Kent and Medway
NHS and Social Care Partnership Trust

ALCOHOL DETOXIFICATION POLICY

INPATIENT WARDS ONLY

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Replacing document	KMPT.CliG.187.03
Target audience	All clinical staff with direct patient contact and all managers with responsibilities derived from the policy
Author	Chief Pharmacist, Deputy Chief Pharmacist, Lola Ogungbangbe, Dr Annie McCloud and Vilma Gillis, An acknowledgement of the contributions of Dr. Ken Checinski, Consultant Psychiatrist in Addictive Behaviour (CGL)
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DOCUMENT TRACKING SHEET

ALCOHOL DETOXIFICATION POLICY FOR INPATIENTS

Version	Status	Date	Issued to/approved by	Comments
0.1		14.05.20	D & T committee	Trust's Alcohol Detox policy sent out to D & T members for virtual ratification on 17.04.20. Changes made to policy after comments.
1.0	Final	24.06.20	Trust Wide Patient Safety and Mortality Review Group	Ratified
2.0	Final	11.01.22	Trust Wide Patient Safety and Mortality Review Group	Ratified
2.1	Draft	06.12.22	D & T committee	Approved
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3.1	Draft	04.06.24	D & T committee	Approved
4.0	Final	15.07.24	Trust Wide Patient Safety and Mortality Review Group	Approved

REFERENCES

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

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

Alcohol-use disorders: Diagnosis and management (August 2011) NICE Quality Standard (QS11)

Alcohol withdrawal including the Symptom triggered CIWA score management. Salford Royal NHS Foundation Trust.

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

Manyo-Smith MF et al (2004) Management of Alcohol Withdrawal Delirium Arch. Int Med. 164:1405-1412

The Maudsley Prescribing Guidelines in Psychiatry (13th Edition, 2018)

Regional Medicines Optimisation Committee. Position statement: Oral Vitamin B supplementation in alcoholism, November 2019.

Alcohol units- https://www.nhs.uk/live-well/alcohol-support/calculating-alcohol-units/
Accessed 4/1/2020

RELATED POLICIES/PROCEDURES/protocols/forms/leaflets

Medical Emergencies Management Policy	
Rapid Tranquilisation Policy	
Pabrinex Guidelines	
Bridge House Guideline	
Medicines Management Policy	

SUMMARY OF CHANGES

Date	Author	Changes (brief summary)
11/05/2020	Lola Ogungbangbe	Included information on EPMA (now eMeds).
11/09/2020	Lola Ogungbangbe	Recommendation on oral Vitamin B supplementation updated to reflect RMOC guidance.
31/10/2022	Lola Ogungbangbe	Added information regarding a possible genotoxicity risk following changes to the SPC.
08/03/2024	Chief Pharmacist/Deputy Chief Pharmacist	Diazepam changed to benzodiazepine of choice for management of alcohol detoxification.
08/03/2024	Chief Pharmacist/Deputy Chief Pharmacist	Appendix F – flow chart amended highlighting recommended doses for diazepam administration (including max. doses).
08/03/2024	Chief Pharmacist/Deputy Chief Pharmacist	Appendix H – fixed dose regimen changed to diazepam from chlordiazepoxide with appropriate doses.
08/03/2024	Chief Pharmacist/Deputy Chief Pharmacist	7.1.5. EPMA changed to eMeds
23/05/2024	Chief Pharmacist/Deputy Chief Pharmacist/Dr. Ken Checinski (CGL)	7.1.8. Recommendation to start z-drug for insomnia after diazepam treatment

CONTENTS

1 INTRODUCTION

1.1 Alcohol dependence affects 4% of people aged between 16 and 65 in England (6% of men and 2% of women), and over 24% of the English population (33% of men and 16% of women) consume alcohol in a way that is potentially or actually harmful to their health or well-being (NICE 115).

1.2 Acute withdrawal from alcohol in the absence of medical management can be hazardous in people with severe alcohol dependence, as it may lead to seizures, delirium tremens and, in some instances, death. NICE clinical guidelines 100 and 115 recommend pharmacotherapy to treat the symptoms of acute alcohol withdrawal.

2 WHO DOES THIS POLICY APPLY TO?

2.1 All Clinical staff on acute inpatient units.

3 PURPOSE

3.1 This policy has been developed to help promote high quality, safe and cost effective management of alcohol withdrawal syndrome and to help ensure equivalence of treatment across the trust.

3.2 The purpose of this document is to provide a resource for clinical staff to manage alcohol detoxification of patients who are admitted to the Trust inpatient units with alcohol intoxication as a co-morbid condition.

4 DUTIES

4.1 The trust board is accountable for:

4.1.1 Delegating responsibility to the trust wide Clinical Governance group to ensure that the alcohol detoxification policy is in force, current and reviewed regularly.

4.2 The Drugs and Therapeutics group is responsible for:

4.2.1 Developing and updating the alcohol detoxification policy to reflect current practice within the Trust.

4.3 Chief Executive:

4.3.1 Is ultimately responsible for ensuring the Trust complies with legal requirements and national recommendations.

4.4 Medical Director:

4.4.1 Is executive lead for medicines management and responsible for implementation of the policy.

4.4.2 Is responsible for reporting to the Trust Board on performance in relation to the policy

4.5 Chief Pharmacist:

4.5.1 Is accountable for establishing and maintaining a safe and secure system for medicines management throughout the Trust.

4.5.2 Is responsible for reporting to Trust wide Clinical Governance Group in relation to medicines management.

4.6 Clinical Directors/Leads and Service Directors/Leads

4.6.1 Are responsible for ensuring that their staff are aware of this policy.

4.7 Service Managers

4.7.1 Disseminate, implement and monitor implementation of the policy within areas of responsibility.

4.7.2 Report any issues, which may affect implementation of the policy, to the nursing director.

4.8 Ward managers/team leaders

4.8.1 Facilitate effective training of all new starters on the policy.

4.8.2 Ensure all staff are aware of the policy and implement the policy.

4.8.3 Maintain a record of training completed by staff.

4.8.4 Report any issues which may affect the effective implementation of this policy to the service manager.

4.9 Clinical Staff

4.9.1 Implement the policy.

4.9.2 Report any issues which may affect the effective implementation of this policy to their line manager.

4.10 Medical Team

4.10.1 Assess for alcohol withdrawal, initiate treatment plan in accordance to policy and monitor ongoing response to treatment.

4.11 Nursing staff

4.11.1 Carry out physical observations, monitor response to treatment and feedback to medical team.

4.12 Pharmacists

4.12.1 Clinical validation of prescriptions, counsel patients on treatment.

5 ALCOHOL WITHDRAWAL SYNDROME

5.1 Alcohol withdrawal syndrome is a range of symptoms that occur when someone who is alcohol dependent abruptly stops drinking or considerably reduce their alcohol intake. These include simple symptoms like tremors through to life threatening conditions such as delirium tremens and Wernicke's encephalopathy.

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

- mood disturbance
- panic

- tremor
- nausea
- sleep disturbance
- sweating
- anxiety
- pain

5.3 Withdrawal Seizures

5.3.1 Between 10 and 60 hours post alcohol abstinence, alcohol withdrawal seizures can occur. These are usually generalised and may precede or accompany delirium tremens.

5.3.2 The risk of seizures appears greater in the following groups of patients:

- history or family history of seizure disorder.
- history of head injury or intracranial pathology.
- history of previous withdrawal seizures
- history of previous metabolic disturbance (including hypoglycaemia, hypocalcaemia, hypomagnesaemia and epilepsy).

5.4 Delirium tremens

5.4.1 Symptoms of delirium tremens occur in about 5% of patients but is associated with a risk of mortality up to 15-20%. This can be reduced to 0-1% with appropriate treatment. Onset is usually between 48-72 hours, but can occur any time between 1-5 days.

5.4.2 The development of delirium tremens is a potentially serious development with a significant mortality if untreated, urgent medical advice should be sought and consideration should be given to transfer to a general hospital if symptoms are other than mild or controllable with good general care and tranquillisation.

5.4.3 Diagnostic symptoms include:

- Fear
- Visual hallucinations
- Agitation
- Restlessness
- Delirium
- Delusions
- Increased startle reaction
- Sweating
- Dehydration
- Fever
- Increased blood pressure

5.5 Wernicke 's encephalopathy

5.5.1 Wernicke's encephalopathy (WE) 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
- Drowsiness
- Coma/unconsciousness
- Hypothermia and hypotension
- Abnormal eye movements that may seem like a squint
- Double vision
- Poor balance
- Memory disturbance

5.5.2 If a patient presents with neuropsychiatric signs suggestive of Wernicke's encephalopathy an urgent referral to Accident and Emergency for assessment should be done and treatment with parenteral (intravenous) high potency B vitamins should be given.

5.6 Risk factors for severe withdrawal symptoms include:

- High alcohol intake (>15 units per day)
- Previous history of severe withdrawal, seizures or delirium tremens
- Concomitant use of other psychotropic drugs
- Poor physical health
- Poor nutrition
- High levels of anxiety or other psychiatric disorders
- Electrolyte disturbance
- Fever or sweating
- Insomnia
- Tachycardia

6 PATIENT ASSESSMENT

6.1 All admitted patients should be routinely asked about their alcohol intake. The Alcohol Use Disorders Identification Test (AUDIT- Appendix C) is a quick tool that may be used for identifying patients with alcohol dependence. .Where a high level of alcohol consumption is identified (e.g. AUDIT score >15), a more detailed assessment should be carried out. This should include the following:

6.1.1 History of alcohol use e.g. daily consumption, recent drinking patterns

6.1.2 History of previous episodes of alcohol withdrawal e.g. delirium tremens, seizures, WE

6.1.3 Time of most recent drink

6.1.4 Collateral history

6.1.5 Other drug use

6.1.6 Coexisting medical and psychiatric problems

6.1.7 Physical examination including cognitive function

6.1.8 ECG

6.1.9 Breath Alcohol Content (BAC)

6.1.10 Laboratory investigations including:

- Full blood count
- Liver function tests including AST
- Urea and Electrolytes including magnesium
- International normalised ratio (INR)
- Prothrombin Time
- Urinary drug screen

6.1.11 Severity of dependence and of withdrawal symptoms

6.2 The severity of dependence should be assessed using "The Severity of Alcohol Dependence Questionnaire" (SADQ-appendix D) assessment scale. The Clinical Institute Withdrawal Assessment for Alcohol – Revised (CIWA-AR See appendix E) should be used for assessing severity of withdrawal symptoms.

6.3 These assessment scales are also available on RiO (electronic patient record) in the "Specialist Assessments" folder.

6.4 Assess patient for any associated complications or risk of developing Wernicke's encephalopathy, delirium tremens and Korsakoff's Syndrome

6.5 Referral to the acute hospital should be made if a patient is exhibiting symptoms of Wernicke's encephalopathy, delirium tremens or has had a seizure.

7 MANAGEMENT OF ALCOHOL WITHDRAWAL

7.1 Detoxification

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

7.1.2 In Kent and Medway NHS and Social Care Partnership Trust (KMPT), diazepam has now replaced chlordiazepoxide as the drug of choice for alcohol detoxification, as in May 2022, changes were made to the Summary of Product Characteristics (SPC) of Librium® (chlordiazepoxide) regarding a possible genotoxicity risk. The updated SPC states "Due to the genotoxic potential of chlordiazepoxide, women of childbearing potential should use effective contraceptive measures while being treated with Librium and for 7 months following completion of treatment. If the patient suspects to be pregnant or intends to become pregnant, she should be warned to contact her physician to discuss discontinuation of Librium. Men are recommended to use effective contraceptive measures and to not father a child while receiving Librium and for 4 months following completion of treatment." More information can be found on the UKTIS website:

7.1.3 There are two main approaches to detoxification: symptom-triggered approach and fixed dose approach.

7.1.4 A fixed dose diazepam reducing regimen is the preferred method of alcohol detoxification in KMPT, treatment is usually over a period of 5-10 days. Chlordiazepoxide regimen is reserved for high-risk patients at Bridge House (Trust alcohol detox unit), as outlined in section 7.1.9, and must be prescribed by a consultant addictions psychiatrist. Oxazepam may have to be considered as detailed in 7.1.7

7.1.5 The regimens should be prescribed on eMeds which has the predefined reducing doses already set up, in line with the KMPT detoxification charts detailed in appendix H and I. In circumstances where eMeds is not available, this should be used to initiate a patient on the diazepam reducing regimen and attached to a corresponding physical drug chart whilst in use and uploaded onto RiO on completion of treatment.

7.1.6 Additional diazepam may be prescribed when required, to help with the management of breakthrough withdrawal symptoms, up to 30mg/24hrs in addition to the regular dose.

7.1.7 Oxazepam should be considered as an alternative to diazepam in the elderly or where there is significant hepatic dysfunction (appendix I).

a) It is less prone to accumulation and toxicity, however, due to its short half-life close observation is required to identify breakthrough withdrawal symptoms.

b) It can be substituted for diazepam at the same dose e.g. 5mg diazepam = 10mg oxazepam.

7.1.8 A Z-drug (e.g. zopiclone) may be offered for insomnia for 5 to 7 days after treatment has ceased.

7.1.9 Both reducing regimen charts 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 delirium tremens or have a previous history of it.

7.1.10 For patients that are not suitable for a fixed dose diazepam or oxazepam reducing regimen, specialist advice should be sought from Bridge House, KMPT's Detoxification Treatment Centre (appendix J). These include patients with the following:

- Cognitive Impairment
- Severe Liver Disease
- Other drugs dependency e.g. opioids
- SADQ score above 40
- Daily alcohol consumption above 40units.

7.1.11 For the above patients, a symptom triggered approach maybe more appropriate. Seek further guidance from Bridge House in managing these patients.

7.1.12 Psychological phenomena such as cravings do not respond to benzodiazepines and may persist much longer despite the completion of adequate detoxification regimes. All patients receiving alcohol detoxification treatment should be offered anti-craving medication and advice should be sought from Bridge House (appendix J) for appropriate treatment plans if they agree to this.

7.2 Vitamin Supplementation

7.2.1 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.

7.2.2 Prophylactic Vitamin B supplementation is recommended for all patients undergoing alcohol detoxification presenting with any evidence of chronic alcohol misuse or dependence, and one or more risk factor for Wernicke's encephalopathy, as detailed in Pabrinex guidelines (Appendix G).

7.2.3 For those considered at risk one pair of Pabrinex should be given Intramuscularly for 5 days, followed by oral thiamine. For further information see KMPT guidelines for the use of Pabrinex (Appendix G).

7.2.4 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.

7.2.5 Facilities for treating anaphylactic reactions should be available whenever Pabrinex is administered as there is a small risk of a severe (anaphylactic) reaction. Every ward in KMPT should have an emergency box containing Adrenaline injection.

7.2.6 For patients with signs of deficiency symptoms, i.e:

a) Wernicke-encephalopathy: confusion+/-nystagmus, ophthalmoplegia, ataxia, memory disturbance, hypothermia or hypotension. Note that only 10% show the classical triad of the first three symptoms).

b) Delirium tremens

these patients will require urgent intravenous administration of Pabrinex to avoid the risk of enduring cerebral damage. Transfer to a general hospital for these patients should be arranged.

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

7.2.8 The recommended oral supplementation is Thiamine 100 mg TDS. Continue whilst taking diazepam or until a normal diet is established. Thiamine 100mg TDS should also be continued if there is evidence of cognitive impairment after detoxification.

7.3 Seizure management

7.3.1 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 and medical advice should be sought if in doubt.

7.3.2 Diazepam rectal or buccal midazolam should be routinely prescribed when required on admission, for use in the event of prolonged seizures.

8 DRUGS FOR ALCOHOL ABSTINENCE

8.1 Treatment should only be commenced after discussion with a GP or the local drug and alcohol agency.

9 IMPLEMENTATION INCLUDING TRAINING AND AWARENESS

9.1 Training needs analysis

	Staff Group	Initial Training	Refresher Training
Staff with a clinical practice professional registration e.g. RMN, RGN, RMNH, Staff Nurse	Inpatient Adult	✓	
	Inpatient Older Adult	✓	
	Community Older		
	Rehabilitation Services	✓	
	Learning Disabilities - Inpatient	✓	
	Learning Disabilities - Community		
	Specialist Inpatient	✓	
	Specialist Community		
	Forensic Inpatient	✓	
	Pharmacy team	✓	
Staff without a Clinical Practice Professional Registration Healthcare Assistants, Support Workers, STR Workers Technical Instructors	Inpatient Adult		
	Inpatient Older Adult		
	Community Adult		
	Community Older		
	Rehabilitation Services		
	Learning Disabilities Inpatient		
	Specialist Inpatient		
	Specialist Community		
	Forensic Inpatient		
Allied Health Professionals	Psychologists		
	Occupational Therapists		
	Physiotherapists		
	Drama Therapist		
	Art Therapist		
	Psychotherapist		
	Social Worker		
	Speech and Language Therapists		
Admin. Clerical and Strategic Trust Staff, IT, Finance Staff, Portering Staff, Domestics, Canteen Staff	Direct Client Contact		
	Non-Client Contact		
	Senior Manager Client Contact		
	Senior Managers Non-Client Contact		
	Director		
Medical Staff	Inpatient Adult/Community	✓	
	Junior Doctors	✓	
	Locums	✓	
Agency Staff	Inpatient Community	✓	
	Admin. & Clerical Client contact		
	Admin. & Clerical Non-Client contact		
Board	Non-Executive Directors		
Board	Board Members		
Volunteers	Volunteers		

10 STAKEHOLDER, CARER AND USER INVOLVEMENT

10.1 Members of Drugs and Therapeutics Group – development, consultation and approval.

10.2 Members of Trust wide Clinical Governance Group – consultation and ratification.

10.3 Implementation by global email, team brief, medicines management newsletter.

10.4 Changes to be notified by policy manager via team brief, intranet, medicines management newsletter.

11 RECORD KEEPING

11.1 A patient's record is a basic clinical tool used to give a clear and accurate picture of their care and treatment, and competent use is essential in ensuring that an individual's assessed needs are met comprehensively and in good time (General Medical Council 2006, the Royal College of Psychiatrists 2009 and Nursing and Midwifery Council 2009 Standards and NHS Record Keeping - NHS Code of Practice for Record Keeping 2006)

11.2 All NHS Trusts are required to keep full, accurate and secure records (Data Protection Act 1998) demonstrate public value for money (Auditors Local Evaluation) and manage risks (NHS Litigation Authority, Information Governance Toolkit, Essential Standards). Compliance with this Policy and these legal and best practice requirements will be evidenced through information input onto the electronic patient record-Rio

11.3 For full details of the specific information needed to ensure compliance with this policy see the RiO training guides and the Service Line Standard Operating Procedures

12 EQUALITY IMPACT ASSESSMENT SUMMARY

12.1 The Equality Act 2010 places a statutory duty on public bodies to have due regard in the exercise of their functions. The duty also requires public bodies to consider how the decisions they make, and the services they deliver, affect people who share equality protected characteristics and those who do not. In KMPT the culture of Equality Impact Assessment will be pursued in order to provide assurance that the Trust has carefully considered any potential negative outcomes that can occur before implementation. The Trust will monitor the implementation of the various functions/policies and refresh them in a timely manner in order to incorporate any positive changes.

13 HUMAN RIGHTS

13.1 The Human Rights Act 1998 sets out fundamental provisions with respect to the protection of individual human rights. These include maintaining dignity, ensuring confidentiality and protecting individuals from abuse of various kinds. Employees and volunteers of the Trust must ensure that the trust does not breach the human rights of any individual the trust comes into contact with. If you think your policy/strategy could potentially breach the right of an individual contact the legal team.

14 EXCEPTIONS

14.1 There are no exceptions to this policy

APPENDIX A: EXPLANATION OF TERMS USED

Alcohol Use Disorders Identification Test (AUDIT)- consists of ten alcohol identification questions, is the gold standard of identification tests and was developed by the World Health Organisation.

Diazepam – a benzodiazepine and the mainstay of treatment for assisted alcohol withdrawal.

Clinical Institute of Withdrawal Assessment-Revised (CIWA-Ar)– an objective rating scale for severity of alcohol withdrawal.. A high score indicates a greater risk of complications i.e. seizures, confusion and hallucinations.

Delirium tremens : the most severe form of alcohol withdrawal with disorientation, confusion and severe autonomic instability tremor, hallucinations and autonomic instability.

Detoxification: This refers to a treatment designed to control the medical and psychological complications that may occur after a period of heavy and sustained alcohol use.

Korsakoff's syndrome: Chronic disabling condition with severe impairment of short term memory, confabulation, disorientation in time and place.

Severity of Alcohol Dependence Questionnaire (SADQ) - a short, self-administered, 20-item questionnaire designed by the World Health Organisation to measure severity of dependence on alcohol

Wernicke's encephalopathy: An acute or subacute delirium caused by thiamine deficiency. Other features may include ophthalmoplegia (paralysis of eye muscles), ataxia and memory disturbance.

APPENDIX B UNITS OF ALCOHOL IN COMMON ALCOHOLIC BEVERAGES

You can work out how many units there are in any drink by multiplying the total volume of a drink (in ml) by its ABV (measured as a percentage) and dividing the result by 1,000.

- strength (ABV) x volume (ml) ÷ 1,000 = units

For example, to work out the number of units in a pint (568ml) of strong lager (ABV 5.2%):

- 5.2 (%) x 568 (ml) ÷ 1,000 = 2.95 units

For a quicker method, visit: https://alcoholchange.org.uk/alcohol-facts/interactive-tools/unit-calculator

Drinks and units

Type of drink	Number of alcohol units
Single small shot of spirits * (25ml, ABV 40%)	1 unit
Alcopop (275ml, ABV 5.5%)	1.5 units
Small glass of red/white/rosé wine (125ml, ABV 12%)	1.5 units
Bottle of lager/beer/cider (330ml, ABV 5%)	1.7 units
Can of lager/beer/cider (440ml, ABV 5.5%)	2 units
Pint of lower-strength lager/beer/cider (ABV 3.6%)	2 units
Standard glass of red/white/rosé wine (175ml, ABV 12%)	2.1 units
Pint of higher-strength lager/beer/cider (ABV 5.2%)	3 units
Large glass of red/white/rosé wine (250ml, ABV 12%)	3 units

*Gin, rum, vodka, whisky, tequila, sambuca. Large (35ml) single measures of spirits are 1.4 units.

APPENDIX C – ALCOHOL USE DISORDERS IDENTIFICATION TEST (AUDIT)

Questions	Scoring system					Score
	0	1	2	3	4	
How often do you have a drink containing alcohol? *(skip to Qs 9-10 if score 0)*	Never	Monthly or less	2 to 4 times per month	2 to 3 times per week	4 times or more per week	
How many units of alcohol do you drink on a typical day when you are drinking?	0 to 2	3 to 4	5 to 6	7 to 9	10 or more	
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year? *(Skip to Qs 9 and 10 if total score for Qs 2 and 3 =0)*	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Have you or somebody else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		but not in the last year		Yes, during the last year	
Total Score (out of 40)						

If score 8 or more, give brief advice to reduce risk for alcohol harm.
Scores of 15 or more indicate alcohol dependence and need for in depth assessment.

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 thing 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 REVISED (CIWA-AR)

Kent and Medway
NHS and Social Care Partnership Trust

Patient…………………………………………………………

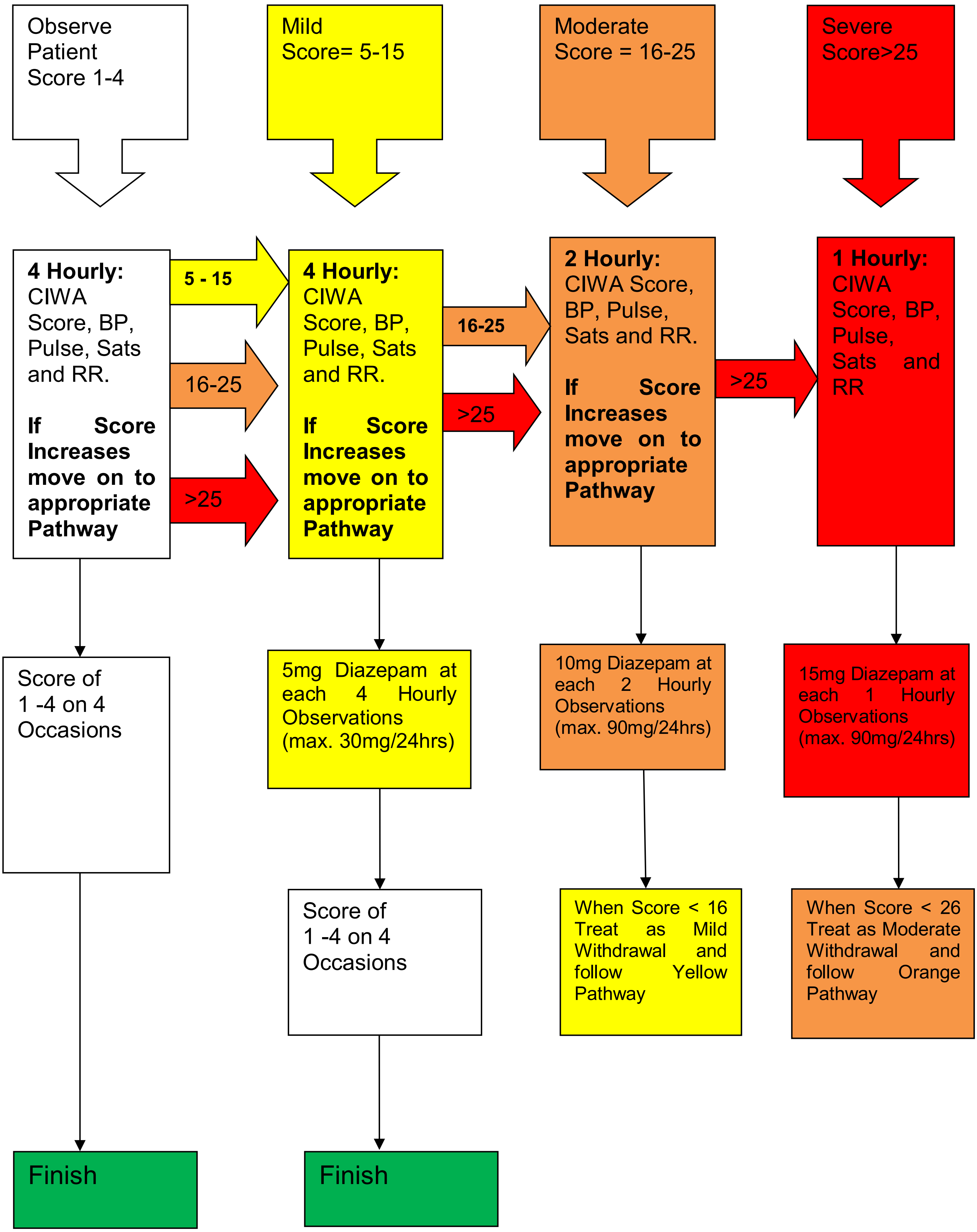
Date………………… Time…………... Pulse……………….

Total CIWA-Ar Score (max. possible score 67)………………..

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?"

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-
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
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- FLOW CHART - CARE PATHWAY FOLLOWING CIWA-AR ASSESSMENT



Adapted from Royal Salford Guidelines

APPENDIX G: GUIDELINES FOR THE PROPHYLACTIC USE OF PABRINEX

1. Background

1.1 Wernicke's encephalopathy has been shown to occur in 12.5% of alcohol misusers. It may develop rapidly or over a number of days. Inappropriately managed, it is the primary or a contributory cause of death in 17% of patients and results in permanent brain damage in 85% of survivors. It is initially reversible with parenteral B vitamins, and therefore treatment should be initiated immediately a diagnosis is suspected or when there are identified risk factors during alcohol detoxification.

1.2 There is considerable doubt regarding the suitability of oral thiamine as a prophylactic treatment for Wernicke's-Korsakoff syndrome due to poor oral absorption. It has also been shown that oral thiamine supplementation has little or no effect on CNS vitamin status; whereas parenteral thiamine replacement is rapidly effective in the treatment of established Wernicke's encephalopathy and is an effective prophylactic treatment for high-risk patients.

1.3 Parenteral high potency vitamin supplementation (Pabrinex) is therefore recommended prophylactically in patients with alcohol dependence and one or more risk factors for Wernicke's encephalopathy.

2. Risk factors for Wernicke's encephalopathy

2.1 All patients presenting with any evidence of alcohol dependence and any of the following risk factor should be treated with Pabrinex

- LFT results indicative of compromised liver disease
- History of complicated alcohol detoxification
- Severe weight loss – poor diet and/or malnutrition
- Recent diarrhoea and vomiting
- Homelessness
- Acute withdrawal

2.2 When initially seen, patients may still be drunk but treatment should not be withheld on these grounds

2.3 A presumptive diagnosis of Wernicke's Encephalopathy should be made if any of the following occur during detoxification:

- Ataxia (problems with coordination and balance)
- Confusion
- Memory disturbance
- Hypothermia (an abnormally low body temperature)
- Hypotension (lowered blood pressure)
- Ophthalmoplegia (partial or total paralysis of the eye muscles)
- Nystagmus (uncontrolled movement of the eyes, usually from side to side)
- Coma/unconsciousness

2.4 If Wernicke's encephalopathy is suspected, the patient should be transferred to a medical ward for treatment with intravenous Pabrinex.

3. Prophylactic Treatment

3.1 A pair of Pabrinex ampoules contain thiamine hydrochloride 250mg, ascorbic acid 500mg, nicotinamide 160mg, pyridoxine hydrochloride 50mg and riboflavin 4mg.

3.2 Anaphylaxis is a rare complication of Pabrinex treatment but should not preclude the use of Pabrinex in patients who need treatment. Anaphylaxis is more likely to occur with IV use, it is extremely rare after IM administration and therefore this is the preferred route of administration.

3.3 It is recommended that nursing staff only administer Pabrinex IM when there is a doctor readily available on site and when basic life support facilities are available. All wards should ensure that drugs to treat anaphylactic shock are readily available and that staff are suitably trained to manage anaphylaxis when Pabrinex is administered.

4. Administration

4.1 The contents of one ampoule Number 1 and one ampoule Number 2 of Pabrinex IM injection (total 7ml) should be drawn up into a syringe to mix them just before use, and then injected slowly high into the gluteal muscle, 5cm below the iliac crest.

4.2 Licensed practice is to administer a single 7ml injection unless patient preference/clinical need require splitting the dose.

4.3 Following administration patients should be monitored for early signs of an allergic reaction to Pabrinex intramuscular (e.g. sneezing or mild asthma) and those treating patients need to note that the administration of further injections to patients who develop these symptoms may give rise to anaphylactic shock.

4.4 All locations should ensure that facilities for treating anaphylaxis are readily available when Pabrinex is administered. All staff administering Pabrinex must have attended anaphylaxis training.

4.5 Prophylactic treatment for Wernicke's Encephalopathy should be:

- **1 pair Pabrinex ampoules IM daily for 5 days**

4.6 It is recommended that all patients should receive this as a minimum

4.7 If the patient can manage oral therapy after five days of IM Pabrinex, then oral thiamine should be started at a dose of 200-300mg in divided doses. This should be continued for at least six weeks in abstinent patients with a well-balanced diet or indefinitely in those patients who continue to use alcohol or who have poor nutritional intake.

4.8 Oral Vitamin B compound preparation are no longer recommended in the prevention of Wernicke's Encephalopathy and should therefore not be routinely prescribed in alcoholism.

4.9 Vitamin B compound preparation are only indicated in medically diagnosed deficiency or chronic malabsorption.

4.10 Where oral vitamin B preparation is indication, the vitamin B compound strong preparation should be prescribed as this is more cost effective.

APPENDIX H: ALCOHOL DETOXIFICATION CHART - DIAZEPAM

Attach to drug chart and upload to RiO on completion of treatment

Name		**NHS No.**		**DoB**	
Ward		**Consultant**		**SADQ score**	

GUIDANCE NOTES FOR USE

- This chart should be used if eMeds is unavailable and attached to the front of the main drug chart
- The Trust Policy on Alcohol Detoxification should be read prior to completing this chart
- The Severity of Alcohol Dependence Questionnaire (SADQ) should be completed as part of the assessment process, this chart is **NOT VALID** for use without a SADQ score
- The prescriber must indicate in the regular section of the drug chart a detoxification chart is in use
- Additional diazepam may be prescribed in the “when required” section of the drug chart for the first few days for breakthrough symptoms up to 30mg/24hrs in addition to the regular dose. The reasons for additional dosing should be recorded which may include the unidentified use of sedatives, hypnotics or gabapentinoids.
- Cross out treatment days (columns) not needed (e.g. for moderate dependence cross off first three columns)
- Oxazepam should be considered as an alternative to diazepam in the elderly or where there is significant hepatic dysfunction
- It can be substituted for diazepam at the same dose e.g. 5mg diazepam = 10mg oxazepam
- For patient with hepatic impairment use oxazepam at the same dose as diazepam
- IM Pabrinex should be considered in all patients with alcohol withdrawal symptoms, for prevention of Wernicke’s encephalopathy
- Baseline physical health observations should be carried out prior to starting treatment
- Daily review for at least first 5 days, to assess for breakthrough symptoms and side effects
- A Z-drug (e.g. zopiclone) may be offered for insomnia for 5 to 7 days after treatment with diazepam has ceased.

IM Pabrinex prescribed	**Yes / No**	**Baseline Observations completed** (HR, RR, BP)	**Yes / No**

Diazepam

	For severe dependence (e.g SADQ>30) start below then proceed to moderate dependency			**For moderate dependence (e.g. SADQ 15-30) start below and cross off severe dependency section.**				
Day								
Date /Time								
Breakfast Dose	15mg	15mg	15mg	10mg	10mg	5mg	5mg	
Given by								
Lunch Dose	15mg	10mg	10mg	10mg	5mg	5mg		
Given by								
Teatime Dose	15mg	10mg	10mg	10mg	5mg	5mg		
Given by								
Bedtime dose	15mg	15mg	10mg	10mg	10mg	5mg	5mg	5mg
Given by								

Physical health observations must be carried out after each administration and recorded on MEWS chart

Prescriber’s Name:	Prescriber’s Signature:
Duration of treatment (days):	Date:

APPENDIX I: ALCOHOL DETOXIFICATION CHART – OXAZEPAM

Attach to drug chart and upload to RiO on completion of treatment

Name		**NHS No.**		**DoB**	
Ward		**Consultant**		**SADQ score**	

GUIDANCE NOTES FOR USE

- This chart should be used if eMeds is unavailable and attached to the front of the main drug chart
- The Trust Policy on Alcohol Detoxification should be read prior to completing this chart.
- The Severity of Alcohol Dependence Questionnaire (SADQ) should be completed as part of the assessment process, this chart is NOT VALID for use without a SADQ score.
- The prescriber must indicate in the regular section of the drug chart a detoxification chart is in use.
- Additional oxazepam may be prescribed in the "when required" section of the drug chart for the first few days for breakthrough symptoms. Total combined dose not to exceed 200mg daily.
- Cross out treatment days (columns) not needed (e.g. for moderate dependence cross off first four columns)
- IM Pabrinex) should be considered in all patients with alcohol withdrawal symptoms, for prevention of Wernicke's encephalopathy
- Baseline physical health observations should be carried out prior to starting treatment
- Daily review for at least first 5 days, to assess for breakthrough symptoms and side effects

IM Pabrinex prescribed	**Yes / No**	**Baseline Observations completed** (HR, RR, BP)	**Yes / No**

Oxazepam

	For severe dependence (e.g SADQ>30) start below then proceed to moderate dependency				For moderate dependence (e.g. SADQ 15-30) start below and cross off severe dependency section.				
Day									
Date /Time									
Breakfast Dose	40mg	40mg	30mg	25mg	20mg	15mg	10mg	10mg	5mg
Given by									
Lunch Dose	40mg	30mg	30mg	25mg	20mg	15mg	10mg		
Given by									
Teatime Dose	40mg	30mg	30mg	25mg	20mg	15mg	10mg		
Given by									
Bedtime dose	40mg	40mg	30mg	25mg	20mg	15mg	10mg	10mg	5mg
Given by									

Physical health observations must be carried out after each administration and recorded on MEWS chart

Prescriber's Name:	Prescriber's Signature:
Duration of treatment (days):	Date:

APPENDIX J: USEFUL RESOURCES AND CONTACTS

Bridge House Detoxification Treatment Centre
Tel : 01622 726896

Drug and alcohol services in Kent

- Dartford and Gravesham- Change Grow Live (CGL)
  Tel: 01474566659 (out of hours number 0808 800 0015)

- East Kent -Forward
  Tel: 03001231186 (Same out of hours number)

- Maidstone - Change Grow Live (CGL)
  Tel: is 01622 690044 (out of hours number 0808 800 0015)

- Medway- Turning point
  Tel: 0300 123 1560 (Same out of hours number)

- Tonbridge – Change Grow Live
  Tel: 01892556580 (out of hours number 0808 800 0015)