11-26

FALL RISK REDUCTION ASSESSMENT

This protocol is for trained CIP Paramedics only. If during assessment, procedure, or treatment the patient is found to have a medical emergency in need of hospital treatment, the CIP visit will be suspended, and local MCA protocols utilized.

Purpose: To provide guidelines for the minimum elements of a fall risk reduction assessment and when it should be performed with the intent of reducing preventable falls.

Aliases: Home safety assessment, Fall risk check

I. Indications
   a. CIP encounter
II. Contraindication
   a. None
III. Equipment
   a. MCA approved fall risk reduction assessment checklist which will include
      i. Evaluation of environment
      ii. Evaluation of patient's ability in current state to maneuver in environment
   b. An MCA may elect to use an MCA approved abbreviated version of the fall risk reduction checklist for the following situations:
      i. Subsequent visits of an enrolled patient with no notable change in environment or patient status.
      ii. Non-scheduled visits that do not allow time for a fall risk reduction assessment due to the disposition of the patient
IV. Procedure
   a. Perform fall risk reduction assessment following MCA approved checklist.
   b. Findings that present threats to the patient's immediate health and well-being must be reported to the referring prior to the conclusion of the visit.
V. Documentation **see CIP Documentation protocol**
   a. Additionally
      i. Completion of checklist
      ii. Findings
      iii. Corrections or plan for corrections
      iv. Inability to complete corrections and reason

11-27

SOCIAL DETERMINANTS OF HEALTH ASSESSMENT

This protocol is for trained CIP Paramedics only. If during assessment, procedure, or treatment the patient is found to have a medical emergency in need of hospital treatment, the CIP visit will be suspended, and local MCA protocols utilized.

Purpose: To provide guidelines for the minimum elements of a Social Determinants of Health (SDOH) assessment and when it should be performed with the intent of reducing barriers to optimal health.

Aliases: Health care barriers

I. Indications
   a. Intake/enrollment assessments
   b. Referring physician request
   c. As deemed necessary by CIP provider

II. Contraindications
   a. None

III. Equipment
   a. MCA approved SDOH Assessment Form which will include:
      i. Housing, transportation access, safety within their environment, food security, social exclusion, social support, healthcare access and addiction.

IV. Procedure
   a. Perform SDOH assessment following MCA approved checklist.
   b. Assess both the patient and their environment
   c. Findings that present threats to the patient's immediate health and well-being must be reported to the referring physician prior to conclusion of the visit.

V. Documentation **see CIP Documentation protocol**
   a. Additionally
      i. Completion of check list
      ii. Findings
      iii. Corrections, referrals or plans for either
      iv. Inability to complete corrections or referrals and reason

11-28

MEDICATION AUDIT

This protocol is for trained CIP Paramedics only. If during assessment, procedure, or treatment the patient is found to have a medical emergency in need of hospital treatment, the CIP visit will be suspended, and local MCA protocols utilized.

Purpose: To provide guidelines for the minimum elements of a medication audit and when it should be performed.

I. Indications
   a. CIP Encounter
II. Contraindications
   a. None
III. Equipment
   a. MCA approved medication audit checklist which will include:
      i. Medication expiration dates
      ii. Dispensing method of medications that works for the patient
      iii. Barriers to obtaining medications
      iv. Questions or concerns patient has regarding medications which will be forwarded to PCP or referring physician.
IV. Procedures
   a. Perform medication audit according to referring physician directions or MCA approved medication audit checklist when physician orders are not present.
   b. Findings that present threats to the patient's immediate health and well-being must be reported to the referring physician prior to the conclusion of the visit.
V. Documentation **see CIP Documentation protocol**
   a. Additionally
      i. Completion of medication audit
      ii. Findings
      iii. Name of provider notified of the discrepancy along with date and time of notification
      iv. Course of action determined appropriate by online medical control if applicable

11-29

FEEDING TUBES

This protocol is for trained CIP Paramedics only. If during assessment, procedure, or treatment the patient is found to have a medical emergency in need of hospital treatment, the CIP visit will be suspended, and local MCA protocols utilized.

Purpose: Provide guidelines for CIP paramedics to maintain a percutaneous tract into the stomach or a nasogastric tube through evaluation of efficacy and either rectifying or making a referral for ineffective tracts.

Aliases: Feeding Tubes, NG tubs, PEG tubes

I. Indications
   a. Complaints including blockage, damage or need for replacement

II. Contraindication
   a. Signs of infection or active bleeding

III. Equipment
   a. 10 ml syringe
   b. Warm water or carbonated beverage such as diet cola
   c. Approved de-clogging device designed for the tube.

IV. Procedure
   a. Identify the type of feeding tube.
   b. Examine for patency, functionality, and placement.
   c. If there is evidence of blockage, using sterile technique flush the tube using a 10 ml syringe and water or carbonated beverage.
      i. If unable to flush use carbonated beverage and let it sit for 5-10 minutes and reattempt flushing.
   d. If unable to establish good flow and the tube is in place, consider making arrangement for replacement.

   e. ☐ Nasogastric tube removal (optional)
      i. Obtain medical direction prior to procedure
      ii. Position patient a minimal of a 30-degree incline from supine to prevent aspiration
      iii. Discontinue gastric suction
      iv. Flush the tube with a small bolus of air to clear any remaining gastric contents
      v. Remove securement device
      vi. Fold over or clamp the proximal end of the tube to prevent backflow of gastric contents

vii. Direct patient to hold the breath to close the epiglottic and withdraw the tube gently and steadily.

viii. When the distal end of the tube reaches the nasopharynx, it can be pulled quickly

ix. Inspect the tube to ensure it is intact

f. ☐ Replacement of damaged percutaneous tube in a well-established tract (optional)

i. Indications

a. Inadvertent removal of a tube

ii. Contraindications

1. Initial gastrostomy placed less than 2 months ago
2. Tube has been out of place for more than 24 hours iii. Procedure
   1. Consider analgesics
   2. Utilize sterile technique
   3. Insert largest appropriate replacement tube (urinary catheter)

g. Concerns that present threats to the patient's immediate health and well-being must be reported to the referring physician prior to the conclusion of the visit.

V. Documentation **see CIP Documentation protocol**

a. Additionally (if applicable)

i. Results of attempts to flush tubes

ii. Removal of NG tubes, tube intact and patient reaction

iii. Replacement of percutaneous tract tube, confirmation of placement and measurements

URINARY CATHETER 11-30

This protocol is for trained CIP Paramedics only. If during assessment, procedure, or treatment the patient is found to have a medical emergency in need of hospital treatment, the CIP visit will be suspended, and local MCA protocols utilized.

Purpose: Provide guidelines for CIP paramedics to evaluate efficacy, rectify issues or make appropriate referrals for ineffective urinary catheters. Allow placement of urinary catheters for patients with known recurring urinary retention.

Aliases: Foley, cath, suprapubic catheter, indwelling catheter, urinary catheter, sterile technique = aseptic technique.

I. Indications for urinary catheter care
   a. blockage or damage of the catheter
   b. physician ordered replacement
   c. need for removal
   d. need for removal and reinsertion
   e. catheterization for relief of urinary retention
   f. Consult with referring physician prior to initial placement of a urethral catheter unless it is explicitly written in the physician's orders.

II. Contraindications
   a. Recent external trauma to pelvis

III. Equipment
   a. Appropriate size urethral catheter (5Fr-26Fr)
   b. Collection bag
   c. Syringe (10ml, 20ml or 30ml)
   d. Lubricant
   e. Lidocaine Jelly 2%
   f. Sterile water
   g. Sterile field kit

IV. Procedures
   a. Flushing of an indwelling catheter
      i. Identify the type of catheter.
      ii. Examine the catheter for patency, functionality, and placement.
      iii. If there is evidence of blockage, using sterile technique flush the tube using a 10-30 ml syringe using sterile water at room temperature. .
      iv. If unable to establish good flow, the catheter is non-functional, damaged or has become displaced consider removal and replacement.
   b. Removal of urethral or suprapubic catheter
      i. Empty bag of urine
      ii. Remove all fluid from balloon
      iii. Gently remove

iv. Note length of the tube section that was inserted

c. Placement or replacement of urethral catheter
- i. Obtain medical direction prior to initial placement of an indwelling urethral catheter
- ii. Prepare sterile field, utilize sterile technique
- iii. Check balloon for patency
- iv. Generously coat the distal portion (2-5 cm) of the catheter with lubricant and/or 2% Lidocaine Jelly 5 to 30 ml for males and 3-5 ml for females.
- v. Females, separate labia using non-dominant hand. For males, hold the penis with the non-dominant hand.
- vi. Maintain hand position until preparing to inflate balloon. vii. Using dominant hand to handle forceps, cleanse peri-urethral mucosa with cleansing solution. Cleanse anterior to posterior, inner to outer, one swipe per swab, discard swab away from sterile field. viii. Pick up catheter with gloved (and still sterile) dominant hand. Hold end of catheter loosely coiled in palm of dominant hand. ix. In the male, lift the penis to a position perpendicular to patient's body and apply light upward traction (with non-dominant hand)
- x. Identify the urinary meatus and gently insert until 1 to 2 inches beyond where urine is noted
- xi. Inflate balloon, using correct amount of sterile liquid (usually 10 cc but check actual balloon size)
- xii. Gently pull catheter until inflation balloon is snug against bladder neck
- xiii. Connect catheter to drainage system
- xiv. Secure catheter to abdomen or thigh, without tension on tubing
- xv. Place drainage bag below level of bladder
- xvi. Evaluate catheter function and amount, color, odor, and quality of urine
- xvii. Remove gloves, dispose of equipment appropriately, wash hands
- xviii. Document size of catheter inserted, amount of water in balloon, patient's response to procedure, and assessment of urine

d. Replacement of existing suprapubic catheter
- i. Prepare sterile field, utilize sterile technique
- ii. Check balloon for patency
- iii. Clean and lubricate the insertion site area
- iv. Insert the catheter into the suprapubic site the same distance as the catheter removed.

v. Inflate balloon, using correct amount of sterile liquid (usually 10 cc but check actual balloon size)
vi. Gently pull catheter until inflation balloon is snug against bladder neck
vii. Connect catheter to drainage system
viii. Secure catheter to abdomen or thigh, without tension on tubing
ix. Place drainage bag below level of bladder
x. Evaluate catheter function and amount, color, odor, and quality of urine
xi. Remove gloves, dispose of equipment appropriately, wash hands
xii. Document size of catheter inserted, amount of water in balloon, patient's response to procedure, and assessment of urine

V. Concerns that present threats to the patient's immediate health and well-being must be reported to the referring physician at the conclusion of the visit, all other concerns within 24 hours.

VI. Documentation **see CIP Documentation protocol**
a. Additionally:
i. Color, odor, and quantity of urine when applicable

OSTOMY BAG REPLACEMENT 11-31

This protocol is for trained CIP Paramedics only. If during assessment, procedure, or treatment the patient is found to have a medical emergency in need of hospital treatment, the CIP visit will be suspended, and local MCA protocols utilized.

Purpose: Provide guidelines for CIP paramedics to change an ostomy bag and/or evaluate efficacy and make a referral for ineffective ostomies.

Aliases: Colostomy, ileostomy.

I. Indications
   a. Need for bag replacement or evaluation for complaints including blockage, damage, or signs of infection.

II. Equipment
   a. One or two-piece ostomy appliance

III. Procedure for bag change
   a. Examine the ostomy site for herniation, bleeding, or signs of infection.
      i. If signs of herniation, bleeding or infection are present contact referring physician for orders.
   b. Identify ostomy appliance as either a one piece or a two-piece appliance.
   c. Measure the ostomy site if it is less than 6 weeks old.
   d. Remove per manufacturer's directions.
   e. Remove excess stool from skin
   f. Prepare skin/site for replacement of flange/wafer if applicable.
   g. Place following manufacturer's directions
   h. Concerns that present threats to the patient's immediate health and well-being must be reported to the referring physician at the conclusion of the visit, all other concerns within 24 hours.

IV. Documentation **see CIP Documentation protocol**

NASAL PACKING PLACEMENT AND REMOVAL 11-32

This protocol is for trained CIP Paramedics only. If during assessment, procedure, or treatment the patient is found to have a medical emergency in need of hospital treatment, the CIP visit will be suspended, and local MCA protocols utilized.

Purpose: Provide guidelines for CIP paramedics to place and/or remove anterior nasal packing as approved by the MCA.

Aliases: Rhino rockets, nasal tampons

I. ☐ Anterior Nasal Packing Placement (optional)

a. Indications
   i. Nasal packing for nosebleeds that have not been controlled by lesser measures **see CIP Non-Traumatic Nosebleed protocol**
b. Contraindications
   i. Nosebleeds caused by trauma
c. Equipment
   i. MCA approved manufactured nasal packing that includes manufacturer recommendations for placement and usage
d. Procedure
   i. Obtain medical direction prior to procedure
   ii. Follow manufacturer's directions for placement
   iii. Remain with patient for 30 minutes to assure bleeding has stopped
      1. If bleeding has not stopped activate 9-1-1 for transport to an emergency department
   iv. Arrange for follow-up with PCP within 24-48 hours.
      1. If follow-up with PCP cannot be made withing 24-48 hours schedule CIP follow-up within 24 for nasal packing removal.
e. Documentation **see CIP Documentation protocol**

II. ☐ Anterior Nasal Packing Removal (optional)

a. Indications
   i. Nasal packing has been in place for 24-48 hours
b. Contraindications
   i. Active bleeding
c. Equipment
   i. Syringe

d. Procedure
   i. Obtain medical direction prior to procedure
   ii. Evaluate for presence of balloon
   iii. Deflate balloon completely with appropriate size syringe
   iv. Gently pull the strings attached to the packing until packing is completely removed
   v. Observe patient for 5 minutes to ensure bleeding does not reoccur.

      1. If bleeding reoccurs **see CIP Non-Traumatic Nosebleed protocol**

e. Documentation **see CIP Documentation protocol**

SPECIMEN COLLECTION 11-33

This protocol is for trained CIP Paramedics only. If during assessment, procedure, or treatment the patient is found to have a medical emergency in need of hospital treatment, the CIP visit will be suspended, and local MCA protocols utilized.

Purpose: Provide guidelines for CIP paramedics to obtain and transport specimen at the request of a health care provider as approved by the MCA

Aliases: labs, strep test, swab test

I. Indications

a. Order from a clinician requesting specimen collection to be obtained and transported to the appropriate testing facility when a patient has a barrier to submitting specimens in a timely manner.

b. Specimen collection for the purpose of point of care testing.

II. Procedure

a. For all procedures accompanied by a physician's order.

i. Review order for special instructions prior to collecting the specimen

ii. Label with the patient's name, date of birth, and additional information required for the specific specimen (source, date, time) or required by the MCA or specimen testing facility.

iii. Complete appropriate lab paperwork.

iv.Transport sample in a biohazard bag or follow clinician's order for shipping.

b. ☐ Lab Draw (optional)

i. Considerations: Patients who are on blood thinners may require prolonged direct pressure after blood draw. Equipment

1. Appropriate needle
2. Rainbow tubes

ii. Procedure

1. Select an appropriate site and using universal precautions cannulate the vein.
2. Blood tubes should be collected in the order of red, green, purple, pink and blue.

c. ☐ Urine Specimen (optional)

i. Equipment

1. Urine specimen cup
2. wipes ii. Procedure

1. Obtain sample through method ordered (clean catch, foley bag, etc.)

d. ☐ Nasal Swab

i. Equipment – appropriate swabs for specific test
ii. Procedure
1. Place patient in seated position
2. Tilt patient's head back slightly to visualize nasal passages
3. Gently insert swab along nasal septum, just above the floor of the nasal passage, to the nasopharynx
a. Stop when resistance is met & do not force the swab further
b. If resistance is detected, pull back slightly and try reinserting at a different angle, closer to the floor of the nasal canal
c. The swab should reach a depth equal to the distance from the nostrils to the outer opening of the ear
4. Rotate swab several times, remaining in the passage for 10 seconds
5. Gently removed swab while rotating
6. Place swab into collection tube according to directions and prior to breaking the stick
7. Secure lid on the tube

e. ☐ Throat Swab

i. Equipment – appropriate swabs for specific test
ii. Procedure
1. Place patient in seated position
2. Tilt patient's head back, instruct them to open their mouth and stick out their tongue
3. Use a wooden tongue depressor to hold the tongue in place
4. Visualize the posterior nasopharynx and tonsillar arches
5. Without touching the side of the mouth, insert the swab reaching the posterior nasopharynx and tonsillar arches wiping the swab on the area
6. Place swab into collection tube according to directions and prior to breaking the stick
7. Secure the lid on the tube

III. Documentation **see CIP Documentation protocol**
a. Additionally: testing procedure used and results if applicable

POINT OF CARE TESTING FOR BLOOD ANALYSIS 11-34

This protocol is for trained CIP Paramedics only. If during assessment, procedure, or treatment the patient is found to have a medical emergency in need of hospital treatment, the CIP visit will be suspended, and local MCA protocols utilized.

Purpose: Provide guidelines for CIP paramedics to perform advanced point of care testing at patient's side with a CLIA waived device that performs blood analysis. This protocol was designed around the use of the Abbot i-STAT system and Piccolo Xpress system. Always follow manufacturer instructions.

Aliases: Handheld blood analyzer, portable clinical analyzer, i-STAT, Piccolo

I. Indications
   a. Physician's order
   b. CIP Patients who require point of care testing to guide treatment.

II. Contraindications
   a. Not CLIA waived

III. Equipment
   a. CLIA waived point of care testing device with appropriate CLIA waived cartridges for testing.
   b. Appropriate equipment for specific device.

IV. Procedure
   a. Obtain appropriate blood sample.
   b. Follow device's instructions for use.

V. Documentation **see CIP Documentation protocol**
   a. Additionally: cartridges utilized and test results

SUTURE REMOVAL 11-35

This protocol is for trained CIP Paramedics only. If during assessment, procedure, or treatment the patient is found to have a medical emergency in need of hospital treatment, the CIP visit will be suspended, and local MCA protocols utilized.

Purpose: To provide guidelines for CIP paramedics to safely remove sutures and/or staples as approved by the MCA.

Aliases: Stitches, staples

I. Indications
   a. Request from a clinician to remove a known type of suture
II. Contraindications
   a. Signs of wound complications or infection
III. Equipment
   a. Forceps
   b. Suture scissors
   c. Staple remover
   d. Sterile gauze
   e. Sterile 0.9% sodium chloride solution
   f. Sterile wound strips
IV. Procedure
   a. Plain suture removal (optional)
      i. Gently grasp the knot or the tail with forceps and raise it slightly
      ii. Place the curved tip of the suture scissors directly under the knot or on the side, close to the skin
      iii. Gently cut the suture and pull it out with the forceps
      iv. Make sure all suture material is removed and placed on clean gauze
      v. Remove alternate sutures
      vi. Assess the wound for dehiscence (edges of the wound do not meet)

   1. Absence of dehiscence
      a. Remove remaining sutures
      b. Apply sterile wound strips to prevent dehiscence
   2. Presence of dehiscence
      a. Do not continue to remove sutures
      b. Cover wound with sterile gauze saturated with sterile 0.9% sodium chloride solution
      c. Contact physician **see CIP Medical Direction protocol**

b. Staple removal (optional)
    i. Place the lower jaw of the remover under a staple
    ii. Squeeze the handles completely to close the device bending the staple in the middle and pulling the edges of the staple out of the skin
    iii. Gently move the staple away from the incision site when both ends are visible
    iv. Hold the staple remover over a sharps container, relax pressure on the handles, let the staple drop into the sharps container

v. Remove alternate staples
vi. Assess the wound for dehiscence (edges of the wound do not meet)
    1. Absence of dehiscence
        a. Remove remaining staples
        b. Apply sterile wound strips to prevent dehiscence
    2. Presence of dehiscence
        a. Do not continue to remove staples
        b. Cover wound with sterile gauze saturated with sterile 0.9% sodium chloride solution
        c. Contact physician **see CIP Medical Direction protocol**

V. Documentation **see CIP Documentation protocol**
    a. Additionally:
        i. Date and time of removal
        ii. Number of sutures or staples removed
        iii. Dressings or adhesive wound strips applies iv. Appearance of the incision

OTOSCOPE 11-36

Purpose: Provide guidelines for CIP paramedics to utilize an otoscope or disposable speculum for patient evaluation.

Aliases: Speculum

I. Indications
   a. Need for visualization of the eardrum
II. Contraindications
   a. None
III. Equipment
   a. Otoscope
   b. Otoscope with disposable specula (eartip)
IV. Procedure
   a. Adult positioning
      i. Use otoscope with largest ear speculum that the ear canal will accommodate
      ii. Position patient's head and neck upright
      iii. Grasp auricle firmly and gently, pull upwards, backward and slightly away from the head
      iv. Hold otoscope handle between thumb and fingers and brace hand against patient's face
      v. Insert speculum into ear canal, directing it somewhat down and forward and through hairs
   b. Child positioning
      i. Child may sit up or lie down
      ii. Hold otoscope with handle pointing down toward child's feet while pulling up on auricle
      iii. Hold the head and up on auricle with one hand while holding otoscope with the other hand
      iv. Insert speculum into ear canal, directing it somewhat down and forward and through hairs
   c. Inspection for both adult and child
      i. Inspect ear canal noting discharge, foreign bodies, redness and/or swelling
      ii. Inspect eardrum noting color and contour and perforations
V. Documentation **see CIP Documentation protocol**
   a. Additionally:
      i. Eardrum color, translucency, and presence or absence of swelling or perforation.

      ii. ii. Ear canal discharge, foreign bodies, redness and/or swelling

11-37

PERIPHERALLY INSERTED CENTRAL CATHETER (PICC) ACCESS

This protocol is for trained CIP Paramedics only. If during assessment, procedure, or treatment the patient is found to have a medical emergency in need of hospital treatment, the CIP visit will be suspended, and local MCA protocols utilized.

Purpose: Provide guidelines for the use of PICC lines.

Aliases: PICC

I. Peripherally Inserted Central Catheters (PICC
   a. Description: PICC lines are long catheters inserted through a vein in the arm, leg or neck with the terminal end positioned in the superior vena cava, inferior vena cava, or the proximal right atrium. PICC lines are used for long duration access generally up to 6 months.
   b. CIP Uses: Accessing for medications, antibiotics, parenteral nutrition, and blood draws.
   c. Indications
      i. Accessing for blood draws or administration of fluids and/or medications
      ii. Maintenance including flushing, dressing change and evaluation of insertion site
   d. Contraindications
      i. Has not been used and confirmed
      ii. Suspicion it is not patent
      iii. Signs of infection at site
   e. Equipment
      i. Saline Flush (x2)
      ii. 10 cc syringe (x2)
   f. Procedure
      i. Appropriate PPE and use sterile technique
      ii. Evaluate the site for redness, pain, exudate, and the arm for swelling, pain and stiffness
      iii. Flush the PICC line with 10ml of NS
      iv. Administer medications and/or fluids a prescribed or draw blood for labs
      v. Flush the PICC line with 10ml NS

II. Documentation **see CIP Documentation protocol**

VACCINATIONS 11-38

This protocol is for trained CIP Paramedics only. If during assessment, procedure, or treatment the patient is found to have a medical emergency in need of hospital treatment, the CIP visit will be suspended, and local MCA protocols utilized.

Purpose: To provide guidelines for the administration of vaccinations as approved by the MCA.

Aliases: Immunizations

I. Indications
   a. Order from a clinician requesting the administration of a vaccination
   b. Participation in mass immunization settings

II. Vaccinations eligible for administration by CIP paramedics as approved by the MCA include:
   a. ☐ Chickenpox (Varicella)
   b. ☐ Diphtheria
   c. ☐ Flu (Influenza)
   d. ☐ Hepatitis A
   e. ☐ Hepatitis B
   f. ☐ Hib (Haemophilus influenzae type b)
   g. ☐ HPV (Human Papillomavirus)
   h. ☐ Measles
   i. ☐ Meningococcal
   j. ☐ Mumps
   k. ☐ Pneumococcal
   l. ☐ Polio (Poliomyelitis)
   m. ☐ Rotavirus
   n. ☐ Rubella (German Measles)
   o. ☐ Shingles (Herpes Zoster)
   p. ☐ Tetanus (Lockjaw)
   q. ☐ Whooping Cough (Pertussis)
   r. ☐ COVID 19 when available

VACINATIONS 11-38

III. Contraindications
a. Allergies noted in pre immunization screening

IV. Equipment
a. Vaccine
b. Appropriate delivery device

V. Procedure
a. Timing and dosing of immunizations will be determined by the PCP and/or public health department
b. Pre immunizations screening must be done prior to administration of the vaccination

c. Vaccinations may be administered via IM, SQ or intranasal route as appropriate for the specific vaccination

d. Verify Michigan Care Improvement Registry (MCIR) documentation

VI. Documentation **see CIP Documentation protocol**

NALOXONE LEAVE BEHIND 11-39

This protocol is for trained CIP Paramedics only. If during assessment, procedure, or treatment the patient is found to have a medical emergency in need of hospital treatment, the CIP visit will be suspended, and local MCA protocols utilized.

Purpose: Provide guidelines for CIP paramedics to leave a Naloxone kit with patients who are being evaluated and cared for due to a narcotic substance use disorder.

Aliases: Leave behind, Narcan kit

I. Indications
   a. Patient is enrolled in a CIP program
II. Contraindications
   a. Under the age of 18
III. Equipment
   a. Prepackaged naloxone kit **see CIP Naloxone Medication Kit Contents and Distribution protocol**
IV. Procedure
   a. Provide naloxone kit to patient
   b. Educate patient and support persons on use of naloxone kit
      i. Demonstrate administration with dummy intranasal device and water
         1. Allow patient to express water from intranasal device
      ii. Discuss the importance of respiratory support
      iii. Discuss the importance of initiating a 9-1-1 response
      iv. Discuss the risks of an opioid medication half-life potentially being longer than the duration of naloxone
      v. Discuss the risks of a single does of naloxone being insufficient for full reversal
V. Documentation **see CIP Documentation protocol**

Naloxone Medication Kit Contents and Distribution Procedure

I. Medications and supplies for naloxone kits will be supplied by member facilities within the MCA.
II. Assembly, labeling, and access to kits will be done according to the **Pharmacy, Drug Box and IV Supply Exchange Procedure.**
III. Overdose Medication Kit Contents List

Medication / Item	Concentration	Packaging	Quantity
Naloxone (Narcan)	4mg / spray	Nasal Spray	1
MDHHS Safety Advice for Patient and Family Members Card			1
Resuscitation Face shield*			1* *(MCA Optional)
Replacement Form			1
Local Treatment Resources Form			1

IV. Procedure

A. Each participating EMS Agency will stock each of its licensed vehicles with 2 Naloxone Medication Kits. After deployment, the naloxone medication kit will be replaced within 24 hours at the assigned stocking hospital pharmacy.
B. Kits will be stored on the EMS vehicle in a secure way, not accessible to the public.
C. Deployment of a Naloxone Medication Kit will be documented the patient care record and uploaded to the Michigan EMS Information System.
D. The replacement/use form will be completed and returned to the designated hospital pharmacy for dispensing of a replacement Naloxone Kit.