Name: _____

DOB: _____

Band #: _____

Health Card: _____

KASHECHEWAN NURSING STATION

Clinical Institute Withdrawal Assessment for Alcohol (CIWA-A)

Addiction Research Foundation

Date / Time										
a) Nausea & Vomiting (0-7)										
b) Tremor (0-7)										
c) Sweats (0-7)										
d) Anxiety (0-7)										
e) Agitation (0-7)										
f) Tactile (0-7) Disturbances										
g) Auditory (0-7) Disturbances										
h) Visual (0-7) Disturbances										
i) Headache (0-7) Head Fullness										
j) Orientation (0-4)										
Total Score (Max = 67)										
Vital Signs – Temp										
Vital Signs – Pulse										
Vital Signs – Resp.										
Vital Signs – BP										
Initials										

Diazepam Loading Protocol for Alcohol Withdrawal

For CIWA score of ≥, loading protocol will not prevent seizures in patients taking large doses of benzodiazepines or barbiturates I addition to alcohol. A physician must write CIWA-Ar protocol and pharmacological orders on the physician's order sheet.

Basic Protocol	• Diazepam 20mg PO q1-2h until symptoms abate (*some inpatients require several hundred milligrams)* • Observe for 1-2 hours after last dose • Thiamine 100mg IM, then 100mg PO for 3 days • Take-home medication is generally not required, if take-home diazepam is necessary, give no more than 2-3@ 10mg tablets
History of withdrawal seizures	• Diazepam 20mg PO q1h for a **minimum** of three doses.
If can not tolerate oral diazepam	• Diazepam 2-5mg IV/min – maximum 10-20mg q1h; or Lorazepam SL.
If severe liver disease, severe asthma or respiratory failure:	• Lorazepam SL, PO 1-2mg tid-qid or… • Oxazepam 15-30g PO tid-qid
If hallucinosis:	• Haloperidol 2-5mg IM/ PO q1-4h max 5/day * *Haloperidol lowers seizure threshold. Use with caution in first 3 days; give 3 doses of diazepam 20mg as a seizure prophylaxis.*
Admit to hospital if:	• Still in withdrawal after 80g or more of diazepam • Delirium tremens, recurrent arrhythmias or multiple seizures

CIWA-A Score (record on front)

a) Nausea and Vomiting (0-7)

- Ask "Do you feel sick to your stomach?" "Have you vomited?" Observation

7. Constant nausea, frequent dry heaves and vomiting
4. Intermittent nausea with dry heaves.
0. No nausea or vomiting.

b) Tremor (0-7)

- Arms extended and fingers spread apart. Observation

7. Severe, even with arms not extended
4. Moderate, with arms extended
1. Not visible, but can be felt fingertip to fingertip
0. No tremor

c) Paroxysmal Sweats (0-7)

7. Drenching Sweats
4. Beads of sweat obvious on forehead
1. Barely perceptible sweating, palms moist
0. No sweat visible

d) Anxiety (0-7)

- Ask, "Do you feel Nervous?"

7. Acute panic as seen in severe delirium or acute schizophrenic reactions
4. Moderately anxious or guarded, so anxiety is inferred
1. Mildly anxious
0. No anxiety, at ease.

e) Agitation (0-7)

- Observation

7. Paces back and forth during most of interview, or constantly thrashes about
4. Moderately fidgety and restless.
1. Somewhat more than normal activity
0. Normal activities.

f) Tactile Disturbances (0-7)

- Ask: "Do you have any itching, pins and needles sensations, any burning, numbness or do you feel bugs crawling on or under your skin?" Observation.

7. Continuous hallucinations
6. Extremely severe hallucinations
5. Severe hallucinations
4. Moderately severe hallucinations
3. Moderate pins and needles, burning or numbness
2. Mild itching, pins and needles, burning or numbness
1. Very mild itching, pins and needs, burning or numbness
0. None

g) Auditory Disturbances (0-7)

- Ask "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?" Observation

7. Continuous Hallucinations
6. Extremely Severe Hallucinations
5. Severe Hallucinations
4. Moderately Severe Hallucinations
3. Moderate mild harshness or ability to frighten
2. Mild harshness or ability to frighten
1. Very mild harshness or ability to frighten
0. Not present

h) Visual Disturbances (0-7)

- Ask, "Does the light appear to be too bright? Is its colour different? Does it hurt your eyes? Are you seeing anything that is disturbing to you? Are you seeing things you know are not there? Observation

7. Continuous Hallucination
6. Extremely Severe Hallucinations
5. Severe Hallucinations
4. Moderately Severe Hallucinations
3. Moderate sensitivity
2. Mild Sensitivity
1. Very mild sensitivity
0. Not present

i) Headache Fullness in head (0-7)

- Ask: "Does your head feel different? Does it feel like there is a band around your head?" Do not rate for dizziness or lightheadedness. Otherwise rate severity.

7. Extremely severe
6. Very Severe
5. Severe
4. Moderately severe
3. Moderate
2. Mild
1. Very mild
0. Not present

j) Orientation and Clouding of Sensorium (0-4)

- Ask, "What day is this? Where are you? Who am I?"

4. Disoriented for place and/or person
3. Disoriented for date by more than 2 calendar days.
2. Disoriented for date by no more than 2 calendar days.
1. Cannot do serial additions or is uncertain about date.
0. Oriented and can do serial additions.

Guidelines:

- Take the scale with you when assessing the client.
- Explain the procedure to the client, the frequency of assessment, and the outcomes – i.e. the need to adjust medication based on scoring.
- Ask of there are any questions, and take time to answer the questions
- If necessary, attend to comfort measures for the client before starting the assessment. Take the vital signs. These are not factored into the overall scoring, but they provide important clinical information. Slight elevation of these signs is common.
- Ask each question as it appears on the CIWA-Ar and assign a score to each item.
- Add up the number of points and assign a total score.
- Inform the client of the outcome of the assessment. Inform them of what to expect next. Will they receive medication? Supportive care.
- Provide comfort measures at the end of the process. Offer fluids, light meals, blankets, and dry clothing. Offer reassurance and positive support.
- If indicated, and ordered, administer the medication as soon as possible after the assessment to maximize the loading potential of the benzodiazepines and to respond promptly to client needs.

When to start the CIWA-Ar:

- What the client's history indicated a likelihood of withdrawal reaction – large amounts over a long period of time, history of withdrawal symptoms, and last drink within the past 12 hours?
- If history not evident, observe informally until symptoms occur – not all people develop withdrawal symptoms.

When to stop the CIWA-Ar:

- When the score if <10 after three consecutive assessments – this time may vary with individual clients.
- Continue to monitor informally to ensure there is not a re-emergence of symptoms.

Important Points to remember:

- In the first hours of assessment, or if the withdrawal is moderate to severe, always awaken the client for the assessment. Severe withdrawal symptoms can be exhibited upon wakening.
- Maintain eye contact when asking questions
- Speak slowly and clearly; reword questions, if necessary
- Do not verbally contradict when the client tells you. Adjust the score based on the subjective and objective signs and symptoms.
- Give positive feedback as much as possible.