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To Advanced Life Support Provider Agency Coordinators
Basic Life Support Agency Coordinators
Base Hospital Nurse Coordinators
Base Hospital Medical Directors
EMT - Paramedic Training Program Coordinators

CLARIFICATION/CORRECTIONS TO JULY 2009 PROTOCOL AND POLICY REVISIONS

Several Protocols, as indicated below, are in need of clarification and/or revision.

The ET medication route can still be found in the protocols but IV/IO is preferred. Using the ETAD dosing for esophageal placement, medication can be delivered via the King Airway, but again IV/IO is preferred.

Adult IO: The intent is that an IO would be started on an acute status patient requiring fluid/medication administration when unable to establish other IV. Because Lidocaine can be given to the adult patient for management of IO discomfort any medication that can be administered IV can be administered IO in *the adult patient*. This was a late change and all protocols do not reflect IO as a route. In addition, only selected patients should need IO administration.

Careful attention should be paid to the trauma patient. Critical patients should not be delayed on scene for establishment of venous access, including IO lines. The benefits of fluid in theses patients is not established and delay may cause significant worsening.

The pediatric patient is unchanged, the only medications that can administered IO without a physician variation are: fluids, atropine, epinephrine and lidocaine.

King Airway: Water soluble lubricant should only be placed posterior on the distal tip, taking care to not occlude the ventilation holes. There is limited experience with the use of the Toomey or Positube with the King Airway, EtCO2 is the standard to determine correct placement.

Per S-103, one small adult and one large adult ETAD are required inventory, unless replaced with the 3 sizes of the perilaryngeal airway. The large ETAD is required for those patients >6 feet.

P-104: Should be dated 07-01-09

- 12-Lead EKG: The removal of the statement "Consider atypical presentations especially in elderly, diabetics and women" does not mean these patients cannot have a 12-Lead EKG performed. The predictive value of the EKG in patients without chest pain has been found to be low, so field 12-leads in these patients are as likely to be misleading as helpful for field activation.
- Indications for CPAP: should read "O2 Sat <92%".

S-110: The following additions should be made:

- Charcoal 50 Gm PO (excluding isolated alcohol, heavy metal, caustic agents, hydrocarbons or iron ingestion).
- Epinephrine 1:1000:

  ?Respiratory Etiology

  Severe respiratory distress or inadequate response to Albuterol/Atrovent consider:
  - ***If no known cardiac history and <65 y;*** 0.3mg IM. MRx2 q10".
- NTG ointment: "If systolic BP ≥ 100: NTG ointment 1 inch"

P- 117: Corrected and re-issued to reflect 5mg as the maximum dose for Versed IN for those patients weighing 30-36 kg (Green). The corrected version is labeled P-117a.

S-127: The IV 250ml fluid bolus remains at the beginning of the protocol and applies to all dysrhythmias. Because this protocol is several pages long it was added to individual dysrhythmias for clarity.

S-168: For cardiogenic shock, the repeat fluid bolus should be removed from the Pediatric Standing Orders (P-112).

The Table of Contents has been updated to reflect the revisions. All updated protocols can be found on the County EMS website: www.SanDiegoCountyEMS.com, select EMS PreHospital System.

Please take this opportunity to review the updates with your staff. Thank them also for all their hard work caring for our ill and injured patients each day.

Sincerely,

Bruce E. Haynes, M.D., Medical Director
Emergency Medical Services

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