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April 20, 2015

**MEMORANDUM TO:** Paramedic Service Chiefs, Municipal CAOs, Ornge and First Nations

**FROM:** Richard Jackson  
Director  
Emergency Health Services Branch

**RE:** **Advanced Life Support Patient Care Standards and Provincial Equipment Standards for Ontario Ambulance Services**

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I am pleased to announce the approval and release of the revised *Advanced Life Support Patient Care Standards*, version 3.3 and *Provincial Equipment Standards for Ontario Ambulance Services*, version 2.3. A Summary of Changes document has also been attached for your reference to identify some minor updates that have been made to these Standards.

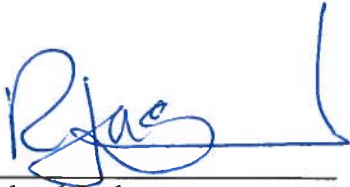
Please ensure that your personnel are informed of and become familiar with the application of the revised *Advanced Life Support Patient Care Standards* and *Provincial Equipment Standards for Ontario Ambulance Services*, to be implemented no later than **February 1, 2016**, on which date these Standards come into force.

As a reminder, implementation only applies to mandatory Core Medical Directives and mandatory Equipment Standards. The implementation of Auxiliary Medical Directives is only required if they have been delegated as such by a Regional Base Hospital Medical Director in conjunction with a certified ambulance service provider.

**Advanced Life Support Patient Care Standards and  
Provincial Equipment Standards for Ontario Ambulance Services**

The revised Standards have been attached in PDF format. Additionally, the Standards will be made available on the [www.ambulance-transition.com](http://www.ambulance-transition.com) website shortly.

If you have any questions, please contact Denise D'Souza, Paramedic Standards and Certification Coordinator at (416) 327-1580.



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Richard Jackson

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- Senior Field Managers/Field Managers, EHSB
- N. Gale, President, OAPC
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- E. Graham, Chair, OBHG
- Regional Training Coordinators
- Paramedic Program Coordinators

Enclosures

# ALS

## Advanced Life Support Patient Care Standards

Version 3.3

**Comes into force on February 1, 2016**

Emergency Health Services Branch  
Ministry of Health and Long-Term Care

To all users of this publication:

The information contained herein has been carefully compiled and is believed to be accurate at date of publication. Freedom from error, however, cannot be guaranteed.

For further information on  
the *Advanced Life Support Patient Care Standards*,  
please contact:

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## **ADVANCED LIFE SUPPORT PATIENT CARE STANDARDS**

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### **ACKNOWLEDGEMENTS**

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The development of this edition of the Advanced Life Support Patient Care Standards is the result of a collaborative effort of a number of stakeholders including:

Association of Paramedic Chiefs (OAPC)

Ontario Base Hospital Group (OBHG)

Ministry of Health and Long Term Care – Emergency Health Services Branch (MOHLTC EHSB)

EHSB Medical Advisory Committee (MAC)

In particular, the Ministry would like to gratefully acknowledge the following members of the MAC and Regional Base Hospitals (RBH) who provided the medical input into these standards:

Dr. Michael Lewell, Chair

Dr. Jason Prpic, Past Chair

Dr. Andrew Affleck

Mr. Andy Benson, Chair, Education Subcommittee

Mr. Chris Day, Primary Care Paramedic Rep.

Dr. Richard Dionne

Mr. Kyle Grant, Advanced Care Paramedic Rep.

Dr. Derek Garniss

Ms. Mary Osinga, College Rep.

Dr. Bruce Sawadsky

Dr. Rudy Vandersluis

Dr. Richard Verbeek

Dr. Michelle Welsford

## **LEVELS OF PARAMEDICS**

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In Ontario, there are three occupational levels of paramedics: Primary Care Paramedic (PCP), Advanced Care Paramedic (ACP), and Critical Care Paramedic (CCP). A level of paramedic is specified in Ontario Regulation 257/00 made under the *Ambulance Act*, RSO 1990, c A-19. Schedules 1, 2 and 3 to this regulation specify the mandatory controlled acts for each level of paramedic.

A paramedic may be authorized by a Medical Director of a RBH to perform controlled acts from the Schedule immediately above their prime occupational level. In this circumstance, the paramedic will perform the skill to the specific standard set for the skill. This general concept also applies to the performance of all advanced medical procedures that are not listed as controlled acts in Schedules 1, 2 and 3, but which are also specified in these standards.

## **PURPOSE OF STANDARDS**

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The purpose of the Advanced Life Support Patient Care Standards (ALS PCS) is to guide the specifics of patient care that are to be undertaken consistent with the scope of practice of the three occupational levels of paramedics.

The ALS PCS:

- Reflects current practices for paramedics in Ontario and provides benchmarks for paramedic performance.
- Communicates the standards of practice and care by paramedics in Ontario to paramedics, patients, other disciplines and the public in general.
- Delineates paramedic professional responsibilities and accountabilities.
- Provides a basis for evaluation of patient care practice by Ontario's paramedics.
- Recognizes that the scope of practice for each occupational level of paramedic may have incremental add-ons, with appropriate rationale and accountability.

## **Summary**

ALS PCS for the three occupational levels of paramedics in Ontario establish the practice and patient care parameters needed to provide high quality patient care in the varied settings throughout the province. The standards are designed to be dynamic, in order to allow for changes based upon new medical evidence and/or standards of medical practice.

## **FORMAT OF THE ADVANCED LIFE SUPPORT PATIENT CARE STANDARDS**

This document is comprised of an Introduction 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 – Provincial Maintenance of Certification Policy. Critical Care Paramedics and Advanced/Primary Care Flight Paramedics will perform controlled acts in accordance with the Base Hospital Medical Directives issued by the Orange Base Hospital Physician.

## **USE OF THE MEDICAL DIRECTIVES BY PARAMEDICS**

These Medical Directives apply to paramedics who provide patient care under the license and/or authority of the RBH Medical Director. Delegation of controlled acts or Medical Directives in the ALS PCS to paramedics falls under the exclusive oversight of the MOHLTC's RBH Programs.

The Medical Directives are designed to guide a paramedic in the provision of timely and appropriate care to ill and injured patients in the prehospital setting, in accordance with the paramedics' training and authorized skill set. While great care has been taken in developing these Medical Directives, they cannot account for every clinical situation. Thus, they are not a substitute for sound clinical judgment.

## **REGIONAL BASE HOSPITAL COMPLIANCE WITH CPSO POLICY**

As licensed physicians in the Province of Ontario, the RBH Medical Directors must comply with the policies of the College of Physicians and Surgeons of Ontario (CPSO). The Delegation of Controlled Acts CPSO policy, as may be amended from time to time, provides direction to Ontario physicians on the delegation of controlled acts, regardless of practice setting or type. RBHs will also follow a parallel process for delegation of other advanced medical procedures included in these Standards.



## **GENERAL STRUCTURE OF A MEDICAL DIRECTIVE**

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

<b>Indication:</b>	The general medical complaint or problem to which the medical directive applies.
<b>Conditions:</b>	Clinical parameters that must be present for a procedure to be performed or for a drug to be administered.
<b>Contraindications:</b>	Clinical parameters that if present, preclude the performance of a procedure or the administration of a drug.
<b>Treatment:</b>	Description of the type of procedure to be performed or the dosing of a drug.
<b>Clinical Considerations:</b>	Key clinical points that provide general guidance to the proper performance of a procedure or the administration of a drug.

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

## **ALS PATIENT CARE STANDARDS PARAMEDIC SKILL SET**

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The mandatory skill set for each level of paramedic is derived from the controlled acts outlined in Schedules 1, 2, and 3 (as referenced above) and is implemented through the PCP and ACP Medical Directives. A paramedic must meet all applicable requirements set out in Regulation 257/00 to receive delegation from a RBH Medical Director.

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 operator that employs the paramedic. Some PCP and ACP Medical Directives contain the phrase, “(if available)”. This phrase qualifies the skill or procedure as optional (i.e. auxiliary) even if included in PCP or ACP Medical Directives.

## **CONSENT TO TREATMENT & CAPACITY ASSESSMENT**

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Except in emergency circumstances described below, paramedics must obtain the patient's consent prior to initiating treatment. Consent may be informed or implied. Informed consent may be either verbal or written. Implied consent may be assumed where a person provides a physical indication that they consent to the treatment. 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 procedure.

The elements required for consent to treatment are:

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

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

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

The paramedic who proposes a treatment to a person shall ensure that consent is obtained. 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. However, a capacity assessment may be required 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:

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

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

If a person is incapable with respect to a treatment, consent may be given or refused on his or her behalf by a person who is authorized to do so under section 20 of the *Health Care Consent Act, 1996*.

In some instances, a person may present in an emergency situation where the person for whom the treatment is proposed is apparently experiencing severe suffering or is at risk, if the treatment is not administered promptly, of sustaining serious bodily harm.

A paramedic may administer treatment to a person without consent in an emergency situation, if there is no other authorized person available to give or refuse consent and, in the opinion of the paramedic:

- the person is not capable of giving a consent or refusal to treatment; and
- the delay required to obtain a consent or refusal on the person's behalf will prolong the suffering that the person is apparently experiencing or will put the person at risk of sustaining serious bodily harm.

## **REFUSAL OF TREATMENT**

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If a patient refuses treatment, either in whole or in part, a paramedic must comply with the applicable directions contained in the Basic Life Support Patient Care Standards (BLS PCS), Section 1, Part I, Patient Refusal of Treatment and/or Transport.

## **COMPREHENSIVE CARE**

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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 Standards.

## **INTRAVENOUS (“IV”) ACCESS AND THERAPY BY PRIMARY CARE PARAMEDICS**

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Two levels of certification of PCPs for IV cannulation and therapy are possible.

“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 the Intravenous Access and Fluid Therapy Medical Directive - Auxiliary. The ACP will perform all IV therapy in accordance with the Intravenous Access and Fluid Administration Protocol once intravenous access is obtained. PCPs certified in PCP Assist IV are not authorized to administer IV therapy.

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

Certification at each level shall meet the requirements established by the provincial Medical Advisory Committee.

## **HOME MEDICAL TECHNOLOGY AND NOVEL MEDICATIONS**

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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 Base Hospital Physician. 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**

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A paramedic should patch to the Base Hospital:

- When a medical directive contains a mandatory provincial patch point;  
**OR**
- When a RBH introduces a mandatory BH patch point;  
**OR**
- 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**
- When 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 judgment 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**

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

## **CONTROLLED SUBSTANCES**

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Where applicable, paramedics and ambulance service operators shall comply with the *Canada Controlled Drug and Substances Act*, SC 1996, c 19 and its Regulations, in accordance with the ambulance operator and RBH policy. This shall include that controlled substances (opiates and benzodiazepines) are stored in different carrying cases than other medications.

## **RESPONSIBILITY FOR CARE**

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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:

- current CTAS level;
- a history of the patient's current problem(s) and relevant past medical history;
- pertinent physical findings;
- a summary of management at scene/enroute;
- the patient's response to treatment, including most recent vital signs;

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**

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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. In recognition of the importance of prehospital clinical research, RBH Medical Directors may delegate changes in patient care standards to paramedics if the research-related treatment is endorsed by MAC–OBHG and the certified ambulance operator that employs the paramedics, approved by MOHLTC, and is supported by an appropriate research ethics review board. Changes to patient care standards will be introduced as an auxiliary medical directive. Upon completion of a prehospital clinical trial, research-related treatment must be halted and care as prescribed by BLS PCS and ALS PCS must resume.

## **CONVENTIONS**

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“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.



## 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  $\geq$ 100mmHg

**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** - <50 BPM

**Tachycardia** -  $\geq$ 100 BPM

**Tachypnea** - RR  $\geq$ 28 breath/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  $\geq$ 90 mmHg + (2 x age in years)

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

**Weight (kg) = (age x 2) + 10**

### HYPOGLYCEMIA:

Age  $\geq$ 2 years: glucometry <4.0 mmol/L

Age <2 years: glucometry <3.0 mmol/L

**LOA (Level of Awareness):**

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.

## LIST OF ABBREVIATIONS

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The following abbreviations, in alphabetical order, appear in the Advanced Life Support Patient Care Standards:

### **A**

ACP	Advanced Care Paramedic
ALS	Advanced Life Support
ALS PCS	Advanced Life Support Patient Care Standards
ASA	acetylsalicylic acid
AV	atrioventricular

### **B**

BH	Base Hospital
BHP	Base Hospital Physician
BLS	Basic Life Support
BP	blood pressure
BPM	beats per minute
BVM	bag-valve-mask

### **C**

CCP	Critical Care Paramedic
COPD	chronic obstructive pulmonary disease
cm	centimeter
CPAP	continuous positive airway pressure
CPR	Cardiopulmonary Resuscitation
CPSO	College of Physicians and Surgeons of Ontario
CTAS	Canadian Triage and Acuity Scale
CVA	cerebral vascular accident
CVAD	central venous access device

### **D**

DKA	diabetic ketoacidosis
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### **E**

ECD	electronic control device
ECG	electrocardiogram
EDD	esophageal detection device
ETCO <sub>2</sub>	end tidal carbon dioxide
ETT	endotracheal tube

### **F**

FiO <sub>2</sub>	fraction of inspired oxygen
FRI	febrile respiratory infection

**G**

g gram  
 GCS Glasgow Coma Scale

**H**

H<sub>2</sub>O water  
 HR heart rate  
 Hx history

**I**

IM intramuscular  
 IN intranasal  
 IO intraosseous  
 IV intravenous

**K**

kg kilogram

**L**

LOA level of awareness  
 LOC level of consciousness/loss of consciousness

**M**

MAC Medical Advisory Committee  
 mcg microgram  
 MDI metered dose inhaler  
 mg milligram  
 min minute  
 ml/kg milliliter per kilogram  
 mmHg millimeters of mercury  
 MOHLTC Ministry of Health and Long-Term Care

**N**

N/A not applicable  
 NaCl sodium chloride  
 nare nostril  
 NEB nebulized  
 NPA nasopharyngeal airway  
 NSAID non-steroidal anti-inflammatory drug

**O**

OBHG Ontario Base Hospital Group  
 OPA oropharyngeal airway

**P**

PCP Primary Care Paramedic  
 PO by mouth/oral  
 PRN as needed

**Q**

q every

**R**

RBH Regional Base Hospital  
 ROSC return of spontaneous circulation  
 RR respiratory rate

**S**

SC subcutaneous  
 SL sublingual  
 SBP systolic blood pressure  
 SpO<sub>2</sub> saturation of peripheral oxygen  
 STEMI ST-segment elevation myocardial infarction

**T**

TBI traumatic brain injury  
 TCA tricyclic antidepressant  
 TCP transcutaneous pacing

**U**

URTI upper respiratory tract infection

**V**

VSA vital signs absent

**W**

WNL within normal limits

## **REFERENCE AND EDUCATIONAL NOTES**

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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.

# Advanced Life Support Patient Care Standards

Version 3.3

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# **Appendix 1**

## **Primary Care Paramedic Core Medical Directives**



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## MEDICAL CARDIAC ARREST MEDICAL DIRECTIVE

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

### INDICATIONS

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Non-traumatic cardiac arrest

### CONDITIONS

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#### CPR

AGE: N/A  
LOA: Altered  
HR: N/A  
RR: N/A  
SBP: N/A  
Other: Performed in 2  
minute intervals

#### AED Defibrillation

AGE:  $\geq 30$  days  
LOA: Altered  
HR: N/A  
RR: N/A  
SBP: N/A  
Other: Shock indicated

#### Manual Defibrillation

AGE:  $\geq 30$  days  
LOA: Altered  
HR: N/A  
RR: N/A  
SBP: N/A  
Other: VF or pulseless VT

#### Epinephrine

AGE: N/A  
LOA: Altered  
HR: N/A  
RR: N/A  
SBP: N/A  
Other: Anaphylaxis  
suspected as  
causative event

#### Medical TOR

AGE:  $\geq 18$  years  
LOA: Altered  
HR: N/A  
RR: N/A  
SBP: N/A  
Other: Arrest not witnessed by EMS **AND** No  
ROSC **AND** No shocks delivered

## CONTRAINDICATIONS

### CPR

Obviously dead as per BLS Standards  
Meet conditions of DNR Standard

### AED Defibrillation

Non-shockable rhythm

### Manual Defibrillation

Rhythms other than VF or pulseless VT

### Epinephrine

Allergy or sensitivity to epinephrine

### Medical TOR

Arrest thought to be of non-cardiac origin

## TREATMENT

Consider **CPR**

Consider **AED defibrillation**:

	Age ≥30 days to <8 years		Age ≥8 years
	With Ped attenuator	Without Ped attenuator	
<i>Dose</i>	1 shock	1 shock	1 shock
<i>Max. single dose</i>	As per BH / manufacturer	As per BH / manufacturer	As per BH / manufacturer
<i>Dosing interval</i>	2 min.	2 min.	2 min.
<i>Max. # of doses</i>	4	4	4

Consider **Manual defibrillation**: (if certified and authorized)

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

Consider **epinephrine** (only if anaphylaxis suspected as causative event):

	Weight N/A
	Route IM
	Concentration 1:1,000
<i>Dose</i>	0.01 mg/kg*
<i>Max. single dose</i>	0.5 mg
<i>Dosing interval</i>	N/A
<i>Max. # of doses</i>	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 Termination of Resuscitation (TOR) (if applicable). If the BH patch fails, or the medical TOR does not apply, transport to the closest appropriate receiving hospital following ROSC or the 4<sup>th</sup> analysis.

## **CLINICAL CONSIDERATIONS**

---

In unusual circumstances (e.g. pediatric patients or toxicological overdoses), consider initiating transport following the first rhythm analysis that does not result in a defibrillation being delivered.

A Paramedic may choose to move the patient to the ambulance prior to initiating the TOR if family is not coping well or the arrest occurred in a public place.

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

## TRAUMA CARDIAC ARREST MEDICAL DIRECTIVE

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

### INDICATIONS

---

Cardiac arrest secondary to severe blunt or penetrating trauma

### CONDITIONS

---

#### CPR

AGE: N/A  
LOA: Altered  
HR: N/A  
RR: N/A  
SBP: N/A  
Other: Performed in 2  
minute intervals

#### AED Defibrillation

AGE:  $\geq 30$  days  
LOA: Altered  
HR: N/A  
RR: N/A  
SBP: N/A  
Other: Shock indicated

#### Manual Defibrillation

AGE:  $\geq 30$  days  
LOA: Altered  
HR: N/A  
RR: N/A  
SBP: N/A  
Other: VF or pulseless VT

#### Trauma TOR

AGE:  $\geq 16$  years  
LOA: Altered  
HR: 0  
RR: 0  
SBP: N/A  
Other: No palpable pulses  
No defibrillation delivered **AND**  
monitored HR = 0 (asystole) **OR**  
monitored HR  $>0$  **AND** the  
closest ER  $\geq 30$  min transport  
time away.



## CONTRAINDICATIONS

### CPR

Obviously dead as per BLS standards

Meet conditions of DNR standard

### AED Defibrillation

Non-shockable rhythm

### Manual Defibrillation

Rhythms other than VF or pulseless VT

### Trauma TOR

Age <16 years

Shock delivered

Monitored HR >0 and closest ER <30 min away

## TREATMENT

Consider **CPR**

Consider **AED defibrillation**:

	Age ≥30 days to <8 years		Age ≥8 years
	With Ped attenuator	Without Ped attenuator	
<i>Dose</i>	1 shock	1 shock	1 shock
<i>Max. single dose</i>	As per BH / manufacturer	As per BH / manufacturer	As per BH / manufacturer
<i>Dosing interval</i>	2 min.	2 min.	2 min.
<i>Max. # of doses</i>	1	1	1

Consider **Manual defibrillation**: (if certified and authorized)

	Age ≥30 days to <8 years	Age ≥8 years
Dose	1 shock	1 shock
Initial dose	2 J/kg	As per BH / manufacturer
Dosing interval	2 min.	2 min
Max. # of doses	1	1

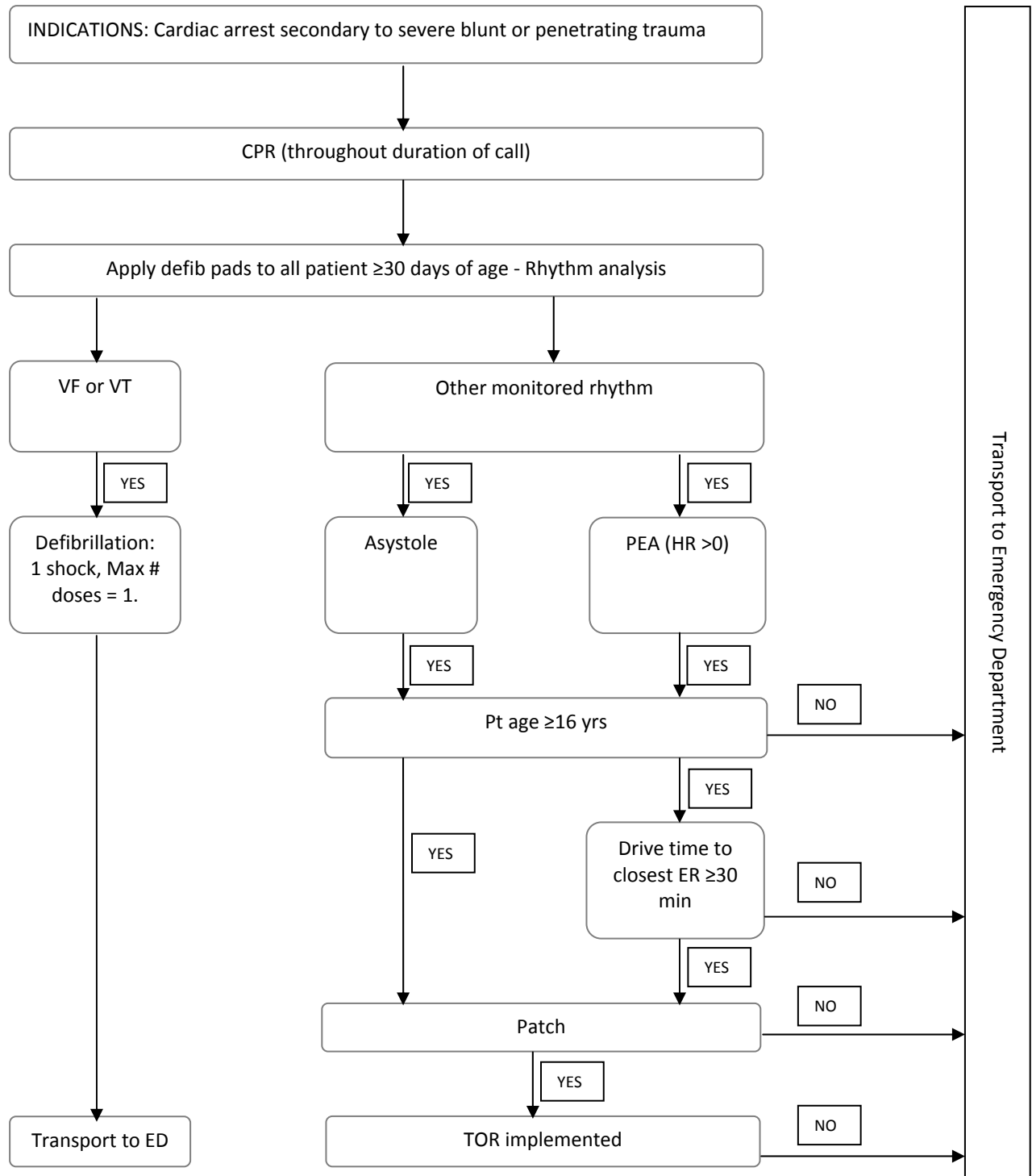
**MANDATORY PROVINCIAL PATCH POINT:**

Patch to BHP for authorization to apply the *Trauma (TOR) Termination of Resuscitation*, if applicable. If the BH patch fails, or the trauma TOR does not apply, transport to the closest appropriate receiving hospital following the first analysis/shock.

**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 certified and authorized.*

### INDICATIONS

---

Cardiac arrest secondary to severe hypothermia

### CONDITIONS

---

#### CPR

AGE: N/A  
LOA: Altered  
HR: N/A  
RR: N/A  
SBP: N/A  
Other: Performed in 2  
minute intervals

#### AED Defibrillation

AGE:  $\geq 30$  days  
LOA: Altered  
HR: N/A  
RR: N/A  
SBP: N/A  
Other: Shock indicated

#### Manual Defibrillation

AGE:  $\geq 30$  days  
LOA: Altered  
HR: N/A  
RR: N/A  
SBP: N/A  
Other: VF or pulseless VT

### CONTRAINDICATIONS

---

#### CPR

Obviously dead as per BLS  
standards  
Meet conditions of DNR  
standard

#### AED Defibrillation

Non-shockable rhythm

#### Manual Defibrillation

Rhythms other than VF or  
pulseless VT

## TREATMENT

Consider **CPR**

Consider **AED defibrillation**: (with pediatric attenuator if available)

	Age ≥30 days to <8 years		Age ≥8 years
	With Ped attenuator	Without Ped attenuator	
<i>Dose</i>	1 shock	1 shock	1 shock
<i>Max. single dose</i>	As per BH / manufacturer	As per BH / manufacturer	As per BH / manufacturer
<i>Dosing interval</i>	2 min.	2 min.	2 min.
<i>Max. # of doses</i>	1	1	1

Consider **Manual defibrillation**:

	Age ≥30 days to <8 years	Age ≥8 years
<i>Dose</i>	1 shock	1 shock
<i>Initial dose</i>	2 J/kg	As per BH / manufacturer
<i>Dosing interval</i>	2 min.	2 min.
<i>Max. # of doses</i>	1	1

Transport to the closest appropriate facility without delay following the first analysis.

## CLINICAL CONSIDERATIONS

N/A

## FOREIGN BODY AIRWAY OBSTRUCTION CARDIAC ARREST MEDICAL DIRECTIVE

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

### INDICATIONS

Cardiac arrest secondary to an airway obstruction

### CONDITIONS

#### CPR

AGE: N/A  
LOA: Altered  
HR: N/A  
RR: N/A  
SBP: N/A  
Other: Performed in 2  
minute intervals

#### AED Defibrillation

AGE: ≥30 days  
LOA: Altered  
HR: N/A  
RR: N/A  
SBP: N/A  
Other: Shock indicated

#### Manual Defibrillation

AGE: ≥30 days  
LOA: Altered  
HR: N/A  
RR: N/A  
SBP: N/A  
Other: VF or pulseless VT

### CONTRAINDICATIONS

#### CPR

Obviously dead as per BLS  
standards  
Meet conditions of DNR  
standard

#### AED Defibrillation

Non-shockable rhythm

#### Manual Defibrillation

Rhythms other than VF or  
pulseless VT

### TREATMENT

Consider **CPR**

Consider **foreign body removal**: (utilizing BLS maneuvers)

Consider **AED defibrillation**:

	Age ≥30 days to <8 years		Age ≥8 years
	With Ped attenuator	Without Ped attenuator	
<i>Dose</i>	1 shock	1 shock	1 shock
<i>Max. single dose</i>	As per BH / manufacturer	As per BH / manufacturer	As per BH / manufacturer
<i>Dosing interval</i>	2 min.	2 min.	2 min.
<i>Max. # of doses</i>	1	1	1

Consider **Manual defibrillation**:

	Age ≥30 days to <8 years	Age ≥8 years
	<i>Dose</i>	1 shock
<i>Initial dose</i>	2 J/kg	As per BH / manufacturer
<i>Dosing interval</i>	2 min.	2 min
<i>Max. # of doses</i>	1	1

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 first analysis.

## CLINICAL CONSIDERATIONS

N/A

## NEONATAL RESUSCITATION MEDICAL DIRECTIVE

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

### INDICATIONS

---

Severe cardio-respiratory distress

### CONDITIONS

---

#### Resuscitation

AGE: newborn or <30  
days of age

LOA: N/A

HR: N/A

RR: N/A

SBP: N/A

Other: Less than full  
term, or  
meconium, or  
poor APGAR score

### CONTRAINDICATIONS

---

#### Resuscitation

Clear of meconium

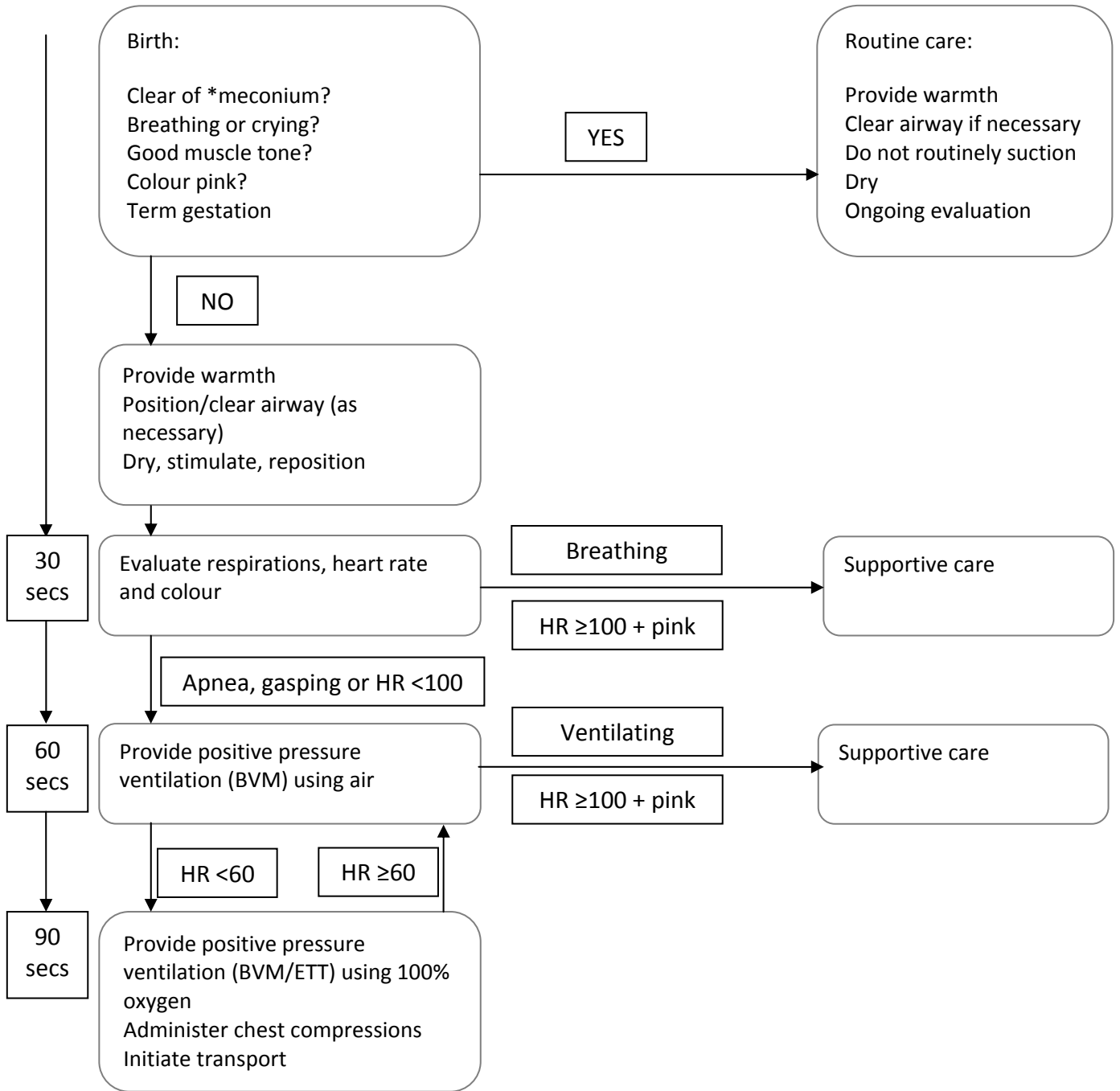
Breathing or crying

Good muscle tone

Pink in colour



**TREATMENT**



\*if meconium is present and baby not vigorous, suction mouth and pharynx and provide BVM ventilations as required and then continue with the remainder of the initial steps following birth.

## RETURN OF SPONTANEOUS CIRCULATION (ROSC) MEDICAL DIRECTIVE

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

### INDICATIONS

---

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

### CONDITIONS

---

#### **0.9% NaCl Fluid Bolus**

AGE: N/A

LOA: N/A

HR: N/A

RR: N/A

SBP: Hypotension

Other: Chest auscultation is clear

#### **Therapeutic hypothermia**

AGE: males  $\geq 18$  years

females  $\geq 50$  years

LOA: Altered

HR: N/A

RR: N/A

SBP:  $\geq 90$  mmHg  
(spontaneous or following bolus administered)

Other: N/A

## CONTRAINDICATIONS

### 0.9% NaCl Fluid Bolus

Fluid overload  
SBP  $\geq$ 90 mmHg

### Therapeutic hypothermia

Traumatic cardiac arrest  
(blunt, penetrating or burn)

Sepsis or serious infection  
suspected as cause of  
arrest

Hypothermic arrest

Known coagulopathy  
(medical history or  
medications)

## TREATMENT

Consider **rapid transport**

Consider **optimizing ventilation and oxygenation:**

Titrate oxygenation  $\geq$ 94%

Avoid hyperventilation and target an ETCO<sub>2</sub> of 35-40 mmHg with continuous waveform capnography (if available)

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

	Age <12 years	Age $\geq$ 12 years
	Route IV	Route IV
<i>Infusion</i>	10 ml/kg	10 ml/kg
<i>Infusion interval</i>	Immediate	Immediate
<i>Reassess every</i>	100 ml	250 ml
<i>Max. volume</i>	1,000 ml	1,000 ml

Consider **12-lead ECG acquisition**

Consider **Therapeutic hypothermia** (if available)

## **CLINICAL CONSIDERATIONS**

---

The application of therapeutic hypothermia should not detract from rapid transport, optimizing ventilation and oxygenation or the management of a re-arrest.

## CARDIAC ISCHEMIA MEDICAL DIRECTIVE

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

### 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

#### Nitroglycerin

AGE: ≥18 years

LOA: Unaltered

HR: 60-159/min

RR: N/A

SBP: Normotension

Other: Prior history of nitroglycerin use  
**OR** 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 infarct

## TREATMENT

Consider **ASA**:

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

Consider **12-lead ECG acquisition**

Consider **nitroglycerin**:

	<b>SBP</b> ≥100 mmHg
	<b>Route</b> SL
<i>Dose</i>	0.3 <b>or</b> 0.4 mg
<i>Max. single dose</i>	0.4 mg
<i>Dosing interval</i>	5 min.
<i>Max. # of doses</i>	6

## CLINICAL CONSIDERATIONS

N/A

## ACUTE CARADIOGENIC PULMONARY EDEMA MEDICAL DIRECTIVE

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

### INDICATIONS

---

Moderate to severe respiratory distress

**AND**

Suspected acute cardiogenic pulmonary edema

### CONDITIONS

---

#### **Nitroglycerin**

AGE: ≥18 years

LOA: N/A

HR: 60-159/min

RR: N/A

SBP: Normotension

Other: Ascertain prior  
history of  
nitroglycerin use  
**OR** establish IV  
access



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

**NOTE:** Hx refers to a patient with a prior history of nitroglycerin use.

Consider **12-lead ECG acquisition**

## CLINICAL CONSIDERATIONS

IV condition applies only to PCPs certified to the level of PCP Autonomous IV.

## CARDIOGENIC SHOCK MEDICAL DIRECTIVE

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

### INDICATIONS

---

STEMI-positive ECG

**AND**

Cardiogenic shock

### CONDITIONS

---

#### **0.9% NaCl Fluid Bolus**

AGE: ≥18 years

LOA: N/A

HR: N/A

RR: N/A

SBP: Hypotension

Other: Clear chest on auscultation

### CONTRAINDICATIONS

---

#### **0.9% NaCl Fluid Bolus**

N/A

## TREATMENT

Consider **0.9% NaCl fluid bolus**:

	<b>Age</b> ≥18 years
	<b>Route</b> IV
<i>Infusion</i>	10 ml/kg
<i>Infusion interval</i>	N/A
<i>Reassess every</i>	250 ml
<i>Max. volume</i>	10 ml/kg

## CLINICAL CONSIDERATIONS

N/A

## HYPOGLYCEMIA MEDICAL DIRECTIVE

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

### INDICATIONS

---

Agitation **OR** altered LOA **OR** seizure **OR** symptoms of stroke

### CONDITIONS

---

#### Dextrose

AGE:  $\geq 2$  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 to glucagon  
Pheochromocytoma

### TREATMENT

---

Perform ***glucometry***

Consider **dextrose** (if certified and authorized) **or glucagon**:

	<b>Medication</b> <i>Dextrose</i>		<b>Medication</b> <i>Glucagon</i>	
	<b>Age</b> ≥2 years		<b>Age</b> N/A	
	<b>Weight</b> N/A		<b>Weight</b> <25 kg	<b>Weight</b> ≥25 kg
	<b>Concentration</b> <i>D50W</i>		<b>Concentration</b> N/A	<b>Concentration</b> N/A
	<b>Route</b> <i>IV</i>		<b>Route</b> <i>IM</i>	<b>Route</b> <i>IM</i>
<i>Dose</i>	0.5 g/kg (1 ml/kg)		0.5 mg	1 mg
<i>Max. single dose</i>	25 g (50 ml)		0.5 mg	1 mg
<i>Dosing interval</i>	10 min.		20 min.	20 min.
<i>Max. # of doses</i>	2		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 certified to the level of PCP Autonomous IV.

## BRONCHOCONSTRICTION MEDICAL DIRECTIVE

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

### INDICATIONS

---

Respiratory distress

**AND**

Suspected bronchoconstriction

### CONDITIONS

---

#### Salbutamol

AGE: N/A  
LOA: N/A  
HR: N/A  
RR: N/A  
SBP: N/A  
Other: N/A

#### Epinephrine

AGE: N/A  
WEIGHT: N/A  
LOA: N/A  
HR: N/A  
RR: BVM ventilation  
required  
SBP: N/A  
Other: Hx of asthma

#### Epinephrine Autoinjector

AGE: N/A  
WEIGHT:  $\geq 10$  kg  
LOA: N/A  
HR: N/A  
RR: BVM ventilation  
required  
SBP: N/A  
Other: Hx of asthma

### CONTRAINDICATIONS

---

#### Salbutamol

Allergy or sensitivity to salbutamol

#### Epinephrine

Allergy or sensitivity to epinephrine

#### Epinephrine Autoinjector

Allergy or sensitivity to epinephrine

**TREATMENT**

Consider *salbutamol*:

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

\*1 puff=100mcg

Consider *epinephrine*:

	Weight <i>N/A</i>	Weight ≥10 kg to <25 kg	Weight ≥25 kg
	Route <i>IM</i>	Route <i>Pediatric Autoinjector</i>	Route <i>Adult Autoinjector</i>
	Concentration <i>1:1,000</i>	Concentration <i>1:1,000</i>	Concentration <i>1:1,000</i>
<i>Dose</i>	0.01 mg/kg**	1 injection (0.15 mg)	1 injection (0.3 mg)
<i>Max. single dose</i>	0.5 mg	1 injection	1 injection
<i>Dosing interval</i>	<i>N/A</i>	<i>N/A</i>	<i>N/A</i>
<i>Max. # of doses</i>	1	1	1

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

## **CLINICAL CONSIDERATIONS**

---

Epinephrine should be the first 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.

***MANDATORY PROVINCIAL PATCH POINT:***

Patch to BHP for authorization to use pediatric autoinjector for patients <10 kg.



## MODERATE TO SEVERE ALLERGIC REACTION MEDICAL DIRECTIVE

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

### INDICATIONS

---

Exposure to a probable allergen

**AND**

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

### CONDITIONS

---

#### Epinephrine

AGE: N/A

WEIGHT: N/A

LOA: N/A

HR: N/A

RR: N/A

SBP: N/A

Other: For anaphylaxis only

#### Epinephrine Autoinjector

AGE: N/A

WEIGHT:  $\geq 10$  kg

LOA: N/A

HR: N/A

RR: N/A

SBP: N/A

Other: For anaphylaxis only

#### Diphenhydramine

AGE: N/A

WEIGHT:  $\geq 25$  kg

LOA: N/A

HR: N/A

RR: N/A

SBP: N/A

Other: N/A

### CONTRAINDICATIONS

---

#### Epinephrine

Allergy or sensitivity to epinephrine

#### Epinephrine Autoinjector

Allergy or sensitivity to epinephrine

#### Diphenhydramine

Allergy or sensitivity to diphenhydramine

**TREATMENT**Consider **epinephrine**:

	<b>Weight</b> N/A	<b>Weight</b> ≥10 kg to <25 kg	<b>Weight</b> ≥25 kg
	<b>Route</b> IM	<b>Route</b> Pediatric Autoinjector	<b>Route</b> Adult Autoinjector
	<b>Concentration</b> 1:1,000	<b>Concentration</b> 1:1,000	<b>Concentration</b> 1:1,000
<i>Dose</i>	0.01 mg/kg*	1 injection (0.15 mg)	1 injection (0.3 mg)
<i>Max. single dose</i>	0.5 mg	1 injection	1 injection
<i>Dosing interval</i>	N/A	N/A	N/A
<i>Max. # of doses</i>	1	1	1

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

Consider **diphenhydramine** (if certified and authorized):

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

**CLINICAL CONSIDERATIONS**

Epinephrine should be the first medication administered in anaphylaxis.

IV administration of diphenhydramine applies only to PCPs certified to the level of PCP Autonomous IV.

***MANDATORY PROVINCIAL PATCH POINT:***

Patch to BHP for authorization to use pediatric autoinjector for patients <10 kg

## CROUP MEDICAL DIRECTIVE

*A Primary Care Paramedic may provide the treatment prescribed in this Medical Directive if certified and 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**

AGE: <8 years

LOA: N/A

HR: <200/min

RR: N/A

SBP: N/A

Other: N/A

### CONTRAINDICATIONS

---

#### **Epinephrine**

Allergy or sensitivity to epinephrine

**TREATMENT**

Consider *epinephrine*:

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

**CLINICAL CONSIDERATIONS**

The minimum initial volume for nebulization is 2.5 ml.

## ADULT ANALGESIA MEDICAL DIRECTIVE

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

### INDICATIONS

---

Mild – Moderate Pain (Acetaminophen/Ibuprofen) **OR**

Mild – Severe Pain (Ketorolac)

**AND**

isolated hip or extremity trauma **OR** burns **OR** renal colic with prior history **OR** acute musculoskeletal back strain **OR** current history of cancer related pain.

### CONDITIONS

---

	Acetaminophen	Ibuprofen
AGE:	≥18 years	≥18 years
LOA:	Unaltered	Unaltered
HR:	N/A	N/A
RR:	N/A	N/A
SBP:	N/A	N/A
Other:	When used for trauma patients, restricted to those with isolated hip or extremity trauma	When used for trauma patients, restricted to those with isolated hip or extremity trauma

**Ketorolac**

AGE: ≥18 years  
LOA: Unaltered  
HR: N/A  
RR: N/A  
SBP: Normotension  
Other: For isolated hip or extremity trauma, 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 take oral medication

**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

**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

**TREATMENT**

Consider **acetaminophen**:

	<b>Route</b>
	<i>PO</i>
<i>Dose</i>	960-1000 mg
<i>Max. single dose</i>	1000 mg
<i>Dosing interval</i>	N/A
<i>Max. # of doses</i>	1

Consider **ibuprofen**:

	<b>Route</b>
	<i>PO</i>
<i>Dose</i>	400 mg
<i>Max. single dose</i>	400 mg
<i>Dosing interval</i>	N/A
<i>Max. # of doses</i>	1



Consider ***ketorolac***:

	<b>Route</b> <i>IM/IV</i>
<i>Dose</i>	10-15 mg
<i>Max. single dose</i>	15 mg
<i>Dosing interval</i>	N/A
<i>Max. # of doses</i>	1

## CLINICAL CONSIDERATIONS

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

In patients with isolated hip or extremity trauma, ibuprofen and acetaminophen is preferred to ketorolac except where the patient is unable to tolerate oral medications.

If ketorolac is administered, neither acetaminophen nor ibuprofen should be administered.

Suspected renal colic patients should routinely be considered for ketorolac.

## OPIOID TOXICITY MEDICAL DIRECTIVE

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

### INDICATIONS

---

Altered LOC

**AND**

Respiratory depression

**AND**

Inability to adequately ventilate

**AND**

Suspected opioid overdose

### CONDITIONS

---

#### **Naloxone**

AGE: ≥18 years

LOA: Altered

HR: N/A

RR: <10/min

SBP: N/A

Other: N/A

### CONTRAINDICATIONS

---

#### **Naloxone**

Allergy or sensitivity to naloxone

Uncorrected hypoglycemia

## TREATMENT

**MANDATORY PROVINCIAL PATCH POINT:**

Patch to BHP for authorization to proceed with naloxone

Consider **naloxone**:

	Route <i>SC</i>	Route <i>IM</i>	Route <i>IN</i>	Route <i>IV*</i>
<i>Dose</i>	0.8 mg	0.8 mg	0.8 mg	Up to 0.4 mg
<i>Max. single dose</i>	0.8 mg	0.8 mg	0.8 mg	0.4 mg
<i>Dosing interval</i>	N/A	N/A	N/A	N/A
<i>Max. # of doses</i>	1	1	1	1

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

## CLINICAL CONSIDERATIONS

IV administration of naloxone applies only to PCPs certified to the level of PCP Autonomous IV.

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

Naloxone is shorter acting than many narcotics and these patients are at high risk of having a recurrence of the narcotic effect. Therefore, every effort should be made to transport the patient to hospital for ongoing monitoring. If there is a refusal of transport initiated by the patient ensure safe monitoring by an available, reliable individual.

Combative behaviour should be anticipated following naloxone administration and paramedics should protect themselves accordingly. BVM with basic airway management and oxygenation are preferred over naloxone administration.



# **Appendix 2**

## **Advanced Care Paramedic Core Medical Directives**



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## MEDICAL CARDIAC ARREST MEDICAL DIRECTIVE

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

### INDICATIONS

Non-traumatic cardiac arrest

### CONDITIONS

#### CPR

AGE: N/A  
LOA: Altered  
HR: N/A  
RR: N/A  
SBP: N/A  
Other: Performed in 2  
minute intervals

#### Manual Defibrillation

AGE:  $\geq 30$  days  
LOA: Altered  
HR: N/A  
RR: N/A  
SBP: N/A  
Other: VF or pulseless VT

#### AED Defibrillation

AGE:  $\geq 30$  days  
LOA: Altered  
HR: N/A  
RR: N/A  
SBP: N/A  
Other: Shock indicated  
Alternative to  
manual  
defibrillation

#### Epinephrine

AGE:  $\geq 30$  days  
LOA: Altered  
HR: N/A  
RR: N/A  
SBP: N/A  
Other: If anaphylaxis  
suspected as  
causative event,  
IM route may be  
used

#### Amiodarone

AGE:  $\geq 30$  days  
LOA: Altered  
HR: N/A  
RR: N/A  
SBP: N/A  
Other: VF or pulseless VT

#### Lidocaine

AGE:  $\geq 30$  days  
LOA: Altered  
HR: N/A  
RR: N/A  
SBP: N/A  
Other: VF or pulseless VT  
where  
amiodarone is  
not available



**0.9% NaCl Fluid Bolus**

AGE: N/A

LOA: Altered

HR: N/A

RR: N/A

SBP: N/A

Other: PEA

Any other rhythm  
where  
hypovolemia is  
suspected

---

**CONTRAINDICATIONS**

---

**CPR**

Obviously dead as per BLS Standards

Meet conditions of DNR Standard

**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	
	≥30 days to <8 years	≥8 years
<i>Dose</i>	1 shock	1 shock
<i>First dose</i>	2 J/kg	As per BH / manufacturer
<i>Subsequent and max. dose(s)</i>	4 J/kg	As per BH / manufacturer
<i>Dosing interval</i>	2 min	2 min
<i>Max. # of doses</i>	N/A	N/A

Consider **AED defibrillation**: (alternative to manual defibrillation)

	Age		Age ≥8 years
	≥30 days to <8 years		
	With Ped attenuator	Without Ped attenuator	
<i>Dose</i>	1 shock	1 shock	1 shock
<i>Max. single dose</i>	As per BH / manufacturer	As per BH / manufacturer	As per BH / manufacturer
<i>Dosing interval</i>	2 min	2 min	2 min
<i>Max. # of doses</i>	N/A	N/A	N/A

Consider **epinephrine**:

In the event anaphylaxis is suspected as the causative event of the cardiac arrest, a single dose of 0.01 mg/kg 1:1,000 solution, to a maximum of 0.5 mg IM, may be given prior to obtaining the IV/IO.

	Age ≥30 days to <12 years		Age ≥12 years	
	Route		Route	
	IV / IO / CVAD	ETT	IV / IO / CVAD	ETT
<i>Solution</i>	1:10,000	1:1,000	1:10,000	As per BH
<i>Dose</i>	0.01 mg/kg*	0.1 mg/kg to a max of 2 mg	1 mg	2 mg
<i>Min. single dose</i>	0.1 mg	1 mg	1 mg	2 mg
<i>Dosing interval</i>	4 min.	4 min.	4 min.	4 min.
<i>Max. # of doses</i>	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		Age ≥12 years	
	Route		Route	
	IV / IO / CVAD	IV / IO / CVAD	IV / IO / CVAD	IV / IO / CVAD
<i>Initial Dose</i>	5 mg/kg	300 mg	300 mg	300 mg
<i>Max. initial dose</i>	300 mg	300 mg	300 mg	300 mg
<i>Repeat dose</i>	5 mg/kg	150 mg	150 mg	150 mg
<i>Max. repeat dose</i>	150 mg	150 mg	150 mg	150 mg
<i>Dosing interval</i>	4 min.	4 min.	4 min.	4 min.
<i>Max. # of doses</i>	2	2	2	2

Consider **lidocaine**: (if amiodarone not available)

	Age ≥30 days to 12 years		Age ≥12 years	
	Route		Route	
	IV / IO / CVAD	ETT	IV / IO / CVAD	ETT
<i>Dose</i>	1 mg/kg	2 mg/kg	1.5 mg/kg	3 mg/kg
<i>Min. single dose</i>	N/A	N/A	N/A	N/A
<i>Dosing interval</i>	4 min.	4 min.	4 min.	4 min.
<i>Max. # of doses</i>	2	2	2	2

Consider **0.9% NaCl fluid bolus**:

	Age ≥30 days to <12 years	Age ≥12 years
	Route	
	IV / IO / CVAD	IV / IO / CVAD
<i>Infusion</i>	20 ml/kg	20 ml/kg
<i>Infusion interval</i>	Immediate	Immediate
<i>Reassess every</i>	100 ml	250 ml
<i>Max. volume</i>	20 ml/kg up to 2,000 ml	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/ETT access). If the BH patch fails, transport to the closest appropriate receiving hospital following the 4<sup>th</sup> epinephrine administration (or 4<sup>th</sup> analysis if no IV/IO/ETT access).

## **CLINICAL CONSIDERATIONS**

---

In unusual circumstances (e.g. pediatric patients or toxicological overdoses), consider initiating transport following the first rhythm analysis that does not result in a defibrillation being delivered.

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. >5 min.)

## TRAUMA CARDIAC ARREST MEDICAL DIRECTIVE

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

### INDICATIONS

Cardiac arrest secondary to severe blunt or penetrating trauma

### CONDITIONS

#### CPR

AGE: N/A  
LOA: Altered  
HR: N/A  
RR: N/A  
SBP: N/A  
Other: Performed in 2  
minute intervals

#### Manual Defibrillation

AGE:  $\geq 30$  days  
LOA: Altered  
HR: N/A  
RR: N/A  
SBP: N/A  
Other: VF or pulseless VT

#### AED Defibrillation

AGE:  $\geq 30$  days  
LOA: Altered  
HR: N/A  
RR: N/A  
SBP: N/A  
Other: Shock indicated

#### Trauma TOR

AGE:  $\geq 16$  years  
LOA: Altered  
HR: 0  
RR: 0  
SBP: N/A  
Other: No palpable pulses  
No defibrillation delivered **AND**  
monitored HR =0 (asystole) **OR**  
monitored HR >0 **AND** the  
closest ER  $\geq 30$  min transport  
time away.

## CONTRAINDICATIONS

### CPR

Obviously dead as per BLS standards

Meet conditions of DNR standard

### Manual Defibrillation

Rhythms other than VF or pulseless VT

### AED Defibrillation

Non-shockable rhythm

### Trauma TOR

Age <16 years

Shock delivered

Monitored HR >0 and closest ER <30 min away

## TREATMENT

Consider **CPR**

Consider **Manual defibrillation:**

	Age ≥30 days to <8 years	Age ≥8 years
<i>Dose</i>	1 shock	1 shock
<i>Initial dose</i>	2 J/kg	As per BH / manufacturer
<i>Dosing interval</i>	2 min	2 min
<i>Max. # of doses</i>	1	1

Consider **AED defibrillation**: (alternative to manual defibrillation)

	Age ≥30 days to <8 years		Age ≥8 years
	With Ped attenuator	Without Ped attenuator	
<i>Dose</i>	1 shock	1 shock	1 shock
<i>Max. single dose</i>	As per BH / manufacturer	As per BH / manufacturer	As per BH / manufacturer
<i>Dosing interval</i>	2 min	2 min	2 min
<i>Max. # of doses</i>	1	1	1

**MANDATORY PROVINCIAL PATCH POINT:**

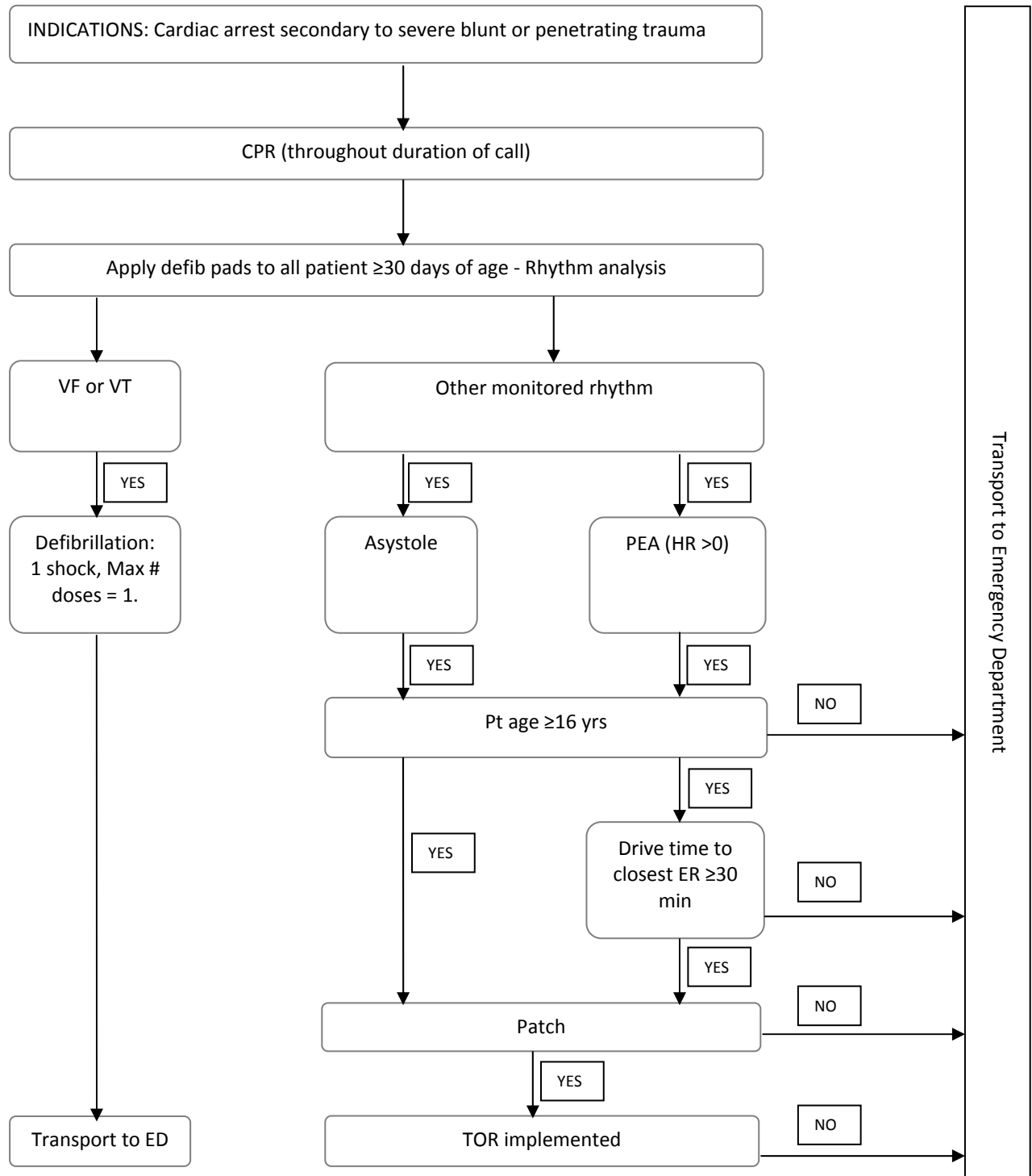
Patch to BHP for authorization to apply the *Trauma (TOR) Termination of Resuscitation* if applicable. If the BH patch fails, or the trauma TOR does not apply, transport to the closest appropriate receiving hospital following the first analysis/shock.

**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 certified and authorized.*

### INDICATIONS

---

Cardiac arrest secondary to severe hypothermia

### CONDITIONS

---

#### CPR

AGE: N/A  
LOA: Altered  
HR: N/A  
RR: N/A  
SBP: N/A  
Other: Performed in 2  
minute intervals

#### Manual Defibrillation

AGE: ≥30 days  
LOA: Altered  
HR: N/A  
RR: N/A  
SBP: N/A  
Other: VF or pulseless VT

#### AED Defibrillation

AGE: ≥30 days  
LOA: Altered  
HR: N/A  
RR: N/A  
SBP: N/A  
Other: Shock indicated

### CONTRAINDICATIONS

---

#### CPR

Obviously dead as per BLS  
standards  
Meet conditions of DNR  
standard

#### Manual Defibrillation

Rhythms other than VF or  
pulseless VT

#### AED Defibrillation

Non-shockable rhythm

## TREATMENT

Consider **CPR**

Consider **Manual defibrillation:**

	Age ≥30 days to <8 years	Age ≥8 years
<i>Dose</i>	1 shock	1 shock
<i>Initial dose</i>	2 J/kg	As per BH / manufacturer
<i>Dosing interval</i>	2 min	2 min
<i>Max. # of doses</i>	1	1

Consider **AED defibrillation:** (alternative to manual defibrillation)

	Age ≥30 days to <8 years		Age ≥8 years
	<i>With Ped attenuator</i>	<i>Without Ped attenuator</i>	
<i>Dose</i>	1 shock	1 shock	1 shock
<i>Max. single dose</i>	As per BH / manufacturer	As per BH / manufacturer	As per BH / manufacturer
<i>Dosing interval</i>	2 min	2 min	2 min
<i>Max. # of doses</i>	1	1	1

Transport to the closest appropriate facility without delay following the first analysis.

## CLINICAL CONSIDERATIONS

N/A

## FOREIGN BODY AIRWAY OBSTRUCTION CARDIAC ARREST MEDICAL DIRECTIVE

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

### INDICATIONS

Cardiac arrest secondary to an airway obstruction

### CONDITIONS

#### CPR

AGE: N/A  
LOA: Altered  
HR: N/A  
RR: N/A  
SBP: N/A  
Other: Performed in 2  
minute intervals

#### Manual Defibrillation

AGE: ≥30 days  
LOA: Altered  
HR: N/A  
RR: N/A  
SBP: N/A  
Other: VF or pulseless VT

#### AED Defibrillation

AGE: ≥30 days  
LOA: Altered  
HR: N/A  
RR: N/A  
SBP: N/A  
Other: Shock indicated

### CONTRAINDICATIONS

#### CPR

Obviously dead as per BLS  
Standards  
Meet conditions of DNR  
Standard

#### Manual Defibrillation

Rhythms other than VF or  
pulseless VT

#### AED Defibrillation

Non-shockable rhythm

### TREATMENT

Consider **CPR**

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

Consider **Manual defibrillation**:

	Age ≥30 days to <8 years	Age ≥8 years
<i>Dose</i>	1 shock	1 shock
<i>Initial dose</i>	2 J/kg	As per BH / manufacturer
<i>Dosing interval</i>	2 min	2 min
<i>Max. # of doses</i>	1	1

Consider **AED defibrillation**: (alternative to manual defibrillation)

	Age ≥30 days to <8 years		Age ≥8 years
	<i>With Ped attenuator</i>	<i>Without Ped attenuator</i>	
<i>Dose</i>	1 shock	1 shock	1 shock
<i>Max. single dose</i>	As per BH / manufacturer	As per BH / manufacturer	As per BH / manufacturer
<i>Dosing interval</i>	2 min	2 min	2 min
<i>Max. # of doses</i>	1	1	1

If the obstruction cannot be removed, transport to the closest appropriate facility without delay following the first analysis.

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

## CLINICAL CONSIDERATIONS

N/A

## NEONATAL RESUSCITATION MEDICAL DIRECTIVE

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

### INDICATIONS

---

Severe cardio-respiratory distress

### CONDITIONS

---

#### Resuscitation

AGE: newborn or <30  
days of age

LOA: N/A

HR: N/A

RR: N/A

SBP: N/A

Other: Less than full  
term **OR**  
meconium **OR**  
poor APGAR score

### CONTRAINDICATIONS

---

#### Resuscitation

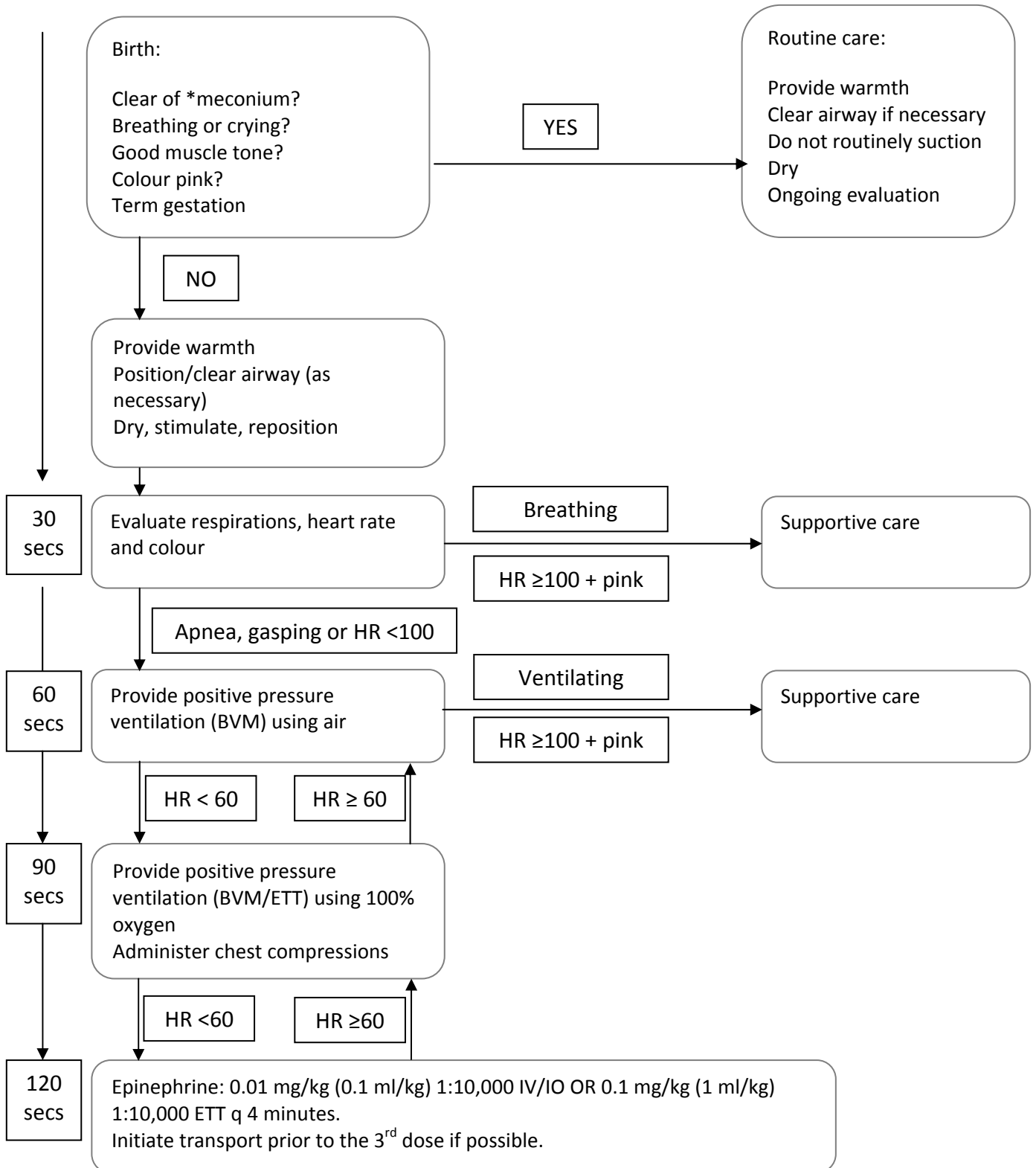
Clear of meconium

Breathing or crying

Good muscle tone

Pink in colour

**TREATMENT**



\*if meconium is present and baby not vigorous, suction mouth and pharynx, consider ETT and provide BVM ventilations as required and then continue with the remainder of the initial steps following birth.

## RETURN OF SPONTANEOUS CIRCULATION (ROSC) MEDICAL DIRECTIVE

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

### INDICATIONS

---

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

### CONDITIONS

---

#### 0.9% NaCl Fluid Bolus

AGE: N/A  
LOA: N/A  
HR: N/A  
RR: N/A  
SBP: Hypotension  
Other: Chest auscultation is clear

#### Dopamine

AGE:  $\geq 18$  years  
LOA: N/A  
HR: N/A  
RR: N/A  
SBP: Hypotension  
Other: N/A

#### Therapeutic hypothermia

AGE: males  $\geq 18$  years  
females  $\geq 50$  years  
LOA: Altered  
HR: N/A  
RR: N/A  
SBP:  $\geq 90$  mmHg  
(spontaneous, following bolus administered or with dopamine)  
Other: N/A



## CONTRAINDICATIONS

---

### 0.9% NaCl Fluid Bolus

Fluid overload  
SBP  $\geq$ 90 mmHg

### Dopamine

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

### Therapeutic hypothermia

Traumatic cardiac arrest (blunt, penetrating or burn)  
Sepsis or serious infection suspected as cause of arrest  
Hypothermic arrest  
Known coagulopathy (medical history or medications)

## TREATMENT

---

Consider ***rapid transport***

Consider ***optimizing ventilation and oxygenation:***

Titrate oxygenation  $\geq$ 94%

Avoid hyperventilation and target an ETCO<sub>2</sub> of 35-40 mmHg with continuous waveform capnography (if available)

Consider **0.9% NaCl fluid bolus**:

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

Consider **dopamine**:

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

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

Consider **12-lead ECG acquisition**

Consider **Therapeutic hypothermia** (if available)

## CLINICAL CONSIDERATIONS

The application of therapeutic hypothermia should not detract from rapid transport, optimizing ventilation and oxygenation or the management of a re-arrest.

## CARDIAC ISCHEMIA MEDICAL DIRECTIVE

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

### 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

#### Nitroglycerin

AGE: ≥18 years

LOA: Unaltered

HR: 60-159/min

RR: N/A

SBP: Normotension

Other: Prior history of nitroglycerin use or IV access obtained

#### Morphine

AGE: ≥18 years

LOA: Unaltered

HR: N/A

RR: N/A

SBP: Normotension

Other: N/A

## 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 infarct

### Morphine

Allergy or sensitivity to morphine  
 Injury to the head or chest or abdomen OR pelvis  
 SBP drops by one-third or more of its initial value after morphine is administered

## TREATMENT

Consider **ASA**:

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

Consider **12-lead ECG acquisition**

Consider **nitroglycerin**:

	<b>SBP</b> ≥100 mmHg
	<b>Route</b> SL
<i>Dose</i>	0.3 or 0.4 mg
<i>Max. single dose</i>	0.4 mg
<i>Dosing interval</i>	5 min.
<i>Max. # of doses</i>	6

Consider **morphine** (after the third dose of nitroglycerin or if nitroglycerin is contraindicated):

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

## CLINICAL CONSIDERATIONS

N/A

## ACUTE CARADIOGENIC PULMONARY EDEMA MEDICAL DIRECTIVE

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

### INDICATIONS

---

Moderate to severe respiratory distress

**AND**

Suspected acute cardiogenic pulmonary edema

### CONDITIONS

---

#### **Nitroglycerin**

AGE: ≥18 years

LOA: N/A

HR: 60-159/min

RR: N/A

SBP: Normotension

Other: Ascertain prior  
history of  
nitroglycerin use  
**OR** establish IV  
access

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

**NOTE:** Hx refers to a patient with a prior history of nitroglycerin use.

Consider **12-lead ECG acquisition**

## CLINICAL CONSIDERATIONS

N/A

## CARDIOGENIC SHOCK MEDICAL DIRECTIVE

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

### INDICATIONS

---

STEMI-positive ECG

**AND**

Cardiogenic shock

### CONDITIONS

---

#### **0.9% NaCl Fluid Bolus**

AGE: ≥18 years

LOA: N/A

HR: N/A

RR: N/A

SBP: Hypotension

Other: Clear chest on auscultation

#### **Dopamine**

AGE: ≥18 years

LOA: N/A

HR: N/A

RR: N/A

SBP: Hypotension

Other: N/A

### CONTRAINDICATIONS

---

#### **0.9% NaCl Fluid Bolus**

N/A

#### **Dopamine**

Allergy or sensitivity to dopamine

Tachydysrhythmias excluding sinus tachycardia

Mechanical shock states

Hypovolemia

Pheochromocytoma



## TREATMENT

Consider **0.9% NaCl fluid bolus**:

	Age	
	≥18 years	
	Route	Route
	IV	IO
<i>Infusion</i>	10 ml/kg	10 ml/kg
<i>Infusion interval</i>	N/A	N/A
<i>Reassess every</i>	250 ml	250 ml
<i>Max. volume</i>	10 ml/kg	10 ml/kg

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

Consider **dopamine**:

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

**NOTE:** Titrate dopamine to achieve a systolic BP of 90-110 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 certified and authorized.*

### INDICATIONS

---

Bradycardia

**AND**

Hemodynamic instability

### CONDITIONS

---

#### **Atropine**

AGE:  $\geq 18$  years  
LOA: N/A  
HR:  $< 50/\text{min}$   
RR: N/A  
SBP: Hypotension  
Other: N/A

#### **Transcutaneous Pacing**

AGE:  $\geq 18$  years  
LOA: N/A  
HR:  $< 50/\text{min}$   
RR: N/A  
SBP: Hypotension  
Other: N/A

#### **Dopamine**

AGE:  $\geq 18$  years  
LOA: N/A  
HR:  $< 50/\text{min}$   
RR: N/A  
SBP: Hypotension  
Other: 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*** (if this won't delay therapy)

Consider ***atropine***:

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

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

**NOTE:** Titrate dopamine to achieve a systolic BP of 90-110 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, first degree AV block, or second-degree Type I AV block.

A single dose of atropine should be considered for second degree Type II or third degree AV blocks with fluid bolus while preparing for TCP OR if there is a delay in implementing TCP OR if TCP is unsuccessful.

The dopamine infusion should be initiated at 5 mcg/kg/min. and titrated upward to effect in increments of 5 mcg/kg/min every 5 minutes up to a maximum of 20 mcg/kg/min.

The desired effect is a SBP of 90-110 mmHg.

## TACHYDYSRHYTHMIA MEDICAL DIRECTIVE

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

### INDICATIONS

---

Symptomatic Tachydysrhythmia

### CONDITIONS

---

#### Valsalva Maneuver

AGE:  $\geq 18$  years  
LOA: Unaltered  
HR:  $\geq 150$ /min  
RR: N/A  
SBP: Normotension  
Other: Narrow complex and regular rhythm

#### Adenosine

AGE:  $\geq 18$  years  
LOA: Unaltered  
HR:  $\geq 150$ /min  
RR: N/A  
SBP: Normotension  
Other: Narrow complex and regular rhythm

#### Amiodarone

AGE:  $\geq 18$  years  
LOA: Unaltered  
HR:  $\geq 120$ /min  
RR: N/A  
SBP: Normotension  
Other: Wide complex and regular rhythm

#### Lidocaine

AGE:  $\geq 18$  years  
LOA: Unaltered  
HR:  $\geq 120$ /min  
RR: N/A  
SBP: Normotension  
Other: Wide complex and regular rhythm

#### Synchronized Cardioversion

AGE:  $\geq 18$  years  
LOA: N/A  
HR:  $\geq 120$ /min (wide) or  $\geq 150$ /min (narrow)  
RR: N/A  
SBP: Hypotension  
Other: Altered mental status, ongoing chest pain, other signs of shock

---

## 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***: To confirm QRS width (if this won't delay therapy)

Consider ***valsalva maneuver***:

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

Consider **adenosine**:

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

**MANDATORY PROVINCIAL PATCH POINT:**

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

Consider **amiodarone** (if available) **OR lidocaine**:

	<b>Drug</b>	<b>Drug</b>
	<i>Amiodarone</i>	<i>Lidocaine</i>
	<b>Route</b>	<b>Route</b>
	<i>IV*</i>	<i>IV</i>
<i>First Dose</i>	150 mg	1.5 mg/kg
<i>Subsequent Dose(s)</i>	150 mg	0.75 mg/kg
<i>Max. single dose</i>	150 mg	150 mg
<i>Dosing interval</i>	10 min	10 min
<i>Max. # of doses</i>	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 three 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 certified and authorized.*

### INDICATIONS

---

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

### CONDITIONS

---

#### IV

AGE: N/A  
LOA: N/A  
HR: N/A  
RR: N/A  
SBP: N/A  
Other: N/A

#### 0.9% NaCl Fluid Bolus

AGE: N/A  
LOA: N/A  
HR: N/A  
RR: N/A  
SBP: Hypotension  
Other: N/A

### CONTRAINDICATIONS

---

#### IV

Suspected fracture proximal to the access site.

#### 0.9% NaCl Fluid Bolus

Signs of fluid overload

**TREATMENT**

Consider **IV cannulation**

Consider **0.9% NaCl** maintenance infusion:

	<b>Age</b> <i>&lt;12 years</i>	<b>Age</b> <i>≥12 years</i>
	<b>Route</b> <i>IV / IO / CVAD</i>	<b>Route</b> <i>IV / IO / CVAD</i>
<i>Infusion</i>	15 ml/hr	30-60 ml/hr
<i>Infusion interval</i>	N/A	N/A
<i>Reassess every</i>	N/A	N/A
<i>Max. volume</i>	N/A	N/A

**MANDATORY PROVINCIAL PATCH POINT:**

Patch to BHP for authorization to administer IV NaCl bolus to patients <12 years with suspected Diabetic Ketoacidosis (DKA)

Consider **0.9% NaCl fluid bolus:**

	<b>Age</b> <i>&lt;12 years</i>	<b>Age</b> <i>≥12 years</i>
	<b>Route</b> <i>IV / IO / CVAD</i>	<b>Route</b> <i>IV / IO / CVAD</i>
<i>Infusion</i>	20 ml/kg	20 ml/kg
<i>Infusion interval</i>	Immediate	Immediate
<i>Reassess every</i>	100 ml	250 ml
<i>Max. volume*</i>	20 ml/kg up to 2,000 ml	2,000 ml

\*The maximal volume of NaCl is lower for patients in cardiogenic shock.

## **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 ACP will perform all IV further therapy in accordance with the *Intravenous and Fluid Therapy Medical Directive* once intravenous access is obtained. PCPs certified in PCP Assist IV are not authorized to administer IV fluid or medication therapy.

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

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

## PEDIATRIC INTRAOSSEOUS MEDICAL DIRECTIVE

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

### INDICATIONS

---

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

**AND**

Intravenous access is unobtainable

**AND**

Cardiac arrest or near-arrest state

### CONDITIONS

---

**IO**

AGE: <12 years

LOA: N/A

HR: N/A

RR: N/A

SBP: N/A

Other: N/A

### CONTRAINDICATION

---

**IO**

Fracture or crush injuries or 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 certified and authorized.*

### INDICATIONS

---

Agitation **OR** altered LOA **OR** seizure **OR** symptoms of stroke

### CONDITIONS

---

#### Dextrose

AGE: N/A  
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 to glucagon  
Pheochromocytoma

### TREATMENT

---

Perform *glucometry*

Consider *dextrose or glucagon*:

<b>Drug</b>			
<i>Dextrose</i>			
	<b>Age</b>	<b>Age</b>	<b>Age</b>
	<30 days	≥30 days to <2 years	≥2 years
	<b>Weight</b>	<b>Weight</b>	<b>Weight</b>
	N/A	N/A	N/A
	<b>Concentration</b>	<b>Concentration</b>	<b>Concentration</b>
	D10W	D25W	D50W
	<b>Route</b>	<b>Route</b>	<b>Route</b>
	IV	IV	IV
<i>Dose</i>	0.2 g/kg (2 ml/kg)	0.5 g/kg (2 ml/kg)	0.5 g/kg (1 ml/kg)
<i>Max. single dose</i>	5 g (50 ml)	10 g (40 ml)	25 g (50 ml)
<i>Dosing interval</i>	10 min.	10 min.	10 min.
<i>Max. # of doses</i>	2	2	2

<b>Drug</b>		
<i>Glucagon</i>		
	<b>Age</b>	
	N/A	
	<b>Weight</b>	<b>Weight</b>
	<25 kg	≥25 kg
	<b>Concentration</b>	<b>Concentration</b>
	N/A	N/A
	<b>Route</b>	<b>Route</b>
	IM	IM
<i>Dose</i>	0.5 mg	1.0 mg
<i>Max. single dose</i>	0.5 mg	1.0 mg
<i>Dosing interval</i>	20 min.	20 min.
<i>Max. # of doses</i>	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.



## SEIZURE MEDICAL DIRECTIVE

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

### INDICATIONS

---

Active generalized motor seizure

### CONDITIONS

---

#### **Midazolam**

AGE: N/A

LOA: Unresponsive

HR: N/A

RR: N/A

SBP: N/A

Other: N/A

### CONTRAINDICATIONS

---

#### **Midazolam**

Allergy or sensitivity to midazolam

Hypoglycemia

## TREATMENT

Consider *midazolam*:

	<b>Route</b> <i>IV</i>	<b>Route</b> <i>IM</i>	<b>Route</b> <i>IN</i>	<b>Route</b> <i>Buccal</i>
<i>Dose</i>	0.1 mg/kg	0.2 mg/kg	0.2 mg/kg	0.2 mg/kg
<i>Max. single dose</i>	5.0 mg	10 mg	10 mg	10 mg
<i>Dosing interval</i>	5 min.	5 min.	5 min.	5 min.
<i>Max. # of doses</i>	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 certified and authorized.*

### INDICATIONS

---

Altered LOC

**AND**

Respiratory depression

**AND**

Suspected opioid overdose

### CONDITIONS

---

#### **Naloxone**

AGE:  $\geq 18$  years

LOA: Altered

HR: N/A

RR:  $< 10$ /min

SBP: N/A

Other: N/A

### CONTRAINDICATIONS

---

#### **Naloxone**

Allergy or sensitivity to naloxone

Uncorrected hypoglycemia

## TREATMENT

### **MANDATORY PROVINCIAL PATCH POINT:**

Patch to BHP for authorization to proceed with naloxone

Consider *naloxone*:

	<b>Route</b> <i>SC</i>	<b>Route</b> <i>IM</i>	<b>Route</b> <i>IN</i>	<b>Route</b> <i>IV*</i>
<i>Dose</i>	0.8 mg	0.8 mg	0.8 mg	Up to 0.4 mg
<i>Max. single dose</i>	0.8 mg	0.8 mg	0.8 mg	0.4 mg
<i>Dosing interval</i>	N/A	N/A	N/A	N/A
<i>Max. # of doses</i>	1	1	1	1

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

## CLINICAL CONSIDERATIONS

N/A

## OROTRACHEAL INTUBATION MEDICAL DIRECTIVE

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

### INDICATIONS

---

Need for ventilatory assistance or airway control

**AND**

Other airway management is inadequate or ineffective

### CONDITIONS

---

#### Lidocaine Spray

AGE: N/A

LOA: N/A

HR: N/A

RR: N/A

SBP: N/A

Other: Orotracheal  
Intubation

#### Orotracheal Intubation

AGE: N/A

LOA: N/A

HR: N/A

RR: N/A

SBP: N/A

Other: N/A

### CONTRAINDICATIONS

---

#### Lidocaine

Allergy or sensitivity to  
lidocaine

Unresponsive patient

#### Orotracheal Intubation

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

**TREATMENT**

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

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

Consider **oro-tracheal intubation**: with or without intubation facilitation devices. The maximum number of intubation attempts is 2.

Confirm **oro-tracheal tube placement**:

<b>Method</b>	<b>Method</b>
<i>Primary</i>	<i>Secondary</i>
Visualization	ETCO <sub>2</sub>
Auscultation	EDD
Chest rise	Other

## **CLINICAL CONSIDERATIONS**

---

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

The maximum number of supraglottic airway attempts is two (2) and the maximum number of intubation attempts is two (2).

At least two primary and one secondary ETT placement confirmation methods must be used.

If the patient has a pulse, an ETCO<sub>2</sub> device (quantitative or qualitative) must be used for ETT placement confirmation.

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 certified and authorized.*

### INDICATIONS

Respiratory distress

**AND**

Suspected bronchoconstriction

### CONDITIONS

#### Salbutamol

AGE: N/A  
LOA: N/A  
HR: N/A  
RR: N/A  
SBP: N/A  
Other: N/A

#### Epinephrine

AGE: N/A  
WEIGHT: N/A  
LOA: N/A  
HR: N/A  
RR: BVM ventilation  
required  
SBP: N/A  
Other: Hx of asthma

#### Epinephrine Autoinjector

AGE: N/A  
WEIGHT:  $\geq 10$  kg  
LOA: N/A  
HR: N/A  
RR: BVM ventilation  
required  
SBP: N/A  
Other: Hx of asthma

### CONTRAINDICATIONS

#### Salbutamol

Allergy or sensitivity to salbutamol

#### Epinephrine

Allergy or sensitivity to epinephrine

#### Epinephrine Autoinjector

Allergy or sensitivity to epinephrine



**TREATMENT**

Consider *salbutamol*:

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

\*1 puff=100mcg

Consider *epinephrine*:

	Weight Any	Weight ≥10 kg to <25 kg	Weight ≥25 kg
	Route IM	Route Pediatric Autoinjector	Route Adult Autoinjector
	Concentration 1:1,000	Concentration 1:1,000	Concentration 1:1,000
<i>Dose</i>	0.01 mg/kg**	1 injection (0.15 mg)	1 injection (0.3 mg)
<i>Max. single dose</i>	0.5 mg	1 injection	1 injection
<i>Dosing interval</i>	N/A	N/A	N/A
<i>Max. # of doses</i>	1	1	1

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

**CLINICAL CONSIDERATIONS**

Epinephrine should be the first drug 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.

***MANDATORY PROVINCIAL PATCH POINT:***

Patch to BHP for authorization to use pediatric autoinjector for patients <10 kg.

## MODERATE TO SEVERE ALLERGIC REACTION MEDICAL DIRECTIVE

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

### INDICATIONS

---

Exposure to a probable allergen

**AND**

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

### CONDITIONS

---

#### Epinephrine

AGE: N/A  
WEIGHT: N/A  
LOA: N/A  
HR: N/A  
RR: N/A  
SBP: N/A  
Other: For anaphylaxis only

#### Epinephrine Autoinjector

AGE: N/A  
WEIGHT:  $\geq 10$  kg  
LOA: N/A  
HR: N/A  
RR: N/A  
SBP: N/A  
Other: For anaphylaxis only

#### Diphenhydramine

AGE: N/A  
WEIGHT:  $\geq 25$  kg  
LOA: N/A  
HR: N/A  
RR: N/A  
SBP: N/A  
Other: N/A

### CONTRAINDICATIONS

---

#### Epinephrine

Allergy or sensitivity to epinephrine

#### Epinephrine Autoinjector

Allergy or sensitivity to epinephrine

#### Diphenhydramine

Allergy or sensitivity to diphenhydramine

**TREATMENT**Consider **epinephrine**:

	<b>Weight</b> <i>N/A</i>	<b>Weight</b> <i>≥10 kg to &lt;25 kg</i>	<b>Weight</b> <i>≥25 kg</i>
	<b>Route</b> <i>IM</i>	<b>Route</b> <i>Pediatric Autoinjector</i>	<b>Route</b> <i>Adult Autoinjector</i>
	<b>Concentration</b> <i>1:1,000</i>	<b>Concentration</b> <i>1:1,000</i>	<b>Concentration</b> <i>1:1,000</i>
<i>Dose</i>	0.01 mg/kg*	1 injection (0.15 mg)	1 injection (0.3 mg)
<i>Max. single dose</i>	0.5 mg	1 injection	1 injection
<i>Dosing interval</i>	N/A	N/A	N/A
<i>Max. # of doses</i>	1	1	1

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

Consider **diphenhydramine** (if available):

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

**CLINICAL CONSIDERATIONS**

Epinephrine should be the first drug administered in anaphylaxis.

**MANDATORY PROVINCIAL PATCH POINT:**

Patch to BHP for authorization to use pediatric autoinjector for patients &lt;10kg

## CROUP MEDICAL DIRECTIVE

*An Advanced Care Paramedic may provide the treatment prescribed in this Medical Directive if certified and 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**

AGE: <8 years

LOA: N/A

HR: <200/min

RR: N/A

SBP: N/A

Other: N/A

### CONTRAINDICATIONS

---

#### **Epinephrine**

Allergy or sensitivity to epinephrine

**TREATMENT**

Consider *epinephrine*:

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

AGE: N/A

LOA: N/A

HR: N/A

RR: N/A

SBP: Hypotension or  
VSA

Other: 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 second intercostal space in the midclavicular line.



## PEDIATRIC ANALGESIA MEDICAL DIRECTIVE

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

### INDICATIONS

---

Severe pain

#### AND

Isolated hip **OR** extremity fractures or dislocations **OR** major burns **OR** current history of cancer related pain

### CONDITIONS

---

#### **Morphine**

AGE: <18 years

LOA: Unaltered

HR:  $\geq 60$ /min

RR: N/A

SBP: Normotension

Other: N/A

## CONTRAINDICATIONS

### Morphine

Allergy or sensitivity to morphine

Injury to the head or chest or abdomen or pelvis

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

## TREATMENT

### **MANDATORY PROVINCIAL PATCH POINT:**

Patch to BHP for authorization and dosage verification before administering the medication for children <8 years.

Consider ***morphine***:

	Route IV/SC
<i>Dose</i>	0.05 mg/kg
<i>Max. single dose</i>	3 mg
<i>Dosing interval</i>	5 min.
<i>Max. # of doses</i>	2

## CLINICAL CONSIDERATIONS

N/A

## ADULT ANALGESIA MEDICAL DIRECTIVE

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

### INDICATIONS

---

Mild – Moderate Pain (Acetaminophen/Ibuprofen) **OR**

Mild – Severe Pain (Ketorolac) **AND/OR**

Moderate – Severe Pain (Morphine)

#### **AND**

trauma **OR** burns **OR** renal colic with prior history **OR** acute musculoskeletal back strain **OR** current history of cancer related pain.

### CONDITIONS

---

	<b>Acetaminophen</b>	<b>Ibuprofen</b>
AGE:	≥18 years	≥18 years
LOA:	Unaltered	Unaltered
HR:	N/A	N/A
RR:	N/A	N/A
SBP:	N/A	N/A
Other:	When used for trauma patients, restricted to those with isolated hip or extremity trauma	When used for trauma patients, restricted to those with isolated hip or extremity trauma

**Ketorolac**

AGE: ≥18 years

LOA: Unaltered

HR: N/A

RR: N/A

SBP: Normotension

Other: When used for trauma patients, restricted to those with isolated hip / extremity trauma **AND** who are unable to tolerate oral medications

**Morphine**

AGE: ≥18 years

LOA: Unaltered

HR: N/A

RR: N/A

SBP: Normotension

Other: N/A

---

## CONTRAINDICATIONS

---

### Acetaminophen

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

### 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

### 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

### Morphine

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

**TREATMENT**

Consider **acetaminophen**:

	<b>Route</b>
	<i>PO</i>
<i>Dose</i>	960-1000 mg
<i>Max. single dose</i>	1000 mg
<i>Dosing interval</i>	N/A
<i>Max. # of doses</i>	1

Consider **ibuprofen**:

	<b>Route</b>
	<i>PO</i>
<i>Dose</i>	400 mg
<i>Max. single dose</i>	400 mg
<i>Dosing interval</i>	N/A
<i>Max. # of doses</i>	1

Consider **ketorolac**:

	<b>Route</b>
	<i>IM/IV</i>
<i>Dose</i>	10-15 mg
<i>Max. single dose</i>	15 mg
<i>Dosing interval</i>	N/A
<i>Max. # of doses</i>	1

Consider **morphine**:

	<b>Route</b>
	<i>SC/IV</i>
<i>Dose</i>	2-5 mg
<i>Max. single dose</i>	5 mg
<i>Dosing interval</i>	5 min
<i>Max # doses</i>	4

## **CLINICAL CONSIDERATIONS**

---

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

In patients with isolated hip or extremity trauma, ibuprofen and acetaminophen is preferred to ketorolac except where the patient is unable to tolerate oral medications.

If ketorolac is administered, neither acetaminophen nor ibuprofen should be administered.

Suspected renal colic patients should routinely be considered for ketorolac AND morphine.

## HYPERKALEMIA MEDICAL DIRECTIVE

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

### INDICATIONS

---

Suspected hyperkalemia in patients at high risk, including:

- currently on dialysis **OR**
- history of end-stage renal disease (ESRD) **OR**
- other reason to be highly suspicious of hyperkalemia (i.e. prolonged crush injury)

### AND

one of the following clinical situations:

- Cardiac Arrest

### OR

- pre-arrest (i.e. hypotension, altered level of consciousness, symptomatic bradycardia) with 12-lead ECG suggestive of hyperkalemia (i.e. wide and often bizarre QRS (>120 ms) with peaked T waves, loss of p waves and/or may have sine wave appearance)

### CONDITIONS

---

#### Calcium Gluconate 10%

AGE: ≥18 years  
WEIGHT: N/A  
LOA: N/A  
HR: N/A  
RR: N/A  
SBP: N/A  
Other: N/A

#### Salbutamol

AGE: ≥18 years  
WEIGHT: N/A  
LOA: N/A  
HR: N/A  
RR: N/A  
SBP: N/A  
Other: N/A



## CONTRAINDICATIONS

### Calcium Gluconate 10%

Patients on Digoxin

### Salbutamol

Allergy or sensitivity to salbutamol

## TREATMENT

### MANDATORY PROVINCIAL PATCH POINT:

Patch to BHP for authorization to proceed with calcium gluconate and salbutamol therapies. Record ECG before and after treatment.

Consider **calcium gluconate 10%**:

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

Consider **salbutamol** (this may not be possible in cardiac arrest):

	Route	
	<i>MDI</i>	<i>Nebulized</i>
<i>Dose</i>	1600 mcg* (16 puffs)	10 mg
<i>Max. single dose</i>	1600 mcg	10 mg
<i>Dosing interval</i>	immediate	immediate
<i>Max. # of doses</i>	2	2

\*1 puff=100 mcg

## **CLINICAL CONSIDERATIONS**

---

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

If appropriate, refer to the *Symptomatic Bradycardia, Tachydsrhythmia, 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 given.

Caution that calcium gluconate should only be administered in an IV/IO that is running well and that calcium gluconate and sodium bicarbonate should not be mixed or given in the same IV without flushing well.

# **Appendix 3**

## **Primary Care Paramedic Auxiliary Medical Directives**



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## INTRAVENOUS AND FLUID THERAPY MEDICAL DIRECTIVE - AUXILIARY

*A Primary Care Paramedic may provide the treatment prescribed in this auxiliary Medical Directive if certified and authorized according to the PCP Autonomous IV level.*

### INDICATIONS

---

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

### CONDITIONS

---

#### IV

AGE: ≥2 years  
LOA: N/A  
HR: N/A  
RR: N/A  
SBP: N/A  
Other: N/A

#### 0.9% NaCl Fluid Bolus

AGE: ≥2 years  
LOA: N/A  
HR: N/A  
RR: N/A  
SBP: Hypotension  
Other: N/A

### CONTRAINDICATIONS

---

#### IV

Suspected fracture proximal to the access site.

#### 0.9% NaCl Fluid Bolus

Signs of fluid overload

### TREATMENT

---

Consider ***IV cannulation***

Consider **0.9% NaCl** maintenance infusion:

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

**MANDATORY PROVINCIAL PATCH POINT:**

Patch to BHP for authorization to administer IV NaCl bolus to a patient ≥2 years to <12 years with suspected Diabetic Ketoacidosis (DKA)

Consider **0.9% NaCl fluid bolus:**

	<b>Age</b> ≥2 years to <12 years	<b>Age</b> ≥12 years
	<b>Route</b> IV	<b>Route</b> IV
<i>Infusion</i>	20 ml/kg	20 ml/kg
<i>Infusion interval</i>	Immediate	Immediate
<i>Reassess every</i>	100 ml	250 ml
<i>Max. volume*</i>	20 ml/kg up to 2,000 ml	2,000 ml

\*The maximum volume of NaCl is lower for patients in cardiogenic shock

## **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 certified in 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 less than 12 years of age.



## CONTINUOUS POSITIVE AIRWAY PRESSURE (CPAP) MEDICAL DIRECTIVE - AUXILIARY

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

### INDICATIONS

---

Severe respiratory distress

**AND**

Signs and/or symptoms of acute pulmonary edema **OR** COPD

### CONDITIONS

---

#### CPAP

AGE: ≥18 years

LOA: N/A

HR: N/A

RR: Tachypnea

SBP: Normotension

Other: 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**:

<i>Initial setting</i>	5 cm H <sub>2</sub> O	Or equivalent flow rate of device as per BH direction
<i>Titration increment</i>	2.5 cm H <sub>2</sub> O	Or equivalent flow rate of device as per BH direction
<i>Titration interval</i>	5 min.	
<i>Max. setting</i>	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):

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

### INDICATIONS

---

Need for ventilatory assistance **OR** airway control

**AND**

Other airway management is inadequate or ineffective

### CONDITIONS

---

#### **Supraglottic Airway**

AGE: N/A

LOA: N/A

HR: N/A

RR: N/A

SBP: N/A

Other: 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 attempts is 2.

Confirm **supraglottic airway placement**:

<b>Method</b>	<b>Method</b>
<i>Primary</i>	<i>Secondary</i>
Auscultation	ETCO <sub>2</sub>
Chest rise	Other

## CLINICAL CONSIDERATIONS

---

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

## NAUSEA / VOMITING MEDICAL DIRECTIVE - AUXILIARY

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

### INDICATIONS

---

Nausea **OR** vomiting

### CONDITIONS

---

#### **Dimenhydrinate**

AGE: N/A

WEIGHT:  $\geq 25$  kg

LOA: Unaltered

HR: N/A

RR: N/A

SBP: N/A

Other: 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
	<i>IV</i>	<i>IM</i>	<i>IV</i>	<i>IM</i>
<i>Dose</i>	25 mg	25 mg	50 mg	50 mg
<i>Max. single dose</i>	25 mg	25 mg	50 mg	50 mg
<i>Dosing interval</i>	N/A	N/A	N/A	N/A
<i>Max. # of doses</i>	1	1	1	1

## CLINICAL CONSIDERATIONS

IV administration of dimenhydrinate applies only to PCPs certified to the level of PCP Autonomous IV.

Prior to IV administration, dilute dimenhydrinate (concentration of 50 mg/1 ml) 1:9 with Normal Saline or sterile water. If given 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 certified and authorized.*

### INDICATIONS

---

Electronic Control Device probe(s) embedded in patient.

### CONDITIONS

---

#### Probe Removal

AGE: ≥18 years

LOA: Unaltered

HR: N/A

RR: N/A

SBP: N/A

Other: 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.

## MINOR ABRASIONS MEDICAL DIRECTIVE – AUXILIARY – SPECIAL EVENT

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

### INDICATIONS

---

Minor abrasions

#### AND

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

### CONDITIONS

---

#### Topical Antibiotic

AGE: N/A

LOA: Unaltered

HR: N/A

RR: N/A

SBP: N/A

Other: 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 certified and authorized.*

### INDICATIONS

---

Signs consistent with minor allergic reaction

#### AND

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

### CONDITIONS

---

#### **Diphenhydramine**

AGE: ≥18 years

LOA: Unaltered

HR: WNL

RR: WNL

SBP: Normotension

Other: 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**:

	<b>Route</b>
	<i>PO</i>
<i>Dose</i>	50 mg
<i>Max. single dose</i>	50 mg
<i>Dosing interval</i>	N/A
<i>Max. # of doses</i>	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 certified and authorized.*

### INDICATIONS

---

Minor musculoskeletal pain

#### AND

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

### CONDITIONS

---

#### Acetaminophen

AGE: ≥18 years

LOA: Unaltered

HR: N/A

RR: N/A

SBP: N/A

Other: N/A

### CONTRAINDICATIONS

---

#### Acetaminophen

Acetaminophen use within previous 4 hours

Allergy or sensitivity to acetaminophen

Signs or symptoms of intoxication

## TREATMENT

---

Consider **acetaminophen**:

	<b>Route</b>
	<i>PO</i>
<i>Dose</i>	325-650 mg
<i>Max. single dose</i>	650 mg
<i>Dosing interval</i>	N/A
<i>Max. # of doses</i>	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 certified and authorized.*

### INDICATIONS

---

Uncomplicated headache conforming to the patient's usual pattern

#### AND

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

### CONDITIONS

---

#### Acetaminophen

AGE: ≥18 years

LOA: Unaltered

HR: N/A

RR: N/A

SBP: N/A

Other: N/A

### CONTRAINDICATIONS

---

#### Acetaminophen

Acetaminophen use within previous 4 hours

Allergy or sensitivity to acetaminophen

Signs or symptoms of intoxication



## TREATMENT

Consider **acetaminophen**:

	<b>Route</b>
	<i>PO</i>
<i>Dose</i>	325-650 mg
<i>Max. single dose</i>	650 mg
<i>Dosing interval</i>	N/A
<i>Max. # of doses</i>	1

Consider **release from care**

## CLINICAL CONSIDERATIONS

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

## HOME DIALYSIS EMERGENCY DISCONNECT MEDICAL DIRECTIVE - AUXILIARY

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

### INDICATIONS

---

Patient receiving home dialysis (hemo or peritoneal) and connected to dialysis machine

**AND**

Patient requires transport to the hospital

**AND**

Patient is unable to disconnect **OR** there is no family member or caregiver available or knowledgeable in dialysis disconnect

### CONDITIONS

---

**Home Dialysis Emergency Disconnect**

AGE: N/A

LOA: N/A

HR: N/A

RR: N/A

SBP: N/A

Other: 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.



# **Appendix 4**

## **Advanced Care Paramedic Auxiliary Medical Directives**



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## ADULT INTRAOSSEOUS MEDICAL DIRECTIVE - AUXILIARY

*An Advanced Care Paramedic may provide the treatment prescribed in this auxiliary Medical Directive if certified and 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

---

#### IO

AGE: ≥12 years

LOA: N/A

HR: N/A

RR: N/A

SBP: N/A

Other: N/A

### CONTRAINDICATION

---

#### IO

Fracture or crush injuries or suspected or known replacement / prosthesis 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 certified and 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

AGE: N/A

LOA: N/A

HR: N/A

RR: N/A

SBP: N/A

Other: Patient has a pre-existing, accessible central venous catheter in place

### CONTRAINDICATIONS

---

#### CVAD Access

N/A

## TREATMENT

---

Consider **CVAD access**

## CLINICAL CONSIDERATIONS

---

N/A

## CONTINUOUS POSITIVE AIRWAY PRESSURE (CPAP) MEDICAL DIRECTIVE - AUXILIARY

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

### INDICATIONS

---

Severe respiratory distress

**AND**

Signs and/or symptoms of acute pulmonary edema **OR** COPD

### CONDITIONS

---

#### CPAP

AGE: ≥18 years

LOA: N/A

HR: N/A

RR: Tachypnea

SBP: Normotension

Other: 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**:

<i>Initial setting</i>	5 cm H <sub>2</sub> O	Or equivalent flow rate of device as per BH direction
<i>Titration increment</i>	2.5 cm H <sub>2</sub> O	Or equivalent flow rate of device as per BH direction
<i>Titration interval</i>	5 min.	
<i>Max. setting</i>	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):

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

### INDICATIONS

---

Need for ventilatory assistance **OR** airway control

**AND**

Other airway management is inadequate **OR** ineffective **OR** unsuccessful

### CONDITIONS

---

#### Supraglottic Airway

AGE: N/A

LOA: GCS = 3

HR: N/A

RR: N/A

SBP: N/A

Other: 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 attempts is 2.

Confirm **supraglottic airway placement**:

<b>Method</b>	<b>Method</b>
<i>Primary</i>	<i>Secondary</i>
Auscultation	ETCO <sub>2</sub>
Chest rise	Other

## CLINICAL CONSIDERATIONS

---

An attempt at supraglottic airway insertion is defined as the insertion of the supraglottic airway into the mouth. The maximum number of supraglottic airway attempts is two (2) and the maximum number of intubation attempts is two (2).



## CRICOTHYROTOMY MEDICAL DIRECTIVE - AUXILIARY

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

### INDICATIONS

---

Need for advanced airway management

**AND**

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

**AND**

Unable to ventilate

### CONDITIONS

---

#### **Cricothyrotomy**

AGE: ≥12 years

LOA: Altered

HR: N/A

RR: N/A

SBP: N/A

Other: 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*

Confirm *cricothyrotomy*: tube placement

Method	Method
<i>Primary</i>	<i>Secondary</i>
Auscultation	ETCO <sub>2</sub>
Chest rise	Other

**CLINICAL CONSIDERATIONS**

At least two primary and one secondary Cricothyrotomy tube placement confirmation methods must be used.

If the patient has a pulse, an ETCO<sub>2</sub> device must be used (quantitative or qualitative) for cricothyrotomy tube placement confirmation.

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 certified and authorized.*

### INDICATIONS

---

Nausea **OR** vomiting

### CONDITIONS

---

#### **Dimenhydrinate**

AGE: N/A

LOA: Unaltered

HR: N/A

RR: N/A

SBP: N/A

Other: N/A

### CONTRAINDICATIONS

---

#### **Dimenhydrinate**

Allergy or sensitivity to dimenhydrinate or other antihistamines

Overdose on antihistamines or anticholinergics or tricyclic antidepressants

## TREATMENT

Consider *dimenhydrinate*:

	Weight <25 kg		Weight ≥25 kg to <50 kg		Weight ≥50 kg	
	Route	Route	Route	Route	Route	Route
	IV	IM	IV	IM	IV	IM
<i>Dose</i>	<i>Patch</i>	<i>Patch</i>	25 mg	25 mg	50 mg	50 mg
<i>Max. single dose</i>	N/A	N/A	25 mg	25 mg	50 mg	50 mg
<i>Dosing interval</i>	N/A	N/A	N/A	N/A	N/A	N/A
<i>Max. # of doses</i>	N/A	N/A	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 given IM do not dilute.

## COMBATIVE PATIENT MEDICAL DIRECTIVE - AUXILIARY

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

### INDICATIONS

---

Combative patient

### CONDITIONS

---

#### Midazolam

AGE: ≥18 years

LOA: N/A

HR: N/A

RR: N/A

SBP: Normotension

Other: No reversible causes (i.e. hypoglycemia, hypoxia, hypotension)

### CONTRAINDICATIONS

---

#### Midazolam

Allergy or sensitivity to midazolam

## TREATMENT

### **MANDATORY PROVINCIAL PATCH POINT:**

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

Consider *midazolam*:

	Route <i>IV</i>	Route <i>IM</i>
<i>Dose</i>	2.5-5 mg	2.5-5 mg
<i>Max. single dose</i>	5 mg	5 mg
<i>Dosing interval</i>	5 min.	5 min.
<i>Max. total dose</i>	10 mg	10 mg
<i>Max. # doses</i>	2	2

## CLINICAL CONSIDERATIONS

N/A

## PROCEDURAL SEDATION MEDICAL DIRECTIVE - AUXILIARY

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

### INDICATIONS

---

Post-intubation **OR** transcutaneous pacing

### CONDITIONS

---

#### Midazolam

AGE: ≥18 years

LOA: N/A

HR: N/A

RR: ≥8/min\*

SBP: Normotension

Other: N/A

\*Non-intubated patients only

### CONTRAINDICATIONS

---

#### Midazolam

Allergy or sensitivity to midazolam

## TREATMENT

---

Consider *midazolam*:

	Route
	<i>IV</i>
<i>Dose</i>	2.5-5 mg
<i>Max. single dose</i>	5 mg
<i>Dosing interval</i>	5 min.
<i>Max. total dose</i>	10 mg
<i>Max. # doses</i>	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 certified and authorized.*

### INDICATIONS

---

Electronic Control Device probe(s) embedded in patient.

### CONDITIONS

---

#### Probe Removal

AGE: ≥18 years

LOA: Unaltered

HR: N/A

RR: N/A

SBP: N/A

Other: 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.

## MINOR ABRASIONS MEDICAL DIRECTIVE – AUXILIARY – SPECIAL EVENT

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

### INDICATIONS

---

Minor abrasions

#### AND

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

### CONDITIONS

---

#### Topical Antibiotic

AGE: N/A

LOA: Unaltered

HR: N/A

RR: N/A

SBP: N/A

Other: N/A

### CONTRAINDICATIONS

---

#### Topical Antibiotic

Allergy or sensitivity to topical antibiotics

### 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 certified and authorized.*

### INDICATIONS

---

Signs consistent with minor allergic reaction

#### AND

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

### CONDITIONS

---

#### **Diphenhydramine**

AGE: ≥18 years

LOA: Unaltered

HR: WNL

RR: WNL

SBP: Normotension

Other: 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
	<i>PO</i>
<i>Dose</i>	50 mg
<i>Max. single dose</i>	50 mg
<i>Dosing interval</i>	N/A
<i>Max. # of doses</i>	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 certified and authorized.*

### INDICATIONS

---

Minor musculoskeletal pain

#### AND

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

### CONDITIONS

---

#### Acetaminophen

AGE: ≥18 years

LOA: Unaltered

HR: N/A

RR: N/A

SBP: N/A

Other: N/A

### CONTRAINDICATIONS

---

#### Acetaminophen

Acetaminophen use within previous 4 hours

Allergy or sensitivity to acetaminophen

Signs or symptoms of intoxication

## TREATMENT

---

Consider **acetaminophen**:

	<b>Route</b>
	<i>PO</i>
<i>Dose</i>	325-650 mg
<i>Max. single dose</i>	650 mg
<i>Dosing interval</i>	N/A
<i>Max. # of doses</i>	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 certified and authorized.*

### INDICATIONS

---

Uncomplicated headache conforming to the patient's usual pattern

#### AND

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

### CONDITIONS

---

#### Acetaminophen

AGE: ≥18 years

LOA: Unaltered

HR: N/A

RR: N/A

SBP: N/A

Other: N/A

### CONTRAINDICATIONS

---

#### Acetaminophen

Acetaminophen use within the previous 4 hours

Allergy or sensitivity to acetaminophen

Signs or symptoms of intoxication

## TREATMENT

---

Consider **acetaminophen**:

	<b>Route</b>
	<i>PO</i>
<i>Dose</i>	325-650 mg
<i>Max. single dose</i>	650 mg
<i>Dosing interval</i>	N/A
<i>Max. # of doses</i>	1

Consider **release from care**

## CLINICAL CONSIDERATIONS

---

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

## NASOTRACHEAL INTUBATION MEDICAL DIRECTIVE - AUXILIARY

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

### INDICATIONS

---

Need for ventilatory assistance **OR** airway control

**AND**

Other airway management is inadequate or ineffective

### CONDITIONS

---

#### **Xylometazoline**

AGE: N/A

LOA: N/A

HR: N/A

RR: N/A

SBP: N/A

Other: Nasotracheal  
Intubation

#### **Lidocaine Spray**

AGE: N/A

LOA: N/A

HR: N/A

RR: N/A

SBP: N/A

Other: Nasotracheal  
Intubation

#### **Nasotracheal Intubation**

AGE: ≥8 years

LOA: N/A

HR: N/A

RR: N/A

SBP: N/A

Other: Spontaneous  
Breathing

## CONTRAINDICATIONS

### Xylometazoline

Allergy or sensitivity to xylometazoline

### Lidocaine

Allergy or sensitivity to lidocaine

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***: for nasotracheal intubation

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

Consider topical **lidocaine** spray (to the nares and/or hypopharynx) for “awake” nasotracheal intubation:

	<b>Route</b>
	<i>TOPICAL</i>
<i>Dose</i>	10 mg/spray
<i>Max. dose</i>	5mg/kg
<i>Dosing interval</i>	N/A
<i>Max. # of doses</i>	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>
Auscultation	ETCO <sub>2</sub>
Chest rise	EDD
	Other

## CLINICAL CONSIDERATIONS

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

The maximum number of supraglottic airway attempts is two (2) and the maximum number of intubation attempts is two (2).

The two primary and at least one secondary nasotracheal placement confirmation methods must be used.

An ETCO<sub>2</sub> device (quantitative or qualitative) must be used for ETT placement confirmation.

Additional secondary ETT placement confirmation devices may be authorized by the local medical director.

ETT placement must be reconfirmed immediately after every patient movement.

## HOME DIALYSIS EMERGENCY DISCONNECT MEDICAL DIRECTIVE - AUXILIARY

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

### INDICATIONS

---

Patient receiving home dialysis (hemo or peritoneal) and connected to dialysis machine

#### **AND**

Patient requires transport to the hospital

#### **AND**

Patient is unable to disconnect **OR** there is no family member or caregiver available or knowledgeable in dialysis disconnect

### CONDITIONS

---

#### **Home Dialysis Emergency Disconnect**

AGE: N/A

LOA: N/A

HR: N/A

RR: N/A

SBP: N/A

Other: 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.





# **Appendix 5**

## **Chemical Exposure Medical Directives**

# **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.

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## HYDROFLUORIC ACID EXPOSURE MEDICAL DIRECTIVE

When the listed indication and condition exist, a paramedic is authorized to administer Calcium Gluconate and/or topical anaesthetic eye drops according to the following protocol. The paramedic will comply with local BHP patching protocols.

### INDICATIONS:

---

Patient was exposed to vapour, and/or liquid hydrofluoric acid.

### CONDITIONS:

---

Patient is exhibiting signs and symptoms of hydrofluoric acid poisoning.

### CONTRAINDICATIONS:

---

Topical anaesthetic eye drops (see Procedure, point #6a) are contraindicated if the patient is allergic to anaesthetics.

### PROCEDURE:

---

1. Don appropriate PPE.
2. Remove patient from further hydrofluoric acid exposure, remove contaminated clothing, jewellery, etc.
3. Decontaminate if not already decontaminated.
4. Assess vital signs; apply cardiac monitor and high flow oxygen.
5. **Inhalation:**
  - a) Ensure airway patency and breathing.
  - b) For dyspnea see *Bronchoconstriction Medical Directive*.
  - c) If airway pain (suspected inhalation injury), consider delivering a nebulized Calcium Gluconate 2.5% solution (1 ml 10% Calcium Gluconate and 3 ml sterile normal saline) with high flow oxygen.

6. **Eye Contact:**

For eye discomfort, irrigate thoroughly with copious amounts of normal saline.

- a) Remove contact lenses.
- b) Administer 2 drops of topical anaesthetic eye drops in each eye, repeat every 10 minutes as needed.
- c) Monitor the patient for 20 minutes after the last dose.

7. **Skin Contact:**

- a) Irrigate thoroughly with copious amounts of saline for 1 minute if not already done.
- b) Massage Calcium Gluconate 2.5% Gel (if available) liberally into the burn area and continue applying during transport if pain persists.

**NOTES:**

---

1. Transport to hospital as soon as possible.
2. Latex gloves are not sufficient. Use Neoprene or Nitrile gloves.

## **ADMINISTRATION OF ATROPINE, EITHER PRALIDOXIME CHLORIDE (2 PAM) OR OBIDOXIME AND DIAZEPAM FOR NERVE AGENT EXPOSURE MEDICAL DIRECTIVE**

When the listed indication and conditions exist, a paramedic is authorized to administer Atropine, either Pralidoxime or Obidoxime and Diazepam to a victim of nerve agent (or organophosphate) exposure. The paramedic will comply with local BHP patching protocols.

### **INDICATIONS:**

---

Patient was exposed to known or suspected nerve agent.

### **CONDITIONS:**

---

1. Adult ( $\geq 40$  kg)
2. The patient is exhibiting signs and symptoms of a cholinergic crisis.

### **PROCEDURE:**

---

#### **Mild Exposure:**

Signs: anxiety about being exposed, may see miosis, rhinorrhea.

1. Remove patient from area of exposure.
2. Remove all contaminated clothing.

#### **Moderate Exposure:**

Signs: (ANY ONE OF) vomiting, diarrhea, bronchospasm or bronchial secretions, shortness of breath, any known liquid exposure.

- ❑ Administer:
  1. One (1) Atropine 2mg IM or autoinjector. Repeat Atropine 2mg IV/IM every 5 minutes as needed until symptoms improve.
  2. One (1) Pralidoxime 600mg IM or autoinjector OR Obidoxime 150mg IM or autoinjector.
  3. One (1) Diazepam 10mg IM or autoinjector.

**Severe Exposure:**

Signs: Signs of moderate exposure and (ANY ONE OF) Decreased LOC, paralysis, seizures, apnea.

❑ Administer:

1. Three (3) doses Atropine 2mg IV/IM or autoinjectors. If bronchial secretions persist, continue Atropine 2mg IV/IM every 5 minutes as needed until secretions clear.
2. Three (3) doses Pralidoxime 600mg IM or autoinjectors OR three (3) Obidoxime 150mg IM or autoinjectors.
3. One (1) Diazepam 10mg IM or autoinjector.

**NOTES:**

---

1. Patients receiving treatment should also receive oxygen and be on a cardiac monitor if available.
2. Only Advanced Care Paramedics may administer intravenous medications.
3. ABC's must also be secured as appropriate in an MCI/contaminated environment. Atropine should be administered prior to airway interventions if secretions are copious.
4. Decontamination procedures must be integrated with antidote administration.
5. Personal Protective Equipment must be worn at all times.
6. Drugs may be given IV but do not delay IM administration if IV access is not already established.

## **PEDIATRIC ADMINISTRATION OF ATROPINE, EITHER PRALIDOXIME CHLORIDE (2 PAM) OR OBIDOXIME AND DIAZEPAM FOR NERVE AGENT EXPOSURE MEDICAL DIRECTIVE**

When the listed indication and conditions exist, a paramedic is authorized to administer Atropine, either Pralidoxime or Obidoxime and Diazepam to a victim of nerve agent (or organophosphate) exposure. The paramedic will comply with local BHP patching protocols.

### **INDICATIONS:**

---

Patient was exposed to known or suspected nerve agent.

### **CONDITIONS:**

---

1. <40 kg
2. The patient is exhibiting signs and symptoms of a cholinergic crisis.

### **PROCEDURE:**

---

#### **Mild Exposure:**

Signs: anxiety about being exposed, may see miosis, rhinorrhea.

1. Remove patient from area of exposure.
2. Remove all contaminated clothing.

#### **Moderate/Severe Exposure:**

Signs: (ANY ONE OF) vomiting, diarrhea, bronchospasm or bronchial secretions, shortness of breath, decreased LOC, paralysis, seizures, apnea, any known liquid exposure.

- Administer:

For patients <10kg:

1. Atropine 0.5 mg IM, repeat IV/IM every 5 minutes as needed until symptoms improve.
2. Diazepam 2mg IV/IM.
3. Pralidoxime 15mg/Kg IV/IM every 1 hour maximum 600mg/single dose, total maximum dose 1200mg  
OR Obidoxime 8mg/Kg maximum 320mg total dose.



For patients from 10kg to 39kg:

1. Atropine 1 mg IM, repeat IV/IM every 5 minutes as needed until symptoms improve.
2. Diazepam 0.2 mg/kg IV/IM.
3. Pralidoxime 15mg/Kg IV/IM every 1 hour maximum 600mg/single dose, total maximum dose 1200mg OR Obidoxime 8mg/Kg maximum 320mg total dose.

**NOTES:**

---

1. Patients receiving treatment should also receive oxygen and be on a cardiac monitor if available.
2. Only Advanced Care Paramedics may administer intravenous medications.
3. ABC's must also be secured as appropriate in an MCI/contaminated environment. Atropine should be administered prior to airway interventions if secretions are copious.
4. Decontamination procedures must be integrated with antidote administration.
5. Personal Protective Equipment must be worn at all times.
6. Drugs may given IV but do not delay IM administration if IV access is not already established.

## ADMINISTRATION OF ANTIDOTES FOR CYANIDE EXPOSURE MEDICAL DIRECTIVE

When the listed indication and condition exist, a paramedic is authorized to administer antidotes to victims of Cyanide exposure according to the following protocol. The paramedic will comply with local BHP patching protocols.

### INDICATIONS:

---

Patient was exposed to vapour, liquid or solid, suspected to contain cyanide.

### CONDITIONS:

---

Patient is exhibiting signs and symptoms of cyanide poisoning.

### PROCEDURE:

---

1. Remove patient from further exposure and remove clothes.
2. Assess vital signs, GCS.
3. Ensure airway, administer oxygen and apply cardiac and oxygen saturation monitors as possible.
4. If GCS 15 and patient is asymptomatic, decontaminate and transport to hospital.
5. If GCS <15 administer:
  - a) Sodium Thiosulfate 12.5 gm (50 ml of 25% solution) IV  
(Pediatric dose = 1.65 ml/kg to max 50 ml).
  - OR**
  - b) CYANOKIT (hydroxocobalamin) 5.0 g by rapid IV infusion over 30 minutes  
(Pediatric dose = 70 mg/kg)
6. Initiate treatment and continue while transport to hospital.

## SYMPTOMATIC RIOT AGENT EXPOSURE MEDICAL DIRECTIVE

When the listed indication and condition exist, a paramedic is authorized to administer therapy to victims of Riot Agent exposure according to the following protocol. The paramedic will comply with local BHP patching protocols.

### INDICATIONS:

---

Exposure to a known or suspected riot agent.

### CONDITIONS:

---

Signs and symptoms of riot agent exposure.

### CONTRAINDICATIONS:

---

Topical anaesthetic eye drops (see Procedure, point #5a) are contraindicated if the patient is allergic to anaesthetics.

### PROCEDURE:

---

1. Remove patient from further exposure, and decontaminate.
2. Assess vital signs, with careful focus on bronchoconstriction.
3. Assess visual acuity by the ability to see light and count fingers at 1 foot. Consider removing contact lenses.
4. For dyspnea see *Bronchoconstriction Medical Directive*.
5. For eye discomfort, irrigate thoroughly with copious amounts of normal saline.
  - a) Administer 2 drops of topical anaesthetic eye drops in each eye, repeat every 10 minutes as needed.
  - b) Monitor the patient for 20 minutes after the last dose.

**NOTES:**

---

1. If a patient is experiencing significant respiratory distress or eye irritation, immediately advise the patient of the need for transport to hospital. Transport should be initiated as soon as possible.
2. MDIs are intended for single patient use only. If an MDI is used to treat more than one patient, cross contamination may occur regardless of whether or not an aerochamber or spacer is used. The MDI should be safely discarded once the patient has completed treatment.
3. The eye drop bottle is designed for multiple patient use. Do not allow the bottle's administration nozzle to make contact with the patient. If the administration nozzle does make contact with the patient, the bottle is considered contaminated and must be discarded appropriately.
4. Under no circumstances should the MDI or eye drop bottle be given to a patient.
5. Advise patient to refrain from rubbing eyes, whether or not anaesthetic drops are used.
6. Have the patient remove their contact lenses. Help if necessary.
7. If a patient with dyspnea or eye irritation *caused by a riot control agent* refuses EMS transport to hospital, advise:

***CONTINUED EXPOSURE MAY LEAD TO FURTHER PROBLEMS. RELIEF FROM TREATMENT SO FAR MAY BE TEMPORARY. IF PROBLEMS RECUR OR PERSIST, CONSULT A PHYSICIAN AS SOON AS POSSIBLE***



# **Appendix 6**

## **Provincial Maintenance of Certification Policy**

**Summer 2000**  
(under review)



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## Provincial Maintenance of Certification

### Preamble:

Upon completion of a recognized Paramedic Training Program, a paramedic must maintain certification as per Regulation 257/00 of the Revised Regulations of Ontario 1990 made under the *Ambulance Act R.S.O. 1990* as amended by the *Services Improvement Act 1997*. A person employed as a Paramedic shall be the holder of a valid document signed by the Medical Director of a Base Hospital Program designated by the Ministry of Health for that purpose.

Maintenance of Certification requires that the Paramedic:

1. Be employed by an Emergency Medical Service and work as a Paramedic, and/or Paramedic Preceptor, *(and meet the annual eligibility requirements outlined in the proposed Provincial Base Hospital Standards)* and work for a minimum of 144 scheduled hours in the previous 12 months in an emergency medical/clinical experience. If less than 144 scheduled hours has been accumulated, an evaluation may be initiated by the Medical Director to ensure competency in the skills the paramedic has been certified to perform. This will include, but not be limited to:
  - i) Proof of reasonable attempts to complete 144 scheduled hours of emergency medical experience.
  - ii) Documentation of practice of skills overseen by the Base Hospital.
2. Meets all Base Hospital administrative requirements including completion and submission of forms and successfully complete all Base Hospital CME requirements. Credit for equivalent learning will be at the discretion of the Medical Director. If a Paramedic is absent from CME, the Paramedic is responsible for contacting the Program Director to make arrangements to successfully complete the CME objectives.
3. Demonstrates competency and adherence to standards, protocols and legislation associated with the performance of Controlled Acts and the provision of patient care at their level of certification. This will be determined through Base Hospital CQI initiatives. They may include, but are not limited to:
  - Chart Audits
  - Peer Review
  - Rideouts
  - Dispatch/Base Hospital Physician Communication Review
  - Patch/Communication Review
  - Field Performance Evaluation
  - Successful Performance at CME
  - Review of Skills Inventory

If at anytime in the judgment of the Base Hospital Medical Director, conditions have not been maintained, the Base Hospital Medical Director may deactivate/decertify the Paramedic. The employer of the paramedic will be given written notice by the Base Hospital. The Paramedic will be notified verbally immediately by the employer followed by written notice from the Base Hospital.

The Paramedic will not be authorized to perform Controlled Acts while they are deactivated/decertified. The conditions for reactivation/recertification will be determined by the Base Hospital. The conditions will be communicated in writing to the Paramedic.

Should a Paramedic fail to successfully complete the prescribed reactivation process, the Medical Director may prescribe further remediation or decertify the Paramedic from the Program.

4. Adhere to the Paramedic Conduct Directives. The Paramedic Conduct Directives will apply whenever paramedics participate in on-duty assignments or duties related to the certification processes endorsed by individual Base Hospital Programs. These Directives will be routinely evaluated and uniformly enforced by the employer.

#### **Clarification of Terms:**

**Base Hospital** means a hospital that is designated as a Base Hospital by the Minister in accordance with clause 4(2)(d) of the *Ambulance Act* as amended by the *Services Improvement Act 1997*.

In this document, unless otherwise stated, the use of the following terms refer to ambulance personnel as defined by the *Ambulance Act*, and by Ontario Regulation 257/00:

- **Emergency Medical Attendant**
- **Paramedic**
- **Primary Care Paramedic (P1)**
- **Advanced Care Paramedic (P2)**
- **Critical Care Paramedic**

**Emergency Medical Service** means an ambulance service duly licensed to perform this service as defined under the *Ambulance Act*.

**Hours of Service** means work normally defined as field assignments. Where a Paramedic has no clinical duties, but is a clinical educator/manager, working hours may be credited on the condition that at least once every 12 months the Paramedic is tested by the Base Hospital to ensure competency in the skills the paramedic has been certified to perform.

**Certification** is written approval to perform selected medical controlled acts under the license/registration of a Base Hospital medical director.

**Deactivation** is the temporary suspension of selected certified paramedic privileges to perform controlled acts by the Base Hospital medical director for the purpose of performing remediation.

**Reactivation** is the reinstatement of the suspended privileges after a period of deactivation. A paramedic may be reactivated by the medical director at the time that such requirements for remediation have been met. The expense of remediation delivery (excluding paramedic attendance) will be borne by the Base Hospital.

**Decertification** is the revocation of a certified paramedic's privileges to perform controlled acts.

## GUIDELINES FOR PATIENT CARE REVIEWS

1. Complaints that do not involve patient care will be dealt with by the employer. If the Base Hospital is made aware of such complaints they will forward them to the employer and copy them to the Regional EHS manager.
2. Patient Care Concerns or Call Reviews\*
  - if identified by the Base Hospital\* will be copied to the employer.
  - if identified by the employer will be copied to the Base Hospital.
  - if identified by an outside source will be copied to the employer.

The identifying party is responsible for ensuring their Regional EHS manager is notified.

\*Minor patient care concerns identified during the Continuous Quality Improvement Program normally will be communicated between the Base Hospital and the paramedic during the normal CQI process. The employer will be made aware of minor concerns from aggregate reports. If the minor patient care concern becomes repetitive the Base Hospital will inform the employer.

The employer will investigate the complaint. The employer will provide relevant evidence gathered with written conclusions, to the other party within 2 weeks of receiving the complaint. If the investigator requires an extension this will be communicated to the other parties with a new date of completion.

3. The Base Hospital reserves the right to act on all patient care deficiencies.

To maintain and measure patient care performance the Base Hospital may perform field audits, ACR reviews and conduct other continuous quality improvement initiatives independent of complaint investigations.

## PATIENT CARE DEFICIENCY CLASSIFICATIONS

If a paramedic has performed a Controlled Act(s) or any patient care below the recognized standards/guidelines, the Base Hospital response may be guided by the severity of the event(s) in accordance with the following table:

### MINOR OMISSION/COMMISSION:

A minor omission/commission is defined as an action or lack of action by the paramedic that did not have any direct effect on patient morbidity, however, may have affected patient care in a minor way. If a minor deficiency is identified, the paramedic may be given verbal counselling (confirmed in writing) or written counselling via the Ambulance Call Review Process.

### MAJOR OMISSION/COMMISSION:

A major omission/commission is defined as an action or lack of action by the paramedic that has affected or the potential to affect patient morbidity, however, the outcome would not be life threatening. If a major deficiency is identified, or there is a repetition of minor deficiencies, the paramedic will be given written counselling and *may* be required to complete remedial education. At the discretion of the Medical Director the paramedic *may* be deactivated.

### CRITICAL OMISSION/COMMISSION:

A critical omission/commission is defined as an action or lack of action by the paramedic that has a clear affect on patient morbidity with a potentially life threatening outcome. If a critical deficiency is identified or there is a repetition of major or a combination of major and minor deficiencies the paramedic *will* be given written counselling and *will* be required to successfully complete remedial education. At the discretion of the Medical Director, the paramedic *may* be decertified.

## REMEDIAL PROGRAM OPTIONS

A remedial program based on individual needs will be made available at the Base Hospital Medical Director's discretion. Base Hospital training costs will be separately funded by EHS with prior written approval.

### REMEDIAL PROGRAMS MAY REQUIRE:

1. Time in clinical rotations or supplemental educational processes deemed necessary by the Medical Director.
2. Base Hospital recovery costs paid by the Paramedic in compliance with EHS direction.

## **GUIDELINES FOR DECERTIFICATION REVIEWS**

### **DECERTIFICATION**

If a Paramedic wants to have their decertification reviewed by the Base Hospital the paramedic may do so. The request for the review must be in writing and received by the Base Hospital staff within 2 weeks of being notified of a change in certification status. The Paramedic must include in the request the reason he/she thinks a review should be considered. The Paramedic must also include alternative solutions or conclusions before the review will proceed.

The review committee will consist of a Medical Director, a Program Director and a practicing certified peer paramedic from another Provincial Base Hospital Program. This process must be approved by the Ministry of Health - Emergency Health Services for any required funding. The Paramedic's submission to the review committee will be pre-circulated to the members. The purpose of the review will be to determine:

- a) If the information used by the Base Hospital in its evaluation was valid.
- b) The appropriateness of the Base Hospital action for the event(s) involved.
- c) If the requirements for recertification are "reasonable" for the event(s).

The review committee will provide a recommendation within 48 hours.

