

This toolkit was used to implement the VHA Rapid Naloxone Initiative in Fall 2018. When possible, we tried to integrate relevant information from the VA Police Naloxone toolkit (which was developed after this toolkit) as well as integrate links to corollary external VHA websites when internal VHA websites were referenced. Because this toolkit was developed before the COVID-19 pandemic, it does not include any specific COVID-19 recommendations (e.g., [American Heart Association \(AHA\)](#) interim guidance for Basic and Advanced Life Support [BLS and ACLS] for individuals with suspected or confirmed COVID-19). In addition, this toolkit was developed before the September 5, 2018 Deputy Under Secretary for Health for Operations and Management (DUSHOM) Memorandum on “Rapid Naloxone Availability to Prevent Opioid-Related Death”. This memorandum required VHA facilities to identify a champion and backup champion to coordinate implementation of the Rapid Naloxone Initiative and had a goal of implementing this practice no later than December 2, 2018.

Since implementing this initiative in Fall 2018, some key updates are worth noting:

- VHA developed a short, standardized national training in response to requests from the field. VA Boston Health Care System originally used a video from the pharmaceutical company in their standardized training <https://www.youtube.com/watch?v=hGVSaO1oxpg>; however, VHA worked with the pharmaceutical company to adapt the video for national VHA training purposes. The adapted video is included in VA’s Talent Management System training 37795 “[How to Use Naloxone Nasal Spray \(Narcan®\)](#)” released in February 2019 and will be placed on the public-facing website [www.train.org](http://www.train.org).
- This toolkit is based on one approach that was determined to have met The Joint Commission (TJC) standards in the way that it was presented and described at the time. Notably, a number of questions came up related to the VA Boston HCS model during implementation (e.g., daily checks) and we reached out to TJC for guidance. Based on that meeting we shared the following information below with the field. Notably, TJC recently released a Standards FAQ specifically related to “[Stocking Reversal Agents in Non-traditional Areas](#)” that should help inform future AED cabinet naloxone efforts (updated December 2019).

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## MEETING WITH THE JOINT COMMISSION (11/29/18)

- ***This initiative is based on Boston's approach which was determined to have met TJC standards in the way that it was presented and described at the time***
  - TJC is not prescriptive—sites should develop local policy and process to meet its standards
- Naloxone storage in AEDs
  - Key TJC standards
    - The hospital safety stores medications and keeps unauthorized persons from accessing medications
    - The hospital must safely manage emergency medications
    - Hospital leaders will decide which emergency medications will be accessible in patient areas according to the population served, and medications and supplies will be easily accessible
    - When emergency medications are used, they are replaced as soon as possible
  - Helpful feedback:
    - TJC does not tell hospitals how to meet standards—hospitals have the freedom to determine how to meet or exceed those requirements.
    - TJC has no standard that requires daily checks. Therefore, it is up to the facility to determine how to ensure that naloxone is secure and readily available when needed (as well as meet other medication standards).
    - Regarding staff who can conduct daily checks, this is a facility decision. Facility should ensure the person doing the checks is trained (e.g., on what to look for and how to respond if the naloxone is missing).
    - Regarding whether naloxone can be kept in its original packaging, TJC requirement is to store medication according to manufacturer instructions.
- **BOTTOM LINE: You should ensure your process is consistent with TJC standards regardless of whether you choose to implement VA Boston's model or not. We recommend that you work closely with your local quality management and/or accreditation staff to ensure your facility processes are consistent with TJC standards and VHA guidelines.**

We would also like to acknowledge the support of various program offices and staff that were critical to the success of the Rapid Naloxone Initiative:

- Care Management and Social Work (Susan Shelton, Jennifer Silva, Laura Taylor)
- Diffusion of Excellence (Blake Henderson, Carl McCoy, Ryan Vega; Atlas Research Contractors: Mollie Brick, Dana Schmucker, Katrina Young)
- External Accreditation Services and Programs (Gloria Williams)
- Homeless Programs Office (Michal Wilson)
- National Center for Patient Safety (Mary Burkhardt, William Gunnar, Robin Hemphill)
- Office of Mental Health and Suicide Prevention (Jennifer Burden, Eleanor Lewis, Marsden McGuire, Elizabeth Oliva, Jodie Trafton)
- Office of Nursing Services (Elizabeth Czekanski)
- Office of Security & Law Enforcement (Darryl Blackwell)
- Pharmacy Benefits Management Services (Melissa Christopher, Thomas Emmendorfer, Mariano Franchi, Michael Harvey, Chikara Hasegawa, David Hillgoth, Julianne Himstreet, Mitchell Nazario, Michael Valentino)
- Pain Management and Opioid Safety (Amy Aylor, Rachel Brophy, Jenie Perry, Friedhelm Sandbrink)
- VA Boston Health Care System (Pamela Bellino, Michael Charness, Alan Kershaw)
- Veterans Integrated Service Network 8 (VISN 8; Steve Elliott, John Richardson)
- VHA Police (Troy Brown)



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# INTRODUCTION

The United States is in the midst of a devastating opioid epidemic with opioid overdose deaths due to prescription opioids, heroin, and other synthetic opioids (e.g., fentanyl) at an all-time high.<sup>1</sup> Veterans are particularly vulnerable compared to non-Veterans, given their higher prevalence of chronic pain conditions and substance use disorders, including opioid dependence. Moreover, Veterans are **twice as likely to die from accidental overdose** when compared to the non-Veteran population.<sup>2</sup>

Opioids include naturally occurring opiate substances (e.g., morphine, opium, codeine) found in the opium poppy, derivatives of these substances (e.g., heroin), as well as synthetic or semi-synthetic compounds (e.g., oxycodone, hydrocodone, etc.). In practice, the term “opioid” is currently used to refer to both synthetic/semi-synthetic (opioids) and naturally occurring compounds (opiates). While opioids are effective at reducing pain, they depress respiration and, when taken in excess, can lead to respiratory arrest (opioid overdose), which can be deadly. Because of this danger, providers should carefully monitor patients who are taking opioids, and hospitals and communities should consider steps to prevent and reverse overdoses.

Naloxone, an opioid receptor antagonist, is a highly effective treatment for opioid overdose. If administered promptly, appropriately, and in sufficient amount, naloxone reverses opioid overdose by blocking opioid receptors in the brain to restore breathing and prevent death.<sup>5</sup>

To improve opioid safety and reduce risk for opioid use disorder among Veterans, the Department of Veterans Affairs (VA) is utilizing alternative pain treatments, prescribing opioids only when necessary, consulting state prescription drug monitoring databases to avoid duplicate opioid prescriptions, and referring patients to substance use disorder and mental health treatment when appropriate.

Despite these efforts, many of our nation’s Veterans continue to overdose on opioids, including at VA facilities. To reduce the risk of death from opioid overdose on VA premises, **VA is implementing naloxone programs and practices to rapidly reverse any onsite opioid overdoses.**

Since 1999, over **350,000 people** have died from overdoses related to opioids.<sup>3</sup>

In 2016, opioid overdoses killed **42,249 people**, which is over 5x the number of people who experienced lethal overdoses in 1999.<sup>4</sup>

Naloxone complements VA’s efforts to address opioid safety (between July 2012 to June 2018 there were 308,911 fewer patients receiving opioids-- 679,376 patients to 370,465 patients, a 45% reduction).<sup>4</sup>

For example:



The VA [Opioid Overdose Education and Naloxone Distribution \(OEND\) Program](#) aims to reduce the harm and risk of life-threatening opioid-related overdose and death among Veterans. Key components of the OEND Program include education and training on opioid overdose prevention, recognition of an opioid overdose, opioid overdose rescue response, and issuing naloxone<sup>6</sup>.



VA released an [Equipping VA Police Services With Intranasal \(IN\) Naloxone](#) toolkit (internal VHA website) to support national implementation of this practice.



VA released a Deputy Under Secretary for Health for Operations and Management (DUSHOM) memorandum, entitled “**Rapid Naloxone Availability to Prevent Opioid-Related Death**”, to encourage implementation of the VHA Diffusion of Excellence Gold Status Practice that equipped at-risk patients and first responders with naloxone<sup>7</sup>. This included equipping VA police and select Automated External Defibrillator (AED) Cabinets with naloxone (see the memorandum in Appendix A).

The VHA Diffusion of Excellence Gold Status Practice was based on VA Boston Health Care System’s (HCS) program that expanded naloxone availability on site. One facet of VA Boston HCS’ program is the **Automated External Defibrillator (AED) Cabinet Naloxone Program**, in which facility staff place naloxone in select AED cabinets. The program makes naloxone more readily available, increasing the likelihood of successful reversal in the event of an opioid overdose.

VA Boston HCS worked closely with The Joint Commission (TJC) to develop its AED Cabinet Naloxone Program. This toolkit summarizes the steps VA Boston HCS used to implement its innovative AED Cabinet Naloxone Program, which was based on the guidance received by TJC to remain in compliance with TJC standards and elements of performance that were in place at the time of implementation. The goals of this toolkit are to provide background on VA Boston HCS’ AED Cabinet Naloxone Program and instructions on how to implement it at your facility in order to diffuse this life-saving innovation across Veterans Health Administration (VHA).

# EXPANDING NASAL NALOXONE AVAILABILITY TO HIGH-RISK AREAS

## About the Program

Opioid overdoses sometimes occur in areas infrequently traveled by facility personnel, and/or areas that do not have a crash cart readily available. In those instances, overdose victims may not be able to get naloxone quickly enough to reverse the overdose. To enable the fastest response times, VA Boston HCS established the AED Cabinet Naloxone Program and utilized the easy-to-administer, FDA-approved for layperson administration nasal spray formulation of naloxone.

Nasal naloxone is a single-step nasal spray requiring minimal training to administer properly. In a study of nasal naloxone usability, **90.5%** of individuals were able to successfully use it without training.<sup>7</sup> When trained, both clinical and non-clinical personnel may be able to administer nasal naloxone if they encounter a suspected overdose victim.

The goal of the **AED Cabinet Naloxone Program** is to expand naloxone access at VA facilities across the country, so that first responders can administer naloxone as timely as possible. It involves equipping select AED cabinets with nasal naloxone based on how close they are to other sources of naloxone.

AED cabinets containing nasal naloxone should be clearly marked to indicate the presence of naloxone, and facility staff should be trained to recognize which AED cabinets contain naloxone so they can quickly respond in the event of an overdose.

Through the AED Cabinet Naloxone Program all cardiopulmonary resuscitation (CPR)-trained hospital staff should be trained in the assessment and administration of nasal naloxone and may be able to assist in naloxone administration during an overdose in their proximity. Additionally, staff who do not normally receive CPR training may be able to receive nasal naloxone training if they work near an AED Cabinet containing nasal naloxone. For insight into what the AED Cabinet Naloxone Program looks like at the facility level, refer to VA Boston HCS's local naloxone policy.

Additionally, the steps below are meant to assist you in implementing VA Boston HCS' approach.

**NOTE:** It is important to comply with TJC requirements for medication management when equipping AED cabinets with nasal naloxone. This toolkit is based on one approach that was determined to have met TJC standards in the way that it was presented and described at the time.

### VA Boston HCS Local Naloxone Policy



VA Boston HCS Local  
Naloxone Policy.docx

# Joint Commission Standards and Requirements for AED Cabinet Nasal Naloxone

Specific information on Joint Commission Standards and Elements of Performance related to AED Cabinet Naloxone that VA Boston HCS used to inform its approach can be found in the embedded *Joint Commission Guidance Sheet* as well as in Appendix A. Below is a brief overview of these requirements and how VA Boston HCS met those requirements, which are integrated into the steps described in the *Implementing the AED Cabinet Naloxone Program* section.

1. AED Cabinet Identification
  - a. All facilities that implement the AED Cabinet Naloxone Program must conduct a **Risk Assessment** to determine which specific AED cabinets should contain nasal naloxone, rather than globally equipping all AEDs with nasal naloxone.
2. AED Cabinet Physical Set Up
  - a. AED cabinets in which naloxone is stored must be properly **alarmed** and marked with a **defined symbol** that is recognizable to responders but does not make it obvious to patients and non-clinicians that the cabinet contains a medication.
  - b. Nasal naloxone within the AED cabinets must be secured with a **tamper-resistant seal** (e.g., a zip tie).
3. Staff Training
  - a. Facility staff must receive standardized training on nasal naloxone administration, signs of an opioid overdose, and locations of AEDs equipped with naloxone around the facility. **NOTE:** *Training on when to give naloxone is included in VA's Talent Management System (TMS) Basic Life Support Training (Course 3871645). More in-depth training on naloxone administration is included in VA's OEND TMS training (Course 27440; available externally at <https://www.train.org/main/course/1087390/>). Contact [Elizabeth Oliva](#) for any issues accessing the referenced TMS modules. Employee Education may be able to assist with guidance on how to develop and document training in employees' educational records.*
4. AED Cabinet Monitoring
  - a. **Daily documented checks** must be conducted to ensure nasal naloxone in AED cabinets is secured and is not expired. **NOTE:** *Local policy should reflect the process for documenting daily AED checks to include designating accountable staff. Refer to the VA Boston HCS local naloxone policy as an example.*
  - b. **Document administration** of nasal naloxone according to facility policy and ensure that any overdose events among VHA patients are documented in CPRS using the VHA national Suicide Behavior and Overdose Report (SBOR) note template. **NOTE:** *Local policy should reflect the process for documenting administration of nasal naloxone and overdose events among VHA patients using the SBOR note. The SBOR note is meant to help document these critical events and ensure providers consider the range of risk factors and treatment considerations to help VHA patients post-overdose.*

Contact [Elizabeth Oliva](#) for any questions about this note. If the overdose victim is not a VHA patient, documentation of the incident is still necessary. Facilities should establish procedures for documentation (see Step 8. Monitoring and Program Evaluation below).

- c. Develop a process for ensuring that nasal naloxone in AED cabinets are **refilled** if they are used or expired.
- d. Develop a process for reporting any evidence of **tampering or missing** nasal naloxone to the appropriate authorities (e.g., VA Police Service, Pharmacy).

**NOTE:** All VHA medical facilities that implement this practice must develop a local policy to specifically address all accountable individuals, as well as other facility-specific information or aspects that may affect implementation.

For information on how the AED Cabinet Naloxone Program that VA Boston HCS implemented complied with specific Joint Commission Standards and Elements of Performance, refer to The Joint Commission Guidance/Reference Sheet, also found in Appendix A.

### Joint Commission Guidance Sheet



Joint Commission  
Guidance Sheet

**TIP:** If your site has an existing policy that addresses expanding naloxone availability on facility grounds, such as through the OEND Program, you may add guidance for the AED Cabinet Naloxone Program to that policy.

**A Note on Reporting:** It is important to clarify reporting responsibilities in the event of an opioid overdose, given that there may be multiple reporting expectations at the facility level (e.g., VA Police System (VAPS), Joint Patient Safety Reporting (JPSR), Suicide Behavior and Overdose Report (SBOR) Note, etc.). It is recommended that the **SBOR Note** is completed after responding to VHA patients who overdose on campus, as it is an effective reporting tool to ensure all opioid overdoses among VHA patients are recognized. Be sure to clearly indicate requirements for reporting that involve AED Cabinet Naloxone administration in your facility's formal policy.

# IMPLEMENTING THE AED CABINET NALOXONE PROGRAM

## Implementation Roadmap

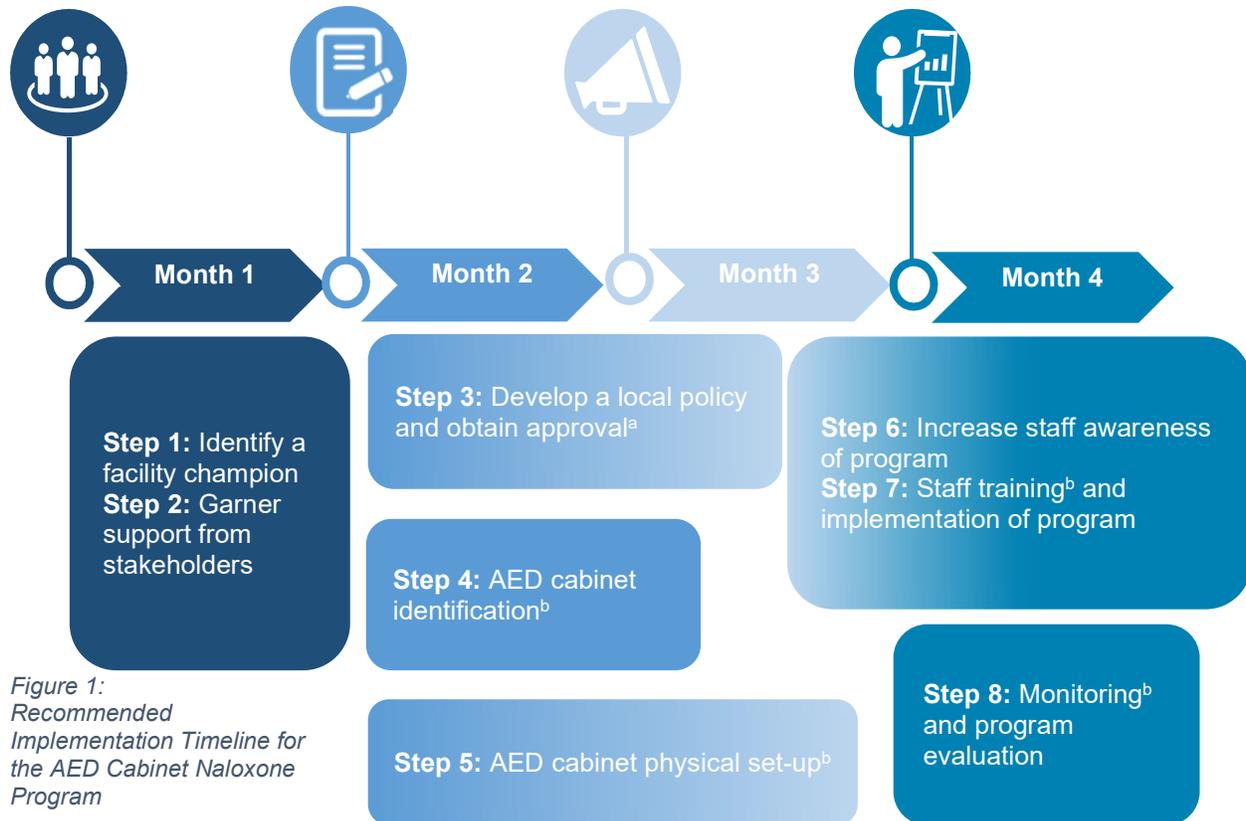


Figure 1:  
Recommended  
Implementation Timeline for  
the AED Cabinet Naloxone  
Program

<sup>a</sup>Local policy should address Joint Commission Standards and Requirements for AED Cabinet Nasal Naloxone mentioned above—specifically processes for AED Cabinet Identification, AED Cabinet Physical Set Up, AED Cabinet Monitoring, and Staff Training

<sup>b</sup>Joint Commission Standards and Requirements for AED Cabinet Naloxone

From start to finish, you can expect implementation of the AED Cabinet Naloxone Program to take approximately three to four months. This may differ slightly among facilities due to local factors, including policy concurrence and supply acquisition processes. Setting target deadlines can assist in enforcing accountability among facility stakeholders and improve the likelihood of successful and timely implementation. Figure 1 provides a roadmap for implementation.

In the following sections, we detail each implementation step.

## Step 1: Identify a Facility Champion

Your facility must first **identify a Facility Champion** who should be an advocate of the AED Cabinet Naloxone Program and vested in its success. The Champion should serve as your facility’s point of contact about the program and be responsible for overseeing implementation (e.g., coordinating across stakeholder groups to ensure all program requirements are met). Potential champions could include a local Opioid Overdose Education and Naloxone Distribution (OEND) champion, Opioid Safety Initiative point of contact, Quality Management (QM) Chief, or Patient Safety Manager. The key is identifying someone willing to advocate for the program and who has adequate time to dedicate to implementation.



The Facility Champion can use the Implementation Roadmap to guide efforts to implement the AED Cabinet Naloxone Program. Successful implementation of the program requires the Facility Champion to work closely with facility stakeholders to carry out the necessary steps, as this is an interdisciplinary initiative.

## Step 2: Garner Support from Facility Stakeholders

Successful implementation of the AED Cabinet Naloxone Program requires support and buy-in from several facility stakeholder groups (e.g., facility leadership, Pharmacy, QM, Patient Safety, Engineering, CPR Committee Chairpersons, responding medical team and other staff who may serve as potential first responders). A “kickoff meeting” and regular implementation meetings with facility stakeholders can also help get the ball rolling and expedite implementation!



In the event that leadership is unaware of your interest in implementing the AED Cabinet Naloxone Program, it is recommended that you inform them and obtain their support before proceeding further. **Leadership support is imperative to ensuring successful implementation.** It may be helpful to remind them that this practice was recommended by the DUSHOM and selected by the Under Secretary for Health (USH) as a Gold Status Practice in the Diffusion of Excellence Initiative’s Shark Tank, meaning that it is an intervention that the USH recognizes as a best practice to share and diffuse across VHA. Please reach out to [Pamela Bellino](#) or [Elizabeth Oliva](#) for support if you are experiencing barriers to garnering support from facility stakeholder groups, and they can try to assist you.

The following are examples of how stakeholders can help support implementation of the AED Cabinet Naloxone Program:

- **Pharmacy:** Pharmacy Service is a key stakeholder because it is the department that supplies the naloxone medication. As such, coordinating with Pharmacy to identify roles and responsibilities to help meet TJC requirements is critical when

developing a local policy. Important aspects to discuss with Pharmacy include processes for supplying naloxone and replacing naloxone upon use or expiration.

- **Patient Safety:** Facility Patient Safety Managers (PSM) are a key stakeholder because they can facilitate the implementation process. Since they work closely with hospital leadership the PSM can also assist with breaking down any barriers that may exist.
- **Quality Management (QM):** Obtaining support from QM staff can assist with ensuring that the procedures are compliant with The Joint Commission regulations. QM staff can also assist with development of a performance improvement plan.
- **Engineering:** Because the way in which VA Boston HCS met TJC requirements involved modifying all naloxone-containing AED cabinets to ensure naloxone was secure, the Facility Champion may need to engage with Engineering service to ensure any required modifications are made. The primary modification that VA Boston HCS made for securing naloxone was to drill two holes into the cabinet door so that a tamper-resistant seal could be applied. Refer to the AED Cabinet Setup Guide, found in Appendix A, for further guidance on how VA Boston HCS prepared its facility's AED cabinets for containing naloxone. Facilities interested in alternative approaches to the AED Cabinet physical set up should reach out to TJC to ensure their approach is in compliance with TJC standards. Notably, TJC recently released a Standards FAQ specifically related to "[Stocking Reversal Agents in Non-traditional Areas](#)" that may be helpful.
- **Responding Medical Team:** Communication and collaboration with the responding medical team are vital to ensure that administered medications are documented and understood and that transitions are seamless. Responders should document naloxone use and communicate use to clinical personnel through a locally defined protocol. Overdose events among VHA patients should be documented in CPRS using the VHA national Suicide Behavior and Overdose Report (SBOR) note template.
- **OEND Champions:** OEND has been implemented in every VA facility and many facilities have OEND champions who helped facilitate implementation (e.g., pharmacists, nurses, social workers, and physicians across primary care, pain management, mental health, and substance use disorder treatment settings). OEND champions may be able to assist with various aspects of the AED Cabinet Naloxone Program (e.g., development of policies/procedures; training staff, etc.).
- **Academic Detailing Service:** VA has supported implementation of [Academic Detailing](#) (internal VHA website; external site is [here](#))—clinical pharmacists who train staff in evidence-based practices—across VA. [OEND is one of ADS' campaigns](#) (internal VHA website; external site is [here](#)) and Academic Detailers may be available to help train staff in how to recognize and respond to opioid overdose with naloxone.

## Step 3: Develop a Local Policy and Obtain Approval

As you prepare for implementation at your facility, you should **create a local policy** to ensure that all stakeholder roles, responsibilities, and protocols are clearly defined. Fortunately, this step is as simple as adapting existing local policies, such as the policy from VA Boston HCS, to your facility. Work with your facility stakeholders to update the policy to meet the needs and conditions of your facility. Once you have a complete draft of your facility's local policy, route the policy through your site's concurrence process for signature by leadership. Refer to Appendix A for the local policy example from VA Boston HCS.



**NOTE:** The sample facility policy in the Appendix provides specific information for how VA Boston HCS executes its policy. If you have questions on logistics, refer to the sample policy for guidance. You may also direct questions about the policy to [Pamela Bellino](#).

**TIP:** If your site has an existing policy that addresses expanding naloxone availability on facility grounds, such as through the OEND Program, you may add guidance for the AED Cabinet Naloxone Program to that policy.

**A Note on Reporting:** It is important to clarify reporting responsibilities in the event of an opioid overdose, given that there may be multiple reporting expectations at the facility level (e.g., VA Police System (VAPS), Joint Patient Safety Reporting (JPSR), Suicide Behavior and Overdose Report (SBOR) Note, etc.). It is recommended that the **SBOR Note** is completed after responding to VHA patients who overdose on campus, as it is an effective reporting tool to ensure all opioid overdoses among VHA patients are recognized. Be sure to clearly indicate requirements for reporting that involve AED Cabinet Naloxone administration in your facility's formal policy.

## Step 4: AED Cabinet Identification

To ensure naloxone placement in AEDs is as efficient as possible, each facility should **conduct a Risk Assessment** to determine which AED cabinets are located in high-risk areas and should contain naloxone. In this context, “high risk” refers to an area of your facility that does not have naloxone close by, such as in an area where there is no crash cart or one that is less accessible to first responders.



The Risk Assessment can be carried out by a **task force** established by the Facility Champion and stakeholders. Potential task force members could include representatives from Pharmacy, QM/Patient Safety, your facility’s CPR committee (if applicable), or other staff members interested and willing to serve.

### Risk Assessment Guidance



Risk Assessment Guidance

Your task force may use the following criteria to categorize locations with AED cabinets as high risk:

- No crash cart present
- Near a high-risk patient population (e.g., methadone clinic, domiciliary, substance use disorder treatment programs).
- Located remotely (e.g., a less traveled area, or an area that may be difficult for first responders, such as VA Police, to reach quickly)
- Common areas (e.g., outpatient clinic waiting rooms, cafeterias)

VA Boston HCS’ task force deemed the following areas as high risk: outpatient clinics; cafeterias; warehouses; waiting rooms; domiciliary; gym and recreation areas; Fisher House; Huntington House Lodge; methadone clinic; and residential and outpatient substance abuse treatment programs, and Compensated Work Therapy (CWT) programs. These are the locations that VA Boston now has nasal naloxone in each AED Cabinet. Your facility task force should conduct risk assessments on an **annual basis** and should apply risk ratings to all new AEDs cabinets placed at your facility when applicable.

### Risk Assessment Template



Risk Assessment Template.xlsx

You may use the Risk Assessment template provided in this toolkit to conduct your facility’s Risk Assessment. It may be helpful to report the Risk Assessment results and recommendations on which AED cabinets should be equipped with nasal naloxone to your facility leadership for concurrence.

## Step 5: AED Cabinet Physical Set Up

Several pieces of equipment, many of which your facility already likely has in place, are necessary to implement the AED Cabinet Naloxone Program. For items that your facility does not already have, work with facility leadership, as well as personnel from logistics and/or supply chain to acquire what is necessary.



To implement this program in a way that is consistent with VA Boston HCS' approach (which met The Joint Commission standards in the way that it was presented and described at the time), you will need the following **equipment and resources**:

- Metal AED Cabinet with transparent glass front
- AED, with case and cabinet alarm (**Note:** alarm must be in the “on” position)
- Adult Pads/Electrodes
- Pediatric Pads/Electrodes (if currently part of current AED set up)
- Tamper-evident seal
- Laminated AED Daily Check Instruction Sign
- Laminated “N” sign indicating that the cabinet contains nasal naloxone
- Paper log for documenting daily checks of AED cabinets with nasal naloxone
- Nasal Naloxone:
  - Reference card for nasal naloxone administration
  - Two doses of nasal naloxone
  - Rubber gloves (optional, was not required by TJC when VA Boston HCS implemented its program)
  - Face shield (optional, was not required by TJC when VA Boston HCS implemented its program)
  - Quick Reference Guide with phone number to report emergency (optional, was not required by TJC when VA Boston HCS implemented its program)

The list of stakeholders below can help you obtain the equipment and resources in the list above:

- **Clinical Engineering**, to provide the AED Cabinet and AEDs
- **Engineering**, to drill holes in AED cabinets to make them secure
- **The Service responsible for supplying tamper-evident seals for code/crash carts**, to supply tamper-evident seals and nasal naloxone
- **Distribution**, to supply AED electrodes/pads
- **Logistics**, to provide and record tracking of AED identification numbers

The instructions in the embedded AED Cabinet Setup Guide describes VA Boston HCS' approach (also in Appendix A) for equipping its facility's AED cabinets with nasal naloxone. You may also use the template for the paper log to track daily AED checks that were part of their approach. Each AED Cabinet containing nasal naloxone had its own daily check log. In VA Boston HCS this log was either located on a clipboard atop the AED Cabinet or within possession of the Service Chief of the area in which the AED Cabinet was located. The local policy should include whom to report the daily check log of each AED Cabinet containing nasal naloxone.

### AED Cabinet Setup Guide



AED Cabinet Setup Guide

## Step 6: Increase Staff Awareness of Program

When implementing the AED Cabinet Naloxone Program, you should make sure that facility staff are aware of the presence of nasal naloxone in the event of a nearby opioid overdose. From clinicians to administrative staff, increased awareness of the AED Cabinet Naloxone Program is important to maximize the benefits of the program. The table below includes sample key messages you may use when communicating across your facility.

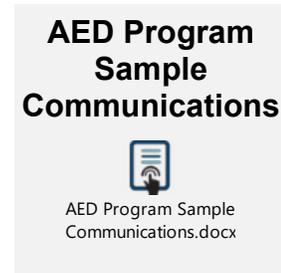


<p><b>Key Message ONE</b></p>	<p>Select AED cabinets in high-risk areas now contain nasal naloxone, making this lifesaving medication easier to access in the event of an opioid overdose.</p>
<p><b>Key Message TWO</b></p>	<p>First responders to an opioid overdose can act quickly with lifesaving nasal naloxone found in select AED cabinets.</p>
<p><b>Key Message THREE</b></p>	<p>We've established processes to make sure that our nasal naloxone-equipped AEDs meet standards set by The Joint Commission.</p>

**NOTE:** When VA Boston HCS implemented its program, guidance they received required that AED cabinets with nasal naloxone had an identifiable symbol *known only to designated responders*, who were nearby staff trained in CPR. For that reason, **they did not** disseminate flyers or other public-facing communications that would alert anyone other than VA employees of the AED Cabinet Naloxone Program, as doing so could have increased the chance of naloxone theft or diversion.

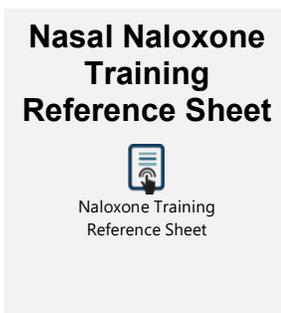
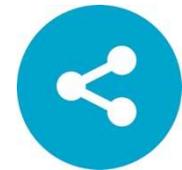
Some suggested communications channels and vehicles include:

- **Internal email blasts:** to send to all facility staff, and/or to select staff groups as appropriate (see sample text in Appendix A)
- **Blurbs in your facility’s newsletter:** to include whenever your site issues facility-wide communications via newsletter or comparable format (see sample in Appendix A)
- **Computer screen savers:** if commonly used at your facility to raise awareness of local happenings

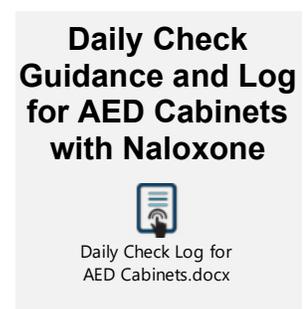


## Step 7: Staff Training and Implementation of Program

To ensure successful implementation of the AED Cabinet Naloxone Program, staff must: (1) be aware of the program (Step 6), (2) be trained to identify AEDs equipped with naloxone, and (3) be trained in naloxone administration. Staff training is critical for the last two points and part of increasing staff awareness can include training/messaging on how to identify AEDs equipped with naloxone. Given that nasal naloxone *will not be contained in all AED cabinets*, it might be helpful to develop a list and/or map of all AED cabinets at your facility that contain nasal naloxone and disseminate it to staff, so they can quickly locate nasal naloxone-containing AED cabinets in their proximity. **Remember, naloxone in an AED Cabinet does no good if no one knows it is there!**



Training on when to give naloxone is included in VA’s Talent Management System (TMS) Basic Life Support Training (Course 3871645) which is available to clinically active staff. More in-depth training on naloxone administration is included in VA’s OEND TMS training (Course 27440; see *IN Naloxone Training Reference Sheet*, in Appendix B; available externally at <https://www.train.org/main/course/1087390/>). Another option for training staff could include local training on the administration of nasal naloxone, as well as on the AED Cabinet Naloxone Program. Stakeholders listed in Step 2 may be able to help with in-person training of staff and/or this training could be incorporated into the facility’s CPR training program. For instance, a CPR Committee Chairperson and/or Instructor could help integrate nasal naloxone administration and information about the AED Cabinet Naloxone Program into local CPR courses. Fortunately, nasal naloxone comes in the form of a nasal spray, is simple to administer, and fits well with the CPR certification curriculum. Employee Education may be able to assist with guidance on how to develop and/or document training in employees’ educational records.



**TIP:** See the Nasal Naloxone Training Reference Sheet in Appendix A for training resources.

Once VA Boston HCS equipped select AED Cabinets with nasal naloxone, they designated staff to conduct daily checks to ensure nasal naloxone was not tampered with, missing, or expired. Appendix A provides additional guidance and a paper log that can be printed and stored outside your AED cabinets (see “Daily Check Guidance and Log for AED Cabinets with Naloxone”).

## Step 8: Monitoring and Program Evaluation

VA Boston HCS’ approach to meeting The Joint Commission standards involved monitoring and evaluating the effectiveness of the AED Cabinet Naloxone Program. Any process for naloxone storage is required to be compliant with VHA policy (e.g., [VHA Directive 1108.06](#) regarding ward stock). Key monitoring requirements used by VA Boston HCS included:



1. Daily AED checks for AED cabinets containing nasal naloxone
2. The number of nasal naloxone dosages deployed to facility AED cabinets, including their precise locations and expiration dates (to ensure all dosages are accounted for and replaced upon expiration)
3. Recording and tracking each opioid overdose reversal resulting from AED cabinet-acquired naloxone, including but not limited to information such as:
  - a. Name and role/department of individual who administered nasal naloxone
  - b. Date of nasal naloxone administration
  - c. Name of individual with opioid overdose
  - d. If the overdose reversal was successful
  - e. Location of overdose (i.e., where on facility grounds the overdose occurred)
  - f. Overdose victim current prescription information (if victim is enrolled in VA care and/or if information is available)

### Tracker for Naloxone in AED Cabinets



AED Naloxone Tracker

To help with monitoring and program evaluation of the AED Cabinet Naloxone Program across your facility and Veterans Integrated Service Network (VISN), your local policy could identify a designee from your facility to submit updated monitoring and program evaluation data to facility and VISN leadership each month (if such mechanisms/processes are developed). At least annually, it may be helpful to analyze data from your facility to identify potential trends with opioid overdoses at your facility. Your local policy could identify stakeholders with whom to collaborate in interpreting monitoring and program evaluation data in order to develop

recommendations to help improve and tailor the AED Cabinet Naloxone Program in response to any reported trends or indications.

Appendix A includes sample tracking spreadsheets, as well as a template, that you may use to monitor the AED Nasal Naloxone Program at your facility.

# ADDITIONAL RESOURCES

If you have questions about implementation at the facility level, refer to the facility policy from VA Boston HCS as one example of how it met TJC standards when it implemented its program. This comprehensive policy provides insights into how VA Boston HCS implemented its AED Cabinet Naloxone Program, as well as SOPs for what to do in the event of an opioid overdose. We recognize that VA leaders will need to tailor the program to suit facility environments and populations, and that there is no “one size fits all” implementation strategy.

Additionally, you may wish to visit the [National OEND Program SharePoint site](#) (internal VHA website) which has a multitude of resources developed in support of naloxone availability expansion, including training resources, communications materials, related research, and information on monthly community of practice calls. The [VA Academic Detailing Service OEND SharePoint site](#) (internal VHA website; external site is [here](#)) contains additional resources, including quick reference guides, brochures and handouts, and data collection methods and metrics.

For more information or if you have additional questions, contact [Elizabeth Oliva](#) (VA National OEND Coordinator), [Pamela Bellino](#) (Patient Safety Manager at VA Boston HCS), or [Alan Kershaw](#) (OEND Pharmacist at VA Boston HCS).

# Appendix A: ATTACHMENTS

Sample Docs		Source File
<b>VA Boston HCS Local Naloxone Policy</b>	Local policy developed at VA Boston HCS outlining guidelines and requirements for equipping AED cabinets with nasal naloxone	 VA Boston HCS Local Naloxone Policy.docx
<b>DUSHOM Memorandum on Rapid Naloxone Availability to Prevent Opioid-Related Death</b>	Memorandum signed by the Deputy Under Secretary for Health for Operations and Management (DUSHOM) on Rapid Naloxone Availability, published on September 5, 2018	 DUSHOM Memo on Rapid Naloxone
<b>AED Program Sample Communications</b>	Document containing sample communications to promote awareness of the AED Cabinet Naloxone Program	 AED Program Sample Communications.docx
References		Source File
<b>Joint Commission Guidance Reference Sheet</b>	Guidance used by VA Boston HCS to meet The Joint Commission standards when it equipped select AED cabinets with nasal naloxone	 Joint Commission Guidance Sheet
<b>Risk Assessment Guidance</b>	Detailed steps to conduct a Risk Assessment at your facility to determine which AED cabinets should contain nasal naloxone	 Risk Assessment Guidance
<b>Nasal Naloxone Training Reference Sheet</b>	Document containing quick training information pertaining to administration of nasal naloxone in the event of an opioid overdose	 Naloxone Training Reference Sheet
<b>AED Cabinet Setup Guide</b>	Detailed instructions used by VA Boston HCS to outfit AED cabinets with nasal naloxone	 AED Cabinet Setup Guide
Templates		Source File
<b>Risk Assessment Template</b>	Template to assist in completing an AED Cabinet Risk Assessment	 Risk Assessment Template.xlsx
<b>Daily Check Guidance and Log for AED Cabinets with Naloxone</b>	Guidance and fillable form for daily checks of AED cabinets containing nasal naloxone	 Daily Check Log for AED Cabinets.docx
<b>Tracker for Naloxone in AED Cabinets</b>	Excel spreadsheet template to track use of nasal naloxone sourced from AED cabinets	 AED Naloxone Tracker

# Appendix B: SOURCES

1. <https://www.cdc.gov/drugoverdose/data/index.html>
2. Bohnert AS, Ilgen MA, Galea S, McCarthy JF, Blow FC. Accidental poisoning mortality among patients in the Department of Veterans Affairs Health System. *Med Care* 2011;49: 393–396.
3. Hedegaard H, Warner M, Miniño AM. (2017). Drug overdose deaths in the United States, 1999–2016. NCHS Data Brief, no 294. Hyattsville, MD: National Center for Health Statistics. <https://www.cdc.gov/nchs/data/databriefs/db294.pdf>
4. VA Opioid Safety Initiative Dashboard (internal VA dashboard) accessed July 2018.
5. Krieter, P. Pharmacokinetic Properties and Human Use Characteristics of an FDA-Approved Intranasal Naloxone Product for the Treatment of Opioid Overdose. *Journal of Clinical Psychology* 2016;00(0): 1-11.
6. Oliva EM, Christopher MLD, Wells D, Bounthavong M, Harvey M, Himstreet J, Emmendorfer T, Valentino M, Franchi M, Goodman F, Trafton J, & VHA OEND National Support & Development Workgroup. (2017). Opioid overdose education and naloxone distribution: Development of the Veterans Health Administration’s National Program. *Journal of the American Pharmacists Association*, 57, S168-179.
7. DUSHOM Memorandum on Rapid Naloxone Availability to Prevent Opioid-Related Death, signed and published by the DUSHOM.

## Special Thanks To:

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Michael E. Charness, MD, Chief of Staff at VA Boston HCS, who conceived the idea to equip AED cabinets with nasal naloxone as an intervention to address the occurrence of opioid overdoses at his facility.

Pamela Bellino, OTR/L, Patient Safety Manager at VA Boston HCS, who implemented the idea to equip AED cabinets with nasal naloxone as an intervention to address the occurrence of opioid overdoses at her facility. She entered this practice into the Under Secretary for Health (USH) Shark Tank Competition, and was selected as one of 13 Cohort 2 Gold Status Practices.

Elizabeth Oliva, PhD, National Opioid Overdose Education and Naloxone Distribution (OEND) Coordinator, who provided subject matter expertise on expanding access to naloxone and training non-clinical staff to use naloxone properly. Her willingness to collaborate across initiatives has been integral to the success of the program.

Jennifer Burden, PhD, Deputy Director, Mental Health Residential Rehabilitation Treatment Program (MH RRTP), who provided strong support for this initiative from a subject matter and policy standpoint. Dr. Burden's work to spearhead the increase of naloxone availability at VA facilities has been invaluable in further spreading this practice.

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Gloria Williams, BSN, MHSA, Director of External Accreditation Services and Programs, Office of Quality, Safety, and Value (10E2B3) for working directly with The Joint Commission to ensure that VA Boston's AED Cabinet nasal naloxone practice met The Joint Commission standards and provided guidance to VHA for implementation of the Gold status practice.

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