Authorizing Prescriber(s)

Rapid Access Addiction Medicine Clinic Physicians and Infectious Disease Physicians supporting the Positive Care Clinic.

Authorized to Whom

Lakeridge Health (LH) Mental Health and Addiction Program, Pinewood Centre staff, Rapid Access and Addictions Management Clinic, and Positive Care clinic staff who have successfully completed the Take-Home Naloxone Kit in-person training provided by Public Health or Pinewood Mental Health and Addictions Program Nurse Practitioners (NPs) or Clinical Practice Leaders.

Patient Description/Population

Any Lakeridge Health patient or family member or caregiver within Lakeridge Health's Pinewood Mental Health and Addictions Program or Positive Care clinics who meet any one of the criteria indicated below.

Order and/or Procedure

Distribute one Take-Home Naloxone Kit following the procedure below:

1. Retrieve Take-Home Naloxone Kit from medication room or designated storage location.
2. Record name and date on pre-printed Take-Home Naloxone Kit label(s) and affix to kit.
3. Complete the Naloxone Kit Distribution Record.
4. Provide patient/family/caregiver with required education.
5. Send copy of Naloxone Kit Distribution Record to Pharmacy.

Note: Naloxone nasal spray is the preferred option for Take-Home Naloxone Kits; however, in the event of a shortage, naloxone injection may be supplied by Pharmacy or Public Health. Follow the same procedure above.

Indications to the Implementation of the Directive

Patient meets any one of the following criteria:

- Received emergency medical care due to opioid toxicity or misuse
- Prescribed methadone or buprenorphine for addiction
- Voluntarily requests a Naloxone Kit

- A history of opioid or cocaine or other recreation or illicit drug use
- Receiving an opioid prescription

Contraindications to the Implementation of the Directive

Patient/family/caregiver refuses Take-Home Naloxone Kit and/or education provided.

If the intended, potential recipient of the naloxone has a known sensitivity to naloxone or one of its ingredients. Or if the intended, potential recipient is pregnant or breastfeeding (refer to an NP or physician for distribution of Take-Home Naloxone Kit).

Consent

Consent will be obtained prior to distributing Naloxone Kit to patient/family/caregiver and education is provided.

Documentation Requirements

In addition to standard documentation, ensure the Naloxone Kit Distribution Record is completed.

Review/Evaluation Process

This medical directive will be reviewed every 2 years by the Mental Health and Addictions Program.

References

Adapt Pharma. Narcan Nasal Spray. https://www.narcan.com/

Brant Community Healthcare System. Naloxone Distribution Policy. July 2017

Bluewater Health. Provision of Naloxone for Individuals at High Risk for Opioid Overdose Medical Directive Order Set. 8/5/17

Approvals and Signatures

Sponsor/Owner Group	_____ Name	_____ Program
Contact	_____ Name	_____ Position/Title

Department Chief	_____ Name	_____ Signature	_____ Date
Medical Director	_____ Name	_____ Signature	_____ Date
Program Director	_____ Name	_____ Signature	_____ Date
Chair of IPPC	_____ Name	_____ Signature	_____ Date
Chair of NPPC	_____ Name	_____ Signature	_____ Date
Chair of P & T	_____ Name	_____ Signature	_____ Date
Final Approval Chair of MAC	_____ Name	_____ Signature	_____ Date

Authorized By	_____ Name	_____ Signature	_____ Date
	_____ Name	_____ Signature	_____ Date
	_____ Name	_____ Signature	_____ Date
	_____ Name	_____ Signature	_____ Date

Appendix A – Outpatient Distribution Record

Lakeridge Health Site:_____

Naloxone 4 mg/0.1 mL Nasal Spray (Adapt Pharma) Distribution Record

				Fill out these columns if the last kit was used in an overdose.	
DATE/ LOT	**Recipient**	**Training provided?**	**1ST KIT OR REPLACEMENT**	**If naloxone was administered, how many doses?**	**If naloxone was administered, was 911 called?**
MM/DD/YY Lot # Exp:	☐Client ☐Family/friend Patient's Name: MRN#:	☐Training ☐No training	☐1st Kit ☐Replacement (Last Kit Used) ☐Replacement (Other Reason) Distributed by: _____	☐ 1 ☐ 2 ☐ Other ☐ Unsure	☐ Yes ☐ No ☐ Unsure ☐ Prefer not to say
MM/DD/YY Lot # Exp:	☐ Client ☐Family/friend Patient's Name: MRN#:	☐Training ☐No training	☐1st Kit ☐Replacement (Last Kit Used) ☐Replacement (Other Reason) Distributed by: _____	☐ 1 ☐ 2 ☐ Other ☐ Unsure	☐ Yes ☐ No ☐ Unsure ☐ Prefer not to say
MM/DD/YY Lot # Exp:	☐ Client ☐Family/friend Patient's Name: MRN#:	☐Training ☐No training	☐1st Kit ☐Replacement (Last Kit Used) ☐Replacement (Other Reason) Distributed by: _____	☐ 1 ☐ 2 ☐ Other ☐ Unsure	☐ Yes ☐ No ☐ Unsure ☐ Prefer not to say

Fax Copy to Oshawa Pharmacy 905-721-7799 Faxed on:_____(Date) By:_____(Name and signature)