Treatment Protocol: OVERDOSE / POISONING / INGESTION **Ref. No. 1241-P**

1. Assess airway and initiate basic and/or advanced airway maneuvers prn (MCG 1302)

2. Administer **Oxygen** prn *(MCG 1302)*

3. Establish vascular access prn *(MCG 1375)* ❶

4. For suspected opioid overdose with altered mental status and hypoventilation/apnea:
   Naloxone (1mg/mL) 0.1mg/kg IM/IN/IV, dose per *MCG 1309* ❶ or
   Naloxone 2-4 mg IN if using pre-packaged nasal spray (1mg per nostril or 4mg/0.1 mL IN depending on formulation available); excludes newborns ❷
   Maximum dose all routes 8 mg
   Titrate to adequate respiratory rate and tidal volume

5. If partial response to Naloxone and strong suspicion for opioid overdose:
   CONTACT BASE for additional doses of **Naloxone**

6. For respiratory distress, treat in conjunction with *TP 1237-P, Respiratory Distress*

7. Initiate cardiac monitoring prn *(MCG 1308)*
   For suspected cardiac ischemia or dysrhythmia, perform 12-lead ECG and **CONTACT BASE**
   For patients with dysrhythmias, treat in conjunction with *TP 1212-P, Cardiac Dysrhythmia - Bradycardia* or *TP 1213-P, Cardiac Dysrhythmia - Tachycardia*

8. Evaluate for other causes of altered level of consciousness *(MCG 1320)*

9. Assess for signs of trauma
   If traumatic injury suspected, treat in conjunction with *TP 1244-P, Traumatic Injury*

10. Check blood glucose
    If < 60mg/dL or > 250mg/dL, treat in conjunction with *TP 1203-P, Diabetic Emergencies*

11. For alcohol intoxication, document Provider Impression – *Alcohol Intoxication*
    For other intoxications, including overdose or ill affects of prescription medications and illicit substances, document Provider Impression – *Overdose/Poisoning/Ingestion*

12. For poor perfusion *(MCG 1355)*:
    Normal Saline 20mL/kg IV rapid infusion per *MCG 1309*
    For persistent poor perfusion, treat in conjunction with *TP 1207-P, Shock/Hypotension*

13. **CONTACT BASE** to discuss antidote administration

    Calcium channel and/or beta blocker overdose: **Calcium chloride (100mg/mL) 20mg/kg slow IV push**, dose per *MCG 1309* ❸
    Tricyclic antidepressant overdose: **Sodium bicarbonate (1mEq/mL) 1mEq/kg slow IV push**, dose per *MCG 1309* ❹

14. Assess for co-ingestion of other substances

15. Consider contacting the Poison Control Center (1-800-222-1222) in conjunction with Base for assistance with identification and management of unknown medications/toxins *(Ref. 805)*

16. Bring containers of ingested substances to the emergency department with patient

17. If patient refuses treatment or transport, **CONTACT BASE**
    Patient/parent must demonstrate decision-making capacity (*Ref. 834*)
    If EMS personnel or Base Hospital determines it is necessary to transport the patient against their will and/or the will of the parent, contact law enforcement for assistance❺

SPECIAL CONSIDERATIONS

❶ The first priority for apneic patients after narcotic overdose is to begin positive pressure ventilation. Once ventilations are established, naloxone should be administered with the goal of restoring spontaneous ventilations. Vascular access should not take priority over initial treatment with Naloxone (IN or IM) for patients with suspected opiate overdose. Patients who are awake and alert with normal respirations after naloxone therapy may not require IV access or additional doses of naloxone.

❷ Higher dose pre-packaged nasal spray should not be used in the newborn/neonate due to potential risk to precipitate withdrawal.

❸ Signs of calcium channel overdose include bradycardia along with hypotension and hyperglycemia. Signs of beta blocker overdose include bradycardia along with hypotension and hypoglycemia. Consider when the patient is taking or has access to a calcium channel and/or beta blocker medication. Ask about potential exposures including medications in the home.

❹ ECG findings consistent with tricyclic overdose include wide QRS (>0.12mm) and terminal R in aVR. Consider when the patient is taking or has access to a tricyclic medication. Ask about potential exposures including medications in the home.

❺ EMS Personnel are mandated reporters of child abuse and neglect. Communicate concerns about child abuse and/or neglect to accepting ED staff when home suggests children could be at risk for harm (e.g., unkempt home, evidence of drug or alcohol abuse, unsafe living conditions, known or suspected domestic violence), when the history does not match with the severity of physical findings (e.g., child posturing after a roll off the couch), when patterned injury or burns or noted (e.g., circular burns as from a cigarette, whip marks on the skin, burns of both hands or feet), or when child reports physical or sexual abuse. Children < 3 years of age and those with developmental delay are at increased risk of abuse. This must also be accompanied by notification to Department of Children and Family Services.