RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

ACTION
ALCOHOL CARE TEAM INNOVATION AND OPTIMISATION NETWORK

Alcohol Care Team Innovation & Optimisation Network (ACTION)

Standards used within the ACTION review cycle

The standards have been developed from two key publications: 'Alcohol Care Teams: Core Service Descriptor (NHS England & Improvement, Public Health England)' (NHSE&I, 2019) and 'Clinical Competencies for the Care of Hospitalized Patients with Alcohol Use Disorders (nih.gov)' (Phillips, Porter, Sinclair, 2020).

	Core Service descriptors
1	A multi-disciplinary ACT should be able to provide packages of care that include:
1a	Case identification/alcohol identification and brief advice (IBA)
1b	Comprehensive alcohol assessment
1c	Specialist nursing and medical care planning
1d	Management of medically-assisted alcohol withdrawal (MAW)
1e	Provision of psychosocial interventions
1f	Planning safe discharge, including referral to community services
1g	Provision of trust-wide education and training in relation to alcohol
	Key Operating Principles
2	Assess patients presenting to A&E with acute intoxication, in acute alcohol withdrawal or with alcohol-related complications
3	Undertake an initial assessment for risk that would require immediate admission in patients not ready to be fully assessed
4	Assess patients in acute withdrawal, stabilise their condition and manage MAW as appropriate to their needs.
5	Assess patients presenting with other alcohol-related complications and contribute to their care plan
6	There is a screening system in place to ensure that patients admitted for any condition are identified as possibly alcohol-dependent
7	Patients identified by screening as possibly alcohol dependent will be referred to the ACT to undertake a comprehensive alcohol assessment
8	Based on the assessment outcome, contribute an alcohol care plan, integrated with the care plan for any other presenting condition
9	Alcohol care plans will give consideration of:
9a	a medication regimen to support MAW (see NICE CG100)

9b	medication to support sustained abstinence or consumption reduction (see NICE CG115)
9c	Thiamine to reduce risk of alcohol related brain injury (see NICE CG100)
9d	need for screening for liver fibrosis (see NICE NG50)
9e	specialist mental health assessment
9f	psychosocial interventions to support engagement with community alcohol treatment (see NICE CG115 -1.3)
10	Alcohol-dependent patients are referred to specialist alcohol support in the community for continuation of alcohol treatment on discharge if appropriate
11	When patients are medically fit for discharge before their MAW is complete, the ACT will advise on the appropriateness of completion of MAW in the community on a case-by-case basis, based on a) a comprehensive assessment and b) the availability of services
	Establishing the ACT within the local alcohol harm reduction system
12	Each ACT should have an active a multi-agency steering group involved partners from across the local alcohol pathway
13	Each ACTs should know their local commissioning arrangements and have a working relationship with them
14	ACT staff should develop and operate within a well-coordinated joint working programme with services providing ongoing community support for dependent drinkers
15	ACT team leaders should work closely with community alcohol services to agree on discharge pathways, so that patients transfer seamlessly to specialist support to sustain abstinence
16	Community alcohol services should in-reach into the hospital to prepare patients for transfer
17	Joint governance and oversight with clear lines for escalation for any clinical/service issues should be in place
18	The ACT has clinical leadership by a senior clinician with dedicated time (0.2 WTE) for the team

19	Specialist alcohol care should be available for patients who need it in every inpatient ward and emergency department in the trust, 7 days per week, with robust pathways in place to support other departments outside business hours
20	At least one of the specialist clinicians is a senior alcohol specialist nurse (ASN), to support complex cases and manage the team
21	There is 0.8 WTE team admin per trust (additional support may be required where higher patient throughput requires additional clinical staff)
	Case Identification/alcohol identification and brief advice (IBA)
22	The team oversees the provision of training to deliver IBA in the hospital.
	Triage & comprehensive alcohol assessment
23	The team provides brief triage assessment to all patients referred which includes: • The pattern and severity of the alcohol use; • The need for urgent treatment including; assisted alcohol withdrawal; • Identifying any associated risks to self or others
24	The team listens to concerns about the patient that carers, families and other key people may express.
25	The team assesses and acts on risks and safeguarding concerns related to the patient or others identified in the assessment.
26	The team considers the impact of the patient's drinking on the parent–child relationship when in contact with parents with AUD. *Guidance: This is done in line with the requirements of the Children Act*

	Comprehensive assessment
27	The team provides a comprehensive assessment for all patients referred to the ACT who score more than 15 on the AUDIT (Saunders et al, 1993). This structured clinical interview, uses relevant and validated clinical tools, and covers the following: - Alcohol use consumption, level of dependence and problems; - Other substance use including over the counter and prescribed medication; - Alcohol-related physical health problems supported by the use of biochemical and other measures (e.g. fibroscan); - Screening for common mental health problems (see relevant NICE guidelines www.nice.org.uk); - Social circumstances and problems; - Cognitive function; - Risk assessment and areas of safeguarding; - Readiness and belief in ability to change.
28	The team utilises and advises on the appropriate validated tools for assessment and monitoring of patients with alcohol use disorder throughout their care.
	Goals and Care Planning
29	Following assessment, the team develops a collaborative plan of care which takes into account the patients' preferences, outcomes of any previous treatment and includes agreed goals for treatment.
30	Clinicians consider the capacity of the patient to make informed choices when agreeing goals and care planning.
31	When assessing the severity of alcohol dependence and determining need for assisted withdrawal, criteria is adjusted appropriately. *Guidance: This includes adjusting criteria for women, older patients, children and young patients, and patients with established liver disease who may have problems with the metabolism of alcohol.*
32	The service advocates for a lower threshold for admission to hospital for medically assisted alcohol withdrawal for certain vulnerable patients experiencing acute alcohol withdrawal. *Guidance: This could include those who are frail, have cognitive impairment or multiple comorbidities, vulnerably housed, have learning difficulties.*
33	The service advocates admission to hospital for medically assisted alcohol withdrawal for patients in, or at high risk of developing severe alcohol withdrawal, alcohol withdrawal seizures or delirium tremens.

	Specialist nursing and medical care planning
34	Treatment options are discussed with the patient and their families and carers to determine the appropriate treatment plan in line with clinical governance. *Guidance: This includes effects, side effects, potential interactions, lifestyle and risk factors.*
35	For patients experiencing alcohol withdrawal, the team monitors them care in a calm environment.
	Advisory roles and function
36	The team advises and supports non-specialists on the assessment, management, and recovery care planning for patients drinking at higher risk and dependent levels.
37	The team advises on risks/harms of sudden reduction and offers an appropriate forward referral to local services in patients who are not requiring admission.
38	The team supports the appropriate management of alcohol-related conditions for patients with the most severe and complex needs including specific populations. *Guidance: This could include frail elderly, young people, pregnant women, patients who require palliative care and/or have comorbid conditions*
39	The team recognises and can advise on the needs of patients at the end of life.
40	The team advises on the use of parenteral thiamine therapy to patients with suspected alcohol-related brain damage or those who are intoxicated who could be at risk of Wernicke's.
41	The team supports the assessment and referral to specialist treatment for alcohol-related liver disease and alcohol-related pancreatitis.
42	The team differentiates the symptoms and signs of alcohol withdrawal from withdrawal from other drugs including prescription and over the counter (OTC) medications.
43	The team can recognise and respond to over sedation and other complications associated with withdrawal medication.
44	The team explains the indications, contraindications and mechanisms of action of pharmacological agents used to treat alcohol withdrawal to those involved in the patients' care. *Guidance: This includes professionals, patients, families and carers.*

45	The team supports the appropriate and timely assessment and referral to specialist services for those with cognitive impairment, having excluded features of acute intoxication or withdrawal.
46	The team has knowledge in Mental Capacity Assessment for patients with alcohol dependence to support the multi-disciplinary team in making decisions about deprivation of liberty, enforcement of treatment and involvement of the Court of Protection in discharge planning.
47	The team understands the possible drug/alcohol and medication interactions when delivering or advising on provision of care.
48	The team ask patients for their feedback about their experiences of using the service, and this is used to inform the delivery and development of the service.
49	The team's policies, protocols and written information is coproduced with patients to ensure the appropriate use of language and terminology.
50	Patients are offered a range of evidence-based resources to support their care. *Guidance: This includes websites, digital and/or paper resources.*
51	The team completes a comprehensive clinical assessment before commencing treatment with any relapse prevention medication, and this is discussed with the patient. *Guidance: This includes baseline urea, creatinine and electrolytes, and liver function tests.*
52	The team ensures that patients, families and carers are fully informed about the risks and interactions of prescribed disulfiram, prior to discharge.
53	After successful withdrawal for patients with moderate/severe alcohol dependence, the team supports the prescribing of relapse prevention medication in combination with psychological intervention, monitoring and supervision in line with NICE guidelines (NICE, 2011).
	Management of medically assisted alcohol withdrawal (MAAW)
54	The team are able to identify, support and care for patients experiencing signs and symptoms of alcohol withdrawal. *Guidance: This includes anxiety, agitation, tremors and shakes, nausea and vomiting, diarrhoea, diaphoresis, clamminess, hypersensitivity to auditory and visual stimuli, Delirium Tremens & seizures.*
55	Patients with suspected alcohol withdrawal are assessed in a timely manner and are managed jointly with the primary requesting service.

56	The team includes families and carers (with patient consent) in the support and management of patients undergoing MAAW.
57	The team provides advice and information about MAAW to patients, families, carers and other professionals. *Guidance: This includes the risks associated with withdrawal for those with severe alcohol dependence, such as delirium tremens and seizures.*
58	The team identifies patients admitted to hospital who are at risk of acute alcohol withdrawal and facilitates immediate assessment of alcohol withdrawal, to implement MAAW as clinically indicated. *Guidance: Typically this would apply to patients drinking greater than 15 units of alcohol per day and/or scoring 20 or more on the AUDIT.*
59	The team identifies patients most likely to meet the criteria for inpatient care. This includes those experiencing one or more of the following: - drinks over 30 units of alcohol per day - scores 30 or more SADQ (Stockwell et al, 1983)(or equivalent) - has a history of epilepsy, withdrawal-related seizures or delirium tremens during previous withdrawal programmes - may need concurrent withdrawal from alcohol and benzodiazepines - experiences significant comorbidities, learning or cognitive impairment
60	The team recognises that patients requiring inpatient stay may require higher doses of alcohol withdrawal medication, longer periods of parenteral vitamins, increased monitoring of side effects and complications
61	The team provides and supports the use of the symptom-triggered treatment protocols where staff are competent in monitoring symptoms effectively.
62	The team provides and supports the use of fixed-dose treatment protocols which titrate the initial dose of medication to the severity of alcohol dependence and/or regular daily level of alcohol consumption. *Guidance: Acknowledgement is given that in severe alcohol dependence, higher doses will be required to adequately control withdrawal and is prescribed according to local Trust Policy or guidelines. Adequate supervision of high doses is monitored.*
63	The team uses, interprets and records breath alcohol measurement as part of the management of MAAW, where appropriate.
64	The team provides pharmacological advice regarding consideration of reduced benzodiazepine doses for patients as appropriate. *Guidance: This includes younger or older patients, those with liver and/or renal impairment, respiratory disease, head injury/trauma.*

65	The team supports and advises on the management of withdrawal from co-existing benzodiazepine and alcohol dependence.
66	The team provides pharmacotherapy to treat symptoms of acute alcohol withdrawal. *Guidance: This may include the prescribing of benzodiazepines, carbamazepine or clomethiazole and the formal measurement of withdrawal symptoms using validated tools.*
67	During MAAW, the team monitors the patients' blood pressure, pulse, respiratory rate, and withdrawal signs and symptoms.
68	The team supports the management of acute alcohol withdrawal to patients with decompensated alcohol related liver disease.
69	The team supports the assessment and management of patients with delirium tremens based on evidence-based Trust protocols. *Guidance: This includes the use of oral or parenteral benzodiazepines and haloperidol where indicated.*
70	The team reviews patients' MAAW regimen if delirium tremens develops during the treatment for acute alcohol withdrawal.
71	The team supports the assessment and management of alcohol withdrawal seizures.
72	The team provides and supports the assessment and management of patients at high risk of developing, or with alcohol-related brain damage, including Wernicke's encephalopathy. *Guidance: This includes offering advice on the prescribing of oral or parenteral thiamine according to the assessed level of risk.*
	Provision of psychosocial interventions
	Provision of Motivational Enhancement Therapy
73	The team offers psychosocial interventions to help patients address their alcohol use in the form of motivational interview principles or motivational-enhancement therapy with the aim of helping patients drink to low risk levels, reduce risk-taking behaviour as a result of drinking alcohol, or to consider abstinence.
74	The team provides patients with evidence-based information leaflets or digital resources and refers/signposts to local specialist services if the patient wishes to seek further help and mutual aid encouragement and support.

75	The team follows a trauma informed approach in assessment and treatment of all patients, and their families (where appropriate) to enhance acceptance and engagement with the team.
76	The team possess a sound knowledge of the theories and treatment of addiction
	Supporting families
77	Where appropriate, families and carers of people with AUD, are offered guided self-help. *Guidance: This will usually consist of a single session, with the provision of written materials.*
78	The team identifies information, resources and support groups that may help families and carers to manage their relationship with the patient more effectively
	Planning safe discharge, including referral to community services
79	The team facilitates the safe discharge of patients and transfer of care to the community, which includes clear communication between families and carers (with patient consent), including goals of care and discharge instructions.
80	Appropriate professionals e.g. social services, link workers, community elders are involved in discharge planning.
81	The team supports patients to access community specialist alcohol services for follow-up interventions, care coordination, supervision, monitoring and psychological interventions to promote abstinence and prevent relapse for those commencing acamprosate, naltrexone or disulfiram.
82	The team supports early discharge planning and consideration of referral to appropriate specialist services for all patients wishing to receive further help for AUD. *Guidance: This includes patients who show signs of alcohol related cognitive impairment, and those with an alcohol related co-morbidity (ARLD, ARBD, dual diagnosis or other related mental health problems).*
83	The team encourages families and carers to be involved in the treatment and care of patients with AUD to help support and maintain positive change.
84	On discharge, the team has clear communication with the GP which details of patient alcohol consumption and risk level (e.g. AUDIT-C score; Bush et al, 1998)

	Provision of trust-wide education and training in relation to alcohol
85	The team develops educational materials on alcohol use to support both prevention and recovery.
86	The team provides ongoing support, implementation and training of systematic screening and brief interventions for frontline employees.
87	The team provides a clear referral route for more complex cases.
88	The team liaises and supports frontline staff caring for inpatients and emergency departments attendees in the appropriate NICE-compliant management of patients with alcohol use disorders
89	The team provides training and support to appropriate NHS professionals in the assessment and monitoring of patients experiencing acute alcohol withdrawal.
	Clinical leadership by a senior clinician with dedicated time for the team
90	The team have dedicated time to facilitate strategic direction, governance structures, research and audit activity, and clinical supervision to the Alcohol Care Team
91	The team have the skills and knowledge to be able to develop, implement, monitor and evaluate effective treatment pathways both within the acute trust as well as across acute, mental health and community services
92	The team establish good working relationships with local specialist alcohol services to ensure effective ongoing management tailored to the patient's needs to ensure effective individualised patient care
93	The team have enough time and resources to carry out their roles and responsibilities effectively using evidence-based interventions
94	Within the team, there is specialist knowledge to advise on complex clinical presentations and scenarios involving alcohol use disorders, particularly where there is an absence of clinical guidance or evidence.
95	The team work strategically with local authority, public health, clinical commissioning groups, patient groups and other key stakeholders (including HEIs) to optimise training opportunities, commissioning arrangements, care pathways, prevention and treatment strategies, and develop the evidence base through research.

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