PARAGON MEDICAL
COMPREHENSIVE TRAINING SOLUTIONS

COMPLIANCE GUIDE — ONTARIO

Naloxone Is Not a First Aid Requirement. Here's What It Actually Is.

What Ontario's naloxone rules say, what they don't, and why Regulation 1101 has nothing to do with it.

THE CONFUSION IS STRUCTURAL, NOT PERSONAL

If you find the naloxone rules hard to place, that isn't a gap in your knowledge. It's a consequence of where the requirement actually lives.

Almost every other piece of workplace medical readiness you manage — first aid kits, first aid stations, certified first aiders, the inspection card, the Form 82 poster — comes from **Regulation 1101 under the Workplace Safety and Insurance Act**, administered by the WSIB.

Naloxone does not. It comes from **section 25.2 of the Occupational Health and Safety Act**, with details in **O. Reg. 559/22: Naloxone Kits**, administered by the Ministry of Labour, Immigration, Training and Skills Development and enforced by MLITSD inspectors.

Different statute. Different regulator. Different logic entirely.

That single fact explains most of the confusion in the field — including the two most common errors: assuming naloxone is required everywhere first aid is required, and assuming naloxone belongs in the first aid kit. Neither is correct.

Two different kinds of rule

	REGULATION 1101 (FIRST AID)	OHSA S. 25.2 (NALOXONE)
Statute	Workplace Safety and Insurance Act	Occupational Health and Safety Act
Administered by	WSIB	MLITSD
Applies to	All businesses covered by the WSIA — universally	Only workplaces meeting a three-part risk test
Trigger	Headcount per shift	Employer awareness of a specific risk
Nature	Prescriptive and permanent	Conditional and situational
Can it change?	Only if headcount changes	Yes — a workplace can move in or out of scope

Regulation 1101 asks a counting question: *how many people are on shift?* Five or fewer means at least one certified first aider; six or more means the higher certification level.

Section 25.2 asks an awareness question: *do you know, or ought you reasonably to know, that one of your own workers might overdose here?*

A workplace can be fully compliant with Regulation 1101 and have no naloxone obligation at all. A workplace can also have a naloxone obligation that didn't exist last quarter, because something changed.

THE THREE-PART TEST

The obligation arises only where the employer becomes aware, or ought reasonably to be aware, of **all three** of the following. This is narrower than most employers assume.

01 There is a risk of a worker opioid overdose

Awareness can arise several ways: an overdose has already happened at the workplace; a worker voluntarily discloses the risk; the employer observes opioid use or discovers it during an investigation; discarded paraphernalia such as used needles is found; or the JHSC, a health and safety representative, a union representative, or HR raises it.

02 The risk exists at a workplace where that worker works

Risk that exists somewhere else doesn't count. The province's own example: a worker on leave who is at risk is not, while on leave, creating a risk of overdose *at work* — so the obligation doesn't attach.

03 The risk is posed by a worker who works for that employer

On a multi-employer site, only the employer of the at-risk worker carries the duty. Not the constructor by default. Not every employer on site.

THE DECISIVE POINT

If any one of the three is absent, the section 25.2 requirement does not apply.

What the requirement is *not*

Customers and the public don't trigger it. If a customer, client, patient, or visitor overdoses in your workplace, that alone does not create a section 25.2 obligation. The requirement is about *worker* risk. This is counterintuitive for retail, transit, libraries, shelters, and hospitality, where the realistic risk is often public-facing — and it is precisely where a voluntary program, not the OHSA requirement, is the right instrument.

Prescribed opioid use alone doesn't trigger it. If a worker discloses they take opioids prescribed by a medical practitioner, that alone is unlikely to establish awareness of overdose risk, because the use is medically supervised.

You are not required to go looking. The OHSA does not require an employer to assess or inquire about workers' overdose risk. A risk assessment is described as a best practice, not a duty. Note the tension: the duty is triggered by awareness, and you have no obligation to acquire awareness — but once you have it, the clock starts.

You can't over-disclose to comply. Employers must not disclose more personal information than is reasonably necessary. The designated kit holder may need to know a risk exists; they do not need the at-risk worker's identity or file.

WHY NALOXONE DOES NOT GO IN THE FIRST AID KIT

This is the single most common compliance error, and it produces a specific, avoidable failure: an auditor finds naloxone in the Reg 1101 box, and the employer has now created a first aid problem while trying to solve an OHSA one.

The WSIB is explicit that businesses should not include medications or ointments in first aid kits, or equipment first aiders are not trained to use. It applies the same logic to EpiPens — not required under Regulation 1101, and not to be included in the kits. First aid training does not cover administering medication, so it falls outside a first aider's scope.

Naloxone is a drug. It sits outside the first aid kit by design.

> **STRUCTURAL SEPARATION**
>
> O. Reg. 559/22 requires that naloxone kit contents be kept in a **hard case**; used, stored and maintained per the manufacturer's instructions; single-use; promptly replaced after use; and never expired.

Required contents

NASAL SPRAY KIT	INJECTABLE KIT
Hard case	Hard case
2 doses naloxone hydrochloride nasal spray (4 mg/0.1 ml)	2 vials or ampoules (0.4 mg/1 ml)
1 one-way rescue breathing barrier	2 safety-engineered syringes, 25g 1" needles attached
1 pair non-latex gloves	2 alcohol swabs
	2 ampoule breakers/openers
	1 one-way rescue breathing barrier
	1 pair non-latex gloves

Co-locate the naloxone kit *near* the first aid station if that makes operational sense. Do not put it *in* the first aid box.

How many kits?

At least one in each workplace where the risk is present — not one per organization, and not one in workplaces where the risk isn't present.

But section 25.2 doesn't stop there. The general duty to take every precaution reasonable in the circumstances still applies, which means a single kit may not discharge the obligation on a large site, or where several at-risk workers are spread across a facility. Ontario's guidance names both scenarios explicitly. Treat "at least one" as a floor, and retrieval time as the real design criterion.

WHAT MOST PROGRAMS MISS

Providing the kit is the visible duty. These four are the ones that fail audits.

Designation

At any time workers are present, the kit must be in the charge of a worker who works in the vicinity of the kit and has received the required training. In practice this is a *coverage* problem, not a headcount problem — multiple shifts mean multiple trained designates. The OHSA doesn't specify a number; it specifies a result.

Posting

The names and workplace locations of the trained workers in charge of the kit must be posted conspicuously near the kit. This is a discrete, checkable item, and it is frequently missing.

Training content

Training must enable the worker to recognize an opioid overdose, administer naloxone, and understand the hazards of administration. That third element is the one commonly skipped. Naloxone can precipitate acute withdrawal, which can present as pain, distress, agitation and aggression — a genuine risk to the responder — alongside biological exposure risk from vomiting. Employers may deliver the training themselves or use an external provider; no specific provider is mandated.

Maintenance

Replace used single-use items promptly, keep nothing expired, and store per manufacturer instructions — typically room temperature, 15–25°C, protected from light. Expired or unused kits can be taken to any Ontario pharmacy for safe disposal.

The funding picture has changed

The Workplace Naloxone Program that launched alongside the requirement — free training for up to two workers per workplace and one free nasal spray kit — was time-limited. St. John Ambulance's program funding ended March 31, 2024.

Employers should also understand they are generally **not** eligible for the publicly funded community take-home naloxone programs. The Ontario Naloxone Program and the pharmacy program serve community organizations and individuals; businesses meeting an OHSA obligation are expected to purchase directly.

> **BUDGET CHECK**
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> If you budgeted for naloxone on the assumption of free kits, that assumption has expired.

ENFORCEMENT IS TIGHTENING — BUT BE PRECISE ABOUT HOW

Two developments matter, and they're often overstated in vendor marketing.

The maximum OHSA fine for a corporation is **$2,000,000 per contravention**, following Bill 79 in October 2023 — the highest in Canada. Directors and officers face up to $1.5 million; other individuals up to $500,000.

Separately, Bill 30 (*Working for Workers Seven Act, 2025*) received Royal Assent on November 27, 2025, adding **administrative monetary penalties** to the OHSA through Part IX.1, with O. Reg. 365/25 supplying the mechanics as of January 1, 2026. AMPs let inspectors impose financial penalties administratively, without a court prosecution.

THE HONEST CAVEAT

As the regime stands, the AMP regulation's prescribed penalties currently attach to a narrow set of public-sector procurement contraventions, with broader amounts expected to be set by further regulation. Anyone telling you naloxone non-compliance carries an automatic on-the-spot fine today is ahead of the law. The direction of travel is unmistakable — but plan against it rather than react to it.

Two things changed in 2026 — and one did not

The WSIB First Aid Program was updated June 22, 2026. Training is now aligned to CSA Z1210:24. Course names changed: Emergency First Aid is now **Basic First Aid**; Standard First Aid is now **Intermediate First Aid**. Certificates issued up to June 21, 2026 remain valid until they expire, and out-of-province certificates meeting CSA Z1210 are accepted.

Regulation 1101 itself did not change. The WSIB has stated this directly. The thresholds, the three-year certificate validity, and the kit requirements all stand. Basic is equivalent to Emergency; Intermediate is equivalent to Standard.

And naloxone was not folded into any of it. If your organization is currently re-papering its first aid program because of the June 2026 update, do not assume naloxone came along for the ride. It didn't. It never has.

A useful parallel

As of January 1, 2026, O. Reg. 157/25 requires an AED on construction projects with 20 or more workers regularly employed and an expected duration of three months or longer — with specified accessories, signage, quarterly inspection, records, and a CPR/AED-trained worker present whenever work is underway. AEDs remain *not* required under Regulation 1101.

The pattern is consistent: Ontario is mandating life-saving equipment through the OHSA, condition by condition, while Regulation 1101 holds still. If you are mapping your obligations against Reg 1101 alone, you will keep missing things.

MANDATORY VERSUS ADVISABLE: A STRAIGHT ANSWER

Ask two questions in sequence.

Is it mandatory? Only if all three parts of the test are met. That is a narrower group of workplaces than the sector conversation implies.

Is it advisable? Frequently yes, even when not mandatory — and this is a legitimate decision an employer can make on its own reasoning rather than under compulsion. Voluntary adoption tends to be the right call where:

- the workplace is public-facing and overdose risk comes primarily from non-workers, which the OHSA requirement does not capture
- emergency response times are long, or the site is remote or isolated
- the workforce is large, transient, or has significant contractor turnover
- your status under the three-part test is genuinely ambiguous — the cost of a kit and training is trivial against the cost of being wrong
- your JHSC has raised the issue, in which case a documented decision either way is better than an undocumented one

> **ONE CAUTION WHEN ADOPTING VOLUNTARILY**
>
> If the worker trained in naloxone is not also first aid trained, the province notes it is best practice for a first-aid-trained person to accompany them in a suspected overdose response. An unresponsive worker may be experiencing something else entirely — a diabetic emergency, a cardiac event — and naloxone will not help. Naloxone competence supplements first aid competence. It does not substitute for it.

A practical sequence

01 **Determine status.** Run the three-part test honestly and write down the conclusion and its date. A documented determination is worth far more than an assumption, in either direction.

02 **Set a review trigger.** Status is not permanent. Re-run the test after an incident, when paraphernalia is found, when the JHSC raises it, or on a fixed annual cycle.

03 **Separate the equipment.** Naloxone in its own hard case. Nothing added to the Reg 1101 box.

04 **Solve for coverage, not headcount.** Map trained designates against every shift and every area, then check retrieval time.

05 **Post the names.** Conspicuously, near the kit. It takes ten minutes and it is the item most often missing.

06 **Train the hazards, not just the steps.** Recognition, administration, and the risks of administration — including agitation and biological exposure.

07 **Put maintenance on your first aid inspection cycle.** Reg 1101 requires quarterly first aid kit inspections; there's no reason the naloxone expiry check shouldn't ride the same schedule, even though it comes from a different statute.

08 **Rehearse it once.** A kit nobody has opened is a kit nobody will open well.

THE POINT UNDERNEATH THE COMPLIANCE QUESTION

The three-part test tells you whether you must. It does not tell you whether your people could actually respond.

A kit on the wall, a name on a poster, and a training record in a file satisfy an inspector. None of them answer the question that matters at the moment it matters: when someone goes down in your building and the person nearest to them has ninety seconds of useful time, will they recognize what they're looking at, retrieve the right thing from the right place, and use it — while managing a person who may wake up frightened and combative?

That is a different standard than compliance, and it is the one your workers will be held to.

NALOXONE AND FIRST AID TRAINING ACROSS THE GTA

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SOURCES

Ontario, *Naloxone in the workplace* (ontario.ca/page/naloxone-workplace) · Occupational Health and Safety Act, s. 25.2 · O. Reg. 559/22: Naloxone Kits · WSIB, *First Aid Program* (wsib.ca/en/firstaid) · Regulation 1101, First Aid Requirements (WSIA) · O. Reg. 157/25, Construction Projects · Bill 30, Working for Workers Seven Act, 2025 · O. Reg. 365/25, Administrative Penalties · Bill 79, Working for Workers Act, 2023