MAC/OAC Comments on Policies/Protocols

December 9, 2021

Policy/Page	Provider/Agency	Comments/Suggested Edits	Response
8032 – Traumatic Cardiac Arrest	B. Law	Add 8020 – Respiratory Distress: Airway Management to the references In BLS #2 & ALS #4, change "Policy" to PD# so it's consistent throughout the document. Should we add a caveat to reassess lung sounds in the IV section since we're giving up to 4 liters? Change "or 4 liters" to "repeat bolus during arrest until SBP >90 or maximum of 4 liters administered".	Done Done Done Done
8031 – Traumatic Cardiac Arrest Flow Chart	B. Law	In the first box add the word criteria and PD name so it reads "Does patient meet obvious death criteria as outlined in PD # 2033 Determination of Death?" Add a bullet "Prepare for Immediate Transport" in the start CPR box. Add PD document name in the special box so it reads, "If suspected medical arrest follow PD# 8031 Cardiac Arrest	Done Done Done
8032 – Traumatic Cardiac Arrest	Dr. Mackey	Suggested wording changes for "Protocol" section, which should probably be renamed to "Introduction" or "Background" A. The pathophysiology of traumatic cardiac arrest differs from medical cardiac arrest and is primarily due to hypovolemia, obstruction of blood flow, and/or hypoxia. Attention should focus on addressing immediate life threats	This was left as 'Protocol' to stay consistent with all other Policies. Agree to leave as is -hg For Dr. Garzon to Review In A. It looks like he wants **"Attentions should focus on addressing immediate life threats".** The other language he suggested is what it basically already states. Leave as is - hg This language is already in B. It is just worded a different way. Leave as is -hg

MAC/OAC Comments on Policies/Protocols

December 9, 2021

		B. Survivable traumatic cardiac arrest typically presents with pulseless electrical activity (PEA). C. Traumatic cardiac arrest patients who undergo resuscitation shall be transported immediately D. Patients with trauma in cardiac arrest who by prehospital presentation may have suffered a medical event before trauma shall undergo medical cardiac arrest resuscitation per Policy# 8031 (Cardiac Arrest), with attention and appropriate management to emergent trauma needs (hemorrhage control, pneumothorax decompression as indicated, and orthopedic immobilization as indicated) E. Epinephrine and Amiodarone are NOT indicated in traumatic cardiac arrest	BLS 4. Of the BLS sections already states "Chest compressions should be performed when possible without delaying transport or other treatments". "Rapid Transport" was added to the flow chart as well. I am ok with shortening Policy.C to: "C. ~~Because the etiology of traumatic cardiac arrest is different from medical cardiac arrest,~~ traumatic cardiac arrest patients undergoing resuscitation shall be transported as quickly as possible to the hospital." -hg This language is under "Protocol: D" Leave as is -hg I added Amiodarone and changed PEA or Asystole to traumatic cardiac arrest. Agree -hg
8032 – Traumatic Cardiac Arrest Cont.	Dr, Mackey	Suggested changes to POST RESUSCITATION CONSIDERATIONS: B. Treatment Guidelines: • Intravenous (IV) or Intraosseous (IO) fluids should be placed wide open with pressure bags titrating SBP to 90 mmHg. • Re-assess for and control external hemorrhage	Dr. Mackey would like formatting change with language that is already in the policy. Leave as is -hg

MAC/OAC Comments on Policies/Protocols

December 9, 2021

		• Administer TXA as indicated per Policy# 8065 (Hemorrhage Control)	
5050 – Destination	Dr. Mackey	Policy C, 1 and 3 Why is the word "Guardian" under 1 AND 3? Doesn't 1 cover both? Suggest rewording 3 to "Family" and delete guardian. The reason why Prepaid Health Plan is supersedes the "Family/Guardian" part, which creates confusion. Policy E Is the intent of a. to have a paramedic establish base contact in an unstable patient to go to a farther hospital? Can you come up with a situation where that would apply and had not already been covered in this or other policies? In the sub-notes on the bottom of page 2, the new sub-note for the VA has a typo. Last sentence "but" should be changed to "and".	I put a line strike through '3. Family/Guardian's request.' I am not sure if you want "Guardian" deleted and using "Family" unless we stipulate Family is 18 years and over and can make medical decisions for the patient. Leave as is! This is NOT a consent for treatment, which would require a more legally appropriate term like parent/DPOA. It is just who can direct/suggest an appropriate hospital destination. For a slightly confused post-ictal or hypoglycemic patient, I'd be happy with a sibling or even friend saying "they usually get care at Sutter" to determine destination. Let's not 'fix" what's not broken. Kathy and I think this language should remain unchanged. Agree. Leave as is -hg Done
5052 – Trauma Destination and 5053 – Trauma Triage Criteria	Dr. Mackey	With very little effort, these policies could be combined. 90% of the destination decision points in the "Destination" policy are covered in the side bar "Special Considerations when Triaging Critical Trauma" under "Trauma Triage" policy. You would only need to add wording about tourniquets in peds and adults, which is one sentence like "any patient with a tourniquet in place shall be transported to the closest appropriate trauma center".	Dr. Garzon to Review Leave as 2 policies -hg

MAC/OAC Comments on Policies/Protocols

December 9, 2021

5053 – Trauma Triage Criteria	Dr. Mackey	Under new "notes" section, suggested wording change: NOTES: Patients meeting anatomic or physiologic trauma triage criteria should be transported as soon as possible. On-scene procedures should be limited to triage, patient assessment, BASIC airway management, control of external hemorrhage, and SPINAL MOTION RESTRICTION. Additional interventions should be completed enroute (exception: incidents requiring prolonged extrication). In the triage Protocol, under "Mechanism of Injury", please add the following SUBNOTE to be consistent with ACS policy for Intrusion: Intrusion refers to INTERIOR compartment intrusion, as opposed to deformation which is exterior damage	This change is asking for Airway Management to be changed to BASIC Airway Management. I think the language should be kept the same. If an ETT is needed, isn't is better to do on scene rather than a back of a moving ambulance? Immobilization was replace with 'Spinal Motion Restrictions.' Leave with this change -hg Added
8015 - Trauma	Dr. Mackey	In ALS section, 4. Decompression of Tension Pneumothorax: Please change "5" to "c" since the placement of the needle should be under the tension PTX heading. Likewise, please make "6" a "d" for the same reason. And "7" a "e" for the same reason. Then change "8. Orthopedic trauma" a "5" to follow the corrections above Next, I would like a discussion on changing the preferred site of needle thoracostomy. The ACS COT changed ATLS several years ago to the midaxillary location based upon several Prehospital and Trauma studies. Reference found here: https://bulletin.facs.org/2018/06/atls-10th-edition-offers-new-insights-into-managing-trauma-patients/ Not a hill to die on, but would like the input of the trauma community. When we place a hole in the upper chest, then the	Done Dr. Garzon to Review Checking with Dr. Shatz -hg Dr. Garzon to Review. Not sure what the requested change is

		trauma center places a chest tube, air leaks can happen from the needle site performed by prehospital treatment that delays the patient's recovery.	
8030 – Discomfort/Pain Suspected Cardiac Origin	Dr. Mackey	Suggested Edit: 4. Obtain 12-Lead ECG. 5. If the patient's ECG is consistent with an acute STEMI, the following shall be performed without delay: • Transmit the 12 lead to the closest designated STEMI center • Transport to closest designated STEMI center • Perform a Pre-Alert Notification to the closest designated STEMI center Note: A copy of all 12-Lead ECG's shall be delivered with the patient. Spell check: 5. Nitroglycerine (NTG) (If 12-lead ECG is not consistent with an ACUTE STEMI): Suggested Edit (if above accepted): 6. Administer Nitroglycerine (NTG): • 0.4 mg sublingual if Systolic Blood Pressure (SBP) >90mmHg. May be repeated every 5 minutes. • Titrate subsequent NTG to pain relief as long as the SBP> 90 mmHg while simultaneously establishing vascular access. • Absence of vascular access shall not preclude use of NTG as long as all other criteria are met. Note: Nitroglycerine is CONTRAINDICATED in the setting of STEMI	Done Bullet Point replaced with term: NOTE Corrected I removed "Administer NTG" from ALS 6. And added it to the first bullet point. Added below ALS 5.
8031 – Medical Cardiac Arrest	Dr. Mackey	Post Resuscitation Considerations: A. Any patient with an initial shockable rhythm (VT/VF/shocked by an AED) who has ROSC during any part	

		of the resuscitation, and who is transported, shall be transported to a STEMI (PCI) center 1. Any other cardiac arrest patient who is transported, shall be transported to the time closest hospital. Suggested Edits (Shock in ROSC states best respond to pressors, not fluid, especially considering the myocardial state post-arrest): C. Post-resuscitation bradycardia, hypotension, shock and pulmonary edema. 1. Bradycardia, refer to Cardiac Dysrhythmias Policy PD# 8024. 2. Congestive Heart Failure/Pulmonary Edema refer to Respiratory Distress Policy# 8026 (Respiratory Distress) 3. Hypotension/Shock • Push Dose Epinephrine 0.01 mg/ml (10mcg/ml). • Dose: 0.5-2 ml every 2-5 minutes (5-20mcg). Titrate to SBP ≥ 90 mmHg. NOTE: Monitor SBP frequently once ROSC is obtained	I'm not sure what he wants on this edit. Maybe he wants the Push Dose Epi before the 1000 ml bolus? I would leave as is. AHA guideline still lists IV fluids, 1-2 liters, before Epi. -hg "Once ROSC is obtained" added to Post resuscitation Considerations under **NOTE.**
8024 – Cardiac Dysrhythmias	Dr. Mackey	Suggested edits: 12-Lead; 12-Lead ECG if possible. Please consider changing this to "Obtain 12 lead without delay". Reason: the 12 lead is a destination decision point for STEMI and according to the current policy atropine should be withheld based on the 12 lead. Suggest removing the arrow pointing away from TCP indicating "Pacing Not Available". Pacing should be available on all ALS units and BLS units would not carry atropine anyway. Pacing is a requirement on the ALS inspection form. Suggested Changes: BRADYCARDIA Protocol applies to adults who are symptomatically bradycardic	Dr. Garzon to review The vast majority of arrhythmias are NOT STEMI related, and I would much rather an unstable arrythmia be treated appropriately before a 12-lead is done. Leave Note as is. -hg I agree with this, however, "Pacing Not Available" encompasses equipment failure as well, so I think we need to leave it. Agree -hg

		with a heart rate of < 50 bpm documented by monitor, a systolic blood pressure (SBP) < 90 mmHg, -AND/OR- other signs or symptoms of hypoperfusion that may include decreased sensorium, diaphoresis, chest pain, capillary refill greater than two seconds, cool extremities, or cyanosis. Suggesting "OR" because waiting til hypotension occurs is pending cardiovascular collapse, and symptomatic bradycardia from STEMI with diaphoresis often is not hypotensive. Suggested Changes: Move Atropine to below pacing and above PDP, assuming pacing has failed.	Dr. Garzon to Review I'm fine with changing "AND" or "AND/OR" -hg