Clinical Institute Withdrawal Assessment (CIWA-Ar scale)

Clinical Institute Withdrawal Assessment, protocol

CIWA-Ar scale

The most objective and best-validated tool to assess the severity of alcohol withdrawal is the Clinical Institute Withdrawal Assessment for Alcohol, Revised (CIWA-Ar).[2] This survey consists of 10 items and can be administered rapidly at the bedside. The 10 items include nausea and vomiting, anxiety, tremor, sweating, auditory disturbances, visual disturbances, tactile disturbances, headache, agitation, and clouding of sensorium. Zero to 7 points are assigned to each item, except for the last item, which is assigned 0-4 points, with a total possible score of 67.

This scale has been demonstrated to have high reliability, reproducibility, and validity, based on comparisons with ratings by experienced clinicians, and has been shown to be usable in detoxication units, psychiatry units, and hospital medical/surgical wards.

The CIWA-Ar scale is intended only for patients who have been drinking recently. It relies on patients' ability to respond to questions about their symptoms. Patients must be able to communicate and have a clear enough sensorium to reply logically, because many of the items require coherent answers. The CIWA-Ar scale has not been validated in complex medical patients, postsurgical patients, and critically ill patients.

A score of greater than 15 is seen in patients with moderate to severe alcohol withdrawal. Patients with a score of greater than 15 or those who have a history of alcohol withdrawal seizures should be treated with medication upon presentation. These patients need to be monitored carefully for the development of Delirium tremens (DTs). Patients with a score of 8-15, who have mild alcohol withdrawal, should probably also receive drug treatment. Careful and frequent monitoring with the CIWA-Ar is particularly helpful in patients receiving treatment with symptom-triggered drug therapy (also known as prn therapy).

Procedure:

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. Prophylactic medication should be started for any patient with a total CIWA-Ar score of 8 or greater (ie. start on withdrawal medication). If started on scheduled medication, additional PRN medication should be given for a total CIWA-Ar score of 15 or greater.

Document vitals and CIWA-Ar assessment on the Withdrawal Assessment Sheet. Document administration of PRN medications on the assessment
sheet as well.

The CIWA-Ar scale is the most sensitive tool for assessment of the patient experiencing alcohol withdrawal. Nursing assessment is vitally important. Early intervention for CIWA-Ar score of 8 or greater provides the best means to prevent the progression of withdrawal.

Alcohol Withdrawal Assessment Scoring Guidelines (CIWA - Ar)

Nausea/Vomiting - Rate on scale 0 - 7

0 - None

1 - Mild nausea with no vomiting

2

3

4 - Intermittent nausea

5

6

7 - Constant nausea and frequent dry heaves and vomiting

Tremors - have patient extend arms & spread fingers. Rate on scale 0 - 7.

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 w/ arms not extended

Anxiety - Rate on scale 0 - 7

0 - no anxiety, patient at ease

1 - mildly anxious

2

3

4 - moderately anxious or guarded, so anxiety is inferred

5

6

7 - equivalent to acute panic states seen in severe delirium or acute schizophrenic reactions.

Agitation - Rate on scale 0 - 7

0 - normal activity

1 - somewhat normal activity

2

3

4 - moderately fidgety and restless

5

6

7 - paces back and forth, or constantly thrashes about

The sample show only 4 of 10 test criteria.