Policy Title: CIWA (Clinical Institute Withdrawal Assessment) Protocol	**Review/Revision by:** P. Moore, BSN, RN, CCRN, Assistant Director, CCU
Approved by: Dr. Perez; J. Mazzola, DO, CPE, MBA, VP of Medical Affairs; Dr. Shah; B. Wagner, DNP, RN, Chief Nursing Officer, Vice President, Nursing and Patient Care Services	**Approval Date:** February, 2023
Summary of revisions: Assessment scale times changed	

Acute alcohol withdrawal commonly occurs as an episode typically lasting 4 to 5 days after an extended period of heavy drinking. Withdrawal is more likely to occur in people with heavier alcohol intake. Withdrawal states are commonly more severe in older individuals, individuals who are also dependent on anti-depressants and individuals who have had previous alcohol withdrawal experiences.

Policy: Signs and symptoms of withdrawal from alcohol will be recognized and treated promptly to prevent further complications. Signs and symptoms may include but are not limited to nausea and vomiting, tremors, paroxysmal sweats, anxiety, agitation, tactile, auditory and/or visual disturbances, headache/fullness in head, confusion and clouding of sensorium.

CIWA scale: Measures and scores 10 symptoms. Scores of less than 8 to 10 indicate minimal to mild withdrawal. Scores 11 to 15 indicate moderate withdrawal, and scores >15 indicate severe withdrawal. (Refer to attached CIWA scale for details)

Alcohol use disorder: Alcohol use disorder and dependency is characterized by having more than fourteen standard drinks per week for men, eleven drinks per week for women, and more than three drinks per week for older adults greater than sixty-six years old. (Kane, Horton, McWilliams, Melson, & Moony, 2014)

Alcohol withdrawal syndrome: Alcohol withdrawal syndrome (AWS) is the name for the symptoms that occur when a heavy drinker suddenly stops or significantly reduces their alcohol intake. Symptoms often start within 6 hours after a person stops drinking. The symptoms may be present for 1 or 2 days, or may last for up to 7-10 days. ("Alcohol Withdrawal. The Basics," 2019).

Patient Outcome: There will be prompt recognition of withdrawal signs and symptoms. The patient experiencing signs/symptoms of withdrawal will receive appropriate interventions as quickly as possible to decrease risk of severe withdrawal (delirium tremens) and to maintain optimal health.

Personnel: RN, LPN

Procedures:

1. Upon admission to the hospital, every patient will be screened for alcohol use, and documented in the Adult Admission History. Patients that have been identified as having alcohol use disorder or who have a history of alcohol abuse will have CIWA scale assessed every 4 hours for the first 72 hours after admission. If CIWA scale is scored greater than or equal to 8 the scale will continue per protocol until the score remains less than 8 for 6 consecutive increments.
2. Phase 1 of CIWA protocol will be initiated on all patients identified with alcohol use disorder or have a history of alcohol abuse.
3. At any time during patient hospitalization if patient exhibits or expresses to staff signs and symptoms of withdrawal, nursing will initiate CIWA protocol phase 1.

Phase 1

1. Vital signs (VS): Heart rate (HR) and Blood pressure (BP) at least every 4 hours. May be required more often based on patient condition, and location within the hospital. **Notify provider if: HR > 130, SBP > 180, DBP > 110.**
2. Ensure wall suction is set up and functioning properly in room.
3. Initiate Aspiration Precautions.
4. Initiate Falls Precautions.
5. Give thiamine 100 mg PO/IM/IV now, and then thiamine 100 mg PO/IM/IV BID. (If patient able to swallow give PO, if unable to swallow give IV/IM)
6. Give folic acid 1 mg PO/IV once daily (If patient able to swallow give PO, if unable to swallow give IV)
7. Give multi-vitamin 1 tab by mouth daily.
8. If CIWA is > 0 but < 8 and all VS are stable, no additional medications required. Repeat VS every 4 hours and prn, and CIWA scale every 4 hours and prn.
9. After initial 72 hours of CIWA assessments are complete, complete an additional 24 hours of CIWA assessments. If CIWA score is < 8 for 6 consecutive 4 hour increments (24 additional hours/ 96 hours total), discontinue CIWA assessments and VS, maintain medications administrations (thiamine, folic acid, and MVI).

Phase 2 - (Requires provider order to initiate)

1. When CIWA score is ≥ 8, notify MD and obtain order for initiation of Phase 2 of CIWA protocol. (Unless Phase 2 and medications for withdraw are already ordered)
2. When CIWA score ≥ 8 administer chlordiazepoxide PO (MD to determine dose and frequency) - Hold if too sedated.
3. If CIWA is ≥ 8 but < 15, may give lorazepam 1 - 2 mg PO/IM/IV (MD to determine dose) every 2 hours as needed if chlordiazepoxide is not effective and patient remains agitated; repeat VS every 2 hours and CIWA scale every 4 hours.
4. **When CIWA ≥ 15, notify provider** (only notify provider 1st time score is 15 or greater)**.**

5. If CIWA is ≥ 15 or DBP > 110, give lorazepam 1-2 mg PO/IM/IV (MD to determine dose) every 1 hour until CIWA score is <15 or DBP <110. Repeat VS and CIWA every 1 hour until CIWA score is < 15 and DBP < 110. When CIWA is between 8 - 15, resume lorazepam every 2 hours as needed, VS every 2 hours and CIWA scale every 4 hours.
6. **Notify provider if patient requires ≥ 8 mg of lorazepam in 4 hours, or uncontrolled behavior. May require additional orders.**
7. May awaken patient to complete CIWA scale and VS.
8. When CIWA is < 8 for 6 consecutive 4 hour increments (24 hours), discontinue CIWA protocol phase 2. Maintain medications ordered in phase 1 (thiamin, folic acid, and MVI).
9. Administer Zofran 4 mg PO/IVP every 6 hours as needed for nausea/vomiting (If patient able to swallow give PO, if unable to swallow give IV).

CIWA scale is found in Cerner - Interactive view (I-view), Substance Withdrawal band, Alcohol Withdrawal CIWA.

Nausea and Vomiting: Ask, "Do you feel sick to your stomach? Have you vomited?" Observation: 0 No nausea and no vomiting 1 Mild nausea and no vomiting 2 3 4 Intermittent nausea with dry heaves 5 6 7 Constant nausea, frequent dry heaves and vomiting.	**Tactile Disturbance:** Ask, "Have you any itching, pins and needles sensations, any burning, any numbness, or do you feel bugs crawling under your skin?" Observation: 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 Moderate severe hallucinations 5 Severe hallucinations 6 Extremely severe hallucinations 7 Continuous hallucinations
Tremor: Arms extended and fingers spread apart. Observation: 0 No tremor 1 Not visible but can be felt fingertip to fingertip 2 3 4 Moderate, with patient's arm extended 5 6 7 Severe, even with arms not extended	**Auditory Disturbances:** Ask, "Are you more aware of sounds around you? Are they harsh? Do they frighten you? Are you hearing anything that is disturbing to you? Are you hearing things you know are not there?" Observation: 0 Not present 1 Very mild harshness or ability to frighten 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:

0 No sweat visible
1
2
3
4 Beads of sweat obvious on forehead
5
6
7 Drenching sweats

Visual Disturbances: Ask, "Does the light appear to be too bright? Is the color different? Does it hurt your eyes? Are you seeing anything that is disturbing to you? Are you seeing things you know are not there?" Observation:

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:

0 No anxiety, at ease
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

Headache, Fullness in Head: Ask, "Does your head feel different? Does it feel like there is a band around your head?" Do not rate dizziness or lightheadedness. Otherwise, rate severity.

0 Not present
1 Very mild
2 Mild
3 Moderate
4 Moderately severe
5 Severe
6 Very severe
7 Extremely severe

Agitation: Observation

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 about

Orientation and Clouding of Sensorium: Ask, "What day is this? Where are you? Who am I?" Observation:

0 Oriented and can do serial additions
1 Cannot do serial additions or is uncertain about date
2 Disoriented for date by no more than 2 calendar days
3 Disoriented for date by more than 2 calendar days
4 Disoriented for place and/or person

References

Alcohol Withdrawal. The Basics. (2019). Retrieved April 16, 2019, from http://online.lexi.com/lco/action/doc/retrieve/docid/disandproc/3755782?searchUrl=%2Flco%2Faction%2Fsearch%3Fq%3Dalcohol%2520%26t%3Dname%26va%3Dalcohol%2520#the-basics.

Kane, M., Horton, T., McWilliams, J., Melson, J., & Mooney, R. (2014). Improving alcohol withdrawal outcomes in acute care. The Permanente Journal, 18(2), 141-145.