Northamptonshire Healthcare
NHS Foundation Trust

MMG028 GUIDELINES FOR OUT OF HOURS TREATMENT OF OPIOID DEPENDENT PATIENTS ON INPATIENT WARDS

Table of Contents

Why we need this Guideline

Opioid dependent patients can be admitted to inpatient areas at any time and, if provision is not made to manage their opioid dependence, they may experience withdrawal symptoms. It is important that doctors understand the steps to follow and factors to consider when managing these patients particularly when expert advice is not readily available out of hours.

What the Guideline is trying to do

To provide advice for Doctors for the initial treatment of opioid dependent patients on admission

Which stakeholders have been involved in the creation of this Guideline

Medicines Management Committee

Dr A Nayar

Any required definitions/explanations

NHFT - Northamptonshire Healthcare NHS Foundation Trust

Key duties

Medicines Management Committee

Will approve and review these guidelines

Medical Director

Is responsible for the dissemination of this guideline to their Clinical Directors and Clinical Tutors

Clinical Directors

Are responsible for the dissemination and implementation of the guideline in their service areas

Heads of Service

Are responsible for the dissemination and implementation of the guideline in their service areas

Doctors

Are responsible for reviewing the patient and prescribing opioid substitution treatment where appropriate

Guidelines for management of Opioid Dependent Patients on Inpatient Wards Out of Hours

General Guidance

- Always obtain a history of recent substance use - prescribed and non-prescribed drugs, including duration of use, frequency of use and route of administration (including any misuse of prescribed medication). Drug interactions should also be considered. Concomitant use of opiates with benzodiazepines, alcohol and other CNS depressant drugs may result in fatal respiratory depression.

- Always check the Summary of Product Characteristics (SPC) for full details of side effects, contraindications and drug interactions.

- Avoid prescribing other opiate medications (for example, codeine). This increases the risk of opiate related side effects/toxicity and also may interfere with urine drug screening.
- Always perform an ECG on admission.
- Always consider blood borne infections

If patient is already in treatment and in receipt of a replacement opioid script

Contact the dispensing pharmacy to verify the script specifics and the prescribing service. Confirm the dispensing arrangements and the dates of latest collection. Confirm whether the medication is consumed supervised at the pharmacy or collected to be consumed at home (unsupervised). Several pharmacies open late and are open on weekends.

If the dispensing pharmacist verifies the script and confirms that the patient is in a treatment programme, you may consider continuation of the prescription (as below). You need to request that the prescription at the pharmacy is cancelled to avoid double scripting.

Always try to confirm the script details from the prescribing service as soon as possible so that they can provide additional details and continue the patient's treatment on discharge.

Always confirm the above details with the patient (how much prescribed medication was used over the last few days and when was the last time medication was consumed).

Always conduct a drug screening test (commonly a urine sample is used) prior to prescribing any opioid substitution treatment.

- If the medication (methadone or buprenorphine) is consumed on site (supervised dispensing at the pharmacy) and the patient has not missed 3 days or more of their regular prescribed dose, treatment may continue at the current doses.
- If the medication (methadone or buprenorphine) is not consumed on site (medication is collected to be consumed at home) and the patient has not missed 3 days or more of their regular prescribed dose, treatment could continue at the current doses but regular monitoring will be required (especially at doses of methadone over 40 ml) to avoid opioid toxicity in cases where the medication was not used as prescribed. Split dosing may be used to decrease risk of toxicity. In any case of uncertainty, re-titration of the prescribed opioid medication is the preferred approach.
- If the patient has missed 3 days or more of their regular prescribed dose, re-titration of the prescribed opioid medication will be required. Seek advice from substance misuse service at earliest opportunity.

Always inform the prescribing service of the date of discharge with as much notice as possible (at least one day) and take into account drug services opening hours, especially if considering discharge on a Friday or over the weekend.

If a patient is not in a treatment programme and does not have a script

Please bear the following in mind:

- The opioid withdrawal symptoms are not commonly life threatening unless the individual is severely physically compromised. However, opioid toxicity may be fatal.

- Withdrawal symptoms usually occur 6 to 8 hours after last heroin use and 18 to 48 hours after last methadone use.
- Always contact the local Drug services, if possible before initiating treatment to discuss the clinical circumstances and make post-discharge arrangements.
- Always contact the local Drug services as a matter of priority if you have a pregnant opiate user.
- An admission in the evening commonly allows decisions to be made the following morning as withdrawal symptoms from opioids may not be severe for at least a few hours.
- Always take a full history and do a urine drug test.

Establish broadly which category below the patient falls into:

Category 1- Minimal heroin use and an immediate cessation of drug use is wanted by the patient

In this case symptomatic drugs can be prescribed such as hyoscine butylbromide (Buscopan®) for stomach cramps, ibuprofen for pain and loperamide for diarrhoea, with regular monitoring. Small doses of codeine within BNF limits and on a reducing scale may be considered.

Category 2 - The patient requires opioid substitution treatment.

In this case the additional following steps should be taken:

- The process for starting a patient on Methadone/Buprenorphine can happen in the morning after the admission the previous evening.
- Titration can be carried out in low small increments, for example with 10ml methadone with a further 10ml FOUR hours later with a maximum of 20ml on Day 1. The dose can be increased to 30ml on day 2 and to 40ml on day 3. If the dose needs to go above this, to contact the local drug services.
- Regularly assess withdrawal symptoms and symptoms of opioid intoxication. (The use of formal rating scales may be considered as an adjunct to, but not a substitute for, clinical assessment.)
- Higher trainees or consultants on call can discuss the case with the trust's clinical lead on substance misuse, if needed.
- All wards should have rapid access to naloxone hydrochloride in case of opiate induced respiratory depression.

Information that the local drug services will require:

- Urine drug screening results
- Substance misuse history, particularly of opioids/heroin: amounts, patterns of use and route of administration.
- Other substances: cocaine (powder or crack), amphetamines, benzodiazepines (illicit or prescribed) and alcohol.
- History of past treatment under Drug and Alcohol services, outcomes, complications.
- Past medical and psychiatric history / reasons for current admission.
- Social circumstances / family circumstances / dependents
- Risk assessment / MHA status
- Post discharge arrangements / CPA provisions

Training requirements associated with this Guideline

Mandatory Training

There is no mandatory training associated with this guideline.

Specific Training not covered by Mandatory Training

Not applicable to this document

How this Guideline will be monitored for compliance and effectiveness

There is no monitoring associated with this guideline.

Equality considerations

Refer to MMP001 Control of Medicines Policy

Reference Guide

BNF online

Department of Health (England), the Scottish Government, Welsh Assembly Government and Northern Ireland Executive (2017). *Drug misuse and dependence UK guidelines on clinical management.*

National Institute for Clinical Excellence. (2007). *Methadone and buprenorphine for the management of opioid dependence* (Technology Appraisal Guidance TA 114*).*

Document control details

Author:	Dr Konstantinos Stagias - Consultant in Addictions Psychiatry
Approved by and date:	MMC – September 2018
Responsible committee:	Medicines Management Committee
Any other linked Policies:	-
Guideline number:	MMG028
Version control:	2

Version No.	Date Ratified/ Amended	Date of Implementation	Next Review Date	Reason for Change (eg. full rewrite, amendment to reflect new legislation, updated flowchart, minor amendments, etc.)
1	15.11.16	15.11.16	30.11.18	Review
2	11.09.18	01.11.2018	30.09.20	Review