CHAPTER 41

MOBILE INTENSIVE CARE PROGRAMS

Authority

N.J.S.A. 26:2K–17.

Source and Effective Date

R.1998 d.433, effective August 17, 1998.
See: 30 N.J.R. 1549(a), 30 N.J.R. 3089(a).

Executive Order No. 66(1978) Expiration Date

Chapter 41, Mobile Intensive Care Programs, expires on August 17, 2003.

Chapter Historical Note

Chapter 41, Mobile Intensive Care Programs, was adopted as R.1987 d.112, effective February 17, 1987. See: 18 N.J.R. 602(a), 19 N.J.R. 357(a).

Pursuant to Executive Order No. 66(1978), Chapter 41, Mobile Intensive Care Programs, was readopted as R.1992 d.113, effective February 13, 1992. See: 23 N.J.R. 3734(a), 24 N.J.R. 938(a). Chapter 41 expired on February 13, 1993.

Chapter 41, Mobile Intensive Care Programs, was adopted as new rules by R.1993 d.202, effective June 21, 1993. See: 24 N.J.R. 3255(b), 25 N.J.R. 2721(b). Subchapter 11, Paramedic Clinical Training Objectives, was adopted as R.1994 d.35, effective January 18, 1994. See: 25 N.J.R. 2665(a), 26 N.J.R. 355(a). Pursuant to Executive Order No. 66(1978), Chapter 41 expired on June 21, 1998.

Chapter 41, Mobile Intensive Care Programs, was adopted as new rules by R.1998 d.433, effective August 17, 1998. See: Source and Effective Date. See, also, section annotations.

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SUBCHAPTER 1. AUTHORITY, SCOPE AND DEFINITIONS

8:41–1.1 Authority; delegation

These rules are promulgated pursuant to N.J.S.A. 26:1A–15 and 26:2K–17, which authorize the Commissioner to enact rules pertaining to the operation of mobile intensive care units, and the provision of prehospital advanced life support in general.

Amended by R.1998 d.433, effective August 17, 1998.
See: 30 N.J.R. 1549(a), 30 N.J.R. 3089(a).
Changed a reference to the Commissioner.

8:41–1.2 Scope and purpose

These rules shall apply to all hospitals, agencies, persons and authorized programs that operate mobile intensive care programs, or which are seeking authorization to do so. These rules serve to define the operational requirements of these programs, to provide for a uniform application of standards, and to specify the personnel, equipment, organization and other resources required to operate a mobile intensive care program.

8:41–1.3 Definitions

The following words and terms, as used in this chapter, shall have the following meaning, unless the context in which they are used clearly indicates otherwise:

"Advanced life support (ALS)" means an advanced level of prehospital, inter-hospital and emergency medical service care which includes basic life support functions, cardiac monitoring, cardiac defibrillation, telemetered electrocardiography, intravenous therapy, administration of specific medications, drugs and solutions, use of adjunctive ventilation devices, trauma care, and other techniques and procedures authorized by the Commissioner.

"Advanced life support ambulance" means a vehicle which is utilized for the delivery of advanced life support and for the purpose of emergency patient transportation, which serves as a mobile intensive care unit as defined by this chapter, and which serves as an emergency ambulance as defined by N.J.A.C. 8:40, Manual of Standards for Licensure of Mobility Assistance Vehicle and Ambulance Services.

"Authorized" means approved by the Commissioner, or his or her designee, in accordance with the provisions of this chapter.

"Authorized mobile intensive care unit" means a mobile intensive care unit authorized by the Department to provide advanced life support services to a specific population, geographic region, or political subdivision.

"Available" means ready for immediate use (pertaining to equipment, vehicles and personnel); or, immediately accessible (pertaining to records).

"Base station physician" means any physician licensed by the Board of Medical Examiners of New Jersey who provides medical command to advanced life support personnel by radio, telephone or other direct means, as part of an authorized intensive care program.

13. The printed name and signature of the medical command physician;

14. The receiving hospital or facility;

15. The receiving hospital's disposition of the patient to include admitting or discharge diagnosis and type of admission (for example, critical care floor);

16. A section to record the medication dosage, route and time of administration (flow sheet); and

17. The signature of the preparer of the record.

(d) The prehospital ALS providers in attendance with the patient shall prepare the medical record.

(e) A copy of the medical record shall be given to the physician or licensed registered nurse accepting the patient at the receiving facility. No additions to the chart shall be made once it is given, unless such changes are initialed and dated by the person making the change, and the receiving facility is notified.

(f) A copy of the medical record that has been signed by the medical command physician shall be retained by the program at the place of business and shall be available for inspection. Reports shall be presented to an authorized representative of the Department upon demand.

(g) If a patient should present to the MICU staff and should refuse care, the prehospital ALS providers shall complete a medical record for that patient and shall attempt to obtain the signature of the patient (or guardian) on a refusal of care statement.

(h) The program shall keep a record of all calls answered by the unit and shall track the destination, diagnosis and disposition of each patient evaluated by the unit. The emergency department of a licensed hospital receiving a patient evaluated by an approved MICU shall provide the information needed to comply with this section.

8:41–9.6 Quarterly reports

(a) Each program shall file a report with the Department stating the activity of the unit for that quarter. These reports shall be made on a form and in the manner specified by the Department (see Appendix A, incorporated herein by reference) and shall be received in the Office of Emergency Medical Services (OEMS) on or before the due date. The reporting period and due dates are:

Period	Due
Jan. 1–Mar. 31	Apr. 30
Apr. 1–June 30	July 31
July 1–Sept. 30	Oct. 31
Oct. 1–Dec. 31	Jan. 31

(b) The Department shall keep the data on file and shall generate a yearly report reflecting the activities of the MICU programs. Yearly reports shall be made available to the programs and general public for inspection at OEMS.

8:41–9.7 Quality assurance; roles and responsibilities

(a) The program medical director or his or her physician designee meeting the requirements of N.J.A.C. 8:41–6.3 shall review at least 10 percent of all calls that were evaluated by the MICU, excluding cancelled calls. The method of determining which 10 percent of the calls will be reviewed shall be at the discretion of the medical director. The review shall determine:

1. Consistency with accepted treatment and triage protocols;

2. Consistency of the record with the tape recording of the call-in by the MICU;

3. Appropriateness of orders received by the MICU from the physician; and

4. Completeness of the medical record.

(b) The program director shall ensure that all medical records produced by the program meet standards, with regard to:

1. Completeness of the medical record;

2. Adherence to policies regarding treatment and triage of patients;

3. Compliance with the requirements of this chapter;

4. Documentation of excessive scene times based on the nature of the call, deviations from established protocols, unsuccessful procedures, radio failure, and other unusual incidents; and

5. The conditions set forth in (a) above.

Amended by R.1998 d.433, effective August 17, 1998.
See: 30 N.J.R. 1549(a), 30 N.J.R. 3089(a).
In (a), inserted "or his or her physician designee meeting the requirements of N.J.A.C. 8:41–6.3" in the introductory paragraph.

8:41–9.8 Quality assurance; compliance with standards

(a) Each program approved under this chapter shall develop and maintain a quality assurance plan in accordance with N.J.A.C. 8:43G–27.1 and 27.2.

(b) Each program shall identify an individual responsible for the coordination of all aspects of the quality assurance program.

(c) There shall be an ongoing process of monitoring patient care. Evaluation of patient care on the MICU shall be criteria-based, so that certain review actions are taken or triggered when specific quantified, predetermined levels of outcomes or potential problems are identified.

(d) The quality assurance individual shall be available to provide ongoing consultation to the program, including as-

sistance with the development of specific indicators used to evaluate service outcomes on the MICU.

(e) The program shall follow up on its findings to assure that effective corrective action is taken, including, at a minimum, policy revisions, procedural changes, educational activities and follow-up on recommendations, or shall establish that additional actions are no longer indicated or needed.

(f) The quality assurance program shall identify and establish indicators of quality care specific to the MICU that are monitored and evaluated which encompass:

1. Medical calls;

2. Trauma calls;

3. Pediatric calls;

4. Cardiac/respiratory arrest incidents;

5. Patients triaged to BLS;

6. Use of radio failure protocols;

7. Use of standing orders;

8. On-scene times;

9. Use of special procedures;

10. Triage to specialty care facilities; and

11. Other areas the medical director finds necessary to track in this manner.

(g) The quality assurance review must encompass at least 10 percent of all calls the mobile intensive care unit(s) handle, excluding cancelled calls.

(h) The program shall keep written records of medical director reviews and shall produce them on demand to an authorized member of the Department. Medical director reviews shall include the comments of the medical director or his or her physician designee in accordance with N.J.A.C. 8:41–9.7. The program shall keep quality assurance reviews for a period of one year from the date of the review.

Amended by R.1998 d.433, effective August 17, 1998.
See: 30 N.J.R. 1549(a), 30 N.J.R. 3089(a).
In (h), added "or his or her physician designee in accordance with N.J.A.C. 8:41–9.7" at the end of the second sentence, and added a third sentence.

8:41–9.9 Additional reports

Nothing in this chapter shall be deemed to prevent a program from gathering other information it deems necessary, providing such information is not otherwise restricted by law or rule. Other information gathered may include that which is necessary to process billing claims and insurance information. A receiving emergency department of a licensed hospital shall make such billing information available to the MICU staff.

SUBCHAPTER 10. STANDING ORDERS

8:41–10.1 Standing orders for cardiac arrest

(a) The following cardiac dysrhythmias and treatment protocols shall be considered standing orders in cardiac arrest for patients over 12 years of age:

1. For ventricular fibrillation or ventricular tachycardia (without pulse):

i. Defibrillate 200 Joules;

ii. Defibrillate 300 Joules;

iii. Defibrillate 360 Joules;

iv. Establish IV access in accordance with the standards established at N.J.A.C. 8:41–10.4;

v. Intubate, if possible; and

vi. Administer Epinephrine 1.0 mg intravenously or 2.0 mg endotracheally.

2. For asystole:

i. If rhythm is unclear and possibly ventricular fibrillation, defibrillate as for ventricular fibrillation as in (a)1 above;

ii. Continue CPR;

iii. Establish IV access in accordance with the standards established at N.J.A.C. 8:41–10.4;

iv. Intubate if possible; and

v. Administer Epinephrine 1.0 mg intravenously or 2.0 mg endotracheally.

3. For Pulseless Electrical Activity (PEA):

i. Continue CPR;

ii. Establish IV access in accordance with the standards established at N.J.A.C. 8:41–10.4;

iii. Intubate, if possible; and

iv. Administer Epinephrine 1.0 mg intravenously or 2.0 mg endotracheally.

(b) General guidelines are as follows:

1. Check rhythm after each shock. Check the patient's pulse after the final shock in the sequence, or if the patient's cardiac rhythm should change. If ventricular fibrillation recurs after transiently converting to another rhythm, use whatever energy level was previously successful on the patient and defibrillate again.

2. Paramedics shall initiate radio communication with their base station physician as soon as the above treatments have been completed. At no time should initial communication with the medical control physician be delayed due to difficulty in intubating the patient and/or initiating an intravenous line.

3. The program medical director shall determine the type of fluids to be used in each of the above cases.

4. Each case utilizing these standing orders shall be so documented on the run form. The program's quality assurance plan shall include provisions for review of calls where standing orders are utilized, in accordance with the standards set forth at N.J.A.C. 8:41–9.8. Cases which do not follow these protocols as promulgated or where contact is never made with the base station physician shall be forwarded to the program medical director for a mandatory review.

5. Initial standing orders shall not replace communication with a base station physician and should not be considered as instructions for total treatment of the patient.

6. Should ventricular fibrillation recur after contact is made with the base station physician, the prehospital advanced life support provider may deliver a shock at the energy level that was previously successful, without contacting the base station physician, if such contact would significantly delay the delivery of the shock.

Amended by R.1994 d.35, effective January 18, 1994.
See: 25 N.J.R. 2665(a), 26 N.J.R. 355(a).
Amended by R.1995 d.392, effective July 17, 1995.
See: 27 N.J.R. 808(a), 27 N.J.R. 2744(a).
Amended by R.1998 d.433, effective August 17, 1998.
See: 30 N.J.R. 1549(a), 30 N.J.R. 3089(a).
In (a), added "for patients over 12 years of age" at the end of the introductory paragraph; and in (b)4, rewrote the first sentence.

8:41–10.2 Standing orders for multiple trauma patients

(a) The following treatment protocols shall be considered standing orders, to be used when treating multiple trauma patients over 12 years of age.

1. Provide Basic Life Support as necessary;

2. Provide airway management with cervical spine precautions;

3. Assist ventilation, providing highflow oxygen at 100 percent by non rebreather mask and/or performing intubation utilizing cervical spine precautions when indicated;

4. Apply pneumatic anti-shock garment and inflate if applicable;

5. Transport as soon as possible;

6. Enroute to the hospital establish two large bore intravenous lines of Ringer's lactate. Attempt to draw blood. Obtain two full red top tubes.

7. Paramedics shall initiate radio communication with their base physician as soon as the above treatments have been completed. Transportation shall not be delayed due to difficulty in intubating the patient and/or initiating an intravenous line, except at the specific direction of the medical control physician; and

8. Each case utilizing these standing orders shall be documented on the run form and monitored in accordance with the standard in N.J.A.C. 8:41–10.1(b)4.

Amended by R.1998 d.433, effective August 17, 1998.
See: 30 N.J.R. 1549(a), 30 N.J.R. 3089(a).
In (a), added "over 12 years of age" at the end of the introductory paragraph, and rewrote 6.

8:41–10.3 Standing orders for endotracheal intubation

(a) The protocols contained in this section shall be considered standing orders for endotracheal intubation.

(b) Endotracheal intubation may be performed prior to contacting medical control if the patient presents:

1. In respiratory arrest;

2. In respiratory failure with associated inadequate spontaneous ventilatory volume; and/or

3. Unconscious with absent protective gag reflex.

(c) Advanced interventions should only be attempted after all basic life support interventions have been instituted. The patient may be intubated either by the orotracheal or nasotracheal route; however, nasotracheal intubation shall be withheld in children less than 12 years old.

(d) It is imperative that the MICU staff initiate contact with their base station physician as soon as possible after the above treatment has been rendered. These procedures should not delay the transportation of a patient in the event of a difficult intubation; nor should contact with the base physician be delayed by a difficult intubation.

(e) Each case utilizing these standing orders shall be documented on the run form and shall be monitored in accordance with the standards established in N.J.A.C. 8:41–10.1(b)4.

8:41–10.4 Standing orders for the establishment of intravenous therapy

(a) The protocols contained in this section shall be considered standing orders for the initiation of intravenous therapy prior to contacting the base physician, without existing radio failure.

(b) In cases where an emergent or potentially emergent condition exists and current advanced life support treatment protocols require the initiation of intravenous therapy, mobile intensive care unit staff may begin an intravenous line at keep vein open rate or establish intravenous access with a saline port prior to contacting a base physician.

(c) Mobile intensive care unit staff shall contact the base physician as soon as possible after the initiation of the intravenous line. Contact with the base physician shall not be delayed by, or as a result of, unsuccessful intravenous attempts in the field.

(d) The time of the initiation of intravenous therapy and the time of base station contact shall be recorded on the patient run form.

8:41–10.5 Applicability of standing orders

(a) The standing orders established in N.J.A.C. 8:41–10.6 through 10.13, inclusive, may be adopted in their entirety by the medical director of an approved MICU program, after notification to the Office of Emergency Medical Services (OEMS). The standing orders shall not be altered or abbreviated or enhanced in any manner except as specified by N.J.A.C. 8:41–10.14, Variance of standing orders.

(b) The protocols established in N.J.A.C. 8:41–10.6 through 10.13 are initial treatment protocols which may be utilized by prehospital advanced life support providers operating on an approved MICU. These protocols apply only to patients over 12 years old, and may be utilized prior to physician contact. In the event the implementation of these standing orders is delayed for any reason, the base station physician shall be contacted immediately.

(c) Any situation other than those specifically identified in these rules requires the prehospital advanced life support provider to contact the base station physician for medical command before providing any advanced life support treatment not authorized under N.J.A.C. 8:41–10.1 through 10.4, inclusive.

(d) These protocols shall not be interpreted as a requirement to administer advanced life support therapy prior to base station physician contact. The prehospital advanced life support providers may elect to contact the base station physician at any time during the provision of therapy, in accordance with this subchapter. Standing orders cease to be operative once base station physician contact is made.

(e) These standing orders shall not be considered to represent total patient management. Medical command shall be established after the protocols are utilized.

(f) The presence of an allergy to any medication in these rules shall be deemed to be a contraindication to the administration of that agent, and said agent shall not be administered under these protocols.

(g) Each case utilizing these standing orders shall be reviewed in accordance with the standards established by N.J.A.C. 8:41–10.1(b)4.

Amended by R.1998 d.433, effective August 17, 1998.
See: 30 N.J.R. 1549(a), 30 N.J.R. 3089(a).
In (a), changed N.J.A.C. reference in the first sentence, and added an exception at the end.

8:41–10.6 Sustained ventricular tachycardia

(a) The following standing orders are authorized in the event a patient presents with a stable (systolic blood pressure greater than or equal to 120 mmHg) ventricular tachycardia:

1. Provide appropriate airway management;

2. Establish intravenous access in accordance with the standards set at N.J.A.C. 8:41–10.4;

3. Perform patient assessment, including medical history and allergies;

4. Administer Lidocaine HCL at a dose of 1mg/kg IV push, if the patient is not allergic to it;

5. Continue to assess the patient and monitor the cardiac rhythm; and

6. Contact the base station physician.

(b) The following standing orders are authorized in the event a patient presents with an unstable (unconscious or hemodynamic compromise) ventricular tachycardia:

1. Provide appropriate airway management;

2. Establish intravenous access in accordance with the standards set at N.J.A.C. 8:41–10.4;

3. Cardiovert the patient at 100 joules. Check the pulse and monitor after the cardioversion;

4. If the rhythm fails to convert, cardiovert the patient at 200 joules. Check the pulse and monitor after the cardioversion;

5. If the rhythm fails to convert, cardiovert the patient at 300 joules. Check the pulse and monitor after the cardioversion;

6. If the rhythm fails to convert, cardiovert the patient at 360 joules. Check the pulse and monitor after the cardioversion;

7. If the rhythm is converted at any point, administer Lidocaine one mg/kg, if there is no history of allergy to the drug; and

8. Contact the base station physician for medical command.

8:41–10.7 Bradycardia

(a) The following standing orders are authorized in the case of bradycardia if the patient is symptomatic and/or hemodynamically unstable:

1. Provide appropriate airway management;

2. Establish intravenous access in accordance with the standards set at N.J.A.C. 8:41–10.4;

3. Administer Atropine Sulfate one mg IV; and

4. Contact the base station physician for medical command.

8:41–10.8 Pulmonary Edema/Congestive Heart Failure; systolic blood pressure greater than or equal to 120 mmHg

(a) The following standing orders are authorized in the case of pulmonary edema/congestive heart failure, with systolic blood pressure greater than, or equal to, 120 mmHg:

1. Provide appropriate airway management;

2. Establish intravenous access in accordance with the standards set at N.J.A.C. 8:41–10.4;

3. Administer nitroglycerin (0.4 mg) sublingually;

4. Administer Furosemide one mg/kg IV; and

5. Contact the base station physician for medical command.

8:41–10.9 Suspected myocardial infarction/chest pain: systolic blood pressure greater than or equal to 120 mmHg

(a) The following standing orders are authorized in the case of suspected myocardial infarction/chest pain, with systolic blood pressure greater than, or equal to, 120 mmHg:

1. Provide appropriate airway management;

2. Establish intravenous access in accordance with the standards set at N.J.A.C. 8:41–10.4;

3. Administer nitroglycerin (0.4 mg) sublingually; and

4. Contact the base station physician for medical command.

8:41–10.10 Unstable paroxysmal supraventricular tachycardia: unconscious and hemodynamically unstable

(a) The following standing orders are authorized in the case of unstable paroxysmal supraventricular tachycardia, with unconscious and hemodynamically unstable patient:

1. Provide appropriate airway management;

2. Establish intravenous access in accordance with the standards set at N.J.A.C. 8:41–10.4;

3. Perform a synchronized cardioversion at 50 joules. Check the patient's pulse and cardiac rhythm after the shock;

4. If the rhythm fails to convert perform a synchronized cardioversion at 100 joules. Check the patient's pulse and cardiac rhythm after the shock;

5. If the rhythm fails to convert perform a synchronized cardioversion at 200 joules. Check the patient's pulse and cardiac rhythm after the shock;

6. If the rhythm fails to convert perform a synchronized cardioversion at 300 joules. Check the patient's pulse and cardiac rhythm after the shock;

7. If the rhythm fails to convert perform a synchronized cardioversion at 360 joules. Check the patient's pulse and cardiac rhythm after the shock; and

8. Contact the base station physician for medical command.

8:41–10.11 Anaphylactic shock

(a) This standing order shall apply when the patient exhibits signs of acute respiratory distress and/or hypotension (systolic blood pressure of less than 90 mmHg).

1. Provide appropriate airway management;

2. Establish an intravenous line of 0.9 percent normal saline and give a 300cc fluid bolus;

3. Administer Epinephrine 1:1000 sol. at a dose of 0.5 mg subcutaneously;

4. Administer 50 mg of Diphenhydramine HCL IV; and

5. Contact the base station physician for medical command.

8:41–10.12 Bronchospasm

(a) The standing order shall apply in the case of bronchospasm:

1. Provide appropriate airway management;

2. Administer albuterol 2.5 mg via nebulizer;

i. A program's medical director may elect to substitute metaproterenol or isoetharine for albuterol. This substitution shall be declared at the time these standing orders are authorized by the medical director and approved by the Department.

3. Establish intravenous access in accordance with the standards set at N.J.A.C. 8:41–10.4; and

4. Contact the base station physician for medical command.

8:41–10.13 Unconscious person

(a) The treatment of an unconscious person shall be directed by the suspected etiology of the event. The following standing orders shall apply:

1. Provide appropriate airway management;

2. Draw a blood sample using a red-top tube;

3. Evaluate a blood glucose reagent strip, if available;

4. Establish intravenous access in accordance with the standards set at N.J.A.C. 8:41–10.4;

5. Administer Naloxone 2 mg IV;

6. Administer Thiamine 100 mg IV;

7. Administer 25 gm of 50 percent dextrose in water IV; and

8. Contact the base station physician for medical command.

8:41–10.14 Variance of standing orders

An approved program's medical director may request variance of any standing order(s) set forth in this subchapter and in N.J.A.C. 8:41–10A. Such request shall be directed to the Office of Emergency Medical Services, PO Box 360, Trenton, New Jersey 08625–0360, and shall include: a description of the standing order variance requested; the public health considerations supporting the variance; the specific period of time the variance is to be in effect, not to exceed six months; and any other supporting information the approved program's medical director believes shall be useful to the Department in making its determination. Any variance granted by the Department under this section may include specific conditions determined by the Department to be necessary in the interests of public health and safety. The Department shall respond to any request under this section within 60 days after receipt of the request. Should the public health considerations cited in the application which resulted in the initial approval extend beyond the six months approved under this section and if rulemaking has not been finalized, the program's medical director may apply for an additional six month period, and approval of the extension shall not be unreasonably denied.

New Rule, R.1998 d.433, effective August 17, 1998.
See: 30 N.J.R. 1549(a), 30 N.J.R. 3089(a).

SUBCHAPTER 10A. PEDIATRIC STANDING ORDERS

8:41–10A.1 Applicability and restrictions

(a) The standing orders for pediatric patients established in this subchapter may be adopted in their entirety by the medical director of the approved MICU program, after notification to the Office of Emergency Medical Services (OEMS). The standing orders shall not be altered or abbreviated or enhanced in any manner.

(b) The pediatric standing orders as defined in (a) above are initial treatment protocols which may be utilized by prehospital advanced life support personnel operating on an approved MICU. These protocols apply to patients 12 years old or younger and may be implemented prior to physician contact. In the event the implementation of these standing orders is delayed for any reason, the base station physician shall be contacted immediately.

(c) Any situation other than those specifically identified in these rules required the prehospital advanced life support provider to contact the base station physician for medical command before providing any advanced life support treatment not authorized under N.J.A.C. 8:41–10.3, 10.4, and this subchapter, inclusive.

(d) These protocols shall not be interpreted as a requirement to administer advanced life support therapy prior to base station physician contact. The prehospital advanced life support provider may elect to contact the base station physician at any time during the provision of therapy, in accordance with this subchapter. Unless otherwise provided in these rules, standing orders cease to be operative once base station physician contact is made.

(e) These pediatric standing orders shall not be considered to represent total patient management. Medical command shall be established at the point indicated in the protocol, unless established sooner in accordance with (d) above.

(f) The presence of any allergy to any medication or therapeutic agent in these rules shall be deemed to be a contraindication to the administration of that agent, and said agent shall not be administered under these protocols.

(g) Each case utilizing these standing orders shall be reviewed in accordance with the standards established by N.J.A.C. 8:41–10.1(b)4.

8:41–10A.2 Standard terms for use in pediatric standing orders

(a) As used in the pediatric standing orders established in this subchapter, inclusive, the term "stable" means vital signs, cardiovascular parameters and level of response within the ranges defined in chapter Appendix B , incorporated herein by reference.

(b) As used in the pediatric standing orders established in this subchapter, inclusive, the term "unstable" means vital signs, cardiovascular parameters and level of response not within the ranges defined in chapter Appendix B.

8:41–10A.3 Active seizures

(a) The following are pediatric standing orders for active seizures:

1. Assess and secure the airway. Administer 100 percent oxygen;

2. Observe and note the character of the seizure, including the duration of the seizure activity and postictal time;

3. Maintain normal body temperature; and

4. Obtain a rapid glucose test (for example, Chemstrip).

i. If the blood glucose reading is 60 mg/dl or greater:

(1) Establish medical command and begin transporting the patient to the hospital;

ii. If the blood glucose is less than 60 mg/dl: