Hamilton Health Sciences

CENTRE FOR PARAMEDIC EDUCATION AND RESEARCH

Policy Manual

Revised – September 2015

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Revision History Dates: May 2013, August 2014	
Title: **Policy and Procedure Protocol**	

1.0 Purpose & Goals Description

1.1 To outline the procedure for the development, consultation, approval, implementation, and evaluation of policies and procedures at the Centre for Paramedic Education and Research (CPER).

1.2 The goals **of CPER Policies and Procedures** are to:

- align and support with the mission, vision and values of CPER and Hamilton Health Sciences in the provision of service, education, and research;
- meet legislative and legal requirements;
- meet provincial review standards;
- manage risk to staff and/or hospital;
- clarify roles, responsibilities and accountabilities;
- facilitate consistent and safe performance;
- define a minimum expectation of quality;
- serve as a record of administrative and clinical/service decisions;
- support professional standards;
- improve quality of patient care, education and research;
- support performance evaluation;
- improve productivity;
- increase co-ordination and communication across programs and services;
- serve as an orientation and education tool.

2.0 References

2.1 Hamilton Health Sciences Mission, Vision and Values
2.2 CPER Mission, Vision and Values
2.3 Ontario Ambulance Act
2.4 Ontario Regulation 257/00
2.5 Regional Base Hospital Performance Agreement

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3.0 Policy

3.1 Principles:

- All CPER policies will be reviewed at least once every year by the CPER Senior Management Team (SMT). The SMT consists of the Regional Program Manager/Director, Program Supervisor, Quality Specialist, Lead Paramedic Educator, Medical Director and Associate Medical Director.
- SMT Quality and Education will ensure input from the respective CPER staff.
- CPER policies cannot conflict with associated legislation and/or CPER Medical Directives.

3.2 Responsibilities:

- All CPER staff (full-time and/or part-time) are responsible to be familiar and follow all CPER policies and procedures.
- Compliance to policies and procedures shall be monitored by the Regional Program Manager/Director and Program Supervisor.
- Non-compliance shall be reported to the Regional Program Manager/Director.

3.3 Procedure:

- Identification for the need of a policy can be determined by the CPER staff, CPER Senior Management Team, Service Operators, Program Committee, Paramedics, Partnering Organizations and/or the HHS Senior Leadership (or designate) overseeing the management of CPER.
- Policy development shall be administered by the Regional Program Manager/Director (or designate).
- During policy development, the CPER Regional Program Manager/Director will ensure consultation with identified stakeholders.
- Once a draft policy has been developed, the policy will be presented to the Medical Director for review and thereafter to the SMT.
- After the review by the SMT, the draft policy will be presented to the Program Committee for formal review.
- If conflicts arise that cannot be mitigated, the matter will be presented to the HHS Senior Leadership for resolution.

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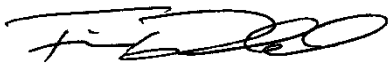
- After review from the Program Committee, the CPER Regional Program Manager/Director will approve the policy.
- A policy is considered "approved and final" when the policy document has been signed by the Regional Program Manager/Director.
- Once a policy has been approved, it will be distributed to stakeholders as required, and at a minimum, will be posted on the website of the Centre for Paramedic Education and Research.

4.0 Appendices

None

5.0 Regional Program Manager/Director Approval Signature



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CPER POLICY MANUAL	
Date Issued: **April 01, 2011**	Policy Number: **A-002**
Revision History Dates: October 31, 2011; May 2013; June 2014	
Title: **Controlled Medication Policy**	

1.0 Policy

1.1 Paramedic Service Operators are responsible for ensuring that the Controlled Medications Policy that is administered by the Service, meets the policy components as set out by CPER. Alternatively, CPER has developed a Controlled Medications Policy template that a Service Operator may choose to use as their service policy.

2.0 References

2.1 Controlled Drugs and Substances Act (S.C. 1996, c. 19)

2.2 Narcotic Control Regulations (C.R.C., c. 1041)

3.0 Procedure

3.1 All narcotics and controlled medications must be securely stored, as approved by CPER.

3.2 There must be a secure Paramedic sign-in for controlled medications for each shift and documentation of Paramedic sign-in for controlled medications.

3.3 The local policy must address secure access to narcotics and controlled medications utilizing passwords, Bio ID, keys and/or other security measures.

3.4 Weekly controlled medication use summaries from each dispensing location (e.g.; ambulance base, hospital supply, Pyxis unit etc.) must be kept and made available to CPER when requested.

3.5 Weekly aggregate controlled medication use summary for the entire service to be submitted to CPER monthly (or as approved).

3.6 Weekly aggregate controlled medication reconciliation for the entire service to be submitted to CPER monthly (or as approved).

3.7 The EMS Operator must have a policy that addresses maximum and minimum numbers for each controlled medication at each EMS dispensing and storage location.

3.8 The EMS Operator must have a policy to determine quarterly prescription requests according to known and estimated use.

3.9 The EMS Operator must have a policy to request additional interim prescriptions if required at least 3 weeks in advance of the need for the controlled substances. In exceptional circumstances CPER will make its best effort to accommodate shorter notice.

3.10 The EMS Operator must have a policy to address which EMS personnel can access and transport controlled medication from storage to dispensing units.

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Title: **Controlled Medication Policy**	

3.11 The EMS Operator must have a policy to address the disposal of expired controlled medications.

3.12 The EMS Operator must have a policy to track and account for any wasted controlled substances.

3.13 The EMS Operator must have a policy to track and account for any broken vials or ampules of controlled medications.

3.14 The EMS Operator must have a policy to address any lost or unaccounted for controlled substances.

3.15 The EMS Operator must have a policy that outlines the notification of proper authorities and CPER in the case of suspected or confirmed loss, theft or unauthorized use of controlled medications. This should include notification of CPER Medical Director, EHSB Field Office and the local Police agency within 5 business days. CPER will notify Health Canada within 10 days of the reported loss, theft or unauthorized use of controlled medications, and CPER will copy the service operator.

3.16 The EMS Operator must have a policy that outlines controlled medication record retention.

3.17 The EMS Operator must have a policy that allows authorized CPER staff to access controlled medication records on request.

3.18 The EMS Operator must have a policy that outlines a process for random audits of controlled medication records.

4.0 Appendices

4.1 Controlled Medication Policy Template

4.2 Local Paramedic Service's Controlled Medication Policy:

4.2a Dufferin County EMS

4.2b Guelph-Wellington EMS

4.2c Region of Waterloo EMS

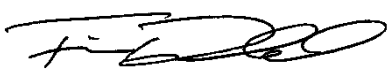
4.2d County of Brant Ambulance Service

4.2e Six Nations Ambulance Service

4.2f Hamilton Paramedic Service

4.2g Niagara EMS

5.0 Regional Program Manager/Director Approval Signature



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Date Issued: **October 2012**	Policy Number: **A-003**
Revision History Dates: October 2012; May 2013, October 2014	
Title: **Niagara Region Cross Border Transport**	

1.0 Policy

1.1 For patients that meet the Field Trauma Triage Guidelines and the most appropriate Level One Trauma Centre is located in Buffalo, New York, transport decisions will be made based on geographical boundaries established by Service policy.

2.0 References

2.1 Advanced Life Support Patient Care Standards
2.2 Basic Life Support Patient Care Standards
2.3 CPER Medical Directives
2.4 Field Trauma Triage Guidelines
2.5 Niagara EMS Cross-Border Transport Policy

3.0 Procedure

3.1 For patients within the geographical boundaries established by Service policy for transport to a Level One Trauma Centre in Buffalo, New York, and that meet the Field Trauma Triage Guidelines, the Paramedic is not required to contact a BHP / CPER for preapproval.

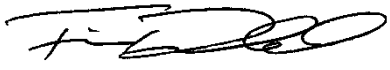
3.2 In rare circumstances, Paramedics may determine that a patient meets trauma criteria, are outside of the geographical boundaries established by Service policy, and believe they can reach the Level One Trauma Centre in Buffalo, New York, in less than 30 minutes transport time. In this rare circumstance, the Paramedic must contact a BHP for approval prior to transport.

3.3 The Paramedic will follow any Service policy and procedure that is in place for the transport of patients across the border.

4.0 Appendices

None

5.0 Regional Program Manager/Director Approval Signature



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CPER POLICY MANUAL	
Date Issued: **May 2010**	Policy Number: **A-004**
Revision History Dates: October 31, 2011 May 2013, Oct 2014	
Title: **Guideline for Out of Country Insured Health Services**	

1.0 Policy/Preamble

1.1 There are times when the most appropriate hospital emergency unit capable of providing the medical care apparently required by the patient is a hospital that is in the United States. This situation would apply mainly to areas of the Niagara Region that are within 30 minutes of a level one trauma centre in Buffalo, New York.

2.0 References

2.1 Advanced Life Support Patient Care Standards
2.2 Basic Life Support Patient Care Standards
2.3 Bulletin 4512 Out of Country Health Services (MOHLTC)
2.4 CPER Medical Directives
2.5 CPER Policy A-003 - Niagara Region Cross Border Transport
2.6 Provincial Field Trauma Triage Guidelines

3.0 Procedure

3.1 Paramedics working in areas that are close to the USA borders will at times transport critically ill or injured patients to centres in Buffalo, New York without contacting a Base Hospital Physician prior to transport, according to NEMS Service Policy.

3.2 Prior written Ministry approval is not required for emergency circumstances.

3.3 After the call is completed, NEMS Ambulance Communication Service staff will complete an OHIP Prior Approval Form with as much patient information that is available at the time.

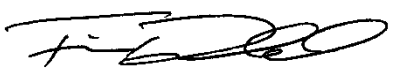
3.4 NEMS staff will then fax the Prior Approval Form to CPER, and send an email to CPER to confirm receipt of the form.

3.5 CPER medical staff will complete and submit a Prior Approval Application form on the patient's behalf.

4.0 Appendices

4.1 Bulletin 4512 Out of Country Health Services (MOHLTC)

5.0 Regional Program Manager/Director Approval Signature



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Date Issued: **October 31, 2011**	Policy Number: **A-005**
Revision History Dates: May 2013, August 2014	
Title: **Public Relations and Communication with Media**	

1.0 Policy

1.1 Hamilton Health Sciences has a Public Relations and Communication Department which is responsible for the following: community relations, media relations, organization-wide communication, communication to support corporate initiatives, web communication and hospital publications.

1.2 CPER Regional Program Manager/Director will consult with the HHS Public Relations and Communication Department should any member of the media request information of any type.

1.3 CPER Regional Program Manager/Director will consult with the Service Operator(s) prior to information release to the media on any matters relating to the EMS Service or its employees.

2.0 References

2.1 HHS Intranet Public Relations

3.0 Procedure

3.1 Any employee of CPER who is contacted by a member of the media with regards to any information will direct the member of the media to the CPER Regional Program Manager/Director.

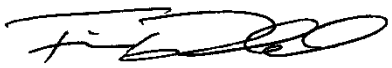
3.2 CPER employees should not disclose any information to the media, unless prior authorization has been obtained by the CPER Regional Program Manager/Director or by the HHS Public Relations and Communications Department.

3.3 If the CPER Regional Program Manager/Director is not available, the CPER employee will direct the member of the media to the HHS Public Relations and Communications Department.

4.0 Appendices

None

5.0 Regional Program Manager/Director Approval Signature



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CPER POLICY MANUAL	
Date Issued: **October 31, 2011**	Policy Number: **A-006**
Revision History Dates: May 2013, August 2014	
Title: **Response to Customer Inquiries**	

1.0 Policy

1.1 The Centre for Paramedic Education and Research (CPER) strives to provide excellent and efficient services to their stakeholders. As such, CPER welcomes constructive feedback from our stakeholders with regards to the services that are provided.

1.2 CPER is committed to responding to all complaints and concerns in a timely, courteous and sincere manner with a confidential, non-punitive, system-based process that supports appropriate follow-up, investigation, action and communication.

2.0 References

2.1 HHS Policy – Complaints and Compliments Protocol

2.2 Regional Base Hospital Performance Agreement

3.0 Procedure

3.1 Upon receipt of positive feedback CPER will forward the feedback to the appropriate person in order for the positive feedback to be shared with the relevant parties. Acknowledgement and thanks will be provided in an appropriate manner.

3.2 Upon receipt of a complaint or constructive feedback the staff member who initially receives the complaint or feedback will acknowledge the concerns and forward the concern to the Regional Program Manager/Director at CPER.

3.3 The Regional Program Manager/Director will contact the individual who has brought the concern forward to CPER in order to reassure the individual that the concern will be investigated and dealt with appropriately.

3.4 Complaints about a CPER staff member will be submitted in writing to the Regional Program Manager/Director.

3.5 The Regional Program Manager/Director will ensure that all complaints are investigated as per the HHS Complaints and Compliments Protocol, as appropriate and applicable to CPER.

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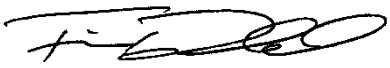
3.6 The Regional Program Manager/Director will follow up with complainant once the investigation is concluded and the necessary actions have been taken. The complainant will not be privy to the actions that have been taken but will be informed that their issue has been resolved.

3.7 The compliment and/or complaint will be reported to EHS as per the Regional Base Hospital Performance Agreement.

4.0 Appendices

4.1 HHS – Complaints and Compliments Protocol

5.0 Regional Program Manager/Director Approval Signature



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CPER POLICY MANUAL	
Date Issued: **August 1, 2010**	Policy Number: **A-007**
Revision History Dates: October 31, 2011 May 2013, August 2014	
Title: **Conflict of Interest**	

1.0 Policy

1.1 The duties of the Centre for Paramedic Education and Research (CPER) are to be carried out in a manner that is free of actual, potential or perceived conflict of interest.

2.0 References

2.1 Regional Base Hospital Performance Agreement

2.2 HHS Code of Conduct

3.0 Procedure

3.1 A conflict of interest exists where a CPER employee (full or part time) engages in any private or personal activity that advances, potentially advances or may be perceived to advance the employee's private interest at the expense of or to the prejudice of the interest of the Minister, the Host Hospital, or CPER.

3.2 CPER will ensure that employees do not engage in any private or personal activity that will, may or may be perceived to be in a Conflict of Interest, for example:

3.2.1 Conflict with the employee's duties or obligations owed to CPER.

3.2.2 Influence, interfere with, or detrimentally affect the employee's ability to perform the duties or obligations owed to CPER.

3.2.3 Provide any person or entity with any financial or other advantage or benefit, where such advantage or benefit arises because of the employee's association with CPER or Host Hospital.

3.3 Any actual, potential or perceived conflict of interest shall be disclosed in writing by the employee to the CPER Regional Program Manager/Director.

3.4 The CPER employee shall disclose the conflict of interest as soon as the employee becomes aware of such circumstance and shall take all steps to avoid the conflict.

3.5 CPER will take immediate actions to end any actual, potential or perceived conflict of interest and will report such actions and findings to the Host Hospital and to the EHS Senior Field Manager.

3.6 This policy aligns with the Hamilton Health Sciences Policy entitled "Conflict of Interest – Code of Conduct" as revised (See Appendix 4.1)

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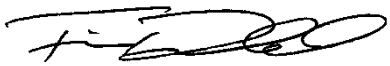
4.0 Appendices

4.1 HHS Conflict of Interest-Code of Conduct

5.0 Regional Program Manager/Director Approval Signature



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CPER POLICY MANUAL	
Date Issued: **September 2009**	Policy Number: **C-001**
Revision History Dates: Sept. 2009, Sept. 2011, Aug 2014	
Title: **Certification Policy**	

1.0 Preamble

1.1 A person employed as a Paramedic must be authorized by the Medical Director of a Base Hospital Program designated by the Ministry of Health & Long-Term Care (MOHLTC) to perform Controlled Acts as described in the Regulation. The College of Physicians and Surgeons of Ontario's Delegation of Controlled Acts acknowledges the Provincial Base Hospital standard for Paramedic certification in the performance of Controlled Acts. Thus through this process, the Medical Director of a designated Base Hospital Program may authorize or "certify" a Paramedic to be able to perform Controlled Acts with specific requirements for initial education, verification, documentation, ongoing education and CQI.

This policy serves to document the steps necessary for Initial and Maintenance of Certification for all Paramedics under the Centre for Paramedic Education & Research (CPER) as recommended by the Provincial Medical Advisory Council. This policy is consistent with the Ambulance Act, Regulation and Standards, the CPSO Delegation Policy, and the associated Provincial Certification Policies. This process is to ensure that all Paramedics meet the high level of cognitive and skill levels that are expected of Paramedics and to ensure the best quality of Paramedic medical care is delivered. This process describes two distinct guidelines for Initial Certification depending upon whether the Paramedic is currently certified by another Base Hospital designated by the MOHLTC&LTC. Additionally, it outlines the Maintenance of Certification Policies for all Paramedics once certified.

2.0 References

2.1 Advanced Life Support Patient Care Standards
2.2 Basic Life Support Patient Care Standards
2.3 Ambulance Act

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3.0 Policy

3.1 Initial Certification Process: This process applies if the Paramedic is not currently certified under a MOHLTC-EHSB designated Base Hospital.

3.1.1 Eligibility (Emergency Medical Service responsibility):
The Paramedic must be employed by a licensed Ontario Ambulance Service Provider under the Regulations of the Ambulance Act. The Emergency Medical Service is responsible for ensuring the requirements are met and forwarding written confirmation of the intent to offer employment to the Paramedic at a specific level pending certification with CPER. The Service will also forward the following information: the applicant's name, OASIS number (if applicable) and contact information.

3.1.2 Documentation (Paramedic Candidate responsibility):
The Paramedic shall complete the Request for Certification Form for new applicants and to provide documentation a minimum of two weeks prior to any scheduled orientation/evaluation; which includes the following:

- Certification status and experience from all Base Hospital/Licensing Authorities/Education Programs under which the Paramedic is currently certified or practicing.
- Certification status and experience from all Base Hospital/Licensing Authorities/Education Programs under which the Paramedic was certified or practicing over the last three years.
- A declaration of any and all decertifications (or equivalent) as a Paramedic.
- A declaration of any and all deactivations (or equivalent) in the last three years.
- A list of education programs completed (PCP, ACP, CCP or equivalent) including documentation.
- Permission for CPER to obtain information from other identified Base Hospitals/Licensing Authorities/Education Programs regarding Paramedic performance and to verify information indicated above.
- Originals or copies of number 3 and 4 below for verification.

3.1.3 Education verification for Advanced Care or Critical Care Paramedics:

- The Paramedic shall provide evidence of graduation from an approved paramedic education program in Ontario.
- If the above is not applicable, the Paramedic is required to obtain equivalency verification from the MOHLTC and obtain documentation.

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3.1.4 Provincial Exam:

- The paramedic will provide evidence of successful completion of the provincial examination for the appropriate level (if applicable).

3.1.5 CPER Orientation/Evaluation:

- CPER will arrange for an evaluation, which may include written, simulated scenario, skill and oral evaluation with the Medical Director or Delegate.
- CPER will also provide an orientation to its policies, procedures and medical directives. This process should not normally exceed two days in duration. If the Paramedic has not been clinically active in the last 90 days, the Medical director may require an Advanced Care Paramedic to complete hospital clinical or additional simulated scenarios prior to completing step six.

3.1.6 Consolidation/Field Evaluation (Advanced Care Paramedic only):

- An Advanced Care Paramedic will be paired with at least one other experienced CPER approved Advanced Care Paramedic for the purposes of education and orientation. The orientation will focus on equipment, skills, and Medical Directives. During this period, CPER may perform 100% Ambulance Call Report review. The Paramedic may be involved in clinical education/evaluation in areas identified in step 6 and may be required to complete a field evaluation with the Medical Director or delegate. For CPER certification purposes, this will be a minimum of 168 hours and should normally be completed within 60 days. This may be extended with agreement from the Service. The Service will provide documentation when this orientation has been completed. The Service may have an additional requirement for orientation beyond this period.

3.1.7 Final Certification:

- After completion of steps 1 to 6, CPER Medical Council will decide if the Paramedic has met the requirements for certification; the service will be notified regarding the decision. CPER Medical Council may recommend further clinical, field education or field orientation; this will only occur with agreement from the service.

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Title: **Certification Policy**	

3.2 Cross-Certification Process: To be eligible for cross-certification, a Paramedic must be currently certified at the same level or higher elsewhere under a MOHLTC designated Base Hospital.

3.2.1 Eligibility (Emergency Medical Service responsibility):

- The Paramedic must be employed by a licensed Ontario Ambulance Service Provider under the Regulations of the Ambulance Act. The Emergency Medical Service is responsible for ensuring the requirements are met and forwarding written confirmation of the intent to offer employment to the Paramedic at a specific level pending certification with CPER. The Service will also forward the following information: the applicant's name, OASIS number (if applicable), and contact information.

3.2.2 Documentation: The Paramedic shall complete the Request for Certification Form for new applicants and provide documentation a minimum of 2 weeks prior to any scheduled orientation/evaluation, and which includes the following:

- Certification status and experience from all Base Hospital/Licensing authorities/Education Programs under which the Paramedic is currently certified/practicing.
- Certification status and experience from all Base Hospital/Licensing authorities/Education Programs over the last three years.
- A declaration of any and all decertification action (or equivalent) as a Paramedic.
- A declaration of all deactivations (or equivalent) in the last three (3) years.
- List of Education programs completed (EMCA, ACP, CCP or equivalent) including documentation.
- Permission for CPER to obtain information from other identified Base Hospitals/Licensing Authorities/Education Programs regarding Paramedic performance and to verify information indicated above.
- Originals or copies of 3 and 4 below for verification.

3.2.3 Education Verification for Advanced Care or Critical Care:

- The Paramedic shall provide evidence of graduation from an approved Paramedic education program in Ontario.
- If the above is not applicable, the Paramedic is required to obtain equivalency verification from MOHLTC and obtain the appropriate documentation.

3.2.4 Provincial Exam:

- The Paramedic will provide evidence of successful completion of the provincial examination for the appropriate level (if applicable).

3.2.5 CPER Orientation/Evaluation:

- CPER will arrange for an orientation to its policies, procedures, and Medical Directives. This may also include an evaluation, which may utilize written, scenario-based and oral examinations with the Medical Director or delegate. This process should not normally exceed one (1) day in duration. If an Advanced Care Paramedic has not been clinically active at the level they are requesting certification in the last 90 days, the Medical Director may require the Paramedic to complete hospital clinical or additional simulated patient encounters prior to completing step 6.

3.2.6 Field Orientation/Evaluation (Advanced Care Paramedic only)

- An Advanced Care Paramedic will be paired with at least one other experienced CPER approved Advanced Care Paramedic for the purposes of education and orientation. The orientation will focus on equipment, skills, and Medical Directives. The Paramedic may be involved in clinical education/evaluation in areas identified in step 5 and may be required to complete a field evaluation with the Medical Director or delegate. For CPER certification purposes, this will not normally exceed 36 hours. This may be extended with agreement from the Service. The Service will provide documentation when this orientation has been completed. The Service may have an additional requirement for orientation beyond this period.

3.2.7 Final Certification:

- After completion of steps 1-6, the CPER Medical Director will render a decision whether or not to certify the Paramedic and notify the Service. CPER may recommend further clinical or field education/orientation but this can only occur with agreement from the Service.

3.3 Maintenance of Certification:

The Paramedic must meet the following requirements to maintain their certification:

3.3.1 Employment:

- Be employed by an Emergency Medical Service associated with CPER, and work as a Paramedic and/or Paramedic Preceptor.

3.3.2 Patient Care Activity/Clinical Hours:

- The Paramedic must work a minimum of 144 scheduled hours in the previous 12 months in an emergency medical environment, **with an absence from clinical activity of no longer than 90 consecutive days.** As a guideline, CPER has also outlined the suggested minimum patient care activity that corresponds to these minimum hours (see chart). If these criteria are not fulfilled, an evaluation **may** be initiated by the Medical Director to ensure competency in the skills the Paramedic has been certified to perform. Enrollment in a proactive maintenance program (skills practice monthly) or other EMS/medically related activity is recommended and may be requested if ongoing minimal clinical activity only. This will be submitted annually for approval by the Medical Director.

3.3.3 CME:

- Meets all CPER administrative requirements including completion and submission of forms and successful completion of all CPER Continuing Medical Education (CME) requirements on an annual basis (see chart). 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 CPER to make arrangements to successfully complete the CME objectives.

3.3.4 CQI/QA:

Demonstrates competency and adherence to standards, Medical Directives 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 the CPER Continuous Quality Improvement (CQI) initiatives. They may include, but are not limited to:

- Ambulance Call Report (ACR or ePCR) Reviews
- Peer Reviews
- Field Performance Evaluation
- Dispatch/BHP/Receiving Hospital Communication Reviews
- CME/Recertification Evaluations/Performance
- Skills Maintenance/Inventory Reviews

3.3.5 Annual Recertification Evaluation:
Each Paramedic must successfully complete an Annual Practice Review at the level for which s/he is certified. This evaluation may include:

- Theory (pathophysiology and pharmacotherapy).
- Skill review (indications and contraindications).
- Practical skills (skill completion in a simulated setting).
- Scenarios.

3.3.6 Additional Information:

- All of the five criteria above must be successfully fulfilled for annual recertification and maintenance of certification.
- If at any time, CPER Medical Council deems that all of these conditions have not been maintained, Medical Council may request remediation or may deactivate, decertify, or otherwise place conditions on the certification of the Paramedic. The employer will be notified and the employer and Paramedic will be given written notice by CPER, which will outline the specific concerns and/or requirements.
- Please see Appendix 4.1 for "Annual Maintenance of Certification Requirements Chart".

3.4 Inactive Status:
Maintenance of certification requires that a Paramedic be employed by an Ambulance Service Provider and work as a paramedic and/or paramedic preceptor and meet the annual eligibility requirements outlined in the Maintenance of Certification policy.
Notwithstanding the Maintenance of Certification Policy, a Paramedic employed by an Emergency Medical Service, who is not actively engaged in the provision of patient care as a Paramedic for the required minimum hours or patient contacts as outlined in the Maintenance of Certification Policy may request Inactive Status to be granted certification as a Paramedic with the provision that they are "INACTIVE". The Paramedic must be in good standing at the time and must voluntarily request this status in writing and be approved by both their Service and the Medical Director. Paramedics who are certified but "INACTIVE" will NOT be authorized to perform controlled acts at that level of certification. There is a 90 day period immediately following this change whereby a Paramedic may request in writing to have their full certification reinstated at the discretion of the Medical Director.

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CPER POLICY MANUAL	
Date Issued: **September 2009**	Policy Number: **C-001**
Revision History Dates: Sept. 2009, Sept. 2011, Aug 2014	
Title: **Certification Policy**	

3.4.1 Paramedic Certification – Inactive
Status: The inactive Paramedic shall:

- Meet all conditions for employment and paramedic status as outlined in the Ambulance Act.
- Successfully complete all mandatory CME requirements.
- Demonstrate competency and adherence to standards, Medical Directives 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 successful performance at CME, review and demonstration of skills competency and at the Annual Practice Review session.

3.4.2 If at any time, in the judgment of the CPER Medical Council, conditions have not been met or maintained, the Medical Director may deactivate or decertify the Paramedic. The employer will be notified in writing.

3.4.3 The inactive Paramedic will not be authorized to perform controlled acts at that level of certification. The conditions for reactivation will be determined by CPER once notified of a pending change of status that will place the Paramedic back on active duty and a written request by the Paramedic. An Advanced Care Paramedic on inactive status may be authorized to perform controlled acts as a Primary Care Paramedic (PCP) if the conditions required for maintenance of certification of a PCP are met.

3.4.4 A Paramedic on inactive status may apply to gain educational certification status for up to a 3-month time frame. The steps required to achieve educational certification will be decided on a case-by-case basis at the discretion of the Medical Director. When the 3-month period is complete, the Paramedic must either return to inactive status or be successful in reactivation to full certification.

3.5 All records pertaining to certification, re-certification, change in certification status, deactivation, decertification and remediation will be maintained by the RBHP.

3.6 All decertification, deactivation and re-certification notices will be forwarded to the Service Operator and the Senior Field Manager at the time of the notice.

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Title: **Certification Policy**	

4.0 Appendices

4.1 Annual Maintenance of Certification Requirements Chart:

	PRIMARY CARE PARAMEDIC	**ADVANCED CARE PARAMEDIC**
Employment	Be employed by a certified employer	
Clinical Hours (Minimum)	144 hours	144 hours
Annual CME (Minimum)	8 hours	24 hours
Annual Practice Review	8 hours (included in above) – written, skills, and scenario evaluation	8 hours (included in above) – written, skills, and scenario evaluation
Patient Care Activity (Guideline)	Minimum **10** patients managed with a controlled medical act at a PCP level (Symptom relief, SAED, IV).	Minimum **10** patients managed with a controlled medical act at an ACP level (more than Symptom Relief, SAED, IV)
Skills Maintenance Program	**Optional and may be requested** if ongoing minimal clinical activity only: Documentation of a proactive skills maintenance program (skills practice monthly) or other EMS / medical related activity. This will be submitted annually for preapproval by the Medical Director	**Optional and may be requested** if ongoing minimal clinical activity only: Documentation of a proactive skills maintenance program (skills practice monthly) or other EMS / medical related activity. This will be submitted annually for approval by the Medical Director.

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Title: **Certification Policy**	

4.2 Clarification of Terms and Conditions

4.2.1 Base Hospital: means a hospital that is designated as a Base Hospital by the Minister in accordance with the Ambulance Act of June 16, 2000.
In this document, unless otherwise stated, the use of the following terms refer to ambulance personnel as defined by the Ambulance Act, as amended by the Ontario Regulation 257/00:

Emergency Medical Attendant
Paramedic
Primary Care Paramedic
Advanced Care Paramedic
Critical Care Paramedic

4.2.2 Emergency Medical Service: or "Service" means an Ontario ambulance service provider duly licensed to perform this service as defined under the Ambulance Act.

4.2.3 Hours of Service: means work normally defined as field assignments.

4.2.4 Certification: Is written approval to perform selected medical controlled acts under the license/registration of a Base Hospital Medical Director.

4.2.5 CPER: is the Centre for Paramedic Education and Research which is the "Base Hospital" Program at Hamilton Health Sciences.

4.2.6 Educational Certification: Is permission granted by a local Base Hospital Medical Director to a Paramedic, to perform controlled acts in the presence of a certified Paramedic (at the same level or higher) or a physician supervisor, for the purposes of orientation, evaluation, and education.

4.2.7 Inactive Status: Is a voluntary status (with the approval of the Emergency Medical Service) where the Medical Director may grant certification to a Paramedic with the provision that they are "inactive" and thus not authorized to perform Controlled Acts at that level. The Paramedic must still complete an Annual Practice Review session.

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4.2.8 **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 investigation and/or remediation.

Deactivation may occur as a result of:

i. A critical omission/commission.
ii. A serious major omission/commissions.
iii. Repeated major omission/commissions.
iv. Failure to respond to Base Hospital requests for feedback or interviews.
v. Failure to successfully complete prescribed remediation for minor/major omission/commission within a reasonable period of time (2 weeks).
vi. Professional misconduct deemed by the Medical Director to be remediable (see the Provincial Paramedic Conduct Directives).
vii. Failure to maintain Certification as outlined in Section C of this document.

4.2.9 **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 remediation plan will be outlined by the Base Hospital and be completed by the Paramedic within a reasonable period of time (2 weeks).

4.1.10 **Decertification:** Is the revocation, by the Medical Director, of a certified Paramedic's privileges to perform controlled acts while in the employ of a certified Emergency Medical Service.

Decertification would normally be preceded by a review by a Paramedic Practice Review Committee (PPRC). The PPRC will review the details and reasons for a proposed decertification and make recommendations / comments about the Paramedic's certification status. A Paramedic may decline a PPRC's review of the situation (in writing). It is understood that as per the CPSO guidelines for delegation, that the Medical Director has the ultimate authority and responsibility for the decision about the Paramedic's certification status.

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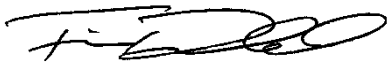
Decertification may occur as a result of:

i. Gross professional misconduct (Provincial Paramedic Conduct Directives).
ii. Falsification of documentation.
iii. A critical omission/commission.
iv. Failure to successfully complete prescribed deactivation remediation.
v. Repeated deactivations in similar clinical areas.

NOTE:
Upon deactivation or decertification, the Paramedic has a professional duty to notify Medical Directors of all other Base Hospitals under which s/he is certified (see Provincial Paramedic Conduct Standard).

5.0 Regional Program Manager/Director Approval Signature



Hamilton Health Sciences CENTRE FOR PARAMEDIC EDUCATION AND RESEARCH	**Page 1 of 2**
CPER POLICY MANUAL	
Date Issued: **November 8, 2013**	Policy Number: **C-002**
Revision History Dates: June 2014	
Title: **Return to Clinical Practice (RTCP)**	

1.0 Policy

1.1 This policy has been developed to aid in the process of reactivation for Paramedics who are returning to clinical practice for the following reasons not associated to patient care deficiencies:

- Leaves of absence for greater than 90 days
- Paramedics returning to the profession

2.0 References

None

3.0 Procedure

3.1 The Paramedic will fill out the Return to Clinical Practice form and submit it to the Service Operator.

3.2 The Service Operator will complete their section of the form and forward to CPER.

3.3 CPER will create an educational needs assessment and reactivation plan. All Return to Clinical Practice files will be acted upon within 2 weeks of receipt.

3.4 Creation of the education needs and reactivation plan by CPER may require an interview with the Paramedic.

The table below (Appendix A-PCP, Appendix B-ACP) will be used as a resource to guide reactivation requirements although the Paramedic's years of experience at their level, education and/or other activities completed during the time away, and information gained from the interview will be considered when making the individualized plan.

3.5 All Paramedics will be required to complete any new mandatory Base Hospital training initiatives that occurred in their absence prior to return to clinical practice.

4.0 Appendices

4.1 Appendix A – PCP RTCP Recommendations Chart

4.2 Appendix B – ACP RTCP Recommendations Chart

4.3 Appendix C – Return to Clinical Practice Process Map

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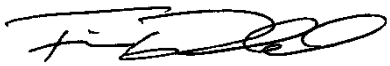
CPER POLICY MANUAL	
Date Issued: **November 8, 2013**	Policy Number: **C-002**
Revision History Dates: June 2014	
Title: **Return to Clinical Practice (RTCP)**	

5.0 Regional Program Manager/Director Approval Signature



Hamilton Health Sciences CENTRE FOR PARAMEDIC EDUCATION AND RESEARCH	Appendix A Policy Number: C-002 PCP RTCP Recommendations Chart

The following table outlines the potential requirements for the Paramedic's return to clinical practice according to the duration of time that the Paramedic has been away from practice. This is a guideline as all RTCP plans will be specific to each individuals needs as identified by CPER and may require clinical placements if deemed necessary and appropriate.

PCP Length of Absence	Potential reactivation requirements
3 Months- 6 months	1. Must complete all outstanding CPER-mandated education and on-line evaluations, and current and/or prior APRs if applicable. 2. Interview with a Paramedic Educator.
7 Months- 11 Months	1. Must complete all outstanding CPER-mandated education and on-line evaluations, and current and/or prior APRs if applicable. 2. Must perform assigned Skills and Scenario(s) through CPER or an approved Service Trainer, with assessment and determination of completion by CPER Representative. 3. Minimum of 2 shifts (24 hours) with partner of equal or greater certification. The number of shifts required may be extended based upon call volume, types of calls, and other factors as determined by CPER. 4. Call logs must be submitted for evaluation. 5. Interview with Paramedic Educator.
12 Months- 17 Months	1. Must complete all outstanding CPER-mandated education and on-line evaluations, and current and/or prior APRs if applicable. 2. Must perform assigned Skills and Scenario(s) through CPER or an approved Service Trainer, with assessment and determination of completion by CPER Representative. 3. Minimum of 1 shift (12 Hours) of consolidation as a third person on an ambulance, with a minimum of 3 additional shifts (36 Hours) with partner of equal or greater certification. The number of shifts required may be extended based upon call volume, types of calls, and other factors as determined by CPER. 4. Call logs must be submitted for evaluation. 5. Interview with Paramedic Educator.
18 Months- 23 Months	1. Must complete all outstanding CPER-mandated education and on-line evaluations, and current and/or prior APRs if applicable. 2. Must perform assigned Skills and Scenario(s) through CPER or an approved Service Trainer, with assessment and determination of completion by CPER Representative. 3. Minimum of 1 shift (12 Hours) of consolidation as a third person on an ambulance, with a minimum of 6 additional shifts (72 Hours) with partner of equal or greater certification. The number of shifts required may be extended based upon call volume, types of calls, and other factors as determined by CPER. 4. Call logs must be submitted for evaluation. 5. Interview with Paramedic Educator.
24 Months or Greater	The plan will be created based upon an individual needs assessment after discussion with the service operator, CPER Education, and CPER Medical Council. The final decision on the RTCP plan will be determined by CPER.

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CENTRE FOR PARAMEDIC EDUCATION AND RESEARCH

Appendix B
Policy Number: C-002
ACP RTCP Recommendations Chart

ACP Length of Absence	Potential reactivation requirements
3 Months- 6 Months	1. Must complete all outstanding CPER-mandated education and on-line evaluations, and current and/or prior APRs if applicable. 2. Interview with a Paramedic Educator.
7 Months- 11 Months	1. Must complete all outstanding CPER-mandated education and on-line evaluations, and current and/or prior APRs if applicable. 2. Must perform assigned Skills and Scenario(s) through CPER or an approved Service Trainer, with assessment and determination of completion by CPER Representative. 3. Must have 1 shift (12 Hours) of consolidation as a third person on an ambulance, with a minimum of 3 additional shifts (36 Hours) with partner of equal or greater certification. The number of shifts required may be extended based upon call volume, types of calls, and other factors as determined by CPER. 4. ACP call logs must be submitted for evaluation. 5. Interview with Paramedic Educator.
12 Months- 17 Months	1. Must complete all outstanding CPER-mandated education and on-line evaluations, and current and/or prior APRs if applicable. 2. Must perform assigned Skills and Scenario(s) through CPER or an approved Service Trainer, with assessment and determination of completion by CPER Representative. 3. Must have 2 shifts (24 Hours) of consolidation as a third person on an ambulance, with a minimum of 5 additional shifts (60 Hours) with partner of equal or greater certification. The number of shifts required may be extended based upon call volume, types of calls, and other factors as determined by CPER. 4. ACP call logs must be submitted for evaluation. 5. Interview with Paramedic Educator.
18 Months- 23 Months	1. Must complete all outstanding CPER-mandated coursework, and current and/or prior APR's (through RTCP exams or at alternate service operator) if Applicable. 2. Must perform assigned Skills and Scenario(s) through CPER or an approved Service Trainer, with assessment and determination of completion by CPER Representative. 3. Must have 2 shifts (24 Hours) of consolidation as a third person on an ambulance, with a minimum of 12 additional shifts (144 Hours) with partner of equal or greater certification. The number of shifts required may be extended based upon call volume, types of calls, and other factors as determined by CPER. 4. ACP call logs must be submitted for evaluation. 5. Interview with Paramedic Educator.
24 Months or Greater	The plan will be created based upon an individual needs assessment after discussion with the service operator, CPER Education, and CPER Medical Council. The final decision on the RTCP plan will be determined by CPER.

Hamilton Health Sciences CENTRE FOR PARAMEDIC EDUCATION AND RESEARCH	Appendix C Policy Number: C-002 Return to Clinical Practice Process Map

Return to Clinical Practice Process Map

RTCP form completed by Paramedic and endorsed by service operator

↓

Form received by CPER staff and file processed and referenced (CQI)

↓

RTCP plan created and approved by CPER Paramedic Educator. Must be individually approved by Medical Director (or alternate) for RTCP 18 months or longer, where additional requirements are recommended, or for any unusual circumstances.
Note: RTCP plan must include any mandatory or initial auxiliary education that was not completed during absence.

↓

RTCP plan sent to Paramedic and applicable service operator/s

↓

Paramedic completes RTCP plan including interview with CPER Paramedic Educator.

↓

Paramedic Educator recommends full certification or alternate plan. Must be approved by Medical Director (or alternate).

↓

Certification memo sent to Paramedic and service operator

↓

Paramedic returns to clinical practice

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CPER POLICY MANUAL	
Date Issued: **October 31, 2011**	Policy Number: **C-003**
Revision History Dates: May 2013, June 2014	
Title: **Reassignment of Paramedic level of Certification**	

1.0 Policy

1.1 This policy serves to outline the procedure that an active, fully-certified Advanced Care Paramedic under the auspices of the Hamilton Health Sciences, Centre for Paramedic Education and Research (CPER) must undertake in order to voluntarily have his/her certification level reassigned to that of a Primary Care Paramedic.

1.2 For the purpose of this policy, voluntary reassignment of certification means revocation of privileges to perform specific delegated medical acts due to a request of reassignment to an alternate skill level by the Paramedic. Reassignment of level of Paramedic does not imply that the Paramedic has been deactivated as described in the Certification Policy.

1.3 Conditions:

i. A certified Advanced Care Paramedic may request certification as a Primary Care Paramedic as per Policy C-006.

ii. The associated Paramedic Service Operator must agree to the reassignment and provide CPER with verification of an offer of employment at the level being requested.

2.0 References

None

3.0 Procedure

3.1 The reassignment of certification level must coincide with a reclassification of the Paramedic by the Service Operator. Supporting documentation from the employer must be provided to the CPER office.

3.2 CPER will provide official notification of the reassignment of certification level to the Paramedic and the employer in writing.

3.3 A Paramedic requesting reassignment of certification level may request a skills review/assessment at the reassigned level of certification; however, no mandatory training or assessment is required provided that the Paramedic is in good standing with CPER.

3.4 Upon reassignment of certification level the Paramedic is certified and authorized to perform those delegated acts that fall within the reassigned scope of practice.

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CPER POLICY MANUAL	
Date Issued: **October 31, 2011**	Policy Number: **C-003**
Revision History Dates: May 2013, June 2014	
Title: **Reassignment of Paramedic level of Certification**	

3.5 A Paramedic who has been reassigned may request to have his or her previous level of certification reinstated provided the request is made in writing within 90 days of the original reassignment and at least two weeks prior to the effective date to CPER. The reassignment of certification level must coincide with a reclassification of the Paramedic by the Paramedic Service Operator. Supporting documentation from the employer must be provided in advance.

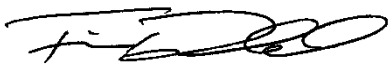
3.6 A Paramedic requesting reinstatement within the 90 day time frame will not be required to undergo assessment or training provided he or she remains in good standing with CPER and has met all CME requirements.

3.7 A Paramedic who is reassigned will become permanently decertified from the original level of certification if a letter of intent to reactivate is not received by CPER within 90 days of reassignment.

4.0 Appendices

None

5.0 Regional Program Manager/Director Approval Signature



Hamilton Health Sciences CENTRE FOR PARAMEDIC EDUCATION AND RESEARCH	**Page 1 of 1**
CPER POLICY MANUAL	
Date Issued: **August 1, 2010**	Policy Number: **C-004**
Revision History Dates: October 31, 2011, May 2013, August 2014	
Title: **Adherence to Provincial Medical Directives**	

1.0 Policy

1.1 The West Regional Base Hospital Program (as entitled the Centre for Paramedic Education and Research - CPER) provides delegation of controlled medical acts to Paramedics in accordance with the Advanced Life Support Patient Care Standards as recommended by the Provincial Medical Advisory Committee and approved by the Director, Emergency Health Services Branch.

2.0 References

2.1 Ambulance Act

2.2 CPER Medical Directives

2.3 Regional Base Hospital Performance Agreement

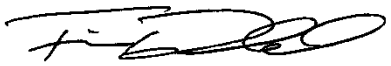
3.0 Procedure

3.1 CPER will only delegate controlled acts as outlined in the Ambulance Act and/or approved by the Director, Emergency Health Services Branch.

4.0 Appendices

4.1 Advanced Life Support Patient Care Standards

5.0 Regional Program Manager/Director Approval Signature



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CPER POLICY MANUAL	
Date Issued: **October 31, 2011**	Policy Number: **C-005**
Revision History Dates: May 2013, June 2014	
Title: **Advanced Care Paramedic Scope of Practice**	

1.0 Policy

1.1 The Advanced Care Paramedic scope of practice includes all core Medical Directives and any auxiliary skills within the core directives or the Auxiliary Medical Directives authorized by the CPER Regional Medical Director. The auxiliary scope of practice must be requested by the affiliated Paramedic Service Operator and approved by the Regional Medical Director.

1.2 Advanced Care Paramedics are only authorized to use the approved Medical Directives as outlined in this policy.

2.0 References

2.1 Advanced Life Support Patient Care Standards

2.2 Basic Life Support Patient Care Standards

2.3 CPER Medical Directives

3.0 Procedure

3.1 Advanced Care Paramedic Scope of Practice:

- All procedures as described in the Basic Life Support Patient Care Standards
- All procedures outlined in the PCP Scope of Practice Policy, Section 3.0
- Advanced Patient Assessment
- Base Hospital Patching
- Cardiac monitoring and rhythm interpretation
- Manual Defibrillation
- Valsalva Maneuver
- Synchronized cardio version
- Transcutaneous pacing
- Intraosseus access
- Intravenous access and fluid administration
- Laryngoscopic removal of foreign bodies
- Nasal and oral tracheal intubation
- End tidal CO_2 monitoring
- Needle thoracostomy
- Drug/substrate administration as described in the Provincial Medical Directives (see Appendix B)

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CPER POLICY MANUAL	
Date Issued: **October 31, 2011**	Policy Number: **C-005**
Revision History Dates: May 2013, June 2014	
Title: **Advanced Care Paramedic Scope of Practice**	

3.2 The Advanced Care Paramedic scope of practice may also include:

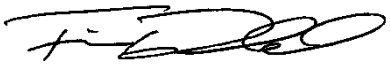
- See Appendix C

4.0 Appendices

4.1 ACP Medical Directives

4.2 Identified ACP Auxiliary Medical Directives

5.0 Regional Program Manager/Director Approval Signature



Hamilton Health Sciences CENTRE FOR PARAMEDIC EDUCATION AND RESEARCH	**Page 1 of 2**
CPER POLICY MANUAL	
Date Issued: **October 31, 2011**	Policy Number: **C-006**
Revision History Dates: May 2013, June 2014	
Title: **Primary Care Paramedic Scope of Practice**	

1.0 Policy

1.1 The Primary Care Paramedic scope of practice includes all core Medical Directives and any auxiliary skills within the core directives or Auxiliary Medical Directives authorized by the CPER Regional Medical Director. The auxiliary scope of practice must be requested by the affiliated Paramedic Service Operator and approved by the Regional Medical Director.

1.2 Primary Care Paramedics are only authorized to use the approved Medical Directives as outlined in this policy.

2.0 References

2.1 Advanced Life Support Patient Care Standards

2.2 Basic Life Support Patient Care Standards

2.3 CPER Medical Directives

3.0 Procedure

3.1 Primary Care Paramedic Scope of Practice:

- All procedures as described in the Basic Life Support Patient Care Standards
- Defibrillation (semi-automated or manual as per service)
- Cardiac Monitoring
- Base Hospital Patching
- Symptom Relief drug administration and procedures as described in the Provincial Medical Directives
    - ASA (Acetylsalicylic acid)
    - Nitroglycerin
    - Salbutamol
    - Blood Glucometry
    - Glucagon
    - Epinephrine 1:1000

3.2 The Primary Care Paramedic scope of practice may also include:

- See Appendix A

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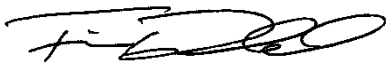
CPER POLICY MANUAL	
Date Issued: **October 31, 2011**	Policy Number: **C-006**
Revision History Dates: May 2013, June 2014	
Title: **Primary Care Paramedic Scope of Practice**	

4.0 Appendices

4.1 PCP Medical Directives

4.2 Identified PCP Auxiliary Medical Directives

5.0 Regional Program Manager/Director Approval Signature



Hamilton Health Sciences CENTRE FOR PARAMEDIC EDUCATION AND RESEARCH	**Appendix A, B, C** **Policy C-005, C-006**
	Page 1 of 2
CPER POLICY MANUAL	
Title: **Appendix A, B, C – ACP/PCP Scope of Practice**	

Appendix A

- Intravenous Access and Fluid Administration Medical Directive
- First time nitroglycerin administration
- Intravenous dextrose administration
- Benadryl
- Gravol
- Supraglottic Airway Medical Directive
- End tidal CO_2 monitoring
- Continuous Positive Airway Pressure Medical Directive
- 12-Lead Acquisition Protocol
- Nausea and Vomiting Medical Directive
- Electronic Control Device Probe Removal Medical Directive
- Home Dialysis Emergency Disconnect
- Analgesia Medical Directive
- Other Medical Directives as certified and authorized from time to time

Appendix B

- Adenosine
- Atropine
- Benadryl
- Dextrose
- Midazolam
- Dopamine
- Epinephrine 1:10,000 and 1:1,000
- Furosemide (with Base Hospital Physician order only)
- Gravol
- Lidocaine – topical
- Lidocaine IV (with Base Hospital Physician order only)
- Morphine
- Naloxone
- Sodium Bicarbonate

Hamilton Health Sciences CENTRE FOR PARAMEDIC EDUCATION AND RESEARCH	**Appendix A, B, C** **Policy C-005, C-006**
	Page 2 of 2
CPER POLICY MANUAL	
Title: **Appendix A, B, C – ACP/PCP Scope of Practice**	

Appendix C

- Supraglottic Airway Medical Directive
- Continuous Positive Airway Pressure Medical Directive
- 12-Lead Acquisition Protocol
- Nausea and Vomiting Medical Directive
- Cricothyrotomy Medical Directive
- Central Venous Access Device Medical Directive
- Combative Patient Medical Directive
- Electronic Control Device Probe Removal Medical Directive
- Fentanyl
- Other Medical Directives as certified and authorized from time to time

Hamilton Health Sciences CENTRE FOR PARAMEDIC EDUCATION AND RESEARCH	**Page 1 of 2**
CPER POLICY MANUAL	
Date Issued: **January 01, 2011**	Policy Number: **C-007**
Revision History Dates: October, 2011; May 2013; June 2014	
Title: **Provision of Care in an ACP/PCP Crew**	

1.0 Policy

1.1 In all patient care, the Paramedic with the higher level of certification has the primary responsibility for the care of the patient.

2.0 References

2.1 Advanced Life Support Patient Care Standards
2.2 Basic Life Support Patient Care Standards
2.3 CPER Medical Directives

3.0 Procedure

3.1 The Paramedic with the highest level of certification shall assess the patient and make a decision on the level of care required.

3.2 The Primary Care Paramedic may perform patient care that they are certified and authorized to perform. (Refer to Policy C-006).

3.3 The ACP is not permitted to direct the PCP to administer a drug or perform any treatment beyond that which the PCP is certified and authorized.

3.4 In a PCP/ACP configuration the ACP may transfer care to a PCP under the following conditions:

- The ACP has completed an initial assessment of the patient;
- The patient does not require treatment beyond that which the PCP is certified and authorized;
- The patient has not received treatment beyond that which the PCP is certified and authorized;
- The patient is improving after receiving treatment included in that which the PCP is certified and authorized; and
- Treatment beyond that which the PCP is certified and authorized is not anticipated.

3.5 The ACP will provide care for the patient under the following conditions:

- The patient requires interventions or assessment beyond that which the PCP is certified and authorized;
- The patient is reasonably expected to require treatment beyond that which the PCP is certified and authorized; and
- The patient deteriorates en route to the point that ACP care is required

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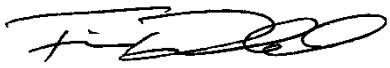
CPER POLICY MANUAL	
Date Issued: **January 01, 2011**	Policy Number: **C-007**
Revision History Dates: October, 2011; May 2013; June 2014	
Title: **Provision of Care in an ACP/PCP Crew**	

4.0 Appendices

None

5.0 Regional Program Manager/Director Approval Signature



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CPER POLICY MANUAL	
Date Issued: **January 01, 2011**	Policy Number: **C-008**
Revision History Dates: October 31, 2011, May 2013, June 2014	
Title: **Provision of Care in the Presence of Auxiliary Medical Directives**	

1.0 Preamble

1.1 The situation may exist where two Paramedics of the same level (PCP/PCP or ACP/ACP) are working together where only one Paramedic is certified and authorized to perform a specific Auxiliary Medical Directive.

1.2 The Paramedic who is certified and authorized in the Auxiliary Medical Directive will care for the patient when it has been determined that the patient may or will require treatment under the Auxiliary Medical Directive.

2.0 References

2.1 Advanced Life Support Patient Care Standards

2.2 Basic Life Support Patient Care Standards

2.3 CPER Medical Directives

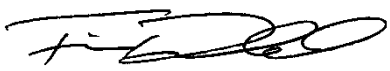
3.0 Policy

3.1 In the case of two or more Paramedics of the same level where one Paramedic has been certified and authorized in any Auxiliary Medical Directive; this Paramedic will be responsible for all aspects of patient care should the patient require or possibly require application of the Auxiliary Medical Directive.

4.0 Appendices

None

5.0 Regional Program Manager/Director Approval Signature



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CPER POLICY MANUAL	
Date Issued: **October 31, 2011**	Policy Number: **C-009**
Revision History Dates: May 2013, June 2014	
Title: **Acceptance of Medical Delegation from a Non-CPER Base Hospital Physician**	

1.0 Policy

1.1 Paramedics will not accept medical delegation from a physician other than an on-duty CPER Base Hospital Physician.

2.0 References

2.1 Advanced Life Support Patient Care Standards
2.2 Basic Life Support Patient Care Standards
2.3 CPER Medical Directives

3.0 Procedures

3.1 Should a Paramedic encounter a physician who attempts to delegate a controlled medical act to the Paramedic, the Paramedic will inform the physician that Paramedics are not able to accept delegation from any physician other than the on-duty CPER Base Hospital Physician.

3.2 The Paramedic will continue treating the patient utilizing approved medical directives and may contact the CPER Base Hospital Physician for advice or additional orders if necessary.

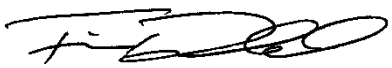
3.3 The Paramedic will advise the Base Hospital Physician that there is a physician on scene requesting that the patient be treated above the certification level of the Paramedic. The Paramedic should suggest that the on scene physician consult with the CPER Base Hospital Physician

3.4 Any orders that are discussed between the two physicians must be confirmed by the Paramedic through discussion with the CPER Base Hospital Physician.

4.0 Appendices

None

5.0 Regional Program Manager/Director Approval Signature



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CPER POLICY MANUAL	
Date Issued: **October 31, 2011**	Policy Number: **C-010**
Revision History Dates: May 2013, June 2014	
Title: **Medical Responsibility of an On-Scene Physician**	

1.0 Policy

1.1 Paramedics will advise an on scene physician that they cannot take orders for controlled medical acts from any medical doctor other than a CPER Base Hospital Physician.

2.0 References

2.1 Advanced Life Support Patient Care Standards
2.2 Basic Life Support Patient Care Standards
2.3 CPER Medical Directives

3.0 Procedure

3.1 If approached by a physician wishing to direct the medical care at a scene the Paramedic will advise the physician that Paramedics may only treat the patient using the provincially approved medical directives.

3.2 Paramedics will only initiate controlled medical acts which they are certified and authorized to perform under the authority of the Regional Medical Director of the Centre for Paramedic Education and Research and/or orders that are received directly from a CPER Base Hospital Physician.

3.3 The Paramedic will endeavour to confirm that the physician is licensed to practice medicine in Ontario.

3.4 The Paramedic will confirm that the physician is willing to assume responsibility for the care of the patient and that the physician is willing to accompany the patient in the ambulance to the hospital.

3.5 If both 3.3 and 3.4 are met the Paramedic may assist the physician in the use of equipment and patient care provided the Paramedic does not practice above what they are certified and authorized to do.

3.6 Should the physician ask the Paramedic that the patient be treated above the certification level of the Paramedic, the Paramedic will adhere to Policy C-009 entitled "Acceptance of Medical Delegation from a non-CPER Base Hospital Physician".

4.0 Appendices

None

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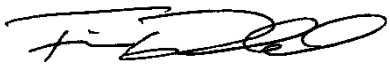
CPER POLICY MANUAL	
Date Issued: **October 31, 2011**	Policy Number: **C-010**
Revision History Dates: May 2013, June 2014	
Title: **Medical Responsibility of an On-Scene Physician**	

5.0 Regional Program Manager/Director Approval Signature



Hamilton Health Sciences CENTRE FOR PARAMEDIC EDUCATION AND RESEARCH	**Page 1 of 2**
CPER POLICY MANUAL	
Date Issued: **February 01, 2010**	Policy Number: **C-011**
Revision History Dates: May 2013; June 2014	
Title: **Discontinuing the use of a Cardiac Monitor While in Hospital**	

1.0 Purpose

1.1 To assist in the transfer of care from the Paramedic to the staff at the receiving hospital.

1.2 To provide an outline as to when a Paramedic may discontinue the use of a cardiac monitor on a patient while at the receiving hospital.

2.0 References

2.1 Advanced Life Support Patient Care Standards

2.2 Basic Life Support Patient Care Standards

2.3 CPER Medical Directives

3.0 Policy

3.1 As per Paragraph 7 Heading F of Section 1 of the BLS Standards, and other references in the BLS Standard; and
As per "Cardiac Monitoring and Oxygen Administration" of the ALS Standards, and other references in the ALS Standard; and
As per the CPER Medical and Auxiliary Medical Directives;
Paramedics will apply the cardiac monitor to the patient.

3.2 Paramedics will continue to monitor the patient en route to the receiving facility and while awaiting the transfer of care at the receiving facility.

3.3 At the receiving facility, the Paramedic will transfer the care of the patient to staff of the receiving facility as per Section M of the BLS Standards - and associated references in the BLS, ALS, Medical and Auxiliary Medical Directives.

3.4 Where a cardiac monitor has been applied by Paramedics, the cardiac monitor may be removed at the receiving facility, if:

- Patient's vitals are stable/normal;
- The patient has not complained of ischemic type chest pain at any point;
- There is no incident history of loss of consciousness (of any duration);
- Patient shows no electrical cardiac activity that is abnormal or inconsistent with previous medical history (e.g. rate or rhythm);
- The patient exhibits no signs of respiratory distress;
- The patient has had no further symptoms requiring medication for at least 30 minutes post treatment by Paramedics; and
- If an IV is in place, it is TKVO (30-60 ml/hr adult) only.

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CPER POLICY MANUAL	
Date Issued: **February 01, 2010**	Policy Number: **C-011**
Revision History Dates: May 2013; June 2014	
Title: **Discontinuing the use of a Cardiac Monitor While in Hospital**	

3.5 Prior to removing the cardiac monitor, the Paramedic will inform the receiving facility staff (such as the triage nurse) of the intentions.

3.6 As per Section 3.4 and 3.5 above, the Paramedic may remove the cardiac monitor. After removal of the cardiac monitor, the patient remains the responsibility of the Paramedic until there is a transfer of care to hospital staff.

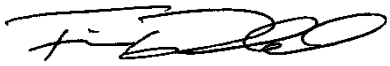
3.7 If there is a difference of opinion between the Paramedic and the staff at the receiving facility that the cardiac monitor is no longer required, the Paramedic may contact the CPER Base Hospital Physician for medical direction. The Paramedic may need to facilitate dialogue between the staff at the receiving facility and the CPER Base Hospital Physician.

3.8 If section 3.7 is applied, the final decision on the monitoring of the patient with a cardiac monitor will be with the CPER Base Hospital Physician.

4.0 Appendices

None

5.0 Regional Program Manager/Director Approval Signature



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CPER POLICY MANUAL	
Date Issued: **October 31, 2011**	Policy Number: **C-012**
Revision History Dates: May 2013; June 2014	
Title: **Paramedics Starting Intravenous Therapy (IVs) in the Emergency Department**	

1.0 Policy

1.1 CPER recognizes that some IV certified Paramedics may not have an opportunity to start enough IV's in the field in order to maintain their skill level. In order to assist those IV certified Paramedics to maintain their IV skill level, CPER will authorize Paramedics to start an IV in specific circumstances in the Emergency Department after the transfer of care has occurred.

1.2 Prior to this policy coming into effect, there must be a written agreement between the receiving hospital, the affiliated Paramedic Service Operator, and CPER.

1.3 It must be clear to all parties that this initiative is for continuing education purposes.

2.0 References

2.1 Advanced Life Support Patient Care Standards

2.2 CPER Medical Directives

3.0 Procedure

3.1 Upon arrival at the Emergency Department the Paramedic will give a report to the triage nurse.

3.2 In consultation with the triage nurse or the nurse that will be looking after the patient, the Paramedic will inquire if the patient will require an IV by the hospital.

3.3 If it is decided by Emergency Department staff that the patient will require an IV start; the Paramedic may start the IV if Emergency Department staff are in agreement.

3.4 The Paramedic will use the IV catheter that they would normally use when they are starting an IV in the field. These IV catheters will be provided for this use by the Paramedic Service Operator. Hospital tubing and IV fluids will be used when starting all IV's in the hospital setting.

3.5 The Paramedic will be allowed to attempt one IV site, if unsuccessful Emergency Department staff will start the IV.

3.6 In patients where Emergency Department staff anticipates a difficult IV start, Emergency Department staff will use their discretion in whether or not to allow the Paramedic to attempt an IV start.

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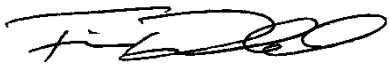
CPER POLICY MANUAL	
Date Issued: **October 31, 2011**	Policy Number: **C-012**
Revision History Dates: May 2013; June 2014	
Title: **Paramedics Starting Intravenous Therapy (IVs) in the Emergency Department**	

3.7 Upon attempting an IV start in the Emergency Department the Paramedic will document the IV attempt whether successful or not successful on their ACR in the procedure section. Documentation will include all of the usual documentation requirements.

4.0 Appendices

None

5.0 Regional Program Manager/Director Approval Signature



Hamilton Health Sciences CENTRE FOR PARAMEDIC EDUCATION AND RESEARCH	**Page 1 of 2**
CPER POLICY MANUAL	
Date Issued: **August 2015**	Policy Number: **C-014**
Revision History Dates:	
Title: **Guidelines for Resuscitation in Locations with Difficult Access**	

1.0 Preamble

1.1 This policy applies for patients that are vital signs absent from either trauma or medical causes. There are occasions when a critical illness or injury occurs in locations with difficult access. This policy deals with patients who are vital signs absent in these difficult access locations. Examples would be: falls into a gorge or from the Niagara Escarpment or medical cardiac arrests in remote locations accessible only by ATV, bicycle or on foot. Most of these rescue operations also involve the Fire Department. Some cases involve locations where mobile phone and radio service is poor.

2.0 References

Advanced Life Support Patient Care Standards
Basic Life Support Patient Care Standards
CPER Medical Directives
Deceased Patient Standard

3.0 Procedure

3.1 Rescuers (Fire or EMS personnel) will access the patient and perform a patient assessment following service policies around safety. In addition to the medical assessment and potential injuries, also consider the following additional information: mechanism of injury, down time, time required to safely extricate the patient, and ability to provide medical care during extrication.

- If safe to do so: start CPR and full resuscitation. If access to a cardiac monitor/AED is possible, continue usual resuscitation and contact the Base Hospital Physician (BHP) after the appropriate number of analyses (1 if trauma, 3 if medical).
- If no access to a cardiac monitor/AED is possible in the first 10 minutes, then two rescuers should confirm pulselessness and absence of signs of life (pulse, respiratory effort, pupillary response, spontaneous movement) and contact the BHP early. If only one rescuer is able to access the patient in the first 10 minutes and a cardiac monitor/AED is not available, then the single rescuer may confirm absence of signs of life.
- If ongoing CPR puts the providers' safety at risk or is not possible during transport/extrication for any period $\geq$ 5 minutes, then call the BHP.
- If time to hospital is definitely $\geq$ 30 minutes and ongoing CPR is difficult or impossible, contact the BHP.
- If the above does not apply, then continue resuscitation and transport.

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CPER POLICY MANUAL	
Date Issued: **August 2015**	Policy Number: **C-014**
Revision History Dates:	
Title: **Guideline for Resuscitation in Locations with Difficult Access**	

3.2 When reporting to the Base Hospital Physician the Paramedic should report that the call is for a "Termination of Resuscitation (TOR) in a location with difficult access". Apparent injuries, mechanism of injury, down time, extrication time and ability to provide medical care, and findings on examination of the patient should be communicated clearly to the BHP.

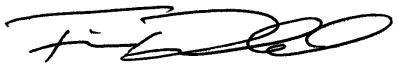
3.3 On occasions, when Paramedics cannot access the patient and the rescuers are Firefighters, then the information as above can be transmitted to the BHP by a third party at the scene of the rescue. That third party should be the highest qualified Paramedic on scene or EMS supervisor.

3.4 If a TOR is given by the BHP, the coroner must be called.

4.0 Appendices

None

5.0 Regional Program Manager/Director Approval Signature



Hamilton Health Sciences CENTRE FOR PARAMEDIC EDUCATION AND RESEARCH	**Page 1 of 2**
CPER POLICY MANUAL	
Date Issued: **October 31, 2011**	Policy Number: **D-001**
Revision History Dates: May 2013, August 2014	
Title: **Confidentiality of Information**	

1.0 Policy

1.1 All employees (full and part time) of the Centre for Paramedic Education and Research (CPER) will keep patient information confidential as per the Personal Health Information Protection Act.

1.2 All employees (full and part time) of CPER must sign a confidentiality agreement prior to the commencement of employment.

2.0 References

2.1 Ambulance Act
2.2 Basic Life Support Patient Care Standards
2.3 MOHLTC Documentation Standards
2.4 Personal Health Information Protection Act
2.5 Regional Base Hospital Performance Agreement

3.0 Procedure

3.1 Paramedics must keep all patient care information written or oral confidential.

3.2 All employees (full and part time) of the Centre for Paramedic Education and Research will maintain all information whether written or oral confidential as per the confidentiality agreement and the Personal Health Information Protection Act.

3.3 All employees (full and part time) of CPER will sign the "Confidentiality Agreement" as identified in the Appendix prior to the commencement of employment.

3.4 Any breach of confidentiality by a CPER employee (full and part time) must be immediately reported to the individual's direct supervisor.

3.5 It is the responsibility of the immediate supervisor to monitor and enforce this policy. In the event of a breech in policy, the event will be reported to the CPER Regional Program Manager/Director. The Regional Program Manager/Director will forward the event to the Hamilton Health Sciences Human Resources Department for an investigation and recommended outcome/actions including discipline and/or termination of employment, as determined.

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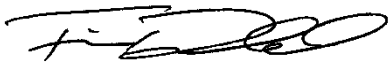
CPER POLICY MANUAL	
Date Issued: **October 31, 2011**	Policy Number: **D-001**
Revision History Dates: May 2013, August 2014	
Title: **Confidentiality of Information**	

4.0 Appendices
4.1 CPER Confidentiality Agreement

5.0 Regional Program Manager/Director Approval Signature



Hamilton Health Sciences CENTRE FOR PARAMEDIC EDUCATION AND RESEARCH	**Page 1 of 2**
CPER POLICY MANUAL	
Date Issued: **October 31, 2011**	Policy Number: **D-002**
Revision History Dates: May 2013, August 2014	
Title: **Security of Confidential Information**	

1.0 Policy

1.1 All information containing Personal Health Information must be kept secure at all times.

1.2 Security measures include locking information in file cabinets, ensuring all exterior doors are securely locked when the office is closed and securely locking all information up at the end of the day.

1.3 All information that is stored electronically is secured by a firewall, antivirus software, in a locked room, and backups of the information are saved on tapes and retained as per HHS IT policy.

2.0 References

2.1 Regional Base Hospital Performance Agreement

2.2 Personal Health Information Protection Act

3.0 Procedure

3.1 This policy covers all information that may contain personal health information including but not limited to: ACR's, incident reports, medical control logs and patch audio and any other information that could identify a patient.

3.2 Transmission of patient information by fax machine to the CPER office should only occur via the secure fax server for those services who use ePCR and can securely transmit information.

3.3 Any time that patient care data is submitted for research all patient identifiers must be removed from the chart prior to the information being sent. Appropriate REB authorization must be received prior to release of research information.

3.4 All ambulance call reports that contain any information are considered confidential and must be secured at all times.

3.5 CPER will immediately report any unauthorized use or disclosure of confidential information to the Host Hospital and the EHS Senior Field Manager.

3.6 CPER complies with the Personal Health Information Protection Act as do all employees of CPER including full time and part time employees.

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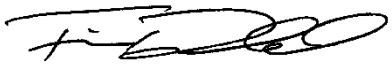
CPER POLICY MANUAL	
Date Issued: **October 31, 2011**	Policy Number: **D-002**
Revision History Dates: May 2013, August 2014	
Title: **Security of Confidential Information**	

4.0 Appendices

None

5.0 Regional Program Manager/Director Approval Signature



Hamilton Health Sciences CENTRE FOR PARAMEDIC EDUCATION AND RESEARCH	**Page 1 of 1**
CPER POLICY MANUAL	
Date Issued: **October 31, 2011**	Policy Number: **D-003**
Revision History Dates: May 2013, August 2014	
Title: **Release of Confidential Information**	

1.0 Policy

1.1 All personal health information is considered confidential. As such, no employee (full or part time) will release personal health information to any party outside of CPER.

1.2 Requests for the release of personal health information will be directed to the CPER Regional Program Manager/Director.

2.0 References

2.1 Personal Health Information Protection Act

2.2 Regional Base Hospital Performance Agreement

3.0 Procedure

3.1 Requests from patients for their health information will be directed to the appropriate Paramedic Service Operator.

3.2 Requests for personal health information from police, lawyers or other public and/or private agencies will be directed to the appropriate Paramedic Service Operator and/or to the Hamilton Health Sciences' Freedom of Information Officer.

3.3 Personal Health Information will be released to appropriate Paramedic Service Operator or appropriate hospital staff provided the person requesting the information is entitled to the information as part of their professional duties.

3.4 All release of information will be conducted via the office of the CPER Regional Program Manager/Director (or his/her designate).

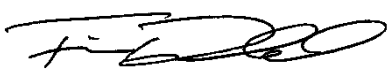
3.5 Where applicable by law, such as a Coroner's request, the CPER Regional Program Manager/Director will release the requested information.

3.6 Any appeal or concern to these procedures will be forwarded by the CPER Regional Program Manager/Director to the Hamilton Health Sciences' Freedom of Information Officer.

4.0 Appendices

None

5.0 Regional Program Manager/Director Approval Signature



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CPER POLICY MANUAL	
Date Issued: **October 31, 2011**	Policy Number: **D-004**
Revision History Dates: May 2013, August 2014	
Title: **Capture of Chart Data**	

1.0 Preamble

1.1 The Centre for Paramedic Education and Research (CPER) receives patient care charts from Service Operators in both electronic and paper formats for inclusion into the CPER data base that has been developed in accordance to the Ontario Emergency Medical Services Minimum Data Set.

2.0 References

2.1 ACR Documentation Standard
2.2 Ambulance Act
2.3 Ontario Emergency Medical Services Minimum Data Set
2.4 Regional Base Hospital Performance Agreement

3.0 Policy

3.1 Upon receipt of patient care charts in paper format as per the ACR Documentation Standard, CPER will ensure that chart data is entered into the data base in accordance with the Ontario Emergency Medical Services Minimum Data Set.

3.2 CPER will enter all paper patient care charts where a delegated act has been performed into the data base. CPER will monitor and provide feedback to Paramedic Service Operators with regards to the timeliness of their paper patient care charts reaching CPER's office.

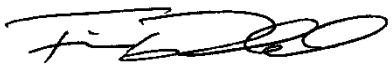
3.3 CPER will monitor the quality of data that is received electronically and ensure that all required data points are available.

3.4 Once the designated provincial warehouse database has been developed, CPER will forward the applicable Minimum Data Set to the designated provincial data warehouse.

4.0 Appendices

None

5.0 Regional Program Manager/Director Approval Signature



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CPER POLICY MANUAL	
Date Issued: **September 2014**	Policy Number: **D-005**
Revision History Dates:	
Title: **Retention of Base Hospital Information**	

1.0 Policy

1.1 Records of a confidential nature must be kept in a secure location whether electronic or by hard copy.

1.2 The retention period is determined by the information content of the record

1.3 In the absence of legislative requirements, the creator/custodian should have knowledge of the record's information content and common practice to decide on the retention period.

1.4 This policy covers information that may contain Personal Health Information including but not limited to: ACR's/ePCRs, incident reports, medical control logs and patches, CME records, Paramedic investigations, Paramedic certification information, financial records and other office records.

1.5 The term "record" in this policy could include but is not limited to emails, audio or visual recordings, paper documents, electronic files, reports, memos, draft documents, or letter correspondence.

2.0 References

2.1 Regional Base Hospital Performance Agreement

2.2 Hamilton Health Sciences IRMG – Information Records Management Guideline

2.3 Freedom of Information and Protection of Privacy Act

3.0 Procedure

3.1 Ambulance Call Reports - Adults

- Retained in a date order filing system for a minimum of 33 years from call date.
- Onsite – Previous year plus current quarter
- Offsite at *Exclusive Record Storage* – Minimum of 32 years

3.2 Ambulance Call Reports – Child

- Retained in a date order filing system for a minimum of 33 years from call date.
- Onsite – Previous year plus current quarter
- Offsite at Exclusive Record Storage – Minimum of 32 years

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CPER POLICY MANUAL	
Date Issued: **September 2014**	Policy Number: **D-005**
Revision History Dates:	
Title: **Retention of Base Hospital Information**	

3.3 Paramedic Files – Includes Initial Certification documents, Continuing Medical Education requirements, Contact Information, Call logs, Annual Practice Review documents, Change in Certification documents and evaluations not related to clinical deactivation / decertification.

- Retained for a minimum of 7 years after departure of Paramedic employment with Service.

3.4 Paramedic Clinical Deactivation / Decertification, Paramedic Investigations, PPRC.

- Retained indefinitely following creation of any Paramedic deactivation or decertification for clinical reasons. All documents pertaining to a PPRC held by CPER would be kept for a minimum of 7 years plus the current year.

3.5 Base Hospital Patches – Audio files / Call Logs

- Retained for a minimum of 7 years from call date.

3.6 Audit Clarifications / Follow up with Paramedic

- Retained for a minimum of 7 years in the AuditDB and/or on email electronic file.

3.7 Financial Records – Billing, expenditures, salary, budgets, proposals, and any records, ledgers, correspondence and reports related to CPER Finances.

- Retained for 7 years plus current Fiscal Year.

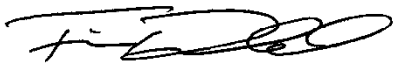
3.8 Base Hospital Administrative Documents – Including CPER staffing files, committee minutes, proposals, or any document or file relating to Base Hospital functions not listed above.

- Retained in the CPER office and/or on CPER / HHS servers for a minimum of 7 years.

4.0 Appendices

None

5.0 Regional Program Manager/Director Approval Signature



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CPER POLICY MANUAL	
Date Issued: **January 1, 2011**	Policy Number: **Q-001**
Revision History Dates: October 31, 2011 May 2013, August 2014	
Title: **Regional Quality Assurance (QA) and Continuous Quality Improvement (CQI) Program**	

1.0 Policy

1.1 The Centre for Paramedic Education and Research (CPER) is responsible for ensuring that a QA/CQI program is in place. This program must encompass each Paramedic that is employed or engaged by land ambulance service operators.

1.2 The QA/CQI program must ensure the provision of regular commentary to each paramedic and operator.

1.3 The QA/CQI Program is administered by the Quality Specialist as assigned and receives medical oversight by the CPER Medical Council.

2.0 References

2.1 ACR Documentation Standard

2.2 Advanced Life Support Patient Care Standards

2.3 Basic Life Support Patient Care Standards

2.4 CPER Medical Directives

2.5 Regional Base Hospital Performance Agreement

3.0 Procedure

3.1 CPER will regularly receive ACRs and/or ePCRs from all Paramedic Service Operators under their designated jurisdiction as per the ACR Documentation Standard.

3.2 Upon receipt of the ACRs, CPER will perform clinical audits related to delegated acts that paramedics have performed. Any individual patient care variation will be subject to an investigation process as outlined in Policy Q-005.

3.3 If during the clinical audit there is a patient care variation discovered, the Paramedic will be contacted with regards to the variation via email, telephone or via interview and the local Paramedic Service Operator will be notified as agreed upon.

3.4 Should a negative patient care trend be recognized during the clinical audit process, this trend will be discussed with the CPER Medical Council and the CPER Education team in order to address the finding on a regional basis.

3.5 A statistically relevant sample of calls where no delegated acts have been performed will also be reviewed. This review of patient care variations will be forwarded to the appropriate Paramedic Service Operator.

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CPER POLICY MANUAL	
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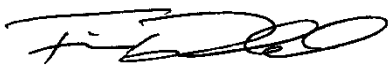
Revision History Dates: October 31, 2011 May 2013, August 2014	
Title: **Regional Quality Assurance (QA) and Continuous Quality Improvement (CQI) Program**	

3.6 Any Basic Life Support Patient Care Standard variations that are found during the clinical audit will be forwarded to the appropriate Paramedic Service Operator.

4.0 Appendices

None

5.0 Regional Program Manager/Director Approval Signature



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CPER POLICY MANUAL	
Date Issued: **October 31, 2011**	Policy Number: **Q-002**
Revision History Dates: May 2013; June 2014	
Title: **Patient Care Error Reporting**	

1.0 Policy

1.1 In the event of a patient care error the Paramedic will report the error to the Emergency Department physician, Base Hospital office and their Service Operator.

2.0 References

2.1 Advanced Life Support Patient Care Standards
2.2 Basic Life Support Patient Care Standards
2.3 CPER Medical Directives

3.0 Procedure

3.1 When an error involving a controlled medical act is recognized, the Paramedic will closely observe the patient for any adverse reaction and prepare to intervene and treat the patient. In the event of a medication error the Paramedic will check for allergies to the medication.

3.2 The Paramedic will immediately consult with the BHP (Base Hospital Physician) for guidance if the patient is still under the care of the Paramedic when the error is recognized.

3.3 If the patient care error is recognized by the non-attending Paramedic he/she will immediately notify the attending Paramedic of the error.

3.4 Upon arrival at hospital, the Paramedic will advise the Emergency Department physician of the error and any efforts to treat the effects of the error.

3.5 The Paramedic will complete their patient care documentation accordingly and provide a copy to the receiving hospital as soon as possible.

3.6 The Paramedic will concurrently notify the Service Operator and CPER staff of the incident. The notification to CPER may be accomplished by the self-report system, email, voicemail or by speaking directly to a Quality Specialist. The Paramedic will include the call date and run number in any communication with regards to the incident.

3.7 CPER will gather all relevant information in order to fully review the patient care. Information reviewed may include; ACR, incident reports, patch and dispatch audio, ECG strips and uploaded ECG files.

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CPER POLICY MANUAL	
Date Issued: **October 31, 2011**	Policy Number: **Q-002**
Revision History Dates: May 2013; June 2014	
Title: **Patient Care Error Reporting**	

3.8 The call will be evaluated via the call review process. The review may include an interview with the Paramedics, allied agencies, patient, patient's family and Emergency Department staff.

3.9 In the case where the incident had the potential to cause significant harm to the patient CPER Medical Council will be notified immediately.

3.10 It is recognized that in many cases the Paramedic completes their own self-remediation as they review call performance. In these cases the file may be closed after a discussion with the Paramedic.

3.11 In accordance with the CPER Certification Policy and after careful review of the incident CPER Medical Council may select one or more courses of action:

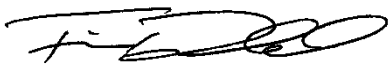
- Close the file after providing feedback to the Paramedic
- Provide remediation to the Paramedic
- Conduct a clinical evaluation of the Paramedic
- Deactivate the Paramedic pending remediation
- Other appropriate action

3.12 Upon completion of the recommended course of action the file will be closed, and a copy of the final report will be forwarded to the EHSB MOH Field Office.

4.0 Appendices

None

5.0 Regional Program Manager/Director Approval Signature



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CPER POLICY MANUAL	
Date Issued: **March 5, 2010**	Policy Number: **Q-003**
Revision History Dates: October 31, 2011 May 2013, August 2014	
Title: **Paramedic Self Report Policy**	

1.0 Policy

1.1 To provide all CPER staff with direction when Paramedics contact CPER to report potential errors in patient care.

1.2 The Centre for Paramedic Education and Research (CPER) encourages Paramedics to self-report potential errors and medical directive variances. Self reporting is professional and it shows that the Paramedic has a good understanding of medical directives and can recognize where they may have made an error. At times the self report itself can serve as remediation of the error. It is also very important that Paramedics realize their error at the time of occurrence so that hospital staff can be informed in order to watch for any untoward effects that the patient may experience.

1.3 Self reporting does not excuse the Paramedic from being assigned a protocol violation or error if warranted. All self reported errors are fully reviewed by the CQI team (as per Policy A-007). There may be times that a change in certification is necessary in order to provide immediate remediation of the Paramedic. Remediation activities may be assigned without a change in certification; these activities would be carried out by the Education team. The remediation may include a written assignment, performance of skills or simulated scenarios, educational ride out with one of the Paramedic Educators, clinical placement or other educational activities as determined by the Education team.

2.0 References

2.1 Advanced Life Support Patient Care Standards

2.2 Basic Life Support Patient Care Standards

2.3 CPER Medical Directives

3.0 Procedure

3.1 When a CPER staff member receives a call or contact from a Paramedic who feels that they may have made an error on a call, the CPER staff member will notify the Quality Specialist or the Peer Paramedic Practice Auditor.

3.2 The Paramedic may directly contact the Quality Specialist or the Peer Paramedic Practice Auditor. Once the Quality Specialist or the Peer Paramedic Practice Auditor has been notified, he/she will take the following steps:

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CPER POLICY MANUAL	
Date Issued: **March 5, 2010**	Policy Number: **Q-003**
Revision History Dates: October 31, 2011 May 2013, August 2014	
Title: **Paramedic Self Report Policy**	

3.2.1 Record the following information:
- Date of call
- Call number
- Service provider
- The nature of the potential error or concern

3.2.2 Provide feedback to ensure that the Paramedic understands the nature of the potential error involved and does not pose a risk to patient safety.

3.2.3 Provide any emotional support if the Paramedic is upset about the potential error. Suggest that the Paramedic contact their employer's employee assistance program if available.

3.2.4 The Quality Specialist or designate will ensure that the Paramedic understands that the call will be reviewed and that there may be remedial education provided and that self reporting does not eliminate any assignment of error.

3.3 The Quality Specialist will gather the required documentation to review the call (as per Policy A-007). This documentation may include the ambulance call report, ePCR, incident report, dispatch audio as authorized by the MOHLTC for release to Base Hospitals, base hospital patch form and audio, ECG strips and any other pertinent documentation.

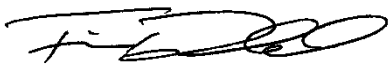
3.4 A CQI team member may need to speak to the Paramedic crew involved; this will be arranged by the CQI team. The CQI team will coordinate with the Paramedic Service Operator as per procedure outlined in Appendix 4.1 Paramedic Interviews.

3.5 The investigation process as outlined in Policy Q-005 will be followed.

4.0 Appendices

4.1 Paramedic Interviews Policy Q-006

5.0 Regional Program Manager/Director Approval Signature



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CPER POLICY MANUAL	
Date Issued: **October 31, 2011**	Policy Number: **Q-004**
Revision History Dates: May 2013, August 2014	
Title: **Investigation of Patient Care Complaints**	

1.0 Policy

1.1 CPER will work cooperatively with Paramedic Service Operators to investigate patient care complaints.

1.2 Any complaint that is reported to CPER by an external stakeholder will be shared with the Paramedic Service Operator. CPER's primary responsibility will be to investigate patient care that is performed under the ALS-PCS (see Policy C-005 and C-006).

2.0 References

2.1 Advanced Life Support Patient Care Standards
2.2 Basic Life Support Patient Care Standards
2.2 CPER Medical Directives
2.3 Regional Base Hospital Performance Agreement

3.0 Procedure

3.1 Upon receipt of an external complaint the Quality Specialist will review the complaint and decide if the complaint is regarding EMS operations, BLS-PCS or ALS-PCS.

3.2 If it has been determined that the complaint is regarding EMS operations or BLS-PCS, the concern will be forwarded to the appropriate Paramedic Service Operator.

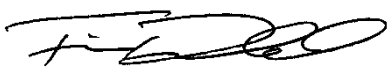
3.3 If the complaint involves the ALS-PCS, CPER will follow the investigation process as outlined in Policy A-007.

3.4 EMS operators may request that CPER investigate complaints involving BLS-PCS at their discretion.

4.0 Appendices

None

5.0 Regional Program Manager/Director Approval Signature



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CPER POLICY MANUAL	
Date Issued: **October 31, 2011**	Policy Number: **Q-005**
Revision History Dates: May 2013, August 2014	
Title: **Investigation Policy and Procedure**	

1.0 Policy

1.1 CPER will fully investigate any call where an internal (via the chart review process or other means) or an external concern is received by CPER.

1.2 All aspects of the patient care may be reviewed, including but not limited to: the ACR, ePCR, dispatch audio as per MOH&LTC guidelines, patch audio and interviews with the Paramedic(s) (Policy Q-006), allied agencies, emergency department staff and physicians and the patient and/or bystanders.

1.3 The investigation process and meetings are collaborative in nature; where errors, changes in certification and remediation are discussed by the CPER Quality Review Committee chaired by the CPER Quality Specialist and overseen by the CPER Medical Council.
The CPER Quality Review Committee recommends to the CPER Medical Council, who in turn, renders a decision of Paramedic practice and/or patient care. In the rare event of non-consensus, the Medical Director has the final decision.

2.0 References

2.1 Advanced Life Support Patient Care Standards

2.2 Basic Life Support Patient Care Standards

2.3 Regional Base Hospital Performance Agreement

3.0 Procedure

3.1 Upon receiving an internal or external patient care concern, CPER will review the event to decide if the concern is in regards to a delegated medical act or ALS Patient Care Standard. Concerns that relate to EMS operational issues or BLS issues will be forwarded to the Paramedic Service Operator. Concerns that involve delegated medical acts or ALS Patient Care Standards (see Policy C-005 and C-006) will be investigated by CPER in collaboration with the Service Operator.

3.2 The Quality Specialist will assign an investigation number and begin to gather all the necessary information required to fully review the patient care.

3.3 The information will be reviewed by the Quality Specialist and appropriate CPER staff.

3.4 The Quality Specialist will compose a draft investigation report.

3.5 The investigative report will be reviewed at the CPER Quality Review Committee meeting.

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Revision History Dates: May 2013, August 2014	
Title: **Investigation Policy and Procedure**	

3.6 During the call review meeting, identified variances will be reviewed and errors (if applicable) will be assigned. If no errors are assigned the case will be closed and feedback will be provided to the Paramedic Service Operator and to the Paramedic.

3.7 Remediation as required (with or without a change in certification) will be recommended in writing to the Paramedic Service Operator and the Paramedic.

3.8 The Lead Paramedic Educator will assign the remediation to the designated Educator who in consultation with the Lead Educator will develop the specific remediation that is required.

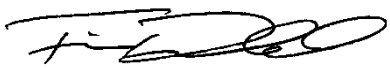
3.9 Upon completion of the remediation by the Paramedic, the Educator will complete the remediation report and send the report to the Quality Specialist.

3.10 The Quality Specialist will close the file and inform the Paramedic Service Operator and the Paramedic in writing that the remediation is complete and that the file is closed.

4.0 Appendices

None

5.0 Regional Program Manager/Director Approval Signature



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CPER POLICY MANUAL	
Date Issued: **September 2014**	Policy Number: **Q-006**
Revision History Dates: September 2014	
Title: **Paramedic Interviews**	

1.0 Policy

1.1 The purpose of the Paramedic interview is to gather information to evaluate a Paramedic's practice. A Paramedic interview may be requested to be completed with CPERs Quality Team and/or Medical Director or Designate.

2.0 References

2.1 Advanced Life Support Patient Care Standards
2.2 Basic Life Support Patient Care Standards
2.3 CPER Medical Directives

3.0 Procedure

3.1 This process is initiated when CPER's Quality Review Committee and/or CPER's Medical Council identifies that an interview is necessary to gather information not already provided and/or to assist with clarification of Paramedic practice or remedial process and call details.

3.2 Please refer to Policy Q-005 regarding the investigation process and other pertinent information.

3.3 When a Paramedic interview is deemed to be required, the CPER Quality Specialist or designate will request via email to the Paramedic(s) involved that a Paramedic interview is to be conducted to further evaluate identified potential concerns. The Paramedic(s) will be informed about the nature of the interview and requirement of information. The Paramedic(s) will also be notified that all corresponding documents required for the interview will be provided with the opportunity to review if required. This initial request will be sent to the main contact email address as provided by the Paramedic(s) with the Service Operator copied on the e-mail.

3.4 Once the initial email request is made to the appropriate Paramedic(s), one phone call within a week may also be made to the main contact phone number as provided by the Paramedic(s) to relay the request for an interview.

3.5 It will be relayed to the Paramedic(s) involved that they will have a 2 week time frame to respond and complete the interview process. The Paramedic(s) will be given multiple dates and times where an interview may be conducted during the 2 week time frame by the CPER Quality Specialist.

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CPER POLICY MANUAL	
Date Issued: **September 2014**	Policy Number: **Q-006**
Revision History Dates: September 2014	
Title: **Paramedic Interviews**	

3.6 Upon receipt of the interview request, the Service Operator will identify to CPER those Paramedics who are on leave or vacation and the date of expected return. Upon notification, CPER will consider an extension to the time frame at the discretion of the CPER Quality Review Committee and/or Medical Council.

3.7 Interviews will primarily be held in person at the CPER office. A phone/web interview or interview at the employer's site may be allowed in certain circumstances. The requirements for a private space that allow confidentiality of the documents and discussions will be communicated by CPER. In these cases, the Paramedic may make the request to CPER and then will be responsible to make arrangements of a suitable location at the Service Operator's site. CPER holds the sole discretion on the location of the Paramedic interview.

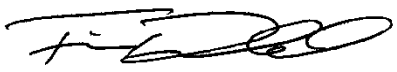
3.8 If the Paramedic(s) does not meet the 2 week time frame for scheduling and completion of the interview, the CPER Quality Specialist will inform CPER Medical Council of the delay and any difficulties identified. One of the following decisions will be made by CPER Medical Council:

- If a response is received from the Paramedic; an extension to the time frame may be granted upon written request of the Paramedic for extenuating circumstances.
- If a response is not received from the Paramedic with the confirmation of a leave from the employer; if the potential concern is not considered serious or urgent in nature, the Paramedic may be granted a short extension until he/she returns to work for the scheduling and completion of the interview.
- Dependent upon the seriousness of the variances identified, the Paramedic may be deactivated until the interview is completed.

4.0 Appendices

4.1 Investigation Policy Q-005

5.0 Regional Program Manager/Director Approval Signature



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CPER POLICY MANUAL	
Date Issued: **January 1, 2011**	Policy Number: **Q-007**
Revision History Dates: October 31, 2011 May 2013, August 2014	
Title: **Medical Control Log Quality Review**	

1.0 Policy

1.1 The Centre for Paramedic Education and Research will review a statistically relevant number of Base Hospital Physician (BHP) contacts – either in written format (ACR, BHP Patch Form) or patch audio recording - between the Paramedic and the BHP.

1.2 CPER will also review base hospital physician contacts on an as needed basis, such as part of an investigation process.

2.0 References

2.1 Ambulance Act
2.2 Advanced Life Support Patient Care Standards
2.3 Basic Life Support Patient Care Standards
2.4 CPER Medical Directives
2.5 Regional Base Hospital Performance Agreement

3.0 Procedure

3.1 Each month, all Base Hospital Physicians (BHPs) are required to forward their completed patch records to CPER.

3.2 Patch records are filed by date for reference.

3.3 Patch records (either in written or audio format) are reviewed for medical quality review.

3.4 A statistically relevant sample size will also be reviewed, these patches will be matched to the corresponding patient care report and a full review of the call will be done.

3.5 Findings of the Medical Quality Review are forwarded to the CPER Medical Council for subsequent BHP continuous medical education.

3.6 If an individual finding requires attention, the CPER Medical Council will advise the identified BHP accordingly for remediation, or, the QA/CQI team (via the Paramedic Educator) will advise the individual Paramedic and the local Service Operator accordingly for remediation.

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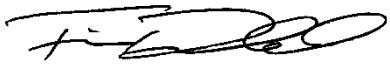
CPER POLICY MANUAL	
Date Issued: **January 1, 2011**	Policy Number: **Q-007**
Revision History Dates: October 31, 2011 May 2013, August 2014	
Title: **Medical Control Log Quality Review**	

4.0 Appendices

4.1 Copy of BHP Patch Form

4.2 CQI Process for Base Hospital Physician Patches

5.0 Regional Program Manager/Director Approval Signature



The host hospital shall ensure that host hospital physician and paramedic online interactions are subject to medical quality review.
Regional Base Hospital Performance Agreement; pg. 48

All patch audio received at CPER from Hamilton CACC, Cambridge CACC or Niagara EMS Dispatch Centre

Patch audio is selected for review in three ways:

Random selection by matching the call report with the patch audio

During the call review process the patch audio will be matched for a proportion of calls where a base hospital physician patch was performed. A random selection will be reviewed by the chart reviewer.

Selected based on concerns received by the BHP or Paramedic involved in the call

Upon receipt of a concern from a BHP or Paramedic the call report will be located and the patch audio will be reviewed in conjunction with the call. Should there be further review required an investigation may be initiated.

As part of a formal internal or external investigation into a call

During the course of a formal investigation into a call the patch audio may be reviewed in order to provide additional details for the investigation. Review of patch audio during investigation is on an as needed basis.

Review of the BHP patch will include:

1. Review of the information provided to the BHP by the Paramedic for accuracy and completeness.
2. Review of the orders provided by the BHP to Paramedic.
3. Review of the care provided by the Paramedic, adherence to the BHP orders and documentation of the orders.
4. To ensure that the Paramedic verbally confirmed the BHP orders.

Possible results:

1. QA review sent to Paramedic or BHP
2. Identified trends discussed at Medical Council and appropriate corrective action taken (Paramedic or Base Hospital Physician education).