Evaluation of Alcohol Withdrawal Management Practices at a Community Hospital
A Doctor of Nursing Practice (DNP) Scholarly Project

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Background & Significance
- Alcohol most addictive, abused substance in the U.S.
  - 66.8% (122 million) are current drinkers
  - 7.6% (17 million) are severe drinkers (Data: 2005)
  - 2001 Cost to society $500 billion (27% health care) (Revewed 2005)
- Alcohol dependence (AD) [4]
  - 5% population, age 18-64, meet diagnostic criteria (Gable et al, 2006)
  - Morbidity/mortality (5+ times the general population) (Lipsky et al, 2004)
  - An estimated 35-40% hospital admissions (Gable et al, 2006; Switowsky et al, 2005)
- Unrecognized, mismanaged alcohol withdrawal (AW) [5]
  - Health care cost (length of stay, resource utilization, complications)
  - Frequency (up to 50% patient episodes, restraint use)
  - Staff & patient satisfaction

Purpose
- Evaluate processes and outcomes of an initiative intended to minimize or eliminate untoward effects of AW in AD hospitalized patients at SAMC
- Identify baseline metrics prior to "retooling" of electronic medical record with EPIC implementation

Setting
- 1,554-bed nonprofit community hospital
- Level 1 Trauma Center
- Isolated by ANCC

Theoretical Foundation
- Synergy Model (Wenger, 2003)
  - Ensure "safe passage" across the continuum
  - Competent fit with patient needs
- Logic Model (Quinn & Webber, 2004)
  - Focus structure, process, outcomes
  - Evaluation matrix
  - Core concepts, key indicators, methods

Methods
- Retrospective Chart review
  - 121 patients (4/2008-2009)
  - AW related ID: 9 codes (2510, 2511, 2513, 2514)
  - Three 8-month periods (Plan, Pilot, Implement)
- Staff Nurse Questionnaire
  - 251 direct care RNs
  - Self-rated understanding & confidence, knowledge

Analysis
- Descriptive statistics
  - Nurse Questionnaire: ICU, general, aggregate scoring
  - Chart Review: Trends between Periods I, II, & aggregate

Limitations
- Generalizability to other organizations/populations
- Controlling variables (patient & practice variation)
- Patient population dependent on physician assent
- Correlation of interventions to outcomes

Discussion
- Standardized processes for AW management yet to be hardened into patient care processes
  - Risk Identification: Basic foundation present. Need for: "Reassess" link to interventions & understanding
  - Symptom assessment: Within workflow & staff familiarity, need for "timeliness & consistency"
  - Management: Order set readily implemented & utilized. Decreasing trends: (1) RN AD: 1st drug; (2) staff & restraint use & (3) violent episodes.
  - Support: Increased trends in alcohol use counseling, education, and referral, primarily by LSW & RN

Conclusion
- The provision of effective, efficient, evidence-based care across the acute care continuum is imperative to ensure safe passage to patients who experience AW while in the hospital.
- Utilization of the Logic Model's evaluation matrix provided a useful means to evaluate & target future improvements for care delivered to a high-risk patient population.
- Opportunity to decrease cost and improve outcomes without significant expenditure through more efficient & effective workflows & processes.