

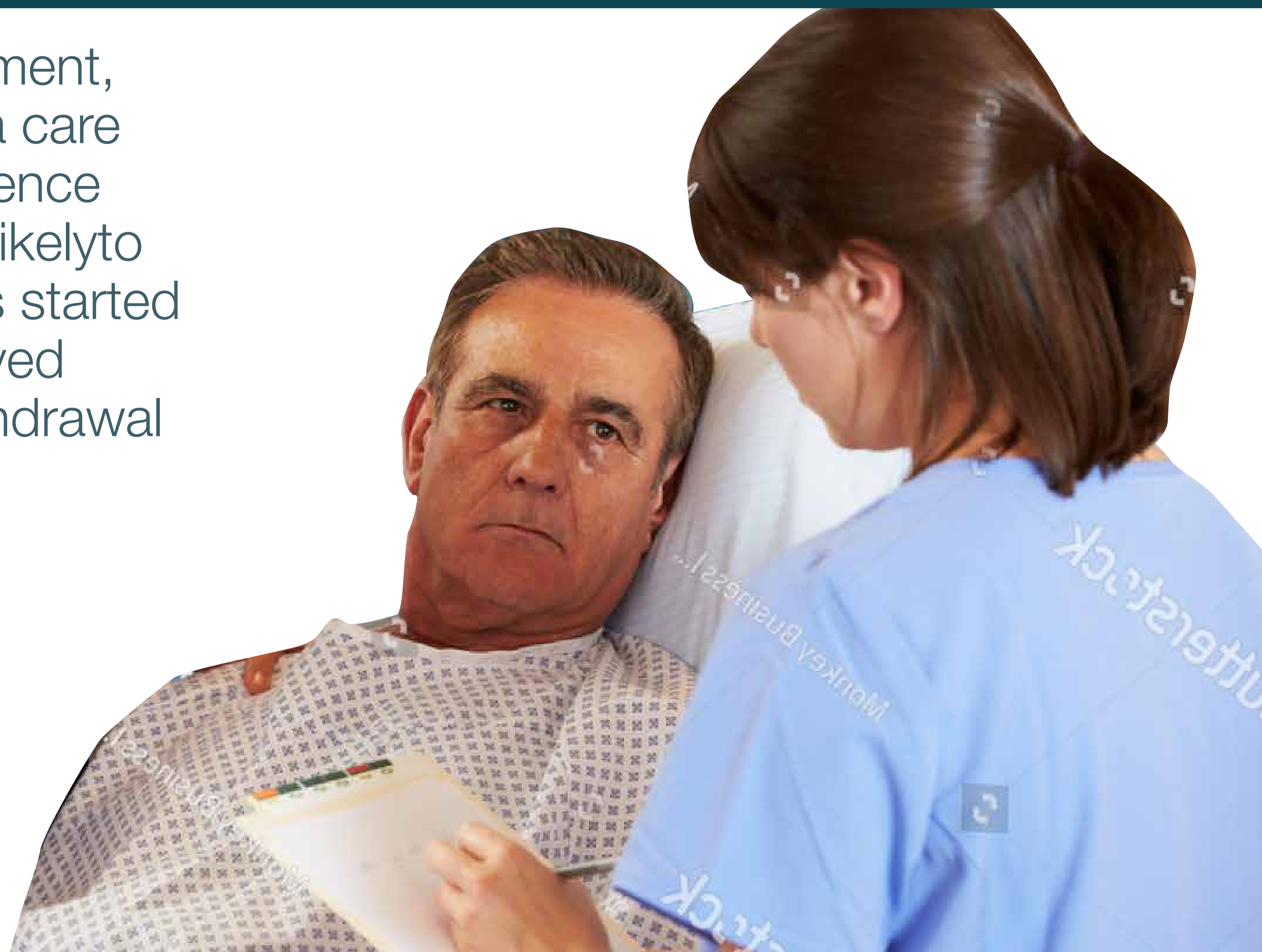
Alcohol withdrawal management for acute admissions to hospital

20
YEARS OF
NICE
1999-2019

We updated our alcohol withdrawal management, in line with NICE guidance (CG100), so that a care pathway was followed when alcohol dependence was suspected. Medical treatment was less likely to be delayed by severe symptoms if detox was started earlier. We found that fewer people had delayed discharge due to onset of severe alcohol withdrawal after admission.

“It seemed a tall order given the range of staff involved, but now the alcohol pathway is properly embedded it is difficult to imagine how we managed without it.”

Dr Jacob De Wolff, Consultant Acute Physician, Acute Medicine, Northwick Park Hospital



What we did and why

We needed to promote best practice because there was wide variation in prescribing practices for people at risk of alcohol withdrawal. Where alcohol dependence was recognised, there was not always the best initiation and reduction of medication. In too many cases, symptoms were not recognised early enough, resulting in severe withdrawals.

The project was led by Adrian Brown, alcohol nurse specialist, working alongside Justin Baker who had personal experience of detox in hospital, with Alex Thomson, consultant psychiatrist, and Susan Barber, Improvement Science Manager at NIHR CLAHRC Northwest London. We held monthly steering groups, at which acute admissions nurses, pharmacists and medical colleagues were key participants.

We identified key stakeholders from all departments, kept people informed who could not attend meetings and established ‘champions’ among staff on admissions wards. During the pilot stage we changed the main forms frequently to reflect feedback from these meetings. We used plan-do-study-act cycles to outline our intentions and our development, and produced a tool that we could pilot for several months to evaluate its impact.

Outcomes and impact

The alcohol care pathway included an alcohol withdrawal scale, which improved care for people at risk of alcohol dependence. This facilitated closer monitoring by nursing staff, which allowed higher doses to be triggered earlier and symptoms to be reduced sooner.

Trust policy has been reviewed to include the alcohol withdrawal scale hourly for the first 24 hours of admission – including time spent in the emergency department.

Average length of stay in hospital	9 days	7 days
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Average duration of detox	6 days 39% ended by day 6	5 days 51% ended by day 6
Average doses chlordiazepoxide	116mg to 115mg by day 3	134mg to 106mg by day 3

In addition, 78 people received correct protocol doses of Pabrinex, but when the bundle was not followed, 14 had an incorrect Pabrinex regimen and 6 had no Pabrinex prescribed.

What we learnt

- Our baseline study showed that diagnostic coding was inaccurate for many patients. We used these findings to influence changes in practice – an unexpected gain.
- A simple one-page version of the alcohol protocol was introduced to our admissions unit. This was favourably received by ward staff, who felt they had been involved in its introduction and recognised changes made according to their feedback.
- A modified alcohol withdrawal scale has been established to help non-specialist staff identify symptoms and set a more effective initial prescription.
- Staff surveys have shown improved knowledge about alcohol problems and, despite staff turnover, this has been sustained. We inform medical staff about this at their four-monthly rotation.

We recommend continuously auditing information about prescribing daily rather than retrospectively auditing case notes and prescriptions. Most people who started alcohol care bundles during the project had their notes audited (137/210), but only 98 of those had all documentation present.

Project Team: Adrian Brown, Susan Barber, Justin Baker, Alan Poots, Alex Thomson