MOC/OOC Comments on Policies/Protocols

March 11, 2021

Policy/Page	Provider/Agency	Comments/Suggested Edits	Response
2220–EMT Scope of Practice	Barbie Law	Does this mean that EMTs can't volunteer at high school football games, camps, Rock Med, etc.	**Intent is to not have EMTs provide care (02, BGL, Epi, ASA etc.) when not affiliated with a provider**
2055-On-Viewing Medical Emergencies by ALS and BLS Providers	Barbie Law	I don't support the change of verbiage in Protocol A.	There has been no change in the verbiage in Protocol A.
2039-Physician and/or Registered Nurse at the Scene	Barbie Law	The CMA advisement card is listed in the document twice, and doesn't really need to be.	**Fixed**
PP 2033-Determination of Death	Barbie Law	Definition D. Correct typo. "tow" should be two.	**Fixed**
8062-Behavioral Crisis Restraint	Barbie Law	For the Protocol BLS Section, **Protocol 2:** Ensure EMS provider and family/bystander safety. Request law enforcement as needed to ensure scene safety is maintained at all times. **Protocol 3:** Assess and treat as appropriate for underlying cause. **Protocol 5:** This section needs to be reorganized so its more clear. I suggest the following for the remainder of this section: 5. Attempt verbal de-escalation with a calm and reassuring approach and manner prior to involuntary restraint of the patient. • Involve your partner or another provider who has patient rapport if appropriate. 6. Law enforcement should be requested to assist with determination of necessity to involuntarily restrain a combative patient for his/her safety. 7. Before restraining any patient, prehospital personnel must	Protocol 2 – I'm fine with this suggested change.- Added Protocol 3 – would not change as this point is addressed in #4. Protocol 5 – already incorporated Protocol 6 – similar content added under #5 Protocol 7 – training issue Protocol 8-12 added under #5. 13-15 included as 6-8. #16 – please add the "Supplemental O2 as necessary

		ensure there are sufficient properly trained personnel available to physically restrain the patient safely. **Bullet- A** general rule of thumb is one person per limb & one at the head. **Bullet-** Providers will explain to the patient and any family present on scene that the patient is being restrained so that he/she does not injure themselves or others. **Bullet-** Restraints should be prepared for placement prior to commencing the procedure. **8.** Law enforcement personnel are responsible for the apprehension and restraint of assaultive or potentially assaultive patients. • Law enforcement agencies retain primary responsibility for safe transport of patients under arrest. **9.** Handcuffs may only be applied by law enforcement personnel. • If safe to do so, handcuffs should be replaced with leather or cloth restraints prior to transport. **10.** Patients under arrest, if handcuffed, must always be accompanied in the ambulance by law enforcement personnel. **11.** Prehospital personnel and law enforcement officers should mutually agree on the need for law enforcement assistance during transport of patients on a psychiatric detention. **12.** All restrained patients will be placed in a sitting, supine, semi-Fowler's or Fowlers or lateral recumbent position.	to maintain SpO2 ≥ 94%. Use lowest concentration and flow rate of O2 as possible." Under the ALS #2 SPO2 monitoring bullet at the bottom of the ALS box. - Added

		Bullet- late term pregnant patients shall be transported i in position of comfort or left lateral position. **13.** Document all of the following information on the ePCR: patient's mental status, lack of response to verbal attempts to de-escalate behavior, the need for physical restraint, the method of restraint used, any injuries to the patient or EMS personnel resulting from the restraint efforts, the need for continued restraint and methods of monitoring the restrained patient. **14.** Frequent assessment of the patient's cardiovascular and respiratory status shall be made and documented in the combative patient with delirium who requires either physical or pharmacological restraint. **15.** If extremities are restrained, assess and document neurovascular status after restraint placement and during transport. **16.** Supplemental O2 as necessary to maintain SpO2 ≥ 94%. Use lowest concentration and flow rate of O2 as possible. Protocol ALS: consider the following changes: **1.** Continued Combativeness: if patient remains combative despite physical restraint such that further harm to the patient or providers is possible. Midazolam: a) Intravenous (IV) - 0.1 mg/Kg (max dose 6 mg) slow IV push in 2 mg increments- titrate to reduction in agitation. b) Intranasal (IN) – 0.1 mg/Kg (max dose 6 mg) one-half dose in each nares.	

		c) Intramuscular (IM) - 0.1 mg/Kg (max dose 6 mg) in single IM injection (may be split into two sites if sufficient muscle mass is not present for a single injection). **2.** Advanced airway adjuncts as needed. **3.** Cardiac monitoring for possible dysrhythmias. **4.** Consider vascular access and titrate to SBP ≥ 90 mmHg. Precautions: I think all of this needs to be worked into the protocol section as they really aren't "precautions". Discussion is needed on the new item G.	