NHS Grampian

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Date: 1st February 2024
Our Ref: JA/Guide_AcuteAlcohol/MGP1104
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Dear Colleagues

This guidance is currently under review by the author.

Management Of Acute Alcohol Withdrawal And Medically Assisted Withdrawal In Those At Risk, For Adults Admitted In Acute Hospitals Along With Guidance For Vitamin Replacement – Version 1.1

This document has been risk assessed by the author and deemed appropriate to be used during this review period. A copy of the risk assessment can be provided on request.

If you have any queries regarding this, please do not hesitate to contact the Medicines Guidelines and Policy Group (MGPG) email at gram.mgpg@nhs.scot

Yours sincerely

Lesley Coyle
Chair of MGPG, NHSG

NHS Grampian

Management Of Acute Alcohol Withdrawal And Medically Assisted Withdrawal In Those At Risk, For Adults Admitted In Acute Hospitals Along With Guidance For Vitamin Replacement

Co-ordinators:	Consultation Group:	Approver:
Consultant in Acute Medicine Unscheduled Care Pharmacist	See Page 12	Medicine Guidelines and Policies Group

Signature:		Signature:
		

Identifier:	Review Date:	Date Approved:
NHSG/Guide/Acute_Alcohol /MGPG1104	June 2022 **Expiry Date:** June 2023	June 2020

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Version 1.1 (Amended December 2020)

Executive Sign-Off

This document has been endorsed by the Director of Pharmacy and Medicines Management

Signature: 

Title: Management Of Acute Alcohol Withdrawal And Medically Assisted Withdrawal In Those At Risk, For Adults Admitted In Acute Hospitals Along With Guidance For Vitamin Replacement

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Across NHS Boards	Organisation Wide	Directorate	Clinical Service	Sub Department Area

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Purpose/description: To provide best management to patients who are admitted with acute alcohol withdrawal in order to reduce the risk of alcohol withdrawal seizures and delirium tremens.

Responsibilities for implementation:

Organisational: Chief Executive and Management Teams
Corporate: Senior Managers
Departmental: Heads of Service/Clinical Leads
Area: Line Managers
Hospital/Interface services: Assistant General Managers and Group Clinical Directors
Operational Management Unit: Unit Operational Managers

Policy statement: It is the responsibility of all staff to ensure that they are working to the most up to date and relevant policies, protocols procedures.

Review: This policy will be reviewed in three years or sooner if current treatment recommendations change.

Responsibilities for review of this document:	Consultant in Acute Medicine/ Unscheduled Care Pharmacist
Responsibilities for ensuring registration of this document on the NHS Grampian Information/ Document Silo:	Consultant in Acute Medicine/ Unscheduled Care Pharmacist
Physical location of the original of this document:	Acute Medicine
Job/group title of those who have control over this document:	Consultant in Acute Medicine/ Unscheduled Care Pharmacist
Responsibilities for disseminating document as per distribution list:	Consultant in Acute Medicine/ Unscheduled Care Pharmacist

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25/06/2019	N/A	New Document	NA
09/12/2020	June 2020	Amendment to tables 5 and 6.	Page 9

* Changes marked should detail the section(s) of the document that have been amended, i.e. page number and section heading.

Management Of Acute Alcohol Withdrawal And Medically Assisted Withdrawal In Those At Risk, For Adults Admitted In Acute Hospitals Along With Guidance For Vitamin Replacement

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1. Introduction

Twenty six percent of adults in Scotland consume alcohol above the recommended limits, and in Scotland adults buy 17% more alcohol than in England and Wales.

Harmful drinking is associated with multiple physical, psychological and psychiatric health problems. Abrupt reduction in alcohol intake in those who are dependent may lead to acute alcohol withdrawal.

Patients with acute alcohol withdrawal are at risk of alcohol withdrawal seizures or delirium tremens and may therefore need medical management of their withdrawal.

Those admitted to hospital for other reasons, but who are at risk of developing alcohol withdrawal may need medically assisted withdrawal whilst an inpatient.

Those who wish to suddenly stop drinking may also be in need of medically assisted withdrawal, often within the community, but this is not within the scope of this policy.

1.1. Objectives

To provide best management to patients who are admitted with acute alcohol withdrawal in order to reduce the risk of alcohol withdrawal seizures and delirium tremens, and to prevent the development of alcohol withdrawal in those at risk who are admitted for other reasons.

1.2. Definitions

Acute Alcohol Withdrawal - The physical and psychological symptoms that people can experience when they suddenly reduce the amount of alcohol they drink if they have previously been drinking excessively for prolonged periods of time.

Delirium Tremens - Symptoms of severe alcohol withdrawal with profound confusion, autonomic hyperactivity, sometimes including cardiovascular collapse.

Alcohol Dependence - 3 or more of:

(a) a strong desire or sense of compulsion to take the substance
(b) difficulties in controlling substance-taking behaviour in terms of its onset, termination, or levels of use
(c) a physiological withdrawal state when substance use has ceased/been reduced
(d) evidence of tolerance, such that increased doses of alcohol are required in order to achieve effects originally produced by lower doses

(e) progressive neglect of alternative pleasures or interests because of alcohol use, increased amount of time necessary to obtain or take the substance or to recover from its effects
(f) persisting with alcohol use despite clear evidence of overtly harmful consequences.

Harmful Drinking - A pattern of alcohol consumption that is causing mental or physical damage.

Hazardous Drinking - A pattern of alcohol consumption that increases someone's risk of harm. Some would limit this definition to the physical or mental health consequences (as in harmful use). Others would include the social consequences. The term is currently used by the World Health Organization to describe this pattern of alcohol consumption.

1.3. Clinical Situations

Patients presenting to the Emergency Department (ED) or Acute Medical Initial Assessment (AMIA) with symptoms of alcohol withdrawal, having recently decreased their alcohol consumption suddenly.

Patients who are alcohol dependent and are admitted to an acute hospital bed for a reason not related to alcohol withdrawal, but who are at risk of developing alcohol withdrawal due to the sudden cessation of alcohol consumption imposed on them.

1.4. Patient Groups To Which This Document Applies

- Patients who are 18 years and over.
- Patients who have established alcohol withdrawal syndrome requiring medical treatment, or those in hospital for a reason not relating to alcohol withdrawal, who are at risk of developing alcohol withdrawal, in whom a medically assisted withdrawal is appropriate.

1.5. Patient Groups To Which This Document Does Not Apply

- Patients under the age of 18 years.
- Patients who are electively trying to give up alcohol, either in the community or as an “elective inpatient detoxification” programme.
- Patients with minor withdrawal symptoms, who are not intending on cutting back their alcohol consumption.

2. Process Document Main Components and Recommendations

2.1. Identifying Patients who are at Risk of Acute Alcohol Withdrawal

All patients with a diagnosis of alcohol dependence are at high risk of alcohol withdrawal, as are those who have previously been diagnosed with alcohol withdrawal, if they have drank alcohol in the previous 7 days, but have recently reduced their consumption suddenly.

For those without an existing diagnosis but for whom there is concern, an initial Fast Alcohol Screening Tool (FAST) should be carried out:

Calculate FAST Score					
Score	0	1	2	3	4
How often do you drink > 8 units (male) > 6 units (female) on one occasion?	Never	< Monthly	Monthly	Weekly	> Weekly
How often have you been unable to remember what happened the night before because you have been drinking?	Never	< Monthly	Monthly	Weekly	> Weekly
How often have you failed to do what was normally expected of you because of drinking?	Never	< Monthly	Monthly	Weekly	> Weekly
In the last year has anyone been concerned about your drinking or suggested you cut down?	No		Yes, once		Yes, > once
Total					

A score of 3 or more would suggest harmful drinking, in which case an Adult Use Disorder Identification Test (AUDIT) should be conducted. Note the first 4 questions are from the FAST score, so only the bottom 6 questions are required additionally:

Calculate AUDIT Score					
Score	0	1	2	3	4
How often do you drink > 8 units (male) > 6 units (female) on one occasion?	Never	< Monthly	Monthly	Weekly	> Weekly
How often have you been unable to remember what happened the night before because you have been drinking?	Never	< Monthly	Monthly	Weekly	> Weekly
How often have you failed to do what was normally expected of you because of drinking?	Never	< Monthly	Monthly	Weekly	> Weekly
In the last year has anyone been concerned about your drinking or suggested you cut down?	No		Yes, once		Yes, > once
How often do you have a drink containing alcohol?	Never	Monthly	2 - 4 times per month	2 - 3 times per week	4+ times per week
How many units of alcohol do you drink on a typical day when you are drinking?	1-2	3-4	5-6	7-8	10+
How often during the last year have you found that you were not able to stop drinking once you had started?	Never	< Monthly	Monthly	Weekly	> Weekly
How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	< Monthly	Monthly	Weekly	> Weekly
How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	< Monthly	Monthly	Weekly	> Weekly
Have you or somebody else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year

Those with an AUDIT score of 20 or above, indicative of possible alcohol dependence, have a significant risk of developing alcohol withdrawal, and are therefore more likely to need medically assisted withdrawal, if they have drank alcohol in the last week, and are being admitted to hospital for reasons not related to alcohol withdrawal (i.e. will be reducing their consumption suddenly).

2.2. Treatment

Glasgow Modified Alcohol Withdrawal Scale

The Glasgow Modified Alcohol Withdrawal Scale (GMAWS) is a simplified version of the Clinical Institute Withdrawal from Alcohol (CIWA) tool which has been shown to be easy to use and safe. Staff should familiarise themselves with the tool, and training to use it should be cascaded from ward staff with regular updates.

It is recommended for the treatment of those with acute alcohol withdrawal (and for those admitted to hospital who are at risk of developing acute alcohol withdrawal) and uses benzodiazepines in a symptom triggered approach.

Chlordiazepoxide is the benzodiazepine of choice in NHS Grampian, except for those with established Delirium Tremens (a more severe syndrome with profound confusion, psychomotor agitation and autonomic hyperactivity), in whom lorazepam is preferred. Due to the longer half-life of chlordiazepoxide, we also recommend the shorter acting lorazepam in those with significant liver disease (defined as any of ascites, encephalopathy, albumin <30, bilirubin >50 or INR >1.3), the elderly (65 years or older), and those who would be at additional risk from over-sedation (recent head injury requiring neurological observations or risk of severe respiratory depression). See Inpatient Adult Alcohol Decision Aid (Appendix 1).

The decision to commence treatment should be documented and either a Chlordiazepoxide Prescription and Administration Record (Appendix 2) or Lorazepam Prescription and Administration Record (Appendix 3) should be prescribed. The scoring intervals outline in the prescription chart must be adhered to including, overnight, even if this requires briefly waking the patient to perform. Patients can still be withdrawing whilst sleeping.

A minority of patients have symptoms, not related to alcohol withdrawal, which may affect their GMAWS score (e.g. essential tremor, generalised anxiety disorder, sepsis), and if it is thought that the GMAWS score is not correlating well with their syndrome a fixed dose regimen would be preferred (an example of this is provided in Appendix 4 and 5, but can be personalised to the patients estimated requirements).

A small minority of patients may still exhibit symptoms despite having reached their “maximum daily dose” outlined in the protocol below. Where possible these patients should be identified during core working hours prior to reaching the maximum dose, to allow early discussions with medical staff. Such patients will required an individual risk-benefit assessment, taking the information below in to account, by a senior member of their medical team.

Firstly, ensure that the diagnosis is correct, and that the patient is not suffering from another condition that could be confused for alcohol withdrawal such as hepatic encephalopathy, encephalitis, meningitis or infection.

Secondly, the reliability of the scoring system should be assessed, to ensure that the patient’s scoring is adequately reflecting their symptoms due to alcohol withdrawal, and not any other conditions, as mentioned above, in which case a fixed dosing-regimen may be more appropriate.

Thirdly, an assessment of the side effects of their current benzodiazepine dose should be made, paying attention to sedation, respiratory depression and hypotension.

If after this assessment the patient is still considered to have significant symptoms related to their alcohol withdrawal despite reliable scoring and without significant adverse side effects, an increase in the maximum dose by 50% may be appropriate. Adequate monitoring for the above side effects would be important, and consideration of escalation to an area able to offer such monitoring should be considered (i.e. critical care). In patients with severe agitation, the rapid tranquilisation protocol (https://foi.nhsgrampian.org/globalassets/foidocument/foi-public-documents1---all-documents/Guide_NHSGRapTranq.pdf) might be more appropriate.

2.3. Vitamin Supplementation for Acute Alcohol Withdrawal

Wernicke-Korsakoff Syndrome

Wernicke-Korsakoff Syndrome is a manifestation of thiamine deficiency which is seen particularly in patients with alcohol dependence. Early recognition and treatment is important due to the risk of collapse and sudden death and to prevent irreversible damage to the nervous system.

Patients with signs or symptoms of Wernickes Encephalopathy should be prescribed 2 Pairs (2x I+II) of IV Pabrinex three times daily. Treatment is usually for 3-5 days, then change to oral thiamine 100mg three times daily for 3 months (if they remain abstinent, or continuously if still drinking). This applies to harmful/dependent drinkers with any of:

1. Confusion
2. Ataxia
3. Nystagmus
4. Ophthalmoplegia
5. Decreased GCS (Glasgow Coma Scale)
6. Hypothermia

Harmful/dependent drinkers, without any of the above signs/symptoms, but who are at high risk of developing Wernicke-Korsakoff syndrome (see below) should receive 1 pair (I+II) of IV Pabrinex once daily for 3-5 days. This applies if they have **two** or more of:

1. Malnutrition
2. Weight loss
3. Diarrhoea
4. Vomiting
5. MUST score ≥2 (see local policy)

All dependent/harmful drinkers should receive oral thiamine 100mg three times daily, if not receiving Pabrinex. This should be continued on discharge for 3 months (if still abstinent, or continuously if not).

2.4. Prescribing Guidance

2.4.1. Prescription and Administration Record (PAR)

a. Complete all biographical details on the PAR (if not already done) according to *Instructions for NHS Grampian Staff on the Prescribing and Administration of Medicines Using the NHS Grampian Prescription and Administration Record*. Ensure the 'Known Medicine Allergies/Sensitivities" box has been completed on the PAR and that there is no record that the patient has sensitivity to the drug which is to be prescribed.

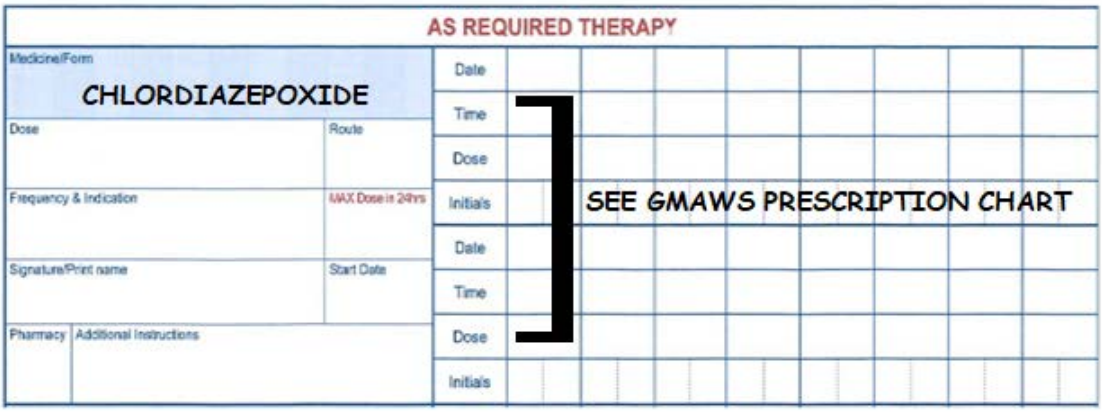
b. In the 'Other Medicine Charts or Treatment Plans in Use' section of the PAR, ensure that the 'Other' box is ticked, indicating that there is another prescription chart in use (Example 1).

Example 1: 'Other Medicine Chart or Treatment Plans in Use' Entry

OTHER MEDICINE CHARTS OR TREATMENT PLANS IN USE (Please tick)					
CHART TYPE		CHART TYPE		CHART TYPE	
1. Diabetes prescription sheet		5. Anaesthetic Record		9. Mental Health Care and Treatment (Scotland) Act 2003 - T2/T3 form	
2. Intravenous Patient-controlled analgesia prescription sheet		6. Oral anticoagulant prescription sheet		10. Adults with Incapacity (Scotland) Act 2000 (Section 47 Certificate and Treatment Plan)	
3. Fluid (additive medicine) prescription and recording sheet		7. Dermatology sheet		11. Syringe Driver	
4. Chemotherapy prescription sheet		8. Ophthalmology sheet		12. Other	✓

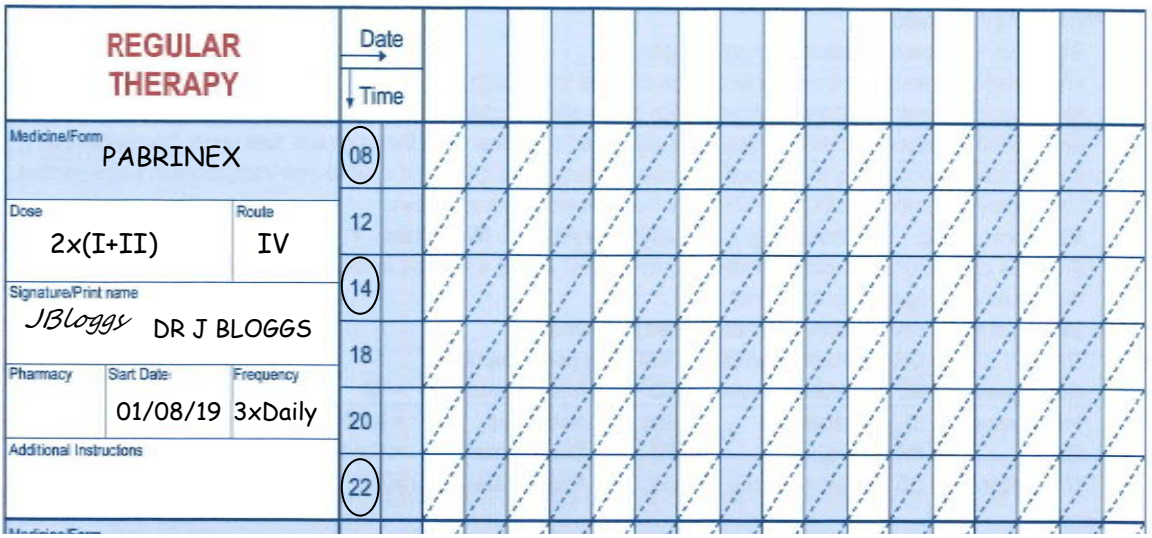
c. Prescribe the drug of choice in the 'As Required Therapy' section of the PAR (Example 2).

Example 2: 'As Required Therapy' Entry.



d. Prescribe intravenous Pabrinex or oral thiamine in the 'Regular Therapy' section of the PAR, as per the Inpatient Adult Alcohol Decision Aid in Appendix 1 (Example 3).

Example 3: Inpatient Prescribing of Vitamin Replacement for Treatment or Prophylaxis of Wernicke-Korsakoff Syndrome



2.4.2. In-patient Chlordiazepoxide and Lorazepam Symptom Triggered Treatment of Alcohol Withdrawal Prescription and Administration Records

See Appendix 2 for Chlordiazepoxide Prescription and Administration Record and Appendix 3 for Lorazepam Prescription and Administration Record.

Both the Chlordiazepoxide and Lorazepam Prescription and Administration Records are 4 page charts available on PECOS, with Page 1 detailing the Adult Inpatient Decision Tool, Page 2 detailing the Prescription (Page 1 of Appendix 2 and 3) and Page 3 and 4 detailing the Administration Record (Page 2 of Appendix 2 and 3, duplicated).

a. Complete the biographical details at the top of the 'In-patient Chlordiazepoxide/Lorazepam Prescription and Administration Record'.

- Patient's name: Full name in BLOCK CAPITALS
- Date of Birth: Written as, e.g. 01.01.80
- CHI number in full: 0101801000
- A printed patient demographic label may be used for the above
- Ward: Ward name/number
- Hospital: Abbreviations can be used, e.g. ARI
- Consultant: Surname should be written in full
- Date of admission
- Prescription number – record chronologically

b. Prescriber name should be printed and signed, along with date prescribed and contact number.

c. Complete patient name and CHI number on reverse of PAR.

d. Calculate GMAW score using Step 1 on 'In-patient Chlordiazepoxide/Lorazepam Prescription and Administration Record' (Example 4).

Example 4: Step 1 – Calculate GMAW Score

Step one – Calculate GMAW Score			
Score	**+ 0**	**+ 1**	**+ 2**
Tremor	None	On Movement	At rest
Sweating	None	Moist	Drenching
Hallucinations	None	Dissuadable	Not Dissuadable
Orientation	Orientated	Vague or Detached	Disorientated
Agitation	Calm	Anxious	Panicky

e. Calculate the dose of chlordiazepoxide or lorazepam using Step 2 on 'In-patient Chlordiazepoxide/Lorazepam Prescription and Administration Record' (Example 5 and 6).

Example 5: Step 2 – Calculate Chlordiazepoxide Dose and When to Repeat GMAW Score

Step Two - Calculate Oral dose and when to repeat GMAW Score		
GMAW Score	Dose	Interval unti next GMAW Score
0	None	2 hours Stop if zero on 4 consecutive occasions
1 - 3	20mg	2 hours
4 - 8	30mg	1 hour
9 - 10	40mg	1 hour AND inform medical staff

Example 6: Step 2 – Calculate Lorazepam Dose and When to Repeat GMAW Score

Step Two - Calculate Oral dose and when to repeat GMAW Score		
GMAW Score	Dose	Interval unti next GMAW Score
0	None	2 hours Stop if zero on 4 consecutive occasions
1 - 3	500 micrograms	2 hours
4 - 8	1mg	1 hour
9 - 10	2mg	1 hour AND inform medical staff

f. Record administration of chlordiazepoxide/lorazepam on the reverse of the 'In-patient Chlordiazepoxide/Lorazepam Prescription and Administration Record' detailing:

- Date and time of scoring
- GMAW score calculated
- Dose given to the patient
- Time the next scoring is due
- Initials of the person administering the medicine
- Any additional comments should be noted in the 'Comments' section (Example 7 and 8).

Example 7: Recording Administration of Chlordiazepoxide Using 'In-patient Chlordiazepoxide Prescription and Administration Record'

Chlordiazepoxide Administration Sheet

Patient Name: Jane Smith | Patient CHI: 1010801000

Maximum dose per 24 hours = 250 mg

Date	Time (24:00)	GMAW Score	Chlordiazepoxide Dose (mg)	Given By (initials)	Time next score due (24:00)	Comments
01/08/20	09:10	9	40mg	CD	10:10	Medical Staff Informed
01/08/20	10:10	7	30mg	CD	11:10	

Example 8: Recording Administration of Lorazepam using 'In-patient Lorazepam Prescription and Administration Record'

Lorazepam Administration Sheet

Patient Name: John Smith | Patient CHI: 0101801000

Maximum dose per 24 hours = 10 mg

Date	Time (24:00)	GMAW Score	Lorazepam Dose (mg)	Given By (initials)	Time next score due (24:00)	Comments
01/08/20	11:20	3	500micrograms	AB	13:20	
01/08/20	13:20	0	None	AB	15:20	

g. The scoring intervals outlined must be adhered to, even throughout the night as the patient will still be withdrawing whilst asleep, to reduce the risk of withdrawal seizures and delirium.

h. If the patient is scoring 9 - 10 on the GMAW calculator, medical staff should be informed.

i. If the patient is likely to reach the maximum daily dose (250mg of chlordiazepoxide or 10mg of lorazepam), medical staff should be informed and a senior review carried out to decide how to proceed.

j. If the patient has scored 0 on the GMAW score 4 consecutive times, medical staff should be informed and the GMAW prescription can be withdrawn by a prescriber by scoring through both the chart and the prescription on the PAR with the prescriber's signature, printed name and date.

2.5. Alcohol Liaison Nurse Service

The Alcohol Liaison Nurse Service (ALNS) is currently operational in specific areas within ARI. This is a developing service which has expanded over the past 4 years. The ALNS is available to carry out specialist assessment of patients presenting with alcohol related issues. The ALNS can provide patient specific advice via telephone for areas not currently covered by the service. Contact telephone number for the ALNS is (5)54505.

3. References

1) Alcohol-use disorders: diagnosis, assessment and management of harmful drinking (high-risk drinking) and alcohol dependence | Guidance | NICE [Internet]. Nice.org.uk. 2019 [cited 12 November 2019]. Available from: https://www.nice.org.uk/guidance/CG115

2) Alcohol Framework 2018 - gov.scot [Internet]. Gov.scot. 2019 [cited 12 November 2019]. Available from: https://www.gov.scot/publications/alcohol-framework-2018-preventing-harm-next-steps-changing-relationship-alcohol/

3) Benson G e. An alcohol withdrawal tool for use in hospitals. - PubMed - NCBI [Internet]. Ncbi.nlm.nih.gov. 2019 [cited 12 November 2019]. Available from: https://www.ncbi.nlm.nih.gov/pubmed/22866483

4) McPherson A e. Appraisal of the Glasgow assessment and management of alcohol guideline: a comprehensive alcohol management protocol for use in general hospitals. - PubMed - NCBI [Internet]. Ncbi.nlm.nih.gov. 2019 [cited 12 November 2019]. Available from: https://www.ncbi.nlm.nih.gov/pubmed/22328545

4. Distribution/Consultation List:

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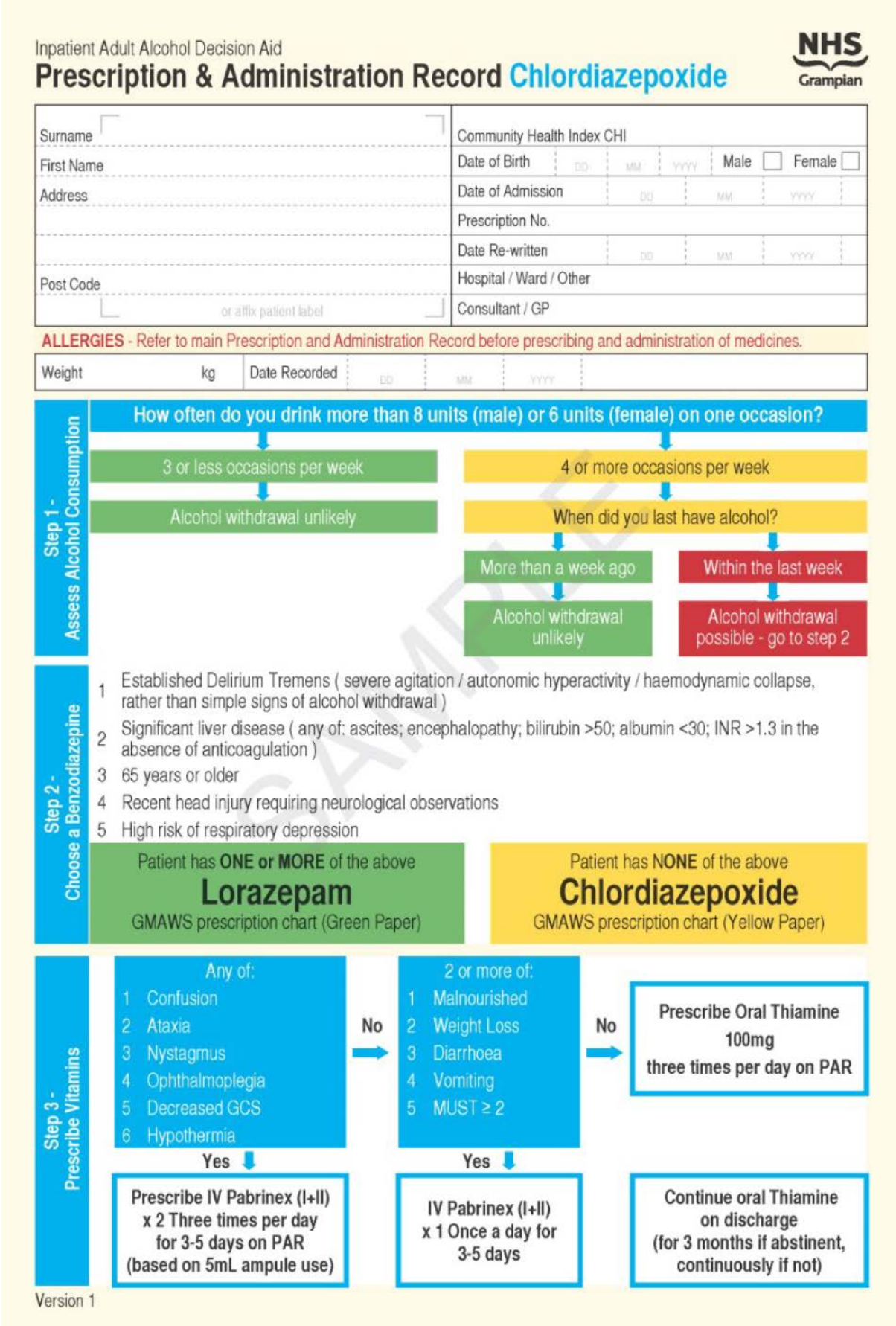
Mhairi Williams	Pharmacist, Dr Gray's Hospital

Appendix 1 – Inpatient Adult Alcohol Decision Aid (Chlordiazepoxide & Lorazepam Versions)



Inpatient Adult Alcohol Decision Aid

Prescription & Administration Record Chlordiazepoxide

NHS Grampian

Surname	Community Health Index CHI
First Name	Date of Birth DD MM YYYY Male ☐ Female ☐
Address	Date of Admission DD MM YYYY
	Prescription No.
	Date Re-written DD MM YYYY
Post Code	Hospital / Ward / Other
or affix patient label	Consultant / GP

ALLERGIES - Refer to main Prescription and Administration Record before prescribing and administration of medicines.

Weight kg	Date Recorded DD MM YYYY

Step 1 - Assess Alcohol Consumption

How often do you drink more than 8 units (male) or 6 units (female) on one occasion?

- 3 or less occasions per week → Alcohol withdrawal unlikely
- 4 or more occasions per week → When did you last have alcohol?
  - More than a week ago → Alcohol withdrawal unlikely
  - Within the last week → Alcohol withdrawal possible - go to step 2

Step 2 - Choose a Benzodiazepine

1. Established Delirium Tremens (severe agitation / autonomic hyperactivity / haemodynamic collapse, rather than simple signs of alcohol withdrawal)
2. Significant liver disease (any of: ascites; encephalopathy; bilirubin >50; albumin <30; INR >1.3 in the absence of anticoagulation)
3. 65 years or older
4. Recent head injury requiring neurological observations
5. High risk of respiratory depression

Patient has **ONE or MORE** of the above
Lorazepam
GMAWS prescription chart (Green Paper)

Patient has **NONE** of the above
Chlordiazepoxide
GMAWS prescription chart (Yellow Paper)

Step 3 - Prescribe Vitamins

Any of:
1. Confusion
2. Ataxia
3. Nystagmus
4. Ophthalmoplegia
5. Decreased GCS
6. Hypothermia

Yes ↓ **Prescribe IV Pabrinex (I+II) x 2 Three times per day for 3-5 days on PAR (based on 5mL ampule use)**

No →

2 or more of:
1. Malnourished
2. Weight Loss
3. Diarrhoea
4. Vomiting
5. MUST ≥ 2

Yes ↓ **IV Pabrinex (I+II) x 1 Once a day for 3-5 days**

No → **Prescribe Oral Thiamine 100mg three times per day on PAR**

Continue oral Thiamine on discharge (for 3 months if abstinent, continuously if not)

Version 1

Inpatient Adult Alcohol Decision Aid

Prescription & Administration Record Lorazepam

NHS Grampian

Surname	Community Health Index CHI
First Name	Date of Birth DD MM YYYY Male ☐ Female ☐
Address	Date of Admission DD MM YYYY
	Prescription No.
	Date Re-written DD MM YYYY
Post Code	Hospital / Ward / Other
or affix patient label	Consultant / GP

ALLERGIES - Refer to main Prescription and Administration Record before prescribing and administration of medicines.

Weight kg	Date Recorded DD MM YYYY

Step 1 - Assess Alcohol Consumption

How often do you drink more than 8 units (male) or 6 units (female) on one occasion?

- 3 or less occasions per week → Alcohol withdrawal unlikely
- 4 or more occasions per week → When did you last have alcohol?
  - More than a week ago → Alcohol withdrawal unlikely
  - Within the last week → Alcohol withdrawal possible - go to step 2

Step 2 - Choose a Benzodiazepine

1. Established Delirium Tremens (severe agitation / autonomic hyperactivity / haemodynamic collapse, rather than simple signs of alcohol withdrawal)
2. Significant liver disease (any of: ascites; encephalopathy; bilirubin >50; albumin <30; INR >1.3 in the absence of anticoagulation)
3. 65 years or older
4. Recent head injury requiring neurological observations
5. High risk of respiratory depression

Patient has **ONE or MORE** of the above → **Lorazepam** GMAWS prescription chart (Green Paper)

Patient has **NONE** of the above → **Chlordiazepoxide** GMAWS prescription chart (Yellow Paper)

Step 3 - Prescribe Vitamins

Any of:
1. Confusion
2. Ataxia
3. Nystagmus
4. Ophthalmoplegia
5. Decreased GCS
6. Hypothermia

Yes → **Prescribe IV Pabrinex (I+II) x 2 Three times per day for 3-5 days on PAR (based on 5mL ampule use)**

No → **2 or more of:**
1. Malnourished
2. Weight Loss
3. Diarrhoea
4. Vomiting
5. MUST ≥ 2

Yes → **IV Pabrinex (I+II) x 1 Once a day for 3-5 days**

No → **Prescribe Oral Thiamine 100mg three times per day on PAR**

Continue oral Thiamine on discharge (for 3 months if abstinent, continuously if not)

Version 1

Appendix 2 – Chlordiazepoxide Prescription & Administration Record

In-patient Chlordiazepoxide Symptom Triggered Treatment of Alcohol Withdrawal

NHS Grampian

Surname	Community Health Index CHI
First Name	Date of Birth DD MM YYYY Male ☐ Female ☐
Address	Date of Admission DD MM YYYY
	Prescription No.
	Date Re-written DD MM YYYY
Post Code	Hospital / Ward / Other
or affix patient label	Consultant / GP

ALLERGIES - Refer to main Prescription and Administration Record before prescribing and administration of medicines.

Prescription		
Medication: Oral Chlordiazepoxide	**Dose:** As per GMAW Score. Maximum 250mg in 24 hours	**Route:** Oral
Prescriber's Signature	Print Name	Date DD MM YYYY
	Contact	Time (24 hour) :

Step One - Calculate GMAW Score			
Score	**+ 0**	**+ 1**	**+ 2**
Tremor	None	On Movement	At Rest
Sweating	None	Moist	Drenching
Hallucinations	None	Dissuadable	Not Dissuadable
Orientation	Orientated	Vague or Detached	Disorientated
Agitation	Calm	Anxious	Panicky

Step Two - Calculate Oral dose and when to repeat GMAW Score		
GMAW Score	Dose	Interval unti next GMAW Score
0	None	2 hours Stop if zero on 4 consecutive occasions
1 - 3	20mg	2 hours
4 - 8	30mg	1 hour
9 - 10	40mg	1 hour AND inform medical staff

Chlordiazepoxide Administration Sheet	
Patient Name	CHI No.

Maximum Dose per 24 hours = 250mg

Date DD	MM	YYYY	Time (24:00)	GMAW Score	Chlordiazepoxide dose (mg)	Given by (initials)	Time next score due (24:00)	Comments
			:				:	

Chlordiazepoxide Administration Sheet	
Patient Name	CHI No.

Maximum Dose per 24 hours = 250mg

Date DD MM YYYY	Time (24:00)	GMAW Score	Chlordiazepoxide dose (mg)	Given by (initials)	Time next score due (24:00)	Comments
	:				:	

Pecos XXXXXXX CGD 200349

Appendix 3 – Lorazepam Prescription & Administration Record

In-patient Lorazepam Symptom Triggered Treatment of Alcohol Withdrawal

NHS Grampian

Surname	Community Health Index CHI
First Name	Date of Birth DD MM YYYY Male ☐ Female ☐
Address	Date of Admission DD MM YYYY
	Prescription No.
	Date Re-written DD MM YYYY
Post Code	Hospital / Ward / Other
or affix patient label	Consultant / GP

ALLERGIES - Refer to main Prescription and Administration Record before prescribing and administration of medicines.

Weight	kg	Date Recorded	DD MM YYYY	

Prescription

Medication: Oral Lorazepam	**Dose:** As per GMAW Score. Maximum 10mg in 24 hours	**Route:** Oral
Prescriber's Signature	Print Name	Date DD MM YYYY
	Contact	Time (24 hour) :

Step One - Calculate GMAW Score

Score	+ 0	+ 1	+ 2
Tremor	None	On Movement	At Rest
Sweating	None	Moist	Drenching
Hallucinations	None	Dissuadable	Not Dissuadable
Orientation	Orientated	Vague or Detached	Disorientated
Agitation	Calm	Anxious	Panicky

Step Two - Calculate Oral dose and when to repeat GMAW Score

GMAW Score	Dose	Interval unti next GMAW Score
0	None	2 hours Stop if zero on 4 consecutive occasions
1 - 3	500 micrograms	2 hours
4 - 8	1mg	1 hour
9 - 10	2mg	1 hour AND inform medical staff

Lorazepam Administration Sheet	
Patient Name	CHI No.

Maximum Dose per 24 hours = 10mg

Date DD	MM	YYYY	Time (24:00)	GMAW Score	Lorazepam dose (mg)	Given by (initials)	Time next score due (24:00)	Comments
			:				:	

Lorazepam Administration Sheet	
Patient Name	CHI No.

Maximum Dose per 24 hours = 10mg

Date DD	MM	YYYY	Time (24:00)	GMAW Score	Lorazepam dose (mg)	Given by (initials)	Time next score due (24:00)	Comments
			:				:	

Appendix 4 – Example Fixed Dose Chlordiazepoxide Regimen

Chlordiazepoxide Fixed Dose Reducing Regimen	10:00	13:00	18:00	22:00
Day 1	30mg	30mg	30mg	30mg
Day 2	20mg	20mg	20mg	20mg
Day 3	15mg	15mg	15mg	15mg
Day 4	10mg	10mg	10mg	10mg
Day 5	10mg	5mg	5mg	10mg
Day 6	5mg	5mg	5mg	5mg
Day 7	5mg			5mg

Appendix 5 – Example Fixed Dose Lorazepam Regimen

Lorazepam Fixed Dose Reducing Regimen	10:00	13:00	18:00	22:00
Day 1	1mg	1mg	1mg	1mg
Day 2	1mg	0.5mg	0.5mg	1mg
Day 3	0.5mg	0.5mg	0.5mg	1mg
Day 4	0.5mg	0.5mg	0.5mg	0.5mg
Day 5	0.5mg	0.5mg		0.5mg
Day 6	0.5mg			0.5mg