

Date: January 1, 2016

To: MCB Physicians

From: Jeffrey M. Goodloe, MD, NRP, FACEP  
Medical Director

Re: 2016 Protocol Set Recommended Changes

In another year's sincere effort to make first of year protocol change deliberations as efficient as possible for the MCB meeting this month, I am summarizing the changes I recommend to the current protocol set. We will ensure all formatting/editing throughout the protocol set will reflect these changes by the end of January month to allow our partner agencies time to train on these changes in February and March, with an effective date of April 1, 2016, as we did last year and in accordance with the usual and customary timeframe from MCB action to effective dating for standard of care changes in the protocols. I have personally reviewed each and every protocol in this process.

Here are the recommended changes:

1. **Oxygenation during oral intubation via nasal cannula high flow at 15 lpm for all pulsatile adult patients.** The benefit of this procedure, well established in the medical literature now and commonplace in our metro EDs is to minimize any intra-intubation desaturation. This is reflected in a direction in **Protocol 2F – Oral Intubation.**
2. **Changing defibrillator pad placement from apex/sternum to anterior/posterior for all defibrillations.** The benefit of this change is to deliver more effective energy during defibrillations. With an ever increasing obesity co-morbidity and refractory VF for other reasons, a physical change in pad placement will help the effectiveness of defibrillation therapy. This is reflected in directions in **Protocols 4A – Resuscitation; 4B – Resuscitation Team Roles; 4C – AED; 4D – Manual Defibrillation; 4E – Double Sequential External Defibrillation (new recommended protocol).**
3. **Changing defibrillator energy strategies with wt basis. If greater than or equal to estimated wt of 100kg, initial three defibrillations all at 360J biphasic. If less than estimated wt of 100kg, retain current escalating energy strategy of 200J/300J/360J biphasic, with fourth and subsequent defibrillations for all adults utilizing doubles sequential external defibrillation when 2 monitor/defibs are available as outlined in Protocol 4E (below).** The benefit of this change is to deliver more effective energy during defibrillations. With an ever increasing obesity co-morbidity and refractory VF for other reasons, a physical change in energy strategies will help the effectiveness of defibrillation therapy. This is reflected in directions in **Protocols 4E – Double Sequential External Defibrillation (new recommended protocol) and 4G – VF/Pulseless VT.**
4. As per the information I shared with you right after the November 2015 MCB meeting, **adoption of the technique of double sequential external defibrillation.** This involves 2 manual monitor/defibrillators present, which is expected to be available on scene with EMSA and Fire Paramedic Response (Sand Springs does have LP15s with Intermediate/Advanced EMTs as well). This will not be available with EMSA and Fire BLS

Response. There is not any expectation of EMSA sending 2 ambulances for this possibility alone. In very limited situations, such EMSA response may be operationally possible and/or response of the Field Operations Supervisor. To the extent possible, OMD personnel may also be able to provide response for dual defibrillator capabilities. The benefit of this change is to deliver more effective energy during defibrillations. With an ever increasing obesity co-morbidity and refractory VF for other reasons, a physical change in energy strategies will help the effectiveness of defibrillation therapy. This is reflected in directions in **Protocols 4E – Double Sequential External Defibrillation (new recommended protocol) and 4G – VF/Pulseless VT**. This defibrillation strategy is in use and shown effective in ROSC in systems such as MedStar (Ft Worth), New Orleans EMS, and Wake County (NC) EMS.

5. **Reducing scene times and providing early radio communication in the setting of suspected sepsis.** Notes to this effect are added to the Paramedic scope of practice instructions in **Protocol 9B – Fever**.
6. **Further clarifying the continued use of the long spine backboard (spinal immobilization) in the setting of clearly evident spinal injury eg. paralysis, priapism, neurogenic shock.** A text box highlight to this effect is added to the flow algorithm in **Protocol 100a – Spinal Motion Restriction**.
7. **Updating Formulary for accuracy with treatment protocols. Changes are reflected in Protocol 16H adding D10; Protocol 16GG adding all EMS professional scopes of practice for naloxone administration; and Protocol 17K adding TXA for ages 10 and above.**
8. **Multiple “housekeeping” edits to ensure correct weblink addresses.** There are multiple protocols that direct resources available via external websites. A careful review has been made throughout the protocol set to confirm website accuracy as of Jan 1, 2016.

As with prior years starting in the 2013 protocol set, I have performed an exhaustive PubMed based literature search in the interim period since the last wholesale review of the protocol set by the MCB. We will add those relevant reference citations in the Reference Version of the protocols. For relative brevity sake, these evidence-based medicine citations are excluded from the Field Version of the protocols. Both versions will be made available to all EMS professionals in the system via the okctulomd.com website, soon with its Gen 2.0 design.