Seed GLOBAL HEALTH

Project ECHO

Sedative/Hypnotic/Opioid Toxidromes – Nursing Care

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Introduction

The Nursing Care Plan focuses on;

- Recognizing the toxidromes
- Stabilizing airway, breathing, and circulation
- Administering specific antidotes or reversal agents as needed
- Symptom management
- Closely monitoring the patient’s cardiac rhythm and vital signs

Assessment

- Monitor vitals – RR, HR, BP, Temp, SPO2 and LOC, cardiac rhythm
- Assess airway status – breathing pattern, airway obstruction, respiratory effort, secretions
- Evaluate Neurological status – LOC/GCS, pupillary response, mental status, orientation
- Monitor for complications – aspiration, trauma, organ dysfunction, withdrawal symptoms, seizure activity
- Review risk factors – h/o substance use, psychiatric hx, social support system

Subjective Data

- Chest pain
- DIB
- Nausea or vomiting
- Confusion
- Anxiety or agitation
- Dizziness
- Physical discomfort

Objective Data

- Altered mental status - drowsiness, confusion, coma, lethargy to unresponsiveness
- Respiratory depression
- Changes in vital signs – Bradycardia <60 bpm, Hypotension SBP <90 mmHg, Bradypnea (RR <12 breaths/min), Hypothermia (Temp < 35°C)
- Pupil changes (pinpoint or dilated)
- Loss of consciousness
- Skin color changes - cyanosis
- Cardiac arrhythmias
- Decreased bowel sounds
- Slurred speech, ataxia

Nursing Diagnoses

- Ineffective Breathing Pattern
- Risk for Decreased Cardiac Output
- Impaired Gas Exchange
- Risk for Injury
- Deficient Knowledge

Assessment	Nursing Diagnosis	Goal/Desired Outcome	Intervention	Rationale
Bradypnea	Ineffective Breathing pattern RT CNS depression secondary to drug overdose AEB decreased respiratory rate and oxygen saturation.	The patient will maintain respiratory rate within normal limits	Monitor respiratory rate and depth	Identifies the need for immediate intervention
		The patient will maintain a patent airway	Position patient for optimal breathing	Maintains airway patency
		The patient will demonstrate improved oxygen saturation	Administer oxygen as ordered	Improves oxygenation

Assessment	Nursing Diagnosis	Goal/Desired Outcome	Intervention	Rationale
Bradycardia Hypotension Arrhythmias	Decreased Cardiac Output RT effects of drug toxicity AEB irregular heart rate and blood pressure changes..	The patient will maintain a stable cardiac rhythm	Monitor cardiac rhythm continuously	Detects life-threatening arrhythmias
		The patient will demonstrate adequate perfusion	Maintain IV access	Ensures route for emergency medications
		The patient will maintain stable blood pressure	Document vital signs frequently	Tracks cardiovascular status

Assessment	Nursing Diagnosis	Goal/Desired Outcome	Intervention	Rationale
Shallow or irregular breathing Cyanosis Reduced LOC	Impaired Gas Exchange RT respiratory depression AEB decreased oxygen saturation and altered mental status.	The patient will maintain oxygen saturation >95%	Monitor oxygen saturation continuously	Detects deterioration early
		The patient will demonstrate clear breath sounds	Suction airway as needed	Maintains airway clearance
		The patient will show improved mental status	Prepare for intubation if necessary	Ensures readiness for respiratory failure

Assessment	Nursing Diagnosis	Goal/Desired Outcome	Intervention	Rationale
Drowsiness Confusion	Risk for Injury RT altered mental status and impaired physical mobility AEB confusion and unsteady gait.	The patient will remain free from injury	Implement safety precautions	Prevents falls and injury
		The patient will demonstrate improved coordination	Monitor neurological status	Tracks mental status changes
		The patient will maintain a safe environment	Provide constant observation	Ensures immediate response to deterioration

Evaluation

- **Continuous Monitoring -** Vital signs (HR, BP, RR, SpO2, Temp), ECG, LOC, pupil size and reactivity
- **Frequent Neurological Assessments -** Evaluate for changes in mental status, seizures, or focal deficits
- **Labs -** ABG to assess oxygenation and ventilation, Electrolytes, BUN, creatinine, liver function tests, and toxicology screen to assess organ function
- **Urine output -** Insert foley catheter, Monitor for rhabdomyolysis or kidney damage

References

- Ackley, B. J., Ladwig, G. B., Makic, M. B., Martinez-Kratz, M. R., & Zanotti, M. (2023). Nursing diagnoses handbook: An evidence-based guide to planning care. St. Louis, MO: Elsevier.
- https://nursestudy.net/drug-overdose-nursing-diagnosis/

Thank you