	Section 1 General Treatment	Release for Public Comment	Due
1.1	General Pre-Hospital Care	28-Jun	29-Aug
1.2	Abdominal Pain (Non-Traumatic)	28-Jun	29-Aug
1.3	Nausea & Vomiting	28-Jun	29-Aug
1.4	Syncope	28-Jun	29-Aug
1.5	**Shock**	**11-Jul**	**9-Sep**
1.6	**Anaphylaxis/Allergic Reaction**	**11-Jul**	**9-Sep**
1.7	Adrenal Crisis	28-Jun	29-Aug
1.8	**Behavioral Emergencies**	**11-Jul**	**9-Sep**
1.9	Return of Spontaneous Circulation (ROSC)	28-Jun	29-Aug
1.10	**Opioid Overdose Treatment and Prevention NEW**	**11-Jul**	**9-Sep**

Shock

Assessment: Consider etiologies of shock

1. Follow **General Pre-hospital Care Protocol**.
2. Control major bleeding per **Bleeding Control (BCON) protocol**.
3. Remove all transdermal patches using gloves.
4. Prompt transport following local MCA protocol.
5. Special consideration
    A. If 3rd trimester pregnancy, position patient left lateral recumbent.

6. Obtain vascular access (in a manner that will not delay transport).
    A. Administer NS fluid bolus up to 1 liter IV/IO wide open,
        i. IV/IO fluid bolus is contraindicated with pulmonary edema.
    B. Fluid should be slowed to TKO when SBP greater than 90 mm/Hg.
    C. For pediatrics, fluid bolus should be 20 mL/kg, and based on signs/symptoms of shock.
7. Consider establishing a second large bore IV of Normal Saline en route to
8. Obtain 12-lead ECG, if suspected cardiac etiology.
9. If anaphylactic shock, refer to the **Anaphylaxis/Allergic Reaction Protocol.**
10. If hemorrhagic shock, refer to **Hemorrhagic Shock Protocol.**
11. If accompanying head injury, refer to **Head Injury Protocol**.
    A. Maintain SpO2 ≥ 90%
    B. Maintain SBP > 90 mmHg < 140 mmHg
    C. Do NOT hyperventilate.

Additional IV/IO fluid bolus – contact medical control prior to administration.
    D. Adult total maximum volume administered is 2L
    E. Pediatric total maximum volume administered is 40mL per kg

12. If hypotension persists after IV/IO fluid bolus, administer Epinephrine by push dose (dilute boluses).
    a. Prepare (Epinephrine 10 mcg/mL) by combining 1mL of 1mg/10mL Epinephrine in 9mL NS, then
    b. Adults:
        i. Administer 10-20 mcg (1-2 mL Epinephrine 10 mcg/mL)
        ii. Repeat every 3 to 5 minutes
        iii. Titrate SBP greater than 90 mm/Hg.
    c. Pediatric
        i. Administer 1 mcg/kg (0.1 mL Epinephrine 10 mcg/mL)
        ii. Maximum dose 10 mcg (1 mL)
        iii. Repeat every 3-5 minutes

Shock[BN(1)]

Assessment: Consider etiologies of shock

1. Follow **General Pre-hospital Care Protocol**.
2. Control major bleeding per ~~**Soft Tissue and Orthopedic Injuries Protocol**~~ **Bleeding Control (BCON) protocol**.
3. Remove all transdermal patches using gloves.
4. Prompt transport following local MCA protocol.
5. Special consideration
   A. If 3rd trimester pregnancy, position patient left lateral recumbent.

6. Obtain vascular access (in a manner that will not delay transport).
   A. Administer ~~The standard~~ NS fluid bolus up to 1 liter IV/IO ~~fluid bolus volume will be up to 1 liter,~~ wide open, ~~repeated as necessary~~[KK(C2]~~, unless otherwise noted by protocol.~~
      ~~A.~~i. IV/IO fluid bolus is contraindicated with pulmonary edema.
   B. Fluid should be slowed to TKO when SBP greater than 90 mm/Hg.
   C. For pediatrics, fluid bolus should be 20 mL/kg, and based on signs/symptoms of shock.
7. Consider establishing a second large bore IV of Normal Saline en route to
8. Obtain 12-lead ECG, if suspected cardiac etiology.
9. If anaphylactic shock, refer to the **Anaphylaxis/Allergic Reaction Protocol.**
10. If hemorrhagic shock, ~~For possible hemorrhagic shock,~~ refer to **Hemorrhagic Shock Protocol**[BN(3]**.**
11. If accompanying head injury, refer to **Head Injury Protocol**.
    A. Maintain SpO2 ≥ 90%
    B. Maintain SBP > 90 mmHg < 140 mmHg
    ~~10.~~C. Do NOT hyperventilate.~~NO hyperventilation(reword more appropriately)~~

Additional IV/IO fluid bolus – contact medical control prior to administration.
   ~~A.~~D. Adult total maximum volume administered is ~~Up to~~ 2L ~~total for adult~~
   ~~B.~~E. Pediatric total maximum volume administered is ~~Up to~~ 40mL per kg ~~total for pediatric.~~

12. If hypotension persists after IV/IO fluid bolus, administer Epinephrine by push dose (dilute boluses).
    a. Prepare (Epinephrine 10 mcg/mL) by combining 1mL of 1mg/10mL Epinephrine in 9mL NS, then
    b. Adults:
       i. Administer 10-20 mcg (1-2 mL Epinephrine 10 mcg/mL)
       ii. Repeat every 3 to 5 minutes
       iii. Titrate SBP greater than 90 mm/Hg.
    c. Pediatric

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i. Administer 1 mcg/kg (0.1 mL Epinephrine 10 mcg/mL)
ii. Maximum dose 10 mcg (1 mL)
iii. Repeat every 3-5 minutes

NOTE: ALOGRITHM REMOVED.

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Initial Date: 5/31/2012
Revised Date: 09/20/2019
2022 REVISIONS – PUBLIC COMMENT READY
1-6A

Anaphylaxis/Allergic Reaction

A. Initial
   a. Follow **General Pre-hospital Care Protocol**.
   b. Ensure ALS response
   c. Determine if Anaphylaxis/Severe Allergic reaction (wheezing or hypotension)
   d. Allergic reaction (itching, hives)
   e. Determine substance or source of exposure, remove patient from source if known and able.

B. Anaphylaxis/Severe Allergic reaction
   a. Assist patient in administration of their own epinephrine auto-injector, if available

   OR

   b. Administer Epinephrine Auto-Injector
   ***MCA Approval for MFR epinephrine auto-injector (Agency Option).**

MCA Approval of Epinephrine Auto-injector for Select MFR Agencies
(Provide participating agency list to BETP)

☐ YES ☐ NO Basic EMT only for section B.b.

1. Contact Medical Control if child appears to weigh less than 10 kg (approx. 20 lbs.), prior to epinephrine, if possible .
2. Administer pediatric epinephrine dose auto-injector If child weighs between 10-30 kg (approx. 60 lbs
3. Administer epinephrine auto-injector for adults and children weighing greater than 30 kg
4. May repeat auto-injector one time after 3-5 minutes if the patient remains hypotensive, and auto-injector available

OR

c. Administer Epinephrine

1. Contact Medical Control if child appears to weigh less than 10 kg (approx. 20 lbs.), prior to epinephrine, if possible.

2. Administer 0.15 mg (0.15 mL) of Epinephrine (1mg/mL) if child weighs between 10-30 kg (approx. 60 lbs.)
3. Administer 0.3 mg (0.3 mL) of Epinephrine (1mg/mL) for child weighing over 30 kg (approx. 60 lbs.) or adult patients.
4. May repeat Epinephrine administration one time after 3-5 minutes if the patient remains hypotensive.

d. For patients with wheezing, administer bronchodilator per **Nebulized Bronchodilators Protocol**.

e. For patients with hypotension
1. Administer a Normal Saline IV/IO fluid bolus
2. The standard NS IV/IO fluid bolus volume will be up to 1 liter, wide open, repeated as necessary
3. Fluid should be slowed to TKO when SBP greater than 90 mm/Hg.
   i. TKO is contraindicated for patients with pulmonary edema once a SBP of 90 mm/Hg has been achieved.

4. For pediatrics, fluid bolus 20 mL/kg, based on signs/symptoms of shock.

f. Profound anaphylaxis shock (near cardiac arrest) with hypotension unresponsive to fluid bolus or severe respiratory distress unresponsive to nebulized treatment administer push dose Epinephrine IV/IO per **Shock Protocol** .
1. Prepare (Epinephrine 10 mcg/mL) by combining 1mL of 1mg/10mL Epinephrine in 9mL NS, then
2. Adults:
   i. Administer 20 mcg (2 mL Epinephrine 10 mcg/mL) IV/IO
   ii. Repeat every 3 minutes
   iii. Titrate SBP greater than 90 mm/Hg.

3. Pediatric
   i. Administer 1 mcg/kg (0.1 mL Epinephrine 10 mcg/mL) IV/IO
   ii. Maximum dose 10 mcg (1 mL)
   iii. Repeat every 3-5 minutes

C. If patient is symptomatic of an allergic reaction but not in a severe allergic reaction/anaphylaxis OR after Epinephrine administration

a. Administer Diphenhydramine.
1. Adult 50 mg IM or IV/IO

2. Pediatric 1 mg/kg IM/IV/IO (maximum dose 50 mg).

b. For patients with wheezing, administer bronchodilator per **Nebulized Bronchodilators Protocol**.

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c. Per MCA Selection, administer Prednisone **OR** methylprednisolone.

Medication Options:

☐ **Prednisone 50 mg tablet PO**
(Children > 6 y/o)

☐ **Methylprednisolone**
Adult 125 mg IV/IO/IM or

Pediatric 2 mg/kg IV/IO/IM (max 125 mg)

* For MCA with both selected, Prednisone PO is the preferred medication. Methylprednisolone is secondary and reserved for when a PO route is inappropriate.

D. Patients unresponsive to treatment, contact medical control

DRAFT

Anaphylaxis/Allergic Reaction

A. Initial

a. Follow **General Pre-hospital Care Protocol**.
b. Ensure ALS response
c. Determine if Anaphylaxis/Severe Allergic reaction (wheezing or hypotension)
d. Allergic reaction (itching, hives)
~~A.~~e. Determine substance or source of exposure, remove patient from source if known and able.

~~In cases of severe allergic reaction, wheezing or hypotension, administer epinephrine via auto-injector.~~

~~B. Assist the patient in administration of their own epinephrine auto-injector, if available.~~

B. Anaphylaxis/Severe Allergic reaction
a. Assist patient in administration of their own epinephrine auto-injector, if available

OR

b. Administer Epinephrine Auto-Injector

~~C.~~ ***MCA Approval for MFR epinephrine auto-injector (Agency Option).**

MCA Approval of Epinephrine Auto-injector for Select MFR Agencies
(Provide participating agency list to BETP)

☐ YES ☐ NO Basic EMT only for section ~~5~~B.b.

~~a.~~ 1. Contact Medical Control if child appears to weigh less than 10 kg (approx. 20 lbs.), prior to epinephrine, if possible ~~If child appears to weigh less than 10 kg (approx. 20 lbs.), contact medical control prior to epinephrine, if possible~~.

~~b.~~ 2. Administer pediatric epinephrine dose auto-injector If child weighs between 10-30 kg (approx. 60 lbs~~If child weighs between 10-30 kg (approx. 60 lbs.); administer pediatric epinephrine auto-injector.~~

~~c.~~ 3. Administer epinephrine auto-injector for adults and children weighing greater than 30 kg~~For adults and children weighing greater than 30 kg; administer epinephrine auto-injector.~~

4. May repeat auto-injector one time after at 3-5 minutes intervals if the patient remains hypotensive, and auto-injector available May repeat at 3-5 minute intervals if the patient remains hypotensive, if available.

OR

c. Administer Epinephrine

1. Contact Medical Control if child appears to weigh less than 10 kg (approx. 20 lbs.), prior to epinephrine, if possible.
2. Administer 0.15 mg (0.15 mL) of Epinephrine (1mg/mL) if child weighs between 10-30 kg (approx. 60 lbs.)
3. Administer 0.3 mg (0.3 mL) of Epinephrine (1mg/mL) for child weighing over 30 kg (approx. 60 lbs.) or adult patients.

d. 4. May repeat Epinephrine administration one time after at 3-5 minutes intervals if the patient remains hypotensive.

d. For patients with wheezing, administer bronchodilator perAlbuterol may be indicated. Refer to **Nebulized Bronchodilators Protocol Procedure**.

D. Albuterol may be indicated. Refer to **Nebulized Bronchodilators Procedure**.

e. For patients with hypotension

E. 1. Administer a Normal Saline IV/IO fluid bolus in the presence of hypotension.

a. 2. The standard NS IV/IO fluid bolus volume will be up to 1 liter, wide open, repeated as necessary, unless otherwise noted by protocol. IV/IO fluid bolus is contraindicated with pulmonary edema.

3. Fluid should be slowed to TKO when SBP greater than 90 mm/Hg.

b. i. TKO is contraindicated for patients with pulmonary edema once a SBP of 90 mm/Hg has been achieved.

c. d4. For pediatrics, fluid bolus should be 20 mL/kg, and based on signs/symptoms of shock.

f. In cases of suspected Pprofound anaphylaxis shock (near cardiac arrest) with hypotension unresponsive to fluid bolus or with hypotension, severe respiratory distress unresponsive to nebulized treatment, and/or angioedema, administer push dose Epinephrine IV/IO per **Shock Protocol**.

1. Prepare (Epinephrine 10 mcg/mL) by combining 1mL of 1mg/10mL Epinephrine in 9mL NS, then
2. Adults:
   i. Administer 20 mcg (1-2 mL Epinephrine[BE(C1)] 10 mcg/mL) IV/IO
   ii. Repeat every 3 minutes
   iii. Titrate SBP greater than 90 mm/Hg.
3. Pediatric
   i. Administer 1 mcg/kg (0.1 mL Epinephrine 10[BE(C2)] mcg/mL) IV/IO

ii. Maximum dose 10 mcg (1 mL)
iii. Repeat every 3-5 minutes

~~Adult (1mg/1mL) 0.3 mg (0.3mL) IM may repeated 1 time in 3-5 minutes if patient is still hypotensive.~~

~~b. If child appears to weigh less than 10 kg (approx. 20 lbs.), contact medical control prior to epinephrine, if possible.~~

~~If child weighs between 10-30 kg (approx. 60 lbs.); administer pediatric epinephrine dose (1mg/1mL) 0.15 mg (0.15 ml) IM.~~

~~If child weighs 30 kg or greater; administer Epinephrine (1mg/1mL) 0.3 mg (0.3 mL) IM~~

~~May repeat 1 time in 3-5 minutes if patient is still hypotensive.~~

~~F.~~

~~a. Adult (1mg / 1mL), 0.3 mg (0.3 mL) IM. May repeat 1 time in 3-5 minutes if patient is still hypotensive.~~

~~b. Pediatric~~

~~1. For children less than 10 kg (approx. 20 lbs.), contact medical control prior to epinephrine if possible.~~
~~2. For children weighing less than 30 kg (approx. 60 lbs.); administer Epinephrine (concentration of 1mg/1mL) 0.15 mg (0.15mL) IM OR administer pediatric epinephrine auto-injector, if available.~~
~~3. Child weighing 30 kg or greater; administer Epinephrine (concentration of 1mg/1mL) 0.3 mg (0.3 mL) IM OR via epinephrine auto-injector if available.~~
~~4. May repeat 1 time in 3-5 minutes if patient is still hypotensive.~~

D. If patient is symptomatic of an allergic reaction but not in a severe allergic reaction/anaphylaxis OR after Epinephrine administration

~~G.~~ a. Administer ~~, administer~~ Diphenhydramine.

~~a.~~ 1. Adult 50 mg IM or IV/IO.

iv. 2. Pediatric 1 mg/kg IM/IV/IO (maximum dose 50 mg).

b. For patients with wheezing, administer bronchodilator per **Nebulized Bronchodilators Protocol**.

~~b.~~

~~H. Per MCA selection, administer bronchodilator per **Nebulized Bronchodilators Procedure**.~~

~~I.~~ c. Per MCA Selection, administer Prednisone **OR** methylprednisolone.

Medication Options:

☐ **Prednisone 50 mg tablet PO**
(Children > 6 y/o)

☐ **Methylprednisolone**
Adult 125 mg IV/IO/IM or

Pediatric 2 mg/kg IV/IO/IM (max 125 mg)

* For MCA with both selected, Prednisone PO is the preferred medication. Methylprednisolone is secondary and reserved for when a PO route is inappropriate.

E. Patients unresponsive to treatment, contact medical control

~~J.~~

~~K.~~F. If patient remains hypotensive after treatment, refer to **Shock Protocol**.

~~L.~~G. If patient is symptomatic after treatment without hypotension.

~~a.~~1. Additional epinephrine via auto-injector .

~~b.~~

~~c.~~2. Additional epinephrine (1mg / 1 mL), 0.3 mg (0.3 mL) IM.

*MCA approval required for MFR auto-injector use.

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Behavioral Health Emergencies

1. Assure scene is secure.
2. Follow **General Pre-hospital Care Protocol.**
3. Respect the dignity of the patient.
4. Treat known conditions such as hypoglycemia, hypoxia, or poisoning. Refer to appropriate protocol.
5. Patients experiencing behavioral health emergencies should be transported for treatment if they have any of the following:
    a. Can be reasonably expected to intentionally or unintentionally physically injure themselves or others or has engaged in acts or made threats to support the expectation.
    b. Are unable to attend to basic physical needs.
    c. Have judgement that is so impaired that he or she is unable to understand the need for treatment and whose behavior will cause significant physical harm.
    d. Have weakened mental processes because of age, epilepsy, alcohol or drug dependence which impairs their ability to make treatment decisions.
6. Communicate in a calm and nonthreatening manner. Be conscious of personal body language and tone of voice.
7. Keep contacts to a minimum; when prudent, utilize a single rescuer for assessment.
8. Offer your assistance to the patient.
9. Constantly monitor and observe patient to prevent injury or harm.
10. Control environmental factors; attempt to move patient to a private area. Maintain escape route.
11. Attempt de-escalation, utilize an empathetic approach. Avoid confrontation.
12. If patient becomes violent or actions present a threat to patient's safety or that of others, restraint may be necessary. Refer to **Patient Restraint Procedure**.
13. If the patient is severely agitated, combative/aggressive, and shows signs of sweating, delirium, elevated temperature, and lack of fatiguing, refer to **Delirium with Agitated Behavior Protocol**.[BN(1]

Protective Custody - The temporary custody of an individual by a law enforcement officer with or without the individual's consent for the purpose of protecting that individual's health and safety, or the health and safety of the public and for the purpose of transporting the individual if the individual appears, in the judgment of the law enforcement officer, to be a person requiring treatment. Protective custody is civil in nature and is not to be construed as an arrest. (330.1100c (7), Sec. 100c, Michigan Mental Health Code)

Behavioral Health Emergencies[BN(1)]

1. Assure scene is secure.
2. Follow **General Pre-hospital Care Protocol.**
3. Respect the dignity of the patient.
4. Treat known conditions such as hypoglycemia, hypoxia, or poisoning. Refer to appropriate protocol.
5. Patients experiencing behavioral health emergencies should be transported[BE(C2)] for treatment if they have any of the following:
    a. Can be reasonably expected to intentionally or unintentionally physically injure themselves or others or has engaged in acts or made threats to support the expectation.
    b. Are unable to attend to basic physical needs.
    c. Have judgement that is so impaired that he or she is unable to understand the need for treatment and whose behavior will cause significant physical harm.
    d. Have weakened mental processes because of age, epilepsy, alcohol or drug dependence which impairs their ability to make treatment decisions.
6. Communicate in a calm and nonthreatening manner. Be conscious of personal body language and tone of voice.
7. Keep contacts to a minimum; when prudent, utilize a single rescuer for assessment.
8. Offer your assistance to the patient.
9. Constantly monitor and observe patient to prevent injury or harm.
10. Control environmental factors; attempt to move patient to a private area. Maintain escape route.
11. Attempt de-escalation, utilize an empathetic approach. Avoid confrontation.
12. If patient becomes violent or actions present a threat to patient's safety or that of others[BE(C3)], restraint may be necessary. Refer to **Patient Restraint Procedure**.
13. If the patient is severely agitated, combative/aggressive, and shows signs of sweating, delirium, elevated temperature, and lack of fatiguing, refer to ~~**Excited**~~ **Delirium with Agitated Behavior** ~~**Delirium**~~ **Protocol**.[BN(4)]

~~Aggravated Psyche~~[BN(5)]

Protective Custody [BN(6)][BE(C7)]- The temporary custody of an individual by a law enforcement officer with or without the individual's consent for the purpose of protecting that individual's health and safety, or the health and safety of the public and for the purpose of transporting the individual if the individual appears, in the judgment of the law enforcement officer, to be a person requiring treatment. Protective custody is civil in nature and is not to be construed as an arrest. (330.1100c (7), Sec. 100c, Michigan Mental Health Code)

Opioid Overdose Treatment and Prevention

Aliases: OD, Naloxone administration, Naloxone leave behind, Accidental overdose

Indications: Decreased level of consciousness associated with respiratory depression from Opioid Overdose, signs of opioid use, scenes with indications of opioid use. For critically ill patients see **Crashing Patient/Impending Arrest protocol**.

Procedure:

1. Follow **General Prehospital Care Protocol**.
2. If patient has respiratory depression, provide oxygenation and support ventilations. Treatment goal is to restore effective respirations; the patient need not be completely awakened.
    a. Administer Naloxone when:
        i. Ventilations have been established and patient has not regained consciousness.
        ii. There is more than 1 rescuer on scene for personnel safety precautions.

MCA Selection for Naloxone Administration

☐ MFR ☐ EMT

        iii. MCAs will be responsible for maintain a roster of the MFR agencies choosing to participate.
    b. Per MCA Selection (below), administer Intranasal via prefilled syringe with atomizer (half the dose in each nostril), OR Narcan® Nasal Spray. May repeat one time in 3-5 minutes if effective respirations not restored.

MFR/EMT Administration Options (MUST SELECT AT LEAST ONE):

☐Narcan® Nasal Spray 4 mg (Adults Only)

☐Naloxone Prefilled-2 mg/2 ml IN via Atomizer

- Adult and child over 3 years: 2 ml
- Pediatric Dosing:
    - Up to 3 months: 0.5 ml
    - 3 months up to 18 months: 1 ml
    - Children 19-35 months: 1.5 ml

c. Administer naloxone IM, IN or slowly IV, titrating to restore effective respirations.
   i. Adult: 2 mg IM or IN via atomizer.
      1. IN max of two doses total.
   ii. Adult: Up to 2 mg IV slowly, titrating to improvement in respiratory status. Repeat as needed every 3-5 minutes.
   iii. Pediatric: 0.1mg/kg IM/IN/IV-Refer to the MI-MEDIC Cards for proper dosing.

d. Patients not responding to naloxone should have continued airway and ventilatory support.
e. Transport

3. For patients with signs and symptoms or reporting opioid withdrawal (tremors, chills, nausea/vomiting, hallucinations, muscle cramps, etc)
   a. Establish IV, per **IV Therapy Procedure**
   b. For signs of dehydration,
      i. administer NS IV/IO fluid bolus up to 1 liter, wide open.
      ii. Pediatrics receive 20 ml/kg
   c. Hypotensive patients should receive additional IV/IO fluid boluses, as indicated by hemodynamic state.
      i. Continue IV/IO fluid bolus to a maximum of 2 liters.
      ii. Pediatrics repeat dose of 20 ml/kg
   d. For nausea/vomiting, administer Ondansetron
      i. Adults 4mg IV/IM (if ODT not already administered).
      ii. Pediatrics 0.1 mg/kg IV/IM, max dose of 4 mg
   e. Transport according to Destination and Diversion Protocol
4. **Leave Behind Naloxone**

MCA Selection for Naloxone Leave Behind
Providers must be part of an MCA designated Leave Behind Naloxone agency
☐ Not Included
☐ MFR ☐ EMT ☐ AEMT ☐ Paramedic

   a. Indications
      i. Patients ≥ 15 years old who received Naloxone with symptom improvement
      ii. Patients ≥ 15 years old who report substance use disorder
      iii. Scenes where there are signs of opioid use and an individual ≥ 15 years old available to receive the Naloxone.
   b. For patients who are transported, naloxone kits may either be provided to
      i. family and friends on scene (≥ 15 years old) OR
      ii. to the patient when arriving at the hospital, if the patient is awake
   c. For patients who have naloxone administered and refuse transportation to the emergency department, contact medical control.

i. Patient may not:
    1. Have sustained altered mental status
    2. Have intentionally overdosed (for self-harm)
    3. Have any suicidal/homicidal ideations or thoughts of self-harm
ii. If medical control authorizes the refusal see Refusal of Care Adult and Minor Protocol, document the name of the facility and physician in the PCR

d. Provide a naloxone kit to patient or family/friends on scene, if accepted
e. Document in PCR administration of kit (in procedure section)
f. Other possible offerings when administering a kit:
    i. Offer to properly dispose of any used needles following your agency policy
    ii. Refer to a community peer support team, if available
    iii. Provide literature outlining resources for Opioid Use Disorder or Substance Use Disorder treatment programs in the community
    iv. For patients who have not suffered an acute overdose AND are willing to accept treatment for Opioid Use Disorder or Substance Use Disorder, the following may be offered if available:
        1. Alternate destination according to MCA approval (including inpatient or outpatient treatment facilities)
        2. Mobile crisis teams
        3. Other local treatment options

Opioid Overdose Treatment and Prevention

Aliases: OD, Naloxone administration, Naloxone leave behind, Accidental overdose

Indications: Decreased level of consciousness associated with respiratory depression from Opioid Overdose, signs of opioid use, scenes with indications of opioid use. For critically ill patients see **Crashing Patient/Impending Arrest protocol**.

Procedure:

1. Follow **General Prehospital Care Protocol**.
2. If patient has respiratory depression, provide oxygenation and support ventilations. Treatment goal is to restore effective respirations; the patient need not be completely awakened.
    a. Administer Naloxone when:
        i. Ventilations have been established and patient has not regained consciousness.
        ii. There is more than 1 rescuer on scene for personnel[BE(C1)] safety precautions.

MCA Selection for Naloxone Administration

☐ MFR ☐ EMT

        iii. MCAs will be responsible for maintain a roster of the MFR agencies choosing to participate.
    b. Per MCA Selection (below), administer ~~Naloxone intramuscular auto injection OR~~ Intranasal via prefilled syringe with atomizer (half the dose in each nostril), OR Narcan® Nasal Spray. May repeat one time in 3-5 minutes if effective respirations not restored.

MFR/EMT Administration Options (MUST SELECT AT LEAST ONE):

☐Narcan® Nasal Spray 4 mg (Adults Only)

☐Naloxone Prefilled-2 mg/2 ml IN via Atomizer

- Adult and child over 3 years: 2 ml
- Pediatric Dosing:
    - Up to 3 months: 0.5 ml
    - 3 months up to 18 months: 1 ml
    - Children 19-35 months: 1.5 ml

c. Administer n~~N~~aloxone IM, IN or slowly IV, titrating to restore effective respirations.
   i. Adult: 2 mg IM or IN via atomizer.
      1. IN max of two doses total.
   ii. Adult: ~~or~~ Up to 2 mg IV slowly, titrating to improvement in respiratory status. Repeat as needed every 3-5 minutes.

~~i.~~

~~ii.~~ iii. Pediatric: 0.1mg/kg IM/IN/IV-Refer to the MI-MEDIC Cards for proper dosing.

SPECIALIST/PARAMEDIC Administration Options (Must select at least one):

☐Naloxone 2.0 mg/2ml IM, or IV
- Adult and child over 3 years: 2ml.
- Pediatric Dosing:
  - Up to 3 months: 0.5 ml
  - 3 months up to 18 months: 1 ml
  - Children 19-35 months: 1.5 ml

☐Naloxone Prefilled-2 mg/2 ml IN via Atomizer –
- Adult and child over 5 years: 2 ml
  - Distribute half of the dose in each nostril.
  - Up to 3 months: 0.5 ml
  - 3 months up to 18 months: 1 ml
  - Children 19-35 months: 1.5 ml

~~d. Repeat every 3-5 minutes as needed to restore effective respirations. Note IN Naloxone should only be repeated one time.~~
d. Patients not responding to naloxone should have continued airway and ventilatory support.
e. Transport ~~supporting ventilations as needed~~

3. For patients with signs and symptoms or reporting opioid withdrawal (tremors, chills, nausea/vomiting, hallucinations, muscle cramps, etc)
   a. Establish IV, per **IV Therapy Procedure**
   b. For signs of dehydration,
      i. administer NS IV/IO fluid bolus up to 1 liter, wide open.
      ii. Pediatrics receive 20 ml/kg
   c. Hypotensive patients should receive additional IV/IO fluid boluses, as indicated by hemodynamic state.
      i. Continue IV/IO fluid bolus to a maximum of 2 liters.
      ii. Pediatrics repeat dose of 20 ml/kg
   d. For nausea/vomiting, administer Ondansetron
      i. Adults 4mg IV/IM (if ODT not already administered).
      ii. Pediatrics 0.1 mg/kg IV/IM, max dose of 4 mg
   e. Transport according to Destination[BE(C2)] and Diversion Protocol
4. **Leave Behind Naloxone**

MCA Selection for Naloxone Leave Behind
Providers must be part of an MCA designated Leave Behind Naloxone agency
☐ Not Included
☐ MFR ☐ EMT ☐ AEMT ☐ Paramedic

a. Indications
   i. Patients ≥ 15 years old who received Naloxone with symptom improvement
   ii. Patients ≥ 15 years old who report substance use disorder
   iii. Scenes where there are signs of opioid use and an individual ≥ 15 years old available to receive the Naloxone.
b. For patients who are transported, naloxone kits may either be provided to
   i. family and friends on scene (≥ 15 years old~~/o~~) OR
   ii. to the patient when arriving at the hospital, if the patient is awake
c. For patients who have naloxone administered and refuse transportation to the emergency department, contact medical control.
   i. Patient may not:
      1. Have sustained altered mental status
      2. Have intentionally overdosed (for ~~self-harm~~self-harm)
      3. Have any suicidal/homicidal ideations or thoughts of self-harm
   ii. If medical control authorizes the refusal see Refusal of Care Adult and Minor Protocol, document the name of the facility and physician in the PCR
d. Provide a naloxone kit to patient or family/friends on scene, if accepted
e. Document in PCR administration of kit (in procedure section)
f. Other possible offerings when administering a kit:
   i. Offer to properly dispose of any used needles following your agency policy
   ii. Refer to a community peer support team, if available
   iii. Provide literature outlining resources for Opioid Use Disorder or Substance Use Disorder treatment programs in the community
   iv. For patients who have not suffered an acute overdose AND are willing to accept treatment for Opioid Use Disorder or Substance Use Disorder, the following may be offered if available:
      1. Alternate destination according to MCA approval (including inpatient or outpatient treatment facilities)
      2. Mobile crisis teams
      3. Other local treatment options