Alcohol Withdrawal Assessment Scoring Guidelines

Nausea/Vomiting - Rate on scale 0 - 7

0 - None
1 - Mild nausea with no vomiting
2
3
4 - Intermittent nausea
5
6
7 - Constant nausea and frequent dry heaves and vomiting

Tremors - have patient extend arms & spread fingers. Rate on scale 0 - 7.
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 w/ arms not extended

Anxiety - Rate on scale 0 - 7
0 - no anxiety, patient at ease
1 - mildly anxious
2
3
4 - moderately anxious or guarded, so anxiety is inferred
5
6
7 - equivalent to acute panic states seen in severe delirium or acute schizophrenic reactions.

Agitation - Rate on scale 0 - 7
0 - normal activity
1 - somewhat normal activity
2
3
4 - moderately fidgety and restless
5
6
7 - paces back and forth, or constantly thrashes about

Paroxysmal Sweats - Rate on Scale 0 - 7.
0 - no sweats
1- barely perceptible sweating, palms moist
2
3
4 - beads of sweat obvious on forehead
5
6
7 - drenching sweats

Orientation and clouding of sensorium - Ask, "What day is this? Where are you? Who am I?" Rate scale 0 - 4
0 - Oriented
1 – cannot do serial additions or is uncertain about date

2 - disoriented to date by no more than 2 calendar days

3 - disoriented to date by more than 2 calendar days
4 - Disoriented to place and / or person

Tactile disturbances - Ask, "Have you experienced any itching, pins & needles sensation, burning or numbness, or a feeling of bugs crawling on or under your skin?"
0 - none
1 - very mild itching, pins & needles, burning, or numbness
2 - mild itching, pins & needles, burning, or numbness
3 - moderate itching, pins & needles, burning, or numbness
4 - moderate hallucinations
5 - severe hallucinations
6 - extremely severe hallucinations
7 - continuous hallucinations

Auditory Disturbances - Ask, "Are you more aware of sounds around you? Are they harsh? Do they startle you? Do you hear anything that disturbs you or that you know isn't there?"
0 - not present
1 - Very mild harshness or ability to startle

2 - mild harshness or ability to startle
3 - moderate harshness or ability to startle

4 - moderate hallucinations
5 - severe hallucinations
6 - extremely severe hallucinations
7 - continuous hallucinations

Visual disturbances - Ask, "Does the light appear to be too bright? Is its color different than normal? Does it hurt your eyes? Are you seeing anything that disturbs you or that you know isn't there?"
0 - not present
1 - very mild sensitivity
2 - mild sensitivity
3 - moderate sensitivity
4 - moderate hallucinations
5 - severe hallucinations
6 - extremely severe hallucinations
7 - continuous hallucinations

Headache - Ask, "Does your head feel different than usual? Does it feel like there is a band around your head?" Do not rate dizziness or lightheadedness.

0 - not present
1 - very mild
2 - mild
3 - moderate
4 - moderately severe
5 - severe
6 - very severe
7 - extremely severe

Procedure:

1. Assess and rate each of the 10 criteria of the CIWA scale. Each criterion is rated on a scale from 0 to 7, except for "Orientation and clouding of sensorium" which is rated on scale 0 to 4. Add up the scores for all ten criteria. This is the total CIWA-Ar score for the patient at that time. **Prophylactic medication should be started for any patient with a total CIWA-Ar score of 8 or greater** (ie. start on withdrawal medication). If started on scheduled medication, additional **PRN medication should be given for a total CIWA-Ar score of 15 or greater.**
   Document obs and CIWA-Ar assessment in the patients' notes. Document administration of PRN medications on drug kardex.
2. The CIWA-Ar scale is the most sensitive tool for assessment of the patient experiencing alcohol withdrawal. Nursing assessment is vitally important. Early intervention for CIWA-Ar score of 8 or greater provides the best means to prevent the progression of withdrawal.

Blackpool Teaching Hospitals NHS
NHS Foundation Trust

Clinical Institute Withdrawal Assessment – Alcohol, revised (CIWA-Ar)

See reverse for guidelines on use

Write patient details or affix Identification label

Hospital Number:
Name:
Address:

Date of Birth
NHS Number

Date of Birth:
NHS Number:

Assessment Protocol a. Obs & Assessment Now. b. If initial score ≥ 8 repeat hourly for 8 hrs, then if stable 2 hourly for 8 hrs, then if stable 4 hourly. c. If initial score < 8, assess 4 hourly for 72 hrs. If score < 8 for 72 hrs, discontinue assessment. If score ≥ 8 at any time, go to (b) above. d. If indicated, (see indications below) administer PRN medications													
	Date												
	Time												
	Pulse												
	Resps												
	SPO2												
	BP												
Assess and rate each of the following (CIWA-Ar Scale):		**Refer to reverse for detailed instructions in use of the CIWA-Ar scale.**											
Nausea/vomiting (0 - 7) 0 - none; 1 - mild nausea ,no vomiting; 4 - intermittent nausea; 7 - constant nausea , frequent dry heaves & vomiting.													
Tremors (0 - 7) 0 - no tremor; 1 - not visible but can be felt; 4 - moderate w/ arms extended; 7 - severe, even w/ arms not extended.													
Anxiety (0 - 7) 0 - none, at ease; 1 - mildly anxious; 4 - moderately anxious or guarded; 7 - equivalent to acute panic state													
Agitation (0 - 7) 0 - normal activity; 1 - somewhat normal activity; 4 - moderately fidgety/restless; 7 - paces or constantly thrashes about													
Paroxysmal Sweats (0 - 7) 0 - no sweats; 1 - barely perceptible sweating, palms moist ; 4 - beads of sweat obvious on forehead; 7 - drenching sweat													
Orientation (0 - 4) 0 - oriented; 1 - uncertain about date; 2 - disoriented to date by no more than 2 days; 3 - disoriented to date by > 2 days; 4 - disoriented to place and / or person													
Tactile Disturbances (0 - 7) 0 - none; 1 - very mild itch, P&N, ,numbness; 2-mild itch, P&N, burning, numbness; 3 - moderate itch, P&N, burning numbness; 4 - moderate hallucinations; 5 - severe hallucinations; 6 – extremely severe hallucinations; 7 - continuous hallucinations													
Auditory Disturbances (0 - 7) 0 - not present; 1 - very mild harshness/ ability to startle; 2 - mild harshness, ability to startle; 3 - moderate harshness, ability to startle; 4 - moderate hallucinations; 5 severe hallucinations; 6 - extremely severe hallucinations; 7 - continuous. hallucinations													
Visual Disturbances (0 - 7) 0 - not present; 1 - very mild sensitivity; 2 - mild sensitivity; 3 - moderate sensitivity; 4 - moderate hallucinations; 5 - severe hallucinations; 6 - extremely severe hallucinations; 7 - continuous hallucinations													
Headache (0 - 7) 0 - not present; 1 - very mild; 2 - mild; 3 - moderate; 4 - moderately severe; 5 - severe; 6 - very severe; 7 - extremely severe													
Total CIWA-Ar score:													
Time of PRN medication administration:													
Assessment of response (CIWA-Ar score 30-60 minutes after medication administered)													
Nurse Initials													

Scale for Scoring: **Total Score =**

0 – 9: absent or minimal withdrawal
10 – 19: mild to moderate withdrawal
more than 20: severe withdrawal

Indications for PRN medication:

a. Total CIWA-AR score 8 or higher if ordered PRN only (Symptom-triggered method).
b. Total CIWA-AR score 15 or higher if on a reducing regime. (Reducing regime + PRN method)

For Senior review if : Total score above **35**, if hourly assessment required for more than 8hrs, more than 4 mg/hr lorazepam over 3 hours, or respiratory distress.