One + all | we care

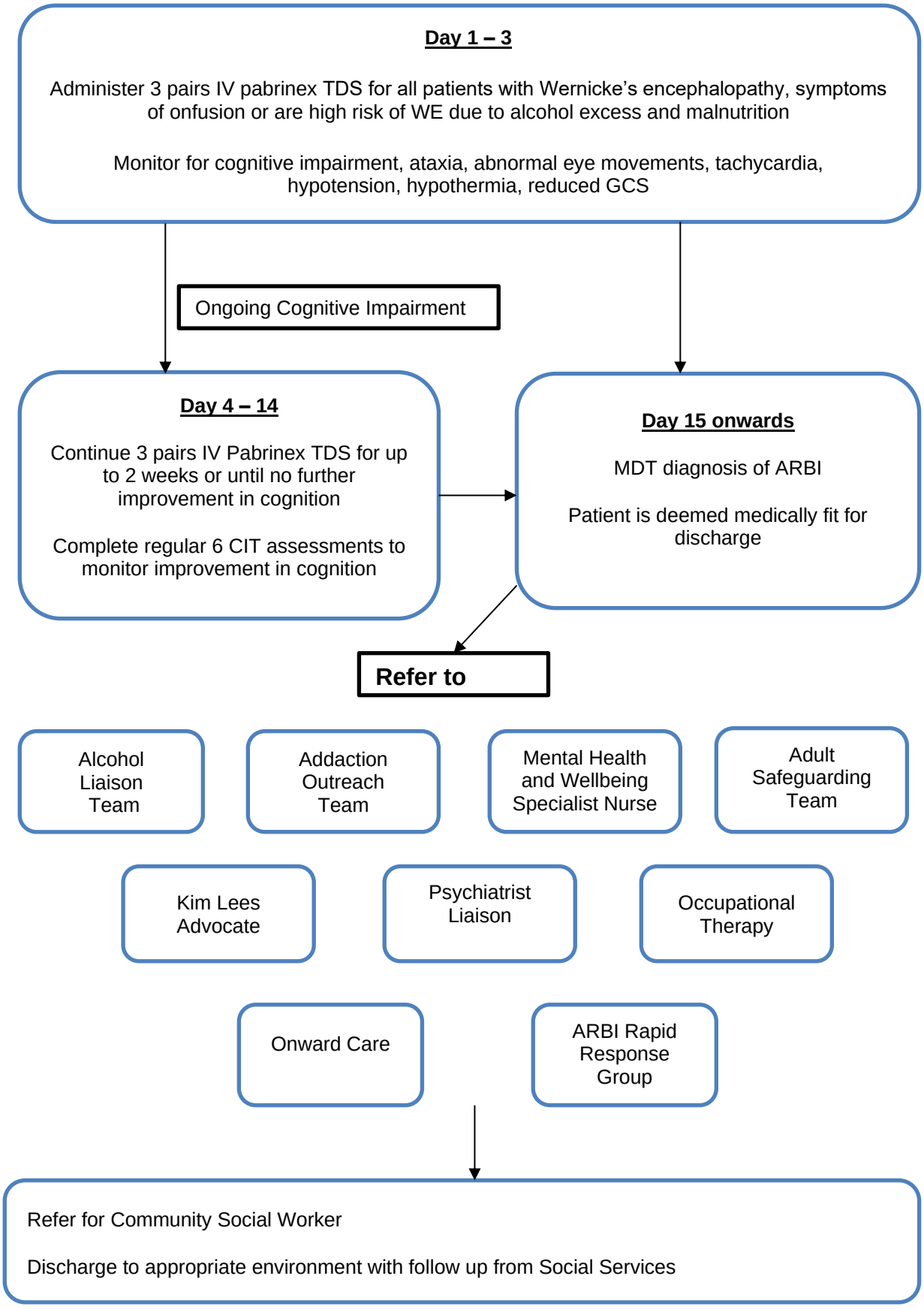
Royal Cornwall Hospitals NHS Trust

Patients Diagnosed with Alcohol Related Brain Injury Clinical Guideline

V2.0

June 2022

Summary


Day 1 – 3
Administer 3 pairs IV pabrinex TDS for all patients with Wernicke's encephalopathy, symptoms of onfusion or are high risk of WE due to alcohol excess and malnutrition
Monitor for cognitive impairment, ataxia, abnormal eye movements, tachycardia, hypotension, hypothermia, reduced GCS
Ongoing Cognitive Impairment
Day 4 – 14
Continue 3 pairs IV Pabrinex TDS for up to 2 weeks or until no further improvement in cognition
Complete regular 6 CIT assessments to monitor improvement in cognition
Day 15 onwards
MDT diagnosis of ARBI
Patient is deemed medically fit for discharge
Refer to
Alcohol Liaison Team
Addaction Outreach Team
Mental Health and Wellbeing Specialist Nurse
Adult Safeguarding Team
Kim Lees Advocate
Psychiatrist Liaison
Occupational Therapy
Onward Care
ARBI Rapid Response Group
Refer for Community Social Worker
Discharge to appropriate environment with follow up from Social Services

1. Aim/Purpose of this Guideline

1.1. Guidance for all clinical staff at RCHT for the identification, management and treatment of Alcohol Related Brian Injury and Pathway for the safe discharge of patients from hospital.

1.2. This version supersedes any previous versions of this document.

Data Protection Act 2018 (General Data Protection Regulation – GDPR) Legislation

The Trust has a duty under the Data Protection Act 2018 and General Data Protection Regulations 2016/679 to ensure that there is a valid legal basis to process personal and sensitive data. The legal basis for processing must be identified and documented before the processing begins. In many cases we may need consent; this must be explicit, informed, and documented. We cannot rely on opt out, it must be opt in.

Data Protection Act 2018 and General Data Protection Regulations 2016/679 is applicable to all staff; this includes those working as contractors and providers of services.

For more information about your obligations under the Data Protection Act 2018 and General Data Protection Regulations 2016/679 please see the Information Use Framework Policy or contact the Information Governance Team

Royal Cornwall Hospital Trust rch-tr.infogov@nhs.net

2. The Guidance

2.1. Background

Alcohol Related Brain Injury (ARBI) is a spectrum of neuropsychological disorders characterised by prolonged cognitive impairment due to chronic alcohol excess. It is an umbrella term that can include several diagnoses such as cerebella atrophy, peripheral neuropathy, hepatic encephalopathy and frontal lobe dysfunction. It can also be known as alcohol dementia, alcohol amnesic syndrome, Wernicke's encephalopathy, Korsakoff's psychosis or Wernicke's-Korsakoff's syndrome.

Alcohol excess can cause injury to the brain via multiple different mechanism that are not fully understood but the most prominent cause is through prevention of thiamine absorption required for effective cellular function in neuronal cells. When combined with chronic malnourishment, which is common in those that are alcohol dependent due to lack of finances and preoccupation with drinking overeating, long term depletion of thiamine results in brain cell loss and development of ARBI. This pathological process can, without adequate assessment and treatment, become a lengthy continuum with impact of the cellular loss ranging from mild to extremely severe.

ARBI sufferers can have a wide variety of cognitive defects which can make diagnosis difficult and delay treatment. ARBI can cause problems with anterograde memory (the ability to create new memories) and retrograde memory (memory of events that have already occurred). This can be

complicated by experiencing distortions in time and confabulation, which results in fabricated, altered or misinterpreted memories influenced by emotion. Individuals can become very disorientated to time and location which can hinder treatment, independence in the community and maintenance of alcohol abstinence. People with ARBI may also experience difficulties with reasoning, weighing up options to make decisions and understanding the implications of decisions, and learning new information and skills. Frontal Executive Dysfunction may also be present which effects social intelligence, visuospatial performance, impulsivity, emotion management, inhibition of inappropriate behaviour, ability to cope with stress and motivation. This can lead to poor engagement with Addiction services and increased likelihood of relapse to alcohol consumption.

The long-term prognosis for those diagnosed with ARBI is relatively favourable, with approximately 50% making a partial recovery and 25% making a complete recovery with alcohol abstinence. Cognitive intervention, tailored to the care needs of the individual, may have an accelerant role in improvement and psychosocial integration. Those referred to specialist services showed improvements in social processing and information services; however standard care homes for older people have little rehab opportunity and can lead to further functional loss and exacerbation of comorbid physical and mental health problems. As individuals suffering with ARBI have a disproportionate impact on health services, due to having higher care needs, significantly delayed discharges and higher financial costs, it is important for acute hospital trusts to rapidly identify and treat early indications of ARBI and use an MDT approach to ensure they are offered tailored, person-centred interventions in a holistic way.

2.2. Assessment and Treatment of ARBI in Hospital

2.2.1. Initial treatment

Patients that present to hospital with a diagnosis of Wernicke's encephalopathy, cognitive impairment alongside excessive alcohol consumption or are deemed high risk due to excessive alcohol consumption and malnutrition should be treated with 3 pairs of ampules of IV Pabrinex three times daily for three days. If patients also experience symptoms of alcohol withdrawal, they should be commenced on the Alcohol detoxification protocol using CIWA scoring and chlordiazepoxide reducing regime. See the Clinical Guideline for the detection and management of Alcohol Withdrawal and the management of Wernicke's Encephalopathy at RCHT for further information on the identification and management of Wernicke's encephalopathy.

2.2.2. Extended Treatment

If symptoms of Wernicke's encephalopathy or cognitive impairment persist after 3 days of high dose IV Pabrinex treatment (3 pairs given three times daily), then high dose treatment should be continued until symptoms resolve or clinical improvement plateaus. High dose IV treatment can continue for up to 2 weeks within hospital. If the patient fully recovers and return to their baseline then they can be safely discharged, ideally following discussion about how their alcohol use can impact on their brain function and with a consented referral to

Addaction (Cornwall Drug and Alcohol Service) to aid long term alcohol abstinence and prevention of further episodes of Wernicke's encephalopathy. If their cognitive impairment endures after 2 weeks of treatment, then it is likely that they have developed a long term ARBI. Once the improvement in their cognitive function has levelled out and a diagnosis of ARBI has been agreed, and there are no other medical concerns, they should be considered medically fit for discharge and the focus should move to supported discharge.

It is important to investigate other potential causes for cognitive impairment if a patient has not significantly improved following the initial treatment of 3 days. Other diagnoses can cause similar presentations and may be missed if a diagnosis of ARBI is made and no further investigations are completed. Patients could have cognitive impairment due to Delirium Tremens, illicit or prescribed drug misuse, sepsis, traumatic brain injury/stroke, dementia, electrolyte imbalance, hypoglycaemia or hypoxia. It is advisable for patients with cognitive deficits to undertake a CT head and full blood tests before a diagnosis of ARBI is made.

2.2.3. ARBI Assessment

2.2.3.1. There is currently no validated diagnostic tool that can be used to identify ARBI in all its variations of impairment and severity, from mild to extreme. Therefore diagnosis should be made based on the presentation of the patient after completion of inpatient alcohol withdrawal and extended treatment with high dose IV Pabrinex. The following criteria can be used to support a diagnosis of ARBI:

- A history of heavy alcohol consumption or more than 35 units a week for a period of at least 5 years
- Evidence of confusion, memory problems, cognitive impairment or Frontal Executive Dysfunction and concerns about capacity
- Three or more attendances to hospital or A&E associated with alcohol or one or more delayed discharges from hospital ward within a year
- All other clinical diagnoses has been excluded through scans and tests

2.2.3.2. For inpatients admitted with alcohol related cognitive impairment, the 6 Item Cognitive Impairment Test (6-CIT – See Appendix 3) is a quick and easy tool to support the identification of cognitive impairment on initial assessment and to monitor improvements in cognition during early and extended treatment until the patient returns to baseline or there is no further improvement. Patients that have 6-CIT scores which indicate cognitive impairment should be further assessed to establish their mental capacity to make decisions regarding their

treatment and care within hospital. Please see the RCHT Mental Capacity Policy and RCHT Deprivation of Liberty Policy and Procedure for further information.

2.2.3.3. Once a diagnosis of ARBI has been made, further cognitive assessment should be completed to generate an early baseline cognitive ability which then can be continued with regular assessments in the community setting to monitor progression in an abstinent individual. The Addenbrooke's Cognitive Examination (ACE-III – See Appendix 4) is a more detailed and extensive cognitive screening tool that should be completed when the individual is abstinent, has received the extended treatment for ARBI and prior to discharge.

Note: this tool has not been fully validated for use on people with ARBI therefore may not capture the full range of cognitive deficits and Executive Dysfunction experienced by the individual.

2.3. Referral to Services

Royal Cornwall Hospital has a wide range of Specialist Services that can aid in diagnosis, management and safe discharge planning for individuals with ARBI that are admitted to hospital. A referral should be made to all these services, particularly once the patient has become medically fit for discharge to ensure correct treatment is given and to prevent extended delays in discharge.

- **Alcohol Liaison Team**: Management of Inpatient Alcohol detoxification, treatment of Wernicke's encephalopathy, extended treatment of ARBI, cognitive assessment, and support with diagnosis

- **Addaction Hospital** Outreach Team: Provide history of alcohol use and community treatment, regular supportive contact with patient, discharge planning and follow on support, provided patient is engaged with Addaction

- **Mental Health and Well-being Nurse**: Clinical Assessment of cognitive impairment, support with management of challenging behaviour and mental capacity

- **Adult Safeguarding** Team: maintain safe management of challenging behaviour on the ward, protect vulnerable patient from self-neglect or abuse and provide a second opinion of mental capacity

- **Hospital Advocate**: Advocate for the patient's needs and preferences with treatment, care and discharge and support for the patient following DOLs application

- **Psychiatric Liaison**: Diagnosis and management of any co-morbid or underlying psychiatric diagnosis and management of challenging behaviours

- **Occupational Therapy**: Assessment of needs of the patient and provision of supportive equipment and care on discharge

- **Onward Care**: Safe discharge planning, referral for a social worker, package of care or long term care placement

- **ARBI Rapid Response Group**: MDT approach to support management and safe discharge of patient, development and adaptation of ARBI pathway (referral via Alcohol Liaison Team)

2.4. Discharge

2.4.1. Once a diagnosis of ARBI has been made then the patient should be considered to be medically fit for discharge, unless there are other medical presentations that require treatment.

2.4.2. Emphasis should move to supporting a rapid and safe discharge from hospital to a setting that can promote ongoing rehabilitation and recovery from ARBI and ensure all their care needs are met. Due to the variations in presentation of ARBI, previous history of the patient, preferences of the patient and their family and services available, their discharge destination and the support provided needs to be individually tailored to suit each patient and provide the most suitable rehabilitation and care options. It is important to consider the risks to the patient, such as alcohol relapse, self-neglect, getting lost, isolation and vulnerability to abuse, and their risk to others, such as aggression or abuse. Here are some examples of the pathways that can be used for a person with a diagnosed ARBI:

- **Home**: For some patients with mild cognitive impairment, it may be appropriate to discharge them back to a familiar environment, supported by family members that can provide physical and mental care, and Addaction for support with alcohol abstinence. They may require temporary or long term support from a care package to meet their care needs. Risks: relapsing back to alcohol use, causing harm to themselves due to their cognitive impairment or self-neglect

- **Alcohol Rehab Unit**: Patients may be discharged to either Boswyns/Bosence Farm or Addaction Chy which can maintain alcohol abstinence, ensure good nutrition and provide the tools for improving cognition and returning to independence. They will need to be referred to the rehab unit and then assessed to determine if they are appropriate for this care setting. Risks: self-neglect as these facilities are unable to provide support for physical care needs and can often only provide short term (6 months) rehabilitation before the patient needs to move on to suitable housing or placement

- Specialist ARBI Unit: There are few specialist units within the UK that are adapted to take younger individual with ARBI and provide longer term rehabilitation but they are not local to Cornwall and can be costly to fund. Risks: isolation from family due to significant distance from Cornwall and potential limited engagement for people with milder cognitive deficits

- **Residential/Nursing Home**: Individuals with more significant cognitive impairment and/or higher care needs will need placement in a care home, either for short term until more suitable accommodation is available or long term to manage their mental and physical health needs. Care home placements can provide 24 hour care to maintain patient safety and provide good nutrition and alcohol abstinence. Risks: lack of specialised rehabilitation options and older residents can prevent improvement in cognition resulting in further functional losses and cause development of mental health problems through isolation and boredom

2.4.3. All patients diagnosed with ARBI should be referred for a Social Worker prior to discharge to ensure their care needs are being met, monitor changes in their cognition to ensure they are in the appropriate setting and support the smooth transition between care environment and home.

2.4.4. It may be beneficial for ward staff or patient's relatives/carers to complete the ARBI passport (see Appendix 5) as well as their baseline Addenbrooke's assessment. This can provide the discharge destination with a comprehensive baseline of their care needs, preferences and the specific difficulties the patient experiences due to their ARBI.

2.4.5. Optimal recovery from ARBI and the return to independent living can take 3-5 years and individuals can have long lasting cognitive effects which may impact of their quality of life and mental health. It is important to ensure early diagnosis of Alcohol-Related Brian Injury is made, effective treatment is provided to reverse and stabilise any cognitive impairments and that patients are discharged to appropriate environments that can ensure their safety and continued recovery long term.

3. Monitoring compliance and effectiveness

Information Category	Detail of process and methodology for monitoring compliance
Element to be monitored	Diagnosis of ARBI Referrals to Alcohol Liaison for ARBI Prescribing and administration of Pabrinex in the treatment of Wernicke's Encephalopathy
Lead	Alcohol Liaison Team
Tool	Diagnosis of ARBI Referrals to Alcohol Liaison for ARBI Prescribing and administration of Pabrinex in the treatment of Wernicke's Encephalopathy

Information Category	Detail of process and methodology for monitoring compliance
Frequency	No Specific Tool will be used by the Alcohol Liaison Team to Audit the outcome of this Guideline Outcome of this Guideline will be monitored through observation by the Alcohol Liaison Team and feedback from Clinical Staff at RCHT
Reporting arrangements	Reporting of this Guideline will be presented to the Hepatology Team yearly at the Hepatology Strategy Meeting
Acting on recommendations and Lead(s)	The Alcohol Liaison Team will undertake subsequent recommendations and action planning for any or all deficiencies and recommendations within reasonable timeframes This will be overseen by the Hepatology Team
Change in practice and lessons to be shared	Required system or practice changes will be identified and actioned within a three month time frame. A lead member of the Alcohol Liaison Team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders

4. Equality and Diversity

4.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the 'Equality, Inclusion & Human Rights Policy' or the Equality and Diversity website.

4.2. Equality Impact Assessment

The Initial Equality Impact Assessment Screening Form is at Appendix 2.

Appendix 1. Governance Information

Information Category	Detailed Information
Document Title:	Patients Diagnosed with Alcohol Related brain Injury Clinical Guideline V2.0
This document replaces (exact title of previous version):	Patients Diagnosed with Alcohol Related brain Injury Clinical Guideline V1.0
Date Issued/Approved:	March 2022
Date Valid From:	June 2022
Date Valid To:	June 2025
Directorate / Department responsible (author/owner):	Hannah Le Ruez, Alcohol Specialist Nurse
Contact details:	01872 252513
Brief summary of contents:	Guidance for the identification, management and onward referrals required for a patient with ARBI at RCHT
Suggested Keywords:	Alcohol, Wernicke's, Pabrinex, Korsakoff's, Brain Injury, Dementia
Target Audience:	RCHT: Yes CFT: No KCCG: No
Executive Director responsible for Policy:	Director of Nursing, Midwifery & AHPs
Approval route for consultation and ratification:	Hepatology Consultant & Nurse Consultant Team Addaction Specialist Substance Misuse Consultant
General Manager confirming approval processes:	Roz Davies
Name of Governance Lead confirming approval by specialty and care group management meetings:	Maria Lane
Links to key external standards:	None
Related Documents:	Alcohol Withdrawal Detection and Management and the Management of Wernicke's

Information Category	Detailed Information
	Encephalopathy Clinical Guideline V6.0 RCHT Mental Capacity Policy, RCHT Deprivation of Liberty Policy and Procedure RCHT Enhanced Care and Meaningful Activities Policy
Training Need Identified?	No
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet & Intranet
Document Library Folder/Sub Folder:	Clinical / Hepatology

Version Control Table

Date	Version Number	Summary of Changes	Changes Made by
26 January 2019	V1.0	Initial Version	Hannah Le Ruez
June 2022	V2.0	No changes made to the guideline	Hannah Le Ruez, Alcohol Specialist Nurse

Appendix 2. Equality Impact Assessment

Section 1: Equality Impact Assessment (EIA) Form

The EIA process allows the Trust to identify where a policy or service may have a negative impact on an individual or particular group of people.

For guidance please refer to the Equality Impact Assessment Policy (available from the document library) or contact the Equality, Diversity & Inclusion Team rcht.inclusion@nhs.net

Information Category	Detailed Information
Name of the strategy / policy / proposal / service function to be assessed:	Patients Diagnosed with Alcohol Related Brain Injury Clinical Guideline V2.0
Directorate and service area:	Clinical Services
Is this a new or existing Policy?	Existing
Name of individual completing EIA (Should be completed by an individual with a good understanding of the Service/Policy):	Hannah Le Ruez, Alcohol Specialist Nurse
Contact details:	01872 252513

Information Category	Detailed Information
1. Policy Aim - Who is the Policy aimed at? (The Policy is the Strategy, Policy, Proposal or Service Change to be assessed)	To provide guideline for clinical staff at RCHT in the assessment, treatment and onward referral of patients with alcohol-related brain injury
2. Policy Objectives	To ensure all clinical staff have an understanding and are able to appropriately and safely care for patients with ARBI and support safe and suitable discharge
3. Policy Intended Outcomes	To improve care and treatment of patients with ARBI and ensure safe and appropriate discharge is obtained with follow up as necessary
4. How will you measure each outcome?	AUDIT, ARBI Working Group, Staff Feedback
5. Who is intended to benefit from the policy?	Adults that attend RCHT with new or existing Alcohol Related Brain Injury

Information Category	Detailed Information
6a. Who did you consult with? (Please select Yes or No for each category)	• Workforce: Yes • Patients/ visitors: No • Local groups/ system partners: No • External organisations: No • Other: No
6b. Please list the individuals/groups who have been consulted about this policy.	**Please record specific names of individuals/ groups:** Addaction KCCG ARBI working group
6c. What was the outcome of the consultation?	Need to create and implement policy for consistent management across Trust
6d. Have you used any of the following to assist your assessment?	**National or local statistics, audits, activity reports, process maps, complaints, staff or patient surveys:** **No**

7. The Impact

Following consultation with key groups, has a negative impact been identified for any protected characteristic? Please note that a rationale is required for each one.

Where a negative impact is identified without rationale, the key groups will need to be consulted again.

Protected Characteristic	(Yes or No)	Rationale
Age	No	
Sex (male or female)	No	
Gender reassignment (Transgender, non-binary, gender fluid etc.)	No	
Race	No	
Disability (e.g. physical or cognitive impairment, mental health, long term conditions etc.)	No	
Religion or belief	No	

Protected Characteristic	(Yes or No)	Rationale
Marriage and civil partnership	No	
Pregnancy and maternity	No	
Sexual orientation (e.g. gay, straight, bisexual, lesbian etc.)	No	

A robust rationale must be in place for all protected characteristics. If a negative impact has been identified, please complete section 2. If no negative impact has been identified and if this is not a major service change, you can end the assessment here.

I am confident that section 2 of this EIA does not need completing as there are no highlighted risks of negative impact occurring because of this policy.

Name of person confirming result of initial impact assessment: Hannah Le-Ruez

If a negative impact has been identified above OR this is a major service change, you will need to complete section 2 of the EIA form available here:
Section 2. Full Equality Analysis