



# NYC REMAC

Advisory No.	2011-04		
Title:	Revision/Update of REMAC Prehospital Treatment & Transport Protocols AHA Guideline Update		
Issue Date:	June 23, 2011		
Effective Date:	August 1, 2011		
Supersedes:	n/a	Page:	1 of 32

The Regional Emergency Medical Advisory Committee (REMAC) of New York City is responsible to develop, approve and implement prehospital treatment and transport protocols for use within the five boroughs of the City of New York. The Regional Emergency Medical Advisory Committee (REMAC) of New York City operates under the auspices of Article Thirty of the New York State Public Health Law.

The Regional Emergency Medical Advisory Committee (REMAC) of New York City has revised and updated the regional prehospital treatment and transport protocols. All protocols have been approved by the New York State Emergency Medical Advisory Committee for use in the NYC region.

A list of all revised protocols summarizing changes is attached, along with actual protocols identifying specific changes. New Language is **underlined and bold**. Deleted Language is **~~struck-out~~**.

***PROTOCOLS ARE TO BE IMPLEMENTED AND ALL EMS PERSONNEL UPDATED BY AUGUST 1, 2011. Agencies that require additional time for implementation must submit requests for extension in writing to the NYC REMAC. Requests can be emailed to [mdiglio@nycremsco.org](mailto:mdiglio@nycremsco.org)***

Current and Updated Protocols can be accessed at the Regional EMS Council website: [www.nycremsco.org](http://www.nycremsco.org).

Owners/operators of Ambulance and ALS First Response Services providing prehospital medical treatment within the five boroughs of the City of New York are responsible to provide copies of the NYC REMAC Prehospital Treatment Protocols to their personnel, and to ensure that Service Medical Directors and EMS personnel are informed of all changes/updates to the NYC REMAC Prehospital Treatment Protocols.

**In order to provide evidence that all EMS personnel have been updated in current protocols, the EMS Agency must provide a list of updated personnel accompanied by a letter of affirmation signed by the service medical director and Chief Executive Officer no later than FOUR (4) weeks after completion of training/in-service.**

Lewis W. Marshall, Jr., MD, JD  
Chair, Regional Emergency Medical Advisory Committee of New York City

Chair, Regional Emergency Medical Advisory Committee of New York City

**Paramedic (ALS) Protocols**

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**503-B: PULSELESS ELECTRICAL ACTIVITY (PEA)/ASYSTOLE**

**Atropine Removed**

**Paramedic (ALS) Protocols: Pediatrics**

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**543: NEONATE RESUSCITATION**

**Moving IV/IO and epinephrine to Standing Order, and resulting removal of all Medical Control Options**

Rationale: Although neonatal resuscitation to the point of requiring or receiving epinephrine is a rare event, the committee felt that those neonatal resuscitations progressing to this stage in the prehospital setting should not require OLMC contact for medications that are routinely given under standing orders in other resuscitations, particularly given the delay in care that occurs with OLMC contacts. For this reason, it was recommended that the use of epinephrine in neonatal resuscitations be moved from medical control options to standing orders.

**550: PEDIATRIC RESPIRATORY ARREST**

**Naloxone changes**

Rationale: Consistent with the adult ALS respiratory failure / arrest management protocol, the committee recommends that this protocol be changed to emphasize the airway management aspects of such cases and therefore recommends the removal of Naloxone from the protocol. Reference will be made to the altered mental status protocol, but the committee felt that a child for whom airway management had already been performed (and therefore the narcotic-induced issue already remedied) should not routinely receive Naloxone and put that airway management at risk.

**551: PEDIATRIC OBSTRUCTED AIRWAY**

**Cuffed endotracheal tube clarification**

**553: PEDIATRIC NON-TRAUMATIC CARDIAC ARREST**

**AHA change regarding joule setting, also includes clarification regarding advanced airway management**

**559: PEDIATRIC TRAUMATIC CARDIAC ARREST**

**Clarification of advanced airway management**

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

*Revision/Update of REMAC Prehospital Treatment & Transport Protocols*

**Protocols Appendices: (see attached)**

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## **APPENDIX A: TELEPHONE DIRECTORY AND REFERRALS**

- Updated

## **APPENDIX B: PATIENT ASSESSMENT - ADULT and PEDIATRIC PRIMARY SURVEY**

- Transportation Decision clarified
- CUPS deleted

## **APPENDIX C: DO NOT RESUSCITATE ORDER / MOLST**

- Updated to be consistent with NYS DOH

## **APPENDIX D: AUTOMATED EXTERNAL DEFIBRILLATION (AED) GUIDELINES**

- Deleted

## **APPENDIX H: FACILITIES PROVIDING SPECIALTY CARE**

- Updated

## **APPENDIX I: HOSPITAL LISTINGS (AMBULANCE DESTINATIONS)**

- Updated
- Pediatric age limited added

## **APPENDIX S: New York City Burn Disaster Receiving Hospitals**

- Updated

## **APPENDIX T: USE OF TOURNIQUETS <sup>1</sup>**

- New

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<sup>1</sup> Based on information from the Prehospital Trauma Life Support course  
*Regional Emergency Medical Advisory Committee*  
*New York City*

503-B

PULSELESS ELECTRICAL ACTIVITY (PEA)/ASYSTOLE

NOTE: CONSIDER THE POSSIBILITY OF CONDITIONS MASQUERADING AS PEA/ASYSTOLE WHICH REQUIRE IMMEDIATE TREATMENT.

1. Continue CPR with minimal interruption.
2. If a tension pneumothorax is suspected, perform Needle Decompression. (See Appendix O.)
3. Perform **Advanced Airway Management Endotracheal Intubation**.
4. Begin an IV/IO/ infusion of Normal Saline (0.9% NS) to keep vein open, or a Saline Lock.
5. Administer Vasopressin 40 units IV/IO/Saline Lock Bolus, single dose.
6. Administer Dextrose 25 gm (50 ml of a 50% solution), IV/IO/Saline Lock bolus.
7. If there is no change in the rhythm within 3 – 5 minutes after administration of Vasopressin, administer Epinephrine 1 mg (10 ml of a 1:10,000 solution), IV/IO/Saline Lock bolus, every 3 – 5 minutes.
- ~~8. If the patient has a heart rate (based on rhythm strip) less than 60 beats/min, administer Atropine Sulfate 1 mg, IV/IO/Saline Lock bolus. If the heart rate, remains less than 60 bpm, repeat Atropine Sulfate 1 mg, IV/IO/Saline Lock bolus, every 3 – 5 minutes. (Maximum total dosage is 3 mg.)~~
9. If there is insufficient improvement in hemodynamic status, contact Medical Control for implementation of one or more of the following MEDICAL CONTROL OPTIONS:

**MEDICAL CONTROL OPTIONS:**

- OPTION A:** Administer Sodium Bicarbonate 44-88 mEq IV/IO/Saline Lock bolus. Repeat doses of Sodium Bicarbonate 44 mEq, IV/IO/Saline Lock bolus, may be given every 10 minutes.
- OPTION B:** In cases of hyperkalemia or Calcium Channel Blocker overdose administer Calcium Chloride (CaCl<sub>2</sub>) 1 gm, SLOWLY, IV/IO/Saline Lock bolus. Follow with a Normal Saline (0.9% NS) flush.
- OPTION C:** Begin rapid IV/IO/Saline Lock infusion of Normal Saline (0.9% NS), up to three (3) liters.
- OPTION D:** Transportation Decision.

NEONATE RESUSCITATION

~~For neonates requiring resuscitation whose amniotic fluid does not contain thick meconium:~~

1. Begin Basic Life Support Neonatal Resuscitation procedures.

~~For neonates requiring resuscitation whose amniotic fluid does contain thick meconium and who are limp, apneic, or pulseless:~~

- ~~1. Begin Basic Life Support Neonatal Resuscitation procedures only after the airway has been cleared of thick meconium, as follows:~~
  - ~~a. Perform Endotracheal Intubation and directly suction the Endotracheal Tube via a Meconium Aspirator/Adapter while slowly withdrawing the Endotracheal Tube.~~
  - ~~b. Repeat this procedure until the Endotracheal Tube is clear of thick meconium, up to 2 more times (total of 3 times).~~

~~NOTE: DO NOT REPLACE THE ENDOTRACHEAL TUBE ONCE THE AIRWAY HAS BEEN CLEARED OF THICK MECONIUM UNLESS THE NEONATE REMAINS LIMP, APNEIC, OR PULSELESS.~~

~~For ALL neonates requiring resuscitation once Basic Life Support Neonatal Resuscitation procedures have begun:~~

2. If CPR has been initiated, and the heart rate remains less than 60 beats per minute and not rapidly increasing after 30 seconds of CPR, perform Endotracheal Intubation.

~~NOTE: DO NOT INTUBATE UNLESS OTHER METHODS OF AIRWAY MANAGEMENT ARE NOT EFFECTIVE, I.E., DO NOT SUCCESSFULLY INCREASE THE HEART RATE.~~

During transport, or if transport is delayed:

3. If abdominal distention occurs, pass a Nasogastric Tube. If unsuccessful, pass an Orogastic Tube.
4. If Endotracheal Intubation has been performed, and the heart rate remains less than 60 beats per minute, administer Epinephrine 0.1 mg/kg (1 ml/kg of a 1:10,000 solution), via the Endotracheal Tube.
5. If transport is delayed or extended, begin an IV or IO infusion of Normal Saline (0.9% NS) to keep vein open, or a Saline Lock. Do not attempt vascular access more than twice.
6. Begin an IV/Saline Lock or IO infusion of Normal Saline (0.9% NS), 10ml/kg.
7. Administer Epinephrine 0.01 mg/kg (0.1 ml/kg of a 1:10,000 solution) IV/Saline Lock or IO, every 3-5 minutes.
8. Transport Decision
  - ~~1. If Epinephrine has been administered, and the heart rate still remains less than 60 beats per minute, the respiratory rate remains less than 30 breaths per minute, or the neonate remains~~

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~~cyanotic or limp, contact Medical Control for implementation of one or more of the following  
MEDICAL CONTROL OPTIONS:~~

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### ~~MEDICAL CONTROL OPTIONS~~

~~OPTION A: Repeat Epinephrine 0.1 mg/kg (1 ml/kg of a 1:10,000 solution), via the Endotracheal Tube.~~

~~OPTION B: If transport is delayed or extended, begin an IV or IO infusion of Normal Saline (0.9% NS) to keep vein open, or a Saline Lock. Do not attempt vascular access more than twice.~~

~~OPTION C: If transport is delayed or extended, and the neonate is pale and has slow or absent central pulses, administer Epinephrine 0.01 mg/kg (0.1 ml/kg of a 1:10,000 solution) IV/Saline Lock, or IO.~~

~~OPTION D: If transport is delayed or extended, and the neonate is pale and has weak but rapid central pulses, begin an IV/Saline Lock or IO infusion of Normal Saline (0.9% NS) 10 ml/kg.~~

~~OPTION E: Transportation Decision.~~

PEDIATRIC RESPIRATORY ARREST

For pediatric patients in actual or impending respiratory arrest, or who are unconscious and cannot be adequately ventilated:

**NOTE: IF OVERDOSE IS SUSPECTED, REFER TO PROTOCOL 556 (Pediatric Altered Mental Status)**

1. Begin Basic Life Support Pediatric Respiratory Distress/Failure procedures.

**NOTE: DO NOT HYPER-EXTEND THE NECK. IF AN OBSTRUCTED AIRWAY IS SUSPECTED, SEE PROTOCOL #551.**

2. Perform Endotracheal Intubation, if less invasive methods of airway management are not effective.
3. If a tension pneumothorax is suspected, perform Needle Decompression, using an 18-20 gauge catheter. (See Appendix O.)

**NOTE: TENSION PNEUMOTHORAX IN A CHILD IN RESPIRATORY ARREST MAY DEVELOP AFTER RESUSCITATIVE EFFORTS HAVE BEGUN.**

During transport, or if transport is delayed:

4. Administer Naloxone, **titrate in increments of 0.8 mg, IM, up to response, up to 2 mg, in patients two (2) years of age or older. In patients less than two (2) years of age, titrate up to 1 mg. 2 mg, IM, or via the Endotracheal Tube, in patients two (2) years of age or older. Use half the amount (1 mg) of this drug in patients less than two (2) years of age.** (Refer to Length Based Dosing Device)
5. If abdominal distention occurs, pass a Nasogastric Tube. If unsuccessful, pass an Orogastric Tube.
6. If there is insufficient improvement in respiratory status, contact Medical Control for implementation of one or more of the following MEDICAL CONTROL OPTIONS:

**MEDICAL CONTROL OPTIONS:**

**OPTION A:** Begin an IV or IO infusion of Normal Saline (0.9% NS) to keep vein open, or a Saline Lock. Attempt vascular access no more than twice.

**~~OPTION B: Administer Naloxone 2 mg, IV/Saline Lock or IO bolus, via the Endotracheal Tube or IM, in patients two (2) years of age or older. Use half the amount (1 mg) of this drug in patients less than two (2) years of age. (Refer to Length Based Dosing Device)~~**

**OPTION C:** Transportation Decision.

PEDIATRIC OBSTRUCTED AIRWAY

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For pediatric patients who are unconscious or cannot breathe, cough, speak, or cry:

1. Begin Basic Life Support Pediatric Obstructed Airway procedures.
2. Perform Direct Laryngoscopy. Attempt to remove the foreign body with appropriate size Magill Forceps.

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NOTE: IF AN ENLARGED EPIGLOTTIS IS VISUALIZED, SEE PROTOCOL #552.

3. Perform Endotracheal Intubation, if less invasive methods of airway management are not effective.
4. If able to confirm intubation via direct visualization but unable to ventilate:
  - a. Note the Endotracheal Tube depth
  - b. **If using a cuffed tube, deflate** the Endotracheal Tube cuff
  - c. Advance the Endotracheal Tube to its deepest depth
  - d. Return the Endotracheal Tube to its original depth
  - e. **If using a cuffed tube, reinflate** the Endotracheal Tube cuff and attempt ventilation again
  - f. If unable to effectively ventilate the patient using the above maneuvers, immediately initiate transport
4. Transportation Decision.



553 (AHA Change)

PEDIATRIC NON-TRAUMATIC CARDIAC ARREST

1. Begin Basic Life Support Pediatric Non-Traumatic Cardiac Arrest procedures.
2. Begin Cardiac Monitoring, record and evaluate EKG rhythm.
3. If in ventricular fibrillation or pulseless ventricular tachycardia:
  - a. Immediately Defibrillate at **42** joules/kg, using **pad**dles of appropriate size. (Refer to Length Based Dosing Device)
  - b. Immediately resume CPR for 5 cycles while defibrillator is recharging.
4. If still in ventricular fibrillation or pulseless ventricular tachycardia:
  - Immediately repeat Defibrillation at **104** joules/kg, using **pad**dles of appropriate size. (Refer to Length Based Dosing Device)
4. Immediately resume CPR for 5 cycles while defibrillator is recharging.

NOTE: IF THE DEFIBRILLATOR IS UNABLE TO DELIVER THE RECOMMENDED DOSE, USE THE LOWEST AVAILABLE SETTING.

5. Perform **Endotracheal Intubation** Advanced Airway Management if less invasive methods of airway management are not effective.

During transport, or if transport is delayed:

6. If the patient is intubated, administer Epinephrine 0.1 mg/kg (0.1 ml/kg of a 1:1,000 solution), via the Endotracheal Tube. (Refer to Length Based Dosing Device)
7. If abdominal distention occurs, pass a Nasogastric Tube. If unsuccessful, pass an Orogastic Tube.
8. Begin an IV or IO infusion of Normal Saline (0.9% NS) to keep vein open, or a Saline Lock. Attempt vascular access no more than twice.
9. If still in ventricular fibrillation or pulseless ventricular tachycardia:
  - Immediately repeat Defibrillation at **104** joules/kg, using **pad**dles of appropriate size. (Refer to Length Based Dosing Device)
  - Immediately resume CPR for 5 cycles while the Defibrillator is recharging.
  - Administer Amiodarone, 5 mg/kg, IV/Saline Lock, or IO. (Refer to Length Based Dosing Device)
10. Repeat Epinephrine 0.01 mg/kg (0.1 ml/kg of a 1:10,000 solution) IV/Saline Lock or IO bolus every 3-5 minutes. (Refer to Length Based Dosing Device)

OR

If vascular access has not been established, repeat epinephrine 0.1 mg/kg (0.1 ml/kg of a 1:1,000 solution) via the Endotracheal Tube every 3-5 minutes. (Refer to Length Based Dosing Device)

NOTE: THE IV/SALINE LOCK OR IO DOSE OF EPINEPHRINE FOR PEDIATRIC PATIENTS IS 0.01 MG/KG (0.1 ML/KG OF A 1:10,000 SOLUTION). THE ENDOTRACHEAL TUBE

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DOSE OF EPINEPHRINE FOR PEDIATRIC PATIENTS IS 0.1 MG/KG (0.1 ML/KG OF A 1:1,000 SOLUTION).

11. If there is insufficient improvement in hemodynamic status, contact Medical Control for implementation of one or more of the following MEDICAL CONTROL OPTIONS:

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### MEDICAL CONTROL OPTIONS:

OPTION A: Repeat any of the above Standing Orders.

OPTION B: Administer Naloxone 2 mg IV/Saline Lock or IO bolus, or via the Endotracheal Tube, in patients two years of age or older. Use half the amount (1 mg) of this drug in patients less than two (2) years of age. (Refer to Length Based Dosing Device)

OPTION C: Administer Dextrose 0.5 gm/kg, IV/Saline Lock or IO bolus. Use 10% Dextrose in patients less or equal to one (1) month of age. Use 25% Dextrose in patients greater than one (1) month of age and less than 14 years of age. (Refer to Length Based Dosing Device)

OPTION D: Administer Sodium Bicarbonate 1 mEq/kg, IV/Saline Lock or IO bolus. (Refer to Length Based Dosing Device)

OPTION E: If torsades de pointes is present, administer Magnesium Sulfate, 25-50 mg/kg, IV/Saline Lock, or IO.

OPTION F: Begin rapid IV/Saline Lock, or IO infusion of Normal Saline (0.9% NS), 20 ml/kg. (Refer to Length Based Dosing Device)

OPTION G: Transportation Decision.

PEDIATRIC TRAUMATIC CARDIAC ARREST

NOTE: FOR PEDIATRIC PATIENTS IN TRAUMATIC CARDIAC ARREST, RAPID TRANSPORT IS THE HIGHEST PRIORITY!

1. Begin transportation of the patient and other Basic Life Support Traumatic Cardiac Arrest procedures.

During transport, or if transport is delayed:

2. Perform ~~Endotracheal Intubation~~ Advanced Airway Management if other methods of airway control are not effective.
3. If a tension pneumothorax is suspected, perform Needle Decompression. (See Appendix O.)
4. Begin rapid IV/Saline Lock or IO infusion of Normal Saline (0.9% NS) or Ringer's Lactate (RL), 20 ml/kg, via a large bore IV (18-22 gauge) or IO catheter, or a Saline Lock. Attempt vascular access no more than twice. (Refer to Length Based Dosing Device)
5. If abdominal distention occurs, pass a Nasogastric Tube. If unsuccessful, or in patients with craniofacial trauma, pass an Orogastric Tube.

NOTE: DO NOT PASS A NASOGASTRIC TUBE IN PATIENTS WITH CRANIOFACIAL TRAUMA.

6. If the patient remains in traumatic cardiac arrest, continue rapid IV/Saline Lock or IO infusion of Normal Saline (0.9% NS) or Ringer's Lactate (RL), 20 ml/kg (total of 40 ml/kg), via a second large bore IV (18-22) catheter, or a Saline Lock (if necessary). Attempt second IV no more than twice. (Refer to Length Based Dosing Device)
7. If the patient still remains in traumatic cardiac arrest, contact Medical Control for implementation of one or more of the following MEDICAL CONTROL OPTIONS:

MEDICAL CONTROL OPTIONS:

OPTION A: Continue rapid IV or IO infusion of Normal Saline (0.9% NS) or Ringer's Lactate (RL) up to an additional 20 ml/kg (total of 60 ml/kg). (Refer to Length Based Dosing Device)

OPTION B: Transportation Decision.

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## APPENDIX A TELEPHONE DIRECTORY AND REFERRALS

<b>EMS OFFICES</b>	
Regional EMS Council of NYC	(212) 870-2301
Regional Emergency Medical Advisory Committee (REMAC) of NYC	(212) 870-2301
NYS Dept. of Health (Central Office)	(518) 402-0996
NYS Dept. of Health – NYC Field Office	(212) 417-4455

<b>FDNY BUREAU OF EMERGENCY MEDICAL SERVICES</b>	
Telemetry	(718) 899-5062
Toll Free	(800) 281-TELM (8356)
EMS Operations	(718) 999-2770
Division of Training	(718) 281-8325
REMAC Testing	(718) 999-2671
<b>EMD POSITIONS</b>	
ADMINISTRATION 1	(347) 250-6363
ADMINISTRATION 2	(347) 250-6364
ADMINISTRATION 3	(347) 250-6365
ADMINISTRATION FAX	(347) 250-6091
ARD SUPERVISOR (RM 306)	(347) 253-6422
ARD SUPERVISOR (RM 310)	(347) 250-6423
BRONX ASSIST	(347) 250-6352
BRONX NORTH	(347) 250-6353
BRONX SOUTH	(347) 250-6351
BROOKLYN ASSIST 1	(347) 250-6344
BROOKLYN ASSIST 2	(347) 250-6346
BROOKLYN CENTRAL	(347) 250-6345
BROOKLYN NORTH	(347) 250-6347
BROOKLYN SOUTH/S.I.	(347) 250-6343
CBEMS	(347) 250-6329
CITYWIDE 1	(347) 250-6334
CITYWIDE 1 ASSIST	(347) 250-6335
CITYWIDE 2	(347) 250-6337
CITYWIDE 2 ASSIST	(347) 250-6336
COMMANDING OFFICER	(347) 250-6361
DEPUTY CHIEF	(347) 250-6360
DISPATCH COMMANDER	(347) 250-6362
DISPATCH COMMANDER FAX	(347) 250-6090
DIVERSIONS DESK	(347) 250-6332
DIVERSIONS DESK FAX	(347) 250-6083
FIRE DESK	(347) 250-6330
INQUIRY/TRACKING DESK	(347) 250-6331

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INQUIRY/TRACKING DESK FAX	(347) 250-6082
MANHATTAN ASSIST 1	(347) 250-6339
MANHATTAN ASSIST 2	(347) 250-6341
MANHATTAN CENTRAL	(347) 250-6340
MANHATTAN NORTH	(347) 250-6342
MANHATTAN SOUTH	(347) 250-6338
QUEENS ASSIST	(347) 250-6349
QUEENS EAST	(347) 250-6350
QUEENS WEST	(347) 250-6348
RELAY DESK	(347) 250-6333
SUPERVISOR BK/SI	(347) 250-6324
SUPERVISOR BX	(347) 250-6325
SUPERVISOR MN	(347) 250-6326
SUPERVISOR QN	(347) 250-6327

### ABUSE/DOMESTIC VIOLENCE

<b>NYS Child Abuse/Maltreatment Register (Mandated Reporter Express Line)</b>	<b>(800) 635-1522</b>
NYS 24 Hour Child Abuse Hot-Line	(800) 342-3720
Domestic Violence 24 Hour HOT-LINE	(800) 621-4673 (HOPE)

### CRIME VICTIMS

Crime Victims 24 Hour Hot-Line	(212) 577-7777
State Crime Victims Compensation Board	(212) 417-5160
Sex Crimes Report Line (NYCPD)	(212) 267-7273

### AGING

NYC Department for the Aging Central Information and Referral	(212) 442-1000
Social Security (MEDICARE)	(800) 772-1213
Alzheimer's Resource Center	(212) 442- 3086

### CPR TRAINING

Regional EMS Council of NYC	(212) 870-2301
New York Heart Association	(212) 661-5335
American Red Cross	(212) 787-1000

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## APPENDIX A (continued) TELEPHONE DIRECTORY AND REFERRALS

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### SOCIAL SERVICES

Human Resources Administration General Information	(877) 474-8411
Utility Cut-Off Emergencies (Public Service Assistance)	(800) 342-3355
Legal Services (Legal Aid Society)	(212) 577-3300

### OTHER SERVICES

ASPCA (Injured Animals)	(718) 649-8600
Transportation (NYC Transit Authority)	(718) 330-1234
Gas Leaks	(718) 643-4050
POISON Control	(212) POISONS (764-7667)

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## APPENDIX B PATIENT ASSESSMENT

### ADULT PRIMARY SURVEY

	Assessment	Management
<b>Scene size-up</b>	<ul style="list-style-type: none"> <li>▪ Body Substance Isolation</li> <li>▪ Scene safety</li> <li>▪ Mechanism of Injury/Nature of Illness</li> <li>▪ Consider C-spine</li> </ul>	<ul style="list-style-type: none"> <li>▪ Goggles, gloves, gown, mask – as needed</li> <li>▪ Ensure safety of <b>self &amp; partner</b>, patient &amp; bystanders</li> </ul>
<b>Initial</b>	<ul style="list-style-type: none"> <li>▪ General impression of the patient</li> <li>▪ Level of Consciousness</li> <li>▪ Chief complaint</li> </ul>	<ul style="list-style-type: none"> <li>▪ <b>A</b>-Alert</li> <li>▪ <b>V</b>-Responds to Verbal stimuli</li> <li>▪ <b>P</b>-Responds to Painful stimuli</li> <li>▪ <b>U</b>-Unresponsive – no gag or cough</li> </ul>
<b>Airway and Breathing</b>	<ul style="list-style-type: none"> <li>▪ Manage airway</li> <li>▪ O2, as needed</li> <li>▪ Ensure adequate ventilation</li> <li>▪ Treat any life threatening airway or breathing problems</li> </ul>	<ul style="list-style-type: none"> <li>▪ Modified Jaw Thrust</li> <li>▪ Suction, as needed</li> <li>▪ OPA/NPA, as needed</li> <li>▪ CPR, as needed</li> </ul>
<b>Circulation</b>	<ul style="list-style-type: none"> <li>▪ Skin color</li> <li>▪ Assess for pulses (BP estimation)                             <ul style="list-style-type: none"> <li>-Radial = 80+</li> <li>-Femoral = 70+</li> <li>-Carotid = 60+</li> </ul> </li> <li>▪ Major Bleeding</li> </ul>	<ul style="list-style-type: none"> <li>▪ Control any obvious bleeding</li> <li>▪ Elevation of legs, as needed</li> <li>▪ Support circulation</li> </ul>
<b>Transport Decision</b>	<ul style="list-style-type: none"> <li>▪ Identify <b>speed</b> <u>urgency</u> of transport</li> </ul>	<ul style="list-style-type: none"> <li>▪ Immediate or continued assessment</li> </ul>
<b>CUPS</b>	<ul style="list-style-type: none"> <li>▪ <del>For transport decision only</del></li> </ul>	

### ~~DETERMINE THE PATIENT CUPS STATUS (C.U.P.S.)~~

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## APPENDIX B (continued) PATIENT ASSESSMENT

### PEDIATRIC PRIMARY SURVEY

	Assessment	Management
<b>Scene size-up</b>	<ul style="list-style-type: none"> <li>▪ Body Substance Isolation</li> <li>▪ Scene safety</li> <li>▪ Mechanism of Injury/Nature of Illness</li> <li>▪ Consider C-spine</li> </ul>	<ul style="list-style-type: none"> <li>▪ Goggles, gloves, gown, mask – as needed</li> <li>▪ Ensure safety of <b>self &amp; partner</b>, patient &amp; bystanders</li> </ul>
<b>Initial</b>	<ul style="list-style-type: none"> <li>▪ General impression of the patient</li> <li>▪ Level of Consciousness</li> <li>▪ Chief complaint</li> </ul>	<ul style="list-style-type: none"> <li>▪ <b>A</b>-Alert</li> <li>▪ <b>V</b>-Responds to Verbal stimuli</li> <li>▪ <b>P</b>-Responds to Painful stimuli</li> <li>▪ <b>U</b>-Unresponsive – no gag or cough</li> </ul>
<b>Airway and Breathing</b>	<ul style="list-style-type: none"> <li>▪ Manage airway</li> <li>▪ O2, as needed</li> <li>▪ Ensure adequate ventilation</li> <li>▪ Treat any life threatening airway or breathing problems</li> </ul>	<ul style="list-style-type: none"> <li>▪ Modified Jaw Thrust</li> <li>▪ Suction, as needed</li> <li>▪ OPA/NPA, as needed</li> <li>▪ CPR, as needed</li> </ul>
<b>Circulation</b>	<ul style="list-style-type: none"> <li>▪ Skin color</li> <li>▪ Assess for pulses (BP estimation)</li> <li>▪ Major Bleeding</li> </ul>	<ul style="list-style-type: none"> <li>▪ Control any obvious bleeding</li> <li>▪ Elevation of legs, as needed</li> <li>▪ Support circulation</li> </ul>
<b>Transport Decision</b>	<ul style="list-style-type: none"> <li>▪ Identify <b>speed urgency</b> of transport</li> </ul>	<ul style="list-style-type: none"> <li>▪ Immediate or continued assessment</li> </ul>
<b>CUPS</b>	<p><b>*-For transport decision only</b></p>	

### DETERMINE THE PATIENT CUPS STATUS (C.U.P.S.)

#### Assess respiratory effort

- ⇒ Use of accessory muscles
- ⇒ Sternal retractions
- ⇒ Stridor/grunting
- ⇒ Posturing

Normal BP estimate: 90+ (2 x child's age)



**APPENDIX B (continued)**  
**PATIENT ASSESSMENT**

**DETERMINE THE PATIENT STATUS (C.U.P.S.)**  
**For transport decision only**

<p><b>Critical</b></p>	<ul style="list-style-type: none"> <li>▪ <del>Patients either receiving CPR, in respiratory arrest or requiring and receiving life-sustaining ventilatory/circulatory support.</del></li> </ul>
<p><b>Unstable</b></p>	<ul style="list-style-type: none"> <li>▪ <del>Poor general impression</del></li> <li>▪ <del>Unresponsiveness with no gag or cough reflexes</del></li> <li>▪ <del>Responsive but unable to follow commands</del></li> <li>▪ <del>Difficulty breathing</del></li> <li>▪ <del>Pale skin or other signs of poor perfusion (shock)</del></li> </ul>
<p><b>Potentially Unstable</b></p>	<ul style="list-style-type: none"> <li>▪ <del>Complicated childbirth</del></li> <li>▪ <del>Uncontrolled bleeding</del></li> <li>▪ <del>Severe pain in any part of the body</del></li> <li>▪ <del>Severe chest pain, especially with a systolic of BP of less than 100 mm Hg</del></li> </ul>
<p><b>Stable</b></p>	<ul style="list-style-type: none"> <li>▪ <del>Minor illness, minor isolated injury, uncomplicated extremity injuries, and/or any patient that cannot be categorized as Critical, Unstable or Potentially unstable.</del></li> </ul>

APPENDIX C

DO NOT RESUSCITATE ORDER / MOLST

The following is the NYS DOH BEMS Policy Statement  
**DNR and Medical Orders for Life- Sustaining Treatment (MOLST)**

Bureau of EMS Policy Statement	
Policy Statement #	11-02
Date	March 1, 2011
Subject	Re: DNR and Medical Orders for Life- Sustaining Treatment (MOLST)
Supercedes/Updates	99-10, 08-07, 10-05

**Purpose**

This policy updates all EMS providers and agencies of changes in the laws regarding Do Not Resuscitate (DNR) orders and Medical Orders for Life-Sustaining Treatment (MOLST). The Department now has an approved MOLST form, DOH-5003 Medical Orders for Life-Sustaining Treatment. This form does not replace the Non-hospital Order Not to Resuscitate in either the English or the Spanish version (DOH-3474, DOH-3474es), but rather provides an alternative. Nonhospital DNR orders are now governed by Public Health Law Article 29 CCC.

Additionally, this policy will provide an introduction to the Family Health Care Decisions Act (FHCDA). FHCDA allows family members or certain other individuals to make health care decisions, including decisions about the withholding or withdrawing of life-sustaining treatment, on behalf of patients who lose their ability to make such decisions and have not prepared advance directives regarding their wishes. **FHCDA went into effect on June 1, 2010.**

**Nonhospital Order Not to Resuscitate**

The New York State Department of Health has an approved standard Out of Hospital DNR form (DOH-3474) that is legally recognized statewide for DNR requests occurring outside of Article 28 licensed facilities. This form is intended for patients not originating from a hospital or nursing home.

For patients with a valid Nonhospital DNR or MOLST form with a DNR order, the Public Health Law allows a standard metal bracelet to be worn by the patient, which includes a caduceus and the words "DO NOT Resuscitate." EMS providers should assume that there is a valid DNR in place when a DNR bracelet is identified on a patient.

**Medical Orders for Life-Sustaining Treatment (MOLST)**

MOLST is an alternative form for patients to document their end-of-life care preferences and to assure that those preferences are made known to health care providers across the health care delivery system. Unlike the Nonhospital Order Not to Resuscitate, the MOLST form documents DNI orders and orders regarding other life-sustaining treatment, in addition to DNR orders. MOLST should be honored by EMS agencies, hospitals, nursing homes, adult homes, hospices and other health care facilities and their health care provider staff. MOLST has been approved by the Office of Mental Health and the Office for People With Developmental Disabilities for use as a nonhospital DNR/DNI form for persons with developmental disabilities, or persons with mental illness, who are incapable of making their own health care decisions or who have a guardian of the person appointed pursuant to Article 81 of the Mental Hygiene Law or Article 17-A of the Surrogate's Court Procedure Act.

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## *Revision/Update of REMAC Prehospital Treatment & Transport Protocols*

Chapter 197 of the Laws of 2008 authorized the MOLST form to be used statewide as an alternative form for nonhospital DNR and/or DNI and allowed EMS providers to honor this form in all counties in New York State.

Both the Nonhospital Order Not to Resuscitate form (DOH-3474) and the MOLST form (DOH-5003) are New York State Department of Health forms. The MOLST form was updated in June 2010 to make it more user-friendly and to align the form with the recently enacted Family Health Care Decisions Act. The MOLST form is currently utilized by many health care systems. **If a patient has a prior version of the MOLST in place and signed by a physician, the form is still considered VALID, and the patient care orders should be honored, unless it is known that the patient's form has been revoked.**

What are the DNR/DNI rules that affect EMS agencies and providers now?

1. Effective July 7, 2008, the MOLST form is approved for use statewide without the need for a standard one-page Nonhospital Order Not to Resuscitate form.
2. EMS agencies must still honor the standard one-page nonhospital DNR form or bracelet.
3. When a patient wears a DNR bracelet, it refers ONLY to the do not resuscitate rules that apply to the nonhospital DNR order. At present there are no nonhospital DNI bracelets.
4. The MOLST form also provides the patient and his/her physician with the ability to give a Do Not Intubate (DNI) order to health care providers including EMS. Refer to Section E on the MOLST form to review DNI information.
5. Occasionally EMS providers may encounter a patient who has a newly completed MOLST that does not have the authorizing physician's signature. While the unsigned MOLST form may provide the EMS provider with information about the patient's treatment preferences, it is not a valid DNR or other order. In the case of an unsigned MOLST form EMS providers should:
  1. Initiate resuscitation following applicable state and/or regional protocols;
  2. Obtain clinical information on status of the patient;
  3. Confirm the MOLST form is specific to the patient;
  4. Consult with local medical control and relay the above information; and
  5. Follow the direction of the medical control physician.

What are the differences and similarities between the standard one-page nonhospital DNR order and the MOLST form?

1. The MOLST form (DOH-5003) is a bright pink multi-page form; however, a photocopy or facsimile of the original form is acceptable and legal. A Nonhospital Order Not to Resuscitate form (DOH-3474) is a single-page form on white paper with black ink.
2. The MOLST form is meant to be utilized by health care providers across the health care system. It is not limited to EMS agencies; it travels with the patient to different care settings. The Nonhospital Order Not to Resuscitate form is not intended for use in facilities.
3. MOLST provides for end-of-life orders concerning resuscitation and intubation for Advanced EMTs when the patient is in full cardio-pulmonary arrest or has progressive or impending pulmonary failure without acute cardiopulmonary arrest. The Nonhospital Order Not to Resuscitate form (DOH-3474) only applies to patients in full cardio or pulmonary arrest.
4. Both forms, the MOLST form and the Nonhospital Order Not to Resuscitate form (DOH-3474), must be authorized by a physician.
5. Unlike the Nonhospital Order Not to Resuscitate form, there are multiple patient orders contained on the MOLST form that are intended for other health care providers to follow in other health care settings such as the hospital or nursing home.

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6. The MOLST form gives prehospital care providers and agencies direction regarding the patient's end-of-life treatment orders in Section A (page 1) and Section E (page 2). See below.

### **Orientation to the MOLST Form, DOH-5003 (June 2010)**

#### **Section A - Resuscitation Instructions When Patient has No Pulse and/or is Not Breathing**

Section A is titled Resuscitation Instructions When a Patient Has No Pulse and/or Is Not Breathing. It provides two boxes, only one of which will be checked. The first box, "CPR Order: Attempt Cardio-Pulmonary Resuscitation," indicates that the patient wants all resuscitation efforts to be made, including defibrillation and intubation, if they are found in cardiac and/or respiratory arrest.

The second box, "DNR Order: Do Not Attempt Resuscitation (Allow Natural Death)," indicates the patient does not want any resuscitation efforts made, and the patient wishes to be allowed a natural death. This does not prevent treatment up to the point of resuscitation.

#### **Section B - Consent for Resuscitation Instructions**

This section MUST be filled out in accordance with New York State law. A box should always be checked to indicate who consented to the decision, and the name of the decision-maker should be printed. If the signature line is left blank, the box for verbal consent should be checked. If the box for verbal consent is checked, the attending physician who signed the order should have witnessed the consent or two other adult witnesses should be indicated.

#### **Section C - Physician Signature for Sections A and B and for section E**

A licensed physician must always sign the orders. If the physician is licensed in a border state, the physician must insert the abbreviation for the state in which he/she is licensed, along with the license number.

As with the Nonhospital Order Not to Resuscitate form (DOH 3474), the MOLST form is required to be reviewed by the physician periodically. However, both forms should be considered valid unless it is known that the medical order has been revoked.

#### **Section D - Advance Directives**

This section contains multiple check boxes listing advanced directives for the patient.

#### **Section E - Orders for Other Life-Sustaining Treatment and Future Hospitalization When the Patient has a Pulse and the Patient is Still Breathing**

This section contains several parts containing treatment options that must be reviewed by prehospital care providers and includes:

##### **Treatment Guidelines**

- Comfort measures only
- Limited medical interventions
- No limitations

##### **Instructions for Intubation and Mechanical Ventilation**

- Do Not Intubate (DNI)

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- A trial period
  - Intubation and mechanical ventilation
  - Non-invasive ventilation (e.g. BIPAP)
- Intubation and long-term mechanical ventilation

### **Future Hospitalization/Transfer**

- Do not send to hospital unless pain or severe symptoms cannot otherwise be controlled
- Send to hospital if necessary, based on MOLST orders.

### **Artificially Administered Fluids and Nutrition**

- No feeding tube
- A trial period of feeding tube
- Long-term feeding tube
- No IV fluids
- A trial period of IV fluids

### **Antibiotics**

- Do not use antibiotics
- Limited use of antibiotics
- Use antibiotics

### **Other Instructions (e.g. dialysis, transfusions)**

If any part of Section E is completed, additional consent and a physician signature, similar to Section B, must be documented at the end of this section. Sometimes two boxes will be checked in Section E. If the form was completed in the community (as opposed to a hospital or nursing home), a Public Health Law Surrogate may consent to a nonhospital DNR and/or DNI order, but may not consent to withholding other life-sustaining treatment unless the consent is based on clear and convincing evidence of the patient's wishes. For that reason, the box for "based on clear and convincing evidence of the patient's wishes" may be checked in addition to the box for "Public Health Law Surrogate."

### ***Liability Protection***

PHL § 2994-gg provides: "No person shall be subjected to criminal prosecution or civil liability, or be deemed to have engaged in unprofessional conduct, for honoring reasonably and in good faith pursuant to this section a nonhospital order not to resuscitate, for disregarding a nonhospital order pursuant to section twenty-nine hundred ninety-four-ee of this article, or for other actions taken reasonably and in good faith pursuant to this section."

## **Frequently Asked Questions**

### **What should I do if I am uncertain how to proceed?**

Contact Medical Control.

### **What do I do if the patient has both a nonhospital DNR order and a MOLST form? Which do I honor?**

If the forms have different orders, you should follow the form that has the most recently dated authorization. In all instances you should follow the DNI instructions on the MOLST form if the form is signed by a physician, as the nonhospital DNR order does not provide this advice.

### **What if the old MOLST form was signed prior to June 1, 2010, the date the Family Health Care Decisions Act became effective?**

You may honor the previous versions of the form as if it were authorized after the statutory effective date.

### **Does the MOLST law allow EMS to honor other advance directives?**

The law does not expand the ability of EMS personnel to honor advance directives such as a Health Care Proxy or Living Will.

### **What procedures are, and are not, performed if the patient presents a DNR?**

Do not resuscitate (DNR) means, for the patient in cardiac or respiratory arrest (i.e., when the patient has no pulse and/or is not breathing), NO chest compressions, ventilation, defibrillation, endotracheal intubation, or medications. If the patient is NOT in cardiac or respiratory arrest, full treatment for all injuries, pain, difficult or insufficient breathing, hemorrhage and/or other medical conditions must be provided, unless Section E of the MOLST form provides different instructions. Relief of choking caused by a foreign body is usually appropriate, although if breathing has stopped, ventilation should not be assisted.

CPR must be initiated if no Out of Hospital or facility DNR is presented. If a DNR order is presented after CPR has been started, stop CPR.

### **What documentation is required for a patient with a DNR order?**

Prehospital care providers should attach a copy of the Out of Hospital DNR form, MOLST form, hospital DNR order and/or copy of the patient's chart to the patient care report, along with all other usual documentation. It should be noted on the patient care report that a written DNR order was present including the name of the physician, date signed and other appropriate information.

If the cardiac/respiratory arrest occurred during transport, the DNR form should accompany the patient so that it may be incorporated into the medical record at the receiving facility.

Patients who are identified as dead at the scene need not be transported by ambulance; however, local EMS agencies should consider transportation for DNR patients who collapse in public locations. In these cases it may be necessary to transport the individual to a hospital without resuscitative measures in order to move the body to a location that provides privacy. Local policies need to be coordinated with the Medical Examiner/Coroner and law enforcement.

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## **MOLST Training**

EMS providers and agencies who are interested in more specific training regarding the MOLST form and process may go to <http://www.compassionandsupport.org>. This site has a specific training program for EMS providers. The site contains frequently asked questions and a training video that would be useful to better understand the MOLST form and process.

If you have other questions about this policy guidance please contact your DOH Regional EMS office or you may call 518-402-0996.

## **Resources**

New York State Department of Health MOLST Information:

- [http://www.health.state.ny.us/professionals/patients/patient\\_rights/molst/index.htm](http://www.health.state.ny.us/professionals/patients/patient_rights/molst/index.htm)

MOLST Forms

- <http://www.health.state.ny.us/forms/doh-5003.pdf>

Compassion and Support Website:

- <http://www.compassionandsupport.org>

MOLST Training Center:

- [http://www.compassionandsupport.com/index.php/for\\_professionals/molst\\_training\\_center](http://www.compassionandsupport.com/index.php/for_professionals/molst_training_center)

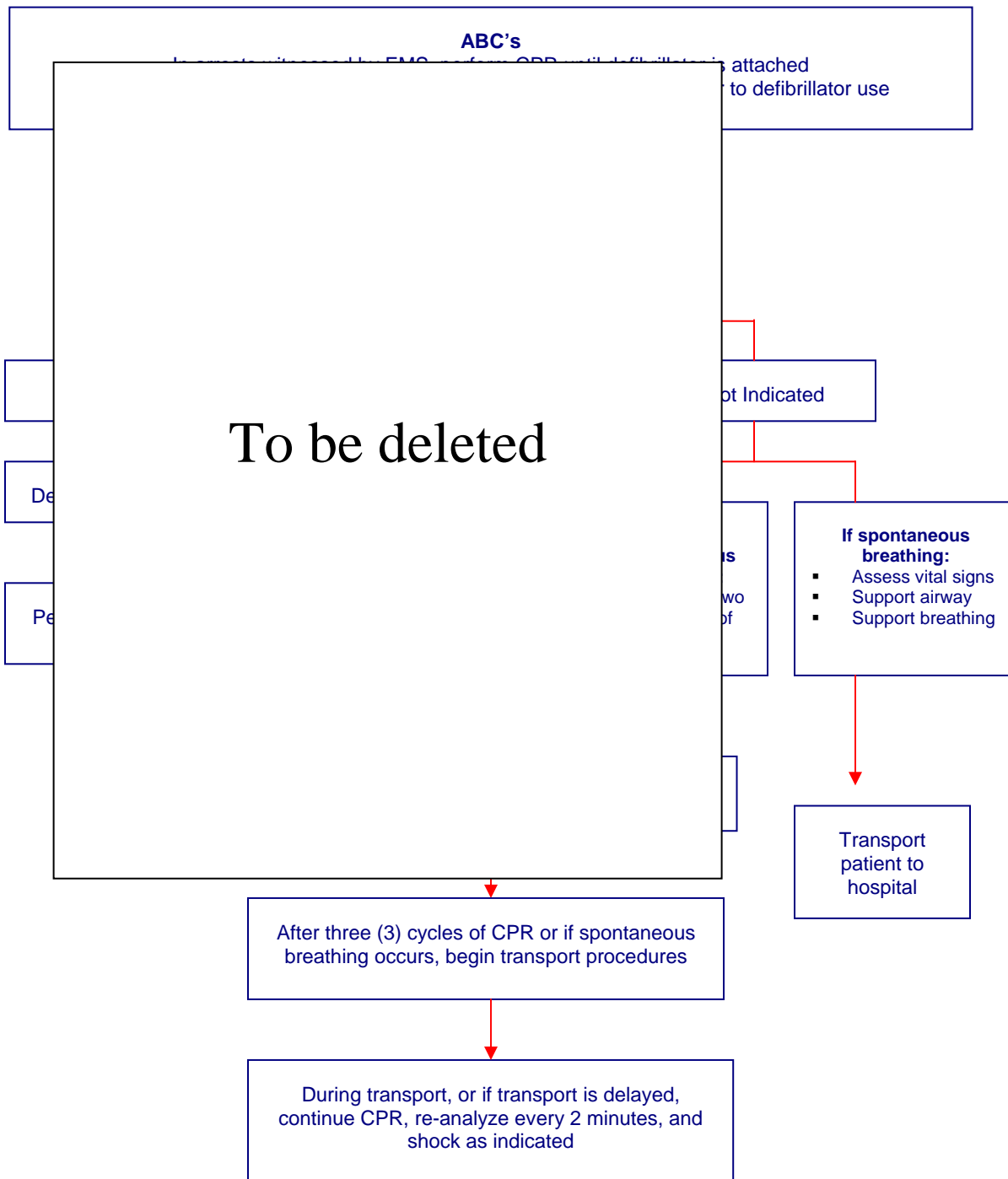
MOLST EMS Training Page:

- [http://www.compassionandsupport.com/index.php/for\\_professionals/molst\\_training\\_center/ems\\_molst\\_training](http://www.compassionandsupport.com/index.php/for_professionals/molst_training_center/ems_molst_training)

Issued and authorized by Lee Burns, Acting Director of the Bureau of EMS

APPENDIX D

AUTOMATED EXTERNAL DEFIBRILLATION (AED) GUIDELINES





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## APPENDIX H FACILITIES PROVIDING SPECIALTY CARE

<b>TRAUMA CENTERS</b>	<b>Brooklyn</b>	Brookdale Hospital
		Kings County Hospital
		Lutheran Medical Center
	<b>Bronx</b>	Jacobi Hospital
		Lincoln Medical Center
		St. Barnabas Hospital
	<b>Manhattan</b>	Bellevue Medical Center
		Harlem Hospital
		New York Presbyterian Hospital (Cornell Campus)
		New York Presbyterian Hospital (Columbia Campus) – <b>Pediatric Trauma Only</b>
		St. Luke's/Roosevelt Medical Center (St. Luke's Division) – <b>Adult Trauma Only</b>
	<b>Queens</b>	Elmhurst General Hospital
		Jamaica Hospital
		North Shore University Hospital (Long Island Jewish-Hillside Campus/Schnieder Children's Hospital) – <b>Pediatric Trauma Only</b>
		New York Medical Center of Queens
<b>Staten Island</b>	Richmond University Medical Center of SI	
	Staten Island University Hospital (North Division)	

<b>BURN CENTERS</b>	<b>Bronx</b>	Jacobi Hospital
	<b>Manhattan</b>	Harlem Hospital
		New York Presbyterian Hospital (Cornell Campus)
	<b>Staten Island</b>	Staten Island University Hospital (North Division)

<b>SPINAL CORD INJURY CENTER</b>	<b>Manhattan</b>	Bellevue Hospital Center
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<b>REPLANTATION CENTERS</b>	<b>Bronx</b>	Montefiore Medical Center
	<b>Manhattan</b>	Bellevue Hospital Center

<b>HYPERBARIC CENTER</b>	<b>Bronx</b>	Jacobi Hospital
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<b>VENOMOUS BITE CENTER</b>	<b>Bronx</b>	Jacobi Hospital
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## APPENDIX I HOSPITAL LISTINGS (AMBULANCE DESTINATIONS)

### MANHATTAN

FDNY Hospital #	FACILITY	ADDRESS	Upper Pediatric Age Limits
02	Bellevue Hospital Center	472 First Avenue New York, NY 10016	25
03	Beth Israel Medical Center – Petrie Campus	10 Nathan D. Perlman Place New York, NY 10003	17
07	Harlem Hospital Center	506 Lenox Avenue New York, NY 10037	18
11	Lenox Hill Hospital	100 East 77 <sup>th</sup> Street New York, NY 10021	17
	<i>Manhattan Eye/Ear/Throat Hospital</i>	210 East 64 <sup>th</sup> Street New York, NY 10021	
	<i>Department of Veterans Affairs Harbor Health Care- New York Campus</i>	1 <sup>st</sup> Avenue & 23 <sup>rd</sup> Street New York, NY 10016	
	<i>Memorial Sloan Kettering Hospital</i>	1275 York Avenue New York, NY 10021	
12	Metropolitan Hospital Center	1901 First Avenue New York, NY 10029	18
13	Mount Sinai Medical Center Hospital	One Gustave L. Levy Plaza New York, NY 10029	21
	<i>New York Eye &amp; Ear Infirmary</i>	Second Avenue & 14 <sup>th</sup> Street New York, NY 10003	
14	New York Presbyterian Hospital - New York Weill Cornell Campus	525 East 68 <sup>th</sup> Street New York, NY 10021	Pending
01	New York University Downtown Hospital	170 William Street New York, NY 10038	Not listed
15	New York University Medical Center – Tisch Hospital	550 First Avenue New York, NY 10016	Not listed
17	New York Presbyterian Hospital- Columbia Presbyterian Medical Center	622 West 168 <sup>th</sup> Street New York, NY 10032	19
16	New York Presbyterian Hospital - Allen Pavilion	5141 Broadway New York, NY 10034	Not listed
18	St. Luke's/Roosevelt Hospital Center St. Luke's Hospital Division	Amsterdam Avenue and 114 <sup>th</sup> Street New York, NY 10025	Not listed
20	St. Luke's/Roosevelt Hospital Center Roosevelt Hospital Division	428 West 59 <sup>th</sup> Street New York, NY 10019	21

*Italics indicate non-911 destination facility*

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### BRONX

FDNY Hospital #	FACILITY	ADDRESS	Upper Pediatric Age Limits
23	Bronx Lebanon Hospital Center – Concourse Division	1650 Grand Concourse Bronx, NY 10457	18
	<i>Bronx Lebanon Hospital Center – Fulton Division</i>	1276 Fulton Avenue Bronx, NY 10456	
	<i>Bronx VA Medical Center</i>	Sedgewick Avenue Bronx, NY 10400	
25	Jacobi Medical Center	1400 Pelham Parkway South Bronx, NY 10461	18
27	Lincoln Medical & Mental Health Center	234 East 149 <sup>th</sup> Street Bronx, NY 10451	18
29	Montefiore Medical Center – Moses Division	111 East 210 <sup>th</sup> Street Bronx, NY 10467	Not listed
70	North Central Bronx Hospital	3424 Kossuth Avenue Bronx, NY 10467	18
28	Montefiore Medical Center – North Division	600 East 233 <sup>rd</sup> Street Bronx, NY 10466	21
83	St. Barnabas Hospital	4422 Third Avenue Bronx, NY 10457	17
22	Montefiore Medical Center – Weiler Division	1825 Eastchester Road Bronx, NY 10467	21
88	NY Westchester Square Hospital Medical Center	2475 Raymond Avenue Bronx, NY 10401	

### WESTCHESTER

FDNY Hospital #	FACILITY	ADDRESS	Upper Pediatric Age Limits
	<i>Lawrence Hospital</i>	55 Palmer Avenue Bronxville, NY 10708	
	<i>Saint John's Riverside Hospital</i>	967 North Broadway Yonkers, NY 10701	
	<i>Saint Joseph's Medical Center</i>	127 South Broadway Yonkers, NY 10701	
	<i>Sound Shore Medical Center of Westchester</i>	16 Guion Place New Rochelle, NY 10802	
	<i>The Mount Vernon Hospital</i>	12 North 7 <sup>th</sup> Avenue Mount Vernon, NY 10550	
	<i>Westchester Medical Center</i>	95 Grasslands Road Valhalla, NY 10595	

*Italics indicate non-911 destination facility*

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## BROOKLYN

FDNY Hospital #	FACILITY	ADDRESS	Upper Pediatric Age Limits
93	Beth Israel Medical Center – Kings Highway Division	3201 Kings Highway Brooklyn, NY 11234	
41	Brookdale University Hospital Medical Center	Linden Boulevard at Brookdale Plaza Brooklyn, NY 11212	18
	<i>Department of Veterans Affairs Harbor Health Care- Brooklyn Campus</i>	Poly Place & 7 <sup>th</sup> Avenue Brooklyn, NY 11213	
42	Coney Island Hospital	2601 Ocean Parkway Brooklyn, NY 11235	18
55	Interfaith Medical Center - St. John's Division	1545 Atlantic Avenue Brooklyn, NY 11213	
48	Kings County Hospital Center	451 Clarkson Avenue Brooklyn, NY 11203	18
47	Kingsbrook Jewish Medical Center	585 Schenectady Avenue Brooklyn, N. Y. 11203	18
49	Long Island College Hospital	339 Hicks Street Brooklyn, NY 11201	18
51	Lutheran Medical Center	150 55 <sup>th</sup> Street Brooklyn, NY 11220	17
52	Maimonides Medical Center	4802 Tenth Avenue Brooklyn, NY 11220	17
92	New York Community Hospital of Brooklyn	2525 Kings Highway Brooklyn, NY 11229	Not listed
54	New York Methodist Hospital	506 Sixth Street Brooklyn, NY 11215	20
95	The Brooklyn Hospital Center	121 DeKalb Avenue Brooklyn, NY 11201	Not listed
44	University Hospital of Brooklyn-SUNY Downstate Medical Center	445 Lenox Road Brooklyn, NY 11203	18
45	Woodhull Medical & Mental Health Center	760 Broadway Brooklyn, NY 11206	
58	Wyckoff Heights Medical Center	374 Stockholm Street Brooklyn, NY 11237	

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## QUEENS

FDNY Hospital #	FACILITY	ADDRESS	Upper Pediatric Age Limits
32	Elmhurst Hospital Center	79-01 Broadway Elmhurst, NY 11373	
33	Flushing Hospital Medical Center	45-00 Parsons Boulevard Flushing, NY 11355	17
34	Jamaica Hospital	89 <sup>th</sup> Avenue & Van Wyck Expressway Jamaica, NY 11418	17
35	Long Island Jewish Hillside Medical Center	270-05 76 <sup>th</sup> Avenue New Hyde Park, NY 11042	18
31	New York Hospital Medical Center of Queens	56-45 Main Street Flushing, NY 11355	21
77	North Shore University Hospital – Forest Hills	102-01 66 <sup>th</sup> Road Forest Hills, NY 11375	Not listed
37	Peninsula Hospital Center	51-15 Beach Channel Drive Far Rockaway, NY 11691	17
38	Queens Hospital Center	82-68 164 <sup>th</sup> Street Jamaica, NY 11432	
40	St. John's Episcopal Hospital – South Shore Division	327 Beach 19 <sup>th</sup> Street Far Rockaway, NY 11691	
71	Mount Sinai Hospital of Queens	25-10 30 <sup>th</sup> Avenue Long Island City, N. Y. 11102	Permanent Diversion

## NASSAU

FDNY Hospital #	FACILITY	ADDRESS	Upper Pediatric Age Limits
74	Franklin Hospital Medical Center	900 Franklin Avenue Valley Stream, NY 11580	Not listed
68	Mercy Medical Center	1000 North Village Avenue Rockville Centre, NY 11571	
	<i>Nassau University Medical Center</i>	2201 Hempstead Turnpike East Meadow, NY 11501	
78	North Shore University Hospital Center Manhasset	300 Community Drive Manhasset, NY 11030	18
	<i>Saint Francis Hospital</i>	100 Port Washington Blvd. Roslyn, NY 11576	
	<i>Winthrop University Hospital</i>	259 First Street Mineola, NY 11501	

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## RICHMOND

<b>FDNY Hospital #</b>	<b>FACILITY</b>	<b>ADDRESS</b>	<b>Upper Pediatric Age Limits</b>
60	Richmond University Medical Center	355 Bard Avenue Staten Island, NY 10310	18
62	Staten Island University Hospital – North Ocean Breeze Campus	475 Seaview Avenue Staten Island, NY 10305	21
59	Staten Island University Hospital – South Prince's Bay Campus	375 Seguine Avenue Staten Island, NY 10309	Not listed

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## APPENDIX S

### New York City Burn Disaster Receiving Hospitals

#### Current List of New York City Burn Disaster Receiving Hospital (BDRH) Locations and Tier

Name of Hospital	BDRH Tier
Jacobi Medical Center	1
Harlem Hospital Center	1
New York Presbyterian/Weill Cornell	1
Staten Island University Hospital (North)	1
Lincoln Medical and Mental Health Center	2
St. Barnabas Hospital	2
Brookdale University Hospital Medical Center	2
Kings County Hospital	2
Lutheran Medical Center	2
Bellevue Hospital Center	2
New York Presbyterian/Children's Hospital	2
St. Luke's Roosevelt Hospital Center	2
Elmhurst Hospital Center	2
Jamaica Hospital Medical Center	2
New York Hospital Queens	2
Richmond University Medical Center	2
Montefiore Medical Center	3
North Central Bronx Hospital	3
Coney Island Hospital	3
Kingsbrook Jewish Medical Center	3
Maimonides Medical Center	3
Wyckoff Heights Medical Center	3
Metropolitan Hospital Center	3
Mount Sinai Medical Center	3
NYP/Columbia	3
NYU Hospitals Center	3
Flushing Hospital Medical Center	3
Forest Hills Hospital	3

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## APPENDIX T USE OF TOURNIQUETS <sup>2</sup>

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**Scope:** To reduce or stop severe extremity hemorrhage that cannot be controlled by direct pressure, by applying mechanical circumferential pressure to an open wound.

**Choice of Tourniquet:**

1. A tourniquet with a wider band is more effective at controlling bleeding than a very narrow one. The wider the tourniquet, the lower the pressure that is required to stop the bleeding. A tourniquet that is at least one inch wide is less likely to damage the surrounding tissues, including other vessels and nerves. Therefore, narrow tourniquets (like a thin string or wire) should be avoided.
2. Please see the most recent TCCC guidelines for a list of suggested commercial tourniquets. [<http://www.naemt.org/education/PHTLS/TCCC.aspx>]

**Application Process:**

1. Apply direct pressure.
2. Apply pressure dressings.
3. If these fail to control the bleeding, apply a tourniquet 2-3 inches proximal to the bleeding site.
4. Tighten the tourniquet until the bleeding stops and distal pulses are lost.
  - a. If bleeding continues or the patient has positive distal pulses, apply a second tourniquet parallel and proximal to the first, and tighten until bleeding stops.
5. Leave the tourniquets exposed so that they can be easily seen and monitored.
6. Document the TIME of tourniquet application (1) on the PCR/ACR, and (2) on a piece of tape on or near the tourniquet.
7. Once applied, a tourniquet should not be removed in the prehospital setting.
8. A patient with a tourniquet in place should be transported to the nearest Trauma Center.

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<sup>2</sup> Based on information from the Prehospital Trauma Life Support course