Southwest Texas Regional Advisory Council

Law Enforcement Support Documents
STRAC Regional EMS Medical Directors Recommended Guidelines
Narcan Administration for Law Enforcement Officers

The following document can be used as a model policy by law enforcement agencies in partnership with EMS agencies. It outlines the indications, usage, documentation, and handling of naloxone (Narcan) for the treatment of complications resulting from opioid use or abuse. This guideline has been reviewed and approved by the STRAC EMS Medical Directors Committee and is recommended for use in informing local department policies. It is recommended that law enforcement agencies collaborate with local first response EMS organizations to ensure policy is adopted in a joint process.

I. PURPOSE

This policy aims to provide guidelines and regulations for using Intra-Nasal spray Naloxone, also known as Narcan, by trained personnel in the Police Department. The aim is to treat and decrease injuries and deaths caused by opioid-related overdoses when law enforcement is the first to respond to a suspected overdose. Furthermore, this policy outlines guidelines and regulations for the administration, storage, and reporting of naloxone used by the Police Department.

II. DEFINITIONS

A. **Emergency services personnel** – Includes firefighters, emergency medical services personnel as defined by Texas Health and Safety Code section 773.003, emergency room personnel, and other individuals who, in the course and scope of employment or as a volunteer, provide services for the benefit of the general public during emergencies (Texas Health and Safety Code 483.101 Definitions).

B. **Naloxone** – This medication is an opioid antagonist meant to be used in emergencies to treat suspected opioid overdoses. Its purpose is to counter the effects of an overdose by removing opioids from the receptors in the brain that control the central nervous and respiratory systems. It is available under different trade names, such as Narcan ®, Nalone, and Narcanti, but it should not be confused with naltrexone, an opioid receptor antagonist with different effects. Naltrexone is used for dependence treatment, not emergency overdose treatment.

C. **Opiate**- A substance that can cause addiction or be turned into an addictive drug, similar to morphine. (Texas Health and Safety Code 481.002 Definitions)

D. **Opioid** – Drugs that have either been derived from the opium poppy or mimic its effects. They work as narcotic sedatives, which depress the central nervous system, relieve pain, and induce sleep. Some commonly used opioids are morphine, methadone, codeine, heroin, fentanyl, oxycodone, and hydrocodone.

E. **Opioid antagonist** – Any drug that binds to opioid receptors and blocks or inhibits

the effects of opioids acting on those receptors (Texas Health and Safety Code 483.101 Definitions).

F. **Opioid-related drug overdos**e – A condition evidenced by symptoms such as an altered level of consciousness, respiratory depression, apnea, or coma that a layperson would reasonably believe to result from the ingestion or use of an opioid. (Texas Health and Safety Code 483.101 Definitions)

G. **Qualified immunity** - In U.S. federal law, this doctrine protects local law enforcement officers and department management from liability for their lawful actions under 42 U.S. Code §1983 and federal officials under 403 U.S. 388. Qualified immunity only applies if government officials' actions don't violate an individual's federal constitutional rights. This immunity is available to state or federal officers performing discretionary functions, and even if their actions later turn out to be unlawful, they won't be held liable if they did not violate established law. Liability in a federal civil rights lawsuit depends on whether a hypothetical reasonable person in the officer's position would have known their actions violated the established law. This immunity protects all but those who are plainly incompetent or knowingly violate the law. In other words, officers won't be liable for damages if their actions are consistent with the rights they are accused of violating.

H. **Universal Precautions** - Guidelines for preventing the spread of infection when handling human blood and certain bodily fluids that could be infectious for diseases such as HIV and HBV. These precautions are defined by U.S. 29 CFR 1910.1030 and require employees to avoid contact with blood or other potentially infectious materials, especially when distinguishing between different body fluids is difficult or impossible. All body fluids are considered potentially infectious, so it is essential to take appropriate precautions, such as:

1) Wearing gloves, masks, and eye protection if there is a risk of exposure to blood or other potentially infectious materials.

2) Using work practice controls and other strategies to minimize exposure.

I. **Unconsciousness** - The person is entirely unresponsive and without motor skills, even when a verbal or painful stimulus is applied to a pressure point.

J. **Apnea** - When breathing stops completely, it can result in low oxygen levels, respiratory acidosis, and ultimately death.

III. LEGAL OVERVIEW

Officers in the department should undergo training on the proper use and deployment of Naloxone. Senate Bill 1462 and the opinions published by the Texas Attorney General allow law enforcement agencies and peace officers access to opioid antagonists. These medications can be administered by law enforcement personnel in specific situations. The law also limits civil and criminal liability for law enforcement agencies and peace officers who possess, distribute, and use opioid antagonists in approved circumstances

Generally, peace officers performing an official act do not have immunity but may receive quality immunity for their actions. In the application of naloxone, to have qualified immunity under state and federal applications of the law, you must:

a. Act in good faith, with reasonable care, and under the belief that the individual was indeed suffering from an opioid-related drug overdose.
b. Have completed approved training before administering naloxone to an overdose victim.
c. Promptly request medical assistance during an overdose encounter before administering naloxone.

Nothing in this guideline requires any employee to administer or not to administer naloxone. To act either way is discretionary by the officer at the scene and is not judged with the benefit of 20/20 hindsight.

Texas Senate Bill 1462, passed in 2015, authorizes the administration of opioid antagonists by emergency services personnel. This authorization and governance are enumerated in the Texas Health and Safety Code, Section 483, Subchapter E, Opioid Antagonists.

Texas Health and Safety Code 483.106 Administration of Opioid Antagonist

a. A person who, acting in good faith and with reasonable care, administers or does not administer an opioid antagonist to another person whom the person believes is suffering an opioid-related drug overdose is not subject to criminal prosecution, sanction under any professional licensing statute, or civil liability, for an act or omission resulting from the administration of or failure to administer the opioid antagonist.
b. Emergency services personnel are authorized to administer an opioid antagonist to someone who appears to be suffering an opioid-related drug overdose, as clinically indicated.

IV. ADMINISTRATION OF NALOXONE NASAL SPRAY

A. Whenever EMS personnel are on the scene, always encourage and support them in taking the lead in assessing and providing support to any subject demonstrating the need for medical or mental aid.
B. If the patient is found before EMS is dispatched, the officer should immediately call for EMS before administering aid.
C. When an officer(s) arrives at the scene of a medical emergency before Emergency Medical Services and has determined that the patient is suffering from an opioid overdose.
   a. The officer should ensure safety and avoid needle sticks or exposure to bodily fluids using universal safety precautions.
   b. The officer(s) should conduct a medical assessment of the victim per training

and take into account known drug user history, nearby items of concern, statements from witnesses and/or family members, etc.

c. Open the airway by pushing the chin up until the neck is extended; Listen for breathing and feel for chest rise.
d. If the patient is not breathing and is unconscious, **START CPR IMMEDIATELY**
e. If the patient is difficult to awaken or not responding normally, taking shallow, slow breaths, or has signs of bluing of the skin, ADMINISTER the entire Intranasal naloxone.

D. The responding officer should administer naloxone to the patient through the nasal passages. The following steps should be taken:

a. The officer(s) should ensure that the victim is in a safe location and remove any objects from the victim's immediate reach that could injure themselves or be used as a dangerous instrument.
b. If the officers determine that naloxone is necessary, they will administer it by placing the nozzle into the nostril and pressing the plunger to deliver the drug.
c. Advise the dispatcher that the patient is in a potential opioid overdose, and naloxone has been administered, noting the time.
d. The goal of naloxone is to improve breathing, **NOT TO WAKE THE PATIENT**.
e. Place the patient in the recovery position on their side so their airway remains open.
f. If the patient's breathing does not improve after 2-3 minutes or the patient, **START CPR IMMEDIATELY**.
g. Once CPR has been initiated, a SECOND dose of the entire content of intranasal naloxone may be administered.
h. Continue CPR until EMS arrives or the patient becomes conscious with purposeful movements.

E. Officer(s) should be aware that treated victims who are revived from an opioid overdose may regain consciousness and may experience acute opioid withdrawal. Rapidly reversing opioid overdose may cause projectile vomiting, severe headache, confusion, chest pain, fast or irregular heartbeat, seizures or convulsions, and/or violent and agitated behavior.

F. The administering officer should inform EMS/Fire about the treatment and condition of the victim. The administering officer should not relinquish care of the victim until relieved by a person with a higher level of training.

a. Once used, the intranasal naloxone device is considered a bio-hazardous material. It should be disposed of following protocols for similar materials or turned over to EMS/Fire personnel for disposal.

G. Repeat Doses

a. Only one dose of intranasal naloxone is authorized for use. NO REPEAT DOSES unless CPR is initiated.
b. Patients who do not fully regain consciousness may still show improved

respiratory effort, taking faster and deeper breaths and becoming more responsive to painful stimuli.

c. If the patient is not improving, other causes may be low blood glucose levels, stroke, or non-opioid sedatives.

d. When in doubt, start hands-only CPR. It is not harmful but is lifesaving.

VI. OFFICER SAFETY

Opioids, including fentanyl, especially in a form commonly used illicitly, are not able to be absorbed transdermally. Therefore, the risk of a fatal or life-threatening exposure is almost non-existent. However, it is essential to exercise caution when dealing with unknown substances and to take steps to prevent exposure. This includes not handling the substance without protective equipment, such as puncture-resistant gloves, eye protection, and splash protection if liquids are present. Unknown substances should never be tasted or smelled, and if there is a concern for hazardous materials, follow the policy for informing hazardous material response. Naloxone should only be used if an individual exhibits signs of respiratory depression or apnea.

VII. REPORTING

A. A report number should be generated, and a report should be completed when naloxone is administered according to agency policy.

B. The report should include all pertinent information, including but not limited to identifying information for those involved; officers' observations; statements made by witnesses; condition/symptoms experienced by the victim as observed by the officer; that the victim was released to Emergency Medical Services and transported; and that the naloxone was disposed of properly.

C. It is recommended that statistics related to naloxone use should be kept to support public policy or funding opportunities for opioid harm reduction.

VIII. STORAGE

A. The naloxone, when feasible, will be stored following the manufacturer's recommendations.

B. The surplus inventory of naloxone will be stored consistent with the manufacturer's storage recommendations.

C. Naloxone should be stored at room temperature and away from light. According to the manufacturer, Naloxone must be kept out of direct sunlight and at temperatures between 59º and 77º Fahrenheit.

D. Naloxone kits should not be left in a patrol vehicle or exposed to extreme heat or cold if carried on or about the person.

IX. SHELF LIFE

The shelf life of Naloxone is approximately two years. All doses should be checked for the integrity of the packaging at least every three months to ensure the packing is not damaged. A dose of naloxone is adulterated when:

a. It is beyond the manufacturer or distributor's expiration date; or

b. There are signs of discoloration or particles in the naloxone solution.

X. EQUIPMENT AND MAINTENANCE

A. Inspection of issued naloxone should be the responsibility of the personnel assigned the equipment and should be conducted each shift.

B. Naloxone that is missing, damaged, expired, or otherwise unusable should be immediately reported and replaced.

XI. REPLACEMENT

A. The department should replace any naloxone that has been administered and all naloxone that is missing, damaged, expired, or otherwise unusable.

XII. TRAINING

A. Officers should receive a standard training course administered by the Police Department in coordination with the local EMS Agency and Medical Director. Education should include this department's regulation, including but not limited to opioid antagonists, opioid exposure and overdose symptoms, intranasal naloxone and its administration, reporting requirements, and other applicable information.

B. Training should be completed during orientation for new hires and every two years for all officers.