Ministry of Health and Long-Term Care

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Ministère de la Santé et des Soins de longue durée

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Ontario

February 1, 2017

MEMORANDUM TO: Paramedic Service Chiefs, First Nations and Ornge

FROM: Chris Georgakopoulos
Senior Manager, Regulatory and Standards Oversight
Emergency Health Services Branch

RE: **Opioid Toxicity Medical Directives**

I am announcing the publication and release of an amendment to the *Advanced Life Support Patient Care Standards* (ALS PCS), version 3.4. The Opioid Toxicity Medical Directives at pages 1-39, 1-40 and 2-44, 2-45 in Version 3.4 of the ALS PCS are revoked and replaced with the attached respective Opioid Toxicity Medical Directives.

Version 3.4 of the ALS PCS was released on October 19, 2016 with an in force date as of February 1, 2017. The attached directives were previously released on December 23, 2016 to amend Version 3.3 of the ALS PCS.

Pursuant to clause 11(b) of O. Reg. 257/00 under the *Ambulance Act* each ambulance service operator and every paramedic shall ensure that patient care is provided in accordance with the ALS PCS as published by the Ministry, as that document may be amended from time to time.

This amendment **comes into force as of February 1, 2017**.

The table below has been updated to reflect the new version.

Please contact your local Base Hospital with any further questions regarding the administration of naloxone.

If you have any questions, please contact Mr. Corey Freedman, Paramedic Standards and Certification Coordinator, at (416) 326-3608 or corey.freedman@ontario.ca.

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Paramedic Practice Document	In Force As Of*
Advanced Life Support Patient Care Standards (ALS PCS)	
• **Version 3.4 (including the revised Opioid Toxicity Medical Directives released February 1, 2017)**	• February 1, 2017
• **Version 4.0.1 (replaces Version 4.0, which has been amended prior to the in force date)**	• July 17, 2017
• **Version 4.1**	• December 11, 2017
Basic Life Support Patient Care Standards (BLS PCS)	
• **Version 2.0 (including amendments made through various training bullets, *e.g. Training Bulletin No. 108 - DNR Standard*)**	• Currently in force
• **STEMI Hospital Bypass Protocol (amendment made through *Training Bulletin No. 118 – STEMI Hospital Bypass Protocol*)**	• February 1, 2017
• **Version 3.0.1 (replaces Version 3.0, which has been amended prior to the in force date)**	• December 11, 2017
Ontario Ambulance Documentation Standards (supplemented by *Ambulance Call Report Completion Manual - v3.0*)	
• **Version 2.1**	• Currently in force
• **Version 3.0**	• April 1, 2017
Provincial Equipment Standards for Ontario Ambulance Services (Equipment Standards)	
• **Version 2.3**	• Currently in force
• **Version 3.0**	• July 17, 2017
• **Version 3.1**	• December 11, 2017

*once a new version of a standard comes into force, it replaces the existing in force version.

ORIGINAL SIGNED BY

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Chris Georgakopoulos

c: ALS PCS / Equipment Standards Working Group
Senior Managers/Managers, EHSB
S. Haddad, Senior Manager, EESO 2.0
N. Roberts, President, OAPC
Dr. M. Lewell, Chair, OBHG-MAC
S. Kriening, Chair, OBHG-Executive
Paramedic Program Coordinators
Regional Training Coordinators

Enclosures

Opioid Toxicity Medical Directive

A Primary Care Paramedic may provide the treatment prescribed in this Medical Directive if authorized.

Indications

Altered LOC;

AND

Respiratory depression;

AND

Inability to adequately ventilate;

AND

Suspected opioid overdose.

Conditions

	Naloxone
Age	≥18 years
LOA	Altered
HR	N/A
RR	<10 breaths/min
SBP	N/A
Other	N/A

Contraindications

Naloxone
Allergy or sensitivity to naloxone
Uncorrected hypoglycemia

Treatment

Consider naloxone

	Route	Route	Route	Route
	SC	IM	IN	IV
Dose	0.8 mg	0.8 mg	0.8 mg	Up to 0.4 mg
Max. single dose	0.8 mg	0.8 mg	0.8 mg	0.4 mg
Dosing interval	10 min	10 min	10 min	immediate
Max. # of doses	3	3	3	3*

***For the IV route, titrate naloxone only to restore the patient's respiratory status.**

Clinical Considerations

IV administration of naloxone applies only to PCPs authorized for PCP Autonomous IV.

Naloxone may unmask alternative toxidromes in mixed overdose situations (leading to possible seizures, hypertensive crisis, *etc*.).

Naloxone is shorter acting than most narcotics and these patients are at high risk of having a recurrence of their narcotic effect. Every effort should be made to transport the patient to the closest appropriate receiving facility for ongoing monitoring.

Combative behaviour should be anticipated following naloxone administration and paramedics should protect themselves accordingly, thus the importance of gradual titrating (if given IV) to desired clinical effect: respiratory rate ≥10, adequate airway and ventilation, not full alertness. If adequate ventilation and oxygenation can be accomplished with a BVM and basic airway management, this is preferred over naloxone administration.

Opioid Toxicity Medical Directive

An Advanced Care Paramedic may provide the treatment prescribed in this Medical Directive if authorized.

Indications

Altered LOC;

AND

Respiratory depression;

AND

Inability to adequately ventilate;

AND

Suspected opioid overdose.

Conditions

	Naloxone
Age	≥18 years
LOA	Altered
HR	N/A
RR	<10 breaths/min
SBP	N/A
Other	N/A

Contraindications

Naloxone
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