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

Emergency Medical Services Agency

URGENT

Bulletin 2025-01 – January 17th, 2025

PLEASE POST

Policy and Protocol Changes/Update

The San Luis Obispo County Emergency Medical Services Agency (SLOEMSA) has taken Policy #152: STEMI Triage and Destination, Policy #153: Trauma Triage and Destination, Policy #153 Attachment A./Trauma Triage Matrix, Policy #219: Assisting Patients with Their Emergency Medications, and Protocol #601: Universal, Protocol #611 Allergic Reaction/Anaphylaxis through the committee process. On 01/16/2025, EMCC reccomened approval for all. Please see below for a summary of the changes.

Policy #152: STEMI Triage and Destination

- "STEMI Alert" notifications and 12 lead submittals should happen on-scene if the first agency is ALS, regardless of whether transport personnel are on scene. Repeat during transport.
- Target off-scene time is 10 minutes or less for transport personnel.
- For South County, the dividing line for transporting to either FHMC or MRMC is El Campo Rd.

Policy #153: Trauma Triage and Destination and Attachment A/Trauma Triage Matrix

- For trauma steps 1-3, the target off-scene time should be 10 minutes or less for transport personnel.
- For South County, the dividing line for transporting to either SVRMC or MRMC is El Campo Rd.

Addition of Policy #219: Assisting Patients with Their Emergency Medications

- 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.

Protocol #601: Universal

- Allows paramedics to use their discretion to determine what patients would benefit from a 500mL fluid bolus (or comparable fluid bolus for pediatrics).
- The patient does NOT have to be hypotensive to administer bolus.
- Repeat x1 if the patient is hypotensive.
- Adds Policy #219 to base hospital orders.

Protocol #611 Allergic Reaction/Anaphylaxis- Due to a hesitancy to administer IM EPI in the field, the following has been changed:

- If unsure between allergic reaction and anaphylaxis, treat as suspected anaphylaxis and give Epinephrine **early**.
- Stable/Unstable language eliminated, replaced with skin signs only, suspected anaphylaxis and suspected anaphylaxis with respiratory involvement.
- Definition of anaphylaxis signs/symptoms at the top of the protocol.
- Elimination of SL EPI administration.
- Epinepherine formulary updated to reflect.

Please note the attached policies and protocols are for comparative purposes only. The live documents can be found online at Policies, Procedures, and Protocols (includes Forms)

For any questions regarding this bulletin, please get in touch with EMS Director Ryan Rosander at rrosander@co.slo.ca.us

OR

EMS Medical Director Dr. Mulkerin wmulkerin@co.clo.ca.us

POLICY #152: STEMI TRIAGE AND DESTINATION

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 target off-scene time should be 10 minutes or less for transport personnel.

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).

(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:

(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

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 target off-scene time should be 10 minutes or less for transport personnel.

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 target off-scene time should be 10 minutes or less for transport personnel.

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 TRAUMA 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.

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 target off-scene time should be 10 minutes or less for transport personnel

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)**

The target off-scene time should be 10 minutes or less for transport personnel

Injured patients meeting any one 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. **STEP 3 (Mechanism of Injury Criteria)**

The target off-scene time should be 10 minutes or less for transport personnel

Injured patients meeting any one 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. **STEP 4 (Special Patient or System Considerations)**

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)

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:

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.~~

IV. AUTHORITY

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

V. ATTACHMENTS

A. Trauma Triage Matrix

Trauma Triage Decision Scheme

Patients meeting one or more criteria activates

1

Criteria Adult Physiologic – TARGET 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

→ **TRAUMA ALERT** Transport to closest TC

NO

Assess for anatomic injury

2

Anatomic Criteria – TARGET 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

→ **TRAUMA ALERT** Transport to closest TC

NO

Assess for mechanism

3

Mechanism of Injury – TARGET DEPART SCENE ≤ 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

→ **CONSULT TC** for destination

NO

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

→ **CONSULT TC** for destination

NO

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.

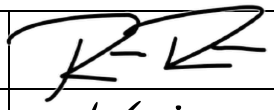
B. Base Hospital shall be contacted to determine the appropriate course of action if faced with this rare situation. With Base Hospital orders, paramedics may assist patients/families in drawing up and administering emergency medication.

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	

UNIVERSAL

MEDICAL	TRAUMA
BLS Procedures	

• 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
	• 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	

• Vascular access – Procedure #710
• Consider 12-lead ECG early
• Capnography (if available/applicable)
• Blood Glucose Measurement
• Transport Determination
• ALS Treatment Protocols
Adult
• Consider Normal Saline up to 500mL IV
  ○ May repeat x1 for persistent hypotension
Pediatric
• Consider Normal Saline up to 10mL/kg
  ○ May repeat x1 for persistent hypotension
	• Trauma Triage and Destination
	• ALS Treatment Protocols

Base Hospital Orders Only	
• Determined on patient needs • If applicable, see Policy #219: Assisting Patients with Their Emergency Medications	• 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). Target scene departure ≤ 10 minutes for transport personnel.

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.	