Alberta Health Services

PROCEDURE

TITLE
SUSPECTED OVERDOSE

SCOPE
Calgary Zone: Sheldon M. Chumir Health Centre
South Zone: Lethbridge Mobile Overdose Prevention Service

DOCUMENT #
PS-94-04

APPROVAL AUTHORITY
Chief Zone Officer, Calgary Zone
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Supervised Consumption / Overdose Prevention Services Policy (#PS-94)

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NOTE: The first appearance of terms in bold in the body of this document (except titles) are defined terms – please refer to the Definitions section.

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OBJECTIVES

- To provide direction to **staff** in the assessment and intervention of **patients** who display signs and symptoms of overdose from substances (including **illicit substances**) while accessing **Supervised Consumption / Overdose Prevention Services (SCS/OPS)**.

APPLICABILITY

Compliance with this document is required by all Alberta Health Services employees, members of the medical and midwifery staffs, students, volunteers, and other persons acting on behalf of Alberta Health Services (including contracted service providers as necessary).

ELEMENTS

1. Points of Emphasis

1.1 This Procedure shall be initiated in **emergency situations** where a substance overdose is suspected.

1.2 Treatment of overdose is symptom-based and may include, but is not limited to, initiation of rescue breathing, oxygen administration, administration of naloxone, and initiation of cardiopulmonary resuscitation (CPR) if required.

1.3 Naloxone is an effective opioid antagonist that can act as a reversal agent for the treatment of an opioid overdose. This medication is ineffective for overdoses that are not caused by an opioid.

1.4 Staff should assess the patient, situation, and environment then don the appropriate personal protective equipment (PPE) prior to providing direct care interventions.

2. Opioid Overdose

2.1 Background:

a) The standard treatment of an opioid overdose is rescue breathing, and if required, administration of naloxone.

b) Naloxone is an unscheduled medication in community. It can be administered by staff with the knowledge, skills and competency to do so and who are authorized under professional regulations and applicable restricted activities to administer a medication via the intramuscular (IM) route.

c) Naloxone is not effective in counteracting central nervous system (CNS) depression caused from barbiturates, tranquilizers, psychostimulants, alcohol or other non-opioid drugs/medications. However, in a CNS depressant overdose, naloxone should still be given to reverse the opioid component of the overdose.

2.2 Assess the patient for the following signs and symptoms of opioid overdose that should trigger immediate intervention:

a) unresponsive to verbal stimulation and/or sternal rub;

b) breathing is very slow (less than 10-12 breaths/minute), erratic or the patient is apneic;

c) fingernails/lips are blue or purple, or gray/ashen in darker skin tones;

d) body is limp or the patient is unconscious;

e) is snoring or gurgling;

f) pupils are constricted;

g) is experiencing seizures;

h) has cold and clammy skin; and

i) slow, erratic or absent heart rate.

2.3 If an opioid overdose is suspected and several of the above symptoms are present, the staff shall make a clinical judgment whether to call 911 immediately to activate Emergency Medical Services (EMS). See more detailed information under Section 2.6 *Reassessment and Interventions*.

2.4 Maintain the patient's airway and breathing according to basic cardiac life support (BCLS) principles and standards.

a) Administering oxygen and/or bag-valve-mask ventilation are primary interventions preceding naloxone administration. Insertion of an oral or nasal pharyngeal airway adjunct only as a secondary intervention if required to maintain a patient airway.

2.5 Administration of Naloxone:

a) Naloxone is stored in one (1) mL vials and contains 0.4 mg/mL of medication per vial.

b) The dose for administration is 0.4 mg. If adequate ventilation and oxygen saturation can be established and maintained, a lower initial dose (0.2 mg) may be considered in certain clinical presentations: for patients with opioid dependence to minimize acute withdrawal or if there are concerns regarding concurrent stimulant overdose. See more detailed information under Section 2.7 *Naloxone Dosing - Special Considerations*.

c) Draw up 0.4 mg of naloxone using an appropriate needle and syringe.

d) Naloxone should be administered intramuscularly. Subcutaneous administration is not to be used as absorption is slower. The preferred site of administration for rapid absorption is the vastus lateralis or the mid-section of the thigh. Administration into the deltoid muscle will result in very slow absorption and a delayed response.

e) Expose the patient's thigh and clean the mid-section (vastus lateralis) of the thigh with an alcohol swab. Based on clinical judgment, the medication can be administered through clothing if exposing the site will cause significant and potentially harmful delays in treatment.

f) Repeat IM doses every three (3) to five (5) minutes, if clinically required. Onset of IM naloxone is three (3) to five (5) minutes.

g) If after two (2) doses of naloxone, there is no clinical response, other causes of decreased level of consciousness should be considered as this may not be the result of an opioid overdose.

h) The recommended maximum dose is 1.6 mg or four (4) doses.

2.6 Reassessment and Interventions:

a) Once the first dose of naloxone has been administered, assess the patient for:

(i) increased level of consciousness;

(ii) improved quality of breathing; and

(iii) responses to stimulus.

b) If the patient becomes responsive and is no longer showing signs of overdose risk, place the patient in a recovery position (on their side). Staff shall encourage patients to stay on-site for at least two (2) hours to monitor for possible reversal to an overdose due to the short half-life of naloxone (i.e., 30 - 90 minutes).

(i) If the patient's quality of breathing improves, but they remain **minimally responsive** for 15 minutes post-overdose response, call 911 for EMS.

(ii) If a patient refuses to stay, document in the patient's **health record** their decision and provide a Community Based Naloxone Kit in accordance with the AHS *Distribution of Community Based Naloxone Kits* Policy.

c) Continue with rescue breathing if the patient is not responding to the first dose of naloxone.

d) If no improvement is noted after a maximum of three (3) to five (5) minutes, administer a second dose of naloxone and call 911 for EMS.

e) Continue rescue breathing if required while awaiting the arrival of EMS.

2.7 Naloxone Dosing - Special Considerations:

a) The goal of naloxone administration is to:

(i) achieve adequate spontaneous ventilation (respiratory rate greater than 10 respirations per minute) and oxygen saturation; and

(ii) maintain the airway.

b) When adequate ventilation and oxygen saturation can be established and maintained, an initial dose of 0.2 mg IM of naloxone may be administered in the following patient clinical presentations:

(i) known history of opioid dependence;

(ii) patient is minimally responsive or **non-responsive** should be administered 0.4 mg IM of naloxone;

(iii) rapid fluctuation from minimally responsive to alert and responsive with verbal stimuli, then return to minimally responsive within one (1) to two (2) minutes;

(iv) in the absence of supplemental oxygen, patient maintains a respiratory rate of eight (8) to 10 respirations per minute and oxygen saturation of 88 – 90% for 10 to 15 minutes post-use of a psychoactive substance; and

(v) known concurrent use of a stimulant and opioid, and has a pulse above 100 beats per minute, in order to reduce risk of severe post naloxone administration hypertension, tachycardia or fibrillation.

3. Stimulant Overdose

3.1 Assessment:

a) Whenever a stimulant overdose is suspected, staff should attempt to assess the patient's vital signs as soon as possible including:

(i) blood pressure (BP);

(ii) temperature;

(iii) heart rate; and

(iv) respiratory rate.

b) The presence of one or more of the following symptoms/signs should alert staff to the possibility that a patient is shifting along the continuum from stimulant effects to stimulant toxicity and overdose:

(i) severe agitation (responses may vary for each patient from swearing, hallucinations, rapid pacing to violent behaviors);

(ii) behaviour that poses risk to client or others, such as increased aggressiveness;

(iii) complaints of severe headaches (measure of severe varies per patient);

(iv) muscle rigidity, clenched jaw or teeth grinding;

(v) respiratory distress or apnea;

(vi) seizure;

(vii) chest pain or chest tightness;

(viii) focal neurologic disturbance including numbness or paralysis on one side of the body or blindness in one eye;

(ix) loss of consciousness;

(x) BP greater than 160/100 (indicates hypertension of concern);

(xi) pulse greater than 170 beats per minute (bpm);

(xii) temperature greater than 38º (degrees) Celsius;

(xiii) delusions (e.g., feeling paranoid, feeling watched or chased); or

(xiv) hallucinations (e.g., hearing voices, seeing objects or feeling bugs crawling on skin).

3.2 Intervention:

a) The staff shall decide whether to call 911 immediately based on the clinical status of the patient, or if any of the following occurs:

(i) patient is hypertensive with BP greater than 160/100 and pulse of greater than 170 bpm:

(ii) progressing respiratory distress (i.e., O_2 saturation less than 95% on room air or O_2 saturation less than 90% on oxygen per pulse oximetry);

(iii) agitation beyond what is manageable by staff;

Note: Protective Services should be called if this is present and they will determine whether a call to the local police service is warranted.

(iv) chest pain;

(v) seizures; and

(vi) other symptoms that indicate medical distress (e.g., losing consciousness, focal neurologic changes such as paralysis).

b) While awaiting the arrival of EMS, staff shall ensure that emergency supplies (e.g., airways, oxygen) are readily available and attend to the airway, breathing and circulatory needs of the patient according to standard BCLS standards.

c) Continue to monitor the patient and work to maintain a calm environment.

d) <u>DO NOT</u> physically restrain the patient. Physical restraint of someone who is stimulant intoxicated will increase the level of CNS stimulation and can cause cardiovascular collapse and death.

4. Transfer of Care

4.1 The call to the 911 EMS dispatcher shall include a message that police are not required if there are no concerns for patient or staff safety at this time. EMS dispatch may decide the resources required based on the details of the call.

4.2 The transfer of care to EMS and the proposed transfer destination, if available, shall be recorded in the patient's health record.

4.3 If the patient refuses to be transferred to Emergency with EMS, then the patient shall be monitored on-site according to direction from the Emergency Physician on-call for EMS dispatch and according to SCS site capacity as determined by the **Program Manager or delegate**.

5. Documentation

5.1 Staff shall document in the patient's AHS *Emergency Intervention Record – Supervised Consumption Services Ambulatory Site* Form (hereafter, *Emergency Intervention Record* Form) and their health record, all interventions performed including:

a) clinical treatment;

b) emergency procedures undertaken;

c) transfer information; and

d) follow-up.

5.2 A copy of the *Emergency Intervention Record* Form shall be provided to the EMS providers.

6. Post-Overdose

6.1 If the patient is alert and able, staff shall offer education related to what had occurred, triggers and safe practices. A Community Based Naloxone Kit shall be provided with instructions on when and how to use the kit if an overdose occurs. In some cases, the patient may choose to return on another day for the education.

6.2 The Program Manager or delegate should arrange for a staff debriefing session following any overdose incident. This session would provide staff the opportunity to discuss the steps taken, address any issues, and identify areas for improvement and support for the future.

a) The process for debriefing shall be at the discretion of the Program Manager or delegate.

DEFINITIONS

Emergency situation means a circumstance which requires immediate health care that is necessary to preserve life, to prevent serious physical or mental harm, or to alleviate severe pain.

Health record means the collection of all records documenting individually identifying health information in relation to a single person.

Illicit substances means illegally obtained drugs that are used for non-medical purposes.

Minimally responsive means the patients' eye opening only to pain, verbally responds with confusion or incomprehensible speech or sounds, and withdrawals from painful stimuli but is unable to obey commands)

Non-responsive means the patient shows no response to pain, voice and no motor response.

Patient means an adult or child who receives or has requested health care or services from Alberta Health Services and its health care providers or individuals authorized to act on behalf of Alberta Health Services. This term is inclusive of residents, clients, and outpatients.

Program Manager or delegate means the Responsible Person in Charge or Alternative Responsible Person in Charge as defined by Health Canada. The Program Manager or delegate is responsible for, among other things, ensuring that any health care providers involved in activities with illicit substances comply with the terms and conditions specified in Health Canada's exemption.

Staff means all Alberta Health Services employees, midwifery staff, students and other persons acting on behalf of or in conjunction with Alberta Health Services.

Supervised Consumption / Overdose Prevention Services (SCS) means health services where individuals can inject or consume substances (including illicit substances) in a hygienic environment under the supervision of trained staff, and have opportunities to engage in and access other health and social services.

REFERENCES

- Alberta Health Services Governance Documents:
  - *Distribution of Community Based Naloxone Kits* Policy (#HCS-246)
- Alberta Health Services Forms:
  - *Emergency Intervention Record – Supervised Consumption Services Ambulatory Site* Form (#20980)
- Non-Alberta Health Services Documents:
  - Parkdale Queen West Community Health Centre *Stimulant Overdose Protocol*, Toronto, Ontario (Nov. 24, 2016)
  - BC Centre for Disease Control Clinical Prevention Services *Decision Support Tool – Administration of Naloxone*, Vancouver British Columbia (2016)