Physician’s Orders

Alcohol Withdrawal Prevention

Medication Orders

Protocol Inclusion: Recent history of alcohol use and able to communicate verbally.

Protocol Exclusion: Nonverbal and intubated patients.

1. Nursing Orders
   a. Use CIWA–Ar Alcohol Withdrawal Assessment Tool to assess need for symptom–based treatment.
   b. Document Alcohol Withdrawal Score, treatment, and reassessment on assessment flowsheet
      (or HED when available).
   c. Routine Vital signs with each CIWA–Ar Alcohol Withdrawal Assessment
   d. Notify nurse manager/house supervisor to evaluate for ICU transfer if patient has
      CIWA score above 10 on 2 consecutive assessments.

2. Laboratory
   ☐ CBC, CMP ☐ Magnesium, Phosphorus ☐ Urine Drug Screen ☐ Blood Alcohol Level

3. Supportive Care
   a. Supplements—may add daily to IV Fluids if patient unable to take PO and IV Fluids ordered
      ☐ Thiamine 100 mg PO/NGT/IV daily on Days 1–3. First does STAT
      ☐ Multivitamin 1 tablet PO or 5 mL NGT starting on Day 2
      ☐ Folic Acid 1 mg PO/NGT starting on Day 2
   b. IV Fluids: do not give dextrose containing fluids until patient receives thiamine
      ☐ NS at ______ mL per H ☐ 1/2 NS at ______ mL per H ☐ ______ at ______ mL per H
   c. To first liter of fluid (if not already given) add:
      ☐ Folic Acid 1 mg ☐ Multivitamin 10 mL

4. Discontinue all previously ordered PRN and scheduled lorazepam (ATIVAN) and chlordiazepoxide (LIBRIUM).

5. CIWA Protocol—choose one:
   ☐ Symptom Triggered Therapy—recommended for the majority of patients unless there is a history of alcohol
      withdrawal seizures or severe alcohol withdrawal

      ☐ lorazepam (ATIVAN) short acting benzodiazepine. Recommended in patients 65 years of age or older
      and/or hepatic dysfunction
      Dose according to CIWA score below. Dose may be given IV, IM, or PO. Hold if respirations below 10/min.

<table>
<thead>
<tr>
<th>CIWA</th>
<th>lorazepam (ATIVAN) PO/IM/IV</th>
<th>Reassess/Remedicate</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;8</td>
<td>Monitor</td>
<td>Q 4 H</td>
</tr>
<tr>
<td>8–10</td>
<td>2 mg</td>
<td>Q 2 H</td>
</tr>
<tr>
<td>11–14</td>
<td>3 mg</td>
<td>Q 1 H</td>
</tr>
<tr>
<td>15–25</td>
<td>4 mg</td>
<td>Q 1 H</td>
</tr>
<tr>
<td>Over 25</td>
<td>4 mg and notify MD</td>
<td></td>
</tr>
</tbody>
</table>

OR

☐ chlordiazepoxide* (LIBRIUM) intermediate/long acting benzodiazepine; not recommended in
    patients over age 65 or history of hepatic dysfunction.
    Dose according to CIWA score below. Hold if respirations below 10/min.
Physician’s Orders

## Alcohol Withdrawal Prevention

### Medication Orders

<table>
<thead>
<tr>
<th>CIWA</th>
<th>Medication Description</th>
<th>Dose/Route</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Below 8</td>
<td>Monitor</td>
<td>Q 4 H</td>
<td></td>
</tr>
<tr>
<td>8–10</td>
<td>25 mg</td>
<td>Q 2 H</td>
<td></td>
</tr>
<tr>
<td>11–14</td>
<td>50 mg</td>
<td>Q 2 H</td>
<td></td>
</tr>
<tr>
<td>15–25</td>
<td>75 mg</td>
<td>Q 2 H</td>
<td></td>
</tr>
<tr>
<td>Over 25</td>
<td>lorazepam (ATIVAN) 4 mg PO/IM/IV and notify MD</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Max recommended dose of 300 mg/24 hours; Notify MD if patient approaching max

- **Fixed Dose with Symptom Triggered Therapy**—for patients with a history of alcohol withdrawal seizures or history of severe alcohol withdrawal

  **Age below 65 (choose 1):**
  - Lorazepam (ATIVAN) 2 mg or 4 mg PO/IV/IM Q 6 H x 4 doses then Q 8 H x 6 doses
  - Chlordiazepoxide (LIBRIUM) 25 mg or 50 mg PO Q 6 H x 4 doses then Q 8 H x 6 doses

  **Age 65 or greater/hepatic dysfunction (choose 1):**
  - Lorazepam (ATIVAN) 2 mg or 4 mg PO/IV/IM Q 6 H x 4 doses then Q 8 H x 6 doses
  - Chlordiazepoxide (LIBRIUM) 10 mg or 25 mg PO Q 6 H x 4 doses then Q 8 H x 6 doses

  **AND**
  - Symptom triggered therapy (choose 1); dose per tables on page 1
    - Lorazepam (ATIVAN)
    - Chlordiazepoxide (LIBRIUM)

6. Notify physician for seizure activity, respiratory rate below 9/min; pulse oximetry below 90%; CIWA less than 8 for 24 hours (consider stopping protocol); or patient has significant symptoms/CIWA 8 or greater after 4 or more days on the protocol (assess for continued use of protocol & other causes of continued symptoms)

7. Adjunct Therapies
   - Ondansetron (ZOFRAN) 4 mg IV Q 4 H PRN nausea/vomiting
   - Clonidine 0.1 mg PO Q 6 H PRN autonomic symptoms (SBP above 180, HR above 100)
   - Dexmedetomidine (PRECEDEX) ICU patients only; start at 0.2 mcg/kg/hour & titrate for symptom relief/CIWA less than 8; max of 0.7 mcg/kg/hour. Hold for SBP below 100, HR below 60. Recommended for ventilated patients or patients unable to complete CIWA assessment; add on therapy for patients that have developed delirium tremens

   Alternative Therapies (Not recommended, not to be used with CIWA orders. Separate order required)
   - One can of beer or 30 mL of whisky for patients tolerating diet
   - Ethanol 10% in 100 mL NS over 60 minutes (usually Q 6 H) if patient is NPO

8. Discontinue CIWA protocol after 96 hours. Begin lorazepam (ATIVAN) 0.5 mg to 2 mg IV/PO Q 4 H PRN agitation/anxiety.

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**PA or RN Signature**

**Date**

**Time**

**Physician Signature**

**Date**

**Time**

Developed: January 2014
### Alcohol Withdrawal Prevention Assessment Scoring Guidelines

**CIWA–Ar (Clinical Institute Withdrawal Assessment) Assessment for Alcohol Withdrawal**

**Nausea & Vomiting**—Ask "Do you feel sick to your stomach? Have you vomited?"
- Observe:
  - 0–No nausea, No vomiting
  - 1–Mild nausea, no vomiting
  - 4–Intermittent nausea with dry heaves
  - 7–Constant nausea, frequent dry heaves & vomiting.

**Tremor**—Ask patient to extend arms & spread fingers apart
- Observe:
  - 0–No Tremor
  - 1–Tremor not visible but can be felt fingertip to fingertip
  - 4–Moderate tremor with arms extended
  - 7–Severe tremor, even with arms not extended.

**Paroxysmal Sweats**
- Observe:
  - 0–No sweat visible
  - 1–Barely perceptible sweating, palms moist
  - 4–Beads of sweat obvious on forehead
  - 7–Drenching sweats

**Anxiety**—Ask "Do you feel nervous?"
- Observe:
  - 0–No anxiety, at ease
  - 1–Mildly anxious
  - 4–Moderately anxious, or guarded, so anxiety is inferred
  - 7–Equivalent to acute panic states as seen in severe delirium or acute schizophrenic reactions.

**Agitation**
- Observe:
  - 0–Normal activity
  - 1–Somewhat more than normal activity
  - 4–Moderately fidgety & restless
  - 7–Paces back & forth during most of interview, or constantly thrashes about.

**Tactile Disturbances**—Ask "Have you had any itching, pins/needles sensations, burning, numbness, or feel bugs crawling on/under your skin?"
- Observe:
  - 0–None
  - 1–Very mild itching/pins & needles/burning/numbness
  - 2–Mild itching/pins & needles/burning/numbness
  - 3–Moderate itching/pins & needles/burning/numbness
  - 4–Moderately severe hallucinations
  - 5–Severe hallucinations
  - 6–Extremely severe hallucinations
  - 7–Continuous hallucinations

**Auditory Disturbances**—Ask "Are you more aware of sounds around you? Are they harsh? Do they scare you? Are you hearing anything disturbing to you? Are you hearing things that you know are not there?"
- Observe:
  - 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

**Visual Disturbances**—Ask "Does the light appear too bright? Is its color different? Does it hurt your eyes? Are you seeing anything disturbing to you? Are you seeing things you know are not there?"
- Observe:
  - 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

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

**Orientation & Clouding of Sensorium**—Ask "What day is this? Where are you? Who am I?"
- Observe:
  - 0–Oriented & 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/or person

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**Physician’s Orders**

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>
Alcohol Withdrawal Prevention Assessment Flowsheet

Assessment Protocol

a. If initial score <8, repeat Q 4 H
   If initial score 8–10, repeat Q 2 H
   If initial score 11–24, repeat Q 1 H
   If initial score 25, notify MD
b. If initial score <8, assess Q 4 H x 96 H
   If score > 8 at any time, go to (a) above
c. If indicated, (see indications below)
   administer PRN medications as ordered
   and record in HED and below.
d. If score is ≥11 on 2 consecutive assessments
   notify Nurse Manager/House Supervisor to
   evaluate for ICU transfer.

<table>
<thead>
<tr>
<th>Scale for Scoring</th>
<th>Total Score=</th>
</tr>
</thead>
<tbody>
<tr>
<td>(0–9) absent or minimal withdrawal</td>
<td></td>
</tr>
<tr>
<td>(10–19) mild to moderate withdrawal</td>
<td></td>
</tr>
<tr>
<td>(more than 20) severe withdrawal</td>
<td></td>
</tr>
</tbody>
</table>

Nausea/vomiting (0–7)
0– none; 1– mild nausea, no vomiting; 4– intermittent nausea; 7– constant nausea, frequent dry heaves & vomiting

Tremors (0–7)
0– no tremor; 1– not visible but can be felt; 4– moderate w/arms extended; 7– severe, even w/arms not extended.

Anxiety (0–7)
0– none, at ease; 1– mildly anxious; 4– moderately anxious or guarded; 7– equivalent to acute panic state.

Agitation (0–7)
0– normal activity; 1– somewhat normal activity; 4– moderately fidgety/restless; 7– paces or constantly thrashes about.

Paroxysmal Sweats (0–7)
0– no sweats; 1– barely perceptible sweating, palms moist; 4– beads of sweat obvious on forehead; 7– drenching sweat.

Orientation (0–4)
0– oriented; 1– uncertain about date; 2– disoriented to date by no more than 2 days; 3– disoriented to date by > 2 days; 4– disoriented to place and/or person.

Tactile Disturbances (0–7)
0– none; 1– very mild itch, P&N, numbness; 2– mild itch, P&N burning, numbness; 3– moderate itch, P&N, burning, numbness; 4– moderate hallucinations; 5– severe hallucinations; 6– extremely severe hallucinations; 7– continuous hallucinations.

Auditory Disturbances (0–7)
0– not present; 1– very mild harshness/ability to startle; 2– mild harshness, ability to startle; 3– moderate harshness, ability to startle; 4– moderate hallucinations; 5– severe hallucinations; 6– extremely severe hallucinations; 7– continuous hallucinations.

Visual Disturbances (0–7)
0– not present; 1– very mild sensitivity; 2– mild sensitivity; 3– moderate sensitivity; 4– moderate hallucinations; 5– severe hallucinations; 6– extremely severe hallucinations; 7– continuous hallucinations.

Headache (0–7)
0– not present; 1– very mild; 2– mild; 3– moderate; 4– moderately severe; 5– severe; 6– very severe; 7– extremely severe

Total CIWA–Ar score:

<table>
<thead>
<tr>
<th>PRN Med:</th>
<th>Dose given (mg):</th>
</tr>
</thead>
<tbody>
<tr>
<td>lorazepam</td>
<td>Route:</td>
</tr>
<tr>
<td>chlordiazepoxide</td>
<td></td>
</tr>
</tbody>
</table>

Time of PRN medication administration:
Assessment of response (CIWA–Ar score 30–60 minutes after medication administered)

Indications for PRN medication:
Total CIWA–Ar score 8 or higher if ordered PRN only
(Symptom–triggered method). Consider transfer to ICU for any of the following: Total score above 11 x 2 consecutive readings or respiratory distress.

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