MOC/OOC Comments on Policies/Protocols

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Policy/Page	Provider/Agency	Comments/Suggested Edits	Response
8065-Hemorrhage in Trauma	J. Gunter/AMR	On Pg.2, First step of direct pressure and pressure bandage, if bleeding is controlled, you are then told to treat per trauma policy. After that, the arrow sends you down to place a TQ. I believe that arrow should be removed.	**Dr. Garzon to Review** Agree. That arrow (the right-most one on the flow diagram) should be removed
8018-Overdose and/or Poison Ingestion	J. Gunter/AMR	Can we combine CCB and Beta Blocker OD for consistency? The treatment is the same. Seems there could be one algorithm to reduce confusion.	**Dr. Garzon to review** Once we took Glucagon out of B-blocker OD, these are the same treatment algorithm. I'm ok with combining them into one.
8018-Overdose and/or Poison Ingestion	Dr. Mackey	1. Consider making the epi in this policy similar to push dose epi like other policies. See SSV policies (they use PDP) 2. Pacing for beta blocker but not CCB. Any reason why? 3. No glucagon for beta blocker or CCB OD, correct?	**Dr. Garzon to review** Agree with changing Epi to push dose instructions. As above, combine CCB and B-blocker into one and keep "consider pacing" box. Correct, no Glucagon (we removed previously)
8827-12-Lead ECG	J. Gunter/AMR	Minor spelling error for "symptomatic tachycardia"	**Corrected**
8038-Shock	Dr. Mackey	Insulin shock in this policy is misleading. Insulin shock is not actually shock, in the true sense of the word. It is hyperinsulinemia causing hypoglycemia, fixed with dextrose, not fluids and pressors. Suggest removing this phrase. But on a larger note, is this policy even necessary since all of the treatments are listed in other policies. Just thinking out loud. Also suggest rewording "Sepsis" to "Septic"	**Dr. Garzon to review** Agree with removing "Insulin shock" from this policy, and with changing "sepsis" to "septic". The policy has been around since 1992, but agree that it primarily summarizes clinical thinking for "shock," but largely references other policies for treatment algorithms based on etiology of shock. I would be ok with deleting this

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			policy, but would want input from other stakeholders.
8062-Behavioral Crisis	Dr. Mackey	Request this policy be pulled from the scheduled document review until MAC can discuss with SCEMSA the possibility of adding Ketamine to the medical treatment of acute agitation. Specifically the use of Ketamine in acute non-traumatic agitation will save lives. I would like to request a discussion at MAC	**Dr. Garzon to review** We can defer to next in-person meeting.
8827-STEMI	Dr. Mackey	"Diabetics" under indications for 12 lead is vague. ALL diabetics? Suggest rewording to something like "Diabetics with atypical symptoms (like you have under patients >75 years old)	**Dr. Garzon to review** Please combine the second and last bullet, so it reads: "Diabetic patients or patients over 75 with atypical* signs and symptoms…."
8018-Overdose/Poison Ingestion	Scott Clark/Cosumnes FD	Recommend change Epi 1;10,000 to Push Dose in Beta blocker and Calcium channel blocker. As I understand it Epi 1;10,000 IV/IO is not ideal and even dangerous for patients other then in cardiac arrest. Our Paramedics are well trained in Push Dose Epi and it should be used consistently in the protocols as a presser. Dose: 0.5-2 ml every 2-5 minutes (5-20mcg). Titrate to SBP ≥ 90mmHg	**Dr. Garzon to review** Agree as noted in suggestion for same edit above
8044- Spinal Motion Restrictions (SMR)	Scott Clark/Cosumnes FD	Remove D & E under procedure as they are repeated and worded better in F & G. Also recommend removed SMR from uncooperative patient. This cannot realistically be done and will usually make the condition worse if attempted.	**Dr. Garzon to Review** Agree with deleting D&E. I believe "uncooperative patient" is covered under "special Notes:" A5 and B
8018-Overdose/Poison Ingestion	Wendin Gulbransen	Overdose and/or Poison Ingestion - Beta Blockers flow chart ○ Change max dose for the fluid challenge to read 1000ml for consistency - Should the fluid challenge box for all three algorithms look the same, start with 500ml then advance to max dose of 1000ml? Shock	**Dr. Garzon to Review** Please change the fluid challenge box for all three algorithms look the same, start with 500ml then advance to max dose of 1000ml

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		- Under the BLS protocol, #3 – should this say Consider Spinal Motion Restriction (SMR) and reference the policy – use consistent language throughout the SCEMSA policies Vascular Access - Under policy – A. reword to say saline locks may be used only when administration of medication is indicated	Yes, for shock policy please change BLS protocol #3 to be "SMR" if necessary by protocol Yes, please change to "only when"
8038-Shock	Wendin Gulbransen	- Under the BLS protocol, #3 – should this say Consider Spinal Motion Restriction (SMR) and reference the policy – use consistent language throughout the SCEMSA policies	**Dr. Garzon to Review** Addressed above
8808-Vascular Access	Wendin Gulbransen	- Under policy – A. reword to say saline locks may be used only when administration of medication is indicated	**Dr. Garzon to Review** Addressed above
8827-12 Lead EKG	Barbie Law/SMFD	Remove the first bullet under B since this was removed from abdominal pain protocol. Add language to clearly state the importance of obtaining 1 quality EKG as soon as possible. Repeat EKGs can be performed if there is a change in the patients clinical presentation, but otherwise, prehospital serial EKGs are not indicated due to the high instance of false alerts.	**Dr. Garzon to Review** Yes, remove Abd pain as indication for ECG. Please add the following as bullets B & C under Special Considerations: B. Obtaining 1 high quality EKG as soon as possible is important to patient care and accurate diagnosis. C. Repeat EKGs can be performed if there is a change in the patient's clinical presentation,

			but otherwise, prehospital serial EKGs are not indicated due to the high instance of false alerts.
8808-Vascular Access	Barbie Law/SMFD	Under IO, previous versions of the protocol contained a requirement to document the reason IO was indicated. Please add this back.	**Dr. Garzon to Review** Agree to add back
8065-Hemorrhage	Barbie Law/SMFD	Is the intent for TXA that it can be administered without trauma (e.g. post partem hemorrhage, ruptured vericose veins, esophageal varices, bleeding from shunts, etc.)? If not, TXA should be moved to the trauma protocol. The flow diagram needs to be edited too if "in trauma" is removed from the protocol name. For example, why does the compressible hemorrhage box direct the medic to follow the trauma protocol if bleeding is controlled? Correct "Trauma Designation" protocol to Trauma Destination in the box to the right of compressible hemorrhage. This is another protocol that I think warrants in person discussion to make sure we get it right.	**Dr. Garzon to Review** Please add Notes: E as follows – While most life-threatening bleeding is a result of trauma, hemorrhage control strategies and sections of this policy also apply to non-traumatic hemorrhage, including but not limited to bleeding AV-shunts, and non-traumatic bleeding in patients on anti-coagulants
8062-Behavioral Crisis/Restraint	Barbie Law/SMFD	The policy now conflicts with new verbiage in Destination "Law enforcement agencies retain primary responsibility for safe transport of patients under arrest. 1. Patients under arrest or on a psychiatric detention shall be searched thoroughly by law enforcement for weapons and contraband prior to placement in the ambulance. 2. Patients under arrest, if handcuffed must always be accompanied in the ambulance by law enforcement personnel. 3. Prehospital personnel and law enforcement officers should mutually agree on the need for law enforcement assistance during transport of patients on a psychiatric detention." The second bullet in Protocol 5 needs to be amended to match the Destination requirement that patients in cuffs must have law in the medic. In light of events both locally and nationally I believe this protocol needs to clearly prohibit the use of any type of choke hold/carotid restriction while restraining a patient. I think we also need to prohibit prone restraint, and	**Dr. Garzon to Review** Policy deferred to next in person meeting and can address then. Please transfer this to the notes when reviewed in a future meeting

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		hobbles only permitted if already in place by law prior to our arrival. Have we given any thought to creating an excited delirium protocol or adding a section to this protocol with consideration for Ketamine? I think this is worthy of discussion once we can meet again as a group. I don't think this policy can be effectively reviewed/revised solely by email.	
8038- Shock	Barbie Law/SMFD	Airway adjuncts as needed should be a stand alone item in the Protocol section. Protocol 3, change "spinal immobilization" to "spinal motion restriction". Add SMR, Trauma, Cardiac Dysrhythmias, Respiratory Distress to the list of protocol references.	**Dr. Garzon to Review** Agree with airway adjuncts getting a separate bullet Agree with changing to SMR Agree with adding those policies to the cross references
8017- Dystonic Reaction	Barbie Law/SMFD	Add cardiac monitoring under ALS. All other protocols with medication administration include cardiac monitoring. Add a third item for reassessment after diphenhydramine.	**Dr. Garzon to Review** Agree with changes
8018- Overdose/Poison	Paula Green	Wording in BLS and ALS boxes that says to refer to Decreased Sensorium if patient is "non-responsive" etc...should be changed to ---refer to Decreased Sensorium if patient has Decreased Sensorium etc.... In addition, controlling n/v is important enough to be written into the policy. Zofran for n/v management under protocols other than the nausea /vomiting protocol is grossly underutilized.	**Dr. Garzon to Review** Agree with changing "decreased sensorium" language. Addressing nausea and vomiting where appropriate in policies. In poisonings, however, vomiting is often welcome to evacuate a toxin, and I would not add treatment to suppress vomiting in the pre-hospital setting for overdose.
8062- Behavioral Crisis Restraint	Paula Green	Recommendations based off of EMS referrals: Transporting a patient in the PRONE / Hobble position is not allowed. Do not use the word "avoid". No dog piles on patients. When a patient becomes quiet and quits fighting, check a pulse.	**Dr. Garzon to Review** This policy being deferred to another meeting. Can review recommended additions then

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		All patients that become quiet must have cardiac monitoring in place with ETCO2 and must be accompanied by frequent pulse checks. Law enforcement should be called in for patients that are not safely managed utilizing steps outlined in this protocol.	
9016- Pediatric Parameters	Paula Green	Blood Pressure on backside: "80 + (2x age in years)" ----the pediatric cardiac arrest uses "90" instead of "80" but also states for over one year old. ETT insertion depth and tube size. If we dont allow ped intubation, this needs to be taken out.	**Dr Garzon to Review** Please change this policy to "90 + (2x age in years)" Intubation still allowed for >8 years, so leave ETT depth info in policy