



**Toxins & Environmental
OPIOID OVERDOSE
Practice Guideline**

Patient Care Goals
 1. Rapid recognition and intervention of a clinically significant opioid poisoning or overdose
 2. Prevention of respiratory and/or cardiac arrest

Patient Presentation:
Inclusion Criteria
 Patients of all age groups with access to opioids and known or suspected opioid use or abuse
 Altered consciousness
 Inadequate respirations

Patient Management:
 Naloxone 0.5 mg IV, IM
 Naloxone 1.0 mg IN
 Max single dose 1.0 mg; titrated q 3 minutes until respiratory depression improves, not necessarily consciousness.
 No upper limit of naloxone
 Ondansetron
 ODT: 15-30kg: 4 mg
 >30kg: 8 mg
 IV/IO: 0.1 mg/kg MAX 4 mg

Patient Safety Considerations:
 Ventilation is crucial. Support depressed respirations with BVM/O2
 NOT INDICATED IN CARDIAC ARREST REGARDLESS OF PRESENTING RHYTHM
 Non-invasive capnography may aid in early detection of hypoventilation and can be used in decision-making for subsequent naloxone dosing
 Patient at risk for agitation or violence after opioid reversal
 Patient at risk for opioid withdrawal, vomiting or aspiration after naloxone
 Routine use of lights and sirens is not recommended during transport unless severe or refractory to EMS interventions
 Naloxone effects may be temporary—encourage transport to hospital
 Pts in custody of law enforcement should be transported by EMS (not LE vehicle)

*****Consider Narcan Leave Behind Operational Policy*****

Quality Improvement:
 Key Documentation Elements
 1. Airway management
 2. GCS monitoring
 3. Glucose level
 4. Narcan prior to EMS arrival (law enforcement, citizen, etc)
 5. Medical decision-making for turndown to BLS transport
 6. Criteria for refusal: Elements of refusal/transport checklist should be documented and signed by patient or their guardian.

*Complete HIDTA OD Map Entry

