MAC/OAC Comments on Policies/Protocols

September 10, 2021

Policy/Page	Provider/Agency	Comments/Suggested Edits	Response
9010 – Pediatric Overdose	K. Mackey	Suggest adding wording to the title for clarity, something like “Pediatric Non-Narcotic Overdose”, since there will be potentially a pediatric narcotic overdose policy.	What are your thoughts on combining the two and making one policy for just “Pediatric Overdose” instead of having a Non-Narcotic and a Narcotic overdose policy? I think we should combine these, and add the Ca-channel Beta-blocker, and Tricyclic sections to the current narcotic OD policy. Just rename it “Peds OD policy”
8029 – Hazardous Materials	K. Mackey	Cross references a policy that has changed or does not exist: 8836? Can’t find it anywhere on the website or policies just approved.	Removed as a cross reference
9011 – Pediatric Suspected Narcotic Overdose	K. Mackey	Current wording: 4. If trauma is suspected, assess for traumatic injury per PD# 9017. 5. Spinal motion restrictions when indicated per PD# 8044. Recommend remove. Again, as I said, policies that are simple, less wordy, and applicable to the vast majority of cases help our providers THINK and stay focused. The likelihood of narcotic od in a kid with trauma to is remotely infinitesimally small.	Dr. Garzon to review I would leave in. These bullets are for those cases of ALOC where the etiology is not so clear, as is called out in Protocol C.
9008 – Pediatric Seizures	K. Mackey	Current wording: Assess and treat the possibility of narcotic overdose per PD# 9011. Literature searches on the prevalence of seizures in the setting of narcotic overdose reveals seizures are non-existent as a result of the overdose. Seizures in the setting of narcotic overdose result	Dr. Garzon to review OK with removal of reference to 9011

		from the use of naloxone, especially in Tramadol OD. Suggest removing this. A narcotic overdose is respiratory arrest, hypoxia, pin point pupils, not seizures Suggest removing SMR here as well. It not necessary, and more of a distraction. If SMR for some bizarre reason is indicated, we already have a policy for that. We don't need to remind them in ever policy to consider SMR. They already have consideration for that, and a policy for that. Current wording: The majority of seizures are self-limited with resolution before medication administration Please move this statement to the top as letter "D" under protocol. I think this is an important consideration for all pediatric seizures. Perhaps moving the wording up there too about "non-febrile seizures, etc." We see a fair amount of febrile seizures get slammed with versed when all they need is to wait a bit, cool off the kid, and observe.	I would leave the cross reference to SMR No need to change. The instruction for administration of medication is for “continuing seizures.” (#7). If patients are seizing upon EMS arrival (7-15 min after first medical contact) they likely need meds.
9007 – Pediatric Diabetic Emergencies	K. Mackey	Questioning why SMR is part of this policy. What is the likelihood that a spinal injury occurs in the setting of a diabetic event in a child? I worry that this language will create more confusion than clarity. If it is an unlikely event and does not add to	Dr. Garzon to review

		the treatment in some meaningful way, I suggest removing it.	
8032 – Traumatic Arrest	K. Mackey	Current wording: Treatment on scene- Movement of a patient may interrupt CPR or prevent adequate depth and rate of compressions. Consider resuscitative efforts on scene to maximize chances of Return of Spontaneous Circulation (ROSC). Have you checked with the trauma community on this wording? If a person is in traumatic arrest and does not meet criteria for determination of death, they should be moving with that patient to a trauma center, not staying on scene for any length of time more than necessary. Wording current: Termination of Resuscitation Considerations: A. Consider termination of resuscitation efforts after twenty (20) minutes of Advanced Life Support (ALS) care if BOTH of the following are present: 1. Pulseless, apneic, or agonal, or apneustic respirations with no signs of life (non-reactive pupils, no response to pain, no spontaneous movement). 2. Asystole, or wide complex PEA with HR < 40 bpm. Remove this completely	Dr. Garzon to review This was already edited
2085 – Do Not Resuscitate	K. Mackey	An EMT or Paramedic may discontinue resuscitation if after the	Dr. Garzon to review

		resuscitation was instituted and the following is presented: Suggested wording change: An EMT or Paramedic may discontinue resuscitation if after the resuscitation was instituted and the ONE of the following is presented:	Agree with this change
		Current Wording: In the event the patient expires enroute, continue to the destination hospital Suggest removing this altogether or else moving the new "note" up to this line.	We can remove Letter G as it is now covered in the new "NOTE:" section
		Current Wording: After assessment, the medic determines that the patient's comfort needs are being met at their current location. Suggest removal of this phrase entirely. How can a medic determine if the comfort needs are being met adequately? Would prefer base contact (which is already in there)	This was added at the last revision to allow medics to leave non-transport DNR patients if POLST form is being met and staff/family agree. Would leave in.