

and our legislative priorities. In addition to those who came to Albany for the Lobby Day, we also had several hundred virtual contacts made with legislators through our Voter Voice platform. Thank you to all who participated in our 2026 Lobby Day!

Now that the session has concluded, the Legislative Committee will be reviewing the legislative agenda for 2027 – 2028 and preparing to present this to the membership for review and vote at the annual meeting in November. Be on the lookout for these materials in the Annual Meeting information.

As noted above, this is an election year in New York. The Primary Elections took place on Tuesday, June 23, and we now shift attention to the General Election on

Tuesday, November 3, when all 213 seats of the State Legislature, the statewide offices for Governor, Lieutenant Governor, Attorney General and Comptroller, and all 26 New York seats in the U.S. House of Representatives will be on the ballot. There were changes as a result of the Primary Elections, and we know that there will be further changes after the General Election. Further, since many legislators will not be returning to their current positions because of retirements or seeking other elected offices, there will be many new members in both houses for the next legislative session. In addition, many of those leaving are chairs of key committees or members of leadership, so we will see many new committee chairs next year.

While always important, given that this is an election year, we would like to remind you that ANA-NY has a Political Action Committee (PAC). The ANA-NY PAC is supporting candidates that support the profession and issues of importance to our members. The ANA-NY PAC would love to see as much member participation as possible, and we urge you to visit the ANA-NY PAC website and make a donation today.

If you have any questions about the legislative process or the priorities of ANA-NY, please contact a member of the Legislative Committee. As always, we welcome your questions, thoughts, ideas or comments on legislation. ■

Evidence You Can Use

Enhancing CIWA-Ar Scoring Consistency with an Educational Intervention for Nurses in Orthopedic Acute Care

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Background

Alcohol Use Disorder (AUD) is a medical condition that is classified as mild, moderate, or severe. According to the National Institute on Alcohol Abuse and Alcoholism (2025), AUD is defined as the reduced ability to stop alcohol consumption despite its negative consequences. According to Tanner and colleagues (2022), the lifetime prevalence of AUD in the United States is 29.1%, with half of cases classified as severe. The incidence and prevalence of AUD increased nationwide during COVID-19 and remains elevated post-pandemic (Ayyala-Somayajula et al., 2025).

AUD presents a significant challenge in healthcare, particularly in hospital settings where comorbidities and critical illness complicate diagnostic accuracy and clinical management.

Individuals with AUD are at risk for de-

veloping alcohol withdrawal symptoms (AWS), which can occur after the rapid reduction or cessation of alcohol consumption. AWS typically starts within 6–24 hours after a person's last drink (Pribek et al., 2021). If AWS are not identified in a timely manner and managed appropriately, this can negatively impact patient safety and clinical outcomes. Sullivan and colleagues (1989) developed the Clinical Institute Withdrawal Assessment for Alcohol (CIWA-Ar) to categorize AWS and their severity. Nurses commonly use the CIWA-Ar to assess and score patients' risk for experiencing AWS. The total score of the CIWA-Ar informs clinical protocols to safely support and care for the patient. The primary objectives in managing AWS are to alleviate and prevent serious complications, such as withdrawal seizures or delirium tremens (DT) (Pribek et al., 2021).

In orthopedics, AUD can negatively impact a patient's postoperative recovery trajectory in both elective and traumatic cases (Gold et al., 2020; Ng et al., 2021; Petr et al., 2025). In elective surgical cases, patients with AUD can be identified early and individualized plans of care can be developed to support patients in the preoperative, intraoperative and postoperative phases. However, if an individual finds themselves unexpectedly admitted for orthopedic surgery because of a traumatic event such as a fall or accident, or an elective surgical patient is not entirely forthcoming about the extent of their alcohol use, the nurse's admission and ongoing assessments are critical to identifying patients who may experience AWS.

AWS are assessed at discrete points in time using CIWA-Ar, which relies in part by patient-self report and nurse judgement.

This point-in-time assessment approach may introduce subjectivity and contribute to variability in CIWA-Ar scores. This prompted the Nursing Professional Development Specialists (NPDS) and Quality Nurse Specialists (QNS) to evaluate current nursing practice related to AWS assessment using the CIWA-Ar instrument.

The objective of this quality improvement (QI) project was to develop an educational intervention to support reliability and precision of CIWA-Ar scoring within the acute care setting of an orthopedic specialty hospital.

Methods

A Plan-Do-Study-Act (PDSA) process model guided the team's iterative improvement cycles, and the SQUIRE 2.0 (Ogrinc et al., 2016) guidelines structured the overall QI project design and its reporting.

The Planning Phase

An NPDS-led interprofessional team including nurse leaders (acute care unit managers, senior quality leader), a data analyst, and a nurse researcher, convened regularly to develop the education plan and intervention for the nurses. The team's stated goal was to reach at least 90% of the 55 nurses on staff (e.g., 35 RNs and 20 NPs). The collaborative nursing care model informed the project, emphasizing principles of effective communication and fostering high-quality relationships among team members (Wei et al., 2022). To enhance the consistency of scoring practices, RNs and NPs were paired together (the RN:NP dyad) and participated in a facilitated education session. This session focused on developing a shared understanding of the scoring process and reinforcing collaboration between team members to ensure alignment and mutual understanding. To evaluate nurses' application of CIWA-Ar, a scoring exercise with three case study scenarios. The program included an NPDS-facilitated in-person simulation session in which the nurse dyads would be presented with three

NPDS-created patient scenarios. These scenarios illustrated mild, moderate, and severe withdrawal levels, and were structured around the policy and practice of the organization. The dyads would then score each "patient" using the CIWA-Ar instrument. Their scores would be compared and discussed after each scenario, and the NPDS would provide feedback and additional education and clarification, if necessary. Prior to the simulation sessions, RN and NP preparation included a review of nursing policies on alcohol and substance use and withdrawal screening, assessment, and management, which included the 10-question CIWA-Ar; nursing interventions based on CIWA-Ar scoring ranges; and clinical escalation tip sheets. Additionally, NPs completed the organization systemwide 7-minute CIWA-Ar Assessment instructional video via the Learning Management System (LMS). Finally, scheduling workflows were coordinated to ensure RN and NPs availability and attendance at designated times and locations. Sessions were held in conference rooms on clinical units, so staff didn't have to travel too far to attend sessions.

The Education Intervention Implementation Phase

The educational sessions were held over a period of six weeks and were conducted at various times to ensure that nurses and NPs working all shifts could participate. Flexibility with NPDS' schedules was necessary to accommodate all the sessions. Case study scenarios were presented in a blind format to the dyads, following a consistent sequence (mild, severe, then moderate) across all sessions and were facilitated by the same three NPDS. Participants received a blank laminated reusable CIWA-Ar. The NPDS read each case study aloud, and participants independently documented on the scoring sheet for each item based on scenario details. After each scenario, RN and NP scores were displayed on a screen for group comparison, followed by a facilitated discussion offering an immediate feedback

loop to enhance scoring accuracy and consistency. Special emphasis was placed on interpreting subtle symptom differences, such as distinguishing mild nausea/vomiting scores of 1, 2, or 3. The NPDS facilitated a discussion after each scenario where the individual questions and how to break them down for accuracy and consistency were reviewed. Each session was documented on a master excel file with tabs labelled for every session conducted for data collection. The NPDS recorded clinical roles (e.g., RN, NP), individual item scores, and total CIWA-Ar scores for each scenario. Staff attendance was maintained on a separate sheet.

Results

Twenty-three 45-minute in-person sessions were scheduled for various times and shifts over a six-week period in May and June 2025. Fifty-five nurses (RNs and NPs) participated. While a 1:1 RN to NP dyad was originally scheduled, the actual RN-NP ratios for the education session varied (e.g., 1 RN and 1 NP; 2 RNs and 2 NPs; 2 RNs and 1 NP; and 3 RNs and 1 NP) and were dependent on the changing clinical priorities or unit needs. There were three instances in which nurses participated twice to preserve the dyadic structure (e.g., one night shift NP, one day shift RN, and one day shift NP)

The reference scores for the scenarios were 7 (mild), 9 (moderate), and 36 (severe), and the scenarios were always presented to learners as mild, severe, and moderate schema. The individual scores of specific CIWA-Ar elements and resultant total scores varied widely in some cases, the overall symptom classification was generally correct. For example, all participants accurately identified the severe scenario (23/23 sessions). The moderate scenario was classified correctly most of the time (22/23 sessions). In one session there was a discrepancy in the scoring and classification, with one individual underscoring the scenario (e.g., mild). Finally, the mild scenario was the most challenging. There was only one session in

which the dyad (1/23) accurately scored and identified the scenario as mild. In the remaining 22 sessions, there were 12 sessions in which all participants overscored the scenario to be moderate, and in the remaining 10 there was a discrepancy between participants, with scores ranging from mild to moderate classifications.

The decision to debrief after each scenario before moving on to the next may have preemptively mitigated any misinterpretation or ambiguity related to the CIWA-Ar instrument. The variability in the accuracy and precision in the mild scenario scoring was not replicated in the remaining scenarios when the nurses and NPs were accurate in their identification and categorization of moderate (54/55 nurses) and severe (55/55 nurses) scenarios.

Strategic planning and close coordination with nursing unit leaders and managers was key, as all nurses participated (100% completion rate), exceeding the team's initial goal of 90%.

Discussion

This QI initiative was designed to improve accuracy in CIWA-Ar scoring, and it positively impacted on scoring consistency. Having NPDS-facilitated discussion after each scenario was beneficial and yielded aligned scoring by the nurses. Nurses recognized the initiative as a valuable refresher on CIWA-Ar scoring and the delineation of roles and responsibilities for both providers and nurses. Incidentally, the exercise generated many thoughtful and collaborative discussions between the RNs and the NPs that went beyond CIWA-Ar scoring, and included conversations about nurse autonomy, RN empowerment, and provider expectations. Since this initiative, CIWA-Ar assessments have been performed with no scoring inconsistencies reported or observed.

There were limitations identified during the project. One of the primary challenges was the subjective interpretation of certain CIWA-Ar assessment components. For example, nausea/

vomiting, tremors, and anxiety have a limited description within the tool. This is why dedicated time was allocated for an in-depth discussion on scoring immediately after the each scenario. Logistics, including the scheduling sessions and adhering to that schedule, occasionally presented challenges. There were instances when scheduled RN or NPs were unable to attend due to patient needs or acuity. These unavoidable clinical realities resulted in delayed session starts, or required rescheduling, and in a few cases nurses completed the sessions twice to meet the 1:1 RN:NP minimum.

Conclusions

This project calibrated participants' scoring approaches and fostered a shared understanding of CIWA-Ar application. Through dyad discussions and feedback, nurses and NPs aligned their approach to applying the CIWA-Ar tool, which improved accuracy and consistent scoring. These sessions strengthened interdisciplinary communication and clarified expectations between RNs and NPs, contributing to a more collaborative clinical environment. The project demonstrated the value of employing exercises to improve the accuracy and precision of CIWA-Ar scoring. These improvements translated to increased professional collaboration among RNs and NPs, which not only enhanced team dynamics but also ensured safer and more effective patient care. To sustain and build on these outcomes, it is recommended that the project be repeated annually across all units, reinforcing accurate scoring practices and strengthening clinician competency. Such initiatives foster a culture of empowerment through evidence-based knowledge, refined clinical judgment, and reflective practices, ultimately improving patient outcomes, and promoting professional growth.

Implications for Practice

This initiative highlighted the need for ongoing education tailored to specific

clinical settings. For orthopedic nurses, consistent CIWA-Ar scoring ensures early interventions for vulnerable patients, preventing postoperative complications. Clinically, management of AUD and AWS raises several critical questions; for example, "How can clinical teams, including NPs and nurses, be further equipped to identify and manage withdrawal symptoms effectively while navigating the variability and comorbid presentations common in this population?". The introduction of CIWA-Ar protocols, including potential expansion of administration responsibilities to NPs, offers healthcare systems an opportunity to reevaluate care delivery, and improve situational awareness surrounding AUD management. This project reinforces the need for interdisciplinary collaboration to better equip frontline nurses in navigating the challenges of AUD diagnosis and treatment in increasingly complex clinical scenarios in orthopedic patients.

Take Home Message

This focused, interactive educational intervention with RNs and NPs increased their knowledge of AUD, CIWA-Ar instrument comprehension, and improved consistency with CIWA-Ar scoring. Taking this dyadic approach was an opportunity to engage in shared learning and the exchange of intraprofessional perspectives. ■

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For references online:
myamericannurse.com/?p=427146