Rotherham Doncaster and South Humber NHS Foundation Trust

Alcohol Detoxification (Doncaster Inpatients) Policy

DOCUMENT CONTROL:	
Version:	2
Ratified by:	Clinical Policies Review and Approval Group
Date ratified:	6 October 2020
Name of originator/author:	Consultant Psychiatrist
Name of responsible committee/individual:	Executive Medical Director
Unique Reference Number:	104
Date issued:	27 November 2020
Review date:	October 2023
Target Audience	All managers with responsibilities derived from the policy and all clinical staff with direct service user contact
Description of Changes:	Minor changes to practices including dose ranges, observations and structure

CONTENTS

1. INTRODUCTION

Withdrawal symptoms occur when a person who is physically dependent on alcohol stops drinking or reduces their alcohol consumption.

Alcohol detoxification is a treatment provided to help control the physical and psychological symptoms that occur during the alcohol withdrawal process. Depending on the severity of withdrawals symptoms detoxification usually takes seven to 10 days.

2. PURPOSE

The purpose of this document is to set out the protocol that should be followed to ensure alcohol detoxification occurs safely and effectively.

3. SCOPE

This document is primarily intended for staff within New Beginnings Inpatient Drug and Alcohol unit. Only staff with appropriate training and skills should be providing care to patients requiring an inpatient detoxification.

4. RESPONSIBILITIES, ACCOUNTABILITIES AND DUTIES

4.1 Service Managers and Modern Matrons

- Disseminate, implement and monitor implementation of the policy within areas of responsibility
- Facilitate, support and monitor staff in their responsibilities with regard to policy implementation and monitoring
- Identify and allocate resources in order to comply with this policy
- Make available appropriate and suitably maintained equipment, maintaining up to date Medical Devices Inventories in all areas.
- Promote incident reporting and audit requirements as specified within trust policies.
- Facilitate an environment where incidents are reviewed in an open and positive manner, involving staff at all levels in improving practice and promoting organisational
- Report any issues, which may affect implementation to the attention of their Assistant Director.

4.2 Ward managers/team leaders

- Facilitate effective local induction processes for all new starters.

- Manage the process of releasing staff for training and updating at least annually in the skills relevant for their area, in line with the Mandatory Risk Management Training Policy
- Maintain staff training records for the area, including temporary, bank and agency staff
- Proactively identify risks due to lack of training or resources to the Manager/Modern Matron/Service manager

4.3 Clinical Staff

- Implement the protocol.
- Report any issues which affect the effective implementation of this policy to their manager, e.g. access to training or equipment
- Report all incidents as per the Incident Reporting.
- Maintain a personal record of their own training
- Contribute to the review of incidents in an open and positive manner in order to improve practice and promote organisational learning

4.4 Prescribers (Medical staff or Non-Medical Prescribers)

- Comprehensive assessment of the client to ensure suitability for detoxification.
- Assessment of the pharmacological requirements for detoxification.
- Being available to provide advice.

5. UNDERSTANDING ALCOHOL DEPENDENCE

5.1 Alcohol Withdrawal Syndrome

Symptoms of alcohol withdrawal

Common	Less Common	Severe Withdrawals
• Sweating • Tachycardia • Anxiety, agitation • Nausea, vomiting, • Diarrhoea • Tremor • Insomnia • Hallucinations in clear • Consciousness	• Arrhythmias • Hypertension	• Seizures • Delirium tremens

40% of individuals will develop an acute withdrawal syndrome upon stopping or significantly curtailing alcohol intake. The risk of withdrawal is not directly related to intake. Symptoms are seen within hours (typically 6 to 8) of the last

drink and may develop before the blood alcohol level has fallen to zero. Symptoms outlined below may vary in severity, commonly peaking at 10 to 30 hours and usually subsiding by 40 to 50.

5.2 Withdrawal Fits

Withdrawal fits can occur at 12 to 48 hours and are more likely if there is a previous history of withdrawal fits or epilepsy. Fits tend to be generalised tonic clonic (if focal, suspect other causes e.g. head injury) and may occur in bouts. In 30% of cases, fits are followed by delirium tremens.

5.3 Severe withdrawal / delirium tremens (DT)

Severe withdrawal / delirium tremens usually develop after 72 hours but can be sooner. Clinical features include; marked tremor, confusion, disorientation, agitation, restlessness, fearfulness, visual and auditory hallucinations, delusions, autonomic disturbances, tachycardia, sweating, fever and dehydration. Risk factors include severe dependence, previous history of DT's, older age, coexisting medical conditions such as infection.

5.4 Wernicke's Encephalopathy.

Wernicke's encephalopathy is a potentially fatal consequence of alcohol dependence. A presumptive diagnosis of Wernicke's should be made in any patient detoxifying and experiencing any of the following:

- Confusion/apathy
- Drowsiness
- Coma/unconsciousness
- Hypothermia and hypotension
- Abnormal eye movements that may seem like a squint
- Double vision
- Poor balance
- Memory disturbance

Wernicke's is a medical emergency and patients should be transferred for treatment to a general hospital.

6. CRITERIA FOR INPATIENT DETOXIFICATION

The majority of patients with alcohol dependence, including those with withdrawal symptoms, can be managed in the community but in-patient detoxification is usually required if the person:

- Is severely dependent on alcohol

- Is currently having (or has had) severe withdrawal symptoms such as delirium tremens (DTs) or seizures
- Has significant co-morbid substance dependence
- Suffers with a serious medical or psychiatric co-morbid condition, liver dysfunction
- Is at risk of suicide or homicide
- Lacks social support / supervision in the community
- Has a history of failed community detoxifications
- Has significant cognitive impairment

7. PROCEDURE

7.1 Assessment

Careful assessment of the patient is required to ensure safe and effective management. Assessment is important in establishing the safest place for the patient to complete an alcohol detoxification. If there are serious concerns about patients' physical heath then alternative provision may need to be made such as through the general hospital.

The purpose of alcohol detoxification is to control withdrawals whilst avoiding side effects and to support the patient to successfully complete this treatment.

Assessment must include:

ALCOHOL USE BY:

- Number of units
- Breathalyser reading(s)
- Severity of Alcohol Dependence Questionnaire (SADQ) (appendix 1)
- Past history of seizures and delirium tremens
- Withdrawal symptoms

MENTAL HEALTH

SOCIAL CIRCUMSTANCES

PHYSICAL HEALTH:

Physical health examination must be completed for inpatient admissions. This includes

- Current and past
- Blood tests including full blood count, urea and electrolytes, liver function tests, clotting (International Normalised Ratio - INR)

- A full set of baseline physical and neurological observations documented on the trust charts
- Examination of cardiovascular, neurological and gastrointestinal and respiratory systems.

Please refer to policy and **appendix 2**: minimum standards for the physical assessment and examination of inpatient in mental health and learning disabilities services.

Plan following detoxification including relapse prevention. If not already engaging with drug and alcohol services please consider referral.

7.2 Pharmacological management of alcohol detoxification

Benzodiazepines are the treatment of choice in the management of alcohol withdrawal.

Dosage should be ***individually titrated*** and will depend on severity of dependence, withdrawal severity, gender, body mass index (BMI), general health and liver function.

Chlordiazepoxide is the drug of choice as it has a long half-life, slow absorption and lower abuse potential. Alternatively if chlordiazepoxide is unavailable diazepam may be used. For example for a 30mg chlordiazepoxide starting regime use 10mg starting dose regime; for 40mg to 50mg chlordiazepoxide regime use 15-20mg diazepam regime.

Special caution is necessary in the case of older people, severe liver impairment (e.g. cirrhosis) as the metabolism of benzodiazepines may be reduced and lead to over-sedation. Lorazepam or oxazepam may be suitable alternatives to diazepam or chlordiazepoxide if there are concerns especially if signs of liver dysfunction/failure.

Extra medication (referred to as PRN (as needed medication)) will be prescribed routinely. This allows for extra medication to be administered if required. Usually this will be prescribed as doses of 5-10mg of chlordiazepoxide with an additional maximum 40mg-60mg in 24 hours. A Clinical Institute Withdrawal Assessment of Alcohol (CIWA - revised version is CIWA-Ar) must be completed prior to administering PRN medication. The reason for administering the medication must be written in the patients notes.

CHLORDIAZEPOXIDE REDUCING REGIMES

DAILY alcohol intake		20 – 24 units		25 – 40 units		41 – 45 units	46 – 50 units
Level of dependence		SADQ 20 - 25		SADQ 26 – 40		SADQ 41-45	SADQ >45
DAY 1	Daily total	80mg	100mg	120mg	160mg	180mg	200mg
Dosing time	09:00	20mg	25mg	30mg	40mg	45mg	50mg
	13:00	20mg	25mg	30mg	40mg	45mg	50mg
	18:00	20mg	25mg	30mg	40mg	45mg	50mg
	22:00	20mg	25mg	30mg	40mg	45mg	50mg
DAY 2	Daily total	60 mg	80mg	100mg	140mg	160mg	180mg
Dosing time	09:00	15mg	20mg	25mg	35mg	40mg	45mg
	13:00	15mg	20mg	25mg	35mg	40mg	45mg
	18:00	15mg	20mg	25mg	35mg	40mg	45mg
	22:00	15mg	20mg	25mg	35mg	40mg	45mg
DAY 3	Daily total	40mg	60mg	80mg	120mg	140mg	160mg
Dosing time	09:00	10mg	15mg	20mg	30mg	35mg	40mg
	13:00	10mg	15mg	20mg	30mg	35mg	40mg
	18:00	10mg	15mg	20mg	30mg	35mg	40mg
	22:00	10mg	15mg	20mg	30mg	35mg	40mg
DAY 4	Daily total	40mg	60mg	80mg	100mg	120mg	140mg
Dosing time	09:00	10mg	15mg	20mg	25mg	30mg	35mg
	13:00	10mg	15mg	20mg	25mg	30mg	35mg
	18:00	10mg	15mg	20mg	25mg	30mg	35mg
	22:00	10mg	15mg	20mg	25mg	30mg	35mg
DAY 5	Daily total	20mg	40mg	60mg	80 mg	100mg	120mg
Dosing time	09:00	5mg	10mg	15mg	20mg	25mg	30mg
	13:00	5mg	10mg	15mg	20mg	25mg	30mg
	18:00	5mg	10mg	15mg	20mg	25mg	30mg
	22:00	5mg	10mg	15mg	20mg	25mg	30mg
DAY 6	Daily total	10mg	20 mg	40mg	60mg	80mg	100mg
Dosing time	09:00	5mg	5mg	10mg	15mg	20mg	25mg
	13:00		5mg	10mg	15mg	20mg	25mg
	18:00	-	5mg	10mg	15mg	20mg	25mg
	22:00	5mg	5mg	10mg	15mg	20mg	25mg
DAY 7	Daily total		10mg	20mg	40mg	60mg	80mg
Dosing time	09:00		5mg	5mg	10mg	15mg	20mg
	13:00	-	-	5mg	10mg	15mg	20mg
	18:00	-		5mg	10mg	15mg	20mg
	22:00		5mg	5mg	10mg	15mg	20mg
DAY 8	Daily total			10mg	20mg	40mg	50mg
Dosing time	09:00			5mg	5mg	10mg	15mg
	13:00		-		5mg	10mg	10mg
	18:00		-	-	5mg	10mg	10mg
	22:00			5mg	5mg	10mg	15mg
DAY 9	Daily total				10mg	20mg	30mg
Dosing time	09:00				5mg	5mg	10mg
	13:00					5mg	5mg
	18:00				-	5mg	5mg
	22:00				5mg	5mg	10mg
DAY 10	Daily total					10mg	10mg
Dosing time	09:00					5mg	5mg
	13:00					-	
	18:00					-	
	22:00					5mg	5mg

PRN dosing increments for chlordiazepoxide

- Individual doses of 5 to 10mg
- Daily maximum of 40-60mg

OXAZEPAM REDUCING REGIMES

Drug Misuse and dependence UK Guidelines on clinical management 2017:
Chlordiazepoxide 12.5-15mg is equivalent to Oxazepam 10-15mg
Oxazepam use in alcohol detox is outside of its licenced indications and doses above 120mg/day are above BNF maximum doses. It's use must be discussed with patient and rationale for use clearly documented.

DAILY alcohol intake		**20 – 24 units**		**25 – 40 units**		**41 – 45 units**	**46 – 50 units**
Level of dependence		**SADQ 20 - 25**		**SADQ 26 – 40**		**SADQ 41-45**	**SADQ >45**
DAY 1	Daily total	80mg	100mg	120mg	160mg	180mg	200mg
Dosing time	09:00	20mg	25mg	30mg	40mg	45mg	50mg
	13:00	20mg	25mg	30mg	40mg	45mg	50mg
	18:00	20mg	25mg	30mg	40mg	45mg	50mg
	22:00	20mg	25mg	30mg	40mg	45mg	50mg
DAY 2	Daily total	60 mg	80mg	100mg	140mg	160mg	180mg
Dosing time	09:00	15mg	20mg	25mg	35mg	40mg	45mg
	13:00	15mg	20mg	25mg	35mg	40mg	45mg
	18:00	15mg	20mg	25mg	35mg	40mg	45mg
	22:00	15mg	20mg	25mg	35mg	40mg	45mg
DAY 3	Daily total	40mg	60mg	80mg	120mg	140mg	160mg
Dosing time	09:00	10mg	15mg	20mg	30mg	35mg	40mg
	13:00	10mg	15mg	20mg	30mg	35mg	40mg
	18:00	10mg	15mg	20mg	30mg	35mg	40mg
	22:00	10mg	15mg	20mg	30mg	35mg	40mg
DAY 4	Daily total	40mg	60mg	80mg	100mg	120mg	140mg
Dosing time	09:00	10mg	15mg	20mg	25mg	30mg	35mg
	13:00	10mg	15mg	20mg	25mg	30mg	35mg
	18:00	10mg	15mg	20mg	25mg	30mg	35mg
	22:00	10mg	15mg	20mg	25mg	30mg	35mg
DAY 5	Daily total	20mg	40mg	60mg	80 mg	100mg	120mg
Dosing time	09:00	5mg	10mg	15mg	20mg	25mg	30mg
	13:00	5mg	10mg	15mg	20mg	25mg	30mg
	18:00	5mg	10mg	15mg	20mg	25mg	30mg
	22:00	5mg	10mg	15mg	20mg	25mg	30mg
DAY 6	Daily total	10mg	20 mg	40mg	60mg	80mg	100mg
Dosing time	09:00	5mg	5mg	10mg	15mg	20mg	25mg
	13:00		5mg	10mg	15mg	20mg	25mg
	18:00	-	5mg	10mg	15mg	20mg	25mg
	22:00	5mg	5mg	10mg	15mg	20mg	25mg
DAY 7	Daily total		10mg	20mg	40mg	60mg	80mg
Dosing time	09:00		5mg	5mg	10mg	15mg	20mg
	13:00	-	-	5mg	10mg	15mg	20mg
	18:00	-		5mg	10mg	15mg	20mg
	22:00		5mg	5mg	10mg	15mg	20mg
DAY 8	Daily total			10mg	20mg	40mg	50mg
Dosing time	09:00			5mg	5mg	10mg	15mg
	13:00		-		5mg	10mg	10mg
	18:00		-	-	5mg	10mg	10mg
	22:00			5mg	5mg	10mg	15mg
DAY 9	Daily total				10mg	20mg	30mg
Dosing time	09:00				5mg	5mg	10mg
	13:00					5mg	5mg
	18:00				-	5mg	5mg
	22:00				5mg	5mg	10mg
DAY 10	Daily total					10mg	10mg
Dosing time	09:00					5mg	5mg
	13:00					-	
	18:00					-	
	22:00					5mg	5mg

PRN dosing increments for oxazepam

- Individual doses of 5 to 10mg
- Daily maximum of 40-60mg

7.3 Monitoring

Starting the detoxification

- Patients should be breathalysed and the first dose of the benzodiazepine given if there are signs of withdrawals or serial readings show a falling alcohol concentration and there is no evidence of alcohol intoxication.
- A high breathalyser reading with no signs of intoxication may indicate a high level of tolerance. In this situation treatment will be necessary when there are signs of withdrawals. Failure to do so will result in withdrawals becoming severe quickly.
- Observations should be completed which includes:

Routine observations

- Pulse
- Blood pressure
- Respiratory rate
- Oxygen saturations
- Temperature
- Neurological observations on admission
- Physical observations will be carried out twice a day for the first three days then once a day during the detoxification

Following this, physical observations will be continued if there any concerns. These observations should be recorded on the Trust documentation and always calculated using the **early warning score**. **The Early Warning Score is** an escalation tool used to alert clinical staff to the need to contact a doctor, or emergency services, for patients who give cause for concern due to a sudden or deteriorating illness. Please refer to **Appendix 3** and Policy: Resuscitation Policy

Patients should be orientated and reassured that any distressing symptoms will eventually settle. An explanation of the symptoms and their relationship to alcohol withdrawals should be given.

Patients will be reviewed daily by nursing staff. During the first two days the patient will be reviewed by medical staff to ensure the detoxification regime is correct.

Staff to also to monitor for potential signs of Wernicke's (see below for signs and symptoms.

Assessment of Alcohol Scale

- The CIWA- Ar will be used to monitor withdrawal symptoms. See **Appendix 4**.
- The CIWA-Ar measures 10 items with a maximum score of 67. A CIWA-Ar score of, 10 indicates mild withdrawal, 10-20 moderate and 20+ severe.
- This will be completed twice a day during the first three days. If scores continues to be high (i.e. 15 and above) then the CIWA- Ar should be repeated until the score reduces (to below 10).
- If the CIWA-Ar remains high, please contact medical staff/ the prescriber for advice.
- A score above 15 indicates a risk of severe alcohol withdrawals. The regime should be reviewed using clinical judgement. Consider changing the medication as below.
- A one off extra dose of Chlordiazepoxide may be required (between 10mg to 20mg or is CIW-Ar is high then use of PRN indicated.
- The medication regime increased by 50% (for example 30mg instead of 20mg of Chlordiazepoxide) – with a maximum of 40mg in a single dose.
- The regime may need altering to slow down the rate of reduction (for example, repeat the previous day's regime).

7.4 Vitamin supplements

Alcohol dependence can lead to poor diet and impaired absorption resulting in vitamin deficiencies. Oral thiamine is poorly absorbed in alcohol dependent patients.

For the majority of patients identified as requiring an inpatient **detoxification** prophylactic treatment **with parental thiamine** (Pabrinex) is routinely recommended for those patients with a high risk of developing thiamine deficiency e.g. those with severe alcohol dependence, history of seizures/delirium tremens, diarrhoea, vomiting, physical illness, malnourished, poor diet and weight loss.

In the UK, Pabrinex is the only parenteral high-potency B-complex vitamin therapy available. Two ampoules contain thiamine hydrochloride 250mg in combination with ascorbic acid 500mg, nicotinamide 160mg, pyridoxine hydrochloride 50mg and riboflavin 4mg.

Administer one pair of Pabrinex ampoules (thiamine 250mg) once daily intra-muscularly for the first three days of the detoxification. Pabrinex is administered only by trained nursing staff.

Please refer to the Standard Operating Procedure for the Administration of the High dose intra-muscular vitamin supplement.

Oral vitamin prophylaxis

Oral vitamins are sufficient for patients with a lower risk of developing complications. This group include mild alcohol dependence (patients who could be detoxed at home for example), no weight loss, good diet. **Thiamine 100mg three times daily** is prescribed during the detoxification. Consider recommending to the General Practitioner (GP) continuation of thiamine 50mg long term if there is evidence of cognitive problems.

Treatment of Suspected or Diagnosed Wernicke's encephalopathy

Wernicke's encephalopathy is a medical emergency. If suspected an assessment of the client must be made immediately to consider transfer to a medical ward. As well as examining the client for Wernicke's an assessment should include possibilities of co morbid physical health problems e.g. infection, dehydration, head injury etc.

Risk of Anaphylaxis with Pabrinex

This should not preclude the use of parenteral thiamine in patients where this route of administration is required, particularly those at risk of Wernicke's where treatment with thiamine is essential.

Facilities for treating Treatment for anaphylaxis Is available in all inpatient areas including adrenaline, oxygen and resuscitation equipment.

The risk of anaphylaxis is very low and even less when given Intramuscular Injection (IM). The cases documented actually occurred for Parentrovite, which Pabrinex replaced. Four reports were documented for 1million pairs of ampoules used Intravenous (IV) and one report per 5 million pairs of ampoules when used IM

Alcohol related seizures

Most seizures are self-limiting. With careful assessment and monitoring withdrawal seizures can be avoided when detoxifications are planned adequately.

NICE guidance recommends IV lorazepam first line. Mental health wards cannot support the use of IV medicines. NICE guidance recommends the use of buccal midazolam or rectal diazepam in a community setting.

NICE guidance recommends treatment of prolonged seizures (seizures lasting more than 5 minutes).

During the seizure, monitor and maintain the airway as best possible. If the patient is in the convulsive phase of the seizure, and the airway is not compromised the seizure should be left to run its course. Monitor patient and maintain a safe environment at all times.

If the seizure lasts more than 5 minutes administer Buccal Midazolam 10mg (or 10mg Rectal Diazepam) as prescribed. Repeat after 10 minutes if the seizure continues

In the recovery phase of a seizure the patient may be placed in the recovery position where the patient's physical observations should be taken using the Airway, Breathing, Circulation, Disability, Exposure (ABCDE) approach.

If the patient does not recover as expected, or there are concerns with the physical observations call an ambulance via (9)999. If the patient recovers well and physical observations raise no concerns the patient should be discussed with medical staff as soon as possible.

8. TRAINING IMPLICATIONS

INPATIENT ALCOHOL DETOX					
Staff groups requiring training	**How often should this be undertaken**	**Length of training**	**Delivery method**	**Training delivered by whom**	**Where are the records of attendance held?**
ALL	On induction to unit	Varies	Face to Face	Supervisor	Electronic Staff Record System (ESR)

A variety of means such as;

Team brief	Weekly newsletter
Trust wide mail drop	Trust wide email
Team meetings	Special meetings
One to one meeting/supervision	Group supervision
Posters	Practice development days
CPD sessions	Local induction

The Training Needs Analysis (TNA) for this policy can be found in the Training Needs

Analysis document which is part of the Trust's Mandatory Risk Management Training

Policy located under policy section of the Trust website

All staff using this policy will receive training on induction to the unit by their supervisor and line manager. Training will involve the assessment and management of alcohol detoxifications as per this policy. Staff will receive on-going training and support through supervision, clinical meetings and when reviewing incidents.

Staff will also be made aware of the policy and its contents in the following ways:

- Dissemination of policy to all staff through service manager, line managers and supervisors
- Policy contents to be covered during local induction for new staff members
- Issuing of the policy to be an agenda item on staff meetings
- A copy of the policy will be available for staff to view on the Trust web site

9. MONITORING ARRANGEMENTS

Area for monitoring	How	Who by	Reported to	Frequency
Evidence of dissemination of policy	Minutes of clinical meetings	Service Managers	Care Group Director	Once
Implementation of policy by staff	Clinical audit	Business division using this policy	Clinical Effectiveness Committee	Yearly

10. EQUALITY IMPACT ASSESSMENT SCREENING

The completed Equality Impact Assessment for this Policy has been published on this Policy's webpage on the Trust website.

10.1 Privacy, Dignity and Respect

The NHS Constitution states that all patients should feel that their privacy and dignity are respected while they are in hospital. High Quality Care for All (2008), Lord Darzi's review of the NHS, identifies the need to organise care around the individual, 'not just clinically but in terms of dignity and respect'. As a consequence the Trust is required to articulate its intent to deliver care with privacy and dignity that treats all service users with respect. Therefore, all procedural documents will be considered, if relevant, to reflect the requirement to treat everyone with privacy, dignity and respect, (when appropriate this should also include how same sex accommodation is provided).	**Indicate how this will be met** *No issues have been identified in relation to this policy*

10.2 Mental Capacity Act

Central to any aspect of care delivered to adults and young people aged 16 years or over will be the consideration of the individuals capacity to participate in the decision making process. Consequently, no intervention should be carried out without either the individual's informed consent, or	**Indicate how this will be achieved** *All individuals involved in the*

the powers included in a legal framework, or by order of the Court. Therefore, the Trust is required to make sure that all staff working with individuals who use our service are familiar with the provisions within the Mental Capacity Act. For this reason all procedural documents will be considered, if relevant, to reflect the provisions of the Mental Capacity Act 2005 to ensure that the interests of an individual whose capacity is in question can continue to make as many decisions for themselves as possible.	*implementation of this policy should do so in accordance with the Guiding Principles of the Mental Capacity Act 2005 (section one)*

11. LINKS TO ANY ASSOCIATED DOCUMENTS

- Incident Management Policy
- Mandatory and Statutory Training Policy
- Medical Devices Management Policy
- Mental Capacity Act 2005 Policy
- Patient Falls Prevention and Management Policy
- Physical Assessment (Minimum Standards Mental Health and Learning Disability Services) Policy
- Physical Health Policy
- Resuscitation Policy
- Slips, Trips and Falls for Staff and Visitors, Prevention and management Policy

12. REFERENCES

- NICE, February 2010, Alcohol use disorders: sample chlordiazepoxide dosing regimens for use in managing alcohol withdrawal , https://www.nice.org.uk/guidance/cg115/resources/sample-chlordiazepoxide-dosing-regimens-for-use-in-managing-alcohol-withdrawal-pdf-4489950493
- NICE, January 2012, Epilepsies: diagnosis and management Clinical guideline [CG137], https://www.nice.org.uk/guidance/cg137, accessed January 2015
- NICE, June 2010, Alcohol-use disorders: diagnosis and management of physical complications Clinical guideline [CG100] https://www.nice.org.uk/guidance/cg100, accessed June 2010
- NICE, February 2011, Alcohol-use disorders: diagnosis, assessment and management of harmful drinking (high-risk drinking) and alcohol dependence Clinical guideline [CG115] https://www.nice.org.uk/guidance/cg115, accessed February 2011

13. APPENDICES

- **Appendix 1:** Severity of Alcohol Dependence Questionnaire
- **Appendix 2:** Physical Health Examination Template
- **Appendix 3:** Early Warning Score
- **Appendix 4:** Clinical Institute Withdrawal Assessment of Alcohol Scale, Revised (CIWA-Ar)

APPENDIX ONE

Rotherham Doncaster and South Humber NHS Foundation Trust

Severity of ALCOHOL Dependence Questionnaire (SADQ-C)

Name: _____ Age: _____

Date: _____

Please recall a typical period of heavy drinking in the last 6 months.

When was this? Month:_____ Year:_____

Please answer all the following questions about your drinking by ticking your most appropriate response.

During that period of heavy drinking	ALMOST NEVER	SOME TIMES	OFTEN	NEARLY ALWAYS
1. The day after drinking alcohol, I woke up feeling sweaty.				
2. The day after drinking alcohol, my hands shook first thing in the morning				
3. The day after drinking alcohol, my whole body shook violently first thing in the morning if I didn't have a drink				
4. The day after drinking alcohol, I woke up absolutely drenched in sweat.				
5. The day after drinking alcohol, I dread waking up in the morning.				
6. The day after drinking alcohol, I was frightened of meeting people first thing in the morning.				
7. The day after drinking alcohol, I felt at the edge of despair when I awoke.				
8. The day after drinking alcohol, I felt very frightened when I awoke.				
9. The day after drinking alcohol, I liked to have an alcoholic drink in the morning.				
10. The day after drinking alcohol, I always gulped my first few alcoholic drinks down as quickly as possible.				
11. The day after drinking alcohol, I drank alcohol to get rid of the shakes.				
12. The day after drinking alcohol, I had a very strong craving for a drink when I awoke.				
13. I drank more than a quarter of a bottle of spirits in a day (OR 1 bottle of wine OR 7 beers).				
14. I drank more than half a bottle of spirits per day (OR 2 bottles of wine OR 15 beers).				
15. I drank more than one bottle of spirits per day (OR 4 bottles of wine OR 30 beers).				
16. I drank more than two bottles of spirits per day (OR 8 bottles of wine OR 60 beers).				

Imagine the following situation:

1. You have been **completely off drink for a few weeks**
2. You then drink **very heavily** for **two days**
3. How would you feel the **morning after** those two days of drinking?

During that period of heavy drinking	**NOT AT ALL**	**SLIGHTLY**	**MODE-RATELY**	**QUITE A LOT**
17. I would start to sweat.				
18. My hands would shake.				
19. My body would shake.				
20. I would be craving for a drink.				

Score:_____

Checked by: _____

Alcohol Detox Prescribed: Yes ☐ No ☐

NOTES ON THE USE OF THE SADQ

The Severity of Alcohol Dependence Questionnaire was developed by the Addiction Research Unit at the Maudsley Hospital. It is a measure of the severity of dependence. The AUDIT questionnaire, by contrast, is used to assess whether or not there is a problem with dependence. The SADQ questions cover the following aspects of dependency syndrome :

- Physical withdrawal symptoms
- Affective withdrawal symptoms
- Relief drinking
- Frequency of alcohol consumption
- Speed of onset of withdrawal symptoms

Scoring Answers to each question are rated on a four-point scale:

Question 1-16	**Questions 17-20**	**Points**
ALMOST NEVER	NOT AT ALL	0
SOMETIMES	SLIGHTLY	1
OFTEN	MODERATELY	2
NEARLY ALWAYS	QUITE A LOT	3

Score	**Indication**
0-15	Mild physical dependency
16-30	Moderate dependence
31+	Severe alcohol dependence

- A chlordiazepoxide detoxification regime is usually indicated for someone who scores 16 or over
- It is essential to take account of the amount of alcohol that the patient reports drinking prior to admission as well as the result of the SADQ
- There is no correlation between the SADQ and such parameters as the MCV or GGT

APPENDIX TWO

Rotherham Doncaster and South Humber NHS Foundation Trust

Name: _____ **NHS Number:** _____

Name of admitting Doctor: _____ **Signature:** _____

Date: _____ **Time:** _____

(Please print)

Admission Medical Examination Form

M1:

Capacity and Consent Status

Does the patient have the capacity to consent to a physical examination? Yes ☐ No ☐

Is the patient able to give informed consent? Yes ☐ No ☐

If no, are they subject to detention Mental Health Act (please give details)

M2:

General Physical Condition

(Mark clearly any recent or old bruises, cuts, scars, injuries)

M3:

Circulatory System

Pulse:

Oedema:

BP:

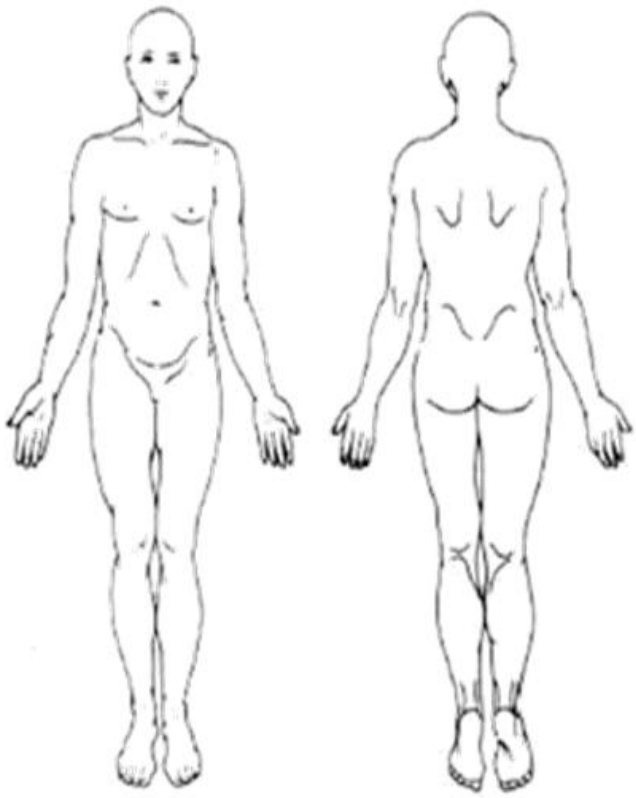
Apex Beat:

Peripheral Circulation:

JVP:

Heart Sounds: I……..II

ECG:



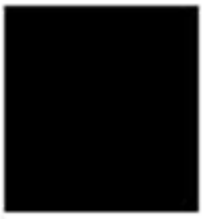
M4:

Respiratory System:

Clubbing:

Dyspnoea:

Trachea:



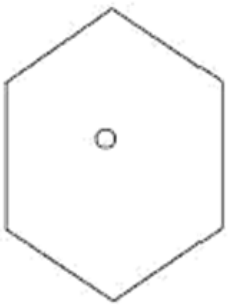
Oxygen Saturation Level:

M5:

Alimentary System:

Mucous Membranes?

Dentition?



M6:

Nervous System

M7:

Other Findings

Level of consciousness Cranial Nerves Pupils Fundi	
Limb Tone Gait Limb power Co-ordination Romberg Tremor Reflexes: Right: B T S K A PL Clonus Left: B T S K A PL Clonus Sensation	**M8:** Blood Tests Required? Yes ☐ No ☐ If yes, please state for which tests: ECG Required? Yes ☐ No ☐ Any other tests (please state):

Weight:	
Height:	
Date of Birth:	
BMI:	
Urine Testing:	
Smoking History	

Glasgow Coma Scale (only to be completed when there are concerns over patient's level of consciousness) 13 or more = Mild Brain Injury 9-12 = Moderate Injury 8 or less = Severe Injury	**Eye Response (4)**	**Verbal Response (5)**	**Motor Response (6)**
	1. No eye opening 2. Eye opening to pain 3. Eye opening to verbal command 4. Eyes open spontaneously	1. No verbal response 2. Incomprehensible sounds 3. Inappropriate words 4. Confused 5. Orientated	1. No motor response 2. Extension to pain 3. Flexion to pain 4. Withdrawal from pain 5. Localising pain 6. Obeys commands
	Best eye response: _____	Best verbal response: _____	Best motor response: _____
Total GCS score:	_____		

NEWS 2

KNOWN ALLERGIES

APPENDIX THREE

Rotherham Doncaster and South Humber NHS Foundation Trust

Name:

NHS no: DOB: Ward:

NEWS Key				Date																Date
0	1	2	3	Time																Time
					Baseline															
A +B **Respirations** Breaths/min				>25							3									>25
				21-24							2									21-24
				18-20																18-20
				15-17																15-17
				12-14																12-14
				9-11							1									9-11
				<8							3									<8
A +B **SpO_2Scale 1** Breaths/min				>96																>96
				94-95							1									94-95
				92-93							2									92-93
				<91							3									<91
SpO_2Scale 2* Oxygen saturation (%) Use Scale 2 if target range is 88-92% e.g. in hypercapnic respiratory failure *ONLY use scale 2 under the direction of a qualified				>97 on O2							3									>97 on O2
				95-96 on O2							2									95-96 on O2
				93-94 on O2							1									93-94 on O2
				>93 on air																>93 on air
				88-92																88-92
				86-87							1									86-87
				84-85							2									84-85
				<83%							3									<83%
Air or oxygen				A=Air																A=Air
				O2L/min							2									O2L/min
				Device																Device
C **Blood pressure** Score uses systolic BP only				>220							3									>220
				201-219																201-219
				181-200																181-200
				161-140																161-140
				141-160																141-160
				121-140																121-140
				111-120																111-120
				101-110							1									101-110
				91-100							2									91-100
				81-90							3									81-90
				71-80							3									71-80
				61-70							3									61-70
				51-60							3									51-60
				<50							3									<50
C **Pulse** Beats/min				>131							3									>131
				121-130							2									121-130
				111-120							2									111-120
				101-110							1									101-110
				91-100							1									91-100
				81-90																81-90
				71-80																71-80
				61-70																61-70
				51-60																51-60
				41-50							1									41-50
				31-40							3									31-40
				>30							3									>30
D **Consciousness** Score for NEW onset of confusion (no score if chronic)				Alert																Alert
				Confusion							3									Confusion
				V							3									V
				P							3									P
				U							3									U
E **Temperature** °C				>39.1°							2									>39.1°
				38.1-39.0°							1									38.1-39.0°
				37.1-38.0°																37.1-38.0°
				36.1-37.0°																36.1-37.0°
				35.1-36.0°							1									35.1-36.0°
				<35.0°							3									<35.0°
NEWS TOTAL																				**Total**
				Initials																

Always take into account the patient's baseline parameters. An EWS should not replace sound clinical judgement.

A sick patient may not trigger the EWS, likewise a patient who triggers the EWS may not be acutely unwell, hence the importance of a baseline observations and a **normal parameter exception care plan.**

Modifications For Abnormal Physiology (see care plan)

To be completed by clinicians who medically assess and instruct medical treatment e.g. Medics, CCP's and Nurse Consultants.

.....

.....

News	Observations	Clinical Response
1-4	1-4 hourly (dependant on score)	Refer to registered nurse using SBAR **RN** – face to face assessment of the patient, NEWS of 1 – 2, increase observations to a minimum of 4 hourly and consider review by Medic if concerned. NEWS 2 of 3 – 4, increase observations to minimum of hourly and contact Medic for advice. **Any acute rise or clinical concern such as sepsis should be reviewed by medic.** **If in doubt escalate to acute hospital.** **Medic** – ABCDE assessment and formulate a management plan. Consider escalation to acute hospital.
5-6	Minimum hourly	Refer to registered nurse using SBAR **RN** – urgent face to face assessment of the patient. **Any acute rise or clinical concern such as sepsis should be reviewed by medic.** **Urgent review by Medic within 30 minutes.** **If no assessment by Medic within 30 minutes escalate to acute hospital via ambulance.** **Medic** – ABCDE assessment and formulate a management plan. Consider urgent escalation to acute hospital via ambulance.
7 or more		Urgently refer to registered nurse using SBAR **RN** – immediate face to face assessment of the patient. Immediate face to face assessment by Medic if available or ambulance. Immediate escalation to acute hospital via ambulance.

RAPID TRANQ

Any medication given at the point of violence or aggression

EWS must be taken – minimum of CNS rating + Resps

EVERY 15 mins for 1st hour

EVERY 30 mins for next 3 hours.

ALWAYS CALCULATE EWS

Each observation has its own score.

If you are unable to take a certain observation for whatever reason, always calculate the score of those observations available.

RESTRAINT

EWS must be taken

During restraint

EVERY 5 mins

After release

EVERY 15 mins for 1st hour

EVERY 30 mins for next 3 hours

IF NO OTHER OBSERVATIONS CAN BE TAKEN ALWAYS RECORD CNS (ACVPU) AND RESP RATE AND CALCULATE EWS

A – Airway Can the patient talk?

Are there any unusual sounds? Signs of airway obstruction

B – Breathing Is the patient breathing?

Take respiratory rate; look at pattern and depth of respirations. Take O2 saturations, are they on oxygen, are they sitting upright, can you hear unusual sounds, can they finish a sentence?

C – Circulation Does the patient have a pulse?

What is the heart rate? Is it regular? What colour are the patient's hands/digits, how does the skin feel, what is the capillary refill time? Take blood pressure, what is the urine output? Is there any bleeding?

D – Disability Is the patient alert and oriented?

Assess AVPU. Are the pupils equal and reacting? What is the BM? Are they in plain?

E – Exposure Have you missed anything, look top to toe

Take temperature. Do they have a rash, cool peripheries, swollen legs etc?

S – Situation – what is happening now?

B – Background – what has happened before (relevant)?

A – Assessment – what have you done?

R – Response – what do you need now?

EARLY WARNING SCORE

The New Early Warning Score (NEWS 2) is an escalation tool used to alert clinical staff to the need to contact a doctor or emergency services for patients who give cause for concern because of sudden or deteriorating illness. Within Mental Health and Learning Disabilities in-patient areas, it is also to be used for patients being observed during or after a period of restraint or rapid tranquillisation.

HOW TO USE THE CHART

Record your observation on the Observation (TPR) chart as normal. Now look up your findings scoring grid and take the score for that column from the top of the column. For example: Your patient is alert, flushed and slightly distressed, has a respiratory rate of **22 breaths per minute**, a pulse rate of **108 beats per minute**, systolic blood pressure is **90 mmHg** and his temperature is **38.2 deg C.**

- Alert scores 0
- Respiratory rate scores 1
- Pulse scores 1
- Blood Pressure scores 1
- Temperature scores 1
- **Total score is 4**

Looking at the second part of the chart a score of 4 is greater than 3 but less than 6, so the Nurse should call the doctor immediately and increase the frequency of observations to every 30 minutes.

Refusal: a patient has the right to refuse physical contact with staff; this may be due to agitation, Confusion, fear or lack of understanding. However, physical observations can always be carried Out without contact and the minimum of this is central nervous system (CNS – AVPU) and Respiratory rate. These physical observations should be recorded on the physical observation chart.

Refusal of any other physical observation for example blood pressure should be recorded in the Nursing notes with an explanation as to why the patient has refused and a plan for repeating required Observations and how this may be undertaken should also be documented. The word refused

MUST NOT be recorded on the physical observation chart, as the rational for refusal cannot be documented fully in the small space available.

Baseline: on admission the patient's physical observations must be taken, these will become the Patient's initial baseline. If the patient's physical presentation changes at any time during their stay Their baseline observation should be reviewed and if needed a new baseline should be recorded.

If this becomes necessary a new sheet should be started and the word NEW should be recorded Underneath BASELINE. This will communicate changes to the baseline to all staff. If a patient Is admitted with a known physical health condition and therefore the baseline scores and triggers on The NEWS 2 a normal parameter exception care plan should be devised with the admitting doctor. This should state the exceptions for this particular patient and give instructions as to when the Patient should be escalated.

The NEWS 2 only uses the Systolic blood pressure measurement within its escalation calculations (both the systolic and diastolic measurement should always be recorded on the physical observation Chart) as the score is used to note early deterioration in patients to

enable a response before a Critical illness where ever possible. In these situations the systolic measurement is the Measurement that tells us the most about the patient, and the one that will change early enough for a response to be effective. The diastolic measurement is important for day to day health, and should still be noted and acted upon when a patient is unwell; however tends to be slower to change in critical illness and therefore no use from an EARLY warning point of view.

Clinical Judgement

The NEWS 2 score and track and trigger flow is only a guide, if the Registered Nurse becomes concerned

With other aspects of the patient's condition then further action may well be necessary.

Example One:

If the patient's baseline scores a 3, we take their physical observations and their NEWS 2 is now a 4, we need to take into account the reasons behind the initial 3 on admission and any normal parameter.

Exceptions and care plans.

A NEWS 2 of 3 in any one category needs attention in its own right.

Patient complains of feeling unwell, we take his physical observations.

CNS=A	-NEWS 2 0	-BASELINE = 0
Resps = 22	-NEWS 2 1	-BASELINE = 1
Blood pressure = 98/60	-NEWS 2 1	-BASELINE = 1
Pulse = 112	-NEWS 2 2	-BASELINE = 1 (baseline pulse=109)
Sats = 100%	-NEWS 2 0	-BASELINE = 0
Temp = 37%	-NEWS 2 0	-BASELINE = 0
Overall EWS	**4**	**3**

Example Two:

A patient presents as flushed, sweaty skin and in obvious discomfort. He does not allow any physical contact; therefore we can only gain a CNS and respiratory rate reading;

CNS=A	-NEWS 2 = 0	-BASELINE = 0
Resps = 29	-NEWS 2 = 1	-BASELINE = 0
Overall EWS	**1**	**0**

Just looking at the flow chart and EWS of 1 would state to increase the observations and consider speaking to a doctor. However, for this patient the increased respiratory rate added to Flushing, sweating and pain should lead to a nurse making the decision to speak to a doctor.

Example three:

Patient complains of being unwell. We take her physical observations.

CNS=A	-NEWS 20	-BASELINE = 0
Resps = 16	-NEWS 20	-BASELINE = 0
Blood Pressure = 180/96	-NEWS 20	-BASELINE = 2(baseline 222/110)
Pulse = 90	-NEWS 20	-BASELINE = 2(baseline 115)
Sats = 100%	-NEWS 20	-BASELINE = 0
Temp = 37%	-NEWS 20	-BASELINE = 0
Overall EWS	**0**	**4**

In this scenario, although the NEWS 2 is a 0 this is a considerable change from the patient's

Baseline. A negative change in baseline, although the flow chart would not show concern is

Equally concerning as a positive change in baseline. Therefore this patient needs to be seen

By a doctor.

Decisions are made after physical observations are taken and EWS calculated. Each physical Observation has its own EWS, and if staff are unable to take a full set of physical observations (for any reason – see above) an EWS score must still be calculated no matter how many physical

Observations have been taken i.e. at the bare minimum we would expect to see CNS and respiratory Rate recorded. We should still see an EWS calculated score, or lying and standing BP. We should still see the EWS calculated for each recording, this can act as a prompt for action to be taken, particularly if the staff are not prompted by the readings alone (a safety net).

KEY – a key has been introduced to the chart, this will help staff to see the "bigger picture". You will be able to look back at the last like for like incident and compare, which in turn will aid any decisions that need to be made.

- R = restraint
- T = rapid tranquilisation
- U = unwell
- M = monitoring
- B = baseline

How to calculate an New Early Warning Score (NEWS 2) and what action is to be taken

SCORE	**0**	**1**	**2**	**3**
Pulse	51 – 100	41 – 50 or 101 - 110	111 - 129	< 40 or > 130
Systolic BP	101 – 200	81 - 100	71 – 80 or 201 - 220	< 70 or > 221
Resp rate	9–20	21-30	31-34	< 8 or > 35
Temp	36.1 – 37.9	35.1 – 36 or 38 – 38.5	34 – 35 or 38.6 – 39.9	< 33.9 or > 40
CNS AVPU	ALERT	VOICE	PAIN	UNCONSCIOUS
O2 Saturation	100% - 95%	94% - 90%	89% - 86%	< 85%
SCORE	**0**		**2**	**3**

ESCALATION PROCEDURE

NEWS 2 greater than 0	Inform registered nurse, suggest repeat observations and note in file. Use clinical judgement to decide if further action is required.
NEWS 2 1-2	Increase frequency of observations to at least 4 hourly, consider informing Doctor if concerned.
NEWS 2 3 in any one category	Contact doctor for advice, increase frequency of observations to at least hourly. Use clinical judgment as patient may be very poorly.
NEWS 2 3-5	Contact doctor and request urgent visit, or if a possible delay of more than 1 hour call an ambulance (or emergency team) unless other advice.
NEWS 2 5 or over	Call doctor for immediate visit, or if a possible delay of more than 30 minutes call an ambulance (or emergency team), unless other advice given by the doctor. Increase observations to at least every 15 minutes.

APPENDIX FOUR

Rotherham Doncaster and South Humber NHS Foundation Trust

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

Patient:_____ **Date:** _____

Time: _____ (24 hour clock, midnight = 00:00)

Pulse or heart rate, taken for one minute:_____

TACTILE DISTURBANCES -- Ask "Have you any itching, pins and needles sensations, any burning, any numbness, or do you feel bugs crawling on or under your skin?"

Scale	Descriptor
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.

Scale	Descriptor
0	no tremor
1	
2	not visible, but can be felt fingertip to fingertip
3	
4	moderate, with patient's arms extended
5	
6	
7	severe, even with arms not extended

AUDITORY DISTURBANCES -- Ask "Are you more aware of sounds around you? Are they harsh? Do they frighten you? Are you hearing anything that is disturbing to you? Are you hearing things you know are not there?"

Scale	Descriptor
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.	
Scale	**Descriptor**
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 anything that is disturbing to you? Are you seeing things you know are not there?"
Descriptor
not present
very mild sensitivity
mild sensitivity
moderate sensitivity
moderately severe hallucinations
severe hallucinations
extremely severe hallucinations
continuous hallucinations

ANXIETY -- Ask "Do you feel nervous?"	
Scale	**Descriptor**
0	no anxiety, at ease
1	mild 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

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.
Descriptor
not present
very mild
mild
moderate
moderately severe
severe
very severe
extremely severe

AGITATION -- Observation	
Scale	**Descriptor**
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

ORIENTATION AND CLOUDING OF SENSORIUM – Ask "What day is this? Where are you? Who am I?"	
Scale	**Descriptor**
0	oriented and 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

Total **CIWA-Ar** Score _____

Rater's Initials _____

Maximum Possible Score 67

Patients scoring less than 10 do not usually need additional medication for withdrawal.

*The **CIWA-Ar** is not* copyrighted and may be reproduced freely. This assessment for monitoring withdrawal symptoms requires approximately 5 minutes to administer