CRYSTAL POLICE DEPARTMENT

Department Policy Manual

TITLE: NARCAN AND OPIOD OVERDOSE

NUMBER: 9.21

DATE: 09/13/2023

NO. PAGES: 5

PURPOSE

This policy provides guidelines for the administration of intranasal opioid antagonist in emergency situations where opioid overdose is suspected.

DEFINITIONS

A. **OPIOID:** Substance occurring naturally in the body, those derived from the poppy plant and those synthesized to have similar effects to opium (the dried extract of the poppy plant), that work on the nervous system and are used medically to treat pain. These include but are not limited to the following: morphine, heroin, hydromorphone (e.g. Dilaudid®), hydrocodone, oxycodone, fentanyl, carfentanyl, and oxymorphone.

B. **OPIOID ANTAGONIST:** A synthetic drug that blocks opiate receptors in the nervous system.

ADMINISTRATION OF OPIOID OVERDOSE MEDICATION

Each on-duty peace officer who is assigned to respond to emergency calls must have at least two unexpired opiate antagonist doses readily available when the officer's shift begins. An officer who depletes their supply of opiate antagonists during the officer's shift shall replace the expended doses from the officer's agency's supply so long as replacing the doses will not compromise public safety (Minn. Stat. § 626.5443).

Only officers who receive training in the recognition of signs of opiate overdose and the use of opiate antagonists may administer opioid overdose medication. Officers may administer opioid overdose medication in accordance with protocol specified by the physician who prescribed the overdose medication for use by the officer (Minn. Stat. §151.37; Minn. Stat. §604A.04).

OPIOID OVERDOSE MEDICATION USER RESPONSIBILITIES

Officers who are qualified to administer opioid overdose medication, should handle, store, and administer the medication consistent with their training and the drug specifications. The treating officer shall inform responding Emergency Medical Services (E.M.S.) about any administration. Officers are required to properly dispose of expended opioid overdose medication devices. Opioid medication devices should not be left behind at a scene.

Officers shall check the medication and associated administration equipment at the beginning of their shift to ensure they are serviceable and not expired. Any expired medication or unserviceable administration equipment should be removed from service immediately and given to the on-duty supervisor for replacement.

OPIOID OVERDOSE MEDICATION REPORTING

Any officer administering opioid overdose medication should detail its use appropriately in a report. Any officer administering opioid overdose medication should place the patient who received the overdose medication on a 72-hour Emergency Health and Welfare hold. Use of opioid overdose medication should be reflected on the daily notable activity report.

OPIOID OVERDOSE MEDICATION TRAINING

All licensed officers are required to receive training in the administration of opioid antagonist medication prior to being assigned the medication and associated administration equipment and prior to administering such medication. North Memorial Emergency Medical Services (EMS) Education, will provide training to officers who administer opioid medication as authorized by North Memorial Medical Director (Minn. Stat. §151.37).

STORAGE AND RESUPPLY

Each officer will be issued an opioid overdose hard case with two doses of Naloxone (Narcan). If the medication is used, damaged, or expired, it will be the responsibility of the officer to resupply through their sergeant. The medication must be kept in a temperature stable environment and not be allowed to fall below 39 degrees or rise above 104 degrees Fahrenheit. Recommended storage temperature is between 59 and 77 degrees Fahrenheit.

Spare Naloxone will be stored in the evidence room. Any sergeant checking out additional Naloxone should document the same on the Narcan sign out log. Sergeants will be responsible for notifying the Patrol Lieutenant when the supply goes below 5 doses. When the Narcan log is full, it should be submitted to records to be scanned into Laserfiche.

FIRST RESPONDER OPIOID TOXICITY PROTOCOL – MEDICAL DIRECTION FROM NORTH MEMORIAL

ADULT AND PEDIATRIC PROTOCOL

INCLUSION CRITERIA

- Patients with physical exam findings suggestive of opioid toxicity, including constricted pupils, altered mental status, decreased respirations, hypotension and/or unconsciousness.
- Patients with altered mental status and known or potential intentional or accidental opioid exposure by oral, intravenous, intramuscular injection or inhaled routes.

- Patients who have received opioid medications administered by a medical provider who develop undesired alteration of mental status and also exhibit physical exam findings suggestive of toxicity.

EXCLUSION CRITERIA

- Patients with altered mental status that lack physical exam findings suggestive of opioid toxicity.

PATIENT CARE GOALS

- Ensure adequate oxygenation and ventilation of patient with altered mental status and impaired breathing.
- Ensure adequate circulation of patients with altered mental status.
- Evaluate for and treat alternative causes of altered mental status, including hypoglycemia, stroke, seizure or effect of other sedating substances.
- Avoid "over reversal" of opioid toxicity and resultant potential patient agitation or associated physical violence.

AIRWAY MANAGEMENT

Airway Devices

- Oropharyngeal or nasopharyngeal airway insertion should be considered on all patients with a Glasgow Coma Scale of 8 or less and/or unconscious patients for airway maintenance.

Pulse Oximetry If Available

- May be used, providing staff has had appropriate training in the use of pulse oximetry, for any patient in which determining and/or monitoring SP02 may assist in the course of assessment or treatment.
- In general, when administering oxygen, the patient's saturation level should be monitored if appropriately trained.

Patient Ventilation Rates

- Adult patients should be ventilated at the rate of 8-10 breaths per minute unless otherwise indicated in these guidelines. Lifetymer (LED Metronome) should be used to indicate when to administer breaths. 1st Responders should refrain from ventilating patients at rates greater than 12 breaths per minute unless they have a physician's order to do so.

Oxygen Therapy

Indications

- If pulse oximetry is less than 93% on room air, or at baseline level
- Baseline need for oxygen, such as COPD patients chronically dependent on oxygen

Treatment

- Begin oxygen at 2/1pm by nasal cannula and increase to obtain SaO2 above 93%. If pulse oximetry is not available and signs or symptoms of respiratory distress or shortness of breath continues, begin O2 by nasal cannula at 2/1pm and increase as needed.

Protocol - First Responder Care

- If airway and oxygen interventions do not improve the condition of the patient, First Responders may administer Naloxone intra-nasally.
- First Responders should continue to monitor the patient airway and provide ventilations as needed until the ambulance arrives.

Please fill out the information below before taking a new NARCAN® unit. The product serial/LOT# can be found on the vile (i.e. RLXXXXX).

When the supply gets below 5 NARCAN® units, please notify Lt. Underthun.

			NARCAN®	
DATE	**OFFICER**	**CPD CASE #** *Reason for replenishment*	**SERIAL/LOT#** (RLXXXXX)	**EXP. DATE**