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Manual for Nurse Practitioners:

Using a Computer-Based Naloxone Training Module

To Prepare Community Members for Opioid-Associated Overdose Rescue



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Introduction

To begin, thank you for all you do to keep our communities safe and healthy. Thank you especially for your willingness to train community members to perform the critical life-saving role of providing naloxone to victims of opioid-associated overdose.

For the first time in United States History, overdose from prescription medication has exceeded automobile accidents as the leading cause of accidental death in 16 states. It is the leading cause of accidental death in 35-54 year-olds in the nation. In the United States the sale of opioid pain relievers reached 710 milligrams annually per person in 2010. Sources estimate as little as 80 mg of oxycodone and 120 mg of morphine can be lethal, depending on a person's tolerance.¹ Fatal overdoses, from both prescription and street drugs, have increased dramatically in recent years and continue to increase, primarily due to abuse of opioids. In 2010 38,329 deaths occurred from drug overdose in the United States; 22,134 (60%) were related to pharmaceuticals. Of these, 16,651 (75%) involved opioid painkillers.² The epidemic of lethal overdose affects all sectors of society regardless of income level, ethnicity, gender, age, or geography. Deaths caused by opioids are especially tragic because they are largely preventable. A safe, cheap, easy way to administer an antidote exists – naloxone hydrochloride or Narcan (the trade name). Naloxone restores respiration rates that have been depressed by the overdose.

Nurses practitioners, particularly those involved in pain management with prescription opioids, have a special role to play in promoting overdose prevention, recognition, and response education by screening and educating at-risk patients, and prescribing naloxone. Nurse practitioners are uniquely positioned to aid in an epidemic caused primarily by medical prescriptions and for which they have the skills and resources to address. As nurses, nurse practitioners also have the privilege of being part of "the most trusted profession in America", giving them great capacity to develop confidence with and influence laypersons who have the potential to become bystanders to overdose and save lives by administering naloxone and rescue breathing.

Fortunately, due to recent changes in legislation, laypeople around the country now have the capacity to carry naloxone and use it to rescue family, friends, or others in case of opioid-associated overdose. There are currently over 200 overdose prevention programs across the country that are providing naloxone rescue kits to laypersons who are potential overdose bystanders (people at risk of overdose and those in their social network). Still, as of 2012, 69% of the states in the highest quartile for drug overdose death rates did not yet have community-based naloxone programs.⁴ Consequentially, starting in 2010, the Obama Administration's National Drug Control Strategy has called for increased access to naloxone to address the overdose epidemic. The 2013 National Drug Control Strategy released from the White House Office of National Drug Control Policy reiterated the increasing need for the

¹ Addictionblog.org (2012). Oxycodone Overdose- How Much Amount of Oxycodone to OD? <http://prescription-drug.addictionblog.org/oxycodone-overdose-how-much-amount-of-oxycodone-to-od/>; accessed 5 March, 2014.

²Centers for Disease Control. Vital Signs: Overdoses of Prescription Opioid Pain Relievers ---United States, 1999--2008. http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6043a4.htm?s_cid=mm6043a4_w; Accessed 13 July, 2012.

³ Centers for Disease Control. Drug Overdose in the United States: Fact Sheet. <http://www.cdc.gov/homeandrecreationsafety/overdose/facts.html>. Accessed 14 March, 2014.

⁴Centers for Disease Control. Community-Based Opioid Overdose Prevention Programs Providing Naloxone — United States, 2010. February 17, 2012 / 61(06);101-105

development of additional naloxone programs.⁵ Unintentional overdose deaths have increased more than 150% since 2000 and currently more than 100 overdose deaths occur daily in the United States alone.⁶ Responding to this crisis, the American Medical Association's Resolution on Nasal Naloxone for the Reversal of Opioid Overdose in 2012 invoked a call to action for "routine education of all patients receiving prescription opioids, all patients at risk for opioid overdose, and their caregivers in the signs and symptoms of opioid overdose, and the use of nasal naloxone in the reversal of opioid overdose".⁷ More recently, the Stop Overdose Stat Act was reintroduced in 2014 to address what the Centers for Disease Control has called a "public health epidemic."

As a result of the changes in legislation and the growing danger that prescription-associated overdose presents, this computer-based module has been developed to help nurse practitioners teach laypeople how to recognize an opioid-associated overdose and deliver naloxone and rescue breathing when needed.

As a nurse practitioner you can make a difference by using the module, which can be accessed online, as part of a complete training program for lay persons to rescue overdose victims and provide them with naloxone. The module has been designed to be cost-effective and educationally sound. It includes interactive components and testing to improve understanding of the essentials of overdose rescue. The approximate time to complete the module is 25 minutes, saving you time that insurers do not always reimburse for naloxone education, while allowing you to make a difference.

The module may be used as the central component of training in naloxone rescue or as an adjunct to in-person individual or group training. Please share it with your collaborating physician to ensure effective collaboration on any proposed naloxone program.

Whether you are using the module as part of your everyday practice as an NP or to start or participate in an initiative to help out your community, congratulations in taking this step towards saving lives and helping to stop the epidemic of opioid-associated overdose.

Module Funding, Access and Rights to Use the Module

The computer-based naloxone-training module may be accessed by download to a tablet or PC. It is supported on Windows 7, Windows 8, Android, and Mac OS X and iPad platforms.

The module is available to you for free online through givenaloxone.org or at the Social Science Innovations, Inc. website at ssic.us.com.

The National Institutes of Health, National Institute on Drug Abuse, Grant #1R43D033746-01, funded development of this computer-based naloxone-training module, and the Rita and Alex Hillman Foundation provided supplemental funds to develop this training manual for Nurse Practitioners. We

⁵ Office of National Drug Control Policy. National Drug Control Strategy.

<http://www.whitehouse.gov/ondcp/national-drug-control-strategy> Accessed 14 March, 2014.

⁶ Drug Policy Alliance. Congresswoman Donna Edwards Reintroduces S.O.S. Act to Combat Nationwide Overdose Epidemic. <http://www.drugpolicy.org/news/2014/03/congresswoman-donna-edwards-reintroduces-sos-act-combat-nationwide-overdose-epidemic>. Accessed 14 March 2014.

⁷ American Medical Association Resolution on Nasal Naloxone for Reversal of Opioid Overdose.

<http://www.drugpolicy.org/resource/american-medical-association-resolution-nasal-naloxone-reversal-opioid-overdose>. Accessed 14 March, 2014.

are providing the module and the manual free of charge. However, optional donations of any amount are encouraged to help keep the module and the manual up-to-date and to disseminate them where they are most needed.

We ask that you complete a short survey about yourself and give us contact information, as we would like to contact you in the future to give updates on the module or to evaluate implementation. If you prefer, module download can be made anonymously by clicking “make me anonymous”. Non-authorized commercial distribution is prohibited.

Social Media

The module and updates on the manual may be accessed at givenaloxone.org. Join the conversation by following us on twitter @givenaloxone. Learn about overdose prevention news through our Tumblr blog, tumblr.com/givenaloxone.

Rationale and Evidence for Community Education in Overdose Recognition and Naloxone Rescue

As of January 2014, within months of opening, New Jersey's first naloxone program received its first report of a layperson using prescribed naloxone to save someone's life. This rescue occurred as a result of training from staff at South Jersey AIDS Alliance's syringe access program in Atlantic City.⁸

In the short time following legislation enabling the prescription of naloxone to laypeople, naloxone programs have proven their ability to save lives. Thousands of people have already been trained to call 911, perform rescue breathing, administer naloxone, and wait with the person who overdosed until police, firefighters, EMT's, or paramedics arrive.

Prescription naloxone programs were initiated in Europe in the late 1990's.⁹ Positive outcomes from these programs led to over-the-counter access in Italy, and the development of prescription programs in 4 U.S. cites.¹⁰ Since 1996 when the first opioid overdose prevention program started distributing naloxone, the Harm Reduction Coalition found that the 50 community-based programs it identified had given naloxone out to 53,032 persons and received reports of 10,171 overdose rescues. In 2010, 48 naloxone programs responding to a Harm Reduction Coalition survey distributed 38,860 vials of naloxone to community members.¹¹

The first large-scale evaluation of community-based overdose prevention, recognition, and rescue programs was undertaken in NYC with an evaluation of S.K.O.O.P. (Skills and Knowledge on Overdose Prevention). S.K.O.O.P. was developed by Co-Investigator Sharon Stancliff, M.D., Medical Director of the Harm Reduction Coalition (HRC). S.K.O.O.P. has been evaluated and proven efficacious in 3 published

⁸NOPE list-serv report, Roseanne Scotti, New Jersey Drug Policy Alliance, 1/9/2014

⁹Dettmer K, Saunders B, Strang J. Take home naloxone and the prevention of deaths from opiate overdose: two pilot schemes. *BMJ* 2001;322(7291):895-6.

¹⁰Piper TM, Stancliff S, Rudenstine S, Sherman S, Nandi V, Clear A. Evaluation of a naloxone distribution and administration program in New York City. *Substance Use and Misuse* 2008;43(7):858-870.

¹¹Centers for Disease Control. Community-Based Opioid Overdose Prevention Programs Providing Naloxone — United States, 2010. February 17, 2012 / 61(06):101-105

studies. It has been used since 2005 in a face-to face format to train medical providers, trainers and community participants (including current and former drug users) in NYC and State. In NYC alone, where overdose deaths total over 600 per year, S.K.O.O.P. has trained over 5,000 individuals and been credited with 350 reported overdose reversals with no reported adverse effects). The evaluation of S.K.O.O.P. reported similar findings to the pilot programs: no reports of discomfort with the use of naloxone to reverse an overdose and no adverse consequences. The majority of responders (86%) were able to recognize that naloxone is only appropriate during opioid-associated overdoses. During 50 overdose events, naloxone was administered 82 times (many responders used both vials of naloxone to reverse the overdose). An ambulance was called in 37 of the 50 (74%) overdose events indicating the value of overdose education. Prior to the inception of the program, calls to ambulances were statistically lower. Sixty-eight (83%) of the overdose victims survived; and the outcome for the other 14 (17.1%) is unknown. In the most comprehensive and rigorous evaluation targeting the first 17 programs operating in the U.S., a total of 60 program participants were asked to complete a brief, validated questionnaire on overdose knowledge that included rating 16 putative overdose scenarios for whether an overdose was occurring and if naloxone was indicated. The evaluators found that overdose training programs *“improved participants’ recognition and response to opioid overdoses compared to those untrained ($p<.001$) and that trained respondents were as skilled as medical experts in recognizing opioid overdose situations (weighted kappa=0.85) and knowing when naloxone was indicated (kappa=1.0) ().* The authors concluded that: *“The study reports initial evidence of effectiveness of overdose training and naloxone distribution programs in opioid overdose recognition and response. People trained through these programs identify opioid overdoses and indications for naloxone as well as medical experts and consistently score higher in knowledge of overdose and naloxone indication scenarios than their untrained counterparts. ...Expansion of overdose training and naloxone distribution programs for drug-using populations is warranted.”*^{12, 13}

Overall, naloxone programs since S.K.O.O.P. have been met with great success. Chicago found a 30% decrease in overdose concurrent with the implementation of their citywide overdose prevention, recognition, and rescue program.¹⁴ A program in Boston training 385 potential bystanders at a needle-exchange program resulted in 74 reversals over the study period alone.¹⁵

There are many published studies showing the effectiveness of bystander training in naloxone. A few recent ones are:

¹²Piper TM, Stancliff S, Rudenstine S, Sherman S, Nandi V, Clear A. Evaluation of a naloxone distribution and administration program in New York City. *Substance Use and Misuse* 2008;43(7):858-870.

¹³Piper TM, Stancliff S, Rudenstine S, Sherman S, Nandi V, Clear A. Evaluation of a naloxone distribution and administration program in New York City. *Substance Use and Misuse* 2008;43(7):858-870.

¹⁴ Maxwell S, Bigg D, Stanczykiewicz K, Carlberg-Racich S. Prescribing naloxone to actively injecting heroin users: a program to reduce heroin overdose deaths. *J Addict Dis* 2006;25:89–96.

¹⁵ Maya Doe-Simkins, Alexander Y. Walley, Andy Epstein, and Peter Moyer. Saved by the Nose: Bystander-Administered Intranasal Naloxone Hydrochloride for Opioid Overdose. *American Journal of Public Health*: May 2009, Vol. 99, No. 5, pp. 788-791.

Piper TM, Rudenstine S, Stancliff S, et al. Overdose prevention for injection drug users: lessons learned from naloxone training and distribution programs in New York City. *Harm Reduct J* 2007;4:3.

Seal KH, Thawley R, Gee L, et al. Naloxone distribution and cardiopulmonary resuscitation training for injection drug users to prevent heroin overdose death: a pilot intervention study. *J Urban Health* 2005;82:303–311.

Community-based opioid overdose prevention programs providing naloxone - United States, 2010. Centers for Disease Control and Prevention (CDC). *MMWR Morb Mortal Wkly Rep*. 2012 February 17; 61(6): 101–105.

Michele M Straus, Udi E Ghitza, Betty Tai “Preventing deaths from rising opioid overdose in the US – the promise of naloxone antidote in community-based naloxone take-home programs” *Substance Abuse Rehabilitation*. 2013; 4: 65–72.

Karla D. Wagner, Peter J. Davidson, Ellen Iverson, Rachel Washburn, Emily Burke, Alex H. Kral, Miles McNeeley, Jennifer Jackson Bloom, Stephen E. Lankenau. “I Felt Like a Superhero”: The Experience of Responding to Drug Overdose Among Individuals Trained in Overdose Prevention *Int J Drug Policy*. Author manuscript; available in PMC 2015 January 1.

Research indicates a need to eradicate myths about overdose among laypeople, including drug users. Opioid-dependent users of legal drugs tend to be wholly misinformed about the dangers of overdose, or even how to recognize an overdose. The overdose scene in the popular film *Pulp Fiction*, for example, has become synonymous with an opioid-associated overdose in the national psyche. Unfortunately, this depiction is wholly inaccurate because it shows a person thrashing around rather than slowly descending into unconsciousness and then death as typically happens. Most illicit drug users report witnessing at least one overdose but only 13%–68% (depending on the study) report calling 911 the last time they witnessed an overdose. While fear of arrest is commonly cited as a reason for not calling 911, misinformation is also to blame. In a study of almost 3000 injection drug users recruited for the ALIVE study in Baltimore in 2003-2004, 69.7% had witnessed an overdose. However, only 12.8% called 911 as their first response. Most (75%) believed they could revive the victim. The authors found a high rate of inappropriate witness response such as: walking the victim around, shaking, pinching, slapping or otherwise inflicting pain, putting ice on their groin, or injecting the victim with salt water. They also found that those who received information about overdose were less likely to delay the 911 call (AOR=0.35, 95% CI=0.17-0.72), less likely to utilize inappropriate responses (AOR=0.40, 95% CI=0.22-0.72), and administration of rescue breathing was often sufficient in the absence of naloxone.^{16 17 18 19}

¹⁶ Davidson PJ, Ochoa KC, Hahn JA, Evans JL, Moss AR. Witnessing heroin-related overdoses: the experiences of young injectors in San Francisco. *Addiction* 2002;97(12):1511-6.

¹⁷ Pollini RA, McCall L, Mehta SH, Celentano DD, Vlahov D, Strathdee SA. Response to overdose among injection drug users. *American Journal of Preventive Medicine* 2006;31(3):261-264.

¹⁸ Beletsky L, Burris S, Kral A. Closing death's door: Action steps to facilitate emergency opioid drug overdose reversal in the United States: A Conference Report from the Center for Law, Politics and Policy, Temple University Beasley School of Law (unpublished white paper), 2009.

Preliminary evaluation shows improvement following completion of the computer-based module in scores assessing understanding of overdose recognition and naloxone use on pre- and post-tests. Further evaluation is in progress researching usability and objective-based learning gains from the computer-based module.

Forums for Distribution of Naloxone to Community Members

Potential forums for distribution of naloxone to community members depends on your state and local laws. Forums that have been used to date include:

Emergency Departments

Outpatient settings (walk-in clinics)

Pain clinics

Inpatient settings (hospitals)

Behavioral treatment centers

Methadone clinics and drug treatment programs

Community outreach/centers

Support groups (Narcotics Anonymous, etc.)

Parent/family support groups (NarAnon, etc.)

Syringe access programs

Detox facilities

Homeless Shelters

Jails and prisons

Street corners

Home visits/mobile crisis teams

AIDS coalitions

Prescription take-back programs

Pharmacies

Schools

¹⁹Dasgupta N, Brason F, Albert S, Stanford K. Project Lazarus: Overdose prevention and responsible pain management. *North Carolina Medical Board Forum* 2009;1.

Legal Considerations

Please refer to your state and county laws regarding the right to distribute naloxone to members of the community and required physician oversight. Many states do not yet allow community members to carry and give naloxone. A prescription is always required. The need for a standing order and/or patient specific prescription varies by state. Refer to your local authority to view the current status of laws in your county: Law Atlas, <http://lawatlas.org/preview?dataset=laws-regulating-administration-of-naloxone> maintains an easily accessible database on current naloxone legislation. State Track maintains updates of naloxone bills in progress that may impact your practice in the future. Visit <http://www.cqstatetrack.com/texis/statetrack/insession/viewrpt?report=52d0204177a>.

As of March, 2014:

19 states have naloxone laws:

California, Colorado, Connecticut, DC, Illinois, Kentucky, Massachusetts, Maryland, North Carolina, New Jersey, New Mexico, New York, Ohio, Oklahoma, Oregon, Rhode Island, Virginia, Vermont, and Washington

15 states have laws enabling prescription of naloxone to laypersons:

California, Colorado, Illinois, Kentucky, Massachusetts, Maryland, North Carolina, New Jersey, New Mexico, Ohio, Oklahoma, Oregon, Virginia, Vermont, and Washington

4 states have naloxone laws that do not allow third party prescription:

Connecticut, DC, New York, and Rhode Island

Prescription by standing orders is legalized in:

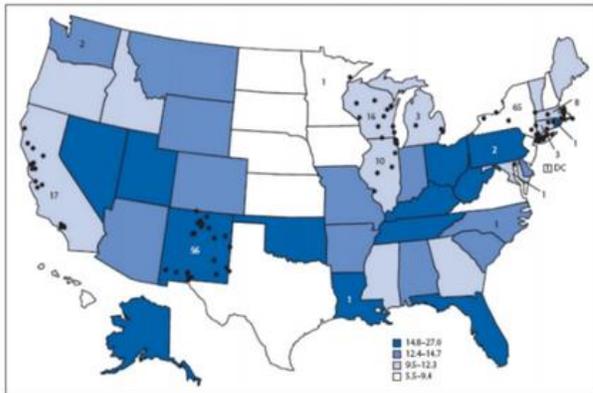
California, Illinois, Kentucky, North Carolina, New Jersey, and Vermont

According to a recent study, the malpractice risks associated with prescribing naloxone are consistent with the general risks associated with providing healthcare.²⁰ Enhanced naloxone prescription laws in several states have also enabled protection of prescribers distributing and administering naloxone. As of March 2014 prescribers acting with reasonable care are immune from civil and criminal liability in the states of California, Colorado, Connecticut, DC, Illinois, Kentucky, Massachusetts, Maryland, North Carolina, New Jersey, New Mexico, New York, Ohio, Oklahoma, Oregon, Rhode Island, Virginia, Vermont, and Washington.

²⁰ Burriss S, Norland J, Edlin BR. Legal aspects of providing naloxone to heroin users in the United States. *Int J Drug Policy*. 2001;12:237–248.

Number of Drug Overdose Prevention Programs Providing Naloxone by State as of 2010²¹

FIGURE 2. Number (N = 188) and location* of local drug overdose prevention programs providing naloxone in 2010 and age-adjusted rates[†] of drug overdose deaths[‡] in 2008 — United States



* Not shown in states with fewer than three local programs.
† Per 100,000 population.
‡ Source: National Vital Statistics System. Available at <http://www.cdc.gov/nchs/nvss.htm>. Includes intentional, unintentional, and undetermined.

As a nurse practitioner, you should make sure you have the legal right to prescribe and/or provide mental health services before providing training in naloxone. For nurse practitioners applying to be providers for the purposes of Medicare and Medicaid reimbursement after 2003, a master's or doctoral degree in nursing, state registration as a professional nurse, and certification by a nationally recognized certifying body are required. Recognized certifying bodies at the time of publication are the American Academy of Nurse Practitioners; American Nurses Credentialing Center; National Certification Corporation for Obstetric, Gynecologic and Neonatal Nursing Specialties; Pediatric Nursing Certification Board (previously named the National Certification Board of Pediatric Nurse Practitioners and Nurses); Oncology Nurses Certification Corporation; American Association of Colleges of Nursing (AACN) Certification Corporation; and the National Board on Certification of Hospice and Palliative Nurses.

Physician oversight (see Appendix A for sample collaborative agreements)

In most states physician oversight is necessary for a nurse practitioner initiative that involves giving naloxone, which is a prescription medicine. Be sure to follow your state's laws and Nurse Practice Acts and refer to your own collaborative physician agreement before initiating a naloxone prescription program. Collaborative agreements may also allow for nurses and other staff working with you to distribute naloxone. Any collaborating physician should be informed at the start of a naloxone program.

Some states require special certification or board approval to provide naloxone and other prescriptions; others allow independent prescribing by nurse practitioners. See the table below.

²¹ Wheeler E et al. Morbidity and Mortality Weekly Report. 2012; 61: 101-5.

TABLE I: AUTHORITY OF APNs AND PAs TO PRESCRIBE NALOXONE

	May prescribe naloxone without on-site physician supervision	May prescribe naloxone with on-site physician supervision	Cannot prescribe naloxone
Advanced Practice Nurse	AL, AK*, AR*, AZ*, CA, CO*, CT, DE*, DC, FL, GA, HI*, ID*, IL, IN*, IA, KS, KY, LA*, ME*, MD, MA, MI, MN, MS, MO, MP, NC, NE, NV, NH, NJ, NM, NY, ND*, OH*, OK, OR*, PA, RI, SC*, SD, TN*, TX, UT*, VT, VA, WA*, WV*, WI, WY		
Physician Assistant	AL, AK, AR, AZ, CA, CO, CT, DE, DC, FL†, GA, HI, ID*, IL, IN, IA, KS, KY, LA, ME, MD, MA, MI, MN, MS, MT, NE, NC, NV, NH, NJ, NM, NY, ND, OH*, OK, OR, PA, RI, SC*, SD, TN, TX, UT, VT, VA, WA*, WI, WY*	MO	WV

* Special license or board certification required

† For nasal administration only

The role of the person providing medical oversight is crucial, but rarely requires a large amount of time. Responsibilities of the person providing medical oversight might include signing a standing order for the prescription and distribution of naloxone by those without prescriptive authority (aka staff nurses); reviewing and approving departmental protocol; reviewing and approving informational/training materials; reviewing record keeping or data collection (if required), and being available for as-needed consultation for unique or unusual events.

The legality of standing orders and the need for patient-specific prescription varies by state.

Good Samaritan Protection

Enhanced Good Samaritan Laws have been passed in many places to encourage people to call 911 in life threatening situations where there may be illegal activity (like underage drinking in college dorms or opioid use). The intention of these laws is to maximize the willingness to call 911 by minimizing the likelihood of criminal charges to the caller and/or the victim. Good Samaritan Laws also protect bystanders who have been trained to administer naloxone. The number of people trained is increasing all the time. You may arrive on a scene where someone has made a 911 call before reviving the overdose victim. Good Samaritan laws protect them from arrest in many cases; even if illicit drugs are involved. Many states are enacting these laws so that citizens can serve in this lifesaving role.²³

Laypersons to whom you prescribe naloxone may have variable protection by Good Samaritan Laws when reporting overdose particularly if they have been using or there are drugs on the scene. Naloxone

²² Burris S, Beletsky L, Castagna C, Casey C, Colin C, McLaughlin, J.M. Stopping An Invisible Epidemic: Legal Issues In The Provision Of Naloxone To Prevent Opioid Overdose, Drexel Law Review; 2009: 1(2):273 – 339.

²³ Banta-Green C. Good Samaritan overdose response laws: Lessons learned from Washington State. Washington, DC: Office of National Drug Control Policy, Executive Office of the President, The White House, March 29, 2013. [Accessed at <http://www.whitehouse.gov/blog/2013/03/29/good-samaritan-overdose-response-laws-lessons-learned-washington-state>]

laws also remove criminal liability for persons carrying naloxone in several states- California, DC, Illinois, Massachusetts, Maryland, New Jersey, Rhode Island, Vermont, and Washington. In several states criminal and civil liability is additionally removed for both carrying and administering naloxone; these are California, DC, New Jersey, Rhode Island, and Vermont.

Good Samaritan Laws applicable in your state can be found at http://www.networkforphl.org/_asset/qz5pvn/network-naloxone-10-4.pdf

Special Issues: Anonymity and Patient Specific Prescription

Using the Module as Part of a Complete Naloxone Training Program

The module can be used in combination with other training modalities to maximize effectiveness.

Hands-on demonstration and return demonstration may improve the trainee's confidence and competence in naloxone administration. Patients in medical settings immediately forget around 40-80% of medical information they have been given; use the "teachback" method consistently to ensure trainees have understood the way you explained information is recommended.²⁴ If you are not comfortable in the "teachback" method or it was not part of your nursing training, you can obtain training in this technique.

Videos can be a useful adjunctive tool. Prescribe to Prevent.org has multiple free videos on naloxone administration in IN and IM formats, overdose recognition, and a special video geared towards overdose prevention post-incarceration. Availability of these videos may change. The current selection can be accessed at: <http://prescribetoprevent.org/video/>. Project Lazarus also has useful educational videos at: <http://projectlazarus.org/patients-families/videos>.

You may wish to provide your own institution's educational materials on overdose and naloxone administration. If you do not have these, the Substance Abuse and Mental Health Services Administration (SAMHSA) provides a toolkit with brochures and printouts with further information for trainees to read and review at home.²⁵ Prescriptions can be accompanied by tear-off instructions. Posters in your clinic setting can also impactfully reiterate the message about the importance of overdose response.

Samples of all of these are provided in Appendix C, refer to <http://store.samhsa.gov/product/Opioid-Overdose-Prevention-Toolkit/SMA13-4742> and <http://prescribetoprevent.org/materials/> for the latest available materials.

²⁴ Kessels RP. Patients' memory for medical information. J R Soc Med. May 2003;96(5):219-22.

²⁵ Substance Abuse and Mental Health Services Administration. SAMHSA Opioid Overdose Prevention Toolkit: Safety Advise for Patients. HHS Publication No. (SMA) 13-4742. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2013.

See Appendix B for examples of previous non-computer based naloxone training programs and various combinations of teaching modalities that have been used in the past. Providers' Clinical Support System for Opioid Therapies has provided a video on how to incorporate a naloxone training program into an existing medical practice, <http://pcss-o.org/archived-webinar-65>.

Naloxone formulations

As of December, 2013, naloxone is approved by the US Food and Drug Administration (FDA) for intravenous (IV), intramuscular (IM) and subcutaneous (SQ) injection. While naloxone is not approved for intranasal (IN) administration, it is the standard of care in many areas mostly because it is a needleless alternative. Naloxone is currently available in the US in 0.4mg/ml and 2mg/2ml concentrations. The only formulation used intranasally is the stronger 2mg/2ml formulation. As such, we focus only on nasally administered naloxone.

Injectable naloxone may also be available to laypersons in the community. Some reports have suggested that injectable naloxone is easier to use than the intranasal form owing to the required assembly of the intranasal administration device. Some claim a greater use rate by laypeople prescribed injectable forms.²⁶ Further research is required to substantiate these reports. The assembly steps for both forms are covered in the module.

Current research indicates that the IN and IM naloxone are similarly effective treating opioid overdoses with IM acting slightly faster and IN inducing slightly fewer withdrawal symptoms. The following are key research studies comparing IN and IM administered naloxone:

- Kerr D, Kelly AM, Dietze P, Jolley D, Barger B. [“Randomized Controlled Trial Comparing the Effectiveness and Safety of Intranasal and Intramuscular Naloxone for the Treatment of Suspected Heroin Overdose.”](#) *Addiction*, Jul 2009; 104: 2067-2074.
- Barton E, Colwell C, Wolfe T, Fosnocht D, Gravitz C, Bryan T, Dunn W, Benson J, Bailey J. [“Efficacy of Intranasal Naloxone as a Needleless Alternative for Treatment of Opioid Overdose in the Prehospital Setting.”](#) *Journal of Emergency Medicine*, March 2005; 29(3): 265-271.

Sourcing^{27,28}

Naloxone in the 2mg/2mL IN formulation is manufactured by [IMS/Amphastar](#) (NDC 76329-3369-1). This product is available through most EMS supply distribution companies and hospital pharmacy suppliers and some community pharmacy distribution companies. This is the concentration that is used for IN administration. While naloxone is not approved for intranasal administration by the FDA, it is the standard of care in many areas and currently the only formulation used by non-paramedic first responders.

²⁶ NOPE list serv debate, January 2014

²⁷ Please note that this section lists all known available sources in the US for these products.

²⁸ References to any company are to ease procurement and not to specifically support any corporation. None of the business mentioned have contributed financially or otherwise to this project.

The 0.4/mL naloxone formulation for injection is available in two forms from [Hospira](#) (NDC 0409-1219-01 for 10mL multi-dose vial and NDC 00409-1215-01 for 1mL single dose vial) and now from Mylan Inc. This product is available through most EMS supply distribution companies and hospital pharmacy suppliers. This formulation is used by some community bystander overdose prevention programs, paramedics, emergency medicine and anesthesiologist providers.

The mucosal atomization device (MAD-300) from [Teleflex \(formerly LMA North America\)](#) fits onto the luer-lock of the IMS/Amphastar naloxone for adaptation for nasal administration. This product is available directly from the manufacturer and through some EMS supply distribution companies.

See the costs and funding section for contact information to purchase naloxone.

Sample Overdose Rescue Kit Contents: IM and IN Formulations



Naloxone rescue kits are available by prescription and may include:

- Nasal atomizer device with naloxone, or syringe and vial system
- Additional naloxone supply for a second dose
- Alcohol wipes for naloxone injection
- Gloves
- Barrier shield for personal protection during rescue breathing
- Collapsible face mask for delivering rescue breaths
- Instructions

Naloxone storage & integrity

Naloxone needs to be stored at room temperature (59°-86° F/15°-30° C) and protected from light and crushing.³⁰ These are several strategies that existing bystander training programs have used themselves and taught to potential naloxone users.

²⁹ Image courtesy of the Harm Reduction Coalition, harmreduction.org

³⁰ Naloxoneinfo.org. "Frequently Asked Questions- Naloxone".

http://naloxoneinfo.org/sites/default/files/Frequently%20Asked%20Questions-Naloxone_EN.pdf. Accessed 3 Mar 2014.

Carrying naloxone itself or the whole rescue kit in a pocketbook or pocket ensures the greatest likelihood that a potential overdose bystander will have naloxone when needed. Overdose rescue kits are relatively compact. If the kit is too large, some ideas include putting the contents into a ziplock bag. Opaque ziplock bags are preferable because they protect naloxone from light exposure. Another idea that has been employed in Rhode Island naloxone programs is to place the naloxone itself and the delivery system in a small prescription pill bottle. This is very portable with the caveat that most pill bottles are not light-protective.

Other ideas include placing naloxone in jump kits and storing naloxone with first aid kits in the home. However, this is less effective than carrying naloxone on one's person so that it is readily available when needed.

Particularly in the context of lower usage rates, exposure to sunlight, and unstable temperature conditions, naloxone rescue kits may be usable for shorter periods of time than the indicated expiration date. Patients should be encouraged to return for new naloxone kits before their naloxone expires, as with any other prescription medication.

Costs & funding options

There are two methods of providing potential bystanders with naloxone: (1) a provider may choose to give overdose rescue kits directly; or, (2) refer to a pharmacy to fill prescriptions. The approximate cost of a naloxone rescue kit that contains two doses of 2mg/2mL naloxone and two MAD 300 nasal adaptors is \$40. Prices are currently on the rise for both IM and IN formulations. Increasing competition for the sale of injectable .4mg/mL formulations with the recent FDA approval of Mylan's product could eventually lower costs. Medicaid and Medicare may pay for the naloxone, but do not cover the mucosal atomizer device, which costs around \$4. Private insurance varies and the potential bystander may have to pay the full cost at an outpatient pharmacy. Since overdose kits are not unduly expensive, often times bystanders are willing to pay out of pocket. Sometimes local programs such as an ADAP (AIDS Drug Assistance Program) will cover the cost of the kit itself.

Many outpatient pharmacies do not carry naloxone. Collaborate with your local pharmacists to establish a list of which insurers cover naloxone in your area and which pharmacies stock it.

Providing naloxone onsite may be beneficial to potential bystanders if your local pharmacies will not stock it. Providing kits at the conclusion of the training also assures that the kit is actually acquired and ready for use.

Several companies such as LMA, IMS, and R&S Northeast sell naloxone and can be used to stock your clinical setting. LMA will take orders for as little as 25 kits and is available at 1-800-788-7999. International Medications Systems (IMS) can be reached at (800 423-4136) and Customer Service and charges \$16.95 each (package of 10 = \$169.50) with discounts for groups purchasing regularly. R&S sells naloxone in packs of 25 for \$16 a dose (\$402 per pack). Their telephone is 1-800-262-7770.

These are several strategies that existing programs have used or considered using to pay for the naloxone:

- Using existing departmental budgets
- Collaboration with local or state level public health agency initiatives to reduce fatal overdose rates
- Collaboration with local emergency departments
- Application for funds from local philanthropic organization whose mission involves maximizing community health and wellbeing

There are ways to be compensated for your time. As a nurse practitioner, you can identify which of the services you provide are currently covered by Medicare at 42 CFR 410.75 at http://edocket.access.gpo.gov/cfr_2009/octqtr/42cfr410.75.htm and in the Medicare Benefits Policy Manual (Chapter 15, Section 200).

If you work in an Emergency Department, you may be able to bill for naloxone training as part of a Screening, Brief Intervention, and Referral to Treatment (SBIRT) program. Insurers covering these programs currently include the Federal Employee Health Benefits Program, Aetna (nationwide), CIGNA (nationwide), Anthem Blue Cross and Blue Shield (Colorado, Connecticut, Indiana, Kentucky, Ohio, Maine, Missouri, Nevada, New Hampshire, Virginia, and Wisconsin), Blue Cross of California, Blue Cross-Blue Shield in Georgia, Blue Cross-Blue Shield of Minnesota, Empire Blue Cross-Blue Shield in New York, and Independence Blue Cross HealthPlus (Michigan).³¹

Medicaid and Medicare may cover naloxone training in your setting as billing codes are becoming increasingly available. Billing codes (Medicaid HCPCS and Medicare G) cover structured assessment and brief interventions covering 15-30 minutes of care and reimbursing at fees ranging from \$24-\$65 dollars as of the writing of this manual. Updated information and codes may be obtained at: <http://www.samhsa.gov/prevention/SBIRT/coding.aspx>. Additional documentation and billing requirements are located at <http://prescribetoprevent.files.wordpress.com/2012/01/sbirt-guidance-document.pdf>.

Suggested policies (see appendix A for examples)

A departmental policy should be tailored to the local context, existing state level laws and regulations, and the advice of the individuals charged with medical and legal oversight. Consider starting with a very simple policy and revisit the policy after a period of piloting to incorporate any lessons learned during the pilot phase.

Rationale for ventilations under compression-only guidelines

- The current American Heart Association (AHA) guidelines recommending compressions-only resuscitation for bystanders have received extensive media publicity, much of which has ignored exceptions to compressions-only CPR. In the AHA informational guide Hands-Only CPR: Learn More the question is asked, "Not all people who suddenly collapse are in cardiac arrest. Will CPR seriously hurt them?". The AHA answers, "If a teen or adult has collapsed for reasons other than sudden cardiac arrest, Hands-Only CPR could still help by causing the person to respond (begin to move, breathe normally or speak)." Unfortunately, while CPR itself may not hurt victims of overdose and may be helpful, withholding rescue breathing can

³¹ SASSI (2014). SBIRT. Accessed at <https://www.sassi.com/news-updates/sbirt/>.

be fatal. An important message about addressing overdose is found in response to a more pointed question in the informational guide, "Are there times when I should use conventional CPR with breaths?"

The simple answer is, as also stated by the AHA, "Yes." According to the AHA, "There are many medical emergencies that cause a person to be unresponsive and to stop breathing normally. In those emergencies, conventional CPR that includes mouth-to-mouth breathing may provide more benefit than Hands-Only CPR. The American Heart Association recommends CPR with a combination of breaths and compressions for:

- All infants (up to age 1)
- Children (up to puberty)
- Anyone found already unconscious and not breathing normally
- Any victims of drowning, drug overdose, collapse due to breathing problems, or prolonged cardiac arrest."³²

- These exceptions are drug overdose, drowning, or respiratory crises such as asthma attacks. As a result, the Harm Reduction Coalition has released a policy alert. Key facts to note from this alert are:
 - Rescue breathing with or without chest compressions if an opioid overdose is suspected is essential.
 - Further research is needed to evaluate the effectiveness of hands-only compressions in overdose and other cases involving asphyxia.³³

The American Heart Association further addresses the issue of special scenarios of cardiac arrest in part 12.7 "Cardiac Arrest in Special Situation", where further research is called for to determine the best response to poisoning and other scenarios involving respiratory crises.³⁴

Bystanders should be taught to follow the instructions of trained emergency dispatchers who will be familiar with the needs of ventilation in overdose as well as the situations where the addition of compressions is appropriate. It may be helpful for bystanders to mention their training in administering naloxone to dispatchers in order to receive instructions supporting their level of training.³⁵

Record keeping & data collection

You may or may not receive feedback on saves made with the naloxone kits you prescribe. While collecting information on incidents that involve overdose is important for program monitoring and

³² American Heart Association (2013). Hands-Only CPR: Learn More. Accessed at http://www.heart.org/HEARTORG/CPRandECC/HandsOnlyCPR/LearnMore/Learn-More_UCM_440810_FAQ.jsp.

³³ Harm Reduction Coalition (2013). Policy Alert: Hands-Only CPR. Accessed at <http://harmreduction.org/wp-content/uploads/2012/02/alert-hands-only-cpr.pdf>.

³⁴ Vanden, Terry et al. (2010). "2010 American Heart Association Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care Science Part 12: Cardiac Arrest in Special Situations" *Circulation*. 2010; 122: S829-S861.

³⁵ Berg RA. Role of mouth-to-mouth rescue breathing in bystander cardiopulmonary resuscitation for asphyxial cardiac arrest. *Crit Care Med*. 2000 Nov;28(11 Suppl):N193.

evaluation as well as review of any rare adverse events, the process should be incorporated into existing documentation protocols to the fullest extent possible.

The module developers are always keen to hear about your program's successes and reported saves. Please contact us at info@givenaloxone.org to share your experiences with the module.

Referrals as part of an enhanced overdose initiative

Providing laypersons with naloxone rescue kits and the training on how to use them is an important contribution to safeguarding a community's safety and wellbeing.

In addition, providing laypeople seeking naloxone training with drug treatment referrals to available services for themselves or others in a nonjudgmental manner may further improve outcomes. Useful sites for finding appropriate referrals include:

National Substance Abuse Treatment Facility Locator:
www.findtreatment.samhsa.gov/TreatmentLocator

Buprenorphine Physician & Treatment Program Locator:
www.buprenorphine.samhsa.gov/bwns_locator

State Substance Abuse Agencies:
<http://findtreatment.samhsa.gov/TreatmentLocator/faces/>

It can be especially helpful to develop relationships with sites in your area to which you can refer patients.

A current list of available substance use disorder treatment organizations, education about safe prescription disposal options for unneeded scheduled prescription medicines and National Take-Back days, information about safe disposal options for needles and sharps, and contact information for emergency resources (aka 911, Poison Control- 1-800-222-1222) may be helpful.

The Substance Abuse and Mental Health Services Administration (SAMHSA)'s National Treatment Referral Helpline can also be a tremendous resource for laypeople to seek help. The numbers are 1-800-662-HELP (4357) or 1-800-487-4889 (TDD — for hearing impaired). You may also want to check the website to locate resources in your area.

Information to Cover During Teachback

Below is some of the key information covered in the module that you may choose to review with participants.

Risks for Overdose

Opioid toxicity depends on how much was used, the timing of use, the user's tolerance for the drug and the user's overall health. Opioid-associated overdoses tend to occur after a period of abstinence such as hospitalization, drug treatment, incarceration or any period of time without use of the drug. Even a relatively small amount of an opioid can lead to an overdose emergency when tolerance is low. Poly-

drug abuse, using alone, chronic illness, and use of long-acting opioids contribute to increasing the risk of fatal overdose.

Recognizing Overdose

In an opioid-associated overdose, breathing is suppressed, which decreases the amount of oxygen in the blood. Lack of oxygen leads to damage to the brain and heart, and, ultimately, death. Signs that you can observe during an opioid-associated overdose include slow or no breathing, unconsciousness, and cyanosis (when lips and nail beds appear ashen, blue or purple). Other symptoms include pale or clammy skin, and (sometimes) gurgling sounds or snoring—also called the “death rattle.”

What's the difference between observing someone who is really high and someone who is overdosing?

A person who is really high:

WILL RESPOND to stimulation (calling out their name, sternum rub)

Has small, pinpoint pupils

Has slowed or slurred speech

Has a heavy nod (is sleepy looking)

A person who is overdosing:

WILL NOT RESPOND to stimulation

And often:

Has bluish lips or nail beds and/or grayish or ashen appearance

Has very infrequent or no breathing (less than 8 breaths/minute)

Has slow, erratic or no pulse

May be snoring or gurgling

Overdoses due to toxicity from other drugs have different symptoms. For example, physical symptoms associated with an overdose of cocaine can include dilated pupils, agitation, high blood pressure, high temperatures, seizures and chest pains.

Assembly and Use of the Atomizer

Request a return-demonstration if this is the form of naloxone you will be prescribing.

- a. Open the Overdose Rescue Kit supplied to you. The kit comes with directions, but you don't want to be reading the directions when you arrive at the scene. Select one of the two doses of naloxone in the pack to continue.
- b. Pop off the two yellow caps from the needleless syringe and one red cap from the glass medication vial.
- c. Screw the medication vial *gently* into the syringe.
- d. Attach the atomizer *gently* onto the top of the syringe.
- e. Spray half the medication (1 mg/1ml) in one nostril and then the other by pushing on the unit dose cylinder or syringe plunger.

Administer 2nd dose (1 mg/1 ml per nostril) if the victim's respiratory rate does not increase to greater than 8 within 3-5 minutes of initial naloxone administration (10 if you are using an ambu bag valve mask).

Steps for Injecting Intramuscular Naloxone

Request a return-demonstration if this is the form of naloxone you will be prescribing.

- a. Open the Overdose Rescue Kit supplied to you. The kit comes with directions, but you don't want to be reading the directions when you arrive at the scene. Select one of the two doses of naloxone in the pack to continue.
- b. Pop off the cap covering the needle of the syringe and one cap from the glass medication vial.
- c. Insert the needle of the syringe into the rubber plug on the vial
- d. Pull back on the syringe plunger to withdraw 1ml into the syringe.
- e. Insert the needle into the thigh or upper arm, through clothing or bare skin and push the plunger in to inject naloxone solution. .
- f. Administer 2nd dose if the victim's respiratory rate does not increase to greater than 8 within 3-5 minutes of initial naloxone administration (10 if you are using an ambu bag valve mask).

Common Opioids

Overdoses can occur with almost any drug. However, in the U.S. today, most overdoses are due to opioid toxicity or poisoning from drugs like heroin or prescription pain relievers, either alone or in combination with other substances. Poly-drug use, combining an opioid with other commonly used substances like cocaine, alcohol or benzodiazepines, can increase the risk of a fatal overdose. If a bystander is unsure what someone has taken or whether someone has taken multiple drugs, he or she can and still should deliver naloxone.

Overdose from the following opioid-associated substances may be reversible with naloxone:

- Codeine (Tylenol 3[®])
- Diphenoxylate (Lomotil[®])
- Fentanyl (Duragesic[®])
- Heroin (slang: junk, dope, smack, shot, shit, h, manteca)
- Hydrocodone (Vicodin[®], Norco[®], Lortab[®], Lorcet[®])
- Hydromorphone (Dilaudid[®])
- Meperidine (Demerol[®])
- Morphine (Astramorph[®], Avinza[®])
- Opium (slang: O.P., hop, midnight oil, tar, dope, Big O)
- Oxycodone (OxyContin[®], Percocet[®], Percodan[®])
- Oxymorphone (Opana[®])
- Propoxyphene (Darvon[®])
- Levorphanol (Levo-Dromoran[®])
- Morphine (Kadian, Avinza[®], MS Contin[®])
- Fentanyl (Duragesic[®])
- Methadone (Dolophine[®])

In the list of common opioids, you will see that both street drugs and prescription opioids are involved in opioid-associated overdoses. It is important to recognize that people from all walks of life use both street drugs and prescription opioids. And, as prescription opioids become harder to get, many people dependent on them have begun to convert to using heroin due to ease of access and cost.

Identifying Potential Training Recipients and Broaching the Subject

Identification of recipients who will benefit from overdose rescue training depends on the setting of your naloxone program and your clinical judgment. Existing screening tools from SASSI and Prescribe to

Prevent may be helpful. Any requests for kits and training or self-identification as a potential overdose bystander should be followed up with training whenever possible. This includes family or friends of users who seek overdose rescue kits. Drug users themselves are particularly likely to witness overdose. For example, a study by the Centers for Disease Control found 64.6% of drug users had witnessed an overdose and 34.6% experienced one themselves.³⁶

If a person has not requested training or been identified as a potential bystander, Prescribe to Prevent's additional inclusion criteria for naloxone training and rescue kit prescription may be useful. Their criteria for determining appropriate candidates for training are as follows:

1. Received emergency medical care involving opioid intoxication or poisoning
2. Suspected history of substance abuse or nonmedical opioid use
3. Prescribed methadone or buprenorphine
4. Higher-dose (>50 mg morphine equivalent/day) opioid prescription
5. Receiving any opioid prescription for pain plus:
 - a. Rotated from one opioid to another because of possible incomplete cross tolerance
 - b. Smoking, COPD, emphysema, asthma, sleep apnea, respiratory infection, or other respiratory illness or potential obstruction.
 - c. Renal dysfunction, hepatic disease, cardiac illness, HIV/AIDS
 - d. Known or suspected concurrent alcohol use
 - e. Concurrent benzodiazepine or other sedative prescription
 - f. Concurrent antidepressant prescription
6. Patients who may have difficulty accessing emergency medical services (distance, remoteness).

It is important to note that there is another school of thought on naloxone distribution that calls for more liberal prescribing without invoking the screening process described above. There is also currently a movement to make naloxone available over the counter and one to make it a standard part of first aid kits. It is important to know that there is justification for making broader community access the norm but that opinions at present are divided. The decision is yours to make based on clinical and ethical judgment as well as your specific legal and practical constraints.

The DAST-10 Drug Abuse Screening Test is a standard for drug abuse screening and can also be used to identify recipients who may benefit from training.

DAST-10 Drug Abuse Screening Test³⁷

³⁶ Centers for Disease Control. "Community-Based Opioid Overdose Prevention Programs Providing Naloxone — United States, 2010." *Morbidity and Mortality Weekly Report*. February 17, 2012 / 61(06); 101-105.

³⁷ Skinner HA. The Drug Abuse Screening Test. *Addictive Behavior*. 1982;7(4):363-371

Patient's Name:		Date:	
Drug Abuse Screening Test—DAST-10			
These Questions Refer to the Past 12 Months			
1	Have you used drugs other than those required for medical reasons?	Yes	No
2	Do you abuse more than one drug at a time?	Yes	No
3	Are you unable to stop using drugs when you want to?	Yes	No
4	Have you ever had blackouts or flashbacks as a result of drug use?	Yes	No
5	Do you ever feel bad or guilty about your drug use?	Yes	No
6	Does your spouse (or parents) ever complain about your involvement with drugs?	Yes	No
7	Have you neglected your family because of your use of drugs?	Yes	No
8	Have you engaged in illegal activities in order to obtain drugs?	Yes	No
9	Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	Yes	No
10	Have you had medical problems as a result of your drug use (eg, memory loss, hepatitis, convulsions, bleeding)?	Yes	No

Guidelines for Interpretation of DAST-10		
Interpretation (Each "Yes" response = 1)		
Score	Degree of Problems Related to Drug Abuse	Suggested Action
0	No problems reported	Encouragement and education
1-2	Low level	Risky behavior – feedback and advice
3-5	Moderate level	Harmful behavior – feedback and counseling; possible referral for specialized assessment
6-8	Substantial level	Intensive assessment and referral

Broaching the subject of training for an individual who has not requested naloxone should be sensitive. Follow your instincts, listen carefully, and remain non-judgmental at all times.

Tips for Motivational Interviewing

Motivational interviewing is a powerful technique that can improve the effectiveness of your clinical interventions. The best way to learn motivational interviewing is through in-person interactive training.

Free online training for nurse practitioners, created with federal support, can be obtained at <http://www.vhcf.org/for-those-who-help/resources-for-providers/nurse-practitioner-resources/motivational-interviewing/>. Motivationalinterview.org also provides free online instructor-led training at http://motivationalinterview.org/quick_links/mitraining.html.

Guide to motivational interviewing:

Miller and Rollnick (2012). *Motivational Interviewing: Helping People Change*. Third Edition. The Guilford Press: New York, New York.

Part of the motivational interviewing process involves asking trainees questions about their personal experiences and response to the module, listening, and responding. Prescribe to prevent recommends the following as part of the patient interview:

- “Where is the patient at as far as overdose?
 - Ask your patients whether they have overdosed, witnessed an overdose or received training to prevent, recognize, or respond to an overdose
- Overdose history:
 1. Have you ever overdosed?
 1. What were you taking?
 2. How did you survive?
 2. What strategies do you use to protect yourself from overdose?
 3. How many overdoses have you witnessed an overdose?
 1. Were any fatal?
 2. What did you do?
 4. What is your plan if you witness an overdose in the future?
 1. Have you received a Narcan rescue kit?
 2. Do you feel comfortable using it?”³⁸

Frequently Asked Participant Questions

Many of these questions are answered in the computer-based module. The below is a reference sheet in case participants still have questions.

1. **What if I can rouse the person and get them to breathe after doing a sternal rub? Do I still need naloxone?** No. If the victim is breathing adequately on his own, he does not need naloxone. But, if the victim is not breathing adequately, proceed immediately to administer naloxone and provide ventilation. It is important not to waste time if the victim is not getting enough oxygen on his own.
2. **What if the victim chronically uses pain relievers because she has a chronic medical condition like cancer or other pain source (e.g. back pain)?** Victims should be treated the same. If a victim cannot be aroused and is not breathing or has inadequate breathing, rescue breathing and naloxone are indicated. In these cases, the pain may return. But it is more important to save the person’s life than avoiding rebound pain.

³⁸ Prescribe to Prevent (2013). Expanding Prescription Access to Naloxone. Powerpoint presentation accessed at prescribetoprevent.org on Mar 14, 2014.

3. **Is intranasal naloxone as effective as intramuscular or intravenous naloxone?** It has similar effects (e.g. similar blood levels as IM and IV). While it is slightly slower to take effect, administration is quicker because IV access does not need to be obtained. Nasal administration also allows public safety personnel to avoid the risk of needle stick injury.
4. **What is the difference between naloxone and Narcan?** Naloxone is the generic name for Narcan. Narcan is a naloxone formulation.
5. **What should we do after administering naloxone?** Stay with the victim and monitor his or her breathing and responsiveness. Be prepared to deliver a second dose and rescue breathing.
6. **Can you administer naloxone if you don't know what drug(s)/medication(s) the person took?** Yes. Naloxone will not cause harm if it is given for a different type of overdose (e.g. stimulant, alcohol). In an opioid-associated overdose, usually you will see small (pinpoint) pupils and depressed breathing. If the overdose is not opioid-associated because it is a stimulant overdose, other signs will be present (racing heartbeat, sweating, hyperventilation, anxiety). Naloxone will not help in a stimulant or alcohol overdose (depressed breathing with dilated pupils, alcohol breath). But, if an overdose victim combined an opioid with stimulants or alcohol, the opioid is likely the cause of respiratory depression, and you can administer naloxone and save a life.
7. **What if the overdose victim does not have a pulse?**

An opioid-associated overdose can cause a victim's heart to stop. If the heart is not beating, the naloxone will not be circulated through the body, and will not help. In this situation, call 911, start CPR and follow the dispatcher's instructions. You can tell the dispatcher you know how to give rescue breaths and naloxone. Do not panic. You can still use the skills you have learned.
8. **If the person is not breathing, how will naloxone work?**

Some medications (like for asthma) need to make it into the lungs, but naloxone is absorbed by the nasal membranes, much like snorting a drug, so it is not necessary for the person to be breathing for the naloxone to work.
9. **Once an overdose has occurred, how much time is there to administer the naloxone?**

The naloxone has the potential to reverse the effects of the overdose at any point before the victim has a cardiac arrest due to hypoxia (decreased O₂ in the blood). However, the sooner the naloxone is administered, the more likely the victim will be saved and the less likely she or he will be to experience brain damage. As the saying goes, "time is brain."
10. **How long should we wait before administering a second dose of naloxone?** If there is no response, or limited response, give another dose in 3 minutes.

11. **Does it matter if a person overdosed on a prescription drug as opposed to heroin?** No. Both prescription and non-prescription opioids will be reversed by the naloxone. It is increasingly common that people are overdosing with prescription medications. Also, overdose victims can be first-time users of opioids or have not used opioids for a long time.
12. **Does naloxone work on somebody with a Fentanyl patch?** Yes. Be sure to remove the patch if it is applied to the skin. Fentanyl overdose victims may need multiple doses.
13. **What if we give the naloxone to someone who does not need it?** If the person has not taken an opioid, there will be no effect from the naloxone.
14. **Can you give naloxone if the person is seizing?** If the person is actively seizing, it is unlikely that they will be overdosing on an opioid. However, if they are not breathing and then begin to tremor or seize, it may be due to hypoxia (decreased oxygen in the blood) caused by the overdose. In short, you can give naloxone if a person is seizing.
15. **Is naloxone temperature-sensitive?** Yes, but not terribly so. It should be stored away from light and at “room temperature” as much as possible.
16. **What can we expect once the naloxone has reversed the overdose?** The victim may sit up quickly, gasp for air, be disoriented, confused or angry (he or she may be experiencing withdrawal symptoms) or they may simply appear to “wake up.” Withdrawal symptoms are a good sign that the medication has worked and they include shakiness, sweating, high blood pressure, fast heart rate, diarrhea, and discomfort. The victim should be reassured that these symptoms will be short lived because naloxone only lasts 30-90 minutes. In addition, signs of other drugs that the victim may have ingested may be more obvious (alcohol, cocaine, benzodiazepines).
17. **Can naloxone be abused?** Naloxone has no significant potential for abuse.

Support Line

Do you or your trainees have unanswered questions?

Please contact us at info@givenaloxone.org. Basic support may be free; more extensive or institutional support may require a fee. Please do not hesitate to contact us with questions you may have.

Do not use this email when immediate assistance is necessary or in case of medical emergency. Please call 911 or contact your medical director in these situations.

Additional Web Resources

Prescribing Information and Materials: Prescribe to Prevent

- [Prescribetoprevent.org](http://prescribetoprevent.org)

Harm Reduction Coalition

- <http://harmreduction.org/>

Project Lazarus

- <http://projectlazarus.org>

Overdose Prevention Alliance

- [Overdosepreventionalliance.org](http://overdosepreventionalliance.org)

Overdose Prevention Information

- http://www.networkforphl.org/_asset/qz5pvn/network-naloxone-10-4.pdf
- <http://www.mass.gov/eohhs/gov/departments/dph/programs/substance-abuse/prevention/opioid-overdose-prevention.html>
- learn2cope.org
- naloxoneinfo.org

SAMSHA Opioid Overdose Prevention Toolkit

- <http://store.samhsa.gov/product/Opioid-Overdose-Prevention-Toolkit/SMA13-4742>

National Substance Abuse Treatment Facility Locator

- www.findtreatment.samhsa.gov/TreatmentLocator

Buprenorphine Physician & Treatment Program Locator:

- www.buprenorphine.samhsa.gov/bwns_locator

State Substance Abuse Agencies:

- <http://findtreatment.samhsa.gov/TreatmentLocator/faces/>

Substance Abuse and Mental Health Services Administration SAMHSA Publications

- www.store.samhsa.gov

Centers for Disease Control and Prevention (CDC) Statistics

- www.cdc.gov/Features/VitalSigns/PainkillerOverdoses
- www.cdc.gov/HomeandRecreationSafety/Poisoning

White House Office of National Drug Control Policy (ONDCP) State and Local Information:

- www.whitehouse.gov/ondcp/state-map

American Association for the Treatment of Opioid Dependence (AATOD)

- www.aatod.org/

Providers' Clinical Support System for Opioid Therapies

- <http://pcss-o.org/archived-webinar-65>

Additional References

Appendix A- Sample collaborative agreements and protocols

Overdose Prevention and Narcan Program Self-Assessment Tools from SPHERE³⁹

³⁹ SPHERE Statewide Partnership for HIV Education in Recovery Environments (2012). Overdose Prevention Inventory. Accessed March 27, 2014.

<http://healthimperatives.org/sites/default/files/spiritweb/SPHERE%20OD%20Inventory-AOD%20RX%201-12.pdf>



Name _____ Program _____ Date _____

Overdose Prevention Inventory

Check if yes	Programmatic & Staff Activities
	Are all STAFF TRAINED on overdose, signs and symptoms, risk factors and response?
	Do we address overdose history in our INTAKE forms?
	Do we SCREEN every client/program participant for overdose (OO) risks?
	Do we ASK CLIENTS/PROGRAM PARTICIPANTS if they have survived an overdose?
	Do we ASK CLIENTS/PROGRAM PARTICIPANTS if they have witnessed an overdose?
	Do we have EDUCATIONAL MATERIALS (brochures, fact sheets) for clients/program participants on overdose in languages that they can read/understand?
	Do we have EDUCATIONAL MATERIALS (brochures, fact sheets) for clients/program participants on Narcan in languages that they can read/understand?
	Do we have POSTERS up about preventing or responding to an overdose?
	Do we talk about the risk of overdose WHEN PEOPLE LEAVE the program?
	Do we TALK TO CLIENTS/PROGRAM PARTICIPANTS about the availability of narcan?
	Do we offer a NARCAN REFERRAL ?
	Do we offer training to our staff to become NARCAN RESPONDERS ?
	Do we offer training to our clients/program participants to become NARCAN RESPONDERS ?
	Do we know if our LOCAL POLICE accompany every EMS call?
	Do we discuss or incorporate overdose prevention IN GROUPS ?
	Do we integrate overdose prevention and reversal into our DISCHARGE PLANNING ?
	Do we integrate overdose prevention and reversal into our RELAPSE PREVENTION PROGRAM ?
	Have we talked with our clients/program participants about WHAT TO DO if they're WITH SOMEONE who is overdosing?
	Has program STAFF received TRAINING on OVERDOSE PREVENTION AND REVERSAL ?
	Other (please specify):

SPHERE'S Overdose Prevention Training Initiative, a program of Health Imperatives
www.healthimperatives.org/sphere



Statewide Partnership for Opioid Education, Recovery, and Treatment • Opioid Inequities Grant

Name _____

Date _____

Narcan & Overdose Reversal Inventory

Check if yes	Programmatic & Staff Activities
	Do we SCREEN every client/program participant for overdose (OU) risks?
	Do we TALK about overdose prevention and reversal with clients/program participants?
	Do we incorporate overdose prevention and reversal education into INDIVIDUAL CLIENT EDUCATION ?
	Do we incorporate overdose prevention and reversal education into GROUP CLIENT EDUCATION ?
	Do we have EDUCATIONAL MATERIALS (brochures, fact sheets) for clients/program participants on Narcan/rescue breathing?
	Do we have POSTERS up about reversing an overdose and administering Narcan/rescue breathing?
	Do we offer a NARCAN REFERRAL ?
	Do we offer a NARCAN responder training for clients/program participants?
	Do we offer a NARCAN responder training for staff?
	Do we offer a rescue breathing training for clients/program participants?
	Do we integrate overdose prevention and reversal into our DISCHARGE PLANNING ?
	Do we integrate overdose prevention and reversal into our RELAPSE PREVENTION PROGRAMMING AND SUPPORT ?
	Do we REFER to a SYRINGE EXCHANGE program?
	Do we make sure that clients/program participants know about SYRINGE ACCESS in pharmacies?
	Has STAFF received TRAINING on overdose prevention and narcan?
	Has STAFF received HARM REDUCTION TRAINING ?
	Has STAFF received REFERRAL CAPACITY TRAINING ?
	Am I trained and enrolled as a NARCAN RESPONDER ?
	Other (please specify): _____

SPHERE's Overdose Prevention Training Initiative, a program of Health Imperatives
www.healthimperatives.org/ophot

Massachusetts OEND Client Enrollment Form⁴⁰

⁴⁰ Walley, Alexander Y.. Bystander Overdose Education and Naloxone Distribution in Massachusetts.

Presentation given April 20, 2012. Accessed March 27, 2014.
<http://www.fda.gov/downloads/Drugs/NewsEvents/UCM300869.pdf>.

Date: 05/19/2011 Site: [03] Location: [05]

13823

Overdose Prevention & Narcan Enrollment Form

ALL PARTICIPANTS: What is the zip code where the overdose lives? [redacted] Other: M/F Other

How many times have you witnessed an overdose in your life? (Write in the NUMBER. Never = 0)

During the last thirty (30) days, did you use any of the following substances? (Write in the NUMBER of days used. No use in past 30 days = 0)

Heroin	# 30
Methadone	# 00
Suboxone/Subutex / buprenorphine	# 00
Benzos/Barbiturates (Klonopin, Xanax, Ativan, Valium, Librium, Phenobarbital, Fiorinal, etc)	# 15
Clonidine	# 00
Cocaine/Crack	# 15
Alcohol	# 00
Methamphetamine	# 00
Any other opioid (Percocet, OxyContin, Oxycodone, Vicodin, Darvocet, Fentanyl, etc)	# 00
Other:	# 00

STAFF ASSESSMENT OF ACTIVE/INACTIVE ONLY:
Is client interested in referral to treatment? Not/Not Appropriate Yes, but not

Notes/Comments:

ver 1.5 03/09/2010 Page 1 of 2

Massachusetts OEND Report-Back and Refill Form⁴¹

Date: 10/25/2011 Site: [03] Location: [05]

35936

Overdose Report-Back & Narcan Refill Form

Regarding the overdose experience: Date of Overdose: [10/25/2011]

Who overdosed? (check one) Friend Partner Client Self Family Stranger

Gender of the person who overdosed? Female Male M/F F/M Unknown

Overdosed on what drugs? (check all that apply) Heroin Benzos/Barbiturates Cocaine/Crack Methadone Suboxone Any other Opioid Alcohol

What setting did it occur in? Private (apt/house) Public (park, subway, bathroom, car, hospital)

Did the person live? Yes No Don't know

Was 911 called? Yes No Don't know

Were Police/EMTs/Firefighters present? Yes No Don't know

If YES, was the interaction: Positive Neutral Negative

Did you stay with the person until the Narcan wore off and/or the person got medical attention? Yes No

What else was done? (check all that apply) Sips Ice/Water Salt/Cocaine shot Recovery Position Other: Sternal/Lip Rub Rescue Breathing → If Yes, was a barrier used? Yes No Don't know

Copyright © 2010: All rights reserved. For more information, contact the author's Web site at: www.op.nysed.gov/prof/nurse/np-sample-collaborative-agreement.pdf. Accessed March 14, 2014.

New York State- Sample NP/MD Collaborative Practice Agreement⁴²

(Sample) Collaborative Practice Agreement

This agreement sets forth the terms of the Collaborative Practice Agreement between (nurse practitioner and specialty as listed on the State issued certificate) and (name of collaborating physician and specialty if any) at (name and address of agency or entity where practice takes place). This agreement shall take effect as of (date).

Introduction

(YOUR NAME RN, NP) meets the qualifications and practice requirements as stated in Chapter 257 of the Laws of 1988 and Article 139 of the Education Law of New York State, holds a New York State license and is currently registered as a registered professional nurse in good standing, holds a certificate as a nurse practitioner pursuant to Sec. 6910 of the Education law and herein meets the requirement of maintaining a collaborative practice agreement with (NAME OF COLLABORATOR, MD/DO) a duly

⁴¹ See footnote 40.

⁴² New York State Department of Education. Sample Collaborative Agreement. <http://www.op.nysed.gov/prof/nurse/np-sample-collaborative-agreement.pdf>. Accessed March 14, 2014.

licensed and currently registered physician in good standing under Article 131 of the New York State Education Law.

I. Scope of Practice

The practice of a registered professional nurse as a nurse practitioner may include the diagnosis of illness and physical conditions and the performance of therapeutic and corrective measures including prescribing medications for patients whose conditions fall within the authorized scope of the practice as identified on the college certificate. This privilege includes the prescribing of all controlled substances under a DEA number. The nurse practitioner, as a registered nurse, may also diagnose and treat human responses to actual or potential health problems through such services as case finding, health counseling, health teaching, and provision of care supportive to or restorative of life and well-being. This practice will take place at (above identified agency) or in such other facility or location as designated by (name of identified agency) or by the parties of this contract. The following exceptions to the certified scope of practice have been agreed upon by the undersigned parties: (list exception(s)).

II. Practice Protocols

The protocols used in this (identify specialty as listed on State issued certificate) practice are contained in (name approved protocol text with all bibliography citations) and in (cite location of any other protocols which are germane to this particular practice).

III. Physician Consultation

The parties shall be available to each other for consultation either on site or by electronic access including but not limited to telephone, facsimile and email. Each party will cover for the other in the absence of one of them or (names of third parties) who are designated by (YOUR NAME, RN, NP and NAME OF COLLABORATOR MD/DO) as appropriate for coverage in the absence of both parties. In the event that there is an unforeseen lack of coverage, patients will be referred to the appropriate emergency room.

IV. Record Review

A representative sample of patient records shall be reviewed by the collaborating physician every three months to evaluate that (name of NP)'s practice is congruent with the above identified practice protocol documents and texts. Summarized results of this review will be signed by both parties and shall be maintained in the nurse practitioner's practice site for possible regulatory agency review. Consent forms for such review will be obtained from any patient whose primary physician is other than (name of collaborating physician).

V. Resolution of Disagreements

Disagreement between (name of nurse practitioner) and (name of collaborating physician) regarding a patient's health management that falls within the scope of practice of both parties will be resolved by a consensus agreement in accordance with current medical and nursing peer literature consultation. In case of disagreements that cannot be resolved in this manner, (name of collaborative physician's) opinion will prevail. In disagreements between the nurse practitioner and non-collaborating physicians, the collaborating physician's opinion will prevail.

VI. Alteration of Agreement

The collaborative practice agreement shall be reviewed at least annually and may be amended in writing in a document signed by both parties and attached to the collaborative practice agreement.

VII. Agreement

Having read and understood the full contents of this document, the parties hereto agree to be bound by its terms.

Nurse Practitioner

(Specialty)

:

Printed Name _____ RN license # _____

Certificate # _____

Signature _____ Date _____

Collaborating Physician

:
Printed Name _____ MD license # _____
Board Certification _____
Signature _____ Date _____

University of Rhode Island College of Pharmacy-

Collaborative Agreement Enabling Distribution By Those Other Than the Provider

NALOXONE PROTOCOL
A COLLABORATIVE PRACTICE AGREEMENT FOR OPIOID OVERDOSE PREVENTION
AND RESPONSE

Purpose: To reduce morbidity and mortality from opioid overdose.

Policy: Under this collaborative practice agreement, eligible pharmacists who have completed certificate training program in opioid overdose prevention (CE program) and are CPR certified, may initiate naloxone and educate patients based on the criteria below.

Continuing Education (CE) in the area of practice covered by the agreement may include any of the following areas related to the safe prescribing of opioids:

- Opioid overdose prevention
- Reducing the risk of prescription opioid abuse
- The safe use of opioids for the management of chronic pain
- The use of screening tools to detect opioid abuse or dependency, specialist referrals and management of difficult patients
- Preventing diversion of prescribed opioid medications
- Treating patients with pain and addiction
- Naloxone administration technique
- Review of collaborative practice agreement

Procedure:

1. **Pharmacists listed below** will identify patients eligible for participation, meeting any of the criteria of overdose risk:
 - a. Voluntary request
 - b. Recipient of emergency medical care for acute opioid poisoning
 - c. Suspected illicit or nonmedical opioid user
 - d. High dose opioid prescription (>100 morphine equivalence per day)
 - e. Any methadone prescription to opioid naïve patient
 - f. Any opioid prescription and smoking/COPD or other respiratory illness or obstruction
 - g. Any opioid prescription for patients with renal dysfunction or hepatic disease
 - h. Any opioid prescription and known or suspected concurrent alcohol use
 - i. Any opioid prescription and concurrent benzodiazepine prescription
 - j. Any opioid prescription and concurrent SSRI or TCA anti-depressant prescription
 - k. Release prisoners from correctional facilities
 - l. Release from opioid detoxification and mandatory abstinence program
 - m. Patients entering methadone maintenance treatment programs (for addition or pain)
 - n. Patients may have difficulty accessing emergency medical services
2. Pharmacists will be allowed to initiate naloxone prescriptions if patient meets criteria above:

- a. Naloxone HCl (Narcan® or generic equivalent) will be dispensed for intramuscular administration (standard naloxone concentration of 0.4mg/mL).
 - i. The preferred container type is 1mL single dose flip-top vials, but 10mL multi-dose flip-top vial, or 2mL Carpujet Luer Lock glass syringes without needles may also be dispensed.
 - ii. If 1mL vials or Carpujet Luer Lock syringes are dispensed, the patient should receive a total of at least 2mL, strongly recommend a total of 4 mL.
 - iii. The total amount of naloxone dispensed per patient is not to exceed 10mL.
 - b. The recommended dose of Naloxone to be used in the event of an overdose is 1-3mL, administered in increments of 1mL
 - c. Naloxone must have a shelf life of at least 12 months at time of dispensing
 - d. At least 2 IM syringes (recommended 4) must be sold with naloxone for intramuscular administration
 - i. Syringes will be equipped with a 1-1.5", 21-23 gauge needle, with a syringe capacity of 1-3mL
 - e. At least 1 MAD Nasal Drug Delivery Device must be sold with naloxone for intranasal administration
 - f. Before dispensing naloxone, the pharmacist shall ensure that patients are properly trained in over opioid overdose recognition, response, and naloxone administration
3. Pharmacists will provide patient education on the following:
 - a. Purpose for Naloxone, correct way to administer Naloxone, precautions regarding medications that may interact with Naloxone.
 - b. High-risk overdose situations, risk reduction strategies, and appropriate response sets in addition to Naloxone administration, including rescue breathing and call 911.
 - c. Review indications for use and naloxone administration upon re-fill
 4. Pharmacists will document each patient's participation information by the following:
 - a. Record the date the prescription was dispensed, the manufacturer and lot number, and the name and title of the person providing mediation and education.
 - b. The pharmacist shall provide written notification via fax to medical provider listed on collaborative agreement of patient participation and/or naloxone dispensing within seven (7) days and will maintain records for a minimum of 5 years.
 - c. Contact the medical provider listed on collaborative agreement in the event that the pharmacist requires medical consultation for a particular patient
 - d. The pharmacy will retain a copy of the consent form, re-fill form, and a log of monthly activity, which will be reviewed by OD program staff and the collaborating physician on a monthly basis.
 5. The collaborating medical provider may override a collaborative practice decision made by the pharmacist, if appropriate and/or in the best interest of the patient.
 6. Both parties shall maintain a copy of licensing and liability insurance information in their respective records for both the pharmacists and physician named below.
 7. Either party may cancel the agreement by written notification.

This policy and procedure shall remain in effect until rescinded or for 2 years after the effective date.

Effective date of implementation: _____

Signatures:

Physician or Medical Provider

Date

Pharmacist Signatures and Settings (Store Locations):

Pharmacist - Store Name

Date

Address _____

City _____

Pharmacist - Store Name

Date

Address _____

City _____

Pharmacist - Store Name

Date

Address _____

City _____

Pharmacist - Store Name

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Pharmacist - Store Name

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Pharmacist - Store Name

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Address _____

City _____

Pharmacist - Store Name

Date

Address _____

City _____

Proof of liability insurance will be included for above signatories in the appendix to this document.



Policy and Procedure Manual

Policy #:	13.09.45
Issued:	Sept. 2013
Reviewed/ Revised:	
Section:	Pharmacy

Intranasal Naloxone Kit Discharge Order Protocol

Purpose:

To establish a Standing Discharge Order Protocol and dispensing procedure for Nasal Naloxone Kit Discharge Prescriptions in the BMC Emergency Department.

Policy Statement:

This protocol allows for Nasal Naloxone Kits to be ordered by licensed personnel for patients *at risk for opioid overdose* who are being discharged from the BMC Emergency Department. Under the protocol, BMC Inpatient Pharmacy is granted authority to dispense Nasal Naloxone Kits as a discharge prescription when the BMC Outpatient Pharmacies are closed. BMC waives the payment for these prescriptions.

Application:

All Pharmacy and Emergency Department (ED) staff

Exceptions:

None

Procedure:

Background

- The Massachusetts Department of Public Health (DPH) approves community programs to provide overdose education and naloxone distribution services and train potential witnesses to an overdose in accordance with their guidelines.
- The Project Assert program (sponsored by the Boston Public Health Commission), is an example of a community-based program. When a Project Assert team member is on-duty in the ED, patients are enrolled in the program and provided with Nasal Naloxone Kits obtained from the Project Assert supply.
- Intranasal naloxone rescue kits can be prescribed via a regular outpatient prescription by any licensed prescriber to a patient who is at risk for an overdose regardless of the provider's or patient's enrollment in a DPH program.
 - Prescriptions may be sent to BMC's outpatient pharmacies for filling during normal business hours.

Section: Pharmacy
Policy: 13.09.45
Title: Intranasal Naloxone Kit Discharge Order Protocol

⁴³ Boston Medical Center (2013). Naloxone Discharge Kit Order Protocol. Accessed March 27 2014. http://prescribetoprevent.org/wp-content/uploads/NaloxoneKitDischargeOrderProtocol_091313.pdf

- The establishment of this Protocol augments the services provided in community-based pilot programs for patients admitted to the ED at BMC, but is not a part of Project Assert or any other DPH approved pilot program.

Protocol

1. When Project Assert is unavailable and the outpatient pharmacies are closed, a nurse or physician may fax a Discharge Prescription for Nasal Naloxone Kit Standing Order to the inpatient pharmacy for a patient who is at risk for opioid overdose.
 - o The Discharge Prescription form will be placed in the patient's medical record.
 - o Under this protocol, prescriptions are considered to be signed by Alexander Walley, MD (the requirement for an actual signature is waived).
2. At risk patients in the following groups may be prescribed an intranasal naloxone rescue kit:
 - Received emergency medical care involving opioid intoxication or poisoning
 - Suspected history of substance abuse or nonmedical opioid use
 - Prescribed methadone or buprenorphine
 - Receiving an opioid prescription for pain:
 - o higher-dose (>50 mg morphine equivalent/day)
 - o rotated from one opioid to another because of possible incomplete cross tolerance
 - o Smoking, COPD, emphysema, asthma, sleep apnea, respiratory infection, or other respiratory illness or potential obstruction.
 - o Renal dysfunction, hepatic disease, cardiac illness, HIV/AIDS
 - o Known or suspected concurrent alcohol use
 - o Concurrent benzodiazepine or other sedative prescription
 - o Concurrent antidepressant prescription
 - Patients who may have difficulty accessing emergency medical services (distance, remoteness)
 - Voluntary request from patient or caregiver
3. The inpatient pharmacy will prepare a Nasal Naloxone Kit containing:
 - Two Naloxone 1mg/ml 2ml luer-lock prefilled syringes
 - Two mucosal atomization devices (MAD300)
 - Risk factor information and assembly directions
 - o DPH Opioid Overdose and Prevention Programs Information Sheets
 - o Step-by-step instructions for administration of nasal naloxone
 - o "Get the SKOOP" information pamphlet from DPH
4. Each kit shall be labeled in accordance with MA Board of Pharmacy standards, including the phone number for the BMC Outpatient Pharmacy at Shapiro.
5. The kit will be sent via pneumatic tube to the ED for the nurse to provide to the patient.

6. Each kit contains educational material for the patient. The nurse or prescriber should educate patients about the risks of opioid-related overdose, how to reduce them and the importance of seeking help by calling 911 in the setting of a suspected overdose.

Responsibility:

Emergency Medicine Staff, Nursing and Medical-Dental Staff, Pharmacy

Forms:

Order Form:

- BMC ED Discharge Prescription for Nasal Naloxone Kit

Pharmacy Label

- Print from Centricity using the Free Format label

Patient Education Materials:

- Naloxone_Instruction-Sheet_110112.pdf also see <http://www.prescribeprevent.org/wp-content/uploads/2012/11/naloxone-one-pager-in-nov-2012.pdf>
- DPH-Info_Opioid-Overdose-Prevention-Programs_020413.pdf also see <http://www.mass.gov/eohhs/docs/dph/substance-abuse/naloxone-info.pdf>
- "Get the SKOOP" pamphlets are available from Massachusetts DPH 617-624-5111.

Related Policies:

Section:

Policy No.:

Title:

Initiated by: Pharmacy

Contributing Departments:

1. Medicine
2. Emergency Department

Section: Pharmacy

Policy: 13.09.45

Title: Intranasal Naloxone Kit Discharge Order Protocol

Appendix B- Current Naloxone Training Programs

A running list of current naloxone programs may be obtained at:

<http://overdoseprevention.blogspot.com/p/od-prevention-program-locator.html>.

Some examples and contact information:

Community centers/community outreach

Tapestry Health, Florence, MA, tapestryhealth.org, (413) 586-2016

Support groups (Narcotics Anonymous, etc.) and friends/family support groups (NarAnon, etc.)

Learn to Cope, Randolph, MA

Syringe access programs:

Prevention Point Pittsburgh (PPP), Pittsburgh, PA, pppgh.org, (412) 247-3404

Vermont CARES Needle Exchange Program, Saint Johnsbury, VT, vtcares.org, (802) 748-9061

Detox facilities

Long Beach Medical Center, Long Beach, NY, lbmc.org, (516) 897-1082

Homeless Shelters

Project Renewal, New York, NY, projectrenewal.org, (212) 620-0340

Jails and prisons

Nassau Intimate Advocacy Group (NIAG), Hempstead, NY, <https://www.facebook.com/pages/nassau-inmate-advocacy-group>

Inmate specific program advice: <http://www.fda.gov/downloads/Drugs/NewsEvents/UCM300868.pdf>.

Street corners

Safe Horizon Streetwork, New York, NY, safehorizon.org, 1.800.621.HOPE

Street Outreach Supporters (SOS), San Francisco, CA, shootclean.org, (831) 239-0657

Home visits/mobile crisis teams

Mobile Medical Office, Eureka, CA, mobilemed.org, 707-443-1186

AIDS coalitions

Massachusetts AIDS Action Committee, Roxbury, MA, aac.org, (800) 235-2331

AIDS Project Worcester, Worcester, MA, aidsprojectworcester.org, (508) 755-3773

Behavioral treatment centers

Lahey Health Behavioral Services, Lawrence, MA, nebhealth.org, 877.255.1261

Methadone clinics and drug treatment programs

S.K.O.O.P. <http://harmreduction.org/our-work/overdose-prevention/new-york-skoop/>

New York, NY, (212) 213-6376

Oakland, CA (510) 444-6969

Inpatient settings (hospitals)

Preventing Overdose and Naloxone Intervention, The Miriam Hospital, Providence, RI 401.455.6879

Emergency Departments

Metro Health Cleveland, Cleveland, OH, metrohealth.org, (216) 778-7800

Denver Health, Denver, CO, denverhealth.org, (303) 436-6000

Boston Medical Center, Boston, MA, bmc.org, 617.638.6841

Outpatient settings (walk-in clinics, primary care):

Project Lazarus, Wilkes County, North Carolina, projectlazarus.org, (336) 667-8100

Good Neighbor Health Clinic, Burlington, VT, goodneighborhealthclinic.org, (802) 295-1868

The Free Medical Clinic of Greater Cleveland, Cleveland, OH, thefreeclinic.org, (216) 778-2100

Pain clinics

MaineGeneral Health, Augusta, ME, mainegeneral.org, 1-855-4MGHINFO (1-855-464-4463)

Pharmacies

Walgreen's of Rhode Island, Warwick, RI, walgreens.com, (401) 739-1732

Schools

Impact Quincy, Quincy, MA, quincypublicschools.com/blog/2013/09/16/quincy-schoolcommunity-partnership-profile-baystate-community-servicesimpact-quincy/ 617.471.8400 x189

Appendix C- Patient Education Materials

American Society of Anesthesiologists: Opioid Overdose Resuscitation Card⁴⁴

⁴⁴ American Society of Anesthesiologists (2013). *Opioid Overdose Resuscitation Card*. Accessed at <http://www.asahq.org/WhenSecondsCount/resources>.

OPIOID OVERDOSE RESUSCITATION

Symptoms of an overdose:

1. Slow and shallow breathing.
2. Very sleepy and unable to talk, or unconscious.
3. Skin color is blue or grayish, with dark lips and fingernails.
4. Snoring or gurgling sounds.

If there are symptoms of an overdose:

1. Lightly tap, shake, and shout at the person to get a response.
If there is still no response, rub knuckles on the breast bone.
2. If the person responds, keep them awake.
3. Call 911.

If you get little or no response:

1. Call 911.*
2. If their breathing is shallow or non-existent, or if the skin color is blue or grayish, with dark lips and fingernails, perform mouth-to-mouth rescue breathing by tilting head back and lifting up chin until mouth opens, clearing airway. Give two quick breaths to start and then a strong breath every 5 seconds.
3. If the person no longer has a heartbeat (pulse), continue to perform rescue breathing. Perform CPR by pushing hard on the chest bone at a rate of 100 times per minute.
4. Stay with the person. If you have to leave the person alone or vomiting occurs, place the person in the recovery position – on their side, hand supporting the head, mouth facing downward, and leg on the floor to keep the person from rolling onto stomach.

**If you have access to naloxone (also called Narcan – a medication that can rapidly reverse the overdose of opioids), administer it according to the package instructions, in addition to calling 911.*



Perform mouth-to-mouth rescue breathing.



Perform chest compressions.



Place the person in the recovery position.

If you or a family member is facing a substance abuse or mental health issue, call the Substance Abuse and Mental Health Services Administration at 1-800-662-HELP (4357).

American Society of
Anesthesiologists® 

Prescribe to Prevent.org, How to Respond to An Overdose

How to prevent an OVERDOSE.

- **Start at a lower dose or do a test shot** if you haven't used in a while (because in hospital, jail, or detox). Your body is not used to the same amount as before.
- **Don't use alone** (no one can help you).
- **Don't mix drugs** like benzos, alcohol and opioids* like heroin.
- **Talk with friends and family** about responding to an overdose.

***Opioids include:** Heroin, methadone, and pain pills (prescribed to you or not).

Is someone having an OVERDOSE?

If a person has **any** of these signs **and can't respond to you**, they are having an overdose. An overdose usually happens 1 to 3 hours after a person has used.

First, look for these things:

- **Heavy nodding**
- **No response when you yell person's name or rub the middle of the chest hard**
- **Blue lips or blue fingertips**
- **Slow breathing (less than 1 breath every 5 seconds) or no breathing**
- **Very limp body and very pale face**
- **Choking sounds or a gurgling, snoring noise**

What to do for an overdose:

1. Try to wake person up by yelling their name and rubbing the middle of the chest hard.
2. Call 911 right away. Give the address and say your friend is not breathing.
3. Try rescue breathing (see below).
4. Use Narcan if you or someone else has it, may need more than one dose (see back of card).
5. Put the person on their side so they don't choke.
6. Stay until the ambulance arrives (this is best), or leave the door open.

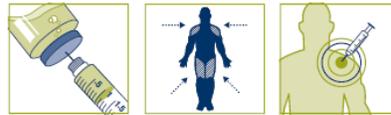


RESCUE BREATHING

- | | | |
|---|---|--|
| ① | ② | ③ |
| Make sure nothing is in person's mouth. | Tilt their head back, lift chin, pinch nose shut. | Give 1 slow breath every 5 seconds until they start breathing. |

Naloxone/Narcan works for OPIOIDS only.

Intramuscular administration:



Inject 1cc/mL in large muscle.

Intranasal administration:



Screw parts together. Use one full vial. Spray half in each nostril.

Overdose help and resources:

Poison Control
1-800-222-1222

Naloxone for Overdose Prevention

patient name _____

date of birth _____

patient address _____

patient city, state, ZIP code _____

Rx _____
prescriber name

prescriber address _____

prescriber city, state, ZIP code _____

prescriber phone number _____

Naloxone HCl 0.4 mg/mL (Narcan)
1 x 10 mL as one flip-top vial (NDC 0409-1219-01) OR
2 x 1 mL single dose vials (NDC 0409-1215-01)

Refills: _____

Intramuscular (IM) syringe, 23 G, 3cc, 1 inch

Qty: _____ Refills: _____

Sig: For suspected opioid overdose,
inject 1mL IM in shoulder or thigh.
Repeat after 3 minutes if no or minimal response.

prescriber signature _____

date _____

Dienach for patient



Are they breathing?

Signs of an overdose:

- Slow or shallow breathing
- Gasping for air when sleeping or weird snoring
- Pale or bluish skin
- Slow heartbeat, low blood pressure
- Won't wake up or respond (rub knuckles on sternum)

How to Avoid Overdose

- Only take medicine prescribed to you
- Don't take more than instructed
 - Call a doctor if your pain gets worse
- Never mix pain meds with alcohol
- Avoid sleeping pills when taking pain meds
- Dispose of unused medications
- Store your medicine in a secure place
- Learn how to use naloxone
- Teach your family + friends how to respond to an overdose



Call 911 for help

All you have to say:
"Someone is unresponsive and not breathing."
Give clear address and location.



Airway

Make sure nothing is inside the person's mouth.



Rescue breathing

Oxygen saves lives. Breathe for them.
One hand on chin, tilt head back, pinch nose closed.
Make a seal over mouth & breathe in 1 breath every 5 seconds
Chest should rise, not stomach.



Evaluate

Are they any better? Can you get naloxone and prepare it quickly enough that they won't go for too long without your breathing assistance?



Prepare naloxone

- Remove cap from naloxone and uncover needle
- Insert needle through rubber plug, with bottle upside down
- Pull back on plunger and take up 1 cc into the syringe
- Don't worry about air bubbles (they aren't dangerous in muscle injections)



Muscular injection

Inject 1cc of naloxone into a big muscle (shoulder or thigh)



Evaluate + support

- Continue rescue breathing
- Give another shot of naloxone in 3 minutes if no or minimal breathing or responsiveness
- Naloxone wears off in 30-90 minutes
- Comfort them; withdrawal can be unpleasant
- Get them medical care and help them not use more opiate right away
- Encourage survivors to seek treatment if they feel they have a problem

For More Info
PrescribeToPrevent.com

Poison Center
1-800-222-1222
(free & anonymous)

v01.2012.1

Naloxone for Overdose Prevention

patient name _____

date of birth _____

patient address _____

patient city, state, ZIP code _____

Rx _____
prescriber name

prescriber address _____

prescriber city, state, ZIP code _____

prescriber phone number _____

Naloxone HCl 1 mg/mL
2 x 2 mL as pre-filled Luer-Lock needless syringe
(NDC 78329-3369-1)

Refills: _____

2 x Intranasal Mucosal Atomizing Device (MAD 300)

Refills: _____

For suspected opioid overdose, spray 1mL in each nostril.
Repeat after 3 minutes if no or minimal response.

Pharmacist: Call 1-800-788-7999 to order MAD 300.

prescriber signature _____

date _____

How to Avoid Overdose <ul style="list-style-type: none"> • Only take medicine prescribed to you • Don't take more than instructed 	<ul style="list-style-type: none"> • Call a doctor if your pain gets worse • Never mix pain meds with alcohol • Avoid sleeping pills when taking pain meds 	<ul style="list-style-type: none"> • Dispose of unused medications • Store your medicine in a secure place • Learn how to use naloxone 	<ul style="list-style-type: none"> • Teach your family + friends how to respond to an overdose
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Are they breathing? → **Call 911 for help**

Signs of an overdose:

- Slow or shallow breathing
- Gasp for air when sleeping or weird snoring
- Pale or bluish skin
- Slow heartbeat, low blood pressure
- Won't wake up or respond (rub knuckles on sternum)

All you have to say:
"Someone is unresponsive and not breathing."
Give clear address and location.

Airway → **Rescue breathing**

Make sure nothing is inside the person's mouth.

Oxygen saves lives. Breathe for them.
One hand on chin, tilt head back; pinch nose closed.
Make a seal over mouth & breathe in 1 breath every 5 seconds.
Chest should rise, not stomach.

Prepare Naloxone

Are they any better? Can you get naloxone and prepare it quickly enough that they won't go for too long without your breathing assistance?

PrescribeToPrevent.org

1 Put or pry off yellow caps

2 Pry off red cap

3 Clip clear plastic wings

4 Gently screw capsule of naloxone into barrel of tube

5 Insert white cone into nostril; give a short, vigorous push on end of capsule to spray naloxone into nose; one half of the capsule into each nostril

6 If no reaction in 3 minutes, give the second dose

Source: HarmReduction.org

Evaluate + support

- Continue rescue breathing
- Give another 2 sprays of naloxone in 3 minutes if no or minimal breathing or responsiveness
- Naloxone wears off in 30-90 minutes
- Comfort them; withdrawal can be unpleasant
- Get them medical care and help them not use more opioids right away
- Encourage survivors to seek treatment if they feel they have a problem

POISON HELP
1-800-222-1222
AAPCC

©2012/11

Spanish Language Pamphlet from the D.O.P.E. Project⁴⁵

⁴⁵ The D.O.P.E. Project (2013). *Opiato: Sobredosis, Prevencion, y Sobrevivencia*. Accessed at http://harmreduction.org/wp-content/uploads/2011/12/naloxonebrochure_spanish.pdf.

La Sobredosis es más común cuando:

- ✗ Tu tolerancia esta baja. Si dejas de usar heroína o metadona durante un tiempo, estuviste en la cárcel o en un programa de desintoxicación tu tolerancia baja y tu cuerpo no puede tolerar la cantidad que antes toleraba.
- ✗ Cuando mezclas drogas, especialmente la mezcla de heroína con otros depresivos como alcohol o clonopina.
- ✗ Cuando usas solo y no hay nadie que se ocupe de ti, al perder el conocimiento.

Señales de advertencia de una sobredosis de Heroína:

- ✗ El ruido y el dolor no despiertan a la persona. Trata de despertarla gritándole su nombre o la palabra "Narcas", sacúdela por los hombros, apriétale la punta de los dedos o frótale los nudillos sobre el esternón.
- ✗ Labios y uñas azules o pálidas.
- ✗ Lento (menos de un respiro de cada cinco segundos) o respiración superficial.
- ✗ Sonidos como de ahogo.
- ✗ Vómitos.

Si la persona esta consciente, pero no puede hablar, intenta mantenerla despierta.

MÁS INFORMACIÓN

Prevención de Sobredosis
Llame gratis al teléfono:
1-866-786-7637

Tratamiento de Drogadicción en California
Llame gratis al teléfono:
1-800-879-2772 o
1-800-862-4357

Tratamiento y Prueba para el VIH en California
Llame gratis al teléfono:
1-800-387-2437
TDD 1-888-225-2437

D.O.P.E. PROJECT

Proyecto sobre la prevención y educación sobre la sobredosis es un programa de la Coalición para la Reducción de Daño.



1440 Broadway, Suite 510
Oakland, CA 94612
510-444-8989 x 16
dope@harmreduction.org
www.harmreduction.org

OPIATO: SOBREDOSIS, PREVENCIÓN Y SOBRE VIVENCIA

¿tienes naloxone?

got naloxone?



MIENTRAS ALGUIEN SUFRE UNA SOBREDOSIS... ACUERDATE DE LO SIGUIENTE:

Estimulación

- ✗ Intenta despertarle llamando su nombre, grita "Narcas", (conmociónale), pellizca sus dedos, o frota su esternón con tus nudillos.



Llama al 911

- ✗ Si no responde al ruido o dolor, llama al 911. Si tienes que dejar la persona sola, mientras haces la llamada, ponla en posición de recuperación.*
- ✗ Da una dirección o ubicación.
- ✗ Explica que "La persona esta inconsciente y sin respiración."
- ✗ No tienes que decir que drogas estan involucradas hasta que llegue la ambulancia.



Respiración

- ✗ Asegurate que no tenga un bloqueo en la vía respiratoria, luego observa el pecho y pon tu mejilla sobre su nariz y boca para sentir su respiración.



Respiración Artificial

- ✗ Si no esta respirando por lo menos un respiro cada cinco segundos, inclina la cabeza hacia atrás, apriétale la nariz cerrada, y sopla lentamente en su boca una vez cada cinco segundos hasta que lleguen los paramédicos. Vigila que su pecho sube y baja con cada respiro.



Evaluar

- ✗ ¿Esta mejor?
- ✗ ¿Tienes acceso a naloxone, (Narcas) y puedes prepararlo rápido para que no este sin respiración artificial por demasiado tiempo?



Inyección Muscular

- ✗ Prepara el naloxone e inyéctalo directamente a un músculo (ante brazo, nalga, o muslo).
- ✗ Sigue con las respiraciones artificiales hasta que el naloxone funcione o lleguen los paramédicos.



Evaluar y Apoyar

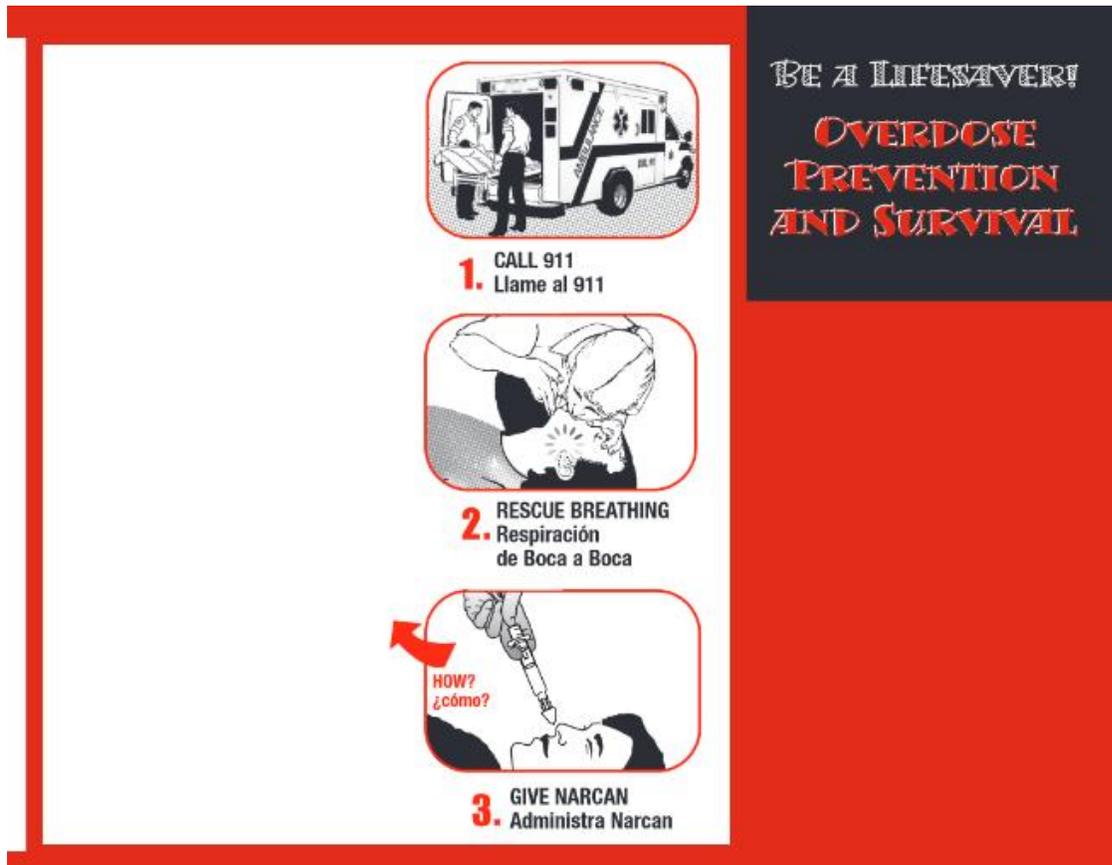
- ✗ ¿Puede respirar sin ayuda?
- ✗ Si la primera inyección no funciona después de 4 minutos, dale una segunda dosis de naloxone.
- ✗ Los efectos de naloxone pasan después de 30-90 minutos.
- ✗ Consuela a la persona - el/ella estará sintiendo los síntomas de retraimiento. Intenta no dejarle usar más opiato hasta que el naloxone deje de funcionar.



*Posición de Recuperación

Si tienes que irte, dale a la persona respiración artificial hasta que escuches las sirenas de la ambulancia. Entonces, coloca la persona de lado, con sus manos debajo de su cabeza. De esta manera si vomita, no se ahogará con su propio vomito.





The graphic is a vertical brochure with a red border. On the right side, there is a dark grey vertical band with the text "BE A LIFESAVER!" in white, "OVERDOSE PREVENTION AND SURVIVAL" in red, and a large red rectangular area below. The main white area contains three numbered steps, each with an illustration and text in English and Spanish.

1. CALL 911
Llame al 911

2. RESCUE BREATHING
Respiración de Boca a Boca

3. GIVE NARCAN
Administra Narcan

HOW?
¿cómo?

⁴⁶ The D.O.P.E. Project (2013). *Be a Lifesaver*. Accessed at <http://harmreduction.org/wp-content/uploads/2012/02/dope-brochure-sept-2010.pdf>.

OVERDOSE IS MOST COMMON WHEN:

- Your tolerance is down due to not using—whether you took a break, were in treatment, jail or had cut down on your use.
- When you mix drugs, especially a few kinds of downers, like heroin, methadone, benzos/pills and alcohol or any combo of those.
- When you get stronger drugs than you're used to. If the supply changes or you go to a new dealer or you're new in town.
- When you're alone—nobody is around to help if you go out.
- When you've been sick, tired, run down or dehydrated—your body can't handle the drugs as well if it is not healthy and nourished.

HOW TO RECOGNIZE AN OVERDOSE:

- Blue or grayish lips and fingernails
- Clammy, sweaty skin
- Shallow or raspy breathing, snoring or gurgling sounds
- Won't wake up to yelling their name, or yelling "I'm going to Narcan you!"

If your friend is just in a heavy nod, but is still conscious and breathing, make sure to stay with them, walk them around, keep them talking and moving. Watch their breathing.

Someone can slip into an overdose hours after they got high!

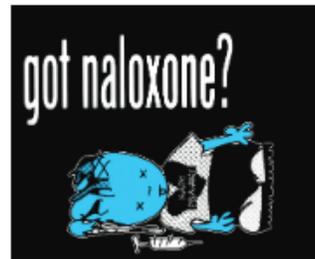
Have your Narcan kit around just in case, you never know when you'll need it.

ACTIONS:

- 1. Check to see if they can respond**
 - Give them a light shake, yell their name. Any response? Are they breathing?
 - If you can't get a response, try a **STERNUM RUB** (rub your knuckles on their chest bone for about 10 seconds).
- 2. Call 911**
 - You don't need to mention drugs on the call—stick to the basics:
 - Give the address and location
 - Say "my friend is unconscious and I can't wake them up" or "my friend isn't breathing"
- 3. Rescue Breathing**
 - Make sure nothing is in their mouth
 - Tilt head back, lift chin, pinch nose
 - Give a breath every five seconds
- 4. Give Narcan**
 - If you have the Nasal Spray Narcan, spray half up one nostril, half up the other.
 - If you have the Injectable Narcan, inject 1cc into the muscle of the upper arm, upper thigh, or upper/outer quarter of the butt.
 - Keep rescue breathing if they haven't started breathing on their own.
 - Give second dose of Narcan if there is no response after about 3 minutes.
- 5. After Narcan**
 - Remind the person that Narcan will wear off in about 30-45 minutes.
 - Stay with them until they go to the hospital or the Narcan wears off to make sure the overdose doesn't come back.

PREVENTING OVERDOSE

- Eat, sleep, drink water—keeping our bodies healthy can help reduce the risk of overdose!
- Be careful if you mix alcohol, benzos/pills, heroin or methadone—any combo of these drugs can cause your breathing and heart to stop working.
- Prepare your own drugs, know how strong your shot is and exactly what's in it.
- Have an OD plan with the people you use with. Empower yourself, learn how to do rescue breathing and get a Narcan kit!
- Always use with a friend or let someone know you're getting high so they can check on you. Keep doors unlocked so help can reach you if you're in trouble.
- Test out a new supply to see how strong it is—inject slowly or do less to start. Talk to others who copped from the same source.
- Go slow if you're just picking up after a period of not using, do a tester shot and have someone with you. Remember...you can always do more, but you can't do less!



S.K.O.O.P. Overdose Prevention Poster⁴⁷

⁴⁷ S.K.O.O.P. (2010). Is Your Friend Turning Blue? Prevent an Overdose. <http://harmreduction.org/wp-content/uploads/2011/12/SKOOPPoster.pdf>. Accessed March 27, 2014.

Is Your Friend Turning Blue? Prevent Overdose

STEP 1.

CALL 911
Llame al 911



Call 911

• Give instructions:
• Say "my friend is unconscious and I can't wake her up," or "my friend isn't breathing."
• You don't need to say that any drugs have been taken until the ambulance arrives.

Leave at 911

y espere a la ambulancia:
• La dirección del lugar
• Diga "mi amigo está inconsciente y no le puedo despertar" o "mi amigo no está respirando".
• No tiene que decir que ha consumido drogas hasta que llegue la ambulancia.

STEP 2.

RESCUE
BREATHING
Respiración
Boca a Boca



Rescue breathing

• Make sure there is nothing in the mouth.
• Tilt head back, lift chin, pinch nose.
• Give a breath every 5 seconds.

Respiración boca a boca:

• Asegúrese que no haya nada en la boca.
• Inclínalo en cabeza hacia atrás, levante la barbilla y apriete la nariz.
• Soplo en la boca de cada cinco segundos.

STEP 3.

GIVE NALOXONE
Administre
Naloxone



Give Naloxone

• Inject into upper arm, buttock or thigh – in the muscle or on the fat is ok. A diabetic who needs will go if that is what you have.
• Repeat after 2-5 minutes if not waking up and call 911 if you haven't yet.
• Repeat the process but naloxone will wear off in a little while and they will stop feeling like sick.
• Stay with them until they go to the hospital.

Administre Naloxona

• Inyecte la Naloxona en el músculo de la parte posterior del brazo, o en la cadera, o en el brazo con aguja para uso de inyección, intramuscular completamente.
• Repetido después tiene hasta cinco minutos y llame al 911 si no que se lo ha hecho aún.
• Repetido que el efecto de la naloxona no es permanente, y espere a ver el efecto de la naloxona repetidamente, la herida en la piel eliminado del cuerpo.
• Acompañado hasta que llegan la ayuda de emergencia.

Naloxone must be prescribed to the carrier by a medical professional. If you have questions or concerns please contact:
New England Coalition
202-212-0370



Drug Treatment/
Tratamiento de Drogas
1-800-LIFENET
HWYB
1-800-541-AIDS /
Español 1-800-233-SIDA



A joint Program of the Harm Reduction Coalition and the Drug Services Prevention and Education (DSPE) Project
22 West 27th St., 10th Floor
New York, N.Y. 10001
www.harmreduction.org



Naloxone Instructions Formatted for Business Cards⁴⁸

⁴⁸ NOPE Rhode Island.org (2014). Naloxone Pocket Cards.
<https://www.dropbox.com/s/p0awwanxplej08x/pocket%20card4.pdf> Accessed March 25, 2014.

www.nopeRI.org

OVERDOSE RECOGNITION

Signs of overdose include:

- Can't be woken up
- Slow or no breathing
- Limp body
- Fingernails or lips turning blue
- Unable to speak/Incoherent
- Vomiting or gurgling noises

OVERDOSE RESPONSE

1. Call 911 - tell them someone is not breathing
2. Rescue breathing
3. Give naloxone (Narcan)
4. Stay until help arrives, roll the person on their side if you have to leave

OVERDOSE PREVENTION

Overdose is more likely when:

- You use by yourself
- You mix opioids with alcohol or other drugs
- Your tolerance is low because you haven't used recently
- You have a chronic disease (HIV/AIDS, HepC, COPD) or an acute illness (pneumonia, flu).

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www.nopeRI.org

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www.nopeRI.org

www.nopeRI.org

NALOXONE	INJECTABLE NALOXONE 1. Remove cap from naloxone and syringe. 2. Insert needle through rubber plug. 3. Pull back on plunger until there is 1cc in the syringe. 4. Inject into a large muscle (thigh or upper arm). 	NASAL NALOXONE 1. Remove all caps. 2. Screw glass vial into plastic tube. 3. Screw nasal atomizer into plastic tube. 4. Inject half of vial into each nostril. 	NALOXONE
	<ul style="list-style-type: none"> - Naloxone starts working in 3-5 minutes and lasts 30-90 minutes - Keep rescue breathing until naloxone starts to work. - If there is no improvement in 5 minutes, give another dose. - Naloxone may cause withdrawal symptoms - DO NOT let person use more opioids. 	<ul style="list-style-type: none"> - Naloxone starts working in 3-5 minutes and lasts 30-90 minutes - Keep rescue breathing until naloxone starts to work. - If there is no improvement in 5 minutes, give another dose. - Naloxone may cause withdrawal symptoms - DO NOT let person use more opioids. 	
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SAMHSA Opioid Overdose Toolkit⁴⁹

⁴⁹ Substance Abuse and Mental Health Services Administration. SAMHSA Opioid Overdose Prevention Toolkit: Safety Advice for Patients. HHS Publication No. (SMA) 13-4742. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2013.

SAMHSA
Opioid Overdose
TOOLKIT:
Safety Advice for Patients
& Family Members



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Also see the other components of this Toolkit:

- ★ Facts for Community Members
- ★ Five Essential Steps for First Responders
- ★ Information for Prescribers
- ★ Recovering from Opioid Overdose:
Resources for Overdose Survivors & Family Members

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SAFETY ADVICE FOR PATIENTS & FAMILY MEMBERS

WHAT IS NALOXONE?

Naloxone (Narcan) is an antidote to opioid overdose. It is an opioid antagonist that is used to reverse the effects of opioids. Naloxone works by blocking opiate receptor sites. It is not effective in treating overdoses of benzodiazepines (such as Valium, Xanax, or Klonopin), barbiturates (Seconal or Fiorinal), clonidine, Elavil, GHB, or ketamine. It also is not effective in treating overdoses of stimulants such as cocaine and amphetamines (including methamphetamine and Ecstasy). However, if opioids are taken in combination with other sedatives or stimulants, naloxone may be helpful.

IMPORTANT SAFETY INFORMATION. Naloxone may cause dizziness, drowsiness, or fainting. These effects may be worse if you take it with alcohol or certain medicines. Use naloxone with caution. Do not drive or perform other possibly unsafe tasks until you know how you react to it.

If you experience a return of symptoms (such as drowsiness or difficulty breathing), **get help immediately.**

REPORT ANY SIDE EFFECTS

Get emergency medical help if you have any signs of an allergic reaction after taking naloxone, such as hives, difficulty breathing, or swelling of your face, lips, tongue, or throat.

Call your doctor or 911 at once if you have a serious side effect such as:

- Chest pain, or fast or irregular heartbeats;
- Dry cough, wheezing, or feeling short of breath;
- Sweating, severe nausea, or vomiting;
- Severe headache, agitation, anxiety, confusion, or ringing in your ears;
- Seizures (convulsions);
- Feeling like you might pass out; or
- Slow heart rate, weak pulse, fainting, or slowed breathing.

If you are being treated for dependence on opioid drugs (either an illicit drug like heroin or a medication prescribed for pain), you may experience the following symptoms of opioid withdrawal after taking naloxone:

- Feeling nervous, restless, or irritable;
- Body aches;
- Dizziness or weakness;
- Diarrhea, stomach pain, or mild nausea;
- Fever, chills, or goosebumps; or
- Sneezing or runny nose in the absence of a cold.

This is not a complete list of side effects, and others may occur. Talk to your doctor about side effects and how to deal with them.

STORE NALOXONE IN A SAFE PLACE

Naloxone is usually handled and stored by a health care provider. If you are using naloxone at home, store it in a locked cabinet or other space that is out of the reach of children or pets.

SUMMARY: HOW TO AVOID OPIOID OVERDOSE

1. Take medicine only if it has been prescribed to you by your doctor.
2. Do not take more medicine or take it more often than instructed.
3. Call a doctor if your pain gets worse.
4. Never mix pain medicines with alcohol, sleeping pills, or any illicit substance.
5. Store your medicine in a safe place where children or pets cannot reach it.
6. Learn the signs of overdose and how to use naloxone to keep it from becoming fatal.
7. Teach your family and friends how to respond to an overdose.
8. Dispose of unused medication properly.

READ MORE AT www.drugs.com/cdi/naloxone.html.

REFERENCES

1. BMJ Evidence Centre. Treatment of opioid overdose with naloxone. *British Medical Journal*. Updated October 23, 2012. [Accessed March 24, 2013, at www.bmj.com]
2. National Treatment Referral Helpline 1-800-662-HELP (4357) or 1-800-487-4889 (TDD for hearing impaired)
3. National Substance Abuse Treatment Facility Locator: www.findtreatment.samhsa.gov/TreatmentLocator to search by state, city, county, and zip code
4. Buprenorphine Physician & Treatment Program Locator: www.buprenorphine.samhsa.gov/twns_locator

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SAMHSA
Opioid Overdose
TOOLKIT:

Recovering from Opioid Overdose—
*Resources for Overdose Survivors
& Family Members*



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Also see the other components of this Toolkit:

- ★ Facts for Community Members
- ★ Five Essential Steps for First Responders
- ★ Information for Prescribers
- ★ Safety Advice for Patients

RECOVERING FROM OPIOID OVERDOSE

RESOURCES FOR OVERDOSE SURVIVORS AND FAMILY MEMBERS

Survivors of opioid overdose have experienced a life-changing and traumatic event. They have had to deal with the emotional consequences of overdosing, which can involve embarrassment, guilt, anger, and gratitude, all accompanied by the discomfort of opioid withdrawal. Most need the support of family and friends to take the next steps toward recovery.

While many factors can contribute to opioid overdose, it is almost always an accident. Moreover, the underlying problem that led to opioid use — most often pain or substance use disorder — still exists and continues to require attention [1].

Moreover, the individual who has experienced an overdose is not the only one who has endured a traumatic event. Family members often feel judged or inadequate because they could not prevent the overdose. It is important for families to work together to help the overdose survivor obtain the help that he or she needs.

FINDING A NETWORK OF SUPPORT

As with any disease, it is not a sign of weakness to admit that a person or a family cannot deal with the trauma of overdose without help. It takes real courage to reach out to others for support and to connect with members of the community to get help. Health care providers, including those who specialize in treating substance use disorders, can provide structured, therapeutic support and feedback.

If the survivor's underlying problem is pain, referral to a pain specialist may be in order. If it is addiction, the patient should be referred to an addiction specialist for assessment and treatment, either by a physician specializing in the treatment of opioid addiction, in a residential treatment program, or in a federally certified Opioid Treatment Program (OTP). In each case, counseling can help the individual manage his or her problems in a healthier way. Choosing the path to recovery can be a dynamic and challenging process, but there are ways to help.

In addition to receiving support from family and friends, overdose survivors can access a variety of community-based organizations and institutions, such as:

- Health care and behavioral health providers
- Peer-to-peer recovery support groups such as Narcotics Anonymous
- Faith-based organizations
- Educational institutions
- Neighborhood groups
- Government agencies
- Family and community support programs

RECOVERING FROM OPIOID OVERDOSE

RESOURCES

Information on opioid overdose and helpful advice for overdose survivors and their families can be found at the following websites:

Substance Abuse and Mental Health Services Administration (SAMHSA)

- National Treatment Referral Helpline 1-800-662-HELP (4357) or 1-800-487-4889 (TDD — for hearing impaired)
- National Substance Abuse Treatment Facility Locator: www.findtreatment.samhsa.gov/TreatmentLocator to search by state, city, county, and zip code
- Buprenorphine Physician & Treatment Program Locator: www.buprenorphine.samhsa.gov/bwns_locator
- State Substance Abuse Agencies: <http://findtreatment.samhsa.gov/TreatmentLocator/faces/abuseAgencies.jspx>

Centers for Disease Control and Prevention (CDC): www.cdc.gov/Features/VitalSigns/PainkillerOverdoses

National Institutes of Health (NIH), National Center for Biotechnical Information: www.ncbi.nlm.nih.gov

The Partnership at Drug-Free.org: www.drugfree.org/uncategorized/opioid-overdose-antidote

Project Lazarus: <http://projectlazarus.org>

Harm Reduction Coalition: <http://harmreduction.org>

Overdose Prevention Alliance: <http://overdosepreventionalliance.org>

Toward the Heart: <http://towardtheheart.com/naloxone>

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2. Bazazi AR, Zaller ND, Fu JJ, Rich JD. Preventing opiate overdose deaths: Examining objections to take-home naloxone. *J Health Care Poor Underserved*. 2010 Nov;21(4):1108-1112.
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Sample Overdose Prevention Poster

If you let her
“sleep it off,”
she may never wake up.



Drug overdose is the #1 cause of
accidental death for adults in Rhode Island.

Learn how to spot an overdose and what to do.



POISON
Help
1-800-222-1222

www.risipisoncenter.com

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