
When a patient is admitted to an inpatient ward and claims to be taking opiate substitute medication such as methadone or buprenorphine, the following advice should be considered:

**In addition to methadone and buprenorphine obtain details of any other opiates and all other prescribed medicines.** Check details from the label on the supplies brought in, the GP summary / Summary Care Record, the pharmacy that supplied the medicine or the substance misuse team. Patient specific advice from the patient’s substance misuse service must be sought whenever possible, and consider that the patient may not be totally honest about their prescription and use of opiates.

If the dose is confirmed, consider continuing the current dose. Check what the patient has already taken on the day of admission and if any prescribed doses have been missed. More than 3 consecutive days missed will usually mean that the dose will need adjusting downwards. (See missed dose guidance)

**Check if previous doses have been supervised.**

**Perform a urine drug test to confirm recent opioid consumption.** Do not prescribe to those with a negative opioid drug screen unless there is a clear history of opioid use and the patient is manifesting clear and marked signs of opioid withdrawal. Methadone and buprenorphine can be identified on multi-test analysis urine drug tests.

If the dose is confirmed consider continuing at this dose and titrate according to the patient’s complaints of withdrawal. Check there is no sign of intoxication.

See overleaf....

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CAUTION: Patients may die from overdose but do not die from withdrawal. Prescribe naloxone injection 400mcg by IM injection every 2-3 minutes on the prn side of the chart for those with uncertain tolerance to opioids.

Guidance on missed doses, where history is confirmed, (or consult SMS team)

Methadone
In the event of 3 consecutive missed doses, (ie 3 days), the daily dose should be reduced by 50%. In the event of 5 consecutive missed doses, (ie 5 days), the patient should be started as would a new induction with an initial daily dose of up to 30mg. The dose can be titrated upwards at a rate of 10mg per day, although note that due to the long half-life of methadone peak plasma levels will be delayed as it reaches steady state after several days. In the first 7 days the total weekly increase should not usually exceed 30mg above the starting dose.

Buprenorphine (Subutex/Suboxone)
In the event of 3 consecutive days of buprenorphine missed, review the patient and re-titritate to an appropriate maintenance dose. If the patient has returned to using heroin then wait for at least 8 hours after last use before starting at 4mg first dose.

Liaise with the substance misuse team and community pharmacy about the patient’s admission to hospital.

ON DISCHARGE – No medication is usually supplied.
Continuing prescriptions will need to be planned with the community substance misuse team. If discharging patient with a history of opioid overdose, consider prescribing Prenoxad injection to those who don’t have one and instruct on its use.

References: