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.

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.

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.

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

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 **B**lack/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.

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).

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.

Protocols

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 <u>not</u> 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.

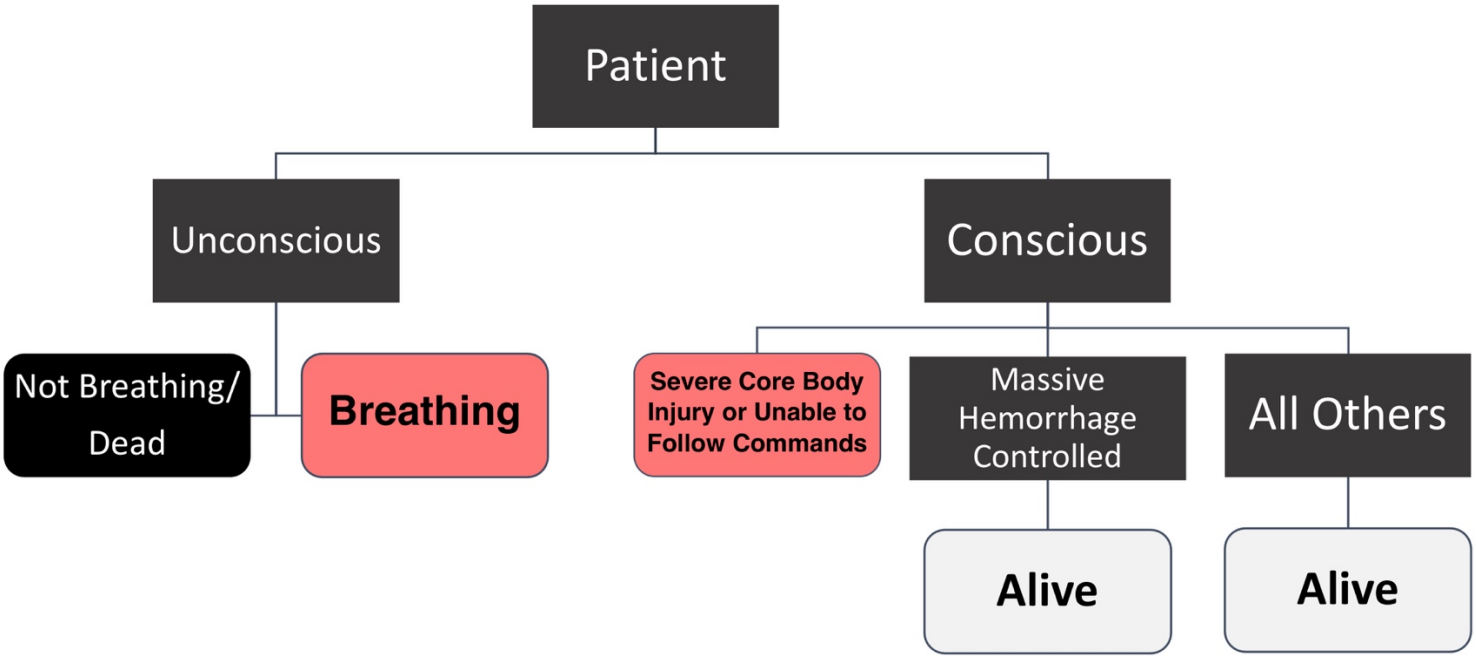
1. Determine appropriate Warm Zone Triage color according to below list and flowchart.

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



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).

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.

CFR and All Provider Levels

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. Determine priority for patient extraction.
5. 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).

6. If a penetrating eye injury is noted or suspected, cover affected eye with a rigid eye shield.

CFR STOP

EMT

7. Place fingertip pulse oximeters on patients for continuous monitoring, if available.
8. Stabilize potentially unstable pelvic fractures, if possible.
9. Attempt to reposition angulated extremity deformities and apply splint.

EMT STOP

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 mcg/kg IN/IM (maximum 100 mcg). For continued pain after 15 minutes, may repeat dose once.

PARAMEDIC STOP

PHYSICAN

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)

PHYSICIAN STOP

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

Eye shield
Fentanyl
Naloxone
Intranasal atomizer
Fingertip pulse oximeter
Mylar blanket
Splint
Elastic gauze (Kling)

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

Cefotetan
Epinephrine (1:1000)
Needle (18 gauge)
Alcohol swabs
Sharp shuttle
Syringe (1mL)
Syringe (10mL)