MOC/OAC Comments on Policies/Protocols

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Policy/Page	Provider/Agency	Comments/Suggested Edits	Response
8830-Supraglottic AIrway	Dr. Mackey	I would like to advocate for the use of iGels in pediatric patients. I have looked through similar policies and found Alameda County had perhaps the best written and clearest of all. Here is the challenge: the state allows intubation above 8 years of age or, more precisely, according to weight and color section for Broslowe/Handtevy. The largest child in both is 30kg (not 40kg as in Alameda). I request consideration for the implementation of iGels in 2021 in children. Here is a model policy: Supraglottic Airway Device (i-gel®) Definition: A supraglottic airway attempt is defined as the insertion of the supraglottic airway device into the patient's mouth. For patients ≥ 30kg, a supraglottic airway (i-gel®) device may be placed as a primary airway or after unsuccessful attempt(s) at endotracheal intubation. For patients < 30kg, BVM ventilation is the preferred method of ventilatory management. If BVM ventilation is unsuccessful or impossible, an SGA device may be placed. The i-gel® SGA device comes in seven sizes determined by the patient's weight. Finally, I would urge the "Procedures" section be excluded. Protocols are not intended to train. They are intended to provide direction based upon patient complaint and condition. Training should be left to paramedic schools, EMS divisions, and employer education.	Will investigate more deeply but not add to the Sept policy review -hg
8805-Intubation Stomal	Barbie Law	Indications, add cardiac arrest Typos: Equipment: Manufacturer's Kit & in Policy 2. correct "tue" to tube Why is this being changed from Procedure to policy? The only other program document in the 8800 series with a policy statement is Vascular Access.	Cardiac Arrest added to indications. Typo Corrected. Cardiac Arrest PP 8031 and Respiratory Distress PP #8020 added to Cross Reference

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5060-Hospital Diversion	Dr. Mackey	**Typo** Any planned service OUTAGE AND any outage expected to last more than 12 hours, must also be communicated by email and phone call to the SCEMSA to ensure communication of status to all stakeholders.	**Fixed**
8026-Respiratory Distress	Dr. Mackey	I would like to ask the county to consider adding waveform capnography IF AVAILABLE to non-intubated respiratory distress patients, and possibly for patients receiving >1 dose of opioid medications (pain control, agitation, seizures, etc). There is a fair amount of literature to support it, and adding it now will enable providers to develop training for implementation by next July. Not looking to make it mandatory, just optional. This policy would be one place that it could live, like "Consider waveform capnography in moderate to severe distress when an advanced airway is not in use", or something like that. Thank you.	EtCO2 monitoring would have minimal use in mild or even moderate distress. Need to balance this objective measure of hypoventilation with other available measures (clinical judgement) and available methods and cost of adding. Can discuss at meeting
8067-Sepsis	Dr. Mackey	Please consider rewording this section for clarity since SIRS criteria are spelled out earlier in the policy. Some providers think SBP is a SIRS criteria and I spent a lot of time explaining the confusion here during training: **Current:** Any two of the following SIRS criteria: a. Temperature of >38 °C (100.4 °F) or b. Respiratory rate >20 breaths per minute. c. Heart rate >90 bpm. d. SBP **Suggested:** Any two of the following: a. Temperature of >38 °C (100.4 °F) or b. Respiratory rate >20 breaths per minute. c. Heart rate >90 bpm. d. SBP	I'm fine with eliminating the term "SIRS" as follows: Any two of the following ~~SIRS~~ criteria: **DONE**

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8805-Stomal Intubation	Dr. Mackey	1. Several typos. Please check ;) 2. "Manufacturers Kit"? Will the county describe the approved kits? Please consider adding "Hypoxia" to the Indications. And also please explain the "loss of gag reflex" logic as a sole indication. I think I understand but I am not completely clear.	**Fixed**
Agitation	Dr. Mackey	I know Dr Garzon pulled the Agitation policy last time for discussion. Will this be discussed this time around, or at a future meeting? ACEP and the Society of Anesthesiologists recently came out with a position statement on the use of Ketamine in Excited Delirium. Would like to look at implementation with 100% case review before next July. Thank you	My concern with this is if you need to chemically restrain a patient-it is easier to give an IM injection..versus establishing an IV and then administering the medication. In order to get an IV, you would most likely need to get the patient restrained first. If you give an IM injection it can be administered without being placed in restraints first.. (Less of a fight) Investigating further -hg
8067-Sepsis/Shock	Barbie Law	Change #1 under BLS interventions to Supplemental O2 as necessary to maintain SpO2 > 94%. Use lowest concentration and flow rate of O2 as possible.	Agree. Let's update the language **DONE**
8830-Supraglottic Airway	Barbie Law	The link itself has a typo, should be supraglottic, not supragottic	**Fixed**
2512-Designation Requirements for Administration of Naloxone by Law Enforcement First Responders	Barbie Law	The link itself has a typo, should be Designation	**Fixed**
7509-Out of County Response	Barbie Law	In Policy. B. remove "Physician Order Only".	**Line Strike Done**
8830-Supraglottic Airway	Barbie Law	I think the wording in the indications section is very confusing. Is there an intent that EMTs only use iGel for cardiac arrest? If so, I suggest the following changes:	Please separate "Indications" section into Paramendic, and EMT as follows:

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		Indications: Paramedic Only for patients age ≥ 8. If the age is unknown, only children who meet or exceed the GREEN length on Handtevey or Broselow length based tapes: A. As a secondary advanced airway device after failure of OTI for respiratory failure in an unconscious patient. C. As an advanced airway device when non-invasive airway management is inadequate. D. As a primary advanced airway in cardiac arrest. E. As per Respiratory Distress: Airway Management Policy PD# 8020 and Pediatric Respiratory Distress: Reactive Airway Disease, Asthma, Bronchospasm, Croup, or Stridor PD# 9003. EMT for age ≥ 15: A. As an advanced airway in cardiac arrest. In the Emergency Removal section, remove item 3. There is no cuff on an iGel.	**Indications:** **PARAMEDIC** A. As a secondary advanced airway device for paramedics after failure of OTI, in respiratory failure in an unconscious patient, age ≥ 8 unless age not known, and then only children who meet or exceed the GREEN length on Handtevy or Broselow length based tapes. B. As an advanced airway device when non-invasive airway management is inadequate, age 15 and above C. As a ~~primary~~ preferred advanced airway for paramedics in cardiac arrest airway management, for age ≥ 8 unless age not known, and then only children who meet or exceed the GREEN length on Handtevy or Broselow length based tapes. D. As per Respiratory Distress: Airway Management Policy PD# 8020 and Pediatric Respiratory Distress: Reactive Airway Disease, Asthma, Bronchospasm, Croup, or Stridor PD# 9003. **EMTs** A. As an advanced airway for EMTs in cardiac arrest management, for age ≥ fifteen (15). **DONE**

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			Line Strike through Emergency Removal: 3. Deflate Cuff
8830-Supraglottic Airway	Cosumnes Fire	Indications: C. Suggestion to add "The preferred advanced airway for paramedics in cardiac arrest airway management..." not "primary advanced airway..." The cardiac arrest policy does not indicate SGA as a primary airway. The paramedic should be able to determine the best and most effective airway in the situation.	Edit made in previous comment
8830-Supraglottic Airway	Cosumnes Fire	page 2 i–Gel H. Additional language suggestion: Tube position shall be assess at a minimum with each patient move. Page 3 Precautions and Special Considerations: A. 3. Deflate cuff–––DELETE no cuff with iGel B. Airway management This is a very good paragraph, it maybe repeating although I would suggest adding "reassessment and snapshot of wave form indicating correct placement at turn over of care documented in the patient care record."	3. "Deflate Cuff---Delete no cuff with iGel" has been edited.

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5060-Hospital Diversion	Cosumnes Fire	There seems to be a missing piece to communicate the status of facilities in real time with the line. Is there opportunity for facility status to be communicated at time of dispatch either voice or CAD for types of calls, e.g. Chest pain -- KHS on STEMI diversion.	Please add the following additional bullet: A. Any change in facility status shall be communicated through the facility status on EMResource. B. Medics will verify receiving status of destination facility upon leaving the scene. C. Any planned service outange AND any outage expected to last more than 12 hours, must also be communicated by email and phone call to the SCEMSA to ensure communication of status to all stakeholders **DONE**
7501-Muli-Casualty Critique	Cosumnes Fire	Are all forms now intended to be electronically submitted? Is this policy outdated?	Ben and I started to revise policy and met with all stakeholder to start working on it… Then COVID hit.
8020-Respiratory Distress: Airway Management	Cosumnes Fire	Policy: B.3. delete the added s on devices. BLS vs. ALS Move SGA and Narcan administration from ALS to BLS.	"s" has been removed from "devices"
8067-Sepsis/Septic Shock	Cosumnes Fire	Addressing ALS fluid bolus. If after 2 into 3 or 3 into the 4th bolus and no or inadequate response, would it be appropriate to anticipate a course and administer a dose of push dose epi? The intent is to appropriately treat with fluid replacement, but also not delaying the pressor. The emphasis is and should be on fluid replacement. However would a delay in raising profusion provide more risk than to provide a dose of epi which has a short half life and buys some time?	Even in the hospital setting we often hold pressors until full fluid bolus is administered. Given short response times, would leave the Epi until after all 200 cc given pre-arrival.
8833-Ventricular Assist Device (VAD)	Cosumnes Fire	Update format to reflect most all other policies.	
8020-Respiratory Distress: Airway Managment	Barbie Law	Policy 3, it sounds like the only approved supraglottic device is the iGel, so making device plural is unnecessary.	Yes, intent is to eliminate King tubes by July 2021

		Also, Policy 3 conflicts with the new policy in that this document says the supraglottic device may be the advanced airway of choice and used on the first attempt, but program document 8830.07 states that the supraglottic airway is indicated as a secondary advanced airway device after failure of OTI. In ALS 4, specify that there should be documentation that BLS airway interventions were adequate to maintain the airway and ventilation. In ALS 6 add a comma to this sentence: If BLS airway interventions are insufficient, a third advanced airway attempt will be made by a different (non-intern) Paramedic if available, or a supraglottic airway device shall be used. Is ALS 6 even needed any more? Why would we permit 4 attempts at intubation if the iGel can be used on the first attempt? Do we have any data to support that a different medic has a better chance of success? In the Cross Reference section, strike King Tube Last, can we have a conversation about RSI? We have no options for patients with clenched jaw since nasal intubation was removed from the protocols.	
8026-Respiratory Distress	Barbie Law	On the asthma/COPD side of the algorithm, does epi IM really need to be a base hospital order for severe respiratory distress? The anaphylaxis protocol permits epi IM without base hospital order for the same subset of patients in severe distress. BASE HOSPTIAL ORDER:	

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		for patients ≥ 40 years of age and/ or BP ≥ 180 mmHG	
8067-Sepsis/Septic Shock	Barbie Law	In Indications 2.a. should there be a timeframe specified for temperature reported by patient, family, or care home? Change Protocol 1. to: Supplemental O2 as necessary to maintain SpO2 > 94%. Use lowest concentration and flow rate of O2 as possible.	Not really. Any recent temp is relation to current symptoms would be an indication of possible sepsis Agree to supp O2 change **DONE**
8827-12 Lead ECG	Barbie Law	With the removal of consideration for obtaining a 12-Lead ECG for upper abdominal pain, is there any need to keep the age over 40 language?	Yes! We don't need field ECGs on 15 yo diabetics!