Created: April 2024

Reviewed: January 2026

Revised: January 2026

Alcohol Misuse Screening for Trauma Patients

Purpose:

To provide a guideline for identifying injured patients who will require alcohol screening upon inpatient or observation status admission. Alcohol Screening and Brief Intervention to Treatment (SBIRT) involves utilizing a validated set of questions to identify patients' drinking patterns that may place them and others at risk. A positive screening result would indicate that the patient is drinking more than the recommended amount and therefore would likely benefit from a brief intervention and potential referral that can help to motivate a reduction in at-risk drinking.

Scope:

The scope includes all patient observation and inpatient admissions meeting trauma inclusion criteria with the following exceptions.

Exclusions to patient screening:

A. Patient must be participatory. Therefore, any patient with an altered mental status or is chemically or cognitively impaired should be excluded from screening as these patients cannot be considered participatory. Unit staff or the Crisis Assessment Intervention Team (CAIT) performing screening should document the inability to participate.

B. Patients who are readmitted for complications from their initial injury.

C. Those patients that refuse the AUDIT-C screening and/or AUDIT questionnaire. This refusal should be documented.

D. Patients that have an observation or inpatient stay of < 24 hours

Guidelines:

A. Trauma patients experiencing injuries that are admitted to observation or inpatient services will be identified during the nursing initial admission assessment. Within the

admission assessment, a trauma specific question “Does the patient have an injury?” is addressed in the SBIRT section of nursing flowsheets.

1. A “YES” answer will trigger an AUDIT-C screening t be completed by nursing
2. A “NO” answer will require no further actions

B. All identified trauma patients who are 12 years of age or older that are admitted to observation or inpatient statuses should be assessed by nursing staff for alcohol use during the initial admission assessment utilizing the Alcohol Use Disorder Identification Test – Concise (AUDIT-C).

1. AUDIT-C scoring:
   a) A positive screening score for women of ≥ 3 or a positive score for men ≥ 4 will require the nurse to place an “Inpatient Consult to Care Team” order with reason as “SBIRT” for CAIT to provide further evaluation.
   b) A negative screening score will require no further action.
2. Once CAIT receives an order for an “Inpatient Consult to Care Team” for SBIRT, a crisis assessment therapist will then round on the patient and complete the full AUDIT tool. Based on the results of the full AUDIT, the crisis assessment therapist will complete additional interventions and referrals as needed and appropriate.

Equipment:

A. AUDIT-C Screening Tool

Alcohol Use Disorders Identification Test-Concise (AUDIT-C)

1. **How often do you have a drink containing alcohol?**
   - ☐ Never
   - ☐ Monthly or less
   - ☐ 2-4 times a month
   - ☐ 2-3 times a week
   - ☐ 4 or more times a week
2. **How many standard drinks containing alcohol do you have on a typical day?**
   - ☐ 1 or 2
   - ☐ 3 to 4
   - ☐ 5 to 6
   - ☐ 7 to 9
   - ☐ 10 or more
3. **How often do you have six or more drinks on one occasion?**
   - ☐ Daily or almost daily
   - ☐ Weekly
   - ☐ Monthly
   - ☐ Less than monthly
   - ☐ Never

B. AUDIT full Screening tool

Alcohol screening questionnaire (AUDIT)

Drinking alcohol can affect your health and some medications you may take. Please help us provide you with the best medical care by answering the questions below.

One drink equals:  12 oz. beer  5 oz. wine  1.5 oz. liquor (one shot)

1. How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times a month	2 - 3 times a week	4 or more times a week
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	0 - 2	3 or 4	5 or 6	7 - 9	10 or more
3. How often do you have five or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, in the last year
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, in the last year
	0	1	2	3	4

Have you ever been in treatment for an alcohol problem? ◯ Never ◯ Currently ◯ In the past

I	II	III	IV
0-3	4-9	10-13	14+

Scoring and interpreting the AUDIT:

1. Each response has a score ranging from 0 to 4. All response scores are added for a total score.

2. The total score correlates with a risk zone, which can be circled on the bottom left corner.

Score	Zone	Explanation	Action
0-3	I – Low Risk	"Someone using alcohol at this level is at low risk for health or social complications."	Positive Health Message – describe low risk drinking guidelines
4-9	II – Risky	"Someone using alcohol at this level may develop health problems or existing problems may worsen."	Brief intervention to reduce use
10-13	III – Harmful	"Someone using alcohol at this level has experienced negative effects from alcohol use."	Brief Intervention to reduce or abstain and specific follow-up appointment (Brief Treatment if available)
14+	IV – Severe	"Someone using alcohol at this level could benefit from more assessment and assistance."	Brief Intervention to accept referral to specialty treatment for a full assessment

Measures of Compliance:

A. AUDIT-C screening must be achieved and documented with at least an 80% screening rate for those patients meeting inclusion criteria

B. An AUDIT questionnaire must be completed and documented on at lest 80% of patients screening positive on the AUDIT-C

C. The results of the AUDIT-C and AUDIT documentation will be recorded in the Trauma Registry and will also include notation when the AUDIT-C or AUDIT was not performed or not recorded as done

D. Compliance with the measure will be included on the HIPPA compliant Trauma Score Card. The Scorecard data is shared with Quality Council and is also reviewed at the bimonthly, multi-disciplinary Trauma Outcomes Process Improvement meeting (TOPI).

References:

American College of Surgeons, Committee on Trauma, (2022). Resources for the optimal care of the injured patient: 2-22. Chicago, IL, American College of Surgeons, Standard 5.30 and 5.31.

American College of Surgeons, Alcohol Screening and Brief Interventions (SBI) for Trauma Patients, (n.d.)