

Protocol 7-1

SECTION: Toxicological Emergencies

PROTOCOL TITLE: Medical – Overdose/Poisoning – Opioid

REVISED: 06/2017

OPIATE OVERDOSE

OVERVIEW:

The goal in treating an opiate overdose patient is generally not to wake the patient, but to maintain breathing and the airway. While difficult, this is especially important as opiates are often mixed with stimulants and other drugs at the street level, and the opiate may be masking or suppressing other toxic effects. Unfortunately, the history of poisoning / overdose is notoriously unreliable whether it is obtained from the patient, friends and family members or emergency services personnel, and especially **what else** was taken. Poison Control may be contacted at any time for information on poisoning (1-800-222-1222) but **only Medical Control may give patient care direction**. Despite the possible inaccuracies, the most important historical factors include **what** poison was involved, **how much** was taken, **how** it was taken, **when** it was taken, **why** it was taken **treatment orders**.

HPI	Signs and Symptoms	Considerations
<ul style="list-style-type: none"> • Use or suspected use of a potentially toxic substance • Substance ingested, route, and quantity used • Time of use • Reason (suicidal, accidental, criminal) • Available medications in home • Past medical history 	<ul style="list-style-type: none"> • Mental status changes • Hypotension / hypertension • Hypothermia / hyperthermia • Decreased respiratory rate • Tachycardia, other dysrhythmias • Seizures 	<ul style="list-style-type: none"> • Tricyclic anti-depressants (TCAs) • Acetaminophen (Tylenol) • Depressants • Stimulants • Anticholinergic • Cardiac medications • Solvents, alcohols, Cleaning agents • Insecticides

	EMR	EMT	A	I	P
1. Obtain general patient assessment.	•	•	•	•	•
2. Administer Oxygen to maintain <u>SPO₂</u> 94 - 99%	•	•	•	•	•
3. Suction oropharynx as necessary.	•	•	•	•	•
4. Obtain blood glucose sample. If glucose is < 60 mg / dL or > 300 mg / dL, refer to the <u>Hypoglycemia or Hyperglycemia Protocol</u> .	•	•	•	•	•
5. If necessary, refer to <u>Patient Restraint protocol</u> .	•	•	•	•	•
6. Place patient on cardiac monitor.				•	•
7. Establish IV of Normal Saline. Titrate rate to maintain systolic BP > 90 mmHg.			•	•	•
8. If respiratory effort remains diminished and opiate administration is suspected, give <u>NARCAN</u> INTRANASAL 2mg (one vial) to maintain an adequate respiratory effort. *Dose may be repeated as necessary.		•	•	•	•

Protocol

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Continued

OPIATE OVERDOSE

	EMR	EMT	A	I	P
a. If respiratory effort remains diminished and opiate administration is suspected, give <u>NARCAN</u> 0.4 - 2.0 mg slow IVP/IM (<i>ALS levels only</i>) to maintain an adequate respiratory effort. Dose may be repeated as necessary.			•	•	•
9. Transport promptly in position of comfort. Reassess VS as indicated.		•	•	•	•

Opiate Toxidrome

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| <ul style="list-style-type: none"> • Altered Mental Status • Miosis • Unresponsiveness • Shallow Respirations | <ul style="list-style-type: none"> • Slow Respiratory Rate • Decreased Bowel Sounds • Hypothermia • Hypotension |
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PEARLS:

1. If patient is a suspected opiate addict, the administration of Naloxone should be titrated to increase respirations to normal levels without fully awakening patient to prevent hostile and confrontational episodes and withdrawal symptoms.
2. Any patient receiving Naloxone should be transported for continued monitoring. Many opiates have a longer bioavailability than Naloxone, therefore re-sedation may occur.
3. Do not rely on patient history of ingestion, especially in suicide attempts.
4. The administration of Naloxone should be titrated to increase respirations to normal levels without fully awakening patient to prevent hostile and confrontational episodes and withdrawal symptoms.
5. Any patient receiving Naloxone should be transported for continued monitoring. Some opiates may have a longer bioavailability than Naloxone, therefore re-sedation may occur.
6. Some opiates may require significant Naloxone dosing.
7. Do not rely completely on patient history of ingestion (route, dose, substance), especially in suicide attempts.
8. Providers who may encounter fentanyl or fentanyl analogs should be trained to recognize the symptoms and objective signs of opioid intoxication, have naloxone readily available, and trained to administer naloxone.
9. For opioid toxicity to occur the drug must enter the blood and brain from the environment. Toxicity cannot occur from simply being in proximity to the drug.
10. Toxicity may occur in canines utilized to detect drug. The risks are not equivalent to those in humans given the distinct contact that dogs, and not humans, have with the local environment.
11. Nitrile gloves provide sufficient protection against dermal absorption. In situations where an enclosed space is heavily contaminated with a potential highly potent opioid, water resistant coveralls should be worn.
12. Incidental dermal exposures should immediately be washed with copious amounts of water.
13. Alcohol based hand sanitizers should not be used for decontamination as they do not wash opioids off the skin and may increase dermal drug absorption.
14. In the unusual circumstance of significant airborne suspension of powdered opioids, a properly fitted N95 respirator is likely to provide reasonable respiratory protection.
15. OSHA-approved protection for eyes and face should be used during tasks where there exists possibility of splash to the face.