Managing Alcohol Withdrawal Syndrome Using CIWA-Ar Order Set

Frequently Asked Questions (FAQs)

Q. Do I need a physician’s order to initiate a CIWA assessment?
A. No. On admission or at any time you suspect your patient is at risk for alcohol withdrawal symptoms, you should do a CIWA assessment. Notify the physician of your findings and your concern that they are at risk for withdrawal. To use the entire order set, including the lorazepam sliding scale, requires a physician to order the Alcohol Withdrawal Order Set - NonICU.

Q. How do I access the order set?
A. The order is an option under “Order Sets.” Select > enter orders > order set > dx alc wd non ICU. The order set includes a sliding scale lorazepam as well as adjunctive medications and nursing orders specific to alcohol withdrawal. The order set should not be used in conjunction with other medications used to treat withdrawal, e.g., Librium or Valium, and care must be taken with concurrent use of other sedating medications such as opioids (e.g. morphine, Percocet) and antiemetics (e.g. Phenergan) to avoid over-sedation and respiratory suppression.

Q. Can this order set be used on ICU patients?
A. This order set is not appropriate for ventilated or otherwise unresponsive patients for whom a full CIWA assessment is not possible. It can, however, be used on any unit, including ICU and Progressive Care, when the patient’s condition allows for assessment of the CIWA parameters.

Q. Where do I get the CIWA flow sheet?
A. It can be printed from One Source. Clinical Care > Best Practice > Guidelines > Alcohol Withdrawal as a Secondary Diagnosis. It can also be found as a Frequent Monitoring Flow Sheet in Essentris.

Q. How long do we continue the orders for the AWS protocol, i.e., q 4 hr assessment, after admission?
A. The protocol states that we may stop CIWA after 24 hours of a CIWA under “8.” This is based on the premise that after 24 hours of abstinence, at least some symptoms and signs of alcohol withdrawal will occur, if they are going to occur. However, we know that certain things might trigger the response, i.e., surgery, etc., and you might see symptoms of alcohol withdrawal occurring long after the 24-hour window specified in the order set. Use your nursing judgment and acute assessment skills to recognize the need to call the physician for an order to reinstitute the protocol.

Q. Why do I see wide variations in the scoring of the CIWA assessment? Is it possible for one nurse to obtain a score of “6” and another to obtain a much higher score?
A. When completing a CIWA assessment, follow the instructions and descriptors carefully for each measurement parameter. Don’t evaluate on your “gut feeling.” Explain to patients that you must go through specific questions and observations with each assessment in order to treat them correctly and keep them safe. For example, have patients put their arms out to detect tremors. Feel their palms to see if they are moist; ask them if they feel sweaty. Ask if their skin feels any different. Ask “do you feel nervous, jittery?” Ask if they seem to be more bothered by bright lights, are they seeing/hearing things they think they shouldn’t be seeing/hearing? Of course, you are going to want to observe non-verbal clues, but include the patient in your assessment. Don’t be afraid that the power of suggestion is going to give inaccurate answers; we have to trust that they are telling us the truth.

Q. If the patient is only a “6” on the CIWA scale, but still complains of being “nervous” should I just give the prn lorazepam?
A. The PRN lorazepam is for breakthrough symptoms of alcohol withdrawal. If the patient is a “6,” but is complaining of being anxious, go through the assessment carefully to see if you are missing something. Chances are, if you go through the entire assessment, you will find the score is higher than you thought, particularly if the patient is verbalizing the need for “help.” If it seems that the patient’s anxiety is unrelated to withdrawal symptoms, notify MD to confirm the most appropriate intervention to address the patient’s anxiety.

Q. Does the route of the lorazepam matter in how it controls the patient’s symptoms; is one route more effective and/or safer than the other?
A. IV lorazepam takes effect more rapidly; however, the bioavailability of oral (enteral) lorazepam is similar to that of IV. Patients requiring lorazepam every 1-2 hours will likely benefit from a more rapid onset of effect, so the IV route may be preferred. Patients requiring lorazepam only every 3-4 hours may do just as well with oral medication.
Q. I have been trying to get the patient sedated all night; do you really want me to wake him/her for an assessment?
A. Yes, he/she should be wakened for the assessment. If he/she is sedated properly, he/she will wake easily and return quickly to a resting state.

Q. It just seems I am giving so much of the medication. Isn’t there a danger that I might over medicate?
A. The absence of alcohol causes brain hyperactivity. If the patient is a heavy drinker, a large amount of lorazepam may be needed to replace the large amount of alcohol that the patient’s brain is accustomed to. Lorazepam has a relatively rapid onset of action and a relatively short half life, which makes it safe to be used in the sliding scale as prescribed. The critical safety activity is frequent reassessment of the patient using the CIWA. You want the patient to be dozing, but easily awakened. Also a dose of flumazenil (Ramazicon) is in the order set, in case your patient develops respiratory suppression.

Q. At what point should this patient be transferred to a higher level of care?
A. Although there is always room for clinical judgment, if the patient’s CIWAA score remains above 15 for 4 hours despite hourly administration of lorazepam per protocol, a higher level of care should be considered. Rapid worsening of symptoms or vital signs (i.e., hypertension/hypotension, tachycardia/bradycardia), hyperthermia/hypothermia) should also trigger consideration of transfer to a higher level of care.

Q. When do you use the other suggested medications such as clonidine or metoprolol?
A. Use clonidine if lorazepam is contraindicated and the patient is not bradycardic. Clonidine and lorazepam are not often used together, but combined use is not contraindicated. Metoprolol should be administered ONLY after the patient has been adequately sedated with benzodiazepine, or if the patient has evidence of myocardial ischemia, in which case emergent transfer to cardiac care is indicated.

Q. Do all patients going through withdrawal need a sitter?
A. Just as with everything, there are degrees of the severity of alcohol withdrawal. If the patient has a history of alcohol withdrawal, the severity of subsequent bouts of withdrawal may typically be worse. Appropriate use of lorazepam, using symptoms measured by the CIWA scale, should limit the severity of symptoms. If the patient, however, exhibits delirium or marked agitation, potentially causing harm to self or others, a sitter may be needed until symptoms subside.

Q. Do you ever use restraints on a patient going through alcohol withdrawal?
A. Only if other measures to maintain the patient’s safety are not successful. Restraints in general tend to increase agitation, so limit their use to as short a period as possible to maintain safety. As you would any patient, think of alternatives to restraints and use the least restrictive as your first choice: bed alarms, locking bed belt, freedom splints. Remember, you will need a physician order for the restraints. All patients in AWS should be on fall precautions and aspiration precautions.

Q. Should the patient on the AWS protocol travel with an RN?
A. Again, it depends on the severity of the symptoms. If the patient’s symptoms are escalating, requiring a q 1 hour lorazepam, the patient should be accompanied by an RN, or consider postponing the test until the patient is calmer. When making any determination, think to yourself, “How safe will he/she be in any circumstance and/or what could happen if he/she gets just a little worse?” Always error on the side of caution.

REMEMBER
The national mortality of 20 percent of patients hospitalized with delirium tremens has been decreased to 5 percent because of the aggressive use of benzodiazepines. These patients can be very sick. The Guideline and Order Set for treating acute alcohol withdrawal syndrome provide valuable tools to prevent the progression of this disease process.

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