

Nassau Regional Emergency Medical Services



Nassau Regional EMS Council

Advanced Life Support Policy – Procedure - Protocol Manual

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		Approved/ <u>Revised</u>	<u>Effective</u>
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* = *New*

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Critical Care & Paramedic	Respiratory Arrest/Agonal Respirations	Protocol III.A
		Revised: 6/3/2009
		Effective: 9/01/2010

Standing Orders:

- A. Establish airway and ventilate PRN with BVM w/ O2
- B. If airway obstruction suspected and unable to clear by BLS maneuvers, perform direct laryngoscopy and use Magill forceps to remove foreign body
- >C. Perform endotracheal intubation *
A colorimetric CO2 detector must be used for secondary confirmation of proper endotracheal tube placement. Utilize waveform capnography.
- >D. If unable to intubate successfully after 2 attempts, or feasibility of successful intubation is questionable, consider alternate airway device, and immediately begin transport
- E. Establish IV access (Protocol III.S)
- F. Monitor ECG and Vital Signs

Medical Control Options:

- Consider Altered Mental Status protocol (III.F-2)
- If a Tension Pneumothorax is suspected, Needle Decompression

* **NOTE:** Digital Intubation may be attempted by EMT-P if direct visualization is not possible and the patient is unconscious and unable to bite provider.

> = New/changed information

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Critical Care & Paramedic	Ventricular Fibrillation/Pulseless V-Tach	Protocol III.B-1
		Approved: 10/4/2006
		Effective: 10/4/2006

Standing Orders:

- A. Begin BLS Cardiac Arrest procedures, if not already in progress.
- B. Cardiac monitoring
- C. * If unwitnessed arrest, immediately perform 5 cycles of CPR then check pulse
- D. Defibrillate 120-200 Joules biphasic (manufacturer specific) **or** 360 Joules monophasic
- E. Perform endotracheal intubation; establish IV access (Protocol III.S)
- F. Perform 5 cycles of CPR, do a rhythm/pulse check - after **EACH** shock or medication administration,
- G. Defibrillate maximum Joules (all devices), this and all future shocks
- H. Epinephrine 1:10,000 1 mg IV push or 2 mg via ET may be repeated every 3-5 mins.
- I. Defibrillate maximum Joules
- J. Amiodarone 300 mg IV push (if **no IV access** Lidocaine 3 mg/kg ET)

NOTE: CPR compressions should not be paused to administer meds, if possible

Medical Control Options:

- Epinephrine
- Amiodarone 150 mg IV push as a 2nd dose (Lidocaine if Amiodarone not available)
- Magnesium Sulfate 1-2gm IV over 10-20 min.

Any of the above orders may be repeated as per physician discretion

* If witnessed - perform CPR while preparing defibrillator and start with step "D"

NOTE: All cardiac medications should be followed by a 20 ml fluid flush prior to defibrillation

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Critical Care & Paramedic	Pulseless Electrical Activity (PEA) / Asystole	Protocol III.B-2
		Approved: 8/2/2006
		Effective: 8/2/2006

*** Consider causes; Shock, Traumatic Cardiac Arrest, Pericardial Tamponade, Hypovolemia, Tension Pneumothorax etc.**

Standing Orders:

- A. Begin BLS Cardiac Arrest procedures, if not already in progress.
- B. Perform endotracheal intubation; establish IV access (Protocol III.S)
- C. Cardiac monitoring – No shockable rhythm
- D. Perform 5 cycles of CPR, do a rhythm/pulse check
- E. Epinephrine 1:10,000 1 mg IV push (2 mg ET, if no IV) may be repeated every 3-5 mins.
- F. **If rate is below 60** Atropine 1 mg IV push (2 mg ET, if no IV) may be repeated every 3-5 minutes - **Maximum of 3 doses**
- G. Perform 5 cycles of CPR, do a pulse check – if NO shockable rhythm – Go to step “D”
- H. If shockable rhythm – see Protocol III.B-1 for V.Fib./Pulseless V-Tach.

NOTE: CPR compressions should not be paused to administer meds, if possible

Medical Control Options:

- Epinephrine
- Atropine
- If a tension pneumothorax is suspected consider orders to perform Needle Decompression
- Consider Altered Mental Status protocol (III.F-2)
- Consider Trauma/Shock protocol (III.R)
- Consider Field Termination of Resuscitative Efforts Procedure (II.C)

Any of the above orders may be repeated as per physician discretion

NOTE: All cardiac medications should be followed by a 20 ml fluid flush prior to defibrillation

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Critical Care & Paramedic	Return of Pulse Following Cardiac Arrest	Protocol III.B-3
		Revised: 8/2/2006
		Effective: 8/2/2006

Standing Orders:

- A. Secure Airway and support ventilatory needs
- B. Establish IV access (Protocol III.S)
- C. Monitor ECG
- D. Consider Protocol appropriate to presenting condition

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Critical Care & Paramedic	Chest Pain: Angina and Suspected MI	Protocol III.C-1
		Approved: 6/03/2009
		Effective: 9/01/2010

Standing Orders:

- A. Oxygen
- >B. Continuous cardiac monitoring
- >C. Aspirin 325 mg. chewed
- >D. Acquire 12-Lead ECG and transmit ECG to Medical Control, if capable.**
- E. Establish IV access (Protocol III.S)
- F. Administer Nitroglycerin 1/150 gr. SL or 1 metered spray *If BP is greater than 120 systolic or greater than 100 systolic WITH IV access*

Medical Control Options:

- Nitroglycerin
- Morphine Sulfate
- Aspirin
- >Fluid challenge
- >Transport to nearest PCI capable Hospital

Any of the above orders may be repeated as per physician discretion

>** *Medical Control physician will make determination if diversion to a PCI capable hospital is appropriate - if transmission of ECG is not possible or transmission is poor, EMT-CC is to be guided by machine' interpretation, EMT-P may make an interpretation by field reading.*

> = New/changed information

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Critical Care & Paramedic	Cardiogenic Shock with no Dysrhythmia	Protocol III.C-2
		Approved: 6/2/99
		Effective: 7/1/99

Standing Orders:

- A. Oxygen
 - B. Establish IV access (Protocol III.S)
 - C. Monitor ECG (if dysrhythmia present refer to appropriate protocol)
-

(Paramedic) D. Fluid Challenge

Medical Control Options:

- A. Dopamine 2-20 $\mu\text{g}/\text{Kg}/\text{min}$ IV Drip titrated to effect
- B. Fluid Challenge

Any of the above orders may be repeated as per physician discretion

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Critical Care & Paramedic	Wide Complex Tachycardia with Pulse	Protocol III.D-1
		Approved: 2/4/04
		Effective: 4/1/04

Standing Orders:

- A. Oxygen
- B. Establish IV access (Protocol III.S)
- C. Monitor ECG

(Paramedic) D. Administer Lidocaine 1.5 mg/Kg IV push

Medical Control Options:

- Synchronized or unsynchronized cardioversion 50 - 360 Joules.
- If Available, pre-medicate with Diazepam 2-10 mg IV push **or** Midazolam 2-5 mg IV push **or** Morphine Sulfate 2-10 mg IV push
- Lidocaine 1- 1.5 mg/Kg IV push
- Lidocaine IV Drip 2-4 mg/min
- Magnesium Sulfate 1-2 gm IV over 1-2 min
- Adenosine 6 mg Rapid IV push followed by a 20cc flush
- Adenosine 12 mg Rapid IV push followed by a 20cc flush

Any of the above orders may be repeated as per physician discretion

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Critical Care & Paramedic	Narrow Complex Tachycardia	Protocol III.D-2
		Approved: 2/4/04
		Effective: 4/1/04

Standing Orders:

- A. Oxygen
 - B. Establish IV access (Protocol III.S)
 - C. Monitor ECG
-

(Paramedic)

- D. *Valsalva maneuver*
- E. *If patient is conscious and alert, Adenosine 6 mg Rapid IV push followed by a 20 cc flush.*
- H. *If unsuccessful, Adenosine 12 mg Rapid IV push followed by a 20 cc flush.*

Medical Control Options:

- Valsalva maneuver
- Synchronized cardioversion 50 - 360 Joules
- If Available, pre-medicate with Diazepam 2-10 mg IV push **or** Midazolam 2-5 mg IV push **or** Morphine Sulfate 2-10 mg IV push
- Adenosine 6 mg Rapid IV push, followed by a 20 cc flush
- Adenosine 12 mg Rapid IV push, followed by a 20 cc flush
- Fluid Challenge

Any of the above orders may be repeated as per physician discretion

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Critical Care & Paramedic	Symptomatic Bradycardia	Protocol III.D-3
		Revised: 2/4/04
		Effective: 4/1/04

Standing Orders:

- A. Oxygen
- B. Establish IV access (Protocol III.S)
- C. Monitor ECG

(Paramedic) D. *If heart rate is less than 50 beats/min. and signs of decreased cardiac output, administer Atropine Sulfate 0.5 mg IV push (Except in the presence of second degree heart block Mobitz II or third degree heart block)*

Medical Control Options:

- Atropine 0.5-1 mg IV push
- Transcutaneous Pacing, if available, pre-medicate with Diazepam 2-10 mg IV push **or** Midazolam 2-5 mg IV push **or** Morphine Sulfate 2-10 mg IV push
- Dopamine 2-20 µg/Kg/min IV Drip titrated to effect
- Epinephrine 2-10 µg/min IV Drip
- Fluid Challenge

Any of the above orders may be repeated as per physician discretion

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Critical Care & Paramedic	Ventricular Ectopy	Protocol III.D-4
		Approved: 10/3/01
		Effective: 12/1/01

Standing Orders:

- A. Oxygen
- B. Establish IV access (Protocol III.S)
- C. Monitor ECG

Medical Control Options:

- Lidocaine 1-1.5 mg/Kg IV push
- Lidocaine 2-4 mg/min IV Drip
- Magnesium Sulfate 1-2 gm IV over 1-2 min

Any of the above orders may be repeated as per physician discretion

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Critical Care & Paramedic	Acute Pulmonary Edema	Protocol III.E
		Approved: 10/3/01
		Effective: 12/1/01

Standing Orders:

- A. Oxygen (be prepared to intubate)
- B. Establish IV access (Protocol III.S)
- C. Monitor ECG
- D. If Diastolic B/P at least 100 - Nitroglycerin 1/150 gr. SL or 1 metered spray (with or without IV access)

(Paramedic)

***IF SYSTOLIC BP 120 OR HIGHER
or SYSTOLIC BP 100 OR HIGHER WITH IV ACCESS***

- D. Nitroglycerin 1/150 gr. SL or 1 metered spray*
- E. Furosemide 40 mg, IV push (80 mg if already on Furosemide)*

Medical Control Options:

- Nitroglycerin 1/150 gr. SL or 1 metered spray
- Furosemide 40 - 100 mg IV push
- Morphine Sulfate 2-10 mg IV push
- Dopamine 2-20 µg/Kg/min IV Drip titrated to effect

Any of the above orders may be repeated as per physician discretion

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Critical Care & Paramedic	Anaphylaxis	Protocol III.F-1
		Approved: 2/5/03
		Effective: 5/1/03

Standing Orders:

- A. Oxygen, Intubate as indicated
- B. Establish IV access (Protocol III.S)
- C. Monitor ECG
- D. If due to insect sting, remove stinger

(Paramedic)

-
- E. Epinephrine 1:1000 0.4 mg SC
For patients in **SHOCK** *Epinephrine 1:10,000 0.5 mg IV push or 1 mg ET*
 - F. *Diphenhydramine 50 mg PO, IV push, or IM*
 - I. *Fluid Challenge*

Medical Control Options:

- Epinephrine 1:1,000 0.3-0.5 mg SC
- Epinephrine 1:10,000 0.1-0.5 mg IV or 1 mg ET
- * Albuterol OR Levalbuterol - one unit dose (1.25mg dose)
- Diphenhydramine 25-50 mg IM or IV or PO
- Fluid Challenge
- Dopamine 2-20 µg/Kg/min IV Drip titrate to effect
- Epinephrine IV Drip 2-10 µg/min

Any of the above orders may be repeated as per physician discretion

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Critical Care & Paramedic	Altered Mental Status	Protocol III.F-2
		Reviewed:
		Approved: 6/06/2007
		Effective: 12/01/2007

Standing Orders:

- A. Oxygen
- B. Establish IV access (Protocol III.S)
- C. Monitor ECG
- D. Thiamine 100 mg IV push
- * E. 50% Dextrose 25 grams IV over 1-2 min
- F. Glucagon 1 mg IM may be used if no IV access

Note: Perform a Glucometer test for blood sugar level, if it is less than 80 administer dextrose or glucagon as indicated in step E or F and continue monitoring, as needed, after administration.

(Paramedic)

-
- G. *In the presence of respiratory depression, Naloxone 0.4 mg IV push or IM or Nasal atomizer. Maybe repeated x2 if respiratory depression persists*

Medical Control Options:

- Dextrose
- Thiamine
- Naloxone
- Glucagon

Any of the above orders may be repeated as per physician discretion

Note: Use of a glucometer by any agency requires a NYS Limited Clinical Laboratory permit.

* = New/changed information

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Critical Care & Paramedic	Burns (Thermal and Electrical)	Protocol III.G
	Reviewed:	Approved: 6/06/2007
		Revised: 12/01/2007

Standing Orders:

- A. Remove smoldering and burnt clothing
- B. Oxygen & Maintain Patent Airway
- C. Establish IV access (Protocol III.S) (in unburned extremity)
- D. Monitor ECG
- E. Assess for shock, treat accordingly (Protocol III.R)
- F. Cover with sterile/clean dry dressings or Waterjel (or equivalent).
- G. Transport to a Burn Center if there is a manageable airway
- * H. See Pain Management Protocol III.P

Medical Control Options:

- Fluid Challenge
- * See Pain Management Protocol III.P

If transport is delayed, contact medical control for direction

* = New material

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Critical Care & Paramedic	Poisoning	Protocol III.J
		Approved: 6/2/99
		Effective: 7/1/99

Standing Orders:

- A. Oxygen (intubate if indicated)
- B. Establish IV access (Protocol III.S)
- C. Monitor ECG and Vital Signs
- D. If from external contamination, remove clothing and rinse with copious amounts of water

Medical Control Options:

- A. If organophosphate poisoning, Atropine 2 mg IV or IM,
Note - unusually high does may be required.
- B. Activated Charcoal 0.5-1.0 gm/Kg

Any of the above orders may be repeated as per physician discretion

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Critical Care & Paramedic	Suspected Cyanide Toxicity	Protocol III.K
	Reviewed:	Approved: 4/02/2008
		Effective: 11/01/2008

Standing Orders:

Ensure that the patient has been removed to a non-contaminated area

- A. Begin Basic Life Support procedures
- B. Establish airway and administer 100% Oxygen as appropriate
- C. Perform Endotracheal Intubation as necessary
- D. Establish IV access
- E. Monitor ECG and Vital Signs (Obtain SpCO reading if available)
- F. Begin transport

Medical Control Options:

- Initiate second IV Normal Saline (if possible obtain blood samples: (fluoride oxalate, K2 EDTA , lithium heparin tube)
- Hydroxocobalamin 5g (2 – 2.5g vials of crystalline powder) *(if available)*
** *Hydroxocobalamin must be administered in a dedicated IV*
- Sodium Thiosulfate 12.5g IV drip *(if available)*

** Sodium Thiosulfate, and Diazepam **MAY NOT** be administered via the same IV line as Hydroxocobalamin.

NOTE: A supply of Hydroxocobalamin kits will be maintained at Nassau Medical Control and will be available to be dispatched in an emergency.

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Critical Care & Paramedic	Acute Respiratory Distress (Asthma/COPD)	Protocol III.M
		Approved:12/07/2005
		Effective: 2/01/2006
		<i>Corrected: 8/04/2010</i>

Standing Orders:

- A. Oxygen (be prepared to intubate)
- * B. Albuterol Sulfate 0.083% (one unit dose of 3 ml) **OR**
Levalbuterol 1.25mg (one unit dose of 3 ml) **AND** one unit dose of Ipratropium (500mcg dose Atrovent); Albuterol **OR** Levalbuterol may be repeated once if symptoms persist
- C. Monitor ECG
- D. Establish IV access (Protocol III.S)

Medical Control Options:

- A. Epinephrine 1:1,000 0.3-0.5 mg SC
- B. Albuterol **OR** Levalbuterol
- C. Ipratropium (Atrovent)

Any of the above orders may be repeated as per physician discretion

* = *corrected*

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Critical Care & Paramedic	Emergency Child Birth	Protocol III.O
	Approved: 6/7/00	Revised: 6/7/00
		Effective: 9/1/00

Standing Orders:

- A. Evaluate the mother for signs of imminent delivery (contractions 2-3 minutes apart lasting for 60-90 seconds, crowning)
- B. If birth is imminent prepare for delivery
- C. Establish IV access (Protocol III.S)
- D. Assist in delivery of baby
- E. Provide post partum care to both mother and child
- F. If complications occur during or after delivery, follow appropriate procedures and contact medical control immediately
- G. If birth is not imminent, transport mother, on her left side, to an appropriate hospital with an obstetric service.
- H. Contact Medical Control

Medical Control Options:

- A. Fluid challenge
- B. Hospital Diversion
- C. Magnesium Sulfate 1-2 gm IV over 1-2 min

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Critical Care & Paramedic	Pain Management	Protocol III. P
		Reviewed:
		Effective: 12/01/2007

This protocol is designed to provide relief from severe pain for patients with the following types of conditions:

- A. Burns without hemodynamic compromise
- B. Isolated extremity fractures or dislocations with severe pain involved and anticipated long transport or disentanglement time
- C. Other conditions deemed appropriate by “on-line” Medical Control

Standing Orders:

- A. Manage ABC’s as necessary.
- B. Establish IV access
- C. Ketorolac (Toradol) 30 mg IV over 1 minute or 60 mg IM (ages 14-65)
(Over age 65 – halve the dose)

Medical Control Options:

- Morphine Sulfate
- Ketorolac (Toradol)

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Critical Care & Paramedic	Seizures	Protocol III.Q
	Reviewed:	Approved: 6/06/2007
		Effective: 12/01/2007

Standing Orders:

- A. Oxygen
- B. Establish IV access (Protocol III.S)
- C. Monitor ECG
- * D. In status epilepticus, Thiamine 100 mg IV push, followed by 50% Dextrose (25 gm) IV over 1-2 min

Note: If a Glucometer is available and blood sugar level is less than 80 administer dextrose or glucagon as indicated in step D and continue monitoring, as needed, after administration.

Medical Control Options:

- Diazepam
- Dextrose
- Thiamine
- Glucagon
- Magnesium Sulfate

Any of the above orders may be repeated as per physician discretion

Note: Use of glucometers by any agency requires a NYS Limited Clinical Laboratory permit.

* = New/changed information

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Critical Care & Paramedic	Major Trauma/Hypovolemic Shock	Protocol III. R
	Revised:	Approved: 6/06/2007
		Effective: 12/01/2007

Standing Orders:

- A. Initiate BLS stabilization procedures
- B. Oxygen, Intubate if indicated (use caution with possible C-spine injury)
- C. **BEGIN TRANSPORT AS PER NYS BLS TRAUMA PROTOCOL**
- D. Establish IV access (Protocol III.S) (do not delay transport to start IV)
Run wide open and titrate to BP of 90 systolic then run KVO. (**No more than 3 liters unless ordered by medical control**)
- E. Monitor ECG
- * F. See Pain Management Protocol III.P

Medical Control Options:

- Continue IV Drip beyond 3 Liters
- Hospital Diversion
- If a Tension Pneumothorax is suspected, Needle Decompression
- * See Pain Management Protocol III.P

* = New/changed information

Nassau Regional Emergency Medical Services



Critical Care & Paramedic	Adrenal Crisis	Protocol III. R-1
	Revised:	Approved: 8/04/2010
		Effective: 5/01/2011

Note: This protocol is **only for use** on patients who have been diagnosed with congenital adrenal hyperplasia and this is confirmed by medical alert tag, patient record, family or medical staff and presenting with signs of adrenal crisis.

Standing Orders:

- A. Oxygen
- B. Establish IV access (Protocol III.S)
- C. Administer Hydrocortisone Sodium Succinate (Solu-Cortef) 2 mg/kg IV push, (Not to exceed 100 mg.)
- D. Begin transport ASAP
- E. Have MedCon notify receiving hospital that patient has received Stress Dose of Hydrocortisone Sodium Succinate (Solu-Cortef).

Medical Control Options:

- Normal saline 20cc/kg IV bolus

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Critical Care & Paramedic	Crush Injury/Syndrome	III.R-2
		Approved: 8/04/2010
		Effective: 5/1/2011

This Protocol should be considered when the patient has been entrapped at the scene for more than two hours, one or more extremities trapped by an object capable of causing a crush injury, including machinery, dirt, rock, and rubble or there is entrapment of patient with history of previous cardiac or renal disease or dialysis treatment.

Crush Syndrome should be suspected in patients with entrapment/compression of greater than one hour, especially when a large muscle mass/group is involved. Treatment of the patient for Crush Syndrome *should begin before the patient is removed when practical.*

Standing Orders:

- A. Begin Basic Life Support procedures
- B. Establish airway and administer 100% Oxygen as appropriate — provide a barrier protection mask if Oxygen is not safe to administer, to act as a dust filter
- C. Perform Endotracheal Intubation as necessary
- D. Establish IV assess in unaffected limb:
 - Normal Saline 20 cc/kg up to 2 liters for fluid resuscitation, prior to release of compression force (limit bolus for patients with history of cardiac or renal dysfunction)
- E. Monitor ECG and Vital Signs (Obtain SpCO reading if available). Carefully monitor for dysrhythmia during the period immediately after release of pressure and during transport
- F. Consider Albuterol for possible hyperkalemia (peaked T-waves or wide QRS > 0.12 seconds), wheezing or bronchospasm:
 - 3 ml (2.5 mg) of a 0.083% solution nebulized, may be repeated.
- G. Release compression and transport patient to closest appropriate trauma facility.
- H. Non-compressive splints/dressings as needed
- I. Keep affected limb at level of the heart

Medical Control Options:

- Continued Normal Saline fluid bolus, 500 ml — 1000 ml
- Sodium Bicarb (NaHCO₃) 1 mEq/kg IVP at 10 minute intervals (**FOR CRUSH SYNDROME**)
- Morphine sulfate, if available, for pain: 0.1 mg/kg slow IVP or SQ one time — isolated extremity trauma. Not recommended for multi-system injury of systolic BP < 100 (due to vasodilator properties).

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Critical Care & Paramedic	Intravenous Access	Protocol III. S
		Approved: 10/3/2001
		Revised: 4/5/2006
		Effective: 10/5/2006

Standing Orders:

- A. For patients who do not require a fluid challenge, it is acceptable to initiate IV access via a saline lock or KVO line with normal saline
- B. For patients who require rapid volume IV Drip, at least one (1) large bore IV line with normal saline should be established.

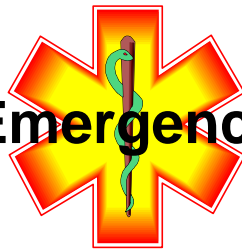
NOTE: KVO = 30 ml per hour

Using mini or micro set = 30 drops per minute
macro set = 5-8 drops per minute (depending on set)

NOTE: Peripheral veins other than the external jugular (EJ) should be used as the primary access site. For adult patients *in extremis*, the EJ vein may be used as an alternate site if other sites are not accessible.

NOTE: An FDA approved Tibial IO device may be used for adult patients *in complete vascular collapse* if other sites are not accessible.

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Critical Care & Paramedic	Special Medical Control Options	Protocol III.T
	Revised:	Approved: 6/06/2007
		Effective: 12/01/2007

The medications indicated below will be stocked by all Nassau REMAC approved ALS Ambulances and ALS First Response vehicles. These medications are not specific to any one protocol; however, a need has been identified for these medications to be available for medical control physicians to order as needed.

Medical Control Options:

Calcium Chloride – 250mg

Sodium Bicarbonate – 44meq in 50cc pre-filled syringe.

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		<u>Approved/ Revised</u>	<u>Effective</u>
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Paramedic Skills Use _____ →	I.K	10/01/08	11/01/08
* Expired Agency Operating Certificate	I.O	8/03/11	10/01/11
Hazardous Materials Treatment Teams _____ →	I.W	4/07/04	12/01/04

* = Recent Changes

Nassau Regional Emergency Medical Services



Policies	Introduction	Policy I.A
	Reviewed: 8/08/2007	Approved: 2/6/2008
		Effective: 3/01/2008

The Nassau Regional Emergency Medical Service's Advanced Life Support Protocols and Procedures have been approved by both the Nassau Regional Medical Advisory Committee and the Nassau Regional Emergency Medical Services Council Inc. They are to be used as a guide and a reference for all EMS personnel in their delivery of care. They represent both the standard New York State D.O.H. course curricula and current research and thinking in Emergency Medicine.

BLS providers are to use the New York State BLS Protocols which have been adopted by the Nassau Regional Medical Advisory Committee (REMAC).

The EMS provider is an extension of the physician and these policies are an integral part of the EMS system. Although much time and effort went into the development of these protocols, policies, and procedures, situations may arise which are not covered in this manual, when such a conflict or question arises, Medical Control is to be used as a resource. In the event of communication failure, standing orders should be combined with the providers training and judgment to deliver care which is both appropriate and within the scope of the providers training and certification.

Medical Control physicians have the discretion to order medication or dosages other than those indicated in "Medical Control Options."

The protocols and policies apply to all EMS personnel providing care within the Nassau Regional EMS System.

Nassau Regional Emergency Medical Services



Policies	Medical Control / Direction	I.B
	Reviewed: 6/13/2011	Revised: 8/3/2011
		Effective: 10/1/2011

Medical Control is defined by New York State law as advice and direction provided by a physician or under the direction of a physician to certified first responders, emergency medical technicians, or advanced emergency medical technicians who are providing medical care at the scene of an emergency or en route to a health care facility. Medical control may be contacted at any time, however when following ALS standing orders, they must be contacted within twenty (20) minutes of patient contact, except as indicated below. *If Medical Control was contacted during a call, then upon completion of the call the provider will call Medical Control and be given a run number and get times/treatments/MD information, patient demographics does not need to be provided.*

BLS Notification

Medical Control notification on routine BLS transports is suggested. In circumstances where the hospital may need to prepare for patient arrival (i.e. Major trauma, cardiac arrest, burns, or the administration of medications) the BLS provider must contact the hospital, by any means possible, and make a BLS notification.

Medical control may be used as a resource when questions arise as to proper patient care or transport.

ALS Notification

When the Advanced EMT initiates any ALS protocol or procedure, other than routine IV access and/or ECG monitoring, contact with medical control must be made. This contact should be made as soon as possible but should not delay appropriate patient care under standing orders. In the event of communication failure, the AEMT will be limited to the standing orders in the applicable protocol being followed.

Once medical control is contacted, standing orders are no longer applicable and the Medical Control physician is responsible for treatment options. After contact with medical control, if the patient's condition changes, the appropriate standing orders for the new presenting condition may be used until medical control is re-contacted.

Discretionary Decision

Where there is no existing protocol and a clear need for Advanced Life Support exists, the AEMT may initiate appropriate therapy (oxygen administration, cardiac monitoring, intravenous access and should contact medical control. At that time, the Medical Control physician may order the most appropriate treatment within the AEMT's scope of practice.

Nassau Regional Emergency Medical Services



Policies	Medical Authority at the Scene	Policy I.B-1
	Reviewed: 8/08/2007	Approved: 2/06/2008
		Effective: 3/01/2008

The EMS Provider at the scene with the highest level of New York State EMS certification is responsible for patient care. This does not relieve the BLS provider from providing appropriate BLS care when an ALS Provider is present.

In accordance with New York State guidelines and Nassau Policy I.H, an ALS provider may turn patient care over to a BLS provider if he or she deems that no ALS care is indicated.

In the event that a New York State licensed physician (MD or DO) wishes to assume responsibility for patient care at the scene they must first establish their identity by presenting one of the following and must agree to accompany the patient IN THE AMBULANCE to the hospital:

- Medical society card
- Professional organization membership card
- New York State Physician ID card
- Any other form appropriate of identification

Once the physician's identity is established, the ALS technician must limit his/her procedures to those contained in the protocol and procedure manual. At this point the physician must agree to accompany the patient IN THE AMBULANCE to the hospital. If a conflict or question arises, the ALS technician must contact medical control and carry out the directions of the medical control physician.

Nassau REMAC credentialed physicians can provide on-scene medical control and transfer patient care, as appropriate, to the on-line physician and are then not required to accompany the patient to the hospital.

If the on scene physician is the patient's attending and can not accompany the patient to the hospital, subsequent care will be carried out by the ALS technician in conjunction with the medical control physician, following the applicable EMS protocol(s). If a procedure has been initiated that is not within the ALS technician's scope of practice, the medical control physician will assume the responsibility for continuing or discontinuing this therapy.

In all cases of on-scene physician intervention, the ALS technician must document the physician's name and address (and license number, if available) in the comment section of the PCR.

Nassau Regional Emergency Medical Services



Policies	Ambulance Capacity	I.C
	Reviewed: 8/08/2007	Approved: 4/02/97
		Effective: 4/02/97

The following should be used as a guideline when confronted with a situation where there is multiple aided requiring transport. The guideline is intended to enhance the EMS technician's decision making process and does not replace the judgment of the technician responsible for transportation decisions. The number of aided to be transported in each ambulance is a decision that should be made by the highest medical authority at the scene. The decision is a judgment of risk and benefit to each patient's outcome.

Considerations:

The following issues are unique to each situation and should be taken into account when making the final transport decision:

- Type of patients: severity, need for specialty care (trauma, pediatric) relationships (supportive or hostile), medical considerations such as physical or emotional disabilities, need for privacy and infection disease risk.
- Type of Crew (ALS, BLS, gender)
- Response time for additional ambulances
- Transport times to receiving hospitals
- Unusual circumstances: weather, equipment failure at receiving hospitals etc.
- Medical Control Physician consultation

In general, patients requiring ALS care should not be transported with another patient unless extenuating circumstances exist.

An EMS technician may decide that there is a need to transport more than one patient in a single ambulance. When this is the case, every effort should be made to assign a technician to each patient in the ambulance. The level of care (ALS, BLS) should always match or be greater than the patient's needs.

Nassau Regional Emergency Medical Services



Policies & Procedures	Drug and Equipment Exchange List	I.E - Page 1 of 2
	Reviewed: 10/03/2007	Approved: 2/06/2008
		Effective: 3/01/2008

Airway/O2:

BVM
 Colorimetric CO2 detector
 Combitube
 EGTA
 End Tidal CO2 monitors
 ET Tube
 Hand held nebulizer with tubing

Nasal Cannula
 Nasopharyngeal airways
 Non-rebreather mask
 Oropharyngeal airways
 Suction catheters (Yankauer and soft)
 Surgilube

Trauma:

Padded board splints

Rigid cervical collars

Fluids and Administration Sets:

0.9% Sodium Chloride
 Saline Locks
 Minidrip administration sets
 Macro drip administration sets

Y tubing administration sets
 Buretrol administration sets

Medications:

Activated Charcoal
 Adenosine
 Albuterol 0.083% or Levalbuterol (Xopenex)
 Amiodarone HCL
 Aspirin
 Atropine Sulfate
 Calcium Chloride
 50% Dextrose & 10% or 25% Dextrose
 Diazepam
 Diphenhydramine
 Diphenhydramine capsule/tablet
 Dopamine
 Epinephrine 1:1000
 Epinephrine 1:10,000
 Furosemide

Glucagon kits
 Glucose paste
 Ipratropium (Atrovent)
 2% Lidocaine
 0.4% Lidocaine infusion
 Ketorolac (Toradol)
 Magnesium sulfate
 Midazolam
 Naloxone
 Nitroglycerin tablet or metered spray
 Morphine Sulfate
 Sodium bicarbonate
 Syrup of Ipecac
 Thiamine

Nassau Regional Emergency Medical Services



Policies & Procedures	Drug and Equipment Exchange List	I.E - Page 2 of 2
Reviewed: 10/03/2007		Approved: 2/06/2008
		Effective: 3/01/2008

Syringes and Needles (Should be needleless type):

- 1cc TB syringe with 26g 3/8 inch needle
- 3cc with 25g 5/8 inch needle
- 5cc with 18 g or 21 g 1½ inch needle
- 10 cc syringe
- 30 cc syringe

Needles

- 25 g 5/8 inch
- 21 g 1½ inch
- 18 g 1½ inch

Angiocaths

- 20g – 24g 1¼ inch assorted
- 18g 1¼ inch or 2 inch
- 16g 1¼ inch or 2 inch
- 14g 1¼ inch or 2 inch
- 15 or 17g spinal or I/O needle

Blood Drawing Equipment:

- Assorted blood tubes
- Vacutainer adapters

- Luer needles
- Lancets

Miscellaneous:

- Towels
- Sheets
- Pillows
- Pillowcases
- Blankets
- Emesis basins
- ECG electrodes
- Sterile Water
- Sterile Saline

Nassau Regional Emergency Medical Services



Policies	Agency Medical Director Credentialing	I.F
	Reviewed: 10/03/2007	Approved: 8/01/2007
		Effective: 11/01/2007

It is the policy of the Nassau Regional Medical Advisory Committee that in order to be eligible to become a credentialed EMS Agency Medical Director, a physician must meet the following criteria:

- Must hold a current NYS License to practice Medicine and Surgery
- Have ACLS training or equivalent medical specialty training with a preference to ABEM and ABOEM.
- Must have completed a specialty training program in Emergency Medicine, or other appropriate medical specialty with adequate documentation for verification.
- Must complete the Credentialing/information packet and return the necessary items including:
 - a. Must complete a REMAC Protocol take home exam
 - b. Must submit a copy of the physicians CV to REMAC
 - c. Return Letter of Agreement between physician and agency with both signatures
 - d. Submit copy of diploma indicating successful completion of medical specialty training program
 - e. Submit a copy of current ACLS card

Final Medical Director Credentialing is subject to REMAC approval

Note: Attendance at REMAC meetings is **strongly** encouraged.

Nassau Regional Emergency Medical Services



Policies	ALS to BLS Transfer Guidelines	I. H
	Reviewed: 8/08/2007	Approved: 2/06/2008
		Effective: 3/01/2008

These guidelines are intended to assist EMS providers in determining when patients who are evaluated by an EMT/AEMT may safely be transferred to a EMT for continued care and transportation. They can be utilized when an EMT/AEMT responds to and assesses a patient as requiring a basic life support level of care.

The highest certified EMT (P, CC, Basic) at the scene is responsible for the patient care. These guidelines are not intended to limit the on-scene judgment of any EMS provider in the Prehospital setting.

I. ALS personnel should transport patients with the following problems:

- Major Trauma
- Chest pain or **pertinent** history of a cardiac condition
- Altered mental status
- Cardiopulmonary Arrest
- Physiologic Shock
- Respiratory distress as evidenced by dyspnea with:
 - a. Respiratory rate less than 10 or greater than 29 **or**
 - b. Altered mental status **or**
 - c. Cyanosis **or**
 - d. Pulmonary edema
- Anaphylaxis
- **Pertinent** history of a diabetic condition
- Drug overdose/Poisoning
- Moderate to severe burns
- Complications of childbirth or pregnancy

II. 1. Complete the Initial Assessment and make a determination if the patient is stable for BLS transport
 2. Verify that no ALS procedure has been initiated or indicated

III. If the level of care is questioned, the Medical Control Physician will make the final determination as to level of care and transfer, the Medical Control Physician has the authority to order ALS transport

Nassau Regional Emergency Medical Services



Policies	Decision Not To Initiate C.P.R.	Policy I. J
	Reviewed: 10/03/2007	Approved: 10/01/2003
		Effective: 11/01/2003

Pronouncement of death is the determination that life does not exist. New York State law does not require that death be pronounced by a physician. There is no official standard to pronounce death and pronouncement is implied by the decision not to initiate Cardiopulmonary Resuscitation (New York State Department of Health Vital Records Registration Handbook, 2nd Ed.).

A. Making Determination NOT to Initiate CPR

In review of the State Health Department Policy, the EMT may decide not to initiate CPR in the following situations:

1. The arrest occurs during an inter-facility transfer and the sending facility has provided the EMT's with a written order not to resuscitate the patient.
2. The patient is enrolled in a Hospice program and a **written order not to resuscitate** the patient is presented by the family, **or patient has a DNR bracelet**, or the prehospital personnel have prior notification of the order in writing from the Hospice program.
3. In cases of obvious death such as, decapitation or other similarly mortal injuries or where rigor mortis, tissue decomposition, or extreme dependent lividity is present.

The following Policy shall be in effect for the Nassau Regional Emergency Medical Services System:

B. Actions to be Taken After Determination is Made

In accordance with the New York State Emergency Medical Services Policy of Cardiopulmonary Resuscitation, when an EMT responds to the scene of a call as a member of the Nassau County EMS system and decides not to initiate CPR:

1. The Prehospital Care Report (PCR) should be completed and include all appropriate clinical and identifying information including description of patients clinical condition, time of decision and crew names/ID numbers.
2. The hospital copy of the PCR must be given to a Police Officer and either the Police Officer or the EMT must contact the Medical Examiner's Office (24 hr. # 542-5166) prior to leaving the scene.
3. The Nassau County Medical Examiner's Office will consider this PCR as documentation of a pronouncement of death and render any further pronouncement unnecessary.

Nassau Regional Emergency Medical Services



Policies	Paramedic Skills Use	Policy I.K
	Reviewed: 8/28/2008	Approved: 10/8/2008
		Effective: 11/1/2008

The EMT-P skills identified in the Nassau Regional EMS Protocols may be used by the following:

1. Currently NYS Certified EMT-P with current Nassau REMAC ETI credentials.
2. Physician Assistants (PA) or Registered Nurses (RN), with a current NYS EMT-CC certification, ACLS and PALS certification, and current Nassau REMAC ETI credentials.

PA's and RN's who meet the criteria in 2 may apply for authority to practice at the EMT-P level by submitting a request, in writing, with a copy of their license, registration and each of the above certifications.

Requests must be submitted to:

Nassau Regional Emergency Medical Advisory Committee
2201 Hempstead Tpk. Bin#78
East Meadow, NY 11554

PA's and RN's must provide copies of Registration, ACLS and PALS certifications each time that they are renewed.

PA's & RN's who are credentialed to perform EMT-P protocol skills are responsible to comply with all the duties and responsibilities that pertain to an EMT-P.

The authority for all patient management will permanently reside with the physician at Medical Control, unless Medical Authority at the Scene (I.B-1) criteria is met.

Nassau Regional Emergency Medical Services



Policies	Expired Agency Operating Certificate	I. O
	Reviewed: 6/13/2011	Approved: 8/3/2011
		Effective: 10/1/2011

The New York State Department of Health Bureau of Emergency Medical Services has determined that when an ambulance agency fails to renew their NYS Operating Certificate at or before its expiration date they are no longer authorized to provide ambulance service. In fact they have deemed that any ambulance agency that continues operating after their certificate has expired is in violation of NYS Public Health Law 3005 and multiple section of Part 800, NYS EMS Code. Further, it should be noted that, during the uncertified period, the agency is no longer afforded any of the protections under the law and places their certified personnel at risk.

The State has advised the REMAC that any Advanced Life Support (ALS) service that allows their certification to expire is no longer authorized to provide care, to include ALS level of care. They have also indicated that **any ALS agency that subsequently renews an expired certification must make new application to the REMAC** to be authorized to operate at any ALS level of care.

Agencies applying for authorization to operate at an ALS level of care must complete and submit the following to the REMAC:

- A letter on agency letterhead requesting that the agency be authorized to operate at the EMT-CC or EMT-P level of care, the letter must be signed by the agency Chief/President.
- Agency Personnel Roster form (DOH-2828b)
- Medical Director's Verification form (DOH-4362)
- Certified EMS Agency Information Update form (DOH-2936)

Agencies are reminded that the REMAC must vote to approve these requests and they currently meet on the 1st Wednesday of even numbered months.

Nassau Regional Emergency Medical Services



Policies	Hazardous Materials Treatment Teams	I. W – Page 1 of 4
	Reviewed: 10/03/2007	Approved: 4/07/2004
		Effective: 12/01/2004

Introduction

Protocols to facilitate rapid medical intervention at the scene of Hazardous Materials incidents have been developed by the Protocol Subcommittee to the Regional Emergency Medical Advisory Committee (ReMAC). To ensure that these aggressive protocols are under more direct medical oversight, and are only used by skilled and trained technicians, ReMAC has created the following policy.

This policy establishes the following:

1. Scope of Application
2. Organization
3. Medical Supervision
4. Treatment review and reporting (Quality Improvement)
5. Training
6. Dispatch Recommendations
7. Requirements for internal procedures

Scope

This policy applies to the utilization of Nassau ALS Protocol III.X — Hazardous Material Treatment, herein referred to as "Advanced HazMat Treatments" or "AHT".

Organization

Only qualified and authorized members of a team organized by a volunteer fire department, volunteer ambulance corps, Police Department or hospital based EMS agency and approved by Nassau ReMAC are authorized to provide Advanced HazMat Treatments.

Nassau Regional Emergency Medical Services



Policies	Hazardous Materials Treatment Teams	I. W – Page 2 of 4
	Reviewed: 10/03/2007	Approved: 4/07/2004
		Effective: 12/01/2004

Medical Oversight

The recognized team, or other organization, shall have a written agreement with a physician Board Certified in Emergency Medicine or who is ReMAC qualified.

The written agreement, a current copy of which must be submitted to the ReMAC, shall include the following at a minimum:

1. Name and contact information for the designated physician
2. Qualifications of the physician and a copy of their New York State Medical License.
3. Physician participation in Team Quality Improvement (QI) Activities
4. Physician review each use of AHT
5. Submission of a written summary of each physician review of AHT to the regional Quality Improvement Coordinator with appropriate recommendations if applicable.
6. Physician approval of team training
7. Requirement for the physician to participate in the Regional QI program.
8. A copy of any procedures or polices developed by or for the team/organization.

Quality Improvement

Each team shall have a quality improvement plan that specifically ensures that training, use of AHT, and availability of AHT, is assessed and documented following each Hazardous Materials Incident to which the team is dispatched. At a minimum, an annual assessment shall be conducted and documented.

A summary of each assessment with observations and recommendations as appropriate shall be sent to the regional Quality Improvement Coordinator.

A specific person in each team or organization shall be designated to coordinate Quality improvement. The designated person shall respond to requests for information from the regional Quality Improvement Coordinator.

To the extent practical, and at the discretion of the team or organization, the QI plan may be part of the existing QI program, so long as it includes the elements above.

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Policies	Hazardous Materials Treatment Teams	I. W – Page 3 of 4
	Reviewed: 10/03/2007	Approved: 4/07/2004
		Effective: 12/01/2004

Training

Specific written Training requirements for the team or organization shall be developed and approved by the designated physician. At a minimum, all personnel authorized to administer AHT shall be trained to the Hazardous Materials Operations Level as defined in 29CFR1910.120 the OSHA Hazardous Waste Operations and Emergency Response (HAZWOPER) Standard.

Teams and organizations providing AHT should be familiar with County Police and Fire Marshal Hazardous Materials Teams and their procedures.

Dispatch

Each team or organization should notify and be on file with the 911 and Fire Communications dispatch with availability information.

It is desired that at least one or more Advanced Medical Technicians be assigned with their properly equipped unit to each Hazardous Materials Incident where personnel are thought to be contaminated or where public sector Hazardous Materials teams are operating in Level A, B, or C personnel protective levels.

No AHT protocol procedures may be initiated unless Advanced Life Support (ALS) personnel authorized and approved under this policy are present at the scene to administer them.

Procedures

Each team or organization providing AHT shall have written procedures approved by the current Medical Director.

The procedures shall include at the minimum the following elements:

1. Training Requirements
2. Quality Improvement Plan

Nassau Regional Emergency Medical Services



Policies	Hazardous Materials Treatment Teams	I. W – Page 4 of 4
	Reviewed: 10/03/2007	Approved: 4/07/2004
		Effective: 12/01/2004

3. How to determine when approved protocols will be used (e.g. how the technician will determine what chemical the patient has been exposed)
4. Response procedure
5. Equipment List and Location
6. Access Control to Medications
7. A Current list of personnel with each persons NYS EMS certification number, level, and expiration date, authorized to provide AHT

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Policies	Hazardous Materials Treatment Teams	I. W – Page 3 of 4
		Approved: 4/7/2004
		Effective: 12/1/2004

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Policies	Hazardous Materials Treatment Teams	I. W – Page 4 of 4
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Nassau Regional EMS Council
Advanced Life Support
Policy – Procedure - Protocol Manual

Section II – Procedures - Table of Contents

	<u>Approved</u>	<u>Effective</u>
Alternative Hospital Destinations —————→	II.A	4/04/1999 7/01/1999
EMS Helicopter Guidelines —————→	II.B	2/06/2008 3/01/2008
Field Termination of Resuscitative Efforts —————→	II.C	2/04/2004 4/01/2004
* Hospital Diversion —————→	II.D-1	12/08/2008 8/01/2009
* Ambulance Redirection —————→	II.D-2	12/08/2008 8/01/2009
* ALS Technician Credentialing —————→	II.E	6/03/2009 6/03/2009

* = Recent Change

Nassau Regional Emergency Medical Services



Procedures	Alternative Hospital Destinations	II.A - Page 1 of 2
		Approved: 4/4/99
		Effective: 7/1/99

This procedure supersedes the New York State Basic Life Support Protocol "General Approach to Prehospital Management" Transport section. This procedure applies to all BLS and ALS transports as appropriate.

The purpose of this guideline is to assist EMS agencies with transportation decisions in situations where there is no major trauma and the technician or patient/family request transportation to a hospital which is not the nearest hospital. This guideline is intended to enhance the EMS technician's decision making process and does not replace or challenge the judgment of the scene technician responsible for transportation decisions. The decision to transport an emergency patient in an ambulance to an alternative destination is a risk/ benefit judgment and remains with the emergency medical technician responsible for patient care. Consultation with the on-line medical control physician is encouraged, especially when the technician and patient/family do not agree on the hospital disposition.

A. Transport the patient as soon as possible to the nearest appropriate hospital.

1. If mechanism of illness/injury and/or historical/physical findings do not indicate major trauma:
 - a. Transport the patient to the nearest regionally approved hospital emergency department (ED); **or**
 - b. Transport the patient to a regionally approved alternative destination* if:
 - (1) The patient remains stable or potentially unstable throughout the transport, **and** the patient requests treatment, or receives regular medical/surgical care, at the alternative destination, **and** the additional transport time to the alternative destination is less than 10 minutes; **or**
 - (2) The patient requires specialty care at the alternative destination that is unavailable at the nearest hospital; **or**
 - (3) An on-line medical control physician so directs.

*** Hospitals are the only Nassau ReMAC regionally approved alternative destinations to receive emergency patients by ambulance.**

Nassau Regional Emergency Medical Services



Procedures	Alternative Hospital Destinations	II.A - Page 2 of 2
		Approved: 4/4/99
		Effective: 7/1/99

NOTE:

Patients who are critical or unstable must be transported to the nearest hospital emergency department!

2. If mechanism of injury and/or physical findings do indicate major trauma:
 - a. Transport the patient to the nearest regionally designated Regional or Area Trauma Center if the total time elapsed between the estimated time of injury and the estimated time of arrival at the Trauma Center is less than one hour; **or**
 - b. Transport the patient to the nearest hospital emergency department if:
 - (1) The total time elapsed between the estimated time of injury and the estimated time of arrival at the Trauma Center is more than one; **or**
 - (2) The patient is in cardiac arrest; **or**
 - (3) The patient has an unmanageable airway; **or**
 - (4) An on-line medical control physician so directs.

B. Intercept with an ALS unit (if available) en route to the nearest appropriate hospital as noted in specific treatment protocols.

NOTE:

Do not delay patient transport to await the arrival of an ALS unit!

Agency Resources: Allocation of ambulances and technicians at the time of a request for an alternative hospital destination is unique to each situation and should be considered in transportation decisions. Nassau ReMAC requests that each EMS agency in the Region develop an agency policy that addresses alternative destinations.

Nassau Regional Emergency Medical Services



Procedures	EMS Helicopter Guidelines	Procedure II. B Page 1 of 5
	Reviewed: 12/12/2007	Approved: 2/06/2008
		Effective: 3/01/2008

Utilization: The Nassau County EMS System utilizes the Nassau County Police Department Aviation Unit helicopters for aero medical emergency transportation. These helicopters are certified as ambulances in New York State and are staffed by a pilot and an EMT-CC or Paramedic (herein referred to as “medic”). There are special circumstances and injuries that may require the use of the helicopter to enhance the care of the patient and the speed of transport to the hospital.

Request System: Each helicopter has the capacity to transport two patients in a bunked position. There is a crew on site at the Aviation Unit for two tours from 7:30 a.m. to 11:20 p.m. daily. Between 11:20 p.m. and 7:30 a.m. crews are “on call” and there is a 45-minute response time

The highest medically qualified individual at the scene will request the helicopter for EMS transport. The NCPD Aviation Unit can be requested via:

- Direct Phone – 573-4000
- Nassau Police Communications Center (by Radio or call 911)
- Fire Communications (FireCom)
- Medical Control

Direct radio communications with the helicopter(s) can be established through Medical Control. Medical Control will assign a medical control channel to communicate directly with the flight crew.

Aviation Unit medics will contact medical control for all notifications and ALS runs.

Patient Selection: It is recognized that the decision to request air transport is one, which is made by EMS personnel, based on the patient’s clinical condition and consequent “safety vs. benefit” analysis

The following clinical situations serve as guidelines in determining when to request helicopter transport:

- A. Patients Appropriate for Helicopter Transport

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Procedures	EMS Helicopter Guidelines	Procedure II. B Page 2 of 5
Reviewed: 12/12/2007		Approved: 2/06/2008
		Effective: 3/01/2008

1. Patients that meet the New York State Trauma Deferral Guidelines **when transportation time can be decreased by more than 15 minutes**
2. Patients with Second and Third Degree Burns covering greater than of 30% of the body **when ground transportation time to the referral site can be decreased by 15 minutes or more**
3. When patient extrication and ground transport begins to infringe on the "Golden Hour" or trauma care, the helicopter should be considered **if transport time can be decreased by 15 minutes or more**
4. Patients with suspected spinal injury when ground transport on unpaved roads interferes with spinal stabilization or may further compromise the patient's condition

B. Patients Inappropriate for Helicopter Transport

1. Patients who weight more than 250-300 lbs. (flight crew will make the final determination)
2. Patients with a potential altered mental status (emotion disorders, drug/alcohol abuse, or general agitation)
3. Patients with acute CHF, acute MI, and any patient who must be positioned with the head and upper body elevated
4. Patients who express fear of specific aversion to air transport
5. Any patient who, in the judgment of the medic, is potentially inappropriate

NOTE: If a patient is deemed inappropriate, if requested, the medic will assist the ground crew for ground transportation.

C. Transfer of Medical Responsibility

The NCPD Aviation Unit has the authority to refuse air transport

The ground EMS crew is responsible for care and transport of all patients, who, in their judgment, are inappropriate for air transport or when the NCPD Aviation Unit is unable to transport

Nassau Regional Emergency Medical Services



Procedures	EMS Helicopter Guidelines	Procedure II. B Page 3 of 5
	Reviewed: 12/12/2007	Approved: 2/06/2008
		Effective: 3/01/2008

NCPD Aviation Unit medics will assume the medical responsibility for the patient once the decision to use the helicopter for patient transport has been made

In the event that the helicopter responds without an Aviation Unit medic aboard, the ground technician will continue medical responsibility for the patient by accompanying the patient in the helicopter

- D. Document all helicopter transport information on PCR and forward to receiving hospital

Practical Considerations:

Ground crew should place patient on narrow backboard (16" maximum) or scoop stretcher in preparation for helicopter transport. Large backboard is too wide to be place aboard the ship

Because electrical equipment may not meet FAA specifications, the EMS ground crew defibrillator should be replaced with the Aviation Unit equipment in preparation for transport. The oxygen will be switched to the aviation unit oxygen equipment.

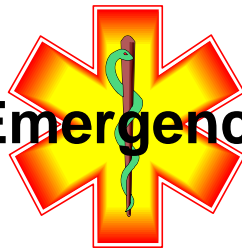
Because of the helicopter's ability to illuminate areas in the dark (30 million candle watt), it is a useful tool for searching an accident scene for victims who may have wandered or have been ejected from a vehicle. Helicopters are also equipped with Forward Looking Infrared Equipment (FLIR). NCPD Aviation Unit does not provide helicopter EMS transport out of state

Helicopter transportation is not affected by change in atmospheric and barometric pressure

Safety Guidelines: All participants at the scene must obey the Police Officer who manages the landing site. It is the responsibility of all participants at the scene to maintain the strictest safety procedures

To make the helicopter safe for all concerned, and to minimize potential hazards, observe the following practices:

Nassau Regional Emergency Medical Services



Procedures	EMS Helicopter Guidelines	Procedure II. B Page 4 of 5
	Reviewed: 12/12/2007	Approved: 2/06/2008
		Effective: 3/01/2008

- Identify a landing area with a minimum of 100 x 100 feet
- Inform communications of any obstacles at the landing site (trees, telephone lines, antennas, etc.)
- Secure the landing area to prevent unauthorized persons from approaching
- Keep the landing zone clear of loose articles and hazardous debris, and protect the patient from rotor wash
- Keep well clear of the landing area when the helicopter is approaching or taking off
- Turn off all strobe lights
- Do not approach the helicopter. Helicopter medic will approach ground crew
- Approach within the pilot's field of vision (see diagram)
- Carry equipment horizontally, below your waist level – never upright or over your shoulder.
- Follow the suggestions of the flight crew when assisting near the helicopter
- No smoking
- Do not wear hats when approaching the helicopter

Nassau Regional Emergency Medical Services



Procedures	EMS Helicopter Guidelines	Procedure II. B Page 5 of 5
Reviewed: 12/12/2007		Approved: 2/06/2008
		Effective: 3/01/2008

Approaching or Leaving A Helicopter

APPROACHING OR LEAVING A HELICOPTER

Do not approach or leave without the pilot's knowledge and clearance. Keep in pilot's field of vision. **Observe Helicopter Safety Zones** (see diagram right)

PROHIBITED

ACCEPTABLE

PROHIBITED

ACCEPTABLE

On sloping ground always approach or leave on the downslope side for maximum rotor clearance.

If blinded by swirling dust or grit, **STOP** – crouch lower, or sit down and await assistance.

If disembarking while helicopter is at the hover, get out and off in a smooth unhurried manner.

Proceed in a crouching manner for extra rotor clearance. Hold onto hat unless chin straps are used. Never, never, reach up or chase after a hat or other articles that blow away.

Do not approach or leave a helicopter when the engine and rotors are running down or starting up.

Carry tools, etc, horizontally below waist level – never upright or on the shoulder.

It is recommended that all Nassau County EMS providers, including hospital personnel receiving helicopter transports, participate in the course on Helicopter Safety developed by the Nassau County Police Department Aviation Unit. Contact Aviation Unit at 573-4000 to set up a training program.

Nassau Regional Emergency Medical Services



Policies & Procedures	Field Termination of Resuscitative Efforts	Procedure II. C
		Approved: 2/4/04
		Effective: 4/1/04

Corrected – 3/2004

This procedure is for use by Nassau REMSCO credentialed ALS (EMT-CC, EMT-P) personnel only. It is intended for use on patients in **asystole** who do not respond to field (prehospital) ACLS treatments as per Nassau REMAC protocols. The termination of resuscitative efforts is a medical control option and may only be determined by a medical control physician.

A. The criteria to be used as the basis for this procedure:

1. This procedure is for use on adult patients only.
2. This procedure may not be used on traumatic patients.
3. This procedure is to be used on patients who remain in asystole secondary to a cardiac event.
4. This procedure may not be used on hypothermic patients.

B. Actions to be taken

1. Treat the patient as per standing orders *Asystole* protocol (III.B-3).
2. Contact medical control as usual.
3. If no change in patient's condition request field termination from medical control physician.
4. If scene circumstances dictate (i.e. physical or verbal confrontation), transport patient to hospital.
5. Record Medical Control Physician's Name and License number.
6. ET tubes will be left in place.
7. IV access – if access was gained through a IV lock, remove needle, tubing, and solution bag and leave IV lock in-place. If access was gained by cannula/needle then tie a knot in the IV tubing close to the connection with the cannula/needle, cut tubing and dispose of solution bag and remaining tubing, insure that cannula/needle and knotted tubing piece are adequately secured. This should preclude blood from leaking from the IV site and contaminating the surrounding area.
8. Attach ECG strip to the back of the Agency copy of the PCR.

If field termination is ordered, cease resuscitative efforts. Inform family (others) that a physician has determined that no more treatment is indicated, and that all has been done for the patient. Contact the Nassau County Medical Examiner's Office. Request a police response. Follow the *Actions to be taken* in the *Decision Not to Initiate CPR* Policy (I. J).

Nassau Regional Emergency Medical Services



Procedure	Hospital Diversion	II. D-1 Page 1 of 2
	Reviewed: 8/28/2008	Approved: 12/08/2008
		Effective: 8/01/2009

Purpose

To insure the continued delivery of high quality medical care to prehospital patients upon arrival at an Emergency Department and to insure the continued availability of prehospital resources to the regional EMS System.

Definition

Diversion is a temporary status of 3 hours duration granted by the regional EMS system upon request when hospital leadership has determined that their emergency department has reached its maximum ability to manage new patients.

Policy

A hospital's Diversion status does not apply to ambulances bearing patients in extremis, to include, cardiac arrest, respiratory arrest, with an unmanageable & insecure airway or trauma patients en route to Regional or Area Trauma Centers.

The regional EMS System will grant Diversion status only upon request and only after considering the regional demand and the number of other hospitals requesting or granted Diversion status.

The EMS System reserves the right to cancel a 3-hour Diversion status before it expires if regional demand requires it.

Hospitals shall define the individuals with authority to request diversion and shall notify Nassau County Medical Control in writing of those titles.

Diversion will automatically expire after three (3) hours and must be requested again if it is still required.

Procedure:

1. If no neighboring hospitals are on diversion Nassau County Medical Control will authorize diversion for three (3) hours at a time.
2. Once diversion has been authorized Nassau County Medical Control shall notify the Nassau County Police Communications Bureau and the Nassau County Fire Communications Center.

Nassau Regional Emergency Medical Services



Procedure	Hospital Diversion	II. D-1 Page 2 of 2
	Reviewed: 8/28/2008	Approved: 12/08/2008
		Effective: 8/01/2009

3. The Nassau County Fire Communications Center shall notify all other fire department dispatch centers in Nassau County, Suffolk County Fire Communications Center, and FDNY Emergency Medical Dispatch.
4. Ambulances transporting patients to a hospital on diversion shall be notified by their dispatch center of the hospital's diversion status and divert when appropriate to the next closest hospital.
5. Patients shall be notified of the change in destination. If the patient insists on going to the diverted hospital the patient must sign the back of the New York State Department of Health Prehospital Care Report Against Medical Advice Section and then maybe transported to the diverted hospital after consultation with Nassau County Medical Control.

After hospital advises of no beds being available in the emergency department and three (3) or more ambulances awaiting triage for greater than thirty (30) minutes Nassau County Medical Control shall send a Nassau County Police Department Emergency Ambulance Bureau supervisor to ascertain the emergency department's capacity. Based on this information Nassau County Medical Control may place the hospital on diversion status.

Nassau County Medical Control shall submit a monthly diversion report to the REMSCo office with the number of hours a hospital was on diversion.

Nassau Regional Emergency Medical Services



Procedure	Ambulance Redirection	II. D-2 Page 1 of 2
	Reviewed: 8/28/2008	Approved: 12/08/2008
		Effective: 8/01/2009

Purpose

To insure the continued delivery of high quality medical care to prehospital patients upon arrival at an Emergency Department and to insure the continued availability of prehospital resources to the regional EMS System.

Definition

Redirection is a temporary status of 3 hours duration determined by the regional EMS system when a particular hospital cannot process routine ambulance arrivals in a timely manner.

Policy

A hospital's Redirection status does not apply to ambulances bearing patients in extremis, to include, cardiac arrest, respiratory arrest, with an unmanageable & insecure airway or trauma patients en route to Regional or Area Trauma Centers.

The regional EMS System will determine Redirection status only after considering the regional demand and the number of other hospitals requesting or granted Diversion status.

The EMS System will cancel a 3 hour Redirection status before it expires if regional demand requires it.

Procedure:

1. When three (3) or more ambulances have been held at a hospital for thirty (30) minutes without getting an appropriate stretcher the ambulances shall contact Nassau County Medical Control. Nassau County Medical Control shall contact the hospital emergency department.
2. After confirmation of no beds being available in the emergency department and three (3) or more ambulances for greater than thirty (30) minutes, Nassau County Medical Control will send a Nassau County Police Department Emergency Ambulance Bureau supervisor to ascertain the emergency department's capacity.
3. Based on this information Nassau County Medical Control may place the hospital on Redirection status if no neighboring hospitals are on redirection.
4. Nassau County Medical Control will activate Redirection for three (3) hours at a time.

Nassau Regional Emergency Medical Services

Procedure	Ambulance Redirection	II. D-2 Page 2 of 2
	Reviewed: 8/28/2008	Approved: 12/08/2008
		Effective: 8/01/2009

5. Once Redirection has been authorized Nassau County Medical Control shall notify the Nassau County Police Communications Bureau and the Nassau County Fire Communications Center.
6. The Nassau County Fire Communications Center shall notify all other dispatch centers in Nassau County, Suffolk County Fire Communications Center, and FDNY Emergency Medical Dispatch.
7. Ambulances transporting patients to a hospital on Redirection shall be notified by their dispatch center of the hospital's redirection status and will redirect when appropriate to the next closest hospital.
8. Patients shall be notified of the change in destination. If the patient insists on going to the closest hospital of their choice the patient must sign the back of the New York State Department of Health Prehospital Care Report Against Medical Advice Section and will be transported to the hospital on Redirection status after consultation with Nassau County Medical Control.
9. Nassau County Medical Control shall submit a monthly diversion report to the REMSCo office with the number of hours a hospital was on diversion.

Nassau Regional Emergency Medical Services



Procedure	ALS Technician Credentialing	II. E
		Approved: 6/3/2009
		Effective: 6/3/2009

NYS Law states personnel are not legally allowed to practice at the ALS level unless authorized & properly credentialed by the Regional Medical Advisory Committee (REMAC) of the local Regional EMS Council. **Practicing without proper credentials is considered by the NYSDOH to be the same as practicing without certification. This is a serious violation and in some cases a criminal offense. Credentials require yearly renewal.**

Original ALS Credentials

The Candidate will have successfully passed their original EMT-CC or EMT-P training or recently refreshed with a Nassau Regional EMS Course Sponsor. The following information must be submitted to the Nassau Regional EMS Council Office (Nassau REMSCo), attention QI Coordinator to obtain credentials.

- * Copy of current NYS EMT-CC/P Certification card or on site scoring success letter
- Copy of NYS drivers license with current address
- Letter of support form (blank forms are obtainable from REMSCo office or our website) signed by a Chief Officer and Agency Medical Director for **ALL** agencies that you will wish to practice ALS skills.
- Endotracheal Intubation Annual Credential Verification form signed by a Nassau Regional Course sponsor I/C, CLI, or Credentialed Medical Director
- Contact phone numbers
- E-mail address

* NOTE: If candidate's original EMT-CC/P training was done outside of the Nassau Region & he/she has not recently refreshed with a Nassau Regional EMS Course Sponsor, an additional written protocol credentialing exam is required. This credentialing test is available at any one of the Nassau Regional EMS Course Sponsors by appointment.

Renewal ALS Credentials

- Candidate will be e-mailed an Endotracheal Intubation Annual Credential Verification form approximately 3 months prior to REMAC credentials expiration.
- Candidate must make an appointment with one of the three Nassau Regional EMS Training Academies to demonstrate ETI manikin proficiency and have the Endotracheal Intubation Annual Credential Verification form signed.
- Form can be faxed or mailed to the Nassau REMSCo Office, attention QI Coordinator, at least 10 days prior to yearly ETI credential expiration.
- **Practicing without proper credentials is considered by the NYSDOH the same as practicing without certification. This is a serious violation and in some cases a criminal offense. Credentials require yearly renewal.**

Technicians must provide the Nassau REMSCo office with a copy of their certification card (or on site scoring success letter) each time their certification is renewed.

Questions regarding the credentialing process should be directed to the Nassau Regional EMS QI coordinator at 516-542-0025.



Nassau Regional EMS Council

2201 Hempstead Turnpike Building A 4th floor box 78
East Meadow, NY, 11554
516-542-0025 Fax:516-542-0049

Nassau County EMS Provider Agency Letter of Support

Print Name of EMT-CC or EMT-P

New York State Certification Number

The technician identified above is an active member of:

Print Name of Nassau County EMS Agency

The Nassau County EMS agency identified above supports the participation of the technician named in the advanced life support system of Nassau County in accordance with the rules and regulations of the Nassau Regional EMS Council and The New York State Department of Health.

This letter of support will automatically terminate at the end of the above named technician's association with the Nassau County EMS agency listed.

This support is limited to work done **by the technician listed above** as a member of the **agency named above**.

Signature of Chief of Department/ Commanding Officer

Date

Print Name of Chief of Department/ Commanding Officer

Signature of Agency Medical Director

Date

Print Name of Agency Medical Director