

| June 2026 EMSAC Public Comments | | |
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| Protocol/Policy | Public Comments | EMSA/Medical Director Responses |
| Needle Thoracotomy | Do we think asking paramedics to differentiate the decompression site based on age or BMI simultaneously may lead to errors? A single, universal preferred site (lateral) with maybe the option for a secondary alternative would be clearer. | Revised. Clarified that 4th or 5th intercostal space is preferred. |
| 2030 Paramedic Program Approval | <p>General comments: Replace "EMTP-P" with Paramedic in each place it appears (3.1, 4.1.6, 4.1.7, 4.1.9, 4.1.10) to make consistent with state regulations and national standards</p> <p>References to Title 22 CCR Division 9, Chapter 4 should read "Chapter 3.3" (3.7, 3.8.1), not Chapter 4 (old)</p> <p>Paramedic training is a PROGRAM, not a course. References to "course" or "course director" need to be changed to "program" and "program director" in keeping with CAAHEP standards and 22 CCR § 100092.02 I realize that there are other areas of the state regulations that use the term "course" but these are older sections and this is inconsistent with national education standards, CAAHEP accreditation standards and CoAEMSP interpretations of the CAAHEP standards.</p> <p>Note: the one exception to the above comment is under 4.2.1.5 "A copy of the course completion record" (should say record, not certificate; 22 CCR § 100093.01)</p> <p>There are references in state regulation and in this policy 2030 to the 2009 National EMS education standards; however, the most current version is 2021, not 2009. The state regulations need to update so do we really want to perpetuate this older language? One solution could be to instead reference the 2023 CAAHEP accreditation standards (effective 1/1/2024) Appendix B: Curriculum Competencies for Educational Programs in the Emergency Medical Services Professions</p> | <p>Revised. Replaced EMT-P with "Paramedic"</p> <p>Revised. Now reads "Chapter 3.3" (3.7, 3.8.1)</p> <p>Revised. Updated to indicate "program" consistently as suggested</p> <p>Revised. Updated reference to "current CAAHEP" accreditation to allow the policy to be evergreen.</p> |
| 2030 Paramedic Program Approval | <p>Section 3.6: remove course content, hours of instruction, course director, provisions for hospital clinical experience or field internship.</p> <p>Rationale: the only changes that need to be reported within 30 days are the program director and medical director. I would also add the need to report any change in the sponsorship of the paramedic program (ex. college, consortium, etc.). Other things listed here are not possible or relevant. There is no "course director". Changes to program hours and content should be reviewed during the regular four year cycle or upon request but not within 30 days and to the LEMSA. As an example, at CCSF, the paramedic program is 11 courses, each has a course outline of record that goes through revision to our college curriculum committee, board of trustees approval, and into the State Chancellors office curriculum inventory. It takes a full year to finalize updates and become effective. At the teaching level, syllabi and lesson plans are developed in reference to the course outline of record, which stipulates hours, type (lec, lab, etc.), content, evaluations, assessments, etc. The rationale for removing "provisions for hospital clinical experience or field internship" is simply that I don't know what that means. We hold written clinical and field affiliation agreements and these are always in progress with varying dates of expiration, etc. These are reviewed during the four year review and are available on request but there is no need to inform within 30 days of obtaining a fully executed contract with each clinical or field site.</p> <p>Section 3.7: "Course director" should be Program director. Chapter 4 should be Chapter 3.3.</p> <p>Section 4.1 Suggest it reads "Applications for Paramedic program approval to the EMS agency shall include"</p> <p>Section 4.1.2 I know this is the language at the state regulation level but the national EMS education standards were updated in 2021. I think the program should have a statement verifying that the paramedic program curriculum content meets the current national EMS education standards.</p> <p>Section 4.1.3 Again this sounds like a paramedic program is a single course. I think you should require an outline of the paramedic program curriculum that includes learning outcomes/objectives, content, methods of assessment, and evaluations of competency in the cognitive, psychomotor, and affective domains.</p> <p>Section 4.1.5 replace "course" director with "program" director</p> <p>Section 4.1.12 This is not necessary if you require the curriculum as in section 4.1.3</p> | <p>Section 3.6: Revised</p> <p>Section 3.7: Revised</p> <p>Section 4.1: Revised</p> <p>Section 4.1.2: Revised</p> <p>Section 4.1.3: Revised</p> <p>Section 4.1.5: Revised</p> <p>Section 4.1.12: Revised. Removed as recommended</p> <p>Section 4.2.1.1: Revised</p> <p>Section 4.2.1.3: Revised</p> <p>Section 4.2.1.5: Revised</p> |
| 4000.1 Ambulance Turnaround Time Standard | <p>5.1.2.5 - I would specify what meds those are so it's clear. I'd say ibuprofen, ketorolac, NS, zyprexa (if pt has improvement), zofran are reasonable.</p> <p>5.2.1.2 - is the implication here that if the patient meets all criteria, the patient can be offloaded without explicit consent from the ED staff? Or is the implication that EMS keeps the patient and documents the refusal? I think as long as the patient is registered, and they meet EMS criteria, consent from the staff should not be 100% required if done in good faith.</p> | <p>5.1.2.5: Revised. now includes the following: "Examples of acceptable medication may include: ibuprofen, ketorolac, normal saline, ondansetron, olanzapine (with documented patient improvement)"</p> <p>5.2.1.2: Correct, these are sub-bullets to 5.2.1 outlining documentation requirements AFTER patient offload.</p> |
| 4000.1 Ambulance Turnaround Time Standard | <p>5.1.2.5: consider additional language after, "that require close monitoring..." such as, "...as outlined via medication protocol" or "...in the judgment of EMS personnel" (similar to the language in 5.1.2.6).</p> <p>5.2.1.2: references Section 6.5.1.4, which is marked for deletion.</p> | <p>5.1.2.5: Revised. Includes specific drug examples for clarity</p> <p>5.2.1.2: Revised. Reference removed to Section 6.5.1.4.</p> |
| 4000.1 Ambulance Turnaround Time Standard | <p>5.1 Change "shall" to "should"</p> <p>5.1.2.1 Recommend keeping consistency with TAD criteria</p> <p>5.2.1.2 Referred to Section 6.5.1.4, which is to be removed.</p> <p>6.5.1.4 Keep language as reference to 5.2.1.2</p> <p>8.1 Change "shall" to "should"</p> | <p>5.1. Revised. Suggested language adopted</p> <p>5.1.2.1: Reviewed. Agreed. TAD criteria referenced and linked in 5.1.2.3</p> <p>5.2.1.2: Revised. Reference removed to section 6.5.1.4.</p> <p>6.5.1.4: Reviewed. Section removed for simplicity.</p> <p>8.1. Revised. Suggested language adopted</p> |
| 5011 Base Hospital Standards | <p>Policy 2080, 3.1.4.1 says Board eligible or certified in Emergency Medical Services or with proof of significant experience and practice in EMS, which seems to be a more lax standard compared to this policy 3.3.4.1.</p> <p>I think the standard for an EMS provider medical director should be at least as high as the base hospital standards. So, I vote to make them both require EMS BE/BC, which is the standard for medical direction in most urban EMS systems. Perhaps this could be an admin change in 2080 to ensure consistency.</p> <p>For 3.4.2, why not just have the criteria be the exception report criteria instead of having these separate ones?</p> <p>Lastly, do you want to define what a "senior" base physician is in this document? I think it could be simply put as "someone who meets criteria for base hospital physician who also has EMS credentialing at ZSFG"</p> | <p>3.1.4.1.: Agreed. If 5011 passes June EMSAC, an administrative update to 2080 will be made for language consistency in which EMS board eligibility or certification is a requirement</p> <p>3.4.2: Reviewed. the current text allows for base hospital personnel discretion. Base Hospital QI should not only be about exception reports, but also should send feedback on good cases, system-level issues that do not directly affect patient care, follow-up on cases (for educational purposes), and other quality improvement reasons that may not align with exception reporting.</p> <p>"Senior" Base Physician is an internal designation based on ZSFGH criteria.</p> |

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| 5011 Base Hospital Standards | 3.3.2.1 Keep previous language. RNs with prior experience no regularly assigned to ED may not be up to date with policies. | 3.3.2.1. Reviewed. Agreed RN with current practice may be preferred. Section 3.3.2.2. emphasizes that significant experience with prehospital policies and procedures is a requirement. |
| Airway Management | For rate (bottom of page 1), those are normal RR's, but I think the rate in which someone is ventilated also depends on their physiology. For instance, if someone has severe metabolic acidosis from DKA, then their RR should be elevated (30s?) to compensate. So, in other words, perhaps mention normal RR, with the caveat of "or higher, depending on the patient's physiologic state" and then we can discuss more in training. | Revised. "Normal" rate added for clarification |
| Airway Management | BLS Management, Tidal volume: delete 6-8ml/kg reference as this is not readily measurable. ALS Management, Monitoring: Grammar Change "(EtCO2) is indicated for:" to "(EtCO2) is indicated:" OR keep "is indicated for:" and change the tense of all subsequent bullet points. For example, change "To assess and monitor ventilatory..." to "Assessment and monitoring of..." | BLS Management/Tidal Volume: Revised ALS Management, Monitoring: Revised |
| Airway Management | Comments Section: 1st Bullet – Change to reassess EtCO2 continuously, not just when you move or transfer the patient. Advanced airways may go unchecked during a resuscitation on scene due to the patient not being transferred. | Comment: Revised. Suggested language adopted |
| CPAP | I wouldn't say "consider" EtCO2, I would require it, again, to be consistent with other policies and best practice around resp distress. Under signs of improvement, I might add "normalizing EtCO2" | Revised. "Consider" removed. "Normalizing EtCO2" added to signs of improvement |
| CPAP | Indications: For clarity, make the second bullet point one sentence, "Severe respiratory distress or impending respiratory failure from causes such as acute pulmonary edema, acute bronchospasm, pneumonia or drowning." Technique: Missing a space between "10-15" and "minutes" Discontinuation: Change "Discontinuation of CPAP" to "Discontinue CPAP" for the sentence to read appropriately. Perhaps then underline, "Discontinue CPAP", as well for clarity. | Indications: Revised. Suggested language adopted Technique: Revised. Discontinue: Revised |
| Supraglottic Airway | For contraindications, add: Caustic ingestion Unresolved complete airway obstruction Trismus or inability to open the mouth and insert the device Oral trauma (relative) Distorted anatomy that prohibits proper device placement for technique #2, I would say based on ideal body weight For confirming, I would say "confirm breath sounds in bilateral lung fields" as opposed to just auscultate, which doesn't necessarily imply that anything is heard | Contraindication: Revised. Added suggested text Technique #2: Revised. Added ideal body weight Technique #11: Revised. Replaced "auscultate" with "confirm" |
| Supraglottic Airway | Technique, Point 4: Consider additional language after, "or slightly extended sniffing position...", such as, "...if no concern for spinal injury" or "...if spinal motion restriction not indicated" (Can also reference/link to Protocol 7.13). Technique, Point 11: (Grammar) Either change the language to, "To confirm initial correct placement:" OR change the grammar of subsections a-c. For example, change "Observe bilateral chest rise..." to "Observation of bilateral chest rise...", etc. Technique, Point 14: (Grammar) Change language to, "Monitor patient through continuous pulse oximetry and EtCO2" Note: All of the new changes do not use a period at the end of the bullet points, but the old language largely did. Consider editing for consistency. | Technique #4: Revised. Suggested language adopted Technique #11: Revised Technique #14: Revised Note: Periods at the end of bullet point removed for consistency |
| Supraglottic Airway | Contraindication Clarifying that <34 weeks gestational age is calculated a "corrected" age. E.g. If you have a 30 week premature, would the patient need to be 4 weeks old to receive an SG Move <2kg to second bullet point Include ingestion of caustic substances, Gag reflex, Trismus, Significant Airway or Facial Trauma Technique #12 Add "insertion" to end of last sentence | Contraindication: Minimum age/weight changed to indication rather than contraindication for clarity. Yes, "corrected age" is acceptable. Contraindication: Revised. Suggested language added Technique #12: Revised. Suggested language added |

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| <p>Oral Endotracheal Intubation</p> | <p>For confirming, I would say "confirm breath sounds in bilateral lung fields" as opposed to just auscultate, which doesn't necessarily imply that anything is heard</p> <p>16 is redundant because it says continuous EtCO2 in #14. I also think direct visualization is best because a tube can move partially out of the cords and still have end tidal. So, I think just say "reassess tube placement after each patient movement, ideally with direct visualization"</p> <p>18 - bougie doesn't have to be for difficult airways. It can be used in standard airways if that's what the provider prefers. So, I might say "especially for difficult airways"</p> | <p>Technique #12: Revised. Replaced "auscultate" with "confirm"</p> <p>Technique #16: Revised. EtCO2 language removed.</p> <p>Technique #18: Revised. Language added</p> |
| <p>Oral Endotracheal Intubation</p> | <p>Video Laryngoscopy:</p> <p>Consider removing "replacing supraglottic airway" in the first bullet point.</p> <p>Note: In general, there is an inconsistent use of periods at the end of bullet points. Consider editing for consistency.</p> | <p>VL: Reviewed</p> <p>Note: Periods at the end of bullet point removed for consistency</p> |
| <p>Oral Endotracheal Intubation</p> | <p>Technique #12 Confirm initial correct placement with all the following: Remove (D), redundant with Technique #17</p> <p>Technique #16 Change "CO2 detection device" to "Waveform capnography EtCO2"</p> <p>VL Box 2nd Bullet Point – Add to "A successfully placed and maintained ALS airway device..." 2nd Bullet Point – add "." After laryngoscopy.</p> | <p>Technique #12: Revised. Technique # 17 removed to avoid redundancy</p> <p>Technique #16: Revised.</p> <p>VL: Revised.</p> |
| <p>Needle Thoracotomy</p> | <p>Delete SBP <90 and just leave hypotension. It's relative to patient age and defined elsewhere.</p> <p>Clarify indication with the word "if"</p> <p>If BMI >30, then 4th or 5th space</p> <p>Spell out PTX in a formal policy</p> <p>Technique, #2, delete "either" and maybe say "perpendicular" to keep it simple</p> <p>Add 6: Apply one-way valve, if available</p> | <p>Indication: Revised. SBP <90 removed</p> <p>Indication: Revised. "if" added</p> <p>Technique #1: Reviewed. BMI reference removed based on other public comment</p> <p>Technique #2: Revised. "Either" deleted and "perpendicular" replaced</p> <p>Technique #6: Revised. Suggested language added</p> <p>PTX replaced with "pneumothorax"</p> |
| <p>Needle Thoracotomy</p> | <p>Technique, 1, a): Considering adding, "Preferred in:" to mirror the use of language in b) and for clarity of the bullet point which immediately follows.</p> | <p>Technique #1: Revised.</p> |
| <p>Needle Thoracotomy</p> | <p>Indication Remove SBP<90mmhg</p> <p>Technique #1a Remove language involving BMI or "potentially" anatomy. Keeping original language of preferred site would be simpler.</p> <p>Technique #1b Second bullet point, "PTX"→"Pneumothorax"</p> <p>Technique #6 Add "Respiratory Status" for reassessments</p> | <p>Indication: Revised</p> <p>Technique #1a: Revised</p> <p>Technique #1b: Revised</p> <p>Technique #6: Revised</p> |
| <p>Tourniquet</p> | <p>As discussed at TSAC, add indication of "or continuous direct pressure not feasible due to scene safety, MCI, etc"</p> <p>What do you mean by above and side to side?</p> <p>Discontinuation: I think we can simplify and delete the first and 2nd bullet and say "If EMS personnel assess a patient and...."etc. Doesn't matter who placed it, if it's no longer indicated, I think EMS should be able to remove it.</p> | <p>Indication: Revised. Suggested language added</p> <p>Technique: Revised. "Side by side" language removed for clarity.</p> <p>Discontinuation: Revised. First and second bullet point removed. Tourniquet removal at EMS discretion.</p> |
| <p>Tourniquet</p> | <p>Precaution: Consider addition of language regarding AV fistula bleeding, such as: "Consider first holding direct pressure followed by direct pressure both above and below bleeding site prior to use of tourniquet."</p> | <p>Precaution: Revised.</p> |
| <p>Tourniquet</p> | <p>Indication Add Indications from 4.05: Amputation or near amputation of the limb. Severe bleeding from a site which is not accessible (example: entrapment). Severe bleeding from an impaled object. When holding direct pressure is not practical.</p> <p>Technique #1 Add language to place the tightening band over the artery</p> <p>Technique #2 Reword language revolving around three fingers. Space for <3 fingers is still very loose. Suggest changing to "Tighten band to manufacturer's specifications."</p> <p>Technique #3 Reword "above" to "proximal"</p> | <p>Indication: Reviewed. Additional indications added as suggested however not all are automatically indications, the guiding principle is hemorrhage control. For example, impaled objects or near amputations may not require a tourniquet if hemostatic.</p> <p>Technique #1: Reviewed. Source of arterial bleed might be difficult to identify especially if not superficial.</p> <p>Technique #2: Revised Suggested language adopted.</p> <p>Technique #3: Revised. Suggested language adopted.</p> |

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| <p>Mechanical CPR Device</p> | <p>For indications: Transporting cardiac arrest patient or patient with ROSC, if available</p> <p>LUCAS devices are only kept with RCs and may not be on all cardiac arrest scenes. If the decision is made to transport to a STAR center that is 2 blocks away, I think that's reasonable to do instead of calling an RC. It's rare, but I think it should be allowable if documented in the narrative.</p> <p>For trauma: I don't think we should do CPR in trauma. However, if we are doing CPR, why not allow the LUCAS device? I think it puts our personnel at unnecessary risk to do CPR in a moving ambulance. Maybe add "remove the device upon arrival to the ambulance bay, however the backplate may be left in place" if we're worried about it being in the way of a thoracostomy. It's very easy and quick to remove and I think it can be done safely and quickly as the ambulance pulls up.</p> | <p>Indications: Revised. "If available" language added Contraindications/Trauma: Reviewed. If a patient has an underlying medical etiology suspected (e.g. minor trauma and cardiac arrest) then LUCAS is appropriate.</p> |
| <p>Mechanical CPR Device</p> | <p>Contraindications, 2nd bullet point: Capitalize "Patient" at the start of the sentence. In the same sentence, change "...suction cup, and inability" to "...suction cup with inability". Alternatively, just delete the "and" after "...suction cup,".</p> <p>Contraindications, 3rd bullet point: Capitalize "Patient" at the start of the sentence.</p> | <p>Contraindications: Revised. Suggested language adopted</p> |
| <p>Mechanical CPR Device</p> | <p>Indication 1st Bullet - Change to "Cardiac arrest due to suspected medical etiology" if keeping contraindication of traumatic cardiac arrest 2nd Bullet – Remove as indication, redundant with Technique #14. Contraindications 4th Bullet – Remove traumatic cardiac arrest Technique #13 Add language specifying obtaining ROSC during pulse check Technique #14 Change "post ROSC" to "ROSC patient"</p> | <p>Indication: Revised. Suggested language added. Contraindication. Revised. Technique #13: Revised Technique #14: Revised</p> |
| <p>Intaosseous Access</p> | <p>simplify with "in less than 90 seconds"</p> <p>As mentioned in TSAC, I think difficult to identify landmarks and infection could be relative contraindications</p> <p>Technique - notes - quick drug uptake?</p> <p>for conscious patient - flushing over 10 minutes is a long time. Over 2 min? And maybe say "if time allows" because if they need to give D10 to a patient who has a BGL of 22, I wouldn't want them to wait 2 more min just for the lido, you know?</p> | <p>Indication: Revised. language simplified Precaution: Revised. Based on TSAC, "inadequate or difficult to identify anatomic landmarks" and "infection overlying placement site" added as precautions instead of contraindications Technique #3: Revised. Language revised for clarity now reads Proximal Humerus- " optimal site for faster, higher-flow drug delivery" Technique #9a: Reviewed. If a patient is conscious, they are likely stable enough to wait 2 minutes.</p> |
| <p>Intaosseous Access</p> | <p>Technique #3 Table Add which size for distal femur site Specify distal femur is for pediatrics only, preferred <6 y/o Technique #9a Recommend changing 10 minutes. Lidocaine flush over 10 minutes is a very long time for an unstable patient in need of fluid/medications, keep at 2 minutes. Recommend striking dosage of lidocaine and adding hyperlink to Lidocaine Drug Card. 0.5mg/kg is the pediatric dose, no adult dose noted</p> | <p>Technique #3: Reviewed. Exact size depends on patient anatomy, most important anatomic reference for verifying size is one black line from the hub (5mm). "Pink" or "blue" would be appropriate in most scenarios. Technique TABLE: Revised. "Pediatric only" added Technique #9a: Revised. Now "120 seconds". Will link to drug card.</p> |
| <p>12 Lead ECG</p> | <p>I don't think we should say "non-traumatic" chest pain, because that would exclude blunt cardiac injury, which can cause clinically useful ECG changes. And syncope is included as an example of ACS, but I would say it's a separate indication and in fact not usually related to ACS, but rather an arrhythmia. So, I would keep dizziness, near/full syncope as a separate indication. What about HyperK? TCA overdose? Maybe say "certain poisonings, overdoses, and electrolyte derangements as clinically warranted"</p> <p>For STEMI alert: Says 0.1mm, should be 1mm, right? And would you consider 2mm? The number of false positives we get is very high, why not stick to the standard definition of STEMI? I understand we want a higher sensitivity, but I think the sensitivity is currently too high with low specificity.</p> <p>For inconsecutive ECGs, or suspected false positives or false negatives, transmit the ECG and contact base hospital for consultation.</p> <p>This is picky but our ambulances are 3 digits now. So, no SFFD 74 but rather 574.</p> <p>It also says transmit if capable. I would say it should be a requirement to be capable.</p> | <p>Indications: Revised. Great point. Language revised as suggested. <u>STEMI Alert criteria:</u> Revised to 1mm. The AHA ECG criteria of a STEMI gets a little more complicated based on the age and sex of the patient than a simple 2mm cut off (Table 3: https://www.ahajournals.org/doi/10.1161/CIR.000000000001309#T3). Technique #6: Revised. Added suggested language regarding base hospital consultation Documentation: Revised. Added ambulance digit number</p> |
| <p>12 Lead ECG</p> | <p>Indication Change "post ROSC following cardiac arrest" to "Post Cardiac Arrest" or "ROSC" Keep "Other 'suspicious symptoms'" Add electrical burns/tazings Technique Table 1 Change 0.1mm to 1mm Technique #5 Add specialty criteria for cardiac arrest with pregnancy to facilities with both STAR and L&D capabilities. Documentation Last Bullet – Change "Shall" to "Should" as 12 Leads are transmitted and given to staff upon arrival of ambulance.</p> | <p>Indications: Revised. Suggested language added. Table 1: Revised Technique #5: Reviewed. Specified in Policy 5000 Documentation: Revised</p> |
| <p>Spinal Motion Restriction</p> | <p>Contraindication, second bullet point: Specify "cervical" kyphosis.</p> | <p>Revised. Removed and reworded in comments section to address anatomical variants.</p> |

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| <p>Spinal Motion Restriction</p> | <p>Contraindication 1st Bullet – Requesting clarification, even with neurological deficits? 2nd Bullet – Move to comment section. Add language to add padding to all voids to achieve spinal motion restriction Technique – Rigid Long Board applications: 2. Move exclusions long board to end of statement. As is, reads that Rigid Long Board should ONLY be used for extrication, except in the following situations</p> | <p>Contraindication: 1st bullet: Revised. The following language added for clarification : "Contraindication: •Penetrating injury to the neck, trajectory suggests direct cervical spine injury" (PMID: 19741415) 2nd bullet: Revised. Reference to anatomic variation (e.g. kyphosis) moved to comments section</p> <p>Technique- Rigid Long Board: Revised. Language reformatted for clarity. In general, transport on long boards should be avoided except in the extenuating clinical circumstances outlined (PMID: 40736221)</p> |
| <p>Splinting</p> | <p>As discussed at TSAC, let's get rid of traction splinting here, and in the minimum equipment list.</p> | <p>Traction Splinting: Revised and removed</p> |
| <p>Splinting</p> | <p>Technique #1 3rd Bullet – change "tough" →"touch" Technique #11 Add language to stabilize impaled foreign bodies Traction - Contraindication (misspelled) Last Bullet – Remove, redundant Traction - Technique Add bullet point – Stabilize extremity without holding traction</p> | <p>Technique #1: Revised. Technique #11: Revised</p> <p>Traction: Reviewed. Not applicable - section to be removed as proposal discussion at recent trauma subcommittee.</p> |
| <p>Suspected Abuse Reporting and Resources</p> | <p>Consider additional language regarding transportation of SA patient such as, "prioritize medical need when considering transport destination".</p> | <p>Reviewed. ZSFGH is the only designated sexual assault forensic (adult and pediatric) exam facility at this time.</p> |
| <p>2.09 Pain & Nausea Control</p> | <p>still ketorolac. This would need to be updated in a few protocols, I think, such as the trauma one, unless you want to keep it just for non-traumatic pain (which is reasonable) Clarify: Change ketamine should not be combined with fentanyl to language in ketamine protocol "DO NOT co-administer Fentanyl and ketamine at the same time. If administering Fentanyl and Ketamine to the same patient, administer 15 minutes after completion of the first dose"</p> | <p>ALS: Revised. Ketorolac added for Moderate-severe/very severe pain (non-traumatic) Comments: Revised. Suggested language adopted</p> |
| <p>2.09 Pain & Nausea Control</p> | <p>BLS Management 4th Bullet – Strike inhalation of alcohol fumes from swab Comments Add language stating you can switch Fentanyl→Ketamine or Ketamine→Fentanyl after a 15 minute wait. Last Bullet – only monitor EtCO2, cardiac monitoring after second dose of pain management?</p> | <p>BLS Management- 4th bullet: Reviewed. Alcohol swabs can have a modest effect in improving nausea compared to placebo (PMID: 37076258) Comments: Revised. Clarification of ketamine/fentanyl or fentanyl/ketamine 15 minute wait and EtCO2 after first dose of pain management.</p> |
| <p>2.11/2.12 Respiratory Distress</p> | <p>Flowchart Bronchospasm Suspected – Specify order Albuterol→Epi→Mag Sulfate Pulmonary Edema Suspected – Lower threshold for NTG? SBP >160 = 0.8mg NTG Comments 2nd Bullet – Add IN/nebulized saline to break up mucus</p> | <p>Bronchospasm suspected: Revised. Medications enumerated to specify order of escalation Pulmonary Edema suspected: Revised. 180mmHg -> 160mmHg Comments: Hypertonic nasal saline is not indicated for bronchiolitis. American Academy of Pediatrics (AAP) does not specifically recommend for or against nasal saline drops due to insufficient evidence (PMID: 25349312).</p> |
| <p>4.01 General Trauma Management</p> | <p>We mention needle thoracostomy in our protocols, but I don't see chest seals mentioned anywhere except the equipment list? Does that belong in a protocol like this? Change "transport to any appropriate ED" and "transport to trauma center as trauma activation" (since you can still go to a trauma center and just have them not be trauma activated if they're not on divert).</p> | <p>Airway/Breathing: Revised. specific reference to chest seal added to clarify "occlusive dressing on wounds with air leaks" Transport: Reviewed. The decision for level of trauma activation is the trauma center.</p> |
| <p>4.01 General Trauma Management</p> | <p>Flowchart Airway – Occlusive dressing to 3-sided occlusive or chest seal</p> | <p>Flowchart/Airway: Revised</p> |
| <p>5.01 Childbirth</p> | <p>Extra space before "do NOT routinely suction" What does the I mean in the upper left corner of 5.01, page 1? What does BLS BHC mean in the upper left of page 2? That if you're a BLS provider, you should call base in all these situations? That phone symbol is not something we use elsewhere, in terms of being standardized.</p> | <p>Revised. Top left corner is a legend of the colors. Phone symbol: will be used to indicate Base Hospital Call in flowcharts. Further efforts to standardize planned for later in the year</p> |
| <p>5.01 Childbirth</p> | <p>Base Hospital Contact: I'm not certain what the question from EMS would be or what input the Base Physician may be able to offer. Presumably, it's just a question of gestational age? What are the capabilities of local hospitals in terms of management those in the 20-25 week range? For instance, if no hospital in the city can manage a 20-22 week old, should we not just define a cutoff based on local resources and their capabilities?</p> | <p>Reviewed. Yes, age of viability might be one possible scenario. These are inherently stressful calls and EMS is encouraged to call if they have any concerns.</p> |
| <p>5.01 Childbirth</p> | <p>Complications Comments Midwives and Birthing Centers - Question about writing something for RN and Certified Midwives and Oxytocin or other out of scope interventions.</p> | <p>Revised. Physician on-scene (including Nurse Practitioner or Certified Professional Midwife) may provide additional medications and management (see Policy 4041)</p> |
| <p>5.02 Eclampsia & Pre-Eclampsia with Severe Features</p> | <p>In notes, maybe say Midazolam is the abortive medication indicated for seizures (link protocol) meeting the definition of status epilepticus Magnesium sulfate is indicated to prevent recurrence of an eclamptic seizure</p> | <p>Revised. Suggested language added</p> |

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| <p>Magnesium</p> | <p>Indication First line medication for asthma exacerbation or refractory to albuterol/epi Adult Dose/Route Remove NS/Mag Sulfate infusion (100cc NS not stocked) Preeclampsia/Eclampsia – Changed to admin over 20 mins, not highlighted. Currently over 5 mins for Eclampsia, 15 for Preeclampsia with severe features Pediatric Dose Add maximum single/cumulative dose in Torsades/Asthma Notes Remove lidocaine from Mag Sulfate IM Injection. No medical cocktails exist, possible increase in med admin errors. MgSO3 to Magnesium Sulfate</p> | <p>Indication: Reviewed. Magnesium isn't a first line medication for asthma, but can be a helpful adjunct in certain scenarios -- severe or life-threatening exacerbations that fail to respond to initial standard treatment (https://ginasthma.org/wp-content/uploads/2024/05/GINA-2024-Strategy-Report-24_05_22_WMS.pdf). It is not effective in COPD exacerbation.</p> <p>Adult Dose/Route: Reviewed. NS/Mag infusion listed as an option/alternative to D5W in the event of drug shortages. Adult Dose/Route: Preeclampsia/Eclampsia: Revised. Highlighted 20 minutes to emphasize the change in rate.</p> <p>Pediatric dose: Revised. Added maximum single dose 2g for polymorphic V-Tach and severe acute asthma.</p> <p>Notes: Lidocaine: Revised. Mixing lidocaine with magnesium removed to minimize drug errors.</p> |
| <p>Jail Health Services ED DCI for Medical Clearance</p> | <p>I think this document is a valuable resource for hospitals, but I do not think it should be an EMS policy. Just keep it as a PDF that you can send to hospitals, but not as a policy.</p> | <p>Reviewed. Agreed. This is a guideline not a EMS policy. It is undergoing the public EMSAC process for transparency.</p> |
| <p>Jail Health Services ED DCI for Medical Clearance</p> | <p>Would this serve best as a memo from the EMS agency or information provided to hospitals? It doesn't seem to be EMS related.</p> | <p>Reviewed. Agreed. This is a guideline not a EMS policy. It is undergoing the public EMSAC process for transparency.</p> |
| <p>Administrative Changes (Non-voting items)</p> | | |
| <p>4049 Discontinuing Resuscitative Efforts</p> | <p>3.1.2 Remove criteria 5; redundant with change to 3 With criteria 4, add "throughout resuscitation"</p> | <p>3.1.2 Criteria #5: Revised. Removed to reduce redundancy</p> |
| <p>Buprenorphine</p> | <p>Contraindication (List out all exclusion criteria from 2.18) No opioid withdrawal signs or symptoms Under 16 years of age Any methadone use within last 10 days Severe medical illness (sepsis, respiratory distress, etc.) Altered mental status and unable to give consent or comprehend potential risks and benefits for any reason</p> | <p>Revised. Reformatted to resemble other medication sheets.</p> |
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