Institution Name: Al Masarra Hospital

Document Title: Alcohol Withdrawal Treatment Guideline

Approval Process

	Name	Title/Designation	Institution	Date	Signature
Written by	Dr. Asila Al Zaabi	HoD Addiction Department	Al Masarra Hospital	19/12/2022	
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سلطنة عمان - وزارة الصحة مستشفى المسرة قسم إدارة الجودة QUALITY MANAGEMENT DEPT. AL-MASARRA HOSPITAL SULTANATE OF OMAN- MINISTRY OF HEALTH

Content Table:

Acronyms

AMRH	Al Masarra Hospital
P&P	Policy & procedure
DT	Delirium Tremens
WE	Wernicke's encephalopathy
WKS	Wernicke-Korsakoff syndrome
OPD	Outpatient Department
ICU	Intensive Care Unit
P.O	Per oral
I.V	Intravenous
AWS	Alcohol withdrawal Scale
CIWA-Ar	Clinical Institute Withdrawal Assessment Alcohol- Revised Scale

Alcohol Withdrawal Treatment Guideline

1. Introduction

Alcohol withdrawal is the physical and psychological symptoms a persistent alcohol drinker can experience from a sudden reduction in the amount of alcohol intake.

Symptoms of alcohol withdrawal differ in range and in severity which may include tremor, sweating, nausea, retching, vomiting, tachycardia, agitation, headache, insomnia , and malaise, a typical bad hangover but can precede to complicated withdrawal symptoms such as alcohol withdrawal seizures, hallucinations, wernicke's encephalopathy (we), wernicke-korsakoff syndrome (wks), and delirium tremens (dt).

2. Scope

This document is applicable to all health care workers of Al Masarra Hospital (AMRH) who are involved in the care management of alcohol abuse cases.

3. Purpose

3.1 To provide all health care workers a guideline on proper management of alcohol withdrawal symptoms among patients across AMRH who are considered to be in alcohol withdrawal state may they be in triage, OPD, or inpatient wards.

3.2 To ensure a safe clinical practice of alcohol withdrawal management and approaches by all healthcare staff

4. Definitions

4.1 *Alcohol withdrawal seizures* (rum fits) are seizures, typically generalized in nature that can occur 12-24 hours after abrupt cessation or reduction in alcohol consumption

4.2 *(WE) Wernicke's encephalopathy* is an acute neurological condition characterized by a clinical triad symptoms of ophthalmoplegia, ataxia, and confusion, commonly due to lack of thiamine, (vitamin B1) but also due to many other reasons like alcohol dependence.

4.*3* *(WKS): Wernicke-Korsacoff syndrome* is a brain and memory disorder that occurs due to a severe lack of thiamine (vitamin B1), causing damage to the brain.

4.*4* *(DT): Delirium Tremens* is a toxic state of confusion, and a life-threatening condition that occurs when alcohol withdrawal symptoms are severe; typically peaks between 72–96 hours after the last intake. The classic triad of d.t symptoms includes clouding of consciousness and confusion, vivid hallucinations affecting every sensory modality, and marked tremor.

4.5 *CIWA-Ar: Clinical Institute Withdrawal Assessment- Alcohol revised* is a ten-item scale tool to be administered by health care provider to determine the severity of alcohol withdrawal symptoms.

5. Guidelines

5.1 ***General Assessment of Alcohol Use in Addiction Clinic.***

Baseline assessment should include detailed significant information such as: longitudinal history of alcohol use including duration, recent consumption patterns, and time of most recent drink (last alcohol intake); history or previous episodes of alcohol withdrawal symptoms including observed severity or complication (e.g., hallucinations, withdrawal seizure, WE,WKS, or DT); impact of alcohol to social, medical, legal and occupational aspects; previous alcohol abstinence, medications response, anti-craving medications, rehabilitation program attended (e.g., AA); use of illicit and/or prescribed substance/ drugs; co-existing medical or psychiatric problems;

5.1.1Physical examination of signs of withdrawal such as autonomic hyperactivity/high B.P and PR, hand tremor, sweating, and level of consciousness.

5.1.2. Mental state examination

5.1.3. Routine and Significant Laboratory investigations (CBC, RFT, LFTs, RBS, Alcohol level, GGT, Urine drug Serology, and Pregnancy test for female).

5.1.3. Other relevant diagnostic workups (imaging, ECG, EEG, etc.,)

5.2 ***Medications for Alcohol Withdrawal Management.*** Benzodiazepines are considered the first treatment of choice for the management of alcohol withdrawal symptoms. Benzodiazepines reduce the signs and symptoms of alcohol withdrawal, and the incidence of delirium and seizures.

5.2.1. Diazepam (Valium®) is recommended due to its efficacy profile, wide therapeutic window, long half-life, and self-tapering effect.

5.2.1.2. Oxazepam or Lorazepam (*Oxazepam not available in AMRH, Request Form for Lorazepam filled*) are short acting benzodiazepines which can also be considered in cases where Diazepam is or relatively contraindicated (e.g. liver cirrhosis, decompensated liver disease, deep jaundice, COPD, severe asthmatic attack, and old age patients.)

5.2.1.3. Midazolam can be initiated for some patients for safety while waiting for transfer to a higher medical care centre for further and immediate care

5.2.1.4. Thiamine P.O/I.V**:** is used in alcohol dependent clients to prevent or treat wernicke's encephalopathy as per clinical indication in this guideline

5.2.1.5. Supportive medications**:** IVF for dehydration, poor oral intake or electrolyte imbalance; Metoclopramide for nausea or vomiting.

5.2.1.6. Special consideration in management of alcohol withdrawal are patients age <16 and > 60, due to lower threshold for benzodiazepines so consideration for lower doses of benzodiazepines must be made.

5.3 ***Outpatient Alcohol Withdrawal Management.*** Only about 20% of problem drinkers require an inpatient setting for alcohol detoxification, while most of them can be managed as outpatient.

5.3.1. For low risk patients with mild to moderate withdrawal symptoms, benzodiazepine regimen can be commenced preferably on the earliest day of the week like Sunday, and doses to be tapered accordingly.

5.3.1.2**.** Outpatien**t** Benzodiazepine detoxification regimen must be initiated only under supervision of a reliable family member or caregiver; otherwise planned inpatient detoxification is the option due to patient's poor social support.

5.3.1.3 On first day of treatment, the usual benzodiazepine average dose is 40 mg in split doses or as per clinical judgment; with usual duration of 5-7 days in most cases and can be extended up to 10 days for patient with history of recent benzodiazepine use until tapering doses is set.

5.3.1.4. Prescribe oral thiamine (Vitamin B_1) 100 mg OD for five days if patient is well nourished. Doses can be increased up to 300mg/ day in split doses for malnourished patient then to be tapered off in a one to three month period.

5.3.1.5. Follow up patient in clinic after 48-72 hours for the first two visits or as per clinical judgment.

5.3.1.6. Advise patient to seek treatment in emergency unit as needed during first two visits if withdrawal symptoms persist that may require a regimen adjustment.

5.3.1.7. Emphasize to relative to bring the patient to nearest emergency unit available if observed to develop a complicated withdrawal symptoms such as withdrawal seizure or D.T. for immediate provision of medical care.

5.3.1.8 During OPD follow-up visits, assess or review patient's condition accordingly as written in *Guidelines 5.1 to 5.1.4 (refer to page 5)*

5.3.1.9 Encourage patient to follow up scheduled clinic visits, and to attend OPD psychosocial rehabilitation

5.3.1.10. Encourage intake of fluids with electrolytes, food with mild taste and smell; and avoidance of natural remedies, and caffeine containing food/drinks.

5.3.1.11. Teach to maintain minimal exercise only and avoid any activities that induces sweating (e.g., hot baths)

5.3.1.12 Monitor relapse, discontinue diazepam regimen accordingly on signs of relapse and offer inpatient detoxification program.

5.3.1.13 Discuss relapse prevention strategies and options with the client including anti-craving medication, attending psychosocial intervention and supportive community programs (e.g. an Alcoholics Anonymous (AA) meeting or any other community support system)

5.4 ***Inpatient Alcohol Withdrawal Management.*** Inpatient admissions are categorized as booked and immediate.

5.4.1. *Booked admission*: for alcohol dependent patient who is not in acute withdrawal state but noted with the following predisposing/risk factors: history of previous complicated withdrawal; (e.g., seizure or delirium tremens) comorbid stable

medical conditions;(e.g., hypertension, insulin-dependent diabetes mellitus, asthma, etc.,) with comorbid psychiatric disorders; concomitant dependence on other substances; (e.g., benzodiazepines, barbiturates, opiates, etc.,) pregnant; very young or elderly; lacking a safe, substance- free environment; lacking social support and caregiver to supervise medications; homeless; with history of failed OPD detoxification attempts.

5.4.2. *Immediate admission:* after proper consideration on all admission exclusion criteria as per this guideline, immediate admission is intended for alcohol dependent patient exhibiting the following presentations: acute to moderate or severe alcohol withdrawal symptoms during OPD or Emergency room visit; manifesting psychiatric emergency symptoms of psychotic disorder with active hallucinations or delusions or agitation, suicidal or homicidal risk; people ages <16 and > 60; and pregnant women.

5.5 ***Exclusions for Inpatient Detoxification Due to Hospital Setting Condition*****:**

5.5.1. Exclusion criteria for inpatient admissions are established due to limited capacity of the hospital to provide patients an acute medical care and treatment which are available in other tertiary medical facilities such as high dependency units (HDU) or intensive care unit (ICU) thus, referral and consultation on these facilities are imperative.

5.5.2. Patients with the following conditions are considered to be unsuitable for inpatient detoxification in AMRH and must be referred to other medical facilities for prompt treatment: *complicated withdrawal state at time of presentation such as status epilepticus or recurrent withdrawal seizures, delirium tremens, and wernicke's encephalopathy; acute unstable medical or surgical emergencies requiring medical attention e.g., head injury, unconscious, febrile, acute infection, heart failure, exacerbation of asthma or COPD, signs of severe liver compromise like jaundice, ascites, etc.,;and failure to respond to initial treatment after six hours observation period in emergency room.*

5.6 ***Inpatient Alcohol Withdrawal Assessment and Monitoring***

5.6.1**.** Follow full assessment of all alcohol use and withdrawal presentation as per OPD protocol.

5.6.1.2 Regular checking of withdrawal symptom and its severity along with the use of an appropriate assessment tools for monitoring is paramount to safe patient care. The Alcohol withdrawal Scale (AWS) and the Clinical Institute Withdrawal Assessment Alcohol- Revised Scale (CIWA-Ar) are the two monitoring tools that can be utilized in AMRH inpatient ward.

5.6.1.3. Alcohol withdrawal Scale (AWS) are categorized as: Mild with AWS score of 0-4; Moderate with AWS score of 5-9; and Severe with AWS score of 10-14.

5.6.1.4. Use CIWA-Ar Scale in cases of severe or complicated alcohol withdrawal. This is to be utilized for some clients for adjustment of high doses of benzodiazepines with close monitoring of their progress and response guiding doctor's decision the need of transfer to other facility or not.

5.6.1.5 Monitor for vital signs in the first 24 hours of admission, and then Q8hrs based on severity of withdrawal symptoms.

5.6.2 *Benzodiazepine regimen*: Benzodiazepines are fixed –dose regimen for slow tapering set as individualized care plan for each patient based on clinical evaluation of the severity of withdrawal symptom and should be commenced as soon as patient exhibits acute withdrawal symptoms. Breakthrough Benzodiazepines PRN doses can be given if diastolic BP > 100 and PR >100; or CIWA scale > 8, minimum of 30 min-1 hr from the last fixed dose.

5.6.3 *Thiamine*: Thiamine is prescribed to people at high risk of developing, or with suspected W.E. Oral doses can be given as 100mg tablet; Parenteral Thiamine can be given as high potency Parentrovite (Pabrinex) which comes as paired ampoules with one containing 250mg thiamine and the other as vitamin C.

5.6.4 *Supportive IVF and medications*:

5.6.4.1. A 5% Dextrose IV/D5W, 500ml over 2 hours might be required in patient with poor oral intake or dehydrated patient. Correct any electrolyte imbalance and/or any nutritional deficiency especially hypokalemia, hyponatremia, and hypomagnesemia.

5.6.4.2. In cases with comorbid medical illness, resume regular medications if contraindication with benzodiazepine is ruled out and consultation with physician is done as needed.

5.7 ***Withdrawal Management According to State/Severity***

*5.7.1. In mild withdrawal state***,** as per clinical judgement**,** admit the patient only when admission criteria are met despite mild withdrawal state. Low doses benzodiazepines might be required to control irritability or insomnia. Average total diazepam doses may range from 20-30 mg in day 1 and to be tapered off over 3 days. Thiamine 100mg P.O OD for 5 days can be initiated for well nourished; Thiamine 100mg TID can be prescribed for malnourished patients, or for patient with medical comorbidities, dose can be extended until 1-3 months**.**

5.7.2. In moderate withdrawal state, monitor vitals and CIWA Q2hrs. Diazepam (P.O/IV) with total of 45-50 mg in split doses might be sufficient and to be tapered for over 5 days. Breakthrough doses of Diazepam for moderate withdrawal, can be given as per clinical judgment, as PRN if insomnia, irritability or agitation is observed with dosing of 5-10mg P.O/I.V. Parenteral Thiamine 1-2 pairs OD or BID for 3 days will be needed if patient is malnourished or has poor oral intake, then to shift to oral thiamine 100mg TID and when applicable, follow guideline for W.E. prophylaxis or treatment *(Guideline 5.7.4.4, page 12).* Administer supportive IVFs and medications as needed.

5.7.2.1. Example of Diazepam regimen in moderate withdrawal state:
Day 1: T. Diazepam 15mg - 10mg- 10mg- 15mg hs

Day 2: T. Diazepam 15mg- 10mg - 15mg

Day 3: T. Diazepam 10mg-5mg-15mg

Day 4: T. Diazepam 5mg-5mg - 10mg hs

Day 5: T. Diazepam 10mg hs

5.7.3. Severe Alcohol withdrawal management requires monitoring of vitals and CIWA-Ar Scale Q1hr, and initiating Benzodiazepines preferably Diazepam. In day 1, Diazepam 15 mg q6hours can be initiated and patient to be reassessed every 4-6 hours with appropriate alcohol withdrawal monitoring tool, preferably CIWA -Ar Scale along with

patient's latest vitals to determine the need for any additional breakthrough doses. Diazepam Breakthrough dose for severe withdrawal is10mg P.O/I.V, can be given PRN if insomnia, irritability or agitation is observed. In day 2, reassess client for the clinical response and taper down doses by not more than 20% from previous day after calculating total doses received by the patient including any additional doses. Before giving the dose, assure patient is conscious and not in respiratory depression. Continue tapering off within 7-10 days or till symptoms resolved. For some patients who are agitated or unable to tolerate oral doses, parenteral Diazepam 10mg can be administered until patient is stabilized and then to be shifted to oral Diazepam. Parenteral Thiamine with 2-3 pairs BID or TID might be given to patients for 3 -5 days if malnourished or has poor oral intake then to shift to oral thiamine 100mg TID, and if applicable to follow guidance for W.E. prophylaxis or treatment *(guideline 5.7.4.4., page 12).*Administer supportive IVF and medications as needed.

5.7.3.1. Example of Diazepam regimen in severe withdrawal state:-

Day 1: T. Diazepam 15mg QID

Day 2: T. Diazepam 15mg - 10mg- 10mg- 15mg

Day 3: T. Diazepam 15mg-10mg-15mg

Day 4: T. Diazepam 10 -5mg-15mg /or 10 TID (Total 30 mg/day)

Day 5: T. Diazepam 10mg bid or 5mg-5mg-10mg (total 20mg/day)

Day 6: T. Diazepam 10mg hs.

5.7.3.2 Tapering of Benzodiazepine may be slower, approximately for over 3 more days if patient has h/o withdrawal seizure, withdrawal from concomitant benzodiazepine use, or c/o insomnia.

5.7. 4. Complicated withdrawal (seizure, hallucinations, DT and WE): All cases with complicated withdrawal must be ruled out for other medical diagnosis such as fever, trauma, intracranial hemorrhage, etc., and should have a patent I.V access, parenteral Thiamine, hydrated with IVF (5% Dextrose IV/D5W 500ml over 2hrs).

5.7.4.1. Management of alcohol withdrawal seizures involves a quick-acting benzodiazepine (such as lorazepam) to reduce the likelihood of further seizure episodes.

.(Lorazepam is not yet available in AMRH, under request). If a patients develops an alcohol withdrawal seizure during the course of treatment for acute withdrawal, review patient's withdrawal drug regimen thoroughly. Diazepam can be started 10mg I.V as STAT dose then consult physician as medical emergency, and if patient is not responding to initial management, refer to acute medical hospital as medical emergency.

*5.7.4.2. Agitation or hallucination*s as complicated withdrawal state necessitates a review of benzodiazepines regimen to ensure enough doses of benzodiazepines is being given. Parenteral or low oral dose of Haloperidol can be added as adjunctive therapy to treat agitation and hallucination for as long as adequate doses of benzodiazepines are being administered. Mechanical restraint can be used using least restrictive type, in shortest possible time.

5.7.4.3. Recommended management for delirium tremens implies oral Lorazepam as first-line of treatment. If symptoms persist, or oral medication is declined by the patient, give parenteral Lorazepam (Lorazepam is not yet available in AMRH) or Haloperidol. In case of agitation, consider Haloperidol I.M and mechanical restraint if needed. Consult physician as medical emergency and refer to a tertiary medical hospital for higher medical care *5.7.4.4 Wernicke's Encephalopathy (W.E)*treatment comprises prophylactic oral thiamine 100mg TID P.O, or a Prophylactic parenteral thiamine high potency Parentrovite (Pabrinex) in 1-2 pairs, I.V , TID for 3 days, followed by oral Thiamine 100mg TID if patient is at risk of malnourishment; or has decompensated liver disease; or in acute withdrawal; or are admitted to hospital with an acute illness or injury Parenteral treatment should be given for a minimum of 5 days, followed by oral thiamine .

5.7.4.5. Wernicke-Korsakoff Syndrome (WKS) management may involve referral to a neurologist for management as it should be treated aggressively in the acute medical setting. If a patient shows no improvement in the Korsakoff amnestic state for 7 days, then a strategy for complication prevention should be pursued like oral maintenance of thiamine; and treatment of comorbidities and rehabilitation.

5.8. Inpatient Rehabilitation Program

5.8.1. Rehabilitation program starts when a patient becomes stable and ready for transfer to rehabilitation ward. Routine group therapy/ activities or individual therapy for patient/s' rehabilitation can be facilitated through internal referrals to multidisciplinary team members which include but not limited to: social worker, psychologist, physiotherapist, occupational therapist and music therapist as decided by the treating team or treating specialist.

5.8.2. Longer rehabilitation program in Halfway Houses (HWH) will be facilitated for eligible patients for duration of 6 months or more upon patient request or for court mandated treatment patients and will undergo same internal referral just like the other therapies.

6. Responsibilities

6.1 Doctors Shall

6.1.1. Perform comprehensive alcohol clinical assessment and formulate the patient care plan

6.1.2. Document all clinical assessment of patients and management plan in Al Shifa system.

6.1.3 Adjust withdrawal regimen and other prescribed medications doses.

6.1.4 Refer patient internally and externally to specialist or services when indicated.

6.2 Physicians shall provide medical assessment and expert opinion when required for referred patients with physical comorbidities or complicated withdrawal like withdrawal seizures, D.T, WE or WKS.

6.3 Nursing staff Shall

6.3.1. Complete nursing procedures including blood collection, breathalyzer testing, and vital signs checking.

6.3.2 Complete admission procedures including securing admission contract consent.

6.3.3 Observe patient for withdrawal symptoms and its severity using the available alcohol withdrawal monitoring tools and document observations of patients' progress in Kardex.

6.3.4 Administer medications as prescribed.

6.3.5 Report any incidents in Incident Reporting System (IRLS) accordingly.

6.4 Psychologists Shall:

6.4.1 Perform psychological assessments including personality assessment, I.Q Test, Cognitive Assessments, etc., for referred patients.

6.4.2 Conduct therapeutic individual sessions for referred patients when indicated.

6.4.3 Conduct regular group sessions as a part of multidisciplinary rehabilitation program.

6.5 Social Workers Shall:

6.5.1. Perform social assessments and intervention including family education for referred patients Conduct therapeutic individual sessions for referred patients when indicated.

6.5.2. Conduct regular group sessions as part of multidisciplinary rehabilitation program.

6.6 Occupational therapists shall Provide regular occupational therapy sessions as part of multidisciplinary t rehabilitation program

6.7 Physiotherapist shall provide a regular physiotherapy session as part of multidisciplinary rehabilitation program.

6.8 Music therapist shall provide regular musical sessions as part of multidisciplinary rehabilitation program.

6.9 Security staff shall perform patient body inspection and search with staff nurse supervision for any banned substances and objects before and after admission.

6.10 Public relation staff shall:

6.10.1 Provide support for admitting team in clinic and in the addiction wards.

6.10.2 Complete all required signatures from the patients when leaving against advice from wards.

6.10.3 Communicate with patient's family and Police if needed upon patient's violation of admission contract and ward policy and facilitate patient's discharge.

7. Document History and Version Control Table

Document History and Version Control			
Version	**Description of Amendment**	**Author**	**Review Date**
01	Initial Release	Dr.Asila Al.Zaabi	01/11/2025
02			

Written by	Reviewed by	Approved by
Dr.Asila Al.Zaabi	Dr.Pretti Ph.Sharifa AlRuzaiqi	Dr. Bader Al Habsi

8. Related Documents

8.1 Appendix 4. Audit Tool

8.2 Appendix 5. Document Request Form

8.3 Appendix 6. Document Validation Checklist

9. References

Title of book/Journal/articles/Website	Author	Year of publication	Page
-NICE Acute Alcohol withdrawal guideline -The Maudsley prescribing guidelines in psychiatry - WHO management of alcohol withdrawal -FV -Inpatient Assisted Alcohol Withdrawal pathway, NHS Fourth Valley		2021 2014	

10. Appendices

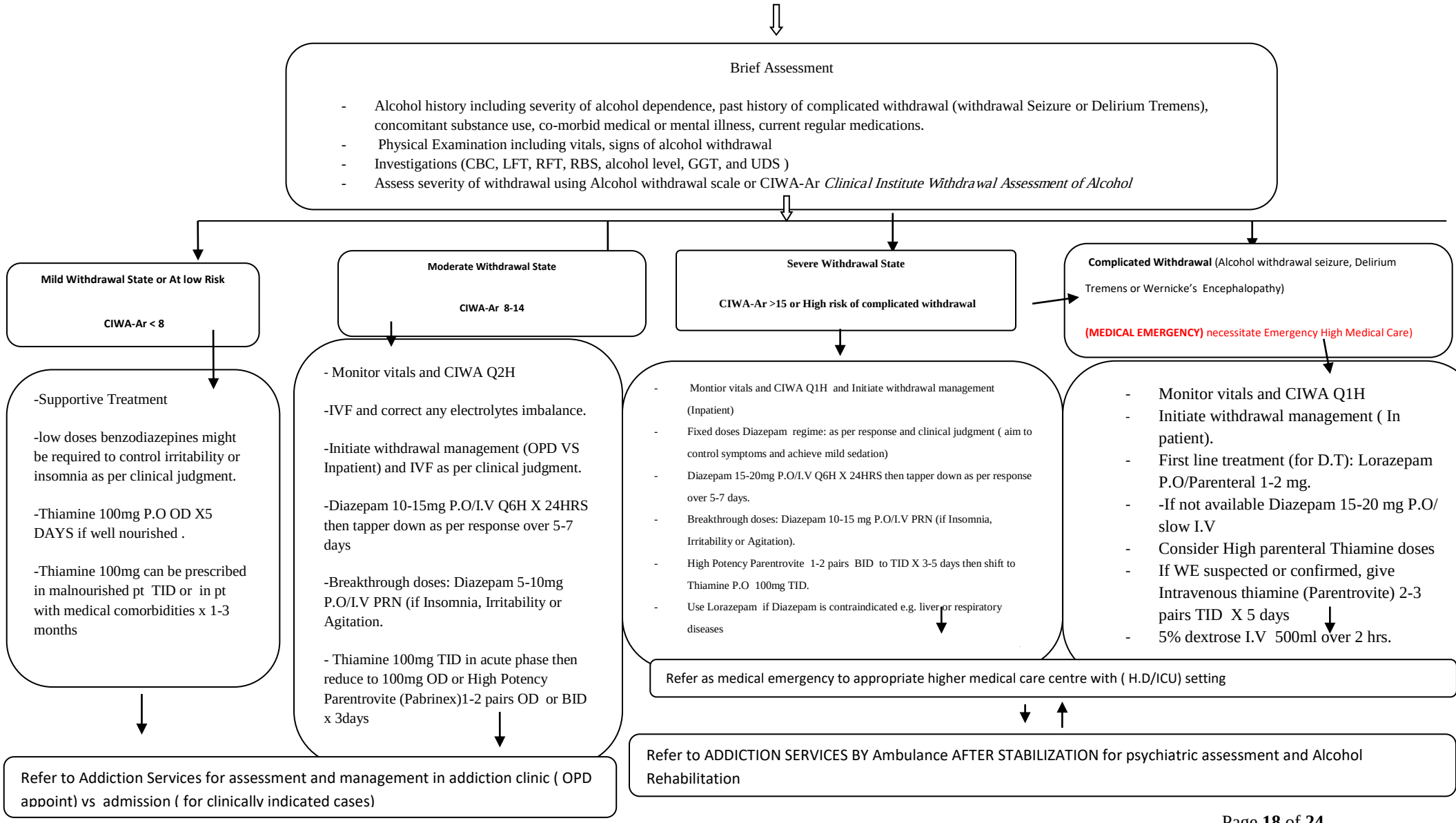
10.1 Appendix 1. Algorithm for Management of Patients with Alcohol Withdrawal Syndrome

10.2 Appendix 2. CIWA scale

10.3 Appendix 3. Alcohol Withdrawal scale (AWS)

Appendix 1 Algorithm for Management of Patients with Alcohol Withdrawal Syndrome

Algorithm for Management of Patients with Alcohol Withdrawal Syndrome



Appendix 2.CIWA scale

Clinical Institute Withdrawal Assessment of Alcohol Scale, Revised (CIWA-Ar)

Patient:_____ **Date:** _____ **Time:** _____ (24 hour clock, midnight = 00:00)

Pulse or heart rate, taken for one minute:_____ **Blood pressure:**_____

NAUSEA AND VOMITING -- Ask "Do you feel sick to your stomach? Have you vomited?" Observation.
0 no nausea and no vomiting
1 mild nausea with no vomiting
2
3
4 intermittent nausea with dry heaves
5
6
7 constant nausea, frequent dry heaves and vomiting

TACTILE DISTURBANCES -- Ask "Have you any itching, pins and needles sensations, any burning, any numbness, or do you feel bugs crawling on or under your skin?" Observation.
0 none
1 very mild itching, pins and needles, burning or numbness
2 mild itching, pins and needles, burning or numbness
3 moderate itching, pins and needles, burning or numbness
4 moderately severe hallucinations
5 severe hallucinations
6 extremely severe hallucinations
7 continuous hallucinations

TREMOR -- Arms extended and fingers spread apart. Observation.
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 with arms not extended

AUDITORY DISTURBANCES -- Ask "Are you more aware of sounds around you? Are they harsh? Do they frighten you? Are you hearing anything that is disturbing to you? Are you hearing things you know are not there?" Observation.
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 color 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.
0 not present
1 very mild sensitivity
2 mild sensitivity
3 moderate sensitivity
4 moderately severe hallucinations

AGITATION -- Observation.
0 normal activity
1 somewhat more than normal activity
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 oriented and can do serial additions
1 cannot do serial additions or is uncertain about date
2 disoriented for date by no more than 2 calendar days
3 disoriented for date by more than 2 calendar days
4 disoriented for place/or person

Total **CIWA-Ar** Score _____
Rater's Initials _____
Maximum Possible Score 67

*The **CIWA-Ar** is not* copyrighted and may be reproduced freely. This assessment for monitoring withdrawal symptoms requires approximately 5 minutes to administer. The maximum score is 67 (see instrument). Patients scoring less than 10 do not usually need additional medication for withdrawal.

Sullivan, J.T.; Sykora, K.; Schneiderman, J.; Naranjo, C.A.; and Sellers, E.M. Assessment of alcohol withdrawal: The revised Clinical Institute Withdrawal Assessment for Alcohol scale (**CIWA-Ar**). *British Journal of Addiction* 84:1353-1357, 1989.

Appendix 3 Alcohol Withdrawal scale (AWS)

SULTANATE OF OMAN MINISTRY OF HEALTH DOCUMENT CODE: NSS - 20 DATE CREATED: 20/11/2011 DATE REVIEWED: 18/05/2016 DEVOLOPED BY: CNI APPROVED BY : NSG AFFAIRS DEPT	AL- MASARRA HOSPITAL NURSING AFFAIRS DEPARTMENT ALCOHOL WITHDRAWAL SCALE	PATIENT STICKER

SYMPTOMS	0	1	2	3	4
Perspiration	No sweating	Barely perceptible sweating, Moist palms	Moist palms & localized beads of sweat on face and chest.	Whole body wet with perspiration	Profuse sweating, Patients clothes and bed linen completely wet.
Anxiety	Calm	Mildly anxious	Moderately anxious or guarded so anxiety is inferred	Anxious and fearful and difficult to control/calm down	Uncontrolled anxiety including panic attacks
Tremors	No tremors	Positional hand tremor only	Constant slight tremor of hands	Constant marked tremor of hands	Tremors observed even with arms not extended
Agitation	Normal activity	Slight restlessness, unable to remain in one place & unable to sleep.	Tense, moves constantly, but obeys requests/instruction.	Constantly restless, unable to remain on bed and unable to sleep disturbing other clients.	Highly excited
Hallucination	No evidence of hallucination	Distorted by existing objects but aware of it	Verbalizes appearance of totally new objects or false perception. But accepts not real if pointed out	Believes that hallucinations are real.	Hallucinations with no meaningful contact with reality.
Orientation	Fully oriented to time place and person.	Oriented to person but not sure of time and place	Oriented to per son but disoriented to time and place	Disoriented to time and place & patchy in person	Totally disoriented, no meaningful contact can be established.
Temperature	37.0 C	37.1 to 37.5 C	37.6 to 38.0 C	38.1 to 38.5 C	Above 38.5 C

Scoring keys:
0 to 4: Mild
5 to 9: Moderate
10 to 14 Severe

Appendix 4 **Audit Tool**

Department: _____ **Date: _____**

S.N.	Audit Process	Standard / Criteria	Yes	Partial	No	N/A	Comment
1.	Document review	Is full assessment of all alcohol use cases presenting to OPD performed as per OPD protocol of assessment, and documented by treating doctor in progress notes?					
2.	Document review	Does the staff nurse measures vitals and alcohol level in all booked admission alcohol cases attending OPD and documented in patient's Kardex?					
3.	Document review	Is the protocol and criteria for outpatient alcohol withdrawal management being followed for eligible patients?					
4.	Document review	Are procedures of OPD follow-up visits followed?					
5.	Document review	Is the protocol and criteria for initiating inpatient alcohol withdrawal management being followed for eligible patients?					
		IN PATIENT					
6	Document review	Does staff nurse completes admission procedures including admission contract consent?					
8.	Observation	Does the security staff under staff nurse supervision perform patient body check and search for banned substances and objects before and after admission?					
9.	Document review	Are alcohol assessment tools for monitoring the severity of					

		withdrawal utilized and documented in Kardex?					
10	Document review	Are vital signs: Temp, B.P, PR and P.R monitored by staff in the first 24 hrs of admission and documented in Kardex as directed by the admitting doctor?					
11	Document review	Is reassessment done by doctors within 24 hrs of admission or when required?					
12	Document review	Are management plan and medications (benzodiazepine regimen, thiamine and other supportive treatment) are clearly documented in the patient file by admitting doctor?					
13	Document review	Are the management guideline for cases with complicated alcohol withdrawal (seizure, hallucinations, DT, WE and WKS) being followed?					
14	Document review	Is routine internal referral for multidisciplinary team members (psychologists, social workers, occupational therapists, physiotherapists and music therapist) done accordingly as applicable for patient's rehabilitation activities?					

Appendix 5 **Document Request Form**

Document Request Form			
Section A: Completed by Document Requester			
1. Requester Details			
Name	Dr.Asila Al.Zaabi	Date of Request	25/09/2022
Institute	Al Masarra Hospital	Mobile	90133303
Department	Addiction Department	Email	Umsadeen700@gmail.com
The Purpose of Request			
√ Develop New Document	☐ Modification of Document	☐ Cancelling of Document	
1. Document Information			
Document Title	Alcohol Withdrawal Treatment Guideline		
Document Code	AMRH/AP/GUD/001/Vers.01		
Section B: Completed by Document Controller			
☑ Approved	☐ Cancelled	☐ Forward To:……..	
Comment and Recommendation:	to proceed with the document		
Name	Kunooz Al Balushi	Date	November 2022
Signature	for Kunooz	Stamp	

Appendix 6 **Document Validation Checklist**

Document Validation Checklist					
Document Title: Alcohol Withdrawal Treatment Guideline		**Document Code:** AMRH/AP/GUD/001/Vers.01			
No	Criteria	**Meets the Criteria**			**Comments**
		Yes	**No**	**N/A**	
1.	**Approved format used**				
1.1	Clear title – Clear Applicability	✓			
1.2	Index number stated	✓			
1.3	Header/ Footer complete	✓			
1.4	Accurate page numbering	✓			
1.5	Involved departments contributed	✓			
1.6	Involved personnel signature /approval	✓			
1.7	Clear Stamp	✓			
2.	**Document Content**				
2.1	Clear purpose and scope	✓			
2.2	Clear definitions	✓			
2.3	Clear policy statements (if any)			✓	
3.	**Well defined procedures and steps**				
3.1	Procedures in orderly manner	✓			
3.2	Procedure define personnel to carry out step	✓			
3.3	Procedures define the use of relevant forms	✓			
3.4	Procedures to define flowchart	✓			
3.5	Responsibilities are clearly defined	✓			
3.6	Necessary forms and equipment are listed	✓			
3.7	Forms are numbered	✓			
3.8	References are clearly stated	✓			
4.	**General Criteria**				
4.1	Policy is adherent to MOH rules and regulations	✓			
4.2	Policy within hospital/department scope	✓			
4.3	Relevant policies are reviewed			✓	
4.4	Items numbering is well outlined	✓			
4.5	Used of approved font type and size	✓			
4.6	Language is clear, understood and well structured	✓			
Recommendations	……. For implementation …✓……. More revision ……... To be cancelled				
Reviewed by:	**Kunooz Balushi** per Kunooz	**Reviewed by: Maria Claudia Fajardo-Bala**			

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