ENDING HOMELESSNESS TOGETHER

Riverside

Opioid Medication Management (Methadone)

TEMPORARY PROCEDURE (During COVID-19 Pandemic)

1. Introduction

As a result of the current Coronavirus (COVID-19) crisis there is a need to introduce a number of **temporary** procedures across Care and Support. These will provide guidance on activities and support being provided as emergency measures, to ensure the safety of our customers and staff.

2. Overview

The introduction of Covid - 19 control measures, such as social distancing and self-isolation have caused some medication prescribing agencies we work with to make changes to their procedures with regard to the management and administration of opioid prescriptions (in particular, Methadone).

Some prescribing agencies (prescribers) have made the following changes to their usual methods of management of customers' Opioid prescriptions:

- Changing the frequency of prescription administration (e.g. from every day to up to 28 days)
- Changing the method of administration from supervised administration to take-home supplies, sometimes in large quantities and sometimes in single doses of large quantities.

This is also causing issues with regard to the storage of methadone, as **Riverside will not store Methadone or any other Opioid medication on behalf of customers under any circumstances.**

In most cases prescribers are not contacting Riverside to explain the changes; customers are being contacted without the knowledge of Riverside or changes are being made when a customer next attends an appointment. This creates issues where colleagues are having to work reactively.

The purpose of this temporary procedure is to provide guidance for colleagues working in services where there are customers who are currently prescribed Opioids, in order to mitigate any extra risks posed by the current Covid –19 outbreak, as described above.

Please note: This temporary procedure has been shared by The Riverside Group to provide outline guidance with partner organisations and should be adapted and deployed depending on local circumstances and activity. 17.4.20

It should be noted that this temporary procedure is designed to adapt to a changing environment, in a very challenging situation. It is therefore unlikely to be exhaustive and may not cover every eventuality. It is therefore very important that where colleagues come across new situations that may affect this guidance, that they contact their Regional Operations Manager for their region who will feedback appropriately.

3. Risks

The reduction of supervision of medication management from prescribers and the increase of take home supplies carries a number of risks including:

- Overdose- intentional or accidental
- Illicit sale or theft
- Increased drug use
- Increased violence and aggression at the service

This procedure aims to take reasonable steps to minimise those risks.

4. Storage of medication

With regard to the storage of medication, the following should be noted:

Medication must not be stored on behalf of customers, under any circumstances. Colleagues are not clinically trained and at most services there is a lack of suitable storage facilities, both of these issues make the storage of medication by Riverside an increased risk to colleagues.

Where customers are given take-home medication by their prescriber, they are to be encouraged to keep their medication in a storage facility provided by the prescriber.

Where no facilities are provided, customers should be encouraged to store their medication safely in their accommodation, i.e. in a locked drawer or cupboard, where available, and they should keep their accommodation locked at all times.

5. Administering and Dispensing

Colleagues must not dispense or administer medication for customers, under any circumstances. Colleagues are not clinically trained and therefore any administration could pose a risk to all parties involved.

Whether or not a customer needs to be prompted to take their medication, when and at what frequency should be assessed on a case by case basis and should be recorded on the individual customer’s risk assessment on SP Provider.

6. Actions to be taken

6.1 Identifying changes to management of opioid prescription and administration

It is important for all services working with customers who are prescribed Opioids to have a clear and up to date understanding of any changes prescribers are making to the management and administration of opioids to customers.

It should be noted in that where a high level of support is being provided to customers, Service Managers should contact the local prescriber and challenge any significant changes, on the grounds that unsupervised, take home medication is very unsafe and extremely difficult to manage.

For support in this area, colleagues should contact their Area Manager or Regional Operations Manager.

Where further guidance is required from Area and Regional Operations Managers, the National Care Manager can be contacted – Victoria.salm@riverside.org.uk.

As there are currently inconsistencies in prescribers notifying us of changes, and issues causing reactive management, colleagues in every service affected should:

Contact their local prescriber immediately to understand the issues below.

a. **What are the changes** - What changes the prescriber has or intends to make to their usual prescribing procedures, including the timeframe to be operated and what guidance will be provided

b. **Risk assessment** - Obtain a copy of the risk assessment the prescriber has conducted as part of the changes they are making, including detailed risk reduction/mitigation measures they have will be introducing for Riverside customers and colleagues. Colleagues should also share Riverside's risk assessments with the prescriber, as there may be risks in our accommodation that they have not taken into account.

c. **Storage** – what storage facilities the prescriber will be providing for any medication. Explain that the Riverside policy is that we will only accept as appropriate medication provided to the customer in a locked container by the

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pharmacy or the drugs agency. **We will not store methadone on behalf of a customer.**

d. **Administration of packaging** – Riverside will only accept as appropriate pre-measured medication for daily administration, e.g. if a 14 day prescription is to be issued, 14 separate, pre-measured, separately sealed bottles should be provided to the customer. This is to avoid the risk of overdose.

e. **Naloxone Stock** – how much stock of Naloxone the prescriber has, as the changes increase the risk of overdose, which in turn means that prescribers may need to increase their stock of Naloxone available to services.

f. **Customer awareness, choice and control** – discuss how the customer has been informed of any changes and ensure that the customer has been able to share any concerns they may have in order for them to exercise maximum control and choice. Some customers may not want these changes, as they may feel at risk.

g. **Raising concerns** – all colleagues working with customers are encouraged to challenge the prescriber where concerns are identified and these concerns should be discussed and shared amongst team members, where appropriate. Colleagues should challenge decisions where there are concerns – e.g. by contacting the prescribing service manager, outlining concerns and ensuring these are recorded in writing. Details can be found in item 4.2.

h. **Local records** – detailed and accurate records of all changes agreed with the prescriber should be detailed on SP Provider by which ever colleague is dealing with the situation in the service.

i. **Global records** – a designated person per service should complete and maintain records regarding the service's current prescription administering position on the Methadone Tracker in the Central Evidence Folder, see link:

DFSDepartments\Operational Team\Central Evidence Folder\Methadone Tracker (Covid-19)\Methadone tracker (Covid-19).xlsx .

The spreadsheet is password protected and has been sent to Area Managers and Regional Operations Managers – all Service Managers should ensure all colleagues know how to access this password.

It is vitally important that these records are up to date, so that senior management can monitor the situation across the organisation and make any policy changes as required.

j. **Commissioner awareness** – discuss with the prescriber what knowledge and involvement the local authority/CCG commissioner has had with any decisions made and to what extent they are in agreement, if they are aware of the risks and what guidance they have given. A letter should be sent to commissioners, see item 4.2 for details.

k. **Delivery of medication** – Riverside will not normally collect medication; the prescriber or pharmacy should deliver to the service. Colleagues should ensure they have outlined the risks to the pharmacy.

   The exception to this policy is when customers are self –isolating – please refer to the 'collection of methadone for self-isolating customers' procedure on the Coronavirus Pandemic Information folder on the RIC. See link below:

   http://ric/sorce/beacon/singlepageview.aspx?pii=589&row=8994&SPVPrimaryMenu=5&SPVReferrer=Business%20Continuity&SPVPrimaryMenu=5&SPVReferrer=Business%20Continuity

l. **Quantity of medication** – where significant changes to the administration and management of medication are made e.g. supervised daily contact to 14 day take-home supply, efforts should be made to negotiate a method of management that poses the least risk to customers and colleagues e.g. changing the frequency of prescriptions to twice a week to reduce the quantity of medication at a service, therefore lowering any risk.

6.2. Actions to be taken – Letters to prescribers and commissioners

In addition to the above actions the Service Manager should send a letter to the prescriber detailing our concerns, which is available in **Appendix One** - **Letter to Prescriber, Opioid Management, Covid – 19.**

A copy of this letter should also be sent to the Local Authority/CCG commissioner for the service to ensure they are up to date with any changes to be made**.** A covering letter - **Letter to Commissioners, Opioid Management, Covid-19** is available in **Appendix Two.**

6.3 Actions to be taken - Customer Welfare

All customers who are affected by the changes detailed in this procedure should be contacted to discuss these changes, a follow up letter should be sent to the customer in every case, which should include information on:

- How medication should be stored – i.e. self-storage in locked cupboard or cabinet and that they should keep their accommodation locked at all times.

Increased welfare checks to affected customers should be carried out due to the increased risk of overdose.

Where there any concerns about the welfare of a customer due to these changes, the prescriber should be contacted immediately.

6.4 Actions to be taken - Risk Assessments

Individual risk assessment - Colleagues should update all customers' risk assessments on SP Provider where any changes have been made.

Service risk assessment – **Appendix Three** contains the '**Covid -19 Opioid Management Service Risk Assessment'**. All services should complete and maintain this document.

Service Managers should ensure this is up to date and shared with colleagues at the service, as appropriate.

7. Naloxone

Naloxone is drug that temporarily reverses the symptoms of an overdose caused by heroin and other opiates or opioids (such as methadone, morphine and fentanyl). Customers on methadone prescriptions may also have stocks of Naloxone in the form of epipens. In certain circumstances Naloxone can be administered to customers by Riverside colleagues.

For further guidance on the administration of Naloxone, please refer to the 'Administration of Naloxone Hydrochloride (Prenoxad)' Procedure. *RIC > Central Services > Care and Support > Supported > Supported Housing Manual*

Colleagues should encourage customers to check they have a good stock of Naloxone and to ask the prescriber to provide this for them where they have not. These conversations should be documented on SP Provider.

Colleagues should ensure they know how to support the customer to access more Naloxone epipens, should they be required. Service Managers should ensure their team are aware of the procedure for accessing more Naloxone.

8. Medicinal assistance

In an event where medicinal assistance is required the following people should be contacted:

- Dispenser
- Pharmacy
- 111 (long waiting times)
- 999 as required

9. Colleague welfare

When lone working colleagues must never put themselves at risk. Where faced with violence, colleagues should always contact police.

Where a colleague feels there may be a risk of a situation escalating into violence or aggression, colleagues must always move away from the situation and into a locked, safe space e.g. an office.

Colleagues should always be made aware of the on call procedure and how to contact an on call manager in a situation where it is deemed is unsafe or where guidance is required.

Colleagues should contact another local service and buddy up with them and agree to check in to ensure safety at an agreed period e.g. every 3 – 4 hours. Where no contact is made, this should be escalated to the on call manager.

Appendix One – Template Letter to Prescribers (delete or add info as appropriate below)

Insert Prescriber Service Manager Name & title

Address 1

Address 2

Address 3

Date

Dear <insert name>

RE: Changes to the Management of Opioid Medication at <insert service name>

I am writing to raise a number of concerns in regards to your decision to move to <insert description of new procedure e.g. fortnightly methadone prescriptions> and to explain how this is will impact on our service.

We have recently been made aware that you intend to change the way you prescribe medication-assisted treatment. We have been informed that people who are currently accessing supervised consumption will move to a <insert details of new procedure e.g. two-week take-home supply>.

We understand that in these exceptional times and your primary concern is focused on the safety of your staff, customers and services and you are having to look at the most appropriate way to continue meeting the needs of the people you support.

We are however, concerned that the decisions you have taken will negatively impact on the way we deliver services at <insert service name>. We believe that providing a <insert new details of new procedure e.g.14 day prescription for methadone> will significantly increase the risk to both our staff and our customers.

Our issues are: <delete as appropriate to match what you have been asked to do by the prescriber and add any other concerns not detailed>

- We cannot store any controlled drugs on site as we are not clinicians and our staff are not trained to administer methadone.
- The larger prescriptions will mean there will be a considerable amount of a controlled drug under one roof. Customers do not have adequate storage facilities in their rooms meaning their supply may not be appropriately secured
- There is a risk of overdose, intentional or accidental. We believe that for particularly vulnerable people this is a safeguarding issue and there is an increased risk of fatalities in the scheme
- There is an increased likelihood of Illicit sale, theft and intimidation
- There could be increased drug use if people use their increased supply, leading to risk of overdose, an increase in violence and aggression, people ignoring self-isolation, an increase in the number of visitors and potentially a risk of eviction
- On a local level it is also worrying that prior to the changes that have been made we were not contacted or consulted with.
- There was no discussion about potential alternative options.
- We weren't involved any individual risk assessments or asked our opinion on how changes could impact on other customers.

We are also concerned that in order to ensure that we are able to keep our service operating we are employing an increasing number of relief and agency staff. People on shift will not be trained substance misuse practitioners or clinicians. We are concerned that changes in prescribing leading to the points raised will increase the risk to staff, customers and the local community.

As stated previously, we understand that the current crisis requires us to do things differently. We also understand the importance of ensuring customers who require treatment have access to the correct medication.

We would be grateful if you could consider the points raised above and get back to me to discuss further.

Yours sincerely

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<insert name>

Service Manager, <Insert Service Name>

Appendix Two

Covering letter to Commissioners, Opioid Management, Covid-19

Insert Commissioner Name and title

Address 1

Address 2

Address 3

Date

Dear <insert commissioner name>

RE: Changes to the Management of Opioid Medication at <insert service name>

Due to the current Covid-19 pandemic, <insert prescribing service name> have made changes to the way they manage and administer Opioid Medication (Methadone) to the customers who live at <insert service name>.

Riverside believes there are many risks associated with this new procedure and have highlighted those to <insert prescribing service name>.

I have enclosed a copy of the letter sent to <insert prescribing service name>.

I would be grateful if you could contact me to discuss further.

Yours sincerely,

<insert service manager name>

<insert service>

Covid -19 Opioid Management Service Risk Assessment

Where there are any customers in a service that are currently receiving methadone through a local drug service, this risk assessment should be completed and stored locally. Service Managers should ensure that this is kept up to date, referred to on a daily basis and shared with the appropriate people.

1. Checklist

Below is a checklist of actions to be taken by Support Workers, these actions should be checked by the Service Manager:

Action to be taken	Person Respon sible	Progress/Completed	Date
Customers affected			
Detail number of customers affected by changes			
Contact made with local prescribing service			
Contact made with local prescribing service to check for any changes to medication process (detail any new approach below in item 2)			
Prescribing service Risk Assessment requested, received and shared with the team			
This risk assessment to be shared with prescribing service once complete			
Individual risk assessments			
Changes are made to every customer's risk assessment to reflect the changes to medication management			

Medication Storage			
Check all medication is stored in a locked container and customer has been advised to lock bedroom door at all times			
Packaging			
Check medication packaging is sealed and divided up into daily amounts			
Naloxone			
Every customer has been asked to check their stocks of Naloxone and this has been recorded on SP Provider			
Methadone Tracker			
Check service has updated the ‘Methadone Tracker’ on the central evidence folder			
Quantities			
Check the quantities are the minimum possible from the prescriber			
Welfare checks			
Ensure customers at risk receive more welfare checks and document on SP Provider			
Identify customers who need prompting to take medication and detail on SP Provider			
Colleague welfare			
Has a ‘buddy service’ with similar hours been identified? Provide detail			
Insert manager on call details here			
Colleagues to call ‘buddy’ service every 3-4 hours (document agreement and contact details here)			

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Concerns re: process			
Conversation has been had with prescriber raising any concerns			
Letter has been sent to prescriber to follow up conversation (see appendix one)			
Conversation has been had with service commissioner raising concerns			
Letter has been sent to commissioner (see appendix two)			

2. New Approach to Opioid Management

If a new approach to the administration and management of Opioid Medication has been put in place by the prescribing service we work with, please detail the changes below:

Is the prescriber still supervising medication – yes/no
Is the prescriber sending home medication for self –administration at home? yes/no
How many days medication is the prescriber sending home? Detail below
Is the prescriber sending the medication in separate, sealed bottles? (if no, raise with the service manager who should contact the prescriber as this is a risk)
Any other comments on risk of process