Do Not Resuscitate (DNR) Guidelines #1

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:

1. When irreversible signs of death, such as rigor mortis, dependent lividity, decapitation, decomposition, incineration, other obvious lethal injuries are present.

2. When down time has been unknown or greater than 20 minutes with no bystander CPR performed and the patient is cool to touch (not from exposure), no audible heart sounds, and fixed/dilated pupils.

3. 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/Submersion Injuries protocol, **Yellow 11**)

B. All Normothermic Patients: Major trauma victims who have no respiration and no pulse, no signs 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. Devices, such as jewelry, must have the patient's name clearly displayed and must indicate the patient's wishes to be DNR. If there are no specific instructions beyond "DNR", follow Maine EMS Comfort Care/DNR Guidelines, **Grey 2**

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 . Follow the order as written. If it is nonspecific as to the care to provide or withhold, follow the MEMS Comfort Care/DNR guidelines, **Grey 2**

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 DNR Directive form or Maine EMS-approved DNR Directive jewelry is presented to EMS personnel - Once executed by the patient and signed by a physician/PA/NP, the DNR 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

Do Not Resuscitate (DNR) Guidelines #2

III. Treatment/Comfort Care

F. When treating a patient with a Maine EMS Comfort Care/DNR Order or DNR 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 DNR 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 DNR 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 (ALS per OLMC/Hospice provider);
f. Be supportive of the patient and family;
g. Contact patient's physician/PA/NP/Hospice provider or OLMC if questions arise

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 DNR Directive status).
a. CPR;
b. Intubation (ET Tube, or other advanced airway management);
c. Surgical procedures;
c. Defibrillation;
d. Cardiac resuscitation medications;
e. Artificial ventilation by any means;
f. Related procedures per OLMC.

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Do Not Resuscitate (DNR) Guidelines #3

IV. Revocation, Documentation & When to Stop Resuscitation

H. Who may revoke an EMS Comfort Care/DNR Order or Maine DNR Directive:

1. The patient (by destroying EMS Comfort Care/DNR Order Form, wallet card, plastic bracelet and DNR jewelry, or by destroying the DNR 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 DNR 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, DNR 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 criteria as defined in the Termination of Resuscitation protocol (**Red 13**) have been met.
c. When the rescuers are physically exhausted or when equally or more highly trained health care personnel take over
d. When it is found that the patient has a DNR order or other actionable medical order (i.e. POLST/MOLST etc.) form
e. Continue resuscitation if conditions on scene are NOT amenable to cessation of resuscitation
f. Continuation of resuscitation beyond these protocols must be in consultation with OLMC

(continued next page)

2. Witnessed arrest:

a. When the patient regains pulse/respiration
b. When criteria as defined in the Termination of Resuscitation protocol **(Red 13)** 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 (**Yellow 8**)
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 form, etc.) .
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~~ Patient Remains

If resuscitation efforts are discontinued, follow your service's policy for disposition of patient remains. In cases of uncertainty, arrangements should be made with OLMC with regards to disposition of the patient's body. Contact your local ED with regard to tissue donation options and procedures in advance.

Do Not Resuscitate (DNR) Guidelines #5

Pearls for DNR Guidelines: Neither 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):
POLST Section A
The 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 guidance.

POLST Section B
When confronted with a seriously ill patient who has a POLST form (green form) and is not in cardiac arrest :

- If "Full Treatment" box is checked: Use all appropriate measures to stabilize/resuscitate patient.
- If "Selective Treatments"" box is checked: The maximum respiratory interventions include interventions such as 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-rebreather mask, suctioning and treatment of airway obstruction, as needed. Medications to relieve pain or discomfort may be utilized. Transfer to hospital only if comfort cannot be achieved in current setting.

POLST Section C
Refers to IV therapy for hydration, nutrition, and other orders. Advanced EMTs and Paramedics may start an IV for the purpose of medication administration outlined in Section B

Pre-Hospital Management of Hospice Patients, #1

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 anxious. In these circumstances, **EMS Clinicians 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/her 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.

Pre-Hospital Management of Hospice Patients, #2

E

EMT

Routine Patient Care.

1) Contact the hospice team (preferred) or Medical Control to coordinate care and determine administration of hospice kit medications
2) Consider paramedic response for medication administration.

3) Breakthrough Pain: Suggest administration of breakthrough pain medication by patient / families. For pain of sudden onset, seek to determine and treat the underlying cause (e.g., pathological fracture).
4) Anxiety: Consider potential causes for patient's anxiety, such as increased pain and shortness of breath. Suggest administration of medication by patients/families.
5) 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.
6) Constipation: Suggest administration of constipation medication by patient/family
7) Terminal Dehydration: Moisten lips with petroleum jelly; use artificial saliva/mouth sponges and ice chips.
8) 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.

A

Advanced EMT

9) Nausea/Vomiting: Suggest administration of nausea medication or refer to Nausea/Vomiting Protocol, Gold 19.

Paramedic

10) Consider following written orders for medications in hospice kit. As an adjunct, consider:
    a) For Breakthrough Pain, refer to Universal Pain Management Protocol, Green 17-19
    b) For Anxiety, contact OLMC for Ketamine 0.5 mg/kg IN for a max dose of 25 mg.
    c) For Bronchospasm, refer to Respiratory Distress with Bronchospasm Protocol, Blue 7-9.

P

Pre-Hospital Management of Hospice Patients, #3

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 be treated 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 in the dying trajectory and the patient's specific 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.

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 Donor Services 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-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/guardians, 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.

Maine Death with Dignity Law

PEARLS
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 judgment, 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.

Patients should have a either a form that identifies their participation in the Maine Death with Dignity Program or a DNR/POLST form.

It is possible that Maine EMS personnel may be called to respond to an individual who has voluntarily entered into an agreement with his/her Attending physician to end their life under the Death with Dignity Act.

If dispatched to such a patient, and questions arise regarding patient care, please contact OLMC.

Bariatric Patients

E A P

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 personnel resources for the extrication process
- 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
- Consider the patient's immediate needs (CT scan, surgery, cardiac catheterization, etc.) when determining hospital destination. If the patient is stable and there exists a potential requirement for alternate destination, please contact OLMC for guidance and discussion regarding the most appropriate patient destination.
- If not present, request ALS (Paramedic) especially in situations in which on-scene time will be prolonged

PEARLS

- It may be difficult to establish IV and IO access. Consider intramuscular or intranasal as alternatives for some medications. For IM, ensure that the needle used is sufficiently long.
- Weight-based calculations may yield inappropriately large doses in obese patients. Consult with 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 rapid desaturation. 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, internal leakage at the surgical site, ulcers, localized infection, sepsis, etc.

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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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 – hemorrhage control
- 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.

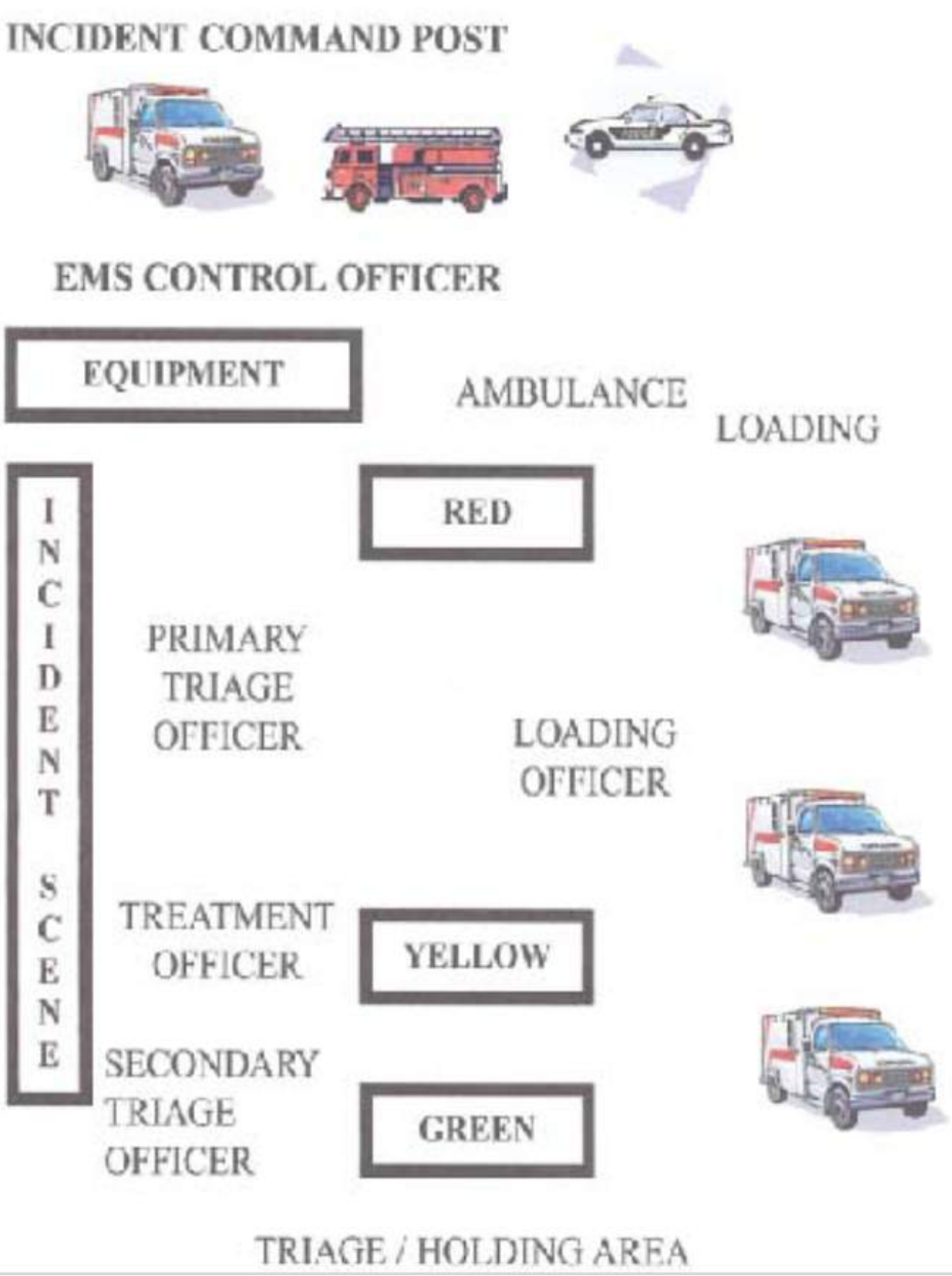
BLACK (O): Are obviously dead, or dying from lethal injuries, or requiring CPR when no personnel are available to do so without compromising other patients.

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, then 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, 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.

Child Abuse
Management and Reporting #1

CHILD ABUSE
(Title 22 MRSA, Chapter 1071, Subsection 4011-A)

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. 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, **Gold 5**, the child in shock, **Gold 14** or the child in cardiac arrest, **Red 8**

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, shock, altered mental status or other medical emergencies.

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 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 NEGLECT.
(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 a bone;
b. Substantial bruising or multiple bruises;
c. Subdural hematoma;
d. Burns;
e. Poisoning; or
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
(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)

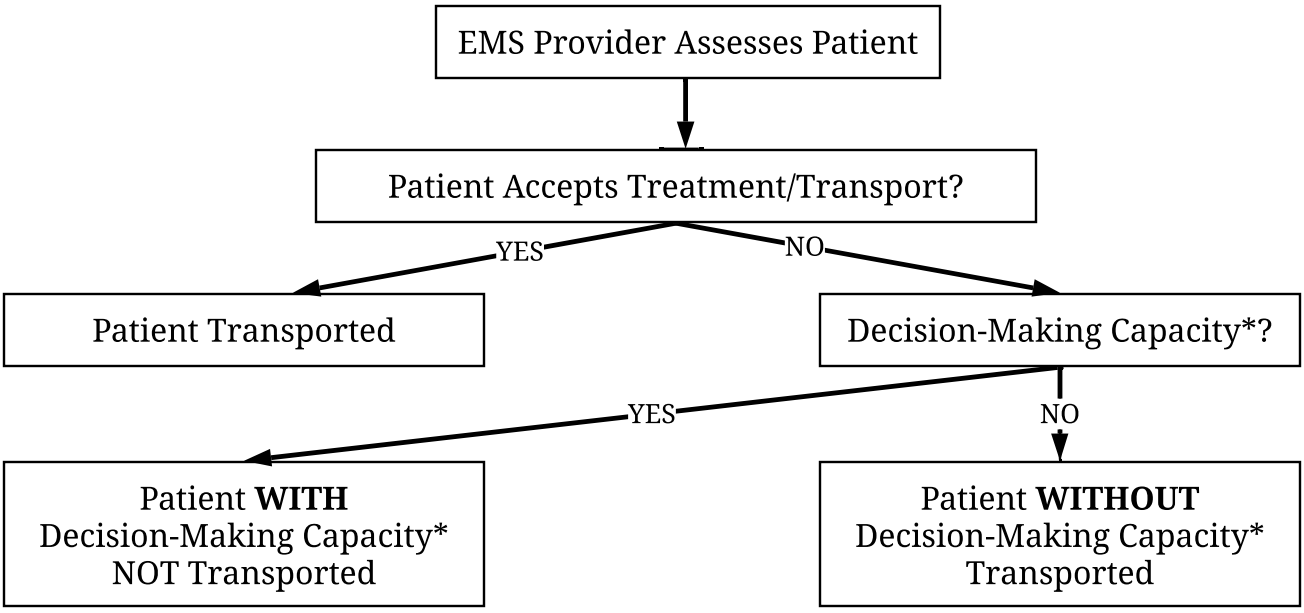
§ 2405 (1) “Persons who may report If, while acting in a professional capacity a…emergency medical services person…knows or has reasonable cause to believe that a person has been operating a motor vehicle, hunting or operating a snowmobile, all-terrain vehicle or watercraft while under the influence 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



*A patient without decision making capacity would be one who has one or more of the following: an altered mental status or intoxicated, confused, delirious, psychotic, comatose, unable to understand the language, 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.

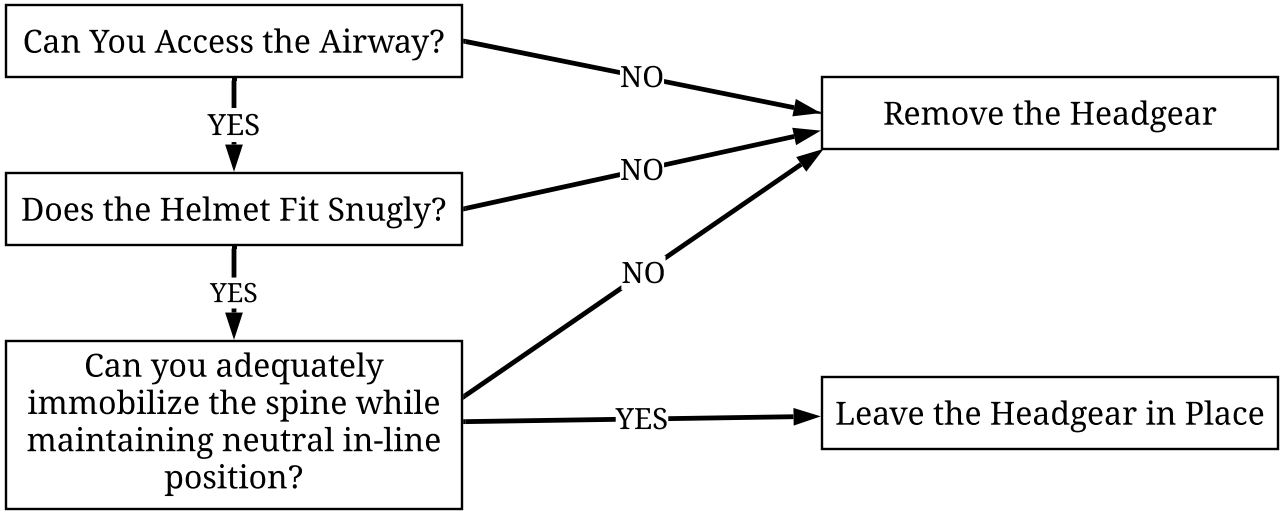
1. If there is a question of decision making capacity or the patient does not appear to understand the consequences of his/her refusal of transport, then contact OLMC.
2. The patient must be informed of the consequences of his/her refusal to be transported. This must be documented in the patient care 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.

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:



Defibrillation/Cardioversion Settings

DEFIBRILLATION SETTINGS*

	Initial	Second	Third	Subsequent
Adult	Per device recommendations* If unknown, use maximum available energy		Maximum available energy	Maximum available energy
Pediatric	2 J/kg	4 J/kg	6 J/kg	Max 10 J/kg

* Each device manufacturer recommends initial adult defibrillation settings. Please follow the recommendation of your device manufacturer.
** All settings are biphasic. If using monophasic machine refer to manufacturer recommendations.

CARDIOVERSION SETTINGS*

	Initial	Second	Third	Subsequent
Adult VT (wide regular)	100 J	150 J	200 J	Maximum available energy
Adult SVT (narrow regular)	50 J	100 J	120-150 J	Maximum available energy
Adult A-fib (narrow irregular)	120-200 J	200 J	Maximum available energy	
Pediatric	0.5-1.0 J/kg	2 J/kg	2 J/kg	2 J/kg

* All settings are biphasic. If using monophasic machine refer to manufacturer recommendations.

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
Acetaminophen IV
Activated Charcoal (without sorbitol)
Adenosine
Albuterol
Amiodarone
Aspirin
Atropine
Calcium Gluconate
Ceftriaxone
Cyanide poisoning kit contents
Dexamethasone
Dextrose (D_{10}, D_{50})
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 to this at the end to ensure no new medications

Telephone/Radio Reference/Contact Numbers #1

	NAME	Radio Frequency	Phone Number
Hospital:			
Hospital:			
Hospital:			
Hospital:			
Hospital:			
Hospital:			
Dispatch:			

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

Jay Bradshaw, Director
Jason Oko, NR-Paramedic, Licensing Agent
Jessica Ricciadelli, Licensing Assistant
Tim Nangle, BS, Paramedic, Data & Preparedness Coordinator
Chris Azevedo, NR-Paramedic, Education & Training Coordinator
Marc Minkler, NR-Paramedic, EMS-C 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 Sally Taylor, Coordinator
Medical Director: Mike Bohanske, M.D.

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

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

Region 4 - Atlantic Partners EMS, Inc. (207)974-4880
e-mail: office@apems.org Sally Taylor, Coordinator
Medical Director: David Saquet, DO

Telephone/Radio Reference/Contact Numbers #2

Region 5 – Aroostook EMS (207)492-1624
e-mail: aroostookems@gmail.com Chase Labbe, Coordinator
Medical Director: Beth Collamore, M.D.

Region 6 - Atlantic Partners EMS, Inc. (207)877-0936
e-mail: office@apems.org Sally Taylor, Coordinator
Medical Director: Bruce Lowry, MD

Maine ACEP Representative
Kelly Meehan-Coussee, M.D.

At-Large Representative
Peter Tilney, DO

Clinical Pharmacist/Pharmacology Representative
Bethany Nash, PharmD, AEMT

ALS Representative
Clair Dufort, EMT-P

BLS Representative
Alan Thacker, AEMT

Pediatic Representative/EMS-C Medical Director
Rachel Williams, MD

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

Adult Protective Services	1-800-624-8404	
Child Abuse Reporting	1-800-452-1999	
Divers Alert Network Emergency Hotline	1-919-684-9111	
New England Donor Services	1-800-446-6362	
Office of the Chief Medical Examiner	1-800-870-8744	207-624-7180
Poison Control Center	1-800-222-1222	
Bureau of Labor Standards	207-623-7923	207-592-4501
Bureau of Health Emergency Reporting (DHHS)	1-800-821-5821	
Maine Emergency Management Agency	207-684-4400	

Trauma & Cardiac Centers

Maine Medical Center 207-662-2950
22 Bramhall St
Portland, ME 04102

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

Northern Light/Eastern Maine Medical Center 207-973-8000
489 State St
Bangor, ME 04401

EMS Offices

Maine Emergency Medical Services 207-626-3860
45 Commerce Dr - Suite 1
152 State House Station
Augusta, ME 04333

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:

https://www.pfr.maine.gov/ALMSOnline/ALMSQuery/SearchIndividual.aspx?Board=383

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"

Coma - Pediatric	Gold 5	61
Comfort Care	Grey 2	126
Contact Lists	Grey 22	146
COPD	Blue 7	24
CPAP	Blue 7	24
CPAP - Anxiolysis	Blue 10	27
Crush Injury	Green 21	96
Cyanide Exposure	Yellow 4 - 5	102 - 103
Death Situation Guidelines	Grey 5-6	129 - 130
Defibrillation Settings	Grey 18	142
Depression/Sucidal Ideation	Orange 1	120
Diabetic Emergencies	Gold 6	62
Diabetic Emergencies - Pediatric	Gold 6	62
DNR Orders	Grey 1-4	125 - 128
Double Sequential Defibrillation	Red 12	45
Drowning (adult and pediatric)	Yellow 11	109
Emergency Childbirth	Pink 4	113
Emphysema	Blue 7	24
Eye Pain - Chemical	Green 23	98
Eye Pain - General	Green 23	98
Faces Pain Scale - Pediatric (Wong-Baker)	Green 19	94
Facial/Dental Injury	Green 22	97
Failed Airway	Blue 5	22
Fainting	Red 21	54
Fibrinolytic Checklist	Gold 13	69
FLACC Behavioral Pain Assessment Scale - Pediatric	Green 19	94
Fluid Bolus	Purple 2	15
GCS	Green 9	84
Glasgow Coma Scale - Adult	Green 9	84
Glasgow Coma Scale - Pediatric	Green 9	84
Head Trauma	Green 11	86
Heat Exhaustion	Yellow 9	107
Heat Stroke	Yellow 10	108
Helicopter Landing Zone	Green 1 - 2	76 - 77
Helmet Removal	Grey 17	141
Hemorrhage	Green 12	87
Hemorrhagic Shock	Green 13 - 14	88 - 89
Hemostatic Agents	Green 12	87
Home Health Care Devices	Brown 4	11
Hyperthermia - Heat Exhaustion	Yellow 9	107
Hyperthermia - Heat Stroke	Yellow 10	108
Hypoglycemic Emergencies	Gold 6	62
Hypothermia	Yellow 7 - 8	105 -106
Intoxicated Drivers	Grey 13	137
Intubation	Blue 2	17
Intubation - Failed	Blue 5	22
IO Use	Purple 2	15

Ketamine	Blue 6 & 10, Green 18, Orange 3 - 5	23 & 27, 93, 122 - 124
Landing Zone - Helicopter	Green 1 - 2	76 - 77
LVAD	Brown 4	11
Mass Casualty	Grey 7-9	131 - 132
Medical Shock	Gold 14 - 17	70 - 73
Medical Shock - Pediatric	Gold 14 - 17	70 - 73
Medication Dosages - Cardiac Arrest - Pediatric	Red 11	44
Medication List - Maine EMS approved	Grey 19	143
MEMS Run Record	Brown 2	9
Narrow Complex Tachycardia	Red 16 - 17	49 - 50
Nausea	Gold 19	75
Neonatal Resuscitation	Pink 6	115
Neonatal Young Infant Fever	Pink 3	112
Nitronox	Green 17	92
Non EMS Medical Interveners	Black 1	147
Opiates - Toxins	Yellow 1	99
Opthalmology	Green 23	98
Organophosphates - Toxins	Yellow 3	101
Pain - Abdominal	Gold 18	74
Pain - Eye	Green 23	98
Pain "Faces" Scale - Pediatric (Wong-Baker)	Green 19	94
Pain Control - Pediatric	Green 17 - 19	92 - 94
Pain Control - Post Intubation	Blue 6	23
Pain Management - Trauma	Green 17 - 19	92 - 94
Pain Management - Traumatic - Pediatric	Green 17 - 19	92 - 94
Pain Management - Universal	Green 17 - 19	92 - 94
Pain Scale - Pediatric (FLACC)	Green 19	94
Patient Centric Devices	Brown 4	11
Patient Sign-offs	Brown 4-5	11 - 12
Pediatic Seizures	Gold 8 - 9	64 - 65
Pediatric Airway	Blue 3	20
Pediatric - Coma	Gold 5	61
Pediatric Diabetic Emergencies	Gold 6	62
Pediatric - Respiratory Distress	Blue 7	24
Pediatric Cardiac Arrest	Red 8	41
Pediatric Cardiac Arrest - Medication Dosages	Red 11	44
Pediatric Equipment Sizes	Pink 8	117
Pediatric Medical Shock	Gold 14 - 17	70 - 73
Pediatric Pain Control	Green 17 - 19	92 - 94
Pediatric Transportation	Pink 9 -10	118 -119
Pediatric Traumatic Pain Management	Green 17 - 19	92 - 94
Pediatric Vital Signs	Pink 7	116
Pelvic Binders	Green 14	89
Post Intubation Anxiolysis	Blue 6	23
Post Intubation Pain Control	Blue 6	23
Post Resuscitation - Adult	Red 15	48

Prehospital Stroke Scale	Gold 10	66
Pre-Intubation Checklist	Blue 2	17
Protective Headgear Removal	Grey 17	141
Pulmonary Edema	Blue 11	28
Pulmonary Hypertension	Blue 12	29
Pulseless Ventricular Tachycardia	Red 7-11	40 - 44
Pulseless V-Tach	Red 7-11	40 - 44
Radiation Injuries	Yellow 6	104
Radio Contact Numbers	Grey 20	144
Recurrent V-Fib	Red 12	45
Refractory V-Fib	Red 12	45
Refusal of Transport or Care	Grey 14-15	138 - 139
Refusals	Brown 4-5	11 - 12
Remodulan	Blue 12	29
Respiratory Distress - Adult	Blue 7	24
Respiratory Distress - Pediatric	Blue 7	24
Respiratory Distress with Stridor - Pediatric	Pink 2	111
Respiratory Distress with Wheezing - Pediatric	Blue 7 - 9	24 - 26
Restraints	Orange 2	121
Rule of 9's	Green 16	91
Seizures	Gold 8 - 9	64 - 65
Seizures - Pediatric	Gold 8 - 9	64 - 65
Septic Shock - Adult	Gold 14 - 17	70 - 73
Septic Shock - Pediatric	Gold 14 - 17	70 - 73
Sexual Assault	Grey 10	134
Shock - Classification of	Green 14	89
Shock - Pregnancy	Green 13 - 14	88 - 89
Sign-offs	Brown 4-5	11 - 12
Special Circumstances Protocol	Brown 5	12
Spine Assessment	Green 6	81
Spine Management	Green 6 - 8	81 - 83
ST Elevation Myocardial Infarction (STEMI)	Red 2-3	35 - 36
STEMI Criteria	Red 3	36
Stridor - Pediatric	Pink 2	111
Stroke	Gold 10 - 13	66 - 69
Stroke Checklist	Gold 13	69
Stroke Scale	Gold 10	66
Submersion Injuries	Yellow 11	109
Surgical Cricothyrotomy	Blue 13	30
Syncope	Red 21	54
Tachycardia	Red 16 - 17	49 - 50
Taser Probes	Brown 6	13
Telephone Contact Numbers	Grey 20-22	144 - 146
Termination of Resuscitation	Red 13-14	46
Termination of Resuscitation - Trauma	Green 20	95
Tourniquets	Green 12	87

Toxins	Yellow 1 - 5	99 - 103
Tracheostomy Care	Blue 15	32
Transport - Refusal	Grey 14-15	138 - 139
Transport of Mentally Ill	Grey 16	140
Trauma - Chest	Green 10	85
Trauma Head	Green 11	86
Trauma Pain Management - Pediatric	Green 17 - 19	92 - 94
Trauma Triage	Green 3-5	78 - 80
Tricyclic Antidepressants - Toxins	Yellow 2	100
TXA -Tranexamic Acid	Green 13 - 14	88 - 89
Universal Pain Management	Green 17 - 19	92 - 94
VAD - Ventricular Assistive Device	Red 22 - 23	55 - 56
Vagus Nerve Stimulator	Brown 5, Gold 9	Dec-65
Vital Signs - Pediatric	Pink 7	116
Vomiting	Gold 19	75
Wheezing - Pediatric	Blue 7 - 9	24 - 26
Wong-Baker Pain Scale	Green 19	94
Wound Management	Green 12	87

Pandemic Response Protocol #1

This protocol is specific to the 2020 COVID-19/SARS-CoV-2 response. It is authorized by delegation of authority of the MDPB to the Maine EMS Medical Directors for use during the COVID-19 Pandemic.

This protocol is divided into steps which are on unique pages. These steps are essential for EMS clinician and patient safety and **must** be exercised during all patient encounters during the pandemic. Maine EMS, the MDPB and the State Medical Directors expect these steps to remain in place until public health experts determine that these increased safety measures are no longer necessary. These steps **must** be considered in **all** patient encounters while this protocol is in place.

Trigger: Preparation for pandemic and upon first reported cases in Maine.

EMT/ADVANCED EMT/PARAMEDIC
Step 1: EMD surveillance for all callers based on symptoms and contact with presumed positive COVID-19 patients.
Rationale: *Allows EMS clinicians situational awareness prior to arrival.*

Step 2: Limit the number of clinicians that interact directly with the Person Under Investigation (PUI). Consider safety, operations and patient needs. If possible, limit the number of EMS clinicians who come into contact with the patient.
Rationale: *Experience with SARS (also a coronavirus) demonstrated increased transmission when three or more healthcare workers attended a patient. Also assists in preserving PPE.*

Step 3: Assess for symptoms [fever, chills, symptoms of lower respiratory illness (e.g., cough or shortness of breath), fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea, vomiting, or diarrhea] using a combination of social distancing (when clinically or operationally indicated) and PPE.
Rationale: *Confirms patient is a PUI for COVID-19, protects EMS workforce through social distancing (minimum of 6 feet) and preserves Personal Protective Equipment (PPE) when possible.*

E A P

Step 4: Clinicians **must** use **AIRBORNE precautions** for all patients who screen positive for a PUI for COVID-19 based on clinical symptoms (above) and/or epidemiologic risk factors (exposure to a laboratory-confirmed COVID-19 patient within the past 14 days). AIRBORNE precautions include gloves, gown, eye protection*, and an N-95 or equivalent respirator. EMS clinicians **must** also don **AIRBORNE precautions** if the patient requires any aerosol-generating procedure (including CPR) or if the patient is unwilling/unable to wear a mask (see Step 5).
Rationale: *Protects EMS workforce.*

Step 5: Place surgical mask on all patients (regardless of PUI status). All clinicians **must** wear a minimum of a surgical mask, eye protection and gloves during all patient encounters. If the patient is a PUI, known COVID-19 positive, or if the patient is unable or unwilling to wear a surgical mask, the crew **must** don **full AIRBORNE PPE** protection including an N95 respirator or equivalent, gloves, gown, and eye protection.*
Rationale: *Limits spread of virus through the respiratory route. Patients with COVID-19 may not be exhibiting signs or symptoms at the time of the encounter.*

Step 6: Document in the MEFIRS run form *every individual in the ambulance with the patient (including drivers and students).* In addition, if the patient's condition allows and operations permit, please consider documenting *EVERYONE within 6 feet of the patient or with prolonged contact (greater than 15 minutes). This may include law enforcement officers, firefighters, etc. Please note the level of PPE being used by the personnel.*
Rationale: *Excellent documentation of ALL public safety personnel involved in the patient's care allows thorough contact tracing if an asymptomatic or presymptomatic patient is found to be infected with COVID-19. Contact tracing is an essential tool that limits spread of the disease throughout not only the EMS community and the healthcare workers with whom we interface, but our patients, their families and our communities as a whole.*

Step 7: Decontaminate the ambulance and all equipment per CDC Guidelines.
Rationale: *Prevents transmission of disease to EMS clinicians and other patients. Details may be found in the Maine EMS Clinical Updates found on the Maine EMS website.*

Step 8: Notify the receiving hospital as soon as appropriate of the patient and their PUI/COVID status.
Rationale: *Allows the receiving hospital to prepare for patient arrival.*

Eye protection, as defined for AIRBORNE precautions, is goggles or a face shield that covers the front and sides of the face. Protective eyewear (e.g., safety glasses, trauma glasses) with gaps between glasses and the face likely do not protect eyes from all splashes and sprays and do **not provide adequate protection when AIRBORNE precautions are required.*

Pandemic Response Protocol #2, Management of Acute Respiratory Symptoms during COVID-19 Pandemic

Follow PPE guidelines as outlined in Pandemic Response Protocol #1 (Steps #4 and #5) and alert hospital that patient is suspected to have COVID-19

All patients presenting with acute respiratory symptoms, especially respiratory failure, should be considered to be infected with SARS-CoV-2 which causes the disease COVID-19. This includes patients with known asthma, COPD and CHF. This protocol is written to minimize exposure of the disease to the clinician.

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EMT

1. O_2 as appropriate to maintain SpO2 > 93%
    a. Nasal cannula (NC) with surgical mask placed over the cannula is the preferred method. May use higher than normal flow rates (up to 7 L/min) if needed to maintain desired oxygen saturation
    b. If persistently hypoxic despite NC, apply nonrebreather (NRB)
2. Assist patient with their own albuterol or albuterol/ipratropium **MDI**[*, **] with a spacer, if available
    a. 6-8 **puffs** per dose of MDI, may repeat every 20 minutes, as needed
3. If needed, assist ventilations with BVM with 100% O_2; BVM should be equipped with a HEPA filter
4. Request ALS

A

AEMT

5. Albuterol or albuterol/ipratropium **MDI**[*, **] with spacer, if available. ***Use of the patient's own MDI is preferred***.
    a. 6-8 **puffs** per dose of MDI, may repeat every 20 minutes, as needed
6. For patients who have moderate to severe respiratory distress/wheezing, consider:
    a. **Adult**: EPINEPHrine 0.3 mg **IM** [0.3 mL of 1 mg/mL] in anterolateral thigh every 20 minutes, or
    b. **Pediatric** EPINEPHrine (in anterolateral thigh every 20 minutes):
        i. < 25 kg, 0.15 mg **IM** [0.15 mL of 1 mg/mL],
        ii. > 25 kg, 0.3 mg **IM** [0.3 mL of 1 mg/mL]

7. Restrict nebulizer treatments to patients who are exhibiting signs of moderate to severe bronchospasm/wheezing. Again, **MDI** is the preferred route for medication administration.
    a. Albuterol 2.5 mg by nebulization (use 3 mL premix or 0.5 mL of 0.5% solution mixed in 2.5 mL of normal saline)
8. Consider CPAP[***] for patients in either of the following 2 categories:
    a. Patients with a history of CHF whose symptoms are more consistent with an acute exacerbation of CHF (i.e. rales, elevated JVD, increasing lower extremity edema) or
    b. Patients with COPD who fail to improve with increased O2 flow rate, use of their own inhaler and/or IM EPINEPHrine.

If progression to CPAP is necessary in either of these instances, please alert OLMC.

P

PARAMEDIC

9. *Do not* administer corticosteroids in patients suspected to have COVID-19 unless they are critically ill.
10. Consider Magnesium Sulfate after use of MDIs and IM EPINEPHrine.
    a. **Adult**: Magnesium Sulfate 2 grams **IV/IO** over 10 minutes, consider placing this medication on a pump
    b. **Pediatric:** Magnesium Sulfate 50 mg/kg **IV/IO** with a MAX dose of 2 grams over 10 minutes; consider placing this medication on a pump.

Pandemic Response Protocol #3, Management of Acute Respiratory Symptoms and Care Considerations during COVID-19 Pandemic

PEARLS for the Management of Acute Respiratory Symptoms during COVID-19 Pandemic

- *Nebulized medications should be avoided if at all possible due to aerosolization of the virus.
- **Metered dose inhalers (MDIs) with spacers are at least as effective, and likely more effective than nebulized medications. Albuterol MDIs are currently in shortage. Use of the patient's albuterol MDI conserves resources.
- ***CPAP is associated with **significantly** increased risk of coronavirus aerosol transmission and EMS clinician exposure.
- Steroids are **not** recommended in these patients as it may slow down the clearance of the virus.
- Non-rebreather masks appear to have the lowest risk of causing aerosolized particle spread and should be considered when clinically appropriate.

PEARLS for Airway Management and Management of Out of Hospital Cardiac Arrest during COVID-19 Pandemic

- Please avoid intubations whenever possible as this procedure generates a significant number of aerosolized particles. Please consider the goals of airway management (Oxygenation/Ventilation/Protection) and begin with less invasive means, pausing at the procedure that meets the patient's immediate needs. The most common clinical scenario that leads to intubation is out-of-hospital cardiac arrest (OHCA). Please consider basic measures (BVM with OPA/NPA) during resuscitation. If additional measures are required in the ROSC phase, begin with supraglottic airways. If this step meets the patient's needs, please do not proceed to intubation. Only consider intubation in the circumstance when the patient is not adequately oxygenated or ventilated or when concerned for airway protection.
- Please consider placing a HEPA filter on the exhalation port of BVMs to reduce exposure to aerosolized particles.
- Please consider pre-donning any necessary PPE to reduce time to EMS CPR.
- For more information, please refer to the *Cardiac Arrest and Pandemic Response Protocol*

PEARLS for Peripartum Care during COVID-19 Pandemic

- There have been some reports of increasing numbers of home births during the COVID-19 pandemic. While there have NOT been associated reports of increased calls for EMS assistance during this increase in home births, there are important nuances to the management of the newborn in the event that the mother is either a PUI for COVID-19 OR is laboratory confirmed to have the disease. Maine EMS expects that MOST of these instances will be managed in the hospital in an effort to oversee the complexities of this circumstance, however, in the event this is not the case and a child is born to a COVID-19 PUI mother or a mother confirmed to have COVID-19 please consider the following:
- The CDC and the American College of Obstetrics and Gynecology BOTH recommend that heathcare clinicians consider "temporarily separating" the newborn from the COVID-19 PUI mother or COVID-19 confirmed mother. The risks and benefits of temporary separation should be discussed with the mother prior to initiation. Should the mother refuse, document her refusal in the medical record and alert hospital staff on arrival. Consider allowing contact with non-infected immediate relatives if necessary. Follow all steps in the Maine EMS Protocols regarding transport of newborns, which includes the provision of transporting mother and newborn in different ambulances.

https://www.cdc.gov/coronavirus/2019-ncov/hcp/inpatient-obstetric-healthcare-guidance.html

Cardiac Arrest and Pandemic Response Protocol

Revised July 27, 2020

The following is a list of what is KNOWN about COVID-19 and the risk of transmission to EMS clinicians.
1) SARS-CoV-2/COVID-19 can be spread by aerosolized particles. Certain procedures may either *generate* or *expose* EMS clinicians to those aerosolized particles.
2) Airborne precautions and proper PPE in the form of eye protection*, gown, gloves and an N95 mask or equivalent respirator are highly protective, even in the face of exposure to COVID-19 patients.
3) In addition to proper PPE, other infection control measures described in Maine EMS Clinical Bulletins and the *Pandemic Response Protocols* are highly effective, especially social distancing and limiting the number of clinicians attending to a patient, when possible.

There remain certain unknowns surrounding the care of patients suffering from COVID-19, such as the true risk of each different aerosol-generating procedure to EMS clinicians in proper PPE and the best means to manage a patient's airway that best balances patient outcome and EMS clinician protection.
In addition to these, we also know important fundamental facts surrounding the management of patients suffering out-of-hospital cardiac arrest, including:
1) The most important therapy provided to patients suffering from OHCA is high-performance CPR (HP-CPR).
2) HP-CPR includes compressing at the proper rate and depth, allowing for adequate recoil and minimizing interruptions.

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Based on the KNOWN risks of COVID-19 transmission and what is known regarding the effective management of OHCA, the MDPB recommends the following when caring for a patient with OHCA during the COVID-19 pandemic:

1) **Personal Protective Equipment**
   a. *PPE is the most protective measure EMS clinicians can take when caring for a patient with COVID-19*. Per the Pandemic Response Protocol, **proper PPE (airborne precautions) MUST be worn in all cases of OHCA**. Consider strategies of pre-donning to reduce time to patient care. CPR, assisting ventilations, and placing airways are all aerosol-generating procedures. N95 masks (or equivalent) as well as gowns, gloves, and eye protection* are essential prior to management of these patients.

2) Treatment – CPR
   a. While CPR is being performed, please limit the number of clinicians to those absolutely necessary. EMS clinicians should establish a 6-foot distance from the patient when not performing procedures.
   b. If available, consider changing chest compressors every 2 minutes to reduce individual clinician exposure during CPR.
   c. If available, consider placement of a mechanical CPR device.If such a device is available, initiate resuscitation with manual CPR, placing the device on between the first and second pause for rhythm check, initiating the device as early as the third round of CPR.

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3) Treatment – Airway Management
   a. If available, place a HEPA filter between the BVM and airway device (e.g. Mask, BIAD, or ETT). Place the filter as close to the patient as possible. Minimize any disconnections between the HEPA filter and the patient.
   b. The MDPB strongly recommends placing a clear plastic shroud over the patient's head and neck, while performing all airway management techniques, including ongoing bagging underneath the shroud. This strategy reduces the risk of ongoing exposure to EMS clinicians.

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The above figures are examples of the clear plastic shroud. The shroud may be placed directly over the patient's head and neck while the EMS clinician managing the airway does so with the airway management device and their hands UNDER the shroud.

Controversy remains regarding the most protective airway management strategy. There is risk inherent in performing the procedure and risk of exposure after the procedure. In balance, the MDPB recommends maintaining the strategy of basic airway measures first, maintaining these measures as long as they are effective. This strategy reduces the risk to clinicians of performing intubation, which generates significant aerosolized secretions.

CAUTION: FIRE RISK: If a drape is being used AND the patient requires defibrillation, ensure the drape does not accumulate oxygen and that defibrillation pads are not under the drape during defibrillation.

c. If Blind Insertion Airway Devices are used and the device has a gastric port for insertion of OG tube, consider blocking that port in an effort to further reduce release of aerosolized secretions.

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d. If intubation is necessary, the MDPB strongly recommends performing this under a clear plastic shroud to limit exposure to aerosolized respiratory secretions. Consider the following:

i. Intubation should be performed by the clinician most experienced with intubation. No more than 2 attempts should be performed.

ii. Consider video laryngoscopy, if available and the intubator is experienced in its use.

iii. Do NOT pause chest compressions to perform intubation. Instead, consider intubating during the 2-minute rhythm/pulse checks.

iv. Continue ventilations under the clear plastic shroud.

4 .Treatment – Termination of Resuscitation

a. Follow all existing Maine EMS guidelines for Termination of Resuscitation (**Page 46, RED #13)**

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Eye protection, as defined for AIRBORNE precautions, is goggles or a face shield that covers the front and sides of the face. Protective eyewear (e.g., safety glasses, trauma glasses) with gaps between glasses and the face likely do not protect eyes from all splashes and sprays and do **not provide adequate protection when AIRBORNE precautions are required.*