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Policy and Procedures Manual

NALOXONE ADMINISTRATION BY NON-NURSING STAFF

Mental Health and Addictions Services		POLICY & PROCEDURES
Applies To:	All non-nursing Mental Health and Addictions (MH&A) staff	
Monitoring:	MH&A Leadership Team	
Approving Authority:	Executive Director of MH&A	
Date:	Effective: May 2023 **Next Review: May 2026**	

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1.0 POLICY

1.1 Naloxone administration by non-nursing Mental Health and Addictions (MH&A) staff is only permitted where the individual is rendering first aid or temporary assistance in an emergency to treat suspected or known/witnessed opioid overdose while at work in MH&A facilities and community settings. See Appendix A for information on recognizing the signs of overdose.

1.2 Non-nursing staff are not required to treat opioid overdose as part of their regular duties. However, all non-nursing MH&A staff, and particularly those working with clients known to be using illegal drugs or to have a recent history of illegal drug use, are encouraged to do so.

1.3 Non-nursing MH&A staff who wish to administer Naloxone must be certified to administer Naloxone through successful completion of a training program approved by the MH&A Research and Education Department.

1.4 An authorized prescriber's order is **not required** for MH&A non-nursing staff to administer Naloxone via intramuscular (IM) or intranasal applications in emergency situations.

1.5 Staff who are certified in Naloxone administration and carrying or have immediate access to a Naloxone kit are required to administer Naloxone when witnessing confirmed or suspected opioid overdose.

1.6 All MH&A staff must be knowledgeable on the MH&A Naloxone Administration by Non-nursing Staff Policy, regardless if they are trained in Naloxone administration.

1.7 A Provincial Safety Management System (PSMS) incident report must be completed for any incidents involving opioid overdose on MH&A premises and/or Naloxone administration by a non-nursing MH&A staff member.

Roles and Responsibilities

1.8 Non-nursing MH&A staff who administer Naloxone are responsible for:

(a) Maintaining training and competency in Naloxone administration through annual recertification.

(b) Awareness of the side effects and hazards associated with Naloxone administration

(c) Ensuring they are familiar with and comply with emergency response procedures when responding to a suspected opioid overdose.

(d) Documenting the incident in PSMS and client files as appropriate to their role, in accordance with the *HPEI Acceptable Use of Integrated Systems Management (ISM) Policy* and *HPEI Acceptable Use of Patient Records – in the Clinical Information System Policy*.

1.9 MH&A is responsible for:

(a) Providing orientation to staff on the MH&A Naloxone Administration by Non-nursing Staff Policy;

(b) Overseeing the acquisition, safe storage, and replacement of Naloxone;

(c) Overseeing the acquisition of personal protective equipment (PPE);

(d) Identifying accepted naloxone training courses and supporting staff access to those courses;

(e) Determining MH&A staff competency in Naloxone administration via evidence of approved course completion; and

(f) Supplying naloxone kits to trained staff and implementing processes for appropriate storage and monitoring to dispose of expired supplies.

2.0 DEFINITIONS

Authorized Prescriber:	A health care professional who is permitted by Federal and Provincial legislation, their regulatory college, Health PEI, and practice setting (where applicable) to prescribe medications.
Client and Family Centered Care:	An approach that guides all aspects of planning, delivering, and evaluating services. The focus is always on creating and nurturing mutually beneficial partnerships among the organization's team members and the clients and families they serve. Providing client and family centered care means working collaboratively with clients and their families to provide care that is respectful, compassionate, culturally safe, and competent, while being responsive to their needs, values, cultural backgrounds, beliefs, and preferences.
Emergency Situation:	A circumstance which requires immediate health care that is necessary to preserve life, to prevent serious physical and mental harm, or to alleviate severe pain.
Harm Reduction:	A pragmatic, non-judgmental set of strategies to reduce individual and community harm caused by drug use. The focus is on taking incremental steps to reduce harm rather than on eliminating drug use. Abstinence may or may not be the end goal.

Known/ Witnessed Overdose:	To directly witness the person overdosing, or to receive a direct report from a third party who has witnessed the person experience an overdose.
Naloxone:	Naloxone (also known as Narcan®) is a medication called an "opioid antagonist." Naloxone blocks the effects of opioids, temporarily reversing an opioid overdose. The effect of Naloxone is temporary, as the half-life of Naloxone is shorter than the half-life of opioids – necessitating follow-up care after the administration of Naloxone.
Non-nursing Staff:	All staff not included in Health PEI's *Naloxone Administration* Medical Directive.
Opioid:	Opioids belong to a class of drug known as Central Nervous System (CNS) depressants. CNS depressants are substances that slow the body down and can make people sleepier. Opioids may be prescribed or used illegally to reduce pain, manage opioid dependence or produce a state of relaxation. Common opioids include heroin, fentanyl, morphine, methadone, codeine, and oxycodone.
Opioid Overdose:	The state that occurs when an opioid or an opioid combined with other substances overwhelms the body and consequently the CNS is no longer able to control basic life functions (i.e., breathing, heart rate, body temperature, consciousness).
Personal Protective Equipment (PPE):	Specialized clothing or equipment used by healthcare workers to provide a barrier or shield to prevent potential exposure to potential infectious microorganisms, and exposure to chemical or physical hazards used or present during the decontamination or sterilization process. Consists of gowns, gloves, masks, facial protection (e.g., disposable nitrile gloves, responder rescue mask, or face shield for use in rescue breathing or CPR, etc.)
Substitute Decision Maker (SDM):	Someone who makes health care and treatment decisions on your behalf when you are *not* able to do so yourself. It may be someone you formally appoint to make health care decisions for you (known as a Proxy) or may be someone else who is chosen based on the hierarchy set out in the *Consent to Treatment and Health Care Directives Act*.
Suspected Overdose:	A person's point of view that an overdose has occurred because of symptoms present, direct observations of physical state and context, or concerns obtained from other people.
Trauma Informed Care:	A universal, systematic approach that is grounded in an understanding of, and responsiveness to, the impact of trauma. Being informed is about using the principles of trauma informed care to create: 1. Safety and trustworthiness through practices 2. Safe physical and emotional environments 3. Positive social interactions with clients, families, staff, volunteers, and physicians

3.0 PURPOSE/SCOPE

3.1 This policy supports and encourages non-nursing MH&A staff with the training and established competency to act and respond in the event they encounter a suspected or known/witnessed opioid overdose while at work.

3.2 This policy provides direction to non-nursing MH&A staff regarding the administration of Naloxone while rendering temporary assistance in an emergency situation.

Naloxone Administration: Background

3.3 Opioid overdose is an emergency situation. If it is not detected or treated in a timely manner overdose can lead to neurological damage or death from respiratory depression or arrest. Naloxone is a safe treatment that can be used to help prevent these outcomes in situations where opioid overdose is suspected.

3.4 Naloxone is **not effective** against overdoses caused by non-opioid drugs (e.g., benzodiazepines, tranquilizers, barbiturates, alcohol, and psychostimulants). However, Naloxone **should still be given** as it can reverse the effects of the opioid component of the overdose if multiple substances are present, and will not have harmful impacts unless the individual is allergic.

3.5 Naloxone is active in the body for only 20 to 90 minutes but the effects of many opioids last longer. This means that the effects of Naloxone may wear off before the opioids are gone from the body, which could cause breathing to stop again.

4.0 GUIDING PRINCIPLES

Client and family centered care, trauma informed care, as well as the principles of harm reduction, shall guide the opioid overdose training, response and treatment.

5.0 APPLICATION

Applies to all non-nursing MH&A staff employed by Health PEI, including contracted service providers and other persons acting on behalf of MH&A, who are not governed and directed by *HPEI Acute Care Naloxone Administration – Adult Medical Directive.*

6.0 PROCEDURES

6.1 When non-nursing MH&A staff witness or suspect a client opioid overdose in MH&A work settings, including on MH&A premises or in the community:

(a) Activate the emergency response process (e.g., call 911).

(b) Do not withhold treatment while waiting for EMS arrival.

(c) Seek help from a colleague on site if available. Where a nursing professional is available in the emergency situation, that individual should administer the naloxone.

(d) Obtain consent whenever possible from the client (or substitute decision maker) to administer Naloxone.

6.2 While waiting for EMS to arrive for transfer of care, non-nursing staff:

(a) Stay with the client

(b) Assess scene safety

(c) Speak loudly to the person. Try to wake them up if they appear to be asleep

(d) Check to see if they are breathing (their chest is rising and falling)

(e) Start CPR if the client loses pulse and/or is not breathing

6.3 Administer Naloxone and continue to administer Naloxone in accordance with approved training until client responds or until help arrives.

6.4 Stop Naloxone administration when the client can respond (open eyes, talks, can take deep breaths).

6.5 If staff need to leave the client to get assistance, if the client starts breathing on their own, or if breathing improves, place the client in the recovery position (client lying on side with head stabilized on extended arm, knee bent and stabilized):

(a) Extend client's closest arm above the client's head

(b) Position other arm across the client's chest and bend furthest leg at the knee

(c) Roll client towards responder and place on side

(d) Continue to assess and re-assess level of consciousness and number of breaths the client is taking.

6.6 If the client resists attempts to provide care and attempts to leave the scene before emergency services arrive, follow the client if it is safe to do so.

6.7 If the client is alert and able, inform them of the opioid overdose and actions taken, and provide reassurance and support to manage client fear, confusion, or agitation.

6.8 Provide a history of the incident to EMS, including the total Naloxone dose administered and client response.

6.9 If applicable to the duties of the non-nursing staff member, document the incident appropriately in accordance with the *HPEI Acceptable Use of Integrated Systems Management (ISM) Policy* and *HPEI Acceptable Use of Patient Records – in the Clinical Information System Policy*.

6.10 Conduct a staff debrief with all staff members involved in the incident as soon as reasonably possible.

7.0 MONITORING

The MH&A Leadership Team is responsible for ensuring this policy is reviewed every three years according to Health PEI's policy review cycle and standards.

8.0 REFERENCES

Related Documents

HPEI Acceptable Use of Integrated Systems Management (ISM) Policy
HPEI Acceptable Use of Patient Records – in the Clinical Information System Policy
HPEI Acute Care Naloxone Administration – Adult Medical Directive
PEI's *Regulated Health Professions Act*

References

Alberta Health Services. (2019). Naloxone administration: Suspected opioid poisoning (overdose). Policy #HCS-247.

Alberta Health Services. (2019). Intramuscular Naloxone administration: Suspected opioid poisoning (overdose). Policy #HCS-247-02.

Alberta Health Services. (2019). Nasal Naloxone administration: Suspected opioid poisoning (overdose). Policy #HCS-247-01.

Canadian Union of Public Employees. (2020). Opioid overdose response.

Nova Scotia Health Authority. (2018). Provision of opioid overdose prevention/Naloxone administration training and take home Naloxone hydrochloride (Naloxone) kit. Policy #MA-HPP-001.

University of Toronto. (2020). Naloxone administration.

Appendices

Appendix A - Signs of a Drug Overdose

9.0 STAKEHOLDER REVIEW

Group/Committee	Dates of Review
Naloxone Policy Sub-Committee	November 15, 2022
Mental Health and Addictions Policy Working Group	March 27, 2023
HPEI Policy	March 13, 2023
McInnis Cooper (legal review)	May 5, 2023
Quality & Patient Safety	May 12, 2023
Provincial Drugs & Therapeutics	Jun 6, 2023

10.0 REVIEW HISTORY

Review Dates: _____ _____ _____

_____ _____ _____

Appendix A - Signs of a Drug Overdose

Signs and Symptoms of opioid intoxication include:

- Absence of respirations or decreased respiratory rate
- Gurgling or snoring type sounds
- Altered mental status to loss of consciousness
- Constricted/pinpoint pupils, though the presence of pinpoint pupils **alone** is not sufficient to infer opioid intoxication
- Slow, erratic or absent heart rate
- Vomiting
- Pale face
- Cold and clammy skin
    - May appear blueish, especially around the lips and/or nailbeds in individuals with lighter skin
    - Individuals with darker skin may be grayish or ashen
    - Seizure-like movements or rigid posture