August 28, 2015

To: All CCMCA agencies that operate Basic Life Support vehicles (MFR & Basic)

Regarding: Adoption of Narcan mandatory protocol

On October 14, 2014, Governor Snyder signed into law Public Act 312 that many have referred to as the Narcan Law. In this law, all EMS agencies are required to carry and use the drug Narcan as part of their treatment protocols for unconscious states where opiate-based drug overdose is suspected. Compliance by all EMS agencies is required by October 14, 2015. It is for that reason we are contacting you.

When this legislation was passed on October 14, 2014, there were more questions than answers regarding how to implement it. The administration of medications is not normally part of the Medical First Responder scope of practice. On June 11, 2015, the CCMCA received its first guidance from the state regarding this new protocol. Unfortunately, that guidance did not include critical information such as storage and securing of the medication for the MFR level, dispensing information, and who was required to pay for it. In short, the CCMCA did not have sufficient information to act responsibly on this law. We contacted the State of Michigan for clarification and received it July 20th and 29th, 2015. Based on this information and subsequent follow-up by the CCMCA with involved parties, a motion to adopt this protocol was passed on August 17th, 2015. As part of this motion, a plan was developed to implement this protocol by October 15, 2015 at all CCMCA agencies.

Attached to this letter are a number of documents for your review. The first is a copy of Public Act 312 of 2014. The second is a copy of the protocols (Intranasal Medication Administration, Poison OD protocol, and Narcan Administration). The third is a common questions and answers sheet on Narcan. In it, you may find many of the questions you have about the Narcan protocol answered. Lastly, a form your agency must complete and return to the CCMCA by September 14, 2015. Electronic versions have been emailed to agency contacts. This can be returned electronically or via regular mail.

The next steps for your agency are;
1) Complete the attached form and return to CCMCA by 9/14/15.
2) Schedule the training for your licensed personnel by a licensed EMS I/C.
3) Submit a roster representing 100% of your licensed personnel trained in this protocol.
4) Obtain the initial dose of Narcan from the CCMCA.
5) Install the Narcan in a secured temperature controlled lockable location on/in your vehicle.
You may have additional questions regarding this. There will be an informational meeting at the Calhoun County Fire Chiefs Association on September 9th, 2015 at 7:00 p.m. (Marshall Township Fire Station, 13551 15 Mile Rd, Marshall Township) as part of their regular meeting to answer questions on this protocol and its implementation. In addition, Dr. Dalski is available to answer any questions you may have regarding implementation of this protocol by your agency.

If you have any questions regarding this, please contact us.

Sincerely,

Chet Dalski, PhD, EMT-P I/C, RN
CCMCA Secretary/Treasurer
269-660-2324
dalskic@kellogg.edu

Daniel Stewart, M.D.
CCMCA Medical Director
269-965-3931 x2650

c: CCMCA Board of Directors
Daniel Stewart, M.D., CCMCA Medical Director
ENROLLED HOUSE BILL No. 5404

AN ACT to amend 1978 PA 368, entitled “An act to protect and promote the public health; to codify, revise, consolidate, classify, and add to the laws relating to public health; to provide for the prevention and control of diseases and disabilities; to provide for the classification, administration, regulation, financing, and maintenance of personal, environmental, and other health services and activities; to create or continue, and prescribe the powers and duties of, departments, boards, commissions, councils, committees, task forces, and other agencies; to prescribe the powers and duties of governmental entities and officials; to regulate occupations, facilities, and agencies affecting the public health; to regulate health maintenance organizations and certain third party administrators and insurers; to provide for the imposition of a regulatory fee; to provide for the levy of taxes against certain health facilities or agencies; to promote the efficient and economical delivery of health care services, to provide for the appropriate utilization of health care facilities and services, and to provide for the closure of hospitals or consolidation of hospitals or services; to provide for the collection and use of data and information; to provide for the transfer of property; to provide certain immunity from liability; to regulate and prohibit the sale and offering for sale of drug paraphernalia under certain circumstances; to provide for the implementation of federal law; to provide for penalties and remedies; to provide for sanctions for violations of this act and local ordinances; to provide for an appropriation and supplements; to repeal certain acts and parts of acts; to repeal certain parts of this act; and to repeal certain parts of this act on specific dates,” by amending sections 20919 and 20965 (MCL 333.20919 and 333.20965), section 20919 as amended by 2006 PA 582 and section 20965 as amended by 2000 PA 375.

The People of the State of Michigan enact:

Sec. 20919. (1) A medical control authority shall establish written protocols for the practice of life support agencies and licensed emergency medical services personnel within its region. The medical control authority shall develop and adopt the protocols required under this section in accordance with procedures established by the department and shall include all of the following:

(a) The acts, tasks, or functions that may be performed by each type of emergency medical services personnel licensed under this part.

(b) Medical protocols to ensure the appropriate dispatching of a life support agency based upon medical need and the capability of the emergency medical services system.

(c) Protocols for complying with the Michigan do-not-resuscitate procedure act, 1996 PA 193, MCL 333.1051 to 333.1067.

(d) Protocols defining the process, actions, and sanctions a medical control authority may use in holding a life support agency or personnel accountable.

(e) Protocols to ensure that if the medical control authority determines that an immediate threat to the public health, safety, or welfare exists, appropriate action to remove medical control can immediately be taken until the medical...
control authority has had the opportunity to review the matter at a medical control authority hearing. The protocols must require that the hearing is held within 3 business days after the medical control authority's determination.

(f) Protocols to ensure that if medical control has been removed from a participant in an emergency medical services system, the participant does not provide prehospital care until medical control is reinstated, and that the medical control authority that removed the medical control notifies the department within 1 business day of the removal.

(g) Protocols to ensure that a quality improvement program is in place within a medical control authority and provides data protection as provided in 1967 PA 270, MCL 331.531 to 331.554.

(h) Protocols to ensure that an appropriate appeals process is in place.

(i) Protocols to ensure that each life support agency that provides basic life support, limited advanced life support, or advanced life support is equipped with epinephrine or epinephrine auto-injectors and that each emergency services personnel authorized to provide those services is properly trained to recognize an anaphylactic reaction, to administer the epinephrine, and to dispose of the epinephrine auto-injector or vial.

(j) Protocols to ensure that each life support vehicle that is dispatched and responding to provide medical first response life support, basic life support, or limited advanced life support is equipped with an automated external defibrillator and that each emergency services personnel is properly trained to utilize the automated external defibrillator.

(k) Except as otherwise provided in this subdivision, within 12 months after the effective date of the amending act that added this subdivision, protocols to ensure that each life support vehicle that is dispatched and responding to provide medical first response life support, basic life support, or limited advanced life support is equipped with opioid antagonists and that each emergency services personnel is properly trained to administer opioid antagonists. Beginning 3 years after the effective date of the amending act that added this subdivision, a medical control authority, at its discretion, may rescind or continue the protocol adopted under this subdivision.

(2) A medical control authority shall not establish a protocol under this section that conflicts with the Michigan do-not-resuscitate procedure act, 1996 PA 193, MCL 333.1051 to 333.1067.

(3) The department shall establish procedures for the development and adoption of written protocols under this section. The procedures must include at least all of the following requirements:

(a) At least 60 days before adoption of a protocol, the medical control authority shall circulate a written draft of the proposed protocol to all significantly affected persons within the emergency medical services system served by the medical control authority and submit the written draft to the department for approval.

(b) The department shall review a proposed protocol for consistency with other protocols concerning similar subject matter that have already been established in this state and shall consider any written comments received from interested persons in its review.

(c) Within 60 days after receiving a written draft of a proposed protocol from a medical control authority, the department shall provide a written recommendation to the medical control authority with any comments or suggested changes on the proposed protocol. If the department does not respond within 60 days after receiving the written draft, the proposed protocol is considered to be approved by the department.

(d) After department approval of a proposed protocol, the medical control authority may formally adopt and implement the protocol.

(e) A medical control authority may establish an emergency protocol necessary to preserve the health or safety of individuals within its region in response to a present medical emergency or disaster without following the procedures established by the department under this subsection for an ordinary protocol. An emergency protocol established under this subdivision is effective only for a limited period and does not take permanent effect unless it is approved according to the procedures established by the department under this subsection.

(4) A medical control authority shall provide an opportunity for an affected participant in an emergency medical services system to appeal a decision of the medical control authority. Following appeal, the medical control authority may affirm, suspend, or revoke its original decision. After appeals to the medical control authority have been exhausted, the affected participant in an emergency medical services system may appeal the medical control authority's decision to the state emergency medical services coordination committee created in section 20915. The state emergency medical services coordination committee shall issue an opinion on whether the actions or decisions of the medical control authority are in accordance with the department-approved protocols of the medical control authority and state law. If the state emergency medical services coordination committee determines in its opinion that the actions or decisions of the medical control authority are not in accordance with the medical control authority's department-approved protocols or with state law, the state emergency medical services coordination committee shall recommend that the department take any enforcement action authorized under this code.

(5) If adopted in protocols approved by the department, a medical control authority may require life support agencies within its region to meet reasonable additional standards for equipment and personnel, other than medical first responders, that may be more stringent than are otherwise required under this part. If a medical control authority
proposes a protocol that establishes additional standards for equipment and personnel, the medical control authority and the department shall consider the medical and economic impact on the local community, the need for communities to do long-term planning, and the availability of personnel. If either the medical control authority or the department determines that negative medical or economic impacts outweigh the benefits of those additional standards as they affect public health, safety, and welfare, the medical control authority shall not adopt and the department shall not approve protocols containing those additional standards.

(6) If adopted in protocols approved by the department, a medical control authority may require medical first response services and licensed medical first responders within its region to meet additional standards for equipment and personnel to ensure that each medical first response service is equipped with an epinephrine auto-injector, and that each licensed medical first responder is properly trained to recognize an anaphylactic reaction and to administer and dispose of the epinephrine auto-injector, if a life support agency that provides basic life support, limited advanced life support, or advanced life support is not readily available in that location.

(7) If a decision of the medical control authority under subsection (5) or (6) is appealed by an affected person, the medical control authority shall make available, in writing, the medical and economic information it considered in making its decision. On appeal, the state emergency medical services coordination committee shall review this information under subsection (4) and shall issue its findings in writing.

Sec. 20965. (1) Unless an act or omission is the result of gross negligence or willful misconduct, the acts or omissions of a medical first responder, emergency medical technician, emergency medical technician specialist, paramedic, medical director of a medical control authority or his or her designee, or, subject to subsection (5), an individual acting as a clinical preceptor of a department-approved education program sponsor while providing services to a patient outside a hospital, in a hospital before transferring patient care to hospital personnel, or in a clinical setting that are consistent with the individual's licensure or additional training required by the medical control authority including, but not limited to, services described in subsection (2), or consistent with an approved procedure for that particular education program do not impose liability in the treatment of a patient on those individuals or any of the following persons:

(a) The authorizing physician or physician's designee.
(b) The medical director and individuals serving on the governing board, advisory body, or committee of the medical control authority and an employee of the medical control authority.
(c) The person providing communications services or lawfully operating or utilizing supportive electronic communications devices.
(d) The life support agency or an officer, member of the staff, or other employee of the life support agency.
(e) The hospital or an officer, member of the staff, nurse, or other employee of the hospital.
(f) The authoritative governmental unit or units.
(g) Emergency personnel from outside the state.
(h) The education program medical director.
(i) The education program instructor-coordinator.
(j) The education program sponsor and education program sponsor advisory committee.
(k) The student of a department-approved education program who is participating in an education program-approved clinical setting.
(l) An instructor or other staff employed by or under contract to a department-approved education program for the purpose of providing training or instruction for the department-approved education program.
(m) The life support agency or an officer, member of the staff, or other employee of the life support agency providing the clinical setting described in subdivision (k).
(n) The hospital or an officer, member of the medical staff, or other employee of the hospital providing the clinical setting described in subdivision (k).

(2) Subsection (1) applies to services consisting of any of the following:

(a) The use of an automated external defibrillator on an individual who is in or is exhibiting symptoms of cardiac distress.
(b) The administration of an opioid antagonist to an individual who is suffering or is exhibiting symptoms of an opioid-related overdose.

(3) Unless an act or omission is the result of gross negligence or willful misconduct, the acts or omissions of any of the persons named below, while participating in the development of protocols under this part, implementation of protocols under this part, or holding a participant in the emergency medical services system accountable for department-approved protocols under this part, does not impose liability in the performance of those functions:

(a) The medical director and individuals serving on the governing board, advisory body, or committees of the medical control authority or employees of the medical control authority.
(b) A participating hospital or freestanding surgical outpatient facility in the medical control authority or an officer, member of the medical staff, or other employee of the hospital or freestanding surgical outpatient facility.

(c) A participating agency in the medical control authority or an officer, member of the medical staff, or other employee of the participating agency.

(d) A nonprofit corporation that performs the functions of a medical control authority.

(4) Subsections (1) and (3) do not limit immunity from liability otherwise provided by law for any of the persons listed in subsections (1) and (3).

(5) The limitation on liability granted to a clinical preceptor under subsection (1) applies only to an act or omission of the clinical preceptor relating directly to a student’s clinical training activity or responsibility while the clinical preceptor is physically present with the student during the clinical training activity, and does not apply to an act or omission of the clinical preceptor during that time that indirectly relates or does not relate to the student’s clinical training activity or responsibility.

This act is ordered to take immediate effect.

Approved .............................................................

............................................................. Governor
Common Questions and Answers regarding the CCMCA Narcan Protocol

The following are common questions that agencies may have regarding implementation of the Narcan protocol.

1. Why was this protocol adopted?
   Answer: Public Act 312 of 2014 was signed into law by Governor Snyder on October 14, 2014. Amongst its provisions, it requires that all EMS agencies carry Narcan by October 14, 2015. After clarification with the State of Michigan EMS Section, the CCMCA was mandated to adopt this new protocol or face disciplinary actions that could include removal of the CCMCA as an oversight agency. As far as we know, there was not a lot of consultation with EMS physicians or agencies prior to its signature into law.

2. Is administration of a medication outside the scope of practice for a licensed Medical First Responder or Basic EMT?
   Answer: The state has made the decision to add this to the scope of practice within Michigan for both of these levels, as long as the required training program is attended by the licensed person(s) administering the medication.

3. How do I know if my agency is affected by this protocol?
   Answer: All agencies must be compliant with this protocol, whether they are Medical First Responder, Basic Life Support, Limited Advanced Life Support or Advanced Life Support agency licensed. Because Limited and Advanced Life Support Agencies already carry Narcan and have individuals trained in its use, compliance is nearly automatic. For Basic Life Support (Medical First Responder and Basic level EMT) Agencies, additional training and expansion of the scope of practice is required.

4. When must BLS agencies have the Calhoun County Narcan Protocol implemented by?
   Answer: October 14, 2015. The protocols were put into effect as of 8/28/15 with the State of Michigan. Agencies that complete all requirements for this protocol (training, installation of the equipment, etc.) may begin use of this drug immediately.

5. Will this protocol expire? If so, when?
   Answer: Currently, the CCMCA has adopted the protocol until the sunset date of October 14, 2017 when it may discontinue the use of this protocol. At this time, there is no plan to renew this protocol upon its expiration on October 14, 2017. You will be notified if this changes.
6. Who will pay for Narcan required of my agency?
   Answer: The CCMCA has offered to pay the initial costs of stocking this drug on every licensed Basic Life Support vehicle in Calhoun County. After the initial stocking, restocking must be paid for by the Basic Life Support Agency. Currently it can be obtained at either Bronson Battle Creek or Oaklawn Hospitals for approximately $35.00/dose by authorized individuals from each agency. Agencies must submit a list of individuals authorized to purchase Narcan on their behalf to the CCMCA PRIOR to attempting purchase. Additional information will be provided to agencies regarding the specifics of where and how to replace the drug. Understand that the price of this drug may change over the next two years.

7. Where can I obtain Narcan if it is used by my agency?
   Answer: Bronson Battle Creek and Oaklawn hospital are the only places you can replenish your Narcan, if used, under the CCMCA. State law requires that Life Support Agencies replace medications through a hospital based pharmacy. In Calhoun County, these are the only two hospitals that are authorized for this process.

8. Can I use a local pharmacy to obtain Narcan for use on an EMS licensed vehicle?
   Answer: No, under state law, you must use a hospital based pharmacy.

9. When will my agency receive its initial stock of Narcan?
   Answer: When the agency has completed all provisions of this protocol. This includes having personnel trained, submitting a roster of trained individuals to the CCMCA (CE roster from training class is acceptable), return of completed Agency Narcan Form to CCMCA, and an adequate storage location is identified and prepared.

10. When do providers administer Narcan to patients?
    Answer: The procedure and indications for its use are explained within the protocols supplied by the CCMCA. These include the Adult Treatment for Poisoning/Overdose, General Procedures Intranasal Medication Administration, and General Procedures Narcan Administration protocols.

11. Can Narcan be used on children?
    Answer: Yes, pediatric dosing is included in the training.
12. Is it dangerous to administer Narcan to patients?
Answer: While there is no contraindication against administering Narcan to patients, following its administration, patients in opiate overdose who are physically dependent may experience acute withdrawal syndrome. This may include extreme agitation, body aches, diarrhea, tachycardia, fever, runny nose, sneezing, piloerection, sweating, yawning, nausea/vomiting, nervousness, restlessness, irritability, shivering or trembling, abdominal cramps, weakness, ventricular tachycardia or fibrillation, pulmonary edema and increased blood pressure. While rare, cardiac arrest can occur following administration of Narcan. The withdrawal symptoms may appear within minutes of administration and will usually subside within 2 hours. Providers are required to monitor the patient and provide adequate airway support including the use of suction, if needed, following administration of the drug.

13. Does Narcan always work on drug overdoses?
Answer: No, Narcan only works against opiate based drugs. If drugs (legal or illegal) other than opiates were involved, Narcan will have little to no effect on these.

14. Do pediatric doses require a different form or concentration of Narcan?
Answer: No, only the total dose administered is reduced from 1 cc per nostril to ½ cc per nostril. The identical pre-loaded syringe and Intranasal Mucosal Atomization Device (MAD) used on adults is used on children. There is no need to carry a second device for pediatrics.

15. How many times is Narcan administered to in a patient by Basic Life Support Agencies?
Answer: One time. The total dose of Narcan administered to an adult is 2 mg in 2 cc. This dose will neutralize a significant amount of opiate based material. If additional dosing is required, it should be performed by Advanced Life Support agencies under medical guidance.

16. In storage, how long does the Narcan last for?
Answer: The shelf life will depend on how Narcan is packaged (ampule, vial, pre-loaded syringe, auto-injector). For that reason, a drug expiration date is printed on each container containing the drug. The drug within that container must be replaced prior to the expiration date. It is the agencies responsibility to monitor drug expiration dates and replace them when necessary.
17. We’ve heard this referred to as Narcan or also naloxone. What’s the difference?  
Answer: Narcan is a brand name given to naloxone by a specific manufacturer to market the product. Often, the brand name is what a drug is known by since it is patent protected for a number of years after its entry into the market. The generic name for actual drug in Narcan is naloxone HCL. Both are the same drug, but under different names. Usually, the generic form a drug is cheaper in cost than the brand name. Both have the same actions on the body. Other than the name, there is no difference between the two drugs.

18. What is EVZIO?  
Answer: EVZIO is a brand name given to naloxone HCL when packaged in an auto-injector device. Similar to Epi-Pens, this device audibly prompts a person through the process of administering Narcan to a patient intramuscularly. The device has an automatic needle/syringe system built into it.

19. How is the Narcan supplied?  
Answer: In the Narcan protocol, medical control authorities are allowed to select either Narcan (naloxone HCL) in a preloaded syringe and nasal atomizer or a self-contained automatic delivery brand named device (EVZIO). The EVZIO device can be obtained for approximately $350-550.00/unit, depending on the source. The preloaded syringe and atomizer are approximately $35.00. For cost containment reasons, the CCMCA selected the generic preloaded syringe. This is the only supplied format allowed for use by Basic Life Support Agencies in Calhoun County.

20. What must be in place for my agency to be compliant with this protocol?  
Answer: You must have returned the form to the CCMCA, implemented the training for your staff, installed a lockable location for storage of the drug, and obtained the Narcan for each licensed unit in your agency.

21. How long is the Narcan training class?  
Answer: The class is recommended to take 1 hour in length. It does not require practical practice.

22. Who can teach the Narcan training class?  
Answer: The course must be taught by a licensed EMS Instructor-Coordinator. If they have been through the Narcan training themselves, an MFR or Basic EMT licensed EMS I/C can teach this curriculum. If they have not been through the Narcan training, it requires a Specialist EMS I/C or Paramedic EMS I/C licensed individual to teach this curriculum.
23. What must be taught in the Narcan training class?
   Answer: There is a prescribed curriculum from the State of Michigan that is used to present this material to MFR and Basic EMT licensed individuals along with additional supplemental materials from the CCMCA. These materials can be obtained by a licensed EMS I/C from the CCMCA.

24. Where is the Narcan stored when not in use on a patient?
   Answer: Per MDHHS EMS Section, “Any medication carried on an EMS vehicle are required to be secured in a locked area. Any of the following are acceptable:
   a. glove compartment
   b. under-seat compartment
   c. outside vehicle compartment
   d. storage case mounted to the vehicle (Pelican case, for example)
   e. homemade storage box mounted to the vehicle
   Again, each of the above are required to be locked and mounted to the vehicle. What is not acceptable is storing the medication in a tagged bag or jump kit in an unlocked area of the vehicle.

25. What temperature can Narcan be stored at?
   Answer: Per the manufacturer, Narcan must be stored above 32°F (0°C) (freezing) and below 77°F (25°C). The location you select for securely housing the Narcan must be kept within these temperatures. If your department carries Epi-Pens, you should have them in this same location.

26. Where can I obtain answers to questions I have that may not have been addressed above?
   Answer: Contact Chet Dalski, EMS Director at 269-660-2324 or dalskic@kellogg.edu.
Narcan Administration

**Purpose:** This protocol is intended for the management of patients with a known or suspected opioid overdose with respiratory depression **AFTER POSITIVE PRESSURE VENTILATION HAS BEEN ESTABLISHED**

**Indications:**
Naloxone (Narcan) is indicated for the complete or partial reversal of opioid induced respiratory depression caused by opioid narcotic medications such as: Heroin, Morphine, Hydromorphone (Dilaudid), Methadone, Meperidine (Demerol), Fentanyl (Sublimaze), Oxycodone (Percocet, Percodan), Hydrocodone (Vicodin, Norco) or Codeine (Tylenol 3, Tylenol 4).

**Relative Contraindications for Intranasal Administration:**
1. Nasal trauma
2. Epistaxis, nasal congestion, (significant) nasal discharge
3. Known cocaine use is a relative contraindication

**Pre-Medical Control**

**MFR/EMT/SPECIALIST/PARAMEDIC**
1. Follow the General Pre-Hospital Care Protocol.
2. If in cardiac arrest, refer to Cardiac Arrest – General Protocol.
3. If altered mental status due to hypoglycemia, refer to Altered Mental Status Protocol.
4. If respiratory distress, support ventilation and refer to the Respiratory Distress Protocol and the Emergency Airway Procedure.

**MFR/EMT**
1. Consider administration of Naloxone when:
   a. LALS or ALS ETA is > 5 minutes or not available AND
   b. There is more than 1 rescuer on scene for personnel safety precautions.
2. Treatment goal is adequate patient breathing effort; the patient need not be woken up completely.
3. Per MCA Selection, administer Naloxone Intramuscular auto injection OR Intranasal via prefilled syringe with atomizer:
Michigan
General Procedures
NARCAN ADMINISTRATION

Date: June 4, 2015

MFR/EMT Administration Options:
Must select at least one

☐ Naloxone Auto Injector - 0.4mg IM

☐ Naloxone Prefilled-2 mg IN via Atomizer –
  • Adult and child over 5 years: 2ml distribute 1 ml in each nostril.
  • Child 5 years or younger: 1ml (half of the pre-filled syringe) distributed equally in each nostril.

Note: Maximal volume per nostril is 1 ml.

SPECIALIST/PARAMEDIC
1. Administer Naloxone IM, IN or IV slowly, titrating to improve respiratory status.
   a. Adult: 2 mg IM, or IN or IV if an IV is already established
   b. Pediatric: 0.1mg/kg IM/IN/IV-Refer to the MI-MEDIC for proper dosing.
2. Repeat as needed.
3. Treatment goal is adequate patient breathing effort; the patient need not be woken up completely.

SPECIALIST/PARAMEDIC Administration Options:
Must select at least one

☐ Naloxone 2 mg IM, IN, or IV

☐ Naloxone Prefilled-2 mg IN via Atomizer –
  • Adult and child over 5 years: 2ml distribute 1 ml in each nostril.
  • Child 5 years or younger: 1ml (half of the pre-filled syringe) distributed in each nostril

☐ Naloxone 0.4mg IM, or IV

EMT/SPECIALIST/PARAMEDIC
4. Transport
5. Notify Medical Control.
Intranasal Medication Administration

**Purpose:** This procedure authorizes intranasal medication administration by EMS providers an FDA-approved atomizing device. This procedure authorizes the substitution of the intranasal route for other routes specified in individual protocols as approved for specific indications stated below by the local medical control authority.

**MFR/EMT-B/SPECIALIST:** Narcan™ (Naloxone) only

**Indication:**
- Altered Mental Status with Suspected Opiate Overdose

**PARAMEDIC**

**Indications:** In general, the intravenous route is preferred for medication administration. This procedure may be considered when IV access is unavailable or when a needleless delivery system is desired because of patient agitation, combativeness, or similar conditions that may pose a safety risk to personnel.

**CHECK MCA APPROVED INDICATION**
- Adult Seizures
- Pediatric Seizures
- Sedation
- Adult Pain Control
- Pediatric Pain Control
- Altered Mental Status with Suspected Opiate Overdose

**Relative Contraindications:**
1. Nasal trauma
2. Epistaxis, nasal congestion, (significant) nasal discharge
3. Known cocaine use is a relative contraindication

**Pre-Medical Control**

**MFR/EMT/SPECIALIST – Limited to Naloxone administration ONLY.**
1. Attach atomizing device to prefilled Naloxone syringe.
2. Use one hand to support back of patient’s head as needed.
3. Place tip of atomizing device snuggly against nostril aiming slightly upward and outward.
4. Rapidly administer one half of the dose of medication, briskly pushing plunger.
5. Repeat with other nostril delivering the remaining volume of medication.
6. Note: Maximal dose per nostril is 1 cc.

**PARAMEDIC**

7. Select desired medication and determine dose (See Medication Table).
8. Draw up appropriate dose (volume) of medication plus an additional 0.1 ml to account for device dead space.
9. Attach atomizing device to syringe.
10. Use one hand to support back of patient’s head as needed.
11. Place tip of atomizing device snugly against nostril aiming slightly upward and outward.
12. Rapidly administer one half of the dose of medication, briskly pushing plunger.
13. Repeat with other nostril delivering the remaining volume of medication.
14. Note: Maximal dose per nostril is 1 mg.

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<thead>
<tr>
<th>Indication</th>
<th>Medication</th>
<th>Dose</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Seizure</td>
<td>Midazolam (5 mg/1 cc)</td>
<td>10 mg</td>
<td>Always use 5 mg/1 ml concentration</td>
</tr>
<tr>
<td>Pediatric Seizure</td>
<td>Midazolam (5 mg/1 cc)</td>
<td>0.2 mg/kg Max 10 mg</td>
<td>Always use 5 mg/1 ml concentration</td>
</tr>
<tr>
<td>Sedation</td>
<td>Midazolam (5mg/1cc)</td>
<td>0.2 mg/kg Max 10 mg</td>
<td>Always use 5 mg/1 ml concentration, Causes brief burning lasting approximately 30 seconds</td>
</tr>
<tr>
<td>Suspected Opiate Overdose</td>
<td>Naloxone (1mg/1ml)</td>
<td>2 mg</td>
<td>2 mg/2ml refer to individual MCA Narcan Administration Protocol</td>
</tr>
<tr>
<td>Adult Pain Control</td>
<td>Fentanyl</td>
<td>2 mcg/kg</td>
<td></td>
</tr>
<tr>
<td>Pediatric Pain Control</td>
<td>Fentanyl</td>
<td>2 mcg/kg</td>
<td></td>
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Use most concentrated form of medication. Do Not dilute. Maximum 1 cc per nostril
Poisoning/Overdose

Pre-Medical Control

GENERAL MANAGEMENT OF TOXIC EXPOSURE (INCLUDING INGESTION)

MFR/EMT/SPECIALIST/PARAMEDIC

1. Follow General Pre-hospital Care Protocol.
2. Use proper protective equipment and prepare for decontamination if necessary.
3. Remove clothing exposed to chemical (dry decon).
4. Identification of the substance (patient has been exposed to).

EMT/SPECIALIST/PARAMEDIC

5. Alert receiving hospital if patient may present HAZMAT risk.
6. Sample of drug or substance and any medication or poison containers should be brought in with patient if it does NOT pose a risk to rescuers.

PARAMEDIC

7. Refer to Pain Management Procedure

INHALATION EXPOSURES:

MFR/EMT/SPECIALIST/PARAMEDIC

1. Dilute noxious gas inhaled (including carbon monoxide & smoke), ensure high concentration of oxygen is provided.
2. If suspected cyanide gas exposure, refer to Cyanide Exposure Protocol and contact medical control immediately.

EYE CONTAMINATION:

MFR/EMT/SPECIALIST/PARAMEDIC

1. Irrigate continuously with Normal Saline or tap water for 15 minutes (attempt to continue enroute) or as directed by Medical Control.
2. For alkali exposure, maintain continuous irrigation.

PARAMEDIC

3. If available, administer Tetracaine, 1-2 drops per eye to facilitate irrigation. Ensure patient does not rub eye.

SKIN ABSORPTION:

MFR/EMT/SPECIALIST/PARAMEDIC

1. Brush off dry chemicals before irrigation
2. Irrigate continuously with Normal Saline, or tap water for 15 minutes or as directed by Medical Control.

INGESTION:

MFR/EMT/SPECIALIST/PARAMEDIC

1. If altered mental status, refer to Altered Mental Status Protocol.
2. If respiratory distress, refer to Respiratory Distress Protocol.
3. If the patient is seizing, refer to **Seizure Protocol**.

**PARAMEDIC**

4. If cardiac dysrhythmia, refer to appropriate dysrhythmia protocol.

**ORGANOPHOSPHATE EXPOSURE (MALATHION, PARATHION)**

**MFR/EMT/SPECIALIST/PARAMEDIC**

1. Administer Mark I Kit/Duo Dote auto injector per **CBRNE Nerve Agent/Organophosphate Pesticide Exposure Treatment Protocol**.
2. Mild or moderate symptoms
   A. 1 Mark I Kit/Duo Dote auto injector
3. Severe signs & symptoms
   B. 3 Mark I Kits/Duo Dote auto injectors
   C. If 3 Mark I Kit/Duo Dote auto injectors are used, administer 1st dose of benzodiazepine, if available.

**PARAMEDIC**

4. If Mark I Kit/Duo Dote auto injector is not available, administer Atropine 2 mg IV/IM (if available) per each Mark I Kit/Duo Dote auto injector indicated (each Mark I Kit contains 2 mg of Atropine) repeated every 5 minutes until "SLUDGEM" symptoms improve or as directed. **(Salivation, Lacrimation, Urination, Defecation, Gastrointestinal hypermotility, Emesis, Muscle twitching or spasm)**.

**MANAGEMENT OF BITES AND STINGS**

**SPIDERS, SNAKES AND SCORPIONS:**

**MFR/EMT/SPECIALIST/PARAMEDIC**

1. Protect rescuers. Bring in spider, snake or scorpion if captured and contained or if dead for accurate identification.
2. Ice for comfort on spider or scorpion bite; **DO NOT** apply ice to snake bites.

**BEES AND WASPS:**

**MFR/EMT/SPECIALIST/PARAMEDIC**

1. Remove sting mechanism from honey bees only by scraping out. Do not squeeze venom sac if this remains on stinger.
2. Provide wound care.
3. Observe patient for signs of systemic allergic reaction. Treat anaphylaxis per **Anaphylaxis/Allergic Reaction Protocol**.

**DRUG< CHEMICAL< PLANT< MUSHROOM INGESTION:**

**MFR/EMT/SPECIALIST/PARAMEDIC**

1. Use protective eye equipment.
2. In situations of potential ingestion or inhalation of petroleum distillates, do NOT induce vomiting.
3. Monitor the patient's respiratory and mental status very closely.
4. If patient is alert and oriented, prepare for emesis; recover and save emesis. Use appropriate barriers according to universal precautions guidelines.

**MFR/EMT/SPECIALIST/PARAMEDIC**

5. *In suspected opioid overdose with respiratory compromise,* begin BLS airway ventilation.
6. Follow the *Narcan Administration Procedure Protocol.*

**Post Medical Control**
**SPECIALIST/PARAMEDIC**

7. If Beta Blocker overdose is suspected AND the patient is bradycardic and hypotensive; per MCA selection administer Glucagon 1 mg IV/IM/IO. May be repeated after contact with Medical Control and if additional Glucagon is available.

![Glucagon](image)

**PARAMEDIC**

8. For symptomatic tricyclic antidepressant ingestions (tachycardia, wide complex QRS), administer sodium bicarbonate 50 mEq IV, repeat as needed.
9. For extrapyramidal dystonic reactions, administer diphenhydramine 50 mg IV.
10. For symptomatic calcium channel blocker overdose, per MCA selection administer Glucagon 1 mg IV/IM/IO. Consider calcium chloride 1 gm IV.
Refer to risk to rescuers
Containers should be brought in with patient if it does NOT pose a risk to rescuers
Sample of drug or substance
Alert receiving hospital if patient may present HAZMAT risk
Identify substance
Remove clothing exposed to chemical
Use proper equipment and PPE
Dilute noxious gas inhaled including carbon dioxide & smoke
Ensure high concentration of oxygen is provided
If suspected cyanide gas exposure – refer to Cyanide Exposure Protocol and contact Medical Control immediately
Irrigate continuously with Normal Saline or tap water for 15 min (attempt to continue enroute) or as directed by Med Control
Alkaline exposure, maintain continuous irrigation
If available, administer Tetracaine 1-2 drops per eye, to facilitate irrigation ensure patient does not rub eyes.
If patient is alert, Hypertension: DO NOT induce vomiting
If patient is alert, Seizure – refer to Seizure Protocol
Cardiac dysrhythmia – refer to appropriate dysrhythmia protocol
Administer Mark I Kit/Duo Dote auto injector per CBRNE Nerve Agent/Organophosphate Pesticide Exposure Treatment Protocol
Mild or moderate symptoms
1 Mark I Kit/Duo Dote auto injector
Severe signs & symptoms
3 Mark I Kits/Duo Dote auto injectors
If 3 Mark I Kit/Duo Dote auto injectors used, administer 1st dose benzodiazepine, if available
If Mark I Kit/Duo Dote auto injector unavailable, administer Atropine 2 mg IV/IM, if available, per Mark I Kit/Duo Dote auto injector indicated, (each Mark I Kit contains 2 mg of Atropine) repeated every 5 min. until SLUDGEM symptoms improve or as directed.
(Salivation, Lacrimation, Urtication, Defecation, Gastrointestinal hypermotility, Emsis, Muscle twitching or spasm)
Drug, chemical, plant, mushroom ingestion
Use protective eye equipment
For potential ingestion or inhalation of petroleum distillates: DO NOT induce vomiting
Monitor respiratory & mental status very closely
If patient is alert & oriented: prepare for emesis, recover & save emesis
Use appropriate barriers according to universal precautions guidelines
If suspected narcotic overdose with respiratory compromise or hemodynamic instability, administer Naloxone 2 mg IV slowly, titrating to improve respiratory status or IM, repeat as needed.
Contact Medical Control
If Beta Blocker overdose is suspected AND patient is bradycardic & hypotensive; per MCA selection, administer Glucagon 1 mg IV/IM/IO. May be repeated after contact with MCA & Glucagon is available
Symptomatic tricyclic antidepressant ingestion (tachycardia, wide complex, QRS), administer sodium bicarbonate 50 mEq IV, repeat as needed.
Extrapyramidal dystonic reactions, administer diphenhydramine 50 mg IV.
Symptomatic calcium channel blocker overdose, per MCA selection administer Glucagon 1 mg IV/IM/IO. Consider calcium chloride 1 gm IV.

**Toxic Exposure (including ingestion)**
- Use proper equipment & prepare for decontamination if necessary
- Remove clothing exposed to chemical (dry decon)
- Identify substance (patient exposed to)
- Alert receiving hospital if patient may present HAZMAT risk
- Sample of drug or substance & any medication or poison containers should be brought in with patient if it does NOT pose a risk to rescuers
- Refer to Pain Management Procedure

**Inhalation exposures**
- Dilute noxious gas inhaled including carbon dioxide & smoke
- Ensure high concentration of oxygen is provided
- If suspected cyanide gas exposure – refer to Cyanide Exposure Protocol and contact Medical Control immediately

**Eye contamination**
- Irrigate continuously with Normal Saline or tap water 15 min (attempt to continue enroute) or as directed by Med Control
- Alkaline exposure, maintain continuous irrigation
- If available, administer Tetracaine 1-2 drops per eye, to facilitate irrigation ensure patient does not rub eyes.

**Skin absorption**
- Brush off dry chemicals before irrigation.
- Irrigate continuously with Normal Saline or tap water for 15 min or as directed by Med Control

**Ingestion**
- Altered Mental Status – refer to Pediatric Altered Mental Status Protocol
- Respiratory distress – refer to Respiratory Distress Protocol
- Seizure – refer to Seizure Protocol
- Cardiac dysrhythmia – refer to appropriate dysrhythmia protocol

**Organophosphate exposure (Malathion, Parathion)**
- Administer Mark I Kit/Duo Dote auto injector per CBRNE Nerve Agent/Organophosphate Pesticide Exposure Treatment Protocol
  - Mild or moderate symptoms
    - 1 Mark I Kit/Duo Dote auto injector
    - 3 Mark I Kits/Duo Dote auto injectors
    - If 3 Mark I Kit/Duo Dote auto injectors used, administer 1st dose benzodiazepine, if available
    - If Mark I Kit/Duo Dote auto injector unavailable, administer Atropine 2 mg IV/IM, if available, per Mark I Kit/Duo Dote auto injector indicated, (each Mark I Kit contains 2 mg of Atropine) repeated every 5 min. until SLUDGEM symptoms improve or as directed.
  - (Salivation, Lacrimation, Urtication, Defecation, Gastrointestinal hypermotility, Emsis, Muscle twitching or spasm)

**Spiders, snakes & scorpions**
- Protect rescuers
- Bring in if captured & contained or dead for accurate I.D.
- Ice for comfort – spiders & scorpions ONLY

**Bees & wasps**
- Remove sting mechanism (honeybees only) – scrape out
- Do not squeeze venom sac if remains on stinger
- Provide wound care
- Observe patient for systematic allergic reaction
- Treat Anaphylaxis – refer to Pediatric Anaphylaxis/Allergic Reaction Protocol

**Contact Medical Control**
- If Beta Blocker overdose is suspected AND patient is bradycardic & hypotensive; per MCA selection, administer Glucagon 1 mg IV/IM/IO. May be repeated after contact with MCA & Glucagon is available

**Glucagon**
- Included
- Not Included

**Symptomatic tricyclic antidepressant ingestion** (tachycardia, wide complex, QRS), administer sodium bicarbonate 50 mEq IV, repeat as needed.

**Extrapyramidal dystonic reactions**, administer diphenhydramine 50 mg IV.

**Symptomatic calcium channel blocker overdose**, per MCA selection administer Glucagon 1 mg IV/IM/IO. Consider calcium chloride 1 gm IV.

**Toxic Exposure Including Ingestion**
- Refer to Pain Management Procedure

**Inhalation Exposures**
- Dilute noxious gas inhaled including carbon dioxide & smoke
- Ensure high concentration of oxygen is provided
- If suspected cyanide gas exposure – refer to Cyanide Exposure Protocol and contact Medical Control immediately

**Eye Contamination**
- Irrigate continuously with Normal Saline or tap water 15 min (attempt to continue enroute) or as directed by Med Control
- Alkaline exposure, maintain continuous irrigation
- If available, administer Tetracaine 1-2 drops per eye, to facilitate irrigation ensure patient does not rub eyes.

**Skin Absorption**
- Brush off dry chemicals before irrigation.
- Irrigate continuously with Normal Saline or tap water for 15 min or as directed by Med Control

**Ingestion**
- Altered Mental Status – refer to Pediatric Altered Mental Status Protocol
- Respiratory distress – refer to Respiratory Distress Protocol
- Seizure – refer to Seizure Protocol
- Cardiac dysrhythmia – refer to appropriate dysrhythmia protocol

**Organophosphate Exposure (Malathion, Parathion)**
- Administer Mark I Kit/Duo Dote auto injector per CBRNE Nerve Agent/Organophosphate Pesticide Exposure Treatment Protocol
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- Observe patient for systematic allergic reaction
- Treat Anaphylaxis – refer to Pediatric Anaphylaxis/Allergic Reaction Protocol

**Contact Medical Control**
- If Beta Blocker overdose is suspected AND patient is bradycardic & hypotensive; per MCA selection, administer Glucagon 1 mg IV/IM/IO. May be repeated after contact with MCA & Glucagon is available

**Glucagon**
- Included
- Not Included

**Symptomatic Tricyclic Antidepressant Ingestion** (tachycardia, wide complex, QRS), administer sodium bicarbonate 50 mEq IV, repeat as needed.

**Extrapyramidal Dystonic Reactions**, administer diphenhydramine 50 mg IV.

**Symptomatic Calcium Channel Blocker Overdose**, per MCA selection administer Glucagon 1 mg IV/IM/IO. Consider calcium chloride 1 gm IV.
Narcan BLS Agency Information Form

Agency Name:
Primary Contact Name:
Primary Contact Title:
Mailing Address:
    City:  
    Zip:  
Email Address:
Phone Number:
Number of Licensed Basic Life Support vehicles:
Level of Agency License:

Authorized Individuals to purchase Narcan from Oaklawn/Bronson BC on behalf of your agency

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<thead>
<tr>
<th>Driver’s License Name</th>
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EMS I/C who will be providing training on Narcan Protocol:

Email Address of EMS I/C providing training:

Date of planned Narcan Training:

Date your agency will be in service (compliant) with Narcan Protocol:

Additional Comments/Notes:

Please return to dalsic@kellogg.edu or mail to CCMCA, Attn: Dr. Chet Dalski, 450 North Ave., Battle Creek, MI. 49017