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Staff Education to Enhance Nonmedical Staff Competency in Withdrawal Management

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Walden University

College of Nursing

This is to certify that the doctoral study by

Katherine Sandoval Hedrick

has been found to be complete and satisfactory in all respects, and that any and all revisions required by the review committee have been made.

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Walden University
2025

Executive Summary: Staff Education Project
Staff Education to Enhance Nonmedical Staff Competency in Withdrawal Management
by
Katherine Sandoval Hedrick

Executive Summary Submitted in Partial Fulfillment
of the Requirements for the Degree of
Doctor of Nursing Practice

Walden University

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Summary

This Doctor of Nursing Practice (DNP) project addressed a significant gap in staff training at a behavioral health residential treatment facility. Nonmedical staff, including substance abuse counselors, lacked formal education in recognizing, assessing, and escalating symptoms of substance withdrawal. This lack of competency posed a risk to patient safety, regulatory compliance, and quality of care.

The goal of the project was to evaluate the impact of a structured, simulation-based training program on nonmedical staff's knowledge and confidence in using validated withdrawal assessment tools and monitoring vital signs. Six nonmedical staff participated in the training, which incorporated lecture, hands-on simulation, and case-based role-playing. The project was guided by adult learning theory and the ADDIE instructional design framework.

Findings demonstrated substantial improvements: Correct identification of assessment tools rose from 17% pretraining to 100% posttraining, and confidence levels increased by between 2.0 and 2.7 points across all measured domains.

This initiative supports nursing practice by enhancing interprofessional collaboration, expanding the competency of support staff, and strengthening withdrawal safety protocols. The project promotes positive social change by improving equity in care delivery, especially for vulnerable populations, and aligning practice with state-mandated standards.

Background

Withdrawal from substances, such as alcohol, opioids, benzodiazepines, and stimulants, presents critical clinical risks if not promptly and accurately monitored. The project site behavioral health substance abuse services residential treatment program facility operates at the nexus of mental health and substance use disorder treatment in the West Coast, with a client population that often experiences withdrawal from substances, such as alcohol, opioids, benzodiazepines, and stimulants. As emphasized by Gupta et al. (2024) and Newman et al. (2024), failure to recognize and escalate withdrawal symptoms can result in severe medical complications, including seizures, delirium, and even death.

At the project site, the existing clinical framework within the facility lacked a structured, evidence-based educational program for nonmedical staff. The nonmedical staff, such as substance abuse counselors, who are on the front lines of patient care and whose role in patient observation during withdrawal episodes is critical, lack formal training in vital signs monitoring and the use of standardized withdrawal assessment tools. These individuals, while deeply involved in day-to-day patient interactions, reported low confidence and inconsistent competencies in monitoring vital signs and applying tools, such as CIWA-Ar, CIWA-B, COWS, and ACSA. According to internal observations and informal performance audits, this gap in practice compromises patient safety and undermines adherence to state training mandates. The facility's reliance on informal training practices created considerable variability in practice, reduced staff confidence, and left a gap in compliance with state-mandated withdrawal training protocols.

I conducted this DNP project aimed at implementing and evaluating a structured 1-hour training program designed to enhance nonmedical staff competency in withdrawal observation and reporting. This staff education project was guided by the following practice-focused question: How does structured, simulation-based training on withdrawal management tools impact nonmedical staff's knowledge, confidence, and ability to identify and escalate withdrawal symptoms?

The gap in practice identified at the implementation site was two-fold: a lack of competency in applying standardized withdrawal tools and low staff confidence in assessing and escalating withdrawal-related symptoms. The absence of this knowledge posed risks to patient safety, organizational compliance, and overall care quality. This DNP project addressed these deficiencies by advancing structured, evidence-based staff education aligned with Knowles's adult learning theory and using the analysis, design, development, implementation, and evaluation instructional design model to ensure measurable outcomes. The purpose of this staff education project was to increase competency among nonmedical staff in recognizing withdrawal symptoms and equip them with practical tools to improve patient monitoring and care escalation practices.

Staff Education Project Development

To develop this project, I followed the analysis, design, development, implementation, and evaluation model of instructional design, giving focused attention to adult learning strategies. The training content was informed by clinical guidelines from the World Health Organization (2009), the American Society of Addiction Medicine (2020), and various psychometric studies validating the CIWA and COWS tools. The

training emphasized core competencies in vital signs assessment and tool usage, such as CIWA-Ar (for alcohol withdrawal), CIWA-B (benzodiazepine withdrawal), COWS (opioid withdrawal), and ACSA (amphetamine withdrawal; see Busto et al., 1989; McGregor et al., 2008; Sapra et al., 2023; Sullivan et al., 1989).

Participants included six nonmedical staff members, primarily substance abuse counselors, selected based on their direct patient care roles and lack of prior structured withdrawal training. I recruited these individuals voluntarily through internal organizational channels. Training delivery involved a blend of short lectures, hands-on clinical simulations, and role-playing exercises with real-world scenarios. Materials included a PowerPoint presentation, scoring guides, case studies, vital sign demonstration equipment, and quick reference job aids. All materials were validated by the facility's medical director and reviewed by an internal panel for clarity and alignment with learning objectives. The training content included a lecture, visual aids, and role-play scenarios to reinforce learning. The instructional PowerPoint is provided in Appendix A. The assessment tools used before and after training are located in Appendices B and C, while participant feedback data were gathered using the form in Appendix D.

The training was delivered over 1 week in a dedicated session facilitated by me, a registered nurse trainer, at the facility. The instructional environment included simulation stations for vital signs and collaborative group spaces for scenario-based assessment. I aligned the assessment tools, including pre- and posttraining knowledge quizzes and self-efficacy questionnaires, with learning objectives and evaluated them for clarity and validity before implementation.

Results

The implementation of the structured staff education program at the project site facility yielded substantial improvements in participant knowledge, skill application, and confidence. The training was conducted with six nonmedical staff members, including substance abuse counselors, all of whom completed pre- and posttraining assessments. The results clearly demonstrated that the educational intervention closed identified knowledge gaps, strengthened clinical competence in withdrawal monitoring, and improved readiness to comply with state-mandated protocols.

Pretraining Assessment Results

Before the training, participants completed a 35-item assessment that included multiple-choice questions, Likert scale confidence ratings, and a true-or-false knowledge inventory. Data analysis showed that only 17% of participants (i.e., 1 out of 6) could correctly identify all four validated withdrawal tools. Moreover, only 33% correctly defined which vital signs are essential to withdrawal observation and 67% of staff had never used a standardized tool. The participants' overall confidence was low, with confidence scores for vital signs monitoring (2.2), CIWA-Ar usage (1.8), and symptom escalation (2.0) on a 5-point scale. These findings confirmed that the problem was both knowledge based and experiential, validating the existence of a training gap but also informing content customization to address the precise deficits in skill and understanding (see Table 1).

Table 1

Pre- and Posttraining Knowledge and Confidence Outcomes (N = 6)

Metric	Pretraining score	Posttraining score	Change
Correct identification of all tools	17%	100%	+ 83%
Knowledge of vital signs	33%	100%	+ 67%
Confidence in vital signs monitoring (1–5)	2.2	4.5	+ 2.3 points
Confidence in CIWA-Ar use (1– 5)	1.8	4.0	+ 2.2 points
Confidence in symptom escalation (1–5)	2.0	4.7	+ 2.7 points

Note. Data reflects percent accuracy and self-reported confidence on a 5-point scale based on pre- and posttraining assessments completed by six nonmedical staff participants.

Postimplementation Results

Following the training, all participants exhibited substantial gains in their ability to correctly apply withdrawal management tools and perform vital signs monitoring. Prior to the intervention, only 17% of participants could identify all four key tools: CIWA-Ar, CIWA-B, COWS, and ACSA. After training, this rose to 100%, indicating full acquisition of foundational knowledge across the cohort. Similarly, accurate identification of the vital signs essential for withdrawal monitoring rose from 33% pretraining to 100% posttraining.

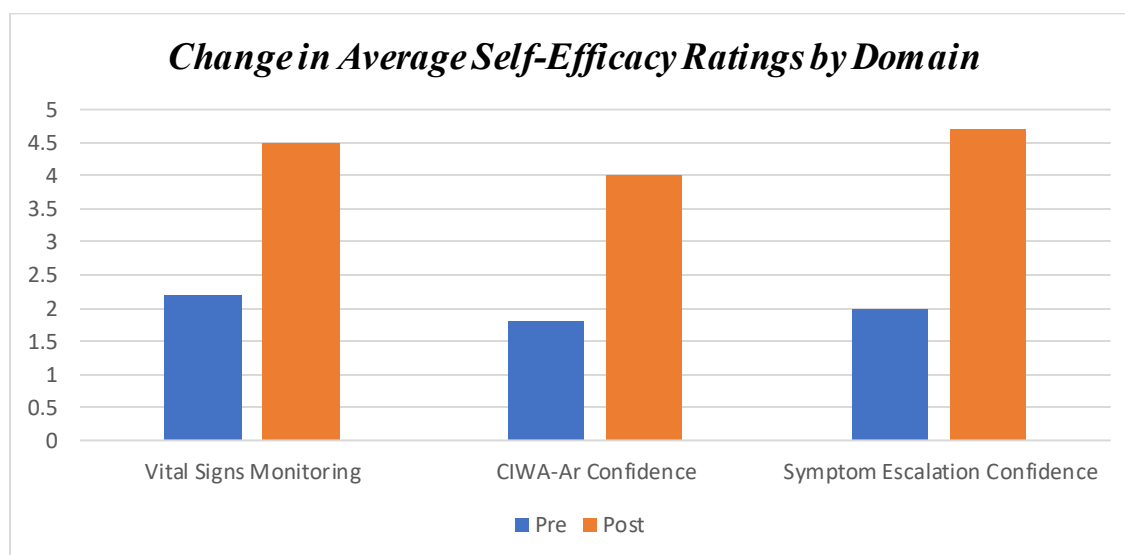
In addition to knowledge-based improvements, participants' practical skills were also markedly enhanced. During simulation scenarios, every participant demonstrated correct use of at least two validated withdrawal assessment tools. This was particularly relevant for tools, such as CIWA-Ar and COWS, which were integrated directly into role-playing activities and case-based simulations. These results suggest a successful

transition from passive learning to active skill application, a primary objective of experiential training frameworks.

Self-reported confidence metrics also improved substantially. On a 5-point Likert scale, average participant ratings for confidence in vital signs monitoring increased from 2.2 pretraining to 4.5 posttraining. Participants' confidence in using the CIWA-Ar scale rose from 1.8 to 4.0, while confidence in escalating withdrawal symptoms appropriately rose from 2.0 to 4.7. These numbers highlight both improved competence and psychological readiness to act, indicating that the training was not only informative but also empowering. Importantly, these findings affirm that the 1-hour training model was sufficient to produce meaningful gains in a short period of time, a critical consideration given operational constraint in behavioral health settings (see Figure 1).

Figure 1

Change in Average Self-Efficacy Ratings by Domain



Impact on the Organization

The training's organizational impact is multifaceted. Most immediately, the program addressed a longstanding gap in compliance with state-mandated standards on withdrawal management education for nonmedical staff. By enabling staff to accurately identify vital signs and assess withdrawal severity using standardized tools, the program improved the facility's readiness to intervene in clinical deterioration and escalate care appropriately. This enhancement in clinical vigilance directly supports safer patient outcomes and aligns with the organization's strategic goals around quality improvement.

Additionally, the training served as a catalyst for internal culture change. Participants expressed greater appreciation for structured protocols, and informal postsession discussions indicated that staff began using terminology from the training in daily conversations. These cultural shifts suggest a stronger alignment between frontline staff practices and the expectations of clinical leadership, ultimately supporting a more unified approach to patient safety.

The program also demonstrated the feasibility of integrating targeted training into an already time-constrained work environment. Despite the short duration, the training produced outcomes comparable to longer interventions, confirming that microlearning formats can be both efficient and effective. The ability to achieve these results without disrupting core operations suggests the model could be scaled and repeated with minimal impact on staffing logistics.

Limitations and Constraints

Despite the program's success, several limitations were encountered during implementation. One notable shortcoming was scheduling difficulty. Staff were managing high caseloads and variable shifts, resulting in one participant having to reschedule. This minor delay did not affect overall results but highlighted the importance of flexibility when implementing education in dynamic clinical environments.

Environmental factors also introduced challenges. Construction noise from an adjacent department created distraction during part of the simulation session. While this did not appear to diminish learning outcomes, it underscored the need for controlled, quiet learning environments for future sessions. In addition, initial apprehension around clinical terminology was evident, with some participants expressing uncertainty about language, such as "autonomic hyperactivity" or "tachycardia." To overcome this, facilitators simplified terminology and used visual aids to clarify concepts. These adjustments improved engagement and comprehension.

Perhaps the most significant limitation was the short-term nature of the data collected. While the assessments demonstrate clear learning and behavior changes, longer-term outcomes, such as improved patient safety metrics, reduced incident reports, or sustained adherence to protocols, have not yet been evaluated. These will require follow-up data collection at 3- and 6-month intervals. Nonetheless, early indicators suggest a strong foundation has been established for lasting impact.

Implications Beyond the Local Site

The results of this project hold value beyond the implementation site. Many behavioral health and substance abuse facilities operate with limited access to medical personnel and depend on nonmedical staff for patient observation and safety. The success of this short, simulation-based educational intervention demonstrates that even brief, focused training can significantly elevate care quality among nonmedical staff.

The scalability of the model is especially relevant. The 1-hour duration, combined with the use of easily accessible materials, such as printed guides and job aids, makes the intervention replicable across diverse settings. Furthermore, the alignment with state-mandated standards provides a framework that can be adopted by other institutions seeking to improve compliance without investing extensive time or financial resources.

The findings also suggest broader implications for equity in workforce training. By empowering staff without formal medical education to make clinically sound judgments based on structured protocols, the program elevates the contribution of traditionally underrecognized team members. This has the potential to reduce hierarchical silos in patient care and promote interdisciplinary collaboration, a cornerstone of effective addiction treatment and behavioral health support.

Conclusions

The implementation of a structured educational training program for nonmedical staff significantly enhanced both cognitive and applied competencies in withdrawal management. The positive trajectory of assessment results and unanimous participant feedback demonstrate the training's effectiveness in bridging critical practice gaps.

Beyond individual competency gains, this project lays the groundwork for sustainable quality improvement by recommending the integration of the training into standard onboarding processes. Biannual refresher sessions and peer-mentorship initiatives can further reinforce skill retention and foster a culture of continual learning.

The project also holds broader implications for nursing practice. The clear alignment with evidence-based tools and regulatory mandates positions the facility to meet state compliance requirements more confidently. Moreover, this initiative reflects a scalable model that other behavioral health facilities can adopt to enhance patient safety, reduce liability, and improve organizational outcomes. In terms of positive social change, empowering frontline staff with critical assessment skills enhances equity in care delivery, particularly for vulnerable populations undergoing substance withdrawal.

Future considerations should include longitudinal tracking of clinical outcomes, such as reduced incident reports and improved patient stabilization metrics. Evaluating these indicators over 6 to 12 months will offer further insight into the program's long-term efficacy and return on investment. Additionally, expanding the training to encompass pharmacological education for staff with advanced scopes of practice may extend its reach and impact.

This DNP project affirms the transformative potential of structured staff education in complex care settings. The integration of adult learning principles, real-world scenarios, and validated tools resulted in measurable advancements in knowledge, confidence, and clinical readiness. This not only elevates organizational standards but

contributes to the professional growth of nonmedical staff, advancing nursing practice and reinforcing a culture of safety and competence.

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Appendix A: Training PowerPoint

Withdrawal Observation Training for Non-Medical Staff

Vital Sign Monitoring & Withdrawal Assessment Tools (CIWA-Ar, CIWA-B, COWS, ACSA)

Katherine Hedrick Sandoval

Training Objectives

- Purpose: Recognize and monitor withdrawal symptoms
- Focus: Vital signs and assessment tools
- Tools: CIWA-Ar, CIWA-B, COWS, ACSA
- Goal: Ensure early detection and intervention
- When to escalate findings to clinical staff
- Improve safety for patients in withdrawal
- Follow state-mandated protocols and procedures



Overview of Withdrawal Observation

- Non-medical staff play an important role in withdrawal management
- Observe and report withdrawal symptoms early
- Early detection can save lives
- Recognize withdrawal symptoms across substances
- Symptoms vary by alcohol, opioids, and stimulants
- Effective communication with clinical staff is critical
- Accurate observation prevents serious complications



Vital Signs to Monitor

- Pulse: Normal range 60–100 beats per minute
- Blood Pressure: Check for high or low readings
- Respiration Rate: Normal 12–20 breaths per minute
- SpO2: Below 95% may indicate distress
- Temperature: Fever may signal complications
- Recognize abnormal readings quickly
- Escalate concerns to clinical staff (Sapra et al., 2023).



Proper Techniques for Measuring Vital Signs


- Proper technique ensures accurate measurements
- Pulse: Use fingertips, not thumbs
- Blood Pressure: Correct cuff placement is key
- Respiration: Count breaths for a full minute
- SpO2: Ensure the sensor fits snugly
- Avoid common errors for accuracy
- Practice techniques for confidence (Manglik, 2024; Sapra et al., 2023)





Overview of the COWS Assessment Tool

- COWS: Tool to assess opioid withdrawal
- Helps monitor and guide treatment decisions
- Key symptoms: heart rate, sweating, nausea
- Restlessness, tremors, pupil size, anxiety
- Scores range from 0 (none) to 4 (severe)
- 11 symptoms to evaluate withdrawal severity
- Supports timely intervention and better care (CHOCS Children, 2022; Manglik, 2024).







Application of the COWS Tool

- Observe symptoms: Restlessness, sweating, tremors
 - Assess vital signs: Pulse, pupil size
 - Score each symptom from 0 to 4
 - Add scores from all 11 symptoms
 - Mild: 0–12, Moderate: 13–24
 - Severe: 25–36, Very Severe: 37+
 - Severe cases require immediate intervention (CHOCS Children, 2022; Manglik, 2024).
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Case Scenario Activity

- Case: 35-year-old male, opioid withdrawal
 - Observed symptoms: Restless, pacing, sweating
 - Pulse rate: 95 bpm, hand tremors noted
 - Nausea reported, no vomiting observed
 - Pupils moderately dilated, appears anxious
 - Task: Score symptoms using COWS scale
 - Discuss interpretation and next steps.
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Overview of the CIWA-Ar Tool

- CIWA-Ar: Assess alcohol withdrawal severity
- Guides monitoring and symptom management
- Evaluates 10 symptoms, including tremors
- Nausea, agitation, hallucinations, confusion
- Key signs: anxiety, sweating, disorientation
- Early assessment prevents severe complications
- Helps avoid seizures or delirium tremens (DTs) (ASAM, 2020; CHOCS Children, 2022; Harding et al., 2023).



Application of the CIWA-Ar Tool

- Step 1: Ask or observe for symptoms
- Step 2: Score each symptom 0–7
- Step 3: Add up all symptom scores
- Step 4: Reassess regularly for changes
- Mild: 0–9, Moderate: 10–19
- Severe: 20–29, Risk of complications: 30+
- Urgent care for scores above 30





Case Scenario Activity

- Patient: 45-year-old female, alcohol withdrawal
 - Symptoms: Moderate tremors (score = 4)
 - Mild nausea (score = 2), severe anxiety (score = 6)
 - Moderate agitation (score = 4), mild sweats (score = 2)
 - No visual disturbances (score = 0)
-
- Task: Calculate total CIWA-Ar score
 - Discuss what actions to take next








Overview of the CIWA-B Assessment Tool

- A clinical assessment tool used to measure the severity of benzodiazepine withdrawal.
- CIWA-B is used to monitor and manage symptoms during benzodiazepine withdrawal.
- CIWA-B helps assess withdrawal severity to guide treatment decisions.
- CIWA-B comprises of ten key symptoms to monitor.
- CIWA- B helps clinicians to determine if withdrawal is mild, moderate, or severe.
- CIWA-B helps prevent complications (e.g., seizures, delirium) during the withdrawal process (BUSTO et al., 1989; CHOCS Children, 2022; Harding et al., 2023).





Application of the CIWA-B Tool

- Check for signs of withdrawal and ask about their symptoms.
 - Use the CIWA-B scale to rate each of the 10 symptoms on a scale from 0-7. Score each symptom based on severity (e.g., 0 = none, 7 = very severe).
 - 0-10: Mild withdrawal – Monitor the patient, consider supportive care.
 - 11-20: Moderate withdrawal – May require intervention (e.g., benzodiazepine tapering).
 - 21-30: Severe withdrawal – Intensive intervention needed (hospitalization, IV medications).
 - 31+: Medical emergency – Requires urgent medical attention, possible ICU care.
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Case Scenario Activity

Case Scenario:

- 45-year-old patient who has been on long-term benzodiazepine therapy for anxiety.
- Patient reports increased anxiety, sweating, and mild tremors.
- Patient denies any hallucinations or confusion but appears visibly agitated.

Activity Instructions

- Rate the symptoms using the CIWA-B tool.
 - Determine overall score
 - Interpret whether the patient is experiencing mild, moderate, severe, or very severe withdrawal.
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Overview of the ACSA Tool

- The ACSA tool is used to assess and monitor symptoms of amphetamine withdrawal.
- The ACSA tool helps quantify the severity of withdrawal symptoms in patients discontinuing amphetamines.
- The tool has 16 major symptoms to monitor
- Each question is scored on a 5-point scale (0,1,2,3, or 4)
- A higher total score reflects more severe withdrawal symptoms (McGregor et al., 2008)



Case Scenario Activity

- 32-year old male patient has a 4-year history of using amphetamines for recreational purposes.
- John discontinued use and presents with withdrawal symptoms in the last 24 hours.
- ACSA assessment shows mild difficulty concentrating, excessively sleepy, appears tense.
- Patient has vivid disturbing dreams, easily irritable, extremely tired, and easily agitated.
- Patient has no suicidal ideations, less active, highly anxious, and feels overwhelmed and disconnected.
- Patient feels increasingly paranoid, sad throughout the day, sluggish, has been craving amphetamines intensely.
- Calculate the overall score and interpret



When to Escalate to Medical Staff?

- Red flags: Severe symptoms need attention
- Seizures, hallucinations, confusion are critical
- Act quickly to prevent serious complications
- Communicate clearly and concisely
- Report objective observations only
- Use timely and accurate documentation
- Immediate action can save lives





Common Challenges and Solutions

- Vital sign monitoring can be difficult
- Clients may resist or refuse monitoring
- Stay calm and patient when challenged
- Explain why monitoring is important
- Ask for help from clinical staff if needed
- Ensure accurate documentation always
- Practice and patience build confidence







Conclusion

- Accurate monitoring improves patient safety
 - Use CIWA, COWS, ACSA for assessments
 - Recognize early warning signs of withdrawal
 - Escalate concerns promptly to clinical staff
 - Clear documentation is essential
 - Early intervention saves lives
 - Ongoing support and resources are available
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**Thank you for your time.
I welcome any questions you may
have**



Appendix B: Pretest Questionnaire

Pre-test Assessment: Withdrawal Management Training for Substance Abuse

Please answer all questions to the best of your ability. This pre-test assesses your current knowledge of vital signs monitoring and withdrawal assessment tools (CIWA-Ar, CIWA-B, COWS, and ACSA) prior to a one-hour training session. Responses remain confidential and are used only to tailor the training to your learning needs and evaluate knowledge improvement post-training. A post-test with identical questions will follow the training to measure learning outcomes. Complete all sections accurately to ensure the training meets its objectives.

Multiple Choice Questions

Please choose the best answers for each question.

1. Which vital signs are most important to monitor in withdrawal observation?
 - Height and weight
 - Pulse, blood pressure, respiration rate, SpO₂
 - BMI and hydration status
 - Skin color and pupil size
2. What is considered a dangerously high blood pressure reading that should be reported immediately?
 - 120/80 mmHg
 - 140/90 mmHg
 - 180/120 mmHg
 - 110/70 mmHg

3. Which withdrawal assessment tool is used to measure alcohol withdrawal severity?
- CIWA-Ar
 - COWS
 - ACSA
 - CIWA-B
4. Which tool measures benzodiazepine withdrawal symptoms?
- A. CIWA-Ar
 - B. CIWA-B
 - C. COWS
 - D. ACSA
5. A client presenting with confusion, seizures, and hallucinations is likely experiencing:
- Mild withdrawal symptoms
 - Moderate withdrawal symptoms
 - Severe alcohol withdrawal requiring medical intervention
 - Dehydration
6. Which withdrawal assessment tool is specifically used to measure benzodiazepine withdrawal symptoms?
- CIWA-Ar
 - CIWA-B
 - COWS
 - ACSA
7. A COWS score above 24 indicates:
- Mild opioid withdrawal
 - Moderate opioid withdrawal

- Severe opioid withdrawal requiring medical intervention
 - No withdrawal symptoms
- 8.** What should you do if a client presents with an irregular pulse, rapid breathing, and a CIWA-Ar score of 22?
- Encourage hydration and rest
 - Report immediately to medical staff
 - Provide reassurance and observe for changes
 - Administer over-the-counter medication
- 9.** Which symptoms might indicate severe stimulant withdrawal that requires escalation?
- Yawning, runny nose, and muscle aches
 - Severe agitation, hallucinations, and cardiovascular distress
 - Increased appetite and fatigue
 - Mild restlessness and difficulty sleeping
- 10.** What is a normal adult pulse rate?
- A. 40–60 beats per minute
 - B. 60–100 beats per minute
 - C. 100–140 beats per minute
 - D. Over 140 beats per minute
- 11.** Which symptom signals severe alcohol withdrawal needing immediate attention?
- A. Mild headache
 - B. Confusion and seizures
 - C. Increased appetite
 - D. Fatigue

Agreement Scale Questions

Please indicate your level of agreement using the scale provided

Statement	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
I feel confident accurately measuring vital signs such as pulse and blood pressure.					
I feel confident recognizing abnormal vital signs that require reporting.					
I feel confident using the CIWA-Ar tool to assess alcohol withdrawal.					
I feel confident applying the COWS tool to evaluate opioid withdrawal.					
I feel confident applying the CIWA-B assessment tool to assess for benzodiazepine withdrawal.					
I feel confident applying the ACSA assessment tool for amphetamine cessation symptoms assessment.					
I feel confident identifying when to escalate withdrawal symptoms to medical staff.					

I believe this training will improve my ability to observe and report withdrawal symptoms.					
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Please answer the following questions by ticking Yes or No.

Question	Yes	No
Have you ever observed clients showing signs of withdrawal?		
Do you know how to take and record vital signs?		
Do you feel confident in recognizing abnormal vital sign readings?		
Have you used the CIWA –Ar assessment tool before?		
Have you used the CIWA –B assessment tool before?		
Have you used the ACSA assessment tool before?		
Have you used the COWS assessment tool before?		
Do you think early observation of withdrawal symptoms can improve client safety?		

Please indicate whether the following statements are *True* or *False*

Statement	True	False
Withdrawal symptoms can vary depending on the substance used.		
Opioid withdrawal is rarely life-threatening but can be extremely uncomfortable.		
Benzodiazepine withdrawal can cause seizures and requires careful monitoring.		
Stimulant withdrawal is always mild and does not require assessment.		

CIWA-Ar and CIWA-B are used for assessing alcohol and benzodiazepine withdrawal, respectively.		
The COWS scale is specifically designed to assess opioid withdrawal symptoms.		
Proper monitoring of vital signs can help prevent severe withdrawal complications.		

Please rate your knowledge of the following topics

Topic	No Knowledge	Basic Knowledge	Moderate Knowledge	Adequate Knowledge	Expert Knowledge
How to take and record vital signs					
Recognizing abnormal vital signs					
Using the CIWA-Ar scale for alcohol withdrawal					
Using the CIWA-B scale for benzodiazepine withdrawal					
Using the COWS scale for opioid withdrawal					
Using the ACSA scale for stimulant withdrawal					

To participants:

Thank you for participating in this pre-test assessment. This pre-test will help guide our training by assessing your current knowledge. After completing the training, you will take a post-test to measure improvement. Successful completion of the training and assessment will qualify you for a certificate of competency in withdrawal observation training.

Appendix C: Posttest Questionnaire

Post-Test Questionnaire: Withdrawal Observation Training

Instructions:

Please answer all the questions to the best of your ability. This questionnaire will help evaluate the effectiveness of the training. Your responses will remain confidential and will only be used for improving the training program.

Section 1: Multiple-Choice Questions

1. Which vital signs are most important to monitor in withdrawal observation?
 - Height and weight
 - Pulse, blood pressure, respiration rate, SpO₂
 - BMI and hydration status
 - Skin color and pupil size
2. What is considered a dangerously high blood pressure reading that should be reported immediately?
 - 120/80 mmHg
 - 140/90 mmHg
 - 180/120 mmHg
 - 110/70 mmHg
3. Which withdrawal assessment tool is used to measure alcohol withdrawal severity?
 - CIWA-Ar
 - COWS
 - ACSA
 - CIWA-B

4. Which tool measures benzodiazepine withdrawal symptoms?
- A. CIWA-Ar
 - B. CIWA-B
 - C. COWS
 - D. ACSA
5. A client presenting with confusion, seizures, and hallucinations is likely experiencing:
- Mild withdrawal symptoms
 - Moderate withdrawal symptoms
 - Severe alcohol withdrawal requiring medical intervention
 - Dehydration
6. Which withdrawal assessment tool is specifically used to measure benzodiazepine withdrawal symptoms?
- CIWA-Ar
 - CIWA-B
 - COWS
 - ACSA
7. A COWS score above 24 indicates:
- Mild opioid withdrawal
 - Moderate opioid withdrawal
 - Severe opioid withdrawal requiring medical intervention
 - No withdrawal symptoms
8. What should you do if a client presents with an irregular pulse, rapid breathing, and a CIWA-Ar score of 22?
- Encourage hydration and rest
 - Report immediately to medical staff

- Provide reassurance and observe for changes
 - Administer over-the-counter medication
- 9.** Which symptoms might indicate severe stimulant withdrawal that requires escalation?
- Yawning, runny nose, and muscle aches
 - Severe agitation, hallucinations, and cardiovascular distress
 - Increased appetite and fatigue
 - Mild restlessness and difficulty sleeping
- 10.** What is a normal adult pulse rate?
- A. 40–60 beats per minute
 - B. 60–100 beats per minute
 - C. 100–140 beats per minute
 - D. Over 140 beats per minute
- 11.** Which symptom signals severe alcohol withdrawal needing immediate attention?
- A. Mild headache
 - B. Confusion and seizures
 - C. Increased appetite
 - D. Fatigue

Section 2: Agreement Scale Questions

Please answer the following questions by indicating Yes or No

Question	Yes	No
Did the training help you feel more confident in taking vital signs?		
Do you feel that you can use the withdrawal assessment tools in real-life situations?		
Have you ever encountered a client with withdrawal symptoms since the training?		
Do you know when to escalate a client's withdrawal symptoms to medical staff?		
Have you used the ACSA tool to assess stimulant withdrawal since completing the training?		
Have you used the CIWA-Ar tool to assess alcohol withdrawal since completing the training?		
Have you used the CIWA-B tool to assess benzodiazepine withdrawal since completing the training?		
Have you used the COWS tool to assess opioid withdrawal since completing the training?		
Would you recommend this training to other staff members?		
Would you like additional training on advanced withdrawal observation techniques?		

Please indicate how much you agree with the following statements.

Statement	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
I understand how to use the CIWA-Ar tool to assess alcohol withdrawal					
I can recognize symptoms of stimulant withdrawal and apply the ACSA tool accurately					
I feel prepared to escalate concerns when a client shows severe withdrawal symptoms.					
I believe the training has improved my ability to observe and report withdrawal symptoms.					
I feel confident in using the CIWA-B tool for benzodiazepine withdrawal assessment.					
I can correctly interpret withdrawal scores and take appropriate action.					
I understand when a client's vital signs require immediate reporting to medical staff.					
I feel confident in recognizing the progression of withdrawal symptoms					
I understand the key differences between alcohol, opioid, benzodiazepine, and stimulant withdrawal					
I am able to use the ACSA tool effectively for assessing stimulant withdrawal					

I feel comfortable escalating concerns to medical staff when needed					
I can monitor and document vital signs accurately and consistently					

Section 3: Knowledge and Skill Retention Self –Assessment

Rate your knowledge and skills on the following topics on a scale below

Statement	No Knowledge	Beginner	Moderate	Proficient	Expert
Monitoring and recording vital signs accurately					
Recognizing abnormal vital signs that require reporting					
Using CIWA-Ar for alcohol withdrawal assessment					
Using CIWA-B for benzodiazepine withdrawal assessment					
Using the COWS tool for opioid withdrawal assessment					
Using the ACSA tool for stimulant withdrawal assessment					

Understanding how to escalate severe withdrawal symptoms to medical staff					
Applying skills learned during case scenarios to real-life client monitoring					

Appendix D: Withdrawal Management Training Feedback Form

Withdrawal Observation Training for Non-Medical Staff

Participant Feedback Form

Instructions

Thank you for participating in today's training session. Your feedback is essential in helping us improve the content, delivery, and relevance of this program. Please complete the form honestly. Your responses will remain confidential and used for educational quality improvement only.

Section 1: Training Satisfaction and Relevance

Please rate the following statements based on your experience today.

Statement	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
The training was relevant to my role.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The objectives of the training were clearly stated.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The content was easy to understand.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The session helped me understand when and how to report abnormal vital signs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel more prepared to use CIWA-Ar, COWS, CIWA-B, and ACSA tools.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

The facilitators encouraged participation and addressed questions effectively.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The case studies and simulations improved my learning.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Section 2: Confidence in Skills Post-Training

Please rate your confidence after the training on a scale of 1 (Not confident) to 5 (Very confident).

Skill Area	1	2	3	4	5
Taking and recording accurate vital signs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recognizing abnormal vital signs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Knowing when to escalate withdrawal symptoms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Using the CIWA-Ar scale	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Using the CIWA-B scale	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Using the COWS scale	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Using the ACSA scale	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Section 3: Training Format and Delivery

1. Was the pace of the training appropriate?

Yes No Not sure

2. Was the use of simulation/case studies helpful?

Yes No Somewhat

3. Do you feel the length of the training (1 hour) was adequate?

Yes No Needs more time

4. Would you recommend this training to other non-medical staff?

Yes No Maybe

Section 4: Open-Ended Questions

1. What did you find most helpful about the training?

Your response:

2. What areas would you like more training on?

Your response:

3. Do you have any suggestions to improve this training session?

Your response:

Thank you for completing this feedback form. Your input will help us enhance future training efforts and improve patient care in withdrawal management.