Reference Number: UHBOBS097 **Version Number: 3**	**Date of Next Review: 17/05/2022** **Previous Trust/LHB Reference Number: UHB2**

Guidelines for the management of opioid-dependent pregnant individuals admitted to UHWand Llandough hospitals.

Guideline for substance using women and their babies.

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

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

- 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 policy applies to all healthcare professionals in all locations including those with honorary contracts

Equality Health Impact Assessment	*An Equality Health Impact Assessment (EHIA) has not been completed.*
Documents to read alongside this Procedure	**UHB046 The ordering, storage, disposal and safe prescribing and administration of controlled drugsin secondary care policy (Clinical Portal)**
Approved by	Maternity Professional Forum and Obs & Gynae Quality & Safety

Accountable Executive or Clinical Board Director	*Ruth Walker, Executive Nurse Director*
Author(s)	*Sarah James, Specialist Midwife for Substance Misuse*

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.

Summary of reviews/amendments

Version Number	Date of Review Approved	Date Published	Summary of Amendments
1			
2	May 2012	May 2012	Reviewed and Updated by Lois Mortimer, Neil Jones, Rosanna Oretti and Rachel Collis
3	17/05/2019	21/05/2019	Reviewed and Updated by Sarah James, Specialist Midwife

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2 Introduction

Pregnant 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.

Patients using drugs problematically may attend the obstetric assessment 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.

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3 Scope and purpose of the guidance

This document is intended to provide guidance for the care of pregnant women who are admitted as inpatients to Cardiff and Vale UHB. This might include women who are:

Using heroin

Are requesting opioids

Are symptomatic of opioid withdrawals

On a substitute prescription of methadone

On a substitute prescription of buprenorphine

Emergency admission of pregnant women requires careful assessment including urine toxicology. Due to the complexities of presentation only general guidance can be provided as opposed to clear protocol.

All efforts should be made to engage the woman in treatment, both in the short term as an inpatient, but also before discharge to the community team.

The majority of women admitted will already be in the care of the Substance Misuse Team (Community Addictions Unit (CAU) and Substance Misuse Midwife). Contact should be made with the Substance Misuse Team on *each* admission to verify the woman's current treatment plan.

For those women not established on an opioid substitute who are displaying clear opioid withdrawals (see included opioid withdrawal scale on p.8), stabilisation on to a licensed opioid substitute is the preferred option. However this should not be done without specialist advice and co-operation of the CAU. Specialist advice should always be sought when prescribing substitute treatment for clients not already in treatment.

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3.1 Urgent Advice - Contacts

For urgent advice regarding substance misuse contact:

Inpatient liaison services

Professional referral only – from treating staff on relevant hospital site.

Telephone: 02920744901

Community Addiction Unit – Cardiff
House 56, CRI Buildings, Newport Road, Cardiff, CF24 0SZ

Telephone: 029 2046 1742

Opening times:
Monday to Thursday: 9.00 - 5.00
Friday: 9.00 - 4.30

Drug team – Dispensing and Treatment Team (DATT)
The Angove Unit (DATT), Longcross Street, Cardiff. CF24 0SZ
Tel: 029 2033 5226

Opening times:
Mon to Friday 9.00 – 1.30, and 2.00 -4.30

Community Addictions Unit - VALE
26 Newland Street, Barry, Vale of Glamorgan. CF62 8AE

Telephone: 01446 700943

Opening times:

Monday: 9.00 - 1.30, and 1.30 - 5.00 (closed for appointments but Reception accepts telephone calls and messages)
Tuesday to Thursday: 9.00 - 1.00, and 1.30 - 5.00
Friday: 9.00 - 1.00, and 1.30 - 4.30.

Out of hours: on-call psychiatrist at Pine Ward, Hafan y Coed, University Hospital Llandough, Penlan Road, Penarth CF64 2XX
Telephone: 029 2182 4830

Substance Misuse Midwife: Sarah James 07817170121

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4 Pregnant/postnatal women not on Registered Methadone/Buprenorphine Programme Requesting Opioids or Symptomatic of Opioid Withdrawals

4.1 Management

1. Establish whether the woman is on a registered programme and prescribed opioid substitution in the community. **Do not** prescribe methadone or buprenorphine before establishing that the patient is on a registered programme and that they have been receiving this dose of medication in the prior three days. Liaise closely with the prescriber and the community pharmacist

2. Clinical assessment of the woman to include signs and symptoms of opioid withdrawal (see included an opioid withdrawal score on p.8) and to 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

3. Request a urine sample for drug screening (a supervised sample is optimal)

4. If the woman is requesting opioids or is symptomatic of opioid withdrawals contact the Specialist Midwife in Drugs and Alcohol on 07966 403925 and the Community Addictions Unit on 02920 461742 if within working hours, for advice or assessment and to check if a client of theirs

5. When admitted out of working hours treatment should be the symptomatic relief of opioid withdrawals ONLY until the Community Addictions Unit is able to be contacted OR if 1) above can be verified. If any doubt consult the on call psychiatrist at Whitchurch Hospital on 02920 693191. Advise on assessing opioid withdrawal can be sought through the Adfer Unit, the specialist inpatient substance misuse service – 029 20336340.

IF IN ANY DOUBT, IT IS SAFER FOR THE WOMAN AND UNBORN CHILD **NOT** TO PRESCRIBE OPIOIDS

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4.2 Signs and Symptoms of Opioid Withdrawals

Abdominal cramps
Vomiting and diarrhoea
Agitation including restlessness, irritability and insomnia
Muscle cramps and pain: bone pain
Sweats
Raised blood pressure and increased pulse
Dilated pupils
Psychological drug craving
Lacrimation and runny nose
Yawning
Goose flesh (piloerection)

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4.3 Treatment for Symptomatic Relief of Opioid Withdrawals

The objective signs of withdrawal are more robust than symptoms described. Prescribing symptomatically can reduce some of the physical effects of withdrawal. Care is needed concerning the risks of polypharmacy and appropriate medical review should be sought. For those experiencing opioid withdrawal symptoms offer on a **'when required`** basis (as long as no contraindications to treatment) the following medication:

1. Dihydrocodeine (DHC) 30mgs every 4-6 hours as required for short term relief of discomfort
2. Hyoscine butylbromide (Buscopan) 20mgs QDS to alleviate abdominal cramps
3. Loperamide 4mgs stat followed by 2mgs as required following loose bowel movement up to a maximum of 16mgs daily
4. Ibuprofen 400-600mg QDS or Diclofenac 50mgs TDS for muscle and bone pains
5. Diazepam10mgs TDS for a maximum of 3 days for agitation and restlessness
6. Metoclopramide 10mgs TDS to alleviate nausea and vomiting (DOH, 2007)

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

Medication used to manage opioid withdrawals should be offered for **approximately 3-5 days** and should not be continued on discharge. Patients should be advised of this when medication is initiated.

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5 Women on Current Prescription of Substitute Opioid Medication (Methadone or buprenorphine)

A stock of buprenorphine sublingual tablets (0.4mg and 2 mg) and methadone mixture (Sugar Free 1mg/1ml) are usually kept on the ward, but in the event of there being no stock, contact inpatient pharmacy or the on-call pharmacist.

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5.1 When admitted Monday-Saturday

1. **Confirm the dose and whether the day's dose has already been given** by contacting the prescriber (usually CAU, but may be GP or other treatment agency) and the community pharmacy where the client picks up the prescription

2. Ask a doctor to prescribe accordingly, on the 'Regular prescriptions' part of the inpatient chart

3. Give medication at approximate time of day client usually picks up from community. However, giving the medication a couple of hours early/late should not cause medical problems.

4. Please ensure that all patients are observed consuming their methadone or buprenorphine on the ward (note- for sublingual buprenorphine may take about 5 minutes).

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5.2 When admitted after 5pm or on Sundays

1. If the current dose cannot be verified by the prescriber or the dispensing community pharmacy, the medication should not be given. The prescriber/ pharmacist should be contacted on the next working day to confirm the dose.

2. If the client states that she is on a buprenorphine product or methadone and is symptomatic of opioid withdrawal, follow the treatment for non-opioid symptomatic relief of opioid withdrawals (p5)

See Section 6 for advice on discharge.

For other information relating to controlled drugs, please refer to:

UHB046The ordering, storage, disposal and safe prescribing and administration of controlled drugs in secondary care policy (Clinical Portal).

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6 Discharge of Women on Current Prescription of Substitute Opioid Medication (methadone or buprenorphine)

6.1 If discharged Mon-Fri

1. Give day's supervised dose prior to discharge

2. Contact community pharmacist and prescriber (usually CAU but might be GP) to inform of discharge, and restart community prescription for next day.

3. **Do not supply TTOs**, as buprenorphine / methadone can be picked up the following day from the usual nominated community pharmacist

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6.2 If discharged Saturday

1. **If discharged early enough to get to community pharmacy before it closes:** contact the usual designated community pharmacy to inform of discharge and confirm current dose. Client will be able to collect Saturday and Sunday doses from the community pharmacy.

2. **If discharge anticipated as being too late to go to community pharmacy to pick up Saturday and Sunday doses:** give Saturday's dose on ward. Contact inpatient pharmacist to dispense Sunday's dose as a TTO.

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6.3 If discharged after working hours or on a Sunday or Bank Holiday

1. Give day's supervised dose prior to discharge

2. Contact designated community pharmacist and the prescriber to inform of discharge and confirm current dose ASAP (i.e., on the morning of the next working day following discharge).

3. **TTOs not to be given** unless this has been organised with the hospital pharmacist, in the event of the client being unable to pick up the next due dose from the usual community pharmacist

NEVER GIVE TTOS FROM WARD STOCK.

For other information relating to controlled drugs, please refer to:

UHB046 The ordering, storage, disposal and safe prescribing and administration of controlled drugsin secondary care policy (Clinical Portal)

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7 Appendices

7.1 APPENDIX 1 Clinical Opiate Withdrawal Scale (COWS)

Flow-sheet for measuring symptoms over a period of time

For each item, write in 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:_____

Buprenorphine induction:

Enter scores at time zero, 30min after first dose, 2 h after first dose, etc.

Times: _____

Resting Pulse Rate: (record beats per 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

Sweating: *over past ½ hour not accounted for by room temperature or patient activity.*

0 no report of chills or flushing

1 subjective report of chills or flushing

2 flushed or observable moistness on face

3 beads of sweat on brow or face

4 sweat streaming off face

Restlessness *Observation during assessmen*t

0 able to sit still

1 reports difficulty sitting still, but is able to do so

3 frequent shifting or extraneous movements of legs/arms

5 Unable to sit still for more than a few seconds

Pupil size

0 pupils pinned or normal size for room light

1 pupils possibly larger than normal for room light

2 pupils moderately dilated

5 pupils so dilated that only the rim of the iris is visible

Bone or Joint aches *If patient was having pain previously, only the additional component attributed to opiates withdrawal is scored*

0 not present

1 mild diffuse discomfort

2 patient reports severe diffuse aching of joints/ muscles

3 patient is rubbing joints or muscles and is unable to sit still because of discomfort

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7.2 APPENDIX 2 – Useful Contacts And Community Pharmacy Providers of Supervised Consumption and Needle Exchange

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

Inpatient liaison services

Professional referral only – from treating staff on relevant hospital site.

Telephone: 02920744901

Community Addiction Unit – Cardiff
House 56, CRI Buildings, Newport Road, Cardiff, CF24 0SZ

Telephone: 029 2046 1742

Opening times:
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Out of hours: on-call psychiatrist at Pine Ward, Hafan y Coed, University Hospital Llandough, Penlan Road, Penarth CF64 2XX
Telephone: 029 2182 4830

Substance Misuse Midwife: Sarah James 07817170121

E-DAS (Cardiff)
7 St Andrews Place, Cardiff, CF10 3BE
Tel - 0300 300 7000
Fax - 02920 570708

EDAS (or Entry to Drug and Alcohol Services, to give it its full name) is a single point of entry for

anyone who feels that they have an issue with any substance in both Cardiff and the Vale of Glamorgan. EDAS provide simple and effective access to the full range of substance misuse services in Cardiff and the Vale of Glamorgan

Whether you have never been to services before or know them well EDAS staff will provide you with a free and confidential appointment. We will use this time to discuss you, your circumstances and what you might want from services. Together we can decide the best pathways that will meet your needs and take the first step in your journey together.

Not sure if this service is for you? Why not give us a call or drop-in to meet with one of our friendly workers to discuss what's out there.

Opening Times

Cardiff Office

Monday	9:30am – 3:00 pm	Drop-in Clinic
Tuesday	9:30am – 3:00 pm	Drop-in Clinic
Wednesday	1pm – 3 pm	**Pre booked Appointments Only** Be sure to phone in advance if you need to attend on this day.
Thursday	9:30am – 3:00 pm	Drop-in Clinic
Friday	10am – 12pm	**Pre booked Appointments Only** Be sure to phone in advance if you need to attend on this day.

Vale Office

Monday	9:30am – 3:00 pm	**Pre booked Appointments Only** In Barry we are currently only able to offer appointments, however if you phone ahead, we may be able to fit you in on the same day.
Thursday	9:30am – 3:00pm	

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