Addiction Nursing Competencies: Skills Checklist

A Comprehensive Toolkit for the Addictions Nurse

Corresponding Manuscript:

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Introduction

The nursing scope of practice includes extensive training in chronic disease management and patient education, making nurses ideally suited to deliver care to persons with substance use disorders across the spectrum of disease severity and remission. The entirety of the nursing workforce is needed to address the continuum of substance use, prevent the progression of disease, and address the harms associated with substance use (1).

Healthcare consumers expect and deserve proficiency from the nurses who care for them. Competency frameworks provide clear expectations of clinicians and organizations and are utilized to train nurses and assess their ability to provide patient care (2). The Addiction Nursing Competencies are intended to inform and guide nursing practice in the provision of comprehensive, evidence-based care to persons with substance use disorders. These competencies aim to support a holistic approach to patient care, focusing on an individual's strengths, motivation, and personal definition of recovery. Paired with tools such as medications for addiction treatment and harm reduction strategies, this toolkit strives to enable nurses to safely and effectively deliver care to persons across the spectrum of the substance addiction from active use to sustained recovery.

How to Use the Addiction Nursing Competencies Toolkit

The Addiction Nursing Competencies consist of three documents: *Foundation, Assessment,* and the *Skills Checklist.* This stratified approach captures the expansive principles of nursing theory that form critical knowledge and skills. The combined use of these tools aims to promote a standard of care in addiction nursing practice by providing groundwork for both administrative and front-line nurses to assess knowledge, provide education, and build concrete skills in addiction nursing care.

Document 1: Foundations

This higher-level document outlines the theoretical framework of quality addiction nursing care, including essential nursing knowledge, attitudes, and behaviors. Foundation sets the stage for the non-judgmental, empathetic and comprehensive approach to patient care and harm reduction philosophy.

Foundation is based on and adapted from the *Massachusetts Nurse of the Future: Nursing Core Competencies* (March 2016) by the Massachusetts Department of Higher Education Nursing Initiative (3). The Nurse of the Future: Nursing Core Competencies was chosen as a guiding document as it synthesized competencies from other states, current practice standards, education accreditation criteria, national initiatives, and projected patient demographic and health care profiles.

Document 2: Assessment

Assessment is a bridge document that may be used at the both the management and individual nurse level, to structure the assessment of nursing knowledge and skills when caring for persons with substance addiction. This document includes learning objectives paired with nationally recognized supportive education to promote evidence-based knowledge.

Document 3: Skills Checklist

This final document outlines concrete steps of the nursing process for specific skills to determine the proficiency of an individual nurse. This tool can be used for nurses' self-assessment and training, as well as by administrators to determine nurse proficiency in each skill.

Definitions of Commonly Used Acronyms

OBAT: Office-Based Addiction Treatment

SUD: Substance use disorder

OUD: Opioid Use Disorder

COWS: Clinical Opiate Withdrawal Scale

MOUD: Medications for Opioid Use Disorder

OTP: Opioid Treatment Program also referred to as a Methadone Maintenance Treatment Program

nPEP: Non-occupational post-exposure prophylaxis for HIV

PrEP : pre-exposure prophylaxis for HIV

SSP: syringe service program

INH: Inhaled

IN: Insufflation

IV: Intravenous

IR: Intrarectal

NRT: Nicotine Replacement Therapy

REMS: Risk Evaluation and Mitigation Strategies

MTD: Methadone

PEG scale: Pain, Enjoyment, General Activity

CIWA: Clinical Institute Withdrawal Assessment for Alcohol

Skills Checklists

Substance Use History Collection

Assess current substance use	YES	NO
Assess the patient's presenting state of intoxication/withdrawal.		
Assess the current (e.g. within the past 24hrs) substance use of the patient including, substance, amount, frequency, route, and duration of use.		
Assess recent substance use (e.g. within the past week). • Assess for opioids, stimulants, benzodiazepines, non-prescribed medications, alcohol, cannabis, nicotine products • Assess route, frequency, quantify of use, and date of most recent use.		
At initial visit, assess historical substance use. If patient is in moderate-severe withdrawal or experiencing acute intoxication, this history may be deferred to a later encounter. • Assess age of first use for opioids, stimulants, benzodiazepines, non-prescribed medications, alcohol, cannabis, nicotine products, and any other substances significant to patient history. • Assess route, frequency and quantify of use.		
Explore periods of recovery including: duration of recovery as well as activities that supported or threatened recovery.		
Assess substance use disorder treatment history including: medically supervised withdrawal, residential programming, medications for opioid disorder treatment, behavioral health programming, peer support.		
Assess safety: • Overdose history and access to nasal naloxone • Access to safer consumption supplies • Use of risk reduction strategies such as using with others, fentanyl test strips,		
Educate the patient regarding the overdose prevention properties of continuing their MOUD.		
Educate the patient regarding Overdose Prevention and Safer Consumption Practices (as appropriate)		
Educate the patient about evidence-based treatment options for care of substance use disorders		

Nursing Assessment sections that contain learning objectives and supplemental education that support further education on this topic include:

- Safety

Urine Collection

Prior to Meeting with the Patient	YES	NO
Review the results of the patient's previous urine drug screen.		
Confirm the need for an additional urine specimen.		
Collecting the Urine		
Call patient from the waiting room.		
Confirm patient with at least 2 identifiers (Name, DOB, MRN, etc).		
Educate the patient that urine specimens are meant to evaluate the effectiveness of treatment and not be punitive.		
Ask the patient to hand you their belongings including jackets, bags, and food containers.		
Advise the patient regarding the process for urine collection and that they should not flush the toilet until they have opened the door for the nurse.		
Escort the patient to the bathroom and wait outside of the bathroom for the patient to collect the specimen.		
After the specimen in received, advise the patient to wash their hands.		
Provide the patient's belongings back to the patient.		
Assess the urine specimen for clarity, color, and temperature.		
If urine is within expectations then label the specimen container with the appropriate lab requisition.		
When the Urine is Unexpected		
If urine does not meet expectations, then discuss your concerns with the patient in an exam room.		
If the patient does not disclose adulteration, request a repeat urine specimen from the patient and reassess expectation of the urine.		
Do not send urine specimens that are thought to be adulterated to the lab for testing.		
Do NOT perform an observed urine even in the setting of an unexpected urine specimen.		
Notify the provider of your concerns.		

Nursing Assessment sections that contain learning objectives and supplemental education that support further education on this topic include:

- Evidence-Based Practice

Addressing Recurrent Use

Discovery of recurrent use:	YES	NO
If the patient discloses use • Thank the patient for disclosure of recurrence. Provide education as appropriate • Make adjustments to treatment plan. If the patient doesn't disclose use • Provide education as appropriate • Review objective data with the patient.		
Collaborate with treatment team to assure the patient that recurrence of use does not result in discharge from treatment.		
Assess adherence to current medications for addiction treatment.		
Assess the patient's current state of intoxication/withdrawal.		
Assess the current substance use of the patient including, substance, amount, frequency, route, and duration of use.		
Discuss the events surrounding the recurrent use: antecedents, behaviors and consequences.		
Educate the patient that a UTS is an opportunity to have a frank discussion with their treatment team about their use and that it is not punitive.		
Educate the patient regarding the options to revise/augment the current treatment plan.		
Educate the patient regarding the overdose prevention properties of continuing their MOUD.		
Educate the patient regarding Overdose Prevention and Safer Consumption Practices (as appropriate)		
Determine if a dose adjustment may be indicated		

Nursing Assessment sections that contain learning objectives and supplemental education that support further education on this topic include:

- Safety
- Evidence-Based Practice

Opioid Overdose Prevention, Education, and Reversal

Initial Assessment of Opioid Overdose Risk	YES	NO
Ask patient about specific substance of use.		
Ask patient regarding their method of use (INH, IN, IR, IV, PO).		
Ask the patient about their history of opioid overdose (quantity, most recent overdose, time down, injury sustained, associated hospitalization).		
Ask if the patient has ever reversed an opioid overdose.		
Assess the patient's accessibility to nasal naloxone.		
Identifying Opioid Overdose Prevention Strategies		
Review the risks of polysubstance use related to opioid overdose.		
Educate the patient on testing supply for potency.		
Counsel patient on the importance of not using alone.		
Identify potential friends or contacts that could be present while patient is using to prevent isolation and offer naloxone education for those support people.		
Identify public spaces that would be private but could facilitate being found if patient overdosed.		
Review strategies to obtain a consistent supply by purchasing substance from the same person regularly.		
Provide the patient with a prescription for nasal naloxone.		
Identification of Opioid Overdose		
Describes symptoms of an opioid overdose, including respiratory depression.		
Differentiates between patients who have recently used opioids and are intoxicated from those experiencing an opioid overdose.		
Communicates, nasal naloxone if patient over sedated or minimally responsive (e.g. 'verbal' naloxone).		
Demonstrates the appropriate use of painful stimuli (e.g. sternal rub, maxilla rub, etc.) to differentiate between opioid overdose and opioid intoxication.		

Opioid Overdose Reversal	YES	NO
Understand Good Samaritan Law in your state, as it often protects people who call 911 during an overdose from being charged with possession of a controlled substance.		
Assess the safety of the environment and situation.		
Assess the patient's respiratory status and level of somnolence.		
Request help by activating rapid response (calling 911 if indicated).		
Assess for pulse at central artery (femoral or carotid). If no pulse within 10 seconds, then begin CPR.		
Demonstrates ability to follow American Heart Association protocols for CPR and rapid response.		
Obtain nasal naloxone or send ancillary staff to obtain the medication.		
Administer available naloxone formulation (e.g., 2-4 mg nasal naloxone per the Peel, Pack, Push Model)		
Wait 2-3 minutes after medication administration while continuing to provide respiratory support.		
If no response, administer 2nd dose of naloxone.		
Wait 2-3 minutes after medication administration while continuing to provide respiratory support.		
Assess effect of 2 doses of nasal naloxone. If the patient has had no effect, consider alternative reasons for unresponsiveness including potential for requiring additional naloxone dosing if receiving methadone maintenance for MOUD or CNS depression from other substances.		
When patient has return of spontaneous respirations, give the patient space for recovery.		
Provide safe and calming reorientation for patient recovering from opioid overdose and continue to support the patient to go to the ED for evaluation and monitoring for repeat overdose.		

Nursing Assessment sections that contain learning objectives and supplemental education that support further education on this topic include:

- Safety

Safer Consumption Education

Initial Assessment of Substance Use	YES	NO
Introduce yourself and build rapport with the patient.		
Ask patient about specific substance of use.		
Regardless of substance being used, ensure the patient has naloxone on hand, understands how to use it and counsel on importance of avoiding using alone.		
For patients using alone, encourage them to make others aware of their use and direct them to resources to improve safety (ex – Never Use Alone, Canary App).		
Ask patient regarding their method of use [inhaled (IH), intranasal (IN), intrarectal (IR), intravenous (IV), oral (PO), other]. *Based on the substance of use and the route of use, follow checklist to conduct consumption assessment and education.*		
Ask patients about sex during substance use and advise to prepare for safer sex with condoms, lubricant and plan for STI screening or contraception.		
Anxiety, depression and agitation are common after periods of use. Educate patients on how to connect with local support services or emergency services if feeling unsafe.		

Injection Supply Gathering/Distribution	YES	NO
Ask the patient what supplies they usually require for IV use.		
Ask the patient about their method and location of injection.		
Ask the patient is they share any supplies including needles, cookers, cottons/filters, tourniquets, pipes, etc.		
Ask the patient what they do to stay safe when using.		
Obtain safer injection supplies including cookers, cottons/filters, mixing agents (diluent or acids for injection of crack cocaine) and tourniquets.		
Obtain cleaning supplies including alcohol prep pads, triple antibiotic ointment, and hand sanitizer.		
Obtain prescription for needles typically insulin syringes ½”-5/8” and a 28-32 gauge.		
Provide gauze for cleaning skin from residual blood.		
Injection Education		
Review safer injection sites on the body.		
Review risks associated with injecting in the neck.		
Demonstrate use of alcohol-based hand sanitizer and promote hand washing prior to injection.		
Review tourniquet application.		
Review the importance of injecting from distal to proximal in extremity injection.		
Identify strategies to determine a healthy vein and to rotate injection sites.		
Demonstrate appropriate use of alcohol prep pads to clean injection site prior to injection.		
Educate the patient on the importance of ‘cooking’ prior to injection and consideration for double cooking if there is concern for additional biological concerns.		
Review the importance of a filter for needle to prevent drawing up particulate matter prior to injection.		

Educate the patient on inserting the needle into the vein, bevel up, at 5-15°angle until a flash of blood is noted in the needle.		
Educate the patient on the need to release tourniquet prior to injecting substance.		
Educate the patient on a test shot prior to injecting full contents of syringe.		
Review that if the needle is removed from the skin that the skin should be cleansed again prior to injecting.		
Educate that removal of the needle should be followed with holding pressure at the site of injection to prevent excess bleeding/bruising.		
Review application of triple antibiotic ointment after substance use to prevent injection site infection.		
Stress the importance of single use needles and that it is best practices to dispose of single use needles in hard plastic container to prevent unintended needle stick injuries.		
Management of Basic Injection Complications		
Warm pack application to sites of missed injections (skin popping) to help alleviate localized infection.		
Counsel the patient on the importance of monitoring injection sites for localized infection (redness at the site that is getting worse, swelling, pain, fever) and when to report for urgent evaluation.		
Educate that patients with concerns for retained needle should be referred to ED for ultrasound for potential removal.		
Educate the patient on vein care including avoiding injection of stimulants, safer mixing agents and rotating sites.		

Safer Smoking Education	YES	NO
Obtain safer smoking supplies including straight stem, mouth piece, screens, push stick, and lighter.		
Obtain cleaning supplies including alcohol prep pads, triple antibiotic ointment, vitamin E, band aids, Chapstick, and hand sanitizer.		
Prior to smoking, pull back hair and loose clothing to prevent catching fire.		
Fit mouthpiece onto a glass or metal "stem" or pipe when possible to decrease risk for oral lesions and burns. *Rubber band can substitute as a mouthpiece over the end of a stem to prevent oral burning.*		
Insert screen by twisting it into a cone shape or clean chore by rolling it into a ball and using the push stick to pack screen/chore into place within the stem. *Screens are preferred over chore as it can decompose with repeated use and accidentally inhaled.*		
While smoking, touch flame to pipe as briefly as possible, inhale slowly and then exhale immediately to decrease risk for burning of lungs and will not impact effect of substance.		
Allow pipe to cool between hits to prevent burns.		
Avoid sharing smoking supplies especially those in contact with mouth or with risk for blood transfer.		
In between periods of use, clean pipe by wiping mouthpiece with alcohol and replace chore or screens.		
Discard broken pipes, mouth pieces or any supply with visible blood.		
Smoking Self-care		
Never use alone or connect with others than can check on you.		
Try to eat something before you smoke and to stay hydrated during/after use.		
Plan a safe place to take a break from use for rest, water and food.		

Safer Vaping Education	YES	NO
Review that while smoking e-cigarettes may be considered in some ways less harmful than cigarettes, it is unknown what chemicals are in e-cigarettes and there has been an outbreak of lung injuries and death associated with vaping.		
Understand the amount of nicotine in each pod or cartridge you are using (ex – one JUUL pod contains as much nicotine as a 20 pack of cigarettes) and try to use that pod for the same amount of time it would take you to smoke that number of cigarettes.		
Counseling on avoiding THC-containing vaping products.		
Discuss how patient is obtaining pods or cartridges for vaping device.		
Encourage patients to buy pods or cartridges from a reliable source.		
Advise not to modify or add substances to a vaping device not intended by manufacturer.		
Vaping Cessation Strategies		
Identify triggers associated with vaping or using e-cigarette.		
Provide nicotine replacement therapy.		
Replace vaping with hard candy, gum or other activities to fight cravings.		
Identify support through family, friends or smoking cessation group.		

Safer Sniffing	YES	NO
Obtain safer sniffing supplies including straws, plastic razor or "snuff card", clean surface ("snuff board" or mirror), grinder, and wraps or plastic bags.		
Obtain cleaning supplies including alcohol prep pads, vitamin E, saline nasal spray, antiseptic wipes, and hand sanitizer.		
Wash or sanitize hands and all surfaces before use and avoid sniffing from other people's bodies.		
Crush powder as fine as possible in a clean grinder or a plastic razor or snuff card.		
Start with a test dose to determine strength of supply being used.		
Divide drug supply into smaller portion sizes in an effort to control rate/amount of use.		
Use paper straws to decrease the risk for cutting nares. *Post-it notes are a good alternative.*		
Avoid sharing straws, razors, cards or other smoking supplies.		
Sniffing Self-care		
Take care of your nose by rinsing with saline and applying vitamin E to the inside of your nose.		
Plan ahead for a safe place to rest, hydrate and eat after a period of use.		
Assess patient with cocaine use for vasculitis and skin break down including nasal septum decay associated with repeated intranasal use.		

Safer Oral Consumption: Alcohol	YES	NO
Assess for alcohol dependency and history of alcohol withdrawal related seizure or delirium tremens. *Patients with dependency at risk for seizures or DT's should be assessed for inpatient medical management of withdrawal.*		
Assess the type of alcohol being consumed, frequency and amount.		
Discuss drinking behaviors and patterns of use to determine methods for alcohol moderation.		
Set timers to try to decreasing high volume consumption in short window of time.		
Switch to a beverage of lower alcohol content.		
Aim to limit consumption to a certain number of drinks per day by buying less or limiting funds available to purchase alcohol.		
Avoid operating machinery or motor vehicle (including bicycles) while under the influence of alcohol.		
Use plastic glassware and remove area rugs or other potential hazards in home to avoid accidental injury.		
Log out of social media accounts or put away electronic devices prior to drinking.		
Identify days, times or situations that are high risk for alcohol consumption and aim to increase activities that provide stress relief or engagement in non-drinking socialization during those times.		
Provide education regarding self-care: • Eating small frequent meals and hydrating with water before and after binge periods. • Supplementing diet with multivitamins (folic acid, vitamin B, thiamine). • Encourage use of a PPI to decrease inflammation and damage to GI tract.		
Safer Oral Consumption: Pills		
Assess the type of pill being consumed and the method of obtaining (ex – friend, prescription, supplier).		
Encourage patient to obtain pills from the pharmacy when possible or from a reliable source.		
Provide education regarding risk for buying pressed pills on the street containing fentanyl.		
Encourage patients using benzodiazepines to ration amount used prior to beginning substance use of any kind to decrease risk for binge patterns that could lead to overdose.		
Encourage patients using benzodiazepines to use pills following use of other substances as they impact memory.		
Counsel on risk for CNS suppression and overdose when mixing both over the counter, prescribed and illicit substances.		

Nursing Assessment sections that contain learning objectives and supplemental education that support further education on this topic include:

- Safety
- Evidenced-Based Practice

Safer Sex Education & Testing

Initial Assessment of Sexual Risk for Infection	YES	NO
Ask the patient about the type of sexual encounters they are having (i.e. vaginal, anal, oral).		
Ask the patient if they are utilizing any form of birth control, if applicable.		
Ask the patient about condom use.		
Ask the patient whether they have ever been on PrEP or nPEP.		
Assess the patient for any overt signs and symptoms of sexually transmitted infections (e.g. dysuria, polyuria, malodorous discharge, genital lesions).		
Ask the patient when they were last tested for STIs and their history of STIs.		
Screen the patient for transactional sex work or concerns for coercive sex.		
Safer Sex Education		
Educate the patient about the use of condoms to prevent pregnancy and STI.		
Educate the patient about the use of contraception options (including LARCs) for the prevention of unwanted pregnancy.		
Assess the patient's knowledge about HIV transmission, PrEP and nPEP.		
Educate the patient on HIV transmission and PrEP and nPEP, if appropriate.		
Assess the patient's knowledge about HCV transmission.		
Educate the patient on HCV transmission and treatment options, if appropriate.		
Provide the patient with resources for patients involved in transactional or coercive sex including the sex trafficking pamphlet.		
Sexually transmitted infection testing		
Identify appropriate testing protocols based on the patient's sexual history.		
Educate the patient about various forms of collection needed (i.e. serum, urine, genital, and extragenital).		
Follow your institutional protocols on ordering tests and collecting samples.		

Nursing Assessment sections that contain learning objectives and supplemental education that support further education on this topic include:

- Evidenced-Based Practice

De-escalation of Agitated Patient

Assessment of the Agitated Patient	YES	NO
Approach the patient/situation in a calm manner.		
Introduce yourself and your role.		
Ask the patient what is causing their agitation.		
Assess what may be contributing to the patient's current presentation including triggers of trauma, agitation, or substances.		
Ask patient-centered questions to determine the patient's motivation.		
Ask the patient what would be helpful to them in their current situation.		
Responding to the Agitated Patient		
Reflect on your experience interacting with the patient and stay calm.		
From a safe distance, continue to ask open ended questions allowing the patient to express their concerns.		
Use empathetic listening to repeat identified concerns to the patient.		
Maintain non-threatening body language to avoid further escalation of the patient.		
Provide concrete, truthful answers to the patient's concerns.		
Observe the patient for signs that they are calming down.		
Call for assistance from a supervisor or charge nurse when readily available.		
Offer the patient positive reinforcement for de-escalation to reinforce the desired behavior.		
***Request additional security support should the patient fail to de-escalate.		

Nursing Assessment sections that contain learning objectives and supplemental education that support further education on this topic include:

- Patient-Centered Care

Warm Hand Off

Identifying the Need for a Transfer of Care	YES	NO
Review patient treatment plan with care team prior to meeting with patient.		
Assess the patient's current state of use and effectiveness of current treatment plan.		
Use motivational interviewing to determine the patient's desired goals of treatment.		
Identify alternative treatment modalities using shared decision-making.		
Obtain contact info for direct care staff at the patient's desired location.		
Determine patient's eligibility for transfer of care.		
Have patient sign appropriate confidential Release of Information for the given facility.		
Conducting the Warm Hand Off		
Meet either in-person or telephonically with the provider or staff at a different level of care.		
Identify yourself and your relationship to the patient.		
Identify the reason the patient is seeing you.		
Identify the reason the patient requires a transfer of care.		
Review the patient's goals and how the transfer will help achieve them.		
Provide other relevant clinical information verbally.		
Ask if the receiving provider/staff have any additional questions.		
Ask patient to add anything to the report that you provided to the receiving staff/patient.		
Schedule a new appointment with the receiving provider or staff.		
Provide the receiving provider with your office/contact information to confirm that the patient has transferred care or to reach out if the patient is unable to make the first appointment.		
Provide the patient with both written and verbal confirmation of the appointment with the receiving provider/staff.		
Ensure the patient has your office contact information in case there is an issue with the transfer.		
Educate the patient that they are welcome back for reassessment at any time after the transfer, if applicable.		
Advocate to continue the patient's medication until confirmation of the completion of the warm-hand off.		
After the Warm Hand Off		
Contact the patient to remind them of transfer of care information.		
Contact the patient to confirm that they attended the appointment.		
Contact the receiving facility to confirm that the patient was able to make it to their appointment and they do not require any additional documentation.		

Nursing Assessment sections that contain learning objectives and supplemental education that support further education on this topic include:

- Teamwork & Collaboration

Buprenorphine Initiation

Initial Assessment of Opioid Withdrawal	YES	NO
Confirm patient with at least 2 identifiers (Name, DOB, MRN, etc).		
Ask the patient about their last use of an opioid including type, how much, and route of use.		
Assess the patient's opioid withdrawal with the Clinical Opiate Withdrawal Scale (COWS). • For patients transitioning from a full agonist, educate the patient on the need to be in opioid withdrawal for the buprenorphine to be effective and to prevent precipitated withdrawal. • For patients transitioning from a full agonist, assess readiness for first dose of buprenorphine when the patient has a COWS score of 8-20. • For the patients initiating buprenorphine who are non-dependent on opioids, a COWs score would be less than 5.		
Assess readiness for first dose of buprenorphine when the patient has a COWS score of 8-20.		
Buprenorphine Administration		
Educate the patient about the sublingual/buccal administration of the medication.		
Help the patient remove the initial dose of medication from the package.		
Have the patient place film or tablet under the tongue or in the buccal mucosa.		
Observe the patient while the film or tablet dissolves under the tongue or in the buccal mucosa.		
Educate the patient on the importance of pooling the medication under the tongue or the buccal mucosa.		
Educate the patient on avoiding eating, drinking, or smoking up to 15 minutes after administration.		
Educate the patient about safe storage and handling of buprenorphine at home.		
Following Bupe Administration		
Assess the patient's state of withdrawal 30-60 minutes after bupe administration.		
Reassess the patient's COWS score and document it.		
Have the patient self-administer an additional dose if symptoms of withdrawal continue.		
Provide the patient with the buprenorphine community administration handout.		
Review subsequent dosing of buprenorphine for Day 1.		
Review buprenorphine for dosing on Day 2 and the rest of the week.		
Schedule the patient for a follow up visit within the next week.		
Provide the patient with information for after-hours paging.		

Documentation	YES	NO
Document the patient's first dose of medication.		
Document the patient's response to the medication.		
Ensure documentation of pre- and post- COWS scores in the patient's record.		
Document the patient's plan of care and route note to buprenorphine prescriber..		

Nursing Assessment sections that contain learning objectives and supplemental education that support further education on this topic include:

- Evidence-Based Practice

Buprenorphine Prescription Preparation

Prior to Preparing Prescription (following in-person visit or televisit)	YES	NO
Review previous encounter note and the results of the patient's previous urine toxicology screen.		
Review previous prescription in the system for dose, quantity, frequency, and duration.		
Follow state and institutional protocols for accessing, reviewing, and documenting from the PDMP for: • Current active prescriptions and appropriate fill dates. • Any additional controlled substances that have been filled since the last visit. • Any prescriptions that are not on the patient medication list.		
Per state availability, review Prescription Drug Monitoring Program (PDMP) to review prescribed controlled substances and acknowledge that methadone, injectable buprenorphine and naltrexone do not appear on the PDMP.		
**For buprenorphine dose adjustments, skip to section M. Buprenorphine Dose Adjustment.*		
Sending an Initial Prescription		
Identify the provider that has indicated they will be the prescriber for the patient.		
For patients who are opioid dependent (using illicit opioids) provide two initial prescriptions with the following information: 1. Buprenorphine-naloxone 2-0.5mg: Take 1 film/tablet under the tongue as needed every 2-4 hours as need to alleviate withdrawal during induction. #4 x 0 2. Buprenorphine-naloxone 8-2mg: Take 1-2 films/tablets under the tongue daily. Do not exceed 16mg daily dose. # 14 x 0		
For patients taking buprenorphine without a prescription (buying on the street) ask about current dose and effectiveness in managing cravings, as an increased dose may be indicated, and provide initial prescription similar to the following: 1. Buprenorphine-naloxone 8-2mg: Take 1-2 films/tablets under the tongue daily. Do not exceed 16mg daily dose. # 14 x 0		
For patients who are opioid naïve, start on a low dose and increasing dose every 3-5 days until therapeutic dose (8-16 mg) is reached and cravings are managed using an initial prescription similar to the following: 1. Buprenorphine-naloxone 2-0.5mg: Take 1 films/tablets under the tongue daily for 3 days. #3x0		
Review the prescription for all parts including appropriate dose, directions, quantity, date of renewal, and the providers NADEAN #.		
Review the prescription is to be routed to the appropriate pharmacy for initial prescription.		
Educate the patient to pick up the initial prescriptions prior to returning to clinic for their induction appointment.		
Notify the prescriber that the prescription has been sent to them and needs to be signed for the patient's induction appt.		

Sending a Prescription Renewal	YES	NO
To send a renewal, choose the bupe prescription in the electronic medical record, ensure appropriate signature, send to the pharmacy.		
Review the prescription for all parts including appropriate dose, directions, quantity, date of renewal, and the providers DEA X waiver / NADEAN #.		
Review the prescription is to be routed to the patient's requested pharmacy.		
Check that the prescription has been signed the next clinic day for non-urgent renewals.		
***For prescriptions that are urgent ensure that they have been signed before the end of business day.		
Ensure that the patient has also received a co-prescription for nasal naloxone or facilitate a co-prescription for the renewal.		

Nursing Assessment sections that contain learning objectives and supplemental education that support further education on this topic include:

- Systems-Based Practice

Buprenorphine Dose Adjustment

Initial Assessment for Dose Adjustment	YES	NO
Review previous UTS results for the indicated patient.		
Call the patient from the waiting room.		
Confirm patient with at least 2 identifiers (Name, DOB, MRN)		
Ask the patient about how their week has gone since the last appointment.		
Assess the patient for ongoing opioid withdrawal symptoms and cravings.		
Assess the efficacy of buprenorphine in managing the patient's withdrawal symptoms and cravings and review administration technique if indicated to ensure maximum absorption.		
Confirm the current dose of buprenorphine with the patient and assess if they have been taking any additional buprenorphine.		
Confirm the current frequency of medication administration (ex – once daily, twice daily) .		
Advocating for Dose Adjustment		
If the patient continues to have cravings or symptoms of opioid withdrawal and a dose adjustment seems appropriate, contact the provider to advocate for dose adjustment.		
Review assessment findings with the provider including UTS results, continued cravings, and withdrawal symptoms.		
If indicated by provider, adjust dose of medication or frequency of medication in the prescription renewal.		
Review the prescription for all parts including appropriate dose, directions, quantity, date of renewal, and the providers NADEAN #.		
Review dose adjusted prescription with provider after completing the dose adjustment in the electronic medical record.		
Confirm that the dose adjustment required is available at the pharmacy indicated by the patient.		
Ensure that the prescription is sent to the patient's preferred pharmacy.		

Evaluating Dose Adjustment	YES	NO
Contact the patient within 48-72 hours of dose adjustment to assess effect.		
Schedule a visit to reevaluate dose adjustments.		
Reevaluate effect of medication on cravings.		
Reevaluate effect of medication on withdrawal symptoms.		
Reevaluate effect of medication on patient sedation.		
Notify the patient's provider regarding the response to the dose adjustment.		
Continue monitoring for patient's continued cravings, withdrawal symptoms, and medication effect.		

Nursing Assessment sections that contain learning objectives and supplemental education that support further education on this topic include:

- Evidence-Based Practice

Injectable Buprenorphine Administration

Prior to Initial Injection	YES	NO
Identify appropriate patients for use of injectable buprenorphine (i.e. patient known to tolerate transmucosal buprenorphine)		
Educate the patient about injectable buprenorphine including relevant pharmacology, indications, contraindications, administration, side effects, potential adverse reactions..		
Review treatment agreements and consents with patient.		
Patient signs and retains a copy of the treatment agreement and consents.		
Educate the patient regarding medication and appointment adherence		
Obtain toxicology screen and urine pregnancy test if appropriate.		
Ensure consultation with a waivered provider about plan for injectable buprenorphine.		
Obtain order for initial injection of buprenorphine.		
Contact pharmacy/insurance to obtain prior authorization for injectable buprenorphine (if indicated).		
Coordinate delivery of injectable buprenorphine from pharmacy to clinic double locked refridgerator per organization protocols for storing controlled substances.		
Complete medication count of buprenorphine following institutional and DEA regulations regarding storing controlled substances on site.		
Set Up for Day of Injection		
Confirm provider order for injectable buprenorphine and confirm dose		
Ensure refrigerator temperature has been maintained between 2-8°C		
Perform scheduled medication count on locked refrigerator with 2nd licensed healthcare professional.		
Remove medication from refrigerator and appropriately document removal within the designated medication log.		
Keep medication in manufacturer packaging and in personal possession until the medication is administered or the medication is returned to the refrigerator.		

Administration of Injection	YES	NO
Call patient from the waiting room and confirm patient with Name and DOB.		
Confirm the 5 Rights of Medication Administration with the patient and verify with a second licensed provider when available.		
Ask about any recent substance use, medication side effects and assess the patient for signs of withdrawal, cravings, sedation or impairment.		
Assess the patient for tolerance to transmucosal formulation of buprenorphine, if this is the first injection.		
Assess site of previous injection for signs of tampering and site reaction.		
Remove injection from pouch and affix the manufacturer supplied needle to the prefilled syringe.		
Assess color and consistency of medication.		
Educate patient on the administration process for a subcutaneous injection.		
Position patient on the exam table and exam site for injection.		
Cleanse hands with alcohol-based sanitizer or wash hands.		
Don gloves.		
Cleanse a site for injection with an alcohol prep pad.		
Ensure rotation of injection sites.		
Pinch subcutaneous tissue.		
Inject buprenorphine at a 45° angle, bevel up at a slow and steady rate.		
Remove needle and gently apply gauze to the injection site to avoid excess leaking.		
Doff gloves and discard needle and syringe after administration in appropriate sharps disposal container.		
Assess for depot formation.		
Post-Injection/Documentation		
Document administration of the injectable buprenorphine in the electronic medical record including site of injection.		
Schedule appointment for subsequent injection and follow up sooner if indicated to assess for possible dose adjustment.		
Request and confirm the order for the patient's next injection.		
Ensure appropriate billing of injectable buprenorphine with visit note.		
Sign note and send message to provider to confirm receipt of injection.		
*****If the patient fails to come for the schedule appt and the medication has been removed. Return the medication to the refrigerator and appropriately document the number of times it has been removed from the refrigerator. The medication needs to be discarded according to REMS protocols after 1 excursion.		

Nursing Assessment sections that contain learning objectives and supplemental education that support further education on this topic include:

- Evidence-Based Practice

Injectable Naltrexone Administration

Prior to Initial Injection	YES	NO
Identify appropriate patients for use of injectable naltrexone.		
Educate patient about injectable naltrexone including pharmacology, indications, contraindications, administration, side effects. Emphasize risk of overdose if opioids are resumed during treatment.		
Educate and ensure that the patient is opioid naïve for 7-10 days prior to initiating naltrexone (PO or IM).		
Review treatment agreements and consents with patient.		
Patient signs and retains a copy of the treatment agreement and consents.		
Educate the patient regarding medication and appointment adherence.		
Obtain toxicology screen and pregnancy test if appropriate.		
Review labs including liver function, platelets and consult with provider if abnormalities are present.		
Ensure consultation with a provider about the use and need for injectable naltrexone.		
Coordinate pharmacy ordering and delivery of injectable naltrexone.		
Coordinate prescription for oral formulation of naltrexone to initiate prior to injection.		
Set Up for Day of Injection		
Perform medication count as necessary per your institutional protocol.		
Ensure refrigerator temperature has been maintained between 2-8°C.		
Confirm provider order for injectable naltrexone.		
Remove medication from refrigerator and appropriately document removal in designated medication log per institutional protocol.		
Allow medication to rise to room temperature prior to injection usually 60 minutes before administration.		
Administration of Injection		
Call patient from the waiting room and confirm patient with Name and DOB.		
Confirm the 5 Rights of Medication administration with the patient.		
Ask about any recent substance use, medication side effects and assess the patient for signs of cravings.		
Assess the patient for tolerance to oral formulation of naltrexone.		
Consider an oral naltrexone challenge if there are concerns re: the patient's last opioid use.		
Educate patient on the administration process for an intramuscular injection.		
Review the manufacturer medication guide with the patient prior to injection.		
Cleanse hands with alcohol-based sanitizer or wash hands. Don gloves		
Draw up and reconstitute medication with the patient in the office		
Assess medication to ensure complete mixing.		
Have the patient bend over or lay down on the exam table exposing the ventrogluteal site.		
Cleanse a site for injection with an alcohol prep pad at the ventrogluteal site, either right or left.		
Ensure rotation of injection sites between ventrogluteal muscles.		
Use thumb and pointer finger to identify appropriate muscular markers for site of IM injection.		
Inject naltrexone at a 90° angle, bevel up at a slow and steady rate.		
Remove needle and gently apply gauze to the injection site to avoid excess leaking/bleeding.		
Doff gloves and discard needle and syringe after administration in appropriate sharps disposal container.		
Educate the patient about pain management techniques after IM administration including warm packs and acetaminophen and NSAIDs as appropriate.		

Post-Injection/Documentation	YES	NO
Document administration of the injectable naltrexone in the electronic medical record including site of injection.		
Provide patient with appointments for subsequent injection and next follow up if not on monthly visits.		
Request and confirm the order for the patient's next injection.		
Ensure appropriate billing of injectable naltrexone with visit note.		
Sign note and send message to provider to confirm receipt of injection.		
*****If the patient fails to come for the schedule appt and the medication has been removed. Return the medication to the refrigerator and appropriately document the number of times it has been removed from the refrigerator. After 7 days of removal from the refrigerator, the medication needs to be discarded.		

Nursing Assessment sections that contain learning objectives and supplemental education that support further education on this topic include:

- Evidence-Based Practice

Methadone Initiation

Initial Assessment	YES	NO
Understand organizations policies and procedures based on federal regulations required to provide methadone treatment through OTP.		
In preparation for admission, complete comprehensive history including assessment of substance use disorder, opioid use (type of opioid use, route and last use), co-occurring psychiatric disorders, medical issues, and social issues. *Note: OTPs can not treat patients for pain management.*		
Ensure provider documentation of OUD including documented opioid dependence in the last 12 months (ex – detox, emergency room encounter, MOUD treatment previously). *Note: exceptions may be made based on state regulations for high risk individuals, for example pregnant patients or following release from incarceration. Please refer to organization/state specific regulations/policies.*		
Complete physical exam including lab work (urine HCG for women of childbearing age) and EKG per organization protocol.		
Complete toxicology screening including assessment for other opioids (ex – buprenorphine, methadone) and educate patient regarding requirement for urine/oral swab testing policy/schedule based on federal and state requirements.		
Review organization specific consents to treatment and complete applicable releases of information for external providers, emergency contacts and others involved in patient's care.		
Per state availability, review Prescription Drug Monitoring Program (PDMP) to review prescribed controlled substances and acknowledge that methadone, injectable buprenorphine and naltrexone do not appear on the PDMP.		
Prepare patient for induction process including process of initiating methadone dosing, importance of daily dosing, dose titration/taper policies, missed dose policies, reasons dose may be denied, eligibility requirements of take-home dosing, hours of operation, after hours contact information, and other organization specific information.		
Review side effects of methadone (dizziness, nausea, vomiting, sweating, constipation, and sexual dysfunction) and reassure patient most subside once dose stabilized.		
Determine if patient is currently taking other medications that may interact with methadone including perpetuation of effects (ex- permethazine) and assist in coordinating with external providers if medications need to be adjusted.		
For women of childbearing age, discuss family planning with referral as needed to primary care/women's health, indication for pregnancy testing, and referral to high risk OB for management if patient becomes pregnant.		
Provide counseling regarding substance use disorder, other substances of misuse, intranasal naloxone education with medication/prescription, HIV screening and education, and provide referrals to community resources (ex – housing, educational, vocational rehab, employment).		

Initiating Methadone and Dose Stabilization	YES	NO
Understand organization workflows/policies pertaining to dosing methadone using a computer including understanding mechanics/process of using dispensing machine, troubleshooting, alternative hand dosing policy, split dosing, lost doses (ex – spilled or vomited with redosing), preparing take home doses, and dosing errors.		
Confirm patient identification with at least 2 identifiers (ex - Name, DOB, MRN/DRS).		
Confirm patient presenting in mild withdrawal (COWS > 8-10) and initiate methadone (ex – federal regulations indicate maximum of 30 mg for initial dose and maximum of 40 mg in the first 24 hours) following organizations protocols.		
Administer dose, watch patient drink methadone and speak with the patient before leaving to ensure dose has been swallowed.		
During initiation or dose titration, ensure assessment of opioid withdrawal (COWS), persistent opioid cravings or medication side effects especially over-sedation in order to advocate for dose increase/decrease.		
Educate patient regarding slow titration of methadone dose due to long half-life of medication (approximately 50% of dose still active 24 hours later) and need to reassess tolerability of dose during titration (4-7 days following dose adjustment) to avoid overdose risk.		
Caution patient about driving or operating heavy machinery until stabilized on methadone treatment.		
Educate patient regarding dangers of concurrent benzodiazepines, cocaine, or additional methadone use above provided dose, as it will delay achieving a stabilization dose and risk overdose.		
Monitoring		
Once dose stabilized, continue to assess for opioid withdrawal, cravings, and medication side effects.		
Reinforce importance of continuing methadone for MOUD for opioid prevention and counsel regarding alternative forms of MOUD.		
Continue reassessing for illicit substance use and provide education regarding harm reduction strategies (ex – overdose prevention, safer consumption practices), smoking cessation, and options to revise dose/treatment plan in the event of substance use or life changes due to absence of substance use.		
Identify risk factors that require patient be further assessed by provider.		
EKG assessment for QTc prolongation, Torsade de Pointes and other arrhythmias per organization protocol for patients on high dose methadone or those receiving other medications in addition to methadone that may increase risk for cardiac changes.		
Assess for ability to receive take home (unsupervised) dosing based on organization policies and federal criteria for substance use and time in treatment. For individuals eligible for take home dosing, ensure the patient has locked container for transportation and storage, understands safe administration and documentation of methadone dosing at home, call back/assessment policies, and reasons take homes may be rescinded.		

Nursing Assessment sections that contain learning objectives and supplemental education that support further education on this topic include:

- Evidence-Based Practice

Methadone Initiation: Inpatient setting

Inpatient Initiation of Methadone for OUD	YES	NO
Collaborate with provider to confirm diagnosis of opioid use disorder.		
Assess patient's opioid use disorder including patterns of use (amount, frequency, route, duration), history of overdose, other substances of use, and history/current MOUD.		
Discuss primary diagnosis for hospitalization and determine if medical symptoms may decrease/heighten symptoms of opioid withdrawal.		
Assess the patient's current state of intoxication/withdrawal to collaborate with treatment team to initiate methadone if appropriate.		
Initiate comfort medication for withdrawal symptom management.		
Depending on length of stay, reassess effectiveness of methadone dose to achieve adequate management of withdrawal and cravings and understand that dose reached during inpatient stay is unlikely to have achieved opioid blockade. Counsel patient on risk for overdose and importance fo following up with OTP for dose increase as indicated. *Short-term hospital stays may be required to taper MTD prior to discharge.*		
Ensure OTP has been identified for transfer of care following inpatient stay and coordinate with OTP Team to complete intake process while patient is hospitalized (if possible) to ensure transition without gaps in care.		
If transferring patient to rehabilitation or long-term are facility, ensure the facility accepts patients on methadone treatment prior to planned discharge.		
Inpatient Continuation of Methadone		
Confirm with the patient's OTP current enrollment and last dose amount, date and time prior to administering methadone. If the OTP is unavailable at time of admission, give no more than 40mg and confirm current dose the next day.		
Obtain release of information to communicate with OTP.		
Work closely with the OTP if there is an indication for dose adjustment (ex – pain management, medication interactions, withdrawal symptoms, pregnancy).		
Consider splitting the total daily dose in the hospital to assist with issues, such as sleep, anxiety or pain, and educate the patient that this will be transitioned back to daily dosing when returning to the OTP unless otherwise coordinated.		
Coordinate closely with OTP prior to discharge and ensure patient is returned to OTP with last dose letter that confirms amount, date and time.		
If there will be <u>less than a three day gap</u> in patient care following discharge until going to OTP, a physician can directly administer methadone to the patient each day. Bridge prescriptions or dispensing of methadone to the patient to self-administer is illegal based on DEA regulations.		

Nursing Assessment sections that contain learning objectives and supplemental education that support further education on this topic include:

- Evidence-Based Practice

Methadone Dose Adjustment

Advocating for Methadone Dose Adjustment	YES	NO
If a patient continues to experience symptoms of withdrawal, cravings or continued illicit opioid use and a dose adjustment may be appropriate, contact provider to advocate for dose adjustment by reviewing pertinent findings both subjective (patient report) and objective (COWS, UDS). *Reasons for dose increase may include persistent cravings, ongoing withdrawal symptoms and pregnancy*. *Reasons for dose decrease may include continued opioid use, concurrent CNS depressant use and medication interactions resulting in EKG changes.*		
Assess for fast or slow metabolizing by assessing peak (2-4 hours after dose) and trough (24 hour prior to administering next daily dose) and consulting with provider to interpret.		
Following dose adjustment, continue to reassess the patient to determine resolution of symptoms or decrease in illicit substance use.		
Tapering or Discontinuing Methadone		
Educate patient regarding process of methadone taper involving slow incremental decrease in dose with reassessment of withdrawal/cravings.		
Educate patients requesting dose decrease regarding therapeutic levels of methadone to achieve opioid blockade and decrease overdose risk.		
For patients requesting voluntary taper with or without discontinuation of methadone therapy, discuss reason for decrease/discontinuation, educate regarding risks/benefits of taper, discuss risk for overdose/recurrent substance use, and educate regarding alternative MOUD.		
Reassure/encourage patient if during/after taper patient experiences increased withdrawal, cravings or substance use the dose will be re-stabilized or patient may be readmitted back to OTP.		
Understand organization policy for involuntary tapering/discontinuation of methadone (ex – behavioral, medical necessity, transfer to alternative care).		
For individuals interested in guest dosing, the patient must be stabilized on their current methadone dose and have an absence of substance use or high-risk behaviors, provide written verification of their last dose (date, time and amount), and indicate intention to be temporary or temporary pending transfer to OTP. *Note: Emergency guest dosing may accept verbal communication of dose information from originating OTP depending on state regulations and location of guest dosing OTP.*		

Nursing Assessment sections that contain learning objectives and supplemental education that support further education on this topic include:

- Evidence-Based Practice

Acute Withdrawal Management

Opioids	YES	NO
Ask patient about recent history of opioid use including method of use (INH, IN, IR, IV, PO), amount, duration of use, last use, history of overdose, other substance use, and history of treatment for opioid withdrawal/management.		
Assess severity of withdrawal using the Clinical Opioid Withdrawal Scale (COWS).		
Ask patient to elaborate on self-assessment of withdrawal (e.g. are these symptoms consistent with mild/moderate/severe opioid withdrawal in their experience?) to help guide timing for induction with buprenorphine and dosing for methadone. *Patient report regarding previous successful or unsuccessful inductions with buprenorphine following use should be used in conjunction with COWS score.*		
Ask patient regarding preferred medication for opioid use disorder upon discharge from inpatient setting. *Helpful in selecting appropriate treatment for patient if facility offers both buprenorphine and methadone treatment for treatment of opioid use disorder.*		
Advocate for prompt initiation of buprenorphine/methadone for opioid withdrawal and comfort medications as indicated.		
Follow organization protocols for initiating buprenorphine or methadone therapy and ensure reassessment of patient using the COWS scale in conjunction with patient report to determine efficacy of treatment.		
Consult with provider to ensure comfort medications are administered promptly for management of withdrawal symptoms and reassess for efficacy.		
Advocate for maintenance therapy for buprenorphine or methadone while inpatient and for transfer of care to outpatient programming to prevent gap in treatment.		
If facility does not offer maintenance dosing of buprenorphine or methadone, ensure comfort medications are adjusted to treat symptoms associated with withdrawal.		

Benzodiazepines/Alcohol	YES	NO
Ask patient about recent history of benzodiazepine/alcohol use including method of use (INH, IN, IR, IV, PO), amount, duration of use, history of seizures (withdrawal or known seizure disorder), other substance use, and history of treatment for benzodiazepine/alcohol withdrawal. *Benzodiazepine only* – source obtained (e.g. prescribed, illicit)		
Ask patient to elaborate on self-assessment of withdrawal (e.g. are these symptoms consistent with mild/moderate/severe withdrawal in their experience?) and history of seizures/delirium tremens (DTs).		
Assess severity of withdrawal using the Clinical Institute Withdrawal Assessment Alcohol Scale (CIWA) regardless of organization protocol for medication management (e.g. Librium, Ativan, phenobarbital). *Note: CIWA assessment is recommended to assess severity of symptoms and risk for seizure in order to best advocate for prompt medication management.*		
Determine timing of last use and initiate protocol for medication management of benzodiazepine/alcohol withdrawal upon entry to decrease risk for seizure. *Note: The goal is to initiate medication management for benzodiazepine/alcohol withdrawal prior to exhibiting withdrawal symptoms (elevated CIWA scores) to decrease risk for seizure. Patients with chronic benzodiazepine use are at higher risk for protracted withdrawal and associated seizure.*		
Follow organization protocols for initiating medication and ensure reassessment of patient using the CIWA scale in conjunction with patient report to determine efficacy of treatment.		
Consult with provider to ensure comfort medications are administered promptly for management of withdrawal symptoms and reassess for efficacy. *Benzodiazepines only – Use benzodiazepine conversion scale to determine recommended dosage for treatment.*		
Educate patient regarding treatment options following discharge from the inpatient setting including medications for alcohol use disorder (naltrexone, acamprosate and disulfiram) and coordination with external prescribers (ex – psychiatrist previously prescribing benzodiazepines)..		
Stimulants		
Ask patient about recent history of stimulant use including method of use (INH, IN, IR, IV, PO), amount, duration of use, last use, history of overdose, other substance use, and history of treatment for stimulant withdrawal/management. *If patient reports a recent binge assess the duration of binge and the last period of sleep the patient experienced.*		
Assess severity of intoxication including symptoms of altered perceptions of reality and withdrawal including symptoms of self-harm.		
Ask patient to elaborate on self-assessment of withdrawal (e.g. are these symptoms consistent with mild/moderate/severe withdrawal in their experience?) to help guide the need for symptom specific medication management (comfort medications) and additional mental health support during the time of greatest self-harm risk.		
Assess the patient for overt signs and symptoms of malnutrition and dehydration and provide food supplementation and hydration as appropriate.		
Advocate for the patient to have extended periods of uninterrupted rest.		
Follow organization protocols for managing stimulant withdrawal including administration of comfort medications to alleviate symptoms of withdrawal and reassess for efficacy.		
If available, advocate for initiation of contingency management and behavioral health supports.		
If facility does not offer longitudinal outpatient treatment consider coordination of patient care to other outpatient addiction treatment provider.		

Inpatient Coordination of Care or Inpatient Treatment Planning	YES	NO
Throughout treatment process, check-in with patient frequently to ensure their comfort and safety.		
Educate patient regarding levels of care of addiction treatment including addressing current treatment goals/expectations and outpatient treatment include medications for addiction treatment.		
Educate patient regarding relationship between withdrawal or patterns of use and medical complications that may be associated with use or skew symptoms.		
Assess for infectious diseases (ex. HIV, HCV) discuss, initiate, refer to treatment if willing.		
Provide safe and calm space for patient to rest and minimize disruptions to sleep at night.		
Ensure proper fluid hydration, adequate food and nutritional supplementation as indicated.		
Discuss overdose prevention and harm reduction interventions.		
Consult behavioral health, care coordinators and other advocates as indicated to begin addressing patient current psychological and social issues while inpatient.		
Sign release of information for outpatient providers to better coordinate care following discharge.		
Collaborate with established outpatient services or make appropriate referrals to support transfer to services including primary care, OBAT, behavioral health, psychiatry, and case management.		

Nursing Assessment sections that contain learning objectives and supplemental education that support further education on this topic include:

- Evidence-Based Practice

Pain Management for Patients with Substance Use Disorders

General Pain Management Strategies for Acute and Chronic Pain	YES	NO
Assess the patient for pain using an evidence-based screening tool (e.g. PEG tool, review your institutional protocols).		
Educate the patient that pain is multidimensional and may require multiple interventions including nonpharmacological treatments for effective management.		
Educate the patient about realistic expectations for pain (e.g. pain reduction rather than elimination and improved functioning).		
Reassure the patient that their substance use disorder will not be an obstacle to receiving adequate pain management.		
Obtain appropriate releases of information to facilitate collaboration with external pain management care teams.		
Patients may decline medications for acute pain management for fear of recurrence of use or rejection from recovery groups or sponsors. Educate the patient that medications for acute pain when taken as prescribed is not a recurrence of use.		
For patients on methadone or buprenorphine, collaborate with MOUD prescribers to optimize dosing to promote adequate treatment of pain and management of their OUD.		
Reassure patient that their pain will be closely monitored and reassessed in order to adapt the treatment plan to meet their needs.		
Non-Pharmacologic Pain Management Strategies		
Assess what non-medication pain management strategies the patient is using.		
Educate the patient on appropriate supportive care interventions for pain management, such as stretching or heat/cold application.		
Consult with primary care or addiction provider to request appropriate referrals to physical therapy, acupuncture, psychotherapy, complementary medicine, or specialty care as appropriate.		

Utilization of Non-Opioid Medications for Pain Management	YES	NO
Assess over-the-counter medications, including dosages and frequency, the patient is using for pain management.		
Optimize the patient's over the counter medication regimen: • Educate the patient on the synergistic pain relief effects of acetaminophen and NSAID dual therapy. • Review the use of NSAIDs, if no contraindication such as renal or GI dysfunction • Review the use of acetaminophen up to 3g daily, if no hepatic dysfunction. • Review use of topical medications, such as lidocaine, voltaren gel, capsaicin, etc • Communicate with provider team about use of over the counter medications to ensure appropriate monitoring and potential provision of prescriptions for medications.		
Discuss other non-opioid medications that are approved for pain management and may be indicated (e.g. tricyclic antidepressants, serotonin-norepinephrine reuptake inhibitors, muscle relaxants, etc.)		
For patients prescribed buprenorphine, optimize their maintenance medication: • Educate the patient on divided dosing of their maintenance dose into six to eight-hour intervals to enhance analgesic effect (e.g., 24 mg per day changed to 8 mg every 8 hours). • Collaborate with buprenorphine prescriber to consider modest buprenorphine dose increase (e.g., increase from 16 mg per day to 20 mg per day).		
For patients engaged in methadone maintenance programming: • Consult with OTP to confirm methadone dose and communicate anticipated pain management plan for patient.		
Discuss with patients that chronic opioid prescribing is typically not appropriate for long term pain management.		
Collaborate with patient's care team, including MOUD provider, regarding medication, timeframe and monitoring.		

Utilization of Opioid medications for Acute and Perioperative Pain Management	YES	NO
For all patients with a history of opioid use disorder, advocate to optimize multimodal, non-opioid interventions (e.g. NSAIDS, acetaminophen, nerve blocks, epidural/spinal analgesia, etc), as well as maintaining MOUD treatment as priority.		
If pain continues to be insufficiently managed with non-opioid pharmacologic and supportive interventions, opioids may be temporarily indicated. Ensure collaboration between procedural team, primary care team, and MOUD care team.		
For patients prescribed either methadone or buprenorphine for OUD, reassure patients that only in rare instances will MOUD need to be discontinued and that in circumstances of severe, acute pain opioids may be prescribed short-term for pain management.		
Educate patient on safe storage and use of medications including increased risk of overdose.		
Encourage patients with SUDs (active or in recovery) to involve a support person and/or sponsor.		
Recognize that patients being treated with MOUD will require more frequent assessment of pain management and often require up-titration of opioid dose higher than non-opioid dependent patients in order to effectively manage pain.		
Advocate to avoid PRN medications and instead utilize regularly medication schedules (e.g., TID, QID) for administration of opioid pain treatment.		
If opioid prescriptions are needed upon discharge, small prescriptions are recommended with close follow up by MOUD and primary care teams and coordination with pharmacy to confirm MOUD with addition of short prescription of full agonist opioid medication for acute pain.		
Educate patient about strategies to stay safe, such as administering one dose of medication at a time, storing remaining medication in a locked container for safe keeping, and involvement of a support person to hold medications if needed post-discharge.		
Monitor patients closely and offer close follow-up support		
For patients who are prescribed methadone and opioid pain medication: • Confirm methadone dose with opioid treatment program. • Consider split doses of methadone while the patient is inpatient for improved analgesic effect in addition to opioid pain medications, but remind patient that dosing will return to once daily upon discharge.		
For patients who are prescribed buprenorphine and opioid pain medication: • Confirm buprenorphine dose by checking prescription drug monitoring program and collaborating with buprenorphine treatment team. • Advocate to optimize buprenorphine with divided dose schedule and increased total daily dose.		
For patients who are prescribed naltrexone and opioid pain medication: • IM naltrexone: discontinue medication 4-6 weeks prior for a planned procedure • Oral naltrexone: discontinue medication 3 days prior for a planned procedure • Provide anticipatory education for patients who are prescribed naltrexone, that during unplanned, emergent events resulting in severe acute pain, strong opioids may be necessary to break through the opioid-blockade effects of naltrexone. During these events, there is a risk for severe respiratory depression and therefore collaboration must occur anesthesia and acute care teams.		

Nursing Assessment sections that contain learning objectives and supplemental education that support further education on this topic include:

- Evidenced-Based Practice

Supplemental Materials

Peer Support Organization Contacts:

- Alcoholics Anonymous https://www.aa.org/
- Al-Anon https://al-anon.org/
- Narcotics Anonymous https://www.na.org/
- Refuge Recovery https://refugerecovery.org/
- SMART Recovery https://www.smartrecovery.org/

Safer Smoking

- North Carolina Harm Reduction Coalition. Safer Crack Use http://www.nchrc.org/harm-reduction/crack-use/
- Catie - Safer Crack Smoking https://www.catie.ca/client-publication/safer-crack-smoking
- Catie - Hepatitis C: An In-Depth Guide. Safer Crack Smoking https://www.catie.ca/client-publication/safer-crack-smoking#equipment
- Smoke Works – Harm Reduction Tools for Safer Smoking. https://smokeworksboston.wordpress.com/

Using Alone Resources

- Never Use Alone https://neverusealone.com/
- Canary App – Prevent overdose. Available through Apple Store free of charge.

Safer Vaping

- John Hopkins Medicine – 5 Vaping Facts You Need to Know https://www.hopkinsmedicine.org/health/wellness-and-prevention/5-truths-you-need-to-know-about-vaping
- Center for Disease Control – Quick Facts on the Risks of E-cigarettes for Kids, Teens, and Young Adults https://www.cdc.gov/tobacco/basic_information/e-cigarettes/Quick-Facts-on-the-Risks-of-E-cigarettes-for-Kids-Teens-and-Young-Adults.html?s_cid=OSH_emg_GL0001
- Healthline – How to Quit Vaping https://www.healthline.com/health/how-to-quit-vaping

Sniffing

- National Harm Reduction Coalition – Safe(r) Drug Use 101 https://harmreduction.org/issues/safer-drug-use/facts/
- Catie – Hepatitis C: An In-Depth Guide. Safer Snorting http://librarypdf.catie.ca/ATI-70000s/70220.pdf
- EMHC – Safer Snorting https://ourhealthyeg.ca/safer-snorting

Alcohol Consumption

- Here to Help – Alcohol and Other Drugs. Harm Reduction Strategies. https://www.heretohelp.bc.ca/workbook/you-and-substance-use-harm-reduction-strategies
- Single E. (1996). Harm Reduction as an Alcohol-Prevention Strategy. *Alcohol health and research world*, *20*(4), 239–243. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6876518/