

OPIOID / OVERDOSE

UPDATED 9/2024

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
- 12-lead ECG, if available
- Treatment Plan**
 - **Opioid Overdose:** Initial focus is on providing/assisting with adequate ventilation with BVM immediately.
 - Ensure patient SpO₂ is adequate (>92%) utilizing NC, NRB, or BVM prior to Naloxone administration.
 - Dosing 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.
 - Initial dose of naloxone should be given IN/IM while preparing for IV.
- 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 other drugs are ingested in addition to opiates (such as alcohol or benzodiazepines), the response to naloxone may be incomplete.
 - 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.
 - Patients who regain consciousness and are GCS 15, should be offered ED transport, but if they refuse, they may be left on scene after Naloxone administration **IF**:
 - A second dose of Naloxone is available and/or provided to any patient and left on scene
 - There is a responsible person on scene who is not intoxicated and will care for the patient.

ADULT

PEDIATRIC

Pediatric weight based dosing should not exceed adult dosing.

EMT

- Naloxone 0.4–2 mg IN/IM** for suspected opioid overdose. May repeat as necessary to maintain adequate respirations.

EMT

- Naloxone 0.1 mg/kg (max 2mg per dose)** IN/IM for suspected opioid overdose. May repeat as needed to maintain adequate respirations

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 adequate respirations

PARAMEDIC

- Sodium bicarbonate 1 mEq/kg** slow IV/IO push for tricyclic antidepressant overdose with sustained HR >120 bpm, QRS >0.12, hypotension unresponsive to fluids, or ventricular dysrhythmias
- Epinephrine Drip - 2-10 mcg/min** IV/IO infusion. Titrate to maintain a SBP of 90 mmHg or MAP of 65.
- Push Dose Epinephrine - 0.1-0.5mcg/kg/min** as needed to maintain a SBP of 90 mmHg or MAP of 65.
- Norepinephrine - 1 mcg/kg/min** IV/IO infusion for shock. Titrate up to 30mcg/min to maintain a SBP >90 mmHg.

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 adequate respiration.

PARAMEDIC

- Sodium bicarbonate for tricyclic antidepressant overdose: Contact OLMC**
- Epinephrine Drip - 0.1-1mcg/kg/min** IV/IO for hypoperfusion. Titrate to maintain a SBP >70 + (age in years x 2) mmHg.
- Push Dose Epinephrine - 0.1-1mcg/kg** as needed to maintain a SBP >70 + (age in years x 2) mmHg.
- Norepinephrine 0.05–2 mcg/kg/min** IV/IO for hypoperfusion. Titrate to maintain a SBP >70 + (age in years x 2) mmHg.