CIWA-Ar Screening Tool

For Assessment of Patient with Alcohol Withdrawal

Southern Health-Santé Sud
Alcohol Withdrawal Program
October 2023

Alcohol Withdrawal Syndrome **(AWS)**

Usually develops in alcohol-dependent patients within 6 – 24 hoursafter abrupt discontinuation or *decrease in alcohol consumption*.

- Tremors, Diaphoresis, Nausea, Vomiting, Hypertension, Tachycardia, Hyperthermia, Tachypnea

- Visual (most often), auditory & tactile hallucinations
- Not associated with altered cognitions (ie. disorientation).
- *Vitals are usually normal*

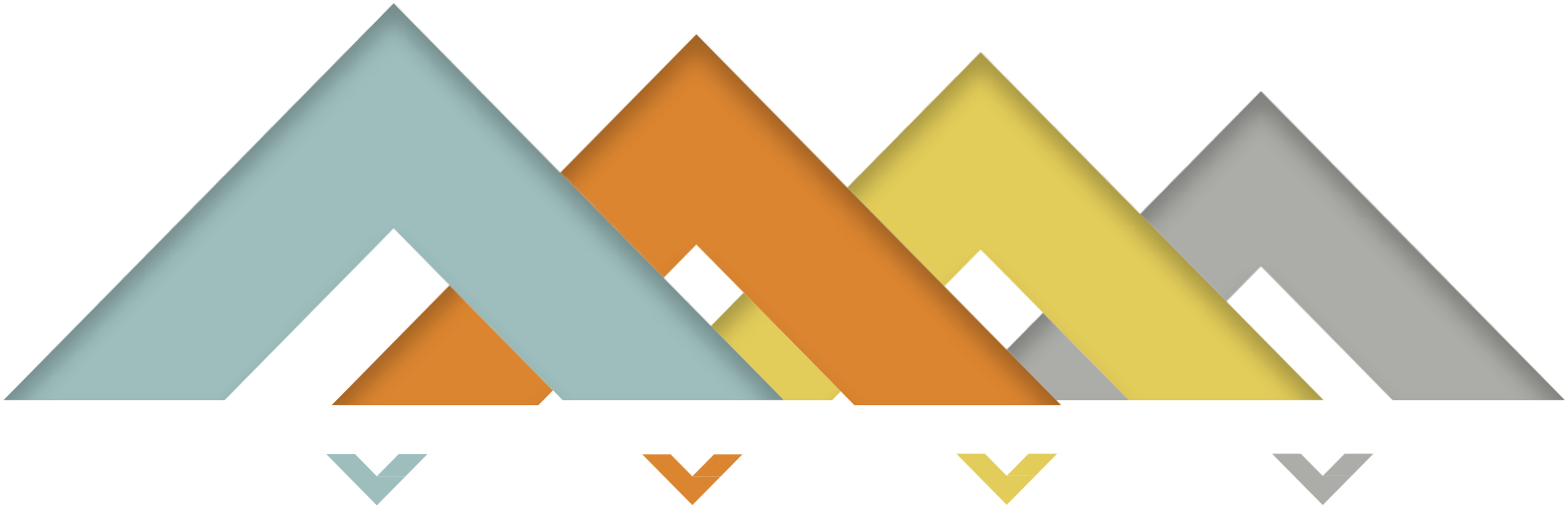
- Usually grand mal (tonic-clonic, short or no postictal period)

A medical emergency!

- Delirium, psychosis, hallucinations, intense agitation, hyperthermia, hypertension, seizures, coma

The Who, What, When & Why of **CIWA-Ar!**

CIWA-Ar is a scientifically validated screening tool used to predict the *severity* of alcohol withdrawal. It is not a diagnostic test for withdrawal.



WHO?

Nurses &

Physicians

WHAT?

- CIWA-Ar Flowsheet
- Standard Orders *(coming soon)*
- IPN
- Glasgow coma scale (in cases of severe withdrawal)

WHEN?

May be initiated in ED and/or continue/be initiated on the adult units

WHY?

- To standardize the care approach
- To align with best practice

CIWA-Ar
Alcohol Withdrawal Assessment Flowsheet

For patients with CIWA-Ar ordered, perform vitals as per the "Assessment Protocol"

There are 10 items to be assessed (a combination of subjective and objective data)

Record the score for each of the 10 items on the flowsheet. Total the column and initial.

Some items DO NOT permit scores of 2, 3, 5 or 6. You must select only from the options listed.

Note that 'Orientation' has a range of 0 – 4 unlike others which range from 0 – 7

The total score determines the frequency of reassessments and medications required

Southern Health Santé Sud

Alcohol Withdrawal Assessment Flowsheet

CIWA-Ar MOCKUP

Using the CIWA-Ar Scale, record the score of each item, then total the scores. Record the action(s)*taken and the result.

Ina Minute
26-Mar-1668

Assessment Protocol								
a. Vitals, CIWA-Ar Assessment on initiation and BEFORE each Benzodiazepine done. THEN; b. Continue CIWA-Ar q1h until score less than 10 x 3 consecutive measurements. THEN; c. If score remains less than 10 continue q4h x 2 then q8h x 6. If score remains less than 10 continue CIWA-Ar once daily x 72 hours. Then discontinue. IF score greater than 10 at ANYTIME, go to (b) above.	DATE (DD/MM/YYYY)	18/07/2022						
	TIME (24HOUR)	1730						
	PULSE							
	RESPIRATORY RATE							
	0_2 Saturations							
	Blood Pressure							
Nausea/Vomiting ..... (0-7) 0-none; 1-mild nausea; 4-intermittent nausea with dry heaves; 7-constant nausea, frequent dry heaves and vomiting		4						
..... (0-7) …ed; 7-severe, even with arms not extended		0						
Anxiety ..... (0-7) 0-none, at ease; 1-mildly anxious; 4-moderatly anxious or guarded; 7-equivalent to acute panic state		4						
Agitation ..... (0-7) 0-normal activity; 1-somewhat normal activity; 4-moderatly fidgety/restless; 7-paces or constantly thrashes about		4						
Paroxysmal Sweats..... (0-7) 0-no sweats; 1-barely perceptible sweating, palms moist; 4-beads of sweat obvious on forehead; 7-drenching sweat		1						
Orientation..... (0-4) 0-oriented; 1-uncertain about date; 2-disoriented to date by no more than 2 days; 3-disoriented to date by greater than 2 days; 4 – disoriented to date and/or person		3						
Tactile Disturbances ..... (0-7) 0-none; 1-very mild itch, tingling, numbness; 2-mild itch, tingling, burning, numbness; 3-moderate itch, tingling, burning, numbness; 4-moderate hallucinations; 5-severe hallucinations; 6-extremely severe hallucinations; 7-continuous hallucinations		0						
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		4						
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		0						
Headache ..... (0-7) 0-not present; 1-very mild; 2-mild; 3-moderate; 4-moderately severe; 5-severe; 6-very severe; 7-extremely severe		0						
TOTAL CIWA-Ar Score/Initials:		20 LS						

Scale for Scoring: Total Score
0-9 ..... = absent or minimal withdrawal
10-19 ..... = mild to moderate withdrawal
More than 19 ..... = severe withdrawal

Interpreting the CIWA-Ar Score

CIWA-Ar Score (max. score of 67)	**Indicative of**	**Interventions**
0 - 9	Absent / minimal withdrawal	As per the applicable Alcohol Withdrawal Standard Orders.
10 - 19	Mild to moderate withdrawal	
More than 19	Severe withdrawal	

CIWA-Ar Assessment Flowsheet:
Patient Questions

CIWA-Ar Assessment Flowsheet: Patient Questions

These are possible questions to ask a patient during an assessment when using the CIWA-Ar scoring tool.

Assess and rate each of the following (CIWA-Ar Scale)	Questions:
Nausea/Vomiting 0-none; 1-mild nausea; 4-intermittent nausea with dry heaves; 7-constant nausea, frequent dry heaves and vomiting	"Do you feel sick to your stomach? Have you vomited?"
Tremor 0-none; 1-not visible but can be felt; 4-moderate with arms extended; 7-severe, even with arms not extended	Extend your arms and spread your fingers apart.
Anxiety 0-none, at ease; 1-mildly anxious; 4-moderatly anxious or guarded; 7-equivalent to acute panic state	"Do you feel nervous?"
Agitation 0-normal activity; 1-somewhat normal activity; 4-moderatly fidgety/restless; 7-paces or constantly thrashes about	*Observe patient*
Paroxysmal Sweats 0-no sweats; 1-barely perceptible sweating, palms moist; 4-beads of sweat obvious on forehead; 7-drenching sweat	*Observe patient*
Orientation 0-oriented; 1-uncertain about date; 2-disoriented to date by no more than 2 days; 3-disoriented to date by greater than 2 days; 4 – disoriented to date and/or person	"What day is this? Where are you? Who am I?"
Tactile Disturbances 0-none; 1-very mild itch, tingling, numbness; 2-mild itch, tingling, burning, numbness; 3-moderate itch, tingling, burning, numbness; 4-moderate hallucinations; 5-severe hallucinations; 6-extremely severe hallucinations; 7-continuous hallucinations	"Have you any itching, pins and needles sensation, any burning or numbness or do you feel bugs crawling on your skin?"
Auditory Disturbances 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	"Are you more aware of sounds around you? Are they harsh? Do they frighten you? Are you hearing anything that is disturbing you? Are you hearing things you know are not there?"
Visual Disturbances 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	"Does the light appear to be too bright? Is its color different? Does it hurt your eyes? Are you seeing anything that is disturbing you? Are you seeing things you know that are not there?"
Headache 0-not present; 1-very mild; 2-mild; 3-moderate; 4-moderately severe; 5-severe; 6-very severe; 7-extremely severe	"Does your head feel different? Does it feel like there is a band around your head?" Do not rate for dizziness or light-headedness.

Case Study #1

Josie is a 58 year old female with paranoid schizophrenia. She drinks "occasionally". Her daughter brought her to the Emergency Dept. last night with confusion and mild agitation. She received Haldol 5 mg & Ativan 2 mg with good effect. It's 10 hours later and she has just been admitted to your unit. CIWA-Ar was ordered by the physician.

Josie presents with:

- Intermittent nausea
- No tremor
- Moderately anxious/guarded
- Moderately fidgety/restless
- Moist palms
- Disoriented by date by greater than 2 days
- No tactile disturbances
- Moderate auditory hallucinations
- No visual disturbances
- No headache

Note re: scoring orientation/hallucinations: If there is **no change from baseline** (i.e. has chronic auditory hallucinations), may not include in total score but mark with an asterisk and write an IPN providing rationale.

Alcohol Withdrawal Assessment Flowsheet (CIWA-Ar)

Instructions: Using the CIWA-Ar Scale, record the score for each item, then total the scores and record the action(s) taken*

Assessment Protocol		
a. Vitals, CIWA-Ar Assessment on initiation and BEFORE each Benzodiazepine dose. THEN; b. Continue CIWA-Ar q1h until score less than 10 x 3 consecutive measurements. THEN; c. If score remains less than 10 continue q4h x 2, then q8h x 6. If score remains less than 10 continue CIWA-Ar once daily x 72 hours. Then discontinue. If score greater than 10 at ANYTIME, go to (b) above.	Date (DD/MMM/YYYY)	28/09/2020
	Time (24 HOUR)	1730
	Pulse	
	Respiratory Rate	
	O_2 Saturations	
	Blood Pressure	

Assess and rate each of the following (CIWA-Ar Scale)	
Nausea/Vomiting (0 - 7) 0 - none; 1 - mild nausea, no vomiting; 4 - intermittent nausea; 7 - constant nausea, frequent dry heaves and vomiting	4
Tremor (0 - 7) 0 - no tremor; 1 - not visible but can be felt; 4 - moderate with arms extended; 7 - severe, even with arms not extended	0
Anxiety (0 - 7) 0 - none, at ease; 1 - mildly anxious; 4 - moderately anxious or guarded; 7 - equivalent to acute panic state	4
Agitation (0 - 7) 0 - normal activity; 1 - somewhat normal activity; 4 - moderately fidgety/restless; 7 - paces or constantly thrashes about	4
Paroxysmal Sweats (0 - 7) 0 - no sweats; 1 - barely perceptible sweating, palms moist; 4 - beads of sweat obvious on forehead; 7 - drenching sweat	1
Orientation (0 - 4) 0 - oriented; 1 - uncertain about date; 2 - disoriented to date by no more than 2 days; 3 - disoriented to date by greater than 2 days; 4 - disoriented to place and/or person	3
Tactile Disturbances (0 - 7) 0 - none; 1 - very mild itch, tingling, numbness; 2 - mild itch tingling, burning, numbness; 3 - moderate itch, tingling, burning, numbness; 4 - moderate hallucinations; 5 - severe hallucinations; 6 - extremely severe hallucinations; 7 - continuous hallucinations	0
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	4
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	0
Headache (0 - 7) 0 - not present; 1 - very mild; 2 - mild; 3 - moderate; 4 - moderately severe; 5 - severe; 6 - very severe; 7 - extremely severe	0
TOTAL CIWA-Ar Score/Initials:	20 LS

Case Study #2

Trevor was admitted 2 days ago with depression. On admission he reported "occasional" alcohol usage but overnight developed symptoms of alcohol withdrawal. He has been confused, trying to find the conservation office.

<u>Trevor reports:</u>

- No nausea
- No tremor
- Mildly anxious
- Moderately fidgety/restless
- No sweats
- Not oriented to date and place
- **Mild** itch
- No auditory disturbances
- Moderate visual sensitivity
- Mild Headache
- VS: R 22; O2 sat 97% on Room Air; BP 160/92; P 142; T 37.7

Trevor is confused about his whereabouts (is looking for conservation office), so you need to score this as a 4, as 4 is the only option which includes disorientation to place

Alcohol Withdrawal Assessment Flowsheet (CIWA-Ar)

Instructions: Using the CIWA-Ar Scale, record the score for each item, then total the scores and record the action(s) t*

Assessment Protocol		
a. Vitals, CIWA-Ar Assessment on initiation and BEFORE each Benzodiazepine dose. THEN; b. Continue CIWA-Ar q1h until score less than 10 x 3 consecutive measurements. THEN; c. If score remains less than 10 continue q4h x 2, then q8h x 6. If score remains less than 10 continue CIWA-Ar once daily x 72 hours. Then discontinue. If score greater than 10 at ANYTIME, go to (b) above.	Date (DD/MMM/YYYY)	10/10/20
	Time (24 HOUR)	1615
	Pulse	
	Respiratory Rate	
	O_2 Saturations	
	Blood Pressure	

Assess and rate each of the following (CIWA-Ar Scale)	
Nausea/Vomiting (0 - 7) 0 - none; 1 - mild nausea, no vomiting; 4 - intermittent nausea; 7 - constant nausea, frequent dry heaves and vomiting	
Tremor (0 - 7) 0 - no tremor; 1 - not visible but can be felt; 4 - moderate with arms extended; 7 - severe, even with arms not extended	0
Anxiety (0 - 7) 0 - none, at ease; 1 - mildly anxious; 4 - moderately anxious or guarded; 7 - equivalent to acute panic state	1
Agitation (0 - 7) 0 - normal activity; 1 - somewhat normal activity; 4 - moderately fidgety/restless; 7 - paces or constantly thrashes about	4
Paroxysmal Sweats (0 - 7) 0 - no sweats; 1 - barely perceptible sweating, palms moist; 4 - beads of sweat obvious on forehead; 7 - drenching sweat	0
Orientation (0 - 4) 0 - oriented; 1 - [illegible] to date by no more than 2 days; 3 - disoriented to date by greater than 2 days; 4 - disoriented to place and/or person	4
Tactile Disturbances (0 - 7) 0 - none; 1 - very mild itch, tingling, numbness; 2 - mild itch tingling, burning, numbness; 3 - moderate itch, tingling, burning, numbness; 4 - moderate hallucinations; 5 - severe hallucinations; 6 - extremely severe hallucinations; 7 - continuous hallucinations	2
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	0
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	3
Headache (0 - 7) 0 - not present; 1 - very mild; 2 - mild; 3 - moderate; 4 - moderately severe; 5 - severe; 6 - very severe; 7 - extremely severe	2
TOTAL CIWA-Ar Score/Initials:	16 LS

References

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Public Health Agency of Canada. (2020). Communicating about Substance Use in Compassionate, Safe, and Non-Stigmatizing Ways: Resource for Canadian Health Professional Organizations and their Membership. Retrieved from https://www.canada.ca/content/dam/phacaspc/documents/services/publications/healthy-living/communicating-about-substance-use-compassionate-safe-non-stigmatizing-ways-2019/guilding-rinciples-eng.pdf

WRHA Emergency Program Guideline. (2020). *Management of a Patient with Alcohol Withdrawal*. Retrieved from https://home.wrha.mb.ca/emergency/files/management-of-pt-with-aw-guideline.pdf

Note: This is a modified version of the HSC Mental Health Program (June 2022) and Victoria General Hospital's CIWA-Ar presentation (Sept 2020).