Emergency Departments
Opioid Overdose Post-Naloxone Patient Care Guidelines

Background

The emergency department (ED) services of Rhode Island Hospital, The Miriam Hospital, Hasbro Children's Hospital and Newport Hospital recognize the impact and potential threat that opioid drugs like oxycodone, methadone, heroin, and fentanyl present to the health of our patients. Misuse and overdose of these drugs killed over 28,000 people in the U.S. in 2014 and continues to kill about 78 people each day nationally.[1]

To help combat this epidemic of opioid deaths and its imminent threat to public health, we must commit ourselves to immediate and long-term measures. The Lifespan EDs developed, support, and participate in programs to provide patient and community access to the opioid reversal agent naloxone (Narcan), which is used to temporarily reverse life-threatening respiratory depression in opioid overdose patients.

Statement of Purpose

Individuals who have had an opioid overdose are at very high risk of having another near-fatal overdose - up to 79% of near-fatal overdoses suffer subsequent severe injury.[2] Patients who require naloxone in the pre-hospital setting or ED for the reversal of an opioid overdose can be considered as high risk and in need of further evaluation and treatment. Although some patients with opioid use or addiction may not realize their risk or wish to engage in further care, attempts should be made to provide brief intervention and referral to treatment.

Recommended Approach

Any patient requiring intranasal or intravenous naloxone administration because of an opioid overdose will have a 4 hour clinical assessment and observation period in the ED. During this time the following can be accomplished:

1) Medical and psychiatric interventions as needed.[2]
2) Evaluation by a substance use-addiction specialist and/or recovery coach who will assess the need for detoxification and provide counseling and continuing treatment options.
3) Clinical observation to detect recurrence of opioid overdose that can happen when the temporary effects of naloxone wear off.[3,4]
4) Clinical observation to allow detection of delayed onset of pulmonary edema or other complications from the opioid overdose.[5]
5) Communication with the patient's family, friends, or other social support if the patient is willing.

No patient who has received naloxone pre-hospital or in the ED should be allowed to leave the ED without an attending physician evaluation. In the event that a patient who has received naloxone insists on leaving the ED before the 4 hour observation period is completed, the provider, along with the attending physician, will assess the patient and encourage the patient to stay. If the patient is judged to be awake, alert, oriented and has the capacity to make decisions, he/she will be allowed to leave the ED against medical advice after being informed of the risks of doing so. The provider will document the AMA decision.

References

1. Rudd RA, Aleshire N, Zibbell JE, Gladden RM. Increases in Drug and Opioid Overdose Deaths - United States, 2000-2014. *MMWR Morb Mortal Wkly Rep.* 2016;64(50-51):1378-1382.
2. Warner-Smith M, Darke S, Day C. Morbidity associated with non-fatal heroin overdose. *Addiction.* 2002;97(8):963-967.
3. Dahan A, Aarts L, Smith TW. Incidence, Reversal, and Prevention of Opioid-induced Respiratory Depression. *Anesthesiology.* 2010;112(1):226-238.
4. Boyer EW. Management of opioid analgesic overdose. *The New England journal of medicine.* 2012;367(2):146-155.
5. Sporer KA. Heroin-Related Noncardiogenic Pulmonary Edema*. *CHEST Journal.* 2001;120(5):1628.

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