This patient group direction (PGD) must only be used by registered health professionals who have been named and authorised by their organisation to practice under it. The most recent and in date final signed version of the PGD should be used.

Patient Group Direction (PGD)

For the administration

Diazepam 5mg tablets

By registered health care professionals for

Initial treatment for new patients with Benzodiazepine dependency, and for those who are caught attempting to divert their prescribed Diazepam

For Police Custody, Prison and Mental Health Services only

PGD NUMBER 118

1. Change history

Version number	Change details	Date
1	Original PGD Ratified	June 2021

2. Medicines practice guideline 2: *Patient group directions*

Refer to the relevant sections of NICE medicines practice guideline 2: *Patient group directions* as stated in the blank template notes. For further information about PGD signatories, see the NHS and Manx Care PGD website FAQs.

3. PGD development

Refer to the NICE PGD competency framework for people developing PGDs

Job Title & organisation	Name	Signature	Date
Author of the PGD			
Member of the PGD working group			

4. PGD authorisation

Refer to the NICE PGD competency framework for people authorising PGDs

Job Title	Name	Signature	Date
Medical Director			
Chief Pharmacist/ Pharmaceutical Adviser			
Senior Paramedic			
Director of Nursing			
GP Adviser			
Senior Microbiologist (if PGD contains antimicrobials)			

5. PGD adoption by the provider

Refer to the NICE PGD competency framework for people authorising PGDs

Job title and organisation	Signature	Date	Applicable or not applicable to area

6. Training and competency of registered healthcare professionals, employed or contracted by the Manx Care, GP practice or Hospice

Refer to the NICE PGD competency framework for health professionals using PGDs

	Requirements of registered Healthcare professionals working under the PGD
Qualifications and professional registration	• Registered healthcare professionals, working within or contracted by the Manx Care, GP practice or Hospice who are permitted staff groups outlined within the current PGD policy • Pharmacists must be practising in Manx Care authorised premises i.e. contracted pharmacy premises • In house competency assessment for the treatment of drug withdrawal • **For Police Custody, Prison and Mental Health Services only**
Initial training	• Knowledge of current guidelines and the administration of the drug specified in this PGD/BNF and of the inclusion and exclusion criteria • Training which enables the practitioner to make a clinical assessment to establish the need for the medication covered by this PGD • Local training in the use of PGDs
Competency assessment	Staff will be assessed on their knowledge of drugs and clinical assessment as part the competency framework for registered health professionals using PGDs
Ongoing training and competency	The registered health care professionals should make sure they are aware of any changes to the recommendations for this medication; it is the responsibility of the registered health care professionals to keep up to date with continuing professional development. PGD updates will be held every two years

7. Clinical Conditions

Clinical condition or situation to which this PGD applies	Initial treatment for new patients who are either prescribed diazepam or have a positive urine sample for benzodiazepines. For those patients who are caught attempting to divert Diazepam
Inclusion criteria	• All adult patients who are prescribed Diazepam or taking illicitly • Patients who are a new reception who are prescribed diazepam previously • Patients who are a new reception who have a positive urine sample and show signs of withdrawal using the withdrawal scale in appendix 1 of the Isle of Man Prison Management of Diazepam Reduction Regime Policy
Exclusion criteria	• If patients are already being treated for alcohol withdrawal with Diazepam • Patients under the age of 18 years • Absence of valid consent • Patients with a known allergy to benzodiazepines • Individuals with severe renal impairment • Respiratory depression • Myasthenia Gravis or other muscle weakness • Liver failure or severe liver disease • Pregnancy • If the patient in intoxicated
Cautions (including any relevant action to be taken)	Liver disease (avoid if severe)
Arrangements for referral for medical advice	Patient should be referred to a more experienced clinical practitioner for further assessment
Action to be taken if patient excluded	Patient should be referred to a more experienced clinical practitioner for further assessment
Action to be taken if patient declines treatment	• A verbal explanation should be given to the patient on: the need for the medication and any possible effects or potential risks which may occur as a result of refusing treatment • This information must be documented in the patients' health records • Any patient who declines care must have demonstrated capacity to do so • Where appropriate care should be escalated

8. Details of the medicine

Name, form and strength of medicine	Diazepam 5mg tablets
Legal category	Prescription Only Medication (POM)
Indicate any <u>off-label use</u> (if relevant)	None
Route/method of administration	Oral
Dose and frequency	20mg twice daily
Quantity to be administered	20mg (4 x 5mg tablets) twice daily
Maximum or minimum treatment period	Five days
Storage	Do not store above 25°C
Adverse effects	• Amnesia • Changes in libido • Drowsiness, confusion and ataxia • Dependence, paradoxical increase in aggression • Dizziness • Dysarthria • GI disturbances • Gynaecomastia • Hypotension • Headache • Incontinence • Muscle weakness • Slurred speech • Salivation changes • Tremor • Urinary retention • Vertigo • Visual disturbances
Records to be kept	The administration of any medication given under a PGD must be recorded within the patient's medical records

9. Patient information

Verbal/Written information to be given to patient or carer	• Verbal information must be given to patients and or carers for all medication being administered under a PGD • Where medication is being supplied under a PGD, written patient information leaflet must also be supplied • A patient information leaflet is available on request
Follow-up advice to be given to patient or carer	If symptoms do not improve or worsen or you become unwell, seek medical advice immediately

10. Appendix A

References
1. British National Formulary (BNF) available online: https://bnf.nice.org.uk 2. Nursing and Midwifery (2018) "The code" available online: https://www.nmc.org.uk 3. Current Health Care Professions Council standards of practice 4. General Pharmaceutical Council standards 5. The General Optical Council 6. Electronic medicines compendium available online: https://www.medicines.org.uk 7. Isle of Man Prison Management of Diazepam Reduction Regime Policy 8. Clinical Opiate Withdrawal Scale (COWS): https://www.cntw.nhs.uk/content/uploads/2015/09/PPT-PGN-18-App1-Clinical-Opiate-Withdrawal-Scale-V03-Iss1-Mar16.pdf 9. The Orange Book section: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/673978/clinical_guidelines_2017.pdf 10. The Blue Book (pages 61/62/63): https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/college-reports/college-report-cr227.pdf

11. Appendix B

Health professionals agreed to practice
• Each registered healthcare professional will hold their own Competency framework which will be signed and agreed by their mentor • A mentor is defined within the Manx Care policy as any ward/area managers, sisters, senior nurses, GPs, pharmacists or senior paramedics who has completed the PGD training themselves

12. Appendix C

Clinical Opiate Withdrawal Scale (COWS)

For each item, circle the number that best describes the patient's signs or symptom. Rate on just the apparent relationship to opiate withdrawal. For example, if heart rate is increased because the patient was jogging just prior to assessment, the increase pulse rate would not add to the score.

Patient's Name: _____ Date and Time ____/____ /_____:_____

Reason for this assessment:_____

Resting Pulse Rate:_____beats/minute

Measured after patient is sitting or lying for one minute

0 pulse rate 80 or below
1 pulse rate 81-100
2 pulse rate 101-120
4 pulse rate greater than 120

GI Upset: *over last ½ hour*

0 no GI symptoms
1 stomach cramps
2 nausea or loose stool
3 vomiting or diarrhea
5 Multiple episodes of diarrhea or vomiting

Sweating: *over past ½ hour not accounted for by room temperature or patient activity.*

0 no report of chills or flushing
1 subjective report of chills or flushing
2 flushed or observable moistness on face
3 beads of sweat on brow or face
4 sweat streaming off face

Tremor *observation of outstretched hands*

0 No tremor
1 tremor can be felt, but not observed
2 slight tremor observable
4 gross tremor or muscle twitching

Restlessness *Observation during assessment*

0 able to sit still
1 reports difficulty sitting still, but is able to do so
3 frequent shifting or extraneous movements of legs/arms
5 Unable to sit still for more than a few seconds

Yawning *Observation during assessment*

0 no yawning
1 yawning once or twice during assessment
2 yawning three or more times during assessment
4 yawning several times/minute

Pupil size

0 pupils pinned or normal size for room light
1 pupils possibly larger than normal for room light
2 pupils moderately dilated
5 pupils so dilated that only the rim of the iris is visible

Anxiety or Irritability

0 none
1 patient reports increasing irritability or anxiousness
2 patient obviously irritable anxious
4 patient so irritable or anxious that participation in the assessment is difficult

Bone or Joint aches *If patient was having pain previously, only the additional component attributed to opiates withdrawal is scored*

0 not present
1 mild diffuse discomfort
2 patient reports severe diffuse aching of joints/ muscles
4 patient is rubbing joints or muscles and is unable to sit still because of discomfort

Gooseflesh skin

0 skin is smooth
3 piloerrection of skin can be felt or hairs standing up on arms
5 prominent piloerrection

Runny nose or tearing *Not accounted for by cold symptoms or allergies*

0 not present
1 nasal stuffiness or unusually moist eyes
2 nose running or tearing
4 nose constantly running or tears streaming down cheeks

Total Score _____

The total score is the sum of all 11 items

Initials of person completing Assessment: _____

Score: 5-12 = mild; 13-24 = moderate; 25-36 = moderately severe; more than 36 = severe withdrawal
Source: Wesson and Ling 2003[324]

13. Appendix D

Alcohol Withdrawal Assessment Scoring Guidelines (CIWA - Ar)

Nausea/Vomiting - Rate on scale 0 - 7

0 - None
1 - Mild nausea with no vomiting
2
3
4 - Intermittent nausea
5
6
7 - Constant nausea and frequent dry heaves and vomiting

Tremors - have patient extend arms & spread fingers. Rate on scale 0 - 7.
0 - No tremor
1 - Not visible, but can be felt fingertip to fingertip
2
3
4 - Moderate, with patient's arms extended
5
6
7 - severe, even w/ arms not extended

Anxiety - Rate on scale 0 - 7
0 - no anxiety, patient at ease
1 - mildly anxious
2
3
4 - moderately anxious or guarded, so anxiety is inferred
5
6
7 - equivalent to acute panic states seen in severe delirium or acute schizophrenic reactions.

Agitation - Rate on scale 0 - 7
0 - normal activity
1 - somewhat normal activity
2
3
4 - moderately fidgety and restless
5
6
7 - paces back and forth, or constantly thrashes about

Paroxysmal Sweats - Rate on Scale 0 - 7.
0 - no sweats
1- barely perceptible sweating, palms moist
2
3
4 - beads of sweat obvious on forehead
5
6
7 - drenching sweats

Orientation and clouding of sensorium - Ask, "What day is this? Where are you? Who am I?" Rate scale 0 - 4
0 - Oriented
1 – cannot do serial additions or is uncertain about date

2 - disoriented to date by no more than 2 calendar days

3 - disoriented to date by more than 2 calendar days
4 - Disoriented to place and / or person

Tactile disturbances - Ask, "Have you experienced any itching, pins & needles sensation, burning or numbness, or a feeling of bugs crawling on or under your skin?"
0 - none
1 - very mild itching, pins & needles, burning, or numbness
2 - mild itching, pins & needles, burning, or numbness
3 - moderate itching, pins & needles, burning, or numbness
4 - moderate hallucinations
5 - severe hallucinations
6 - extremely severe hallucinations
7 - continuous hallucinations

Auditory Disturbances - Ask, "Are you more aware of sounds around you? Are they harsh? Do they startle you? Do you hear anything that disturbs you or that you know isn't there?"
0 - not present
1 - Very mild harshness or ability to startle
2 - mild harshness or ability to startle
3 - moderate harshness or ability to startle
4 - moderate hallucinations
5 - severe hallucinations
6 - extremely severe hallucinations
7 - continuous hallucinations

Visual disturbances - Ask, "Does the light appear to be too bright? Is its color different than normal? Does it hurt your eyes? Are you seeing anything that disturbs you or that you know isn't there?"
0 - not present
1 - very mild sensitivity
2 - mild sensitivity
3 - moderate sensitivity
4 - moderate hallucinations
5 - severe hallucinations
6 - extremely severe hallucinations
7 - continuous hallucinations

Headache - Ask, "Does your head feel different than usual? Does it feel like there is a band around your head?" Do not rate dizziness or lightheadedness.

0 - not present
1 - very mild
2 - mild
3 - moderate
4 - moderately severe
5 - severe
6 - very severe
7 - extremely severe

Procedure:

1. Assess and rate each of the 10 criteria of the CIWA scale. Each criterion is rated on a scale from 0 to 7, except for "Orientation and clouding of sensorium" which is rated on scale 0 to 4. Add up the scores for all ten criteria. This is the total CIWA-Ar score for the patient at that time. Prophylactic medication should be started for any patient with a total CIWA-Ar score of 8 or greater (ie. start on withdrawal medication). If started on scheduled medication, additional PRN medication should be given for a total CIWA-Ar score of 15 or greater.
2. Document vitals and CIWA-Ar assessment on the Withdrawal Assessment Sheet. Document administration of PRN medications on the assessment sheet as well.
3. The CIWA-Ar scale is the most sensitive tool for assessment of the patient experiencing alcohol withdrawal. Nursing assessment is vitally important. Early intervention for CIWA-Ar score of 8 or greater provides the best means to prevent the progression of withdrawal.

Assessment Protocol a. Vitals, Assessment Now. b. If initial score ≥ 8 repeat q1h x 8 hrs, then if stable q2h x 8 hrs, then if stable q4h. c. If initial score < 8, assess q4h x 72 hrs. If score < 8 for 72 hrs, d/c assessment. If score ≥ 8 at any time, go to (b) above. d. If indicated, (see indications below) administer prn medications as ordered and record on MAR and below.	**Date**											
	Time											
	Pulse											
	RR											
	O_2 sat											
	BP											
Assess and rate each of the following (CIWA-Ar Scale):	**Refer to reverse for detailed instructions in use of the CIWA-Ar scale.**											
Nausea/vomiting (0 - 7) 0 - none; 1 - mild nausea ,no vomiting; 4 - intermittent nausea; 7 - constant nausea , frequent dry heaves & vomiting.												
Tremors (0 - 7) 0 - no tremor; 1 - not visible but can be felt; 4 - moderate w/ arms extended; 7 - severe, even w/ arms not extended.												
Anxiety (0 - 7) 0 - none, at ease; 1 - mildly anxious; 4 - moderately anxious or guarded; 7 - equivalent to acute panic state												
Agitation (0 - 7) 0 - normal activity; 1 - somewhat normal activity; 4 - moderately fidgety/restless; 7 - paces or constantly thrashes about												
Paroxysmal Sweats (0 - 7) 0 - no sweats; 1 - barely perceptible sweating, palms moist; 4 - beads of sweat obvious on forehead; 7 - drenching sweat												
Orientation (0 - 4) 0 - oriented; 1 - uncertain about date; 2 - disoriented to date by no more than 2 days; 3 - disoriented to date by > 2 days; 4 - disoriented to place and / or person												
Tactile Disturbances (0 - 7) 0 - none; 1 - very mild itch, P&N, ,numbness; 2-mild itch, P&N, burning, numbness; 3 - moderate itch, P&N, burning ,numbness; 4 - moderate hallucinations; 5 - severe hallucinations; 6 – extremely severe hallucinations; 7 - continuous hallucinations												
Auditory Disturbances (0 - 7) 0 - not present; 1 - very mild harshness/ ability to startle; 2 - mild harshness, ability to startle; 3 - moderate harshness, ability to startle; 4 - moderate hallucinations; 5 severe hallucinations; 6 - extremely severe hallucinations; 7 - continuous hallucinations												
Visual Disturbances (0 - 7) 0 - not present; 1 - very mild sensitivity; 2 - mild sensitivity; 3 - moderate sensitivity; 4 - moderate hallucinations; 5 - severe hallucinations; 6 - extremely severe hallucinations; 7 - continuous hallucinations												
Headache (0 - 7) 0 - not present; 1 - very mild; 2 - mild; 3 - moderate; 4 - moderately severe; 5 - severe; 6 - very severe; 7 - extremely severe												
Total CIWA-Ar score:												
PRN Med: (circle one) Diazepam Lorazepam	**Dose given (mg):**											
	Route:											
Time of PRN medication administration:												
Assessment of response (CIWA-Ar score 30-60 minutes after medication administered)												
RN Initials												

Scale for Scoring:
Total Score =
0 – 9: absent or minimal withdrawal
10 – 19: mild to moderate withdrawal
more than 20: severe withdrawal

Indications for PRN medication:
a. Total CIWA-AR score 8 or higher if ordered PRN only (Symptom-triggered method).
b. Total CIWA-Ar score 15 or higher if on Scheduled medication. (Scheduled + prn method)
Consider transfer to ICU for any of the following: Total score above 35, q1h assess. x more than 8hrs required, more than 4 mg/hr lorazepam x 3hr **or** 20 mg/hr diazepam x 3hr required, or resp. distress.

Patient Identification (Addressograph)

Signature/ Title	Initials	Signature / Title	Initials

Alcohol Withdrawal Assessment Flowsheet (revised Nov 2003)