SOUTH DAKOTA BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS

Emergency Medical Services Advisory Council

DRAFT AGENDA

February 06, 2026 – 10:00 am (Central)

The public may attend the meeting using one of the following options:

Microsoft Teams

Join the meeting now

Meeting ID: 239 004 611 808 41
Passcode: RC2tV2JJ

Dial in by phone

+1 605-679-7263,,339693823# United States, Sioux Falls
Find a local number
Phone conference ID: 339 693 823#

36-4B-37. Emergency medical services personnel council--Appointment--Terms--Meetings--Duties--Board communication.

The board shall appoint an emergency medical services personnel council composed of five members:

(1) One emergency medical technician;
(2) One emergency medical technician-intermediate/85, emergency medical technician-intermediate/99, or advanced emergency medical technician;
(3) Two paramedics; and
(4) One physician licensed in accordance with chapter 36-4 and trained in emergency medicine.

The term of office for each member is three years. No member may serve more than three consecutive, full terms. If a vacancy occurs, the board must appoint a new member to fill the unexpired term. The appointment of a member to an unexpired term is not considered a full term.

The council shall meet at least twice each year, at a time and place set by the council, and may hold additional meetings as necessary to conduct business. The council shall meet the requirements of chapter 1-25 regarding open meetings.

The council shall assist the board in all matters related to the licensure, practice, education, continuing education, investigation, and discipline of emergency medical services personnel pursuant to this chapter. The council shall make recommendations to the board regarding rules promulgated pursuant to this chapter. The council shall submit meeting minutes and any recommendations to the board following each council meeting.

The board shall communicate activity on all matters relating to emergency medical services personnel with the council.

Meeting Agenda

1. 10:00 am Welcome. Call to order, Roll Call
2. Draft Agenda Approval
3. Meeting Minutes Approval
4. Public Comment Period (5 minutes) - pursuant to SDCL 1-25-1 where the chair of the public body shall reserve at every official meeting by the public body a period for public comment, limited at the chair's discretion, but not so limited as to provide for no public comment.
5. Advisory Council Business
    - ALS Scope Petition Review
    - EMS Scope Clarification Question
    - Dr. Luther DNR discussion
    - Paramedics and Blood Products Document

SOUTH DAKOTA BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS (SDBMOE)

EMERGENCY MEDICAL SERVICES ADVISORY COUNCIL

July 31, 2025

Unapproved Draft Minutes

12:00 pm (Central Time)

Public Advisory Council Meeting

Unapproved Draft Minutes[1]. Votes are roll call voice vote. [2]

Advisory Council Members present: Andrew Binder, Chris Hermes, Dr. Jeff Luther, Matt McQuisten, David Mitchell
Board Member present: Gary Langerock
Staff Members present: Whitney Burrows, Margaret Hansen, Randi Sterling
This was a public meeting, and other parties may have been in attendance.

The meeting was called to order at 12:02 PM. Roll was called, and quorum was established.

A motion for approval of the agenda was ratified (McQuisten/Binder/Unanimous).

A motion for approval of the minutes was approved. (Binder/Luther/Unanimous).

The request for any public comment was made pursuant to SDCL 1-25-1 and there was no public comment.

The advisory council discussed whether paramedics are permitted to perform arterial blood draws for ABG testing. It was determined that this procedure is not currently within the paramedic scope of practice. However, this could be considered for inclusion in the future. In the meantime, paramedics may submit a scope petition to request approval to perform this procedure on a case-by-case basis.

The advisory council discussed a concern brought to Board staff regarding an AEMT program.

Board staff provided an update to the council on the status of the administrative rules approved by the Interim Rules Committee. The rules are currently awaiting filing by the Secretary of State. Once filed, they will take effect 20 days later.

As there was no further business, the meeting was adjourned at 12:32 PM.

---

[1] 1-27-1.17. Draft minutes of public meeting to be available--Exceptions--Violation as misdemeanor. The unapproved, draft minutes of any public meeting held pursuant to § 1-25-1 that are required to be kept by law shall be available for inspection by any person within ten business days after the meeting. However, this section does not apply if an audio or video recording of the meeting is available to the public on the governing body's website within five business days after the meeting. A violation of this section is a Class 2 misdemeanor. However, the provisions of this section do not apply to draft minutes of contested case proceedings held in accordance with the provisions of chapter 1-26.

[2] Format for motions, second and vote results: Council member Name (Making the motion/Second/Vote result is either unanimous or Yes: and No: results and abstentions noted by name)

State of South Dakota
Board of Medical and Osteopathic Examiners

Petition

Pursuant to the provisions of SDCL 1-26-15, Michael Frost, M.D., of 424 Millstone Way Rapid City, SD, an Emergency Room Physician working in the emergency department for Monument Health Rapid City and Medical Director of the Rapid City Fire Department, and Robert Rendon, a Paramedic working as the Medical Operations Section Chief of the Rapid City Fire Department, do hereby petition the South Dakota Board of Medical and Osteopathic Examiners for their decision in regard to the following:

1. The Board Action in question is as follows: Due to South Dakota's super rural settings and that the systems find difficulty in routinely supporting adequate staffing numbers for full time paramedic level of care we request approval to administer medications to be granted to Advanced Emergency Medical Technicians (A-EMT) (SDCL 36-4B-16.2) and further approved by the Board.

2. The facts and circumstances which give rise to the petition or request to be decided by the Board are as follows:

   The petitioners are the Section Chief for the Rapid City Fire Department (RCFD) and the current Medical Director. The petitioners oversee all emergency medical technicians (all levels) employed under RCFD. RCFD currently mandates annual ACLS and PALS training, to include mega-code scenario testing, for all Paramedic level ALS providers. This is in contrast to the AHA mandated biennial cycle. This is done to ensure continued competency. The proposed medication administration approval would require all A-EMT ALS providers to pass initial ACLS and PALS certification and they would be required to re-certify annually through the RCFD biennial training of ACLS and PALS. Any A-EMT not demonstrating proficiency will be remanded for a didactic review and clinical practice. Proficiency is evaluated by the RCFD Medical Training Section,Section Chief of Medical Operations and Medical Director as is currently done for Paramedic level providers. The petitioned medication has been added to the pharmacology section of the RCFD A-EMT curriculum as well as the didactic information from ACLS and PALS to ensure the proposed medication is covered in detail should the board choose to approve the request.

   The Emergency Medical Services Department under the National Highway Traffic Safety Administration developed the National Emergency Medical Services Standards in 2009. The current standards allow jurisdictions to allow the use of certain medications specific to their area. We recognize the deciding jurisdiction in the State of South Dakota as the South Dakota Board of Medical and Osteopathic Examiners[1].

A. We are requesting the following nonscheduled controlled medications to be added for use by Advanced Emergency Medical Technicians: epinephrine 1:10,000 (IV/IO) for cardiac arrests as directed by ACLS and PALS protocols.

3. The precise petition or request to be decided by the Board is as follows:

   We request a decision by the Board to approve the aforementioned administration of medications by Advanced Emergency Medical Technicians (SDCL 36-4B-16.2).

Dated at Rapid City, South Dakota, this _____ day of _____, 20____.

_____ _____

Robert Rendon, NREMT-P Michael Frost, M.D.

References:

1. National Emergency Medical Services Standards in 2009, US Department of Transportation, National Highway Traffic Safety Administration, DOT HS 811 077A, January 2009.
2. National EMS Scope of Practice Model, from theNational Highway Traffic Safety Administration.

State of South Dakota
Board of Medical and Osteopathic Examiners

Petition

Pursuant to the provisions of SDCL 1-26-15, Michael Frost, M.D., of 424 Millstone Way Rapid City, SD, an Emergency Room Physician working in the emergency department for Monument Health Rapid City and Medical Director of the Rapid City Fire Department, and Robert Rendon, a Paramedic working as the Medical Operations Section Chief of the Rapid City Fire Department, do hereby petition the South Dakota Board of Medical and Osteopathic Examiners for their decision in regard to the following:

1. The Board Action in question is as follows: Due to South Dakota's super rural settings and that the systems find difficulty in routinely supporting adequate staffing numbers for full time paramedic level of care we request approval to administer medications to be granted to Advanced Emergency Medical Technicians (A-EMT) (SDCL 36-4B-16.2) and further approved by the Board.

2. The facts and circumstances which give rise to the petition or request to be decided by the Board are as follows:

   The petitioners are the Section Chief for the Rapid City Fire Department (RCFD) and the current Medical Director. The petitioners oversee all emergency medical technicians (all levels) employed under RCFD. RCFD currently mandates annual ACLS and PALS training, to include mega-code scenario testing, for all Paramedic level ALS providers. This is in contrast to the AHA mandated biennial cycle. This is done to ensure continued competency. The proposed medication administration approval would require all A-EMT ALS providers to pass initial ACLS and PALS certification and they would be required to re-certify annually through the RCFD biennial training of ACLS and PALS. Any A-EMT not demonstrating proficiency will be remanded for a didactic review and clinical practice. Proficiency is evaluated by the RCFD Medical Training Section,Section Chief of Medical Operations and Medical Director as is currently done for Paramedic level providers. The petitioned medication has been added to the pharmacology section of the RCFD A-EMT curriculum as well as the didactic information from ACLS and PALS to ensure the proposed medication is covered in detail should the board choose to approve the request.

   The Emergency Medical Services Department under the National Highway Traffic Safety Administration developed the National Emergency Medical Services Standards in 2009. The current standards allow jurisdictions to allow the use of certain medications specific to their area. We recognize the deciding jurisdiction in the State of South Dakota as the South Dakota Board of Medical and Osteopathic Examiners[1].

A. We are requesting the following nonscheduled controlled medications to be added for use by Advanced Emergency Medical Technicians: epinephrine 1:10,000 (IV/IO) for cardiac arrests as directed by ACLS and PALS protocols.

3. The precise petition or request to be decided by the Board is as follows:

   We request a decision by the Board to approve the aforementioned administration of medications by Advanced Emergency Medical Technicians (SDCL 36-4B-16.2).

Dated at Rapid City, South Dakota, this 8th day of October, 2025.

Robert Rendon, NREMT-P

Michael Frost, M.D.

References:

1. National Emergency Medical Services Standards in 2009, US Department of Transportation, National Highway Traffic Safety Administration, DOT HS 811 077A. January 2009.
2. National EMS Scope of Practice Model, from theNational Highway Traffic Safety Administration.

What is the reason for the request?

The Rapid City Fire Department became the soul emergency medical service provider for the City of Rapid City, numerous surrounding municipalities, as well as a large portion of Pennington County in 2003. The Rapid City Fire Department has shifted our response model to provide a more well rounded higher level of care to the citizens of Rapid City and surrounding mutual aid areas. We have operated under the common EMT/Paramedic ALS model until Fall of 2023. We moved to an all ALS model utilizing paramedic and Advanced EMT (AEMT) staffing. This means that you may end up with an ambulance that has ALS at either of those levels, or both. We have had to do this due to the struggles in recruitment and retention of a sufficient number of paramedic level providers for our system readiness. This is even with having an extremely successful in house CAAHEP accredited paramedic program (100% pass rate since its inception). This staffing issue is something felt by most emergency service providers in South Dakota and the country alike. By providing high quality education to AEMTs, RCFD believes that we can continue to provide a higher quality patient care experience in some of the most emergent and rural settings. There are currently multiple states throughout the country that allow AEMT's to administer not only cardiac epinephrine but all ACLS medication with additional and approved training. I have attached the page specific to other states as well as a link to the entire state protocol should you wish to look through it.

What duties, procedures, medications, etc. are requested?

We are requesting that RCFD AEMTs be allowed to administer the following medication: Epinephrine 1: 10,000 IV in a cardiac arrest scenario in accordance with AHA ACLS and PALS certification.

What risks are associated with the requested duties, procedures, etc?

While there are no contraindications noted for Epinephrine during use in cardiac arrest, Epinephrine has side effects such as dysrhythmias and hypertension, to name a couple. These risks are present whether an AEMT is administering the medication or if a paramedic is administering the medication. The positive effect is that the earlier cardiac epinephrine is administered, the better the outcomes tended to be. Early administration of epinephrine after collapse is associated with significantly higher rates of ROSC in patients with asystole and significantly higher rates of survival to hospital discharge in patients with an initially shockable rhythm(1). This would be important in a rural setting where only an AEMT is present and awaiting arrival of a paramedic.

What training must be completed?

All RCFD providers that will fall under this expanded scope of practice will be required to complete additional training beyond the standard National AEMT curriculum. That training will include, at minimum, the initial AHA ACLS and PALS course with refresher course work being done annually instead of the AHA required two year recertification. Epinephrine education will be added to the Pharmacology section of the Advance EMT education. In addition to the RCFD and National Registry Exam All personnel will have a written and practical test in accordance with AHA ACLS and PALS guidelines. All providers will require sign off by the department medical training section, Section Chief of Medical Operations and the department Medical Director.

Who should provide the training?

The RCFD EMS Training Section Captain and RCFD's Paramedic Lead Instructor will conduct all initial training and ongoing training. Dr. Michael Frost,MD,RCFD EMS Medical Director, has approved the added curriculum. Our training program has had the highest success in passing rates in the state. Because of that we do not doubt that the providers coming out of our system will be more than equipped for this added scope, if approved.

Will there be ongoing continuing education provided to the petitioners? If so, who should providethe continuing education and how often should it be provided?

A competency-based hands-on training every 12months (ACLS and PALS recertification) and review of department protocols, procedures and drugs will be added into our current monthly continuing education program. RCFD EMS Training Section Captain and RCFD's Paramedic Lead Instructor will provide all ongoing continuing education with oversight being provided by the EMS Division Chief and EMS Section Chief. Dr. Michael Frost,MD,RCFD EMS Medical Director, will also provide overall protocol oversight.

Are logs required that document the number of these advanced procedures/duties performed, who performed them, the number of times the procedures/duties were performed, and description of any adverse effects for review in the event of an audit?

An individual providers procedures and medication administrations are all part of the QA/QI process. The Section Chief of Medical Operations in conjunction with the Medical Training Section Captain do at a minimum a bi-weekly review of procedures done. Those charts are reviewed for successes and needed areas of improvment. This is coordinated with the training section in order to operate the quality improvement of not only our education system but the overall health of our providers abilities within the department.

References:

1.https://bmcemergmed.biomedcentral.com/articles/10.1186/s12873-025-01351-4 (Results: paragraph 2)

2.Georgia State EMS Protocols - https://dph.georgia.gov/EMS/protocols-and-scope-practice

3.Rhode Island State EMS Protocols - https://health.ri.gov/sites/g/files/xkgbur1006/files/publications/protocols/StatewideEmergencyMedicalServices-2024.pdf

4.New York State EMS Protocols - https://www.health.ny.gov/professionals/ems/pdf/ny_collaborative_protocols_v25.1.pdf

5.Washington State EMS Protocols - https://doh.wa.gov/sites/default/files/2024-08/530-281-BLS-ILSProtocolGuidance.pdf

6.West Virginia State EMS Protocols - https://www.wvoems.org/media/463069/2024%20protocol%20booklet%20final%207-10-2024%20-%20interactive%20(2)%20(1).pdf

Pharmacological Interventions/Skills	Levels							Interpretive Guidelines
3. Advanced pharmacological skills: Medication/Fluid administration								
f. Administration of SL nitroglycerin to a patient experiencing chest pain of a suspected ischemic origin		E*	I*	A	C	P	CC	*EMTs and EMT-Is may only administer SL nitroglycerin using the patient's own prescribed medication.*
g. Administration of epinephrine for cardiac arrest				A	C	P	CC	
h. Administration of epinephrine via auto-injector for anaphylaxis	R GA	E	I	A	C	P	CC	
i. Parenteral administration of epinephrine for anaphylaxis		E*	I*	A*	C	P	CC	*EMTs and EMT-Is may administer epinephrine from a vial/syringe from a commercially or pharmacy pre-assembled and pre-measured kit, via the IM route.* *AEMTs may prepare and administer epinephrine via the IM route only.*
j. Administration of inhaled (nebulized) beta agonist/ bronchodilator and anticholinergic agents for dyspnea and wheezing		E*	I*	A	C	P	CC	*EMTs and EMT-Is may only administer pre-measured unit doses of nebulized medications.*
k. Administration of a narcotic antagonist to a patient with a suspected narcotic overdose	R*	E*	I*	A	C	P	CC	*EMT-Rs, EMTs and EMT-Is may only administer narcotic antagonists via the intranasal route or via an auto-injector.*
l. Adminstration of non-narcotic/non-controlled analgesics				A*	C	P	CC	*AEMTS may only administer non-narcotic/non-controlled analgesics*
m. Adminstration of antiemetics				A*	C	P	CC	*AEMTS may only administer Zofran via the parenteral or ODT route*
n. Administration of nitrous oxide (50% mixture) for pain relief				A	C	P	CC	*Nitrous oxide is required to be patient self-administered.*

Cardiac Arrest – Adult: Asystole or Pulseless Electrical Activity (PEA)

For pediatric see, **"Asystole or Pulseless Electrical Activity (PEA) – Pediatric"**

CFR AND ALL PROVIDER LEVELS

EMT

- General cardiac arrest care, see "Extremis: Cardiac Arrest - Adult: General Approach"

CFR AND EMT STOP

ADVANCED

- Manage airway: Use of naso- and/or oropharyngeal airway and bag-valve-mask (BVM) is acceptable while deferring advanced airway until more urgent care is completed
- Vascular access; check glucose level
- Normal Saline 500 mL bolus
- Epinephrine (1:10,000 / 0.1 mg/mL) 1 mg IV; repeat every 3-5 minutes to a max of 5 doses

ADVANCED STOP

CC

- Cardiac monitor

CC STOP

PARAMEDIC

- For suspected hyperkalemia:
  - Sodium Bicarbonate 50 mEq IV
  - Calcium Chloride 1 gram IV

PARAMEDIC STOP

MEDICAL CONTROL CONSIDERATIONS

- Additional Epinephrine
- Termination of resuscitation in instances that are not covered by standing order criteria may be authorized by medical control

Key Points/Considerations

- Do not interrupt compressions for placement of an advanced airway
- Minimize interruption in compressions for placement of a mechanical CPR device
- If the cardiac monitor shows asystole, confirm in more than one lead
- A minimum of 50 mL of Normal Saline should be given between the bolus of Calcium Chloride and the bolus of Sodium Bicarbonate
- As indicated, see "Extremis: Termination of Resuscitation"
- Search for and treat possible contributing factors that EMS can manage according to your level of certification:
  - **H**ypoglycemia, **H**ypovolemia, **H**ypoxia, **H**ydrogen ion (acidosis), **H**yperkalemia, **T**oxins, **T**ension pneumothorax, **T**rauma

A

- Consider early IV placement (preferred) in a site above the diaphragm. If attempts at IV access are unsuccessful or not feasible, IO access (if available) may be attempted, preferably using a site above the diaphragm in age-appropriate patients (adolescents [age => 12] and adults).
- For **non-shockable rhythms**, administer EPINEPHRINE (1 mg/10 ml) 1 mg IV/IO every 5 minutes to a maximum of 5 doses.
- For **non-shockable rhythms**, administer LACTATED RINGER'S **or** NORMAL SALINE 500 -1000 ml IV/IO (may repeat x1).

C

- Orotracheal intubation shall only be performed if the use a BIAD is insufficient to facilitate adequate ventilation. In cardiac arrest, studies indicate that orotracheal intubation offers no appreciable benefit to patient outcome when a BIAD is providing adequate ventilation. Additionally, interruptions in the delivery of chest compressions during attempts at orotracheal intubation may be harmful.
- Consider early IV placement (preferred) in a site above the diaphragm. If attempts at IV access are unsuccessful or not feasible, IO access (if available) may be attempted, preferably using a site above the diaphragm in age-appropriate patients (adolescents [age => 12] and adults).
- For **non-shockable rhythms**, administer EPINEPHRINE (1 mg/10 ml) 1 mg IV/IO every 5 minutes, to a maximum of 5 doses.
- For **shockable rhythms**, administer EPINEPHRINE (1 mg/10 ml) 1 mg IV/IO every 5 minutes to a maximum of 3 doses, after three cycles of CPR and electrical therapy followed by first dose of AMIODARONE or LIDOCAINE.
- For **ventricular fibrillation (VF) or pulseless ventricular tachycardia (VT):**
  - AMIODARONE 300 mg IV/IO, repeat 150 mg for VF/VT refractory to at least one defibrillation attempt.
  - As alternative to amiodarone or for VF/VT refractory to amiodarone, LIDOCAINE 100 mg IV/IO, repeat every 10 minutes x2.
- For **refractory VF/VT:**
  - Change defibrillator pads and apply second set of pads at a new site.
  - Consider *Double Sequential External Defibrillation Procedure* if resources allow.
- For **non-shockable rhythms and suspected hypovolemia**, LACTATED RINGER'S **or** NORMAL SALINE 500-1000 ml IV/IO (may repeat x1).

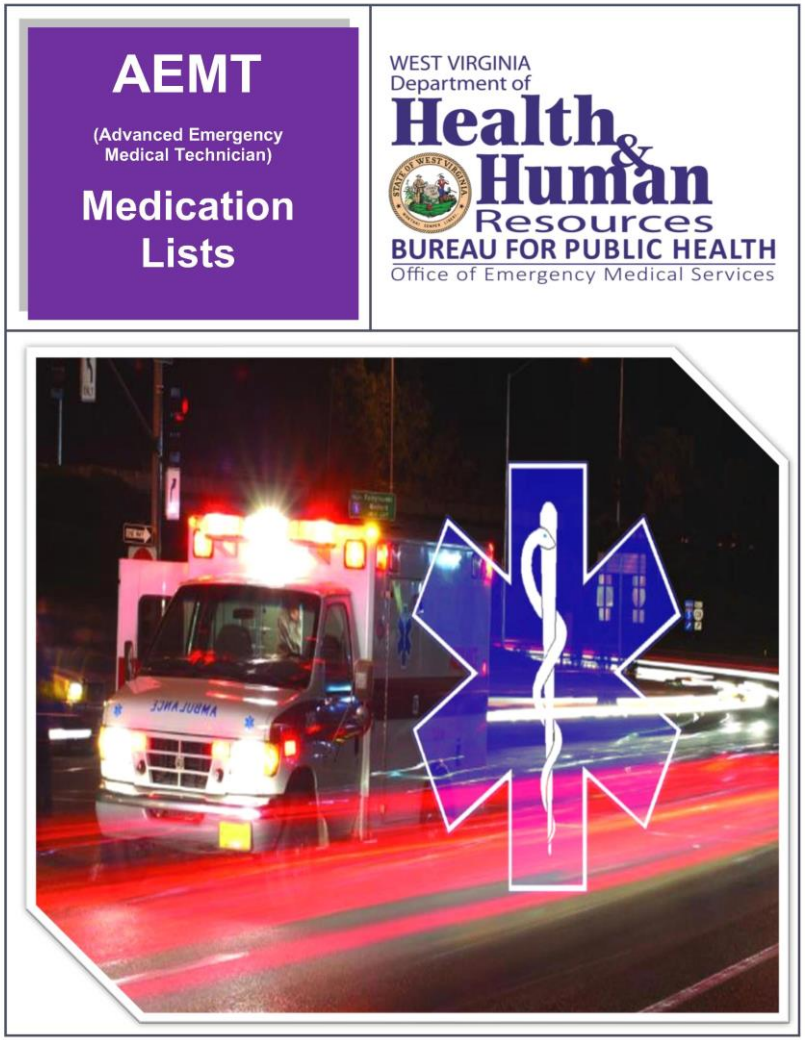
TABLE OF CONTENTS

Epinephrine (Adrenaline)

EMR/EMT*/AEMT*

Classification	• Beta adrenergic and alpha stimulator • Sympathomimetic agent (catecholamine)
Action	• Alpha- and beta-adrenergic effects. • Increases force of myocardial contraction. • Increases pulse rate and systolic blood pressure. • Increases conduction velocity through the A-V node. • Increases irritability of ventricles. • Dilates bronchi and coronary arteries. • Increases cerebral blood flow (alpha effects).
Onset of Action	• IV/IO: Immediate. • Push-dose IV: 1 minute. • IM: Variable. • SQ: 6-15 minutes.
Duration of Action	• IV/IO: 1-4 hours. • Push-dose IV: 2-5 minutes. • IM: varies. • SQ: varies.
Indication	• Cardiac arrest: VF, pulseless VT, asystole, PEA. • Allergic reactions. • Status asthmaticus.
Contraindication	• Chest pain accompanied by ectopic beats or tachycardia.
Use with Caution/Precautions	• Bronchial asthma and significant emphysema, when patients may also have congestive heart disease. • Raising BP and P may cause myocardial ischemia, angina and increase O2 demand.
EMR **Dosage and Administration**	Anaphylaxis • Adult- EPI-PEN 0.3 mg • Pediatric- EpiPen Jr 0.15mg IM
EMR (W*) / EMT (W*) /AEMT **Dosage and Administration**	Anaphylaxis • Adult: 0.3 -0.5 mg of 1:1,000 IM • Pediatric: 0.01 mg/kg of 1:1,000 IM, max dose 0.3 mg
AEMT (W*) **Dosage and Administration**	Adult Cardiac Arrest: 1 mg (10 mL of 1:10) IV/IO every 3-5 min; follow with 20 mL NS flush elevate arm for 10-20 secs Pediatric Cardiac Arrest: 0.01 mg/kg 1:10,000 IV/IO (max dose 1 mg) every 3-5 minutes during resuscitation
Adverse Reaction	• Hypertension • Tachycardia • Increased myocardial oxygen demand
Reference in Protocols	• Allergic Reaction/Anaphylaxis • Bites/Envenomation • Cardiac Arrest- Adult • Cardiac Arrest- Pediatric

New AEMT Medication List



West Virginia Office of Emergency Medical Services Certification Policies

New AEMT Medication List

Acetaminophen (Tylenol®), 160mg/5mL oral suspension
Albuterol, 2.5mg/3mL unit dose ampule
Albuterol/Ipratropium (Duo-Neb®), 2.5mg/0.5mg in 3mL unit dose ampule
Amiodarone, 450mg total (May be substituted with Lidocaine)
Amiodarone, 150mg pre-mixed solution (May be substituted with Lidocaine)
Aspirin, 81mg chewable tablets
Adenosine (Adenocard®), 18mg total
Atropine, 1mg pre-loaded syringe
Combivent® -**OR**- Duoneb® - 2.5mg Albuterol mixed with 0.5mg Ipratropium Bromide
$D^{50}W$, 25g pre-loaded syringe
$D^{25}W$
$D^{10}W$
Epinephrine, 1:10,000, 1mg pre-loaded syringe
Epinephrine, 1:1000
EpiPen
EpiPen Jr.
Furosemide (Lasix®), 80mg total
Glucagon, 1mg
Ipratropium Bromide (Atrovent®) 500 microgram unit dose ampules
Lidocaine (Xylocaine®), 100mg pre-loaded syringe (May be substituted with Amiodarone.)
Lidocaine (Xylocaine®), 1gm pre-mixed solution (May be substituted with Amiodarone.)
Naloxone (Narcan®), 4mg total
Nitroglycerin, 0.4mg (1/150) tablets or spray
Normal Saline (0.9%), 1,000ml
Ondansetron (Zofran®), 8mg total
Ondansetron (Zofran®) 4mg ODT
Oral Glucose, 15g tubes
Tetracaine

EPINEPHRINE 1:10,000

Scope	AEMT	PARAMEDIC

Generic Name: **Epinephrine 1:10,000**

Trade Name: Adrenalin®

Chemical Class: Catecholamine

Therapeutic Class: Bronchodilator, vasopressor

Actions: Epinephrine is a naturally occurring catecholamine. It acts directly on α- and β-adrenergic receptors. Its effect on β-receptors is much more profound that its effect on α-receptors. The effects of Epinephrine on β_1-adrenergic receptors include a positive chronotropic effect (increased heart rate) and a positive inotropic effect (cardiac contractile force). The effects of Epinephrine on α-adrenergic receptor sites include increased systemic vascular resistance. The effects on these receptors sites together cause an increased blood pressure. Epinephrine also causes bronchodilation due to its effects on β_2-adrenergic receptors.

Pharmacokinetics: *IV:* Onset immediate; Peak 5 minutes; Duration short

Indications:
- Cardiac arrest.
- Anaphylaxis and asthma patients in severe distress.

Contraindications: No contraindications when used for indicated conditions.

Precautions: No precautions when used for indicated conditions.

Pregnancy Cat. C

Side Effects: *CNS:* anxiety, dizziness, restlessness, tremulousness, headache
CV: anginal pain, dysrhythmias, hypertension, palpitations
GI: nausea, vomiting
SKIN: pallor

Administration:

Adult	Give 1 mg (10 mL) IV/IO. Repeat every 3 to 5 minutes if needed.
Pediatric	Give 0.01 mg/kg (0.1 mL/kg) IV/IO. Repeat every 3 to 5 minutes if needed.

Supply: Prefilled syringe containing 1 mg in 10 mL

Notes:

TOC

We recently received a request for clarification on scope of practice for EMT level licensees under the following scenarios:

1. If a patient has a saline lock in place, with no fluids or medications infusing, may an EMT attend to and care for that patient? I understand that EMT scope does not include initiating or managing IV therapy, but there have been questions from some long-standing employees regarding whether caring for a patient with an existing saline lock (that is not being used) has been considered allowable in the past.
2. If a paramedic places a 4-lead ECG on a patient for a quick rhythm assessment, and the patient is otherwise stable (not hypotensive, tachycardic, pale, cool, diaphoretic, etc.), may the paramedic remove the 4-lead and have a lower-certified partner attend to the patient afterward?

Many paramedics have been part of ambulance services where they have already petitioned for this expansion of their scope of practice. Further even if the paramedic hasn't yet petitioned, it is a fairly simple process to petition as this precedent exists.

Identifying and managing blood and blood products are part of the paramedic critical care endorsement. See subsection (5) of ARSD 20:61:02:02

Paramedic Scope of Practice Expansion Petition:

First, it may already be in place for some paramedics. For those who do not have this in place, the paramedics requests a scope of practice expansion petition. This typically comes to the Board in by the ambulance service. The request would need to include what additional scope items being requested along with the protocol for these scope items and training documentation to be used by the medical director to train the paramedics on the additional scope items. A petition form will then be created for the paramedic and medical director to be signed with the specific items listed on the petition form.

If these are items that have not been approved by the Board previously for other paramedics, it will require approval from the Board at a Board meeting. If the items have been previously approved the protocol and training documentation will be compared to what was previously approved and Board staff can move forward with approval if equivalent as delegated by the Board's previous authority. Once the signed form is received back, Board staff will communicate that approval or how to proceed for the Board's approval.

As mentioned, there are agencies that have been granted approval for managing blood and blood products, so a precedent in place, allows faster approval.

Paramedic Critical care endorsement:

Eligible paramedics can take and pass the International Board of Specialty Certification (IBSC) exam or complete a Board approved education and training program and submit a request as outlined in 2.

1. Statute: Codified Law 36-4B-18.1 | South Dakota Legislature
    - Exam: Most critical care endorsements received are to licensed paramedics certified as a critical care paramedic or a flight paramedic by taking and passing the IBSC exam under 36-4B-18.1 (2).

    - The option to complete a Board approved education and training program is available for those who do not take the IBSC exam. These paramedics use 36-4B-18.1 (1), and Administrative Rule: https://sdlegislature.gov/Rules/Administrative/20:61:02

2. To request the **Critical Care Paramedic Endorsement,** send an email with the information below to sdbmoe@state.sd.us

    1. **Subject Line of Email** your Full Name (first and last name) Critical Care Endorsement
    2. **Attach a Copy** of your completion certificate from the International Board of Specialty Certification or documentation of your Board approved program of study.
    3. Put this **message in the body** of email:
        1. If certified by exam: “I am certified as a critical care paramedic or flight paramedic by the International Board of Specialty Certification. Please add this to my file.”
        2. If certified by education and training: “I have completed a Board approved Critical Care program of study. Please add this to my file.”