Alameda County
Health Care Services Agency

Alcohol Management for People Who Plan to Consume Alcohol During Quarantine or Isolation for COVID-19- a Pilot Service

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PURPOSE:

Alameda County Health Care Services Agency recognizes the impact of COVID-19 on individuals' overall health and aims to integrate the fundamentals of harm reduction while caring for persons who consume substances, at risk of withdrawal, and are ordered to quarantine or self-isolate due to COVID-19 at County designated facilities. It is the intent of this policy to outline the management of alcohol for people in quarantine or self-isolation to keep guests at or near baseline consumption and to avoid an early exit or emergency room visits due to alcohol withdrawal or complications.

SCOPE:

I. Applies to all County employees and contracted management, clinical and non-clinical staff involved with management of supplies, client assessments, or delivery of materials to individuals in quarantine status

II. Applies to individuals or clients who are in quarantine who plan on continuing the consumption of alcohol throughout any part of their duration in quarantine or self-isolation

PROCEDURES:

I. ALCOHOL SUPPLY MANAGEMENT

A. All alcohol products intended for consumption shall be stored behind a locked door
B. Stock is managed by Abode
C. Stock will include common liquors available as 50ml "miniature" bottles and 12oz beer(s)
D. Each 50ml miniature bottle and each 12-ounce beer is considered a *standard drink*

II. **SCREENING**

Any person who reduces or discontinues alcohol consumption after chronic use is at risk for alcohol withdrawal symptoms.

A. Nursing intake will include an alcohol consumption assessment to identify persons at moderate-high risk of alcohol withdrawal vs low risk and assess if they are currently in a substance use disorder treatment program (e.g. outpatient program, sober living environment)
   1. Questions to ask client upon intake:
      a. Do you currently drink alcohol?
      b. How much and how often?
      c. Have you had seizures or "DTs" when you stopped?
      d. Have you ever had withdrawal symptoms when you stopped? What kind?
      e. Are you currently in a residential or outpatient treatment program for substance use? Name and contact of program?

2. Moderate-high risk persons are current alcohol consumers PLUS one of the following:
   a. Consumption of 4 or more standard drinks on most days
   b. History of withdrawal seizures from benzodiazepines or alcohol
   c. History of delirium tremens
   d. Subjective report of experience of alcohol withdrawal symptoms
3. Low risk persons:
   a. Absence of any withdrawal history
   b. Consumes less than 4 standard drinks daily

B. Nursing staff will initiate/pre-populate the appropriate alcohol delivery log for low risk (blue log) and moderate to high risk (yellow log) and indicate their current SUD treatment program status (examples in Appendix A)

1. One log per guest
2. Nurse populates guest name, room number, and indicates their current SUD treatment program status
3. For guests at moderate to high risk of withdrawal, RN shall estimate the client's baseline use, in standard drinks, on the delivery log
   a. Standard drink definitions[1]:
      i. 1 standard drink = 12-ouce beer = 9-ouce malt liquor = 5-ouce wine = 1.5-ouce (a "shot") distilled spirit (e.g. vodka, rum, tequila, whiskey)
      ii. Distilled spirits:
         a) ½ pint of distilled spirits = 4.5 standard drinks
         b) 1 pint of distilled spirits = 8.5 standard drinks
         c) A "fifth" of distilled spirits = 17 standard drinks
      iii. Wine
         a) 1 table wine bottle = 5 standard drinks
         b) 1 3 Liter box wine = 20 standard drinks

III. SERVING ALCOHOL

A. General serving provisions:

1. Alcoholic products will be provided to guests 21 and over
2. Alcoholic products should be consumed at the facility
3. Abode staff shall deliver the alcoholic product(s) directly to the end user/guest
4. Abode staff will distribute or make available alcoholic products during the three scheduled breaks or upon request by the guest

B. Considerations for guests enrolled in or referred by a substance use disorder program

1. To the extent possible, provide a supportive environment to help maintain a guest's recovery or sobriety during quarantine

2. Provide supportive measures and offer to link guests to their counselor or program for additional support
3. Provide alcohol per this protocol when other supportive measures are no longer feasible or available
4. Do not withhold alcohol for the sole reason a client is actively engaged in a SUD program

C. Serving quantity and frequency

1. Use the following table to identify the amounts and frequency of alcohol that may be distributed to a guest based on their self-reported alcohol use upon intake

Self-reported daily consumption	Max Amount & Frequency	Daily limit*
1-3 standard drinks	1-2 standard drinks every 1 hour	3 drinks/day
4-6 standard drinks	2 standard drinks every 2-4 hours	6 drinks/day
7-10 standard drinks	3 standard drinks every 2-4 hours	10 drinks/day
11-15 standard drinks	3 standard drinks every 2-4 hours	15 drinks/day
16-20 standard drinks	4 standard drinks every 2-4 hours	20 drinks/day
>20 standard drinks	Consult provider	

*May periodically provide 1 or 2 additional standard drinks (exceeding max) if delivering additional drinks avoids risk of elopement or early exit and enhances comfort unless the person is intoxicated and presenting with behavioral challenges

IV. Monitoring:

A. Moderate-high risk guests may require more frequent wellness checks
B. Guests actively engaged in a substance use disorder program may require more frequent wellness checks
C. Managing difficult situations:
   1. Consult RN and/or supervisor if guest appears too intoxicated or presenting with other behavioral concern at any time
   2. Staff shall consider using the alcohol intoxication scale to objectively support further action (Appendix B) such as:
      a. Performing additional safety assessment(s)
      b. Withhold additional standard drinks for 1 or more hours
      c. Increase frequency of wellness checks
      d. With consultation, the team may decide to reduce total daily limits of alcohol
   3. Guest complains of withdrawal discomfort
      a. Provide additional drinks if they have not exceeded their limits
      b. If the client has exceeded their limits then contact RN to perform a withdrawal assessment using CIWA-Ar (Appendix C) and provide additional standard drinks where necessary
         i. If CIWA Score <5; no recommendation for additional standard drinks
         ii. If CIWA Score 5-14 and no severe medical risk established; recommend 1 additional standard drinks
         iii. If CIWA Score >15 and no severe medical risk established; provide 2 standard drinks and consult a provider

Note: If CIWA >5 – increase the frequency of wellness checks until withdrawal symptoms are well managed (e.g.: every 1-3 hours)

D. RN shall consult a provider for any guest with withdrawal symptoms that may require additional medical or pharmacological support

V. Documentation

A. Nursing staff initiates the appropriate log
B. Abode staff shall maintain an alcohol delivery log for each guest at the facility
C. Abode staff shall check the alcohol delivery log prior to each delivery to avoid excessive alcohol distribution
D. Abode staff shall document the date, time, and quantity of standard drinks distributed on the log in real-time
E. All logs shall be securely stored but accessible to all staff involved in assessing, monitoring, or delivery of alcohol and persons monitoring or evaluating the overall service

VI. Privacy:

A. Information about an individual guest's request(s) for alcohol or alcohol consumption, or behaviors thereof, shall be treated with the same level of integrity as patient health information

VII. QUARANTINE EXIT

A. All precautions shall be taken to avoid dangerous activities for persons consuming alcohol beverages on day of exit (e.g. driving, riding a bicycle)
B. Staff may not provide additional alcohol products to persons "to go" upon exiting quarantine for any reason

References:

1. National Institute of Health. National Institute on Alcohol Abuse and Alcoholism (NIAAA): Alcohol's Effects on Health. 2020. Retrieved at: https://www.niaaa.nih.gov/alcohols-effects-health

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Appendix A- Alcohol Delivery Log (Yellow)

Guest Name: _____ Baseline ETOH use (# standard drinks/day):_____ Comfort Inn Room #: _____

Check 1 box (RN)	Self-reported daily consumption	Amount & Frequency to Provide	Daily limit*	**Is the guest referred by or currently receiving care at a SUD Treatment Program?**	☐ **Yes**	☐ **No**
☐	4-6 standard drinks	2 standard drinks every 2-4 hours	6 drinks/day			
☐	7-10 standard drinks	3 standard drinks every 2-4 hours	10 drinks/day			
☐	11-15 standard drinks	3 standard drinks every 2-4 hours	15 drinks/day	To the extent possible, provide supportive measures to maintain sobriety or progress in recovery but do provide alcohol per the protocol when those measures are no longer available or feasible		
☐	16-20 standard drinks	4 standard drinks every 2-4 hours	20 drinks/day			
☐	>20 standard drinks	Consult provider				

Date	Time	Amount Delivered (# of standard drinks)	Initials	Comments

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Alcohol Delivery Log (Blue)

Guest Name: _____ Comfort Inn Room #: _____

Check 1 box (RN)	Self-reported daily consumption	Amount & Frequency to Provide	Daily limit*	**Is the guest referred by or currently receiving care at a SUD Treatment Program?**	☐ **Yes**	☐ **No**
☒	1-3 standard drinks	1-2 standard drinks every 1 hour	3 drinks/day	To the extent possible, provide supportive measures to maintain sobriety or progress in recovery but do provide alcohol per the protocol when those measures are no longer available or feasible		

Date	Time	Amount Delivered (# of standard drinks)	Initials	Comments

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Appendix B-Rapid Intoxication Assessment Tool

Score of equal to, or greater than, 3 then do not give provided additional alcohol.

CRITERIA	SCORE			
SPEECH	0 Normal	1 Slurred; Slow	2 Mumbling	3 Disjointed; Unintelligible
COORDINATION	0 Regular walking and movements	1 Tripping	2 Unsteady; Tottering; Staggering	3 Falling; Difficulty coming to or maintaining a standing position
MENTAL SIGNS	0 Focused, appropriate behaviour, judgement and emotions			3 Confused, disoriented, mood swings, overly angry & fighting
LEVEL OF CONSCIOUSNESS	0 Alert; Attentive	1 Drowsy; Easily aroused	2 Nodding off; Losing train of thought	3 Unable to have a conversation; unable to perform any task
PHYSICAL SIGNS	0 Normal breathing; Pupils reactive			3 Slow breathing***;** Pupils pinpoint

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Appendix C- CIWA- Alcohol Withdrawal

Alcohol Withdrawal Assessment Scoring Guidelines (CIWA - Ar)

Nausea/Vomiting - Rate on scale 0 - 7

0 - None
1 - Mild nausea with no vomiting
2
3
4 - Intermittent nausea
5
6
7 - Constant nausea and frequent dry heaves and vomiting

Tremors - have patient extend arms & spread fingers. Rate on scale 0 - 7.
0 - No tremor
1 - Not visible, but can be felt fingertip to fingertip
2
3
4 - Moderate, with patient's arms extended
5
6
7 - severe, even w/ arms not extended

Anxiety - Rate on scale 0 - 7
0 - no anxiety, patient at ease
1 - mildly anxious
2
3
4 - moderately anxious or guarded, so anxiety is inferred
5
6
7 - equivalent to acute panic states seen in severe delirium or acute schizophrenic reactions.

Agitation - Rate on scale 0 - 7
0 - normal activity
1 - somewhat normal activity
2
3
4 - moderately fidgety and restless
5
6
7 - paces back and forth, or constantly thrashes about

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

Orientation and clouding of sensorium - Ask, "What day is this? Where are you? Who am I?" Rate scale 0 - 4
0 - Oriented
1 – cannot do serial additions or is uncertain about date

2 - disoriented to date by no more than 2 calendar days

3 - disoriented to date by more than 2 calendar days
4 - Disoriented to place and / or person

Tactile disturbances - Ask, "Have you experienced any itching, pins & needles sensation, burning or numbness, or a feeling of bugs crawling on or under your skin?"
0 - none
1 - very mild itching, pins & needles, burning, or numbness
2 - mild itching, pins & needles, burning, or numbness
3 - moderate itching, pins & needles, burning, or numbness
4 - moderate hallucinations
5 - severe hallucinations
6 - extremely severe hallucinations
7 - continuous hallucinations

Auditory Disturbances - Ask, "Are you more aware of sounds around you? Are they harsh? Do they startle you? Do you hear anything that disturbs you or that you know isn't there?"
0 - not present
1 - Very mild harshness or ability to startle
2 - mild harshness or ability to startle
3 - moderate harshness or ability to startle
4 - moderate hallucinations
5 - severe hallucinations
6 - extremely severe hallucinations
7 - continuous hallucinations

Visual disturbances - Ask, "Does the light appear to be too bright? Is its color different than normal? Does it hurt your eyes? Are you seeing anything that disturbs you or that you know isn't there?"
0 - not present
1 - very mild sensitivity
2 - mild sensitivity
3 - moderate sensitivity
4 - moderate hallucinations
5 - severe hallucinations
6 - extremely severe hallucinations
7 - continuous hallucinations

Headache - Ask, "Does your head feel different than usual? Does it feel like there is a band around your head?" Do not rate dizziness or lightheadedness.

0 - not present
1 - very mild
2 - mild
3 - moderate
4 - moderately severe
5 - severe
6 - very severe
7 - extremely severe

Procedure:

1. Assess and rate each of the 10 criteria of the CIWA scale. Each criterion is rated on a scale from 0 to 7, except for "Orientation and clouding of sensorium" which is rated on scale 0 to 4. Add up the scores for all ten criteria. This is the total CIWA-Ar score for the patient at that time. Prophylactic medication should be started for any patient with a total CIWA-Ar score of 8 or greater (ie. start on withdrawal medication). If started on scheduled medication, additional PRN medication should be given for a total CIWA-Ar score of 15 or greater.
2. Document vitals and CIWA-Ar assessment on the Withdrawal Assessment Sheet. Document administration of PRN medications on the assessment sheet as well.
3. The CIWA-Ar scale is the most sensitive tool for assessment of the patient experiencing alcohol withdrawal. Nursing assessment is vitally important. Early intervention for CIWA-Ar score of 8 or greater provides the best means to prevent the progression of withdrawal.