Worcestershire Acute Hospitals NHS Trust

RECOGNITION AND TREATMENT OF ALCOHOL MISUSE IN ACUTE HOSPITAL SETTINGS

This guidance does not override the individual responsibility of health professionals to make appropriate decision according to the circumstances of the individual patient in consultation with the patient and /or carer. Health care professionals must be prepared to justify any deviation from this guidance.

Introduction

- Hospital episode statistics for 2010/11 show a rise in the number of hospital admissions wholly attributable to alcohol to 198,900; this was a 2.1% rise on 2009/10 and a 40% increase since 2002/03. **NCEPOD (2013)**
- Data from the Office for National Statistics demonstrated that there were 8,748 alcohol-related liver disease deaths in the UK in 2011 **NCEPOD (2013)**
- Alcohol misuse is estimated to cost the NHS £3.5bn a year. Almost one in four of all adults drink in a way that is potentially or actually harmful. **NCEPOD (2013)**

THIS GUIDELINE IS FOR USE BY THE FOLLOWING STAFF GROUPS:
All staff involved in delivery of hands on care in Acute Hospitals

Lead Clinician(s)

Emma Davies	Alcohol Liaison Nurse, A&E
Approved at Urgent Care Divisional Governance	April 2023
Approved by Medicines Safety Committee on:	31st October 2023
Review Date: This is the most current document and is to be used until a revised version is available	31st October 2026

Date	Amendment	Approved by:
April 2010	Contents page added along with section 10 Alcohol Ketoacidosis. Monitoring tool also added.	Mark Vardy
February 2011	Reviewed and amended to take account of released NICE guidance.	Mark Vardy
January 2013		Mark Vardy

	Added M-SASQ to screening tools to take account of new evidence. **M. Vardy ALN/WRH.** Clarification of limited amount of withdrawal medication dispensed on discharge compliant with NICE guidance. CG115 **M. Vardy ALN/WRH.**	
January 2013	References to CIWA Scale added to quick reference algorithm (CIWA scale already in main body of guideline) **E. Davies ALN/ALX.**	Mark Vardy
February 2013	Various clarifications to medication regimen in body of guideline and quick reference algorithm. Suggested by **L. Beale, Pharmacy**.	Mark Vardy
April 2015	NICE complete review of Alcohol guidance (CG 100 and CG 115)	Mark Vardy
June 2015	Revision on guidance on Vitamin B co strong tablets **M. Harris and E. Lowther, Pharmacy, WRH.**	Mark Vardy
June 2015	Revision of IV Pabrinex® prescribing against NICE guidance **E. Davies, ALN/ALX and M. Vardy, ALN/WRH. M. Harris and E. Lowther Pharmacy WRH.**	Mark Vardy
June 2015	Addition of AUDIT-C screening tool to appendices **E. Davies ALN/WRH.**	Mark Vardy
June 2015	Revision of contact information for community alcohol services to reflect new local service provision.	Mark Vardy
July 2015	Review of monitoring tool **E. Davies ALN/ALX I. Levett Cons A&E WRH M. Vardy ALN/WRH**	Mark Vardy
July 2015	Addition of further names of people contributing to the document at this review.	Mark Vardy
Sept 2017	Rewrite of introduction to update information	Mark Vardy
Sept 2017	**Addition** of section 11.5 regarding driving to reflect DVLA medical advice released 2016 updated in 2017 Suggested by **E Davies and M Vardy, ALNs**	Mark Vardy
August 2017	Rewrite of medication regimen table 1 in body of guideline and quick reference algorithm. Suggested by **S. Connop, Pharmacy**	Mark Vardy
August 2017	**Adjustments** to Maximum dosage in Chlordiazepoxide prescribing to reflect NICE and BNF guidance suggested by **S.Connop, Pharmacy**	Mark Vardy
October 2019	Document extended for 6 months whilst under review	Emma Davies
May 2020	Document extended for 6 months during COVID-19, whilst under review	Emma Davies

July 2020	Document updated with the following changes: • Updated to all ALN details • Change to screening in line with NCEPOD 2013 • Updated definitions of levels of risk in line with current NICE guidance • Removal of Paddington Alcohol Test, M-SASQ Screening Questionnaire, as these are not currently used within the Trust. • Addition of SADQ as per NICE guidance to support identification of dependency • Changes to acute management of the alcohol withdrawal syndrome (7.5) in relation to symptom triggered use using the CIWA-Ar • Addition of 'Kindling process' to support avoidance of repeated admissions for detoxification • Updated Chlordiazepoxide reducing regimen as per CIWA-Ar scale [approved June 2020] • Change to 7.6 from Lorazepam to Liver impairment to include Oxazepam • Information relating to seizures taken from NICE • Addition of Oxazepam to cautions in prescribing • Addition of 'Relapse Prevention' in line with NICE guidance • Suggested change to monitoring tool regarding Lorazepam to state use of Oxazepam/Lorazepam if significant liver or renal failure • Reference list updated accordingly • Appendix 1: revised Management algorithm for the alcohol withdrawal syndrome for in-patients • Addition of Appendix 2:Management algorithm for the alcohol withdrawal syndrome in the Emergency Department • Appendix 8: Severity of Alcohol Dependency Questionnaire (SADQ) • Appendix 10: Details of alcohol withdrawal assessment scale and pre-printed chlordiazepoxide chart WR5519 • Appendix 11: Standard Oxazepam regimen	Emma Davies
November 2020	• Section 7.6 amended to 'patients with significant liver disease such acute alcoholic hepatitis or cirrhosis' • Section 7.2 addition of Poor English, Confused, Delirious or Psychotic Patients.	Sarah Pittaway Pharmacist Frailty Practitioner Dr Gee Consultant

February 2021	Document extended as per Trust agreement 11.02.2021	
April 2021	Document approved for 3 years	Medicines Safety Committee
April 2023	• Addition of Lorazepam IV to be used as an alternative for nil by mouth patients under section 7.5 Recommended regimes • Addition of guidance for Patients Nil by Mouth under section 7.7 • Addition of guidance for patients with Enteral tubes/Swallowing difficult under section 7.8 • Appropriate references added to reference list • Lorazepam suggested regimen (appendix 12) • Addition of: - Nil by mouth/enteral tubes/difficulty swallowing, - confused/poor English/delirium/psychotic patients - frequency of CIWA scoring based upon severity of symptoms to management algorithm for alcohol withdrawal syndrome for in-patients and Emergency Departments (appendix 1 & 2) • Update to ALN contact details	Emma Davies Alison Smith Emman Abdullah Specialist Gastroenterology Pharmacist

Contents

In emergency please refer direct to treatment algorithms on pages 19-20

RECOGNITION AND TREATMENT OF ALCOHOL MISUSE IN ACUTE HOSPITAL SETTINGS

1. INTRODUCTION

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- Data from the Office for National Statistics demonstrated that there were 8,748 alcohol-related liver disease deaths in the UK in 2011 **NCEPOD (2013)**

- Alcohol misuse is estimated to cost the NHS £3.5bn a year. Almost one in four of all adults drink in a way that is potentially or actually harmful. **NCEPOD (2013)**

2. COMPETENCIES REQUIRED

- Standard Clinical Assessment Skills

- Standard Health Promotion Advice Delivery Skills

- For brief motivational intervention, training is available from external agencies and in-house (Please contact Alcohol Liaison Nurse via the email link on the intranet or at Worcester on 01905 763333 bleep 565 or at the Alex on 01527 503030 bleep 1340)

3. STAFF COVERED

All staff involved in delivery of hands on care in acute hospitals.

4. PATIENTS COVERED

4.1 Screening

All patients presenting to hospital services should be screened for alcohol misuse. An alcohol history indicating the number of units drunk weekly, drinking patterns, recent drinking behaviour, time of last drink, indicators of dependence and risk of withdrawal should be documented. **NCEPOD (2013)**

4.2 Brief Intervention

Patients identified as drinking alcohol at levels associated with increased risk of alcohol related illness or dependency according to current DH guidance. (See Definitions) should receive Brief Advice in accordance with NICE guidelines.

4.3 Management of alcohol withdrawal

Patients identified as clinically dependent on alcohol.

5. DEFINITIONS

Patterns of Alcohol Misuse

Alcohol related risk may be viewed as dose related. The terminology to describe alcohol use disorders is currently evolving. There is no “safe level” of drinking and the risk of harm increases with frequency of consumption or amount consumed

[Day, E. Copello, A. Hull, M. *(2015)*]

New Guidance for men and women advises that alcohol use above 14 units per week or involving single episodes of drinking 6 units or more increases the risk of alcohol related harm to health.

[CMOUK (2016)**]**

Hazardous drinking
Hazardous drinking (increasing-risk drinking) is a pattern of alcohol consumption that increases someone's risk of harm.

Consumption (units per week): drinking more than 14 units a week, but less than 35 units a week for women. Drinking more than 14 units a week; but less than 50 units for men

Harmful drinking
Harmful drinking (high-risk drinking) is a pattern of alcohol consumption causing health problems directly related to alcohol. This could include psychological problems such as depression, alcohol-related accidents or physical illness such as acute pancreatitis.

Consumption (units per week): drinking **35 units a week** or more for women. Drinking **50 units a week** or more for men.

Dependent drinking
Alcohol dependence is categorised by craving, tolerance, a preoccupation with alcohol and continued drinking in spite of harmful consequences (for example, liver disease or depression caused by drinking). Although alcohol dependence is defined in ICD-10 and DSM-IV in categorical terms for diagnostic and statistical purposes as being present or absent, in reality dependence exists on a continuum of severity. However, it is helpful from a clinical perspective to subdivide dependence into categories of mild, moderate and severe.

[NICE (2011)**]**

6. GUIDELINES

6.1 Identification
Alcohol misuse may be identified using a range of methods including,

- Laboratory markers including raised LFT and MCV values. Serum phosphate may be very low (<0.4mmol/l) in acute alcohol withdrawal as may magnesium.
- Clinical findings/medical history elicited during clerking
- Brief structured questionnaires (such as AUDIT, AUDIT-C, SADQ see appendices 4-9)

6.2 Initial screening and advice
Health professionals should routinely carry out alcohol screening as an integral part of practice**.**
[22.P12 NICE PHG 24 (2010)]

Where practical ALL patients in admitting areas should be asked about alcohol use
and as a minimum intervention advised of the current guidelines for sensible drinking which are;

- You are safest not to drink regularly more than 14 units a week, to keep health risks from drinking alcohol to a low level.
- If you do drink as much as 14 units per week, it is best to spread this evenly over 3 days or more. If you have one or two heavy drinking sessions, you increase your risks of death from long term illnesses and from accidents and injuries.

- The risk of developing a range of illnesses (including for example, cancers of the mouth, throat, and breast increases with any amount you drink on a regular basis.

- It is a good idea to have several drink free days each week

- If you are pregnant or planning a pregnancy the safest approach is not to drink alcohol at all, to keep risks to your baby to a minimum. **[UKCMO** (2016)**]**

6.3 Identifying dependence

It is important to get an accurate account of a patients drinking pattern on admission paying particular attention to reports of:

- Compulsive drinking (including avoidance of withdrawal symptoms)

- Loss of control over drinking.

- Experience of withdrawal on abstinence.

- Evidence of tolerance to alcohol (escalating intake to obtain desired effect).

- Evidence of salience of drinking (obtaining and drinking alcohol is the main activity in daily life).

- Persistence of use (despite evidence of mounting health and social harm).

Three or more of the above occurring together for at least 1 month or repeatedly over the last year identifies **dependence** [**WHO** (*1992)*] and will require further treatment.

Dependency exists on a continuum and it can be helpful from a clinical perspective to subdivide dependence into categories of mild, moderate and severe. 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.

People with mild dependence (those scoring 15 or less on the Severity of Alcohol Dependence Questionnaire; SADQ see appendix 8) usually do not need assisted alcohol withdrawal. People with moderate dependence (with a SADQ score of between 15-30) usually need assisted alcohol withdrawal, which can typically be managed in the community setting unless there are other risks. People who are severely alcohol dependent (with a SADQ score of more than 30) will need assisted alcohol withdrawal, typically in an in-patient setting.

[Stockwell, T., Murphy, D. & Hodgson, R. (1983)]

7. ALCOHOL WITHDRAWAL MANAGEMENT GUIDELINES

(See Appendix 1 for in-patients Algorithm and Appendix 2 for Emergency Department Algorithm on Page 25-26)

7.1 Case identification

Alcohol withdrawal may be a presenting feature or occur as an unexplained development in a patient who has been admitted for other reasons and ceased drinking alcohol deliberately or as a consequence of ill health. The extent of drinking in a person's life may be knowingly or unknowingly concealed.

Signs and symptoms of alcohol withdrawal can appear anywhere between 6 and 72 hours after the last consumption of alcohol, and the range and severity of symptoms depends on factors such as the degree of alcohol dependence and the current level of consumption.

Possible symptoms and signs include [**Hall, W. and D. Zador**, *(1997)*]:

- Signs & symptoms of autonomic over-arousal:
  - sweating
  - tachycardia (100+ bpm)
  - raised BP
  - Pyrexia (37-38 ^{o}C)
  - hyperreflexia

- Characteristic tremor, starting in the hands but progressing to the head and trunk as the severity worsens

- Anxiety, restlessness, irritability, depression, insomnia and tiredness

- Anorexia, nausea and weakness

- Confusion

Alcohol withdrawal can be seen as presenting along a spectrum from mild tremulousness, with or without changes in mood, through to seizures, hallucinations and delirium [**Raistrick, D.**, **(*2001*)]**. A major concern is to prevent the severely alcohol dependent person from developing Delirium Tremens (DTs), seizures or Wernicke's encephalopathy.

7.2 Acute Management of the Alcohol Withdrawal Syndrome

Treatment of alcohol withdrawal should be symptom triggered, i.e. commenced upon display of symptomology, tailored to the person's individual needs and determined by the severity of withdrawal signs and symptoms

[**P5 NICE CG 100 (2010)**

If dependent drinking is suspected assessment and monitoring of Alcohol Withdrawal can be identified by using the Clinical Institute of Withdrawal Assessment for Alcohol revised **(CIWA-Ar)** scale, as an adjunct to clinical judgement. See appendix 9 and WR5519 Alcohol Withdrawal Assessment Form and Adult Chlordiazepoxide Prescription Chart

It is important that patients who are being treated for alcohol withdrawal are given a clear, supportive explanation of the withdrawal management regimen at the outset. They should be oriented to time and place where necessary and reassured that distressing symptoms will be effectively treated.

Poor English, Confused, Delirious or Psychotic Patients.
For these patients the CIWA scale is inappropriate as the patient will not be able to score on Anxiety, orientation and clouding of sensorium, tactile, auditory and visual disturbances. It may be more appropriate to assess physical symptoms objectively and use a FIXED reduction regime immediately dependent upon severity of symptoms and level of dependency.

7.3 Mild Symptoms

- These can generally be managed with reassurance and general support.

- A well lit, cool environment with friendliness and reassurance from nursing staff or relatives is ideal for the confused patient [**CRAG Working Group on Mental Illness**, ***(1998)*****]**

- Attention should be paid to optimising nutrition and fluid balance.

7.4 Risk factors for progression to severe withdrawal include [**Raistrick, D.**, ***(2001)***]:

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

The greater the number of these symptoms, the greater the need for inpatient medical supervision to prevent seizures or DTs.

People at high risk of alcohol withdrawal seizures or Delirium tremens or aged under 16 and in acute withdrawal, and/or who are frail, cognitively impaired, lack social support, have learning difficulties or have other vulnerabilities or are aged 16-17 years should be offered admission to hospital. **[P6 NICE CG 100 (2010)]**

Detoxification outcomes are better where there is some evidence of a desire and intention to change drinking behaviour elicited from the patient, evidence of engagement with specialist psychosocial support for avoidance of alcohol after detoxification should also be considered.

There is evidence that multiple detoxifications are associated with poorer treatment response.

[Raistrick, Heather, Godfrey (2006) p.128]

Kindling process

Evidence suggests that the severity of alcohol withdrawal symptoms progressively increases over years of alcohol abuse in a stepwise fashion similar to the kindling process. The model is presented that the limbic system hyperirritability which accompanies each alcohol withdrawal serves over time to kindle increasingly widespread subcortical structures. These long-term changes in neuronal excitability might relate to the progression of alcohol withdrawal symptoms from tremor to seizures and delirium tremens, as well as the alcoholic personality changes between episodes of withdrawal.

[Becker HC. (1998)]

In more severe cases, medication can reduce symptoms and reduce the risk of the patient developing convulsions or delirium tremens **[Mayo-Smith, M.F., *(1997)*]** [**Williams, D. and A.J. McBride**, ***(1998)***]. Medium- to long-acting benzodiazepines are the treatment of choice, provided the patient does not have severe liver disease or severe respiratory disease.

7.5 Recommended regimens are given below:
The benzodiazepine of choice for alcohol withdrawal syndrome is **Chlordiazepoxide [p7 NICE 100/115 (2010)]**

The following regimen (***Table 1***) will be suitable in most cases (see section 7.6 for liver impairment and 7.7 for nil by mouth/enteral tubes/swallowing difficulties).

- The dose should ***always*** be titrated to the individual patients' response. Typically a maximum dose of 200mgs Chlordiazepoxide in 24 hours will control withdrawal symptoms. **[p7 NICE 100/115 (2010)]**

- Doses **may have to be increased** in more severely dependent drinkers (by adding 10-20 mg qds on a prn basis), up to a **maximum of 250 mgs in 24 hours [BNF 2017]**

- **Lorazepam IV should be used as an alternative to Chlordiazepoxide in cases where patients are unable to take oral medication.** Please see appendix 12 for suggested regimen.

- Smaller, frail/elderly, less dependent patients or **patients with compromised liver function may need a reduced dosage.**

- Generally, in the first three to four days, doses should ideally be spread across four drug rounds, with night and morning doses reduced last in order to maintain drug levels.

- The patient should be carefully monitored for signs of benzodiazepine toxicity.

Table 1 Recommended chlordiazepoxide tapering regimen *See* WR5519 Alcohol Withdrawal Assessment Form and Adult Chlordiazepoxide Prescription Chart

NB Clinical areas may have their own locally agreed treatment guidance.

	Severe withdrawal (CIWA > 15) Start here ⬇		Moderate withdrawal (CIWA 10-15) Start here ⬇		Mild withdrawal (CIWA 8-10) Start here ⬇					
Day	1	2	3	4	5	6	7	8	9	10
Time	Dose	Dose	Dose	Dose	Dose	Dose	Dose	Dose	Dose	Dose
09:00	40mg	40mg	30mg	30mg	20mg	20mg	10mg	10mg	10mg	
13:00	40mg	30mg	30mg	20mg	20mg	10mg	10mg			
18:00	40mg	30mg	30mg	20mg	20mg	10mg	10mg	10mg		
22:00	40mg	40mg	30mg	30mg	20mg	20mg	10mg	10mg	10mg	10mg

The aim in managing alcohol withdrawal is to keep the patient comfortable without over sedation or progression to delirium tremens.

Patients who are less dependent on alcohol can be started on smaller doses but night doses should be the last to be reduced.
Doses are best tapered smoothly to reduce patients' discomfort and the risk of further complications of alcohol withdrawal.

7.6 Liver impairment:
Lorazepam or Oxazepam should be used for the treatment of patients with significant liver disease such acute alcoholic hepatitis or cirrhosis'. The shorter half-life of lorazepam and the absence of active metabolites with oxazepam may prevent prolonged effects if oversedation occurs. Oxazepam OR Lorazepam are not metabolised by the liver and is the drug of choice where there is substantial or suspected impairment of liver function. Oxazepam has a much shorter half-life and is less prone to accumulation and toxicity. **This should be used as an alternative to Chlordiazepoxide where there are clinical signs or a history of *significant***

liver function impairment. (see appendix 11 for suggested Oxazepam regime Max dose 200 mg in 24 hours. See appendix 12 for suggested Lorazepam regime.)

People with decompensated liver disease who are being treated for acute alcohol withdrawal should be offered advice from a healthcare professional experienced in the management of patients with liver disease. [CG 100 2010]

7.7 Nil by Mouth

It is not appropriate to simply omit an oral medicine without first clarifying the instruction with the relevant team. It may be appropriate to give the oral medicine or to change to an alternative product using an alternative route. Failure to continue a patient's usual medication can potentially cause an exacerbation of their chronic condition or adverse effects from abrupt drug withdrawal to occur.

When changing the route of administration of a drug care should be taken to ensure that the appropriate dose and frequency is prescribed, as these may not be the same as for the oral route. Please check with the ward pharmacist, anaesthetist Medicines Information (extension 30235) or the on-call pharmacist (available via switchboard).

Lorazepam IV should be used as an alternative to Chlordiazepoxide in cases where patients are unable to take oral medication. Please see appendix 12 for suggested regimen.

Lorazepam oral vs IV dosing

- Oral bioavailability: 90%
- Lorazepam is absorbed from the GI tract and peak serum levels are reached within 2 hours of administration.

IV/IM bioavailability:

- Peak plasma concentrations occur in 60-90 minutes following IM administration
- Elimination half-life is about 12-16 hours when given intramuscularly or intravenously.

7.8 Enteral tubes/Swallowing difficulty: Options for Benzodiazepine use in alcohol detox

- **Oxazepam:**
  - The tablets will disperse easily in water. Crushing the tablets is NOT recommended
- **Chlordiazepoxide:**
  - The capsules can be opened and the contents mixed with water. Crushing the tablets is not recommended.
- **Lorazepam:**
  - The tablets can be crushed and mixed with water for administration, without crushing the tablets disperse in water in one to five minutes.
  - The tablets can also be given sublingually but the patient must have a sufficiently moist mouth for sublingual absorption.
  - The injections can be used sublingually.

***Please note that crushing/dispersing tablets or capsule contents renders their use unlicensed**

7.9 Cautions in Benzodiazepine Use

Benzodiazepines can cause respiratory depression as well as sedation. The use of such drugs should be carefully considered and monitored in certain clinical situations such as liver or renal impairment or in cases of suspected or recent head injury where neurological symptoms may be masked. A head CT scan should be considered and the situation balanced with the need to

manage significant alcohol withdrawal effectively. Lorazepam may be more appropriate due to shorter half-life.
For people with alcohol withdrawal seizures consider offering lorazepam to reduce the likelihood of further seizures, Phenytoin is not recommended for alcohol withdrawal seizures

[P.7 NICE CG 100 (2010)]

7.9 Seizures

Optimisation of withdrawal control with benzodiazepine may be sufficient to relieve seizures. If a seizure occurs during withdrawal it is more likely to recur in subsequent episodes of withdrawal. Evidence shows that benzodiazepines significantly reduce the incidence of seizures. **Adding anticonvulsants to this regime does not add any great advantage.**

7.10 Severe withdrawal

The following clinical features may warrant admission to hospital for treatment:

- Previous history of severe withdrawal or seizures
- High risk of developing Wernicke's Encephalopathy
- Alcoholic hallucinosis
- Depression
- Suicidal ideation
- Poor or absent social support

8. DELIRIUM TREMENS (DTs)

This has a mortality rate of up to 20% if untreated, and is recognised by:

- Increasing confusion and disorientation
- Severe tremor and autonomic disturbance
- Visual and auditory hallucinations
- Delusional beliefs

Prompt recognition of the risk of alcohol withdrawal and treatment with benzodiazepines will usually prevent this. Initial management of the severely confused or agitated patient requires the administration of adequate sedative doses of benzodiazepines (intravenously if necessary).
The object of treatment is to keep the patient calm and sedated but easily roused.

- For patients able to take oral medication, doses of chlordiazepoxide as high as 50mg every 2 hours may be necessary (**do not exceed 200 mgs in 24 hours**)

  [NICE CG100/115 (2010)]

  However in exceptional circumstances 250 mgs in 24 hours may be required in well supervised in-patient settings. [BNF 2017]

- Rectal diazepam may be useful where there is difficulty establishing venous access

  [CRAG Working Group on Mental Illness, *(1998)*]
- For patients with significant liver or renal impairment, IV lorazepam at doses of up to 1-2mg every 30 minutes, given slowly into a large vein. IM lorazepam may only be used when the oral/IV routes not possible. Dilute with equal volume of 0.9% sodium chloride. **(Do not exceed 8mg/24 hours)**

- Clomethiazole is **not** recommended [**Duncan, D. and D. Taylor, *(1996)*]** since it has a narrower safety margin than benzodiazepines.

- Severe psychotic symptoms may be managed by the addition of haloperidol 1-5mg 2-3 times per day, although adequate treatment with benzodiazepines should be the priority, as haloperidol alone will not control alcohol withdrawal, and may lower seizure threshold.

- Close monitoring of fluid balance is important. Urea and electrolytes (including **magnesium) should be regularly checked [CRAG Working Group on Mental Illness, *(1998)*]**

Cautions in Prescribing in Alcohol Withdrawal

Benzodiazepines

Benzodiazepine prescribing in patients with a history of alcoholism should be time limited and symptom triggered due to increased risk of dependence.

Diazepam and **Chlordiazepoxide** have UK marketing authorisation for the management of acute alcohol withdrawal symptoms.

Clomethiazole has UK market authorisation for alcohol withdrawal treatment under close inpatient supervision or by specialist services.

Lorazepam does not have UK market authorisation for this indication therefore informed consent should be obtained and documented.

Oxazepam does not have UK market authorisation for this indication therefore informed consent should be obtained and documented.

Cautions in Prescribing in Delirium Tremens

Lorazepam is used for this indication however it does not have UK marketing authorisation so informed consent should be obtained and documented.

Haloperidol is used for this indication however it does not have UK marketing authorisation so informed consent should be obtained and documented. Haloperidol should be used with caution in patients with conditions predisposing to convulsions

[P12 NICE CG 100 (2010)]

"**Where an adult patient lacks the mental capacity (either temporarily or permanently) to give or withhold consent for themselves**, no-one else can give consent on their behalf. However, **treatment may be given if it is in their best interests**, as long as it has not been refused in advance in a valid and applicable advance directive." **WAHT – CG – 075** Policy for consent to examination or treatment.

9. WERNICKE'S ENCEPHALOPATHY (WE)
(See Appendix 3 - Treatment Algorithm on Page 27)

Inappropriately managed this complication of alcohol misuse

- Carries a mortality rate of over 15% **[Victor, M., R.D. Adams, and G.H. Collins, *(1989)*]**
- Results in permanent brain damage (Korsakoff's psychosis) in 85% of survivors [**Victor, M., R.D. Adams, and G.H. Collins**, ***(1989)***]

The classical triad of signs (acute confusion, ataxia and ophthalmoplegia) only occurs in 10% of patients [**Duncan, D. and D. Taylor**, (1996)]. Therefore the triad cannot be used as the basis of diagnosis and a high index of suspicion is needed. **The presence of only one of the following**

signs should be sufficient to assign a diagnosis and commence treatment [**Cook, C.C.H**., ***(2000)***]

- Acute confusion
- Decreased consciousness level including unconsciousness or coma
- Memory disturbance
- Ataxia/unsteadiness
- Ophthalmoplegia
- Nystagmus
- Unexplained hypotension with hypothermia

9.1 Treatment:

- Give Pabrinex® IV High Potency* 2-3 ampoule pairs (4-6 ampoules in total) three times daily for 5 days unless Wernickes Encephalopathy is excluded, if no improvement, review possible alternative causes of presentation.
- Do not stop IV Pabrinex® until Wernickes is excluded.

[NICE CG100 (2010)] PATHWAY

**Pabrinex® IV High Potency is described generically in the BNF as `Vitamin B Substances with Ascorbic Acid. In this guideline the widely used trade name Pabrinex® is used throughout for convenience, however where available an equivalent generic product may be used instead.*

Administration details: Draw the contents of one pair of ampoules into a syringe and mix. Add to 50-150ml 0.9% sodium chloride (i.e. **a minimum of 50 mls 0.9% sodium chloride per ampoule pair**) Administer IV over 30 minutes. Monitor patient for anaphylaxis.

Pabrinex® should be continued until there is no further improvement of the clinical symptoms. Then start oral supplementation Thiamine 100mg bd. The routine prescribing of Vitamin B co strong is not recommended in the BNF or by NICE. But is indicated in higher doses for the specific treatment of peripheral neuropathy **[Ang, C.D. et al (2008)]**

9.2 Prophylaxis:
Prophylactic treatment is indicated in patients with concomitant findings that place increased demands on already depleted B-vitamin stores thereby increasing the risk of precipitation of WE

All patients undergoing alcohol withdrawal in association with acute illness or injury should be treated prophylactically with IV Pabrinex®.

Offer higher dose **prophylactic oral thiamine (BNF recommends 200 - 300mgs daily in divided doses)** to harmful or dependent drinkers if;

- They are malnourished or at risk of malnourishment.
- They have decompensated liver disease.
- They are in acute withdrawal.
- Before and during a planned medically assisted alcohol withdrawal.

Offer **prophylactic IV Pabrinex®** (See below) if;

- They are malnourished or at risk of malnourishment.
- They have decompensated liver disease.
- They attend an Emergency department.
- They are admitted to hospital with an acute illness or injury

[**P8 NICE CG100 (2010)]**

Give Pabrinex® IV High Potency 1 ampoule pair daily for 3 to 5 days.
Followed by oral supplementation of Thiamine 100mg bd. The routine prescribing of Vitamin B co strong is not recommended in the BNF or by NICE. But is indicated in higher doses for the specific treatment of peripheral neuropathy **[Ang, C.D. et al (2008)]**
Intravenous dextrose should not be given before Pabrinex® due to the risk of precipitating WE. This is because glucose metabolism utilises thiamine and therefore may deplete reserve.

10. ALCOHOLIC KETOACIDOSIS

This is may be a rare cause of sudden death in patients with severe alcoholism. When treated it resolves rapidly and without any apparent sequelae (McGuire LC et al 2005). The condition is thought to be associated with a ketoacidosis, a lactic acidosis, an acetic acidosis and a hyperchloraemic acidosis.

10.1 Clinical features

- Chronic alcoholic, plus **recent binge**
- Binge terminated by **severe nausea**, **vomiting** and **abdominal pain**
- Tachycardia, hypotension and increased respiratory rate
- Abdominal tenderness with no other specific abdominal findings
- Minimal alteration conscious level despite marked metabolic acidosis

10.2 Biochemical features

- Raised anion gap metabolic acidosis
- Normal or low blood glucose
- Normal or moderately elevated urea and creatinine
- Lactate insufficiently high to explain extent of acidosis
- Low or absent blood alcohol level
- Urinary ketones on dipstix testing but absence does not exclude diagnosis

10.3 Management

- Pabrinex® IVHP 1 ampoule pair (2 ampoules in total) daily
- Intravenous rehydration with 5% glucose (avoid sodium chloride 0.9% which paradoxically worsens acidosis). Monitor BMs regularly, persisting hyperglycaemia may necessitate an insulin infusion.
- Potassium supplementation (may be low on presentation or fall rapidly on rehydration)
- Magnesium and phosphate supplementation if indicated.
- Exclude other serious pathology (sepsis, intra-abdominal pathology)

11. SPECIAL SITUATIONS

11.3 Pre-admission Benzodiazepine Prescription

Some patients will have been prescribed long term benzodiazepines prior to admission.
In these cases where such prescribing can be reliably confirmed, continue the prescription unaltered and titrate alcohol withdrawal dosage **in addition** to the long term prescription.

11.4 Nausea/vomiting/dehydration may occur with alcohol withdrawal and exacerbate the condition and should be managed with metoclopramide 10mgs P.O IM or IV (not recommended in severe liver disease, seek alternative anti emetic)

11.5 Alcohol withdrawal seizures
For people with alcohol withdrawal seizures consider offering a quick acting benzodiazepine such as Lorazepam to reduce the risk of further seizures**, alternatively PRN diazepam per rectum 10-20mg should be prescribed**

11.6 Violence and Aggression
If violence and aggression occur then these incidents should be managed and recorded in accordance with the hospital policy on violence and aggression.

11.7 Driving and DVLA
The DVLA has issued revised guidance regarding fitness to drive in people with **alcohol dependency that is associated with abnormal biological markers**, and some conditions associated with chronic liver disease such as,

- hepatic cirrhosis with chronic encephalopathy
- alcohol induced psychosis
- cognitive impairment

These are in addition to long standing controls on drivers who have had fits associated with alcohol withdrawal that may result in revocation or suspension of driving licences, where alcohol related conditions persist.

Discharge documentation to GPs must clearly reflect that the issue of fitness to drive may need to be addressed and medical professionals are reminded of their duty to report medical conditions impacting on driver safety within professional duties of confidentiality weighed with criteria set out on the DVLA website and documents.

[DVLA 2017]

Please see:

https://www.gov.uk/guidance/drug-or-alcohol-misuse-or-dependence-assessing-fitness-to-drive

12. DISCHARGE

Patients who have had alcohol withdrawal managed secondary to their reason for acute admission/ attendance at A+E may request chlordiazepoxide or other benzodiazepine to be dispensed on discharge to “complete their detox”.

This may be appropriate if the following criteria can be met and must be confirmed with the third party concerned. Information regarding met criteria must be documented in the patient’s record.

- Patient otherwise medically fit for discharge and 72 hours post last witnessed seizure.
- Confirmed supervision by responsible family or other appropriate social support.
- Clear understanding by the patient and carer of the risk of overdose attached to drinking alcohol with benzodiazepines.

The above safety guidelines must be supported by either,

- Confirmed support from GP.
  OR
- Confirmed current engagement and attendance with community alcohol team.

N.B. Large amounts of chlordiazepoxide should not be supplied on discharge where there is any evidence of stock-piling (e.g. receipt of existing benzodiazepine prescription from primary care) or risk of diversion to illicit drug markets.

Prescribe only enough to cover the period between discharge and the earliest possible GP appointment. **Warn against driving or operating machinery whilst taking benzodiazepines**.
[BNF 2017]
No more than 2 days medication for assisted withdrawal should be supplied. [**NICE CG115]**
Patients who are detoxifying must be under the supervision of their GP or other nominated clinician. **The expressed desire to cease drinking does not of itself justify risky prescribing**. Detoxification from alcohol in highly dependent drinkers is not a risk free procedure and reliable social support in the community is essential.

12.1 Relapse Prevention

As part of a comprehensive discharge plan, patients should already have a referral to the Alcohol Liaison Nurse during their admission in order to provide monitoring and guidance regarding treatment of alcohol withdrawal, to provide psychological support and facilitate referral to community based alcohol treatment services.

NICE recommends that, after a successful withdrawal, clinicians should consider offering people with moderate and severe alcohol dependence acamprosate or oral naltrexone in combination with an individual psychological intervention (CBT, behavioural therapy or social network and environment-based therapy) focused specifically on alcohol misuse. This should be discussed with the Alcohol Liaison Team regarding the patient's suitability and current engagement with community based alcohol treatment services.
[NICE CG115 (2011)]

12.2 Further supportive action
All patients with alcohol related problems should be managed according to this guidance. In addition to withdrawal management which is a medical issue, there is also the need for patients to be offered a session of structured brief advice on alcohol, this advice would include support in making an offer of access by referral or self referral to longer term contact with alcohol treatment services where appropriate.

12.3 Brief Intervention
Brief intervention enables the patient to spend 5-15 minutes to discuss with a specialist or trained non-specialist the potential risk of harm to physical and mental health associated with the patients drinking, possible barriers to changing drinking patterns, identifying further resources for longer term help with drinking problems, with goal setting as appropriate**.**
[P14 NICE PHG 24 (2010)]
Brief Alcohol Interventions in general hospitals can reduce alcohol intake at 6 and 12 months follow up. [**McQueen,J. et al (2009)]**

12.4 Referral to treatment
At **Worcester** and **Redditch** the alcohol liaison nurse should be the first point of contact for clarification or additional guidance on withdrawal management or for psychological input.

Patients should be referred to the **alcohol liaison nurses** based in A+E (Worcester and Redditch) – who will be able to offer psychological input as well as offer the patient the opportunity to engage with their local community substance misuse service on discharge for longer term counselling and support.

Wards and Units at **Worcester** and **Redditch** (when the Alcohol Liaison Nurse is unavailable), **Kidderminster** and **elsewhere** can suggest that the patient self refer to community substance misuse services directly, supplying them with the telephone number and encouragement to do so. **See p.15**

12.4 Screening
There are 6 very useful tools which are available for clinical use. (See page 28 onwards)

Alcohol Use Disorders Identification Test- WHO validated instrument to identify patterns of alcohol use**. [P11 NICE PHG 24 (2010)]**

AUDIT-C - (3 questions derived from the above for brevity and sensitivity in initial screening) **[Bush et al 1998]**

F.A.S.T. Screening Tool for initial identification of drinkers in A&E. [**P11 NICE PHG 24 (2010)]**

CAGE Questionnaire

Clinical Institute Withdrawal Assessment for Alcohol – Revised (CIWA-R) which allows clinicians to objectively score a patients alcohol withdrawal symptoms thus guiding administration of symptom triggered benzodiazepine regimen. These tools are available below for use and reference (Page 20). [**P 11 NICE PHG 24 (2010)]**

Severity of Alcohol Dependency Questionnaire (SADQ) which allows clinicians to objectively determine level of dependency into mild, moderate or severe**. [NICE CG 100/115 (2010/2011)]**

For further information on screening tools please contact Alcohol Liaison Nurse at Worcester on Bleep 565 or Redditch on Bleep 1340.

Monitoring Tool

This should include realistic goals, timeframes and measurable outcomes.

How will monitoring be carried out?

Who will monitor compliance with the guideline?

Page/ Section of Key Document	Key control:	Checks to be carried out to confirm compliance with the policy:	How often the check will be carried out:	Responsible for carrying out the check:	Results of check reported to: *(Responsible for also ensuring actions are developed to address any areas of non-compliance)*	Frequency of reporting:
	WHAT?	**HOW?**	**WHEN?**	**WHO?**	**WHERE?**	**WHEN?**
Page 14	**Referral to ALN** 80% of Alcohol related attendances should (when sober and consenting) be referred to the Alcohol Liaison Nurse.	Comparison between patients identified as AUDs in A&E and referral returns. Pilot study pending re application of systematic electronically recorded screening and uptake	4 times a year	ALN	ALN and A&E clinical governance lead.	Quarterly End of March June September December
Page 8	**Alcohol Withdrawal** 80% of those diagnosed with alcohol withdrawal treated. For acute management of the alcohol withdrawal syndrome, Chlordiazepoxide in a	Retrospective case notes review.	2 times per year	Nominees of A&E Clinical governance lead	A&E clinical governance lead	Bi-annually at end of March and end of December

	tapering regime is used with a maximum of 200mg/day Lorazepam/Oxazepam should be used if significant liver or renal failure.					

CONTACTS

Alcohol Liaison Nurses:
Emma Davies
Working hours: Monday to Friday 08:00 – 16:00

In hours **Bleep 1340** or email: emma.davies22@nhs.net

Out of hours please email patients details, Name, hospital ID, reason for admission, location if still admitted, patients consent and current telephone number on: wah-tr.alcoholliaisonref@nhs.net and ALN will respond next working day.

Patients or carers/concerned others should be offered the opportunity to contact the community services for ongoing counselling and support:

CRANSTOUN

Single point of contact for referrals 0300 303 8200

Alcoholics Anonymous regional helpline 0121-212-0111

Al-anon (12 step family support) national helpline 020-7403-0888

Cocaine Anonymous (also for alcohol use) 0300 111 2285

SMARTrecovery: available via CRANSTOUN offices or https://www.smartrecovery.org.uk/

ALCOHOL TRAINING / BRIEF INTERVENTION TRAINING / EXPERIENTIAL PLACEMENTS

Are available to trust employees and students by arrangement in formal or informal training sessions by the Alcohol Liaison Nurses details can be obtained on Bleep 565/1340
Brief intervention training can be delivered to **all** levels of staff.

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APPENDIX 1: Management algorithm for the alcohol withdrawal syndrome for in-patients

Patient admitted

Oversedated/intoxicated by alcohol consumed prior to admission

Close observation and monitoring of vital signs and level of alertness

If Signs and symptoms compatible with alcohol withdrawal emerging e.g. tachycardia, sweating, tremors.

Complete CIWA

Poor English, Confused, Delirious or Psychotic Patients CIWA is not appropriate. It may be more appropriate to assess physical symptoms objectively and use a FIXED reduction regime immediately dependent upon severity of symptoms and level of dependency.

If CIWA score 7 or below: **Do NOT Initiate detoxification**

Monitoring clinically and repeat CIWA if indicated

If CIWA = 8 or above… see below

Are there symptoms of alcoholic liver disease?

Nil by mouth/enteral tubes/difficulty swallowing see WAHT-A&E-031 for BZD alternatives

No

Yes - Oxazepam (see appendix 11 WAHT-A&E-031)

Initiate Chlordiazepoxide schedule based upon CIWA-Ar scale score (see pre-printed Chlordiazepoxide prescription sheet WR5519)

CHECKLIST for admitting Doctor

- Regular Chlordiazepoxide prescribed
- PRN Chlordiazepoxide prescribed
- Alcohol Liaison Nurse Referral bleep 565/1340
- Pabrinex® I+II, 2-3 pairs TDS IV until Wernicke's excluded clinically
- After 5 days Thiamine 100mg BD-TDS PO

	CIWA 15 + Start here		**CIWA 10 – 15 Start here**		**CIWA 8 - 10 Start here**					**CIWA 0 - 7**
Day	1	2	3	4	5	6	7	8	9	10	**DETOX NOT INDICATED MONITOR FOR EMERGING SYMPTOMS**
Time	Dose	Dose	Dose	Dose	Dose	Dose	Dose	Dose	Dose	Dose	
09:00	40mg	40mg	30mg	30mg	20mg	20mg	10mg	10mg	10mg		
13:00	40mg	30mg	30mg	20mg	20mg	10mg	10mg				
18:00	40mg	30mg	30mg	20mg	20mg	10mg	10mg	10mg			
22:00	40mg	40mg	30mg	30mg	20mg	20mg	10mg	10mg	10mg	10mg	

****Review CIWA-Ar scale score after 60 mins of administering first dose of benzodiazepines****

If CIWA 0-7

Adequate dose prescribed, however continue monitoring with CIWA-Ar every 90 mins for first 24 hours or until no evidence of breakthrough withdrawal after 24 hours. Then complete daily during detoxification.

If CIWA 8+

Use additional Chlordiazepoxide as PRN 10-20mg (max dose 200mg in 24 hrs). Repeat CIWA every 60 mins until CIWA reduced <8. Consider use of second line medications if Chlordiazepoxide is ineffective in reducing CIWA-Ar score, consider treatment for DT's using Lorazepam, Haloperidol – see WAHT-A&E-031

APPENDIX 2: Management algorithm for the alcohol withdrawal syndrome in the Emergency Department

Patient attends

Oversedated/intoxicated by alcohol consumed prior to attendance

Close observation and monitoring of vital signs and level of alertness

If alcohol misuse suspected administer stat dose IV Pabrinex® I+II 2 ampoule pairs.

If signs and symptoms compatible with alcohol withdrawal emerging e.g. tachycardia, sweating, tremors.

Complete CIWA

Poor English, Confused, Delirious or Psychotic Patients CIWA is not appropriate. It may be more appropriate to assess physical symptoms objectively and use a FIXED reduction regime immediately dependent upon severity of symptoms and level of dependency.

If CIWA score 7 or below
Do NOT Initiate detoxification

Monitoring clinically and repeat CIWA if indicated

If CIWA = 8 or above… see below

Are there symptoms of alcoholic liver disease?

Nil by mouth/enteral tubes/difficulty swallowing see WAHT-A&E-031 for BZD alternatives

No

Yes – Oxazepam (see appendix 11 WAHT-A&E-031) → Consider admission and continue treatment

Initiate Chlordiazepoxide schedule based upon CIWA-Ar scale score (see pre-printed Chlordiazepoxide prescription sheet within Patient First).
NB: An initial stat dose between 20-50mg chlordiazepoxide dependent upon severity of symptoms may be required to avoid delay in treatment repeat CIWA-Ar 60 mins following administration of dose. **Review dosage if patient over sedated. Max total dose of 200mgs per day**. [up to 250mgs in exceptional cases of severe withdrawal / Delirium Tremens]

	CIWA 15 + **Start here** ⬇		**CIWA 10 – 15** **Start here** ⬇		**CIWA 8 - 10** **Start here** ⬇					**CIWA 0 - 7**
Day	1	2	3	4	5	6	7	8	9	10	**DETOX NOT INDICATED MONITOR FOR EMERGING SYMPTOMS and repeat CIWA-Ar**
Time	Dose	Dose	Dose	Dose	Dose	Dose	Dose	Dose	Dose	Dose	
09:00	40mg	40mg	30mg	30mg	20mg	20mg	10mg	10mg	10mg		
13:00	40mg	30mg	30mg	20mg	20mg	10mg	10mg				
18:00	40mg	30mg	30mg	20mg	20mg	10mg	10mg	10mg			
22:00	40mg	40mg	30mg	30mg	20mg	20mg	10mg	10mg	10mg	10mg	

****Review CIWA-Ar scale score after 60 mins of administering first dose of benzodiazepines****

If CIWA 0-7

Adequate dose prescribed, however continue monitoring with CIWA-Ar every 60-90 mins dependent upon severity of symptoms whilst patient in the department.

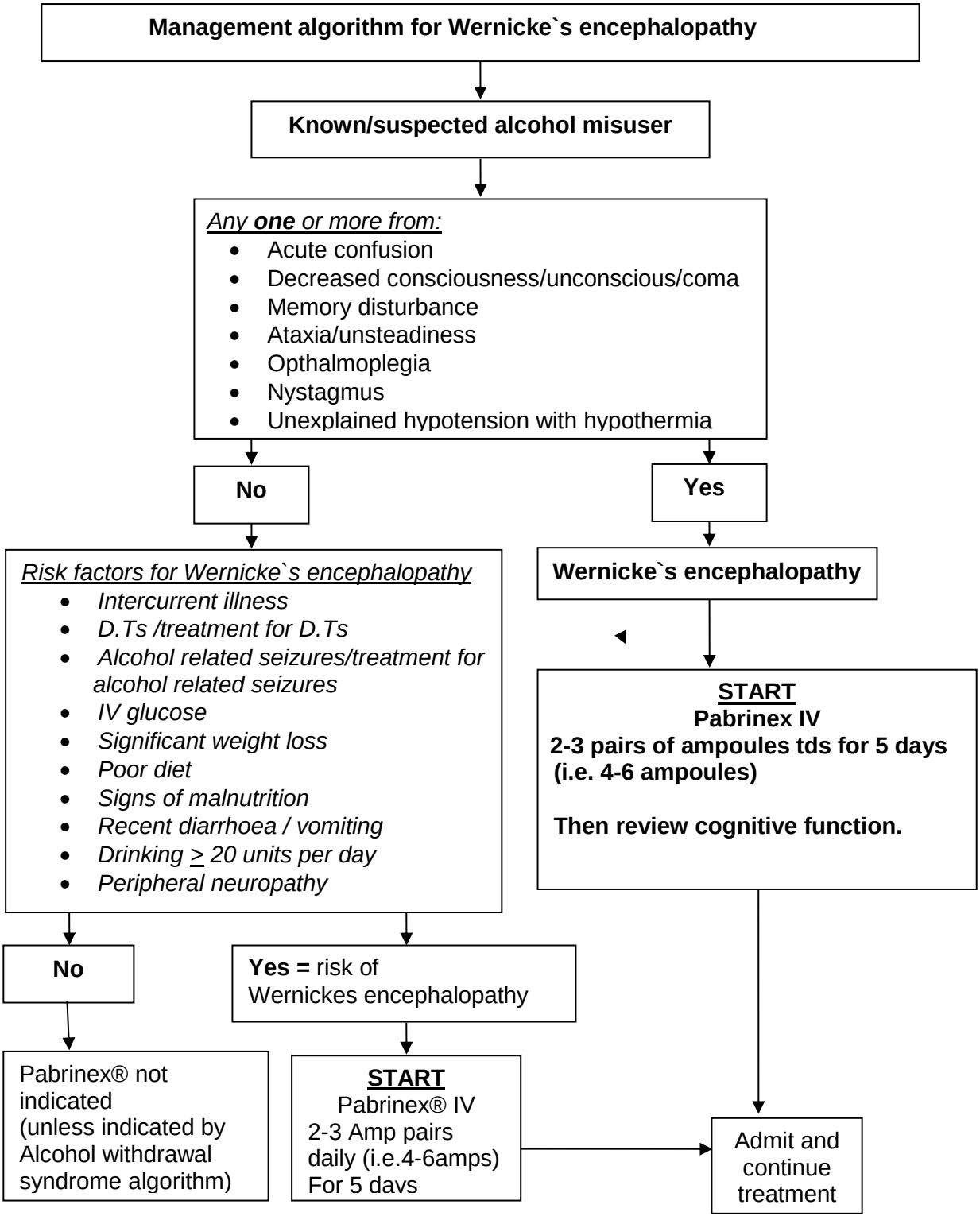
If otherwise medically optimised for discharge providing CIWA-Ar scale score is below 8 the patient can be safely discharged with Brief Advice regarding gradual reduction of alcohol use and risks of sudden cessation of alcohol. **Provide patient information leaflet 'Alcohol dependence' and offer referral to the Alcohol Liaison Nurse. Do not discharge the patient with Chlordiazepoxide unless this is discussed and agreed with the ALN.**

If CIWA 8+

Use additional Chlordiazepoxide as PRN 10-20mg (max dose 200mg in 24 hrs). Continue to monitor with CIWA every 60 mins until score <8.
Consider use of second line medications if Chlordiazepoxide is ineffective in reducing CIWA-Ar score, see Management of DT's, Lorazepam, Haloperidol – see WAHT-A&E-031

Discuss with ALN, if ALN not available discuss with your Consultant
Admit and continue treatment

APPENDIX 3



Administration of Pabrinex® IV
Ampoule pairs diluted in 50 mls to 100 mls sodium chloride 0.9%
Infuse over 30 minutes
NB. Small risk of anaphylaxis. Facilities to manage should be available

APPENDIX 4

The Alcohol Use Disorders Identification Test (AUDIT)

[Saunders, J. B., Aasland, O.G., Babor, T. F., De La Fuente, J. R. & Grant, M. (1993)]

1. **How often do you have a drink containing Alcohol?**
   (0) Never (1) Less than Monthly (2) 2-4 times a month (3) 2-3 times a week
   (4) 4 or more times a week

2. **How many units of alcohol do you drink on a typical day when you are drinking?**
   (0) 1or 2 (1) 3 or 4 (2) 5 or 6 (3) 5-9 (4) more than 10

3. **How often do you have six or more units of alcohol on one occasion?**
   (0) Never (1) Less than Monthly (2) Monthly (3) Weekly (4) Daily or almost daily

4. **How often in the last year have you found you were not able to stop drinking once you had started?**
   (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily

5. **How often in the last year have you failed to do what was expected of you because of drinking?**
   (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily

6. **How often in the last year have you needed a drink first thing in the morning to get yourself going after a heavy drinking session?**
   (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily

7. **How often in the last year have you had a feeling of guilt or remorse about drinking?**
   (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily

8. **How often in the last year have you been unable to remember what happened the night before because you had been drinking?**
   (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily

9. **Have you or someone else ever been injured as a result of your drinking?**
   (0) No (2) Yes but not in the last year (4) Yes, during the last year

10. **Has a relative or friend or Doctor or other health worker been concerned about your drinking or suggested you cut down?**
    (0) No (2) Yes but not in the last year (4) Yes, during the last year

1 Unit of alcohol = Half a pint of beer, cider, lager under 5% Alcohol by Volume (ABV)
One small glass of wine (125 mls)
One single measure of spirits
Small glass of sherry
Single measure aperitif

A score of 8 or more indicates that a closer examination of alcohol intake is warranted. A score of 20 or over suggests a harmful or dependent pattern of drinking and closer questioning may be required to establish the likelihood of the alcohol withdrawal syndrome developing.

APPENDIX 5

AUDIT-C

Bush,K., Kivlahan,D.R. McDonnell, M.B., Fihn, S.D. & Bradley, K.A. (1998)

(Available on Patient First System for use in ED triage)

1. **How often do you have a drink containing Alcohol?**
   (0) Never (1) Less than Monthly (2) 2-4 times a month (3) 2-3 times a week
   (4) 4 or more times a week

2. **How many units of alcohol do you drink on a typical day when you are drinking?**
   (0) 1or 2 (1) 3 or 4 (2) 5 or 6 (3) 5-9 (4) more than 10

3. **How often do you have six (female) / Eight (male) or more units of alcohol on one occasion?**
   (0) Never (1) Less than Monthly (2) Monthly (3) Weekly (4) Daily or almost daily

Score questions as scored in (brackets) **A score of 3 or more points** on the AUDIT-C, or a report of **drinking 6 or more drinks on one occasion ever in the last year**, should lead to a more in-depth assessment of drinking and related problems.

APPENDIX 6

F.A.S.T. Screening Tool

Hodgson,R., Alwyn,T. John, B.,Thom,B. & Smith A. (2002)

1. **In the last 3 months how often have you had eight or more units of alcohol on one occasion?**

   Never Less than once monthly weekly daily or almost daily

   (If NEVER please do not answer further)

2. **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 once monthly weekly daily or almost daily

3. **How often during the last year have you failed to do what was normally expected from you because of your drinking?**

   Never Less than once monthly weekly daily or almost daily

4. **Has a relative, friend, doctor or other health worker been concerned about your drinking or suggested you cut down?**

   NO YES but not in the last year YES in the last year

One unit of alcohol is equal to…
Half a pint of ordinary strength beer, lager or cider
One small (125mls) glass of wine
One single measure of spirits
One single glass of sherry
One single measure of aperitif

(Score questions 1-3: 0, 1,2,3,4. Score question 4: 0, 2, 4
A score of 3 or more indicates probable hazardous drinking)

APPENDIX 7

The CAGE Questionnaire

CAGE [**Cook, C.C.H**., (2000)] is an acronym
Derived from four questions:

- Have you ever felt you should **c**ut down on your drinking?
- Have people **a**nnoyed you by criticising your drinking?
- Have you ever felt bad or **g**uilty about your drinking?
- Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (**e**ye opener)?

The CAGE takes only a minute to complete and has been a widely used screening test in clinical practice [**Mayfield, D., McLeod, G. & Hall, P.** *(1974*)]. The items are easy to remember and can be administered orally by a practitioner.

Asking patient to restrict answers to last 6 months can give a clearer picture of current situation.

A positive reply to 2 or more questions warrants closer questioning of alcohol intake.

APPENDIX 8

SEVERITY OF ALCOHOL DEPENDENCY QUESTIONNAIRE (SADQ)

Patient details: Date:	ALMOST NEVER (0)	SOMETIMES (1)	OFTEN (2)	NEARLY ALWAYS (3)
During a heavy drinking period do you/does your/are you…				
Wake up feeling sweaty				
Have hands that shake first thing in the morning				
Whole body shakes violently first thing in the morning if you don't have a drink				
Wake up absolutely drenched in sweat				
Dread waking up in the morning				
Frightened of meeting people first thing in the morning				
Feel at the edge of despair when you awake				
Feel very frightened when you awake				
Like to have a morning drink				
Gulp my first few drinks down as quickly as possible				
Drink in the morning to get rid of the shakes				
Have a very strong craving for a drink when you awake				
Drink more than a quarter bottle of spirits per day (4 doubles or 1 bottle of wine or 4 pints of 4% beer or lager)				
Drink more than half a bottle of spirits per day (or 2 bottles of wine or 8 pints of 4% beer/lager)				
Drink more than one bottle of spirits per day (or 4 bottles of wine or 15 pints of 4% beer/lager				
Drink more than two bottles of spirits per day (or 8 bottles of wine or 30 pints of 4% beer/lager)				
IMAGINE THE FOLLOWING SITUATION: You have been completely off drink for a few weeks .You then drink very heavily for two days, how would you feel the morning after those two days of heavy drinking?				
	Not at all (0)	Slightly (1)	Moderately (2)	Quite a lot (3)
I would start to sweat				
My hands would shake				
My body would shake				
I would be craving for a drink				

Total score _____ (scores lower than or equal to 15 indicate low dependence, 16-30 indicates moderate dependence, 31-60 indicates severe dependence.

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. **[Stockwell, T., Murphy, D. & Hodgson, R. (1983)]**

APPENDIX 9

CLINICAL WITHDRAWAL ASSESSMENT SCALE (CIWA– Ar)

(Available for printing and combined with prescribing chart on Patient First system or pre-printed prescription WR5519 Alcohol Withdrawal Assessment Form and Adult Chlordiazepoxide Prescription Chart)

[Sullivan, J.T., Sykora, K., Scneiderman, J. Naranjo, C.A. and Sellers, E.M. *(1989)***]**

The scale on page 28 below can be used to assess alcohol withdrawal.

The frequency of when this scale should be used is up to your own clinical experience.

However, if a patient is in the early stages of withdrawal it is recommended that this is used every **90 minutes**.

The tool will enable you to decide whether your patient requires to be given any PRN medication. It is recommended that if the patient scores ***>10 (more than 10) then the patient should be given their PRN Chlordiazepoxide***.

If the patient scores <10 (less than) then no PRN medication should be given. However**, the regular prescribed medication should be given at all times unless the patient becomes overly sedated.**

Scores of less than 8-10 indicate minimal to mild withdrawal.

Scores of 8-15 indicate moderate withdrawal (marked autonomic arousal).

Scores of 15 or more indicate severe withdrawal with risk of developing Delirium Tremens.

NAUSEA AND VOMITING – ask 'Do you feel sick to your stomach? Have you vomited? **0** no nausea, no vomiting **1** mild nausea with no vomiting **2** **3** **4** intermittent nausea with dry heaves **5** **6** **7** Constant nausea, dry heaves and vomiting	**TACTILE DISTURBANCES–** ask "have you any itching, pins and needles, burning, numbness, do you feel bugs under your skin? **0** none **1** very mild itching, pins and needles or numbness **2** mild **3** moderate **4** moderately severe hallucinations **5** severe hallucinations **6** extremely severe hallucinations **7** continuous hallucinations
TREMOR arms extended and fingers spread apart, Observe. **0** no tremor **1** not visible, but can be felt fingertip to fingertip **2** **3** **4** moderate with patients arms extended **5** **6** **7** Severe, even without arms extended	**AUDITORY DISTURBANCES-** Ask "are you more aware of sounds around you, are they harsh, frightening, are you hearing things that frighten you or that you know are not there? **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. **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 things you know are not there? **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"? Observe. **0** no anxiety, at ease **1** mild anxiety **2** **3** **4** moderately anxious, or guarded so anxiety is inferred **5** **6** **7** acute panic state as seen in severe delirium or psychosis	**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 of light headedness. **0** not present **1** very mild **2** mild **3** moderate **4** moderately severe **5** severe **6** very severe **7** extremely severe
AGITATION- Observation. **0** normal activity **1** somewhat more than normal anxiety **2** **3** **4** moderately fidgety and restless **5** **6** **7** paces back and forth during most of the interview or constantly thrashes about	**ORIENTATION AND CLOUDING OF SENSORIUM** Ask "what day is this? Where are you? Who am I? **0** orientated and can do serial additions **1** cannot do serial additions or uncertain of date **2** disoriented for date by no more than 2 days **3** disoriented for date by more than 2 days **4** disoriented for place/person
Patients scoring less than 10 do not usually need additional medication for alcohol withdrawal.	**TOTAL CIWA Ar SCORE:** **ASSESSORS INITIALS:**

APPENDIX 10

Order WR5519 Alcohol Withdrawal Assessment Form and Adult Chlordiazepoxide Prescription Chart

APPENDIX 11

Standard Oxazepam regimen

This regime is suitable for patients with alcohol dependence. It is suitable for patients with hepatic impairment and/or COPD and is also suitable for the elderly.

Oxazepam is used in patients with signs and symptoms compatible with moderate to severe liver impairment (ascites, peripheral oedema, jaundice etc.).

Patients who misuse alcohol are at higher risk of intracranial haematoma. Any patient who has sustained a head injury within the previous 48 hours should not receive benzodiazepines, which could significantly alter neurological observations.

The patient's response to treatment should be monitored and dosage adjusted where over – sedation or severe breakthrough symptoms occur.

Day	09:00	13:00	18:00	22:00
1	20mg	20mg	20mg	20mg
2	15mg	15mg	15mg	15mg
3	10mg	10mg	10mg	10mg
4	10mg		10mg	10mg
5	10mg			10mg
6	5mg			5mg

Please note more severely dependent patients may require additional PRN. Regular monitoring of symptoms using the CIWA-Ar will determine need for additional medication. (Max dose 200mg in 24 hours).

Oxazepam does not have UK market authorisation for this indication therefore informed consent should be obtained and documented.

APPENDIX 12

Suggested Lorazepam regimen

This regime is suitable for patients with alcohol dependence. It is suitable for patients with hepatic impairment and/or COPD and is also suitable for the elderly.

Suitable for patients who are unable to take oral medication.

Lorazepam is used in patients with signs and symptoms compatible with moderate to severe liver impairment (ascites, peripheral oedema, jaundice etc.).

Patients who misuse alcohol are at higher risk of intracranial haematoma. Any patient who has sustained a head injury within the previous 48 hours should not receive benzodiazepines, which could significantly alter neurological observations.

The patient's response to treatment should be monitored and dosage adjusted where over–sedation or severe breakthrough symptoms occur.

	LORAZEPAM						
	Moderate to Severe (CIWA-Ar 10-15+) Start here ⬇		**Mild (CIWA-Ar 8-15)** Start here ⬇				Please note more severely dependent patients may require additional PRN especially in the first 48 hours. Regular monitoring of symptoms using the CIWA-Ar will determine need for additional medication.
Day	1	2	3	4	5	6	PRN
Time							½ mg – 1 mg **Maximum dose 8 mg in 24 hours** including regular prescribed
09:00	1 mg	1 mg	½ mg	½ mg	½ mg		
13:00	1 mg	½ mg	½ mg				
18:00	1 mg	½ mg	½ mg	½ mg			
22:00	1 mg	1 mg	½ mg	½ mg	½ mg	½ mg	

Please note Lorazepam does not have UK market authorisation for this indication therefore informed consent should be obtained and documented.

APPENDIX 13

Alcohol-related liver disease

Assessment and diagnosis

- Exclude alternative causes of liver disease in people with a history of harmful or hazardous drinking who have abnormal liver blood test results.
- Refer people to a specialist experienced in the management of alcohol-related liver disease to confirm a clinical diagnosis of alcohol-related liver disease.
- Consider liver biopsy to investigate alcohol-related liver disease. When considering liver biopsy:
  - take into account the risks of morbidity and mortality
  - discuss the risks and benefits with the patient **and**
  - ensure informed consent is obtained.
- Consider a liver biopsy to confirm diagnosis in people with suspected acute alcohol-related hepatitis that is severe enough to need corticosteroid treatment.

Referral for consideration of transplantation

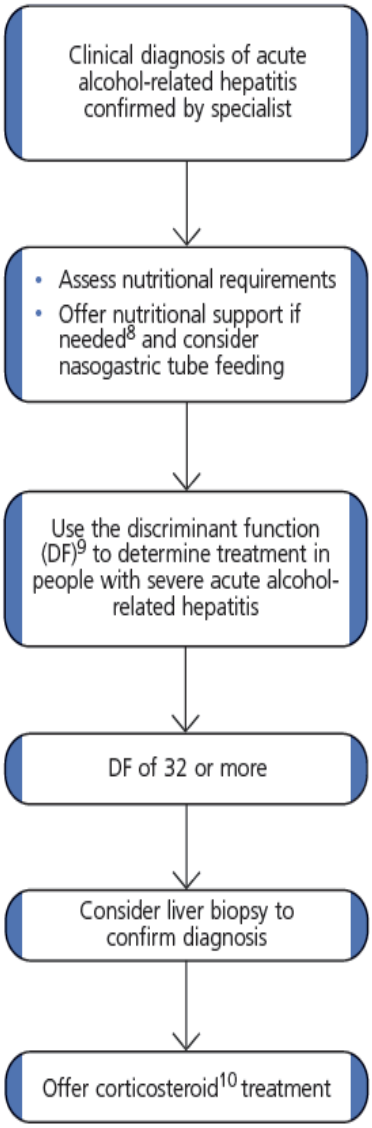
Refer patients with decompensated liver disease to be considered for assessment for liver transplantation if they:

- still have decompensated liver disease after best management and 3 months' abstinence from alcohol **and**
- are otherwise suitable for transplantation[7].

[7] For the nationally agreed guidelines for liver transplant assessment in the context of alcohol-related liver disease, see www.uktransplant.org.uk/ukt/about_transplants/organ_allocation/pdf/liver_advisory_group_alcohol_guidelines-november_2005.pdf

APPENDIX 13

Management of acute alcohol-related hepatitis



Corticosteroids

Are used in UK clinical practice in the management of severe acute alcohol related hepatitis

NICE caution that at the time of writing guideline CG100 **Prednisolone** did not have UK marketing authorisation for this indication. Informed consent should be obtained and documented.

APPENDIX 14

Alcohol-related pancreatitis

Chronic alcohol-related pancreatitis

Diagnosis

For diagnosis of chronic alcohol-related pancreatitis use all of the following:

- the person's symptoms
- imaging to determine pancreatic structure **and**
- tests of pancreatic exocrine and endocrine function.

Use computed tomography as the first-line imaging modality for people with a history and symptoms suggestive of chronic alcohol-related pancreatitis.

Management

- For people with steatorrhoea or poor nutritional status, offer pancreatic enzyme supplements.
- If pain is the only symptom, do not give enzyme supplements.

For people with pain:

- Refer to a specialist centre for multidisciplinary assessment.
- Offer surgery (in preference to endoscopic therapy) to people with large-duct (obstructive) chronic pancreatitis.
- Offer coeliac axis block, splanchnicectomy or surgery to people with small-duct (non-obstructive) chronic pancreatitis if their pain is poorly controlled.

Acute alcohol-related pancreatitis

Management

Offer nutritional support to people with acute alcohol-related pancreatitis:

- early (on diagnosis) **and**
- using enteral tube feeding rather than parenteral support, if possible.

Do not give prophylactic antibiotics to people with mild acute pancreatitis, unless otherwise indicated.

Supporting Document 1 - Equality Impact Assessment Tool

To be completed by the key document author and included as an appendix to key document when submitted to the appropriate committee for consideration and approval.

Please complete assessment form on next page;

Herefordshire & Worcestershire STP - Equality Impact Assessment (EIA) Form
Please read EIA guidelines when completing this form

Section 1 - Name of Organisation (please tick)

Herefordshire & Worcestershire STP		Herefordshire Council		Herefordshire CCG	
Worcestershire Acute Hospitals NHS Trust	x	Worcestershire County Council		Worcestershire CCGs	
Worcestershire Health and Care NHS Trust		Wye Valley NHS Trust		Other (please state)	

Name of Lead for Activity	**Emma Davies**

Details of individuals completing this assessment	**Name**	**Job title**	**e-mail contact**
	Emma Davies	**Alcohol Specialist Nurse**	**Emma.davies22@nhs.net**
Date assessment completed	**04/05/2021**		

Section 2

Activity being assessed (e.g. policy/procedure, document, service redesign, policy, strategy etc.)	**Title: Recognition and Treatment of Alcohol Misuse in Acute Hospital Settings - WAHT-A&E-031 - Version 7**			
What is the aim, purpose and/or intended outcomes of this Activity?	To provide accurate up to date evidence based clinical guidelines to inform practice and care management of patients attending the Trust who may be misusing alcohol.			
Who will be affected by the development & implementation of this activity?	☑ ☑ ❑ ❑	Service User Patient Carers Visitors	☑ ❑ ❑ ❑	Staff Communities Other _____
Is this:	☑Review of an existing activity ❑ New activity ❑ Planning to withdraw or reduce a service, activity or presence?			

What information and evidence have you reviewed to help inform this assessment? (Please name sources, eg demographic information for patients / services / staff groups affected, complaints etc.	41. **Becker HC. (1998)** Kindling in alcohol withdrawal. Alcohol Health and Research World.;22(1):25-33.] Accessed online 20-08-2020 at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6761822/ 42. **BNF (2017) British National Formulary** accessed online 01-09-2017 at, https://bnf.nice.org.uk/drug/chlordiazepoxide-hydrochloride.html#indicationsAndDoses 43. ***DVLA2017] accessed online 07-09-2017*** *https://www.gov.uk/guidance/drug-or-alcohol-misuse-or-dependence-assessing-fitness-to-drive* 44. **NCEPOD (2013**) Measuring the Units A review of patients who died with alcohol-related liver disease. 45. **NICE PHG 24 (2010)** Alcohol use disorders: Preventing harmful drinking. Public Health Guidance 24 (Quick reference guide) 46. **NICE CG 100 (2010)** Alcohol Use Disorders. Diagnosis and clinical management of alcohol – related physical complications. (Quick reference guide) 47. **NICE CG 100/115 (2010)** Alcohol use disorders: sample chlordiazepoxide dosing regimens for use in managing alcohol withdrawal 48. **NICE CG 115 (2011)** Alcohol-use disorders: diagnosis, assessment and management of harmful drinking (high-risk drinking) and alcohol dependence 49. **Stockwell, T., Murphy, D. & Hodgson, R. (1983).** The severity of alcohol dependence questionnaire: Its use, reliability and validity. British Journal of Addiction, 78(2), 45-156. 50. WAHT Medicines Safety Committee 51. Urgent Care Divisional Governance
Summary of engagement or consultation undertaken (e.g. who and how have you engaged with, or why do you believe this is not required)	Document was disseminated for comments to the following groups: • Service Lead Consultants • Pharmacy • Clinical Specialist Clinicians and Matrons • Governance Leads • Community Substance Misuse service
Summary of relevant findings	All approved, any comments were responded to and changes incorporated into the policy accordingly.

Section 3

Please consider the potential impact of this activity (during development & implementation) on each of the equality groups outlined below. **Please tick one or more impact box below for each Equality Group and explain your rationale**. Please note it is possible for the potential impact to be both positive and negative within the same equality

group and this should be recorded. Remember to consider the impact on e.g. staff, public, patients, carers etc. in these equality groups.

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Age	x			The policy takes into account the differences between age and metabolism of medications, therefore suggesting alternative dosing if appropriate it does not discriminate between ages of service user. The policy does not apply to those under the age of 18 years.
Disability	x			The policy provides clinical guidelines for use of any adult attending and acute hospital setting who are dependent upon or using alcohol in a harmful manner.
Gender Reassignment	x			The policy refers to any adult regardless of gender.
Marriage & Civil Partnerships	x			
Pregnancy & Maternity	x			This policy is not specific to maternity or pregnancy, however in relation to the identification and screening of alcohol misuse, If you are pregnant or planning a pregnancy the safest approach is not to drink alcohol at all, to keep risks to your baby to a minimum. **[UKCMO** (2016)**]**
Race including Traveling Communities	x			No concerns identified
Religion & Belief	x			No concerns identified
Sex	x			None
Sexual Orientation	x			None
Other Vulnerable and Disadvantaged Groups (e.g. carers; care leavers; homeless; Social/Economic deprivation, travelling communities etc.)	x			None
Health Inequalities (any	x			None

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
preventable, unfair & unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental & economic conditions within societies)				

Section 4

What actions will you take to mitigate any potential negative impacts?	Risk identified	Actions required to reduce / eliminate negative impact	Who will lead on the action?	Timeframe
		.		
How will you monitor these actions?				
When will you review this EIA? (e.g in a service redesign, this EIA should be revisited regularly throughout the design & implementation)	**This EIA will be reviewed alongside the agreed policy review date.**			

Section 5 - Please read and agree to the following Equality Statement

1. Equality Statement

1.1. All public bodies have a statutory duty under the Equality Act 2010 to set out arrangements to assess and consult on how their policies and functions impact on the 9 protected characteristics: Age; Disability; Gender Reassignment; Marriage & Civil Partnership; Pregnancy & Maternity; Race; Religion & Belief; Sex; Sexual Orientation
1.2. Our Organisations will challenge discrimination, promote equality, respect human rights, and aims to design and implement services, policies and measures that meet the diverse needs of our service, and population, ensuring that none are placed at a disadvantage over others.
1.3. All staff are expected to deliver services and provide services and care in a manner which respects the individuality of service users, patients, carer's etc, and as such treat them and members of the workforce respectfully, paying due regard to the 9 protected characteristics.

Signature of person completing EIA	Emma Davies
Date signed	04/05/2021
Comments:	
Signature of person the Leader Person for this activity	Emma Davies
Date signed	04/05/2021
Comments:	

Supporting Document 2 – Financial Impact Assessment

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

	Title of document:	Yes/No
1.	Does the implementation of this document require any additional Capital resources	no
2.	Does the implementation of this document require additional revenue	no
3.	Does the implementation of this document require additional manpower	no
4.	Does the implementation of this document release any manpower costs through a change in practice	no
5.	Are there additional staff training costs associated with implementing this document which cannot be delivered through current training programmes or allocated training times for staff	no
	Other comments:	

If the response to any of the above is yes, please complete a business case and which is signed by your Finance Manager and Directorate Manager for consideration by the Accountable Director before progressing to the relevant committee for approval.