Policy Document Control Sheet

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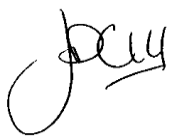
Executive Sponsor's Signature	
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Version Control Table

Date of Issue	Version Number	Status
Jan 2008	1.0	Superseded
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Table of Revisions

Date	Section	Revision	Author
Feb 2013	Full	Full	J Colllins
Feb 2013	1	Addition of updated reference 'ANZCA'	J. Collins
Feb 2013	4	Addition of updated guidance	J. Collins
Feb 2013	4.1	Insertion of bleep numbers for APS	J. Collins
Feb 2013	5.0	Strengthened evidence	J. Collins
Feb 2013	8	Removal of treatment centre manager's name	J. Collins
Feb 2013	9	Updated reference 'ANZCA'	J. Collins
Feb 2013	9	Updated Reference 'Acute pain management'	J. Collins
Feb 2013	9	Updated Reference 'BNF'	J. Collins
July 2016	5.2	Inclusion of hyperlink to CDDFT Naloxone Protocol	J. Collins
July 2016	5.3	Inclusion of hyperlink to CDDFT Naloxone Protocol	J. Collins
July 2016	6	Inclusion of Glossary of terms	J. Collins
July 2016	9	Updated reference 'ANZCA'	J. Collins
July 2016	9	Updated reference NMC 'The Code'	J. Collins
July 2016	9	Updated reference NMC 'Standard for Medication Management	J. Collins
July 2016	9	Updated Reference Royal Marsden Manual of Clinical Procedures	J. Collins
August 2019	Whole document	Whole document updated in line with current trust policy template and guidance	S Cairney
August 2019	Whole document	Whole document updated in line with current guidance and evidence	S Cairney

August 2019	3	Added excludes paediatric and obstetric patients.	S Cairney
August 2019	5.2	Added functional activity score	S Cairney
	5.3 5.4, and 5.5,	Added monitoring of pain scores Added Regularly monitor news, AVPU scores, and respiratory rates. Changed to clinical opioid withdrawal scale (COWS)	S Cairney
August 2019	8	References updated	S Cairney
August 2019	9	Documents updated	S Cairney
August 2019	10	Added appendix COWS	S Cairney

Contents

1 Introduction

Acute pain management in the group of patients who misuse opioids is recognised to be difficult. The terminology used to differentiate between physical dependence, tolerance and addiction may confuse healthcare professionals and may also lead to sub-optimal or inappropriate analgesic regimes (ANZCA, 2015). Often communication between this group of patients and healthcare professionals is poor leading to difficulties in care delivery. Research has shown that these patients often experience more pain than those who don't misuse opioids. It can be expected that it will be necessary to deviate from standard protocols when treating this patient group, (McIntyre & Schug, 2015).

2 Purpose

The guidance offered in the document should enable clinical staff, to effectively manage acute pain in this group of patients.

This document is intended for in conjunction with the Trust's 'Guidance on the Management of Opiate Misusers in the Acute Trust'. The document in divided into several sections, to ensure that the most appropriate treatment plan is followed.

3 Scope

This document is intended to be used by healthcare professionals who are involved in the care of individuals who have substance misuse issues and who are in acute pain.

This policy excludes pediatric and obstetric patients.

4 Duties

Ward Staff

To ensure patient safety and appropriate management of acute pain in the hospital setting for patients who misuse opioids. To ensure patients receive medications in a timely and appropriate manner. To prevent any break in treatment for substance misuse. To contact appropriate specialist services for patient review.

Acute Pain Service

To establish effective acute pain management programmes for individuals in this client group. To promote a positive relationship between patients who are known to misuse substances and the healthcare professionals responsible for their care whilst in the acute setting.

This policy will be reviewed by the Acute Pain Service on a 3 yearly basis, or in line with any local or national changes or directives that occur sooner.

5 Acute Pain Management in Substance Misuse

5.1 Immediate Acute Pain Management

People who are admitted to hospital with acute pain conditions; following surgery and or trauma and who misuse opioids should have a detailed pain history conducted as soon as possible after presentation to hospital. Assessment and management should focus on effective analgesia, prevention of withdrawal, close liaison with other healthcare professionals involved in their care i.e. substance misuse teams; GP or pharmacy. Effective use of strategies that may attenuate tolerance or opioid induced hyperalgesia should be implemented. It can be expected that higher doses of opioid medications may be required to treat acute pain.

5.2 Pain And Functional Activity Assessment With Analgesia Suggestions

Complete CP07 pain assessment and care plan on nerve center. Use recognized pain assessment tool to assess pain at rest and on movement pre and post analgesia– see assessment tools on acute pain intranet site. An assessment of functional activity score (FAS) should also be performed - this is an activity related score the patient is asked to perform a task appropriate to their injury or rehabilitation requirements they are then rated on how pain affects their ability to perform the task. (ANZCA 2015)

A- No limitation
B- Mild limitation
C- Severe limitation
Contact the Acute Pain Service for advice/patient referral.

PAIN SCORES	**ANALGESIA SUGGESTIONS** Continue oral maintenance dose of Methadone/ buprenorphine where possible.
Mild Pain (Pain Score 0-3)	Paracetamol + NSAID unless contraindicated
Moderate Pain (Pain Score 4-6)	Paracetamol + NSAID unless contraindicated ***Plus consider*** Nefopam *30*- 60mg TDS *Adjusted according to response* Refer to most current BNF for special precautions / contraindications
Severe Pain (Pain Score 7-10) After discussion with Acute Pain Team or 1st on call Anaesthetists at DMH / 2nd on call Anaesthetist!st at UHND out of hours	Paracetamol + NSAID unless contraindicated Nefopam *30*- 60mg TDS *Adjusted according to response* Refer to most current BNF for special precautions / contraindications ***Plus consider*** PRN Oral/IV Opioids /Regional / rectus sheath Analgesia

See BNF for drug dose, cautions, contraindications, side effects and necessary monitoring.

Additional caution needs to be taken in prescribing analgesia if patients also have respiratory disease, renal or liver disease/ failure or have suffered a head injury.

5.3 Patients in Treatment Receiving Methadone

Methadone is a long acting opioid agonist, which can be used for the treatment of addiction. It is commonly prescribed in a range of doses, once daily to reduce the symptoms of opioid withdrawal. It has a half-life of 24-36 hours; withdrawal is not apparent for 24 hours following a missed dose. Follow guidance in the table below where Methadone is used as **maintenance therapy** in the opioid addicted patient. Wherever possible the usual dose of Methadone should be continued. The dose should be confirmed by the patients 'key worker' from the substance misuse team.

Action	**Rationale**
Conduct patient history to identify drug use, this should be done routinely. Complete CP07 pain care plan on nerve centre	To ensure that most appropriate treatment plan can be implemented.
Refer emergency admissions to the acute pain team / 1st call Anaesthetist DMH or 2nd on call Anaesthetist at UHND (out of hours) at earliest opportunity.	To ensure that acute pain team are aware of admission and can assist in any treatment plan if required.
Planned admissions should be referred preoperatively to the acute pain team.	To ensure that the pain team can assist in treatment plan if required.
Ensure dosage confirmation ,as well as when last dose taken and this should be documented in patient's notes and be prescribed on Epma	To allow continuation of maintenance therapy
Dosage not known, treat the presenting pain problem.	Administer prescribed analgesia titrate to effect.
Unable to confirm dosage with 24 hours follow Guidelines in Management of Opiate Misusers in the Acute Trust'.	Administer prescribed analgesia; titrate to effect.
Missed doses, where regular doses have been missed for 3 or more days patients may be at risk of overdose due to loss of tolerance. Reduced doses of Methadone should be considered in these patients.	To prevent inadvertent overdose.
Regular recording pre and post analgesia of pain scores, functional activity score and administration of analgesia as per acute pain team recommendations. (See 5.2).	To ensure that the patient receives optimum treatment for the presenting acute pain problem.
If patient nil by mouth – please clarify with treating team if this includes medication Contact Acute Pain Team/ 1st call	To prevent withdrawal from methadone.

Anaesthetist DMH or 2nd on call Anaesthetist at UHND (out of hours) for advice	
Regularly monitor NEWS, AVPU scores, and respiratory rates.	To observe the patient for signs of respiratory depression and sedation
Have a supply of Naloxone available to administer if required	Use CDDFT protocol for Naloxone administration to treat respiratory depression if it occurs. http://intranet/Directorates/CCG/CSS/Pharmacy/Drug%20Protocols/Emergency%20treatment%20of%20poisoning/Naloxone%20Hydrochloride%20(in%20adults)%20-%20%20DRUG-GEN-0012%20V3.pdf
Once acute pain has subsided, discontinue opioid use and continue maintenance therapy with methadone and alternative multimodal analgesia.	To ensure that the patient receives optimum treatment for the presenting acute pain problem.
Assess withdrawal symptoms using COWS (clinical opioid withdrawal scale) appendix 1	To observe for signs of acute withdrawal
Inform patient's community substance misuse team -Key worker of admission, current medication and planned discharge date. Follow up in writing.	To ensure that discharge prescription can be accessed. To ensure that all involved parties are aware of discharge plans.

5.4 Patients in Treatment receiving Buprenorphine

Buprenorphine is a partial opioid agonist that is used as maintenance treatment in substance misuse. It has a half-life of 48 hours. It should not be used as analgesia. Wherever possible the usual dose of Buprenorphine should be continued. The dose should be confirmed by the patients 'key worker' from the substance misuse team.

ACTION	**RATIONALE**
Conduct patient history to identify drug use, this should be done routinely. Complete CP07 pain care plan on nerve centre	To ensure that most appropriate treatment plan can be implemented.
Refer emergency admissions to the acute pain team / 1st call anaesthetist (out of hours) at earliest opportunity.	To ensure that acute pain team are aware of admission and can assist in any treatment plan if required.

Planned admissions should be referred preoperatively to the acute pain team.	To ensure that the pain team can assist in treatment plan if required.
Ensure dosage confirmation and this should be documented in patient's notes and be prescribed on Epma	To allow continuation of maintenance therapy.
Regular recording pre and post analgesia of pain scores, functional activity score and administration of analgesia as per acute pain team recommendations. (See 5.2).	To ensure that the patient receives optimum treatment for the presenting acute pain problem.
Avoid abrupt discontinuation of Buprenorphine. Continue Buprenorphine maintenance and titrate short-acting opioid until analgesic effect is achieved; high doses may be required to compete with Buprenorphine.	To ensure that the effects of acute withdrawal are minimised.
Regularly monitor of NEWS, AVPU scores, and respiratory rates.	To observe the patient for signs of respiratory depression and sedation
Have a supply of Naloxone available to administer if required.	Use CDDFT protocol for Naloxone administration to treat respiratory depression if it occurs. http://intranet/Directorates/CCG/CSS/Pharmacy/Drug%20Protocols/Emergency%20treatment%20of%20poisoning/Naloxone%20Hydrochloride%20(in%20adults)%20-%20%20DRUG-GEN-0012%20V3.pdf
Once acute pain has subsided, discontinue opioid use and continue maintenance therapy with Buprenorphine and alternative multimodal analgesia.	To ensure that the patient receives optimum treatment for the presenting acute pain problem.
Assess withdrawal symptoms using COWS (clinical opioid withdrawal scale) appendix 1	To observe for signs of acute withdrawal
Inform patient's community substance misuse team -Key worker of admission, current medication and planned discharge date. Follow up in writing.	To ensure that discharge prescription can be accessed. To ensure that all involved parties are aware of discharge plans

5.5 Patients In Treatment Receiving Naltrexone

Naltrexone is an opioid antagonist. It is used as a treatment option in the formerly opioid-dependent patient, who is highly motivated to abstain from opioids. A single dose reaches peak plasma concentration in 1 – 2 hours and has a half-life of about 14 hours. It works by blocking the "high" associated with opioid drugs. Patients receiving Naltrexone pose major challenges to healthcare professionals when they

are in acute pain, (Vickers & Jolley, 2006). Naltrexone is available as an oral preparation or implants.

ACTION	**RATIONALE**
Conduct patient history to identify drug use, this should be done routinely. Complete CP07 pain care plan on nerve centre	To ensure that most appropriate treatment plan can be implemented.
Refer emergency admissions to the acute pain team / on call anaesthetist (out of hours) at earliest opportunity.	To ensure that acute pain team are aware of admission and can assist in any treatment plan if required.
Planned admissions should be referred preoperatively to the acute pain team.	To ensure that the pain team can assist in treatment plan if required.
Prior to surgery discussion should take place between hospital staff, the patient, and community drug worker this will enable anaesthetic staff to establish the best form of analgesia following surgery.	To ensure that the most appropriate form of post-operative analgesia is used. To prevent any relapse of the patient in treatment for addiction.
Removal of Naltrexone Implants will be determined on an individual basis.	
Minor or Intermediate surgery- STOP oral Naltrexone 48- 72 hours prior to surgery. Pain should be managed with non-opioid analgesia, such as infiltration of local anaesthetic, IV Paracetamol (in line with trust policy) and/or NSAID's, where appropriate.	To ensure adequate postoperative pain relief.
Major surgery – STOP oral Naltrexone 48-72 hours prior to surgery. Epidural analgesia, regional / rectus sheath blocks should be considered.	To ensure adequate postoperative pain relief.
Emergency surgery/trauma – use non-opioid analgesia such as regional /rectus sheath block if appropriate.	To ensure adequate postoperative pain relief.
Attempts to overcome the blockade of opioid receptors by overdosing could result in acute opioid intoxication. **Therefore, opioids should be prescribed only after discussion with Consultant Anaesthetist with an interest in pain management.**	To maintain patient safety.
Where opioid analgesia has to be administered it can be expected that the patient may have a degree of resistance to the drugs, although there may also be	To maintain patient safety.

a possibility of drug sensitivity. Close monitoring of NEWS, AVPU scores, and respiratory rates of these patients is strongly advised.	To observe the patient for signs of respiratory depression and sedation
Regular recording pre and post analgesia of pain scores, functional activity score and administration of analgesia as per acute pain team recommendations. (See 5.2).	To ensure that the patient receives effective acute pain management
Once acute pain has subsided, discontinue opioid use and continue alternative multimodal analgesia.	To ensure that the patient receives optimum treatment for the presenting acute pain problem.
Inform patient's community substance misuse team -Key worker of admission, current medication and planned discharge date. Follow up in writing.	To ensure that all involved parties are aware of discharge plans. To ensure that Naltrexone is recommenced in the community once the patient has been free of opioids for 7-10days.

6 Monitoring

6.1 Compliance and Effectiveness Monitoring

Training Attendances; adherence to the policy at patient review. Compliance with this policy will be monitored as outlined in the table below.

6.2 Compliance and Effectiveness Monitoring Table

Monitoring Criterion	
Who will perform the monitoring?	The Acute Pain Service
What are you monitoring?	Compliance with this policy follows • Prescription standards • Adherence to policy on the management of substance misuse • Associated documentation
When will the monitoring be performed?	At Acute Pain Service ward rounds
How are you going to monitor?	By direct patient review at Acute Pain Service ward rounds
What will happen if any shortfalls are identified?	• A incident form will be completed • This will be reported at Anaesthetic Departmental Clinical Governance meetings. Any further training or retraining will then be addressed.

Where will the results of the monitoring be reported?	• At Anaesthetic Departmental Clinical Governance meetings and noted in the minutes. • At Acute Pain Link Nurse meetings and recorded in minutes
How will the resulting action plan be progressed and monitored?	This will be monitored by the Acute Pain Service as above.
How will learning take place?	Training facilitated by the Acute Pain Service via LLLD.

7 Glossary Of Terms

Tolerance – a predictable physiological decrease in the effect of a drug over time so that progressive increase in the amount of that drug is required to achieve the same effect. Tolerance develops to desired (analgesia) and undesired (euphoria, opioid-related sedation, nausea or constipation) effects at different rates.

Physical dependence – A physiological adaptation to a drug whereby abrupt discontinuation or reversal of that drug, or a sudden reduction in its dose, leads to a withdrawal syndrome

Addiction – A disease that is characterized by the aberrant drug-seeking and maladaptive drug taking behaviours that may include cravings, compulsive drug use and loss of control over drug use, despite the risk of physical, social and psychological harm.

Opioid agonist – an opioid drug that binds to and stimulates receptors they are capable of producing maximal response from the receptor.

Opioid antagonist – drugs that bind to but do not stimulate opioid receptors; they may reverse the effect of opioid agonists.

Partial agonist – drugs that stimulate opioid receptors but have a ceiling effect, i.e. produce a submaximal response compared with an agonist.

Hyperalgesia – increased pain from a stimulus that normally provokes pain; increased response to a normal threshold.

8 Associated Documentation

This policy refers to the following CDDFT Trust policies and procedures:

Management of Opiate Misusers In An Acute Setting
Hand Hygiene
Infection Control Guidelines
Naloxone Hydrochloride (In Adults)
Medical Devices Policy- Medical Devices Training And Competencies Policy
Policy For Trust Policies, Trust Procedure And Clinical Guidelines
Trust Medicine Policy
Controlled Drug Policy

This policy refers to the following guidance, including national and international standards:

Clinical Guidelines on Drug Misuse and Dependence update 2017 independent expert working group (2017) **: Drug Misuse and Dependence UK guidelines on clinical management.** London.

NICE, **Methadone and Buprenorphine for the management of opioid dependence: NICE technology appraisal 114.** 2007

NICE, **Naltrexone for the management of opioid dependence: NICE technology appraisal 115.** 2007

NICE, **Drug Misuse: Opioid Detoxification: NICE Clinical guideline 52.** London. 2007

References

Dougherty & Lister (Eds) (2015) *Royal Marsden Manual of Clinical Procedures* 9th edition. Accessed online *www.rmmonline.co.uk*

ANZCA (2015) *Acute pain management: scientific evidence* 4th Edition.
Australian and New Zealand College of Anaesthetists and Faculty of Pain Medicine.

Macintyre and Schug (20150 Acute pain management- a practical guide 4th edition

NMC (2018) *The Code – Professional Standards of practice and behaviour for nurses and midwives.* Nursing and Midwifery Council. London

NMC and RPS 2019 professional guidance on the administration of medicines in the health care setting

NPSA (2009) *Safety in doses: improving the use of medicines in the NHS*
National Patient Safely Agency. London.

RPS 2018 Professional guidance on the safe and secure handling of medicines

Wesson Dr, ling w. The clinical opiate withdrawal scale (COWS) Journal of Psychoactive drugs 2003 April; 35 (20 253-9)

9 Appendices

Appendix 1 – Clinical Opiate Withdrawal Scale
Appendix 2 – Equality Impact Assessment

9.1 Appendix 1 - Clinical opiate withdrawal scale

APPENDIX 1
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 1/2 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 1/2 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 piloerrection
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

This version may be copied and used clinically.

Journal of Psychoactive Drugs Volume 35 (2), April - June 2003

Source: Wesson, D. R., & Ling, W. (2003). The Clinical Opiate Withdrawal Scale (COWS). *J Psychoactive Drugs*, 35(2), 253–9.

9.2 Appendix 2 - Equality Analysis / Impact Assessment

Division/Department:	Surgery - Acute Pain Service
Title of policy, procedure, decision, project, function or service:	Policy for acute pain management in substance misuse
Lead person responsible:	Acute Pain Service
People involved with completing this:	Acute Pain Service

Type of policy, procedure, decision, project, function or service:

Existing	√
New/proposed	☐
Changed	☐

Date Completed:

Step 1 – Scoping your analysis

What is the aim of your policy, procedure, project, decision, function or service and how does it relate to equality?

To provide guidance tor trust staff on effective acute pain management for patients with substance misuse

Who is the policy, procedure, project, decision, function or service going to benefit and how?

Staff and patients

What barriers are there to achieving these outcomes?

Staff being unaware of the policy and not following the guidance it offers

How will you put your policy, procedure, project, decision, function or service into practice?

The policy will be disseminated trust wide and will be available via the trust intranet

Does this policy link, align or conflict with any other policy, procedure, project, decision, function or service?

Yes –to be used with Management of opiate misusers in an acute setting

Step 2 – Collecting your information

What existing information / data do you have?

The policy is based on current national guidance and pre-existing widespread and established practice in the UK.

Who have you consulted with?

Acute Pain Service, Consultant Anaesthetists, Pharmacists General Surgeons, Ward Sisters and Matrons.

What are the gaps and how do you plan to collect what is missing?

None

Step 3 – What is the impact?

Using the information from Step 2 explain if there is an impact or potential for impact on staff or people in the community with characteristics protected under the Equality Act 2010?

Ethnicity or Race

No impact or potential impact on any group

Sex/Gender

No impact or potential impact on any group

Age

Paediatrics not included in the policy – specialist individual advise to be sought

Disability

No impact or potential impact on any group

Religion or Belief

No impact or potential impact on any group

Sexual Orientation

No impact or potential impact on any group

Marriage and Civil Partnership (applies to workforce issues only

No impact or potential impact on any group

Pregnancy and Maternity

Obstetrics not included in this policy see trust policy - women who misuse substances in pregnancy

Gender Reassignment

No impact or potential impact on any group

Other socially excluded groups or communities e.g. rural community, socially excluded, carers, areas of deprivation, low literacy skills etc.

No impact or potential impact on any group

Step 4 – What are the differences?

Are any groups affected in a different way to others as a result of the policy, procedure, project, decision, function or service?

No

Does your policy, procedure, project, decision, function or service discriminate against anyone with characteristics protected under the Equality Act 2010?

Yes ☐ **No** X

If yes, explain the justification for this. If it cannot be justified, how are you going to change it to remove or mitigate the affect?

Step 5 – Make a decision based on steps 2 - 4

If you are in a position to introduce the policy, procedure, project, decision, function or service? Clearly show how this has been decided.

This is an existing policy for trust staff. Following approval the policy will be disseminated trust wide and will be available via the trust intranet.

If you are in a position to introduce the policy, procedure, project, decision, function or service, but still have information to collect, changes to make or actions to complete to ensure all people affected have been covered please list:

N/A

How are you going to monitor this policy, procedure, project or service, how often and who will be responsible?

As detailed in section 6 of this policy