July 2025 EMSAC Public Comments		
Protocol/Policy	**Public Comments**	**EMSA/Medical Director Responses**
Policy 2000-Pre-Hospital Scope of Practice	3.1.1.7 Interfacility blood products Not out of scope but requires moderate training. We would like some guidance on the concepts you have in mind.	Reviewed. Continuation of interfacility blood products should focus on infrequent scenarios where blood administration should be stopped (e.g. severe adverse reaction)
Policy 2050-Paramedic Accreditation	Instead of requiring ongoing CPR certification (5.1.4.1), what about requiring a certain amount of CE hours from in-person training? I think the time members spend in a class about ACLS would be so much more high yield if those hours were spent covering high-yield topics identified through CQI, training staff, the EMSA, etc.	Reviewed. CE hours suggested could be given at an EMS Provider level in addition to CPR, and CEs are already required for Paramedic licensure. Will consider in future
Policy 2050-Paramedic Accreditation	Appendix A Table at the bottom Typo – CP @ Required? “All paramedics wo work…” should be “All paramedic who work…”	Agree. Policy revised.
Policy 2080-Physician Oversight	3.2.5.1 - What is the guidance for when, say, the SFFD Medical Director is on scene with RC3, E09 and King American? Would the RC and engine crew take direction from me but not King American? I'm not sure where it's best described, but I think there need to be guidance for how to handle base physicians on scene. For instance, a resident doing a ride along. Dr Yeh doing a ride along. Dr Mercer responding to a field amputation. I personally think a base physician should be able to provide on-scene medical direction agnostic of the agency on scene just based on their qualification of being a base physician that would otherwise be giving them guidance by phone if they were working at SFGH. I know liability is a part of this (some physicians are covered and some aren't) but I think the individual should determine liability and not EMSA policy. It's up to the physician to know if they are covered or not to perform clinical duties outside the hospital.	Edited. Based on comments, 3.2.5.1 has been removed. Physicians can help provide care on scene as outlined in policy 4041. In situations where the EMS providers request hospital resources and /or physicians on scene (e.g. field amputation), responding physicians will be able to provide on scene medical direction. Future revision of this policy will continue to be discussed with the base hospital physician group.
Policy 2080-Physician Oversight	• 3.1.2 Change “and” to “of” • 3.2.1 Change “oversee” to “support” (We would like to see more of a supportive role from the medical record) • 3.2.4 Change “Oversees” to “Ensures” • 3.3.2 Change “Oversees” to “Ensures” • 3.4.2 Change “Oversees” to “Ensures”	• 3.1.2: Edited. Changed “and” to “of” • 3.2.1 Edited. Changed “oversee” to “support” • 3.2.4. Edited. Changed “Oversees” to “Ensures” • 3.3.2. Edited. “Oversees” to “Ensures” • 3.4.2. Edited. Change “Oversees” to “Ensures”
Policy 2080-Physician Oversight	3.2.5.1. The EMTs, paramedics, the provider agency medical director on scene must be currently employed by or contracted with the same provider agency Remove	Edited/Removed
Policy 2080-Physician Oversight	3.2.5.1 Recommend striking this section. As discussed in Medical Directors committee meeting, this language is potentially in conflict with physician on scene policy anguage and creates ambiguity between employment and medical authority on scene. Coordination between physicians and other prehospital clinicians can be addressed through training.	Edited/Removed
Policy 4000/4001a-Vehicle Equipent List/Vehicle Minimum Requirements	3.3 Quick-Response Vehicle (QRV) - Response vehicle, usually staffed by a paramedic, that provide supplemental field response and patient care. This vehicle does not have the ability to transport patients. "should be "provides" instead of "provide." Also, "QRV" might be a confusing name to use... we only use that name for a first response vehicle staffed by regular EMTs and medics and not supervisors.	Reviewed. Given the overlap in supplies outlined in the QRV and ALS-supervisor columns, the two have been combined. Of note, there is an annotation for bougies that are only required for ALS-Supervisors made.

Policy 4000/4001a-Vehicle Equipent List/Vehicle Minimum Requirements	• Adenosine - Change 18mg to 30 mg for ALS Ambulance (6, 12, 12) • Magnesium Sulfate - Increase requirements to 6 gms for ALS Ambulance - Will allow an ambulance plus one additional unit to have the proper dose for Eclamptic Sz IM injection (10gm) • Sterile Water - Increase requirements to 3 vials for ALS First Responder and ALS Ambulances - Vials are 20mL - Sodium Bicarb is 50mL, requiring 50mL for proper dilution	Adenosine: edited Magnesium: edited Sterile Water: edited
Policy 4000/4001a-Vehicle Equipent List/Vehicle Minimum Requirements	Line 159 and 160 Recommend removing "auto injector", as prefilled or check-and-inject kits are approved	Reviewed. Check and inject kits require approved EMT training. Will consider removal of prefilled syringes with widespread training adoption.
Policy 4042 Limited Language Proficiancy (LEP)	3.2.2 - "then they may proceed" 3.4 "if the patient is non-critical, the interpretive..." 3.4.1 I would think hierarchy is: - translation service - fluent provider - family, etc I don't think 3.5 is necessary. If they're critical, regardless of psych complaint or not, they should prioritize transport, I would think. And if they're not critical, then it still falls under 3.4.	Re 3.2.2. Agreed on edit Re 3.4. In section 3.2. the text states that "If on scene EMS provider is fluent in patient's primary language, then then may proceed with normal assessment and care using EMS provider as translator." Fluent EMS provider has been added to the hierarchy in section 3.4 to further clarify (Fluent provider, translation service, etc) Re 3.5. Reviewed. It may be difficult to establish if a complaint is psychiatric (versus medical or traumatic), or the acuity of the psychiatric compliant without an attempt at translation. As written, the policy allows EMS providers to determine how critical their patient is.
Policy 4042 Limited Language Proficiancy (LEP)	We have a question about utilizing SFPD/SO/family/bystander for translation. -Can we rely on SFPD if they translate for the EMS crews? Question of HIPAA compliance -In the event of suspected elder abuse, we may want to add a note not to rely on the potential abuser to translate accurately. -Using bystanders to translate, ok? Question of HIPAA as well.	3.4. Fluent first responder (e.g. SFPD) has been added to the hierarchy alongside fluent bystander EMS providers and translation services are preferred because of their training and HIPAA compliance. Clinical circumstances may arise where patient health/safety is a more immediate priority than patient privacy.
Policy 4042 Limited Language Proficiancy (LEP)	Add to Section 2: "Language identification cards" or "I Speak cards" are cards used to identify the language spoken by non-English speakers. Add to Section 3.3: Any on scene EMS provider who is not rendering aid to the patient should obtain adequate interpretation according to the interpretive option hierarchy listed in Section 3.4 to communicate with the patient, family member, and/or bystanders. New section (Section 3.6): Training on language access services. EMS providers should receive annual training on how to identify LEP persons, identify an LEP person's primary language using language identification tools (including use of language identification cards), and how to request on-scene interpretation. This training should include education on identifying dialects.	Re Language Identification Card: Great suggestion. This will be added as a reference (Section 14 Language Identfication Card). Section 3.4: Edited. Fluent EMS provider added to the hierarchy to provide additional clarification. Language training program outlined would improve language access services utilization, however mandating annual training on the topic is currerently outside the scope of this policy.
Policy 4042 Limited Language Proficiancy (LEP)	3.5.1. Patient requesting to leave against medical advice 3.5.2. Assault or abuse 3.5.3. Psychiatric complaint ***3.5.4. Destination determination e.g. stroke	3.5.: Edited
Policy 4049-Discontinuation Resusitative Efforts	This seems like a general policy for TOR but only mentions >18 years old. Do you want to include something about <18 years old? "Currently, there is no clear evidence for patients <18 years old and provider discretion should be used with base hospital consult" or something. If you do decide to include peds, then "palpable carotid pulse" should probably be changed to "palpable pulse" to include brachial etc. Instead of "no indication for defib" I think the more common language is "non-shockable rhythm" For trauma "no heart sounds" - I don't think EMS providers are routinely trained on detecting heart sounds. Contact base hospital is bold here but not for medical, I would suggest making it uniform. 3.1.3.2 - "should be treated as a medical cardiac arrest" might be better than "ALS resuscitation initiated" Also, this policy discusses	If pediatric patients are obviously dead, then policy 4050 (death pronouncement) applies. There is no age restriction to policy 4050. There is not great scientific literature in agreement about pediatric termination of resuscitation guidelines. If there is evolving scientific evidence about TOR in pediatrics, please submit so that we can consider. Re defibrillation: Edited. Changed from no defibrillation to non-shockable rhythm Re heart sounds: Reviewed. Although not routinely part of EMS evaluation, this might be a scenario where this is appropriate, esspecially if there are bystanders/family present. Re contact base hospital: Agreed, the language is uniform

Policy 4049-Discontinuation Resuitative Efforts	• Supersedes date of document that doesn't exist until now • 3.1.2 Medical etiology o Add "when" or "if" prior to criteria being listed o Will emphasize that ALL of the following bullet points are required for this criteria o Replace bullet points with numbers (all are required) o Define "persistent" (length of time?) o A specific number of minutes or when the code begins would be ideal. o Confirming that we are discontinuing CPR after 15 minutes in both PEA/Asystole and shockable rhythms after 15 minutes. Conflicts with Policy 2.04 • 3.1.3 Traumatic etiology - Bold "traumatic" -How much time should pass after life-saving measure was completed before deciding to transport/field pronouncement o For example, administered pleural decompression was administered, we work it up as a code for how long before transporting/pronouncing - What defines as a "lifesaving intervention" for this policy o Decompression, airway, tourniquet, etc. -3.1.3.2 Trauma vs medical o Remove unless there is a specific reason to keep -3.1.3.3 MCI o Remove – redundant with MCI policy	• 3.1.2 Medical etiology: Edited for clarification. The option box in Policy 2.04 will be removed to prevent conflict and can be added as a priority for future protocol updates. After 15 minutes of PEA/Asystole --> consider discontinuation of resuscitation if all other criteria met. After 15 minutes of persistently shocklable rhythm --> transport to STAR or contact base. • 3.1.3 Traumatic etiology: Edited for clarification. o 3.1.3.2 Trauma vs medical: Reviewed. o 3.1.3.3 MCI: Removed/Edited.
Policy 4049-Discontinuation Resuitative Efforts	Policy 4049 3.1.3. Initial cardiac rhythm and activity is non-perfusing (e.g., asystole or wide complex PEA less than 40 BPM, no heart sounds) 3.1.3.3. ***refer to policy XXXX	3.1.3.: Edited 3.1.3.: Edited
Policy 4049-Discontinuation Resuitative Efforts	4.1 EMS personnel should not be placed in unsafe situations or pressured/coerced into providing futile or potentially harmful care. Consider adding language to this section such as: If personnel undertake medical interventions or transport due to scene safety concerns it shall be reported to the EMS Agency through Unusual Occurrence/Sentinel Event process.	4.1.: Edited
Policy 4050-Death Pronouncment	• 2.2.6 Submersion o Only states witnessed submersion vs reasonable suspicion o Clarify bystander witnessed patient entering the water or going underwater/out of view o We like the language of the current policy regarding submersion. o "Drowning victims where it is reasonably determined that submersion has been 30 minutes or greater." • 3.1 EMS Safety o More consistent language with 4049 (4.1) • 3.2 Honor Pause o Add language for people where resuscitation is not attempted. Specifically, the welfare checks that SCRT has absorbed. It would be appropriate to acknowledge they have provided closure to the family/friends. o Change "recognize the care provided by our team." to recognize the care provided by our present team." • 3.4 Crime scenes o Add MCI to this criterion. Many MCIs are not innocent and should be treated as a crime scene. Movement of black/zebra patients should not be done unless they inhibit access. • 3.5 ME Notified by medical authority o Change "shall be" to "shall always be" o Change so the pronouncing PM to call ME o The reasoning is that if there is a DOA in a setting with IDLH (Immediate danger to life or health), the transport medics won't be able to make contact. Suppression members will be able to, and the transport medics should not rely on second-hand information for a report.	2.2.6. Submersion: Edited 3.1. EMS Safety: Edited 3.2. Honor Pause: Edited. Option included for not attempt at resuscitation. The provided langauge is a suggestion and individual providers may customize as appropriate to the individual scenario. 3.4. Crime scenes: Reviewed 3.5. ME: Edited
Policy 4050-Death Pronouncment	See prior comment regarding P-4049 4.1	3.1. Edited

Policy 4051-DNR/POLST	• 2.1.5 Change patients to patient • 2.3.2. Remove medical treatment, too ambiguous and includes everything we do • 3.1 DNR or POLST • 3.6 Change "has an DNR" to "has a DNR" • 3.7 EOLOA Will 3.5 conflict with this section. Can a family member revoke the DNR if EOLOA is taken? -Consider making a separate bullet point for what EOLOA is and how much paperwork/red tape they must go through to prove its validity. We understand that this concept may go against providers' personal beliefs and morals, so the more we explain this, the more understanding and accepting everybody will be. -Attach an example of an EOLOA form as reference • 3.8 ESO suite does not have a feature to capture DNR/POLST paperwork.	2.1.5. Edited 2.3.2. Edited. Of note this language is copied verbatim from the CA POLST comfort-focused treatment 3.1. Edited 3.6. Edited 3.7. EOLOA: Reviewed. Currently, this is infrequently used in California and EMS involvement in these cases limited. This section provides some basic context, but in depth educational discussion is beyond the scope of this policy. No standardized forms exist. Recommendation to contact base hospital if ethically challenging situations arise. 3.8. DNR/POLST paperwork: Reviewed. Photos of the POLST can be taken for the ePCR. In addition NEMSIS eHistory.05 includes the presence of a valid for of living will of document directing end of life or healthcare treatment decisions.
Policy 4051-DNR/POLST	3.7. For patients who have chosen the End of Life Option Act (EOLOA), commonly referred to medical aid in dying, any DNR medical order is still in effect. The Act allows qualified terminally ill adult patients who are mentally competent, diagnosed with a terminal illness, and whose life expectancy is six (6) months or less to self-administer lethal doses of medication prescribed by their physician. This process requires two physicians to verify eligibility. The patient must make two (2) oral requests in person, A written request must be witnessed by two (2) people, neither of which can be the person's attending physician, consulting physician, or mental health specialist, and one cannot be related to the individual or their heir. What is the role EMS has in EOLOA or intent in including this information in the policy?	3.7. Reviewed. Currently, EOLOA is infrequently used in California, but it is possible that EMS providers may encounter these patients. As requested by several paramedics, this section provides some basic context, but in depth educational discussion is beyond the scope of this policy.
Policy 5000/5000.1-Desitation Policy/Destination Chart	4.7 - This gets awkward with the crews at SFO. So maybe say "San Francisco EMS providers who transport to destinations outside the county in cases like these shall continue to use San Francisco EMS protocols." 6.15 - space needed between "following criteria". 6.15.1.7 - change to 100.4 to match with 38 and definition of fever? 6.15.2.1 - specify - "commercially available alcoholic beverage" so patients who ingest rubbing alcohol etc are not eligible to go here To clarify, 6.15.3 - is Geary an alternate destination ambulances can go to? I'm only aware of sobering, PES and VA.	4.7. Edited for clarification. 6.15: Edited. 6.14.1.7: Edited. 6.15.2.1: Reviewed. 6.15.3: Reviewed. In parallel to this policy update, GSU is in the process of becoming an additional triage alternate destination (TAD) site for 9-1-1 ambulances.
Policy 5000/5000.1-Desitation Policy/Destination Chart	• 4.6 Out of County -Can we include phone numbers to out-of-country numbers for ringdowns. • 6.15 -Typo – "followingcriteria" • 6.15.1.13 No lacerations that have not been treated -Define treated (wash with soap, bandage, treated by EMS, urgent care, ER visit, etc) • 6.15.2.2 Sobering criteria -Remove parenthesis statement (when not oriented enough to give verbal consent) -Is drug use still an exclusion? • 6.15.3.2 -Remove "Suspected or diagnosed psychiatric disorder and" • 6.15.4.1 -Include that the patient needs to be between 18 and 65 years old • 6.15.4.2 -Remove "Suspected or diagnosed psychiatric disorder and" • (Other) Add 5150 and conservatorship specific language. I believe the writer of the hold or conservator dictates destination regarding diversion status. • (Other) Transporting a patient who was given Droperidol or Olanzapine to Geary Stabilization Unit ok?	4.6. Reviewed. Suggestion will be addressed in a future reference section update. 6.15: Edited 6.13.1.13. Edited for clarification. Un-sutured lacerations used as an example for active bleeding 6.15.2.2. Sobering Criteria: Edited. Drugs use is not an EMS policy exlcusion. 6.15.3.2. GSU Only: Reviewed. Patients should have a suspected or diagnosed psychiatric disorder to be eligible for the GSU 6.15.4.1. Reviewed. All alternate destinations are only appropriate for patients at least 18 years of age (6.15.1.1) 6.15.4.2. PES Only: Edited. Patients should have a suspected or diagnosed psychiatric disorder to be eligible for PES 6.15.4.2. Reviewed. Other: Adressed in Policy 5000 section 6.11.2.4 Additional languaged added to GSU criteria to help clarify. Patients receiving prehospital droperidol (IM sedation) should not go to the GSU. Patients receiving olanzapine prehospital would be eligible for the GSU.

Policy 5000.2-Psychiatric Patient Destination	For 5000.2 TAD criteria, the new policy: you mention no 5150 patients for several, can you comment on conserved patients? And again here, consider changing 100.5 to 100.4 to be consistent with medical definition of fever	Reviewed. Conserved patients do not have the ability to consent (although can assent) Edited.
Policy 5000.2-Psychiatric Patient Destination	•Remove "Suspected or diagnosed psychiatric disorder" language •Define "treated" wound more clearly •Sobering center exclusion – drug use still excluded? •Sobering center – Phone number	Reviewed: "Suspected" psychiatric disorder provides opportunity for EMS provider judgement Edited Reviewed. Drug use is not an explicit exclusion from the EMS policy Reviewed. Phone numbers are available on Reddinet. Will consider a list of relevant phone numbers as a reference in the future
Policy 5011-Base Hospital Standards	I think base physicians should really be required to do at least one ride along within a year of them becoming a base physicians. It's tricky because they may not get paid during that time and enforcement may be difficult, but I think if SFGH hires a physician who will end up working at SFGH as a base physician for the next 20 years, they should be on one of our systems' ambulances at least once to see the "other side" of the phone. Residents are required to do a ride along, so that's not an issue.	Reviewed. Ridealongs are an important part of base hospital physician education. Ongoing discussion with base hospital leadership.
Policy 5030-IFT	•2.9 Exception Report Criteria oInclude 2.8 in this language •"May consider: STEMI Activation, Stroke/LVO, OB emergency ***" oKey referring to this only has 2 x ** •(Other) We've had some experiences where the sending facility has a patient on a ventilator, calling for EMS. They would take the automated vent off and request that the EMS crew apply the BVM, essentially lowering care. This will create many potential conflicts.	2.8: Edited to include suggested examples 2.9: Edited. 2.8 added Reviewed. As described, patients on a ventilator should be transported by critical care transport. An incident report and possibly base hospital would be recommended when conflict arises.
Policy 5030-IFT	Section 2-If applicable, clarify that this policy pertains to interfacility transport between Acute Care Hospitals, rather than other CDPH designated healthcare facilities such as SNFs, Hospice, clinics etc.	Reviewed.
EMS Vision and Ethics	•Last bullet point – change from "out" to "our" •Change "Patients who are competent have the right to determine" to "Patients who have capacity have the right to determine"	Edited. "Suspected" psychiatric history Edited. Re-ordered for alphabetization. Either droperidol or midazolam might be used as paramedic preference
Re-Triage Guidelines	I encourage the EMSA to make this into something user friendly that can be posted in ED's. A flowchart, quick reference style chart.	Reviewed. Agreed.
Protocol 2.04 Cardiac Arrest	Unrelated to changes, but for cardiac arrest in pregnancy, why is flushing prior to CaCl given? I think the overlap between HyperK or CCB's and pregnancy is pretty low and this may just be confusing and erroneous.	Reviewed. To be discussed further at future date
Protocol 2.04 Cardiac Arrest	•Options on Bottom of Page: oPolicy 4049 states to discontinue CPR after 15 minutes and does specify the rhythm. Here is says 20 minutes or 30 for vf/pvt. Conflicts with Policy 4049 (3.1.2) oConsider adding "with an etco2 less than 20" after Stop resuscitation.	Edited. Options box removed to prevent conflicing policies
Protocol 2.20-Hospice	Thank you for including this protocol. It says opioids are preferred, but why? I think ketamine is a powerful drug that could help a lot of people.	Reviewed. Ketamine is acceptable. Opioids are prefererd by most hospice and palliative care clinicians. This is partly because many patients have pain and dyspnea near the end of life, opioids can help with both symptoms.
Protocol 2.20-Hospice	•Definition – change "Nursing" to "Nurse" •(BLS Treatment) Request transport, only if comfort needs cannot be met in the current location. oDoes this mean that we are no longer transporting hospice patients for cultural reasons. Example some cultures do not want a death in the family home and request hospice patients to be transported to a hospital because of this. •(Other) What if patient's wishes differ from family wishes for transport. For example: if the patient wants to die at home vs. family has superstition about family dying at home	Definition: Edited BLS: Reviewed. Family or cultural discomfort may be a reason for transport. Recommend base contact in ethically challenging scenarios.
Protocol 2.20-Hospice	ALS treatment • For refractory pain, follow pain control procedure (2.09). Opioids are preferred. I would expect hospice patients to be on opioids already for pain, and fentanyl is short acting and may not be dose high enough if chronic opioid use, I would use ketamine if already on opioids	Reviewed. Ketamine is acceptable. Opioids are preferred by most hospice and palliative care clinicians.
Protocol 4.02 Trauma Arrest	in isolated trauMATIC cardiopulmonary arrest I would change the 2nd to last bullet to "Attempt to do all interventions en route to minimize scene time". hemorrhage control and needle decompression can be done en route too, depending on the flow of things. Instead of saying epi and compressions of have no role in the comment section, I would make it the first point in BLS treatment "chest compressions are not indicated in traumatic arrest". It's a huge change from what we do and deserves emphasis. WIthin ALS, say "epinephrine is not indicated in traumatic cardiac arrest."	Reviewed. Hemorrhage control and needle decompression are interventions that may alter disposition. For example if pulses are regained after tourniquet or needle decompression, then transportation is appropriate, if no pulses are regained than death pronouncment and non-transport indicated. Edited. Added to BLS treatment and ALS treatment. It will be left in the comment section for emphasis given the paradigm shift.

Protocol 4.02 Trauma Arrest	• ALS Treatment o third bullet point -<15 minutes are referenced to scene time or hospital distance -If >15 minutes away from SFGH, we don't transport • Opens up concept that different locations get different care -Last bullet point -Referred to 4050.1. Needs to have a better reference. • Comments -(2nd Bullet Point) If there is any suspicion of a medical cause for cardiopulmonary arrest (e.g. older patient with low mechanism), refer to medical cardiac arrest protocol. Chest compressions and epinephrine do not have a role in isolated trauma cardiopulmonary arrest. -Does this mean we are no longer administering chest compressions in cardiac arrest. -Does this mean we are no longer administering epi in cardiac arrest. -How much ACLS do we adhere to in a traumatic arrest? • Consideration for LUCAS device -If LUCAS device is still contraindicated in traumatic cardiac arrest, please add to protocol.	ALS Treatment: Reviewed. 15 minutes transport time/from hospital. Edited Comments: Reviewed. In a traumatic etiology for cardiopulmonary arrest, ACLS, chest compressions and epinephrine are not indicated. By extension, mechanical chest compressions (e.g. Lucas) device is not indicated.
Protocol 4.02 Trauma Arrest	"If there is suspected thoracoabdominal trauma and clinical concern for a tension pneumothorax, consider chest needle decompression." " If there is any suspicion of a medical cause for cardiopulmonary arrest (e.g. older patient with low mechanism), refer to medical cardiac arrest protocol. Chest compressions and epinephrine do not have a role in isolated trauma cardiopulmonary arrest." I think traumatic arrests from blunt or penetrating thoracoabdominal trauma with arrest should more strongly support chest needle decompressions. "If suspected traumatic arrest caused by thoracoabdominal blunt or penetrating trauma, consider bilateral chest needle decompressions."	Edited
Protocol 4.02 Trauma Arrest	See prior comments regarding P-4049 and unsafe scene. Consider removing this comment or adding reporting language.	Reviewed
Protocol 6.01 Aggitated/Violent Patient	Why can't we use droperidol after zyprexa if they escalate? I know there is a prolonged QT component, but is it significant enough to preclude giving both? Also, I think we should explore giving droperidol to patients if versed is not enough IF they meet certain criteria: it has been 10 minutes, they have vitals, they have exhausted other resources etc. It is really impractical to call base in these situations and I think most base docs would approve it if certain criteria are met, the same way we would do it in the ED if versed wasn't enough. In fact, we give versed and haldol together often and it's safe.	Reviewed. After the initial pilot of olanzapine and droperidol in the system, co-administration or serial administration may be considered.
Protocol 6.01 Aggitated/Violent Patient	• Remove requirement to have a psych history • ALS o Put Droperidol above Midazolam because it is the first line of medication.	Edited. "Suspected" psychiatric history Edited. Re-ordered.
Protocol 6.01 Aggitated/Violent Patient	For anxious, cooperative patients with a psychiatric history experiencing a behavioral health emergency (e.g. auditory hallucinations) offer the patient Olanzapine ODT to self-administer or have the paramedic assist in administering.	Edited
Protocol 7.01 Airway Management	Makes me nervous to get rid of needle cric in kids. This population is more prone to choking than others. Did we happen to look at data from the state to see how often it's done? If it's basically never done in the state then that is reassuring.	In the 2024 draft of California EMS Children's Report (Figure 19) includes airway procedures. There were 173 supraglottic airways and 37 endotracheal intubations of pediatric patients across the state in 2024. Needle cric is not listed as a procedure since most LEMSA's do not include it as a procedure. Further consultation with a pediatric anesthesiologist advised against any attempts at needle cricothyroidotomy in pediatric patients.
Protocol 7.01 Airway Management	• Confirming we are removing Needle Cricothyrotomy from protocol? • Replace jet insufflation with BVM through Cricothyrotomy fitting?	Reviewed. In October 2026, needle cricothyroidotomy and jet insufflation will be retired as a protocol and procedure. For patients ≥12 years of age, percutaneous cricothyroidotomy will be an option during the period of phasing out and thereafter. BVM can be performed directly through a percutaneous cricothyroidotomy.
Protocol 7.02 Oral ETI	What does mechanical confirmation mean? Can you just divide this into 2 sections: You must have one of the following in category A and one of category B to make it easy.	Edited for clarification.
Protocol 8.02 Pediatric AMS	I don't think we need trauma treatment mentioned in BLS hypoglycemia section.... we can strike SMR, wounds, etc. Maybe we can add EtCO2 in here in case they are AMS from DKA? or sepsis? It would give a clue of ventilation but also metabolic acidosis etc	Agreed. Agreed. Added that "EtCO2 should be considered."

Protocol 8.02 Pediatric AMS	• BRIEF UNRESOLVED UNEXPLAINED EVENT (BRUE) o Change to Brief Resolved Unexplained Event (BRUE)	Edited.
Protocol 8.04 Pediatric Tachycardia	Yes, NS for sinus tach, but also calming measures, as crying kids and anxiety can be a big component. Also consider checking temp for fever. Also, I don't see irregularly irregular rhythms mentioned in here, like a fib. It's rare, but should perhaps be acknowledged somewhere?	Agreed. Because of it's rarity, PALS algorithms do not provide specific guidance for pediatric atrial fibrillation. In alignment with PALS, an unstable supraventricular tachycardic rhythm should be treated with attempted synchronized cardioversion.
Protocol 8.04 Pediatric Tachycardia	• "Strongly consider Midazolam prior to cardioversion. Do NOT delay Midazolam to start an IV/IO or synchronized cardioversion" o Confusing to read. Do you mean Do NOT delay Synchronized cardioversion for IV/IO Midazolam? • Flowchart o Consider replacing Yes/No with Stable/Unstable	Edited. Agreed. Added that "EtCO2"
Protocol 8.04 Pediatric Tachycardia	Flow Diagram Page 3 Unstable? • Patient has a pulse • Altered mental status and/or signs of hypoperfusion I think there is a typo/error. "Patient has a pulse" 'Yes/No' doesn't flow to next steps correctly.	Edited.
Reference 14.I-Droperidol	Bp should be mmHg "obtaining and ECG on the combative" etc. Is it standard of care to get an ECG on a patient who gets sedated? I don't think that's needed. Cardiac monitoring, sure, but I don't think crews need to wrestle to get an ECG before they give droperidol or anything.	Edited. Agreed. Added that "EtCO2"
Reference 14.I-Droperidol	• Indications o Add that this is the first line medication for severe agitation over versed. o Is there any indication to use for less severe agitation • Remove language requiring psych history. • Potential Side Effects o Move from Notes: Prolonged QT line to Potential side effect, explain caution of potentiation between Droperidol and other prolonging QT interval drugs. • Adult Dose o Add line that allows additional dose(s) with BHPC in the Adult Dose section • Pediatric Dose o Remove unnecessary Pediatric Dose or say "Not indicated" • Notes: o Add that if we want to co-administer droperidol with versed then it is a base hospital contact. o Can we give this medication with Zofran with concerns of prolonged QT-Interval. • Would the administration of this drug automatically disqualify patients from GSU? PES?	Indications: Edited Potential Side Effects: Qt prolongation at the doses specified should not have a clinically signficant effect on QT prolongation. In doses of greater than 10mg, this becomes a bigger concern. Adult dose: Reviewed. Maintaining consistency with other protocols Pediatric dose: Reviewed. Maintaining consistency with other protocols Notes: Edited. Droperidol has anti-emetic effects. If administering zofran, use caution (e.g. obtain in ECG prior to zofran). patients recieving droperidol are considered to agitated for PES or GSU.
Reference 14.I-Olanzapine	longer than the length-based tape Would you say hearing voices in an emergency? I might call it a symptom. Or "unpleasant behavioral health symptoms such as auditory hallucinations" or something	Reviewed. The safety and effectiveness of olanzapine in children under 13 years of age have not been established, and its use in this age group is not recommended (https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=71c6577c-ffea-4934-bc10-2d35942f8a16) Edited
Reference 14.I-Olanzapine	• Consider added stimulant induced psychosis. In indication section? • Remove language requiring psych history. • Adverse effects vs Side effects -Different format than other drug cards. • Prehospital Considerations -Can we give this medication with Zofran with concerns of prolonged QT-Interval. -Avoid admin to patients with known pregnancy or suspected -"Monitor airway and sedation if concomitant CNS depressant use is suspected as depressant effects may be enhanced." -Make note of potentiation with other CNS depressants (?) -The drug names olanzapine and ondansetron are similar enough to cause confusion. A second check of drug names should be performed before administration." • Would the administration of this drug automatically disqualify patients from GSU? PES?	Stimulant Psychosis: Edited. Stimulant induced psychosis would be appropriate for olanzapine use. Psych history: Reviewed. Addition of "suspected" psychiatric history Potential Side Effects: Edited Formatting: Edited. QtC: This class of medications has anti-emetic properties. Use with caution if co-administering zofran. or other QT-prolonging drugs Reviewed: known pregnancy Reviewed: patients receiving prehospital olanzapine may still be eligible for both GSU and PES if they meet all the other inclusion/exclusion criteria.