

Problem & PURPOSE

- Naloxone (Narcan) is the reversal agent for opioid overdose.
- Co-prescription law in 18 states
- Patients and families at risk in the home for opioid overdose
- A large urban emergency department in the Metro area in need of standardized co-prescription policies.
- PURPOSE:** to implement naloxone co-prescribing at ED discharge to increase access for high-risk adult patients and their families receiving opioid prescriptions, while enhancing staff knowledge and confidence in naloxone co-prescribing practices over a 30-day period.

Available Knowledge & Rationale

Available Knowledge:

- ED opioid prescribing may occur with limited patient risk information.
- 1 in 3 patients do not finish opioid prescriptions, increasing diversion and misuse risk.
- CDC guidelines and opioid risk tools support safer prescribing; Naloxone co-prescribing is required in 18 U.S. states; Naloxone co-prescribing increases overdose protection for high-risk patients and families.
- Patient education improves overdose recognition and naloxone use.

Rationale:

- Guided by the Iowa Model of Evidence-Based Practice.
- Needs assessment identified a gap in ED naloxone co-prescribing; Evidence supports naloxone co-prescribing as a feasible, effective intervention.

Methods

Context

- IRB approved QI project conducted in a large urban Midwestern ED; Part of a multi-hospital health system providing 24/7 emergency care; ED capacity: 23 beds and 3 flex-track recliners.
- Daily patient volume: 40–140 patients.
- Participants included ED physicians, APPs, nurses, technicians, and paramedics.

Intervention

- Adults (≥19 years) prescribed opioids at ED discharge were screened using the Opioid Risk Tool; Patients scoring ≥4 were considered for Naloxone co-prescribing.
- ED staff completed pre-/post-surveys on naloxone knowledge and confidence; Staff received 3 weeks of education (presentations, emails, infographic).
- Patients received naloxone education using the teach-back method.

Study of Intervention

- Pretest–posttest design to evaluate staff knowledge and confidence; Anonymous surveys completed before and after the 3-week education.
- Reviewed completed Opioid Risk Tool forms and de-identified chart data after the 30-day pilot; Evaluated naloxone co-prescribing rates for high-risk patients.

Measure

- Pre/post surveys assessed staff knowledge and confidence about naloxone education, administration, and co-prescribing.
- Survey included: 4 true/false items (knowledge), 4-point Likert scale (confidence), and 1 open-ended question (education needs); Survey was self-developed (adapted from CDC resources).
- Quality metrics included: Number of completed Opioid Risk Tool forms, Naloxone prescriptions, and Changes in staff knowledge and confidence post-intervention
- Data sources included EHR review and paper tool documentation to track naloxone co-prescribing rates.

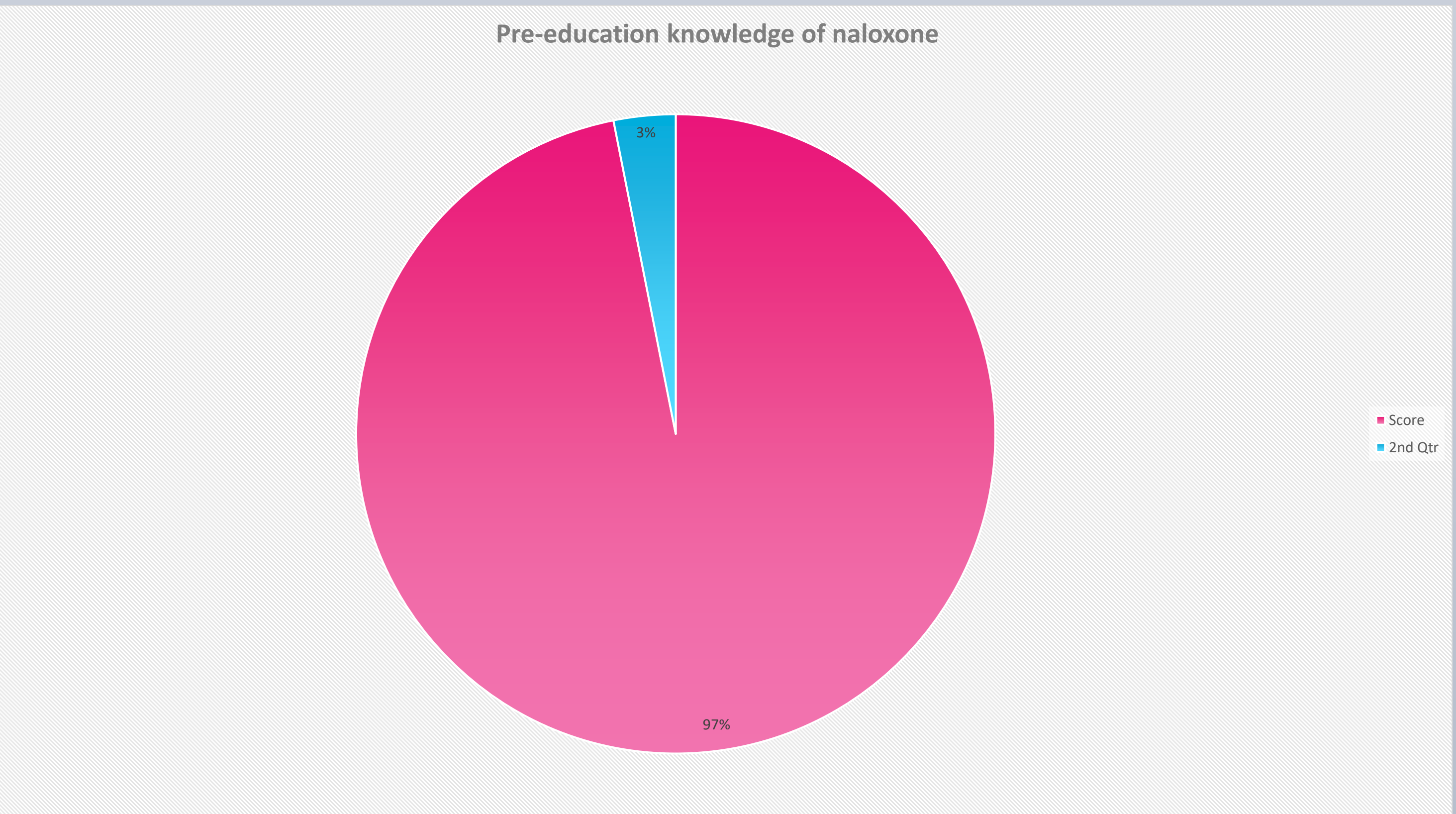
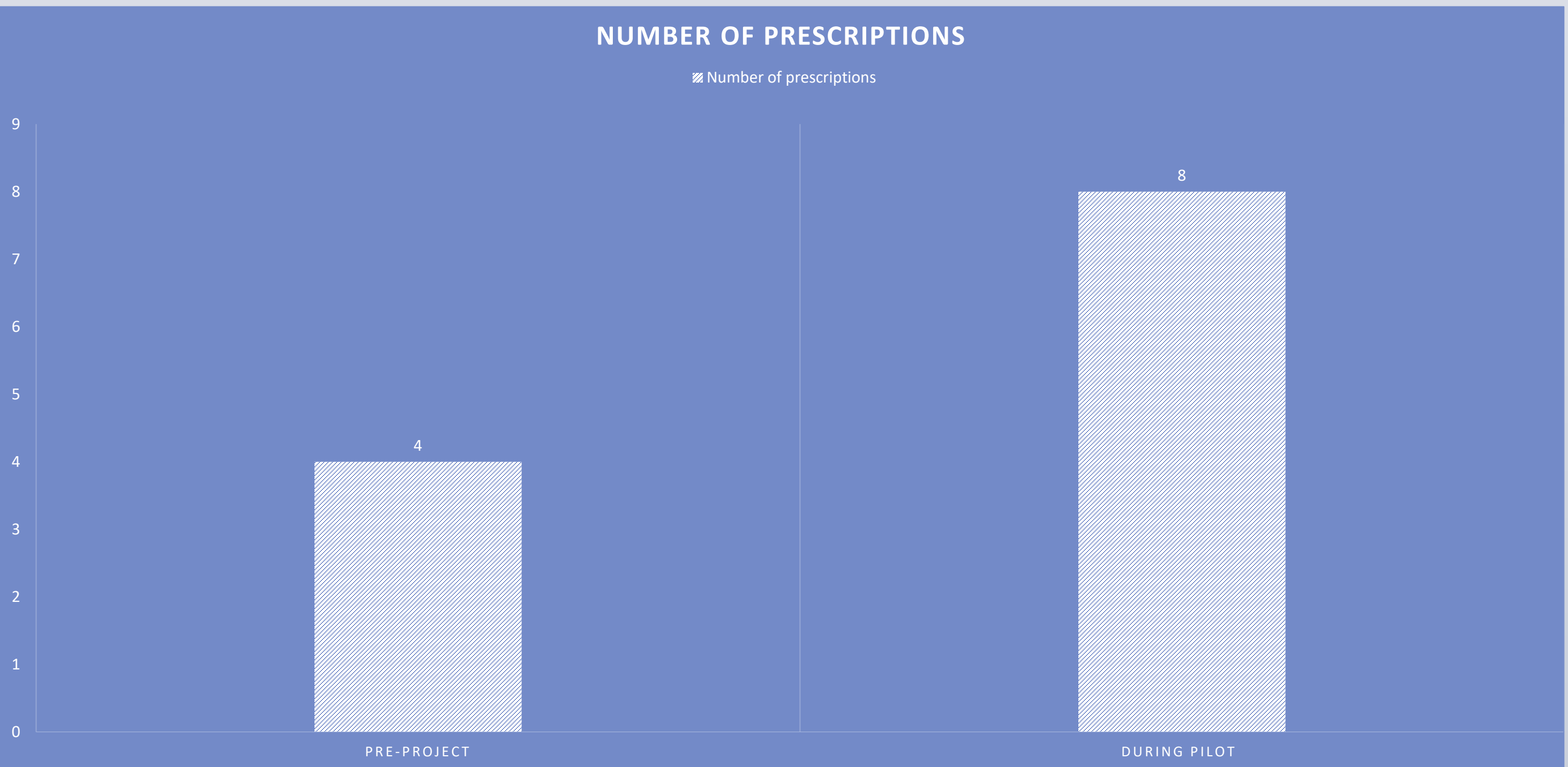
Data Analysis

- Mixed-methods evaluation.
- Paired pre-/post-survey analysis was intended to measure changes in staff knowledge and confidence.
- Descriptive statistics were planned to evaluate Opioid Risk Tool use and naloxone co-prescribing.
- Statistical analysis was not performed due to low survey participation and limited data.



Results

- Naloxone co-prescriptions increased by 50% during the pilot.
- Staff average score for knowledge of naloxone was 93%.



Discussion

- Staff demonstrated high baseline knowledge of naloxone education.
- Naloxone co-prescribing increased during the 30-day pilot, improving community access.
- Low participation and limited use of the Opioid Risk Tool limited evaluation; Workflow barriers and time constraints reduced provider compliance.
- Project was low-cost and used existing departmental resources.
- Future efforts should focus on EHR integration, longer implementation, and greater staff engagement.

Conclusions

- Naloxone co-prescribing is a feasible ED intervention to improve patient safety.
- Naloxone co-prescribing increased during the pilot.
- Low participation, limited statistical analysis, and evaluation.
- Integrating risk tools into the EHR may improve provider adoption and sustainability.
- Ongoing staff education and workflow improvements are needed.
- Future work should evaluate patient outcomes and expand implementation to other care settings.

Acknowledgements

