METHADONE / BUPRENORPHINE ADMISSION & DISCHARGE PROTOCOL

All NHSL inpatient sites

ADMISSION

Methadone or buprenorphine should NOT be prescribed for patients until their dose is CONFIRMED with the community pharmacy, prescriber or addictions key worker.

Opioid withdrawal can be unpleasant for the patient but is extremely unlikely to be fatal, therefore if in doubt or unable to confirm the methadone / buprenorphine dose it is safer for the patient to withhold a dose of methadone / buprenorphine rather than provide a dose which could cause an opioid overdose.

It is essential to confirm a patient's dose of methadone or buprenorphine and the time of the last dose before any methadone / buprenorphine is administered in hospital. This process can begin as soon as the patient is admitted e.g. A&E, ward areas. Confirmation should be recorded on the medical notes/medicines reconciliation page of the admission paperwork.

Patients' own methadone / buprenorphine, dispensed within the previous seven days and properly labelled by the community pharmacy, can be regarded as confirmation of the dose until contact can be made. Every effort must be made to confirm the dose of methadone / buprenorphine as soon as possible after admission.

Occasionally methadone will appear on the patient's Emergency Care Summary (ECS) as a reminder for clinical staff however, the dose is often just a treatment flag for a medication not prescribed by the GP and may not be accurate. Therefore, ECS should not be used as a source of confirmation of dose.

Monday – Friday – for those wards receiving a regular clinical pharmacy service, contact the ward clinical pharmacist who will liaise with the appropriate community pharmacy. Contact the substance misuse nurses where available (Monday to Fridays) for further management advice.

Saturday, Sunday and public holidays – the ward should contact the patient's community pharmacy directly and refer onto the ward clinical pharmacist when they are next available. Most community pharmacies are open on Saturday and some for a limited time on Sundays**.** Document the following information on the medicines reconciliation paperwork/medical notes:

1. the daily dose that the patient is prescribed
2. confirm this is a stable – non titrating / reducing dose?
3. the last time the dose(s) were dispensed
4. the community pharmacy details.
5. confirm whether any other medicines are currently supplied on a daily basis, and if so record the drug name, daily dose and date of last supply for each medicine on the list.

Patient' s Own Drugs – Admission

Most community pharmacies will provide supervised methadone or buprenorphine administration on Saturdays and supply a dose away for Sundays / public holidays so the patient may have their own Sunday / public holiday supply.

For methadone only: Patient's own medication should be retained but NOT supplied to the patient. The supply of medication should only come from the hospital pharmacy.

For buprenorphine products: use the standard POD policy.

Patient's own methadone / buprenorphine must be stored in the controlled drug cupboard and receipt and administration of patient's own methadone / buprenorphine must be recorded in the controlled drug register in accordance with hospital procedure.

Inability to Confirm Dose

Where all attempts to confirm a patients dose and time of last dose have been exhausted (i.e. contacting community pharmacy, GP or addictions key worker), and the patient is experiencing an uncomfortable level of withdrawal , symptomatic relief should be used e.g. paracetamol, ibuprofen, loperamide. If symptomatic relief is still insufficient, dihydrocodeine 30mg tablets may be prescribed and administered up to a maximum of 60mg four times a day (maximum of 240mg/day). If the patient is still symptomatic after receiving the maximum dose, seek senior clinical review.

Remember both methadone and buprenorphine have a long half-life and will last in the body at a therapeutic level for longer than 24 -36 hours. Missing one dose is unlikely to cause significant withdrawal symptoms.

Contact the substance misuse nurses where available (Monday to Fridays) for further management advice.

Missed Doses (from NHSL Addictions Services Guideline 2019)

When medication doses are missed for three or more consecutive day's tolerance to opioids may be reduced, placing patients at increased risk of overdose when recommencing medication. The dose should be withheld or reduced until the patient has been assessed or telephone advice sought from the prescriber. The patient should be assessed for signs of withdrawal or intoxication before medication is recommenced. In general the following schedule can be presumed to be safe:

No. of days missed	Action METHADONE	Action BUPRENORPHINE
One or Two days	No change in dose. Normal dose may be taken if no evidence of intoxication.	No change in dose. Normal dose may be taken if no evidence of intoxication.
Three days.	Recommended dose is half current dose or 30mg (whichever is greater) and re-titrate.	Recommended dose is half current dose or 8mg (whichever is greater) and re-titrate.

Four Days	Recommended daily dose is half current dose or 30mg whichever is lower and re-titrate.	Recommended daily dose is half current dose or 8mg whichever is lower and re-titrate.
Five days or more	Regard as new induction – Contact substance misuse nurse or addiction services	Regard as new induction – Contact substance misuse nurse or addiction services

Patients on Weekend Pass or short periods off ward

On occasions where a patient on methadone or buprenorphine is discharged from hospital for a short period, for example, on weekend pass, it is the responsibility of the **hospital** to continue methadone / buprenorphine prescribing during this period. The patient should be advised prior to leaving hospital to return to the ward for daily dispensing of methadone/ buprenorphine.

Do not give a supply of methadone/ buprenorphine home with the patient on pass.

Prior to the patient leaving the ward, the community addiction team and the dispensing community pharmacy must be made aware of this arrangement.

In the event of longer passes, or if the patient has genuine difficulty in returning to the ward for their supervised treatment, the ward staff should liaise closely with the patients addiction worker on a case by case basis to discuss bespoke arrangements for supply of medication. This may in some exceptional circumstances include the community addictions team providing a prescription for the patient to be dispensed at their community pharmacy.

In the event of a change in the agreed arrangements or if the dates of the pass are altered, ward staff must ensure the community pharmacy and community addictions team are made aware of the situation.

DISCHARGE

Record on discharge paperwork
Ensure daily dose is clarified as admission process if not already done so.

<u>Monday to Friday</u>

- On discharge,
  - Option 1, where possible direct patient to collect normal daily dose from the community pharmacy if a current prescription is still valid.
  - Option 2, supervise the administration daily dose of methadone / buprenorphine on ward before discharge

  Irrespective of how the supply is made this should be discussed with the patient's community pharmacy <u>before</u> the patient is discharged from the ward
- Contact the ward clinical pharmacist prior to discharge if possible or where the patient has been discharged out with pharmacy hours, as soon as possible thereafter. The ward clinical pharmacist will contact the community pharmacy by telephone to advise them of the patient's discharge and make arrangements for the continuing supply of methadone/ buprenorphine.
- If there is no valid prescription at the community pharmacy when the patient is discharged, it is the patient's responsibility to seek advice / arrange a prescription from

the community addictions team. (may be facilitated by the substance misuse nurses where available)

- If the ward does not have a designated clinical pharmacist, the hospital pharmacy dispensary is available for advice. However, the responsibility for ensuring accurate medicines reconciliation with regards methadone/buprenorphine prescribing must be completed and recorded by the ward staff.

Saturday, Sunday and public holidays (and other days of pharmacy closure)

Confirm if the patient's pharmacy is open on date of discharge, if open follow the Monday to Friday procedure above

If closed (i.e. Sunday and public holidays):

- The ward should contact the community pharmacy when they re-open to inform them of the patient's discharge and advise them what arrangements were made for the patient on the day of discharge.
- Supply options at discharge:

1. If the patient already has doses at home, a supply will not be provided on discharge
2. If the patient has brought their own supply in and it is deemed safe and appropriate, this can be returned for the patient to take on the days the community pharmacy is closed
3. If no supply available, in exceptional circumstances, the minimal supply required to cover the days the community pharmacy is closed should be prescribed on discharge. This should be agreed between senior medical staff and pharmacy. Contact the substance misuse nurses when available (Monday to Fridays) for further management advice including patient discharge.

Patient' s Own Drugs – discharge

For methadone only: If patient brings their own medication in with them, they should be offered the choice of taking the medication back home or having this destroyed on the ward after the patient is discharged following CD destruction procedures. The community pharmacy the patient attends should be advised when the patient should return to collect the next prescribed dose.

For buprenorphine products: use the standard POD policy.

For patients with altered doses following hospital admission

- Liaise closely with community pharmacy and addictions services to ensure safe ongoing patient care and prescribing

Methadone / buprenorphine should not be supplied routinely to take home upon discharge from hospital.