

POLICY: 554.65
TITLE: Non-Fatal Drowning

EFFECTIVE: 09/01/2026
REVIEW: 8/2028
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

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DROWNING

- I. AUTHORITY
Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9
- II. PURPOSE
To serve as a patient treatment standard for EMRs, EMTs, AEMTs and Paramedics within their scope of practice.
- III. PROTOCOL
Definition of drowning: Respiratory impairment from submersion or immersion in a liquid. Duration of submersion is the most important predictor of outcome. Encourage transport of all symptomatic patients due to potential worsening over the next six hours.

Patients may also have significant head, neck, and back injuries. Strongly consider spinal immobilization when a history of jumping or diving into the water exists, or the history is unclear.

Surfactant is fluid from the lungs and is usually “foam-like”. DO NOT waste time with suction attempts. Ventilate through the foam and suction only when excessive water or vomit is present.

Early initiation of effective ventilation and CPR are most critical to improve survivability and neurologic outcomes. Hypoxia is the primary reversible cause of morbidity and mortality.

Provider Key: F = First Responder/EMR E = EMT O = EMT Local Optional SOP
P = Paramedic A=Advanced EMT D = Base Hospital Physician Order Required

	F	E	O	A	P	D
SPINAL MOTION RESTRICTION: as indicated.	X	X	X	X	X	
ASSESSMENT: Obtain accurate time of drowning if able.	X	X	X	X	X	
ALS ASSESSMENT: required for persistent signs or symptoms of cough, abnormal lung sounds, altered mental status, hypoxia, hypotension, or dyspnea.				X	X	
Apnea or Cardiac Arrest: 5 initial rescue breaths prior to compressions. PEEP valve with BVM when available. Trained rescuers may initiate in-water resuscitation with rescue breaths during extrication/rescue if safe and effective. Do not delay rapid extrication.	X	X	X	X	X	X
PULSE OXIMETRY: apply and monitor.		X	X	X	X	
CAPNOGRAPHY: apply and monitor.					X	
OXYGEN: if pulse oximetry < 94% or signs of respiratory distress or hypoperfusion.	X	X	X	X	X	
BLS AIRWAY: okay if airway patent. Support ventilations with appropriate airway adjuncts.	X	X	X	X	X	

ADVANCED BLS AIRWAY: if GCS is < 8 and not rapidly improving, consider SGA.			X	X	X	
ADVANCED ALS AIRWAY: if GCS is < 8 and not rapidly improving, consider ETI.					X	
ECG MONITOR: lead placement may be delegated. Treat as indicated.					X	
VASCULAR ACCESS: P - IV/IO, AEMT - IV only, rate as indicated.				X	X	
CPAP: as indicated.		X	X	X	X	
PUSH DOSE EPINEPHRINE: for hypotension – titrate to SBP ≥ 90 - Mix 1 mL of Epi 1:10,000 (0.1 mg/mL) with 9 mL of NS = concentration of 1:100,000 (0.01 mg/mL) - Label syringe “epinephrine 10 mcg/mL” 0.5 – 1 mL (5 – 10 mcg) IVP every 1 – 5 minutes If SBP does not stabilize ≥ 90 after two doses, consider epinephrine drip. Refer to 554.88 Rx GUIDELINES					X	

CONSIDER:

555.62 Hypothermia-Frostbite

555.82 Trauma and Traumatic Shock