Worcestershire Acute Hospitals NHS Trust

RECOGNITION AND TREATMENT OF ALCOHOL MISUSE IN ACUTE HOSPITAL SETTINGS

This guidance does not override the individual responsibility of health professionals to make appropriate decision according to the circumstances of the individual patient in consultation with the patient and /or carer. Health care professionals must be prepared to justify any deviation from this guidance.

Introduction

- Hospital episode statistics for 2010/11 show a rise in the number of hospital admissions wholly attributable to alcohol to 198,900, this was a 2.1% rise on 2009/10 and a 40% increase since 2002/03. **NCEPOD (2013)**
- Data from the Office for National Statistics demonstrated that there were 8,748 alcohol-related liver disease deaths in the UK in 2011 **NCEPOD (2013)**
- Alcohol misuse is estimated to cost the NHS £3.5bn a year. Almost one in four of all adults drink in a way that is potentially or actually harmful. **NCEPOD (2013)**

THIS GUIDELINE IS FOR USE BY THE FOLLOWING STAFF GROUPS:
All staff involved in delivery of hands on care in Acute Hospitals

Lead Clinician(s)

Mark Vardy	Alcohol Liaison Nurse, A&E WRH
Approved by Clinical Effectiveness Committee on:	9th September 2017
Approved by Medicines Safety Committee on:	13th October 2015
Extension approved on:	27th May 2020

Review Date: 27th November 2020
This is the most current document and is to be used until a revised version is available

Date	Amendment	Approved by:
April 2010	Contents page added along with section 10 Alcohol Ketoacidosis. Monitoring tool also added.	Mark Vardy
February 2011	Reviewed and amended to take account of released NICE guidance.	Mark Vardy
January 2013	Added M-SASQ to screening tools to take account of new evidence. **M. Vardy ALN/WRH.**	Mark Vardy

	Clarification of limited amount of withdrawal medication dispensed on discharge compliant with NICE guidance. CG115 **M. Vardy ALN/WRH.**	
January 2013	References to CIWA Scale added to quick reference algorithm (CIWA scale already in main body of guideline) **E. Davies ALN/ALX.**	Mark Vardy
February 2013	Various clarifications to medication regimen in body of guideline and quick reference algorithm. Suggested by **L. Beale, Pharmacy**.	Mark Vardy
April 2015	NICE complete review of Alcohol guidance (CG 100 and CG 115)	Mark Vardy
June 2015	Revision on guidance on Vitamin B co strong tablets **M. Harris and E. Lowther, Pharmacy, WRH.**	Mark Vardy
June 2015	Revision of IV Pabrinex prescribing against NICE guidance **E. Davies, ALN/ALX and M. Vardy, ALN/WRH. M. Harris and E. Lowther Pharmacy WRH.**	Mark Vardy
June 2015	Addition of AUDIT-C screening tool to appendices **E. Davies ALN/WRH.**	Mark Vardy
June 2015	Revision of contact information for community alcohol services to reflect new local service provision.	Mark Vardy
July 2015	Review of monitoring tool **E. Davies ALN/ALX I. Levett Cons A&E WRH M. Vardy ALN/WRH**	Mark Vardy
July 2015	Addition of further names of people contributing to the document at this review.	Mark Vardy
Sept 2017	Rewrite of introduction to update information	Mark Vardy
Sept 2017	**Addition** of section 11.5 regarding driving to reflect DVLA medical advice released 2016 updated in 2017 Suggested by **E Davies and M Vardy, ALNs**	Mark Vardy
August 2017	Rewrite of medication regimen table 1 in body of guideline and quick reference algorithm. Suggested by **S. Connop, Pharmacy**	Mark Vardy
August 2017	**Adjustments** to Maximum dosage in Chlordiazepoxide prescribing to reflect NICE and BNF guidance suggested by **S.Connop, Pharmacy**	Mark Vardy
October 2019	Document extended for 6 months whilst under review	Emma Davies
May 2020	Document extended for 6 months during COVID-19, whilst under review	Emma Davies

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In emergency please refer direct to treatment algorithms on pages 19-20

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2. COMPETENCIES REQUIRED

- Standard Clinical Assessment Skills

- Standard Health Promotion Advice Delivery Skills

- For brief motivational intervention, training is available from external agencies and in-house (Please contact Alcohol Liaison Nurse at Worcester on 01905 763333 bleep 565 or at the Alex on 01527 503030 bleep 0340)

3. STAFF COVERED

All staff involved in delivery of hands on care in acute hospitals.

4. PATIENTS COVERED

4.1 Screening
All patients who present for treatment with or without overt histories of alcohol misuse.

4.2 Brief Intervention
Patients identified as drinking alcohol at levels associated with increased risk of alcohol related illness or dependency according to current DH guidance. (See Definitions)

4.3 Management of alcohol withdrawal
Patients identified as clinically dependent on alcohol.

5. DEFINITIONS

Patterns of Alcohol Misuse

Alcohol related risk may be viewed as dose related. The terminology to describe alcohol use disorders is currently evolving. There is no "safe level" of drinking and the risk of harm increases with frequency of consumption or amount consumed

[Day, E. Copello, A. Hull, M. *(2015)*]

New Guidance for men and women advises that alcohol use above 14 units per week or involving single episodes of drinking 6 units or more increases the risk of alcohol related harm to health.

[CMOUK (2016)**]**

Harmful use

A pattern of psychoactive substance use that is causing damage to health. The damage may be physical (as in cases of hepatitis from the self-administration of injected drugs) or mental (e.g. episodes of depressive disorder secondary to heavy consumption of alcohol). **[WHO** (1992)**]**

Dependent drinker (See below)

6. GUIDELINES

6.1 Identification

Alcohol misuse may be identified using a range of methods including,

- Laboratory markers including raised LFT and MCV values. Serum phosphate may be very low (<0.4mmol/l) in acute alcohol withdrawal as may magnesium.
- Clinical findings/medical history elicited during clerking
- Brief structured questionnaires (see appendices 3-8)

6.2 Initial screening and advice

Health professionals should routinely carry out alcohol screening as an integral part of practice**.** **[22.P12 NICE PHG 24 (2010)]**

Where practical ALL patients in admitting areas should be asked about alcohol use and as a minimum intervention advised of the current guidelines for sensible drinking which are;

- You are safest not to drink regularly more than 14 units a week, to keep health risks from drinking alcohol to a low level.
- If you do drink as much as 14 units per week, it is best to spread this evenly over 3 days or more. If you have one or two heavy drinking sessions, you increase your risks of death from long term illnesses and from accidents and injuries.
- The risk of developing a range of illnesses (including for example, cancers of the mouth, throat, and breast increases with any amount you drink on a regular basis.
- It is a good idea to have several drink free days each week
- If you are pregnant or planning a pregnancy the safest approach is not to drink alcohol at all, to keep risks to your baby to a minimum. **[UKCMO** (2016)**]**

6.3 Identifying dependence

It is important to get an accurate account of a patients drinking pattern on admission paying particular attention to reports of:

- Compulsive drinking (including avoidance of withdrawal symptoms)
- Loss of control over drinking.
- Experience of withdrawal on abstinence.
- Evidence of tolerance to alcohol (escalating intake to obtain desired effect).
- Evidence of salience of drinking (obtaining and drinking alcohol is the main activity in daily life).
- Persistence of use (despite evidence of mounting health and social harm).

Three or more of the above occurring together for at least 1 month or repeatedly over the last year identifies **dependence** [**WHO** (*1992)*] and will require further treatment.

7. ALCOHOL WITHDRAWAL MANAGEMENT GUIDELINES
(See Appendix 1 Algorithm on Page 14)

7.1 Case identification

Alcohol withdrawal may be a presenting feature or occur as an unexplained development in a patient who has been admitted for other reasons and ceased drinking alcohol deliberately or as a consequence of ill health. The extent of drinking in a persons life may be knowingly or unknowingly concealed.

Signs and symptoms of alcohol withdrawal can appear anywhere between 6 and 72 hours after the last consumption of alcohol, and the range and severity of symptoms depends on factors such as the degree of alcohol dependence and the current level of consumption.

Possible symptoms and signs include [**Hall, W. and D. Zador**, *(1997)*]:

- Signs & symptoms of autonomic over-arousal:
  - sweating
  - tachycardia (100+ bpm)
  - raised BP
  - Pyrexia (37-38 ^{o}C)
  - hyperreflexia
- Characteristic tremor, starting in the hands but progressing to the head and trunk as the severity worsens
- Anxiety, restlessness, irritability, depression, insomnia and tiredness
- Anorexia, nausea and weakness
- Confusion

Alcohol withdrawal can be seen as presenting along a spectrum from mild tremulousness, with or without changes in mood, through to seizures, hallucinations and delirium [**Raistrick, D.**,

(*2001*)]. A major concern is to prevent the severely alcohol dependent person from developing Delirium Tremens (DTs), seizures or Wernicke's encephalopathy.

7.2 Acute Management of the Alcohol Withdrawal Syndrome

Treatment of alcohol withdrawal should be symptom triggered, i.e. tailored to the persons individual needs and determined by the severity of withdrawal signs and symptoms

[**P5 NICE CG 100 (2010)**

Follow locally specified protocols for assessment and monitoring of Alcohol Withdrawal, and consider using an assessment tool such as CIWA-Ar scale in addition to clinical judgement see p 27.

It is important that patients who are being treated for alcohol withdrawal are given a clear, supportive explanation of the withdrawal management regimen at the outset. They should be oriented to time and place where necessary and reassured that distressing symptoms will be effectively treated.

7.3 Mild Symptoms

- These can generally be managed with reassurance and general support.
- A well lit, cool environment with friendliness and reassurance from nursing staff or relatives is ideal for the confused patient [**CRAG Working Group on Mental Illness**, ***(1998)***]
- Attention should be paid to optimising nutrition and fluid balance.

7.4 Risk factors for progression to severe withdrawal include [**Raistrick, D.**, ***(2001)***]:

- High alcohol intake (>15 units per day)
- Previous history of severe withdrawal, seizures or DTs
- Concomitant use of other psychotropic drugs
- Poor physical health
- High levels of anxiety or other psychiatric disorders
- Electrolyte disturbance
- Fever or sweating
- Insomnia
- Tachycardia

The greater the number of these symptoms, the greater the need for inpatient medical supervision to prevent seizures or DTs.

People at high risk of alcohol withdrawal seizures or Delirium tremens or aged under 16 and in acute withdrawal, and/or who are frail, cognitively impaired, lack social support,

have learning difficulties or have other vulnerabilities or are aged 16-17 years should be offered admission to hospital. [P6 NICE CG 100 (2010)]

Detoxification outcomes are better where there is some evidence of a desire and intention to change drinking behaviour elicited from the patient, evidence of engagement with specialist psychosocial support for avoidance of alcohol after detoxification should also be considered.

There is evidence that multiple detoxifications are associated with poorer treatment response. [Raistrick, Heather, Godfrey (2006) p.128]

In more severe cases, medication can reduce symptoms and reduce the risk of the patient developing convulsions or delirium tremens **[Mayo-Smith, M.F., *(1997)*]** [**Williams, D. and A.J. McBride**, ***(1998)***]. Medium- to long-acting benzodiazepines are the treatment of choice, provided the patient does not have severe liver disease or severe respiratory disease.

7.5 Recommended regimens are given below:
The benzodiazepine of choice for alcohol withdrawal syndrome is **Chlordiazepoxide [p7 NICE 100/115 (2010)]**

The following regimen (***Table 1***) will be suitable in most cases.

- The dose should ***always*** be titrated to the individual patients' response. Typically a maximum dose of 200mgs Chlordiazepoxide in 24 hours will control withdrawal symptoms. **[p7 NICE 100/115 (2010)]**

- Doses **may have to be increased** in more severely dependent drinkers (by adding 10-20 mg qds on a prn basis), up to a **maximum of 250 mgs in 24 hours [BNF 2017]**

- Smaller, frail/elderly, less dependent patients or **patients with compromised liver function may need a reduced dosage.**

- Generally, in the first three to four days, doses should ideally be spread across four drug rounds, with night and morning doses reduced last in order to maintain drug levels.

- The patient should be carefully monitored for signs of benzodiazepine toxicity.

Table 1 Recommended chlordiazepoxide tapering regimen NB for guidance purposes only. Clinical areas may have their own locally agreed treatment guidance.

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Morning	30mgs	30mgs	20mgs	20mgs	10mgs	10mgs	10mgs
Midday	30mgs	20mgs	20mgs	10mgs	10mgs	10mgs	0
Afternoon	30mgs	20mgs	20mgs	10mgs	10mgs	0	0
Night	30mgs	30mgs	20mgs	20mgs	10mgs	10mgs	10mgs
Total daily dose	120mgs	100mgs	80mgs	60mgs	40mgs	30mgs	20mgs

Less dependent patients may commence on “Day 3” of the above regimen, with provision for prn chlordiazepoxide to cover breakthrough withdrawal symptoms. More seriously dependent patients or those scoring over 20 on the CIWA scale may require a starting dose of 40 mgs.

The aim in managing alcohol withdrawal is to keep the patient comfortable without over sedation or progression to delirium tremens.

Patients who are less dependent on alcohol can be started on smaller doses but night doses should be the last to be reduced.
Doses are best tapered smoothly to reduce patients’ discomfort and the risk of further complications of alcohol withdrawal.

7.6 Lorazepam

This should be used as an alternative to Chlordiazepoxide where there are clinical signs or a history of *significant* liver function impairment. However, lorazepam has a much shorter half-life and is less prone to accumulation and toxicity, this means that the patient needs to be monitored more frequently between doses to avoid breakthrough alcohol withdrawal symptoms.

7.7 Cautions in Benzodiazepine Use

Benzodiazepines can cause respiratory depression as well as sedation. The use of such drugs should be carefully considered and monitored in certain clinical situations such as liver or renal impairment or in cases of suspected or recent head injury where neurological symptoms may be masked. A head CT scan should be considered and the situation balanced with the need to manage significant alcohol withdrawal effectively. Lorazepam may be more appropriate due to shorter half-life.
For people with alcohol withdrawal seizures consider offering lorazepam to reduce the likelihood of further seizures, Phenytoin is not recommended for alcohol withdrawal seizures

[P.7 NICE CG 100 (2010)]

Optimisation of withdrawal control with benzodiazepine may be sufficient to relieve seizures.

7.8 Severe withdrawal

The following clinical features may warrant admission to hospital for treatment:

- Previous history of severe withdrawal or seizures
- High risk of developing Wernicke’s Encephalopathy
- Alcoholic hallucinosis
- Depression
- Suicidal ideation
- Poor or absent social support

8. DELIRIUM TREMENS (DTs)

This has a mortality rate of up to 20% if untreated, and is recognised by:

- Increasing confusion and disorientation
- Severe tremor and autonomic disturbance
- Visual and auditory hallucinations
- Delusional beliefs

Prompt recognition of the risk of alcohol withdrawal and treatment with benzodiazepines will usually prevent this. Initial management of the severely confused or agitated patient requires the administration of adequate sedative doses of benzodiazepines (intravenously if necessary). **The object of treatment is to keep the patient calm and sedated but easily roused.**

- For patients able to take oral medication, doses of chlordiazepoxide as high as 50mg every 2 hours may be necessary (**do not exceed 200 mgs in 24 hours**)
  [NICE CG100/115 (2010)]
  However in exceptional circumstances 250 mgs in 24 hours may be required in well supervised in-patient settings. [BNF 2017]

- Rectal diazepam may be useful where there is difficulty establishing venous access
  [CRAG Working Group on Mental Illness, *(1998)*]
- For patients with significant liver or renal impairment, IV lorazepam at doses of up to 1-2mg every 30 minutes, given slowly into a large vein. IM lorazepam may only be used when the oral/IV routes not possible. Dilute with equal volume of 0.9% sodium chloride. **(Do not exceed 8mg/24 hours)**

- Clomethiazole is **not** recommended [**Duncan, D. and D. Taylor, *(1996)*]** since it has a narrower safety margin than benzodiazepines.

- Severe psychotic symptoms may be managed by the addition of haloperidol 1-5mg 2-3 times per day, although adequate treatment with benzodiazepines should be the priority, as haloperidol or olanzapine alone will not control alcohol withdrawal, and may lower seizure threshold.

- Close monitoring of fluid balance is important. Urea and electrolytes (including **magnesium) should be regularly checked [CRAG Working Group on Mental Illness, *(1998)*]**

Cautions in Prescribing in Alcohol Withdrawal

Benzodiazepines

Benzodiazepine prescribing in patients with a history of alcoholism should be time limited and symptom triggered due to increased risk of dependence.

Diazepam and **Chlordiazepoxide** have UK marketing authorisation for the management of acute alcohol withdrawal symptoms.

Clomethiazole has UK market authorisation for alcohol withdrawal treatment under close inpatient supervision or by specialist services.

Lorazepam does not have UK market authorisation for this indication therefore informed consent should be obtained and documented.

Cautions in Prescribing in Delirium Tremens

Lorazepam is used for this indication however it does not have UK marketing authorisation so informed consent should be obtained and documented.

Haloperidol is used for this indication however it does not have UK marketing authorisation so informed consent should be obtained and documented. Haloperidol should be used with caution in patients with conditions predisposing to convulsions

[P12 NICE CG 100 (2010)]

"**Where an adult patient lacks the mental capacity (either temporarily or permanently) to give or withhold consent for themselves**, no-one else can give consent on their behalf. However, **treatment may be given if it is in their best interests**, as long as it has not been refused in advance in a valid and applicable advance directive." **WAHT – CG – 075** Policy for consent to examination or treatment.

9. WERNICKE'S ENCEPHALOPATHY (WE)
(See Appendix 2 - Treatment Algorithm on Page 15)

Inappropriately managed this complication of alcohol misuse

- Carries a mortality rate of over 15% **[Victor, M., R.D. Adams, and G.H. Collins, *(1989)*]**
- Results in permanent brain damage (Korsakoff's psychosis) in 85% of survivors [**Victor, M., R.D. Adams, and G.H. Collins**, ***(1989)***]

The classical triad of signs (acute confusion, ataxia and ophthalmoplegia) only occurs in 10% of patients [**Duncan, D. and D. Taylor**, (1996)]. Therefore the triad cannot be used as the basis of diagnosis and a high index of suspicion is needed. **The presence of only one of the following signs should be sufficient to assign a diagnosis and commence treatment** [**Cook, C.C.H**., ***(2000)***]

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

9.1 Treatment:

- Give Pabrinex IV High Potency 2-3 ampoule pairs (4-6 ampoules in total) three times daily for 5 days unless Wernickes Encephalopathy is excluded, if no improvement, review possible alternative causes of presentation.
- Do not stop IV Pabrinex until Wernickes is excluded.

[NICE CG100 (2010)] PATHWAY

Administration details: Draw the contents of one pair of ampoules into a syringe and mix. Add to 50-150ml 0.9% sodium chloride (i.e. **a minimum of 50 mls 0.9% sodium chloride per ampoule pair**) Administer IV over 30 minutes. Monitor patient for anaphylaxis.

Pabrinex should be continued until there is no further improvement of the clinical symptoms. Then start oral supplementation Thiamine 100mg bd. The routine prescribing of Vitamin B co strong is not recommended in the BNF or by NICE. But is indicated in higher doses for the specific treatment of peripheral neuropathy **[Ang, C.D. et al (2008)]**

9.2 Prophylaxis:
Prophylactic treatment is indicated in patients with concomitant findings that place increased demands on already depleted B-vitamin stores thereby increasing the risk of precipitation of WE

All patients undergoing alcohol withdrawal in association with acute illness or injury should be treated prophylactically with IV Pabrinex.

Offer higher dose **prophylactic oral thiamine (BNF recommends 200 - 300mgs daily in divided doses)** to harmful or dependent drinkers if;

- They are malnourished or at risk of malnourishment.
- They have decompensated liver disease.
- They are in acute withdrawal.
- Before and during a planned medically assisted alcohol withdrawal.

Offer **prophylactic IV Pabrinex** (See below) if;

- They are malnourished or at risk of malnourishment.
- They have decompensated liver disease.
- They attend an Emergency department.
- They are admitted to hospital with an acute illness or injury

[**P8 NICE CG100 (2010)]**

Give Pabrinex IV High Potency 1 ampoule pair daily for 3 to 5 days.
Followed by oral supplementation of Thiamine 100mg bd. The routine prescribing of Vitamin B co strong is not recommended in the BNF or by NICE. But is indicated in higher doses for the specific treatment of peripheral neuropathy **[Ang, C.D. et al (2008)]**
Intravenous dextrose should not be given before Pabrinex due to the risk of precipitating WE. This is because glucose metabolism utilises thiamine and therefore may deplete reserve.

10. ALCOHOLIC KETOACIDOSIS

This is may be a rare cause of sudden death in patients with severe alcoholism. When treated it resolves rapidly and without any apparent sequelae (McGuire LC et al 2005). The condition is thought to be associated with a ketoacidosis, a lactic acidosis, an acetic acidosis and a hyperchloraemic acidosis.

10.1 Clinical features

- Chronic alcoholic, plus **recent binge**
- Binge terminated by **severe nausea**, **vomiting** and **abdominal pain**
- Tachycardia, hypotension and increased respiratory rate
- Abdominal tenderness with no other specific abdominal findings
- Minimal alteration conscious level despite marked metabolic acidosis

10.2 Biochemical features

- Raised anion gap metabolic acidosis
- Normal or low blood glucose
- Normal or moderately elevated urea and creatinine
- Lactate insufficiently high to explain extent of acidosis
- Low or absent blood alcohol level
- Urinary ketones on dipstix testing but absence does not exclude diagnosis

10.3 Management

- Pabrinex IVHP 1 ampoule pair (2 ampoules in total) daily
- Intravenous rehydration with 5% Dextrose (avoid saline which paradoxically worsens acidosis). Monitor BMs regularly, persisting hyperglycaemia may necessitate an insulin infusion.

- Potassium supplementation (may be low on presentation or fall rapidly on rehydration)
- Magnesium and phosphate supplementation if indicated.
- Exclude other serious pathology (sepsis, intra-abdominal pathology)

11. SPECIAL SITUATIONS

11.1 Pre-admission Benzodiazepine Prescription

Some patients will have been prescribed long term benzodiazepines prior to admission.
In these cases where such prescribing can be reliably confirmed, continue the prescription unaltered and titrate alcohol withdrawal dosage **in addition** to the long term prescription.

11.2 Nausea/vomiting/dehydration may occur with alcohol withdrawal and exacerbate the condition and should be managed with metoclopramide 10mgs P.O IM or IV (not recommended in severe liver disease, seek alternative anti emetic)

11.3 Alcohol withdrawal seizures

For people with alcohol withdrawal seizures consider offering a quick acting benzodiazepine such as Lorazepam to reduce the risk of further seizures

11.4 Violence and Aggression

If violence and aggression occur then these incidents should be managed and recorded in accordance with the hospital policy on violence and aggression.

11.5 Driving and DVLA

The DVLA has issued revised guidance regarding fitness to drive in people with **alcohol dependency that is associated with abnormal biological markers**, and some conditions associated with chronic liver disease such as,

- hepatic cirrhosis with chronic encephalopathy
- alcohol induced psychosis
- cognitive impairment

These are in addition to long standing controls on drivers who have had fits associated with alcohol withdrawal that may result in revocation or suspension of driving licences, where alcohol related conditions persist.

Discharge documentation to GPs must clearly reflect that the issue of fitness to drive may need to be addressed and medical professionals are reminded of their duty to report medical conditions impacting on driver safety within professional duties of confidentiality weighed with criteria set out on the DVLA website and documents.
[DVLA 2017]

Please see:

https://www.gov.uk/guidance/drug-or-alcohol-misuse-or-dependence-assessing-fitness-to-drive

12. DISCHARGE

Patients who have had alcohol withdrawal managed secondary to their reason for acute admission/ attendance at A+E may request chlordiazepoxide or other benzodiazepine to be dispensed on discharge to "complete their detox".

This may be appropriate if the following criteria can be met and must be confirmed with the third party concerned. Information regarding met criteria must be documented in the patient's record.

- Patient otherwise medically fit for discharge and 72 hours post last witnessed fit.
- Confirmed supervision by responsible family or other appropriate social support.
- Clear understanding by the patient and carer of the risk of overdose attached to drinking alcohol with benzodiazepines.

The above safety guidelines must be supported by either,

- Confirmed support from GP.
  OR
- Confirmed current engagement and attendance with community alcohol team.

N.B. Large amounts of chlordiazepoxide should not be supplied on discharge where there is any evidence of stock-piling (e.g. receipt of existing benzodiazepine prescription from primary care) or risk of diversion to illicit drug markets.

Prescribe only enough to cover the period between discharge and the earliest possible GP appointment. **Warn against driving or operating machinery whilst taking benzodiazepines**. **[BNF 2017]**

No more than 2 days medication for assisted withdrawal should be supplied. [**NICE CG115]**

Patients who are detoxifying must be under the supervision of their GP or other nominated clinician. **The expressed desire to cease drinking does not of itself justify risky prescribing**. Detoxification from alcohol in highly dependent drinkers is not a risk free procedure and reliable social support in the community is essential.

12.1 Further supportive action

All patients with alcohol related problems should be managed according to this guidance. In addition to withdrawal management which is a medical issue, there is also the need for patients to be offered a session of structured brief advice on alcohol, this advice would include support in making an offer of access by referral or self referral to longer term contact with alcohol treatment services where appropriate.

12.2 Brief Intervention

Brief intervention enables the patient to spend 5-15 minutes to discuss with a specialist or trained non-specialist the potential risk of harm to physical and mental health associated with the patients drinking, possible barriers to changing drinking patterns, identifying further resources for longer term help with drinking problems, with goal setting as appropriate**.**

[P14 NICE PHG 24 (2010)]

Brief Alcohol Interventions in general hospitals can reduce alcohol intake at 6 and 12 months follow up. [**McQueen,J. et al (2009)]**

12.3 Referral to treatment

At **Worcester** and **Redditch** the alcohol liaison nurse should be the first point of contact for clarification or additional guidance on withdrawal management or for psychological input.

Patients should be referred to the **alcohol liaison nurses** based in A+E (Worcester and Redditch) – who will be able to offer psychological input as well as offer the patient the opportunity to engage with their local community substance misuse service on discharge for longer term counselling and support.

Wards and Units at **Worcester** and **Redditch** (when the Alcohol Liaison Nurse is unavailable), **Kidderminster** and **elsewhere** can suggest that the patient self refer to community substance misuse services directly, supplying them with the telephone number and encouragement to do so. **See p.15**

12.4 Screening
There are 6 very useful tools which are available for clinical use. (See page 21 onwards)

Single Alcohol Screening Question for initial identification of drinkers in A+E
[SIPS study (2012)]
Paddington Alcohol Test for initial identification of drinkers in A+E. [**P11 NICE PHG 24 (2010)]**

CAGE Questionnaire

Alcohol Use Disorders Identification Test- WHO validated instrument to identify patterns of alcohol use**. [P11 NICE PHG 24 (2010)]**
F.A.S.T. Screening Tool for initial identification of drinkers in A&E. [**P11 NICE PHG 24 (2010)]**

AUDIT-C - (3 questions derived from the above for brevity and sensitivity in initial screening)
[Bush et al 1998]

Clinical Institute Withdrawal Assessment for Alcohol – Revised (CIWA-R) which allows clinicians to objectively score a patients alcohol withdrawal symptoms thus guiding administration of symptom triggered benzodiazepine regimen. These tools are available below for use and reference (Page 20). [**P 11 NICE PHG 24 (2010)]**

For further information on screening tools please contact Alcohol Liaison Nurse at Worcester on Bleep 565 or Redditch on Bleep 0340.

Monitoring Tool

This should include realistic goals, timeframes and measurable outcomes.

How will monitoring be carried out?

Who will monitor compliance with the guideline?

Page/ Section of Key Document	Key control:	Checks to be carried out to confirm compliance with the policy:	How often the check will be carried out:	Responsible for carrying out the check:	Results of check reported to: *(Responsible for also ensuring actions are developed to address any areas of non-compliance)*	Frequency of reporting:
	WHAT?	**HOW?**	**WHEN?**	**WHO?**	**WHERE?**	**WHEN?**
Page 14	**Referral to ALN** 80% of Alcohol related attendances should (when sober and consenting) be referred to the Alcohol Liaison Nurse.	Comparison between patients identified as AUDs in A&E and referral returns. Pilot study pending re application of systematic electronically recorded screening and uptake	4 times a year	ALN	ALN and A&E clinical governance lead.	Quarterly End of March June September December
Page 8	**Alcohol Withdrawal** 80% of those diagnosed with alcohol withdrawal treated. For acute management of the alcohol withdrawal syndrome, Chlordiazepoxide in a tapering regime is used with	Retrospective case notes review.	2 times per year	Nominees of A&E Clinical governance lead	A&E clinical governance lead	Bi-annually at end of March and end of December

	a maximum of 200mg/day IV Lorazepam should be used if in unable to take medication orally or orally if significant liver or renal failure.					

CONTACTS

Alcohol Liaison Nurses: Emma Davies **Bleep 0340** Alexandra Hospital
Mark Vardy **Bleep 565** Worcestershire Royal Hospital

Patients or carers/concerned others should be offered the opportunity to contact the community services for ongoing counselling and support:

SWANSWELL (Worcestershire recovery partnership)

Single point of contact for referrals 0300 303 8200

Offices at:

Kidderminster 01562 510 330
Redditch 01527 406 920
Worcester 01905 721 020

Alcoholics Anonymous regional helpline 0121-212-0111

Al-anon (12 step family support) national helpline 020-7403-0888

Cocaine Anonymous (also for alcohol use) 0300 111 2285

SMART recovery: available via Swanswell offices or https://www.smartrecovery.org.uk/

ALCOHOL TRAINING / BRIEF INTERVENTION TRAINING / EXPERIENTIAL PLACEMENTS

Are available to trust employees and students by arrangement in formal or informal training sessions by the Alcohol Liaison Nurse in Worcester and details can be obtained on Bleep 565 Brief intervention training can be delivered to **all** levels of staff.

REFERENCES

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APPENDIX 1

Management algorithm for the alcohol withdrawal syndrome

Characteristics symptoms of DTs
Auditory/visual illusions/hallucinations
Clouding of consciousness
Confusion/disorientation
Delusions
Severe tremor/Agitation
Tachycardia
Pyrexia

Plus symptoms of autonomic over activity
Impaired attention /marked anxiety, Paranoid ideas
Systolic hypertension
Tachypnoea,
Insomnia
Drenching sweats (1-3 Litres in 24 hrs)
CIWA SCALE SCORE 11>

NO

Alcohol withdrawal symptoms/signs
Anxiety/agitation/irritability
Tremor of hands, tongue, eyelids
Sweating
Nausea/Vomiting/Retching
Insomnia, Fever, Tachycardia
Hallucinations in clear sensorium

CONSIDER CIWA SCALE SCORE

Mild
CIWA <10

Moderate/Severe
CIWA 11>

Oral Chlordiazepoxide** with
Pabrinex IV 1 pair amps O.D (2 amps)

Admit and continue treatment

YES = D.T.s

Oral Chlordiazepoxide and PRN doses if objectively withdrawing 50 mg P.O. 2 hourly
DO NOT exceed 200 mgs in 24 hours
Or **Diazepam** 10 mg **P.R** PRN max 30mg
Lorazepam 2-4mgs IV at 30 min intervals max 8mg
Pabrinex IV 2 ampoule pairs tds* (4 amps)
(If benzodiazepines not controlling severe psychosis consider **Haloperidol** 1-5 mgs IV/PO bd/tds Max daily dose 18mgs)

Obtain expert advice

Risk Factors for progression to severe withdrawal
High alcohol intake (>15 units/day)
History of withdrawal fits /D.T.s
Concomitant use of other Psychotropic drugs
Dual diagnosis
Poor physical health
High level of anxiety
Hypoglycaemia
Hypokalaemia
Respiratory Alkalosis
Pyrexia
Sweating
Insomnia
Tachycardia
Hypocalcaemia

NO
(No treatment necessary)

YES

Oral chlordiazepoxide** with
Pabrinex IV 1 Amp Pair O.D. (2 amps)

Admit and continue treatment

**A suggested oral chlordiazepoxide regime

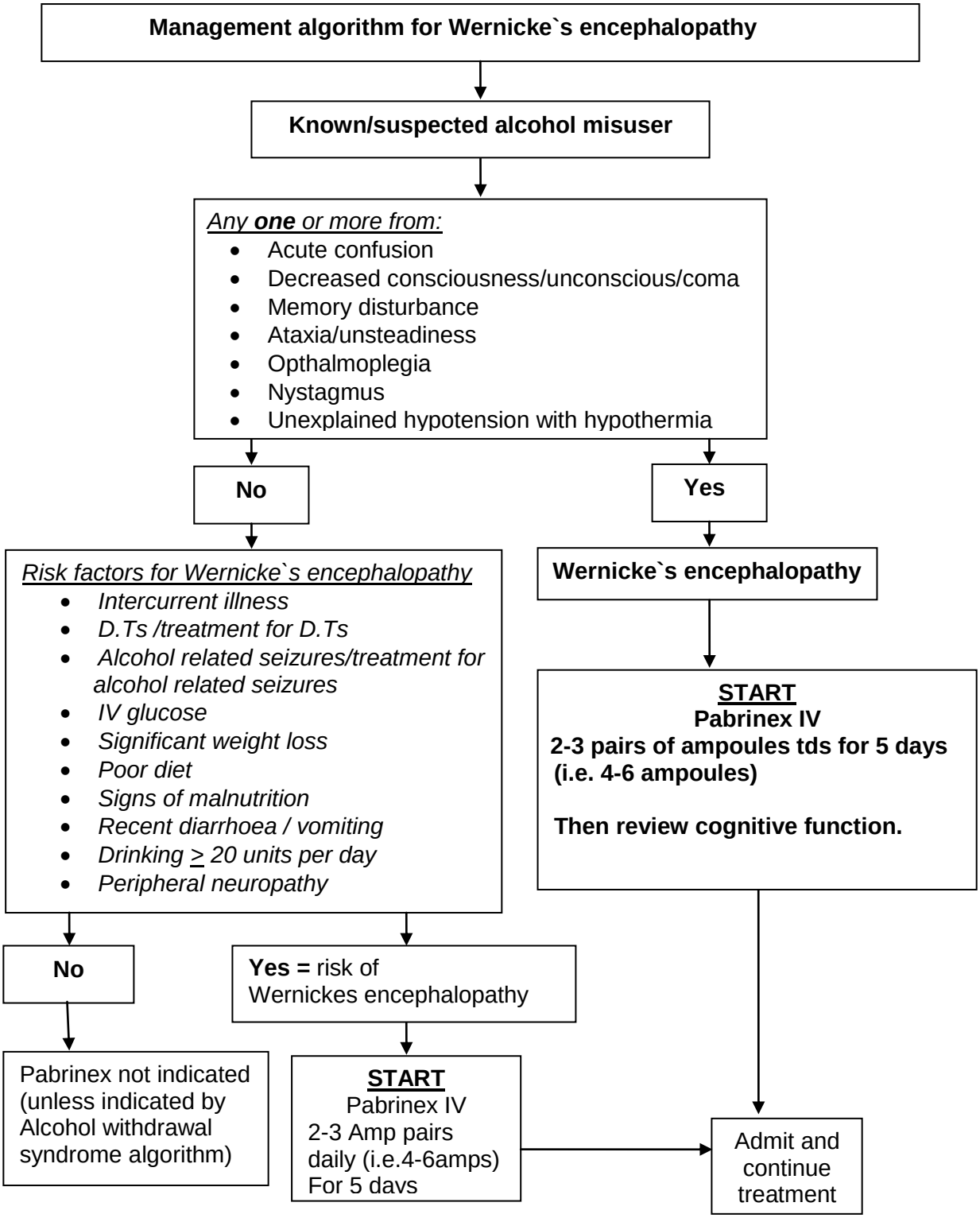
	1	2	3	4	5	6	7
Morning	30mg	30mg	20mg	20mg	10mg	10mg	10mg
Midday	30mg	20mg	20mg	10mg	10mg	10mg	0
Afternoon	30mg	20mg	20mg	10mg	10mg	0	0
Night	30mg	30mg	20mg	20mg	10mg	10mg	10mg
TOTAL	**120mg**	**100mg**	**80mg**	**60mg**	**40mg**	**30mg**	**20mg**

Add prn 10-20 mgs titrated to individual patient response**, aim for comfort without sedation.**
Review dosage if patient over sedated.
Max total dose of 200mgs per day. [up to 250mgs in exceptional cases of severe withdrawal / Delerium Tremens]

*Administration of Pabrinex IV
Pair of ampoules diluted in 50-100ml NaCl
Infuse over 30 mins

NB : Risk of anaphylaxis. Facilities to manage should be available

APPENDIX 2



Administration of Pabrinex IV
Ampoule pairs diluted in 50 mls to 100 mls Normal Saline
Infuse over 30 minutes
NB. Small risk of anaphylaxis. Facilities to manage should be available

APPENDIX 3

The Paddington Alcohol Test

[**Patton, R., Hilton, C., Crawford, M.J. & Touquet, R**. *(2004)*]

Initial screening tool designed for A+E use (14)

Circle number(s) for specific trigger(s); consider for all the top `10.

1. FALL (inc. trip) 2. COLLAPSE (inc. fits) 3. HEAD INJURY (inc. facial)

4. ASSAULT 5. NON-SPECIFIC GI 6. "UNWELL" (inc asking for Detox)

7. PSYCHIATRIC (inc. overdose) 8. CARDIAC (inc. palpitations)

9. SELF-NEGLECT 10. REPEAT attender

Other (specify) _____

After dealing with patient's "agenda", i.e. patient's reason for attendance:

1. **"We routinely ask all patients in A&E if they drink alcohol – do you drink?"**
If '**yes**', go to question two.

2. **"Quite a number of people have times when they drink more than usual; what is the most you will drink in any one day?"** (Pub measures in brackets; home measures often x3!)

Beer/lager/cider __ Pints (2) __ Cans (1.5) total units/day

Strong beer/lager/cider __ Pints (5) __ Cans (4) _____

Wine __ Glasses (1.5) __ Bottles (9)

Fortified wine (sherry, Martini) __ Glasses (1) __ Bottles (12)

Spirits (gin, whisky, vodka) __ Singles (1) __ Bottles (30)

3**. If this is more than eight units/day for a man, or six units/day for a woman, does this happen….**

….Everyday? = **YES** PAT +ve **Dependent drinker** (? Pabrinex + assess for withdrawal)
NO

….At least once a month? = **YES** PAT +ve Hazardous drinker
NO

4. **'Do you feel your current attendance in A&E is related to alcohol?**
Yes = PAT+ve **No** = PAT –ve

If PAT +ve: "We gently advise you this drinking is harming your health. Would you like to see Alcohol Liaison Nurse? **Y/N**

APPENDIX 4

The M-SASQ (single alcohol screening question)

Based on Williams and Vinson 2001(adapted for A&E WAHT)

Is this incident related to alcohol Y/N?

If so, over the last year, how often have you had 6 or more alcoholic drinks on a single occasion:

Never / Monthly / Weekly / Daily?

If monthly or more offer referral to the alcohol liaison nurse

APPENDIX 5

The CAGE Questionnaire

CAGE [**Cook, C.C.H**., (2000)] is an acronym
Derived from four questions:

- Have you ever felt you should **c**ut down on your drinking?
- Have people **a**nnoyed you by criticising your drinking?
- Have you ever felt bad or **g**uilty about your drinking?
- Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (**e**ye opener)?

The CAGE takes only a minute to complete and has been a widely used screening test in clinical practice [**Mayfield, D., McLeod, G. & Hall, P.** *(1974*)]. The items are easy to remember and can be administered orally by a practitioner.

Asking patient to restrict answers to last 6 months can give a clearer picture of current situation.

A positive reply to 2 or more questions warrants closer questioning of alcohol intake.

APPENDIX 6

The Alcohol Use Disorders Identification Test (AUDIT)

[Saunders, J. B., Aasland, O.G., Babor, T. F., De La Fuente, J. R. & Grant, M. (1993)]

1. **How often do you have a drink containing Alcohol?**
   (0) Never (1) Less than Monthly (2) 2-4 times a month (3) 2-3 times a week
   (4) 4 or more times a week

2. **How many units of alcohol do you drink on a typical day when you are drinking?**
   (0) 1or 2 (1) 3 or 4 (2) 5 or 6 (3) 5-9 (4) more than 10

3. **How often do you have six or more units of alcohol on one occasion?**
   (0) Never (1) Less than Monthly (2) Monthly (3) Weekly (4) Daily or almost daily

4. **How often in the last year have you found you were not able to stop drinking once you had started?**
   (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily

5. **How often in the last year have you failed to do what was expected of you because of drinking?**
   (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily

6. **How often in the last year have you needed a drink first thing in the morning to get yourself going after a heavy drinking session?**
   (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily

7. **How often in the last year have you had a feeling of guilt or remorse about drinking?**
   (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily

8. **How often in the last year have you been unable to remember what happened the night before because you had been drinking?**
   (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily

9. **Have you or someone else ever been injured as a result of your drinking?**
   (0) No (2) Yes but not in the last year (4) Yes, during the last year

10. **Has a relative or friend or Doctor or other health worker been concerned about your drinking or suggested you cut down?**
    (0) No (2) Yes but not in the last year (4) Yes, during the last year

1 Unit of alcohol = Half a pint of beer, cider, lager under 5% Alcohol by Volume (ABV)
One small glass of wine (125 mls)
One single measure of spirits
Small glass of sherry
Single measure aperitif

A score of 8 or more indicates that a closer examination of alcohol intake is warranted. A score of 20 or over suggests a harmful or dependent pattern of drinking and closer questioning may be required to establish the likelihood of the alcohol withdrawal syndrome developing.

APPENDIX 7

AUDIT-C

Bush,K., Kivlahan,D.R. McDonnell, M.B., Fihn, S.D. & Bradley, K.A. (1998)

(Available on Patient First System for use in ED triage)

1. **How often do you have a drink containing Alcohol?**
   (0) Never (1) Less than Monthly (2) 2-4 times a month (3) 2-3 times a week
   (4) 4 or more times a week

2. **How many units of alcohol do you drink on a typical day when you are drinking?**
   (0) 1or 2 (1) 3 or 4 (2) 5 or 6 (3) 5-9 (4) more than 10

3. **How often do you have six (female) / Eight (male) or more units of alcohol on one occasion?**
   (0) Never (1) Less than Monthly (2) Monthly (3) Weekly (4) Daily or almost daily

Score questions as scored in (brackets) **A score of 3 or more points** on the AUDIT-C, or a report of **drinking 6 or more drinks on one occasion ever in the last year**, should lead to a more in-depth assessment of drinking and related problems.

APPENDIX 8

F.A.S.T. Screening Tool

Hodgson,R., Alwyn,T. John, B.,Thom,B. & Smith A. (2002)

1. **In the last 3 months how often have you had eight or more units of alcohol on one occasion?**

   Never Less than once monthly weekly daily or almost daily

   (If NEVER please do not answer further)

2. **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 once monthly weekly daily or almost daily

3. **How often during the last year have you failed to do what was normally expected from you because of your drinking?**

   Never Less than once monthly weekly daily or almost daily

4. **Has a relative, friend, doctor or other health worker been concerned about your drinking or suggested you cut down?**

   NO YES but not in the last year YES in the last year

One unit of alcohol is equal to…
Half a pint of ordinary strength beer, lager or cider
One small (125mls) glass of wine
One single measure of spirits
One single glass of sherry
One single measure of aperitif

(Score questions 1-3: 0, 1,2,3,4. Score question 4: 0, 2, 4
A score of 3 or more indicates probable hazardous drinking)

APPENDIX 9

CLINICAL WITHDRAWAL ASSESSMENT SCALE (CIWA– Ar)

(Available for printing and combined with prescribing chart on Patient First system)

[Sullivan, J.T., Sykora, K., Scneiderman, J. Naranjo, C.A. and Sellers, E.M. *(1989)***]**

The scale on page 28 below can be used to assess alcohol withdrawal.

The frequency of when this scale should be used is up to your own clinical experience.

However, if a patient is in the early stages of withdrawal it is recommended that this is used every **90 minutes**.

The tool will enable you to decide whether your patient requires to be given any PRN medication. It is recommended that if the patient scores ***>10 (more than 10) then the patient should be given their PRN Chlordiazepoxide***.

If the patient scores <10 (less than) then no PRN medication should be given. However**, the regular prescribed medication should be given at all times unless the patient becomes overly sedated.**

Scores of less than 8-10 indicate minimal to mild withdrawal.

Scores of 8-15 indicate moderate withdrawal (marked autonomic arousal).

Scores of 15 or more indicate severe withdrawal with risk of developing Delirium Tremens.

APPENDIX 9 CIWA –Ar ALCOHOL WITHDRAWAL SCALE

NAUSEA AND VOMITING – ask 'Do you feel sick to your stomach? Have you vomited? **0** no nausea, no vomiting **1** mild nausea with no vomiting **2** **3** **4** intermittent nausea with dry heaves **5** **6** **7** Constant nausea, dry heaves and vomiting	**TACTILE DISTURBANCES–** ask "have you any itching, pins and needles, burning, numbness, do you feel bugs under your skin? **0** none **1** very mild itching, pins and needles or numbness **2** mild **3** moderate **4** moderately severe hallucinations **5** severe hallucinations **6** extremely severe hallucinations **7** continuous hallucinations
TREMOR arms extended and fingers spread apart, Observe. **0** no tremor **1** not visible, but can be felt fingertip to fingertip **2** **3** **4** moderate with patients arms extended **5** **6** **7** Severe, even without arms extended	**AUDITORY DISTURBANCES-** Ask "are you more aware of sounds around you, are they harsh, frightening, are you hearing things that frighten you or that you know are not there? **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** barely perceptible sweating, palms moist **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 its colour different? Does it hurt your eyes? Are you seeing things you know are not there? **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"? Observe. **0** no anxiety, at ease **1** mild anxiety **2** **3** **4** moderately anxious, or guarded so anxiety is inferred **5** **6** **7** acute panic state as seen in severe delirium or psychosis	**HEADACHE, FULLNESS IN HEAD** – Ask "does your head feel different? Does it feel like there is a band around your head? Do not rate for dizziness of light headedness. **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 anxiety **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? **0** orientated and can do serial additions **1** cannot do serial additions or uncertain of date **2** disoriented for date by no more than 2 days **3** disoriented for date by more than 2 days **4** disoriented for place/person
Patients scoring less than 10 do not usually need additional medication for alcohol withdrawal.	**TOTAL CIWA Ar SCORE:** **ASSESSORS INITIALS:**

APPENDIX 10

Alcohol-related liver disease

Assessment and diagnosis

- Exclude alternative causes of liver disease in people with a history of harmful or hazardous drinking who have abnormal liver blood test results.
- Refer people to a specialist experienced in the management of alcohol-related liver disease to confirm a clinical diagnosis of alcohol-related liver disease.
- Consider liver biopsy to investigate alcohol-related liver disease. When considering liver biopsy:
  - take into account the risks of morbidity and mortality
  - discuss the risks and benefits with the patient **and**
  - ensure informed consent is obtained.
- Consider a liver biopsy to confirm diagnosis in people with suspected acute alcohol-related hepatitis that is severe enough to need corticosteroid treatment.

Referral for consideration of transplantation

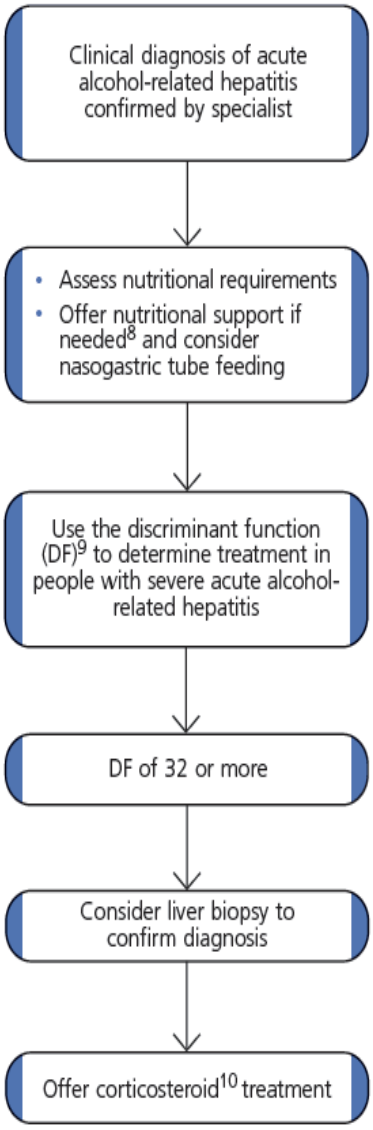
Refer patients with decompensated liver disease to be considered for assessment for liver transplantation if they:

- still have decompensated liver disease after best management and 3 months' abstinence from alcohol **and**
- are otherwise suitable for transplantation[7].

[7] For the nationally agreed guidelines for liver transplant assessment in the context of alcohol-related liver disease, see www.uktransplant.org.uk/ukt/about_transplants/organ_allocation/pdf/liver_advisory_group_alcohol_guidelines-november_2005.pdf

APPENDIX 10

Management of acute alcohol-related hepatitis



Corticosteroids

Are used in UK clinical practice in the management of severe acute alcohol related hepatitis

NICE caution that at the time of writing guideline CG100 **Prednisolone** did not have UK marketing authorisation for this indication. Informed consent should be obtained and documented.

APPENDIX 11

Alcohol-related pancreatitis

Chronic alcohol-related pancreatitis

Diagnosis

For diagnosis of chronic alcohol-related pancreatitis use all of the following:

- the person's symptoms
- imaging to determine pancreatic structure **and**
- tests of pancreatic exocrine and endocrine function.

Use computed tomography as the first-line imaging modality for people with a history and symptoms suggestive of chronic alcohol-related pancreatitis.

Management

- For people with steatorrhoea or poor nutritional status, offer pancreatic enzyme supplements.
- If pain is the only symptom, do not give enzyme supplements.

For people with pain:

- Refer to a specialist centre for multidisciplinary assessment.
- Offer surgery (in preference to endoscopic therapy) to people with large-duct (obstructive) chronic pancreatitis.
- Offer coeliac axis block, splanchnicectomy or surgery to people with small-duct (non-obstructive) chronic pancreatitis if their pain is poorly controlled.

Acute alcohol-related pancreatitis

Management

Offer nutritional support to people with acute alcohol-related pancreatitis:

- early (on diagnosis) **and**
- using enteral tube feeding rather than parenteral support, if possible.

Do not give prophylactic antibiotics to people with mild acute pancreatitis, unless otherwise indicated.

Supporting Document 1 - Equality Impact Assessment Tool

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

		Yes/No	Comments
1.	**Does the policy/guidance affect one group less or more favourably than another on the basis of:**		
	Race	no	
	Ethnic origins (including gypsies and travellers)	no	
	Nationality	no	
	Gender	no	
	Culture	no	
	Religion or belief	no	
	Sexual orientation including lesbian, gay and bisexual people	no	
	Age	no	
2.	**Is there any evidence that some groups are affected differently?**	no	
3.	**If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?**	no	
4.	**Is the impact of the policy/guidance likely to be negative?**	no	
5.	**If so can the impact be avoided?**	-	
6.	**What alternatives are there to achieving the policy/guidance without the impact?**	-	
7.	**Can we reduce the impact by taking different action?**	-	

If you have identified a potential discriminatory impact of this key document, please refer it to Human Resources, together with any suggestions as to the action required to avoid/reduce this impact.

For advice in respect of answering the above questions, please contact Human Resources.

Supporting Document 2 – Financial Impact Assessment

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

	Title of document:	**Yes/No**
1.	Does the implementation of this document require any additional Capital resources	no
2.	Does the implementation of this document require additional revenue	no
3.	Does the implementation of this document require additional manpower	no
4.	Does the implementation of this document release any manpower costs through a change in practice	no
5.	Are there additional staff training costs associated with implementing this document which cannot be delivered through current training programmes or allocated training times for staff	no
	Other comments:	

If the response to any of the above is yes, please complete a business case and which is signed by your Finance Manager and Directorate Manager for consideration by the Accountable Director before progressing to the relevant committee for approval.