Adult Care Facility Naloxone Policy & Procedure Toolkit

October 2024

Acknowledgements

The original toolkit was created for the use in Nursing Homes by IPRO QIN-QIO Nursing Home Naloxone Workgroup which included:

Robert C. Accetta, RPh, BCGP, FASCP, Rivercare Consulting, LLC and Senior Pharmacist, IPRO, Lake Success, New York

Mary Gracey-White, RN, BSN, QCP, Greater New York Health Care Facilities Association. New York, New York

William C. Hallett, Pharm.D., MBA, BCGP, President/CEO, Guardian Consulting Services, Inc., New York, New York

Anita Jacobson, Pharm.D, Clinical Professor, University of Rhode Island, College of Pharmacy, Kingston, Rhode Island

Diane Judson, RN, BSHA, IPC, Assistant Director, IPRO, Lake Success, New York

Carrie Lang, MSPOD, Project Manager, Non-Profit & Opioid Programs, The Center for Health Affairs, Cleveland, Ohio

Anne Myrka, RPh, MAT, Senior Director, IPRO, Albany, New York

Dallas L. Nelson, M.D. Associate Professor of Medicine, University of Rochester School of Medicine and Dentistry, Department of Medicine/Geriatric Medicine Division, Rochester, New York

Amy Terry, MS, Director, Northeast Ohio Hospital Opioid Consortium, The Center for Health Affairs, Cleveland, Ohio

Tara Vargovich, Program Manager, Emergency Preparedness, The Center for Health Affairs, Cleveland, Ohio

Lynn Wilson, MS, Senior Quality Improvement Specialist, IPRO, Albany, NY

With permission from Robert Accetta, the Adult Care Facility Toolkit was developed using the nursing home toolkit as a basis and modified accordingly by:

Karen Walker/Deputy Director, Office of Long -Term Care and Aging, Center for Residential Surveillance, Division of Adult Care Facility and Assisted Living Surveillance, Albany, NY

Heather Evans, BSN, RN, Bureau of Quality and Surveillance, Albany, NY

Table of Contents

Introduction

The Opioid Crisis in the United States has been fueled due to the availability of prescription and illicit drugs.

The Acting Secretary of the Department of Health & Human Services (HHS) declared a Public Health Emergency on October 26, 2017. The Centers for Disease Control and Prevention (CDC) has defined the opioid overdose crisis as arriving in three distinct waves: the first wave with an increase in deaths due to prescription opioids in the 1990s; the second wave due to increased deaths related to heroin beginning in 2010; and the third wave due to synthetic and illicitly manufactured fentanyl beginning in 2013. The number of drug overdose deaths increased by nearly 30% from 2019 to 2020 and quintupled since 1999. Provisional data from CDC's National Center for Health Statistics indicate there were an estimated 107,622 drug overdose deaths in the United States during 2021, an increase of nearly 15% from the 93,655 deaths estimated in 2020. [1]

"I, Surgeon General of the United States Public Health Service, VADM Jerome Adams, am emphasizing the importance of the overdose-reversing drug naloxone. For patients currently taking high doses of opioids as prescribed for pain, individuals misusing prescription opioids, individuals using illicit opioids such as heroin or fentanyl, health care practitioners, family and friends of people who have an opioid use disorder, and community members who come into contact with people at risk for opioid overdose, ***knowing how to use naloxone and keeping it within reach can save a life.***

BE PREPARED. GET NALOXONE. SAVE A LIFE.[2]

Facilities should have a written policy to address opioid overdoses.

The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.

According to a CMS memo regarding Mental Health/Substance Use Disorder (SUD), CMS has identified a need to improve guidance related to meeting the unique health needs of residents with mental health diagnoses and SUD. CMS clarified that when facilities care for residents with these conditions, policies and practices must not conflict with resident rights or other requirements of participation. They further clarified that facility staff should have knowledge of signs and symptoms of possible substance use, and are prepared to address emergencies (e.g., an overdose) by increasing monitoring, administering naloxone, initiating cardiopulmonary resuscitation (CPR) as appropriate, and contacting emergency medical services.[3]

This naloxone Adult Care Facility toolkit is intended to provide easy to adapt policies and procedures for Adult Homes that need to implement or improve their emergency response to opioid overdose, which includes naloxone administration. Additionally, every Adult Care Facility has been registered has an Opioid Overdose Prevention Program which allows for resources, training, and reordering of naloxone by visiting www.nyoverdose.org.

---

[1] CDC. U.S. Overdose Deaths In 2021 Increased Half as Much as in 2020 - But Are Still Up 15%. CDC. Published May 11, 2022. https://www.cdc.gov/nchs/pressroom/nchs_press_releases/2022/202205.htm

[2] U.S. Surgeon General's Advisory on Naloxone and Opioid Overdose | HHS.gov

[3] Revised Long-Term Care Surveyor Guidance | CMS. www.cms.gov. Accessed January 17, 2023. https://www.cms.gov/medicareprovider-enrollment-and-certificationsurveycertificationgeninfopolicy-and-memos-states-and/revised-long-term-care-surveyor-guidance

How to Use this Toolkit

The goal of the Adult Care Facility Naloxone Workgroup was to provide easily accessible, customizable, naloxone policies, procedures, and education resources in a brief toolkit. This toolkit includes evidence-based recommendations for responding to opioid-induced respiratory depression. The example policies and procedures can be edited to meet the needs of your organization. These are suggested policies that you can select and/or modify when creating policies for your facility.

A variety of resources for additional information on topics including substance use disorder, risks associated with opioid use, and guidance on the prescribing of opioids for pain management are included in the Resource Section.

Polysubstance Use and the Use of Naloxone:

This toolkit is intended to address opioid overdoses only. If naloxone doesn't work after multiple attempts, the loss of consciousness may be due to other drugs.

Assessing Residents with Risk Index for Overdose or Serious Opioid-Induced Respiratory Depression (RIOSORD)

[Company]	**FACILITY LOGO**
[Company Address]	

Policy Name	Assessing Residents with Risk Index for Overdose or Serious Opioid-Induced Respiratory Depression	**Policy No.**	
Effective Date		**Date Of Last Revision**	
Version No.		**Distribution**	Nursing/Case Manager
Applicable Regulations or Standard			
Administrator Signature		**Contact Information**	

Version	Approved By	Revision Date	Description Of Change	Author

Version History

Accountable Leadership

Administrator, Director of Nursing

Procedure Responsible Parties

Nursing, authorized staff

Policy

All residents with new opioid orders and not on a comfort measure only plan will be assessed for risk for overdose or serious opioid-induced respiratory depression using the RIOSORD Tool.

It is the responsibility of the facility/organization to ensure the policy aligns with all federal, state, and local agencies. This policy will be revised as required by updates or changes to federal, state, and local regulations and guidance.

Procedure

1. Nursing, Primary Care Physician or designee, will assess resident risk for opioid overdose or serious opioid-induced respiratory depression using the RIOSORD Tool (see attached "Risk Index for Overdose or Serious Opioid-Induced Respiratory Depression"). The risk result will be documented and noted in the care plan. Residents with a risk score of > 32 should receive a resident-specific naloxone medication order, if consistent with the resident's goal of care. For all residents receiving opioids, the care plan will include the availability of naloxone standing orders or naloxone rescue emergency supply in the event of opioid-induced respiratory depression.

Related Policies:

- Naloxone Education and Competency
- Naloxone Emergency Drill
- Naloxone Use for Opioid-Induced Respiratory Depression Policy and Procedures
- Standing Order for Use of Naloxone for Residents, Staff, or Visitors

Directions for Completing RIOSORD Assessment Tool

Consider completing this assessment upon admission, every 6 months, annually, and upon significant change (unless resident is on a comfort measure only plan). Tally the results and follow the instructions in the above policy for who to notify, obtain any resident specific naloxone orders, and complete the required documentation in the resident care plan. File completed assessments in the medical record.

Morphine Milligram Equivalent Calculation/Conversion Chart (To be used to answer the RIOSORD tool. Not to be used for prescription conversions. Please discuss prescription conversions with attending physician or prescriber.) Adapted from: https://www.cdc.gov/opioids/providers/prescribing/pdf/calculating-total-daily-dose.pdf

Opioid	**Conversion Factor**
Codeine	0.15
Fentanyl Transdermal (in mcg/hr)	2.4
Hydrocodone	1
Hydromorphone	4
Methadone 1-20mg/day	4
21-40mg/day	8
41-60mg/day	10
>= 61-80mg/day	12

Morphine	1
Oxycodone	1.5
Oxymorphone	3

Risk Index for Overdose or Serious Opioid-Induced Respiratory Depression (RIOSORD)

Description	Y/N	Score
In the past 6 months, has the resident had a health care visit (outpatient, inpatient, or ED) involving:		
Opioid dependence?		15
Chronic hepatitis or cirrhosis?		9
Bipolar disorder or schizophrenia?		7
Chronic pulmonary disease? (e.g., emphysema, chronic bronchitis, asthma, pneumoconiosis, asbestosis)		5
Chronic kidney disease with clinically significant renal impairment?		5
Active traumatic injury, excluding burns? (E.g., fracture, dislocation, contusion, laceration, wound)		4
Sleep apnea?		3
Does the resident consume:		
An extended-release or long-acting (ER/LA) formulation of any prescription opioid or opioid with long and/or variable half-life? (e.g., OxyContin, Oramorph-SR, methadone, fentanyl patch, levorphanol)		9
Methadone? (Methadone is a long-acting opioid, so also write Y for “ER/LA formulation”)		9
Oxycodone? (If it has an ER/LA formulation [e.g., OxyContin], also write Y for “ER/LA formulation”)		3
A prescription antidepressant ? (E.g., fluoxetine, citalopram, venlafaxine, amitriptyline)		7
? (e.g., diazepam, alprazolam) A prescription benzodiazepine		4
Is the resident’s current maximum prescribed opioid dose:		
>100 mg morphine equivalents per day?		16

Description	Y/N	Score
In the past 6 months, has the resident had a health care visit (outpatient, inpatient, or ED) involving:		
Opioid dependence?		15
Chronic hepatitis or cirrhosis?		9
Bipolar disorder or schizophrenia?		7
Chronic pulmonary disease? (e.g., emphysema, chronic bronchitis, asthma, pneumoconiosis, asbestosis)		5
Chronic kidney disease with clinically significant renal impairment?		5
Active traumatic injury, excluding burns? (E.g., fracture, dislocation, contusion, laceration, wound)		4
Sleep apnea?		3
Does the resident consume:		
An extended-release or long-acting (ER/LA) formulation of any prescription opioid or opioid with long and/or variable half-life? (e.g., OxyContin, Oramorph-SR, methadone, fentanyl patch, levorphanol)		9
Methadone? (Methadone is a long-acting opioid, so also write Y for "ER/LA formulation")		9
50-100 mg morphine equivalents per day?		9
20-50 mg morphine equivalents per day?		5
In the past 6 months, has the resident:		
Had 1 or more ED visits?		11
Been hospitalized for 1 or more days?		8
Total Score		

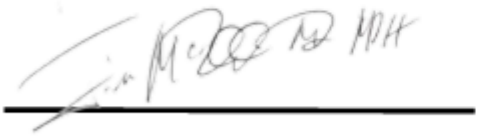
Adapted from: Zedler B, Xie L, Wang L et al. Development of a Risk Index for Serious Prescription Opioid-Induced Respiratory Depression or Overdose in Veterans' Health Administration Patients. Pain Medicine. Jun 2015. 16;1566-1579.

Assessment Completed by: _____Date_____

Non-Patient Specific Prescription for Naloxone with Pharmacy Dispensing Protocol

February 12, 2024

This non-patient specific prescription (standing order) for naloxone dispensing by pharmacists in New York State is issued contingent on compliance with the protocol and terms below. It is effective for the period February 13, 2024, through February 12, 2026 or until such time that I am no longer Commissioner of Health or if this prescription is rescinded or revised, whichever comes first. Questions regarding the scope or applicability of this standing order should be directed to naloxonepharmacy@health.ny.gov.



New York State License Number 186383
National Provider Identifier 1619966959
Medicaid no. 076963570

Dr. James V. McDonald, MD, MPH
Commissioner of Health
New York State Department of Health

Section 1: Purpose

Naloxone hydrochloride (naloxone HCL; naloxone), an opioid antagonist, is an easily administered medication proven to reverse opioid overdoses effectively when used in a timely manner. For more than 15 years, non-medical persons in New York State have successfully administered this medication on friends, family members, and complete strangers averting disability and loss of life. New York State is committed to ensuring broad, low threshold availability of naloxone, including in pharmacies where the public is accustomed to having its medication needs addressed. To that end, this standing order is issued authorizing pharmacists in New York State complying with the protocols established herein to dispense naloxone to individuals requesting this medication or who may otherwise benefit from it without a patient-specific prescription being in place. An individual prescribed and dispensed naloxone under this standing order may possess naloxone and the necessary supplies for its administration and administer it to anyone they believe may be experiencing an opioid overdose.

Section 2: Authority

The Commissioner of Health has broad authority under Public Health Law Section 3309(1) pertaining to the "opioid antagonist prescribing, dispensing, distribution, possession and administration." Non-patient specific prescribing and dispensing of naloxone is explicitly authorized in Public Health Law Section 3309(3)(b).

Section 3: Clinical Indication for Naloxone

Naloxone is indicated for the complete or partial reversal of respiratory depression induced by opioids. Untreated respiratory depression may lead to a cascade of catastrophic consequences, including cardiac arrest, brain damage and death.

Section 4: Warnings

In opioid dependent individuals, naloxone may precipitate acute opioid withdrawal whose symptoms include anxiety, running nose and eyes, chills, muscle discomfort, disorientation, combativeness, nausea, vomiting and diarrhea. These reactions may be dose dependent.Currently, the 4 mg variation is the approved and preferred dosing.

Section 5: Contraindications

Use of naloxone may be contraindicated in persons with a known history of adverse hypersensitivity to this medication or to a component of it, a rare eventuality. A history of opioid withdrawal symptoms is not a contraindication for naloxone administration.

Section 6: Authorized dispensers

This standing order applies to all pharmacists in New York State who are registered and are in good standing with the New York State Education Department's Board of Pharmacy and who are dispensing medications at a pharmacy licensed by the Board of Pharmacy in accordance with the Education Law.

Section 7: Eligible patients

Persons who request naloxone are eligible to have naloxone dispensed to them under this standing order. These persons include individuals who are at risk of experiencing an opioid overdose, as well as family members, friends and others in a position to assist an individual who is at risk of experiencing an opioid overdose.

Pharmacist-initiated dispensing of naloxone is also covered under this standing order. Pharmacists may be well-positioned to identify patients for whom having naloxone is advisable.

Adolescent patients under the age of 18 may be furnished naloxone if, in the opinion of the pharmacist, there are reasonably foreseeable circumstances in which this minor will be positioned to save a life by administering naloxone. This minor must be deemed to be sufficiently mature with respect to intellect and emotions to recognize an opioid overdose and to respond to it appropriately by calling 911 and administering naloxone. Where the requisite maturity or intellect out dispensing naloxone, may still stress the importance of calling 911 in all medical emergencies.

Section 8 Naloxone formulations

The following naloxone formulations may be dispensed under this standing order:

- Nasal naloxone with each single-dose spray containing 4 mg in a 0.1mL solution, to be dispensed in units of 2 doses.
  Current applicable product National Drug Codes (NDCs) include:
  - 69547-353 (Emergent Devices)
  - 0781-7176 (Sandoz)
  - 0093-2165 (Teva)
  - 45802-811 (Padagis)
- Injectable naloxone in single-use 1 mL vials with a strength of 0.4 mg/mL to

be dispensed in units of 2 vials accompanied by an intramuscular syringe for each vial.
Current applicable product National Drug Codes include:

- 0409-1215 (Hospira)
- 67457-292, 67457-599 and 06457-645 (Mylan)

In addition to the products specifically enumerated above, other naloxone formulations may be dispensed under this standing order so long as they have been approved by the United States Food and Drug Administration and are identical to one of the listed formulations in strength, dose volume, route of administration and pharmacologic action.

Section 9: Patient education

Patients are to be counseled and/or provided materials that address the following:

- Naloxone overview
  - Naloxone blocks the effect of opioids. Opioids include hydrocodone (Vicodin, Lorcet, Lortab, etc.), oxycodone (Percocet, Oxycontin, etc.), morphine, codeine, fentanyl, methadone, and heroin.
  - It usually takes effect within 2-5 minutes and lasts for 30-90 minutes, after which period an overdose state may return.
  - It is safe and effective when administered in a timely manner and has no effect if opioids are not present.
  - It will not reverse overdoses caused by substances than opioids, such as stimulants (cocaine, amphetamine, methamphetamine), alcohol and benzodiazepines.
  - If unsure what substances were used, administer naloxone.
- Risk factors for opioid overdose
  - Use of any opioid can slow breathing and put individuals at risk for overdose.
  - Risk for overdose may be increased by changes in tolerance or mixing opioids with other drugs, alcohol, or certain medications.
  - Periods of abstinence decrease tolerance and increase likelihood of an opioid overdose.
  - Using opioids alone decreases the chance someone will be able to help if an overdose occurs.
  - Fentanyl is now in many drugs, including heroin, cocaine, and pressed pills. Fentanyl is a strong opioid which increases the chance of an overdose, and which sometimes requires more than a single dose of naloxone after waiting 2-3 minutes after the first dose.
  - Patients who have experienced an overdose are at greater risk of having another one.
- Signs of opioid overdose
  - Person may be unresponsive and does not wake up even, when shaken and shouted at. If uncertain, apply a sternal rub (rubbing vigorously and with pressure up and down the center of the chest with one's knuckles) to verify an

unresponsive state.
    - Breathing is very slow or not apparent.
    - There may be gurgling sounds.
    - Lips or fingernails may be blue, pale, or gray.
- Steps in responding to an overdose
    - Administer naloxone
        - <u>For nasal naloxone:</u>
            1) Peel back the package to remove the device.
            2) Place and hold the tip of the nozzle in either nostril until your fingers touch the bottom of the patient's nose.
            3) Press the plunger firmly to release the dose into the patient's nose.
            4) Repeat with a second dose if there is no response after 2-3 minutes.

            Note: do NOT test the device. All medication is dispensed upon pushing plunger.
        - <u>For injectable naloxone: (not used in ACF)</u>
            1) Uncap the naloxone vial and remove the syringe from its packaging.
            2) Insert the needle through the rubber membrane on the naloxone vial, turn the vial upside down, draw up the entire content of the vial, and withdraw the needle.
            3) Insert the needle into the muscle of the upper arm or thigh, through clothing if necessary, and push on the plunger to inject all the naloxone.
            4) Repeat with a second dose if there is no response after 2-3 minutes.
    - Call 911
        1) Do this as soon as possible for any person not responding to sternal rub or otherwise. suspected of experiencing an opioid overdose.
        2) Tell the dispatcher that you are with someone who may have overdosed and let them know the precise location.

        Note: The 911/Good Samaritan law provides substantial protection against prosecution for possessing illegal drugs or for illegally providing alcohol in an emergency when aid is summoned.
    - After using naloxone
        - If you can, stay with the person until emergency medical services personnel arrive.
        - If the person wakes up:
            - Stay with them for at least 3 hours. They may stop breathing again and need more naloxone.
            - Encourage that they go with emergency medical personnel.
        - If the person does is not breathing and responsive to stimuli after the first dose and if

the responder knows either rescue breathing or cardiopulmonary resuscitation (CPR), use one of those techniques.
    - If the person is not breathing and remains unresponsive to stimuli 2-3 minutes after the first dose, administer another dose.
    - If you need to leave, turn the overdosed person on their side, placing one arm under the head to prevent them from choking.
- Information on how to access the New York State Office of Addiction Services and Supports (OASAS) HOPEline by calling 1-877-8-HOPENY (1-877-846-7369) or by texting to HOPENY (467369).
- Additional information as determined appropriate by the pharmacist.

Section 10: Record keeping and reporting naloxone dispensing

All naloxone dispensing must be documented consistent with applicable laws and regulations and with standard pharmacy practice.

Naloxone dispensing under this standing order must be reported to New York State Department of Health on a quarterly basis in a format provided by New York State Department of Health.

The timeframes for this reporting are three- month periods starting January 1, April 1, July 1 and October 1, with report.

Section 11: Naloxone Co-payment Assistance Program (N-CAP)

Pharmacists should make best efforts to ensure maximum use of Naloxone Co-payment Assistance Program by 1) being enrolled for participation in this program; and 2) processing Naloxone Co-payment Assistance Program claims for persons with prescription drug coverage as part of their health insurance. N-CAP will cover copays up to $40 when filling through the pharmacy. For further information please visit: Naloxone Co-payment Assistance Program Frequently Asked Questions and Answers (ny.gov)

Section 12: Public directory of pharmacies dispensing naloxone

All pharmacies must provide their address, hours of operation and telephone number in a format specified by New York State Department of Health for purposes of inclusion in an online, public-facing directory. Public directory of pharmacies must be submitted to the New York State Department of Health Quarterly Reporting Naloxone Dispensing and Public directory Portal that can be found HERE.

Template for naloxone administration education policy and procedure (Facility should modify as necessary)

Accountable Leadership

Administrator, Director of Nursing

Procedure Responsible Parties

Nursing, authorized staff

Policy

Upon a physician's medication order per resident (if it is resident specific) or NYS standing order for pharmacy distribution if necessary, or by becoming an Opioid Overdose Prevention Program, naloxone may be administered by staff to residents/patients/staff/visitors as indicated for the complete or partial reversal of suspected opioid-induced respiratory depression.

Identifying suspected opioid-induced respiratory depression:

- Person with recent inpatient hospitalization for suspected opioid overdose
- Person with diagnosis of opioid use disorder
- Person with history of opioid use or dependence, or diagnosed substance use disorder
- Person with current prescribed opioid orders
- Person with current prescribed opioid and benzodiazepine orders
- Past opioid use and justice involved resident
- Person with co-morbid diseases that may adversely affect respiratory status
- Current or recent registrant of a methadone maintenance program, or a detox program
- Visitor: Friends and family members of the above who may visit the resident and provide illicit or prescription opioids
- Resident who frequently attempt to elope or leave the facility premises

It is the responsibility of the facility/organization to ensure the policy aligns with all federal, state, and local agencies. This policy will be revised as required by updates or changes to federal, state, and local regulation and guidance.

Equipment

- Naloxone nasal spray
- Medication administration record (if applicable)
- Dispensing tracking form

Procedure

FACILITY

1. Naloxone intranasal formulation should be stocked in the emergency medication kit or automated dispensing machine (ADM) with at least 2 doses in each emergency medication kit or equivalent in the ADM. This kit should be accessible to all staff, residents, and visitors.
2. All Adult Care Facility staff will be educated upon employment orientation and annually on Naloxone Administration. Education should include the Use for Opioid-Induced Respiratory Depression, including participation in response drills, competency evaluations, awareness applicable Good Samaritan law, federal, state and local regulations. Training by the Office of Drug User Health will be offered and is available online. Facilities should also train their residents on the use of naloxone as appropriate.

Purpose:

1. To prevent delay in treatment that may result in resident harm, the facility shall use the approved standing order (see, “Standing Order for Use of Naloxone”) for the facility to allow administration of Naloxone to any resident, staff or visitor upon reasonable suspicion of opioid-induced respiratory depression, without having to first obtain a verbal or written order. Such reasonable suspicion shall be based on presentation of symptoms of opioid-induced respiratory depression as described in this policy and procedure.

Procedure:

1. CALL 911 if opioid-induced respiratory depression/overdose is suspected. Activate Code Blue/Activate Emergency Response Protocol
    - If resident is receiving comfort only plan of care, hospice or end-of-life care, seek direction from the supervising nurse before initiating procedure.
2. Begin recovery breathing using bag valve mask/manual resuscitator (Ambu bag) and CPR if indicated.
3. Residents/individuals should meet the following criteria before naloxone is administered:
    - Suspected opioid-induced respiratory depression.
    - Loss of consciousness, difficult to arouse, or no response to physical stimuli.
    - Breathing is shallow or not apparent
    - Lips may be blue, gray, or pale
4. Administer naloxone in accordance with the procedures listed below depending on the product available for use (intranasal spray). In the event that manufacturer’s instructions for administration differ from this policy, follow manufacturer’s instructions.
5. Once naloxone is administered, turn individual on one side and stay with individual and continue to attempt to arouse.
6. Re-administer a second dose of naloxone 2-3 minutes after the first dose if the individual does not respond or responds and then relapses into respiratory depression.
7. The effect of the opioid may outlast the effect of naloxone. Naloxone only lasts between 30-90 minutes, while the effects of the opioids may last much longer.
8. After event, perform the following:
    - Inform the responsible physician or physician extender, the administrator, the director of nursing.
    - Inform individual’s representative/next of kin
    - Document naloxone administration on the medication administration record (if applicable)
    - Document the outcome of naloxone administration in nursing notes and the condition of the resident upon emergency medical service transport (if applicable)
    - Order replacement naloxone doses from The Office of Drug User Health
    - Conduct a debrief meeting with responders, administrator, director of nursing, and the consultant pharmacist
    - Conduct an opioid-induced respiratory depression event root-cause analysis to determine precipitating event and opportunities for prevention/what could be done differently, including but not limited to:
        - Medication issue: ordering (e.g., drug-drug interaction, concentration issue), transcribing, dispensing, administering, documenting, monitoring, resident level issue
        - Visitor supplying non-prescribed opioid
        - Other (e.g., package delivery)

Procedures for administration of naloxone (Narcan®) nasal spray

1. Hold the naloxone nasal spray with your thumb on the bottom of the plunger and your first and middle fingers on either side of the nozzle. Place individual in supine position, do not prime, insert the cone into the nostril, give short vigorous push into nostril.
2. Administer one dose of naloxone intranasally in 1 nostril.
    a. If the individual does not respond in 2 to 3 minutes, or responds and then relapses into respiratory depression, administer additional doses of naloxone nasal spray, using a new nasal spray with each dose.
    b. Additional doses of naloxone nasal spray may be given every 2 to 3 minutes until emergency medical assistance arrives.
3. *See naloxone nasal spray full prescribing information:* Food and Drug Administration. Narcan® Nasal Spray 4mg. Full Prescribing Information can be found here https://www.accessdata.fda.gov/drugsatfda_docs/label/2017/208411s001lbl.pdf .

Related Policies:

- Assessing Residents for Risk Index for Overdose or Serious Opioid-Induced Respiratory Depression
- Naloxone Education and Competency
- Naloxone Emergency Drill
- Standing Order for Use of Naloxone for Residents, Staff, or Visitors

What to do after Naloxone has been administered:

- Document in the resident case management notes if applicable.
- Complete the NYDOH Opioid Overdose Prevention Initiative Community Naloxone Usage Form. Found online at www.nyoverdose.org

Resources:

Policy and procedure adapted from:

- ASCP Opioid Stewardship Toolkit – A Pharmacist's Guide for Older Adults © 2020 American Society of Consultant Pharmacists, "SAMPLE POLICY – Administration of Naloxone in the Long-Term Post-Acute Care Facility"
- Guardian Consulting, LLC, "Opioid Overdose Management/Use of Naloxone"
- Rivercare Consulting, LLC, "Treatment of Suspected Opioid Overdose and Use of Naloxone"

(Template) Use of Naloxone for Residents, Staff, or Visitors Policy and Procedures

Facility Name	**FACILITY LOGO**
[Company Address]	

Policy Name	Use of Naloxone for Residents, Staff, or Visitors	**Policy No.**	
Effective Date		**Date Of Last Revision**	
Version No.		**Distribution**	
Applicable Regulations or Standard			
Administrator Signature		**Contact Information**	

Version History

Version	Approved By	Revision Date	Description Of Change	Author

Accountable Leadership

Administrator, Director of Nursing

Procedure Responsible Parties

Nursing, authorized staff

Policy

Upon a physician's medication order per resident (if applicable), naloxone (Narcan®) may be administered by staff to residents/patients/staff/visitors as indicated for the complete or partial reversal of suspected opioid-induced respiratory depression. A standing order is not necessary if not resident specific.

Identifying suspected opioid-induced respiratory depression:

- Person with recent inpatient hospitalization for suspected opioid overdose

- Person with diagnosis of opioid use disorder
- Person with history of opioid use or dependence, or diagnosed substance use disorder
- Person with current prescribed opioid orders
- Person with past opioid use and justice involved, resulting in reduced opioid tolerance from lack of use
- Current or recent registrant of a methadone maintenance program, or a detox program
- Friends and family members of the above who may visit the resident and provide illicit or prescription opioids
- Resident who frequently attempt to elope or leave the facility premises

**It is the responsibility of the facility/organization to ensure the policy aligns with all federal, state, and local agencies. This policy will be revised as required by updates or changes to federal, state, and local regulation and guidance.

Procedure

1. In order to prevent delay in treatment that may result in resident, staff, or visitor harm, the Department Of Health MD has signed standing orders (see attached form: "Standing Order for Use of Naloxone for Residents, Staff, or Visitors") to allow administration of Naloxone to any resident, staff, or visitor upon reasonable suspicion of opioid-induced respiratory depression, without having to first obtain a verbal or written order. Such reasonable suspicion shall be based on presentation of symptoms of opioid-induced respiratory depression as described in this policy and procedure.

NURSING

1. "Standing Order for Use of Naloxone for Residents, Staff, or Visitors", the original shall be kept in the Administrator and Director of Nursing Policy and Procedure manual.
2. A copy of the standing orders shall be placed on each nursing unit in a location that is easily accessible, such as the Medication Administration Record Book or posted at the Nursing Station.

Related Policies:

- Assessing Residents with Risk Index for Overdose or Serious Opioid-Induced Respiratory Depression
- Naloxone Education and Competency
- Naloxone Emergency Drill
- Naloxone Use for Opioid-Induced Respiratory Depression Policy and Procedures

Suspected Overdose Drill

Facility Name	**FACILITY LOGO**
[Company Address]	

Policy Name	Suspected Overdose Drill	**Policy No.**	
Effective Date		**Date Of Last Revision**	
Version No.		**Distribution**	
Applicable Regulations or Standard			
Administrator Signature		**Contact Information**	

Version History

Version	Approved By	Revision Date	Description Of Change	Author

Accountable Leadership

Administrator, Director of Nursing

Procedure Responsible Parties

Administrator, Nursing, authorized staff

Policy

An overdose drill can help prepare staff to respond quickly and with confidence and potentially save a life. Announcing an Overdose Drill ahead of time may prevent panic, fear, and confusion so participants can practice the facility Suspected Overdose Response procedures with awareness and cooperation.

The facility will identify a Suspected Overdose Response team by role for each shift, to include at least one staff member trained in first aid and CPR, and at least one, preferably two other staff members.

Recommendation is to conduct one Suspected Overdose Response drill at least annually and as needed.

Procedure

1. Plan a time and location for the drill. Advise staff and visitors in the area.
2. Conduct drill.
3. Complete a post drill review to capture successes and develop an action plan that incorporates lessons learned.

Suspected Overdose Response Drill

Before the Drill

1. Develop the overdose drill scenario.
    - When will the drill occur (choose a location where an overdose may occur)?
    - How will the alarm be called and what will it sound like?
    - Designate a staff member to play the role of the person who has overdosed and explain their role (unresponsive to intervention attempts).
    - Plan how you will proactively communicate the date, time, location, and purpose of the drill (e.g., to staff, residents around the drill location, and visitors). Include how you will proactively reassure observers during the drill.
2. Prepare staff for the drill.
    - Notify all staff, including administration and security, of the date, time and location of the drill, and review the overdose response plan.
    - Assign specific staff to roles and orient them to their task(s). Each task can be assigned to a different person.

        Roles to be assigned:
        - Discoverer of an individual with a suspected overdose.
        - Individual experiencing the overdose.
        - Obtain naloxone training device/verbalize location and how to obtain actual naloxone and how to identify expiration date of naloxone.
        - Obtain crash cart/emergency supplies (e.g., CPR board, oxygen).
        - Call 911.
        - Meet fire/EMS at the door.
        - Use Ambu bag to support respiration, as needed. (If utilized by facility)
        - Administer naloxone.
        - Provide crowd control.
        - Observer.
        - Person to facilitate and complete the Suspected Overdose Response Drill Debrief Form
    - Review "***Tips for Overdose Reversal Using Naloxone"***[4]
3. Gather equipment
    - Naloxone training kit.
    - CPR doll and board to be used to simulate administration of naloxone.

[4] Overdose Response Practice Drill. Accessed January 17, 2023. https://www.fraserhealth.ca/-/media/Project/FraserHealth/FraserHealth/Health-Topics/Mental-Health-Substance-Use/Fraser-Health-Overdose-Response-Practice-Drill-Toolkit-_-FINAL_2019.pdf?la=en&rev=84bb5f44d0d247008b8316b976ae5453&hash=FBCB3589105BCF728B169954E19740E682CF65B3

Conduct the Drill

1. Conduct the drill as planned and in accordance with the Naloxone Use for Opioid-Induced Respiratory Depression Policy and Procedures.

After the Drill (Use ***Suspected Overdose Response Drill Debrief Form***)

- Debrief with the team and the person playing the overdose role together.
  - What went well?
  - What would you do differently?
  - What needs improvement?
  - Who will be responsible for follow-up actions, and by when?
- Develop/modify your Suspected Overdose Response plan.
- Provide additional education as needed.

Suspected Overdose Response Drill Debrief Form

Facility Name		**Location of Drill**	
Drill Leader		**Drill Date/Time**	
Person Completing this Form		**Title**	
Drill Participants			

Use the following questions to debrief the drill, identify strengths and lessons learned and opportunities for improvement.

	Yes	**No**	**N/A**
1. Were the overdose supplies easily located?			
2. Was someone designated to control on-lookers?			
3. Did the person designated to phone 911 know the site address?			
4. Was someone designated to do rescue breathing?			
5. Was the drill debrief conducted with all participants together?			
6. Did staff who participated in the drill have the knowledge/skills to respond to an overdose?			
7. Do staff who did not participate in the drill have the skills/knowledge to respond to an overdose?			

Lessons Learned

What went well?

What would we do differently the next time?
What opportunities for improvement were identified?
What are the next steps? Who is responsible? What are target dates?

Selected Resources

Federal Government

- DRUG MISUSE: Most States Have Good Samaritan Laws and Research Indicates They May Have Positive Effects Report to Congressional Committees. United States Government Accountability Office; 2021. https://www.gao.gov/assets/gao-21-248.pdf

Life Support

- Adult Basic Life Support Algorithm for Healthcare Providers https://cpr.heart.org/-/media/CPR-Files/CPR-Guidelines-Files/Algorithms/AlgorithmBLS_Adult_200624.pdf
- Opioid-Associated Emergency for Healthcare Providers Algorithm https://cpr.heart.org/-/media/CPR-Files/CPR-Guidelines-Files/Algorithms/AlgorithmOpioidHC_Provider_200615.pdf

Naloxone

- The Office of Drug User Health, Opioid Overdose Prevention Program. **https://www.health.ny.gov/diseases/aids/general/opioid_overdose_prevention/**
- OASAS virtual training. Click link to register here. Attendees receive a certification upon completion
- NYS AIDS Institute offers an online, self-paced training called Preventing Opioid Overdose; Training the Trainer. Attendees receive a certification upon completion. Upcoming Courses (hivtrainingny.org)
- Naloxone training for healthcare providers Naloxone Training | Naloxone | Opioids | CDC
- Visitor and resident education regarding naloxone Naloxone Saves Lives: IPRO QIN-QIO Resource Library (Visitor, resident, education)

Opioid Crisis

- Understanding the Opioid Overdose Crisis https://www.cdc.gov/opioids/basics/epidemic.html
- The Centers for Medicare & Medicaid (CMS) discusses recognition of the opioid overdose epidemic and reference to its roadmap and strategy to address the opioid crisis https://www.cms.gov/about-cms/agency-information/emergency/epro/current-emergencies/ongoing-emergencies https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Opioid-epidemic-roadmap.pdf

Pain/Opioid Guidelines

- The Society for Post-Acute and Long-Term Care Medicine (AMDA) opioid guidelines https://paltc.org/opioids%20in%20nursing%20homes
- National Institute on Drug Abuse Benzodiazepines and Opioids https://www.drugabuse.gov/drugs-abuse/opioids/benzodiazepines-opioids
- Exposure-Response Association Between Concurrent Opioid and Benzodiazepine Use and Risk of Opioid-Related Overdose in Medicare Part D Beneficiaries

https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2685628

- Resources and Tools for Quality Pain Care
  https://geriatricpain.org/

  NOTE: These guidelines do not apply to individuals being treated for pain related to active cancer treatment, palliative care, and end-of-life care. Individual states also have initiatives and requirements related to opioid use for acute and chronic pain.

Understanding Substance Use Disorder

- The Power of Perceptions and Understanding: Changing how we Deliver Treatment and Recovery Services
  https://www.samhsa.gov/sites/default/files/programs_campaigns/02._webcast_1_resources-508.pdf
- Stigma and Discrimination | National Institute on Drug Abuse (NIDA) (nih.gov)
- Healthcare Worker's Feelings About People With Substance Use Disorders – Recovery Research Institute (recoveryanswers.org)
- Barriers for Elders with SUDs in Post–Acute Care (asaging.org)