

STANDING ORDER

ALCOHOL WITHDRAWAL

I. ASSESSMENT

- A.** Obtain medical history, including amount of alcohol ingested, any other drugs taken, normal drinking patterns, amounts and time of last drink. Inquire about past history of seizures, infectious hepatitis, tachycardia >120bpm, or current BAC. These pre-existing factors increase the risk of Delirium Tremens. A past history of Delirium Tremens greatly increases a future episode of DTs which can be fatal.
- B.** Take vital signs, including temperature, as soon as possible after arrest on any inmate felt to be at risk for alcohol withdrawal. Assess inmate's symptoms on the CIWA (Clinical Institute for Withdrawal of Alcohol). CIWA should be scored and vital signs assessed at least once each shift that alcohol withdrawal is present, or until medication for withdrawal is no longer prescribed. Blood pressure >180/100 should be reported to provider for medication management. Tachycardia must be addressed, when assessed, if it does not begin to resolve with the initiation of medication for withdrawal. In severe withdrawal, more frequent monitoring may be necessary. Provider should be called, or when necessary, inmate transported to emergency room if unstable medical conditions persist.
- C. Assessing acute signs of alcohol withdrawal.** Symptoms of acute withdrawal include: sleeplessness, nausea, vomiting, headache, sweating, nervousness, tremors, tachycardia, hypertension, diaphoresis, dilated pupils, visual, tactile and auditory hallucinations. Vital signs and the CIWA score (0-67 possible) indicate how severe the withdrawal symptoms are; the higher the score the more severe the withdrawal. Medication is usually prescribed for a CIWA >10. A score of 15 + means the inmate may be at increased risk of withdrawal effects such as confusion and seizures. Older adults do not always show withdrawal signs in the same way that younger adults do. Older adults may not demonstrate signs of anxiety, 'shakes' or sweating. On the other hand, older adults, or those with impaired liver function, may have a prolonged period of time before symptoms are noticed. This can increase the risk of 'missing' those symptoms after housing the inmate.
1. **Seizures** (grand mal) were found to have occurred in up to 33% of alcoholics in one study, with <3% evolving into status epilepticus. Seizures tend to peak 24 hours after the last drink, corresponding to the EEG abnormalities. Seizure risk increases with the number of alcoholic withdrawal episodes (the "kindling effect"). Symptoms of alcohol withdrawal can begin from 4-48 hours after the last drink. Withdrawal

symptoms have been documented in some patients for weeks, although usually resolve within a week.

2. **Alcohol withdrawal delirium (DTs).** Refer immediately to Facility Provider or emergency room if fever (greater than 100.4 F), disorientation, changes in responsiveness of pupils, cognition changes, pulse > 100, increased deep tendon reflexes, auditory, tactile or visual hallucinations, or loss of consciousness occurs. Also refer to provider for any CIWA >25. (DTs are reflected by hyperautonomia and disorientation/confusion/hallucinations). This disturbance develops over a short period of hours-days and may fluctuate during the day. It also must be documented during or shortly after an alcohol withdrawal syndrome.

II. MANAGEMENT

- A. Do not begin pharmacological intervention until approximately twelve (12) hours after the inmate's last alcohol intake, unless unstable and otherwise ordered by provider. A CIWA should be performed when it is apparent that the client is in alcohol withdrawal.
- B. Use CIWA-AR tool BID X 7 days, vital signs and oxygen saturation with assessment, more often as necessary for CIWA > 25. Call provider for >3 consecutive CIWAs >25, seizures, questions or marked changes. **Hold any dose for excess sedation.**
- C. No more than 200 mg of Librium shall be given in twenty-four (24) hour period without consulting the Facility Provider.
- D. Manage as follows:
 - Librium 100 mg PO loading dose X1 if protocol started PM of first day.
 - Librium 100mg PO BID X2 day, then
 - Librium 75 mg PO BID X 1 day, then
 - Librium 50 mg PO BID X 2 days, then
 - Librium 50 mg PO HS X 2 days, then stop
 - High Complex B vitamin BID X 7 days
 - PNV 1 tab daily X 7 days
- E. If this dosage is not providing relief of symptoms, contact the Facility Provider for further orders. Some clients with liver disease may not be able to adequately metabolize Librium and may need to be prescribed a short acting benzodiazepine like Ativan, which has a much shorter half-life and requires assessments that are more frequent.
- F. May give Phenergan 25 mg one suppository rectally, or one tablet orally every six hours as needed for nausea and vomiting for 3 days.

- G.** Zofran ODT 4mg TID for 3 days for vomiting not improved with Phenergan, May increase to 8mg TID for 1 day then decrease back to 4mg TID if 4mg not initially effective. Notify Facility Provider if needing to use 8mg of Zofran
- H.** For abdominal cramping and diarrhea may give loperamide 2mg orally every 8 hours as needed for 3 days.

III. EVALUATION

- A.** Check and record vital signs at least each medical shift (BID) during the 7 days clients are on medication/CIWA for withdrawal, and as indicated, if unstable, thereafter.