February 2026 EMSAC Public Comments		
Protocol/Policy	**Public Comments**	**EMSA/Medical Director Responses**
Policy 2020-EMT Program Approval	grammatical choices in policy section-follow established style 2.3 "ninety (90)" 2.4 "four (4)" - occurs twice 2.6.3.2 "Deny, withdraw or suspend program approval" 3.2.1 "thirty (30)" 3.2.2 "thirty (30)" 3.2.3 "The program director" 3.2.4 "thirty (30)"	Revised

Policy 2040-EMT Certification	gammatical choices in policy section-follow established style 3.1 "eighteen (18)" 3.2 recommend removal of URL, as this may change 4.1 "Section 3" not "Section III" 4.2 "two (2)"; "twenty-four (24)" 4.3 Q: why do out of state applicants need to provide contact details for the issuer of their National Registry cert/card when the issuer is... National Registry? 5.1 "Section 3" not "Section III" 5.5 "twenty-four (24)" 6.1 "Section 5" not "Sections V" 7.1 "Section 5" not "Sections V"; "thirty-six (36) hours" 8.1 "Section 5" not "Sections V"; "fourty-eight (48)"	Revised 3.2. Agreed. Hyperlink removed 4.3. Out of state documentation requirements remove
Policy 2050-Paramedic Accreditation	4.2.3 Looks like this is part of 4.2.2 - separated by mistake 4.3.10.1 "9-1-1" 5.1.5.1 Looks like this is part of 5.1.5 - separated by mistake	Revised

Policy 2050-Paramedic Accreditation	4.2.3 and 5.1.5.1 font is different	Revised
Policy 4041-Physician On-Scene	1.2 and 1.4 blank - assume you'll clean this up	Revised
Policy 4041-Physician On-Scene	3.2.5 feels very event specific based on something that happened, as opposed to a general policy. Perhaps to generalize it more, it could say "in the event of a time-sensitive emergency where verification of the physicians credentials and/or base contact is not feasible, care should be provided that is in the best interest of the patient and EMS shall remain in control of patient care."	Revised. Updated language now reads: "where verification of the physician credentials and/or base contact is not feasible, care should be provided that is in the best interest of the patient. This may include rapid transport to definitive care in an emergency department."
Policy 4044-Scene Management	2.5 "policy (#6020)" 4.1.1 "There is NOT a patient" 5.3 missing word(s) "may be longer than transport to DEFINITIVE CARE, the EMT..."	Revised

Policy 4044- Scene Management	"3.2.11 - maybe add ""if a second paramedic is not yet on scene, the transporting paramedic may decide to transport without a second paramedic in certain cases where a delay would adversely affect patient care."" This would be for times the ambulance is first on scene with a patient in status, or a sick trauma pt, etc, and waiting for an engine would delay care. Or perhaps the call was code 2 and the patient turned out to be sick, etc. I would suggest changing 3.2.1.2 to ""beneficial to patient care"" and not ""necessary"". If the medic would feel more comfortable having a rider just because, even if it's not ""necessary"", I think that should be enough. 4.2- usually if it's code 2 there is only one responding unit and therefore no one else to upgrade. Also, not every life-threatening condition needs more people quickly (like anaphylaxis that gets an epi pen). I think language like ""shall consider additional resources as needed"" is reasonable and realistic. 4.3 instead of ""reduce"" I would say ""downgrade."" I would also change ""shall"" to ""should"" downgrade the responding units. There is so much going on when responders first arrive on scene, I don't think they should be held accountable for downgrading other units every single time the patient is stable 100% of the time. 5.2.2.2 - In the absence of other symptoms, I don't think an SBP of >190 is clinically significant, nor would an ALS response affect treatment or assessment really. Again, in the absence of other symptoms, there is no indication for a 12 lead, or nitro, or any other ALS assessment/treatment. So, I propose striking the upper BP criterion. 5.2.3.2 strike ""requiring medication."" Severe agitation should get	3.2.1.1.: Revised. The following is added to clarify this point "If a second paramedic is on scene,..." 3.2.1.2. Revised 4.2. Revised 4.3. Revised 5.2.2.2 Revised 5.3. Revised

	additional help and have meds available in and of itself. 5.3 missing word and also suggested language: ""longer than transport to the hospital, the BLS crew may transport to the closest appropriate facility, if in their judgement, this will provide the most rapid needed care for the patient."" I see that an exception report is required. To me, this makes it seem like it would be discouraged to do this, when in reality, I see it as quite possible that a crew would be closer to a hospital than waiting 5-7 min for ALS to arrive, get situated, etc. 6.1.1.1 why does a paramedic unit need to be assigned? For instant, what if the patient they onview has a BLS-level injury or complaint? I think they should follow the same criteria listed higher in the document and decide whether or not ALS is needed. 6.1.2.3 - same comment about the exception report as above.	

Policy 4044- Scene Management	5.2.3.1 - I don't think we should limit the need for ALS assessment of chest pain by age, people under the age of 35 can have an MI. Maybe "chest pain >35 or <35 and suspected to be of cardiac origin" at the least. 5 - Obviously states it is not limited to those listed but it should be consistent with Policy 8000 Appendix D to avoid confusion/inconsistencies. Needs to include protocols that list "request ALS response" such as Protocol 2.03, 2.13, etc. or add 5.2.4 "protocol regarding relevant pt complaint/presentation specifically states need to call for ALS resource" Consider adding: GCS specific guidance (currently policy 8000 appendix D lists GCS less than or equal to 13), with added phrasing "unless consistent with pt's baseline GCS" Pt's meeting trauma triage criteria Seizure/post seizure Need for pain control or medication outside of EMT scope Allergic reaction (with or without use of Epi PTA or administered by EMT) OB pt with OB related complaint 6.1.2 - combine first parts of "establish patient contact and render aid" as 6.1.2.2, it makes it more clear that regardless of being available or not, you must make contact and render aid until another ALS resource is on scene - "no unit responding" and "unit is responding" doesn't make sense to have, I suggest "unit on scene is available" and "unit on scene is unavailable (ex. currently has a pt, is out of service for critical restock AND unable to render continued care required, etc.)" or something along those lines. If a unit is responding but the one that arrived on scene first is available (and ALS), the unit originally assigned should be cancelled. No	5. Revised. Policy 8000 Appendix D will reference this policy to avoid confusion/inconsistencies. "GCS ≤ 13 (unless consistent with patient's known baseline)" added. 6.1.2.Revised

	need to delay pt transport or have two ambulances out of the system for one call that doesn't require a second one.	
Policy 5000.1- Destination Chart	Please standardize UCSF naming convention (use of hyphen) and alphabetize the UC facilities UCSF - Hyde UCSF - Mission Bay Children's UCSF - Parnassus UCSF - Stanyan	

Policy 5000.1- Destination Chart	"Instead of ""sobering"" as the heading, change to ""Alt Dest"" to encompass both. Also, #3 still says St Francis instead of UC Hyde. Also, instead of ""major trauma"" change to ""meeting trauma criteria"""	
Policy 5020- Diversion Policy	change all instances of "911" to "9-1-1" 3.5.4 - presume this number will be socialized amongst relevant emergency dept staff? 4.2 - please alphabetize list of facilities 5.2.3 reference "3.4.3." not "III.D." 5.2.5 remove word 'or' in "who are or transported from"	3.5.4. Reviewed. Agree, that number should be easily accessible. Contact info will be available to hopsital users in Reddinet" Revised 5.2.3. Revised 5.2.5. Revised

Policy 5020-Diversion Policy	Sorry, some of this is not part of the highlighted text, but thought I'd mention anyway: 2.3 instead of ""comprised specialty center function"" say ""comprised essential function."" If a CT scanner at a non-specialty hospital is down, that would count, right? But that's not specialty related. Same for 3.5 3.4.3.1 so, stable kids can go to a hospital even if it's on divert, even though any hospital can accept a stable pediatric medical patient? I would think divert should apply to peds medical too. Why list 3.5.3 separately instead of just as part of the list within 3.5.2? 3.5.4 - should you list the phone number for the duty officer? There is a policy for what to do if SFGH is on bypass, but what about UC Hyde, since it's the only burn center?	2.3. Revised 3.4.3.1. Revised. "Pediatric Medical" removed from list. Pediatric Critical Medical remains. 3.5.3. Revised 3.5.4. Reviewed. The duty officer phone number is available on Reddinet Burn Bypass: Reviewed
Policy 5020-Diversion Policy	4.4.1 - UCSF Mission Bay and CPMC Van Ness pediatric EDs are excluded from diversion suspension, yet “Pediatric Medical” is listed under 3.4.3.1 as specialty criteria that can bypass diversion (not to be confused with Pediatric Critical Medical, listed underneath). So can you transport there or not? If not, can an option be added on ReddiNet for Van Ness to differentiate pediatric ED on divert vs. adult? 5.2.3 Update reference to “III.D”to “3.4.3”	4.4.1. Revised. Pediatric Medical removed. 5.2.3. Revised
Policy 6030-Pilot Research Study	Section 1.1: "requesting relase of EMS data"	Revised

Policy 6050-Documentation of Pre-Hospital Care	Section 4.4 contains a typo: "complete andtransfer the PCR"	Revised
Policy 6050-Documentation of Pre-Hospital Care	4.2 "twenty-four (24)" 4.4 missing space "andtransfer"	Revised
Policy 6050-Documentation of Pre-Hospital Care	2.1, not all calls end with handoff at a medical facility. So I would say ""from initial dispatch to disposition"" 3.0 - Do I understand correctly that all EMS PCRs are supposed to be electronic? https://california.public.law/codes/health_and_safety_code_section_1797.227?utm_source If that's the case, I would mention that in 4.1 and strike ""paper"" in 4.3. I do think paper charts should be acceptable in an MCI, during a tech outage, etc. 4.6. Sometimes interns/newer people are asked to write the chart under the supervision of the lead medic, which I think is good for education. Perhaps it could say ""shall be responsible for the report""	3.0. Yes that is correct. However, transporting ePCRs are intended to capture care and procedures obtained by first responders and thus satisfy current state requirement. 4.6. Revised

Policy 6050-Documentation of Pre-Hospital Care	4.7 -State paramedic number clarification 6.5 -State paramedic number clarification	Revised

Policy 7010-EMS at Special Events	**Related to 4.3 - consider requirement for "Stop the Bleed" training for event staff** Every page after page 1 is labeled page 12 10.8 - begin with something akin to "The party responsible for an event's medical plan shall report..." Appendix A, page 1, All Levels: remove "and CPR" (already says CPR trained) Change all instances of "911" to "9-1-1" Appendix A, page 1, section 2 (yellow): typos in the "Depending on the event..." sentence Appendix A, page 2, Swim or Water Events: requirement for EMT to have 2+ years of 9-1-1 experience and direct access to 9-1-1 center --- this is not necessarily happening today. Non-transport event EMTs are often approved to fill this role. Either rephrase to reflect strong recommendation or enforce. Appendix B, page 1, BLS (Basic Life Support) Ambulance: typo - 'not may NOT'; reference to Section X should be changed to Section 13 Appendix B, page 2, ALS (Advanced Life Support) Ambulance: the "(ALS)" after EMT in this section appears to be a typo? Appendix B, page 2, Mobile Resources: correct reference to "Policy 4040 Section IV, B" - old nomenclature; believe this may be referencing what is now Policy 4040 4.2.1. (could also reference Policy 4040 Appendix 3 -	10.8. Revised Appendix A: Revised Regarding swim water events: Revised for clarity. The following will be required/recommended: mandatory completion of LEMSA's Aquatic Events module and direct access to 9-1-1 center; strongly recommend 2+ years 9-1-1 experience. The SF EMSA is working on an Aquatic Events module that will be available prior to October 2026. Appendix B: Revised

	whichever resource is deemed most appropriate) Appendix B, page 2, Water-Based Resources: same comment as in Appendix A Swim or Water Events above Last page, matrix: needs a header/label; "Swim or water component" has a typo of the word "assets"; "Suggested Resources" box has the same requirement of 2+ years of 9-1-1 experience that I've noted above; typo 'Leval' instead of "Level"	

Policy 7010- EMS at Special Events	13.1 -Can EMTs sign out patients without a paramedic assessment. AMA/PDT?	Revised. The following text is added back from original #7010 "EMTs that are an approved resource within an approved EMS medical plan may respond, evaluate, and create PDT documentation (NOT Against Medical Advice). All Against Medical Advice (AMA) patients require a paramedic Assessment and shall follow Policy #4040. "
Protocol 2.13 Adult Seizure	ACOG-NAEMSP: Eclampsia is characterized by new-onset tonic-clonic, focal, or multifocal seizures in the absence of other causative conditions such as hypoglycemia or drug/alcohol withdrawal in pregnant women ≥ 20 weeks' gestation or ≤ 6 weeks post-partum. Patients with eclampsia may not be hypertensive.	Revised
Protocol 2.13 Adult Seizure	"Do you need a ""no"" arrow from ""if suspected eclampsia"" to ""status epilepticus"" For comments, missing an ""s"" after ""minutes"" in 2nd arrow	Reviewed Revised

Protocol 2.13 **Adult Seizure**	Flow Chart -Misspelled medications -Misspelled convulsant -Move suction above oxygenation -“If continues to actively seize for >5 mins” ------Does the > 5 mins mean total seizing time or >5 mins after giving mag sulfate ------When giving midazolam, do we continue mag sulfate infusion? Comments -For patients that are seizing, do not delay medication administration for IV access --Add language including eclampsia ALS Management - Status -Change language to IV preferred, if no IV established, IM preferred ALS Management - Eclampsia -Continue magnesium infusion when giving midazolam?	Revised Revised Revised -- "If continues to actively seize for total >5 minute" -- "IM preferred" and added to comments section additional bullet: "If no IV access available, do not delay administration of midazolam to obtain IV, give IM" -- Agree that magneisum infusion could be continued when giving midazolam. Consider training point.

Protocol 2.13 Adult Seizure	Can the wording be more clear regarding versed vs. mag if pt is considered status. Ex. “if suspected eclampsia, including those meeting status epilepticus definition, give Magnesium, if seizing continues for another >5min after administration, give midazolam”, or vice versa because I’m a little confused here and I want to make sure I’m not ignoring status to give Mag if it’s not the intended treatment here. Removing IV dose of midazolam here along with “IM preferred” makes it sound like you give IM regardless of having an IV. I think “if no IV access, do not delay administration of midazolam to obtain IV, give IM” followed by the dosing for IM/IV/IO would be appropriate. Consider modified Midazolam dose for partial seizures. If someone is GCS15, I don’t want to take away their ability to protect their own airway or risk respiratory depression and hypotension with such a large dose. When I have brought in patients with partial seizures to the ED, I have asked what initial treatment the physician planned on doing and I consistently hear, “1mg of Ativan and see if that terminates it”. I have also made base contact for guidance for dosing with partial seizures and have been told to give a modified dose of 5mg versed which worked great, the seizure activity stopped, pt remained alert and no respiratory depression or hypotension occurred. If we can do a modified dose, the option to repeat the dose if seizure activity continues should be included.	Revised language to clarify: "If continues to actively seizue for total >5 minute" Reviewed. In comments section box it states "For patients that are seizing, do not delay medication administration for IV access." On the associated drug page for midazolam can be given IV for seizures if one already exists. Partial seizures: after several conversations with neurologist and pharmacist, there is no clinical indication or benefit to the treatment of partial seizures. This is a common practice for many ED physicians, but is not recommended. If a patient has a partial seizure for >10 minutes, they would meet the criteria for status epilepticus.

Protocol 2.21-Alcohol Withdrawl	Consider alternative diagnoses, including infection, or trauma, or opioid withdrawal Consider dose of 2.5mg instead of 2, due to it being much easier to calculate (half a mL instead of 0.4mL) add comment in notes section that says "patients in alcohol withdrawal are at higher risks of seizures. If the patient seizes, follow protocol 2.13 and give standard doses of midazolam, as indicated." (Trying to emphasize that if they give versed for withdrawal, they don't need to reduce the dose if there is a new indication of a seizure).	Revised Revised Revised
Protocol 2.21-Alcohol Withdrawl	Appendix 1 -There are 5 symptoms listed in instructions but chart listing 4 only. Missing confusion/orientation	Revised
Protocol 2.21-Alcohol Withdrawl	Amazing protocol! Under ALS management, rephrase to “BAWS score ≥3: administer 2 mg IV midazolam. Reassess BAWS score after 5 minutes and if ≥3 and administer additional dose 2mg IV midazolam (maximum total dose is 4mg IV)”. Phrasing is more consistent with other med reference pages that have max dose listed at the end when repeat doses are given. Include hyperlink to midazolam	Revised
Protocol 3.03-Near Drowning	typo: cheek's	Revised (3.05)

Protocol 3.03-Near Drowning	General Assessment -Add language to consider medical reasons for drowning? E.g. Syncopal or MI during swimming Comments -Make consistent with 4050 by changing 4050 to include lack of hypothermia OR change this language to be consistent with April 2026 version of 4050 -Reference Policy 4050, not 4040 Contact-Base Hospital -Unsure about intent of this language, as near drowning < 30 mins would normally be worked up as a medical code	Revised. Added consideration of medical reasons for drowning. Revised Base Hospital Contact requirement removed
Protocol 3.03-Near Drowning	Would suggest amending to exclude pediatric patients from discontinuation of resuscitative efforts	This is an explicit part and first bullet point of the updated discontinuation of resuscitative efforts policy (#4050)
Protocol 3.03-Near Drowning	List CPAP under ALS management	Revised
Protocol 3.05-Heat Injury	Is there something more specific we can put in here? For instance, it says external heat to chest and back. Can we phrase this in a clearer way? As in, "apply several heat backs to front and back of patient's chest."	Revised

Protocol 3.05-Heat Injury	Base hospital contact -Unclear of the intent of the language, no language involving hyperthermia in 4049/4050 as criteria.	Revised. Base Hospital Criteria removed.
Protocol 3.05-Heat Injury	list examples of “aggressive cooling measures”	Revised. Aggressive cooling measures may include cold IV fluids, ice water immersion etc.
Protocol 3.06-Cold Injury	ALS Management -Indication for 12-lead Comments -Defibrillation is not as effective on hypothermia, should we have a limit on defibrillations of hypothermic patients? Should we not defibrillate patients until they are rewarmed? Base Hospital Contact Criteria -Unsure of intent of language. 4049 and 4050 have language addressing hypothermia. -Reference 4049	Revised. 12 lead ECG added Revised. Defibrillation. The following clarification is added "If three (3) initial attempts at defibrillation are not successful, then further attempts should be delayed until rewarming" Revised. Base Hospital Criteria removed

Protocol 3.06- Cold Injury	consider listing under comments: - Bradycardia is expected in a hypothermic pt, Atropine and ESPECIALLY TCP are not recommended, focus on active rewarming. - Expect pt to become hypotensive as they are rewarmed due to the potential for rapid peripheral vasodilation (emphasize rewarming core to prevent) - Consider alternative BGL testing site (as opposed to cold extremities) due to potentially inaccurately low BGL readings from hypoperfused tissue	Revised to include: "Atropine and transcutaneous pacing are not recommended." The additional comments you mention are very relevant and can be emphasized in training.
Protocol 6.01- Aggitated/Violent Patient	for peds agitation, it says to give versed IM. Perhaps it could say administer midazolam without specifying route? Perhaps the kid already has an IV or IO, as mentioned on the versed med page? Perhaps we could revisit the need for base hospital contact for repeated doses of versed/droperidol? If it has been 15 minutes between doses and the crew is trying hard to monitor the patient, get vitals with EtCO2 ASAP, etc, I think it's reasonable to give a 2nd dose. Calling base while also dealing with a severely agitated patient is very difficult. I believe so far, everytime EMS has called base, it has been approved 100% of the time (based on SFFD data at least).	Revised: IM removed Revised

Protocol 6.01- Aggitated/Violent Patient	Pediatric management Instead of midazolam, which can cause a paradoxical reaction (especially in kids with autism spectrum disorder) and/or respiratory depression, can use olanzapine for ≥ 6 years of age. Dosing would be- 6-10 years of age: 2.5 mg 10+: 5 mg adult size: 10 mg	This is a very interesting suggestion. Currently our local optional scope of practice (LOSOP) for olanzapine that is approved by the state is limited to patients to oral formulations for >14years old. This could be a topic of discussion for pediatric committee
Protocol 6.01- Aggitated/Violent Patient	Add last note from Droperidol med page to ALS section “If additional sedating medication is needed for persistent violent agitation 15 minutes after first dose of droperidol, consider administering 5mg IM midazolam. Contact Base Hospital, if additional doses of sedation are needed.”	Revised
Protocol 11.03- Hazmat, Chemical, Radiation	What is the purpose of notifying the base hospital physician of a HazMat incident? What are they supposed to do? I ask because HazMat patients may present to any hospital (not just SFGH) and unless there is a clinical question or field response requested, I'm not sure what a base doc would do. For the last bullet on page 1, I believe ""hot zone"" is the more appropriate term than ""hazmat zone"" Arrival to hospital - should we ask EMS to stage outside the ED with non-critical patients for hospital staff to eval for further decon? A lot of hospitals have their decon equipment just outside the ER. Does every hospital have this capability? Should it be required to be a receiving hospital for EMS? I definitely worked at some EDs that did not have it available and we don't want them calling 911 for help during an actual incident last minute.	Revised. "Base Hospital Physician" replaced with "Receiving Hospital" Revised Revised Revised

	organophosphates - blurry ""vision"" is hyperlinked to the prehospital vision statement incorrectly Chempack note - ""If a nerve agent is suspected, early notification shall be made to DEC."" Protocol says ""chief officer"" but really if anyone calls with a credible concern, it should be enough to get the process started."	
Protocol 11.03- Hazmat, Chemical, Radiation	Under Chlorine protocol: What is the Nebulized sodium bicarb dose? and list on med reference page with hyperlink	Reviewed. Hyperlinked added to final documents. To reduce errors, the dose will be limited to the drug page.
Albuterol	chlorine gas is also an indication - perhaps you could just say "bronchospasm" and leave it at that.	Revised
Albuterol	Contraindications -Clarification on definition “child”, <18 has wide range for normal vital signs -Add lines for neonate/infant/child/adolescent and their heartrates	Revised to "Severe tachycardia." To avoid being overly prescriptive, examples are provided guidance but permit paramedic clinical judgement.

Albuterol	All pediatric ages that are able to get MDI you can give 4 puffs. Are there spacers available? If not, the MDI is not very reliable in younger age group.	Revised. MDIs and spacers are not required by ambulances to routinely stock, but patients supply can be used. In the comments section, the use of spacers is emphasized for both adults and pediatrics
Aspirin	Contraindications -Recommend changing to: “Known severe allergic reaction to ASA” Notes -Adding blood thinners to first bullet point	Revised.
Dextrose	Do you want to mention in indications that the BGL threshold for adults is 60 but for infants it's 50 for the first 48hrs of life? Some even say the threshold of treatment for a neonate is 36mg/dL.	Reviewed.
Dextrose	Pediatric Dose / Route -Add language to Neonate and Children to include the use of the Buretrol device -List max dose and cumulative dose for Neonates -List max cumulative dose for Children	Revised. Max cumulative dose for children

Droperidol	Notes: If additional sedating medication is needed for persistent violent agitation 15 minutes after first dose of droperidol, consider administering 5mg IM midazolam. Contact Base Hospital, if additional doses of sedation are needed Does this mean base contact is needed to administer 5mg IM midazolam after droperidol or is only needed if a medic has given droperidol and midazolam but needs more doses?	Revised. Yes, the following has been added for clarity. " Contact Base Hospital if additional sedating medication beyond those two medications are needed"
Droperidol	Same comment as before - consider removing BH requirement.	Revised. See clarification above.
Droperidol	Notes -Clarification in contacting base for which additional dose -----E.g. First dose of droperidol ineffective, next dose of versed requires Base MD? Second versed dose requires Base MD?	Revised. See clarification above.

Epinephrine	What's the reason for using a buretrol on everyone instead of just with peds? I don't think there's an issue with using a normal macro gtt chamber for adults. If we change to buretrol with a micro gtt chamber, that would make dosing much more difficult for an adult because of the rapid rate. The table on the first page says to use 10 drops/mL chamber (which is what is preferred and is different than a buretrol). Also, I think SBP <90 is a good threshold to start epi gtt, but after that, maybe we can say "titrate to normotension" Next, I see no reason to limit to 20mcg. Should be reasonable to give at regular intervals as long as it's needed. Maybe in methods of admin we can say a drip can be made, but if you want to convert to PDE because you can't hang the bag (like you're going down stairs with a ROSC patient), you can use an empty syringe and draw up 10cc's from your already made 1L bag and use that as push dose while you go down the stairs or whatever the case may be. Wording would be "after making the epinephrine infusion, you may draw up 10cc's of fluid in an empty syringe and use push dose epi while the infusion is paused"	Buterol: Revised to specify for pediatrics only. Reviewed. SBP >90 is listed since it's association with cerebral perfusion. Revised. 20mcg max removed. Reviewed. Can consider as alternative training.
Epinephrine	Chart -Keep Buretrol in language for pediatric infusion	Revised

Epinephrine	Should leave buretrol in ped dose section at top, the adult side specifies that it's a macro drip so it would make sense that the ped side specifies too. At a quick glance, the dose is less so you might assume it's the same drip chamber as adults. Consider "using buretrol device (preferred) or 60 drops/mL microdrip chamber". Appendix 2 is a reference for preparing the infusion, why is it limited to peds? I think it would make more sense to just keep 1 and 2 then under it specify what you connect it to for adults and peds. I think the note for IV epi can be taken out completely. It's up top in the table. IM epi note might read better as "Anteriolateral thigh is preferred when using IM epi for anaphylaxis" since it's really just referring to that and not all IM epi, unless you want it to be the preferred site for all… and it might be helpful to clarify there for anaphylaxis "if hypotension continues after 2 IM doses, administer Epi infusion"	Revised. Buterol added back to pediatric column. Revised. Buterol clarified for pediatrics. Reviewed. IM versus IV epi is a frequent medication error confusion, that is emphasized here. Revised.
Glucagon	Why do we need base hospital contact for BB overdoses? I see no harm in giving the med even if was not needed. If they are to make any phone call, I would say it should be to poison control. And I think the recommended dose is 3-5mg as opposed to 1. And it can/should be given IV, so I would recommend keeping IV as a route. Also, I've seen a few patients who get glucagon and are still obtunded with a BGL of 20 in the ED. Perhaps we could add a line saying ""in patients who do not respond to glucagon, consider D10 via IO""."	Reviewed. In consultation with toxicologist, limited clinical benefit in glucagon doses that are available on ambulance, glucagon can be administered for beta blocker overdose if recommended by poison control.
Glucagon	Indications -No longer requires base MD contact for beta blocker overdose (2.10 4/1/26 edit)	Revised. No base hospital contact needed, can follow poison control recommendations.

Midazolam	Again, suggest changing all 2mg doses to 2.5 for ease of administration. 2mg would be 0.4ml whereas 2.5 would be an easier 0.5.	Revised.
Midazolam	Adult Dose Adult -Status – would IV be preferred followed by IM? Referencing 2.13 above Notes -Add line to include monitoring the patient's airway, vital signs, EtCO2, consistent with 6.01, 2.09	-Status: if an IV is already established it can be used, however IM might be preferred for operational reasons (accessing IV in an actively seizing patient) and pharmacoknetic reasons (IM midazolam has a slower, but more predicatable onset with higher bioavailability) -Revised.
Midazolam	Same suggestion as before for severe alcohol withdrawal, consider rephrasing to "BAWS score ≥3: administer 2 mg IV midazolam. Reassess BAWS score after 5 minutes and if ≥3 and administer additional dose 2mg IV midazolam (maximum total dose is 4mg IV)" to be more consistent with phrasing in other areas. Under notes, would be helpful to include phrasing from 6.01, "…must have continuous cardiac, EtCO2, and pulse-oximetry monitoring and have frequent reassessment OR documentation as to why monitoring was limited AND other non-technological assessment options that were utilized (e.g. airway, breathing, circulation)", the EtCO2 is the main thing people miss, especially when it's only referenced on the protocol and not on the med reference page. Notes section, bullet two, I suggest being clear on what you're trying to	Revised as suggested. Of note, in an effort to minimize dosing errors, doses and routes will be focused to the drug sheets, and not on the protocol documents. Revised. Revised.

	communicate and just adding, “therefore patients may re-overdose as the effects of naloxone wear off”	
Naloxone	extra space before : after nebulized. Consider adding "mask may be removed once improved" so providers don't feel pressured to finish the whole dose.	Revised.

Naloxone	Adult Dose -What is max cumulative dose -Nebulized Narcan- add GCS or AMS assessment, e.g. difficult to arouse, somnolence Pediatric Dose -Repeat neonate language from contraindications ------Currently reads as to never give to neonates, even if poisoning of opiates -<20 kg – confirm max dose is cumulative? ->20kg – 2mg doses, repeats? Higher dosage than adults. -------List max cumulative dose Notes -High-potency opioids require higher doses. Increase maximum doses for adults and children or call Base MD for dosing beyond published maximum?	- Adults: Revised - maximum cumulative dose 10mg. Revised- added "responsive to light tactile stimuli" for nebulized naloxone - Pediatric: Revised to clarify naloxone is contraindicated in neonatal opioid dependence, but may consider in acute opioid induced respiratory depression. Revised- maximum cumulative doses added. - Notes: Revised.
Nitroglycerin	acute pulmonary edema WITH suspected	Revised
Administrative Change		
Atropine	Minor thing. Do we need to keep “Atropine is no longer recommended for adult or pediatric asystole”? It was removed from ACLS 16 years ago.	Revised
Ketamine	Dosage -Confirm that the 10 minute wait period begins when infusion has completed or IN dose was given	Agreed.