THE REGIONAL EMERGENCY MEDICAL SERVICES COUNCIL OF NEW YORK CITY, INC.

Regional Emergency Medical Advisory Committee

Minutes

November 15, 2017

The Regional Emergency Medical Advisory Committee (REMAC) of New York City met on Tuesday, November 15, 2017 at the FDNY EMS Training Academy, Fort Totten, Bldg. 405, Room 100, Queens, New York City. This meeting can be viewed via webcast at www.nycremsco.org.

Members		*Present*	*Absent*
Burn Surgeon (1)	Robert J. Winchell, MD		√
Downstate New York Ambulance Association			
Ambulance Service Medical Director (1)	Josef Schenker, MD, Chair	√	
Emergency Medical Technicians (Basic/Paramedic) (2)	Michael Vatch, EMTP Robert Ackerman, Alt		
	Vacant vacant, alt		
EMS Community Emergency Department			
Medical Directors (3)	Nikolaos Alexandrou, MD	√	
	Christopher Graziano, MD	√	
	Vacant		
Nurses (2)	Eric Cohen, RN		√
	Mimi Langsam, RN	√	
Administrators (2)	Kevin Munjal, MD		√
	Cindy Baseluos, MD	√	
FDNY EMS			
Commissioner or Non-Physician Designee	Vacant		
Medical Director (3)	Dario Gonzalez, MD		√
	Glenn Asaeda, MD	√	
	Bradley Kaufman, MD, 2nd Vice Chair		√
Online Medical Control Physicians (2)	Doug Isaacs, MD		√
	Nathan Reisman, MD	√	
Emergency Medical Technicians (Basic/Paramedic) (2)	Telina Lloyd, EMTP	√	
	Samuel Jimenez, EMTP	√	
Greater New York Hospital Association			
President or Non-Physician Designee (1)	Alison Burke	√	
Emergency Physician (1)	Jeffrey Rabrich, MD, 1st Vice Chair	√	
Ambulance Service Medical Director (1)	Heidi Cordi, MD	√	

THE REGIONAL EMERGENCY MEDICAL SERVICES COUNCIL OF NEW YORK CITY, INC.

On Line Medical Control Physicians (2)	Lewis Marshall, JD, MD	√	
	Michael Redlener, MD		√
Emergency Department Administrator (2)	Michael Guttenberg, DO	√	
	Pamela Lai, MD	√	
Emergency Medical Technicians (Basic/Paramedic) (2)	Dominick Battinelli, EMTP		√
	Scott Chiang, EMTP	√	
Medical Society of New York Physician (1)	Peter Wyer, MD		√
Medical Standards Committee			
ALS Physician (1)	Paul Barbara, MD	√	
BLS Physician (1)	David Ben-Eli, MD	√	
New York City Department of Health & Mental Hygiene-Emergency Preparedness Program Physician (1)	Celia Quinn, MD, MPH		√
New York City Health & Hospitals Corporation Physician (1)	Vacant		√
New York City Police Department Physician (1)	Charles Martinez, MD	√	
NYS Volunteer Ambulance & Rescue Association/District 4 & 18			
Ambulance Service Medical Director (1)	Joseph Bove, MD		√
Emergency Medical Technicians (Basic/Paramedic) (2)	Martin Grillo, EMTP		√
	Vacant		√
Pediatric Emergency Medicine Physician (1)	Vacant		
	Stephen Blumberg, MD, alternate		√
Psychiatric Emergency Medicine Physician (1)	William Fisher, MD	√	
Regional EMS Council NYC Physician (1)	Robert Crupi, MD		√
Training & Education Committee Physician (1)	Jessica van Voorhees, MD	√	
Trauma Surgeon (1)	Arthur Cooper, MD		√
	Gary Marshall, MD, alternate		
Non-Voting Members			
At Large	Yedidyah Langsam, PhD, EMTP	√	
At Large	Vacant		
Public	Christopher Sorrentino, RN		√

THE REGIONAL EMERGENCY MEDICAL SERVICES COUNCIL OF NEW YORK CITY, INC.

STAFF: Nancy Benedetto, Executive Director Administration
Marie Diglio, Executive Director Operations
Joseph Raneri, Disaster Preparedness Coordinator

GUESTS: Rich Menalk, MD, FDNY
Jason Zimmerman, DO, Maimonides Medical Center / InstaCare

Dr. Josef Schenker, Chair, called the meeting to order. For the purposes of web casting, a roll call was performed. A quorum was present. The Minutes of the September 27, 2016 REMAC Meeting were unanimously approved.

Voting Requirements. A quorum is based on the number of voting seats – whether they are filled or vacant. Currently, REMAC has 30 voting seats, so when voting, a majority of members must vote in the affirmative to pass any motion. That means, 16 votes in the affirmative are needed to pass any motion.

Dr. Schenker took the agenda out of order to discuss the status of the NYPH Mobile Stroke Unit. After the September REMAC meeting, the REMAC Executive Committee discussed the proposed mobile stroke unit with NYS DOH and FDNY. NYS DOH stated that NYPH's proposal was valid, and not a demonstration project. No standard of care was being affected. NYPH met all requirements of REMAC: Physician OLMC credentials were completed prior to operationalizing the MSU; QA is being submitted to REMAC and FDNY; paramedics are operating within their scope of practice. Based on these discussions, and a valid vote by REMAC, the pilot was supported.

CORRESPONDENCE REPORT

The Offices of the Council received the following correspondence:

- Membership:
  - Celia Quinn, MD, NYC DOHMH requests appointment of Timothy Styles, MD as her REMAC alternate.
  - Bradley Kaufman, MD, nominates Matthew Isaac Harris, MD, for the vacant Pediatric Physician seat. Dr. Harris' CV was submitted.
  - Anthony Shallash, MD, requests appointment to a vacant At Large seat. His resume was submitted.

REMAC approved all nominations. These will be forwarded to REMSCO for approval.

- From NYS DOH:
  - Public Notice from New York State Department of Health, Bureau of EMS, Operations Unit, to be read into the REMAC Minutes of the following enforcement actions:

Provider /Agency Name	EMT / Agency #	Penalty	Violation	County of Residence
John Hughey	307098	Certification Revoked, $5000 fine.	800.16(a)(1) and 800.16(a)(4)	Depew
Ali Fattah	400015	Suspended effective 11/8/16, $2000 fine	800.16(4) and 800.3(ap)	Brooklyn

- FDNY EMS:
  - CFR Demonstration Project
- Epi-Pen Auto Injector Applications received from:
  - None

The Office of the Council sent the following correspondence:

- Agendas, Minutes and associated attachments for the meeting.
- Letter to NYPH approving Mobile Stroke Unit Initiative.

SUBCOMMITTEE REPORTS

Medical Standards Committee *(David Ben-Eli, MD, Chair, Paul Barbara, MD, Vice-Chair)*

Dr. Ben-Eli presented the following seconded motions for discussion and vote:

STEMI Advisory This advisory was revised to remove FDNY as the primary agency responsible for transportations. These responsibilities belong to contracted private ambulance agencies. These types of transports are part of interfacility protocols.

The Protocol Committee recommends removing reference to "segments", and use the term "Rescue" to identify the transport of STEMI patients directly to Cath Lab. The terms "Acute Transport" and "Critical Transport" must be defined. Protocol also recommended that the completed STEMI Advisory be sent to AHA Mission Lifeline. AHA will be asked to provide REMAC with data. There must be a robust QA Component if a hospital must use a 911 ambulance for this type of transport. *Unanimously approved by REMAC.*

Non-Solicited Medical Intervention: Language that was previously revised will be placed into the GOP. There are still many issues with this language. Dr. Zimmerman will continue revision and present to Protocol Committee. *Unanimously approved by REMAC.*

Norepinephrine was added as an option to ALS Protocols 500A, 500B, 504A, and 510. This is an alternate to dopamine. *Unanimously approved by REMAC.*

Norepinephrine will be added as an 'if available' medical control option to the ALS Sepsis Protocol. A second IV will be mandatory. *Unanimously approved by REMAC.*

530 Excited Delirium Protocol: the mandatory QA component requiring every administration of standing order midazolam be reviewed and submitted to REMAC for regional QA, was recommended for removal. This has been ongoing for 1 ½ years. *Unanimously approved by REMAC.*

BLS Glucometer use and finger stick

- The use of Finger Stick Blood Glucose (FSBG) in Protocol 556 – Pediatric AMS was discussed.
- Protocol recommended that the same wording for FSBG in Protocol 557 would be utilized in ALS Protocols 556 and 530.
- NYS DOH BLS protocol language should be used for consistency: *"Diabetics may exhibit signs of hypoglycemia with a blood sugar between 60-80mg/dl. If suspected, treat accordingly."*
- Protocol also recommended that the BG level would be lowered from 120 to 60.
- The following is the Note from ALS protocol 557, showing Proposed changes:
  NOTE: A glucometer should be used to document blood glucose level prior to administration of Dextrose or Glucagon. If the glucometer reading is above ~~120~~ 60 mg/dl, Dextrose and Glucagon should be withheld.

- BLS Glucometry (BLS Protocols 411 and 413) recommended as an, 'if available' option.

  Unanimously approved by REMAC.

Update ALS Protocol 511 AMS to be in-line with protocols 311 and 411:

- 5. If an overdose is strongly suspected, and the patient's respiratory rate is less than 10/minute ~~the patient's mental status fails to improve significantly~~, administer Naloxone, titrate in increments of 0.5 mg up to response, up to 4 mg, IV/IO/IN/IM.
  Unanimously approved by REMAC.

The next meeting of the Protocol Committee will be on Friday, December 9 at 12 noon, at NY Methodist Hospital.

The C&C Committee continues to work on exam questions. Exam validation is being postponed. The REMAC wanted to validate test questions, not evaluate demographic data. REMAC requires continuation of item analysis of the exams. The On Line Medical Control Physician exam development will be formalized.

The next meeting of the Medical Standards Committee is scheduled for January 24, 2017.

REGIONAL COUNCIL UPDATE

- No report. The next meeting will be held on November 29, 2016.

JOINT REMSCO/REMAC QA COMMITTEE UPDATE *(JOSEPH SCHENKER, MD, CHAIR)*

The Joint Regional Emergency Medical Services Council/Regional Emergency Medical Advisory Committee (REMAC) Quality Improvement Committee met on Wednesday, October 26, 2016. The following is a summary:

QA Studies:

- ALS 513: Seizures (Administration of SO Midazolam): *QA Committee members stated that midazolam QA requirement ended as of July 2016. A final report should be generated so this can be closed.*
- Active QA Studies Naloxone Use by BLS data will be presented to REMAC. The amount of naloxone used, RMA's, and transports to hospitals are among the items to be reviewed.

Demonstration/Pilot Projects: A process for future proposals must be developed.

TRAUMA NOTIFICATIONS: QA recommended that the Protocol Committee develop a notification process for Trauma, Burn, etc. Develop an adult and pediatric trauma criteria and triggers for notifications.

The next QA Meeting is scheduled for Wednesday, November 30, 2016, at 3pm.

STATE EMS COUNCIL/SEMAC UPDATE *(Yedidyah Langsam, PhD)*

No report. The next SEMSCO will next meet on January 10 & 11, 2017. The meetings will remain at the Hilton Garden Inn in Troy.

UNFINISHED BUSINESS

FDNY CFR Demo Project

Dr. Glenn Asaeda presented the FDNY CFR Demo Project. FDNY requests to expand the scope of practice of CFRs (Fire Fighters on fire trucks) to include administration of albuterol, naloxone and epinephrine. Dr. Asaeda stated FDNY is considering adding skills to the CFR level so that Fire Fighters at the CFR level can provide more care. Dr. Asaeda stated that 911 call volume continues to increase; it is no greater than 4000/24 hour. The extra care would be limited to epi auto-injector for asthma and anaphylaxis, aspirin for chest pain, and nebulized albuterol. This project was discussed at the last meeting and approved in concept. Additional information including training materials for CFRs was distributed to members electronically and is attached to these Minutes. There was additional brief discussion. REMAC voted unanimously to approve the demonstration project. This will be forwarded to SEMAC/SEMSCO for approval.

NEW BUSINESS

Specialty Referral Centers were discussed. REMAC will remove Replant from the SRC list. All patients with any amputations should be transported to trauma centers.

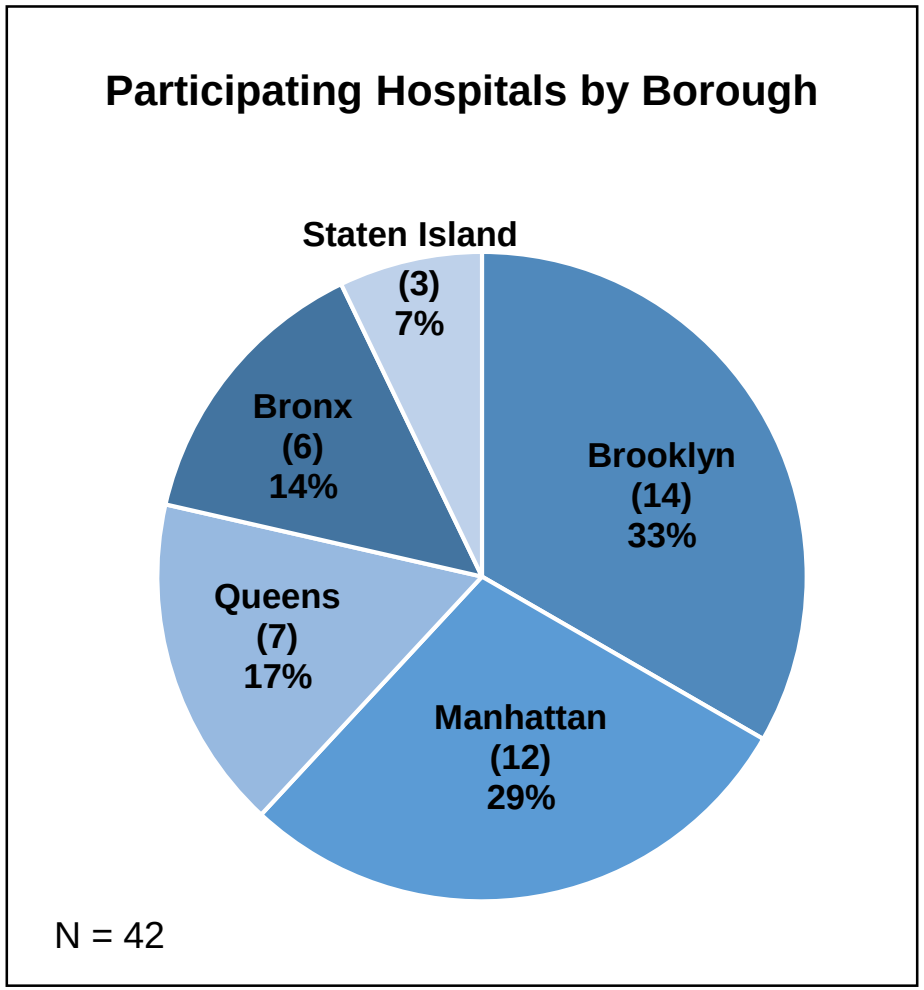
No further discussion, the meeting adjourned at 8:00 pm. The next meeting of the REMAC is scheduled for January 24, 2017.

REMAC/FDNY Severe Stroke Hospital Survey: Data Snapshot as of 11-15-2016

REMAC/FDNY Severe Stroke Hospital Survey: NYC Hospital Survey Participation

Survey Response Rate = 89%
(42/47) of NYC Hospitals completed the survey

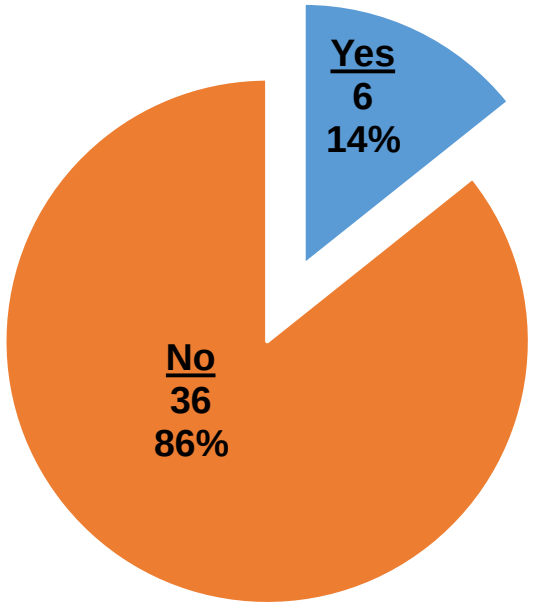
Borough	Number of Respondents	Number of Non-Respondents	Response Rate
All Boroughs	42	5	89%
Bronx	6	1	86%
Brooklyn	14	0	100%
Manhattan	12	2	86%
Queens	7	2	78%
Staten Island	3	0	100%



REMAC/FDNY Severe Stroke Hospital Survey: Comprehensive Stroke Centers

Is your hospital a Comprehensive Stroke Center (CSC)?

Yes = 14% *(6/42)*



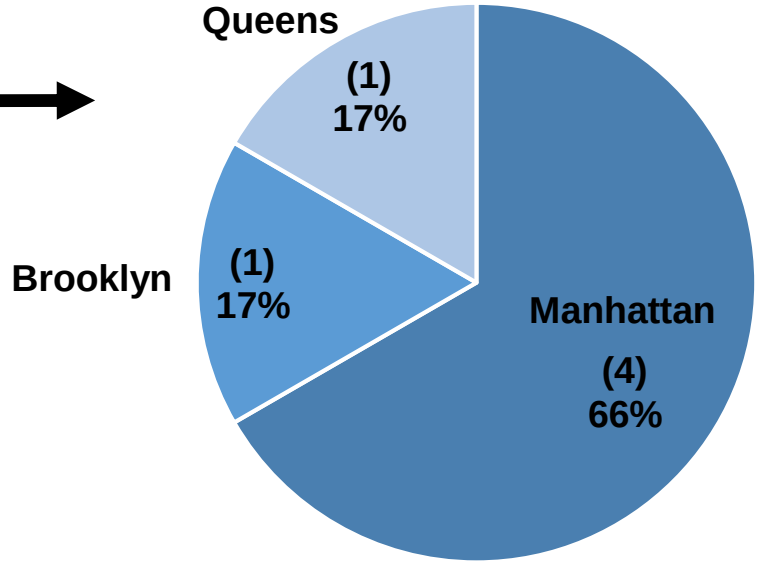
YES

**All 6 (100%) said they are certified by The Joint Commission (TJC)*

N=42

TJC CSCs by Borough

66% (4/6) of sites in Manhattan



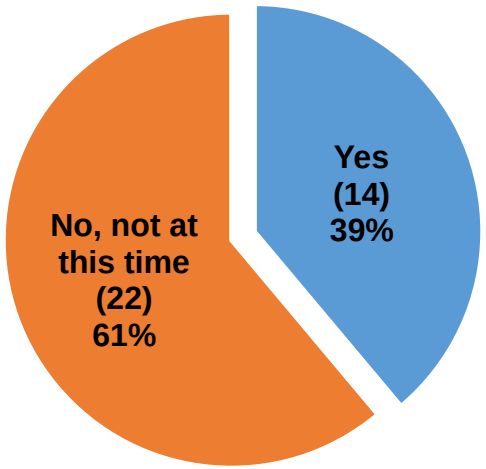
n=6

REMAC/FDNY Severe Stroke Hospital Survey: Certification Plans for Non-CSC Sites

Among non-Comprehensive Stroke Center (non-CSC) hospitals, which plan to apply for certification?

Planning to apply for CSC Certification?

Yes = 39% *(14 of 36 sites)*



n=36

YES

Breakdown of the 14 sites that plan to apply, by borough and approximate application date

Bronx

(1 of 14 hospitals = 7%)

No.	Application Date
1	Jul-17

Brooklyn

(6 of 14 hospitals = 43%)

No.	Application Date
1	Feb-17
2	Jul-17
3	Jul-17
4	Jul-17
5	Aug-17
6	Jan-18

Manhattan

(2 of 14 hospitals = 14%)

No.	Application Date
1	Sep-17
2	Nov-17

Queens

(4 of 14 hospitals = 29%)

No.	Application Date
1	Sep-17
2	Jan-18
3	Jan-18
4	Jan-18

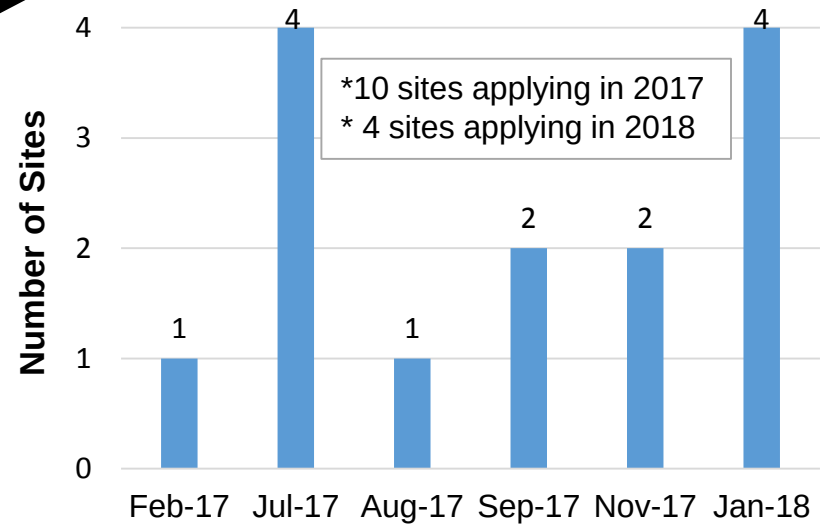
Staten Island

(1 of 14 hospitals = 7%)

No.	Application Date
1	Nov-17

n=14

Frequency of Approximate Application Dates



Which Accrediting Organization is your hospital using?

TJC: 100%*

**All 14 sites plan to apply through TJC; no other accrediting organizations indicated.*

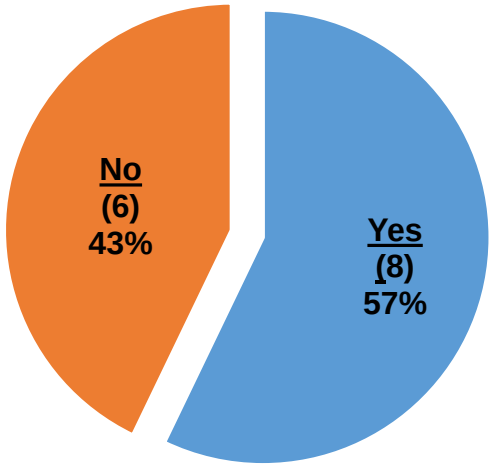
REMAC/FDNY Severe Stroke Hospital Survey: Endovascular Capabilities among Non-CSC Sites Seeking Certification

Among non-CSCs that plan to apply for certification, what are their endovascular capabilities?

1

Currently have the **ability to perform** endovascular intervention?

8 of 14 non-CSC sites planning to apply for certification have endovascular capabilities.



n=14

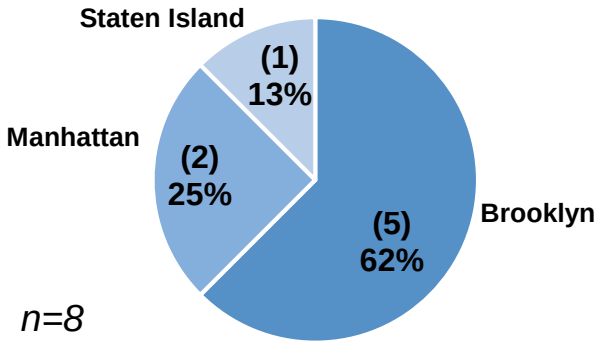
YES →

2

Currently perform endovascular intervention on a 24/7 basis?

Yes = 100% *(8 of 8 sites)*

24/7 Endovascular-Capable Sites by Borough



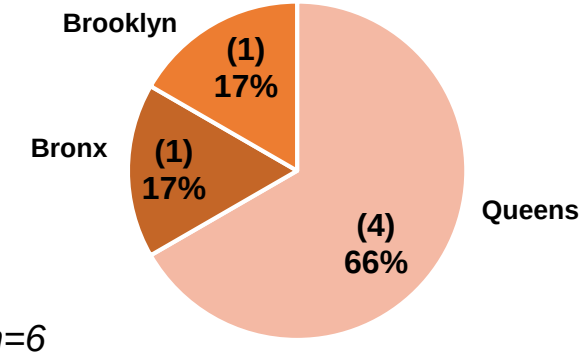
n=8

NO →

Would your hospital be willing and able to commit to performing endovascular intervention on a 24/7 basis?

Yes = 100% *(6 of 6 sites)*

Non-Endovascular Sites by Borough



n=6

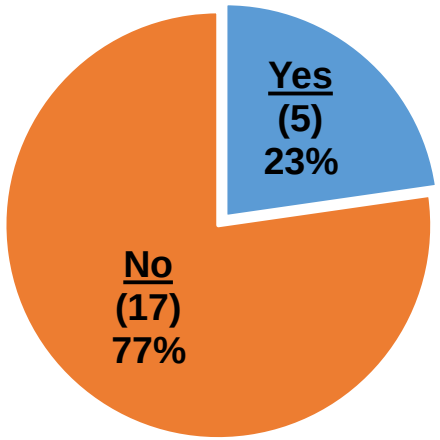
REMAC/FDNY Severe Stroke Hospital Survey: Endovascular Capabilities among Non-CSC Sites NOT Seeking Certification

Among non-CSCs that DO NOT plan to apply for certification, what are their endovascular capabilities?

1

Currently have the **ability to perform** endovascular intervention?

5 of 22 non-CSC sites that do NOT have plans to apply for certification have endovascular capabilities.



n=22

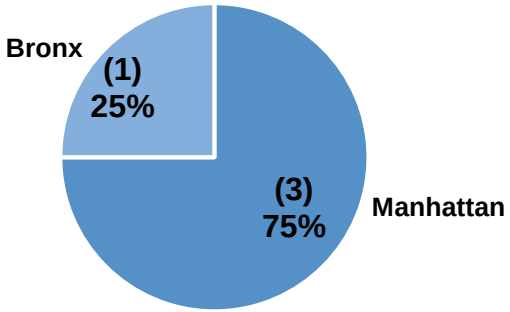
YES →

2

Currently perform endovascular intervention on a 24/7 basis?

Yes = 80% *(4 of 5 sites)*

24/7 Endovascular-Capable Sites by Borough



n=4

NO →

Would your hospital be willing and able to commit to performing endovascular intervention on a 24/7 basis?

No, not at this time = 100%
(17 of 17 sites)

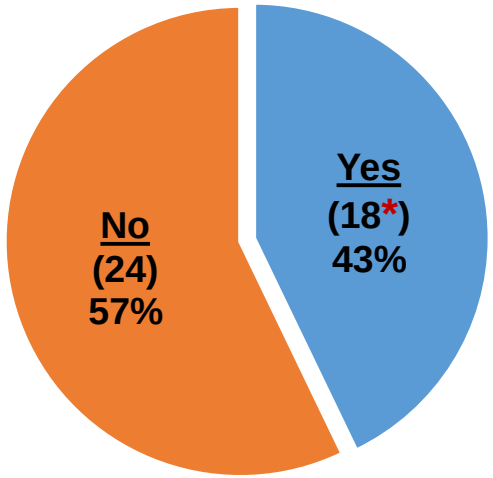
REMAC/FDNY Severe Stroke Hospital Survey: Current State of Endovascular Capabilities in New York City

Among ALL hospital survey respondents, which sites currently have 24/7 endovascular capabilities?

- YES: Currently has 24/7 endovascular intervention capabilities
- NO: Currently does NOT have 24/7 endovascular intervention capabilities

Among All Survey Respondents

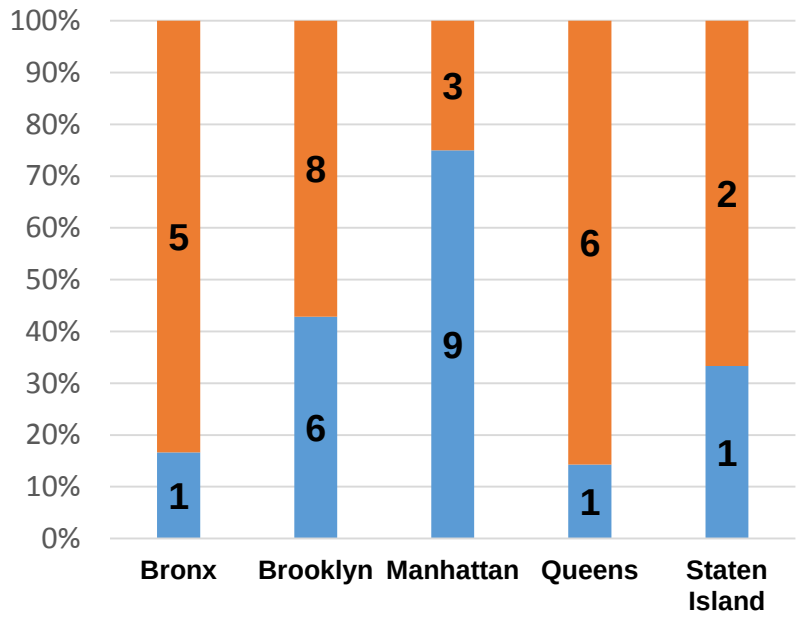
43% (18/42) of hospitals have 24/7 endovascular capabilities



N=42

***18 above sites = 6 current TJC CSCs and 12 current non-CSCs with 24/7 endovascular intervention.**

By Borough



N=42

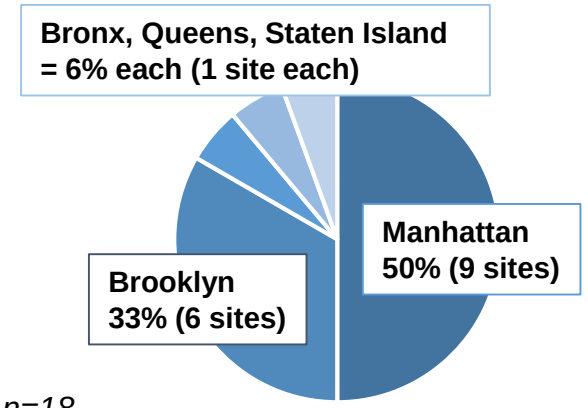
NO →

Transfer plan in place?

All hospitals without 24/7 endovascular intervention have a transfer plan in place.

YES →

24/7 Endovascular-Capable Sites by Borough



n=18

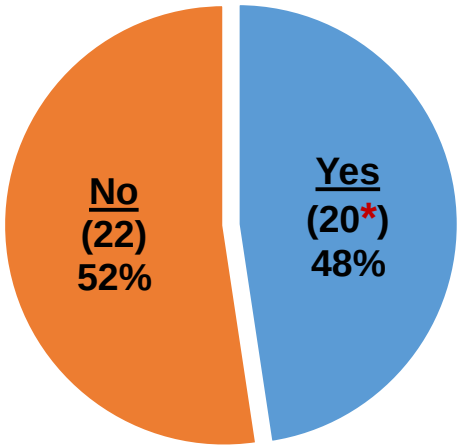
REMAC/FDNY Severe Stroke Hospital Survey: Future State of Endovascular Capabilities in New York City

Among ALL hospital respondents, which sites HAVE or PLAN TO APPLY for CSC Certification (a Certification that requires 24/7 endovascular capabilities)?

- YES: Currently HAS or PLANS TO APPLY for a CSC designation by 2018
- NO: Currently DOES NOT have and DOES NOT PLAN TO APPLY for CSC designation

Among All Survey Respondents

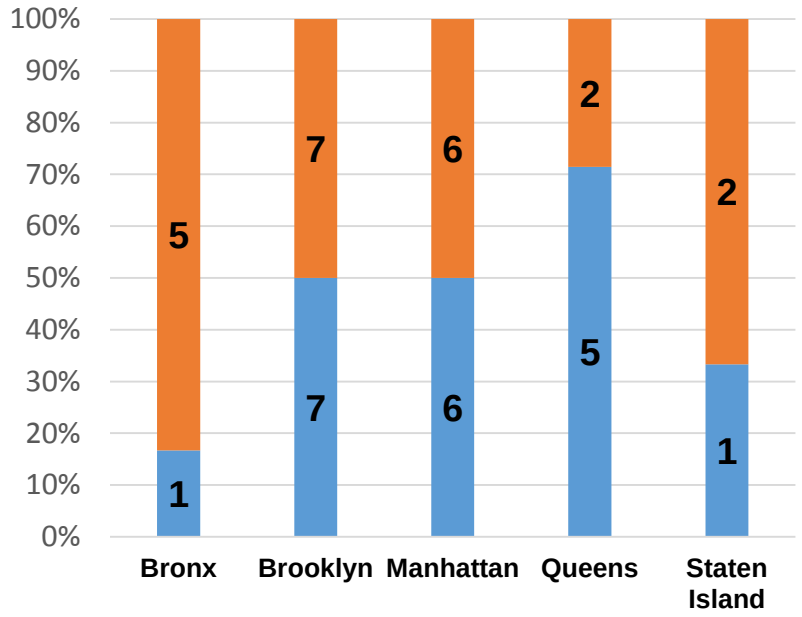
48% (20/42) of hospitals currently are CSCs or plan to apply for CSC Certification by 2018



N=42

***20 above sites = 6 current TJC CSCs and 14 current non-CSCs that plan to apply for Certification by 2018.**

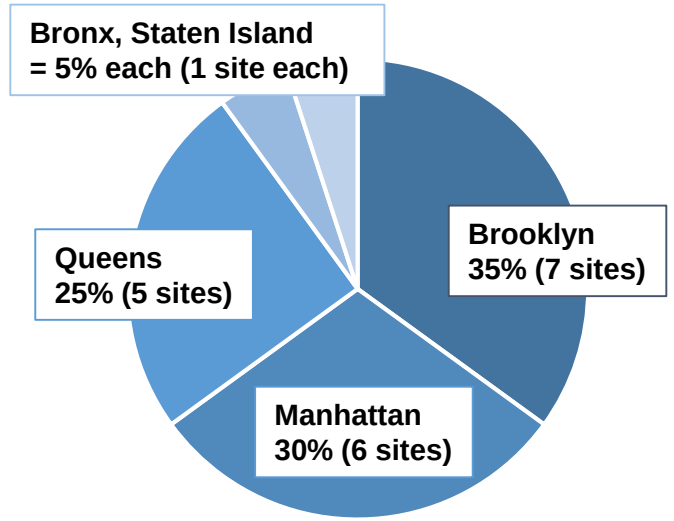
By Borough



N=42

YES

Distribution of current and expected CSC sites by borough



n=20

REMAC/FDNY Severe Stroke Hospital Survey: Summary of Findings

Summary Statistics from REMAC/FDNY Severe Stroke Hospital Survey
85% (40/47) of hospitals in NYC have completed the REMAC/FDNY Severe Stroke Survey
15% (6/40) of responding sites are Joint Commission Certified Comprehensive Stroke Centers (TJC CSCs)
41% (14/34) of non-CSC sites are planning to apply for TJC CSC Certification by Jan-2018 (6 of these sites are located in Brooklyn)
45% (18/40) of all participating sites have 24/7 endovascular capabilities (15 of these sites are located in Manhattan and Brooklyn)
57% (8/14) of non-CSCs sites planning to apply for certification have 24/7 endovascular capabilities (5 of these sites are located in Brooklyn)
20% (4/20) of non-CSC sites that do NOT have plans to apply for certification have 24/7 endovascular capabilities
All sites without 24/7 endovascular intervention have a transfer plan in place
98% (39/40) of sites are willing to share stroke patient outcome data with REMAC/FDNY for quality improvement purposes

FDNY DEMONSTRATION PROJECT FOR ADDITIONAL CFR SKILLS

Demonstration Project to Add Skills to CFRs

Introduction: Over the past year and continuing currently, NYC EMS responds to over 4,000 calls per day for an ambulance request. With such high call volumes, the number of patients being treated and transported to NYC 911-receiving emergency departments has hit record highs. An unfortunate result of increased call volumes and transports is the increase in response times to 911 calls.

As part of the EMS response, Fire Engine Companies with CFR members respond to approximately 700 to 800 medical emergencies daily. In 50% of these medical assignments, the CFR Engine Company is the first arriving EMS resource. And when they are the first arriving EMS unit, they are on scene approximately 3 minutes and 47 seconds prior to an ambulance arriving on scene. Some of the potentially life-threatening medical emergencies that CFR Engines respond to include: anaphylaxis and asthma (approximately 28,000 911 requests per year) as well as approximately 20,000 911 calls for cardiac arrest cases which frequently are chest pain and not actual cardiac arrest cases. Furthermore, there are numerous asthma, COPD, and chest pain calls that, despite our best efforts at call triaging, are call-typed as "DIFFBR" (approximately 140,000 per year) which CFR Engine Companies currently do not respond to but could, with our newer computerized triage process (which would be able to pull out those specific calls). With additional skills, the CFR members would be properly trained and equipped to offer assistance (potentially several thousand additional cases annually).

Proposal: To ensure the highest level of patient care in a timely manner when a CFR Engine Company arrives first on scene, a demonstration project to add the following skills to the Certified First Responders would medically benefit patients while awaiting the arrival of the transporting ambulance resource:

1) Nebulized albuterol
2) Epinephrine auto-injectors
3) Aspirin

Rationale: When a CFR Engine Company is first on scene, during the potential time while awaiting an ambulance, for cases of anaphylaxis, asthma exacerbation, and chest pain, the addition of the ability to administer added medications will be beneficial. Albuterol would be beneficial in cases of asthma/COPD, epinephrine would be beneficial in cases of asthma and anaphylaxis, and aspirin would be beneficial for those cases of suspected myocardial infarction.

Training: The current curriculum utilized for our EMT members, to safely add these medications as part of this demonstration project including pathophysiology, pharmacology, indications/contraindications, skills, and proper documentation would be followed as a template for didactics, skills sessions, and final testing.

QA/I: A strict QA/I medical oversight policy would be in place throughout the duration of the demonstration project to ensure patient safety. If at any time detriment to patients is identified, the project would immediately be discontinued.

THE REGIONAL EMERGENCY MEDICAL SERVICES COUNCIL OF NEW YORK CITY

CERTIFIED FIRST RESPONDER PROTOCOLS

301

RESPIRATORY DISTRESS/FAILURE

1. Monitor the airway.
2. If an obstructed airway is suspected (see Protocol #302).
3. Administer oxygen.
4. Do NOT permit physical activity.
5. Update dispatch of a high priority patient.
6. Monitor breathing for adequacy.
7. Place the patient in a position of comfort.
8. Monitor breathing continuously for signs of hypoxia and/or increasing respiratory distress.
9. **FOR PATIENTS OVER ONE (1) YEAR OF AGE WHO ARE EXPERIENCING EXACERBATION OF ASTHMA OR WHEEZING**
   - **A. PLACE THE PATIENT IN A FOWLER'S OR SEMI-FOWLER'S POSITION**
   - **B. ASSESS THE FOLLOWING PRIOR TO ADMINISTRATION OF NEBULIZED ALBUTEROL**
     - **VITAL SIGNS**
     - **PATIENT'S ABILITY TO SPEAK IN COMPLETE SENTENCES**
     - **ACCESSORY MUSCLE USE**
   - **C. ADMINISTER ALBUTEROL SULFATE 0.083%, ONE (1) UNIT DOSE OR 3 CC VIA NEBULIZATION AT A FLOW RATE THAT WILL DELIVER THE SOLUTION OVER 5 TO 15 MINUTES.**
   - **D. ADMINISTRATION OF ALBUTEROL MUST BE DOCUMENTED ON THE PATIENT CARE REPORT.**
10. For the patient with signs of on-going hypoxia, inability to adequately protect their airway, and/or exhibiting signs of inadequate respiration, assisted ventilations may be required.
    - If unable to maintain an open airway and if tolerated, an airway adjunct may be required.
11. If respiratory arrest, ventilate using one of the ventilation devices and an airway adjunct, if tolerated.

Note: all patients who are in respiratory arrest must have ventilator assistance unless a valid New York State Prehospital DNR Order and/or MOLST is presented (GOP).

Ventilation Devices

- Pocket Mask with supplemental oxygen set at 10-15 liters/minute.
- Bag-Valve-Mask with reservoir with supplemental oxygen set at 10-15 liters/minute.

- Mouth-to-Mouth or Mouth-to-Mouth/Nose (at provider option, only when adjuncts are not available).

Note: Do not use a Demand Valve Resuscitator

THE REGIONAL EMERGENCY MEDICAL SERVICES COUNCIL OF NEW YORK CITY

CERTIFIED FIRST RESPONDER PROTOCOLS

304

NON-TRAUMATIC CHEST PAIN

1. Monitor the airway.
2. Monitor breathing for adequacy.
3. Administer oxygen.
4. DO NOT permit physical activity.
5. Update dispatch of a high priority patient.
6. Place the patient in a position of comfort.
7. Continue to monitor initial assessment and monitor vital signs.
8. **IF THE PATIENT IS SUSPECTED OF SUFFERING FROM A MYOCARDIAL INFARCTION:**
   - **ADMINISTER TWO (2) CHEWABLE ASPIRINS, TOTALING 162 MG, BY MOUTH, UNLESS THE PATIENT HAS A KNOWN ASPIRIN ALLERGY OR HYPERSENSITIVITY.**
9. **ADMINISTRATION OF THE ASPIRIN MUST BE DOCUMENTED ON THE PATIENT CARE REPORT.**

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THE REGIONAL EMERGENCY MEDICAL SERVICES COUNCIL OF NEW YORK CITY

CERTIFIED FIRST RESPONDER PROTOCOLS

310

ANAPHYLACTIC REACTION

NOTE: Anaphylaxis can be a potentially life threatening situation most often associated with a history of exposure to an inciting agent/allergen (bee sting or other insect venom, medications/drugs, or foods such as peanuts, seafood, etc.). The presence of respiratory distress (upper airway obstruction [stridor], severe bronchospasm [wheezing]) and/or cardiovascular collapse/hypotensive shock characterize the clinical findings that authorize and require treatment according to this protocol.
Patients 9 years of age and older or weighing more than 30 kg (66 lbs) use adult Epi-auto injector (0.3 mg); patients younger than 9 years of age or weighing less than 30 kg (66 lbs) use pediatric Epi-auto injector (0.15 mg).

1. Determine that the patient's history includes a history of anaphylaxis, severe allergic reaction and/or recent exposure to an allergen or inciting agent.
2. Update dispatch of a high priority patient.
3. Monitor the airway.
4. Administer oxygen.
5. Do NOT permit physical activity.
6. Place the patient in a position of comfort and monitor vital signs.
7. Assess the cardiac and respiratory status of the patient.
   a. If either the cardiac or respiratory status of the patient is abnormal, proceed as follows:
      i. If the patient is having severe respiratory distress or shock and has been prescribed an Epinephrine auto-injector, assist the patient in administering the Epinephrine. If the patient's auto-injector is not available or expired administer Epinephrine via an auto-injector.
      ii. If the patient has not been prescribed an Epinephrine auto-injector, administer Epinephrine (ONE DOSE ONLY) via an auto-injector.

NOTE: Administration of epinephrine via auto-injector must be reported to your agency's medical director as soon as possible

      iii. Refer immediately to the REMAC Prehospital Treatment Protocol for Respiratory Distress/Failure (#301, Obstructed Airway (#302), or Shock (#315) as appropriate.
8. Administration of epinephrine must be documented on the Patient Care Report.

CFR Update Class

Certified Instructor Coordinator:

Primary Skills Coordinator:

All Classes begin promptly at 0700 hours				
Date	**Day**	**Topic**	**Time**	**Notes**
	1	General Pharmacology Presentation	0700 - 0800	Lecture Progression:
		Respiratory Emergencies requiring Albuterol & Epinepherine Presentation	0800 - 1000	Anatomy & Physiology
		Scenario Format Demo: Respiratory Assessment - Albuterol	1000 - 1030	System Function
		Scenario Format Demo: Respiratory Assessment - Epinepherine	1030 - 1100	Emergencies
		Meal	1100 - 1130	Treatment
		Respiratory Assessment Skills Lab and Evaluation	1130 - 1500	Protocol Review
	2	Cardiovascular requiring the use of ASA Presentation	0700 - 0830	
		Scenario Format Demo: Cardiac Assessment	0830 - 0900	Demonstrations:
		Cardiac Assessment Skills Lab and Evaluation	0900 - 1100	2 person Instructor crew performing a scenario based demonstration for each skill
		Meal	1100 - 1130	
		Anaphylaxis requiring the use of Epinepherine Presentation	1130 - 1230	Skills Labs:
		Scenario Format Demo: Anaphylaxis Assessment	1230 - 1300	Practice and Evaluation
		Anaphylaxis Assessment Skills Lab and Evaluation	1300 - 1500	Remediation as needed

CFR Update Class – Skills Lab Evaluation Sheet

Student: _____ **Date:** _____ **Time:** _____

Scenario: ___ **Cardiac** ___ **Respiratory** ___ **Anaphylaxis**

Key: **P = Performed** **C = Corrected**

P C Dons appropriate BSI

P C Conducts an appropriate Scene Size Up

P C Forms a General Impression of the patient

P C Identifies the patient's Chief Complaint

P C Determines the Level of Responsiveness (AVPU)

P C Assesses and maintains an open airway

P C Assesses for adequacy of breathing

P C Initiates the appropriate oxygen therapy

P C Assesses circulation

P C Identifies the patient priority and updates incoming EMS units

P C Obtains Vital Signs:

___/___ Blood Pressure

_____ Pulse (rate, rhythm, and quality)

_____ Respirations (rate, rhythm, and quality)

P C Asks the appropriate HPI questions

P C Provides the appropriate treatment according to protocol

P C Verbalizes the need to reassess

P C Verbalizes the hand off report to EMS

Lab Instructor: _____ _____

Print Name *Signature*

Lecture: CFR Update Class – General Pharmacology

Prepared by: Grubert, Ronald, Lt. Date Prepared: 5 October 2016

Lecture Outline	Notes
Objectives: 1. Review medication terminology. a. Generic vs. Trade b. Action c. Administration d. Dose e. Indication f. Contraindication g. Side Effect 2. Discuss the assisting with vs. administering of medications, as well as the various techniques of providing the drug. 3. Identify and explain the "Six Rights". 4. Listing the medications assisted with or administered by the CFR. 5. Review the need for reassessment and documentation. Presentation Time: 1 hour Presentation Supplies/Equipment: Appropriate sized and prepared classroom, computer / laptop with network access or lecture flash-drive, projector, screen. Training medications for students to view. * There are no skills demonstration or skills lab components to the general pharmacology session.	

Lecture: CFR Update Class - Respiratory

Prepared by: Grubert, Ronald, Lt. Date Prepared: 5 October 2016

Lecture Outline	Notes
Presentation Objectives: 1. Describe the structure of the respiratory system, including the upper and lower airways, as well as the lungs. 2. Define common terminology. 3. Explain the process of ventilation and respiration. 4. Identify and recognize respiratory compromise through the assessment of the patient and thorough history taking. 5. Discuss asthma as a respiratory emergency. a. Predisposing factors b. Pathophysiology c. Signs and symptoms 6. Explore treatment options including the use of albuterol and epinephrine. Presentation Time: 2 hours Presentation Supplies / Equipment: Appropriate sized and prepared classroom, computer / laptop with network access or lecture flash-drive, projector, screen. Skills Demonstration: Two person crew (staff) performing a scenario based demonstration comprising of patient assessment for a patient with chest pain, providing treatment which includes the use of albuterol. The demonstration will then be repeated with a new scenario to show the use of epinephrine. Skills Demonstration Time: 1 hour (30 minutes each) Skills Lab: Students will participate in a scenario based practice session, receiving corrective instruction from the instructor staff as needed, and further be evaluated accordingly. Skills Lab Time: 3 hours, 30 minutes Skills Demonstration and Skills Lab Supplies / Equipment: Patient Assessment kit, oxygen w/ regulator, adult non-rebreathers, albuterol, and an Epi-Pen trainer.	

Lecture: CFR Update Class - Cardiovascular

Prepared by: Grubert, Ronald, Lt. Date Prepared: 4 October 2016

Lecture Outline	Notes
Presentation Objectives: 1. Describe the structure of the cardiovascular system, including the heart, vessels, and the blood components. 2. Explain the cardiac cycle, central and peripheral pulses, blood pressure, and their effect on circulation. 3. Identify and recognize cardiac compromise through the assessment of the patient and thorough history taking. 4. Explore treatment options including, proper positioning, pharmacological interventions, and the need for additional resources. Presentation Time: 1 hour and 30 minutes Presentation Supplies / Equipment: Appropriate sized and prepared classroom, computer / laptop with network access or lecture flash-drive, projector, screen. Skills Demonstration: Two person crew (staff) performing a scenario based demonstration comprising of patient assessment for a patient with chest pain, providing treatment which includes the use of aspirin. Skills Demonstration Time: 30 minutes Skills Lab: Students will participate in a scenario based practice session, receiving corrective instruction from the instructor staff as needed, and further be evaluated accordingly. Skills Lab Time: 2 hours Skills Demonstration and Skills Lab Supplies / Equipment: Patient Assessment kit, oxygen w/ regulator, adult non-rebreathers, and Aspirin.	Pharmacological Interventions - ASA - Nitroglycerin - Oxygen Additional Resources - ALS

Lecture: CFR Update Class - Anaphylaxis

Prepared by: Grubert, Ronald, Lt. Date Prepared: 5 October 2016

Lecture Outline	Notes
Presentation Objectives: 1. Define common terminology for immunology. 2. Compare allergic reaction with anaphylaxis. 3. Describe the risk factors for an immune system response and common allergens. 4. Review the immune system and it's interaction with the respiratory and cardiovascular systems. 5. Identify and recognize an immune system response through the assessment of the patient and thorough history taking. 6. Discuss the management of an immune system emergency, including the use of epinephrine as a treatment option. Presentation Time: 1 hour Presentation Supplies / Equipment: Appropriate sized and prepared classroom, computer / laptop with network access or lecture flash-drive, projector, screen. Skills Demonstration: Two person crew (staff) performing a scenario based demonstration comprising of patient assessment for an anaphylactic patient, providing treatment which includes the use of epinephrine. Skills Demonstration Time: 30 minutes Skills Lab: Students will participate in a scenario based practice session, receiving corrective instruction from the instructor staff as needed, and further be evaluated accordingly. Skills Lab Time: 2 hours Skills Demonstration and Skills Lab Supplies / Equipment: Patient Assessment kit, oxygen w/ regulator, adult non-rebreathers, and an Epi-Pen trainer.	

FDNY-OFFICE of MEDICAL AFFAIRS

Certified First Responder
Medical Skills Pilot Project
QA/QI Form

Date: _____ EMS CAD #: _____ Fire Unit: _____

Personnel Name/Badge #: _____ / _____ / _____ / _____ / _____

Incident Information	
Final Call Type:	
EMS at Scene:	☐ ALS ☐ BLS
EMS Time of Arrival:	
Protocol:	☐ Respiratory Distress/Failure ☐ Non-Traumatic Chest Pain ☐ Anaphylactic Reaction
Intervention:	☐ Nebulized Albuterol ☐ 1 neb ☐ 2 nebs ☐ 3 nebs ☐ Epinephrine Auto-Injector ☐ Aspirin
Pre-Intervention Vital Signs:	BP: ____ /____ HR: _____ RR: _____
Post-Intervention Vital Signs:	BP: ____ /____ HR: _____ RR: _____
Condition:	☐ Improved ☐ Unchanged ☐ Worse
Further Interventions by EMS:	
EMS Presumptive Diagnosis:	
Disposition:	☐ 10-82 ☐ 10-93

Medical Director Review	
Intervention Appropriately Applied:	☐ Yes ☐ No
If no, action taken:	

Comments:

_____

_____