

MAC/OAC Comments on Policies/Protocols

September 8, 2022

Policy/Page	Provider/Agency	Comments/Suggested Edits	Response
8026 – Respiratory Distress	D. Sutton	<p>Policy states B. Moderate Distress - Patient is able to speak a few words; patient may have an elevated pulse and blood pressure; patient may be diaphoretic and weak; mental status is unaffected; mild cyanosis of lips and digits may be present.</p> <p>-since mild is able to speak full sentences and severe is unable to speak then recommend moderate be changed to " speaks incomplete sentences". If not then where would you categorize patients speaking 4+ word sentences? This change would also affect the flow diagram to be changed to "inability to speak full sentences" instead of "inability to speak >3 word sentences.</p> <p>Policy states -Assessment should usually yield a single treatment plan. In general, commit yourself to a single assessment - you may modify this assessment based on response to therapy and as additional information becomes available.</p> <p>Recommend changing the last sentence to " you may modify this assessment based on response to therapy and as additional information becomes available modify treatment plan.</p>	<p><i>Dr. Garzon to Review</i> <i>I am unaware of confusion by medics for the way the policy is currently worded, and that medics understand the intent of the descriptions for mild, moderate, and severe. A patient providing "yes"/"no" answers only is speaking in complete sentences, but may be limiting the length of sentences due to respirator distress. I would not change the policy. -HG</i></p> <p><i>I am fine with adding: "you may modify this assessment based on response to therapy and as additional information becomes available modify treatment plan." -HG</i></p>

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		<p>Policy flow chart states _Epinephrine: Epi 1:1000 0.3 mg IM For patients with severe asthma/ bronchospasm ONLY. Can be given at same time as Albuterol. BASE HOSPITAL ORDER: for patients ≥ 40 years of age and/ or BP ≥ 180 mmHG</p> <p>Recommend removing "BASE HOSPITAL ORDER: for patients ≥ 40 years of age and/ or BP ≥ 180 mmHG"</p> <p>In other protocols like 8001.18 Anaphylaxis it is not a base hospital order and states "NOTE: Epinephrine should be used cautiously in patients > 35 years old, or with a history of CAD or HTN." Calling Base hospital is a delay in emergent treatment with a patient unable to speak or breath. They are in respiratory failure and almost arrest. Recommend using same language as protocol 8001.18</p> <p>Policy flow chart Push Dose Epinephrine Epinephrine 0.01mg/ml (10mcg/ml) DOSE: 0.5-2 ml every 2- 5 minutes (5-20 mcg) Titrate to SBP > 90 mmHg. NOTE: Monitor SBP while administering/titrating.</p> <p>Recommendation to</p>	<p><i>Agree with changing the "base hospital order" in the IM Epi box to be consistent with the language in 8001: "NOTE: Epinephrine should be used cautiously in patients > 35 years old, or with a history of CAD or HTN." -HG</i></p> <p><i>Agree with suggested edit: For SBP ≤ 90 mmHG Push Dose Epinephrine: Epinephrine 0.01 mg/ml (10mcg/ml) Dose: 0.5-2 ml (5-20mcg) IV/IO every 2-5 minutes. Titrate to SBP > 90 mmHg. NOTE: Monitor SBP while administering/titrating. -HG</i></p> <p>The use of ETCO₂ monitoring for medics is for assessing the placement and adequacy of ventilation of an advanced airway.</p>
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		<p>change it to</p> <p>For SPB \leq 90 mmHG Push Dose Epinephrine: Epinephrine 0.01 mg/ml (10mcg/ml) Dose: 0.5-2 ml (5-20mcg) IV/IO every 2-5 minutes. Titrate to SBP > 90 mmHg. NOTE: Monitor SBP while administering/titrating.</p> <p>Policy states under Acute respiratory Distress</p> <ul style="list-style-type: none"> • Cardiac Monitor and SpO₂, and ETCO₂ (continuous waveform) with advanced airways. <p>Recommend removing "with advanced airway" since we use it with BVM and via nasal capnography also</p>	<p>While physicians may use ETCO₂ values to determine need for placing an advanced airway, medics' algorithm for determining need for an advanced airway is simpler and does not involved understanding subtle significance of ETCO₂ values. Would not change. -HG</p>
<p>8805 – Intubation: Stomal</p>	<p>Dave Sutton</p>	<p>-Policy:</p> <p>A. Note proper tube placement and secure tube.</p> <ol style="list-style-type: none"> 1. Continuous waveform capnography shall be utilized. 2. Re-evaluate the position of the tube after each move of the patient and document finding in ePCR. <p>** recommendation to add procedure **</p> <p>Example. Procedure:</p> <ol style="list-style-type: none"> 1. Select the largest endotracheal tube (ETT) that will fit through the stoma without force; check the cuff and remove the stylette. 2. Pre-oxygenate the patient with 100% 	<p>Dr. Garzon to Review</p> <p>It does make sense that a "skills" policy have a "procedure" section. See policy edit in email. Please update draft policy with revisions for MAC/OAC meeting. -HG</p>

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		<p>oxygen using a BVM.</p> <ol style="list-style-type: none">3. Lubricate the ETT.4. Suction if necessary.5. Pass the ETT and inflate the cuff. The pharynx has been bypassed, so the ETT will protrude from the neck by several inches.6. Hold the tube in place and attach the BVM.7. While ventilating the patient, watch for equal rise and fall of the chest.8. Secure the tube and ventilate with 100% oxygen.9. Auscultate for bilaterally equal breath sounds. Examine the neck for subcutaneous emphysema indicating false passage.10. Do not take longer than 30 seconds to perform this procedure.11. Document ETT size, time, result (success) and placement location by the centimeter marks either at the stomal opening in the ePCR. Document all devices used to confirm initial tube placement. Also document positive or negative breath sounds before and after each movement of the patient.12. It is required that the airway be monitored continuously through waveform capnography (ALS providers) and pulse oximetry. <p>Lastly is stomal intubation allowed in pediatric patients less than 8 years old? Per protocol 8837.03</p> <p>D. Pediatric Advanced Airway Considerations (≥ 8 years of age):</p>	<p>Policy 8837 is not up for review this meeting, but will be considered 3/2023 as scheduled. PD 8805 - Intubation: Stomal, is a skills policy, and already cross-references PD 8837 – Peds Airway Management. For clarification, we can add under “Special Note:” a bullet C. which states: “This policy applies to adult and pediatric patients with an existing tracheostomy stoma in need of a secure airway.” -HG</p>
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		<p>1. Endotracheal intubation in children requires special training because the pediatric airway anatomy differs from that of the adult. The likelihood of successful endotracheal tube placement with minimal complications is related to the length of training, supervised experience in the field, and adequate ongoing experience.</p> <p>Complications and lack of success in orotracheal intubation in pediatrics anatomy has led to the removal of nasal and orotracheal intubation but with stomal intubation the major anatomy issues of the pharynx are bypassed with insertion of stomal tube and evaluation of chest rise/fall and capnography can confirm placement and adequacy</p>	
<p>8801 – Percutaneous Cricothyrotomy(with jet ventilation)</p>	<p>Dave Sutton</p>	<p>This policy brings many questions and concerns.</p> <p>-The policy seems to support a device like manujet with jet insufflation that does not allow exhalation. i.e, I believe this is the reason we have a contraindication of complete airway obstruction.</p> <p>Other agencies devices exist like the ENK, which does allow exhalation therefore should not have the same contraindication but the protocol doesn't differentiate.</p> <p>-vote to add language for the other SCEMS devices (ENK), BVM,</p>	<p>Dr. Garzon to Review</p> <p>It is incorrect that SCEMSA allows for devices that do not allow exhalation. The “ventilation” section addressing “A. Jet Ventilation” provides specific instructions for 10-12 BMP, which presumes a jet ventilation phase followed by an exhalation phase (otherwise how do you give multiple breaths?). But for clarification lets edit “Equipment: C. to read: “Jet insufflation device with pressure gauge OR oxygen flow modulator designed for transtracheal ventilation, and which allows intermittent ventilation for an inspiratory and expiratory phase (i.e. Enk Oxygen Flow Modulator)”</p> <p>-HG</p>

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		<p>and include if different there indications, contraindications, equipment, procedure for oxygenation/ventilation.</p> <p>-under procedures and ventilation. A. it says (10-12 bpm) B. BVM it doesn't say how much volume it bag in. i.e 250ml, 500, 1000</p> <p>-vote to add device specific. follow manufactures recommendation. Also capnography and SPO2 with normal or appropriate ranges to monitor oxygenation/ventilation and Co2 removal to support patient physiological needs.</p> <p>-due to the high possibility of barotrauma</p> <p>-vote to add language of potential complication. suspect pneumo or evaluate for signs of pneumo or incase of pneumo see appropriate protocol.</p> <p>-under absolute contraindications it says to use intermittent high flow ventilation for complete airway obstruction.</p> <p>-vote to add definitions of what that means or use simple language like BVM or ENK and adding definitions of ENK device and jet insufflator.</p> <p>- I have questions on age appropriateness.</p>	<p>These are Emergency airways which at best provide minimum and inadequate ventilation and probably oxygenation. It's unlikely medics can get 1000cc per breath through a cric needle, and training should reflect the best possible volume given the circumstance (this need not be in policy – it's a training issue). I also don't see the purpose of taking time and resources to monitor ETCO2 or SPO2 in the back of an ambulance, as this is a procedure of last resort, and no other options than what's being done to modify bad ETCO2 or SPO2 values. I'd rather the medic spend time on maximizing the limited ventilation possible in an otherwise very difficult situation.</p> <p>Also, the instruction to follow manufacturers guidelines is already in the "NOTE:" section. Pneumothorax is already listed as a complication. -HG</p> <p>"Intermittent high flow" is already defined in the contexts of the policy – O2 source at 40-60psi, O2 flow rate at 5 l/min, BPM at 10-12. -HG</p> <p>While needle crics can be done on infants younger than 3, there is no literature that it's the preferred management option for infant airway obstruction in the pre-hospital setting. With a total of zero crics done in SCEMSA in the last 3 years, this is at best a very unfamiliar procedure for medics. Given the lack of supporting literature showing benefit for the < 3 you age group, it's my preference that we have medics focus on clearing obstructions (back blows, McGill forceps, etc.) or ET intubation past the obstruction if below the cords. -HG</p> <p>If the "indication" for JV is "adult," it seems redundant to list "Peds" as a contraindication.</p>
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		<p>Why (3) years or 15 kg? The device manual says it can be used on infant, child, and adult. Why can we use this on a 3 year old but not their sister next to them that is 2 1/2 with an emergent need for an airway?</p> <p>Vote to reduce age to greater than 1 if no contraindications or supportive education can be provided.</p> <p>-under jet ventilation indications it says for use in an adult but in absolute contraindications it does not say it can't be used on anyone less than an adult. I do not believe the enk provides the same high pressures and can be used in children. As well a BVM</p> <p>-vote to add language in absolute contraindication * not to use in children or a specific age. however not a contraindication with ENK or BVM</p>	<p>Data I've seen for the ENK show that at high flow rates, with all holes occluded, the ENK can exceed the ALPS recommended flow rates. For simplicity, JV will stay for adults only.</p>
<p>PD# 8833 – Ventricular Assist Device (VAD)</p>	<p>Dave Sutton</p>	<p>Language seems to vary.</p> <p>This policy references using the MAP (mean arterial pressure) under BLS. 4. (which a math calculation is needed when auscultated, and we are advised not to use automated)</p> <p>-If we are to use map I recommend putting the equation $DBP \times 2 + SBP$ divided by 3.</p> <p>In ALS. #2.</p>	<p>Please change BLS Protocol #4 “mean arterial pressure of < 50” to “SBP < 60” -HG</p>

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		<p>it says If auscultated blood pressure is less than (60 mmHG), pulmonary edema is not present and patient exhibits symptoms such as dyspnea, hypotension, syncope, and loss of consciousness then:</p> <p>-This doesn't state if we are now using systolic or still using MAP</p> <p>Below that it says</p> <ul style="list-style-type: none">· Establish Intravenous access with Normal Saline, titrate to a (systolic blood pressure of 70 mmHg) not exceeding 1500 ml of fluid. <p>-I recommend using same language throughout the policy or being specific (MAP or Systolic) in what we are using as a parameter.</p> <p>In ALS 4. it says Patients with total artificial hearts (BiVADs) do not respond to CPR and should not receive medication "of" CPR</p> <p>-change to medication OR CPR</p> <p>Under precautions E. it says The patient or caregiver "will" interpret any VAD controller unit alarms.</p> <p>-recommend changing (will) to (may be able to)</p> <p>Over all, while this policy identifies the majority of emergent assessment and</p>	<p>Please change ALS Protocol #2 from "auscultated blood pressure to "auscultated systolic blood pressure." -HG</p> <p>Agree with changing "of" to "or" in ALS #4 -HG</p> <p>Agree with changing (will) to (may be able to) under precautions E. -HG</p> <p>The SCEMSA VAD policy was drafted with significant input from the 3 VAD centers in Sacramento. SCEMS field treatment policies are intended to be operational and not educational. Given our 3 centers use different</p>
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		<p>treatments, as a field provider it leaves a lot of questions, voids, and uncertainties.</p> <p>I have reviewed Yolo County VAD policy and in the policy it directs to reference the ICCAC EMS guide for VAD. it addresses the Heartmate III and II, but also HeartWare, Jarvik 2000, and the Total artificial heart. Though some might not be prevalent, some or any of these devices can be presented. As stressful and emergent as these encounters can be, an easier and more comprehensive guide would be beneficial and appreciated for our paramedics in the field.</p> <p>-recommend adding the ICCAC EMS guide and changing the protocol to Reference it for assessment and treatment</p>	<p>devices, and they change and update with frequency, our centers opted to not put device specific information in the policy. But happy to add a reference.</p> <p>Please add a "NOTE:" section at the bottom under the "Precautions:" section to add a "Reference for additional information: The International Consortium of circulatory Assist Clinicians Mechanical Circulatory Support Emergency Guide 2020-2021" - ICCAC Emergency Guides 20 21.pdf</p> <p>-HG</p>
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