Brief guide: substance misuse services – detoxification or withdrawal from drugs or alcohol

Context

Detoxification or withdrawal is a key stage in achieving abstinence for people who are dependent on drugs or alcohol. It carries health risks which can be serious and, occasionally, result in death. Staff must identify and respond to these complications. Some people will have underlying healthcare conditions which also need treatment (see **appendix 1**). Services should follow National Institute for Health and Care Excellence (NICE) guidance and newly updated Department of Health (DH) guidelines for treatment of drug misuse.

Evidence required

Records and/or interviews should demonstrate:

- A clinician has made a comprehensive assessment of the person's drug or alcohol dependence level, healthcare and other needs before treatment starts.
- The prescriber has conducted a face-to-face assessment of the person before issuing the first prescription and before making any changes to the prescription (or it should be clear how they are assured that it is safe to do so).[1]
- Relevant staff members understand NICE, DH and other national guidance that describe best practice in detoxification or withdrawal and use appropriate tools/scales.[2]
- The prescriber uses medicines recommended by NICE and DH as the first line of treatment[3] (or justifies why other medicines are preferred).[4]
- Dose reduction schedules take the person's assessed needs into account (ultra-rapid, rapid or accelerated detox regimes must not be routinely offered).[5]
- The person's physical health status (including blood pressure, pulse and respiratory rate) is monitored and recorded at regular intervals during withdrawal.
- The person has given their consent to treatment and has been given sufficient information about treatment options and risks and has the capacity to make an informed decision.
- Prescribers are qualified and competent to assess and prescribe for addiction issues (see Royal College of Psychiatrists report on responsibilities and competencies of doctors)[Ref]
- Other staff have the knowledge and ability to monitor and recognise signs of deterioration in people's physical and mental health during detoxification or withdrawal and know how to seek or provide help.
- Staff work within their qualification or competency level and, when necessary, appropriately refer people to more qualified colleagues or to specialist services.
- The provider has appropriate arrangements in place to respond to clinical emergencies (see **appendix 3** for requirements in residential settings).
- Staff know the contact details for their local[6] or regional NHS England lead controlled drugs accountable officer (CDAO) and report to them any significant events or incidents relating to controlled drugs.
- There are robust prescribing, dispensing, administration and monitoring arrangements over weekends and public holidays as appropriate to the patients' needs and risks.
- See **appendix 4** for further details and information about best practice after the initial stage of detoxification or withdrawal.

[1] It is never considered safe for prescribers to increase methadone without having seen the service user in person.
[2] Opioids – SOWS, OOWS or COWS; alcohol – CIWA or AWS.
[3] Opioids – methadone or buprenorphine; alcohol - benzodiazepines, either chlordiazepoxide or diazepam.
[4] Medicines used in detoxification or withdrawal should be dispensed, administered, stored and disposed of in line with usual safe medicines practice, including those required for controlled drugs - see **appendix 2**.
[5] This is because of the risk of serious adverse events, including death. If used, NICE clinical guideline 52 must be followed. For more information see **appendix 1**.
[6] Only those services fitting the description of 'hospital' in the Controlled Drugs (Supervision of Management and Use) Regulations 2013 are required to appoint a local CDAO. You can check whether a service has a CDAO by checking the CQC's national CDAO register.

Reporting

In the **assessing and managing risk to people and staff** section in **safe,** describe how staff identify and manage risks (including under and over treatment with medicines) associated with detoxification or withdrawal.

In the **reporting incidents and learning from when things go wrong** section in **safe,** describe how staff identify, report and respond to adverse incidents and how lessons learned inform practice. Serious incidents and deaths should be reported to CQC in a timely way.

In the **assessment of needs and planning of care** section of **effective** describe the quality of the assessment on admission, with a particular emphasis on the assessment of the level of drug or alcohol dependence and physical and mental health.

In the **best practice in treatment and care** section of **effective,** describe how the provider makes sure that it follows NICE guidance when prescribing for and monitoring the physical status of people undergoing detoxification or withdrawal.

In the **skilled staff to deliver care** section of **effective,** refer to the training and qualifications of prescribers. If employed by a different organisation, how does the provider satisfy itself they are competent in this area? Refer also to the qualifications and competency of other staff, including those without a professional qualification.

In the **involvement of people in the care they receive** section of **caring,** report whether people have been informed about any risks and if they were involved in making decisions about the best medicines for them and other aspects of their care and support.

Policy[7]

NICE quality standards:

- QS11 Alcohol-use disorders: diagnosis and management
- QS23 Drug use disorders in adults

NICE clinical guidelines:

- CG52 Drug misuse in over 16s: opioid detoxification
- CG100 Alcohol-use disorders: diagnosis and management of physical complications
- CG115 Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence

Public Health England, Quality governance guidance for local authority commissioners of alcohol and drug services (2015)[8] and Better care for people with co-occurring mental health and alcohol/drug use conditions: A guide for commissioners and service providers (2017).

Department of Health et al, Drug misuse and dependence: UK guidelines on clinical management (2017), known as 'the orange book'.

Link to regulations

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Regulations 9 (person-centred care), 11 (need for consent), 12 (safe care and treatment) and 18 (staffing) are most relevant.

[7] Some of the guidance contains different recommendations for people receiving treatment under the age of 18 years; please refer to the source documents if the service accepts referrals for young people.

[8] See page 34 for best practice guidance for handling adverse/serious incidents.

Appendix 1: risks associated with detoxification or withdrawal

There are known physical and mental health risks for people who are detoxifying from drugs or alcohol. They range from mild symptoms, such as sleeping difficulties, to life-threatening ones, such as seizures, and occasionally death. Services must have systems in place to identify people at risk and to monitor their physical and mental health while they are engaged in detoxification programmes so that appropriate treatment can be offered.

Ultra-rapid detoxification, rapid detoxification and accelerated detoxification have inherent health risks and should not routinely be offered to people who misuse drugs.[9] If they are this should be carried out in accordance with national guidance.[10]

- Ultra-rapid detoxification takes place over a 24-hour period, typically under general anaesthesia or heavy sedation. It should only be used under expert medical supervision because of the risk of adverse events, including death.
- Rapid detoxification involves sedation, but takes place over one to five days. It should only be considered for people who specifically request it and clearly understand the associated risks. It must be supported by healthcare professionals who have appropriate skills and knowledge.
- Accelerated detoxification, typically using naloxone and naltrexone medicines at lower doses to shorten detoxification, should not be routinely offered. This is because of the increased severity of withdrawal symptoms and the risks associated with the increased use of and interactions between medicines used to manage the symptoms of withdrawal.

Alongside medicines prescribed to assist detoxification, service users should also be offered medicine or other treatments for symptom relief, so they are as comfortable as possible during the detoxification process. Significant loss of fluids, due to diarrhoea and vomiting may lead to heart and circulatory problems, so maintaining hydration should be a priority.

Staff working in **alcohol misuse services** should have the skills and knowledge to recognise the following side effects of alcohol withdrawal and know how to support people when they are experiencing them (this may include referring people in a timely manner to an appropriate professional or emergency service).

Alcohol withdrawal – less severe	Alcohol withdrawal – complicated
• Tremors and shakes • Nausea and vomiting (risk of aspiration which can lead to pneumonia) • Diarrhoea • Diaphoresis (copious sweating) – especially nocturnal • Generalised clamminess of skin • Hypersensitivity to auditory and visual stimuli	• Delirium Tremens (DTs) – main features are delirium, tremors, hallucinations • Seizures • Wernicke's encephalopathy (neurological symptoms), often after abrupt and untreated withdrawal in people who are malnourished (thiamine therapy must be administered if any risk present)[11] There can be a risk of death if these

[9] NICE CG52
[10] NICE QS23
[11] NICE CG100

• Disturbing dreams • Depression, anxiety, fatigue • Insomnia • Palpitations and fever • Headaches • Dehydration and poor appetite	symptoms are not treated quickly. Suicide risk is also increased.

Staff working in **drug misuse services** should have the skills and knowledge to recognise the following symptoms of drug withdrawal and know how to support people when they are experiencing them (this may include referring people in a timely manner to an appropriate professional or emergency service).

Opiate withdrawal – less severe	**Opiate withdrawal – complicated**
• Yawning • Lacrimation (the secretion of excessive tears) • Sneezing, runny nose • 'Goose bumps' • Raised blood pressure/pulse • Dilated pupils • Stomach cramps • Diarrhoea • Nausea and vomiting • Diaphoresis (copious sweating) • Fine muscle tremor, muscle aches • Generalised clamminess of skin • Anxiety and agitation • Insomnia • Palpitations and fever • Headaches • Dehydration Symptoms may intensify after first 24 hours, but usually start to improve within 72 hours.	For pregnant women opiate withdrawal is a potential obstetric emergency e.g. placental abruption, foetal distress, premature labour. Providers offering services for pregnant women should have access to appropriate emergency care. One risk during or after detoxification is to service users who restart their previous dose of opiate and inadvertently overdose, as opioid tolerance is lost relatively quickly. Another common risk is over-prescribing (too frequent or too high dose) of opioids during detoxification leading to overdose. Suicide risk is also increased.

Note that there are many 'unknowns' in relation to the impact of new psychoactive substances (NPS), also known as 'legal highs' or 'party drugs', on people, due to the lack of clinical experience of these substances and the problems they can cause.[12]

[12] For an outline of the issue, see introduction to RAPt Research and Policy Briefing Series No.4 Tackling the issue of New Psychoactive Substances in prisons

Other healthcare risks
People who misuse substances may also have other underlying physical or mental health needs which require treatment or management alongside their detoxification, for example, diabetes or schizophrenia.

In addition, people who are injecting drugs and people who have unprotected sex are at high risk of developing of infections and/or long-term conditions such as blood-borne viruses (including Hepatitis B or C and HIV). Engagement with a detoxification programme is an opportunity for screening, diagnosis, vaccination and treatment of such conditions.

If the provider offers testing or screening, there should be an appropriate protocol in place which includes aftercare and support for anyone found to have a positive diagnosis.

People may be misusing alcohol or drugs to mask mental health or other conditions, such as depression and autism spectrum disorders. Therefore, their mental health needs to be reviewed post-detoxification.

All physical and mental health issues must always be communicated to the person's GP and other relevant professionals.

Appendix 2: controlled drugs in substance misuse services

Substance misuse detoxification or withdrawal programmes may use, but are not limited to, the following controlled drugs:

Medicine	Other name/s	Reason for prescription	Notes	Requirements
Methadone	Physeptone, Methadose	Opioid detoxification	Schedule 2 (CD)	Safe storage; entries in CD register required
Buprenorphine	Subutex, Natzon, Prefibin, Tephine, Espranor	Opioid detoxification	Schedule 3 (CD no register)	Safe storage; no CD register requirement
Buprenorphine / naloxone	Suboxone	Opioid detoxification	Schedule 3 (CD no Register)	
Chlordiazepoxide	Librium	Alcohol withdrawal	Schedule 4 (CD Benz)	No safe storage; no CD register requirement
Diazepam	Valium	Alcohol withdrawal	Schedule 4 (CD Benz)	
Midazolam	Buccolam, Hypnovel	Seizures	Schedule 3 (CD no register exempt safe custody)	No safe storage due to the need for it to be available for emergency treatment; no CD register requirement
Pregabalin / Gabapentin	Lyrica / Neurontin	Antiepileptic / neuropathic pain but also misused	Schedule 3 (CD no register exempt safe custody)	No safe storage; no CD register requirement from 1 April 2019

This list is supplied as an indication of the controlled drugs which might be in use within a substance misuse service (other medicines mentioned in the brief guide are not defined as CDs). Inclusion in this list does not necessarily mean CQC considers its use to be best practice. Fuller information can be found in:

- British National Formulary (BNF)
- CQC's web page on CDs
- Nigel's surgery 28: Management of Controlled Drugs - this contains a number of links to national documents and regulations

Other useful information about medicines:

- Nigel's surgery 19: Patient Group Directions (PGDs) / Patient Specific Directions (PSDs)

The majority of prescriptions for CDs dispensed by community pharmacists will be computer generated either by the prescriber or a member of their team then signed by the prescriber. When the prescriber has not seen the person (in SMS or elsewhere), the governance process behind the generation of the prescription is crucial for ensuring safety. Who puts forward amendments or additions to the prescriber and how does the prescriber ensure they are appropriate?

Appendix 3: managing clinical emergencies in residential services providing drug or alcohol detoxification

This appendix describes best practice for preparing for and responding to clinical emergencies which sometimes occur when people are detoxifying from drugs or alcohol. Some people will be too unwell to detoxify unless they have direct access to acute medical emergency services, this should be determined on assessment. In addition relevant services need to be able to respond to drug overdoses, a particular risk if people return to drug misuse after detoxification as their tolerance will have changed.[13]

Indicators of good practice include:

- A competent clinician has carried out a comprehensive assessment before the detoxification or withdrawal commences. This has identified as far as possible, if the chosen setting for withdrawal is appropriate, and the risk of a clinical emergency occurring. This risk has been communicated to relevant staff through an appropriate care plan and monitoring and other mitigating actions have been put in place for the person reflect the level of risk.
- Indicators of raised risk include, but are not limited to, a history of seizures, epilepsy or delirium tremens (DTs) linked to previous withdrawal, acute or chronic mental illness, suicidal ideation, congestive cardiac failure, unstable angina, chronic or acute liver disease, infections (e.g. pneumonia), significant cognitive impairment, moderate or severe learning disability, malnutrition, pregnancy and those aged under 16 years or over 60 years.
- Residential units undertaking alcohol and or drug detoxification should have appropriate facilities to monitor and supervise withdrawal. Appropriate protocols should be in place for staff to regularly monitor the progress of detoxification and take appropriate and timely action to prevent and or respond to withdrawal complications.
- The provider should have appropriate policies and procedures to guide staff practice in respect of foreseeable emergencies related to detoxification, including delirium tremens (DTs), seizures and drug overdoses. This must include monitoring of vital signs, including blood pressure, pulse and respiratory rate, and withdrawal symptoms and signs.
- The provider has policies and procedures that specify how the service will respond to a medical emergency. This will include what basic / immediate / advanced life support staff are expected to provide and the circumstances in which they would call 999.
- If opiate detoxification is carried out naloxone must be kept for life-saving purposes and staff must be competent to administer it. Appropriate prescribing, storage, administration and disposal of medicines should be in accordance with relevant legislation and guidance. Resuscitation equipment must also be available in inpatient and residential settings undertaking detoxification.
- Training records and interviews with staff demonstrate that staff know how to identify deterioration in a person's condition which may require a medical intervention or an emergency response. If there are any shared care arrangements it will be clear which staff members/agencies are responsible for monitoring the person's health to prevent an emergency according to NICE guidelines.
- Training records confirm that all staff have undertaken a first aid course which includes cardio-pulmonary resuscitation as a minimum, with evidence of further intermediate or

[13] Also a high risk on release from prison or discharge from impatient MH care.

advanced life support training for some/all of the staff in line with what is stated in the provider's policy.

- If only certain staff have responsibility for resuscitation and/or the administration of emergency medicines, the staff rota shows one or more of them are on duty throughout the opening hours of the service. The exact number should be detailed in the provider's policy and/or associated procedures and will vary according to the type and size of the service, the level of clinical risk and the layout of the building.
- If resuscitation equipment is available, it is subject to regular checks to ensure that it is in a good condition and that it is maintained and serviced in line with the manufacturer's instructions. In hospital inpatient settings a fully equipped crash trolley should be available. If a residential rehabilitation service is undertaking medically managed detoxification a defibrillator must be available on site.
- Inpatient services for alcohol detoxification have midazolam available (or a similar fast acting benzodiazepine) and other parenteral medications for dealing with emergency complications which may arise during alcohol withdrawal according to NICE guidelines. Flumazenil (antidote) should also be available. Staff responsible for administering these medicines must have appropriate training and competencies.
- Appropriate reporting and follow up of any incidents, including reference to a local clinical governance group or internal committee which reviews incidents and trends, and to CQC. There is evidence that information about any 'lessons learned' is passed on within the service and to commissioners and relevant others, including CQC.

Appendix 4: good practice for drug and alcohol detoxification

If a substance misuse service is managing detoxification or withdrawal in an inpatient or residential setting, inspectors should ascertain which model[14] is being followed place:

- **Medically managed** – there is 24-hour, medically directed evaluation, care and treatment of substance misuse disorders on site;
- **Medically monitored** – enough medical supervision is provided by a visiting GP/other doctor, who is appropriately trained, with sufficient knowledge of and competence in the management of addiction problems.

Medically managed treatment should be offered to those with severe substance misuse disorders/ complex needs. It often takes place in an inpatient unit. Medically monitored treatment is likely to be the model in residential rehabilitation settings, but some may offer medically managed treatment. **Services should not accept referrals of people whose needs they are not competent to meet**.

Many people are suitable for detoxification/withdrawal in their own homes, if they are assessed to be healthy, are not heavy consumers of alcohol and substances, lack significant co-morbidities and have supportive friends or family on hand 24 hours a day for the first three days, as well as regular clinical monitoring.

Further information about evidence required on inspection

Applicable to all substance misuse services

- Records must show that a person receiving pharmacological treatment (medicines) to enable detoxification has had a comprehensive assessment of their drug or alcohol misuse level before starting treatment.
- The comprehensive assessment should include mouth swabs and/or urine testing and clinical assessment; it may include confirmatory laboratory testing. Appropriate detoxification tools are used and understood (Opioids – SOWS, OOWS or COWS; alcohol – CIWA or AWS).
- People should be screened for comorbid mental health conditions, such as depression, anxiety and suicide risk, as part of the initial comprehensive assessment. General physical health should also be assessed.
- The prescriber should have conducted a face-to-face assessment before issuing the first prescription for detoxification/withdrawal. They must also record their assessment and document their prescribing decision.
- After the initial assessment and prescription, if the prescriber issues further prescriptions without seeing the person, the notes (in line with the provider's protocol or similar) must clearly record how the prescriber is assured that it is safe to prescribe. For example, is the service user responding well to the treatment?
- Processes should be in place to make sure prescribing regimes are shared between all agencies or clinicians providing care to a person who misuses drugs or alcohol. The shared information should also make clear who is responsible for monitoring the person during detoxification or withdrawal.

[14] SCAN Consensus Project, Inpatient Treatment of Drug and Alcohol Misusers in the National Health Service, 2006

- The prescriber uses medicines recommended by the National Institute for Health and Care Excellence (NICE) as the first line of treatment (or provides justification if other medicines preferred) – see below.
- The starting dose of the detoxification or withdrawal agent to be used must take into account the severity of dependence, the stability of the service user's mental and physical health, setting for detoxification or withdrawal and any other medicines being taken.
- There should be records that show the following have been monitored during detoxification – blood pressure, pulse, respiratory rate, and withdrawal signs and symptoms.
- Records must show that instalment dispensing and supervised consumption are being used during detoxification, unless there are documented reasons for not doing so (NHS services should use FP10 (MDA) prescription forms for instalment dispensing).[15]
- Records must show that, once the person has achieved abstinence, an effort is made to make sure continued support is available to them for a minimum of six months after the initial detoxification or withdrawal. This is often arranged by the referrer, however, the service should check it is in place and work to actively manage a safe transition.
- Those prescribing medications used for detoxification or withdrawal must hold suitable qualifications and be competent in this area.[16]
- Other staff must also be competent to carry out their role within the service and recognise when they need to involve others, including qualified professionals, to ensure people's health and wellbeing.
- Prescribers must be able to demonstrate people have consented to treatment, having received information about detoxification and the associated risks.
- Staff should know how to contact their local or regional NHS England lead controlled drugs accountable officer (CDAO). Any events/incidents or concerns relating to controlled drugs should have been reported to them.
- Lessons learned from any event/incident, and associated changes in practice, should have been recorded, shared with the staff team and, if applicable, implemented.
- Protocols (or similar) should contain information about how prescribing, dispensing, administration and monitoring is handled over weekends and public holiday periods.
- There should be the offer of abstinence focussed medicines in line with NICE guidance.
- Within the incident log, or similar, any transfer to the acute sector or psychiatric unit[17] or request for police assistance is recorded so any trends can be identified and lessons can be learned and shared with the staff team.

Applicable to detoxification from drugs

[15] NICE CG52 refers to detoxification taking up to four weeks in an inpatient/residential setting and 12 weeks in a community setting.

[16] Royal College of Psychiatrists CR173 Delivering quality care for drug and alcohol users; the roles and competencies of doctors, Sept 2012

[17] Admissions to acute or psychiatric units can be seen as positive or negative. For example, they might indicate a staff team that is monitoring people well and responding to signs of deterioration or, alternatively, a failure to complete comprehensive assessments.

- People detoxing from opioids must be informed of the risk of overdose due to loss of opioid tolerance following detoxification. The risk of overdose is increased if people resume opiate use after detoxification, even at a lower level than they previously used.
- Protocols/procedures must demonstrate how the risk of accidental overdose during detoxification from opioids is managed.
- If a person is on a maintenance dose of medicine before detoxification, they should usually be detoxified on the same medicine they have been maintained on. Otherwise, medicines records should show methadone or buprenorphine have been offered as the first-line treatment in opioid detoxification.[18],[19] If other medicines or formulations have been preferred, the prescriber must be able to justify their decision and the reason must be recorded.
- The risks to others, particularly the person's children or other children visiting the home, should be assessed whenever opioid substitution therapy (OST) at home is considered.[20] For example, there may be the risk of accidental ingestion and/or inappropriate use of methadone by people other than the service user.
- Ultra-rapid, rapid and accelerated detoxification should not be routinely used. See **appendix 2** for definitions. Ultra-rapid detox, in particular, carries a risk of death. If they are used it must be in line with NICE Clinical Guideline 52.
- The dose reduction schedules used should be in line with national guidance but also responsive to service user preference.[21] Prescribers should be able to tell inspectors which national guidance they are following and/or the provider's medicines policy and procedures should contain this information. The service user's views, including those they hold on treatment options, should be recorded as part of their assessment or review.
- Unless a different approach is required to meet people's assessed needs, most people should increase their start-up dose of medicine in line with an agreed titration protocol. Records must show this protocol is followed, any increases beyond those outlined in the protocol should not be agreed without the person being seen by the prescriber.
- If detoxification is completed there should be evidence that an abstinence focused medicine (naltrexone) was considered.

Applicable to withdrawal from alcohol

- People being considered for withdrawal programmes for their alcohol misuse should be assessed for their dependency and risk status (including pattern of use and severity of dependence) using a validated method, for example, Severity of Alcohol Dependence Questionnaire (SADQ), Leeds Dependence Questionnaire (LDQ) [22,] or Alcohol Use Disorders Identification Test (AUDIT).[23]
- Nutritional status should be assessed and oral vitamin B and thiamine should be prescribed for those who are malnourished. For all those undergoing inpatient alcohol

[18] See appendix 1 for list of alternative names.
[19] NICE CG52 Drug misuse in over 16s: opioid detoxification, 2007
[20] Adfam Medications in Drug Treatment: Tackling the risks to children – one year on, 2015
[21] For example, RCGP Guidance for the use of buprenorphine for the treatment of opioid dependence in primary care, 2004
[22] NICE CG 115 - Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence, 2011
[23] A WHO tool.

detox vitamin B & C should be prescribed in line with NICE CG 115. This is to reduce the risk of neurological damage (Wernicke's encephalopathy).

- People who are assessed as having a severe alcohol physical dependence should be offered (or referred to services that offer) a medically managed programme, due to the risks of withdrawal.
- People with severe alcohol physical dependence must be made aware of the risks associated with withdrawal, such as delirium tremens (DTs) and seizures.
- The preferred agent for alcohol withdrawal is a benzodiazepine – either chlordiazepoxide or diazepam. The choice of medicine may be affected by any degree of liver impairment. If an alternative medicine is used, the reasons for doing so should be documented.
- Fixed-dose or symptom-triggered medicine regimes can be used in inpatient or residential settings. Staff need to be competent to appropriately identify and respond to withdrawal signs and symptoms.
- People with moderate to severe alcohol dependence who have successfully withdrawn should be considered for acamprosate or naltrexone prescribing, alongside psychological therapies to support their abstinence.

Extra considerations for community-based alcohol withdrawal programmes:

- If people are assessed to be well enough to undergo community-based detoxification in their own home, clinicians must have taken appropriate steps to satisfy themselves the person will have access to 24-hour support for at least three days from a friend or family member. This person/s should have been briefed on (a) what to expect and (b) indicators of deterioration or emergency situations.
- Chlormethiazole should not be offered for community-based assisted withdrawal because of the risk of overdose and/or misuse.
- Fixed-dose treatment can be used within a community-based programme.
- Community-based services should not give more than two days' supply of medicine at a time and the person should be reviewed on alternate days. It should be clear how long the detoxification should take from the outset, with the opportunity available, if necessary, to make adjustments in response to the person's symptoms and discomfort.
- Community-based service users should be provided with a schedule of visits which details the responsibility of each staff member and/or team involved with the care of the service user during detoxification. All relevant staff members/ agencies must have access to a copy of this.

Documents to view

Exact titles and functions may vary.

Document or equipment	**Notes**
Statement of purpose	For info on medical model in use and entry criteria
Medicines policy and procedures, including those relating to controlled	Covering storage, prescribing, supply, administration and disposal (including

drugs	medicines for emergencies)
Prescribing guidelines	Including titration protocol (if applicable)
Emergency life-saving equipment	Required in any premises where people receive detoxification treatments
Risk management plan	Including dealing with predictable emergencies during detoxification, level of resuscitation provided, arrangements for calibration / checks / repair and maintenance of life-saving equipment (if held).
Assessment and screening tools	
Testing protocols	Info on tests used in the service, who can carry them out and any laboratory arrangements (including quality assurance)
Care records	Including completed assessments, risk management plans, treatment or recovery plans, monitoring charts (such as blood pressure, pulse, and respiratory rate), evidence of consent to treatment and records of discussion of options and risks with service user (and friends/ family if applicable)
Mental Capacity Act 2005 / Deprivation of Liberty Safeguards policy and procedures with associated paperwork for individual service users (if applicable)	If Deprivation of Liberty Safeguards have conditions attached, ensure they are being implemented
Professional registrations	For example: Nursing and Midwifery Council Royal College of Psychiatrists Royal College of General Practitioners Health Professions Council General Pharmaceutical Council
Staff training records and any assessments of competence	For example: competence in administration of medicines
Medicine administration records and controlled drugs register	
Incident/ accident logs	
Team meeting minutes or similar	To show ‘lessons learned’ are passed on

	and changes to practice are implemented when necessary
Service level agreements, joint protocols or similar	Covering joint working arrangements between different teams or agencies
Contracts with commissioners	If best practice is not followed and 'contract limitations' is given as the reason