Shared health Soins communs Manitoba	A01 - EMERGENCY MEDICAL SERVICE OVERVIEW
	POLICY / PROCEDURE
Version date: 2024-04-14	Effective Date: 2024-05-15 (0700)

SECTION A - DEFINITIONS

NOTE: The following definitions apply for the operational purposes of Shared Health Emergency Response Service (ERS). They may vary from, and are not intended to replace, the lawful definitions as outlined in the Regulated Health Professions Act (RHPA), the College of Paramedics of Manitoba (CPMB) General Regulation, and CPMB practice directions.

1. **PARAMEDIC:** All emergency medical responders (EMR) and paramedics employed by ERS, as well as those employed by service providers operating under service purchase agreements (SPA) with ERS.
2. **RESERVED ACT:** A medical procedure or function that can only be performed by a regulated health professional.
3. **SCOPE OF PRACTICE:** The set of reserved acts that a paramedic is lawfully able to perform, as defined by the College of CPMB General Regulation.
4. **SCOPE OF WORK:** The set of medical functions / procedures that may be performed and the medications that may be administered and managed by a paramedic when on-duty under an employment agreement with ERS or one of its SPA providers. It is established by ERS leadership and detailed in the ERS care maps and medication orders.
5. **CARE MAPS:** These include clinical policies and procedures, destination protocols, and patient care caps.
    a. **POLICIES & PROCEDURES:** Section A contains directives that a paramedic must follow when providing clinical care to all ERS patients.
    b. **DESTINATION:** Section B contains the protocols for determining the transport destination for all ERS patient. These include a combination of guidelines that may be followed and directives that must be followed.
    c. **CARE MAP**: Sections C through F contain guidelines and directives for the provision of medical care to all ERS patients. These include reserved acts as well as medical functions that are not reserved acts.
6. **MEDICATIONS**: Section M contains the directives that must be followed when administering the various ERS medications. These are standing orders from ERS medical directors as defined under section 4.8 of the CPMB General Regulation.
7. **ERS WORK SCOPES:** The ERS-specific work scopes are based on the paramedic's employment classification with ERS and apply regardless of the individual's registration level with the CPMB, professional scope of practice, or scope of work under another employer.
    a. **BASIC WORK SCOPE**: The procedures that may be performed and medications that can be administered by an individual employed as an emergency medical responder (EMR) or medical first responder (MFR). This requires College registration at the EMR level or above.
    b. **PRIMARY WORK SCOPE:** The procedures that may be performed and medications that can be administered by an individual employed as a primary care paramedic (PCP). This requires College registration at the PCP level or above.

c. **INTERMEDIATE WORK SCOPE:** The procedures that may be performed and medications that can be administered by an individual employed as an intermediate care provider (ICP). This requires registration with the CPMB at or above the level of primary care paramedic with the intermediate care notation (PCP-IC).

d. **ADVANCED WORK SCOPE:** The procedures that may be performed and medications that can be administered by an individual employed as an advanced care provider (ACP). This requires registration with the CPMB at or the ACP level or above.

8. **WORK SCOPE IDENTIFIERS:** The work scopes are indicated using three-letter identifiers as follows (appendix A). Note that where there is no identifier, the action can be performed by a paramedic employed at any level.

   a. **EMR:** This action can be performed an individual employed as an EMR, PCP, ICP, or ACP.

   b. **PCP:** This action can be performed by an individual employed as a PCP, ICP, or ACP.

   c. **ICP:** This action can be performed by an individual employed as an ICP or ACP.

   d. **ACP:** This action can be performed by an individual employed as ACP only.

9. **DELEGATION OF A RESERVED ACT:** Under exigent circumstances, a paramedic with the primary or intermediate work scope may receive authorization from an ERS physician, ERS-affiliated physician, or ERS advanced care paramedic (ACP) to perform a reserved act that is not within their usual work scope, by way of a delegation. The reserved act must be within the receiving paramedic's scope of practice and competency.

   An EMR cannot receive a delegation to perform a reserved act outside of their usual work scope.

10. **STANDING ORDER:** Under the CPMB General Regulation, the ability to administer a medication by a particular route is part of the paramedic's practice scope. However, a paramedic requires a physician order to administer any specific medication. Section M contains the medication standing orders from ERS medical leadership that authorize the administration of specific medications based upon the paramedic's designated scope of work.

11. **VARYING A STANDING ORDER:** In a situation where a medication standing order is insufficient to meet the clinical needs of the patient, a physician may authorize a paramedic to vary from the standing order on a one-time basis, by way of delegation. An ACP cannot authorize the administration of a medication and cannot give a delegation to vary a medication order.

    An EMR cannot deviate from a medication standing order, even with a subsequent physician order.

12. Policies and destination protocols apply to all age groups unless otherwise specified. Most care maps will apply to all age groups. Some are unique to a particular age group such as E01 - CROUP (6 years & under) or E04 - ACS & STEMI (17 years & older). Some are relevant to a certain condition, such as C08 - LVAD or D02 - DELIVERY, rather than a particular age. If not specified, the following definitions will apply:

    a. **ADULT:** Seventeen (17) years and older

    b. **ADOLESCENT:** Ten (10) up to seventeen (17) years

    c. **CHILD:** One (1) up to ten (10) years

    d. **INFANT:** Three (3) days post-partum up to twelve (12) months

    e. **NEWBORN:** Birth up to three (3) days post-partum

13. **KNOWN**: A clinical condition shall be considered *known* to be present if based on all currently available information an average paramedic should reasonably conclude that the condition is present.

14. **SUSPECTED:** A clinical condition shall be considered *suspected* to be present if based on all currently available information an average paramedic should reasonably conclude that the condition is more likely than not the cause of a patient's presentation.

15. **CONSIDER:** Paramedics will consider performing an action by analyzing all currently available information to determine if that action may be more likely than not to benefit the patient given the clinical circumstances.
16. **CLOSEST:** An emergency department (ED) or health care facility (HCF) will be considered closest if it has the shortest estimated transport *time* from the patient's current location, regardless of the RHA boundaries or the Provincial border. When two facilities have similar transport times, the closest will be considered that which has the shortest estimated transport *distance*.
17. **OPEN:** An ED will be considered open and able to accept patients transported by EMS if it is accepting patients who walk-in or self-present without EMS.
18. **HEALTH CARE PROXY:** An individual who has been appointed to make medical decisions for a patient if the patient is unable to do so (also referred to as a proxy, or representative). This may be indicated in a written document such as a living will or health care directive. In the absence of appropriate documentation, a paramedic may follow the directions of an individual who indicates that they have been designated as the proxy if they reasonably believe the individual to be truthful.
19. **SUBSITUTE DECISION MAKER:** In the absence of a proxy, the following hierarchy of individuals who may act as a on behalf of the patient:
    a. Spouse or common-law partner
    b. Parent with primary care and control
    c. Parent with legal access
    d. Child
    e. Sibling
    f. Other first degree relative

SECTION B - GENERAL

1. All patient care must be provided in accordance with the standards of practice established by the CPMB and the policies, procedures, protocols, care maps, and medication orders established by ERS.
2. Paramedics will operate in good faith and provide care in accordance with the patient's best interests and will work collaboratively with other health care providers in the shared care model.
3. *Informed* consent from the patient or their proxy is required for any significant intervention. Consent may be obtained verbally unless specified otherwise. In critical circumstances where consent cannot be obtained, the principle of implied consent will apply. Paramedics must abide by a known health care directive (or advanced care plan).

SECTION C - ASSESSMENT

1. Paramedics must always utilize personal protective equipment (PPE) and follow appropriate body substance isolation (BSI) procedures; they must comply with all Shared Health policies and procedures for infection prevention control and post exposure care.
2. An initial *scene assessment* must be conducted, including an evaluation of safety, the need for additional EMS resources, and the need for assistance from other agencies or services (e.g., law enforcement). If additional resources are anticipated to be required, paramedics should request these as soon as possible.

3. A *primary assessment* must be conducted efficiently and systematically on every patient. Steps may be performed sequentially or concurrently, depending upon the patient's condition and on-scene resources. Paramedics should repeat the primary assessment whenever there is a significant change in the patient's condition.
4. For victims of major trauma, a *rapid trauma survey* including a screen for life-threatening injuries should precede the secondary assessment.
5. If an immediate life-threatening condition is identified or suspected, appropriate *life-saving interventions* must be promptly initiated before continuing the assessment. With sufficient resources on the scene, further assessment may be performed concurrently with life-saving procedures. In the event that a life-threatening condition is also time-sensitive (e.g., major trauma), certain interventions (e.g. vascular access) should be initiated during transport.
6. After immediate life-threatening conditions are managed, paramedics will conduct a *secondary assessment* that includes an appropriate history, collateral information, details of the incident, and a relevant physical examination. The examination may be generalized or focused as indicated by the patient's condition or complaint(s).
7. Unless otherwise specified, at least one *core set of vital signs* including heart rate, respiratory rate, blood pressure and oxygen saturation must be performed for every patient, unless precluded by resuscitative or other life-saving measures. Temperature, Glasgow coma scale (GCS) and blood glucose measurements will be obtained as required. Vital signs must be repeated at appropriate intervals based upon the patient's chief compliant and stability.
8. Appropriate monitoring and interventions will be performed as dictated by the patient's complaint(s) or condition.
9. If a life-threatening or time-sensitive condition is not identified or suspected, further assessment can be initiated or performed on-scene or during transport as appropriate.

SECTION D - MANAGEMENT

1. Paramedics must consider the patient's complaint(s), clinical condition, transport duration and potential for deterioration during transport when deciding to perform a medical function in the field. Medical functions that are more appropriately performed in a health care facility should be deferred, where safe and appropriate.
2. If a paramedic initiates or establishes a medical function (e.g., traction splinting, vascular access), they remain responsible for ongoing management until care is transferred to another appropriate health care provider or the intervention is discontinued.
3. Management of subjective symptoms (e.g., pain, nausea) should be carried out using pharmacologic and, where appropriate, non-pharmacologic measures (e.g., splinting of injuries) in accordance with the paramedic's clinical judgment as to the cause and the patient's stability. The patient's subjective report as to the severity of a symptom (e.g., pain severity scale) must be used to inform management decisions.
4. Unstable patients should not receive anything by mouth (NPO), except for essential medications.

SECTION F - TRANSPORT

1. The timing and urgency of transport, and the complexity and frequency of monitoring during transport, will be based on the patient's condition or complaint(s). For time sensitive situations (e.g., acute stroke) paramedics should consider strategies (e.g., air intercept) that will expedite arrival at the destination.
2. Paramedics will transport as per the published destination and bypass protocols (section B).

Paramedics may consult on-line medical support (OLMS) at any time for assistance with destination decision making within the established protocols.

3. If it is known or reasonably anticipated that a medical function beyond the paramedic's practice scope may be required during an interfacility transport (IFT), paramedics should request that an appropriate health care provider (HCP) who can perform the function (e.g., newborn resuscitation when transporting a patient in active labor) accompany the patient.
4. Non-clinical issues such as road and weather conditions that can impact patient, provider and public safety will be at the discretion of the vehicle operator.
5. Paramedics must transport at safe vehicular speeds and comply with all aspects of the Highway Traffic Act. All patients must be appropriately positioned, and all occupants must be appropriately secured prior to transport. Minors should be transported in the company of a parent or legal guardian.
6. Paramedics will transport as per established destination protocols. The on-line medical support (OLMS) physician or on-call superintendent / supervisor (OCS) may be contacted for assistance regarding destination decision making.

SECTION G - DOCUMENTATION & TRANSFER OF CARE

1. Except for mass casualty situations, paramedics will only transfer the ongoing care of the patient to an appropriate HCP whose scope of work allows them to assume the transfer of care.
2. Paramedics must document in a legible fashion all relevant clinical information on the patient care record (PCR). Accepted medical terminology should be used and abbreviations should be avoided.

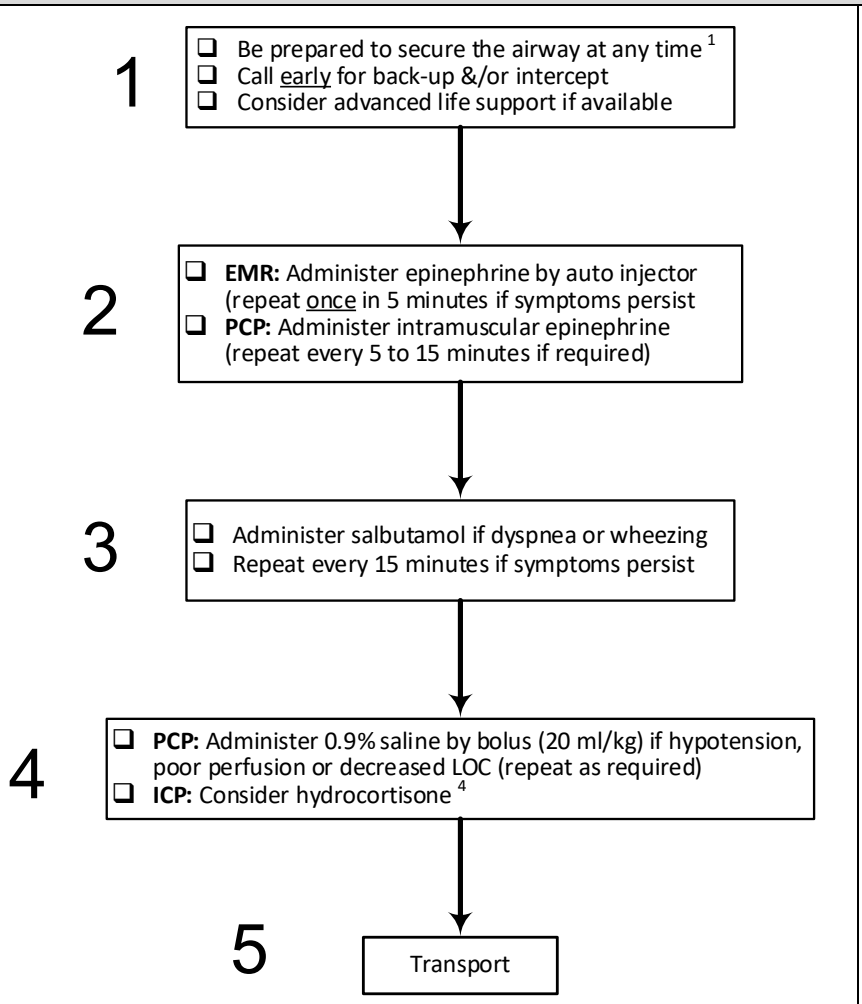
   When a paramedic co-signs, a PCR written out by a colleague they are taking the same responsibility as the paramedic who filled out the PCR for the accuracy and completeness of the contents.
3. For high-alert medications, the paramedic who prepared the medication and the paramedic who performed the double-check must both sign the PCR.
4. The transfer of care to facility personnel occurs with triage by a registered nurse and the assignment of a CTAS score.
5. Paramedics will cooperate with facility staff to ensure safe and appropriate off-loading.
6. Paramedics will provide an appropriate report to a receiving HCP and will ensure that EMS is not immediately required for further assistance or emergent IFT before departing the patient drop-off destination.

LINKS / REFERENCES
• CPMB PRACTICE DIRECTION - DELEGATION OF RESERVED ACTS • CPMB PRACTICE DIRECTION - PARAMEDIC SCOPE OF PRACTICE • CPMB PRACTICE DIRECTION - PROVIDING CARE WHILE OFF DUTY

APPROVED BY	
	
EMS Medical Director	EMS Associate Medical Director

VERSION CHANGES (refer to X01 for change tracking)
• Contains clearer language defining work scope, clearer language regarding standing medication orders and varying standing orders, and age groupings • Addition of definition for “open” ED • Stipulations that both paramedics must sign for high-alert medications

APPENDIX A: WORK SCOPE IDENTIFIERS



- *The steps in boxes 1 can be performed by paramedics at all levels.*
- *In box 2, an EMR will administer epinephrine by autoinjector. A PCP or ICP should administer it by IM injection but the autoinjector could be substituted if necessary. However, an EMR cannot administer by intramuscular injection.*
- *The steps in box 3 can be performed by paramedics at all levels.*
- *In box 4, a PCP or ICP can administer IV fluid, but only an ICP can consider to give hydrocortisone.*
- *The steps in box 3 can be performed by paramedics at all levels.*

ERS WORK SCOPE	**EMR:** EMR - ACP	**PCP:** PCP - ACP	**ICP:** ICP - ACP	**ACP:** ACP only	None - all providers