## Summary of Changes
### 2020 Field Treatment Guidelines

<table>
<thead>
<tr>
<th>Treatment Guideline Number</th>
<th>Treatment Guideline Name</th>
<th>Change(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A02</td>
<td>Adult Airway</td>
<td>Changes to guideline</td>
</tr>
<tr>
<td></td>
<td></td>
<td>o Definition of intubation attempt – An intubation attempt is defined as inserting the laryngoscope blade with the intent to intubate or inserting an advanced airway passed the teeth</td>
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<tr>
<td></td>
<td></td>
<td>o Remove PEARL “This Treatment Guideline is only for use with patients &gt;15 years of age.” It is the Adult Airway protocol</td>
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<tr>
<td></td>
<td></td>
<td>o King Airway Removed</td>
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<td></td>
<td></td>
<td>o Addition of i-Gel</td>
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<td></td>
<td></td>
<td>o Optional Scope EMT’s may only use i-Gel in Adults defined as 15 y.o. or greater</td>
</tr>
<tr>
<td>A03</td>
<td>Adult Behavioral</td>
<td>Changed “Establish IV” to “Consider IV”. Risk to establishing an IV on combative patient, removal upon arrival to PES, risk of infection</td>
</tr>
<tr>
<td>A4</td>
<td>Allergic Reaction</td>
<td>Added Epi Auto Injector for administration by EMTs</td>
</tr>
<tr>
<td>A9</td>
<td>Dyspnea (Excluding CHF)</td>
<td>Considerable reworking of Field Treatment Guideline</td>
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<tr>
<td></td>
<td></td>
<td>o Combined A09 and AC09 – CHF to create treatment guideline A09 – Shortness of Breath</td>
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<tr>
<td></td>
<td></td>
<td>o Uses lung sounds and assessment to determine which treatment pathway to take</td>
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<tr>
<td></td>
<td></td>
<td>o New Field Treatment Guideline: <strong>A09 – Shortness of Breath</strong></td>
</tr>
<tr>
<td>A13</td>
<td>Overdose</td>
<td>Added Naloxone administration by EMT</td>
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<tr>
<td></td>
<td></td>
<td>Added range to IN dose of Naloxone 2-4mg for Paramedic and EMT</td>
</tr>
<tr>
<td>A14</td>
<td>Adult Pain Control</td>
<td>Addition of Ketamine and IV Acetaminophen</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mild pain arm removed. BLS measures such as splinting, ice, position of comfort should be attempted first for mild pain, patients in minimal distress</td>
</tr>
<tr>
<td>A18</td>
<td>Stroke</td>
<td>Expanded Stroke alert from 4 to 6 hours of time last known well/last seen normal</td>
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<tr>
<td></td>
<td></td>
<td>Patients between 6-24 hours will transported to Primary Stroke Centers</td>
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<tr>
<td></td>
<td></td>
<td>Patients over 24 hours, please follow Policy 4002 – Patient Destination</td>
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<tr>
<td></td>
<td></td>
<td>Added Stanford – Valley Care as an out-of-county receiving center</td>
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<tr>
<td>AC09</td>
<td>CHF/Pulmonary Edema</td>
<td>Field treatment guideline removed</td>
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<tr>
<td></td>
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<td>Integrated into A09</td>
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<tr>
<td>P01</td>
<td>Pediatric Airway</td>
<td>o Added “Direct Laryngoscopy” under Complete Obstruction</td>
</tr>
<tr>
<td></td>
<td></td>
<td>o Added definition of intubation attempt – same as Adult</td>
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<tr>
<td></td>
<td></td>
<td>o Please note!!!! I-Gel’s will not be used in children less than 40kg</td>
</tr>
<tr>
<td>P02</td>
<td>Pediatric Allergic Reaction</td>
<td>o Added Epinephrine Auto injector for EMT</td>
</tr>
<tr>
<td>P09</td>
<td>Pediatric Overdose/Toxicology</td>
<td>o Changed to 2-4mg Narcan IN for patients greater than 22kg (50lbs)</td>
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<tr>
<td></td>
<td></td>
<td>o Removed PediaTape for EMT use.</td>
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<tr>
<td></td>
<td></td>
<td>o Paramedics continue to use PediaTape</td>
</tr>
<tr>
<td>T03</td>
<td>Burns</td>
<td>o Removed PEARL “Contact Base for Burn Bed Availability”</td>
</tr>
<tr>
<td>G03, AC08, I01</td>
<td>End of Life Care Cardiac – Chest Pain: Suspected</td>
<td>o Ketamine should not be administered in this patient population. Fentanyl continues to be only appropriate medication</td>
</tr>
<tr>
<td></td>
<td>cardiac or STEMI Interfacility Transfer of STEMI</td>
<td></td>
</tr>
<tr>
<td>FP06</td>
<td>Airway: King Airway</td>
<td>o Changed name to Airway: Supraglottic Airway</td>
</tr>
<tr>
<td></td>
<td></td>
<td>o Outlines use of iGel</td>
</tr>
<tr>
<td>FP24</td>
<td>Pediatric Medication Administration</td>
<td>o Brought this one back to outline a procedure for administering medications to pediatric patients</td>
</tr>
<tr>
<td>FP25</td>
<td>Fingerstick Blood Glucose Analysis</td>
<td>o Created a procedure for FSBS. Now in EMT scope of practice with approved training</td>
</tr>
<tr>
<td>FP26</td>
<td>EMT Epinephrine Administration</td>
<td>o Created a procedure for Epi admin for EMTs. Now in EMT scope of practice with approved training</td>
</tr>
<tr>
<td>FP27</td>
<td>EMT Naloxone Administration</td>
<td>o Created a procedure for Naloxone Administration for EMTs. Now in EMT scope of practice with approved training</td>
</tr>
<tr>
<td>Multiple</td>
<td>Throughout the manual</td>
<td>o Blood Glucose Analysis by EMTs</td>
</tr>
<tr>
<td>Multiple</td>
<td>Throughout the manual</td>
<td>o For clarification purposes, Base Hospital contact is only as needed and not to be done with every transport to the Base or a receiving hospital</td>
</tr>
</tbody>
</table>

**Notify receiving facility.**
Contact Base Hospital for medical direction, as needed.
Contra Costa County Emergency Medical Services

Adult Airway

Assess respiratory rate, effort, oxygenation
Is airway/breathing adequate?

- Yes
  - Supplement oxygen
    - Goal oxygen saturation ≥ 94%
    - Exit to appropriate TG

- No
  - Basic maneuvers first
    - Open airway chin lift/jaw thrust
    - Nasal or oral airway
    - Bag-valve mask (BVM)
  
  - Spinal motion restriction if indicated

  - No
    - Airway patent?

    - Yes
      - Supplemental oxygen via BVM
      
      - P Monitor continuous EtCO₂

    - No
      - Breathing/oxygenation support required?

        - Yes
          - Supplemental oxygen via BVM
          
          - P Monitor continuous EtCO₂

        - No
          - Complete obstruction?

            - Yes
              - Abdominal thrusts (conscious)
              - Chest compression (unconscious)

            - No
              - Direct laryngoscopy

  
  - The maximum allowed attempts for an advanced airway placement is two (2).

  - If an attempt fails, reassess and approach with a different technique.

- E Reassess airway procedure and adjust if necessary

- D I-Gel, as indicated in cardiac arrest

- O I-Gel or intubation, as indicated

- P Consider, sedation if I-Gel or ETT in place

- Midazolam IV/IO
  - Maximum 5 mg total

- Notify receiving facility.
  - Contact Base Hospital for medical direction, as needed.

Effective Jan. 2020
Always weigh the risks and benefits of endotracheal intubation in the field against transport. All prehospital endotracheal intubations are considered high risk. If ventilation/oxygenation is adequate, transport may be the best and safest option. The most important airway device is the BVM, not the laryngoscope.

Cormack-Lehane Difficult Airway Assessment:

<table>
<thead>
<tr>
<th>Grade I</th>
<th>Grade II</th>
<th>Grade III</th>
<th>Grade IV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete view of glottic opening and surrounding structures</td>
<td>Partial view of the glottic opening</td>
<td>Only the epiglottis is visible</td>
<td>No distinguishable anatomy is visible</td>
</tr>
</tbody>
</table>

**Trauma:** Utilize in-line cervical stabilization during intubation, BLS airway or BVM use. During intubation, the cervical collar front should be open or removed to facilitate translation of the mandible/mouth opening.

**Pearls**
- Continuous capnometry (EtCO₂) is mandatory with all methods of airway management. Document results.
- If an effective airway is being maintained with a BVM and a basic airway adjunct with continuous pulse oximetry values of ≥ 90% or values expected based on pathophysiologic condition with otherwise reassuring vital sign (e.g. pulse oximetry of 85% with otherwise normal vital signs in a post-drowning patient), it is acceptable to continue with basic airway measures rather than placing an advanced airway.
- For the purposes of this TG, a secure airway is achieved when the patient is receiving appropriate oxygenation and ventilation.
- An intubation attempt is defined as inserting the laryngoscope blade with the intent to intubate or inserting an advanced airway past the teeth.
- An appropriate ventilatory rate is one that maintains an EtCO₂ of 35 or greater. Avoid hyperventilation.
- A Bougie is strongly encouraged for all ET intubation attempts.
- Effective use of a BVM is best achieved with two (2) people.
- The airway should be reassessed with each patient move. Document findings and EtCO₂ readings for each.
- Maintain spinal motion restriction for patients with suspected spinal injury.
- Document visualization and grading scale in prehospital record.
- Hyperventilation in deteriorating head trauma should only be done to maintain an EtCO₂ of 30-35.
- It is important to secure the advanced airway well and consider c-collar use (in the absence of trauma) to better maintain advanced airway placement. Manual stabilization of advanced airway should be used during all patient moves/transfers.
**History**
- Situational crisis
- Psychiatric illness/medications
- Injury to self or threats to others
- Medical alert tag
- Substance abuse/overdose
- Diabetes

**Signs and Symptoms**
- Anxiety, agitation or confusion
- Affect change or hallucinations
- Delusional thoughts or bizarre behavior
- Combative or violent
- Expression of suicidal/homicidal thoughts

**Differential**
- Altered mental status
- Alcohol intoxication
- Toxin / substance abuse
- Medication effect/overdose
- Withdrawal symptoms
- Depression
- Bipolar (manic-depressive)
- Schizophrenia
- Anxiety disorders
- Hypoglycemia

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### Excited Delirium Syndrome
Paranoia, disorientation, extremely aggressive or violent, hallucinations, tachycardia, increased strength, hyperthermia, and clearly a danger to self or others

- Midazolam 5mg IM/IN
- May repeat 2.5mg every 5 minutes to effect.
- Maximum 10mg

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### Midazolam 5mg IM/IN or Midazolam 1-3mg IV in 1mg increments
- Age ≥ 65 years of age 1mg IV/IM
- May repeat every 5 minutes to effect.
- Maximum 5mg

---

### Exit to appropriate TG, if indicated
- Altered Mental Status TG
- Overdose/Toxic Ingestion TG
- Head Trauma TG
- Assume patient has medical cause of behavioral change

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### Notify receiving facility.
Contact Base Hospital for medical direction, as needed.

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### Midazolam
Contact Base Hospital Physician for additional order
Excited Delirium Syndrome:
This is a medical emergency. The condition is a combination of delirium, psychomotor agitation, anxiety, hallucinations, speech disturbances, disorientation, violent/bizarre behavior, insensitivity to pain, hyperthermia and increased strength. The condition is life-threatening and is often associated with use of physical control measures, including physical restraints, and tasers. Most commonly seen in male patients with a history of serious mental illness or drug abuse, particularly stimulant drugs such as cocaine, crack cocaine, methamphetamine, amphetamines, bath salts, or similar agents. Alcohol withdrawal or head injury may also contribute to the condition.

Pearls
- Crew/responder safety is the main priority. See Policy 1008 – Managing Assaultive Behavior/Patient Restraint.
- Avoid using benzodiazepines for patients with alcohol intoxication.
- Limit IN administrations to ½ dose in each nare.
- All patients who receive either physical restraint or chemical sedation must be continuously observed by EMS personnel. This includes direct visualization of the patient as well as cardiac and pulse oximetry monitoring.
- Consider all possible medical/trauma causes for behavior (e.g. hypoglycemia, overdose, substance abuse, hypoxia, seizure, head injury, etc.).
- Use caution when considering the use of Midazolam with postictal patients.
- Do not irritate the patient with a prolonged exam. Be thorough but quick.
- Do not overlook the possibility of associated domestic violence or child abuse.
- If patient suspected of excited delirium and suffers cardiac arrest, consider fluid bolus and sodium bicarbonate early.
- Do not position or transport any restrained patient in a way that negatively affects the patient’s respiratory or circulatory status (e.g. hog-tied or prone positions). Do not place backboards, splints or other devices on top of the patient.
- If restrained, the extremities that are restrained will have a circulation check at least every 15 minutes. The first of these checks should occur as soon after placement of the restraints as possible. This shall be documented in the EHR.
Contra Costa County Emergency Medical Services

Allergic Reaction/Anaphylaxis

**History**
- Onset and location
- Insect sting or bite
- Food allergy / exposure
- Medication allergy / exposure
- New clothing, soap or detergent
- Past history of reactions
- Past medical history
- Medication history

**Signs and Symptoms**
- Itching or hives
- Coughing, wheezing or respiratory distress
- Chest or throat restriction
- Difficulty swallowing
- Hypotension or shock
- Edema
- Nausea or vomiting
- Feeling of impending doom

**Differential**
- Urticaria (rash only)
- Anaphylaxis (systemic effect)
- Shock (vascular effect)
- Angioedema (drug induced)
- Aspiration or airway obstruction
- Vasovagal event
- Asthma or COPD
- CHF

---

**Assess symptom severity**

**Systemic**
- Establish IV/IO
- Cardiac monitor
- Airway Procedure if indicated

**Localized**
- Establish IV/IO
- Cardiac monitor
- Monitor and reassess
- Monitor for worsening signs and symptoms

**Airway Procedure if indicated**
- Epinephrine 1:1,000 0.3mg IM (Use 0.15mg for patients > 50 years of age)
- Normal Saline bolus 500ml IV/IO
- Repeat as needed to Max of 1L
- If hypotensive or no improvement, Epinephrine 1:10,000 titrated in 0.1mg increments slow IV/IO Maximum 0.3mg
- Consider, Diphenhydramine 50mg IV/IO/IM
- Consider, 12-Lead ECG

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**Notify receiving facility.**
**Contact Base Hospital for medical direction, as needed.**
Pearls

- Anaphylaxis is an acute and potentially lethal multisystem allergic reaction.
- Epinephrine is the drug of choice and the first drug that should be administered in acute anaphylactic reactions with moderate or severe symptoms. IM Epinephrine should be administered as priority before or during attempts at IV or IO access.
- Anaphylaxis that is unresponsive to initial treatment of IM Epinephrine may require IV Epinephrine administration.
- Allergic reactions may occur with only respiratory and gastrointestinal symptoms and have no rash or skin involvement.
- Angioedema is seen in moderate to severe reactions and is swelling involving the face, lips, or airway structures. This can also be seen in patients taking ACE-inhibitor blood pressure medications such as Prinivil, Zesteril, or Lisinopril; medications typically ending in -il.
- Epinephrine may precipitate cardiac ischemia. The following patients should receive half the adult dose of Epinephrine (0.15mg Epinephrine 1:1,000) for the initial dose and any repeated doses:
  - Patients with a history of coronary artery disease, MI, stents, CHF, cardiac surgery; OR
  - Patients over 50 years of age.
  - EMTs use an EpiPen Junior.
- Adult patient who receive Epinephrine should receive a 12-Lead ECG at some point during their care, but this should NOT delay the administration of Epinephrine.
- All patients with respiratory symptoms must have continuous pulse oximetry and EtCO₂ measurement.
- The shorter the onset of symptoms from contact with an allergen, generally the more severe the reaction.
Contra Costa County Emergency Medical Services

Shortness of Breath

**History**
- Asthma; COPD – chronic bronchitis and emphysema
- Home treatment (e.g. oxygen or nebulizer)
- Medications (e.g. Theophylline, steroids, inhalers, digoxin, lasix, Viagra, Sildenafil, levitra, vardenafil, cialis, or tadalafil)
- Toxic exposure or smoke inhalation
- Cardiac History including MI

**Signs and Symptoms**
- Shortness of breath
- Increased respiratory rate and effort
- Diminished or abnormal lung sounds
- Tachycardia
- Purse lip breathing
- Use of accessory muscles
- Peripheral edema or diaphoresis
- Pink, frothy sputum

**Differential**
- Asthma
- COPD
- Congestive Heart Failure
- Myocardial Infarction
- Aspiration
- Pneumonia
- Pulmonary embolus
- Hyperventilation
- Inhaled toxin

---

**Airway Obstructed?**
- Yes → Exit to A02 - Adult Airway TG
- No → Allergic Reaction/Anaphylaxis?
  - Yes → Exit to A04 – Allergic Reaction/Anaphylaxis TG
  - No → Ventilation Adequate? Oxygenation Adequate?
    - Yes → Lung Sounds
      - Wheezes, Hx of Asthma/COPD
      - Rales, pedal edema, hx of heart disease
    - No → Apply Oxygen maintain goal SpO2 93 to 95%

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**PERI-ARREST OR Severe Distress?** Consider administering Epinephrine 1:1,000 0.3mg IM

**Albuterol nebulizer 5mg** Repeat as needed
Consider CPAP

**Improving?**
- No → If no improvement, consider Epinephrine 1:1,000 0.3mg IM (Use 0.15mg for patients > 50 years of age)

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**BP > 90**
- Nitroglycerin 0.4mg sublingual
  - If systolic BP > 150, double Nitroglycerin to 0.8mg sublingual
  - Repeat every 5 minutes as needed

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**Hypotensive Systolic < 90**
- Remove CPAP
- Consider A12 Hypotension/Shock TG

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**Consider A02 Adult Airway TG**
**Pearls**

- If a patient is in CHF AND the 12 lead indicates STEMI, treat with nitroglycerine as on this treatment guideline. Nitro is withheld if the patient has a STEMI and CHF symptoms are not present.
- Patients receiving epinephrine should receive a 12-Lead ECG at some point in their care in the prehospital setting, but this should NOT delay the administration of Epinephrine.
- Epinephrine may precipitate cardiac ischemia. The following patients should receive half the adult dose of Epinephrine (0.15mg Epinephrine 1:1,000) for the initial dose and any repeated doses:
  1. Patients with a history of coronary artery disease, MI, stents, CHF, cardiac surgery; OR
  2. Patients over 50 years of age and has a heart rate ≥ 150.
- Pulse oximetry and continuous EtCO₂ monitoring is required for all respiratory patients.
- A silent chest in respiratory distress is a pre-respiratory arrest sign.
- CPAP is not a ventilation device. Patients with an inadequate respiratory rate or depth of respiration will need assistance with a BVM.
- Opioids have NOT been shown to improve the outcomes of EMS patients with pulmonary edema. Even though this has historically been a mainstay of EMS treatment, it is no longer routinely recommended.
- Avoid Nitroglycerin in any patient who has used Viagra (Sildenafil) or Levitra (Vardenafil) in the past 24 hours or Cialis (Tadalafil) in the past 36 hours due to potential for severe hypotension.
- Carefully monitor the patient’s level of consciousness, chest pain, and respiratory status with the above interventions.
- If a patient has taken their own nitroglycerin without relief, consider potency of medication. Provider maximum doses do not include patient administered doses.
- Consider MI in all of these patients: Diabetic, geriatric, and female patients often have atypical pain or only generalized complaints.
- Document CPAP application using the CPAP procedure in the EHR. Document the 12-Lead ECG in the EHR as a procedure along with the interpretation.
**History**
- Ingestion or suspected ingestion of a potentially toxic substance
- Substance ingested, route, and quantity
- Time of ingestion
- Reason (suicidal, accidental or criminal)
- Available medications in home
- Past medical history and medications

**Signs and Symptoms**
- Mental status changes
- Hypo or hypertension
- Decreased respiratory rate
- Tachycardia or dysrhythmias
- Seizures
- S.L.U.D.G.E.

**Differential**
- Tricyclic antidepressants (TCAs)
- Acetaminophen (Tylenol)
- Aspirin
- Depressants
- Stimulants
- Anticholinergics
- Cardiac medications
- Solvents, alcohols or cleaning agents
- Insecticides (organophosphates)

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**California Poison Control Center**
(800) 222-1222

**Blood glucose analysis**
- Yes: Exit to Diabetic/Behavioral TGs as indicated
- No:
  - Blood glucose analysis
    - Yes: Exit to Diabetic/Behavioral TGs as indicated
    - No: Exit to Hypotension/Shock TG as indicated

**Adequate respirations (>8) and oxygenation?**
- Yes: 12-Lead ECG
- No:
  - Altered mental status?
    - Yes: Naloxone 2-4 mg IN or Auto Injector
      - Naloxone is titrated to effect of adequate ventilation and oxygenation
      - NOT ADMINISTERED TO RESTORE CONSCIOUSNESS
    - No: Exit to Airway TG as indicated

**Systolic BP < 90**
- Yes: Atropine 1-2 mg IV/IO
  - Repeat every 3-5 minutes until relief of symptoms achieved
  - Calcium Chloride 500mg IV/IO
    - (5ml of 10% solution)
    - For tetany or cardiac arrest
    - Consider Fentanyl 50-200mcg IV
      - Titrated in 25-50mcg increments to pain relief
      - OR
      - Fentanyl 100mcg IN/IM if no IV access
      - May repeat once in 15 minutes
  - Notify receiving facility.
  - Contact Base Hospital for medical direction, as needed.

**Tricyclic Antidepressant OD**
- QRS ≥ 0.12 sec and BP < 90?
  - Yes: Sodium Bicarbonate 1mEq/kg IV/IO
    - Notify receiving facility.
    - Contact Base Hospital for medical direction, as needed.
  - No: Exit to Symptomatic Bradycardia TG as indicated

**Hydrofluoric Acid Exposure**
- Calcium Chloride 500mg IV/IO
  - (5ml of 10% solution)
  - For tetany or cardiac arrest
  - Consider Fentanyl 50-200mcg IV
    - Titrated in 25-50mcg increments to pain relief
    - OR
    - Fentanyl 100mcg IN/IM if no IV access
      - May repeat once in 15 minutes
Pearls

- Overdose or toxic ingestion patients with significant ingestion/exposures should be monitored very closely and aggressively treated as indicated. Do not hesitate to contact the Base Hospital for advice as certain critically ill overdose patients may quickly overwhelm medication supplies. For example, a tricyclic overdose with a wide QRS and altered mental status may need to receive multiple Sodium Bicarbonate boluses until QRS narrowing and clinical improvement; patients with organophosphate toxicity with SLUDGE syndrome may require more Atropine than is usually available on an ambulance.
- Do not rely on patient history of ingestion, especially in suicide attempts. Make sure patient is still not carrying other medications or has any weapons.
- Bring medication bottles, contents, and emesis to the Emergency Department.
- S.L.U.D.G.E.: Salivation, Lacrimation, Urination, Defecation, GI distress, and Emesis
- Tricyclic: 4 major areas of toxicity include decreased mental status, dysrhythmias, seizures, hypotension then coma and death.
- Acetaminophen: Initially normal or with nausea/vomiting. If not detected and treated, causes irreversible liver failure.
- Aspirin: Early sign consist of abdominal pain and vomiting. Tachypnea and altered mental status may occur later. Renal dysfunction, liver failure or cerebral edema among other things can present later.
- Depressants: Decreased heart rate, blood pressure or temperature, decreased respirations, and non-specific pupils.
- Stimulants: Increased heart rate, blood pressure or temperature, dilated pupils, and seizures.
- Anticholinergics: Increased heart rate or temperature, dilated pupils, and mental status changes.
- Cardiac medications: Dysrhythmias and mental status changes.
- Solvents: Nausea, vomiting, coughing, and mental status changes.
- Insecticides: Increased or decreased heart rate, increased secretions, nausea, vomiting, diarrhea, and pinpoint pupils. Consider restraints if necessary for patient’s or personnel’s protection per Restraint Procedure.
- Consider contacting the California Poison Control Center for Guidance.
**History**
- Age
- Location and duration
- Severity (0 – 10 scale)
- Past medical history
- Pregnancy status
- Drug allergies and medications

**Signs and Symptoms**
- Severity (pain scale)
- Quality (e.g. sharp, dull, or stabbing)
- Radiation
- Relation to movement or respiration
- Increased with palpation of area

**Differential**
- Per the specific TG
- Musculoskeletal
- Visceral (abdominal)
- Cardiac
- Pleural/respiratory
- Neurogenic
- Renal (colic)

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**Position of comfort**

**Apply cold pack if applicable**

**Monitor and reassess**

**Consider IV/IO procedure**

**Assess and monitor respiratory status**

**Monitor continuous EtCO₂**

**Apply and monitor cardiac rhythm**

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**Moderate to severe pain**

**Acetaminophen 1g IV/IO infusion over 15 minutes (single dose only)**

Monitor and reassess every 5 minutes following administration

**Fentanyl 25 – 50mcg IV/IO**

titrated in 25 – 50mcg increments to pain relief. Consider 25mcg increments in elderly patients

**Fentanyl 100mcg IN**

If no IV access. May repeat once after 15 minutes

**Fentanyl 50 – 100mcg IM**

If no IV access and IN route not advisable. May repeat once after 15 minutes

**Maximum of 200mcg total**

Monitor and reassess every 5 minutes following administration

**Ketamine IV/IO**

50-69 kg – 15mg
70-89 kg – 20mg
90+ – 30mg

or

Refer to dosing guide

**Maximum of 30mg total**

Administer slowly over 2 minutes

Monitor and reassess every 5 minutes following administration

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**DO NOT ADMINISTER FENTANYL AND KETAMINE TO THE SAME PATIENT.**

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**Notify receiving facility. Contact Base Hospital for medical direction as needed**

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**Fentanyl or Ketamine**

Contact Base Hospital for additional order

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**Effective Jan. 2020**

Contra Costa County Emergency Medical Services

Adult Pain Control

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**Effective Jan. 2016**

Contra Costa County Emergency Medical Services

Adult Pain Control

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**Treatment Guideline A14**

Page 1 of 2
**Pearls**

- **DO NOT ADMINISTER FENTANYL AND KETAMINE TO THE SAME PATIENT.**
- Pain severity (0 – 10 scale) is a vital sign to be recorded before and after all BLS pain control measures and ALS pain medication delivery. Monitor blood pressure and respirations closely as pain control medications may cause hypotension or respiratory distress.
- Patients may display a wide variation of response to opioid pain medication (Fentanyl). Consider the patient’s age, weight, clinical condition, other recent drugs, or alcohol and prior exposure to opiates when determining initial dosing. Minimal doses of opioids may cause respiratory depression in the elderly or those patients who weigh less.
- USE EXTREME CAUTION when administering opioids together with benzodiazepines; this combination results in a deeper level of anesthesia with a significant risk for airway and respiratory compromise.
- For patients who have a tolerance to opioids, non-narcotic therapies may be appropriate until evaluation at the receiving facility.
- Acetaminophen may be administered once in addition to Fentanyl or Ketamine for patients with severe pain.
- Do not administer Acetaminophen to patients with severe liver impairment or active liver disease.
- Contraindications of Fentanyl and Ketamine include:
  - Closed head injury
  - Hypotension (BP < 90)
  - Altered level of consciousness
  - Respiratory failure/worsening status
  - Headache
  - Childbirth/suspected active labor
  - Have Naloxone available to reverse respiratory depression should it occur.
- Burn patients may require higher than usual opioid doses to achieve adequate pain control. IF A PATIENT HAS SUFFERED BURNS THAT REQUIRE TRANSPORT TO A BURN CENTER, THE PATIENT MAY REQUIRE MORE THAN THE MAXIMUM TOTAL DOSE OF FENTANYL OR KETAMINE TO ACHIEVE PAIN CONTROL. CONTACT THE BASE HOSPITAL FOR ADDITIONAL ORDERS.
History
- Previous stroke or TIA
- Previous cardiac or vascular surgery
- Associated diseases (diabetes, hypertension, CAD)
- Atrial fibrillation
- Medications (blood thinners)
- History of trauma

Signs and Symptoms
- Altered mental status
- Weakness or paralysis
- Blindness or other sensory loss
- Aphasia or dysarthria
- Syncope
- Vertigo or dizziness
- Vomiting
- Headache
- Seizure
- Respiratory pattern change
- Hypertension/hypotension

Differential
- See Altered Mental Status
- TIA
- Seizure
- Todd’s paralysis
- Hypoglycemia
- Stroke
  - Thrombotic or embolic (~85%)
  - Hemorrhagic (~15%)
- Tumor
- Trauma
- Dialysis or renal failure

Approved Stroke Receiving Centers
- John Muir – Concord
- John Muir – Walnut Creek
- Kaiser – Antioch
- Kaiser – Richmond
- Kaiser – Walnut Creek
- San Ramon Regional
- Eden – Castro Valley
- Kaiser – Oakland
- Kaiser – Vallejo
- Marin General
- Summit – Oakland
- Sutter – Solano
- Valley Care

Recent signs and symptoms consistent with Stroke

CINCINNATI STROKE SCREEN consistent with acute Stroke?

Time of onset OR last seen normal is < 6 hours

INITIATE TRANSPORT
Keep scene time < 10 minutes
If available, transport a family member or guardian with patient

 Declare a Stroke Alert

Time of onset OR last seen normal is >= 6 hours but <= 24 hours

Establish IV
Consider one 20g or larger IV or saline lock in each AC
Transport to a Stroke Receiving Center

Time of onset OR last seen normal is > 24 hours

Consider IV
Transport per Policy 4002

Approve Receiving Centers
- John Muir – Concord
- John Muir – Walnut Creek
- Kaiser – Antioch
- Kaiser – Richmond
- Kaiser – Walnut Creek
- San Ramon Regional
- Eden – Castro Valley
- Kaiser – Oakland
- Kaiser – Vallejo
- Marin General
- Summit – Oakland
- Sutter – Solano
- Valley Care

Consider other causes
Monitor and reassess

Notify receiving facility. Contact Base Hospital for medical direction, as needed
Pearls

- Acute stroke care is evolving rapidly.
- Time last seen normal: One of the most important items that prehospital providers can obtain, on which all treatment decisions are based. Be very precise in gathering data to establish the time of onset and report as an actual time (i.e. 13:45 NOT “about 45 minutes ago”). Without this information, patients may not be able to receive thrombolytics at the hospital. For patients with “woke up and noticed stroke symptoms,” time starts when the patient was last awake.
- The differential listed on the Altered Mental Status TG should also be considered.
- Be alert for airway problems (difficulty swallowing, vomiting and aspiration).
- Hypoglycemia can present as a LOCALIZED neurologic deficit, especially in the elderly.
- Document the Cincinnati Stroke Screen and LAMS in the EHR.

Contra Costa County Emergency Medical Services

Pediatric Airway

Basic maneuvers first
- Open airway chin lift/jaw thrust
- Nasal or oral airway
- Bag-valve mask (BVM)

Spinal motion restriction
if indicated

Supplement oxygen
Goal oxygen saturation ≥ 94%
Exit to appropriate TG

Airway patent?
Yes

Breathing/oxygenation support required?
Yes

Monitor/reassess supplemental oxygen
If indicated
Exit to appropriate TG

Airway foreign body obstruction procedure
No

Complete obstruction?
Yes

Abdominal thrusts (conscious)
Chest compression (unconscious)

Direct laryngoscopy
No

Transport to closest receiving facility

The maximum allowed attempts for an advanced airway placement is two (2).
If an attempt fails, reassess and approach with a different technique.

Reassess airway procedure and adjust if necessary

For patients > 15 years of age in cardiac arrest
Place i-Gel as appropriate

For patients > 40kg
Intubate with ETT as appropriate or
Place i-Gel, refer to weight-based guide

Consider, sedation if i-Gel or ETT in place

Midazolam IV/IM/IO
Use Pediatape and refer to dosing guide

Notify receiving facility. Contact Base Hospital for medical direction, as needed.
**Pearls**

- Placement of an advanced airway is not a priority during the first five minutes of resuscitation unless ventilation is unable to be maintained with basic maneuvers.
- Endotracheal intubation is only approved for patients over 40kg.
- Capnometry is mandatory with all methods of airway management. Document results.
- Continuous capnometry (EtCO\(_2\)) is mandatory for the monitoring of all respiratory patients.
- If an effective airway is being maintained with a BVM and a basic airway adjunct with continuous pulse oximetry values of ≥ 90% or values expected based on pathophysiologic condition with otherwise reassuring vital sign (e.g. pulse oximetry of 85% with otherwise normal vital signs in a post-drowning patient), it is expected to continue with basic airway measures.
- For the purposes of this TG, a secure airway is achieved when the patient is receiving appropriate oxygenation and ventilation.
- An intubation attempt is defined as inserting the laryngoscope blade with the intent to intubate or inserting advanced airway past the teeth.
- An appropriate ventilatory rate is one that maintains an EtCO\(_2\) of 35 or greater. Avoid hyperventilation.
- Patients with perfusing pulses should be managed with a BLS airway unless unable to successfully ventilate.
- Contraindications for i_Gel:
  - Presence of gag reflex
  - Caustic ingestion
  - Known esophageal disease
  - Laryngectomy with stoma (alternatively place ET in stoma)
- Effective use of a BVM requires two (2) people.
- Airway is a more important intervention in pediatric arrests. This should be accomplished quickly with a BVM and appropriately sized mask. Patient survival is often dependent on proper ventilation and oxygenation.
- Maintain spinal immobilization for patients with suspected spinal injury.
- Hyperventilation in deteriorating head trauma should only be done to maintain an EtCO\(_2\) of 30-35.
- It is important to secure the advanced airway well and consider c-collar (in the absence of trauma) to better maintain advanced airway placement. Manual stabilization of advanced airway should be used during all patient moves/transfers.
Contra Costa County Emergency Medical Services

Pediatric Allergic Reaction/Anaphylaxis

Treatment Guideline P02
Page 1 of 2

Effective Jan. 2020

History
- Onset and location
- Insect sting or bite
- Food allergy / exposure
- Medication allergy / exposure
- New clothing, soap or detergent
- Past history of reactions
- Past medical history
- Medication history

Signs and Symptoms
- Itching or hives
- Coughing, wheezing or respiratory distress
- Chest or throat restriction
- Difficulty swallowing
- Edema
- Hypotension or shock
- Nausea or vomiting
- Feeling of impending doom

Differential
- Urticaria (rash only)
- Anaphylaxis (systemic effect)
- Shock (vascular effect)
- Angioedema (drug induced)
- Aspiration or airway obstruction
- Vasovagal event
- Asthma or COPD
- CHF

Assess symptom severity

Systemic

Administer weight appropriate Epinephrine auto injector or assist patient with their prescribed auto injector

Epinephrine 1:1,000 IM
Use Pediatape and refer to dosing guide

Establish IV/IO
Cardiac monitor
EtCO₂ monitoring

Albuterol nebulizer 5mg
Repeat as needed to Max of 3 doses if indicated

Normal Saline bolus
Use Pediatape and refer to dosing guide

If hypotensive or no improvement, Epinephrine 1:10,000 slow IV/IO
Use Pediatape and refer to dosing guide

Airway Procedure if indicated

Notify receiving facility. Contact Base Hospital for medical direction, as needed.

Localized

Consider IV/IO
Cardiac monitor

Consider Diphenhydramine IM/IV/IO
Refer to weight-based dosing guide

Monitor and reassess
Monitor for worsening signs and symptoms
Pearls

- Anaphylaxis is an acute and potentially lethal multisystem allergic reaction.
- Epinephrine is the drug of choice and the first drug that should be administered in acute anaphylaxis reactions with moderate or severe symptoms. IM Epinephrine should be administered as priority before or during attempts at IV or IO access.
- Anaphylaxis unresponsive to repeat doses of IM Epinephrine may require IV Epinephrine administration. Contact the Base Hospital for refractory anaphylaxis.
- Allergic reactions may occur with only respiratory and gastrointestinal symptoms and have no rash or skin involvement.
- All patients with respiratory symptoms must have continuous pulse oximetry and EtCO₂ measurement.
- The shorter the onset of symptoms from contact with an allergen, generally the more severe the reaction.
Pediatric Overdose/Toxic Ingestion

### History
- Ingestion or suspected ingestion of a potentially toxic substance
- Substance ingested, route and quantity
- Time of ingestion
- Reason (suicidal, accidental or criminal)
- Available medications in home
- Past medical history and medications

### Signs and Symptoms
- Mental status changes
- Hypo or hypertension
- Decreased respiratory rate
- Tachycardia or dysrhythmias
- Seizures
- S.L.U.D.G.E.

### Differential
- Tricyclic antidepressants (TCAs)
- Acetaminophen (Tylenol)
- Aspirin
- Depressants
- Stimulants
- Anticholinergics
- Cardiac medications
- Solvents, alcohols or cleaning agents
- Insecticides (organophosphates)

### Signs and Symptoms
- Mental status changes
- Hypo or hypertension
- Decreased respiratory rate
- Tachycardia or dysrhythmias
- Seizures
- S.L.U.D.G.E.

### pearl
- Do not rely on patient history of ingestion, especially in suicide attempts. Make sure the patient is still not carrying other medications or weapons. Bring bottles, contents, and emesis to ED.

### Flowchart
- **History**
- **Signs and Symptoms**
- **Differential**

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**California Poison Control Center**
(800) 222-1222
Advisory ONLY

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**Treatment Guideline P09**
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Effective Jan. 2020
Contra Costa County Emergency Medical Services

**Bums**

**History**
- Type of exposure (heat, gas or chemical)
- Inhalation injury
- Time of injury
- Other trauma
- Past medical history
- Medications

**Signs and Symptoms**
- Burns, pain, or swelling
- Dizziness
- Loss of consciousness
- Hypotension/shock
- Airway compromise or distress could be presented as hoarseness or wheezing

**Differential**
- Superficial – red and painful (do **not** include in TBSA)
- Partial thickness – blistering
- Full thickness – painless with charred or leathery skin
- Chemical injury
- Thermal injury
- Radiation injury
- Blast injury

---

**Assess burn injury severity**

**Minor**

- < 20% TBSA partial or full thickness burns
- No inhalation injury
- GCS > 13

- **E**
  - Remove rings, bracelets, and constricting items
  - Apply clean dressing to burn area
  - Consider IV
  - Cardiac monitor

- **P**
  - Trauma Triage TG **if indicated**
  - Pain Control TG **if indicated**

- Transport to facility of choice. **Consider transporting** to Burn Center for burns to the face, hands, perineum, or feet and circumferential burns

**Major**

- ≥ 20% TBSA partial or full thickness burns, burns with suspected inhalation injury or high voltage electrical burns

- **E**
  - Remove rings, bracelets, and constricting items
  - Apply clean dressing to burn area
  - Maintain airway
  - Establish IV/IO **Consider**, one 20g or larger IV in each AC
  - Cardiac monitor
  - EtCO2 monitoring

- **P**
  - Trauma Triage TG **if indicated**
  - Pain Control TG **if indicated**

- Transport to appropriate facility
  - Burns with trauma to Trauma Center
  - Burns only to Burn Center

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**Notify receiving facility. Contact Base Hospital for medical direction, as needed.**

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**Approved Burn Receiving Centers**

- St. Francis – San Francisco
- Valley Med. Center – San Jose
- UC Davis – Sacramento

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**Effective Jan. 2020**

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**Treatment Guideline T03**

Page 1 of 2
Pearls

- Airway burns may lead to rapid compromise of the airway and can be identified by soot around the nares or mouth or visible burns or edematous mucosa in the mouth.
- Early intubation is required when the patient experiences significant inhalation injuries. If the patient requires advanced airway management that cannot be quickly achieved in the field, transport to the nearest facility for stabilization prior to transfer to the Burn Center. Do not wait for a helicopter if airway patency is a critical concern.
- For major burns, do not apply wet dressings, liquids or gels to burns unless it is to remove whatever caused the burn (i.e. dry chemical agent, etc.). Cooling large burns may lead to hypothermia.
- Burn patients are often trauma patients. If burns are evident in the presence of trauma, follow trauma triage guidelines and transport to trauma center if activation criteria is met. Do not transport a trauma patient with burns to a burn center.
- Circumferential burns to extremities are dangerous due to potential vascular compromise secondary to soft tissue swelling.
- Never administer IM pain medication into a burned area.

Rule of Nines

- Seldom will you find a complete isolated body part that is injured as described in the Rule of Nines. More likely, it will be portions of one area, portions of another, and an approximation will be needed.
- For the purpose of determining the extent of serious injury, differentiate the area with minimal (superficial) burn from those of partial or full thickness burns.
- When calculating TBSA of burns, include only partial and full thickness burns; do not include superficial burns in the calculation.
Definitions:
1. Supraglottic Airway Device (SAD): A device that is placed into the oral pharynx and subsequently placed over the glottic opening. This is done in a ‘blind’ maneuver without the aid of a laryngoscope. This will aid in the oxygenation and ventilation of the patient.
2. The I-Gel is the approved supraglottic airway device for Contra Costa County EMS.

Indications:
1. Cardiac Arrest
2. Respiratory arrest with no immediate reversible cause (i.e. hypoglycemia or opioid overdose)
3. Inability to adequately ventilate a patient with a Bag Valve Mask (BVM) and basic airway adjunct.
4. An unconscious patient without a gag reflex who is apneic or is demonstrating inadequate respiratory effort
5. For EMT's with approved optional scope: Patients greater than or equal to 15 years of age in need of airway protection or unable to be adequately ventilated with BVM.

Contraindications:
1. Gag reflex
2. Caustic ingestion – Esophageal burns
3. Known esophageal disease (e.g. cancer, varices or stricture)
4. Laryngectomy with stoma – if present, place ETT in stoma
5. Severe airway trauma
6. Trismus

Complications:
1. Airway and/or esophageal trauma
2. Regurgitation
3. Aspiration

Procedure:
1. Prepare, position and oxygenate the patient with 100% Oxygen.
2. Document the pre-intubation EtCO₂ reading.
3. Select proper I-Gel using weight based chart.
4. Lubricate the I-Gel with water-based lubricant, get suction ready.
5. If present, remove dentures or plates from the mouth prior to insertion.
6. Remove the I-Gel cradle and gently press the chin downwards and introduce the iGel into the mouth with the opening towards the chin, along the hard palate until a definitive resistance is felt. **Do not apply excessive force on the I-Gel upon insertion.**
7. Attach BVM, ETCO2 and ventilate the patient.
8. Auscultate for breath sounds and sounds over the epigastrium and look for the chest to rise and fall.

9. **Confirm tube placement using EtCO₂ and waveform capnography.** It is required that the airway be monitored continuously through waveform capnography (ALS providers) and pulse oximetry.

10. Secure I-Gel airway to patient with an approved method.

<table>
<thead>
<tr>
<th>i-gel size</th>
<th>Patient size</th>
<th>Patient weight guidance (kg)</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>Small adult</td>
<td>30-60</td>
</tr>
<tr>
<td>4</td>
<td>Medium adult</td>
<td>50-90</td>
</tr>
<tr>
<td>5</td>
<td>Large adult+</td>
<td>90+</td>
</tr>
</tbody>
</table>
Patient Safety is medication administration is paramount. Accurate administration of pediatric medication requires multiple steps. Follow each of the steps below in every case.

Clinical Indications:
1. Any patient under 15 years of age that requires a medication intervention.

Procedure:
1. **Assess Patient**
   - Use the 6 RIGHTS – Right patient, Right drug (and indication), Right dose, Right route of administration, Right timing and frequency, and Right documentation.

2. **Obtain weight estimate in Kilograms**
   - A. Use the Pediatape measurement device in every child of appropriate height to determine color range of weight. *Pediatape applies to patients less than 147 cm tall (4 foot, 10 inches)*
   - B. If taller than the Pediatape tape, estimate weight by patient/parent history or paramedic estimate and ALWAYS convert to kilograms using conversion table.

3. **Determine volume on Drug Chart**
   - A. Consult drug chart based on medication name to determine volume in ml.
   - B. If patient is 50 Kg or greater, utilize adult dosages.

4. **Draw up medication**
   - A. Verify drug being administered.
   - B. Utilize smallest syringe for volume (e.g. 1 ml or less, use tuberculin syringe).
   - C. When giving IM or intranasal medication, load syringe ONLY with amount to be administered.

5. **Double check to confirm volume**
   - A. **Double-check volume and dose with drug chart in hand** – verbalize name of medication, volume, dosage and route to another paramedic or trained EMT on scene. If possible, have another provider visually confirm dose in syringe and as called for on drug card.

6. **Administer Medication**
   - A. Administer medication by appropriate route.
   - B. Observe the patient for signs of an adverse reaction.

7. **Documentation**
   - A. Always document dosages in your patient care report by milligrams (or if Dextrose, in grams).
   - B. Document response to medication and any observed adverse reaction.
Clinical Indications:
1. Suspected diabetic patient
   a. Signs and symptoms may include, altered mental status, combative or irritable, diaphoresis, seizure, abdominal pain, nausea or vomiting, weakness, dehydration, deep or rapid breathing
   b. Medical bracelet found, insulin or other diabetic medications found, information received from patient and bystanders
2. Decreased LOC with unknown origin

Contraindications:
1. None

Equipment:
1. PPE
2. Glucometer
3. Alcohol prep pads
4. Blood glucose test strips
5. Lancet & band-aid
6. Sharps container

Procedure:
1. Activate 9-1-1 if not already activated
2. Assess patient to confirm indications are met
3. Insert test strip into glucometer
4. Cleanse finger with alcohol prep
5. Gently massage finger to promote blood flow and pierce with lancet
6. Apply blood sample to blood strip and document results
7. If BGL glucometer reading is < 60 follow treatment guideline for administration of oral glucose.
8. Continue to monitor, reassess and treat patient

Special Considerations:
1. Glucometer manufacturer instructions should be included in all Agency specific training

Treatment Guidelines:
1. Adult: G01, A03, A05, A07, A08, A12, A13, A16, A17, A18, A19, A20, T08
2. Pediatric: PC01, PC04, P03, P04, P05, P06, P07, P09, P12, P13
Clinical Indications:
1. Patient exposed to allergen and displays systemic signs and symptoms such as:
   a. Mental status: Anxiety, sense of impending doom, confusion, unconscious
   b. Onset: Sudden, but can be more than an hour after exposure
   c. Skin/vascular system: Severe flushing, rash or hives, edema to the face and neck
   d. Respiration: Severe bronchoconstriction (wheezing), laryngospasm (stridor), difficulty breathing
   e. GI system: Severe cramps. Abdominal rumbling, diarrhea, vomiting
   f. Vital Signs: Early signs include increased heart rate and respiratory rate. Late signs included falling respiratory rate and blood pressure, shock

Contraindications:
1. Use caution with patients who are >50 years of age and patients with cardiac history
   a. Patients >50 years of age should receive pediatric dose (0.15 mg)

Equipment:
1. PPE
2. Epinephrine auto-injector (adult and pediatric)
3. Alcohol prep pads
4. Sharps container

Procedure:
1. Activate 9-1-1 if not already activated
2. Assess patient to confirm indications are met
   a. Remove allergens
   b. Manage life threats, airway, breathing and circulation
3. Consider aseptic technique if appropriate
4. Administer appropriate epinephrine auto-injector (record time of administration)
   a. Adult auto-injector: 15 through 49 years of age
   b. Pediatric auto-injector: 0 through 15 years of age and > 50 years of age
5. Continue to monitor, reassess and treat patient
   a. Be ready to support ventilations
   b. Secondary administration should be via IV route by a Paramedic

Special Considerations:
1. Manufacturer instructions should be included in all Agency specific training

Treatment Guidelines:
1. A04, P02
Clinical Indications:
1. Patient >22 kg. (50 lbs.)
2. Patient with suspected narcotic overdose and inadequate breathing (respiratory rate <8). Signs and symptoms include:
   a. Deep snoring or gurgling
   b. Pale and or clammy skin
   c. Depressed LOC, no response to stimulation, heavy nod
   d. Pinpoint pupils

Contraindications:
1. Patient is breathing adequately and able to maintain own airway
2. Relative contraindication for allergy to naloxone
3. Not advised when patient has exercised their right under the California End of Life Act, are on hospice or who are newly born

Equipment:
1. PPE
2. Naloxone prefilled syringe (pre-load or auto-injector)
3. Nasal atomizer (pre-load)
4. Alcohol prep pads
5. Sharps container

Procedure:
1. Activate 9-1-1 if not already activated
2. Assess patient to confirm indications are met
   a. Manage life threats, airway, breathing and circulation
3. Administration of naloxone should be titrated to effect adequate breathing not to restore consciousness.
4. Consider aseptic technique if appropriate
5. Administer naloxone intranasal (Record time of administration)
   a. Attach nasal atomizer
   b. Administer 1 mg / 1mL into each nostril
6. Prepare for patient to vomit; utilize recovery position and suction
7. Continue to monitor, reassess and treat patient

Special Considerations:
1. Manufacturer instructions should be included in all Agency specific training

Treatment and Field Procedure Guidelines:
1. G02, G03, A13, A14, P08, P09, P10, FP09