camh
Centre for Addiction and Mental Health
Centre de toxicomanie et de santé mentale

addressograph

CLINICAL INSTITUTE WITHDRAWAL ASSESSMENT FOR ALCOHOL (CIWA)

Client/Patient Name:_____

Health Record #:_____ Date (dd/mm/yyyy):_____

NAUSEA & VOMITING: Ask "do you feel sick to your stomach?" Have you vomited?" Observation. 0 No nausea/vomiting 1 2 3 4 Intermittent nausea with dry heaves 5 6 7 constant nausea, frequent dry heaves & vomiting **score score score score**	**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 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 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 mild harshness or ability to frighten 4 moderately severe hallucinations 5 severe hallucinations 6 extremely severe hallucinations 7 continuous hallucinations
PAROXYSMAL SWEATS: 0 no sweat visible 1 barely perceptible sweating, palms moist 2 3 4 beads of sweat obvious on forehead 5 6 7 acute panic as seen in severe delirium or acute schizophrenic reactions	**VISUAL DISTURBANCES:** Ask: "does the light appear to be too bright? Is its color different? Does 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 sever hallucinations 5 severe hallucinations 6 extremely severe hallucinations 7 continuous hallucinations
ANXIETY: Ask "do you feel nervous?" 0 no anxiety, at ease. 1 Mildly anxious 2 3 4 Moderately anxious, or guarded, so anxiety is inferred. 5 6 7 acute panic as seen in severe delirium or acute schizophrenic reactions	**HEADACHE, FULLNESS IN HEAD:** 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. 0 note present 1 very mild 2 mild 3 moderate 4 moderately severe 5 severe 6 very severe 7 extremely severe
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 interview, or constantly thrashes about	**ORIENTATION & 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 and/or person

Time:_____ Total Score (max score=67)_____ Temp:_____B/P:_____/_____ Apex rate:_____ Resps:_____ Initials:____

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Revised as of May 2001

GUIDELINES

- Take the scale with you when assessing the client.
- Explain the procedure to the client-the frequency of assessment and the outcomes-ie: the need to adjust medication based on scoring.
- Ask if 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 are 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 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, 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 clients history indicated a likelihood of withdrawal reaction-large amounts over a long period of time, history of withdrawal symptoms, 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 is <10 after three consecutive assessments-this time may vary with individuals clients.
- Continue to monitory 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.

For CIWA score of =>10. Loading protocol will not prevent seizures in patients taking large doses of benzodiazepines or barbiturates in addition to alcohol.
CIWA-Ar protocol and pharmacological orders must be written by a physician on the physicians order sheet.

Basic Protocol

- *Diazepam 20 mg PO q 1-2 H until symptoms abate (Some inpatients require several hundred milligrams)*
- *Observe for 1-2 hours after last dose*
- *Take-home medication is generally not required; if take-home diazepam is necessary, give no more than 2-3 10 mg*

If history of withdrawal seizures:

- *Diazepam 20 mg q1H for a **minimum** of three doses*

If cannot tolerate oral diazepam:

- *Diazepam 2-5 mg IV/min - maximum 10-20 mg q1H; or lorazepam SL*

If severe liver disease, severe asthma or respiratory failure:

- *Lorazepam SL, PO 1-2 mg tid-qid*
  OR
- *Oxazepam 15-30 mg PO tid-qid*

If hallucinosis:

- *Haloperidol 2-5 mg IM/PO q1-4 H - max. 5/day*

** haloperidol lowers seizure threshold. Use with caution in 1st 3 days; give 3 doses of diazepam 20 mg as seizure prophylaxis.*

Admit to hospital If:

- *Still in withdrawal after 80 mg or more of diazepam*
- *Delirium tremens, recurrent arrhythmias or multiple seizures*
- *Medically ill*