Somerset Partnership NHS
NHS Foundation Trust

ALCOHOL ASSESSMENT AND DETOXIFICATION POLICY FOR INPATIENTS

Version:	4
Date issued:	**August 2017**
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Applies to:	All staff working within Trust Inpatient settings

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DOCUMENT CONTROL

Reference AS/Apr15/AAD	**Version** 4	**Status** Final	Consultant Psychiatrist in Rehabilitation and Dual Diagnosis
Amendments New policy created to reflect new service delivery arrangements in Somerset and new areas of evidence as they have emerged as per NICE (CG 100/115). Oct 2015 updated with revised Chlordiazepoxide dosing regime and monitoring requirements. June 2017 amended to include the option of administering Pabrinex by the IV route in exceptional circumstances			
Document objectives: To inform good practice within the Trust for the management of patients with alcohol misuse. Note that the lead agency for alcohol in the county is the Somerset Drug and Alcohol Service			

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Lead Director	Medical Director	

CONTRIBUTION LIST Key individuals involved in developing the document

Designation or Group
Consultant with Special Interest in Substance Misuse
Chair of Drugs and Therapeutics Group
Head of Division, Adult Mental Health Inpatient and Assessment.
Drugs & Therapeutics Group
Alcohol & Substance Misuse Best Practice Group
Equality and Diversity Lead
Clinical Policy Review Group
Clinical Governance Group

CONTENTS

1. INTRODUCTION

1.1 Somerset Drugs and Alcohol Service is the lead agency for the treatment of alcohol misuse within Somerset.

1.2 Inpatient staff will manage alcohol detoxification of patients referred by the Somerset Drug and Alcohol Service and where patients are admitted as an emergency to Trust inpatient units with alcohol as a co-morbid condition.

1.3 ***In the absence of serious psychiatric or medical co-morbidity, detoxification should not be undertaken as an emergency procedure.***

2. PURPOSE & SCOPE

2.1 This policy has been developed to help promote high quality, safe, cost effective management of inpatient alcohol detoxification and to help ensure equivalence of treatment across the county.

2.2 The purpose of this document is to provide a resource for clinical staff working with those admitted to trust inpatient units for inpatient alcohol detoxification.

2.3 Somerset Partnership has a contract with the Somerset Drug and Alcohol Service to undertake inpatient alcohol detoxifications and this document aims to underpin this area of clinical work.

3. DUTIES AND RESPONSIBLITIES

3.1 The **Trust Board** has a responsibility to ensure training is available to all relevant staff.

3.2 The **Chief Executive** is ultimately responsible for ensuring the Trust complies with legal requirements and national recommendations.

3.3 The **Lead Director** is the Medical Director who has responsibility for implementation of this policy.

3.4 The **Drugs & Therapeutics Group** is responsible for reviewing and updating the policy and appendices in conjunction with the Lead Author.

3.5 The **Learning and Development Department** will ensure the necessary mandatory training is available to all Inpatient staff.

3.6 **Line Managers** will ensure that staff are adhering to this policy and are trained appropriately according to the Mandatory Training Matrix.

3.7 **All staff including temporary staff** are individually responsible for their actions including complying with this policy and undertaking any training in line with the Mandatory Training Matrix. This policy will help inform their

decision making, but staff should also refer to other sources of information, for example, NICE Guidance and the British National Formulary.

4. DEFINITIONS

Detoxification refers to a treatment designed to control the medical and psychological complications that may occur after a period of heavy and sustained alcohol use. Inpatient detoxification follows assessment by Somerset Drug and Alcohol Service. The pre-admission assessment process includes an agreement on treatment goals and an outline follow up plan. This is followed by a visit to the admitting unit when possible and the completion of the treatment agreement (Appendices A and B).

SDAS – Somerset Drugs and Alcohol Service

SADQ – Severity of Alcohol Dependence Questionnaire

CIWA-AR – Clinical Institute Withdrawal Assessment for Alcohol form

DT – Delirium tremens

RIO – Electronic Patient Record

5. ALCOHOL WITHDRAWAL

5.1 Alcohol Withdrawal Symptoms

5.1.1 Withdrawal symptoms start 3-6 hours after stopping drinking, peak within 24-48 hours and usually last for 5-7 days.

5.1.2 Early symptoms (up to 12 hours after last drink) include:

- mood disturbance
- panic
- tremor
- nausea
- sleep disturbance
- anxiety
- sweating
- muscle pain

5.2 Withdrawal Seizures

5.2.1 Between 10 and 60 hours, alcohol withdrawal seizures can occur. These are usually generalised and may precede or accompany delirium tremens (DT).

5.2.2 The risk of seizures appears greater in the following groups:

- A history or family history of seizure disorder.
- A history of head injury or intracranial pathology.
- A history of previous withdrawal seizures.

- Metabolic disturbance (including hypoglycaemia, hypocalcaemia, hypomagnesaemia and epilepsy)

5.2.3 Symptoms of DT may emerge up to 7 days after ceasing alcohol and last for 3-5 days.

5.2.4 The development of DT is a potentially serious development with a significant mortality if untreated. Consideration should be given to transfer to a general hospital if symptoms are other than mild or controllable with good general care and tranquillisation.

5.2.5 Diagnostic symptoms include:

- fear
- visual hallucinations
- agitation
- restlessness
- delirium
- delusions
- increased startle reaction
- tremor
- sweating
- dehydration
- fever
- increased blood pressure

5.2.6 Anticonvulsant prophylaxis is not recommended routinely for alcohol withdrawal. For the patients at risk evidence is limited and conflicting on the addition of an anticonvulsant to adequate sedative – hypnotic medication. Anticonvulsant prophylaxis thus remains a matter of clinical judgement depending on the balance of risks/benefit.

5.2.7 Carbamazepine may be the anticonvulsant of choice when one is used. There is a case for starting carbamazepine a week or more prior to admission in cases where withdrawal seizures are thought to be a particular risk in order to achieve a therapeutic serum carbamazepine level at the point of alcohol withdrawal.

Phenytoin must not be prescribed to prevent or treat alcohol withdrawal seizures.

6. DETOXIFICATION

6.1 The aim of detoxification is the control of physical symptoms, the prevention of fits and the care of the patients' physical health. Staff should be aware that in cases of multi drug dependence each substance will require separate consideration.

6.2 Inpatient detoxification should be considered in patients with:

- History of withdrawal seizures.
- Concurrent serious physical illness.
- High risk of delirium tremens.
- Concurrent serious mental illness.
- Inadequate home support (the patient should have someone at home with them during detoxification).
- Pregnancy.

- Presence of any neuropsychiatric signs suggestive of Wernicke's Syndrome/ Korsakoff's Syndrome (these patients require urgent referral to Accident & Emergency for assessment of the need for admission to a medical ward and treatment with parenteral high potency B vitamins).
- Consistent extreme alcohol intake i.e. SADQ> 40.
- Concurrent serious poly-drug abuse.
- Frail elderly.

Note: Detoxification without adequate preparation is unlikely to be followed by abstinence and can produce harm.

6.3 A fixed dose chlordiazepoxide schedule is the preferred method of alcohol withdrawal in Somerset Partnership NHS Foundation Trust. For patients excluded from fixed dose chlordiazepoxide or lorazepam detoxification, specialist advice should be sought from the responsible Consultant. **The procedure for Inpatient Alcohol Detoxification can be found at Appendix C**. The CIWA-AR form (Appendix E) is available on RiO: This is an easy to administer objective scale that can be used to assess and monitor the severity of withdrawal symptoms.

6.4 Lorazepam (chlordiazepoxide 15milligrams is equivalent to lorazepam 0.5-1milligrams) is an alternative in those with severe hepatic dysfunction and when there is a risk of serious medical consequences following sedation e.g. elderly, severe lung disease.

6.5 **Reducing Chlordiazepoxide Detoxification Regime**

Chlordiazepoxide may be given on a dosing schedule derived from withdrawal symptoms predicted from the SADQ score. Regimes are indicative and should be amended to take account of clinical observations of withdrawal severity. They should be extended in the case of people who develop DTs or have a previous history of DTs. To assist with this method a Chlordiazepoxide Reducing Regime Chart (Appendix G) has been developed.

7. VITAMIN SUPPLEMENTATION

7.1 A history of heavy drinking over a long period is associated with a deficiency in water-soluble vitamins, especially the B vitamins, namely thiamine, pyridoxine, riboflavin and nicotinamide. Causes include inadequate food intake and malabsorption caused by irritation of the gut by alcohol or previous bowel resection.

7.2 Pabrinex is the drug of choice for Somerset Partnership. Intramuscular (IM) route administration is used on inpatient units in Somerset Partnership. In exceptional circumstances when IM is declined or not appropriate, Intravenous (IV) administration of Pabrinex may be considered as an option. The IV route will need to be administered by a doctor by infusion over 30 minutes.

7.3 **Prophylactic Vitamin B supplementation is recommended for patients at risk, i.e.**

- Most cases requiring inpatient detoxification
- Significant weight loss
- Poor diet, signs of malnutrition.

For those considered at risk give one pair Pabrinex Intramuscular High Potency for 3-5 days. The injections are then replaced by oral administration of thiamine i.e. 100milligrams tds daily for 6 weeks.

7.4 Repeated injections of preparations containing high concentrations of vitamin B1 (thiamine) may give rise to anaphylactic shock. Mild allergic reactions such as sneezing or mild asthma are warning signs that further injections may give rise to anaphylactic shock. Facilities for treating anaphylactic reactions should be available whenever Pabrinex Intramuscular High Potency is administered as there is a small risk of a severe (anaphylactic) reaction. Guidelines for the treatment of Anaphylaxis are contained within the Medical Emergencies Management Policy. Subsequently treat as for low risk group with oral supplementation.

7.5 **For patients with signs of deficiency symptoms, i.e.**

- Wernicke-Korsakov's Syndrome (Confusion+/-nystagmus, opthalmoplegia, ataxia, memory disturbance, hypothermia or hypotension. Note that only 10% show the classical triad of the first three symptoms).
- Delirium tremens.

These patients will require urgent parenteral supplementation with *Pabrinex* to avoid the risk of enduring cerebral damage. Transfer to a general hospital for those with suspected Wernicke-Korsakoff syndrome. They will require IV *Pabrinex* infusions.

7.6 **Low risk cases and those declining parenteral vitamins**

For patients who are declining parenteral vitamins or where there are specific contraindications then oral supplementation will be required.

7.6.1 The recommended oral supplementation is Vitamin B Co. Strong 2 tablets tds and thiamine 200 milligrams qds. Continue whilst taking chlordiazepoxide or until a normal diet is established. Continue vitamin B Co strong 2 tablets three times daily if there is concern about diet. Thiamine 50 milligrams four times daily should also be continued if there is evidence of cognitive impairment after detoxification.

8. MEDICATIONS USED TO ENCOURAGE ABSTINENCE

8.1 Commencement of the following drugs is not normally undertaken by Somerset Partnership but patients admitted to our Wards may already be prescribed some of these preparations and staff should have some familiarity with them.

8.2 **Disulfiram**

This is a deterrent medication used as adjunctive therapy in selected clients aiming for abstinence.

Disulfiram and alcohol interact to produce increased levels of acetaldehyde, the accumulation of which leads to flushing, nausea, vomiting, vertigo, headache, abdominal pain, and diaphoresis.

Supporting patient information is provided in appendix I on Disulfiram.

A checklist has been drawn up in appendix H to help prescribers ensure there are no contraindications and a consent form is available at Appendix J.

Initiation of Disulfiram should only be completed by Somerset Drug and Alcohol Services (SDAS) or clinicians familiar with its safety profile.

8.3 **Acamprosate**

Acamprosate is licensed as a therapy to maintain abstinence in alcohol dependence.

Treatment can be initiated at the time of detoxification as it may exert a neuroprotective effect at this time. It is recommended that acamprosate be initiated and monitored for the first 12 weeks by a specialist (SDAS) after which prescribing may transfer to a GP.

9. OPIOID ANTAGONISTS IN ALCOHOL DEPENDENCE

These drugs are currently prescribed and monitored by the Somerset Drug and Alcohol services (SDAS).

The main practical difference between Naltrexone and Nalmefene is that the former requires liver function test to be undertaking both before and during treatment, whereas this is not a requirement with Nalmefene.

9.1 **Naltrexone**

9.1.1 If using oral naltrexone, start treatment after assisted withdrawal. Start prescribing at a dose of 25 milligrams per day and aim for a maintenance dose of 50 milligrams per day. Draw the service user's attention to the information card that is issued with oral naltrexone about its impact on opioid-based analgesics. Oral naltrexone should:

- usually be prescribed for up to 6 months, or longer for those benefiting from the drug who want to continue with it
- be stopped if drinking persists 4–6 weeks after starting the drug.

9.1.2 Service users taking oral naltrexone should stay under supervision of SDAS at least monthly, for 6 months, and at reduced but regular intervals if the drug is continued after 6 months. Do not use blood tests routinely, but consider them for older people, for people with obesity, for monitoring recovery of liver function and as a motivational aid for service users to show improvement. If the service user feels unwell advise them to stop the oral

naltrexone immediately. (NICE CG 115)

9.2 Nalmefene

9.2.1 Nalmefene is a selective opioid receptor antagonist licenced for use in the reduction of alcohol consumption in adults who have a high drinking risk level (DRL), without physical withdrawal symptoms and who do not require immediate detoxification. **Nalmefene is only licensed for prescribing in conjunction with continuous psychosocial support focused on treatment adherence and reducing alcohol consumption.** Please refer to the BNF for dosing instructions.

9.2.2 Recommendations are that it is used in:

- Those who have a 'high drinking risk level', i.e., 7.5 units of alcohol per day or more in men or 5 units per day or more in woman
- Those who do not require immediate detoxification. It should then be prescribed in conjunction with 'continuous psychosocial support', focused on treatment adherence and reducing alcohol consumption
- Those patients who continue to have a 'high drinking risk level' two weeks after initial assessment

9.2.3 Nalmefene is an opioid receptor antagonist and its contra-indications include:

- Patients taking opioid analgesics
- Patient with current or recent opioid addiction
- Patients with acute symptoms of opioid withdrawal
- Patients for whom use recent use of opioid is suspected
- Patients with a recent history of acute alcohol withdrawal syndrome
- The manufacturers also advise caution in patients with current psychiatric comorbidity.

9.3 It suggests that one tablet of Nalmefene is taken when the patient perceives there to be a risk of drinking alcohol, preferably one to two hours prior to the anticipated time of drinking. If a patient starts drinking, one tablet should be taken as soon as possible. No dose adjustment is recommended for older people or patients with mild or moderate renal or hepatic impairment but the treatment should be used cautiously in these groups, and its use is contraindicated in patients with severe renal or hepatic impairment.

9.4 Nalmefene might be initiated in the community by Somerset's specialist alcohol service, SDAS, in patients admitted to our units. Ongoing prescribing post discharge would be the responsibility of SDAS and not Somerset Partnership (except for supply of the appropriate and commissioned quantities of discharge medicines).

9.5 Nalmefene prescribing originating in Primary Care should not be continued as maintenance treatment in the community by Somerset Partnership prescribers.

10. ALCOHOL AND LIVER DISEASE

Some 5000 people die annually from chronic liver disease in England and Wales. In most of this group the cause is excessive alcohol consumption resulting in alcoholic hepatitis, cirrhosis or both. Patients with liver impairment may not be suitable for detoxification on a psychiatric ward, and the information below will help in guiding this decision.

10.1 Recognising alcoholic hepatitis

When the disorder is mild the person may appear well. If severe it presents with anorexia, malaise, weight loss, jaundice, and pyrexia. Ascites is common and other signs of liver disease may develop. The liver becomes enlarged and is tender. Complications include liver failure, hepatic encephalopathy, oesophageal varices and the hepatorenal syndrome.

10.2 Blood tests

Blood tests in alcoholic hepatitis are commonly deranged and should be monitored as clinically appropriate.

10.3 Nutrition

Malnutrition is common in patients with alcoholic hepatitis and worsens the prognosis. Specialist dietetic support is required and for patients identified as malnourished through their MUST score, detoxification should take place on a medical ward.

11 ASSESSING RISK IN INTOXICATED INDIVIDUALS

Where an admission is unplanned and the patient presents in an intoxicated state, the decision as to when to assess that patient will be based on presenting risk factors.

11.1 The legal framework

11.1.1 If you are unable to carry out an adequate assessment of clinical risk because of the level of intoxication, there is still a duty of care towards the patient and appropriate steps should be taken to protect the patient until an adequate level of assessment has been carried out.

11.1.2 What might be appropriate would clearly depend on the individual circumstances of the case, but the aim should be to support the individual in a safe environment until an assessment can be completed.

11.1.3 When in doubt this can be discussed with a more senior clinician.

11.1.4 Consider admission to an Acute Trust in those situations where the patient is losing consciousness or where there is a likelihood of self-poisoning.

11.2 **Special factors to consider in assessment**

Recognition of intoxication

11.2.1 The extent of the patient's intoxication with alcohol is a function of:

- body weight and tolerance
- the volume of alcohol consumed
- the percentage of alcohol in the drinks consumed
- the period over which the alcohol was ingested.

11.2.2 Estimation of the intoxication level may be possible from findings on history taking and physical examination (see Appendix K), but the diagnosis of alcohol intoxication should not be made on the basis of behaviour alone.

11.2.3 Blood alcohol concentration (BAC) is the definitive standard for assessing the level (but not the effects) of intoxication and is expressed in milligrams per decilitre (milligrams/dL). BAC can be derived from the alcohol concentration in exhaled air (see Appendix K). Breath alcohol testing meters are available in some Partnership acute units.

11.3 **Assessment of intoxication**

Various conditions can cause symptoms that mimic the mental state changes of alcohol consumption.

Mental state changes noticed to be markedly uncharacteristic of a patient's previous intoxication pattern require further assessment (see Appendix L).

11.4 **Drug interactions with alcohol**

Many drugs compete metabolically with alcohol. There are other drugs which interact with alcohol in the same fashion as disulfiram. The current BNF should be consulted.

12. TRAINING REQUIREMENTS

12.1 The Trust will ensure that all necessary staff (qualified, unqualified, other clinical staff, bank and agency staff) are appropriately trained in line with the organisation's training needs analysis.

12.2 Elements of management of those with alcohol misuse form part of a wide range of Trust training, for example, the management of vulnerable adults, assessment of risk and the recovery care plan approach.

12.3 Advice on alcohol misuse can be sought from the County's lead agency for alcohol misuse, that is Somerset Drug and Alcohol Service and from the Best Practice Group for Substance Misuse.

13. MONITORING COMPLIANCE AND EFFECTIVENESS

13.1 The policy and appendices will be regularly reviewed and maintained by the Drugs and Therapeutics Group.

13.2 The responsibility for undertaking clinical audits is held by the Alcohol and Substance Misuse Best Practice Group. These audits may be local Trust based or national clinical audits, driven by NICE, NPSA, POMH-UK and other national guidance

13.3 The Alcohol and Substance Misuse Best Practice Group and/or the Medical Audit Group will sign off key recommendations from clinical audits, and report implementation of actions to the Drugs and Therapeutics Group within their six-monthly best practice group report

13.4 The Alcohol/Substance Use Best Practice Group provide assurance to the Clinical Governance Group highlighting good practice, areas of concern, significant risks and lessons learned.

13.5 Clinical audit reports will be hyperlinked into the Trust newsletter to raise staff awareness and where appropriate influence future training.

14. REFERENCES, ACKNOWLEDGEMENTS AND ASSOCIATED DOCUMENTS

14.1 References

NICE CG100 Alcohol-use disorders: Diagnosis and clinical management of alcohol-related physical complications (June 2010)

NICE CG115 Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence (February 2011)

NICE TA325 Nalmefene for reducing alcohol consumption in people with alcohol dependence (2014)

NICE Quality Standard (QS11) for Alcohol Dependence and Harmful Alcohol Use (August 2011)

BAP evidence-based guidelines for the pharmacological management of substance abuse, 2012

The Maudsley Prescribing Guidelines in Psychiatry (11th Edition, 2012)

14.2 Cross reference to other procedural documents

Consent and Capacity to Consent to Examination and/or Treatment Policy
Medical Emergencies Management Policy
Medicines Policy
Physiological Observations Policy for Inpatients and Minor Injury Units

Rapid Tranquilisation Policy
Record Keeping and Records Management Policy

All current policies and procedures are accessible in the policy section of the public website (on the home page, click on 'Policies and Procedures'). Trust Guidance is accessible to staff on the Trust Intranet.

15 APPENDICES

15.1 For the avoidance of any doubt the appendices in this policy are to constitute part of the body of this policy and shall be treated as such.

Appendix A	Pre-admission agreement for detoxification
Appendix B	Detoxification Care Pathway: Rowan/Rydon admissions
Appendix C	Inpatient Alcohol Detoxification steps
Appendix D	SADQ. Severity of Alcohol dependence questionnaire
Appendix E	Clinical institute withdrawal assessment for alcohol (CIWA-Ar)
Appendix F	Alcohol detoxification observations
Appendix G	Chlordiazepoxide Reducing Regime Chart
Appendix H	Disulfiram – checklist
Appendix I	Information sheet 1 and 2 – Disulfiram
Appendix J	Disulfiram consent to treatment
Appendix K	Alcohol consumption and clinical manifestations in nontolerant persons
Appendix L	Factors in differential diagnosis of altered mental status in an acutely intoxicated patient

Appendix A

PRE-ADMISSION AGREEMENT FOR DETOXIFICATION

1. I, …… agree to follow a detoxification regime from …….. as an in-patient.

2. I will not bring alcohol or drugs onto the ward and I agree to my bags and belongings being searched, in my presence, by a member of staff should they request this of me.

3. I will not use alcohol or illicit drugs while on the ward and will agree to an alcohol or drug-screening test if requested by either the medical or nursing team.

4. I agree to remain within the building unless accompanied by nursing staff in the grounds for the duration of the detoxification.

5. I will agree all visits beforehand with my nursing key worker or deputy.

6. I understand and will abide by the rules of the ward community and have been supplied with a copy of these rules.

7. The medication I shall receive to facilitate my detoxification will be as follows:

   I consent to the above medication but understand that changes can be reached by negotiation with the medical/nursing team. I will be fully informed of any potential side effects and receive all necessary care to protect my health.

8. I will have access to a minimum of three one to one sessions, either with my community alcohol worker or my ward key worker. This does not preclude me from approaching a member of staff at any other time.

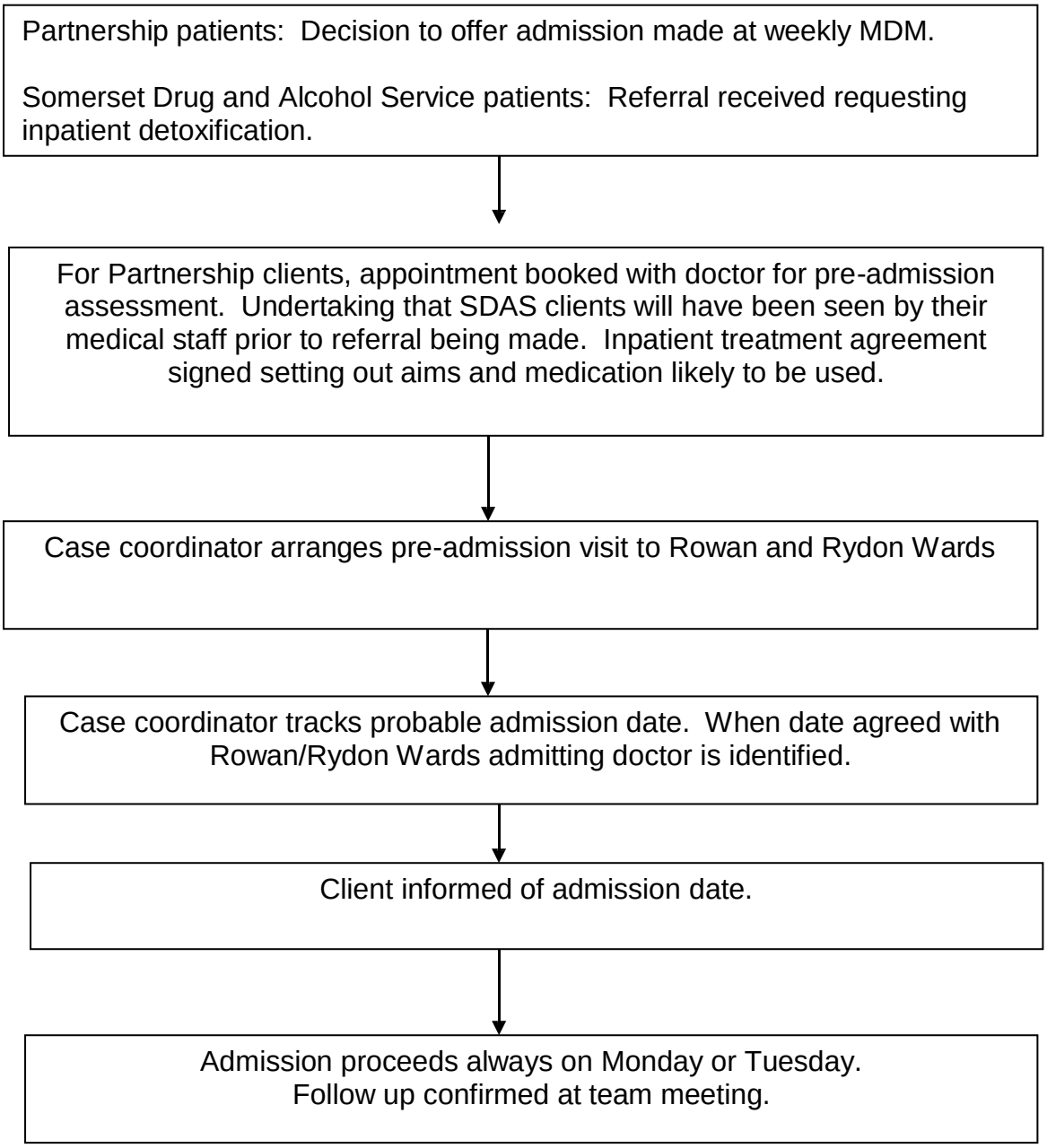
9. I understand that if I am in breach of any of the conditions laid down in this contract I may have to leave at short notice in the interests of other patients on the ward.

1. SIGNED (Client)……. DATE:……..

2. SIGNED (For team)…… DATE:……..

Appendix B

DETOXIFICATION CARE PATHWAY: ROWAN/RYDON ADMISSIONS



Appendix C

Inpatient Alcohol Detoxification Steps

1. Inpatient detoxification should be part of scheduled care and be pre-booked with the admitting unit. Refer to the care pathway for in patient detoxification admissions (Appendix B). Arrange for full blood count, liver function with GGT and any other appropriate tests to be completed prior to admission by the patient's GP.

2. Patients should sign the pre-admission treatment agreement (Appendix A).

3. Patients should be admitted in the morning whenever possible. Ideally they should not have consumed alcohol for the previous 6 hours.

4. A full history should be documented in the patient record, including a full history of alcohol and substance misuse.

5. All patients should receive a full physical examination with particular attention to neurological examination and signs of Wernicke's encephalopathy such as confusion, ataxia, and opthalmoplegia.

6. Blood investigations which include FBC, U&E, LFT, GGT, blood glucose, Milligrams and INR must have been completed recently before admission or shortly after. Any of these blood investigations not undertaken prior to admission must be completed as soon as practicable afterwards.

7. Administer the Severity of Alcohol Dependence Questionnaire (SADQ Appendix D) and write up the Alcohol Withdrawal Prescription Chart (Appendix G) using the derived score from the SADQ as a guide to the appropriate dosing regime from the table on the reverse of the Chart.

    a) Reducing chlordiazepoxide detoxification for most patients. Use Lorazepam for those with significant deterioration in hepatic function.

    b) Vitamin supplementation – all patients, as outlined in Section 7.

    c) Consider the need for a single, appropriate dose of "as required" diazepam rectal solution to be given in the case of a seizure when medical staff are not immediately available.

8. Chart of vital signs (PR, BP, Temp, respiratory rate) should be initiated and completed 6 hourly for first 24 hours before reassessment (Appendix F).

9. Monitor withdrawal symptoms over the course of the admission. Patient and nursing staff to complete CIWA-Ar as indicated but at least daily for duration of detoxification (Appendix E).

10. Consider monitoring blood glucose 2 hourly in patients with signs of altered consciousness, aggression agitation or somatic symptoms consistent with hypoglycaemia.

11. Advise using shower only for first 48 hours in case of withdrawal seizures. Supervise the use of a bath.

Appendix D

SADQ – SEVERITY OF ALCOHOL DEPENDENCE QUESTIONNAIRE

First of all, recall a recent month when you were drinking heavily in a way, which, for you, was fairly typical of a heavy drinking period. Please fill in the month and year:

Month……. **Year**

During this time and during other periods when your drinking was similar, how often did you experience the feelings listed below? Please reply to each statement by circling the number for the most accurate answer for each question.
These questions are about the physical symptoms that you have experienced first thing in the morning during these typical periods of heavy drinking.

PLEASE ANSWER EVERY QUESTION

Circle one answer	Almost never	Some-Times	Often	Nearly Always
1) During a heavy drinking period I wake up feeling sweaty.	0	1	2	3
2) During a heavy drinking period my hands shake first think in the morning	0	1	2	3
3) During a heavy drinking period my whole body shakes violently first thing in the morning if I do not have a drink	0	1	2	3
4) During a heavy drinking period I wake up absolutely drenched in sweat.	0	1	2	3

The following statements also refer to the recent period when your drinking was heavy, and to periods like it.

PLEASE ANSWER EVERY QUESTION

Circle one answer	Almost never	Some-Times	Often	Nearly Always
5) During a heavy drinking period I like to have a morning drink	0	1	2	3
6) During a heavy drinking period I gulp my first few morning drinks down as quickly as possible	0	1	2	3
7) During a heavy drinking period I drink in the morning to get rid of the shakes	0	1	2	3
8) During a heavy drinking period I have a very strong craving for a drink when I awaken	0	1	2	3

The following statements refer to moods and states of mind you may have experienced first thing in the morning during these periods of heavy drinking

PLEASE ANSWER EVERY QUESTION

Circle one answer	Almost never	Some-Times	Often	Nearly Always
9) When I am drinking heavily I dread waking up in the morning	0	1	1	3
10) During a heavy drinking period I am frightened of meeting people first thing in the morning	0	1	2	3
11) During a heavy drinking period I feel at the edge of despair when I awaken	0	1	2	3
12) During a heavy drinking period I feel very frightened when I awaken	0	1	2	3

Again the following statements refer to the recent period of heavy drinking and the periods like it.

PLEASE ANSWER EVERY QUESTION

Circle one answer	Almost never	Some-Times	Often	Nearly Always
13) During a heavy drinking period I drink more than a quarter of a bottle of spirits per day (4 doubles or 1 bottle of wine or 6 beers)	0	1	1	3
14) During a heavy drinking period I drink More than half a bottle of spirits per day (or 2 bottles of wine, or 12 beers)	0	1	2	3
15) During a heavy drinking period I drink more than one bottle of spirits per day (or 1 gallon of wine, or 24 beers)	0	1	2	3
16) During a heavy drinking period I drink more than two bottles of spirits per day (or 2 gallons of wine, or 48 beers)	0	1	2	3

IMAGINE THE FOLLOWING SITUATION:

1) You have COMPLETELY ABSTAINED FROM ALCOHOL FOR A FEW WEEKS

2) You then drink VERY HEAVILY for TWO DAYS

How would you feel the morning after those two days of heavy drinking?

PLEASE ANSWER EVERY QUESTION

Circle one answer	Not at all	Slightly	Moderate	Quite a lot
17) I would start to sweat	0	1	2	3
18) My hands would shake	0	1	2	3
19) My body would shake	0	1	2	3
20) I would be craving for a drink	0	1	2	3

Thank you!

Appendix E

CLINICAL INSTITUTE WITHDRAWAL ASSESSMENT FOR ALCOHOL (CIWA-Ar)

Sullivan et al., 1989

Patient……

Date…… Time……... Pulse…….

Total CIWA-Ar Score (max. possible score 67)……..Please add score to attached ST-T monitoring form

NAUSEA AND VOMITING - Ask "Do you feel sick to your stomach?" Observation	TACTILE DISTURBANCES – Ask "Have you any itching, pins and needles, any burning or numbness or do you feel bugs crawling under the skin?"
0 No nausea 1 2 3 4 Intermittent nausea with dry heaves 5 6 7 Constant nausea, frequent dry heaves and vomiting.	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 Moderately severe hallucinations 5 Severe hallucinations 6 Extremely severe hallucinations 7 Continuous hallucinations
TREMOR – Arms extended and fingers spread apart Observation	AUDITORY DISTURBANCES – Ask "Are you more aware of sounds around you? Are they harsh? Do they frighten you?"
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 with arms not extended.	0 Not present 1 Very mild sensitivity 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	VISUAL DISTURBANCES – Ask "Does the light appear to be too bright? Is its

	colour different? Does it hurt your eyes? Are you seeing anything that is disturbing to you? Are you seeing things that you know are not there?" Observation
0 No sweat visible 1 Barely perceptible sweating, palms moist 2 3 4 Beads of sweat obvious on forehead 5 6 7 Equivalent to acute panic states as seen in severe delirium or acute schizophrenic reactions.	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	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 or light-headedness. Otherwise rate severity
0 No anxiety 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.	0 Not present 1 Very mild 2 Mild 3 Moderate 4 Moderately severe 5 Severe 6 Very severe 7 Extremely severe
AGITATION Observation	ORIENTATION AND CLOUDING OF SENSORIUM – Ask, "What day is this/where are you? Who am I?"
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 out.	0 Orientated and can do serial additions 1 Cannot do serial additions or is uncertain about date 2 Disorientated for date by no more than two calendar days 3 Disorientated for place and/or person

Appendix F

ALCOHOL DETOXIFICATION OBSERVATIONS

Admission observations:

Temp:

BP:

Pulse:

		DAY 1	DAY 2	DAY 3	DAY 4	DAY 5
08h00	Temp					
	Pulse					
	BP					
	RR					
14h00	Temp					
	Pulse					
	BP					
	RR					
20h00	Temp					
	Pulse					
	BP					
	RR					
02h00	Temp					
	Pulse					
	BP					
	RR					

CIWA-Ar at 1800					
	DAY 1	DAY 2	DAY 3	DAY 4	DAY 5

Appendix G

Inpatient Alcohol Detoxification

Chlordiazepoxide Reducing Regimen Chart

Name				DoB	
Ward		Consultant		SADQ score	
Hospital No		NHS No			

BEFORE PRESCRIBING

1. Assess level of alcohol dependence using (SADQ) - see Inpatient Alcohol Assessment & Detoxification Policy.
2. The starting dose of chlordiazepoxide should be determined from a combination of SADQ score and other clinical factors. From starting dose follow the appropriate regimen set out on reverse of chart.
3. Detoxification normally occurs over a maximum of 10 days.
4. Vitamin supplementation should be prescribed as per guidance on reverse of chart.

GUIDANCE NOTES FOR USE

1. The prescriber must enter all the patient's details above.
2. The date and dose and frequency must be entered in the appropriate boxes.
3. Prescribers must sign for each individual dose prescribed.
4. The prescriber must also write on the inpatient drug chart "chlordiazepoxide as per reducing chart."
5. Consider the need for any additional chlordiazepoxide to be prescribed on the "As required" section of the drug chart.
6. The chart should be kept on the ward with the patient's drug chart and on completion should be filed with the drug chart.

Date	Drug	Dose Frequency / Administration Record					Prescribers Signature
	Chlordiazepoxide	Time	8.30	12.30	17.00	22.00	
		Dose					
		Given by					
	Chlordiazepoxide	Time	8.30	12.30	17.00	22.00	
		Dose					
		Given by					
	Chlordiazepoxide	Time	8.30	12.30	17.00	22.00	
		Dose					
		Given by					
	Chlordiazepoxide	Time	8.30	12.30	17.00	22.00	
		Dose					
		Given by					
	Chlordiazepoxide	Time	8.30	12.30	17.00	22.00	
		Dose					
		Given by					
	Chlordiazepoxide	Time	8.30	12.30	17.00	22.00	
		Dose					
		Given by					
	Chlordiazepoxide	Time	8.30	12.30	17.00	22.00	
		Dose					
		Given by					
	Chlordiazepoxide	Time	8.30	12.30	17.00	22.00	
		Dose					
		Given by					
	Chlordiazepoxide	Time	8.30	12.30	17.00	22.00	
		Dose					
		Given by					
	Chlordiazepoxide	Time	8.30	12.30	17.00	22.00	
		Dose					
		Given by					

	LOWER DOSE REGIME (SADQ score <40) Chlordiazepoxide dose in milligrams				HIGHER DOSE REGIME (SADQ score >40) Chlordiazepoxide dose in milligrams				Additional chlordiazepoxide may be needed (particularly in first 3 days) if patient remains symptomatic	
Time	8:30	12:30	17:00	22:00	8:30	12:30	17:00	22:00	Lower dose regime PRN in	Higher dose Regime PRN in
Day 1	30	30	30	30	40	40	40	40	10-20 qds	20-30 qds
Day 2	30	20	30	30	40	30	40	40	If higher doses of medication have needed to be given, re-write the remaining regime to take this into account (i.e. taper off the total daily dose to avoid an abrupt drop)	
Day 3	30	20	20	30	40	30	30	40		
Day 4	20	20	20	20	30	30	30	30		
Day 5	20	10	10	20	30	20	20	30		
Day 6	10	10	10	20	20	20	20	20		
Day 7	10	10	10	10	20	10	10	20		
Day 8	10		10	10	10	10	10	10		
Day 9	10			10	10			10		
Day 10				10				10		

- In case of liver failure prescribe lower doses of chlordiazepoxide or consider using lorazepam and observe vital signs more closely.
- If patient is consistently over-sedated, omit the next dose pending review.
- Extend regimen in the case of people who develop DT or have a previous history of DT.
- For Symptom Titration Method using the CIWA-Ar system refer to Appendix D of the Inpatient Alcohol Assessment and Detoxification Policy.

Vitamin Supplementation

Low risk cases and those declining parenteral vitamins.

Oral vitamin replacement - vitamin B Co. Strong 2 tablets tds and thiamine 200 milligrams qds. Continue whilst taking chlordiazepoxide or until a normal diet is established. Continue vitamin B Co strong 2 tablets three times daily if there is concern about diet. Thiamine 50milligrams four times daily should also be continued if there is evidence of cognitive impairment after detoxification.

Prophylactic treatment for patients at risk, i.e.

- Most cases requiring in patient detoxification
- Significant weight loss
- Poor diet, signs of malnutrition.

For those considered at risk give one pair *Pabrinex* i.m. daily for 3-5 days. Patients should be closely observed following administration as there is a small risk of a severe (anaphylactic) reaction. The injections are then replaced by oral administration of thiamine i.e. 100milligrams t.d.s. for 6 weeks. Subsequently treat as for low risk group.

For patients with deficiency symptoms, i.e.

- Wernicke-Korsakov's Syndrome (Confusion+/-nystagmus, opthalmoplegia, ataxia, memory disturbance, hypothermia or hypotension***. Note that only 10% show the classical triad of the first three symptoms***).
- Delirium tremens.

These patients will require urgent parenteral supplementation with *Pabrinex* to avoid the risk of enduring cerebral damage. Consider transferring to a general hospital those with suspected Wernicke-Korsakoff syndrome. They will require IV *Pabrinex* infusions. For established or incipient Wernicke's give two pairs IV three times daily by slow (10 minutes) infusion each day for 3 days followed by one pair daily for 5 days then treat as for the low risk group.

Appendix H

DISULFIRAM - CHECKLIST

Client's Name:…… Date:……

- ❑ **Caution if history of heart failure** (no swollen ankles and/or breathlessness, likely to be on diuretics or ACE inhibitors if have this).
- ❑ **Caution if history of coronary artery disease** (no tight central chest pain on exertion relieved by rest, no coronary artery by-pass).
- ❑ **Caution if history of a stroke.**
- ❑ **Caution if hypertensive** (diastolic average over 100 mm Hg systolic average above160mm Hg).
- ❑ **Caution if history of psychosis.**
- ❑ **Caution if a suicide risk** – do not prescribe if actively suicidal.
- ❑ **If pregnant or breast-feeding do not prescribe.**
- ❑ **Is aware of unpredictable, potentially fatal interaction with alcohol up to one week after taking disulfiram.**
- ❑ **Likely reaction has been explained** (one or more of vomiting, flushing, headache and palpitations).
- ❑ **BAL = 0 when starts disulfiram plus no alcohol for at least 24 hours prior to starting.**
- ❑ **Client has treatment card, disulfiram leaflet and sheet detailing products containing alcohol.**
- ❑ **Client aware that, uncommonly, side effects can occur** (initially fatigue, drowsiness, nausea, vomiting, bad breath, reduced libido), rarely skin conditions, psychiatric illness, nerve damage and in the first six months, liver damage. Therefore must have LFTs checked before starting disulfiram AND should have them re-checked at six-monthly intervals.
- ❑ **Drugs – caution if taking any of the following:**

  Warfarin, antipyrine, phenytoin, morphine and amphetamines – amitriptyline, isoniazid, metronidazole, paraldehyde, rifampicin, pimozide and chlorpromazine (disulfiram blocks the breakdown of the above drugs).

Appendix I

INFORMATION SHEET 1 – DISULFIRAM

What is disulfiram?

Disulfiram is a drug that is used to help you overcome the temptation to drink. If you consume alcohol while taking disulfiram you will almost certainly experience a number of very unpleasant side effects known as Antabuse-Alcohol Reaction (AAR).

What will happen to me during disulfiram - Alcohol Reaction?

One or more of the following normally occurs: nausea, vomiting, flushing, headache and heart palpitations. The reaction varies with different people, but can be severe. It is therefore important that you do not drink any alcohol while taking disulfiram. If you do, contact your doctor immediately.

Will disulfiram cure my alcohol dependency?

No. Only you can do that. But by consenting to the use of this medicine, you have taken the first major step in successfully overcoming your dependency on alcohol. You have, in fact shown that you are totally motivated – not only in your desire not to take a drink but, more crucially, in your willingness to take the tablets.

How long will I have to take disulfiram?

This is a decision between you and your doctor. Take one day at a time. Decide on a short period of time you think you can go without a drink. Once you have achieved that period of time and have experienced the well being that comes from sobriety, you will probably wish to continue your treatment for a longer period.

Is disulfiram safe?

Disulfiram is generally well tolerated by dry alcoholics, and any side effects you may experience are usually mild and reversible. These may include a feeling of tiredness and lethargy, and sometimes a skin rash. If any of these symptoms affect you, tell your doctor. Often a reduction in dosage will resolve the problem.

Remember: unpleasant effects will occur if disulfiram and alcohol are taken in combination.

If I lose my resolve, what then?

No matter how great is the temptation to drink, don't. Disulfiram will normally remain in your system for up to seven days after you stop taking it. So even if you don't take your tablet(s) for a day or two, the effects of the disulfiram – alcohol reaction will occur if you have an alcoholic drink for up to one week after stopping the tablets.

There are a number of things you can do to help you get over the rough spots. Continue to take your medicine. Talk to your doctor or the health professional who is supervising your treatment. If you find your self in situations that trigger the urge to drink, get away from them and do something else that you enjoy. Change old habits for new ones. Look to your spouse or close friends for support. Prove to yourself that you are stronger than any alcoholic drink.

What else should I know about disulfiram?

Take your tablets with water, unless otherwise instructed by your doctor.

Avoid liquid medicines such as cough mixtures and tonic, which often contain alcohol.

Refrain from the use of toiletries such as perfume and after-shave, as these also may contain alcohol.

Store your medication in its container in a cool, dry place away from children.

Take your medication at the same time every day; if you feel you need some added motivation have your spouse or a trusted friend supervise your tablet taking.

Keep a daily diary, such as the one printed below. It will provide you with a record of your daily medication – and, more importantly, it should show how much better you feel with every day that you remain alcohol-free.

Daily Diary

Date	Time	Tick When Taken	Remarks (describe how you feel)

INFORMATION SHEET 2 – DISULFIRAM – WHAT TO AVOID

If you are taking disulfiram, the following guidelines will be important for you.

Many proprietary products contain alcohol and you should look carefully at the ingredients listed on any products you may purchase. If you purchase a product from a pharmacy and you are in any doubt, please consult the pharmacist.

Aftershave – use an alcohol-free aftershave.

Vinegars and Pickles – if they are (or contain) cider or wine-vinegar, avoid them.

Antiperspirants – buy alcohol-free antiperspirants.

Mouthwashes – some contain alcohol, but there are alcohol-free mouthwashes on sale.

Cough Medicines – consult your pharmacist before buying any cough medicines.

Cooking with Alcohol – most sauces eg white or red wine sauce, contain alcohol. It is possible to evaporate that alcohol while cooking but some alcohol may remain. Uncooked alcohol, eg sherry trifle or liqueur chocolates, must be avoided.

Hair Dyes/Soap/Tar Gel – that contain alcohol are best avoided, as they are absorbed through the skin due to friction, heat and moisture when used.

Nebulisers/Ear Drops – some contain alcohol and will need to be discontinued.

Hand Wipes – these can contain alcohol and should not be used.

Hand Creams – some contain alcohol and should not be used.

Blood Donation – this must be completely avoided.

Appendix J

DISULFIRAM CONSENT TO TREATMENT

I…….
(in capitals please)

agree to be prescribed and to take disulfiram medication.

I have had the beneficial effects and possible side effects of disulfiram explained to me and have been given an information leaflet. I have understood the risks I run if I drink alcohol whilst taking disulfiram.

For female clients

I understand that I need to take precautions against pregnancy whilst taking disulfiram.

Signed…….

Date……..

I……. agree to witness ……taking this medication. I understand that responsibility to continue treatment remains with them; however I will support them in their endeavour.

Appendix K

Alcohol consumption, approximate BAC, and clinical manifestations in nontolerant persons

Alcohol consumption (units)* 55-kg person	90-kg person	**Approximate BAC,milligrams/dL (mmol/L)****	**Probable clinical manifestations**
1-3	2-5	50-100 (10.9-21.7)	Impaired sensation, incoordination
3-5	5-8	100-150 (21.7-32.6)	Behavioural changes, ataxia, cognitive and memory difficulties
5-7	8-11	150-200 (32.6-43.4)	Marked in coordination, worsening ataxia, cognitive impairment
7-9	11-14	200-300 (43.4-65.1)	Nausea, vomiting, diplopia, lethargy, aspiration risks (impairment of protective reflexes)
≥10	≥15	300-400 (65.1-86.8)	Decreased respiratory drive, hypothermia, cardiac arrhythmias
Extreme		>400 (>86.8)	Coma, respiratory arrest, death

BAC, blood alcohol concentration. *one unit equals ½ pint of ordinary bitter, a single measure of spirits, a 125cl glass of wine or a small glass of sherry
**1 unit in a 70-kg person raises BAC by 25 milligrams/dL (5.4 mmol/L).

To convert Breath Alcohol readings (mcg/100mls) to the Blood Alcohol equivalent (milligrams/l) multiply by 2.3 and round up to the nearest whole number

Appendix L

Factors in differential diagnosis of altered mental status in an acutely intoxicated patient

Toxic

Ethanol intoxication
Intoxication with other alcohols (e.g., methanol, isopropyl alcohol)
Other psychoactive drugs (e.g., tetrahydrocannabinol, cocaine, opiates)
Disulfiram reactions, disulfiram like reactions

Metabolic

Hepatic encephalopathy
Hypoglycaemia (alcohol induced)
Electrolyte abnormalities (hypernatraemia, hyponatraemia)
Hypoxia secondary to aspiration or depression of respiratory drive
Pre-existing diagnosis of diabetes mellitis. Hypoglycaemia may be profound.

Infectious disease

Sepsis
Meningitis
Encephalitis

Neurological

Alcohol withdrawal or alcohol hallucinosis
Postictal states
Wernicke-Korsakoff syndrome
Cerebrovascual accident

Miscellaneous

Hypotension (due to dehydration, vomiting, haemorrhage)
Hypothermia

Trauma

Closed head injuries (e.g., intracranial bleeding, concussion syndromes)