Shared health Soins communs Manitoba	**A01 – OVERVIEW OF CLINICAL CARE**
	POLICIES & PROCEDURES
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SECTION A - DEFINITIONS

For the purposes of all EMS/PT policies, procedures, patient care maps and medication standing order, the following definitions shall apply.

1. **PARAMEDIC:** All emergency medical responders (EMR) and paramedics employed by ERS, as well as those employed by any service provider operating under an SPA with ERS.
2. **RESERVED ACT:** A medical function that can only be performed by health professionals. Paramedics are a self-regulating profession and are allowed to perform certain reserved acts by registration with the College.
3. **SCOPE OF PRACTICE** : The set of reserved acts that a paramedic is lawfully able to perform. It is established by regulation, and determined by the paramedic's subregistration with the College (also referred to as practice scope, or professional scope). Paramedics may not perform a reserved act that is not allowed by the CPMB General Regulation, even with a physician's order.
4. **SCOPE OF WORK:** The set of medical functions (reserved acts) that a paramedic is allowed to perform when working for EMS/PT or one of its SPA providers (also referred to as work scope). It cannot exceed a paramedic's professional scope of practice, even with a physician's order (H07 - DIFFERENTIATING PRACTICE & WORK SCOPE).
5. The patient care maps and medication standing orders identify the scope of work for EMS/PT, and are grouped as follows:
    a. **BASIC WORK SCOPE:** The set of medical functions that may be performed by individuals employed at the EMR or basic provider level , and registered with the CPMB at the emergency medical responder (EMR) level.
    b. **PRIMARY WORK SCOPE:** The set of medical functions that may be performed by individuals employed at the PCP or primary provider level, and registered with the CPMB at the primary care paramedic (PCP) level or above.
    c. **INTERMEDIATE WORK SCOPE:** The set of medical functions that may be performed by individuals employed at the ICP or intermediate provider level, and registered with the CPMB at the primary care paramedic with the notation "intermediate care" level (PCP-IC) or above.
6. **PATIENT CARE MAP:** A protocol by which a clinical condition or patient care situation is to be managed, when all indications are met, and no contraindications are present.
7. **MEDICATION STANDING ORDER:** This authorizes a paramedic to administer a medication under a specified set of conditions which include the indications, contraindications, route, dosing, and frequency of administration (refer to A02 - PHYSICIAN ORDERS, CLINICAL SUPPORT AND OLMS).
8. **WORK SCOPE INDICATOR:** Within each care map or medication document, paramedics with different work scopes will be authorized to perform different medical functions. This will be indicated by the following three letter indicators, and an italicized scope of work statement at the top or bottom of each flow chart (appendix A).

    As used here, the abbreviations PCP and ICP refer to the EMS/PT work scope, and not specifically the CPMB subregistration level (eg. an individual registered with the CPMB at the PCP-IC level, may be employed with the primary work scope).

a. **ICP:** This medical function may be performed by paramedics with the intermediate work scope only.

b. **PCP:** This medical function may be performed by paramedics with the primary and intermediate work scopes only.

c. **ALL**: This medical function may be performed by paramedics with the basic, primary, and intermediate work scopes (when a step in a care map applies to all paramedics, there may be no work scope indicator).

d. **EMR:** This medical function may be performed by paramedics with all work scopes, but is primarily intended for those with the basic work scope. Usually there will be other medical functions reserved for paramedics with the primary and/or intermediate work scopes.

9. **DELEGATION:** Under exigent circumstances, a paramedic may be delegated to perform a reserved act that is not within their usual scope of work from an EMS/PT or ERS-affiliated physician (refer to A02 - PHYSICIAN ORDERS, CLINICAL SUPPORT AND OLMS).

10. **AGE COHORTS**: Different care maps and medication orders may apply to patients of different age. These cohorts are standardized as follows, and may be indicated by a suffix in the map's alphanumeric indicator (eg. E04A - ACS & STEMI. When a care map applies to patients of all ages, or a clinical condition (rather than an age cohort) the suffix will be deleted (eg. D02 - PREHOSPITAL DELIVERY).

    a. **ADULT (A):** seventeen (17) years and older)

    b. **ADOLESCENT (B):** - ten (10) up to seventeen (17) years

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

    d. **INFANT (D):** 72 hours up to twelve (12) months

    e. **NEWBORN (E):** birth up to seventy-two (72) hours post-partum

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

12. **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.

13. **CLOSEST ED:** An emergency department (ED) or health care facility will be considered closest if it has the shortest estimated transport *time* from the patient's current location, regardless of Service Delivery Organization (SDO) 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*.

14. **HEALTH CARE PROXY: A**n 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.

15. **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 College of Paramedics of Manitoba (CPMB) and the policies, procedures, patient care maps, and medication standing orders established by EMS/PT.
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 valid health care directive (refer also to A05 - TREATMENT / TRANSPORT REFUSALS) .

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 EMS/PT protocols 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 known or suspected to be required, paramedics should request these as soon as possible.
3. A *primary clinical 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 (eg. vascular access) should be initiated during transport.
6. After immediate life-threatening conditions are managed, paramedics will conduct a *secondary clinical 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.
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 E - SUPPORT

1. Paramedics should contact the on-call superintendent / supervisor (OCS) for assistance with operational issues and problem solving, or where directed to do so by a specific care map.
2. Paramedics may contact the Medical Transportation Coordination Centre (MTCC) for assistance in determining the closest appropriate facility, or for information about hospital status.
3. For information on clinical support refer to A02 - PHYSICIAN ORDERS, CLINICAL SUPPORT AND OLMS.

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 contact the on-line medical support (OLMS) physician or on-call superintendent / supervisor (OCS) for assistance with destination decision making within the established protocols.

   Paramedics may not contact OLMS or OCS to over-ride a destination protocol (eg. transporting a stable trauma patient who does not meet established indicators for bypass to an alternate destination to avoid a secondary interfacility transfer).
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.
7. Mechanical devices (eg. Autopulse) may be used to provide chest compressions during transport.

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. Accepted medical terminology should be used and abbreviations should be avoided.

   When a paramedic co-signs a patient care report (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. The transfer of care from SHM-ERS to facility personnel occurs with triage by a registered nurse and the assignment of a CTAS score.
4. Paramedics will cooperate with facility staff to ensure safe and appropriate off-loading.
5. Paramedics will provide an appropriate report to a receiving HCP and will ensure that EMS is not immediately required or further assistance or emergent IFT.

LINKS

A02 - PHYSICIAN ORDERS, CLINICAL SUPPORT & OLMS
A03 - COMPLIANCE
A05 - TREATMENT / TRANSPORT REFUSAL
A06 - EMS/PT SCOPES OF WORK
H07 - DIFFERENTIATING SCOPES OF PRACTICE & WORK

APPROVED BY	
	
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VERSION CHANGES (refer to X01 for change tracking)
• Compliance statement moved out of header to become policy & procedure A03 • Work scope statement added to header • Clarification of definitions (care map, standing order, delegation) • Removal of “interim order” from definitions (replaced by instruction to consult medical lead) • Addition of EMR work scope identifier to section A, note 8. • Clarification of responsibility when co-signing PCR

APPENDIX A - EXAMPLE OF WORK SCOPE 3-LETTER INDICATORS & STATEMENT