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

NYC REMAC

Advisory No.	2014-04		
Title:	2nd Revision/Update of REMAC Prehospital Treatment & Transport Protocols Clarifications / Corrections		
Issue Date:	April 10, 2014		
Effective Date:	May 1, 2014		
Supersedes:	n/a	Page:	1 of 5

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.

Corrections/clarifications have been made to Protocol revisions (REMAC Advisory 2014-01).

Attached: List of corrections/clarifications
Updated General Operating Procedures (version 05012014C)
Updated Advanced Life Support Protocols (version 05012014C)
Updated Appendices (version 05012014C)

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 ON MAY 1ST, 2014. All EMS PERSONNEL MUST BE UPDATED IN TIME FOR MAY 1ST, 2014 IMPLEMENTATION DATE. 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

Current and Updated Protocols can be accessed at the Regional EMS Council website: 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

Marie C. Diglio, EMT-P
Executive Director Operations
Regional Emergency Medical Services Council
of New York City

Corrections to May 2014 Protocols
Version "C"

Deleted = ~~**Red/Bold/Struck-out**~~; New = **Blue/Bold/Underscored**

General Operating Procedures

INTRAOSSEOUS (IO) ACCESS AND DRUG ADMINISTRATION

In cases of adult cardiopulmonary **arrest** or patients in decompensated shock, ~~**arrest**~~ in which IV access is unable to be obtained after no more than two attempts, IO access should be attempted via an approved extremity approach. Drug administration via this route will utilize doses identical to those used for IV administration. IO access via the sternum is considered to be unacceptable in the NYC region. ~~**Drug administration via this route will utilize doses identical to those used for IV administration. IO access via the sternum is considered to be unacceptable in the NYC region.**~~

1. If intraosseous access is established on a conscious patient, administer 0.5 mg/kg of 2% preservative-free Lidocaine via IO port, slowly over 2-3 minutes, up to a maximum of 50 mg prior to any other administration.

2. For continued discomfort or pain due to infusion repeat 0.25 mg/kg Lidocaine via IO port, slowly over 30 seconds, up to a maximum of 25 mg.

NOTE: When administering 2% preservative-free Lidocaine, it must be infused slowly to prevent it from being sent directly into the central circulation. Medications intended to remain in the medullary space, such as a local anesthetic, must be administered very slowly until the desired anesthetic effect is achieved.

NOTE: Drug administration via IO route will utilize doses identical to those used for IV administration.

IO access via the sternum is considered to be unacceptable in the NYC region.

Paramedic Advanced Life Support Protocols

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NON-CARDIOGENIC SHOCK

1. Begin Basic Life Support Shock procedures.
2. If a tension pneumothorax is suspected, perform Needle Decompression. (See Appendix O.)
3. Begin rapid IV/Saline Lock infusion of Normal Saline (0.9% NS) or Ringer's Lactate (RL) via one to two large bore (14 - 16) gauge catheters, up to 3 liters, via a macro-drip. **Consider using the intraosseous route if peripheral attempts have failed.**
4. Begin Cardiac Monitoring, record and evaluate EKG rhythm.
5. Transportation Decision.

Paramedic Advanced Life Support Protocols

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SEVERE SEPSIS/SEPTIC SHOCK

NOTE: THIS PROTOCOL IS TO BE USED FOR PATIENTS WITH ILLNESS OF A PRESUMED INFECTIOUS SOURCE. REFER TO APPENDIX U FOR CRITERIA.

1. Begin Basic Life Support Shock Measures.
2. If the patient is demonstrating signs of inadequate ventilation, perform Advanced Airway Management*.
3. Begin rapid IV/Saline Lock infusion of Normal Saline (0.9% NS) or Ringers' Lactate (RL) via one to two large bore (14-18) gauge catheters, up to 2 liters, via a macro-drip. Attempt IV access no more than twice. **Consider using the intraosseous route if peripheral attempts have failed.**
    a. Accurate documentation of pre-arrival fluid administration is required.
4. Begin Cardiac Monitoring, record and evaluate EKG rhythm.
5. Measure and record lactate level (if available).
6. Measure and record oral temperature (if available), also consider using last temperature obtained at patient's facility (if available).
7. Transport decision.
8. Contact Medical Control for implementation of one or more of the following MEDICAL CONTROL OPTIONS:

MEDICAL CONTROL OPTIONS:

OPTION A: Administer one (1) additional liter of Normal Saline (0.9% NS) or Ringers' Lactate (RL) via one to two large bore (14-18) gauge catheters.

* *If the patient is alert prior to performing Advanced Airway Management, refer to Prehospital Sedation in General Operating Procedures. Prior permission from Medical Control is required.*

Protocol Appendices

APPENDIX R

STROKE PATIENT CRITERIA

Patients exhibiting signs and symptoms of a stroke (CVA):

1. Utilize the modified Cincinnati Pre-Hospital Stroke Scale (PSS):
    a. Assess for facial droop: have the patient show teeth or smile,
    b. Assess for arm drift: have the patient close eyes and hold both arms straight out for 10 seconds,
    c. Assess for abnormal speech: have the patient say a simple sentence, for example: "you can't teach an old dog new tricks."

2. If any **one** of the findings of the modified Cincinnati Pre-Hospital Stroke Scale are positive, establish onset of signs and symptoms by asking the following:
    a. To patient – "When was the last time you remember before you became weak, paralyzed, or unable to speak clearly?"
    b. To family or bystander – "When was the last time you remember before the patient became weak, paralyzed, or unable to speak clearly?"
    c. If the patient woke with the deficit, the time of onset is the time patient went to sleep.
3. If the historical/physical findings indicate an acute stroke, transport the patient to the nearest NYS DOH designated Stroke Center (See Appendix R, Stroke Patient Criteria), unless **one** of the following conditions is met:
    a. The patient is in cardiac arrest;
    b. The patient has other medical conditions that warrant transport to the nearest appropriate hospital emergency department as per protocol;
    c. The total time from when the patient's symptoms and/or signs first began to when the patient is first assessed by EMS is greater than **three and one half (3 ½) hours**;
    ~~**d. The closest NYS DOH designated Stroke Center is more than 20 minutes away;**~~
    e. An on-line medical control physician so directs.