San Francisco EMS Agency
Emergency Medical Services Advisory Committee
January 31, 2024

Public Comment – Medical Director Response

Document	Name	Organization	Section	Comment	Medical Director Response
Policy 2000 Prehospital Personnel Standards and Scope of Practice	Jeremy Lacocque	SFFD	VII, 4c	"via direct or video laryngoscopy" would be the more standard language. Both are "visual" What will provider agencies do to help ensure EMTs drawing up epi is done safely and effectively? Epi is not given often, and meds are otherwise never drawn up by EMTs... so I'm concerned this is a skill that would require a lot of skills maintenance to be done safely.	Agree. Will change language Provider Agencies will have to provide a standardized training (materials supplied by the EMS Agency) and PMD's will have to certify that individual providers have passed the training and are qualified to perform draw up and administer epi. This skill is optional for EMS providers to adopt.
Policy 2041 EMT Optional Skills	Jeremy Lacocque	SFFD	VIII A 1 a	I thought suboxone was standard scope now?	Correct-Suboxone is a local optional scope of practice.
Policy 4000.1 Ambulance Turnaround Time Standard	Jeremy Lacocque	SFFD	VI: A c i	I would consider removing "18 years or older" especially if a guardian is present. If a 16 year old sprains an ankle and has a parent with them, I would argue they're safer than an adult who is by themselves. Perhaps changing the language to "patient is 18 years or older, or has a guardian present with them." Typo: table vital signs instead of stable Section iii: A&Ox4 and I would add: and has capacity	I agree if we add the language about the guardian that you suggest. Agree to both suggested changes.

				Maybe add another criterion: x. any other patient hospital staff deem appropriate for the waiting room. (in other words, maybe the patient doesn't meet criteria because it's level 10 (and not level 5) but the charge RN says it's okay for them to go to the waiting room. I would want our providers to know that's okay and they should document. Section F b - "burn bypass" is mentioned. What does that refer to? I haven't heard that phrase used elsewhere in EMS policy.	Agree if you think this clarification would help. The crews can do this currently (for many years during my ride alongs patients were directed from ambulance gurneys to the waiting rooms at SFH and SMH). Good point. We don't have an official policy on burn bypass. I will refer to the TSAC for development as all single-source specialty centers need disaster contingencies.
Policy 4001a Minimum Equipment Requirements for First Responder Ambulances	Jeremy Lacocque	SFFD		Maybe I'm missing it, but I see "naloxone IV" but not IN. (I know this isn't a change, but just happened to notice.) How come epi auto-injectors are optional for EMTs? I think BLS units (such as engines/ambulances) should have some sort of epi, whether it's draw up or auto injector. Anaphylaxis is a time-sensitive, life threatening condition, so I think it should be a required medication. I don't see the "effective" date updated, and I also don't see the "backup" section listed anywhere.	Agree, all reference to naloxone should include any method of administration. We will clarify that epi is a required medication for any BLS unit. Back up list readded
Protocol 2.09 Pain Control	Jeremy Lacocque	SFFD		I don't think the first step in the pain protocol should be an IV when we have PO and IN options for pain control. Confusing that "severity" points to "N/V" section. I made comments in other sections that would apply here - like ketorolac is not a bolus but rather IVP. I also think it's appropriate for more severe pain - than just 1-3. Ketamine dose/route could be modified and also	Agree. Will reverse the order of the 1st box (Manage Pain. Manage N/V, then "If needed, start an IV with Normal Saline) Good point. Will change flow to: N/V? Yes, then ondansetron and then on to severity. No, then go directly to severity. The concept of push vs. bolus for IV medications is important and needs to be standardized. Will plan to use "push" for all meds to indicate method of

				could/should be used for severe pain as well. I don't think there's any evidence to suggest it's less effective for severe pain than fentanyl is. Why does the protocol mention lorazepam for cardioversion? Should be midazolam. I would include base contact for repeat doses of ketamine as well. Similar to my other comments, I would advocate for removing morphine. We don't mention ativan in places where we mention versed, we don't mention dopamine where we mention epi drips. We should just have a section that describes back ups and have it be separate so it's not confusing.	delivery and reserve "bolus" for IV fluid replacement. I agree. I would like to give providers flexibility in pain management. Will plan to keep pain score elements in algorithm, but add to the notes section: "Use of non-narcotic pain medications is preferred at all levels of pain. Ketorolac may be given sequentially with either Ketamine or Fentanyl as a secondary medication. Ketamine should not be combined with Fentanyl" Agree, will change lorazepam to midazolam and include BH contact for repeat doses of ketamine.
Protocol 2.09 Pain Control	Jenni Wiebers	SFFD		Consider Lorazepam for premedication before cardioversion, external pacing, and other painful procedures. Lorazepam Dose: 2mg slow push IV/IO/IM Consider changing language to Versed on algorithm, as providers only administer Lorazepam in case of a Versed Shortage. Same for the bottom when "consider lorazepam for external pacing..." Consider adding language with Ketorolac about IV/IO being preferred route on algorithm.	

Protocol 4.01 General Trauma Evaluation and Overview	Jeremy Lacocque	SFFD		"taped on 3 sides" is not applicable to the chest seals SFFD carries. Maybe just say "apply occlusive dressing" and leave it to provider training to describe how it's done. The ibuprofen dose here is different than the one on the med sheet (600mg) Why is ketorolac listed as "bolus"? Isn't it IV push? I don't agree with pain/nausea in an unstable patient needing base contact. Base contact is not listed in other protocols for hypotensive patients and is not listed on the medication pages. Providers already know not to give NSAIDs in significant trauma, and to not give fentanyl if the patient is hypotensive. Ketamine should be safe regardless of BP. I also wouldn't want providers to be on the phone while caring for an unstable trauma patient. The dose of zofran is wrong - should be 4mg ODT PO Being unstable should not preclude administration of zofran. I would just make an arrow from normal saline back up to stable? And if no, more fluid, if yes, move to pain/nausea. Also, the fentanyl med page says hypotension is a contraindication, whereas this flowchart says "SBP <90." I see SBP mentioned in repeat doses, but not initial dose. I also respectfully disagree with including the morphine box. It will so rarely (if ever) be used, it just adds clutter. Instead, we can just say on the morphine med page it's there as a backup, or	Agree. Ibuprofen should be the same dose for all adults (prefer 600 mg in med sheet) See my comments above. Agree—will remove BH contact here. Agree Agree Agree We should define what we mean as hypotension for all conditions. Propose SBP < 90. Should be a factor in all dosing considerations.

				include "morphine" is a hyperlink at the bottom of the fentanyl box. Maybe instead of "report formats to trauma team at ZSFG" say "to the trauma center" so include transports to Highland from the bridge or Stanford in an MCI and any future backup trauma center. Also, it's not the trauma team that gets the report, it's the ED nurse. It says to report any incident of suspected abuse to ED staff - I think it's worth emphasizing all providers, including EMS, are required to file APS/CPS reports and telling the ED is not enough.	Agree. I believe reporting to the ED staff (and documenting the name of the person that the report is given to) is considered by state law to fulfill the reporting requirement.
Protocol 4.03 Head, Neck and Facial Trauma	Jeremy Lacocque	SFFD		My comments for this are the same as for the general trauma protocol 4.01	See above
Protocol 4.04 Chest, Abdominal, and Pelvic Trauma	Jeremy Lacocque	SFFD		My comments for this are the same as for the general trauma protocol 4.01. Maybe make all these trauma protocols one, with a subsection for head/abdomen/extremity since they're 90% the same?	See above. Open to combining in a future protocol review process.
Protocol 4.05 Extremity Trauma	Jeremy Lacocque	SFFD		Instead of saying "during a mass casualty" I would say "when holding direct pressure is not practical" for instance, during an MCI, during patient movement, when scene is unsafe, etc There is no arrow leading to "bleeding controlled" "Do not remove tourniquet without physician	Agree Agree Agree, will change to “Base Contact”

				approval" - I would consider removing this. If police place one above a GSW to the ankle, I don't think it would be unreasonable to remove it to assess the limb after the scene is safe, etc. If this is kept in the protocol, I would change it to "base contact" not "physician."	
				For the AV fistula box: I might change the title to "hemodialysis fistula" to be clear. Also, I might say "direct pressure to the bleeding site with a gloved hand." I see too often providers (including hospital providers) wrap it with gauze, etc. Usually a single finger being placed on the tiny hole (where the access site was for HD) of bleeding is sufficient.	Agree
				Can you clarify direct pressure proximal/distal to site? Usually the direct pressure should be placed directly on the bleeding. When it comes to the tourniquet, however, some people advocate for placement of one above and one below the fistula because of the high-pressure vessels coming from both directions in a fistula.	I think both pressure on and pressure above and below are clear here. Recommend covering this in training, e.g. start with direct pressure on site, then progress to above then below then tourniquet above then tourniquet above and below.
				I would delete "life-threatening". I would consider uncontrolled bleeding from a fistula to be life threatening.	Agree
				What does the * refer to? Again, I would advocate for removing base hospital contact. Zofran can be given regardless of BP. If SBP <90, I don't think a medic or base physician would agree to give it. The ALS portion mentions morphine and not fentanyl. Is there a way for the EMSA to search all protocols to look for things like this, so they're not missed? Also,	The section on cautions about considering the effect of permanent damage to the AV fistula by tourniquet use. Open to other ideas on a way to indicate this. Agree, will remove BH contact. Thanks for pointing this out, will change to fentanyl. Agree

				Maybe instead of "report formats to trauma team at ZSFG" say "to the trauma center" so include transports to Highland from the bridge or Stanford in an MCI and any future backup trauma center. Also, it's not the trauma team that gets the report, it's the ED nurse. ALS tx section says :fluids bolus IV/IO at TKO. I would suggest "bolus" and not TKO if a patient is hypotensive. I would also advocate to change "head injury" as a contraindication to fentanyl. I think "Significant head injury with AMS" would be reasonable. If someone is GCS 15 with an abrasion but has a femur fracture, I wouldn't want to exclude them for getting pain meds.	Agree Agree. Will change to “significant head injury with AMS”
Protocol 4.05 Extremity Trauma	Jenni Wiebers	SFFD	ALS section of algorithm:	Consider removing Morphine language and adding Fentanyl	Agree
Protocol 4.06-Burns	Jeremy Lacocque	SFFD		Electrical burns - I don't think the all caps/red is necessary. No other protocol has language like that. I also have the same comments as before about the medications. For chemical burns - it says "do not apply water." I was under the impression we treated dry chemical burns with dry decon (brushing it off) and wet chemicals by flushing with water? For base contact - maybe just say "if maximum dose of pain medication is reached and addition pain management is required" so that way you	Agree See prior comments Good point. We will add “do not apply water—consider base contact” and will add a line to base contact (see comment below) I agree. Will add the statement “For chemical burns, consider contacting base hospital or

				don't have to list all of our past/current/future meds available.	California Poison Control Center for field decontamination direction.”
Protocol 8.03 Pediatric Bradycardia	Jeremy Lacocque	SFFD		Shout out to Gino for his hard work on this. Under H's&T's, ALL of these are possible causes. So, I would say "most common" instead. Also, instead of saying "administer appropriate medication/electrical therapy" maybe just have an arrow that points to the box on the left that describes them.	Thank you Agree Agree
Procedure 7.18 TCP	Jeremy Lacocque	SFFD		Shout out to Dr Friend for a great protocol! Under indications for peds: persistent symptomatic bradycardia, refractory to medications	Thank you Agree
Medication 14.1 Ibuprofen	Jeremy Lacocque	SFFD		Usually the max pediatric dose is the adult dose. I would therefore recommend changing max peds dose to 600 to accommodate our adult-sized pediatric patients. Also, I don't believe "aspirin" should be a contraindication to a single dose of ibuprofen. A lot of folks are on daily aspirin and I think giving them one dose of ibuprofen for their wrist sprain is appropriate.	Agree Disagree, due to the potential of asa/nsaid interactions. For mild pain in such cases (until we can offer acetaminophen) would recommend non-medical treatments such as ice/immobilization.
Medication 14.1 Ketamine	Jeremy Lacocque	SFFD		I would change the indication to "where ketorolac, ibuprofen or BLS measures may be insufficient in controlling pain." otherwise it sounds like ketorolac and ibuprofen need to be given before ketamine is considered.	Agree

				This protocol lists the 0.25mg/kg IV/IO. I would add 0.5mg/kg for IN.	Agree
				I would remove IM, as there isn't much evidence to support IM dosing for pain (just double checked with 2 ED pharmacists Helen and Joyce). I would also add "under 3 years of age" as a contraindication, although some literature supports 3 months.	Agree—would keep the 3 years of age as the minimum age for use.
				I would also allow repeat dosing every 20 minutes, up to 2 doses.	Agree
				https://www.ashp.org/-/media/assets/policy-guidelines/docs/endorsed-documents/endorsed-documents-ketamine-use-In-prehospital-and-hospital-treatment.pdf	
				As the statement above references, I don't think we need to have fentanyl as a contraindication. I think it would be reasonable to give fentanyl, realize it's not enough, and then give ketamine after. Benzo's, however, seem dangerous, so I would add "benzodiazepines" as a contraindication.	I would prefer not to start using ketamine in addition to opiate pain medication. So disagree to remove fentanyl as a contraindication (for now) but agree with adding benzodiazepines as a contraindication.
				Under contraindications, I would specifically mention "laryngospasm" because it presents differently than say, apnea would from respiratory depression with fentanyl.	Agree
				The reference above, among others, also mentions it's safe to give ketamine even with a history of schizophrenia.	Agree

Medication 14.1 Ketamine	Jenni Wiebers	SFFD	Contra-indications	Consider adding head trauma	Ketamine is no longer considered contraindicated in head trauma but will add head trauma with AMS is a contraindication to both ketamine and opiate pain medcation.