MOC/OOC Comments on Policies/Protocols

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Policy/Page	Provider/Agency	Comments/Suggested Edits	Response
2525-Prehospital Notification	Chief Law/Sac Metro	make sure the definitions and terminology is consistent with the definitions contained in Medical Oversight 2200.18 for a Notification Report and a Medical Consultation Report. In Protocol B. delete "when time and resources allow". If the medic is unable to give the notification report, it should be delegated to another crew member or the driver. This language gives the medics an out from communicating that I don't think is needed. In Protocol D., arrival is spelled wrong. FIXED In Pre-Hospital Notification Format cardiac arrest is not included, but its mentioned as an alert in the previous section. ADDED In MCI Report change "Expectant" to "Deceased" which is the terminology used in 7508.16 START/Jump Triage Do we need to add a category for what is expected in a Medical Consultation Report?	**Can we edit: "**Prehospital notifications shall be called to the receiving facility on all transports when time and resources allow**"** **To:** **Prehospital notification shall be called to the receiving hospital on call calls. When the medic is unable to complete the notification, it shall be delegated to another crew member."** **-Garzon**
2200-EMT Scope of Practice	Chief Law/Sac Metro	in Policy 7 & 8.c. Delete "or immobilization". 8.d. conflicts with the SMR protocol which states "SMR cannot be properly performed with a patient in a sitting position". I recommend deleting 8.d. altogether. It's already covered in 8.c.	**Dr. Garzon to review** Agree with Delete "or immobilization" in 7. Agree with delete of 8d all together
2507-STEMI System Data Elements	Chief Law/Sac Metro	The footer has the wrong page counts. I think all of the pre-hospital elements should specify the data element to be reported. The stroke elements include the Agency and response unit , but STEMI doesn't. Was this intentional?	**Footer Corrected** We should include response agency and unit in STEMI elements as well.

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2528-Stroke System Data Elements	Chief Law/Sac Metro	I think all pre-hospital elements should specify the data element to be reported. As much as possible, the list of elements should be consistent between the STEMI and Stroke system policies. Stroke reporting requirement is still monthly. Is this intentional or should this requirement be quarterly too?	**Dr. Garzon to review** **I think we should change the wording on the "reporting data elements" section of both of these documents to say that SCEMSA will extract the EMS elements from the ICEMA database, and that hospitals data elements shall be reported an least quarterly. This should be consistent for both STEMI and Stroke.**
5010-Transfer of Care	Chief Law/Sac Metro	F. needs clarification. Is the intent that a non-transporting medic who makes the initial patient contact and accompanies the medic to the hospital to provide care must complete the PCR? If so, this needs to be written more clearly. Non-transport medics accompany the medic when they weren't the primary/initial caregiver too.	**Dr. Garzon to review** The intent of this is to capture the care delivered by the non-transporting medic. Perhaps this is covered in the documentation policy and is not needed here?
5050-Destination	Chief Law/Sac Metro	Policy A. refers to "Special Triage Receiving Facility" but this term isn't on the definitions list. Is Definitions E. even needed? The phrase isn't used anywhere in the policy. I do think there needs to be some recognition in the policy statement that patients should be taken to a hospital in-plan whenever possible (i.e. Kaiser members to Kaiser, Sutter patients to Sutter, VA to VA). We are contributing to our own wall time problem by transporting patients to the wrong facility for their healthcare plan without justifiable reason to do so.	**Dr. Garzon to review** Please add a Definition bullet for: Special Triage receiving facility: An acute care hospital designated by SCEMSA to receive per SCEMSA protocol patients for Critical Trauma, STEMI, Stroke, Burn, Ventricular Assist Devices, or Obstetrics (see SCEMSA policy 2060). We can eliminate Definition E because those things are covered and identified in the policy section. Change Policy C.1. to: Patient's/Guardian's request ~~(if patient is a minor),~~ including consideration for the patient's existing in-plan hospital system affiliation

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5052-Trauma Destination	Chief Law/Sac Metro	I don't agree with changing "Shall" to "will" throughout. What is the purpose of this change?	**Dr. Garzon to review** I believe both convey a future instruction, and the issue seems to be more with grammatical use. According to lexico.com**, "**The traditional rule is that **shall** is used with first person pronouns (i.e. I and we) to form the future tense, while **will** is used with second and third person forms (i.e. you, he, she, it, they). For example: I **shall** be late.**"** I would leave the edit as it is, but there should be consistency across all our policies.
8024-Cardiac Dysrhythmias	Chief Law/Sac Metro	Clarification is needed on the expectation for atropine administration. Can atropine be given if it won't delay pacing for 2nd & 3rd degree block? For example, with 5 medics on scene, atropine could be given before they are ready to implement pacing. Is the intent that if the patient is ***not*** in 2nd or 3rd degree block that atropine be attempted prior to pacing? Clarify when the medic should move to push dose epi. How long should medics attempt pacing before moving on to the next step? Is there a need to specify an endpoint for mA. We've had a couple of instances of medics increasing up to 200 mA without capture, and not moving on to push dose epi. For tachycardia, we're giving amiodarone if the patient is cardioverted into a stable wide complex rhythm, but if they were stable to start, we're not giving amiodarone. Consider adding amiodarone to the right side of the algorithm for wide complex	**Dr. Garzon to review** **Please change brady algorithm bubble to:** Symptomatic Type II 2nd degree blocks and 3rd degree blocks shall have pacing implemented without delay. Atropine shall be given if administration does not delay pacing. Please edit Push Dose Epi bubble to read: For SPB≤90 mmHg Push Dose Epinephrine:… Epi is for hypotension, and not for bradycardia. This is an education point in ACLS and not for the algorithm. For various reasons I do not feel Amiodarone is indicated in the field for stable patients with short transport times.

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		tachycardia so we aren't waiting for them to become unstable before treating.	
8025- Burns	Chief Law/Sac Metro	In ALS 4. Change to "moderate to severe pain" so we're consistent with the Pain Management protocol.	**Added**
8029-Hazardous Materials	Chief Law/Sac Metro	Special Note A. Hazardous doesn't need to be capitalized.	**Fixed**
8030-Discomfort/Pain of Suspected Cardiac Origin	Chief Law/Sac Metro	Reconsider use of the phrase "treatment and transport should occur concurrently". We want a quality 12-lead, and obtaining a 12-lead in a moving ambulance is problematic. Is there value in moving 12-lead up before NTG so we aren't giving nitrates at all for STEMI?	**Dr. Garzon to Review** Please change ALS #1 to: "treatment and transport should occur concurrently, after a single good quality ECG is completed." **Please move "Obtain ECG" bullet to #4, above NTG bullet**
8031-Cardiac Arrest	Chief Law/Sac Metro	In Protocol D. add language to require end tidal CO2 for advanced airway, not just OTI so we're consistent with the language in respiratory distress protocol. Also in the Advanced Airway section of the grey box on page 3 of 3. Remove "ET" in the 2nd bullet. Make sure the verbiage added to the Destination protocol regarding ROSC & VFIB including AED use is the same in this policy. In Termination of Resuscitation change A.1. to, "Pulseless, apneic, agonal, or apneustic respirations with no signs of life (non-reactive pupils, no response to pain, no spontaneous movement).	**Dr. Garzon to review**
8836-Medication Administration	Chief Law/Sac Metro	DuoDote Auto-Injectors- there is no need to capitalize hazardous in Special Note A.	**Fixed**
8015-Trauma	Dr. Beckerman	At our most recent MSJ trauma peer review meeting we discussed the	**Dr. Garzon to review**

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8031-Cardiac Arrest		case of a trauma arrest that received epinephrine per ACLS protocol. While this was done in the ED, the question came up of use of epi in the field in traumatic arrest. Our trauma service strongly feels there is no role for epinephrine in traumatic arrest. Currently the only mention specifically of traumatic arrest in the trauma policy is to direct bilateral chest decompression. There is no distinction in the cardiac arrest policy (8031) between medical and traumatic arrest. Should we consider changing the cardiac arrest policy to apply only to NON-traumatic arrests, and then address traumatic arrests in the trauma policy (and state no use of epi)?	Dr Garzon awaiting input from Dr. Shatz and Beckerman about adding a "traumatic Arrest" algorithm to this document
5050-Destination	Dr. Beckerman	Definitions Section E6 mentions a special triage policy for Obstetrics. Destination is not mentioned in the Childbirth policy. To my knowledge, there is not a specific Obstetrics triage policy. Should there be, since some hospitals have no L&D, vs basic L&D, vs NICU? Consideration should be given to the patient's pre-determined hospital for delivery, if possible.	**Dr. Garzon to review** This policy does not need modification, but agree that our childbirth policy should include destination language, such as: Any patient in labor or who delivers in the field shall be taken to a facility with L&D services. Consideration should be given to the patient's pre-determined hospital for delivery, if possible.