Trust Guideline for the Management of Opioid Dependence in Adults

Document Control:

For Use In:	Norfolk and Norwich University Hospital and James Paget University Hospital		
	All medical staff.		
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None	Not applicable

Note which Trust, where applicable.

Distribution Control

Printed copies of this document should be considered out of date. The most up to date version is available from the Trust Intranet.

Consultation

The following were consulted during the development of this document:
Consultant Psychiatrist in addiction- CGL

Monitoring and Review of Procedural Document

The document owner is responsible for monitoring and reviewing the effectiveness of this Procedural Document. This review is continuous however as a minimum will be achieved at the point this procedural document requires a review e.g. changes in legislation, findings from incidents or document expiry.

Relationship of this document to other procedural documents
This document is a clinical guideline applicable to NNUH; please refer to local Trust's procedural documents for further guidance, as noted in Section 4.

Contents Page

Quick reference

SAFETY FIRST:

Do not give in to pressure to prescribe immediately.
Take time to assess

- Polydrug users and alcohol misusers may develop multiple withdrawal syndromes and you need to differentiate. Methadone may mask alcohol and benzodiazepine withdrawal symptoms.
- Do not try to match your prescription with the dose of opioid an individual claims to have been taking.
- Do NOT use tables of equivalent doses, as these can be misleading.
- TAKE GREAT CARE! Especially in cases of respiratory disease, head injury and liver diseases.
- Be extremely careful when giving other analgesics or sedatives. Consider contacting the Substance Misuse Team (DECT 6489 or 1799) if available in the Trust and liaise with the acute pain team.
- For pregnant patients please seek senior medical advice and liaise with the Substance Misuse Team (DECT 6489 or 1799).
- Inappropriate dosing can result in overdosing in the first few days, cumulative toxicity develops to methadone. There is no uniquely fatal dose of methadone and deaths have occurred following doses as little as 10-30mg.
- In general, if commencing or recommencing methadone the initial dose will be in the range of 10-30mg.
- After initial induction (over 3-4 days) allow time for methadone levels to reach steady state (5-7 days) then reassess. DO NOT keep increasing the dose over the first week outside of following the induction protocol below.
- Prescribe methadone in milligrams not millilitres of 1mg per ml mixture as wards may hold stocks of more concentrated strengths of methadone mixture. A 10-times error will be potentially fatal.
- Ensure the patient is observed swallowing the prescribed dose – by asking the patient to speak and/or drink water immediately afterwards.

Signs of intoxication such as drowsiness, slurred speech or constricted pupils indicate a need to discontinue the drug or reduce dosage.

METHADONE FLOW CHART

BEFORE FOLLOWING THIS PLEASE ENSURE YOU HAVE READ THE SAFETY NOTE AT THE START OF THIS SECTION

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BUPRENORPHINE FLOW CHART

BEFORE FOLLOWING THIS PLEASE ENSURE YOU HAVE READ THE SAFETY NOTE AT THE START OF THIS SECTION

No

Yes

1. Introduction

1.1. Rationale

This guideline has been developed to support appropriate and safe prescribing and treatment of this specific patient group.
Opioid 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 guideline is to help clinicians prescribe safely, and manage opioid withdrawal, so that the patient can have appropriate treatment for the condition that has resulted in the hospital admission/attendance.

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 opioid 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. Many such pharmacies have late opening hours enabling this information to be more available.

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

NICE TA114 Methadone and Buprenorphine for managing opioid dependence reviewed February 2016

1.2. Objective

The aims and objectives of the clinical guideline is to:

- Maintain current community prescribing
- To assist in the assessment and treatment of patients who report opioid addiction during an acute admission on a medical or surgical ward.
- To minimise the risk of patients engaging in risky or drug-taking behaviour in hospital or discharging themselves before their treatment is complete.
- Offer an opportunity to stabilise drug intake and lifestyle whilst breaking with previous illicit drug use and associated unhealthy behaviours
- Help maintain contact and offer opportunity for individuals to engage with community services.

1.3. Scope

These guidelines are intended for both medical and nursing staff to act as a resource in the management of patients with drug misuse issues.

1.4. Glossary

The following terms and abbreviations have been used within this document:

Term	Definition
CDS	Community Drug Service
PRN	Pro re nata
BD	Twice daily
NNUH	Norfolk and Norwich University Hospital
CGL	Change Grow Live
ICE	Pathology request system
IV	Intravenous
DVT	Deep Vein Thrombosis
TB	Tuberculosis
HIV	Human Immunodeficiency virus
OST	Opioid Substitution Treatment
GP	General Practitioner
COWS	Clinical Opioid Withdrawal Scale
NICE	National Institute for Health and Care Excellence
QTc	Hearth rate corrected QT interval on echocardiogram
ECG	Echocardiogram
CNS	Central Nervous System
BNF	British National Formulary
OTC	Over the counter
QDS	Four times a day
TDS	Three times a day

2. Responsibilities

Responsibility of all staff:

Management of opioid dependence requires a multidisciplinary approach and expert management. It is the responsibility of all staff to read this policy and follow the guideline when caring for patients who require management of opioid dependence.

Responsibility of prescribers:

Responsibility for any prescription rests ultimately with its prescriber. This role is conducted in collaboration with others particularly the pharmacy team at NNUH and the Substance Misuse team.

3. Processes to be followed

See section 3.2 onwards for processes to be followed.

3.1. Broad recommendations

A full comprehensive assessment of dependence on heroin or other opioids requires specialist addiction knowledge and expertise. While hospitalisation can offer an excellent opportunity to engage a patient in starting specialist treatment of dependence, hospital doctors are strongly encouraged only to initiate OST as part of,

or with clear advice and support from, a specialist drug treatment team (either through any liaison service available or by contacting the relevant community drug service).(Department of Health Drug Misuse and Dependence UK Guidelines 2017)

Always request advice from the substance misuse services- the NNUH team are available 8am-4pm weekdays on DECT 6489 or 1799. Referrals can also be made on ICE

Alternatively, community services can be contacted as follows:

CGL -Norfolk- 01603 514096
Turning Point -Suffolk – 01502 531138

The services are open Monday-Friday 09.00-17.00

3.2. Assessment

The admitting clinician must ensure that an adequate assessment has been made before prescribing substitute opioids or other controlled drugs.

Overview

- **A full history of recent drug use should be obtained and include:**
    - Names of drugs used (always ask about other drugs such as benzodiazepines and alcohol).
    - Average daily dose (and estimated highest recent daily dose if able – beware of peak effects and overestimation of tolerance).
    - Routes of administration - if IV, ask where they inject and specifically enquire about use of groin or neck sites as these may often not be volunteered on general inquiry and represent significant increased risk.
    - Patterns of use: intermittent/continuous daily use.
    - Experience of withdrawal symptoms.
    - Duration of use.
    - When were the drugs last used?
    - Is the patient experiencing opioid withdrawal symptoms?
- Some **medical complications** should alert staff to the possibility of underlying drug use:
    - Cellulitis, abscess, thrombophlebitis, DVT.
    - TB, hepatitis, HIV related conditions.
    - Respiratory infections, endocarditis, septicaemia.
    - False aneurysm.

- On **examination,** look for:
    - Evidence of drug use e.g., needle marks, abscesses, bruising and old scars.
    - Signs of **intoxication:**
        - Constricted pupils.
        - Drowsiness.
        - Slurred speech.
        - Poor attention / concentration.
        - Euphoria / relaxation.
        - Feeling of wellbeing.

3.3. Signs of Opioid withdrawal

Mild - moderate	Severe
Sniffing	Running nose
Eyes watery	Eyes streaming/wiping eyes
Fidgeting	Agitated (can't sit still)
Clammy skin	Beads of sweat
Goose flesh barely palpable	Readily palpable goose flesh
Mild abdominal cramps	Marked cramps+/- diarrhoea
No vomiting	Vomiting
No shivering	Shivering
Yawning 3-5/10mins	Yawning (>6/10mins)
Pulse (80-100)	Pulse (>100)
Dilated pupils (4-6mm)	Dilated pupils (>6mm)
Mild increase in respiratory rate	Marked increase in respiratory rate

3.4. Urine Screening

Urine analysis should be regarded as an adjunct to the history and examination; ideally it should be obtained at the outset of prescribing and randomly throughout treatment.

The Substance Misuse Team have access to instant urine drug screens, however out of hours or in the event the team aren't available please send a urine sample to Pathology using the ICE request process for "URINE DRUGS OF ABUSE"

3.5. Existing community patient- Methadone/ Buprenorphine (Subtext, Suboxone, Espranor or Buvidal)

3.5.1. Dose confirmation

For patients prescribed OST in the community, confirmation must be obtained from any of the following:

- GP.
- Drugs and Alcohol Service.
- Dispensing Community Pharmacy Find a Pharmacy.
- NNUH Substance Misuse Team (DECT 6489 or 1799)
- Some of the Hospital Pharmacy team have read only access to community drug teams notes in key admission areas and can confirm doses.

Once medicine, dose, dispensing and/or consumption have been confirmed, the usual full daily dose should be prescribed as soon as it is next due. Provided they have not missed more than 3 days of their methadone/buprenorphine (see section 3.5.3 – missed doses)

Buvidal is a prolonged release injection of Buprenorphine and comes as a weekly or monthly depot preparation in multiple strengths. It is non formulary at NNUH as only a relatively small proportion of individuals may be prescribed Buvidal and admitted to hospital. Patients admitted on Buvidal should be referred to the Substance Misuse team at NNUH.

The dispensing pharmacy should always be informed of the patient's admission to prevent continued (fraudulent) collection of medicines in the community. The drug and alcohol service should also be informed to allow them to plan for discharge arrangements.

Where confirmation is not immediately possible, patients should be managed according to section 3.5.2 and efforts to confirm opioid substitution use should continue.

When confirmation is possible, full daily doses may be prescribed but consideration of opioid consumption during the previous 24 hours should be used to adjust initial doses accordingly.

The following information should be confirmed with either the patient's community pharmacy or community drug team and documented prior to prescribing.

Check	Variable
Drug Type	Methadone SF 1mg/1ml Buprenorphine (Subutex/Suboxone/Espranor)
Daily Dose	Mg
Pick up Frequently	Daily / 2 x weekly / 3 x weekly / weekly
Pharmacy	Name, Telephone number
Date of last dose	Day / Time

Missed Doses	Potential loss of Tolerance
Patients own Supplies	Risk of double dosing, Risk to others

3.5.2. Out of hours/ pharmacy closed

There are times such as Bank Holidays, weekends and evenings when it is not possible to confirm patient dose with the community pharmacy or community drug team.

Caution is advised as the patient may have already taken a dose.

Where the patient can produce proof of ongoing prescribing such as a current prescription or appropriately labelled bottle this is sufficient evidence with which to prescribe (noting the above point).

Where the patient cannot produce proof and there is evidence of acute opioid withdrawal syndrome go to New Starter Titration in Quick Reference guide.

3.5.3. Missed doses

Missed doses can be associated with the emergence of an opioid withdrawal syndrome after two or three days, and it can take up to three days for blood levels to return to normal.

If a person misses doses of methadone or buprenorphine:

- Do not replace the missed doses (i.e. do not give a double dose the next day).
- It may be appropriate to assess the person to find out why this occurred, especially if several doses have been missed.
- Ensure they are not intoxicated before prescribing.
- Assess for symptoms and signs of withdrawal.

1, 2, or 3 days: the usual dose may be given. If a patient on a daily dispensing regimen misses a pick-up from the pharmacy, the patient should resume the daily prescribed dose the next day as usual. The missed dose should not be replaced.

4 days: it may be appropriate to reduce the dose and titrate back up to the original dose as their tolerance may be reduced or lost. Often the person who uses drugs claims to have used street drugs, but this can never be verified, or the purity known. If doses are missed for more than three days, then treatment should be reviewed to discover how the patient has managed without medication and to consider recommencing from a lower dose.

5 days or more: If doses are missed for five days or more, a re- assessment must be undertaken, and consideration given to restarting the medication.

NOTE: In all cases please refer to on ICE to the Substance Misuse Nurses

3.5.4. Patient's own supply

Patients should routinely be asked if they have any of their own Methadone/Buprenorphine in their possession.

Patients own supplies should be removed for safe storage and / or disposal. Patients should normally only receive doses from ward stock.

Patients own supplies can be returned on discharge provided they are still appropriate, and the community drug team are made aware to prevent a shortfall or accumulation

3.6. Patient using illicit Opioids in the community

For patients not on opioid substitution treatment, or where there is uncertainty about recent compliance, it is appropriate to exercise particular care in initiating opioid substitution treatment.

When it is concluded that it is appropriate to initiate opioid substitution in hospital to manage the risk of withdrawal, methadone may sometimes be preferred over buprenorphine, as the latter acts as a partial antagonist and may interfere with acute pain management. However, the choice of an appropriate substitute will depend on the circumstances of the individual case (especially, for example, if respiratory depression is a concern).

- Observe for mild/moderate or severe opioid withdrawal symptoms as above using the Clinical Opioid Withdrawal scale (COWS). See Appendix 1.
- Options are symptomatic relief (detoxification) or opioid maintenance therapy with methadone or sublingual buprenorphine.
- Consider titration on to opioid maintenance therapy only if the clinical assessment is that the patient is opioid dependent.
- NB if there is established dependence then initiating detoxification without the patient's full agreement and/or adequate after-care may increase mortality rates as the reduced opioid tolerance puts the patient at risk of overdose if they relapse on discharge. It is mandatory therefore to discuss the risks of reduced tolerance and means to reduce the risk if relapse occurs. Unless the degree of opioid dependence is felt to be very low or uncertain initiation of maintenance therapy is usually a safer option.

Both drugs are recommended by NICE for maintenance treatment. The choice of drug is based on an assessment of:

- Level of opioid use - clinical experience suggests that those using 1 gram or more of heroin daily are more easily titrated on to methadone.
- Safety and overdose risk - risk of injecting with sublingual buprenorphine vs. increased risk of overdose with methadone.
- Patient preference and experience with both illicit and prescribed medications, treatment history and response - most local opioid dependent individuals have knowledge of both drugs and many have strong views as to their preferred option[7].

- Retention and treatment compliance - strong evidence that methadone retains more people in treatment (Cochrane).
- Analgesia requirements – buprenorphine will block the effects of other opioids so if strong analgesia is likely to be required use methadone.
- The prescriber's experience with different medications.

3.6.1. Prescribing of Opioid Substitution Treatment (OST)

(See Quick Reference Guide flow chart)

OST should only be prescribed following an assessment, including where possible ascertaining independently when the last prescribed dose of OST was dispensed and, if possible, when it was consumed.

Prescribers should not be pressured to initiate prescribing prematurely but should carefully consider how to manage the balance of risks if a patient is developing opioid withdrawals that make it difficult for them to engage in their required clinical treatment.

Care should be taken to differentiate the multiple withdrawal syndromes that may develop in polydrug and alcohol misusers in order to prioritise treatment. Methadone may initially mask alcohol and benzodiazepine withdrawal symptoms.

Particular care should be exercised in cases of respiratory disease, head injury and liver diseases.

Extreme caution should be used when prescribing additional drugs such as sedatives and it may be necessary to contact the relevant pain control team for further advice on improving pain control.

3.6.2. Methadone

Methadone is a long-acting full opioid agonist. The half-life of methadone varies greatly between individuals with a range of 13-50 hours. It takes 3-10 days to reach steady state. Therefore, even at the same dose blood levels will continue to rise within this time frame so rapid induction can lead to fatal respiratory depression several days later (Department of Health Drug Misuse and Dependence) (Auriacombe et al, 2001).

Although available in tablet form this is not licensed for maintenance treatment and methadone should therefore always be prescribed as methadone mixture 1mg in 1mL. Always specify the strength of the mixture and prescribe in mg. not mL. as more concentrated forms are available.

Methadone also increases the QTc interval, and an ECG is recommended if the dose is above 99mg or if it is prescribed in combination with other drugs which increase the QTc interval e.g. tricyclic antidepressants and antipsychotic medicines. Other side effects include sedation, constipation and sweating.

Risk factors for respiratory depression during induction are (Department of Health Drug misuse and Dependence 2017):

- Low opioid tolerance.
- Concomitant use of CNS depressant drugs (e.g. benzodiazepines, alcohol).
- High starting dose.
- Rapid dose increase.
- Slow methadone metabolism – this can be affected by drug interactions see below (this is not a complete list – check BNF).

Drugs which Increase Blood Levels of Methadone or Buprenorphine by Inhibition of the Enzyme CYP3A4	Drugs which Decrease Blood Levels of Methadone or Buprenorphine by Induction of the Enzyme CYP3A4
Cimetidine	Anticonvulsants (e.g., barbiturates, carbamazepine, phenytoin)
Ciprofloxacin	HIV medicines (e.g., efavirenz, nevirapine)
Erythromycin	Rifampicin
Clarithromycin	Spironolactone
Fluconazole	St John's Wort
Ketoconazole	
Fluvoxamine and possibly other SSRIs	

3.6.3. Methadone Titration (see Quick reference guide flow chart)

Ensure there is immediate access to naloxone. A dose of 30mg of methadone can cause fatal respiratory depression.

- Give 10 to 30mg methadone mixture **1mg in 1mL** orally according to the severity of withdrawals (mild 10mg – severe 30mg) and observe for signs of intoxication.
- A second dose of 10 to 20mg can be repeated if withdrawal symptoms persist after 2-6 hours.
- Do not give second dose after 6pm as night-time dosing increases the risk of failing to notice over-sedation and respiratory depression.
- The total dosage in the first 24 hours should not exceed 30mg unless discussed with the Substance Misuse Team.
- The total dosage needed to suppress withdrawal (but not cause intoxication or over-sedation) in the first 24 hours is the **stabilisation dose**. This dose can be given on a daily basis thereafter in divided doses.
- If necessary, further increases can be made over subsequent days by no more than 5 to 10mg per day.
- Doses should be prescribed with instructions to omit if there is evidence of over-sedation.

- In patients who have been vomiting prior to admission, assess the likelihood of other medication having been poorly absorbed. Consider that overdosing may occur when the vomiting resolves.

3.6.4. Burprenorphine

Buprenorphine is a partial agonist with high affinity but low intrinsic activity at the Mu opioid receptor and high affinity but no activity at the kappa receptor. Importantly this results in a ceiling effect on respiratory depression giving a better safety profile (Bertschy 1995). The risks of overdose are however increased where the drug is combined with other sedatives such as alcohol and benzodiazepines, both of which are commonly used by opioid dependent individuals.

The high affinity of buprenorphine for opioid receptors confers a more effective opioid blockade and there is some evidence that this leads to reduced illicit opioid use. As a partial agonist buprenorphine confers reduced subjective effects of intoxication such as sedation and is perceived as easier than methadone to withdraw from.

Due to its high affinity for opioid receptors and low activity it can precipitate withdrawal symptoms if it displaces more potent opioids (e.g., heroin). To avoid this, it is important to wait until there are signs of opioid withdrawal to administer the first dose. The necessity of experiencing even mild withdrawal at induction is off-putting to some. There is a risk of individuals crushing and injecting the tablets, a practice which increases both the risk of overdose and of hepatic toxicity in addition to the inherent risks of injecting a crushed tablet (Mattick et al 2014).

Buprenorphine is available as a sublingual tablet in 400mcg, 2mg and 8mg strengths.

Espranor – this is Buprenorphine in wafer form. This means the drug is absorbed on top of the tongue not under the tongue. This is non-formulary at the NNUH; please use equivalent dose of Buprenorphine.

Buprenorphine prolonged-release injection- It is likely that at some point following the completion of the guidance, long-acting depot injections of buprenorphine may start to be used in routine clinical practice. If a patient reports to be on this, it is essential that no opioids are given before discussion with the Community Drug Service/Substance Misuse Liaison Team as maintenance should already be established and further opioids would have limited effects. If there is clear evidence of withdrawal despite adherence to the treatment, this indicates a need for a comprehensive treatment review involving the Community Drug Service responsible for the prescription rather than immediate acute changes.

3.6.5. Buprenorphine Titration (See Quick Reference Guide flow chart)

Buprenorphine should not be used in those requiring opioid analgesia due to its blockade of the opioid receptors.

The main risk with buprenorphine titration is of precipitating withdrawal symptoms. Withholding the first dose until opioid withdrawal symptoms are clearly evident

(though not necessarily severe) reduces the risk. This would normally be at least 6-12 hours after the last use of short acting opioids (e.g., heroin) and 24-48 hours after the last use of long acting opioids (e.g. methadone).

- First dose 2 to 4mg.
- If no precipitation of withdrawal symptoms after 1-2 hours further doses can be given up to a total dose of 8mg in the first 24 hours.
- The dose can be increased on subsequent days as required up to a maximum of 32mg (18mg if using Espranor).
- In patients who have been vomiting prior to admission, assess the likelihood of other medication having been poorly absorbed. Consider that overdosing may occur when the vomiting rapidly resolves following buprenorphine administration.

3.7. Pregnancy

- Opioid withdrawal during pregnancy may induce foetal distress and lead to intrauterine death or premature labour. It is therefore essential to prevent or minimise withdrawal symptoms in pregnant patients.
- Titration onto opioid maintenance therapy is the preferred management strategy. This can be achieved by following the above guidance as for non-pregnant patients, with **methadone** being the usual drug of choice. Opioid detoxification should **not** be initiated in pregnant patients.
- Patients presenting with opioid dependence during pregnancy may have poor nutritional status, social issues relating to chaotic lifestyles (for example, housing problems, domestic violence, sex-working) and may have not attended prenatal appointments/scans etc. In addition to reducing the risks associated with continued heroin use, stabilisation onto methadone maintenance allows the opportunity for such issues to be addressed.
- Following stabilisation, it may be possible for some pregnant patients to reduce their dose during the 2nd trimester. This should be supervised by their community key-worker and undertaken at a pace that does not induce withdrawal or risk return to on-top illicit opioid use.
- It is not uncommon for methadone requirement to increase during the 3rd trimester due to increased metabolism and it is important to discuss this with patients earlier in pregnancy where able as many believe that requesting increases in dose will be perceived as reflecting continued illicit use. Split dosing can sometimes help overcome mild discomfort associated with this, but in others a dose increase may become necessary.
- Babies born to opioid dependent mothers require monitoring for the development of neonatal withdrawal syndrome.

3.8. Analgesic Requirements

- Patients maintained on methadone because of their addiction are tolerant to that dose. Therefore, they will require additional analgesia for pain depending on their medical or surgical condition

- If indicated opioid analgesia in the usual dosage and frequency can be given and the patient carefully observed for signs of over sedation.
- Buprenorphine should be avoided due to its mixed agonist/antagonist effects.

3.9. Over the counter Opioids

The use/abuse of over-the-counter medications containing opioids such as codeine has become increasingly widespread.

Patients regularly taking OTC codeine may display symptoms of opioid dependency i.e., increased tolerance, physical withdrawal.

Patients may be unaware that they are dependent / withdrawing. A detailed history including the use of OTC medication is advised.
In most cases, where pain is the trigger, continued prescribing, gradual withdrawal and analgesic review is sufficient.

For a few patients, where the mood-altering effects of opioids is attractive, specialist help from the Substance Misuse Team may be required.

3.10. Discharge planning/ take home supply

When planning hospital discharge involve the Substance Misuse Nurses on DECT 6489 or 1799. Alternatively the CGL hospital team (Norfolk only) may have left contact details in the patient notes for discharge planning/ ongoing prescribing.. They are based in the hospital Monday-Friday 09.00-17.00.

Every effort should be taken to minimise the need for take home dosing, and additional
steps should be considered to prevent discharge at weekends or public holidays.

If the patient has been started on opioid maintenance therapy whilst in hospital, and wishes to continue with this, a community prescription with appropriate dispensing arrangements (e.g., daily supervised consumption) must be arranged **prior to discharge** with the substance misuse team/ CGL hospital Liaison. This will avoid patients going home with large quantities of controlled drugs as prescriptions can usually be arranged to start on the day after discharge (except at weekends).

3.11. Adjunctive Medication used for Opioid withdrawals if patient declined OST

Below is a suggested list of adjunctive medications that can be considered during inpatient detoxification.

Only one medication for any symptom should be prescribed at a time

Diazepam	Maximum: 20mg / day prn (for irritability and anxiety)
Nitrazepam	Maximum: 10mg nocte (for sleep)
Zopiclone	Maximum: 15mg nocte (for sleep)
Promethazine (143.3 mg/5 mL)	25-50mg (for sleep)

Hyoscine Butylbromide	10mg qds prn (for abdominal cramps)
Loperamide	2mg qds prn (for diarrhoea)
Domperidone	10 mg qds prn (for nausea and vomiting)
Metoclopramide	10 mg tds prn (for nausea and vomiting)
Ibuprofen	400 mg tds prn (for aches and muscle pains)

- Adjunctive medication should be prescribed on a PRN basis as far as possible.
- The decision about the type of adjunctive medication and its dose should be determined by assessing withdrawal symptoms and individualized.

In patients who have been vomiting prior to admission, assess the likelihood of other medication having been poorly absorbed. Consider that overdosing may occur when the vomiting rapidly resolves during the detoxification.

4. Related Documents

NICE TA114 Methadone and Buprenorphine for managing opioid dependence reviewed February 2016

Trust Guidelines for the Management of Acute Alcohol Withdrawal (excluding pregnancy) (Trust docs 1229)

http://intranet/depart/SafeguardingAdults/index.htm

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NICE TA114 Methadone and buprenorphine for managing opioid dependence 2007, (reviewed February 2016).

6. Audit of the process

Compliance with the process will be monitored through the following:

Key elements	Process for Monitoring	By Whom (Individual / group /committee)	Responsible Governance Committee /dept	Frequency of monitoring
Were pre prescribing checks carried out and documented	Audit of electronic prescribing system	Substance Misuse team	Mental Health and Complex care board	Each admission/ prescription
Incidents related to inappropriate use of methadone or Buprenorphine	Datix incidents	Substance Misuse team	Mental Health and Complex care board	Each incident

The audit results are to be discussed at relevant governance meetings to review the results and recommendations for further action. Then sent to Mental Health and Complex Care Board who will ensure that the actions and recommendations are suitable and sufficient

7. Appendices

7.1. Appendix 1 – Symptom Severity Chart

Symptom Severity Chart for measuring Opioid Withdrawals over a period of time during Buprenorphine/ Methadone titration

Or add a patient identifier label

Patients Name:……. Hospital No: ……..
Date of Birth:…….. Ward:……

Date *dd/mm/yyyy* and **Time** *24-hour clock – write sideways*

Resting Pulse Rate
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

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 assessmen*t
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

Bone or Joint aches *If patient was having pain previously, only the additional component attributed to opioids 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

Sub-total scores

Observer Print Name and Signature
write sideways

Score: **5-12 = mild; 13-24 = moderate;**
25-36 = moderately severe; More than 36 = severe withdrawal

Symptom Severity Chart for measuring Opioid Withdrawals over a period of time during Buprenorphine/ Methadone titration	*Or add a patient identifier label* Patients Name:……. Hospital No: …….. Date of Birth:…….. Ward:……									
Date *dd/mm/yyyy* and **Time** *24-hour clock* – *write sideways*										
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										
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 three 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** Piloerrection of skin can be felt or hairs standing up on arms **5** Piloerrection										
2nd sub-total										
Add 1st and 2nd sub-total = total										
Observer's initials										

Score: **5-12 = mild;** **13-24 = moderate;**
25-36 = moderately severe; More than 36 = severe withdrawal

8. Equality Impact Assessment (EIA)

Type of function or policy	Existing

Division	Corporate	**Department**	Complex Health Hub
Name of person completing form	Marita Isaac	**Date**	Jan 2024

Equality Area	Potential Negative Impact	Impact Positive Impact	Which groups are affected	Full Impact Assessment Required YES/NO
Race	No	No		No
Pregnancy & Maternity	No	No		No
Disability	No	No		No
Religion and beliefs	No	No		No
Sex	No	No		No
Gender reassignment	No	No		No
Sexual Orientation	No	No		No
Age	No	No		No
Marriage & Civil Partnership	No	No		No
EDS2 – How does this change impact the Equality and Diversity Strategic plan (contact HR or see EDS2 plan)?				

- **A full assessment will only be required if: The impact is potentially discriminatory under the general equality duty**
- **Any groups of patients/staff/visitors or communities could be potentially disadvantaged by the policy or function/service**
- **The policy or function/service is assessed to be of high significance**

IF IN DOUBT A FULL IMPACT ASSESSMENT FORM IS REQUIRED

The review of the existing policy re-affirms the rights of all groups and clarifies the individual, managerial and organisational responsibilities in line with statutory and best practice guidance.