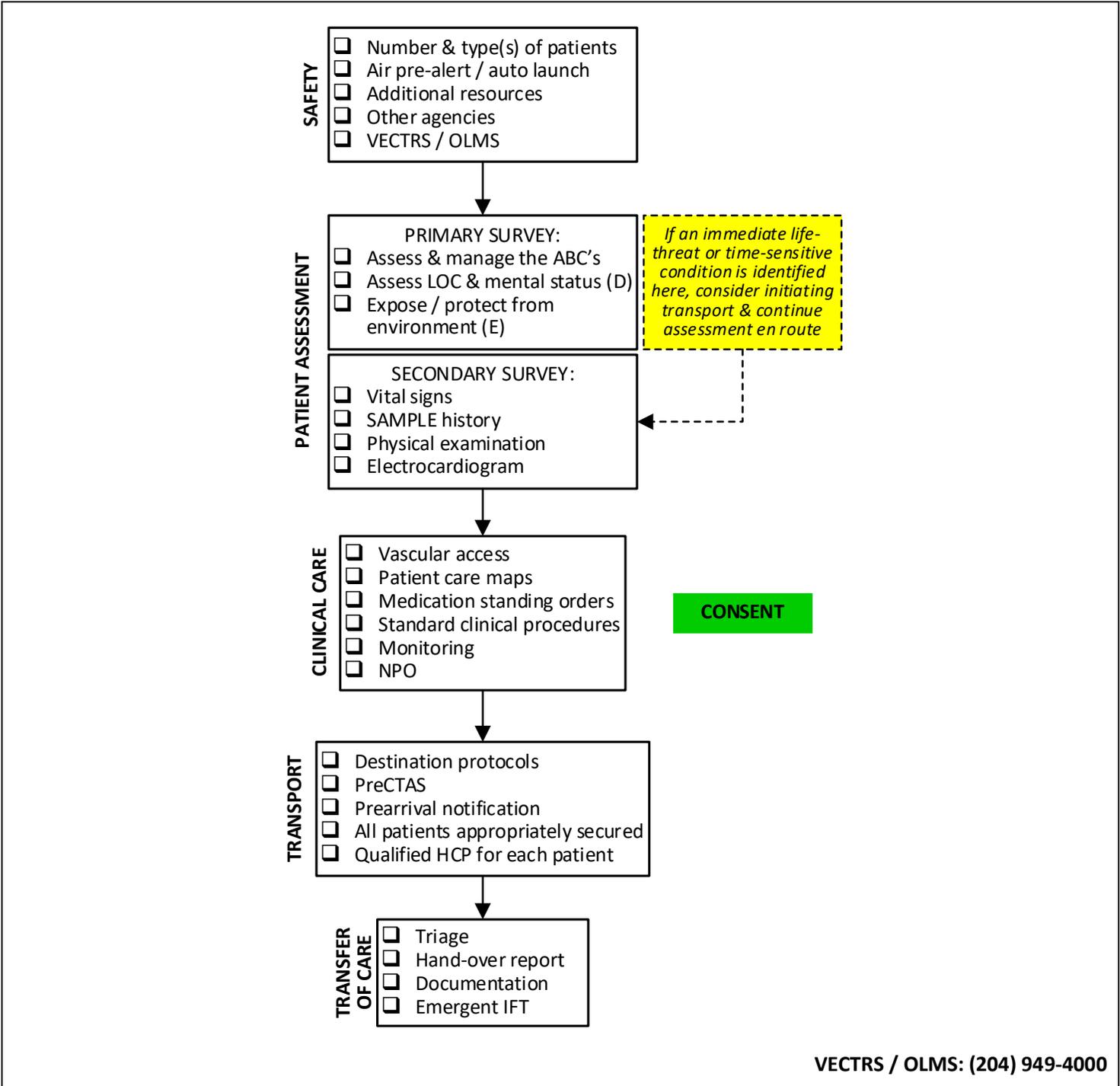


	<b>A01 - STANDARD CLINICAL APPROACH</b>	
	Version date: 2025-03-16	Effective Date: 2025-04-30 (07:00)
EMR / PCP / ICP / ACP		ALL AGES



## NOTES

1. This document outlines the Shared Health Emergency Response Service (ERS) Standard Clinical Approach (SCA) to patient care and transport. It applies to all paramedics and every patient encounter. Each step must be considered in every case, but the patient's complaint and condition will determine the extent to which an action needs to be performed.
2. All care must be provided in accordance with the standards of practice established by the College of Paramedics of Manitoba (CPMB) and the policies, procedures and protocols established by ERS.
3. A paramedic must apply critical thinking and use their best clinical judgement at all times. They must always operate in good faith and provide care in accordance with the patient's best interests and goals of care. And, they should always work collaboratively with other health care professionals (HCP) involved in the patient's care.
4. Unless otherwise stated, the following age cohorts apply to all ERS clinical document. If no age or age category is explicitly stated, the document applies to patient of all ages.
  - NEWBORN - birth up to day 6 (the end of 5 days from birth)
  - INFANT - day 6 up to 12 months (the end of 364 days from birth)
  - CHILD - 12 months up to 10 years (the end of 364 days from the start of year 9)
  - ADOLESCENT - 10 up to 18 years (the end of 364 from the start of year 17)
  - ADULT - 18 years & older
5. SCENE & PARAMEDIC SAFETY:
  - a. Assess the scene and determine if it is safe for entry. If not, retreat to a safe position and await backing.  
 If there is evidence that unlawful activity has occurred or is occurring, contact the Medical Transportation Coordination Center (MTCC) and request assistance from law enforcement. Do not enter the scene until it is secured.  
  
 Be aware that this may be a potential crime scene. If so, law enforcement will be in charge. Comply with all directions, limit the personnel and activity on scene to the minimum required to provide patient care, and do not move or remove anything except for extrication, patient care, and egress from the scene.  
  
 If there is evidence of chemical, biological, radiation, or nuclear (CBRN) contamination do not enter the scene. Contact MTCC and request assistance from the local fire service or hazardous materials (HAZMAT) team. Do not proceed until it is declared to be safe to do so.
  - b. Depending on the nature of the occurrence and number of victims, a mass casualty incident (MCI) may be declared (F06).
  - c. Determine if additional EMS resources are required for advanced life support (ALS) backup or intercept. Additional "bodies" may be needed for egress and loading (e.g. bariatric patient). Request help early.
  - d. If MTCC has provided a pre-alert or auto launch to air EMS for the same call, they will request that you provide an initial radio report as soon as possible. This will allow the transport physician to decide whether to launch, continue, or stand down the asset (A12).
  - e. Paramedics may contact the Virtual Emergency Care & Transport Resource Service (VECTRS) at any time and request on-line medical support (OLMS) for assistance with clinical and destination decision-making. In some situations, consult with VECTRS / OLMS is mandatory (A07).
  - f. Perform hand hygiene, utilize recommended personal protective equipment (A09), and follow appropriate body substance isolation procedures.

## 6. PATIENT ASSESSMENT:

### a. PRIMARY SURVEY:

- i. Conduct a preliminary assessment on every patient following the ABCDE sequence, and repeat it whenever there is a change in the patient's condition.
- ii. With major trauma, the primary survey will require some modification. Immediately control external hemorrhage, protect the cervical spine when managing the airway, and perform a *rapid trauma survey* to screen for obvious immediate life-threatening injuries (F01).
- iii. If an immediate life-threatening condition or time-sensitive situation is identified during the primary survey, it must be addressed (e.g. opening the airway) before continuing on with the assessment. With sufficient personnel on scene, necessary interventions can be performed concurrently with assessment.
- iv. With some conditions (e.g. major trauma, stroke), initiate emergency transport and continue further assessment and patient care during transport.

### b. SECONDARY SURVEY:

- i. VITAL SIGNS: Every patient should have an initial set of vital signs (VS) including the heart rate, blood pressure, respiratory rate, and oxygen saturation. Measurement of the end-tidal CO<sub>2</sub>, temperature and blood glucose, and calculation of the Glasgow coma score (GCS) may also be indicated.

The frequency at which VS are to be repeated on scene and during transport will depend on the patient's complaint, condition, and stability.

The *National Early Warning Score (NEWS-2)* can be calculated from the VS and may help determine if the patient is stable enough for transport to an alternate destination in the event of a redirection advisory.

- ii. HISTORY: Information should be collected from the patient if possible, and/or any collateral source if available. The SAMPLE mnemonic provides an easy to recall format for taking a patient history, and includes the following components:
  - S = signs & symptoms
  - A = allergies
  - M = medications
  - P = Pertinent medical history
  - L = last ins & outs
  - E = events leading up to the presentation
- iii. PHYSICAL EXAMINATION: The exam may be generalized or focused, depending on the nature of the patient's complaint. Any relevant system(s) should be re-examined if the patient's condition worsens.
- iv. ELECTROCARDIOGRAM: A patient with a known or suspected cardiac condition requires a 12 or 15 lead electrocardiogram (ECG). As well, an ECG may be indicated for other clinical conditions (e.g. syncope, overdose).

In the case of a known or suspected acute coronary syndrome, the ECG should be repeated as often as needed if the symptoms persist, progress or recur.

## 7. CLINICAL CARE:

- a. CONSENT: Informed consent (A05) is required for any intervention, including hospital redirection. Consent may be verbal unless otherwise specified. You must abide by any advanced health care directive (AHCD) or advanced care plan (ACP) that is presented or readily available to you (e.g. ERIK).

In critical circumstances where consent cannot be obtained from the patient or a proxy, the principle of implied consent will apply.

- b. VASCULAR ACCESS: For certain conditions such as shock, two intravenous (IV) access sites should be obtained if possible.

In the event that IV access is essential and venous cannulation cannot be achieved, a paramedic with the intermediate (ICP) or advanced (ACP) work scope can establish intraosseous (IO) access. It should never be established solely to administer non-essential medications.

A paramedic with the primary (PCP) work scope cannot establish an IO device, but can administer any medication within their routine work scope through a device established by another HCP.

- c. PATIENT CARE MAP: ERS medical leadership has established specific care maps for a number of commonly encountered clinical conditions. Where additional functions or variations to the SCA are required, it will be stated in the care map. A paramedic must always provide care in accordance with the care map.
- d. MEDICATION STANDING ORDER: For general symptoms, such as nausea or vomiting, there may be no specific care map. A paramedic can provide general symptom relief in accordance with their ERS work scope for medications (A06.3). They must adhere to all of the conditions (indications, cautions and contraindications, administration route, initial and repeat dosing) outlined in a standing order.
- e. STANDARD CLINICAL PROCEDURE: A paramedic may perform a medical function or procedure in accordance with their ERS work scope for medical functions and procedures (A06.2). It must be performed as outlined in the applicable procedure document.

For a high-risk procedure, a paramedic should use their best clinical judgement when deciding whether to perform it in the field, or defer it to another health care providers (HCP) at the destination facility.

If a paramedic establishes a procedure (e.g. traction splinting, CPAP) they are responsible for its ongoing management until care is transferred to another appropriate HCP, or the procedure is no longer required.

- f. MONITORING: The level and complexity of monitoring will depend on the patient's chief complaint, condition, and stability. A patient who is unstable or has the potential to deteriorate requires all of the following:
- Continuous cardiac monitor
  - Non-invasive blood pressure (NIBP) manometry
  - Pulse oximetry
  - End-tidal capnometry / capnography
  - Direct visual observation
- g. Keep patients fasting who are unstable, are receiving opioids or sedatives, or may require a medical or surgical procedure within the next few hours.

## 8. TRANSPORT:

- a. DESTINATION: Under most circumstances, a patient whose is picked up at a location that is closer to a Regional hospital than the Perimeter Highway must be transported to the closest Regional emergency department (ED) as specified in destination protocol B01. In the event of a redirection advisory for the closest ED, paramedics will transport as per algorithm C in the document.

Conversely, if the patient is picked up at a location that is closer to the Perimeter Highway than a Regional hospital, they must be transported to a Winnipeg ED or urgent care center as per destination protocol B03.1, B03.2, or B03.3. Note that Winnipeg facilities will not routinely redirect patients, but may do so under exigent circumstances (e.g. MCI).

If the patient meets the criteria for major trauma bypass, they must be transported as per destination protocol B04.1, B04.2, or B04.3 regardless of where they were picked up.

For some clinical conditions (e.g. acute coronary syndrome, acute stroke, obstetrical emergency) the transport destination will be specified in the pertinent patient care map.

Note that in some locations in the Province there may be a nursing station (NS) instead of a local hospital with an ED. Paramedics will transport to the closest NS when directed to transport to the closest ED.

- b. The Canadian Prehospital Acuity Scale (Pre-CTAS) is required to determine transport urgency and, in some cases, the patient destination.
- c. A paramedic must ensure the pre-arrival notification (including the transporting Pre-CTAS score and an estimated time of arrival) of receiving facility staff at an appropriate interval in advance.
- d. All individuals (including newborns) must be appropriately positioned and secured for transport as per the Highway Traffic Act.
- e. When performing an interfacility transport (IFT) for a patient in active labor, if there is a reasonable possibility that delivery may occur during transport, there should be one additional HCP for each *potential* patient (e.g. laboring patient with twins should be accompanied by two additional providers). The individual(s) must be capable and qualified to assist as needed with delivery, newborn care (including resuscitation), or postpartum maternal care. This may be another paramedic, the CSL, or an HCP from the referring facility.
- f. When performing an IFT, if there is a reasonable possibility that a procedure beyond your scope and competency might become necessary during transport (e.g. reintubation, vasopressor infusion) another HCP capable and qualified to perform the procedure must accompany the transport. This may be a paramedic with a higher work scope, the CSL, or an HCP from the referring facility.

#### 9. TRANSFER OF CARE:

- a. Upon arrival at your destination, work collaboratively with facility staff to ensure efficient off-loading and a safe transfer of care.
- b. The *transfer of care* from prehospital personnel to facility staff is presumed to occur when the patient has been triaged by a registered nurse (RN). Documentation by clerical or administrative personnel for the purpose of hospital registration does not constitute a valid transfer of care.
- c. In addition to that obtained directly from the patient or their proxy, the triage nurse may require information from paramedics to complete the triage process. Provide your hand-over report in an organized, thorough and concise manner.
- d. At your earliest opportunity, document all relevant clinical information in the patient care record (PCR), including any discussions with VECTRS / OLMS. Accepted medical terminology should be used, abbreviations should be avoided, and documentation must be legible. High-alert medications have specific documentation requirements (A03). Proper documentation enhances patient care and provider protection

A paramedic is required to leave a copy of the completed and signed patient care record (PCR) with the next HCP who will be looking after the patient.

- e. Even after the nursing triage, it may be necessary for you to remain with the patient and continue to provide medical care until a prescribing provider (i.e. physician, nurse practitioner, physician assistant) is available to take over. VECTRSS can assist you as necessary.
- f. Before leaving the receiving facility, ensure that you are not needed for assistance with further care or an emergency IFT.

LINKS
<ul style="list-style-type: none"> <li>• A03 - High Alert Medications</li> <li>• A06.2 - EMS Work Scope (Medical Functions &amp; Procedures)</li> <li>• A06.3 - EMS Work Scope (Medications)</li> <li>• A05 - Consent &amp; Refusal</li> <li>• A07 - VECTRS / OLMS</li> <li>• A09 - Aerosol Generating Medical Procedures</li> <li>• B01 - Standard Destination &amp; Redirection</li> <li>• B03.1 - Winnipeg Destination for Acute Care</li> <li>• B03.2 - Winnipeg Destination for Maternal &amp; Newborn Care</li> <li>• B03.3 - Winnipeg Destination for Mental Health &amp; Addictions</li> <li>• B04.1 - Trauma Destination for IERHA &amp; SHSS Geographic Areas</li> <li>• B04.2 - Trauma Destination for PMH Geographic Area</li> <li>• B04.3 - Trauma Destination for NRHA Geographic Area</li> <li>• A12 - Air Pre-alert &amp; Auto Launch</li> <li>• F01 - Major Trauma</li> <li>• F06 - Mass Casualty Incident</li> </ul>



APPROVED BY	
	
EMS Medical Director	EMS Associate Medical Director

VERSION CHANGES (refer to X01 for change tracking)
<ul style="list-style-type: none"> <li>• New (replaces EMS overview)</li> </ul>