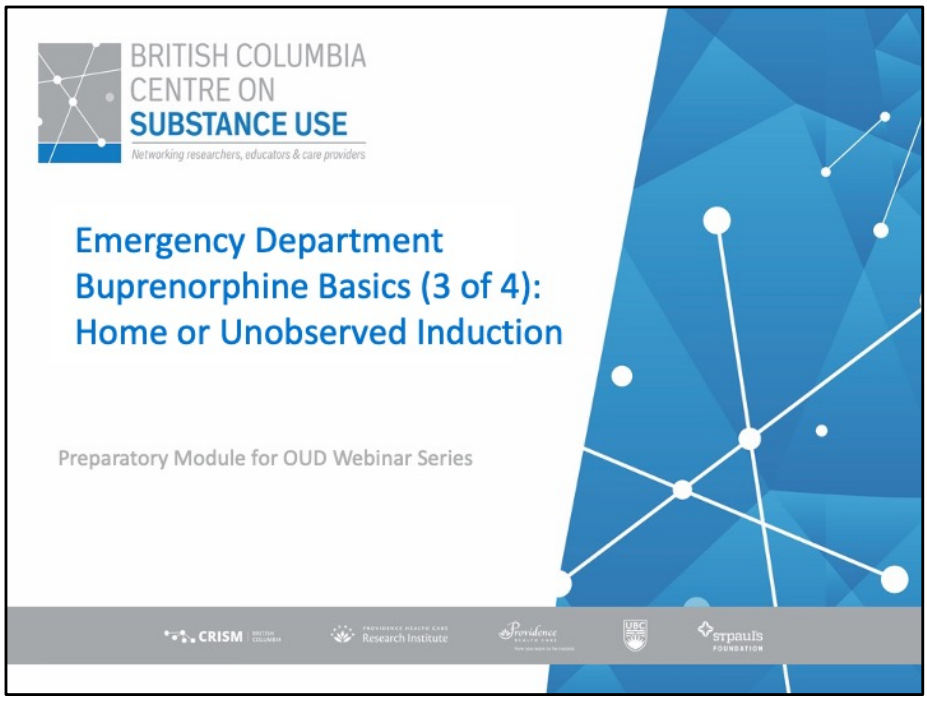

BRITISH COLUMBIA
CENTRE ON
SUBSTANCE USE
Networking researchers, educators & care providers
Emergency Department
Buprenorphine Basics (3 of 4):
Home or Unobserved Induction
Preparatory Module for OUD Webinar Series
CRISM
Research Institute
Providence
UBC
stpauls
FOUNDATION

We respectfully acknowledge the land on which we work is the unceded traditional territory of the Coast Salish Peoples, including the traditional territories of xʷməθkwəy̓əm (Musqueam), Sḵwx̱wú7mesh (Squamish), and səl̓ílwətaɬ (Tsleil-Waututh) Nations

Disclaimer

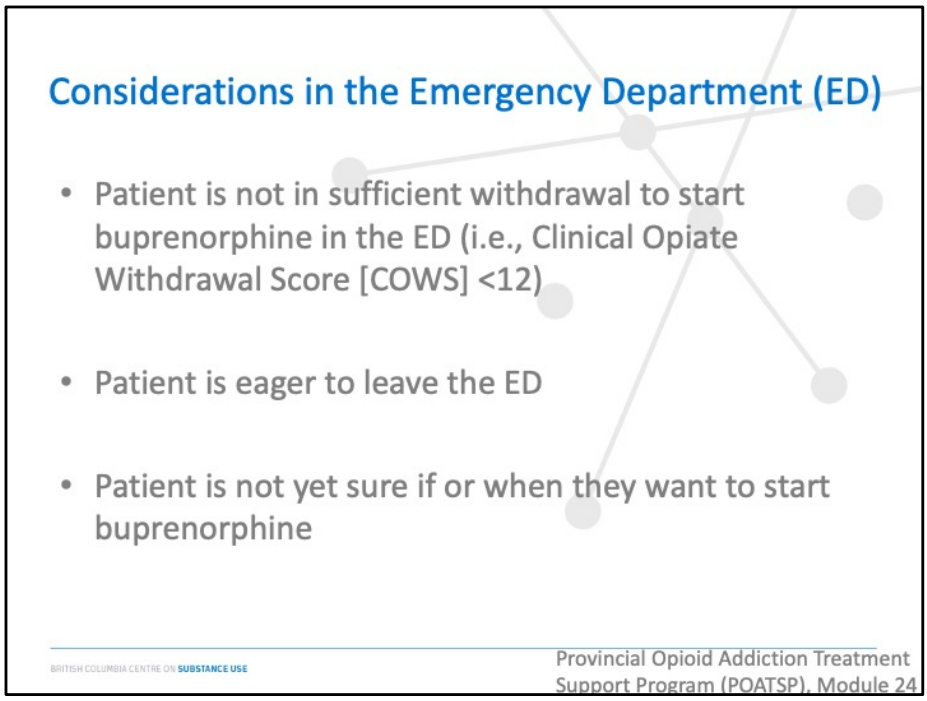
Some of the approaches described in this series of modules have evolved in response to the ongoing opioid crisis due to fentanyl in the illicit drug supply and may not represent current BCCSU Guidelines.

This includes innovative and novel approaches specific to emergency settings that are based on clinical experience and small observational studies. There is a still a relative lack of research into the effectiveness of these approaches, therefore clinical judgement is advised.

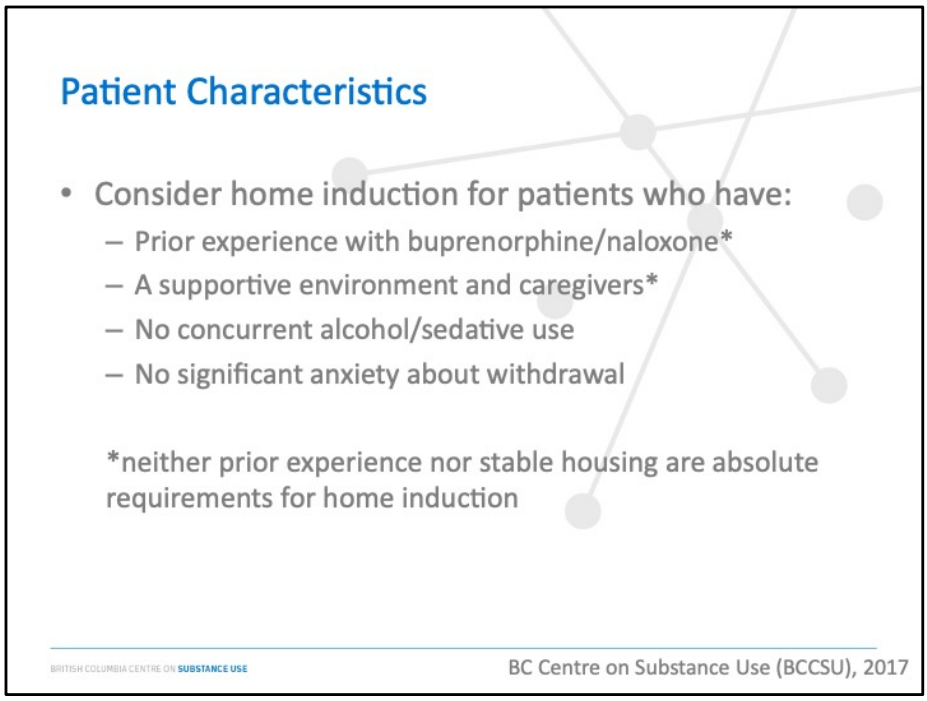
This caution sign will appear next to recommendations that are off-label and/or differ from current BCCSU guidelines

Outline

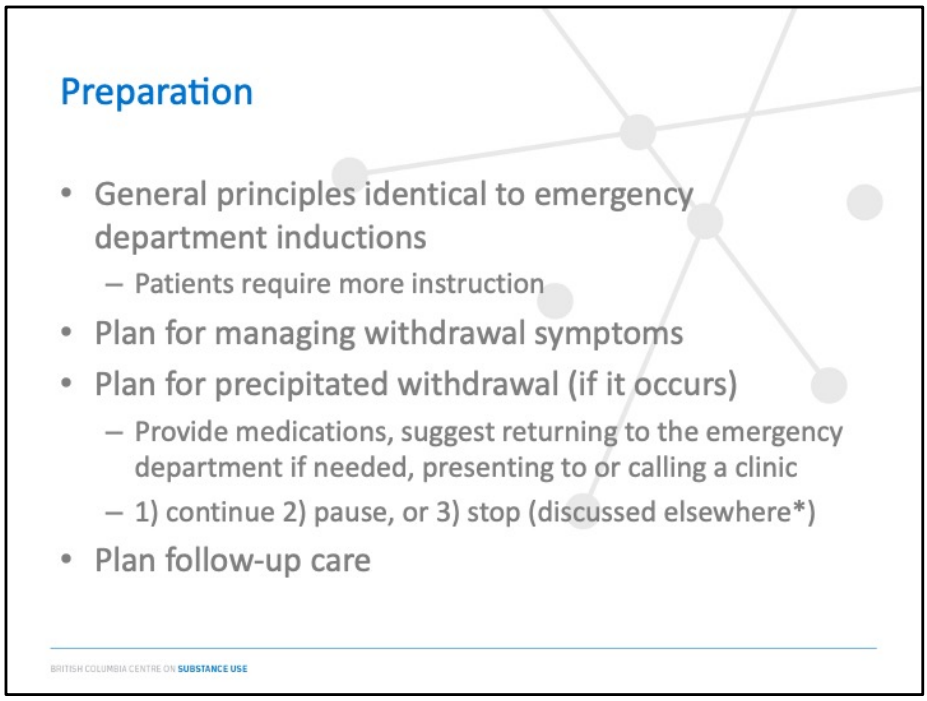
- Considerations for ED-based) (emergency department based) home induction
- Preparing the patient for home induction
- Dosing for home induction



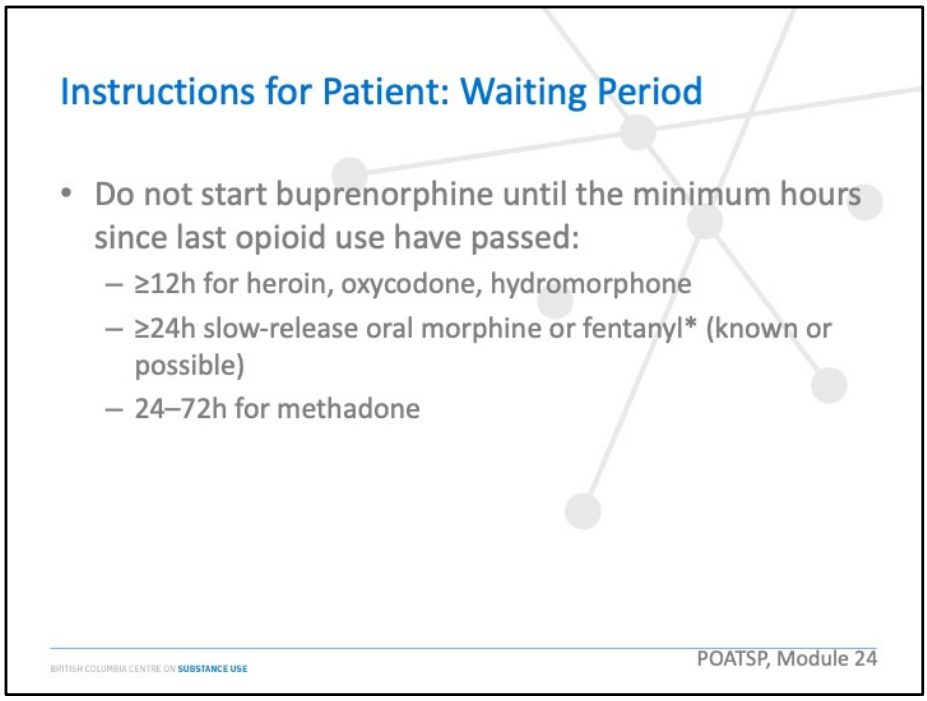
Depending on the observation space and patient preference, the patient may be kept in observation until more severe withdrawal develops



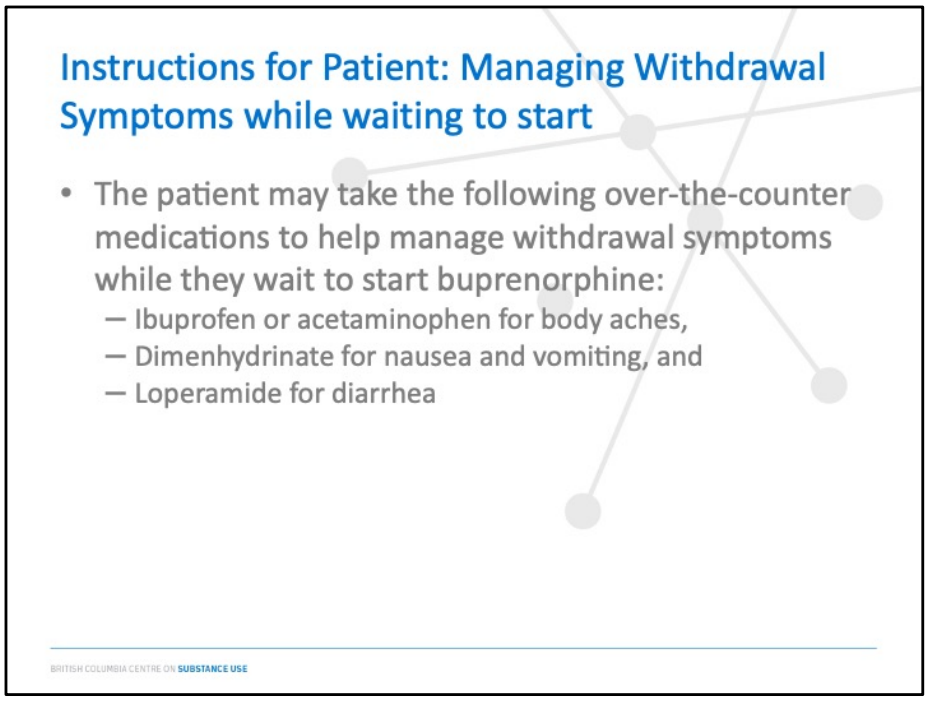
- Note that lack of experience with buprenorphine is not a contraindication, it just may require extra preparation with the patient,
- Likewise, homelessness is not a contraindication to a home induction, but again, may require additional planning
- Some patients my prefer to wait in the emergency department and undergo withdrawal there, while others may prefer to undergo withdrawal outside of the hospital



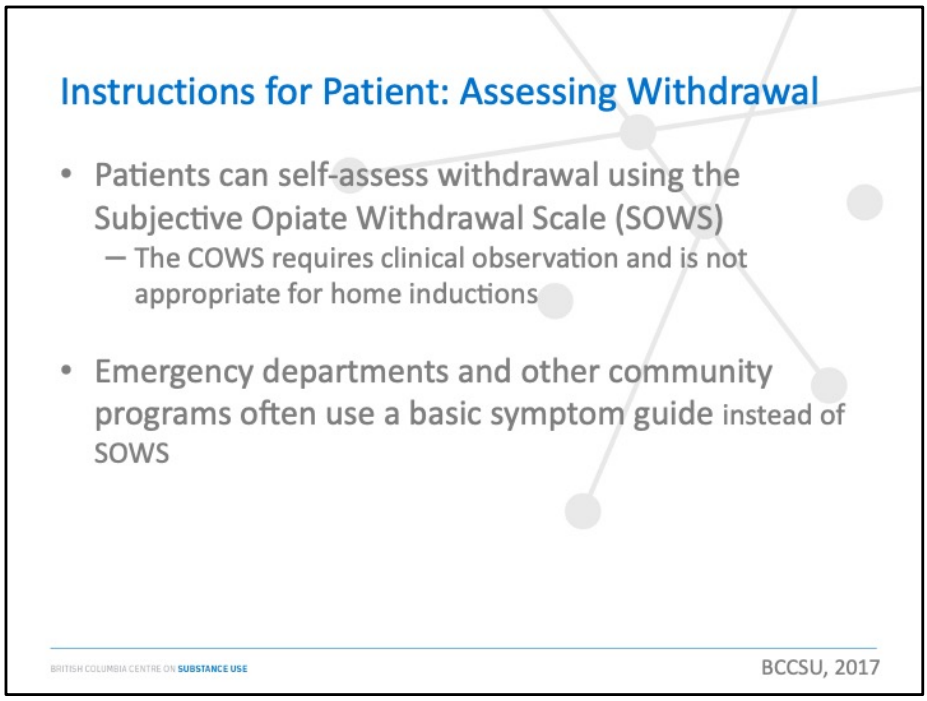
- *See precipitated withdrawal module in the Buprenorphine Basics module series at: https://https://www.bccsu.ca/edcare/



- The same waiting period that is used for emergency department-inductions is used for home inductions
- Advise the patient not to start buprenorphine until the minimum hours since last opioid use have passed:
    - *Some providers recommend 36 hours after last dose of fentanyl



- If diarrhea develops, the patient is often already in sufficient withdrawal to start bup/nlx



- Depending on patient and provider preference and comfort, the patient self-assess withdrawal symptoms using a list of symptoms or the Subjective Opiate Withdrawal Scale (SOWS)
- Multiple different “symptom guides” or criteria lists exist

Instructions for Patient: SOWS needs to be >17

Item	Symptom	Not at all	A little	Moderately	Quite a bit	Extremely
1	I feel anxious	0	1	2	3	4
2	I feel like yawning	0	1	2	3	4
3	I am perspiring	0	1	2	3	4
4	My eyes are teary	0	1	2	3	4
5	My nose is running	0	1	2	3	4
6	I have goosebumps	0	1	2	3	4
7	I am shaking	0	1	2	3	4
8	I have hot flushes	0	1	2	3	4
9	I have cold flushes	0	1	2	3	4
10	My muscles and bones ache	0	1	2	3	4
11	I feel restless	0	1	2	3	4
12	I feel nauseous	0	1	2	3	4
13	I feel like vomiting	0	1	2	3	4
14	My muscles twitch	0	1	2	3	4
15	I have stomach cramps	0	1	2	3	4
16	I feel like using now	0	1	2	3	4
Total score:						

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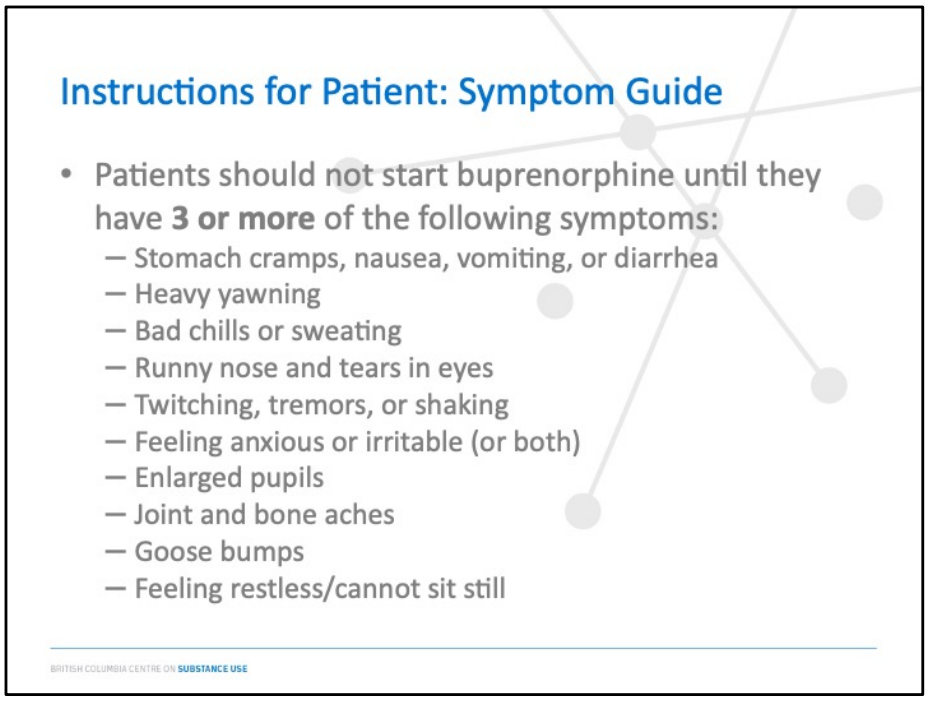
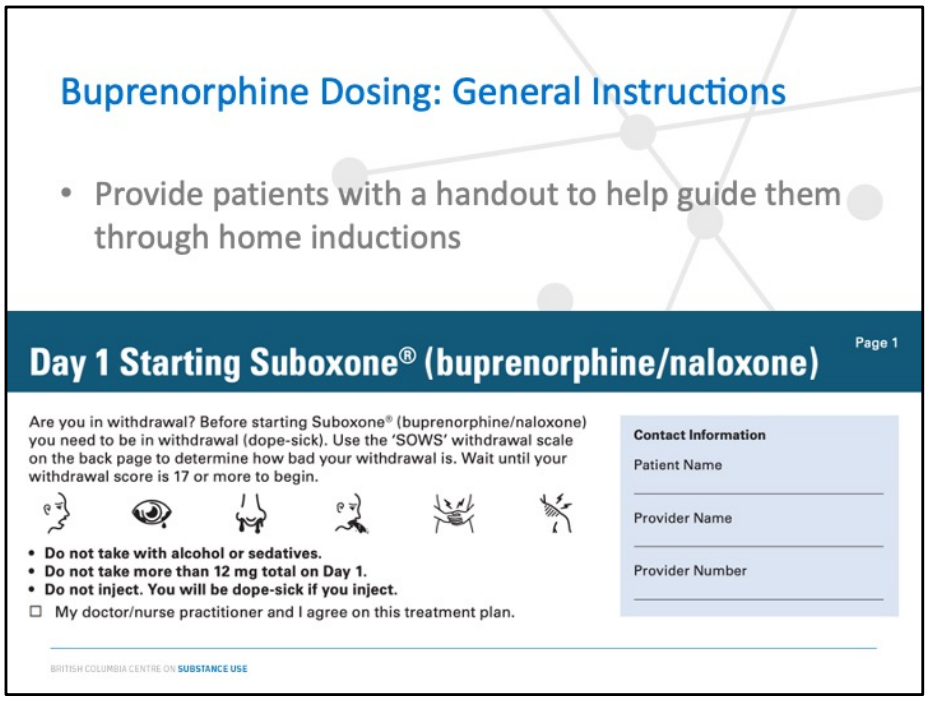
BCCSU, 2017
POATSP, Module 12

- If the patient is using the SOWS to assess withdrawal, their SOWS score should be above 17 before they begin buprenorphine



- Symptom guide often easier to follow than SOWS
- For either approach, same waiting period applies, e.g., ≥ 24 since last known or possible fentanyl
- The above is an example of a symptom guide used in emergency departments. Patients should not start buprenorphine until they have 3 or more of the symptoms lisetd



Buprenorphine Dosing: General Instructions

- Provide patients with a handout to help guide them through home inductions

Day 1 Starting Suboxone® (buprenorphine/naloxone)

Page 1

Are you in withdrawal? Before starting Suboxone® (buprenorphine/naloxone) you need to be in withdrawal (dope-sick). Use the 'SOWS' withdrawal scale on the back page to determine how bad your withdrawal is. Wait until your withdrawal score is 17 or more to begin.

- **Do not take with alcohol or sedatives.**
- **Do not take more than 12 mg total on Day 1.**
- **Do not inject. You will be dope-sick if you inject.**

☐ My doctor/nurse practitioner and I agree on this treatment plan.

Contact Information

Patient Name

Provider Name

Provider Number

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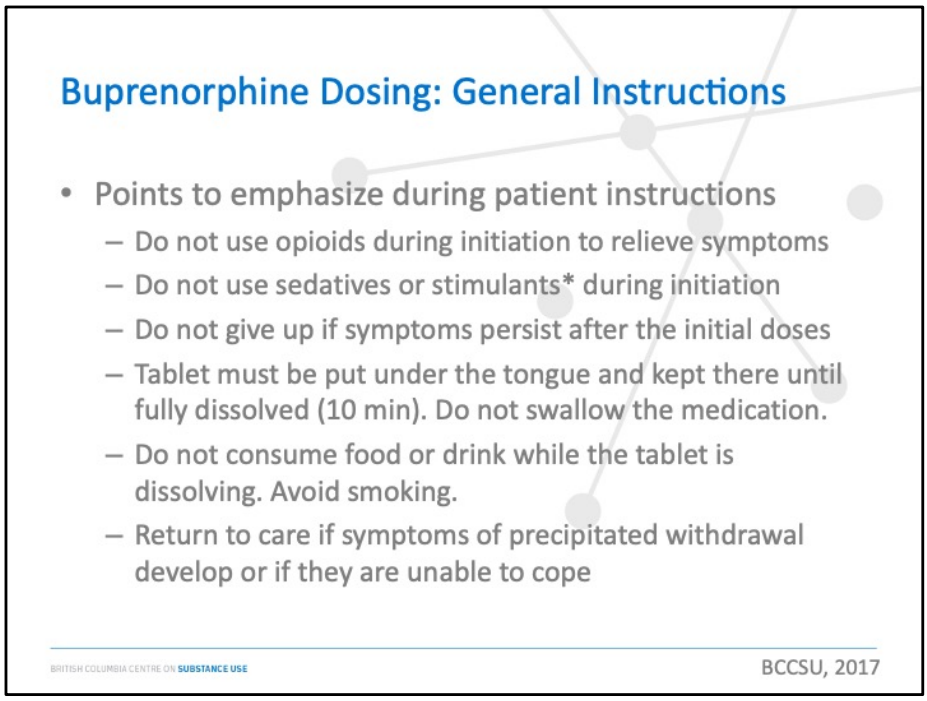
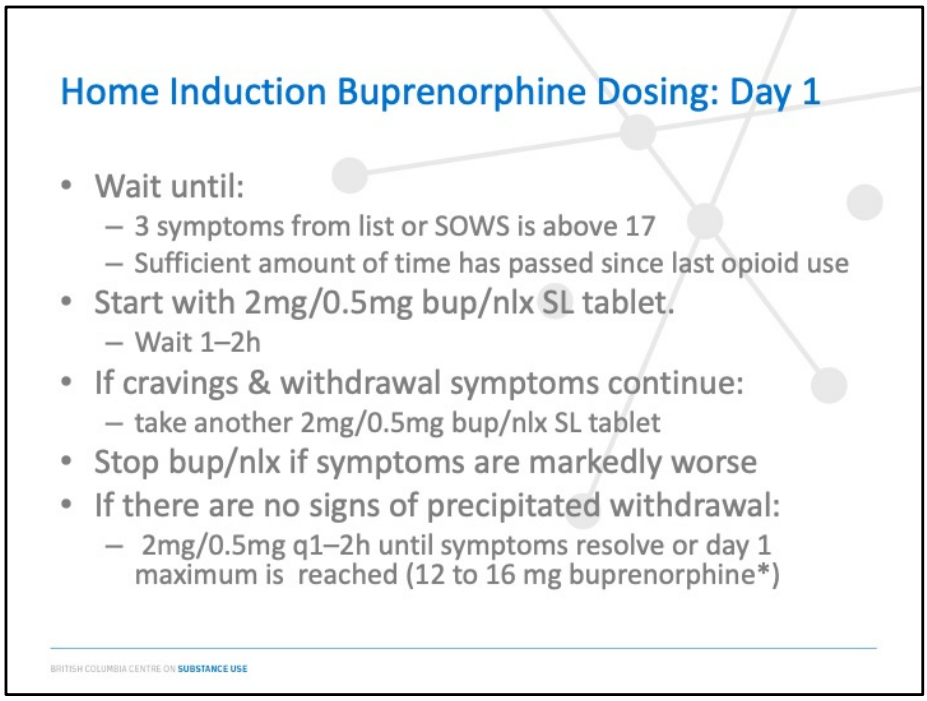
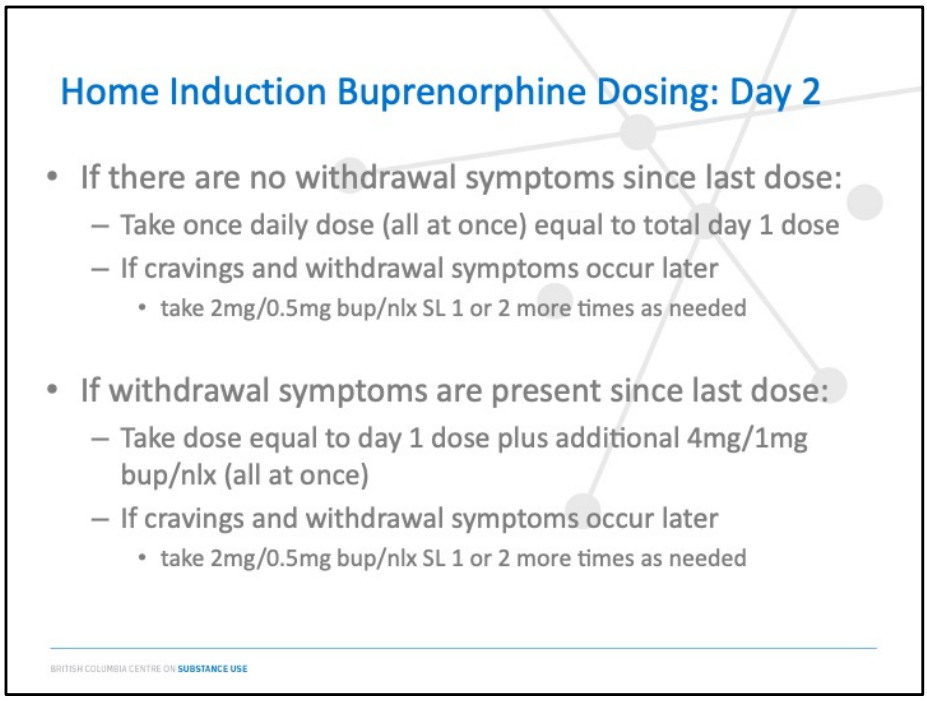
- A patient handout is available on the Government of BC website to guide patients through home inductions



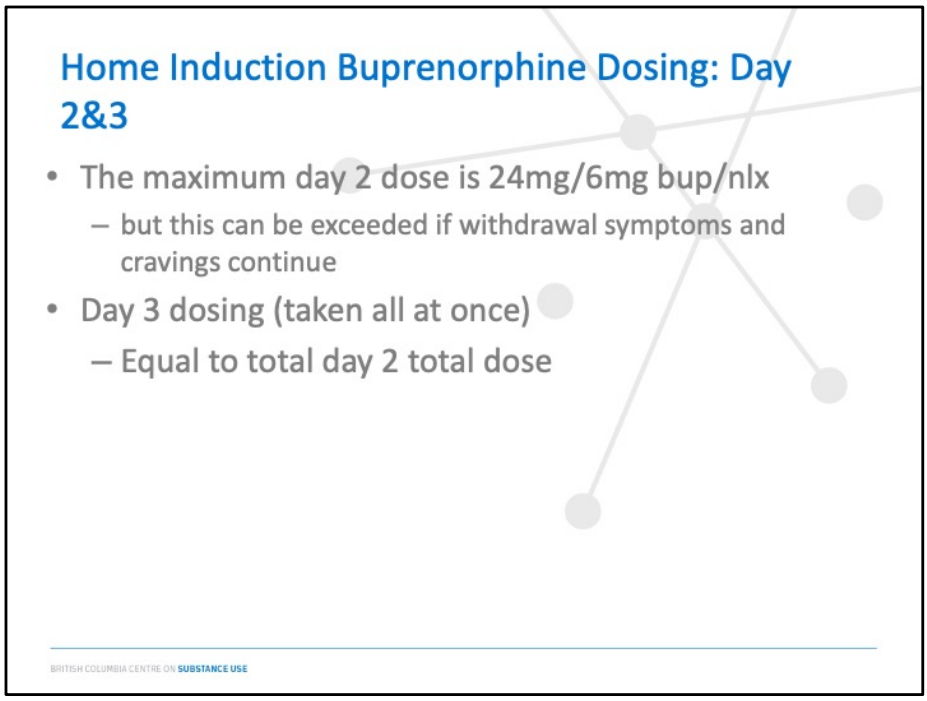
- *Reasons why not to use other drugs during initiation and/or preceding waiting period
    - Opioids: will re-start the clock on the waiting period and/or increase the risk of precipitated withdrawal
    - Sedatives: Risk of respiratory depression, and also make it more difficult for someone to gauge their level of withdrawal (SOWS or symptom list)
    - Stimulants: Some stimulants in street supply contain opioids, increasing the risk of precipitated withdrawal
- Wait one hour after taking the first tablet. If craving or withdrawal symptoms continue, take another tablet and wait another hour. Continue to do this until all tablets are taken or craving or withdrawal symptoms are resolved (next slide)



- *12 and 16 mg are the most common day 1 maximum doses in guidelines, however, in practice, the day 1 maximum is often 24 mg, and sometimes higher



- If there are no withdrawal symptoms since last dose, continue once daily dose equal to total day 1 dose, titrating up by 2mg/0.5mg–4mg/1mg bup/nlx to suppress cravings and withdrawal symptoms
- If withdrawal symptoms are present since last dose, administer dose equal to day 1 dose, plus additional 4mg/1mg bup/nlx
- The maximum day 2 dose is 24mg/6mg bup/nlx, but this can be exceeded if withdrawal symptoms and cravings continue



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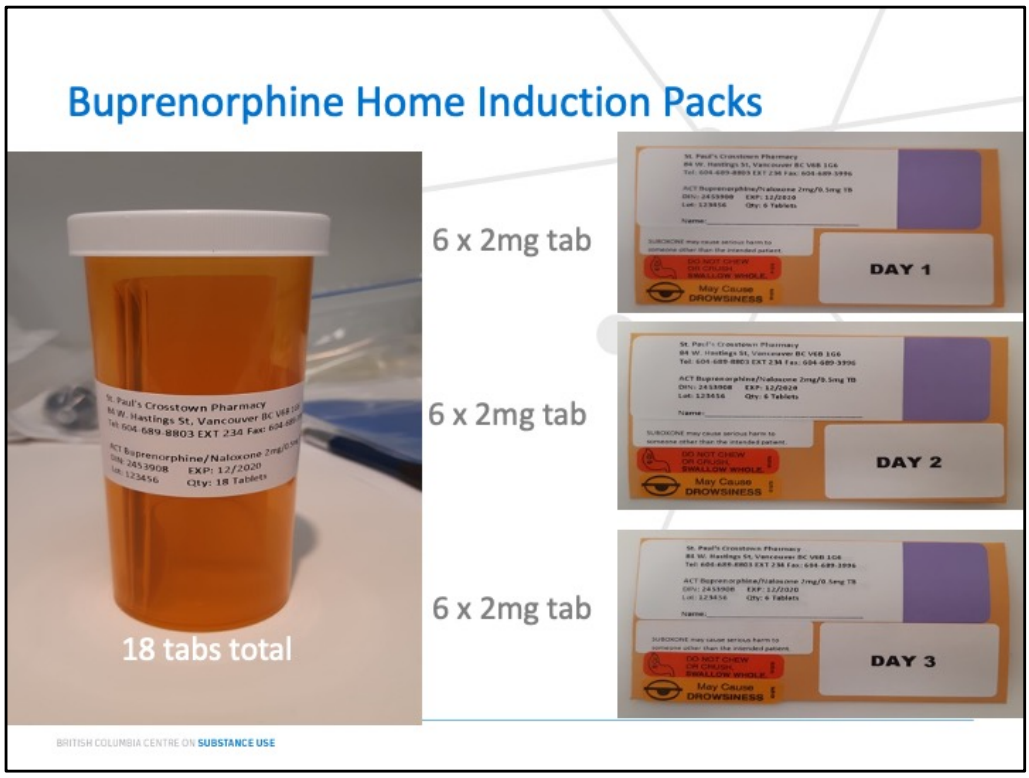
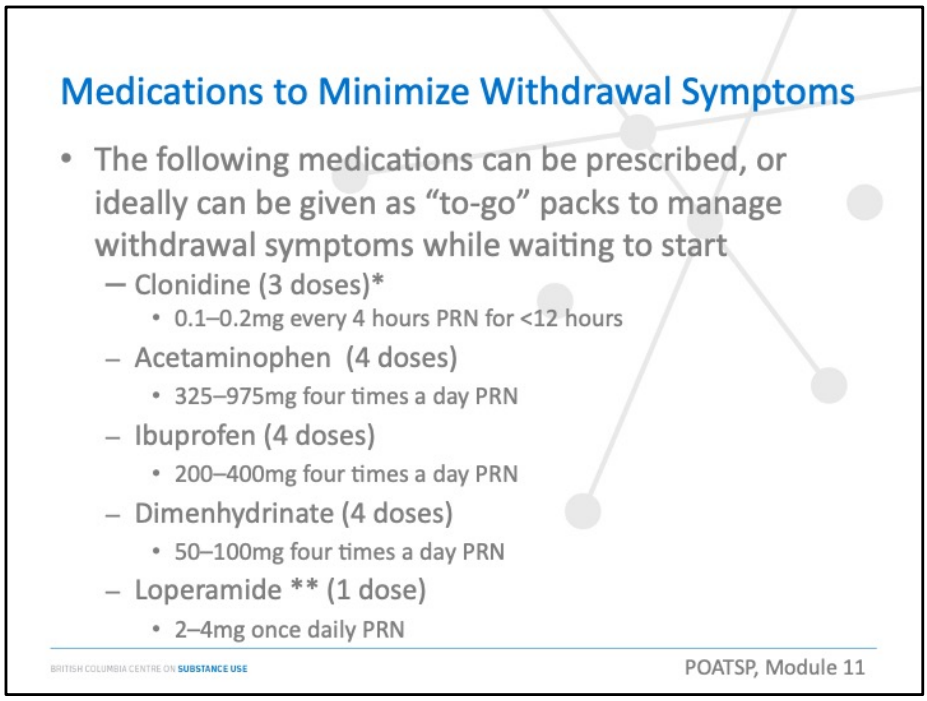
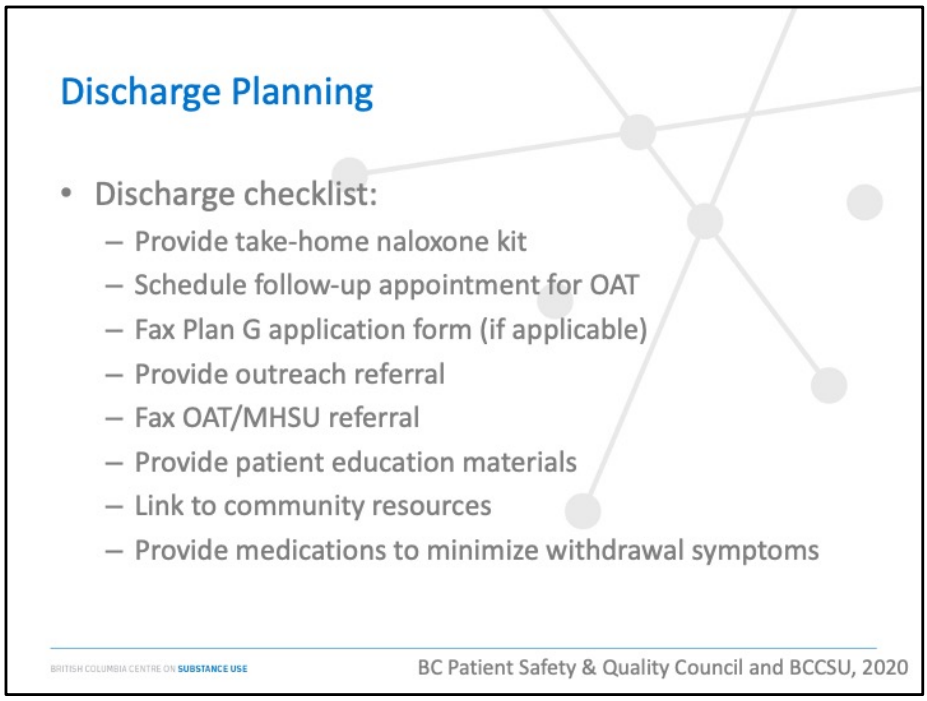


- These are St. Paul's home induction packs or "BUP" to go. The containers are childproof .
- Prescribing buprenorphine/naloxone in these home induction packs removes the added barrier of going to the pharmacy
- There is less concern with diversion of buprenorphine/naloxone due to its superior safety profile, including ceiling effect on respiration. Generally, diverted buprenorphine goes to people interested in treatment or who are avoiding dangerous street fentanyl (Cicero 2018)



- Clonidine*
    - Clonidine may lower SOWS score
- Loperamide **
    - Loperamide is only rarely necessary. Diarrhea is typically severe when patient has sufficient withdrawal symptoms and there has been a long enough duration since last opioid use to start buprenorphine

- Some clinicians will provide carry doses of hydromorphone 8mg tabs to help patients deal with precipitated withdrawal, if it occurs
- Ideally, clinicians should provide these medications as "to-go" medications at the same time as dispensing and prescribing buprenorphine

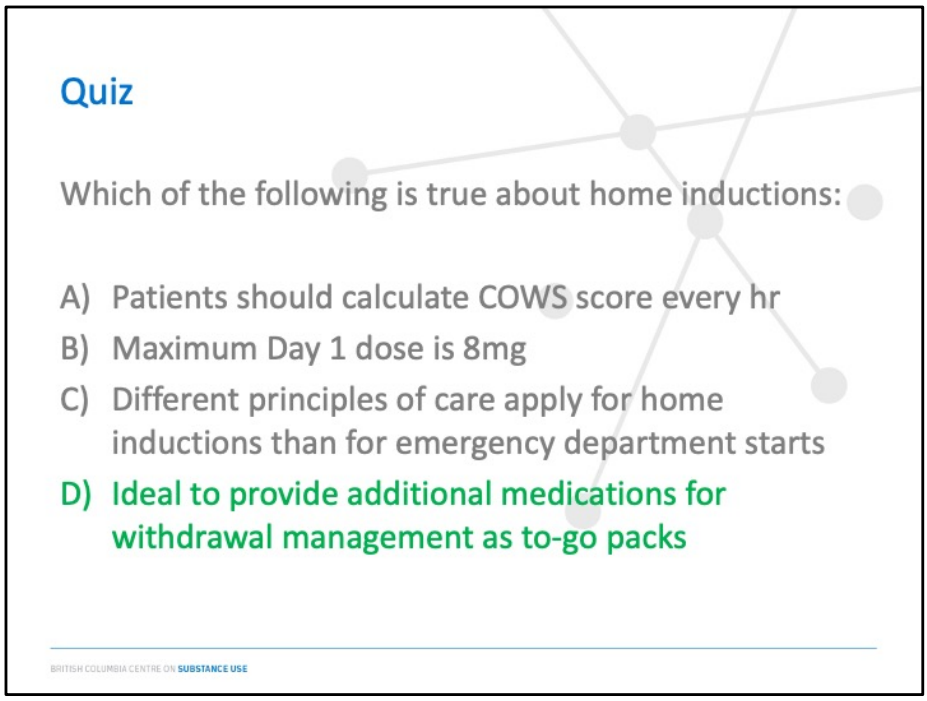


- Discharge planning is nearly identical to starting in the emergency department, except the bridging prescription is usually not necessary and “remaining doses” are not applicable
- Before discharging a patient from the emergency department, consider which of the actions on th discharge checklist above are applicable:
- Be systematic in discharge planning and try to maximize your patient’s success
- Discharge checklist adapted from: https://bcpsqc.ca/wp-content/uploads/2020/11/F2.0_LOUD_ED-Clinical-DST.pdf

Quiz

Which of the following is true about home inductions:

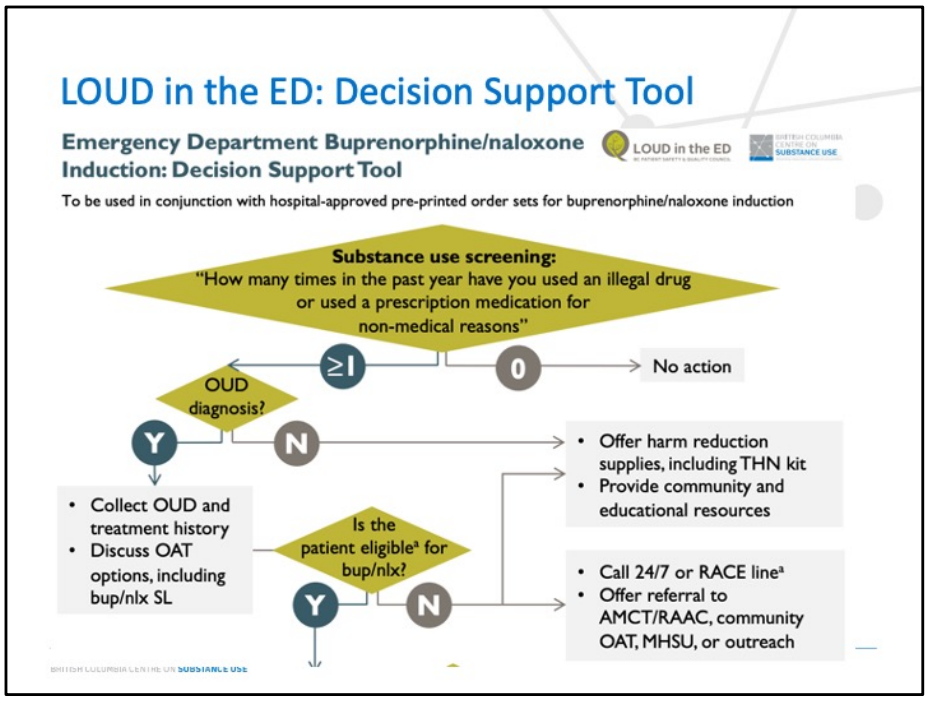
A) Patients should calculate COWS score every hr
B) Maximum Day 1 dose is 8 mg
C) Different principles of care apply for home inductions than for emergency department starts
D) Ideal to provide additional medications for withdrawal management as to-go packs



- The correct answer is D, it is ideal to provide additional medications for withdrawal management as to-go packs.
- A is incorrect. The COWS is not appropriate for self-administrations because it involves assessing vital signs. Patients who are doing a home induction should instead use the SOWS to self-assess withdrawal symptoms
- B is incorrect. The maximum day 1 dose in most protocols is 12mg to 16mg of buprenorphine,
    - in practice there is no maximum dose. With PRN doses, some patients will reach 24 mg or beyond on day 1 (disclaimer: this later point is outside of current BCCSU guidelines)
- C is incorrect. The principles of care are the same for both home inductions and emergency department starts.

Buprenorphine Basics Modules

- You have completed 1 of 4 “Basics” modules:
  - ❑Pharmacology
  - ❑Emergency Department Induction
  - ✓Home or Unobserved Induction
  - ❑Precipitated Withdrawal
- Please find the remaining modules at:
  - – https://https://www.bccsu.ca/edcare/



- A decision support tool for buprenorphine induction in emergency departments in BC is available through the BC Patient Quality and Safety Council. More resources are available on their website.
- https://bcpsqc.ca/wp-content/uploads/2020/11/F2.0_LOUD_ED-Clinical-DST.pdf

•If you need support managing precipitated withdrawal, inducting a patient on to buprenorphine/naloxone, or providing any other aspect of addiction and substance use care, you can call the 24/7 addiction medicine support line.

• The 24/7 addiction medicine clinician support line provides telephone consultation for physicians, nurse practitioners, nurses, mid-wives, and pharmacists who provide addiction and substance use care. It is available 24/7, 365 days a year. The number to call is 778-945-7619. More information can be found at www.bccsu.ca/24-7.

- The Provincial Opioid Addiction Treatment Support Program contains modules with more information on opioid use disorder and opioid agonist treatments, including buprenorphine/naloxone. This program is available online and it is free of charge.

References

1. Provincial Opioid Addiction Treatment and Support Program. *Module 24: Buprenorphine/naloxone in Acute Care Settings*. Available at: https://www.bccsu.ca/provincial-opioid-addiction-treatment-support-program/
2. BC Centre on Substance Use and BC Ministry of Health. Provincial Guideline for the Treatment of Opioid Use Disorder. 2017. Available at: https://www.bccsu.ca/opioid-use-disorder/
3. Provincial Opioid Addiction Treatment and Support Program. *Module 12: Home Induction of Buprenorphine/naloxone*. Available at: https://www.bccsu.ca/provincial-opioid-addiction-treatment-support-program/
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5. BC Patient Safety & Quality Council and BC Centre on Substance Use. 2020. *LOUD in the ED Decision Support Tool*. Available at: https://bcpsqc.ca/resource/loud/


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