2019 NYS EMS Collaborative Protocol Update for the MLREMS System

The MLREMS region has previously incorporated many of the changes in the 2019 New York State EMS Collaborative Protocols through the implementation of our local care bundles. As a result, there should be no significant changes to patient care performed within the MLREMS region related to the release of the 2019 NYS EMS Collaborative Protocols.

There are a few changes in the 2019 NYS EMS Collaborative Protocols that are worth noting. However, each provider will be expected to familiarize themselves with the entirety of the current protocols that will guide their level of care.

Before reviewing the newest protocols, each provider is encouraged to download the appropriate Smartphone App and use the App to review the protocols:

NYS EMS Collaborative Protocols (iPhone)

NYS EMS Collaborative Protocol (Android)

General changes:

- Formatting and numbering of the protocols, as the adult and pediatric protocols are intermingled rather than being divided in two unique sections. The numbering convention is as follows:
    - Single (#.#.#) – covers both adult and pediatric care
    - Adult (A#.#.#)
    - Pediatric (P#.#.#)
- You will notice marks (most commonly an asterisk*) used to indicate footnotes within individual protocols. The definition and/or explanation is typically found in the 'Key Points' section of that specific protocol.
- The protocols are designed so that BLS interventions should be completed before ALS interventions. Advanced providers are also responsible for, and may implement, the standing orders indicated for the preceding levels of care. Protocols are listed for each provider level and STOP lines indicate the end of standing orders for that level of provider.
- Several protocols have been moved to the reference section and vice-versa.

Recurring ideas that are not currently incorporated in the MLREMS region:

- Acetaminophen and Ibuprofen are listed with indications and contraindications
- 12-Lead ECG acquisition by EMTs
- CPAP (or BiPAP) use by EMTs
- Use of Nitrous oxide

There is no formal training module in the MLREMS region associated with the release of the NYS EMS Collaborative Protocols. An affirmation of understanding will be assigned through the Cypherworx Learning Management System to all regional providers.

The following are new sections and/or protocols that were not previously included in prior versions of the NYS EMS Collaborative Protocols. As mentioned previously, no substantial changes to patient care in the MLREMS region should result from these additions and modifications.

Introduction- NEW

- The provider levels now include "CFR and all Providers Levels"

Pediatric Definition and Discussion - NEW

- Considered for all patients who have not reached their 15th birthday

Protocols

(1.1) General Approach to the EMS Call (pages 10-11) NEW
- Provides a standardized framework for approaching ***the scene***

(1.2) General Approach to the Patient (pages 12-14) NEW
- Provides a standardized framework for approaching ***the patient***

(1.3) General Approach to Safety Restraining Devices (page 15) NEW
- Provides a standardized framework for approaching ***patient transport***

(1.4) General Approach to Transportation (pages 16-17) NEW
- The closest ***appropriate hospital*** may not be the closest hospitals, even for patients in extremis such as those in cardiac or respiratory arrest

(A2.2) and (P2.2) Foreign Body Obstructed Airway NEW

- There are now specific protocols for patients (adult and pediatric) with a partial or complete foreign body airway obstruction – the care remains unchanged

(A2.4) and (P2.4) Respiratory Arrest / Failure NEW

- These protocols focus on patients (adult and pediatric) with absent or ineffective breathing regardless of the underlying cause and focuses on adequate ventilation

(P3.4.1) Behavioral Emergencies: Agitated Patient – Pediatric NEW

- There is now a specific pediatric protocol for managing behavioral emergencies separate from the adult protocol

(P3.7) Cardiac Related Problem – Pediatric NEW

- There is now a specific pediatric protocol for managing cardiac related problems separate from the adult protocol

(A3.12) and (P3.12) Fever NEW

- These protocols address the management of patients (adult and pediatric) with a fever separate from the management of sepsis and septic shock

(P3.29) Technology Assisted Children NEW

- This protocol provides a useful reference for several of the most common special health care needs requiring technological assistance for life support

(3.30) Total Artificial Heart (TAH) NEW

- This protocol should be referenced for any request for service that requires evaluation and transport of a patient with a Total Artificial Heart

(3.31) Ventricular Assist Device (VAD) – NEW

- This protocol should be referenced for any request for service that requires evaluation and transport of a patient with a Total Artificial Heart

References

(P5.2) APGAR NEW

- A simple reference for a infrequently used assessment by prehospital providers

(5.5) Glascow Coma Score (GCS) NEW

- A reference to help ensure accurate documentation of eyes / verbal / motor responses

(5.6) Incident Command NEW

- Statement to establish the National Incident Management System (NIMS) as the standard system of command and control for emergency operations in New York State – not previously a standalone section in previous protocols

(P5.14) Pediatric Assessment Triangle NEW

- References a method of quickly determining the acuity of the child, as well as assisting in the determination of whether a child is in respiratory distress, respiratory failure, or shock

(5.16) Refusal of Medical Attention NEW

- This reference outlines several important considerations that all levels of providers should take into account when any patient with an actual or potential injury or other medical problem wishes to refuse medical care or transport.

(5.18) Transfer of Patient Care NEW

- This reference will aide providers in ensuring that the highest level of patient care is maintained until that patient reaches definitive care.
- Additional training on these exchanges can be found on Cypherworx in the course entitled:

Effective Prehospital Patient Handoffs between Providers

BLS specific changes:

(A2.1.0) Cardiac Arrest: General Approach

- After 20 minutes consider calling medical control for: termination of resuscitation, continuing efforts, or transportation in extenuating circumstances.

(P2.1.2) Cardiac Arrest: Ventricular Fibrillation or Pulseless V Tachycardia – Pediatric

- Pediatric AED pads preferred for children with weight < 25 kg or age < 8 years
- Different from definition of pediatric patients being those that have not reached their 15th birthday

(A3.3) Anaphylaxis – Adult

- Medical Control Consideration for additional IM epinephrine for levels with limited standing order (CFR and EMT).

(3.11.1) Environmental – Cold Emergencies

- Rewarm the extremity (if the means to do so are available) only if the anticipated time to the hospital exceeds 60 minutes . . .
- Previous time was 30 minutes

(A3.15) and (P3.15 Hypoglycemia

- Check pupils and if constricted, consider Opioid (Narcotic) Overdose protocol

Note the different combinations for the types of shock:

- (A3.25.1) Shock: Shock / Hypoperfusion – Adult
- (A3.25.2) Shock: Severe Sepsis / Septic Shock
- (P3.25.3) Shock: Sepsis / Shock / Hypoperfusion – Pediatric

(3.28) Stroke

- Determine the "Last Known Well" . . .
- If the time from the last known well or time of symptom onset to estimated arrival in the ED will be less than 3.5 hours, unless regionally directed . . .
- Follow any local or regional guidelines for triage of stroke patient to centers with endovascular capabilities, if available
- Make sure to collect family or witness contact information to assist with hospital care

ALL of the above are addressed in the MLRES Care Bundle which remains unchanged and will be updated as local practices change.

(5.15) Prescribed Medication Assistance

- CFR included in the administration of many medications

ALS specific changes:

(A3.19) Pain Management - Adult

- Ketorolac is now standing order
- Continue to dose according to MLREMS recommendations

(P3.19) Pain Management - Pediatric

- Max dose of fentanyl is 100 mcg on standing order

(A3.21) Post Intubation Management

- Fentanyl and Midazolam – no max given in the protocol
- Continue to dose according to the MLREMS recommendations

(A3.22) Procedural Sedation - Adult

- Midazolam – no max given in the protocol
- Continue to dose according to the MLREMS recommendations

(A3.23) Rapid Sequence Intubation (RSI) - Adult

- The Key Points/Considerations sections of this protocol states rocuronium is to be used for paralysis only when succinylcholine is contraindicated. However, the MLREMS Regional Medical Director encourage all RSI providers to continue to use their best clinical judgement when determining the most appropriate paralytic to be used for any specific patient encounter.

(4.7) Morgan Lens has been moved to (4.4) Trauma: Burns