AUTHORIZATION FOR PROTOCOLS

These protocols are issued by the Medical Direction and Practices Board and govern the practice of EMS licensees by the authority of 32 MRSA § 86.2-A. All **Maine emergency physicians healthcare providers in Maine involved in the EMS system** and the regional EMS programs were invited to participate in the review and adoption of these protocols through their MEMS Regional Councils.

The Regional Medical Directors agree that when treatments are adopted in their regions, they will be consistent with these protocols.

The protocols will be continually reviewed. New or revised protocols will be listed on the Maine EMS website (maine.gov/ems). The MDPB may entertain substitutions as needed for drug shortages. Protocol Errata form located on the Maine EMS website.

Consider hyperlinking MDPB members' email addresses

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</tr>
<tr>
<td>Seth Ritter, M.D.</td>
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<td>Timothy Pieh, M.D.</td>
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<td>Beth Collamore, M.D.</td>
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<td>David Saquet, D.O.</td>
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<td>Maine EMS Director</td>
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The Maine EMS Prehospital Treatment Protocols are dedicated to Maine’s EMS providers both past and present, as well as the numerous physicians, PAs, NPs, nurses, and other medical personnel, who have provided their time and guidance over the years to make the development of these protocols possible. This document reflects the planned review which occurs every two years by the Medical Direction and Practices Board. We attempt to combine the best available evidence from the current literature and medical consensus together to produce protocols that will enhance prehospital care in the State of Maine.

Many individuals have spearheaded the effort for this work to become a reality. Although there are too many to mention individually, it is important to realize the common commitment shared to empower a continually improving system where those citizens who need emergency medical assistance receive the best care possible.

For those of you reading this document...please keep in mind the great commitment and sacrifice Maine EMS providers make daily in the course of providing superlative prehospital care. Their work is physically, emotionally and mentally stressful. Yet 24 hours a day, 365 days a year, these individuals provide care with the skill and compassion that promises the best prehospital care for all of the citizens of Maine. What you do matters and we thank you.
These protocols are a "living document" maintained electronically by Maine EMS and as such may be edited or updated as required at any time. A detailed review and editing of these protocols will occur on a biennial time frame and an updated version will be released every other year.

All licensed providers who practice within the Maine EMS system are required to be familiar with the contents of this document pertinent to their level of training. For the latest corrections/updates to these protocols, please visit the Maine EMS website at: http://www.maine.gov/ems.

There are protocols within this document that are the result of the collaboration between the Northern New England States (Maine, New Hampshire and Vermont) to provide uniform, evidence-based care to our patients. These protocols are identified by a joint statement at the bottom of the protocol.
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*Need to alphabetize and add color and space between sections*
Definitions

**ACLS** means Advanced Cardiac Life Support.

**Advanced Airway** means the skills of endotracheal intubation and use of other airway modalities such as Blind Insertion Airway Devices (BIAD) performed only by those who have completed practical training in each of these skills.

**AEMT** (Advanced EMT) means the ability to provide Advanced EMT level of care (previously called Intermediate EMT).

**AHA** means the American Heart Association

**ALS (Advanced Life Support)** means the ability to provide advanced level of medical care, which in the prehospital realm means *Paramedic*. The ALS skills may include the following: IV access, advanced airway, cardiac monitoring, and/or oral or parenteral medications.

**ALS (Advanced Life Support) If Available** means that the patient shall receive the highest appropriate ALS intervention as soon as possible. The decision in this realm as to which interventions may be appropriate rests with the Paramedic, if available. If any skills other than basic life support are deemed necessary or initially implemented, an ALS response should be sought, with simultaneous dispatch if possible. The use of a medical priority dispatching program, approved by the State Medical Director, is encouraged. When this cannot happen, the crew in attendance should bring ALS care and the patient together in the fastest of three ways: (1) ALS back-up at the scene; (2) ALS back-up met en route; or (3) ALS by hospital staff in the emergency department if prehospital rendezvous is not possible.

The BLS providers on the scene may modify the ALS response as appropriate.

**BP** in these protocols refers to the systolic blood pressure.

**Continuous Nebulization** is administration of 3 unit doses of albuterol or albuterol-ipratropium without interruption; that is, put all 3 unit doses into the nebulizer at the same time (if volume allows) and administer until complete OR administer 1 unit dose x 3 without waiting between administrations.

**Emergency Department** means a hospital that provides an organized Emergency Service or Department that is available twenty-four (24) hours a day, seven (7) days a week and has the capability to provide On-Line Medical Control, to evaluate, treat, stabilize, and to refer to an appropriate outside resource for all persons who present themselves for treatment.
Emergency Medical Responder
The MDPB recognizes the Emergency Medical Responder (EMR) scope of practice to include the following:
   a. Airway management, including manual maneuvers, suctioning, application of supplemental O₂, and use of the following airway adjuncts - pocket mask, OPA/NPA, BVM
   b. Acquisition of manual vital signs
   c. Application of medications for force protection only (such as the Mark 1 kit)
   d. Performance of manual CPR and use of AED
   e. Assistance in normal childbirth
   f. Manual stabilization of the cervical spine or extremity injuries
   g. Hemorrhage control, including use of a tourniquet
   h. Emergency patient moves (such as drags, carries, etc.)

The Maine EMS EMR may practice within this scope of practice to include these skills

EMS Provider means any person or service licensed by Maine EMS to provide emergency medical services.

End-tidal CO₂ (ETCO₂) is a measurement of carbon dioxide in exhaled air used to assess ventilation, also referred to as capnography. The capnography monitoring must be continuous and with a device that displays a waveform

Fluid Bolus indicates maximum fluid administration achievable without pumps or other special equipment in the field setting. Specifically, running a large bore IV wide open until the desired clinical condition or blood pressure, based on the patient’s underlying condition, is achieved. A true IO bolus, at the appropriate dose with a syringe/3-way stop-cock assembly or pressure bag, is acceptable. Pediatric boluses are 20 mL/kg, and may be repeated one time if patient remains hypotensive, unless a specific alteration is noted in the protocols. Unless a specific volume of fluid is specified in the specific protocol, if the patient requires more than 40 mL/kg of IV fluid, contact OLMC to further guide fluid administration.

Hypoglycemia is a blood glucose less than 60 mg/dL.

IO in these protocols, means intraosseous access. IO may be used by the Advanced EMT or Paramedic. The IO route should be considered in any patient if an IV is not established within two attempts or 90 seconds and that patient has one of the following:
   a. Altered mental status (GCS less than or equal to 8)
   b. Respiratory failure (SpO₂ less than or equal to 90% after appropriate oxygen therapy, respiratory rate less than 10 or greater than 40 breaths per minute) with alteration of mental status
   c. Profound hypovolemia or hemodynamic instability with alteration of mental status or other evidence of shock – recall, the use of an IO for volume resuscitation requires the use of a pressure bag/3-way stop-cock to achieve optimal flow rates
   d. Cardiac arrest (medical or traumatic)

(Continued on next page)
(continued)
Additionally, the provider may choose to utilize the IO route first in critical patients for whom IV access may be difficult.

**With After** discussion with OLMC, may consider IO placement for the following conditions:

- a. Profound hypovolemia (Systolic BP less than 90 mmHg) without alterations in mental status or other evidence of shock
- b. Burn patients with bilateral upper extremity burns

*IO is CONTRAINDICATED in the following conditions

- a. Fracture of the tibia or femur in lower extremity placement or fracture of the humerus in upper extremity placement
- b. Infection at insertion site
- c. IO within the prior 24 hours in the same bone
- d. Knee or shoulder replacement (identified by midline vertical scar over the patella or anterior proximal humerus)
- e. Tumor near site
- f. Inability to locate landmarks
- g. Excessive tissue at insertion site
- h. IO access is not intended for prophylactic use

Approved Sites (one per bone): Per manufacturer recommendations

**Paramedic:** If infusion of medications or fluids causes significant pain, consider the following:

1. Adult: Consider lidocaine 2% (preservative free) 40 mg slow push followed by 10 mL Normal Saline flush. If pain continues, contact OLMC for OPTION of additional 20 mg bolus
2. Pediatric: Consider lidocaine 2% (preservative free) 0.5 mg/kg (MAX 40 mg) slow push followed by 10 mL Normal Saline flush. If pain continues, contact OLMC for OPTION of additional 0.25 mg/kg (MAX 20 mg) slow push

**IV means** any balanced electrolyte solutions may be used, such as Lactated Ringers, Normal Saline and 5% Dextrose in Water. IV solutions, as defined in this document, DO NOT include other additives (such as potassium) or medications. Normal Saline is the fluid of choice for patients with history of renal failure, not Lactated Ringers. Recommended catheter size for rapid fluid resuscitation in adults is 14-18 gauge. If rapid fluid resuscitation is not required, smaller catheter sizes and heparin/saline locks may be used. Heparin used for this procedure is not considered a medication.

**MDPB** means Maine EMS Medical Direction and Practices Board, which consists of the six Regional Medical Directors, a physician representing the Maine Chapter of the American College of Emergency Physicians, an At-Large physician representative, a Clinical Pharmacist or Toxicologist, the State Assistant EMS Medical Director and the State EMS Medical Director.

**NR** means a non-rebreather oxygen mask.

**O₂** means oxygen therapy as appropriate for patient.
Definitions

On-Line Medical Control (OLMC) refers to the on-line physician/physician assistant/nurse practitioner who is licensed by the State of Maine and authorized by a hospital to direct emergency medical services personnel consistent with the protocols developed by the MDPB.

Other Appropriate Destination means a facility that has been approved by the Board of EMS to receive, via ambulance, patients who are in need of emergency care.

Paramedic Back-up means use of an advanced life support resource when a presenting patient needs more than basic life support. As noted above, in the prehospital setting this indicates a Paramedic response. An ALS back-up agreement should be written between EMS provider services routinely offering and accepting ALS back-up support. This would establish medical/operational/liability expectations of both services. These protocols cannot mandate any service to routinely offer or receive back-up. However, any decision in this regard, particularly to refuse to offer or accept ALS back-up, should be grounded in reasonable medical, operational, or financial considerations and should be reviewed by the individual service's legal counsel.

Pediatric Patient in these protocols, means pre-pubertal (without pubic, axillary, or facial hair).

PPV means Positive Pressure Ventilation such as (in order of preference): two-person bag-valve-mask technique with oxygen, one-person bag-valve-mask technique with oxygen, mouth-to-mask ventilation with oxygen, and mouth-to-mask ventilation without oxygen.
Foreword

These protocols were developed for the following reasons:
1. To provide the EMS provider with a quick field reference, and
2. To develop written standards of care which are consistent throughout the State of Maine

Users of these protocols are assumed to have knowledge of more detailed and basic patient management principles found in EMS textbooks and literature appropriate to the EMS provider’s level of training and licensure.

EMS providers are encouraged to contact OLMC in any situation in which advice is needed, not only in situations as directed by theses written protocols.

To use these protocols as they were intended, it is necessary to know the philosophy, treatment principles, and definitions which guided the physicians and other EMS providers who drafted these protocols:

• **Delays in treatment should very RARELY delay transport!** This is especially true for trauma patients, patients with chest pain and patients with suspected stroke. IVs should be started en route except in those situations where treatment at the scene is in the patient’s best interest, such as shock, prolonged extrication, or a cardiac patient when full ACLS care is available. Delays in transport should be discussed with OLMC.

• **Inability to establish voice contact with OLMC:** There are rare situations where the patient is unstable and delay in treatment threatens the patient’s life or limb. If, after good faith attempts, the EMS provider cannot contact OLMC, then the EMS provider is authorized to use any appropriate treatment protocols as if they were standing orders. In such cases, treatments must still be consistent with the EMS provider’s training and licensure. Continue attempts to contact OLMC and document these attempts on the patient run record.

• **Transports and transfers:** During transports and transfers, ambulance crews will follow these MEMS protocols, including use of only those medications and procedures for which they are trained and authorized by protocol.

• **Hospital destination choice:** If a patient needs care which the ambulance crew, in consultation with OLMC, believes cannot be provided at the most accessible hospital, the patient will be transported to the nearest facility capable of providing that care upon the patient’s arrival. If, with OLMC consultation, a patient is believed to be too unstable to survive such a diversion, then the patient will be transported to the most accessible hospital with an emergency department. Diversion is also non-binding, and if a patient insists or if the crew deems that bypass is not in the patient’s best interest, then going to a hospital “on diversion” is appropriate. If OLMC contact is not possible, the ambulance crew is authorized to make this determination. OLMC cannot legally refuse these patients.
• **Regional destination**: Each region has the authority to develop protocols which designate the appropriate destination for patients transported from the scene. Any such protocol should be patient-centric and created exclusively to offer patients emergent care only available at selected regional sites. Examples of such protocols include the Maine EMS Trauma System.

• **Treatments/medications should be given in the order specified.** However, the MDPB recognizes that often treatments are delivered simultaneously and more than one protocol may be used. OLMC or Advanced Providers may request treatments/medications out of sequence for medical reasons.

• **MEMS patient/run record** will be legible and thoroughly completed for each call or for each patient when more than one patient is involved in a call. This document is our legacy of patient care and holds valuable information for hospital providers. This information is essential to patient care and safety. Services must provide a patient care document before leaving the hospital. In MOST circumstances, this document will be a completed copy of the patient run report, although, in rare circumstances, when it is not possible to complete the electronic patient care record before leaving the hospital, services may provide the hospital with a Maine EMS-approved, one page, patient care summary. **THIS DOCUMENT DOES NOT REPLACE THE COMPLETED RUN REPORT.** These documents may become part of the patient’s hospital record and, in an effort to ensure excellent patient care, all information on this written summary must reflect the information in the electronic run report. Services must still complete the electronic patient care report and make the report available to the hospital as soon as possible.

• **Quality Assurance**: All EMS providers and services must be in compliance with the Regional and State Quality Improvement Program to the satisfaction of the Regional Medical Director.

• **Assuming and Reassessing care already provided**: EMS providers who will be assuming the responsibility for patient care will also be responsible for assessing the care provided before their arrival, and for all subsequent care after they arrive up to and including their level of training and licensure. If an EMS provider has not been trained in a particular treatment listed at his level, or if that treatment is not within the EMS provider’s scope of practice, the provider may not perform the treatment.

• **If there is a Paramedic on scene that is willing to:**
  a. Accompany the AEMT on the call, and
  b. Accept responsibility for the AEMT’s actions

Then the Paramedic may direct the AEMT to administer medications that are within the AEMT’s scope of practice. This may be accomplished without contacting OLMC as long as the medication administration would not require OLMC for the Paramedic. If the Paramedic is unwilling to accept the above responsibilities, then the AEMT must contact OLMC before administering any medications.
• **Defibrillations:** Advanced EMTs are expected to follow these protocols within the limitations of the monitor/defibrillator available to them.

• **Carbon monoxide monitors:** Carbon monoxide monitors may be used for informational purposes only. Any alterations of treatment based on pulse carboximetry readings must be approved by OLMC.

• **Medical Control permission:** If a treatment is listed as requiring Medical Control permission at one level and is listed again without requiring OLMC permission at a higher level, the higher-level EMT need not seek OLMC permission.

• **Deviation from protocols:** These protocols represent a consensus of the MDPB. In unusual situations, OLMC may deviate from these protocols if done in the patient’s best interest. The deviation in care ordered must be within the scope of practice, training and skill of the EMS provider. The reasons for deviating from these protocols must be documented in the patient’s chart. Under such circumstances, if the ALS provider agrees, the ALS provider will verify and will comply with OLMC orders, will fully document the deviation on the patient run record, and will not consider the care rendered to be an emergency medical treatment to be routinely repeated.

• **Arrival of officially dispatched EMS personnel:** Once EMS personnel have arrived on the scene, they may interact with other medical personnel on the scene who are not a part of the organized EMS system responses in the following manner:

  • **Maine EMS licensees not affiliated with one of the responding services may only provide care within their scope of practice with the approval of the ambulance crew-member in charge of the call.**

  • **The patient’s own physician,** physician assistant, or nurse practitioner may direct care as long as they remain with the patient (in their absence, direction of care is subject only to these protocols and OLMC). You may assist this person within the scope of your practice and these protocols. Only a physician, physician assistant authorized to offer OLMC by their hospital, or independent nurse practitioner may give orders outside of the MEMS protocols. Questions in this regard should be resolved by OLMC. You may show this person Black 1, the “Non-EMS System Medical Interveners” protocol to assist with your explanation.

  • **Other unsolicited medical interveners** must be Maine licensed physicians, nurses, nurse practitioners or physician assistants whose assistance you request. The Black 1 “Non-EMS System Medical Interveners” protocol describes this, and should be shown to such interveners.

  • **Other healthcare providers in the home:** Other healthcare providers in the home attending the patient (i.e. R.N., L.P.N., C.N.A., Nurse Midwife, etc.) are a valuable source of information and assistance. Any aid or treatment they wish to give must be authorized by OLMC. Any dispute over treatment or transport should be settled by OLMC.
Foreword

- **Home healthcare devices and appliances**: Many patients will may have devices and appliances (drains, ports, LVAD, insulin pumps, etc.) with which they are routinely discharged home. Patients (or their licensed care providers or previously instructed family members), are expected to maintain them on their own. These devices have some risks associated with them, but are generally considered safe in the home environment. As such, EMS providers are not restricted in the care or transfer of these patients based solely on the presence of these devices or appliances. **If an issue arises and unfamiliarity with, or any questions concerning these devices that cannot be immediately resolved by the patient or caregivers, it should be referred to OLMC.**

- **Left Ventricular Assist Device (LVAD)**: A surgically implanted pump to assist left ventricular function. An LVAD can be a bridge to a heart transplant (although used for chronic care as well). Inform OLMC as soon as possible when interacting with a patient with an LVAD, as diversion to a hospital with a higher level of care may be suggested. Direct contact with the cardiac service responsible for this patient is also suggested at the earliest possible moment. The patient or patient’s family should have this contact information readily available. No cardiac arrhythmia should be treated if the LVAD is functioning, as judged by an audible sound or pulse, without medical control approval for any treatment. Be sure to bring the patient’s batteries (including the 24-hour battery), the large battery charger and all other accessories. Local EMS services may receive specialized training and protocol exemptions to extend help to these patients by working with regional EMS Medical Directors and MEMS.

- **Graduates with a current certification from a Maine EMS-approved wilderness EMT course** may apply the principles of care taught in that course with the approval of the service Medical Director and when patient arrival at a definitive care setting will be more than 2 hours.

- **Repeated Treatment**: Unless otherwise indicated, any treatment included in these protocols may be repeated after reassessment and with OLMC permission.

- **External Pacing** (where indicated in these protocols) should be performed if a pacer is available.

- **Oxygen supplementation** will be by nasal cannula or non-rebreather mask as appropriate.

- **Patient Sign-Offs**: There exist three origins for patient sign-offs:
  a. A patient refuses transport and the provider agrees transport is not warranted
  b. The patient refuses transport but the provider does not feel this is safe
  c. The patient requests transport but the provider refuses (this final example is called an EMS System-initiated sign-off)
Foreword

Patient-initiated sign-offs should only be considered in patients with decision-making capacity and resources available to care for themselves and when non-transport is considered safe. These sign-offs do not require discussion with On-Line Medical Control. In situations which the patient requests sign-off but the EMS provider deems inappropriate, please refer to OLMC. **EMS System-initiated patient sign-offs (i.e.: when the patient requests transfer but the EMS provider refuses) are tremendously risky interactions and are not permissible. These sign-offs must be approved by OLMC and the service is expected to review all of these events through the service’s quality assurance mechanism. Patient medical records must be completed for all of these interactions.**

- **Maine EMS Special Circumstance Protocols:** Maine EMS protocols are intended to address the vast majority of medical emergencies encountered by an EMS provider. While intended to be comprehensive, certain patients exist with rare medical conditions that require highly specialized emergent care. In such situations, Maine EMS has created the “Special Circumstance Protocols”. These are prearranged medical protocols specialized to individual patients, suggested by the patient’s medical provider and ratified by the **MDPB EMS service Medical Director.** Patients will present with a “Maine EMS Special Circumstance Protocol Form” that outlines the patient’s individual protocol and is signed by the patient’s physician, the patient or their guardian, the local EMS service chief, the EMS service Regional Medical Director, and the State of Maine EMS Medical Director. These special circumstance protocols should be made known to local EMS services and providers. In cases of question or uncertainty regarding the nature of the protocol, please refer to OLMC.

- **During transport,** patients should be secured to the stretcher utilizing both lateral and shoulder straps.

- **Paramedics and AEMTs** are expected to perform all duties in their listed scope of practice as well as those of the prior scopes of practice in the appropriate logical order.

- **Vagus Nerve Stimulators (VNS)** are implanted devices that are used to treat refractory partial seizures by stimulating the vagus nerve. They are not currently approved to treat generalized seizures. The exact mechanism is unclear but the devices provide continuous on-off cycles of vagal stimulation to prevent seizures. Patients with a VNS typically have a magnet that they can use to trigger an additional 30 second stimulation period when they feel a seizure coming on or when they are having a seizure. Caregivers are typically trained to assist with the magnet. In the event no one is available who is trained to use the magnet, the EMS provider at any level may assist the patient if the patient can confirm that the device is a VNS and after the EMS provider consults with medical control.

- **In the critically ill patient,** vascular access may be difficult to obtain. The decision on which technique to use first, IV versus IO, is based on the assessment and judgment of the provider. Ultimately, an IV is the superior form of vascular access but the IO is appropriate for the initial resuscitation of the critically ill patient if, in the provider’s judgment, attempts to obtain IV access would lead to an unreasonable delay in initiating fluid resuscitation.
• **Option to Cancel ALS policy:** If the patient meets the protocol specific cancellation criteria, the EMT and AEMT, in consultation with OLMC, may determine that it is appropriate to cancel the ALS response based on transport time, patient co-morbidities, and any other applicable factors.

• **All equipment** referenced in these protocols must be “Maine EMS-Approved.” In addition, it is expected that all providers will be appropriately trained before using any piece of equipment, device, or technique.

**TASER PROBES**

The use of a TASER does not automatically necessitate an EMS response or involvement. In assessing such patients, be cognizant of the potential for underlying metabolic dysfunction. TASER probes may be removed from the subject by the deploying officer. Probes that are embedded in a sensitive area (i.e. face, neck, breast, and genital area) may need to be removed by medical personnel. In these cases, the subject should be transported to the hospital for examination and removal of the probes by medical personnel at the hospital. Other adverse affects, if any, (i.e. respiratory difficulty, seizures, etc.) should be treated as appropriate by the applicable protocol(s).
I. When to Start Resuscitation:
As soon as the absence of pulse and respiration is established.

II. When Not to Start Resuscitation:

A. All Patients: Any patient displaying obvious and accepted signs of irreversible death such as rigor mortis, dependent lividity, decapitation, decomposition, incineration, other obvious lethal injuries, evidence of central freezing (such as ice in the airway), core temperature less than 50 degrees F, chest wall so stiff that compressions cannot be performed, or patients submerged in cold water (for specific recommendations in drowning, refer to Drowning Protocol, Yellow 17)

B. All Normothermic Patients: Major trauma victims who have no respiration and no pulse, no sign of life at the time of Maine EMS licensed crew member arrival

C. When a Do Not Resuscitate (DNR) order is presented in one of three forms:

1. EMS DNR orders from other states: EMS/DNR programs. If the order or device (i.e., plastic bracelet, jewelry, or card) appears to be in effect, and is understandable to the crew, follow the order’s specific instructions. If there are no specific instructions beyond “DNR”, follow Maine EMS Comfort Care/DNR Guidelines

2. Non-EMS actionable medical order (i.e. POLST/MOLST, etc.): A written order executed by a patient’s personal physician/PA/NP should be honored if it is understandable to the crew and if it is dated within 1 (one) year. Follow the order as written. If it is nonspecific as to care to provide or withhold, follow the MEMS Comfort Care/DNR guidelines

3. Maine EMS Comfort Care / DNR Program - A Maine EMS Comfort Care/DNR order does not have an expiration date. Once activated, it remains in effect until the patient or someone acting on their behalf as described and authorized on the Comfort Care/DNR form cancels it. (Note: Although no longer distributed by Maine EMS, extant DNR/Comfort Care “orange” forms, wallet cards and plastic bracelets remain valid)

D. When a signed Maine EMS Do Not Resuscitate Directive form or Maine EMS- approved Do Not Resuscitate Directive jewelry is presented to EMS personnel; once executed by the patient and signed by a physician, physician’s assistant or nurse practitioner, the Do Not Resuscitate Directive remains in effect until the expiration date on the form or, if no expiration date is noted on the form, until the patient cancels it

E. A photocopy is acceptable as proof of the existence of valid DNR Order or DNR Directive, provided that the photocopy is legible and understandable by EMS personnel

(continued next page)
III. Treatment/Comfort Care

F. When treating a patient with a Maine EMS Comfort Care/DNR Order or Do Not Resuscitate Directive, the responding EMS provider should perform routine patient assessment and resuscitation or intervention until EMS personnel verify:

1. That an EMS Comfort Care/DNR Order or Do Not Resuscitate Directive exists; or,

2. That a Maine EMS-approved EMS Comfort Care/DNR wallet card, plastic bracelet or Maine EMS-approved DNR jewelry is present, intact and not defaced. The plastic bracelet may be worn on the wrist or ankle or on a necklace; or,

3. That Maine EMS-approved Do Not Resuscitate Directive jewelry is present, intact and not defaced; and,

4. The identity of the patient through family or friends present, or with photo ID such as a driver’s license. A good faith effort only is required

G. Follow these EMS Comfort Care/DNR procedures in all cases:

1. **These comforting interventions are encouraged:**
   a. Open the airway manually (NO intubation, No BVM unless invited by conscious patient);
   b. Suction and provide oxygen;
   c. Make the patient comfortable (position, etc.);
   d. Control bleeding;
   e. **Provide pain and other medications of comfort only to a conscious patient only** (ALS per OLMC/Hospice provider On-Line Medical Control);
   f. Be supportive of the patient and family;
   g. Contact patient’s physician/PA/NP/Hospice provider or On Line Medical Control if questions arise or problems

2. **Resuscitative measures to be avoided:** (to be withheld, or withdrawn if resuscitation has begun prior to confirmation of EMS Comfort Care/DNR Order or Do Not Resuscitate Directive status).
   a. CPR;
   b. Intubation (ET Tube, or other advanced airway management);
   c. Surgical procedures;
   d. Defibrillation;
   e. Cardiac resuscitation medications;
   f. Related procedures per On Line Medical Control.

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IV. Revocation, Documentation & When to Stop Resuscitation

H. Who may revoke an EMS Comfort Care/DNR Order or Maine Do Not Resuscitate Directive:

1. The patient (by destroying EMS Comfort Care/DNR Order Form, wallet card, plastic bracelet and DNR jewelry, or by destroying the Do Not Resuscitate Directive and DNR jewelry, or verbally withdrawing the order or directive);

2. For the EMS Comfort Care/DNR Order form only:
   a. The patient’s physician/PA/NP who signed the order;
   b. The Authorized Decision-Maker for the patient who signed the order.

I. Documentation:

1. Use the Maine EMS patient/run report.
2. Describe assessment of patient’s status.
3. Document which identification (i.e., form, wallet card, plastic bracelet or DNR jewelry) was used to confirm EMS Comfort Care/DNR or Do Not Resuscitate Directive status and indicate that it was intact and not canceled.
4. Indicate the patient’s physician/PA/NP name, on the patient/run report.
5. If the patient has expired on arrival, comfort the family and follow your EMS agency’s procedure for death at home. A Maine EMS patient/run report still needs to be completed.
6. If transporting the patient, EMS providers should keep the original EMS Comfort Care/DNR Order Form, wallet card, plastic bracelet, Do Not Resuscitate Directive Form or DNR jewelry with the patient.

J. When to Stop Resuscitation: Resuscitation should be terminated:

1. Unwitnessed Arrest:
   a. When the patient regains pulse/respiration
   b. When the patient remains in a non-shockable rhythm (PEA/Asystole) for > 20 minutes OR is unresponsive to advanced cardiac life support with a non-shockable rhythm after 20 minutes of resuscitation. When criteria as defined in the Termination of Resuscitation Protocol have been met.
   c. When irreversible signs of death, such as dependent lividity, pupils fixed and dilated, palpable hypothermia (not from exposure) and no audible heart sounds are noted in a patient with unknown downtime or downtime > 20 minutes.
   d. When the rescuers are physically exhausted or when equally or more highly trained health care personnel take over
   e. When it is found that the patient has a DNR order or other actionable medical order (i.e. POLST/MOLST etc.) form.
   f. Continue resuscitation if conditions on scene are NOT amenable to cessation of resuscitation
   g. Continuation of resuscitation beyond these protocols must be in consultation with OLMC

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2. **Witnessed arrest:**
   a. When the patient regains pulse/respiration
   b. **When the patient remains in a non-shockable rhythm (PEA/Asystole) for > 20 minutes OR is unresponsive to advanced cardiac life support with a non-shockable rhythm after 20 minutes of resuscitation.** When criteria as defined in the Termination of Resuscitation Protocol have been met.
   c. In the absence of ALS, when the same Maine EMS licensed crew member has determined the absence of all vital signs for 20 minutes, in spite of BLS, except in the case of hypothermia.
   d. When the rescuers are physically exhausted or when equally or more highly trained health care personnel take over.
   e. When it is found that the patient has a DNR or other actionable medical order (i.e. POLST/MOLST etc.) form.
   f. Continue resuscitation if conditions on scene are NOT amenable to cessation of resuscitation
   g. Continuation of resuscitation beyond these protocols must be in consultation with OLMC

**V. Management of Bodies**
If resuscitation efforts are discontinued, follow your service’s policy for disposition of patient remains. In cases of uncertainty, arrangements should be made with On Line Medical Control with regards to disposition of the body. Contact your local ED with regard to tissue donation options and procedures in advance.
Death Situations for Emergency Responders #1

PREPARED JOINTLY BY: Attorney General, Office of Chief Medical Examiner, and Maine State Police.

GENERAL AIM: Preservation of scene, including body as found, for investigative purposes within practical limits consistent with the role and responsibilities of emergency medical care givers.

Death Situation Guidelines

I. Preserve life: While forensic guidelines emphasize that the scene should not be disturbed, the first and most important course of action is to follow all usual procedures to ensure the preservation of life.

II. Once Death is confirmed: If the decedent is clearly dead, the body should not be moved or disturbed unless there is a danger that the body may be lost or further damaged.
   A. Maine statutes do not require a pronouncement of death.
   B. The scene should be secured and left undisturbed.
      1. If the police are present, they should take charge in order to determine whether the case falls under the jurisdiction of the Office of Chief Medical Examiner (OCME) or whether the death certificate may be certified by the patient's private attending physician.
      2. If there is no police officer present, EMS should call the local police or call the OCME directly to report the case, so that a determination may be made as to the need for further investigation into the cause and manner of death. OCME emergency line to report deaths: 1-800-870-8744.
      3. If it is determined not to be a Medical Examiner case, try to accommodate the family's request or contact OLMC for guidance.
      4. Consider contacting the New England Organ Bank 1-800-446-6362
   C. Tubes and medical devices should be left in place. Certain reusable equipment may be removed to resupply the ambulance; however written documentation of any such action must be given to investigators.
   D. Any clothing or property should be left undisturbed.

III. What is a Medical Examiner (ME) case?:
   A. Any suspected HOMICIDE
   B. Any suspected SUICIDE
   C. Any death involving any ACCIDENT or INJURY
   D. Any death of a CHILD
   E. Any death in CUSTODY
   F. Deaths caused by SUSPECTED GROSS NEGLIGENCE during a Medical Procedure
   G. SUDDEN DEATH from an UNKNOWN cause or any death where there is no private attending physician
   H. UNIDENTIFIED persons
   I. OCCUPATIONAL deaths (work-related)
   J. Unnatural deaths in a Mental, or Residential Care of DHS Residential Care Facility
   K. Any death that might ENDANGER or THREATEN the Public Health
IV. Deaths in Children:
   A. All deaths in children under the age of three automatically become medical examiner cases unless the death is expected based on previously diagnosed natural disease.
   B. Determination of the cause of death in infants and children is very difficult. While the OCME understands the concerns of the parents, the child must be left undisturbed until investigating police officers have finished the initial investigation. SIDS is not an acceptable reason to transport a deceased infant or allow the infant to be moved prior to investigation.

V. Reports and follow up on Medical Examiner cases:
   A. If families have questions, they may be referred to the OCME. Families should call the office using the 24 hour business line at 207-624-7180
   B. Copies of EMS run sheets should be given to police investigators and/or the OCME (refer to Brown 2)
   C. If any EMT wishes follow-up information on any specific case, or if there is a question of infectious exposures, call the OCME on the business line, 207-624-7180.
GENERAL RESPONSIBILITY FOR DECEASED PERSONS: The Office of Chief Medical Examiner is responsible for deceased victims of mass disasters including identification and removal from the scene. The Office of Chief Medical Examiner (1-800-870-8744, restricted emergency call number) should be informed immediately of any multiple fatality situations.

1. BODIES SHOULD BE LEFT IN PLACE AT THE SCENE except when they must be moved to preserve them from destruction or when they block access. The resting place of the victim may be critical for identification of the body and/or reconstruction of the incident. They can be tagged as fatalities to prevent other medical personnel from repeating examination.

2. IF DEATH OCCURS EN ROUTE TO THE HOSPITAL, the body need not be returned to the scene but can be brought to the hospital or other suitable storage place as determined by distances and/or the needs of other patients in the ambulance. If the body is left anywhere other than the hospital or designated temporary morgue, the body should be tagged and the Office of Chief Medical Examiner should be advised.

3. THE SITE A VICTIM IS REMOVED FROM SHOULD BE NOTED on a tag along with the name and agency of the person who removed it whenever removal is needed and in cases of death after removal. Such information may be critical for identification of the body and/or reconstruction of the accident.

4. IF AN IDENTIFICATION OF A PATIENT IS MADE, a tag with at least the name and date of birth and time of death of the patient/decedent along with the identifier’s name, relationship, address and where he/she can be located should be put on the body.

5. PERSONAL PROPERTY SHOULD BE LEFT WITH THE BODY including clothing removed from a patient if the victim dies. Nothing should be removed from those already deceased.

Consistent with New England EMS Council MCI Management, the action priorities for the first medical crews arriving on the scene are:

1. Assess and avoid exposure to existing dangers
2. Notify dispatch of type of MCI and estimate of number and type of patients
   a. Request EMS, fire, police assistance
   b. Request hospital notification
3. First ambulance or other vehicle with medical frequencies becomes EMS command vehicle – locate near fire and police command vehicles. Strip equipment/supplies – place in equipment area (near planned patient collection/treatment area).
4. Designate, in the following order, the following positions as qualified personnel become available:

EMS CONTROL OFFICER – Reports to Incident Commander. Responsible for overall patient triage, treatment, and transportation. Procures EMS back-up, supplies, equipment, transport vehicles as needed, supervises and assigns all other medical personnel.

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Mass Casualty/Disasters/HazMat #2

PRIMARY TRIAGE OFFICER – Rapidly assesses all patients then assigns personnel to provide treatment to those patients in most need of immediate treatment, who will most benefit from immediate care with the resources available. Treatment is limited to:
  • Bleeding – rapid pressure dressing if severe
  • Airway – reposition patient
  • Shock – elevate extremities

SECONDARY TRIAGE OFFICER – Rapidly tags all patients, or assigns personnel to do tagging (with METTAGS, SMART Tags, or other locally approved Triage System) and, supervises immobilization after classification, and oversees transfer to collection/treatment area.

Tag categories are:

RED (I): Conditions requiring immediate transport by ambulance to prevent jeopardy to life or limb and which will not unduly deplete personnel/equipment resources (examples: progressive shock, major blood loss, major multiple injuries, severe respiratory distress. Cardiac arrest – only if personnel can be spared).

YELLOW (II): Not requiring immediate transport to prevent jeopardy to life or limb, but eventually will require ambulance transport to hospital for attention.

GREEN (III): Minor conditions probably not requiring ambulance transport to hospital.

BLACK (O): Are obviously dead, or dying from lethal injuries, or requiring CPR when no personnel are available to do so without compromising other patients.

TREATMENT OFFICER – Sets up / supervises patient collection / treatment area. Reassesses and re-tags (if necessary) patients, assigns patients and personnel to treatment areas. Prioritizes for transport. Coordinates with Loading/Transport officer to make single radio transmission to receiving facility (pt. ID#, METTAG priority, nature of injury, ambulance, and ETA ONLY).

LOADING OFFICER – Stages ambulances in holding area. Instructs crews to put all available equipment in equipment area. Assigns patients to vehicles. Directs drivers to hospital(s). Instructs not to contact hospital unless OLMC required for condition change. Notifies hospital, or coordinates communication to hospital notification times, patient ID#’s and destination of all transporting vehicles.

In the event of a public health emergency or declared disaster, EMS providers may be asked to divert selected patients with certain conditions to hospital-established or state-established alternate care sites by OLMC.
Suggested Scene Organization
(Not for HazMat)
Sexual Assault Victim

ALL LEVELS
1. Treat any life-threatening emergency first and according to these protocols.
2. Try to attend to maintenance of forensic evidence. Try not to cut through tears or stains in clothing. Do not cleanse any skin area more than necessary to provide immediate care.
3. If the patient so desires and/or mandated reporting is indicated, police should be called if they have not already been notified.
4. If no life-threatening situation is present, prehospital care may require waiting for police to secure the scene which is a potential crime scene.
5. Victims of sexual assault commonly have much guilt, and may require psychological support. Please respect the stress that they are enduring.
6. By nature of this event, any touch may be traumatic for this patient. Overtly and repeatedly explain what you are doing to try to lessen the impact of procedures and touching.
7. Advise the patient not to eat, drink, smoke, bathe, change clothing or go to the bathroom if at all possible in order to preserve any forensic evidence. If they must urinate, request that they do not wipe.
8. If the patient has removed any clothing worn in the assault, each piece of clothing should be separately bagged in paper bags and brought to the hospital with the patient.
9. When transporting the patient, it is preferable whenever possible to have a same sex provider as the primary provider. If the assault is a same sex assault, than a provider of the opposite sex may be more comfortable for the patient.
10. To maintain privacy and confidentiality, use a land-line for hospital reporting whenever possible and do not clarify the type of assault, only that you are transporting a “victim of assault.”
11. The patient should be encouraged to go to the hospital for a sexual assault forensic examination that would allow not only the option to have collection of forensic evidence, but also treatment of possible injuries, and the chance to obtain pregnancy and sexually transmitted disease prophylactic treatment, and appropriate counseling.
12. If the patient refuses treatment and/or transportation to the hospital, document all findings and observations as completely as possible. When signing the patient off at the scene, try to have a police officer witness this sign off.
All levels

- Child abuse and child neglect are sufficiently widespread to guarantee that virtually every EMS provider will encounter them at least once during his/her career.
- It is estimated that approximately 2-3 million cases occur each year or approximately 11 cases per every 1,000 children within the U.S. Each year at least 2,000 children die from physical abuse.
- The most commonly identified forms of abuse by the EMS provider are physical abuse and severe physical neglect, although sexual abuse may on occasion be observed.
- The EMS provider must at all times demonstrate and maintain a supportive and non-judgmental attitude with primary caregivers. Accusation and confrontation delay immediate treatment as well as transportation to a definitive care facility.
- When abuse is a possibility, the healthcare professional has two major responsibilities: first, to provide medical care to the child; and second, to collect and document all information that may possibly establish the occurrence of abuse or neglect. Refrain from asking the child too many questions and specifically do not ask any leading questions – keep questions simple and open-ended such as “What happened?” and “Are you hurt?”
- As an EMS provider, you must report immediately to Child Protective Services any child whom you have “reasonable cause to suspect” has been abused or will be abused. Failure to do so is punishable as a civil violation. It is not enough to tell someone else of your suspicions. If a child is abused and unreported, there is a 50% chance that the child will be abused again and a 10% chance that the child will die from future abuse.

Possible Indicators of Abuse
1. Injured child under two years of age, especially hot water burns or fractures
2. Facial, mouth, or genital injuries
3. Multi-planar injuries (front and back, right and left) Atypical, diffuse, and/or severe injuries – especially when not over bony prominences
4. Poor nutrition or poor care
5. Delay in seeking treatment or not wanting the provider to speak alone with the child
6. Vague, inconsistent, or changing history
7. Refer to appropriate protocol for the comatose child, Pink
   or the child in cardiac arrest, Pink

Treatment of suspected child abuse in the field
1. Suspect abuse but do not accuse the caretaker. Every time a child is encountered by the healthcare professional having a traumatic injury, the question that should come to mind is, “Could this be abuse?”. In most cases the answer will be an obvious “no”; however, enough uncertainty will exist in some cases to warrant further assessment.
2. Follow normal initial assessment priorities of the ABC's and mental status when caring for the child.
3. Provide the appropriate intervention procedures for any abnormal findings such as respiratory, trauma, or other medical emergencies; shock; or altered mental status.
4. EMS providers are in key positions to assess environmental conditions and the observable interactions of family and child. Environmental signs of possible abuse or neglect may include but are not limited to: unsanitary conditions; garbage scattered about the house; unsafe conditions such as open, unguarded windows or potentially dangerous objects within reach of children.

5. Perform a detailed physical examination on any child in stable enough condition to allow for such. Examine all parts of the body for deformities, ecchymosis, lacerations, abrasions, punctures, burns, tenderness, and swelling. It is vitally important that injuries of the mouth and sternum be observed in detail prior to the initiation of resuscitative measures and documented that such injuries were found prior to resuscitation.

6. It is important to transport all children having evidence of abuse or neglect due to the possibility of additional injuries not immediately obvious. Transport of potentially abused or neglected children ensures that they receive the appropriate and necessary social service. Assistance may be necessary from law enforcement, OLMC, etc.

7. Convey your impressions and information to the hospital staff.

8. Write a detailed and descriptive report, which provides an accurate and clear record of all observations and treatment from the time of the initial call through transfer of the patient to the ED staff. Do not make a diagnosis of abuse, and refrain from including personal opinions, emotional overtones, or interpretations. Primary caregiver quoted statements must be documented as such with quotation marks, and exactly word for word as stated by the person. As well, this legal document must be legible.

9. You must contact Adult (1-800-624-8404) and Children’s (1-800-452-1999) Emergency Services at to make a report. This is a 24-hour a day reporting number. You will be protected by law from civil liability for making such a report if made in good faith.

Title 22 MRSA, Chapter 1071, Subsection 4014

AN ACT TO STRENGTHEN THE LAWS GOVERNING MANDATORY REPORTING OF CHILD ABUSE OR NEGLICT.

(Title 22 MRSA Section 4011-A, Subsection 7)

"Children under 6 months of age or otherwise non-ambulatory. A person required to make a report under subsection 1 shall report to the department if a child who is under 6 months of age or otherwise nonambulatory exhibits evidence of the following:

a. Fracture of the bone;
b. Substantial bruising or multiple bruises;
c. Subdural hematoma;
d. Burns;
e. Poisoning;
f. Injury resulting in substantial bleeding, soft tissue swelling, or impairment of an organ."

(Title 22 MRSA Section 4011-A, Subsection 9)

"Training requirement: A person required to make a report under subsection 1 shall complete at least once every 4 years mandated reporter training approved by the department."
Adult Abuse, and Intoxicated Drivers

ADULT ABUSE
(Title 22 MRSA, Chapter 958-A, Subsection 3477)

“Reasonable cause to suspect. The following persons while acting in a professional capacity...ambulance attendant, emergency medical technician or other licensed medical service provider, Unlicensed assistive personnel shall immediately report to the department when the person knows or has reasonable cause to suspect that an incapacitated or dependent adult has been or is likely to be abused, neglected or exploited.”

Call Adult Protective Services: 1-800-624-8404 (24 hours a day). Similar protection from liability for reporting exists.

INTOXICATED DRIVERS
(Title 29- A)

§ 2405 (1) “Persons who may report If, while acting in a professional capacity a...emergency medical services person...knows or has reasonable cause to believe that a person has been operating a motor vehicle, hunting or operating a snowmobile, all-terrain vehicle or watercraft while under the influence of intoxicants and that motor vehicle, snowmobile, all-terrain vehicle or watercraft or a hunter has been involved in an accident, that person may report those facts to a law enforcement official.”

§ 2405 (2) Immunity from liability. A person participating in good faith in reporting under this section, or in participating in a related proceeding, is immune from criminal or civil liability for the act of reporting or participating in the proceeding.

§ 2524 (1) Persons qualified to draw blood for blood tests. “Only a physician, registered physician’s assistant, registered nurse or person whose occupational license or training allows that person to draw blood samples may draw a specimen of blood for the purpose of determining the blood-alcohol level or the presence of a drug or drug metabolite.”

§ 2528 Liability. “A physician, physician's assistant, registered nurse, person whose occupational license or training allows that person to draw blood, hospital or other health care provider in the exercise of due care is not liable for an act done or omitted in collecting or withdrawing specimens of blood at the request of a law enforcement officer pursuant to this chapter.”
Transport Protocol #1

1. If there is a question of decision making capacity or the patient does not appear to understand the consequences of his/her refusal of transport, then contact OLMC.
2. The patient must be informed of the consequences of his/her refusal to be transported. This must be documented in the patient care report.
3. This screening may typically arise when an ambulance is requested by someone other than the patient (i.e. the police, a bystander). The EMS run report must always be completed.
4. If the patient refuses transport and is judged to be without decision making capacity, the EMT must speak directly with OLMC. If unable to reach OLMC, the patient is transported.
5. EMS System initiated patient sign offs are tremendously risky interactions and are not condoned by Maine EMS.
6. The service is expected to review all patient sign offs through the service’s quality assurance mechanism. Patient medical records must be completed for all of these interactions, and must include the following information:
   a. The patient must be calm, competent, sober, and alert with the absence of any acute medical/surgical or traumatic process that impairs the patient’s decision-making capacity
   b. Greater than 18 years, emancipated, or contact with guardian
   c. Service(s) offered
   d. Reason service(s) declined
   e. Statement of risks and patient understanding of risk
   f. Discussion of alternatives to service offered and potential consequences of declining offered service
   g. Discussion with patient that EMS services may be accessed at any time, and that the patient had decision making capacity.
7. In some circumstances, patient transport is requested by an off site medical provider. Should a patient refuse transport and be found to have decision making capacity, EMS providers should communicate the discovery of decision making capacity and the patient’s right to refuse transfer with invested parties. OLMC or the physician ordering transport must be contacted by EMS in this decision making process. It is suggested that the consulted physician discuss the refusal of care or transport directly with the patient.

8. When the patient is found to lack decision-making capacity but continues to refuse transport, contact OLMC for assistance. Should the patient continue to refuse transport, consider accessing other community advocates and resources (such as family/friend when appropriate and/or police). Consider direct dialogue between OLMC and the patient or OLMC and law enforcement to assist in resolving the conflict.
Transport of Mentally Ill Patients

Maine EMS personnel are generally called to transport a mentally ill patient in one of two situations:

**Emergency Transport**
Safety for the patient and the crew is the primary concern in the transport of the mentally ill patient. Personnel should make sure they do a thorough evaluation of the patient to find and treat possible medical causes of the behavior. Refer to the Agitation/Excited Delirium Protocol, **Yellow 12**.

EMS personnel are authorized under Maine law as physician extenders to **physically** restrain any patient who poses a threat to themselves or others. Providers are cautioned to use physical restraint as a last resort, preferably with the assistance of local law enforcement. Once the decision is made to restrain a patient, the patient should remain restrained until arrival at the emergency department, unless it interferes with the delivery of medical care.

**Non-Emergency Transfer**
Mentally ill patients who are being transferred usually fall into one of these categories:

**Voluntary Committal** – These patients have agreed to be transferred to a facility for evaluation and treatment of an underlying mental illness. It is important to get a thorough report on the patient prior to transport to avoid surprises en route. Voluntary committal patients can change their mind during transport. In this case, it is the responsibility of the EMS personnel to discharge the patient at a safe location, preferably at the originating facility. If it is not possible to return the patient to the originating facility, notify local law enforcement to meet you at your location.

**Involuntary Committal** – Patients who are being committed involuntarily must have committal papers (blue papers) completed prior to transport. Between the hours of 7 a.m. and 11 p.m. a judge has to sign the committal papers. After 11 p.m. and before 7 a.m. the papers do not have to be signed except for Riverview Psychiatric Center (formerly AMHI) – this is known as the “pajama clause”. Make sure that the transporting service is listed correctly on the papers. According to Maine law, the patient must be transported in the least restrictive form of transportation available. Make sure you get a thorough history to determine whether restraints will be necessary. **If the receiving facility refuses to accept the patient after evaluating them, the transporting service is required by law to transport the patient back to the originating facility.**


Protective Headgear Removal

The decision to remove protective headgear from an injured patient rests with the EMS provider on scene unless a Maine licensed physician is on scene and takes responsibility for the patient. It is important to immobilize the patient in a neutral in-line position, regardless of whether or not you choose to remove the helmet. This requires that you evaluate each patient and determine if other equipment (i.e. shoulder pads) must be removed or if additional padding under the shoulders or head is necessary. In the case of an athletic injury, the EMS provider should consider input from athletic trainers. Disputes should be referred to OLMC for resolution.

When deciding whether to remove protective headgear, please evaluate the following criteria:

Can You Access the Airway?

- YES
  - Does the Helmet Fit Snugly?
  - YES  
    - Can you adequately immobilize the spine while maintaining neutral in-line position?
      - YES  
        - Leave the Headgear in Place
      - NO
  - NO
- NO
  - Remove the Headgear

DRAFT
Defibrillation/Cardioversion Setting

DEFIBRILLATION SETTING*

<table>
<thead>
<tr>
<th></th>
<th>Initial</th>
<th>Second</th>
<th>Third</th>
<th>Subsequent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult</td>
<td>360 J</td>
<td>360 J</td>
<td>360 J</td>
<td>360 J</td>
</tr>
<tr>
<td>Pediatric</td>
<td>2 J/kg</td>
<td>4 J/kg</td>
<td>4 J/kg</td>
<td>4 J/kg</td>
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* Adult 360 J monophasic or MEP or equivalent biphasic for all attempts

DRAFT

CARDIOVERSION SETTING*

<table>
<thead>
<tr>
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<th>Initial</th>
<th>Second</th>
<th>Third</th>
<th>Subsequent</th>
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</thead>
<tbody>
<tr>
<td>Adult (VT)</td>
<td>100 J</td>
<td>200 J</td>
<td>300 J</td>
<td>360 J</td>
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<tr>
<td>Adult (SVT)</td>
<td>50 J</td>
<td>100 J</td>
<td>200 J</td>
<td>300 J</td>
</tr>
<tr>
<td>Pediatric</td>
<td>0.5-1.0 J/kg</td>
<td>2 J/kg</td>
<td>2 J/kg</td>
<td>2 J/kg</td>
</tr>
</tbody>
</table>

* Use closest machine setting possible

For biphasic defibrillation device, use monophasic equivalents as noted above
Maine EMS Medication List

The following are medications currently approved for use by Maine EMS licensees - as authorized by the Maine EMS Protocols. This list may be altered through protocol revision.

Prehospital Medications:

- Acetaminophen chewable tablets
- Activated Charcoal (without sorbitol)
- Adenosine
- Albuterol
- Amiodarone
- Aspirin
- Atropine
- Cyanide poisoning kit contents
- Dexamethasone
- Dextrose (D₁₀, D₅₀)
- Diphenhydramine
- EPINEPHrine 1 mg/mL (1:1000) & 1 mg/10mL (1:10,000)
- EPINEPHrine Auto-injector
- Fentanyl
- Glucagon
- Hemostatic Agents
- Heparin Solution (for use in maintaining IV access in a heparin lock only; otherwise this is not considered a prehospital medication. Approved also at Advanced EMT level).
- Ipratropium Bromide (Combivent)
- Ketamine
- Lidocaine 2% (preservation free)
- Magnesium Sulfate
- Metoprolol (Lopressor)
- Midazolam
- Naloxone (Narcan)
- Nitroglycerin (Non-parenteral)
- Nitrous Oxide
- NOREPInephrine
- Oxygen
- Ondansetron IV and ODT
- Tetracaine Ophthalmologic Drops
- Tranexamic Acid (TXA)
- Sodium Bicarbonate

come back at the end here if any formulary changes
State wide EMS Frequency 155.3850

Maine EMS Phone: (207)626-3860; Fax: (207)287-6251
 e-mail: maine.ems@maine.gov www.maine.gov/ems

Shaun St. Germain, BS, NR-Paramedic, Director
Alan Leo, EMT, Licensing Agent
Jason Oko, NR-Paramedic, Licensing Agent
Katie Boynton, BA, Licensing Assistant
Tim Nangle, BS, Paramedic, Data & Preparedness Coordinator
Don Sheets, BS, NR-Paramedic, Education & Training Coordinator
State Medical Director: Matthew Sholl, M.D.
State Assistant Medical Director: Kate Zimmerman, D.O.

Region 1 – Atlantic Partners EMS, Inc (207)741-2790
 e-mail: office@apems.org
 Medical Director: Mike Bohanske, M.D.

Region 2 – Tri-County EMS (207)795-2880
 e-mail: lebrunj@cmhc.org
 Medical Director: Joanne LeBrun, Coordinator

Region 3 - Atlantic Partners EMS, INC. (207)877-0936
 e-mail: office@apems.org
 Medical Director: Timothy Pieh, M.D.

Region 4 - Atlantic Partners EMS, Inc. (207)974-4880
 e-mail: office@apems.org
 Medical Director: Jonnathan Busko, M.D.
Telephone/Radio Reference/Contact Numbers #2

Region 5 – Aroostook EMS
e-mail: arems@maine.rr.com
Medical Director: Beth Collamore, M.D.
(207)492-1624
Benjamin Zetterman, Coordinator

Region 6 - Atlantic Partners EMS, Inc.
e-mail: office@apems.org
Medical Director: Tracy Jalbuena, M.D.
(207)877-0936
Rick Petrie, Coordinator

Maine ACEP Representative
Kevin Kendall, M.D.

At-Large Representative
David Saquet, D.O.

Clinical Pharmacist/Pharmacology Representative
Bethany Nash, PharmD, AEMT

Bioterrorism /WMD
If you suspect a chemical or biological agent threat, call your local law enforcement agency immediately.

Maine Bureau of Health Emergency
Reporting and Consultation 1-800-821-5821
Maine National Guard 11th Civil Support Team (WMD) 207-877-9623
Maine Emergency Management Agency 207-624-4400

To Report Workplace Injury:
Bureau of Labor
Business Hours 207-623-7923
Evenings & Weekends 207-592-4501
### Additional Contact List

<table>
<thead>
<tr>
<th>Service</th>
<th>Phone Numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Protective Services</td>
<td>1-800-624-8404</td>
</tr>
<tr>
<td>Child Abuse Reporting</td>
<td>1-800-452-1999</td>
</tr>
<tr>
<td>Divers Alert Network Emergency Hotline</td>
<td>1-919-684-9111</td>
</tr>
<tr>
<td>New England Organ Bank</td>
<td>1-800-446-6362</td>
</tr>
<tr>
<td>Office of the Chief Medical Examiner</td>
<td>1-800-870-8744 207-624-7180</td>
</tr>
<tr>
<td>Poison Control Center</td>
<td>1-800-222-1222</td>
</tr>
<tr>
<td>Bureau of Labor Standards</td>
<td>207-623-7923 207-592-4501</td>
</tr>
<tr>
<td>Bureau of Health Emergency Reporting (DHHS)</td>
<td>1-800-821-5821</td>
</tr>
<tr>
<td>Maine Emergency Management Agency</td>
<td>207-684-4400</td>
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<thead>
<tr>
<th><strong>Trauma &amp; Cardiac Centers</strong></th>
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<tbody>
<tr>
<td>Maine Medical Center</td>
<td>207-662-2950</td>
</tr>
<tr>
<td>22 Bramhall St</td>
<td></td>
</tr>
<tr>
<td>Portland, ME 04102</td>
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</table>

| Central Maine Medical Center                                 | 207-782-1110                      |
| 300 Main St                                                 | 207-795-2200                      |
| Lewiston, ME 04240                                           |                                   |

| Eastern Maine Medical Center                                 | 207-973-8000                      |
| 489 State St                                                |                                   |
| Bangor, ME 04401                                             |                                   |

<table>
<thead>
<tr>
<th><strong>EMS Offices</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Maine Emergency Medical Services</td>
<td>207-626-3860</td>
</tr>
<tr>
<td>45 Commerce Dr - Suite 1</td>
<td></td>
</tr>
<tr>
<td>152 State House Station</td>
<td></td>
</tr>
<tr>
<td>Augusta, ME 04333</td>
<td></td>
</tr>
</tbody>
</table>

| Atlantic Partners (Southern Maine) EMS                        | 207-536-1719                      |
| 253 Warren Ave                                               |                                   |
| Portland, ME 04001                                           |                                   |

| Tri County EMS                                               | 207-795-2880                      |
| 300 Main St                                                 |                                   |
| Lewiston, ME 04240                                           |                                   |

| Atlantic Partners (Kennebec Valley) EMS                      | 207-877-0936                      |
| 71 Halifax Ave                                               |                                   |
| Winslow, ME 04901                                            |                                   |

| Atlantic Partners (Northeast) EMS                            | 207-974-4880                      |
| 354 Hogan Rd                                                |                                   |
| Bangor, ME 04401                                             |                                   |

| Aroostook EMS                                                | 207-492-1624                      |
| 111 High St., Ste 1                                          |                                   |
| Caribou, ME 04736                                           |                                   |
Non-EMS System Medical Interveners

Thank you for your offer of assistance.

Please be advised that these Emergency Medical Technicians are operating under the authority of the State of Maine and under protocols approved by the State of Maine. These EMS providers are also operating under the authority of a Medical Control physician and standing medical orders.

If you are currently providing patient care, you will be relinquishing care to these EMS personnel and their Medical Control physician.

No individual should intervene in the care of this patient unless the individual is:
1. Requested by the attending EMT, and
2. Authorized by the Medical Control physician, and
3. Is capable of assisting, or delivering more extensive emergency medical care at the scene

If you are the patient’s own physician, PA, or nurse practitioner, the EMTs will work with you to the extent that their protocols and scope of practice allow.

If you are not the patient’s own physician, PA, or nurse practitioner, you must be a Maine licensed physician who will assume patient management and accept responsibility. These EMTs will assist you to the extent that their protocols and scope of practice allow. They will not assist you in specific deviations from their protocols without Medical Control approval. This requires that you accompany the patient to the hospital and that their Medical Control physician is contacted and concurs.

The EMS providers or medical control may request that you provide evidence that you are a Maine licensed physician: a copy of your pocket card, an identification issued by a Maine Hospital or healthcare agency, or confirmation of active license status through the Maine Board of Medicine or Nursing website at:


MDs, DOs, PAs and NPs are listed at the same website.
For MDs and PAs - select Regulator "Medicine"
For DOs - select Regulator "Osteopathic Medicine"
For NPs - Select Regulator "Nursing"