## OPIOID WITHDRAWAL

1. POLICY:

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| Function: | Assess, differentiate, and plan interventions for the presentation of a patient who is experiencing opioid withdrawal. Beginning June 1, 2021, patients who report recent opioid use and have signs and symptoms of moderate to severe opioid withdrawal will be started on buprenorphine/naloxone (Suboxone) 16mg/4mg maintenance therapy with two suboxone 8mg/2mg films instead of a buprenorphine taper. This maintenance therapy will be continued indefinitely through the patient’s time in custody. Patients will still require monitoring for opiate withdrawal symptoms for the first 72 hours. |
| Circumstances: | 1. Initial history and assessment of status to be done by an RN when the patient presents, with more thorough evaluation to be done by a clinician during a Priority 2 Clinician Visit (ideally 1-3 days after intake). 2. Supervision: none required 3. Patient contraindications:    1. known allergies to any medications indicated in the protocol.    2. any opioid use within the previous 12 hours. |
| Purpose: | To provide appropriate assessment and management of patients who are withdrawing from opiates within the jail setting. |
| Policy Affects: | All RN classifications assigned to Jail Health Services. |

1. PROTOCOL
   1. Definition: Cessation of opioid use leads to an abstinence syndrome that usually begins 8-12 hours following the last use, depending on the type of opioid used (see below for more information). Symptoms can reach peak intensity in 36 to 72 hours following withdrawal of the drug. The intense withdrawal syndrome usually lasts 5 to 7 days, though craving for the drug may continue for months.
   2. Data Base:
      1. The RN will collect the following subjective information from the patient:
         * Route of substance use (i.e. smoking, inhalation, IV)
         * Average amount and frequency of use
         * Length of time of use
         * Time, amount, and type of substance(s) last used
         * Early symptoms of withdrawal (8 - 14 hours after last dose)
           1. Sweating
           2. Anxiety
           3. Restlessness
           4. Insomnia
           5. Lacrimation
           6. Yawning
           7. Rhinorrhea
           8. Anorexia
           9. Abdominal cramps
         * Late symptoms of withdrawal (48 -72 hours after last dose)
           1. General diffuse body pain
           2. Tremor
           3. Muscle spasms
           4. Tachycardia
           5. Chills
           6. Weakness
           7. Nausea/vomiting/diarrhea
         * LMP: Women at risk for opiate withdrawal are screened for pregnancy at Triage and refused acceptance and referred to SFGH if pregnant. Do not give medications for opiate withdrawal to pregnant women per standardized procedure. See Policy and Procedure #302: Receiving Screening.
      2. Objective:
         * General appearance, note distress.
         * Vital Signs: BP/P/T Respirations (rate/depth/quality). Vital Signs will be ordered q8 hrs (TID) x 3 days.
         * If the patient is complaining of vomiting and/or diarrhea or appears dehydrated, obtain orthostatic vital signs and check the urine for ketones.
         * Presence of track marks
         * Pupil size
         * Skin turgor
         * Piloerection
         * Rhinorrhea
         * Diaphoresis
         * Tremors
         * Frequently shifting position, fidgeting
      3. Chart Review: the RN will review the patient’s electronic health record for evidence of opioid use in the past including prior episodes of incarceration, ED or outpatient clinic visits, and hospital admissions.
   3. Plan:
      1. Patients who are at risk for withdrawal (based on the combination of subjective, objective, and chart review information gathered) will be placed on the high-risk list and monitored q8 hrs (TID) x 3 days or more frequently, as needed. Severity of signs and symptoms will be assessed using the COWS scale. (See JHS Standardized Procedure: Heroin Withdrawal – COWS).
      2. In addition, patients with mild to moderate signs and symptoms will be placed on the following treatment regimen PRN:
         * Diarrhea – Loperamide (Imodium) 4 mg (2 X 2 mg capsules) po qid prn X 3 days
         * Vomiting - Ondansetron (Zofran) 4mg SL QID PRN x 3 days.   
           If the patient has impaired liver function, give 4mg SL BID PRN x 3 days (maximum dose 8mg in 24 hours).
         * For continuous vomiting, Tigan 200mg/2ml IM injection can be ordered via verbal order from the clinician.
         * Diffuse aching of joints/muscles – Acetaminophen (Tylenol) 325 mg, 2 tablets qid prn x 3 days
         * Dehydration – follow Dehydration standardized procedure
      3. If patient continues to have signs and symptoms of moderate to severe withdrawal and has a Clinical Opiate Withdrawal Score of > 8, the patient shall be relocated to FPOD or CPOD for 72 hours to monitor for signs or symptoms of withdrawal
      4. It is important that the patient has abstained from opioids before initiating buprenorphine as follows to minimize the risk of precipitated withdrawal:

* Heroin, hydrocodone, oxycodone, Norco, Vicodin, hydromorphone (Dilaudid): 12-24 hours from last use
* Known fentanyl (patient is knowingly using fentanyl), sustained-release oxycodone or sustained-release morphine: 24 hours from last use
* Illicit methadone use (not prescribed by a methadone clinic): 48-72 hours from last use

If there is concern about precipitated withdrawal, please alert the FPod clinician or the clinician on-call.

* + 1. Initiate maintenance therapy with buprenorphine/naloxone (suboxone) 8mg/2mg films (#2) QD x 7 days (total daily dose = 16mg/4mg) as a verbal order by the on-call MD.
    2. Patients with observed vomiting, and when orthostatic vitals signs indicate dehydration, or a urine dipstick is positive for ketones, refer to the Standardized Procedure for Dehydration for management.
  1. Follow-up (Re-evaluation):
     1. Advise increased PO fluids.
     2. If medications are given for vomiting or diarrhea, re-evaluate in 2-4 hours. If symptoms are not improving, obtain orthostatic vital signs, check the urine for ketones, and contact the F pod clinician or on-call physician.
     3. Re-evaluate patients with vomiting, diarrhea or moderately severe symptoms every shift.
     4. For patients whose COWS scores remain >8 after receiving 16mg of buprenorphine, consult with the F Pod clinician or the on-call physician.
     5. If a patient for any reason chooses to discontinue therapy, please alert the FPod Clinician or On-Call MD to discuss a safe taper plan. The nurse should not discontinue the medicine.
  2. Patient Education (Health Promotion):
     1. Advise patient of drug treatment programs available in the jail.

At the follow up Priority 2 Clinician Visit, the clinician will:

* Ensure patient is tolerating buprenorphine well and wants to continue maintenance therapy. The clinician can use their clinical assessment to increase the maintenance dose to a maximum of 24mg daily (or to the patient’s existing community dose if it is higher than 24mg). The patient can also choose to discontinue therapy if they would prefer not to be on maintenance.
* Provide the patient with a discharge prescription (3-5 day supply) and a letter with community resources including harm reduction education, pharmacy hours, and drop-in clinic information. If the clinician and patient decide physical films would be helpful, the clinician can reach out to the attorney, reentry, and/or consult SFSO website to determine if a release date is known, and then prescribe a 5 day supply of physical films to the CJ2 pharmacy which will then be delivered to the patient’s property.
* Consider referral to Project JUNO for navigation support to the OBIC clinic
* Ensure Narcan has been ordered. The HIVIS team will provide education and place Narcan on the patient’s property.
* Review expectations of buprenorphine administration including consequences of diversion.