NORTH MIAMI POLICE DEPARTMENT MEMORANDUM

To: Chief Laurence Juriga

Date: November 7, 2017

From: Sergeant Joseph Kissel

Subject: Naloxone (Narcan) Research

Distribution:

Per your request to research the use of Naloxone (Narcan) by this agency, I have yielded the following information. I conducted an internet search of the use of Naloxone in law enforcement and found **(Exhibit A)**, Law Enforcement Training. Naloxone has saved thousands of lives within the United States, people who otherwise would have died of an overdose if someone hadn't been prepared and trained with the antidote. Some of the highlights of this research reflect the following:

Contact was made with the following agencies regarding the use of Naloxone, Bay Harbor, Miami-Dade, Coral Gables, and Fort Lauderdale.

My research yielded the following data, which should be utilized in the use and training of Naloxone.

1. The training of the use of the Naloxone should be provided by the staff of the local hospital, another health facility, health department, or EMS service.

2. How often do participants need to be retrained? There are currently no legal requirements for retraining in law enforcement overdose response programs. Just like with any other law enforcement activity, annual or other periodic re-training may be needed to ensure effective and compliant practices.

3. What does the education and training element of a law enforcement overdose reversal program typically cover? Typically last from 40 to 90 minutes. At the very least, such training includes three basic elements: 1) information on how to recognize signs of an opioid overdose, 2) information on how to provide basic life support and proper administration of naloxone, and 3) an applied component providing trainees an opportunity to practice their skills.

4. What should the training include:

    a. Drug abuse basics, including the chronic nature of addiction

    b. Mechanisms by which opioids can cause overdoses and the reversal properties of naloxone

    c. Occupational safety considerations

d. Legal considerations, including naloxone authorization and applicable Good Samaritan laws or policy provisions covering overdose victims and bystanders

e. Standard operating procedures for the administration of naloxone

f. Overdose education and naloxone distribution programs available to community members

5. What is my state's policy related to the prevention and treatment of prescription drug abuse, including opiates?

   a. The profiles provide an understanding of the current environment of state activities to address prescription drug abuse, ranging from prevention strategies to surveillance and monitoring (PDMPs), law enforcement, and treatment and recovery.

6. Do law enforcement overdose response programs require the creation of specific operating procedures?

   a. While not legally required, it is strongly encouraged. Each agency should establish standard operating procedures (SOPs) for law enforcement overdose response activities.

The attachment of **Exhibit B**, the news article dated May 23, 2107 when the City of Fort Lauderdale Police Department started it implementation of the use of Naloxone. **Exhibit C** is the Standard Operating Procedures of the City of Fort Lauderdale Police Department of the Administration of Naloxone. The City of Fort Lauderdale purchases their Naloxone from Broward Sheriff's Office's Regional Logistics. They purchased 60 units for several thousand dollars in their first round of purchases. Their second shipment was from a grant and they received 600 units. They are looking at "Bid Sync" for future vendors. All patrol officers and sergeants are required to carry the Naloxone. They do not have a usage form for the Naloxone. Their training unit is responsible for coordinating and providing an approved emergency opioid antagonist training course for all employees with first responder responsibilities.

Contact with the City of Coral Gables Police and Fire Departments on their use of Naloxone, yielded the following information. The City of Coral Gables Police officers do not carry the Naloxone. They solely rely on their fire department for the administration of Naloxone. After making contact with Major Raul Pedroso of the police department, I was directed to Captain Kenneth Anderson of the Coral Gables Fire Department, as their fire personnel are the ones who carry the Naloxone. Captain Anderson was able to provide the following information on the use of the Naloxone.

Exhibit D, their protocol for paramedics to administer Naloxone (Narcan).

Each time Narcan is utilized in the field a memo is sent to Captain Anderson and to the Professional Standards Chief stating the number, circumstances of the incident, and the outcome. They track the administration data and forward it to the Coral Gables Police Department who then send it to Miami Dade Police Department for their county wide tracking initiative. Their training is administered in Paramedic School, and they provide annual protocol training and CEU training in-house either through their training department or they may bring in an outside agency.

Contact was made with Sergeant Victor Milan of Miami-Dade Police Department's Public Safety Training Institute and received the following information from him.

As for their Standard Operation Procedures, the policy is on their director's desk for review and for signing (October 25, 2017), pending for decision on full implementation. They get their Naloxone from the Miami-Dade Fire Rescue. Currently any uniformed patrol officer that has been trained and certified in the Miami-Dade Police Department's 8 hour program can carry the Naloxone. The training for the Miami-Dade police officers is conducted by their training unit, in a collaborative effort with the Miami-Dade Fire Department. They do have a usage form that is utilized in the event the Naloxone is utilized.

Contact was made with Sergeant John Grimes of the Bay Harbor Police Department, and their agency is in the early stages of implementing the use of Naloxone. Their Standard Operating Procedures are currently under review by Chief Sean Hemingway.

Exhibit A:

Law Enforcement Training

https://www.bjatraining.org/tools/naloxone/law-enforcement-training

As with any new initiative, officers should be trained in the proper handling and use of the medication. The length and content of the training are discretionary in most states. The vast majority of law enforcement overdose reversal programs are administered in collaboration with state or local departments of health, community-based organizations, healthcare organizations, or EMS agencies that provide officer trainings at no charge.

In the case of dual-role officers holding additional medical response certifications (e.g. EMTs), existing training and certification could be sufficient to carry and administer naloxone.

Who is responsible for the delivery of the education and training element of a law enforcement overdose response program?

Several options exist for providing training to law enforcement overdose response program participants.

One model is for the training to be provided by the staff of the local hospital, another health facility, health department, or EMS service. In these situations, the same medical organization often acts as a liaison for the naloxone supply. Some law enforcement agencies have an existing emergency response training infrastructure to maintain required first aid and first responder certifications. Depending on the organization's internal capabilities, this training may be provided by a designated training officer, who often has additional medical training, or provided by staff of the external health agencies. Opioid overdose response training can be incorporated into this existing training infrastructure.

Another option is for a community-based organization providing naloxone access to members of the public to provide such training.

A third option is for the training to be organized at the state or county level using a distance learning or train-the-trainer model. E-learning tools may be especially useful for rural and tribal agencies.

By including presentations from law enforcement professionals in opioid overdose trainings, agencies can take advantage of the benefits of peer-to-peer learning, thus improving uptake and retention.

How often do law enforcement overdose response program participants need to be re-trained?

There are currently no legal requirements for retraining in law enforcement overdose response programs. Just like with any other law enforcement activity, annual or other periodic re-training may be needed to ensure effective and compliant practices. In some jurisdictions, refresher trainings have become part of the annual training programs.

What does the education and training element of a law enforcement overdose reversal program typically cover?

Law enforcement overdose response program trainings typically last from 40 to 90 minutes. At the very least, such training includes three basic elements: 1) information on how to recognize signs of an opioid overdose, 2) information on how to provide basic life support and proper administration of naloxone, and 3) an applied component providing trainees an opportunity to practice their skills. Trainings also typically include time for the completion of requisite documentation to authorize naloxone possession and administration by law enforcement officers.

Most trainings also cover some combination of the following content:

- Drug abuse basics, including the chronic nature of addiction
- Mechanisms by which opioids can cause overdoses and the reversal properties of naloxone
- Occupational safety considerations
- Legal considerations, including naloxone authorization and applicable Good Samaritan laws or policy provisions covering overdose victims and bystanders
- Standard operating procedures for the administration of naloxone
- Overdose education and naloxone distribution programs available to community members
- Substance abuse treatment resources available in the jurisdiction

Programs that meet best practices cover information and skills that equip officers to engage in prevention and treatment program referral. The particular mix of training content and delivery channels depends on local needs and circumstances. Employees who hold existing medical response certifications such as CPR or basic life support may require an abridged training.

What is my state's policy related to the prevention and treatment of prescription drug abuse, including opiates?
In June 2014, the Association of State and Territorial Health Officials administered a survey to collect information about activities and policies to address prescription opioid abuse and overdose. Individual profiles were created for the 48 states, two U.S. territories, and one freely associated state that responded to the survey. The profiles provide an understanding of the current environment of state activities to address prescription drug abuse, ranging from prevention strategies to surveillance and monitoring (PDMPs), law enforcement, and treatment and recovery. See the 2014 Policy Inventory: State Action to Prevent and Treat Prescription Drug Abuse resource.

Do law enforcement overdose response programs require the creation of specific operating procedures?
While not legally required, it is strongly encouraged. Each agency should establish standard operating procedures (SOPs) for law enforcement overdose response activities. These procedures should be drafted in consultation with the governing laws of the jurisdiction and any applicable collective bargaining units. If applicable, policies should integrate the provisions of relevant 9-1-1 Good Samaritan laws, as well as the department's policy on information gathering, searches, arrests, and other activities at the scene of an overdose. Any triage plans developed with EMS and fire agencies can also be reflected in the department's SOP.

Exhibit B:

May 23, 2017

FORT LAUDERDALE, Fla. – Fort Lauderdale's Police and Fire Rescue departments are the latest South Florida agencies teaming up to train and arm officers with medicine to try to stop deaths from opioid overdoses.

"Opioids are a respiratory depressant, so it slows your breathing down eventually to where you'll stop breathing and go into respiratory arrest and then cardiac arrest," Fort Lauderdale Fire Rescue Battalion Chief Daniel Oatmeyer said.

Fort Lauderdale police now have 30 kits equipped with naloxone, which is commonly known by the brand name Naloxone (Narcan). It reverses an overdose from drugs such as heroin and fentanyl that are becoming increasingly dangerous.

"In the past few years, the overdose encounters that police are having with opioids — those types of drugs have reached epidemic proportions," Fort Lauderdale Police Chief Rick Maglione said.

"Year to date, we've administered Narcan over 450 times," Oatmeyer said. "It's one of those things that's consistent, so yes, we see it on a daily basis."

Local 10 News recently showed viewers video of a Miami-Dade police officer using naloxone to revive an overdose victim. The Miami-Dade Police Department began using the medication early this month.

"We want to reduce the amount of time a patient in need of Narcan and the time that the Fire Department can arrive on scene," Maglione said. "There may be some cases where we either encounter someone who overdoses and we will call the Fire Department, or if one of our own officers are exposed."

The goal is for all Fort Lauderdale patrol officers to eventually carry naloxone. First responders said the need is clear.

"The brain needs oxygen and if it's deprived for four to six minutes of oxygen, it's going to die," Oatmeyer said.

Exhibit C

Fort Lauderdale Police Department Standard Operation Procedure

POLICY 513	ADMINISTRATION OF NALOXONE HCI	
	REVISED: 10/17	RELATED POLICIES:
	CFA STANDARDS: 14.14	REVIEWED: AS NEEDED

PURPOSE:

The purpose of this policy is to establish guidelines and procedures governing the utilization of the naloxone nasal spray.

B. POLICY

It is the policy of the Fort Lauderdale Police Department for First Responders to be trained in the safe use and administration of the naloxone nasal spray as authorized by FS 381.887.

C. OBJECTIVE OF THIS POLICY

The objective of this policy is to safely and effectively treat and reduce injuries and fatalities due to opioid-induced overdose.

D. DEFINITIONS

1. **Naloxone Hydrochloride** – A prescription medication used as an emergency opioid antagonist/antidote that blocks the effects of opioids administered from outside the body and that is approved by the United States Food and Drug Administration for the treatment of opioid overdose.

2. **Naloxone Nasal Spray** – The device issued to trained personnel to administer the prefilled dose of naloxone hydrochloride opioid antagonist via the intranasal mucosal atomization device (nasal spray) in accordance with medical and training protocols.

3. **Opioid** – Containing or derived from opium. Opioids are medications that relieve pain. They reduce the intensity of pain signals reaching the brain and affect those brain areas controlling emotion. Medications that fall within this class include hydrocodone (e.g. vicodin), oxycodone (e.g. OxyContin, Percocet), morphine, codeine, heroine and related drugs.

4. **Administer/administration** – To introduce an emergency opioid antagonist into the body of a person.

5. **Patient** – A person at risk of experiencing an opioid overdose.

6. **Opioid Overdose** – An acute condition due to excessive opioids in the body, manifested by respiratory and/or central nervous system depression.

7. **Recovery Position** – Lateral, left or right side position.

8. **Emergency Opioid Antagonist –**

   a. Naloxone hydrochloride or any similarly acting drug that blocks the effects of opioids administered from outside the body and that is approved by the United States Food and Drug Administration for the treatment of an opioid overdose.

   b. A drug that nullifies in whole or in part the administration of an opioid. The opioid antagonist for the purpose of this policy is limited to naloxone hydrochloride (naloxone).

9. **Naloxone Coordinator** – The training sergeant and/or designee will be the designated Naloxone Coordinator. This position will ensure maintenance of training records and administration records

10. **Naloxone Liaison** – This position will be the Captain of Support Services overseeing Police Supply who will liaise with the certified medical physician licensed to practice medicine in the State of Florida who will prescribe the and naloxone nasal spray kits to trained personnel. This position will also ensure adequate supplies of naloxone for issuance to personnel as appropriate and ensuring the Naloxone supply, integrity and current expiration dates.

E. NALOXONE NASAL SPRAY

1. Storage:

   a. Naloxone nasal spray kits shall be carried and or kept in a manner consistent with proper storage guidelines as detailed by the manufacturer for temperature and sunlight exposure.

      (1). Naloxone nasal spray medication shall be kept in an approved pouch o, the officer's utility belt, outer vest carrier or uniform pocket. The nasal spray doses shall be stored in a temperature controlled environment when the officer is not on duty.

      (2). Do not freeze medication

      (3). Protect from light until ready to use.

      (4). Replace medication before expiration date.

   b. Naloxone nasal spray kits will include:

      (1). Shears

      (2). Gloves

      (3). One pair of safety glasses

(4). One 4X4 CPR pocket face mask with one-way valve

(5). Red biohazard disposal bag

(6). Antimicrobial wipes

(7). One 4mg Naloxone Nasal Spray Device

2. Maintenance

a. An inspection of the naloxone nasal spray kit shall be the responsibility of the personnel receiving the equipment and will be conducted at issuance and return for each shift. If the required medical seal is broken or removed, the kit will need to be replaced and restocked.

b. Missing or damaged naloxone nasal spray kit(s) will be reported directly to the Naloxone Liaison who shall issue a new kit. The missing/damaged kit(s) will be documented on an offense report.

F. DEPLOYMENT

1. Naloxone nasal spray kits will be issued to properly trained and authorized personnel. Naloxone nasal spray medication shall be kept in an approved pouch on, the officer's utility belt, outer vest carrier or uniform pocket.

2. Upon arriving at a scene of a medical emergency where it has been determined that an overdose has likely occurred, the responding officer will ensure the safety of the scene, request the response of Fire Rescue personnel and a supervisor with a Naloxone nasal spray kit.

3. When using an naloxone hydrochloride nasal spray kit, officers will first adhere to the following:

a. Utilize universal precautions to protect against blood borne pathogens and other communicable diseases.

b. Assess the patient to determine unresponsiveness and other indicators of an opioid-induced overdose.

c. Provide CPR if needed.

d. Prepare and administer the naloxone hydrochloride in accordance with proper medical and training protocols.

e. Be aware that patients revived from an opioid overdose may regain consciousness in an agitated or combative state, and may exhibit symptoms associated with withdrawal. Officers should be prepared to use appropriate defensive tactics control measures if necessary.

f. If the naloxone is effective, immediately place the patient into and maintain the recovery position while providing supportive care until relieved by Fire Rescue personnel.

Immediately notify responding Fire Rescue personnel of the use of the naloxone hydrochloride, the manner in which it was administered and the number of doses used.

g. If the patient refuses medical treatment or transportation to a medical facility and no criminal charges are to be filed, the subject may be held in protective custody under the Baker Act or Marchman Act (FS 397.677) provided all required criteria have been met. Once a police officer administers Naloxone nasal spray to a patient, the patient must be transported to a medical facility by Fire Rescue personnel.

h. The administration of the naloxone shall be documented in an offense report and will indicate the responding Fire Rescue unit designator who assumed primary care of the patient. The offense report will detail the officer's observations of the necessity to deploy the naloxone, the number of doses and manner in which administered and the final disposition of the patient. The offense report will be forwarded to the Training Unit and the Naloxone Liaison for tracking purposes.

i. Used naloxone nasal spray kits will be discarded in appropriate biohazard disposal bags and discarded in accordance with policy 105.1.

M. TRAINING

1. The Training unit is responsible for coordinating and providing an approved emergency opioid antagonist training course for all employees with first responder responsibilities.

2. Initial training

   a. All sworn personnel will receive the initial naloxone hydrochloride training prior to the issuance or administration of naloxone.

   b. The initial training will include but not be limited to:

      (1). An overview of FS 381.887 which permits law enforcement use of naloxone hydrochloride.

      (2). An overview of the Marchman Act FS 397.677.

      (3). Proper carrying and storage of the naloxone hydrochloride administration devices.

      (4). Patient assessment. (e.g. signs, symptoms of opioid overdose)

      (5). Universal precautions to protect against blood borne pathogens and other communicable diseases.

      (6). The use and administration of the intra-nasal naloxone spray.

      (7). Recovery position and follow-up care.

      (8). Simulated/scenario based administration.

3. Continuing education

a. After receiving initial training, personnel will be required to receive recertification training biannually, which will coincide with the CPR recertification schedule. This training will consist of an overview of the initial training including:

(1). Updates to policy and or state statute

(2). Refresher of patient assessment and universal precautions

(3). Refresher on the use and administration of the nasal spray.

(4). Simulated/scenario based administration.

b. During the continuing education for all certified personnel, the naloxone coordinator or designee will conduct an inspection of all naloxone kits.

N. Quality Control and Oversight

1. The Naloxone Liaison, Coordinator or designee will attend the Fire Department monthly Continuous Quality Improvement (CQI) meeting. This meeting occurs with the City's Medical Director and Fire Rescue to ensure the quality medical services provided by the City. The City's Medical Director will oversee the quality control of the Naloxone administration within the police department as part of the prescription process.

2. The Naloxone Coordinator will be responsible for maintaining all records related to the Naloxone program to include:

a. Training Records

b. Police reports documenting the administration of Naloxone nasal spray.

3. The Naloxone Coordinator will coordinate all training for certification and mandatory retraining.

4. The Naloxone Liaison will be responsible for inventory control of the Naloxone nasal spray medication and kits.

5. The Naloxone Liaison will also be the primary point of contact between the Medical Director and the police department and will ensure any issues or recommendations related to the Naloxone program as a result of the CQI meetings or other information provided by the Medical Director are addressed.

Common EMS Protocols

Adult Protocols
Poisoning/Overdose

GENERAL TREATMENT

1. Universal Initial Adult Patient Assessment/Care.
2. Stabilize airway, breathing, and circulation
3. Attempt to identify any medications or products taken. Save any drug vials, pills, or material. Estimate the amount taken.
4. Be alert for changes in respiratory and circulatory status. Monitor cardiac rhythm, ETCO2, and SpO2. Give supplemental oxygen if SpO2 is less than 94%.
5. Be alert for the development of any altered mental status and treat according to the Impaired or Altered Consciousness Protocol.
6. Manage active Seizures.
7. Treat any Systemic / Anaphylactic Reactions.
8. Treat per any appropriate protocols and procedures as needed.
9. Determine if you have an antidote.

Morphine / Fentanyl / Percocet / Vicodin / Dilaudid / Methadone / Carfentanil /Opiates Excess / OD:
(pinpoint pupils, respiratory depression)

a. Administer naloxone (Narcan). **2 mg *slow* IV or IM or IntraNasal** (or **4 mg diluted with normal saline to a total of 10 mL via Advanced Airway** if IV access cannot be established. After the drug has been administered, provide 5 rapid ventilations to enhance the drug delivery into the lungs. This can be repeated once in 2-3 minutes. Additional doses may be given after consultation with Poison Control (1-800-222-1222).

Beta Blocker or Calcium Channel Blocker excess/OD:
(typically bradycardia)

a. Administer atropine sulfate. **1 mg IV** every 2-3 minutes to a maximum of 3 mg.
b. If patient is bradycardic and hypotensive administer calcium chloride. 1 grams IV ***slowly over 1 minute***. Flush with at least 20 mL of normal saline. This may be repeated once in 2-3 minutes if indicated.
c. If the patient remains hypotensive after the administration of calcium chloride, administer normal saline. **500 mL IV bolus**. May repeat once if patient remains hypotensive.

Suspected Opiate-Type Overdose Or Unconsciousness Of Unknown Origin

TREATMENT

1. Universal Initial Adult Patient Assessment / Care

2. If there are signs of narcotic OD (e.g., pinpoint pupils, track marks) with respiratory depression (including morphine/fentanyl OD) or unconsciousness of unknown origin, administer naloxone (Narcan). **2 mg slow IV/IM or IntraNasal (or 4 mg diluted with normal saline to a total of 10 mL through an Advanced Airway** if IV access cannot be established. After the drug has been administered, provide 5 rapid ventilations to enhance the drug delivery into the lungs). This can be repeated once in 2-3 minutes.

HEAD INJURY Or Signs Of Increased Intracranial Pressure (ICP) (Cushing's Triad: HTN, bradycardia, irregular respirations) Without Hypotension

TREATMENT

1. Universal Initial Adult Patient Assessment / Care

2. Keep the head elevated approximately 30 degrees (12-18"). The patient can either be placed in a semi-fowlers position, or in the case of the suspected C-spine injury, immobilized on a backboard and the head of the entire backboard elevated.

3. Avoid administration of dextrose solutions (D50W, D5W) unless hypoglycemia (glucose less than 60) is identified. Dextrose may increase cerebral edema.

4. If GCS is less than or equal to 8, **AND** an advanced airway is established, hyperventilate (ventilate at a rate adequate enough to maintain an ETCO2 of 30-34 mmHg) **ONLY** with signs of brainstem herniation (e.g. dilated pupil, a blown pupil, or decorticate/decerebrate posturing).

5. **Start a saline lock, but restrict fluid administration, or run IVs at TKO.**

6. If the patient's BP is less than 90mmHg administer normal saline, **500 mL IV/IO** to maintain at least 90 mmHg. This may be repeated once.

Action

Narcan antagonizes the effect of opiates by competing at the same receptor sites. When given IV, the action is apparent within 2 minutes. When given intranasal administration, the action is rapid.

Indication

1. Narcan is indicated for the complete or partial reversal of narcotic depression and respiratory depression secondary to narcotics or related drugs.

2. Narcan can also be used for suspected acute opiate overdose. When patients with suspected opioid overdose have respiratory insufficiency plus a detectable pulse, give Narcan before placing an advanced airway.

3. Consider Narcan administration to newborns with a slow heart rate and depressed respirations if the mother has used narcotics within 4 hours of the delivery.

Contraindication

Known hypersensitivity to Narcan (naloxone).

Additional Information

1. IV narcotic users frequently have sclerotic veins that can be very difficult to access. It may be prudent to try **IntraNasal** Narcan early to prevent Respiratory Arrest, Narcan can be given via Advanced Airway at twice the IV dose.

2. Narcan should only be administered to IV drug abuse patients, including newborns of mothers suspected of IV narcotic drug abuse, when the patient's breathing is so depressed that an advanced airway may be needed, because it may precipitate an acute withdrawal. The patient may become violent and combative as level of consciousness increases.

3. If adult patient is unresponsive and believed to be an opiate overdose, and patients ventilation are slow **AND/OR** SpO2 is less than 94% give Narcan.

4. **If patient is believed to be opiate dependent, give lower dose of Narcan, 0.4 mg IV, in increments, in order to achieve SpO2 greater than 94%.**