MAC/OAC Comments on Policies/Protocols

September 14, 2023

Policy/Page	Provider/Agency	Comments/Suggested Edits	Response
PD# 2530 – Trauma Center Designation	Dr. Shatz	Staffing requirements A.1 - this must say "general surgeon" to be in compliance with ACS verification. Level II Surgical specialist availability requirements B - Vascular must be included. Pediatric Trauma Center Standards, Staffing requirements, A.1 - "qualified board-certified physician" needs to be changed to "general or pediatric surgeon" to be in compliance with ACS verification.	This was already discussed with Dr. Kann, and the language was updated.
PD# 2530 – Trauma Center Designation	Dr. Beckerman	Under Level II Supplemental Service Requirements, "Burn Center" is listed, without any further clarification. The corresponding language under the Level I Supplemental Service Requirement reads "Burn Unit (Service may be provided through written transfer agreement with a burn center}". As written, the Level II language gives a requirement not present for Level I.	Dr. Kann to Review Remove Burn Center from Level II Supplemental Service Requirements.
PD# 2530 – Trauma Center Designation	Dr. Callcut	The policy states: "Trauma Program Medical Director: A qualified board-certified physician by the American Board of Medical Specialties (ABMS) designated by the hospital that is responsible for the trauma program, performance improvement, and patient safety programs related to a trauma critical care system." The American College of Surgeons requires this person to be a surgeon. I would recommend this designation be changed in the EMS policy to state that a board-certified surgeon fill this role.	This was already discussed with Dr. Kann and changes were made
PD# 2033 – Determination of Death	Dr. Shatz	Mercy San Juan trauma service disagrees with the removal of PEA <40bpm from criteria for determination of death in trauma patients as proposed for the September MAC. These patients are considered non-salvageable and when transported, are pronounced dead on arrival. Removal of this criteria will result in unnecessary	This was already discussed with Dr. Kann who made the decision to keep the edits as is.

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		Code 3 transports and ED resource utilization.	
PD# 9007	CFD	Take out 14 plus years old D50, 50 ml preload - full adult dose. They will be treated under protocol then. Any child 14 or younger is pediatric. Any child older than 14 is an adult. Are we going to treat for less than 60 or less than or equal 60 either initially or in repeat….which is it, we should not be flipping back and forth. Please clarify in the event of a glucometer failure, administer 0.5 gm/kg for a maximum dose of 1 gm/kg of dextrose or 0.5 mg of glucagon IM. Should this be to a max of 12/5 gm. As it stands it does not make sense.	Dr. Kann to Review Agree to the removal of 14 plus years old – this is an adult and falls under adult treatment protocol. Treat all glucometer readings less than or equal to 60. Under ALS 2-14 years old: D25, 2 ml/kg or D50 1 ml/kg. Glucometer Failure has been removed from the policy per Dr. Kann
PD# 9009	Adam Blitz	1) Page 3 is completely blank 2) I know I left EMS for a spell, but why is APGAR not mentioned at all here, even near the routine care section?	APGAR is in the childbirth Protocol. APGAR has no role in neonatal resuscitation.
PD# 9008	Adam Blitz	Towards the end, in the Notes section, why is the "***Diazepam may be substituted" stated twice - it is at Notes 1. and again after Notes 3., just a couple lines down.	Fixed
PD# 8001	CFD	Why is this pulled out sequence as this was due for review June 2024. If an auto-injector is available under BLS they are not managing the dose. They are assisting a prescribed dose. The dosing information is not needed. Keep it simple. What does Secure Airway under allergic reaction BLS mean? It should probably say Assess Airway.	Dr. Kann to Review Pulled out of sequence due to addition of TXA for angioedema. Assess airway is fine.
PD# 8026	CFD	Hemoptysis do we need to know causes in a treatment policy. It is inconsistent with other policies. BLS Secure airway is too arbitrary. CPAP for moderate to severe dyspnea. ALS should read consider manual respiratory support, prepare for advanced airway establishment.	Dr. Kann to Review OK with removing B on page 2 – Hemoptysis (common causes). Consider respiratory support and prepare for advanced airway management – ok.
PD# 8032	Dave Sutton	BLS 1. Treat immediate threats to life 2. External hemorrhage control per PD# 8065 - Hemorrhage Control. Apply tourniquets as necessary.	Dr. Kann to Review SCEMSA has decided to accept the traumatic cardiac arrest protocol put forth by STAC. There is general

		3. Airway and Breathing: Clear airway when indicated; place OPA and BVM ventilation. 4. Chest Compressions: Chest compressions should be performed, when possible, without delaying transport or other treatments. Chest compressions/high-quality CPR for any rhythm other than Asystole. Automatic compression devices shall not be used as they will delay transport. Number 4 reads as "shall" not be used. if no delay or manual compressions are initiated, the Lucas device offers uninterrupted compressions while hemorrhage control, vascular access, and critical airway management can be done without personnel standing and hovering over the patient in a small compartment ambulance traveling C3 on the roadway. It could be argued that effective compressions could not be maintained as well as the safety of unrestrained standing ems personnel was jeopardized. Suggestion: reword number 4 to state Automatic compression devices shall not be used "if they will cause delay to transport	consensus to avoid automatic compression devices. We will NOT use automatic compression devices for traumatic arrest.
PD# 8032	Adam Blitz	According to our paramedics, the Lucas does not slow down a CPR scene. Do you have data to show that it does?	Dr. Kann to Review See above.
PD# 8032	CFD	Why are we taking out PEA <40 from the protocol? So we are transporting anyone in PEA with a traumatic arrest.	Dr. Kann to Review STAC recommendations accepted by SCEMSA.
PD# 8065	CFD	Secure airway Change consider to prepare for intubation, etc. We do no have RSI and we are intubating in reaction to an unconscious pt with no GAG reflex. Soaking of TXA in a cotton pledget in the field with 1/2 a back of TXA which cannot touch the medics skin let the patients.....would it not be	Dr. Kann to Review. OK with prepare for intubation in the event of significant hypoxia, dyspnea or impending airway loss. TXA is not harmful to skin. Studies on efficacy in epistaxis treatment involved soaked gauze inserted into

		easier to give IV or nebulized TXA. I get the expanded use but is this practical in a back of rig travelling down the road. Under ALS there is no mention of IV TXA but in the algorithm it is mentioned. The TXA doses for page 3 of 3 and 4 of 3 do not match. One side says to 2 gm and the other side states 1 gm to infuse.	the nose. We will continue with previous wording. TXA IV dose of 2 g has been identified previously. ← This was fixed.
PD# 2003 and 2001	Adam Blitz	Under #2003 Procedure F. states: If the patient refuses transport after the assessment is completed and/or any treatment provided, "Against Medical Advice" paperwork and process must be completed. Complete the process as outlined in SCEMSA policy 2101.18. Why is the county lumping all refusals of transport as AMA? If you have a band-aid on a cut that has been cleaned and dressed, does SCEMSA really want EMS to consider not going AMA? I thought we were regarded as "clinicians" now. I don't know any clinicians who don't know the difference between what is an appropriate refusal and what is legitimately Against Medical Advice. Policy 2101 makes the same broad assumption. FYI, at AMR, refusals are PRS-RAS (released at scene) or PRS-AMA (against medical advice), and they let the clinician decide.	Dr. Kann to Review Maintain current language. Having AMA paperwork performed for a refusal – even if treatment offered – protects the crew and provides a signed document that the patient/or guardian understood the risk of non-transport.
PD# 2033 – Determination of Death	CFD	This was just updated in May. Isit just because of PEA < 40 is no longer on the protocol. Where is the research that PEA <40 in traumatic	Dr. Kann to Review STAC consensus policy to be adopted by SCEMSA.

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		arrests is survivable. We are taking this out of turn.	
PD# 9021	Adam Blitz	Two issues under Protocol #7: 1) It states: Pre-hospital personnel will not perform any of the items noted below. These actions are the responsibility of law enforcement. • Law enforcement personnel are responsible for the Capture, detention, and restraint of assaultive or potentially assaultive patients. There are times when no law enforcement is on scene or available, and Fire/EMS need to restrain a patient for their own + the patient's safety. This sweeping statement sounds like it negates that. 2) It also states: Patients under arrest, if handcuffed, must always be accompanied in the ambulance the law enforcement personnel. This is an EMS policy. We can't hold PD to EMS policies and they often will refuse to accompany but instead follow the ambulance. Better off giving us steps to take to make the transport happen when they won't - instead making rules requiring something of law enforcement that we cannot enforce.	Dr. Kann to review. This policy was worked on extensively by Fire Agencies and Legal Counsel the last time it was up for review. This is the language Fire wanted in there, and they agreed with the language. This is a consensus document that has been agreed upon policy and will not change.
PD# 4302	Adam Blitz	The new verbiage regarding submitting a course for CEs (in blue): * was never discussed * is in the wrong section. It is currently in Section A. 5. Application for Approval as a provider which is how to become a CE provider and get a provider number. * Section B speaks to our responsibilities as CE providers, and Section D to the assignment hours as identified by the CE provider. Does this not clash with the above - that every CE must be approved by SCEMSA? * What about the section describing the conversion of college units to CE? Is that no longer approved for us - or do the paramedics submit transcripts directly to SCEMSA now	Dr. Kann to Review. Edits were made by Katey to clarify what is in title 22. I will defer to Katey here. My understanding here is that there are State level requirements. We just need to follow the State direction. Title 22 states: "The CE approving authority shall approve or disapprove the CE request within sixty calendar days of receipt of the completed request." this is in regards to any CE course that providers want to teach - all classes need to be

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		-which is a change? Are CECBEMS CE's still permissible or do they need SCEMSA approval too? How about SSVs CE's? JEMS CEs? I feel this should have been discussed	approved by SCEMSA before being taught. Providers have always been required to submit their CEs courses for review before teaching the class. There are no changes for paramedics submitting their transcripts.
PD# 2026 – TRC	CFD	There is no representation of the ALS providers and the CQI coordinators to help with defining and assess trauma related care.	Dr. Kann to Review TRC document will be tabled, as the new Trauma Improvement Committee policy will supercede the TRC document.