Protocol
R-01

SECTION: R-01

PROTOCOL TITLE: Toxicological Emergencies

REVISED: November 1, 2017

TOXICOLOGICAL EMERGENCIES

GENERAL COMMENTS: This is a general protocol for non-specific toxicological emergencies, including altered LOC of unclear origin.

When possible this protocol should supplement other, more specific protocols. Care should be used to rule out more specific causes, such as closed head injury, CVA, sepsis, and diabetic emergencies.

BLS SPECIFIC CARE:

- Scene safety:
  - Insure law enforcement is on scene for traditional overdoses
  - Wear appropriate PPE including respiratory and topical skin protection
  - Request HAZMAT for suspected toxic exposure, such as meth labs, chemical mishaps, and topical poisons
- Basic BLS assessments and V/S every 15 minutes unless unstable, then reassess and V/S every 5 minutes
- Assess a Blood Glucose. Treat as appropriate. See *Adult Hypoglycemia Protocol (M-06)*
- All toxicological emergencies should receive ALS evaluation.
- Patients with respiratory complaint or abnormality should receive supplemental oxygen, regardless of oxygen saturation. Assist ventilations as needed
- Restraints may be used for patient and/or rescuer safety. See the *Behavioral Emergencies and Combative Patients Protocol (M-14).*
- Monitor temperature

AEMT/O.M. Specific Care:

Vascular Access

- IV access (to a max of 3 attempts) or IO access if needed due to severity of underlying injury or illness, otherwise consider deferring until arrival of ALS providers
  - IV: Crystalloid solution at a TKO rate. May administer 200-500 ml if S/S of dehydration are present, repeat as needed to a maximum of 2 liters
  - Withhold fluids and maintain IV at TKO rate if patient is hemo-dynamically stable or signs and symptoms of fluid overload are present

Respiratory Support (if appropriate and available)

- *Consider* Assisted/Intermittent Positive Pressure Ventilation
- *Consider* Placement of SGA

ALS SPECIFIC CARE:

- *Airway Management:* Secure the airway using means best determined by good clinical decision making.
  - See " *Appendix 6: Medication Assisted Intubation" for* guidelines for current and anticipated clinical needs
- Assess and identify causes of complaints, treat as needed
- All potential overdose patients should have basic ECG assessment done
- Follow appropriate seizure protocol for seizure activity
- Restraints and /or sedation may be used for patient and/or rescuer safety. See the *Behavioral Emergencies and Combative Patients Protocol (M-14).*

PHYSICIAN PEARLS:

Many of these patients will have multiple underlying pathologies, which will pose many challenges to overcome. Patient care should be focused on recognition of risks, preventing/mitigating hyperthermia, agitated delirium, positional asphyxia, hypoxia, and physical self-harm. Provider safety is of primary importance, injuries are decreased with prudent planning and police involvement.

Comment on agents used in sedation:

- Consider using lower initial doses of sedatives when alcohol is involved

ALS Providers may decrease the dosage, or prolong the administration intervals of any medication with sedative properties when doing so would decrease adverse effects and still likely obtain the clinical goal.

It is important to rule out other causes for altered mental status. This particularly includes, but is not limited to:

- Hypoglycemia
- Stroke
- Medication error
- Closed head injury from falls or other causes.
- Sepsis