San Francisco EMS Agency
Emergency Medical Services Advisory Committee
August 2, 2023

Public Comment – Medical Director Response

Document	Name	Organization	Section	Comment	Medical Director Response
Policy 4001a Vehicle Equipment and Supply List	Debbie Palmer	SFFD	Cardiovascular Line 55	Can the very specific requirements for the cardiac monitor be removed? These requirements are very specific for just the Zoll monitors. There are other ECG monitors out there with advancements constantly being made for the better of the patient and ease of use for the crews that include basically "See-thru CPR", it's just not delivered through the hands free pads and actually do not interfere with the LUCAS device. Other requirements in this policy don't pigeonhole equipment/supplies to just one vendor so why is it that way for the ECG monito? Please take this into serious consideration.	Reviewed. Thank you and appreciate the feedback. SFEMSA takes any and all feedback into consideration, and this suggestion is no exception. However, as a much broader discussion, we are unable to make a policy change during this revision cycle.
	KJH	SF EMSA	page 6, medication item 133	the medication name Aspirin (chewable), 81mg tablet" is missing	Agree. Will correct with the reformatting following addition of bougie.
	kayleigh hillcoat	EMSA	(multiple)	"Combat Application Tourniquets OR approved equivalent" appears in multiple sections --- "Combat Application Tourniquets" should be removed from the 'approved equivalent' list (cannot be an approved equivalent for itself)	Agree. Will correct with the reformatting following addition of bougie.
	kayleigh hillcoat	EMSA	page 6, item 108	suggest replacing zeroes with dashes for uniform document format	Agree. Will correct with the reformatting foll0wing addition of bougie

Policy 4001a Vehicle Equipment and Supply List	kayleigh hillcoat	EMSA	n/a	Intranasal Naloxone not listed as a required medication for any category. Consider adding at this or future EMSAC - particularly for BLS First Responder	Agree. Will add 2 IN dispensers of 2 mg naloxone to BLS First Responder list with the reformatting following addition of bougie.
Policy 4050 Death in Field	Young Choi	Sffd	II policy 5 a	Why do we have "30 minutes or greater" listed for drowning here but "> 25 minutes" in 3.03 near drowning	We will be changing this policy with other additions later; it is going to be pulled for now.
Policy 5000 Destination	Jeremy Lacocque	SFFD	IV. B.	Patients who are under arrest or detained and have NOT been transported to or located at county jail shall follow Adult Medical criteria should instead read "shall follow standard destination criteria non-incarcerated patients would follow." Not all people who people who are detained are adults. Not all would meet "adult medical" criteria if, for instance, they had trauma, burns, critical medical, etc.	Agree. Policy updated.
	Jeremy Lacocque	SFFD	F	I favor keeping the explaining of what "STAR" stands for in the policy because I can never remember what it stands for.	Agree. STAR is defined in section F (title).
	Jeremy Lacocque	SFFD	K	This section seems essentially copy and pasted from section B, which can be confusing and leaves room for error if things change down the road. Is psychiatric even considered specialty if every hospital in SF can care for them? I would consider removing this section entirely or saying "patients with psychiatric emergencies, with or without a 5150 hold, may go to any receiving facility. For those who are also is custody, please refer to Section B.	Disagree that the section shoud be removed as we hope to bring PES back on line as a destination for 911 patients. Until this occurs, will follow your suggested wording.
	kayleigh hillcoat	EMSA	Page 3, C (note: Apologies - all previous comments for	The reference in parentheses to Destination Decision section doesn't read well. Is it necessary to keep, or can we cut it? "Ambulances are not permitted to transport to a Receiving Facility while on EMS Alert except (ref. Destination Decision above section IV, A):"	Agree. Policy updated.

			'5020' are actually for '5000')		
Policy 5000 Destination	kayleigh hillcoat	emsa	5000.1 Footnote 1 re: PES	update section in parentheses - it's Section VI now, instead of Section V	Agree. Will update both as admin updates for October 1 Policy release.
	kayleigh hillcoat	EMSA	n/a	Update 5000.1 move both TAD locations to bottom of the chart, clearly listing them as Alternate Destinations.	Agree. Will update both as admin updates for October 1 Policy release since this is formatting.
	Ray Ryan	SFFD	IV(B)	1. New subsections below IV(B) be relabeled from "a." and "b." to "1." and "2." respectively to maintain consistency with document's format. 2. IV(B)(a)/(b) do not match the distinctions of who must be transported to ZSFG as (a) lists more than just a call originating from county jail. Suggest leaving (a) as is and replacing the first sentence of (b) with the following or similar: Patients who are in Law Enforcement Custody who do not meet the conditions as described in previous subsection shall follow Adult Medical criteria, which allows for transport to any Receiving Hospital and is subject to Diversion and EMS Alert. 3. What if they request Kaiser South or Seton? Will SFPD be willing or allowed to accompany patients to those destinations? 4. To clarify, do the parking lots and jail cells of police stations count as the described locations in IV(B)(a)?	Agree. Policy updated. Agree. Policy updated. To point #3 it's the Law Enforcement (LE) officer, not the patient, who determines hospital destination within the parameters of P5000. I do not know of instances where SF LE officers have requested to go out of county with their patients. Please submit an exception report if this happens and we will pursue with SF LE. #4 – No, the issue is for incarcerated patients under Jail Health scope and services.

				5. Are the receiving hospitals aware of the pending increased need for chairs? (See ZSFG hallways) 6. Kind of off topic but just wanted to reemphasize that a base contact for a patient in custody is not necessarily an AMA refusal. This change proposed to 5000 in how custody patients are transported may result in more non transports and by extension more base physicians asking if I've advised the patient of the risk of death or permanent disability to a patient not remotely meeting AMA criteria. Maybe for another day add "PDT" in front of the lonely "refusals" to 4040(A)(1) where it says "including refusals and AMA refusals".	#5 – SFEMSA has sought pre-public comment feedback from hospital via APOT/Diversion Workgroup and several SF law enforcement agencies. #6 – Thanks for your feedback. We can certainly review this suggestion for future policy revision.
Policy 5020 Diversion	kayleigh hillcoat	emsa	Page 2, B, a.	Minor grammatical edits. Replace this: "All patients who are IN incarcerated (e.g., inmate from county jail or to/from court hearing) or ___ law enforcement custody" with: "All patients who are incarcerated (e.g., inmate from county jail or to/from court hearing) or in law enforcement custody"	Agree. Revised policy.
	kayleigh hillcoat	emsa	Page 2, D	hyperlink Policy 4030	Agree. Will do for final document.
	kayleigh hillcoat	EMSA	Page 3, B	hyperlink Policy 5020	Agree. Will do for final document.
Protocol 13.1 Atropine Sulfate	Jeremy Lacocque	SFFD	Adult dose/route	Formatting issues "every5min" Also, I believe the "1mg" is a change from 0.5, but it isn't highlighted here. Also, did we update policy 2.07? It still mentions morphine and dopamine and includes the SBP >90 criterion for versed.	Agree, will improve formatting as suggested. Policy 2.07 is scheduled to be updated on 10/1/23 with the medication changes you specify.

Protocol 13.1 Diphenhydramine (Benadryl)	Jeremy Lacocque	SFFD	Dosing	I'm unfamiliar with reasoning behind "IM preferred." Is that to avoid delay in getting an IV? I'm asking because if the patient already has an IV, I think I would prefer giving it through that than IM (which is more painful) unless there is a clear clinical benefit	Agree, will change language to be neutral between IM and IV.
Protocol 13.1 Ondansetron (Zofran)	Jeremy Lacocque	SFFD	Pediatric dose, route	Amend dosing to align with hospital based practice. Use of ondansetron ODT is preferred for children over IV given opportunity to avoid IV placement and potential pain and delays associated with it. For patients greater than or equal to 8kg and less than 15 kg, give 2mg ODT (half tab). For patients greater than or equal to 15kg, give 4mg ODT. Reference: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3077311/ For patients < 8kg, defer ondansetron until evaluated by physician. (Usually better to go liquid formulation which can be given in hospital setting. Not recommended to give ondansetron for < 6 months of age.	Agree. Will add ODT as an option and reflect this dosing regimen.
	Rajesh Daftary	UCSF	Pediatric dose/route	Why is PO not a route of administration when it is the preferred method in and out of hospital	Agree. See note above.
Protocol 13.1 Oxygen (O2)	Jeremy Lacocque	SFFD	Dose/route	I would change the word "hyperoxygenation" to "apneic oxygenation" or "passive oxygenation". The idea isn't to hyperoxygenate the patient, the idea is to fill their dead space with oxygen-rice air to help prevent hypoxia and maintain their oxygenation. Also, while I support this clinically, it does have significant operational consequences. Crews will need multiple oxygen tanks, and with one going 15lpm for a BVM and another 15lpm for a NC,	Agree. Will change term to apneic oxygenation and will indicate that it should be performed when two oxygen sources are easily available.

				they may end up depleting them quickly. I ask that we weigh the potential clinical benefit with the operational stress it causes (and potentially running out of oxygen during egress). It could be an option as opposed to a requirement during intubation.	
Protocol 2.04 Cardiac Arrest	Jeremy Lacocque	SFFD	Hypoglycemia	I believe this is new but it is not highlighted as a change. Also, the formatting is incorrect.	Agree. Have corrected.
	Jeremy Lacocque	SFFD	LVAD Section	Here, it says do not do chest compressions. I thought we had decided we SHOULD do chest compressions and we had already changed that?	Agree, and the LVAD section now reads to follow ACLS guidelines which include chest compressions for LVAD patients.
Protocol 2.08 Dysrhythmia: Tachycardia	Jeremy Lacocque	SFFD	Unstable	I thought we decided to get rid of the SBP>90 part? The idea being if someone is awake with an SBP of 80 with V tach, I would still advocate to sedate them with versed knowing I would hopefully be addressing the underlying cause of their hypotension by shocking them	Agree. Will change wording to reflect use of cardioversion/defibrillation for unstable patients.
Protocol 7.02 Oral Endotracheal Intubation	Jeremy Lacocque	SFFD	10 & 17	10) My understanding is: high-flow nasal canula is meant to be used as apneic oxygenation DURING intubation. Between attempts, a BVM should be used with supplemental oxygen. 17) I'd say difficulty visualizing the cords is one indication for a bougie, but not the only one. I think it's also reasonable to use it on the initial attempt. So, perhaps "consider using a gum elastic bougie for difficult airways."	Disagree. High flow NC O2 should be used for intubations whenever possible with or without BVM to maintain maximum oxygenation. Agree with proposed bougie language. Will change.
	Rajesh Daftary	UCSF	Procedure	While adding a bougie as a adjunct may help pass an ETT if cords are visualized, I would advise against using it to intubate by "feel" if the cords cannot be visualized and instead resort to an LMA or similar airway adjunct. Blind intubation carries high risk with little benefit over an LMA.	Agree that this risk needs to be emphasized in training . Will plan to generalize language as listed in above comment.