STATE OF NEW YORK
DEPARTMENT OF HEALTH

433 River Street, Suite 303 Troy, New York 12180-2299

Richard F. Daines, M.D.
Commissioner

Wendy E. Saunders
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May 1, 2008

Dear Colleague:

Enclosed you will find an update to the New York State Basic Life Support Protocols for Emergency Medical Technicians and Advanced Emergency Medical Technicians. The protocols were developed by the State Emergency Medical Advisory Committee and approved by the State EMS Council. Also included is a curriculum and access to a PowerPoint presentation to be used for training and updating EMS providers.

The updated protocol will be implemented in the following manner:

1. NYS BEMS strongly encourages all training sessions be conducted by Certified Instructor Coordinators (CIC). In the event a CIC is not available a CLI is acceptable. If a CIC and CLI are unavailable to a particular agency, then the appropriate training officer for the agency can conduct the training, but only with the approval of their medical director.

2. Where ever possible, Regional EMS Councils should assist in developing several region-wide training updates.

3. NYS BEMS approved Course Sponsors must begin using this material in all current and future certification courses testing after July 1, 2008.

4. EMS agencies must assure that all of their EMT-B and AEMT's are updated to the new protocol.

5. Although this protocol is in effect immediately, implementation of the protocol at the agency level can not occur until all employees/members of the agency have completed the training. ***All training must be completed by December 31, 2008***.

The entire protocol book as well as all updates and the PowerPoint presentations are available on our web site at http://www.health.state.ny.us/nysdoh/ems/main.htm. The protocol book is designed so you can remove the old version of these protocols and insert these new pages without the need to obtain an entire new book. Please check our web site regularly for any updates to the protocols and other Bureau of EMS documents.

If you have any questions please feel free to contact our Education Unit at (518) 402-0996, ext. 1, 4.

Sincerely,

Edward G. Wronski

Director,
Bureau of Emergency Medical Services

Suspected Spinal Injuries
(Not Meeting Major Trauma Criteria)

This protocol is for awake and stable adult and pediatric patients <u>NOT</u> meeting the Major Trauma Criteria (Protocol T – 6).

Spine injury should be suspected if blunt mechanism of injury is present and should be treated if one or more of the following criteria is present:

<u>IMMOBILIZATION CRITERIA</u>

1. **Altered Mental Status for any reason, including possible intoxication from alcohol or drugs (GCS <15 or AVPU other than A).**
2. **Complaint of neck and/or spine pain or tenderness.**
3. **Weakness, tingling, or numbness of the trunk or extremities at any time since the injury.**
4. **Deformity of the spine not present prior to this incident.**
5. **Distracting injury or circumstances (i.e. anything producing an unreliable physical exam or history).**

High risk mechanisms of injury associated with unstable spinal injuries include, but are not limited to:

- **Axial load (i.e. diving injury, spearing tackle)**
- **High speed motorized vehicle crashes or rollover**
- **Falls greater than standing height**

<u>IF THERE IS ANY DOUBT, SUSPECT THAT A SPINE INJURY IS PRESENT</u>!

<u>Note:</u>

Once spinal immobilization has been initiated (i.e. extrication collar placed on patient), spinal immobilization must be completed and may not be removed in the prehospital setting.

<u>Note:</u>

Standing Takedown with Spinal Immobilization should only be performed if a patient is found in a standing position.

Use a short board immobilization device for patients who are found in the sitting position.

I. Establish and maintain airway control while manually stabilizing the cervical spine.

II. Place the head and neck in a neutral in-line position unless the patient complains of pain or the head is not easily moved into a neutral in-line position.

III. Perform initial assessment.

IV. Assess level of consciousness.

V. Assess the patient's ventilatory status and assist the patient's ventilations 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.

VI. Assess the patient's circulatory status.

VII. Assess motor, sensory, and circulatory function in all extremities.

VIII. Immobilize patient with appropriate immobilization device(s).

IX. Reassess motor, sensory, and circulatory function in all extremities.

X. Initiate transport based on assessment and patient condition.

XI. Ongoing assessment. Repeat and record the patient's vital signs, including Glasgow Coma Scale and level of consciousness, enroute as often as the situation indicates.

XII. Keep the patient warm during transport.

XIII. Record all patient care information, including all treatment provided, on a Prehospital Care Report (PCR).