COMMUNITY PARAMEDIC

Patient Care Standards

Version 2.4
Effective October 1, 2024

Middlesex-London Paramedic Service

CREDITS

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Recommendation of Revisions for Approval
Dr. Sheldon Cheskes**,** Medical Director, Middlesex-London Paramedic Service

AUTHORIZATION FOR DELEGATION OF MEDICAL DIRECTIVES

The Medical Directives contained in this handbook have been approved for use by Paramedics authorized to operate as a Community Paramedic with Middlesex-London Paramedic Service.

Delegation of these Medical Directives is under the authorization of the Community Paramedicine Medical Director, Middlesex-London Paramedic Service, in conjunction with the patient's primary care provider.

This document is subject to change in accordance with the medical direction/advice of the Middlesex-London Paramedic Service Medical Director and authorized by the Office of the Chief.

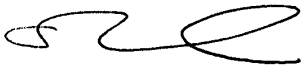
Effective Date: October 1, 2024

Implementation Recommended By: Dr. Daniel Pepe, Past Medical Advisor
Date: June 1, 2021

Signature:

Recommended Revisions By: Dr. Sheldon Cheskes, Medical Director
Date: April 10, 2024

Signature:

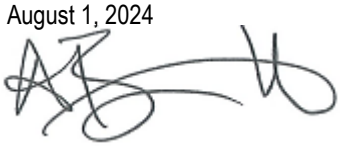


Approved By: Neal Roberts, Chief
Date: June 7, 2024

Signature:

Revisions Approved By: Adam Bennett, Interim Chief
Date: August 1, 2024

Signature:



AREAS OF MEDICAL OVERSIGHT

MIDDLESEX-LONDON PARAMEDIC SERVICE MEDICAL DIRECTOR
Provides medical direction/advice and recommendations to Middlesex-London Paramedic Service Community Paramedics to the Office of the Chief.

Provides medical oversight to Middlesex-London Paramedic Service Community Paramedics through a delegated scope of practice and clinical review.

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PREAMBLE

Background

Paramedics are government-regulated health professionals who provide patient care under an ambulance service provider, as part of the emergency response system. They are delegated the ability to perform controlled acts and other advanced medical procedures by physicians who work for a provincial network of Base Hospitals.

Community Paramedicine programs have emerged in an effort to maximize efficiencies in patient care and resources by permitting paramedics to apply their education and skills beyond the traditional role of emergency medical response. Community Paramedicine is currently not included under the definition of ambulance service in the Ambulance Act, nor is it a core activity under the current legislation that governs Emergency Medical Services and resources.

Purpose of Standards

The Community Paramedic Patient Care Standards (CPPCS) reflects an innovative model of care that permits paramedics to apply their education and skills beyond the traditional role of emergency medical response with expanded roles and an extended scope of practice.

Use of the Medical Directives by Community Paramedics

These Medical Directives apply to paramedics who are authorized to operate as a Community Paramedic and provide patient care. Delegation of these Medical Directives is under the direction of the Middlesex-London Paramedic Service Community Paramedicine Medical Director.

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 of for a medication to be administered.

Contraindications:

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

Treatment:

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

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.

Use clinical judgement to determine the most appropriate level of care while taking into consideration the patient goals.

If severe signs or symptoms are exhibited, and if in alignment with patient goals of care, consider activation of 911 for transport for more definitive care.

CHRONIC CARE DIRECTIVES

Chronic Obstructive Pulmonary Disease Exacerbation Medical Directive

A Community Paramedic may provide the treatment prescribed in this Medical Directive if authorized, or in collaboration with the Primary Care Provider.

Indications:

Respiratory distress; **AND** Suspected exacerbation.

Conditions:

Salbutamol/Ipratropium/Prednisone/Amoxicillin/Doxycycline/Clarithromycin	
Age	≥ 18 years
LOA	Unaltered
HR	60-139
RR	N/A
SBP	Normotension
Other	Ascertain history of increased dyspnea, sputum production, sputum purulence, and change in sputum colour from baseline

Co-Amoxiclav	
Age	≥ 18 years
Weight	≥40 kg
LOA	N/A
HR	N/A
RR	N/A
SBP	N/A
Other	Physician order is obtained

Contraindications:

Ipratropium
Allergy or sensitivity to Ipratropium
Currently prescribed Spiriva

Salbutamol
Allergy or sensitivity to Salbutamol

Amoxicillin
Allergy or sensitivity to Amoxicillin or Penicillin

Doxycycline
Hypersensitivity to Doxycycline, other tetracycline's, or any component of the formulation; or Myasthenia Gravis; or concurrent use with Isotretinoin

Clarithromycin
Allergy or sensitivity to antibiotics, Clarithromycin, Azithromycin or Other macrolides

Co-Amoxiclav
Allergy or sensitivity to Co-Amoxiclav or Penicillin

Prednisone
Allergy or sensitivity to Prednisone

Consider Physician Consultation Point

If any concerns regarding the clinical stability of the patient, or appropriateness of the directive for treatment, contact the Primary Care Physician for consultation prior to administration of treatment.

Treatment:

The Community Paramedic is able to provide the patient up to a 3 day supply of medication. After 3 days the patient will be required to fill a prescription to continue treatment if directed by their Primary Care Provider.

Consider Ipratropium	
Dose	4 puffs QID; 2 puffs Q4H PRN
Route	MDI
Max. # of doses	16 puffs / 12 puffs in 24 hours
Duration	3 Days

Consider Salbutamol	
Dose	4 puffs QID; 2 puffs Q4H PRN
Route	MDI
Max. # of doses	Up to 8 puffs q 4 hours / 48 puffs in 24 hours
Duration	3 Days

Consider Amoxicillin	
Dose	500 mg
Route	PO
Max. # of doses	TID
Duration	3 Days

Consider Doxycycline	
Dose	100 mg
Route	PO
Max. # of doses	BID
Duration	3 Days

Consider Clarithromycin	
Dose	500 mg
Route	PO
Max. # of doses	BID
Duration	3 Days

Consider Co-Amoxiclav	
Dose	500/125 mg
Route	PO
Max. # of doses	BID
Duration	3 Days

Consider Prednisone	
Dose	50 mg
Route	PO
Max. # of doses	OD
Duration	3 Days

Mandatory Primary Care Provider notification required when treatment is provided without direct orders.
Mandatory patient follow-up required when treatment is provided: phone call in 24 hours & home visit in 48-72 hours

Clinical Considerations:

If a patient is on home O2 consider flow rate titration to improve oxygenation.

Consider to ascertain a point-of-care order during the mandatory patch point, if applicable.

When considering an antibiotic a community paramedic should determine if a patient has received Amoxicillin, Doxycycline or Clarithromycin in the past with good effect to determine the most appropriate first line. In the absence of prior treatment, or if a patient does not recall previous treatments, a community paramedic should treat according to the following escalation:

First line: Amoxicillin
Second line: Doxycycline
Third line: Clarithromycin
Fourth line: Co-Amoxiclav

Acute Heart Failure Episode Medical Directive

A Community Paramedic may provide the treatment prescribed in this Medical Directive if authorized, or in collaboration with the Primary Care Provider.

Indications:

Respiratory distress; **OR** Fluid retention; **OR** Acute episode.

Conditions:

Furosemide	
Age	≥ 18 years
LOA	Unaltered
HR	N/A
RR	N/A
SBP	Normotension
Other	Prior use of Furosemide

Contraindications:

Furosemide
Allergy or sensitivity to Furosemide or Sulfa class drugs

Physician Consultation Point

Contact the Primary Care Physician for consultation prior to administration of treatment.

Treatment:

The Community Paramedic is able to provide the patient up to a 3 day supply of medication. After 3 days the patient will be required to fill a prescription to continue treatment if directed by their Primary Care Provider.

Consider PO Furosemide	
Dose	As Rx or consultation
Route	PO
Max. # of doses	As Rx or consultation
Duration	3 Days

Consider SC Furosemide	
Dose	As Rx or consultation
Route	SC
Max. # of doses	As Rx or consultation
Duration	3 Days

Mandatory patient follow-up required when treatment is provided: phone call in 24 hours & home visit in 48-72 hours

Clinical Considerations:

If a patient is on home O2 consider flow rate titration to improve oxygenation.

A community paramedic may consider to assess the weight of the patient over a course of treatment to support informed clinical decision making.

Consider to ascertain a point-of-care order during the mandatory patch point, if required.

Hypoglycemia Medical Directive

A Community Paramedic may provide the treatment prescribed in this Medical Directive if authorized, or in collaboration with the Primary Care Provider.

Indications:

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

Conditions:

Dextrose	
Age	≥ 18 years
LOA	Altered
HR	N/A
RR	N/A
SBP	N/A
Other	Hypoglycemia

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

Contraindications:

Dextrose
Allergy or sensitivity to Dextrose

Glucagon
Allergy or sensitivity or Glucagon
Pheochromocytoma

Consider Physician Consultation Point

If any concerns regarding the clinical stability of the patient, or appropriateness of the directive for treatment, contact the Primary Care Physician for consultation prior to administration of treatment.

Treatment:

Consider Dextrose (D10W)	
Dose	0.2 g/kg (2 ml/kg)
Route	IV
Max. single dose	25 g (250 ml)
Dosing interval	10 min
Max. # of doses	2

Titrate dextrose to a level of awareness where the patient can safely consume complex carbohydrate.

Consider Glucagon		
	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

Mandatory post treatment blood glucose ≥ 5.0mmol/L for 30 minutes required prior to discharging patient.
Mandatory Primary Care Provider notification required when treatment is provided without direct orders.
Mandatory patient follow-up required when treatment is provided: phone call in 12 hours & home visit in 24-48 hours

Clinical Considerations:

If the patient responds to dextrose or glucagon, they 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.

Intravenous and Fluid Therapy Medical Directive

A Community Paramedic may provide the treatment prescribed in this Medical Directive if authorized, or in collaboration with the Primary Care Provider.

Indications:

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

An order is received by the Primary Care Provider.

Conditions:

IV Cannulation	
Age	≥ 18 years
LOA	N/A
HR	N/A
RR	N/A
SBP	N/A
Other	N/A

0.9% NaCl Fluid Therapy	
Age	≥ 18 years
LOA	N/A
HR	N/A
RR	N/A
SBP	N/A
Other	N/A

Contraindications:

IV Cannulation
Suspected fracture proximal to the access site

0.9% NaCl Fluid Therapy
Fluid overload

Physician Consultation Point

Contact the Primary Care Physician for consultation prior to administration of treatment where no prior order has been received.

Treatment:

Consider 0.9% NaCl fluid therapy	
	Age
	≥ 18 years
	Route
	IV
Infusion rate	As Rx
Infusion volume	As Rx
Reassess every	250 ml*
Max. volume	1,000 ml

***** A community paramedic may consider to leave a patient with a maintenance infusion rate to a maximum of 60ml/hr after ensuring there are no complications with the infusion, and the community paramedic has reasonable grounds to believe the patient and/or SDM/caregiver is capable with respect to the monitoring of the treatment and notifying the community paramedic if a situation rises.

Prior to release from care, the patient and/or SDM/caregiver must be provided with education on self-management, signs and symptoms of complications, and community paramedic contact information. Community paramedics must document these instructions and patient and/or SDM/caregiver consent to the plan of care.

Treatment must be completed or discontinued prior to discharging patient
Mandatory patient follow-up required when treatment is provided: phone call within 24 hours

Clinical Considerations:

If considering to release a patient from care with a maintenance infusion, community paramedics should exercise a high degree of caution for patients with a PMHx of CHF, renal failure, and/or high dose of Rx diuretics.

A community paramedic may consider to re-establish IV access without receiving written/verbal orders, if in alignment with the patient's goals of care and current clinical status in the case where IV access has been lost.

A community paramedic will remove the cannula after the treatment provided if further treatment is not anticipated. In the event the treatment is prolonged, the cannula should be changed every 72 hours or sooner if necessary.

Urinary Tract Infection Medical Directive

A Community Paramedic may provide the treatment prescribed in this Medical Directive if authorized, or in collaboration with the Primary Care Provider.

Indications:

Known or suspected urinary tract infection

Conditions:

Amoxicillin	
Age	≥ 18 years
LOA	N/A
HR	N/A
RR	N/A
SBP	N/A
Other	Urinalysis test positive for Nitrites, Leukocytes, and/or blood

Fosfomycin	
Age	≥ 18 years
LOA	N/A
HR	N/A
RR	N/A
SBP	N/A
Other	Urinalysis test positive for Nitrites, Leukocytes, and/or blood

Co-Amoxiclav	
Age	≥ 18 years
Weight	≥40 kg
LOA	N/A
HR	N/A
RR	N/A
SBP	N/A
Other	Symptomatic with indwelling catheter; or positive culture; or suspected complex UTI

Contraindications:

Amoxicillin
Allergy or sensitivity to Amoxicillin or Penicillin

Fosfomycin
Allergy or sensitivity to Fosfomycin or any component of the formulation

Co-Amoxiclav
Allergy or sensitivity to Co-Amoxiclav or Penicillin

Physician Consultation Point

Contact the Primary Care Physician for consultation prior to administration of treatment.

Treatment:

The Community Paramedic is able to provide the patient up to a 3 day supply of medication. After 3 days the patient will be required to fill a prescription to continue treatment if directed by their Primary Care Provider.

Consider Amoxicillin	
Dose	500 mg
Route	PO
Max. # of doses	TID
Duration	3 Days

Consider Fosfomycin	
Dose	3 g
Route	PO
Max. # of doses	1
Duration	Single Dose

Consider Co-Amoxiclav	
Dose	500/125 mg
Route	PO
Max. # of doses	BID
Duration	3 Days

Mandatory patient follow-up required when treatment is provided: phone call in 24 hours & home visit in 48-72 hours

Clinical Considerations:

A community paramedic must practice antibiotic stewardship and ensure that asymptomatic bacteria is not over treated with antibiotics when no symptoms are present.

Urinary tract infections (UTIs) are among the most common causes of sepsis presenting in hospitals. UTIs have a wide variety of presentations. Some are simple UTIs that can be managed with outpatient antibiotics and carry a reassuring clinical course with an almost universally good outcome. On the other end of the spectrum, florid urosepsis in a comorbid patient can be fatal. UTIs can also be complicated by several risk factors leading to treatment failure, repeat infections, or significant morbidity and mortality with a poor outcome. It is vitally important to determine if the presenting episode results from these risk factors and whether the episode is likely to resolve with first-line antibiotics.

A community paramedic will exercise a high degree of suspicion when considering possible urinary tract infection and relay pertinent history (e.g. indwelling catheter, recurring UTI etc.) and assessment findings to the primary care provider for consideration for possible treatment options.

Catheter-acquired urinary tract infection or recurrent infections within a 30 day period is one of the most common health care acquired infections. The most common clinical presentation of symptomatic catheter-acquired urinary infection is fever alone. Catheter-acquired urinary tract infections can be difficult to detect and we cannot rely upon fever or urinary sediment alone. Fever, hypothermia, abdominal/pelvic pain, nausea, confusion and/or reduced PO intake are all among the symptoms that must be present to make a diagnosis. A community paramedic should inquire about anti pyretic's used when patching to the physician.

Analgesia Medical Directive

A Community Paramedic may provide the treatment prescribed in this Medical Directive if authorized, or in collaboration with the Primary Care Provider.

Indications:

Pain.

Conditions:

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

Ibuprofen	
Age	≥ 18 years
LOA	Unaltered
HR	N/A
RR	N/A
SBP	N/A
Other	N/A

Contraindications:

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

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

Consider Physician Consultation Point

If any concerns regarding the clinical stability of the patient, or appropriateness of the directive for treatment, contact the Primary Care Physician for consultation prior to administration of treatment.

Treatment:

Consider Acetaminophen	
Dose	960-1,000 mg
Route	PO
Max. single dose	1,000 mg
Dosing interval	N/A
Max. single doses	3 Days

Consider Ibuprofen	
Dose	400 mg
Route	PO
Max. single dose	400 mg
Dosing interval	N/A
Max. single doses	3 Days

Mandatory patient follow-up required when treatment is provided: phone call in 12 hours & home visit in 24-48 hours

Clinical Considerations:

Whenever possible, consider co-administration of Acetaminophen and Ibuprofen.

Suspected renal colic patients should be considered for Ibuprofen only.

Uncomplicated headache conforming to the patient's usual pattern should be considered for Acetaminophen only.

Febrile patients may be considered for Acetaminophen only.

Nausea/Vomiting Medical Directive

A Community Paramedic may provide the treatment prescribed in this Medical Directive if authorized, or in collaboration with the Primary Care Provider.

Indications:

Nausea **OR** vomiting.

Conditions:

Ondansetron	
Age	≥ 18 years
Weight	≥ 25kg
LOA	Unaltered
HR	N/A
RR	N/A
SBP	N/A
Other	N/A

Dimenhydrinate	
Age	≤ 65 years
Weight	≥ 25kg
LOA	Unaltered
HR	N/A
RR	N/A
SBP	N/A
Other	N/A

Contraindications:

Ondansetron
Allergy or sensitivity to Ondansetron
Prolonged QT syndrome (known to patient)
Apomorphine use

Dimenhydrinate
Allergy or sensitivity to Dimenhydrinate
Overdose on antihistamines or anticholinergics or tricyclic antidepressants
Co-administration of Diphenhydramine

Consider Physician Consultation Point

If any concerns regarding the clinical stability of the patient, or appropriateness of the directive for treatment, contact the Primary Care Physician for consultation prior to administration of treatment.

Treatment:

Consider Ondansetron	
Dose	4 mg
Route	PO
Max. single dose	4 mg
Dosing interval	N/A
Max. # of doses	1

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

Mandatory patient follow-up required when treatment is provided: phone call in 12 hours & home visit in 24-48 hours

Clinical Considerations:

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

If a patient has received Ondansetron and has no relief of their nausea and vomiting symptoms after 30 minutes, Dimenhydrinate may be considered (or vice versa).

POINT-OF-CARE DIRECTIVES

Urinalysis Medical Directive

A Community Paramedic may provide the treatment prescribed in this Medical Directive if authorized, or in collaboration with the Primary Care Provider.

Indications:

Patient exhibiting signs and symptoms suggestive of a urinary tract infection (urgency, frequency, dysuria, hematuria, fevers, chills, nausea, abdominal pain); **OR**

Suspected exacerbation of Diabetes Mellitus where the paramedic feels the patient may benefit from this directive; **OR**

Where the community paramedic feels the patient may benefit from this directive.

Conditions:

Urinalysis	
Age	≥ 18 years
LOA	N/A
HR	N/A
RR	N/A
SBP	Normotension
Other	N/A

Contraindications:

Urinalysis
N/A

Consider Physician Consultation Point

If any concerns regarding the clinical stability of the patient, or appropriateness of the directive for treatment, contact the Primary Care Physician for consultation prior to administration of treatment.

Treatment:

Urinalysis
1. Obtain urine sample per best practice guidelines
2. Perform test as per manufacturer's guidelines
3. Provide results to Primary Care Provider: verbal report required if a value is outside normal ranges

Clinical Considerations:

Urinalysis is the physical, chemical and microscopic examination of urine to detect and measure various compounds that pass through the urine. Urinalysis may be performed to detect compounds present in urine for patients with diabetes, kidney disease and/or diagnosis of urinary tract infections.

Point-of-Care Blood Test Medical Directive

A Community Paramedic may provide the treatment prescribed in this Medical Directive if authorized, or in collaboration with the Primary Care Provider.

Indications:

Suspected exacerbation of Diabetes Mellitus, Chronic Obstructive Pulmonary Disease, Heart Failure; **OR**

Chronic kidney disease, suspected delirium, or suspected infection Not Yet Diagnosed (NYD); **OR**

Where the community paramedic feels the patient may benefit from this directive.

Conditions:

Venipuncture	
Age	≥18 years
LOA	N/A
HR	N/A
RR	N/A
SBP	Normotension
Other	N/A

Contraindications:

Venipuncture
Veins in the lower limbs, abdomen or chest
Affected arm of a mastectomy patient
Arm containing a hemodialysis port
Arm with a intravenous solution in progress
Areas of broken, bruised or erythematous skin

Consider Physician Consultation Point

If any concerns regarding the clinical stability of the patient, or appropriateness of the directive for treatment, contact the Primary Care Physician for consultation prior to administration of treatment.

Treatment:

Obtaining a blood sample through venipuncture	
1.	Obtain necessary equipment and wash hands thoroughly for 30 seconds before applying PPE
2.	Explain procedure and expected outcomes to patient/SDM
3.	Select an appropriate site – see contraindications
4.	Position the patients arm in a comfortable extended position with adequate access to the chosen site
5.	Apply the tourniquet approximately 4-5 finger-widths above the planned venipuncture site
6.	Palpate the vein you have identified to assess if it is suitable
7.	Clean the site with an alcohol swab starting in the middle and moving outwards, allow to dry
8.	Unsheathe the butterfly needle
9.	Insert the needle at a 30 degree angle or less with the bevel facing upwards
10.	Advance the needle a further 1-2 mm into the vein after flashback is noted to ensure you are within the lumen
11.	Lower and anchor the needle to the patient's skin using the wings of the butterfly needle
12.	Attach blood sample collection device
13.	Release the tourniquet
14.	Withdraw the needle, apply gentle pressure to the site with gauze
15.	Immediately dispose of the needle into a sharps container
16.	Perform test as per the manufacturer's guidelines
17.	Provide results to Primary Care Provider: verbal report required if a value is outside normal range
18.	Document date/time/location of the venipuncture on associated report

Clinical Considerations:

The Community Paramedic is able to sample blood and provide reliable results to patients and Primary Care Provider on site including CHEM 8.

Mandatory Primary Care Provider notification is required if a value is outside normal range.

Analyte Value Reference Chart

Analyte	i-STAT Range
Sodium (Na)	138 –146 mmol/L
Potassium (K)	3.5 – 4.9 mmol/L
Chloride (Cl)	98 – 109 mmol/L
Total Carbon Dioxide (TCO2)	24 – 29 mmol/L
Anion Gap	10 – 20 mEq/L
Ionized Calcium (iCa)	1.12 – 1.32 mmol/L
Glucose (Gl)	3.9 – 5.8 mmol/L
Urea	2.9 – 9.4 mmol/L
Creatinine (Crea)	53 – 115 µmol/L
Hematocrit (Hct)	38 – 51%
Hemaglobin (Hgb)	120 – 170 g/L

Hemoglobin A1C Test Medical Directive

A Community Paramedic may provide the treatment prescribed in this Medical Directive if authorized, or in collaboration with the Primary Care Provider.

Indications:

Received written/verbal order from the patients Primary Care Provider; **OR**

Patient exhibiting signs and symptoms suggestive of Diabetes Mellitus where the paramedic feels the patient may benefit from this directive.

Conditions:

Hemoglobin A1C	
Age	≥ 18 years
LOA	N/A
HR	N/A
RR	N/A
SBP	N/A
Other	Physician order is obtained

Contraindications:

Hemoglobin A1C
N/A

Consider Physician Consultation Point

If any concerns regarding the clinical stability of the patient, or appropriateness of the directive for treatment, contact the Primary Care Physician for consultation prior to administration of treatment.

Treatment:

Hemoglobin A1C	
1.	Obtain blood sample per best practice guidelines
2.	Perform test as per manufacturer's guidelines
3.	Provide results to Primary Care Provider

Clinical Considerations:

The hemoglobin A1C or HbA1c test is a simple blood test that measures the average blood sugar levels over the past 3 months.

The hemoglobin A1C is one of the commonly used tests to diagnose prediabetes and diabetes, and is the leading test used by primary care providers to manage diabetes.

A1C / Estimate Average Glucose Levels

	A1C Percentage	Estimated Average Glucose (EAG)	
In-range	< 5.7%	< 117 mg/dL	6.5 mmol/L
Prediabetes	5.7 – 6.4%	117 – 137 mg/dL	6.5 – 7.6 mmol/L
Diabetes	> 6.4%	> 137 mg/dL	> 7.6 mmol/L
Increased risk of complications ↓	6.5%	140 mg/dL	7.8 mmol/L
	7.0%	154 mg/dL	8.6 mmol/L
	7.5%	169 mg/dL	9.4 mmol/L
	8.0%	183 mg/dL	10.1 mmol/L
	8.5%	197 mg/dL	10.9 mmol/L
	9.0%	212 mg/dL	11.8 mmol/L
	9.5%	226 mg/dL	12.6 mmol/L
	10.0%	240 mg/dL	13.4 mmol/L

COMPLEX CARE DIRECTIVES

Nausea or Vomiting Medical Directive

A Community Paramedic may provide the treatment prescribed in this Medical Directive if authorized and, in collaboration with the Primary Palliative Care Provider and the patient/SDM, to honour wishes to remain at home.

Assessment:

History and physical assessment; **AND**

Complete set of vitals; **AND**

Palliative Performance Scale; **AND**

Edmonton Symptom Assessment System; **AND**

Do Not Resuscitate – Goals of care.

Indications:

Stated palliative goals of care; **AND** Nausea and/or vomiting.

Conditions:

Haloperidol	
Age	≥ 18 years
LOA	N/A
HR	N/A
RR	N/A
SBP	N/A
Other	N/A

Contraindications:

Haloperidol
Allergy or sensitivity to Haloperidol

Physician Consultation Point

Contact the Primary Palliative Care Provider for consultation prior to administration of treatment.

Treatment:

Consider Haloperidol	
Dose	0.5 - 1.0 mg
Route	SC
Dosing interval	4 hours
Max. # of doses	3

Dosage & Volume:

Haloperidol
0.5 mg = 0.1 ml
1.0 mg = 0.2 ml

Clinical Considerations:

Dimenhydrinate is rarely used in the palliative care population as it can cause delirium, increase drowsiness, and does not target the appropriate receptors to control the nausea in most patients. It should only be used in patients with contraindications to haloperidol where haloperidol cannot be used.

Hallucination or Agitation Medical Directive

A Community Paramedic may provide the treatment prescribed in this Medical Directive if authorized and, in collaboration with the Primary Palliative Care Provider and the patient/SDM, to honour wishes to remain at home.

Assessment:

History and physical assessment; **AND**

Complete set of vitals; **AND**

Palliative Performance Scale; **AND**

Edmonton Symptom Assessment System; **AND**

Do Not Resuscitate – Goals of care.

Indications:

Stated palliative goals of care; **AND** Increased agitation or suspected new or increased hallucinations.

Conditions:

Haloperidol	
Age	≥ 18 years
LOA	N/A
HR	N/A
RR	N/A
SBP	N/A
Other	N/A

Midazolam	
Age	≥ 18 years
LOA	N/A
HR	N/A
RR	N/A
SBP	N/A
Other	N/A

Lorazepam	
Age	≥ 18 years
LOA	N/A
HR	N/A
RR	N/A
SBP	N/A
Other	N/A

Contraindications:

Haloperidol
Allergy or sensitivity to Haloperidol
Known Parkinson's or Lewy Body Dementia
Neuroleptic Malignant Syndrome

Midazolam
Allergy or sensitivity or Midazolam

Lorazepam
Allergy or sensitivity to Lorazepam
Delirium
≥ 75 y/o with advanced disease

Physician Consultation Point

Contact the Primary Palliative Care Provider for consultation prior to administration of treatment.

Treatment:

Consider Haloperidol	
Dose	2.0 mg
Route	SC
Dosing interval	1 hour
Max. # of doses	2

Consider Midazolam	
Dose	0.5 - 2 mg
Route	SC
Dosing interval	1 hour
Max. # of doses	2

Consider Lorazepam	
Dose	1.0 mg
Route	SL
Dosing interval	2 hours
Max. # of doses	1

Dosage & Volume:

Consider Haloperidol
2.0 mg = 0.4 ml

Consider Midazolam
0.5 mg = 0.1 ml
1.0 mg = 0.2 ml
1.5 mg = 0.3 ml
2.0 mg = 0.4 ml

Consider Lorazepam
1 mg

Clinical Considerations:

Haloperidol should be used as the first line agent for the treatment of agitation and hallucinations. Midazolam can be used in patients with contraindications to Haloperidol. Lorazepam can be used for mild to moderate anxiety.

Pain or Dyspnea Medical Directive

A Community Paramedic may provide the treatment prescribed in this Medical Directive if authorized and, in collaboration with the Primary Palliative Care Provider and the patient/SDM, to honour wishes to remain at home.

Assessment:

History and physical assessment; **AND**

Complete set of vitals; **AND**

Palliative Performance Scale; **AND**

Edmonton Symptom Assessment System; **AND**

Do Not Resuscitate – Goals of care.

Indications:

Stated palliative goals of care; **AND**

Uncontrolled pain or dyspnea.

Conditions:

Hydromorphone	
Age	≥ 18 years
LOA	N/A
HR	N/A
RR	N/A
SBP	N/A
Other	N/A

Contraindications:

Hydromorphone
Allergy or sensitivity to Hydromorphone

Physician Consultation Point

Contact the Primary Palliative Care Provider for consultation prior to administration of treatment.

Treatment:

Consider Hydromorphone	
Dose	0.5 - 2 mg
Route	SC
Dosing interval	4 hours
Max. # of doses	4

Dosage & Volume:

Hydromorphone
0.5 mg = 0.25 ml
1.0 mg = 0.50 ml
1.5 mg = 0.75 ml
2.0 mg = 1.0 ml

Clinical Considerations:

If existing orders are available for the patient, hydromorphone may be administered within the range specified within this directive. If there are no orders available or patients are opioid naïve the lower range of doses should be used. If the patient is already on a regular opiate, the same opiate should be used. If the patient is on a regular opiate regimen that does not include hydromorphone and does not have emergency orders available, paramedics should confirm medication and dose with the on call PCOT.

Terminal Congested Breathing Medical Directive

A Community Paramedic may provide the treatment prescribed in this Medical Directive if authorized and, in collaboration with the Primary Palliative Care Provider and the patient/SDM, to honour wishes to remain at home.

Assessment:

History and physical assessment; **AND**

Complete set of vitals; **AND**

Palliative Performance Scale; **AND**

Edmonton Symptom Assessment System; **AND**

Do Not Resuscitate – Goals of care.

Indications:

Stated palliative goals of care; **AND**

Congested/loud/rattling breathing in patients near the end of life.

Conditions:

Scopolamine	
Age	≥ 18 years
LOA	N/A
HR	N/A
RR	N/A
SBP	N/A
Other	N/A

Contraindications:

Scopolamine
Allergy or sensitivity to Scopolamine

Physician Consultation Point

Contact the Primary Palliative Care Provider for consultation prior to administration of treatment.

Treatment:

Consider Scopolamine	
Dose	0.4 mg
Route	SC
Dosing interval	4 hours
Max. # of doses	4

Dosage & Volume:

Scopolamine
0.4 mg = 1.0 ml

Clinical Considerations:

Patient repositioning and gentle turning of the head to the side can be done instead of medication. However suction of the oropharynx is not appropriate as it will likely cause discomfort and a gag reflex.

Status Epilepticus Medical Directive

A Community Paramedic may provide the treatment prescribed in this Medical Directive if authorized and, in collaboration with the Primary Palliative Care Provider and the patient/SDM, to honour wishes to remain at home.

Assessment:

History and physical assessment; **AND**

Complete set of vitals; **AND**

Palliative Performance Scale; **AND**

Edmonton Symptom Assessment System; **AND**

Do Not Resuscitate – Goals of care.

Indications:

Stated palliative goals of care; **AND**

Patient is in status seizure.

Conditions:

Midazolam	
Age	≥ 18 years
LOA	N/A
HR	N/A
RR	N/A
SBP	N/A
Other	N/A

Contraindications:

Midazolam
Allergy or sensitivity to Midazolam

Treatment:

Consider Midazolam	
Dose	5 mg
Route	SC
Dosing interval	5 min
Max. # of doses	3

Dosage & Volume:

Consider Midazolam
5 mg = 1.0 ml

Physician Consultation Point

Contact the Primary Palliative Care Provider for consultation following the administration of treatment.

Clinical Considerations:

A physician consultation patch is not required prior to the initial dose.

This protocol may be applied to a seizure that has not self-terminated within 2 minutes.

Terminal Bleed Medical Directive

A Community Paramedic may provide the treatment prescribed in this Medical Directive if authorized and, in collaboration with the Primary Palliative Care Provider and the patient/SDM, to honour wishes to remain at home.

Assessment:

History and physical assessment; **AND**

Complete set of vitals; **AND**

Palliative Performance Scale; **AND**

Edmonton Symptom Assessment System; **AND**

Do Not Resuscitate – Goals of care.

Indications:

Stated palliative goals of care; **AND**

Suspected terminal arterial bleed.

Conditions:

Midazolam	
Age	≥ 18 years
LOA	N/A
HR	N/A
RR	N/A
SBP	N/A
Other	N/A

Contraindications:

Midazolam
Allergy or sensitivity to Midazolam

Treatment:

Consider Midazolam	
Dose	10 mg
Route	SC
Dosing interval	10 min
Max. # of doses	3

Dosage & Volume:

Consider Midazolam
10 mg = 2.0 ml

Physician Consultation Point

Contact the Primary Palliative Care Provider for consultation following the administration of treatment.

Clinical Considerations:

A physician consultation patch is not required prior to the initial dose.

Consider need for assistance from the Primary Palliative Care Provider, other Community Paramedics or an Operations Superintendent.

Although very uncommon, catastrophic events at end of life can be very distressing to patients, families and caregivers. Providing sedation to a patient in these circumstances is acceptable standard of care.

Subcutaneous Port Initiation and/or Medication Administration Medical Directive

A Community Paramedic may provide the treatment prescribed in this Medical Directive if authorized and, in collaboration with the Primary Palliative Care Provider and the patient/SDM, to honour wishes to remain at home.

Assessment:

History and physical assessment; **AND**

Complete set of vitals; **AND**

Palliative Performance Scale; **AND**

Edmonton Symptom Assessment System; **AND**

Do Not Resuscitate – Goals of care.

Indications:

Stated palliative goals of care; **AND**

An order is received by the Primary Palliative Care Provider to establish/change a subcutaneous port for administration of medication and/or fluids; **OR**

An order is received by the Primary Palliative Care Provider to administer medication through a subcutaneous port**.**

Conditions:

SC Port Cannulation	
Age	≥ 18 years
LOA	N/A
HR	N/A
RR	N/A
SBP	N/A
Other	N/A

Contraindications:

Establishing a SC Port Cannulation
Suspected fracture proximal to the access site

Consider Physician Consultation Point

If any concerns regarding the clinical stability of the patient, or appropriateness of the directive for treatment, contact the Primary Care Physician for consultation prior to administration of treatment.

Treatment:

Establishing a SC Port	
1.	Obtain necessary equipment
2.	Wash hand thoroughly for 30 seconds and apply appropriate PPE
3.	Explain procedure and expected outcomes to patient/SDM
4.	Select an appropriate SC port insertion site – Preferred sites are upper arms, abdomen, anterior aspect of thighs , above the scapula and sub clavicular chest wall
5.	Rotate SC catheter safety barrel to loosen needle inside catheter
6.	Cleanse selected SC port insertion site
7.	Remove protective shield from needle
8.	Using thumb and index finger create a roll of tissue (~2.5 cm) around selected insertion site
9.	Insert entire length of needle bevel up at 45-degree angle
10.	If blood appears in the tubing, remove and discard the device, select new site and start over
11.	Stabilize catheter, grasp safety barrel and pulling in a straight continuous motion, remove needle
12.	Insert 3ml syringe with interlink cannula and gently draw plunger to assess for blood return
13.	Cover insertion site, hub and wings with transparent moisture-responsive dressing

14.	Loop and secure excess tubing with transparent moisture-responsive dressing
15.	Document the date, time and your signature on the SC port

Treatment:

Administering medication through a SC Port	
1.	Determine whether an existing SC port, or one must be established. You require one port per medication.
2.	Obtain necessary equipment
3.	Wash hand thoroughly for 30 seconds and apply appropriate PPE
4.	Explain procedure and expected outcomes to patient/SDM
5.	Draw up medication order
6.	Assess the SC port for damage or signs of infection
7.	Cleanse the interlink injection cap
8.	Insert the medication syringe into the injection cap and gently draw back on the plunger
9.	If blood appears in tubing, remove and discard the SC injection device
10.	If no blood appears in the tubing, instill the medication – DO NOT EXCEED A MAXIMUM OF 2 ML
11.	Wait 15-20 minutes to assess absorption of the medication
12.	If establishing a new port, it is best to prime the port with medication NOT saline. Tubing has a capacity of 0.4 ml and if you do not prime a new port with medication then the patient will not receive a first dose.
13.	Document the medication administered, date, time and your signature on the SC port

Clinical Considerations:

The subcutaneous site should be changed every seven (7) days or sooner, if necessary. When changing sites, the chosen sites should be rotated to avoid using the same site repeatedly.

ICD Deactivation Medical Directive

A Community Paramedic may provide the treatment prescribed in this Medical Directive if authorized and, in collaboration with the Primary Palliative Care Provider and the patient/SDM, to honour wishes to remain at home.

Assessment:

History and Physical Assessment; **AND**

Obtain and document informed consent for deactivation from patient/SDM; **AND**

Obtain a limited baseline set of vitals, if tolerated (BP, HR, RR); **AND**

Palliative Performance Scale; **AND**

Do Not Resuscitate – Goals of care.

Indications:

Receiving a palliative approach to care; **AND**

Urgent need for ICD deactivation to suspend shock therapy which align with goals of care.

Conditions:

Medical grade ICD magnet	
Age	≥ 18 years
LOA	N/A
HR	N/A
RR	N/A
SBP	N/A
Other	N/A

Contraindications:

Medical grade ICD magnet
ICD not activated

Physician Consultation Point

Contact the Primary Palliative Care Provider for consultation prior to administration of treatment.

Treatment

Consider Placement of ICD magnet
1. Locate and palpate the ICD
2. Placed and secure the magnet over the ICD
3. Document date/time/location of magnet application

Clinical Considerations:

Leave magnet in place until time of death. Death is not usually immediate after deactivation of an ICD. A paramedic, in consultation with the physician, may leave the patient/residence after application of the ICD magnet if no other care or symptom management is required. The goal of deactivation is to avoid unnecessary pain and discomfort to the patient. If leaving scene prior to time of death, follow local procedure for recovery of magnet. Once the magnet is applied the device may emit a tone for approximately 10-20 seconds. Not all devices will have this feature. The magnet will not turn off pacing functions.

Palliative Patient Pronouncement Medical Directive

A Community Paramedic may provide the treatment prescribed in this Medical Directive if authorized and, in collaboration with the Primary Palliative Care Provider and the patient/SDM, to honour wishes to remain at home.

Assessment:

History and assessment to confirm death; **AND**

Expected Death in the Home (EDITH); **AND**

Do Not Resuscitate (DNR) – Goals of care.

Indications:

Receiving a palliative approach to care; **AND**

Death was anticipated as a result of a progressive end stage terminal illness; **AND**

Death has occurred.

Conditions:

Palliative Patient Pronouncement	
Age	≥ 18 years
LOA	N/A
HR	0
RR	0
SBP	0
Other	Deceased

Contraindications:

Palliative Patient Pronouncement
Suspicious death; **OR**
Unanticipated death not related to the progressive end stage terminal illness (i.e.: fall)

Treatment:

Palliative Patient Pronouncement	
1.	Confirm the patient is deceased;
2.	Ensure the deceased patient is treated with respect and dignity;
3.	Consider the needs of family members of the deceased and provide compassion-informed decision-making;
4.	Notify the physician of the deceased patient and request confirmation of pronouncement of death;
5.	Determine if the physician or designated health care provider wishes to attend the scene;
6.	If there is a responsible person on-scene, and the paramedic reasonably believe that the responsible person will remain until the physician or designated health care provider arrives, determine if the paramedic shall remain or depart the scene;
7.	If the physician or designated health care provider is unable to attend, or there is no reasonable person on-scene, the paramedic shall notify police or coroner of the death and that there is no one else at scene who can take responsibility for the deceased patient; and
8.	If requested by the coroner, the paramedic will provide the coroner with the circumstances of the death; the paramedic will either be released from the scene or instructed to remain with the deceased patient until the coroner or a person appointed by a coroner or to whom a coroner has delegated any powers or authority pursuant to the Coroners Act (Ontario) or a Responsible Person can attend the scene and assume responsibility for the deceased patient;
9.	Discontinue and disconnect all medication ports and/or IV lines;
10.	Complete section 4 (Pronouncement Information) of the Expected Death in the Home (EDITH) form
11.	Notify the assigned nursing agency of the patient death, and pronouncement is complete;
12.	Notify HCCSS Complex Team and provide death notification
13.	Document date, time of death, and pronouncing physician in the associated Electronic Medical Record (EMR).

Clinical Considerations:

A Community Paramedic, in consultation with the physician and/or coroner, may leave the Deceased Patient/residence after pronouncement of death if no other care or support is required.

Expected Death in the Home (EDITH) Protocol- Community Paramedicine

	Expected death with EDITH completed	Expected death with DNR only and PCOT physician in place	Death is NOT expected, no planning or DNR in place	Expected death with DNR and/or EDITH in place BUT unexpected circumstances leading to death in the home
EDITH	Completed	None	None	Completed
DNR & DNR-C	Completed	Completed	None	Completed
Action required	Follow plan in EDITH and call PCOT physician	Confirm plan with family (if applicable), contact PCOT physician to confirm plan. If unable to contact PCOT physician call the coroner's office	Call 911 as no DNR is in place. If family do not want resuscitation inform the transporting unit immediately upon arrival	Call 911 as unexpected circumstances have lead to the death. Complete a Community Paramedicine Incident Report.
Pronouncement of death	Community Paramedic pronounces death via patch with the PCOT physician	Community Paramedic pronounces death via patch with the PCOT physician	Transporting unit consults with base hospital physician for termination of resuscitation (TOR)	
Transfer to funeral home	Complete section 4 of EDITH form. Family or Community Paramedic calls funeral home	If EDITH is not completed, CP to consult with family to determine funeral home. Funeral home is then notified by family or CP	Coroner is contacted by transporting unit or police and arrangements are made for transport of body to the funeral home	
	***Note:** for patients without a caregiver to assume responsibility for the deceased, the Coroner is contacted. In this situation the physician can not sign the death certificate.			
Completion of Medical Death Certificate	PCOT physician completes electronic certificate of death within 24 hours	PCOT physician completes electronic certificate of death within 24 hours	Coroner signs death certificate	

Palliative Care Outreach Team (PCOT): 844-779-1834 ext. 1, 2 or 3

Coroner's Office: 1-855-299-4100

A Community Paramedic will notify the HCCSS Complex Team (519-474-5754) with confirmation of a palliative patient pronouncement by calling and leaving a voice message with the following:

- Community Paramedic name;
- Community Paramedic contact number;
- Patient name;
- Reason for calling;
- Date;
- Time of death;
- Location of death; AND
- Name of pronouncing physician.

Palliative Care Symptom Relief Kit Utilization Medical Directive

A Community Paramedic may provide treatment using a patient's symptom relief kit (SRK) as outlined in this Medical Directive if authorized by the Primary Palliative Care Provider, and the patient/SDM, to honour wishes to remain at home.

Assessment:

History and physical assessment; **AND**

Complete set of vitals; **AND**

Palliative Performance Scale; **AND**

Edmonton Symptom Assessment System; **AND**

Do Not Resuscitate – Goals of care.

Indications:

Stated palliative goals of care; **AND**

An order is received from the Primary Palliative Care Provider to utilize a medication within the patients SRK.

Conditions:

As defined by the Primary Palliative Care Provider.

Contraindications:

As defined by the Primary Palliative Care Provider.

Treatment:

As ordered by the Primary Palliative Care Provider.

Clinical Considerations:

A Community Paramedic may be authorized by the Primary Palliative Care Provider to perform controlled acts outside of their Certification. In this circumstance, the Community Paramedic is required to perform the controlled act to a specific standard set out by the ordering Primary Palliative Care Provider.

Prior to administration of treatment a Community Paramedic shall determine if they have the authority to provide the ordered patient care management, it is appropriate to provide the ordered patient care management, and they are competent to provide the ordered patient care management.

If the Community Paramedic has any concerns regarding their skill and ability to comply with the ordered patient care management, the Community Paramedic should consider recommending a substitute Medical Directive within the *Community Paramedic Patient Care Standards*.

AUXILIARY DIRECTIVES

Osteoporosis Medication Administration Medical Directive

A Community Paramedic may provide the treatment prescribed in this Medical Directive if authorized, or in collaboration with the Primary Care Provider.

Indications:

Received written/verbal order from the patients Primary Care Provider.

Conditions:

Prolia	
Age	≥ 18 years
LOA	N/A
HR	N/A
RR	N/A
SBP	N/A
Other	Physician order is obtained

Contraindications:

Prolia
Allergy or sensitivity to Prolia

Consider Physician Consultation Point

If any concerns regarding the clinical stability of the patient, or appropriateness of the directive for treatment, contact the Primary Care Physician for consultation prior to administration of treatment.

Treatment:

Consider Prolia	
Dose	60mg (prefilled syringe)
Route	SC
Max. # of doses	1
Duration	Repeat q 6 months

Mandatory 15 minute post administration observation period for adverse reaction.
Mandatory Primary Care Provider notification of administration required when treatment is completed.

Clinical Considerations:

Prolia is administered as a single subcutaneous injection every 6 months. The injection can be administered in the upper arm, upper thigh, or abdomen. It can be given any time with or without food.

If any concerns regarding the clinical stability of a patient referred by the St. Joseph's Health Care London Division of Endocrinology contact:

SJHC Osteoporosis Physician On-Call

Monday, Friday	Geriatric Medicine (Administration)	519-646-6316
Tuesday, Wednesday, Thursday	Geriatric Medicine Osteoporosis Nurse	519-646-6100 ext. 64434

Shingles Vaccine Medication Administration Medical Directive

A Community Paramedic may provide the treatment prescribed in this Medical Directive if authorized, or in collaboration with the Primary Care Provider.

Indications:

Received written/verbal order from the patient's Primary Care Provider.

Conditions:

Shingrix	
Age	≥ 50 years
LOA	N/A
HR	N/A
RR	N/A
SBP	N/A
Other	Physician order is obtained

Contraindications:

Shingrix
Allergy or sensitivity to Shingrix
First dose administered < 2 months prior

Consider Physician Consultation Point

If any concerns regarding the clinical stability of the patient, or appropriateness of the directive for treatment, contact the Primary Care Physician for consultation prior to administration of treatment.

Treatment:

Consider Shingrix	
Dose	0.5mL (reconstituted vaccine)
Route	IM
Max. # of doses	1
Duration	Repeat q 2-6 months

Mandatory 15 minute post administration observation period for adverse reaction.
Mandatory Primary Care Provider notification of administration required when treatment is completed.

Clinical Considerations:

Shingrix is a vaccine indicated for prevention of herpes zoster (HZ) (shingles). Shingrix is not indicated for prevention of primary varicella infection (chickenpox).

Shingrix is administered in two doses (0.5 ml each) for maximum protection, with a gap of 2 to 6 months between doses.

Bronchoconstriction Medical Directive

A Community Paramedic may provide the treatment prescribed in this Medical Directive if authorized, or in collaboration with the Primary Care Provider.

Indications:

Respiratory distress;

AND

Suspected bronchoconstriction.

Conditions:

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

Contraindications:

Salbutamol
Allergy or sensitivity to Salbutamol

Consider Physician Consultation Point

If any concerns regarding the clinical stability of the patient, or appropriateness of the directive for treatment, contact the Primary Care Physician for consultation prior to administration of treatment.

Treatment:

Consider Salbutamol	
Dose	Up to 800 mcg (8 puffs)
Route	MDI
Max. single dose	800 mcg
Dosing interval	5-15 min PRN
Max. # of doses	3

Mandatory Primary Care Provider notification required when treatment is provided without direct orders.
Mandatory patient follow-up required when treatment is provided: phone call in 24 hours & home visit in 48-72 hours

Clinical Considerations:

The rate of administration should be 100 mcg approximately every 4 breaths.

A spacer should be used when administering salbutamol MDI.

Intravenous Antibiotic Medication Administration Medical Directive

A Community Paramedic may provide the treatment prescribed in this Medical Directive if authorized, or in collaboration with the Primary Care Provider.

Indications:

Received written/verbal order from the patient's Primary Care Provider.

Conditions:

Patient has received the first dose of the Rx IV antibiotic in hospital; **OR**

Patient has received prior treatment with the Rx IV antibiotic without adverse effect.

Contraindications:

Allergy or sensitivity to the Rx IV antibiotic.

Treatment:

As ordered by the Primary Care Provider.

Clinical Considerations:

A Community Paramedic may be authorized by the Primary Care Provider to perform controlled acts outside of their Certification. In this circumstance, the Community Paramedic is required to perform the controlled act to a specific standard set out by the ordering Primary Care Provider.

Prior to administration of treatment a Community Paramedic shall determine if they have the authority to provide the ordered patient care management, it is appropriate to provide the ordered patient care management, and they are competent to provide the ordered patient care management. If the Community Paramedic has any concerns regarding their skill and ability to comply with the ordered patient care management, the Community Paramedic will relay this to the primary care provider and consider recommending a substitute treatment plan.

A community paramedic may consider to leave a patient with a maintenance infusion rate to a maximum of 60ml/hr after ensuring there are no complications with the infusion, a responsible SDM/caregiver is on scene, and the community paramedic has reasonable grounds to believe the SDM/caregiver is capable with respect to the monitoring of the treatment and notifying the community paramedic if a situation rises.

A community paramedic may consider to re-establish IV access without receiving written/verbal orders, if in alignment with the patient's goals of care and current clinical status in the case where IV access has been lost.

A community paramedic will remove the cannula after the treatment provided if further treatment is not anticipated. In the event the treatment is prolonged, the cannula should be changed every 72 hours or sooner if necessary.

Suture/Staple Removal Medical Directive

A Community Paramedic may provide the treatment prescribed in this Medical Directive if authorized, or in collaboration with the Primary Care Provider.

Indications:

Received written/verbal order from the patient's Primary Care Provider.

Conditions:

Suture/Staple Removal	
Age	≥ 18 years
LOA	N/A
HR	N/A
RR	N/A
SBP	N/A
Other	N/A

Contraindications:

Suture/Staple Removal
N/A

Treatment:

Suture/Staple Removal
1. The Community Paramedic completes an appropriate assessment of the incision site, in addition to collecting the appropriate health history;
2. The Community Paramedic documents the assessment in the EMR as per the documentation guidelines;
3. The sutures/staples are removed according to practice standards while adhering to Universal Precautions;
4. Patient response is documented by the Community Paramedic according to documentation guidelines.

Clinical Considerations:

Prior to administration of treatment a Community Paramedic shall determine if they have the authority to provide the ordered patient care management, it is appropriate to provide the ordered patient care management, and they are competent to provide the ordered patient care management. If the Community Paramedic has any concerns regarding their skill and ability to comply with the ordered patient care management, the Community Paramedic will relay this to the primary care provider and consider recommending a substitute treatment plan. If there are any concerns regarding the clinical stability of the patient, or appropriateness of the treatment, a Community Paramedic will contact the Primary Care Physician for consultation prior to administration of treatment.

ADVERSE EVENT MANAGEMENT DIRECTIVES

Severe Allergic Reaction Medical Directive

A Community Paramedic may provide the treatment prescribed in this Medical Directive if authorized, or in collaboration with the Primary Care Provider.

Indications:

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

Conditions:

Epinephrine	
Age	≥ 18 years
LOA	N/A
HR	N/A
RR	N/A
SBP	N/A
Other	For anaphylaxis only

Contraindications:

Epinephrine
Allergy or sensitivity to Epinephrine

Treatment:

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

*The Epinephrine dose may be rounded to the nearest 0.05 mg

Activate 911 for transport and definitive care following the administration of treatment.
Mandatory Primary Care Provider notification of the adverse event is required following treatment and transport.

Clinical Considerations:

The community paramedic will provide notification of the adverse event to the primary care provider.

Cardiac Ischemia Medical Directive

A Community Paramedic may provide the treatment prescribed in this Medical Directive if authorized, or in collaboration with the Primary Care Provider.

Indications:

Suspected cardiac ischemia

Conditions:

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

Contraindications:

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

Treatment:

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

Activate 911 for transport and definitive care following the administration of treatment.
Mandatory Primary Care Provider notification of the adverse event is required following treatment and transport.

Clinical Considerations:

The community paramedic will provide notification of the adverse event to the primary care provider.

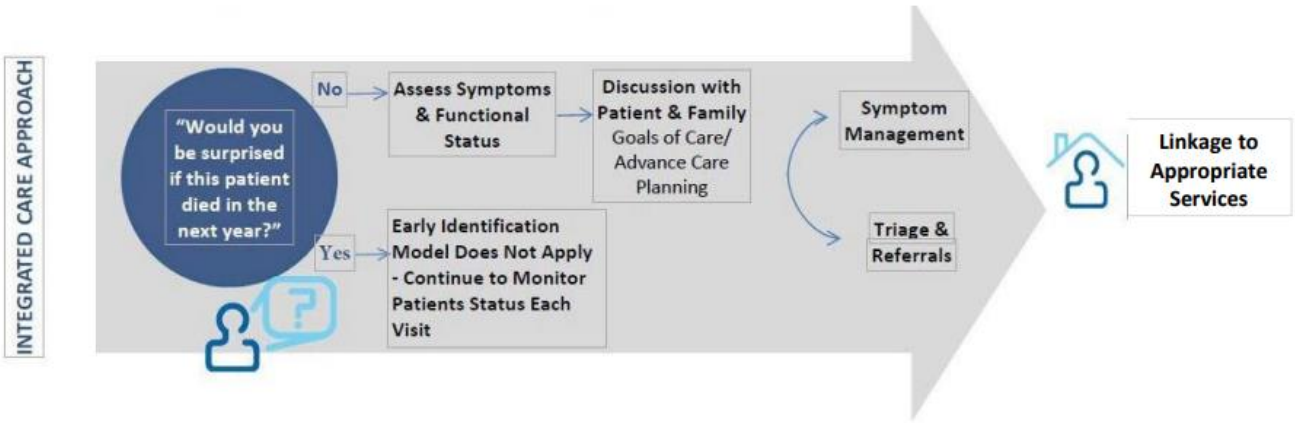
MEDICAL REFERENCES

Palliative Care Early Identification Model

Individuals who have a progressive, life-limiting illness should have their palliative care needs identified early through a comprehensive and holistic assessment.

Identification is the first step, and focuses on identifying those individuals who may benefit from palliative care early in their illness trajectory. Being "identified" does not mean a referral to a palliative care specialist. Instead, identification should lead to a comprehensive and holistic assessment of the individual and their family/caregiver's current and future needs and preferences across all domains of care. Assessment should include validated screening tools, an in-depth history, physical examination and relevant laboratory and imaging tests.

Earlier identification creates opportunities to engage in conversations to improve the patient's understanding of their illness and to identify their values and goals. Conversations can be more meaningful and thoughtful when they are pre-planned, and occur earlier, rather than in a period of rapid decline, or crisis. Importantly, these conversations can help to anticipate the patient's needs as the illness progresses and lead to reduced health care costs. Initiating palliative care earlier in the patient's illness trajectory has also been shown to minimize unnecessary emergency department visits and hospital admissions.



Palliative Performance Score

The Palliative Performance Score (PPS) is a valid, reliable functional assessment tool that provides a framework for measuring progressive decline in palliative patients.

PPS Level	Ambulation	Activity & Evidence of Disease	Self-Care	Intake	Conscious Level
100%	Full	Normal activity & work No evidence of disease	Full	Normal	Full
90%	Full	Normal activity & work Some evidence of disease	Full	Normal	Full
80%	Full	Normal activity *with* Effort Some evidence of disease	Full	Normal or reduced	Full
70%	Reduced	Unable Normal Job/Work Significant disease	Full	Normal or reduced	Full
60%	Reduced	Unable hobby/house work Significant disease	Occasional assistance necessary	Normal or reduced	Full or Confusion
50%	Mainly Sit/Lie	Unable to do any work Extensive disease	Considerable assistance required	Normal or reduced	Full or Confusion
40%	Mainly in Bed	Unable to do most activity Extensive disease	Mainly assistance	Normal or reduced	Full or Drowsy +/- Confusion
30%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Normal or reduced	Full or Drowsy +/- Confusion
20%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Minimal to sips	Full or Drowsy +/- Confusion
10%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Mouth care only	Drowsy or Coma +/- Confusion
0%	Death	-	-	-	-

Instructions for Use of PPS

1. PPS scores are determined by reading horizontally at each level to find a 'best fit' for the patient which is then assigned as the PPS% score.
2. Begin at the left column and read downwards until the appropriate ambulation level is reached, then read across to the next column and downwards again until the activity/evidence of disease is located. These steps are repeated until all five columns are covered before assigning the actual PPS for that patient. In this way, 'leftward' columns (columns to the left of any specific column) are 'stronger' determinants and generally take precedence over others.
3. PPS scores are in 10% increments only. Sometimes, there are several columns easily placed at one level but one or two which seem better at a higher or lower level. One then needs to make a 'best fit' decision. Choosing a 'half fit' value of PPS 45%, for example, is not correct. The combination of clinical judgment and 'leftward precedence' is used to determine whether 40% or 50% is the more accurate score for that patient.

Edmonton Symptom Assessment System

The Edmonton Symptom Assessment System (ESAS) is a valid and reliable assessment tool to assist in the assessment of nine common symptoms experienced by cancer patients, including pain, tiredness, nausea, depression, anxiety, drowsiness, appetite, well-being and shortness of breath. The ESAS is one of the key assessment tools used in Palliative Care.

Please circle the number that best describes how you feel NOW:

No Pain	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Pain
No Tiredness *(Tiredness = lack of energy)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Tiredness
No Drowsiness *(Drowsiness = feeling sleepy)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Drowsiness
No Nausea	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Nausea
No Lack of Appetite	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Lack of Appetite
No Shortness of Breath	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Shortness of Breath
No Depression *(Depression = feeling sad)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Depression
No Anxiety *(Anxiety = feeling nervous)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Anxiety
Best Wellbeing *(Wellbeing = how you feel overall)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Wellbeing
No _____ Other Problem *(for example constipation)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible _____

Confusion Assessment Method

The Confusion Assessment Method (CAM) is a standardized evidence-based tool that enables non-psychiatrically trained clinicians to identify and recognize delirium quickly and accurately by alerting clinicians to the presence of possible delirium.

Feature 1: Acute onset of fluctuation course
This feature is usually obtained from a family member and is shown by positive responses to the following questions:

a. Is there evidence of an acute change in mental status from baseline? ☐ No ☐ Yes
b. Did the (abnormal) behavior fluctuate during the day in frequency or severity? ☐ No ☐ Yes

Feature 2: Inattention
This feature is shown by a positive response to the following question:

a. Did the person have difficulty focusing attention? For example, easily distracted or having difficulty keeping track of what is being said. ☐ No ☐ Yes

Feature 3: Disorganized thinking
This feature is shown by a positive response to the following question:

a. Was the person's thinking disorganized or incoherent? For example, rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject? ☐ No ☐ Yes

Feature 4: Altered level of consciousness
This feature is shown by any answer other than "alert" to the following question:

a. How would you rate the person's level of consciousness?
☐ Alert
☐ Lethargic
☐ Stupor
☐ Unresponsive

Consider delirium if the presence of features 1 and 2, AND either 3 or 4.

Breakthrough Pain

Breakthrough pain (BTP) refers to transient exacerbation of pain that occurs in patients with otherwise baseline persistent pain that is well controlled. When baseline pain is not well controlled, all attempts should be made to first control it before concluding that BTP is out of control.

BTP can present clinically in different ways. BTP can be neuropathic, nociceptive/somatic, visceral or incident pain. Incident pain is a subtype of BTP and is elicited by any movement and can be difficult to control.

Management of BTP
Use short acting opioid formulations. Generally, the same opioid that is used for the regular pain regimen is used for BTP.

10% of the total daily dose of the regular regimen **q4hr** to a max of 3 breakthrough doses in a 24 hour period.

If the BTP is ineffective, consider titrating the dose at 5% increments to a max of 20% of the total daily dose.

Equivalent Dose Chart

Please note that equivalencies are approximate; use this chart as a guide only. PO = Oral, SC = Subcutaneous

ORAL ROUTES	Morphine 10mg PO = Hydromorphone 2 mg PO
ORAL TO SUBCUTANEOUS ROUTES	Hydromorphone 10mg PO = Hydromorphone 5mg SC
SUBCUTANEOUS EQUIANALGESIA:	Morphine 10mg SC = Hydromorphone 2mg SC
FROM TRANSDERMAL FENTANYL TO SUBCUTANEOUS HYDROMORPHONE	Fentanyl 25mcg patch (over 72hrs) = approx. Hydromorphone PO 12-26 mg in 24hr Hydromorphone 12-26 mg PO in 24hrs = Hydromorphone 6 mg SC in 24hrs

Weight Conversion

lbs	kg	lbs	kg	lbs	kg	lbs	kg
40	18	**125**	57	**210**	95	**295**	**134**
45	20	**130**	59	**215**	98	**300**	**136**
50	23	**135**	61	**220**	100	**305**	**139**
55	25	**140**	64	**225**	102	**310**	**141**
60	27	**145**	66	**230**	105	**315**	**143**
65	30	**150**	68	**235**	107	**320**	**145**
70	32	**155**	70	**240**	109	**325**	**148**
75	34	**160**	73	**245**	111	**330**	**150**
80	36	**165**	75	**250**	114	**335**	**152**
85	39	**170**	77	**255**	116	**340**	**155**
90	41	**175**	80	**260**	118	**345**	**157**
95	43	**180**	82	**265**	120	**350**	**159**
100	45	**185**	84	**270**	123	**355**	**161**
105	48	**190**	86	**275**	125	**360**	**164**
110	50	**195**	89	**280**	127	**365**	**166**
115	52	**200**	91	**285**	130	**370**	**168**
120	55	**205**	93	**290**	132	**375**	**170**

Wound Prevention and Management

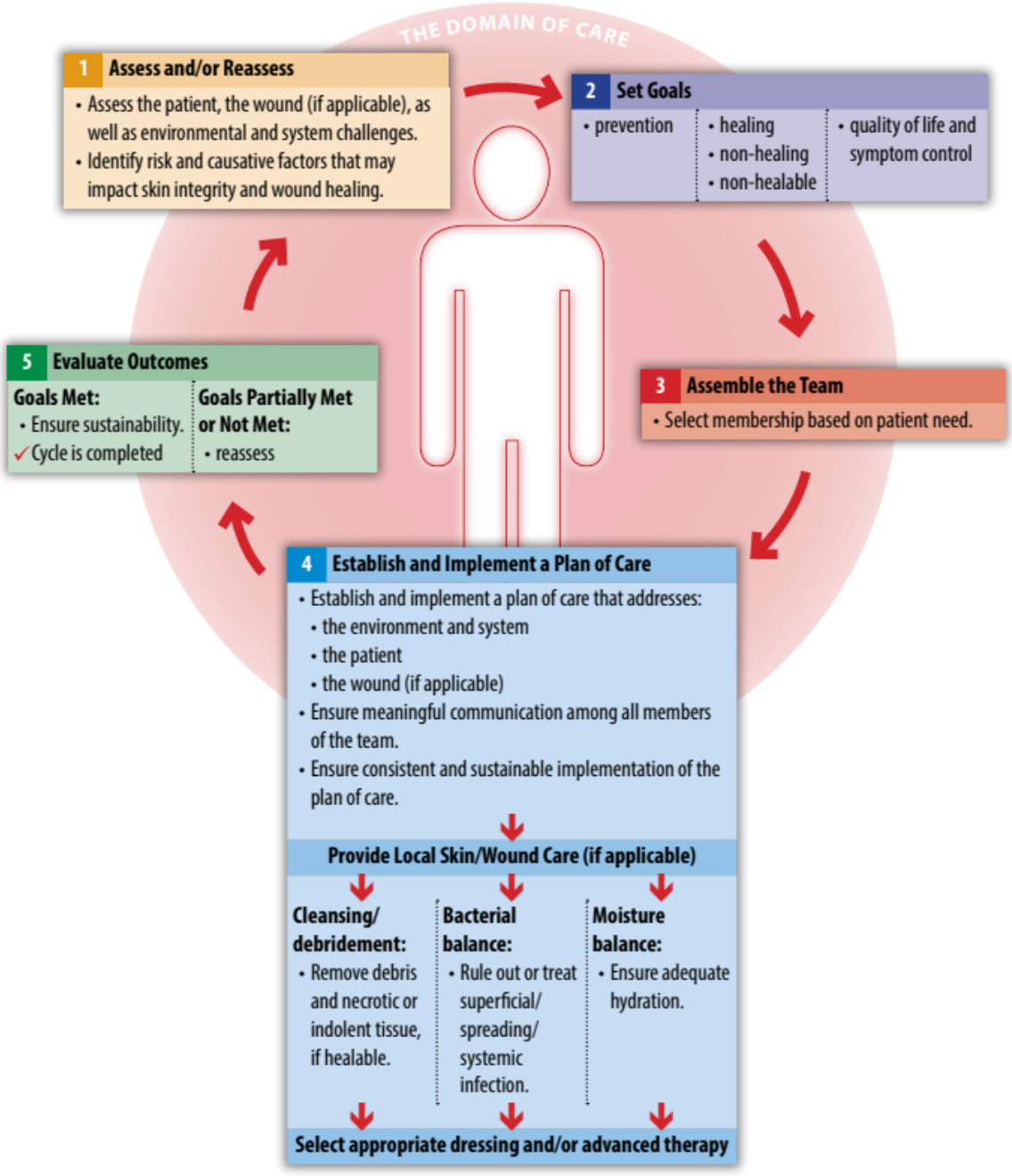
Wound prevention and management can be challenging, particularly when the patient is living with complicating factors that may increase the risk of new wounds or prolong the healing of existing wounds. However, by using the following three guiding principles, health-care professionals can support optimal prevention and management of skin breakdown:

1. The use of a logical and systematic approach, regardless of the specifics, to prevent and manage skin breakdown;

2. The constant, accurate and multidirectional flow of meaningful information with the team and across care settings; AND

3. The patient as the core of all decision making.

These steps are organized into a scheme labeled the Wound Prevention and Management Cycle, which guides the clinician through a logical and systematic method for developing a customized plan for the prevention and management of wounds, from the initial assessment to a sustainable plan targeting self-management for the patient.



Recommendations associated with the five steps in the Wound Prevention and Management Cycle

Step		Recommendation*
1	**Assess and/or Reassess**	1.1 Select and use validated patient assessment tools. 1.2 Identify risk and causative factors that may impact skin integrity and wound healing. 1.2.1 Patient: Physical, emotional and lifestyle 1.2.2 Environmental: Socio-economic, care setting, potential for self-management 1.2.3 Systems: Health-care support and communication 1.3 Complete a wound assessment, if applicable.
2	**Set Goals**	2.1 Set goals for prevention, healing, non-healing and non-healable wounds. 2.1.1 Identify goals based on prevention or healability of wounds. 2.1.2 Identify quality-of-life and symptom-control goals.
3	**Assemble the Team**	3.1 Identify appropriate health-care professionals and service providers. 3.2 Enlist the patient and their family and caregivers as part of the team. 3.3 Ensure organizational and system support.
4	**Establish and Implement a Plan of Care**	4.1 Identify and implement an evidence-informed plan to correct the causes or co-factors that affect skin integrity, including patient needs (physical, emotional and social), the wound (if applicable) and environmental/system challenges. 4.2 Optimize the local wound environment aided through 4.2.1 Cleansing 4.2.2 Debriding 4.2.3 Managing bacterial balance 4.2.4 Managing moisture balance 4.3 Select the appropriate dressings and/or advanced therapy. 4.4 Engage the team to ensure consistent implementation of the plan of care.
5	**Evaluate Outcomes**	5.1 Determine if the outcomes have met the goals of care. 5.2 Reassess patient, wound, environment and system if goals partially met or unmet. 5.3 Ensure sustainability to support prevention and reduce risk of recurrence.

* Each recommendation is supported by the levels of evidence in various guidelines as identified in each Best Practice Recommendation (BPR).

Assessing Wound Infection

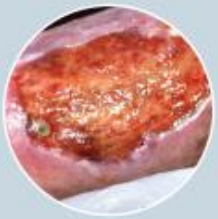
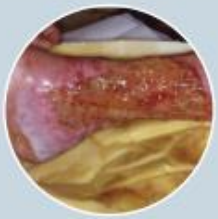
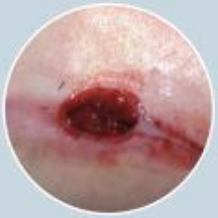
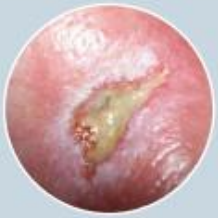
Health-care professionals must recognize that many internal and external stressors can affect the prevention and healing of wounds. Personal health, the environment and the context in which patients live all impact skin integrity and wound healing. Available local and regional resources also contribute to skin health and wound healing. Ultimately, the body must heal itself, so the purpose of the health-care team is to optimize the body's ability to prevent or heal a wound. Assessments must identify all relevant factors, while interventions must acknowledge and align with a patient's culture and values.

NERDS

- **N**ONHEALING
- **E**XUDATIVE
- **R**ED AND BLEEDING
- **D**EBRIS
- **S**MELL

If you observe 3 NERDS then - it is likely a localized infection.

- → Start an antimicrobial wound care dressing.
- → Document.
- → Update primary care provider.
- → Submit an update to care coordinator.

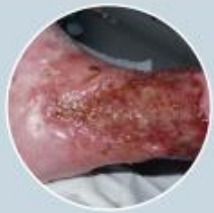
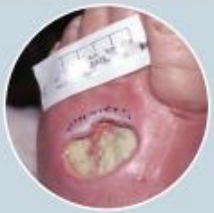
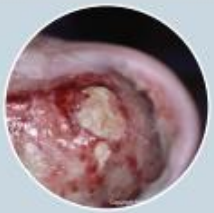
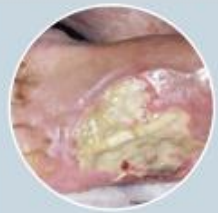
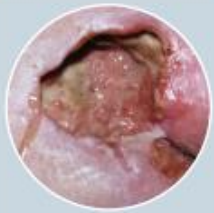
Non-Healing Wound	Exudative Wound	Red and Bleeding Wound	Debris in the Wound	Smell from the Wound
				
Not healing despite appropriate interventions (healable wound with the cause treated and patient-centered concerns addressed). Normal healing should reduce wound size 20-40% after 4 weeks of appropriate treatment.	An increase in wound exudate can indicate bacterial imbalance and that may lead to periwound maceration. More than 50% of the dressing is stained with exudate.	When the wound bed tissue is bright red with exuberant granulation tissues and bleeds easily, bacterial imbalance can be suspected. Granulation tissue should be pink and firm. The exuberant granulation tissue that is loose and bleeds easily reflects bacterial damage to the forming collagen matrix and an increased vasculature of the tissue.	Presence of discoloured granulation tissue, slough, and nonviable tissue. Necrotic tissue and debris in the wound are food sources for bacteria and can encourage a bacterial imbalance. In the presence of adequate circulation, necrotic tissue in the wound bed should be debrided by a qualified health care professional.	Smell from bacterial by-products may be present. Pseudomonas has a sweet characteristic smell/green colour. Anaerobes have a putrid odour due to breakdown of tissue. Clinicians must differentiate between odour from bacterial damage and that of wound exudate interacting with the wound dressing.

STONEES

- **S**IZE IS BIGGER
- **T**EMPERATURE INCREASED
- **O**S (PROBES TO OR EXPOSED BONE)
- **N**EW AREAS OF BREAKDOWN
- **E**RYTHEMA/EDEMA
- **E**XUDATE
- **S**MELL

If you observe 3 STONEES then: it is likely a spreading infection.

- → The patient should see their primary care provider urgently for assessment
- → Start an antimicrobial wound care dressing.
- → Document.
- → Submit an update to care coordinator.

Size is Bigger	Temperature Increased	Os (probes to or exposed bone)	New Areas of Breakdown	Erythema/Edema	Exudate	Smell
						
An increased size may be due to deeper and surrounding tissue damage by bacteria, because the cause has not been treated, or there are host factor impairing healing. An increased size from bacterial damage is due to the bacteria spreading from the surface to the surrounding tissue.	With surrounding tissue infection, temperature is increased. This is best measured using an infrared thermometer. There should be a high suspicion for infection if there is greater than a 3°F difference in temperature between two mirror image sites.	There is a high incidence of osteomyelitis if bone is exposed or if the clinician can probe to the bone in a person with a neurotrophic foot ulcer. An MRI is the most discriminating diagnostic test.	Note the satellite areas of skin breakdown that are separated from the main ulcer.	Reddened skin in periwound area. Presence of swelling in periwound area. These can be due to an inflammatory response. Inflammation can lead to vasodilation (erythema) and leakage of fluid into the tissue (edema). Cause of the infection needs to be addressed to control erythema and edema.	With increased bacterial burden, exudate often increases in quantity and transforms from a clear or serous texture to purulence and may there may be bleeding. Assess for maceration to surrounding skin.	Smell from bacterial by-products may be present. Pseudomonas has a sweet characteristic smell/green colour. Anaerobes have a putrid odour due to breakdown of tissue. Clinicians must differentiate between odour from bacterial damage and that of wound exudate interacting with the wound dressing.

SBAR

Situation, Background, Assessment, Recommendation (SBAR); a technique that can be used to facilitate prompt and appropriate communication.

Before Calling

1. Assess the patient
2. Review the chart for the appropriate physician to call
3. Know the residents diagnosis
4. Read the most recent progress notes and the assessment from the previous health care provider.
5. Have *available* when speaking with the physician: Allergies, Medications, Lab results

S — SITUATION

State your **name** and **unit**
I am calling about: (**Resident & Facility**)
The **problem** I am calling about is:

B — BACKGROUND

State the pertinent **medical history/any recent trauma**
Give a brief synopsis of the **treatment to date and effectiveness**

A — ASSESSMENT OF PAIN

Onset	
Precipitating & Alleviating Factors	
Quality of Pain	
Region & Radiation	
Severity	
Timing	
U "How is the pain affecting you?"	
Values –What is the acceptable level for this symptom?	

R — RECOMMENDATION

Do you think we should: (State what you would like to see done)

- ☐ Order and analgesic? (NB: match the severity of the pain with the analgesic order)
- ☐ Come to see the resident at this time?
- ☐ Consult the Palliative Care Consultant?
- ☐ Order diagnostic tests?
- ☐ Other _____

Are any tests needed?

- ☐ Do you need any tests? ☐ ? XRAY

If a change in treatment is ordered, then ask:

- ☐ If the resident does not improve, **when would you want us to call again?**
- ☐ Consult the Palliative Care Consultant?

DOCUMENT the change in condition & the physician notification