

# Advanced Life Support Patient Care Standards

Version 4.8

Comes into force November 23, 2020

**Emergency Health Regulatory and Accountability Branch  
Ministry of Health**

To all users of this publication:

The information contained in this standard has been carefully compiled and is believed to be accurate at date of publication.

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## Document Control

Version Number	Date of Issue	Comes into Force Date	Brief Description of Change
3.1	N/A	November 2013	Existing document
3.2	Retired	Retired	Retired
3.3	April 20, 2015	February 1, 2016	Finalized version 3.3
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4.0	October 2016	N/A (amended prior to in force date)	Full update. See accompanying Summary of Changes.
4.0.1	November 2016	N/A (amended prior to in force date)	Update to Nausea/Vomiting Medical Directive – AUXILIARY (ACP): Weight condition changed from “<25 kg”, to “≥25 kg”.
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4.2	May 2017	N/A (amended prior to in force date)	Updates to Emergency Childbirth Medical Directive (PCP/ACP), Suspected Adrenal Crisis Medical Directive (PCP/ACP) and various housekeeping edits (e.g. IV provisions)

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4.3	July 2017	July 17, 2017	Amends 4.0.1. Change in the “Age” Condition for naloxone from $\geq 18$ years to $\geq 12$ years and change to epinephrine concentration labeling.
4.4	July 2017	December 11, 2017	Amends 4.2. Change in the “Age” Condition for naloxone from $\geq 18$ years to $\geq 12$ years and change to epinephrine concentration labeling.
4.5	April 2018	May 1, 2018	Updates to the Combative Patient Medical Directive. Addition of Analgesia Medical Directive and Emergency Tracheostomy Tube Reinsertion Medical Directive to the auxiliary appendices. See accompanying Summary of Changes.
4.6	September 2019	September 3, 2019	Minor housekeeping Migration of Analgesia Medical Directive and Emergency Tracheostomy Tube Reinsertion Medical Directive (PCP / ACP) from “Auxiliary” to “Core” appendices. Addition of the Research Trial Standard.
4.6.1	October 2019	October 23, 2019	Amends version 4.6 to correct table formatting and branch name.
4.7	April 8, 2020	April 8, 2020	Addition of the auxiliary “Assessment of Patients with Possible COVID-19” Medical Directive.
4.8	November 9, 2020	November 23, 2020	Updates to the following Medical Directives: Moderate to Severe Allergic Reaction (PCP/ACP), Suspected Adrenal Crisis (PCP/ACP), added Endotracheal and Tracheostomy Suctioning & Reinsertion (PCP/ACP), Intravenous and Fluid Therapy (ACP), Pediatric Intraosseous (ACP), Intravenous and Fluid Therapy – AUXILIARY (PCP), Adult Intraosseous – AUXILIARY (ACP), Assessment of

Version Number	Date of Issue	Comes into Force Date	Brief Description of Change
			Patients with Possible COVID-19 – AUXILIARY (PCP/ACP)

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# **Advanced Life Support Patient Care Standards**

Version 4.8

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**Preamble**

**i**

## Preamble

# Levels of Paramedics

In Ontario, there are 3 levels of qualification for paramedics which lead to Certification as a: Primary Care Paramedic (PCP), Advanced Care Paramedic (ACP), and Critical Care Paramedic (CCP). The qualification for each are set out in Ontario Regulation 257/00 made under the *Ambulance Act*, RSO 1990, c A-19. The qualifications for each include a requirement that the paramedic be authorized by a Medical Director of a Regional Base Hospital (RBH) to perform the controlled acts set out in Schedules 1, 2 and 3 to O. Reg. 257/00.

A paramedic may be authorized by the Medical Director to perform controlled acts from the Schedule immediately above their Certification. In this circumstance, the paramedic is required to perform the controlled act to a specific standard as set out in the *Advanced Life Support Patient Care Standards* (ALS PCS). All advanced medical procedures that are not listed as controlled acts in Schedules 1, 2 and 3, shall also be performed as set out in the ALS PCS.

## Purpose of Standards

The ALS PCS reflects current practices for paramedics in Ontario and provides benchmarks for paramedic performance. It also communicates the standards of practice and care by paramedics in Ontario to paramedics, patients, other disciplines and the public in general.

# Format of the ALS PCS

This document is comprised of a Preamble section and six (6) appendices: Appendix 1 – PCP Core Medical Directives; Appendix 2 – ACP Core Medical Directives; Appendix 3 – PCP Auxiliary Medical Directives; Appendix 4 – ACP Auxiliary Medical Directives; Appendix 5 – Chemical Exposure Medical Directives; and Appendix 6 – Certification Standard. Critical Care Paramedics and Advanced/Primary Care Flight Paramedics will perform controlled acts in accordance with the Base Hospital (BH) Medical Directives issued by the Ornge Base Hospital Physician (BHP).

# Use of the Medical Directives by Paramedics

These Medical Directives apply to paramedics who are authorized by a RBH Medical Director to provide patient care. Delegation of controlled acts in the ALS PCS to paramedics falls under the exclusive oversight of the RBH Programs.

## General Structure of a Medical Directive

All Medical Directives follow the same format and are comprised of the following sections:

### **Indications:**

The general medical complaint or problem to which the Medical Directive applies.

### **Conditions:**

Clinical parameters that must be present for a procedure to be performed or for a medication to be administered.

### **Contraindications:**

Clinical parameters that if present, preclude the performance of a procedure or the administration of a medication.

### **Treatment:**

Description of the type of procedure to be performed or the dosing of a medication.

### **Clinical Considerations:**

Key clinical points that provide general guidance to the proper performance of a procedure or the administration of a medication.

**All of these sections must be taken into account before and during the implementation of a Medical Directive.**

## Auxiliary Medical Directives

Additional (“Auxiliary”) skills may be delegated through use of the Auxiliary Medical Directives. Delegation of Auxiliary Medical Directives by a RBH Medical Director to paramedics is optional

and may be introduced after consultation and mutual agreement between the RBH and the certified ambulance service that employs the paramedic. Some PCP and ACP Medical Directives contain the phrase, “(if available and authorized)”. This phrase qualifies the skill or procedure as optional (*i.e.* auxiliary) even if included in PCP or ACP Medical Directives.

## Consent to Treatment in Non-Emergency Situations

Except in emergency circumstances described below, paramedics shall obtain consent prior to administering treatment. If a patient is incapable of consenting to the treatment being proposed by a paramedic, consent may be given or refused on his or her behalf by the patient’s substitute decision-maker (SDM). Consent may be expressed or implied. Implied consent may be assumed where a person provides a physical indication that they consent to the treatment being proposed. For example, a patient who cannot speak but extends his hand to a paramedic after the paramedic indicates she is going to perform a simple procedure, such as a blood glucose determination, may be giving implied consent to the treatment.

The elements required for consent to treatment are:

- a) consent must be given by a person who is capable of giving consent with respect to treatment;
- b) consent must relate to the treatment;
- c) consent must be informed;
- d) consent must be given voluntarily; and
- e) consent must not be obtained through misrepresentation or fraud.

Consent to treatment is informed if, before it is given by the person, he or she has:

- a) received the following information that a reasonable person in the same circumstances would require in order to make a decision about the treatment:
  - i. the nature of the treatment;
  - ii. the expected benefits of the treatment;
  - iii. the material risks of the treatment;
  - iv. the material side effects of the treatment;
  - v. alternative courses of action;
  - vi. the likely consequences of not having the treatment; and
- b) received responses to his or her requests for additional information about those matters.

Valid consent requires that a person has the capacity to provide consent. A person is presumed to have the capacity to provide consent with respect to treatment and a paramedic may rely on that presumption unless the paramedic has reasonable grounds to believe that the person is incapable with respect to the treatment. A paramedic must perform a capacity assessment if it is not reasonable in the circumstances to presume the person is capable of consenting to the treatment.

A patient is capable with respect to treatment if the patient is:

- a) Able to **understand** the information that is relevant to making a decision about the treatment or alternatives being proposed; **and**
- b) Able to **appreciate** the reasonably foreseeable consequences of a decision or lack of decision with respect to treatment.

If a patient is incapable of consenting to a proposed treatment, and the paramedic is aware or is made aware that the person has a prior capable wish with respect to the proposed treatment, they must respect that wish (for example, if the person does not wish to be resuscitated).

## Consent to Treatment in Emergency Situations

Where the person for whom the treatment is being proposed is apparently experiencing severe suffering or is at risk of sustaining serious bodily harm if the treatment is not administered promptly, it is considered to be an emergency.

For situations involving consent to treatment in emergency situations, a paramedic shall comply with the applicable directions contained in the *Basic Life Support Patient Care Standards* (BLS PCS).

## Refusal of Treatment

If a patient refuses treatment, either in whole or in part, a paramedic shall comply with the applicable directions contained in the BLS PCS.

## Comprehensive Care

While initiating and continuing treatment prescribed by these Medical Directives, a paramedic must ensure that the patient simultaneously receives care in accordance with the BLS PCS.

It is acknowledged that there may be circumstances and situations where complying with ALS PCS is not clinically justified, possible, or prudent (*e.g.* multiple crews on scene, trapped patient, extenuating circumstances, competing patient care priorities). When treatment deviates from the standards, a paramedic must document the care provided, including reasoning for deviating from the ALS PCS.

# Intravenous (IV) Access and Therapy by Primary Care Paramedics

There are 2 types of authorization for PCPs IV cannulation and therapy.

“PCP Assist IV” is authorization for a PCP to cannulate a peripheral IV at the request and under the direct supervision of an ACP. The patient must require a peripheral IV in accordance with the indications listed in the Intravenous and Fluid Therapy Medical Directive - Auxiliary. The ACP will perform all IV therapy in accordance with the Intravenous and Fluid Administration Medical Directive once intravenous access is obtained. PCPs authorized in PCP Assist IV are not authorized to administer IV therapy.

“PCP Autonomous IV” is authorization for a PCP to independently cannulate an IV according to the Intravenous and Fluid Therapy Medical Directive – Auxiliary. PCPs authorized in PCP Autonomous IV are authorized to administer IV therapy according to applicable Medical Directives.

Authorization for each type shall meet the requirements established by the provincial Medical Advisory Committee.

# Home Medical Technology and Novel Medications

As community care advances, new home medical technologies and novel medications are being introduced for home use by highly trained patients and caregivers. They are generally used by patients with complex medical histories who may require emergent interventions which are not described in, or aligned with, the BLS PCS or ALS PCS.

A “home medical technology” is an external or internal mechanical device prescribed by a member of a regulated health profession for the purpose of treating a medical condition.

A “novel medication” is a self/caregiver-administered medication prescribed by a member of a regulated health profession that is required to treat patients with generally rare and unusually complex chronic medical conditions which are often end stage. The medication may be self/caregiver-administered by any route into any part of the body.

These can be encountered unexpectedly by paramedics without any prior knowledge that these technologies or medications are being used in the community. Paramedics may not be familiar with the use of these technologies or medications, even though they may be required to provide care.

In some cases, when Base Hospital Medical Directors are alerted to these devices, medications or care requirements, a local medical directive may be issued to guide specific care for these patients. Such directives should be followed until further consideration by the Medical Advisory Committee.



A paramedic may assume patients or caregivers have knowledge about the technology or medication if they confirm that they were trained in its use and/or administration. A paramedic should advise the patient or caregiver to follow any specific steps or provide any advice about restarting/stopping the device or novel medication. A paramedic may only assist a patient within the authorized paramedic skill set.

When care requirements are uncertain, but the patient is stable, transport the patient. If the patient is unstable, consider patching to the BHP. Alternatively, consider contacting the responsible member of a regulated health profession.

A paramedic may follow written advice provided by their Base Hospital Medical Directors even if this advice is outside the conditions and contraindications of the BLS PCS and ALS PCS.

## Patching

A paramedic shall patch to the Base Hospital when:

- a) a medical directive contains a mandatory provincial patch point; **OR**
- b) an RBH introduces a mandatory BH patch point; **OR**
- c) for situations that fall outside of these Medical Directives where the paramedic believes the patient may benefit from online medical direction that falls within the prescribed paramedic scope of practice; **OR**
- d) there is uncertainty about the appropriateness of a medical directive, either in whole or in part.

In cases where a treatment option requires the prior authorization by the BHP (*i.e.* mandatory provincial patch point or mandatory BH patch point) AND the BHP cannot be reached despite reasonable attempts by the paramedic to establish contact, a paramedic may initiate the required treatment without the requisite online authorization if the patient is in severe distress and, in the paramedic's opinion, the medical directive would otherwise apply. Clinical judgement must be applied and an acceptable standard of care must be met. This may be based on peer and expert review. In such cases, a paramedic should continue attempts to contact the BHP after the treatment has been initiated. All patch failures must be reported in a timely manner in accordance with local policy and procedures. Paramedics should document the attempts to patch to the BH on the Ambulance Call Report (ACR).

If a BHP directs a paramedic to perform an assessment or intervention that exceeds the paramedic's scope of practice, the paramedic must advise the BHP of such and notify the physician that he or she cannot comply with the direction as it exceeds his or her scope of practice. In such cases, a paramedic should ask the BHP to provide alternative direction.

# Incident Reporting

Paramedics shall adhere to their ambulance service policies and the *Ontario Ambulance Documentation Standards* (incorporated by reference in Ontario Regulation 257/00) for incident reporting. Paramedics shall also adhere to additional RBH policies regarding reporting of clinical care incidents to the RBH.

# Responsibility for Care

While on scene, the highest level paramedic shall assess the patient and make a decision on the level of care required, and on the level of paramedic required for the care of the patient. The highest level paramedic is the ultimate patient care authority on the scene. If there is any disagreement between paramedics, the Base Hospital physician may be contacted. It is expected that when an intervention has been performed, the paramedic most appropriate for that intervention will remain responsible for the patient.

In all patient care, the highest level of paramedic is responsible for the care of the patient, including decisions on the level of care required during transport. A paramedic may choose to assign aspects of care and procedures to an alternate level paramedic, as long as the care and procedures are within that paramedic's scope of practice. Paramedics must alert the highest level paramedic of any change of patient status.

When transferring care from one level of paramedic to another, paramedics shall provide:

- a) current CTAS level;
- b) a history of the patient's current problem(s) and relevant past medical history;
- c) pertinent physical findings;
- d) a summary of management at scene/en route;
- e) the patient's response to treatment, including most recent vital signs; and
- f) the reason for transfer in cases of inter-facility transfers.

The transfer of responsibility of patient care is a critical juncture along the clinical care continuum. When transferring patient care to another health care provider (*e.g.* nurse, physician, *etc.*), a paramedic must comply with the BLS PCS regarding such transfers.

# Research

Clinical research is fundamental to the practice of medicine and the development of safer, more effective treatment options for patients. At times, research protocols require temporary changes to patient care standards. Changes to patient care standards will be approved and introduced by the MOH.

# Conventions

“Conventions” refers to a consistent application of terms throughout the Medical Directives based on definitions below.

The word ‘consider’ is used repeatedly throughout the Medical Directives. Where this word appears, it indicates that a paramedic should initiate the treatment unless there is strong clinical rationale to withhold it. A paramedic must document his or her justification for withholding treatment on the ACR.

## Medication Doses and Administration

Medication doses may be either in per kilogram or fixed doses, depending on common clinical practice. The number of recommended medication doses may be administered regardless of any previous self-administration by a patient. When more than one route of medication administration is listed, the order of preference for route of administration is from left to right. Clinical circumstances for each case should determine the final route chosen.

Pediatric medication doses can vary slightly according to the source of expert opinion. The pediatric medication doses in the ALS PCS are the preferred doses. However, medication doses as determined by an up-to-date version of a widely accepted pediatric emergency tape (*e.g.* Broselow Tape) are an acceptable alternative. Use of a pediatric emergency tape shall be documented on the ACR when it is used to determine a pediatric medication dose.

Medication doses may be calculated based upon weight or other factors and result in a fraction that cannot be measured accurately. Depending on the delivery method used, medication doses may require rounding from the exact dose calculated. In these cases, the medication dose delivered will be rounded to the closest dose that can accurately be measured.

## Age and Vital Signs

The general age cut off between adults and pediatrics is 18 years. There is a wide range of “normal” for vital signs in adults and especially pediatrics. As much as possible, ages for pediatrics and cut off points for vital signs have been kept consistent throughout the Medical Directives. However, clinical research and expert opinion have resulted in a number of exceptions which in each case has been deliberately chosen and is clearly noted in each Medical Directive. There is a deliberate gap in the definition of normotension and hypotension in adults.

### Adults

#### Normotension

SBP  $\geq$ 100 mmHg

### Hypotension

SBP <90 mmHg

### Heart rate

Heart rate is always in beats per minute according to a cardiac monitor when it is applied. In situations where a cardiac monitor is not indicated then the heart rate is equal to the pulse rate.

### Bradycardia

HR <50 BPM

### Tachycardia

HR ≥100 BPM

### Tachypnea

RR ≥28 breaths/min

## Pediatrics

Age	Respiratory Rate	Heart Rate
0-3 months	30-60	90-180
3-6 months	30-60	80-160
6-12 months	25-45	80-140
1-3 yr	20-30	75-130
6 yr	16-24	70-110
10 yr	14-20	60-90

### Normotension

SBP ≥90 mmHg + (2 x age in years)

### Hypotension

SBP <70 mmHg + (2 x age in years)

### Weight (kg)

= (age x 2) + 10

### Hypoglycemia

Age	Blood glucose level
<2 yr	<3.0 mmol/L
≥2 yr	<4.0 mmol/L

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### Level of Awareness (LOA)

The word ‘altered’ refers to a GCS that is less than normal for the patient.

The word ‘unaltered’ refers to a GCS that is normal for the patient. This may be a GCS <15.

# Commonly Used Abbreviations

Table 1 below outlines abbreviations commonly used in the ALS PCS.

**Table 1. Abbreviations commonly used in the ALS PCS**

Word/Phrase	Abbreviation
<b>A</b>	
Advanced Care Paramedic	ACP
Advanced Life Support	ALS
<i>Advanced Life Support Patient Care Standards</i>	ALS PCS
Acetylsalicylic acid	ASA
As needed	PRN
Atrioventricular	AV
Automated external defibrillation	AED
<b>B</b>	
Base Hospital	BH
Base Hospital Physician	BHP
Basic Life Support	BLS
<i>Basic Life Support Patient Care Standards</i>	BLS PCS
Beats per minute	BPM
Bag-valve-mask	BVM
By mouth/oral	PO
<b>C</b>	
Critical Care Paramedic	CCP
Chronic obstructive pulmonary disease	COPD
Centimetre	cm
Continuous positive airway pressure	CPAP
Cardiopulmonary Resuscitation	CPR
College of Physicians and Surgeons of Ontario	CPSO
Canadian Triage and Acuity Scale	CTAS

Word/Phrase	Abbreviation
Cerebral vascular accident	CVA
Central venous access device	CVAD
<b>D</b>	
Diabetic ketoacidosis	DKA
Do Not Resuscitate	DNR
Drops	gtts
<b>E</b>	
Electronic control device	ECD
Electrocardiogram	ECG
Esophageal detection device	EDD
Emergency department	ED
End tidal carbon dioxide	ETCO <sub>2</sub>
Endotracheal tube	ETT
Every	q
<b>F</b>	
Fraction of inspired oxygen	FiO <sub>2</sub>
Febrile respiratory infection	FRI
<b>G</b>	
Gram	g
Glasgow Coma Scale	GCS
<b>H</b>	
Heart Rate	HR
History	Hx
<b>I</b>	
Intramuscular	IM
Intranasal	IN

Word/Phrase	Abbreviation
Intraosseous	IO
Intravenous	IV
<b>J</b>	
Joule	J
<b>K</b>	
Kilogram	kg
<b>L</b>	
Level of awareness	LOA
Level of consciousness	LOC
<b>M</b>	
Maximum	Max.
Metered dose inhaler	MDI
Microgram	mcg
Milligram	mg
Milliseconds	ms
Minimum	Min.
Minute	min
Millilitre per kilogram	ml/kg
Millimetres of mercury	mmHg
Ministry of Health	MOH
<b>N</b>	
Not applicable	N/A
Nostril	nare
Nebulized	NEB
Nasopharyngeal airway	NPA
Non-steroidal anti-inflammatory drug	NSAID



Word/Phrase	Abbreviation
<b>O</b>	
Ontario Base Hospital Group-Medical Advisory Committee	OBHG-MAC
Oropharyngeal airway	OPA
<b>P</b>	
Pediatric	Ped
Primary Care Paramedic	PCP
Pulseless electrical activity	PEA
<b>R</b>	
Regional Base Hospital	RBH
Return of spontaneous circulation	ROSC
Respiratory rate	RR
<b>S</b>	
Sodium chloride	NaCl
Subcutaneous	SC
Sublingual	SL
Systolic blood pressure	SBP
Saturation of peripheral oxygen	SpO <sub>2</sub>
ST-segment elevation myocardial infarction	STEMI
<b>T</b>	
Topical	TOP
Termination of Resuscitation	TOR
Traumatic brain injury	TBI
Tricyclic antidepressant	TCA
Transcutaneous pacing	TCP
<b>U</b>	
Upper respiratory tract infection	URTI

Word/Phrase	Abbreviation
<b>V</b>	
Ventricular Fibrillation	VF
Ventricular Tachycardia	VT
Vital signs absent	VSA
<b>W</b>	
Water	H <sub>2</sub> O
Within normal limits	WNL

## Reference and Educational Notes

The RBHs have created a companion document of reference and educational notes intended to assist paramedics in implementing these Medical Directives. This will facilitate regular updating of these notes without having to issue frequent changes to the standards. It is expected that paramedics have mastered the relevant information as part of initial training and certification and have maintained their knowledge through continuing education and self-study. The reference and educational notes do not define a standard of care; however, they should be considered useful in ensuring that an appropriate standard of care is met.

## **Appendix 1 – PCP Core Medical Directives**

# 1

# Medical Cardiac Arrest Medical Directive

A Primary Care Paramedic may provide the treatment prescribed in this Medical Directive if authorized.

## Indications

Non-traumatic cardiac arrest.

## Conditions

CPR	
<b>Age</b>	N/A
<b>LOA</b>	Altered
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	N/A
<b>Other</b>	Performed in 2 minute intervals

Manual Defibrillation	
<b>Age</b>	≥30 days
<b>LOA</b>	Altered
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	N/A
<b>Other</b>	VF OR pulseless VT

AED Defibrillation	
<b>Age</b>	≥30 days
<b>LOA</b>	Altered
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	N/A
<b>Other</b>	Defibrillation indicated

Epinephrine	
<b>Age</b>	N/A
<b>LOA</b>	Altered
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	N/A
<b>Other</b>	Anaphylaxis suspected as causative event

Medical TOR	
<b>Age</b>	≥18 years
<b>LOA</b>	Altered
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	N/A
<b>Other</b>	Arrest not witnessed by EMS <b>AND</b> No ROSC <b>AND</b> No defibrillation delivered

---

## Contraindications

CPR
Obviously dead as per BLS PCS
Meet conditions of <i>Do Not Resuscitate (DNR) Standard</i>

---

Manual Defibrillation
Rhythms other than VF or pulseless VT

AED Defibrillation
Non-shockable rhythm

Epinephrine
Allergy or sensitivity to epinephrine

Medical TOR
Arrest thought to be of non-cardiac origin

## Treatment

Consider CPR

Consider Manual defibrillation (if available and authorized)

	Age	
	≥30 days to <8 years	≥8 years
<b>Dose</b>	1 defibrillation	1 defibrillation
<b>Initial dose</b>	2 J/kg	As per BH / manufacturer
<b>Subsequent dose(s)</b>	4 J/kg	As per BH / manufacturer
<b>Dosing interval</b>	2 min	2 min
<b>Max. # of doses</b>	4	4

Consider AED defibrillation (if not using manual defibrillation)

	Age		Age
	≥30 days to <8 years		≥8 years
	With Pediatric Attenuator Cable	Without Pediatric Attenuator Cable	N/A
<b>Dose</b>	1 defibrillation	1 defibrillation	1 defibrillation
<b>Max. single dose</b>	As per BH / manufacturer	As per BH / manufacturer	As per BH / manufacturer
<b>Dosing interval</b>	2 min	2 min	2 min
<b>Max. # of doses</b>	4	4	4

Consider epinephrine (only if anaphylaxis is suspected as causative event)

	<b>Route</b>
	IM
	<b>Concentration</b>
	1 mg/mL = 1:1,000
<b>Dose</b>	0.01 mg/kg*
<b>Max. single dose</b>	0.5 mg
<b>Dosing interval</b>	N/A
<b>Max. # of doses</b>	1

\*The epinephrine dose may be rounded to the nearest 0.05 mg

### Mandatory Provincial Patch Point

Patch to BHP for authorization, following the 3<sup>rd</sup> analysis, to consider Medical TOR (if applicable). If the BH patch fails, or the medical TOR does not apply, transport to the closest appropriate receiving facility following ROSC or the 4<sup>th</sup> analysis.

## Clinical Considerations

Consider very early transport after the 1<sup>st</sup> analysis (and defibrillation if indicated) in the following settings: pregnancy presumed to be  $\geq 20$  weeks gestation (fundus above umbilicus, ensure manual displacement of uterus to left), hypothermia, airway obstruction, suspected pulmonary embolus, medication overdose/toxicology, or other known reversible cause of arrest not addressed.

Similarly, plan for extrication and transport for patients with refractory ventricular fibrillation and pediatric cardiac arrest (after 3 analyses), ensure quality CPR can be continued.

In cardiac arrest associated with opioid overdose, continue standard medical cardiac arrest directive. There is no clear role for routine administration of naloxone in confirmed cardiac arrest.

Follow the *Deceased Patient Standard* once TOR has been implemented.

## Defibrillation Joule Settings

*This section is intentionally left blank.*



# Trauma Cardiac Arrest Medical Directive

A Primary Care Paramedic may provide the treatment prescribed in this Medical Directive if authorized.

## Indications

Cardiac arrest secondary to severe blunt or penetrating trauma.

## Conditions

CPR	
<b>Age</b>	N/A
<b>LOA</b>	Altered
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	N/A
<b>Other</b>	Performed in 2 minute intervals

Manual Defibrillation	
<b>Age</b>	≥30 days
<b>LOA</b>	Altered
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	N/A
<b>Other</b>	VF <b>OR</b> pulseless VT

AED Defibrillation	
<b>Age</b>	≥30 days
<b>LOA</b>	Altered
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	N/A
<b>Other</b>	Defibrillation indicated

Trauma TOR	
<b>Age</b>	≥16 years
<b>LOA</b>	Altered
<b>HR</b>	0
<b>RR</b>	0
<b>SBP</b>	N/A
<b>Other</b>	No palpable pulses <b>AND</b> No defibrillation delivered <b>AND</b> Monitored HR = 0 <b>OR</b> Monitored HR >0 with the closest ED ≥30 min transport time away.

## Contraindications

CPR
Obviously dead as per BLS PCS
Meet conditions of <i>Do Not Resuscitate (DNR) Standard</i>

Manual Defibrillation
Rhythms other than VF or pulseless VT

AED Defibrillation
Non-shockable rhythm

Trauma TOR
Age <16 years
Defibrillation delivered
Monitored HR >0 and closest ED <30 min transport time away

## Treatment

Consider CPR

Consider Manual defibrillation (if available and authorized)		
	Age	Age
	≥30 days to <8 years	≥8 years
<b>Dose</b>	1 defibrillation	1 defibrillation
<b>Initial dose</b>	2 J/kg	As per BH / manufacturer
<b>Dosing interval</b>	N/A	N/A
<b>Max. # of doses</b>	1	1

**Consider AED defibrillation (if not using manual defibrillation)**

	Age		Age
	≥30 days to <8 years		≥8 years
	With Pediatric Attenuator Cable	Without Pediatric Attenuator Cable	N/A
<b>Dose</b>	1 defibrillation	1 defibrillation	1 defibrillation
<b>Max. single dose</b>	As per BH / manufacturer	As per BH / manufacturer	As per BH / manufacturer
<b>Dosing interval</b>	N/A	N/A	N/A
<b>Max. # of doses</b>	1	1	1

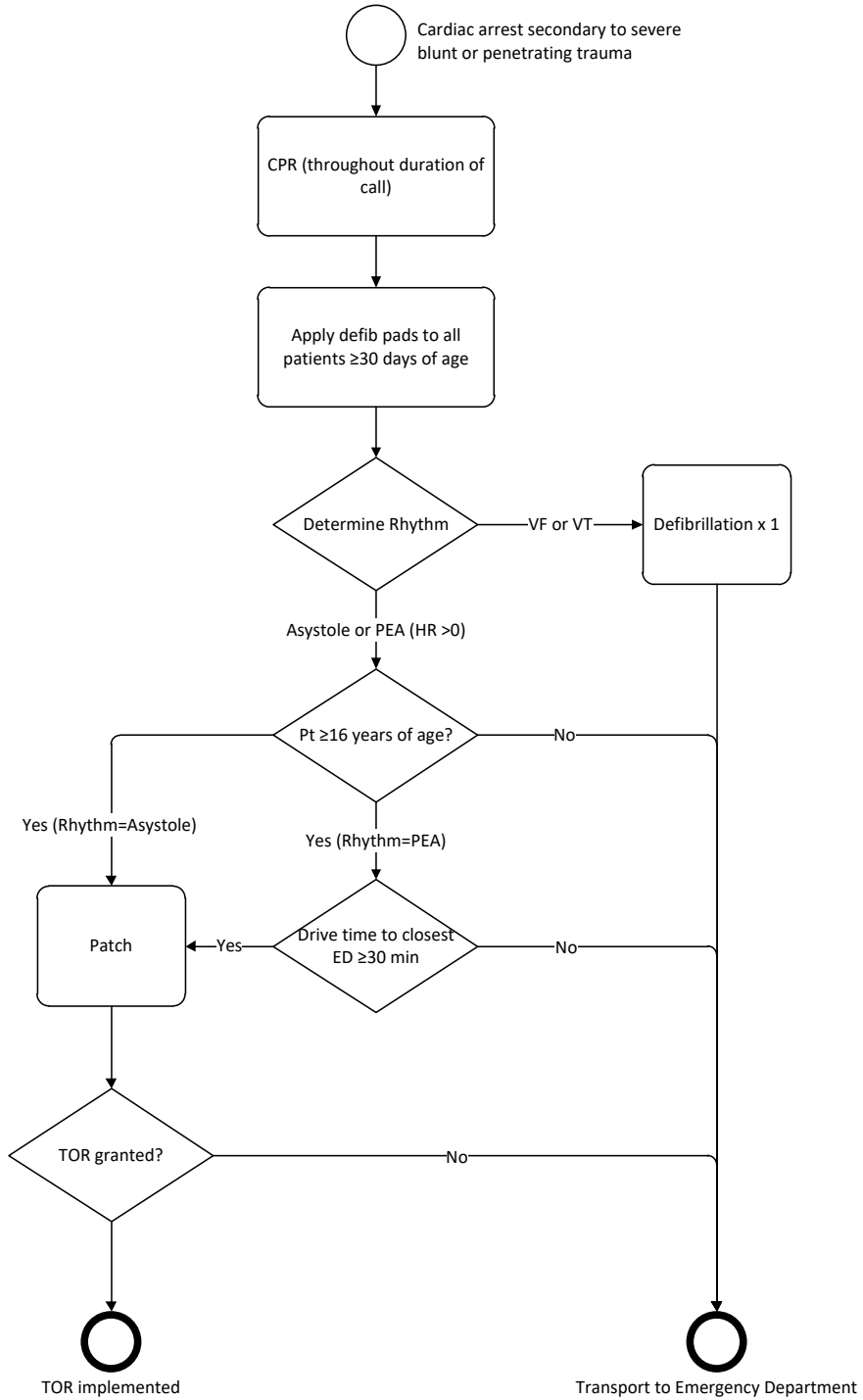
**Mandatory Provincial Patch Point**

Patch to BHP for authorization to apply the Trauma TOR if applicable. If the BH patch fails, or the Trauma TOR does not apply, transport to the closest appropriate receiving facility following the 1<sup>st</sup> analysis/defibrillation.

**Clinical Considerations**

If no obvious external signs of significant blunt trauma, consider medical cardiac arrest and treat according to the appropriate medical cardiac arrest directive.

## Treatment – Algorithm For Trauma Arrest



# Hypothermia Cardiac Arrest Medical Directive

A Primary Care Paramedic may provide the treatment prescribed in this Medical Directive if authorized.

## Indications

Cardiac arrest secondary to severe hypothermia.

## Conditions

CPR	
<b>Age</b>	N/A
<b>LOA</b>	Altered
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	N/A
<b>Other</b>	Performed in 2 minute intervals

Manual Defibrillation	
<b>Age</b>	≥30 days
<b>LOA</b>	Altered
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	N/A
<b>Other</b>	VF OR pulseless VT

AED Defibrillation	
<b>Age</b>	≥30 days
<b>LOA</b>	Altered
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	N/A
<b>Other</b>	Defibrillation indicated

## Contraindications

CPR
Obviously dead as per BLS PCS
Meet conditions of <i>Do Not Resuscitate (DNR) Standard</i>

Manual Defibrillation
Rhythms other than VF or pulseless VT

AED Defibrillation
Non-shockable rhythm

## Treatment

Consider CPR

Consider Manual defibrillation (if available and authorized)		
	Age	Age
	≥30 days to <8 years	≥8 years
<b>Dose</b>	1 defibrillation	1 defibrillation
<b>Initial dose</b>	2 J/kg	As per BH / manufacturer
<b>Dosing interval</b>	N/A	N/A
<b>Max. # of doses</b>	1	1

Consider AED defibrillation (if not using manual defibrillation)			
	Age		Age
	≥30 days to <8 years		≥8 years
	With Pediatric Attenuator Cable	Without Pediatric Attenuator Cable	N/A
<b>Dose</b>	1 defibrillation	1 defibrillation	1 defibrillation
<b>Max. single dose</b>	As per BH / manufacturer	As per BH / manufacturer	As per BH / manufacturer
<b>Dosing interval</b>	N/A	N/A	N/A
<b>Max. # of doses</b>	1	1	1

## Clinical Considerations

Transport to the closest appropriate facility without delay following the 1<sup>st</sup> analysis.

# Foreign Body Airway Obstruction Cardiac Arrest Medical Directive

A Primary Care Paramedic may provide the treatment prescribed in this Medical Directive if authorized.

## Indications

Cardiac arrest secondary to an airway obstruction.

## Conditions

CPR	
<b>Age</b>	N/A
<b>LOA</b>	Altered
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	N/A
<b>Other</b>	Performed in 2 minute intervals

Manual Defibrillation	
<b>Age</b>	≥30 days
<b>LOA</b>	Altered
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	N/A
<b>Other</b>	VF OR pulseless VT

AED Defibrillation	
<b>Age</b>	≥30 days
<b>LOA</b>	Altered
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	N/A
<b>Other</b>	Defibrillation indicated



## Contraindications

CPR
Obviously dead as per BLS PCS
Meet conditions of <i>Do Not Resuscitate (DNR) Standard</i>

Manual Defibrillation
Rhythms other than VF or pulseless VT

AED Defibrillation
Non-shockable rhythm

## Treatment

Consider CPR

Consider foreign body removal (utilizing BLS PCS maneuvers)

Consider Manual defibrillation (if available and authorized)		
	Age	Age
	≥30 days to <8 years	≥8 years
<b>Dose</b>	1 defibrillation	1 defibrillation
<b>Initial dose</b>	2 J/kg	As per BH / manufacturer
<b>Dosing interval</b>	N/A	N/A
<b>Max. # of doses</b>	1	1

Consider AED defibrillation (if not using manual defibrillation)			
	Age		Age
	≥30 days to <8 years		≥8 years
	With Pediatric Attenuator Cable	Without Pediatric Attenuator Cable	N/A
<b>Dose</b>	1 defibrillation	1 defibrillation	1 defibrillation
<b>Max. single dose</b>	As per BH / manufacturer	As per BH / manufacturer	As per BH / manufacturer
<b>Dosing interval</b>	N/A	N/A	N/A
<b>Max. # of doses</b>	1	1	1

## Clinical Considerations

If the patient is in cardiac arrest following removal of the obstruction, initiate management as a medical cardiac arrest.

If the obstruction cannot be removed, transport to the closest appropriate facility without delay following the 1<sup>st</sup> analysis.

# Neonatal Resuscitation Medical Directive

A Primary Care Paramedic may provide the treatment prescribed in this Medical Directive if authorized.

## Indications

Neonatal patient.

## Conditions

	Resuscitation
<b>Age</b>	<30 days of age
<b>LOA</b>	N/A
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	N/A
<b>Other</b>	N/A

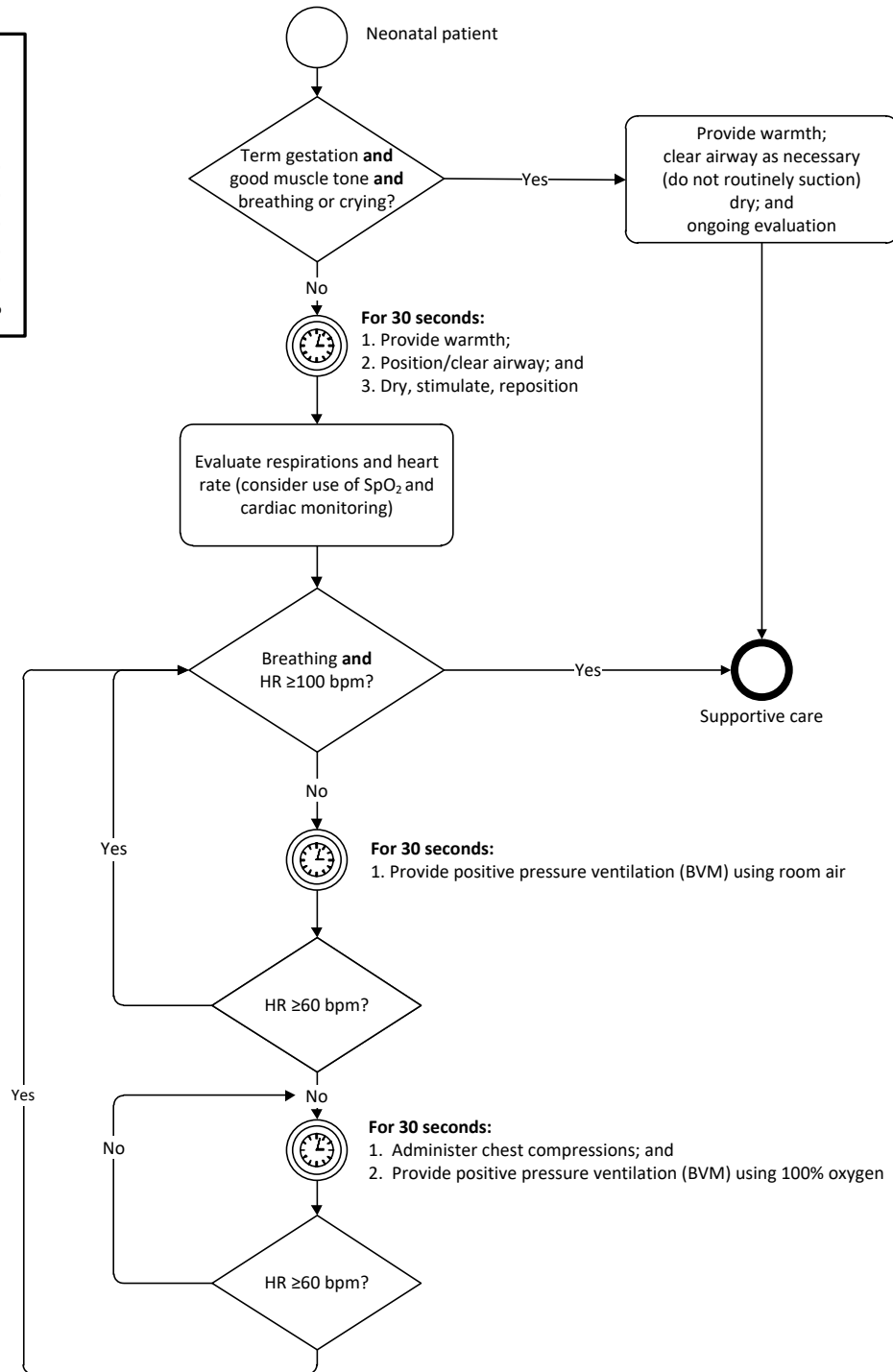
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## Contraindications

Resuscitation
N/A

## Treatment

Targeted Preductal SpO <sub>2</sub> (Right Hand)	
1 min	60% - 65%
2 min	65% - 70%
3 min	70% - 75%
4 min	75% - 80%
5 min	80% - 85%
10 min	85% - 95%



## Clinical Considerations

If neonatal resuscitation is required, initiate cardiac monitoring and pulse oximetry monitoring.

# Return of Spontaneous Circulation (ROSC) Medical Directive

A Primary Care Paramedic may provide the treatment prescribed in this Medical Directive if authorized.

## Indications

Patient with return of spontaneous circulation (ROSC) after the resuscitation was initiated.

## Conditions

0.9% NaCl Fluid Bolus	
<b>Age</b>	≥2 years
<b>LOA</b>	N/A
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	Hypotension
<b>Other</b>	Chest auscultation is clear

## Contraindications

0.9% NaCl Fluid Bolus	
Fluid overload	
SBP ≥90 mmHg	

## Treatment

<b>Consider optimizing ventilation and oxygenation</b>
Titrate oxygenation 94-98%
Avoid hyperventilation and target ET <sub>CO</sub> <sub>2</sub> to 30-40 mmHg with continuous waveform capnography (if available)

**Consider 0.9% NaCl fluid bolus (if available and authorized)**

	<b>Age</b>	<b>Age</b>
	≥2 years to <12 years	≥12 years
	<b>Route</b>	<b>Route</b>
	IV	IV
<b>Infusion</b>	10 ml/kg	10 ml/kg
<b>Infusion interval</b>	Immediate	Immediate
<b>Reassess every</b>	100 ml	250 ml
<b>Max. volume</b>	1,000 ml	1,000 ml

**Consider 12-lead ECG acquisition and interpretation**

### Clinical Considerations

Consider initiating transport in parallel with the above treatment.

IV fluid bolus applies only to PCPs authorized for PCP Autonomous IV.

# Cardiac Ischemia Medical Directive

A Primary Care Paramedic may provide the treatment prescribed in this Medical Directive if authorized.

## Indications

Suspected cardiac ischemia.

## Conditions

ASA	
<b>Age</b>	≥18 years
<b>LOA</b>	Unaltered
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	N/A
<b>Other</b>	Able to chew and swallow

Nitroglycerin	
<b>Age</b>	≥18 years
<b>LOA</b>	Unaltered
<b>HR</b>	60-159 bpm
<b>RR</b>	N/A
<b>SBP</b>	Normotension
<b>Other</b>	Prior history of nitroglycerin use <b>OR</b> IV access obtained

## Contraindications

ASA
Allergy or sensitivity to ASA or NSAIDs
If asthmatic, no prior use of ASA
Current active bleeding
CVA or TBI in the previous 24 hours

Nitroglycerin
Allergy or sensitivity to nitrates
Phosphodiesterase inhibitor use within the previous 48 hours
SBP drops by one-third or more of its initial value after nitroglycerin is administered
12-lead ECG compatible with Right Ventricular MI



## Treatment

Consider ASA	
	<b>Route</b>
	PO
<b>Dose</b>	160-162 mg
<b>Max. single dose</b>	162 mg
<b>Dosing interval</b>	N/A
<b>Max. # of doses</b>	1

Consider 12-lead ECG acquisition and interpretation for STEMI

Consider nitroglycerin		
	STEMI	
	No	Yes
	SBP	SBP
	≥100 mmHg	≥100 mmHg
	Route	Route
	SL	SL
<b>Dose</b>	0.3 mg <b>OR</b> 0.4 mg	0.3 mg <b>OR</b> 0.4 mg
<b>Max. single dose</b>	0.4 mg	0.4 mg
<b>Dosing interval</b>	5 min	5 min
<b>Max. # of doses</b>	6	3

## Clinical Considerations

Suspect a Right Ventricular MI in all inferior STEMI and perform 15-lead ECG to confirm (ST-elevation ≥1mm in V4R). Do not administer nitroglycerin to a patient with Right Ventricular STEMI.

IV condition applies only to PCPs authorized for PCP Autonomous IV.

# Acute Cardiogenic Pulmonary Edema Medical Directive

A Primary Care Paramedic may provide the treatment prescribed in this Medical Directive if authorized.

## Indications

Moderate to severe respiratory distress;

**AND**

Suspected acute cardiogenic pulmonary edema.

## Conditions

	Nitroglycerin
<b>Age</b>	≥18 years
<b>LOA</b>	N/A
<b>HR</b>	60-159 bpm
<b>RR</b>	N/A
<b>SBP</b>	Normotension
<b>Other</b>	N/A

---

## Contraindications

Nitroglycerin
Allergy or sensitivity to nitrates
Phosphodiesterase inhibitor use within the previous 48 hours
SBP drops by one-third or more of its initial value after nitroglycerin is administered

## Treatment

Consider nitroglycerin			
	SBP	SBP	
	≥100 mmHg to <140 mmHg	≥140 mmHg	
	IV or Hx*	IV or Hx*	IV or Hx*
	Yes	No	Yes
	Route	Route	Route
	SL	SL	SL
Dose	0.3 mg or 0.4 mg	0.3 mg or 0.4 mg	0.6 mg or 0.8 mg
Max. single dose	0.4 mg	0.4 mg	0.8 mg
Dosing interval	5 min	5 min	5 min
Max. # of doses	6	6	6

\*Hx refers to a patient with a prior history of nitroglycerin use

Consider 12-lead ECG acquisition and interpretation

## Clinical Considerations

IV condition applies only to PCPs authorized for PCP Autonomous IV.

# Hypoglycemia Medical Directive

A Primary Care Paramedic may provide the treatment prescribed in this Medical Directive if authorized.

## Indications

- Agitation; **OR**
- Altered LOA; **OR**
- Seizure; **OR**
- Symptoms of stroke.

## Conditions

Dextrose	
<b>Age</b>	≥2 years
<b>LOA</b>	Altered
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	N/A
<b>Other</b>	Hypoglycemia

Glucagon	
<b>Age</b>	N/A
<b>LOA</b>	Altered
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	N/A
<b>Other</b>	Hypoglycemia

## Contraindications

Dextrose
Allergy or sensitivity to dextrose

Glucagon
Allergy or sensitivity to glucagon
Pheochromocytoma

## Treatment

Consider glucometry

Consider dextrose (if available and authorized)		
	Age	
	≥2 years	
	Route	
	IV	
	Concentration	
	D10W	D50W
<b>Dose</b>	0.2 g/kg (2 ml/kg)	0.5 g/kg (1 ml/kg)
<b>Max. single dose</b>	10 g (100 ml)	25 g (50 ml)
<b>Dosing interval</b>	10 min	10 min
<b>Max. # of doses</b>	2	2

Consider glucagon (if not using dextrose)		
	Age	
	N/A	
	Weight	Weight
	<25 kg	≥25 kg
	Route	Route
	IM	IM
	Concentration	Concentration
	N/A	N/A
<b>Dose</b>	0.5 mg	1 mg
<b>Max. single dose</b>	0.5 mg	1 mg
<b>Dosing interval</b>	20 min	20 min
<b>Max. # of doses</b>	2	2

## Clinical Considerations

If the patient responds to dextrose or glucagon, he/she may receive oral glucose or other simple carbohydrates.

If only mild signs or symptoms are exhibited, the patient may receive oral glucose or other simple carbohydrates instead of dextrose or glucagon.

If a patient initiates an informed refusal of transport, a final set of vital signs including blood glucometry must be attempted and documented.

IV administration of dextrose applies only to PCPs authorized for PCP Autonomous IV.

# Bronchoconstriction Medical Directive

A Primary Care Paramedic may provide the treatment prescribed in this Medical Directive if authorized.

## Indications

Respiratory distress;

**AND**

Suspected bronchoconstriction.

## Conditions

Salbutamol	
<b>Age</b>	N/A
<b>LOA</b>	N/A
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	N/A
<b>Other</b>	N/A

Epinephrine	
<b>Age</b>	N/A
<b>Weight</b>	N/A
<b>LOA</b>	N/A
<b>HR</b>	N/A
<b>RR</b>	BVM ventilation required
<b>SBP</b>	N/A
<b>Other</b>	Hx of asthma

## Contraindications

Salbutamol
Allergy or sensitivity to salbutamol

Epinephrine
Allergy or sensitivity to epinephrine

## Treatment

Consider salbutamol				
	Weight		Weight	
	<25 kg		≥25 kg	
	Route	Route	Route	Route
	MDI*	NEB	MDI*	NEB
<b>Dose</b>	Up to 600 mcg (6 puffs)	2.5 mg	Up to 800 mcg (8 puffs)	5 mg
<b>Max. single dose</b>	600 mcg	2.5 mg	800 mcg	5 mg
<b>Dosing interval</b>	5-15 min PRN	5-15 min PRN	5-15 min PRN	5-15 min PRN
<b>Max. # of doses</b>	3	3	3	3

\*1 puff=100 mcg

Consider epinephrine	
	Route
	IM
	Concentration
	1 mg/mL = 1:1,000
<b>Dose</b>	0.01 mg/kg*
<b>Max. single dose</b>	0.5 mg
<b>Dosing interval</b>	N/A
<b>Max. # of doses</b>	1

\*The epinephrine dose may be rounded to the nearest 0.05 mg

## Clinical Considerations

Epinephrine should be the 1<sup>st</sup> medication administered if the patient is apneic. Salbutamol MDI may be administered subsequently using a BVM MDI adapter.

Nebulization is contraindicated in patients with a known or suspected fever or in the setting of a declared febrile respiratory illness outbreak by the local medical officer of health.



When administering salbutamol MDI, the rate of administration should be 100 mcg approximately every 4 breaths.

A spacer should be used when administering salbutamol MDI.

# Moderate to Severe Allergic Reaction Medical Directive

A Primary Care Paramedic may provide the treatment prescribed in this Medical Directive if authorized.

## Indications

Exposure to a probable allergen;

**AND**

Signs and/or symptoms of a moderate to severe allergic reaction (including anaphylaxis).

## Conditions

Epinephrine	
<b>Age</b>	N/A
<b>Weight</b>	N/A
<b>LOA</b>	N/A
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	N/A
<b>Other</b>	For anaphylaxis only

Diphenhydramine	
<b>Age</b>	N/A
<b>Weight</b>	≥25 kg
<b>LOA</b>	N/A
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	N/A
<b>Other</b>	N/A

## Contraindications

Epinephrine
Allergy or sensitivity to epinephrine

Diphenhydramine
Allergy or sensitivity to diphenhydramine

## Treatment

Consider epinephrine	
	<b>Route</b>
	IM
	<b>Concentration</b>
	1 mg/mL = 1:1,000
<b>Dose</b>	0.01 mg/kg*
<b>Max. single dose</b>	0.5 mg
<b>Dosing interval</b>	Minimum 5 min
<b>Max. # of doses</b>	2

\*The epinephrine dose may be rounded to the nearest 0.05 mg

Consider diphenhydramine		
	<b>Weight</b>	<b>Weight</b>
	≥25 kg to <50 kg	≥50 kg
	<b>Route</b>	<b>Route</b>
	IV/IM	IV/IM
<b>Dose</b>	25 mg	50 mg
<b>Max. single dose</b>	25 mg	50 mg
<b>Dosing interval</b>	N/A	N/A
<b>Max. # of doses</b>	1	1

## Clinical Considerations

Epinephrine administration takes priority over IV access.

IV administration of diphenhydramine applies only to PCPs authorized for PCP Autonomous IV.

# Croup Medical Directive

A Primary Care Paramedic may provide the treatment prescribed in this Medical Directive if authorized.

## Indications

Severe respiratory distress;

**AND**

Stridor at rest;

**AND**

Current history of URTI;

**AND**

Barking cough or recent history of a barking cough.

## Conditions

	Epinephrine
<b>Age</b>	<8 years
<b>LOA</b>	N/A
<b>HR</b>	<200 bpm
<b>RR</b>	N/A
<b>SBP</b>	N/A
<b>Other</b>	N/A

---

## Contraindications

Epinephrine
Allergy or sensitivity to epinephrine

---

## Treatment

Consider epinephrine			
	Age		Age
	<1 year		≥1 year to <8 years
	Weight	Weight	Weight
	<5 kg	≥5 kg	N/A
	Route	Route	Route
	NEB	NEB	NEB
	Concentration	Concentration	Concentration
	1 mg/mL = 1:1,000	1 mg/mL = 1:1,000	1 mg/mL = 1:1,000
Dose	0.5 mg	2.5 mg	5 mg
Max. single dose	0.5 mg	2.5 mg	5 mg
Dosing interval	N/A	N/A	N/A
Max. # of doses	1	1	1

## Clinical Considerations

The minimum initial volume for nebulization is 2.5 ml.

# Analgesia Medical Directive

A Primary Care Paramedic may provide the treatment prescribed in this Medical Directive if authorized.

## Indications

Pain

## Conditions

Acetaminophen	
<b>Age</b>	≥12 years
<b>LOA</b>	Unaltered
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	N/A
<b>Other</b>	N/A

Ibuprofen	
<b>Age</b>	≥12 years
<b>LOA</b>	Unaltered
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	N/A
<b>Other</b>	N/A

Ketorolac	
<b>Age</b>	≥12 years
<b>LOA</b>	Unaltered
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	Normotension
<b>Other</b>	Restricted to those who are unable to tolerate oral medications

## Contraindications

### Acetaminophen

Acetaminophen use within previous 4 hours

Allergy or sensitivity to acetaminophen

Hx of liver disease

Active vomiting

Unable to tolerate oral medication

Suspected ischemic chest pain

---

### Ibuprofen

NSAID or Ibuprofen use within previous 6 hours

Allergy or sensitivity to ASA or NSAIDs

Patient on anticoagulation therapy

Current active bleeding

Hx of peptic ulcer disease or GI bleed

Pregnant

If asthmatic, no prior use of ASA or other NSAIDs

CVA or TBI in the previous 24 hours

Known renal impairment

Active vomiting

Unable to tolerate oral medication

Suspected ischemic chest pain

---

### Ketorolac

NSAID or Ibuprofen use within previous 6 hours

Allergy or sensitivity to ASA or NSAIDs

Patient on anticoagulation therapy

Current active bleeding

Hx of peptic ulcer disease or GI bleed

Pregnant

If asthmatic, no prior use of ASA or other NSAIDs

CVA or TBI in the previous 24 hours

Known renal impairment

Suspected ischemic chest pain

## Treatment

Consider acetaminophen		
	Age	Age
	≥12 years to <18 years	≥18 years
<b>Route</b>	PO	PO
<b>Dose</b>	500-650 mg	960-1,000 mg
<b>Max. single dose</b>	650 mg	1,000 mg
<b>Dosing interval</b>	N/A	N/A
<b>Max. # of doses</b>	1	1



Consider ibuprofen	
	<b>Age</b>
	≥12 years
<b>Route</b>	PO
<b>Dose</b>	400 mg
<b>Max. single dose</b>	400 mg
<b>Dosing interval</b>	N/A
<b>Max. # of doses</b>	1

Consider ketorolac	
	<b>Age</b>
	≥12 years
<b>Route</b>	IM/IV
<b>Dose</b>	10-15 mg
<b>Max. single dose</b>	15 mg
<b>Dosing interval</b>	N/A
<b>Max. # of doses</b>	1

## Clinical Considerations

Whenever possible, consider co-administration of acetaminophen and ibuprofen.

Suspected renal colic patients should routinely be considered for ketorolac.

IV administration of ketorolac applies only to PCPs authorized for PCP Autonomous IV.

# Opioid Toxicity Medical Directive

A Primary Care Paramedic may provide the treatment prescribed in this Medical Directive if authorized.

## Indications

Altered LOC;

**AND**

Respiratory depression;

**AND**

Inability to adequately ventilate;

**AND**

Suspected opioid overdose.

## Conditions

Naloxone	
<b>Age</b>	≥12 years
<b>LOA</b>	Altered
<b>HR</b>	N/A
<b>RR</b>	<10 breaths/min
<b>SBP</b>	N/A
<b>Other</b>	N/A

---

## Contraindications

Naloxone	
Allergy or sensitivity to naloxone	
Uncorrected hypoglycemia	

---

## Treatment

Consider naloxone				
	Route	Route	Route	Route
	SC	IM	IN	IV
<b>Dose</b>	0.8 mg	0.8 mg	0.8 mg	Up to 0.4 mg
<b>Max. single dose</b>	0.8 mg	0.8 mg	0.8 mg	0.4 mg
<b>Dosing interval</b>	10 min	10 min	10 min	immediate
<b>Max. # of doses</b>	3	3	3	3*

\*For the IV route, titrate naloxone only to restore the patient’s respiratory status.

## Clinical Considerations

IV administration of naloxone applies only to PCPs authorized for PCP Autonomous IV.

Naloxone may unmask alternative toxidromes in mixed overdose situations (leading to possible seizures, hypertensive crisis, *etc.*).

Naloxone is shorter acting than most narcotics and these patients are at high risk of having a recurrence of their narcotic effect. Every effort should be made to transport the patient to the closest appropriate receiving facility for ongoing monitoring.

Combative behaviour should be anticipated following naloxone administration and paramedics should protect themselves accordingly, thus the importance of gradual titrating (if given IV) to desired clinical effect: respiratory rate  $\geq 10$ , adequate airway and ventilation, not full alertness. If adequate ventilation and oxygenation can be accomplished with a BVM and basic airway management, this is preferred over naloxone administration.

# Home Dialysis Emergency Disconnect Medical Directive

A Primary Care Paramedic may provide the treatment prescribed in this Medical Directive if authorized.

## Indications

Patient receiving home dialysis (hemo or peritoneal) and connected to dialysis machine and requires transport to the closest appropriate receiving facility;

**AND**

Patient is unable to disconnect;

**AND**

There is no family member or caregiver who is available and knowledgeable in dialysis disconnect.

## Conditions

Home Dialysis Emergency Disconnect	
<b>Age</b>	N/A
<b>LOA</b>	N/A
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	N/A
<b>Other</b>	N/A

---

## Contraindications

Home Dialysis Emergency Disconnect
N/A

---

## Treatment

### Consider Home Dialysis Emergency Disconnect

## Clinical Considerations

Generally, emergency disconnect kit with materials and instructions can be found hanging from dialysis machine or nearby on the wall.

Ensure both the patient side and machine side of the connection are clamped before disconnecting and attaching end caps.

# Suspected Adrenal Crisis Medical Directive

A Primary Care Paramedic may provide the treatment prescribed in this Medical Directive if authorized.

## Indications

A patient with primary adrenal failure who is experiencing clinical signs of an adrenal crisis.

## Conditions

	Hydrocortisone
<b>Age</b>	N/A
<b>LOA</b>	N/A
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	N/A
<b>Other</b>	<p>Paramedics are presented with a vial of hydrocortisone for the identified patient <b>AND</b></p> <p>Age-related hypoglycemia <b>OR</b></p> <p>GI symptoms (vomiting, diarrhea, abdominal pain) <b>OR</b></p> <p>Syncope <b>OR</b></p> <p>Temperature <math>\geq 38^{\circ}\text{C}</math> or suspected/history of fever <b>OR</b></p> <p>Altered level of awareness <b>OR</b></p> <p>Age-related tachycardia <b>OR</b></p> <p>Age-related hypotension</p>

## Contraindications

Hydrocortisone
Allergy or sensitivity to hydrocortisone

## Treatment

Consider hydrocortisone	
	<b>Route</b>
	IM/IV
<b>Dose</b>	2 mg/kg*
<b>Max. single dose</b>	100 mg
<b>Dosing interval</b>	N/A
<b>Max. # of doses</b>	1

\*Dose should be rounded to the nearest 10 mg

## Clinical Considerations

IV administration of hydrocortisone applies only to PCP's authorized for PCP Autonomous IV.

# Emergency Childbirth Medical Directive

A Primary Care Paramedic may provide the treatment prescribed in this Medical Directive if authorized.

## Indications

Pregnant patient experiencing labour; **OR**  
 Post-partum patient immediately following delivery.

## Conditions

Delivery	
<b>Age</b>	Childbearing years
<b>LOA</b>	N/A
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	N/A
<b>Other</b>	Second stage labour and/or imminent birth

Umbilical Cord Management	
<b>Age</b>	Childbearing years
<b>LOA</b>	N/A
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	N/A
<b>Other</b>	Cord complications <b>OR</b> if neonatal or maternal resuscitation is required <b>OR</b> due to transport considerations

External Uterine Massage	
<b>Age</b>	Childbearing years
<b>LOA</b>	N/A
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	N/A
<b>Other</b>	Post-placental delivery



## Contraindications

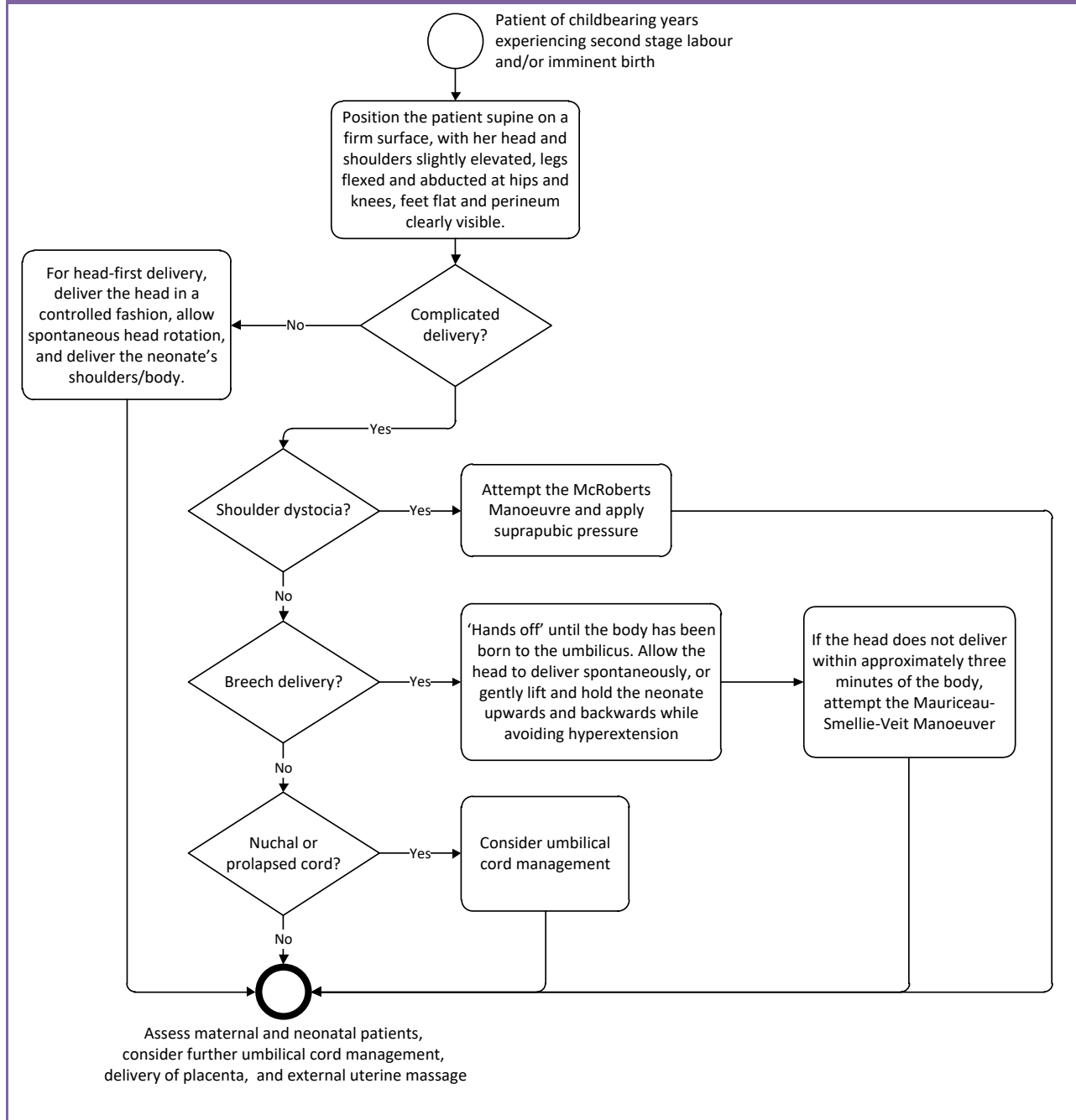
Delivery
N/A

Umbilical Cord Management
N/A

External Uterine Massage
N/A

## Treatment

### Consider delivery



### Consider umbilical cord management

If a cord prolapse is present, the fetal part should be elevated to relieve pressure on the cord. Assist the patient into a knee-chest position or exaggerated Sims position, and insert gloved fingers/hand into the vagina to apply manual digital pressure to the presenting part which is maintained until transfer of care in hospital.

If a nuchal cord is present and loose, slip cord over the neonate's head. Only if a nuchal cord is tight and cannot be slipped over the neonate's head, clamp and cut the cord, encourage rapid delivery.

Following delivery of the neonate, the cord should be clamped and cut immediately if neonatal or maternal resuscitation is required. Otherwise, after pulsations have ceased (approximately 2-3 minutes), clamp the cord in two places and cut the cord.

### Consider external uterine massage

## Clinical Considerations

If the patient presents with limb-presentation, do not attempt to push the limb back into the vagina; discourage the patient from pushing, cover the limb using a dry sheet to maintain warmth, and initiate transport as per the *Load and Go Patient Standard* of the BLS PCS.

If labour is failing to progress, discourage the patient from pushing or bearing down during contractions.

If delivery has not occurred at scene within approximately ten minutes of initial assessment, consider transport in conjunction with the following:

- a. Patient assessment findings:
  - i. Lack of progression of labour;
  - ii. Multiple births expected;
  - iii. Neonate presents face-up;
  - iv. Pre-eclampsia;
  - v. Presence of vaginal hemorrhage;
  - vi. Premature labour;
  - vii. Primip;
- b. Distance to the closest appropriate receiving facility.

When the placenta is delivered, inspect it for wholeness, place in a plastic bag from the OBS kit, label it with the maternal patient's name and time of delivery, and transport it with the maternal or neonatal patient. Delivery of the placenta should not delay transport considerations/initiation.

# Endotracheal and Tracheostomy Suctioning & Reinsertion Medical Directive

A Primary Care Paramedic may provide the treatment prescribed in this Medical Directive if authorized.

## Indications

Patient with endotracheal or tracheostomy tube

**AND**

Airway obstruction or increased secretions.

## Conditions

Suctioning	
<b>Age</b>	N/A
<b>LOA</b>	N/A
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	N/A
<b>Other</b>	N/A

Emergency tracheostomy reinsertion	
<b>Age</b>	N/A
<b>LOA</b>	N/A
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	N/A
<b>Other</b>	Patient with an existing tracheostomy where the inner and/or outer cannula(s) have been removed from the airway <b>AND</b> Respiratory distress <b>AND</b> Inability to adequately ventilate <b>AND</b> Paramedics are presented with a tracheostomy cannula for the identified patient.

## Contraindications

Suctioning
N/A

Emergency tracheostomy reinsertion
Inability to landmark or visualize

## Treatment

Consider suctioning			
Age	< 1 year	≥ 1 year to < 12 years	≥ 12 years
Dose	suction at 60-100 mmHg	suction at 100-120 mmHg	suction at 100-150 mmHg
Max. single dose	10 seconds	10 seconds	10 seconds
Dosing interval	1 minute	1 minute	1 minute
Max. # of doses	N/A	N/A	N/A

Consider emergency tracheostomy reinsertion
The maximum number of attempts is 2

## Clinical Considerations

### Suctioning:

Pre-oxygenate with 100% oxygen.

In an alert patient, whenever possible, have patient cough to clear airway prior to suctioning.

### Emergency tracheostomy reinsertion:

A reinsertion attempt is defined as the insertion of the cannula into the tracheostomy.

A new replacement inner or outer cannula is preferred over cleaning and reusing an existing one.

Utilize a family member or caregiver who is available and knowledgeable to replace the tracheostomy cannula.

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## Appendix 2 – ACP Core Medical Directives



# Medical Cardiac Arrest Medical Directive

An Advanced Care Paramedic may provide the treatment prescribed in this Medical Directive if authorized.

## Indications

Non-traumatic cardiac arrest.

## Conditions

CPR	
<b>Age</b>	N/A
<b>LOA</b>	Altered
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	N/A
<b>Other</b>	Performed in 2 minute intervals

Manual Defibrillation	
<b>Age</b>	≥30 days
<b>LOA</b>	Altered
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	N/A
<b>Other</b>	VF OR pulseless VT

AED Defibrillation	
<b>Age</b>	≥30 days
<b>LOA</b>	Altered
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	N/A
<b>Other</b>	Defibrillation indicated If not using manual defibrillation

Epinephrine	
<b>Age</b>	≥30 days
<b>LOA</b>	Altered
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	N/A
<b>Other</b>	Anaphylaxis suspected as causative event, IM route may be used



Amiodarone	
<b>Age</b>	≥30 days
<b>LOA</b>	Altered
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	N/A
<b>Other</b>	VF <b>OR</b> pulseless VT

Lidocaine	
<b>Age</b>	≥30 days
<b>LOA</b>	Altered
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	N/A
<b>Other</b>	VF <b>OR</b> pulseless VT where amiodarone is not available

0.9% NaCl Fluid Bolus	
<b>Age</b>	≥30 days
<b>LOA</b>	Altered
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	N/A
<b>Other</b>	PEA  Any other rhythm where hypovolemia is suspected

## Contraindications

CPR
Obviously dead as per BLS PCS Meet conditions of <i>Do Not Resuscitate (DNR) Standard</i>

Manual Defibrillation
Rhythms other than VF or pulseless VT

AED Defibrillation
Non-shockable rhythm

Epinephrine
Allergy or sensitivity to epinephrine

Amiodarone
Allergy or sensitivity to amiodarone

Lidocaine
Allergy or sensitivity to lidocaine
Use/Availability of amiodarone

0.9% NaCl Fluid Bolus
Fluid overload

## Treatment

Consider CPR

Consider supraglottic airway insertion: where more than OPA/NPA and BVM required and without interrupting CPR

Consider Manual defibrillation		
	Age	Age
	≥30 days to <8 years	≥8 years
Dose	1 defibrillation	1 defibrillation
Initial dose	2 J/kg	As per BH / manufacturer
Subsequent dose(s)	4 J/kg	As per BH / manufacturer
Dosing interval	2 min	2 min
Max. # of doses	N/A	N/A

Consider AED defibrillation (if not using manual defibrillation)			
	Age		Age
	≥30 days to <8 years		≥8 years
	With Pediatric Attenuator Cable	Without Pediatric Attenuator Cable	N/A
	Pediatric	N/A	N/A
<b>Dose</b>	1 defibrillation	1 defibrillation	1 defibrillation
<b>Max. single dose</b>	As per BH / manufacturer	As per BH / manufacturer	As per BH / manufacturer
<b>Dosing interval</b>	2 min	2 min	2 min
<b>Max. # of doses</b>	N/A	N/A	N/A

Consider epinephrine (if anaphylaxis is suspected as the causative event of the cardiac arrest)	
	Route
	IM
	Concentration
	1 mg/mL = 1:1,000
<b>Dose</b>	0.01 mg/kg*
<b>Max. single dose</b>	0.5 mg
<b>Dosing interval</b>	NA
<b>Max. # of doses</b>	1

\*The epinephrine dose may be rounded to the nearest 0.05 mg

Consider epinephrine				
	Age		Age	
	≥30 days to <12years		≥12 years	
	Route		Route	
	IV/IO/CVAD	ETT	IV/IO/CVAD	ETT
<b>Solution</b>	0.1 mg/mL = 1:10,000	1 mg/mL = 1:1,000	0.1 mg/mL = 1:10,000	as per BH
<b>Dose</b>	0.01 mg/kg*	0.1 mg/kg to a max of 2 mg	1 mg	2 mg
<b>Min. single dose</b>	0.1 mg	1 mg	1 mg	2 mg
<b>Dosing interval</b>	4 min	4 min	4 min	4 min
<b>Max. # of doses</b>	N/A	N/A	N/A	N/A

\*The epinephrine dose may be rounded to the nearest 0.05 mg

Consider amiodarone		
	Age	
	≥30 days to <12 years	
	Route	
	IV/IO/CVAD	
<b>Initial dose</b>	5 mg/kg	300 mg
<b>Max. initial dose</b>	300 mg	300 mg
<b>Subsequent dose(s)</b>	5 mg/kg	150 mg
<b>Max. repeat dose</b>	150 mg	150 mg
<b>Dosing interval</b>	4 min	4 min
<b>Max. # of doses</b>	2	2

Consider lidocaine (if not using amiodarone)				
	Age		Age	
	≥30 days to <12 years		≥12 years	
	Route		Route	
	IV/IO/CVAD	ETT	IV/IO/CVAD	ETT
<b>Dose</b>	1 mg/kg	2 mg/kg	1.5 mg/kg	3 mg/kg
<b>Min. single dose</b>	N/A	N/A	N/A	N/A
<b>Dosing interval</b>	4 min	4 min	4 min	4 min
<b>Max. # of doses</b>	2	2	2	2

Consider 0.9% NaCl fluid bolus		
	Age	
	≥30 days to <12 years	
	Route	
	IV/IO/CVAD	
<b>Infusion</b>	20 ml/kg	
<b>Infusion interval</b>	Immediate	
<b>Reassess every</b>	100 ml	
<b>Max. volume</b>	2,000 ml	

**Consider intubation (if the airway is not being adequately managed)**

**Mandatory Provincial Patch Point**

Patch to BHP following 3 rounds of epinephrine (or after 3<sup>rd</sup> analyses if no IV/IO/CVAD/ETT access). If the BH patch fails, transport to the closest appropriate receiving facility following the 4<sup>th</sup> epinephrine administration (or 4<sup>th</sup> analysis if no IV/IO/CVAD/ETT access).

## Clinical Considerations

Consider very early transport after the 1<sup>st</sup> analysis (and defibrillation if indicated): in the following settings pregnancy presumed to be  $\geq 20$  weeks gestation (fundus above umbilicus, ensure manual displacement of uterus to left), hypothermia, airway obstruction, suspected pulmonary embolus, medication overdose/toxicology, or other known reversible cause of arrest not addressed.

Similarly, plan for extrication and transport for patients with refractory ventricular fibrillation and pediatric cardiac arrest (after 3 analyses), ensure quality CPR can be continued.

In cardiac arrest associated with opioid overdose, continue standard medical cardiac arrest directive. There is no clear role for routine administration of naloxone in confirmed cardiac arrest.

Follow the *Deceased Patient Standard* once TOR has been implemented.

The IV and IO routes of medication administration are preferred over the ETT route. However, ETT administration may be used if the IV/IO routes are delayed (*e.g.*  $\geq 5$  min).

If hyperkalemia is suspected as the causative event of the cardiac arrest, consider patching early for calcium gluconate.

## Defibrillation Joule Settings

*This section is intentionally left blank.*

# Trauma Cardiac Arrest Medical Directive

An Advanced Care Paramedic may provide the treatment prescribed in this Medical Directive if authorized.

## Indications

Cardiac arrest secondary to severe blunt or penetrating trauma.

## Conditions

CPR	
<b>Age</b>	N/A
<b>LOA</b>	Altered
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	N/A
<b>Other</b>	Performed in 2 minute intervals

Manual Defibrillation	
<b>Age</b>	≥30 days
<b>LOA</b>	Altered
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	N/A
<b>Other</b>	VF <b>OR</b> pulseless VT

AED Defibrillation	
<b>Age</b>	≥30 days
<b>LOA</b>	Altered
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	N/A
<b>Other</b>	Defibrillation indicated If not using manual defibrillation

Trauma TOR	
<b>Age</b>	≥16 years
<b>LOA</b>	Altered
<b>HR</b>	0
<b>RR</b>	0
<b>SBP</b>	N/A
<b>Other</b>	No palpable pulses <b>AND</b> No defibrillation delivered <b>AND</b> Monitored HR = 0 <b>OR</b> Monitored HR >0 with the closest ED ≥30 min transport time away.



## Contraindications

CPR
Obviously dead as per BLS PCS
Meet conditions of <i>Do Not Resuscitate (DNR) Standard</i>

Manual Defibrillation
Rhythms other than VF or pulseless VT

AED Defibrillation
Non-shockable rhythm

Trauma TOR
Age <16 years
Defibrillation delivered
Monitored HR >0 and closest ED <30 min transport time away

## Treatment

Consider CPR

Consider Manual defibrillation		
	Age	Age
	≥30 days to <8 years	≥8 years
<b>Dose</b>	1 defibrillation	1 defibrillation
<b>Initial dose</b>	2 J/kg	As per BH / manufacturer
<b>Dosing interval</b>	N/A	N/A
<b>Max. # of doses</b>	1	1

**Consider AED defibrillation (if not using manual defibrillation)**

	Age		Age
	≥30 days to <8 years		≥8 years
	With Pediatric Attenuator Cable	Without Pediatric Attenuator Cable	N/A
<b>Dose</b>	1 defibrillation	1 defibrillation	1 defibrillation
<b>Max. single dose</b>	As per BH / manufacturer	As per BH / manufacturer	As per BH / manufacturer
<b>Max. # of doses</b>	1	1	1

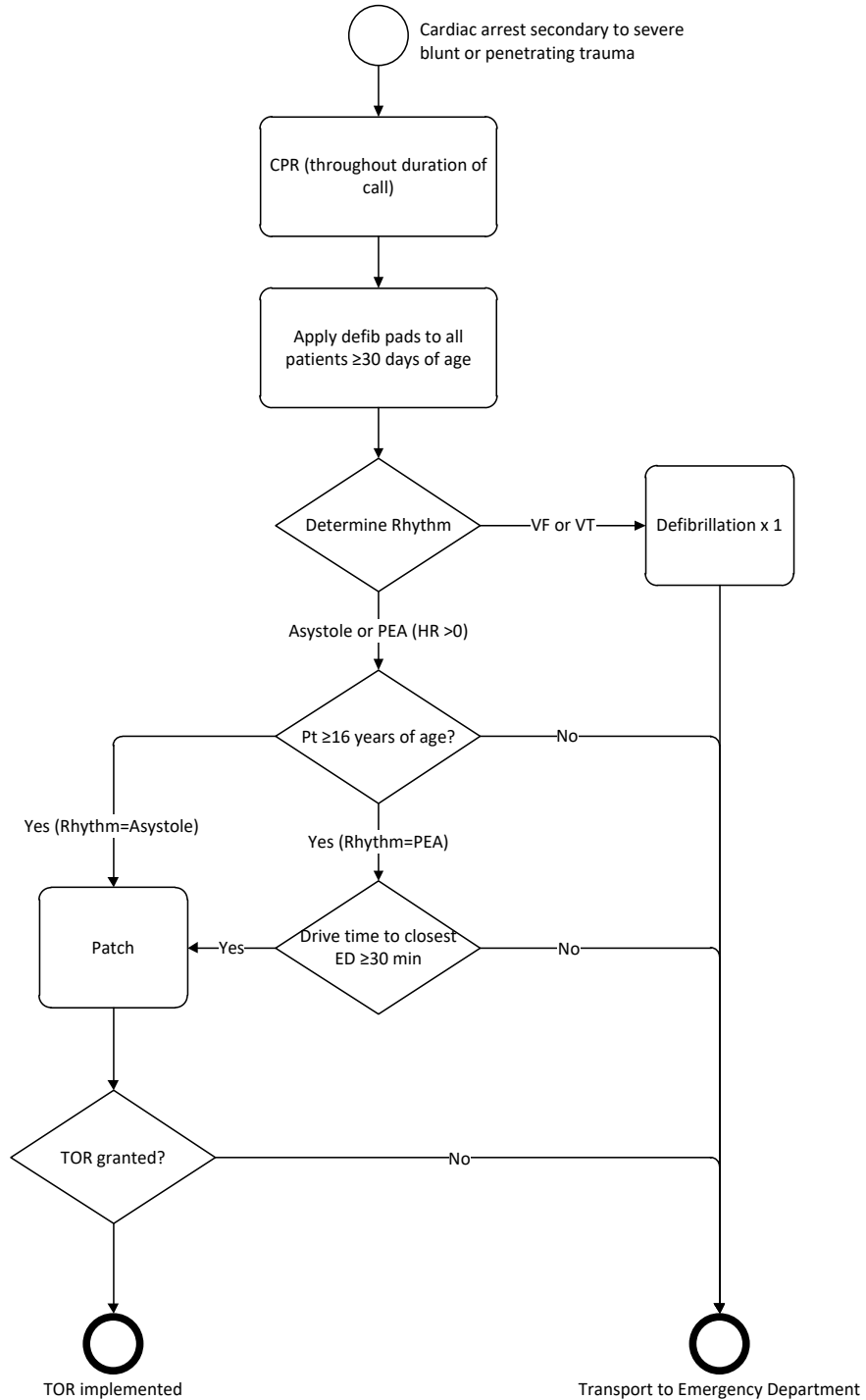
**Mandatory Provincial Patch Point**

Patch to BHP for authorization to apply the Trauma TOR if applicable. If the BH patch fails, or the Trauma TOR does not apply, transport to the closest appropriate receiving facility following the 1<sup>st</sup> analysis/defibrillation.

**Clinical Considerations**

If no obvious external signs of significant blunt trauma, consider medical cardiac arrest and treat according to the appropriate medical cardiac arrest directive.

## Treatment – Algorithm For Trauma Arrest



# Hypothermia Cardiac Arrest Medical Directive

An Advanced Care Paramedic may provide the treatment prescribed in this Medical Directive if authorized.

## Indications

Cardiac arrest secondary to severe hypothermia.

## Conditions

CPR	
<b>Age</b>	N/A
<b>LOA</b>	Altered
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	N/A
<b>Other</b>	Performed in 2 minute intervals

Manual Defibrillation	
<b>Age</b>	≥30 days
<b>LOA</b>	Altered
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	N/A
<b>Other</b>	VF OR pulseless VT

AED Defibrillation	
<b>Age</b>	≥30 days
<b>LOA</b>	Altered
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	N/A
<b>Other</b>	Defibrillation indicated If not using manual defibrillation

## Contraindications

CPR
Obviously dead as per BLS PCS
Meet conditions of <i>Do Not Resuscitate (DNR) Standard</i>

Manual Defibrillation
Rhythms other than VF or pulseless VT

AED Defibrillation
Non-shockable rhythm

## Treatment

Consider CPR

Consider Manual defibrillation		
	Age	Age
	≥30 days to <8 years	≥8 years
<b>Dose</b>	1 defibrillation	1 defibrillation
<b>Initial dose</b>	2 J/kg	As per BH / manufacturer
<b>Dosing interval</b>	N/A	N/A
<b>Max. # of doses</b>	1	1

Consider AED defibrillation (if not using manual defibrillation)			
	Age	Age	
	≥30 days to <8 years	≥8 years	
	With Pediatric Attenuator Cable	Without Pediatric Attenuator Cable	N/A
<b>Dose</b>	1 defibrillation	1 defibrillation	1 defibrillation
<b>Max. single dose</b>	As per BH / manufacturer	As per BH / manufacturer	As per BH / manufacturer
<b>Dosing Interval</b>	N/A	N/A	N/A
<b>Max. # of doses</b>	1	1	1

## Clinical Considerations

Transport to the closest appropriate facility without delay following the 1<sup>st</sup> analysis.

# Foreign Body Airway Obstruction Cardiac Arrest Medical Directive

An Advanced Care Paramedic may provide the treatment prescribed in this Medical Directive if authorized.

## Indications

Cardiac arrest secondary to an airway obstruction.

## Conditions

CPR	
<b>Age</b>	N/A
<b>LOA</b>	Altered
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	N/A
<b>Other</b>	Performed in 2 minute intervals

Manual Defibrillation	
<b>Age</b>	≥30 days
<b>LOA</b>	Altered
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	N/A
<b>Other</b>	VF OR pulseless VT

AED Defibrillation	
<b>Age</b>	≥30 days
<b>LOA</b>	Altered
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	N/A
<b>Other</b>	Defibrillation indicated If not using manual defibrillation

## Contraindications

CPR
Obviously dead as per BLS PCS
Meet conditions of <i>Do Not Resuscitate (DNR) Standard</i>

Manual Defibrillation
Rhythms other than VF or pulseless VT

AED Defibrillation
Non-shockable rhythm

## Treatment

Consider CPR

Consider foreign body removal (utilizing BLS PCS maneuvers and/or laryngoscope and Magill forceps)

Consider Manual defibrillation		
	Age	Age
	≥30 days to <8 years	≥8 years
<b>Dose</b>	1 defibrillation	1 defibrillation
<b>Initial dose</b>	2 J/kg	As per BH / manufacturer
<b>Dosing interval</b>	N/A	N/A
<b>Max. # of doses</b>	1	1



Consider AED defibrillation (if not using manual defibrillation)			
	Age	Age	
	≥30 days to <8 years	≥8 years	
	With Pediatric Attenuator Cable	Without Pediatric Attenuator Cable	N/A
<b>Dose</b>	1 defibrillation	1 defibrillation	1 defibrillation
<b>Max. single dose</b>	As per BH / manufacturer	As per BH / manufacturer	As per BH / manufacturer
<b>Dosing interval</b>	N/A	N/A	N/A
<b>Max. # of doses</b>	1	1	1

## Clinical Considerations

If the patient is in cardiac arrest following removal of the obstruction, initiate management as a medical cardiac arrest.

If the obstruction cannot be removed, transport to the closest appropriate facility without delay following the 1<sup>st</sup> analysis.

# Neonatal Resuscitation Medical Directive

An Advanced Care Paramedic may provide the treatment prescribed in this Medical Directive if authorized.

## Indications

Neonatal patient.

## Conditions

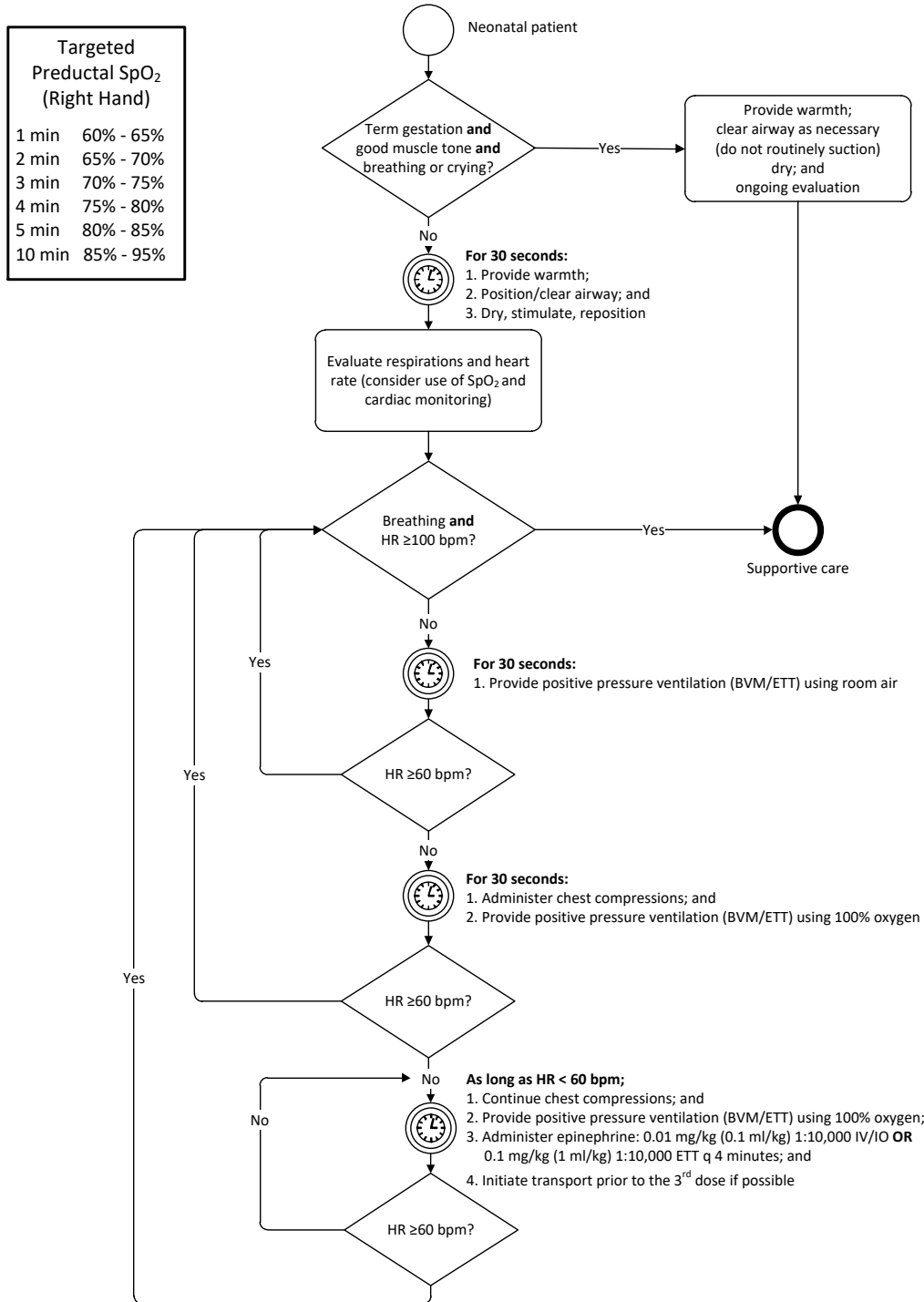
	Resuscitation
<b>Age</b>	<30 days of age
<b>LOA</b>	N/A
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	N/A
<b>Other</b>	N/A

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## Contraindications

Resuscitation
N/A

## Treatment



## Clinical Considerations

If neonatal resuscitation is required, initiate cardiac monitoring and pulse oximetry monitoring.

# Return of Spontaneous Circulation (ROSC) Medical Directive

An Advanced Care Paramedic may provide the treatment prescribed in this Medical Directive if authorized.

## Indications

Patient with return of spontaneous circulation (ROSC) after the resuscitation was initiated.

## Conditions

0.9% NaCl Fluid Bolus	
<b>Age</b>	N/A
<b>LOA</b>	N/A
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	Hypotension
<b>Other</b>	Chest auscultation is clear

Dopamine	
<b>Age</b>	≥8 years
<b>LOA</b>	N/A
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	Hypotension
<b>Other</b>	N/A

## Contraindications

0.9% NaCl Fluid Bolus
Fluid overload
SBP ≥90 mmHg

Dopamine
Allergy or sensitivity to dopamine
Tachydysrhythmias excluding sinus tachycardia
Mechanical shock states
Hypovolemia
Pheochromocytoma

## Treatment

### Consider optimizing ventilation and oxygenation

Titrate oxygenation 94-98%

Avoid hyperventilation and target ETCO<sub>2</sub> to 30-40 mmHg with continuous waveform capnography (if available)

### Consider 0.9% NaCl fluid bolus

	Age	Age
	<12 years	≥12 years
	Route	Route
	IV/IO/CVAD	IV/IO/CVAD
Infusion	10 ml/kg	10 ml/kg
Infusion interval	Immediate	Immediate
Reassess every	100 ml	250 ml
Max. volume	1,000 ml	1,000 ml

### Consider dopamine

	Age
	≥8 years
	Route
	IV
Initial infusion rate	5 mcg/kg/min
Titration increment	5 mcg/kg/min
Titration interval	5 min
Max. infusion rate	20 mcg/kg/min

**NOTE:** Titrate dopamine to achieve a SBP of ≥90 to <110 mmHg. If discontinuing dopamine electively, do so gradually over 5-10 minutes.

Consider 12-lead ECG acquisition and interpretation

## **Clinical Considerations**

Consider initiating transport in parallel with the above treatment.

## Single Strength Dopamine Dosing Chart

**DOPAMINE INFUSION RATE (ml/hr or drops/min with a microdrip set)**  
**[Using an 800 mcg/ml ('single strength') solution]**

Weight (kg)	Drip Rate (drops/min)				
	2 (mcg/kg/minute)	5 (mcg/kg/minute)	10 (mcg/kg/minute)	15 (mcg/kg/minute)	20 (mcg/kg/minute)
5	1	2	4	6	8
10	2	4	8	11	15
15	2	6	11	17	23
20	3	8	15	23	30
25	4	9	19	28	38
30	5	11	23	34	45
35	5	13	26	39	53
40	6	15	30	45	60
45	7	17	34	51	68
50	8	19	38	56	75
55	8	21	41	62	83
60	9	23	45	68	90
65	10	24	49	73	98
70	11	26	53	79	105
75	11	28	56	84	113
80	12	30	60	90	120
85	13	32	64	96	128
90	14	34	68	101	135
95	14	36	71	107	143
100	15	38	75	113	150
105	16	39	79	118	158
110	17	41	83	124	165
115	17	43	86	129	173
120	18	45	90	135	180



# Cardiac Ischemia Medical Directive

An Advanced Care Paramedic may provide the treatment prescribed in this Medical Directive if authorized.

## Indications

Suspected cardiac ischemia.

## Conditions

ASA	
<b>Age</b>	≥18 years
<b>LOA</b>	Unaltered
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	N/A
<b>Other</b>	Able to chew and swallow

Nitroglycerin	
<b>Age</b>	≥18 years
<b>LOA</b>	Unaltered
<b>HR</b>	60-159 bpm
<b>RR</b>	N/A
<b>SBP</b>	Normotension
<b>Other</b>	Prior history of nitroglycerin use <b>OR</b> IV access obtained

Morphine	
<b>Age</b>	≥18 years
<b>LOA</b>	Unaltered
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	Normotension
<b>Other</b>	Severe pain (≥7/10 on pain scale)

## Contraindications

ASA
Allergy or sensitivity to ASA or NSAIDs
If asthmatic, no prior use of ASA
Current active bleeding
CVA or TBI in the previous 24 hours

Nitroglycerin
Allergy or sensitivity to nitrates
Phosphodiesterase inhibitor use within the previous 48 hours
SBP drops by one-third or more of its initial value after nitroglycerin is administered
12-lead ECG compatible with Right Ventricular MI

Morphine
Allergy or sensitivity to morphine
SBP drops by one-third or more of its initial value after morphine is administered

## Treatment

Consider ASA	
	Route
	PO
<b>Dose</b>	160-162 mg
<b>Max. single dose</b>	162 mg
<b>Dosing interval</b>	N/A
<b>Max. # of doses</b>	1

Consider 12-lead ECG acquisition and interpretation for STEMI

Consider nitroglycerin		
	STEMI	
	No	Yes
	SBP	SBP
	≥100 mmHg	≥100 mmHg
	Route	Route
	SL	SL
Dose	0.3 mg <b>OR</b> 0.4 mg	0.3 mg <b>OR</b> 0.4 mg
Max. single dose	0.4 mg	0.4 mg
Dosing interval	5 min	5 min
Max. # of doses	6	3

Consider morphine (after the 3 <sup>rd</sup> dose of nitroglycerin or if nitroglycerin is contraindicated)	
	Route
	IV
Dose	2 mg
Max. single dose	2 mg
Dosing interval	5 min
Max. # of doses	5

## Clinical Considerations

Suspect a Right Ventricular MI in all inferior STEMI and perform 15-lead ECG to confirm (ST-elevation ≥1mm in V4R). Do not administer nitroglycerin to a patient with a Right Ventricular STEMI.

# Acute Cardiogenic Pulmonary Edema Medical Directive

An Advanced Care Paramedic may provide the treatment prescribed in this Medical Directive if authorized.

## Indications

Moderate to severe respiratory distress;

**AND**

Suspected acute cardiogenic pulmonary edema.

## Conditions

	Nitroglycerin
<b>Age</b>	≥18 years
<b>LOA</b>	N/A
<b>HR</b>	60-159 bpm
<b>RR</b>	N/A
<b>SBP</b>	Normotension
<b>Other</b>	N/A

## Contraindications

Nitroglycerin
Allergy or sensitivity to nitrates
Phosphodiesterase inhibitor use within the previous 48 hours
SBP drops by one-third or more of its initial value after nitroglycerin is administered

## Treatment

Consider nitroglycerin			
	<b>SBP</b>	<b>SBP</b>	
	≥100 mmHg to <140 mmHg	≥140 mmHg	
	<b>IV or Hx*</b>	<b>IV or Hx*</b>	<b>IV or Hx*</b>
	Yes	No	Yes
	<b>Route</b>	<b>Route</b>	<b>Route</b>
	SL	SL	SL
<b>Dose</b>	0.3 mg <b>or</b> 0.4 mg	0.3 mg <b>or</b> 0.4 mg	0.6 mg <b>or</b> 0.8 mg
<b>Max. single dose</b>	0.4 mg	0.4 mg	0.8 mg
<b>Dosing interval</b>	5 min	5min	5 min
<b>Max. # of doses</b>	6	6	6

\*Hx refers to a patient with a prior history of nitroglycerin use

Consider 12-lead ECG acquisition and interpretation

## Clinical Considerations

N/A

# Cardiogenic Shock Medical Directive

An Advanced Care Paramedic may provide the treatment prescribed in this Medical Directive if authorized.

## Indications

STEMI-positive 12-lead ECG;

**AND**

Cardiogenic shock.

## Conditions

0.9% NaCl Fluid Bolus	
<b>Age</b>	≥18 years
<b>LOA</b>	N/A
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	Hypotension
<b>Other</b>	Chest auscultation is clear

Dopamine	
<b>Age</b>	≥18 years
<b>LOA</b>	N/A
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	Hypotension
<b>Other</b>	N/A

## Contraindications

0.9% NaCl Fluid Bolus
Fluid overload
SBP ≥90 mmHg

Dopamine
Allergy or sensitivity to dopamine
Tachydysrhythmias excluding sinus tachycardia
Mechanical shock states
Hypovolemia
Pheochromocytoma

## Treatment

Consider 0.9% NaCl fluid bolus	
	<b>Age</b>
	≥18 years
	<b>Route</b>
	IV/IO/CVAD
<b>Infusion</b>	10 ml/kg
<b>Infusion interval</b>	N/A
<b>Reassess every</b>	250 ml
<b>Max. volume</b>	1,000 ml

**NOTE:** If NaCl bolus contraindicated due to pulmonary crackles, consider dopamine.

Consider dopamine	
	<b>Route</b>
	IV
<b>Initial infusion rate</b>	5 mcg/kg/min
<b>Titration increment</b>	5 mcg/kg/min
<b>Titration interval</b>	5 min
<b>Max. infusion rate</b>	20 mcg/kg/min

**NOTE:** Titrate dopamine to achieve a SBP of ≥90 to <110 mmHg. If discontinuing dopamine electively, do so gradually over 5-10 minutes.

## Clinical Considerations

Contact BHP if patient is bradycardic.

# Symptomatic Bradycardia Medical Directive

An Advanced Care Paramedic may provide the treatment prescribed in this Medical Directive if authorized.

## Indications

Bradycardia;

**AND**

Hemodynamic instability.

## Conditions

Atropine	
<b>Age</b>	≥18 years
<b>LOA</b>	N/A
<b>HR</b>	<50 bpm
<b>RR</b>	N/A
<b>SBP</b>	Hypotension
<b>Other</b>	N/A

Transcutaneous Pacing	
<b>Age</b>	≥18 years
<b>LOA</b>	N/A
<b>HR</b>	<50 bpm
<b>RR</b>	N/A
<b>SBP</b>	Hypotension
<b>Other</b>	N/A

Dopamine	
<b>Age</b>	≥18 years
<b>LOA</b>	N/A
<b>HR</b>	<50 bpm
<b>RR</b>	N/A
<b>SBP</b>	Hypotension
<b>Other</b>	N/A



## Contraindications

### Atropine

Allergy or sensitivity to atropine  
 Hemodynamic stability  
 Hypothermia  
 History of heart transplant

### Transcutaneous Pacing

Hemodynamic stability  
 Hypothermia

### Dopamine

Allergy or sensitivity to dopamine  
 Tachydysrhythmias excluding sinus tachycardia  
 Mechanical shock states  
 Hypovolemia  
 Pheochromocytoma

## Treatment

Consider Rhythm determination

Consider 12-lead ECG acquisition and interpretation (if this won't delay therapy)

### Consider Atropine

	Route
	IV
<b>Dose</b>	0.5 mg
<b>Max. single dose</b>	0.5 mg
<b>Dosing interval</b>	5 min
<b>Max. # of doses</b>	2

### Mandatory Provincial Patch Point

Patch to BHP for authorization to proceed with transcutaneous pacing and/or a dopamine infusion.

#### Consider transcutaneous pacing

#### Consider dopamine

	Route
	IV
<b>Initial infusion rate</b>	5 mcg/kg/min
<b>Titration increment</b>	5 mcg/kg/min
<b>Titration interval</b>	5 min
<b>Max. infusion rate</b>	20 mcg/kg/min

**NOTE:** Titrate dopamine to achieve a SBP of  $\geq 90$  to  $< 110$  mmHg. If discontinuing dopamine electively, do so gradually over 5-10 minutes.

### Clinical Considerations

Atropine may be beneficial in the setting of sinus bradycardia, atrial fibrillation, 1<sup>st</sup> degree AV block, or 2<sup>nd</sup> degree Type I AV block.

A single dose of atropine should be considered for 2<sup>nd</sup> degree Type II or 3<sup>rd</sup> degree AV blocks with fluid bolus while preparing for TCP **OR** if there is a delay in implementing TCP **OR** if TCP is unsuccessful.

# Tachydysrhythmia Medical Directive

An Advanced Care Paramedic may provide the treatment prescribed in this Medical Directive if authorized.

## Indications

Symptomatic Tachydysrhythmia.

## Conditions

Valsalva Maneuver	
<b>Age</b>	≥18 years
<b>LOA</b>	Unaltered
<b>HR</b>	≥150 bpm
<b>RR</b>	N/A
<b>SBP</b>	Normotension
<b>Other</b>	Narrow complex and regular rhythm

Adenosine	
<b>Age</b>	≥18 years
<b>LOA</b>	Unaltered
<b>HR</b>	≥150 bpm
<b>RR</b>	N/A
<b>SBP</b>	Normotension
<b>Other</b>	Narrow complex and regular rhythm

Amiodarone	
<b>Age</b>	≥18 years
<b>LOA</b>	Unaltered
<b>HR</b>	≥120 bpm
<b>RR</b>	N/A
<b>SBP</b>	Normotension
<b>Other</b>	Wide complex and regular rhythm

Lidocaine	
<b>Age</b>	≥18 years
<b>LOA</b>	Unaltered
<b>HR</b>	≥120 bpm
<b>RR</b>	N/A
<b>SBP</b>	Normotension
<b>Other</b>	Wide complex and regular rhythm

Synchronized Cardioversion	
<b>Age</b>	≥18 years
<b>LOA</b>	N/A
<b>HR</b>	≥120 bpm (wide) <b>OR</b> ≥150 bpm (narrow)
<b>RR</b>	N/A
<b>SBP</b>	Hypotension
<b>Other</b>	Altered mental status, ongoing chest pain, other signs of shock

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## Contraindications

Valsalva Maneuver
Sinus tachycardia or atrial fibrillation or atrial flutter

Adenosine
Allergy or sensitivity to adenosine
Sinus tachycardia or atrial fibrillation or atrial flutter
Patient taking dipyridamole or carbamazepine
Bronchoconstriction on exam

---

Amiodarone
Allergy or sensitivity to amiodarone

Lidocaine
Allergy or sensitivity to lidocaine

Synchronized Cardioversion
N/A

## Treatment

Consider Rhythm determination (confirm regularity)

Consider 12-lead ECG acquisition and interpretation to confirm QRS width (if this won't delay therapy)

Consider valsalva maneuver

Perform a maximum of 2 attempts lasting 10 to 20 seconds duration each.

Consider adenosine

	Route
	IV
<b>Initial dose</b>	6 mg
<b>Subsequent dose</b>	12 mg
<b>Dosing interval</b>	2 min
<b>Max. # of doses</b>	2

### Mandatory Provincial Patch Point

Patch to BHP for authorization to proceed with amiodarone or lidocaine or if monomorphic wide complex regular rhythm for adenosine.

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Consider amiodarone (if available and authorized) OR lidocaine (if not using amiodarone)

	Medication	Medication
	Amiodarone	Lidocaine
	Route	Route
	IV*	IV
<b>Initial dose</b>	150 mg	1.5 mg/kg
<b>Subsequent dose</b>	150 mg	0.75 mg/kg
<b>Max. single dose</b>	150 mg	150 mg
<b>Dosing interval</b>	10 min	10 min
<b>Max. # of doses</b>	2	3

\*Amiodarone should be administered by IV infusion over 10 min.

**Mandatory Provincial Patch Point**

Patch to BHP for authorization to proceed with synchronized cardioversion.

Consider synchronized cardioversion

Administer up to 3 synchronized shocks in accordance with BHP direction and energy settings. (In the setting of a patch failure, the energy settings to be used are 100 J, 200 J and the maximum manufacturer setting.)

**Clinical Considerations**

N/A

# Intravenous and Fluid Therapy

## Medical Directive

An Advanced Care Paramedic may provide the treatment prescribed in this Medical Directive if authorized.

### Indications

Actual or potential need for intravenous medication **OR** fluid therapy.

### Conditions

IV Cannulation	
<b>Age</b>	N/A
<b>LOA</b>	N/A
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	N/A
<b>Other</b>	N/A

0.9% NaCl Fluid Bolus	
<b>Age</b>	N/A
<b>LOA</b>	N/A
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	Hypotension
<b>Other</b>	N/A

### Contraindications

IV Cannulation
Suspected fracture proximal to the access site

0.9% NaCl Fluid Bolus
Fluid overload

### Treatment

Consider IV cannulation

Consider 0.9% NaCl maintenance infusion		
	Age	Age
	<12 years	≥12 years
	Route	Route
	IV/IO/CVAD	IV/IO/CVAD
<b>Infusion</b>	15 ml/hr	30-60 ml/hr
<b>Infusion interval</b>	N/A	N/A
<b>Reassess every</b>	N/A	N/A
<b>Max. volume</b>	N/A	N/A

### Mandatory Provincial Patch Point

Patch to BHP for authorization to administer 0.9% NaCl fluid bolus to hypotensive patients <12 years with suspected Diabetic Ketoacidosis (DKA).

Consider 0.9% NaCl fluid bolus		
	Age	Age
	<12 years	≥12 years
	Route	Route
	IV/IO/CVAD	IV/IO/CVAD
<b>Infusion</b>	20 ml/kg	20 ml/kg
<b>Infusion interval</b>	Immediate	Immediate
<b>Reassess every</b>	100 ml	250 ml
<b>Max. volume*</b>	2,000 ml	2,000 ml

\*The maximum volume of 0.9% NaCl is lower for patients in cardiogenic shock and return of spontaneous circulation.



## Clinical Considerations

Adult IO and CVAD procedures are auxiliary Medical Directives described elsewhere. Fluid administration via the IO or CVAD routes only apply to paramedics authorized to perform these procedures.

Microdrips and/or volume control administration sets should be considered when IV/CVAD access is indicated for patients <12 years of age.

An intravenous fluid bolus may be considered for a patient who does not meet trauma TOR criteria, where it does not delay transport and should not be prioritized over management of other reversible causes.

# Pediatric Intraosseous Medical Directive

An Advanced Care Paramedic may provide the treatment prescribed in this Medical Directive if authorized.

## Indications

Actual or potential need for intravenous medication **OR** fluid therapy;

**AND**

Intravenous access is unobtainable;

**AND**

Cardiac arrest or pre-arrest state.

## Conditions

IO	
<b>Age</b>	<12 years
<b>LOA</b>	N/A
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	N/A
<b>Other</b>	N/A

## Contraindications

IO
Fracture or crush injuries proximal to the access site
Suspected or known replacement / prosthesis proximal to the access site

## Treatment

Consider IO access

## Clinical Considerations

N/A

# Hypoglycemia Medical Directive

An Advanced Care Paramedic may provide the treatment prescribed in this Medical Directive if authorized.

## Indications

Agitation; **OR**  
 Altered LOA; **OR**  
 Seizure; **OR**  
 Symptoms of stroke.

## Conditions

Dextrose	
<b>Age</b>	N/A
<b>LOA</b>	Altered
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	N/A
<b>Other</b>	Hypoglycemia

Glucagon	
<b>Age</b>	N/A
<b>LOA</b>	Altered
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	N/A
<b>Other</b>	Hypoglycemia

## Contraindications

Dextrose
Allergy or sensitivity to dextrose

Glucagon
Allergy or sensitivity to glucagon
Pheochromocytoma

## Treatment

Consider glucometry

Consider dextrose (D10W pre-mixed)		
	Age	Age
	<30 days	≥30 days
	Concentration	Concentration
	D10W	D10W
	Route	Route
	IV	IV
Dose	0.2 g/kg (2 ml/kg)	0.2 g/kg (2ml/kg)
Max. single dose	5 g (50 ml)	10g (100 ml)
Dosing interval	10 min	10 min
Max. # of doses	2	2

Consider dextrose (D50W diluted as required if not using D10W)			
	Age	Age	Age
	<30 days	≥30 days to <2 years	≥2 years
	Concentration	Concentration	Concentration
	D10W	D25W	D50W
	Route	Route	Route
	IV	IV	IV
Dose	0.2 g/kg (2 ml/kg)	0.5 g/kg (2 ml/kg)	0.5 g/kg (1 ml/kg)
Max. single dose	5 g (50 ml)	10 g (40 ml)	25 g (50 ml)
Dosing interval	10 min	10 min	10 min
Max. # of doses	2	2	2

Consider glucagon (if not using dextrose)		
	Weight	Weight
	<25 kg	≥25 kg
	Route	Route
	IM	IM
Dose	0.5 mg	1 mg
Max. single dose	0.5 mg	1 mg
Dosing interval	20 min	20 min
Max. # of doses	2	2

## Clinical Considerations

If the patient responds to dextrose or glucagon, he/she may receive oral glucose or other simple carbohydrates.

If only mild signs or symptoms are exhibited, the patient may receive oral glucose or other simple carbohydrates instead of dextrose or glucagon.

If a patient initiates an informed refusal of transport, a final set of vital signs including blood glucometry must be attempted and documented.

# Seizure Medical Directive

An Advanced Care Paramedic may provide the treatment prescribed in this Medical Directive if authorized.

## Indications

Active generalized motor seizure.

## Conditions

Midazolam	
<b>Age</b>	N/A
<b>LOA</b>	Unresponsive
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	N/A
<b>Other</b>	N/A

## Contraindications

Midazolam
Allergy or sensitivity to midazolam
Hypoglycemia

## Treatment

Consider midazolam				
	Route			
	IV	IM	IN	Buccal
<b>Dose</b>	0.1 mg/kg	0.2 mg/kg	0.2 mg/kg	0.2 mg/kg
<b>Max. single dose</b>	5 mg	10 mg	10 mg	10 mg
<b>Dosing interval</b>	5 min	5 min	5 min	5 min
<b>Max. # of doses</b>	2	2	2	2

## **Clinical Considerations**

Conditions such as cardiac arrest and hypoglycemia often present as seizure and should be considered by a paramedic.



# Opioid Toxicity Medical Directive

An Advanced Care Paramedic may provide the treatment prescribed in this Medical Directive if authorized.

## Indications

Altered LOC;

**AND**

Respiratory depression;

**AND**

Inability to adequately ventilate;

**AND**

Suspected opioid overdose.

## Conditions

Naloxone	
<b>Age</b>	≥12 years
<b>LOA</b>	Altered
<b>HR</b>	N/A
<b>RR</b>	<10 breaths/min
<b>SBP</b>	N/A
<b>Other</b>	N/A

---

## Contraindications

Naloxone	
Allergy or sensitivity to naloxone	
Uncorrected hypoglycemia	

---

## Treatment

Consider naloxone				
	Route	Route	Route	Route
	SC	IM	IN	IV
<b>Dose</b>	0.8 mg	0.8 mg	0.8 mg	Up to 0.4 mg
<b>Max. single dose</b>	0.8 mg	0.8 mg	0.8 mg	0.4 mg
<b>Dosing interval</b>	10 min	10 min	10 min	immediate
<b>Max. # of doses</b>	3	3	3	3*

\*For the IV route, titrate naloxone only to restore the patient’s respiratory status.

## Clinical Considerations

Naloxone may unmask alternative toxidromes in mixed overdose situations (leading to possible seizures, hypertensive crisis, *etc.*).

Naloxone is shorter acting than most narcotics and these patients are at high risk of having a recurrence of their narcotic effect. Every effort should be made to transport the patient to the closest appropriate receiving facility for ongoing monitoring.

Combative behaviour should be anticipated following naloxone administration and paramedics should protect themselves accordingly, thus the importance of gradual titrating (if given IV) to desired clinical effect: respiratory rate  $\geq 10$ , adequate airway and ventilation, not full alertness. If adequate ventilation and oxygenation can be accomplished with a BVM and basic airway management, this is preferred over naloxone administration.

# Orotracheal Intubation Medical Directive

An Advanced Care Paramedic may provide the treatment prescribed in this Medical Directive if authorized.

## Indications

Need for ventilatory assistance or airway control;

**AND**

Other airway management is ineffective.

## Conditions

Lidocaine spray	
<b>Age</b>	N/A
<b>LOA</b>	N/A
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	N/A
<b>Other</b>	Orotracheal Intubation

Orotracheal Intubation	
<b>Age</b>	N/A
<b>LOA</b>	N/A
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	N/A
<b>Other</b>	N/A

## Contraindications

Lidocaine spray
Allergy or sensitivity to lidocaine
Unresponsive patient

Orotracheal Intubation
Age <50 years <b>AND</b> current episode of asthma exacerbation <b>AND</b> not in or near cardiac arrest.

## Treatment

Consider topical lidocaine spray (to the hypopharynx) for “awake” orotracheal intubation

	<b>Route</b>
	TOP
<b>Dose</b>	10 mg/spray
<b>Max. dose</b>	5 mg/kg
<b>Dosing interval</b>	N/A
<b>Max. # of doses</b>	20

Consider orotracheal intubation

With or without intubation facilitation devices. The maximum number of intubation attempts is 2.

Confirm orotracheal tube placement

<b>Method</b>	<b>Method</b>
<i>Primary</i>	<i>Secondary</i>
ETCO <sub>2</sub> (Waveform capnography)	ETCO <sub>2</sub> (Non-waveform device)
	Visualization
	Auscultation
	Chest rise
	Esophageal detection device

## Clinical Considerations

An intubation attempt is defined as insertion of the laryngoscope blade into the mouth for the purposes of intubation.

Confirmation of orotracheal intubation must use ETCO<sub>2</sub> (Waveform capnography). If waveform capnography is not available or not working then at least 3 secondary methods must be used. Additional secondary ETT placement confirmation devices may be authorized by the local medical director.

ETT placement must be reconfirmed immediately after every patient movement.

# Bronchoconstriction Medical Directive

An Advanced Care Paramedic may provide the treatment prescribed in this Medical Directive if authorized.

## Indications

Respiratory distress;

**AND**

Suspected bronchoconstriction.

## Conditions

Salbutamol	
<b>Age</b>	N/A
<b>LOA</b>	N/A
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	N/A
<b>Other</b>	N/A

Epinephrine	
<b>Age</b>	N/A
<b>Weight</b>	N/A
<b>LOA</b>	N/A
<b>HR</b>	N/A
<b>RR</b>	BVM ventilation required
<b>SBP</b>	N/A
<b>Other</b>	Hx of asthma

## Contraindications

Salbutamol
Allergy or sensitivity to salbutamol

Epinephrine
Allergy or sensitivity to epinephrine

## Treatment

Consider salbutamol				
	Weight		Weight	
	<25 kg		≥25 kg	
	Route	Route	Route	Route
	MDI*	NEB	MDI*	NEB
<b>Dose</b>	Up to 600 mcg (6 puffs)	2.5 mg	Up to 800 mcg (8 puffs)	5 mg
<b>Max. single dose</b>	600 mcg	2.5 mg	800 mcg	5 mg
<b>Dosing interval</b>	5-15 min PRN	5-15 min PRN	5-15 min PRN	5-15 min PRN
<b>Max. # of doses</b>	3	3	3	3

\*1 puff=100 mcg

Consider epinephrine	
	Concentration
	1 mg/mL = 1:1,000
	Route
	IM
<b>Dose</b>	0.01 mg/kg*
<b>Max. single dose</b>	0.5 mg
<b>Dosing interval</b>	N/A
<b>Max. # of doses</b>	1

\*The epinephrine dose may be rounded to the nearest 0.05 mg

## Clinical Considerations

Epinephrine should be the 1<sup>st</sup> medication administered if the patient is apneic. Salbutamol MDI may be administered subsequently using a BVM MDI adapter.

Nebulization is contraindicated in patients with a known or suspected fever or in the setting of a declared febrile respiratory illness outbreak by the local medical officer of health.

When administering salbutamol MDI, the rate of administration should be 100 mcg approximately every 4 breaths.

A spacer should be used when administering salbutamol MDI.

# Moderate to Severe Allergic Reaction Medical Directive

An Advanced Care Paramedic may provide the treatment prescribed in this Medical Directive if authorized.

## Indications

Exposure to a probable allergen;

**AND**

Signs and/or symptoms of a moderate to severe allergic reaction (including anaphylaxis).

## Conditions

Epinephrine	
<b>Age</b>	N/A
<b>Weight</b>	N/A
<b>LOA</b>	N/A
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	N/A
<b>Other</b>	For anaphylaxis only

Diphenhydramine	
<b>Age</b>	N/A
<b>Weight</b>	≥25 kg
<b>LOA</b>	N/A
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	N/A
<b>Other</b>	N/A

## Contraindications

Epinephrine
Allergy or sensitivity to epinephrine

Diphenhydramine
Allergy or sensitivity to diphenhydramine



## Treatment

Consider epinephrine	
	<b>Route</b>
	IM
	<b>Concentration</b>
	1 mg/mL = 1:1,000
<b>Dose</b>	0.01 mg/kg*
<b>Max. single dose</b>	0.5 mg
<b>Dosing interval</b>	Minimum 5 min
<b>Max. # of doses</b>	2

\*The epinephrine dose may be rounded to the nearest 0.05 mg

Consider diphenhydramine		
	<b>Weight</b>	<b>Weight</b>
	≥25 kg to <50 kg	≥50 kg
	<b>Route</b>	<b>Route</b>
	IV/IM	IV/IM
<b>Dose</b>	25 mg	50 mg
<b>Max. single dose</b>	25 mg	50 mg
<b>Dosing interval</b>	N/A	N/A
<b>Max. # of doses</b>	1	1

## Clinical Considerations

Epinephrine administration takes priority over IV access.

# Croup Medical Directive

An Advanced Care Paramedic may provide the treatment prescribed in this Medical Directive if authorized.

## Indications

Severe respiratory distress;

**AND**

Stridor at rest;

**AND**

Current history of URTI;

**AND**

Barking cough or recent history of a barking cough.

## Conditions

	Epinephrine
<b>Age</b>	<8 years
<b>LOA</b>	N/A
<b>HR</b>	<200 bpm
<b>RR</b>	N/A
<b>SBP</b>	N/A
<b>Other</b>	N/A

## Contraindications

Epinephrine
Allergy or sensitivity to epinephrine

## Treatment

Consider epinephrine			
	Age		Age
	<1 year		≥1 year to <8 years
	Weight	Weight	Weight
	<5 kg	≥5 kg	N/A
	Concentration	Concentration	Concentration
	1 mg/mL = 1:1,000	1 mg/mL = 1:1,000	1 mg/mL = 1:1,000
	Route	Route	Route
	NEB	NEB	NEB
Dose	0.5 mg	2.5 mg	5 mg
Max. single dose	0.5 mg	2.5 mg	5 mg
Dosing interval	N/A	N/A	N/A
Max. # of doses	1	1	1

## Clinical Considerations

The minimum initial volume for nebulization is 2.5 ml.

# Tension Pneumothorax Medical Directive

An Advanced Care Paramedic may provide the treatment prescribed in this Medical Directive if authorized.

## Indications

Suspected tension pneumothorax;

**AND**

Critically ill or VSA;

**AND**

Absent or severely diminished breath sounds on the affected side(s).

## Conditions

Needle Thoracostomy	
<b>Age</b>	N/A
<b>LOA</b>	N/A
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	Hypotension or VSA
<b>Other</b>	N/A

## Contraindications

Needle Thoracostomy
N/A

## Treatment

**Mandatory Provincial Patch Point**

Patch to BHP for authorization to perform needle thoracostomy.

Consider needle thoracostomy

## Clinical Considerations

Needle thoracostomy may only be performed at the 2<sup>nd</sup> intercostal space in the midclavicular line.

# Analgesia Medical Directive

An Advanced Care Paramedic may provide the treatment prescribed in this Medical Directive if authorized.

## Indications

Pain

## Conditions

Acetaminophen	
<b>Age</b>	≥12 years
<b>LOA</b>	Unaltered
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	N/A
<b>Other</b>	N/A

Ibuprofen	
<b>Age</b>	≥12 years
<b>LOA</b>	Unaltered
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	N/A
<b>Other</b>	N/A

Ketorolac	
<b>Age</b>	≥12 years
<b>LOA</b>	Unaltered
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	Normotension
<b>Other</b>	Restricted to those who are unable to tolerate oral medications

Morphine	
<b>Age</b>	≥1 year
<b>LOA</b>	Unaltered
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	Normotension
<b>Other</b>	Severe pain

Fentanyl	
<b>Age</b>	≥1 years
<b>LOA</b>	Unaltered
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	Normotension
<b>Other</b>	Severe pain

## Contraindications

Acetaminophen
Acetaminophen use within previous 4 hours
Allergy or sensitivity to acetaminophen
Hx of liver disease
Active vomiting
Unable to tolerate oral medication
Suspected ischemic chest pain

Ibuprofen
NSAID or Ibuprofen use within previous 6 hours
Allergy or sensitivity to ASA or NSAIDs
Patient on anticoagulation therapy
Current active bleeding
Hx of peptic ulcer disease or GI bleed
Pregnant
If asthmatic, no prior use of ASA or other NSAIDs
CVA or TBI in the previous 24 hours
Known renal impairment
Active vomiting
Unable to tolerate oral medication
Suspected Ischemic chest pain

### Ketorolac

NSAID or Ibuprofen use within previous 6 hours

Allergy or sensitivity to ASA or NSAIDs

Patient on anticoagulation therapy

Current active bleeding

Hx of peptic ulcer disease or GI bleed

Pregnant

If asthmatic, no prior use of ASA or other NSAIDs

CVA or TBI in the previous 24 hours

Known renal impairment

Suspected ischemic chest pain

---

### Morphine

Allergy or sensitivity to morphine

Treatment of headache

Treatment of chronic pain

SBP drops by one-third or more of its initial value after morphine is administered

Suspected ischemic chest pain (refer to Cardiac Ischemia Medical Directive for suspected cardiac ischemia)

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### Fentanyl

Allergy or sensitivity to fentanyl

Treatment of headache

Treatment of chronic pain

SBP drops by one-third or more of its initial value after fentanyl is administered

Suspected ischemic chest pain

---



## Treatment

Consider acetaminophen		
	Age	Age
	≥12 years to <18 years	≥18 years
Route	PO	PO
Dose	500-650 mg	960-1,000 mg
Max. single dose	650 mg	1,000 mg
Dosing interval	N/A	N/A
Max. # of doses	1	1

Consider ibuprofen	
	Age
	≥12 years
Route	PO
Dose	400 mg
Max. single dose	400 mg
Dosing interval	N/A
Max. # of doses	1

Consider ketorolac	
	Age
	≥12 years
Route	IM/IV
Dose	10-15 mg
Max. single dose	15 mg
Dosing interval	N/A
Max. # of doses	1

### Mandatory Provincial Patch Point

Patch to BHP for authorization and dosage verification before administering morphine or fentanyl for children < 12 years old.

Consider morphine		
	Age	Age
	≥1 year to <18 years	≥18 years
<b>Route</b>	IV/SC	IV/SC
<b>Dose</b>	0.05-0.1 mg/kg	2 -10 mg
<b>Max. single dose</b>	5 mg	10 mg
<b>Dosing interval</b>	15 min	15 min
<b>Max. # of doses</b>	4	4
<b>Max. cumulative dose</b>	10 mg	20 mg

Consider fentanyl (if available and authorized)		
	Age	Age
	≥1 year to <18 years	≥18 years
<b>Route</b>	IV/IN	IV/IN
<b>Dose</b>	up to 1 mcg/kg	25 -75 mcg
<b>Max. single dose</b>	75 mcg	75 mcg
<b>Dosing interval</b>	5 min	5 min
<b>Max. # of doses</b>	4	4
<b>Max cumulative dose</b>	225 mcg	225 mcg

## Clinical Considerations

Whenever possible, consider co-administration of acetaminophen and ibuprofen.

Suspected renal colic patients should routinely be considered for ketorolac **and** morphine or fentanyl.

Exercise caution when using narcotics in opioid naïve patients and patients ≥ 65 years old as they may be more sensitive to dosages.

Consider starting with lower doses. When higher doses of morphine (5-10 mg) or fentanyl (50-75 mcg) are given intravenously for severe pain, consider administering medication in small aliquots q 3 minutes until desired effect or max. single dose is reached to avoid nausea and vomiting.

Fentanyl should not be used in combination with morphine unless authorized by BHP.

The maximum volume of fentanyl that may be administered IN is 1 mL per nare.

# Hyperkalemia Medical Directive

An Advanced Care Paramedic may provide the treatment prescribed in this Medical Directive if authorized.

## Indications

Suspected hyperkalemia in patients at high risk, including:

Currently on dialysis; **OR**

History of end-stage renal disease; **OR**

Relevant incident history (*i.e.* prolonged crush injury)

**AND**

One of the following clinical situations:

Cardiac Arrest; **OR**

Pre-arrest with 12-lead ECG changes associated with Hyperkalemia.

## Conditions

Calcium Gluconate 10%	
<b>Age</b>	≥18 years
<b>LOA</b>	N/A
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	N/A
<b>Other</b>	N/A

Salbutamol	
<b>Age</b>	≥18 years
<b>LOA</b>	N/A
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	N/A
<b>Other</b>	N/A

## Contraindications

Calcium gluconate
Current Digoxin use

Salbutamol
Allergy or sensitivity to salbutamol

## Treatment

Consider 12-lead ECG acquisition and interpretation

### Mandatory Provincial Patch Point

Patch to BHP for authorization to proceed with calcium gluconate and salbutamol therapies.

Consider calcium gluconate 10%

	Route
	IV/IO/CVAD
<b>Dose</b>	1 g (10 ml) over 2-3 minutes
<b>Max. single dose</b>	1 g (10 ml)
<b>Dosing interval</b>	30 minutes
<b>Max. # of doses</b>	2

Consider salbutamol

	Route	
	MDI*	NEB
<b>Dose</b>	1,600 mcg (16 puffs)	10 mg
<b>Max. single dose</b>	1,600 mcg	10 mg
<b>Dosing interval</b>	Immediate	Immediate
<b>Max. # of doses</b>	2	2

\*1 puff=100 mcg

Consider 12-lead ECG acquisition and interpretation

## Clinical Considerations

In the Indications, the pre-arrest patient would present with one or more of the following: hypotension, altered levels of awareness, or symptomatic bradycardia.

12-lead acquisition is intended for the patient not in cardiac arrest to establish the QRS duration before and after treatment.

12-lead changes suggestive of hyperkalemia are wide and bizarre QRS complexes [ $\geq 120$  ms], peaked T waves, loss of P waves and/or a QRS complex with a “sine wave” appearance.

Whenever possible, both calcium gluconate and salbutamol should be administered as the 2 medications have different modes of action.

If appropriate, refer to the Symptomatic Bradycardia, Tachydysrhythmia, or Cardiac Arrest Medical Directives for further management of these patients.

Sodium bicarbonate is not a very effective agent for hyperkalemia and so should not routinely be administered.

Caution that calcium gluconate should only be administered in an IV/IO/CVAD that is running well.

Calcium gluconate and sodium bicarbonate should not be mixed or administered in the same IV without flushing well.

# Combative Patient Medical Directive

An Advanced Care Paramedic may provide the treatment prescribed in this Medical Directive if authorized.

## Indications

Combative or violent or agitated behaviour that requires sedation for patient safety.

## Conditions

Midazolam	
<b>Age</b>	≥18 years
<b>LOA</b>	N/A
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	Normotension
<b>Other</b>	No reversible causes ( <i>e.g.</i> hypoglycemia, hypoxia, hypotension)

Ketamine	
<b>Age</b>	≥18 years
<b>LOA</b>	N/A
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	Normotension
<b>Other</b>	Suspected excited delirium, severe violent psychosis  No reversible causes ( <i>e.g.</i> hypoglycemia, hypoxia, hypotension)

## Contraindications

Midazolam
Allergy or sensitivity to midazolam

Ketamine
Allergy or sensitivity to ketamine
Known history of asthma
Known pregnancy

## Treatment

### Mandatory Provincial Patch Point

Patch to BHP for authorization to proceed with midazolam or ketamine if unable to assess the patient for normotension or reversible causes.

Consider midazolam	
	<b>Age</b>
	≥18 years
<b>Route</b>	IV/IM
<b>Dose</b>	2.5-5 mg
<b>Max. single dose</b>	5 mg
<b>Dosing interval</b>	5 min
<b>Max. total dose</b>	10 mg
<b>Max. # of doses</b>	2

Consider ketamine (if available and authorized)		
	<b>Age</b>	<b>Age</b>
	≥18 years to <65 years	≥65 years
<b>Route</b>	IM	IM
<b>Dose</b>	5 mg/kg	3 mg/kg
<b>Max. single dose</b>	500 mg	300 mg
<b>Dosing interval</b>	N/A	N/A
<b>Max. # of doses</b>	1	1

## Clinical Considerations

Do not co-administer midazolam and ketamine unless direction received from BHP.

If ketamine emergence reaction develops, a BHP patch is required if further sedation orders are required.

Consider obtaining IV access once patient has been sedated.



End tidal CO<sub>2</sub> monitoring is recommended once patient has been sedated

# Home Dialysis Emergency Disconnect Medical Directive

An Advanced Care Paramedic may provide the treatment prescribed in this Medical Directive if authorized.

## Indications

Patient receiving home dialysis (hemo or peritoneal) and connected to dialysis machine and requires transport to the closest appropriate receiving facility;

**AND**

Patient is unable to disconnect;

**AND**

There is no family member of caregiver who is available and knowledgeable in dialysis disconnect.

## Conditions

Home Dialysis Emergency Disconnect	
<b>Age</b>	N/A
<b>LOA</b>	N/A
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	N/A
<b>Other</b>	N/A

---

## Contraindications

Home Dialysis Emergency Disconnect
N/A

---

## Treatment

Consider Home Dialysis Emergency Disconnect

### Clinical Considerations

Generally, an emergency disconnect kit with materials and instructions can be found hanging from the dialysis machine or nearby on the wall.

Ensure both the patient side and machine side of the connection are clamped before disconnecting and attaching end caps.

# Suspected Adrenal Crisis Medical Directive

An Advanced Care Paramedic may provide the treatment prescribed in this Medical Directive if authorized.

## Indications

A patient with primary adrenal failure who is experiencing clinical signs of an adrenal crisis.

## Conditions

	Hydrocortisone
<b>Age</b>	N/A
<b>LOA</b>	N/A
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	N/A
<b>Other</b>	Paramedics are presented with a vial of hydrocortisone for the identified patient <b>AND</b> Age-related hypoglycemia <b>OR</b> GI symptoms (vomiting, diarrhea, abdominal pain) <b>OR</b> Syncope <b>OR</b> Temperature $\geq 38^{\circ}\text{C}$ or suspected/history of fever <b>OR</b> Altered level of awareness <b>OR</b> Age-related tachycardia <b>OR</b> Age-related hypotension

## Contraindications

Hydrocortisone
Allergy or sensitivity to hydrocortisone

## Treatment

Consider hydrocortisone	
	Route
	IM/IV/IO/CVAD
Dose	2 mg/kg
Max. single dose	100 mg
Dosing interval	N/A
Max. # of doses	1

\*Dose should be rounded to the nearest 10 mg

## Clinical Considerations

N/A

# Emergency Childbirth Medical Directive

An Advanced Care Paramedic may provide the treatment prescribed in this Medical Directive if authorized.

## Indications

Pregnant patient experiencing labour; **OR**  
 Post-partum patient immediately following delivery.

## Conditions

Delivery	
<b>Age</b>	Childbearing years
<b>LOA</b>	N/A
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	N/A
<b>Other</b>	Second stage labour and/or imminent birth

Umbilical Cord Management	
<b>Age</b>	Childbearing years
<b>LOA</b>	N/A
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	N/A
<b>Other</b>	Cord complications <b>OR</b> if neonatal or maternal resuscitation is required <b>OR</b> due to transport considerations

External Uterine Massage	
<b>Age</b>	Childbearing years
<b>LOA</b>	N/A
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	N/A
<b>Other</b>	Post-placental delivery

## Contraindications

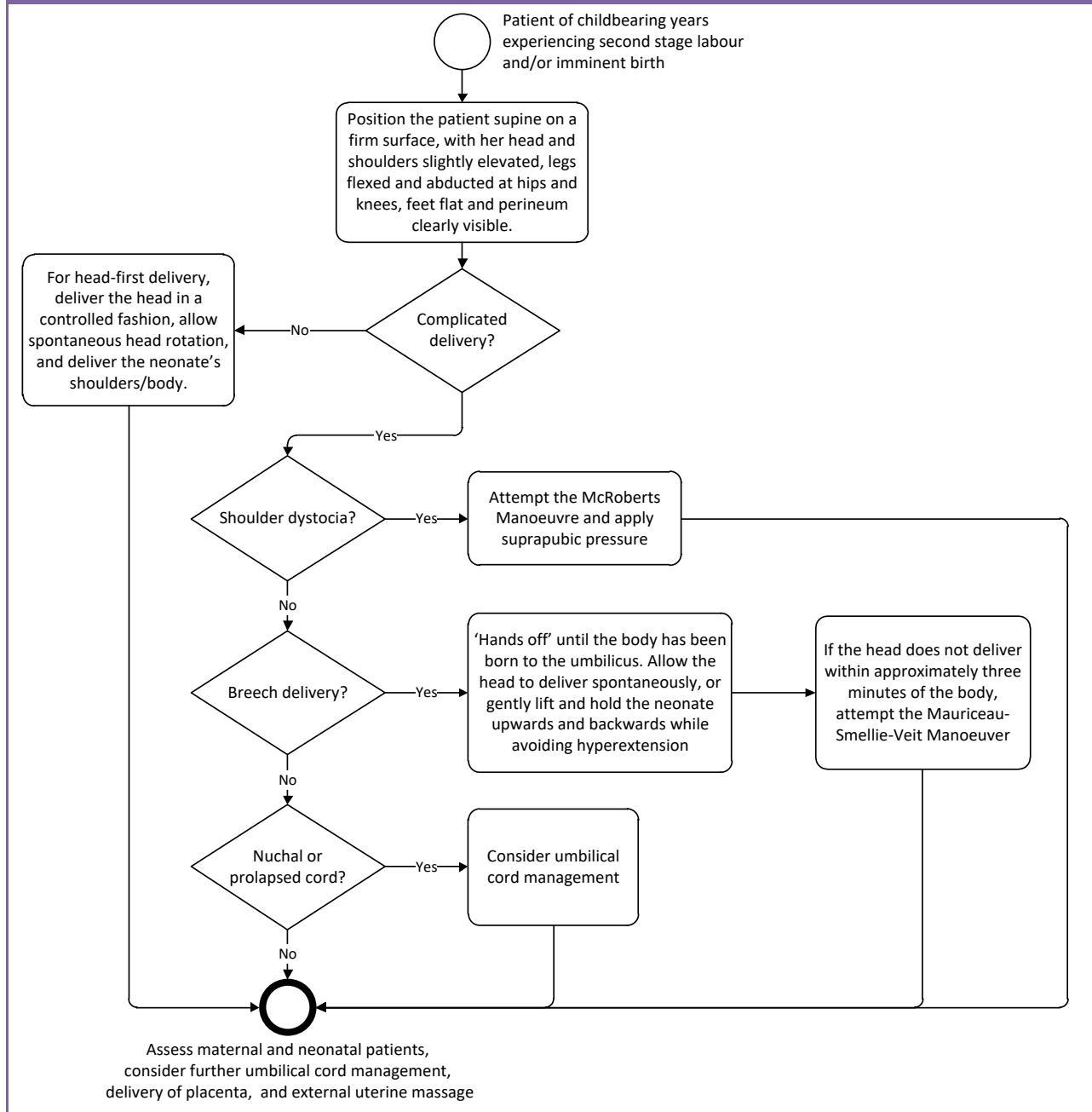
Delivery
N/A

Umbilical Cord Management
N/A

External Uterine Massage
N/A

## Treatment

### Consider delivery





### Consider umbilical cord management

If a cord prolapse is present, the fetal part should be elevated to relieve pressure on the cord. Assist the patient into a knee-chest position or exaggerated Sims position, and insert gloved fingers/hand into the vagina to apply manual digital pressure to the presenting part which is maintained until transfer of care in hospital.

If a nuchal cord is present and loose, slip cord over the neonate's head. Only if a nuchal cord is tight and cannot be slipped over the neonate's head, clamp and cut the cord, encourage rapid delivery.

Following delivery of the neonate, the cord should be clamped and cut immediately if neonatal or maternal resuscitation is required. Otherwise, after pulsations have ceased (approximately 2-3 minutes), clamp the cord in two places and cut the cord.

### Consider external uterine massage

## Clinical Considerations

If the patient presents with limb-presentation, do not attempt to push the limb back into the vagina; discourage the patient from pushing, cover the limb using a dry sheet to maintain warmth, and initiate transport as per the *Load and Go Patient Standard* of the BLS PCS.

If labour is failing to progress, discourage the patient from pushing or bearing down during contractions.

If delivery has not occurred at scene within approximately ten minutes of initial assessment, consider transport in conjunction with the following:

- a. Patient assessment findings:
  - i. Lack of progression of labour;
  - ii. Multiple births expected;
  - iii. Neonate presents face-up;
  - iv. Pre-eclampsia;
  - v. Presence of vaginal hemorrhage;
  - vi. Premature labour;
  - vii. Primip;
- b. Distance to the closest appropriate receiving facility.

When the placenta is delivered, inspect it for wholeness, place in a plastic bag from the OBS kit, label it with the maternal patient's name and time of delivery, and transport it with the maternal or neonatal patient. Delivery of the placenta should not delay transport considerations/initiation.

# Endotracheal and Tracheostomy Suctioning & Reinsertion Medical Directive

An Advanced Care Paramedic may provide the treatment prescribed in this Medical Directive if authorized.

## Indications

Patient with endotracheal or tracheostomy tube

**AND**

Airway obstruction or increased secretions.

## Conditions

Suctioning	
<b>Age</b>	N/A
<b>LOA</b>	N/A
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	N/A
<b>Other</b>	N/A

Emergency tracheostomy reinsertion	
<b>Age</b>	N/A
<b>LOA</b>	N/A
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	N/A
<b>Other</b>	<p>Patient with an existing tracheostomy where the inner and/or outer cannula(s) have been removed from the airway <b>AND</b></p> <p>Respiratory distress <b>AND</b></p> <p>Inability to adequately ventilate <b>AND</b> Paramedics are presented with a tracheostomy cannula for the identified patient.</p>

## Contraindications

Suctioning
N/A

Emergency tracheostomy reinsertion
Inability to landmark or visualize

## Treatment

Consider suctioning			
<b>Age</b>	<b>&lt; 1 year</b>	<b>≥ 1 year to &lt; 12 years</b>	<b>≥ 12 years</b>
<b>Dose</b>	suction at 60-100 mmHg	suction at 100-120 mmHg	suction at 100-150 mmHg
<b>Max. single dose</b>	10 seconds	10 seconds	10 seconds
<b>Dosing interval</b>	1 minute	1 minute	1 minute
<b>Max. # of doses</b>	N/A	N/A	N/A

Consider emergency tracheostomy reinsertion
The maximum number of attempts is 2

## Clinical Considerations

### Suctioning:

Pre-oxygenate with 100% oxygen.

In an alert patient, whenever possible, have patient cough to clear airway prior to suctioning.

### Emergency Tracheostomy Reinsertion:

A reinsertion attempt is defined as the insertion of the cannula into the tracheostomy.

A new replacement inner or outer cannula is preferred over cleaning and reusing an existing one.

Utilize a family member or caregiver who is available and knowledgeable to replace the tracheostomy cannula.

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## **Appendix 3 – PCP Auxiliary Medical Directives**

3

# Intravenous and Fluid Therapy

## Medical Directive - AUXILIARY

A Primary Care Paramedic may provide the treatment prescribed in this auxiliary Medical Directive if authorized for PCP Autonomous IV.

### Indications

Actual or potential need for intravenous medication **OR** fluid therapy.

### Conditions

IV Cannulation	
<b>Age</b>	≥2 years
<b>LOA</b>	N/A
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	N/A
<b>Other</b>	N/A

0.9% NaCl Fluid Bolus	
<b>Age</b>	≥2 years
<b>LOA</b>	N/A
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	Hypotension
<b>Other</b>	N/A

### Contraindications

IV Cannulation
Suspected fracture proximal to the access site

0.9% NaCl Fluid Bolus
Fluid overload

### Treatment

Consider IV cannulation

**Consider 0.9% NaCl maintenance infusion**

	<b>Age</b>	
	$\geq 2$ years to $< 12$ years	$\geq 12$ years
	<b>Route</b>	
	IV	
<b>Infusion</b>	15 ml/hr	30-60 ml/hr
<b>Infusion interval</b>	N/A	N/A
<b>Reassess every</b>	N/A	N/A
<b>Max. volume</b>	N/A	N/A

**Mandatory Provincial Patch Point**

Patch to BHP for authorization to administer 0.9% NaCl fluid bolus to hypotensive patients  $\geq 2$  years to  $< 12$  years with suspected Diabetic Ketoacidosis (DKA)

**Consider 0.9% NaCl fluid bolus**

	<b>Age</b>	
	$\geq 2$ years to $< 12$ years	$\geq 12$ years
	<b>Route</b>	
	IV	
<b>Infusion</b>	20 ml/kg	20 ml/kg
<b>Infusion interval</b>	N/A	N/A
<b>Reassess every</b>	100 ml	250 ml
<b>Max. volume*</b>	2,000 ml	2,000 ml

\*The maximum volume of NaCl is lower for patients in cardiogenic shock and return of spontaneous circulation.

## Clinical Considerations

“PCP Assist IV” authorizes a PCP to cannulate a peripheral IV at the request and under the direct supervision of an ACP. The patient must require a peripheral IV in accordance with the indications listed in this Medical Directive. PCPs authorized for PCP Assist IV are not authorized to administer IV fluid or medication therapy.

Microdrips and/or volume control administration sets should be considered when IV access is indicated for patients <12 years of age.

An intravenous fluid bolus may be considered for a patient who does not meet trauma TOR criteria, where it does not delay transport and should not be prioritized over management of other reversible causes.



# Cardiogenic Shock Medical Directive – AUXILIARY

A Primary Care Paramedic may provide the treatment prescribed in this auxiliary Medical Directive if authorized for PCP Autonomous IV.

## Indications

STEMI-positive 12-lead ECG;

**AND**

Cardiogenic shock.

## Conditions

0.9% NaCl Fluid Bolus	
<b>Age</b>	≥18 years
<b>LOA</b>	N/A
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	Hypotension
<b>Other</b>	Chest auscultation is clear

---

## Contraindications

0.9% NaCl Fluid Bolus	
Fluid overload	
SBP ≥90 mmHg	

---

## Treatment

Consider 0.9% NaCl fluid bolus	
	<b>Age</b>
	≥18 years
	<b>Route</b>
	IV
<b>Infusion</b>	10 ml/kg
<b>Infusion interval</b>	N/A
<b>Reassess every</b>	250 ml
<b>Max. volume</b>	1,000 ml

## Clinical Considerations

N/A

# Continuous Positive Airway Pressure (CPAP) Medical Directive – AUXILIARY

A Primary Care Paramedic may provide the treatment prescribed in this auxiliary Medical Directive if authorized.

## Indications

Severe respiratory distress;

**AND**

Signs and /or symptoms of acute pulmonary edema or COPD.

## Conditions

	CPAP
<b>Age</b>	≥18 years
<b>LOA</b>	N/A
<b>HR</b>	N/A
<b>RR</b>	Tachypnea
<b>SBP</b>	Normotension
<b>Other</b>	SpO <sub>2</sub> <90% or accessory muscle use

---

## Contraindications

CPAP
Asthma exacerbation
Suspected pneumothorax
Unprotected or unstable airway
Major trauma or burns to the head or torso
Tracheostomy
Inability to sit upright
Unable to cooperate

## Treatment

Consider CPAP		
<b>Initial Setting</b>	5 cm H <sub>2</sub> O	Or equivalent flow rate of device as per BH direction
<b>Titration increment</b>	2.5 cm H <sub>2</sub> O	Or equivalent flow rate of device as per BH direction
<b>Titration interval</b>	5 min	
<b>Max. setting</b>	15 cm H <sub>2</sub> O	Or equivalent flow rate of device as per BH direction

Consider increasing FiO <sub>2</sub> (if available)	
<b>Initial FiO<sub>2</sub></b>	50-100%
<b>FiO<sub>2</sub> increment (if available on device)</b>	SpO <sub>2</sub> <92% despite treatment and/or 10 cm H <sub>2</sub> O pressure or equivalent flow rate of device as per BH direction
<b>Max. FiO<sub>2</sub></b>	100%

Confirm CPAP pressure by manometer (if available)

## Clinical Considerations

N/A

# Supraglottic Airway Medical Directive – AUXILIARY

A Primary Care Paramedic may provide the treatment prescribed in this auxiliary Medical Directive if authorized.

## Indications

Need for ventilatory assistance or airway control;

**AND**

Other airway management is ineffective.

## Conditions

Supraglottic Airway	
<b>Age</b>	N/A
<b>LOA</b>	N/A
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	N/A
<b>Other</b>	Patient must be in cardiac arrest

## Contraindications

Supraglottic Airway
Active vomiting
Inability to clear the airway
Airway edema
Stridor
Caustic ingestion

## Treatment

### Consider supraglottic airway insertion

The maximum number of supraglottic airway insertion attempts is 2.

### Confirm supraglottic airway placement

Method	Method
<i>Primary</i>	<i>Secondary</i>
ETCO <sub>2</sub> (Waveform capnography)	ETCO <sub>2</sub> (Non-waveform device)
	Auscultation
	Chest rise

## Clinical Considerations

An attempt at supraglottic airway insertion is defined as the insertion of the supraglottic airway into the mouth.

Confirmation of supraglottic airway must use ETCO<sub>2</sub> (Waveform capnography). If waveform capnography is not available or is not working, then at least 2 secondary methods must be used.

# Nausea/Vomiting Medical Directive – AUXILIARY

A Primary Care Paramedic may provide the treatment prescribed in this auxiliary Medical Directive if authorized.

## Indications

Nausea or vomiting.

## Conditions

Dimenhydrinate	
<b>Age</b>	N/A
<b>Weight</b>	≥25 kg
<b>LOA</b>	Unaltered
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	N/A
<b>Other</b>	N/A

## Contraindications

Dimenhydrinate
Allergy or sensitivity to dimenhydrinate or other antihistamines
Overdose on antihistamines or anticholinergics or tricyclic antidepressants



## Treatment

Consider dimenhydrinate				
	Weight		Weight	
	≥25 kg to <50 kg		≥50 kg	
	Route	Route	Route	Route
	IV	IM	IV	IM
<b>Dose</b>	25 mg	25 mg	50 mg	50 mg
<b>Max. single dose</b>	25 mg	25 mg	50 mg	50 mg
<b>Dosing interval</b>	N/A	N/A	N/A	N/A
<b>Max. # of doses</b>	1	1	1	1

## Clinical Considerations

IV administration of dimenhydrinate applies only to PCPs authorized for PCP Autonomous IV.

Prior to IV administration, dilute dimenhydrinate (concentration of 50 mg/1 ml) 1:9 with Normal Saline or sterile water. If administered IM do not dilute.

# Electronic Control Device Probe Removal Medical Directive – AUXILIARY

A Primary Care Paramedic may provide the treatment prescribed in this auxiliary Medical Directive if authorized.

## Indications

Electronic Control Device probe(s) embedded in patient.

## Conditions

Probe Removal	
<b>Age</b>	≥18 years
<b>LOA</b>	Unaltered
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	N/A
<b>Other</b>	N/A

---

## Contraindications

Probe Removal
Probe embedded above the clavicles, in the nipple(s), or in the genital area

## Treatment

Consider probe removal

## Clinical Considerations

Police may require preservation of the probe(s) for evidentiary purposes.

This directive is for removal of ECD only and in no way constitutes treat and release, normal principles of patient assessment and care apply.

# Assessment of Patients with Possible COVID-19 Medical Directive – AUXILIARY

A Primary Care Paramedic may provide the treatment prescribed in this Medical Directive if authorized.

## Indications

Confirmed COVID-19 or suspected COVID-19 with mild acute respiratory illness characterized by a combination of 2 or more of the following: fever, new onset of cough, worsening chronic cough, shortness of breath or difficulty breathing, sore throat, runny nose/nasal congestion (without any known cause).

### AND

The crisis is straining the resources of the host community

## Conditions

Patient disposition		Nasopharyngeal OR nasal OR pharyngeal swab	
<b>Age</b>	≥ 18 years to < 65 years	<b>Age</b>	≥ 18 years
<b>LOA</b>	unaltered	<b>LOA</b>	N/A
<b>HR</b>	< 110 bpm	<b>HR</b>	N/A
<b>RR</b>	< 22 breaths/min	<b>RR</b>	N/A
<b>SBP</b>	normotension	<b>SBP</b>	N/A
<b>Other</b>	CTAS 3, 4 or 5 SpO <sub>2</sub> ≥ 94%. If temperature ≥ 38° C, does not appear septic/unwell	<b>Other</b>	Patient is being released from care <b>AND</b> Meets COVID-19 testing criteria OR as requested by local Public Health

## Contraindications

Patient disposition	Nasopharyngeal OR nasal OR pharyngeal swab
Patient and/or substitute decision maker (SDM) cannot demonstrate decision-making capacity based on the Aid to Capacity Evaluation Tool	Recent significant facial trauma (all)
Pregnancy	Current epistaxis <b>OR</b> significant abnormality of the nasal anatomy (nasopharyngeal or nasal swab)
	Significant abnormality of the oral anatomy (pharyngeal swab)

## Treatment

### Mandatory Provincial Patch Point

Patch to BHP for authorization to consider release from care

Consider patient disposition* (if authorized)		
	Transport to closest most appropriate emergency department	Consider release from care (following BHP patch)
<b>CTAS</b>	1 & 2  3 with comorbidity or immunocompromise	3 with mild or no respiratory distress (without comorbidity/immunocompromise)  4 & 5 without immunocompromise

\*Assess for safety to remain at home including clinical criteria above, and the following: patient is unaltered, the patient can self-isolate, the patient has access to food, phone, and other necessities, and appropriate caregivers are available (if needed).

Prior to a release from care, the patient and/or SDM must be provided with contact information for their Local Public Health Unit, education on self-isolation and symptom management, and information for accessing assessment centres. Paramedics must document these instructions and patient and/or SDM consent to the plan of care in the remarks section of the Ambulance Call Report. Advise the patient that if the problem persists or worsens they should seek further medical attention.

**Consider obtaining nasopharyngeal OR nasal OR pharyngeal swab (if available and authorized)**

If swab obtained, complete the lab requisition and transport the specimen as per local arrangement.

## Clinical Considerations

### **Base Hospital Physician Patch:**

When a patch is made to the BHP, the Paramedic will provide the following: patient's COVID-19 screening result, history of illness and symptoms, all past medical history, vital signs, and assessment findings, in addition to patient and/or SDM's wishes, and follow-up plans (if known).

### **Immunocompromised definition:**

Patient or caregiver states immunocompromised, cancer treatment within past 6 weeks, HIV/AIDS, organ transplant patient, substance-use disorder, and any immunosuppressive medications.

### **Comorbidity definition:**

Hypertension, cardiovascular disease, cerebrovascular disease, diabetes, chronic lung disease, chronic kidney disease, immunocompromised.

### **Mild Respiratory Distress definition:**

Patient may report dyspnea on exertion, but there is mild or no increased work of breathing, patient able to speak in sentences, and RR < 22 breaths/min **AND** SpO<sub>2</sub> ≥ 94%.

# Minor Abrasions Medical Directive – AUXILIARY- SPECIAL EVENT

A Primary Care Paramedic may provide the treatment prescribed in this auxiliary Medical Directive if authorized.

## Indications

Minor abrasions;

**AND**

Special event: a preplanned gathering with potentially large numbers of people and the Special Event Medical Directives have been preauthorized for use by the Medical Director.

## Conditions

	Topical Antibiotic
<b>Age</b>	N/A
<b>LOA</b>	Unaltered
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	N/A
<b>Other</b>	N/A

## Contraindications

Topical Antibiotic
Allergy or sensitivity to any of the components of the topical antibiotic

## Treatment

Consider topical antibiotic

Consider release from care

## **Clinical Considerations**

Advise patient that if the problem persists or worsens that they should seek further medical attention.



# Minor Allergic Reaction Medical Directive – AUXILIARY - SPECIAL EVENT

A Primary Care Paramedic may provide the treatment prescribed in this auxiliary Medical Directive if authorized.

## Indications

Signs consistent with a minor allergic reaction;

**AND**

Special event: a preplanned gathering with potentially large numbers of people and the Special Event Medical Directives have been preauthorized for use by the Medical Director.

## Conditions

	Diphenhydramine
<b>Age</b>	≥18 years
<b>LOA</b>	Unaltered
<b>HR</b>	WNL
<b>RR</b>	WNL
<b>SBP</b>	Normotension
<b>Other</b>	N/A

---

## Contraindications

Diphenhydramine
Allergy or sensitivity to diphenhydramine
Antihistamine or sedative use in previous 4 hours
Signs or symptoms of moderate to severe allergic reaction
Signs or symptoms of intoxication
Wheezing

## Treatment

Consider diphenhydramine	
	Route
	PO
<b>Dose</b>	50 mg
<b>Max. single dose</b>	50 mg
<b>Dosing interval</b>	N/A
<b>Max. # of doses</b>	1

Consider release from care

## Clinical Considerations

Advise patient that if the problem persists or worsens that they should seek further medical attention.

# Musculoskeletal Pain Medical Directive – AUXILIARY - SPECIAL EVENT

A Primary Care Paramedic may provide the treatment prescribed in this auxiliary Medical Directive if authorized.

## Indications

Minor musculoskeletal pain;

**AND**

Special event: a preplanned gathering with potentially large numbers of people and the Special Event Medical Directives have been preauthorized for use by the Medical Director.

## Conditions

	Acetaminophen
<b>Age</b>	≥18 years
<b>LOA</b>	Unaltered
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	N/A
<b>Other</b>	N/A

---

## Contraindications

Acetaminophen
Acetaminophen use within previous 4 hours
Allergy or sensitivity to acetaminophen
Signs or symptoms of intoxication

---

## Treatment

Consider acetaminophen	
	Route
	PO
Dose	325-650 mg
Max. single dose	650 mg
Dosing interval	N/A
Max. # of doses	1

Consider release from care

## Clinical Considerations

Advise patient that if the problem persists or worsens that they should seek further medical attention.

# Headache Medical Directive – AUXILIARY - SPECIAL EVENT

A Primary Care Paramedic may provide the treatment prescribed in this auxiliary Medical Directive if authorized.

## Indications

Uncomplicated headache conforming to the patient’s usual pattern;

**AND**

Special event: a preplanned gathering with potentially large numbers of people and the Special Event Medical Directives have been preauthorized for use by the Medical Director.

## Conditions

	Acetaminophen
<b>Age</b>	≥18 years
<b>LOA</b>	Unaltered
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	N/A
<b>Other</b>	N/A

## Contraindications

Acetaminophen
Acetaminophen use within previous 4 hours
Allergy or sensitivity to acetaminophen
Signs or symptoms of intoxication

## Treatment

Consider acetaminophen	
	Route
	PO
Dose	325-650 mg
Max. single dose	650 mg
Dosing interval	N/A
Max. # of doses	1

Consider release from care

## Clinical Considerations

Advise patient that if the problem persists or worsens that they should seek further medical attention.

## **Appendix 4 – ACP Auxiliary Medical Directives**

**4**

# Adult Intraosseous Medical Directive - AUXILIARY

An Advanced Care Paramedic may provide the treatment prescribed in this auxiliary Medical Directive if authorized.

## Indications

Actual or potential need for intravenous medication **OR** fluid therapy;

**AND**

IV access is unobtainable;

**AND**

Cardiac arrest or pre-arrest state.

## Conditions

IO	
<b>Age</b>	≥12 years
<b>LOA</b>	N/A
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	N/A
<b>Other</b>	N/A

## Contraindications

IO
Fracture or crush injuries proximal to the access site.
Suspected or known replacement / prostheses immediately proximal to the access site



## Treatment

Consider IO access

## Clinical Considerations

N/A

# Central Venous Access Device Access Medical Directive – AUXILIARY

An Advanced Care Paramedic may provide the treatment prescribed in this auxiliary Medical Directive if authorized.

## Indications

Actual or potential need for intravenous medication **OR** fluid therapy;

**AND**

IV access is unobtainable;

**AND**

Cardiac arrest or near arrest state.

## Conditions

CVAD Access	
<b>Age</b>	N/A
<b>LOA</b>	N/A
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	N/A
<b>Other</b>	Patient has a pre-existing accessible central venous catheter in place

## Contraindications

CVAD Access
N/A

## Treatment

Consider CVAD access

## Clinical Considerations

N/A

# Nasotracheal Intubation Medical Directive – AUXILIARY

An Advanced Care Paramedic may provide the treatment prescribed in this auxiliary Medical Directive if authorized.

## Indications

Need for ventilatory assistance or airway control;

**AND**

Other airway management is ineffective.

## Conditions

Xylometazoline	
<b>Age</b>	N/A
<b>LOA</b>	N/A
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	N/A
<b>Other</b>	N/A

Lidocaine Spray	
<b>Age</b>	N/A
<b>LOA</b>	N/A
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	N/A
<b>Other</b>	Gag reflex

Nasotracheal Intubation	
<b>Age</b>	≥8 years
<b>LOA</b>	N/A
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	N/A
<b>Other</b>	Spontaneous Breathing

## Contraindications

### Xylometazoline

Allergy or sensitivity to xylometazoline

### Lidocaine Spray

Allergy or sensitivity to lidocaine spray

Unresponsive patient

### Nasotracheal Intubation

Age <50 years **AND** current episode of asthma exacerbation **AND** not in or near cardiac arrest.

Suspected basal skull fracture or mid-face fracture

Uncontrolled epistaxis

Anticoagulant therapy (excluding ASA)

Bleeding disorders

## Treatment

Consider xylometazoline 0.1% spray

	Route
	TOP
<b>Dose</b>	2 sprays/nare
<b>Max. single dose</b>	2 sprays/nare
<b>Dosing interval</b>	N/A
<b>Max. # of doses</b>	1

**Consider topical lidocaine spray (to the nares and/or hypopharynx)**

	<b>Route</b>
	TOP
<b>Dose</b>	10 mg/spray
<b>Max. single dose</b>	5 mg/kg
<b>Dosing interval</b>	N/A
<b>Max. # of doses</b>	20 sprays

**Consider nasotracheal intubation**

The maximum number of intubation attempts is 2.

**Confirm nasotracheal tube placement**

<b>Method</b>	<b>Method</b>
<i>Primary</i>	<i>Secondary</i>
ETCO <sub>2</sub> (Waveform capnography)	ETCO <sub>2</sub> (Non-waveform device)
	Auscultation
	Esophageal detection device
	Chest rise

## Clinical Considerations

A nasotracheal intubation attempt is defined as insertion of the nasotracheal tube into a nare.

Confirmation of nasotracheal placement must use ETCO<sub>2</sub> (Waveform capnography). If wave-form capnography not available or not working, then at least 2 secondary methods must be used.

ETT placement must be reconfirmed immediately after every patient movement.

# Continuous Positive Airway Pressure (CPAP) Medical Directive – AUXILIARY

An Advanced Care Paramedic may provide the treatment prescribed in this auxiliary Medical Directive if authorized.

## Indications

Severe respiratory distress;

**AND**

Signs and /or symptoms of acute pulmonary edema or COPD.

## Conditions

	CPAP
<b>Age</b>	≥18 years
<b>LOA</b>	N/A
<b>HR</b>	N/A
<b>RR</b>	Tachypnea
<b>SBP</b>	Normotension
<b>Other</b>	SpO <sub>2</sub> <90% or accessory muscle use

---

## Contraindications

CPAP
Asthma exacerbation
Suspected pneumothorax
Unprotected or unstable airway
Major trauma or burns to the head or torso
Tracheostomy
Inability to sit upright
Unable to cooperate

## Treatment

Consider CPAP		
<b>Initial Setting</b>	5 cm H <sub>2</sub> O	Or equivalent flow rate of device as per BH direction
<b>Titration increment</b>	2.5 cm H <sub>2</sub> O	Or equivalent flow rate of device as per BH direction
<b>Titration interval</b>	5 min	
<b>Max. setting</b>	15 cm H <sub>2</sub> O	Or equivalent flow rate of device as per BH direction

Consider increasing FiO <sub>2</sub> (if available)	
<b>Initial FiO<sub>2</sub></b>	50-100%
<b>FiO<sub>2</sub> increment (if available on device)</b>	SpO <sub>2</sub> <92% despite treatment and/or 10 cm H <sub>2</sub> O pressure or equivalent flow rate of device as per BH direction
<b>Max. FiO<sub>2</sub></b>	100%



Confirm CPAP pressure by manometer (if available)

## Clinical Considerations

N/A

# Supraglottic Airway Medical Directive – AUXILIARY

An Advanced Care Paramedic may provide the treatment prescribed in this auxiliary Medical Directive if authorized.

## Indications

Need for ventilatory assistance or airway control;

**AND**

Other airway management is ineffective.

## Conditions

Supraglottic Airway	
<b>Age</b>	N/A
<b>LOA</b>	GCS = 3
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	N/A
<b>Other</b>	Absent gag reflex

## Contraindications

Supraglottic Airway
Active vomiting
Inability to clear the airway
Airway edema
Stridor
Caustic ingestion

## Treatment

### Consider supraglottic airway insertion

The maximum number of supraglottic airway insertion attempts is 2.

### Confirm supraglottic airway placement

Method	Method
<i>Primary</i>	<i>Secondary</i>
ETCO <sub>2</sub> (Waveform capnography)	ETCO <sub>2</sub> (Non-waveform device)
	Auscultation
	Chest rise

## Clinical Considerations

An attempt at supraglottic airway insertion is defined as the insertion of the supraglottic airway into the mouth.

Confirmation of supraglottic airway must use ETCO<sub>2</sub> (Waveform capnography). If waveform capnography is not available or is not working, then at least 2 secondary methods must be used.

# Cricothyrotomy Medical Directive – AUXILIARY

An Advanced Care Paramedic may provide the treatment prescribed in this auxiliary Medical Directive if authorized.

## Indications

Need for advanced airway management;

**AND**

Intubation AND supraglottic airway (if available and authorized) insertion unsuccessful or contraindicated;

**AND**

Unable to ventilate.

## Conditions

Cricothyrotomy	
<b>Age</b>	≥12 years
<b>LOA</b>	Altered
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	N/A
<b>Other</b>	N/A

## Contraindications

Cricothyrotomy	
Suspected fractured larynx	
Inability to landmark	

## Treatment

### Mandatory Provincial Patch Point

Patch to BHP for authorization to perform cricothyrotomy

Consider cricothyrotomy

#### Consider cricothyrotomy tube placement

Method	Method
<i>Primary</i>	<i>Secondary</i>
ETCO <sub>2</sub> (Waveform capnography)	ETCO <sub>2</sub> (Non-waveform device)
	Auscultation
	Chest rise

## Clinical Considerations

Confirmation of cricothyrotomy must use ETCO<sub>2</sub> (Waveform capnography). If waveform capnography is not available or not working, then at least 2 secondary methods must be used. Additional secondary Cricothyrotomy tube placement confirmation devices may be authorized by the local medical director.

Cricothyrotomy tube placement must be reconfirmed immediately after every patient movement.

# Nausea/Vomiting Medical Directive – AUXILIARY

An Advanced Care Paramedic may provide the treatment prescribed in this auxiliary Medical Directive if authorized.

## Indications

Nausea or vomiting.

## Conditions

Dimenhydrinate	
<b>Age</b>	N/A
<b>Weight</b>	≥25 kg
<b>LOA</b>	Unaltered
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	N/A
<b>Other</b>	N/A

## Contraindications

Dimenhydrinate
Allergy or sensitivity to dimenhydrinate or other antihistamines
Overdose on antihistamines or anticholinergics or tricyclic antidepressants

## Treatment

Consider dimenhydrinate				
	Weight		Weight	
	≥25 kg to <50 kg		≥50 kg	
	Route	Route	Route	Route
	IV	IM	IV	IM
<b>Dose</b>	25 mg	25 mg	50 mg	50 mg
<b>Max. single dose</b>	25 mg	25 mg	50 mg	50 mg
<b>Dosing interval</b>	N/A	N/A	N/A	N/A
<b>Max. # of doses</b>	1	1	1	1

## Clinical Considerations

Prior to IV administration, dilute dimenhydrinate (concentration of 50 mg/1 ml) 1:9 with Normal Saline or sterile water. If administered IM do not dilute.

# Procedural Sedation Medical Directive – AUXILIARY

An Advanced Care Paramedic may provide the treatment prescribed in this auxiliary Medical Directive if authorized.

## Indications

Post-intubation; **OR**

Transcutaneous pacing.

## Conditions

	Midazolam
<b>Age</b>	≥18 years
<b>LOA</b>	N/A
<b>HR</b>	N/A
<b>RR</b>	≥10/min*
<b>SBP</b>	Normotension
<b>Other</b>	N/A

\*Non-intubated patients only

## Contraindications

Midazolam
Allergy or sensitivity to midazolam



## Treatment

Consider midazolam	
	Route
	IV
Dose	2.5-5 mg
Max. single dose	5 mg
Dosing interval	5 min
Max. total dose	10 mg
Max. # of doses	2

## Clinical Considerations

N/A

# Electronic Control Device Probe Removal Medical Directive – AUXILIARY

An Advanced Care Paramedic may provide the treatment prescribed in this auxiliary Medical Directive if authorized.

## Indications

Electronic Control Device probe(s) embedded in patient.

## Conditions

	Probe Removal
<b>Age</b>	≥18 years
<b>LOA</b>	Unaltered
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	N/A
<b>Other</b>	N/A

## Contraindications

Probe Removal
Probe embedded above the clavicles, in the nipple(s), or in the genital area

## Treatment

Consider probe removal

## **Clinical Considerations**

Police may require preservation of the probe(s) for evidentiary purposes.

This directive is for removal of ECD only and in no way constitutes treat and release, normal principles of patient assessment and care apply.

# Assessment of Patients with Possible COVID-19 Medical Directive – AUXILIARY

An Advanced Care Paramedic may provide the treatment prescribed in this Medical Directive if authorized.

## Indications

Confirmed COVID-19 or suspected COVID-19 with mild acute respiratory illness characterized by a combination of 2 or more of the following: fever, new onset of cough, worsening chronic cough, shortness of breath or difficulty breathing, sore throat, runny nose/nasal congestion (without any known cause).

### AND

The crisis is straining the resources of the host community

## Conditions

Patient disposition		Nasopharyngeal OR nasal OR pharyngeal swab	
<b>Age</b>	≥ 18 years to < 65 years	<b>Age</b>	≥ 18 years
<b>LOA</b>	unaltered	<b>LOA</b>	N/A
<b>HR</b>	< 110 bpm	<b>HR</b>	N/A
<b>RR</b>	< 22 breaths/min	<b>RR</b>	N/A
<b>SBP</b>	normotension	<b>SBP</b>	N/A
<b>Other</b>	CTAS 3, 4 or 5 SpO <sub>2</sub> ≥ 94%. If temperature ≥ 38° C, does not appear septic/unwell	<b>Other</b>	Patient is being released from care <b>AND</b> Meets COVID-19 testing criteria OR as requested by local Public Health

## Contraindications

Patient disposition	Nasopharyngeal OR nasal OR pharyngeal swab
Patient and/or substitute decision maker (SDM) cannot demonstrate decision-making capacity based on the Aid to Capacity Evaluation Tool	Recent significant facial trauma (all)
Pregnancy	Current epistaxis <b>OR</b> significant abnormality of the nasal anatomy (nasopharyngeal or nasal swab)
	Significant abnormality of the oral anatomy (pharyngeal swab)

## Treatment

### Mandatory Provincial Patch Point

Patch to BHP for authorization to consider release from care

Consider patient disposition* (if authorized)		
	Transport to closest most appropriate emergency department	Consider release from care (following BHP patch)
<b>CTAS</b>	1 & 2  3 with comorbidity or immunocompromise	3 with mild or no respiratory distress (without comorbidity/immunocompromise)  4 & 5 without immunocompromise

\*Assess for safety to remain at home including clinical criteria above, and the following: patient is unaltered, the patient can self-isolate, the patient has access to food, phone, and other necessities, and appropriate caregivers are available (if needed).

Prior to a release from care, the patient and/or SDM must be provided with contact information for their Local Public Health Unit, education on self-isolation and symptom management, and information for accessing assessment centres. Paramedics must document these instructions and patient and/or SDM consent to the plan of care in the remarks section of the Ambulance Call Report. Advise the patient that if the problem persists or worsens they should seek further medical attention.

**Consider obtaining nasopharyngeal OR nasal OR pharyngeal swab (if available and authorized)**

If swab obtained, complete the lab requisition and transport the specimen as per local arrangement.

## Clinical Considerations

### **Base Hospital Physician Patch:**

When a patch is made to the BHP, the Paramedic will provide the following: patient's COVID-19 screening result, history of illness and symptoms, all past medical history, vital signs, and assessment findings, in addition to patient and/or SDM's wishes, and follow-up plans (if known).

### **Immunocompromised definition:**

Patient or caregiver states immunocompromised, cancer treatment within past 6 weeks, HIV/AIDS, organ transplant patient, substance-use disorder, and any immunosuppressive medications.

### **Comorbidity definition:**

Hypertension, cardiovascular disease, cerebrovascular disease, diabetes, chronic lung disease, chronic kidney disease, immunocompromised.

### **Mild Respiratory Distress definition:**

Patient may report dyspnea on exertion, but there is mild or no increased work of breathing, patient able to speak in sentences, and RR < 22 breaths/min **AND** SpO<sub>2</sub> ≥ 94%.

# Minor Abrasions Medical Directive – AUXILIARY- SPECIAL EVENT

An Advanced Care Paramedic may provide the treatment prescribed in this auxiliary Medical Directive if authorized.

## Indications

Minor abrasions;

**AND**

Special event: a preplanned gathering with potentially large numbers of people and the Special Event Medical Directives have been preauthorized for use by the Medical Director.

## Conditions

	Topical Antibiotic
<b>Age</b>	N/A
<b>LOA</b>	Unaltered
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	N/A
<b>Other</b>	N/A

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## Contraindications

Topical Antibiotic
Allergy or sensitivity to any of the components of the topical antibiotic

## Treatment

Consider topical antibiotic

Consider release from care

## Clinical Considerations

Advise patient that if the problem persists or worsens that they should seek further medical attention.



# Minor Allergic Reaction Medical Directive – AUXILIARY - SPECIAL EVENT

An Advanced Care Paramedic may provide the treatment prescribed in this auxiliary Medical Directive if authorized.

## Indications

Signs consistent with minor allergic reaction;

**AND**

Special event: a preplanned gathering with potentially large numbers of people and the Special Event Medical Directives have been preauthorized for use by the Medical Director.

## Conditions

	Diphenhydramine
<b>Age</b>	≥18 years
<b>LOA</b>	Unaltered
<b>HR</b>	WNL
<b>RR</b>	WNL
<b>SBP</b>	Normotension
<b>Other</b>	N/A

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## Contraindications

Diphenhydramine
Allergy or sensitivity to diphenhydramine
Antihistamine or sedative use in previous 4 hours
Signs or symptoms of moderate to severe allergic reaction
Signs or symptoms of intoxication
Wheezing

## Treatment

Consider diphenhydramine	
	Route
	PO
<b>Dose</b>	50 mg
<b>Max. single dose</b>	50 mg
<b>Dosing interval</b>	N/A
<b>Max. # of doses</b>	1

Consider release from care

## Clinical Considerations

Advise patient that if the problem persists or worsens that they should seek further medical attention.

# Musculoskeletal Pain Medical Directive – AUXILIARY - SPECIAL EVENT

An Advanced Care Paramedic may provide the treatment prescribed in this auxiliary Medical Directive if authorized.

## Indications

Minor musculoskeletal pain;

**AND**

Special event: a preplanned gathering with potentially large numbers of people and the Special Event Medical Directives have been preauthorized for use by the Medical Director.

## Conditions

	Acetaminophen
<b>Age</b>	≥18 years
<b>LOA</b>	Unaltered
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	N/A
<b>Other</b>	N/A

## Contraindications

Acetaminophen
Acetaminophen use within previous 4 hours
Allergy or sensitivity to acetaminophen
Signs or symptoms of intoxication

## Treatment

Consider acetaminophen	
	Route
	PO
Dose	325-650 mg
Max. single dose	650 mg
Dosing interval	N/A
Max. # of doses	1

Consider release from care

## Clinical Considerations

Advise patient that if the problem persists or worsens that they should seek further medical attention.

# Headache Medical Directive – AUXILIARY - SPECIAL EVENT

An Advanced Care Paramedic may provide the treatment prescribed in this auxiliary Medical Directive if authorized.

## Indications

Uncomplicated headache conforming to the patient’s usual pattern;

**AND**

Special event: a preplanned gathering with potentially large numbers of people and the Special Event Medical Directives have been preauthorized for use by the Medical Director.

## Conditions

	Acetaminophen
<b>Age</b>	≥18 years
<b>LOA</b>	Unaltered
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	N/A
<b>Other</b>	N/A

## Contraindications

Acetaminophen
Acetaminophen use within previous 4 hours
Allergy or sensitivity to acetaminophen
Signs or symptoms of intoxication

## Treatment

Consider acetaminophen	
	Route
	PO
Dose	325-650 mg
Max. single dose	650 mg
Dosing interval	N/A
Max. # of doses	1

Consider release from care

## Clinical Considerations

Advise patient that if the problem persists or worsens that they should seek further medical attention.

# **Appendix 5 – Chemical Exposure Medical Directives**

**5**

# Chemical Exposure Medical Directives

## Introduction

The following Medical Directives have been developed for use when chemical exposure to the listed agent is suspected. These Medical Directives may only be used by paramedics who have received special training in treating patients with chemical exposures. This is usually a comprehensive program that includes personal protection and training in CBRNE (Chemical, Biologic, Radiological, Nuclear and Explosive) events.



# Hydrofluoric (HF) Acid Exposure Medical Directive

A Paramedic may provide the treatment prescribed in this Medical Directive if authorized.

## Indications

Exposure to vapour and/or liquid hydrofluoric acid (HF);

**AND**

Exhibits signs and symptoms of HF poisoning.

## Conditions

Calcium Gluconate	
<b>Age</b>	N/A
<b>LOA</b>	N/A
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	N/A
<b>Other</b>	N/A

Topical Anaesthetic Eye Drops	
<b>Age</b>	N/A
<b>LOA</b>	N/A
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	N/A
<b>Other</b>	N/A

## Contraindications

Calcium Gluconate
Allergy or sensitivity to Calcium Gluconate

Topical Anaesthetic Eye Drops
Allergy or sensitivity to local anaesthetics

## Treatment

Consider calcium gluconate		
	Inhalation exposure	Skin exposure
	Concentration	Concentration
	10% solution	2.5% gel
	Route	Route
	NEB	TOP
<b>Dose</b>	100 mg	N/A
<b>Max Single Dose</b>	100 mg	N/A
<b>Dosing Interval</b>	N/A	Immediate
<b>Max # of doses</b>	1	N/A

Consider topical anaesthetic eye drops	
	Eye exposure
	Route
	TOP
<b>Dose</b>	2 gtts/eye
<b>Max Single Dose</b>	2 gtts/eye
<b>Dosing Interval</b>	10 min
<b>Max # of doses</b>	N/A

## Clinical Considerations

For skin contact, ensure thorough irrigation prior to treatment.

For eye exposure remove patient's contact lenses, if applicable, prior to initiating treatment. Use anaesthetic eye drops for comfort and then irrigate eyes with normal saline for at least 15 minutes.

# Adult Nerve Agent Exposure Medical Directive

A Paramedic may provide the treatment prescribed in this Medical Directive if authorized.

## Indications

Exposure to a known or suspected nerve agent;

**AND**

Signs and symptoms of a cholinergic crisis.

## Conditions

Atropine	
<b>Age</b>	≥18 years
<b>LOA</b>	N/A
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	N/A
<b>Other</b>	Suspected cholinergic crisis  <b>Moderate Exposure</b> Any one of the following: vomiting, diarrhea, bronchospasm or bronchial secretions, shortness of breath or any known liquid exposure  <b>Severe Exposure</b> Signs and symptoms of a moderate exposure and any one of the following: decreased LOA, paralysis, seizure or apnea

Pralidoxime	
<b>Age</b>	≥18 years
<b>LOA</b>	N/A
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	N/A
<b>Other</b>	Suspected cholinergic crisis  <b>Moderate Exposure</b> Any one of the following: vomiting, diarrhea, bronchospasm or bronchial secretions, shortness of breath or any known liquid exposure  <b>Severe Exposure</b> Signs and symptoms of a moderate exposure and any one of the following: decreased LOA, paralysis, seizure or apnea

Obidoxime	
<b>Age</b>	≥18 years
<b>LOA</b>	N/A
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	N/A
<b>Other</b>	<p>Suspected cholinergic crisis</p> <p><b>Moderate Exposure</b> Any one of the following: vomiting, diarrhea, bronchospasm or bronchial secretions, shortness of breath or any known liquid exposure</p> <p><b>Severe Exposure</b> Signs and symptoms of a moderate exposure and any one of the following: decreased LOA, paralysis, seizure or apnea</p>

Diazepam	
<b>Age</b>	≥18 years
<b>LOA</b>	N/A
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	N/A
<b>Other</b>	<p>Suspected cholinergic crisis</p> <p><b>Moderate Exposure</b> Any one of the following: vomiting, diarrhea, bronchospasm or bronchial secretions, shortness of breath or any known liquid exposure</p> <p><b>Severe Exposure</b> Signs and symptoms of a moderate exposure and any one of the following: decreased LOA, paralysis, seizure or apnea</p>

## Contraindications

Atropine
Allergy or sensitivity to atropine

Pralidoxime
Allergy or sensitivity to pralidoxime

Obidoxime
Allergy or sensitivity to obidoxime

Diazepam
Allergy or sensitivity to diazepam

## Treatment

Consider Atropine						
	Moderate Exposure	Severe Exposure	Moderate Exposure	Severe Exposure	Moderate Exposure	Severe Exposure
	Route	Route	Route	Route	Route	Route
	IM	IM	Auto-injector	Auto-injector	IV (ACP only)	IV (ACP only)
<b>Initial Dose</b>	2 mg	6 mg	2.1 mg	6.3 mg	2 mg	6 mg
<b>Subsequent doses</b>	2 mg	2 mg	2.1 mg	2.2 mg	2 mg	2 mg
<b>Dosing interval</b>	5 min.	5 min.	5 min.	5 min.	5 min.	5 min.
<b>Max # of doses</b>	N/A	N/A	N/A	N/A	N/A	N/A

Consider Pralidoxime				
	Moderate Exposure	Severe Exposure	Moderate Exposure	Severe Exposure
	Route	Route	Route	Route
	IM	IM	Autoinjector	Autoinjector
<b>Dose</b>	600 mg	1,800 mg	600 mg	1,800 mg
<b>Max. single dose</b>	600 mg	1,800 mg	600 mg	1,800 mg
<b>Dosing interval</b>	N/A	N/A	N/A	N/A
<b>Max # of doses</b>	1	1	1	1

<b>Consider Obidoxime (if not using pralidoxime)</b>				
	<b>Moderate Exposure</b>	<b>Severe Exposure</b>	<b>Moderate Exposure</b>	<b>Severe Exposure</b>
	<b>Route</b>	<b>Route</b>	<b>Route</b>	<b>Route</b>
	IM	IM	Autoinjector	Autoinjector
<b>Dose</b>	150 mg	450 mg	150 mg	450 mg
<b>Max. single dose</b>	150 mg	450 mg	150 mg	450 mg
<b>Dosing interval</b>	N/A	N/A	N/A	N/A
<b>Max # of doses</b>	1	1	1	1

<b>Consider Diazepam</b>		
	<b>Moderate Exposure</b>	<b>Severe Exposure</b>
	<b>Route</b>	<b>Route</b>
	IM	Autoinjector
<b>Dose</b>	10 mg	10 mg
<b>Max. single dose</b>	10 mg	10 mg
<b>Dosing interval</b>	N/A	N/A
<b>Max # of doses</b>	1	1

## Clinical Considerations

Only one of pralidoxime or obidoxime should be administered.

Administration of IV medications applies to ACPs only.

Do not delay IM administration if IV access is not already established.

Atropine should be administered prior to airway interventions if secretions are copious.

Subsequent doses of atropine are intended for patients showing signs of bronchial secretions and may be repeated as indicated until airway secretions are controlled.

Decontamination procedures must be integrated with antidote administration.

# Pediatric Nerve Agent Exposure Medical Directive

A Paramedic may provide the treatment prescribed in this Medical Directive if authorized.

## Indications

Exposure to a known or suspected nerve agent.

## Conditions

Atropine	
<b>Age</b>	<18 years
<b>LOA</b>	N/A
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	N/A
<b>Other</b>	<p>Suspected cholinergic crisis</p> <p>Any one of the following: vomiting, diarrhea, bronchospasm or bronchial secretions, shortness of breath, decreased LOC, paralysis, seizure, apnea or any known liquid exposure</p>

Diazepam	
<b>Age</b>	<18 years
<b>LOA</b>	N/A
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	N/A
<b>Other</b>	<p>Suspected cholinergic crisis</p> <p>Any one of the following: vomiting, diarrhea, bronchospasm or bronchial secretions, shortness of breath, decreased LOC, paralysis, seizure, apnea or any known liquid exposure</p>

Pralidoxime	
<b>Age</b>	<18 years
<b>LOA</b>	N/A
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	N/A
<b>Other</b>	<p>Suspected cholinergic crisis</p> <p>Any one of the following; vomiting, diarrhea, bronchospasm or bronchial secretions, shortness of breath, decreased LOC, paralysis, seizure, apnea or any known liquid exposure</p>

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Obidoxime	
<b>Age</b>	<18 years
<b>LOA</b>	N/A
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	N/A
<b>Other</b>	<p>Suspected cholinergic crisis</p> <p>Any one of the following; vomiting, diarrhea, bronchospasm or bronchial secretions, shortness of breath, decreased LOC, paralysis, seizure, apnea or any known liquid exposure</p>

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## Contraindications

Atropine
Allergy or sensitivity to atropine

Diazepam
Allergy or sensitivity to diazepam

Pralidoxime
Allergy or sensitivity to pralidoxime

Obidoxime
Allergy or sensitivity to obidoxime



## Treatment

Consider Atropine				
	Weight	Weight	Weight	Weight
	<10 kg	<10 kg	≥10 kg to <40 kg	≥10 kg to <40 kg
	Route	Route	Route	Route
	IV (ACP only)	IM	IV (ACP only)	IM
Dose	0.5 mg	0.5 mg	1 mg	1 mg
Max. single dose	0.5 mg	0.5 mg	1 mg	1 mg
Dosing interval	5 min.	5 min.	5 min.	5 min.
Max. # of doses	N/A	N/A	N/A	N/A

Consider Diazepam				
	Weight	Weight	Weight	Weight
	<10 kg	<10 kg	≥10 kg to <40 kg	≥10 kg to <40 kg
	Route	Route	Route	Route
	IV (ACP only)	IM	IV (ACP only)	IM
Dose	2 mg	2 mg	0.2 mg/kg	0.2 mg/kg
Max. single dose	2 mg	2 mg	8 mg	8 mg
Dosing interval	N/A	N/A	N/A	N/A
Max. # of doses	1	1	1	1

<b>Consider Pralidoxime</b>				
	<b>Weight</b>	<b>Weight</b>	<b>Weight</b>	<b>Weight</b>
	<10 kg	<10 kg	≥10 kg to <40 kg	≥10 kg to <40 kg
	<b>Route</b>	<b>Route</b>	<b>Route</b>	<b>Route</b>
	IV (ACP only)	IM	IV (ACP only)	IM
<b>Dose</b>	15 mg/kg	15 mg/kg	15 mg/kg	15 mg/kg
<b>Max. single dose</b>	150 mg	150 mg	600 mg	600 mg
<b>Dosing interval</b>	60 min.	60 min.	60 min.	60 min.
<b>Max. # of doses</b>	2	2	2	2

<b>Consider Obidoxime (if not using pralidoxime)</b>				
	<b>Weight</b>	<b>Weight</b>	<b>Weight</b>	<b>Weight</b>
	<10 kg	<10 kg	≥10 kg to <40 kg	≥10 kg to <40 kg
	<b>Route</b>	<b>Route</b>	<b>Route</b>	<b>Route</b>
	IV (ACP only)	IM	IV (ACP only)	IM
<b>Dose</b>	8 mg/kg	8 mg/kg	8 mg/kg	8 mg/kg
<b>Max. single dose</b>	80 mg	80 mg	320 mg	320 mg
<b>Dosing interval</b>	N/A	N/A	N/A	N/A
<b>Max. # of doses</b>	1	1	1	1

## Clinical Considerations

Only one of pralidoxime or obidoxime should be administered.

Administration of IV medications applies to ACPs only

Do not delay IM administration if IV access is not already established.

Atropine should be administered prior to airway interventions if secretions are copious.

Subsequent doses of atropine are intended for patients showing signs of bronchial secretions and may be repeated as indicated until airway secretions are controlled.

Decontamination procedures must be integrated with antidote administration.

# Cyanide Exposure Medical Directive

A Paramedic may provide the treatment prescribed in this Medical Directive if authorized.

## Indications

Suspected exposure to cyanide with signs and symptoms of poisoning.

## Conditions

Sodium Thiosulfate 25%	
<b>Age</b>	N/A
<b>LOA</b>	Altered
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	N/A
<b>Other</b>	N/A

Hydroxocobalamin	
<b>Age</b>	N/A
<b>LOA</b>	Altered
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	N/A
<b>Other</b>	N/A

## Contraindications

Sodium Thiosulfate 25%
Allergy or sensitivity to Sodium Thiosulfate 25%

Hydroxocobalamin
Allergy or sensitivity to Hydroxocobalamin

## Treatment

Consider sodium thiosulfate 25%		
	Age	Age
	<18 years	≥18 years
	Route	Route
	IV infusion	IV infusion
Dose	1.65 ml/kg	12.5g (50 ml of 25% solution)
Max. single dose	12.5g (50 ml of 25% solution)	12.5g (50 ml of 25% solution)
Dosing interval	N/A	N/A
Max. # of doses	1	1

Consider hydroxocobalamin (if not using sodium thiosulfate 25%)		
	Age	Age
	<18 years	≥18 years
	Route	Route
	IV infusion	IV infusion
Dose	70 mg/kg over 30 min.	5 g over 15 - 30 min.
Max. single dose	5 g	5 g
Dosing interval	N/A	N/A
Max. # of doses	1	1

## Clinical Considerations

Hydroxocobalamin must be reconstituted with 200 ml normal saline prior to use.

## Hydroxocobalamin Dosing Chart

	Dose	Concentration	Volume of Administration
<b>5</b>	70 mg/kg	25 mg/ml	14 ml
<b>10</b>	70 mg/kg	25 mg/ml	28 ml
<b>15</b>	70 mg/kg	25 mg/ml	42 ml
<b>20</b>	70 mg/kg	25 mg/ml	56 ml
<b>25</b>	70 mg/kg	25 mg/ml	70 ml
<b>30</b>	70 mg/kg	25 mg/ml	84 ml
<b>35</b>	70 mg/kg	25 mg/ml	98 ml
<b>40</b>	70 mg/kg	25 mg/ml	112 ml
<b>&gt;40 kg</b>	5 g	25 mg/ml	200 ml

# Symptomatic Riot Agent Exposure Medical Directive

A Paramedic may provide the treatment prescribed in this Medical Directive if authorized.

## Indications

Known or suspected exposure to a riot agent with signs and symptoms of a riot agent exposure.

## Conditions

Topical Anaesthetic Eye Drops	
<b>Age</b>	N/A
<b>LOA</b>	N/A
<b>HR</b>	N/A
<b>RR</b>	N/A
<b>SBP</b>	N/A
<b>Other</b>	N/A

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## Contraindications

Topical Anaesthetic Eye Drops
Allergy or sensitivity to local anaesthetics

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## Treatment

Consider topical anaesthetic eye drops	
	Route
	TOP
Dose	2 gtts/eye
Max. single dose	2 gtts/eye
Dosing interval	10 min
Max. # of doses	N/A

## Clinical Considerations

For skin or mucous membrane contact, ensure thorough irrigation.

For eye exposure, remove patient's contact lenses if applicable prior to initiating treatment. Use anaesthetic eye drops for comfort and then irrigate eyes with normal saline for at least 15 minutes.



## **Appendix 6 – Certification Standard**

6

# Preamble

All Paramedics shall obtain and maintain the qualifications required by the *Ambulance Act*. This document sets out the requirements and processes related to Certification.

# Definitions

Terms defined in the *Ambulance Act* and Ontario Regulation 257/00 shall have the same meaning in this Certification Standard and the following terms have the following meanings:

## “Authorization”

means written approval to perform Controlled Acts and other advanced medical procedures requiring medical oversight of a Medical Director;

## “Business Day”

means any working day, Monday to Friday inclusive, excluding statutory and other holidays, namely: New Year’s Day; Family Day; Good Friday; Easter Monday; Victoria Day; Canada Day; Civic Holiday; Labour Day; Thanksgiving Day; Remembrance Day; Christmas Day; Boxing Day and any other day on which the Province has elected to be closed for business;

## “Certification”

means the process by which Paramedics receive Authorization from a Medical Director to perform Controlled Acts and other advanced medical procedures in accordance with the ALS PCS;

## “Continuing Medical Education (CME)”

means a medical education program and confirmation of its successful completion as approved by the Regional Base Hospital Program (RBHP);

## “Consolidation”

means the process by which a condition is placed on a Paramedic’s Certification restricting his or her practice to working with another Paramedic with the same or higher level of qualification (*i.e.* Certification);

## “Controlled Act”

means a Controlled Act as set out in subsection 27(2) of the *Regulated Health Professions Act, 1991*;

**“Critical Omission or Commission”**

means the performance of a Controlled Act or other advanced medical procedure listed in the ALS PCS that a Paramedic is not authorized to perform; or an action or lack of action, including the performance of a Controlled Act or other advanced medical procedure listed in the ALS PCS, by the Paramedic that has negatively affected or has the potential to negatively affect patient morbidity or mortality, with a potentially life, limb or function threatening outcome;

**“Deactivation”**

means the temporary revocation, by the Medical Director, of a Paramedic’s Certification;

**“Decertification”**

means the revocation, by the Medical Director, of a Paramedic’s Certification;

**“Director”**

means a person who holds that position within the Emergency Health Regulatory and Accountability Branch (EHRAB) of the Ministry of Health (MOH);

**“Employer”**

means an ambulance service operator certified to provide ambulance services as defined in the *Ambulance Act*;

**“Major Omission or Commission”**

means an action or lack of action, including the performance of a Controlled Act or other advanced medical procedure listed in the ALS PCS, by the Paramedic that has negatively affected or has the potential to negatively affect patient morbidity without a potentially life, limb or function threatening outcome;

**“Medical Director”**

means a physician designated by a RBH as the Medical Director of the RBHP;

**“Minor Omission or Commission”**

means an action or lack of action, including the performance of a Controlled Act or other advanced medical procedure listed in the ALS PCS, by the Paramedic that may have negatively affected patient care in a way that would delay care to the patient or lengthen the patient’s recovery period, but has not negatively affected patient morbidity;

**“Ontario Base Hospital Group (OBHG) Executive”**

means a provincial body comprised of representatives from RBHPs as defined in the Terms of Reference for OBHG Executive and approved by the MOH;

**“Paramedic”**

means a paramedic as defined in subsection 1(1) of the *Ambulance Act*, and for purposes of this Standard a reference to the term includes a person who is seeking Certification as a Paramedic, where applicable;

**“Paramedic Practice Review Committee (PPRC)”**

is a committee that performs an independent, external advisory role, providing information and expert opinion to the Medical Director on issues related to Paramedic practice when the Medical Director is considering Decertification of a Paramedic;

**“Patient Care Concern”**

means a Critical Omission or Commission, Major Omission or Commission, or Minor Omission or Commission;

**“Reactivation”**

means the reinstatement of a Paramedic’s Certification after a period of Deactivation;

**“Regional Base Hospital (RBH)”**

means a base hospital as defined in subsection 1(1) of the *Ambulance Act*, and provides an RBHP pursuant to an agreement entered into with the MOH;

**“Regional Base Hospital Program (RBHP)”**

means a base hospital program as defined in subsection 1(1) of the *Ambulance Act*;

**“Remediation”**

means a customized plan by the RBHP to address a Patient Care Concern or to address any concerns identified during Certification, including a failure to meet a requirement for the maintenance of Certification;

**“Senior Field Manager”**

means a person who holds that position within the EHS Division of the MOH, and for the purposes of this Standard a reference to the term means the relevant Senior Field Manager responsible for the applicable RBHP.

# Processes

## Certification

A Medical Director may certify a Paramedic to perform Controlled Acts and other advanced medical procedures listed in the ALS PCS. A Medical Director may stipulate other requirements relating to Paramedic Certification. The Medical Director shall communicate such requirements to the Paramedic and the Employer in writing. The Medical Director shall notify the Paramedic and Employer within three (3) Business Days of the decision with respect to Certification as to whether the Paramedic was successful or not in attaining his or her Certification.

## Consolidation

The Medical Director shall require Consolidation on all new Certifications<sup>1</sup>. A Medical Director may require Consolidation with respect to a Paramedic's Certification where the Paramedic is returning to practice, a Patient Care Concern has been identified in respect of the Paramedic, or as identified in the Paramedic's customized plan for Remediation. Consolidation provides for the opportunity to acquire more skills and confidence while ensuring that a support mechanism is in place for the Paramedic. The Medical Director shall determine the requirements for the Consolidation, which include the presence of another Paramedic, the level of qualification of that other Paramedic, and the restrictions of the Paramedic's practice in relation to the presence of that other Paramedic. The Medical Director, in consultation with the Employer, shall determine the duration for the Consolidation. However, the duration for Consolidation on all new Certifications shall be a minimum of 36 hours for a PCP and a minimum of 168 hours for an ACP or CCP. The Medical Director shall provide notice of Consolidation and the requirements thereof in writing to the Paramedic and Employer within two (2) Business Days. Any changes to the Consolidation by the Medical Director shall be communicated to the Paramedic and Employer immediately and any changes to the requirements thereof shall be provided in writing as soon as possible.

## Responding to a Patient Care Concern

The RBHP shall assess all matters regarding patient care to determine whether or not there is a Patient Care Concern and the Employer shall assist where required. Where a matter regarding patient care is identified by the Employer that may be a Patient Care Concern, the Employer shall notify the RBHP as soon as possible.

Where the Patient Care Concern is a Minor Omission or Commission the RBHP shall notify the Paramedic and Employer by aggregate reports provided semi-annually. Where the Patient Care Concern is a Major Omission or Commission, a Critical Omission or Commission, or a repetition of Minor Omissions or Commissions the RBHP shall immediately notify the Paramedic and Employer of the Patient Care Concern and provide notice in writing as soon as possible. The notice in writing

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<sup>1</sup> See New Certification process

shall indicate that the Patient Care Concern is being considered to determine whether the Paramedic will be subject to Remediation, Deactivation or Decertification.

## Remediation

A Medical Director may require the Paramedic to receive Remediation. The customized plan in the Remediation shall identify the concern, the remedial action to be followed, and the objectives to be achieved. The plan shall include a specific timeframe in which the Paramedic must successfully complete the Remediation. The RBHP shall develop the plan, in consultation with the Employer as necessary, as soon as possible. Once developed, the RBHP shall provide the written plan to the Paramedic and Employer. Any changes to the plan by the RBHP shall be communicated to the Paramedic and Employer immediately and the updated written plan shall be provided as soon as possible. The Medical Director shall notify the Paramedic and Employer in writing within three (3) Business Days of the successful completion of the Remediation.

## Deactivation

A Medical Director may deactivate a Paramedic's Certification for which the Paramedic has received Authorization.

Deactivation may occur as a result of:

1. a Patient Care Concern;
2. failure to respond to the RBHP's requests for feedback or interviews regarding a Critical Omission or Commission, Major Omission or Commission or Minor Omission or Commission within a reasonable period of time as specified by the RBHP;
3. failure to successfully complete Remediation;
4. misconduct related to Certification (*e.g.* falsification of documentation, failure to disclose previous Deactivations and Decertifications, including practice in other jurisdictions);
5. repeated Deactivations in similar clinical areas; or
6. failure to meet the requirements for maintenance of Certification.

The Medical Director shall immediately notify the Paramedic, Employer, the Senior Field Manager and all other RBHPs of a Deactivation. The Medical Director shall provide a brief written reason for the Deactivation to the Paramedic, Employer, the Senior Field Manager and all other RBHPs as soon as possible.

Following a Deactivation, the Medical Director shall determine whether the requirements for Remediation or the requirements for maintenance of Certification have been met, as the case may be, at which time the Medical Director shall either proceed with Reactivation or Decertification. The Remediation and Reactivation process shall be completed as soon as possible; however it shall not exceed ninety (90) consecutive days in length. Where the Medical Director has proceeded with Reactivation, the Medical Director shall immediately notify the Paramedic, Employer, the Senior Field Manager, and all other RBHPs of the Reactivation.

## Decertification

A Medical Director shall revoke a Paramedic's Certification where that person is no longer employed or retained as a volunteer by an Employer and that person shall be deemed to have undergone Decertification and the PPRC process does not apply. In all other circumstances, a Medical Director shall not proceed with a Decertification unless: (i) a PPRC has been convened and has provided its written recommendations to the Medical Director and the Paramedic; or (ii) the Paramedic has waived the PPRC process in writing.

The Medical Director shall immediately notify the Paramedic, Employer, the Senior Field Manager and all other RBHPs of his or her decision to either proceed with Reactivation or Decertification of the Paramedic. Where the Medical Director proceeds with Decertification, he or she shall provide a written explanation to the Paramedic, outlining the reasons for Decertification. The Medical Director shall provide a brief written explanation confirming the reason for the Decertification to the Employer, the Senior Field Manager and all other RBHPs as soon as possible.

## New Certification

The following requirements apply with respect to Paramedics who are seeking Certification from an RBHP and who are not currently certified at that level by another RBHP, including Paramedics who have been previously certified in Ontario.

1. The Paramedic shall be employed or retained by an Employer.
2. The Paramedic shall complete a form provided by the RBHP that includes the following:
  - a. a list of all RBHPs or other certifying bodies under which the Paramedic has previously received Certification within the ten (10) year period immediately preceding the application;
  - b. a declaration of the dates of all previous Deactivations and/or Decertifications that have previously occurred at all other RBHPs or other certifying bodies<sup>2</sup> within the ten (10) year period immediately preceding the application; and
  - c. written permission for the prospective RBHP to obtain information in writing from other employers, other physicians, other programs, *etc.* regarding the Paramedic's previous practice.
3. The Paramedic shall successfully complete an evaluation by the RBHP and any orientation and training required by the RBHP. The evaluation may include:
  - a. an assessment of knowledge and skills;
  - b. scenario evaluation; and
  - c. oral interview or clinical evaluation with the Medical Director or designate.

Upon meeting the above requirements, for new Certification, the Medical Director shall certify the Paramedic and require a condition of Consolidation on the Paramedic's Certification.

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<sup>2</sup> Or a declaration of dates when certification was denied, revoked, suspended or under review as other certifying bodies may not use the terms Deactivation and Decertification

## Cross Certification

The following requirements apply with respect to Paramedics who are already certified and who are seeking Certification by a Medical Director in another RBHP.

1. The Paramedic shall be employed or retained by an Employer within the specified catchment area.
2. The Paramedic shall complete a form provided by the RBHP that includes the following:
  - a. a list of all RBHPs under which the Paramedic has received Certification within the ten (10) year period immediately preceding the application;
  - b. a declaration of the dates of all previous Deactivations and/or Decertifications that have occurred within the ten (10) year period immediately preceding the application;
  - c. status of all current Certifications from all RBHPs; and
  - d. written permission for the prospective RBHP to obtain information in writing from other physicians, other programs, *etc.* regarding the Paramedic's previous practice.
3. The Paramedic shall successfully complete an evaluation by the RBHP and any orientation and training required by the RBHP. The evaluation may include:
  - a. an assessment of knowledge and skills;
  - b. scenario evaluation; and
  - c. oral interview or clinical evaluation with the Medical Director or designate.

Upon meeting the above requirements for Cross Certification, the Medical Director shall certify the Paramedic.

## Maintenance of Certification

The following requirements apply with respect to Paramedics regarding the maintenance of Certification.

1. The Paramedic shall demonstrate competency in the performance of Controlled Acts and other advanced medical procedures, compliance with the ALS PCS, and the provision of patient care at the Paramedic's level of Certification. Competency and compliance shall be determined by the Medical Director and may include chart audits, field evaluations, and RBHP patch communication review.
2. The Paramedic shall not have an absence from providing patient care that exceeds ninety (90) consecutive days.
3. The Paramedic shall either,
  - a. provide patient care to a minimum of ten (10) patients per year whose care requires assessment and management at the Paramedic's level of Certification, or
  - b. where a Paramedic is unable to assess and manage the minimum of ten (10) patients per year, demonstrate alternate experience, as approved by the Medical Director, that may involve 1 or more of the following:
    - i. other patient care activities;
    - ii. additional CME;



- iii. simulated patient encounters; and
- iv. clinical placements.
4. The Paramedic shall complete at least 1 evaluation per year at the appropriate level of Certification, which may include: an assessment of knowledge and evaluation of skills; scenarios; and on-line learning and evaluation.
5. The Paramedic shall complete a minimum of CME hours per year as follows: eight (8) hours for PCPs, twelve (12) hours for PCP Flight, twenty-four (24) hours for ACPs<sup>3</sup>, and seventy-two (72) hours for ACP Flight and CCP. CME hours include hours completed as part of an evaluation required by paragraph 4.

Upon meeting the above requirements for maintenance of Certification, the Medical Director shall certify the Paramedic.

## Paramedic Practice Review Committee (PPRC)

The PPRC is convened by another RBHP through the OBHG Executive Chair to perform an independent, external advisory role, providing information and expert opinion to the affected Medical Director on issues related to Paramedic practice when a Medical Director is considering Decertification of a Paramedic following Deactivation. When the RBHP is engaged for the purposes of a PPRC process the RBHP is termed the "host RBHP". The parties to the PPRC process are the affected Medical Director and the Paramedic who is subject of the consideration of Decertification.

### Membership

The members of the PPRC shall be:

- the host RBHP Manager/Director, who will act as Chair;
- host Medical Director; and
- two (2) Peer Paramedics.

Selection of Peer Paramedics: One (1) peer Paramedic shall be selected by the host RBHP and one (1) peer Paramedic by the affected Paramedic from a pre-identified group of eligible Paramedics. All members of this group shall:

- hold Certification from the host RBHP for the preceding twelve (12) months at the same level or higher as the Paramedic who is subject of the consideration of Decertification; and
- not have any operational relationship or personal relationship with the affected RBHP, Medical Director, or the Paramedic;

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<sup>3</sup> With respect to an ACP whose Certification has been for a period of less than a year and who has completed a minimum of eight (8) hours of CME, the Medical Director shall proportionally adjust the remaining required CME hours.

Confidentiality: All members of the PPRC shall keep confidential all information obtained during the PPRC process.

## Recommendations

The PPRC shall provide written recommendations to the Medical Director who is considering Decertification of a Paramedic. The recommendation of the PPRC shall be made by consensus. The recommendation rendered by the PPRC is not subject to appeal or other challenge, and is not binding on the affected Medical Director. The affected Medical Director is responsible for making the final decision with respect to the Decertification of the affected Paramedic.

## PPRC Process

1. The affected Medical Director shall notify the OBHG Executive Chair that a PPRC is required regarding a consideration to proceed with the Decertification of a Paramedic.
2. If the OBHG Executive Chair is employed by the affected RBHP, he/she shall send the request to the OBHG Executive Vice Chair. (All subsequent references to the “OBHG Executive Chair” shall be references to the OBHG Executive Vice Chair, as applicable.)
3. The OBHG Executive Chair shall ensure that the PPRC adheres to all established timelines in the process by communicating directly with the PPRC Chair.
4. The OBHG Executive Chair shall select an appropriate host RBHP.
5. The OBHG Executive Chair shall provide notice to the affected Medical Director and Paramedic, in a format set out in *Appendix A*, that a PPRC has been convened to review the case.
6. The affected Medical Director and Paramedic shall provide any written submissions to the OBHG Executive Chair within fifteen (15) Business Days of receiving notice that a PPRC has been convened.
7. Submissions shall be sent via courier requiring signature of receipt, registered mail, fax (with confirmation) or email (with confirmation).
8. The OBHG Executive Chair shall provide a copy of each party’s submission to the other party within five (5) Business Days.
9. Both parties shall have the opportunity to respond to the original submissions within fifteen (15) Business Days of their receipt.
10. The OBHG Executive Chair shall provide a copy of all submissions to the affected Paramedic, Medical Director and four (4) copies to the PPRC Chair.
11. The PPRC Chair shall provide copies of the submissions to the other members of the PPRC.
12. The PPRC shall not begin its review until receipt of all submissions.
13. If clarification of an issue or information regarding applicable standards or legislation is required, the PPRC Chair shall request the clarification or information in writing from the relevant party. The response to the request shall be provided to the PPRC Chair and the other party in writing, within ten (10) Business Days of the request.
14. The PPRC Chair shall provide a copy of the response to OBHG Executive Chair.
15. The PPRC shall review the submissions and any responses within fifteen (15) Business Days from receipt of the full submission. If an extension is required the request will be

made to the OBHG Executive Chair. The PPRC will render a written recommendation containing the supporting rationale, within ten (10) Business Days of the final review meeting and submit it to the OBHG Executive Chair.

16. The OBHG Executive Chair shall send a copy of the final recommendation to both parties.

# Appendix A - Paramedic Practice Review Committee Letter

<<Date>>

A Paramedic Practice Review Committee (PPRC) has been convened to review <<brief details of case/incident>>.

The PPRC is convened by another RBHP through the OBHG Executive Chair to perform an independent, external advisory role, providing information and expert opinion to the affected Medical Director on issues related to Paramedic practice when a Medical Director is considering Decertification of a Paramedic following Deactivation. When the RBHP is engaged for the purposes of a PPRC process the RBHP is termed the "host RBHP". The affected Medical Director shall not proceed with Decertification unless a PPRC has been convened and has provided its written recommendations to the affected Medical Director and the Paramedic.

## Recommendations

The PPRC shall provide written recommendations, including supporting rationale, to the Medical Director regarding the consideration to decertify a Paramedic. The recommendation of the PPRC shall be made by consensus. The recommendation rendered by the PPRC is not subject to appeal or other challenge, and is not binding on the affected Medical Director. The affected Medical Director is responsible for making the final decision with respect to the Decertification of the affected Paramedic.

## Membership

<<Medical Director>>                      <<Regional Base Hospital Program Manager/Director>>

<<Peer Paramedic>>                      <<Peer Paramedic>>

**Process:**

- The affected Medical Director shall notify the OBHG Executive Chair that a PPRC is required regarding a consideration to proceed with the Decertification of a Paramedic.
- The OBHG Executive Chair shall select an appropriate host RBHP and provide notice to both parties that a PPRC has been convened to review the case.
- Both parties shall provide any written submissions to the OBHG Executive Chair within fifteen (15) Business Days of receiving notice that a PPRC has been convened.
- The OBHG Executive Chair shall provide a copy of each party's submission to the other party within five (5) Business Days and both parties shall have the opportunity to respond to the original submissions within fifteen (15) Business Days of their receipt.
- The OBHG Executive Chair shall provide a copy of all submissions to both parties and four (4) copies to the PPRC Chair to distribute to the other members of the PPRC. The PPRC shall begin its review once all submissions are received.
- If clarification of an issue or information regarding applicable standards or legislation is required, the PPRC Chair shall request the clarification or information in writing from the relevant party. The response to the request shall be provided to the PPRC Chair and the other party in writing, within ten (10) Business Days of the request.
- The PPRC shall review the submissions and any responses within fifteen (15) Business Days from receipt of the full submission. If an extension is required the request will be made to the OBHG Executive Chair.
- The PPRC will render a written recommendation containing the supporting rationale, within ten (10) Business Days of the final review meeting and submit it to the OBHG Executive Chair.
- The OBHG Executive Chair shall send a copy of the final recommendation to both parties.

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## Appendix 7 – Research Trial Standard



# Research Trial Standard

MOH may, at its discretion, approve research trials that include patient care practices that are different from those otherwise set out in the Standards.

## A paramedic properly enrolled in an approved research trial shall:

1. determine whether a patient may be treated in accordance with a research trial, only if the following conditions have been met:
  - a. MOH has approved the patient care practices set out in the research trial as an alternate standard than to those set out in the Standards;
  - b. The research trial has been approved by a Research Ethics Board (REB) that:
    - i. abides by and is consistent with the version of the Tri-Council Policy Statement on Ethical Conduct for Research Involving Humans current at the time of submission, and
    - ii. meets the requirements for an REB set out in section 15 of O. Reg. 329/04 made under PHIPA, and

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### Guideline

Recall section 44 of PHIPA, which includes provisions related to personal health information and researchers.

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- c. The research trial has been reviewed and supported in writing by the Ontario Base Hospital Group Medical Advisory Committee;
2. obtain the appropriate patient consent for participation in the research trial; and

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### Guideline

Recall paragraph 11 of the *General Measures Standard of the Basic Life Support Patient Care Standards*, which specifies that the paramedic shall also obtain consent for patient care as per the *Health Care Consent Act, 1996* (Ontario)

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3. where authorized, provide care in accordance with the approved research trial.



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