Vanderbilt Psychiatric Hospital

VPH Alcohol Withdrawal / Delirium Tremens Protocol

Criteria for initiation of Alcohol Withdrawal/Delirium Tremens Prevention Protocol (CIWA) is based on patient's report of history of alcohol use, history of alcohol withdrawal, and/or less than 72 hours since last consumption of alcohol.

Contraindications:

DO NOT use the CIWA Protocol if patient reports recent use of and/or has a positive UDS for Central Nervous system (CNS) Depressants, such as hypno-sedatives, barbiturates or benzodiazepines. Notify MD to assess for CNSDP Protocol.

CIWA PROTOCOL INSTRUCTIONS:

Nurses monitor patient using CIWA scoring protocol and document CIWA score on the VPH CIWA scoring form printed off EDOCS. Continue CIWA scoring for a minimum of 48 hours after initiation of CIWA protocol.

- Initiate Seizure Precautions for the duration of the CIWA Protocol.
- **CIWA Score 20 or greater:** Administer diazepam as ordered.
- **CIWA Score 15 to 19:** Repeat CIWA assessment in 1 hour. If score 15-19 the second time, Administer diazepam as ordered.
- Continue CIWA assessment every hour until patient CIWA score 14 or less ***or*** pt has had a total cumulative diazepam dose of 100 mg (5 Doses). If the patient is asleep, do NOT wake the patient to assess the CIWA score; assess CIWA score when the patient awakens.
- Assess patient 1 hr after the 5th dose. If asleep, complete CIWA assessment upon waking. If the CIWA remains above 15, notify the physician to assess the patient for additional doses of diazepam. If CIWA score is 14 or less, follow the instructions below.
- **CIWA Score 10 to 14:** Complete CIWA assessment every 2 hours while awake. If pt is asleep, complete CIWA assessment when patient awakens.
- **CIWA Score less than 10:** Complete CIWA assessment every 4 hours while awake. If pt is asleep, complete the CIWA assessment when patient awakens.
- Continue CIWA for 48 hours after time of first diazepam dose.

MEDICATION:

Diazepam (Valium) **20 mg po prn, based on CIWA score X Max of 5 doses** (100mg).
- After 5th dose, if CIWA Score 15 or higher, call MD to reassess need to give more doses of diazepam.

Additional 3 doses of diazepam – SECOND ROUND ***(after a total of five (5) doses have been given)***:
- Requires MD order to initiate

Diazepam (Valium) **20 mg po q1h prn (Max 3 doses)**
- Give if CIWA score 20 or higher ***or*** if CIWA 15 or higher on two consecutive scores
- Hold medication if patient asleep.

FOR PATIENTS WITH A HISTORY OF ALCOHOL SEIZURES:

- Notify MD for initiation of VPH Alcohol Withdrawal Protocol Orders.
- **Give first diazepam dose NOW.** Do not wait for CIWA score to go to above 15.
- Give 2 more doses of diazepam q1h for a total of 3 doses.
- Assess the patient's CIWA score every hour while awake and 1hr after third dose. After the third dose, give the diazepam q1hr prn per the CIWA score until the protocol is completed ***or*** until patient has received a total of five (5) doses. HOLD diazepam if patient is asleep or somnolent. DO NOT wake patient up to assess CIWA score. Asses the CIWA when patient awakens.
- Assess patient 1 hr after the 5th dose. If asleep, complete CIWA assessment upon waking. If the CIWA remains above 15, notify the physician to assess the patient for additional doses of diazepam. Assess q1hr. If CIWA score is 14 or less, follow the CIWA Protocol Instructions.

MEDICATION *(for patients with history of alcohol seizures):*

Diazepam (Valium) **20 mg po q1h x 3 doses, 1ST NOW**
- HOLD if pt asleep or somnolent
- Assess CIWA score each hour and 1hr after 3rd dose of diazepam

Additional Medication *After* the 3rd dose:

Diazepam (Valium) **20 mg po q1h prn x48 hours**, for up to 2 **additional** doses (MAX 5 **Total** doses)
- .Assess CIWA per Protocol Instructions. Give if CIWA 20 or higher ***or*** CIWA 15 or higher on 2 consecutive scores. Hold if pt asleep.
- Assess CIWA score 1hr after last dose of diazepam. If CIWA score 15 or higher, call MD to reassess need to give more doses of diazepam.

Vanderbilt Psychiatric Hospital

CLINICAL INSTITUTE WITHDRAWAL ASSESSMENT FOR ALCOHOL (CIWA) - VPH

Signature/Title	Initials

	DATE:							
	TIME:							
Temperature: *0= Less than 98.7 1= 98.7 – 99.5 2= 99.6 – 100.4 3= greater than 100.4*	Temp							
	Score							
Pulse: *0= Less than 90 1= 90-95 2= 96-100 3= 101-105 4= 106-110 5= 111-120 6= greater than 120*	Pulse							
	Score							
Respirations: *0= Less than 20 1= 20 – 24 2= greater than 24*	Resp							
	Score							
Diastolic Blood Pressure: *0= Less than 95 1= 95-103 4= 104-112 6= greater than 112*	BP							
	Score							
Orientation: *0= Oriented 2= Disoriented for date more than 2 days 4= disoriented to time/place*								
Nausea and Vomiting: Ask: "Do you feel sick to your stomach?" "Have you vomited?" *0= None to mild nausea, no vomiting 3= Intermittent nausea with dry heaves 7= Constant nausea, dry heaves and vomiting*								
Tremor: Ask patient to extend arms and spread fingers apart w/ eyes closed *0= No tremor 3= Not visible (can be felt fingertip to fingertip) to moderate with arms extended 7= Severe, even without arms extended*								
Paroxysmal Sweats: Observe *0= None visible 3= Barely perceivable sweating (palms moist) to obvious beads of sweat on forehead 6= Drenching sweats*								
Anxiety: Ask: "Do you feel nervous?" *0= At ease, no anxiety 3= Appears 7= Acute anxiety, panic*								
Agitation: Observe *0= Normal activity 3= Somewhat more than normal activity to restless, fidgety 7= Constantly pacing or thrashing about*								
Headache, Fullness in the head: Ask: "Does your head feel different or full?" "Does it feel like there is a band around your head?" (DO NOT include dizziness or lightheadedness) *0= No headache or full feeling 1= Mild to moderate headache, feeling of fullness 7= Severe headache, extreme fullness, feeling of tight band around head*								
Tactile Disturbances: Ask: "Do you feel any itching or pins & needles?" "Any numbness or burning?" "Do you feel bugs crawling on or under your skin?" *0= None 4= Mild itching, pins & needles, burning or numbness to intermittent tactile hallucination(i.e., bugs crawling) 7= Severe, continuous tactile hallucinations (rubbing constantly to remove crawling bugs)*								
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?" "Are you hearing things you know aren't there?" *0= None 4= Mildly harsh / frightening sounds to Intermittently hearing things you can't 7= Continuous auditory hallucinations (speaking to unseen persons)*								
Visual Disturbances: Ask: "Does the light appear to be too bright?" "Is the color different?" "Does it hurt your eyes?" "Are you seeing anything that is disturbing to you?" "Are you seeing things you know aren't there?" *0= None 4= Mild sensitivity to light to occasionally seeing things you can't 7= Constant visual hallucinations*								
	TOTAL CIWA SCORE:							
	Dose in mg (po):							
	Dose #:							
	CUMULATIVE DOSE in mg (po):							
	Initials:							

Psychiatric Hospital at Vanderbilt

Signature/Title	Initials

CLINICAL OPIATE WITHDRAWAL SYMPTOM (COWS) SCALE - PHV		
Resting Pulse Rate: (bpm) *0= less than or equal to 80* *1= 81 - 85* *2= 86 - 90* *4= greater than 90*	**Pupil size:** *0= Pinpoint or normal size in room light* *1= Larger than normal in room light* *2= Moderately dilated* *5= Only rim of iris is visible due to dilation*	**Tremor:** *0= Not present* *1= Tremor can be felt but not observed* *4= Gross tremor or muscle twitching*
Sweating over 30 minutes: *0= No chills or flushing* *1= Pt. report of chills or flushing* *2= Flushed or moistness on face* *3= Beads of sweat on forehead* *4= Drenching sweats*	**Bone or Joint Aches:** *0= No joint or bone pain* *1= Mild discomfort* *2= Moderately severe aching* *4= Constantly rubbing joints/muscles*	**Yawning:** *0= Not present* *1= Yawning 1 or 2 times during assessment* *2= Yawning 3 or 4 times during assessment* *4= Yawning several times per minute*
Restlessness: *0= Able to sit still* *1= Some difficulty sitting still* *3= Frequently shifting/moving legs, arms* *5= Unable to sit still*	**Runny Nose or Tearing:** *0= Not present* *1= Nasal stuffiness or moist eyes* *2= Nose running or eyes tearing* *4= Nose constantly running/tears streaming*	**Anxiety or Irritability:** *0= Not present* *1= Pt. reports some irritability or anxiousness* *2= Pt. obviously irritable or anxious* *4= Pt. so irritable that participation in assessment is difficult*
	G.I. Upset: *0= None reported* *1= Stomach cramps* *2= Nausea* *3= Vomiting or diarrhea* *5= Multiple episodes of vomiting/diarrhea*	**Gooseflesh Skin:** *0= Skin is smooth* *3= Piloerection of skin can be felt or hairs standing up on arms* *5= Prominent piloerection present*

SCORING FLOWSHEET		BASELINE										
	DATE:											
	TIME:											
BP (record SBP/DBP)												
Resting Pulse Rate: (record bpm)												
Resting Pulse Rate: Score												
Sweating												
Restlessness												
Pupil Size												
Bone or Joint Aches												
Runny Nose or Tearing												
G.I. Upset												
Tremor												
Yawning												
Anxiety or Irritability												
Gooseflesh Skin												
TOTAL SCORE												
*** CLONIDINE DOSE in mg**												
CLONIDINE CUMULATIVE TOTAL												
BUPRENORPHINE DOSE in mg												
BUPRENORPHINE DOSE #												
INITIALS												

Hold clonidine for the following: If baseline BP less than or equal to 100/70, hold for BP less than or equal to 80/50
If baseline BP greater than 100/70, hold for BP less than 90/60