

Clinical Practice Guideline

Inpatient

OPIOID DEPENDENCE/WITHDRAWAL

Target Population: Adult/Geriatric

TYPE: Human Response

CLINICAL DESCRIPTION: Hospitalized patient experiencing opioid dependence or acute withdrawal symptoms.

USE IN CONJUNCTION WITH: Other Clinical Practice Guideline(s) applicable to admitting diagnosis

CLINICAL PRACTICE GUIDELINES:

- provide standardized approach to support consistent patient care
- require individualization by adding patient specific information to Plan of Care

PROFESSIONAL PROCESS

GOALS/OUTCOMES:

By discharge/transition of care:

- A. Patient will demonstrate outcomes below:
1. Opioid withdrawal symptoms managed or absent
 2. Psychosocial wellbeing
- B. Teaching/Learning Goals: understanding will be verbalized/demonstrated/addressed. (Refer to Education Outcome Record; address unresolved teaching learning goals in discharge/continuum of care summary)
1. Personal risk factors and signs/symptoms related to opioid dependence/withdrawal.
 2. Self-management (e.g., coping strategies, medication management, self-care).
 3. When to seek medical attention (e.g., unresolved/worsening symptoms).
 4. General goals (e.g., orientation to care setting/routine, advance care planning, admission/transition of care, medication management, tobacco use/smoke exposure, pain assessment process, oral health, treatment plan).
 5. Safety (e.g., call light use, fall prevention, harm prevention, infection prevention).

CLINICAL REASONING/DECISION-MAKING:

- A. Educate based on learning readiness, ability, barriers, needs and preferences. (Refer to Pre-Teaching Assessment on Profile/Education Outcome Record)
- B. Optimize patient outcomes:
1. Collaborate with patient, family, significant other, caregivers and interprofessional team
 2. Individualize care
 3. Mutually develop goals
 4. Mutually assess progress toward goals
- C. Assess and monitor signs/symptoms.
- D. Correlate health status to:
1. Patient history
 2. Admission/baseline assessment data
 3. Ongoing assessment data and response to interventions
 - related risk factors
 - age/gender
 - physiological status
 - psychosocial status (e.g., cultural, developmental, spiritual)
 - safety risks
 4. Plan for discharge and continuum of care.
- E. Implement appropriate interventions per scope of practice.



OPIOID DEPENDENCE/WITHDRAWAL As Evidenced By (AEB) and Interventions: (17; 38; 39; 41)

- Signs/Symptoms/Presentation:
 - central nervous system: altered sleep pattern; tremors; uncoordinated movements; repetitive movements; hyperactive reflexes; clonus; increased muscle tone; startle with touch; visual and/or auditory hallucinations; seizures
 - gastrointestinal: nausea, vomiting, retching, gagging; altered bowel pattern (diarrhea, constipation); abdominal cramping; anorexia
 - sympathetic nervous system: change in pupil size; nasal stuffiness, rhinorrhea; sneezing; frequent yawning; lacrimation; sweating; piloerection; shivering; chills
 - mental/behavioral: cravings; moodiness; depression; irritability; increased anxiety; agitation, restlessness; inability to concentrate; lack of interest in routine activities/self; confusion; delirium; suicidal ideation
 - other: presence of needle marks; nasal septum irritation/erosion; muscle/bone pain; headache
 - Vital Signs: change in heart rate (HR), BP, respiratory rate (RR); increased temperature
 - Laboratory Values: positive urine toxicology screen
 - Diagnostic Results: abnormal ECG (e.g., arrhythmia)
1. Correlate clinical status to current substance use (e.g., type, pattern, amount, last dose, length of use, attempts to decrease/eliminate use, impact on lifestyle, poly-substance use), history of substance use, prescribed medications (e.g., type, cumulative dose, peak dose, duration of administration, time of last dose, concomitant use of neuromuscular blocking agent), risk factors, level of consciousness, underlying medical condition/comorbidities/behavioral health conditions, pain history, withdrawal score and safety. (4; 6; 9; 21; 41) {Grade C}
 2. Obtain a detailed record of all current medications (e.g., prescribed, over-the-counter preparations, herbal supplements, illicit substances). (39) {Grade B}
 3. Develop a therapeutic alliance with patient/support system. (25; 33) {Grade C}.
 - a. Develop trust relationship/rapport (e.g., therapeutic presence, active/empathic listening, sensitivity to nonverbal communication). (25; 33) {Grade C}.
 - b. Normalize/validate the patient experience; utilize a nonjudgmental approach. (18) {Grade C}
 - c. Honoring confidentiality, utilize a family-focused approach; include family/significant others in assessment and planning. (24; 25; 33) {Grade C}
 4. Utilize a validated withdrawal scoring tool to assess onset, progression, severity and resolution of withdrawal symptoms [e.g., Clinical Opiate Withdrawal Scale (COWS)]. (41) {Grade B}
 5. Manage patient currently receiving pharmacotherapy for opioid addiction (e.g., methadone, buprenorphine, naltrexone). (26; 38) {Grade B}
 - a. Advocate for coordinated approach to pain management and opioid dependence/withdrawal (e.g., pain management specialist, addiction medicine). (39) {Grade B}
 - b. Obtain current treatment/maintenance regimen; advocate for continuity of treatment (e.g., dose, frequency). (26; 38) {Grade B}
 - c. Continue to provide pain management (e.g., pharmacologic, nonpharmacologic interventions). (26; 39) {Grade B}
 6. Administer opioid replacement medications for patient with known substance dependence; monitor effect and titrate as ordered to prevent/minimize withdrawal symptoms (e.g., methadone, buprenorphine). (8; 13) {Grade B}
 - a. Consider potential drug interactions prior to administration of opioid medications. (8; 41) {Grade C}
 - b. Consider obtaining a baseline ECG; monitor cardiac status. (8) {Grade C}
 7. Monitor those receiving a continuous opioid infusion for potential withdrawal symptoms. (19) {Grade C}
 - a. Monitor for renal and hepatic effects (e.g., urine output, laboratory values). (19) {Grade C}
 - b. Anticipate need for adjustment in opioid medications (e.g., increasing dose requirements, undesirable side effects). (10) {Grade C}
 - c. Advocate for gradual tapering/weaning of opioid infusion to avoid development of withdrawal symptoms; anticipate potential initiation of opioid replacement therapy. (19; 26) {Grade C}

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8. Provide supportive care. (41) {Grade C}
 - a. Promote sleep/rest (e.g., minimize stimulation, provide quiet/calm environment, modulate noise, adjust level of light, coordinate/ cluster care, match stimuli to patient response, medications). (1; 6; 27) {Grade C}
 - b. Consider administration of adjunctive medications (e.g., alpha adrenergic agonist). (27) {Grade C}
 - c. Update immunizations as needed. (9) {Grade B}
9. Manage gastrointestinal symptoms. (27) {Grade C}
 - a. Administer medications (e.g., anticholinergic, antispasmodic, antidiarrheal, antiemetic). (27) {Grade C}
 - b. Adjust diet/nutritional support to promote optimal nutrition/hydration. (27; 36) {Grade C}
10. Provide pain management. (26; 38; 41) {Grade B}
 - a. Individualize the pain management plan; consider type of pain, age, gender, success/failure of previous pain regimens and likelihood of misuse. (31; 41; 43) {Grade B}
 - b. Evaluate pain using appropriate multidimensional pain assessment tool. (9; 31) {Grade B}
 - c. Administer pharmacologic agents; consider multimodal analgesia (e.g., opioid, nonopioid, local anesthetic). (16; 26; 31; 32) {Grade B}
 - d. Utilize nonpharmacologic measures to manage pain (e.g., diversional activities, positioning, warm/cool application). (26; 38; 41) {Grade B}
11. Assess biopsychosocial status. (34) {Grade C}
 - a. Assess current opioid and other substance use pattern utilizing multiple sources (e.g., self-report, family, prescription monitoring program, urine toxicology screen). (15; 24) {Grade C}
 - b. Screen for presence of risk factors. (24; 28; 35) {Grade C}
 - c. Assess for opioid use disorder (e.g., opioid medications taken in larger amounts or over longer period than was intended; persistent desire/unsuccessful efforts to cut down use; great deal of time spent obtaining, using, recovering from use; cravings). (3; 18; 24) {Grade C}
 - d. Assess history/previous substance use and treatment. (18) {Grade C}
 - e. Assess for behavioral health concerns (e.g., anxiety, depression, suicidal ideation). (2; 11; 24; 37) {Grade A}
 - f. Evaluate quality of life/impact of substance use on social, occupational or other important areas of functioning (e.g., failure to fulfill role obligations, interpersonal problems, important activities given up/reduced, legal issues). (3; 24; 37; 41) {Grade C}
 - g. Assess degree of safety awareness and any risk to dependent children (e.g., use in physically hazardous situations, unsafe sex practices, needle sharing). (24) {Grade C}
12. Provide support/assist with coping. (25; 33) {Grade C}
 - a. Utilize anticipatory guidance (e.g., provide factual information, facilitate meetings with healthcare team, empower patient/support system to ask questions). (25; 33) {Grade C}
 - b. Recognize current coping strategies and develop new strategies (e.g., identify/utilize personal strengths, verbalization, journaling, relaxation techniques, guided imagery, problem solving, spirituality). (25; 28; 33) {Grade C}
 - c. Address concerns/offer reassurance. (25; 33) {Grade C}
 - d. Acknowledge impact of situation on the family. (25; 34) {Grade C}
 - e. Discuss the complexity of substance dependence, including stigma; acknowledge long-term, ongoing treatment may be necessary and relapse is common. (18) {Grade C}
13. Manage identified addiction; provide education and brief intervention. (24) {Grade C}
 - a. Educate about risks of opioid addiction/dependence (e.g., health, increased risk taking behavior). (18; 24) {Grade C}
 - b. Assess readiness to change opioid use patterns. (24) {Grade C}
 - c. Identify stage of change, recognizing client's current level of insight, comprehension and knowledge. (34) {Grade C}
 - d. Explore motivations for change, affirming change-related statements. (18; 34) {Grade C}
 - e. Identify and develop recovery goals via a shared decision-making process. (24) {Grade C}
 - f. Elicit recognition of gap/discrepancy between current behavior and desired life goals. (34) {Grade C}
 - g. Explore and resolve ambivalence associated with commitment to behavior change. (18) {Grade C}
 - h. Support efforts/steps toward change, however small. (34) {Grade C}
 - i. Mutually identify internal and external triggers/cues for substance use and subsequent hazardous behavior (e.g., attempted hoarding or "cheeking" of scheduled medication). (34) {Grade C}

14. Assist with transition to community/next level of care. (18; 24) {Grade C}
 - a. Assess appropriate level of care at discharge (e.g., inpatient detoxification, maintenance, intensive outpatient treatment, counseling, family therapy). (2; 18) {Grade A}
 - b. Mutually develop a transition/discharge plan; establish or re-establish connections (e.g., outpatient providers, support groups); include support system in planning. (18; 24; 28; 37) {Grade C}
 - c. Identify and address factors that impact overall treatment adherence (e.g., childcare, transportation, flexible appointment times, cost). (18; 37) {Grade C}

KEY INFORMATION

- A. Consider obtaining a serum/urine pregnancy test for all females of childbearing age. (39)
- B. Opioid use and repeated opioid intoxication or withdrawal may be associated with severe depression intense enough to lead to suicide attempts and completed suicides. (3)
- C. Evaluate cardiac status and risk for renal and/or liver failure prior to the determination of treatment regimen. (41; 42)
- D. The combination of benzodiazepine agents and opioid analgesics carries an increased mortality risk. (11; 39)
- E. It is important to be aware of drugs that may interact with the medications being administered for withdrawal treatment (e.g., partial or mixed agonist agents, antagonist for pain management). (38)
- F. If buprenorphine is being used as treatment for addiction prior to hospitalization it may have to be suspended temporarily because it can attenuate or block the effects of opioid medications. Opioid doses may need to be adjusted to achieve adequate pain control. (38)
- G. Pain management is vital for patients with opioid dependence. Inadequate pain control can negatively affect any progress in treatment. (42)
- H. Opioid withdrawal can exacerbate psychotic symptoms. (41)
- I. Unless being hospitalized for medical treatment, patients with an opioid addiction should not be given opioid medications for treatment of withdrawal but rather referred to a treatment or detoxification center, per direction from the U.S. DEA Diversion Program: <http://www.justice.gov/dea/ops/diversion.shtml> (41)

GENERAL INFORMATION

RELATED RISK FACTORS: (18; 24; 41)

- Family history of substance use disorder
- Recent stressful life events
- Lack of social supports
- Chronic pain
- Chronic illness
- Mental/behavioral health diagnosis
- Physical and cognitive disabilities
- First substance use before age 15
- Medical condition associated with substance use
- History of alcohol/substance use disorder (past or current)
- Smoking

- Previous incarceration/legal issues
- History of trauma
- Prolonged medical treatment

Risk factors unique to older adults:

- Chronic pain
- Physical disabilities/reduced mobility
- Transitions in care/living situations
- Chronic illness
- Bereavement
- Unexpected or forced retirement
- Social isolation

ADDITIONAL INFORMATION:

1. Overview: (5; 40; 42)
 - a. Substance abuse or dependence is defined by The National Institute of Drug Abuse as a condition in which the use of a legal or illegal substance causes physical, mental, emotional, or social harm.
 - b. Substance misuse has the potential to impair all of the following:
 - Ability to function in daily activities of living
 - Develop/maintain relationships
 - Performance in the home/work environment

2. Definitions: (10; 12; 14; 17; 19; 20; 42)
 - a. Opiate: substances directly derived from the opium poppy (e.g., morphine, codeine)
 - b. Opioid:
 - A group of psychoactive substances that provide much of the same effects as opiates
 - Derived from the chemical manipulation of opiates
 - They include semi-synthetic substances (e.g., heroin, oxycodone, oxymorphone, hydrocodone) as well as synthetic substances (fentanyl, methadone)
 - The desired effect by the user is a sense of increased self-esteem, euphoria, relaxation, relief from pain and anxiety as well as an enhanced ability to cope with difficulties
 - c. Misuse: Use of a prescribed medication in a way or for a purpose other than it was intended.
 - d. Chronic use: Daily (or almost daily) administration of opioid analgesics for a period of at least 90 days
 - e. Abuse: Disorder in which a substance is used without physician guidance; involves behavioral, psychological and physical components.
 - f. Addiction: Process involving continuous drug-seeking and substance use in spite of physical, legal and safety risks.
 - g. Hyperalgesia: increasing doses of opioid medications that lead to paradoxical increased sensitivity to pain. Dose increases do not lead to an increase in clinical effect.
 - h. Tolerance: a decrease in the drug's effect over time or an escalation in the dose to achieve the same level of analgesia/sedation.
 - i. Opioid arousal: reaction to the sight of images associated with opioid analgesics (e.g., pill bottle, syringe).
 - j. Physical dependency: The need for continued administration of the substance to prevent clinical signs of withdrawal based on physiological or biochemical adaptations. Note: Dependence is an expected outcome of extended opioid use and may occur even at doses that have been prescribed. Opioid tolerance and physical dependence can develop as soon as one week following therapy initiation.
 - k. Psychological dependency: the need for a substance for its euphoric effect; also referred to as "craving" for the substance.
 - l. Pseudoaddiction: Demand for higher doses of pain medication, along with behavioral changes to obtain the medication that are the result of insufficient pain management.
 - m. Withdrawal: The presence of physical signs and symptoms when the substance has been abruptly discontinued or pharmacologically reversed in a patient who is physically tolerant.
 - Onset of withdrawal: though onset and duration of withdrawal varies with the substance(s) involved, symptoms of the opioid withdrawal syndrome usually begin two to three half-lives after the last opioid use (e.g., 6 to 12 hours for short half-life opioid medications such as heroin and morphine and 36 to 48 hours for long half-life opioid medications such as methadone). With the cessation of a short half-life opioid, symptoms reach peak intensity within two to four days. The physical signs of withdrawal are usually no longer evident after 7 to 14 days.

3. Geriatric Considerations: (18; 30; 41)
 - a. A growing number of older adults are at risk for prescription drug misuse and illicit substance use/abuse. Older adults are more likely to provide information about potentially stigmatizing behaviors if approached in a gentle and respectful manner, normalizing the behavior without endorsing it.
 - b. Use of opioid medications can increase the risk for falls.
 - c. There is an increased risk of delirium with opioid use.
 - d. Residents in nursing homes who have been on opioid medications typically go through an interruption of their regular therapy if they need to be admitted to the hospital. These interruptions can result in some withdrawal symptoms, increased pain and discomfort. This can also cause delays in recovery.

4. Substance names/terms: (7)
 - a. The types of substances used by adolescents and adults change faster than current literature can document and families may mention drugs that are unknown to staff. The National Institute on Drug Abuse maintains an “Emerging Trends” web page that is a resource for providers to stay informed. (www.drugabuse.gov/drugs-abuse/emerging-trends)
 - b. Table of current common terms for opioid medications and narcotic pain relievers:

Heroin	Smack, junk	Injected, snorted, or smoked
Morphine	M, monkey, white stuff	Injected, snorted, or smoked
Opium	Black stuff, block, gum, hop	Swallowed or smoked
Oxycodone	OxyContin (commercial name), O.C.	Swallowed, injected, or snorted
Hydrocodone	Vicodin (commercial name)	Swallowed

5. Treatment options: (22; 23; 29; 42)
 - a. Medication-assisted therapy: opioid agonists are administered as a substitute for opiate/opioid agents in order to treat opiate/opioid addiction.
 - Methadone: powerful opioid agonist used in treatment of addiction; carries an increased risk of arrhythmia and can interact with antiretroviral medication.
 - Buprenorphine: provides partial agonist opioid activity, well-tolerated with minimal side-effects. A Cochrane review has shown that buprenorphine is effective in treating addiction, although not as effective as methadone in keeping patients in a maintenance program.
 - Buprenorphine/naloxone combination: combination of buprenorphine with naloxone which is an opioid antagonist and can further decrease the chances of misuse/abuse.
 - b. Counseling
 - c. Self-help/support groups
 - d. Rehabilitation programs

PATIENT/FAMILY RESOURCES:

1. American Academy of Pain Management <http://www.painmed.org/>
2. American Pain Society <http://americanpainsociety.org/>
3. American Society of Addiction Medicine <http://www.asam.org/>
4. National Institute of Health National Institute of Drug Abuse <http://www.drugabuse.gov/>
5. Nar-Anon: www.nar-anon.org
6. Narcotics Anonymous: www.na.org
7. SAMSHA National Helpline: www.samhsa.gov/find-help/national-helpline

SAFETY CONSIDERATIONS/INITIATIVES:

1. Substance Use:

Centers for Medicare & Medicaid Services and the Joint Commission:

 - National Hospital Performance Measure: Stroke National Hospital Inpatient Quality Measures. Specifications Manual for National Hospital Inpatient Quality Measures. Last updated 5/29/2015. Retrieved from: http://www.jointcommission.org/specifications_manual_for_national_hospital_inpatient_quality_measures.aspx

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