

You are dispatched for an unconscious male patient. Upon your arrival, the patient is found in an upstairs bedroom in respiratory arrest. While you confirm that the patient has a pulse and hook up the cardiac monitor, your partner inserts an OPA, which is accepted, and initiates ventilations via BVM. A woman on scene tells you that they had been, “shooting up” and had fallen asleep. When she woke up, the patient was making strange noises and was turning blue so she called 911. She also tells you that she did not think that the Narcan kit that she was given from the clinic would help him ([Opioid Overdose Prevention Kits](#)). His vital signs include: HR – 48bpm, RR – 0/min, assisted with BVM with good chest rise and good compliance, BP – unobtainable, GCS – 3, Pupils are both 2 and non-reactive, Sinus bradycardia, BGL – 5.7mmol/L. You will have to extricate the patient down a narrow, winding staircase making it difficult to ventilate the patient adequately.

Which medical directive should you consider applying in this circumstance?

If you answered, Opioid Toxicity Medical Directive, you are correct. (refer to page 81 of PCP and page 112 of ACP CPER Medical Directives pocketbook or at [CPER website](#)). In a normal situation and extrication, it is safer for the provider to ventilate the patient and transport. As the patient is unconscious, in respiratory arrest, with suspicion of an opioid overdose, and there is an inability to adequately ventilate the patient during the difficult extrication, you contact BHP for consideration of naloxone administration.

The BHP understands your situation and orders 0.8mg SC (refer to pages 13 and 24 of the companion document which discusses the order of preference and potential reasons for alternate administration routes at [Ontario Base Hospital Group](#). You complete your “5 Rights” of medication administration with your partner and administer naloxone 0.8mg SC in the right arm.

Approximately 6-8 minutes after administration of naloxone, the patient begins to take breaths unassisted and his GCS improves to 14. His vital signs: HR – 110bpm, full and regular, RR – 14, full and regular, BP – 100/60, SPO2 – 99% with NRB @15Lpm. He is cooperative and you extricate him down the stairs on the stairchair. You continue to have the patient on an NRB and the cardiac monitor during extrication and enroute to hospital to assess his respiratory effort as this patient’s condition could change as the naloxone wears off. Beware of adverse effects at [Annals of Emergency Medicine Journal](#).

What if the female had administered the naloxone to the patient that was provided to her by the clinic? With the same patient presentation, would you administer another dose? Would you discuss this with the BHP? If you answered yes, you are correct. The preamble of the ALS PCS states, “The number of recommended medication doses may be administered regardless of any previous self-administration,” (refer to page 13 of CPER Medical Directives pocketbook). It is important to discuss this prior administration with the BHP. Remember iSBAR (Annual Practice Review 2015/2016)? The information about previous administration of naloxone by a bystander would fit under the (B) for background and could be repeated in (R) response to treatment.

What if this patient was VSA and in asystole? Would it be appropriate to administer naloxone as part of the cardiac arrest? If you answered no, you are correct. Naloxone would not restore a pulse. If the patient was in a PEA with a narrow complex sinus rhythm, it is possible that a pulse may not be detectable but is actually there. In this case, naloxone may be effective.