

Nassau Regional Medical Advisory Committee

Advisories

<u>Advisory#</u>	<u>Subject</u>	<u>Issued</u>	<u>Effective</u>
06-10.1	Pulse Oximeter	10/11/06	1/1/08
07-01.2	Glucometer	1/31/07	1/1/08
07-02.1	BLS Assisted Medications	2/7/07	2/7/07
07-06.1	BLS Use of Pulse Oximeters	6/6/07	6/6/07
08-08.1	Transport of Brain Injured Children	8/6/08	8/6/08
08-12.1	Incident Rehabilitation	12/3/08	12/3/08
08-12.2	Adult Sexual Assault Forensic Examiner (SAFE) Program	12/3/08	12/3/08
09-10.1	Cyanokit Cache	10/07/09	10/07/09
09-10.3	Trauma Notifications	10/07/09	10/07/09
09-11.1	Atropine Cache	11/17/09	11/17/09
11-05.1	Ventricular Assist Device (VAD)	5/04/11	5/04/11

Nassau Regional Emergency Medical Services



Advisory	Pulse Oximeters	06-10.1
		Issued: 10/11/2006

The Nassau REMAC, at its October 4, 2006 meeting, reviewed the use of Pulse Oximeters in patient care.

It was determined that the use of pulse oximeters provides a baseline data point in the care of a patient that is consistent with other vital signs data (e.g. pulse and respiration rate, BP, etc.).

As a result of this determination the REMAC will add Pulse Oximeter to the list of required pieces of medical equipment that must be carried on all ambulances that operate in the Nassau region.

The REMAC recognizes that there are budgeting and purchasing constraints on provider agencies. Therefore, the deadline for having this equipment on each ambulance will be January 1, 2008.

Bernard Beckerman
Chairman

Nassau Regional Emergency Medical Services



Advisory	Glucometer	07-01.2
		Issued: 1/31/2007

The Nassau REMAC determined that the use of a Glucometer provides a minimum level of care for ALS ambulances.

As a result of this determination the REMAC will add glucometer to the list of required pieces of medical equipment that must be carried on all ALS ambulances that operate in the Nassau region.

The NYS DOH currently requires that an ambulance agency that intends to use a glucometer must apply and receive a NYS Limited Lab License before placing a glucometer in service in an ambulance. The forms and filing instructions are available on the DOH Bureau of EMS website, a link to this site is available on the REMSCo's website by clicking on the "Protocol" button.

The REMAC recognizes that there are budgeting and purchasing constraints on provider agencies and the fact that the DOH application process is not instantaneous. Therefore, the deadline for having this equipment on each ambulance will be January 1, 2008.

Bernard Beckerman
Chairman

Nassau Regional Emergency Medical Services



Advisory	BLS Assisted Medication	07-02.1
		Issued: 2/7/2007

The recently revised NYS EMT-B BLS Protocol M-5 Adult Cardiac Related Problem (1/18/07) indicates (step VII.A) the need for a BLS technician to contact medical control, in the absence of standing orders, for authorization to assist a patient in taking a valid prescribed dose of nitroglycerin.

It is the position of the Nassau REMAC that an EMT who assists a patient, who is in possession of their prescribed nitroglycerin in its dispensed container, in self-administering their nitroglycerin is operating under the standing order of the prescribing physician.

Bernard Beckerman
Chairman

Nassau Regional Emergency Medical Services



Advisory	BLS Use of Pulse Oximeters	07-06.1
		Issued: 6/6/2007

The Nassau REMAC, at its June 6, 2007 meeting, reviewed the use of Pulse Oximeters in patient care by BLS personnel.

It was determined that the use of pulse oximeters provides a baseline data point in the care of a patient that is consistent with other vital signs data (e.g. pulse and respiration rate, BP, etc.).

BLS personnel, with proper training, are authorized to utilize Pulse Oximeters.

Bernard Beckerman
Chairman

Nassau Regional Emergency Medical Services



Advisory	Transport of Brain Injured Children	08-08.1
		Issued: 8/6/2008

The Nassau REMAC has been advised that North Shore-LIJ Schneider Children's Hospital is conducting a research study known as "Cool Kids Trial". The study involves cooling children with traumatic brain injury to a point that induces hypothermia which is expected to decrease brain swelling and improve patient outcome.

Patients that can be included in this study are children Age 0 to less than 16 years of age, suffering a traumatic closed head injury with a GCS score of less than 8. The hospital is asking that patients that meet these criteria be brought to Schneider Children's Hospital.

The REMAC has indicated that EMS agencies that encounter patients meeting the above criteria may bring them to Schneider Children's Hospital provided they do NOT by-pass another pediatric trauma center and comply with the REMAC transport procedure II.A Alternative Hospital Destination.

Mark Safford
Chairman

Nassau Regional Emergency Medical Services



Advisory	Incident Rehabilitation	08-12.1 Page 1 of 5
		Issued: 12/03/2008

PURPOSE

To ensure the physical and mental condition of responders operating at the scene of an emergency or training exercise does not deteriorate to a point that affects the safety and health of the responder, fellow responders, or the safety and integrity of the operation. Agency leadership are strongly encouraged to review the United States Fire Administration guide to Emergency Incident Rehabilitation (February 2008 revision) and the National Fire Protection Association Standard 1584 to assist in placing this policy into context. Regardless of how rehabilitation is implemented, it is absolutely crucial that all responders follow this policy. No one, including officers, should be allowed to skip the rehabilitation process as enforcement of this policy will have a measurable affect on the long-term well-being of all responders.

POLICY

The following policy is strongly recommended for events, including training, fire ground operations, hazardous materials incidents, prolonged extrication, and any other event where emergency response personnel are engaged in activities that pose a risk of exceeding a safe level of physical or mental endurance. This policy defines the minimum expectations of Emergency Incident Rehabilitation in the Nassau Region, however agencies may, upon approval of their Medical Director, choose to implement additional criteria for rest, re-hydration, or physiologic measures provided they are not less than the minimum expectations set forth herein.

1. It is the responsibility of all responders at the scene to monitor themselves and their personnel to ensure the safety, health, and welfare of all responders by ensuring adequate rest and hydration following the recommendations as set forth in this policy.
2. All providers are encouraged to participate in self-rehabilitation. This should ideally include 10 minutes between work periods and/or SCBA exchanges whereby the provider is allowed to rest and consume appropriate fluids while awaiting reassignment.
3. The Incident Commander shall consider the circumstances of each incident or training exercise early in the evolution of the incident or exercise, and make adequate provisions for the rest and rehabilitation for all personnel operating at the scene.
4. For any event where the above criteria are met, it is recommended that the Incident Commander or their designee (Incident Safety Officer or Logistics Section Chief) establish the following minimum:
 - a. Rehabilitation Area
 - i. Ample space with preference to seating for responders
 - ii. Protection from the elements, fumes, or hazards
 - iii. Accessible by EMS
 - iv. Clearly identified
 - v. Temperature control including active cooling and re-warming of responders as indicated by environmental conditions
 - vi. Re-hydration to include water and electrolyte replacement

Nassau Regional Emergency Medical Services



Advisory	Incident Rehabilitation	08-12.1 Page 2 of 5
		Issued: 12/03/2008

- vii. Nutrition (as appropriate for the duration of the incident)
 - viii. Staffing should include at least one Rehabilitation Officer/Manager with training of at least the NYS EMT-B and BLS equipment to include oxygen, blood pressure cuff and pulse oximeter. Availability of an AED in proximity to the Rehabilitation Area is strongly encouraged. Pulse CO-oximetry is optional, but recommended.
- b. Treatment Area
- i. Separate from the rehabilitation area
 - ii. In close proximity to a transporting ALS ambulance and the rehabilitation area
 - iii. Staffing should include a fully-staffed ALS transporting ambulance
5. There should be at least one rehabilitation staff member trained to at least the EMT-B level for every 5 responders in the Rehabilitation Area.
6. For large incidents, it may be advisable to have more than one Rehabilitation and/or Treatment Area established. This decision should be made by the Incident Commander or their designee.
7. For incidents greater than a single alarm, it is recommended that a minimum of one fully staffed ALS transporting ambulance is available per alarm assignment. Additional transporting ambulances may be required depending on the type of operation, environmental conditions, and number of responders involved.
8. No personnel should enter the warm or hot zone of a declared Hazardous Materials Incident unless the Rehabilitation and Treatment areas have been established and staffed according to the policies and procedures of the respective Hazardous Materials Team. This should include an ALS transporting ambulance and a regionally credentialed ToxMedic.
9. It is advised that pre-hydration, when possible, occurs to include a minimum of 16 ounces of non-caffeinated fluids over the two hours prior to scheduled events, such as training exercises.

Procedures

1. Responders should be detailed to the Rehabilitation Area by the Incident Commander or their designee after every 45 minutes of continuous hard labor, one 45 minute or 60 minute rated SCBA cylinder, two, thirty-minute rated SCBA cylinders, or after being decontaminated. The Incident Commander or Incident Safety Officer may direct personnel to the Rehabilitation Area at any time for reasons not mentioned above.
2. All responders should be decontaminated (if necessary) and remove personal protective equipment prior to entering the Rehabilitation Area.
3. All responders should follow their agencies accountability system when entering/departing the Rehabilitation and/or Treatment Areas.

Nassau Regional Emergency Medical Services



Advisory	Incident Rehabilitation	08-12.1 Page 3 of 5
		Issued: 12/03/2008

4. Upon entering the Rehabilitation Area, the responder is expected to do the following:
 - a. Drink at least 16 ounces of fluid (water first, then half-strength electrolyte solution).
 - b. No tobacco use in the Rehabilitation or Treatment Areas.
 - c. Follow the directives of the Rehabilitation Officer/Manager with regards to their disposition to the manpower/staging or the treatment areas.
5. The responder will be assessed by the Rehabilitation Officer/Manager or other qualified medically trained personnel.
6. Any responder entering the rehabilitation area with complaints of chest pain, shortness of breath (beyond normal exertion), or altered mental status will be immediately moved to the Treatment Area and may not return to duty for the duration of the incident. This shall be immediately reported to the individual(s) responsible for scene safety, accountability and/or command.
7. Every responder will be assessed for presence of other symptoms to include dizziness, weakness, nausea, headache, cramps, aches or pain, changes in gait, speech or behavior, mental/physical stress, exhaustion, and symptoms of heat or cold-related stress. These symptoms do not require immediate removal to the Treatment Area, but should resolve prior to returning to manpower/staging.
8. Every responder will have vital signs assessed to include Pulse, Respiratory Rate, Blood Pressure, and Pulse-Oximetry over a thirty-second period and recorded on the Incident Rehabilitation Log. Use of pulse CO-oximetry is optional, but recommended.
9. Abnormal Vital Signs are considered any one of the following:
 - a. Pulse >110 per minute
 - b. Respirations >20 per minute
 - c. Systolic Blood Pressure >160
 - d. Diastolic Blood Pressure >100
 - e. Pulse oximetry <96% in ambient air
 - f. Pulse CO-oximetry >5% (if measured)
10. If on any vital sign exam an irregular pulse is identified that is not previously known to the responder, the responder should be moved to the Treatment Area for further evaluation. This shall be immediately reported to the individual(s) responsible for scene safety, accountability and/or command.
11. If vital signs are within normal limits (as defined above) the responder is encouraged to drink at least 16 ounces of fluid and may return to manpower/staging after a minimum of 10 minutes rest.

Nassau Regional Emergency Medical Services



Advisory	Incident Rehabilitation	08-12.1 Page 4 of 5
		Issued: 12/03/2008

12. If vital signs are abnormal (as defined above), the responder will be monitored for 10 minutes and encouraged to rest and consume appropriate fluids.
13. After 10 minutes from time of entry to the Rehabilitation Area, the responder will be reassessed and all vital signs retaken.
 - a. If vital signs are within normal limits, the responder may return to manpower/staging.
 - b. If vital signs continue to remain abnormal (as defined above), the responder will be observed for another 10 minutes and encouraged to rest and consume appropriate fluids.
14. After 20 minutes from time of entry to the Rehabilitation Area, the responder will be reassessed and all vital signs retaken.
 - a. If vital signs are within normal limits, the responder may return to manpower/staging.
 - b. If vital signs continue to remain abnormal (as defined above), the responder will be referred to the Treatment Area. This shall be immediately reported to the individual(s) responsible for scene safety, accountability and/or command.
15. If the responder exhibits any symptoms of chest pain, shortness of breath, or altered mental status during their time in the Rehabilitation Area, they should be moved to the Treatment Area immediately and may not return to duty. This shall be immediately reported to the individual(s) responsible for scene safety, accountability and/or command.
16. No responder may return to manpower/staging unless they fulfill the following:
 - a. No symptoms of dizziness, weakness, nausea, headache, cramps, aches or pain, changes in gait, speech or behavior, and symptoms of heat or cold-related stress.
 - b. Pulse \leq 110 per minute
 - c. Respirations \leq 20 per minute
 - d. Systolic Blood Pressure \leq 160
 - e. Diastolic Blood Pressure \leq 100
 - f. Pulse oximetry \geq 96% in ambient air
 - g. Pulse CO-oximetry \leq 5% (if measured)
17. Any responder moved to the Treatment Area should have care provided in accordance with NYS BLS protocols and Nassau Regional ALS protocols.
18. All personnel should be encouraged to hydrate with at least 36 ounces of appropriate fluids over two hours after the conclusion of the incident.

Nassau Regional Emergency Medical Services



Advisory	Incident Rehabilitation	08-12.1 Page 5 of 5
		Issued: 12/03/2008

Interpreting CO Values During Incident Rehabilitation

1. The use of hand-held pulse CO-oximetry devices is strongly recommended but not required for Incident Rehabilitation.
2. The SpCO reading is to be used as a screening measure. Definitive carboxyhemoglobin determinations are performed via blood draw in the hospital setting. Any patient with complaints of chest pain, shortness of breath, or altered mental status should receive oxygen via a non-rebreather mask and moved to the Treatment Area, regardless of SpCO reading.
3. The following CO treatment guidelines will pertain to the asymptomatic emergency responder on entry to the Rehabilitation Area.
 - a. If SpCO is $<5\%$ and vital signs are within normal limits, the provider is encouraged to drink at least 16 ounces of fluid and may return to manpower/staging after a minimum of 10 minutes rest.
 - b. If SpCO is $\geq 5\%$ and $<12\%$, the responder may breathe ambient air and may not leave the rehabilitation area until their CO level is below 5%.
 - c. If SpCO is $\geq 12\%$ the responder should be moved to the Treatment Area and receive high-flow oxygen until the SpCO is $<5\%$.
 - d. If SpCO is $\geq 25\%$, the responder will be moved to the Treatment Area and transported with high-flow oxygen to an emergency department.

Documentation

1. All responders entering the Rehabilitation Area should have their name, vital signs, and disposition recorded on the Rehabilitation Log (Attached). This Log should be attached and stored with the stand-by PCR associated with the incident and a copy given to the Incident Commander or Incident Safety Officer.
2. A separate PCR should be completed for any responder referred to the Treatment Area, regardless of whether the responder was transported by EMS. Should the responder not wish transport, a Refusal PCR Form should be completed and the individual(s) responsible for scene safety, accountability and/or command shall be notified.

Nassau Regional Emergency Medical Services



Advisory	Adult Sexual Assault Forensic Examiner (SAFE) Program	08-12.2
		Issued: 12/03/2008

The New York State Sexual Assault Reform Act directs the State Health Department to designate interested hospitals in the state as sites of 24-hour Sexual Assault Forensic Examiner (SAFE) programs. These hospitals are centers of excellence for the provision of sexual assault services. All SAFE Centers must meet standards that have been established by DOH.

The goals of the SAFE program are to:

1. Provide timely, compassionate, patient-centered care in a private setting that provides emotional support and reduces further trauma to the patient;
2. Provide quality medical care to the patient who reports sexual assault, including evaluation, treatment, referral and follow-up;
3. Ensure the quality of collection, documentation, preservation and custody of physical evidence by utilizing a trained and New York State Department of Health (DOH) certified sexual assault forensic examiner to perform the exam;
4. Utilize an interdisciplinary approach by working with rape crisis centers and other service providers, law enforcement and prosecutors' offices to effectively meet the needs of the sexual assault victim and the community;
5. Provide expert testimony when needed if the patient chooses to report the crime to law enforcement; and,
6. Improve and standardize data regarding the incidence of sexual assault victims seeking treatment in hospital emergency departments.

Currently Nassau University Medical Center and North Shore University Hospital (Manhasset) have SAFE programs in operation and have been recognized by the New York State Department of Health. The Nassau Regional Medical Advisory Committee and the Nassau Regional EMS Council recognize this capability to enhance the pre-hospital care of victims of sexual assault.

EMS personnel, upon recognition of an ADULT sexual assault victim, based on information provided by the victim, bystanders or law enforcement shall provide the appropriate prehospital care and treatment. If the patient is stable, and the patient concurs, the patient may be transported to the closest SAFE designated hospital. If the patient does not concur, they will be transported to the appropriate destination hospital in accordance with regional protocol.

EMS providers shall not perform physical examinations to confirm sexual abuse.

Mark Safford, MD
Chair — Nassau REMAC

Nassau Regional Emergency Medical Services



Advisory	Cyanokit Cache	09-10.1
		Issued: 10/07/2009

The Nassau REMAC/REMSCO recently received a quantity of Cyanokit Cyanide Treatment Kits from the Regional Resource Center at North Shore. This cache is now stored at Medical Control and available for response. Any agency requesting the Cyanokits must contact Medical Control and an NCPD Emergency Ambulance Bureau supervisor will respond with the requested treatments.

The Cyanokit (Hydroxocobalamin) is approved for use in the Nassau Region under **ALS Protocol III.K**, and is approved to be carried by Nassau ALS agencies as an optional medication. The Cyanokit can only be administered with a medical control order and is not under standing orders.

North Shore/LIJ EMS has advised that they have additional caches of Cyanokits and Rad-57 co-oximeters available for response. They can be contacted directly at 516-719-5000.
Remember – all orders for administration must be received from Medical Control.

Nassau Regional Emergency Medical Services



Advisory	Trauma Notifications	09-10.3
		Issued: 10/07/2009

In an effort to improve trauma care in our region, the attached Trauma Notification Form will be utilized by Medical Control. This form will allow the Medical Control personnel to have one standardized set of questions to be asked of units transporting trauma patients to trauma receiving facilities. This informational set will then be relayed to the receiving trauma facility who will then implement their response protocols based on the information received.

It is imperative that ambulances contact Medical Control for all trauma notifications/runs and the information listed on the form is supplied. This information will enhance the communication process between pre-hospital providers and the receiving hospitals and allow for the appropriate hospital response, including trauma team activation.

The form, which was developed by the Regional Trauma Advisory Committee and the REMAC, will be in effect immediately. Please feel free to contact the REMSCo office with any questions.

Mark Safford, MD
Chairman

Medical Control Trauma Call Information

Date _____ **Time** _____

Unit transporting _____

Age _____

Mechanism of injury _____

Extrication _____

Respirations _____

Intubated/BVM _____

Pulse _____

IV access _____

BP _____

Level of Consciousness _____

Pupils if unresponsive _____

Injuries _____

ETA: _____

Hospital: _____

Nassau Regional Emergency Medical Services



Advisory	Atropine Cache	09-11.1
		Issued: 11/17/2009

The Nassau REMAC/REMSCO recently received a quantity of Atropine Injectors from the New York State Department of Health. This cache will be stored at Medical Control and available for response. Any agency requesting the Atropine cache (as per the **BLS – Adult Nerve Agent/Organophosphate Poisoning Antidote Protocol**) must contact Medical Control and an NCPD Emergency Ambulance Bureau supervisor will respond with the requested treatments.

The Nassau Office of Emergency Management has an additional cache of Atropine injectors that can also be requested if necessary. EMS agencies must contact Medical Control for the activation of either cache and to request medical use authorization.

Mark Safford, MD
Chairman — Nassau REMAC

Nassau Regional Emergency Medical Services



Advisory	Ventricular Assist Device (VAD)	11-05.1
		Issued: 5/04/2011

When responding to a patient that has a Ventricular Assist Device and the nature of the call involves a possible malfunction of the device, EMS personnel should be aware that patient, family and other attending persons may have been trained in specific steps that are to be initiated to resolve the malfunction, if so they should be allowed to follow that training.

If the responding EMS agency's personnel have received special training on the device they may assist in resolving the problem.

> Do NOT perform CPR <

EMS personnel should gather all peripheral equipment and batteries and transport; personnel should also attempt to identify the make & model of the unit and Hot Line phone number for the manufacturer and contact Medical Control.

Any presenting problems not involving the VAD should be treated in accordance with current protocols. ALS personnel should Monitor ECG for treatable arrhythmias.

Medical Control

- May contact the manufacturer's hot line to obtain assistance.
- Consider diversion to a facility equipped to handle the device.

Mark Safford, MD
Chair — Nassau REMAC