Monroe Livingston Region Program Agency

Division of Prehospital Medicine, University of Rochester
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To: All ALS Providers and Agencies

From: Jeremy T. Cushman, MD, MS, EMT-P
Regional Medical Director

Date: February 10, 2014

Re: Advisory 14-02: 2014 Protocols

The 2014 Monroe-Livingston Regional EMS Protocols are now available. These protocols are effective immediately, and agencies are required to ensure that their providers are updated to these standards by no later than May 31, 2014.

The following are the notable protocol changes:

BLS

- Intranasal naloxone for BLS providers is available and is recognized in Protocol 2.25 – Poisoning/Overdose. See Advisory 13-14 for more information.

BLS/ALS

- There are updated protocols for Advanced Directives (1.3), Determination of Death (1.4), and Termination of Resuscitation (1.5). A training program has been developed by the Division of Prehospital Medicine and is being delivered by Agency Medical Directors and EMS Physicians. You should attend this training prior to utilizing these new protocols.

- Updated protocols for Behavioral Emergencies (2.8A) and Excited Delirium (2.8B). Please refer to Advisory 13-03 and the Excited Delirium Training vodcasts available on the MLREMS website.

- The updated Smoke Inhalation (2.39) protocol is included. See Advisory 13-13 for more information.

- The Program Agency has updated the regional protocol tests for ALS and BLS providers. Although providers are not required to successfully pass the respective test prior to utilizing the 2014 Protocols, they are available for agency use here after February 17, 2014.

ALS

- The maximum total amount of midazolam to be administered on standing order has been increased to 10 mg. Providers may give 2.5-5 mg (adult) or 0.1 mg/kg up to 2.5 mg (pediatric) and must call medical control for any total administered doses beyond 10mg. This has been standardized across all protocols that utilize midazolam (Behavioral Emergencies and Excited Delirium 2.8A and 2.8B, Sedation 2.30, and Seizure 2.31).

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ALS (Continued)

- The Respiratory Distress/Bronchospasm protocol (2.29) has been clarified and simplified. For ALS providers, albuterol 2.5 mg should be mixed with ipratropium 0.5 mg and may be repeated twice. Beyond 3 combined albuterol/ipratropium nebulizer treatments the ALS provider should only administer albuterol nebulizers, up to a total of 30 mg/hr.

- Protocol 3.2 (Return of Spontaneous Circulation) has been updated following the removal of therapeutic hypothermia as a treatment option. See Advisory 13-12 for more information.

- Dopamine has been removed, and replaced with Norepinephrine for management of fluid-refractory shock in Protocols 2.18 (Acute Coronary Syndrome), 2.18 (Hypotension/Shock), 2.26 (Pulmonary Edema/CHF), 3.2 (ROSC – Adults), and 4.2 (ROSC – Pediatrics). A vodcast training on the use of Norepinephrine is available for providers here. It is expected that by June 1, 2014 that the transition to Norepinephrine has been made and there will no longer be any dopamine within the system. Many agencies may have one or both during this time of transition.

ALS – RSI

- Protocol 2.27 (Rapid Sequence Intubation) has been updated to include the removal of lidocaine as pre-treatment and the addition of Rocuronium as an alternative paralytic.

- Ketamine has been added to the formulary for RSI providers only. Training is available in first quarter 2014 for all RSI providers as to the use of Ketamine as indicated in the protocols for RSI (2.27), Excited Delirium (2.8B), and Facilitated Extrication (2.40). RSI Agency ALS Chiefs have received information from the Regional Medical Director on how to go about obtaining Ketamine and updating agency controlled substance plans with the State.

Special note for EMT-I and EMT-CC Providers

- The 2014 Protocols identify two levels of care recognized in the Monroe-Livingston Region: EMT-B and EMT-P. Any remaining EMT-I or EMT-CC providers are to continue using the 2012 MLREMS Protocols until June 30, 2014, at which time pursuant to previous REMAC action, they must revert to the EMT-B scope of practice.

With any questions, please do not hesitate to contact our office.