CareCertify LLC

245G Compliance Training

OAT-01

Opioid Antagonist Administration

Participant Guide

Annual HIV Training · Audience: All SUD Treatment Staff

Updated July 2026 — Minn. Stat. 245A.242, subd. 2 (Emergency Overdose Treatment)

Know the Mode. Keep It Close. Never Hesitate.

People with substance use disorder are disproportionately affected by HIV. Minnesota law requires every licensed SUD program to train all treatment staff on the HIV minimum standards every year, and to orient new staff and new clients within 72 hours. This guide follows the course and gives you the facts, the prevention tools, and the referral duties you need — plus a page for your own program's HIV policies and referral list.

Learning Objectives — by the end of this module you will be able to:

- Explain what Minn. Stat. 245A.242 requires of your program and of you
- Recognize the signs of an opioid overdose and rule out look-alikes
- Administer naloxone in the specific mode your program stocks
- Carry out the full response sequence — call, give, breathe, monitor, repeat
- Apply Minnesota's overdose Good Samaritan and immunity protections
- Document the event and restock, per your program's procedures

Section 1: What Minn. Stat. 245A.242 requires

Emergency overdose treatment is a licensing requirement, not an option.

- **Keep a supply.** The license holder must maintain a supply of opiate antagonists on site, available for emergency treatment of opioid overdose.
- **Standing order.** A written standing order protocol from a licensed physician, APRN, or physician assistant permits the program to keep that supply.
- **Train before contact.** Staff must be trained in the specific mode of administration the program uses BEFORE having direct contact with a person served.
- **Not locked away.** Emergency opiate antagonists need not be stored in a locked area — staff and adult clients may carry and store them unlocked.

Section 2: Who must be trained, and when

The trigger is direct contact — not your job title.

- **Every direct-contact role.** Anyone with direct contact as defined in Minn. Stat. 245C.02, subd. 11 — counselors, technicians, nurses, drivers, support staff.
- **Before the first shift.** Training must be completed before direct contact begins, not within 30 days and not at the next in-service.
- **Any knowledgeable trainer.** The trainer need not be a registered nurse or part of an accredited institution — any knowledgeable trainer may provide it.

Section 3: What naloxone is and does

One job, done fast: it knocks opioids off the receptors.

- **Opioids only.** Naloxone reverses opioid overdose by displacing opioids from receptors. It does nothing for alcohol, benzodiazepines, or stimulants alone.
- **Harmless otherwise.** It is non-addictive and has no effect on someone who has no opioids in their system — so when in doubt, give it.
- **Wears off.** Naloxone lasts 30 to 90 minutes — often shorter than the opioid. The person can slip back into overdose, so never leave them.

Fentanyl and its analogs are potent and long-acting — more than one dose is frequently needed.

Section 4: Signs of an opioid overdose

Breathing is the signal that matters most.

- **Breathing stops or slows.** No breathing, or slow, shallow, gurgling, or snoring-like breathing that you cannot wake them from.
- **Unresponsive.** Will not wake to a loud voice, a shoulder shake, or a firm sternal rub.
- **Pinpoint pupils.** Very small pupils, along with limp body and blue or gray lips, fingertips, or skin.
- **When unsure, treat it.** A person who is merely asleep will wake to a sternal rub. If they don't, act as if it is an overdose.

Section 5: Giving intranasal naloxone

The nasal spray device — one dose per device, no priming.

- **1. Position.** Lay the person on their back. Tilt the head back and support the neck with your hand.
- **2. Insert.** Peel the package open. Hold the device with your thumb on the plunger and two fingers on the nozzle. Insert the nozzle into one nostril until your fingers touch the nose.
- **3. Press.** Press the plunger firmly all the way in to release the full dose. Do not test or prime the device first — there is only one dose.
- **4. Repeat as needed.** If there is no response in 2 to 3 minutes, give another dose with a NEW device in the other nostril.

Section 6: Giving intramuscular naloxone

The vial-and-syringe or auto-injector route.

- **1. Draw it up.** Remove the cap from the vial, insert the needle, and draw up the full dose your standing order specifies — commonly 0.4 mg or 1 mL.
- **2. Choose the site.** The outer thigh or the upper outer arm muscle. Injecting straight through clothing is acceptable in an emergency.
- **3. Inject.** Insert the needle straight in at a 90-degree angle and push the plunger down completely.
- **4. Auto-injector.** If your program stocks an auto-injector, follow its voice prompts: pull off the cover, place firmly on the outer thigh, and press.

Section 7: The full overdose response

Six actions, in this order, every time.

- **1. Check & shout.** Try to wake the person — loud voice, shoulder shake, sternal rub.
- **2. Call 911.** Call 911 or have someone else call. Naloxone is not a substitute for emergency medical care.
- **3. Give naloxone.** Administer in the mode your program stocks, following your standing order.
- **4. Support breathing.** Give rescue breaths if trained and if your program's policy allows; keep the airway open.
- **5. Repeat if needed.** No response in 2 to 3 minutes? Give another dose. Multiple doses are common with fentanyl.
- **6. Stay & monitor.** Stay until EMS arrives. Place the person on their side if you must step away.

Section 8: The law protects you for acting

Minnesota removes the legal reasons to hesitate.

- **Immunity to give.** Minnesota's opiate antagonist statute shields people who administer naloxone in good faith during a suspected overdose.
- **Good Samaritan.** Minnesota's overdose Good Samaritan law protects those who seek medical help in good faith for someone experiencing an overdose.
- **The real risk.** The far greater risk is doing nothing. Naloxone cannot harm someone who has not taken opioids.

This is training, not legal advice — your program's counsel and policies govern specific situations.

Section 9: How your program stays compliant

The system behind the box on the wall.

1. Maintain an on-site supply of opiate antagonists
2. Hold a current written standing order protocol
3. Train every direct-contact staff person before contact
4. Train in the SPECIFIC mode the program stocks
5. Keep training transcripts in each personnel file
6. Check expiration dates and restock after every use

Nonresidential SUD programs that administer nothing beyond opiate antagonists describe their procedures in the health care services description under 245G.08, subd. 1.

Section 10: Your program's mode, supply, and protocol

This training is not complete until your program's own information is inserted here.

REQUIRED — complete before this training is delivered
Minn. Stat. 245A.242, subd. 2 ties your training to the SPECIFIC mode of administration used at your program. Generic naloxone content does not satisfy it. Until the fields below are filled in and a hands-on return demonstration is completed, this training does not meet the statute.

Program / license holder	*Name of the licensed program delivering this training*
Mode and product we stock	*Intranasal spray / IM vial and syringe / auto-injector; exact product and dose*
Every storage location	*All places naloxone is kept, and which staff carry it (locked storage is NOT required)*
Our standing order protocol	*Prescriber name, credential (MD/APRN/PA), and date of the written standing order*
Trainer and return demonstration	*Who provides hands-on training; date completed; where the transcript is filed*

Section 11: Hands-on practice and return demonstration

Watching a video is not the same as knowing where the plunger is.

- **Practice the device.** Handle a trainer device in the exact mode your program stocks, until the steps are automatic under stress.
- **Demonstrate it back.** Show your trainer the full sequence — check, call, give, breathe, repeat, monitor — on a manikin or trainer device.
- **Document it.** Your trainer records the topic, your name, the trainer's name and credentials, the competency method, date, and length in hours and minutes.

Apply It — Scenarios

Scenario 1: No response after one dose
You find a client unresponsive in the day room, breathing slowly with blue lips. You call 911 and give one dose of intranasal naloxone. Three minutes later there is no change and you are second-guessing yourself.
The right response: → Give a second dose with a new device in the other nostril — multiple doses are common with fentanyl. → Keep the airway open and support breathing per your program's policy while you wait for EMS. → Do not stop or leave because the first dose 'didn't work' — naloxone takes 2 to 3 minutes and often more than one dose. → Stay with the person until EMS takes over, then document the event and restock the supply.

Scenario 2: Awake, angry, and refusing
Naloxone works. The client wakes up agitated, in sudden withdrawal, and insists he is fine and does not want an ambulance. EMS is four minutes out.
The right response: → Expect this — precipitated withdrawal is a normal reaction to reversal, not a sign you did something wrong. → Stay calm and stay with him; naloxone wears off in 30 to 90 minutes and the overdose can return. → Explain plainly why EMS still needs to assess him, and follow your program's policy on refusal of care. → Document what you gave, when, how he responded, and what he was told — then restock.

Key Terms

Term	What it means
Opiate antagonist	A medication that reverses opioid overdose; defined in Minn. Stat. 604A.04, subd. 1.
Naloxone	The opiate antagonist used in most programs; brand names include Narcan and Kloxxado.
Standing order	A written protocol from a physician, APRN, or PA that lets the program keep a supply on site.
Direct contact	Face-to-face contact with a person served, as defined in Minn. Stat. 245C.02, subd. 11.
Intranasal	Given as a spray into one nostril; one dose per device, no priming.
Intramuscular	Injected into the outer thigh or upper outer arm muscle at a 90-degree angle.
Return demonstration	You perform the steps back to the trainer to show competency — not just watch.
Good Samaritan law	Minnesota protection for people who seek help in good faith during an overdose.

Check Your Understanding

1. Which Minnesota statute requires emergency overdose treatment and naloxone training in licensed SUD programs?

A. Minn. Stat. 245A.242
B. Minn. Stat. 245A.19
C. Minn. Stat. 626.557
D. Minn. Stat. 148F.165

Answer: A — Section 245A.242 governs emergency overdose treatment in these licensed programs.

2. When must a direct-contact staff person complete opioid antagonist training?

A. Before having direct contact with a person served by the program

B. Within 30 days of hire

C. Within 72 hours of hire

D. At the first annual in-service after hire

Answer: A — Training must be completed before direct contact begins.

3. Naloxone reverses an overdose from which class of substances?

A. Alcohol

B. Benzodiazepines

C. Stimulants such as methamphetamine

D. Opioids only

Answer: D — Naloxone displaces opioids from receptors; it does not reverse other classes.

4. Before giving intranasal naloxone, should you prime or test the device?

A. Yes, prime it twice

B. No — there is only one dose per device and priming wastes it

C. Yes, test-spray it into the air first

D. Only if the package looks damaged

Answer: B — Nasal naloxone devices contain a single dose and must not be primed.

5. What is the correct order of the overdose response?

A. Give naloxone, wait 15 minutes, then call 911

B. Call the program director first, then 911

C. Check and shout, call 911, give naloxone, support breathing, repeat if needed, stay and monitor

D. Move the person to a private room, then give naloxone

Answer: C — Emergency medical care is called early; naloxone does not replace it.

6. The agency insert for this course is blank at your program. What does that mean?

A. It is fine; the general content is enough

B. It applies only to nurses

C. The training is not complete — your program's mode, storage locations, and standing order must be inserted

D. The trainer should skip that slide

Answer: C — 245A.242 ties training to the specific mode the program stocks.

7. You were trained on IM vials at a prior employer; your new program stocks only nasal spray. Are you covered?

A. No — training must be in the specific mode used at your current program

B. Yes, naloxone training transfers between employers

C. Yes, if the prior training was within 12 months

D. Yes, if your prior employer was also 245G-licensed

Answer: A — The statute requires training in the specific mode of administration used at the program.

What You Learned

- Minn. Stat. 245A.242 requires an on-site supply, a standing order, and staff training
- Training happens in your program's SPECIFIC mode, BEFORE any direct contact
- Any knowledgeable trainer may provide it — no RN or accredited institution required
- Slow or stopped breathing plus unresponsiveness is an overdose until proven otherwise
- Call 911, give naloxone, support breathing, repeat in 2 to 3 minutes if needed
- Naloxone wears off in 30 to 90 minutes — never leave the person alone
- Minnesota law protects good-faith administration and calls for help

Confirm your program's mode, storage locations, and standing order on the agency insert — and complete a hands-on return demonstration with your trainer.

Legal & Source Basis

Minn. Stat. 245A.19 (HIV minimum standards in SUD treatment programs); Minn. Stat. 245A.19(d) (commissioner outlines required annual training content); DHS Behavioral Health e-Memo #22-96 (08/16/2023, effective Jan. 1, 2024); DHS/HMA “HIV Training & Resources for Substance Use Disorder Programs.” In-depth policy reference: DHS-8419A-ENG “What You Should Know About Substance Use Disorder and HIV.” This course does NOT satisfy Minn. Stat. 245A.242 (opioid antagonist training) — see CareCertify OAT-01.