The Royal College of Emergency Medicine

Alcohol

A toolkit for improving care

June 2015

Foreword from the President of the Royal College of Emergency Medicine

It is a great privilege to introduce this toolkit – the first we have issued as a Royal College - and the subject could not be more worthy.

The EM profession has major concerns with current licensing laws, the increased number of retail outlets selling alcohol, the unwelcome association of alcohol sponsorship with major sporting events and the failure, to date, to introduce a minimum unit price for alcohol. Although we have published numerous articles highlighting these concerns, they have mostly appeared in the 'dull but worthy' section of national newspapers and hence transited to recycling bins without troubling the intended audience. It is heartening to know that the same fate will not befall this toolkit!

Not only is this toolkit comprehensive in scope and applicability, it also includes templates of key documents to assist with all manner of activities from identifying problem drinking to the appointment of an Alcohol Nurse Specialist. I am extremely grateful to Fiona Wisniacki and the Best Practice Sub-Committee for developing this toolkit.

Emergency Medicine is often seen as a reactive specialty but there is much we can do to be pro-active. In no area is this more important than reducing the harms associated with unsafe alcohol consumption. In doing so, we aim to reduce not only the illnesses and injuries sustained by those whose use of alcohol is excessive but also diminish the collateral damage to families, neighborhoods and society.

Dr Clifford Mann FRCP PRCEM

President of the Royal College of Emergency Medicine

Contents

1.1 Aims of the RCEM alcohol toolkit

The aims of the toolkit are:

1. **Promotion of best practice in the area of alcohol management** - methods of screening and complete management of the patient with alcohol related illness and injury in EDs.

2. **Advancement of safe and effective care in this area** - advising on approaches on how to care for this subset of patients and sharing best practice with the use of medications.

3. **Education and training of Emergency Medicine doctors** - by provision of guidelines and advocating training.

Operational aims:

1. **Identification and Brief Advice** – to have a system of alcohol screening in EDs across the UK so that Brief Intervention is followed by input from Alcohol Nurse Specialists.

2. **Departmental Alcohol Care Team** – to develop a framework for establishing Alcohol Services within EDs incorporating Alcohol Nurse Specialists.

3. **Alcohol Champions** - to have a Consultant as an 'Alcohol Champion' for their ED/Trust, to lead on the management of alcohol related illness and injury in the ED/Trust.

4. **Tackle re-attenders** - to reduce alcohol attendances to the ED with strategies for frequent alcohol related re-attenders.

1.2 Main recommendations for Emergency Department Staff

- ALL doctors and nurses who deal with alcohol related attenders to the ED should be trained to routinely screen, to provide early identification and offer brief alcohol advice to patients. Recognition of the alcohol related attendance could start at Triage/Initial Assessment or by clinicians.

- All patients should be treated with dignity and respect, irrespective of their presentation.

- People who need support for alcohol problems should be routinely referred to specialist alcohol services, via an Alcohol Nurse Specialist within the ED, for comprehensive assessment and appropriate treatment.

- There should be a nominated Alcohol Champion Consultant within the ED to ensure the development of the service within the ED and to liaise with other services such as psychiatry, gastroenterology and pharmacy as well as commissioners and local alcohol services.

Section 2 - A toolkit for improving care

2.1 Strategic management of Alcohol related illness and injury in the Emergency Department

Early intervention by health and social care professionals is an important and underexploited opportunity to prevent problems developing. All health and social care professionals should be trained to routinely provide early identification and brief alcohol advice to their patients.

People who need support for alcohol problems should be routinely referred to specialist alcohol services for comprehensive assessment and appropriate treatment.

Every acute hospital should have a specialist, multi-disciplinary alcohol care team tasked with meeting the alcohol-related needs of those attending the hospital and preventing readmissions. This should be led by an 'Alcohol Champion'. An ED Consultant is ideally placed and has the leadership and co-ordinating abilities to take on this position.

2.2 Screening Tools

Screening tools such as the Paddington Alcohol Test (PAT) (1), the Fast Alcohol Screen Test (FAST) and the Audit C are useful in EDs in the UK.

The PAT tool (1) and the FAST can be found in appendices 1and 2.

AUDIT-C
This is now more commonly being used in the Emergency Department Setting and is a shortened version (only 3 questions) of the AUDIT tool. The full AUDIT tool is the best evaluated alcohol-screening tool available and was developed by the WHO (2). It focuses on quickly identifying escalating and higher risk drinking as well as dependent drinking.

Of particular benefit in the ED setting, the AUDIT-C identifies those who are drinking at increasing/higher risk levels *before* their drinking becomes problematic or dependent. The Audit-C tool can be found in appendix 3. AUDIT-C can be used with patients of all ages. NICE guidance recommends the use of AUDIT-C (3).

2.3 Implementing screening

The people who benefit from identification and subsequent brief intervention are the escalating and higher risk drinkers.

An ongoing active education programme to all staff groups needs to include 'screening training' and the taking of an alcohol history, to ensure that the correct questions are being asked of the patient, at the appropriate times in their 'journey' through the Emergency Department pathway. It is appropriate for the Triage/Initial Assessment Nurse to evaluate whether the patient's attendance is alcohol related while the ED Clinician can perform screening using a tool described as above.

Barriers to using screening tools

Screening every patient over the age of 14 years can be thought to be 'daunting' and time consuming for clinicians in the ED. The PAT suggests that if a patient presents with one

of the 'top 10 conditions' (4) then they should be screened, as these are deemed to be 'high risk' alcohol related conditions. This list of conditions is not exhaustive. Information Technology (IT) can be configured to trigger clinicians to 'enquire' about alcohol for every adult patient on entry of the diagnosis. This ensures that the Clinician seeing the patient has to 'think about' alcohol as a secondary diagnosis on every patient. However, the entry is only accurate if the patient has actually been asked about their alcohol consumption.

A paper process to initiate screening is that of the Receptionist inserting a PAT/AUDIT-C form into all adult 'CAS' cards/notes to enable the trigger that the form needs completing or that the screening tool chosen is included within the 'CAS Card'.

The 'Alcohol Champion' (see below) needs to decide on which group of ED staff is the most appropriate to perform the screening in their own ED, and on which patient groups.

It can be difficult to know how a clinician can start a conversation with a patient regarding their drinking but there are ways in which it can be brought up e.g.

'This is a routine set of questions that we ask all patients in the ED'
'During this initial assessment we want to make sure that we can put you in contact with any support you may want/need, so I'm going to ask you about your lifestyle'.

Education also needs to address attitudes of staff to alcohol related attendances. A questionnaire (Appendix 5) is a useful tool to find out about attitudes of staff to this group of patients. Once issues have been addressed (e.g. through education) then a screening process becomes easier to implement within the Emergency Department.

2.4 The Role of the Alcohol Nurse in the ED and Brief Intervention

It is recommended that there is at least one Alcohol and Drug Nurse Specialist within each ED. Examples of job descriptions for Alcohol nurses are found in Appendix 6.

The Alcohol Nurse needs to be dedicated to patients within the ED, including the Clinical Decision Unit (CDU). There should be another dedicated Nurse for hospital ward referrals.

Ideal hours are from 7am or 8am to 10pm, 7 days a week (depending upon numbers of patients attending that particular ED) to aid decision making on CDU patients and to provide Brief Intervention and referral to community services to as many alcohol related ED attenders as possible. NHS England suggests a four-nurse service (5).

There is an evidence basis for providing brief intervention to hazardous and harmful drinkers (6).

Brief Intervention can be:

- A sentence or two of feedback to the patient about his/her drinking based on the screening tool and the person's circumstances
- A sentence or two of feedback plus an information leaflet.
- Five minutes of advice based on the FRAMES structure (i.e. Feedback, Responsibility, Advice, Menu of options, Empathy, Self-efficacy).

The Alcohol Nurse should be available for any patients who have attended with an alcohol related illness or injury. The trigger to contact the Alcohol Nurse should be when the alcohol related illness or injury is recognised (e.g. at Triage/Initial Assessment stage or when the

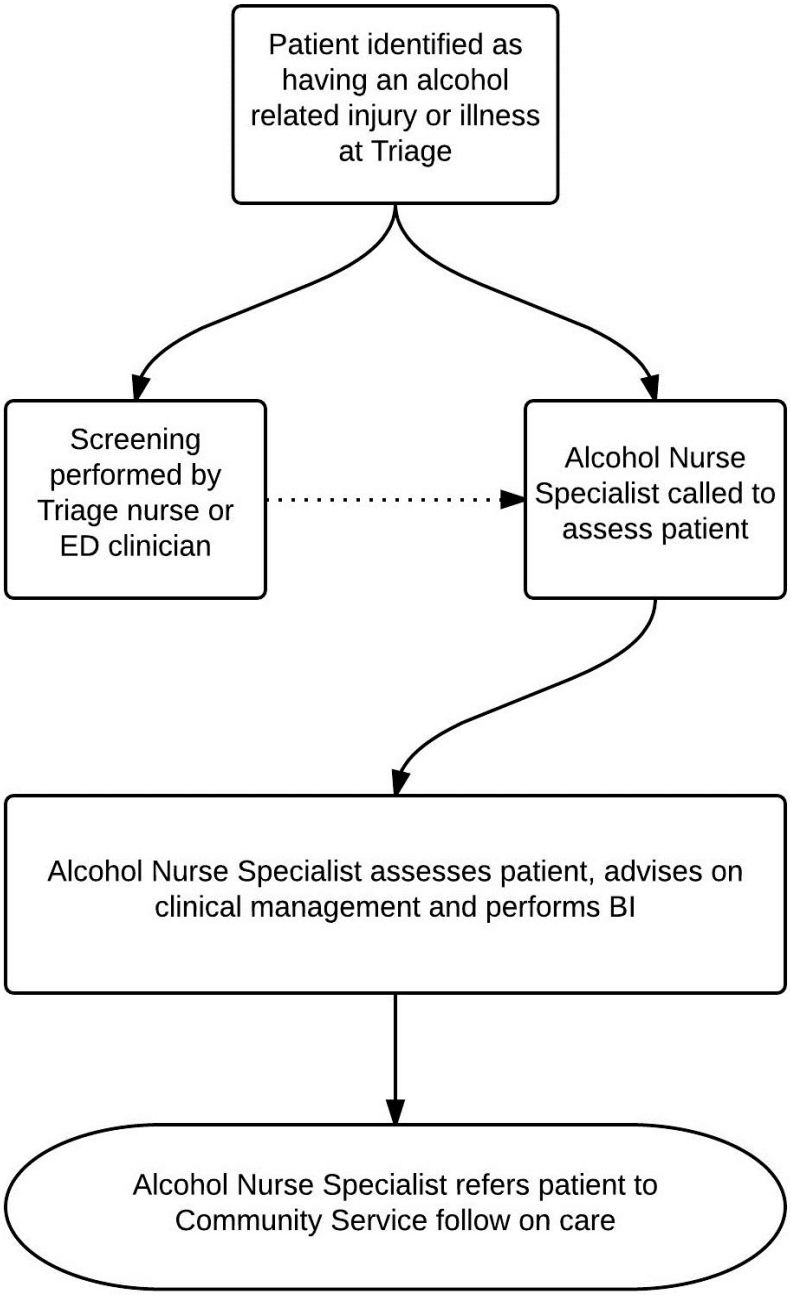
Clinician has screened the patient). The patient should be advised that the Alcohol Nurse will see them in conjunction with the management of their clinical condition. The Alcohol Nurse should be 'adaptable' to work in all areas of the ED (e.g. rapid assessment area, Majors, Resus, ambulatory care) to provide 'Alcohol management' while Clinical management of the patient is on-going.

The Alcohol Nurse should also have the ability, with the aid of the ED IT tracking system, to identify potential patients for him/her to 'consult' without the patient having to be 'referred' to him by the treating clinician (i.e. a 'pull' effect of the patient on the Alcohol Nurse Specialist).

Along with providing 'Brief Intervention', the Alcohol Nurse should be ideally competent to offer clinical management advice to the treating clinician of the patient (e.g. offer alcohol withdrawal pharmacological advice) as well as provision of any background information to the patient (e.g. previous alcohol history/previous engagement within services etc).

If the Alcohol Nurse is not available to see a patient or the patient then Brief Advice (as opposed to Brief Intervention that is delivered by the Alcohol Nurse) should be given to the patient by the treating clinician. This may be as simplistic as giving the patient an advice leaflet with phone numbers of walk in alcohol community services.

Recommended pathway:



2.5 The use of Clinical Decision Units (CDUs)

A Clinical Decision Unit is the ideal place for patients to have time to 'sober up' and be clinically managed for intoxication and thus for screening and brief intervention to take place. All intoxicated patients should ideally be seen by an Alcohol Nurse Specialist prior to discharge, or at least offered an Alcohol Nurse Specialist clinic appointment. The administration of Thiamine replacement therapy (once started in ED) should be given in all cases of intoxicated patients in order to attempt to prevent Wernicke's encephalopathy. It should be prescribed three times a day for the patient's admission on CDU and these doses can be administered throughout a night stay.

The CDU can also be used for management of patients with alcohol withdrawal symptoms. A 'chlordiazepoxide regimen' should be in place and ED nurses can be trained in the use of the CIWA (Clinical Institute Withdrawal Assessment for Alcohol) score (7)(appendix 4) in order to recognise withdrawal symptoms and signs.

The Alcohol Nurse Specialist should be available from early on in the morning in order to provide Brief Intervention to patients, who will be more 'competent' to engage in this management, as well as to complete the Full AUDIT tool to gauge what further clinical management and follow up is required for that individual.

2.6 Management of the Intoxicated Patient

An example of an intoxicated patient pathway is in appendix 7. Junior Doctors and Nurses should be taught on the safe management of the intoxicated patient and the need for regular observations to be performed in a 'safe environment' ie the Majors area/CDU. Patients should not be discharged to the 'waiting area' of the Department to 'sober up' or to wait 'until it is light in the morning' before being escorted off the premises. These are high-risk patients.

2.7 Alcohol Withdrawal Management

NICE guidance should be followed and used to aid the drawing up of hospital (including ED) Alcohol Withdrawal Management pathways (3). The CIWA scale (8) should be used to guide treatment with chlordiazepoxide (Appendix 4).

2.8 The use of Thiamine replacement therapy

Healthcare professionals must know the basics of the management of the intoxicated patient and those at risk of developing Wernicke's or those who present with Wernicke's. AUDIT-C should be used as a trigger to prescribe replacement therapy.

Thiamine replacement iv therapy is given to patients with suspected Wernicke's Encephalopathy as well as to those who are intoxicated and where the symptoms could be masking Wernicke's or who could be at risk of Wernicke's (i.e. secondary to thiamine depletion). The recommended dose is 2 (I + II) (four ampoules) three times a day, diluted with 50 - 100mls saline or glucose 5%. This should be prescribed as a stat dose in the ED and then 3 times a day for those who are staying on a CDU ward. If patients are likely to be referred onto other Specialities then TDS for 5 days should be prescribed for high-risk patients.

2.9 Ambulatory Care Units (ACUs)

Ambulatory Emergency Care Units (A(E)CUs) are now available in many hospitals in order to avoid admission of ambulant patients as well as to reduce ED attendances. It may be appropriate to use the AECU as access for managing certain alcohol patients to avoid admission.

2.10 Re-attenders

The use of care plans

Care plans or Management plans written by the alcohol specialist nursing team jointly with the ED Consultant champion can be useful for patients who are re-attenders (there is RCEM guidelines on frequent re-attenders) (9). These plans can alert junior doctors to patients who are at high risk of complications of alcohol use, and can provide names of the key personnel involved in the patient's care, aiding communication and safe management. These care plans should be drawn up in compliance with the RCEM advice. Appendix 8 shows an example of a care plan.

2.11 The Paediatric Population including Adolescents

The physical and psychological risks of alcohol consumption are much greater for children and young people than they are for adults. In the UK, levels of drinking among 15-year-olds are significantly higher than the European average (10).

Childhood drinking increases the likelihood of 'risky behaviour' leading to a risk of being assaulted, underage pregnancy, contracting sexually transmitted disease and becoming alcohol dependant (15). It also increases the risk of being involved in criminal and anti-social behaviour and reduces potential at school (11).

Child safeguarding responses still apply to under 18 (as they do for the under 16s). These can be the 'lost tribe' as Paediatric services generally will admit or follow up only those under 16 years of age. Systems must be in place within the ED to enquire regarding safeguarding of this group, and to report safeguarding concerns.

Data sharing within health professional organisations can be required due to child safeguarding and so a 'safety net' system needs to be in place to ensure that onward follow up of the child is put in progress.

2.12 Dual Diagnosis

Dual diagnosis is the term used to describe patients with significant mental illness and problematic drug and/or alcohol abuse. When an intoxicated patient is deemed fit for further 'interview', perhaps after a period of observation in the ED, a co-existing mental health (MH) disorder may well be uncovered. In this case a referral to the hospital Psychiatry Liaison Team as well as to the Alcohol Nurse Specialist team would be appropriate in order that appropriate follow up is arranged.

2.13 The Elderly population

As the elderly population increases in size so does the problem of alcohol abuse in this aging group. There are no specific alcohol screening tools for this group, adjusted to co-morbidities and poly-pharmacy. AUDIT-C is the suitable tool to start with but it must be

remembered that a low threshold for intervention and referral to services should be sought if an alcohol related illness or injury is identified.

Patients who fall and who are on warfarin should be asked about alcohol ingestion as a co-factor to serious consequences, assumptions about alcohol consumption based on age (or any socio-demographic data) should not be made.

2.14 Training, competencies and CPD for doctors

Medical students and junior doctors should be taught about alcohol misuse. All clinicians need to have the awareness that alcohol screening is appropriate in all areas of the hospital and that taking a concise alcohol history is an essential tool. The Medical Council on Alcohol's resource 'Alcohol and Health Handbook' is listed in the resources section.

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Version

Published June 2015

Review

June 2018 or sooner if important information becomes available.

Conflicts of Interest

None

Disclaimers

The College recognises that patients, their situations, Emergency Departments and staff all vary. This guideline cannot cover all possible scenarios. The ultimate responsibility for the interpretation and application of this guideline, the use of current information and a patient's overall care and wellbeing resides with the treating clinician.

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Resources

- Health First: an evidence-based alcohol strategy for the UK, University of Stirling, 2013
- Alcohol Care in England's Hospitals. An opportunity not to be wasted, Public Health England, 2014
- Young people's hospital alcohol pathways – support pack for A&E departments, Public Health England, 2014
- Medical Council on Alcohol website: www.m-c-a.org.uk
- Public Health England Alcohol Learning Centre: www.alcohollearningcentre.org.uk
- The Institute of Psychiatry's SIPS Junior Study (www.sipsjunior.net) - ongoing prevalence study of children's alcohol consumption.

Appendix 1: Paddington Alcohol Test (2009)

Ealing Hospital NHS Trust

Emergency Department

PATIENT IDENTIFICATION STICKER:
NAME
D.O.B.

A. **PAT** form needs to be completed for **TOP 10 presentations** – circle appropriate condition:

1. FALL (*incl. trip***)**	**2. COLLAPSE (***incl. fits***)**	**3. HEAD INJURY**	**4. ASSAULT**
5. ACCIDENT	**6. UNWELL**	**7. GASTRO - INTESTINAL**	**8. CARDIAC (***i. Chest pain***)**
9. PSYCHIATRIC *(incl.* ***DSH*** *&* ***OD****) please state*		**10. REPEAT ATTENDER**	***Other (****please state)*

RLY IDENTIFICATION TO REDUCE RE-ATTENDANCE

proceed after dealing with patient's clinical condition

routinely ask all patients having …(above presentation)…**do you drink alcohol?"**

1 Do you drink alcohol?

YES (go to #2) **NO** (end)

What is the most you will drink in any one day?

(UK alcohol units)

Use the following guide to **estimate** total daily units.
(Standard pub units in brackets; home measures often three times the amount!)

Beer /lager/cider	**2)**	☐	**(1.5)**	☐	ottles **(4.5)**	☐	
Strong beer /lager /cider	**5)**	☐	**(4)**	☐	ottles **(10)**	☐	
Wine	es **(1.5)**	☐	ottles **(9)**	☐	**pops**		
Fortified Wine (Sherry, Port, Martini)	es **(1)**	☐	ottles **(12)**	☐	bottles **(1.5)**	☐	
Spirits (Gin, Vodka, Whisky etc)	s **(1)**	☐	ottles **(30)**	☐			

If more than twice daily limits (8 units/day for men, 6 units/day for women) **PAT +ve** tinue to Q3 for all)

How often do you drink?

Every day	May be dependent, advise against daily drinking. Consider pabrinex & chlordiazepoxide
____ times per week	
Less than weekly	tinue to next question)

Do you feel your attendance at A&E is related to alcohol?

YES (PAT+ve)
NO

If PAT +ve give feedback e.g. **"Can we advise that your drinking is harming your health".**
"It is recommended that you do not regularly drink more than 4 units/day for men or 3 units/day for women**".**

We would like to offer you further advice,

would you be willing to see our nurse specialist? **YES** **NO**

PADDINGTON ALCOHOL TEST 2009

If "YES" to Q5: give ANS appointment card and leaflet and make appointment in diary.
Write appointment time on front of CAS card
Other appointment times available, please speak to ANS or write contact details of patient in diary
Give alcohol advice leaflet ("Units and You") to all PAT+ve patients, especially if they decline ANS appointment.

Please note here if patient admitted to ward ……
Name of person completing form:
Signature: **Date:**

EARLY IDENTIFICATION + BRIEF ADVICE REDUCES REATTENDANCE

The Paddington Alcohol Test (PAT) is a clinical and therapeutic tool to **'make the connection'** between Emergency Department (ED) attendance and drinking alcohol. PAT was specifically developed for use in busy EDs to make best use of the **"OPPORTUNISTIC TEACHABLE MOMENT"** (Williams et al 2005).

Any doctor or nurse can follow the PAT to give **Brief Advice** (BA) which is less than a minute for most patients. **BA** is followed by the offer of a **Brief Intervention** (BI) from the Alcohol Nurse Specialist.
(BI is a specialist session lasting 20 minutes or more).

UNITS = (Concentration x volume in mls)/1000

Beer/lager/cider

1 bottle of 5.2% beer 1.4 units
500 can 4% beer/cider = 2 units
1 pint 4% beer/cider = 2.3 units
500 can 5% beer/cider =2.5 units
1 pint 5% beer/cider = 2.8 units
1 pint stella/kronenberg= 3 units
3 litre bottle of cider 7.5% = 22 Units
Can of strong beer/cider = 4.75 units

Spirits

25mls x 40% = 1 unit
35mls x 40% = 1.4 units
50mls x 40% = 2 units
70mls x 40% =2.8 units
¼ bottle = 8 units
70cl x 40% = 28 units
Litre bottle = 40 units

Wine

125mls x 8% = 1 unit
125mls x 12% = 1.5 units
125mls x 14.5 = 1.8 units

175mls x 8% = 1.4 units
175mls x 12% = 2.1 units
175mls x 14.5% = 2.5 units

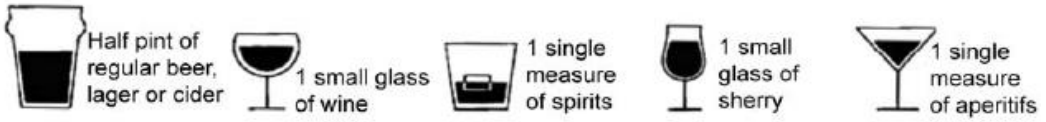
250mls x 8% = 2 units
250mls x 12% = 3 units
250mls x 14.5% 3.6 units

750mls (bottle) x 8% = 6 units
750mls (bottle) x 12% = 9 units
750mls (bottle) x 14.5 = 10.8 units

Home measures can be 3x higher than what is dispensed by the pub/club

Appendix 2: Fast Alcohol Screening Test

This is one unit of alcohol...



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

FAST	ing system					Your score
		1	2		4	
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?	ever	Less than monthly	Monthly	Weekly	Daily or almost daily	
Only answer the following questions if the answer above is Never (0), Less than monthly (1) or Monthly (2). Stop here if the answer is Weekly (3) or Daily (4).						
How often during the last year have you failed to do what was normally expected from you because of your drinking?	ever	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	ever	Less than monthly	Monthly	Weekly	Daily or almost daily	
Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	o		Yes, but not in the ast year		Yes, during he last ear	

Scoring:
If score is 0, 1 or 2 on the first question continue with the next three questions

If score is 3 or 4 on the first question – stop here.
An overall total score of 3 or more is FAST positive.

SCORE

What to do next?

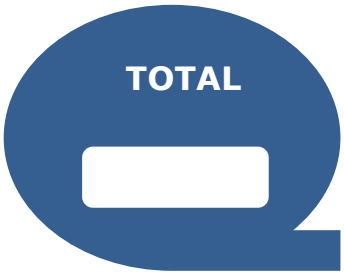
If FAST positive, complete remaining AUDIT questions (this may include the three remaining questions above as well as the six questions on the second page) to obtain a full AUDIT score.

Score from FAST (other side)

Remaining AUDIT questions

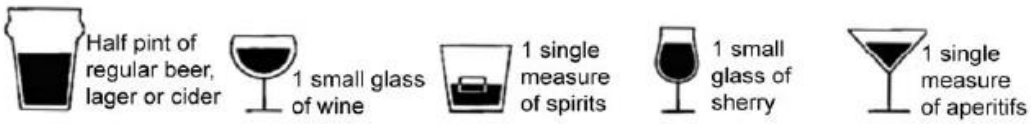
Questions	ing system					Your score
		L	2	3	4	
How often do you have a drink containing alcohol?	ever	Monthly or less	2 - 4 times per month	2 - 3 imes per week	4+ times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	-2	3 - 4	5 - 6	7 - 8	10+	
How often during the last year have you found that you were not able to stop drinking once you had started?	ever	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	ever	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you had a feeling of guilt or remorse after drinking?	ever	Less than monthly	Monthly	Weekly	Daily or almost daily	
Have you or somebody else been injured as a result of your drinking?	o		Yes, but not in the last year		Yes, during the last year	

TOTAL AUDIT Score (all 10 questions completed):
0 – 7 Lower risk,
8 – 15 Increasing risk,
16 – 19 Higher risk,
20+ Possible dependence



Appendix 3: AUDIT-C

This is one unit of alcohol…



…and each of these is more than one unit

AUDIT – C

Questions	Scoring system					Your score
		1		3	4	
How often do you have a drink containing alcohol?	ever	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?	-2	3 - 4	- 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?	ever	Less than monthly	lonthly	Weekly	Daily or almost daily	

Scoring:
A total of 5+ indicates increasing or higher risk drinking.
An overall total score of 5 or above is AUDIT-C positive.

Score from AUDIT- C (other side)

Remaining AUDIT questions

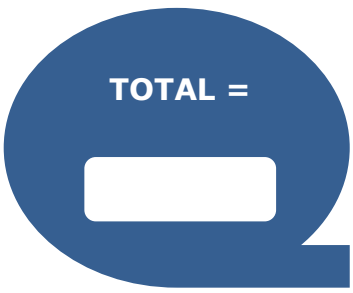
Questions	ring system					Your score
		1		3	4	
How often during the last year have you found that you were not able to stop drinking once you had started?	ever	Less than monthly	onthly	Weekly	Daily or almost daily	
How often during the last year have you failed to do what was normally expected from you because of your drinking?	ever	Less than monthly	onthly	Weekly	Daily or almost daily	
How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	ever	Less than monthly	onthly	Weekly	Daily or almost daily	
How often during the last year have you had a feeling of guilt or remorse after drinking?	ever	Less than monthly	onthly	Weekly	Daily or almost daily	
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	ever	Less than monthly	onthly	Weekly	Daily or almost daily	
Have you or somebody else been injured as a result of your drinking?	)		Yes, but not in the last year		Yes, during the last year	
Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	)		Yes, but not in the last year		Yes, during the last year	

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

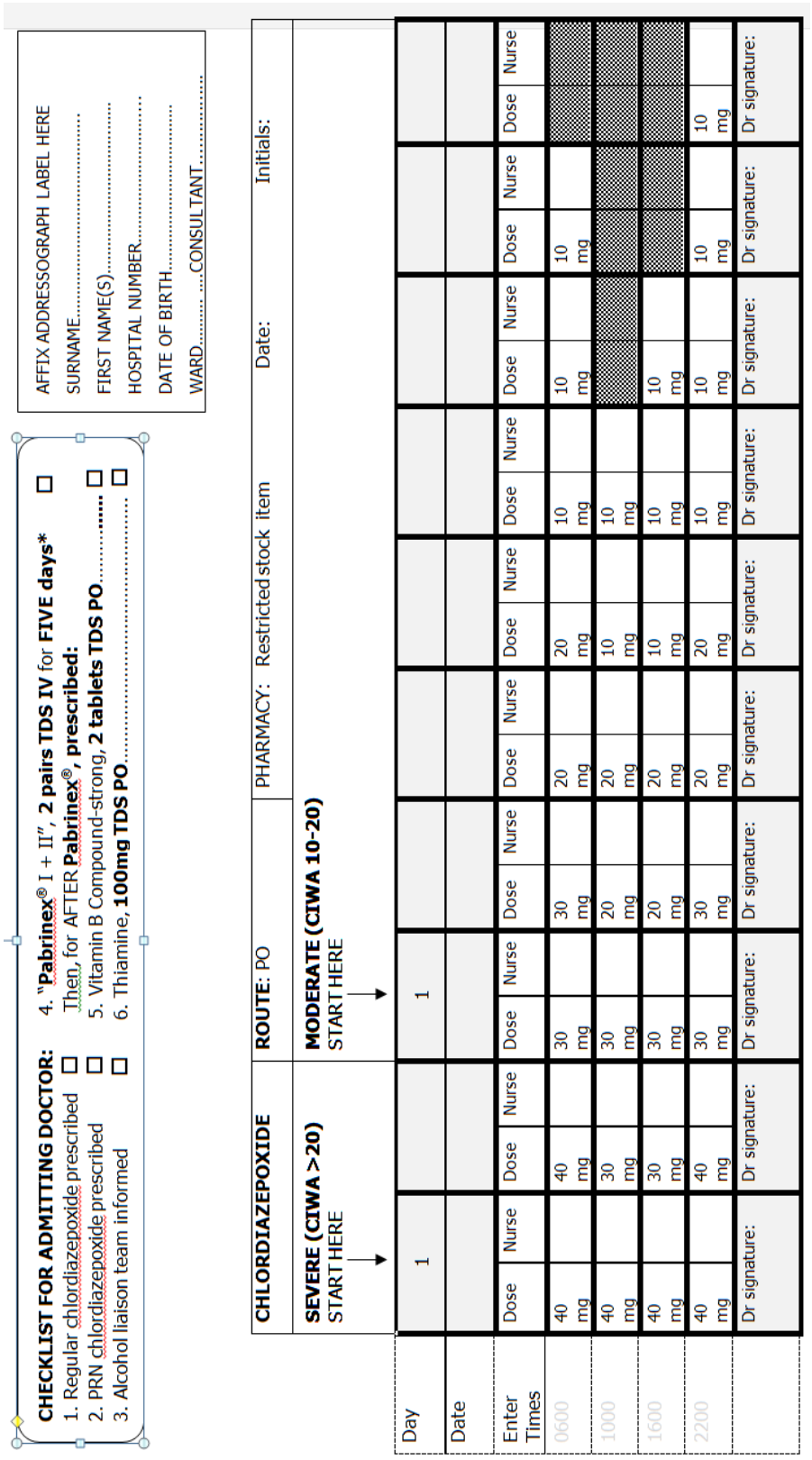
TOTAL Score equals

AUDIT C Score (above) +

Score of remaining questions



Appendix 4: Alcohol Withdrawal Management and CIWA Scale



CHECKLIST FOR ADMITTING DOCTOR:
1. Regular chlordiazepoxide prescribed ☐
2. PRN chlordiazepoxide prescribed ☐
3. Alcohol liaison team informed ☐
4. "**Pabrinex®** I + II", **2 pairs TDS IV** for **FIVE days*** ☐
Then, for AFTER **Pabrinex®**, **prescribed:**
5. Vitamin B Compound-strong, **2 tablets TDS PO**..... ☐
6. Thiamine, **100mg TDS PO**..... ☐

AFFIX ADDRESSOGRAPH LABEL HERE
SURNAME.....
FIRST NAME(S).....
HOSPITAL NUMBER.....
DATE OF BIRTH.....
WARD..... ....CONSULTANT.....

CHLORDIAZEPOXIDE | **ROUTE:** PO | PHARMACY: Restricted stock item | Date: | Initials:

SEVERE (CIWA >20) START HERE → | **MODERATE (CIWA 10-20)** START HERE →

Day	1				1																	
Date																						
Enter Times	Dose	Nurse	Dose	Nurse	Dose	Nurse	Dose	Nurse	Dose	Nurse	Dose	Nurse	Dose	Nurse	Dose	Nurse	Dose	Nurse	Dose	Nurse	Dose	Nurse
0600	40 mg		40 mg		30 mg		30 mg		20 mg		20 mg		10 mg		10 mg		10 mg					
1000	40 mg		30 mg		30 mg		20 mg		20 mg		10 mg		10 mg									
1600	40 mg		30 mg		30 mg		20 mg		20 mg		10 mg		10 mg		10 mg							
2200	40 mg		40 mg		30 mg		30 mg		20 mg		20 mg		10 mg		10 mg		10 mg		10 mg			
	Dr signature:		Dr signature:		Dr signature:		Dr signature:		Dr signature:		Dr signature:		Dr signature:		Dr signature:		Dr signature:		Dr signature:			

*or until Wernicke's

WHEN REQUIRED (PRN) DRUGS			Date	Time	Dose	Sig.	Date	Time	Dose	Sig.
Drug **CHLORDIAZEPOXIDE**	Dose **10-20mg**	Route **PO**								
Pharmacy	Maximum **240mg in 24 hours <u>including</u> regular**									
	Signature	Start date								
Restricted Stock										

NAME		OTHER NAMES					
DATE OF BIRTH	HOSPITAL NUMBER	WARD:					
REPORTED DAILY ALCOHOL CONSUMPTION:							
	TIME /DATE						
Temperature (per axilla)	0) 37.0-37.5°C 1) 37.6-38.0°C 2) Greater than 38.0°C						
Pulse (beats per minute)	0) 90-95 1) 96-100 2) 101-105 3) 106-110 4) 111-120 5) Greater than 120						
Respiration rate (inspirations per minute)	1) 20-24 2) Greater than 24						
Tremor (arms extended, fingers spread)	0) No tremor 2) Not visible—can be felt fingertip to fingertip 4) Moderate with arms extended 6) Severe even with arms not extended						
Sweating (observation)	0) No sweat visible 2) Barely perceptible, palms moist 4) Beads of sweat visible 6) Drenching sweats						
Clouding of sensorium ("What day is this? What is this place?")	0) Orientated 2) Disorientated for date by no more than two days 3) Disorientated for date 4) Disorientated for place (re-orientate if necessary)						
Quality of contact	0) In contact with examiner 2) Seems in contact, but is oblivious to environment 4) Periodically becomes detached 6) Makes no contact with examiner						
Agitation (your observation)	0) Normal activity 2) Somewhat more than normal activity 4) Moderately fidgety and restless 6) Pacing, or thrashing about constantly						

Thought disturbances (flight of ideas, paranoid ideas)	0) No disturbance 2) Does not have much control over nature of own thoughts 4) Constantly troubled by unpleasant thoughts 6) Thoughts come too rapidly and in a disconnected fashion						
Visual disturbances (photophobia, seeing things)	0) Not present 2) Mild sensitivity (bothered by the lights) 4) Intermittent visual hallucinations (occasionally sees things you cannot) 6) Continuous visual hallucinations (seeing things constantly)						
	AL						
Alcohol withdrawal scale regime—NOTE CHANGE IN SCORE 1 Score four-hourly routinely 2 If greater than 6 score two-hourly 3 If greater than 9 score hourly							

Appendix 5: Improving the Detection of Alcohol - Misuse Questionnaire

(September 2008)

This questionnaire is for use to improve attitudes towards alcohol patients and can be used to question all clinical staff in the ED.

Carrying out an alcohol screening tool and intervention by an Alcohol Nurse Specialist referral is intended to help people reduce their health problems later in life, as well as reducing the impact of alcohol on the department.

'We would appreciate your comments/ answers to this questionnaire, which we will treat in confidence, with no names attached. Please return to: ……..ANS in person or.

1 IN A TYPICAL WEEK OF YOUR A&E WORKING PRACTICE

What percentage of patients that you see would you estimate are intoxicated?

What % of patients do you think may have been drinking too much recently?

2 YOUR OPINIONS

Do you tend to agree or disagree with the following sentiments:

circle Y for agree, N for disagree.

agree/yes

"If I had more time I would ask more people about their alcohol consumption"

"It's not my job to detect drinkers"

"I cannot always remember to screen for alcohol use"

"I think it is important to detect alcohol problems early"
On a scale of 0-10 disagree 1-2-3-4-5-6-7-8-9-10- agree

"Detecting and referring drinkers is a GP's work rather than mine"

"I am too busy to do alcohol screening"

"I think that it is good to use a test like the PAT to detect alcohol problems early"

"There is no point to referral as there is no successful treatment for alcohol problems"

"I would only do those PATs that are absolutely necessary"

"It would be negligent to omit PAT for a patient with alcohol-related conditions"

"Drinking alcohol is part of our culture"

" How confident do you feel screening or assessing patients using the PAT in A&E Scale between 0- 10 Not confident 1-2-3-4-5-6-7-8-9-10 confident

"We all drink a lot"

" I always routinely screen for alcohol problems in A&E "

"I think A&E is an appropriate place to carry out the PAT"

"Having the Alcohol Nurse Specialist here will creates more work for the department"

"The PAT starts staff thinking about their own drinking"

"The majority of people drink more than twice the recommended daily limits"

"Having the Alcohol Nurse Specialist here will be positive and help support the staff in the department"

"Most referrals would not return to A&E for an Alcohol Nurse Specialist appointment"

I would value training that focuses on the following:

Alcohol Awareness

Alcohol Withdrawal Management

The Role of the Alcohol Nurse Specialist in A&E

The use of the AUDIT-C

What is your role in the department? (please circle one)

SHO Registrar medical student other doctor nurse other

Additional Comments;

Appendix 6: Job Descriptions for an Alcohol Nurse Specialist

Job Description

Job Title: Hospital Liaison Alcohol Nurse Specialist

Band: **6**

Hours of Work (p/w): **37.5**

Service Centre/Directorate: **Alcohol Liaison Team /**

Base: …… Hospital (some community liaison)

Accountable to: **Alcohol Liaison Team leader**

Reports to: **Alcohol Liaison Team leader**

Substance misuse assessments, review and monitoring of patients with dependence or other related issues.
Assisting colleagues with care planning.
Referral to community substance misuse services.
Delivery of brief interventions for hazardous drinkers.

Key working relationships: Nursing and medical staff in Emergency department including CDU & Acute Medical Unit (AMU)

Role of the Department: The Alcohol Liaison Team provides specialist input for patients with alcohol misuse issues and health problems, and also for drug dependence issues. The service is provided to the ED and to provide ward cover (when the ward cover Alcohol Nurse Specialist is on leave.

Job Summary:
The post holder will be part of a team contributing to:

- the development of a screening and brief alcohol intervention service to patients who have been identified as drinking to a level that is assessed as being potentially harmful to their health.
- the provision of support and facilitation to Acute Trust staff to ensure that best practice is delivered through the national treatment agency guidelines.

The post holder will:

- Assess all patients referred from ED and inpatient wards/clinics and provide expert advice and referral to existing services within the borough of …….
- Work closely with local specialist services providing provision for people with alcohol dependency.
- Be able to communicate and negotiate in complex situations.
- The post holder will be required to work flexible hours which may include some evening and weekend shifts.

Trust Vision & Values:

The postholder is expected to have a clear understanding of how this post contributes to the achievement of the trust vision of:

We expect all our staff to share the values that are important to the Trust, being Excellent, Kind, Responsible & Respectful, and behave in a way that reflect these.

Main Duties/Key Results Areas:

CLINICAL

1.1 Implement and monitor screening tools as an integrated part of nursing and medical; medical triage/assessment. Support Acute Trust staff to become competent in assessing their patients for alcohol screening.

1.2 Assess the extent to which the patient is experiencing alcohol misuse, including the level and pattern of consumption.

1.3 Respond to referrals from all hospital departments including following up those referrals made out of hours.

1.4 Provide brief interventions (clinics or by phone) with easily accessed systems for referral from A&E and other hospital departments where required.

1.5 Where indicated, provide individual structured extended brief interventions lasting up to five sessions and signpost patients into statutory and non-statutory services (i.e. detoxification, counselling, rehabilitation etc).

1.6 The brief intervention will be modelled on evidenced based techniques which include motivational interviewing, CBT, alcohol education and harm reduction, and structured advice regarding the consequences of alcohol misuse on health, family and work.

1.7 To promote health through brief interventions, motivational interviewing, empowering patients, offering appropriate health education, information and advice to patients, relatives and carers.

1.8 Record info on the established systems for measuring the outcomes associated with the delivery of the service.

1.9 To promote the harm reduction concept in respect of alcohol misuse in the general hospital setting.

1.10 To support and advise Acute Trust staff on appropriate treatment regimes including managed alcohol withdrawal and relapse prevention.

1.11 To support the development of treatment pathways between the acute hospital and community based alcohol treatment services.

1.12 To promote wider awareness and ownership of substance misuse as a health issue amongst medical and nursing staff in all relevant hospital departments.

1.13 Provide patients with information and support them to access community addiction services.

1.14 To work closely with the local community Drug and Alcohol teams ensuring that complex cases are supported appropriately.

EDUCATION

2.1 Contribute/support the development of a tailored training package for nursing/medical staff to improve confidence and competence in the use of the screening tools for alcohol misuse.

2.2 To identify training needs that will improve the confidence and competency of nursing and medical staff in treating alcohol misuse in general, and referring on for brief interventions or more structured treatment where indicated.

2.3 To assist with the organisation and delivery of multidisciplinary education and training in general.

MANAGEMENT

3.1 To assist in the management of the effectiveness of the service provided through the collection and collation of data required for performance management.

3.2 To assist with the development of evidence based clinical practice within the specialist discipline.

3.3 To help identify opportunities for service development and role redesign to enhance alcohol services.

CONSULTATION/COLLABORATION

4.1 To attend appropriate steering groups/sub groups alongside team leader.

4.2 Maintain collaborative relationships, partnerships and networks to influence and improve the management of alcohol within the Trust.

4.3 To contribute to and learn from formal mechanisms for sharing good practice in the borough and elsewhere, enhancing own knowledge, skills and clinical expertise.

4.4 To identify clinical networks in maintaining close working relationships to influence and improve health outcomes and health delivery systems.

RESEARCH AND AUDIT

5.1 Support the delivery of mechanisms for the collection of data designed to measure the impact and benefits of the brief interventions project.

5.2 Be familiar with the local prevalence and epidemiological data for alcohol prevalence and to assist with audit to assess the effectiveness of alcohol management in different settings.

PROFESSIONAL RESPONSIBILITIES

6.1 To maintain and improve own professional, clinical, managerial knowledge and skills by promoting self-growth and development through in-service training programmes, and other educational programmes/materials as agreed through the appraisal process with the Team Leader/Associate Director of Nursing.

6.2 To promote and maintain high standards of professional practice and competence in keeping with the NMC Code of Conduct and the Scope of Professional Practice.

6.3 To maintain a record of professional development by use of a personal profile and meet the PREPP requirement for continued registration. Identify needs/goals through supervision, appraisal and development review.

6.4 To initiate and develop nursing/team research projects, and disseminate the knowledge and results from such research to colleagues. Implement and encourage the use of research findings in nursing education and practice.

6.5 To participate in regular managerial supervision with the Liaison Psychiatry Team Leader, and team clinical supervision.

6.6 To be fully conversant with current legislation and its implications, e.g. Mental Health Act, CCA's, Mental Capacity Act and be aware of current trends in substance misuse and mental health care with particular reference to hospital setting and evidence based practice.

6.7 To be fully aware of the principles of Safeguarding and how they apply to vulnerable adults and children. To ensure that any concerns regarding the safeguarding of children or adults are responded to promptly and escalated appropriately.

The following responsibilities are common to all posts in the Trust

- To have responsibility for the Health, Safety and Welfare of self and others and to comply at all times with the requirement of the Health and Safety Regulations.

- To ensure confidentiality at all times, only releasing confidential information obtained during the course of employment to those acting in an official capacity in accordance with the provisions of the Data Protection Act and its amendments.

- To work in accordance with the Trust's Equal Opportunities policy to eliminate unlawful discrimination in relation to employment and service delivery.

- To ensure skills are up-to-date and relevant to the role, to follow relevant Trust policies and professional codes and to maintain registration where this is a requirement of the role.

- To comply with …… …… No Smoking Policies.

- To undertake such duties as may be required from time to time as are consistent with the responsibilities of the grade and the needs of the service.

This job description is not an exhaustive document but is a reflection of the current position. Details and emphasis may change in line with service needs after consultation with the postholder.

……NHS Trust is an Equal Opportunities employer and operates a No Smoking Policy.
Person Specification

Job Title: Alcohol Nurse Specialist Band: 6

	Essential	Desirable	Assessment Details
EDUCATION/QUALIFICATIONS			
Registered Nurse Adult/ Mental Health	Y		Application
Recognised post graduate qualifications in substance misuse		Y	Application/ Interview
Teaching qualification (ENB998) or equivalent experience		Y	Application/ Interview
Extended/Supplementary prescriber or willing to undertake training		Y	Application/ Interview
EXPERIENCE			
Experience as Band 6 nurse or equivalent within substance misuse or mental health.		Y	Application
Demonstrate an understanding of Health Promotion and Harm Reduction		Y	Application/ Interview
Ability to manage complex care scenarios	Y		Application/ Interview
SKILLS			
Able to demonstrate experience of clinical audit, research, critical appraisal and evaluation		Y	Application/ Interview
Excellent communication, negotiating skills	Y		Application
IT skills e.g. Microsoft Office	Y		Application
Skilled at training health care professionals		Y	Application
Experience of developing services		Y	Application
A good understanding of clinical governance	Y		Application
Proven ability to work autonomously and commitment to a learning team environment	Y		Application/ Interview
KNOWLEDGE			
A sound understanding of local and national policies that underpin the treatment of alcohol users	Y		Application/ Interview
A good understanding of the roles of different professional groups in relation to alcohol misuse	Y		Application/ Interview
A good knowledge of the legal and national framework underpinning substance misuse	Y		Application/ Interview

A good knowledge of local education opportunities and funding in relation to alcohol misuse training	Y		Application/ Interview
A good understanding of Equal opportunities and confidentiality issues	Y		Application/ Interview
PERSONAL QUALITIES			
Strong commitment to work closely with commissioners to develop high quality services for alcohol misusers	Y		Application /Interview
Commitment to team working and developing the skills of others	Y		Application/ Interview
Self motivated, pro-active and innovative	Y		Application/ Interview
Strategic awareness	Y		Application/ Interview
Good sense of humour	Y		Interview
Team player, able to work under pressure	Y		Interview

Key:
I = Interview
A = Application Form
T = Practical Test

ALCOHOL NURSE SPECIALIST

Alcohol Nurse Specialist Band 7, 37.5 hours per week

Head of Nursing

The purpose of the Alcohol Nurse Specialist within the gastrointestinal service is to develop and implement the pathway from admission to discharge and referral to community based treatment.

Summary of the Role:

The role of the Alcohol Nurse Specialist is to assess and provide nursing interventions, including personalised feedback and motivational interviewing, to dependent and other high risk drinkers attending … and … hospitals. The post holder will also support the patients to access community- based structured treatment or out-patients services, as appropriate.

The post holder will cover the inpatient gastrointestinal wards and any outliers on other wards. The post-holder will also ensure that A&E and ward staff are aware of alcohol-related issues and committed to screening, identifying and referring patients who are dependent or high risk drinkers. The post-holder will offer on- the-job training equipping the multidisciplinary team to deliver interventions to harmful and hazardous drinkers. The post-holder will also act as a source of expert advice, guidance and support for both A&E and ward staff on alcohol matters. The post holder will develop corporate guidance for clinicians throughout the hospital on alcohol-related matters, including managing withdrawal and detoxification.

Organisation:

Head of Nursing

Matron

Alcohol Liaison CNS Band 7

Key Relationships:

The post will develop strong operational relationships with:

- local drug and alcohol treatment service providers
- Ward Staff, Ward Managers, Matrons, Key clinicians and service managers in … and …Hospitals, including the A&E matron and A&E consultant
- A&E Urgent Care Centre and Elderly care services
- Other relevant wards and clinics, Primary care commissioners
- Police
- Community Safety Team
- Local community and voluntary organisations

Main Responsibilities

Clinical:

i) To conduct full triage assessments of the referred patients attending A&E and / or admitted to other hospital wards.

ii) To provide interventions to referred patients, including personalised feedback, advice and information, aiming to elicit a change in their drinking behaviour, to encourage greater take-up of specialist community-based treatment services, where appropriate, and to avert future hospital attendances / admissions / readmissions.

iii) To advise patients about their alcohol misuse, using motivational interviewing, relapse management and other evidence-based interventions.

iv) To ensure that hospital staff and GPs are aware of alcohol misuse issues, and are committed to screening patients for alcohol misuse and making appropriate referrals to the Alcohol Nurse Specialist.

v) To provide specialist clinical advice and support to staff in both acute and primary care settings on the management of patients with alcohol problems.

vi) To make appropriate referrals to community-based treatment services for longer term interventions, including structured treatment, counselling, mutual aid, family therapy, and pro-actively support patients to take up these services.

vii) To ensure full risk assessments are carried out and risks are effectively managed.

viii) To support the gastrointestinal team within …

Training and Support:

x) To regularly deliver on-the-job training for hospital staff in order to raise awareness of alcohol-related issues and

xi) To act as an expert resource for hospital staff, providing information, training, guidance and support to clinical and other staff.

xii) To train and support hospital staff on the necessary skills and knowledge to undertake alcohol screening, identify dependent, harmful and hazardous drinkers, and deliver interventions for patients with alcohol problems.

Leadership:

xiii) To develop protocols on alcohol withdrawal management and detoxification.

xiv) To encourage consistency in relation to screening, referral, risk management, withdrawal management, and practice for patients with alcohol problems.

xv) To pro-actively promote a culture of alcohol awareness and sensitivity.

xvi) To provide specialist clinical advice and support to staff within the hospital, and other agencies concerned with substance misuse.

xvii) To work in partnership with the police, Ambulance Services and the council's Community Safety Team in order to agree working protocols and practices that will divert dependent drinkers from A&E, where they are uninjured but fall under the Mental Capacity Act.

Communication:

xviii) To participate in multi-disciplinary team meetings and case discussions in the hospital, promoting awareness and understanding of alcohol issues.

xix) To ensure that hospital staff and GPs are fully briefed and enabled to make appropriate referrals, and to provide verbal or written feedback to referrers.

xx) To liaise and communicate clinical information with partner agencies within the protocol for sharing confidential information between substance misuse services, the hospital and other partner agencies.

xxi) To develop and maintain good communication links with key operational and strategic partners, as listed above.

xxii) To work collaboratively and undertake multi-agency planning in order to ensure patients' services are well-co-ordinated, patients are supported to access community-based services, and formal three-way handovers take place at the point of referral.

xxiii) To maintain accurate, up to date documentation of all service patients records, ensuring the confidentiality of such records of information are in line with the Data Protection Act and Information-Sharing Protocol.

Performance Monitoring:

xxiv) To participate in and contribute to clinical and service audits, ensuring that relevant evidence is collated and evaluation findings implemented.

xxv) To collect and collate evidence of patient outcomes in order to evidence averted hospital presentations and / or admissions.

xxvi) Make performance quarterly reports, including numbers of interventions delivered, referrals received and made, patient outcomes and estimated averted hospital presentations / admissions.

ADDITIONAL RESPONSIBILITIES

INFORMATION GOVERNANCE

All NHS workers must abide at all times by the Confidentiality: NHS Code of Practice document issued by the Department of Health, and follow the relevant confidentiality and privacy policies specifically adopted by the Trust. Information relating to patients, employees and business of the Trust must be treated in the strictest confidence and under no circumstances should such information be discussed with any unauthorised person(s) or organisations. All information collected, stored and used must be done so in compliance with the Data Protection Act, the Freedom of Information Act (2000) and all relevant Trust Policy. Breaches of confidentiality or information governance protocol may lead to disciplinary action.

INFORMATION SECURITY

All staff must adhere to the requirements of the Trust's Information Security Policy, which covers the deployment and use of all of the Trust's electronic information systems (i.e. all computers, peripheral equipment, software and data). In serious cases, failure to comply with the Policy may result in disciplinary action and could also result in a criminal offence.

HEALTH AND SAFETY AT WORK Act (1974)

You are required to take reasonable care for your health, safety and welfare and that of other people who may be affected by your actions or omissions. These responsibilities apply at all times whilst you are at work or on duty and apply to all Trust premises and also whilst working in the community or on any other Trust business.

EQUAL OPPORTUNITIES AND EQUALITIES LEGISLATION

It is the policy of …NHS Trust that no user of service, present or future employee or job applicant receives less favourable treatment on the grounds of their sex, perceived or actual sexual orientation, marital status, race, religion or belief, age, creed, colour, nationality, national origin, ethnic origin, or disability, or on the grounds of their association with someone in one of these groups; nor is disadvantaged by any conditions or requirements which cannot be shown to be justified.

PATIENT & PUBLIC INVOLVEMENT

Section 11 of the Health & Social Care Act 2001, places a duty on NHS organisations to involve and consult patients, the public and other stakeholders in the planning and ongoing development of services. It is the responsibility of each member of staff, clinical and non-clinical to appropriately involve and consult patients, the public and other stakeholders.

RISK MANAGEMENT

You are required to contribute to the control of risk and use the incident reporting system to alert the Trust of incidents or near misses that may compromise the quality of services.

CORPORATE / CLINICAL GOVERNANCE

It is the duty of every employee to fulfil their individual clinical governance responsibilities and their expected contribution to ensuring that the Trust complies with benchmarked standards for quality of clinical care.

INFECTION CONTROL AND HOSPITAL-ACQUIRED INFECTION

Infection Control is everyone's responsibility. All staff, both clinical and non-clinical, are required to adhere to the Trust's Infection Prevention and Control Policies and make every effort to maintain high standards to infection control at all times thereby reducing the burden of Healthcare Associated Infections including MRSA. In particular all staff have the following key responsibilities:

- Staff must wash their hands or use alcohol hand rub on entry to or exit from all clinical areas and between each patient contact.
- Staff members have a duty to attend infection control training provided for them by the Trust.
- Staff members who develop an infection that may be transmissible to patients have a duty to contact Occupational Health.

SAFEGUARDING CHILDREN AND VULNERABLE ADULTS

We all have a personal and a professional responsibility within the Trust to identify and report abuse. The abuse may be known, suspected, witnessed or be limited to raised concerns. Early recognition is vital to ensuring the patient is safeguarded and any other people (children and vulnerable adults) who may be at risk. The Trust's procedures must be implemented, working in partnership with the relevant authorities. The sharing of information no matter how small is of prime importance in safeguarding children, young people and vulnerable adults. As an employee of the Trust you have a responsibility to ensure that:

a) you are familiar with and adhere to the Trusts procedures and guidelines for safeguarding children and vulnerable adults

b) you attend safeguarding awareness training and undertake any additional training in relation to safeguarding relevant to your role.

STAFF COMMITMENT TO PATIENT CARE

You are expected to ensure that patients' needs, experience and safety come first and to treat patients, carers, visitors, and colleagues with dignity and respect.

HEALTH RECORDS

Clinical staff must keep accurate and clear information which is essential for the proper care of patients. Clinical and non-clinical staff who handle or use, case notes are individually responsible for the confidentiality, tracking, filing and good order of the case note at all times as outlined in the Medical Records Policy and the Information Lifecycle Management Policy. For further information refer to; Department of Health website-*Records Management; NHS Code of Practice- 2006*

NHS CONSTITUTION AND CODE OF CONDUCT FOR MANAGERS

Staff are required to act in accordance with the legal duties and expectations relating to their responsibilities to the public, their patients and colleagues set out in section 3b of the NHS Constitution and pages 98-109 of the Handbook to the NHS Constitution. For Managerial staff, including anyone with supervisory responsibility, the core standards of conduct set out in the NHS Code of Conduct for NHS Managers (2002) or any subsequent amendments.

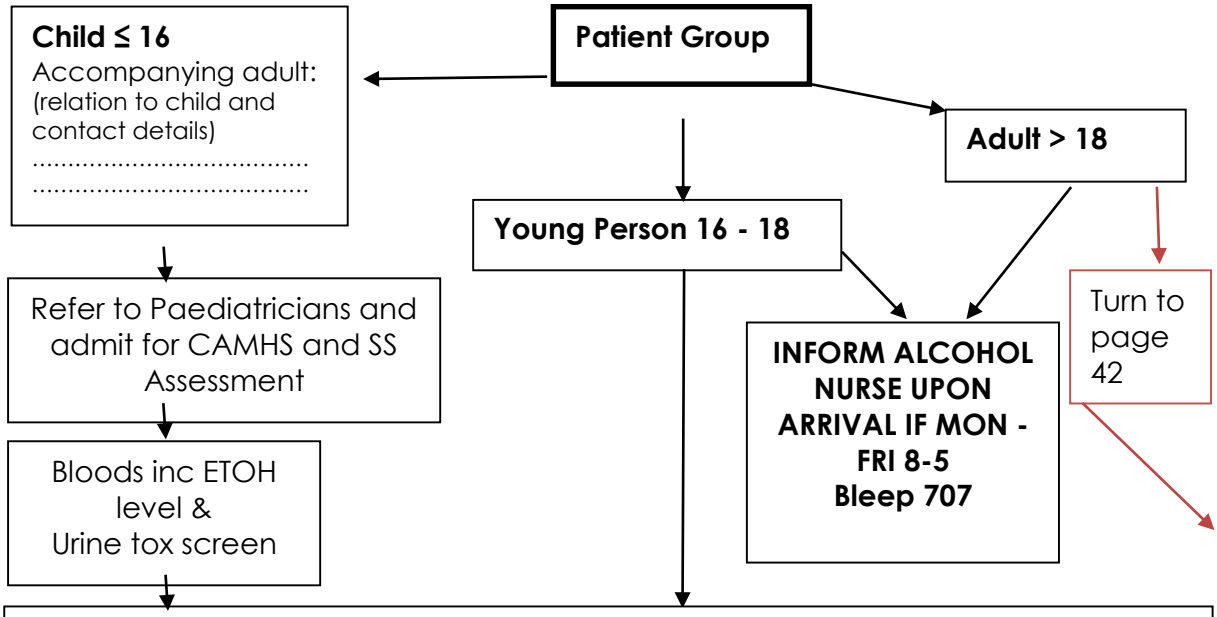
This list is only an indication of the main tasks required to be performed. It is not an exhaustive list of duties and responsibilities and may be subject to amendments to take account of changing circumstances.

The Trust reserve the right that you may be required to undertake such other duties and/or hours of work as may reasonably be required of you commensurate with your grade at your normal place of work or from another location within the Trust

Appendix 7: Intoxicated Pathway

Date of presentation	
Time Seen	
Clinician	

Patient Surname	
Forenames	
Hospital No	
D.O.B.	
Name of school	



PRESENTING COMPLAINT:

Amount Ingested?

Any other substance ingested?

HISTORY OF PRESENTING COMPLAINT:

PAST MEDICAL HISTORY (Make sure this includes any history of ETOH or substance misuse)

EXAMINATION (Include details of GCS, any external injuries, and any evidence of drug ingestion e.g. pupil size)

KEY QUESTIONS:

- Intention to self Harm? □
- History of deliberate self harm? □
- Evidence of mental illness? □
- Any child protection concerns? □
- Is the young person known to CAMHS? □
- Any previous attendances? □
- Evidence or allegation of assault? □
- Patient in full time education? □
- Named social worker? □

If yes to any of these admit to paediatric ward or CDU and discuss with CAMHS or Social services directly as appropriate.
If admission refused discuss with senior clinician. Further discussion with CAMHS / SS will be required

INVESTIGATIONS:

Intoxicated screen on Symphony **+**

- ETOH Level
- Urine Tox Screen
- BM

MANAGEMENT PLAN:

- IV Fluids?
- Consider need for CDU / Medical admission

REVIEW: **TIME:**

Relevant Results:
BM:
ETOH Level:
Urine Tox Screen:

DISCHARGE CHECKLIST:

<u>MANDATORY</u>
Alcohol and Drug Nurse Specialist Informed of attendance: Y / N
Health Visitor / Social Services Referral Made / SAFE form completed: Y / N
Responsible carer present Y/N (if no responsible adult present consider admission to paeds/CDU)

- **Details:**

Consent to being contacted again by support services? Y/N
GP Letter given including details of referral? Y/N

(from first page of pathway on p40)

ADULT presenting with Acute ETOH Ingestion

Inform Alcohol Nurse Specialist (bleep xx) ASAP if Mon-Fri 8-5; book clinic appointment if out of hours. If patient refuses services **still inform** ANS about attendance.

PRESENTING COMPLAINT:

Amount Ingested?

Any other substance taken?

HISTORY OF PRESENTING COMPLAINT:

PAST MEDICAL HISTORY (including past seizures or if known to be ataxic)

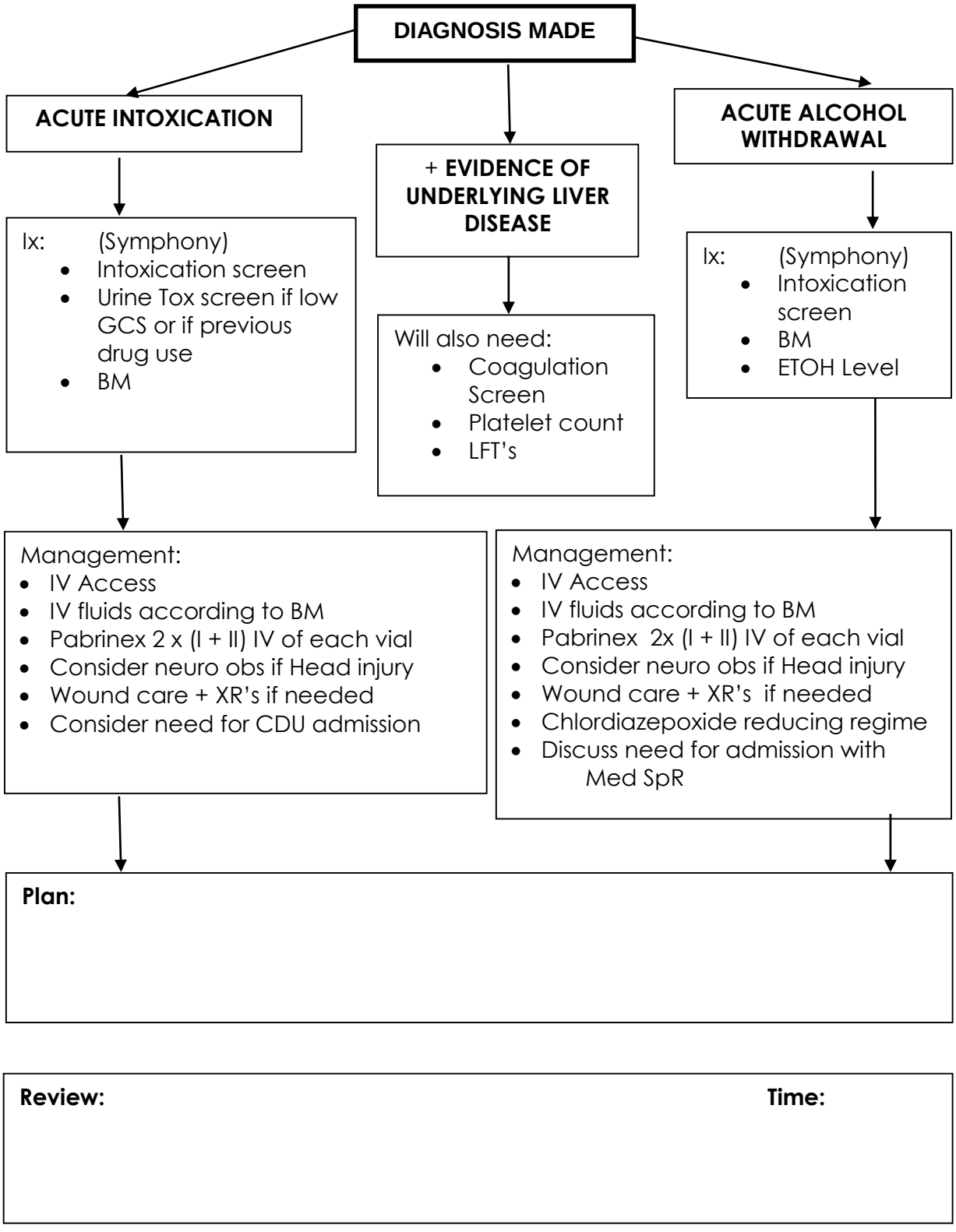
DRUG HISTORY: **ALLERGIES?**

SOCIAL HISTORY (if any children living at home refer to Social Services):

EXAMINATION FINDINGS:

Features to suggest underlying liver disease?			
Jaundice		Spider Naevi	
Ascites		Encephalopathy	
Asterixis		Leuconychia	
Gynaecomastia		Palmar erythema	
		New bruising	

Any Features to suggest acute withdrawal?			
Agitation		Hallucinations	
Seizures		Tachycardia	
Tremor		Confusion	
Or Wernicke's?			
Ataxia		Nystagmus	
Confusion			


DIAGNOSIS MADE
ACUTE INTOXICATION
+ EVIDENCE OF UNDERLYING LIVER DISEASE
ACUTE ALCOHOL WITHDRAWAL
Ix: (Symphony)
Intoxication screen
Urine Tox screen if low GCS or if previous drug use
BM
Will also need:
Coagulation Screen
Platelet count
LFT's
Ix: (Symphony)
Intoxication screen
BM
ETOH Level
Management:
IV Access
IV fluids according to BM
Pabrinex 2 x (I + II) IV of each vial
Consider neuro obs if Head injury
Wound care + XR's if needed
Consider need for CDU admission
Management:
IV Access
IV fluids according to BM
Pabrinex 2x (I + II) IV of each vial
Consider neuro obs if Head injury
Wound care + XR's if needed
Chlordiazepoxide reducing regime
Discuss need for admission with Med SpR
Plan:
Review:
Time:

Discharge Checklist	
Patient GCS < 15	Y / N
Evidence of encephalopathy	Y / N
Delerium Tremens	Y / N
Seizures?	Y / N
Features of severe withdrawal?	Y / N
Any acute blood derangement?	Y / N
DISCHARGE IF NO TO ALL OF ABOVE (IF YES TO ANY OF ABOVE CONSIDER NEED FOR ADMISSION TO CDU OR UNDER MEDICAL TEAM)	
If 8-5 Alcohol Nurse bleeped, or if OOH appointment booked on Symphony	Y / N
Consent from patient to be contacted by telephone?	Y / N
Information slips filled in – one given to patient and one to ALS office?	Y / N

To be given to Alcohol Nurse Specialist

Patient with Alcohol Ingestion related presentation to ED: (For OOH's presentations)
Name:……
Hospital Number……..
Date:……..
Time of presentation:……
Appointment booked? ……

To be given to the patient:

You have been seen in A&E with a problem relating to Alcohol Ingestion. This may be an indication that you have a dependence to alcohol and may benefit from meeting with our Alcohol Nurse Specialists.

Please find below your appointment time with the team:

Name:……..
Date:……
Time:……
Location:……

If you are unable to make this time please feel free to attend the walk in clinic.

Useful telephone numbers:
Alcoholics Anonymous:
Local Alcohol Service:

ent management for patients who are frequent attenders to ED

Appendix 8: Care Plan

Name
DOB
GP Surgery

Number of care plans updated
Hosp Number

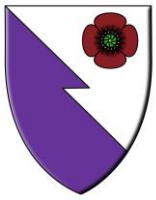
Rationale for plan: (Highlight where appropriate)
Repeat attender to the ED (12 attendances which are alcohol/drugs related in 1 year or 3 attendances in the past 3 months.
Presents with complex alcohol issues (AUDIT-C positive).
Uses illicit drug.
Prescribed opiate substitute medication (Methadone, Buprenorphine or Suboxone).
Presents with dual diagnosis issues (alcohol and mental health)
Open to the Gatehouse alcohol/drug team or other substance misuse service
Have children on CP plan
Frequent admission to hospital
Care plan request by ED consultant
Others (please state)

Brief description of issues.

……
……
……
……
……

Key practitioners in care	**Key practitioners in care**
Name Agency Contact Number Aware of attendance	Name Agency Contact Number Aware of attendance
Key practitioners in care	**Key practitioners in care**
Name Agency Contact Number Aware of attendance	Name Agency Contact Number Aware of attendance

Management/action plan:
Patient aware of plan: Yes/No **If No please given reason**
Matron aware of plan ☐**Yes** ☐**No (if no why not)** **Initiated special case indicator on symphony** ☐**Yes** ☐**No (if no why not)** **Date care plan scanned on to Symphony**
Consultant/senior doctor agreed plan **Care plan written by** Signature: Signature Date Date



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