# Alcohol Withdrawal Assessment Scoring Guidelines (CIWA - Ar)

**Nausea/Vomiting** - Rate on scale 0 - 7

0 - None
1 - Mild nausea with no vomiting
2
3
4 - Intermittent nausea
5
6
7 - Constant nausea and frequent dry heaves and vomiting

**Tremors -** have patient extend arms & spread fingers. Rate on scale 0 - 7.
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 w/ arms not extended

**Anxiety** - Rate on scale 0 - 7
0 - no anxiety, patient at ease
1 - mildly anxious
2
3
4 - moderately anxious or guarded, so anxiety is inferred
5
6
7 - equivalent to acute panic states seen in severe delirium or acute schizophrenic reactions.

**Agitation** - Rate on scale 0 - 7
0 - normal activity
1 - somewhat normal activity
2
3
4 - moderately fidgety and restless
5
6
7 - paces back and forth, or constantly thrashes about

**Paroxysmal Sweats** - Rate on Scale 0 - 7.
0 - no sweats
1- barely perceptible sweating, palms moist
2
3
4 - beads of sweat obvious on forehead
5
6
7 - drenching sweats

**Orientation and clouding of sensorium** - Ask, "What day is this? Where are you? Who am I?" Rate scale 0 - 4
0 - Oriented
1 – cannot do serial additions or is uncertain about date

2 - disoriented to date by no more than 2 calendar days

3 - disoriented to date by more than 2 calendar days
4 - Disoriented to place and / or person

**Tactile disturbances** - Ask, "Have you experienced any itching, pins & needles sensation, burning or numbness, or a feeling of bugs crawling on or under your skin?"
0 - none
1 - very mild itching, pins & needles, burning, or numbness
2 - mild itching, pins & needles, burning, or numbness
3 - moderate itching, pins & needles, burning, or numbness
4 - moderate 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 startle you? Do you hear anything that disturbs you or that you know isn't there?"
0 - not present
1 - Very mild harshness or ability to startle
2 - mild harshness or ability to startle
3 - moderate harshness or ability to startle
4 - moderate hallucinations
5 - severe hallucinations
6 - extremely severe hallucinations
7 - continuous hallucinations

**Visual disturbances** - Ask, "Does the light appear to be too bright? Is its color different than normal? Does it hurt your eyes? Are you seeing anything that disturbs you or that you know isn't there?"
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** - Ask, "Does your head feel different than usual? Does it feel like there is a band around your head?" Do not rate dizziness or lightheadedness.

0 - not present
1 - very mild
2 - mild
3 - moderate
4 - moderately severe
5 - severe
6 - very severe
7 - extremely severe

Procedure:

1. Assess and rate each of the 10 criteria of the CIWA scale. Each criterion is rated on a scale from 0 to 7, except for "Orientation and clouding of sensorium" which is rated on scale 0 to 4. Add up the scores for all ten criteria. This is the total CIWA-Ar score for the patient at that time. Prophylactic medication should be started for any patient with a total CIWA-Ar score of 8 or greater (ie. start on withdrawal medication). If started on scheduled medication, additional PRN medication should be given for a total CIWA-Ar score of 15 or greater.
2. Document vitals and CIWA-Ar assessment on the Withdrawal Assessment Sheet. Document administration of PRN medications on the assessment sheet as well.
3. The CIWA-Ar scale is the most sensitive tool for assessment of the patient experiencing alcohol withdrawal. Nursing assessment is vitally important. Early intervention for CIWA-Ar score of 8 or greater provides the best means to prevent the progression of withdrawal.

**Assessment Protocol**

a. Vitals, Assessment Now.
b. If initial score ≥ 8 repeat q1h x 8 hrs, then if stable q2h x 8 hrs, then if stable q4h.
c. If initial score < 8, assess q4h x 72 hrs. If score < 8 for 72 hrs, d/c assessment. If score ≥ 8 at any time, go to (b) above.
d. If indicated, (see indications below) administer prn medications as ordered and record on MAR and below.

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Date** | | | | | | | | | | | | |
| **Time** | | | | | | | | | | | | |
| **Pulse** | | | | | | | | | | | | |
| **RR** | | | | | | | | | | | | |
| **$O_2$ sat** | | | | | | | | | | | | |
| **BP** | | | | | | | | | | | | |

**Assess and rate each of the following (CIWA-Ar Scale):** **Refer to reverse for detailed instructions in use of the CIWA-Ar scale.**

| Item | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Nausea/vomiting** (0 - 7)<br>0 - none; 1 - mild nausea ,no vomiting; 4 - intermittent nausea; 7 - constant nausea , frequent dry heaves & vomiting. | | | | | | | | | | | | |
| **Tremors** (0 - 7)<br>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)<br>0 - none, at ease; 1 - mildly anxious; 4 - moderately anxious or guarded; 7 - equivalent to acute panic state | | | | | | | | | | | | |
| **Agitation** (0 - 7)<br>0 - normal activity; 1 - somewhat normal activity; 4 - moderately fidgety/restless; 7 - paces or constantly thrashes about | | | | | | | | | | | | |
| **Paroxysmal Sweats** (0 - 7)<br>0 - no sweats; 1 - barely perceptible sweating, palms moist; 4 - beads of sweat obvious on forehead; 7 - drenching sweat | | | | | | | | | | | | |
| **Orientation** (0 - 4)<br>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)<br>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)<br>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)<br>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)<br>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: | | | | | | | | | | | | |
| PRN Med: Lorazepam — **Dose given (mg):** | | | | | | | | | | | | |
| **Route:** | | | | | | | | | | | | |
| **Time** of PRN medication administration: | | | | | | | | | | | | |
| Assessment of response (CIWA-Ar score 30-60 minutes after medication administered) | | | | | | | | | | | | |
| RN Initials | | | | | | | | | | | | |

**Scale for Scoring:**
Total Score =
0 – 9: absent or minimal withdrawal
10 – 19: mild to moderate withdrawal
more than 20: severe withdrawal

**Indications for PRN medication:**
a. Total CIWA-AR score 8 or higher if ordered PRN only (Symptom-triggered method).
b. Total CIWA-Ar score 15 or higher if on Scheduled medication. (Scheduled + prn method)
Consider transfer to ICU for any of the following: Total score above 35, q1h assess. x more than 8hrs required, more than 4 mg/hr lorazepam x 3hr **or** 20 mg/hr diazepam x 3hr required, or resp. distress.

Patient Identification (Addressograph)

| Signature/ Title | Initials | Signature / Title | Initials |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

# Alcohol Withdrawal Assessment Flowsheet (revised Nov 2003)

## EXECUTE ONLY THOSE ORDERS WITH CHECKED BOXES

X **Begin alcohol withdrawal assessment protocol.** (All patients - see protocol in right lower corner)

☐ **Nursing staff to enter referral to Social Services: "Assess for Alcohol Rehab".**

☐ **Baseline labs: CMP, Mag, Phos, Ethanol, CBC, Urine Toxicology Screen.**
Provider: line through any labs already drawn/ not needed,

☐ **Subsequent labs: BMP, Mag, Phos daily x 2 days.** (Recommended for all patients)

☐ **Thiamine 100mg IV in 100ml or more of IV fluid x 1 now.** (Recommended for all patients at initial presentation)

☐ **Thiamine 100mg PO (or IV in 100ml or more of IV fluid) daily for two days.** (Recommended for all patients)

☐ **Multivitamin with minerals (PNV) 1 PO daily when patient taking orally.**

☐ **Place PPD skin test now, evaluate at 48 & 72 hours - document in immunization record.**

☐ **Pneumococcal vaccine 0.5ml IM or SC now - document in immunization record.**

| Withdrawal Medication Prescribing Recommendations | HIGH-RISK Factors for Severe Withdrawal |
|---|---|
| • "PRN" method: all patients (symptom triggered meds only)<br>• "Scheduled" method: if any HIGH-RISK factors (listed at right)<br>• "ICU high dose PRN" method: limited to ICU patients<br>Date and time of last Drink: | ___ Initial CIWA Score 15 or higher<br>___ History of severe alcohol withdrawal<br>___ History of withdrawal-related seizures<br>___ Increasing CIWA score while on treatment<br>___ History of heavy, daily drinking |

Choose one drug (Lorazepam) - but may select multiple methods if "Scheduled" method checked, must also check at least one **"PRN"** method.

**Lorazepam (Ativan®)**

☐ **"PRN" Lorazepam ____ mg** (1 - 4mg recommended) **PO/IV/IM q30min PRN CIWA-Ar score 8 or greater.**

☐ **"Scheduled" Lorazepam ____ mg** (2 or 4mg recommended) **PO/IV/IM q4h x 6 doses, then q6h x 4 doses, then q8h x 3 doses, then q12h x 2 doses, then stop.** HOLD FOR SEDATION or RR less than 12.

**Adjunctive medication:** (optional - prescriber to check if appropriate) Note: haloperidol (Haldol®) may induce arrhythmia, especially if low serum Mag or Potassium present, or with high dose therapy (>35mg/24hours).

☐ **Haloperidol 2.5 - 5mg PO/IV/IM q2h PRN agitation.** Confirm serum Mag, Potassium wnl before administering!

☐ **Atenolol 50mg PO daily.** Hold for HR less than 50 or SBP less than 100.

**Addressograph**

### Alcohol Withdrawal Assessment Protocol

a. Vitals, CIWA-Ar score now. Use assessment sheet for all documentation.
b. If initial CIWA-Ar score = 8 or greater, continue assessment & vitals q1h x 8 hrs, then if stable q2h x 8 hrs, then if stable, q4h thereafter.
c. If initial CIWA-Ar score less than 8, continue assessment q4h x 72 hours If CIWA-Ar score = 8 or more at any time, go to (b) above.
d. If indicated, administer medications as ordered above.

Date________ Time___________AM PM Provider signature:________________

**PHYSICIAN ORDERS FOR TREATMENT OF ALCOHOL WITHDRAWL**

APPENDIX C

Retrieved from: https://www.ncbi.nlm.nih.gov/books/NBK64109/

Figure 2-1: Issues To Consider in Determining Whether Inpatient or Outpatient Detoxification Is Preferred

| **Considerations** | **Indications** |
|---|---|
| Ability to arrive at clinic on a daily basis | Necessary if outpatient detoxification is to be carried out |
| | |
| History of previous delirium tremens or withdrawal seizures | Contraindication to outpatient detoxification: recurrence likely; specific situation may suggest that an attempt at outpatient detoxification is possible |
| | |
| No capacity for informed consent | Protective environment (inpatient) indicated |
| | |
| Suicidal/homicidal/psychotic condition | Protective environment (inpatient) indicated |
| | |
| Able/willing to follow treatment recommendations | Protective environment (inpatient) indicated if unable to follow recommendations |
| | |
| Co-occurring medical conditions | Unstable medical conditions such as diabetes, hypertension, or pregnancy: all relatively strong contraindications to outpatient detoxification |
| | |
| Supportive person to assist | Not essential but advisable for outpatient detoxification |

*Source*: Consensus Panelist Sylvia Dennison, M.D.