Northern Inter-tribal Health Authority

DIRECTIVE FOR A CLIENT POPULATION REGISTERED NURSE SPECIALTY PRACTICE

Acute Alcohol Withdrawal Syndrome

Updated June 26, 2024

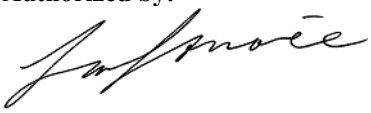
DIRECTIVE FOR CLIENT POPULATION

This RN Specialty Practice Clinical Protocol provides the authority and direction for RNs to treat clients presenting with acute alcohol withdrawal as per the authorizing physician's order for this health condition.

- This directive applies only to the NITHA Primary Care Centres
- This directive is consistent with the NITHA OVERARCHING POLICY FOR SPECIALTY PRACTICE BY REGISTERED NURSES EMPLOYED WITHIN THE NITHA PARTNERSHIP (June 2023)

Updated per Carrie Gardipy, NITHA Nursing Program Advisor

Authorized by:



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BACKGROUND:

According to the Diagnostic and Statistical Manual IV235, acute alcohol withdrawal syndrome is experienced after cessation of or considerable reduction in alcohol ingestion by a person who has been drinking ETOH for several days or weeks with at least 2 acute alcohol withdrawal symptoms (as outlined in chart below) occurring within hours to days. Alcohol withdrawal symptoms rage from mild to severe (life-threatening). Delirium tremens is a late withdrawal symptom (over 48 hr) in chronic alcoholics, carrying a mortality rate up to 20% if untreated; manifested by autonomic hyperactivity, confusion/delirium; maybe complicated by cardiac arrhythmia, dehydration, electrolyte disturbances and aspiration.
This directive is consistent with the overarching policy.

RN COMPETENCIES FOR ACUTE ALCOHOL WITHDRAWAL TREATMENT:

■Current ITLS (International Trauma Life Support)

■Current BLS-CPR Healthcare Provider Course

■Current ACLS (Advanced Cardiac life Support)

■RNs are required to review this protocol annually and to adhere to the procedures relating to Acute Alcohol Withdrawal, as outlined within this protocol and the attached guidelines.

SYMPTOMS OF ACUTE ALCOHOL WITHDRAWAL TREATMENT

Time of Appearance after Cessation of Alcohol Use	Symptoms
6 to 12 hours	Minor withdrawal symptoms: insomnia, tremors, anxiety, gastrointestinal upset, headache, diaphoresis, palpitations, anorexia, nausea, tachycardia, hypertension
12 to 24 hours	Alcoholic hallucinosis: visual, auditory, or tactile hallucinations
24 to 48 hours	Withdrawal seizures: generalized tonic-clonic seizures
48 to 72 hours	Alcohol withdrawal delirium (delirium tremens): fever indicative of DTs, hallucinations (predominately visual), disorientation, agitation, diaphoresis

The Clinical Institute Withdrawal Assessment for Alcohol-revised (CIWA-Ar) Scale

- can help determine the severity of withdrawal. Refer to RN Specialty Practice Appendix.1.
- The CIWA-Ar scale describes the severity of withdrawal, helps determine appropriate care, and can help monitor a client during detoxification.
- It should
  be completed with those clients thought to be in alcohol withdrawal

If CIWA-Ar Score greater than 19 – Severe agitation, increased risk of complications

If CIWA-Ar Score 10 to 19 – Moderate agitation

ADVANCED NURSING ASSESSMENT & TREATMENT

1. Assess ABCs, vital signs, spot blood glucose
2. Complete a CIWA-Ar scale and obtain as much history as possible on client alcohol use, past withdrawal symptoms and treatment, medical history, medications, illegal drug use.
3. Start intravenous access with normal saline if needed. All clients who receive more than 1 dose of medication should have an IV line with normal saline to keep vein open. Depending on the severity of symptoms and potential dehydration, adjust rate appropriately.
4. NPO for clients with moderate to severe symptoms (excludes Diazepam PO or other ordered PO medications).
5. Correct and monitor blood glucose levels in consultation with Physician or NP, or emergency protocol (i.e. Hypoglycemia)
6. Any client with a CIWA-Ar score of 19 points or above should be transferred to an acute care center without delay. Activate EMS and prepare for transfer if warranted.
7. Client may be discharged from care if the CIWA-Ar score is 8 points or under x 2 assessments, 1 hour apart and client has no or minimal tremor
8. Client should be assessed every 15 minutes or less, depending on the severity

DIAGNOSTIC TESTS-POINT OF CARE TESTING

•Urinalysis
•Urine pregnancy test (for premenopausal women)
•EKG
•Rapid capillary glucose

- Rule out any differential diagnoses, in particular if the client has a decreased level of consciousness.

STANDING ORDERS

The CIWA scale should be used and if score over 10 points, the RN may administer:

1. **For clients with no history of Alcohol withdrawal seizures:**

Diazepam (Valium) 5-10mg PO/or IV **OR Lorazepam (Ativan) 2-4mg PO/IM or IV**
AND Thiamine 100mg IM/or IV STAT

OR

2. **For clients with a history of withdrawal seizures regardless of CIWA-Ar score, give the following:**

Diazepam (Valium®) 20mg PO/IV (loading dose) **OR Lorazepam (Ativan) 2-4mg PO/IV/IM**
AND Thiamine 100mg IM/or IV STAT ***If possible, recommend client to return to clinic for additional doses of Thiamine 100 mg IM the following day (24 hours after dose #1) and the day after (48 hours after dose #1)**

After the above single dose has been administered the RN must consult a Physician or a Nurse Practitioner for further medical management.

(Journal of Clinical & Diagnostic Research 2015 Sep; 9(9)

Note:

-Opioid treatment and methadone are not contraindications to benzodiazepines.

-Lorazepam is quite well absorbed IM and diazepam is not. That makes lorazepam ideal in situations where IV access is hard to get.

GOALS:

- Prevent complications of withdrawal (for example, seizure, delirium tremens, death)
- Prevent Wernicke-Korsakoff syndrome.
- Assess for and treat comorbidities
- Ensure the client gets information on appropriate options for treatment to help with their recovery. If appropriate at time –discuss with client referral to mental health, addiction services, Elder, and or detox center. Obtain Client consent prior to mental health referral

DIFFERENTIAL DIAGNOSIS

- Infection (for example, meningitis)
- Trauma (for example, intracranial hemorrhage)
- Metabolic disorders (for example, disturbances of potassium, magnesium, phosphate, glucose)
- Drug overdose
- Liver failure
- Gastrointestinal bleeding

Appendix 1.

Clinical Institute Withdrawal Assessment Scale for Alcohol, Revised (CIWA-Ar)

Nausea and Vomiting
0 – No nausea or vomiting
1
2
3
4 – Intermittent nausea with dry heaves
5
6
7 – Constant nausea, frequent dry heaves and vomiting

Paroxysmal Sweats
0 – No sweat visible
1 – Barely perceptible sweating, palms moist
2
3
4 – Beads of sweat obvious on forehead
5
6
7 – Drenching sweats

Agitation
0 – Normal activity
1 – Somewhat more than normal activity
2
3
4 – Moderate fidgety and restless
5
6
7 – Paces back and forth during most of the interview or constantly thrashes about

Visual Disturbances
0 – Not present
1 – Very mild photosensitivity
2 – Mild photosensitivity
3 – Moderate photosensitivity
4 – Moderately severe visual hallucinations
5 – Severe visual hallucinations
6 – Extreme severe visual hallucinations
7 – Continuous visual hallucinations

Tremor
0 – No tremor
1 – Not visible, but can be felt at finger tips
2
3
4 – Moderate when patient's hands extended
5
6
7 – Severe, even with arms not extended

Tactile Disturbances
0 - None
1 – Very mild paraesthesias
2 – Mild paraesthesias
3 – Moderate paraesthesias
4 – Moderately severe hallucinations
5 – Severe hallucinations
6 – Extremely severe hallucinations
7 – Continuous hallucinations

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

Auditory Disturbances
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

Orientation and Clouding of the Sensorium
0 – Oriented and can do serial additions
1 – Cannot do serial additions
2 – Disoriented for date but not more than 2 calendar days
3 - Disoriented for date by more than 2 calendar days
4 – Disoriented for place/person

Cumulative scoring

Cumulative score	Approach
0 – 8	No medication needed
9 – 14	Medication is optional
15 – 20	Definitely needs medication
>20	Increased risk of complications

References

Women's College Hospital (2017). Emergency Department Protocols for alcohol-and opioid-related presentations.

Alberta Health Services. Emergency Department Alcohol Withdrawal Adult Order Set. Retrieved from Emergency Department Alcohol Withdrawal Order Set albertahealthservices.ca) (July 26, 2021)

Health Canada. (2012), November 22). First Nations and Inuit health: Clinical practice guidelines for nurses in primary care. Ottawa, ON: