NYC REMAC

Advisory No.	2018-11		
Title:	Revision/Update of REMAC Prehospital Treatment & Transport Protocols		
Issue Date:	December 27, 2018		
Effective Date:	January 1, 2019		
Supersedes:	n/a	Page:	1 of 5

The Regional Emergency Medical Advisory Committee (REMAC) of New York City is responsible to develop, approve and implement prehospital treatment and transport protocols for use within the five boroughs of the City of New York. The Regional Emergency Medical Advisory Committee (REMAC) of New York City operates under the auspices of Article Thirty of the New York State Public Health Law.

The Regional Emergency Medical Advisory Committee (REMAC) of New York City has revised and updated the regional prehospital treatment and transport protocols. All protocols have been approved by the New York State Emergency Medical Advisory Committee for use in the NYC region.

Two (2) clarifications are issued:

1. **Midazolam dose via IV**
2. **ALS Burns *Adult & Pediatric Patients* (528): Note regarding pain management**
3. **ALS Pediatric Altered Mental Status (556): IN Administration of naloxone**

PROTOCOLS ARE TO BE IMPLEMENTED JANUARY 1ST, 2019. **Agencies that require additional time for implementation must submit requests for extension in writing to the NYC REMAC. Requests can be emailed to mdiglio@nycremsco.org**

Current and Updated Protocols can be accessed at the Regional EMS Council website: www.nycremsco.org.

Owners/operators of Ambulance and ALS First Response Services providing prehospital medical treatment within the five boroughs of the City of New York are responsible to provide copies of the NYC REMAC Prehospital Treatment Protocols to their personnel, and to ensure that Service Medical Directors and EMS personnel are informed of all changes/updates to the NYC REMAC Prehospital Treatment Protocols.

In order to provide evidence that all EMS personnel have been updated in current protocols, the EMS Agency must provide a list of updated personnel accompanied by a letter of affirmation signed by the service medical director and Chief Executive Officer no later than FOUR (4) weeks after completion of training/in-service.

Josef Schenker, MD, CPE, FACEP, FAEMS
Chair, Regional Emergency Medical Advisory Committee of New York City

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

Summary of Protocol Clarifications

Section	Items Clarified
GENERAL OPERATING PROCEDURES	
Midazolam via IV route	Clarification: Whenever administered via IV, the maximum dose of Midazolam is 10 mg.
PARAMEDIC PROTOCOLS	
528: Burns *(Adult & Pediatric Patients)*	Note regarding pain management does not require medical control consult for burns that do not involve airway.
556: Pediatric Altered Mental Status	Clarification: Although the IN route for naloxone is part of BLS Protocol 411 (AMS), it is again listed as an available route in the ALS Protocol.

PROTOCOLS ARE ATTACHED

PREHOSPITAL SEDATION

Definition of Prehospital Sedation:
Prehospital sedation is a fully monitored pharmacologic intervention applied in instances where conscious patients may need short-term analgesic and/or anxiolytic therapy for procedures that may be painful or anxiety-producing, such as Endotracheal Intubation, Synchronized Cardioversion, and Transcutaneous Pacing. Prior permission from Medical Control is required.

Indications for Prehospital Sedation:

Conscious patients requiring *Endotracheal Intubation*

a) Administer Diazepam 5 – 10 mg, IV bolus. Repeat doses of Diazepam 5 – 10 mg, IV bolus, may be given as necessary. (Maximum total dosage is 20 mg.)

OR

b) Administer Midazolam up to 5 mg, IV/IO bolus. After successful intubation, Midazolam up to 5 mg IV/IO may be repeated. (Maximum total dosage is 10 mg.)

OR

c) Administer Etomidate 0.3 mg/kg, IV bolus. (Maximum total dose is 40 mg.) After successful intubation, administer Diazepam 5 mg IV bolus or Lorazepam 2 mg, IV or IM, or midazolam up to 5mg IV/IO for continued sedation.

d) Administer oxygen by nasal cannula at maximum flow rate during laryngoscopy and intubation.

Conscious patients requiring *Synchronized Cardioversion* OR *Transcutaneous Pacing*

a) Administer Diazepam 5 – 10 mg, IV bolus. Repeat doses of Diazepam 5 – 10 mg, IV bolus, may be given as necessary. (Maximum total dosage is 20 mg.)

OR

b) Administer Midazolam up to 5 mg, IV/IO bolus. Midazolam up to 5 mg IV/IO may be repeated. (Maximum total dosage is 10 mg.)

OR

c) For synchronized Cardioversion only, administer Etomidate, 0.15mg/kg, IV bolus. (Maximum total dose is 20 mg.)

NOTE: Patients receiving prehospital sedation must be continuously administered high concentration oxygen and must be continuously monitored using cardiac monitoring and pulse oximetry.

528

BURNS
(ADULT & PEDIATRIC PATIENTS)

1. Begin Basic Life Support Burns procedures.
2. If there is evidence of burns to the upper airway or upper airway compromise is anticipated, perform Advanced Airway Management[1].
3. For patients with electrical burns, begin Cardiac Monitoring, record and evaluate the EKG rhythm.
4. Begin Pulse Oximetry monitoring.
5. Begin an IV infusion of Normal Saline (0.9% NS) or Ringer's Lactate (RL).
    a. For adult patients:
        1. Administer up to 2 liters, via macro-drip.
        2. If transport is delayed or extended, administer an additional 1 liter. (Maximum 3 liters).
    b. For pediatric patients:
        1) Administer 20ml/kg with a repeat of 20ml/kg (maximum of 2 liters) via macro-drip.
        2) If transport is delayed or extended, administer an additional 20 ml/kg. (Maximum total of 3 liters[2]).

NOTE: ACCURATE DOCUMENTATION OF PRE-ARRIVAL FLUID ADMINISTRATION IS REQUIRED.

6. For patients who are experiencing severe pain

NOTE: FOR PATIENTS WITH BURNS INVOLVING THE ~~FACE AND/OR~~ AIRWAY, CONSULTATION WITH ON-LINE MEDICAL CONTROL IS REQUIRED PRIOR TO ADMINISTRATION OF ANALGESICS.

a. Administer Morphine Sulfate, for patients with a systolic blood pressure greater than 110mmHg, 0.1mg/kg (not to exceed 5mg), IV/IO/IM. For continued pain, repeat dose of 0.1mg/kg (not to exceed 5mg) may be repeated five minutes following the initial dose. (Maximum total dose is 10mg.)

OR

b. Administer Fentanyl 1mcg/kg (maximum total dose is 100mcg.), IV/IO/IN/IM, if available.

NOTE: If hypoventilation develops, administer Naloxone, titrate in increments of 0.5 mg up to response, up to 4 mg, IV/IO/IN/IM.

MEDICAL CONTROL OPTIONS:
OPTION A: Transportation Decision.

[1] *If the patient is alert prior to performing Advanced Airway Management, refer to Prehospital Sedation in General Operating Procedures. Prior permission from Medical Control Is Required.*
[2] *3 liters is a maximum. Fluids for pediatric patients are administered based on weight. Ex: if a child weights 50 kg and receives 3 boluses, that would equal 3 liters.*

556
PEDIATRIC ALTERED MENTAL STATUS

For pediatric patients in coma, with evolving neurological deficit,

or with altered mental status of unknown etiology.

NOTE: Maintenance of normal respiratory and circulatory function is always the priority. Patients with altered mental status due to respiratory failure or arrest, obstructed airway, shock, trauma, near drowning or other anoxic injury should be treated under other protocols.

1. Begin Basic Life Support Altered Mental Status procedures.
2. During transport, or if transport is delayed:
   a. Administer Glucagon 1 mg, IM or IN.
3. Begin an IV or IO infusion of Normal Saline (0.9% NS) to keep vein open. Attempt vascular access no more than twice.

NOTE: A GLUCOMETER SHALL BE USED TO DOCUMENT BLOOD GLUCOSE LEVEL PRIOR TO ADMINISTRATION OF DEXTROSE OR GLUCAGON.

IF THE GLUCOMETER READING IS ABOVE 60 MG/DL, DEXTROSE AND GLUCAGON SHOULD BE WITHHELD.

DIABETIC PATIENTS WITH A BLOOD GLUCOSE LEVEL READING BETWEEN 60-80 MAY STILL BE EXPERIENCING HYPOGLYCEMIA, AND IF THEY DISPLAY SUCH SIGNS AND SYMPTOMS SHOULD BE TREATED ACCORDINGLY.

4. Administer Dextrose 0.5 gm/kg, IV or IO bolus. Use 10% Dextrose in patients less or equal to one (1) month of age. Use 25% Dextrose in patients greater than one (1) month of age and less than 15 years of age. (Refer to Length Based Dosing Device)
5. If the patient's mental status fails to improve significantly, administer Naloxone IN/IM IV/IO:
   a. In patients two (2) years of age or older, titrate in increments of 0.5 mg up to response, up to 2 mg. (Refer to Length Based Dosing Device).
   b. In patients, less than two (2) years of age, titrate up to 1 mg. (Refer to Length Based Dosing Device).
6. If there is still no change in mental status, contact Medical Control for implementation of one or more of the following MEDICAL CONTROL OPTIONS:

MEDICAL CONTROL OPTIONS:

OPTION A: Repeat any of the above standing orders.

OPTION B: Transportation Decision.