Alcohol-related health problems in general hospitals

The latest figures show that 27 per cent of men and 15 per cent of women are drinking more than the recommended limits of alcohol (Office for National Statistics, 2000). Weekly limits advise men to drink no more than 21 units and women no more than 14 units – and not to drink all these in one day. Of greater concern, perhaps, is that almost half of those drinking above these limits are consuming amounts known to be placing their health and personal well-being at risk (that is more than 50 units per week for men and 35 units for women). It has been suggested that one in 13 of Britain’s adult population is dependent upon alcohol (Alcohol Concern, 2001).

The impact on the health service

In many cases the physical consequences of excessive alcohol consumption lead to contact with the local general hospital, while the underlying cause (the patient’s alcohol consumption) may go undetected. Chronic conditions such as liver disease, pancreatitis, cardiac problems, neuropathy and high blood pressure are just a few of the alcohol-related problems that may lead to admission. In addition, simple intoxication (often referred to as hazardous or binge drinking) can lead to rash decisions that may lead to physical harm through accidents or violence. Statistics indicate that one in seven acute hospital admissions is a result of alcohol misuse (Canning et al, 1999) and that one in six A&E attendances is related to alcohol, rising to eight in 10 at peak times during weekend evenings.

Nurses have a role to play in estimating a patient’s alcohol use and, if appropriate, providing ‘brief intervention’ consisting of simple advice and information on sensible drinking.

Brief interventions

While alcohol-dependent patients require specialist services, most excessive but non-dependent drinkers have been shown to benefit greatly from simple advice and information on sensible drinking. This is known as a brief intervention (Heather and Kaner, 2001).

In this context, brief interventions can consist of as little as five minutes of advice and information, targeted at people who drink to excess but are not yet alcohol dependent. The aim is to make the patient aware that they are drinking to levels that may be harming their health and to advise them on sensible drinking limits.

This form of intervention is best given in a conversational manner and can be delivered opportunistically, as the need arises, or when carrying out other duties involving the patient. Typically the patient will be unaware of the risks associated with their drinking. Simple advice on sensible limits should be given in a non-judgemental way and reinforced with self-help and health promotion literature. It is a good idea to talk through the literature with the patient, if possible, to ensure they understand it. Health promotion departments and local specialist alcohol services should be able to advise on the most appropriate leaflets.

Research suggests that many nurses feel it is not within their role to question patients about alcohol or to give patients advice about drinking levels (Lockhart, 1997). The main reason often quoted is lack of time; many nurses feel it would take too much from an already pressured working day to implement any type of intervention for this patient group. However, it need not be a time-intensive task.

Identifying excessive drinkers

To deliver targeted brief interventions it is important that those at risk are identified. This need not be complex, and identifying the patient’s alcohol consumption during a general health assessment should be sufficient and, if appropriate, the brief intervention can be delivered during the assessment. This has many advantages. If the issue is raised at the same time as general health factors such as diet, exercise, sleep patterns, medication and smoking, it demonstrates that alcohol consumption is one of a number of lifestyle issues that affect health. This allows the nurse to legitimately ask questions that some may find sensitive. It also avoids a situation where the patient feels they are being singled out in some way – thereby prompting a defensive reaction.

When asking about alcohol consumption it is useful not to ask closed questions that result in yes and no answers such as, ‘Do you drink?’ Rather ask, ‘What kind of alcohol do you drink? How often do you drink alcohol? How much will you drink in an average day?’ or, ‘Are there some days when you drink more than others?’ Avoid accepting...
answers such as ‘I’m a social drinker’ or ‘A few now and then.’ Evasive answers need to be explored sensitively so that a reasonable approximation of a drinking pattern can be expressed in units per day and per week. It is well to remember that we are seeking to inform and advise: confrontation and argument should be avoided, as this will not achieve either aim.

Units of alcohol are generally well known in the approximate form they appear in health promotion literature. However, in the real world the drinks we consume vary dramatically in their unit content because of the wide variation in the ‘alcohol by volume’ (ABV) the drink contains. The formula (see Box 1) will give the exact figure.

**Box 1. Calculating alcohol units**

\[
\text{ABV} \times \text{volume} \frac{1000}{n \text{ units}}
\]

An example for a 500ml can of strong lager (9 per cent ABV) would be:

\[
9 \times \frac{500\text{ml}}{1000} = 4.5 \text{ units}
\]

Unit levels quickly mount up without the drinker’s awareness. Merely explaining this information has been shown to have an impact on an individual’s drinking. A study by Wilk et al (1997) found that heavy drinkers who received an opportunistic brief intervention were twice as likely to moderate their drinking six to 12 months later compared with those who had received no intervention. Brief intervention and screening allows the nurse to gather the necessary information regarding alcohol consumption and then to advise accordingly. The general hospital setting has great potential for delivering strong and effective health promotion at a time when patients may be most ready to listen.

**Alcohol-dependent patients**

Brief interventions are not suitable for patients who have already developed alcohol dependence. These patients require referral, or at least the offer of such, to specialist alcohol services. However, the symptoms of withdrawal must first be identified and managed effectively.

Most general hospitals admit significant numbers of patients with alcohol dependence who are often admitted for treatment of an illness that may not initially be identified as being alcohol-related. Problems can occur if these patients are not assessed correctly and go on to develop withdrawal symptoms. Untreated withdrawal symptoms can have serious health implications.

In most cases, withdrawal symptoms from alcohol pose little risk to the patient and, though unpleasant, are not life-threatening. These include tremor, sweats, anxiety and insomnia. However, a significant minority experience major problems that include convulsions, disorientation, confusion and hallucinations. Delirium tremens in its full-blown form can be a fatal condition and should be considered a medical emergency.

Although patients who experience the more severe withdrawal symptoms may represent a small percentage of the total alcohol-dependent population, they form a much greater percentage of those admitted to the general hospital. These patients often have other complications such as dehydration, malnutrition, injuries and post-ictal confusion as a result of convulsions; they may also have had a haematemesis or PR (per rectum) bleed with or without signs of some degree of liver disease. These patients are also most at risk from developing Wernicke’s/Korsakoff’s syndrome (brain damage linked to chronic thiamine deficiency resulting in short-term confusion or permanent damage to the short-term memory) and require medical ward care.

It is important that general hospitals ensure they have adequate protocols for assessment and treatment of alcohol withdrawal symptoms. In particular, the flexibility to allow nurses to titrate medication to treat observable withdrawal symptoms as they develop. In most cases a chlordiazepoxide reducing regime, over seven to 10 days, commencing at doses between 20mg and 40mg four times a day is sufficient. However, using chlordiazepoxide as required (PRN) can be invaluable particularly in the early stages when the situation can fluctuate. Nurses should work closely with medical staff, the prescribing doctor and the multidisciplinary team; good communication is essential.

If the medication regime proves inadequate, it is not always possible to get the responsible medical officer to change the regime quickly, particularly at night. The simple tactic of prescribing medication as and when it is needed, as long as nurses have the confidence to do this appropriately, can often manage the situation. The development of appropriate detoxification protocols needs to include consultation between medical, nursing and pharmacy staff. Specialist alcohol nurses and services, if available, can be called upon to advise on the development of these regimes and the appropriate PRN doses.

It is important that nurses in general hospitals recognise the impact of excessive alcohol consumption. Also, if they do not ask about a patient’s alcohol consumption, nurses can neither give the appropriate health advice on sensible drinking levels nor decide on the appropriate nursing care necessary for more serious problems. Efficient management of withdrawal symptoms favours a multidisciplinary approach and offers the best opportunity to manage the patient’s care.

The Royal Bolton Hospital has attempted to address this complex problem by recognising the crossover of issues between the general hospital, psychiatry and specialist community-based alcohol services. As an alcohol liaison nurse, my role has been to provide a link between these services. The aim is to provide training and information to wards and departments together with a focus on alcohol-related health issues within the hospital. Clinically the role provides an assessment, advice and a referral service for alcohol-dependent patients. This fosters a collaborative approach to care and encourages nurses to take a proactive view with the knowledge that back-