

PUBLIC SAFETY FIRST AID NALOXONE PROVIDER TEACHING POINTS

What are Opioids?

Opioids are central nervous system depressants that decrease the perception of pain. They may be prescribed for acute, debilitating, or chronic pain or used illicitly. They can be injected, taken orally or intranasally.

Opioid Overdose

A suspected opioid overdose can be recognized by three characteristics, known as the Triad:

1. Pinpoint Pupils
2. Unconsciousness
3. Respiratory Depression of **less than 8 breaths per minute**

Further observations may include:

- Track Marks
- Heroin Balloons
- Drug Paraphernalia
- Bystander Report

What is Naloxone?

Naloxone is an opioid antagonist which reverses the effects of opioids such as respiratory depression. The trade name is Narcan. Public Safety First Aid (PSFA) providers may administer Naloxone Intranasally. Administering Naloxone is for the purpose of restoring breathing. The onset is within 1 to 3 minutes and lasts 30 to 60 minutes.

Administering Naloxone

1. Approach scene with Narcan kit looking for hazards and considering safety
2. Stimulate the unconscious victim
3. Confirm EMS is enroute
4. Open airway
5. Confirm your suspicion that the patient has overdosed on an opioid.
 - a. Use clues from the patient, witnesses and environment.
 - b. Look for pinpointed pupils, unconsciousness, and less than 8 breaths per minute
6. Administer Nasal Narcan by placing atomizer within one nostril and aim slightly upwards and towards ear on same side of head. Briskly compress atomizer.
7. Place patient in recovery position and monitor breathing.
8. Do not administer more than 2 doses.
9. Report your use to EMS on scene.

Contraindications to Nasal Narcan Use

- Nasal trauma or nasal obstruction
- Cardiac arrest
- Seizure activity
- **Allergic to Naloxone**

Reporting procedure:

A Public Safety First Aid Optional Skills Patient Care Report Form must be completed and forwarded to emsagency@ventura.org within 24 hours of administration.



Ventura County EMS Agency



PSFA Optional Skills Patient Care Report Form

Date:	Incident #:	Incident City:	Cross Streets: Street 1 _____ / Street 2 _____				
Dispatch Time:		Arrive Scene:			Pt. Contact Time:		
EMS Arrival Time:		EMS / Fire Agency:			EMS / Fire Unit#:		
Incident Location Type:							
<input type="checkbox"/> Private Residence (Home / Apt)		<input type="checkbox"/> Car / Vehicle					
<input type="checkbox"/> Outside (street, park, beach)		<input type="checkbox"/> Shelter					
<input type="checkbox"/> School		<input type="checkbox"/> Hotel / Motel					
<input type="checkbox"/> Business / Work		<input type="checkbox"/> Other (Specify) _____					
Patient Information							
Patient Age:				Patient Gender:			
Chief Complaint:				Known / Suspected Drugs Used:			
<input type="checkbox"/> Allergic Reaction		<input type="checkbox"/> Respiratory Arrest		<input type="checkbox"/> Heroin	<input type="checkbox"/> Marijuana		
<input type="checkbox"/> Altered LOC		<input type="checkbox"/> Seizure		<input type="checkbox"/> Methadone	<input type="checkbox"/> Methamphetamine		
<input type="checkbox"/> Cardiac Arrest		<input type="checkbox"/> Shortness of Breath		<input type="checkbox"/> Other Opioid (Oxycontin, Oxycodone, Vicodin)	<input type="checkbox"/> Alcohol		
<input type="checkbox"/> OD / Poisoning		<input type="checkbox"/> Other _____		<input type="checkbox"/> Cocaine	<input type="checkbox"/> Other (Specify) _____		
				<input type="checkbox"/> Unknown			
Remarks:							
Patient Condition – Initial Assessment							
Pulse	Breathing	Mental Status	Orientation	Speech	Skin	Skin Color	
<input type="checkbox"/> Present	<input type="checkbox"/> Normal	<input type="checkbox"/> Alert	<input type="checkbox"/> Person	<input type="checkbox"/> Normal	<input type="checkbox"/> Warm	<input type="checkbox"/> Normal	
<input type="checkbox"/> Absent	<input type="checkbox"/> Shallow	<input type="checkbox"/> Conscious	<input type="checkbox"/> Place	<input type="checkbox"/> Coherent	<input type="checkbox"/> Cool	<input type="checkbox"/> Cyanotic (Blue)	
	<input type="checkbox"/> Labored	<input type="checkbox"/> Unconscious	<input type="checkbox"/> Time	<input type="checkbox"/> Incoherent	<input type="checkbox"/> Cold	<input type="checkbox"/> Pale	
	<input type="checkbox"/> Agonal	<input type="checkbox"/> Hysterical	<input type="checkbox"/> Reason	<input type="checkbox"/> Slurred			
	<input type="checkbox"/> Absent	<input type="checkbox"/> Combative		<input type="checkbox"/> Silent			
Patient Condition – Transfer of Care to Fire/EMS							
Pulse	Breathing	Mental Status	Orientation	Speech	Skin	Skin Color	
<input type="checkbox"/> Present	<input type="checkbox"/> Normal	<input type="checkbox"/> Alert	<input type="checkbox"/> Person	<input type="checkbox"/> Normal	<input type="checkbox"/> Warm	<input type="checkbox"/> Normal	
<input type="checkbox"/> Absent	<input type="checkbox"/> Shallow	<input type="checkbox"/> Conscious	<input type="checkbox"/> Place	<input type="checkbox"/> Coherent	<input type="checkbox"/> Cool	<input type="checkbox"/> Cyanotic (Blue)	
	<input type="checkbox"/> Labored	<input type="checkbox"/> Unconscious	<input type="checkbox"/> Time	<input type="checkbox"/> Incoherent	<input type="checkbox"/> Cold	<input type="checkbox"/> Pale	
	<input type="checkbox"/> Agonal	<input type="checkbox"/> Hysterical	<input type="checkbox"/> Reason	<input type="checkbox"/> Slurred			
	<input type="checkbox"/> Absent	<input type="checkbox"/> Combative		<input type="checkbox"/> Silent			
Procedures Performed and Medication Administered							
Procedures Performed		Medications Administered	Medication Administration				
<input type="checkbox"/> Sternal Rub <input type="checkbox"/> Recovery Position <input type="checkbox"/> Rescue Breathing <input type="checkbox"/> CPR <input type="checkbox"/> AED		<input type="checkbox"/> Naloxone	Time 1st Dose:		<input type="checkbox"/> R Nostril	<input type="checkbox"/> L Nostril	
			Condition: <input type="checkbox"/> Improved <input type="checkbox"/> Worsened <input type="checkbox"/> Unchanged <input type="checkbox"/> Expired				
			Time 2nd Dose:		<input type="checkbox"/> R Nostril	<input type="checkbox"/> L Nostril	<input type="checkbox"/> Not Indicated
			Condition: <input type="checkbox"/> Improved <input type="checkbox"/> Worsened <input type="checkbox"/> Unchanged <input type="checkbox"/> Expired				
Agency Information							
PSFA Provider Agency:		Officer / Deputy Name:		Station:		ID#:	
Signature:				Naloxone Kit ID#			