

New York State
Department of Health
Bureau of Emergency Medical Services

Statewide
Basic Life Support
Adult & Pediatric
Treatment Protocols
Certified First Responder

2003

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Preface and Acknowledgments

The 2003 New York State (NYS) Statewide Basic Life Support Adult & Pediatric Treatment Protocols for the Certified First Responder (CFR) includes revisions to match the current New York State CFR course curricula. These 2003 statewide protocols also include de-emphasizing the use of CUPS. CUPS is no longer required to be taught in NYS Emergency Medical Services (EMS) Courses and is not tested in Practical Skills Examinations or State Written Certification Examinations.

We would like to acknowledge the members of the New York State EMS Council's Medical Standards Committee for the time and effort given to developing this set of protocols. In addition, we would like to recognize the efforts of the Regional Emergency Medical Advisory Committees (REMACS) for their input and review.

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Introduction

The 2003 NYS Statewide Basic Life Support Adult and Pediatric Treatment Protocols designed by the Bureau of Emergency Medical Services of the New York State Department of Health and the New York State Emergency Medical Services Council. These protocols have been reviewed and approved by the New York State Emergency Medical Advisory Committee (SEMAC) and the New York State Emergency Medical Services Council (SEMSCO). The protocols reflect the current minimally acceptable statewide treatment standards for adult and pediatric basic life support (BLS) used by the Certified First Responder (CFR).

These protocols are not intended to be absolute and ultimate treatment doctrines, but rather standards which are flexible to accommodate the complexity of the problems in patient management presented to Certified First Responders in the field. These protocols should be considered as a model or standard by which all patients should be treated. Since patients do not always fit into a "cook book" approach, these protocols are not a substitute for GOOD CLINICAL JUDGMENT, especially when a situation occurs which does not fit these standards.

This manual includes a protocol for the general approach to the prehospital management of a patient, which is applicable to CFRs, and BLS protocols for the management of specific conditions. These protocols apply to both adults and children. In several cases, protocols designed specifically for adults or children are included. These are identified as such in their titles.

Several assumptions have been made in developing the specific protocols. First, the CFR has followed the protocol outlining the general approach to the prehospital management of the patient, that both the subjective and objective patient information has been analyzed to arrive at an appropriate treatment plan. Secondly, specific treatment protocols are referred to once the patient's problem has been identified. Obviously, significant indirect (off-line) medical control has been assumed in the development of these protocols.

Regional EMS councils, regional emergency medical advisory committees (REMACs), course sponsor agencies, regional and local medical directors and squad training officers play an important part in the implementation of these protocols.

The goal of prehospital emergency medical care is to provide DEFINITIVE CARE for the patient as rapidly and safely as the situation indicates with no deterioration of his/her condition and, when possible, in an improved condition. BLS units shall deliver their patients who will benefit from ALS care to this higher level of care as soon as possible. This may be accomplished either by intercepting with an ALS unit or by transport to an appropriate hospital, which ever can be effected more quickly.

A system of ALS intercept (when available within a given area) shall be pre-arranged. Formal written agreements for the request of ALS shall be developed in advance by those agencies not able to provide ALS. ALS requests should be initiated as soon as possible at the dispatch level whenever indicated.

A request for ALS intercept shall occur as noted in specific treatment protocols. Initiation of patient transport shall not be delayed to await the arrival of an ALS unit, unless an on-line medical control physician otherwise directs.

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General Approach

General Approach to Prehospital Patient Management

I. Scene Size-Up

- A. Assess the scene for safety.
- B. Use standard precautions and transmission based precautions for all patients.
- C. Note the number of patients, the mechanism(s) of injury, environmental hazards, etc.
- D. Request additional personnel (i.e. EMTs, AEMTs, police, firefighters, etc. as appropriate), ALS intercept, and/or additional equipment or resources if needed.
- E. Consider C-Spine stabilization.

Note:
Check each patient for responsiveness, breathing, and pulse quickly while protecting the cervical spine.

II. Initial Assessment

A. General Impression

- 1. Determine mechanism of injury, nature of illness and chief complaint.
- 2. Age and sex.
- 3. Find immediate life threatening conditions.

B. Mental Status – What is the patient’s level of consciousness?

- 1. *Assess the patient’s level of consciousness as follows:*

Alert – Patient is awake and alert.

Verbal – Patient responds to verbal stimuli.

Painful – Patient responds to pain.

Unresponsive – Patient does not respond to verbal or painful stimuli.

- 2. *Establish patient’s orientation*

Patient is oriented to:

- 1. his/her name,
- 2. where he/she is, and
- 3. day of the week.

C. Airway, Breathing and Circulation

Airway – Identify and correct any existing or potential airway obstruction problems while protecting the cervical spine when indicated.

General Approach, continued

Breathing – Assess breathing, administer oxygen if necessary and consider positive pressure ventilations.

Circulation – Assess circulation and control life threatening hemorrhaging.

III. **Identify Priority Patients:** Consider the following criteria for *High* priority patients

1. Poor general impression
2. Unresponsive patients
3. Responsive, not following commands
4. Difficulty breathing
5. Shock
6. Complicated childbirth
7. Chest pain
8. Uncontrolled bleeding
9. Severe pain
10. If utilizing CUPS scale – patients who are a C, U, or P

Immediate Transport Decision

If the patient's condition is high priority notify responding EMS units immediately.

Request for an ALS unit should be made as soon as possible. ALS requests should ideally be initiated at the dispatch level.

IV. **Vital Signs:** Obtain and record the following on every patient initially, and repeat as often as the situation indicates.

1. **Respirations:** Rate and quality.
2. **Pulse:** Rate, quality, and regularity.
3. **Skin:** Color, temperature, moisture.

Note:

Do not delay updating the responding EMS unit of a high priority patient to obtain the above information.

General Approach, continued

V. **Updating Responding EMS Units:** Update responding EMS unit/Ambulance with a brief radio report. Include, at a minimum, the following:

1. Age and sex
2. Chief complaint
3. Mental status/Responsiveness (AVPU)
4. Airway and breathing status
5. Circulation status
6. Identification of priority patients
7. Determine estimated time of arrival of additional EMS resources

VI. **Physical Examination:** Perform a physical examination on the patient to gather additional information.

1. Inspect and palpate for signs of injury using the mnemonic **DOTS**:
 - a. **D**eformities
 - b. **O**pen injuries
 - c. **T**enderness
 - d. **S**welling
2. Briefly assess the following areas:
 - a. Head
 - b. Neck
 - c. Chest
 - d. Back
 - e. Abdomen
 - f. Pelvis
 - g. All four extremities

VII. **Obtain History:** Obtain the history from the patient and/or family members. The **SAMPLE** history may be completed prior to the physical exam for medical patients. Determine if the patient has a medical identification tag.

SAMPLE

Signs and Symptoms: “Why did you call EMS today?”

1. Sign – any medical or trauma condition displayed by the patient and identifiable by the CFR.
2. Symptom – any condition described by the patient, e.g., shortness of breath.

Allergies: “Are you allergic to anything?”

1. Medications.
2. Food.
3. Environmental.

General Approach, continued

Medications: “Do you take any prescription or non-prescription medicine?”

1. Prescription (current, recent, birth control pills, etc.).
2. Non-prescription (current, recent, herbal remedies, etc.).

Pertinent Past History: “Are you seeing a Doctor for anything?”

“Have you ever been in the hospital?”

1. Medical.
2. Surgical.
3. Trauma.

Last oral intake: “When was the last time you had anything to eat or drink?”

Solid or Liquid

1. Time.
2. Quantity.

Events leading up to the injury or illness: *Examples*

1. Chest pain on exertion. (i.e. pain while shoveling snow or walking up stairs, etc.)
2. Chest pain while at rest (i.e. pain while laying in bed or watching television, etc.)
3. “What were you doing when this happened?”
4. “Were there any other associated symptoms?”

VIII. **Field Treatment:** Administer appropriate treatment in order of priority. See specific treatment protocols.

IX. **On-Going Assessment:** Continue to assess the patient while waiting for additional EMS resources.

1. Repeat Initial Assessment every 15 minutes for a stable patient
2. Repeat Initial Assessment every 5 minutes for an unstable or high priority patient
3. Repeat Physical Examination as necessary
4. Maintain an open airway
5. Monitor breathing
6. Monitor pulse
7. Monitor skin color and temperature
8. Check effectiveness of treatments and/or interventions

X. **Hand-off Report:** Provide a Hand-off Report to the arriving EMS unit, which will take over care of your patient(s). The report must contain, at a minimum, the following information:

1. Age and sex.
2. Chief complaint
3. Mental status/Responsiveness (AVPU)
4. Airway and breathing status
5. Circulation status
6. Physical Examination findings
7. SAMPLE history
8. Interventions and/or treatment given

General Approach, continued

Documentation

- A. It is recommended that a written report summarizing all information listed in Section X, as a minimum data set, be given to the arriving EMS unit taking over your patient's care. However, patient care and/or transportation to a hospital **must not be delayed to complete this written report.**
- B. Complete a New York State Prehospital Care Report (PCR) or other approved equivalent documenting all information listed in Section X as a minimum data set.
- C. Submit the hospital copy of the Prehospital Care Report (PCR) to the arriving EMS unit taking over your patient's care.

Medical Protocols

Altered Mental Status

(NON-TRAUMATIC AND WITHOUT RESPIRATORY OR CARDIOVASCULAR COMPLICATIONS)

Note:

Request Advanced Life Support if available.

Note:

This protocol is for patients who are not alert (A), but who are responsive to verbal stimuli (V), responding to painful stimuli (P), or unresponsive (U).

- I. Assess the situation for potential or actual danger. If the scene/situation is not safe, retreat to a safe location, create a safe zone and obtain additional assistance from a police agency.

Note:

Emotionally disturbed patients must be presumed to have an underlying medical or traumatic condition causing the altered mental status.

Note:

**All suicidal or violent threats or gestures must be taken seriously. These patients should be in police custody if they pose a danger to themselves or others.
If the patient poses a danger to themselves and/or others, summon police for assistance.**

- II. Perform initial assessment. Assure that the patient's airway is open and that breathing and circulation are adequate.
- III. Administer high concentration oxygen.
- IV. Obtain and record patient's vital signs, including determining the patient's level of consciousness.
 - A. **If the patient is unresponsive (U) or responds only to painful stimuli (P), place the patient in the recovery position, keeping the patient warm.**

Altered Mental Status, continued

Note:

Do not give anything by mouth to patients who are unconscious or to patients with head injuries.

- V. If underlying medical or traumatic condition causing an altered mental status is not apparent; the patient is fully conscious, alert (A) and able to communicate; and an emotional disturbance is suspected, proceed to the Behavioral Emergencies protocol.
- VI. Update the responding EMS unit.
- VII. Perform a physical examination.
- VIII. Obtain history using SAMPLE.
- IX. Ongoing assessment. Repeat the initial assessment and record the patient's vital signs, including the level of consciousness as often as the situation indicates.
- X. Provide a Hand-off Report to arriving EMS unit, which will take over care of your patient.
- XI. Record all patient care information, including the patient's medical history and all treatment provided, on a Prehospital Care Report (PCR) or other approved equivalent.

Behavioral Emergencies

- I. Determine whether the scene/situation is safe. If not, retreat to a safe location, create a safe zone, and obtain additional assistance from a police agency.

Note:
If regionally approved and available, contact a specialized mental health unit response team for assistance.

- II. Perform initial assessment.
- III. Assure that the patient's airway is open and that breathing and circulation are adequate.
- IV. Consider other causes of abnormal behavior (lack of oxygen, shock, diabetic reactions, etc.)
- V. Place the patient in a position of comfort, if possible and no suspicion of spinal injury.
- VI. Attempt to establish a rapport with the patient and keep the patient calm.
- VII. Restrain, *only if necessary*, using soft restraints to protect the patient and others from harm. *Restraints should only be used if the patient presents a danger to themselves or others!*

Note:
Restraints must be utilized in accordance with New York State Mental Health Law. Police or Peace Officer should be present at the scene prior to the application of restraints.

- VIII. After application of restraints, keep the patient in the most appropriate position, while assuring the restraints do not restrict the patient's breathing or circulation.
- IX. Update the responding EMS unit.
- X. Perform a Physical Examination if possible and obtain History using SAMPLE.
- XI. Ongoing assessment. Repeat the initial assessment and record the patient's vital signs, including the level of consciousness as often as the situation indicates.
- XII. Provide a Hand-off Report to arriving EMS unit, which will take over care of your patient.
- XIII. Record all patient care information, including the patient's medical history and all treatment provided, on a Prehospital Care Report (PCR) or other approved equivalent.

Cold Emergencies

I. LOCAL COLD INJURY

- A. Remove the patient from the cold environment.
- B. Protect the injured areas from pressure, trauma, and friction.

Caution:
Do not rub the injured areas! Do not break blisters!
Do not allow the injured areas to thaw if they may refreeze before evacuation is completed!

- C. Perform initial assessment.
- D. Administer high concentration oxygen.
- E. Update the responding EMS unit.
- F. Perform Physical Exam.
- G. Obtain History using SAMPLE.
- H. Remove the clothing from the injured areas.
 - 1. If patient has an early *or superficial* local cold injury:
 - a. Remove jewelry.
 - b. Manually stabilize and cover the area with dry dressings.
 - c. Do not rub, massage, or expose to the cold.
 - 2. If patient has a *late or deep* local cold injury:
 - a. Remove jewelry.
 - b. Cover the exposed area with dry dressings.
 - c. Do not break blisters, rub or massage area, apply heat, rewarm, or allow the patient to walk on the affected extremity.
- I. Keep the patient warm while waiting for the responding EMS unit.

Cold Emergencies, continued

- J. Ongoing assessment. Repeat the initial assessment and record the patient's vital signs, including the level of consciousness as often as the situation indicates
- K. Provide a Hand-off Report to arriving EMS unit, which will take over care of your patient.
- L. Record all patient care information, including the patient's medical history and all treatment provided, on a Prehospital Care Report (PCR) or other approved equivalent.

II. GENERALIZED COLD EMERGENCY:

A. General Treatment Guidelines:

1. Handle the hypothermic patient carefully to prevent cardiac arrest from ventricular fibrillation.
2. Remove the patient from the cold environment and protect the patient from further heat loss.
3. Do not allow the patient to walk or exert themselves.
4. Perform initial assessment.
5. Assure that the patient's airway is open and that breathing and circulation are adequate.
6. Administer high concentration oxygen.
7. Update responding EMS unit.
8. Assess pulses for 30 – 45 seconds. If no pulse begin CPR and refer to appropriate Cardiac Arrest protocol.
9. **If the patient is unconscious or not responding appropriately:**
 - a. **If respirations and pulse are absent, start CPR. It is possible that the patient may still be revived.**

Note:

Vital signs should be taken for a longer period of time than usual so as not to miss a very slow pulse or respiratory rate.

- b. **If defibrillation is indicated by the AED, defibrillate a maximum of three shocks.**

Cold Emergencies, continued

10. Remove any wet clothing and cover patient with a blanket.
11. Do not allow the patient to eat or drink.
12. Perform Physical Exam.
13. Obtain History using SAMPLE.
14. Place the patient in a warm, draft free environment.
15. Ongoing assessment. Repeat the initial assessment and record the patient's vital signs, including the level of consciousness as often as the situation indicates.
16. Provide a Hand-off Report to arriving EMS unit, which will take over care of you patient.
17. Record all patient care information, including the patient's medical history and all treatment provided, on a Prehospital Care Report (PCR) or other approved equivalent.

Pediatric Respiratory Distress/Failure

Note:
Request Advanced Life Support if available.

- I. **If the child is in respiratory distress (signs and symptoms of respiratory distress and any of the following):**
- a. Respiratory rate outside the normal range for the patient's age.
(>60 per min. in infants, >30/40 per min. in children)
 - b. Cyanosis.
 - c. Decreased muscle tone.
 - d. Severe use of accessory muscles.
 - e. Poor peripheral perfusion and color.
 - f. Altered mental status.
 - g. Grunting.
 - h. Stridor.
 - i. Retractions.
- A. Maintain a calm approach to the child and parent. **Allow the child to assume and maintain a position of comfort or to be held by the parent, preferably in an upright position. Do not force the child to lie down!**
- B. Administer high concentration oxygen by a face mask **if tolerated without agitating the child!** Administration of oxygen may best be accomplished by allowing the parent to hold the face mask about 6 – 8 inches from the child's face.
- C. Update the responding EMS unit.
- D. Perform Physical Exam.
- E. Obtain History using SAMPLE
- F. Ongoing assessment. Repeat the initial assessment and record the patient's vital signs, including the level of consciousness as often as the situation indicates.
- G. Provide a Hand-off Report to arriving EMS unit, which will take over care of your patient.
- H. Record all patient care information, including the patient's medical history and all treatment provided, on a Prehospital Care Report (PCR) or other approved equivalent.

Pediatric Respiratory Distress, continued

II. If the child is in respiratory arrest/failure (signs and symptoms of respiratory distress with any of the following):

- a. Breathing at less than 12 breaths/minute in a child.
 - b. Breathing at less than 20 breaths/minute in an infant.
 - c. Retractions.
 - d. Head bobbing.
 - e. Grunting.
 - f. Severe use of accessory muscles.
 - g. Absent or shallow chest wall motion.
 - h. Limp muscle tone.
 - i. Changes in mental status.
 - j. Slow or absent heart rate.
 - k. Cyanosis with a slow heart rate.
 - l. Weak or absent distal pulses.
 - m. Unresponsive.
- A. Open the child's airway with the head-tilt/chin-lift maneuver if no trauma is suspected. Use the modified jaw thrust maneuver if head, neck, or spinal trauma is suspected.
 - B. Ventilate the child at a rate appropriate for the child's age using a pocket mask or bag-valve-mask. **Assure that the chest rises with each ventilation.**
 - C. Supplement ventilations with high concentration oxygen.

Caution:

**Adequate ventilation may require disabling the pop-off valve if the bag-valve-mask unit is so equipped!
BVM must have a volume at least 450 – 500 ml for newborns & infants.**

- D. Update the responding EMS unit.
- E. Perform Physical Exam.
- F. Obtain History using SAMPLE
- G. Ongoing assessment. Repeat the initial assessment and record the patient's vital signs, including the level of consciousness as often as the situation indicates.
- H. Provide a Hand-off Report to arriving EMS unit, which will take over care of your patient.

Pediatric Respiratory Distress, continued

Caution:

If progressive low pulse rate and cyanosis – signs of impending cardiac arrest are present, be prepared to initiate the Non-Traumatic Cardiac Arrest Protocol.

- I. Record all patient care information, including the patient's medical history and all treatment provided, on a Prehospital Care Report (PCR) or other approved equivalent.

Heat Emergencies

- I. Perform initial assessment.
- II. Assure that the patient's airway is open and that breathing and circulation are adequate.
- III. Remove the patient from the heat source and place in a cool environment.
- IV. Administer high concentration oxygen.
- V. Update the responding EMS unit.
- VI. Perform Physical Exam.
- VII. Cool the patient by removing excess clothing and fanning the patient.
- VIII. Place patient in the recovery position.
- IX. Ongoing assessment. Repeat the initial assessment and record the patient's vital signs, including the level of consciousness as often as the situation indicates.
- X. Provide a Hand-off Report to arriving EMS unit, which will take over care of your patient.
- XI. Record all patient care information, including the patient's medical history and all treatment provided, on a Prehospital Care Report (PCR) or other approved equivalent.

Adult Obstructed Airway

Note:
Request Advanced Life Support if available.

- I. **If the patient is conscious and can breathe, cough or speak, do not interfere!** Encourage the patient to cough. **If the foreign body cannot be dislodged by the patient coughing:**
 - A. Administer high concentration oxygen.
 - B. Proceed to step V.
- II. **If the patient is conscious with signs of severe airway obstruction (i.e. signs of poor air exchange and increased breathing difficulty, such as a silent cough, cyanosis, or inability to speak or breathe),** perform obstructed airway maneuvers according to AHA/ARC/NSC guidelines and proceed to step V.
- III. **If the airway obstruction persists after two sequences of obstructed airway maneuvers and/or the patient becomes unconscious:**

Caution:
If obstructed airway is traumatic, manually stabilize the head and cervical spine in a neutral position while opening the patient's airway using the jaw-thrust maneuver.

Continue to attempt removal of the airway obstruction while waiting for EMS unit to arrive.

- A. Begin CPR.
- IV. **If the airway obstruction is cleared and the patient resumes breathing:**
 - A. Administer high concentration oxygen.
 - B. Proceed to step V.
- V. Update the responding EMS unit
- VI. Perform Physical Exam
- VII. Obtain History using SAMPLE

Adult Obstructed Airway, continued

- VIII. Ongoing assessment. Repeat the initial assessment and record the patient's vital signs, including the level of consciousness as often as the situation indicates
- IX. Provide a Hand-off Report to arriving EMS unit, which will take over care of your patient.
- X. Record all patient care information, including the patient's medical history and all treatment provided, on a Prehospital Care Report (PCR) or other approved equivalent.

Pediatric Obstructed Airway

Note:

**Request Advanced Life Support if available.
Do not delay transport to the appropriate hospital.**

- I. **Partial Airway Obstruction – If the child is alert and can breathe, cough, cry or speak:**
 - A. **Do not interfere, and do not perform BLS airway maneuvers! Allow the child to assume and maintain a position of comfort or to be held by the parent, preferably in an upright position. Do not lay the child down.**
 - B. Administer high concentration oxygen (preferably humidified) by a face mask, **if tolerated without agitating the child!** Administration of oxygen may best be accomplished by allowing the parent to hold the face mask about 6 – 8 inches from the patient’s face.
 - C. Transport immediately, keeping the child warm.
 - D. Ongoing assessment. Obtain and record the patient’s initial vital signs, including capillary refill, **if tolerated**, repeat enroute as often as the situation indicates, **without agitating the child**. Limit your exam and do not assess blood pressure.
 - E. Record all patient care information, including the patient’s medical history and all treatment provided, on a Prehospital Care Report (PCR).
- II. **If the child is conscious but cannot breath, cough, speak, or cry, perform obstructed airway maneuvers according to AHA/ARC/NSC guidelines.**

Caution:

Agitating a child with a partial airway obstruction could cause complete obstruction! As long as the child can breathe, cough, cry, or speak, do not upset the child with unnecessary procedures (e.g., blood pressure determination)!
Use a calm, reassuring approach, transporting the parent and child securely as a unit.

Pediatric Obstructed Airway, continued

III. If the child is unconscious, becomes unconscious and is not breathing:

- A. Attempt to establish airway control using BLS techniques. Open the child's mouth, and remove any **visible** foreign body.
- B. Begin CPR according to AHA/ARC/NSC guidelines and transport immediately.

IV. **Immediately upon removal of the foreign body and/or establishment of chest rise in a child of any age (including infants), assess the child's ventilatory status!**

Caution:

If signs of impending cardiac arrest are present (i.e., progressive bradycardia, delayed capillary refill [greater than 2 seconds] and cyanosis), be prepared to initiate the non-traumatic cardiac arrest protocol!

1. **If the ventilatory status is inadequate (the child is cyanotic, the respiratory rate is low for the child's age or capillary refill is greater than 2 seconds):**
 - a. Ventilate at the rate appropriate for the child's age using a pocket mask or bag-valve-mask. **Assure there is adequate chest rise with each ventilation given over one second.**

Caution:

Adequate ventilation may require disabling the pop-off valve if the bag-valve-mask unit is so equipped!

- b. Supplemental ventilations with high concentration oxygen.
 - c. Transport, keeping the child warm.
 - d. Ongoing assessment. Obtain and record the patient's vital signs, repeat enroute as often as the situation indicates.
 - e. Record all patient care information, including the patient's medical history and all treatment provided, on a Prehospital Care Report.
2. **If the ventilatory status is adequate (i.e., the child is breathing spontaneously, the respiratory rate is appropriate for the child's age, cyanosis is absent, and capillary refill is less or equal to 2 seconds):**

Pediatric Obstructed Airway, continued

- a. Administer high concentration oxygen (preferably humidified) by a face mask, **if tolerated, without agitating the child!** Administration of oxygen may best be accomplished by allowing the parent to hold the face mask about 6 – 8 inches from the patient's face.
- b. Transport, keeping the child warm.
- c. Ongoing assessment. Obtain and record the patient's vital signs, including capillary refill, **if tolerated**, repeat enroute as often as the situation indicates, **without agitating the child.**
- d. Record all patient care information, including the patient's medical history and all treatment provided, on a Prehospital Care Report (PCR).

Adult Respiratory Arrest/Failure (Non-Traumatic)

Note:

Determine if the patient has a Do Not Resuscitate (DNR) order. Treatment must not be delayed while making this determination.

Note:

Request Advanced Life Support if available.

- I. Perform initial assessment.
- II. **If ventilatory status is inadequate, (patient is cyanotic, visible retractions, severe use of accessory muscles, altered mental status, respiratory rate less than 10 breaths per minute, signs of poor perfusion) proceed with positive pressure ventilations as follows.**
- III. Insert an oropharyngeal airway if tolerated (i.e., no gag reflex). Provide BLS care according to AHA/ARC/NSC standards. **If ventilations are unsuccessful, refer immediately to the Obstructed Airway Protocol. If the patient is in cardiac arrest refer immediately to the appropriate Cardiac Arrest Protocol.**
- IV. Ventilate with supplemental oxygen.
- V. Update the responding EMS unit.
- VI. Perform physical exam and obtain history using SAMPLE.
- VII. Ongoing assessment. Repeat the initial assessment and record the patient's vital signs, including the level of consciousness as often as the situation indicates.
- VIII. Provide a Hand-Off Report to arriving EMS unit, which will take over care of your patient.
- IX. Record all patient care information, including the patient's medical history and all treatment provided, on a Prehospital Care Report (PCR).

Caution:

Patients with airway obstruction or poor lung compliance *may* require high pressures to be properly ventilated, which can be achieved by disabling the pressure-relief valve of the BVM.

Rates of Ventilations

**Adults: Ventilate every 5 – 6 seconds without an advanced airway in-place and every 6 – 8 seconds if CPR is ongoing and an advanced airway in-place.
Each breath is given over 1 second causing visible chest rise.**

Pediatric Respiratory Arrest/Failure (Non-Traumatic)

Note:

Request Advanced Life Support if available.

I. Establish airway control and ventilations using BLS techniques according to AHA/ARC/NSC guidelines.

A. Open the airway using the head-tilt/chin-lift or jaw-thrust maneuver.

Caution:

If signs of impending cardiac arrest (i.e., progressive bradycardia, delayed capillary refill [greater than 2 seconds], cyanosis and limp muscle tone), be prepared to initiate the appropriate Cardiac Arrest Protocol!

B. Remove any **visible** airway obstruction by hand and clear the airway of any accumulated secretions or fluids by suctioning.

II. **Immediately** determine if the child is breathing adequately.

A. **If the ventilatory status is inadequate (the child is cyanotic, visible retractions, grunting, head bobbing, severe use of accessory muscles, altered mental status, the respiratory rate is low for the child's age, muscle tone is limp, a slow or fast heart rate, or other signs of inadequate perfusion):**

1. Insert a properly sized oropharyngeal airway if the gag reflex is absent. If a gag reflex is present insert a nasopharyngeal airway.
2. Determine if the patient needs positive pressure ventilations. If no, use supplemental oxygen and maintain airway. If yes, maintain airway, give positive pressure ventilations and supplemental oxygen.
3. Ventilate (with high concentration oxygen) at a rate appropriate for the child's age using a pocket mask or bag-valve-mask. **Assure there is adequate chest rise with each ventilation.**

Caution:

Adequate ventilation *may* require disabling the pop-off valve if the bag-valve-mask unit is so equipped. BVM must have a volume of at least 450 – 500 ml for newborns and infants

Rates of Ventilations

Infants and children: Every 3 – 5 seconds without an advanced airway in-place and every 6 – 8 seconds with an advanced airway in-place, each breath given over 1 second, causing visible chest rise.

- III. Identify and correct any other life-threatening conditions found during the initial assessment.
- IV. Update the responding EMS unit.
- V. Perform physical exam.
- VI. Obtain history using SAMPLE.
- VII. Ongoing assessment. Repeat the initial assessment and record the patient's vital signs, including the level of consciousness as often as the situation indicates.
- VIII. Provide a Hand-Off Report to arriving EMS unit, which will take over care of your patient.
- IX. Record all patient care information, including the patient's medical history and all treatment provided, on a Prehospital Care Report (PCR) or other approved equivalent.

Cardiac Arrest Adult and Pediatric (Non – Traumatic)

Note:

**Determine if the patient has a Do Not Resuscitate (DNR) order.
Treatment must not be delayed while making this determination.**

Request Advanced Life Support if available.

- I. If patient is unresponsive and pulseless, begin Cardiopulmonary Resuscitation as per current AHA/ARC/NSC guidelines.

DO NOT DELAY BEGINNING COMPRESSIONS TO BEGIN VENTILATIONS – COMPRESSIONS MUST BEGIN AS SOON AS IT IS DETERMINED THE PATIENT DOES NOT HAVE A PULSE

- A. Artificial ventilation and/or compressions **must not be delayed** to attach supplemental oxygen. Initial ventilations without supplemental oxygen should be used until supplemental oxygen can be attached.
- i. Deliver each breath over 1 second.
 - ii. Give sufficient tidal volume to produce visible chest rise.
 - iii. Avoid rapid or forceful ventilations.
 - iv. When an advanced airway is in-place with 2 person adult CPR, ventilations are to be given at a rate of one breath every 6-8 seconds without attempting synchronization between compressions. **Do not pause compressions for delivery of ventilations.**
- II. During application of the AED:
- A. The AED should be applied to the patient as soon as it is available and without interrupting compressions.
 - B. Assure proper application and adhesion of the pads to the patient's chest.
 - C. If present, remove Nitroglycerin medication patch from the patient's chest.

Cardiac Arrest – Adult and Pediatric – Non-Traumatic, continued

- i. When in doubt of the type of medication patch the patient has on their chest, remove the patch
 - ii. Assure that patient’s medication patch does not come in contact with your skin (wear appropriate PPE).
 - iii. Assure proper disposal of the medication patch at the Emergency Department through use of properly identified biohazard bags.
- III. Once the AED has analyzed the patient’s rhythm, follow the voice prompts to either “check patient” or administer a “shock”.
 - A. Pediatric patients under the age of 8 should be defibrillated using an AED equipped for and by the FDA for use on children.
 - i. In an emergency situation where an AED equipped for use on children is unavailable, an adult AED unit can be used.
- IV. After the first and all subsequent defibrillations immediately begin (approximately 2 minutes), without checking for a pulse, before the next rhythm check and/or defibrillation. Do not check for a pulse or rhythm after defibrillation until CPR has been completed (approximately every 2 minutes) *or* the patient appears to no longer be in cardiac arrest.
- V. All actions and procedures occurring during a cardiac arrest should be accomplished in a way that minimizes interruptions of chest compressions.
- VI. Transporting Agencies - Transport to the Emergency Department:
 - A. A maximum of 3 defibrillations may be delivered at the scene prior to initiating transport. If transportation is unavailable, continue your AED/CPR sequence until transportation is available.
 - B. If the AED advises that no shock is indicated, initiate transport with rhythm checks by the AED occurring approximately every 2 minutes.
 - C. During transport, the AED should perform rhythm checks approximately every 2 minutes with as few interruptions of chest compressions as possible.
- VII. If patient is no longer in cardiac arrest, complete an initial assessment, support airway and breathing, place patient in the recovery position, obtain vital signs, and treat according to appropriate protocol while continuing transport.

Cardiac Arrest – Adult and Pediatric – Non-Traumatic, continued

- A. If pt remains unresponsive with vital signs they may benefit from therapeutic hypothermia and medical control should be contacted to determine appropriate transportation destination.
- VIII. Record all patient care information, including the patient's medical history and all treatment provided (including the total number of defibrillations administered), on a Prehospital Care Report (PCR) or other approved equivalent.

Respiratory Distress

(Shortness of Breath, Difficulty Breathing)

Note:
Request Advanced Life Support if available.

Caution:
Be prepared to deal with respiratory and cardiac arrest!
Monitor the patient's respiratory status continuously.

- I. Perform initial assessment.
- II. Assure that the patient's airway is open. **If the airway is obstructed**, perform obstructed airway maneuvers according to AHA/ARC/NSC guidelines.
- III. Administer high concentration oxygen and assist the patient's ventilations as necessary.

Note:
**Allow the patient to assume and maintain a position of comfort, or
if a child to be held by the parent, preferably in an
upright position**

- IV. Place the patient in position of comfort.
- V. Update the responding EMS unit.
- VI. Perform Physical Exam.
- VII. Obtain History using SAMPLE.
- VIII. Ongoing assessment. Repeat the initial assessment and record the patient's vital signs, including the level of consciousness as often as the situation indicates.
- IX. Provide a Hand-off Report to arriving EMS unit, which will take over care of your patient.
- X. Record all patient care information, including the patient's medical history and all treatment provided, on a Prehospital Care Report (PCR) or other approved equivalent.

Seizures

Note:
Request Advanced Life Support if available.

I. Management of the patient who is seizing:

- A. Protect the patient from harm, **and** remove hazards from the patient's immediate area, **and** avoid unnecessary physical restraint.
- B. Perform initial assessment.
- C. Assure that the patient's airway is open, and that breathing and circulation are adequate.
- D. Suction the airway as needed. Avoid stimulation of the posterior pharynx during suctioning because this may cause vomiting.

Caution:
If the patient's ventilatory status is inadequate (cyanosis, low respiratory rate for the patient's age, decreased tidal volume, retractions, nasal flaring, agonal or irregular respirations), initiate the respiratory arrest/failure protocol.

- E. Position the patient in the recovery if no possibility of cervical spine trauma.

Note:
Do not force the patient's mouth open or force an oral airway or any other device into the patient's mouth if it is clenched tightly during the seizure!
A nasopharyngeal airway may be used.

- F. Administer high concentration oxygen.
- G. Proceed to step III.

II. Management of the post-seizure patient:

- A. Perform initial assessment.
- B. Assure that the patient's airway is open and that breathing and circulation are adequate.

Seizures, continued

- C. Place patient in the recovery if no possibility of cervical spine trauma.
 - D. Administer high concentration oxygen.
 - E. Treat injuries sustained during the seizure.
 - F. Be prepared for additional seizures.
- III. Update the responding EMS unit.
- IV. Perform Physical Exam
- V. Obtain History using SAMPLE
- VI. Ongoing assessment. Repeat the initial assessment and record the patient's vital signs, including the level of consciousness as often as the situation indicates.
- VII. Provide a Hand-off Report to arriving EMS unit, which will take over care of your patient.
- VIII. Record all patient care information, including the patient's medical history and all treatment provided, on a Prehospital Care Report (PCR) or other approved equivalent.

Trauma Protocols

Amputation

- I. Perform initial assessment.
- II. Assure that the patient's airway is open and that breathing and circulation are adequate. Apply oxygen if needed.

Caution:
Manually stabilize the head and cervical spine if trauma of the head and/or neck is suspected!

- III. Place the patient in a position of comfort **only if doing so does not compromise stabilization of the head and cervical spine!**
- IV. Control the bleeding by applying direct pressure.
- V. Elevate the stump above the level of the patient's heart.
- VI. **If bleeding cannot be controlled**, apply pressure on the appropriate arterial pressure point.
- VII. Assess for hypoperfusion. **If hypoperfusion is present, refer immediately to the hypoperfusion protocol!**
- VIII. Wrap the stump with moist sterile dressings.
- IX. Cover the dressed stump with a dry bandage.
- X. Preserve the amputated part as follows:
 - A. Moisten an appropriately sized sterile dressing with sterile saline solution.
 - B. Wrap the severed part in the moistened sterile dressing, preserving all amputated material.
 - C. Place the severed part in a water-tight container (i.e. sealed plastic bag).
 - D. Place the container on ice or cold packs (if available). **Do not freeze or use dry ice! Do not immerse the amputated part directly in water! Do not allow the amputated part to come in direct contact with ice!**
- XI. Manually stabilize the limb to prevent further injury.
- XII. Update the responding EMS unit.

Amputation, continued

Note:

Transportation of the patient should not be delayed to search for amputated parts! Continued searching for missing amputated parts should be continued while the patient is being transported to the appropriate hospital.

- XIII. Perform Physical Exam.
- XIV. Obtain History using SAMPLE.
- XV. Ongoing assessment. Repeat the initial assessment and record the patient's vital signs, including the level of consciousness as often as the situation indicates.
- XVI. Provide a Hand-off Report to arriving EMS unit, which will take over care of your patient.
- XVII. Record all patient care information, including the patient's medical history and all treatment provided, on a Prehospital Care Report (PCR) or other approved equivalent.

Bleeding (External)

- I. Assure that the patient's airway is open and that breathing and circulation are adequate. Apply oxygen if needed.
- II. Control bleeding by:
 - A. Immediately applying pressure directly on the wound with a sterile dressing.

NOTE: If available and bleeding is severe, a hemostatic gauze dressing should be applied directly to the bleeding site simultaneously with direct pressure.
 - B. If bleeding soaks through the dressing, apply additional dressings while continuing direct pressure. **Do not remove dressings from the injured site!**
 - C. Cover the dressed site with a pressure bandage.
- III. **If severe bleeding persists from a limb**, apply a tourniquet just proximal to the bleeding site. If severe bleeding still persists, a second tourniquet may be applied proximal to the first tourniquet. Record time tourniquet was secured and document near the tourniquet site.
- IV. **If severe bleeding persists from the trunk, neck, head or other location where a tourniquet cannot be used**, hemostatic gauze dressings should be used.
- V. Assess for hypoperfusion. **If hypoperfusion is present, refer immediately to the hypoperfusion protocol!**
- VI. Update the responding EMS unit.
- VI. Perform Physical Exam.
- VII. Obtain History using SAMPLE.
- VIII. Ongoing assessment. Repeat the initial assessment and record the patient's vital signs, including the level of consciousness as often as the situation indicates.
- IX. Provide a Hand-off Report to arriving EMS unit, which will take over care of your patient.
- X. Record all patient care information, including the patient's medical history and all treatment provided, on a Prehospital Care Report (PCR) or other approved equivalent.

Burns (Chemical)

- I. Assure that the scene is safe for entry. If danger of contamination is present, it may be necessary to obtain assistance from trained rescue personnel.
- II. Perform initial assessment.
- III. Assure that the patient's airway is open and that breathing and circulation are adequate. Apply oxygen if needed.
- IV. Treat according to the following:
 - A. **IF THE CHEMICAL IS A LIQUID:**

The patient you receive in your **safe zone** should already be decontaminated. Always check to assure that decontamination has been completed. There should be no contaminated clothing or jewelry on the victim. If contaminated items are present, notify the decontamination personnel. Flush the decontaminated areas with copious amounts of water at the scene and enroute to the hospital. If possible, flush site of the burn with water for a minimum of 20 minutes.
 - B. **IF THE CHEMICAL IS A DRY POWDER:**

The patient you receive in your **safe zone** should already be decontaminated. Always check to assure that decontamination has been completed. Brush any remaining chemical off of the patient. **Be careful not to spread it over unaffected areas.** There should be no contaminated clothing or jewelry on the victim. If contaminated items are present notify the decontamination personnel. Flush the decontaminated areas with copious amounts of water at the scene and enroute to the hospital. If possible, flush site of the burn with water for a minimum of 20 minutes.
 - C. **IF THE EYE(s) IS CONTAMINATED:**

The patient you receive in your **safe zone** should already be decontaminated. Always check to assure that decontamination has been completed. Irrigate the eye(s) with saline solution or water continuously for at least 20 minutes, or until arrival to the hospital, while the patient blinks frequently during irrigation. If only one eye is affected, do not contaminate the unaffected eye. After irrigation is complete, cover **both** eyes with moistened dressings or eye pads.
- V. Obtain the name of the product or substance involved and bring it and it's container (if possible and without causing further contamination with the substance) with the patient to the hospital

Burns (Chemical), continued

- VI. Update the responding EMS unit.
- VII. Perform Physical Exam.
- VIII. Obtain History using SAMPLE.
- IX. Ongoing assessment. Repeat the initial assessment and record the patient's vital signs, including the level of consciousness as often as the situation indicates.
- X. Provide a Hand-off Report to arriving EMS unit, which will take over care of your patient
- XI. Record all patient care information, including the patient's medical history and all treatment provided, on a Prehospital Care Report (PCR) or other approved equivalent.

Burns (Thermal/Electrical)

- I. Assure that the scene is safe for entry. If danger of contamination is present, it may be necessary to obtain assistance from trained rescue and/or fire personnel.
- II. Extinguish burning clothing, and stop the burning process.
- III. Perform initial assessment.
- IV. Assure that the patient's airway is open and that breathing and circulation are adequate.
- V. Place the patient in a position of comfort **only if doing so does not compromise stabilization of the head and cervical spine!**
- VI. Administer high concentration oxygen if indicated during the initial assessment *or* if respiratory burns are suspected and in all burns involving flames, exposure to superheated gases or when patient is found in a confined area.
- VII. Remove smoldering clothing not adhering to the patient's skin. Remove rings, bracelets and all other constricting items if possible.
- VIII. Assess for hypoperfusion. **If hypoperfusion is present, refer immediately to the hypoperfusion protocol!**
- IX. **For all burns** determine the thickness and cover the burned area with a dry sterile dressing.
- X. Keep the patient warm. **This is important since these patients tend to lose heat and become hypothermic!**
- XI. Perform Physical Exam.
- XII. Obtain History using SAMPLE.
- XIII. Ongoing assessment. Repeat the initial assessment and record the patient's vital signs, including the level of consciousness as often as the situation indicates.
- XIV. Provide a Hand-off Report to arriving EMS unit, which will take over care of your patient.
- XV. Record all patient care information, including the patient's medical history and all treatment provided, on a Prehospital Care Report (PCR) or other approved equivalent.

Musculoskeletal Trauma

Caution:
**Manually stabilize the head and cervical spine
if trauma of the head and/or neck is suspected!**

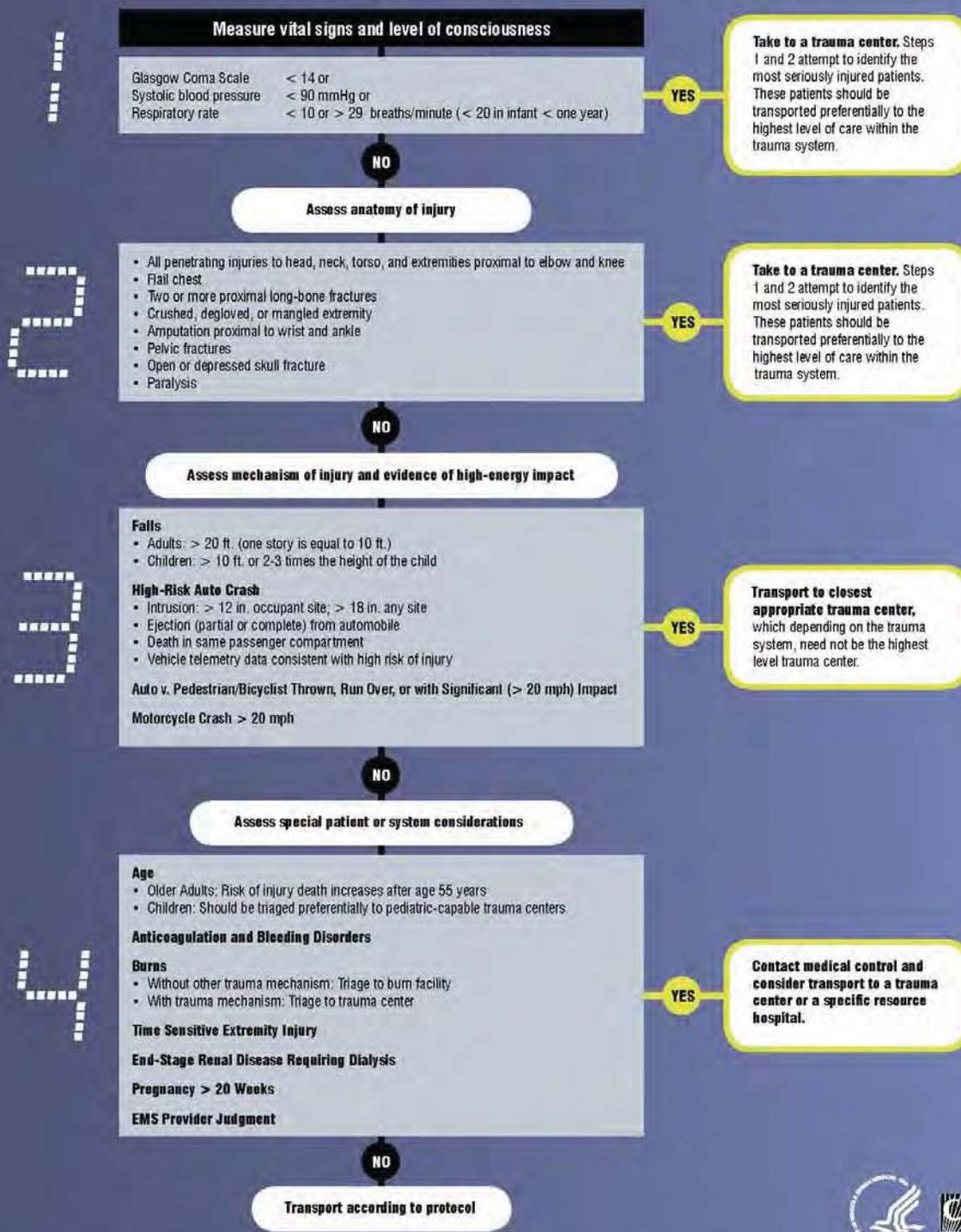
- I. Perform initial assessment.
- II. Assure that the patient's airway is open and that breathing and circulation are adequate. Apply oxygen if needed.

Note:
**Consider any open wound near a suspected bone injury site
to be the result of bone protrusion.**

- III. Manually stabilize the joints above and below the suspected injury site.
- IV. Expose the injured area to locate and identify suspected musculoskeletal injuries.
- V. Cover open wounds with sterile dressings.
- VI. Do not replace any protruding bones.
- VII. Assess for hypoperfusion. **If hypoperfusion is present, refer immediately to the hypoperfusion protocol!**
- VIII. Apply a cold pack to the injured area to reduce swelling and pain.
- IX. Update the responding EMS unit.
- X. Perform Physical Exam.
- XI. Obtain History using SAMPLE.
- XII. Ongoing assessment. Repeat the initial assessment and record the patient's vital signs, including the level of consciousness as often as the situation indicates.
- XIII. Provide a Hand-off Report to arriving EMS unit, which will take over care of your patient.
- XIV. Record all patient care information, including the patient's medical history and all treatment provided, on a Prehospital Care Report (PCR) or other approved equivalent.

Adult Major Trauma (Including Traumatic Cardiac Arrest)

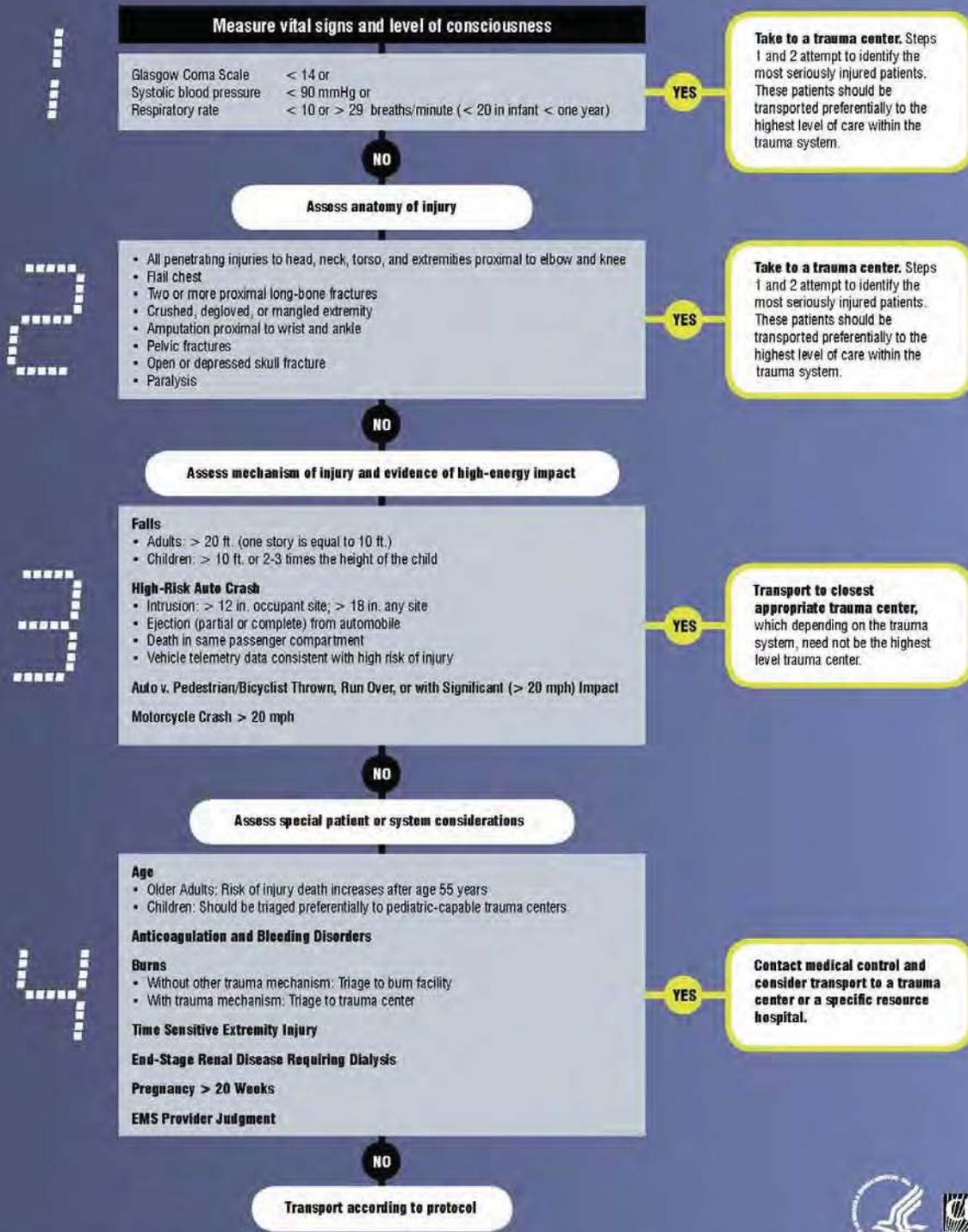
FIELD TRIAGE DECISION SCHEME: THE NATIONAL TRAUMA TRIAGE PROTOCOL



When in doubt, transport to a trauma center.
For more information on the Decision Scheme, visit www.cdc.gov/FieldTriage

Pediatric Major Trauma (Including Traumatic Cardiac Arrest)

FIELD TRIAGE DECISION SCHEME: THE NATIONAL TRAUMA TRIAGE PROTOCOL



When in doubt, transport to a trauma center.
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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION

Suspected Head or Spinal Injuries (Not Meeting Major Trauma Criteria)

Note:

If the patient is found in a standing position, continue your assessment and provide constant manual stabilization of the head and neck in the position found. Maintain manual stabilization of the cervical spine until the responding EMS unit takes over care.

- I. Establish and maintain airway control while manually stabilizing the head and neck.
- II. Perform initial assessment.
- III. Assess level of consciousness.
- IV. Assess the patient's ventilatory status and assist the patient's ventilation as necessary; administer high concentration oxygen and suction as necessary.
 - A. If the ventilatory status is inadequate, ventilate the patient with an adjunctive device and high concentration oxygen at a rate of 12 breaths/minute (adult) or a rate of up to 20 breaths/minute (child). **Assure that the chest rises sufficiently with each ventilation.**
 - B. If the ventilatory status is adequate, administer high concentration oxygen as soon as possible.
- V. Assess the patient's circulatory status.
- VI. Assess pulses, motor function and sensation in all extremities.
- VII. Update the responding EMS unit.
- VIII. Perform Physical Exam.
- IX. Obtain History using SAMPLE
- X. Ongoing assessment. Repeat the initial assessment and record the patient's vital signs, including the level of consciousness as often as the situation indicates.
- XI. Provide a Hand-off Report to arriving EMS unit, which will take over care of your patient.
- XII. Record all patient care information, including the patient's medical history and all treatment provided, on a Prehospital Care Report (PCR) or other approved equivalent.

Special Considerations

Oxygen Administration

I. Perform initial assessment.

A. If the patient requires oxygen therapy:

1. Assure that the patient's airway is open and that breathing and circulation are adequate. **If the airway is obstructed**, perform obstructed airway maneuvers according to AHA/NSC/ARC standards.

Note:

1. **Oxygen should never be withheld from patients requiring it, even though they may have a past medical history of chronic obstructive pulmonary disease!**
2. **When administering oxygen, monitor the patient carefully for any slowing of respirations, be prepared to ventilate the patient as necessary!**
3. **In patients who are being chronically maintained on oxygen and who have called EMS for a condition other than one requiring high concentration oxygen by these protocols, continue the administration of oxygen at the previously prescribed rate of flow.**

2. Administer **high-concentration oxygen**.

- a. First choice—Non-rebreather mask at 12 LPM or greater so reservoir bag does not collapse during inhalation. If reservoir bag collapses and does not refill adequately, increase to 15 LPM.
- b. Second choice—Nasal cannula at 6 LPM (used only if a mask is not tolerated).

Note:

There is no contraindication to high concentration oxygen in pediatric patients in the prehospital setting. Administration of oxygen is best accomplished by allowing the parent to hold the face mask, if tolerated, 6 to 8 inches from the child's face.

Oxygen Administration, continued

B. If the patient demonstrates inadequate ventilations:

1. Assist the patient's ventilations with high concentration oxygen using a positive pressure adjunctive device.
 - a. First choice—Bag-valve-mask (BVM) with reservoir and supplemental oxygen.

Caution:

Adequate ventilation *may* require disabling the pop-off valve if the bag-valve-mask unit is so equipped!

- b. Second choice—Pocket mask with supplemental oxygen set at greater than 10 LPM.
 - c. Third choice—Flow restricted oxygen powered ventilation device.

C. If one or more signs of respiratory distress or respiratory arrest are present, refer immediately to the Respiratory Distress Protocol (M-11) or the appropriate Respiratory Arrest Protocol (M-7 or M-8)!

- II. Complete all other steps required in the individual treatment protocols that indicate the need for oxygen administration.
- III. Record all patient care information, including the patient's medical history and all treatment provided, on a Prehospital Care Report (PCR) or other approved equivalent.

Hypoperfusion

Note:

Request Advanced Life Support if available.

Note:

For the purpose of this protocol, Adult Hypoperfusion is defined as:

- 1. Signs of inadequate perfusion, such as:**
 - A. Altered mental state (restlessness, inattention, confusion, agitation)**
 - B. Tachycardia (pulse greater than 100)**
 - C. Pale, cool, moist skin**
 - D. Rapid shallow respirations**
 - E. Extreme thirst**
- 2. If a cardiac cause for hypoperfusion is suspected, refer immediately to the cardiac related protocol!**

Note:

For the purpose of this protocol, Pediatric Hypoperfusion is defined as signs of inadequate perfusion, such as:

- 1. Altered mental status**
- 2. Tachycardia (see appendix-A [pediatric])**
- 3. Weak or absent distal pulses**
- 4. Pallor**
- 5. Cold, clammy, or mottled skin**

Caution:

Manually stabilize the head and cervical spine if trauma of the head and neck is suspected!

- I. Perform initial assessment.**
- II. Assure that the patient's airway is open and that breathing and circulation are adequate.**
- III. Administer high concentration oxygen, and **be prepared to ventilate the patient!****

Hypoperfusion, continued

- IV. Place the patient in a face-up position **and** elevate the patient's legs 8 - 12 inches if there is no trauma to the legs.
- V. Keep the patient warm while waiting for arrival of EMS unit.
- VI. Update the responding EMS unit.
- VII. Perform Physical Exam.
- VIII. Obtain History using SAMPLE.
- IX. Ongoing assessment. Repeat the initial assessment and record the patient's vital signs, including the level of consciousness as often as the situation indicates.
- X. Provide a Hand-off Report to arriving EMS unit, which will take over care of your patient.
- XI. Record all patient care information, including the patient's medical history and all treatment provided, on a Prehospital Care Report (PCR) or other approved equivalent.

Emergency Childbirth, Resuscitation and Stabilization of the Newborn

Note:
Request Advanced Life Support if available.

- I. Perform initial assessment.
 - A. Assure that the mother's airway is open and that breathing and circulation are adequate.
 - B. Assess the mother for hypoperfusion. **If one or more signs of hypoperfusion are present, refer immediately to the Hypoperfusion Protocol!**
 - C. Obtain the mother's history to determine if the mother is in labor. The history includes:
 1. How long have you been pregnant?
 2. Number of previous pregnancies
 3. Number of previous births
 4. Frequency and duration of uterine contractions
 5. Recent vaginal discharge or bleeding
 6. Presence of urgency to move bowels or pressure in vaginal area
 - D. Be prepared to handle additional patient(s) in addition to the mother.

Caution:
Do not permit the mother to go to the bathroom!

- E. Determine if the mother is having contractions.
 1. **If the mother is having contractions** perform a visual inspection of the external genitalia and perineum for bulging and/or crowning. Have your partner present during this exam. **If there is crowning prepare for immediate delivery by:**
 - a. Updating the responding EMS unit **immediately**.
 - b. Informing the mother of the need for immediate delivery
 - c. Insuring a private, clean and sanitary environment
 - d. Positioning and draping the mother
 - e. Placing the OB kit within easy reach
 - f. Warming several towels (if possible)

Emergency Childbirth, continued

Caution:

Never delay or restrain delivery under normal circumstances!

II. Delivery procedures:

- A. During delivery support the infant's head with one hand while gently guiding it out of the birth canal to prevent an explosive delivery. Using your other hand with a sterile dressing, support the perineum (area between the vagina and the anus) to help prevent tearing during delivery of the head.
- B. If the amniotic sac has not broken, use your finger or a clamp to puncture the sac and pull it away from the infant's head and mouth as they appear.
- C. Attempt to prevent the infant's head from coming in contact with fecal material or other contaminants.
- D. **As soon as the head delivers** continue to support the infant's head with one hand. **Tell the mother to stop pushing.** Inspect the infant for the umbilical cord wrapped around the neck.
 1. **If the umbilical cord is wrapped around the infant's neck:** Gently loosen the cord and slip it over the infant's head.
 2. **If the umbilical cord is wrapped too tightly around the infant's neck or wrapped around the neck more than once, preventing the delivery of the infant, immediately** clamp the umbilical cord with two clamps and cut the cord between them.
- E. Suction the infant's oropharynx only if the airway is obstructed or artificial ventilations are required.
 1. Insert a compressed bulb syringe 1 –1 ½ inches into the infant's mouth.
 2. Suction the infant's oropharynx while controlling the release of the bulb syringe with your fingers.
 3. Repeat suction as necessary.
- G. Instruct the mother to begin pushing during contractions.
- H. **As soon as the infant has delivered,** quickly dry the infant and place the infant on a warm towel (if available) in a face-up position with the head lower than the feet. **Keep the infant at the level of the mother's vagina until the cord is cut.**

Emergency Childbirth, continued

Caution:
Spontaneous respirations should begin within 30 seconds.

- I. Perform an initial assessment of the infant. Quickly assess the infant's respiratory status, pulse and general condition.
 1. **If the infant is breathing spontaneously and crying vigorously and has a pulse greater than 100/min:**
 - a. Clamp the umbilical cord 1 minute after birth with two clamps three inches apart. The first clamp will be 8 – 10 inches from the baby. Place the second clamp 3 inches from the first clamp towards the mother.
 - b. Cover the infant's scalp with an appropriate warm covering.
 - c. Wrap the infant in a dry, warm blanket or towels *and* a layer of foil over the layer of blankets or towels, *or* use a commercial-type infant swaddler if one is provided with the OB kit. **Do not use foil alone!**
 - d. Ongoing assessment. Obtain and record vital signs, as often as the situation indicates.
 - e. **Keep the infant warm and free from drafts.**
 2. **Monitor the infant's respirations continuously. If the infant is not breathing spontaneously and crying vigorously:**
 - a. **If the infant's respirations are absent or depressed (less than 30/minute in a newborn):**
 - i. Rub the infant's lower back **gently**.
 - ii. Snap the bottom of the infant's feet with your index finger **gently**.
 - b. **If the respirations remain absent or become depressed (less than 30/minute in a newborn) despite stimulation, or if cyanosis is present:**
 - i. Clear the infant's airway by suctioning the mouth and nose **gently** with a bulb syringe.

Emergency Childbirth, continued

c. **If respirations remain absent or depressed (less than 30/minute in a newborn) despite stimulation and oxygen:**

- i. Insert the proper size oral airway **gently**.
- ii. Ventilate the infant without supplemental oxygen at a rate of 40 – 60 /minute with an appropriately sized pocket mask or bag-valve-mask as soon as possible. . Each ventilation given over one second **assuring that the chest rises with each ventilation. If patient does not respond within 30 seconds add supplemental oxygen.**

3. **Monitor the infant’s pulse rate continuously.**

- i. **If the pulse rate drops below 100 beats per minute at any time, assist ventilations at a rate of 40 – 60/minute with supplemental oxygen.**
- ii. **If the pulse rate drops below 60 beats per minute at any time, or does not increase above 60 beats per minute after 30 seconds of assisted ventilations, add chest compressions to assisted ventilations following AHA/ARC/NSC guidelines.**

4. Ongoing assessment of the newborn. Obtain and record the vital signs of all patients, and repeat enroute as often as the situation indicates.

III. Update the responding EMS unit.

IV. Prepare for deliver of the placenta. Delivery of the placenta *usually* occurs within 20 minutes of the delivery of the infant. After delivery of the placenta, place the placenta in a plastic bag or other container and deliver to the receiving hospital. Massage the mother’s abdomen where the fundus can be palpated.

V. Ongoing assessment of the mother.

- A. Reassess the mother for hypoperfusion. **If one or more signs of hypoperfusion are present, refer immediately to the Hypoperfusion Protocol!**
- B. Obtain and record the vital signs of all patients, repeat enroute as often as the situation indicates.
- C. Record all patient care information, including the mother’s medical history and all treatment provided for each patient, on a separate Prehospital Care Report (PCR) for each patient.

Emergency Childbirth, continued

VI. Complicated Childbirth.

A. Breech Birth

1. If the buttocks presents first:

- a. Update the responding EMS unit **immediately**.
- b. Administer high concentration oxygen to the mother.
- c. Place the mother in a face-up position with her hips elevated.

2. If a limb presents first:

- a. Update the responding EMS unit **immediately**.
- b. Administer high concentration oxygen to the mother.
- c. Place the mother in a face-up position with her hips elevated

B. Prolapsed Umbilical Cord

- a. Update the responding EMS unit **immediately**.
- b. Administer high concentration oxygen to the mother.
- c. Place the mother in a face-up position with her hips elevated.
- d. Treatment based on specific signs and symptoms.

C. Multiple Births

- a. Update the responding EMS unit **immediately**.
- b. Deliver each multiple birth according to the above protocol for **Uncomplicated Childbirth**, making sure to clamp each umbilical cord between births.
- c. **If the anticipated second birth does not occur after 10 minutes, update the responding EMS unit!**
- d. A Prehospital Care Report (PCR) must be completed for each patient.

Refusing Medical Aid (RMA)

Note:

Certified First Responders must not make an independent decision regarding a patient's refusal of medical care or transport.

The Certified First Responder must assure that additional EMS resources (consisting of an EMT or AEMT) will evaluate the patient.

Note:

Request Advanced Life Support if the patient's condition warrants the need.

Note:

All competent adults have the right to refuse medical treatment and/or transport. It is the responsibility of the prehospital care provider to be sure that the patient is fully informed about their situation and the possible implications of refusing treatment or transport.

- I. Follow the protocol for “**General Approach to Prehospital Patient Management**” and any other specific treatment protocol, which is required according to the patient's condition and your assessment of the patient.
- II. When the patient or legal guardian refuses treatment or requests that you discontinue further treatment of the patient, do not initiate any new treatment modalities.
- III. Discuss with the patient the need for treatment and/or transport. If the patient still refuses treatment or transport and you feel that the patient's condition requires treatment or transport, allow the patient's family members, friends, or anyone else who is familiar with the patient to try and convince the patient of the need for treatment or transport. Update the responding EMS unit. Contact Medical Control per regional protocol and consider assistance from law enforcement.
- IV. If patient still refuses treatment or transport and the patient is 18 years of age or older, or is an emancipated minor, or is the parent of a child, or has married:
 - A. Assess level of consciousness using AVPU.
 - B. Attempt to obtain vital signs and repeat vital signs and AVPU every 5 – 10 minutes.

Refusing Medical Aid (RMA), continued

- C. Evaluate the patient for any apparent medical or physical conditions, which may limit the patient's ability to think rationally. For example:
 - 1. Psychiatric or behavioral disorders.
 - 2. Patient presents a danger to themselves or others.
 - 3. Current alcohol or drug use.
 - 4. History of disease effecting mental capacity (i.e. Alzheimer's).
 - 5. Evidence of abuse to the patient.
 - 6. Inability to ambulate.
- D. If patient is **Alert** with and there is no evidence of any apparent medical or physical conditions, which may limit the patient's ability to think rationally:
 - 1. If patient still refuses treatment or transport offer to call Medical Control or the patient's own physician and have the patient speak with the physician.
 - 2. If patient still refuses treatment or transport continue to step VI.
- E. If patient is not **Alert** or there is evidence of an apparent medical or physical condition, which may limit the patient's ability to think rationally:

A. Obtain assistance from Law Enforcement and if possible contact Medical Control for direction. Update the responding EMS unit.

- V. If the patient still refuses treatment or transport and is under the age of 18, or is not an emancipated minor, or is not the parent of a child, or is not married:
 - A. These individuals cannot give effective legal/informed consent to treatment and therefore, conversely, cannot legally refuse treatment.
 - B. In an emergency situation when a parent or guardian is not available to give consent, emergency treatment and transport should be rendered based on implied consent.
 - C. In an emergency or non-emergency situation when a parent or guardian is present, the EMS provider must obtain consent from the parent or guardian prior to rendering treatment or transport.
 - D. If a parent or guardian is refusing to give consent for treatment or transport, and the EMS provider feels that treatment or transport is necessary, the EMS provider should obtain assistance from a Law Enforcement agency. Medical Control should be contacted and the parent or guardian should be allowed to speak with the physician.
 - E. If the parent or guardian is still refusing treatment or transport and Law Enforcement is not directing the removal of the patient to a hospital, proceed to VI.

Refusing Medical Aid (RMA), continued

- VI. For any patient who refuses treatment or transport, the EMS provider must advise the patient, or if applicable the parent or guardian, of the possible consequences of their refusal.
- VII. Complete a Prehospital Care Report (PCR) or approved equivalent for the patient. At a minimum the following patient information must be documented or the EMS provider must document the reasons why this patient information cannot be documented.
 - A. Documentation Information:
 1. Age and sex.
 2. Patient's name, address, and date of birth.
 3. Chief complaint.
 4. Subjective and objective patient assessment findings.
 5. Pertinent history as needed to clarify the problem (mechanism of injury, previous illnesses, allergies, medications, etc.)
 6. Level of consciousness (AVPU).
 7. One complete set of vital signs
 8. Treatment given and the patient's response.
 9. Parent or guardian's name if applicable.
 10. Identification information of any Law Enforcement personnel, Medical Control, and EMT or AEMT directly involved with the refusal of treatment or transport.
 11. ***Document that risks and consequences were explained and understood.***

**SEMAC
Advisories
and
Bureau of
EMS Policies**

SEMAC Advisories

Bureau of Emergency Medical Services Policies

This section of the protocol book contains medical advisories approved by the State Emergency Medical Advisory Council (SEMAC) and those policy statements published by the NYS DOH Bureau of Emergency Medical Services (BEMS), which will assist you in the use of certain protocols and patient care.

SEMAC Advisories are guidelines, which are issued under the authority of Article 30 of the Public Health Law, Section 3002-a(2) and with the Commissioner of Health's approval. While these guidelines do not have the weight of law, the issuance of guidelines are statutorily authorized and approved by the Department of Health as appropriate guidance for prehospital patient care. They should be followed in the same manner as the statewide or regional patient care protocols.

Bureau of EMS policy statements are issued by the Department of Health and are to be used to assist the EMS provider in direct and in-direct patient care. Policy statements carry the weight of regulation, but are designed to be flexible to meet Public Health needs without following a lengthy regulatory reform process. These policies are designed to assist you in providing appropriate pre-hospital healthcare and provide a standard by which all NYS certified EMS providers can function. The policies which have been included in this book are only policies which have been currently enacted and relevant to patient care and protocols.

All SEMAC Advisories and BEMS policy statements can be found on the Bureau of EMS web site at <http://www.health.state.ny.us/nysdoh/ems/main.htm>. We encourage all providers and agencies to check the web site frequently for updated information.

Advisory No.	97-02
Title	Biphasic Automated External Defibrillator
Date Approved	February 4, 1997
Page	1 of 1

Biphasic Automated External Defibrillator

The Food and Drug Administration (FDA) has recently approved an Automated External Defibrillator (AED) which uses a low energy "biphasic waveform" similar to the technology currently used in implantable cardioverter-defibrillator (ICD). This allows the unit to determine the patient's chest impedance (resistance to electrical flow) and delivers a measured shock in response to that impedance. We can anticipate the FDA approval of more units/models using the biphasic waveform technology in the near future.

Some EMS providers have expressed concern that the units are not set to deliver shocks at the traditionally higher energy settings (200 J to 360 J). This advisory is to clarify that the biphasic automated external defibrillator, as approved by the FDA, is an acceptable device which can be used as outlined in the current New York State, Statewide Basic Life Support Adult Treatment Protocols for the Automated External Defibrillator (AED).

Traditional AED ("monophasic waveform") units, currently approved by the FDA, also remain an acceptable device used as outlined in the current New York State, Statewide Basic Life Support Adult Treatment Protocols for the Automated External Defibrillator (AED).

As always, the decision on the purchase of specific medical devices should be done with the approval of your Service Medical Director and under the guidelines of the Regional Emergency Medical Advisory Committee (REMAC).

Issued by:

Mark Henry, MD
Chair
State Emergency Medical Advisory Committee

Barbara A. DeBuono, MD
Commissioner
Department of Health

Selected References

1. American Heart Association. 2010. Guidelines for cardiopulmonary bypass. *Circulation*. 122:1111-1121.
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ADVISORY

Title:

Secondary Confirmation of ETT

Effective Date:

07/01/2002



Number:

02-01

Replaces/Supersedes:

Purpose

to provide the standard procedure for the placement and confirmation of endotracheal tube placement in adult and pediatric patients.

Background

Endotracheal intubation in adult and pediatric patients to receive respiratory care is a critical life-saving procedure. The presence of an endotracheal tube can be fatal if care is not taken to ensure proper placement. The purpose of this advisory is to provide the primary and secondary methods for endotracheal tube placement to reduce the risk of complications. The purpose of this advisory is to provide the primary and secondary methods for endotracheal tube placement to reduce the risk of complications. The purpose of this advisory is to provide the primary and secondary methods for endotracheal tube placement to reduce the risk of complications.

The advisory is intended to provide the standard procedure for the placement and confirmation of endotracheal tube placement in adult and pediatric patients. The advisory is intended to provide the standard procedure for the placement and confirmation of endotracheal tube placement in adult and pediatric patients. The advisory is intended to provide the standard procedure for the placement and confirmation of endotracheal tube placement in adult and pediatric patients.

- ✓ The CO_2 detector should be used to confirm CO_2 and the patient in the airway after intubation to the endotracheal detector device.
- ✓ The endotracheal tube placement should be confirmed by direct placement of the tube into the endotracheal tube.

Prehospital providers must continue to confirm proper tube placement with clinical signs of adequate ventilation and end tidal CO_2 detector devices throughout treatment and transport. The patient should be placed in the prone position and the patient should be placed in the prone position.

The patient should be placed in the prone position and the patient should be placed in the prone position.

QA/QI

The QA/QI should be performed to ensure that the patient is placed in the prone position and the patient is placed in the prone position.

1. The endotracheal tube placement should be confirmed by direct placement of the tube into the endotracheal tube.

2. The endotracheal tube placement should be confirmed by direct placement of the tube into the endotracheal tube.

The endotracheal tube placement should be confirmed by direct placement of the tube into the endotracheal tube.

References

1. The endotracheal tube placement should be confirmed by direct placement of the tube into the endotracheal tube. *Crit Care Med* 2000;28:26-30.

2. The endotracheal tube placement should be confirmed by direct placement of the tube into the endotracheal tube. *Crit Care Med* 2000;28:26-30.

The endotracheal tube placement should be confirmed by direct placement of the tube into the endotracheal tube. *Acad Emerg Med* 2000;7:6-10.

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ADVISORY

Title:

AED for Pediatric Patients

Effective Date:

07/01/2002



Number:

02-02

Replaces/Supersedes:

Purpose

To provide the care and effective use of approved pediatric AEDs used at the time of a cardiac arrest on the pediatric patient age 8.

Background

A demonstration can be conducted to reduce the risk of a patient's death by using a pediatric AED. The use of approved pediatric AEDs and the trained responder can be performed on the patient if the rescuer is not a trained responder. The use of approved pediatric AEDs is recommended for patients 8 years of age or older. AEDs are designed to be used on patients 8 years of age or older. The use of approved pediatric AEDs is recommended for patients 8 years of age or older.

The standard for the use of AEDs is to use an approved AED adapted to a patient that is at least 8 years of age. The use of approved pediatric AEDs is recommended for patients 8 years of age or older. The use of approved pediatric AEDs is recommended for patients 8 years of age or older.

- Use a search engine/website to find the most current data on pediatric cardiac arrest. Use the data to create a flowchart of the process and the steps that are taken to treat the patient. Use the data to create a flowchart of the process and the steps that are taken to treat the patient. Use the data to create a flowchart of the process and the steps that are taken to treat the patient.

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1. American Heart Association. Guidelines for cardiopulmonary resuscitation and cardiovascular life support. 2000. American Heart Association. 10. *Circulation*. 2000;102:pp1-21-2.
2. American Heart Association. Guidelines for cardiopulmonary resuscitation and cardiovascular life support. 2000. American Heart Association. 8. *Amer Heart J*. 1980;80:8.
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New York State
Department of Health
Bureau of Emergency Medical Services

POLICY STATEMENT

Supersedes/Updates:

No. 88-01

Date: 02/09/88

Re: Patient Carrying Devices

Page 1 of 2

SUBJECT: Patient Carrying Devices

There are a patient carrying devices in the present state of the art which are designed to transport a patient in a safe and secure manner and which are used to transport a patient in a safe and secure manner.

A patient carrying device is a device designed to transport a patient in a safe and secure manner. The device is designed to transport a patient in a safe and secure manner. The device is designed to transport a patient in a safe and secure manner. The device is designed to transport a patient in a safe and secure manner.

The state hereby declares that the use of a patient carrying device is a public health and safety issue. The use of a patient carrying device is a public health and safety issue. The use of a patient carrying device is a public health and safety issue. The use of a patient carrying device is a public health and safety issue.

In any case a patient carrying device is a public health and safety issue. In any case a patient carrying device is a public health and safety issue. In any case a patient carrying device is a public health and safety issue. In any case a patient carrying device is a public health and safety issue.

It is the policy of the state that patient carrying devices are to be used in a safe and secure manner. It is the policy of the state that patient carrying devices are to be used in a safe and secure manner. It is the policy of the state that patient carrying devices are to be used in a safe and secure manner. It is the policy of the state that patient carrying devices are to be used in a safe and secure manner.

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New York State
Department of Health
Bureau of Emergency Medical Services

POLICY STATEMENT

Supersedes/Updates:

No. 92-02

Date: 05/06/92

Re: Tuberculosis

Page 1 of 4

The incidence of tuberculosis (TB) has increased substantially in the last few years. EMS providers should be aware of this infectious disease and the procedures for protecting themselves.

As with all infectious diseases, no precaution is 100% effective; rather, these precautions are designed to reduce the probability that the disease can be transmitted from person to person.

TB is spread when small droplets from the respiratory tract of an infected person enter the air and are inhaled by another person. Precautions can be taken in three areas to reduce the danger.

First, the patient's mouth should be covered with a mask. A disposable micron surgical mask (#M "Aseptix" sub-micron molded surgical mask, Catalog #1812; or equivalent) is best, but a standard surgical mask or even an oxygen mask is helpful. The nature of the medical treatment required by the patient should determine which mask is used.

Second, a disposable micron mask or disposable particulate respirator (PR), should be worn by the provider. It should fit snugly on the face. A beard or mustache will markedly reduce the effectiveness of such protection.

Third, the number of infectious droplets in the air can be reduced by ensuring good ventilation in the patient compartment of the ambulance. Thus, the ventilation system should be maximized and/or side windows opened to provide a steady source of clean air.

Which patients should receive respiratory precautions?

Patients with respiratory symptoms of more than 2 weeks duration or any patient with a respiratory symptom of any duration who is a member of a higher risk group. The CDC defines high risk groups as follows:*

- Alcoholics
- IV drug users
- Contacts of patients known to have active TB
- Low income populations
- Prisoners
- HIV infected persons
- Nursing home residents

- Refugees

Persons with other pre-existing medical conditions which compromise the ability to fight infection are also at increased risk. Such conditions include:

- Chemotherapy
- Diabetes
- Steroid Therapy
- Renal failure
- Some cancers

(source: CDC)

Clearly, TB patients receiving nebulized aerosols of Beta-agonists are likely to spread infectious droplets. In such patients, as well as those presenting with respiratory symptoms such as a persistent cough, special attention should be given to these precautions by EMS providers.

Since air-borne droplet spread is the only means of TB transmission, there is no need to decontaminate or disinfect the ambulance or equipment.

The following sections from the CDC Mortality and Morbidity Weekly Report (December 7, 1990) summarize the CDC recommendations for control of TB in pre-hospital settings:

1. Other source-control methods

A simple but important source-control technique is for infectious patients to cover all coughs and sneezes with a tissue, thus containing most liquid drops and droplets before evaporation can occur. A patient's use of a properly fitted surgical mask or disposable, valveless particulate respirator (PR) (see below) also may reduce the spread of infectious particles. However since the device would need to be worn constantly for the protection of others, it would be practical in only very limited circumstances (e.g., when a patient is being transported within a medical facility or between facilities).

2. For persons exposed to tuberculosis patients.

Appropriate masks, when worn by health-care providers or other persons who must share air space with a patient who has infectious tuberculosis, may provide additional protection against tuberculosis transmission. Standard surgical masks may not be effective in preventing inhalation of droplet nuclei, because some are not designed to provide a tight face seal and to filter out particulates in the droplet nucleus size range (1-5 microns). A better alternative is the disposable PR. PRs were originally developed for industrial use to protect workers. Although the appearance and comfort of PRs may be similar to that of cup-shaped surgical masks, they provide a better facial fit and better filtration capability. However, the efficacy of PRs in protecting susceptible persons from infection with tuberculosis has not been demonstrated.

PRs may be most beneficial in the following situations:

a) when appropriate ventilation is not available and the patient's signs and symptoms suggest a high potential for infectiousness, b) when the patient is potentially infectious and is undergoing a procedure that is likely to produce bursts of aerosolized infectious particles or to result in copious coughing or sputum production, regardless of whether appropriate ventilation is in place, and c) when the patient is potentially infectious, has a productive cough, and is unable or unwilling to cover cough.

Comfort influences the acceptability of PRs. Generally, the more efficient the PRs, the greater is the work of breathing through them and the greater the perceived discomfort. A proper fit is vital to protect against inhaling droplet nuclei. When gaps are present, air will preferentially flow through the gaps, allowing the PR to function more like a funnel than a filter, thus providing virtually no protection.

3. For tuberculosis patients.

Masks or PRs worn by patients with suspected or confirmed tuberculosis may be useful in selected circumstances (see below). PRs used by patients should be valveless. Some PRs have valves to release expired air, and these would not be appropriate for patients to use.

4. Emergency medical services

When emergency-medical-response personnel or others must transport patients with confirmed or suspected active tuberculosis, a mask or valveless PR should be fitted on the patient. If this is not possible, the worker should wear a PR (see above). If feasible, the rear windows of the vehicle should be kept open and the heating and air conditioning system be set on a nonrecirculating cycle.

Emergency-response personnel should be routinely screened for tuberculosis at regular intervals. They should also be included in the follow-up of contacts of a patient with infectious tuberculosis.

(End of CDC recommendations).

Treatment of Exposed Providers

PPD testing should be conducted for pre-hospital providers who are exposed to TB patients for whom adequate infection control measures (outlined above) were not taken.

Unless a negative skin test has been documented within the preceding three months, each exposed worker (except those who are already known to be positive reactors) should receive a PPD (Mantoux) skin test as soon as possible.

If the skin test is negative, the test should be repeated within twelve weeks after the exposure ended.

Persons with skin test reaction of 5mm induration (swelling) or greater, or with symptoms suggestive of active TB, should receive chest x-ray examinations.

Persons with previously known positive skin test reactions who have been exposed to an infectious patient should be evaluated for active TB, but do not require a repeat skin test

or a chest x-ray examination, unless they have symptoms suggestive of active TB.

Optimally, arrangements for treatment should be made by each agency in advance of an exposure. Possible sources of care include: personal physician, receiving hospitals or County Health Departments.

*Core Curriculum on Tuberculosis; Centers for Disease Control, April 1991: p. 11

Issued by: J. Lawrence Mottley, M.D.
Senior Medical Advisor



New York State
Department of Health
Bureau of Emergency Medical Services

POLICY STATEMENT

Supercedes/Updates:

No. 95-04

Date: 09/01/95

Re: EMS Mutual Aid

Page 1 of 3

The purpose of this policy is to provide EMS services with guidance as mutual aid plans and policies are developed. This policy statement discusses the concept, history and legal basis for EMS mutual aid in New York State.

EMS services have the responsibility to routinely provide the type and level of service authorized and/or expected by the community, in a timely and reliable manner.

From time to time, to meet peak demand or extraordinary resource utilization, it may be necessary to request assistance to answer a call or provide additional resources. This is the concept of and intent of EMS mutual aid.

EMS mutual aid requests must be made with the intent of having the closest¹ available EMS unit respond to a patient's medical need, at a time when the resources of the requesting agency are temporarily unavailable or have been expended.

The response to multiple casualty incidents (MCI's) and other large scale events are usually conducted in accordance with a county or other pre-determined resource allocation and management plan. These may require mutual aid responses but are developed independently due to the special planning needs required.

EMS services are required by the State EMS Code (800.21.p) to have a written mutual aid plan. Regional EMS Councils are encouraged to coordinate the development of agency and/or county mutual aid plans and the Councils have the authority to approve an EMS service operating beyond its primary operating territory for purposes of fulfilling the provisions of a mutual aid agreement (PHL3010.1.b).

Issued by: John J. Clair

Associate Director - Operations

Authorized by: Edward G. Wronski

Deputy Director

Background:

The provision of mutual aid by fire departments is provided for in several sections of the General Municipal Law (GML) however, without definition, terms or conditions. The GML does specify that the requesting fire department is responsible for responding equipment and the responding fire service retains responsibility for personnel. The GML

does not address mutual aid with non fire agencies - eg. volunteer or commercial.

For EMS mutual aid, the provisions of Article 30 with regard to primary operating territory must prevail, all other circumstances being the same - eg. response time, location, staffing, etc.

There is no statutory or regulatory definition requiring, presuming or defining who may, or must or who can not request mutual aid. In other words, there is no definition or prohibition regarding what type of agency a requesting agency must call. Therefore any service type may request the assistance of any other EMS service:

•FD < = = > VAC

•VAC < = = > Commercial

•FD < = = > Commercial

Insurance policies are available to cover the assets and liabilities of any agency requesting or responding to a request for EMS assistance. There is no restriction with regard to who may obtain or provide such coverage.

Conclusion:

It may be concluded that mutual aid in New York State may be easily achieved within the current regulatory and statutory definitions if:

•Services providing an EMS response to a request for EMS assistance maintain responsibility for their own liability -specifically; vehicles, equipment and personnel.

•EMS mutual aid is requested from the closest, available, appropriate agency capable of responding at the time of the request.

Mutual Aid Plans:

EMS agencies need to develop and maintain written mutual aid plans (800.21.p). These plans, while agency specific, should be developed in conjunction and cooperation with counties and Regional EMS Councils.

For assistance in developing mutual aid plans, refer to NYS-EMS policy 89.2 Mutual Aid Planning Guidelines.

Mutual aid plans must insure that any request is made with the intent of having the closest [usually means the unit with the shortest response time to the patient] available EMS unit respond to a patient's medical need, at the time the resources of the requesting service are temporarily unavailable or have been expended.

Mutual aid plans and agreements for normal day to day requests are the responsibility of the individual EMS service. Typically such agreements identify the closest EMS unit that is to be requested. Frequently, an EMS service's area of operation is divided, within a plan, to facilitate a timely response based on the location of the neighboring service. Service type (eg. volunteer, fire, hospital, commercial) must not be a consideration in any plan or to any request. Staffing, unit availability, response time and primary operating territory are the

primary concerns to be addressed. The specific agency to be requested for a mutual aid response may vary with day or time based on availability.

Mutual aid plans for multiple patients are usually developed and coordinated at a county level to insure an adequate response as well as to provide coverage of all affected areas.

The statutory definition of mutual aid excludes inter-facility transfers and ALS intercepts.

Counties providing coordinated dispatch, (911, fire control, etc.) will need to monitor crew status and service availability, to assist in implementing agency mutual aid plans - particularly when they act as the service's dispatch.

1 - usually means the unit with the shortest response time to the patient




 New York State
 Department of Health
 Bureau of Emergency Medical Services

POLICY STATEMENT

Supersedes/Updates:

No. 98-05

Date: 5/23/98

**Re: Responsibilities of
EMS Providers &
Coordination of
EMS Resources**

Page 1 of 6

DEFINITION OF THE RESPONSIBILITIES OF PREHOSPITAL PATIENT CARE PROVIDERS AND THE COORDINATION OF EMS RESOURCES AT A SCENE

INTRODUCTION:

The purpose of this policy statement is to provide the prehospital patient care

providers the standards and performance criteria and responsibilities that are expected of them. The standards and performance criteria are based on the current state of the art in prehospital patient care and the needs of the community. The standards and performance criteria are based on the current state of the art in prehospital patient care and the needs of the community.

The standards and performance criteria are based on the current state of the art in prehospital patient care and the needs of the community.

The standards and performance criteria are based on the current state of the art in prehospital patient care and the needs of the community.

- **Establishing guidelines for local Regional Emergency Medical Advisory Committee's (REMAC) to use in the development of Triage, Treatment, Transportation and other protocols, consistent with State Emergency Medical Advisory Committee (SEMACE) standards, which:**

adequate the responsibilities of the providers and the patient care
 standards and performance criteria are based on the current state of the art in prehospital patient care and the needs of the community.

standards and performance criteria are based on the current state of the art in prehospital patient care and the needs of the community.

The standards and performance criteria are based on the current state of the art in prehospital patient care and the needs of the community.

standards and performance criteria are based on the current state of the art in prehospital patient care and the needs of the community.

STATUTORY AUTHORITY and BACKGROUND

The research that provides patient care and the responsibility to the ambulance to conduct operations in the prehospital setting to protect the patient's health and safety and to provide the best possible care to the patient are the primary goals of the research.

The research that provides the responsibility to the ambulance to provide patient care and to conduct operations in the prehospital setting to protect the patient's health and safety and to provide the best possible care to the patient are the primary goals of the research.

The research that provides the responsibility to the ambulance to provide patient care and to conduct operations in the prehospital setting to protect the patient's health and safety and to provide the best possible care to the patient are the primary goals of the research. *This research concludes that the only individual in charge of patient care in the prehospital setting is the NYS certified patient care provider. Specific authority is also identified for the provision of medical control and the responsibility of ambulance and ALS First Response Services to a patient.* Additional research that provides the responsibility to the ambulance to provide patient care and to conduct operations in the prehospital setting to protect the patient's health and safety and to provide the best possible care to the patient are the primary goals of the research.

The research that provides the responsibility to the ambulance to provide patient care and to conduct operations in the prehospital setting to protect the patient's health and safety and to provide the best possible care to the patient are the primary goals of the research. *In the absence of other controlling statutes, Public Health Law, therefore, takes precedence in regard to the provision of prehospital emergency medical care.*

The research that provides the responsibility to the ambulance to provide patient care and to conduct operations in the prehospital setting to protect the patient's health and safety and to provide the best possible care to the patient are the primary goals of the research.

PROVIDING PATIENT CARE

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THE ROLE and USE OF INCIDENT COMMAND

The Incident Command System (ICS) is a standardized, on-scene all-hazards approach to the management of emergencies, incidents or events. ICS is a flexible, scalable system that can be used to manage any type of incident. ICS is a key component of the National Incident Management System (NIMS). ICS is a standardized, on-scene all-hazards approach to the management of emergencies, incidents or events. ICS is a flexible, scalable system that can be used to manage any type of incident. ICS is a key component of the National Incident Management System (NIMS). ICS is a standardized, on-scene all-hazards approach to the management of emergencies, incidents or events. ICS is a flexible, scalable system that can be used to manage any type of incident. ICS is a key component of the National Incident Management System (NIMS).

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POLICY STATEMENT

Supersedes/Updates:

INTRODUCTION

dated the report of the committee on the state of emergency medical services in New York State. The committee was formed in 1996 to study the current state of emergency medical services and to make recommendations for improvement. The committee's report was published in 1997 and is available on the Department of Health website. The committee's findings and recommendations are summarized in the following table.

The purpose of this policy is to:

- ◆ Define ALS intercepts.
- ◆ Define parameters for the utilization of ALS as well as to provide objectives every intercept should meet
 - * Minimize delay in transporting patients to definitive care at a hospital.
 - * Enhance the provision of patient care by maximizing the availability of ALS for those patients identified as being in need of ALS care.
 - * Provide guidelines to assist in identifying and accessing the most appropriate ALS service at the time of request.
- ◆ Encourage REMACs to develop regional specific guidelines and protocols that enhance the availability of ALS and the appropriate use of ALS intercepts in the region.

New York State Statewide BLS Protocol

In 1996, the NYS BLS protocols were changed to introduce the concept of ALS intercepts and their use as the principal method of providing ALS care to patients needing this level of care when the initial EMS system contact is a BLS ambulance.

The provision of ALS by intercept permits the appropriate utilization of ALS resources by identifying a hospital or ALS service as the nearest ALS provider at the time of need. Call location, staffed ALS unit availability and/or direction of travel will effect the decision.

Excerpt from NYS BLS Protocol

The goal of prehospital emergency medical care is DEFINITIVE CARE for the patient as rapidly and safely as the situation indicates with no deterioration of his/her condition and, when possible, in an improved condition. BLS units shall deliver their patients who will benefit from ALS care to this higher level of care as soon as possible. This may be accomplished either by intercepting with an ALS unit or by transport to an appropriate hospital, whichever can be effected more quickly.

A system of ALS intercept when available within a given area shall be prearranged. Normal written agreements for the request of ALS shall be developed in advance by those agencies not able to provide ALS.

A request for ALS intercept shall occur as noted in specific treatment protocols.

Initiation of patient transport shall not be delayed to await the arrival of an ALS unit, unless an on-line medical control physician otherwise directs.

Immediate Transport Decision:

Determine patient status (C/PS)
Critical or unstable Immediate transport
Potentially unstable Secondary survey and transport

If the patient's condition dictates immediate transport, the vital signs, secondary assessment, and treatment should be completed en route to the nearest appropriate hospital as defined below in Section II, Transport

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.

ALS Intercepts

- ◆ An intercept is an authorized and staffed ALS unit, dispatched by request or protocol, meeting a BLS unit while it is en route to the nearest appropriate hospital.
- ◆ A BLS unit assesses the patient, determines the need for and requests ALS, packages and begins patient transport. The BLS unit shall not wait on the scene for the ALS unit's arrival. The request for ALS should be made as soon as the patient's condition is recognized as needing ALS.
- ◆ A hospital emergency department (ED) is the highest level of ALS medical care. Patients should be transported without delay to the nearest appropriate ED by the BLS unit. Definitive medical care can only be provided at a hospital ED.
- ◆ *ALS mutual aid is a misnomer and does not exist.* The statutory definition of mutual aid³ as well as the need for priority transport makes the use of the term "mutual aid" inappropriate in these circumstances.

³ Reference NYS EMS Policy 90000, EMS Mutual Aid

- ◆ BLS services should identify ALS services in advance which are staffed and readily available to provide ALS intercept. More than one service may need to be identified if the BLS service regularly transports to more than one hospital. All formal response agreement needs to be established in advance. Dispatch entities should monitor actual staffing and operational status of ALS resources to insure their availability at the time of the call and minimize any potential delay. The use of the "closest unit" concept is appropriate to dispatch ALS units.
- ◆ All ALS patients should be transported to the hospital without delay by a BLS ambulance, particularly when the arrival of the ALS unit to the scene is estimated to be longer than the transport time to the hospital.
- ◆ In developing ALS intercept relationships, REMACs must consider the patient's and ALS unit's proximity to the hospital. Patient transport to an emergency department should not be delayed. BLS/ALS care should ideally be administered en route.
- ◆ Simultaneous dispatch of BLS and ALS resources should only be provided under the direction of dispatchers trained in the principals of emergency medical dispatch for those calls identified by a recognized dispatch algorithm.
- ◆ REMACs should develop protocols that permit a certified provider who arrives on the scene after the time of dispatch, to cancel initially dispatched ALS resources when, after assessment, it is determined that ALS care is not needed.

Issued by
John J. Clair
Associate Director of Operations Director

Authorized by
Edward J. Lyons, Director



DOH
New York State
Department of Health
Bureau of Emergency Medical Services

POLICY STATEMENT
Supercedes/Updates: 85-13

No. 98-15

Date: 10/15/98

Re: Emergency Patient
Destinations

Page 1 of 2

This policy is intended to clarify the responsibilities of an ambulance service in regard to the transportation destination of an emergency patient being transported by the service.

BACKGROUND

Article 28 of the Public Health Law defines an ambulance service to mean an individual, engaged in providing emergency medical care and the transportation of sick/injured persons by motor vehicle, aircraft or other form of transportation to, from, or between facilities providing hospital services. Part 120.1, the State EMS code uses a similar definition. Neither state any requirement with regard to patient destinations.

The New York State Emergency Medical Services Council has made the following statements concerning the transport of emergency patients:

All ambulance patients can expect to be informed of the need to be taken to a medical facility capable of providing appropriate emergency medical care¹.

The triage and transport of out of hospital patients must be based upon established principles of emergency medical practice, including pre-established state and regional medical protocols and guidelines. For any given patient, the appropriateness of the receiving facility to provide emergency care is a medical decision. Therefore, the direction or redirection of a transporting vehicle cannot be made without medical approval based upon established Regional Emergency Medical Services System protocols².

POLICY

It is the expressed policy of the Department that a patient, in need of emergency medical care be taken to the nearest appropriate health care facility capable of treating the illness, disability or injury of the patient. Ambulance services are under no obligation to transport patients to medical facilities not licensed under Article 28 of the Public Health Law. Ambulance services may make transports to facilities such as physicians' offices, EMS, MCs, or other destinations. However, the ambulance crew must be aware of the emergency care capabilities of such facilities at the time of the patient request.

A patient's choice of hospital or other facility should be complied with unless contraindicated by state, regional or system/service protocol or the assessment by a certified EMS provider shows that complying with the patient's request would be injurious or cause further harm to the patient. Patient transfer can be arranged

following emergency care and stabilization. In such cases, the EMT should fully document the patient's request and the reasons for the alternate destination decision, including any medical control consultation.

DIVERSION REQUESTS

A hospital may notify the EMS community of its temporary inability to provide care in the emergency department (ED) and request ambulances divert patients to an alternate hospital facility. This request may be honored by EMS providers. A diversion request does not mean the hospital ED is closed but usually means the current emergency patient load exceeds the Emergency Department's ability to handle additional patients promptly. If the patient's condition is unstable and the hospital requesting diversion is the closest appropriate hospital, ambulance service personnel should notify the hospital of the patient's condition and expected arrival. This procedure should also be followed when a patient demands transport to a facility on diversion. The hospital may not refuse care for a patient presented.

Endnote

1. Ambulance Patient's Bill of Rights, NYSEMS Council, 199
Access to Emergency Care in a Managed Care Environment, NYSEMS Council, 199
Emergency Medical Services Plan

Issued by John Clair, Associate Director Operations
Authorized by Edward J. Lyons, Director



POLICY STATEMENT

Supersedes/Updates: 84-22 Bee Sting Policy

No. 99 - 01

Date: 2/2/99

Re: CFRasic Assisted Medications

Page 1 of 2

CFRs ASSISTING A PATIENT IN TAKING THEIR OWN PRE-PRESCRIBED MEDICATION(S)

Nitroglycerin (tablet or spray), Bronchodilator (inhaler), Epinephrine (auto-injector)

Definitions:

1. Pre-prescribed medications are those medications that are prescribed for a specific patient prior to an emergency and are present at the scene of the emergency.

2. "Assisting" means delivering a patient's pre-prescribed medication, regardless of who delivers the medication.

Procedure:

1. A certified CFR should deliver pre-prescribed nitroglycerin or a bronchodilator to a patient if the patient indicates (verbally, by gesture, etc.) their desire to take their medication and the delivery of such medication is not contraindicated by protocol or the CFR's training. If there is any question, contact Medical Control.

NOTE: There is no circumstance when it would be proper to deliver either nitroglycerin or a bronchodilator to a patient who can not indicate their desire to take their pre-prescribed medication. As stated, this procedure prevents a CFR from delivering either of these medications to an unconscious or unwilling patient. The contraindication statement is added for cases where the patient indicates their desire to take their medication but it is contraindicated.

2. A certified CFR should deliver pre-prescribed Epinephrine to a patient who exhibits signs/symptoms consistent with the indications for the medication and the medication is not contraindicated by protocol or the CFR's training. If there is any question, contact Medical Control.

NOTE: There are many scenarios in which the patient may not be able to indicate their desire to take their pre-prescribed Epinephrine and the CFR must make the decision to do so. CFRs are trained to recognize the signs and symptoms of

anaphylaxis and the contraindications for epinephrine. In cases of an allergic reaction, as opposed to anaphylaxis, the patient should be able to participate in the decision and the delivery of the epinephrine. □

Special Circumstances

Experience has shown that "assisted medications" may not be labeled with the patient's name on the container, inhaler or auto-injector carried by the patient. In this circumstance if the patient indicates a desire to take the medication, the medication has been identified as being the patient's pre-prescribed medication by a claim or an appearance (is in the patient's pocket or purse, etc), the patient exhibits signs/symptoms consistent with the indications for the medication, the medication is not contraindicated by protocol or the CFR's training, the CFR should assist in delivering the medication. In addition, the container, inhaler or auto-injector may not be labeled with the name of the medication. In no case should an CFR assist in the delivery of a medication from a container, inhaler, or auto-injector that is not labeled with the name of the medication. In cases where the label indicates that the medication is outdated, the CFR must contact Medical Control for direction. If there is any question, contact Medical Control.

[NOTE: Signs/symptoms and indications for the assisted medication are part of the CFR curriculum.]

Developed by:
New York State Emergency Medical Advisory Committee

Issued by:
Bureau of Emergency Medical Services
New York State Department of Health



GUIDELINES FOR EXPOSURE TO BLOOD AND/OR BODY SECRETIONS

BACKGROUND

The New York State Department of Health receives many requests for guidance in the area of infection control from emergency medical service (EMS) personnel who may be exposed to contaminated or potentially contaminated blood or body secretions.

For many years the medical community has been aware of problems caused by human immunodeficiency virus (HIV) and has more recently identified the hepatitis C (HVC) virus as a potential problem.

This policy statement, developed with the assistance of the Department's Adsworth Center for Laboratories and Research, updates the information published in previous versions of this policy.

UNIVERSAL PRECAUTIONS

These guidelines are intended to prevent or minimize exposure to the transmission of bloodborne infectious diseases, particularly HIV and viral hepatitis, to employees whose duties put them at risk. All emergency medical services organizations should ensure full implementation of universal precautions and body substance isolation (BSI) techniques, and require immunization of all employees who are identified as being at risk.

According to the U.S. Department of Labor, Occupational Safety and Health Administration, universal precautions refers to the method of infection control in which all human blood and certain human blood fluids are treated as if known to be infectious for bloodborne pathogens. Universal precautions are to be observed in all situations where there is a potential for contact with blood or other potentially infectious material. In emergency situations, differentiating between body fluid types is difficult or impossible, and all body fluids are to be considered potentially infectious. Universal precautions and BSI techniques must be applied correctly and consistently, to provide a very low incidence of worker exposure to HIV and various hepatitis viruses.

BLOODBORNE PATHOGENS EXPOSURE CONTROL PLAN

EMS services are encouraged to review, with their medical director, the service exposure control plan and the federal Bloodborne Pathogen Regulations, 29 CFR Part 1910.1030, to ensure that all appropriate and required actions are taken with regard to EMS personnel education and training, personal protective equipment, the use of new safer equipment, particularly for sharps, pre-exposure vaccination and post-exposure follow-up.

4 Body substance isolation – an infection control concept and practice that assumes that all body fluids are potentially infectious. Emergency Care and Transportation of the Sick and Injured, AAOS 7th Edition 1998

5 For these purposes, employee means volunteer and paid individuals who act on behalf of the EMS service.

Issued

John Clair

Assoc. Director Operations

Authorized

Edward J. Lyons

Director

SAMPLE OPERATING PROCEDURE

The Department recommends these sample operating procedures be included in EMS service exposure control plans.

What to Report

EMS personnel should *immediately* report to their supervisor all percutaneous, nonintact skin or mucous membrane contact with blood or body secretions and supervisors should refer exposed employees for immediate medical attention.

Initial Response

- *Thoroughly cleanse area of exposure. (See below for cleansing instructions.)*
- See immediate attention and exposure evaluation.
- Review the exposed employee's immunization history.
- Refer the exposed employee for appropriate medical evaluation, care and any necessary post exposure follow up treatment.
- Save the exposed employee's supervisor complete necessary documentation and required reports. (See below for administrative responsibilities)

Testing

- Save service designated officer ID and see any existing information on the source..
- Inform the patient of applicable laws and regulations concerning disclosing the identity and infectious status of the source individual.
- Save the *source individual's* blood tested for HIV and the various forms of hepatitis as soon as consent has been obtained.
- Test the *exposed employee* for HIV and the various forms of hepatitis.

Notification and Counseling

Share test results with the exposed employee, who should also be counseled about his or her health status and, if necessary, treatment options.

Wound Cleansing

- For a puncture cleanse with betadine immediately and follow up by soaping the site for five minutes in a solution of betadine and sterile water.
- For skin contact, first wash the area with soap and water. Then, clean it with betadine.
- For mucous membranes if in mouth, rinse out mouth with large quantity of tap water if eyes, flush with water from eyewash. If eyewash is not available, use tap water.

Administrative Responsibilities

Once the area of contact has been cleansed, and the exposed employee referred for further medical treatment, the supervisor should do all paperwork needed to document the incident. He or she should

- Direct the member/employee to the appropriate location for evaluation and immediate medical treatment.
- Prepare an incident report and note the incident on the prehospital care report for the call in which the exposure took place.
- Advise the employee to initiate a workers' Compensation claim.
- Verify that appropriate employee health records have been updated.
- Follow up on the employee's medical care, and confirm that appropriate medical care has been given.

Testing Guidelines

Supervisors should arrange to have the *source individual's* blood tested for HIV and various forms of hepatitis as soon as possible after consent has been obtained. If the source individual is unable or unwilling to give consent, the EMS organization should consider seeking the legal authority to act without his or her consent. If it is impossible to draw blood from the source individual, but some other sample of his or her blood is available, this should be used. If the source individual is already known to be infected with one or more bloodborne pathogens, the test for that pathogen may be omitted.

Supervisors should assist the *exposed employee* for his or her permission to begin baseline blood tests for HIV and various forms of hepatitis. This should be done as soon as possible after exposure. Follow-up testing for HIV should take place at six weeks, 12 weeks, 16 weeks and 24 weeks after exposure.

Treatment Possibilities

HIV prophylaxis may include the administration of antiretroviral treatment. Highly active retroviral therapy (HAART) should be initiated as soon as possible, preferably within one hour following exposure, particularly if the EMS provider is HIV negative and the source is HIV positive or at risk.

The risk of transmission of hepatitis B (HBV) or hepatitis C (HCV) is significantly greater than the risk of transmission of HIV. Chronic HBV infection can be prevented in the nonimmune employee by administration of prophylactic hepatitis B immune globulin (HBIG) and the hepatitis B vaccine series. There is no known effective prophylaxis for HCV. The exposed employee should be referred for medical management to a specialist knowledgeable in this area. Obtained baseline HCV serology should be repeated in four to six months.

In cases of possible HBV infection, use the attached treatment protocol, developed and recommended by the Adsworth Center.

Because the treatment of pregnant woman can present special medical problems, medical personnel treating women who may be pregnant should implement appropriate additional safeguards.



New York State
Department of Health
Bureau of Emergency Medical Services

POLICY STATEMENT

Supercedes/Updates:

No. 99 – 09
Date: 11/24/99
Re: Patient Care
and Consent
for Minors

Page 1 of 4

It is the purpose of this policy to clarify the legal issues surrounding consent to medical care and/or the refusal of care by minors in the pre-hospital EMS setting. Emergency Medical Services (EMS) providers are often presented with patients who are considered by law to be minors. The issue of providing care and/or the patient's right to refuse care becomes a complex circumstance EMS providers must address. In the prehospital situation the issue at hand is not usually providing care but rather the failure to treat.

Legal Background

A minor, in New York State, is defined as a person who is under eighteen (18) years of age. This is defined by the General Obligations Law § 1-103, Domestic Relations Law § 17 and Public Health Law § 2504. Under this section of Public Health Law, a person who is eighteen or older may give effective consent for health care.

Public Health Law § 2504

Enabling certain persons to consent for certain medical, dental, health and hospital services.

- 1. Any person who is eighteen years of age or older, or is the parent of a child or has married, may give effective consent for medical, dental, health and hospital services for himself or herself, and the consent of no other person shall be necessary.***

- 2. Any person who has been married or who has borne a child may give effective consent for medical, dental, health and hospital services for his or her child.*

- 3. Any person who is pregnant may give effective consent for medical, dental, health and hospital services relating to prenatal care.*

- 4. Medical, dental, health and hospital services may be rendered to persons of any age without the consent of a parent or legal guardian when, in the physician's judgment an emergency exists and the person is in immediate need of medical attention and an attempt to secure consent would result in delay of treatment which would increase the risk to the person's life or health.*

5. Anyone who acts in good faith based on the representation by a person that he is eligible to consent pursuant to the terms of this section shall be deemed to have received effective consent.

In addition to these provisions for health care consent by emancipated individuals, there are other statutory provisions for minors who are in military service or are seeking treatment for AIDS and other sexually transmitted diseases. So long as the individual is a minor, the presumption is that he or she is not emancipated and the burden of proof rests on the individual asserting it.

The Mental Hygiene Law also addresses consent but for situations not usually within the scope of EMS. Additionally in § 9.1 it permits peace and police officers to direct the removal of any person to a hospital who is conducting himself in such a manner which is likely to result in serious harm to himself or others.

Other governmental agencies, such as law enforcement, mental health or corrections, may have legal definitions for individuals under eighteen that describe specific rights or responsibilities. Unfortunately, these do not impact health care decisions including the ability to consent or refuse care in the prehospital setting.

Refusal of Medical Assistance (RMA)

An individual who is legally a minor cannot give effective legal/informed consent to treatment and therefore, conversely, cannot legally refuse treatment.

Documentation

Complete an assessment of the patient. Fully document all circumstances including subjective and objective findings, attempts to contact parents, note any objections or refusals by the patient and all other pertinent situational facts. Include witness statements. Always consider contacting medical control for assistance.

Collaboration with other Agencies

EMS agencies are advised to work with hospital administrators, local law enforcement agencies, school administrators and community youth group leaders to develop policies and procedures to best serve the medical needs of minors in time of an emergency.

There are alternatives to EMS and hospitals for custody and supervision of minors. An uninjured child may be supervised by law enforcement personnel or a school or activity supervisor until a parent is contacted. In some situations, a responsible adult (grandparent, aunt, brother, etc.) with the child can assist in the decisions making.

EMS agencies should work with local youth activities to ensure they have made plans to contact parents, have provided consent to treatment forms or have other permissions in place for the children in their supervision.

EMS agencies also need to work and plan with all police agencies for those situations involving minors, particularly those who are not injured and do not require hospitalization. Local and state police have

broad powers which can be used to protect minors and facilitate custody.

However, all else failing, the EMS provider may remain responsible for providing care and/or transportation of a minor to a hospital.

EMS Agency Protocols

Agency policies and regional BLS and ALS protocol sets can contain guidance for treating minors in the prehospital setting. Contacting medical control is always an acceptable option for EMS providers faced with uncertain situations. Medical control may be able to influence the situation, even if it can't change the consent options.

Recommendations

EMS providers may find themselves responsible for minors, in situations they have been called to when there is no parent or guardian present or reachable.

Although it is easy to determine a legal definition of a minor, the responsibility to treat or release is a much more complex legal, ethical, social and public relations problem. The

nature of children and their special needs coupled with their inability to legally give informed consent, present special and unique matters for EMS personnel to consider and evaluate. Careful assessment, decision making and documentation are key as is discussion and planning with other agencies.

Act in the best interest of the patient EMS providers must strike a balance between abandoning the patient and forcing care. There may be instances in which a minor appears mature enough to make an independent judgment, however legally, the minor is unable to make a decision. Always contact medical control for assistance if there is any question.

Common sense, prior agreements, sufficient documentation, and acting in the best interest of the patient must prevail.

Issued by

John J. Clair

Associate Director of Operations

Authorized by

Edward J. Lyons

Director



New York State
Department of Health
Bureau of Emergency Medical Services

POLICY STATEMENT

Supercedes/Updates:

No. 00 - 01

Date: 4/10/00

Re:

Use of
Epinephrine
Auto Injectors By EMS
Agencies

Page 1 of 2

BACKGROUND

The purpose of this policy is to explain the provisions of Chapter 100 of the Laws of 1999 authorizing the use of an epinephrine auto injector device by certain individuals in ambulance and advanced life support services and children's overnight, summer day or traveling camps. This change in the law is designed to encourage greater acquisition and use of epinephrine auto injectors in communities across the state in an effort to reduce the number of deaths associated with anaphylaxis from increased sensitivity to insects and certain food substances.

AUTHORIZATION

To be authorized to possess and use an epinephrine auto injector under this statute an individual or organization as defined above needs to make specific notification of intent to the local Regional Emergency Medical Services Council (REMSC) and the Department of Health (DOH). *There are no approvals or certifications required.*

To be authorized to possess and use an epinephrine auto injector:

- Identify a physician or hospital knowledgeable and experienced in emergency cardiac care to serve as emergency health care provider (ECP) and participate in a collaborative agreement. This may be the EMS service's medical director.
- Complete a training course approved by the Commissioner of Health (Attachment 1).
- Develop with the ECP, a written collaborative agreement which shall include at least the following:
 - written practice protocols for the use of the epinephrine auto injector.
 - written policies and procedures for the training of authorized users.
 - notice to the ECP of the use of the epinephrine auto injector.
 - documentation of the use of the epinephrine auto injector.
 - written policy and procedure for acquisition, storage, accounting, and proper disposal of used auto injectors.
- Provide written notice to 911 and/or the community equivalent ambulance dispatch entity of the availability of epinephrine auto injectors at the organization's location.
- File with the REMSC serving the area a copy of the Notice of Intent to Possess and use an Epinephrine Auto Injector (DOH 1001) along with a signed copy of the Collaborative Agreement.
- File a new Collaborative Agreement with the REMSC if the ECP changes or with a change in content of the agreement.

REMSCO Actions

REMSCOs must develop a procedure for the following:

- insuring that a copy of the organization's Notice of Intent ... Form 1 is forwarded to the Bureau of EMS.
- maintaining a copy of the Notice of Intent... Form 1 and the Collaborative Agreement.

There are no approvals or certifications required by the REMSCO.

Authorized:

Edward J. Lyons
Director



New York State
Department of Health
Bureau of Emergency Medical Services

POLICY STATEMENT

Supercedes/Updates: New Policy

No. 00-03
Date: 05/19/00
Re: Transition of Care

Page 1 of 2

Transition of Care

With the passage of Chapter 552 of the Laws of 1998 (**Public Access Defibrillation**) and more recently, Chapter 578 of the Laws of 1999 (**Epinephrine Auto-Injector**), EMS Providers will increasingly encounter situations where a patient has been defibrillated or administered epinephrine, prior to the arrival of EMS, by a non-license/non-certified "first responder." It is important that there be a smooth and orderly "transition of care" between civilians and EMS providers as well as between EMS providers of different levels. This includes the transfer of information and continuation of appropriate care.

Public Access Defibrillation

When arriving at a call where a patient is being treated by a "first responder" with an AED, the EMS Provider should immediately confirm the patient's status (responsive, unresponsive, apneic, pulseless, etc.), and determine if a "shock" is indicated. Treat the patient appropriately, request ALS if available and prepare for immediate transport. The "first responder's" AED should remain on the patient until a full cycle of the AED has been completed. The AED and/or pads are usually changed when the patient is ready for transport or upon treatment by an ALS provider.

For patients where "no shock" is indicated, the EMS Provider should continue CPR (verify that CPR is being performed correctly) and prepare for immediate transport.

For patients where a "shock" is indicated, the EMS Provider should administer a complete set of 3 "shocks" and prepare for immediate transport.

If the EMS unit does not have a defibrillator/AED, the "first responder" should accompany the patient to the hospital, follow regional protocols and provide CPR as indicated (the ambulance should pull over and stop when analyzing and shocking the patient).

The EMS Provider should attempt to gather the following information:

1. how long the patient has been down,
2. when was CPR initiated,
3. when was the patient first "shocked,"
4. how many "shocks" the patient has received, and
5. any pertinent patient history that is available.

Transition of Care
Policy 00-03
05/19/00

Epinephrine Auto-Injector for Anaphylactic Reactions with Respiratory Distress or Shock

When arriving on the scene of a patient experiencing an anaphylactic reaction, if the patient is being treated by a "first responder" who has administered epinephrine by an auto-injector, the EMS Provider should immediately confirm the patient's status. The EMS Provider should pay close attention to the patient's airway, respiratory distress and any signs or symptoms of hypoperfusion (shock). Treat the patient appropriately, request ALS if available and prepare for immediate transport.

The EMS Provider should attempt to gather the following information:

1. determine the substance the patient was exposed to,
2. how long ago the exposure occurred,
3. the initial symptoms the patient reported,
4. the time and dosage of the epinephrine administered,
5. the name of the individual who administered it, and
6. the patient's response to the treatment.

Medical Control must be contacted prior to administering a second epinephrine injection.

Authorized: Edward G. Wronski, Director



Purpose

Due to the unique nature of the prehospital environment, medications and intravenous fluids that are stored and used in the prehospital setting are subjected to extreme environmental changes. This may have a negative impact on the stability, strength, quality and purity of these medications. Ultimately this may negatively impact the patients who receive these medications. As such, programs should be implemented with regards to how medications and intravenous solutions are stored in the prehospital setting. This policy applies to all BLS and ALS agencies that carry medications and/or intravenous fluids.

Policy

In an effort to assist agencies in maintaining the integrity of prehospital medications and intravenous fluids, the following should be the minimum requirements implemented by each service authorized to carry prehospital medications and intravenous fluids.

- All EMS services authorized to carry medications and intravenous fluids must develop a policy to define the appropriate storage and maintenance of all medications and intravenous fluids. The policy should also be incorporated in to the agency's policies and procedures as well as the □I program for the agency.
- All medications and intravenous fluids must be stored in an environment that protects them from extreme temperature changes and light according to each medication's manufacturer's guidelines. This includes all vehicles, cabinets or any other storage facilities where medications and intravenous fluids are stored. According to manufacturer's guidelines, most medications must be stored at temperatures that range from □9 degrees to □□ degrees □ahrenheit⁶. □owever, the temperature ranges may differ for many medications.

- Agencies must routinely monitor and record the temperatures for all locations where medications and intravenous solutions are stored.

Authorized by: Edward G. Wronski, Director



DOH
New York State
Department of Health
Bureau of Emergency Medical Services

POLICY STATEMENT

Supersedes/Updates: New

No. 00 – 15

Date: 11/21/00

Re: Storage and safe guarding of medications administered by CFRs.

Page 1 of 1

Purpose

The medications approved for use by CFRs are considered to be a lifesaving measure. As such, care should be taken to allow for immediate access, while safe guarding the medications when not caring for a patient. This policy is developed to address concerns regarding the storage and safe guarding of medications that may be administered in accordance with state and local BLS protocols by CFRs.

Policy

It is recommended that all EMS services carrying medications for use by CFRs develop a policy before placing them into use that includes, but may not be limited to the following items; inventory control, storage and replacement of these items.

In an effort to assist agencies in maintaining control of the medications that may be administered by CFRs, the following should be the minimum requirements implemented by each service providing this level of care.

- ❑ The medications must be stored in an environment that protects them from extreme temperature changes and light. According to the medication manufacturer's guidelines, the medications must be stored at temperatures that range from 59 degrees to 77 degrees.
- ❑ All medications must be secured in a container or location capable of being secured with a lock or numbered tear-away type inventory control tag when not being used for patient care.
- ❑ The medication must be placed in either a closed ambulance compartment or inside a bag or box that is taken to the patient.

- It is strongly recommended that these medications not be placed in the same locked cabinet with medications, syringes or needles used by Advanced Life Support Providers.

Authorized by: Edward G. Wronski, Director



New York State
Department of Health
Bureau of Emergency Medical Services

POLICY STATEMENT

Supersedes/Updates: New

No. 01 - 05

Date: 06/1/01

Re: Abandoned Infant Protection Act

Page 1 of 2

Background Information

The **Abandoned Infant Protection Act** was created in Chapter 106 of the Laws of 2001. Under this provision a parent, guardian or other legally responsible person may leave their infant who must be five days old or less at a safe place. The law requires that an adult must intend that the child be safe from physical injury, cared for in an appropriate manner, with an appropriate person, in a suitable location and promptly notify an appropriate person of the child's location. People leaving an infant in compliance with this law are not required to provide their names. Such individuals will not be prosecuted as a class E felony of Abandonment of a Child and class A misdemeanor of Endangering the Welfare of a Child.

The governing legislation did not specify or define what is an acceptable safe location. Instead, local district attorneys are to determine whether the parent left the child in an appropriate location. Individuals who give up their infants do not automatically surrender their parental rights and may later seek to reclaim the child. It is important to note that this legislation does not amend provisions of the Social Services law which make abandonment of an infant reportable to the New York State Central Register for Child Abuse and Maltreatment.

The New York State Office of Children and Family Services has released several Public Service Announcements and brochures about this program. In these materials the public is provided with the intent of the new law including a listing of suggested safe places where infants may be brought. The sites include hospitals, police stations, fire stations and other safe places. Some county district attorneys have already defined what constitutes a safe place within their county. Other counties have not yet done so.

Role of Emergency Medical Services Agencies

In the event a parent or legal guardian chooses to relinquish care of their newborn infant to an emergency medical service agency; the following guidelines should be considered:

1. In keeping with the intent of the governing legislation, parents are not required to provide their names to the safe location or staff. In a non-judgmental manner, EMS staff may ask the presenting adult if there is any medical information that is important to know in the care of the infant.
 - EMS services and systems may want to contact their county office of the District Attorney to determine what if any locations have been identified as safe places by the District Attorney for the purposes of this legislation.
 - Infants received by an EMS service agency should be transported to the nearest hospital for medical assessment/care. EMS agencies should not be expected to interact with local child protection service agencies unless directed to do so.
 - If a parent seeks follow up information about the child they relinquished to the care of the EMS service agency, a referral should be made to the hospital where the infant was transported or the local office of social services.

Further Information

Information about this program may be obtained by contacting □

New York State Office of Children and Family Services
Capital View Office Park
□ □ Washington Street
Rensselaer, New York 12151

1 800 354 2263 SA-E
<http://www.dfa.state.ny.us>

Issued by
Edward Conroy, Director
Bureau of Emergency Medical Services



New York State
Department of Health
Bureau of Emergency Medical Services

POLICY STATEMENT

Supercedes/Updates:

No. 02 - 01

Date: 01/02/02

Re: Requirement to report instances of suspected child abuse or maltreatment.

Page 1 of 7

On November 13th, 2001 § 413 of the Social Services Law was amended, in relation to persons and officials who are required to report cases of suspected child abuse or maltreatment. Effective February 1st, 2002 the law will require Emergency Medical Technicians to report suspected child abuse they come across while performing their jobs. ***The Bureau of EMS will not require EMTs to attend a specialized course for child abuse.*** The current EMS course curricula include sections on child abuse. However, the Bureau does reserve the right to amend the curricula in the future. Therefore, this Policy Statement and attached fact sheet are intended to be used by New York State EMTs to help them better understand their obligations as well as the signs and symptoms of possible child abuse or maltreatment.

Reporting Procedures:

§ 415 of the Social Services Law states that, “*Reports of suspected child abuse or maltreatment made pursuant to this title shall be made immediately by telephone or by telephone facsimile machine on a form supplied by the commissioner. Oral reports shall be followed by a report in writing within forty-eight hours after such oral report. Oral reports shall be made to the statewide central register of child abuse and maltreatment unless the appropriate local plan for the provision of child protective services provides that oral reports should be made to the local child protective service.*”¹

Oral Reports of suspected child abuse or maltreatment shall be made by calling the NYS Child Abuse and Maltreatment Register at:

1-800-635-1522

NOTE: This phone number is for mandated reporters ONLY and should NOT be provided to the general public.

- All oral reports must be followed up with a written report within 48 hours using Form DSS-2221-A, “Report of Suspected Child Abuse or Maltreatment” (Attached).
- A copy of the completed and submitted Form DSS-2221-A should be attached to the agency copy of the Prehospital Care Report retained by the agency.

Agency Policies

10 NYCRR Part 800.21(p)(11)(ii) requires all ambulance services to have and enforce a written policy regarding the reporting of child abuse. Based on the addition to §413 of Social Services Law all services should ensure that the policy developed regarding this requirement includes the mandatory reporting requirement and the process required by Social Services Law § 415. The agency policy needs to address areas such as Prehospital Care Report documentation, notifying the Emergency Room staff, calling the above 800 telephone number, and the completion of form DSS-2221-A.

Immunity From Liability

Immunity from liability for reporting cases of suspected child abuse or maltreatment is provided to those individuals required to report such cases under § 419 of the Social Services Law so long as the individual was acting in, “good faith”.

Failure To Report

§ 420 Of the Social Services Law states:

- 1. Any person, official or institution required by this title to report a case of suspected child abuse or maltreatment who willfully fails to do so shall be guilty of a class A misdemeanor.**
- 2. Any person, official or institution required by this title to report a case of suspected child abuse or maltreatment who knowingly and willfully fails to do so shall be civilly liable for the damages proximately caused by such failure.**

Attachments:

**Child Abuse/Maltreatment Fact Sheet
Form DSS-2221-A**

**Issued and Authorized by:
Edward G. Wronski, Director
Bureau of Emergency Medical Services**

ⁱ Pertains to Onondoga and Monroe Counties Only

Child Abuse and Maltreatment

Fact Sheet

This fact sheet is intended to be used by New York State EMTs as a learning tool and guide to help them better understand the signs and symptoms of possible child abuse or maltreatment. **The signs and indicators listed in this document are not conclusive proof of child abuse or maltreatment. There can be other, reasonable explanations for what you observe.**

Definition of Child Abuse:

An **abused child** is a child less than eighteen (18) years of age whose parent or other person legally responsible for his/her care

1. Inflicts or allows to be inflicted upon the child serious physical injury, or
2. Creates or allows to be created a substantial risk of physical injury, or
3. Commits or allows to be committed against the child a sexual offense as defined in the penal law.

Definition of Child Maltreatment:

A **maltreated child** is a child under eighteen (18) years of age who has had serious physical injury inflicted upon him/her by other than accidental means.

A **maltreated child** is also a child under eighteen (18) years of age whose physical, mental or emotional condition has been impaired or is in danger of becoming impaired as a result of the failure of his/her parent or other person legally responsible for his/her care to exercise a minimum degree of care

1. In supplying the child with adequate food, clothing, shelter, education, medical or surgical care, though financially able to do so or offered financial or other reasonable means to do so or
 - In providing the child with proper supervision or guardianship or
 - By unreasonable inflicting, or allowing to be inflicted, harm or substantial risk thereof, including the infliction of excessive corporal punishment or
 - By using a drug or drugs or
 - By using alcoholic beverages to the extent that he/she loses self-control of his/her actions or
6. By any other acts of a similarly serious nature requiring the aid of the Family Court.

Some of the physical indicators of possible child abuse:

- ◆ Bruises in different stages of healing, welts, or bite marks on face, lips, mouth, neck, wrist, thighs, ankles, or torso, or on several area of the body such as
 - ✓ Injuries to both eyes or both cheeks (usually only one side of the face is injured)
 - ✓ Marks that are clustered, that form regular patterns, that reflect the shape of such articles as an electrical cord, belt buckle, forktines, or human teeth.
 - ✓ Scrape marks on the arms or shoulders and/or
 - ✓ Bizarre marks, such as permanent tattoos

- ◆ Lacerations or abrasions to mouth, lips, gums, eyes, external genitalia, arms, legs, or torso.
- ◆ Burns
 - ✓ From cigars or cigarettes, especially on soles, palms, back, or buttocks.
 - ✓ From immersion in scalding water (socklike or glove-like on feet or on hands, doughnut-shaped on buttocks or genitalia)
 - ✓ That are patterned like an object, such as an iron or electric burner (burns from ropes on arms, legs, neck, or torso).
- ◆ Any fractures
 - ✓ Multiple or spiral, of the long bones, to skull, nose, or facial structure.
 - ✓ Other injuries, such as dislocation.
- ◆ Head Injuries
 - ✓ Absence of hair or hemorrhage beneath the scalp from hairpulling.
 - ✓ Subdural hematomas
 - ✓ Retinal hemorrhage or detachment, from shaking
 - ✓ Eye injuries
 - ✓ Jaw and nasal fractures
 - ✓ Tooth or frenulum injury
- ◆ Symptoms that suggest fabricated or induced illness, sometimes known as Munchausen Syndrome by Proxy (MSBP) for example, a parent might be repeatedly feeding a child quantities of laxatives sufficient to cause diarrhea, dehydration, or hospitalization, without revealing the child has been medicated.

Some of the emotional and behavioral signs of possible child abuse:

- ✓ Apprehension when other children cry
- ✓ Aggressiveness
- ✓ Withdrawal
- ✓ Fear of going home
- ✓ Fear of parents and other adults
- ✓ Extreme mood swings
- ✓ Inappropriate mood
- ✓ Habit disorder, such as nail biting
- ✓ Low self-esteem
- ✓ Neuroses, such as hypochondria, obsessions
- ✓ Refusal to remove outer garments
- ✓ Attempted suicide

Some of the physical signs of possible child neglect:

- ✓ Newborn with positive toxicology for drugs
- ✓ Lags in physical development
- ✓ Constant hunger
- ✓ Speech disorder
- ✓ Poor hygiene
- ✓ Inappropriate dress for the season
- ✓ Lack of medical care
- ✓ Inadequate supervision

Some of the emotional and behavioral indicators of possible child neglect:

- ✓ Chronic fatigue
- ✓ Habit disorder, such as thumb-sucking by a ten-year-old, rocking, biting
- ✓ Reports no caregiver at home
- ✓ Frequent absences from school or lateness
- ✓ Hypochondria
- ✓ Shifts from complaint to aggressive behavior
- ✓ Age-inappropriate behavior
- ✓ Begging for food
- ✓ Lags in emotional or mental development
- ✓ Use of alcohol or drugs

Some of the signs of possible child sexual abuse:

- ✓ Difficulty in walking and sitting
- ✓ Pain or itching in the genital area
- ✓ Torn, stained, or bloody underclothing
- ✓ Bruises or bleeding of external genitalia or vaginal or anal areas
- ✓ Bruises to the hard or soft palate
- ✓ Sexually transmitted diseases, especially in preteens
- ✓ Painful discharge of urine or repeated urinary infections
- ✓ Foreign bodies in the vagina or the rectum
- ✓ Pregnancy, especially in early adolescence

Some emotional and behavioral signs of possible child sexual abuse:

Many of the following indicators may also reflect problems unrelated to sexual abuse. Moreover, no one child will show all of these signs.

Particularly in children who are less than eight years of age look for

- | | |
|--|---|
| ✓ Eating disorders | ✓ Crying spells |
| ✓ Fear of sleeping alone | ✓ Hyperactivity |
| ✓ Enuresis (bed wetting at night or daytime accidents) | ✓ Change in school behavior (fear of school, drop in grades, trouble concentrating) |
| ✓ Separation anxiety | ✓ Regular tantrums |
| ✓ Thumb or object sucking | ✓ Excessive fear (including of men or women) |
| ✓ Encopresis (soiling) | ✓ Nightmares or night terrors |
| ✓ Language regression | ✓ Sadness or depression |
| ✓ Sexual talk | ✓ Suicidal thoughts |
| ✓ Excessive masturbation | ✓ Extreme nervousness |
| ✓ Sexual acting out, posturing | ✓ Hypochondria |

In children over eight through adolescence:

- ✓ Fear of being alone
- ✓ Peer problems
- ✓ Frequent fights with family members
- ✓ Poor self-esteem
- ✓ Excessive nervousness
- ✓ Emotional numbness, out of body experiences, or feelings of unreality
- ✓ Substance Abuse
- ✓ Excessive guilt or shame
- ✓ Mood swings
- ✓ Sexual concerns or preoccupations
- ✓ Withdrawn, isolated behavior
- ✓ Overly compliant behavior
- ✓ Suicidal thoughts or gestures
- ✓ Self-mutilation
- ✓ Hyperalertness
- ✓ Sexual acting out
- ✓ Avoidant, phobic behavior, including sexual topics
- ✓ Unwillingness to change into gym clothes
- ✓ Violent fantasies
- ✓ Memory problems
- ✓ Fear of future abuse
- ✓ Intrusive, recurrent thoughts, or flashbacks



STATE OF NEW YORK
DEPARTMENT OF HEALTH

Corning Tower

The Governor Nelson A. Rockefeller Empire State Plaza
Albany, New York 12242

Antonia C. Novello, M.D., M.P.H., Dr.P.H.
Commissioner

Dennis P. Halen
Executive Deputy Commissioner

March 6, 2002

Dear EMS Agency:

In an earlier letter we shared that effective February 1, 2002, emergency medical technicians (EMTs) are required to report suspected cases of child abuse or maltreatment to the New York State central child abuse registry. We had also provided a copy of the Department of Health's Policy Statement # 02-01, which describes how EMTs and ambulance services are to comply with this new reporting requirement.

At this time we would like to clarify a few issues that have come to our attention concerning the reporting of suspected child abuse cases by EMTs. Listed below is a summary of these issues:

1. EMTs are not required to take a course on how to comply with the reporting requirements. However, Regional EMS Councils, EMS services, EMS Course Sponsors and other interested parties may offer an overview of the legislation and guidelines on how best to achieve the desired results within their community or EMS agency. Such a course may be designed to meet the continuing medical education requirements of the Pilot Project.
2. For the time being, EMTs are required to be the reporter of record for suspected cases even if the child is transported and admitted to a hospital. EMTs can not and should not transfer the responsibility for reporting a suspected case to hospital personnel or any other health provider.
3. If there are multiple EMTs responding to a call from the same EMS agency, it is only necessary for the EMT of record (in-charge of patient care) from that agency to submit the required form. This may be confusing when there are multiple agencies responding, treating, and transporting the same patient. The EMT of record from each agency must file a separate report.
4. Reporting Procedures: An oral report must be made immediately to the NYS Child Abuse and Maltreatment Register at 1-800-635-1522. This must be followed by a written report, using Form DSS-2221-A, within 48 hours to the **local child protective services for where the child resides**. The only time Form DSS-2221-A is to be sent directly to the NYS Central Register is when the child resides in a Residential Institution.

5. EMS agencies are reminded that they must update their policies and procedures with regards to their personnel reporting child abuse and/or neglect. These policies and procedures need to reflect the guidelines in BEMS policy statement #02-01 as well as the required local reporting procedures for their area.
6. It is understood that EMTs will need to complete the DSS-2221-A form after an emergency situation. EMTs are not expected to have the form filled out in its entirety. EMTs should fill out as much information as possible, with the limited information they have and submit the form to their local child protective service who will obtain the rest of the information on the form.
7. The Bureau of EMS encourages EMS agencies to continue to have open dialogue with their local Child Protective Service to better understand issues at the local level

For assistance on how best EMTs and/or ambulance services can meet the new reporting requirements, please contact the Bureau of EMS at 518-402-0996 Ext. 1, 4 (Education Unit). . EMTs should refrain from contacting the NYS Central Register. The Requirement to Report Instances of Suspected Child Abuse or Maltreatment Policy Statement is accessible at www.health.state.ny.us (click on providers for EMS webpage). If you have questions about the mandatory reporter program, please visit the New York State Office of Children and Family Services at <http://www.ocfs.state.ny.us> or contact them at 518-474-4670.

Thank you for your cooperation with this important reporting initiative.

Sincerely,



Edward G. Wronski, Director
Bureau of Emergency Medical Services

cc: Regional EMS Councils
Regional Emergency Medical Advisory Committees
EMS Course Sponsors

Appendices

Appendix – Pediatric

Appropriate Ventilatory Rates for Assisted Ventilation

<u>Age Group</u>	<u>If Respiratory Rate is:</u>	<u>Ventilate At:</u>
Infant (<1 yr)	< 30/min	20/min
Toddler (1 – 2 yr)	< 24/min	20/min
Preschooler (3 – 5 yr)	< 20/min	20/min
School Age (6 – 12 yr)	< 15/min	20/min
Adolescent (13 – 18)*	< 10/min	12/min

Appropriate Ventilatory Rates for Hyperventilation

<u>Age Group</u> <u>At:</u>	<u>If Glasgow Coma Scale Score Is:</u>	<u>Hyperventilate</u>
Infant (<1 yr)	< 8	25/min
Toddler (1 – 2 yr)	< 8	25/min
Preschooler (3 – 5 yr)	< 8	25/min
School Age (6 – 12 yr)	< 8	25/min
Adolescent (13 – 18)*	< 8	20/min

Criteria for Tachypnea (Rapid Respiratory Rate)

<u>Age Group</u>	<u>Respiratory Rate:</u>
Infant (<1 yr)	< 60/min
Toddler (1 – 3 yr)	< 40/min
Preschooler (3 – 5 yr)	< 35/min
School Age (6 – 12 yr)	< 30/min
Adolescent (13 – 18)*	< 30/min



Use this formula to estimate the upper
limit of respiratory rates in pediatric
patients 1 – 10 yr

$$40 - (2x \text{ age})$$

Criteria for Tachycardia (Rapid Heart Rate)

<u>Age Group</u>	<u>Heart Rate:</u>
Infant (<1 yr)	< 160/min
Toddler (1 – 3 yr)	< 150/min
Preschooler (3 – 5 yr)	< 140/min
School Age (6 – 12 yr)	< 120/min
Adolescent (13 – 18)*	< 100/min



Use this formula to estimate the upper
limit of heart rates in pediatric patients
1 – 10 yr

$$150 - (5x \text{ age})$$

Criteria for Hypotension (Low Blood Pressure)

<u>Age Group</u>	<u>Blood Pressure:</u>
Infant (<1 yr)	< 60 mm Hg
Toddler (1 – 3 yr)	< 70 mm Hg
Preschooler (3 – 5 yr)	< 75 mm Hg
School Age (6 – 12 yr)	< 80 mm Hg
Adolescent (13 – 18)*	< 90 mm Hg



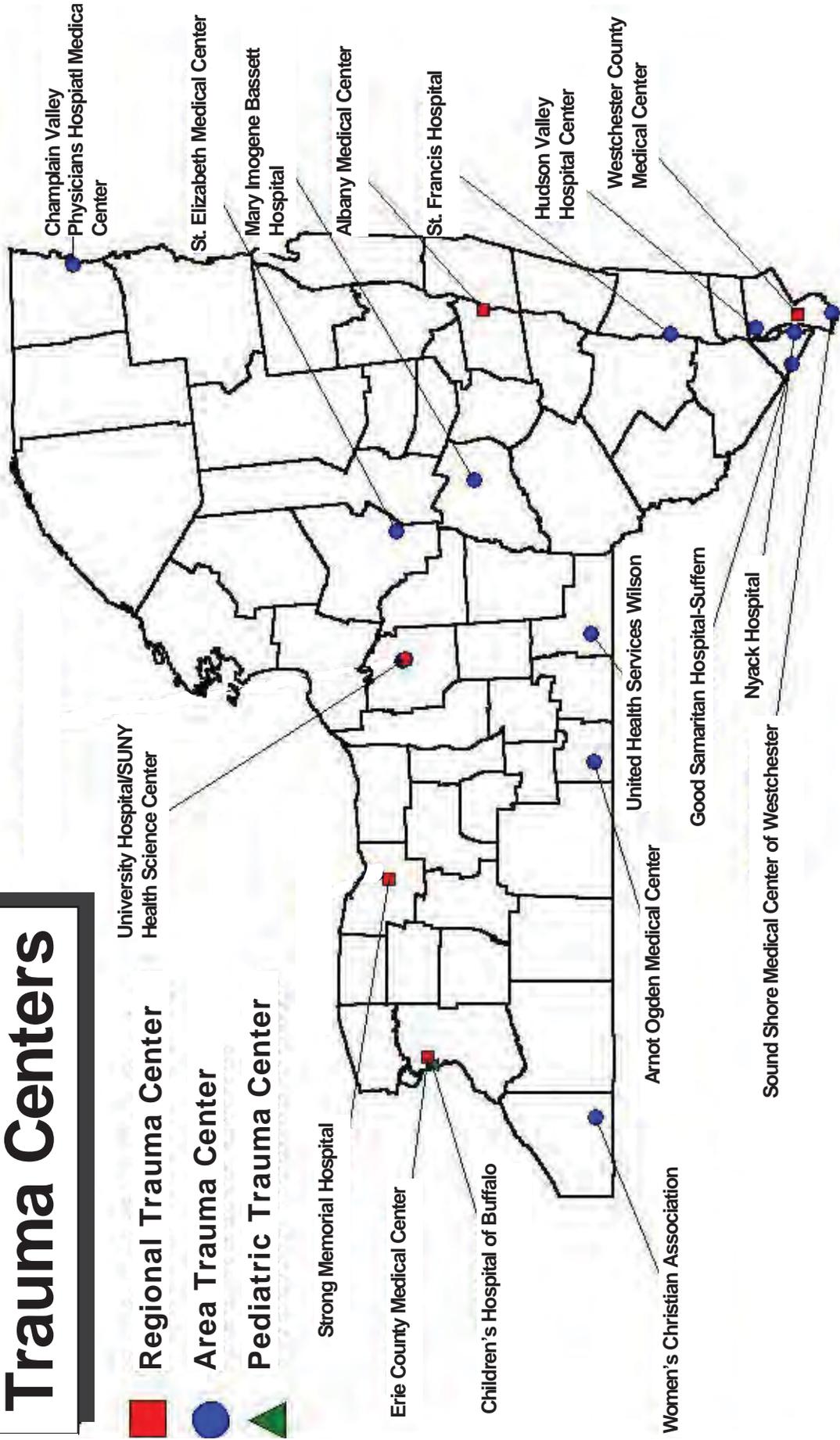
Use this formula to estimate the lower
limit of systolic blood pressure in
pediatric
patients 1 – 10 yr

$$70 + (2x \text{ age})$$

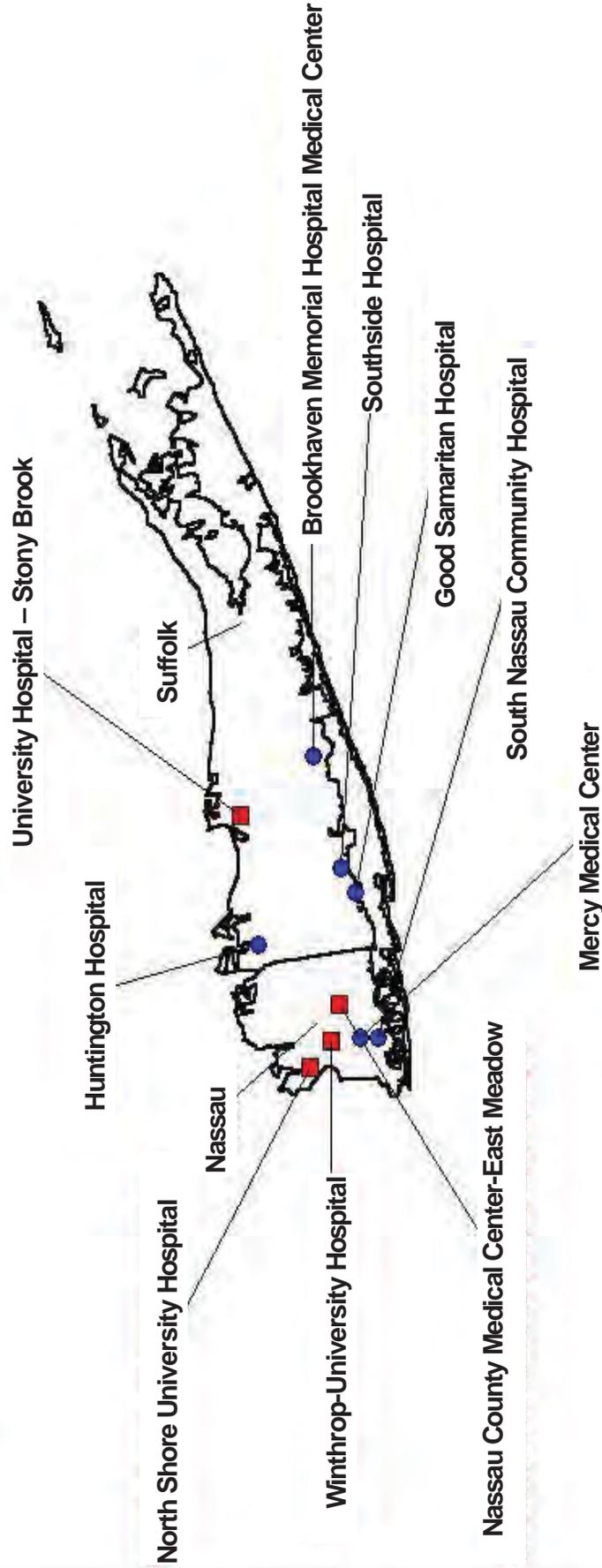
* Adult value used

New York State Trauma Centers

- Regional Trauma Center
- Area Trauma Center
- ▲ Pediatric Trauma Center



Trauma Centers of Long Island



WESTERN NEW YORK REGION

Regional Trauma Center

Erie County Medical Center
600 Rider Street
Buffalo, New York 14215

Regional Pediatric Trauma Center

The Children's Hospital of Buffalo
19 Bryant Street
Buffalo, New York 14203

Area Trauma Center

Woman's Christian Association
100 Foot Avenue
Amestown, New York 14001

FINGER LAKES REGION

Regional Trauma Center

Strong Memorial Hospital
601 Elmwood Avenue
Box 50R
Rochester, New York 14642

Area Trauma Center

Arnot Ogden Medical Center
Trauma Services
600 Roe Avenue
Elmira, New York 14901

NOTE All Regional and Area Trauma Center have the capability to treat pediatric trauma patients. However, EMS providers should refer to local protocols and REMAC directions on any differences in local trauma center capabilities to receive and treat pediatric trauma.

CENTRAL NEW YORK REGION

Regional Trauma Center

University Hospital
State University of New York Health Science Center
440 East Adams Street
Syracuse, New York 13210

Area Trauma Centers

St. Elizabeth's Hospital
4409 Seneca Street
Utica, New York 13501

Wilson Memorial Regional Medical Center
4400 Harrison Street
Johnson City, New York 13790

NORTHEASTERN NEW YORK REGION

Regional Trauma Center

Lifestar Regional Trauma System
A16, Albany Medical Center Hospital
44 New Scotland Avenue
Albany, New York 12202

Area Trauma Centers

Mary Imogene Bassett Hospital
One Atwell Road
Cooperstown, New York 13326-1090

Champlain Valley Physicians Hospital Medical Center
100 Beechman Street
Plattsburgh, New York 12901

NOTE All Regional and Area Trauma Centers have the capability to treat pediatric trauma patients. However, EMS providers should refer to local protocols and REMAC directions on any differences in local trauma center capabilities to receive and treat pediatric trauma.

HUDSON VALLEY REGION

Regional Trauma Center

Westchester County Medical Center
Office of Emergency Medical Services and Trauma
Macy Pavilion, Room 1019
Valhalla, New York 10595-0001

Area Trauma Centers

Nyack Hospital
160 North Midland Avenue
Nyack, New York 10960

St. Francis Hospital
North Road
Poughkeepsie, New York 12601

Hudson Valley Hospital Center
1900 Crompond Road
Peekskill, New York 10566

Sound Shore Medical Center of Westchester
16 Union Place
New Rochelle, New York 10801

Good Samaritan Hospital
1000 La Fayette Avenue
Suffern, New York 10901-0069

NOTE All Regional and Area Trauma Centers have the capability to treat pediatric trauma patients. However, EMS providers should refer to local protocols and REMAC directions on any differences in local trauma center capabilities to receive and treat pediatric trauma.

NASSAU REGION

Regional Trauma Centers

North Shore University Hospital
100 Community Drive
Manhasset, New York 11030-6606

Nassau County Medical Center
1001 Hempstead Turnpike
East Meadow, New York 11001-0000

Lehigh Valley University Hospital
1009 First Street
Mineola, New York 11001-0009

Area Trauma Centers

Mercy Medical Center of Long Island
1000 North Village Avenue
Rockville Centre, New York 11051-0009

South Nassau Communities Hospital
1000 Seaside Road
Seaside, New York 11001-0006

NOTE All Regional and Area Trauma Centers have the capability to treat pediatric trauma patients. However, EMS providers should refer to local protocols and REMAC directions on any differences in local trauma center capabilities to receive and treat pediatric trauma.

SUFFOLK REGION

Regional Trauma Center

University Hospital
State University of New York Health Sciences Center
Division of Trauma, Department of Surgery
Stony Brook, New York 11919

Area Trauma Centers

Long Island Hospital
100 Park Avenue
Long Island, New York 11939

Good Samaritan Hospital
1000 Montauk Highway
West Islip, New York 11994

Southside Hospital
Montauk Highway
Bay Shore, New York 11766

Brookhaven Memorial Hospital Medical Center
101 Hospital Road
Patchogue, New York 11772

NOTE All Regional and Area Trauma Centers have the capability to treat pediatric trauma patients. However, EMS providers should refer to local protocols and REMAC directions on any differences in local trauma center capabilities to receive and treat pediatric trauma.

NEW YORK CITY REGION

Regional Trauma Centers

Bronx County

Lincoln Medical and Mental Health Center
199 East 199th Street
Bronx, New York 10451

Jacobi Medical Center
1999 Pelham Parkway South
Bronx, New York 10461

St. Barnabas Hospital
Third Avenue and 183rd Street
Bronx, New York 10457-2594

Kings County

The Brookdale Hospital Medical Center
One Brookdale Plaza, Room 106
Brooklyn, New York 11216

Kings County Hospital Center
1991 Clarkson Avenue
Brooklyn, New York 11209

Lutheran Medical Center
199 99th Street
Brooklyn, New York 11209

New York County

New York Presbyterian Hospital
New York-Presbyterian Weill Cornell Medical Center
1999 East 69th Street
New York, New York 10021

St. Vincent's Hospital and Medical Center of New York
199 West 11th Street
New York, New York 10011

NOTE All Regional and Area Trauma Centers have the capability to treat pediatric trauma patients. However, EMS providers should refer to local protocols and REMAC directions on any differences in local trauma center capabilities to receive and treat pediatric trauma.

St. Lues/Roosevelt ospital Center
Amsterdam Avenue and 11th Street
New Yoro, New Yoro 1oo19

New York County

Bellevue ospital Center
East oth Street and orst Avenue
New Yoro, New Yoro 1oo16

oarlem ospital Center
o6 Lenox Avenue
New Yoro, New Yoro 1ooo

Queens County

Catholic Medical Center of Brooolyn and oueens
Mary Immaculate Division
Parson-s Manor
o6oo 1o Street
oamaica, New Yoro 11oo

New Yoro ospital Center of oueens
o6oo Main Street
oushing, New Yoro 11o1o

City ospital Center at Elmhurst
o9oo1 Broadway
Elmhurst, New Yoro 11oo

oamaica ospital
o9th Avenue and oan oyco Expressway
oamaica, New Yoro 11o1o

Richmond County

St. oincent-s Medical Center Richmond
oo Bard Avenue
Staten Island, New Yoro 1oo1o

Staten Island oniversity ospital
oo Seaview Avenue
Staten Island, New Yoro 1ooo

NOTE oAll Regional and Area Trauma Center have the capability to treat pediatric trauma patients.
o However, EMS providers should refer to local protocols and REMAC directions on any differences in local trauma center capabilities to receive and treat pediatric trauma.

Regional Pediatric Trauma Center

Long Island Jewish Medical Center, Schneider Children's Hospital
Regional Pediatric Trauma Center
277-0100 6th Avenue
New Hyde Park, New York 11040

Children's Hospital of New York
Columbia Presbyterian Medical Center
629 Broadway, North
New York, New York 10021

NOTE All Regional and Area Trauma Center have the capability to treat pediatric trauma patients.
However, EMS providers should refer to local protocols and REMAC directions on any differences in local trauma center capabilities to receive and treat pediatric trauma.

