
# EMS System
# Basic and Advanced Life Support
# Policy Manual

July 2025

## Acknowledgements

Thank you for the hard work of the many individuals who contributed to the development and updates of this document from REMAC, REMSCO, and Suffolk County EMS.

## Introduction

These policies are intended to guide and direct patient care provided by EMS under the NY Collaborative Patient Care Protocols. They reflect the current evidence-based practice and consensus of content experts. These policies are designed to work alongside the collaborative protocols and are not intended to be absolute treatment documents, rather, as principles and directives which are sufficiently flexible to accommodate the complexity of patient management. No policy can be written to cover every situation that a provider may encounter, nor are protocols a substitute for good judgment and experience. Providers are expected to utilize their best clinical judgment and deliver care and procedures according to what is reasonable and prudent for specific situations. However, it will be expected that any deviations from policy or protocol shall be documented and reviewed, according to regional procedure.

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## Section A: General Administrative Policies

### 1. Suffolk County Medical Control:

Contact with Suffolk County Medical Control is required in cases where medical control options are indicated in protocol or post-call notification for cardiac arrest patients or when an advanced airway is placed. Suffolk County Medical Control may be accessed by any prehospital provider while on duty status with an authorized agency in the Suffolk County 911 system on an emergency medical alarm at any time for consultation and advice regarding patient care including, but not limited to, questions about triage, questions regarding diversion requests, treatment, selection of destination hospital, appropriateness of medevac utilization, and refusal of medical assistance.

Following 12 lead acquisition by an EMT-B, AEMT or EMT-CC, the provider must transmit and contact Suffolk County Medical Control. Paramedics must transmit and contact Suffolk County Medical Control if the 12 EKG lead shows a suspected STEMI. Providers of all levels should make the pre-arrival notification to the receiving hospital as soon as feasible, and before they begin transport, to pass along information regarding a positive STEMI. Suffolk County Medical Control may be reached by cellular or landline telephone at 631-689-1430, or by using the 800 MHz radio system by contacting Suffolk County Medical Control on the talk group identified as ALS Call.

If a system-wide communications system failure occurs, the EMS Division may institute the Catastrophic Communications Failure Policy. If activated, and an ALS Provider is unable to establish contact with Suffolk County Medical Control, the ALS provider may only perform those procedures authorized as **Standing Orders** in the applicable protocol. In these cases, paramedics may repeat their standing orders, based on patient needs while enroute to the hospital. EMT-CCs may only follow their own standing orders while enroute to the hospital.

### 2. Regional Treatments:

Treatments noted as "if trained and equipped" or "if regionally approved" in the New York State Collaborative protocols are noted as a "‡" within that protocol manual. These treatments may be approved for use at an EMS agency at the direction of an agency and agency medical director unless noted below.

NOT authorized for use by the Suffolk County REMAC:

- Nitrous Oxide

### 3. Role of On-Scene Physicians:

a. Designated EMS Physicians: Emergency Medical Services (EMS) Agencies may sponsor a physician to serve as a Field Physician for their EMS agency. These physicians must have a current unrestricted New York State (NYS) Medical License to practice medicine and be a sponsored member of an EMS agency in Suffolk County. To be authorized to serve as a Field Physician, the physician needs to demonstrate competency in the ALS protocols at the highest level in the Suffolk County 911 EMS System with passage of a protocol exam through the Suffolk County EMS Division (this will be waived if the physician also carries current NYS paramedic credentialing) and be authorized to Field Physician Status by Suffolk REMAC. All field physicians will practice Advanced Life Support (ALS) for their EMS Agency at the highest level in the System and provide field medical care under the direction of their sponsored EMS agency. Field physicians may serve as on-scene medical control and do not have to

establish contact with Suffolk County Medial Control where indicated in the NYS BEMSATS Collaborative Protocol Manual. Field physicians may also execute a Refusal of Medical Assistance (RMA) on their own. These physicians may serve as a field physician in any area of Suffolk County as a member of their EMS agency when responding to a mutual aid request. All field medical care, procedures, and RMAs must be documented on an ePCR. Field physicians are subject to the same policies and quality improvement processes as any other EMS provider in the System. Field physicians may request to be Rapid Sequence Intubation (RSI) credentialed by the REMAC RSI Subcommittee.

b. Disaster Medical Response Team (DMRT): Physicians may request to have the additional credentialing as DMRT members. This requires a credentialing process and indemnification from the Suffolk County Department of Health Services. This is a joint approval by the Department of Health Services, the Suffolk County EMS Division, and the Department of Fire Rescue and Emergency Medical Services. This is a Suffolk County credentialing that authorizes the DMRT physician to perform EMS duties as a Physician in the field when called upon to service by Department of Fire Rescue and Emergency Medical Services . DMRT physicians will serve as Deputy Fire Coordinators and may be dispatched by Department of Fire Rescue and Emergency Medical Services for the purposes of major disasters and long scene-time operations, MCI events, HazMat events and USAR deployment, transportation incidents such as plane and train crashes or bus accidents. As DMRT physicians, these physicians may provide field medical care as a physician commensurate with their education and training, provide field medical oversight as a Deputy Fire Coordinator, and function as medical control. DMRT members are sponsored by Department of Fire Rescue and Emergency Medical Services and have the same protections and indemnification as any other Deputy Fire Coordinator. DMRT members may not self-deploy to any scene unless requested and authorized by Department of Fire Rescue and Emergency Medical Services . As an agent of Suffolk County, all field medical care must be documented on an ePCR and submitted to Department of Fire Rescue and Emergency Medical Services and to the Suffolk County EMS Division. DMRT physicians are subject to the same quality improvement processes as any other EMS provider in the System. The lead DMRT physician in Suffolk County will be the Regional EMS System Medical Director who will oversee all administration and quality improvement of the DMRT.

c. Other Physicians: If a non-designated physician is at the scene and wishes to assume responsibility for the care of their patient in their office, or as a passer-by at the scene of a call, the physician must be properly identified. Acceptable forms of identification include, but are not limited to, a medical society card, professional organization membership card, or hospital identification card. Until proper identification has been established, the provider shall render care to the patient in the usual manner.

To assume responsibility for the care of a patient, an on-scene physician must agree to assume all responsibility for the patient, document the assumption of responsibility on the ePCR, and agree to accompany the patient to the hospital in the ambulance**.**
If the on-scene physician agrees to these terms, the physician's orders may be carried out. However, such orders must conform to the level of training of the field personnel and to the protocols established by the NYS BEMSATS

*Orders that are not within established Suffolk County EMS System* policy or NYS BEMSATS protocol, or those that are out of the scope of practice of an CFR, EMT-B, EMT-CC or paramedic require that the physician perform the task, use their own equipment, and accompany the patient to the hospital in the ambulance. Any out-of-protocol procedures initiated by a non-designated physician remain the responsibility of that physician at the scene and during transport. Suffolk County Medical Control need not be contacted until the post-event telephone report if the above conditions are met, unless the BLS/ALS Provider is uncomfortable with the non-designated

physician's actions. EMS Providers should always maintain a professional approach to other health care professionals during the transition of care phase of the alarm. All procedures and medications performed or administered by the physician must be clearly documented on the ePCR.

If the on-scene physician is reluctant to agree to these terms, or is unwilling or unable to perform the task and orders an out-of-protocol procedure, the BLS/ALS Provider must contact Suffolk County Medical Control. The Suffolk County Medical Control Physician will make a judgment concerning the on-scene physician's participation and responsibility. Communication between the Suffolk County Medical Control Physician and on-scene physician is encouraged. If the on-scene physician refuses to communicate with the Suffolk County Medical Control Physician, the BLS/ALS Provider must inform the on-scene physician that the BLS/ALS Provider may only accept the orders of the Suffolk County Medical Control Physician.

**4. Role of On-Scene Physician-Extenders:**

If a "Physician Extender" **(**Physician Assistant or Nurse Practitioner**),** is present at an emergency in their usual employment setting, and requests to assume responsibility for the care of the patient, under the license of their absentee supervising physician**,** the "physician extender" may do so, provided that the individual has been properly identified. Acceptable forms of identification include, but are not limited to, a state registration certificate, professional medical society card or hospital identification card. Until proper identification has been established, the BLS/ALS Provider shall render care to the patient in the usual manner. The "physician extender" must abide by the terms and conditions defined for "other physicians" (see Section F-3 above).

A physician extender outside the normal setting of their usual place of employment may not provide on-scene medical direction and EMS providers may only take medical direction from a physician, as described above.

**5. Other On-Scene Healthcare Professionals:**

In any event where a healthcare professional other than a physician or physician extender, as specified above, is at the scene, the BLS/ALS Provider is to maintain responsibility for patient care.

**6. EMS Providers:**

The Suffolk County EMS System recognizes two levels of care:

- Basic Life Support: BLS is provided by those certified by New York State as Certified First Responders (CFR), Emergency Medical Technician - Basics (EMT-B), and Advanced Emergency Medical Technician (AEMT) and render care in accordance with the NY State Collaborative Protocols.

- Advanced Life Support: ALS is provided by those certified by New York State as Emergency Medical Technician – Critical Care (EMT-CC) or paramedic and render care in accordance with the NY State Protocols and with the policies set forth in the manual.

**7. Selection of Destination Hospital:**

NY State DOH policy for ambulance transport requires that patients be transported to the closest *appropriate* hospital emergency department. When a patient's condition requires advanced level care or interventions or is potentially life threatening, the ambulance service is obligated to transport the patient to the nearest appropriate hospital emergency department, unless directed to another facility by state protocols, regional policies, or by a Suffolk County Medical Control Physician or designated EMS field physician.

- Appropriateness is defined as the hospital most appropriate by NY State DOH designation (i.e.: Trauma Center, Pediatric Trauma Center, Stroke Center, Burn Center, PCI-Capable Center) where an admitting physician has privileges into a recognized specialty care area (i.e.: pediatrics), or in cases where there are no specific services at a particular hospital (i.e.: OB/GYN and Labor and Delivery).
- Please reference the Suffolk County Receiving Hospital Designation List in Appendix B.
- Psychiatric emergencies should be transported to the closest emergency department for medical evaluation and clearance for secondary transfer, as indicated by additional diagnostic testing.
- Patients that may require hyperbaric therapy should be transported to the closest emergency department for evaluation and clearance for secondary transfer, as indicated by additional diagnostic testing.
- In certain cases, patients may request transport to the Northport Veterans Affairs Hospital (NVAH). Patients should not be transported to NVAH if applicable Emergency Medical Dispatch Determinant Code indicates and/or the patient presents with sign/symptoms and/or chief complaint indicative of ischemic chest pain/STEMI, CVA/TIA, trauma, burns, and obstetrical/gynecologic emergencies. Similarly, pediatric patients should not be transported to the NVAH. Suffolk County Medical Control should be used as a resource as some of these cases may lead to delays in definitive care accessed through secondary transfer that may be detrimental and should be avoided.

Patients that are victims of sexual assault should be transported to a hospital that maintains a Sexual Assault Nurse Examiner (SANE) Program, unless the assault is compounded by an unstable illness or injury.

In many instances the patient's illness or injury is not immediately life threatening. In such situations, the following factors should be considered when selecting the destination hospital, provided that the drive time to the alternative receiving hospital does not exceed more than twenty minutes additional time than it would have taken to get to the original facility, per NY State policy:

- NY State or Regional injury/illness specific protocols
- The patient's or family's request to be transported to a more distant hospital
- The hospital affiliation of the patient's private physician
- Travel time and road conditions
- The ambulance agency's internal policy for the selection of a destination.

A decision to transport a patient to a facility other than the nearest hospital implies that a judgment has been made that the risks of prolonged transport are outweighed by the potential benefits to the patient. Suffolk County Medical Control should be contacted for assistance in transport decisions when questions regarding the appropriateness of by-passing a hospital arise.

An ambulance service's duty to act is to the patient in their presence, not the patient they might get, therefore, agency internal policies should reflect care that is most appropriate and safe for the patient, not convenience of returning to the district. The duty to act is not terminated until the transfer at the hospital bedside is complete. If EMS providers at any level are unsure as to the appropriate destination hospital, they should contact Suffolk County Medical Control for physician advice.

In general terms, the duty to act begins upon receipt of a call for EMS assistance and ends upon transfer of care to hospital staff.

## 8. Hospital Diversion:

Section 405.19 (e) (4) of the NYS Hospital Code authorizes hospitals to request diversion of ambulances to other facilities when the acceptance of another critical patient might endanger the life of that or another patient. A *request* for diversion does not require that the ambulance divert from that facility. *EMS personnel are not obligated to honor such a request if they believe that a critically ill or injured patient's condition warrants transport to the closest hospital.* However, EMS providers should consider the negative effects of bringing a patient to an emergency department that has declared that they are over capacity, or don't have enough equipment or space to properly care for additional patients. If it is determined that the patient is stable, the diversion request may be honored. Suffolk County Medical Control may be contacted to assist in the transport decision. Personnel should fully document the reason(s) for their decision on the ePCR.

In cases where a hospital-specific event of magnitude, or a loss of critical infrastructure or diagnostic equipment negatively affects a hospital's ability to receive patients, and the hospital makes an affirmative decision to temporarily place its emergency department out of service, every effort will be made to effectively communicate information to ambulances and to redirect patients. Personnel should expect to receive information via Suffolk County Department of Fire Rescue and Emergency Medical Services Communications, or appropriate Public Safety Answering Point (PSAP) / Dispatch Center and should fully document the reason(s) for their decision on the ePCR.

## 9. Refusal of Medical Assistance (RMA):

In the event that an ambulance service responds to a reported medical emergency where both the individuals at the scene and EMS personnel believe that no injuries or illnesses exist and that there are no individuals requiring or requesting EMS assistance, a ePCR shall be prepared using the following Disposition Codes: Unit Disposition: No Patient Found, Crew Disposition: Back in Service, No Care/Support Services Required, Transport Disposition: No Transport. A thorough assessment of the scene is required to rule out mechanism of injury criteria. A physical assessment may also be necessary to make the determination that there are no patients at the scene. Consider the high-risk criteria identified below before determining that there are no patients at the scene. Refer to the "No Patient Found" policy in Section B of this manual for guidance on determining patients from individuals.

The Suffolk County Medical Control Physician will assess the patient's capability to refuse treatment, encourage the patient to allow appropriate care as indicated, and offer advice and guidance to EMS personnel. If the patient is determined to have capacity, the refusal should be thoroughly documented on the ePCR, signed by the patient and witnessed, preferably by a family member or a police officer.

Documentation should also include a complete patient assessment, and a statement that the patient has received and understands their medical condition, an explanation of the risks associated with refusal of transport, and that there is some level of support in place for them, including an alternative plan. Please refer to "Medical Decision-making Determination" in the key points of the RMA protocol for further points on determining and documenting capacity**.**

The patient's decision to refuse, the risks of refusal, and any recommended follow-up offered to the patient, should be noted on the ePCR and the RMA signed by the patient, indicating they have refused medical treatment and/or transportation. If the EMS provider is unsure if the patient has capacity or high-risk illness or injury exists, Suffolk County Medical Control must be contacted. In all cases where there is no transport to a hospital, an ePCR must be completed and submitted in the prescribed time frame.

If an ALS provider is on the scene, it is expected that the ALS provider with the highest level of certification be responsible for the assessment of the presence/absence of high-risk criteria and that those cases are not triaged down to a BLS provider.

Refer to the NYS Collaborative Protocol on MOLST for patients presenting with these documents

## 10. RMA Suffolk County Medical Control Criteria:

Refer to the NYS Collaborative Protocol on RMAs. An RMA should not be considered without contacting Suffolk County Medical Control if any of the following additional criteria are present. A physical assessment may be necessary to rule out these criteria.

- Any concern that the patient lacks capacity, or situation where it is unclear the patient has capacity including but not limited to:
    - known or suspected intoxication
    - suicidal or homicidal ideation, including verbalizing suicidal intent
    - history of or concern for dementia
    - altered mental status
- is less than one year, including situations where the legal guardian is on scene
- is less than eighteen years old **and** does not have a clearly identified legal guardian, such as a parent, available to refuse medical attention.

EMS personnel should contact Suffolk County Medical Control by telephone at 631-689-1430. For confidentiality purposes, and for ease of use by patients, the radio should not be used for RMA consultations. This policy cannot address every issue or possibility regarding RMA situations, therefore questions regarding appropriate action must be directed to Suffolk County Medical Control.

## 11. Medevac Service:

Guidelines for use of medevac service:

The process for determining that medevac service is appropriate for a particular patient includes consideration of the patient's condition, distance from a designated specialty hospital, physical findings, mechanism of injury, contraindications for medevac service and the logistics of removing a patient unique to the given situation. Effort must be made to first consider ground transport times and the ability of a ground ambulance crew to continue care while enroute to the hospital, before

requesting medevac services. In determining the appropriateness of medevac service, a provider must first evaluate the following:

Inclusion Criteria:

It is appropriate to consider medevac request if the patient's condition:

- Requires expeditious transport to a hospital capable of providing specialized care, such as a designated Trauma Center; Stroke Center; Burn Center; STEMI Center; hospital with Obstetric services, etc. if transport time to the appropriate center by ground is greater than 30 minutes.
- Requires specialized services (medications or procedures) offered by the air medical crew not available to the ground crew prior to arrival at the hospital.
- Is a "life or limb" threatening situation demanding intensive multi-disciplinary treatment and care.
- Includes signs/symptoms/physical findings suggestive of unstable trauma patient.
- Includes critical burn patients.
- Includes signs/symptoms/physical findings suggestive of an ill, unstable medical patient as defined in the medical protocols.
- Is critical, including cardiac arrest on a barrier island or other remote area.
- A medical patient presumed to be suffering from a stroke/CVA in an area where there are no designated stroke centers, or the patient needs comprehensive stroke care; or
- A medical patient with a STEMI per 12 lead EKG and the nearest PCI-capable Center is greater than sixty minutes by ground transport.
- During an MCI event to distribute patients to appropriate receiving hospitals which may not be in the immediate vicinity.

Exclusion Criteria:

It is inappropriate to request medevac service if the drive time to the closest appropriate hospital can be accomplished within thirty minutes.

Suffolk County Medical Control should be contacted to assist with transport decisions if questions as to appropriateness arise.

For specialty hospital referrals, the patient must still meet New York State or Suffolk County criteria for selection of destination hospital.

> In all cases, the goal of prehospital care, selection of transportation mode, and selection of destination hospital should be focused on getting the patient to the hospital best capable of caring for the injury or illness in the most expedient manner.

a. <u>How to request and/or cancel medevac service:</u>
   - The first responding medically certified person on-scene is responsible for making the determination that medevac service is appropriate. To avoid confusion, the decision to cancel medevac response should be made by the same person who made the original medevac service request.
   - The primary method of requesting medevac service is through the police officer at the scene. If there is no police officer present, the medevac service can be requested through the MEDCOM or FIRECOM dispatcher. Establishing a landing zone is primarily the responsibility of the on-scene police. Responding EMS providers should be familiar with guidelines and safety procedures.

- For cases outside the Suffolk County Police District or when there is no sector car on scene, EMS providers should relay their operating frequency type (i.e. UHF, VHF, 800 MHz, other) and number through Department of Fire Rescue and Emergency Medical Services MEDCOM to facilitate direct ambulance-to-helicopter communications.

## 12. Documentation:

Written Documentation: A New York State Electronic Prehospital Care Report (ePCR) must be completed for every request for ambulance response in the Suffolk County EMS System and accounted for per NY State EMS Policy Statement 21-04. Follow NYS policy on chart completion.
Post-Call Follow-up: Suffolk County Medical Control must be contacted by telephone (631-444-3600) at the completion of every call when there is on-line contact with Suffolk County Medical Control, in patients in cardiac arrest, and in cases of advanced airway placement.

## 13. Quality Assurance and Quality Improvement:

Agencies providing EMS care should perform Quality Assurance and Continuous Quality improvement consistent with New York State Laws and Regulations and their agency QA/CQI plan. Guidance from the NYS DOH is available in the *New York State Quality Improvement Manual*. In addition, EMS agencies are required to participate in any Suffolk County REMAC approved CQI initiatives and results of these initiatives should be shared with agencies and agency medical directors.

**Deviation from protocols:**

Any deviation from protocols should be reviewed by the Agency Medical director. Suffolk County REMAC and the Suffolk County EMS Division are available to provide assistance to any Agency Medical Director as requested. A reference for NYS DOH reportable events are available in policy statement 09-08.

## 14. Management of the Patient with an Advanced Airway:

Prevention of unrecognized esophageal intubation is of paramount importance and is a medical and legal necessity. Therefore, the use of End-Tidal CO2 waveform capnography, the use of a commercially available tube holder is required on all endotracheal intubations and supraglottic airways (SGA) performed in the ALS System. Immobilization of the head with a cervical collar may be considered for patients following advanced airway placement. For patients where a waveform is initially obtained and cannot be maintained, the advanced airway must be removed.

For patients with a pulse requiring advanced airway management, whether they have received medication to facilitate intubation, pulse oximetry, continuous ETCO2 waveform capnography, and cardiac monitoring is required prior to intubation and/or SGA placement and is to be maintained throughout transport to the hospital.

The use of continuous ETCO2 capnography should be used for all non-intubated patients complaining of respiratory distress.

An ePCR advanced airway verification dataset must but used with any advanced airway and an airway confirmation by the receiving provider must be documented using the appropriate ePCR signature field.

**15. Controlled Substances:**

Only those controlled substances approved by the NY State Emergency Medical Advisory Committee (SEMAC) and the NY State Department of Health (NYSDOH) may be administered by appropriately certified and authorized ALS Providers of certified ALS ambulance services or certified ALS first response services participating in the Suffolk County ALS System, with a Class 3C Controlled Substance License. Controlled Substances may be administered either under standing orders, or upon the order of a Suffolk County Medical Control Physician or Designated EMS Field Physician, per applicable clinical protocols. Controlled substances may not be carried in the private vehicles of EMS providers. Marked and certified ambulances or emergency ambulance service first responder vehicles must be used to transport controlled substances. All certified personnel and all authorized officers, members and/or employees of an ALS agency are under a continuous duty to immediately report to the EMS System Medical Director, the Service Medical Director, the Controlled Substances Agent and the NYSDOH / BEMSATS any loss, theft, and/or diversion of controlled substances. ALS Providers must be engaged in "active response" with the agency that holds the Class 3C Controlled Substances license to administer controlled substances.

**16. ALS Equipment in Private Vehicles:**

Except as provided for in the next paragraph, ALS personnel are not authorized to carry any item that requires a physician's prescription in their private vehicle. Such items include, but are not limited to, needles, syringes, medications, and defibrillators.

The only circumstance under which such equipment may be legitimately carried in a private vehicle is when the vehicle operator is serving as an authorized agent of an agency participating in the Suffolk County ALS System, functioning as an "ALS First Responder." In those cases, the member's personal vehicle is considered an Emergency Ambulance Service Vehicle (EASV) and must meet the criteria set forth in NY State policy. The ALS equipment may be carried only with the prior knowledge and approval of a chief officer of the ALS Provider's agency, and with the authorization of the NYSDOH. All such ALS equipment must be able to be used under protocols applicable to the ALS Provider's level of certification, and must include, but is not limited to, IV administration supplies and fluids, monitor / defibrillator, endotracheal intubation/airway adjunct equipment, and telemetry / communications equipment.

**17. Area of Operation:**

An EMS Provider credentialed by an EMS agency may only operate within the geographical confines of their agency or as part of a bona fide mutual aid response.

**18. Interaction Between Levels of EMS Providers:**

Common sense and good patient care are to prevail in all provider interactions. When questions arise, patient care activity should be directed by the individual with the highest certification. Suffolk County Medical Control may be contacted to resolve any conflicts occurring during patient care activity.

**19. Patient Transfers:**

From ALS provider (EMT-CC or paramedic) to BLS (EMT or AEMT) provider

A New York State certified EMS provider with a higher level of certification may transfer responsibility for the on-going care of a patient to a provider with a lesser New York State certification if the following conditions are met:

- If medications have been provided by an ALS provider that are outside the scope of the BLS provider, the ALS provider must transport the patient unless specifically noted below.
- The ALS provider must have assessed the patient and made an affirmative decision to transfer care of the patient to a BLS Provider, indicating that the patient is not in need of ALS level interventions and will not likely decompensate to the point where ALS interventions may become necessary during transport to the hospital.
- The ALS Provider must have made the determination that the patient will not require any care or skills which would be possessed by the ALS provider and not possessed by BLS provider.
- If approved by the Agency & Agency Medical Director of the EMS agency: ALS providers who obtained a 12 lead-EKG on patients with complaints not felt to be cardiac in nature may be transferred to a BLS provider following interpretation of the EKG if all of the following criteria are met:
    a. The patient does not require or is not anticipated to require any further ALS level intervention
    b. The patient has normal vital signs (HR > 55 with NSR or rate-controlled atrial fibrillation if the patient has a previous history of atrial fibrillation and the ventricular rate is <110)(SBP>100mmHG SBP and < 180mmHg) (pulse oximetry >94%) (RR is between 12 and 20 per min)
    c. The 12-Lead EKG is interpreted as non-diagnostic of any cardiac arrhythmia (except for rate controlled previously known atrial fibrillation) or any suspected cardiac ischemia = no ST to T segment elevations or depressions, no abnormal-appearing T waves, no new bundle branch block (a LBBB or RBBB that is known to be pre-existing should be documented as such and interpreted as non-diagnostic for acute ischemia)

- ALS providers may transfer care to a BLS provider who has received IN naloxone (Narcan) if the following conditions are met: the patient must be fully awake and breathing normally, EMT must consent to the transfer, transport time to the closest ED must be less than 30 minutes, there is no suspicion or indication that would indicate that the opioid reversal has triggered the onset of agitation / seizure or other medical complication caused by another substance that could be treated by an ALS provider, there is no need for restraint of the patient, and the patient exhibits normal vital signs (BP $\geq$ 110 / 70, HR < 110, RR $\geq$ 12, BG > 80 mg/dl).
- ALS providers may transfer care to a BLS provider for a patient who has received oral Acetaminophen or Ibuprofen if the following conditions, in addition to all other requirements for the transfer of patient care, are met:

When oral Acetaminophen or Ibuprofen have been given for <u>pain management</u>: the patient must not be expected to require additional pain management, the patient has stable vital signs, the EMT must consent to the transfer, there is no expectation that patient will require additional ALS interventions, and the patient does not meet ACS Trauma Point of Entry Criteria.

When oral Acetaminophen or Ibuprofen have been given for fever control: the patient has stable vital signs, the patient is not expected to require other ALS interventions, and the EMT must consent to the transfer

- The BLS Provider must agree to assume responsibility for patient care. If the BLS Provider refuses to accept that responsibility, the provider with the higher level of certification must continue to care for the patient until the transfer at the hospital is complete.
- If either provider who is a party to the transfer has any questions concerning the appropriateness of the transfer, they may contact Suffolk County Medical Control for a physician consultation.
- The patient transfer must be documented on the ePCR. The ALS Provider must document assessment and transfer on the ePCR, as part of the patient care transfer process. If multiple agencies are involved, each agency is responsible for documenting their respective agency's interaction with the patient and with each other.

From paramedic to EMT-CC

A New York State certified EMS provider with a higher level of certification may transfer responsibility for the on-going care of a patient to a provider with a lesser New York State certification if the following conditions are met:

- The paramedic may transfer ALS level care to an EMT-CC provided that the patient does not require an paramedic-level intervention that the EMT-CC is not authorized to carry out, and the patient will not likely decompensate to the point where specific paramedic-level standing order interventions may become necessary during transport to the hospital.

- The paramedic may transfer ALS level care to an EMT-CC provided that the patient is not deemed to be unstable, either by assessment, or by protocol, and that the patient will not likely decompensate to the point of becoming unstable or critical during transport to the hospital. Documentation should include the medications and procedures initiated by the paramedic prior to transfer of care to the EMT-CC, and that the conditions of transfer have been met.

If either provider who is a party to the transfer has any questions concerning the appropriateness of the transfer, they must contact Suffolk County Medical Control for a physician consultation.

## 20. Mobile Stroke Unit:

Interaction with a Mobile Stroke Unit

- On calls where the Mobile Stroke Unit (MSU) is simultaneously dispatched the MSU may be cancelled prior to arrival by EMS providers on-scene if they feel there is low probability the patient is having an acute stroke (ischemic or hemorrhagic).
- Transportation of the patient to the closest appropriate hospital should not be delayed by the remaining on-scene awaiting the arrival of the MSU.
- Upon assuming patient care, the paramedic on the MSU will assume primary responsibility for patient care.
- Suffolk County Medical Control may be contacted at any time if there are questions regarding these criteria.

Requesting a Mobile Stroke Unit

- On calls when a MSU was not simultaneously dispatched, the responding EMS providers may request a MSU response if an acute stroke is suspected; however this request should not delay providers departing the scene to transport the patient to the closest appropriate hospital. As such, this request should not be made if transport is able to be initiated before a MSU may arrive on-scene.

## Section B: Medical Guidelines

### 1. Pediatric ALS Standards:

A REMAC approved commercially available pediatric length-based resuscitation tape must be carried as part of the standard ALS equipment package and must be used to estimate the pediatric patient's body weight, guide medication dosage adjustments, determine energy selection requirements, and tube sizes. IO access may be utilized on any pediatric patient who weighs 3kg or more. For patients under 3kg weight, contact Suffolk County Medical Control.

### 2. Pilot Programs:

Occasionally and in response to additional training or new technology, additional procedures or medications may be authorized by REMAC, with the approval of the NYSDOH, and added to the protocols for use by select agencies in a pilot program prior to adaptation by the entire system. In those cases, it is the responsibility of the agency to ensure that all necessary paperwork required by the pilot program authorization are completed and submitted as required by REMAC. Under no circumstances may an agency implement a pilot project or employ new technology that has not been preapproved the REMAC and the NYSDOH.

### 3. Non-Emergency Transportation:

The NYS BEMSATS protocols are intended for use in emergency situations for care rendered in cases received through the emergency response system. The protocols are not intended for routine transportation use or interfacility transfer situations. In cases where an EMS System ambulance may be necessary to transport a patient between home and a health care facility, or between health care facilities, or in any other non-emergent situation requiring BLS Level care and interventions, prior approval from the EMS system medical director or their designee is required. Interfacility transportation at the ALS level is outside the scope of these protocols and is generally not acceptable but may be approved by the EMS System Medical Director on a case-by-case basis depending on the patient's condition.

### 4. Continuous Quality Improvement Plan:

A variety of appropriateness, statistical, and red-flag monitors are itemized and analyzed by the SC EMS Division and presented to the REMAC and the appropriate Agency Medical Directors. Information will also be made available to local hospitals to assist in fulfilling their 405.19, 708.2b, and 708.5 regulations. On-going and/or topical reports produced by Medical Control and/or EMS Division personnel will be forwarded to the REMAC.

The decision regarding the restriction of ALS or BLS privileges of an EMS provider is the purview of the Agency Medical Director. The Suffolk County REMAC and the SC Division of EMS are available as a resource to Agency Medical Director's as needed.

Except for the case of suspension of a provider's certification by NYS DOH, a provider's restriction is specific to the agency. However, it is the responsibility of the EMS provider to ensure that all agencies and agency medical directors in which that provider is credentialed and authorized are aware of restrictions and/or remedial activity.

A provider may ask the REMAC to review the decision of an Agency Medical Director. This review will result in a recommendation being provided to the Agency Medical Director, the ultimate authority regarding a provider's authorization to practice at a specific level of care remains with the Agency Medical Director. Such a request will be forwarded to the REMAC Chair, who will be asked to convene a Medical Review Committee.

The REMAC's Medical Review Committee ruling may include any of the following dispositions:

- Support the decision of the Agency Medical Director
- Recommend the Agency Medical Director reverse their decision.
- Make a recommendation that the Agency Medical Director modify their proposed remediation plan or suspension of privileges.
- Refer the matter to the NYS DOH

## 5. Provider Registration:

The EMS Program Agency is responsible for managing the registration on behalf of the REMAC for providers in the EMS System. All EMS Providers (CFR, EMT, AEMT, EMT-CC, Paramedic) in Suffolk County must complete an initial registration process. This will include obtaining basic demographic information from the providers. Providers will be required to attest to reviewing the NYS Collaborative Protocols and Suffolk County REMAC policies.

### Annual Registration Update

Agencies are required to ensure that providers receive education on an ongoing basis for all REMAC-approved protocol and policy updates as required. Agencies are required to submit a list of active providers, as determined by the agency, approved by the agency and agency medical director, to the Suffolk County REMAC on an annual basis.

## 6. No Patient Found Policy:

The purpose of this policy is to assist EMS personnel with clear guidance for managing situations when an individual for whom an EMS provider has been dispatched to denies injury or illness and has no apparent injury or illness when assessed by the EMS provider.

A *Patient* is any person who is injured or ill or in need of treatment by medical personnel. Appropriate paperwork will be completed, including an ePCR.
A *No Patient Found* is a disposition is for use in the following situations:

- No physical person found on EMS arrival after an adequate investigation of the surrounding area; or
- Unintentional / accidental activation of an emergency medical alert system; or
- After an adequate investigation it is reasonably certain that the person or persons on-scene did not request an ambulance, and the person:
    - Denies any injury / illness complaints;
    - Does not appear to have an actual or potential injury / illness;
    - Is capable of making competent decisions regarding refusal of care;
    - Does not have a mechanism of injury; and
    - Where EMS personnel on scene ascertain this information having not performed anything other than a visual assessment.

After following the criteria of *No Patient Found* the highest ranking EMT on-scene must thoroughly document the circumstances of the alarm on the ePCR. The ePCR may be completed with a disposition code *No Patient Found.*

Any individual who is given any level of assessment or examination beyond a visual observation, such as a physical assessment / examination, vital signs, treatment or any diagnostic assessment constitutes patient care, and the individual is considered a *Patient* requiring appropriate disposition.

Anytime the EMS provider on-scene feels that an individual has actual or potential for an injury / illness, the individual becomes a *Patient*, and the EMS provider must follow appropriate patient treatment protocol or RMA policy.

Lift assist is a situation that has a high potential for injury, both from the fall and from the conditions that may have precipitated the fall. An individual requiring a lift assist is considered a *Patient* and the EMS provider must follow the appropriate patient treatment protocol or RMA policy.

**7. <u>Use of Restraint Policy:</u>**

Several factors may contribute to a patient's abnormal behavior, including metabolic causes secondary to low blood sugar, hypoxia, or head trauma, the use of mind-altering substances, or psychiatric pathology. Signs and symptoms associated with a "behavioral emergency" should be considered of a medical nature, and patients should be transported to the closest emergency department for evaluation. Suffolk County Medical Control may be contacted in cases where questions about necessity of restraint or care arise. BLS providers should consider ALS intercept. As always, transport should not be delayed.

Patients have the right to refuse treatment and/or transport if they are of legal age and can make an informed decision. A person is considered capable until proven otherwise. There are situations in which the interests of the public outweigh an individual's right to liberty, including:

- the individual is threatening self-harm or suicide; and/or
- the individual presents a threat to third parties, including medical caregivers.

The purpose of this policy is to provide guidelines on the use of humane medical restraint in out- of-hospital situations for patients who are violent, potentially violent, or who may harm themselves or others, regardless of the underlying cause, when restraint is necessary to limit mobility or temporarily immobilize such patients. Providers are to use the minimum and least restrictive amount of humane restraint necessary to safely accomplish patient care and transportation with regard to safety for both

the patient and provider dependent on body size and strength, type of abnormal behavior, and mental state.

Indications for restraint include:

- behavior or threats that imply or create a danger to the patient and others;
- the need for safe and controlled access for medical care (medical restraint); or
- involuntary treatment / transportation of irrational or uncontrollable combative patients (behavioral restraint).

To provide care and transportation without the patient's informed consent, EMS providers must be able to document a reasonable belief that the patient would be a threat to self or others. If during the scene assessment a patient is encountered who threatens the safety of the crew, retreat and await assistance from law enforcement personnel to assure scene safety. Physical restraints should be used:

- in the presence of law enforcement personnel, and after other methods of de-escalating the patient have failed; or
- under standing orders, without law enforcement presence, in situations where crew safety is paramount, based on changes in the patient's mental or behavioral status.

Restraints should only be used in an emergency or crisis where the patient is non-compliant with direction, does not follow orders, or when the actions of the patient may result in physical harm to self or others. Once restraints have been applied, they should not be removed until transfer of care occurs at the hospital, under the direction of accepting hospital personnel. Soft restraints are approved for use by EMS providers. Hard restraints such as handcuffs, cable ties, restraints that require keys and other similar restraint devices are not approved for EMS providers. When soft restraints are necessary such activity will be undertaken in a manner that protects the patient's health and safely preserves their dignity, rights, and well-being.

The method of restraint used shall allow for adequate monitoring of vital signs and shall not restrict the ability to protect the patient's airway or compromise neurological or vascular status. Restrained extremities should be evaluated for the presence of circulation and motor function every five minutes, with findings documented on the ePCR.

In ideal circumstances, four-point restraints should be applied (each limb), and upper arm muscle groups should be isolated by restraining the arms in opposite directions. Once the decision to restrain is made, the team should act quickly, and four persons should approach the patient, each pre-assigned to a separate limb.

EMS personnel must ensure that the patient's position does not compromise the patient's respiratory/circulatory systems or does not preclude any necessary medical intervention to protect the patient's airway should vomiting occur.

If the patient is spitting, EMS providers should cover the patient's face with an oxygen mask, with oxygen flowing, if indicated. Alternatively, a surgical mask may be used as a personal protective barrier, if oxygen is not indicated. Under no circumstances should an EMS provider holdpillows, towels, or other objects over a patient's face.

Patients are to be transported in the supine or left lateral recumbent position. *Never place a patient face down to restrain*. Fractures, dislocations, and positional asphyxia are common complications to the restraint process, and care should be taken to avoid. Do not transport a patient in the prone position.

- Never restrain a patient's hands and feet behind the patient, i.e. hog tying.
- Never sandwich patients between backboards or scoop stretchers.

In situations where EMS providers encounter patients under arrest, or in cases where law enforcement personnel have applied handcuffs or plastic ties, assessment should include ensuring sufficient slack in the restraint device to allow unrestricted abdomen and chest wall movement.

NOTE**:** If a patient is restrained by law enforcement personnel with handcuffs or other lockable devices, law enforcement personnel must accompany the patient to the hospital in the ambulance. In other circumstances where restraints are applied by EMS providers, and the patient represents a safety risk, EMS providers should request that law enforcement personnel accompany the patient and crew to the hospital for safety purposes. In cases where restraints are applied, complete and thorough documentation on the ePCR is essential, and should include specific information as to:

- the reasons restraints were needed, and reasonable force was necessary;
- the need for treatment / transport was explained to the patient regardless of capability;
- evidence of the patient's incapability to make an informed decision;
- whether the restraints were applied by law enforcement or EMS agency and under whose orders the restraints were applied;
- failures of less restrictive measures to de-escalate the incident; and
- on-going assessment regarding the monitoring of airway, breathing and circulation, including circulation and motor function in the restrained extremities.

## 8. Rapid Sequence Intubation (RSI) Policy:

Approval of RSI EMS agencies is performed by the Suffolk County RSI Sub-Committee and REMAC. RSI may be performed as a single paramedic on standing orders in any adult patient requiring advanced airway management. A maximum of two intubation attempts (at passing an endotracheal tube) per provider is allowed. If attempts at intubation fail, insertion of a supraglottic airway is required. Use of RSI in pediatric patients requires Suffolk County Medical Control consultation. Use of RSI in Suffolk County requires the EMS agency and all RSI paramedics' participation in the Suffolk County RSI Sub-Committee regional Quality Improvement process.

## Section C: Appendices

### Appendix A: Designated EMS Field Physicians

| | | |
|---|---|---|
| *MD 1* | *Jason Allen Winslow, MD* | *EMS System Medical Director* |
| *MD 103* | *Maury Greenberg, MD* | *Gordon Heights Fire Department* |
| MD 105 | Michael Torelli, MD | East Islip Fire Department |
| *MD 107* | *Jack Geffken, DO* | *Centerport Fire Department* |
| *MD 108* | *David Kugler, MD* | *Melville Fire Department* |
| *MD 110* | *Carl Goodman, DO* | *Port Jefferson Ambulance* |
| MD 120 | Scott Coyne, MD | Cold Spring Harbor Fire Department |
| MD 132 | Frank Adipietro, MD | Town of Shelter Island EMS |
| MD 134 | David Seres, MD | Ocean Beach Fire Department |
| MD 138 | Brian Blaustein, DO | Commack VAC, Sayville VAC |
| *MD 145* | *Christopher Ng, MD* | *Selden Fire Department* |
| *MD 147* | *Juan Acosta, MD* | *CI-Hauppauge Ambulance, Smithtown Fire District* |
| MD 150 | Ben Zabar, MD | Saltaire Fire Department |
| MD 152 | Christopher Ingram, MD | Fishers Island Fire Department |
| *MD 153* | *James Vosswinkel, MD* | *Suffolk County Police Department* |
| MD 154 | Trevor Marshall, MD | Stony Brook University EMS |
| MD 155 | Lauren Maloney, MD | Stony Brook University EMS, Stony Brook VAC |
| MD 156 | Daryl Williams, MD | Ronkonkoma Fire District |
| MD 157 | Chris Guszack, MD | Bay Shore-Brightwaters VAC |
| MD 158 | Joseph Artale, DO | Shirley Community Ambulance |
| MD 159 | Jerry Rubano, MD | Shirley Community Ambulance |
| MD 160 | Andrew Flanagan, DO | South Country Ambulance |
| MD 161 | David Neubert, MD | Commack Amb, Huntington CFAS |
| MD 162 | Devin Howell, MD | Huntington Community FAS |

The physicians denoted in *italics* are members of the Suffolk County Disaster Medical Response Team (DMRT).

## Appendix B: Receiving Hospitals / Hospital Designations

NY State DOH Policy requires transport to the closest appropriate hospital, based on services available and patient needs. While it is not required, it is allowable for agencies on the western-most border to transport to appropriately designated hospitals in Nassau County.

**DESIGNATED 911 RECEIVING HOSPITALS**

Stony Brook Eastern Long Island Hospital
Stony Brook East Hampton Emergency Department
Good Samaritan University Hospital
Huntington Hospital
NYU Langone Hospital -Suffolk
Mather Hospital
Peconic Bay Medical Center
South Shore University Hospital
St. Catherine of Siena Hospital
St. Charles Hospital
Stony Brook Southampton Hospital
Stony Brook University Hospital

**ADULT TRAUMA CENTERS**

| | |
|---|---|
| Stony Brook University Hospital | Level 1 |
| Good Samaritan University Hospital | Level 1 |
| South Shore University Hospital | Level 1 |
| NYU Langone Hospital -Suffolk | Level 2 |
| Huntington Hospital | Level 3 |
| Peconic Bay Medical Center | Level 3 |
| Stony Brook/Southampton Hospital | Level 3 |

**PEDIATRIC TRAUMA CENTERS**

| | |
|---|---|
| Stony Brook University Hospital | Level 1 Pediatric |
| Good Samaritan University Hospital | Level 2 Pediatric |

**REGIONAL BURN CENTER**

Stony Brook University Hospital

**PCI / STEMI CENTERS**

Good Samaritan University Hospital
Huntington Hospital
NYU Langone Hospital -Suffolk
Mather Hospital

Peconic Bay Medical Center
South Shore University Hospital
St. Catherine of Siena Hospital
Stony Brook/Southampton Hospital
Stony Brook University Hospital

**DESIGNATED STROKE CENTERS**

Good Samaritan University Hospital- Comprehensive Stroke Center
Huntington Hospital
NYU Langone Hospital -Suffolk
Mather Hospital
Peconic Bay Medical Center
South Shore University Hospital- Comprehensive Stroke Center
St. Catherine of Siena Hospital
St. Charles Hospital
Stony Brook/Southampton Hospital
Stony Brook University Hospital- Comprehensive Stroke Center

**HOSPITALS WITH OB/GYN SERVICES**

Good Samaritan University Hospital
Huntington Hospital
Peconic Bay Medical Center
South Shore University Hospital
St. Charles Hospital
Stony Brook/Southampton Hospital
Stony Brook University Hospital

**HOSPITALS WITH SANE CENTER AFFILIATIONS**

Good Samaritan University Hospital
Peconic Bay Medical Center
Stony Brook University Hospital

## Appendix C: EMS Response to School Incidents and School Bus Accidents

The New York State Education Law §912 places legal guardianship of the children involved on the school board/school district, including for the health and welfare of all children and the administration of emergency medical evaluation and care for all ill or injured pupils while in their charge. During the transportation phase, the transportation company acts as an agent of the school district during transportation and the bus driver in turn is able to make legal decisions for the children until the arrival of school board/school district/bus company representatives. In Decision 10,587 (1981), the New York State Education Commissioner ruled that the responsibility for the student's safety shifts from the parent/guardian to the school board / school district / bus company from the point of pick up by the school bus in the morning, to drop off by the school bus in the afternoon.

There is no NY State or Suffolk County EMS policy that states that all children must be taken to the hospital if an ambulance is required at the scene. Proper dispositions include one of the following:

- Transportation to the hospital;
- Refusal of Medical Assistance, per NYS Collaborative Protocol and Suffolk County BLS and ALS Policy Manual, in the presence of a legal guardian; or
- No Patient Found designation.

Complete documentation on an ePCR is required for cases where a child is a patient and is transported or in cases where an RMA is executed.

**General Guidelines:**

- If a child has a complaint, or if the EMS provider observes an actual or potential physical injury / illness, or where there is a mechanism of injury, the EMS provider is permitted to render patient care and transport consistent with prehospital protocols and procedures under implied consent. If there is any doubt, always advocate for emergency department evaluation.

- EMS Providers are expected to treat school board/school district/bus company representatives as if they were the child's parent / legal guardian. Clearly state any findings, assessment, and treatment to them. Clearly articulate concerns about real or potential illness / injury. If there is any doubt, always advocate for emergency department evaluation.

- If the child presents themselves without an actual or potential physical injury / illness and the EMS provider also feels that there is no actual or potential injury / illness or significant mechanism of injury, the school board / school district / bus company representative can make legal decisions for the child and can sign the RMA signature section of an ePCR as if they were the child's parent / legal guardian.

- It is acceptable to use an ePCR for each child involved in the school incident or bus accident if the EMS provider chooses to do so. It is also acceptable to use a single ePCR to document assessment and actions, list the names of the children involved, and obtain a single signature from the school board / school district / bus company representative.

- Accountability and the disposition of every child is paramount. Documentation should be shared with school board / school district / bus company representatives to ensure that records match theirs and all children are accounted for, before the alarm is cleared.

- There are circumstances where some children may be patients and received treatment and transportation to a hospital, while others may not. Likewise, there may be circumstances where the occupant(s) of another vehicle are patients and the bus, by nature of its unique size and construction protects occupants resulting in no patients. Accountability and disposition records should include an accounting of which children were transported to the hospital, by name, and by ambulance company, and which children remained at the scene and were turned over to their legal guardian.

In cases where parents or other legal guardians arrive at the scene, no child should be released to his / her parent or other legal guardian without proper validation from school board / school district / bus company representatives.

This sample form may be duplicated and used to document response as an addendum to agency reports to document accountability for cases where an ePCR is not required:

**Alarm#:**_____ **Date:** _____ **Time:**_____

**Fire/EMS Agency:**_____

**Location of Incident:**_____

**School District:**_____**School Representative:**_____

**Transportation Company:**_____

**Bus Operator:**_____

**Police Officer (Name / Badge #):**_____

The following children were involved in a school bus incident. They have been triaged and have been found to offer no complaint, no actual or no potential injury / illness and no significant mechanism of injury. School board, school district/bus company representatives have been advised to **CALL 911 IMMEDIATELY** if there is change in any of the children that raises any suspicion of a potential injury. The appropriate School Representative has made the legal decision to assume legal responsibility for the children.

1. **Print:**_____

**DOB / AGE**_____

2. **Print:**_____

**DOB / AGE**_____

3. **Print:**_____

**DOB / AGE**_____

4. **Print:**_____

**DOB / AGE**_____

5. **Print:**_____

**DOB / AGE**_____

6. **Print:**_____

**DOB / AGE**_____

7. **Print:**_____

**DOB / AGE**_____

8. **Print:**_____

**DOB / AGE**_____

9. **Print:**_____

**DOB / AGE**_____

**School Representative:**

**Print Name:**_____

**Signature:**_____ **Date:**_____

**Highest Ranking EMS Provider on Scene:**

**Print Name:**_____

**Signature:**_____ **Date:**_____

**Witness:**

**Print Name:**_____

**Signature:**_____ **Date:**_____

## Appendix E: Chempack Program

If EMS providers encounter patients with the signs/symptoms of nerve agent/organophosphate poisoning, Suffolk County Department of Fire Rescue and Emergency Medical Services must be contacted to initiate the response procedures for release of Chempack assets. Suffolk County Medical Control must also be contacted to get required medical approval for the use of chemical agent antidote. This authorization is for the event and does not require a patient-specific order for every patient. Each Chempack has enough antidote to treat approximately 1,000 patients.

HUB HOSPITALS feed themselves, SPOKE HOSPITALS and/or the EMS system as follows:

| **HUB HOSPITAL** | **SPOKES** |
|---|---|
| Good Samaritan Hospital | Good Samaritan and EMS System |
| St Catherine of Siena Medical Center | St. Catherine and Huntington Hospital |
| South Shore University Hospital | |
| NYU Langone Hospital -Suffolk | |
| Stony Brook University Hospital | University, EMS System, St. Charles, J.T. Mather |
| Peconic Bay Medical Center | Peconic Bay Medical Center, EMS System, Eastern LI |
| Southampton Hospital | Southampton, EMS System |

In effort to forward deploy chemical agent antidote into local communities, in preparation for a large-scale mass intoxication scenario, the NY State Department of Health maintains the Chempack Program, in partnership with the Centers for Disease Control Strategic National Stockpile Program. Chempack assets are for treatment of exposure to nerve agent/organophosphate-based chemicals only. The following are referred to as HUB HOSPITALS, meaning that they have Chempack stored at the facility:

| | |
|---|---|
| Good Samaritan Hospital | West Islip, NY |
| NYU Langone Hospital -Suffolk | East Patchogue, |
| Peconic Bay Medical Center | Riverhead, NY |
| South Shore University Hospital | Bay Shore, NY |
| St. Catherine of Siena Medical Center | Smithtown, NY |
| Southampton Hospital | Southampton, NY |
| Stony Brook University Hospital | Stony Brook, NY |

The following are referred to as SPOKE HOSPITALS, meaning that they DO NOT have Chempack stored at the facility, but are fed by a specific pre-determined HUB HOSPITAL:

| | |
|---|---|
| Eastern Long Island Hospital | Greenport, NY |
| Huntington Hospital | Huntington, NY |
| J.T Mather Memorial Hospital | Port Jefferson, NY |
| St. Charles Hospital | Port Jefferson, NY |

Chempack assets are for treatment of nerve agent / organophosphate exposure only; and includes:

- Mark I auto-injectors (Atropine 2.0 mg and Pralidoxime 600 mg {2PAM})
- Atropine for IV use
- Pralidoxime (2-PAM) for IV use
- Diazepam (Valium) auto injectors
- Diazepam (Valium) for IV use
- Atropen (Atropine 0.5 mg for pediatrics) auto-injector
- Atropen (Atropine 1.0 mg for pediatrics) auto-injector

- Sterile water

## Appendix F: Automatic Transport Ventilator (ATV)

This policy is intended for use by paramedics in agencies authorized by their agency medical director, in accordance with training supplied by their agency medical director and with a quality improvement review and data sharing mechanism in place.
ATV's may be used as defined in the *Resources: Automatic Transport Ventilator* in the NYS Collaborative Protocols in the following instances:

- Patients with an advanced airway in place

### Ventilator Specifics

To qualify as a ventilator, any device may be used regardless of vendor, manufacturer or model as long as the device:

- Provides 100% oxygen
- Has an adjustable rate
- Has an adjustable tidal volume
- Provides 5cm H20 of PEEP
- Has an alarm that will notify the providers if there is a problem with the circuit
- Allows for patient spontaneous breathing over the ventilator device
- Has a disposable patient circuit