



Policy for in-patient and out of hours management of adult drug misusers

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Type of document	Policy
Target audience	All CWP staff
Document purpose	<p>This policy is intended to ensure that:</p> <ul style="list-style-type: none"> • Double prescribing of medication does not occur • Good clinical practice is followed for patients with drug misuse problems • There is continuity of care

Approving meeting	Patient Safety and Effectiveness Sub Committee	15-Jun-15
Implementation date	Jun-15	

CWP documents to be read in conjunction with	
HR6	Trust-wide learning and development requirements including the training needs analysis (TNA)
MP1	Medicines Management Policy

Document change history	
What is different?	<ol style="list-style-type: none"> 1. 2. - contacts - Wirral Drug Service, Central Cheshire drug service & West Cheshire Drug service changed to new service providers names - 2. 2.1 - The Clinical Director(s) of the Drug and Alcohol Services of the Cheshire and Wirral Partnership NHS Foundation Trust can be contacted out of hours through every hospital switchboard has been removed 3. 2.10 - Clinical Director changed to pharmacist
Appendices / electronic forms	Appendix 1 & 2 added
What is the impact of change?	

Training requirements	No - Training requirements for this policy are in accordance with the CWP Training Needs Analysis (TNA) with Learning and Development (L&D)
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Financial resource implications	No
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External references	
1.	Drug Misuse and Dependence – UK Guidelines on Clinical Management (last updated September 2007)
2.	Quantum Diagnostics Ltd, Unit 9, Meridian Business Park, Fleming Road, Waltham Abbey EN9 3BZ. Tel: 01992 651 111.
3.	Concateno PLC, Garrett House, Garrett Field, Birchwood Science Park, Warrington, WA3 7BP Tel: 01925 848900, Fax: 01925848949. email: info@altrix.com.

Equality Impact Assessment (EIA) - Initial assessment	Yes/No	Comments
Does this document affect one group less or more favourably than another on the basis of:		
- Race	No	
- Ethnic origins (including gypsies and travellers)	No	
- Nationality	No	
- Gender	No	
- Culture	No	
- Religion or belief	No	
- Sexual orientation including lesbian, gay and bisexual people	No	
- Age	No	
- Disability - learning disabilities, physical disability, sensory impairment and mental health problems	No	
Is there any evidence that some groups are affected differently?	No	
If you have identified potential discrimination, are there any exceptions valid, legal and/or justifiable?		
Is the impact of the document likely to be negative?	No	
- If so can the impact be avoided?	N/A	
- What alternatives are there to achieving the document without the impact?	N/A	
- Can we reduce the impact by taking different action?	N/A	
Where an adverse or negative impact on equality group(s) has been identified during the initial screening process a full EIA assessment should be conducted.		
If you have identified a potential discriminatory impact of this procedural document, please refer it to the human resource department together with any suggestions as to the action required to avoid / reduce this impact. For advice in respect of answering the above questions, please contact the human resource department.		
Was a full impact assessment required?	No	
What is the level of impact?	Low	

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Local Drug Service Contact Details:

East Cheshire Drugs Service: (CWP) Catherine House Crewe:	Tel: 01270216118
	Fax: 01270585412
East Cheshire Drugs Service: (CWP) Barnabas Centre Macclesfield:	Tel: 01625422100
	Fax: 01625669204
Cheshire & West Drug service: (Turning Point) Ellesmere Port & Chester:	Tel: 03001232679
	Fax: 01244409418
Wirral Ways to Recovery: (CRI):	Tel: 0151 556 1335
	Fax: 0151 203 3111

1. Introduction

Opiate dependent people have a high level of medical morbidity and are often admitted to Accident and Emergency Departments or other hospital settings. The aim of this policy is to help clinicians prescribe safely, and manage opioid /opiate withdrawal, so that the patient can have appropriate treatment for the condition that has resulted in the hospital admission. Illicit drug use is common and asking about drug and alcohol use should form part of routine history taking on admission to hospital. The link between illicit drug use and the reason for admission may be simple or complex. Many opiate dependent patients are prescribed methadone or other drugs by their local drug service. Community pharmacists dispense the medication and can verify dosage and dispensing days, thus reducing the risk of double prescribing of medication occurring. CWP Drugs & Alcohol Services only in East Cheshire, so contact must be made with the external locality services above.

Opiate withdrawal is **NOT LIFE THREATENING** and usually occurs 6-12 hours after the last heroin use or 18-48 hours after methadone.

1.1 Assessment

On identifying a patient with a drug misuse issue it is important to undertake an assessment. Take a careful history of recent drug use which should include:

- Name of all drugs used (prescribed, over the counter, purchased via the internet, 'street' drugs and alcohol and benzodiazepine use)
- Average daily amount taken
- Routes of administration (oral/IV/IM/SC/snorted/smoked)
- Does the patient report withdrawal symptoms? (If so what are they?)
- When were the substances last used?
- If prescribed substitute medication for dependency, check with the appropriate drug service and/or pharmacy for details of dose, medication, date last dispensed and whether patient currently on supervised consumption.

Additional confirmation of drug use can be obtained from:

- GP
- Drug & Alcohol Service
- Dispensing Community Pharmacy

On examination look for:

- Signs of intoxication (includes euphoria / relaxation, constricted 'pin point' pupils, drowsiness/sedation, impaired balance, slurred speech, poor attention and concentration, decreased levels of consciousness)(appendix 5)
- Signs of Opioid withdrawal (appendix 4)
- Confirmatory evidence of drugs use (e.g. marks – check groin, thrombosed veins, cellulites, old scars)
- Use instant urine testing to check on opiate, stimulant, methadone and benzodiazepine usage
- Blood can be sent to the laboratory to confirm blood alcohol levels

2. Management Guidance

- Unless obvious opiate withdrawal characteristics are present, urgent prescribing is rarely necessary
- To avoid illicit drug use on the ward patients should be advised that it is against both hospital rules & the Law for them to bring in or use drugs on hospital property & that such activity would put them, other patients and staff at risk of harm
- Ingestion of prescribed medication should be observed. Urine screening can be used to check compliance with treatment
- During the admission, the patient should be given the opportunity to discuss post- discharge treatment with the local Drug & Alcohol Treatment Service
- If the patient does not wish to engage further with the local Drug & Alcohol Treatment Service, then **NO** substitute medication is prescribed at discharge
- Some patients may also be dependent on a variety of other drugs- particularly alcohol and benzodiazepines which may lead to severe withdrawal states and may require a reduction programme using a substitute drug. Chlordiazepoxide is the drug of choice for treatment of alcohol. There is a separate alcohol detoxification guidance within the Trust to refer to (MP)
- Some patients may request benzodiazepines or hypnotics such as zopiclone. Such requests may be for continuation of a regular prescription, for the treatment of opioid withdrawal symptoms or for the treatment of illicit benzodiazepine dependence. Such requests should always be treated with extreme caution. All claims as to current treatment should be checked before starting an inpatient prescription. Benzodiazepines and hypnotics should not be used for the treatment of opioid withdrawal symptoms. Benzodiazepine withdrawal requiring treatment is relatively rare and advice should be generally is sought unless urgent treatment is required

Advice and information can be sought from the Trust local pharmacy department and / or the mental health pharmacist.

2.2 Advice on patients admitted Monday to Friday 09:00- 17:00

- Complete a drug history and take an instant urine to check for; opiate, stimulants, methadone and benzodiazepine
- Assess clinical state of the patient
- Contact the local Drug & Alcohol Treatment Service
- Unless there are contra indications, the patient should continue on the same dose of prescribed medication and the drug service can cancel any outstanding prescriptions
- The regular prescriber and community pharmacist should be contacted to prevent the patient and anyone else collecting their prescription whilst they are in hospital
- If the patient is not known to the service or has been out of contact with the service, the service can advise regards to safe substitute opioid prescribing
- Notice should be given to the drug service in good time prior to discharge so plans can be put in place for continuation of the patient's medication on leaving hospital

2.3 Advice on patient's admitted out of hours

It is essential that the following steps have been followed:

- In the rare event that substitute opioid prescribing is deemed necessary, then:
- Confirm the history with an instant urine drug test
- If there is any doubt about the dose of substitute opioid medication, give an initial dose of methadone mixture (1mg/1ml) of up to **30mg**, & if withdrawal persists, a further dose of **10mg** can be given 12 hours later
- Continued efforts should be made to contact the patient's Drug Service (contact is usually during office hours)
- Follow algorithm for out of hours (appendix1)
- Observe the patient closely for the first 72 hours to look for signs of over sedation and respiratory depression from the methadone
- All wards must have rapid access to Naloxone Hydrochloride (Narcan) to enable reversal of respiratory depression from opiates such as methadone and heroin (appendix2) For mode and sites of administration see (appendix3)

2.4 Patients seen for treatment in Accident & Emergency

Patients attending at Accident & Emergency should not need replacement methadone unless they are admitted to hospital. Opiate withdrawal is **NOT** a medical emergency, as opposed to an alcohol withdrawal, which can be.

2.5 Treatment for stimulant withdrawal

Patients who use stimulants (amphetamines or cocaine) do not usually show a true withdrawal syndrome though they may exhibit intense drug craving behaviour and may become depressed.

2.6 Injectable prescribing

Some patients are on injectable rather than oral methadone and even fewer on prescribed heroin (diamorphine). Injectable drugs should **NOT** be administered in hospital unless there is some specific medical reason

2.7 Benzodiazepines

A small percentage of patients are prescribed benzodiazepines and this prescription may continue as an inpatient following confirmation by the local Drug Service.

2.8 Cautions

- Methadone can interact with other drugs. This especially applies to other medication sedative and enzyme inducers such as rifampicin and phenytoin
- It is important to remember that the half- life of methadone is about 24 hours

2.9 Patients being granted home leave from mental health units

- If an in-patient is prescribed substitute medication for the treatment of dependency (usually methadone) and is granted a period of home leave, the mental health unit is responsible for liaison with other services and the co-ordination of arrangements for dispensing of the substitute medication
- Where the period of leave is less than 72 hours, the substitute medication should be issued either via the hospital pharmacy or by using a community prescription (the pharmacist can advise on this)
- Consideration should be given to arranging daily collection and supervised consumption of the medication depending upon identified risk
- Where the period of leave is greater than 72hours, the ward must contact the local Drug Service and arrangement agreed for the Drug Service to issue a prescription for the dispensing of the substitute medication from the community pharmacy. The Drug Service requires a period of at least 2 working days notice to facilitate this
- When a patient returns to the unit from home leave, the Drug Service must be notified immediately to enable any prescription placed with a community pharmacy to be cancelled. The in-patient unit would then resume responsibility for all prescribing

2.10 Discharge

- The regular prescriber should be informed if possible 48 hours before discharge so there should be no need to take a methadone supply home
- It is important to inform the patient about arrangements that have been made, as they will be anxious if left without medication
- If a patient is discharged over the weekend a supply of medication can be obtained for a maximum of 2 days
- There may be rare occasions e.g. Bank holidays where a 3 day prescription should be supplied as the local Drug Service may be closed on the Bank Holiday

2.11 Atypical prescriptions:

- There is a minority of patients who are prescribed non methadone prescriptions for drug misuse. The three circumstances to phone the pharmacist if there are any problems are:
- Patients prescribed Buprenorphine as there may be complications with prescribing further analgesia
- Patients under the age of 18 years, as very few will fall into the category of requiring a substitute prescription
- Anyone prescribed diamorphine any of its derivatives from the Drug Treatment Service may need to be converted to different medication on in- patient admission
- There are special management issues in pregnancy due to the risk of withdrawal and advice should be obtained from the Community Drug Team and/maternity services and/or mental health pharmacist

2.12 Analgesic Needs

- Patients maintained on methadone may require additional medication for pain control, depending on their medical condition or procedure
- If indicated opioid analgesia in the appropriate dosage and frequency should be given
- Patients should be carefully observed for signs of over sedation

Please not due to the mixed agonist/ antagonist properties, specialist advice should be sought regarding pain control, for patients prescribed Buprenorphine (Subutex or Suboxone)

2.13 Naloxone Hydrochloride

Naloxone may be given for the reversal of opioid depression effects following overdose **but should be used with caution in pregnancy**. See BNF for dosages. The duration of action can last from 45 minutes up to 3-4 hours depending on route of administration, dose and individual variations in liver metabolism. The duration of action of certain opioids such as methadone, dihydrocodeine, buprenorphine and detropoxyphene can outlast a dose of naloxone. Patients who have been treated with naloxone should be observed for signs of recurrent overdose for up to 24 hours. If patient self-discharges they **MUST** be advised of the high risk of overdose when naloxone wears off and if they should take further opiate drugs.

2.14 Symptom control medication

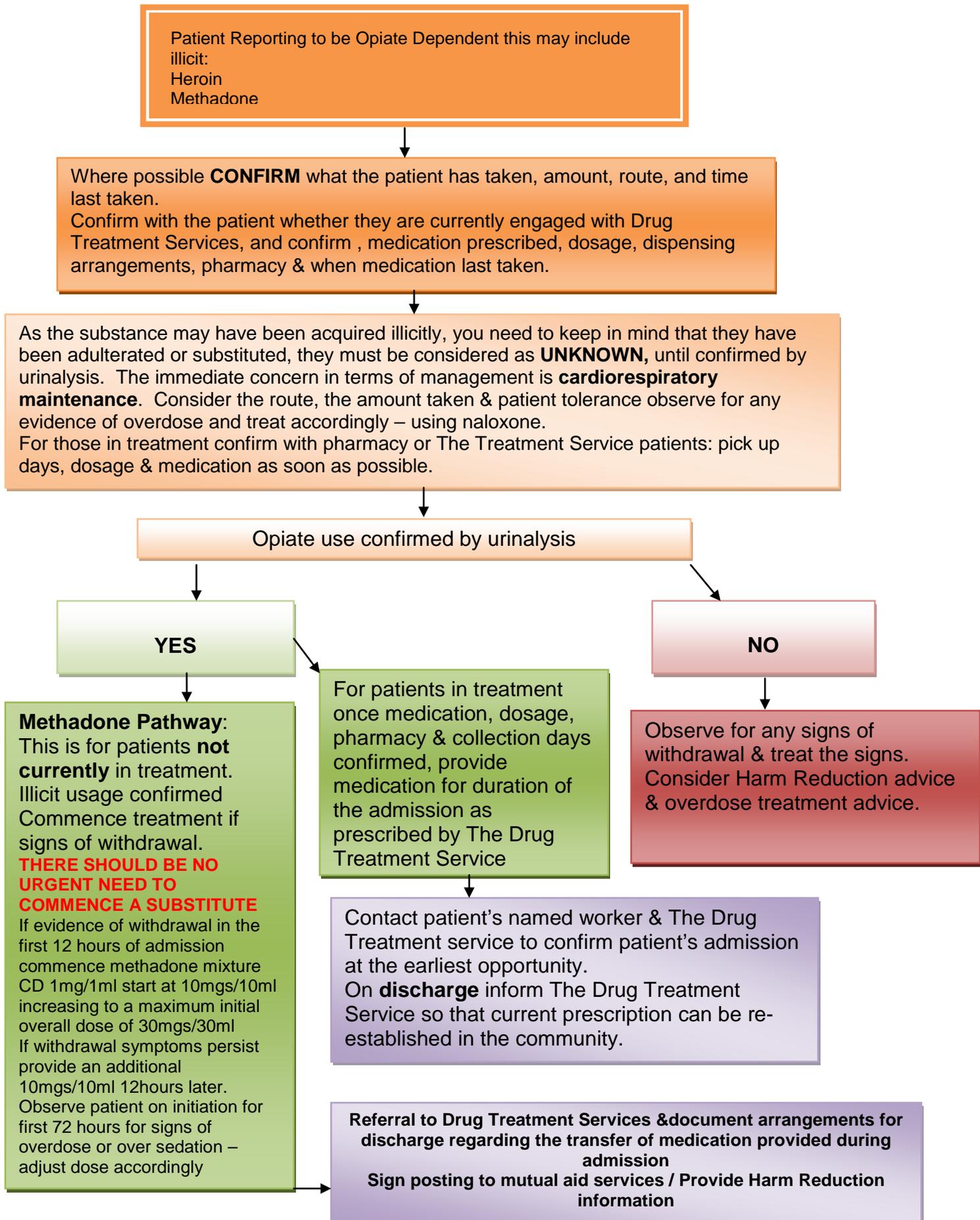
Any patient withdrawing from opiates may benefit from symptomatic relief of the following symptoms with the following non-opiate drugs: Abdominal cramps:	Mebeverine 135mg tds
Diarrhoea:	Loperamide 4mg initially then 2mg with each loose stool
Muscle and joint pain:	Paracetamol or NSAIDS
Anxiety and agitation:	Promazine 25 mg tds prn (maximum 200mg/day) Quetiapine 25-50mg tds (second line)
Night muscle cramps:	Quinine sulphate 200mg nocte (should not be needed at the start of detoxification).

These can be given for a period of 7 to 10 days.

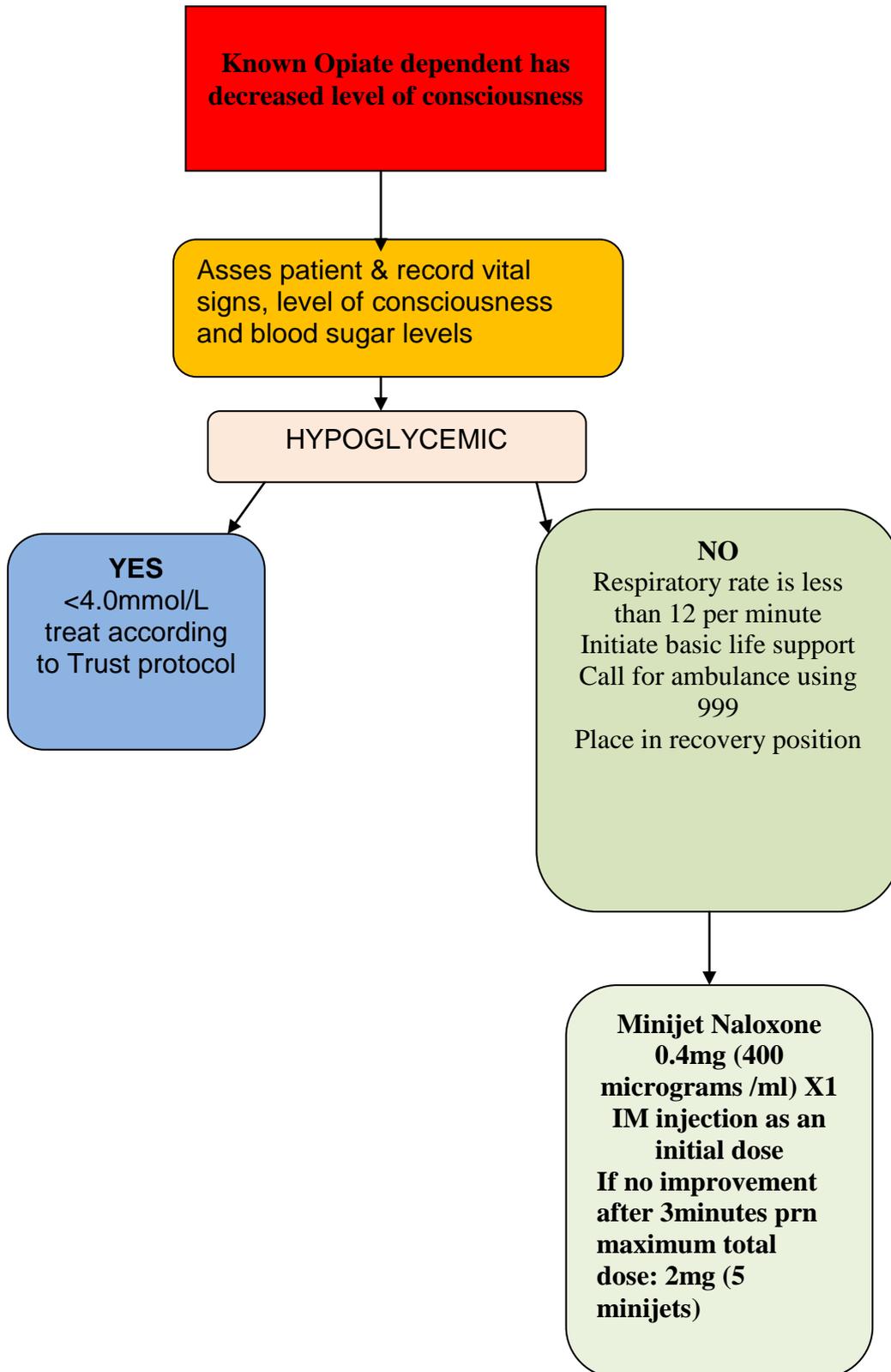
2.15 Summary

- Ask patient if they use illicit drugs & take a history
- Confirm with an instant urine test
- Check with the local Drug Service between Monday – Friday 09:00-17:00
- Telephone pharmacist if any further advice is required
- If the patient is showing signs of opiate withdrawal and the local Drug Service can not be contacted then methadone should be prescribed with care following the algorithm in (appendix1)
- Inform the Drug Service of admission at earliest opportunity and again prior to discharge

Appendix 1 Opiate Misuse Algorithm for out of hours

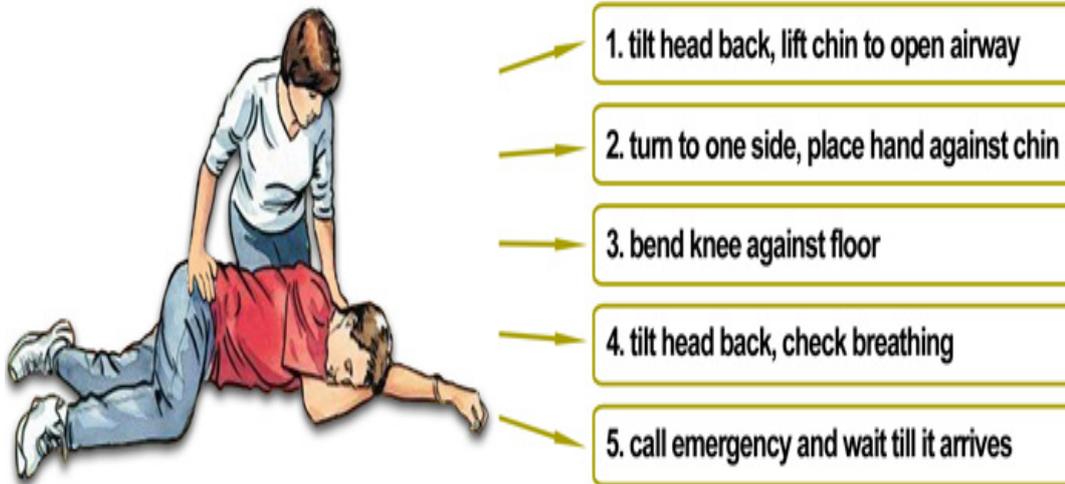


Appendix 2 – Managing suspected Opioid overdose using Naloxone



Appendix 3 Pictorial action when using Naloxone

Overdose Recovery Position



Consider Naloxone



Appendix 4. Subjective Opiate Withdrawal Scale (SOWS)

Instructions: Answer the following statements as accurately as you can. Circle the answer that best fits the way you feel now.

Symptom	Not at all 0	A little 1	Moderately 2	Quite a bit 3	Extremely 4	How long after your last dose did THIS symptom begin? (hours)
I feel anxious.						
I feel like yawning.						
I'm perspiring.						
My eyes are tearing.						
My nose is running.						
I have goose flesh.						
I am shaking						
I have hot flashes						
I have cold flashes.						
My bones and muscles ache.						
I feel restless						
I feel nauseous.						
I feel like vomiting						
My muscles twitch.						
I have cramps in my stomach.						
I feel like using now.						

The Subjective Opiate Withdrawal Scale (SOWS) consist of 16 symptoms rated in intensity by patients on a 5-point scale of intensity as follows:

0=not at all

1=a little

2=moderately

3=quite a bit

4=extremely

The total score is a sum of item ratings, and ranges from 0 to 64.

Mild Withdrawal is considered to be a score of 1 - 10

Moderate withdrawal is considered to be a score of 11 – 20

Severe withdrawal is considered to be 21 - 30

Source: Reprinted from Handelsman et al. 1987, p. 296, by courtesy of Marcel Dekker, Inc.

Other Sources : Gossop 1990; Bradley 1987

Appendix 5 Symptoms of withdrawal

Opioid withdrawal reactions are very uncomfortable but are not life-threatening. Symptoms usually start within 12 hours of last heroin usage and within 30 hours of last methadone exposure

Stage	Grade	Physical Signs and Symptoms
Early Withdrawal (8–24 hours after last use)	1	Lacrimation Rhinorrhea Diaphoresis Yawning Restlessness Insomnia
	2	Piloerection Muscle twitching Myalgia Arthralgia Abdominal pain
Fully Developed Withdrawal (1-3 days after last use)	3	Tachycardia Hypertension Tachypnea Fever Anorexia Nausea Extreme restlessness
	4	Diarrhea Vomiting Dehydration Hyperglycemia Hypotension Curled-up position