Drug Use in Hospital Settings: Why it Happens and How We Respond

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Disclosure Information (Required)

- Presenter 1: Elizabeth Salisbury-Afshar, MD, MPH, FAAFP, DFASAM, FACPM
  - Research grants from AHRQ and NIDA- outside the scope of this presentation
- Presenter 2: Zoe M. Weinstein, MD, MS
  - No Disclosures
- Presenter 3: Hannah Snyder, MD
  - Research and programmatic funding from SAMHSA, California Dept. of Health Care Services, NIAAA
- Presenter 4: Paxton Bach MD, MSc, FRCPC, FASAM
  - Research grants from Canadian Institutes of Health Research and Michael Smith Health Research BC outside the scope of this presentation
- Marlene Martin, MD (non-presenting author)
  - No Disclosures

Learning Objectives

- Describe reasons patients use substances in hospitals.
- Identify the varying hospital responses to inpatient drug use.
- List one proposed change you would like to implement in your own institution's response to inpatient drug use

Workshop Agenda

Activity	Time
Background	5 min
Examples of hospital approaches	15 min
Small group work	30 min
Discussion/debrief	10 min

Non-prescribed substance use in hospital settings- how common is it?

- US studies of hospitalized patients admitted with injection-related infections found **34-41% of patients** used non-prescribed substances during their hospital stay.

- In-hospital injection drug use associated with:
  - **Patient-directed discharge**
  - **30 day readmission**
  - **Death**

Eaton (2020); Fanucchi (2018)

Why do patients use non-prescribed substances in the hospital?

- Attempts to avoid negative experiences:
  - Withdrawal
  - Boredom
  - Sadness
  - Loneliness
  - Untreated pain
- Self-reported level of pain/withdrawal not believed by medical staff
- Requests for higher doses of medication denied
- Stigma

Strike (2020)

Why Does Patient Directed Discharge Happen?

- Inadequate support of withdrawal symptoms
- Inadequate pain management
- Loss of privacy, autonomy, freedom of movement (esp during prolonged hospitalizations, and esp among patients with PTSD)
- Stigma and judgement
  - Negative attitudes of health professionals diminished patients' feelings of empowerment and subsequent treatment outcomes
  - Diminished empathy

Santos (2021); Nolan (2021)

How can we reduce negative outcomes related to substance use in hospital?

- Trauma-informed care principals (empathy, respect)
- Early identification of SUD and support
  - For example, identifying OUD and offering methadone and buprenorphine reduces patient directed discharge
- Optimize therapeutic alliance
- Move from security/legal response to therapeutic response
- Treat pain, insomnia, anxiety, and other concerns
- LInk to outpatient treatment resources when patient is interested
- Overdose prevention education, naloxone, safe injection/smoking kits
- Safe consumption spaces

Santos (2021); Suzuki (2020); Nolan (2021)

Recommendations for Addressing Non-Prescribed Drug Use or Dangerous Drug Diversion in the Inpatient Settings

Goal:

To provide recommendations to ensure patient safety

Population:

The population includes patients who are suspected of using substances on the inpatient unit that were not prescribed. This may include substances that may be illegal, such as heroin or diversion of prescribed medications in a manner that is dangerous to the patient, such as injecting oral medications.

Level of Concern:

Determining level of concern: the following levels of concern are to assist in the identification of patients who may be of concern for diversion or use of illegal substances.

Determining level of concern	
Moderate Concern:	• Actions indicate need for increased awareness • Leaving the unit for long periods of time • IV, PCA, line access tampered with • Family/significant other have concerns about patient's access to drugs • Concerns for visitors bringing in non-prescribed drugs for patient use
High Concern: Observations indicate possible drug use:	• Changes in patient's mental status without cause • Changes in patient's mental status post visitors • Drugs or drug paraphernalia found in room • Toxicology screen indicative of probable illegal / not prescribed drug use • Physical or medical changes that indicate probable illegal / not prescribed drug use i.e., pinpoint pupils, dilated pupils, sudden change in vitals, mental status, infections determined to be likely due to IV drug use or sedation out of proportion to prescribed medications.
Confirmed use: Objective measures:	• Laboratory test with previous negative results or in time frame confirming use in hospital. • Illegal or not prescribed drug use directly observed or witnessed • Acute mental status changes with Narcan (naloxone) used to reverse sedation (excluding new admission/ED). • Objective evidence from a provider indicating high probability of use is confirmatory for the purposes of these recommendations. This includes unexplained sedation directly observed by a provider.

The following recommendations are to be considered when a patient reaches the high or confirmed use level of concern. Each situation is unique and should be taken in the context of the individual patient situation.

Safety and Security:	
Security Services/Police:	• Refer to Policy #2.1.22 Patient Belongings and Valuables • Security and pharmacy should be called and informed of any substances/paraphernalia found. Security will determine if police involvement is needed. • Security/Nursing may search the room, the patient and the patient's belongings. If the patient refuses to cooperate with searching the belongings, the belongings should be removed from the room and secured. • Visitors should also be asked to remove their belongings from the room.
Leaving the Unit:	• Patients with confirmed use or high concern should be considered for restriction to the unit. • If a patient refuses to agree to be restricted to the unit, evaluate as a team the next steps and consider if a Disruptive Event Consultation (DEC) should occur to assist with a plan. This may include the clinical team, Social Work, Patient Relations, and Risk Management / Legal as appropriate. See Resources section for whom to contact to coordinate a DEC.
Leaving AMA:	• Patients may leave AMA if they are determined to have capacity. • Patient should be informed that all IV access will be removed before discharge. • If patient refuses removal of lines, the provider needs to discuss risks of leaving AMA including inappropriate access and infection related to a retained line. This may include specialists such as ID or Addiction Medicine if appropriate. • Details of discussion and patient acknowledgement of understanding should be documented in the clinical record along with patient's signing of the AMA form. Refer to Policy #4.19 Discharge Against Medical Advice / Elopement from the Hospital.
Visitors:	• Refer to Policy 3.3.5 Guidelines for Participation of Patients 'Primary Supports and Guidelines for Visitors'. • Visitors will be asked to leave all belongings outside of the room or in their car. Regardless of the visitor, all visitors will be instructed that belongings are not allowed in the patient's room unless approved by staff. • Visitors who refuse to comply with the request will not be allowed to visit. Security can be called if they refuse to leave. • Disrespectful, disruptive or abusive language by visitors should be addressed by staff and security as needed.
Environment/room:	• Staff should remove the sharps container from the room if possible. • Staff should be diligent about removal of needles/syringes from the room. • Re-searching a room during hospitalization may be indicated if there is evidence of contraband.
Medication Administration/IV access:	• Medication should be taken in front of the nurse administering the medications. • Checking for swallowing of medications or crushing medications in pudding may be considered in some cases. • Limit IV access as much as possible in confirmed or high concerning patient use.
Documentation:	• Objective charting should indicate evidence, including actions taken and patient's response to actions taken.
Constant Observation:	• Constant observation may be indicated in patient with high concern or confirmed use. • Use of a video monitor for constant observation is not currently approved in this population. • Personal Safety Attendants are used to ensure patient safety. Consult the associated algorithm for indications. • Constant observation should be based on a decision to keep the patient safe from use of illegal / non-prescribed drugs. • If constant observation is used, patients should be viewed at all times including during the bathroom or shower similar to a patient on suicide precautions.
Education:	
Patient:	• Education of the risks of use post hospitalization for opiates should occur for all suspected opiate abuse. • Additional education may be indicated based on the individual patient situation. • If opiate use, especially in the setting of benzodiazepine use is illicitly being used the patient and any accompanying family should be training in the use of Naloxone kit and have ti offered to him/her as a prescription.
Consultation	
Consults/Labs:	• The primary team may call Addiction Medicine (M-F) (AODA) if they feel consultation is appropriate. The Primary team should do a direct call from Provider to Provider (Addiction Medicine MD on call) in these cases to determine the needs of the consulting team. • Pain Consult may be indicated. • Objective evidence from a physician or nursing indicating high probability of use is confirmatory for the purposes of these recommendations (this would include unexplained sedation out of proportion to prescribed drugs). • Labs may be ordered to assess use if appropriate.
Readmission for illicit drug use	
Readmission:	• Patients commonly come back into the hospital. If the past, the team should make a determination b time elapsed, a discussion with the patient and the judgement in determining the plan of care. • Consult *Care Everywhere* closely for additional hospitalizations labs that may have been already drawn, or meds that have already been given.
Resources	
Resources	• **Security** (890-5555 or via paging) Assistance with security, searches, safety. • **Addiction Medicine (AODA) via paging or consult in Health Link** to consult and

Zoom out

Using Policies and Procedures to Discourage Putative Responses

Policy #:	03.42.000
Issued:	August 9, 2001
Reviewed/ Revised:	12/2004, 6/2007, 122010, 2/2011, 3/2012, 7/2012, 12/2015, 2/2018
Section:	3.0 Clinical Care/Patient Rights

Eloped, AMA or Missing Patient

Purpose:

To provide Boston Medical Center (BMC) staff with a clear process for caring for patients who elope, leave against medical advice (AMA) from the hospital or are otherwise missing.

Contributing Departments:

1. Addiction Service
2. Emergency Department
3. Office of General Counsel
4. Patient Advocacy
5. Care Management
6. Nursing
7. Quality and Patient Safety
8. Public Safety

Ensuring Medications Are Continued

2.3. If the patient is without any new concerning clinical signs or symptoms, the patient's original medical treatment plan and medications will typically be continued by the team (without need for new orders).

2.4. If there are new/concerning signs or symptoms, the nurse and medical team should discuss any changes to the medication plan.

- 2.4.1. Medications to treat substance use or withdrawal are typically resumed immediately upon the presentation of withdrawal symptoms (CIWA or COWS can be used), as not doing so will increase the risk that the patient will use illicit substances.
- 2.4.2. Sedating medications may be held by the medical team while the patient continues to display concerning signs or symptoms.
- 2.4.3. NO medications may be held/stopped without clinical cause (documented persistent altered mental status etc.) and MD order. NO chronic outpatient medication, including outpatient methadone or buprenorphine, should be stopped by the team (as patient has tolerance to these chronic medications) without a clear clinical cause, and if dose adjustment is needed the medical team should order these adjusted doses or page the Addiction team (pager #6226) for assistance.

Addiction Team and Open Dialogue

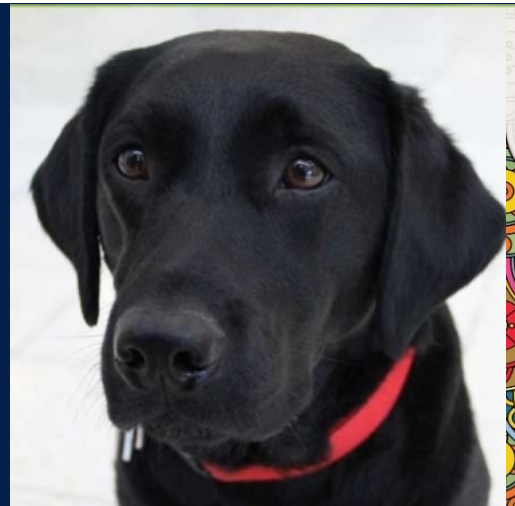
2.5. If there is concern about ongoing substance use or concern about the medication plan which cannot be resolved by the primary nurse and care team, the addiction consult service (pager #6226) should be paged to assist the team.

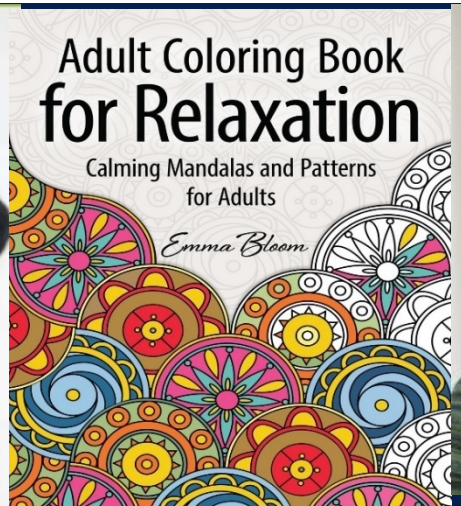
2.6. If a patient appears impaired or the team is otherwise concerned about substance use in the hospital, Public Safety may search the patient's belonging or patients may be asked to provide a urine toxicology test as part of safely resuming medications and the care plan.

2.7. Openly discuss with the patient the goal of maintaining safety, but also the importance of treating symptoms of cravings, withdrawal and pain to help the patient complete his/her medical treatment and not use illicit substances

Positive Engagement in Care

2.9. If the patient continues to leave the unit despite clear expectations to the contrary, positive proactive approaches should be attempted such as use of patient advocacy, therapy dog, volunteer or chaplain intervention or other constructive ways of strengthening or maintaining therapeutic alliances. In addition, the team should consider collaborating with the addiction consult team to discuss what further action is required to keep the patient safe.

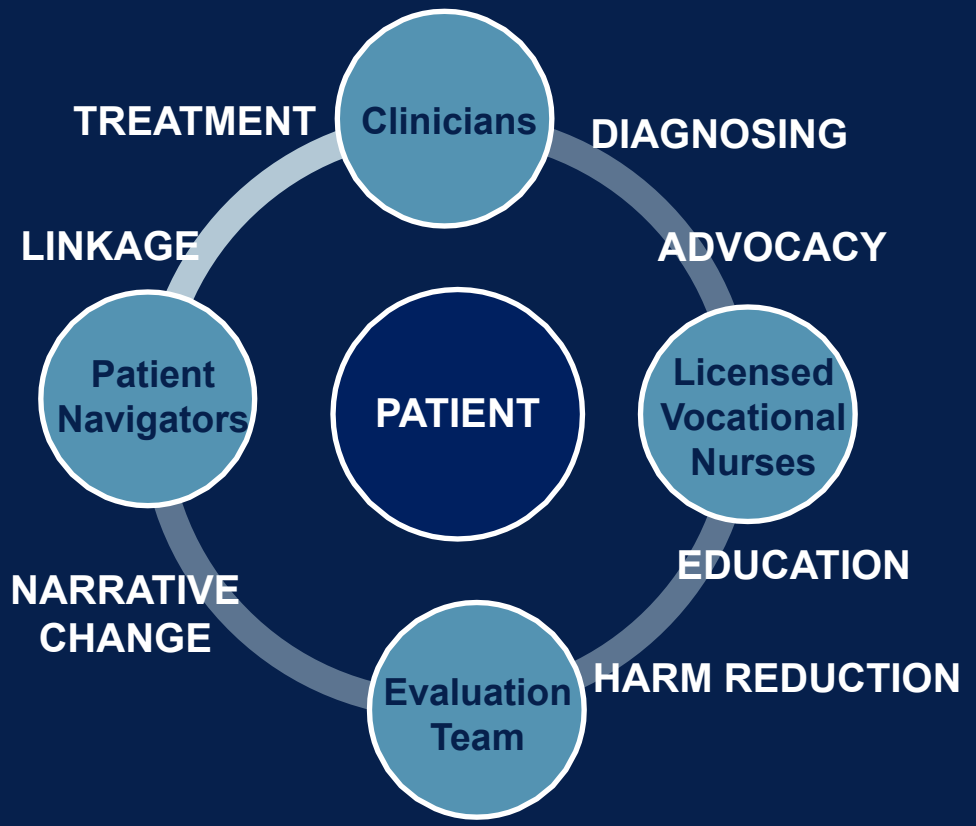




San Francisco General Hospital In-hospital Substance Use Policy

Multidisciplinary Addiction Care Team team led by Marlene Martin, MD

- Help patients tolerate hospitalization safe
- Ensure staff feel supported
- Decrease sheriff presence
- Increase appropriate addiction treatment



Frontline Staff have ***"Reasonable Grounds"*** for substance use

Possible "Reasonable Grounds" examples
- Altered consciousness
- Find paraphernalia at bedside
- Patient observed using substances

Frontline Staff informs ***Primary Treatment Team***

When Primary Care Team not available, contact **AOD** for immediate needs. If nighttime, ok to wait until morning to address.

May involve (if patient amenable):
- Addict
- BERT
- Psychi
- Risk M

ONLY if **risk of harm imminent** to patient or others, the Primary Care Team, Nurse Manager or AOD may involve SFSD but other support will be offered initially

Imminent Risk includes:
- Threats of physical harm to others or self

Primary Treatment Team and nursing meet with **Patient** to ask about substance use, offer support, and educate re ZSFG substance use and possession policy

Patient denies substance use

Patient states they have self managed their symptoms and/or have substances and/or substance use supplies

Inform patient of Substance Use and Possession policy and hospital resources:

1. Our hospital has an Addiction Care Team. They can discuss substance use services including medications for withdrawal, cravings, and harm reduction. Are you interested?
   - If Yes → primary team consults ACT
2. It may be unsafe for people to use substances in the hospital combined with other medications and it is against hospital policy. If you have any substances or substance use supplies, they must be locked in your room's cabinet. This also applies to other medications or pills you may take. You can take all your belongings upon discharge. We can also dispose of any substances you don't want via the Pharmacy Waste Bin.
   - If there is continued concern for substance use, the SFSD may assist with a search per hospital policy, but we would like to support you in other ways instead

Primary Treatment Team

1. Requests patient **not use their own substances** in hospital AND gives patients 2 options: Lock substances and supplies in patient room cabinet or turn substances over for disposal in Pharmacy Waste Bin
2. Discusses **treatment options** with patient including **ACT consult as necessary**

Treatment and Interventions may include:
- Medications
- Harm Reduction
- Decision Making Capacity Assessment
- Behavioral agreement;
- Restriction to room or unit;
- Transfer of bed closer to nursing station for better observation;
- Removal of bed stand, or limitation of access only by staff;
- Removal of personal containers where syringes or drugs or alcohol could be stored;
- Attendance of psychosocial treatment groups
- Restriction or termination of pass privileges (4A-Skilled Nursing Facility); and/or
- A multi-disciplinary patient conference may be called to develop a plan

San Francisco General Hospital

ED distributes fentanyl test strips & naloxone

Other harm reduction supplies distributed by ACT navigators (e.g., smoking, inhaling, injecting)

St. Paul's Hospital, Vancouver BC

- Large interdisciplinary Addiction Medicine Consult Team
  - 3 Addiction Medicine specialists available daily
  - Pharmacist
  - Dedicated ED and ward Addictions RNs
  - Peer Support
  - Social Workers
  - Trainees
    - 10-12 Addiction Medicine fellows
    - >200 elective students per year

- Hospital-based Rapid Access Addiction Medicine Clinic (365 days/year)
- Naloxone kits and sterile supplies available
- In-hospital safe consumption site
- Opioid stewardship program

St. Paul's Hospital, Vancouver BC

Recognition substance use is going to happen in hospital

↓

Treat underlying causes

↓

Harm reduction approach

→

Discussions around safe use (for patient, staff, others)

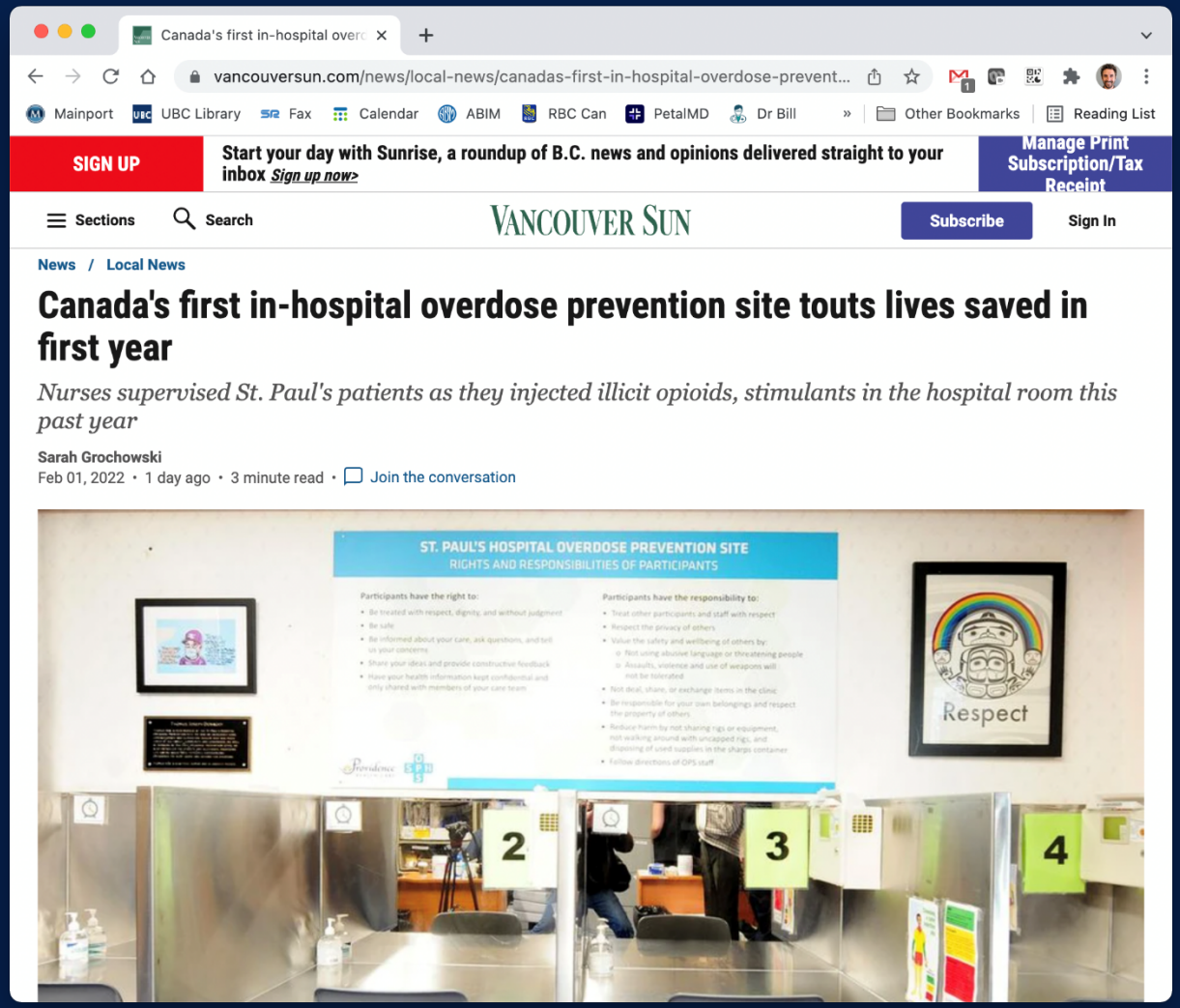
↑

Sterile supplies / naloxone kits

↑

In-hospital safe consumption site

St. Paul's Hospital, Vancouver BC



Canada's first in-hospital overd

vancouversun.com/news/local-news/canadas-first-in-hospital-overdose-prevent...

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News / Local News

Canada's first in-hospital overdose prevention site touts lives saved in first year

Nurses supervised St. Paul's patients as they injected illicit opioids, stimulants in the hospital room this past year

Sarah Grochowski
Feb 01, 2022 • 1 day ago • 3 minute read • Join the conversation

Limitations persist:

- Hours of operation
- No options for smoking of substances
- Mobility issues and medical barriers
- Patient preference

- Participants have the right to:
  - Be treated with respect, dignity, and without judgement
  - Be safe
  - Be informed about your care, ask questions, and tell us your concerns
  - Share your ideas and provide constructive feedback
  - Have your health information kept confidential and only shared with members of your care team

- Participants have the responsibility to:
  - Treat other participants and staff with respect
  - Respect the privacy of others
  - Value the safety and wellbeing of others by:
    - Not using abusive language or threatening people
    - Assaults, violence and use of weapons will not be tolerated
  - Not deal, share, or exchange items in the clinic
  - Be responsible for your own belongings and respect the property of others
  - Reduce harm by not sharing rigs or equipment, not walking around with uncapped rigs, and disposing of used supplies in the sharps container
  - Follow directions of OPS staff

Small Group Exercise

- Discuss your own hospital's policy
- Identify one area to improve, e.g:
  - Pain management for people with high opioid tolerance
  - Initiating and/or continuing methadone and buprenorphine
  - Provide safe supplies in the hospital
  - Transitioning from security response to patient-centered response
  - Smoking policy/patients leaving the floor
- Make a SMARTIE goal

- Identify one action you can take in *next month* to reach goal

https://publications.ici.umn.edu/dhs/hcbs/modules/creating-an-action-plan/writing-smartie-goals

- **S**pecific – details describing what will be done are clear and focused
- **M**easurable – progress is assessed using data that is tracked over time
- **A**ttainable–able to complete the goal as it is written
- **R**elevant – the goal is important and aligned with values
- **T**ime-bound – includes a clear start and end date
- **I**nclusive – It brings traditionally marginalized people—particularly those most impacted—into processes, activities, and policy/decision-making in a way that shares power.
- **E**quitable – Includes an element of fairness and justice that addresses systemic inequity and oppression.

https://publications.ici.umn.edu/dhs/hcbs/modules/creating-an-action-plan/writing-smartie-goals

Using a Tool to Track Change: NIATx

NIATx

Change Project Form

Name of Organization:

PROJECT CHARTER

1. Change Project Title	
2. Aim Statement	
Aim Statement Format	Increase **(or)** Decrease **X** from a baseline of **Y** to a goal of **Z** by **DATE**.
3. Location	
4. Identified start and end dates	Start: End:
5. Name of coalition or program (if applicable)	
6. What customer population are you trying to help?	
7. Executive Sponsor	
8. Change Leader	
9. Change Team (names and roles)	

https://www.niatx.net/download/niatx-change-project-form/

Tracking Change- PDSA

NIATx

Change Project Form

PDSA Cycles (add more as needed)

PDSA Cycle #:	
Cycle Begin Date:	Cycle End Date:
What is the change to be tested?	
P	**PLAN:** Plan the steps to carry out the cycle. Plan for data collection. What is your prediction for the test?
D	**DO:** Carry out the plan. Document observations. Record data.
S	**STUDY:** Analyze the data. Compare results to predictions and pre-change data. Summarize what was learned.
A	**ACT:** Will you adopt, adapt or abandon the change? Why? Move on to next cycle.

https://www.niatx.net/download/niatx-change-project-form/

Tracking Change- Sustainability

Sustainability Plan	
A. Who is the **sustain leader**?	
B. What **changes** do you want to **sustain**?	
C. What **sustain steps** are being taken to ensure that the changes stay in place and that it is not possible to revert back to the old way of doing things?	
D. What is the **target sustain measure**? (i.e., if data drops below this point, the Change Team will intervene to get things back on track.)	
E. What system is in place to effectively **monitor** the **sustain measure**?	

https://www.niatx.net/download/niatx-change-project-form/

Final Takeaways

- Non-prescribed substance use is common among hospitalized patients with SUD
- People use non-prescribed substances in the hospital to self-manage withdrawal, pain, anxiety, loneliness, and boredom and due due stigma
  - Many of these are intervenable factors
- Hospital policies, when they exist, can standardize approaches to suspected or confirmed non-prescribed substance use and improve patient, staff, and clinician experiences

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Resources:

- Management of Substance Use in Acute Care Settings in Alberta: Guidance Document
- Canadian Institutes of Health Research- Supporting People who use substances in acute care settings during the COVID-19 pandemic
- Chan CA, Canver B, McNeil R, Sue KL. Harm Reduction in Health Care Settings. Med Clin North Am. 2022 Jan;106(1):201-217. doi: 10.1016/j.mcna.2021.09.002. PMID: 34823731.

References

1. Eaton EF, Westfall AO, McClesky B, Paddock CS, Lane PS, Cropsey KL, Lee RA. In-Hospital Illicit Drug Use and Patient-Directed Discharge: Barriers to Care for Patients With Injection-Related Infections. Open Forum Infect Dis. 2020 Mar 3;7(3):ofaa074. doi: 10.1093/ofid/ofaa074. PMID: 32258203; PMCID: PMC7096133.
2. Fanucchi LC, Lofwall MR, Nuzzo PA, Walsh SL. In-hospital illicit drug use, substance use disorders, and acceptance of residential treatment in a prospective pilot needs assessment of hospitalized adults with severe infections from injecting drugs. J Subst Abuse Treat. 2018 Sep;92:64-69. doi: 10.1016/j.jsat.2018.06.011. Epub 2018 Jun 22. PMID: 30032946.
3. Strike C, Robinson S, Guta A, Tan DH, O'Leary B, Cooper C, et al. (2020) Illicit drug use while admitted to hospital: Patient and health care provider perspectives. PLoS ONE 15(3): e0229713. https://doi.org/10.1371/journal.pone.0229713
4. Santos CJ, Shofer FS, Lowenstein M, Perrone J. Discharges "Against Medical Advice" in Patients With Opioid-related Hospitalizations. J Addict Med. 2021 Jan-Feb 01;15(1):49-54. doi: 10.1097/ADM.0000000000000688. PMID: 32541363.
5. Suzuki J. Greater Attention Paid to the Patient's Experience Could Improve the Treatment of Individuals With Opioid Use Disorder Hospitalized for Serious Infections. J Addict Med. 2020 Dec;14(6):457-458. doi: 10.1097/ADM.0000000000000649. PMID: 32142057; PMCID: PMC7483130.
6. Nolan NS, Marks LR, Liang SY, Durkin MJ. Medications for Opioid use Disorder Associated With Less Against Medical Advice Discharge Among Persons Who Inject Drugs Hospitalized With an Invasive Infection. J Addict Med. 2021 Apr 1;15(2):155-158. doi: 10.1097/ADM.0000000000000725. PMID: 32804690; PMCID: PMC7995266.
7. Braithewaite V, Ti L, Fairbairn N, Ahamad K, McLean M, Harrison S, Wood E, Nolan S. Building a hospital-based addiction medicine consultation service in Vancouver, Canada: the path taken and lessons learned. Addiction. 2021 Jul;116(7):1892-1900. doi: 10.1111/add.15383. PMID: 33339073.

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