<table>
<tr><td colspan="2">Clinical Procedure</td></tr>
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<tr><td>Approving Authority: Multidisciplinary Clinical Practice Oversight Committee (MCPOC)
Clinical Procedure Sponsor: Executive Director Continuing Care, Urban; Executive Director Clinical Standards and Provincial Clinical Networks
Clinical Procedure Owner: Director, Clinical Integration, Continuing Care Urban; Director Clinical Standard and Professional Practice, Urban</td><td>Effective Date:
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<tr><td colspan="2">Refer to Appendix A for Definitions.</td></tr>
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PURPOSE

To provide direction on how to identify opioid overdose. To identify who can initiate initial treatment and how to provide initial treatment with naloxone in cases of actual or suspected opioid overdose.

CLINICAL STANDARDS STATEMENTS

1. This clinical procedure applies to all Saskatchewan Health Authority (SHA) facilities, Long Term Care Homes, properties, programs, and care environments.
2. This clinical procedure and medical directive applies to any person, employee, patient, volunteer, contracted employee, visitor, or member of the public. As soon as the person meets inclusion criteria, they become a **patient**.
3. All **Clinical Team Members** within any care environment within the SHA will:
   a. Identify actual or suspected opioid overdose.
   b. Initiate **emergency** treatment, and / or activate an emergency response measure or system.
4. Managers of patient care environments are accountable for:
   a. Written emergency response process specific to the clinical area, where not provided in the clinical procedure.
   b. Ensuring access to naloxone and appropriate equipment in the clinical area, where appropriate, based on emergency response process requirements.
   c. Determining appropriateness of training **unregulated care providers (UCP)** to identify and initiate initial treatment of naloxone use in suspected or actual opioid overdose.
   d. Ensuring Healthcare Professionals (HCPs) (and UCP if appropriate) are educated in the identification and initial treatment of naloxone use in suspected or actual opioid overdose.
   e. Training competency is maintained and tracked.
   f. Determining that local incident reporting processes were followed.

INCLUSION CRITERIA

- Any patient receiving care in any SHA facilities, Long Term Care Homes, properties, programs, and care environments

  and / or

- Any person, Practitioner, staff, student, visitor, contract employee, volunteer, member of the public; any person who shows signs of intentional or unintentional suspected or actual opioid overdose.

EXCLUSION CRITERIA

- Patients who are awake and alert.
- Dying patients where pain management goals would not be compatible with naloxone administration.

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ESCALATION CRITERIA

- Where patients have met the inclusion criteria, a first dose of naloxone may be administered prior to initiating escalation.
- Call for help per local process – Notification of the **Most Responsible Practitioner (MRP),** Code Blue, Rapid Response Team, calling 9-1-1 – will occur at the earliest possible opportunity.
- Continued observation is required. Repeat naloxone as required. Where the patient deteriorates or becomes pulseless, initiate Basic Life Support practices or follow direction from Emergency Medical Services dispatchers (9-1-1) or the **MRP**.

CLINICAL TEAM MEMBERS ELIGIBLE TO PERFORM THIS FUNCTION

Approved practice in the care environment, assessment of the patient, and the competence of the individual clinical team member are all considerations in the appropriateness of implementing this procedure.

Physicians may function in the **most responsible practitioner** (MRP) role or as a **Healthcare Professional** performing this skill and are expected to follow this standard however, context of care, clinical experience, judgement, and patient presentation may require deviation from this standard in the best interests of the patient. Other professionals whose scope of employment may include an MRP role will follow the standard unless they are functioning as MRP in which case, context of care, clinical experience, judgement and patient presentation may require deviation from this standard in the best interests of the patient.

All clinical team members who have been trained in the administration of naloxone are eligible to perform this function.

Paramedics and Emergency Medical Responders delivering care within the Emergency Medical (EMS) scope of employment will adhere to the Saskatchewan College of Paramedics clinical practice protocols for management of opioid overdose and the SHA EMS Drug Reference Cards.

SHA Registered Medical First Responders (MFR) will follow the Opioid Poisoning (Administration of Naloxone-Narcan) MRF Clinical Practice Protocol.

Emergency Medical Responders are only authorized to deliver Naloxone through pre-loaded nasal atomizers per the regulatory body.

Licensed healthcare professionals will adhere to regulatory requirements for medication administration.

EDUCATION AND TRAINING REQUIREMENTS

- Licensed healthcare professionals:
  - Review of Clinical Procedure and Medical Directive.
  - Completion of CS-LM-0051 Naloxone Administration for Actual or Suspected Opioid Overdose Learning Module and quiz with minimum success rate of 80%.
- Paramedics delivering care within the Emergency Medical Services scope of employment and Emergency Medical Responders:
  - Will adhere to educational requirements from the Saskatchewan College of Paramedics.

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- SHA Registered Medical First Responders:
  - Will adhere to educational requirements of the SHA Medical First Responder training program.
- Unregulated Care Providers
  - Review of the appropriate sections of the following training resources:
    - Take Home Naloxone Kit (THNK) Training Manual
      - How to recognize an overdose
      - How to respond to an overdose using SAVE ME
    - Take Home Naloxone (THN) Training for Health Care Providers.
      - How to recognize an overdose
      - Responding to an overdose: SAVE ME
- Training on use of intranasal mucosal atomization device, per local area availability.
- Physicians do not require additional training to perform ELCs, however they are required to be competent to perform the function. Competency means they have the required knowledge, skills and judgement to perform the function. Education materials are available for use as required

NOTE: Frequency of training / review should be determined by the operational areas to ensure maintenance of competence.

RESOURCES

- How to Use Naloxone
- Naloxone Made Easy - YouTube (short 1:42 video)
- NARCAN Nasal Spray - How to use - YouTube
- Administering Naloxone Spray (wistia.com) (short 1:25 video)

GENERAL INFORMATION

Clinical Team Members will adhere to all relevant organizational routine practices prior to the initiation of any procedure including:

- Completing an IPAC-G-0010 **Point of Care Risk Assessment (PCRA).** Infection Prevention and Control (IPAC) practices will be adhered to by all team members for all aspects of care. This includes the use of the appropriate Personal Protective Equipment (PPE) and Hand Hygiene as outlined in the SHA-02-005 Policy: Hand Hygiene.
- Identifying what specifically should be documented. Refer to CS-CDCS-0070 What to Document.
- **Adverse event** reporting must occur when patients are treated with naloxone for opioid overdose when the opioid was provided by an SHA HCP in a SHA facilities, Long Term Care Homes, properties, programs, and care environments. Reporting occurs through respective local **safety reporting** process.

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PROCEDURE

A. PATIENT ASSESSMENT / OBSERVATION

PROCEDURE

1. Assess / observe for signs and symptoms.
   a. Suspected or actual opioid use.
   b. Lack of response to physical stimulus or verbal stimulus:
      - Unconscious, can't be woken
      - Not moving, Limp body
      - Breathing 10 breaths a minute or less
        - Breathing less than appropriate for the child's age in Pediatric and Neonates; this includes apnea, slow shallow or no breathing
      - Cyanosis – blue tint to lips, face, nail beds, skin
      - Choking / gurgling / snoring sounds (if can't be woken) when breathing
      - Cool, clammy skin
      - Pinpoint pupils
      - Slow or absent pulse
      - Vomiting

Figure 1. Signs and symptoms of opioid overdose

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2. Call for help as per your local emergency response.

> **NOTE:** This may include a Code Blue, calling 9-1-1, contacting the MRP or other options per local practices.

3. Stop opioid infusion, if administering.
4. Observe breathing.

> **NOTE:** Rescue breaths may be required. Follow **Basic Life Support** principles if required. If oxygen is available and trained to use, administer.

5. Determine best route of administration for naloxone.

> **ALERT:** If in doubt about what type of drug or drugs were ingested, administer naloxone. The risk of harm to the patient is lower when naloxone is provided.

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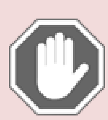
B. NALOXONE ADMINISTRATION

B. 1. DIRECT INTRAVENOUS (IV)



ALERT: Always choose IV route when functional IV in situ AND administration of IV route is within scope of practice.
If IV administration is not within scope of practice, proceed to B.2 Intramuscular or B.3 Intranasal.

EQUIPMENT

- 70% isopropyl alcohol swabs
- Pre-filled 10 mL Normal Saline (NS) syringe x 2 for each dose administered
- Naloxone
- Blunt filtered needle (for glass ampoule) or blunt needle (for multi-dose vial)
- Sterile water
- 1 mL or 10 mL syringe – 1 for each dose administered
- Sterile NS to dilute, if required
- Medication Added Label

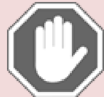
RESOURCES

- Naloxone monograph

PROCEDURE

NOTE: Onset of action of naloxone is 30 seconds to 2 minutes.

1. Assess / observe patient level of consciousness and respiratory rate.
2. Complete vital signs (Heart Rate (HR), Respiratory Rate (RR), Blood Pressure (BP), Oxygen Saturation (SpO2) per naloxone monograph.



ALERT: During reassessment / observation if patient deteriorates or loses pulse, activate emergency response, if not already done, and initiate Basic Life Support measures.

3. Administer naloxone Direct IV as required.
4. Reassess / observe patient level of consciousness and respiratory rate.
5. Repeat naloxone administration as required. Maximum dose consistent with Medical Directive.
6. Document
   - Signs and symptoms observed
   - Dose of naloxone administered
   - Location naloxone administered
   - Effects of naloxone administration
   - Changes to level of consciousness or breathing rate
   - Response for call for help
   - Additional treatments provided

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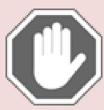
- Additional assessments / observations including signs and symptoms of continued overdose
- Additional administration of naloxone dose(s)

7. Transfer care to another HCP or notification Most Responsible Practitioner, if appropriate.

B. 2. INTRAMUSCULAR (IM)



ALERT: Choose IM route when no functional IV exists. Licensed professionals administer IM according to professional requirements. Unlicensed providers administer according to training.

EQUIPMENT

- **Take home naloxone kit**

or

- 70% isopropyl alcohol swab
- Naloxone
- 3 mL syringe – Utilize a new needle with each subsequent dose administered
- Blunt filtered needle (for glass ampoule) or blunt needle (for multi-dose vial)
- 1 inch or 1 ½ inch 25 gauge needle – based on appropriate size of patient or what is available – 1 for each dose administered
- Gloves
- Sharps container (wall mounted or portable)

RESOURCES

- Video: Landmark deltoid arm muscle
- Video: Landmark vastus lateralis thigh muscle
- Landmark Pediatric patient
- Video: How to give an IM
- SAVE-ME Steps

PROCEDURE

NOTE: May be given through light clothing.

NOTE: Naloxone will start working in 2 to 5 minutes. Peak effect may be seen in 3 or 4 minutes.

1. Assess / observe patient level of consciousness and breathing rate.
2. Administer naloxone IM.
3. Reassess / observe patient level of consciousness and breathing rate.

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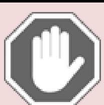
4. Observe for continued signs and symptoms of overdose.

ALERT: During reassessment if patient deteriorates or loses pulse, activate emergency response, if not already done, and initiate Basic Life Support measures.

5. Repeat naloxone administration as required. Maximum dose consistent with Medical Directive.

6. Document
   - Signs and symptoms observed
   - Dose of naloxone administered
   - Location naloxone administered and if through clothing
   - Effects of naloxone administration
   - Changes to level of consciousness or breathing rate
   - Response for call for help
   - Additional treatments provided
   - Additional assessments / observations including signs and symptoms of continued overdose
   - Additional administration of naloxone dose(s)
7. Transfer care to another HCP or notification Most Responsible Practitioner, if appropriate.

B. 3. INTRANASAL (IN)



ALERT: Choose IN option when no other administration option exists.

EQUIPMENT

- Naloxone
  - May be a pre-manufactured single dose
  - May be multi dose vial or ampoule
- Intranasal mucosal atomization device, if multi dose vial or ampoule

NOTE: Additional training is required to use the IN mucosal atomization device.

RESOURCES

- Video: NARCAN Nasal Spray - How to use
- Video: Administering Naloxone Spray (*short duration: 1 minute and 25 seconds*)

PROCEDURE

1. Position patient on back, supporting neck, tilt head back.
   a. Pre-manufactured product (single dose).
      i. Open package. DO NOT squeeze / press device until ready to give.
   OR
   b. Use of intranasal mucosal atomization device.

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2. Follow manufacturer instructions to load naloxone. Place in nostril far enough to create a seal using the nostril around the device.

Figure 2. Placement of IN device in nostril

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3. Press device to spray into nostril.

NOTE: The nasal spray is absorbed even if the patient is not breathing. Onset of action is two to three minutes.

4. Assess / observe patient level of consciousness and breathing rate.
5. Observe for continued signs and symptoms of overdose.

	ALERT: During reassessment if patient deteriorates or loses pulse, activate emergency response, if not already done, and initiate Basic Life Support measures.

6. Repeat naloxone administration (steps 1-5) as required in other nostril. Maximum dose consistent with Medical Directive.
7. Document
   - Signs and symptoms observed
   - Dose of naloxone administered
   - Location naloxone administered
   - Effects of naloxone administration
   - Changes to level of consciousness or breathing rate
   - Response for call for help
   - Additional treatments provided
   - Additional assessments / observations including signs and symptoms of continued overdose
   - Additional administration of naloxone dose(s)
8. Transfer care to another HCP or notification Most Responsible Practitioner, if appropriate.

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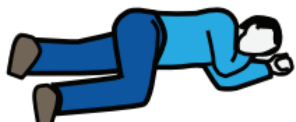
C. AFTER CARE

PROCEDURE

1. Place patient in side-lying recovery position if no known contraindications.

Figure 3. Recovery position



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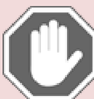
2. Continue to observe respiratory rate and signs level of consciousness, and other signs and symptoms of opioid overdose.



ALERT: If inclusion criteria met again, return to administration of naloxone and repeat until resolved or until care escalated.

3. Inform patient of naloxone administered, when patient regains consciousness.
4. Educate patient and / or family on:
   a. Signs and symptoms of opioid withdrawal including:
      i. Anxiety, irritability, aggressiveness, goosebumps, restlessness, insomnia, yawning, weakness, runny nose, watery eyes, dilated pupils, body aches, sweating, vomiting, stomach cramps, diarrhea, fever, shaking, rapid heartbeat, rapid breathing, high blood pressure, hallucinations, seizures.
      ii. In the dependent infant and child, signs also include excessive crying as well as hyperactive reflexes.
         - The acute withdrawal may be life-threatening if not recognized and properly treated.
   b. Side effects of naloxone including:
      i. Nausea, vomiting, sweating, rapid heart rate, high blood pressure, headache, tremors, pain, irritability, diarrhea.
   c. Overdose symptoms may return.
   d. How to treat if overdose symptoms return.
   e. Further use of narcotics while naloxone remains in system will not cause a high.
5. Review medications / prescriptions as appropriate.
6. Offer Take Home Naloxone Kit.

NOTE: All Emergency Departments in the SHA have Take Home Naloxone Kits. A kit may be retrieved from your local Emergency Department for you to provide to the patient or you may refer the patient to the local Emergency Department to pick up.

Local outreach teams are also available in some areas of the SHA.

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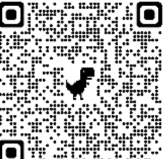
7. Ensure patient / caregiver knows how to use the Take Home Naloxone Kit if accepted. Follow the Take Home Naloxone Participant Knowledge Checklist for specific steps.



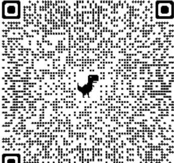
8. Provide patient CS-PIER-0045-Naloxone Training, if willing to accept.

9. Document
   - Length of time of recovery in side-lying position
   - Observations on respiratory rate, level of consciousness or other signs and symptoms of opioid overdose
   - Education provided to patient
   - Patient response to education
   - Offering of Take Home Naloxone Kit
   - If patient accepted or refused
   - Teaching provided on Take Home Naloxone Kit
   - To whom teaching was provided
   - Offer of Patient Education document
   - If Patient Education document was accepted
   - Disposition of the patient (examples – transfer of care to another provider or discharge against medical advice)

D. TAKE HOME NALOXONE KIT FOR PATIENT DISCHARGE OR PASS / TEMPORARY LEAVE FROM CARE

RESOURCES

- Take Home Naloxone Kits are available throughout Saskatchewan. Sites can be found at Take Home Naloxone Program Site



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PROCEDURE

1. Offer Take Home Naloxone Kit

> **NOTE:** In situations where at-risk individuals do not wish to accept a kit or training:
> - A kit can be provided to a friend or caregiver
> - A kit can be provided to the individual without training
> - Training can be provided to a friend or caregiver as they request
> - Refer to SHA -08-003P1 Harm Reduction Procedure

2. Educate patient / caregiver on how to use the Take Home Naloxone Kit if accepted. Follow the Take Home Naloxone Participant Knowledge Checklist for specific steps.

3. Document
   - Offer to Take Home Naloxone Kit
   - If kit accepted or refused, and by whom
   - Education provided and to whom
   - Disposition of the patient

Upon return from Pass / Temporary Leave from Care

1. Verify if Take Home Naloxone Kit was used.
2. Document response.
3. Assess / observe for continued signs and symptoms of overdose if kit was used or if opioid use is suspected (based on signs and symptoms of opioid use) while on pass.
4. Document ongoing assessment / observed findings as appropriate.

REQUIREMENTS FOR CARE TRANSITIONS

1. Signs and symptoms observed that indicated actual or suspect opioid overdose.
2. Total number of Naloxone doses given (total dose in mg if known).
3. Site of administration.
4. Time of last dose.
5. Education if any, and to whom it was provided.
6. Other relevant information, if known, as appropriate, such as – time, type and amount of opioids consumed.

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DOCUMENTS THAT RELATE TO THIS CONTENT

Clinical Standards

CS-CDCS-0070 What to Document

SHA-02-005 Policy: Hand Hygiene

SHA-08-003 Harm Reduction Policy

Clinical Procedures

SHA-08-003P1 Harm Reduction Procedure

Clinical Forms

THN Knowledge Checklist

LTC Adult Annual Order Set

Learning Modules

CS-LM-0051 Naloxone Administration for Actual or Suspected Opioid Overdose

Take Home Naloxone Kit (THNK) Training Manual

Take Home Naloxone (THN) Training for Health Care Providers

Patient Handouts

CS-PIER-0045 Naloxone Training

Other

How to give an IM

Naloxone monograph

THNK - Training Manual

Take Home Naloxone Program Site

Video: Administering Naloxone Spray

Video: NARCAN Nasal Spray - How to use - YouTube

Video: Landmark Deltoid Arm Muscle

Video: Landmark Vastus Lateralis Thigh Muscle

Video: Landmark Pediatric Patient

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REFERENCES

1. Naloxone SK SMART Pump Program Parenteral Manual

NON-CITED BIBLIOGRAPHY

1. A Review of Opioid Overdose Prevention and Naloxone Prescribing: Implications for Translating Community Programming into Clinical Practice: Shane R. Mueller, MSW1 , Alexander Y. Walley, MD, MSc2 , Susan L. Calcaterra, MD, MPH1,4 , Jason M. Glanz, PhD5,6 , and Ingrid A. Binswanger, MD, MPH, MS1,3,4 HHS Public Access, Author manuscript, Subst Abus. Author manuscript; available in PMC 2016 April 01. Published in final edited form as: Subst Abus. 2015 ; 36(2): 240–253. doi:10.1080/08897077.2015.1010032.
2. BC Centre for Disease Control • BCCDC Decision Support Tool –Administration of Naloxone. [December 2016]. http://www.bccdc.ca/resourcegallery/Documents/Educational%20Materials/Epid/Other/NaloxoneDSTUseforRN.pdf
3. Devries J, Rafie S, Polston G. Implementing an overdose education and naloxone distribution program in a health system. Journal of the American Pharmacists Association : JAPhA. 2017;57(2S):S154-S60. DOI: https://dx.doi.org/10.1016/j.japh.2017.01.002
4. Healthcare Improvement Scotland • Scottish Palliative Care Guidelines –Naloxone. [2019]. https://www.palliativecareguidelines.scot.nhs.uk/media/71303/2019-naloxone.pdf
5. Moe J, Godwin J, Purssell R, et al. Naloxone dosing in the era of ultra-potent opioid overdoses: a systematic review. CJEM. 2020;22(2):178-86. DOI: https://dx.doi.org/10.1017/cem.2019.471
6. Sameed M, Teague H. Use of nebulized naloxone to reverse methadone overdose - A case report and review of literature. Journal of community hospital internal medicine perspectives. 2019;9(5):422-4. DOI: https://dx.doi.org/10.1080/20009666.2019.1659664
7. Strang J, McDonald R, Campbell G, et al. Take-Home Naloxone for the Emergency Interim Management of Opioid Overdose: The Public Health Application of an Emergency Medicine. Drugs. 2019;79(13):1395-418. DOI: https://dx.doi.org/10.1007/s40265-019-01154-5
8. Williams K, Lang ES, Panchal AR, et al. Evidence-Based Guidelines for EMS Administration of Naloxone. Prehospital emergency care : official journal of the National Association of EMS Physicians and the National Association of State EMS Directors. 2019;23(6):749-63. DOI: https://dx.doi.org/10.1080/10903127.2019.1597955

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APPENDIX A: DEFINITIONS

Adverse event: The occurrence of an undesirable event during or following the exposure to a drug, but not necessarily caused by the drug itself.

Ampoule (also ampul and ampule): Is a small sealed vial which is used to contain and preserve a drug, usually a liquid.

Basic Life Support (BLS): The foundational course for healthcare professionals who provide care to patients in a wide variety of in-facility and prehospital settings. Teaches the theoretical and hands-on skills needed to respond to medical emergencies.

Clinical Team Member: In the context of Clinical Standards documents, the clinical team members include those who perform direct patient care. This could include healthcare professionals, unregulated care providers, practitioner staff, graduate practitioners, and learners.

Healthcare Professional (HCP): Staff with formal education in their profession and are prepared for practice with entry-level competencies (the knowledge, skills and judgement acquired in a foundational education program). Healthcare professionals are licensed, certified or privileged and have a scope of practice that defines the competencies they are authorized to practice. Healthcare professionals may or may not be regulated by a provincial regulatory body.

Intramuscular: An intramuscular injection is a technique used to deliver a medication deep into the muscles.

Intranasal: A technique used to deliver a medication by way of the nasal structures.

Intravenous: A technique used to deliver a medication by way of a vein.

Most Responsible Practitioner (MRP): The physician / practitioner / nurse practitioner with the overall responsibility for directing and coordinating the care of a patient at the specific point in time.

Overdose: Is when someone accidentally or intentionally consumes more than a safe or typical amount of a substance such as a prescription medication or drug.

Patient: All individuals including clients, residents and members of the public who receive or have requested health care or services from Saskatchewan Health Authority and its healthcare providers.

Point-of-care risk assessment (PCRA): "A PCRA is an activity whereby healthcare workers:

1. Evaluate the likelihood of exposure to an infectious agent
    a. For a specific interaction;
    b. With a specific patient;
    c. In a specific environment (example: single room, hallway);
    d. Under available conditions (example: no designated handwashing sink)
2. Choose the appropriate actions / PPE needed to minimize the risk of exposure for the specific patient, other patients in the environment, the HCW, other staff, visitors, contractors, etc."

Practitioner Staff: Qualified members of a health profession who are legally entitled to practice in Saskatchewan and who have been appointed to the Practitioner Staff of the SHA, and to whom privileges may be granted by the SHA.

Safety report: Is a document prepared to '**report**' on a specific **safety incident**, process or outcome.

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Staff: SHA employees include in-scope, out of scope, full, part time and casual staff in all facilities owned, operated and leased by the SHA as well as SHA staff working in the community.

Team / Team Member: In the context of SHA policy, the team represents all individuals working, volunteering or learning within the SHA. This could include staff, practitioner staff, contracted individuals, patient family partners, knowledge keepers, volunteers, learners and contractors.

Unregulated Care Providers: Clinical workers who are not regulated or licensed. They have no legally defined scope of practice and may or may not have a mandatory education or established standards of practice. Unregulated care providers work within their scope of employment.

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APPENDIX B: MEDICAL DIRECTIVE

MEDICAL DIRECTIVE	
Emergency Treatment of Suspected or Actual Opioid Overdose	
Approval Date: October 17, 2024	**Effective Until:** October 17, 2027

This medical directive authorizes Saskatchewan Health Authority (SHA) staff to treat suspected opioid overdose by administration of naloxone as outlined in the Clinical Procedure CS-CP-0049 Naloxone Administration for Opioid Overdose – Actual or Suspected.

NOTE: Paramedics and Emergency Medical Responders delivering care within the EMS scope of employment will adhere to the Saskatchewan College of Paramedics clinical practice protocols for management of opioid overdose and the SHA EMS Drug Reference Cards.
SHA Registered Medical First Responders will follow the Opioid Poisoning (Administration of Naloxone-Narcan) MFR clinical practice protocol.

Adult dosing

- naloxone 0.4 mg IV push / IM every 2 to 3 minutes PRN, to a maximum of 10 mg
  or if IV / IM not available
- naloxone 4 mg Intranasal every 2 to 3 minutes PRN, to a maximum of 24 mg, alternate nostrils with each dose

Pediatric dosing

- naloxone 0.04 mg/kg IV push / IM per dose (up to 0.4 mg per dose) every 2 to 3 minutes PRN, to a maximum total dose of 10 mg.

Weight (kg)	Naloxone Dose
Less than 10 kg	0.04 mg/kg
10 kg or over	0.4 mg

  Or if IV / IM not available
- naloxone 0.4 mg/kg intranasal (up to 4 mg per dose) every 2 to 3 minutes PRN, to a maximum total dose of 24 mg, alternate nostrils for each dose.
  - Use intranasal mucosal atomization device as the preferred device for patients less than 10 kg.

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- If atomization device not available, for patients of all weights use pre-manufactured intranasal naloxone 4 mg intranasal every 2 to 3 minutes PRN, to a maximum total dose of 24 mg.

Weight (kg)	Naloxone Intranasal Dose	Preferred Device
Less than 10 kg	0.4 mg/kg	Intranasal Mucosal Atomization Device
10 kg or over	4 mg	Pre-Manufactured Intranasal Naloxone

This medical directive has been approved by:

____

Dr. Susan Shaw
Chief Medical Officer

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APPENDIX C: SAVE ME

Go slow, continuously evaluating the impact of your actions on the individual, and remembering to take breaths for yourself. Professionals are the best equipped to deal with an overdose situation - find extra support (if available) until they arrive.

SAVE ME

	S	**Stimulate.** Can you wake them? Call their name, give sternal rub (demonstrate), tell them to breathe. **If you cannot wake them call 911.** If you have to leave them, put them in the recovery position. Calmly, tell the operator the person is **not breathing and not responsive.** **Follow directions given by 911 dispatcher.**	When approaching a stranger – use foot to nudge their foot, yell at them to wake up. Be wary when approaching people who appear to be “sleeping” or “unresponsive”– be sure to say out loud the actions you are doing. Check breathing. A person needs to take a breath every 5 seconds. If person responds keep them moving and awake – watch them for several hours.
	A	**Airway.** Make sure nothing is in their mouth that keeps them from breathing – gum, food, pills, rig cap, etc.	Moving the head can sometimes get someone breathing again. Look, listen, feel if they are breathing. Hold your head above the individual’s mouth, looking towards chest.
	V	**Ventilate.** Breathe for them. Tilt head back, place barrier over mouth, plug nose, and **give 2 breaths**. Breath should be big enough to make person’s chest rise. Continue to breathe for the person – **one breath every 5 seconds**.	The instructions are on the mouth barrier. You cannot catch HIV by giving mouth to mouth. If you are still concerned about touching someone’s mouth and do not have a breathing mask – can give rescue breaths through a shirt placed over their open mouth and plugged nose.

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☑	***E***	**Evaluate.** Are they any better? If not, prepare naloxone. If you are the only responder, you can stop breaths temporarily while you get naloxone ready.	10 second pulse check if (there should be 10-12 heartbeats in this time) Has breathing and skin colour improved? **If you do not have naloxone – just breathe.** Keep breathing for them until the ambulance arrives. This can be very effective.
	M	**Muscular Injection.** Inject 1cc of naloxone into a muscle at a 90° angle. Outer thigh or the meaty part of the shoulder. Can give through clothing.	You should take a deep breath before administering naloxone. If this is not an opioid overdose naloxone will have no effect.
☑	***E***	If you haven't called 911 yet, call **NOW**. It's important to **call 911** because: ➢ there might be another medical emergency that naloxone will not work for, or the overdose may not have been from opioids alone ➢ the person may overdose again when the naloxone wears off ➢ there is a small chance of side effects from the naloxone, such as a hypersensitivity (allergic) reaction **Evaluate and Support.** Is the person breathing on their own? Has their colour improved? If the naloxone has no effect within 5 minutes and opioids are involved administer another dose of naloxone. Tell the person not to use any more drugs for at least 2 hours. If person is feeling dope sick, tell them it will start to wear off in about 30 minutes and opioids in the system can reach the receptors again.	You may need to continue providing normal sized breaths, every five seconds into the person until the naloxone starts to work, and the person starts to breathe on their own or until the ambulance arrives. Counting out loud helps: one one thousand, two one thousand, three one thousand, four one thousand, breathe. Put needles in sharps container or plastic pop bottle with lid to dispose of safely.

When the paramedics arrive – be sure to tell them as much as possible – what the person has taken and what steps you have taken.

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APPENDIX D: REPLACED DOCUMENTS (*TBD*)

SHA Clinical Standards and procedures replaces all related:

- Departmental,
- Unit, or
- Former regional documents.

Teams may need to update local work standards to make sure they are not different from SHA Clinical Standards and procedure before they continue to use them.

This clinical standard and procedure replaces or partially replaces the following former regional health authority policies, procedures, forms or other related documents including but not limited to:

Policy/Procedure- Full Repeals

Name of former health region	Policy/Procedure/Form/Document Title	Document #

Policy/Procedure- Partial Repeals

Name of former health region	Policy/Procedure/Form/Document Title	Document #

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