OBA NURSING ACADEMY · OPIOID SAFETY AND NALOXONE · OBA-OSN-2026

Course Syllabus

Opioid Safety and Naloxone · OBA-OSN-2026 · 7.5 CPD hours · fully self-directed online

DOCUMENT CONTROL

- Programme: Opioid Safety and Naloxone (OBA-OSN-2026)
- Audience: Student and Facilitator
- Version 1.0 | Issued 19/09/2026 | Review due 19/09/2027
- Provider: OBA Nursing Academy

SCOPE OF PRACTICE AND CURRENCY

- This programme is professional development. It is not a prescribing reference, it is not clinical advice about any individual patient, and it does not authorise any learner to administer any medicine. It contains no opioid dose, strength or frequency, NO EQUIANALGESIC OR CONVERSION TABLE, and no naloxone dose or regimen - for those, use the medication chart, the Australian Medicines Handbook or equivalent, the product information, your service's locally approved protocol, and your pharmacist. Naloxone administration in a health service is governed by that locally approved protocol. Where your service's policy or your jurisdiction's legislation differs from anything in this course, those apply.
- Sources and their versions, retrieved 19/09/2026. Monitoring, OIVI and the sedation score: ANZCA and Faculty of Pain Medicine PS41(G) Acute pain management, 2023, Appendix 1: Analgesic Stewardship. CURRENCY NOTE: the previous stand-alone ANZCA statement on identifying and preventing OIVI has been INCORPORATED INTO PS41(G) - some services still circulate the stand-alone version, and the current document is the appendix. Stewardship: ACSQHC Opioid Analgesic Stewardship in Acute Pain Clinical Care Standard, 2022, nine quality statements. Naloxone in the community: Australian Government Take Home Naloxone program, national from 1 July 2022, free and without prescription; naloxone scheduled as a Pharmacist Only medicine for the treatment of opioid overdose since 2016. Regulatory context: TGA prescription opioid reforms. Medication safety: NSQHS Standards second edition.

NOT stated in this course, because they belong to a prescriber, a pharmacist, a product instruction or your workplace: any opioid dose, strength, frequency or duration; any equianalgesic or conversion value; any naloxone dose, interval or maximum; any tapering regimen; any statement about which opioid to use; and your state or territory's Schedule 8 handling requirements.

1. Programme overview

Opioid Safety and Naloxone is a fully self-directed, entirely online professional development programme delivered through the OBA Nursing Academy learning management system. There are no scheduled classes, no live sessions and no clinical placement. Learners complete eleven modules at their own pace, followed by a case study assessment and a single summative assessment.

THE LINE THIS PROGRAMME HOLDS

• IN ANY PATIENT GIVEN AN OPIOID, OVERSEDATION SHOULD BE CONSIDERED TO INDICATE OIVI UNTIL PROVEN OTHERWISE - REGARDLESS OF RESPIRATORY RATE OR OXYGEN SATURATION.

• That sentence is the whole programme. Opioid-induced ventilatory impairment has three components - central respiratory depression, sedation, and upper airway obstruction - and only one of them can be assessed at the bedside by anybody, with no equipment, in about ten seconds.

• Respiratory rate is a very unreliable measure: some patients maintain a rate within acceptable limits even with severe OIVI. Oxygen saturation may remain acceptable while arterial carbon dioxide rises, and supplemental oxygen makes it weaker still. Sedation correlates better than either.

• AND THE ONE SET OF NUMBERS THIS COURSE DOES CARRY IS THE SEDATION SCORE, carried exactly as published - 0, 1, 2, 3, aim always less than 2 - because using a different scale is itself the hazard. It carries no opioid dose, no conversion value and no naloxone regimen.

TWO COURSES THIS ONE IS OFTEN CONFUSED WITH

TWO THINGS TO SETTLE FIRST, BECAUSE BOTH SEND PEOPLE TO THE WRONG PLACE.

THIS IS NOT THE HIGH-RISK MEDICINES COURSE. OBA's High-Risk Medicines: the APINCHS Classification (OBA-HRM-2026) covers seven classes of medicine that carry disproportionate risk, opioids among them as the N. This course takes one class, one failure mode - opioid-induced ventilatory impairment - and one assessment, and it is written for the person holding the observation chart rather than the person writing the order.

AND THIS IS NOT A PRESCRIBING OR CONVERSION REFERENCE. It contains no opioid dose, no strength, no frequency, and above all NO EQUIANALGESIC OR CONVERSION TABLE. Converting between opioids is a prescribing act with a documented history of fatal error, and a course that printed a table would be inviting somebody to use it at three in the morning. Doses come from the chart, the Australian Medicines Handbook or equivalent, your service's protocol, and the pharmacist you can ring.

Who it is for

- Registered and enrolled nurses on any ward where opioids are administered - which is almost every ward, and the cohort this was written for
- Post-anaesthetic care, surgical and orthopaedic nurses, where opioid-naive patients meet their first strong opioid and where most reported OIVI harm has occurred
- Aged care nurses, where opioid use is common, comorbidity is universal, and the patient who snores through the night is the one nobody assesses
- Emergency and community nurses, who meet opioid toxicity outside the hospital's monitoring systems and who give the discharge conversation about take-home naloxone
- Palliative care nurses, for whom the whole subject has to be held differently - and who need the distinction between a dying patient's sedation and an unintended one
- Mental health, alcohol and other drug, and correctional nurses, who work with the population most at risk after a break in tolerance
- Nurse unit managers and educators responsible for monitoring protocols, escalation pathways and whether sedation scores are actually being recorded
- Internationally qualified nurses, for whom the Australian sedation scale, the Take Home Naloxone program and the stewardship standard are usually entirely new

How it is delivered

- Fully self-directed. No scheduled classes, no live sessions, no clinical placement.
- Eleven modules, each with a narrated video, a student learner guide, a reflective workbook activity and a knowledge check.
- A case study assessment of five unfolding situations, and a 60-item summative assessment.
- Five optional interactive practice tools, excluded from the claimable CPD figure.
- Three fillable workplace instruments: a sedation monitoring audit, an OIVI response walk-through, and a take-home naloxone conversation guide.
- No opioid dose, strength or frequency; no conversion table; and no naloxone regimen anywhere in the programme.

How this programme treats the people taking it

SOME OF THE PEOPLE TAKING THIS COURSE HAVE BEEN INVOLVED IN AN OPIOID EVENT. Some found a patient oversedated and escalated in time. Some did not, and have carried it since.

That shapes how the programme is written. ANZCA's own position is that many patients who come to harm from OIVI have no identifiable comorbidities that would have predicted it, and that 'inadequate nursing assessments or responses' is listed as a MODIFIABLE risk factor rather than as a failing of character. Both of those are findings, not reassurances - and they are here because a course that reads as blame produces nurses who do not escalate early.

So the programme carries no named case, no reconstructed death, and nothing written for effect. Where a scenario involves harm, it is described in order to find the condition behind it.

Every module carries the support lines. You may stop at any point and come back; nothing is timed and there is no penalty.

SUPPORT - FOR YOU, NOT FOR A PATIENT

- Nurse & Midwife Support - 1800 667 877. 24 hours, seven days. Free and confidential, for nurses, midwives and students - including after an event involving a patient, which is one of the commonest reasons people ring.
- National Alcohol and Other Drug Hotline - 1800 250 015. 24 hours, seven days. Free and confidential information and support about anybody's alcohol or other drug use, including your own.
- Lifeline - 13 11 14. 24 hours, seven days. National crisis support.
- You may stop this programme at any point and come back. Nothing is timed and there is no penalty.

Programme outcomes

On completion, learners will be able to:

1. State the governing principle: oversedation in a patient given an opioid indicates OIVI until proven otherwise, regardless of respiratory rate or oxygen saturation
2. Name the three components of OIVI and explain why the term is ventilatory impairment rather than respiratory depression

3. Use the sedation score 0 to 3 correctly, state that a score of 2 indicates early OIVI, and explain why the aim is always less than 2
4. Explain why a sedation scale containing an S for normally asleep should not be used, and why AVPU cannot do this job
5. State when a sedation score is taken, including at the expected peak effect, and why it is monitored AND documented
6. Explain why respiratory rate and oxygen saturation mislead, and what the commonly taught thresholds are worth
7. State why all patients given an opioid must be assumed to be at risk, and what the patient risk factor list is and is not for
8. Identify the named modifiable risk factors, including inadequate nursing assessments or responses and chasing pain scores
9. State what happens at a sedation score of 2 - withhold, rouse, escalate, and a smaller dose if more analgesia is needed, regardless of pain score
10. Describe what naloxone does and does not do, that it lasts about 30 to 90 minutes, and that it is given according to the product instructions and a locally approved protocol
11. Explain why re-sedation is the expected risk after naloxone, and what precipitated withdrawal is in an opioid-tolerant person
12. State that take home naloxone is free and available without a prescription, describe the signs of overdose, and conduct the discharge conversation the standard requires
13. Locate the programme inside quality statement 6 of the Clinical Care Standard, and identify the local questions this course deliberately leaves unanswered

2. Module structure

Module	Title	CPD hours	Knowledge check items
00	Orientation: Why Sedation Is the Sign	0.50	6
01	OIVI: What Opioids Do to Breathing	0.50	5
02	The Sedation Score, and the Scale Not to Use	0.50	7
03	Why Respiratory Rate and Saturation Mislead	0.50	6
04	Who Is at Risk - and Why Everybody Is	0.50	5
05	The Modifiable Risks That Are Nursing Practice	0.50	6
06	When Sedation Reaches 2	0.50	7
07	Naloxone: What It Does and Does Not Do	0.50	6
08	After Naloxone: Re-sedation and Withdrawal	0.50	5
09	Take Home Naloxone and the Discharge Conversation	0.50	5
10	Opioid Stewardship: the Standard Around All of It	0.50	4
	Module subtotal	5.50	62
	Programme information documents	1.55	-
	Case study assessment (5 unfolding cases)	0.53	-
	Summative assessment	0.97	60
	CLAIMABLE CPD TOTAL	7.5	

Module hours are the measured time for that module's video, learner guide, knowledge check and workbook activity. The table below shows how every figure was measured.

Indicative workload, and how the CPD hours were arrived at

The CPD figure for this programme is not asserted. It is measured from the content: narration at 135 words per minute, reading at 130 words per minute for dense professional prose, knowledge checks timed to include reading every rationale, and the assessments timed as measured

reading plus a stated decision allowance. Individual learners vary, and a learner who claims a different figure should claim their actual time.

Component	Measured time	How it was measured
Module videos (11)	63 min	Narration word count at 135 wpm
Student learner guides (11)	82 min	Guide word count at 130 wpm
Module knowledge checks (11)	46 min	Stem, options and every rationale, read and answered
Reflective workbook activities (11)	88 min	Writing time for the five prompts in each module
Programme information documents	93 min	Rendered page word counts at 130 wpm
Case study assessment	32 min	19 minutes measured reading plus 30 seconds per decision across 25 steps
Summative assessment	58 min	28 minutes measured reading plus 30 seconds per item across 60 items
MEASURED TOTAL	462 min (7.70 h)	Sum of the above
CLAIMABLE CPD	7.5 hours	The measured total, to the nearest half hour

The measured total is 7.70 hours and the claimable figure is 7.5 - the measured total to the nearest half hour. The programme has not been padded to reach a rounder number, because the whole point of deriving the figure is that it is not chosen. A course that states its own CPD honestly is also the only kind whose other statements are worth trusting.

The five optional practice tools - score the sedation, reassuring or not, what do you do now, naloxone true or not, and the opioid safety self-check - add approximately a further 80 minutes. They are deliberately excluded from the claimable figure, because they are optional. A learner who completes them may claim that time as additional self-directed CPD.

Module 00 - Orientation: Why Sedation Is the Sign

One sentence from ANZCA and the Faculty of Pain Medicine runs through the whole programme: in any patient given an opioid, oversedation should be considered to indicate OIVI until proven otherwise, REGARDLESS of respiratory rate or oxygen saturation. That inverts what most nurses were taught, because the respiratory rate is the number on the chart and it is the least reliable thing on it. What this course is: the nurse's assessment and the nurse's response. What it is not: a prescribing reference, and above all not a conversion table. Why this is not the APINCHS course. And the ten local questions it deliberately leaves for you.

Learning outcomes

- State the sentence this programme is built on, and what it inverts
- Explain why the assessment that detects OIVI earliest needs no equipment
- State what this course does not contain, and why a conversion table is the most dangerous omission to reverse
- Distinguish this course from OBA's High-Risk Medicines (APINCHS) programme
- Describe how the programme treats the people taking it
- Name the local questions that must be answered at the learner's own workplace

Key terms: OIVI; sedation score; opioid safety; naloxone; clinical care standard; conversion table; local protocol

Module 01 - OIVI: What Opioids Do to Breathing

Opioid-induced ventilatory impairment: what the term means and why it replaced 'respiratory depression'. The three components - central respiratory depression, sedation, and upper airway obstruction - which alone or together reduce alveolar ventilation and raise arterial carbon dioxide. Why depth matters as much as rate, and why no observation chart records it. Why snoring is a clinical finding rather than a noise. And why the true incidence is unclear, because most studies measure the wrong things.

Learning outcomes

- State what OIVI stands for and why the term replaced 'respiratory depression'
- Name the three components of OIVI
- Explain why depth of breathing matters as much as rate
- Explain why snoring in a patient given an opioid is a clinical finding
- State what OIVI does to arterial carbon dioxide, and why that is the thing being detected
- Explain why the true incidence of OIVI is unclear

Key terms: OIVI; alveolar ventilation; carbon dioxide; upper airway obstruction; snoring; central respiratory depression; sedation

Module 02 - The Sedation Score, and the Scale Not to Use

The sedation score in full: 0 wide awake, 1 easy to rouse, 2 easy to rouse but unable to remain awake, 3 difficult to rouse. Why 2 - not 3 - is the trigger, and what 'aim to titrate so the score is always less than 2' means at the bedside. Why ANZCA recommends against any scale containing 'S' for normally asleep, and what to do if your chart has one. Why AVPU cannot do this job. When to score: at administration and again at expected peak effect. And why a score noticed but not written is invisible to everybody who comes after you.

Learning outcomes

- State the four levels of the sedation score exactly
- Explain why a score of 2 is the trigger rather than 3
- Explain why a scale containing 'S' should not be used
- Explain why AVPU cannot substitute for a sedation score
- State when a sedation score should be taken in a patient on PRN opioids
- Explain why the score must be documented in the monitoring chart

Key terms: sedation score; early OIVI; titrate to less than 2; AVPU; peak effect; monitoring chart; 'S' scale

Module 03 - Why Respiratory Rate and Saturation Mislead

The thresholds most nurses were taught - a respiratory rate below 8 or 10 - named here in order to be discounted, because ANZCA describes them as a very unreliable measure. Why some patients maintain an acceptable rate with severe OIVI. Why oxygen saturation can stay in range while carbon dioxide rises, why supplemental oxygen makes it less reliable still, and why intermittent pulse oximetry misses the worst of it - because taking the measurement wakes the patient. And what the observations are actually for, since none of this means they should stop.

Learning outcomes

- State why respiratory rate thresholds are described as a very unreliable measure
- Explain why oxygen saturation may remain normal in the presence of OIVI
- Explain why supplemental oxygen weakens saturation as a signal
- Explain why intermittent pulse oximetry misses nocturnal hypoxaemia
- State what does correlate with arterial carbon dioxide
- Explain what observations remain useful for

Key terms: respiratory rate; oxygen saturation; supplemental oxygen; pulse oximetry; carbon dioxide; surrogate measures; track and trigger

Module 04 - Who Is at Risk - and Why Everybody Is

The patient-related risk factors for OIVI, which are largely non-modifiable: older age, female gender, sleep-disordered breathing, obesity, renal impairment, pulmonary disease, cardiac disease, diabetes, hypertension, neurologic disease, two or more comorbidities, genetic variation in metabolism, and opioid tolerance. Then the two sentences ANZCA puts underneath that list: these are reported associations only, and MANY PATIENTS WHO COME TO HARM HAVE NO IDENTIFIABLE COMORBIDITIES AT ALL. Which is why all patients must be assumed to be at risk - and why the list tells you where to look harder rather than who to stop looking at.

Learning outcomes

- Name the principal patient-related risk factors for OIVI
- Explain why the risk list cannot be used to rule a patient out
- State ANZCA's position that all patients must be assumed to be at risk
- Explain why opioid tolerance appears on the risk list
- Explain why a pre-operative sleep-disordered breathing screen does not settle the question
- Use a risk list correctly - to intensify assessment rather than to exclude patients

Key terms: risk factors; sleep-disordered breathing; opioid tolerance; comorbidities; universal assumption; association not causation

Module 05 - The Modifiable Risks That Are Nursing Practice

The modifiable half of the risk list, which is the half you can do something about. Co-administered sedatives - benzodiazepines, gabapentinoids, antipsychotics, sedating antihistamines. Multiple opioid agents, continuous infusions, initiation of long-acting preparations, multiple prescribers. And then the two ANZCA names that describe nursing work directly: 'inadequate nursing assessments or responses', and titrating opioids to a pain score alone - 'chasing' pain scores. Why the pain score is information rather than a dose instruction, and why opioid given for pain that is not opioid-responsive produces sedation without analgesia.

Learning outcomes

- Name the modifiable risk factors for OIVI
- Identify the medicine classes that increase the risk of excess sedation
- Explain why 'inadequate nursing assessments or responses' is on the modifiable list
- Explain why titrating to a pain score alone is a named risk factor
- Distinguish a verified chronic opioid regimen from simultaneous multiple opioid agents
- Explain why opioid-unresponsive pain produces sedation without analgesia

Key terms: modifiable risk; benzodiazepines; gabapentinoids; chasing pain scores; continuous infusion; multiple prescribers; opioid-responsive

Module 06 - When Sedation Reaches 2

What actually happens at a sedation score of 2. Withhold ALL opioids until the patient is awake. Rouse them properly and reassess rather than scoring from the doorway. Escalate under the local protocol, because the commonest failure in published reports is not escalating or escalating late. And the sentence that settles the argument every ward has: if more analgesia is needed, a SMALLER dose is given - regardless of pain score. Then what else to look for, when naloxone enters the picture, and why documenting the event is what makes it useful to anybody else.

Learning outcomes

- State what to do at a sedation score of 2, in order
- Explain why opioids are withheld until the patient is awake
- Explain what 'a smaller dose regardless of pain score' means at the bedside
- Escalate a sedation concern using the local track-and-trigger system
- Identify what else to look for in a sedated patient
- Describe what must be documented after a sedation event

Key terms: withhold; escalation; track and trigger; smaller dose; de-escalate; rapid response; documentation

Module 07 - Naloxone: What It Does and Does Not Do

What naloxone is and how it works: it blocks opioids from attaching to opioid receptors, temporarily. The duration fact that governs everything afterwards - about 30 to 90 minutes, while most opioids last longer. Why the Clinical Care Standard's wording is 'consider the administration of naloxone... according to a locally approved protocol', and why this course gives no dose, interval or maximum. The two presentations. Who may give it, in hospital and in the community. And what it does not do: it is not a routine correction, it does not treat non-opioid causes, and it does not end the episode.

Learning outcomes

- State what naloxone does and how long it lasts
- Explain why the duration fact governs everything that happens afterwards
- State why this course gives no naloxone dose or regimen
- Identify who may administer naloxone in hospital and in the community
- Explain what naloxone does not do
- Describe what must happen alongside naloxone administration

Key terms: naloxone; opioid receptor; duration of action; locally approved protocol; nasal spray; prefilled syringe; emergency reversal

Module 08 - After Naloxone: Re-sedation and Withdrawal

What happens after naloxone, which is most of what matters. Re-sedation as the expected risk rather than the surprise, because naloxone is shorter-acting than most opioids. Precipitated withdrawal in an opioid-tolerant person: what it looks like, why it happens, why titrating to adequate breathing rather than to full consciousness is the principle, and why a distressing reversal makes somebody less likely to accept help next time. The analgesia that was reversed along with everything else. The review of what got them there. And the nurse who found them, who almost nobody asks about.

Learning outcomes

- Explain why re-sedation is expected after naloxone
- Describe what precipitated withdrawal looks like and why it occurs
- State the principle of titrating to adequate breathing rather than to full consciousness
- Explain why reversal creates an analgesia problem that needs a plan
- Describe what a review after a reversal should look for
- State what the nurse who found the patient needs

Key terms: re-sedation; precipitated withdrawal; opioid tolerance; observation period; analgesia plan; system review; second victim

Module 09 - Take Home Naloxone and the Discharge Conversation

The national Take Home Naloxone program, and the discharge conversation the Clinical Care Standard actually requires. What the programme is: free naloxone, without a prescription, to anyone who may experience or witness an opioid overdose - including carers, friends and family of somebody at risk. Where it comes from, who is eligible, and why reduced tolerance is the risk period the programme exists for. Then the signs of overdose in a form that can be said to a family member, what to do while waiting for the ambulance, and why 000 is called every time. And the storage and disposal conversation, which is the one nobody has.

Learning outcomes

- State that take home naloxone has been free and without prescription since 1 July 2022
- Describe who is eligible and where it is supplied
- Explain why reduced tolerance is the highest-risk period
- Recognise and describe the signs of an opioid overdose
- Explain why an ambulance is called after every community administration
- Describe what the discharge conversation must cover, including storage and disposal

Key terms: take home naloxone; Schedule 3; Pharmacist Only; reduced tolerance; signs of overdose; authorised alternative supplier; safe storage and disposal

Module 10 - Opioid Stewardship: the Standard Around All of It

The frame the whole course has been sitting inside. The ACSQHC Opioid Analgesic Stewardship in Acute Pain Clinical Care Standard (2022) and its nine quality statements, with quality statement 6 - monitoring and management of adverse effects - identified as the nurse's. What indicator 6a measures and why it measures a system rather than a nurse. The TGA regulatory reforms that changed what arrives on the ward. The scope matrix across five roles. The ten local questions that only you can answer. And the three support lines.

Learning outcomes

- Name the Clinical Care Standard and state that it has nine quality statements
- State what quality statement 6 requires
- Explain what indicator 6a measures and what it does not measure
- Describe the TGA opioid regulatory reforms and their effect at ward level
- Identify what is within your own scope across the course content
- Answer the local questions that this course cannot answer for you

Key terms: Clinical Care Standard; quality statement 6; indicator 6a; stewardship; TGA reforms; scope of practice; local protocol

3. Assessment

Component	Type	Weighting	Attempts
Module knowledge checks (11)	Formative, immediate feedback with rationales	Not graded	Unlimited
Reflective workbook	Formative, self-directed	Completion required	n/a
Case study assessment	Formative, branching decisions with feedback	Completion required	Unlimited
Summative assessment	60 single-best-answer items	100% - pass mark 80%	2

Summative assessment blueprint

Module	Items
00	4
01	5
02	7
03	6
04	5
05	6
06	7
07	6
08	5
09	5
10	4
TOTAL	60

Pass mark is 80 per cent (48 of 60). Learners have 2 attempts. The certificate of completion is issued automatically on a pass.

The assessment is bound by the same rules as the rest of the programme. The sedation score is carried exactly as published, and no item keys an alternative scale, an S for normally asleep, or AVPU as an adequate substitute. No keyed answer supplies an opioid dose, a conversion value or a naloxone regimen. No keyed answer treats a respiratory rate or an oxygen saturation as excluding OIVI, and none leaves a sedation score of 2 without withholding and escalation. Nothing local is assessed as though it were national, and no keyed answer contains stigmatising language.

4. Standards and regulatory mapping

Framework	Elements addressed	Where
ACSQHC Opioid Analgesic Stewardship in Acute Pain Clinical Care Standard (2022)	Nine quality statements. QS6 - monitoring and management of adverse effects - is the nurse's: sedation levels monitored and documented, excess sedation managed by de-escalating the opioid and continued monitoring, opioids withheld until the patient	Modules 00, 02, 06, 09, 10

	is awake, and naloxone considered according to a locally approved protocol	
ACSQHC Clinical Care Standard - Quality statements 1, 2 and 3	Shared decision making; acute pain assessment using function as well as pain intensity; and risk-benefit analysis before an opioid is prescribed	Modules 05, 09, 10
ACSQHC Clinical Care Standard - Quality statements 5, 7, 8 and 9	Immediate-release at the lowest appropriate dose for a limited duration in opioid-naive patients; documentation of intended duration and review plan; regular review of response; and planning for transfer of care	Modules 05, 09, 10
ANZCA and FPM PS41(G) Acute pain management (2023), Appendix 1: Analgesic Stewardship	The definition of OIVI and its three components; the sedation score; the statement that oversedation indicates OIVI until proven otherwise regardless of respiratory rate or oxygen saturation; the patient-related and modifiable risk factors; and the recommendation against sedation scales containing 'S'	Modules 01, 02, 03, 04, 05
NSQHS Medication Safety Standard (2nd ed), Action 4.15	Identifying high-risk medicines and having systems to store, prescribe, dispense and administer them safely. Opioids are the N in APINCHS - which is the OBA-HRM-2026 course, not this one	Module 00
NSQHS Medication Safety Standard, Actions 4.10 to 4.12	Documenting medicines and monitoring the effects of medicines, including adverse effects - which is where the sedation score lives as a system requirement rather than a preference	Modules 02 and 06
NSQHS Recognising and Responding to Acute Deterioration Standard	The track-and-trigger system, escalation criteria and the rapid response arrangements that a sedation score of 2 or 3 should engage	Module 06
NSQHS Comprehensive Care Standard	Comprehensive care planning and the management of pain as part of it	Modules 05 and 10
Take Home Naloxone Program (Australian Government, national from 1 July 2022)	Free naloxone without a prescription for anyone who may experience or witness an opioid overdose, from participating	Module 09

	pharmacies and authorised alternative suppliers	
Poisons Standard - naloxone	Scheduled as a Pharmacist Only medicine (Schedule 3) for the treatment of opioid overdose since 2016, which is what allows supply without a prescription	Module 09
TGA opioid regulatory reforms	Smaller pack sizes for immediate-release opioids, additional Product Information warnings, updated indications, and better information for prescribers and consumers	Module 10
NMBA Code of conduct for nurses and the Enrolled nurse standards for practice	Practising within scope, escalating concerns about a deteriorating patient, and documenting accurately	Module 00 and the scope documents

5. Scope of practice

This programme is written for registered and enrolled nurses, midwives, and the managers and educators who hold the other half of the subject. Every module identifies what each role may and may not do, and under what condition. The full activity-by-role matrix is published separately as the Scope of Practice Mapping document (facilitator) and the Student Scope of Practice Card.

THE RULE THAT GOVERNS THE PROGRAMME

- Completing this course authorises nothing. It is professional development: it does not authorise a nurse to administer naloxone, and it does not substitute for the employer's protocol, standing order or observation chart.
- Authority to administer naloxone in a health service comes from a locally approved protocol or standing order and from the nurse's own scope of practice. The national scheduling of naloxone explains community supply; it does not decide who may give it on your ward.
- Several rows of the scope matrix read 'No' for every role including the most senior - altering a charted opioid dose in response to a sedation score, supplying a naloxone regimen from memory, and using a sedation scale the service has not approved.
- Where an organisation's policy is more restrictive than this course, the organisation's policy applies as well. Where a state or territory law applies - to storage, supply, or who may do what - the law where you work takes precedence.

6. Resources and further reading

A full directory of Australian organisations, with live links, is published as the Further Reading and Organisation Directory. Four sources matter more than the rest, and all four are free. The ACSQHC Opioid Analgesic Stewardship in Acute Pain Clinical Care Standard (2022) carries the nine quality statements, and quality statement 6 is the nurse's. ANZCA and FPM PS41(G) (2023) carries the sedation score and the OIVI statement this course is built on, in Appendix 1 - the stand-alone OIVI statement has been incorporated into PS41(G), which is why it cannot be found separately. The Take Home Naloxone program pages carry the duration, the eligibility and the signs of overdose in the form you will be saying them in. And the fourth is local: your observation chart, your escalation trigger and your naloxone protocol. Support lines are on every module: Nurse & Midwife Support 1800 667 877, National Alcohol and Other Drug Hotline 1800 250 015, Lifeline 13 11 14.

7. Completion and CPD

14. Complete all eleven module knowledge checks.
15. Complete the case study assessment.
16. Achieve 80 per cent or above in the summative assessment within 2 attempts.
17. The certificate of completion is then issued automatically, carrying the learner's name, the completion date, 7.5 CPD hours and a unique certificate identifier.
18. Registered and enrolled nurses should retain the certificate together with their reflective workbook as CPD evidence, as required by the NMBA registration standard.