WREMAC

Western Regional
Emergency Medical Advisory Committee
462 Grider Street
Buffalo, New York 14215

To: All WREMAC Hospitals, REMSCO's, County EMS Coordinators, EMS Agencies & Providers

From: Brian M. Walters, DO, FACEP, FAAEM
WREMAC Chairman

Date: November 3, 2015

RE: 2015 WREMAC Protocol Changes

Recent protocol revisions were suggested, presented at the WREMAC meeting, and posted for comment. After receiving, reviewing and incorporating that feedback, several important protocol changes have been approved. A summary of the proposed updates is included below. The accompanying "2015 WREMAC Protocol Updates" includes these new changes. This summary and the protocol changes will also be updated in the complete protocol and posted on our website.

1. **CPAP Changes** - In anticipation of final approval of a statewide BLS CPAP protocol, the WREMAC CPAP protocol and other protocols that include CPAP have been amended to be more consistent with the proposed statewide protocol. **CPAP will only be approved for use at the BLS level when the Bureau of EMS officially approves and implements these changes, and when an agency is credentialed to do so by their medical director.** The following protocols have been revised: Procedure: AIRWAY MANAGEMENT, Procedure: CONTINUOUS POSITIVE AIRWAY PRESSURE, Respiratory: ASTHMA / COPD, Respiratory: ACUTE PULMONARY EDEMA, Procedure: PEDIATRIC AIRWAY MANAGEMENT, Pediatric: ACUTE ASTHMA.
2. **Procedure: AIRWAY MANAGEMENT Protocol** - Adds surgical airways for paramedics credentialed by their medical director, this is currently allowed in several protocols across NYS including the Collaborative Protocols.
3. **Procedure: MEDICATION FACILITATED INTUBATION Protocol** - Clarifies that the ADULT PAIN /NAUSEA / SEDATION protocol should be utilized for ongoing sedation and pain management of patients who are already intubated. Ketamine may now be used under standing order for MFI and Excited Delirium.
4. **Cardiac: CHEST PAIN - Suspected ACS Protocol** - Changed the protocol to hold nitroglycerine if erectile dysfunction (ED) medication taken within 72 hours (from 24 hours previously) due to longer acting ED medications and to be more in line with the NYS BLS protocol.
5. **Cardiac: POST CARDIAC ARREST Protocol** - Therapeutic hypothermia has been removed from the protocol given evidence that starting hypothermia in the field may not confer additional benefits versus starting it in the emergency department, as well as studies showing initiating hypothermia with large volumes of cold saline can cause worse outcomes. The removal of hypothermia from the protocol was previously approved by both the SEMAC and WREMAC.
6. **Medical: ALLERGIC REACTION / ANAPHYLAXIS Protocol** - This would allow AEMT's to administer epinephrine to adult patients by drawing up the medication and administering it IM, rather than just allowing auto-injector use. This skill was moved from the CC to the AEMT level in the changes and is consistent with AEMT protocols currently in use in the Central New York EMS Protocols.

7. **Medical: DIABETIC EMERGENCIES Protocol** - The definition of hypoglycemia was clarified to be < 60, as well as defining the dose of an oral glucose unit (19-24 grams) and allowing for administration of other available carbohydrate sources in accordance with the NYS BLS protocol. The wording was also standardized with the Pediatric: DIABETIC EMERGENCIES Protocol.
8. **Medical: SEIZURES Protocol** - The wording of midazolam dose was reworded to be more consistent with other protocols, however, the dose remains the same.
9. **Medical: Excited Delirium Syndrome Protocol** - Ketamine was moved to the paramedic level as this is currently the only level approved to administer ketamine in NYS. It was previously listed as a Critical Care option in error. Ketamine may now be used under standing order for MFI and Excited Delirium.
10. **Trauma: GENERAL CONSIDERATIONS** - Timelines for transport guidelines were clarified to be in line with the NYS BLS protocol and WREMAC, "If the time from injury to arrival at the trauma center is likely to be more than 60 minutes, contact Medical Control and consider transporting patient to the nearest hospital".
11. **ADULT PAIN / NAUSEA / SEDATION Protocol** - The morphine dose and interval for repeat dosing remains the same, but the maximum dose has been clarified. Fentanyl has been moved to standing order, where it was previously a medical control option. Fentanyl is becoming a more commonly utilized analgesic in EMS throughout the country and in other regions of NYS. With all ALS agencies now being required to carry narcotics, many agencies in the region have been approved to carry fentanyl in their controlled substance plans. The fentanyl dosing was taken from that currently utilized in the Collaborative Protocols. The midazolam dose in this protocol was revised to be consistent with the dose in the Medical: SEIZURES Protocol. Previously the doses were slightly different, and this was thought to be confusing to providers and a potential for medication errors. In the Key Points section, it was clarified that this protocol should be utilized for ongoing sedation and pain management of patients who are already intubated. However, this protocol may not be used to facilitate intubation.
12. **Pediatric: DIABETIC EMERGENCIES Protocol** - The intranasal route of administration for glucagon was added. Intranasal glucagon was already in the adult protocol, but has been specifically added to the pediatric protocols.
13. **Pediatric: SEIZURES & Pediatric: PAIN / NAUSEA / SEDATION Protocols** - Under the current protocols there was no differentiation in midazolam dosing based on route of administration. In certain instances, the IV dose could have exceeded our adult midazolam dose. These discrepancies were clarified to differentiate dosing based on route of administration as well as maximum doses to not exceed current adult protocols. The midazolam doses are also standardized between both pediatric protocols for consistency. Rectal doses of benzodiazepines have been clarified in accordance with current dosage recommendations from the Foundation for Education & Research in Neurologic Emergencies. Specifically, the dose of rectal diazepam previously under dosed pediatric patients and was increased to a dose approved by the SEMAC and currently used in the NYC REMAC protocols. Odansetron oral dissolving tablet was added for nausea under standing orders. Intranasal fentanyl has been added under standing orders for pediatric analgesia.
14. **Intranasal Administration** - As intranasal atomizers have become a routinely stocked item on many ambulances due to the NYS BLS intranasal naloxone policy, this route of medication administration is a viable option for many agencies. The accompanying protocol revisions now specifically mention the intranasal route for all adult and pediatric protocols that include fentanyl, midazolam, and glucagon. Under the current protocols IN was listed for these medications in some, but not all the protocols. These three medications along with naloxone are the most commonly administered medications given intranasally with good data supporting their absorption, clinical efficacy, and safety. This will specifically allow for more rapid medication administration when an IV is not immediately available.
15. **Ketamine** - Per recent SEMAC decisions, Ketamine may now be used under standing order for Medication Facilitated Intubation and Excited Delirium Protocols.