

Reference Number: UHB 328 Version Number: 3	Date of Next Review: 01 Apr 2026 Previous Trust/LHB Reference Number: T379
Guidelines for management of opioid-dependent individuals admitted to UHB hospitals	
Introduction and Aim: These guidelines are intended to assist with the management of those attending or admitted to any UHB hospital (but in particular acute settings) who are: Section A: Prescribed opioid substitute medication including Methadone and Buprenorphine (including Subutex, Suboxone, Espranor and long acting Buvidal) in the community. Section B: Not currently prescribed opioid substitute medication but using illicit opiates. Section C: Dependent on opioids, either prescribed or illicit, and requiring acute pain management.	
Objectives: To ensure the safe management of opioid dependence in inpatient settings, and in transition between hospital and community setting.	
Scope: This guidance applies to all inpatient settings within Cardiff and Vale UHB	
Equality Impact Assessment	The Equality Impact Assessment completed for this document found no impact.
Documents to read alongside this Procedure	Pain service guidelines: https://nhswales365.sharepoint.com/sites/CAV_Acute%20Pain%20Management%20Service/SitePages/Acute-Pain-Clinical-Service.aspx Management of patients/visitors in possession of alcohol or unprescribed/ illegal substances policy & procedure Controlled Document Library - Patients Visitors Drug Alcohol Policy.pdf - All Documents (sharepoint.com) Search of Patients Person and Belongings Policy & Procedure Controlled Document Library - Search of Patients Person and belongings.pdf - All Documents (sharepoint.com) Guideline for Symptom-Triggered Alcohol Detoxification in C&V UHB Hospitals
Approved by	Medicines Management Group
Accountable Executive / Clinical Board Director	Medical Director
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Disclaimer If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the Governance Directorate.	

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Summary of reviews/amendments			
Version	Date Review Approved	Date Published	Summary of Amendments
1	07/09/2009	01/07/2012	CSPEC approved
2	01/09/2016	21/09/2016	Reference to Suboxone Change in addresses for community substance misuse services Updated lists of pharmacies and NEXs Ref. COWS Addition of DHC to rescue meds Updated references Reference to emergency naloxone Updated heroin overdose chart Easy to read flowchart Simplified analgesia section in buprenorphine
3	01/04/ 2021	01/04/2021	Added Long Acting Weekly/Monthly Buprenorphine (Buvidal) Amended and updated Sections to include Buvidal Amended / Updated Contact Details
3	14/7/2023 MH MMG	October 2023	Nil amendments

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1. Introduction

- 1.1 Opioid dependent patients pose unique problems for healthcare staff when presenting to hospital. Staff may be unsure of how to manage patients' needs for opioids and pain relief. Such uncertainty may cause unnecessary distress to the patient and lead to unsafe practice around strong opioids.
- 1.2 Patients using drugs problematically may attend the Emergency Unit, or be admitted to hospital, for treatment of conditions common to other patients, or directly related to their drug misuse. In either case, hospital staff should take proper account of any drug misuse and any treatment being provided in the community. The continuation of opioid prescribing on admission and discharge requires understanding of the issues involved and a coordinated response by all professional staff concerned in the care of the patient.

2. Scope and purpose of the guidance

- 2.1 These guidelines are intended to assist the management of those attending or being admitted to any UHB hospital (but in particular acute settings) who are:
 - **Section A** Prescribed opioid substitute medication including Methadone and Buprenorphine (including Subutex®/Suboxone®/Espranor®/Buvidal®) as part of a registered community programme
 - **Section B** Not currently prescribed opioid substitute medication as part of a registered community programme but using illicit opiates
 - **Section C** Dependent on opioids, either prescribed or illicit and requiring acute pain management
- 2.2 The guidance intends to address the following issues:
 - Who to contact for specialist assessment and advice
 - How to continue safely with maintenance therapy for those on an established programme
 - How to manage opioid withdrawal symptoms
 - How to manage pain in opioid users
 - How to manage opioid intoxication
 - What arrangements are required on admission and discharge
- 2.3 For advice on the management of pregnant drug users or pregnant women who are on a substitution programme contact the substance misuse midwives on 07817 170121.

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3. Admission to hospital - For all opioid dependent patients (illicit and prescribed):

3.1 Establish whether the patient is on a registered programme and prescribed opioid substitution in the community.

For all those prescribed opioid substitution in the community follow further guidance outlined in **Section A**.

For all those *not* prescribed opioid substitution in the community follow further guidance outlined in **Section B**.

3.2 Obtain an accurate drug history – including the substances taken, the route of administration, frequency of use, the duration used and the individual's use over the previous week. Ask about benzodiazepine use either prescribed or illicit. If the patient is prescribed benzodiazepines by their General Practitioner (GP), the Community Addictions Unit (CAU) or other prescriber, a clinical decision is required about whether to continue the prescribed dose.

3.3 Establish alcohol intake, the type, amount and frequency. Establish whether the patient has a history of severe alcohol withdrawals including seizures and / or delirium tremens. Consider prescribing vitamin supplementation including Pabrinex[®] (see symptom triggered alcohol detoxification guidance - above hyperlinks)

3.4 Check and document:

- Injection sites such as arms, hands, feet and groins for abscesses/ skin discolouration/ foreign bodies
- Withdrawal signs using the assessment of [Clinical Opiate Withdrawal Scale \(COWS\)](#) (appendix 3)

3.5 Request a urine sample for drug screening. Specify a full drug screen under clinical details and send to the toxicology department at Llandough hospital.

3.6 If the demeanor of a patient alters after visitors, on going off the ward, or going to the toilet consider the possible use of non-prescribed psychoactive substance. If use is suspected undertake a urine screen and monitor closely including examination of IV access sites e.g. Venflons. Refer to the Management of patients/visitors in possession of alcohol or unprescribed / illegal substances policy & procedure (see hyperlinks above) if necessary.

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SECTION A: The Management Of Patients On A Registered Methadone/Buprenorphine (including Subutex®/Suboxone®/Espranor®/Buvidal®) Programme

4. General Management

- 4.1 Never prescribe Methadone or Buprenorphine before establishing a patient is on a registered programme** even if this means that the patient goes without substitute medication. If unable to confirm a patient is on a registered programme, rescue medication (outlined in Section B) should be offered until the community pharmacy / prescribing organisation opens.

4.1.1 Buvidal® - if on this long acting Buprenorphine (usually given weekly or monthly sub-cutaneously), establish when last dose given and when next dose due. Note that there is flexibility in dosing – the weekly can be given +/- 2 days and the monthly +/- 1 week – so there is time to organise this. Other opioids are likely to have reduced effect, similarly to patients on oral buprenorphine. Further details of Buvidal® are in Appendix 5.

- 4.2** Confirm details of the patient's prescription with the dispensing pharmacy and prescribing organisation. Contact details of usual agencies are in Appendix 1 and pharmacies can be found via the inpatient pharmacy.

4.2.1 Cardiff & Vale: - Usual prescribers are CAU (DaTT team, Shared Care Team and Newlands/Vale Team) and Dyfodol (Cardiff & Vale).

- 4.3** Determine the daily dose and the frequency of pick up. The community pharmacy or prescribing agency may also have a list of other prescribed medication; this is useful if a patient is regularly prescribed benzodiazepines.

- 4.4** Confirm with the specified community pharmacist when the last dose was taken or collected. Do not prescribe regular doses of methadone or buprenorphine if the last dose was taken more than **3 days prior to admission**. Tolerance will be reduced during this time, refer to Substance Misuse Liaison Team (Extension UHW - **44901** UHW) for advice on restarting.

Caution is advised for patients who take opioid substitute therapy on an unsupervised basis.

- 4.5** Inform the community pharmacist **and** prescribing organisation that the patient is in hospital and request that any community opioid prescription is suspended - to avoid any chance of double dosing (i.e. those receiving their regular dose of methadone or buprenorphine in hospital but also accessing their regular community prescription). Document all details in the medical notes and the front of the drug chart including telephone numbers of the community pharmacist to avoid duplication of work.

- 4.6** Please ensure that all patients are observed consuming their methadone or buprenorphine on the ward. For buprenorphine (sublingual Subutex®/Suboxone®) or supralingual (Espranor®) this may take about 5 minutes. It is advisable to write in the note section of the drug chart "please supervise consumption" for any prescribed opioid substitute.

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- 4.7** Contact the Substance Misuse Liaison team to inform of admission (Extension UHW - **44901** UHW). When calling out of hours please leave an answer phone message.
- 4.8** Patients should NOT be provided with take home methadone or buprenorphine unless prior agreement made with the Community Addiction Unit and/or usual community prescriber. Where mutually agreed the prescription will have to be written early and taken to hospital pharmacy as soon as possible.
- 4.9** When initiating new medication, be aware of drug interactions with buprenorphine and methadone which can affect plasma levels of both drugs resulting in toxic levels or reduced therapeutic levels. Examples of drug interactions include interactions with antivirals, anticonvulsants and antibiotics. See BNF for full details and contact the pharmacy department for more information.
- 4.10** Despite the prescription of substitution medication, prior to admission, some patients may still have been using illicit opioids on top of their prescribed medication. They may therefore still exhibit opioid withdrawal symptoms.

Do not alter Methadone or Buprenorphine dose without prior discussion with Community Addictions Unit and / or existing community prescriber and manage any withdrawal symptoms as set out in section B of this guideline.

5. Admission out of hours and during the weekend

If a patient is admitted in the evening or on a weekend, the following advice may be helpful:

- 5.1** Community pharmacies are generally open on Saturday mornings and some are open all day Saturday and Sunday. The patient will have been supplied with Sunday's dose from the community pharmacy provided that they collected on Saturday. Some patients may take home several doses of medication at any one time.
- 5.2** If the patient has brought this dose in with him/her then this dose should be stored in the Controlled Drug (CD) cupboard and entered in the CD register under 'patient's own drugs'. This can be used as confirmation of prescribed dose and can be used to administer Sunday's dose. Be careful to check that the dose has been labelled for the admitted patient and that the dose is current by checking name and date on the printed pharmacy label.
- 5.3** Some dispensing clinics provide 'take home' doses on a Friday for Saturday and Sunday; therefore provided that they have collected during the day on Friday then they will have two doses - one for Saturday and one for Sunday.
- 5.4** If the patient is admitted after 5pm, it is likely that he/she has received their daily dose for that particular day. Confirm with the community pharmacy if they are still open but if in doubt never prescribe methadone or buprenorphine. Opioid withdrawal is not fatal but double dosing can be.

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- 5.5** If needing to obtain methadone or buprenorphine out of hours, please follow the UHB's CD borrowing policy – see the [Medicines Code Chapter 9.6. Emergency supply of Controlled Drugs](#)
- 5.6** Inform treatment agency of admission as soon as possible. Contact details are provided in **Appendix 1**.

6. Administration of Methadone or Buprenorphine (including Subutex®/ Suboxone ® /Espranor®) maintenance dose in patients who are nil by mouth

If nil by mouth, clarify with the treating team if this includes medication. If the patient is unable to take any medication by mouth establish with the prescriber if patient is able to tolerate small volumes via nasogastric (NG) tube. If this is the case then methadone concentrate solution can be administered via NG tube.

The methadone concentrate solution is 10mg/ml (i.e. ten times the strength of the usual methadone formulation, methadone SF mixture 1mg / 1ml) and therefore the same dose can be administered in a reduced volume. Care is needed to manage risk of incorrect dosing. If unable to tolerate medication via NG tube refer to Substance Misuse Liaison Nurse or the Pain Management Team for further guidance.

Buprenorphine preparations may be used sublingually (Subutex®/ Suboxone ®) or supralingually (Espranor®) as long as care is taken not to swallow the residue. Buprenorphine is not suitable for NG tube administration.

7. Discharge / Leave from hospital

Discharge

- 7.1** Contact the community pharmacy, and prescribing organisation, as soon as a discharge date is known in order that the community prescription can be re- instated. It is helpful to give as much warning as possible.
- 7.2** Administer the regular dose of methadone or buprenorphine on the ward on the day of discharge and advise the community pharmacy AND prescribing organisation of this in order to avoid double dosing following discharge.
- 7.3** Do not provide take home methadone or buprenorphine unless the patient is discharged over the weekend. In this instance provide a maximum of 1 days' worth of methadone / buprenorphine to take home. For special circumstances and bank holidays contact the ward pharmacist for advice.
- 7.4** Analgesia should be reviewed prior to discharge and careful consideration should be given to the indication and quantity of opioid analgesics given as a 'take home prescription'. Advice can be sought from the ward pharmacist.

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- 7.5** The Substance Misuse Liaison Team (Extension UHW - 44901 UHW) usually suggest extreme caution around issuing TTH pain relief – e.g. ideally limiting to 3 days maximum of, of a lower potency preparation such as Co-codamol with a GP review. The reason for this is the risk of misuse of any dispensed opioids, especially if higher potency or longer prescriptions.

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Leave from hospital

Leave from hospital, without discharge from inpatient status, may apply in some clinical settings (e.g. mental health inpatient setting). The following approach is recommended

7.6 Day Leave / Overnight Leave: Methadone / buprenorphine take home doses should not normally be necessary and take home supply is not recommended. Methadone / buprenorphine dose times maybe adjusted to allow a patient to leave early for overnight leave, and return late the next day

7.7 'Weekend' Leave: The inpatient team may decide to grant leave and prescribe take home methadone / buprenorphine for 1-2 days (usual max) to allow overnight or weekend leave. They should liaise with the usual community prescriber and pharmacy to ensure NO pre-existing community prescription is accessible to the patient when on leave.

In contacting the prescriber, guidance should be sought on the suitability of the patient for take home doses of methadone / buprenorphine, or whether supervised daily consumption (as per 'Longer Periods of Leave' – see 7.8) is safer. Alternatively the team may decide to ask the patient to return to the ward daily for consumption.

7.8 Longer Periods of Leave: Periods of leave beyond 48 hours are probably best managed with a restart of community prescriptions. The usual prescriber should be contacted to this end. Given the time necessary to arrange printing and presentation to the community pharmacy the inpatient team are advised to contact at least 48 hours before any planned leave period.

In planning for leave periods, and before writing a take home prescription, the inpatient drug chart should be reviewed. Careful consideration should be paid to the need for ongoing prescribing of all pre-existing regular or PRN medication, with misuse potential. Of particular concern are the sedative drug groups: benzodiazepines and opioid analgesics. However the potential for misuse of other drugs / drug groups (such as mirtazapine, quetiapine, pregabalin and gabapentin, ADHD medications, anticholinergic drugs, amitriptyline, and sedative antihistamines) should not be forgotten.

7.9 Accurate communication and note keeping is essential, in planning methadone / buprenorphine treatment for leave periods, to ensure correct dosing and timeframes

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SECTION B: The Management Of Those *Not Currently* On A Registered Methadone/ Buprenorphine (including Subutex®/Suboxone ®/Espranor®/Buvidal®) Programme

Follow the recommendations outlined for all patients on admission.

8. The symptomatic relief of opioid withdrawals

- 8.1. Withdrawal symptoms associated with opioids include abdominal cramps, diarrhoea, agitation including restlessness and irritability, muscle cramps, raised blood pressure and increased pulse, dilated pupils and psychological drug craving.
- 8.2. Opioid withdrawal can be assessed and rated using the [Clinical Opiate Withdrawal Scale](#) (appendix 3). The 11 item scale should be used before considering the administration of any the rescue medications shown below.
- 8.3. Untreated heroin withdrawal symptoms typically reach their peak 36-72 hours after the last dose and symptoms will have subsided substantially after 5 days. Untreated methadone withdrawal typically reaches its peak at 4-6 days after last dose and symptoms do not substantially subside for 10-12 days.
- 8.4. Prescribing symptomatically can reduce some of the physical effects of withdrawal but care is needed to avoid the risks of polypharmacy. For those experiencing mild opioid withdrawal symptoms (COWS 8-12) offer on a '**when required**' basis (as long as no contraindications to treatment) the following medication:
 - **Hyoscine butylbromide (Buscopan®)** 20mg *4 times a day* to alleviate abdominal cramps
 - **Loperamide** 4mg stat followed by 2mg *as needed* following loose bowel movement up to a maximum of 16mg daily
 - **Ibuprofen** 400-600mg four times a day or Diclofenac 50mg three times a day +/- proton pump inhibitor (omeprazole 20mg od or lansoprazole 30mg od)
 - **Diazepam** 10mg *three times a day* for a **maximum of three days**. This should be offered in addition to any usual regular dose that the patient is prescribed in the community
 - **Metoclopramide** 10mg *three times a day* to alleviate nausea and vomiting See BNF for full dosage instructions, contraindications and cautions to treatment.
 - **Zopiclone** 3.75mg-7.5mg (female), 7.5mg-15mg (male) nightly for sleep issues, prescribed for up to 5 days and should not be prescribed on discharge.
- 8.5. For COWS scores >12, and or where opiate substitution therapy has not been confirmed (e.g. over a weekend) **Dihydrocodeine** (DHC) may be prescribed in doses of 30 to 60mg up to four times daily. This dose can be reduced or maintained during short admissions depending on the clinical condition of the patient. If required, incremental reductions can be scheduled daily or every second day. Patients on maximum dose dihydrocodeine and still withdrawing may require a step to more potent short acting opioids. This should trigger a SMLT review.

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- 8.6.** Rescue medication, used to manage opioid withdrawals, are usually offered for **approximately three to five days**, but should **NOT** be continued on discharge. Patients should be advised of this when medication is initiated. Diazepam and dihydrocodeine should be reviewed regularly given their misuse potential. Ensure supervised consumption of dihydrocodeine and benzodiazepines.

9. Advice on reduced tolerance and risk of overdose

- 9.1** Tolerance to opioids decreases rapidly. Patients who use opioids on discharge are at risk of overdose, even if their admission was brief. Patients should be warned of the risks of overdose and offered an overdose prevention advice leaflet. See **Appendix 2**. Consider referral to the Substance Misuse Liaison team (who can offer accidental overdose training and emergency naloxone kit provision).
- 9.2** For the management of opioid intoxication and overdose see **Section D**.
- 9.3** Referrals to local substance misuse services can be made via the Substance Misuse Liaison Team or by direct referral to CAVDAS.

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SECTION C: ANALGESIA FOR OPIOID DEPENDENT PATIENTS

Please refer to the Cardiff and Vale **UHB's ACUTE PAIN SERVICE GUIDELINES (ADULT)** - see hyperlinks **above** – which can be accessed via the Guideline section of clinical portal.

Patients using opioids for prolonged periods (prescribed such Methadone, Buprenorphine - Subutex®/Suboxone®/Espranor®/Buvidal® or illicit – such as Heroin) are likely to have developed tolerance to the drug group and larger doses of opioid pain relief may be required.

10. Analgesia for Methadone prescribed patients

10.1 Confirm the dose as last taken (see Section A) and continue with maintenance dose.

10.2 Mild pain – Prescribe paracetamol +/- Non Steroidal Anti-Inflammatory Drugs (NSAID) as long as no contraindications to treatment.

10.3 Moderate/Severe pain – If opioid analgesia is indicated (e.g. codeine or morphine), the drug should be titrated accordingly against pain relief, with the methadone dose remaining constant to alleviate withdrawal symptoms. Select an alternative opioid to provide analgesia in addition to the methadone maintenance dose. This allows a clear distinction between treatment of addiction and treatment of pain.

- a. Oral route – immediate release e.g. Oramorph®. Prescribe regularly and when required.
- b. If nil by mouth use intravenous Patient Controlled Analgesia (PCA) / subcutaneous or rectal route / regional technique. For PCA – larger than average boluses may be needed, but start with standard settings.
- c. When acute pain treatment is no longer required, stop the opioid pain relief, but continue methadone.

11. Analgesia for Buprenorphine prescribed patients (sublingual Subutex®/Suboxone®, supralingual Espranor® & subcutaneous Buvidal®)

11.1. Care should be taken in the use of full opioid agonists for pain relief in **Buprenorphine** maintained individuals, given buprenorphine's partial agonist effect at the mu opioid receptor, and its high affinity for that receptor. The degree of receptor occupancy by buprenorphine is also dependent on the maintenance dose of buprenorphine, and is prone to individual variation. However, in effect, most will have near full occupancy if on 12mg + orally (sublingual Subutex®/Suboxone®, supralingual Espranor®) or 24mg+ weekly/64mg+ monthly Buvidal®. They may, therefore, need higher doses of full opioid agonists.

11.2. When full opioid agonists (e.g. morphine) are given to a patient maintained on buprenorphine the degree of analgesia can be unpredictable. There is no commonly agreed, research based guidance for acute pain management for buprenorphine maintained individuals though the literature and guidance of the last 20 years – using full agonist opioids when

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needed, at times with higher doses needed – has proven generally acceptable and helpful.

- 11.3. Non-opioid analgesics should be used in preference (e.g. paracetamol or NSAIDs if there are no contraindications to treatment).
- 11.4. Despite concerns there is some evidence that the addition of short acting opioids to an ongoing buprenorphine prescription can provide adequate pain relief, even when that pain is expected to be moderate / severe. For many this may be an appropriate first step when strong pain relief is needed, in the acute scenario.
- 11.5. If adequate pain control cannot be achieved, while the patient continues buprenorphine, it may be necessary to transfer the patient to a stable methadone dose so that opioid analgesic can be effectively used for pain control then referring to the above section on '**Analgesia for those prescribed methadone as part of a programme**')
- 11.6. Specialist advice should be sought from the Substance misuse Liaison Nurse, the Community Addictions Unit or the Pain Management Team when converting from buprenorphine to methadone and vice versa. The usual approach includes discontinuing buprenorphine therapy, switching to methadone at 20–40 mg for the opioid dependence, and using short-acting opioid analgesics to treat pain. Monitor the patient closely and ensure naloxone is readily available on the ward.
- 11.7. Discontinue methadone therapy and convert back to buprenorphine therapy before hospital discharge. Wait at least 24 hours before re-commencing the usual buprenorphine dose as withdrawal may be precipitated.
- 11.8. For elective procedures, likely to result in severe post-operative pain, consideration may be given to a planned switch from buprenorphine to methadone 5-7 days before surgery, to simplify later pain management.

N.B. Patient and practitioner should be aware that changing back to buprenorphine can be problematic, especially at methadone doses beyond 30mg od.

12. Analgesia for naltrexone prescribed patients

- 12.1 Naltrexone is a specific, high affinity, long acting competitive antagonist at opioid receptors. It has negligible opioid agonist activity and is taken orally. As a rule of thumb, opioid blockade lasts for ~48-72 hours after the last dose.
- 12.2 Contact Pain Management Team for specialist advice.
- 12.3 Non-opioid analgesics should be used in preference (e.g. paracetamol or NSAIDs if there are no contraindications to treatment).
- 12.4 Concomitant administration of naltrexone with an opioid-containing medication should be avoided if at possible. For all elective procedures naltrexone should be stopped to allow adequate pain management

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12.5 In an emergency requiring opioid analgesia high doses of opioid may be required to control pain.

12.6 The elimination half-life of naltrexone is approximately 4 hours and that of its metabolite (6- β naltrexol) is approximately 13 hours. The metabolite may also possess weak opioid antagonist activity. Opioid dosing will need very regular adjustment as naltrexone levels reduce. The patient should be closely monitored for evidence of respiratory depression or other adverse symptoms and signs.

13. Analgesia in patient using illicit opioids and not currently on a Methadone/Buprenorphine programme.

13.1. Do not commence methadone or buprenorphine. Contact the Substance Misuse Liaison Team or the Pain Management Team.

13.2. Larger than average doses of opioids may be required. Commence morphine orally or as PCA if nil by mouth.

13.3. Do not try to convert street doses as street drug compositions are variable.

13.4. PCA parameters - Larger than average bolus and possibly background infusion may be necessary. This must be supervised by the Acute Pain Service and may necessitate the patient being nursed in a high dependency area for close monitoring. Please contact the Pain Team for advice. Contact details are outlined in **Appendix 1**.

13.5. Manage withdrawal with the rescue medications outlined in **Section B** but DO NOT prescribe the Dihydrocodeine.

14. Prescribing analgesia on discharge from hospital

See section 7 for guidance

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SECTION D: MANAGING ACUTE OPIOID INTOXICATION

Patients may attend Accident and Emergency departments with acute opioid intoxication, or may become intoxicated as inpatients, having continued to use illicit substances following admission. Signs of intoxication including drowsiness, slurred speech or constricted pupils indicate that any prescribed opioids need to be withheld.

15. Intoxication

- 15.1. Methadone or buprenorphine should not be given to any patient showing signs of intoxication, especially when due to alcohol or other depressant drugs (e.g. benzodiazepines). Risk of fatal overdose is greatly enhanced when methadone is taken concomitantly with alcohol and other respiratory depressant drugs.

16. Opioid Overdose

- 16.1. The treatment of opioid overdose is with standard resuscitation techniques and naloxone injection should be administered, following BNF guidelines. Naloxone can be given by the intravenous, intramuscular or subcutaneous route.
- 16.2. It is important to remember the half-life of naloxone is much shorter than methadone and other opioids, its effect may reverse within 20 minutes to 1 hour and an individual can revert back to an overdose state. Medical monitoring should therefore be provided after naloxone administration. Some patients may find it difficult to cope with the precipitated discomfort that can occur on administering naloxone and choose to leave hospital abruptly. Patients should be helped to understand the risk of re- emergence of life-threatening sedation when the naloxone wears off.
- 16.3. While most overdoses are accidental, anecdotal evidence suggests that up to one- third maybe intentional self-poisonings. Everyone involved in the care of drug users should screen patients for acute mental health problems and suicidality. A psychiatric assessment should be offered to all those attending with overdose.
- 16.4. For further information on the management of overdose contact the National Poisons Information Service : professionals only : on **0344 892 0111** or access the TOXBASE website www.toxbase.org (password required)
- 16.5. Refer all patients to Substance Misuse Liaison Team, if not available at point of discharge /out of hours offer referral to CAVDAS.

17. Overdose with buprenorphine

- 17.1. Buprenorphine in overdose is generally regarded as far less risky than methadone and heroin because it causes little respiratory depression. However, in combination with other respiratory depressant drugs respiratory depression maybe more pronounced. Very high doses of naloxone (e.g. 10-15mg) may be needed to reverse buprenorphine effects (although lower doses such as 0.8-2mg may be sufficient); hence, ventilator support may be required in cases

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where buprenorphine is contributing to respiratory depression (e.g. in polydrug overdose).

N.B. Patients at risk of future opioid overdose should be offered overdose training and emergency naloxone provision. This is available as an inpatient through the SM liaison team.

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SECTION E: ADMINISTRATION

18. References

- Anderson T, Aurora N et al; To Stop or Not, That Is the Question: Acute Pain Management for the Patient on Chronic Buprenorphine. Anesthesiology 2017; 126:1180–1186.
- Diaper A, Law F, Melichar J. Pharmacological strategies for detoxification. Br J Clin Pharmacol. 2014 Feb;77(2):302-14.
- Melichar J, Lewis J et al. Benefits of 24/96 Buvidal Assisted Recovery in South Wales – Rapid Service Development due to enhanced country wide Covid-19 funding of this long acting buprenorphine formulation. SSA (Society for the Study of Addiction) 2020 UK Conference
- Wesson and Ling, The Clinical Opiate Withdrawal Scale (COWS) 2003 J Psychoactive Drugs. 2003 Apr-Jun;35(2):253-9.

19. Resources

No additional resources were identified as a result of approval of this guidance.

20. Equality Impact and Assessment

An equality impact assessment has been undertaken to assess the relevance of this guidance to equality and potential impact on different groups, specifically in relation to the General Duty of the Race Relations (Amendment) Act 2000 and the Disability Discrimination Act 2005 and including other equality legislation. The assessment identified that the guidance presented a low risk to the UHB.

21. Audit

Compliance with this guidance will be carried out through audit, if appropriate, on an annual basis.

22. Distribution

This guidance will be available for viewing via the UHB Intranet.

A copy will also be provided to all Directors, General Managers and Directorate Managers for onward distribution and circulation to staff as necessary.

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APPENDIX ONE

Useful contacts including needle exchange (community pharmacy providers can be found via the inpatient pharmacy team)

Substance Misuse (SM) Liaison Team – Drug and Alcohol referrals

Room 104 Monmouth House
University Hospital of Wales, Heath Park,
Cardiff CF14 4XW UHW
Tel: 02920744901

Acute Pain Management Service

UHW Pain Service

Department of Anaesthetics
University Hospital of Wales
Heath Park, Cardiff. CF14 4XW
Tel no. 029 2074 5449
Bleep 5414

Llandough Pain Service

East 5, Llandough Hospital
Penlan Road, Llandough.
Penarth. CF64 2XX.
Tel no. 029 2071 5020
Bleep 4560

Community Addiction Unit (CAU) CAU - Cardiff

House 54-56 CRI Newport Rd Cardiff
CF24 0SZ
Tel: 029 2046 1742

CAU – Vale of Glamorgan (Newlands)

26 Newland St Barry
CF62 8EA
Tel: 01446 700943

Cardiff and Vale Drug and Alcohol Services (CAVDAS)

[Gwasanaeth Cyffuriau ac Alcohol Caerdydd a'r Fro / Cardiff & Vale Drugs & Alcohol Service](http://Gwasanaeth%20Cyffuriau%20ac%20Alcohol%20Caerdydd%20a'r%20Fro%20-%20Cardiff%20&%20Vale%20Drugs%20&%20Alcohol%20Service%20(cavdas.com))
(cavdas.com)

Email - info@cavdas.com

CAVDAS (Cardiff)

7 St Andrews Place
Cardiff CF10 3BE
Tel - 0300 300 7000

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CAVDAS (Vale of Glamorgan)

2-10 Holton Road, Barry
Vale of Glamorgan CF63 4HD
Tel - 0300 300 7000

Dyfodol (cardiff)
Harlech Court Ground Floor
Harlech Court Ground Floor
Bute Terrace
Cardiff CF10 2FE
Tel - 02920 641 213

Dyfodol.CardiffAndVale@uk.g4s.com /
dyfodol.cardiffandvalle@uk.g4s.com.cjsm.net

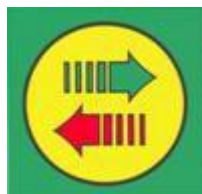
Dyfodol Vale
Gladstone Road
Barry
CF63 1DT

01446 7292

The All Wales Drug and Alcohol Helpline (DAN)

<http://dan247.org.uk/> 0800 6335588

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Needle exchange sites in Cardiff and the Vale of Glamorgan

Service Name	Address	TownCity	County	Postcode	Site Type
Boots - Albany Rd	77-79 Albany Road	Cardiff	Cardiff	CF24 3LN	NSP - Pharmacy
Boots - Boverton Rd	7 Boverton Road	Llantwit Major	Vale of Glamorgan	CF61 1XZ	NSP - Pharmacy
Boots - Windsor Rd	24 Windsor Rd	Penarth	Vale of Glamorgan	CF64 1YJ	NSP - Pharmacy
Boots - Wood Street	Units 1 & 2 Broadcasting House	Cardiff	Cardiff	CF10 1FS	NSP - Pharmacy
Caerau Lane Pharmacy	40 Caerau Lane	Cardiff	Cardiff	CF5 5HQ	NSP - Pharmacy
Park Crescent Pharmacy	8 Park Crescent	Barry	Vale of Glamorgan	CF62 6HD	NSP - Pharmacy
Knights - Ely	3 Wilson Road	Cardiff	Cardiff	CF5 4LJ	NSP - Pharmacy
Knights - Tremorfa	21 South Park Road	Cardiff	Cardiff	CF24 2LU	NSP - Pharmacy
Rhose Pharmacy	53 Fontygary Road	Rhose	Vale of Glamorgan	CF62 3DT	NSP - Pharmacy
St Mellons Pharmacy	Londis Seaview Stores	Cardiff	Cardiff	CF3 5UA	NSP - Pharmacy
The Murch Pharmacy	Dinas Powys Medical Centre	Dinas Powys	Vale of Glamorgan	CF64 4RE	NSP - Pharmacy
Woodville Road Pharmacy	74 Woodville Road	Cardiff	Cardiff	CF24 4EB	NSP - Pharmacy
CAU - DaTT	Cardiff Royal Infirmary, Longcross Street	Cardiff	Cardiff	CF24 0SZ	NSP - Specialist SMS
CAVDAS - Barry	2-10 Holton Road	Barry	Vale of Glamorgan	CF63 4HD	NSP - Specialist SMS
CAVDAS - Neville Street	94 Neville Street	Cardiff	Cardiff	CF11 6LS	NSP - Specialist SMS
Huggard - Centre	Hansen Street	Cardiff	Cardiff	CF10 5DW	NSP - Specialist SMS

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APPENDIX TWO

Information for patients and carers for heroin users



Tolerance

Tolerance to heroin quickly reduces. You will be at risk of overdose when leaving hospital even if your admission was very brief. If you decide to use on discharge:

- ☐ use a lot less than you were used to especially if you inject.
- ☐ Taste the hit – use a small amount and see how it affects you.
- ☐ Never use alone!
- ☐ Remember to get OD training and get a FREE emergency naloxone kit

Mixing Drugs

Using more than one “downer” drug (alcohol, heroin, methadone, subutex, tranquillisers and sleeping tablets) greatly increases the chances of overdose (even if not all taken at the same time). Using heroin (a downer) and cocaine or amphetamine (an upper) at the same time can also be fatal.

What to do if somebody you are with overdoses - If they look asleep or unconscious, their face/lips look pale or blue, their breathing is difficult or noisy

1. Lay them on the floor and check that they have nothing stuck in their throat.
2. Put them in the recovery position: on their side and tilt their head backwards. This will help to make breathing easier and if vomiting occurs it is less likely to go into their lungs or cause choking.
3. CALL AN AMBULANCE (and describe their condition)
4. If you know what substances they have taken, tell the emergency services.
This could save their life.
5. Do not leave them alone unless you have to get help yourself. If you do have to leave them, make sure they cannot roll onto their back by placing a soft object behind them (e.g rolled up coat)
6. If they are not breathing, give mouth-to-mouth resuscitation.

If you have an emergency naloxone kit available to you – this is the time to use it. Instructions will be available in the kit.

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APPENDIX THREE

Clinical Opiate Withdrawal Scale

For each item, circle the number that best describes the patient's signs or symptom. Rate on just 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 and Time ____/____/____:_____
Reason for this assessment: _____		
Resting Pulse Rate: _____ beats/minute <i>Measured after patient is sitting or lying for one minute</i> 0 pulse rate 80 or below 1 pulse rate 81-100 2 pulse rate 101-120 4 pulse rate greater than 120	GI Upset: over last ½ hour 0 no GI symptoms 1 stomach cramps 2 nausea or loose stool 3 vomiting or diarrhea 5 Multiple episodes of diarrhea or vomiting	
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	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	
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	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	
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	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	
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	Gooseflesh skin 0 skin is smooth 3 piloerection of skin can be felt or hairs standing up on arms 5 prominent piloerection	
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	Total Score _____ The total score is the sum of all 11 items Initials of person completing Assessment: _____	

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

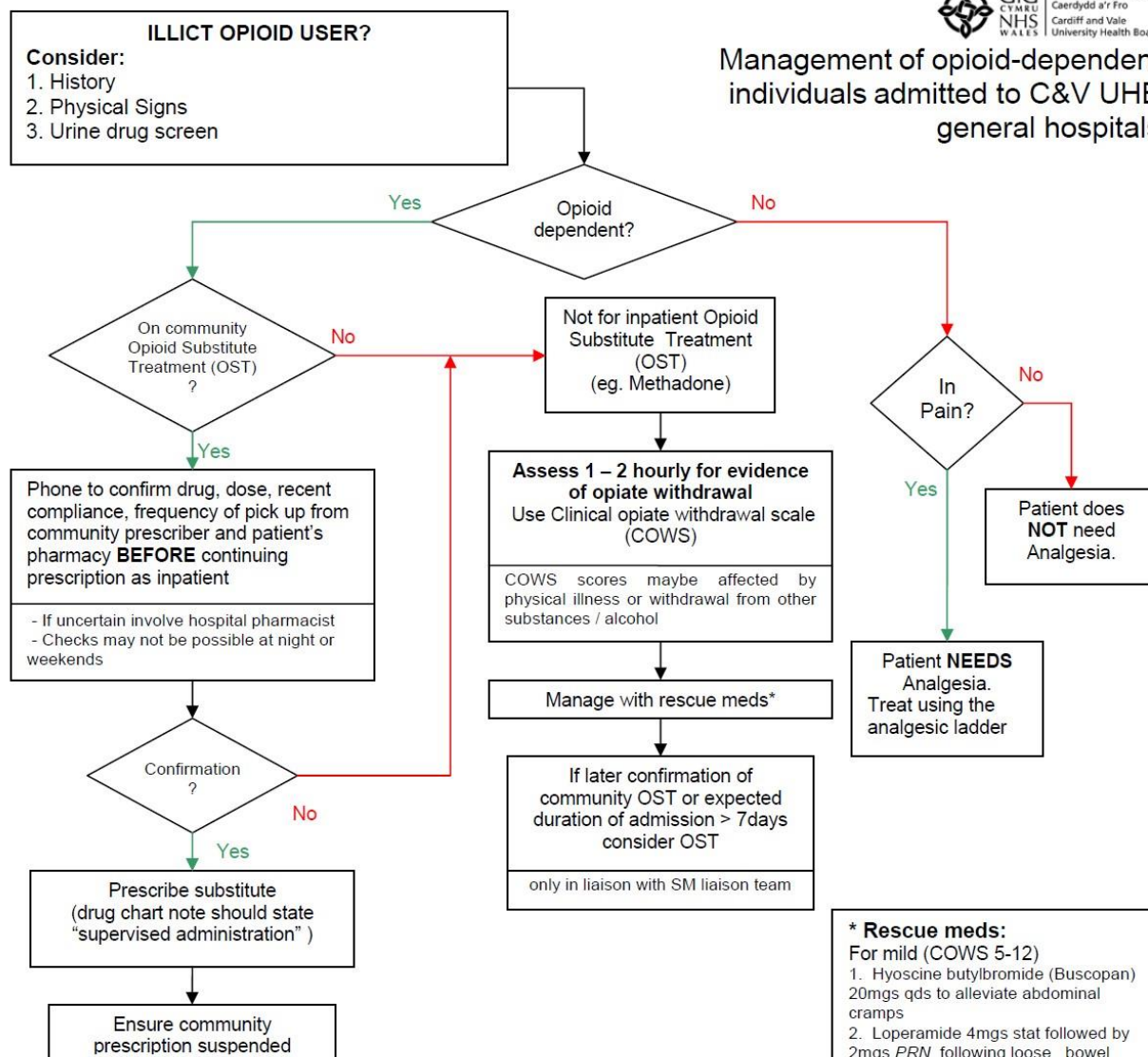
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APPENDIX FOUR

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Management of opioid-dependent individuals admitted to C&V UHB general hospitals



N.B. Acute pain management in opioid dependence (liaise with acute pain team)

The prescription of OST (opioid substitute treatment – such as methadone or buprenorphine) does not manage pain: OST maintained clients maybe more sensitive to pain. Usual pain ladders should be used in addition to OST

- For those on buprenorphine OST consider changing over to methadone (starting at 30mg per day) if strong opioids required for pain relief (only make such a change in liaison with SM liaison team)
- Use rescue meds with caution (avoid diazepam and dihydrocodeine) if prescribing strong opioids for pain relief

* Rescue meds:

For mild (COWS 5-12)

1. Hyoscine butylbromide (Buscopan) 20mgs qds to alleviate abdominal cramps
2. Loperamide 4mgs stat followed by 2mgs *PRN* following loose bowel movement (max 16mgs daily)
3. Ibuprofen 400-600mg qds or Diclofenac 50mgs tds
4. Diazepam 10mgs tds for a **maximum of three days**. (not for TTH)
5. Metoclopramide 10mgs *tds* to alleviate nausea and vomiting

For COWS moderate scores (13 or more) consider the addition of dihydrocodeine 30-60mg 4-6 hourly *PRN* (max 240mg daily) (not for TTH)

For COWS scores >36 seek review

ON DISCHARGE

- Patient wishes to continue illicit drug use - DISCHARGE and advise contact Taith (tel: 02921 833057)
- Patient wishes to detox / management programme, refer to E-DAS (0300 300 7000) www.e-das.nh.uk
- Patient wishes to continue treatment contact community prescribing agency to arrange aftercare

DO NOT PRESCRIBE or DISPENSE METHADONE AS A TTH UNLESS ADVISED BY SM LIAISON TEAM / CAU
EXERCISE EXTREME CAUTION WITH BENZODIAZEPINE PRESCRIBING AS INPATIENT AND TTH

FOR INPATIENT advice on management can be sought from Substance Misuse Liaison Team UHW 44901 for UHW / UHL inpatients. For other clinical areas contact CAU 02920461742

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APPENDIX FIVE Buvidal injections – Detailed information

Administration Instructions

Administration instructions :

Taken from section 6 of SmPC:

Pharmaceutical particulars

6.1 List of excipients: Buvidal® 8 mg, 16 mg, 24 mg, 32 mg

Soybean phosphatidylcholine, Glycerol dioleate, Ethanol anhydrous

6.2 Incompatibilities: This medicinal product must not be mixed with other medicinal products.

6.3 Shelf life: 2 years.

6.4 Special precautions for storage: Do not refrigerate or freeze.

6.5 Nature and contents of container: A 1 mL pre-filled syringe (glass, Type I) with plunger stopper (fluoropolymer-coated bromobutyl rubber) with needle (½-inch, 23 gauge, 12 mm) and needle shield (styrene butadiene rubber). The pre-filled syringe is assembled in a safety device for post-injection needlestick prevention. The needle shield of the safety syringe may contain rubber latex that may cause allergic reactions in latex-sensitive individuals.

Pack sizes: Pack contains 1 pre-filled syringe with stopper, needle, needle shield, safety device and 1 plunger rod.

6.6 Special precautions for disposal and other handling

Important information

- Administration should be made into the subcutaneous tissue
- Intravascular, intramuscular and intradermal administration must be avoided.
- Must not be used if the safety syringe is broken or the packaging is damaged.
- The needle shield of the syringe may contain rubber latex that may cause allergic reactions in latex sensitive individuals.
- Handle the safety syringe carefully to avoid a needle stick. The safety syringe includes a needle protection safety device that will activate at the end of the injection. Do not uncapped the safety syringe until you are ready to inject. Once uncapped, never try to recap the needle.
- Dispose of the used safety syringe right away after use. Do not re-use the safety syringe.

Before administration

Safety syringe parts:

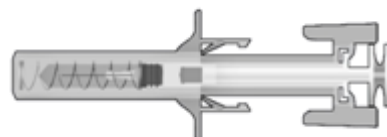
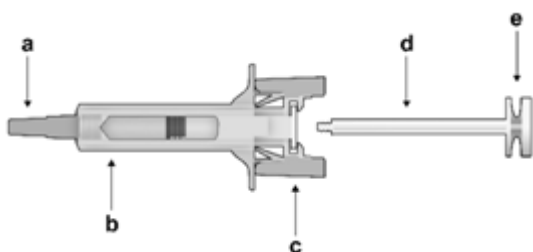


Figure 1: Safety Syringe: Before Use

a) Needle shield, b) Syringe Guard Body, c) Syringe Guard Wings, d) Plunger, e) Plunger Head

Safety Syringe: After Use

(With needle protection mechanism activated)

Please note that the smallest injection volume is barely visible in the viewing window as the spring of the safety device is “covering” part of the glass cylinder close to the needle.

Administration

Figure 2: Take the syringe out of the cardboard box: pick up the syringe by the syringe guard body.

- While holding the syringe by the needle shield, insert the plunger rod into the plunger stopper by gently rotating the plunger rod clockwise until secured (see Figure 2).



Inspect the safety syringe closely:

- Do not use the safety syringe after the expiration date shown on the cardboard box or on the syringe label.
- A small air bubble may be seen, which is normal.
- The liquid should be clear. Do not use the safety syringe if the liquid contains visible particles or is cloudy.

Figure 3: Choose the injection site. Injections should be between sites in the buttock, thigh, abdomen, or upper arm (Figure 3) with a minimum of 8 weeks before re-injecting a previously used injection site. Injections on the waistline or cm of the navel should be avoided.

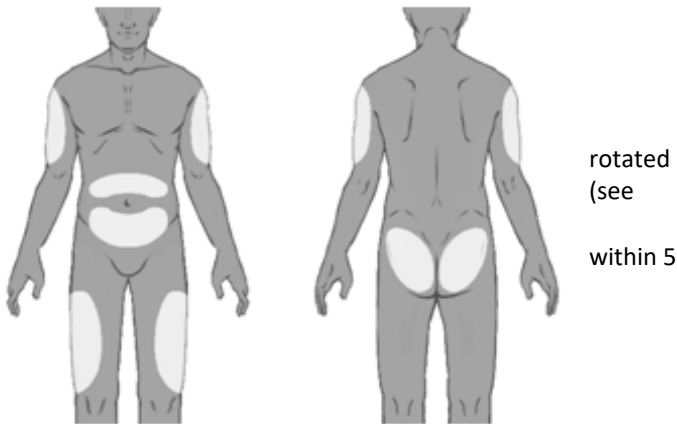


Figure 4: Put on gloves and clean the injection site with a circular motion using an alcohol wipe (not provided in the pack). Do not touch the cleaned area again before injecting.

- While holding the safety syringe by the syringe guard body as shown (see Figure 4), carefully pull the needle shield straight off. Immediately dispose of the needle shield (never try to recap the needle). A drop of liquid may be seen at the end of the needle. is normal.

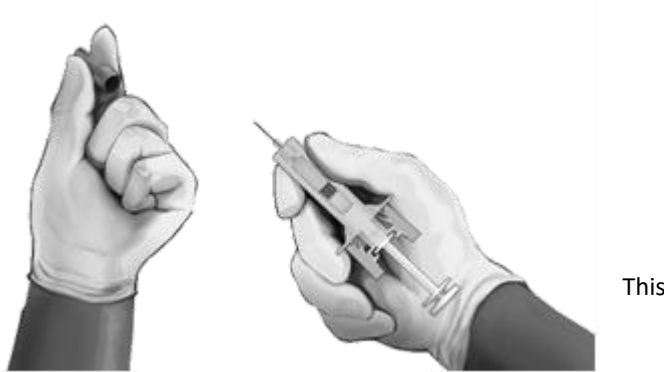


Figure 5: Pinch the skin at the injection site between the thumb and finger as shown (see Figure 5).

- Hold the safety syringe as shown and smoothly insert the needle at an angle of approximately 90° (see Figure 5). Push the plunger all the way in.

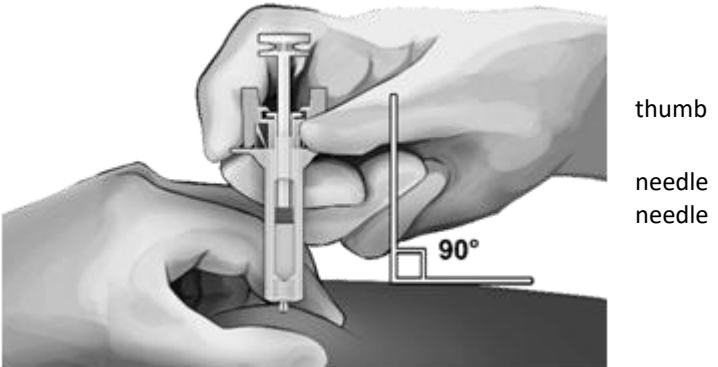


Figure 6: While holding the syringe as shown (see Figure 6), depress the plunger until the plunger head latches between the syringe guard wings and all the solution is injected.



Figure 7: Gently pull the needle out of the skin. It is recommended that the plunger is kept fully depressed while the needle is carefully lifted straight out from the injection site (see Figure 7).

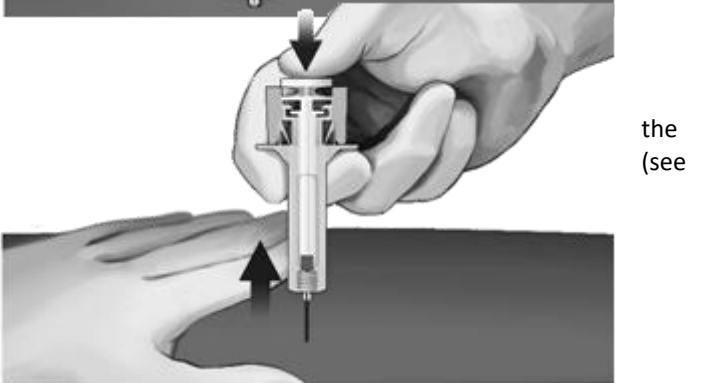


Figure 8: As soon as the needle has been completely removed from the skin, slowly take the thumb off the plunger and allow the guard to automatically cover the exposed needle (see Figure 8). There may be a small amount of blood at the injection site, if wipe with a cotton ball or gauze.



Disposing of the syringe

Any unused medicinal product or waste material should be disposed of in accordance with local requirements