PATIENTS PEOPLE POPULATION

Sandwell and West Birmingham NHS Trust

GUIDELINES ON MANAGEMENT OF PATIENTS WHO ARE DEPENDENT ON OPIOIDS (INCLUDING THOSE ON ORAL SUBSTITUTION THERAPY WITH METHADONE OR BUPRENORPHINE)

SWBH/Toxicology/02

Guideline Author and Job Title	Dr Mark Pucci, Consultant in Clinical Toxicology Professor Sally Bradberry, Director West Midlands Poisons Unit Kathleen McAteer, Drug Clinical Nurse Specialist Dr Jake Kilmartin, Resident Doctor
Group, Directorate and Specialty Approval	Governance group for Clinical Pharmacology and Clinical Toxicology & Emergency Care Directorate; Drugs & Therapeutics Committee
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Search Terms / Words that are Not in the Title	Opioid, opiate, methadone, buprenorphine, heroin

- **Consultation process:**
  This guideline has been written in consultation with Adarsh Ramegowda, Consultant in Addiction Psychiatry for CGL, Angela Arnold, Specialist Midwife, and Lauren Starbrook, Consultant Clinical Scientist.

- **If review of existing guideline what has been changed:**
  This update introduces the role of the Drug CNS and contains important changes to the requesting of urine drugs screens for patients prescribed opioid substitution therapy.

- **What National Guidance has been incorporated:**
  NICE TA114: Methadone and buprenorphine for the management of opioid dependence.

- **Scope (who does the guidelines apply to or not apply to):**
  This guideline applies to all clinicians managing inpatients who are dependent on opioids.

DOCUMENT CONTROL AND HISTORY

Version No	Date Approved	Date of implementation	Next Review Date	Reason for change (e.g. full rewrite, amendment to reflect new legislation, updated flowchart, etc.)
2	Jun. 2013	Jun. 2013	Jun. 2016	
3	Feb. 2018	Feb. 2018	Feb. 2021	Updated to reflect possibility of initiation of substitution therapy in exceptional circumstances
4	Jul. 2019	Aug. 2019	Aug. 2022	Reviewed again in absence of receipt of Emergency Care Directorate approval
5	Nov. 2021	Nov. 2021	Nov. 2024	Updated following consultation with CGL
6	Oct. 2024	Nov. 2024	Nov. 2027	Update to management guidelines

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KEY POINTS

1. The care planning involved in opioid dependent patients is often challenging and expert advice from the Drug Clinical Nurse Specialist (CNS) should be sought whenever there is uncertainty regarding best management. Out of hours, the on-call Consultant Clinical Toxicologist should be consulted.

2. Inpatients who are already prescribed opioid substitution therapy in the community should continue this treatment while in hospital. This should commence as soon as possible. A community prescription must have been confirmed with either community drug services or the community pharmacy to ensure the last dose was not longer than 3 days earlier.

3. Patients who take opioids without prescription and who require an inpatient stay may be considered for opioid substitution therapy but only on the advice and direction of the Drug CNS, who would be advised by the Clinical Toxicologist. Out of hours, the on-call Clinical Toxicologist can be consulted directly if it is urgent.

4. All patients currently prescribed, or being considered for, opioid substitution therapy, are required to provide a urine sample on admission. This should be sent for ‘drugs of abuse screen’ and ‘OST prescribing set.’ Daily urine screens are no longer required.

5. Opioid withdrawal is not a life-threatening condition. Symptoms of opioid withdrawal can usually be managed with symptomatic therapeutic interventions. However, opioid withdrawal must be effectively managed to prevent or minimise discharges against medical advice.

PLEASE NOTE, THAT THIS LIST IS DESIGNED TO ACT AS A QUICK REFERENCE GUIDE ONLY AND IS NOT INTENDED TO REPLACE THE NEED TO READ THE FULL GUIDELINE.

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SWBH/Toxicology/02

INTRODUCTION

These guidelines are intended to help clinicians manage inpatients with opioid dependence across all locations within SWB Trust. These patients can be challenging and with complex social, psychological, and physical health issues, but are entitled to the same high standards of care we afford to all.

Opioids should always be prescribed with caution due to the risk of toxicity and death from respiratory depression in overdose. Patients have died in hospital due to overdose of opioids prescribed by doctors. However, denial of appropriate prescription of opioids in such patients can also have a negative impact on their care, resulting in increased pain, symptoms of withdrawal, and an increased risk of self-discharge against medical advice before adequate treatment has been given.

There are 3 common scenarios that can cause uncertainty for clinicians not experienced in the management of such patients, and these will be the focus of this guideline:

- Patients already prescribed maintenance opioid substitution therapy (OST) prior to admission
- Patients who take opioids without prescription (illicit drug use)
- Pain management in opioid dependent patients

This guideline also covers management of opioid withdrawal and advice regarding pregnant patients who are using opioids.

OTHER POLICIES TO WHICH THIS POLICY RELATES

N/A

GLOSSARY AND DEFINITIONS

- **OST** – Opioid substitution therapy
- **EDDP** – 2-ethylidene-1,5-dimethyl-3,3-diphenylpyrrolidine (methadone metabolite)
- **6-MAM** – 6-monoacetylmorphine (heroin metabolite)
- **COWS** – Clinical Opiate Withdrawal Scale
- **DAS** – Drugs of abuse screen (urine)
- **CNS** – Clinical Nurse Specialist

PRINCIPLES

Patients dependent on opioids may experience psychological and physical symptoms of withdrawal when they do not have access to these drugs. However, while opioid withdrawal may be unpleasant, it is not a life-threatening condition. In contrast, overdose of opioids can be fatal.

ROLES AND RESPONSIBILITIES

It is the responsibility of the Consultant in charge of the patient's care to ensure opioid dependent patients are identified and managed appropriately.

ROLE OF DRUG CLINICAL NURSE SPECIALIST

- Referral to the Drug CNS should be done as soon as illicit drug misuse is identified.
- Referrals can be made through Unity, calling 6143 or bleep 5117.

The role of the Drug CNS is:

- To obtain an accurate history of what illicit substances are currently being used, including how often and how much is being used.
- To identify any risk factors associated with illicit drug use such as safeguarding, sex working, blood-borne virus transmission and overdose.
- To manage/prevent withdrawal from illicit substances.
- To provide psychosocial interventions and harm reduction advice.
- To ensure clear links and communication between hospital and community services, including making referrals to community drug services.
- To guide clinical staff in the appropriate treatment and care of patients with substance misuse.
- To provide necessary education to clinical staff.

Appendix 1: Summarizes the management pathway for all patients.

Additional information and explanations are provided in the text below.

MANAGEMENT OF OPIOID DEPENDENT PATIENTS ON COMMUNITY OPIOID SUBSTITUTION THERAPY

Initial history

An accurate drug history should be taken when a patient is admitted to hospital, including both prescribed and illicit drug use. If a patient states they are prescribed OST, usually either oral methadone (Physeptone) or buprenorphine (Espranor or Subutex), this information needs to be corroborated appropriately before

prescription.

If the patient is already receiving OST, the following information needs to be obtained:

- The usual prescriber (usually GP or Community Drugs Team – which will depend on patient postcode – see Appendix 4)
- The dispensing pharmacy
- Dose
- Form and strength (there is more than one form of methadone and buprenorphine available)
- Whether consumption is supervised or unsupervised
- Date last picked up
- Date and time of last dose taken

The ward pharmacist or Drug CNS can help to acquire this information, but it is the prescriber's responsibility to ensure it is obtained and documented. This information is best obtained from the community pharmacy the patient collects their OST from. Once the above information is confirmed, then the patient's OST prescription can be continued.

Liaison with community prescribers

The healthcare professional obtaining OST information must ensure the community pharmacy understands that this patient is now admitted to hospital, and that the hospital will temporarily be taking over the prescribing and administering of OST. Community prescriptions must be put on hold to ensure patients do not leave the ward to collect their doses, which could result in them receiving duplicate doses of OST for that day.

Be mindful that some dispensing clinics provide 'take home' doses of OST on a Friday for use on Saturday and Sunday. Patients may therefore have their own supply of OST which should be stored in the controlled drug cupboard.

If a patient has not picked up their prescription for 3 or more days, then their usual treatment **should not** be prescribed. The patient's tolerance to opioids will have reduced, and they are at risk of overdose if their previous dose is prescribed. OST can be restarted following guidance from the Drug CNS or Clinical Toxicology team.

It is also important that the community drug service team are aware of the patient's admission to hospital. This will prevent confusion when the patient has not been taking their community doses. Typically, the Drug CNS will communicate with community drug services regarding admission and discharge. **If there is no clear documentation of this communication, please check with the Drug CNS that a prescription is in place before discharging the patient.** Community drug services only provide a Monday to Friday service. If patients are being discharged on a Friday, appropriate arrangements must be made for them to attend community drug services. Otherwise, OST should be considered as a TTO. **Ideally patients should receive a dose of OST on the day of discharge prior to departure.**

Baseline investigations

- On admission, patients are required to provide a urine sample for a drugs of abuse screen (DAS) to confirm which OST they are taking but to also identify the use of other illicit substances. An 'OST prescribing set' should also be requested. **These should be sent in two separate white top universal containers.** Note, a DAS will only be processed by the toxicology laboratory in normal working hours (Monday to Friday), but OST prescribing sets can be completed out of hours (see section below for admission out of hours). **If an OST prescription has been confirmed with community services, the prescriber does not need to wait for these results to prescribe OST.**

- **The urine 'OST prescribing set' is available 24/7 and will test only for EDDP (methadone metabolite) and 6-MAM (heroin metabolite).** You can identify the correct test by searching OST, 6-MAM, heroin, EDDP or methadone.

- Please note 'OST prescribing set' does not test for buprenorphine. Testing for buprenorphine requires a urine DAS.

- If the urine is positive for 6-MAM (heroin metabolite), then a frank discussion should be had with the patient to ensure they understand that illicit opioid use while an inpatient will not be tolerated.

- **All patients being commenced on methadone should have a baseline 12-lead ECG to check the QT interval, as higher doses of methadone can cause QT prolongation.**

- **Baseline blood tests should also be taken for renal function and liver function tests.** Be aware that intercurrent illness can affect how the body handles opioids; for example, acute kidney injury will increase the elimination half-life of opioids and increase the likelihood of overdose.

After the initial urine screens (DAS and OST prescribing set), patients will not routinely require daily urine screens. This is an important change from previous guidelines.

However, if during admission, a patient is suspected to be using illicit opioids, a further 'OST prescribing set' should be requested. If this urine screen is positive for 6-MAM (heroin), discuss with the Drug CNS or Clinical Toxicologist, who might recommend suspension of OST for that day.

For patients who admit to heroin use in addition to a regular methadone script, if there is evidence of opioid withdrawal despite administration of the patient's usual prescribed dose of OST, it may be necessary to increase the OST dose to compensate for the absence of illicit substance use. This should be discussed with the Clinical Toxicologist.

Admissions out of hours
If a patient is admitted out of hours, at weekends or bank holidays and the community prescription cannot be confirmed, steps must be taken to ensure minimal disruption to the patient's prescription.

The patient should still be asked to give a baseline urine sample for DAS and 'OST prescribing set.' Request on Unity as above. Note that the DAS result will not be available until the next normal working day. Contact the toxicology laboratory in the morning of the next normal working day so that the sample can be prioritised.

Patients should be prescribed a lower dose of whichever OST they take in community until community dosing can be confirmed. If there is a significant delay in receiving results from the urine OST screen, patients must be monitored 2-hourly using the Clinical Opiate Withdrawal Scale (COWS) and if they score 13 or above, a STAT dose of OST may be considered after discussion with the Drug CNS or on-call Clinical Toxicologist. Appropriate symptomatic treatment should also be prescribed.

MANAGEMENT OF OPIOID DEPENDENT PATIENTS WHO ARE NOT ON COMMUNITY OPIOID SUBSTITUTION THERAPY

On admission, patients are required to provide a urine sample for drugs of abuse screen (DAS) to identify the use of illicit substances. However, a DAS will only be processed by the toxicology laboratory in normal working hours, Monday to Friday. A request should also be made for an OST prescribing set, as this can be completed out-of-hours.

Some notes on interpretation of DAS opioid results are below.

How to interpret the urine drugs of abuse screen / OST prescribing set

Look for the following drugs or metabolites:

- **Methadone** – may be prescribed or illicit
- **EDDP** – methadone metabolite (useful to confirm methadone not added to urine sample after sample collection)
- **Buprenorphine** – may be prescribed or illicit
- **Norbuprenorphine** – metabolite of buprenorphine
- **6-MAM** – 6-monoacetylmorphine, heroin metabolite, presence confirms recent use of heroin (within 24 hours)
- **Morphine** – if present the patient has taken an opioid such as morphine, codeine, or heroin

As well as reducing or preventing withdrawal symptoms, initiation of OST can offer the opportunity to stabilise illicit drug use, promote engagement with treatment, and potentially, achieve abstinence if the patient is motivated and committed to change.

Starting patients on OST in the Trust should only be done in conjunction with the Drug CNS and/or the on-call Consultant Clinical Toxicologist if it is out of hours. Upon discharge, involvement of the community drugs team for ongoing follow-up is imperative.

Prior to starting OST, patients should have the same baseline blood tests and ECG as described above for patients on a community script. They should also be commenced on a COWS 2-hourly - see appendix 2.

COWS can be found on Unity under ‘assessment/fluid balance’ then ‘adults systems assessment.’

Symptomatic relief medications should be prescribed. If a patient begins to score 13 or above on the COWS, this should be escalated to the Drug CNS or Clinical Toxicologist.

Consideration of whether to start OST is dependent upon many factors and should be done following discussion with the Drug CNS or Clinical Toxicologist. Factors to consider include:

- Expected duration of admission
- Signs of opioid withdrawal
- Engagement with medical treatment

It is particularly important that patients are informed on admission that illicit drug use is not allowed during their hospital stay and that if heroin (as 6-MAM) is identified in urine beyond 24 hours, methadone or buprenorphine may not be issued.

Nicotine replacement therapy should be offered to all patients on OST who smoke cigarettes or vape.

If a patient leaves the ward and on return the staff have concerns that the patient is under the influence of non-prescribed drugs, they should seek advice from the Drug CNS or Clinical Toxicologist before administering OST.

New prescriptions for OST will be gradually titrated. Titration can occur after 3-5 days of the same dose. The Drug CNS can advise when it is appropriate to increase a patient's OST dose. Titration is dependent upon current physical health issues and patients' engagement with the Drug CNS.

Ensure that all patients are observed taking methadone or buprenorphine on the ward.

Contact the Drug CNS as soon as a discharge date is known so that community follow up can be arranged. **Do not provide take home methadone or buprenorphine unless the patient is discharged late on a Friday afternoon, or over a weekend or bank holiday.**

PAIN MANAGEMENT IN OPIOID DEPENDENT PATIENTS.

Opioid dependent patients with genuine pain, such as from trauma, abscess, or deep vein thrombosis, need appropriate analgesia, and the WHO analgesic ladder should be employed. Opioid-induced hyperalgesia is a well-recognised phenomenon, and such patients will often have low pain thresholds. Strong opioids such as morphine should not be withheld if there is a genuine clinical need. The patient will need to be monitored for signs of toxicity, and they should be discouraged from leaving the ward.

Pain management in patients regularly receiving buprenorphine can be difficult as response to opioids in these patients is unpredictable. Non-opioid analgesics should be used wherever possible. If further support is required, please contact the acute pain team. They can be contacted via Switchboard.

MANAGEMENT OF OPIOID WITHDRAWAL

If methadone or buprenorphine are not prescribed, or the patient wishes to discontinue the drug, and the patient suffers withdrawal symptoms, these can be mitigated, for example, by:

- Psychological reassurance;
- Loperamide for diarrhoea;
- Mebeverine or hyoscine butylbromide for abdominal cramps;
- Paracetamol for aches and pains;
- Antiemetics for nausea and vomiting;
- Diazepam 5 mg (PRN 6-8 hourly) on a short-term basis for severe anxiety.

If a patient is likely to experience opioid withdrawal symptoms, then the Clinical Opiate Withdrawal Scale should be commenced.

Specialist advice can be obtained from the Drug CNS or one of the Consultant Clinical Toxicologists out of hours.

Patients who have been taking opioids before admission but discontinue them during their inpatient stay should be warned that their tolerance to high doses will be lost after withdrawal. This will put patients at significant risk of overdose. The patient's prescribing doctor, community drug worker and issuing pharmacy should be informed to discontinue or revise the script on discharge.

PREGNANT WOMEN WHO ARE PRESCRIBED METHADONE OR DEPENDENT ON HEROIN

Heroin and methadone use are associated with decreased birth weight and a higher incidence of medical and obstetric complications. Infants of opioid-dependent mothers are also at risk of suffering neonatal withdrawal.

Please see Appendix 3: **Opioid dependent pregnant women – inpatient management** for further guidance**.**

CONSULTATION

This policy has been revised by the Consultant Clinical Toxicology team following consultation with the Drug CNS, Alcohol Care Team, and Consultant Clinical Scientist, and approved by the Clinical Toxicology Governance Group. There has also been consultation with a Consultant in Addiction Psychiatry for CGL and Specialist Midwife.

AUDITABLE STANDARDS/PROCESS FOR MONITORING EFFECTIVENESS

The prescribing of opioid substitution therapy is monitored closely by pharmacy to ensure that the Trust policy is followed.

TRAINING AND AWARENESS

Please direct any requests for training to Dr Mark Pucci, Consultant Clinical Toxicologist.

EQUALITY AND DIVERSITY

N/A

REVIEW

This policy is due for review in November 2027.

REFERENCE DOCUMENTS AND BIBLIOGRAPHY

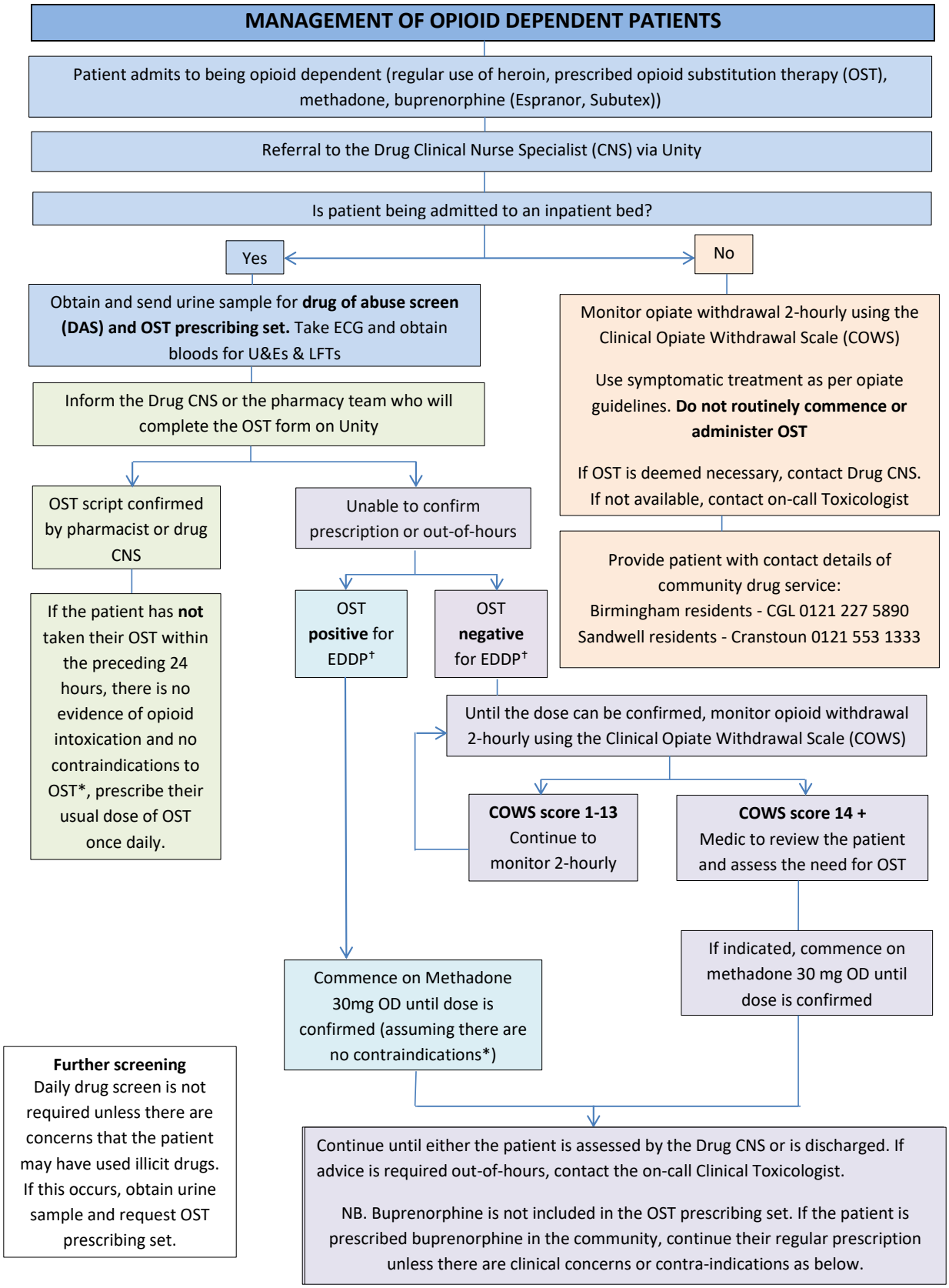
NICE Guidelines: TA114.
Methadone and buprenorphine for the management of opioid dependence.
NICE Technology appraisal guidance
Published January 2007.

FURTHER ENQUIRIES

Please contact: Dr Mark Pucci, Consultant Clinical Toxicologist:

- mark.pucci1@nhs.net
- Sandwell & West Birmingham NHS Trust
- National Poisons Information Service

Appendix 1: Management Flow Chart



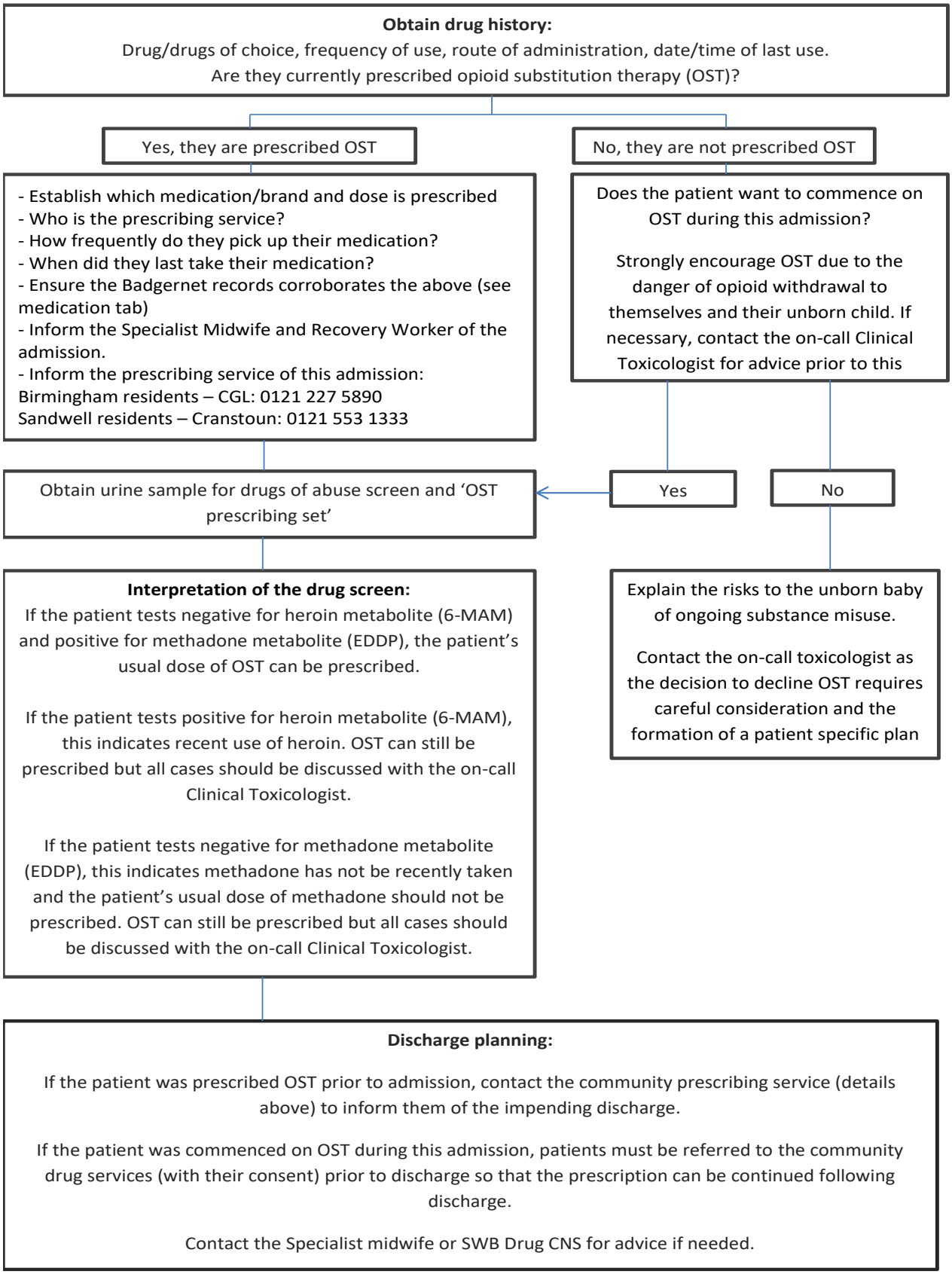
*Contraindications include: head injury, coma, raised intracranial pressure, respiratory depression, and prolonged QT interval.
†EDDP = methadone metabolite.
Seek advice if there are concerns with possible contraindications e.g. AKI (will need dose reduction). Check drug interactions before prescribing OST.

Appendix 2: Clinical Opiate Withdrawal Scale (COWS)

<table>
<tr><th colspan="2">Clinical Opiate Withdrawal Scale (COWS)</th></tr>
<tr><td>a) Resting pulse rate: beats/minute
Measured after patient is sitting or lying for one minute.
• 0 - pulse rate 80 or below
• 1 - pulse rate 81 - 100
• 2 - pulse rate 101 - 120
• 4 - pulse rate greater than 120</td><td>g) Runny nose or tearing - not accounted for by cold symptoms or allergies.
• 0 - not present
• 1 - nasal stuffiness or unusually moist eyes
• 2 - nose running or tearing
• 4 - nose constantly running or tears streaming down cheeks</td></tr>
<tr><td>b) Sweating: over past 1/2 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</td><td>h) GI upset: over last 1/2 hour.
• 0 - no GI symptoms
• 1 - stomach cramps
• 2 - nausea or loose stool
• 3 - vomiting or diarrhoea
• 5 - multiple episodes of diarrhoea or vomiting</td></tr>
<tr><td>c) 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</td><td>i) 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 l for more than a few seconds</td></tr>
<tr><td>d) 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</td><td>j) Yawning observation during assessment.
0 - no yawning
1 - yawning once or twice during assessment
2 - yawning three or more times during assessment
4 - yawning several times per minute</td></tr>
<tr><td>e) Bone or joint aches - if patient was having pain previously, only the additional component attributed to opiates withdrawal is scored.
• 0 - not present
• 1 - mild diffuse discomfort
• 2 - patient reports severe diffuse aching of joints/muscles
• 4 - patient is rubbing joints or muscles and is unable to sit still because of discomfort</td><td>k) Anxiety or irritability.
• 0 - none
• 1 - patient reports increasing irritability or anxiousness
• 2 - patient obviously irritable or anxious
• 4 - patient so irritable or anxious that participation in the assessment is difficult</td></tr>
<tr><td>f) Gooseflesh skin
• 0 - skin is smooth
• 3 - piloerection of skin can be felt or hairs standing up on arms
• 5 - prominent piloerection</td><td><table><tr><th colspan="2">Score:</th></tr><tr><td>5 - 12 =</td><td>Mild</td></tr><tr><td>13 - 24=</td><td>Moderate</td></tr><tr><td>25 – 36 =</td><td>Moderately severe</td></tr><tr><td>>36 =</td><td>Severe withdrawal</td></tr><tr><td colspan="2">Total =</td></tr></table></td></tr>
</table>

Appendix 3: Opioid dependent pregnant women – inpatient management

Opioid dependent pregnant women – inpatient management



Appendix 4: Community Drug Services – Contact Details

Birmingham Residents
Community drug services are provided by Change Grow Live (CGL) Telephone: **0121 227 5890** CGL Hospitals team email: **cgl.hospitalsteam@nhs.net**
• Park House is a residential facility managed by CGL and offers detoxification from drugs and alcohol. • Patients transferred from Park House to Midland Metropolitan University Hospital for medical care are often complex. • It is strongly advised that all prescribing decisions regarding OST are made in conjunction with the Park House clinicians who have a very good working relationship with the Consultant Clinical Toxicologists at SWBH. **The on-call rota for Park House is available by contacting the staff there on 0121 523 5940.**

Sandwell Residents
Community drug services are provided by: • Cranstoun Sandwell, Alberta Building, 128B Oldbury Road, Smethwick, B66 1JE. • General Telephone: **0121 553 1333** • Open: 09:00 - 17:00 (Monday to Friday)
For queries about individual patients, single points of contact are: • Zoe Buczko - Lead prescriber for Cranstoun • Email: **zbuczko@cranstoun.org.uk** • Telephone: **07875689846** • Judy Bolton - **jbolton@cranstoun.org.uk** • Sandeesh Purewal **-** **spurewal@cranstoun.org.uk**