Alcohol And Seniors

Clinical Institute Withdrawal Assessment for Alcohol (CIWA-Ar) scale

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This clinical tool assesses 10 common withdrawal signs. A score of 15 + points means the patient may be at increased risk of alcohol withdrawal effects such as confusion or seizures. Clinicians working with older adults note that a lower cutoff is advisable for older adults, as a score of more than 15 may mean a potential health crisis.

Older adults do not always show withdrawal signs in the same way that that younger adults do. For example, older adults may not demonstrate signs of anxiety, shakes, or sweating. Alternatively, the signs may be confused with other medical conditions that the older adult has, such as Parkinson's disease. In other cases, the person may have some degree of cognitive impairment and may not be able to accurately tell you how she or he is feeling. For that reason, monitoring vital signs before withdrawal (and having a baseline of what is normal for this person) and during withdrawal can provide very important information.

Clinical Institute Withdrawal Assessment for Alcohol (CIWA-Ar) scale

Patient _____ Date ___/___/___ Time _____ : _____

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y m d (24-hour clock, midnight = 00:00)

Pulse or heart rate, taken for 1 minute: _____ Blood pressure: _____ / _____

NAUSEA AND VOMITING — Ask "Do you feel sick to your stomach? Have you vomited?" Observation.

0 no nausea and no vomiting

1 mild nausea with no vomiting

2

3

4 intermittent nausea with dry heaves

5

6

7 constant nausea, frequent dry heaves and vomiting

TREMOR — Arms extended and fingers spread apart. Observation.

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 with arms not extended

PAROXYSMAL SWEATS — Observation.

0 no sweat visible

1 barely perceptible sweating, palms moist

2

3

4 beads of sweat obvious on forehead

5

6

7 drenching sweats

ANXIETY — Ask "Do you feel nervous?" Observation.

0 no anxiety, at ease

1 mildly anxious

2

3

4 moderately anxious, or guarded, so anxiety is inferred

5

6

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

AGITATION — Observation.

0 normal activity

1 somewhat more than normal activity

2

3

4 moderately fidgety and restless

5

6

7 paces back and forth during most of the interview, or constantly thrashes about

TACTILE DISTURBANCES — Ask "Have you any itching, pins and needles sensations, burning sensations, numbness or do you feel bugs crawling on or under your skin?" Observation.

0 none

1 very mild itching, pins and needles, burning or numbness

2 mild itching, pins and needles, burning or numbness

3 moderate itching, pins and needles, burning or numbness

4 moderately severe hallucinations

5 severe hallucinations

6 extremely severe hallucinations

7 continuous hallucinations

AUDITORY DISTURBANCES — Ask "Are you more aware of sounds around you? Are they harsh? Do they frighten you? Are you hearing anything that is disturbing to you? Are you hearing things you know are not there?" Observation.

0 not present

1 very mild harshness or ability to frighten

2 mild harshness or ability to frighten

3 moderate harshness or ability to frighten

4 moderately severe hallucinations

5 severe hallucinations

6 extremely severe hallucinations

7 continuous hallucinations

VISUAL DISTURBANCES — Ask "Does the light appear to be too bright? Is its colour different? Does it hurt your eyes? Are you seeing anything that is disturbing to you? Are you seeing things you know are not there?" Observation.

0 not present

1 very mild sensitivity

2 mild sensitivity

3 moderate sensitivity

4 moderately severe hallucinations

5 severe hallucinations

6 extremely severe hallucinations

7 continuous hallucinations

HEADACHE, FULLNESS IN HEAD — Ask "Does your head feel different? Does it feel as if there is a band around your head?" Do not rate for dizziness or lightheadedness. Otherwise, rate severity.

0 not present

1 very mild

2 mild

3 moderate

4 moderately severe

5 severe

6 very severe

7 extremely severe

ORIENTATION AND CLOUDING OF SENSORIUM — Ask "What day is this? Where are you? Who am I?"

0 oriented and can do serial additions

1 cannot do serial additions or is uncertain about date

2 disoriented for date by no more than 2 calendar days

3 disoriented for date by more than 2 calendar days

4 disoriented for place and/or person

Total CIWA-Ar score: _____

Rater's initials: _____

Maximum possible score: 67

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