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|  Location Section/Page # | Change | Purpose of Change(Provider Input, Stakeholder Input, Evolution of Evidence, Best Practice, etc.) | Evidence for Change | Expected Impact(Operational, Educational, Financial, QI, Medical Direction, Communication, etc.) | Size of Change (Small/Medium/ Large) | Desired Outcome |
| Grey 1 | DNR Guidelines: do we need to change this to be in compliance with state regulations? The following is POLST language from NH protocolsNeither a Living will nor a Durable Power of Attorney for Healthcare (DPOAH) form is a valid DNR order. Neither a patient’s spouse nor a healthcare agent under a DPOAH may direct EMS providers to withhold resuscitation in the absence of a valid DNR Order.When a written DNR order is not available but the patient has a DPOAH and the patient’s healthcare agent requests that resuscitation be withheld, contact online Medical Control for guidance.Living Will:A Living Will is intended to address patients who have been admitted to a healthcare facility. Living Wills rarely, if ever, have application in the prehospital environment.POLST (Provider Orders for Life-Sustaining Treatment)Section AThe POLST constitutes a DNR if “No CPR” is indicated in this section. Otherwise, if the patient has indicated they do not want resuscitation but does not have a separate valid DNR order, contact Medical Control for guidanceSection BWhen confronted with a seriously ill patient who has a POLST form (green form), and is not in cardiac arrest: see POLST (include copy of form in protocols.-If “Full Treatment” box is checked: Use all appropriate measures to stabilize/resuscitate patient. - If “Selective Treatments”” box is checked: The maximum respiratory interventions are non-rebreather mask, CPAP, and suctioning. All appropriate IV medications may be utilized. Avoid intensive care: ventilator, cardioversion, defibrillation. Transfer to hospital if needs cannot be met in current location.-If “Comfort-focused Treatments” box is checked: Limit respiratory interventions to non-rebreathermask, suctioning and treatment of airway obstruction, as needed. Medications to relieve painor discomfort may be utilized. Transfer to hospital only if comfort cannot be achieved in current setting.Section CRefers to IV therapy for hydration and nutrition. Advanced EMTs and Paramedics may start an IV for the purpose of medication administration outlined in Section B |  |  |  |  |  |
| Grey 12Grey 14 | # 9. …Emergency Services at to make a report… (remove “at”)\*…or is a minor, etc. Additionally, a patient who demonstrates a suicidal/self harm gesture or admission, either verbally or in writing, shall be considered to be WITHOUT decision-making capacity. | Grammatical |  |  |  |  |
| Grey 21 | Region 5 email is : aroostookems@gmail.com |  |  | Informational |  |  |
| New | New proposals: Grey (Additions to Grey 2)Hospice patients: EMS may be called to respond to patients on Hospice Care. This may occur because the patient (or family) was unable to reach a Hospice nurse/physician or the patient (or family) became panicked or anxious. In these circumstances, EMS should make every effort to reach a Hospice provider and should remain with the patient until the Hospice provider arrives. Comforting interventions (Grey 2) should be undertaken. Support family members. EMS providers should avoid the following interventions:· Sirens, lights or aggressive interventions · IV therapy (except where other forms of medication administration are not possible). Discuss options with patient, family, caregivers.· Cardiac resuscitation: CPR, resuscitation medications, BVM ventilations.· Cardiac pacing, cardioversion, and defibrillation.· Hospice patients should not be transported to the hospital except where transport is specifically requested by the patient or his healthcare agent or surrogate, and preferably only after consultation with the hospice team and exhaustion of other treatment pathways that do not require transport to the hospital.If the reason for calling 9-1-1 is unrelated to the Hospice patient’s terminal illness, the appropriate protocol should be followed and the patient should be transported to the hospital, if needed and requested by the patient or surrogate (example: laceration requiring sutures). OLMC should be consulted, as needed, to discuss Hospice provider orders and other concerns.· Many hospice patients will have a hospice comfort kit that contains medications that patient’s caregivers are instructed to use to treat commonly encountered medical issues.EMTRoutine Patient Care.· Contact the hospice team (preferred) or Medical Control to coordinate care anddetermine administration of hospice kit medications· Consider paramedic response for medication administration.· Breakthrough Pain: Suggest administration of breakthrough pain medication bypatients / families. For pain of sudden onset, seek to determine and treat the underlying cause (e.g., pathological fracture).· Anxiety: Consider potential causes for patient’s anxiety, such as increased pain and shortness of breath. Suggest administration of medication by patients/families.Dyspnea: Administer oxygen, as appropriate, to relieve shortness of breath and achieve a respiration rate of < 20. Use a fan to blow air directly at the patient’s face.-Constipation: Suggest administration of constipation medication by patient/family· Terminal Dehydration: Moisten lips with petroleum jelly; use artificial saliva/mouthsponges and ice chips.· Confusion/Delirium: Speak slowly and calmly to the person. Remind the patient of where they are, and who you are. Avoid contradicting the patient’s statements. Ensure a patient’s hearing aid and glasses are available. Limit activity/noise in the room.Advanced EMTNausea/Vomiting: Suggest administration of nausea medication or refer to Nausea/Vomiting Protocol, Gold 19.ParamedicConsider following written orders for medications in hospice kit. As an adjunct, consider:-For Breakthrough Pain, refer to Universal Pain Management Protocol, Green 17-19-For Anxiety, contact OLMC for Ketamine 0.5 mg/kg IN for a max dose of 25 mg.-For Bronchospasm, refer to Respiratory Distress with Bronchospasm Protocol, Blue 7-9.PEARLS· Breakthrough Pain assessment and management is important in patients with advanced disease as they may have a high burden of pain, be opiate tolerant, and already be receiving high doses of opioids.· Anxiety ranges from mild to severe, is common in patients nearing death, and should betreated promptly.· Terminal Secretions are noisy, gurgling respirations caused by secretions accumulating in the lungs or oropharynx.· Terminal Dyspnea is exhibited by patients that are expected to die within hours to days.Individuals experiencing dyspnea often experience heightened anxiety.· Constipation is a frequent cause of nausea and vomiting. Opioid-related constipation is dose-related, and patients do not develop tolerance to this side effect. · Nausea / Vomiting can be extremely debilitating symptoms at the end of life. Effective control of nausea can be achieved in most patients.· Fever and Infection treatment should be guided by an understanding of where the patient is inthe dying trajectory and goals of care. Overwhelming sepsis may be a sign of active death not to be reversed.· Delirium is common at end of life and is often caused by a combination of medications,dehydration, infections or hypoxia. It is distressing to families. It often heralds the end of life and may require active sedation.  | Best Practice |  | Educational | Medium | Recognition of Hospice Services |
| New | Death with Dignity Law (Sec. 1. MRSA c. 418 ): The Maine Death with Dignity Act provides eligible Maine residents with terminal, incurable diseases that will, within reasonable medical judgement, result in death within six months, the option to be prescribed a dose of medication that, if taken, will hasten the end of their life.It is possible that Maine EMS personnel may be called to respond to an individual who has voluntary entered into an agreement with his/her Attending physician to end their life under the Death with Dignity Act. In these circumstances, patients may have a form that explains this option. In these situations, life-saving measures should not be initiated. Comforting interventions (Grey 2) should be undertaken. Support Family members. If the patient has expired, follow local protocol for unattended deaths. Make every effort to contact the patient’s Attending physician. These cases do not fall under the jurisdiction of the Office of the Chief Medical Examiner. Contact OLMC with any questions.USE THIS LANGUAGE/PROCESS**Leave the first paragraph** **Then – it may be possible that Maine EMS personnel could be called to these events. Please contact OLMC for questions.** COME BACK WITH LANGUAGE THAT HELPS TO ID THE PATIENT IS ENGZGING IN A DEALTH WITH DIGNITY EVENT \_ EITHER THE SIGNED FORM OR (COULD WE) IDENTIFY THROUGH THE PHARMACY (BUT DO THEY WANT TO BE ID’ed).  |  |  | Educational | Medium | To highlight new Maine Law |
| New | Bariatric Patients: This protocol provides guidance for the triage, extrication, care and transport of bariatric patients. A bariatric patient exceeds 180 kg (400 lbs) or possesses a body habitus that challenges the ability of a two person crew to manage effectively. On scene time may be prolonged for bariatric patients who may require additional resources, personnel and equipment to safely evaluate, manage and transport. Goals include the timely and effective management of these patients while maintaining patient privacy, dignity and comfort. EMT/Advanced EMT/Paramedic: -Equipment: deploy specialized equipment/personnel per local/regional policy-Request a Bariatric ambulance, if feasible, and if time allows-Bariatric stretchers are preferred for patient comfort. Ensure that the weight limit of the utilized stretcher exceeds the weight of the patient.-Request additional manpower for the extrication process-Request ALS (Paramedic) especially in situations in which on-scene time will be prolonged-Providers should be knowledgeable about the utilization of bariatric equipment prior to using it-Early pre-hospital notification is required as special arrangements may be needed at the receiving hospital-Hospital destination may require bypassing the nearest facility based on patient needs (CT scan, surgery, cardiac catheterization, etc…). Contact OLMC for guidance.PEARLS· It may be difficult to establish IV and IO access. Consider intramuscular or intranasal asalternatives for some medications. For IM, ensure that the needle used is sufficiently long. - Weight-based calculations may yield inappropriately large doses in obese patients. Consultwith medical control when in doubt regarding medication dosing. In addition, medication par levels may be exceeded when using weight-based dosing. · Bariatric patients often have decreased functional residual capacity, and are at risk of rapiddesaturation. Extremely obese individuals require more oxygen than non-obese individuals due to their diminished lung capacity. Pulse oximetry may not be reliable due to poor circulation. Even patients without respiratory distress may not tolerate the supine position.· Bariatric patients may present with severe airway challenges. Carefully plan your approach to the airway and be prepared with backup airway plans.· If the patient has had recent bariatric surgery, possible complications may include anemia, dehydration, leakage, ulcers, localized infection, sepsis, etc. |  |  | Operational/Educational | Medium |  |
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