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

NYC REMAC

PUBLIC NOTICE

PROPOSED REVISIONS PREHOSPITAL TREATMENT PROTOCOLS

The Regional Emergency Medical Advisory Committee (REMAC) of New York City Prehospital Treatment Protocols define the minimum standard of care provided to patients by Certified First Responders (CFRs), Emergency Medical Technicians (EMTs), and Advanced Emergency Medical Technicians-Paramedic (AEMT-Ps) in New York City. These protocols reflect both the curriculum and certification requirements of the New York State Department of Health Bureau of Emergency Medical Services and the Regional Emergency Medical Advisory Committee (REMAC) of New York City.

The REMAC of New York City has proposed revisions to the current regional Prehospital Treatment Protocols.

Deleted language is BOLD RED AND STRUCK-OUT --- ~~**DELETED**~~

New language is BOLD BLUE AND UNDERLINED --- **NEW**

In order to meet regional needs, the REMAC of New York City is conducting a public notice and is requesting comments from the Emergency Medical community. Comments must be submitted in writing on the attached 'Comment Form' or via email to mklemm@nycremsco.org . If available, appropriate supporting documentation should also be submitted. **Comments must be received no later than May 12, 2024.**

Draft revised protocols can be reviewed on-line at www.nycremsco.org (under "News and Announcements"). All NYC REMAC Protocols can be accessed in their entirety at www.nycremsco.org.

Date Distributed/Posted: April 12, 2024

DIRECT ALL INQUIRES AND COMMENTS TO:

Pamela Lai, MD
Chair, Protocol Committee
Regional Emergency Medical Advisory Committee of New York City
c/o Regional EMS Council of NYC
475 Riverside Drive, Suite 1929
New York, New York 10115
Email: mklemm@nycremsco.org

PLEASE BE ADVISED THAT pursuant to Section 3004-A of Article 30 of the Public Health Law of the State of New York, the Regional Emergency Medical Advisory Committee (REMAC) of New York City is responsible to develop prehospital triage, treatment, and transportation protocols that are consistent with the standards of the State Emergency Medical Advisory Committee and that address specific local conditions with regards to the provision of prehospital medical care rendered by NYS Department of Health certified First Responders, Emergency Medical Technicians and Advanced Emergency Medical Technicians within the City of New York.

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Regional Emergency Medical Advisory Committee (REMAC) of New York City
Protocol Revision Comment Form

Name:	
Mailing Address:	
Telephone Number:	Fax Number:
e-mail:	Title (e.g., MD, DO, EMT, EMTP, RN, etc.):

Protocol Number: N/A	Protocol Title:

Comments: (Please Type)

(Continue on additional sheet if necessary)

If available, appropriate supporting documentation should be submitted.

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Chair, Protocol Committee
Regional Emergency Medical Advisory Committee of New York City
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This form may be duplicated as needed.

April 12, 2024 Public Notice

THE REGIONAL EMERGENCY MEDICAL SERVICES COUNCIL OF NEW YORK CITY

RESCUE TASK FORCE MEDICAL PROTOCOLS

These protocols apply ONLY to FDNY EMS Providers that are operating in a warm zone as Part of a Rescue Task Force

Purpose

To establish patient care protocols for FDNY EMS providers (CFR, EMT, Paramedic, and Physician) that allow for maximal effectiveness while operating in a warm zone as part of a dedicated Rescue Task Force (RTF).

Scope

The RTF is a team composed of members from the New York City Fire Department (FDNY) and the New York City Police Department (NYPD), which may be activated either in advance of a mass gathering event or after a mass casualty incident has occurred. The mission of the RTF is to provide time critical lifesaving medical treatment and extraction of victims.

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FDNY providers shall administer limited lifesaving medical treatment and extraction of victims. NYPD officers shall provide force protection to the FDNY RTF inside a warm zone. A warm zone is an area that has been determined by NYPD to have no identifiable threats; however, there may be potential threats to personal safety or health.

These protocols are to be used only by FDNY EMS providers when operating in a warm zone as part of an RTF. Standard REMAC protocols may not be used in a warm zone. Standard REMAC protocols will be used when providing care to patients after the patient has been removed to a cold zone.

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Medical Equipment

EMS providers will carry limited medical equipment into a warm zone. The following equipment is required for warm zone patient care. Additional medical supplies may be added based on operational objectives.

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Tourniquets	Gloves
Hemostatic dressing	Chest Seals
Pressure dressing	Decompression needles
Nasopharyngeal airways	Patient movement devices
Trauma shears	Surgical Marking Pen

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Standard Approach to Warm Zone Patient Care

1. Control life-threatening bleeding (see Protocol A: Hemorrhage Control).

2. Assess airway. If not spontaneously breathing, make one attempt to reposition the head to open the airway. If still no spontaneous breathing, the patient shall be marked as Black/Dead (see Protocol B: MCI Triage).

3. If patient is unconscious

    a. Place nasopharyngeal airway (NPA), if available.

    b. Place patient in the recovery position (i.e., on their side).

4. Cover open chest or neck wounds with an occlusive dressing. Chest wounds should be dressed using a vented chest seal, if available.

    a. If the patient subsequently develops worsened respiratory distress, consider the development of a tension pneumothorax, and treat by burping or removing the occlusive dressing.

5. Paramedic Only: If clinical signs of tension pneumothorax are present, perform needle decompression. Open chest wounds shall not be routinely decompressed.

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    Deleted: of chest (if equipped with decompression needle)...

6. Rapidly extract all patients to the cold zone. **ONLY** if unable to extract all patients, determine prioritization for removal (see Protocol B: Warm Zone Triage for Extraction Priority), then immediately extract Warm Zone Triage RED patients to the cold zone (see Protocol C: Patient Extraction).

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Once extracted to the cold zone, patient care will be transferred resources in the cold zone with a report given of injuries found and treatments provided. In the cold zone, EMS providers shall assess and treat the patients in accordance with standard REMAC protocols, including evaluation by modified START triage and application of triage tags.

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Protocols

A: HEMORRHAGE CONTROL

B: WARM ZONE TRIAGE FOR EXTRACTION PRIORITY

C: PATIENT EXTRACTION

D: EXTENDED CARE

A

HEMORRHAGE CONTROL

1. If life-threatening hemorrhage is identified on an extremity, immediately apply a tourniquet on proximal extremity ("HIGH and TIGHT").
    a. If continued life-threatening hemorrhage after the tourniquet is tightened, apply a second tourniquet HIGH and TIGHT, adjacent to the first tourniquet.
    b. If bleeding continues despite a second tourniquet, apply a hemostatic dressing to pack the wound and apply a pressure dressing

2. If life-threatening hemorrhage is identified in a junctional area, insert a hemostatic dressing to pack the wound and apply a pressure dressing.

NOTE: For life-threatening hemorrhage in the warm zone, do not attempt hemorrhage control with direct pressure prior to tourniquet or hemostatic dressing application.

3. Non-life-threatening bleeding may be controlled with gauze or a pressure dressing after other life threats have been addressed.

4. Non-bleeding extremity wounds should not be dressed in the warm zone if this will delay extraction or use limited supplies that may be needed for other patients.

B

WARM ZONE TRIAGE FOR EXTRACTION PRIORITY

Perform Warm Zone Triage **ONLY** if unable to extract all patients immediately.

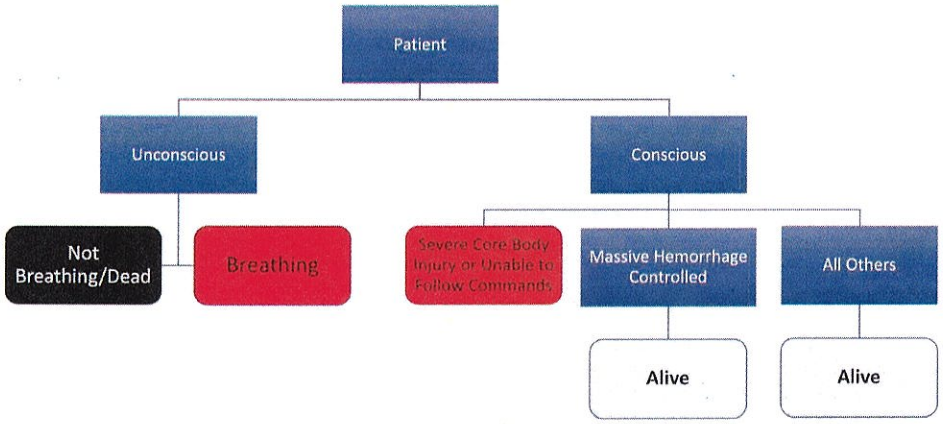
1. Determine appropriate Warm Zone Triage color according to below list and flowchart.

2. Write triage category on forehead of patient using marker. Use "A" for alive, "**RED**" for red, and "B" for black as defined below. Write on the patient's wrist if unable to mark patient on forehead due to moisture, blood, trauma or other condition.

   RED = unconscious, unable to follow commands, or severe core body injury (head / chest / back / abdomen / pelvis)

   Alive = alive

   Black = not breathing



Deleted: first letter of color (A, R, B) on forehead of patient using marker. Apply triage tag

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Deleted: Red = unconscious, unable to follow commands, or severe core body injury (head / chest / back / abdomen / pelvis)¶

RESCUE TASK FORCE MEDICAL PROTOCOLS

C

PATIENT EXTRACTION

Routes and timing of team movement shall be determined by the NYPD based upon tactical considerations. The method of patient transport (e.g., walking, litter etc.) shall be determined by EMS providers.

1. Rapidly extract all patients to the cold zone. If unable to extract all patients immediately, remove RED triaged patients first.

2. If unable to remove any patients due to tactical considerations, assess and treat other patients if possible.

3. Spinal motion restrictions may be deferred to the cold zone at provider discretion.

4. Patients may be assisted to ambulate even if there is an injury or medical condition that typically would require a stair chair or stretcher for movement.

5. RTF members may use alternative movement techniques to evacuate patients (e.g., dragging on a on a sheet, pushing on a wheeled office chair).

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D
EXTENDED CARE

This Extended Care Sub-Protocol is ONLY to be used in the event where immediate patient extraction is not possible.

This Sub-Protocol will only be used if authorized by both the OMA Physician and the Medical Branch Director.

The priority of care in a warm zone is to provide limited lifesaving interventions, followed by immediate patient extraction. Performance of care under this sub-protocol should not delay patient extraction, which should be done immediately when extraction is possible.

In the event where patient extraction is prolonged, either due to the number of patients or tactical situation, it may be beneficial to bring additional RTF-trained EMS providers and equipment into the warm zone to provide extended care.

1. Reassess all patients and re-triage using Warm Zone Triage categories.
2. Ensure patent airway using patient positioning, including sitting up for facial trauma.
3. For conscious patients with isolated head injuries, elevate the head and upper torso approximately twenty (20) degrees using jackets, bags etc.
4. Place fingertip pulse oximeters on patients for continuous monitoring, if available.
5. Determine priority for patient extraction.
6. Stabilize potentially unstable pelvic fractures, if possible.
7. Attempt to reposition angulated extremity deformities and apply splint.

8. Reduce risk of patient developing hypothermia by minimizing exposure to cold ground, wind, or ambient conditions, if possible.
    a. Insulate supine patients from conductive surfaces (e.g., concrete/metal/wet floor).
    b. Cover patient's trunk and extremities (e.g., using a Mylar blanket).
9. If a penetrating eye injury is noted or suspected, cover affected eye with a rigid eye shield.

Paramedic:

10. Reassess tourniquets for distal repositioning or conversion to pressure dressing if less than two (2) hours since placement.
11. For patients having severe pain, administer Fentanyl 1 ug/kg IN/IM (maximum 100 ug). For continued pain after 15 minutes, may repeat dose once.

Physician:

12. Reassess tourniquets for distal repositioning or conversion to pressure dressing if less than six (6) hours since placement.
13. If clinical signs of tension pneumothorax are present despite repeated needle decompressions of the chest, and patient has worsening shortness of breath or hemodynamic deterioration, consider performing finger thoracostomy.
14. Consider administering prophylactic antibiotics for patients with open or penetrating traumatic injuries.
    a. Cefotetan 2gms IM (Pediatric: 30mg/kg IM)

Additional medical equipment and medication required for the Extended Care Protocol:

Self-adhesive elastic bandage
Eye shield
Fentanyl
Fingertip pulse oximeter
Mylar blanket
Flexible splint
Sharp shuttle

Medical equipment and medications to be carried in the Physician RTF Medical Bag for Extended Care Protocol:

Cefotetan
Epinephrine (1:1000)
Intranasal atomizer
Naloxone
Needle (18 gauge)
Sharp shuttle
Syringe (10mL)