GUIDELINES FOR THE MANAGEMENT OF ADULT OPIATE DEPENDENT PATIENTS IN THE ACUTE HOSPITAL SETTING

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Contents

INTRODUCTION

If opiate dependent patients are admitted to acute hospital settings and their opiate dependency needs are not considered appropriately then we are at risk of:

1. Patients discharging themselves and therefore not being able to access appropriate medical care.
2. Behavioural problems associated with withdrawal syndrome and possible increased risk of violence and aggression.
3. Increased use of illicit drugs whilst in hospital
4. Reduction in tolerance to opiates and subsequent risk of overdose on discharge from hospital.
5. Risk of over medication and possibility of overdose whilst in hospital.

Aim of Guidance

1. To guide clinical staff involved in treating drug dependent patients in hospital who require on going management of their dependency.
2. To promote safe and appropriate prescribing of opiate substitute medication during admission
3. To provide for a seamless transfer of care between primary and secondary care including transfer between acute and mental health services both on admission and discharge where appropriate.
4. To highlight the problems that may be associated with the care of this group of patients.
5. These guidelines are intended to be of particular use for out of hours admissions when specialist advice will not be available from the Community Drug and Alcohol Team (CDAT) or Substance Misuse Liaison Nurse.

The guidelines support clinicians in formulating safe decisions about management and promote quality of care and patient comfort. If in doubt about any aspect of management please contact the CDAT or the Substance Misuse Liaison Nurse for advice at the earliest opportunity. (contact details **appendix 1)**

Competencies Required:

Within the acute Trust doctors must be FY2 or above (with full GMC Registration) in order to be able to prescribe methadone or buprenorphine . Ideally, FY2 doctors should usually discuss with more senior medical staff.

Methadone or buprenorphine can be administered by registered nurses caring for opiate dependent patients in all health care settings. **If in doubt, contact a senior member of staff for advice.**

PATIENTS COVERED

These guidelines cover the treatment of patients who are admitted either as an emergency (e.g. ED or AMU/SDMU) or who are coming in as a planned admission for treatment.

Substitute medication such as methadone, buprenorphine, buprenorphine long acting injection (LAI) (Buvidal) and/or symptomatic relief of opiate withdrawal should not be given for patients attending for minor injuries or illnesses unless the patient is admitted to a ward.

Patients being admitted who disclose substance misuse problems and requesting help should be assessed using the appropriate screening test and referred to First Point of Contact (FPOC).

If admission is not required but the patient is requesting help, they can be referred to FPOC with appropriate service leaflets as well as other relevant information: Overdose leaflets, Safer injecting leaflets. These can be found on ED and AMU/SDMU.

GUIDELINES

Patients presenting at ED, AMU or SDMU

1. Treat any emergency or acute problem first. Although opiate withdrawal is an acute problem it is not in itself life threatening. However, left untreated it could lead to the patient discharging themselves against medical advice due to unacceptable levels of discomfort.

NB For pregnant women opiate withdrawal is a potential obstetric emergency e.g. placental abruption, foetal distress, premature labour. Please refer to separate Guidelines “Guideline for the care of the pregnant alcohol / illicit drug user” or discuss with CDAT or Substance Misuse liaison nurse based on site (**Appendix 1)**.

2. If the patient is disclosing dependent use of opiates (whether prescribed or otherwise obtained) :

a. Take history including all drugs used, dosage, route of administration, time last used, and check for injecting sites.

b. Take appropriate screen for opiate drugs to confirm/deny use.

c. Even if the test is positive, only treat symptomatically according to these guidelines until confirmation of the prescription details by the methods below. Do not prescribe methadone/buprenorphine until this has been done. If the test is negative, do not prescribe methadone/buprenorphine and treat symptomatically according to the protocol.

e. If the patient discloses they are on a Methadone, Buprenorphine, Buvidal sub cut injection programme; therefore in treatment - Confirmation is needed – by appropriate urine screening test and confirmation of prescription details from CDAT or prescriber if not CDAT (**appendix1**).

f. Screening: Note the time and date that the patient states the medication was last taken.

g. For the screening to be carried out, consent must be obtained by asking the patient “In order to assess whether we should prescribe Methadone or Buprenorphine for you we would like to do a urine test. If this test is negative it will tell us that you do not require Methadone or Buprenorphine. If the test is positive we will contact the prescribing treatment agency, either CDAT, GP, Dyfodol and PSALT or Community Pharmacy to ensure we prescribe the correct dose for you. Until then we will try to control your symptoms according to our protocol”. This decision must be documented in the patient’s medical notes. If the patient refuses screening then no substitute medication should be given. Symptomatic relief could be prescribed and substance misuse service should be liaised with.

h. Confirmation of prescription details: Ask the patient who provides their substitute medication and contact the prescribing treatment agency – substance misuse key worker (see contact details **appendix 1**) or GP, if it is within weekday working hours. Alternatively contact the dispensing community pharmacist (which depending on opening hours can be especially useful out of hours and weekends).

If the patient claims he or she is on a Methadone/Buprenorphine Programme

All genuine Methadone or Buprenorphine programme users will be able to provide details of the pharmacy they collect their prescription from. Pharmacies keep prescription details of these patients and will dispense on a Saturday. Saturday's prescription will include Sunday's dose and also Monday's if it is a Bank Holiday. Each dose will last the patient 24 hours. Occasionally split pickups will be provided for Buprenorphine users when they will take 2-3 days supply at one time. If the patient claims the prescription is at home, details must be verified by the designated pharmacy or the patient can ask a family member to bring their prescription into hospital if possible for verification. Methadone or Buprenorphine programme users will have a named substance misuse key worker, who should be contacted at the earliest opportunity during the patient's stay to establish if it is possible for the named worker to make a ward visit. This can help facilitate the discharge process at a later date. If the substance misuse liaison nurse is available he/she can be contacted to undertake these arrangements.

NB. Some patients may be prescribed buprenorphine long acting injection (Buvidal) on a weekly or monthly basis.

If a patient claims their Methadone or Buprenorphine has been stolen or lost this must be reported to the police and an incident number given before the prescribing treatment agency will consider whether reissuing a prescription is appropriate or not.

Please note: Unless the prescription is verified by the above methods, methadone/buprenorphine must not be prescribed.

If a prescription is confirmed, liaise with the prescribing treatment agency or prescribing GP regarding arrangements for prescribing for the duration of the patient's admission. The in-patient prescription should be the same formulation and dosage as prior to admission. The prescribing treatment agency or prescribing GP should then ensure that the patient's normal community dispensed supply is withheld until they are informed of the patient's discharge from hospital. Contact details for this notification on discharge should be documented in the patient's medical notes.

On Discharge:

It should not normally be necessary to discharge a patient with a TTO for Methadone or Buprenorphine. Instead, arrangements should be made with the prescribing treatment agency or prescribing GP to re-start the patient's usual supply in the community.

The patient's named ward nurse will need to contact the patient's named substance misuse key worker or prescribing GP prior to discharge to ensure that a current valid prescription is available.

If a patient has been admitted and cannot collect their usual prescription for 3 days, their community pharmacy will put them 'on hold'. On discharge of these patients please contact the prescribing treatment agency or prescribing GP; otherwise the prescription cannot be reactivated. As Methadone and Buprenorphine are controlled drugs and can only be dispensed on the days written on the prescription, it may be that new prescriptions will need to be prepared by the prescribing treatment agency or

prescribing GP. Appropriate notice should be given by the hospital in order to allow this. A minimum of 24 hrs notice is required, Mon - Fri only.

If it has not been possible to prepare a valid prescription, a request may be made by the prescribing treatment agency or prescribing GP for a limited take home supply (TTOs). If a patient is being discharged on a Saturday or Sunday, the dose for the day of discharge should be administered on the ward to limit the take home supply to only those days when a prescription is not available.

Patients should never be discharged with methadone or buprenorphine unless such arrangements have been made.

If a patient discloses opiate use and is not on a programme or details of a programme cannot be confirmed.

Patients may need to be prescribed either symptomatic relief or opioid substitute medication for the duration of their stay in hospital.

No patient should be discharged on such medication unless the Substance Misuse Service have requested and advised on this. Unless there are urgent risk factors that would compromise patient recovery (if they were to return to using street drugs) access to specialist prescribing may be subject to waiting lists. Patients should be reassured that their symptoms will be treated promptly and appropriately, but that buprenorphine will only be prescribed according to the protocol **and only for the duration of their stay in hospital.**

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Wait up to 24 hours (or until confirmation available) so that assessment confirming objective signs of opiate withdrawal can take place i.e. yawning, lacrimation, sneezing, runny nose, raised BP and raised pulse rate, dilated pupils, diarrhoea, nausea, fine muscle tremor, clammy skin. The assessment sheet (Appendix 2) can be used to score the degree of withdrawal. If the patient is using heroin, withdrawal can start 4-6 hrs after last administration. Methadone can take 24 hrs or longer.

Take appropriate screen for opiates as above (including relevant consent). If withdrawal symptoms are mild, prescribe symptomatic relief only as follows: (See separate guideline regarding management of pregnant women as above or contact the specialist substance misuse midwife or CDAT).

Loperamide (diarrhoea) 4mg stat followed by 2mg after each loose stool
(max 16mg daily)
Mebeverine (stomach cramps) 135mg tds
Mirtazepine (sleep) 15mg nocte (short term only)
NSAIDs, Paracetamol (muscular pains/ headaches) as per BNF regimens.
These medications should be used during admission only and not prescribed for discharge.

Buprenorphine

If withdrawal symptoms are not being effectively managed by the above regime and are severe, buprenorphine may be required. It should only be prescribed by an FY2 or above as follows:

Buprenorphine is licensed for the treatment of opiate dependence. It relieves the physical effects of opiate withdrawal and controls cravings. It is not so sedating as

methadone and is less likely to produce severe respiratory depression (unless taken with other CNS depressants such as alcohol or benzodiazepines). However, in overdose larger doses of naloxone are needed to reverse its effects.

Buprenorphine should not be given until the patient is experiencing opiate withdrawal symptoms. Due to its partial opiate agonist effect it may cause precipitated withdrawal symptoms if taken sooner.

Initial dose:
Day 1: Maximum 4mg sublingual as a starting dose, maximum 8mg in the first 24 hours

Day 2 : Give previous day's total dose as a single dose in the morning and increase by 0 to 8mg depending on patient response, 8 hours later. For further increases on following days advice should be sought from CDAT or substance misuse Liaison Nurse.
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Average doses tend to range from between 8 and 24mg daily.
NB If a dose is swallowed rather than retained sublingually, potency is significantly reduced. Please ensure all parties are aware of the correct administration of the drug.

Please note: If the patient does not become stable on buprenorphine then methadone could be used. This should only be done on discussion with CDAT or Substance misuse liaison nurse.

Procedure for wards to obtain supplies of buprenorphine for administration as an in-patient:
During pharmacy opening hours – Order using controlled drug requisition book via the usual route (ward-based pharmacy team or dispensary).
Outside of pharmacy opening hours – follow guidance for obtaining controlled drugs out of hours in the Trust Medicines Policy

Safety considerations:

Naloxone:
Non-medical wards
All patients should have naloxone PRN prescribed on the "as required"
section of their in-patient chart, in case of opiate overdose. Dose:400 micrograms, then 800micrograms for up to 2 doses at 1 minute intervals if no response to preceding dose, then increased to 2mg for 1 dose if still no response (4mg may be required in seriously poisoned patients), then review diagnosis. Discuss with a senior medic if a larger dose is required. The subcutaneous and IM routes should only be used if the IV route is unavailable, due to a slower onset of action than IV. Patients on buprenorphine will need much higher dosages as it is not easily displaced by naloxone from the opioid receptors (Toxbase suggests 0.4 – 2mg, repeated after 2 minutes if no response. Large doses may be required and even then may not be fully effective. Naloxone may provide only partial reversal of buprenorphine induced opioid effects and may not reach a maximum until one hour after naloxone administration. The patient must be observed until at least 6 hours after the last dose of naloxone). Naloxone should only be given if opiate intoxication/overdose is present, as in an opiate dependent patient it will precipitate severe withdrawals.

Signs of opiate intoxication: Drowsiness, slurred speech, constricted pupils.
Overdose will lead to laboured breathing, unconsciousness and likely respiratory/cardiac arrest if not treated.

Medical wards

Existing guidelines/protocols are in place

Be alert to the fact that some patients may continue using illicit substances on the ward. Drug screening should only be undertaken with patient consent and if the patient refuses screening then the prescription should be withheld due to the risk of overdose if the patient has misused illicit drugs. Patients must be discouraged from using illegal substances on Trust premises and documentation of advice should be recorded in notes

Planned Admissions for patients on a programme

If a patient discloses that they are receiving Methadone or Buprenorphine treatment, a letter of confirmation from the prescribing treatment agency or prescribing GP may have been sent to the consultant prior to admission (if the patient has informed the prescriber of the planned admission). If no written confirmation is evident please contact the prescribing treatment agency or prescribing GP to confirm details of the current regime. This will also ensure that the usual prescription is withheld at the community pharmacy.

Patients should not need to bring Methadone or Buprenorphine into hospital. If they do: DO NOT USE and record according to the Health Board Medicines Policy by recording it in the ward controlled drugs register (patient's own section) and storing in the ward controlled drugs cupboard. Do not re-issue to the patient on discharge, contact the ward pharmacist or dispensary as appropriate to arrange destruction.

Prior to discharge contact prescribing treatment agency or prescribing GP to ensure that community prescription will be ready for re-instatement at their usual pharmacy. If a patient has been admitted and cannot collect their usual prescription for 3 days, their community pharmacy will put them 'on hold'. On discharge of these patients please contact the prescribing treatment agency or prescribing GP; otherwise the prescription cannot be reactivated. As Methadone and Buprenorphine are controlled drugs and can only be dispensed on the days written on the prescription, it may be that new prescriptions will need to be prepared by the prescribing treatment agency or prescribing GP. Appropriate notice should be given by the hospital in order to allow this. A minimum of 24 hours notice is required, Mon - Fri only. If it has not been possible to prepare a valid prescription, a request may be made by the prescribing treatment agency/GP for a limited take home supply (TTO's). If a patient is being discharged on a Saturday or Sunday, the dose for the day of discharge should be administered on the ward to limit the take home supply to only those days when a prescription is not available.
Patients should never be discharged with Methadone or Buprenorphine unless such arrangements have been made.

General Safety Notes

1 Do not be pressured into prescribing anything before confirmation of community treatment from substance misuse services or evidence of objective signs of opiate withdrawal are obtained (appropriate urine drug test and opiate withdrawal scale, (see Appendix 2)

2 Patients will need additional analgesia for pain relief compared to a non-opiate user. If prescribed, the baseline Buprenorphine or Methadone dose should remain constant. Contact the Acute Pain Team, CDAT or the liaison team for advice.

3 Caution with patients disclosing poly drug (e.g. benzodiazepines, amphetamines, cocaine) and alcohol use – they may experience multiple withdrawals – seek advice from CDAT or substance misuse liaison nurse.

4 Caution especially in head injury, liver disease and respiratory depression.

5 Please note: It is lawful for Methadone or Buprenorphine to be prescribed for any patient by any registered medical practitioner (i.e. FY2 or above with full GMC Registration. Any prescriptions for TTOs are subject to the requirements of the Misuse of Drugs Regulations 1973 (see the BNF or contact pharmacy for further guidance on writing such prescriptions).

6 If the ward team wishes to initiate a methadone prescription please ensure that the substance misuse liaison nurse is involved to help with safe prescribing. If unable to contact a substance misuse liaison nurse please contact a consultant based in Swansea or Neath Port Talbot CDAT.

Appendix 1

Contact Numbers

Substance Misuse Liaison Nurse:
01792 703312 (internal to SBUHB 33312)
Mob: 07773 667791 or 07811 314809 (Swansea)
(Monday – Friday 8am – 4pm)

SBUHB CDAT (Neath Port Talbot) – 01639 862872

SBUHB CDAT (Swansea) - 01792 530719

Dyfodol Neath Port Talbot – 01639 622360

Dyfodol Swansea – 01792 656400

DIP Neath Port Talbot – 01639 622360

First Point of Contact (FPOC) (N.B. open access, no referral needed) Swansea 0300 7904044
NPT 0300 7904022

PSALT – 01792 475598

Appendix 2

OBJECTIVE OPIATE WITHDRAWAL SCALE

Name of service user: …… D.O.B. ……./……./…….

Completed by: ……..

When Last Used: …….. **Amount: ……**

Start Date: ……/……/……

Symptoms	Severity	Score	Day 1	Day 2	Day 3
Sneezing Yawning	None	0			
	1 ~ 2	1			
	3 ~ 5	2			
	6 or more	3			
Rhinnorhoea & Lacrimination (runny nose & runny eyes)	None	0			
	Watery eyes/sniffing	1			
	Wiping nose or eyes/streaming	2			
	Profuse secretion/tears	3			
Agitation	None	0			
	Slight restlessness/fidgeting	1			
	Unable to remain seated	2			
	Constant restlessness	3			
Perspiration	None	0			
	Moist or clammy skin	1			
	Beads of sweat	2			
	Profuse sweating	3			
Vomiting/ Retching	None	0			
	Retching	1			
	Vomiting one or two times	2			
	Uncontrolled vomiting	3			
Gooseflesh (Piloerection)	None	0			
	Hairs standing up transiently	1			
	Barely palpable/hairs standing	2			
	Readily palpable/hairs visible	3			
Pupil Dilation	Pin point (<2mm)	0			
	Normal (2~4mm)	1			
	Dilated (4~6mm)	2			
	Widely dilated (>6mm)	3			
Pulse Rate	Normal (<65 bpm)	0			
	Mild tachycardia (65~80 bpm)	1			
	Mod. tachycardia (81~100 bpm)	2			
	Severe tachycardia (>100 bpm)	3			
	Total withdrawal symptom for day:				

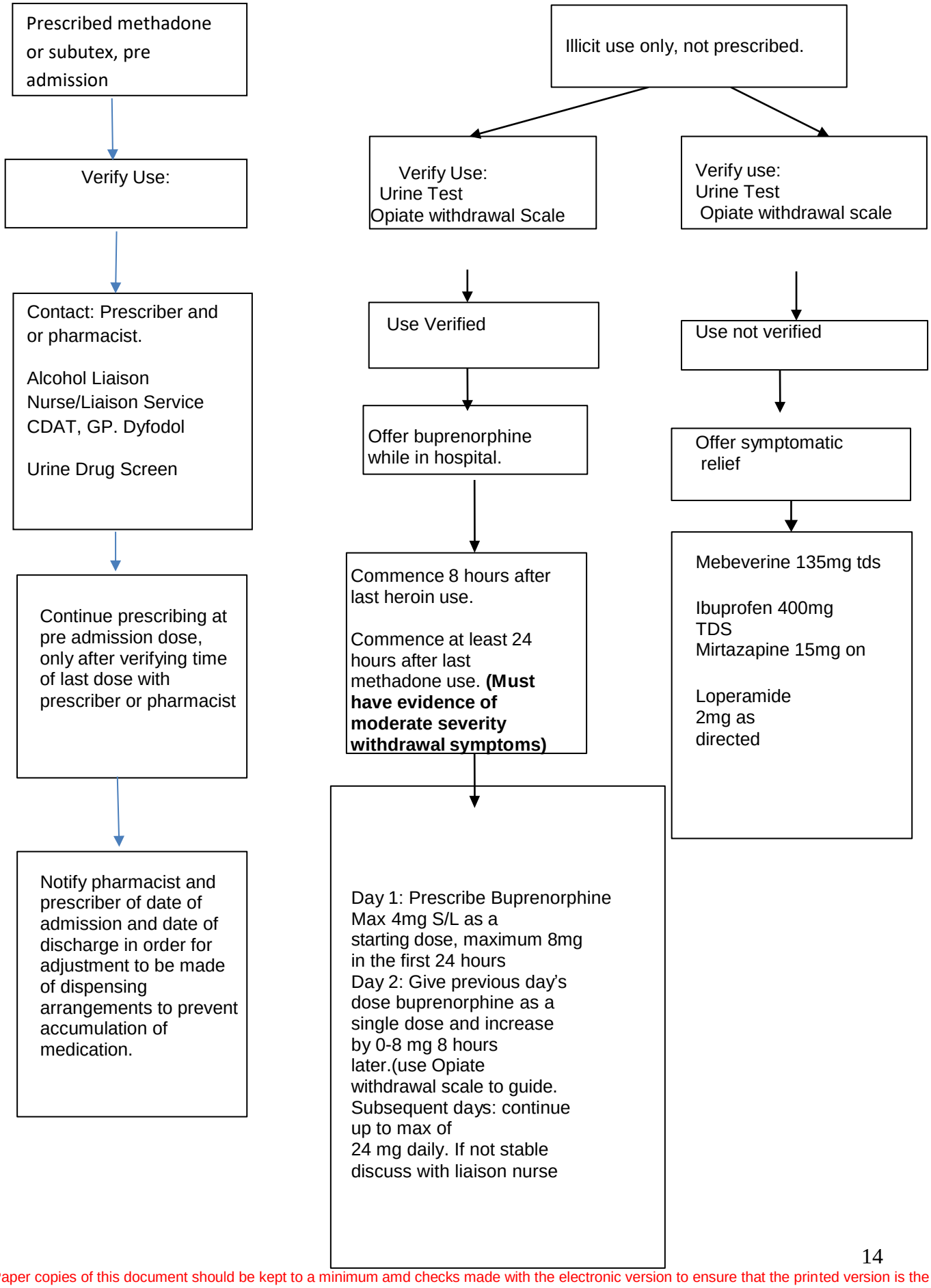
If patient scoring 6 and over = CONSIDERED OPIATE WITHDRAWAL SYMPTOM
MAXIMUM SCORE

= 24

Day	Blood Pressure	Pulse	Respiration
1 Pre	/	Bpm	Pm
1 Post	/	Bpm	Pm
2 Pre	/	Bpm	Pm
2 Post	/	Bpm	Pm
3 Pre	/	Bpm	Pm
3 Post	/	Bpm	Pm

NOTES - sleep patterns/illicit use etc.

Treatment of clients dependent/misusing opiates presenting to inpatient medical settings



REFERENCES

These guidelines have been developed from original guidance produced by Glasgow Drug Problem Service for Glasgow Royal Infirmary (1996).
http://www.nice.org.uk/PHI004
http://www.nta.nhs.uk/publications/documents/clinical_guidelines_2007.pdf