How to use the Clinical Institute Withdrawal Assessment for Alcohol Use - revised (CIWA-Ar) for the Perinatal In-Patient

Performing the assessment:

1. The CIWA-Ar scale is the most sensitive tool for assessment of the patient experiencing alcohol withdrawal. Nursing assessment is vitally important. This assessment for monitoring withdrawal symptoms requires approximately 5 minutes to administer.
2. Take the scale with you when assessing the patient. Explain the procedure, frequency of assessments, and the need to adjust the medication based on the scoring. Attend to comfort measures before doing the assessment. Take the vital signs first. Inform the patient of the outcome of the assessment and what to expect next. If they are withdrawing will they receive medication or supportive care?
3. Assess and rate each of the 10 criteria of the CIWA scale. Each criterion is rated on a scale from 0 to 7, except for "Orientation and clouding of sensorium" which is rated on scale 0 to 4. Add up the scores for all ten criteria. This is the total CIWA-Ar score for the patient at that time.
4. Document vital signs on MEOWS including BP, HR, RR, and O_2 Saturation. Include Temperature at least q4H. These are not factored into the overall scoring but they provide important clinical information.
5. PRN medications are ordered for scores 10 or greater. See Physician Orders. Document administration of PRN withdrawal medications on CIWA-Ar.

Frequency of Assessment:

1. Assess Q1H until the score is below 10 for 3 consecutive measurements, then Q6H x 24 hours.
2. Allow patient to sleep if most recent CIWA less than 10 and not drowsy at the time of that assessment. Monitor respirations only. Wake patient for CIWA assessment if most recent score was 10 or greater, or if drowsy at the time of that assessment.
3. If scores remain less than 10, continue Q24H x 72 hours, then discontinue. Resume CIWA-Ar if alcohol withdrawal returns.
4. If score is between 10-20 (mild stage), continue to assess Q1H. If score is greater than 20 (severe stage) assess Q30-45 minutes.
5. More frequent monitoring (i.e., every 10 minutes) may be indicated if scores continue to increase, in order to quickly titrate patients up to an adequate dose that controls withdrawal symptoms.
6. Monitoring frequency should not be stepped down until a patient's CIWA scores are consistently stable or decreasing over time.
7. If patient refuses 3 consecutive assessments alert physician to determine a patient specific plan.

Notify Physician If:

- Patient experiences a seizure, is confused or agitated, there is evidence of delirium, or difficult to rouse.
- PRN doses administered reach 10 mg or greater of lorazepam, or 50 mg or greater of diazepam over a 24-hour time period.
- CIWA-Ar score greater than 20; a change in score of greater than 10; or intention to medicate below CIWA-Ar score of 10.
- Modified Early Obstetric Warning Score Trigger Tool indicates escalation.
- If patient is on a regular benzodiazepine dose and CIWA-Ar score is less than 9, call physician to taper.

Cautions:

- Stimulant use may present challenges with CIWA scoring, as patients withdrawing from stimulants may experience agitation, hallucinations, restlessness, anxiety and autonomic hyperactivity in substance induced psychosis, withdrawal or intoxication.
- Patients with severe risk for withdrawal complications require CIWA assessments through the night. Patients who go unassessed and unmedicated through the night may wake up in full withdrawal and at risk for severe complications.
- If CIWA-Ar scores above 10, assess for potential complications: seizure activity, dehydration status including I&O, aspiration secondary to vomiting, injury to self or others, AWOL risk, and ongoing alcohol consumption.

Developed By

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Version History

DATE	DOCUMENT NUMBER and TITLE	ACTION TAKEN
23-Feb-2021	C-06-06-60988 Clinical Institute Withdrawal Assessment For Alcohol Use: Perinatal	Approved at: Maternal Newborn Best Practice Committee

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