Useful contacts

Substance Misuse Liaison Team
Room 104, First Floor
Monmouth House
UHW
Ext: 44901

Pinwydd (Pine) Specialist Substance Misuse Inpatient Unit
Hafan Y Coed,
UHL
Ext: 24830 or 24840

EDAS
Entry to Drug and Alcohol Services Cardiff and Vale
Tel: 0300 300 7000
http://www.e-das.wales.nhs.uk

The All Wales Drug and Alcohol Helpline (DAN)
Tel: 0808 808 2234