**CIWA-Ar Tool**

**Alcohol Withdrawal Assessment Scoring Guidelines (CIWA - Ar)**

**Nausea/Vomiting** - Rate on scale 0 - 7 **Tremors -** have patient extend arms & spread fingers. Rate onScale 0 - 7.

0 - None 0 - No tremor

1 - Mild nausea with no vomiting

2

3

1 - Not visible, but can be felt fingertip to fingertip 2 3

4 - Intermittent nausea

5

6

4 - Moderate, with patient’s arms extended

5

6

7 - Constant nausea and frequent dry heaves and vomiting 7 - severe, even w/ arms not extended

**Anxiety** - Rate on scale 0 - 7 **Agitation** - Rate on scale 0 - 70 - no anxiety, patient at ease 0 - normal activity

1 - Mildly anxious

2

3

1 - Somewhat normal activity

2

3

4 - Moderately anxious or guarded, so anxiety is inferred 5 6

4 - Moderately fidgety and restless

5

6

7 - Equivalent to acute panic states seen in severe delirium Or acute schizophrenic reactions.

7 - Paces back and forth, or constantly thrashes about

**Paroxysmal Sweats** - Rate on Scale 0 - 7.0 - no sweats

**Orientation and clouding of sensorium** -Ask, “What day isThis? Where are you? Who am I?” Rate scale 0 - 4

1- Barely perceptible sweating, palms moist 0 - Oriented 2 3

1 – Cannot do serial additions or is uncertain about date 4 - Beads of sweat obvious on forehead

5

2 - Disoriented to date by no more than 2 calendar days 6 3 - disoriented to date by more than 2 calendar days

7 - Drenching sweats 4 - Disoriented to place and / or person

**Tactile disturbances** -Ask, “Have you experienced any

Itching, pins & needles sensation, burning or numbness, or a

Feeling of bugs crawling on or under your skin?”

**Auditory Disturbances** -Ask, “Are you more aware of sounds

Around you? Are they harsh? Do they startle you? Do you hear?

Anything that disturbs you or that you know isn’t there?”

0 - none 0 - not present

1 - Very mild itching, pins & needles, burning, or numbness 1 - Very mild harshness or ability to startle 2 - Mild itching, pins & needles, burning, or numbness 2 - mild harshness or ability to startle

3 - Moderate itching, pins & needles, burning, or numbness 3 - moderate harshness or ability to startle 4 - Moderate hallucinations 4 - moderate hallucinations

5 - Severe hallucinations 5 - severe hallucinations

6 - Extremely severe hallucinations 6 - extremely severe hallucinations 7 - Continuous hallucinations 7 - continuous hallucinations

**Visual disturbances** -Ask, “Does the light appear to be too

Bright? Is its color different than normal? Does it hurt your

Eyes? Are you seeing anything that disturbs you or that you?

Know isn’t there?”

**Headache** - Ask,“Does your head feel different than usual?

Does it feel like there is a band around your head?” Do not rate

Dizziness or lightheadedness. 0 - not present 0 - not present

1 - Very mild sensitivity 1 - very mild

2 - Mild sensitivity 2 - mild

3 - Moderate sensitivity 3 - moderate

4 - Moderate hallucinations 4 - moderately severe

5 - Severe hallucinations 5 - severe

6 - Extremely severe hallucinations 6 - very severe

7 - Continuous hallucinations 7 - extremely severe

Procedure:

1. 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 (i.e. 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.

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

Sheet as well.

1. 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.

**Assessment Protocol**

a. Vitals, Assessment Now.



b. If initial score 8 repeat q1h x 8 hrs. Then

If stable q2h x 8 hrs. Then if stable q4h. c. If initial score < 8, assess q4h x 72 hrs. If score < 8 for 72 hrs. D/c assessment.



If score 8 at any time, go to (b) above.

d. If indicated, (see indications below) Administer prn medications as ordered and Record on MAR and below.

**Date**

**Time**

**Pulse**

**RR**

**O2 sat**

**BP**

**Assess and rate each of the following (CIWA-Ar Scale): Refer to reverse for detailed instructions in use of the CIWA-Ar scale.**

**Nausea/vomiting** (0 - 7)

0 - none; 1 - mild nausea, no vomiting; 4 - intermittent nausea; 7 - Constant nausea, frequent dry heaves & vomiting.

**Tremors** (0 - 7)

0 - no tremor; 1 - not visible but can be felt; 4 - moderate w/ arms

Extended; 7 - severe, even w/ arms not extended.

**Anxiety** (0 - 7)

0 - none, at ease; 1 - mildly anxious; 4 - moderately anxious or Guarded; 7 - equivalent to acute panic state

**Agitation** (0 - 7)

0 - normal activity; 1 - somewhat normal activity; 4 - moderately Fidgety/restless; 7 - paces or constantly thrashes about

**Paroxysmal Sweats** (0 - 7)

0 - no sweats; 1 - barely perceptible sweating, palms moist; 4 - Beads of sweat obvious on forehead; 7 - drenching sweat

**Orientation** (0 - 4)

0 - oriented; 1 - uncertain about date; 2 - disoriented to date by no

|  |  |
| --- | --- |
|  |  |

More than 2 days; 3 - disoriented to date by > 2 days; 4 - Disoriented to place and / or person

**Tactile Disturbances** (0 - 7)

0 - none; 1 - very mild itch, P&N, numbness; 2-mild itch, P&N, Burning, numbness; 3 - moderate itch, P&N, burning, numbness; 4 - Moderate hallucinations; 5 - severe hallucinations;

6 – Extremely severe hallucinations; 7 - continuous hallucinations

**Auditory Disturbances** (0 - 7)

0 - not present; 1 - very mild harshness/ ability to startle; 2 - mild Harshness, ability to startle; 3 - moderate harshness, ability to Startle; 4 - moderate hallucinations; 5 severe hallucinations;

6 - Extremely severe hallucinations; 7 - continuous. Hallucinations

**Visual Disturbances** (0 - 7)

0 - not present; 1 - very mild sensitivity; 2 - mild sensitivity;

3 - Moderate sensitivity; 4 - moderate hallucinations; 5 - severe Hallucinations; 6 - extremely severe hallucinations; 7 - Continuous hallucinations

**Headache** (0 - 7)

0 - not present; 1 - very mild; 2 - mild; 3 - moderate; 4 - moderately Severe; 5 - severe; 6 - very severe; 7 - extremely severe

**Total CIWA-Ar score**:

PRN Med: (circle one)

Diazepam Lorazepam

**Dose given (mg):**

**Route:**

**Time** of PRN medication administration:

Assessment of response (CIWA-Ar score 30-60

Minutes after medication administered)

RN Initials

**Scale for Scoring:**

Total Score =

0 – 9: absent or minimal withdrawal

10 – 19: mild to moderate withdrawal More than 20: severe withdrawal

**Indications for PRN medication:**

a. Total CIWA-AR score 8 or higher if ordered PRN only (Symptom-triggered method).

B. Total CIWA-Ar score 15 or higher if on Scheduled medication. (Scheduled + prn method) Consider transfer to ICU for any of the following: Total score above 35, q1h assess. X more than 8hrs Required, more than 4 mg/hr. lorazepam x 3hr **or** 20 mg/hr. diazepam x 3hr required, or resp. distress.

Patient Identification (Addressograph)

Signature/ Title Initials Signature / Title Initials

**Sullivan, J.T.; Sykora, K.; Schneiderman, J.; Naranjo, C.A.; and Sellers, E.M. Assessment of alcohol withdrawal: The revised Clinical Institute Withdrawal Assessment for Alcohol scale (CIWA-Ar). *British Journal of Addiction* 84:1353-1357, 1989.**