Mountain Counties
EMERGENCY MEDICAL SERVICES AGENCY

POLICIES AND PROCEDURES

POLICY: 554.54
TITLE: Overdose

EFFECTIVE: ~~02/01/2026~~DRAFT
REVIEW: ~~02/2028~~DRAFT
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

OVERDOSE

I. AUTHORITY
Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9

II. PURPOSE
To serve as a patient treatment standard for EMRs, EMTs, AEMT~~'~~s, and Paramedics within their scope of practice.

III. PROTOCOL
Provider Key: F = First Responder/EMR E = EMT O = EMT Local Optional SOP
P = Paramedic A=Advanced EMT D = Base Hospital Physician Order Required

NOTE: DO NOT INDUCE VOMITING

	F	E	O	A	P	D
ASSESSMENT: look for serious signs and symptoms related to bradycardia or myocardial depression: systolic BP < 90, coronary type pain/discomfort, respiratory distress, pulmonary congestion, circulatory shock, CNS depression, ALOC. Critical patients are hypotensive and bradycardic.	X	X	X	X	X	
PULSE OXIMETRY: apply and monitor.		X	X	X	X	
CAPNOGRAPHY: apply and monitor.					X	
OXYGEN: if pulse oximetry < 94% or signs of hypoperfusion or respiratory distress.	X	X	X	X	X	
† ADVANCED BLS AIRWAY: if GCS is < 8 and not rapidly improving, consider SGA.			X	X	X	
† ADVANCED ALS AIRWAY: if GCS is < 8 and not rapidly improving, consider ETI.					X	
ECG MONITOR: lead placement may be delegated. Treat as indicated.					X	
***VASCULAR ACCESS:** P - IV/IO, AEMT - IV only, rate as indicated.				X	X	
NASOGASTRIC TUBE: suction gastric contents only if patient is intubated and oral ingestion has occurred within 60 minutes.					X	
CONSIDER ACTIVATED CHARCOAL: 1 g/kg po if GCS is 15 or via NG tube if patient is intubated and oral ingestion has occurred within 60 minutes.				X	X	
TEST FOR GLUCOSE		X	X	X	X	
ORAL GLUCOSE: consider administering oral glucose to patients who are awake and have an intact gag reflex.	X	X	X	X	X	
D10: infuse 100 mL IV/IO if blood glucose < 70 mg/dL. Recheck blood glucose 10 minutes post infusion. If blood glucose < 70 mg/dL infuse remaining 150 mL.				X	X	
GLUCAGON: If no IV/IO access and unable to tolerate oral glucose, give 1 mg				X	X	

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IM if blood glucose < 70mg/dL. Recheck blood glucose 10 minutes post injection. If blood glucose remains < 70 gm/dL, repeat 1 mg IM.						
BETA BLOCKERS	F	E	O	A	P	D
ATROPINE: 0.5 mg increments slow IVP or 2 mg IM or 4mg ET. Repeat every 3-5 minutes as needed. Maximum total dose of 3 mg.					X	
TRANSCUTANEOUS CARDIAC PACING: AP pad placement. ~~Place pacing pads on the Anterior/Posterior of thorax if possible.~~ If patient remains hemodynamically unstable with serious signs & symptoms, DO NOT delay TCP waiting for vascular access or for atropine to take effect.					X	
PAIN MANAGEMENT: • **FENTANYL**: 1 – 2 mcg/kg IV/IO/IM/IN. If initial dose given IV/IO/IN, may repeat in 5 minutes, or if initial dose given IM may repeat in 10 minutes. Repeat doses at 0.5 mcg/kg. Maximum total 3 mcg/kg. • **MIDAZOLAM:** 0.5 – 1 mg increments IV/IO/IM/IN titrated to patient's pain or spasm up to 2 mg. Hold for SBP < 100.					X	
CALCIUM CHANNEL BLOCKER						
CALCIUM CHLORIDE: 100 mg IV push over 2 minutes if systolic BP < 90 and HR < 60. Repeat doses of 100-200 mg IV over 2-4 minutes, if hypotension and bradycardia persist.					X	
ATROPINE: 0.5 mg increments slow IVP or 2 mg IM or 4mg ET. Repeat every 3 - 5 minutes as needed. Maximum total dose of 3 mg.					X	
TRICYCLIC ANTIDEPRESSANTS						
SODIUM BICARBONATE • 1 mEq/kg slow IV push for cardiac dysrhythmia or QRS complex wider than 0.10 second. Repeat as indicated until QRS ≤ 0.10 seconds. **OR** • Infusion**:** Mix 100 mEq in1000 mL NS. Start at 150 gtt/min (mL/hr), titrate up for cardiac dysrhythmia or QRS complex wider than 0.10 sec.					X	
****MIDAZOLAM FOR SEIZURE:** Do not delay for IV/IO access. Closely monitor respirations/airway and support ventilation as indicated. • IM – 10 mg. May repeat x 1 if seizure continues > 5 minutes. • IN – 10 mg. May repeat x 1 if seizure continues > 5 minutes. • IV/IO - 1-2 mg every 2 minutes until seizure stops or max 10 mg.					X	
OPIOID						
VENTILATE: With oxygen and BVM if hypoventilation, goal ≥ 94%.	X	X	X	X	X	
NALOXONE: one spray pre-packaged IN (typically 2 – 4 mg) for respiratory depression. If opioid overdose is suspected, may repeat every 2-3 minutes in alternating nostrils, to a total of 12 mg. Consider alternate cause of obtundation/respiratory depression if ineffective.		X	X	X	X	
NALOXONE: 0.4-2 mg IN/IV/IO/IM; may repeat every 2–3 minutes to a total of 12 mg. If IN, may repeat every 2-3 minutes in alternating nostrils, to a total of 12 mg.				X	X	
ALL HYPOTENSION						
PUSH DOSE EPINEPHRINE: for hypotension – titrate to SBP ≥ 90 • Mix 1 mL of Epi 1:10,000 (0.1 mg/mL) with 9 mL of NS = concentration of 1:100,000 (0.01 mg/mL) • Label syringe "epinephrine 10 mcg/mL" • 0.5 – 1 mL (5 – 10 mcg) IVP every 1 – 5 minutes If SBP does not stabilize ≥ 90 after two doses, consider epinephrine drip. Refer to 554.88 RX GUIDELINES.					X	

***Administer fluid boluses with caution due to the high incidence of pulmonary edema in tricyclic overdose patients.**

****Most tricyclic overdose seizures are short in duration and do not require midazolam.**

† Maximize naloxone doses prior to attempting advanced airway placement, if narcotic overdose is suspected.