



July 28, 2000

**ERIE COUNTY
MEDICAL CENTER
HEALTHCARE
NETWORK**

Dear EMS Officer,

I would like to take a moment of your time to help clarify some information that you recently received from the NYS Department of Health. The information involved recent legislation to allow Certified First Responders (CFR's) and Emergency Medical Technician-Basics (EMT-B's) to administer Epinephrine Auto-Injectors for severe anaphylaxis and a Nebulizer with Albuterol for asthma. Unfortunately, the information included in the packet did not provide your agency with everything needed to implement these programs.

The Office of Prehospital Care at ECMC and Western Regional EMS (WREMS) will be working collaboratively to make this transition as smooth and simple as possible. To help make our goal come to fruition, I would ask that you do the following:

- Complete the enclosed paperwork to the best of your ability, leaving anything you are unsure of, BLANK.
- Call WREMS (898-5072) to schedule the **required** training session.
- Once the paperwork is completed and signed, please mail to:

Scott Wander, EMT-P, Coordinator
Office of Prehospital Care
Department of Emergency Medicine
462 Grider Street
Buffalo, New York 14215

- Once I receive the completed documents, I will have Dr. Billittier sign them and will then hand deliver them to WREMS.

If you follow this process, your agency will be able to go "on-line" with this program as soon as you complete the training session that you schedule with WREMS. In an effort to present a consistent curriculum at each agency, we will not allow the initial training to be done by "in-house" members. WREMS and/or the Office of Prehospital Care will provide this initial training. We apologize for any inconvenience that this may cause, but it is clear that we need to have a unified, consistent curriculum presented at each agency.

Thank you again for your time and patience. We apologize if any of the information that you have already received was misleading. I assure you that we will make every effort to make this transition simple and expedient. Should you have any questions regarding this matter, please do not hesitate to call 898-3725 or e-mail: swander@ecmc.edu.

Many thanks again for your hard work and dedication!

Sincerely,

Scott Wander, EMT-P
Coordinator
Office of Prehospital Care
Department of Emergency Medicine
Erie County Medical Center

462 Grider Street
Buffalo, New York
14215
716-898-3000
www.ecmc.edu

Medical Director

Anthony Billittier, IV, MD
(716) 898-3525

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(716) 898-3240

Director

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(716) 898-3580

Coordinator

Scott Wander, EMT-P
(716) 898-3725

Assistant Coordinator

Jason Miles, EMT-I
(716) 898-4715

Network Locations

- Erie County Medical Center
- Erie County Home
- Family Health Centers
 - Bailey
 - Cleve-Hill
 - Eggertsville
- Dr. Matt Gajewski
 - Human Services Center
 - Dialysis Center at Cleve-Hill



c/o Erie County Medical Center
462 Grider Street
Buffalo, NY 14215-3098
(716) 898-5072
Fax: (716) 898-5198

Anaphylaxis

Note:

**Request Advanced Life Support if available.
Do not delay transport to the hospital.**

For patients previously prescribed an Epinephrine Auto-Injector, between one (1) and sixty-five (65) years of age, who have a prior history of an allergic reaction to a particular substance, have been exposed to the same substance and are experiencing a significant reaction, such as respiratory distress, shock, or severe hives.

- I. Assure that the patient's airway is open and that breathing and circulation are adequate. Suction as necessary.
-

Note:

In pediatric patients, maintain a calm approach to both parent and child. Allow the child to assume and maintain a position of comfort or to be held by the parent preferably in an upright position.

- II. Administer oxygen.
-

Note:

Avoid agitation of the pediatric patient. Administration of oxygen, preferably humidified, is best accomplished by allowing the parent to hold the face mask, if tolerated about 6 – 8 inches from the child's face.

Anaphylaxis Protocol – Continued

- III. If patient presents with **serious signs/symptoms** (severe respiratory distress, or exhibits signs/symptoms of shock), and has a history of allergic reaction:
- A. **Use the patient's prescribed epinephrine auto-injector if available.**
 - B. If the patient's auto-injector is not available, **administer epinephrine using an epinephrine auto-injector.**
 - 1. Adult Dose: 0.3 mg
 - 2. Pediatric Dose: 0.15 mg
 - a. If patient is over 8 year old, and weighs more than 66 lbs (30 kg), may use adult epinephrine auto-injector
- IV. Begin immediate transport and contact Medical Control.
- V. Contact Medical Control for authorization for a second administration of the epinephrine auto-injector, if needed.
- VI. **If the patient does not have a history of allergies/allergic reactions, begin transport immediately and contact Medical Control for directions.**

Note:

In the event that you are unable to make contact with medical control (radio failure, no communications) and the patient is under 35 years of age, you may administer the epinephrine auto-injector if indicated. The incident should be reported to Medical Control or your agency Medical Director or the physician Emergency Health Care Provider as soon as possible.

- VII. **If shock is present, refer immediately to the New York State BLS Shock Protocol.**
- VIII. **If cardiac arrest occurs, perform CPR according to AHA/ARC standards and refer to the New York State BLS Cardiac Arrest Protocol.**
- IX. Obtain and record the patient's initial vital signs, repeat en route as often as the situation indicates. Be alert for changes in the level of consciousness.
- X. Record all patient care information, including medical history and all treatment provided, on a Prehospital Care Report.

To: _____

(Agency Medical Director)

Notice of Epinephrine Auto-Injector Use

In accordance with the Epinephrine Auto-injector Device Law (Chapter 578 of the Laws of 1999), _____ is advising you of an emergency call requiring the use of the Epinephrine Auto-injector.
(print agency name)

Date of incident: _____ Time: _____ AM PM

Patient Age: _____ Sex M F

Patient presented with the following signs/symptoms, requiring administration of Epinephrine (check all that apply):

Shock Severe Respiratory Distress Severe Hives

Name of transporting ambulance: _____

Transporting ambulance PCR number: _____

Transported to (name of hospital): _____

Patient's signs/symptoms after initial administration (check all that apply):

Shock Severe Respiratory Distress Severe Hives

Total number of Epinephrine Auto-inject administrations: _____

Medical Control contacted? Yes No

If further information is required, please contact this department at: _____

Western Regional Emergency Medical System, Inc.
Epinephrine Auto-Injector Quality Improvement

Name of Organization using Epinephrine Auto-Injector: _____

Date of Incident: _____ Time of Incident: _____

Patient's age: _____ Patient's sex: Male Female

Did the patient present with the following signs/symptoms (check all that apply):

Shock Severe hives Severe respiratory distress

Estimated time from exposure to Epinephrine administration : _____ minutes / unknown

Medical Direction contacted at: _____ AM PM (circle one)

Name of Transporting Ambulance Service: _____

Transport Ambulance Run Number (PCR): _____

Transported to: Name of Hospital: _____

Patient's outcome after initial administration (check all that are applicable):

Shock Severe hives Severe respiratory distress

Did patient require a second administration? Yes No

Please complete and Mail this card promptly after each use of the Epinephrine Auto-Injector.

Thank you for your cooperation!



c/o Erie County Medical Center
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Buffalo, NY 14215-3098
(716) 898-5072
Fax: (716) 898-5198

Asthma

For patients previously diagnosed with Asthma between one (1) and sixty-five (65) years of age, who are experiencing difficulty breathing with audible wheezing.

Note:

**Request Advanced Life Support if available.
Do not delay transport to the hospital.**

- I. Assess the airway
 - II. Administer oxygen
 - III. Monitor breathing
-

Note:

If patient exhibits signs of imminent respiratory failure, refer to the New York State BLS Adult Respiratory Arrest or the Pediatric Respiratory Arrest or Imminent Respiratory Arrest Protocols.

- IV. Place the patient in a position of comfort.
- V. Access vital signs, especially respiratory rate, and for the following prior to administration of the first nebulized treatment:
 - Audible wheezes
 - Retractions
 - Other accessory muscle usage.

Note:

For patients with a history of angina, myocardial infarction, arrhythmia, or congestive heart failure, Medical Control must be contacted prior to initiating step VI.

- VI. Administer Albuterol Sulfate 0.083%, one (1) unit dose or 3cc via nebulizer at a flow rate of 8 – 10 lpm. Do not delay transport to complete medication administration.
- VII. Begin transport and call Medical Control.
- VIII. If symptoms persist, treatment may be repeated once for a total of two (2) doses.
- IX. Upon completion of patient treatment or prior to transfer of patient care to an ALS provider or a Receiving Hospital, reassess the patient.

Note:

Medical Control must be contacted for any patient refusing medical assistance or transport.



c/o Erie County Medical Center
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Fax: (716) 898-5198

Possession and Use of an Epinephrine Auto-Injector Collaborative Agreement

It is the intent of _____ to possess and use an
(Name of Agency)
Epinephrine Auto-Injector for patients in anaphylaxis. This service is being offered in
cooperation with _____
(Physician/Hospital)

In accordance with the provisions of Chapter 578 of the Laws of 1999, our organization has:

- Identified a physician or hospital to serve as our Emergency Health Care Provider (EHCP).
- Selected an approved Epinephrine Auto-Injector training course.
- Provided written notice to 911 and/or community equivalent ambulance dispatch entity of the availability of Epinephrine Auto-Injectors at our organization's location.
- Filed with the Regional Emergency Medical Services Council (REMSCO) serving the area a copy of the "Notice of Intent to Possess and Use Epinephrine Auto-Injector" (DOH-4188) along with a signed copy of this agreement.
- Agreed to file a new Collaborative Agreement with the Regional Emergency Medical Services Council (REMSCO) if the Emergency Health Care provider (EHCP) changes.
- Agreed to participate in the required Quality Improvement Program, mailing in the requested information each time the Epinephrine Auto-Injector is used.

**NEW YORK STATE DEPARTMENT OF HEALTH
Bureau of Emergency Medical Services**

**Notice of Intent to Possess and Use
Epinephrine Auto Injector**

Name of Entity	Agency Code #	Business Phone () ____ - ____
Mailing Address		Fax No. () ____ - ____
City :	State:	
Zip:		
Primary County of Operation:		

Type: Ambulance Service ALSFR Service Overnight Camp Summer Day Camp

Traveling Summer Day Camp Other _____

If a camp check all that apply: Camp Premises or Infirmary Off-Site Trips/Events

Name of Emergency Health Care Provider (MD or Hospital)	Business Phone No. () ____ - ____
If a Hospital Provide Name of Contact:	Fax No. () ____ - ____
Address	
City:	State: Zip:

Number of Trained Providers to Use Auto Injector in EMS service or camp:

Minimum Number of Injectors to be Maintained On-Site: _____

Maximum Number of Injectors to be Maintained On-Site: _____

Authorizations:

Print Name of Service CEO or Camp Director	Date	Print EHC Provider (name)	Date
Signature		Signature	

Send this form and your Collaborative Agreement to the Regional EMS Council listed in the attachment.

Policies:

It is the policy of our organization that person using the Epinephrine Auto-Injector be properly trained; therefore all persons providing treatment with the Auto-Injector shall be certified by _____. They will be retrained in accordance with the certifying agency's standards. An annual review of the Epinephrine Auto-Injector and its use will be presented to each member.

It is the policy of our organization to ensure the rapid arrival of EMS; therefore 911 and/or the community equivalent dispatch entity will be called immediately when the Epinephrine Auto-Injector is used. Our primary responding ambulance is _____ (name of ambulance service). We will notify both the primary responding ambulance agency and the area 911 dispatch center of this availability in writing.

It is the policy of our organization to obtain the Epinephrine Auto-Injectors through _____. The Epinephrine Auto-Injectors will be stored _____, to be protected from exposure to light and extreme changes in temperature. After use, the Epinephrine Auto-Injectors will be disposed of in a sharps container in accordance with OSHA regulation 29CFR 1910.1030.

It is the policy of our organization to ensure the Epinephrine Auto-Injectors are in a state of readiness at all times, and that each unit is accounted for; therefore all regular maintenance, expiration date tracking, and supply accounting of the Epinephrine Auto-Injectors will be performed by _____ (name of individual/initial). Said individual will ensure that _____ (enter number) Adult Dosages and _____ (enter number) Pediatric Dosages will be carried on each Rescue Unit, and also that _____ (enter number) Adult Dosages and _____ (enter number) Pediatric Dosages will be stored in-facility as back-up stock.

It is the policy of our organization to ensure appropriateness in using the Epinephrine Auto-Injectors; therefore we will participate in the Quality Improvement program as determined by the Western Regional Emergency Medical Advisory Committee (WREMAC).

Signed in agreement...

For the Organization

Physician/Hospital

Print Name

Print Name

Date Signed _____

Date Signed _____

Medical Direction Packet Update

I, _____, have agreed to allow _____
(print physician's name)

_____ to possess and administer Albuterol Sulfate, in accordance
(department name)

with the New York State and Western Regional Emergency Medical System, Inc. Protocols.

It is my understanding that the following members have attended an Albuterol Sulfate inservice, and are knowledgeable in the assessment of the asthma patient, the indications and contraindications of Albuterol Sulfate, and have demonstrated the ability to properly administer a nebulized treatment.

Signed in agreement....

For the Organization

Physician/Hospital

Print Name

Print Name

Date Signed

Date Signed