



# NYC REMAC

## PUBLIC NOTICE

### PROPOSED REVISIONS PREHOSPITAL TREATMENT PROTOCOLS

The Regional Emergency Medical Advisory Committee (REMAC) of New York City Prehospital Treatment Protocols define the minimum standard of care provided to patients by Certified First Responders (CFRs), Emergency Medical Technicians (EMTs), and Advanced Emergency Medical Technicians-Paramedic (AEMT-Ps) in New York City. These protocols reflect both the curriculum and certification requirements of the New York State Department of Health Bureau of Emergency Medical Services and the Regional Emergency Medical Advisory Committee (REMAC) of New York City.

**The REMAC of New York City has proposed revisions to the current regional Prehospital Treatment Protocols.**

Deleted language is BOLD RED AND STRUCK-OUT --- **DELETED**

New language is BOLD BLUE AND UNDERLINED --- **NEW**

In order to meet regional needs, the REMAC of New York City is conducting a public notice and is requesting comments from the Emergency Medical community. Comments must be submitted in writing on the attached 'Comment Form'. If available, appropriate supporting documentation should also be attached. **Comments must be received no later than May 16, 2011.**

**Draft revised protocols can be reviewed on-line at [www.nycremsco.org](http://www.nycremsco.org) (under "News and Announcements"). All NYC REMAC Protocols can be accessed in their entirety at [www.nycremsco.org](http://www.nycremsco.org).**

**DIRECT ALL INQUIRES AND COMMENTS TO:**

**Joseph Bove, MD  
Chair, Protocol Committee  
Regional Emergency Medical Advisory Committee of New York City  
c/o Regional EMS Council of NYC  
475 Riverside Drive, Suite 1929  
New York, New York 10115  
Telephone: (212) 870-2301 FAX: (212) 870-2302**

**PLEASE BE ADVISED THAT** pursuant to Section 3004-A of Article 30 of the Public Health Law of the State of New York, the Regional Emergency Medical Advisory Committee (REMAC) of New York City is responsible to develop prehospital triage, treatment, and transportation protocols that are consistent with the standards of the State Emergency Medical Advisory Committee and that address specific local conditions with regards to the provision of prehospital medical care rendered by NYS Department of Health certified First Responders, Emergency Medical Technicians and Advanced Emergency Medical Technicians within the City of New York.



# THE REGIONAL EMERGENCY MEDICAL SERVICES COUNCIL OF NEW YORK CITY, INC.



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April 14, 2011

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Emergency Department Medical Directors

FROM: NYC REMAC

RE: NYC REMAC Public Notice of Protocol Revisions

Please find attached the Public Notice for proposed revisions to the NYC  
REMAC Protocols. A list of proposed revisions is attached.

**Proposed protocol revisions can be reviewed on line at:**  
[www.nycremsco.org](http://www.nycremsco.org) (under "News and Announcements")

All current NYC REMAC Protocols can be accessed in their entirety at  
[www.nycremsco.org](http://www.nycremsco.org).

Deleted language is BOLD RED AND STRUCK-OUT – **DELETED**  
New language is BOLD BLUE AND UNDERLINED – **NEW**

All comments must be submitted in writing no later than **May 16, 2011** on the  
attached 'Comment Form'. If available, please attach all appropriate  
supporting documentation.

Thank you.

**Protocol Revisions as approved by REMAC on April 5<sup>th</sup>, 2011**

**Paramedic (ALS) Protocols: Pediatrics**

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**543: NEONATE RESUSCITATION**

**Moving IV/IO and epinephrine to Standing Order, and resulting removal of all Medical Control Options**

Rationale: Although neonatal resuscitation to the point of requiring or receiving epinephrine is a rare event, the committee felt that those neonatal resuscitations progressing to this stage in the prehospital setting should not require OLMC contact for medications that are routinely given under standing orders in other resuscitations, particularly given the delay in care that occurs with OLMC contacts. For this reason, it was recommended that the use of epinephrine in neonatal resuscitations be moved from medical control options to standing orders.

**550: PEDIATRIC RESPIRATORY ARREST**

**Naloxone changes**

Rationale: Consistent with the adult ALS respiratory failure / arrest management protocol, the committee recommends that this protocol be changed to emphasize the airway management aspects of such cases and therefore recommends the removal of Naloxone from the protocol. Reference will be made to the altered mental status protocol, but the committee felt that a child for whom airway management had already been performed (and therefore the narcotic-induced issue already remedied) should not routinely receive Naloxone and put that airway management at risk.

**551: PEDIATRIC OBSTRUCTED AIRWAY**

**Cuffed endotracheal tube clarification**

**552: PEDIATRIC CROUP/EPIGLOTTITIS**

**Epinephrine as Medical Control Option for Croup**

Rationale: Among the pediatric patients with croup for whom EMS is called, there is a population with moderate to severe croup whose respiratory distress may be prolonged due to the time required to move the patient to the ambulance (multi-story carry down), transport the patient to the hospital (traffic, weather), or for whom the respiratory distress may be immediately recognized to be so severe that awaiting treatment until after arrival in the ED may be perilous. Therefore, the committee recommends adding a medical control option that allows for the use of nebulized epinephrine in such circumstances.

**553: PEDIATRIC NON-TRAUMATIC CARDIAC ARREST**

**AHA change regarding joule setting, also includes clarification regarding advanced airway management**

**555: PEDIATRIC ANAPHYLACTIC REACTION**

**Reprioritizing Epinephrine and Endotracheal Intubation in anaphylaxis**

Rationale: The administration of epinephrine is a time critical skill, as is the need for advanced airway management and the recognition of a severe airway edema in order to avoid respiratory arrest in such patients. Therefore the committee recommends altering this protocol to reflect these priorities.

**557: PEDIATRIC SEIZURES**

**Changes to Benzodiazepine use for pediatric seizures**

Rationale: Given the demonstrated safe use of standing order benzodiazepines in adult seizure patients and the implementation of alternative routes for administration in the pediatric population (IM and IN), the committee recommends allowing for the use of IM/IN midazolam for standing order management in seizures. Should seizure activity continue, medical control options would include the use of additional IN/IM benzodiazepines as well as IV benzodiazepines (the latter appearing only as medical control options out of concern for dosing, adverse effects related to respiratory status, etc). Additionally, given the multiple options available for seizure management and the concerning safety profile for rectal diazepam, the committee recommends the removal of this medical control option from the protocol.

**559: PEDIATRIC TRAUMATIC CARDIAC ARREST**

**Clarification of advanced airway management**

**Complete ALS Protocols can be found at the REMSCO website:**  
[http://www.nycremsco.org/images/articlesserver/ALS\\_Protocols\\_January\\_2010\\_v01012010d.pdf](http://www.nycremsco.org/images/articlesserver/ALS_Protocols_January_2010_v01012010d.pdf)

Draft Revisions to:

- 543: Neonate Resuscitation
- 550: Pediatric Respiratory Arrest
- 551: Pediatric Obstructed Airway
- 552: Pediatric Croup/Epiglottitis
- 553: Pediatric Non-Traumatic Cardiac Arrest
- 555: Pediatric Anaphylactic Reaction
- 557: Pediatric Seizures
- 559: Pediatric Traumatic Cardiac Arrest

New language is **bold/blue/underlined**

Deleted language is **~~red/bold/struckout~~**

543

NEONATE RESUSCITATION

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~~For neonates requiring resuscitation whose amniotic fluid does not contain thick meconium:~~

1. Begin Basic Life Support Neonatal Resuscitation procedures.

~~For neonates requiring resuscitation whose amniotic fluid does contain thick meconium and who are limp, apneic, or pulseless:~~

- ~~1. Begin Basic Life Support Neonatal Resuscitation procedures only after the airway has been cleared of thick meconium, as follows:~~
  - ~~a. Perform Endotracheal Intubation and directly suction the Endotracheal Tube via a Meconium Aspirator/Adapter while slowly withdrawing the Endotracheal Tube.~~
  - ~~b. Repeat this procedure until the Endotracheal Tube is clear of thick meconium, up to 2 more times (total of 3 times).~~

~~NOTE: DO NOT REPLACE THE ENDOTRACHEAL TUBE ONCE THE AIRWAY HAS BEEN CLEARED OF THICK MEGONIUM UNLESS THE NEONATE REMAINS LIMP, APNEIC, OR PULSELESS.~~

~~For ALL neonates requiring resuscitation once Basic Life Support Neonatal Resuscitation procedures have begun:~~

2. If CPR has been initiated, and the heart rate remains less than 60 beats per minute and not rapidly increasing after 30 seconds of CPR, perform Endotracheal Intubation.

~~NOTE: DO NOT INTUBATE UNLESS OTHER METHODS OF AIRWAY MANAGEMENT ARE NOT EFFECTIVE, I.E., DO NOT SUCCESSFULLY INCREASE THE HEART RATE.~~

During transport, or if transport is delayed:

3. If abdominal distention occurs, pass a Nasogastric Tube. If unsuccessful, pass an Orogastic Tube.
4. If Endotracheal Intubation has been performed, and the heart rate remains less than 60 beats per minute, administer Epinephrine 0.1 mg/kg (1 ml/kg of a 1:10,000 solution), via the Endotracheal Tube.
5. If transport is delayed or extended, begin an IV or IO infusion of Normal Saline (0.9% NS) to keep vein open, or a Saline Lock. Do not attempt vascular access more than twice.
6. Begin an IV/Saline Lock or IO infusion of Normal Saline (0.9% NS), 10ml/kg.
7. Administer Epinephrine 0.01 mg/kg (0.1 ml/kg of a 1:10,000 solution) IV/Saline Lock or IO, every 3-5 minutes.
8. Transport Decision
  - ~~1. If Epinephrine has been administered, and the heart rate still remains less than 60 beats per minute, the respiratory rate remains less than 30 breaths per minute, or the neonate remains cyanotic or limp, contact Medical Control for implementation of one or more of the following MEDICAL CONTROL OPTIONS:~~

~~MEDICAL CONTROL OPTIONS~~

~~OPTION A: Repeat Epinephrine 0.1 mg/kg (1 ml/kg of a 1:10,000 solution), via the Endotracheal Tube.~~

~~OPTION B: If transport is delayed or extended, begin an IV or IO infusion of Normal Saline (0.9% NS) to keep vein open, or a Saline Lock. Do not attempt vascular access more than twice.~~

~~OPTION C: If transport is delayed or extended, and the neonate is pale and has slow or absent central pulses, administer Epinephrine 0.01 mg/kg (0.1 ml/kg of a 1:10,000 solution) IV/Saline Lock, or IO.~~

~~OPTION D: If transport is delayed or extended, and the neonate is pale and has weak but rapid central pulses, begin an IV/Saline Lock or IO infusion of Normal Saline (0.9% NS) 10 ml/kg.~~

~~OPTION E: Transportation Decision.~~

550

PEDIATRIC RESPIRATORY ARREST

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For pediatric patients in actual or impending respiratory arrest, or who are unconscious and cannot be adequately ventilated:

**NOTE: IF OVERDOSE IS SUSPECTED, REFER TO PROTOCOL 556 (Pediatric Altered Mental Status)**

1. Begin Basic Life Support Pediatric Respiratory Distress/Failure procedures.

**NOTE: DO NOT HYPER-EXTEND THE NECK. IF AN OBSTRUCTED AIRWAY IS SUSPECTED, SEE PROTOCOL #551.**

2. Perform Endotracheal Intubation, if less invasive methods of airway management are not effective.
3. If a tension pneumothorax is suspected, perform Needle Decompression, using an 18-20 gauge catheter. (See Appendix O.)

**NOTE: TENSION PNEUMOTHORAX IN A CHILD IN RESPIRATORY ARREST MAY DEVELOP AFTER RESUSCITATIVE EFFORTS HAVE BEGUN.**

During transport, or if transport is delayed:

4. Administer Naloxone, **titrate in increments of 0.8 mg, IM, up to response, up to 2 mg, in patients two (2) years of age or older. In patients less than two (2) years of age, titrate up to 1 mg. 2 mg, IM, or via the Endotracheal Tube, in patients two (2) years of age or older. Use half the amount (1 mg) of this drug in patients less than two (2) years of age.** (Refer to Length Based Dosing Device)
5. If abdominal distention occurs, pass a Nasogastric Tube. If unsuccessful, pass an Orogastric Tube.
6. If there is insufficient improvement in respiratory status, contact Medical Control for implementation of one or more of the following MEDICAL CONTROL OPTIONS:

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MEDICAL CONTROL OPTIONS:

OPTION A: Begin an IV or IO infusion of Normal Saline (0.9% NS) to keep vein open, or a Saline Lock. Attempt vascular access no more than twice.

~~OPTION B: Administer Naloxone 2 mg, IV/Saline Lock or IO bolus, via the Endotracheal Tube or IM, in patients two (2) years of age or older. Use half the amount (1 mg) of this drug in patients less than two (2) years of age. (Refer to Length Based Dosing Device)~~

OPTION C: Transportation Decision.

551

PEDIATRIC OBSTRUCTED AIRWAY

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For pediatric patients who are unconscious or cannot breathe, cough, speak, or cry:

1. Begin Basic Life Support Pediatric Obstructed Airway procedures.
2. Perform Direct Laryngoscopy. Attempt to remove the foreign body with appropriate size Magill Forceps.

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NOTE: IF AN ENLARGED EPIGLOTTIS IS VISUALIZED, SEE PROTOCOL #552.

3. Perform Endotracheal Intubation, if less invasive methods of airway management are not effective.
4. If able to confirm intubation via direct visualization but unable to ventilate:
  - a. Note the Endotracheal Tube depth
  - b. **If using a cuffed tube, d**eflate the Endotracheal Tube cuff
  - c. Advance the Endotracheal Tube to its deepest depth
  - d. Return the Endotracheal Tube to its original depth
  - e. **If using a cuffed tube, r**einflate the Endotracheal Tube cuff and attempt ventilation again
  - f. If unable to effectively ventilate the patient using the above maneuvers, immediately initiate transport
4. Transportation Decision.

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552

PEDIATRIC CROUP/EPIGLOTTITIS

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1. Begin Basic Life Support Pediatric Croup/Epiglottitis procedures.

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**NOTE: DO NOT ATTEMPT ENDOTRACHEAL INTUBATION. USE HIGH PRESSURE BAG-VALVE-MASK ~~OR MOUTH-TO-MASK VENTILATION. (MOUTH-TO-MOUTH OR MOUTH-TO-MOUTH AND NOSE VENTILATION MAY BE USED AT PROVIDER OPTION.)~~**

During transport, of if transport is delayed:

2. If abdominal distention occurs, pass a Nasogastric Tube. If unsuccessful, pass an Orogastic Tube.

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**NOTE: DO NOT ATTEMPT TO PASS A NASOGASTRIC OR OROGASTRIC TUBE IN A CONSCIOUS PATIENT.**

3. Transportation Decision.
4. If transportation is delayed or extended, contact Medical Control for implementation of one or more of the following MEDICAL CONTROL OPTIONS:

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**MEDICAL CONTROL OPTIONS:**

**OPTION A: Administer Epinephrine 0.5 mg (1:1,000 solution) diluted in 3 ml normal saline via nebulizer.**

**OPTION B: Transportation Decision.**

553 (AHA Change)  
PEDIATRIC NON-TRAUMATIC CARDIAC ARREST

1. Begin Basic Life Support Pediatric Non-Traumatic Cardiac Arrest procedures.
2. Begin Cardiac Monitoring, record and evaluate EKG rhythm.
3. If in ventricular fibrillation or pulseless ventricular tachycardia:
  - a. Immediately Defibrillate at 4 2 joules/kg, using paddles of appropriate size. (Refer to Length Based Dosing Device)
  - b. Immediately resume CPR for 5 cycles while defibrillator is recharging.
4. If still in ventricular fibrillation or pulseless ventricular tachycardia:
  - Immediately repeat Defibrillation at 10 4 joules/kg, using paddles of appropriate size. (Refer to Length Based Dosing Device)
4. Immediately resume CPR for 5 cycles while defibrillator is recharging.

NOTE: IF THE DEFIBRILLATOR IS UNABLE TO DELIVER THE RECOMMENDED DOSE, USE THE LOWEST AVAILABLE SETTING.

5. Perform ~~Endotracheal Intubation~~ Advanced Airway Management if less invasive methods of airway management are not effective.

During transport, or if transport is delayed:

6. If the patient is intubated, administer Epinephrine 0.1 mg/kg (0.1 ml/kg of a 1:1,000 solution), via the Endotracheal Tube. (Refer to Length Based Dosing Device)
7. If abdominal distention occurs, pass a Nasogastric Tube. If unsuccessful, pass an Orogastic Tube.
8. Begin an IV or IO infusion of Normal Saline (0.9% NS) to keep vein open, or a Saline Lock. Attempt vascular access no more than twice.
9. If still in ventricular fibrillation or pulseless ventricular tachycardia:
  - Immediately repeat Defibrillation at 4 joules/kg, using paddles of appropriate size. (Refer to Length Based Dosing Device)
  - Immediately resume CPR for 5 cycles while the Defibrillator is recharging.
  - Administer Amiodarone, 5 mg/kg, IV/Saline Lock, or IO. (Refer to Length Based Dosing Device)
10. Repeat Epinephrine 0.01 mg/kg (0.1 ml/kg of a 1:10,000 solution) IV/Saline Lock or IO bolus every 3-5 minutes. (Refer to Length Based Dosing Device)

OR

If vascular access has not been established, repeat epinephrine 0.1 mg/kg (0.1 ml/kg of a 1:1,000 solution) via the Endotracheal Tube every 3-5 minutes. (Refer to Length Based Dosing Device)

NOTE: THE IV/SALINE LOCK OR IO DOSE OF EPINEPHRINE FOR PEDIATRIC PATIENTS IS 0.01 MG/KG (0.1 ML/KG OF A 1:10,000 SOLUTION). THE ENDOTRACHEAL TUBE DOSE

# THE REGIONAL EMERGENCY MEDICAL SERVICES COUNCIL OF NEW YORK CITY, INC.

*Public Notice – Proposed Revisions NYC REMAC Protocols – April 2011*

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OF EPINEPHRINE FOR PEDIATRIC PATIENTS IS 0.1 MG/KG (0.1 ML/KG OF A 1:1,000 SOLUTION).

11. If there is insufficient improvement in hemodynamic status, contact Medical Control for implementation of one or more of the following MEDICAL CONTROL OPTIONS:

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## MEDICAL CONTROL OPTIONS:

- OPTION A: Repeat any of the above Standing Orders.
- OPTION B: Administer Naloxone 2 mg IV/Saline Lock or IO bolus, or via the Endotracheal Tube, in patients two years of age or older. Use half the amount (1 mg) of this drug in patients less than two (2) years of age. (Refer to Length Based Dosing Device)
- OPTION C: Administer Dextrose 0.5 gm/kg, IV/Saline Lock or IO bolus. Use 10% Dextrose in patients less or equal to one (1) month of age. Use 25% Dextrose in patients greater than one (1) month of age and less than 14 years of age. (Refer to Length Based Dosing Device)
- OPTION D: Administer Sodium Bicarbonate 1 mEq/kg, IV/Saline Lock or IO bolus. (Refer to Length Based Dosing Device)
- OPTION E: If torsades de pointes is present, administer Magnesium Sulfate, 25-50 mg/kg, IV/Saline Lock, or IO.
- OPTION F: Begin rapid IV/Saline Lock, or IO infusion of Normal Saline (0.9% NS), 20 ml/kg. (Refer to Length Based Dosing Device)
- OPTION G: Transportation Decision.

PEDIATRIC ANAPHYLACTIC REACTION

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1. Begin Basic Life Support Anaphylactic Reaction procedures.
- ~~2. If the patient develops signs of respiratory failure, airway obstruction, or decompensated shock, perform Endotracheal Intubation, and Administer Epinephrine 0.01 mg/kg (0.01 ml/kg of a 1:10,000 solution), via the Endotracheal Tube. (Refer to Length Based Dosing Device)~~
2. ~~If Endotracheal Intubation cannot be accomplished,~~ Administer Epinephrine 0.01 mg/kg (0.01 ml/kg of 1:1,000 solution), IM. Maximum dose is 0.3 mg (0.3 ml of a 1:1,000 solution.) (Refer to Length Based Dosing Device)
3. Perform Endotracheal Intubation, if less invasive methods of airway management are not IMMEDIATELY effective.
4. Monitor vitals signs every 5 minutes.

During transport, or if transport is delayed:

5. If abdominal distention occurs, pass a Nasogastric Tube. If unsuccessful, pass an Orogastic Tube.
6. If the patient develops or remains in decompensated shock, contact Medical Control for implementation of one or more of the following MEDICAL CONTROL OPTIONS:

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MEDICAL CONTROL OPTIONS:

OPTION A: Repeat any of the above Standing Orders.

OPTION B: Begin an IV or IO infusion of Normal Saline (0.9% NS) via a large bore IV (18-22 gauge) or IO catheter to keep the vein open, or a Saline Lock. Attempt vascular access no more than twice.

OPTION C: Begin rapid IV/Saline Lock or IO infusion of Normal Saline (0.9% NS), 20 ml/kg. Repeat as necessary. (Refer to Length Based Dosing Device)

OPTION D: Transportation Decision.

PEDIATRIC SEIZURES

For patients experiencing seizures that are ongoing or recurring:

1. Begin Basic Life Support Seizures procedures.

During transport, or if transport is delayed:

2. Administer Glucagon 1 mg, IM.
3. For on-going seizure activity, administer Midazolam 0.1 mg/kg (maximum dose is 5 mg), IN/IM. (Refer to Length Based Dosing Device).
4. Begin an IV or IO infusion of Normal Saline (0.9% NS) to keep vein open, or a Saline Lock. Attempt vascular access no more than twice.
5. Administer Dextrose 0.5 gm/kg, IV/Saline Lock or IO bolus. Use 10% Dextrose in patients less or equal to one (1) month of age. Use 25% Dextrose in patients greater than one (1) month of age and less than 14 years of age. (Refer to Length Based Dosing Device)
6. If seizures persist, contact Medical Control for implementation of one or more of the following MEDICAL CONTROL OPTIONS:

MEDICAL CONTROL OPTIONS:

OPTION A: Administer Lorazepam (**ATIVAN**) 0.05 mg/kg, IV/~~IN~~/Saline Lock or IO bolus, slowly, over 2 minutes. Repeat doses of Lorazepam (**ATIVAN**) 0.05 mg/kg, IV/~~IN~~/Saline Lock or IO bolus, slowly, over 2 minutes, may be given if seizures persist. (Refer to Length Based Dosing Device)

OR

Administer Diazepam 0.1mg/kg, IV/Saline Lock or IO bolus, slowly, over 2 minutes. Repeat doses of Diazepam 0.1 mg/kg, IV/Saline Lock or IO bolus, slowly, over 2 minutes, may be given if seizures persist. (Refer to Length Based Dosing Device)

~~OPTION B: If IV/Saline Lock or IO access has not been established, administer Midazolam 0.1 mg/kg, IM or IN. (Maximum dose is 5 mg.) (Refer to Length Based Dosing Device)~~

~~OR~~

~~If IV/Saline Lock or IO access has not been established, administer Diazepam 0.5 mg/kg, via rectum. (Refer to Length Based Dosing Device)~~

NOTE: DO NOT ADMINISTER LORAZEPAM, DIAZEPAM, OR MIDAZOLAM IF THE SEIZURES HAVE STOPPED.

OPTION C: Transportation Decision.

PEDIATRIC TRAUMATIC CARDIAC ARREST

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NOTE: FOR PEDIATRIC PATIENTS IN TRAUMATIC CARDIAC ARREST, RAPID TRANSPORT IS THE HIGHEST PRIORITY!

1. Begin transportation of the patient and other Basic Life Support Traumatic Cardiac Arrest procedures.  
During transport, or if transport is delayed:
2. Perform **Endotracheal Intubation** [Advanced Airway Management](#) if other methods of airway control are not effective.
3. If a tension pneumothorax is suspected, perform Needle Decompression. (See Appendix O.)
4. Begin rapid IV/Saline Lock or IO infusion of Normal Saline (0.9% NS) or Ringer's Lactate (RL), 20 ml/kg, via a large bore IV (18-22 gauge) or IO catheter, or a Saline Lock. Attempt vascular access no more than twice. (Refer to Length Based Dosing Device)
5. If abdominal distention occurs, pass a Nasogastric Tube. If unsuccessful, or in patients with craniofacial trauma, pass an Orogastric Tube.

NOTE: DO NOT PASS A NASOGASTRIC TUBE IN PATIENTS WITH CRANIOFACIAL TRAUMA.

6. If the patient remains in traumatic cardiac arrest, continue rapid IV/Saline Lock or IO infusion of Normal Saline (0.9% NS) or Ringer's Lactate (RL), 20 ml/kg (total of 40 ml/kg), via a second large bore IV (18-22) catheter, or a Saline Lock (if necessary). Attempt second IV no more than twice. (Refer to Length Based Dosing Device)
7. If the patient still remains in traumatic cardiac arrest, contact Medical Control for implementation of one or more of the following MEDICAL CONTROL OPTIONS:

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MEDICAL CONTROL OPTIONS:

OPTION A: Continue rapid IV or IO infusion of Normal Saline (0.9% NS) or Ringer's Lactate (RL) up to an additional 20 ml/kg (total of 60 ml/kg). (Refer to Length Based Dosing Device)

OPTION B: Transportation Decision.