Nassau Regional Medical Advisory Committee

Advisories

Advisory#	Subject	Issued	Effective
07-02.1	BLS Assisted Medications	2/7/07	2/7/07
07-06.1	BLS Use of Pulse Oximeters	6/6/07	6/6/07
08-12.1	Incident Rehabilitation	12/3/08	12/3/08
08-12.2	Adult Sexual Assault Forensic Examiner (SAFE) Program	12/3/08	12/3/08
11-05.1	Ventricular Assist Device (VAD)	5/04/11	5/04/11
12-08.2	Glucometer	8/15/12	8/15/12
13-12.1	Intranasal Naloxone	12/18/13	12/18/13
14-08.1	ALS Identification Card	8/06/14	8/06/14
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17-07.1	Non-powered, portable suction apparatus (LifeVac)	7/17/2017	7/17/2017
17-07.2	Medication Expiration Date Extensions	7/18/2017	7/18/2017

Nassau Regional Emergency Medical Services

REMAC

Advisory	Substitute for D50W	17-06.1
		Issued: 6/14/2017

The Nassau Regional Emergency Medical Advisory Committee (REMAC) has been made aware of a shortage of Dextrose D50W.

The following substitute is authorized while the shortage exists:

D50W (25gm in 50ml) – may be substituted by

Adults

D10W = 1 gm Dextrose in 10cc of fluid – to administer 25 gm the patient would get entire 250cc bolus

Pediatric

D10W = 0.5 gm/kg or 5cc/kg Dextrose

David S. Kugler, MD
Chairman — Nassau REMAC

Nassau Regional Emergency Medical Services

REMAC

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

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

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

Bernard Beckerman
Chairman

Nassau Regional Emergency Medical Services

REMAC

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

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

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

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

Bernard Beckerman
Chairman

Nassau Regional Emergency Medical Services

REMAC

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

PURPOSE

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

POLICY

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

1. It is the responsibility of all responders at the scene to monitor themselves and their personnel to ensure the safety, health, and welfare of all responders by ensuring adequate rest and hydration following the recommendations as set forth in this policy.

2. All providers are encouraged to participate in self-rehabilitation. This should ideally include 10 minutes between work periods and/or SCBA exchanges whereby the provider is allowed to rest and consume appropriate fluids while awaiting reassignment.

3. The Incident Commander shall consider the circumstances of each incident or training exercise early in the evolution of the incident or exercise, and make adequate provisions for the rest and rehabilitation for all personnel operating at the scene.

4. For any event where the above criteria are met, it is recommended that the Incident Commander or their designee (Incident Safety Officer or Logistics Section Chief) establish the following minimum:

   a. Rehabilitation Area
      i. Ample space with preference to seating for responders
      ii. Protection from the elements, fumes, or hazards
      iii Accessible by EMS
      iv. Clearly identified
      v. Temperature control including active cooling and re-warming of responders as indicated by environmental conditions
      vi. Re-hydration to include water and electrolyte replacement

vii. Nutrition (as appropriate for the duration of the incident)
viii. Staffing should include at least one Rehabilitation Officer/Manager with training of at least the NYS EMT-B and BLS equipment to include oxygen, blood pressure cuff and pulse oximeter. Availability of an AED in proximity to the Rehabilitation Area is strongly encouraged. Pulse CO-oximetry is optional, but recommended.

b. Treatment Area
i. Separate from the rehabilitation area
ii. In close proximity to a transporting ALS ambulance and the rehabilitation area
iii. Staffing should include a fully-staffed ALS transporting ambulance

5. There should be at least one rehabilitation staff member trained to at least the EMT-B level for every 5 responders in the Rehabilitation Area.

6. For large incidents, it may be advisable to have more than one Rehabilitation and/or Treatment Area established. This decision should be made by the Incident Commander or their designee.

7. For incidents greater than a single alarm, it is recommended that a minimum of one fully staffed ALS transporting ambulance is available per alarm assignment. Additional transporting ambulances may be required depending on the type of operation, environmental conditions, and number of responders involved.

8. No personnel should enter the warm or hot zone of a declared Hazardous Materials Incident unless the Rehabilitation and Treatment areas have been established and staffed according to the policies and procedures of the respective Hazardous Materials Team. This should include an ALS transporting ambulance and a regionally credentialed ToxMedic.

9. It is advised that pre-hydration, when possible, occurs to include a minimum of 16 ounces of non-caffeinated fluids over the two hours prior to scheduled events, such as training exercises.

Procedures

1. Responders should be detailed to the Rehabilitation Area by the Incident Commander or their designee after every 45 minutes of continuous hard labor, one 45 minute or 60 minute rated SCBA cylinder, two, thirty-minute rated SCBA cylinders, or after being decontaminated. The Incident Commander or Incident Safety Officer may direct personnel to the Rehabilitation Area at any time for reasons not mentioned above.

2. All responders should be decontaminated (if necessary) and remove personal protective equipment prior to entering the Rehabilitation Area.

3. All responders should follow their agencies accountability system when entering/departing the Rehabilitation and/or Treatment Areas.

4. Upon entering the Rehabilitation Area, the responder is expected to do the following:

   a. Drink at least 16 ounces of fluid (water first, then half-strength electrolyte solution).
   b. No tobacco use in the Rehabilitation or Treatment Areas.
   c. Follow the directives of the Rehabilitation Officer/Manager with regards to their disposition to the manpower/staging or the treatment areas.

5. The responder will be assessed by the Rehabilitation Officer/Manager or other qualified medically trained personnel.

6. Any responder entering the rehabilitation area with complaints of chest pain, shortness of breath (beyond normal exertion), or altered mental status will be immediately moved to the Treatment Area and may not return to duty for the duration of the incident. This shall be immediately reported to the individual(s) responsible for scene safety, accountability and/or command.

7. Every responder will be assessed for presence of other symptoms to include dizziness, weakness, nausea, headache, cramps, aches or pain, changes in gait, speech or behavior, mental/physical stress, exhaustion, and symptoms of heat or cold-related stress. These symptoms do not require immediate removal to the Treatment Area, but should resolve prior to returning to manpower/staging.

8. Every responder will have vital signs assessed to include Pulse, Respiratory Rate, Blood Pressure, and Pulse-Oximetry over a thirty-second period and recorded on the Incident Rehabilitation Log. Use of pulse CO-oximetry is optional, but recommended.

9. Abnormal Vital Signs are considered any one of the following:

   a. Pulse >110 per minute
   b. Respirations >20 per minute
   c. Systolic Blood Pressure >160
   d. Diastolic Blood Pressure >100
   e. Pulse oximetry <96% in ambient air
   f. Pulse CO-oximetry >5% (if measured)

10. If on any vital sign exam an irregular pulse is identified that is not previously known to the responder, the responder should be moved to the Treatment Area for further evaluation. This shall be immediately reported to the individual(s) responsible for scene safety, accountability and/or command.

11. If vital signs are within normal limits (as defined above) the responder is encouraged to drink at least 16 ounces of fluid and may return to manpower/staging after a minimum of 10 minutes rest.

12. If vital signs are abnormal (as defined above), the responder will be monitored for 10 minutes and encouraged to rest and consume appropriate fluids.

13. After 10 minutes from time of entry to the Rehabilitation Area, the responder will be reassessed and all vital signs retaken.

a. If vital signs are within normal limits, the responder may return to manpower/staging.
b. If vital signs continue to remain abnormal (as defined above), the responder will be observed for another 10 minutes and encouraged to rest and consume appropriate fluids.

14. After 20 minutes from time of entry to the Rehabilitation Area, the responder will be reassessed and all vital signs retaken.

a. If vital signs are within normal limits, the responder may return to manpower/staging.

b. If vital signs continue to remain abnormal (as defined above), the responder will be referred to the Treatment Area. This shall be immediately reported to the individual(s) responsible for scene safety, accountability and/or command.

15. If the responder exhibits any symptoms of chest pain, shortness of breath, or altered mental status during their time in the Rehabilitation Area, they should be moved to the Treatment Area immediately and may not return to duty. This shall be immediately reported to the individual(s) responsible for scene safety, accountability and/or command.

16. No responder may return to manpower/staging unless they fulfill the following:

a. No symptoms of dizziness, weakness, nausea, headache, cramps, aches or pain, changes in gait, speech or behavior, and symptoms of heat or cold-related stress.
b. Pulse $\leq$110 per minute
c. Respirations $\leq$20 per minute
d. Systolic Blood Pressure $\leq$160
e. Diastolic Blood Pressure $\leq$100
f. Pulse oximetry $\geq$96% in ambient air
g. Pulse CO-oximetry $\leq$5% (if measured)

17. Any responder moved to the Treatment Area should have care provided in accordance with NYS BLS protocols and Nassau Regional ALS protocols.

18. All personnel should be encouraged to hydrate with at least 36 ounces of appropriate fluids over two hours after the conclusion of the incident.

Interpreting CO Values During Incident Rehabilitation

1. The use of hand-held pulse CO-oximetry devices is strongly recommended but not required for Incident Rehabilitation.

2. The SpCO reading is to be used as a screening measure. Definitive carboxyhemoglobin determinations are performed via blood draw in the hospital setting. Any patient with complaints of chest pain, shortness of breath, or altered mental status should receive oxygen via a non-rebreather mask and moved to the Treatment Area, regardless of SpCO reading.

3. The following CO treatment guidelines will pertain to the asymptomatic emergency responder on entry to the Rehabilitation Area.

   a. If SpCO is <5% and vital signs are within normal limits, the provider is encouraged to drink at least 16 ounces of fluid and may return to manpower/staging after a minimum of 10 minutes rest.
   b. If SpCO is ≥5% and <12%, the responder may breathe ambient air and may not leave the rehabilitation area until their CO level is below 5%.
   c. If SpCO is ≥12% the responder should be moved to the Treatment Area and receive high-flow oxygen until the SpCO is <5%.
   d. If SpCO is ≥25%, the responder will be moved to the Treatment Area and transported with high-flow oxygen to an emergency department.

Documentation

1. All responders entering the Rehabilitation Area should have their name, vital signs, and disposition recorded on the Rehabilitation Log (Attached). This Log should be attached and stored with the stand-by PCR associated with the incident and a copy given to the Incident Commander or Incident Safety Officer.

2. A separate PCR should be completed for any responder referred to the Treatment Area, regardless of whether the responder was transported by EMS. Should the responder not wish transport, a Refusal PCR Form should be completed and the individual(s) responsible for scene safety, accountability and/or command shall be notified.

Nassau Regional Emergency Medical Services

REMAC

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

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

The goals of the SAFE program are to:

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

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

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

Mark Safford, MD
Chair — Nassau REMAC

Nassau Regional Emergency Medical Services

REMAC

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

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

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

> Do NOT perform CPR <

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

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

Medical Control

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

Mark Safford, MD
Chair — Nassau REMAC

Nassau Regional Emergency Medical Services

REMAC

Advisory	Glucometer	12-08.2
		Issued: 8/15/12

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

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

In addition, the NYS SEMAC has approved the use of Glucometers by properly trained EMT personnel operating with an EMS agency (BLS). Agencies should review NYS Bureau of EMS Policy # 12-01 for requirements and training that must be met before an agency can place a glucometer in service.

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

Joshua Kugler, MD
Chairman

BLS Glucometer Use

- Diabetes mellitus is a disease state characterized by a deranged relationship of insulin and glucose
  - In diabetes, there is insufficient insulin to get glucose into the cells, and thus the cells start to malfunction and produce characteristic findings
  - Emergencies from diabetes are usually from hyperglycemia or hypoglycemia

BLS Blood Glucose Monitoring

- Testing the Blood Glucose Level with a glucose meter

Equipment necessary

- Glucose meter
- Glucose meter test strips
- Lancet or lancet device
- Alcohol swabs

You must read manufacturer's instructions for your *particular* glucometer

BLS Glucometer Use

Blood Glucose Monitoring

- Checking the Blood Glucose Level (BGL)
  - Multiple Brands of Glucometers are commonly found on EMS units
  - Glucometer determines the amount of glucose in the blood, the sample usually coming from a finger stick
    - A normal range is 80–120 mg/dl
    - Hypoglycemia is a BGL <60 mg/dl
    - Hyperglycemia is a BGL >120 mg/dl

You must read manufacturer's instructions for your *particular* glucometer

BLS Blood Glucose Monitoring

- Withdraw strip, turn monitor on confirm code if needed.
- Choose finger, wipe with alcohol swab.

You must read manufacturer's instructions for your *particular* glucometer

BLS Blood Glucose Monitoring

- Lancet finger
- Squeeze blood onto strip fill area fully

You must read manufacturer's instructions for your *particular* glucometer

BLS Blood Glucose Monitoring

- Wait for result.
- Dispose of all materials in the proper container
- Emergency medical care
  - Once you have confirmed altered mental status and a history of diabetes controlled by medications, your care will also focus on possibility of reversing the low blood sugar
  - Follow NYS BLS protocols

You must read manufacturer's instructions for your *particular* glucometer.

Nassau Regional Emergency Medical Services

REMAC

Advisory	Intranasal Naloxone	13-12.1
		Issued: 12/18/2013

The Nassau REMAC determined that the use of Intranasal Naloxone (Narcan) by Basic Life Support (BLS) agencies is an acceptable for of treatment for suspected narcotic overdose.

In addition, the NYS SEMAC has approved the use of Intranasal Naloxone by properly trained EMT personnel operating with an EMS BLS agency. Agencies should review NYS Bureau of EMS Policy # 13-10 for training and requirements that must be met before an agency can place Intranasal Naloxone in service.

The NYS DOH currently requires that an EMS BLS agency that intends to use Intranasal Naloxone must notify the Nassau REMAC, utilizing the included forms:

Agency Letter of Intent
Required Agency Information Sheet
Medical Director's Statement of Agreement

Agencies that had participated in the pilot program do not have to resubmit the above forms, unless information has changed

Joshua Kugler, MD
Chairman

Agency Letter of Intent for
BLS Naloxone Administration

The _____, hereby notifies the Nassau REMSCo of
(*agency name*)
its intent to utilize BLS Naloxone in accordance with NYS DOH BEMS Policy.

We agree to abide by the following:

1. All necessary equipment and IN Naloxone trained personnel will be provided on a twenty-four (24) hour per day, seven (7) days a week schedule.

2. All providers will complete the Naloxone Administration Training Material and complete the Pre & Post Survey.

3. Our agency is regionally certified at the EMT level or higher.

4. The agency and personnel must follow all policies, procedures and protocols set forth by the Regional Medical Advisory Committee and NYS.

5. The agency will provide and document annual BLS Naloxone updates with competency skill testing for all active providers.

6. The agency agrees to participate in the Regional Quality Improvement Program. All calls in which IN Naloxone are administered must be reviewed by the agency Medical Advisor. A copy of the PCR must be sent to REMAC within 24 hours.

7. Any changes to the Required Agency Information will be reported to REMAC within 30 business days.

The ***signatures*** below certify that the above conditions will be maintained and that we will be responsible for all aspects of participation in this Regional program.

_____	_____
Agency Chief/President (Sign)	*Agency Medical Advisor (Sign)*
_____	_____
Print Agency Chief/President	Print Agency Medical Advisor

Required Agency Information (please print)

Agency Name: _____ Agency Phone #: _____

Agency Mailing Address: _____ City: _____ Zip_____

1. **Designated representative responsible for the BLS Naloxone Administration Pilot Program:**
   Name: _____
   Daytime #: _____
   Email (if applicable): _____
2. **Agency Administrator (Chief/President):**
   Name: _____
   Daytime #: _____
   Email (if applicable): _____
3. **Agency Medical Advisor:**
   Name: _____
   Daytime #: _____
   Email (if applicable): _____
4. **Agency QI Coordinator:**
   Name: _____
   Daytime #: _____ Email (if applicable):_____
5. **Naloxone will be stored in the Agency's station in the following manner:**

   _____

   _____

7. **Naloxone will be carried and secured on the ambulance(s) in the following manner:**

   _____

   _____

8. **The following ALS agencies will be called for intercepts:**

   _____

   _____

Must Be Completed By BLS Non-transporting Agencies ONLY:

9. **Primary transporting ambulance service:**

   Name: _____

NASSAU REGIONAL EMERGENCY MEDICAL ADVISORY COMMITTEE
131 Mineola Boulevard, Suite 105
Mineola, NY 11501-3919
FAX: 516-542-0049
Website: www.nassauems.org

Medical Director Statement of Agreement

I hereby agree to serve as the Medical Director for:

_____
(*agency name*)

I understand that all patient care will be provided under my license, in accordance with NYS and Nassau REMAC regional protocols and training guidelines, except in cases of gross negligence resulting in injury or death.

Upon signing this document, I agree to:

- Provide and/or assist with annual Naloxone in-services/updates and training
- Participate in Q.I., and review all calls in which Naloxone was administered and any other calls as necessary
- Provide medical leadership
- Act as a resource for continuing education
- Remain familiar with regional and NYS BLS protocols

If I have any questions concerning my responsibilities, I will contact Nassau REMAC.

MD signature: _____

MD name printed: _____

Date: _____ MD daytime phone #: _____

MD address: _____

_____

Nassau Regional Emergency Medical Services

REMAC

Advisory	ALS Identification Card	14-08.1
		Issued: 8/06/2014

The Nassau Regional EMS has established a new Advanced Life Support Credentialing program which required all current EMT-CC and EMT-P to enroll and successfully complete a training program which is based on the new Nassau Protocols that took effect on April 1, 2014.

Technicians that have successfully completed the new program are issued a Nassau Regional EMS identification card (sample attached). This is positive proof that the individual is properly credentialed to utilize the Nassau protocols.

Joshua Kugler, MD
Chairman


Nassau Regional E.M.S.
EMT-Critical Care
Ann Rich
EMT#
EXP: 08/31/2015

Nassau Regional Emergency Medical Services

REMAC

Advisory	Zoll Lifevest	14-08.2
		Issued: 8/6/2014

This advisory is to educate EMS Providers on a medical device they may encounter during EMS calls. The Zoll lifevest is a wearable cardioverter/defibrillator device.

The Lifevest is a garment and monitor. The garment (vest) contains electrodes and therapy pads. This is connected by a wire to the monitor.

The Lifevest can he used by patients in danger of sudden cardiac arrest (SCA), including those with the following conditions:

- After heart attack (MI)
- Before or after stent placement
- Before/after bypass surgery
- Cardiomyopathy
- Congestive Heart Failure (CHF)
- Implantable Cardioverter/Defibrillator (ICD) explant (patients who had an internal device, and are waiting for re-implant)

EMS Providers can disable the Lifevest by removing the battery located in the monitor unit. They can then place their own monitor/ defibrillator device on the patient.

BE AWARE:

- The lifevest has an alert sequence that is initiated upon recognition of a treatable shock.
- Be sure to listen to the voice prompts before making physical contact with the patient.
- EMS Providers, can be shocked if in contact with patient during treatment sequence.
- If the Lifevest has blue stains, the device has delivered a shock.

For more information, you may watch the Zoll Lifevest video for EMS providers http://lifevest.zoll.com/medical-professionals/how-lifevest-works.asp . This short video includes a visual aid to understanding this device.

Joshua Kugler, MD
Chairman — Nassau REMAC

Nassau Regional Emergency Medical Services

REMAC

Advisory	Long Beach 911 Receiving ER	15-06.1
		Issued: 6/15/2015

Location: 325 East Bay Drive, Long Beach, NY
Scope: Hospital Based Free Standing ED, Initial Care Only

This memo should serve as an official advisory that on or about July 1, 2015 South Nassau community Hospital will open an off-campus hospital-based freestanding emergency department (HBFSED) within the city of Long Beach. This facility will be 911 receiving and will be deemed an "initial care" emergency department facility as per the NYS DOH.

Due to the unique nature of such facility it is imperative that the EMS component of healthcare delivery is properly aligned with the available services. As such the following patient subtypes should **NOT** be brought to the Long Beach Freestanding emergency department:

1. Trauma patients
2. ST elevation MI (STEMI) patients
3. STROKE patients
4. Burn patients
5. Active labor and delivery (L and D) patients
6. Violent behavioral health/ agitated psychiatric patients
7. Patients requiring prolonged ventilation including those with acute and chronic artificial ventilator support needs
8. Isolated hip fractures or hip dislocations
    a. Also consider other complex/unstable joint dislocations
9. Severe gastrointestinal bleeding either by upper or lower G.I. source

This is an official notification. This may be superseded in time as the above stated facilities capabilities change.

Josh Kugler, MD- Chairman, Department of Emergency Medicine, 516-632-4751, jkugler@snch.org
Lori Edelman, BSN ,CEN- Director of Nursing Dept. of Emerg. Medicine, 516-632-3900
ledelman@snch.org

Joshua Kugler, MD
Chairman

Nassau Regional Emergency Medical Services

REMAC

Advisory	Cyanokit	16-06.1
		Issued: 6/13/2016

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

Remember – all orders for administration must be received from Medical Control.

Joshua Kugler, MD
Chairman – Nassau REMAC

This Advisory supersedes 12-08.1 – The only change is a correction to the Protocol number.

Nassau Regional Emergency Medical Services

REMAC

Advisory	Substitute for D50W	17-06.1
		Issued: 6/14/2017

The Nassau Regional Emergency Medical Advisory Committee (REMAC) has been made aware of a shortage of Dextrose D50W.

The following substitute is authorized while the shortage exists:

D50W (25gm in 50ml) – may be substituted by

Adults

D10W = 1 gm Dextrose in 10cc of fluid – to administer 25 gm the patient would get entire 250cc bolus

Pediatric

D10W = 0.5 gm/kg or 5cc/kg Dextrose

David S. Kugler, MD
Chairman — Nassau REMAC

Nassau Regional Emergency Medical Services

REMAC

Advisory	Non-powered, single patient, portable suction apparatus (LifeVac)	17-07.1
		Issued: 7/17/2017

The use of a non-powered, single patient, portable suction apparatus (LifeVac) device is an Agency Medical Director's option.

If an Agency Medical Director approves this use of this device in their agency then all response personnel must be trained and competent in its use before it can be deployed. The agency is responsible to properly document the training and competency by means of maintaining a roster of personnel trained and the date this was accomplished.

The agency must submit a letter to the Nassau REMAC indicating their Agency Medical Director has approved the use of this device and that the training has been completed and the unit is being deployed.

All agency using this device are reminded that this device is in ADDITION TO the required suction apparatus as specified in **NYS EMS Code Part 800.24 (b) (6)** which states "portable suction equipment capable, according to the manufacturer's specifications, of producing a vacuum of over 300 millimeters of mercury when the suction tube is clamped.

David S. Kugler, MD
Chairman — Nassau REMAC

Nassau Regional Emergency Medical Services

REMAC

Advisory	Medication Expiration Date Extensions	17-07.2
		Issued: 7/18/2017

Do to the current shortages in EMS medications, the Nassau REMAC has secured permission from the NYS DOH BEMS&TS to authorize agencies to update the expiration date of medications listed below:

Atropine Sulfate Injection, USP 0.1 mg/mL; 10 mL Ansyr Plastic syringe (NDC 0409-1630-10)

Dextrose injection 50% (0.5 g/mL); 25 g/50 mL Ansyr Plastic Syringe (NDC 0409-7517-16)

Atropine Sulfate Injection, USP 0.1 mg/mL; 5 mL ABBOJECT syringe (NDC 0409-4910-34)

Atropine Sulfate Injection, USP 0.1 mg/mL; 10 mL ABBOJECT syringe (NDC 0409-4911-34)

Dextrose 50% Injection, USP, 50 mL ABBOJECT Syringe (NDC 0409-4902-34)

Epinephrine Injection, USP 0.1 mg/mL; 10 mL ABBOJECT syringe (NDC 0409-4921-34)

In order to extend the expiration date the agency's ALS supply officer must go on-line to the US Food & Drug Administration's (FDA) website https://www.fda.gov/Drugs/DrugSafety/DrugShortages/ucm563360.htm where they will find the medications listed above; they then have to check agency supplies to determine if they have the specific medication AND if the Product/Lot Number and current Expiration Date match. If your agency is in possession of matching medications they should affix a label to the exterior packaging that indicates the NEW expiration date of 12/28/2017 or earlier. NOTE – if the expiration date listed on the FDA page is earlier than 12/28/2017 then the earlier date MUST be used. In accordance with BEMS&TS instructions, if the FDA date is after 12/28/2017 then the packaging must be marked 12/28/2017.

If the shortage situation continues later into the year, the REMAC will have to request a new extension date authorization from BEMS&TS.

David S. Kugler, MD
Chairman — Nassau REMAC