

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

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.

Paroxysmal Sweats - Rate on Scale 0 - 7.

- 0 - no sweats
- 1 - barely perceptible sweating, palms moist
- 2
- 3
- 4 - beads of sweat obvious on forehead
- 5
- 6
- 7 - drenching sweats

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?"

- 0 - none
- 1 - very mild itching, pins & needles, burning, or numbness
- 2 - mild itching, pins & needles, burning, or numbness
- 3 - moderate itching, pins & needles, burning, or numbness
- 4 - moderate hallucinations
- 5 - severe hallucinations
- 6 - extremely severe 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?"

- 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

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

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

Orientation and clouding of sensorium - Ask, "What day is this? Where are you? Who am I?" Rate scale 0 - 4

- 0 - Oriented
- 1 - cannot do serial additions or is uncertain about date
- 2 - disoriented to date by no more than 2 calendar days
- 3 - disoriented to date by more than 2 calendar days
- 4 - Disoriented to place and / or person

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 - not present
- 1 - Very mild harshness or ability to startle
- 2 - mild harshness or ability to startle
- 3 - moderate harshness or ability to startle
- 4 - moderate hallucinations
- 5 - severe hallucinations
- 6 - extremely severe hallucinations
- 7 - continuous hallucinations

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
- 1 - very mild
- 2 - mild
- 3 - moderate
- 4 - moderately severe
- 5 - severe
- 6 - very severe
- 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 (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.
2. Document vitals and CIWA-Ar assessment on the Withdrawal Assessment Sheet. Document administration of PRN medications on the assessment sheet as well.
3. 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.

