Poisoning/Ingestion/Overdose (118)

Adults	Pediatrics *(13 years and under)*
Public Safety First Aid Procedures: Only	**Public Safety First Aid Procedures: Only**
• Support ABC's • Request Fire/EMS • Consider Naloxone if signs of opiate overdose with respiratory depression, 1 mg per nare. • If using 4mg preload intranasal may use this as initial dose.	• Support ABC's • Request Fire/EMS • Consider Naloxone if signs of opiate overdose with respiratory depression, If using 4mg preload intranasal may use this as initial dose.
BLS Procedures: EMT's and Paramedics start here	**BLS Procedures: EMT's and Paramedics start here**
• In HAZ-MAT situations, prevent responder contamination. If is substance is powder brush off first then flush with water, remove clothing, decontaminate. • Administer oxygen only if SpO2 <94% or if in respiratory distress • Support ABC'S • If suspected opiate overdose with respiratory depression administer Naloxone: Adult 2 mg intramuscular or intranasal MAX dose, 1 mg per nare. • Prepare for rapid transport or ALS rendezvous.	• In HAZ-MAT situations, prevent responder contamination. If is substance is powder brush off first then flush with water, remove clothing, decontaminate. • Administer oxygen SpO2 <94% or if in respiratory distress • Support ABC'S • If suspected opiate overdose with respiratory depression administer Naloxone intramuscular or intranasal for children < 1 year give 0.5 mg. Children 1-7 years give 1 mg, for children > 8 give 2 mg. ○ If given intranasal split dose between nares. • Prepare for rapid transport or ALS rendezvous.
ALS Prior to Base Hospital Contact: Paramedic only	**ALS Prior to Base Hospital Contact: Paramedic only**
• If patient has altered mentation, rule out other treatable causes. • If oral ingestion and patient is oriented with patent airway and ingestion was not a caustic substance administer Activated Charcoal 50 grams PO. • If suspected opiate overdose with respiratory depression administer Naloxone 0.4-2 mg IV/IM/IN/IO • If suspected opioid withdrawals, immediately use "COWS" score to determine if patient meets criteria to receive buprenorphine. Patient must have a score of 7 or higher. If criteria met initiate a Tele911 consult to review indications and arrange for follow up, administer 16mg SL after Tele911 consult has been	• If patient has altered mentation, rule out other treatable causes. • If oral ingestion and patient is oriented with patent airway and ingestion was not a caustic substance administer Activated Charcoal 25 grams PO. • If suspected opiate overdose with respiratory depression, administer Naloxone, if 5 years old or older 2 mg IV/IO/IM/IN. If <5 years 0.1 mg/kg IV/IO/IM/IN • If symptomatic tricyclic antidepressant overdose, consider Sodium Bicarbonate 1 mEq/kg IV • If symptomatic calcium channel blocker overdose, consider Calcium Chloride 20 mg/kg slow IV/IO

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initiated. May administer a 2nd dose of 8mg SL if symptoms persist or worsen after 10 minutes. • If symptomatic tricyclic antidepressant overdose, consider Sodium Bicarbonate 1 mEq/kg IV • If symptomatic calcium channel blocker overdose, consider Calcium Chloride 1 gram slow IV/IO • If symptomatic beta blocker overdose, consider Glucagon 2 mg IV/IO • If dystonic reaction to phenothiazines, administer Diphenhydramine 50 mg slow IVP or IM • If symptomatic organophosphate poisoning, administer Atropine 2 mg IV every 5 minutes as needed	• If symptomatic beta blocker overdose, consider Glucagon 0.1 mg/kg IV/IO • If dystonic reaction to phenothiazines administer Diphenhydramine 1 mg/kg slow IV/IM • If symptomatic organophosphate poisoning administer Atropine 0.05-0.1mg/kg IV/IM every 5 minutes as needed
Base Hospital Contact Required	**Base Hospital Contact Required**

118 POISONING/INGESTION/OVERDOSE

Special Considerations

1. Ingestions
   - Obtain accurate history
     a. Name of product or substance
     b. Quantity ingested
     c. Time of ingestion
     d. Pertinent medical history
     e. Pill bottles/ description of pills

2. Haz-Mat
   - Cholinergic crisis:
     a. Initially patients may experience tachycardia.
     b. Bradycardia, salivation, lacrimation, urination, defecation, sweating, twitching, abdominal cramps, vomiting, pinpoint pupils, smell of pesticides, hypoxia, seizure, coma.
   - Obtain name of product or substance.
   - Determine time of exposure.
   - Obtain route of exposure (i.e. inhalation, absorption, etc.).

3. The primary goal in the treatment of an oral ingestion is to prevent the absorption of the toxic substance by the small intestine.

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4. Activated charcoal is considered safe and effective for most ingestions. Activated charcoal should not be used if the toxin is a strong acid, strong alkali, or ethanol. Activated charcoal should not be used if a specific antidote exists. Activated charcoal is given P.O. only, no N.G. tube administration shall be attempted.

5. In caustic ingestions, do not give anything by mouth.

6. **Insecticides** (Organophosphates, Carbonates): decontaminate as soon as possible; avoid contamination of prehospital personnel; assess for SLUDGE (Salivation, Lacrimation, Urination, Diaphoresis/Diarrhea, Gastric Hypermotility, and Emesis/Eye [small pupils and/or blurry vision]). Administer Atropine 2.0mg IVP slowly. If no tachycardia or pupil dilation, may give repeat dose every 5 minutes as needed. Minimum pediatric dose 0.1mg.

7. **Tricyclic Ingestion**: Continued assessment of patients with tricyclic ingestions is very important. These patients can deteriorate rapidly. In the presence of life-threatening dysrhythmias hyperventilate; administer 1mEq/kg Sodium Bicarbonate. Refer to Seizure Activity (121) or Shock/Hypoperfusion Protocol (124) as needed.

8. **Calcium Channel Blockers**: if bradycardic and/or hypotensive, consider administration 1 gram of Calcium Chloride slow IV push. Enter appropriate protocol as needed

9. **Beta Blockers**: If bradycardic and/or hypotensive, consider administration 2mg of Glucagon. Enter appropriate protocol as needed.

10. **Dystonic reactions:** to phenothiazine's or butyrophenone (Haldol) should be treated with 50 mg Diphenhydramine slow IV push preferred, may give IM. Signs and symptoms include fixed, deviated gaze to one side of the body, painful spasm of trunk or extremity muscles, and difficulty speaking. Enter appropriate protocol as needed.

11. Buprenorphine is FDA-approved for managing opioid dependence or opioid withdrawals with a Clinical Opiate Withdrawal Scale (COWS) score of 7 or higher. Do not administer buprenorphine if the following contraindications are present: patient is under 18 years of age, pregnant, any methadone use with in the last 10 days, altered mental status, sepsis, current intoxication or recent use of benzodiazepine, COWS score of less than 7. Review page 65 for COWS score. Tele911 consult is required prior to buprenorphine administration to review indications and arrange for follow up. MDCalc COWS score calculator: https://www.mdcalc.com/calc/1985/cows-score-opiate-withdrawal

Naloxone leave behind shall be dispensed to all patients receiving buprenorphine.

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Patient's Name:_____ Date and Time ____/____/____:_____

Reason for this assessment:_____

Resting Pulse Rate: _____beats/minute *Measured after patient is sitting or lying for one minute* 0 pulse rate 80 or below 1 pulse rate 81-100 2 pulse rate 101-120 4 pulse rate greater than 120	**GI Upset**: *over last 1/2 hour* 0 no GI symptoms 1 stomach cramps 2 nausea or loose stool 3 vomiting or diarrhea 5 multiple episodes of diarrhea or vomiting
Sweating: *over past 1/2 hour not accounted for by room temperature or patient activity.* 0 no report of chills or flushing 1 subjective report of chills or flushing 2 flushed or observable moistness on face 3 beads of sweat on brow or face 4 sweat streaming off face	**Tremor** *observation of outstretched hands* 0 no tremor 1 tremor can be felt, but not observed 2 slight tremor observable 4 gross tremor or muscle twitching
Restlessness *Observation during assessment* 0 able to sit still 1 reports difficulty sitting still, but is able to do so 3 frequent shifting or extraneous movements of legs/arms 5 unable to sit still for more than a few seconds	**Yawning** *Observation during assessment* 0 no yawning 1 yawning once or twice during assessment 2 yawning three or more times during assessment 4 yawning several times/minute
Pupil size 0 pupils pinned or normal size for room light 1 pupils possibly larger than normal for room light 2 pupils moderately dilated 5 pupils so dilated that only the rim of the iris is visible	**Anxiety or Irritability** 0 none 1 patient reports increasing irritability or anxiousness 2 patient obviously irritable or anxious 4 patient so irritable or anxious that participation in the assessment is difficult
Bone or Joint aches *If patient was having pain previously, only the additional component attributed to opiates withdrawal is scored* 0 not present 1 mild diffuse discomfort 2 patient reports severe diffuse aching of joints/muscles 4 patient is rubbing joints or muscles and is unable to sit still because of discomfort	**Gooseflesh skin** 0 skin is smooth 3 piloerrection of skin can be felt or hairs standing up on arms 5 prominent piloerrection
Runny nose or tearing *Not accounted for by cold symptoms or allergies* 0 not present 1 nasal stuffiness or unusually moist eyes 2 nose running or tearing 4 nose constantly running or tears streaming down cheeks	Total Score _____ The total score is the sum of all 11 items Initials of person completing assessment: _____

Score: 5-12 = mild; 13-24 = moderate; 25-36 = moderately severe; more than 36 = severe withdrawal

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12. Naloxone is intended to reverse respiratory depression associated with narcotic use. Naloxone may be withheld if respiratory depression is not present. The goal is to titrate Naloxone to improve respiratory distress but not precipitate severe withdrawals.

    - **ALS**- Generally a full 2 mg IV dose should not be given as an immediate bolus. Naloxone may be repeated as needed after the first dose.
    - **BLS**- Does not repeat intranasal dose after 1 mL of volume per nare. IM doses may be repeated.
    - **Public Safety-First Aid**- If using 4mg preload intranasal may use this as initial dose

Pulseless Arrest Entry Algorithm (119)

Adults	Pediatrics *(13 years and under)*
Public Safety First Aid Procedures: Only	**Public Safety First Aid Procedures: Only**
• If patient is unconscious and pulseless begin High-Performance CPR • Request EMS and Fire response • Begin cycles of 30 compressions and 2 breaths. • Use AED as soon as it is available. Attach AED, follow AED prompts, if AED indicates "shock advised," give 30 compressions and shock as indicated by device. • Resume High-Performance CPR immediately post shock • Closely monitor patient for changes	• If patient is unconscious and pulseless begin High-Performance CPR • Request EMS and Fire response • 1 Rescuer: Begin cycles of 30 compressions and 2 breaths. (Use 15:2 ratio if second rescuer arrives.) • Use AED as soon as it is available. Attach AED, follow AED prompts, if AED indicates "shock advised," give 30 compressions and shock as indicated by device if patient is over 1 year of age • Resume High-Performance CPR immediately post shock • Closely monitor patient for changes
BLS Procedures: EMT's and Paramedics start here	**BLS Procedures: EMT's and Paramedics start here**
• Begin/Continue High-Performance CPR if no signs of obvious death • Give Oxygen and ventilate • Attach AED, follow AED prompts, if AED indicates "shock advised," give compressions as device is charging and shock as indicated by device. • Minimize interruptions in High-Performance CPR • Ensure high quality compressions are being delivered • If no change after 30 minutes, consider termination of efforts per determination of death policy	• Begin/Continue High-Performance CPR if no signs of obvious death • Give Oxygen and ventilate • Attach AED, follow AED prompts, if AED indicates "shock advised," give compressions as device is charging and shock as indicated by device if patient is over 1 year of age. • Minimize interruptions in High-Performance CPR • Ensure high quality compressions are being delivered • Request ALS rendezvous. Initiate transport if ALS ETA is greater than 10 min
ALS Prior to Base Hospital Contact: Paramedic only	**ALS Prior to Base Hospital Contact: Paramedic only**
• Attach Monitor/Defibrillator • Enter V-Fib/Pulseless V-Tach Protocol (125) if shockable rhythm • Enter Asystole/PEA Protocol (104) if non-shockable rhythm • If no change after 30 minutes, consider termination of efforts • Do not pause compressions to perform ALS procedures. • Consider placement of nasogastric tube for gastric distension	• Attach Monitor/Defibrillator • Enter V-Fib/Pulseless V-Tach Protocol (125) if shockable rhythm • Enter Asystole/PEA Protocol (104) if non-shockable rhythm • Consider placement of nasogastric tube for gastric distension