



City and County of San Francisco  
London Breed, Mayor

Department of Public Health  
Emergency Medical Services Agency

Date: November 10, 2020

To: Emergency Medical Services Advisory Committee  
EMS System Providers

From: John Brown MD, San Francisco EMS Agency Medical Director

A handwritten signature in blue ink that reads "John Brown MD".

Subject: **Airway, Needle Thoracostomy and Allergic Reaction Protocols and the Advisory Committee Policy Revisions**

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Thank you for your extensive input into these protocols and policy. I have integrated the EMS Advisory Committee's recommendations to the greatest degree possible that is compatible with the best practice of EMS.

Primary airway management should always be Basic Life Support measures. For Advanced Life Support airway management, my specific direction for initial approach based on current QI measurements in San Francisco is to use the Supraglottic Airway Device (the approved device in our system is the King Airway).

Any use of advanced airway device/technique out of the sequence in the protocol requires documentation of rationale for choosing that sequence and subsequent QI review. Examples of acceptable rationale include:

- Severe head, neck, or facial trauma
- Abnormal airway anatomy
- Severe airway swelling (e.g. burns and inhalation injuries)
- Need to visualize potential obstruction or airway injury
- For use of needle cricothyroidotomy, the inability to access the oropharynx in a critical patient

If alternate sequence of use of the advanced airway device/technique is desired, the EMS provider agency must submit a provider-specific airway management plan to the EMS Agency for approval that includes training, QI review and EMSA Simulation Center evaluation of airway skills.

For all ALS airway management, no more than two total attempts should be made prior to moving to an alternate approach. An attempt at endotracheal intubation occurs once the laryngoscope blade enters the mouth, an attempt at supraglottic airway insertion occurs when the device is placed in the mouth and a seal is attempted, and an attempt at needle cricothyroidotomy occurs when the needle is inserted into the cricothyroid membrane. If airway measures are not successful and the EMS crew assesses the patient to be viable the patient should be brought immediately to the closest Receiving Hospital for assistance with securing the airway.

The EMSA will continue to review the data on airway management and will provide training to increase

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the first pass success rate of all airway techniques. We will re-evaluate the protocol in light of our goal to improve of all airway interventions, including new techniques such as videolaryngoscopy and other supraglottic airway devices.

The airway protocol revision will be effective on November 30, 2020 and will be released with this memo. The Needle Thoracostomy and Allergic Reaction protocol revision effective dates will align with the annual provider training schedules and will be distributed shortly. The Advisory Committee policy will be evaluated by a small workgroup of the EMS Advisory Committee and will report back to EMSAC with their recommendations. In the meantime, I will ask the newly formed stroke committee, an outgrowth of the stroke coordinator committee formed by the SF stroke centers years ago, to provide recommendations to the EMSAC and myself on potential improvements in our stroke system of care.

Thank you for your commitment and willingness to provide excellent EMS care in San Francisco.