

Intramuscular and Nasal Naloxone Administration: Suspected Opioid Poisoning (Overdose) Decision Support Tool

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Introduction

This Decision Support Tool (DST) is intended to support the *Naloxone Administration: Suspected Opioid Poisoning (Overdose)* Policy. This policy enables Alberta Health Services (AHS) staff to administer naloxone in response to a suspected opioid poisoning (overdose) in an emergency situation within AHS settings. In addition to the *Intramuscular Naloxone Administration: Suspected Opioid Poisoning (Overdose)* Procedure and the *Nasal Naloxone Administration: Suspected Opioid Poisoning (Overdose)* Procedure, this DST provides additional information on assessment and interventions when responding to suspected opioid poisoning (overdose) with intramuscular or nasal naloxone.

An authorized prescriber's order is not required to administer naloxone via intramuscular (IM) injection or intranasal (i.e., nasal naloxone) in an emergency situation.

In addition, AHS has a *First Response to a Medical Emergency in Common Areas Inside of an AHS Facility or Outside Within Close Proximity* Policy that staff should review in conjunction with this DST to be informed and prepared to respond to suspected opioid poisoning (overdose) in their work setting.

Program/Site Leadership establishes the first response requirements for a suspected opioid poisoning after assessing the risk of persons experiencing opioid poisoning in their work settings and the availability of resources to respond to a suspected opioid poisoning.

Presentation of Opioid Poisoning (Overdose)

Signs and Symptoms of Opioid Poisoning (Overdose)

- Slow or no breathing (where “slow” breathing means less than 12 breaths per minute)
- Unresponsive to voice or pain
- Pale face
- Lips or nails appear blue
- Gurgling or snoring sounds
- Choking or vomiting
- Cold or clammy skin
- Constricted or tiny pupils
- Seizure like movements or rigid posture

When encountering someone with any of the above signs or symptoms, gather information about the person or event from any witnesses or bystanders if possible.

Other Causes of Similar Presentation

There are many other substances and medical conditions that can cause decreased respirations and loss of consciousness. It is important that naloxone is not withheld due to an inability to confirm the substance consumed. Although substances such as alcohol and benzodiazepines produce the same respiratory effect but will not respond to naloxone administration, poisonings often involve multiple substances and naloxone administration will help to reverse the opioid component of a poisoning.

Some medical conditions such as hypoglycemia, sepsis, airway obstruction or central nervous system disorders can slow breathing rate as well. Although there is no maximum dose of naloxone, other causes of altered mental status or loss of consciousness must be considered if there are no improvements to the person's condition after multiple doses of naloxone. **The code team or 911 should always be engaged as part of all medical first response procedures.**

Naloxone Information

What is naloxone?

Naloxone is a fast-acting medication that temporarily reverses effects of opioids by blocking same receptors that opioid drugs bind to in the nervous system and digestive tract. Naloxone is not effective for central nervous system depression caused by non-opioid drugs (e.g., benzodiazepines, anesthetics, barbiturates, sedatives, alcohol). Naloxone should still be given in the event of a suspected opioid poisoning (overdose) as it can reverse the effects of the opioid component, if a combination of drugs has been taken. Some important medication information helpful for rescuers to know about naloxone is listed below.

Drug Class

Naloxone is classified as an opioid antagonist. It occupies the same receptors that opioids bind to in the brain and nervous system.

Use

Naloxone is used for emergency reversal of known or suspected opioid poisoning (overdose), including symptoms of respiratory and/or central nervous system depression.

Effects

Naloxone has no pharmacological effect in the absence of opioids. It will only act on opioid receptors and will not reverse poisoning (overdose) from other drugs. It begins to produce effects in the body after 3 to 5 minutes (when given by intramuscular injection or nasal spray). Naloxone is active in the body for 20 to 90 minutes and can vary depending on route of administration.

Naloxone has a higher affinity (is more attracted) for opioid receptors than most opioids and rapidly displaces any opioids bound to these receptors, thus temporarily reversing symptoms or effects of opioids in the body.

Routes of Administration

Naloxone is available in injectable or nasal spray formulations. In Canada, injectable naloxone is known by its generic name, naloxone hydrochloride. Injectable naloxone is to be given by intramuscular (IM) injection. IM injections are given in the muscle. The preferred injection site for IM injection of naloxone is the vastus lateralis muscle, located at the middle outer thigh. The recommended alternate site when the vastus lateralis is not available is deltoid muscle, located at the upper outer arm.

Nasal naloxone, which is administered as a spray into the nostril (intranasal route), is known by its trade name, NARCAN™ Nasal Spray. Both injectable and nasal naloxone hydrochloride and are the same medication and produce the same effects despite different routes of administration. The intranasal route is reserved for select settings at AHS

Dosage

Injectable Naloxone

Injectable naloxone is stored in single-use medication ampoules/ vials. Each vial contains 0.4mg of naloxone (1mL of 0.4 mg/mL solution). Each vial is considered 1 dose for children and adults. Dosage recommendations from the injectable naloxone Product Monograph (Omega Labs, 2017) and the AHS *Intramuscular Naloxone Administration: Suspected Opioid Poisoning (Overdose)* Procedure include:

- An initial dose of 0.4 mg followed by repeated doses of 0.4 mg at 3 to 5 minute intervals until desired improvement
- Additional supportive measures may be necessary while waiting for emergency support (e.g., rescue breathing or CPR)

Nasal Naloxone

Nasal naloxone is stored in an intranasal spray device that contains 4mg of naloxone (0.1mL of a 40mg/mL solution). Each 4mg device is considered 1 dose for children and adults. For newborns or children under 2 years old, injectable administration of naloxone (where 1 vial contains 0.4mg of naloxone) may be recommended in order to administer smaller doses. Dosage recommendations from the nasal spray naloxone Product Monograph (Adapt Pharma, 2017) and the AHS *Nasal Naloxone Administration: Suspected Opioid Poisoning (Overdose)* Procedure include:

- An initial dose of 4 mg followed by repeated doses of 4 mg at 3 to 5 minute intervals until desired improvement
Additional supportive measures may be necessary while waiting for emergency support (e.g., rescue breathing or CPR)

Naloxone administration may be repeated every 3 to 5 minutes as needed. Although there is no maximum dose of naloxone, the likelihood of other/additional causes of altered mental status or loss of consciousness increases if there is no improvement to the person's condition after multiple doses of naloxone.

Contraindications and Interactions

The only situation where a person should not be given naloxone (referred to as a contraindication) is known hypersensitivity (allergy) to naloxone hydrochloride or any ingredients in the formulation of the drug or component of the container of the drug. Some of these ingredients include hydrochloric acid, methylparaben, propylparaben, and sodium chloride.

There are no known interactions with any drugs, food or herbs.

These are factors that may not be known to the responder at the time of response to a suspected opioid poisoning (overdose). It is important to note that opioid poisoning (overdose) can result in fatality and measures to reverse opioid effects and restore breathing and vital organ function are priority. In any suspected opioid poisoning, it is important to ensure that the appropriate emergency response processes are activated in your setting so that EMS or the designated first response team can support the person appropriately. This is particularly true in the unlikely event that the person has a hypersensitivity response to naloxone,

Warnings and Adverse Reactions

Before giving anyone naloxone, activate the emergency response process in your work setting (e.g., 911, Code 66, Code Blue) to ensure that appropriate support is on the way to provide continuing care. Many opioids have longer half-lives (last longer in the body) than naloxone. Thus, individuals who receive naloxone should be kept under continued surveillance to monitor for rebound opioid toxicity, which is the re-emergence of symptoms of opioid poisoning (overdose) following the reversal of opioid poisoning (overdose) symptoms by naloxone.

Abrupt reversal of opioid poisoning (overdose) symptoms may result in nausea, vomiting, sweating, increased heart rate and blood pressure, and tremor. For people who have a physical dependence to opioids, administering naloxone may result in acute opioid withdrawal. Refer to [Acute Opioid Withdrawal](#) section for more information.

Storage

Injectable naloxone should be stored between 15°C to 30°C, and protected from light. Nasal spray naloxone should be kept in its box until ready to use, and stored between 15°C to 25°C. Expired naloxone or naloxone exposed outside of the recommended temperature range may not be as effective but will not cause harm and **should still be used if it is the only naloxone available when responding to a suspected opioid poisoning (overdose).**

Note: in AHS settings, Naloxone Kits and naloxone for administration should be stored as per the AHS Accreditation Medication Management. See [AHS Safer Practice Notice: Medication Storage](#) for more information.

Naloxone Response Supplies

Naloxone response supplies shall be available in areas where risk is identified by Site Leadership and be easily accessible so that they can be quickly gathered when responding to an emergency situation. Some sites may have established crash carts or kits with naloxone considered as ward stock medication, while others may be equipped only with naloxone kits intended for staff administration (different from the black naloxone kits supplied by the Community Based Naloxone Program).

Intramuscular naloxone response supplies should include:

- 3 ampoules/vials of injectable naloxone hydrochloride (0.4 mg/mL);
- Disposable gloves;
- Needles;
- Safety engineered syringes;
- Alcohol swabs; and
- One-way barrier mask for rescue breathing.

Nasal naloxone response supplies should include:

- At least 2 nasal naloxone spray devices (1 box from the manufacturer contains 2 nasal spray devices, with 4 mg naloxone in each device);
- Disposable gloves;
- One-way barrier mask for rescue breathing.

Responding to Suspected Opioid Poisoning (Overdose)

There are 2 algorithms that may be used to accompany this section to support decision making and action in response to suspected opioid poisoning (overdose):

1. *Algorithm for Intramuscular Naloxone Administration in Suspected Opioid Poisoning (Overdose)*
2. *Algorithm for Nasal Naloxone Administration in Suspected Opioid Poisoning (Overdose)*

Note that the algorithm step numbers do not align with the numbered steps below, as they are intended to simplify the actions and steps in a visual manner. The numbered steps that follow outline the detailed response to a suspected opioid poisoning (overdose) in an AHS setting.

1. Look for signs and symptoms of opioid poisoning (overdose).

These may include:

- a) Slow or no breathing (where slow breathing is less than 12 breaths per minute);
- b) Unresponsive to voice or pain;
- c) Pale face;
- d) Lips or nails appear blue;

- e) Gurgling or snoring sounds;
- f) Choking or vomiting;
- g) Cold or clammy skin;
- h) Constricted or tiny pupils; and
- i) Seizure-like movements or rigid posture.

If you see any of these signs, call for assistance immediately using the emergency response processes in your work setting (e.g., call 911, Code 66, Code Blue) and proceed to step 2.

2. Assess the scene for safety and check for response.

- a) Assess the scene for any hazards, which may include sharp objects, blood and body fluids, unknown substances, and drug paraphernalia and determine whether it is safe to respond.
- b) If you consider it unsafe to respond, ensure that emergency response processes are activated and clear the surrounding area of bystanders or any obstacles to ensure emergency response can be provided without delay.
- c) If you consider it safe to respond, don disposable gloves and remove any hazards that are safe to remove in order to respond (e.g., dispose of sharps appropriately, clear obstructions carefully) and proceed to step 2. d).
- d) Check for response by speaking loudly to the person. Try to wake them. Verbalize your actions. (e.g., “Hey! Hello! Wake up! Can you hear me? I am trying to wake you up to make sure you are okay.”)
- e) If they do not wake up to loud voice, check for response to pain by performing a sternal rub. Firmly rub your closed fist on the middle of the chest (breast bone) in a back and forth motion. Verbalize this even if the person is not responding. (e.g., “I am going to rub my fist on your chest to try to wake you. Please wake up!”)
- f) If the person does not respond to voice or pain, proceed to step 3.

3. Assess breaths (respirations).

- a) Check for breaths by watching or placing your hand on the person’s chest and abdomen for rising and falling with inhalation and exhalation.
- b) Place your ear by the person’s nose to listen and feel for exhalation.
- c) **If the person is breathing, place them in recovery position** by turning them on their side with their arm bent so that the hand supports the head as it rests on the ground, and the legs are bent and pulled slightly forward to prevent from rolling onto the abdomen. Recovery position allows the person’s airway to remain open and prevents aspiration or choking, should the person start to vomit. Any time the person is to be left alone, they should be placed in recovery position. Remain with the person until help arrives if you can and frequently check for any changes in breathing.
- d) **If the person is breathing less than 12 breaths per minute, unable to**

follow prompts to breathe, or not breathing at all, provide rescue breaths with a barrier mask; proceed to step 4.

- e) **Note:** personnel with CPR training may start CPR if required, until emergency medical assistance arrives.

4. Provide rescue breaths for 2 minutes and evaluate.

Note: some sites may have procedures in place for airway management and should follow their work setting processes.

- a) Place the person on their back on the ground or other firm surface.
- b) Tilt the head back and lift the chin up to open the airway.
- c) Open their mouth and place the barrier mask as instructed in the pictures and text on the mask.
- d) Pinch nostrils with one hand and blow into the mouthpiece of the mask 2 times to check for a clear airway.
 - i. If the airway is clear, the breaths will result in a rise and fall of the chest.
 - ii. If the airway is not clear, there will be no observed rise and fall of the chest, or their cheeks may inflate with air. If this happens, repeat the head tilt, chin lift or jaw-thrust to open the airway and repeat the 2 test breaths until the airway is clear.
 - iii. If a clear airway cannot be established through repositioning, or an obstruction is suspected or visible, follow emergency processes for your site for airway management.
- e) Provide 1 rescue breath every 5 seconds by blowing into the mouthpiece while pinching the person's nostrils.
- f) If after 2 minutes of rescue breathing (about 24 breaths) there is no change—they have not started to wake up or breathe on their own—proceed to preparation and administration of naloxone in step 5.

5. Preparation and administration of naloxone injection or nasal spray.

A. Naloxone for injection.

<p>For naloxone vials:</p> <ul style="list-style-type: none"> a) Pull plastic cap off naloxone vial. b) Attach needle to syringe as needed and remove cap off the needle. c) Insert needle in to the rubber top of the naloxone vial and invert so the vial is upside down with needle still inside. d) Once upside down, pull back on the plunger of the syringe and watch the liquid drip in to the syringe barrel. Ensure the needle tip is always in the liquid and not drawing air from the vial. 	<p>For naloxone ampoules:</p> <ul style="list-style-type: none"> a) Break off the top of the naloxone ampoule at the indicated line using an ampoule breaker, if available, or an alcohol swab in package. b) Attach needle to syringe as needed and remove cap off the needle. c) Carefully insert needle into the open naloxone ampoule and pull back on the plunger of the syringe and watch the liquid draw up into the barrel of the syringe.
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(Pull the needle out slightly as the volume of liquid lowers).	d) Ensure the needle tip is always in the liquid and not drawing air from the ampoule.
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- e) There should be at least 1 mL of naloxone in the syringe when you have drawn up all the contents of the vial/ampoule. Push out any excess liquid or air by pushing the plunger gently. If there are large air bubbles, flick the barrel with your finger to pop them. Small bubbles are not a concern, as the injection will be given in the muscle. Keep the vial or ampoule for emergency support to see when they arrive.
- f) Prepare to inject by exposing the skin at the injection site, if possible, and cleaning with alcohol swab. If not possible, may inject through clothing.
- g) Inject needle at a 90 degree angle into the vastus lateralis muscle (middle outer thigh) for more rapid absorption.
- h) If the vastus lateralis is not available, may inject into the deltoid muscle (upper outer arm), but may result in slower rate of absorption.
- i) Depress plunger of syringe until all contents of the syringe have been injected into the muscle.
- j) Remove the needle from the muscle in the same direction it entered. Do not recap needle. Be aware of safety engineered syringes (e.g., safety needles, SafetyGlide™, VanishPoint™) that are designed to safely secure the needle after injection to prevent accidental needlestick injuries.
- k) Dispose of needle appropriately (e.g., in biohazard container if available, in naloxone kit for later disposal).
- l) Any bleeding at the injection site can be wiped with a gauze or a tissue. Avoid use of alcohol swabs post-injection as they do not stop bleeding and can cause irritation.

B. Nasal naloxone spray.

- a) Read the instructions on the spray device.
- b) Remove the device from the box. **No additional assembly is required for use.**
- c) Hold the spray with thumb on the plunger and first and third finger on either side of the nozzle.
 - a) Tilt person's head back and support their neck with hand.
 - b) Gently insert the tip of the nozzle into single nostril fully (until fingers on either side of the nozzle are against the person's nose). Alternate nostrils with each dose.
 - c) Press the plunger firmly with thumb to give dose of nasal naloxone spray.
 - d) Remove the device from the nostril.

6. Resume rescue breathing for 2 minutes then evaluate.

- a) It is important to wait at least 2 minutes in between doses of naloxone to assess the person's response, and to continue rescue breathing in between doses.
- b) Provide 1 breath every 5 seconds as per step 4.
- c) If after 2 minutes of rescue breathing, there is no change indicating the naloxone is effective (e.g., improved colour, movement, moaning, independent breathing, eyes opening), repeat preparation and administration of naloxone and follow with 2 minutes of rescue breathing in between doses (steps 5 and 6).

- d) Continue to provide rescue breaths as needed or monitor and prompt breaths until help arrives.
- e) Repeated doses of naloxone may be required if the person is not awake, not responding to commands, or emergency medical assistance is delayed

7. Provide support and aftercare.

- a) If the person becomes responsive (e.g., alert and breathing independently), prompt them to breathe every 5 seconds. Put them in recovery position while you wait for help to arrive and continue to monitor and prompt breathing.
- b) The person may be frightened, confused, overwhelmed or agitated once they regain consciousness. Remain calm and supportive and continue to verbalize all your actions so that the person is informed and feels included in their care. This will minimize anxiety, feelings of disorientation or shock. (e.g., “Take a deep breath now. I am going to remind you to take a breath regularly so we can keep you awake. You are safe. You were unconscious and not breathing. Help is on the way. I am going to place you on your side so your airway stays open and you can take better breaths. I will stay with you.”)
- c) Debrief with the person when they are alert and oriented to the present. Explain the events leading up to the decision to administer naloxone and other actions taken.
- d) Provide appropriate information and education to the person affected about naloxone, its effects and duration, safety precautions and risk of rebound or recurrent poisoning (overdose) after naloxone wears off.
 - i. Explain how the effects of naloxone may last for 20-90 minutes, while most opioids will last for 2 hours or more, which can lead to a rebound poisoning (overdose) occurring.
 - ii. Explain the importance of not taking more opioids following naloxone administration, as there is a risk a poisoning (overdose) can re-occur. It is also important to let them know the opioids may not work in the presence of naloxone (i.e. they will not get “high” or feel opioid effects).
 - iii. If individual is opioid dependent and experiencing withdrawal symptoms, let them know that when the naloxone wears off, these symptoms may subside. See [Acute Opioid Withdrawal](#) section for more information.
- e) Explain the importance of receiving follow-up care and monitoring, as
 - i. Poisoning (overdose) signs and symptoms may return.
 - ii. They may have additional injuries (e.g., head injury, lacerations, etc.).
 - iii. They may have aspirated on vomit (a risk for pneumonia).
- f) If available, provide a Naloxone Kit as a precaution, and provide training as needed. Other resources for support after discharge may be offered.

8. Hand over care to emergency medical assistance.

- a) Provide appropriate handover of care and information on the events to the emergency medical assistance personnel taking over care.

- b) If the individual is resolved to leave before emergency support arrives, advise them to remain with people they trust or go to a Supervised Consumption Site, if available, for at least 2 hours to ensure that someone is available to respond, should the poisoning (overdose) symptoms return. If they plan to use again, provide some safer substance use education per the [Naloxone and Poisoning \(Overdose\) Prevention Education](#) section.

Special Considerations

Acute Opioid Withdrawal

For people who have a physical dependence to opioids, administering naloxone may result in acute opioid withdrawal syndrome, which are symptoms of withdrawal. Care in the form of comfort measures and possibly other medications for symptom relief may be required.

Symptoms may include:

- Pain
- Fever
- Sweating
- Runny nose and teary eyes
- Sneezing
- Chills/tremor
- Convulsion
- Irritability
- Diarrhea
- Nausea
- Increased blood pressure and heartrate
- Dilated pupils

Children/Youth

Naloxone is indicated for people of all ages experiencing a suspected opioid poisoning (overdose). For injectable naloxone, each 0.4 mg/mL vial is considered 1 dose for children and adults. For nasal spray naloxone, each 4 mg device is considered 1 dose for children and adults. Children receiving naloxone should receive appropriate follow up care. Naloxone should only be administered to newborns if needed, as it may trigger acute opioid withdrawal in the opioid dependent newborn, which may not be appropriately treated if not recognized immediately.

Note: parts of the Naloxone Kit and response equipment may pose a physical hazard to young children and should be kept out of reach.

Pregnancy

People may use opioids while pregnant. In rat studies with doses up to 1000 times the usual dose for humans, there is no evidence of harm to rat fetuses. Because there have not been any studies specific to human pregnancy, and because naloxone is known to cross the placenta, caution is recommended. This needs to be weighed against the certain danger to the fetus from opioid poisoning (overdose) and death. Lack of oxygen from opioid-induced respiratory depression risks the life and well-being of the pregnant person and the health of their pregnancy. Because acute withdrawal can trigger fetal distress and may initiate premature labour, emergency medical support needs to be called immediately and the person monitored until their arrival. Start with the lowest dose (0.4 mg) and provide additional doses after waiting 3 to 5 minutes, and only if signs and symptoms are still present. Rescue breathing must be provided if the person isn't breathing effectively, regardless of whether or not naloxone is administered. The use of naloxone in pregnancy has been endorsed by the American College of Obstetricians and Gynecologists.

Naloxone and Poisoning (Overdose) Prevention Education

Post-poisoning (overdose) response, the individual should be provided with the following information. AHS staff should use their judgement to determine if timing is appropriate to discuss the following:

1. **Naloxone Kits:** Offer a naloxone kit and training on poisoning (overdose) prevention, recognition and response. Ensure that friends or family know where to find the kit in the event of an emergency.
2. **Poisoning (overdose) prevention education:**
 - Always do a test dose first – sample a small amount of a substance to check for potency or strength and determine how your body will react, and increase slowly.
 - Know your tolerance – tolerance can decrease within a very short period of time of abstinence (e.g., hospitalization, completion of detoxification or treatment, incarceration) and can increase sensitivity to drugs and risk of poisoning (overdose). Consider using less if you have had any period of abstinence.
 - Changing route of administration to one that carries less risk (e.g., switch from intravenous use to oral/nasal administration or smoking).
 - Avoid mixing substances – use one drug at a time to ensure tolerance before adding others to the mix, and be aware of how drugs might interact and produce negative effects (e.g., prescription medications, street drugs, cannabis, alcohol, etc.). Educate about the additive effects of mixing more than 1 depressant substance (e.g., alcohol, benzodiazepines, and opioids).
3. **Safety Planning:** Ask if they would consider incorporating family or friends into a safety plan and educating those identified about poisoning (overdose). If creating a safety plan with a patient admitted to an AHS facility, see [AHS Supporting Documents](#) for the AHS Addiction and Mental Health *Safety Plan* form for guidance.

- Avoid using alone.
 - Use a Supervised Consumption Service or Overdose Prevention Site if available, or use with others.
 - If using with others, stagger use, so that someone is alert and able to respond to any emergencies.
 - If using alone, leave your door unlocked so that emergency support can enter with no delay.
 - If using alone, ask someone to check on you when you plan to use.
 - Have a safety plan in place.
- Know the signs and symptoms of poisoning (overdose) and call 911 always for direction and support.

Aftercare for Responders, Friends and Families

Responder

Caring for someone who has experienced poisoning (overdose) can be traumatic. This can lead to staff/responder burn-out, compassion fatigue, and/or vicarious or secondary trauma. Prevent vicarious trauma and burnout by rapidly responding with debriefing opportunities or stress reduction, like breathing techniques that slow the fight or flight response. Make sure you and your colleagues have the contact information for the Employee and Family Assistance Program (EFAP) or other resources for support. Take the time to compile your own menu of self-care strategies that work for you and are mental health promoting. Use the strategies. Be aware of any changes that may indicate you or your colleagues are experiencing vicarious trauma or burnout. These may include changes in job performance, morale, behaviour, or interpersonal relations.

Friends and Family

If friends or family members witnesses the poisoning (overdose) response, it can also be traumatic for them.

- Provide resources for short-term and long-term support if appropriate
- Offer a Naloxone Kit and training

Potential supports include:

- Alberta Mental Health Help Line: 1 (877) 303-2642
- Alberta Addictions Helpline 1 (866) 332-2322
- Distress Line (Edmonton and area): (780) 482-4357
- Distress Centre (Calgary and area): (403) 266-4357
- Distress Line of South Western Alberta: (403) 327-7905
- First Nations and Inuit Hope for Wellness Help Line 1 (855) 242-3310
- Kids Help Phone 1 (800) 668-6868

- Rural Distress Line: 1 (800) 232-7288
- 2-1-1 to speak to an Information & Referral Specialist, or search the online community resource directory (www.211.ca)
- Inform Alberta (www.informalberta.ca)

Documentation

AHS facilities shall incorporate the processes for documentation of responses to medical emergencies. Document all interventions and medications administered in the patient's health record (if available) as per the [Clinical Documentation Process Directive](#) and any site/unit-specific practices. If the health record is not available or the person is not a registered patient, provide a report to others taking over care of the patient.

If applicable, complete

- Any site or zone-specific documentation as appropriate.
- Incident report as per internal program reporting process (e.g., Protective Services, Reporting and Learning System).
- MySafetyNet report to comply with Workplace Health and Safety reporting (e.g., injury at work, blood or bodily fluid exposure, drug exposure).

Items to consider for documentation

- Time you arrived on scene of incident.
- Time first response was activated, or emergency medical support was called.
- Initial assessment of the patient (objective and subjective assessments).
- Interventions performed, may include:
 - Rescue breathing or CPR
 - Medications administered (including route, time, dose, reason)
- Patient response to interventions
- Disposition of patient (transported to hospital, returned to unit, refused EMS transport, etc.)
- Education and/or referrals provided

References

AHS Supporting Documents

- *Clinical Documentation Process Directive*,
<https://extranet.ahsnet.ca/teams/policydocuments/1/clp-clinical-documentation-process-directive.pdf>

- *First Response to a Medical Emergency in Common Areas Inside of an AHS Facility or Outside Within Close Proximity Policy*,
<https://extranet.ahsnet.ca/teams/policydocuments/1/clp-first-response-med-emerg-common-area-ahs-facility-close-proximity-pol-hcs-198.pdf>
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