Education Pack for the Alcohol Liaison Nurse Service

Welcome to the Alcohol Liaison Nurse Service, this pack is designed to help you get the most out of your time here with us today and set some objectives that we would like you to achieve. These objectives are an understanding of:

The role of the Alcohol Liaison Nurse

Understanding of Units

Risk Levels

Patient Assessment & Audit C

The Alcohol Care Pathway

Giving Brief Advice

How to Refer to the ALNS

The Role of Community Services

The Alcohol Liaison Nurse Service provides an unbiased non judgemental service to all patients admitted to hospital where alcohol may be implicated in their admission or is having an impact on their lives. We provide staff with training, refer to community support and manage inpatient care.

Units and Risk Levels

The government advises that people should not regularly drink more than the daily unit guidelines of 3-4 units of alcohol for men (equivalent to a pint and a half of 4% beer) and 2-3 units of alcohol for women (equivalent to a 175 ml glass of wine). 'Regularly' means drinking every day or most days of the week.

Current advice also advocates two days alcohol free per week (ideally together) and no more than 14 units per week for women and 21 units per week for men.

One unit is 10 ml of pure alcohol - the amount of alcohol the average adult can process within an hour. This means that if the average adult drinks a drink with one unit of alcohol in it, within an hour there should in theory be no alcohol left in their bloodstream, but that length of time could differ depending on a person's body size

Risk to social, physical and psychological health	Men	Women
Low Risk	3-4 units per day regularly	2-3 units per day on a regular basis
Increasing Risk	4-8 units per day regularly	3-6 units per day on a regular basis
Higher Risk	8+ units per day regularly or 50+ units per week	6+ units per day on a regular basis or 35+ units per week

Patient Assessment

AUDIT C

Questions	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	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 - 9	10+	
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

AUDIT-C is a shortened version of the full AUDIT assessment using the first 3 questions only.

This can identify 86% of patients with heavy drinking and/or active alcohol abuse or dependence.

Used in conjunction with the Alcohol Care Pathway it is recommended a score of 5 or more points should lead to a more detailed assessment (completion of the full questionnaire).

A total of 5+ indicates increasing or higher risk drinking.

The AUDIT assessment form can be found on the front page of the intranet.

For example a man who normally drinks two cans of 4% lager twice a week would score as follows

- 3 for drinking twice per week
- 1 for drinking 3-4 units
- 0 for not drinking above 8 or more units on a single occasion

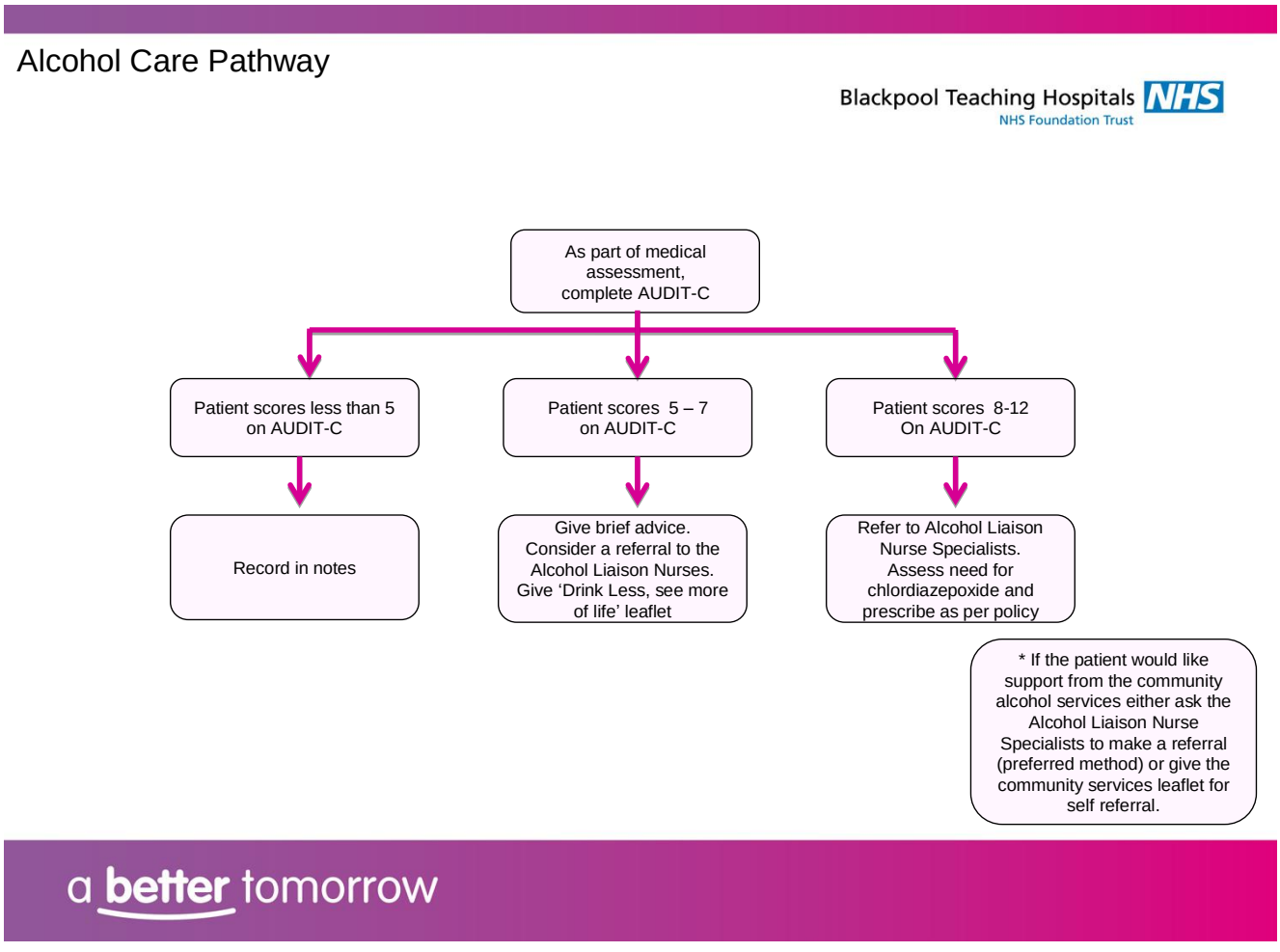
This gives a total of **4**

A woman who normally drinks a bottle of wine 4 nights per week would score as follows

- 4 for drinking 4+ times per week
- 4 for drinking 10 units
- 4 for drinking above 6 units on a single occasion

This gives a total of **12**

The Alcohol Care Pathway



The Alcohol Care Pathway should be used in conjunction with AUDIT C; once the score has been obtained the flow chart should be followed as indicated

- Score of less than 5 – no further action needed, document in notes.
- Score of 5 -7 – Give brief advice, leaflet and consider a referral to the Alcohol Liaison Nurse Service, document in notes.
- Score of 8-12 – Refer to Alcohol Liaison Nurse Service and consider the need for appropriate medical intervention, document in notes.

It is advised to obtain the patients consent for referral. If the patient declines consent but still scores highly the Alcohol Liaison Nurse will still need to visit to ensure the patient is prescribed appropriate medication to prevent alcohol withdrawal syndrome and correct nutritional deficit.

So for the two patients assessed on the previous page what would be your actions for:

The man scoring 4? _____

The woman scoring 12? _____

Giving Brief Advice

Brief advice involves giving simple advice to people drinking at increasing or higher risk levels that may or may not be presenting with an alcohol related problem. We use the FRAMES acronym to help guide the advice given.

F	**Feedback** Give an explanation of AUDIT score and risk level
R	**Responsibility** Place responsibility on the patient to make changes
A	**Advice** Advise the patient to cut down or abstain
M	**Menu** Ask patient for their ideas of ways to cut down and give suggestions
E	**Empathy** Show understanding and empathy towards the patient
S	**Self-efficacy** Encourage and reinforce the patients' belief that they can make changes

For example when we look at the woman who scored 12 on her assessment we might give brief advice like this.

- **Feedback.** You score quite highly on our assessment of your alcohol intake
- **Responsibility.** How do you feel about this? Does this concern you?
- **Advice.** You are drinking above recommended guidelines and it would be advisable to reduce your intake.
- **Menu**. What do you think you could do to help reduce your alcohol intake? Perhaps you could look at lower strength wines or alternating between alcoholic drinks and soft drinks when you're out?
- **Empathy.** I know it can be difficult when you are out with your friends or sat at home feeling low.
- **Self efficacy.** You appear to be quite determined, I'm sure that with appropriate support and planning you will succeed in making the changes we have discussed.

How to Refer

Referral is easy; once you have completed the AUDIT C and followed the Alcohol Care Pathway simply call the Alcohol Liaison Office on 3943 or page one of the Alcohol Liaison Nurses

- Julie Spencer-Bennett 766
- Jess Wright 765
- Julia Gasser 465
- Simon Cook 230

Please ensure you have patient details, number of units they drink per day and the AUDIT C score

Community Services

There are a variety of community based services within the Fylde Coast area; these are divided into Blackpool (FY1-FY4) and Fylde & Wyre (FY5-FY8).

In addition to these Blackpool residents have the option of attending Nurse Led Clinics run by the Alcohol Liaison Nurse Service.

Alcoholics Anonymous cover all areas and are particularly useful in befriending patients who live alone with no support from friends or family who may struggle to cope alone with their alcohol issues.

ACT, Access and Choices Team, Dickson Road Tel No: 01253 311431

Clients aged 24 years and over in Blackpool (FY1 - FY4 postcodes)

- Single point of access for drug and alcohol services in Blackpool
- Support is given for alcohol, and other substances.
- Clients will be triaged after an information session
- Limited to 4-6 weeks for alcohol clients (12 weeks for other clients), and then clients are referred on to other services

Moving Forward, Cookson Street

Referral from ACT for Blackpool residents (FY1 - FY4 postcodes)

- Time-limited clinical and psychosocial interventions (i.e. talking therapies)
- Cognitive Behavioural Therapy (CBT)
- Structured day care and after care
- Detoxification and reduction service
- Transition to Recovery and Social Inclusion Service
- Assessment for referral to inpatient detox and rehab

Recovery, Springfield Road

Referral from ACT and Moving Forward for Blackpool residents (FY1– FY4 postcodes)

- Community based psychosocial interventions
- Aimed at drug and alcohol clients with the aim of maintaining abstinence or within the recommended alcohol units
- Improving relationships and working towards entering education and /or employment
- Community Rehabilitation for 12 weeks

The Hub

Tel No: 01253 476010

Clients aged 24 years and under for Blackpool residents (FY1 - FY4 postcodes)

- Offer advice and support (alcohol, tobacco and drugs)
- Offers time-limited clinical and psycho-social interventions
- Cognitive Behavioural Therapy (CBT)
- Effective care co-ordination and harm reduction
- Offers one-to-one support and is free, friendly and non-judgemental
- Flexible to meet clients needs

Alcoholics Anonymous, Tel No: 0845 7697555

Different AA meetings held in Blackpool, Fylde and Wyre

- Fellowship of people who share their experiences with each other
- Help each other to solve common issues and help each other recover
- Only requirement is a desire to stop drinking
- No fees for membership and it is run by volunteers
- Main purpose is to stay sober and help other alcoholics to achieve sobriety

CRI Inspire, 162 Dock Street, Fleetwood & The Patterson Centre St Albans Road, St Annes Tel No: 0845 894745

Fylde & Wyre residents of all ages (FY5 - FY8 postcodes and some PR4)

- Individualised recovery programmes
- Offer information, advice and guidance
- Services include designated recovery workers, psychosocial interventions, access to prescribing, support for families
- Offer signposting to employment, training and education.
- Offer support with housing and other benefits

Alcohol Dependency

A simple and informal definition of alcohol dependence is that it is a condition resulting from the prolonged and usually intense consumption of alcohol which has resulted in psychological and/or physiological dependence on alcohol consumption. This dependence results in significant problems in one or more areas of the person's life. The diagnosis of alcohol dependence is made when one or more of the following occurs over a one year period:

- compulsive use
- increased frequency
- increased tolerance
- withdrawal symptoms
- lack of control
- neglect of alternative interests

Signs and symptoms of Alcohol Withdrawal Syndrome

Alcohol withdrawal syndrome is the set of symptoms seen when an individual reduces or stops alcohol consumption after prolonged periods of excessive alcohol intake. The severity of the alcohol withdrawal syndrome can vary from mild symptoms such as mild sleep disturbances and mild anxiety to very severe and life threatening including delirium, particularly visual hallucinations in severe cases and convulsions (which may result in death).

- shakes
- sweats
- nausea
- disturbed sleep
- agitation
- Delirium Tremens (life threatening)
- hallucinations (visual & auditory)
- withdrawal fits (life threatening)

If you suspect a patient is at risk of withdrawal start a CIWA assessment form and contact the ALNS as soon as possible failure to do so could endanger the life of the patient.

CIWA

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

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.

What then?

PRN only?- Withdrawal medication should be started for any patient with a total **CIWA-Ar score of 8 or greater.**

Already on a reducing regime? - PRN medication should be given for a total **CIWA-Ar score of 15 or greater.**
Document obs and CIWA-Ar assessment in the patients' notes. Document administration of PRN medications on drug kardex.

Assessment Protocol a. Obs & Assessment Now. b. If initial score ³ 8 repeat hourly for 8 hrs, then if stable 2 hourly for 8 hrs, then if stable 4 hourly. c. If initial score < 8, assess 4 hourly for 72 hrs. If score < 8 for 72 hrs, discontinue assessment. If score ³ 8 at any time, go to (b) above. d. If indicated, (see indications below) administer PRN medications	**Date**												
	Time												
	Pulse												
	Resps												
	SPO2												
	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:													
Time of PRN medication administration:													
Assessment of response (CIWA-Ar score 30-60 minutes after medication administered)													
Nurse Initials													

Scale for Scoring: **Total Score =**	**Indications for PRN medication**
0 – 9: absent or minimal withdrawal 10 – 19: mild to moderate withdrawal more than 20: severe withdrawal	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 a reducing regime. (Reducing regime + PRN method) **For Senior review if**: Total score above 35, if hourly assessment required for more than 8hrs, more than 4 mg/hr orazepam over 3 hours, or respiratory distress.

Suggested Further Reading

Nutrition and Alcohol (Thiamine Deficiency, Refeeding Syndrome)

Management of Alcohol Withdrawal Syndrome (Medications, Nutritional Support)

Driving and Alcohol / The Law and Alcohol

Physical and Mental Health Risks

Useful Websites

www.alcoholconcern.org.uk

www.alcohollearningcentre.org.uk

www.drinkaware.co.uk

www.talktofrank.com

Testing what you have learned today

We would like you to look at the following scenario and using what you have learned today

- Assess the patients' alcohol intake using the appropriate tool.
- State what your plan of care would be based on the assessment.
- Suggest what brief advice you would offer.

Sue is a 46 year old woman, married to Dave with two children 14 and 12. She works part time as a secretary in a busy legal office three days a week. At lunch she goes out with colleagues to a local pub where they eat and have a glass of wine. At home Sue and her husband like to relax with a DVD and twice a week will drink a bottle of wine between them. At weekends they meet up with friends on a Saturday night where Sue will drink 3-4 double vodka and cokes. On Sundays they like to take a ride out in the car for a nice pub lunch where Sue will drink a large glass of wine. She has noticed that she is beginning to put on weight and has had to see her GP regarding recurrent acid reflux. Her GP has referred her to the Gastro Department for endoscopy.

Signature of Mentor/Trainer…… Date ……