# Alcohol Withdrawal UHL Policy

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1. **Introduction**

1.1 This document sets out the University Hospitals of Leicester (UHL) NHS Trust’s policy for patients who are admitted suffering with Alcohol misuse. Alcohol misuse is a common problem resulting in about 1.26 million alcohol-related hospital admissions in England in 2018/19.

1.2 It is estimated that there are 586,780 people that are dependent on alcohol in England (PHE 2017/18). Patients may present to hospital either directly as a result of intoxication or indirectly following a consequence of intoxication or acute alcohol withdrawal.

1.3 All areas of the hospital may be affected. The following policy provides advice for how patients should be screened for harmful drinking as well as the management of patients who are dependent on alcohol.

2. **Policy Scope and Roles and Responsibilities**

2.1 This policy applies to:

**Staff group(s)**

- Substance Misuse Liaison Team (Turning Point)
- The medical team in charge of the patient’s overall care
- The ward nurses
- The hospital pharmacy

**Clinical area(s)**

- All clinical areas across UHL where a patient with alcohol withdrawal is admitted.

**Patient group(s)**

- Adult patients within all clinical areas across UHL

2.2 **Roles and responsibilities in managing alcohol withdrawals**
2.2.1 Management of Alcohol Withdrawals requires a multidisciplinary approach and expert management.

2.2.2 The responsibility of the overall management of the patient sits with the medical team in charge of the overall care. The medical team will hold responsibility for initiating the use of the GMAWS, all prescribing issues and for considering the impact of the Alcohol Withdrawals on the patient’s overall treatment.

Given the potential complexity of co-morbid Alcohol Dependence and other physical health conditions, care will often require regular Registrar or Consultant oversight.

2.2.3 The Substance Misuse Liaison Team (Turning Point) will provide advice, support and start brief interventions to the patient. They can also arrange continuing support from their community resources on patient discharge where applicable. The workers cannot give advice on medical interventions for the patient while an inpatient. The Team will provide patient with an Alcohol Advice Leaflet (see Appendix 9).

2.2.4 The ward nurse will monitor and implement the use of the GMAWS, administer medication as per prescription and guidance, and offer general care and support.

2.2.5 The pharmacist will ensure that necessary medications are supplied to the clinical setting promptly to reduce the potential for complications arising from delayed administration of medication. The pharmacist will also provide relevant pharmacological advice.

3. Confirming Alcohol consumption and identification of alcohol related problems

3.1 Taking an Alcohol History

As part of the admission assessment for all patients they should be asked about their alcohol intake. Please note the following as good practice:

- Consumption of alcohol should be documented in units (see Appendix 1 regarding the calculation of units drunk).
- There is great variation in container sizes (bottles/cans) and strength (%abv) of alcoholic drinks. It is important these variables are recorded to ascertain true intake.
- It is essential to ascertain the pattern of drinking, stating whether the number of units drunk relate to a daily or weekly consumption
- If problematic/ harmful drinking is detected (see appendix 2), the pattern of drinking and length of time the problem has been going on for should also be documented
- Is there a history of alcohol withdrawals? What symptoms the patient experienced should be documented. Has the patient previously suffered seizures?

3.2 Types of Drinkers

3.2.1 Low Risk or sensible drinkers

The recommended maximum daily limits for drinking alcohol are, for both men and women, 14 units per week, spread across 3-5 days, with at least 2-3 days per week abstinent. People drinking at this pattern are considered to be at low risk of developing any problems as a result of their alcohol consumption.

3.2.2 Increasing risk or hazardous drinker

These are people that drink 14-35 units weekly. They are considered to be at risk of developing significant physical or mental health problems due to their drinking. This group also includes binge drinkers. Binge drinkers are defined as those who consume twice the recommended daily limits, about 6 units daily, over a short period of time (1-5 days).
This group of drinkers is harder to detect when they present as they often attend sober and usually appear to have a normal lifestyle. However early detection allows for brief interventions to be offered, which is more likely to result in a reduction in the amount consumed.

### 3.2.3 Higher risk or harmful drinkers

These are people that show signs of clear alcohol-related harm due to their drinking pattern. For women this constitutes drinking at 35+ units weekly.

### 3.2.4 Alcohol Dependent Patients

Alcohol dependence starts at an intake of around 10+ units daily (although it could be less). Alcohol dependent patients are individuals who show a cluster of physiological, behavioural and cognitive problems as a result of their drinking. Alcohol takes on a much higher priority, often with a strong desire to drink despite awareness of harmful consequences.

According to the WHO International Classification of Diseases-10, a definitive diagnosis of dependence should usually be made if three or more of the following are present or have been present at any time within the previous year:

1. A strong desire or sense of compulsion to take alcohol
2. Difficulty in controlling drinking in terms of its onset termination or level of use
3. A physiological withdrawal state when drinking has ceased or been reduced or drinking to avoid alcohol withdrawal symptoms
4. Evidence of tolerance, such that increased doses of alcohol are required in order to achieve effects originally produced by lower doses
5. Progressive neglect of other interests
6. Persisting with alcohol use despite awareness of overtly harmful consequences.

Most patients would present to hospital as a result of complications with point 3 above - a physiological withdrawal state.

**ADVICE:**

Use Audit-C (appendix 2) to help identify types of drinkers. Please note that a score of 20+ indicates possible dependency. Dependency here relates to physical dependency characterised by alcohol withdrawals as opposed to alcohol dependency syndrome.

### 4. Alcohol Withdrawal Management

#### 4.1 What causes Alcohol Withdrawals?

Abrupt cessation of or reduction in, long-term high dose alcohol consumption produces well defined symptoms collectively described as alcohol withdrawal syndrome (AWS). The intensity of alcohol withdrawal is variable between individuals ranging from mild to its most severe manifestation that include seizures, hallucinations and delirium.

Within the WHO International Classification of Diseases-10, for a diagnosis of AWS to be made there must be clear evidence of:

- Recent cessation or reduction of alcohol intake after repeated, and usually prolonged and / or high-dose use.
- Symptoms and signs which are compatible with the known features of the AWS, and
- Symptoms and signs that cannot be accounted for by an alternative medical, mental or behavioural disorder unrelated to alcohol.
4.2 Does this patient require medical admission for alcohol withdrawal?

4.2.1 Patients at high risk of alcohol withdrawal seizures, delirium tremens (DTs), individuals aged under 16 with alcohol withdrawal problems or vulnerable adults with alcohol withdrawal problems should be admitted to hospital and offered medically assisted alcohol withdrawal.

Patients not in these groups may be suitable for treatment in the community. For more information see Appendix 4. (They should be advised to slowly reduce their alcohol intake as outlined in Appendix 7 or in the Alcohol Advice leaflet as per Appendix 9).

4.2.2 It is important to avoid either under-treatment, which may lead to DTs or seizures, or over-treatment, associated with sedation.

DTs are fatal in 15-20 % of patients whilst early detection and prompt initiation of treatment usually prevents onset and reduces mortality to around 1%.

Patients most at risk are those with high fever, tachycardia, and dehydration, an associated illness (pneumonia or pancreatitis) or where diagnosis is delayed. These patients will also be at risk of developing Wernicke’s Encephalopathy and Korsakoff’s Psychosis (See Section 5)

ADVICE:
Please note that patients who are physically dependent on alcohol and not admitted to hospital should be advised to gradually reduce their intake at a rate of not more than 5 units per day.

(See Appendix 7 for information on the gradual reduction of alcohol intake)

4.3 Managing Alcohol Withdrawals for patients admitted to hospital

4.3.1 Oral benzodiazepines are the group of drugs recommended for the routine management of alcohol withdrawals. The most appropriate approach to the management of alcohol withdrawals is considered to be symptom triggered dosing. Within UHL we have chosen the Glasgow Modified Alcohol Withdrawal Scale (section 4.6 and Appendix 5) to help manage alcohol withdrawals in a symptom triggered fashion.

4.3.2 NICE guidelines (2010) recommend that symptom triggered dosing of medication is associated with decreased complication and better patient outcomes. Symptom triggered dosing consists of prescribing benzodiazepines (Diazepam) on an ‘as and when’ basis, with the dose to be administered being guided by the symptoms that the patient presents with.
4.3.3 This allows more flexibility in dose administration and reduces the potential for inadequate or excessive dosing. It can also help avoid unnecessary use of medications, over sedation and other side effects, and has the added benefit of reducing length of stay.

**ADVICE:**

Alcohol withdrawal hallucinations typically occur within the first 2 days after stopping or reducing alcohol intake. For some patients this will not progress to delirium tremens (DTs) and will occur in the presence of a clear sensorium. However the presence of hallucinations is a significant indicator that progression to DTs is more likely and this indicates the need for closer monitoring.

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<tr>
<th>4.4 Signs and Symptoms of Alcohol Withdrawals: see Appendix 3</th>
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<tr>
<td><strong>4.4.1</strong> Considerations for the management of patients undergoing alcohol withdrawal:</td>
</tr>
<tr>
<td>• During alcohol withdrawal management, it is essential to closely monitor for signs of over-sedation or break through withdrawals.</td>
</tr>
<tr>
<td>• Exceptional patient groups, patients with severe withdrawals and patients requiring intravenous or intramuscular sedation, require close monitoring with an early warning score (EWS). Ideally 1 hourly care is required in an appropriately monitored area (such as Liver HDU or ACB).</td>
</tr>
<tr>
<td>• Observe for dehydration or any electrolyte imbalance (all patients should have their electrolytes checked including magnesium, calcium and potassium concentrations)</td>
</tr>
<tr>
<td>• Treat any concurrent conditions. Many patients presenting with alcohol abuse may also have other conditions associated with self-neglect.</td>
</tr>
<tr>
<td>o <strong>Reassure patients</strong></td>
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</table>

**4.5. Glasgow Modified Alcohol Withdrawal Scale (GMAWS)**

**4.5.1** The GMAWS aims to assist staff in selecting treatment pathways for Alcohol Withdrawal Symptoms (AWS). It is a five-variable assessment tool aimed at managing AWS in acute hospitals.

These AWS are:
- Tremor
- Sweating
- Hallucinations
- Orientation
- Agitation

**4.5.2** The scoring allows for withdrawing risk to be assessed and managed through a suggested diazepam dose. It also allows for high risk patients to be assessed and dealt with in both a fixed and symptom triggered fashion. Patients that present with severe withdrawals (DTs) can be managed through parenteral administration of benzodiazepines.

**4.6 How to use the Glasgow Modified Alcohol Withdrawal Scale (GMAWS)**

**4.6.1** After ascertaining physical dependency either through use of the AUDIT tool (**Appendix 2**: Score 20+ signifying possible dependency), patients with recent history of drinking about 15 units/day or presenting with alcohol withdrawal, the GMAWS approach to alcohol withdrawal management should be adopted.
The following procedure should be used in conjunction with the flow-chart set out in Appendix 5:

1. Ensure patient details are documented correctly
2. Identify whether the patient is high risk or otherwise. If high risk and not an exceptional patient (see box 2 appendix 50 then admitting doctor to start on a fixed dose oral diazepam regime and symptom triggered as required (PRN) doses.
3. If patient is not high risk then please start on symptom triggered treatment. Also assess if patient is an exceptional patient as they may need PRN lorazepam instead of diazepam.
4. Diazepam or Lorazepam PRN doses to be guided by the Alcohol Withdrawal Scale and the assessment of the following withdrawal symptoms: Tremor, Sweating, Hallucinations, Orientation and Agitation as per the GMAWS scoring system. Each symptom is scored from 0-2
5. The amount of diazepam to be given and the frequency of assessments is dependent on the score as below:
   - Score 0 = No diazepam Repeat score in 2 hours and discontinue if score remains 0 on 4 consecutive occasions, except if during the first 48 hours after cessation of alcohol
   - Score 1 - 3 = 10mg diazepam. Repeat score in 2 hours
   - Score 4 – 8 = 20mg diazepam. Repeat score in 1 hour
   - Score 9 – 10 = 20mg diazepam. Repeat score in an hour and discuss with medical staff regarding management of severe withdrawal as per regime.
6. All patients who are scoring on the GMAWS system require referral to the Substance Misuse Liaison Team (Turning Point) for review and further support on 07734694857 or 07535658329
7. Seek senior review if high doses of diazepam (over 120mg) or Lorazepam (12mg) are needed (See Appendix 2, Box 3). Some patients may require doses over 120mg diazepam in 24 hours. Please seek senior review if exceeding these doses
8. Discontinue scoring after patient scores 0 (zero) on 4 consecutive occasions, except if during the first 48 hours after cessation of alcohol.

5. Wernicke's Encephalopathy (WE)

Every patient who appears to have signs of alcohol withdrawal and / or started on GMAWS management regime must be assessed for WE.

5.1 What is Wernicke's Encephalopathy (WE)

WE is a neurological disease caused by thiamine (Vitamin B1) deficiency. If untreated it can lead to Korsakoff’s syndrome, characterised by chronic amnesia or death

WE is a medical emergency that is reversible with timely administration of appropriate treatment. Chronic alcohol users are at particular risk of WE because:

- They are more likely to have a lower level of self-care and poor diet
- Their absorption of thiamine is reduced by both alcohol and /or malnutrition
- They have increased metabolic demands in relation to glucose utilisation and alcohol metabolism
- They have reduced hepatic storage of thiamine
- Ethanol neurotoxicity causes impaired utilisation of thiamine

5.2 Signs and Symptoms of WE

5.2.1 Traditionally there has been mention of observing for the classic triad of symptoms:
• Oculomotor abnormalities
• Cerebellar dysfunction (Ataxia)
• Confusion

However: only 16.5% of patients exhibit all 3 signs (the triad of symptoms). Focusing on identifying the triad of symptoms will lead to under diagnosis of WE which can be fatal to 20% of patients if they progress to develop Korsakoff’s psychosis

5.2.2 Therefore clinicians are advised to make a presumptive diagnosis of WE should any patient present with a history of alcohol misuse and any of the signs stated below:

I. Acute Confusion
II. Ataxia
III. Unexplained hypotension with hypothermia
IV. Nystagmus
V. Decreased consciousness level
VI. Ophthalmoplegia

5.3 Prevention and Treatment of WE
Patients presenting with potential signs of WE require urgent treatment with intravenous vitamin B complex (Pabrinex®). Treatment should be given as laid out in Appendix 6. Patients who remain symptomatic should continue to receive intravenous vitamin B therapy.

6. Referrals to the Substance Misuse Liaison team
6.1 All patients admitted with an alcohol related issue as outlined in this policy should be referred to the Substance Misuse Liaison Team, run by the national charity Turning Point. The Substance Misuse Liaison Team is available 5 days a week as below. However, referrals to the team can be made outside of these hours by voicemail, email or ICE:

Monday to Thursday: 08.00 – 17.00
Friday: 08.00 - 16.30

6.2 Please refer on 07734694857 or 07535658329. You can email the team on TurningPointReferral@uhl-tr.nhs.uk. Referrals can also be made via ICE.

6.3 Please note that the following information is required to accept a referral:

• Patient name and ward location. An S number is preferable. (Please specify if patient already discharged) However, do not delay the discharge of a patient who is medically fit for discharge, the Substance Misuse Liaison Team can arrange out-patient follow up with Turning Point
• Amount the patient drinks
• Has the patient consented to being seen by the Substance Misuse Liaison Team?

6.4 In the Emergency Department (ED) or Emergency Decisions Unit (EDU) referrals can be made through completing a Leicester Emergency Department Paddington Alcohol Test (LEDPAT) (See appendix 8).

There are four box files labelled “Alcohol Referral/Turning Point” which contain blank LEDPATs as well as advice and information around alcohol and support available through Turning Point. These box files are located at:

• ED Blue Zone – Injuries – Staff Base
• ED Assessment Bay – Staff Base
• Children’s ED – Office adjacent to Staff Base
• Emergency Decisions Unit - Staff Cupboard (code: 7823)

Once the LEDPAT has been completed please put the form in the relevant boxes in ED arrivals area, EDU or Minors ready for collection. The LEDPAT doubles as both a screening tool and a referral form from ED/EDU

6.5 **In the case of Alcohol Related Liver Disease**, please contact the Gastro Registrar for the week or the in-reach consultant via switch board

7. Teaching and Training

7.1 A comprehensive training package will be provided by the Substance Misuse Liaison Team on the medical and other wards within UHL where patients with alcohol withdrawal symptoms are frequently admitted.

7.2 Training is available for other areas upon request - contact the Alcohol Liaison Team on 07734694857 or 097535658329 or email: TurningPointReferral@uhl-tr.nhs.uk

8. Monitoring and Audit Criteria

Following implementation of this policy the policy will become part of the audit cycle performed by the Acute Medical Unit at the Leicester Royal Infirmary.

<table>
<thead>
<tr>
<th>Element to be monitored</th>
<th>Lead Tool</th>
<th>Frequency Reporting arrangements</th>
<th>Leads for recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review relevant procedure followed</td>
<td>Substance Misuse Liaison Team</td>
<td>See attached appendices</td>
<td>Annual audit by AMU team in conjunction with ALS</td>
</tr>
</tbody>
</table>

9. Keywords

Alcohol, Alcohol withdrawal, Wernicke’s Encephalopathy, WE, WKS, Delirium Tremens, DTs

10. References


Kettering General Hospital (2012), *Guidelines for vitamin supplementation and prevention and/or treatment for Wernicke’s Encephalopathy*, Alcohol Use Disorders Policy, Kettering General Hospital


World Health Organisation (1994) The International Classification of Mental and Behavioural Disorders – Clinical descriptions and diagnostic guidelines, WHO

Link to RMOC guidance here
Appendix 1: Information on Units of Alcohol

A unit of alcohol is a beverage containing 8g or 10mls of ethanol (pure alcohol). This can be calculated as follows

% ABV x Volume (Litres) = Units

e.g. a 2 litre bottle of 7.5% cider will contain 15 units of alcohol

7.5% x 2 Litres = 15 units

What does 1 unit of alcohol look like?

...and each of these is more than one unit

- **2 Units**
  - A standard glass (175ml) of 12% wine
  - A pint of lower strength (4%) lager, beer or cider
  - A 25ml measure of spirits (40%)

- **3 Units**
  - A pint of medium strength (5%) lager, beer or cider
  - A large glass (250ml) of 12% wine

- **4 Units**
  - A 500ml can of high strength (8%) lager
  - A large bottle (750ml) of alcopop

- **7.5 Units**
  - 1 litre bottle of (7.5%) White Cider
  - 70cl bottle of (11%) wine

- **26 Units**
  - 70cl bottle of (37.5%) vodka

Summary: Units are essential in giving a clear indication of amounts consumed and types of drinkers. Current advice is to drink no more than 14 units per week on a regular basis, spread throughout, with at least two days off a week.
Appendix 2: Audit C Questionnaire

This is one unit of alcohol...

...and each of these is more than one unit

AUDIT – C

<table>
<thead>
<tr>
<th>Questions</th>
<th>Scoring system</th>
<th>Your score</th>
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<tbody>
<tr>
<td>How often do you have a drink containing alcohol?</td>
<td>Never</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Monthly or less</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>2 - 4 times per month</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>2 - 3 times per week</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>4+ times per week</td>
<td>4</td>
</tr>
<tr>
<td>How many units of alcohol do you drink on a typical day when you are</td>
<td>1 - 2</td>
<td>0</td>
</tr>
<tr>
<td>drinking?</td>
<td>3 - 4</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>5 - 6</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>7 - 9</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>10+</td>
<td>4</td>
</tr>
<tr>
<td>How often have you had 6 or more units if female, or 8 or more if male,</td>
<td>Never</td>
<td>0</td>
</tr>
<tr>
<td>on a single occasion in the last year?</td>
<td>Less than monthly</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Monthly</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Weekly</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Daily or almost daily</td>
<td>4</td>
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**Scoring:**
A total of 5+ indicates increasing or higher risk drinking.
An overall total score of 5 or above is AUDIT-C positive.
If scoring 5+ Continue AUDIT
### Score from AUDIT-C (other side)

#### Remaining AUDIT questions

<table>
<thead>
<tr>
<th>Questions</th>
<th>Scoring system</th>
<th>Your score</th>
</tr>
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<tbody>
<tr>
<td>How often during the last year have you found that you were not able to stop drinking once you had started?</td>
<td>Never, Less than monthly, Monthly, Weekly</td>
<td>Daily or almost daily</td>
</tr>
<tr>
<td>How often during the last year have you failed to do what was normally expected from you because of your drinking?</td>
<td>Never, Less than monthly, Monthly, Weekly</td>
<td>Daily or almost daily</td>
</tr>
<tr>
<td>How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?</td>
<td>Never, Less than monthly, Monthly, Weekly</td>
<td>Daily or almost daily</td>
</tr>
<tr>
<td>How often during the last year have you had a feeling of guilt or remorse after drinking?</td>
<td>Never, Less than monthly, Monthly, Weekly</td>
<td>Daily or almost daily</td>
</tr>
<tr>
<td>How often during the last year have you been unable to remember what happened the night before because you had been drinking?</td>
<td>Never, Less than monthly, Monthly, Weekly</td>
<td>Daily or almost daily</td>
</tr>
<tr>
<td>Have you or somebody else been injured as a result of your drinking?</td>
<td>No</td>
<td>Yes, but not in the last year, Yes, during the last year</td>
</tr>
<tr>
<td>Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?</td>
<td>No</td>
<td>Yes, but not in the last year, Yes, during the last year</td>
</tr>
</tbody>
</table>

**Scoring:**
- 0 – 7 Lower risk
- 8 – 15 Increasing risk
- 16 – 19 Higher risk
- 20+ Possible dependence

**TOTAL Score equals**

AUDIT C Score (above) + Score of remaining questions
### Appendix 3: Alcohol withdrawal features

<table>
<thead>
<tr>
<th>Time after cessation of alcohol use</th>
<th>Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>6- 12 hours</td>
<td><strong>Minor Withdrawal Symptoms:</strong> tremulousness (hand, tongue, eyelids), diaphoresis, fever (with or without infection), anxiety, agitation, nausea, vomiting and retching.</td>
</tr>
<tr>
<td>12- 24 hours</td>
<td><strong>Alcoholic hallucinosis:</strong> visual and auditory (usually accusatory or derogatory voices) hallucinations, tactile disturbances. These occur in otherwise clear sensorium.</td>
</tr>
<tr>
<td>12- 48 hours</td>
<td><strong>Withdrawal seizures:</strong> these can manifest as early as 2 hours after cessation of alcohol consumption and even before the blood alcohol level has fallen to zero. Fits are rare beyond 48 hours following cessation of alcohol consumption.</td>
</tr>
<tr>
<td>48- 72 hours</td>
<td><strong>Delirium Tremens (DTs):</strong> auditory and visual hallucinations, confusion and disorientation, hypertension, agitation, tachycardia &gt;100/min, fever (with or without infection), severe tremor in hands and body. <strong>DTs represent a medical emergency.</strong> DTs occur in only about 5% of patients undergoing alcohol withdrawal but have a mortality rate of 15-20%. If a patient presents with DTs consider admission for 24 hours minimum to treat withdrawals and monitor. <strong>Patient may need observation for 72 hours after cessation of drinking.</strong> Risk factors of developing DTs: concurrent acute medical illness, heavy daily alcohol use (60+ units), history of DTs and alcohol withdrawal symptoms, older age and abnormal LFTs. (May require Diazemuls see Appendix 2, box 3)</td>
</tr>
</tbody>
</table>
Appendix 4:
Alcohol withdrawal algorithm based on the NICE Clinical Guideline 100.

**Person in acute alcohol withdrawal:**
- Initial assessment including risk of developing delirium tremens or seizures
- Offer thiamine for the prevention or treatment of Wernicke’s encephalopathy (see section 5)

**Person with or at high risk of alcohol withdrawal seizures or delirium tremens**

**Young person under 16 years in acute alcohol withdrawal**

**Vulnerable person in acute alcohol withdrawal** (for example, people who are frail, have cognitive impairment or multiple co-morbidities, lack social support, have learning difficulties or are aged 16 or 17 years)

**Person who is alcohol dependent and**
- 16 years or over
- Not at high risk of delirium tremens or seizures
- Not considered vulnerable

**Offer admission to hospital**

**Offer admission to hospital**

**Do not admit to hospital**

Assess immediately by a healthcare professional skilled in the management of alcohol withdrawal (Refer to Substance Misuse Liaison-07535658329)

- Offer medically assisted alcohol withdrawal; to include use of GMAWS (Appendix 2)
- Offer physical and psychological assessment to all young people under 16 years and as needed to those over 16 years
- Offer advice from a healthcare professional experience in the management of patients with liver disease to people with decompensated liver disease

Advise not to suddenly reduce alcohol intake (See appendix 3)

Offer Referral to the Substance Misuse Liaison Team

07535658329
Appendix 5: Glasgow Modified Alcohol Withdrawal Scale

Management of Alcohol Withdrawal Syndrome

Dependant drinking on screening - High Risk
Any 2 of the following (tick):
- Presents with or has had previous withdrawal seizures
- Previous severely agitated withdrawal (D.T.s)
- High initial symptom score (GMAWS >8) (PTO)

Yes

No

Exceptional Patient Group
Yes □
No □

Symptom Triggered Treatment as per GMAWS (PTO)
(Also consider Box 2 if exceptional group)
Please tick to confirm this treatment option □

Yes

No

Symptom Triggered Treatment on Lorazepam (see Box 2)

Fixed Dose Oral Diazepam
Initial 24 hours: 20 mg / 6 hours
REDUCE as follows:
15 mg Diazepam 6 hourly for 24 hours
10 mg Diazepam 6 hourly for 24 hours
5 mg Diazepam 6 hourly for 24 hours
5 mg Diazepam 12 hourly for 24 hours
(Max 120 mg Diazepam in 24 hours before requesting senior medical review)

AND
- Symptom Triggered Treatment, as per GMAWS (Box 1)
- If unable to take oral give 50% of the oral dose as IV
- In case of DTs please see Box 3

10 mg Diazepam = 1 mg Lorazepam = 30 mg Chloralhydrate

Box 1 GMAWS
- Tremor
- Sweating
- Hallucination
- Orientation
- Agitation

Box 2 Exceptional Patient Group:
1. Elderly >60 Y
2. Head injury
3. Encephalopathy
4. Jaundice
5. COPD / pneumonia
6. Low GCS
Consider use of Lorazepam in a symptom-triggered fashion 1-2 mg / 6 to a max of 12 mg / 24hr period before senior review

Box 3 Special Circumstances: Severe Withdrawal
(Delirium Tremens) with (agitation/aggression)
- Give 5-10 mg IV diazepam initially followed by a maximum of 10 mg every 5 mins, increasing to a maximum of 40 mg diazepam over 30 mins (assessing response) only to be given by FY2/higher grade or trained nurse
- Adjunct Haloperidol 2-10 mg PO / IM up to 18 mg in 24 hrs at 2 hourly intervals
- Fumazenil should be available on ward
- Seek senior review

Please consider Pabrinex for all patients for the prevention and treatment of Wernicke’s Encephalopathy.
Please see full Alcohol Withdrawal guidelines on INsite

Alcohol Withdrawal UHL Policy - Trust ref: B30/2014 (formerly C7/2002)
V4 approved by Policy & Guideline Committee: 21 August 2020
Next review: May 2024
NB: Paper copies of guidelines may not be most recent. The definitive version is held on INsite Documents
### Glasgow Modified Alcohol Withdrawal Scale (GMAWS)

<table>
<thead>
<tr>
<th></th>
<th>Treatment options:</th>
<th>GMAWS only</th>
<th>GMAWS &amp; Fixed Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Date</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Time</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Tremor</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 No tremor</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 On movement</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 At rest</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Sweating</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 No sweat visible</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Moist</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 Drenching sweats</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Hallucination</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 Not present</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Dissuadable</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 Not dissuadable</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Orientation</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 Orientated</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Vague, detached</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 Disorientated, no contact</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Agitation</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 Calm</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Anxious</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 Panicky</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Score</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Score:** (Do not use scoring tool if patient intoxicated, must be at least 8 hours since last drink)

- 0  Repeat score in 2 hours (discontinue after scoring on 4 consecutive occasions, except if less than 48 hours after last drink)
- 1-3  Give 10mg Diazepam: Repeat score in 2 hours
- 4-8  Give 20mg Diazepam: Repeat score in 1 hour
- 9-10 Give 20mg Diazepam: Repeat score in 1 hour and discuss with medical staff regarding management of severe withdrawal as per guideline

All patients should have regular observations documented. Patients receiving high doses of Diazepam should be assessed regularly for over-sedation.

Regular MEWS/SEWS - Frequency 1-4 hrs (GCS, Respiration Rate, Oxygen Saturation, Pulse, Blood Pressure)

Patients may require to be woken for continuing assessment

Co-existing illness may affect score: seek medical advice if in doubt

Fixed dosing and symptom triggered dosing must be no less than 1 hour apart

Developed by the Alcohol Screening and Withdrawal Management Guideline Group. Chaired by Dr. Ewan Forrest, Consultant Physician and Gastroenterologist, Glasgow Royal Infirmary. Copyright: This is the property of NHS Greater Glasgow and Clyde.
Appendix 6:
Guidelines for vitamin supplementation and prevention and/or treatment for Wernicke’s Encephalopathy

Every patient who appears to have signs of alcohol withdrawal and/or who is prescribed benzodiazepines should be assessed for Wernicke’s encephalopathy

ARE ANY ONE OR MORE FROM THE LIST BELOW PRESENT?

- Acute confusion
- Decreased consciousness level
- Memory disturbance
- Ataxia / unsteadiness
- Ophthalmoplegia
- Nystagmus
- Unexplained hypotension with hypothermia

YES

Presume Wernicke’s encephalopathy

- Give Pabrinex® HP amps 2-3 pairs (6 ampoules) IV TDS for 3 days, then 1 pair OD for 5 days. If remains symptomatic to continue with IV Pabrinex until no further improvement. If symptoms have resolved then switch to Thiamine oral 100mg TDS

NO

Are there any further Risk Factors that suggest Wernicke’s Encephalopathy?
- Intercurrent Illness
- Peripheral neuropathy
- DTs/Treatment for DTs
- Drinking > 20 units daily
- Alcohol related seizures
- Recent diarrhoea/vomiting
- IV Glucose infusion
- Signs of malnutrition
- Significant weight loss
- Poor diet / Nil by Mouth

YES

Risk of Wernicke’s encephalopathy

- Thiamine 100mg BD or 100mg TDS

NO

- Pabrinex® HP 2 pairs (4 ampoules) IV TDS for up to 3 days (or until situation has resolved)
- Then Thiamine 100mg BD or 100mg TDS
Appendix 7:  Gradual Reduction of Alcohol Intake

How to Reduce Your Daily Drinking Safely

- The rate you reduce your drinking is up to you as you are in control. It’s important to try to strike a balance between not cutting down so quickly that you get severe withdrawal symptoms and not so slowly that you never actually stop!
- Work out how many units you normally drink a day. This is your starting point.
- From your starting point, a sensible approach is to try to reduce by 2-5 units per day.
- Remember, you are drinking to control withdrawal symptoms, not to get intoxicated
- Do not assume you have to have a drink straight away after waking up. Try delaying drinking until you notice withdrawal symptoms.
- Try to drink only when you start to feel yourself withdraw and then drink approximately 2 units at a time. Wait 20-30 minutes for the alcohol to take effect and repeat this process each time you get withdrawal symptoms.
- If you experience disturbed or disrupted sleep due to withdrawal symptoms, you could try a double dose before bed.
- Remember, as you successfully reduce your daily alcohol intake, you should find your withdrawal symptoms become less severe.
- Keep a daily record of what and when you drink and what withdrawal symptoms you get. This will help you keep track of your progress and give you a guide to how much you should reduce the next day (see sample diary in Alcohol Advice Leaflet)
- If you are having withdrawal symptoms which are making you feel unwell, you may have cut down too quickly. If this is the case, you should discuss this with a health professional as soon as possible.

Disclaimer

This leaflet cannot replace professional advice. Alcohol withdrawal can make physical demands on the body which may put some people at increased risk. If you are unsure, you should discuss your general health and plans for cutting down with an alcohol worker or your GP.
Appendix 8:

Leicester Emergency Department Paddington Alcohol Test

Consider using LEDPAT for ALL of the reasons for attendance given below. Circle number(s) below for any specific trigger(s):

1. Fall
2. Collapse (including fit)
3. Head injury
4. Assault
5. Accident
6. Unwell
7. Non-specific GI
8. Cardiac
9. Psychiatric
10. Regular attenders
11. Evidence of alcohol misuse
12. Other (specify)

Proceed only after dealing with the patient’s “agenda,” i.e. patient’s reason for attendance.

We routinely ask all patients having... (above).... if they drink alcohol?

1. Do you drink alcohol? Yes No

2. What is the most you will drink in one day?
   Please calculate in units:
   % X Volume (litres)
   eg 2 litres of 7.5% cider =
   2 X 7.5 = 15 units
   Amount ________ litres
   ABV ________ %

3. How often do you drink this much?
   Daily ☐ Or _______ Times per week

   (Please turn over for types of drinkers)

4. Do you feel your attendance to the ED is related to alcohol?
   Yes- (If YES then you have started Brief Advice (BA). Give information about alcohol related health harm and the alcohol diary)
   No

5. We would like to offer you advice or support about your alcohol consumption.
   Would you be willing to see our alcohol liaison worker
   Yes ☐ No ☐

   (If YES please give Alcohol Advice Leaflet and obtain patient contact number and/or address and Alcohol Liaison will contact patient within 48hrs)

Patient contact phone number:

Patient signature – Telephone contact consent:

Referrer’s signature: Name Date

Mark Williams & Simbarashe Kashiri August 2012 Version 2

Alcohol Withdrawal UHL Policy- Trust ref: B30/2014 (formerly C7/2002)

V4 approved by Policy & Guideline Committee: 21 August 2020 Next review: May 2024

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Appendix 9: Alcohol Advice leaflet

Introduction

This leaflet will offer you some advice and guidance about alcohol and its effect on your life.

You have been given this leaflet either because it is suspected that alcohol contributed to your attendance today, or because your alcohol consumption has the potential to cause harm to your health.

About Alcohol

Alcohol is a depressant drug that slows down your central nervous system. With at least 90% of the UK population drinking alcohol, it has become known as “our favourite drug”.

Alcohol affects people differently according to age, gender, physical condition, amount of food eaten, other drugs or medication taken, and the amount of alcohol consumed.

People tend to drink because it is sociable and relaxing. However, if we begin drinking out of habit, and our intake rises, it can cause problems.

Drinking too much?

How much is too much?

The UK’s Chief Medical Officer (CMO) guideline for both men and women is that:

You are safest not to drink regularly more than 14 units per week. This is to keep health risks from drinking alcohol to a low level. If you do drink as much as 14 units per week it is best to spread this evenly across the week.

What are Units?

Different drinks have different amounts of pure alcohol (ethanol). One unit is 10ml of ethanol. The stronger the drink, the more ethanol it contains, and the greater the number of units.

Calculate your Units

To work out the how many units are in your drink, multiply the volume of the drink (in millilitres) by the percentage of alcohol (%abv), then divide this number by 1000. For example: Two litres (2000ml) of White Cider (7.5%abv) 2000 \times 7.5 \div 1000 = 15 \text{ (units)}

Look at the bottle or can from which you drink; it will always say how many units are inside.

More information about units can be obtained at www.nhs.uk/units
**Examples of Units in Common Drinks**

**1 Unit**
- Half a pint of lower strength (4%) lager, beer or cider.
- A single measure (25ml) of spirits (40%)
- A single glass (125ml) of 12% wine

**2 Units**
- A standard glass (175ml) of 40% wine
- A standard glass (100ml) of 12% wine
- A standard glass (250ml) of 4% lager
- A standard measure (50ml) of 12% wine
- A standard glass (250ml) of 4.5% lager
- A standard glass (250ml) of 4% beer
- A large glass (250ml) of 4% cider
- A standard glass (250ml) of 4% lager
- A standard glass (200ml) of 4% beer

**3 Units**
- A standard glass (250ml) of 8% lager
- A standard glass (200ml) of 8% lager
- A standard glass (250ml) of 8% cider
- A standard glass (250ml) of 8% wine

**4 Units**
- A standard glass (250ml) of 12% lager
- A standard glass (250ml) of 12% lager
- A standard glass (250ml) of 12% wine
- A standard glass (250ml) of 12% beer
- A standard glass (250ml) of 12% wine

**5 Units**
- A standard glass (250ml) of 16% lager
- A standard glass (200ml) of 16% lager
- A standard glass (250ml) of 16% wine
- A standard glass (250ml) of 16% beer
- A standard glass (250ml) of 16% wine

**6 Units**
- A standard glass (250ml) of 20% lager
- A standard glass (200ml) of 20% lager
- A standard glass (250ml) of 20% wine
- A standard glass (250ml) of 20% beer
- A standard glass (250ml) of 20% wine

**Alcohol Dependence**

**Can I get Physically Addicted to Alcohol?**

If you do drink every day you could possibly have a physical dependence on alcohol.

**What are the Symptoms of Alcohol Dependence?**

If you are physically dependent you may notice some of these withdrawal symptoms, usually in the morning or when you haven’t had a drink for a few hours.

- Tremor in the hands
- Sweats
- Hot and cold flushes
- Anxiety
- Nausea, retching or vomiting
- Increased heart rate
- Cravings

If you get any withdrawal symptoms, **DO NOT STOP DRINKING SUDDENLY.** Withdrawing from alcohol can be extremely serious. Call 999 if your symptoms are severe.

If you have any level of alcohol dependence, then it is unwise to stop suddenly, or go “cold turkey”. Instead, stabilise and reduce your intake. See Tips for Cutting Down on the next page.

**Tips for Cutting Down**

Work out how many units you normally drink a day. This is your starting point.

From your starting point, a sensible approach is to try to reduce by around a tenth every 2-3 days.

**Remember,** you are drinking to control withdrawal symptoms, not to get intoxicated.

- Do not assume you have to have a drink straight away after waking up. Try drinking nothing until you notice withdrawal symptoms.
- Try to drink only when you start to feel yourself withdraw and then drink approximately 2 units at a time (e.g. one can of 4% cider). Wait 20 – 30 minutes for the alcohol to take effect and repeat this process each time you get withdrawal symptoms.
- If you experience disturbed or disrupted sleep due to withdrawal symptoms, you could try a double dose before bed.

**Remember,** as you successfully reduce your daily alcohol intake, you should find your withdrawal symptoms become less severe, although in the short term your sleep could suffer.

Keep a daily record of what and when you drink and what withdrawal symptoms you get. This will help you keep track of your progress. Use the Drink Diary on the next page.

**Remember** to eat little but often. Your blood sugar levels could get too low if you don’t.

If you are having withdrawal symptoms which are making you feel unwell, you may have cut down too quickly. Drink a little more, or seek medical attention if you are very unwell.

- If you can, swap to a lower-strength drink, e.g. 4-5% cider or beer, even if this means you’re drinking more fluid than you’re used to. It is much easier to reduce this way.

Reducing intake using wine or spirits is much harder due to the strength of the drink.

**Reduce your Drinking Safely**

The “textbook” way to overcome alcohol dependence safely is to reduce by around 10% every 2-3 days, but the rate you reduce your drinking is up to you. You are in control. It’s important to try to strike a balance between not cutting down so quickly that you get severe withdrawal symptoms and not too slowly that you never actually stop!
**Example Drink Diary**

<table>
<thead>
<tr>
<th>Day</th>
<th>Type of Drink</th>
<th>Amount/Volume</th>
<th>Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday</td>
<td>Vodka and Coke</td>
<td>5 shots</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Carling</td>
<td>10 cans</td>
<td>+20</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>=25</td>
</tr>
<tr>
<td>Tuesday</td>
<td>Vodka and Coke</td>
<td>Two doubles</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Carling</td>
<td>9 cans</td>
<td>+18</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>=22</td>
</tr>
<tr>
<td>Wednesday</td>
<td>Vodka and Coke</td>
<td>3 shots</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Carling</td>
<td>8 cans</td>
<td>+16</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>=19</td>
</tr>
<tr>
<td>Thursday</td>
<td>Vodka and Coke</td>
<td>One double</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Carling</td>
<td>7 cans</td>
<td>+14</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>=16</td>
</tr>
<tr>
<td>Friday</td>
<td>Vodka and Coke</td>
<td>1 shot</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Carling</td>
<td>6 cans</td>
<td>+12</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>=13</td>
</tr>
<tr>
<td>Saturday</td>
<td>Carling</td>
<td>5 cans</td>
<td>10</td>
</tr>
<tr>
<td>Sunday</td>
<td>Carling</td>
<td>4 cans</td>
<td>8</td>
</tr>
</tbody>
</table>

**TOTAL UNITS = 113**

---

**Drinking Advice**

### One-off Drinking

If you have one or two heavy drinking sessions a month you still increase the risks of death from long-term illnesses, accidents and injuries. When it comes to single drinking occasions you can keep the short term health risks at a low level by:

- Limiting the total amount of alcohol you drink on any occasion
- Drinking more slowly, drinking with food, and alternating with water
- Eat before you start drinking
- Have bottles of beer, or single shots, rather than pints and doubles
- Don’t join in with “rounds” as it may commit you to drinking more than you want
- Stick to lower-strength drinks

**Do something else - Socialising doesn’t have to involve alcohol**

---

### Alcohol and Pregnancy

The Chief Medical Officer (CMO) guidance is that pregnant women should not drink any alcohol at all. If you are pregnant or planning pregnancy, the safest option is not to drink alcohol. This is to keep the risks to your baby to a minimum. The more you drink the greater the risk to your baby.

#### Foetal Alcohol Syndrome

Drinking during pregnancy can lead to Foetal Alcohol Syndrome which can cause learning difficulties and facial deformities for the unborn baby.

What if I have already drunk alcohol in pregnancy?

If you find out you’re pregnant after having drunk alcohol early in the pregnancy you should avoid drinking further. Official advice is that it is unlikely in most cases that the baby would be affected. If you’re worried about how much you’ve been drinking when pregnant, talk to your doctor or midwife.

---

### Driving and Alcohol

**Q:** How many drinks can I safely have and not be over the limit?

**A:** None.

While the legal limit for driving is 80mg of alcohol in 100mls of blood, this cannot be translated into a number of drinks and is dependent on age, gender, weight and metabolism. So the advice is not to drive on any amount of alcohol.

It takes the average liver one hour to process each unit of alcohol, so please beware that after a heavy session of drinking you may still be over the drink-drive limit the following day.

**DON’T DRINK AND DRIVE**

---

### Sleep Advice

The brain can develop a tolerance to the sedative effects of alcohol; this can cause an increase in light sleep and may not immediately return to normal when alcohol consumption is stopped.

Alcohol will normally act as a sedative for approximately 4 hours and then you may find it difficult to fall back to sleep naturally.
Here are some ideas to help you relax and practice a good sleep routine:

- No caffeine after 6pm.
- Try to go to sleep and wake up at the same time every day.
- Exercise daily but not immediately before bedtime.
- Try not to look at phones or tablets, or watch television in bed.
- Try not to use bedtime as worry time. Make a to-do list and leave your worries until the morning.
- Avoid heavy meals at bedtime.
- Limit or eliminate alcohol, caffeine, and nicotine before bedtime.
- Control the night-time environment with a comfortable temperature.
- Create a quiet and dark environment to sleep.
- Try not to clock watch.
- Wear comfortable, loose-fitting clothes to bed.
- If unable to sleep within 30 minutes, get out of bed and perform a soothing activity, such as listening to soft music or reading, but avoid exposure to bright light during these times and things that may stimulate the brain. When you are feeling tired, try again.

Cope with cravings

A craving is when your brain remembers all the good things about alcohol, forgets all the bad things, and tries to convince you to have a drink. Remind yourself of the problems drink has caused you. Challenge "permission-giving" thoughts, e.g. "I deserve a drink," or "one won’t hurt."

Alternatively you can "surf" the craving. Rather than trying to ignore or struggle with the uncomfortable feeling of a craving, imagine you are surfing it like the crest of a wave. You’ll find that eventually the wave will subside, and you will have successfully ridden out your feeling of a craving. Most cravings only last a few minutes.

Distract yourself

Get your mind off alcohol by doing something. Walk the dog, hike round the park. See a friend for lunch or go to a library. Do anything other than just sit there allowing your cravings to fester. Anything physical is perfect as you’ll always feel better after you’ve exerted yourself.

Don’t let a lapse become a relapse

A lapse is one slip-up; a bad day. You’re human – it happens. A relapse is when this quickly returns to regular, excessive drinking. Keep blips to one day, and get back on your plan in the morning.

Relapse Prevention

You can reduce your intake and beat a physical dependence, but the possibility remains of having a relapse.

Identify triggers and high-risk situations

These could include stress, boredom, certain friends, places, unhappy anniversaries. Thinking ahead, how could you handle these situations without turning to alcohol? Or could you avoid these situations altogether?

Handle your problems and feelings as they occur

Each day, as you experience negative (or positive) feelings and problems, deal with them on a here and now basis. This way, you won’t allow stresses to build up and explode.

Make the most of support

Friends, family and Turning Point can help you deal with your problems, emotions and to support your goals.

Take better care of yourself

Eat more healthily, get moving every day, drink plenty of water, and get some sleep. This will improve your wellbeing dramatically and make relapse less likely.