

Just In Time Standing Order June, 2017

Due to recent additions and questions particularly relating to opiate overdose, this JITSO is being issued to address multiple topics.

Naloxone; Adult and Pediatric

Background: the current opiate crisis requires changes in how we approach these patients. We are experiencing wide variability in the dose of naloxone required to resolve respiratory depression. There have been questions as to why opiate overdose patients not responding to typical doses of naloxone are not intubated and ventilated versus providing high dose of naloxone. It is felt that such a strategy would overload our critical care resources. If patients are responding to naloxone and it is available, dosing to affect continues to be the strategy that is in the best interest of the community.

Upper limit of dosing: maximum dosing limits as well as limits on repeat dosing are removed. Consider increasing the initial IN dose to 4 mg if response to 2 mg is infrequent in your community. Continue to titrate according to patient condition and avoid precipitating withdrawal. Consider other causes of altered mental status such as hypoglycemia, head trauma, sepsis, and stroke, and employ appropriate airway and ventilatory management techniques. In the interest of resource management for communities, this JITSO should not be interrupted as to require or recommend additional equipment or personnel be called to the scene beyond what would ordinarily be dispatched only to provide additional naloxone. Individual agency policies will vary based, in part, upon staffing, response configurations, and transport times.

Dosing interval: when given IV, the onset of action is 1 to 2 minutes. Consider repeat IV dosing after this interval if no or inadequate (poor respiratory effort, hypoxemia, hypertension) response is noted. When utilizing the IN route, onset of action is felt to be within 2 to 3 minutes when using a 4 mg initial dose. After this interval, if there is no or inadequate (poor respiratory effort, hypoxemia, hypotension) administer additional naloxone by IV if available, IM IN, or IO as a last option.

Ondansetron (Zofran) is NOT to be given prophylactically with naloxone.

CARDIAC ARREST in Opiate OD: naloxone is NOT proven effective in the reversal of cardiac arrest from opiate overdose though information is limited. Standard dosing would be reasonable; however, quality CPR, defibrillation, airway control, ventilation, routine arrest medications are still the mainstays of treatment. Narcan should NOT be given prior to epinephrine particularly in pediatric arrests. In addition, administration during cardiac arrest should be IV or humeral IO and not IN. Post resuscitation hypotension should be treated as per current standing orders.

Solu-medrol

Solu-Medrol (methylprednisolone) is intended to augment standard therapy for anaphylaxis, allergic reaction, and to address airway edema and inflammation in asthma. No significant change in patient condition in the field should be expected from the administration of Solu-Medrol. This medication is intended for cases that are of a more urgent nature. A general guideline would be not to initiate an IV only to administer this medication when patient condition otherwise does not warrant an IV start. There is definite, time dependent benefit to solu-medrol making field administration of significant value.

Epinephrine for Anaphylaxis and Allergic Reaction

Epinephrine is the mainstay of anaphylaxis and allergic reaction treatment. Diphenhydramine alone is not appropriate. Epinephrine is particularly important in cases of any airway edema, hypotension, or when multiple body systems are involved. The term "severe" lacks definition will be removed from the protocol. Advanced Age is not a contraindication to epinephrine.

Nitroglycerin and Aspirin in Chest Pain

No significant change in patient condition in the field should be expected from the administration of aspirin. The treatment of active chest pain in appropriate patients should include both nitroglycerin (after 12 lead EKG) and aspirin. There is definite, time dependent benefit to aspirin making field administration of significant value.

Repeated AICD Activations

A patient experiencing repeated AICD (automatic implantable cardioverter-defibrillator) activations should receive midazolam under the same standing order as if EMS was preparing to cardiovert. Analgesia with fentanyl may also be appropriate. Be prepared to manually cardiovert or defibrillate in the event of AICD failure. Consult Medical Control.

Calcium and Sodium Bicarbonate in Dialysis Patients

Dialysis patients who are bradycardic or experience cardiac arrest should be given both calcium (chloride or gluconate) and sodium bicarbonate. Flush well between these medications.

12 lead EKG and Cardiac Arrest

A 12 lead EKG only needs be obtained in the context of cardiac arrest after return of spontaneous circulation (ROSC).

Blood Borne Pathogen Exposure Protocol

A regional exposure protocol will soon be in its final form. This will establish standardized baseline laboratory values to be drawn on the exposed provider as well as the source patient. This should include Hep C and/or HIV viral load determinations when the source patient is positive.