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<i>(2017) Age definition for pediatrics “children without secondary signs of puberty” with emphasis on length-based dosing device and ideal body weight for dose calculations.</i>	
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<i>MC Option: Termination of resuscitation in instances that are not covered by standing order criteria may be authorized by medical control</i>	
<i>Considerations updated to include emphasis on limiting delays of treatment, minimizing chest compression interruptions, AED & CPR related complications during transport and potentially needing to disable pop-off valves for adequate ventilation of patients in cardiac arrest.</i>	
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<i>New addition to NYS Collaborative Protocol</i>	

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No change

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No change

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(2019) CC: Absent amiodarone bolus dilution

(2019) Removal of double sequential defibrillation consideration for persistent ventricular fibrillation

(P2.1.2) CARDIAC ARREST: VENTRICULAR FIBRILLATION OR PULSELESS V TACHYCARDIA – PEDIATRIC30

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New addition to NYS Collaborative Protocol

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New addition to NYS Collaborative Protocol

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No change

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New addition to NYS Collaborative Protocol

(P2.4) RESPIRATORY ARREST / FAILURE – PEDIATRIC37

New addition to NYS Collaborative Protocol

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New addition to NYS Collaborative Protocol

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New addition to NYS Collaborative Protocol

(A3.3) ANAPHYLAXIS – ADULT46

(2019) CFR/ALL LEVELS: If the patient does not improve within 5 minutes, you may repeat epinephrine once

(2019) CFR/ALL LEVELS: If SEVERE respiratory distress, facial or oral edema, and/or hypoperfusion:

- o Administer the epinephrine autoinjector (e.g. EpiPen®), as available and as trained Adult autoinjector 0.3 mg IM (e.g. EpiPen®) if ≥ 30 kg**

If patient has a history of anaphylaxis and has an exposure to an allergen developing respiratory distress and/or hypoperfusion and/or rash:

- o Administer the epinephrine autoinjector (e.g. EpiPen®), as available and as trained Adult autoinjector 0.3 mg IM (e.g. EpiPen®) if ≥ 30 kg**

(2019) EMT: The Syringe Epinephrine for EMT may be substituted for an autoinjector

(2019) EMT: If the patient is wheezing, albuterol 2.5 mg in 3 mL (unit dose), via nebulizer; may repeat to a total of three doses

(2019) Advanced: Epinephrine (1:1,000 / 1mg/mL) 0.3 mg IM, ONLY if patient is hypotensive and/or is developing respiratory distress w/airway swelling, hoarseness, stridor, or wheezing. May repeat every 5 minutes if these symptoms persist

(2019) Advanced: Normal saline 500 mL bolus, if SBP < 100 mmHg or MAP < 65 mmHg; may repeat up to a total of 2 L if lung sounds remain clear. Goal SBP > 100 mmHg and MAP > 65 mmHg

Considerations include Anaphylaxis details: “may present with shock associated only with GI symptoms. In the setting of a known exposure to an allergen associated with shock, nausea, vomiting, abdominal pain, and/or diarrhea, consider anaphylaxis in consult with medical control” and clarification of use of syringe epinephrine kits If equipped and trained.

(P3.3) ANAPHYLAXIS – PEDIATRIC48

(2019) CFR/ALL LEVELS: If the patient does not improve within 5 minutes, you may repeat epinephrine once

(2019) CFR/ALL LEVELS: If SEVERE respiratory distress, facial or oral edema, and/or hypoperfusion:

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(2019) Advanced: Normal saline 500 mL bolus, if SBP < 100 mmHg or MAP < 65 mmHg; may repeat up to a total of 2 L if lung sounds remain clear. Goal SBP > 100 mmHg and MAP > 65 mmHg

Considerations include Anaphylaxis details: “may present with shock associated only with GI symptoms. In the setting of a known exposure to an allergen associated with shock, nausea, vomiting, abdominal pain, and/or diarrhea, consider anaphylaxis in consult with medical control” and clarification of use of syringe epinephrine kits If equipped and trained.

(A3.4.1) BEHAVIORAL EMERGENCIES: AGITATED PATIENT – ADULT50

Considerations updated to include scene and crew safety considerations, rule-out causes of underlying condition, developmental disorder complications and emphasis on team based approach to management of patient.

(P3.4.1) BEHAVIORAL EMERGENCIES: AGITATED PATIENT – PEDIATRIC52

New addition to NYS Collaborative Protocol

(A3.4.2) BEHAVIORAL EMERGENCIES: EXCITED DELIRIUM – ADULT54

No change

(3.5) CARBON MONOXIDE EXPOSURE – SUSPECTED56

(2019) CFR/ALL LEVELS: Any patient with suspected carbon monoxide poisoning should receive high flow oxygen via non-rebreather mask (NRB)

(2019) Paramedic: If there is no soot in the airway, consider CPAP 5-10 cm H₂O (if the device delivers 100% oxygen)*

o For the adult patient

o For older pediatric patients consider CPAP, as equipment size allows if available and trained

(2019) BiPAP removed as option in place of CPAP

(A3.6.1) CARDIAC ARRHYTHMIA: BRADYCARDIA / HEART BLOCKS – SYMPTOMATIC - ADULT58

No change

(P3.6.1) CARDIAC ARRHYTHMIA: BRADYCARDIA - PEDIATRIC59

No change

(A3.6.2.1) CARDIAC ARRHYTHMIA: TACHYCARDIA – NARROW COMPLEX – ADULT.....60

No change

(A3.6.2.1) CARDIAC ARRHYTHMIA: TACHYCARDIA – WIDE COMPLEX WITH A PULSE – ADULT62

(2019) CC: If irregularly irregular, cardioversion may be initiated at 200 Joules

(P3.6.2) CARDIAC ARRHYTHMIA: TACHYCARDIA - PEDIATRIC64

No change

(A3.7) CARDIAC RELATED PROBLEM / CHEST PAIN – ADULT66

(2019) Advanced: Nitroglycerin 0.4 mg SL per dose, as needed, 5 minutes apart, provided the patient's systolic BP is > 120mmHg or MAP > 90 mmHg

(P3.7) CARDIAC RELATED PROBLEM – PEDIATRIC68

New addition to NYS Collaborative Protocol

(A3.8) CARDIOGENIC SHOCK – ADULT.....70

(2019) CFR/ALL LEVELS: Airway management and appropriate oxygen therapy

*(2019) CFR/ALL LEVELS: Aspirin 324 mg (4 x 81 mg tabs) chewed, only if able to chew**

(3.9.0) CHILDBIRTH: OBSTETRICS72

No change

(3.9.1) CHILDBIRTH: PRETERM LABOR (24 – 37 WEEKS)74

No change

(P3.9.2) CHILDBIRTH: NEWBORN / NEONATAL CARE75

New addition to NYS Collaborative Protocol (which includes details on delivery AND neonatal resuscitation)

(A3.10.0) DIF BREATHING: ASTHMA / COPD / WHEEZING - ADULT77

(2019) Advanced: Epinephrine (1:1,000 / 1mg/mL) dose 0.3 mg IM for severe distress o If severe distress persists, may repeat in 5 minutes

(2019) Advanced: Albuterol 2.5 mg in 3 mL (unit dose), via nebulizer or ET tube nebulizer; may repeat to a total of three doses for wheezing

(2019) Paramedic: For the patient with asthma, if the patient is not responding to treatments above, administer magnesium 2 grams in 100 mL normal saline IV over 10 minutes

(2019) MC Considerations: Use of albuterol via nebulizer by EMT for indications other than asthma

(2019) MC Considerations: Use of epinephrine by EMT for critical asthma attack (EMT Syringe Epinephrine or autoinjector)

(2019) MC Considerations: Epinephrine (1:1,000 / 1 mg/mL) 3 mg via nebulizer or racemic epinephrine (2.25%) 0.5 mL in 3 mL of normal saline via nebulizer

(2019) MC Considerations: Magnesium for COPD exacerbation

(2019) MC Considerations: Repeat magnesium

(A3.10.1) DIF BREATHING: PULMONARY EDEMA – ADULT79

(2019) MC Considerations: Nitroglycerin option for Advanced

(P3.10.2) DIF BREATHING: ASTHMA / WHEEZING - PEDIATRIC.....81

(2019) CFR/ALL LEVELS: BLS management and updated with direction to additional protocols

(2019) Advanced: removal of Epi autoinjector under standard protocol (MC option)

(2019) Advanced: For older pediatric patients consider CPAP for EMT, as equipment size allows if available and trained

(P3.10.3) DIF BREATHING: STRIDOR - PEDIATRIC83

(2019) Advanced: updated for condition specific protocol direction

Considerations updated

(3.11.1) ENVIRONMENTAL - COLD EMERGENCIES85

(2019) General care for hypothermic patient added to CFR/ALL LEVELS with Paramedic level care including extremity rewarming.

(2019) Considerations include: "Pulse oxygenation measurement may be inaccurate if the patient is hypothermic. If the patient is cyanotic and in apparent respiratory distress, administer oxygen"

(3.11.2) ENVIRONMENTAL - HEAT EMERGENCIES87

No change

(3.12) FEVER – ADULT88

New addition to NYS Collaborative Protocol

(P3.12) FEVER – PEDIATRIC90

New addition to NYS Collaborative Protocol

(A3.13) HYPERKALEMIA - ADULT92

No change

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No change

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No change

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(P3.15) HYPOGLYCEMIA – PEDIATRIC	98
<i>(2019) EMT: Check pupils and, if constricted, consider “General: Opioid (Narcotic) Overdose” protocol</i>	
<i>(2019) EMT: PO management of hypoglycemia outlined</i>	
<i>(2019) Advanced: If unable to obtain adequate results with oral glucose consider glucagon 0.5 mg IM if < 20 kg, otherwise, 1 mg IM*, if needed</i>	
(A3.16) NAUSEA AND/OR VOMITING - ADULT	100
<i>No change</i>	
(P3.16) NAUSEA AND/OR VOMITING (> 2 Y/O) - PEDIATRIC	101
<i>No change</i>	
(3.17) OPIOID (NARCOTIC) OVERDOSE	102
<i>(2019) EMT: In the pediatric patient, administer naloxone (Narcan®) 1 mg** intranasal; 1/2 mg per nostril, may repeat once in 5 minutes, if no significant improvement occurs</i>	
<i>(2019) Advanced (from 2017 Paramedic): Titrate naloxone (Narcan) to max 2 mg per dose IV, IM, or intranasal, ONLY if hypoventilation or respiratory arrest. (Consider administering in ≤ 0.5 mg increments, if giving IV)</i>	
<i>(2019) Considerations include: **May substitute alternative FDA and SEMAC approved, commercially prepared 4mg nasal spray unit dose device</i>	
<i>o This device is approved for the full 4 mg dose in the adult or pediatric patient</i>	
<i>o Administer 4mg in 1 nostril as a single spray</i>	
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<i>(2019) Paramedic: For the pediatric patient: Atropine 1 mg IV every 3-5 minutes, until secretions dry</i>	
<i>• For seizures:</i>	
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<i>For pediatric seizures see, “General: Seizures – Pediatric” protocol</i>	

(A3.19) PAIN MANAGEMENT - ADULT	105
<i>(2019) Advanced: If able to tolerate oral fluid consider one of the following:</i>	
<i>o Acetaminophen 650 mg / 20.3 mL PO (2 – 325 mg / 10.15 mL PO unit doses)*</i>	
<i>o Ibuprofen 400 mg / 20 mL PO (4 – 100 mg / 5 mL PO unit doses)*</i>	
<i>(2019) Paramedic: Ketorolac (Toradol) 15 mg IV or 30 mg IM</i>	
<i>(2019) Considerations updated to include details on NSAIDs (Acetaminophen/Ibuprofen)</i>	
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<i>(2019) Considerations updated to include details on NSAIDs (Acetaminophen/Ibuprofen)</i>	
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No change other than formatting

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No change

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New addition to NYS Collaborative Protocol

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(2019) EMT: For older pediatric patients consider CPAP, as equipment size allows if available and trained

(A3.27) ST ELEVATION MI (STEMI) – CONFIRMED – ADULT131

(2019) EMT: For patients with a STEMI, confirmed by medical control, begin transport to a facility capable of primary angioplasty if estimated arrival to that facility is within 90 minutes of patient contact or if directed by medical control or regional procedure

(2019) Paramedic: Updated BP/MAP guidelines for fluid bolus administration

(3.28) STROKE133

No change

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<i>(2019) Paramedic: Vascular access and "Pain management protocol" referral moved from <u>Advanced</u></i>	
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No change

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No change

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No change

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No change

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<i>No change</i>	
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<i>New addition to NYS Collaborative Protocol</i>	

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No change

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No change