Reference Number: UHB 328 **Version Number:** 2	**Reference Number:** UHB 328 **Version Number:** 2 **Date of Next Review:** 01 Sep 2019 **Previous Trust/LHB Reference Number:** T379

Guidelines for the 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: Prescribed opioid substitute medication including methadone and buprenorphine (including Suboxone) as part of a registered community programme **Section A**

- Not currently prescribed opioid substitute medication as part of a community programme but using illicit opiates **Section B**

- Dependent on opioids, either prescribed or illicit and requiring acute pain management **Section C**

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 (ADULT) http://www.wales.nhs.uk/sitesplus/documents/864/Acute%20Pain%20Guidlines%20Adult.pdf Guideline for the care of substance using women and their babies http://www.wales.nhs.uk/sitesplus/documents/864/Acute%20Pain%20Guidlines%20Adult.pdf Management of patients/visitors in possession of alcohol or unprescribed/ illegal substances policy & procedure http://www.cardiffandvaleuhb.wales.nhs.uk/opendoc/210821 Search of Patients Person and Belongings Policy & Procedure http://www.cardiffandvaleuhb.wales.nhs.uk/opendoc/213381 Alcohol Detoxification in UHW and UHL Guidelines (Symptom Triggered) http://www.cardiffandvaleuhb.wales.nhs.uk/opendoc/223478
Approved by	Medicines Management Group
Accountable Executive or Clinical Board Director	Medical Director

Author(s)	Original author: Louise Poley – Consultant Nurse Revisions: Neil Jones – Addictions Psychiatrist

Version Number	Date of 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

CONTENTS

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 co-ordinated 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:

- Prescribed opioid substitute medication including methadone and buprenorphine (including Suboxone) as part of a registered community programme **Section A**
- Not currently prescribed opioid substitute medication as part of a registered community programme but using illicit opiates **Section B**
- Dependent on opioids, either prescribed or illicit and requiring acute pain management **Section C**

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 07966 403925. Published UHB Guidelines for the Care of Pregnant / Postnatal Inpatients with Opiate Dependence and for the Management of Pain Relief in Maternity Inpatients Prescribed Subutex (Buprenorphine) (see hyperlink above).

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)

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

3.6 If the demeanour 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.

SECTION A: THE MANAGEMENT OF PATIENTS *ON* A REGISTERED METHADONE/ BUPRENORPHINE (SUBUTEX® or SUBOXONE®) 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.

4.2 Confirm details of the patient's prescription with the dispensing pharmacy and prescribing organisation. Contact details of usual agencies and pharmacies are provided in Appendix 1.

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 SM liaison team (see contact list – appendix 5) for advice on restarting.

Caution is advised for those 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 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 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 (note- for sublingual buprenorphine 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.

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.

5.5 If needing to obtain methadone or buprenorphine out of hours, please follow the UHB's controlled drug (CD) borrowing policy.

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 Suboxone®) 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 as long as care is taken not 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 day's 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.

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

7.5 <u>Day Leave / Overnight leave</u>
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.

7.6 <u>'Weekend' LEAVE</u>
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 8.3) is safer. Alternatively the team may decide to ask the patient to return to the ward daily for consumption.

7.7 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.

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

SECTION B: THE MANAGEMENT OF THOSE *NOT CURRENTLY* ON A REGISTERED METHADONE/ BUPRENORPHINE (SUBUTEX) PROGRAMME

Follow the recommendations outlined in section 3 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. 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) 20mgs *four times a day* to alleviate abdominal cramps
- Loperamide 4mgs stat followed by 2mgs *as needed* following loose bowel movement up to a maximum of 16mgs daily
- Ibuprofen 400-600mg four times a day or Diclofenac 50mgs three times a day +/- proton pump inhibitor (omeprazole 20mg od or lansoprazole 30mg od)
- Diazepam 10mgs *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 10mgs *three times a day* to alleviate nausea and vomiting

See BNF for full dosage instructions, contraindications and cautions to treatment.

8.5. For COWs scores >12, and or where OST has not been confirmed (e.g. over a weekend) dihydrocodeine 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.

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 E-DAS.

SECTION C: ANALGESIA FOR OPIOID DEPENDENT PATIENTS

Please refer to the Cardiff and Vale **UHB's ACUTE PAIN SERVICE GUIDELINES (ADULT) - see hyperlinks above -** section 10 – which can be accessed via the Guideline section of the clinical portal.

Patients using opioids for prolonged periods (prescribed or illicit) are likely to have developed tolerance to the drug group and larger doses of opiod pain relief may be required.

10. Analgesia for those prescribed methadone as part of a treatment programme

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 (including Suboxone®) prescribed patients

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 / antagonist affect 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.

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

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 maybe 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.

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

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 (including Suboxone®) 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, suggested in this section.

14. Prescribing analgesia on discharge from hospital

(see page 6 for guidance)

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.

17. Overdose with buprenorphine (Subutex®)

17.1. Buprenorphine (including Suboxone®) in overdose is generally regarded as less risky than methadone and heroin because it causes less 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 is often required in cases where buprenorphine is contributing to respiratory depression (e.g. in polydrug overdose).

17.2. 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.

17.3. For further information on the management of overdose contact the National Poisons Information Service on **0844 892 0111** or access the TOXBASE website www.toxbase.org (password required).

17.4. Refer all patients to Substance Misuse Liaison Nurse, if not available offer referral to E-DAS.

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.

SECTION E : ADMINISTRATION

18. References

Wesson and Ling, 2003 J Psychoactive Drugs. 2003 Apr-Jun;35(2):253-9. The Clinical Opiate Withdrawal Scale (COWS).

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 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.

Appendix One

Useful contacts and community pharmacy providers of supervised consumption and needle exchange

Community Addiction Unit - Cardiff
House 56 CRI
Newport Rd
Cardiff
Tel: 029 2046 1742

Community Addiction Unit – Vale of Glamorgan
26 Newland St
Barry
Tel: 01446 700943

Entry to drug and Alcohol Services (E-DAS)

www.e-das.wales.nh.uk
Email **-** E-DAS.Enquiries.CAV@wales.nhs.uk

E-DAS (Cardiff)
Housing Options Centre,
Hansen Street, (Off Tresillian Terrace),
Cardiff.
CF10 5DW.

Tel - 0300 300 7000
Fax - 02920 570708

E-DAS (Vale of Glamorgan)
2-10 Holton Road,
Barry
Vale of Glamorgan
CF63 4HD

Tel - 0300 300 7000
Fax - 01446 403077

Integrated Offender Interention Service (IOIS)

http://www.cri.org.uk/drr_cardiff.php

Email: wales@cri.org.uk

Cardiff IOIS
Harlech Court
Ground Floor
ButeTerrace
Cardiff
CF10 2FE

Tel - 02920 641 213

Fax - 02920 236 672

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

Substance Misuse (SM) Liaison Team – Drug and Alcohol referrals
Room 262 A1 corridor
University Hospital of Wales,
Heath Park,
Cardiff.
CF14 4XW
UHW
Tel: 02920744901

The All Wales Drug and Alcohol Helpline (DAN)
http://dan247.org.uk/
0808 808 2234

Community pharmacy providers of supervised administration of methadone / buprenorphine : Cardiff and Vale

Name of Pharmacy	Address 1	Postcode	Telephone Number
AE Petersen Ltd	8 Park Crescent	CF62 6HD	01446 735814
Asda Pharmacy	Asda Superstore Longwood Drive	CF14 7EW	02920 544612
Bainbridge Pharmacy	68 Plasmawr Road	CF5 3JX	0292 0563573
Boots UK Limited	48 Countisbury Avenue	CF3 5SL	02920 777646
Boots UK Limited	77-79 Albany Road	CF24 3LN	02920 483043
Boots UK Limited	121/125 Holton Road	CF63 4SW	01446 735280
Boots UK Limited	213-215 Cowbridge Road East	CF11 9AL	02920 225491
Boots UK Limited	5-7 Wood Street	CF10 1NL	02920 377043
Boots UK Limited	7 Boverton Road	CF61 1XZ	01446 792300
Boots UK Limited	24 Winsdor Road	CF64 1YJ	02920 707710 Option 3
Boots UK Limited	Unit D Cardiff Bay Retail Park Ferry Road	CF11 0JR	02920 229612
Boots UK Limited	4 Strathy Road	CF3 0SH	02920 362138
Caerau Lane Pharmacy	40 Caerau Lane	CF5 5HQ	02920 598080
Clifton Pharmacy	7-8 Clifton Street	CF24 1PW	02920 494975
Danescourt Pharmacy	2 Rachel Close	CF5 2SH	02920 578419
Hopwoods Ltd	19 Maelfa Shopping Centre	CF23 9PL	02920 731179
Judith Evans Pharmacy	88 High Street Barry	CF61 7DX	01446 733789
Lloydspharmacy	8 Park Road	CF14 7BQ	02920 626986
Lloydspharmacy	Grange Medical Centre Bishop Street	CF11 6PG	02920 231907
Lloydspharmacy	4C Heol y Deri	CF14 6HF	02920 618000
Lloydspharmacy	42 Merthyr Road	CF14 7ET	02920 621156
Lloydspharmacy	Court Road Surgery	CF63 4YD	01446 736817
Lloydspharmacy	347-349 St Mellons District Shopping Centre, Crickhowell Road	CF3 0EF	02920 797300
Lloydspharmacy	1-2 Chestnut Road	CF5 3HR	02920 563828
Lloydspharmacy	Stirling Road Shopping Precinct Port Road	CF62 8NX	01446 746000
Lloydspharmacy	Waterfront Medical Centre	CF63 4AR	01446 739949
Lloydspharmacy	35 Wilson Road	CF5 4LL	02920 591144
Lloydspharmacy	99-101 Holton Road	CF63 4HG	01446 735488
Lloydspharmacy	99 Caerphilly Road	CF14 4AE	02920 628553
Lloydspharmacy	Llanrumney Medical Centre Ball Road	CF3 5NP	02920 791671
Lloydspharmacy	44 Station Road Llanishen	CF14 5LT	02920 405003
Co-op Chemists Ltd	Unit 3 Trowbridge Local Centre Abergele Rd	CF3 1RR	02920 778522
Co-op Chemists Ltd	1,2 & 3 Upper Clifton Street	CF24 1PU	02920 494373
Co-op Chemists Ltd	148 Holton Road	CF63 4HL	01446 735154
Co-op Chemists Ltd	213 Bute Street	CF10 5HR	02920 481696
Co-op Chemists Ltd	178 Clare Road	CF11 6YG	02920 220174
Co-op Chemists Ltd	Albany Surgery 219-221 City Road	CF24 3JF	02920 488524
Pearns Pharmacies Ltd	36 Windsor Road	CF64 1YD	02920 707568
Pearns Pharmacies Ltd	3 Wilson Road	CF5 4LJ	02920 599511
Rhoose Pharmacy	53 Fontygary Road	CF62 3DT	01446 710277
S R Bailey Ltd	52 Splott Road	CF24 2DA	02920 462012
St Mellons Pharmacy	Wellness Pharmacy Newport Road	CF3 5UA	02920 797300
St Brides Pharmacy	1 St Anns Court	CF62 9DN	01446 743423

Superdrug Pharmacy	81-83 Albany Road	CF24 3LN	02920 490442
Tesco Stores Limited	Tesco Instore Pharmacy Culverhouse Cross	CF5 6XQ	02920 291847
Tesco Stores Limited	Tesco Instore Pharmacy Western Avenue	CF14 3AT	02920 291247
Tesco Stores Limited	Tesco Instore Pharmacy Penarth Haven Terranova Way	CF64 1SA	02920 508847
TH & L Jones LTD	The Murch Pharmacy	CF64 4QY	02920 512279
Virdee Pharmacy	54 Clare Road	CF11 6RT	02920 635750
Woodville Road Pharmacy	74 Woodville Road	CF24 4EB	02920 227835

Needle exchange sites in Cardiff and the Vale of Glamorgan

- at CAU - DATT Cardiff (Mon - Fri 2 - 4.30pm) - see contact us page.
- at TAITH

TAITH (Cardiff)	**Inroads (Vale)**
98 Neville Street Cardiff Tel: 02921 833057	2-10 Holton Road Barry Tel: 02921 833057
Opening Times Monday - Friday 9:30am to 5:00pm	**Opening Times** Monday - Friday 12:30am to 4:30pm

Community pharmacies

Cardiff

Butetown The Co-operative Pharmacy, 213 Bute Street, Butetown, Cardiff, CF10 5HR	02920 481696
Cathays Woodville Road Pharmacy, 74 Woodville Road, Cathays, Cardiff, CF24 4EB	029 2022 7835
Ely Pearns Pharmacies Ltd, 3 Wilson Rd., Ely, Cardiff, CF5 4LJ	029 2059 9511
Caerau Lane Pharmacy, 40 Caerau Lane, Ely, Cardiff, CF5 5HQ	029 2059 8080
Lloyds Pharmacy, 35 Wilson Road, Ely, Cardiff, CF5 4LL	029 2059 1144
St Mellons St Mellons Pharmacy, Seaview Stores Londis, Newport Road, St Mellons, Cardiff, CF3 5UA	029 2077 7026

Tongwynlais Rees & Moore, 17 Merthyr Road, Tongwynlais, CF15 7LF	029 2081 3343
Tremorfa Pearns Pharmacies Ltd, 45 Tweedsmuir Road, Tremorfa, Cardiff, CF24 2QZ	029 2046 2543

Vale of Glamorgan

Barry Park Crescent Pharmacy, 8 Park Crescent, Barry, Vale of Glamorgan, CF62 6HD	01446 735814
Dinas Powys TH & L Jones Ltd, The Murch Pharmacy, 19 Camm's Corner, Dinas Powys, Vale of Glamorgan, CF64 4QY	029 2051 2279
Llantwit Major Boots, 7 Boverton Rd., Llantwit Major, Vale of Glamorgan, CF61 1XZ	01446 792300
Penarth Boots, 24 Windsor Road, Penarth, Vale of Glamorgan, CF64 1YJ	029 2070 7710 Option 3

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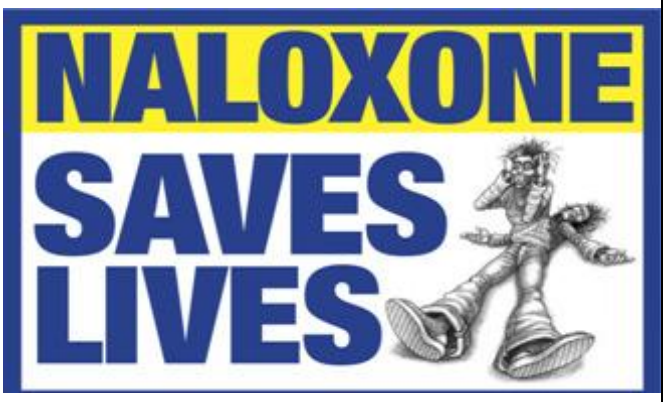
Appendix Two- information for patients and carers for heroin users



HEROIN OVERDOSE

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.

Appendix 3

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 *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	**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 piloerrection 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

(Wesson & Ling 2003)

Appendix 4

GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Caerdydd a'r Fro | Cardiff and Vale University Health Board

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

ILLICT OPIOID USER?
Consider:
1. History
2. Physical Signs
3. Urine drug screen

Opioid dependent?

Yes

On community Opioid Substitute Treatment (OST) ?

Yes

Phone to confirm drug, dose, recent compliance, frequency of pick up from community prescriber and patient's pharmacy **BEFORE** continuing prescription as inpatient

- If uncertain involve hospital pharmacist
- Checks may not be possible at night or weekends

Confirmation ?

Yes

Prescribe substitute (drug chart note should state "supervised administration")

Ensure community prescription suspended

No

No

Not for inpatient Opioid Substitute Treatment (OST) (eg. Methadone)

Assess 1 – 2 hourly for evidence of opiate withdrawal
Use Clinical opiate withdrawal scale (COWS)

COWS scores maybe affected by physical illness or withdrawal from other substances / alcohol

Manage with rescue meds*

If later confirmation of community OST or expected duration of admission > 7days consider OST

only in liaison with SM liaison team

No

In Pain?

Yes

Patient does **NOT** need Analgesia.

Patient **NEEDS** Analgesia. Treat using the analgesic ladder

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