

CODE RECOVER

Overdose Resuscitation + Post-Overdose Care — Quick Reference

Overdose Resuscitation & Naloxone



- **Goal:** restore adequate ventilation — not full arousal.
- **“Low and slow”:** 0.04–0.1mg IV, titrate to adequate ventilation. Somnolent but ventilating adequately? May not need naloxone at all — observe instead.
- **Respiratory arrest:** naloxone without delay, 0.4–2mg initial dose.
- **“Naloxone gap”:** opioid half-life may outlast naloxone’s — risk of re-sedation, especially with long-acting formulations or large ingestions.
- **HOOR Rule** — safe to discharge 1 hour post-naloxone if all six met:
Ambulates normally · SpO₂ > 95% RA · RR 10–20 · Temp 35.0–37.5°C · HR 50–100 · GCS 15
→ **HOOR criteria = medical readiness only.** Requires peer connection + dispensed naloxone kit before discharge.

Post-Overdose Care



- The first hour post-reversal is high-risk, high-opportunity — optimal window for peer introduction (patients most receptive right after reversal).
- **Watch for:** precipitated withdrawal, pulmonary complications, secondary “stacking” overdose as naloxone wears off
- **Mortality after non-fatal overdose:** 0.25% (2 days) · 1.1% (1 month) · 5.5% (1 year)
→ standard of care to initiate/offer MOUD
- **Documentation:** mental status, room-air O₂ sat, ambulation
- **Discharge bundle:** overdose prevention education + peer handoff + bridge MOUD prescription

Fentanyl & multi-substance:



- **Fentanyl:** 50–100x morphine potency, rapid onset — may need multiple naloxone doses
- **Xylazine** doesn’t respond to naloxone; causes necrotic skin ulcers + prolonged sedation. Incomplete naloxone response ≠ “resistant fentanyl” — consider xylazine/other adulterant.