



SOUTH DAKOTA  DEPARTMENT OF CORRECTIONS POLICIES AND PROCEDURES		POLICY NUMBER 1.6.A.18	PAGE NUMBER 1 OF 6
		DISTRIBUTION:	Public
		SUBJECT:	Staff Use of Naloxone (Narcan)
RELATED STANDARDS:	None	EFFECTIVE DATE:	01/01/2024
		SUPERSESION:	09/01/2022
DESCRIPTION: Institutional Operations – Security and Control	REVIEW MONTH: December	 KELLIE WASKO SECRETARY OF CORRECTIONS	

I. POLICY

It is the policy of the South Dakota Department of Corrections (DOC) to establish guidelines and policies governing the issuance, storage, and utilization of Naloxone by DOC staff. Naloxone will be made available to designated units of the DOC to treat opioid overdoses by offenders and harmful exposure to opioids by staff or others.

II. PURPOSE

The purpose of this policy is to establish uniform procedures for administering intranasal Naloxone when a trained staff member knows or suspects an opiate overdose.

III. DEFINITIONS

Fentanyl:

A potent synthetic opioid drug. Fentanyl is a Schedule II Narcotic. Approximately one hundred (100) times more potent than morphine and fifty (50) times more potent than heroin as an analgesic. Can be injected, snorted/sniffed, smoked, taken orally by pill or tablet, or spiked onto blotter paper. Can be present in a variety of forms (e.g., powder, tablets, capsules, solutions, and rocks).

Heroin:

A highly addictive drug processed from morphine. This is a rapidly acting opioid. Typically used in a powdered form. Heroin is a Schedule I Narcotic with a high potential for abuse.

Hydromorphone:

Belongs to the opioid class of drugs, has an analgesic potency of two to eight times greater than that of morphine, and has a rapid onset of action. Typically taken as a tablet, capsule, oral solution, or injectable. This is a Schedule II drug with an accepted medical use as a pain reliever.

Morphine:

A natural Schedule II Narcotic with a high potential for abuse. Derived from opium and used for the treatment of pain. Can be injected or taken as an oral solution as immediate and extended-release tablets and capsules.

Naloxone:

Also known as Narcan, is a medication that can reverse the effects of an overdose of opioid drugs. When administered during an overdose, it can block the effects of opioids on the brain and restore breathing within two (2) to eight (8) minutes. Common methods of administering are intranasal, auto-injector, or intramuscular. Has no potential for abuse.

Opioid:

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Class of drugs containing or derived from opium, including but not limited to, heroin and morphine. All opioids have high abuse potential and will cause physical dependence if taken regularly.

Opioid Antagonist:

A drug that blocks in whole or in part, the administration of an opioid. The opioid antagonist for the purpose of this policy is Naloxone.

Opium:

Highly addictive natural narcotic extracted from the poppy plant. The opium poppy is the key source of many narcotics, including morphine, codeine, and heroin. Usually found in a liquid, solid, or powder form. Can be smoked, intravenously injected, or taken in pill form.

Schedule I Drugs:

Drugs with a high abuse potential and no safe acceptable medical use in the United States. Examples include heroin, marijuana, LSD, PCP, and crack cocaine.

Schedule II Drugs:

Drugs with a high abuse potential but also have safe and acceptable medical uses in the United States. Examples include morphine, Oxycodone (Oxycontin), and Methylphenidate (Ritalin).

Schedule III, IV, or V Drugs:

Drugs with less abuse potential than scheduled two drugs. These drugs also have safe and acceptable medical uses in the United States however contain smaller amounts of certain narcotic and non-narcotic drugs, anti-anxiety drugs, tranquilizers, sedatives, stimulants, and non-narcotic analgesics. Examples include Acetaminophen with Codeine (Tylenol #), Diazepam (Valium), alprazolam (Xanax).

Synthetic Opioids:

Substances synthesized in a laboratory that act on the same targets in the brain as natural opioids (e.g., morphine and codeine) to produce analgesic (pain relief) effects. Can be in any form. Some synthetic opioids like fentanyl are very resistant to the effects of Naloxone.

IV PROCEDURES

1. Training and Management of Naloxone:

- A. All DOC staff will receive training on Naloxone. Training will include the procedures described in SDCL §§ 34-20A-101 and 34-20A-102.
- B. Naloxone training will be provided to staff during new hire or basic training.
- C. Any staff member trained in the administration of Naloxone may possess and administer Naloxone to any person exhibiting symptoms of opiate overdose or opiate exposure (SDCL § 34-20A-98).
- D. The division directors or designee will assign staff to coordinate and direct the process of maintaining Naloxone possessed by staff within all DOC institutions and/or field offices. This does not include Naloxone provided by the pharmacy to clinical services for injectable use. The division director or designee will be responsible for coordinating the following:
 1. Assuring the supply and integrity (including monitoring expiration dates) of the Naloxone issued to authorized staff at institutions and/or field offices.
 2. Knowing how many Naloxone kits each unit maintains (including Naloxone issued to staff).
 3. Assuring the maintenance of records documenting damaged, unusable, expired, or administered Naloxone and requesting replacement Naloxone. Records and inventory shall be kept current.
 4. Working with training staff to ensure all DOC employees have received the required training prior to being granted authority to access, possess, or administer Naloxone, including any required remedial training.

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5. Assuring any administration of Naloxone by staff (does not include clinical services staff) is documented in an incident report or case note. Health services administrator (HSA) or designee shall maintain current records documenting all administration of Naloxone by calendar year for reporting purposes.

2. Protocol:

- A. Staff responding to a possible opioid overdose or exposure will first make sure the scene is safe.
- B. Staff will apply universal precautions. Personal protective equipment is effective in protecting staff from exposure to opioids or other substances that may be present at the scene or on the victim.
 1. Always wear gloves when responding to a possible overdose or exposure incident. Most exposures occur from skin-to-substance contact.
 2. Wear eye protection and a properly fitted N-95 respirator, if available. A medical-grade surgical mask may be worn only if no N-95 respirator is immediately available.
 3. Avoid actions that may cause powder or substance to become airborne. Inhalation of airborne powder may cause harmful effects, including overdose and death.
- C. Staff must first perform a brief assessment of the exposed person, which shall include determining responsiveness, breathing, and pulse.
- D. If the incident occurs within a DOC facility, the Incident Command System (ICS) will be initiated. Clinical services staff will be notified immediately.
- E. If the incident occurs within the community, staff will ensure local Emergency Services (911) are contacted.
- F. Signs of an opioid emergency (overdose or exposure), may include some or all of the following symptoms:
 1. Unusual sleepiness, unresponsiveness, or coma.
 2. Breathing problems, slow or shallow breathing, or respiratory failure.
 3. Constricted or pinpoint pupils.
- G. Staff will determine to the best of their ability whether the person is experiencing an opioid emergency. Staff will respond and offer assistance consistent with DOC training, to the best of their abilities, provided it is safe to do so. If the person is suspected of suffering from the effects of an opioid emergency, staff will respond as follows:
 1. If the person is conscious or easily roused, do not give Naloxone.
 2. If the person is NOT conscious and has abnormal breathing and a pulse, lay the person on his/her back, tilt the head back, and provide support to the neck. Apply one dose of Naloxone in one nostril. Administer Naloxone as quickly as possible as prolonged respiratory depression may result in damage to the brain or death. Turn the person on his/her side after administering the Naloxone.
 3. If the person is NOT conscious with abnormal breathing and NO pulse, CPR and AED should be initiated, as per accepted protocol. Use standard basic life support safety precautions (e.g., pocket mask, gloves) to address exposure risk. Administer one dose of Naloxone in one nostril. Administer Naloxone as quickly as possible as prolonged respiratory depression may result in damage to the person's brain or death.
 - a. When administering Naloxone, lay the person on his/her back, tilt the head back while providing support to the neck, and administer Naloxone to the nostril.
 - b. CPR should be continued as deemed necessary.
 - c. If cardiovascular function and breathing improve, place the person on their side (the standard "CPR Recovery position") and re-assess frequently.
 4. Continue to monitor the person. Do not stop assisting the person or leave the person alone, unless directed to do so by responding medical staff or the scene becomes unsafe.
 5. If breathing does not improve within two to three (2 to 3) minutes, repeat steps in subsections 2 or 3 above using a new kit and administering the Naloxone in the person's other nostril.

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6. Re-administer Naloxone, using a new container if the person initially responds but sleepiness or breathing problems return. Continue steps in subsections 2 or 3 above if the person's condition remains unchanged until medical staff arrives. Administer Naloxone into alternate nostrils with each dose.
 7. If at any time the pulse is lost, CPR and AED must be administered as per the accepted protocol.
- H. Adolescents and children aged five (5) or older should receive the same dose of Naloxone as adults. For infants and children weighing less than forty (40) pounds, consult with Emergency Medical Services or the 911 operator.
- I. All persons receiving Naloxone must be referred for medical follow-up. Offenders will be seen by clinical services and EMS will be called. The effects of Naloxone may only last for a limited time and the person may experience another opiate emergency as the Naloxone wears off. Persons who have experienced opioid overdose or exposure require evaluation by a medical professional. Administration of Naloxone is not a substitute for medical care.

3. Response to Exposure:

- A. If staff have reasonable belief that they or others may have been exposed to dangerous substances, immediately move away from the source of the possible exposure.
- B. Immediately notify another staff person so they may observe those exposed for signs of exposure (see Section IV.2.F.).
- C. Advise others responding to the scene of the possible presence of any dangerous substances.
- D. Do not touch eyes, mouth, nose, or any skin after touching any potentially contaminated surface or drug.
- E. Wash any exposed skin thoroughly with warm water, and soap if available. DO NOT use hand sanitizer as this may enhance absorption through the skin.
- F. If clothing, shoes, or personal protective equipment is contaminated, or suspected to be contaminated, remove these items, and place them in a sealed plastic bag or hazardous material bag/container.
- G. Follow the decontamination instructions listed on the material data safety sheet if applicable and obtain medical care as the situation dictates.

4. Storage/Maintenance/Replacement:

- A. Naloxone kits must be carried and stored in a manner consistent with proper storage guidelines recommended by the manufacturer and/or prescriber. Naloxone is sensitive to temperature and sunlight exposure. Steps shall be taken by staff to ensure the integrity of the Naloxone is not compromised by exposure to adverse conditions.
 1. Staff who are issued Naloxone shall ensure they have reasonable access to the Naloxone while performing work duties that could cause risk of exposure (e.g., searches, including pat-down search of an offender, or being present at an offender's residence/cell, when responding to a possible overdose or exposure incident).
 2. To prevent theft, loss, damage, misuse, or access by unauthorized persons, Naloxone not carried by staff or otherwise in the immediate physical control of the staff member, should be secured in a safe storage area.
 3. Clinical services will monitor and replace DOC staff carried Naloxone per the *Nasal Narcan Accountability List* (see attachment #1).
 4. Institutional staff will turn in Naloxone kits at the end of their shift and pick them up at the start of their shift.

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- B. Naloxone must be kept and stored according to manufacturer guidelines.
- C. Naloxone kits located in DOC institutions will be kept in a location secure from offenders but accessible to staff trained to administer the Naloxone.
- D. All Naloxone kits will be inspected regularly for damage by the staff member who was issued the kit.
- E. Used, damaged, missing, or expired Naloxone kits shall be reported by the employee to their immediate supervisor for documentation. The supervisor will coordinate with the HSA or designee to ensure the kits are replaced in a timely manner.
 - 1. Do not attempt to reuse a Naloxone kit once the Naloxone has been administered. Each container contains a single dose and cannot be reused or partially administered.
- F. Expired Naloxone (per the date specified on the container) or Naloxone suspected to be damaged by exposure to adverse conditions will be properly disposed of per pharmacy instructions.

5. Immunity from Civil Liability:

- A. The staff member who administers Naloxone in good faith, consistent with DOC protocols and requirements set forth for administering Naloxone, shall not be liable for injuries that may be the result of administration and receipt of Naloxone. No such person may be held liable to pay damages to any person for injuries or death associated with the administration of Naloxone (SDCL § 34-20A-103).
- B. A health care professional authorized to prescribe or dispense Naloxone is not subject to any disciplinary action, or civil or criminal liability for prescribing or dispensing Naloxone to an employee or contract staff with whom the health care professional reasonably believes may be in a position to assist or administer Naloxone to a person at risk for an opioid-related drug overdose (SDCL § 34-20A-106).
- C. No staff member is liable for any civil damages as a result of their acts of commission or omission arising out of, and in the course of, their rendering in good faith, any emergency care and services during an emergency which is in their judgment indicated and necessary at the time. Such relief from liability for civil damages extends to the operation of any motor vehicle in connection with any such care or services. Nothing in this section grants any relief to any person causing any damage by his willful, wanton, or reckless act of commission or omission (SDCL § 20-9-4.1).

V. RESPONSIBILITY

The director of Clinical and Correctional Services, the associate director of emergency management and security audit controller, and the wardens of the institutions will be responsible for the maintenance and annual review of this policy.

VI. AUTHORITY

SDCL §§ 20-9-4.1, 34-20A-98, 34-20A-101, 34-20A-102, 34-20A-103, 34-20A-106.

VII. HISTORY

January 2024
June 2021
July 2020
June 2019
August 2018
June 2018
June 2017 – New policy.

ATTACHMENTS *(*Indicates document opens externally)*

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1. Nasal Narcan Accountability List*
2. DOC Policy Implementation / Adjustments

