OVERDOSE – OPIOIDS and Others

ALL PROVIDERS

- Focused history and physical exam
- Assess blood glucose, temperature, and oxygen saturation.
- Assess the time and circumstances of the ingestion.
- Assess patient and scene for possible trauma and additional information on possible toxins, poisons, medications or other related concerns.
- Cardiac monitor, ETCO2, and pulse oximetry monitoring, when available.
- 12-lead ECG, if available

Treatment Plan

Opioid Overdose: Initial focus is on providing/assisting with adequate ventilation with BVM immediately.

- Initial dose of naloxone should be given IN (intranasal) while preparing for IV placement by AEMT/PM.
- Dosing of naloxone should be focused on restoration of adequate spontaneous ventilation, not restoration of full consciousness. Excessive naloxone use can precipitate an acute withdrawal syndrome, putting both the patient and the emergency personnel at risk for injury.
- Begin with small doses of naloxone (0.4 mg IN/IV) and titrate to adequate spontaneous ventilation.

Key Considerations

- Transport any pill bottles, open containers, or potential chemicals that may have been ingested.
- Transport suicide notes or other pre-ingestion communications.
- May contact Poison Control 1-800-222-1222
- With some new opiates, very large doses of naloxone may be required to restore respirations. If no results with 2-3 0.4 mg doses, consider a trial of 2 mg doses.
- If other drugs are ingested in addition to opiates (such as alcohol or benzodiazepines), the response to naloxone may be incomplete.
- All oral opioid overdoses must be transported, as re-sedation will occur after naloxone administration.
- Patients who have attempted suicide by overdose CANNOT be released and MAY be taken in against their will. Police may need to assist in ensuring the transport by providing "pink sheet" and assisting with patient control during transport.

Release on Scene - In cases of reported **heroin-only** overdose, patients should be offered ED transport, but if they refuse they may be left on scene after naloxone administration if:

- An attendant and second dose of naloxone is available or provided for any patient left on scene.
- There is a responsible person on scene who is not intoxicated and can and will care for the patient.

ADULT	PEDIATRIC (<15 years of Age) NOTE: Pediatric weight based dosing should not exceed Adult dosing.
EMT	**EMT**
❑ **Naloxone 0.4–2 mg** (per dose) IN (intranasal) for suspected opioid overdose. May repeat as necessary to maintain respirations. ❑ IM route may be used if unable to administer IN	❑ **Naloxone 0.1 mg/kg (max 2mg per dose**) IN (intranasal) for suspected opioid overdose. May repeat as needed to maintain respirations ❑ IM route may be used if unable to administer IN

AEMT

- ❑ Advanced airway, vascular access and fluid therapy
- ❑ **Naloxone 0.4–2 mg** (per dose) IV/IM/IO/IN for suspected narcotic overdose. May repeat as needed to maintain respirations

PARAMEDIC

- ❑ **Sodium bicarbonate 1 mEq/kg** slow IV/IO push **for tricyclic antidepressant overdose** with sustained HR >120 bpm, QRS >0.10, hypotension unresponsive to fluids, or ventricular dysrhythmias
- ❑ **Epinephrine 2–10 mcg/min** IV/IO infusion for hypoperfusion. Titrate to maintain a SBP >100 mmHg
- ❑ **Push Dose Epinephrine 10mcg** as needed to maintain a SBP >100 mmHg after fluid bolus
- ❑ **Norepinephrine** initial dose: **0.05 – 1 mcg/kg/min** IV/IO for hypoperfusion. Titrate to maintain a SBP > 100 mmHg. For patients in refractory shock: 8-30 mcg/minute

AEMT

- ❑ Advanced airway, vascular access and fluid therapy
- ❑ **Naloxone 0.1 mg/kg (max 2mg per dose)** IV/IM/IO/IN for suspected narcotic overdose. May repeat as needed to maintain respirations

PARAMEDIC

- ✆ Sodium bicarbonate for tricyclic antidepressant overdose: Contact OLMC
- ✆ **Epinephrine** IV/IO infusion for hypoperfusion. Titrate to maintain a SBP >100 mmHg
- ✆ **Push Dose Epinephrine** as needed to maintain a SBP >70 + 2xage mmHg after fluid bolus
- ✆ **Norepinephrine** initial dose: **0.05 – 1 mcg/kg/min** IV/IO for hypoperfusion. Titrate to maintain a SBP > 100 mmHg. For patients in refractory shock: 8-30 mcg/minute