Community Paramedic

Guidelines

Hamilton Health Sciences

CENTRE FOR PARAMEDIC EDUCATION AND RESEARCH

2026 - v1

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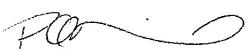
The Centre for Paramedic Education and Research (Outreach) has agreed to provide medical guidelines and develop a Continuous Quality Improvement program for Community Paramedicine (CP) programs. These medical guidelines outline the standards to which these CP programs will provide patient care, in collaboration with their patients' existing health care teams.

This Community Paramedicine guide contains guidelines for at-home care consistent with best practices as well as the Ministry of Health and Long-Term Care BLS/ALS standards.



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Collaboration Opportunities

CPER Outreach welcomes the opportunity to collaborate with Paramedic Services not currently associated with our program. CPER Outreach can provide either full medical direction or infrastructure support for a Community Paramedic program with their own medical director.

In addition to the ongoing Community Paramedicine medical guideline development, CPER Outreach offers online or in person education modules. CPER Outreach is also invested in the development of Quality processes to improve patient safety by implementing evidence-based best practices.

If you would like to discuss collaboration with CPER Outreach, please contact:

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Introduction

ADVANCED LIFE SUPPORT PATIENT CARE STANDARDS

Levels of Paramedics

In Ontario, there are 3 levels of qualification for paramedics which lead to Certification as a: Primary Care Paramedic (PCP), Advanced Care Paramedic (ACP), and Critical Care Paramedic (CCP). The qualification for each are set out in Ontario Regulation 257/00 made under the *Ambulance Act*, RSO 1990, c A-19. The qualifications for each include a requirement that the paramedic be authorized by a Medical Director of a Regional Base Hospital (RBH) to perform the controlled acts set out in Schedules 1, 2 and 3 to O. Reg 257/00.

In the Community Paramedicine setting, the CP will act under their Community Paramedic guidelines unless it is deemed that the patient is experiencing a medical emergency. If the patient is assessed as needing transport under the emergency response system, the Community Paramedic will act under their scope of practice as a PCP or ACP until a transport unit arrives to take over care. In the event that a patient requires ACP care and the Community Paramedic is an Advanced Care Paramedic under CPER Base hospital, the ACP will remain with that patient to render care until another ACP can assume care, or will continue with that patient to the ED.

Purpose of Standards

These Community Paramedic Medical Guidelines are designed to guide the specifics of patient care delivered by Community Paramedics and ensure the practices utilized are consistent with evidence-based best practice.

Format of the Community Paramedic Guideline Book

This document is comprised of a Preamble section and five (5) sections: Section 1 – CP Core Medical Guidelines; Section 2 – CP Wound Management Guidelines; Section 3 – CP Chronic Care Protocols; Section 4 – CP Respiratory Illness Support; and Section 5 – Medical References

Use of the Medical Guidelines by Community Paramedics

These Medical Guidelines apply to Community Paramedics who provide patient care under the license and/or authority of the CPER Outreach Medical Directors. Delegation of controlled acts or other procedures in these medical guidelines to Community Paramedics falls under the exclusive oversight of the CPER Outreach Medical Directors.

The medical guidelines are designed to guide a Community Paramedic in the provision of timely and appropriate care to rostered patients or patients needing community-based support. While great care has been taken in developing these medical guidelines, they cannot take into account for every clinical situation. Thus, they are not a substitute for sound clinical judgement.

General Structure of a Medical Guiedline

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

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

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

Consent to Treatment in Non-Emergency Situations

Most of the work being done by Community Paramedics would not be considered as emergent. Except in emergency circumstances described below, paramedics shall obtain consent prior to administering treatment. If a patient is incapable of consenting to the treatment being proposed by a paramedic, consent may be given or refused on his or her behalf by the patient's substitute decision-maker (SDM). Consent may be expressed or implied. Implied consent may be assumed where a person provides a physical indication that they consent to the treatment being proposed. For example,

a patient who cannot speak but extends his hand to a Community Paramedic after the CP indicates she is going to perform a simple procedure, such as a blood glucose determination, may be giving implied consent to the treatment plan being proposed.

The elements are required for consent to treatment are:

a) consent must be given by a person who is capable of giving consent with respect to treatment;
b) consent must relate to the treatment plan;
c) consent must be informed;
d) consent must be given voluntarily; and
e) consent must not be obtained through misrepresentation or fraud.

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

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

Valid consent requires that a person has the capacity to provide consent. A person is presumed to have the capacity to provide consent with respect to treatment and a Community Paramedic may rely on that presumption unless the CP has reasonable grounds to believe that the person is incapable with respect to the treatment plan. A CP must perform a capacity assessment if it is not reasonable in the circumstances to presume the person is capable of consenting to the treatment.

A patient is capable with respect to the treatment plan if the patient is:

a) Able to **understand** the information that is relevant to making a decision about the treatment or alternatives being proposed; **and**

b) Able to **appreciate** the reasonably foreseeable consequences of a decision or lack of decision with respect to the treatment plan.

If a patient is incapable of consenting to a proposed treatment plan, and the CP is aware or is made aware that the person has a prior capable wish with respect to the proposed treatment, they must respect that wish .

Consent to Treatment in Emergency Situations

Where the person for whom the treatment is being proposed is apparently experiencing severe suffering or is at risk of sustaining serious bodily harm if the treatment is not administered promptly, it is considered to be an emergency. All Community Paramedics will use sound judgement and apply care according to their underlying certification level, requesting backup through local dispatch centre for transport and/or additional paramedic resources.

For situations involving consent to treatment in emergency situations, a paramedic shall comply with the applicable directions contained in the *Basic Life Support Patient Care Standards* (BLS PCS).

Care at home

The goal of Community Paramedicine is to support patients' health care needs at their home or in their community. For the purpose of the applicable Medical Guidelines, a patient or substitute decision maker (SDM) present at the scene, must be capable to make an informed decision about their treatment plan.

A paramedic supporting their patients' care at home shall:

1. Determine whether a patient may be treated in partnership with their health care team through the use of an applicable Medical Guideline,

2. Communicate the appropriate medical concerns and agreed upon treatment plan to the patient or SDM,

3. Discuss the following elements of the treatment plan:
   a. The clinical situation related to the most likely diagnosis and/or differential diagnoses,
   b. The symptoms and signs alerting them to seek further medical care (i.e. clues that the condition is worsening or that the diagnosis may not be correct),

c. Instructions regarding modifications(s) of activities of daily living following the health event,
d. Provide additional contacts for follow up care;
e. Instructions to call the appropriate person in their health care team back if their condition worsens or recurs, and

4. Ensure the patient has the necessary support to follow a discharge treatment plan. These supports may include:
a. access to food,
b. access to transportation,
c. access to alternate health care follow up,
d. a safe place to stay,
e. responsible adult at the scene available to monitor the patient, and
f. consideration of other apparent patient vulnerabilities.

Refusal of Treatment

If a patient refuses treatment, either in whole or in part, a paramedic shall comply with the applicable directions contained in the BLS PCS.

Intravenous (IV) Access and Therapy by Community Paramedics

Any Community Paramedic Guideline that involves IV access shall only be performed by a paramedic of ACP or PCP-IV autonomous certification in good standing.

Exception requests

A paramedic shall initiate an exemption request when:

a) a requested order falls outside of a CPER Outreach medical guideline **OR**

b) for situations that fall outside of these Medical Guidelines where the paramedic believes the patient may benefit from alternate medical direction that falls within the prescribed Community Paramedic scope of practice

In cases where the Community Paramedic cannot contact the patient's health care team despite all reasonable attempts to do so, and the CP believes that the patient

requires assessment or treatment by a physician in a timely manner, CPER Outreach supports a conversation with the patient or their family about transport to the ED.

If an ordering authority directs a Community Paramedic to perform an assessment or intervention that exceeds the CP's scope of practice, the CP must advise their Community Paramedic supervisor or lead of such and notify the ordering authority that they cannot comply with the direction as it exceeds their scope of practice. In such cases, a paramedic should ask CPER Outreach to provide alternative direction through the Exemption request form.

Incident Reporting

Paramedics shall adhere to their ambulance service policies and the *Ontario Ambulance Documentation Standards* (incorporated by reference in Ontario Regulation 257/00) for incident reporting. Paramedics shall also adhere to additional RBH policies regarding reporting of clinical care incidents to the RBHP. Community Paramedics who receive delegation under CPER Outreach also have a duty to report any incidents that involve patient care to CPER Outreach.

Responsibility of Care

Each paramedic is equally responsible for patient care within their scope of practice. If the care exceeds a paramedic's scope of practice, responsibility for that continued care shifts to the higher certified paramedic.

If there is any disagreement between paramedics about management of a patient's health care needs, CPER Outreach may be contacted by way of the CP paramedic supervisor or lead. It is expected that when a delegated medical act has been performed, the paramedic most appropriate for that act will remain responsible for the patient.

In the event that a patient under the care of a Community Paramedic requires transport to or care in the ED, the CP will request a transport unit through the locally agreed-upon CACC pathway and obtain a MOH paramedic run number to initiate care. Once a run number has been obtained, all further documentation will occur as standard practice on the ePCR. In the even that the patient refuses transport once they have been deemed appropriate for further care the CP will obtain a refusal of service per standard documentation practice.

Conventions

"Conventions" refers to a consistent application of terms throughout the Medical Directives based on definitions below.

The word 'consider' is used repeatedly throughout the CP Medical Guidelines. Where this word appears, it indicates that a paramedic shall initiate the discussion with the patient's health care team/primary care physician when the indications are first identified unless there is strong clinical rationale to withhold or delay consultation or other extenuating circumstances. After consultation with the patient's health care team, the paramedic must document the results of this discussion on the Community Paramedic PCR.

Medication Doses and Administration

Unless specified within the medical guideline or protocol, the number of recommended medication doses may be administered regardless of any previous administrations. When more than one route of medication administration is listed, clinical circumstances for each case should determine the final route chosen.

Medication doses may be calculated based upon weight or other factors and result in a fraction that cannot be measured accurately. In these cases, the medication dose delivered will be rounded to the closest dose that can accurately be measured

Age and Vital Signs

The general age cut off between adults and pediatrics is 18 years (under 18 yrs. is generally considered a pediatric patient). There is a wide range of "normal" for vital signs in adults. There is a deliberate gap in the definition of normotension and hypotension in adults.

ADULTS

Normotension SBP ≥100mmHg

Hypotension SBP <90 mmHg

Heart rate Heart rate is always in beats per minute according to a cardiac monitor when it is applied. In situations where a cardiac monitor is not indicated then the heart rate is equal to the pulse rate.

Bradycardia HR <50 BPM

Tachycardia HR ≥100 BPM

Tachypnea RR ≥28 breath/min

Level of Awareness (LOA):
The word 'altered' refers to a GCS that is less than normal for the patient.

The word 'unaltered' refers to a GCS that is normal for the patient.
This may be a GCS <15.

Commonly Used Abbreviations

The following abbreviations, in alphabetical order, appear in the Community Paramedic Medical Guideline Book:

A

ACP	Advanced Care Paramedic
ALS	Advanced Life Support
ALS PCS	Advanced Life Support Patient Care Standards

B

BLS PCS	Basic Life Support Patient Care Standards
BPM	Beats per minute

C

CHF	Congestive Heart Failure
COPD	Chronic Obstructive Pulmonary Disease
COWS	Clinical Opiate Withdrawal Scale
CP	Community Paramedic
cm	Centimeter
CTAS	Canadian Triage Acuity System
CVA	Cerebrovascular Accident

D

DNR	Do Not Resuscitate
DOB	Date of Birth
DVT	Deep Vein Thrombosis

E

ECG	Electrocardiogram
ED	Emergency Department

G

g	Gram
gtts	Drops

H

H_2O	Water
HR	Heart rate
Hx	History

I

IM	Intramuscular
IN	Intranasal
IO	Intraosseous
IV	Intravenous

K

kg	Kilogram

L

LOA	Level of awareness
LOC	Level of consciousness

M

Max.	Maximum
MAID	Medical Assistance in Dying
mcg	Microgram
MDI	Metered dose inhaler
mg	Milligram
MI	Myocardial Infarction
min	Minute
mL/kg	Milliliter per kilogram
mmHg	Millimeters of mercury
MOH	Ministry of Health
MRP	Most Responsible Physician

N

N/A	Not applicable
NaCl	Sodium chloride
NEB	Nebulized
NP	Nurse Practitioner
NSAID	Non-steroidal anti-inflammatory drug
NTG	Nitroglycerin

O

O2	Oxygen

P

PCP	Primary Care Paramedic
PE	Pulmonary Embolism
PO	By mouth/oral
POC	Point of Care
PRN	As needed

Q

q	every

R

RR	Respiratory rate

S

SBP	Systolic blood pressure
SC	Subcutaneous
SDM	Substitute Decision Maker
SL	Sublingual
SpO_2	Saturation of peripheral oxygen

T

TOP	Topical

U

URTI	Upper Respiratory Tract Infection
UTI	Urinary Tract Infection

Blood values abbreviations

Na+ - Sodium

K+ - Potassium

Ca2+ - Calcium

Cl- - Chloride

TCO2 – Total Carbon Dioxide

AGap – Anion Gap

Hct – Hematocrit

Hgb –Hemoglobin

Glu – Glucose

BUN –Blood Urea Nitrogen

Urea –Urea

Crea –Creatinine

Lac – Lactate

pH – pH

pO2 – Partial pressure of oxygen

pCO2 – Partial pressure of Carbon Dioxide

A1C – Glycated Hemoglobin

INR – International Normalized Ratio

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Core Guidelines

COMMUNITY PARAMEDIC GUIDELINES

Medical Guideline: Requested injections (Community Paramedics)

An Advanced Care Paramedic or Primary Care Paramedic may provide the treatment prescribed in this Medical Guieline if they are certified and authorized.

INDICATIONS

Registered Community Paramedic patient with a request from their Primary Care Physician or NP or delegate for an at-home injection

Patient must have a history of having received the requested injection previously.

Authorized injections include:

- B12
- Regularly administered chronic medication
- Any vaccine as requested by physician. Cold chain to be maintained by physician or responsible health care provider.

CONDITIONS

Physician-requested injection

AGE: ≥ 12 years

LOA: Unaltered, or consent by SDM

HR: N/A

RR: N/A

SBP: N/A

Other: Previous use with requested injection

Must have order from patient's Primary Care Physician or NP or delegate

CONTRAINDICATIONS

Physician-requested injection

Patient or SDM does not consent

Previous adverse reaction to requested injection

TREATMENT

Consider **Physician-requested injection**

1. Obtain written request for injection
2. Prior to injection of medication, confirm:
    - Correct patient (name and DOB match)
    - Correct medication
    - Correct dosage to be administered
    - Correct route
    - Correct date/time of medication
3. Administer medication using injection best practices
4. Document date, time, medication name, and dosage administered in patent's care file and send confirmation of delivery to Primary Care Physician or Nurse Practitioner or delegate

CLINICAL CONSIDERATIONS

1. The Community Paramedic may occasionally receive requests for injections not covered implicitly by this guideline. The CP or supervisor may request authorization for delivery of a medication outside of the medical guideline by filling out an exemption request and sending to CPER for review.
2. If the patient discloses pregnancy, the Community Paramedic must speak with ordering Primary Care Physician or NP or Delegate to confirm that injection should proceed.

Medical Directive: Intravenous or Subcutaneous Therapy (Community Paramedics)

A Community Paramedic may provide the treatment prescribed in this Medical Directive if they are certified and authorized.

INDICATIONS

Actual or potential need for intravenous medication

OR

Fluid therapy by IV or SC access (as determined and ordered by physician or nurse practitioner for patient registered in CP program, or patient in LTC or retirement facility, or patient listed as 'Active' with Ontario Health atHome)

OR

For the purposes of Medical Assistance in Dying

AND

Other provider is not able to urgently perform

CONDITIONS

Intravenous Cannulation

AGE: ≥ 18 years
LOA: N/A
HR: N/A
RR: N/A
SBP: N/A
Other: Patient is not intended to be transported

0.9% NaCl Infusion

AGE: ≥ 18 years
LOA: N/A
HR: N/A
RR: N/A
SBP: N/A
Other: Patient is not intended to be transported

Subcutaneous Access

AGE: ≥ 18 years
LOA: Unaltered
HR: N/A
RR: N/A
SBP: N/A
Other: Patient is not intended to be transported

CONTRAINDICATIONS

Intravenous Cannulation

Suspected fracture proximal to the access site
Patient or SDM does not provide consent

0.9% NaCl Infusion

Fluid overload
Patient or SDM does not provide consent

Subcutaneous Access

Localized edema at site
Cellulitis

TREATMENT

Consider IV cannulation or SC access

1. Obtain IV or SC access using best practice techniques
2. Document IV gauge and location. Send report as normal practice to requestor.

0.9% NaCl Infusion – As per clinician order

1. The paramedic shall obtain verbal consent from the patient or SDM. Prior to IV fluids, a complete set of vital signs and chest auscultation should be conducted.
2. Any orders for NS fluid administration to be confirmed with the CP Program Office prior to intravenous cannulation or SC access.
3. Reassess patient every 250mL. Max volume is 2,000 mL.
4. Document total fluids administered and assessment post-administration with vital signs. Send report as normal practice to requestor.

CLINICAL CONSIDERATIONS

All paramedics must be certified in IV (autonomous) to use this directive in full. Any PCP who is not IV (autonomous) certified may use this directive for SC administration of fluid if authorized.

Community Paramedic must confirm order documented in last 24 hours in patient's chart from patient's physician or nurse practitioner and confirm patient meets the criteria of this directive.

Starting IVs for the purposes of MAID requires a willing provider. Paramedics have a "Right of Conscience" to accept or decline the request.

Medical Guideline:
IV Antibiotic (Community Paramedics)

A Community Paramedic (authorized for autonomous IV) may provide the treatment prescribed in this Medical Directive if they are certified and authorized.

INDICATIONS

Any registered patient or patient in LTC or retirement facility, or patient listed as "Active" in Home and Community Care Support Services (HCCSS), or under the care of an affiliated authorized prescriber for homeless outreach, AND

In need of IV antibiotic administration as prescribed by an authorized prescriber, AND

No other care partner can administer under an appropriate timeline

CONDITIONS

IV Antibiotic

AGE: ≥ 18 years

LOA: Unaltered, or consent by SDM

HR: N/A

RR: N/A

SBP: ≥90 mmHg

Other: Patient is not intended to be transported

Must have order from patient's Primary Care Physician or NP or delegate

CONTRAINDICATIONS

Antibiotic

Patient or SDM does not provide consent

Known allergy to prescribed antibiotic

Any known contraindication after consult with prescribing physician or delegate

TREATMENT

Consider IV initiation.

1. Establish an IV using paramedic best practices. If the IV antibiotic order is for a single dose, a single patent IV line is appropriate. The IV will then be discontinued after the medication has been administered. If the patient will be needing repeat doses, consider the safety of leaving an IV lock in place for the duration of the IV medication. If in the paramedic's judgement the IV lock can be kept clean and secure, the CP may initiate and secure an IV lock.
2. The Community Paramedic will assess the IV for patency and flush the IV with normal saline prior to each additional dose of IV antibiotic. The Community Paramedic will discontinue any established IV after 96 hours and initiate a new IV if a longer antibiotic regimen is ordered.

Consider Antibiotic:

1. Confirm order to proceed with antibiotic with patient's Primary Care Physician or NP or delegate
2. **CONFIRM NO KNOWN ALLERGY TO PRESCRIBED ANTIBIOTIC**
3. Explain rationale and potential side effects of using this medication to patient or substitute decision maker. Include instructions that all doses must be taken unless told to stop by Primary Care Physician or NP or delegate.
4. Obtain consent to proceed from patient or substitute decision maker
5. Administer antibiotic per order
6. Observe patient for a minimum 20 minutes in case of adverse reaction for first dose. If adverse reaction occurs, treat with appropriate BLS/ALS standard and initiate transport to hospital. Advise Primary Care Physician or NP or delegate of reaction and transport decision.
7. Confirm appointment for second visit by CPs in 24 hours for follow-up, or at appropriate interval for additional doses of antibiotic.
8. Document results and actions taken in patient care file

CLINICAL CONSIDERATIONS

Any Community Paramedic who assesses a patient to have signs and symptoms of sepsis will contact their emergency dispatch center for transport to the local ED. Sepsis is not to be treated in the out of hospital environment by Community Paramedics.

The following IV antibiotics are safe to use in the out of hospital setting and may be administered under this guideline:

1. Penicillins
2. Ceftriaxone (Rocephin, Ceftrisol)
3. Ertapenem (Invanz)
4. Metronidazole (Flagyl)
5. Ciprofloxacin (Cipro)

The following IV antibiotics are not safe to be administered out of hospital due to potential systemic complications, and will not be administered under this guideline:

1. Gentamicin, Vancomycin, Tobramycin
2. Doxycycline
3. Rifampin (Rifadin, Rimactane)
4. Cefepime (Maxipime)
5. Delafloxacin (Baxdela)

Other IV antibiotics may be approved by CPER Outreach on a case-by-case basis, through the submission of an exemption request form. PO and IM/SC antibiotic administration is covered under other CPER Outreach guidelines.

Medical Guideline: Urinalysis (Community Paramedics)

An Advanced Care Paramedic or Primary Care Paramedic may provide the treatment prescribed in this Medical Guideline if they are certified and authorized.

INDICATIONS

Registered Community Paramedic patient with symptoms of a current urinary tract infection

Patient must have a minimum of one of the following:

- Pain on urination or generalized lower abdominal pain
- Cloudy or foul smelling urine
- Unusually frequent urination or urge to urinate, or new incontinence
- Altered level of awareness – must have history of altered LOA concurrent with UTI
- Ususal presentation of UTI based on patient's previous history

CONDITIONS

POC Urinalysis

AGE: ≥ 18 years

LOA: Unaltered, or consent by SDM

HR: N/A

RR: N/A

SBP: ≥90 mmHg

Other: Patient is not intended to be transported

Patient must have the ability to give a sample

Antibiotic

AGE: ≥ 18 years

LOA: Unaltered, or consent by SDM

HR: N/A

RR: N/A

SBP: ≥90 mmHg

Other: Patient is not intended to be transported

Must have order from patient's Primary Care Physician or NP or delegate

Must be able to take PO medications

Acetaminophen for Fever or Pain

AGE: ≥ 18 years

LOA: Unaltered, or consent by SDM

HR: N/A

RR: N/A

SBP: N/A

Other: Patient is not intended to be transported

Must be able to take PO medications

CONTRAINDICATIONS

Urinalysis

Patient or SDM does not consent

Patient is unable to give a clean urine sample

Antibiotic

Patient or SDM does not provide consent

Known allergy to prescribed antibiotic

Any known contraindication after consult with prescribing physician or delegate

Acetaminophen

Acetaminophen use in previous 4 hours

Allergy or sensitivity to acetaminophen

Hx of liver disease

Active vomiting

Unable to tolerate oral medication

TREATMENT

Consider **POC urinalysis**

1. Contact patient's Primary Care Physician. If the Primary Care Physician or NP or delegate agrees, continue with urinalysis.
2. Obtain urine sample per best practice guidelines
3. Perform test following manufacturer's guidelines
4. If test shows positive result for any of the following, immediately contact patient's Primary Care Physician or NP or delegate for consultation
    - Blood
    - Nitrites
    - Leukocytes
    - Protein
5. If urinalysis is negative for the above, the Community Paramedic may provide results to Primary Care Physician or NP or delegate through normal reporting mechanism
6. Document results and actions taken in patent's care file

Consider **Antibiotic:**

1. Confirm order to proceed with antibiotic with patient's Primary Care Physician or NP or delegate
2. **CONFIRM NO KNOWN ALLERGY TO PRESCRIBED ANTIBIOTIC**
3. Explain rationale and potential side effects of using this medication to patient or substitute decision maker. Include instructions that all doses must be taken unless told to stop by Primary Care Physician or NP or delegate.
4. Obtain consent to proceed from patient or substitute decision maker
5. Administer antibiotic per order
6. Observe patient for a minimum 15 minutes in case of adverse reaction. If adverse reaction occurs, treat with appropriate BLS/ALS standard and initiate transport to hospital. Advise Primary Care Physician or NP or delegate of reaction and transport decision.
7. Confirm appointment for second visit by CPs in 24 hours for follow-up
8. Document results and actions taken in patient care file

Consider **Acetaminophen for fever or pain:**

1. If patient does not have any contraindications, administer 960-1000mg acetaminophen PO. Pt does not require transport to hospital under this guideline if they receive acetaminophen for fever or pain.

CLINICAL CONSIDERATIONS

1. The Community Paramedic must initiate transport of the patient if the patient is exhibiting vital signs, or signs and symptoms, indicating sepsis.
2. A patient with a urinary tract infection may or may not have a fever at presentation. Not having a fever does not mean that infection is absent.
3. The Community Paramedic is responsible for having a dicussion with the Primary Care Physician or NP or their delegate about potential side effects or contraindications based on a thorough assessment.

Medical Guideline:
Point of Care Blood Testing (Community Paramedics)

An Advanced Care Paramedic or Primary Care Paramedic (IV autonomous) may provide the treatment prescribed in this Medical Guideline if they are certified and authorized.

INDICATIONS

Registered Community Paramedic patient with request from Primary Care Physician or NP or delegate within patient's circle of care

Request to test any of the following:

- Na+, K+, Ca2+, Cl-, TCO2, AGap, Hct, Hgb, Glu, BUN, Urea, Crea, Lac, pH, pO2, pCO2
- A1C, INR
- Hepatitis C indicators

CONDITIONS

POC Blood testing

AGE: ≥ 18 years

LOA: Unaltered, or consent by SDM

HR: N/A

RR: N/A

SBP: N/A

Other: Patient is not intended to be transported

CONTRAINDICATIONS

POC Blood testing

Patient or SDM does not consent

Patient presents with acute changes that warrant further assessment in the Emergency Department

TREATMENT

Consider **POC blood testing**

1. Community Paramedic must receive order from Primary Care Physician or NP or delegate to complete POC blood testing.
2. Obtain IV blood sample per best practice guidelines. (Hepatitis C and INR testing may be capillary blood – use lancet for these tests only)
3. Perform test following manufacturer's guidelines.
4. If test shows results outside of normal established parameters, contact primary care or requesting health care practitioner directly with those results.
5. If there are no abnormal results of POC blood testing, the Community Paramedic may send a report as normal practice.
6. Document results and actions taken in patent's care file

CLINICAL CONSIDERATIONS

1. If critical results are reported, obtain a new sample and repeat the POC testing. If critical results persist the Community Paramedic will immediately call the Requestor. If the Requestor does not immediately answer then a 911 call will be generated for transport to the ED. Critical values are any from the chart below. These values are consistent with the HHS Critical Value policy.

Clinical Test	Normal range	Critical high	Clinical effect	Critical low	Clinical effect
Na+	135-145 mmol/L	≥160 mmol/L	Cardiovascular collapse	<120 mmol/L	Weak, neurologic symptoms
K+	3.5-5.3 mmol/L	>6.5 mmol/L	Arrhythmia	≤2.5 mmol/L	Arrhythmia
Ionized Ca2+	1.1-1.3 mmol/L	N/A in adults	N/A	≤0.6 mmol/L	Tetany
HgB	125-170g/L men 115-155 g/L women	>200 g/L	Hemoconcentration, DVT, MI, PE, CVA	<60 g/L	Heart failure, death
Glu	4-7 mmol/L	>25 mmol/L	Hyperglycemia	<2.5 mmol/L	Hypoglycemia
Lac	0.5-2.5 mmol/L	>4 mmol/L (first occurrence)	Lactic acidosis	N/A	N/A
PH	7.35-7.45	>7.7	Alkalosis, nausea, confusion, coma	≤7.0	Acidosis, headache, confusion, weakness, unconsciousness

Medical Guideline:
Phlebotomy for transport to laboratory (Community Paramedics)

An Advanced Care Paramedic or Primary Care Paramedic (IV autonomous) may provide the treatment prescribed in this Medical Guideline if they are certified and authorized.

INDICATIONS

Registered Community Paramedic patient with request from Primary Care Physician or NP or delegate within patient's circle of care

CONDITIONS

POC Blood testing

AGE: ≥ 18 years

LOA: Unaltered, or consent by SDM

HR: N/A

RR: N/A

SBP: N/A

Other: Patient is not intended to be transported

CONTRAINDICATIONS

POC Blood testing

Patient or SDM does not consent

Patient presents with acute changes that warrant further assessment in the Emergency Department

TREATMENT

Consider **Phlebotomy for transport to laboratory**

1. Community Paramedic must receive order from Primary Care Physician or NP or delegate to complete phlebotomy for transport. A complete laboratory requisition must be provided.
2. Obtain IV blood sample per best practice guidelines (see accompanying best practice document)
3. Label vials completely and secure for transport.
4. Once blood samples have been transferred to laboratory, send notice to requestor via normal channels.
5. Document in patent's care file

CLINICAL CONSIDERATIONS

A Community Paramedic may make a maximum of two attempts at venipuncture at any one site, and a maximum of three attempts total.

Medical Guideline:
Medical Device Assist – Diabetic Monitoring Sensor (Community Paramedics)

A Community Paramedic may provide the treatment prescribed in this Medical Guideline if they are certified and authorized.

INDICATIONS

Registered Community Paramedic patient with prescribed Diabetic Monitoring Sensor (Libre, Dexcom)

Patient or family or caregiver unable to remove or apply device

CONDITIONS

Diabetic Monitoring sensor

AGE:	≥ 18 years
LOA:	Unaltered, or consent by SDM
HR:	N/A
RR:	N/A
SBP:	N/A
Other:	Patient is not intended to be transported

CONTRAINDICATIONS

Diabetic Monitoring Sensor

Patient or SDM does not provide consent

TREATMENT

Consider Diabetic Monitoring Sensor:

1. If applicable, remove spent sensor. Brace skin around area and remove sensor with firm upwards pressure. Used sensors should be placed into a biohazard container.
2. Obtain new sensor in package and confirm not expired.
3. Clean skin thoroughly with soap and water, then dry. Swab new application area with cleansing swab provided with new sensor, or with alcohol swab.
4. Follow manufacturer's instructions for application of new sensor. Used applicators should be disposed of into a sharps container.
5. Scan sensor with reading device or smartphone. Sensors typically activate after 60 or 120 minutes.
6. Document results and actions taken in patient care file

CLINICAL CONSIDERATIONS

Current Diabetic Monitoring sensor systems available in Canada function for either 10 or 14 days. As part of routine practice the patient should have the changeover date recorded in an accessible location.

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Wound Management

COMMUNITY CARE PARAMEDIC GUIDELINES

Medical Guideline:
Simple Wound Treatment (Community Paramedics)

A Community Paramedic may provide the treatment prescribed in this Medical Guideline if they are certified and authorized.

INDICATIONS

Registered Community Paramedic patient with request from Primary Care Physician or NP or delegate within patient's circle of care

Minor skin tear

Superficial abrasion or laceration not requiring suturing

Minor scalding to extremity

CONDITIONS

Topical Antimicrobial

AGE:	≥ 12 years
LOA:	Unaltered, or consent by SDM
HR:	N/A
RR:	N/A
SBP:	N/A
Other:	Patient is not intended to be transported

CONTRAINDICATIONS

Topical Antimicrobial

Patient or SDM does not provide consent

Known allergy to topical antimicrobial

Not to be applied to chronic wounds/ulcers

TREATMENT

Consider Topical Antimicrobial:

1. **CONFIRM NO KNOWN ALLERGY TO TOPICAL ANTIMICROBIAL**
2. Explain rationale and potential side effects of using this medication to patient or substitute decision maker.
3. Obtain consent to proceed from patient or substitute decision maker
4. Administer topical antimicrobial and wrap with clean dry gauze. If possible, the bandage should be non-stick.
5. Confirm appointment for second visit by CPs in 24-48 hours for follow-up. If signs of infection develop contact MRP or delegate for consultation.
6. Document results and actions taken in patient care file

CLINICAL CONSIDERATIONS

If bleeding cannot be controlled with standard first aid measures, or if the simple wound shows any signs of infection, then physician assessment should be initiated.

The Community Paramedic should determine if the patient is at risk of Tetanus from the method of injury. If the injury method is one susceptible to Tetanus infection, the CP should determine if the patient has had a Tetanus booster in the previous 10 years. Contact with the MRP or delegate is indicated if the patient is in need of a Tetanus booster.

Approved topical antimicrobial may include polysporin, fucidin, proviodine, or analogues, at the discretion of the Paramedic Service. The Paramedic Service may gain approval from CPER for alternates if required.

Please note age change to ≥ 12 years, effective October 01, 2025.

Medical Guideline:
Wound Assessment and Treatment (Community Paramedics)

A Community Paramedic may provide the treatment prescribed in this Medical Guideline if they are Certified and Authorized.

INDICATIONS

Registered Community Paramedic patient with request from Most Responsible Physician or Nurse Practitioner or delegate within patient's circle of care

Evidence of new or worsening simple wound or skin breakdown OR

Evidence of new or worsening skin infection

CONDITIONS

Antibiotic

AGE:	≥ 12 years
LOA:	Unaltered, or consent by SDM
HR:	N/A
RR:	N/A
SBP:	≥90 mmHg

Other: Patient is not intended to be transported

Must have order from patient's Primary Care Physician or NP or delegate

Must be able to take PO medications

Wound Swabbing

AGE:	≥ 12 years
LOA:	Unaltered, or consent by SDM
HR:	N/A
RR:	N/A
SBP:	N/A

Other: Patient is not intended to be transported

Must have order and requisition from patient's Most Responsible Physician or Nurse Practitioner or delegate

CONTRAINDICATIONS

THIS DIRECTIVE DOES NOT APPLY TO COMPLEX WOUNDS (EXPOSED BONE, DEEP SURGICAL WOUNDS, NECROSIS OR SEPSIS.)

Antibiotic

Patient or SDM does not provide consent

Known allergy to prescribed antibiotic

Any questions or concerns about the medication or prescription that cannot be addressed with a pharmacist or prescribing authority

Wound Swabbing

Patient or SDM does not provide consent

TREATMENT

Consider Antibiotic:

1. For new antibiotic order: Confirm order to proceed with antibiotic with patient's Most Responsible Physician, Nurse Practitioner, or delegate. For ongoing care: Confirm order is up to date and ensure any questions have been clarified with pharmacist or patient's MRP, NP or delegate.
2. **CONFIRM NO KNOWN ALLERGY TO PRESCRIBED ANTIBIOTIC**
3. Explain rationale and potential side effects of using this medication to patient or substitute decision maker. Include instructions that all doses must be taken unless told to stop by Primary Care Physician or NP or delegate.
4. Obtain consent to proceed from patient or substitute decision maker
5. Administer antibiotic per order
6. Observe patient for a minimum 15 minutes in case of adverse reaction. If adverse reaction occurs, treat with appropriate BLS/ALS standard and initiate transport to hospital. Advise Primary Care Physician or NP or delegate of reaction and transport decision.
7. Confirm appointment for second visit by CPs in 24 hours for follow-up. If signs of infection are spreading 48 hours after antibiotic initiation, contact MRP or NP or delegate for further consultation.
8. Document results and actions taken in patient care file

Consider Wound Swabbing:

1. If order for wound swab has been received from MRP or NP or delegate, obtain lab requisition for swab.
2. Using either acquired swab from MRP or one from own stock, ensure swab is not expired.
3. Wound swabs must be clear of excess pus cells or epithelial cells to be accepted. Follow best practices to obtain an acceptable specimen including cleansing the wound with saline to remove pus and debris PRIOR to collection.
4. Place swab in tube and label with Pt name, DOB, and Health Card number. Add date of collection and site of swab.
5. Swab must be dropped off at lab within 24 hours of collection. Swabs should be maintained at room temperature until dropped off at the lab.

CLINICAL CONSIDERATIONS

If necrotic tissue is found, make all reasonable attempts to contact the Most Responsible Physician or Nurse Practitioner or delegate for direction. If severe or new necrosis is present and the CP is unable to contact the MRP or NP or delegate, the patient should be transported to the ED for assessment.

If clinical judgement indicates Sepsis, the patient will be transported to ED through 911 system.

For the non-septic patient, if no contact can be made with the Most Responsible Physician or Nurse Practitioner or their delegate, ensure a follow-up reassessment of the wound in 48-72 hours.

This guideline is for the initiation of oral antibiotics only. If MRP is requesting IV antibiotics, please contact CPER Outreach before proceeding. IM antibiotics are covered under the Requested Injections guideline.

Please note age change to ≥ 12 years, effective October 01, 2025.

Medical Guideline: Suture removal (Community Paramedics)

A Community Paramedic may provide the treatment prescribed in this Medical Guideline if they are certified and authorized.

INDICATIONS

Sutures or staples in need of removal after simple wound closure in registered Community Paramedic patient.

Sutures or staples in place for a minimum of 14 days **OR**

Request by authorized provider to remove sutures or staples

CONDITIONS

Suture or Staple Removal

AGE: ≥12 years
LOA: Alert
HR: N/A
RR: N/A
SBP: N/A
Other:

CONTRAINDICATIONS

Suture or Staple Removal

Sutures or staples in face, groin, or hands

Surgical sutures or staples

Signs of infection or improper wound healing

TREATMENT

Consider **Suture removal:**

1. Assess the wound for full closure and no signs of infection
2. Moisten/clean the wound area with clean gauze and saline
3. Grab the knot of the suture with the forceps and lift just enough to slide the edge of the scissors underneath.
4. Clip one strand of the suture and pull the stitch across the wound to prevent separation of the edges.
5. Ensure all stitches that were placed have been removed.
6. If indicated, apply steri-strips across the wound to support continued healing

Consider **Staple removal:**

1. Assess the wound for full closure and no signs of infection
2. Moisten/clean the wound area with clean gauze and saline
3. Slide the lower part of a medical staple removal tool under the middle of the staple. Begin at one end of the healed laceration.
4. Squeeze the handles of the staple removal tool until they are closed
5. Lift the staple out of the skin opposing the angle of entry
6. Ensure that all staples that were placed have been removed
7. If indicated, apply steri-strips across the wound to support continued healing

CLINICAL CONSIDERATIONS

This guideline is intended to facilitate removal of sutures or staples in the uncomplicated closure of a laceration. Sutures or staples of surgical closures are not intended to be removed by the Community Paramedic under this guideline.

All wounds should be assessed by the Community Paramedic prior to removal of any sutures or staples under this guideline. In the event that the Community Paramedic assesses and finds signs or symptoms of infection, they will consult with the requesting authority prior to any suture or staple removal. Signs and symptoms may include, but are not limited to:

- Significant redness
- Swelling
- Purulent drainage around wound site
- Significant pain that is out of proportion to reason for sutures or staples
- Fever

Chronic Care

COMMUNITY CARE PARAMEDIC GUIDELINES

Medical Guideline:
CHF Protocol (Community Paramedics)

A Community Paramedic may provide the treatment prescribed in this Medical Guideline if they are certified and authorized.

This Protocol is intended to provide temporizing care for a patient experiencing an exacerbation of diagnosed CHF. This protocol should be used in conjunction with a care plan that has been agreed upon with the patient's family physician or specialist. This protocol may be used for a maximum of three consecutive days.

INDICATIONS

Any patient exhibiting signs or symptoms of a known CHF exacerbation, and exhibiting the following:

- Mild distress, as expressed by the patient
- Acute weight gain of less than 5kg

CONDITIONS

NTG Patch

AGE: ≥18 years
LOA: Unaltered
HR: N/A
RR: N/A
SBP: ≥140mmHg
Other: Mild distress

Furosemide PO

AGE: ≥18 years
LOA: Unaltered
HR: N/A
RR: N/A
SBP: ≥140 mmHg
Other: Mild distress

CONTRAINDICATIONS

Nitroglycerin Patch

Allergy or sensitivity to nitrates

Phosphodiesterase inhibitor use within the previous 48 hours

SBP drops by 1/3 of its initial value after nitroglycerin is administered

Furosemide PO

Allergy to furosemide

Severe liver disease

Anuria or urinary retention

TREATMENT

Consider Nitroglycerin Patch

1. If the patient has a previous history of nitroglycerin use (patch, spray or tablets inclusive) with no adverse effects, increase the prescribed regular dose by 0.2 mg/hr by nitroglycerin patch. (ie. If the patient has a normal prescribed dose of 0.4mg/hr, the total dose after increase would be 0.6mg/hr. This could be achieved by adding a 0.2mg patch to the patient's existing 0.4mg patch)

2. If the patient has no previous history of nitroglycerin use, contact the patient's family physician or most appropriate physician or delegate for consultation. If the contacted individual agrees, proceed with nitroglycerin patch application as described.

3. All patients being administered an increased or new dose of nitroglycerin must be monitored for 30 minutes after initial application of patch.

4. The patient should wear the increased patch dose for 12 hours on / 12 hours off

5. Document treatment and send report to patient's family physician or most appropriate physician or delegate.

Consider Furosemide PO

1. If the patient has a history of previous furosemide use and no history of renal failure, increase patient's furosemide dose by 20mg. If the patient has not experienced relief from symptoms after 2-3 hours, the patient may receive another 20mg furosemide PO to max 40 mg above normal prescribed dose.

2. If the patient has a history of previous furosemide use but does have a history of renal failure, contact the patient's family physician or most appropriate physician or delegate prior to increasing their furosemide dose.

3. If the patient has no previous history of furosemide use and no history of renal failure, contact the patient's family physician or most appropriate physician or delegate for consultation. If the contacted individual agrees, administer 20mg furosemide PO. If the patient has not experienced relief from symptoms after 2-3 hours, the patient may receive another 20mg furosemide PO to max 40mg with ordering physician approval.

4. All patients being administered a new or increased dose of furosemide PO must be monitored for 30 minutes after each dose increase.

5. Document treatment and send report to patient's family physician or most appropriate physician or delegate.

CLINICAL CONSIDERATIONS

Any patient being treated under this protocol MUST be diagnosed with CHF and be a known/registered CP patient

If the patient condition worsens during this protocol, the patient must go to the Emergency Department if the family/treating physician cannot be reached. If the patient does not experience relief of symptoms over the duration of the protocol from use of any combination of listed treatments, the CP should consult with the patient's family physician or delegate.

If the patient has not returned to a comfortable baseline with the combined treatment protocol by the end of the three day period, contact the patient's family physician or most appropriate physician or delegate for further guidance. The patient may need to be transported to ED for more involved assessment and treatment.

Patients being treated under this protocol should have the Community Paramedic reassess symptoms every 12-24 hours for the duration of this protocol.

For any patients receiving NTG under this protocol, the Community Paramedic must monitor patient condition for 30 minutes post administration to ensure maintenance of adequate blood pressure. If the blood pressure drops by ≥1/3, discontinue NTG patch and contact family physician again.

If the Community Paramedic is in contact with the patient's family physician or most appropriate physician or delegate and an order for an alternate dosage of nitroglycerin or furosemide PO is given, the Community Paramedic may follow this order. The Community Paramedic will contact CPER Outreach prior to accepting any order for medication change that is not nitroglycerin or furosemide PO.

Any CP patient who is experiencing a CHF exacerbation will be transported to the appropriate Emergency Department if they are experiencing any of the following:

- Respiratory distress
- Ongoing chest pain
- Any new arrhythmia
- An SpO2 <87% or a new drop of 5% from normal
- An acute weight gain of ≥5kg, unless directed otherwise by family physician or most appropriate physician or delegate
- Acutely symptomatic patient with systolic BP ≥180 mmHg, unless directed otherwise by family physician or most appropriate physician or delegate
- In the judgement of the Community Paramedic, any patient who is deemed unable to safely live at home

Medical Guideline: COPD Protocol (Community Paramedics)

A Community Paramedic may provide the treatment prescribed in this Medical Guideline if they are certified and authorized.

This Protocol is intended to provide temporizing care for a patient experiencing an exacerbation of diagnosed COPD. This protocol should be used in conjunction with a care plan that has been agreed upon with the patient's family physician or specialist. This protocol may be used for a maximum of three consecutive days.

INDICATIONS

Any patient exhibiting signs or symptoms of a known COPD exacerbation, and exhibiting any of the following:

- Increased shortness of breath from normal
- Mild respiratory distress, as stated by patient
- Increased sputum volume
- Increased sputum purulence

CONDITIONS

Oxygen

AGE: ≥18 years
LOA: Unaltered
HR: N/A
RR: ≤24 bpm
SBP: N/A
Other: Patient must have their own supply of home oxygen

Salbutamol

AGE: ≥18 years
LOA: Unaltered
HR: N/A
RR: ≤24 bpm
SBP: N/A
Other:

Inhaled Steroid

AGE: ≥18 years
LOA: Unaltered
HR: N/A
RR: ≤24 bpm
SBP: N/A
Other:

Antibiotic

AGE: ≥18 years
LOA: Unaltered
HR: N/A
RR: ≤24 bpm
SBP: N/A
Other:

Oral Steroid

AGE: ≥18 years
LOA: Unaltered
HR: N/A
RR: ≤24 bpm
SBP: N/A
Other:

CONTRAINDICATIONS

Oxygen

Patient not on home 02

Insufficient supply to maintain increase in flow until more can be obtained

Salbutamol

Allergy or sensitivity to salbutamol

Oral steroids

Relative Contraindication for below conditions – consult with ordering physician

Uncontrolled hypertension

CHF at risk for exacerbation

Uncontrolled hyperglycemia

Antibiotic

Allergy or sensitivity to ordered antibiotic

TREATMENT

Consider Oxygen

1. Confirm that the patient has enough oxygen supply to sustain increased flow rate until more can be obtained
2. Obtain an SpO2 at the patient's standard home O2 flow rate.
3. Increase the patient's standard home O2 flow rate by 1 L/min. Monitor the patient for 15 minutes to determine if the patient's work of breathing and signs of oxygenation improves. If the patient is still showing signs of increased exertion over normal, increase the flow rate by an additional L/min to a maximum of 2 L/min above normal. Monitor the patient for an additional 15 minutes.
4. Document treatment and send report to patient's family physician or most appropriate physician or delegate

Consider Salbutamol

1. Using a salbutamol MDI with a spacer, administer up to 4 doses with 4 breaths in between each dose. The Community Paramedic may repeat this 4 dose regimen one additional time after 5 minutes if there is insufficient relief of symptoms. After the initial dosing of the patient with salbutamol, the patient can take an additional two MDI doses every hour as required for relief of bronchoconstriction, to a maximum of 24 doses in the first 24 hour period.
2. All patients being administered a new or increased dose of salbutamol must be initially monitored for 20 minutes
3. Document treatment and send report to patient's family physician or most appropriate physician or delegate

Consider Inhaled Steroid

1. Contact the patient's family physician or most appropriate physician or delegate with order to proceed.
2. Administer patient's prescribed inhaled steroid as directed by family physician or most appropriate physician or delegate. If salbutamol is being administered concurrently, provide inhaled steroid second.
3. Document treatment and send report to patient's family physician or most appropriate physician or delegate.

Consider Oral Steroid

1. Contact the patient's family physician or most appropriate physician or delegate with order to proceed.
2. Administer dexamethasone PO, or prednisone PO, according to order by physician or delegate. If multiple days have been ordered, ensure patient has enough to complete prescription.
3. Document treatment and send report to patient's family physician or most appropriate physician or delegate.

Consider **Antibiotic:**

1. Confirm order to proceed with antibiotic with patient's family physician or most appropriate physician or delegate
2. **CONFIRM NO KNOWN ALLERGY TO PRESCRIBED ANTIBIOTIC**
3. Explain rationale and potential side effects of using this medication to patient or substitute decision maker. Include instructions that all doses must be taken unless told to stop by Primary Care Physician or most appropriate physician or delegate.
4. Obtain consent to proceed from patient or substitute decision maker
5. Administer antibiotic per order
6. Observe patient for a minimum 15 minutes in case of adverse reaction. If adverse reaction occurs, treat with appropriate BLS/ALS standard and initiate transport to hospital. Advise ordering physician or delegate of reaction and transport decision.
7. Confirm appointment for second visit by CPs within 24 hours for follow-up
8. Document treatment and send report to patient's family physician or most appropriate physician or delegate.

CLINICAL CONSIDERATIONS

Any patient being treated under this protocol MUST be diagnosed with COPD and be a known/registered CP patient

If the patient condition worsens during this protocol, the patient must go to the Emergency Department if the family/treating physician cannot be reached. If the patient does not experience relief of symptoms over the duration of the protocol from use of any combination of listed treatments, the CP should consult with the patient's family physician or delegate.

If the patient has not returned to a comfortable baseline with the combined treatment protocol by the end of the three-day period, contact the patient's family physician or most appropriate physician or delegate for further guidance. The patient may need to be transported to ED for more involved assessment and treatment.

Patients being treated under this protocol should have the Community Paramedic reassess symptoms every 12-24 hours for the duration of this protocol

If the Community Paramedic is in contact with the patient's family physician or most appropriate physician or delegate and an order for an alternate dosage of medications listed within this protocol is given, the Community Paramedic may follow this order. The Community Paramedic will contact CPER Outreach prior to accepting any order for medication change that is not part of this protocol.

Be aware that oral steroids may have an effect on fluid balance and may not be appropriate for patients with hypertension or a CHF diagnosis. Please consult with the ordering physician or delegate about potential side effects prior to giving oral steroids to this patient population.

Any CP patient who is experiencing a COPD exacerbation will be transported to the appropriate Emergency Department if they are experiencing any of the following:

- Significant increase in dyspnea from patient normal
- Moderate-severe respiratory distress (tachypnea, cyanosis, indrawing, accessory muscle use, decreased air entry on auscultation)
- Any signs or symptoms of a serious chest infection/sepsis
- Inability to sleep or eat due to symptoms
- Change in mental status compared to patient normal
- In the judgement of the Community Paramedic, any patient who is deemed unable to safely live at home

Medical Guideline:
Insulin Administration (Community Paramedics)

A Community Paramedic may provide the treatment prescribed in this Medical Guideline if they are certified and authorized.

INDICATIONS

Any registered Community Paramedic patient with request from authorized physician or delegate, AND

No other care partner can administer under an appropriate timeline

CONDITIONS

INSULIN SC

AGE: ≥18 years

LOA: Unaltered

HR: N/A

RR: N/A

SBP: N/A

Other: CBG ≥8.0 mmol/L

CONTRAINDICATIONS

INSULIN SC

Allergy to insulin (rare)

Hypoglycemia

Pregnancy – Pregnant patients should be receiving care related to diabetes outside of the CP environment

TREATMENT

Consider **Short-Acting** (Bolus) Insulin administration

1. Obtain order from Pt's physician or delegate. Confirm short-acting insulin and dosage required.
2. Obtain capillary blood glucose prior to administering ANY insulin.
3. Using best practice guidelines, administer correct dosage of insulin via SC route.
4. Short acting (Bolus) insulin must be administered in conjunction with consumption of food. Community Paramedics must ensure that the patient has recently eaten a meal before administration of short-acting insulin.
5. Monitor patient for 15 minutes after insulin administration. Complete post-medication CBG.
6. Document administration of medication via routine practice with communication to ordering physician or delegate.

Consider **Long-Acting** (Basal) Insulin administration

1. Obtain order from Pt's physician or delegate. Confirm long-acting insulin and dosage required.
2. Obtain capillary blood glucose prior to administering ANY insulin.
3. Using best practice guidelines, administer correct dosage of insulin via SC route.
4. Monitor patient for 15 minutes after insulin administration. Complete post-medication CBG.
5. Document administration of medication via routine practice with communication to ordering physician or delegate.

CLINICAL CONSIDERATIONS

Several factors may influence the absorption of insulin, including site, temperature, dose, or movement of injection area. Insulin is most consistently absorbed in the abdomen. The buttocks provide the slowest absorption rate, if that is the preferred outcome. Insulin should only be administered in clear unbroken skin.

Insulin administration should only be undertaken by the Community Paramedic as part of a documented care plan overseen by physician or authorized medical provider. Community Paramedics may assist patients to administer their own insulin as it is prescribed and ordered.

Insulin is only to be administered subcutaneously. IM injection of insulin results in faster absorption of the medication and a potential sharp drop in blood glucose levels. Rubbing of the injection site after injection should be avoided as it may also increase absorption rates. Insulin pens are the only authorized method of administration of insulin, as they are more accurate and are less likely to administer IM doses accidentally.

Blood glucose levels may be higher than normal due to stress or illness. If a patient is demonstrating blood sugar levels higher than their normal, the CP should consider underlying issues and communicate appropriately with the prescribing physician. If a patient is demonstrating significantly elevated blood glucose levels (more than 20.0mmol/L) with symptoms associated, transport to the ED may be warranted. The CP will contact the authorized prescriber of insulin for the patient to discuss potential elevation of care.

If a patient receiving insulin experiences a hypoglycemic event post-administration, the Community Paramedic will perform care according to their ACP/PCP scope. Patients experiencing a hypoglycemic event as a direct result of CP-administered insulin will be transported to ED for monitoring and an Adverse Events form will be completed.

All patients receiving either short- or long-acting insulin must have adequate food available to them in case their blood glucose levels drop after the Community Paramedics leave. If the patient does not have food available or does not have the capacity to feed themselves, a responsible adult must be available to assist the patient. The patient or caregiver must be able to recognize the symptoms of hypoglycemia and check their blood sugar levels if home alone.

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Respiratory Illness Support

COMMUNITY CARE PARAMEDIC GUIDELINES

Influenza Vaccination Medical Directive

2025 – 2026 Flu Season

A Community Paramedic may provide the treatment prescribed in this Medical Directive if they are certified and authorized following completion of the influenza education program approved by the Centre for Paramedic Education & Research. This directive shall apply from September 01, 2025, to April 30, 2026.

INDICATIONS

Persons seeking the influenza vaccine at identified/scheduled locations.

CONDITIONS

Trivalent Inactivated Influenza Vaccine (TIV)

- **Fluviral**
- **Fluzone**
- **Flucelvax**

AGE: ≥12 years
LOA: N/A
HR: N/A
RR: N/A
SBP: N/A
Other: Informed consent obtained

High-Dose Trivalent Inactivated Influenza Vaccine (TIV-HD)

- **Fluzone High-Dose Trivalent**
- **Fluad**

AGE: ≥65 years
LOA: N/A
HR: N/A
RR: N/A
SBP: N/A
Other: Informed consent obtained

CONTRAINDICATIONS

Fluzone Trivalent (TIV) AND Fluzone (TIV) AND Flucelvax (TIV) AND Fluzone HighDose Trivalent (TIV-HD) AND FluAD (TIV-adj)

The following persons should NOT undergo influenza vaccination under this Medical Directive, but should be referred to Public Health or their primary physician for further discussion:

1. Pregnant (unless trained in consent requirements for this population)
2. Fever or current serious acute illness. Note that those with mild illness (such as a mild upperrespiratory tract infection) may be vaccinated with PPE precautions.
3. People who have had an anaphylactic or allergic reaction to any previous vaccine.
4. Severe hypersensitivity or allergy to any component of the vaccine being used. Note: common allergens like Thimerosal, Formaldehyde, Triton X-100, egg protein. Polysorbate 80 vary between vaccine types. NACI advises that egg allergy is NOT a contraindication and any of these vaccines can be safely used.
5. People with a history of Guillain-Barré Syndrome that developed within 6 weeks of a past vaccine.
6. People who have had severe Ocular-Respiratory Syndrome (ORS) after a past influenza vaccine that required them to be in the hospital (see Clinical Considerations)

TREATMENT

The paramedic will have all equipment, supplies and medications available to manage anaphylactic reactions in the clinic prior to proceeding with vaccination. Refer to the CPER Outreach Moderate to Severe Allergic Reaction Medical Directive if applicable.

1. Confirm that person has been screened for COVID-19 symptoms or exposure and follow appropriate infection control and PPE practices.
2. Confirm that person has been provided with the influenza vaccine information sheet (2025-2026 season) and questions have been answered.
3. Complete the Seasonal Flu Screening Questions (2025-2026 Season) and review the contraindications above to ensure the patient is eligible.
4. Five influenza vaccines are available, and this must be discussed if relevant: Fluad (TIV-adj) or Fluzone High Dose (TIV HD) is preferred for persons ≥ 65 years old as it provides a higher immune response, but any of the TIV can be administered if the patient prefers or access is limited. For patients under 65 years old any of the other available TIV are appropriate.

7. Following the method suggested by the Canadian Immunization Guide administer the vaccine using a 1-3 mL syringe and a needle of the recommended size for the person as follows. If only one size of needle isavailable adjust your technique to ensure IM administration avoiding SQ injections or contact with the humerus. Please note that all flu vaccines are in a 0.5mL dose for 2025-2026.

Vaccine	Age	Dose	Route	Site	Max. # of doses
Fluzone Fluviral Flucelvax	≥ 12 years	0.5 mL	IM	Deltoid	1
Fluzone HD	≥ 65 years	0.5 mL	IM	Deltoid	1
Fluad	≥ 65 years	0.5 mL	IM	Deltoid	1

Needle size as recommended by the Canadian Immunization Guide:

Weight	**Needle size (22-25 gauge)**
Any person < 60 kg	1.6-2.5 cm (5/8 inch-1 inch)
Males 60-118 kg and Females 60-90 kg	2.5 cm (1 inch)
Males >118 kg and Females > 90 kg	3.8 cm (1½ inch)

8. Use the designated documentation tool to chart administration of the medication and provide the person with documentation of vaccination.
9. Refer the person to the aftercare instructions.
10. The person should be monitored for 15 minutes for evidence of anaphylactic or allergic reaction and should be advised to report any adverse effects.
11. If allergic reaction occurs, proceed to the CPER Moderate to Severe Allergic Reaction Medical Directive for management and arrange for ambulance transport to local Emergency Department for continued monitoring and/or management.
12. Report any adverse events using the designated adverse event following immunization (AEFI) reporting form (in addition to documenting assessment and management on an ePCR).

CLINICAL CONSIDERATIONS

- All usual protocols for an immunization will be followed including but not limited to infection control, appropriate equipment, safety, documentation, monitoring for any adverse reaction and reporting back to the most responsible physician (MRP).

- If the person has additional questions or possible contraindications that cannot easily be answered, contact Public Health to assist if available or refer the patient to Public Health or their primary physician.
- If this expert advice has occurred and the patient verbally attests and requests immunization, it is reasonable to proceed.
- Patients 12 and over, who are without developmental disabilities, can generally be considered capable of consenting to vaccinations. Support of parents can be very helpful and should be welcomed but is not strictly required. Unaccompanied minorscan be assessed for capacity to make the decision and vaccination offered. Not withstanding this statement, local protocols may introduce limits (i.e. require parental consent) and paramedics should follow local clinic protocols.
- Active resistance and refusal by a patient capable of providing consent must be considered a lack of their consent. Gentle persuasion, managing anxiety / needle phobiaand open discussion must not extend to forced vaccination regardless of the wishes of an accompanying SDM. Paramedic judgement will be critical to determining what an appropriate level of support is, and be comfortable that every patient has consented for vaccination.
- The stoppers/diaphragms used for the vaccines do not contain latex; therefore, latex allergy is not a contraindication to receiving the vaccine.
- Anti-platelet medications such as ASA or Clopidogrel (Plavix) and anticoagulant medications (such warfarin (Coumadin) and others) are not contraindicated, but a 23 gauge or smaller needle should be used and following vaccination, firm pressure should be applied without rubbing to the injection site for 5-10 minutes.
- Oculo- Respiratory Syndrome includes bronchospasm, respiratory distress, and/or facial swelling.
- Administration of COVID mRNA vaccine during the same visit as these influenza vaccines is reasonable. They MUST be given in different syringes, and it is recommended they be given in opposite deltoids.

Pediatric Influenza Vaccination Medical Directive
2025 – 2026 Flu Season

A Community Paramedic may provide the treatment prescribed in this Medical Directive if they are certified and authorized following completion of the influenza education program approved by the Centre for Paramedic Education & Research. This directive shall apply from October 01, 2025, to April 30, 2026.

INDICATIONS

Persons seeking the influenza vaccine at identified/scheduled locations.

CONDITIONS

Standard-dose inactivated influenza vaccine (TIV)

- **Fluviral**
- **Fluzone**
- **Flucelvax**

AGE: ≥ 6 months to <12 years

LOA: N/A

HR: N/A

RR: N/A

SBP: N/A

Other: Informed consent obtained from parent, guardian, or Substitute Decision Maker (SDM)

CONTRAINDICATIONS

Fluviral (TIV) AND Fluzone (TIV) AND Flucelvax (TIV)

The following persons should NOT undergo influenza vaccination under this Medical Directive, but instead should be referred to Public Health or their primary physician for further discussion:

1. Any individual ≥6 months to <12 years who has not previously received an influenza vaccine, or any individual in that age range who previously had an adverse reaction to an influenza vaccine
2. Pregnant
3. Fever or current serious acute illness. Note that those with mild illness (such as a mild upperrespiratory tract infection) may be vaccinated with PPE precautions.
4. People who have had an anaphylactic or allergic reaction to any previous vaccine.
5. Severe hypersensitivity or allergy to any component of the vaccine being used. Note: common allergens like Thimerosal, Formaldehyde, Triton X-100, egg protein. Polysorbate 80 vary betweenvaccine types. NACI advises that egg allergy is NOT a contraindication and any of these vaccines can be safely used.
6. People with a history of Guillain-Barré Syndrome that developed within 6 weeks of a past vaccine.
7. People who have had severe Ocular-Respiratory Syndrome (ORS) after a past influenza vaccine that required them to be in the hospital (see Clinical Considerations)

TREATMENT

The paramedic will have all equipment, supplies and medications available to manage anaphylactic reactions in the clinic prior to proceeding with vaccination.Refer to the CPER Outreach Moderate to Severe Allergic Reaction Medical Directive if applicable.

1. Confirm that person has been screened for COVID-19 symptoms or exposure and follow appropriate infection control and PPE practices.
2. Confirm that the parent, guardian, or SDM of the person to be vaccinated has been provided with the influenza vaccine information sheet (2025-2026 season) and questions have been answered.
3. Complete the Seasonal Flu Screening Questions (2025-2026 Season) and review the contraindications above to ensure the patient is eligible.
4. Three pediatric influenza vaccines are available. Fluviral, Fluzone, and Flucelvax are equally appropriate for administration age ≥6 months to <12 years.
5. Obtain informed consent from parent, guardian, or SDM and document on the Consent for Seasonal Flu Shot(2025-2026 Season).
6. Confirm the correct vaccine, lot, expiry date, check to ensure clarity, colour and absence of precipitate. Review "5R"s of medication administration.

7. Following the method suggested by the Canadian Immunization Guide administer the vaccine using a 1mL syringe and a needle of the recommended size for the person as follows. If only one size of needle is available adjust your technique to ensure IM administration avoiding SQ injections or contact with the humerus.

Vaccine	Age	Dose	Route	Site	Max. # of doses
Fluviral Fluzone Flucelvax	≥ 6 months to <12 years	0.5 mL	IM	Deltoid	1

Needle size as recommended by the Canadian Immunization Guide:

Weight	**Needle size (22-25 gauge)**
Any person < 60 kg	1.6-2.5 cm (5/8 inch-1 inch)
Males 60-118 kg and Females 60-90 kg	2.5 cm (1 inch)
Males >118 kg and Females > 90 kg	3.8 cm (1½ inch)

8. Use the designated documentation tool to chart administration of the medication and provide the parent, guardian, or SDM of the person being vaccinated with documentation of vaccination.
9. Refer the parent, guardian, or SDM of the person being vaccinated to the aftercare instructions.
10. The person should be monitored for 15 minutes for evidence of anaphylacticor allergic reaction and should be advised to report any adverse effects. Report any adverse events using the designated adverse event following immunization (AEFI) reporting form (in addition to documenting assessment and management on an ePCR). Refer to local UIIP guidelines for observation periods.
11. If allergic reaction occurs, proceed to the CPER Moderate to Severe Allergic Reaction Medical Directive for management and arrange for ambulance transport to local Emergency Department for continued monitoring and/or management.

CLINICAL CONSIDERATIONS

- All usual protocols for an immunization will be followed including but not limited to infection control, appropriate equipment, safety, documentation, monitoring for any adverse reaction and reporting back to the most responsible physician (MRP).

- Any patient ≥6 months to <12 years with medical complications should speak to their family physician or specialist prior to receiving the influenza vaccine. In the event that the Community Paramedic is unsure whether the influenza vaccine is appropriate for a patient they may be referred back to their primary care physician.
- If the patient's parent, guardian, or SDM has additional questions or possible contraindications that cannot easily be answered, contact Public Health to assist if available or refer the patient to Public Health or their primary physician.
- If this expert advice has occurred and the pediatric patient's parent, guardian, or SDM verbally attests and requests immunization, it is reasonable to proceed.
- Assessing consent in a pediatric population requires special expertise. Paramedics must use their judgement about the use of gentle persuasion, managing anxiety or needle phobia with open discussion. Paramedics must also ensure that adults accompanying children are the appropriate SDM to provide consent.
- The stoppers/diaphragms used for the vaccines do not contain latex; therefore, latex allergy is not a contraindication to receiving the vaccine.
- Oculo- Respiratory Syndrome includes bronchospasm, respiratory distress, and/or facial swelling.
- Administration of COVID-19 mRNA vaccine during the same visit as these influenza vaccines is reasonable for pediatric patients ≥6 months. They MUST be given in different syringes, and it is recommended they be given in opposite deltoids.
- Health Canada has stated that any child ≥6 months may receive any other vaccine simultaneously with the COVID-19 vaccine.

COVID-19 Vaccination Medical Directive

An Advanced Care Paramedic or Primary Care Paramedic may provide the treatment prescribed in this Medical Directive if they are certified and authorized. This directive shall apply from October 01, 2025, to April 30, 2026.

INDICATIONS

Meets the criteria for receiving a COVID-19 vaccine as designated by the Ontario Ministry of Health and/or Local Medical Officer of Health. This Directive is to be used in conjunction with local public health agreements in place for specific target populations.

CONDITIONS

Pfizer BioNTech Comirnaty 2025-2026

AGE: ≥12 years
LOA: N/A
HR: N/A
RR: N/A
SBP: N/A
Other:

Moderna Spikevax 2025-2026

AGE: ≥12 years
LOA: N/A
HR: N/A
RR: N/A
SBP: N/A
Other:

CONTRAINDICATIONS

COVID-19 mRNA Vaccines

The following patients should NOT undergo vaccination under this medical directive.

1. Patient or SDM does not provide consent
2. Fever or current acute illness
3. Confirmed or suspected active COVID-19 infection
    a. Prolonged symptoms (or 'Long-COVID') is not a contraindication
4. Individuals who have a suspected anaphylactic reaction to (see MOH Decision Making Guide")
    - a previous dose of an mRNA COVID-19 vaccine
    - any components of the mRNA COVID-19 vaccine (including polyethylene glycol [PEG]) or polysorbate 80)

See Clinical Considerations for Special Populations:

Autoimmune disease, immunocompromised or receiving immunosuppressant therapy
Pregnant or breastfeeding
Myocarditis and/or pericarditis following vaccination

TREATMENT

1. mRNA vaccines require specific handling and strict cold chain practices. Cold chain requirements are PRODUCT SPECIFIC and are different for Pfizer BioNTech and Moderna. The mRNA vaccines are NOT like influenza vaccines. All paramedic programs will have cold chain supports from Public Health as detailed on the product monograph. Special training is required to handle, thaw and reconstitute vaccines.
2. Paramedics must not use vaccine for which the cold chain compliance is uncertain or has been breached.
3. Confirm that patient has been provided with vaccine information specific to either Pfizer-BioNTech mRNA vaccine or Moderna mRNA vaccine, and questions have been answered.
4. Confirm patient has indicated verbal consent following the MOH approved questions on COVAX system (or on the MOH COVID-19 Vaccine Consent Form).equivalent
5. Verbal Attestation for special populations can be done in written form or verbally. (see Clinical Considerations).
6. Confirm the correct vaccine, lot, expiry date
7. Visually inspect the vaccine to confirm it is free of particulates and is not discoloured.
8. Review "5R"s of medication administration.

9. Use the designated documentation tool to chart administration of the vaccination and provide the patient with documentation of vaccination.
10. Aftercare is to be provided as directed by local agreement which includes 15 mins of monitoring for evidence of allergic reaction or adverse effects.
11. If allergic reaction occurs and the paramedic is the designated responder or is asked to intervene, proceed to the CPER Moderate to Severe Allergic Reaction Medical Directive for management and arrange for ambulance transport to the local Emergency Department. Other staff (i.e. local RN or MD) may be designated as the primary responder and may follow other guidelines. The primary responder may be assisted by the Paramedics within their scope of practice.
12. Report, or ensure a report is done, on any adverse events using the designated Adverse Event Following Immunization (AEFI) reporting form (in addition to documenting assessment and management on an ePCR as required).

PRIMARY VACCINATION SERIES

Vaccine	Age	Dose	Route	Site	Frequency
Pfizer-BioNtech **Comirnaty 2025-2026**	≥ 12 years	30 µg	IM	Deltoid	1dose, or with second dose as determined by Public Health
Moderna **Spikevax 2025-2026**	≥ 12 years	50 µg	IM	Deltoid	1 dose, or with second dose as determined by Public Health

BOOSTER SERIES

Vaccine	Age	Dose	Route	Site	Frequency
Pfizer-BioNtech **Comirnaty 2025-2026**	≥ 12 years	30 µg	IM	Deltoid	≥ 3 months after primary series or last booster dose, or as directed by Public Health
Moderna **Spikevax 2025-2026**	≥ 12 years	50 µg	IM	Deltoid	≥ 3 months after primary series or last booster dose, or as directed by Public Health

CLINICAL CONSIDERATIONS

- If the patient has additional questions that cannot be answered, contact local clinical staff or your local public health unit.
- NACI recommends that COVID-19 vaccines may be given at the same time as, or any time before or after, other vaccines, including live, non-live, adjuvanted or unadjuvanted vaccines. (Do not mix the COVID-19 vaccines with other vaccines/products in the same syringe).
- Patients 12 and over, who are not developmentally challenged, can generally be considered capable of consenting to vaccinations. Support of parents can be very helpful and should be welcomed but is not strictly required. Unaccompanied minors can be assessed for capacity to make the decision and vaccination offered. Notwithstanding this statement, local protocols may introduce limits (i.e. require parental consent) and paramedics should follow local clinic protocols.
- Active resistance and refusal by a patient capable of providing consent must be considered a lack of their consent. Gentle persuasion, managing anxiety / needle phobia and open discussion must not extend to forced vaccination regardless of the wishes of an accompanying SDM. Paramedic judgement will be critical to determining what is an appropriate level of support and be comfortable that every patient has consented for vaccination.
- Patients who are or may be PREGNANT or IMMUNOSUPPRESSED must (a) attest verbally or in writing that they have been counselled by their treating health care provider regarding the risks and benefits of receiving the vaccine, or (b) have documentation from their physician indicating that they are fit for immunization. For details on immunosuppression please see MOH reference material.
- Until further information is available, further doses of mRNA COVID-19 vaccines should be deferred among individuals who have experienced myocarditis and/or pericarditis within 6 weeks following a previous dose of an mRNA COVID-19 vaccine. This includes any person who had an abnormal cardiac investigation including ECG, elevated troponins, echocardiogram or cardiac MRRI after a dose of mRNA vaccine.
- Booster doses of the COVID-19 vaccines will be offered as determined by the Ministry of Health and local Public Health Officers. Current recommendations are that all persons receive a COVID-19 booster dose when eligible unless otherwise contraindicated. This directive allows for booster doses to be given to the eligible populations and at the intervals outlined by local public health units. Either Moderna or Pfizer mRNA vaccines may be given to patients regardless of which COVID-19 vaccine was used in the primary series.

- Well controlled bleeding disorders, anticoagulant medications or anti-platelet medications are not contraindications. A 23 gauge or smaller needle should be used and following vaccination, firm pressure should be applied without rubbing the injection site for 5-10 minutes.
- The syringes and needle sizes as supplied by your Public Health Unit may vary. Be aware of Canadian Immunization Guide below as you may need to adjust your administration technique or consider a different needle size to ensure accurate IM placement.

Needle size as recommended by the Canadian Immunization Guide:

Weight	Needle size (22-25 gauge)
Any person < 60 kg	1.6-2.5 cm (5/8 inch-1 inch)
Males 60-118 kg and Females 60-90 kg	2.5 cm (1 inch)
Males >118 kg and Females > 90 kg	3.8 cm (1½ inch)

RSV Vaccination Medical Directive

An Advanced Care Paramedic or Primary Care Paramedic may provide the treatment prescribed in this Medical Directive if they are certified and authorized. This directive shall apply from October 01, 2025, to April 30, 2026.

INDICATIONS

Meets the criteria for receiving an RSV vaccine as designated by the Ontario Ministry of Health and/or Local Medical Officer of Health. This Directive is to be used in conjunction with local public health agreements in place for specific target populations.

CONDITIONS

RSVPreF3 or RSVPreF

AGE: ≥60 years
LOA: N/A
HR: N/A
RR: N/A
SBP: N/A
Other:

CONTRAINDICATIONS

RSV Vaccines

The following patients should NOT undergo RSV vaccination under this medical directive.

1. Patient or SDM does not provide consent
2. Patients currently experiencing moderate to severe acute illness, with or without a fever, should defer administration of the RSV vaccine until symptoms are resolved.
3. Known sensitivity or history of a severe (anaphylaxis) reaction to any of the components of the RSV vaccine.

TREATMENT

1. All paramedic programs will have cold chain supports from Public Health as detailed on the product monograph. Special training is required to handle, thaw and reconstitute vaccines.
2. Paramedics must not use vaccine for which the cold chain compliance is uncertain or has been breached.
3. Confirm consent to receive vaccine has been obtained by patient or SDM.
4. Confirm the correct vaccine, lot, expiry date
5. Visually inspect the vaccine to confirm it is free of particulates and is not discoloured.
6. Review "5R"s of medication administration.
7. Use the designated documentation tool to chart administration of the vaccination and provide the patient with documentation of vaccination.
8. Aftercare is to be provided as directed by local agreement which includes 15 mins of monitoring for evidence of allergic reaction or adverse effects.
9. If allergic reaction occurs and the paramedic is the designated responder or is asked to intervene, proceed to the CPER Moderate to Severe Allergic Reaction Medical Directive for management and arrange for ambulance transport to the local Emergency Department. Other staff (i.e. local RN or MD) may be designated as the primary responder and may follow other guidelines. The primary responder may be assisted by the Paramedics within their scope of practice.
10. Report, or ensure a report is done, on any adverse events using the designated Adverse Event Following Immunization (AEFI) reporting form (in addition to documenting assessment and management on an ePCR as required).

Vaccine	Age	Dose	Route	Site	Frequency
RSVPreF3 (Arexvy) or RSVpreF (Abrysvo)	≥ 60 years	0.5 mL reconstituted (120 µg)	IM	Deltoid	1dose before or during RSV season

CLINICAL CONSIDERATIONS

- If the patient has additional questions that cannot be answered, contact local clinical staff or your local public health unit.
- NACI recommends that RSV vaccines may be given at the same time as, or any time before or after, other seasonal vaccines, including live, non-live, adjuvanted or unadjuvanted vaccines. (Do not mix the RSV vaccines with other vaccines/products in the same syringe). It is recommended that the RSV vaccine be administered at least 6 weeks before or after any other non-seasonal vaccine (ie. Shingles). This recommendation is meant to help isolate which vaccine is responsible in the event of an adverse reaction.
- Active resistance and refusal by a patient capable of providing consent must be considered a lack of their consent. Gentle persuasion, managing anxiety / needle phobia and open discussion must not extend to forced vaccination regardless of the wishes of an accompanying SDM. Paramedic judgement will be critical to determining what is an appropriate level of support and be comfortable that every patient has consented for vaccination.
- Well controlled bleeding disorders, anticoagulant medications or anti-platelet medications are not contraindications. A 23 gauge or smaller needle should be used and following vaccination, firm pressure should be applied without rubbing the injection site for 5-10 minutes.

- The syringes and needle sizes as supplied by your Public Health Unit may vary. Be aware of Canadian Immunization Guide below as you may need to adjust your administration technique or consider a different needle size to ensure accurate IM placement.

Needle size as recommended by the Canadian Immunization Guide:

Weight	Needle size (22-25 gauge)
Any person < 60 kg	1.6-2.5 cm (5/8 inch-1 inch)
Males 60-118 kg and Females 60-90 kg	2.5 cm (1 inch)
Males >118 kg and Females > 90 kg	3.8 cm (1½ inch)

Medical Directive: Measles Assessment (Swabbing) – Community Paramedics

An Advanced Care Paramedic or Primary Care Paramedic may provide the treatment prescribed in this Medical Directive if they are certified and authorized.

INDICATIONS

Persons must meet the following inclusion criteria for testing:

- Meets the provincial criteria for measles testing (refer to current criteria as this may change frequently)
  AND
- Referred by local Public Health (or another approved local community program) to the Paramedic Service for testing in a community setting

CONDITIONS

Nasopharyngeal or Throat Swab

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

Other: Patient is identified by Public Health (or another approved local community program) as meeting measles testing criteria

CONTRAINDICATIONS

Nasopharyngeal or Throat Swab

Person or SDM (substitute decision maker) does not provide consent

Current epistaxis or recent significant facial trauma

TREATMENT

Consider obtaining **nasopharyngeal or throat swab**.

The paramedic shall obtain verbal consent from the person / SDM.

Complete the lab requisition and transport specimen as arranged locally with Public Health or primary care provider.

Refer person to education on self-isolation and symptom management.

CLINICAL CONSIDERATIONS

If there are any acute medical concerns raised by the person being tested, or any concerns based upon a visual assessment that cannot be addressed by registered/medical staff on site (if available), then a community paramedic assessment should be conducted and the patient condition should guide management and disposition.

Swabbing should occur within 7 days of onset of measles rash. All completed swabs will be kept cool (2-8°C) and transported to lab for testing ASAP. All swabs for measles must be labelled with patient name, Health Card Number, and date of birth.

Measles Vaccination Medical Directive

An Advanced Care Paramedic or Primary Care Paramedic may provide the treatment prescribed in this Medical Directive if they are certified and authorized.

INDICATIONS

Meets the criteria for receiving a measles vaccine as designated by the Ontario Ministry of Health and/or Local Medical Officer of Health. This directive is to be used in conjunction with local public health agreements in place for specific target populations. This directive is intended to be used to mitigate measles outbreaks and not to replace routine childhood vaccination.

CONDITIONS

MMR-II (Merck) or Priorix (GSK)

AGE: ≥6 months
LOA: N/A
HR: N/A
RR: N/A
SBP: N/A
Other:

TREATMENT

Consider obtaining **nasopharyngeal or throat swab**.

The paramedic shall obtain verbal consent from the person / SDM.

Complete the lab requisition and transport specimen as arranged locally with Public Health or primary care provider.

Refer person to education on self-isolation and symptom management.

CLINICAL CONSIDERATIONS

If there are any acute medical concerns raised by the person being tested, or any concerns based upon a visual assessment that cannot be addressed by registered/medical staff on site (if available), then a community paramedic assessment should be conducted and the patient condition should guide management and disposition.

Medical Guideline:
Remdesivir for Covid-19 (Community Paramedics)

A Community Paramedic (Autonomous IV) may provide the treatment prescribed in this Medical Guideline if they are certified and authorized.

In cooperation with an authorized prescribing authority, the Community Paramedic may administer Remdesivir for a patient with a confirmed COVID-19 infection

INDICATIONS

Any patient who is at high risk for hospitalization or death due to COVID-19 (see clinical considerations)

A COVID-19 diagnosis is required prior to initiating antiviral therapy

Therapy with Remdesivir must be initiated within 7 days of symptom onset

Patients must be able to receive three days of consecutive IV therapy

CONDITIONS

Remdesivir IV

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

Other: Able to initiate IV access

CONTRAINDICATIONS

Remdesivir IV

Known hypersensitivity to Remdesivir

Pregnant or breastfeeding

Current use of chloroquine or hydroxychloroquine

TREATMENT

Consider IV initiation

Consider Remdesivir

1. If a registered Community Paramedic patient is being assessed and has had symptoms of COVID-19 for no more than 7 days, and a positive PCR or rapid antigen test for COVID-19 has been acquired, the Community Paramedic may contact the patient's family physician or responsible prescribing delegate.
2. If an order for Remdesivir (Veklury) is obtained for either an assessed CP patient or if a faxed/emailed order has come to the CP administration office, the Community Paramedic may proceed with this guideline for administration.
3. The Community Paramedic will obtain a baseline set of vitals prior to administration of the medication.
4. The Community Paramedic will ensure a patent IV line is in place prior to reconstituting the medication.
5. During the infusion of the medication, the Community Paramedic will monitor for any adverse effects. If adverse effects occur, the medication will be discontinued and the Community Paramedic MUST contact the ordering authority. The Community Paramedic will treat any allergic reactions or anaphylaxis that may occur according to their scope. Any adverse effects will be documented on the appropriate Adverse Events form
6. A Community Paramedic will return to administer all three daily infusions unless otherwise directed by the prescribing authority, CP Service leadership, or CPER Outreach.
7. Remdesivir should be administered as 200mg over 60 minutes on day 1, and 100 mg over 30 minutes on days 2 and 3.

CLINICAL CONSIDERATIONS

Patients who are considered "High Risk for severe outcomes from COVID-19" may include the following:

1. Adults ≥60 years, regardless of vaccination status, with no other risk factors
2. Adults who are immunocompromised, regardless of age, vaccination status, or prior infections
3. Adults with inadequate immunity
4. Adults with one or more underlying conditions that puts them at higher risk of severe COVID-19 outcomes

Any patient showing signs of severe distress associated with their COVID-19 infection should be considered for transport to ED.

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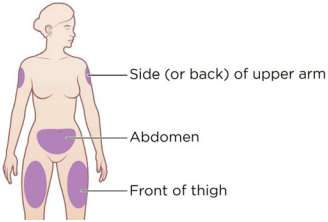
Medical References

COMMUNITY CARE PARAMEDIC GUIDELINES

Subcutaneous Injection

- A subcutaneous (SC) injection is a parenteral medication administration route commonly used by paramedics. It involves injecting a pharmacological agent into the subcutaneous layer between the skin and muscle tissue. Medication absorbed this way is slow compared to intramuscular or intravenous. SC medication is always infused in small volumes. (max. 2mL/site)
- Identify patient that meets criteria for a subcutaneous medication administration (under Requested Injections guideline).
- Ensure all the "rights" of medication administration have been met.
- Confirm medication and dose with paramedic partner if available.
- Follow safe process for responsible medication administration.
- Landmark the intended injection site. Generally the upper arm is easily accessible and an appropriate site for SC injections; however other sites may be appropriate and can be landmarked as per the diagram below.
- Select the appropriate size and gauge needle.
- Cleanse the needle insertion site using aseptic technique.
- Prepare the appropriate medication and dose into the syringe and needle ensuring all air bubbles are removed prior to injection.
- Pinch the skin at the area of injection and insert the needle at a 45º angle. Withdraw the plunger slightly to ensure there is no blood.
- Inject the correct dose of medication.
- Remove the needle and immediately dispose of it in the biohazard container.
- Apply gentle pressure to the site with a dry gauze. Do not rub or massage. Apply a band-aid if needed.



Intramuscular Injection

- An intramuscular (IM) injection is a parenteral medication administration route commonly used by paramedics. It involves injecting a pharmacological agent directly into muscle tissue. Muscle tissue is very vascular, and as a result IM injections tend to have a faster onset of action than subcutaneous administrations.
- Identify patient that meets criteria for an intramuscular medication administration (refer to the Medical Directives or BHP order).
- Ensure all the “rights” of medication administration have been met
- Confirm medication and dose with paramedic partner if available.
- Follow safe process for responsible medication administration.
- Landmark the intended injection site. Generally the deltoid and the vastus lateralis are easily accessible and appropriate sites for IM injections; however other sites may be appropriate and can be landmarked as per the diagram on the following page.
- Select the appropriate size and gauge needle.
- Cleanse the needle insertion site using aseptic technique.
- Prepare the appropriate medication and dose into the syringe and needle ensuring all air bubbles are removed prior to injection.
- Stretch the skin taut and use the “Z-track” technique to displace the skin and soft tissue. Insert the needle with syringe/medication at a 90 degree angle using a “dart style” motion. The Z-track method reduces the chance the medication will leak from the muscle into the subcutaneous tissue.
- Inject the correct dose of medication.
- Remove the needle and immediately dispose of it in the biohazard container.
- Apply gentle pressure to the site with a dry gauze. Do not rub or massage. Apply a band-aid if needed.

Intramuscular Injection Sites

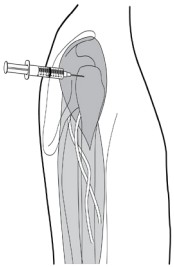


Figure 1 - Deltoid

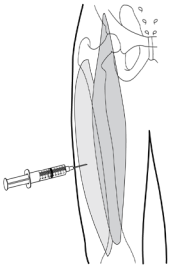


Figure 2 - Lateral Thigh

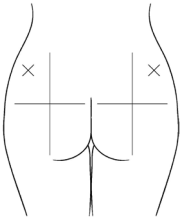


Figure 3 – Buttock

Formulas

NOTE: The formulas below are for reference purposes only. Paramedics must refer to the Medical Guidelines and/or Most Appropriate Physician or prescribing delegate orders for appropriate treatment options.

IV FLOW RATE CALCULATION:

$$\textbf{gtt/min} = \frac{\text{Amount (ml) to be infused} \times \text{Drops per ml (gtt/ml) of administration set}}{\text{Total time of infusion (min)}}$$

MEDICATION INFUSION RATE:

$$\textbf{ml/hr} = \frac{\text{Desired dose (mg/min)} \times 60 \text{ min/ hr}}{\text{Drug concentration (mg/ml)}}$$

Note: Units must be consistent throughout the calculation. For example, the desired dose can be in mcg/ min, as long as the concentration is also converted into mcg/ml.

OXYGEN TANK DURATION:

$$\textbf{Duration of flow (minutes)} = \frac{\text{Gauge pressure} - \text{Safe residual pressure}}{\text{Flow rate (L/min)}} \times \text{Cylinder factor}$$

Cylinder Factor: D-tank = 0.16; M-tank = 1.56

Remdesivir Infusion Guide

How to Reconstitute Remdesivir

1. Confirm expiry dates, and that the Remdesivir vial is intact.
2. Using aseptic technique, draw up 19mL of sterile water and inject into Remdesivir vial. Swirl and invert vial for 30 seconds. DO NOT SHAKE.
3. Confirm all particulates have dissolved. If solids are still seen in solution, swirl until completetely dissolved. Allow the solution to settle for 2-3 minutes prior to withdrawal for dilution.
4. Using a clean syringe, withdraw the contents of the vial. There should be sufficient solution to withdraw 20mL of suspended Remdesivir. Do not draw up more than 20 mL. There may be some residual solution at the bottom of the vial.
5. Withdraw 20 mL of 0.9% NS from IV infusion bag, then inject Remdesivir solution back into infusion bag to replace total volume. Invert the bag 20 times to ensure a uniform mixture.
6. Label the infusion bag with medication name, date, and time infusion initiated.
7. Administer Remdesivir solution according to chart below for appropriate IV infusion time.

Standard dosing for Remdesivir for COVID-19

Remdesivir will typically be prescribed for the treatment of COVID-19 in a three day schedule, with 200mg administered the first day and 100 mg administered on the second and third days. The time of administration should not change for the 200 mg dose, but two vials of the Remdesivir will be reconstituted and administered into the NS IV bag (ie. withdraw 40mL of NS from the bag prior to injecting the 200mg of reconstituted Remdesivir).

Infusion bag volume (mL)	Infusion time (min)	Rate of infusion (mL/min)	Drip rate – microdrip set (gtt/min)	Drip rate – macrodrip set (gtt/min)
100	30	3.33	200	33
	45	2.22	133	22
	60	1.67	100	10
50	30	1.67	100	10
	45	1.11	67	NA*
	60	0.83	50	NA*

*Macrodrip set is not indicated for drip rates less than 10/min

When the infusion is complete, flush the IV line with 30 mL of normal saline at the same infusion rate to ensure all of the medication was administered.

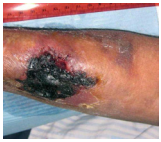
Wound Assessment Overview

Wound assessment involves 6 criteria:

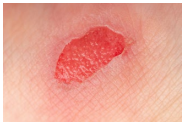
1. Tissue type
2. Exudate (type, volume, colour)
3. Odour
4. Periwound condition (extending 4cm from edges of wound)
5. Pain (at dressing changes, intermittently, or consistently)
6. Size (length, width, depth)

Tissue Types:

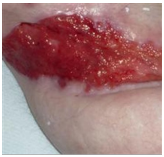
Necrotic – Dead tissue. Needs surgical debridement. Brown, grey, or black in colour. May be moist and slimy (slough) or dry and leathery (eschar)



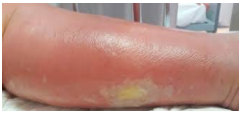
Granulation – Bumpy red tissue. Healthy part of wound closure.



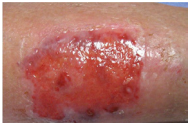
Hypergranulation – Soft, gelatinous red tissue. Granulation tissue raised above the surface of the skin. Often a sign of excessive moisture. May be a sign of underlying infection.



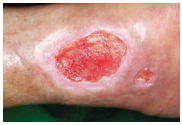
Infective – Spreading, with potential for sepsis. May be warm, itching, or painful. May include red streaks through surrounding skin, with swelling or pitting. Wound may have yellow or green discharge/pus and may also have a bad odour.



Epithelium – Pale pink/mauve tissue at edges of wound. Pale pink or white with smooth (not raised) edges.



Maceration – Pale grey/white tissue at edges of wound. Occurs when wound is exposed to prolonged moisture. White swollen tissue surrounding the edges of a wound. May also cover the surface.



Wound Swabbing for Culture

1. Use sterile cotton-tipped swab and culture medium from pre-packaged collection system. Do not allow the package to be exposed to extreme temperatures before use.
2. Rinse wound with sterile saline (non-bacteriostatic) and dry with clean gauze.
3. Do not swab pus, exudate, hard eschar, or necrotic tissue.
4. Rotate the swab tip in a 1cm^2 area of clean granulation tissue for a period of 5 seconds, using enough pressure to release tissue exudate.
5. Remove protective cap from culture medium and insert cotton-tipped applicator into the culture medium without contaminating the applicator.
6. Transport to the laboratory at room temperature within 24 hours.

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Medication Safety Starts with You

When you see the "5Rs" symbol throughout this guidebook, it is a reminder to always confirm:

- RIGHT PATIENT
- RIGHT DRUG
- RIGHT DOSE
- RIGHT ROUTE
- RIGHT TIME

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