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

This guidance does not override the individual responsibility of health professionals to make appropriate decision according to the circumstances of the individual patient in consultation with the patient and /or carer. Health care professionals must be prepared to justify any deviation from this guidance.

INTRODUCTION

These guidelines are intended to be of particular use for out of hours admissions when specialist advice will not be available from the Substance Misuse Service (SMS); the content is approved by SMS. 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 SMS for advice at the earliest opportunity (see contact details page 8)

THIS GUIDELINE IS FOR USE BY THE FOLLOWING STAFF GROUPS :

This guidance is based on advice from the Worcestershire Substance Misuse Service, and is approved for use within the Trust Medical Directorates and by any other clinicians within the Acute Trust treating adult opiate dependent patients who have an emergency or elective admission to hospital.

Lead Clinician(s)

Dr Miguel Marimon	Consultant Physician, AMU WRH
Approved by Urgent Care Directorate on:	23rd January 2020
Approved by Medicines Safety Committee	10th January 2024
Review Date: This is the most current document and is to be used until a revised version is available	10TH January 2027

Key Amendments made to this guideline

Date	Amendment	By:
20/05/2008	Guideline approved by	Medicines Safety Committee
19/09/2008	Guideline approved by	Trust Management Board
15/09/2010	Guideline extended for a further 6 months	Dr Marimon
24/07/2013	Republish without change – Guideline to undergo major review over the next 6 months	Dr Marimon
07/08/2015	Document extended for 12 months as per TMC paper approved on 22nd July 2015	TMC
November 2016	Further extension as per TMC 22nd July 2015	TMC
November 2017	Document extended for three months whilst under review	TLG
December 2017	Sentence added in at the request of the Coroner	
December 2017	Document extended for 3 months as per TLG recommendation	TLG
March 2018	Document extended for 3 months as approved by TLG	TLG
June 2018	Document extended for 3 months as per TLG recommendation	TLG
January 2020	Document updated with the following changes: • Addition of Espranor® oral lyophilisate as commonly used in community substance misuse services. • Addition of 'Physeptone' as 'Methadone' may also be referred to this by patient. • Addition of 'Analgesia in patients prescribed Methadone/Buprenorphine' • Under safety considerations – addition of harm reduction advice – safer injecting practice, risk of overdose due to loss of tolerance and polydrug use. • Under general safety notes – addition of guidelines regarding use of Buprenorphine with opiate pain management. • Update NTA clinical guidelines. • Email link to current Substance Misuse service. • Addition of Alcohol Liaison Service contact details • Addition of letter of expectation	Swanswell Recovery Partnership/Emma Davies ALN
January 2020	Additional comments to 'General Safety Advice' • Consider contra-indication/cautions to Methadone use before prescription e.g. Hepatic/renal dysfunction, head injury, co-prescription of CYP P450 enzyme inhibitors or other CNS depressants, risk factors for QTc prolongation – check with Pharmacist if unsure. • Complete Liver Function Test for those patients newly started upon Buprenorphine/Methadone. • For those patients who are attending for elective surgery and are prescribed Buprenorphine please contact the pain team for further advice.	Lindsay Stewart CPTL WRH
May 2020	Document extended for 6 months during COVID-19, whilst the approval process is finalised.	Emma Davies
September 2020	Additional information regarding 'Espranor®' following addition to the Formulary	Emma Davies/ Medicines and

		Prescribing Committee
January 2024	Amendment made to ward name, 'MAU' changed to 'AMU' Drug screening details changed as point of care testing kits no longer used and has been superseded by laboratory urine testing	G Kelly Governance lead Urgent Care

Guidelines for Management of Adult Opiate Dependent Patients in the Acute Hospital Setting

Introduction

Aim of Guidance

- To guide clinical staff involved in treating opioid drug dependent patients in hospital who require ongoing management of their dependency.
- To promote safe and appropriate prescribing of opiate substitutes.
- To provide for a seamless transfer of care between primary and secondary care services both on admission and discharge.
- To highlight the problems that may be associated with the care of this group of patients.

These guidelines are intended to be of particular use for out of hours admissions when specialist advice will not be available from the Substance Misuse Service (SMS); the content is approved by SMS. 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 SMS for advice at the earliest opportunity (see contact details page 9)

Competencies Required

Doctors must be FY2 or above (with full GMC Registration) in order to be able to prescribe methadone also known as Physeptone® or buprenorphine also known as Subutex®/Espranor®. SMS are currently prescribing Buprenorphine in Espranor® oral lyophilisate form (wafer rather than sublingual tablet) as a preferred medication choice when Buprenorphine is indicated.

Please note that Espranor® is NOT bioequivalent to buprenorphine sublingual tablets (e.g. Subutex®).

Patients to be maintained on their normal brand if admitted as an inpatient - check specific brand of buprenorphine substitution therapy when performing medication histories. Contact SMS for further advice.

Methadone or buprenorphine can be administered by registered nurses caring for opiate dependent patients in the acute setting.

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. through A&E/ AMU) or who are coming in as a planned admission for treatment. *For pregnant opiate users, see separate guideline 'Guideline for the care of the pregnant alcohol / illicit drug user'*

- Substitute medication such as methadone, buprenorphine and/or symptomatic relief of opiate withdrawal should not be given for patients attending for minor injuries/illnesses unless the patient is admitted to a ward (including the A&E observation ward).

Patients being admitted who disclose substance misuse problems and requesting help should be assessed using the appropriate screening test (see below) and referred to the appropriate prescribing treatment agency (i.e. SMS or GP). Please follow the link to the online referral form for local SMS: https://www.cranstoun.org/services/substance-misuse/cranstoun-worcestershire/

- If admission is not required but the patient is requesting help, they can be referred to the appropriate prescribing treatment agency (i.e. SMS or GP) and SMS service leaflets can be given as well as any other relevant information e.g. Overdose leaflets, Safer injecting leaflets. These can be found on A&E and AMU or obtained from the SMS (see contact details page 9).

GUIDELINE

A: Patients presenting at A&E or AMU

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 Guideline "Guideline for the care of the pregnant alcohol / illicit drug user"

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

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

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

*Send urine sample in a universal pot to biochemistry, selecting urine drug screen on ICE**.**

Drug detection times
Please use these figures as a guide only:

- **Alcohol**: 3-5 days in urine, 10-12 hours in blood
- **Amphetamines**: 1-3 days in urine and around 12 hours in blood
- **Benzodiazepines**: 3-6 weeks in urine and 2-3 days in blood
- **Cannabis**: 7-30 days in urine and up to 2 weeks in blood
- **Cocaine**: 3-4 days in urine and 1-2 days in blood
- **Codeine**: 1 day in urine and up to 12 hours in blood
- **Heroin**: 3-4 days in urine and up to 12 hours in blood
- **Methadone**: 3-4 days in urine and 24-36 hours in blood
- **Morphine**: 2-3 days in urine and 6-8 hours in blood

3. If the patient discloses they are on a methadone / buprenorphine programme

i. **Confirmation is needed** – by appropriate urine screening test and confirmation of prescription details from substance misuse service/ and or designated pharmacy. The dispensing community pharmacy would also be able to confirm last dispensed medication. The SMS would still be first point of contact to be notified/confirmed of admission/any prescribing however the SMS is a service that operates Mon-Fri 9-5pm.

ii. **Screening:** Note the time and date that the patient states the medication was last taken. Use appropriate screening test for additional confirmation of use and any additional drug use. Test kits may be stocked by A&E, AMU and other clinical areas which have a need to do so. Even if the test is positive, only treat symptomatically according to this protocol 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.

iii. **Consent:** For the screening to be carried out, consent must be obtained by asking the patient "In order to assess whether we should prescribe methadone/ buprenorphine for you we would like to do a urine test. If this is negative it will tell us that you do not require methadone/buprenorphine. If this is positive we will contact the prescribing treatment agency/GP/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 or symptomatic relief should be given.**

iv. **Confirmation of prescription details:** Ask the patient who provides their substitute medication and contact the prescribing treatment agency – substance misuse keyworker (see contact details page 9) or GP, if it is within weekday working hours. Alternatively contact the dispensing community pharmacist (which can be especially useful out of hours and weekends). All genuine methadone/ 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 if open. Saturday's prescription will include Sunday's dose, & also Monday's if it is a Bank Holiday. Each dose will last the patient 24 hours. 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/buprenorphine programme users will have a named substance misuse keyworker, who should be contacted at the earliest opportunity during the patient's stay to establish if it is possible and/or appropriate for the named worker to make a ward visit. This can help facilitate the discharge process at a later date.

In the absence of being able to contact the substance misuse keyworker directly, a duty worker can allocate the call and direct to a senior or team leader.

If a patient claims their methadone/buprenorphine has been stolen or lost this must be reported to the police and an incident number given before the prescribing treatment agency will reissue a prescription.

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

i. Prescribing: If a prescription is confirmed, liaise with prescribing treatment agency/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/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.

ii. **On Discharge: It should not normally be necessary to discharge a patient with a TTO for methadone/buprenorphine**. Instead, arrangements should be made with the prescribing treatment agency/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 keyworker/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/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/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/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.

- NB: Patients may be a on a programme with a product called **Espranor®**.

  "What is Espranor®?
  Espranor® is a freeze dried wafer (oral lyophilisate) which contains buprenorphine (2mg or 8mg) and dissolves when placed on the tongue. Espranor® is licensed for substitution treatment for opioid drug dependence, within a framework of medical, social and psychological treatment. It is intended for use in adults who have agreed to be treated for addiction.

  Bioavailability & dose equivalence
  Espranor® is **NOT bioequivalent to buprenorphine sublingual tablets (e.g. Subutex®). Patients to be maintained on their normal brand if admitted as an inpatient - check specific brand of buprenorphine substitution therapy when performing medication histories. Contact Drug and Alcohol Services for further advice**

4. If a patient discloses opiate use & 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 (see Appendix 1 for summary).

However no patient should be discharged on such medication unless the Substance Misuse Service have requested and advised on this. Please ensure a minimum of 24 hrs notice is required, Mon - Fri to allow the SMS to process referral and confirm arrangements.

Patients should be given harm reduction advice upon discharge that their tolerance levels to opiates may have dropped during their admission and on the risk of poly drug

use. Their admission may put them at a heightened risk of overdose should they return to previous use.

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 methadone/buprenorphine will only be prescribed according to the protocol.

i. 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/pulse, 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.

ii. Take appropriate screen for opiates as above (including relevant consent).

iii. **If withdrawals are mild, prescribe symptomatic relief only as follows**: (See separate guideline regarding management of pregnant women as above).

- Loperamide (diarrhoea) 4mg stat followed by 2mg after each loose stool (max 16mg daily)
- Metoclopramide (nausea/vomiting) 10mg tds or Prochlorperazine 5mg tds oral or 12.5mg IM 12 hourly.
- Mebeverine (stomach cramps) 135mg tds
- Diazepam (agitation/anxiety) 5-10mg tds
- Zopiclone (sleep) 7.5mg nocte
- NSAIDs, Paracetamol (muscular pains/ headaches) as per BNF regimens.

These medications should be used during admission only and not prescribed for discharge.

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

Methadone:
Initial dose: 10-20mg orally (as Methadone SF mixture 1mg/1ml)**.**
Give an additional 5-10mg dose at 4hrly intervals for first 8 hours **if objective withdrawal symptoms persist.** This must be **supervised consumption**.

For the next 2 days give the total of the previous days dose as a single oral dose each morning (must be **supervised consumption**).
Adjust the dose up or down depending upon patient response.
No more than 50 mg daily should be prescribed without specialist advice from SMS.

Buprenorphine:
Buprenorphine is licensed for the treatment of opiate dependence. It may be prescribed instead of methadone. It is best suited for patients with milder to moderate opiate dependence, in particular non-injectors. 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 see below.

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

Initial dose:
Day 1: 2mg b.d or t.d.s **sublingual** (SMS advice is to split dose to avoid precipitating withdrawal symptoms).
Day 2: increase by 2 to 4mg depending on patient response; give total as a **single daily dose**. For further increases advice should be sought from SMS. 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.

iv. Procedure for wards to obtain supplies of methadone/buprenorphine for administration as an in-patient:

During pharmacy opening hours – Order using controlled drugs 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 (see Trust Intranet – "Clinical Departments", "Pharmacy", "Medicines Policy" section)

5. Analgesia in patients prescribed Methadone/Buprenorphine

- Methadone/Buprenorphine does **NOT** provide analgesia due to; once daily dosing, tolerance and opioid hyperalgesia syndrome
- Non-opioid analgesics (paracetamol, NSAIDs) should be used in preference whenever possible
- Opioid analgesia (codeine, morphine, oxycodone) should be prescribed if pain is not adequately controlled and titrated according to pain relief
- Patients taking methadone may require more frequent / higher doses of opioid analgesics to achieve adequate pain control due to cross-tolerance and increased pain sensitivity (hyperalgesia)
- **DO NOT titrate methadone dose to provide analgesia.**
- Opioid analgesia may have limited effectiveness in patients taking buprenorphine as buprenorphine is a partial agonist with higher affinity for opioid receptors than most other opiates, options include using tramadol first-line, dividing the total daily buprenorphine dose into 6-8h dosing and/or temporarily increasing the daily dose of buprenorphine or converting patients to methadone plus opioid analgesia whilst in hospital - seek expert advice:

Contact Acute Pain Team Mon – Fri 08:00 – 16:00 Bleep: 238 WRH/0266 ALX

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 (see Appendix 2)**
2. **Caution with patients disclosing poly drug (e.g. benzodiazepines, amphetamines, cocaine) and alcohol use** – they may experience multiple withdrawals – seek advice from SMS.
3. Consider contra-indication/cautions to Methadone use before prescription e.g. Hepatic/renal dysfunction, head injury, co-prescription of CYP P450 enzyme inhibitors or other CNS depressants, risk factors for QTc prolongation – **check with Pharmacist if unsure.**
4. Routinely complete Liver Function Test for those patients newly started upon Buprenorphine/Methadone.
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 Act 1971 (see Trust Intranet – "Clinical Departments", "Pharmacy", "Medicines Policy" section).
6. **Illegal controlled drugs or unidentified substances:** If a patient is found in possession of suspected illegal drugs there are separate guidelines to manage this. **Please see WAHT-CG-580 Medicines Policy for further details.**
7. A letter of expectation (appendix 3) is available for use for those patients being managed with opiate substitute treatment to outline expectations for the Patient and the Trust providing patient care.

Safety considerations:

- **Naloxone**: All patients should have naloxone PRN prescribed on the "as required" section of their in-patient chart, in case of opiate overdose. Dose: 200 - 400 micrograms IV PRN – repeated after 2 – 3 mins to a maximum of 10mg. 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.**

- **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 patient refuses screening then the prescription should be withheld due to the risk of overdose if the patient has misused illicit drugs. Patient's must be discouraged from using illegal substances on trust premises and documentation of advice should be recorded in notes (see appendix 3).**

- **Always offer advice and information on safer injecting practice, access to needle exchange and support with referral to substance misuse service to access treatment and discuss options.**

- **Always offer harm reduction advice upon discharge that there tolerance levels to opiates may have dropped during their admission and on the risk of poly drug use. Their admission may put them at a heightened risk of overdose should they return to previous use.**

B: Planned Admissions for patients on a programme

1. If a patient discloses that they are receiving methadone/buprenorphine treatment, a letter of confirmation from the prescribing treatment agency/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/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 Trust 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 /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/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/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/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.

Contact Numbers

Cranstoun Worcestershire - County wide service

Tel: 0300 303 8200

Secure Email: cranstounworcsreferrals@cranstoun.org.uk.cjsm.net (N.B. any emails must clearly donate in the email subject that they relate to a hospital admission/discharge)

Alcohol Liaison Nurse Service
Emma.Davies22@nhs.net
Emma.Cuckson@nhs.net

Contact numbers:
Bleep 1340 - Alexandra Hospital
Bleep 565 - Worcester Royal Hospital

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
- https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/673978/clinical_guidelines_2017.pdf

CONTRIBUTION LIST

Key individuals involved in developing the document

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Name	Directorate / Department
All Clinical Directors	WAHT
All Modern Matrons	WAHT

Circulated to the chair of the following committee's / groups for comments

Name	Committee / group
Alison Smith	Medicines Safety Committee

Supporting Document 1 – Equality Impact Assessment form

To be completed by the key document author and included as an appendix to key document when submitted to the appropriate committee for consideration and approval.

Please complete assessment form on next page;

NHS Worcestershire Acute Hospitals NHS Trust

Herefordshire & Worcestershire STP - Equality Impact Assessment (EIA) Form
Please read EIA guidelines when completing this form

Section 1 - Name of Organisation (please tick)

Herefordshire & Worcestershire STP		Herefordshire Council		Herefordshire CCG	
Worcestershire Acute Hospitals NHS Trust	✓	Worcestershire County Council		Worcestershire CCGs	
Worcestershire Health and Care NHS Trust		Wye Valley NHS Trust		Other (please state)	

Name of Lead for Activity	**Emma Davies**

Details of individuals completing this assessment	**Name**	**Job title**	**e-mail contact**
	Emma Davies	**Alcohol Specialist Nurse**	**Emma.Davies22@nhs.net**
Date assessment completed	**29/07/2021**		

Section 2

Activity being assessed (e.g. policy/procedure, document, service redesign, policy, strategy etc.)	**Title:** **WAHT-PHA-008 – Guidelines for the Management of Adult Opiate Dependent Patients in the Acute Hospital Setting.**			
What is the aim, purpose and/or intended outcomes of this Activity?	To provide accurate up to date evidence based clinical guidelines to inform practice and care management of patients attending the Trust who may be dependent upon opiates.			
Who will be affected by the development & implementation of this activity?	☑ ☑ ❑ ❑	Service User Patient Carers Visitors	☑ ❑ ❑ ❑	Staff Communities Other _____
Is this:	☑Review of an existing activity ❑ New activity			

	❑ Planning to withdraw or reduce a service, activity or presence?
What information and evidence have you reviewed to help inform this assessment? (Please name sources, eg demographic information for patients / services / staff groups affected, complaints etc.	http://www.nice.org.uk/PHI004 Drug misuse and dependence UK guidelines on clinical management https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/673978/clinical_guidelines_2017.pdf Contributions from local specialist substance misuse treatment service Cranstoun Recovery Worcestershire Methadone and buprenorphine for the management of opioid dependence Technology appraisal guidance [TA114]Published: 24 January 2007 https://pathways.nice.org.uk/pathways/drug-misuse-management-in-over-16s WAHT Medicines safety Committee Hereford & Worcestershire Medicines & Prescribing Committee
Summary of engagement or consultation undertaken (e.g. who and how have you engaged with, or why do you believe this is not required)	• Service lead consultants • Pharmacy • Hereford & Worcestershire Medicines & Prescribing Committee • Clinical specialist clinicians and Matrons • Governance leads • Community substance misuse service
Summary of relevant findings	All approved, any comments were responded to and changes incorporated into the policy accordingly.

Section 3

Please consider the potential impact of this activity (during development & implementation) on each of the equality groups outlined below. **Please tick one or more impact box below for each Equality Group and explain your rationale**. Please note it is possible for the potential impact to be both positive and negative within the same equality group and this should be recorded. Remember to consider the impact on e.g. staff, public, patients, carers etc. in these equality groups.

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Age	✓			The policy takes into account the differences between age and metabolism of medications, therefore suggesting individual tolerances. It does not discriminate between ages of service users. This policy does not apply to those under the age of 18 years.
Disability	✓			The policy provides clinical guidelines for use of any adult attending an acute hospital setting who may be dependent upon opiates.
Gender Reassignment	✓			The policy refers to any adult regardless of gender.

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Marriage & Civil Partnerships	✓			No concerns identified
Pregnancy & Maternity	✓			This policy is not specific to maternity or pregnancy. Please see: **Obstetric Pathways WAHT-TP-094 Alcohol and Illicit Drug User**
Race including Traveling Communities	✓			No concerns identified
Religion & Belief	✓			None
Sex	✓			None
Sexual Orientation	✓			None
Other Vulnerable and Disadvantaged Groups (e.g. carers; care leavers; homeless; Social/Economic deprivation, travelling communities etc.)	✓			None
Health Inequalities (any preventable, unfair & unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental & economic conditions within societies)	✓			None

Section 4

What actions will you take to mitigate any potential negative impacts?	Risk identified	Actions required to reduce / eliminate negative impact	Who will lead on the action?	Timeframe
		.		
How will you monitor these actions?				

When will you review this EIA? (e.g in a service redesign, this EIA should be revisited regularly throughout the design & implementation)	

Section 5 - Please read and agree to the following Equality Statement

1. Equality Statement

1.1. All public bodies have a statutory duty under the Equality Act 2010 to set out arrangements to assess and consult on how their policies and functions impact on the 9 protected characteristics: Age; Disability; Gender Reassignment; Marriage & Civil Partnership; Pregnancy & Maternity; Race; Religion & Belief; Sex; Sexual Orientation

1.2. Our Organisations will challenge discrimination, promote equality, respect human rights, and aims to design and implement services, policies and measures that meet the diverse needs of our service, and population, ensuring that none are placed at a disadvantage over others.

1.3. All staff are expected to deliver services and provide services and care in a manner which respects the individuality of service users, patients, carer's etc, and as such treat them and members of the workforce respectfully, paying due regard to the 9 protected characteristics.

Signature of person completing EIA	Emma Davies
Date signed	29/07/2021
Comments:	
Signature of person the Leader Person for this activity	Emma Davies
Date signed	29/072021
Comments:	

Supporting Document 2 – Financial Impact Assessment

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

	Title of document:	Yes/No
1.	Does the implementation of this document require any additional Capital resources	No
2.	Does the implementation of this document require additional revenue	No
3.	Does the implementation of this document require additional manpower	No
4.	Does the implementation of this document release any manpower costs through a change in practice	No
5.	Are there additional staff training costs associated with implementing this document which cannot be delivered through current training programmes or allocated training times for staff	No
	Other comments:	

If the response to any of the above is yes, please complete a business case and which is signed by your Finance Manager and Directorate Manager for consideration by the Accountable Director before progressing to the relevant committee for approval

Appendix 1 – Unplanned/emergency Adult Opiate Dependant Patients in the Acute Hospital

Unplanned/emergency presentation e.g. at A & E or AMU

Treat any emergency or acute problem *[note: if patient pregnant, opiate withdrawal could cause miscarriage / premature labour. See separate guideline]*

Patient discloses dependence on opiates (illicit or prescribed)

Assessment:
- dosage
- route of admission
- time last used
- check for IV sites

Confirm use with rapid urine screen (AMU WRH/ALX)

Patient discloses that they are on a methadone /buprenorphine prescription

Confirm treatment: Ask who provides medication. Contact SMS / GP accordingly. Alternatively, dispensing pharmacy may verify

Note time and date med last taken
Confirm use with rapid urine screen

Confirmation established?

No

Yes

Symptomatic relief or opiate substitute may be necessary depending on length of admission. Assess objective signs of opiate withdrawal: yawning, lacrimation, sneezing, runny nose, raised BP/pulse, dilated pupils, diarrhoea, nausea, fine muscle tremor, clammy skin (see Appendix 2 assessment tool)
[NB: heroin withdrawal can start 4-6 hrs after last dose, methadone can take 24hrs or longer]

Liaise with named SMS worker re: prescribing for duration of admission. If methadone, prescribe methadone SF 1mg/1ml mixture. ***Do not prescribe in any other form***

Maintain contact with SMS worker

Yes

Severe withdrawal symptoms?

No

If possible, contact Substance Misuse Services and take their advice. If this is not possible, SHO to consider prescribing the following:
Methadone**: 10 – 20mg orally (as Methadone SF mixture 1mg/1ml). Give additional 5-10mg dose at 4 hrly intervals for first 8hrs if objective withdrawal symptoms persist. For next 2 days give previous days total dose as a single dose each morning (supervised).**No more than 50mg should be prescribed without specialist advice from SMS.
Subutex (Buprenorphine): (suited to milder dependence / non injectors and less sedating than methadone). Day 1: give 2mg bd or tds
Day 2: increase by 2-4mg depending on response. Give total as single daily dose and consult SMS for advice on further increases.
The Alcohol Liaison Nurse may also be contacted to offer advice/support WRH 565/ALX 0340

Symptomatic relief only:
- Loperamide (diarrhoea) 4mg stat, then 2mg after each loose stool (max 16mg daily)
- Metoclopramide (nausea / vomiting) 10mg tds or
- Prochlorperazine 5mg tds / 12.5mg IM 12 hourly
- Mebeverine (stomach cramps) 135 mg tds
-Diazepam (agitation/anxiety/sleep) 5-10mg tds or Zopiclone 7.5mg (nocte)
- NSAIDs, Paracetamol (muscular pains/headaches)

Withdrawal symptoms not effectively managed

Discharge: It should not normally be necessary to discharge with TTO. Named nurse to contact SMS worker prior to discharge to ensure 'script available / continuation of treatment (24hrs notice needed, and service available Mon – Fri only). ***Patients should never be discharged with methadone or buprenorphine unless such arrangements have been made.***

Discharge: Contact SMS to discuss further access to specialist prescribing. This may be subject to a waiting list, unless there are urgent risk factors (e.g. returning to using street drugs), which may compromise patient recovery

Appendix 2 - Clinical Opiate Withdrawal Scale (COWS)

This is an assessment tool for measuring opiate withdrawal symptoms over a period of time.

For each item, write in the number that best describes the patient's signs or symptom.
Rate only on 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: _____

Score Enter scores at time zero and every 2 hours thereafter	**Time**	**Time**	**Time**	**Time**	**Time**	**Time**
Resting Pulse Rate: (record beats per minute) Measured after patient is sitting or lying for 1 minute 0 - pulse rate 80 or below 1 - pulse rate 81-100 2 - pulse rate 101-120 4 - pulse rate greater than 120						
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						
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						
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						
GI Upset: over last ½ hour						

0- no GI symptoms 1- stomach cramps 2- nausea or loose stool 3- vomiting or diarrhoea 5- multiple episodes of diarrhoea or vomiting						
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						
Yawning observation during assessment 0- no yawning 1- yawning once or twice during assessment 2- yawning 3 or more times during assessment 4- yawning several times/minute						
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						
Gooseflesh skin 0- skin is smooth 3- pilo-erection of skin can be felt or hairs standing up on arms 5- prominent pilo-erection						
Total scores **with observer's initials**						

Score	Severity
5-12	mild
13-24	moderate
25-36	moderately severe
>36	severe withdrawal

Appendix 3 - Letter of Expectation

Dear

Following a review meeting of your care, the Trust has agreed the following to support you and keep you safe:

We will make sure we are providing you with the correct medication to treat any opiate withdrawals you may experience but cannot ensure we are doing this if you use unknown illicit drugs, as we do not know the impact these drugs may be having on your treatment or the medication we are giving you.

The Trust encourages you to talk to staff if you are struggling to cope both physically and psychologically and they will discuss with you if there is any other medication you feel you need or arrange someone for you to talk to.

As part of this plan, you agree to the following:

 You will only take prescribed medication given to you by hospital staff.

 You will not take any other medication, illicit or otherwise. Doing so may require a review of your prescribed medications

 You understand the risk to yourself by taking unknown substances.

 You understand that if we believe your behaviour has changed or you appear to be under the influence of an unknown substance, to protect and keep you safe, we may need to ascertain this by undertaking a urine or blood test.

We are aware that your stay in hospital may be longer than you expected and we understand that the days and nights can feel long however, the Trust's aim is to try and minimise the amount of time you spend off the ward as we need to be too able to support you at all times. You must liaise with the ward staff if you want to leave the ward, as in the case of a fire or emergency we need to know your whereabouts.

Whilst visitors are encouraged, we need to ensure the safety of all patients and you understand that accepting illicit drugs or being in possession of illicit drugs whilst in the hospital grounds is both dangerous to your health and treatment.

If you are found in possession of suspected illegal drugs, you will be asked to hand it over voluntarily to a member of staff. These will be returned to pharmacy for destruction. If, however, the quantity is so large that the drug could not be purely for personal use, the Accountable Officer Associate Director - Medicines Optimisation or their nominated deputy may decide that the public interest outweighs your right to confidentiality and that therefore the police will be informed.

Unacceptable behaviour on trust property: any threatening, angry abusive attitude/language to staff will not be tolerated. The Trust has a zero toleration policy and that this may lead to you being removed from the ward/unit or police being called.

Ultimately, the Trust wants the best outcome for you and now you have agreed this plan, we hope your treatment will continue to improve your situation and you will be able to return home shortly.

Yours sincerely

Emma Davies

Alcohol Liaison Nurse

Patient's name: ……

Patient's signature:……..……

Date:……

Witnessed by (print name): ……

Designation:……..….

Signature:……

Date:…….