STATE OF MAINE
DEPARTMENT OF PUBLIC SAFETY
MAINE EMERGENCY MEDICAL SERVICES
152 STATE HOUSE STATION
AUGUSTA, MAINE
04333

PAUL R. LEPAGE
GOVERNOR

JOHN MORRIS
COMMISSIONER

JAY BRADSHAW
DIRECTOR

Medical Direction and Practice Board
Dec 21, 2011
9:30 am – 12:30 pm
Agenda

Medical Directors Present – Busko, Randolph, Chagrasulis (by phone), Goth, Pieh, Cormier, Kelly, Sholl
Medical Directors Absent – None
MEMS Staff Present – Bradshaw, Powers, Kenney, Pomelow

Guests –

Nov 2011 Minutes	Presented - approved as amended	Motion to Accept: Busko Seconded: Pieh Approved By: All
ME EMS Update	Bradshaw - updated the group on LD 1621, and LD 1636 – and the CP Resolve	
New Devices	None Submitted	
Special Circumstances Protocol	None Submitted - clarification that if there is a substantive change in a Special Circumstances Protocol, that change needs to go through the same review process as the initial protocol.	
Agitated Patient Pilot Project	Update - MS reported that the Board approved the Agitated Patient Pilot protocol, 25 patients or 1 year deadline, with monthly reports to MDPB. JB & WR plan is to meet with participating services in January 2012.	
Community Paramedicine	Update provided by Jay	
Drug Shortages	Update 1) Fentanyl 2) Morphine 3) Midazolam 4) Magnesium Sulfate 5) Metoprolol 6) Glucagon Status Need for further alternate protocols 1) Narcotics - Fentanyl/Morphine a. Nubain	**MOTION: to approve Nubain as alternatives in the event of shortages of morphine with Toradol discussion planned for January meeting (Busko; Cormier). Unanimous (Tim absent)** **MOTION: to approve diazepam in the event of a shortage of midazolam. (Goth; Klein).**

	b. Toradol i. Both are options when fentanyl and morphine are done 2) Benzodiazepines – Versed a. Valium - Adult: 5 mg IV (or 10 mg IM) q 15 min, titrate to effect with a max dose of 30mg b. Valium - Pediatric: 0.2 mg IV (max dose of 5) may repeat x 2 for a max dose of 10 (> 5 y/o) or 5 (<5 y/o) c. Valium – Pediatric: 0.5 mg PR one time, maximum of 10 mg i. If patient has had a prior placed IO, may use the IV dose through the IO. But if no IO, use IM as the secondary route if no IV in adults and PR as the secondary route if no IV in pediatrics. 2) Magnesium Sulfate – a. Peri-Partum Sz – Benzos with OLMC for dosing options b. Torsades – Marlene ? Overdrive pacing? 3) Metoprolol a. ADULTS - Contact OLMC for the option of: Diltiazem 5 mg – 20 mg IV over 5 minutes. Refer to OLMC for exact dosing. Titrate to effect. May repeat every 15 minutes as needed for effect. 4) Glucagon a. In cases in which an IV cannot be established in a hypoglycemic patient: Glucose paste is to be administered as soon as possible. Balance administration of oral glucose paste with the patient's need for airway management. b. If no effect from oral Glucose Paste in 5 minutes – I/CC/P – Dextrose 25o ml of 10% solution IO Education through MEMSEd – re: drug shortages Intro, Valium, Metoprolol, glucagon - MS Template and Toradol – JB Nubian – KK Mag Sulfate - MC	**Unanimous.** **MOTION: To approve diltiazem as an alternative in the event of a shortage of Metropol unstable patients with longer transport times <u>OLMC required for dosing</u>. (Randolph; Goth). Unanimous** **MOTION: For treatment of hypoglycemia - to approve dextrose as an alternative to glucagon w/emphasis on bucal or I/O with 250cc of D10. (Busko; Klein). Unanimous.**
Discussion: Patients with decision making capacity refusing transport	All - Patients with decision making capacity refusing transport – What is the standard for determining whether a patient has decision making capacity? Patient is generally alert and oriented, aware of their situation and circumstances, articulates the ability to change their mind, and consequences of decision. Same language as spinal assessment: calm, competent, cooperative, sober, and alert. >18 or emancipated minor, contact w/guardian. (get wording from Matt) Wording suggested (will be vetted through AG's office for Legal interpretation – **THIS IS NOT THE FINAL WORDING)** <u>How to determine decision making capacity</u> 1) Calm Competent Sober and Alert (from the C-Spine protocol) – absence of an acute medical/surgical or traumatic process that impairs the patient's capacity process that 2) Greater than 18 years, emancipated, or contact with guardian 3) What services were offered to the patient 4) Their statement for refusal 5) Statement of risks and patient understanding of risk 6) Patient is aware they may change their mind at any time <u>Value of Communication with PCP/Family or POA/Nursing Home Staff/Medical Control</u> A statement to the effect of: "EMS providers should communicate	**TO DO: (JB/MS)** *need to look into legal issues (J->LL/PG) , especially regarding minors – how would indemnification for medical control authorizing protocols be affected?*

	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 directly with the patient." <u>Documentation of DMC and discussion</u> "In all cases of patients who refuse transport, it is essential to document the elements listed above, to include: 5) Calm Competent Sober and Alert (from the C-Spine protocol) – absence of an acute medical/surgical or traumatic process that impairs the patient's capacity 6) Greater than 18 years, emancipated, or contact with guardian 7) What services were offered to the patient 8) Their statement for refusal 9) Statement of risks and patient understanding of risk 10) Patient is aware they may change their mind at any time" Long Term Care Ombudsman (get contact from elder care web site)? APEMS has education program available – consider adding to MEMSEd.	
Out of Drug Box Medication discussion	Tabled until January Meeting – Explanation	
Calendar for early 2012	January – Life Flight of Maine Report	
Old Business		
MEMS Education	None	
MEMS Operations	None	
MEMS QI	Board approved structure of QI Committee. Working today on model QI systems	
IFT Subcommittee	None	
HART Update	None	

Next Meetings – Jan 18, 2012

IFT Sub Committee – 8:30 – 9:30
MDPB – 9:30 – 12:30
QI – 1:00 – 3:00