EMERGENCY MEDICAL CARE COMMITTEE MEETING AGENDA

Thursday, January 16th, 2025, at 8:30 A.M.
2995 McMillan Ave, Ste #178, San Luis Obispo

MEMBERS
CHAIR Chris Javine, *Pre-hospital Transport Providers, 2022-2026*
VICE – CHAIR Matt Bronson, *City Government, 2020-2024*
Dr. Brad Knox, *Physicians*, *2022-2026*
Bob Neumann, *Consumers*, *2022-2026*
Alexandra Kohler, *Consumers, 2020-2024*
Jonathan Stornetta, *Public Providers, 2020-2024*
Michael Talmadge, *EMS Field Personnel, 2020-2024*
Jay Wells, *Sheriff's Department, 2020-2024*
Julia Fogelson, *Hospitals*, *2022-2024*
Diane Burkey, *MICNs*, *2022-2026*
Dr. Rachel May, *Emergency Physicians*, 2022-2026

EX OFFICIO
Ryan Rosander, *EMS Director*
Dr. Bill Mulkerin**,** *EMS Medical Director*
Penny Borenstein, *Health Officer*

STAFF
Maya Craig-Lauer, PHEP Representative
Rachel Oakley, *EMS Coordinator*
Eric Boyd, *EMS Coordinator*
Kaitlyn Blanton, *EMS Coordinator*
Alyssa Vardas, *Administrative Assistant*

AGENDA	ITEM	LEAD
Call To Order	Introductions Public Comment	C. Javine
Action/Discussion	Approval of minutes: September 19th, 2024, Minutes (*attached)*	C. Javine
Action/Discussion	Policy Revisions: • PSFA and CPR Training • 152 - STEMI Triage and Destination • 153 - TRAUMA Patient Triage and Destination • 219 – Assisting Patients with Emergency Medications Protocol Revisions: • 601- Universal • 611- Allergic Reaction Anaphylaxis	R. Oakley R. Rosander K. Blanton
Staff Reports	• Health Officer • EMS Agency Director Report • EMS Medical Director Report • PHEP Staff Report	P. Borenstein R. Rosander B. Mulkerin M. Craig-Lauer
Committee Members' Announcements or Reports	Opportunity for Board members to make announcements, provide brief reports on their EMS-related activities, ask questions for clarification on items not on the agenda, or request consideration of an item for a future agenda (Gov. Code Sec. 54954.2[a][2])	Committee Members
Adjourn	**Next Meeting: March 20th, 2025**	C. Javine

Emergency Medical Care Committee
Meeting Minutes
Thursday November 21st, 2024
2995 McMillan Ave, Ste 178, San Luis Obispo

Members
☒ CHAIR Jonathan Stornetta, Public Providers
☒ VICE CHAIR Dr. Brad Knox, *Physicians*
☒ Bob Neumann, *Consumers*
☒ Alexandra Kohler, *Consumers*
☒ Matt Bronson, *City Government*
☒ Chris Javine, *Pre-Hospital Transport Providers*
☒ Michael Talmadge, *EMS Field Personnel*
☒ Dr. Rachel May, *Emergency Physicians*
☒ Jay Wells, *Sheriff's Department*

☒ Julia Fogelson, *Hospitals*
☒ Diane Burkey, *MICNs*

Ex Officio
☐ Dr. Penny Borenstein, *Acting EMS Division Director*
☐ Dr. Bill Mulkerin, *LEMSA Medical Director*

Staff
☒ Rachel Oakley, EMS Coordinator
☒ Ryan Rosander, EMS Director
☒ Maya Craig-Lauer, *PHEP Program Manager*
☒ Alyssa Vardas, Administrative Assistant
Eric Boyd, EMS Coordinator
Kaitlyn Blanton, EMS Coordinator

Guests – Ben Dore, Natasha Lukasiewich, Jayson Doumas, Pete Gavitte, Jon Ontiveros, Heidi Hutchison, Lisa Epps

AGENDA ITEM / DISCUSSION	ACTION
CALL TO ORDER	The meeting called to order at 08:31 AM
Introductions	
Public Comment	No comments
Approval of Meeting Minutes – Motion to approve with changes.	J. Wells Motioned, R. May Seconded, call for a vote, Approved.
Recommend/Approve Heidi Hutchison and Jon Ontiveros for Clinical Advisory and Operations Committee	
Brown Act Training. **Staff Report for revisions for Protocol #603, #640, #641, and Policy #218 Revisions:** • County Counsel is providing training on the Brown Act. • SLOEMSA has proposed revising the pain management protocol, as well as the chest pain and pulseless cardiac arrest protocols. • SLOEMSA has Updated the upgrade/downgrade policy. • **Brown Act Training:** R. May – Are Trauma, Stemi Ad Hoc Committees? R. Oakley – I think because they aren't public, they wouldn't be. B. Dore – I will look more into them for clarification. Beware of "reply All" in emails before the meeting. **603:** J. Fogelson - Do you intend to take IN out? M. Talmadge – That's for Fentanyl. R. May – I would support IN also, based on multiple sources which all showed the benefits of Ketamine IN with no adverse effects. R. Rosander – I originally put it in there but Bill wanted it out. R. May – Are these action items since they have already been rolled out, so can they actually be discussed? R. Rosander – We just discussed these as upcoming protocols in update class. C. Javine – One method of administration is IV mixing, one agency mixes it and another uses it, will there be guidance on administrating something mixed by another agency? R. Rosander – Some will transfer and some will want to ride in.	R. Rosander/R. Oakley

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R. May – ketamine comes in a high concentration, there is a higher likelihood of error, but Ketamine is very safe. Just need to educate medics on using it. D. Burkey – In hospital there are high-alert stickers on them to let them know that the max is a specific amount. R. May – we need to make sure that we have uniformity with the medication vials. R. Rosander – We need to figure out the most readily available concentration. Put in notes to label the bag for transfer so all crews are doing the same. J. Fogelson – I like Diane's point of putting on stickers, but we also have two people checking on medicine. M. Talmadge – In the language there is a discrepancy between wording on protocol and formulary, one says or and one says Fentanyl first. **640:** R. May – I think these are good changes. M. Talmadge – Was it intentional to not have "maintain a SBP"? R. Rosander – I think we can put that in there for field crews. **641:** R. May – Are you going to add a fluid bolus? **218:** C. Javine – I fall into the camp of having more descriptive language. Currently, there are hardly any reductions in the system. The policy is currently IC judgment. I am curious what criteria they are using to execute that judgement. I would think any thing to reduce number of code 3s would be good. R. Rosander – This should all be heavily discussed in the QI committee. We should shift the culture not the policy. There are no reductions here at all so we definitely need to address that. C. Javine – I completely agree this is a training issue and should be in QI, but what metrics are you using to judge that? R. May – I think we need a new dispatch system. J. Stornetta – It is unheard of to have a system as large as ours with no EMD. C. Javine – It is not all the fact that the IC is not reducing the ambulance, it may be that the ambulance is already there. J. Wells – I think it might be good to have a metric for the reductions if applicable. B. Neuman – Who is delivering EMD now? J. Stornetta – No one. Motion to approve 603, 640, 641, 218.	Motion to approve: M. Talmadge motioned R. May Second. Call for a vote, All Approve
EMS Updates: We have two new coordinators: Eric Boyd, Kaitlyn Blanton. **Health Officer Updates:** None **EMS Medical Director Report:** None **PHEP Staff Report:** We are coordinating with the state to hold a ChemPak training.	R. Rosander P. Borenstein B. Mulkerin M. Craig-Lauer
Announcements: Some members need new letters. Voted on new Chair: Chris Javine, Matt Bronson for Vice Chair.	J. Stornetta

Future Agenda Items: • Letters for board members.	Adjourn at 10:12 AM.
Next Regular Meeting The next meeting is on Thursday, January 16th, 2025, at 08:30 AM at the EMS Agency.	

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COUNTY OF SAN LUIS OBISPO HEALTH AGENCY
PUBLIC HEALTH DEPARTMENT
Nicholas Drews *Health Agency Director*
Penny Borenstein, MD, MPH *Health Officer/Public Health Director*

MEETING DATE	EMCC, January 16th, 2025
STAFF CONTACT	Rachel Oakley
SUBJECT	Public Safety First Aid (PSFA) and Cardio Pulmonary Resuscitation (CPR) and PSFA Optional Skills
SUMMARY	San Luis Obispo County Emergency Medical Services Agency (SLOEMSA) developed a several PSFA policies and procedures, primarily for law enforcement agencies requesting to utilize the optional skill of naloxone administration. Prior versions that will be replaced are: • Policy #213, Naloxone for Public Safety First Responders Requirements (dated 3/1/18) • Policy #214, Naloxone for Public Safety First Responders, which is a clinical procedure guide (dated 2/1/19). The purpose of developing new PSFA policies is to align with California State regulations that apply to Public Safety personnel (peace officers, firefighters, and lifeguards) and provide a clear process to apply for PSFA training program approval or PSFA optional skills authorization. SLOEMSA removed the requirement to submit use and annual reports for optional skills, however, Public Safety providers that apply are required to have an EMS quality improvement (QI) program in place for any issues or necessary retraining that are identified within their agency. There is no expiration date for optional skills authorization. Most of the policy content is taken straight from regulation and some sections align with SLOEMSA operational procedures.
REVIEWED BY	EMSA Staff and Operations Subcommittee
RECOMMENDED ACTION(S)	EMCC Approval
ATTACHMENT(S)	PSFA/CPR Training Program Approval, PSFA Optional Skills Authorization, and corresponding Attachments (Policy numbers TBD)

POLICY # ( ): PUBLIC SAFETY FIRST AID OPTIONAL SKILLS AUTHORIZATION

I. PURPOSE

A. To establish criteria as defined by Title 22, Division 9, of the California Code of Regulations (CCR), for authorization of Public Safety First Aid (PSFA) optional skills in the County of San Luis Obispo (SLO).

II. SCOPE

A. In addition to the skills authorized by an approved PSFA and Cardiopulmonary Resuscitation (CPR) training program, public safety personnel may perform optional skills specified in this policy, when authorized by the Medical Director of SLO Emergency Medical Services Agency (SLOEMSA).

III. DEFINITIONS

- Primarily Clerical or Administrative: the performance of clerical or administrative duties accounts for 90% or more of the time worked each pay period.
- Public Safety First Aid: Immediate care for injury or serious illness, including medical emergencies, by public safety personnel prior to the availability of medical care by licensed or certified health care professionals.
- Public Safety Personnel:
  - Firefighters: Any officer, employee or member of a fire department or fire protection or firefighting agency of the State of California, or any city, county, city and county, district or other public or municipal corporation or political subdivision of California or any member of an emergency reserve unit of a volunteer fire department or fire protection district.
  - Lifeguards: Any officer, employee, or member of a public aquatic safety department or marine safety agency of the State of California, or any city, county, city and county, district or other public or municipal corporation or political subdivision of California.
  - Peace Officers: Any city police officer, sheriff, deputy sheriff, peace officer member of the California Highway Patrol, marshal or deputy marshal or police officer of a district authorized by statute to maintain a police department or other police officer required by law to complete PSFA training.
- Regularly employed: Being given wages, salary, or other remuneration for the performance of those duties normally carried out by lifeguards, firefighters, or peace officers.

IV. POLICY

A. The following optional skills are available for public safety personnel authorization:

1. Administration of naloxone for suspected narcotic overdose.

2. Administration of epinephrine by auto-injector for suspected anaphylaxis.
3. Supplemental oxygen therapy using a non-rebreather face mask or nasal cannula, and bag-valve-mask ventilation.
4. Administration of auto-injectors containing atropine and pralidoxime chloride for nerve agent exposure for self or peer care, while working for a public safety provider.
5. Use of oropharyngeal airways (OPAs) and nasopharyngeal airways (NPAs).

B. Interested public safety providers shall apply for their personnel to be authorized to use the optional skills listed in section (A) of this policy.

1. Approved PSFA optional skills that providers have in operation prior to this policy are authorized and do not need an application.

C. Each personnel shall be trained and tested to demonstrate competence in the optional skills applied for, prior to personnel utilizing optional skills.

D. Training shall include content on bloodborne pathogens and SLOEMSA Policy #123, Contagious Disease Exposure.

E. A PSFA Optional Skills applicant must have and submit a procedure for an EMS quality improvement program (EMSQIP).

F. Personnel shall demonstrate trained optional skills competency every two years or more frequently as determined by the provider's EMSQIP.

G. Patient care provided by public safety personnel will be reported and immediately handed off to any arriving EMS personnel who is authorized at a higher medical level.

H. PSFA optional skills training shall be overseen by a Program Liaison, to ensure that the program is compliant with this policy and CCR.

I. All current CCR will be followed if different than the requirements outlined in this policy.

V. PROCEDURE

A. Submit a complete application, Attachment A – Public Safety First Aid Optional Skills Application, to SLOEMSA and provide the required item below:

1. A copy of the EMSQIP.

B. A written response will be sent to confirm that the application has been received.

C. Allow up to twenty-one (21) days for a written response, which will be sent to confirm that personnel are authorized to utilize optional skills.

VI. AUTHORITY

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- Title 22, Division 9

VII. ATTACHMENTS

A. Public Safety First Aid Optional Skills Application

Approvals:

EMS Agency, Administrator	
EMS Agency, Medical Director	

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PUBLIC SAFETY FIRST AID OPTIONAL SKILLS APPLICATION

APPLICANT INFORMATION	
Public Safety Provider Name:	
Public Safety Provider Address:	Program Liaison Name:
Program Liaison Phone Number:	Program Liaison Email:

OPTIONAL SKILLS APPLYING FOR:
☐ Administration of naloxone for suspected narcotic overdose.
☐ Administration of epinephrine by auto-injector for suspected anaphylaxis.
☐ Supplemental oxygen therapy using a non-rebreather face mask or nasal cannula, and bag-valve-mask ventilation.
☐ Administration of auto-injectors containing atropine and pralidoxime chloride for nerve agent exposure for self or peer care, while working for a public safety provider.
☐ Use of oropharyngeal airways (OPAs) and nasopharyngeal airways (NPAs).

SUBMIT THE FOLLOWING WITH THIS APPLICATION:
☐ Copy of the EMS Quality Improvement Program.

ATTESTATION OF PSFA OPTIONAL SKILLS APPLICANT	
I hereby certify that I have reviewed and understand the County of San Luis Obispo EMS Policy #XXX, Public Safety First Aid Optional Skills Authorization and Title 22, Div. 9 requirements.	
Signature of PSFA Optional Skills Applicant:	Date:

*****EMS AGENCY USE ONLY BELOW THIS LINE*****	
Received Date:	☐ Email confirmation of application received.
Authorization Date (w/in 21 work days):	☐ Letter on file.

POLICY # ( ): PUBLIC SAFETY FIRST AID AND CPR TRAINING PROGRAM APPROVAL

I. PURPOSE

A. To establish criteria as defined by Title 22, Division 9, Chapter 1.5 of the California Code of Regulations (CCR), for approval of Public Safety First Aid (PSFA) and Cardiopulmonary Resuscitation (CPR) training programs in the County of San Luis Obispo (SLO).

II. SCOPE

A. As determined by the employing agency, Public Safety personnel who are not otherwise covered by the following approving authorities: California Department of Forestry and Fire Protection (CAL FIRE), Commission on Peace Officer Standards and Training (POST), California Department of Parks and Recreation (DPR), Department of the California Highway Patrol (CHP), and approved Emergency Medical Services (EMS) training programs.

B. Except those whose duties are primarily clerical or administrative, the following regularly employed public safety personnel, lifeguard, firefighter, and peace officer, shall be trained to administer first aid, CPR and use an automated external defibrillator (AED).

III. DEFINITIONS

- Primarily Clerical or Administrative: the performance of clerical or administrative duties accounts for 90% or more of the time worked each pay period.
- Public Safety First Aid: Immediate care for injury or serious illness, including medical emergencies, by public safety personnel prior to the availability of medical care by licensed or certified health care professionals.
- Public Safety AED Service Provider: An agency, or organization which is responsible for, and is approved to operate, an AED.
- Public Safety Personnel:
  - Firefighters: Any officer, employee or member of a fire department or fire protection or firefighting agency of the State of California, or any city, county, city and county, district or other public or municipal corporation or political subdivision of California or any member of an emergency reserve unit of a volunteer fire department or fire protection district.
  - Lifeguards: Any officer, employee, or member of a public aquatic safety department or marine safety agency of the State of California, or any city, county, city and county, district or other public or municipal corporation or political subdivision of California.
  - Peace Officers: Any city police officer, sheriff, deputy sheriff, peace officer member of the California Highway Patrol, marshal or deputy marshal or police

officer of a district authorized by statute to maintain a police department or other police officer required by law to complete PSFA training.

- Regularly Employed: Being given wages, salary, or other remuneration for the performance of those duties normally carried out by lifeguards, firefighters, or peace officers.

IV. POLICY

A. Initial training requirements shall be satisfactorily completed within one (1) year from the effective date of the individual's initial employment and, whenever possible, prior to assumption of regular duty in one of the public safety personnel categories.

B. The initial course of instruction shall be at least twenty-one (21) hours in first aid and CPR.

C. The content of initial training listed in CCR shall prepare personnel to recognize injury or illness, render basic first aid level treatment, and shall be competency based.

D. Applicable agencies shall apply and be approved to teach the skills listed in section (H) of this policy, prior to training implementation and authorization of personnel to perform PSFA and CPR skills.

1. Approved PSFA and CPR Training Programs in operation prior to policy implementation are valid for the current approval term listed on an official approval letter.

E. A PSFA and CPR Training Program applicant must have and submit a procedure for an EMS quality improvement program (EMSQIP).

F. Initial and retraining courses shall test the knowledge and skills specified in CCR and have a passing standard for course completion and shall ensure the competency of each skill.

1. Each course shall include a written and skills examination which tests the ability to assess and manage all of the conditions, content, and skills listed in CCR.

2. The passing standards shall be established and approved by the San Luis Obispo Emergency Medical Services Agency (SLOEMSA) before administration of the examination.

G. Initial training shall include content on bloodborne pathogens and SLOEMSA Policy #123, Contagious Disease Exposure.

1. Refresher training shall include content on bloodborne pathogens.

H. After completion of training and demonstration of competency to the satisfaction of an approved training provider, personnel are authorized to perform the following emergency medical care while at the scene of an emergency:

1. Evaluate the ill and injured.

2. Provide treatment for shock.
3. Support airway and breathing with manual airway opening methods, including head-tilt and/or jaw thrust, manual methods to remove an airway obstruction in adults, children, and infants, and use the recovery position.
4. Spinal immobilization.
5. Splinting of extremities.
6. Eye irrigation using water or normal saline.
7. Assist with administration of glucose.
8. Assist patients with administration of physician prescribed epinephrine devices and naloxone.
9. Assist with childbirth.
10. Hemorrhage control using direct pressure, pressure bandages, principles of pressure points, and tourniquets. Hemostatic dressings may be used from the list approved by the State EMS Authority.
11. Apply chest seals and dressings.
12. Simple decontamination techniques and use of decontamination equipment.
13. Care for amputated body parts.
14. Provide basic wound care.

I. Patient care provided by public safety personnel will be reported and handed off to any arriving EMS personnel who is authorized at a higher medical level, as soon as is feasible.

J. Retraining is required at least once every two years by successful completion of either:
   1. An approved course which includes review of the topics and demonstration of skills prescribed in CCR, which consists of at least eight (8) hours of first aid and CPR including AED.
   2. Maintaining current and valid certification or licensure as an Emergency Medical Technician (EMT), Paramedic, Registered Nurse, Physician Assistant, Physician, or current and valid National Registry of Emergency Medical Responder (EMR), EMT, Advanced EMT, or Paramedic.
   3. Successful completion of a competency based written and skills pretest of the topics and skills prescribed in CCR. Appropriate retraining of topics indicated by the pretest shall be completed in addition to any new developments in first aid and CPR. A final test shall be provided covering the topics included in the retraining for personnel failing to pass the pretest. The hours for retraining may be reduced to the hours needed to cover topics indicated by the pretest.

K. Training in PSFA and CPR shall be conducted by an instructor who is currently licensed in California (CA) as a Physician, Physician's Assistant, Registered Nurse, or Paramedic, or certified in CA as an EMT, or is approved by SLOEMSA, and who meets the following criteria:

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1. Proficient in the skills taught.
2. Qualified to teach by education or experience.

L. Validation of all instructor's qualifications shall be the responsibility of the agency whose training program has been approved by SLOEMSA.

M. A PSFA training program shall have a Program Director, to ensure that the program is compliant with this policy and CCR.

1. The Program Director may also be an instructor.

N. Every trainee who successfully completes an approved course of instruction that includes successfully passing the competency based written and skills exams shall be given a certificate or written verification of completion that shall include:

1. Initial or refresher training course.
2. Number of training hours completed.
3. Date of issue.
4. Date of expiration, which shall be two (2) years from the date of course completion.

O. An approved PSFA and CPR Training Program shall maintain a record of the names of trainees and the dates on which training courses have been completed on a Public Safety First Aid and CPR Training Record – Attachment B.

1. This record shall be retained for at least four (4) years.
2. This record shall be submitted to the SLOEMSA upon completion of initial training, retraining, and every four (4) years with a Public Safety First Aid and CPR Training Program Application – Attachment A.

P. If a SLOEMSA approved PSFA and CPR Training Program has or plans to acquire AEDs for intended use by trained personnel, an application and approval for Public Safety AED Service Provider, Policy #204, shall be obtained prior to the usage of AEDs.

1. AED authorized personnel will be indicated on the Public Safety First Aid and CPR Training Record – Attachment B.
2. State and federal agencies are approved by the EMS Authority.

Q. All course material and records shall be subject to oversight and must be made available for periodic review as determined by SLOEMSA.

R. Course approval is valid for four (4) years from the date of approval, and shall be reviewed every four (4) years by submitting a Public Safety First Aid and CPR Training Program Application – Attachment A.

S. An approved PSFA and CPR Training Program shall notify SLOEMSA, in writing, within thirty (30) calendar days of any change in Program Director, instructor(s), or course materials.

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1. Changes are subject to SLOEMSA review and must be approved prior to implementation.

T. Program approval and renewal is contingent upon continued compliance with all required criteria and provisions in this policy and CCR and may be revoked by SLOEMSA if the program fails to remain compliant.

1. SLOEMSA will follow the procedures set forth in CCR regarding withdrawal of program approval.

U. All current CCR will be followed if different than the requirements outlined in this policy.

V. Allow sufficient time to apply for approval or renewal, as program review can take up to twenty-one (21) business days, which does not include time for program remediation. Additional turn time would be required if there are deficiencies noted.

W. A non-refundable fee will be collected as part of the application and review requirements. An applicant whose check returns for insufficient funds may result in denial or suspension until fee is paid and will incur additional fees as outlined in SLOEMSA Policy #101 – Fee Collection.

V. PROCEDURE

A. Submit a complete application, Attachment A – Public Safety First Aid and CPR Training Program Application, to SLOEMSA and provide the required items below:

1. A letter of intent.
2. A copy of all course materials, including but not limited to course outline, objectives, and presentations or handouts used for instruction.
3. A copy of course written and skills tests.
4. Passing standards for course written and skills tests.
5. Program Director and Instructor(s) resumes that specify eligibility for program roles.
6. A copy of the course completion certificate (template).
7. A copy of the EMSQIP.

B. Submit payment.

C. A written response will be sent to confirm that the application has been received.

D. Allow up to twenty-one (21) business days for a program review, which will result in a written response detailing whether there is any missing information.

E. A letter of program approval or disapproval will be issued by SLOEMSA as soon as the decision has been reached.

1. The program approval letter will indicate the program effective date and expiration.

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F. Submit a Public Safety First Aid and CPR Training Record – Attachment B, upon completion of initial training and after retraining.

VI. AUTHORITY

- Title 22, Division 9

VII. ATTACHMENTS

A. Public Safety First Aid and CPR Training Program Application

B. Public Safety First Aid and CPR Training Record

Approvals:

EMS Agency, Administrator	
EMS Agency, Medical Director	

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PUBLIC SAFETY FIRST AID AND CPR TRAINING PROGRAM APPLICATION

Check One: ☐ Initial Application ☐ Renewal

APPLICANT INFORMATION	
Public Safety Provider Name:	
Public Safety Provider Address:	Public Safey Provider Phone Number:
Program Director Name:	Program Director Phone Number:
Program Director Email:	Alternate Contact:

SUBMIT THE FOLLOWING WITH THIS APPLICATION
☐ Letter of intent.
☐ Copy of all course materials, including but not limited to course outline, objectives, and presentations or handouts used for instruction.
☐ Copy of course written and skills tests.
☐ Passing standards for course written and skills tests.
☐ Program Director and Instructor(s) resumes that specify eligibility for program role.
☐ Copy of the course completion certificate.
☐ Copy of the EMS Quality Improvement Program.
☐ Submit current application fee.

ATTESTATION OF PSFA&CPR APPLICANT	
I hereby certify that I have reviewed and understand the County of San Luis Obispo EMS Policy #XXX, Public Safety First Aid and CPR Training Program Approval and Title 22, Div. 9.	
Signature of PSFA & CPR Applicant:	Date:

*****EMS AGENCY USE ONLY BELOW THIS LINE*****	
Received Date:	☐ Email confirmation of application received.
Initial Review (w/in 21 work days), Date:	Letter of approval or disapproval, Date:
Update State Database:	Update SLO EMSA records:
☐ Submit Attachment B upon completion of initial training.	

PUBLIC SAFETY FIRST AID AND CPR TRAINING RECORD

Public Safety Provider Name:

Employee Name:	PSFA Exp	Medic/EMT Exp	CPR/AED Exp	AED Authorized (Yes or No)

Please submit to PH_EMSA@co.slo.ca.us or 2995 McMillan Ave., Ste. #178, SLO, 93401

COUNTY OF SAN LUIS OBISPO HEALTH AGENCY
PUBLIC HEALTH DEPARTMENT
Nicholas Drews *Health Agency Director*
Penny Borenstein, MD, MPH *Health Officer/Public Health Director*

MEETING DATE	January 16th 2024
STAFF CONTACT	Ryan Rosander, EMS Director 805.788.2512 rrosander@co.slo.ca.us
SUBJECT	Assisting patients with their emergency medications, STEMI and trauma catchment areas/depart scene times, fluid bolus in universal protocol, anaphylaxis revision.
SUMMARY	Several Congenital Adrenal Hyperplasia advocacy groups have reached out to SLOEMSA, proposing a policy that addresses the need for paramedics to assist patients with their emergency medications, especially for patients in adrenal crisis. This policy will allow paramedics to receive base hospital orders to assist the parents or caregivers in drawing up and administering medications such as Solu-Cortef. It covers not only patients with Congenital Adrenal Hyperplasia but also any patient who needs assistance from a paramedic with their physician-prescribed emergency medications. Over the past year, several stakeholders have approached SLOEMSA with a request to incorporate catchment areas into the STEMI and Trauma destination policies. Currently, the field operates without a defined boundary or cutoff for decisions on transporting STEMI or trauma-alert patients to SVRMC/FHMC (SLO County) or MRMC (SB County). The proposed policy revision will help operations by providing clear boundaries. Furthermore, there has been a lot of discussion surrounding prolonged on-scene times for trauma, STEMI, and CVA. A depart scene time goal of 10 minutes or less was incorporated into policy and protocol to reflect these concerns. During SLOEMSA's 2024 EMS Update Class, numerous paramedics mentioned that they would like to see a discretionary 500mL fluid bolus (with repeat if hypotensive) within the Universal Protocol. This would eliminate the need for paramedics to call a base hospital for orders to administer fluids. During our last CAC, an MD mentioned that they are seeing an increase in anaphylaxis patients being brought into the ED without EPI administered. This was discussed, and a possibility might be the lack of language clarity surrounding anaphylaxis within the protocol. This has been addressed within the revision.
REVIEWED BY	Dr. William Mulkerin, SLOEMSA Staff, Ops, CAC
RECOMMENDED ACTION(S)	Recommend Policy #219, Policy #152, Policy #153, Policy #153 - Attachment A, Protocol #601, and Protocol #611 for approval by the EMCC, with an implementation date following a SLOEMSA bulletin.

ATTACHMENT(S)	Policy #219: Assisting Patients with Their Emergency Medications, Policy #152: STEMI Triage and Destination, Policy #153: Trauma Triage and Destination, Policy #153: Attachment A (Trauma Triage Decision Scheme), Protocol #601: Universal, Protocol #611 Allergic Reaction/Anaphylaxis

POLICY #152: STEMI TRIAGE AND DESTINATION

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I. PURPOSE

A. To establish guidelines for Emergency Medical Services (EMS) personnel to identify and transport patients with acute ST-segment Elevation Myocardial Infarction (STEMI) who could benefit from the rapid response and specialized services of a STEMI Receiving Center (SRC).

II. SCOPE

A. This policy applies to adult patients with chest pain or other symptoms indicative of Acute Coronary Syndrome (ACS) with a 12-lead ECG demonstrating elevated ST-segments indicating a specific type of myocardial infarction.

III. DEFINITIONS/GLOSSARY

- Percutaneous Coronary Intervention (PCI): A broad group of percutaneous techniques utilized for the diagnosis and treatment of patients with STEMI.
- Return of Spontaneous Circulation (ROSC): The return of a palpable pulse after cardiac arrest.
- STEMI: An acute myocardial infarction that generates a specific type of ST-segment elevation on a 12-lead ECG.
- "STEMI Alert": A report from EMS personnel that notifies a STEMI Receiving Center as early as possible that a patient has a specific computer-interpreted prehospital 12-lead ECG indicating a STEMI, allowing the SRC to initiate the internal procedures to provide appropriate and rapid treatment interventions.
- "12-Lead Consultation" – Contact SLO County STEMI Receiving Hospital (French Hospital Medical Center) when the patient does not meet a STEMI ALERT Criteria and transmitting the 12-lead ECG would benefit the consultation.
- STEMI Receiving Center (SRC): A facility licensed for cardiac catheterization laboratory and recognized as an SRC by the County of San Luis Obispo Emergency Medical Services Agency (EMS Agency).
- STEMI Referral Hospital (SRH): An acute care hospital in the County of San Luis Obispo (SLO) that is not designated as a STEMI Receiving Center.
- SLO STEMI Receiving Center (SLO SRC) – refers to the STEMI Receiving Center in San Luis Obispo County (French Hospital Medical Center) to be used for medical direction and or destination decisions.

IV. POLICY

A. Determine if patient condition meets STEMI Patient Triage Criteria.

B. "STEMI Alert" notifications - contact the nearest SRC (French or Marian) as soon as possible, including for any ALS agencies that are first on scene. During the 12-lead

transmittal to the closest SRC, a "STEMI Alert" should be made simultaneously, regardless of whether transport personnel are on scene. After departing scene, an updated "STEMI ALERT" should be called as soon as possible.

C. The expected off-scene time should be 10 minutes or less.

D. "12- Lead ECG Consultations" and/or "Destination" consultations - contact the SLO SRC (French)

V. PROCEDURE

A. Determine if patient condition meets STEMI Patient Triage criteria:

1. Patients meeting EMS Agency Protocol Adult Chest Pain #640: or with indications for 12-lead ECG per EMS Agency 12-lead ECG Policy #707 with computerized interpretation of an accurately performed pre-hospital 12-lead ECG indicating ***STEMI*** (or equivalent computerized interpretation).

B. Destination and Notification

1. Transport to nearest SRC (French or Marian) or as directed by a SLO SRC (French).

a. Patients meeting the STEMI Patient Triage Criteria are considered a "STEMI Alert" and must be transported to the nearest SRC.

b. Patients with ROSC regardless of 12-lead ECG reading

c. The SRC Emergency Department must be notified as early as possible of the incoming "STEMI Alert" and /or ROSC to activate the SRC's internal STEMI/PCI system.

d. The closest SRC for patients being transported within San Luis Obispo County will be defined as follows:

1. A unit on scene of a call that is located within San Luis Obispo County south of El Campo Rd should proceed to Marian Regional Medical Center.

2. A unit on scene of a call that is located within San Luis Obispo County north of El Campo Rd should proceed to French Hospital Medical Center.

3. In any other area west or east of El Campo Rd, crews should exercise discretion in determining which SRC is closest or fastest for patient transport.
4. Discretion in all cases should include abnormal traffic patterns, congestion, or other travel factors affecting transport to the closest and fastest SRC.

2. An Emergency Department physician at the SLO SRC (French) must be consulted to determine patient destination in the following:

a. "STEMI Alert":

(1) The patient is unstable with a SBP<90mmHg and transport time to the SRC would add more than 30 minutes to the transport time to a STEMI Referral Hospital (SRH).

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(2) Patient is uncooperative with the procedure and/or expresses a personal preference for destination other than the SRC; see EMS Agency Policy #203: Patient Refusal of Treatment or Transport.

b. Questionable 12-Lead ECG

c. Patients who, while enroute, develop unmanageable airway or cardiac arrest without ROSC must be transported to the closest hospital, with the transporting provider notifying the intended SRC of the change in destination.

d. When a patient is diverted to another hospital the SLO SRC (French) shall notify the receiving hospital and provide information regarding the destination decision.

C. Contact the nearest SRC as soon as possible with “STEMI Alert” Notification

1. For patients with identified STEMI, destination must be promptly determined after the prehospital 12-lead ECG is completed and read. The SRC must be notified as soon as possible.

2. The “STEMI Alert” notification must contain the following information:

a. Call identified as a “STEMI Alert”.

b. ETA, if available/when en route to the SRC.

c. Patient age and gender.

d. Confirmation of ECG reading and whether it appears to be free of significant artifact.

e. Confirmation that the appropriate treatment protocol is being followed.

f. Results of any medications given.

g. Additional information if required:

(1) Any confusion regarding chief complaint or treatment.

(2) Destination decision assistance.

3. ECG Transmission:

a. With a STEMI Alert or ROSC and the equipment is available, the ALS provider shall transmit a 12-lead ECG to a SRC (French or Marian);

(1) Notify the SRC that you are capable of 12-lead ECG transmission and that you have transmitted or are about to transmit the 12-lead ECG previously obtained.

(2) Include on the transmitted 12-lead ECG the patient age and sex required for the ECG monitor to accomplish its interpretation and be used as an identifier for the SRC.

(3) Do not include the name of the patient with the transmission of the 12-lead ECG.

b. When “Consulting” with a SLO SRC (French) and transmitting the 12-lead ECG would benefit the consultation:

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(1) Notify the SLO SRC (French) that you are capable of 12-lead ECG transmission and that you have transmitted or are about to transmit the 12-lead ECG.

(2) Include on the transmitted 12-lead ECG the patient age and sex required for the ECG monitor to accomplish its interpretation and be used as an identifier for the SRC

(3) Do not include the name of the patient with the transmission of the 12-lead ECG.

4. Documentation

a. Findings of prehospital 12-lead ECGs, the time of the "STEMI Alert," and patient identification must be documented on the 12-lead ECG and the prehospital PCR.

b. Two copies of the prehospital 12-lead ECG (multiple if performed) must be made, with one delivered to the receiving hospital responsible for the continued care of the patient, and one included with the prehospital PCR.

VI. AUTHORITY

- California Health and Safety Code, Division 2.5
- California Code of Regulations, Title 22, Division 9

DRAFT

POLICY #153: TRAUMA PATIENT TRIAGE AND DESTINATION

I. PURPOSE

A. To establish guidelines for EMS personnel to identify and transport "significantly injured" patients who could benefit from the rapid response and specialized services of a trauma center.

II. SCOPE

A. This policy applies to both adult and pediatric injured patients, unless stated otherwise.

III. PROCEDURE

A. Trauma Activation Criteria

1. "STEP 1 or STEP 2 TRAUMA ALERT" - Patient meeting any one of the Physiologic (Step 1) and/or Anatomic criteria (Step 2) following a traumatic event shall be designated a "TRAUMA ALERT" and transported to the closest trauma center. The expected off-scene time should be 10 minutes or less.

2. "STEP 3 TRAUMA CONSULTATION" - Patient meeting (Step 3) Mechanism of Injury - contact with the County of San Luis Obispo (SLO) Trauma Center for patient destination. The expected off-scene time should be 10 minutes or less.

3. "STEP 4 TRAUMA CONSULTATION"- Shall be made with the SLO Trauma Center to determine destination when the paramedic identifies a significantly injured patient that DOES NOT meet the Step 1 (Physiologic), Step 2 (Anatomic) or Step 3 (Mechanism of Injury) criteria but meets one or more of the special patient or system considerations.

B. Trauma Patient Criteria

Patients meeting any one of the Physiologic and/or Anatomic criteria following a traumatic event shall be a "TRAUMA ALERT" and transported to the closest trauma center. Patient meeting Mechanism of Injury and/or Special Patient/System Considerations shall be a TRUAMA CONSULT and contact the County of San Luis Obispo (SLO) Trauma Center for patient destination.

C. Closest Trauma Center

1. The closest Trauma Center for patients being transported within San Luis Obispo County will be defined as follows:

a. A unit on scene of a call that is located within San Luis Obispo County south of El Campo Rd should proceed to Marian Regional Medical Center.

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b. A unit on scene of a call that is located within San Luis Obispo County north of El Campo Rd should proceed to Sierra Vista Regional Medical Center.

c. In any other area west or east of El Campo Rd, crews should exercise discretion in determining which trauma center is closest or fastest for patient transport.
d. Discretion in all cases should include abnormal traffic patterns, congestion, or other travel factors affecting transport to the closest and fastest Trauma Center.

1. **STEP 1 (Physiologic Criteria)**

The expected off-scene time should be 10 minutes or less

a. *Adult* injured patients meeting any one of the following criteria:

1. Glasgow Coma Scale ≤13 (based on patient history and attributed to injury)
2. Systolic blood pressure <90 mmHg
3. Respiratory rate <10 or >29 breaths per minute

b. *Pediatric* injured patients (≤ 34 Kg) meeting any one of the following criteria:

1. Glasgow Coma Scale ≤13 (based on patient history and attributed to injury)
2. Evidence of poor perfusion – color, temperature, etc.
3. Respiratory rate
   - >60 breaths per minute or respiratory distress
   - <20 breaths per minute in infants <1year
4. Heart rate
   - ≤5 years (<22Kg) heart rate <80 beats per minute or >180 beats per minute
   - ≥6 years (23-34Kg) heart rate <60 beats per minute or >160 beats per minute
5. Blood pressure
   - Newborn (<1 month) systolic blood pressure <60mmHg
   - Infant (1 month -1 year) systolic blood pressure <70mmHg
   - Child (1 year-10 years) systolic blood pressure <70mmHg + 2X age in years
   - Child (11-14 years) systolic blood pressure <90mmHg

2. **STEP 2 (Anatomic Criteria)**

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The expected off-scene time should be 10 minutes or less

Injured patients meeting <u>any one</u> of the following criteria:

a. All significant penetrating injuries to head, neck, torso and extremities proximal to knee or elbow

b. Chest wall instability or deformity (e.g. flail chest)

c. Two proximal long bone fractures (above the elbows and or knees)

d. Mangled, degloved or pulseless extremity

e. Open or depressed skull fracture

f. Paralysis

g. Pelvic injury with high-risk mechanism of injury (motor vehicle collisions, auto vs. pedestrian accidents, motorcycle collisions, falls from heights)

3. **<u>STEP 3 (Mechanism of Injury Criteria)</u>**

The expected off-scene time should be 10 minutes or less

Injured patients meeting <u>any one</u> of the following criteria:

a. Falls
   1. Adults: >20 feet (one story is equal to 10 feet)
   2. Pediatric (≤ 34kg) : >10 feet or ≥ two times the height of the child

b. High-risk auto crash:
   1. Passenger Space Intrusion (PSI) of space: >12 inches occupant patient site; or >18 inches anywhere within the passenger space
   2. Ejection (partial or complete) from automobile
   3. Death in same passenger compartment

c. Auto vs. pedestrian/bicyclist thrown, run over, or with significant impact (>20 mph)

d. Motorcycle or unenclosed transport vehicle crash (>20 mph)

4. **<u>STEP 4 (Special Patient or System Considerations)</u>**

Age and co-morbid considerations.

a. EMS provider judgment

b. Age greater than 65
   1. SBP <110 mmHg may represent shock

c. Pediatric (≤ 34kg)

d. Pregnancy > 20 weeks

e. Anticoagulation therapy (excluding aspirin) or other bleeding disorders with head injury (excluding minor injuries)

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f. Burns with trauma mechanism

Note:

A TRAUMA CONSULT is not required for ground level/low impact falls with GCS ≥ 14 or when the GCS is normal for patient

C. Contact the Trauma Center

Contact the receiving trauma center early and immediately upon determining the patient meets trauma patient triage criteria with a "TRAUMA ALERT" or "TRAUMA CONSULTATION"

1. "TRAUMA ALERT"

A "TRAUMA ALERT" is initiated when an injured patient meets any one of the Step 1 (Physiologic) or Step 2 (Anatomic) Criteria. Consider early notification to the intended receiving Trauma Center, from the scene when possible

a. EMS personnel should provide a "TRAUMA ALERT" early and from the scene when possible to assist in early activation of the trauma team and determination of patient destination.

b. ALS personnel must contact the trauma center with the TRAUMA ALERT.

c. A "TRAUMA ALERT" report should include the following:

1. "TRAUMA ALERT" meeting trauma triage step criteria "x"
2. Unit and medic #
3. ETA to trauma center
4. Report on individual patient (MIVT format):

- Age and sex
- Mechanism of injury
- Injury and complaints
- Vital signs including GCS
- Treatment
- Include specific triage findings or considerations that identify the patient as meeting TRAUMA ALERT criteria.

2. "TRAUMA CONSULTATION"

"TRAUMA CONSULTATION" with a SLO trauma center should be obtained to determine trauma patient destination when Step 3 (mechanism(s) of injury) criteria or Step 4 (special considerations) are present and Step 1 (physiologic) and Step 2 (anatomic) criteria are NOT met.

a. Only ALS personnel may request a "TRAUMA CONSULTATION" for patient destination

b. A "TRAUMA CONSULTATION" report should include the following:

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1. "TRAUMA CONSULTATION" meeting trauma triage step criteria "x"
2. Unit and medic #
3. ETA to trauma center and ETA to closest ED (When the trauma center is the closest facility include in the radio contact information notifying them they are the closest receiving facility)
4. Report on the individual patient: (MIVT format)
   - Patient age and sex
   - Mechanism of injury and scene
   - Injury and complaints
   - Vital signs including GCS
   - Treatment and response
   - Include <u>specific</u> findings or considerations that identify the patient as meeting TRAUMA CONSULTATION criteria

c. Paramedic Concerns

3. The Trauma center, when not receiving the patient, shall notify the receiving hospital of the incoming patient and provide that hospital with the prehospital care patient information.
4. When practical, a brief updated report should be given to the trauma center Hospital and include any significant changes in route in vital signs, GCS, physical findings, symptoms or treatments.

D. Exceptions to Direct Transport to a Trauma Center

Trauma patients will be transported to the closest ED in the following situations:

1. Patient condition necessitates transport to the closest ED, such as the following:
   a. Unmanageable airway (intubation attempts are unsuccessful and an adequate airway cannot be maintained with BVM or other device)
   b. Uncontrollable bleeding with rapidly deteriorating vital signs
   c. Traumatic cardiac arrest – see EMS Agency Prehospital Determination of Death/Do Not Resuscitate (DNR) End of Life Care Policy #125.
2. SLO Trauma Center destination order
3. Patient refusal - see EMS Agency Patient Refusal of Treatment and/or Transport Policy #203.
4. Trauma center is on complete diversion – see EMS Agency Hospital Diversion Policy #154: Hospital Diversion.

~~E.~~ The utilization of EMS helicopter for the response and transport of trauma patients must be in accordance with ~~EMS Agency~~ Policy #155: EMS Helicopter Operations. ~~EMS Helicopter Policy #155 transport should be considered when ground transport is greater than 30 minutes from the trauma center and air transport would be more expeditious than ground transport.~~

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IV. AUTHORITY

- California Health and Safety Code, Division 2.5
- California Code of Regulations, Title 22, Division 9

V. ATTACHMENTS

A. Trauma Triage Matrix

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Trauma Triage Decision Scheme

Patients meeting one or more criteria activates

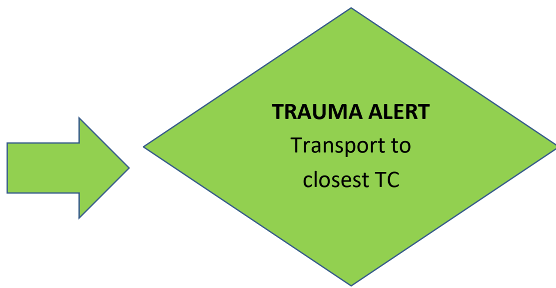
1

Criteria Adult Physiologic – DEPART SCENE ≤ 10 MIN

- Glasgow Coma Scale ≤ 13
- Systolic blood pressure <90 mmHg
- Respiratory rate <10 or > 29 breathe per minute

Pediatric Physiologic Criteria

- Glasgow Coma Scale≤ 13
- Evidence of poor perfusion – color, temperature, etc.
- Respiratory Rate
  - > 60/min or respiratory distress/apnea
  - < 20/min in infants < 1 yr
- Heart Rate
  - ≤ 5 yrs (<22 kg) < 80 or > 180/min
  - ≥ 6 yrs (23-34 kg) < 60 or > 160/min
- Blood Pressure
  - Newborn (<1 month) SBP < 60mmHg
  - Infant (1mo to 1 yr) SBP <70 mmHg
  - Child (1yr to 10 yrs) SBP < 70mmHg + 2X age in yrs
  - Child (11 to 14 yrs) SBP < 90 mmHg

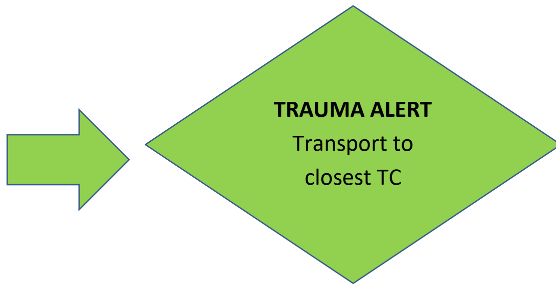


Assess for anatomic injury

2

Anatomic Criteria – DEPART SCENE ≤ 10 MIN

- All penetrating injuries to head, neck ,torso, and extremities proximal to the elbow or knee
- Chest wall instability or deformity (i.e. flail chest)
- Two long bone fractures – proximal to elbow or knee
- Mangled, degloved or pulseless extremity
- Open or depressed skull fracture
- Paralysis
- Pelvic injury with high-risk mechanism of injury

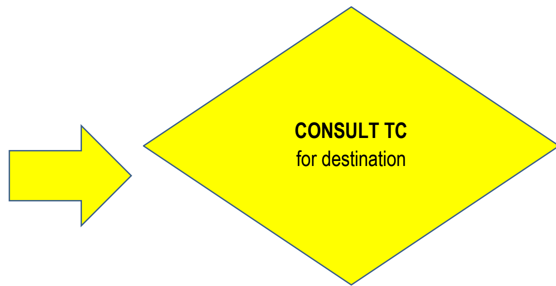


Assess for mechanism

3

Mechanism of Injury – DEPART SCENE TIME ≤ 10 MIN

- Falls
  - Adults - > 20 feet (one story equals 10 feet)
  - Children - > 10 feet or two times their height
- High risk auto crash
  - Intrusion of passenger compartment space > 12 inches occupant site or > 18 inches any site including the roof/floor
  - Ejection (partial or complete) from automobile
  - Death in the same vehicle
- Auto vs pedestrian/bicycle thrown, run over, or with significant impact (> 20 mph)
- Motorcycle or unenclosed transport vehicle crash > 20 mph



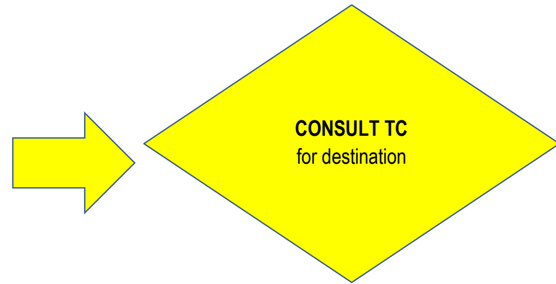
Assess for special considerations

4

Special Patient and System Considerations (*)

- EMS provider judgement
- Age > 65 yrs or < 14 yrs
- Anticoagulants therapy (excluding ASA) or other bleeding disorders with head injury (excluding minor injuries)
- Pregnancy > 20 weeks
- Burns with traumatic mechanism

(*) Trauma Consult is not required for ground level/low impact falls with a GCS ≥ 14 (or GCS is normal for patient) – follow SLO County Destination Policy # 151



Follow SLO County Destination Policy #151

Contact TC and transport to closest ED with

- **Unmanageable airway**
- **Uncontrolled bleeding**
- **Traumatic arrest**

POLICY #219: ASSISTING PATIENTS WITH THEIR EMERGENCY MEDICATIONS

I. PURPOSE

A. To allow EMS personnel in San Luis Obispo County to assist patients in administering physician-prescribed, self-administered emergency medications. This policy is intended for administering emergency medications, not in the EMS personnel's basic scope of practice.

II. POLICY

A. Paramedics may be requested to assist with the administration of a specific, physician-prescribed emergency medication.

B. Paramedics may assist patients with the administration of physician-prescribed devices, including, but not limited to, patient-operated medication pumps and self-administered emergency medications.

C. Please note that this policy applies not only to one condition but any condition in which the patient needs emergency medications administered.

D. This policy is not intended to circumvent any existing SLOEMSA policy or protocol.

III. EXAMPLE CONDITION

A. Some children are born with a genetic defect (Congenital Adrenal Hyperplasia) that prevents their body from producing adequate amounts of Cortisol. The signs & symptoms of an adrenal crisis include nausea, fever, pallor, confusion, weakness, tachycardia, tachypnea, hypoglycemia, hypotension, and shock, symptoms that might lead to their death.

B. Families with such a child should be very aware of their condition. When these children experience an adrenal crisis, the proper treatment is the IM administration of the drug, e.g., hydrocortisone (Solu-Cortef). During this emergency, the parents or caregivers may be unable to deliver the IM medication properly and might request assistance from the EMS system. In this type of emergency, paramedics can assist the parents or caregivers with drawing up and administering the Solu-Cortef. The family members should be familiar with the proper dosage and have the necessary equipment, if available. In some cases, such as when a child is at school, the school personnel may have medication and instructions available.

IV. PROCEDURE

A. State law authorizes a paramedic to assist a patient or parents who request help administering an emergency medication outside the ordinary scope of practice.

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B. Base Hospital shall be contacted to determine the appropriate course of action if faced with this rare situation. With Base Hospital orders, paramedics may assist patients/families in drawing up and administering emergency medication.

C. All patients who have received physician-prescribed emergency medication administered by EMS should be transported to the hospital, for those patients who refuse EMS transport, contact Base Hospital and follow Policy #203: Patient Refusal of Treatment and/or Transport.

V. AUTHORITY

- California Code of Regulations, Title 22, Division 9

Approvals:

EMS Agency, Administrator	
EMS Agency, Medical Director	

DRAFT

UNIVERSAL

BLS Procedures

MEDICAL

- Evaluate Scene Safety/Personal Protective Equipment
- Assess, establish and maintain airway
    - Suction as needed
- Pulse Oximetry
    - O_2 administration per Airway Management Protocol #602
- Evaluate breathing and circulation
- Assess chief complaint
- Focused physical exam and vital signs:
    - Pulse
    - Blood pressure
    - Respiratory rate
    - Lung sounds
    - Skin signs
- BLS treatment protocols

TRAUMA

- Evaluate Scene Safety/Personal Protective Equipment
- Assess, establish and maintain airway
    - Suction as needed
- Pulse Oximetry
    - O_2 administration per Airway Management Protocol #602
- Evaluate breathing and circulation
- Control life-threatening bleeding
- Remove patient's clothing to expose and identify injuries
- Ensure patient warmth – cover patient after clothing removal to maintain core body temperature
- Spinal motion restriction (SMR) if indicated per Spinal Motion Restriction Procedure # 702
- BLS treatment protocols

BLS Elective Skills

Obtain Blood Glucose Level if indicated by:

- Policy #612 ALOC
- Policy #620 Seizures
- Policy #621 CVA/TIA
- As directed by ALS provider

ALS Procedures

MEDICAL

- Vascular access – Procedure #710
- Consider 12-lead ECG early
- Capnography (if available/applicable)
- Blood Glucose Measurement
- Transport Determination
- ALS Treatment Protocols
- Consider Normal Saline up to 500mL IV
    - May repeat x1 for persistent hypotension

TRAUMA

- Trauma Triage and Destination
- ALS Treatment Protocols
- Consider Normal Saline up to 10mL/kg
    - May repeat x1 for persistent hypotension

Base Hospital Orders Only

MEDICAL

- Determined on patient needs
- If applicable, see Policy #219: Assisting Patients with Their Emergency Medications

TRAUMA

- Determined on patient needs

Notes

- Use Pediatric Policies for patients ≤34 kg and consider use of Broselow tape or equivalent
- Rapid transport for Specialty Care patients (Trauma, STEMI, CVA-TIA). Expected scene departure ≤ 10 minutes

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ALLERGIC REACTION/ANAPHYLAXIS

One or more of the following should increase suspicion for anaphylaxis:

- Respiratory symptoms (throat tightness, hoarse voice, wheezing/stridor, cough, SOB)
- Cardiovascular symptoms: fainting, dizziness, tachycardia, hypotension
- GI symptoms: nausea, vomiting, abdominal cramping
- Angioedema of eyelids, lips, tongue, face

ADULT	PEDIATRIC (≤34 KG)
BLS	
• Universal Protocol #601 • Pulse Oximetry ○ O_2 administration per Airway Management Protocol #602 • May assist with the administration of patient's prescribed medication (i.e. Epi Auto-injector, inhaler, etc.)	Same as Adult
BLS Elective Skill (Approved Providers Only)	
~~**Unstable**~~ ~~(Dyspnea/Wheezing/Shock)~~ **Suspected anaphylaxis (e.g. respiratory, cardiovascular, GI, and/or angioedema symptoms)** • **Adult 0.3 mg Epinephrine Auto-Injector** administered in anterolateral thigh ○ May repeat, if indicated, every 5 min, max 3 doses	~~**Unstable**~~ ~~(Dyspnea/Wheezing/Shock)~~ **Suspected anaphylaxis (e.g. respiratory, cardiovascular, GI, and/or angioedema symptoms)** **Pediatric (≥15 kg) 0.15 mg Epinephrine Auto-Injector** administered in anterolateral thigh ○ May repeat, if indicated, every 5 min, max 3 doses
BLS Optional Scope Skill (Approved Providers Only)	
~~**Unstable**~~ ~~(Dyspnea/Wheezing/Shock)~~ **Suspected anaphylaxis (e.g. respiratory, cardiovascular, GI, and/or angioedema symptoms)** **Adult Epinephrine 1:1000 0.3 mg IM** ○ May repeat, if indicated, every 5 min, max 3 doses	~~**Unstable**~~ ~~(Dyspnea/Wheezing/Shock)~~ **Suspected anaphylaxis (e.g. respiratory, cardiovascular, GI, and/or angioedema symptoms)** • **Pediatric (≥15 kg), Epinephrine 1:1000 0.15 mg IM anterolateral thigh** ○ May repeat, if indicated, every 5 min , max 3 doses
ALS Standing Orders	
~~**Stable**~~ **Skin signs only (e.g. Itching/rash/hives/flushing)**	~~**Stable**~~ **Skin signs only (e.g. Itching/rash/hives/flushing)**

• **Diphenhydramine** 50 mg IV/IM
 	
~~**Unstable**~~
~~**(Dyspnea/Wheezing/Shock)**~~
 	
Suspected anaphylaxis (e.g. respiratory, cardiovascular, GI, and/or angioedema symptoms)
 	
• **Epinephrine 1:1,000** 0.01 mg/kg IM – not to exceed 0.5 mg
    ○ may repeat every 5 min, max 3 doses
• **Diphenhydramine** 50 mg IV/IM
 	
• If respiratory involvement add:
    ○ **Albuterol** 2.5-5 mg via HHN/Mask/CPAP/BVM with adjunct, over 5-10 min
    ○ repeat as needed
 	
~~**Extremis**~~
• ~~**Epinephrine 1:1,000** 0.01 mg/kg SL – not to exceed 0.5 mg~~
    ○ ~~may repeat every 5 min, max 3 doses~~
	• **Diphenhydramine** 2 mg/kg IV/IM – not to exceed 50 mg
	~~**Unstable**~~
	~~**(Dyspnea/Wheezing/Shock)**~~
	
	Suspected anaphylaxis (e.g. respiratory, cardiovascular, GI, and/or angioedema symptoms)
	
	• **Epinephrine 1:1,000** 0.01 mg/kg IM – not to exceed 0.3 mg
	    ○ may repeat every 5 min, max 3 doses
	• **Diphenhydramine** 2 mg/kg IV/IM – not to exceed 50 mg
	
	• If respiratory involvement add:
	    ○ **Albuterol** 2.5-5 mg via HHN/Mask/CPAP/BVM with adjunct, over 5-10 min
	    ○ repeat as needed
	
	~~**Extremis**~~
	• ~~**Epinephrine 1:1,000** 0.01 mg/kg SL – not to exceed 0.3 mg~~
	    ○ ~~may repeat every 5 min, max 3 doses~~

Base Hospital Orders Only	
Unresponsive to previous therapy • **Epinephrine 1:10,000** 0.01 mg/kg slow IV titrated – not to exceed 0.5 mg • As needed	Unresponsive to previous therapy • **Epinephrine 1:10,000** 0.01 mg/kg slow IV titrated – not to exceed 0.3 mg • As needed

Notes

- If unsure between allergic reaction and anaphylaxis, treat as suspected anaphylaxis and give Epinephrine **early**
- Auto-injector injection site should be exposed and cleansed with aseptic technique prior to injection.
- Follow manufacturer's instructions when using Epinephrine auto-injector.

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EPINEPHRINE 1:1,000 (Adrenalin®)

Classification: Sympathomimetic agent (catecholamine)

Actions:

1. Increases cardiac output due to increased inotropy, chronotropy, dromotropy, and AV conduction (*b*1 effect)
2. Relaxes smooth muscles of the respiratory tract (*b*2 effect)
3. Increases systolic blood pressure due to increased cardiac output (*b*1effect) and vasoconstriction (*a* effect)
4. Increases coronary perfusion during CPR by increasing aortic diastolic pressure

Indications:

1. Cardiopulmonary arrest
2. Anaphylaxis
3. Respiratory distress with wheezing
4. Pediatric symptomatic bradycardia
5. Neonatal resuscitation
6. Suspected croup or epiglottitis

Contraindications:

1. **Use with caution in pregnancy.**
2. **Consider base physician consultation if possible if the patient has history of MI, angina or hypertension.**

Adverse Effects:

Cardiovascular	**Neurological**
Tachycardia	Anxiety
Hypertension	Dizziness
Chest pain	Headache
Palpitations	Tremors
Ventricular fibrillation	Seizures

Gastrointestinal
Nausea/vomiting

Administration:

ADULT DOSE

1. **Asthma:** 0.01 mg/kg IM, not to exceed 0.5 mg, may repeat every 5 minutes, not to exceed 3 doses

2. **Allergic reaction/anaphylaxis:** 0.01 mg/kg **IM**, not to exceed 0.5 mg, may repeat every 5 minutes, not to exceed 3 doses

3. ~~If the patient is in extremis: 0.01 mg/kg **SL** injection, not to exceed 0.5 mg, may repeat every 5 minutes, not to exceed 3 doses~~

EPINEPHRINE 1:1,000 (Adrenalin®) CONTINUED

PEDIATRIC DOSE

1. **Asthma:** 0.01 mg/kg, IM, not to exceed 0.3 mg, may repeat every 5 minutes, not to exceed 3 doses

2. **Allergic reaction/anaphylaxis:** 0.01 mg/kg, **IM**, not to exceed 0.3 mg, may repeat every 5 minutes, not to exceed 3 doses

3. ~~If the patient is in extremis: 0.01 mg/kg **SL** injection, not to exceed 0.3 mg, may repeat every 5 minutes, not to exceed 3 doses~~

4. **Bradycardia:** The first line drug in pediatric bradycardia is epinephrine 1:10,000

Notes:

- IM administration is with 1-1½" needle in anterior/lateral thigh or deltoid.
- ~~SL injection is with a small 25 gauge ¼" TB syringe.~~
- Tachycardia is not a contraindication to Epinephrine.