Hamilton Health Sciences

CENTRE FOR PARAMEDIC EDUCATION AND RESEARCH

Policy Manual

Final – December 9, 2019

Table of Contents

Administrative Policies

Certification Policies

Data Policies

Education Policies

Quality Policies

Hamilton Health Sciences
CENTRE FOR PARAMEDIC EDUCATION AND RESEARCH

COVID-19 CPER Policy Amendments

The Centre for Paramedic Education and Research's (CPER) highest priority at all times is the health and well-being of the Paramedics and communities we serve and of our staff.

During this period of heightened public health concern and precaution, we are taking a number of steps not only to protect and support our Paramedics, Paramedic Services, staff, and community partners, but also to contribute in every way possible to mitigating the spread of COVID-19.

Temporary measures have been made in consultation with Paramedic Services, provincial partners, CPER Medical Council and staff. Great strides have been made for staff to adhere to timeframes and deadlines noted in policies, however; some COVID-19 changes may result in necessary delays.

Current changes noted for policies:

A-003 Niagara Region Cross Border Transport

Suspended due to COVID-19

A-004 Guideline for Out of Country Insured Health Services

Suspended due to COVID-19

C-001 Certification Policy

All new ACP Certifications have been suspended at this time. A provincial working group is in the process of creating a proposal for consideration of how this work will be completed. All new PCP certifications will follow the "Alternate PCP Certification Process", endorsed by OBHG and shared with Paramedic Services in April 2020.

C-002 Return to Practice Policy

Currently, there are no amendments required to the RTP policy. Should staffing issues/operational pressures become a concern, a Paramedic's plan may be modified in such a way to allow for an expedited return to clinical practice. These will be assessed and modified on a case-by-case basis by a CPER Paramedic Educator in consultation with the Paramedic Service and as endorsed by Medical Council.

C-017 Consolidation Policy

Consolidation requirements for all newly certified ACPs will be addressed by a provincial working group.

Consolidation requirements for all newly certified PCPs has been set for a 6 month period. The PCP is required to work with a Paramedic of the same or higher level of Certification and Authorization with a minimum of 6 months of experience.

Understanding that during extreme circumstances due to the evolving COVID-19 pandemic a Paramedic Service may need to adapt their deployment plan and can therefore consult with CPER about this condition. The base hospital will make a decision to remove this condition based on QA data results or after consultation with a Paramedic Service regarding their deployment plan pressures.

Q-007 Online Medical Control Quality Review

Section 3.3 SUSPENDED ONLY. We still continue to monitor online medical control via patches associated with calls.

Additional resource documents:

1. OBHG Base Hospital Business Continuity Plan COVID_DRAFT_March 12, 2020
2. PCP Alternate Certification Executive Summary – V1.6 April 15, 2020

Though our policies and procedures are being modified in these ways, CPER staff remain accessible during normal working hours via email and phone.

Paramedics and Paramedic Services with specific requirements about continuation of support should communicate with primary program contact directly.

CPER remains here to support you in every way possible.

DRAFT

1.0 Purpose & Goals Description

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

1.2 The goals of CPER Policies and Procedures are to:

- 1.2.1 Align and support with the Mission, Vision and Values of CPER and Hamilton Health Sciences in the provision of service, education, quality, data and research;
- 1.2.2 Meet legislative and legal requirements;
- 1.2.3 Meet provincial review standards;
- 1.2.4 Manage risk to staff and/or hospital;
- 1.2.5 Clarify roles, responsibilities and accountabilities;
- 1.2.6 Facilitate consistent and safe performance;
- 1.2.7 Define a minimum expectation of quality;
- 1.2.8 Serve as a record of administrative and clinical/service decisions;
- 1.2.9 Support professional standards;
- 1.2.10 Improve quality of patient care, education and research;
- 1.2.11 Support performance evaluation;
- 1.2.12 Improve productivity;
- 1.2.13 Increase co-ordination and communication across programs and Paramedic Services; serve as an orientation and education tool.

2.0 References

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

3.0 Policy

3.1 Principles:

- 3.1.1 All CPER policies will be reviewed at least once every year by the CPER Senior Management Team (SMT).
- 3.1.2 The Regional Program Manager/Director will ensure input from the respective CPER Quality, Data and Education staff as well as Medical Council.
- 3.1.3 CPER policies cannot conflict with associated legislation and/or CPER Medical Directives.

3.2 Responsibilities:

- 3.2.1 All CPER staff (full-time and/or part-time) are responsible to be familiar and follow all CPER policies and procedures.

3.2.2 Compliance to policies and procedures shall be monitored by the Regional Program Manager/Director.

3.2.3 Non-compliance shall be reported to the Regional Program Manager/Director.

3.3 Procedure:

3.3.1 Identification for the need of a policy can be determined by the CPER staff, CPER Senior Management Team, Paramedic Service Operators, Program Committee, Paramedics, Partnering Organizations and/or the HHS Senior Leadership (or designate) overseeing the management of CPER.

3.3.2 Policy development shall be administered by the Regional Program Manager/Director (or designate).

3.3.3 During policy development, the CPER Regional Program Manager/Director will ensure consultation with identified stakeholders.

3.3.4 Once a draft policy has been developed, the policy will be presented to the SMT.

3.3.5 After the review by the SMT, the draft policy will be presented to the Program Committee for formal review.

3.3.6 If conflicts arise that cannot be mitigated, the matter will be presented to the HHS Senior Leadership for resolution.

3.3.7 After review from the Program Committee, the CPER Regional Program Manager/Director will finalize and approve the policy.

3.3.8 A policy is considered “approved and final” when the policy document has been signed by the Regional Program Manager/Director.

3.3.9 Once a policy has been approved, it will be distributed to stakeholders as required, and at a minimum, will be posted on the website of the Centre for Paramedic Education and Research.

4.0 Appendices

None

5.0 Regional Program Manager/Director Approval Signature

CPER POLICY MANUAL	
Date Issued: **April 01, 2011**	Policy Number: **2019-A-002**
Revision History Dates: October 31, 2011; May 2013; June 2014, October 2015, August 2017, August 2019	
Title: **Controlled Medication Policy**	

1.0 Policy

1.1 Employers are responsible for ensuring that the Controlled Medications Policy that is administered by the Paramedic, meets the policy components as set out by CPER.

2.0 References

2.1 Controlled Drugs and Substances Act (S.C. 1996, c. 19), as amended from time to time.

2.2 Narcotic Control Regulations (C.R.C., c. 1041), as amended from time to time.

3.0 Procedure

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

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

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

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

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

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

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

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

3.9 The Employer must have a policy to request additional interim prescriptions if required at least 2 weeks in advance of the need for the controlled substances. In exceptional circumstances CPER will make its best effort to accommodate shorter notice. Exceptional circumstances may include inventory loss due to unforeseen events, which must be documented and presented to CPER.

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

3.11 The Employer must have a policy to track expiry dates and address the disposal of expired controlled medications. This includes consideration to batch expiration of controlled substances. Requests to compensate for such batch expiration must be in compliance with section 3.9 outlined above.

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

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

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

3.15 The Employer must have a policy that outlines the notification of proper authorities and CPER in the case of suspected or confirmed loss, theft or unauthorized use of controlled medications. This should include written notification to the CPER Medical Director, Emergency Health Services Branch (EHSB) Field Office and the local Police agency without delay based on best practices. CPER will notify Health Canada within 10 days of the reported loss, theft or unauthorized use of controlled medications, and CPER will copy the service operator.

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

3.17 The Employer must have a policy that allows authorized CPER staff to access controlled medication records on request within a reasonable timeframe (one week).

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

4.0 Appendices

None

5.0 Regional Program Manager/Director Approval Signature

CPER POLICY MANUAL

Date Issued: **October 2012**	Policy Number: **2019-A-003**
Revision History Dates: October 2012; May 2013, October 2014, August 2017, July 2019	
Title: **Niagara Region Cross Border Transport**	

1.0 Policy

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

2.0 References

2.1 Advanced Life Support Patient Care Standards (ALS PCS)
2.2 Basic Life Support Patient Care Standards (BLS PCS)
2.3 Field Trauma Triage Guidelines
2.4 Niagara EMS Cross-Border Transport Policy
2.5 MOHLTC Form "Application for Approval of Full Payment of Insured Out-of-Country (OOC) Health Services, Emergency/911/Criticall Transfers (Form 4524-84E)
2.6 Sample of completed Form 4524-84E

3.0 Procedure

3.1 For patients within the geographical boundaries established by Employer policy, transport to a Level One Trauma Centre in Buffalo, New York, and that meet the Field Trauma Triage Guidelines, do not require contacting a Base Hospital Physician (BHP) / CPER for preapproval.

3.2 In rare circumstances, Paramedics may determine that a patient meets the following criteria:

- Field Trauma Triage Guidelines;
- Outside geographical boundaries established by Service policy;
- Can reach the Level One Trauma Centre in Buffalo, New York, in less than 30 minutes transport time.

In these circumstances, the Paramedic must evaluate the patient and use their judgement as to what is the most appropriate destination. The Paramedic may contact the BHP for medical advice.

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

4.0 Appendices

None

5.0 Regional Program Manager/Director Approval Signature

CPER POLICY MANUAL

Date Issued: **May 2010**	Policy Number: **2019-A-004**
Revision History Dates: October 31, 2011 May 2013, Oct 2014, August 2017, July 2019	
Title: **Guideline for Out of Country Insured Health Services**	

1.0 Policy/Preamble

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

2.0 References

2.1 Advanced Life Support Patient Care Standards (ALS PCS)

2.2 Basic Life Support Patient Care Standards (BLS PCS)

2.3 MOHLTC Form "Application for Approval of Full Payment of Insured Out-of-Country (OOC) Health Services, Emergency/911/Criticall Transfers (Form 4524-84E)

2.4 CPER Policy A-003 - Niagara Region Cross Border Transport

2.5 Provincial Field Trauma Triage Guidelines

3.0 Procedure

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

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

3.3 After the call is completed, NEMS Ambulance Communication Service staff will complete an OHIP Application for Approval of Full Payment of Insured Out-of-Country (OOC) Health Services, Emergency/911/Criticall Transfers (Form 4524-84E) with as much patient information that is available at the time.

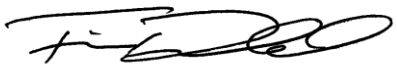
3.4 NEMS staff will send Application for Approval of Full Payment of Insured Out-of-Country (OOC) Health Services, Emergency/911/Criticall Transfers (Form 4524-84E)to the CPER fax drive. CPER administration starts the process and sends documents to the assigned CPER Medical Council MRP and CPER Quality Program to be completed.

3.5 CPER medical staff will complete and submit a Application for Approval of Full Payment of Insured Out-of-Country (OOC) Health Services, Emergency/911/Criticall Transfers (Form 4524-84E) on the patient's behalf.

4.0 Appendices

None

5.0 Regional Program Manager/Director Approval Signature



CPER POLICY MANUAL

Date Issued: **October 31, 2011**	Policy Number: **2019-A-005**
Revision History Dates: May 2013, August 2014, August 2017, July 2019	
Title: **Public Affairs and Communication with Media**	

1.0 Policy

1.1 Hamilton Health Sciences (HHS) has a Communications and Public Affairs Team which is responsible for assisting the media in reporting accurately about HHS and managing communication matters of concern to the general public and will facilitate media contact.

1.2 CPER Regional Program Manager/Director will consult with the HHS Communications and Public Affairs Team should any member of the media request information of any type. (See 3.3)

1.3 CPER Regional Program Manager/Director will consult with the Paramedic Service Operator(s) prior to information release that identifies the respective Paramedic Service Operator or employee.

2.0 References

2.1 C&PA – Media and External Communications Policy

3.0 Procedure

3.1 Any staff, Medical Council or delegate of CPER who are contacted by a member of the media with regards to any information will direct the member of the media to the CPER Regional Program Manager/Director.

3.2 CPER staff, Medical Council or delegate should not disclose any information to the media, unless prior authorization has been obtained by the CPER Regional Program Manager/Director or by the HHS Communications and Public Affairs Team.

3.3 If the CPER Regional Program Manager/Director is not available, the CPER staff, Medical Council or delegate will direct the member of the media to the HHS Communications and Public Affairs Team.

Suggested answer: "***Our Communications and Public Affairs Team is in a better position to respond to your request"***
Phone: 905-521-2100 Ext. 75387
Email: HHSNews@hhsc.ca
After hours: Call paging at 905-521-5030 and ask for C&PA on-call

4.0 Appendices

None

5.0 Regional Program Manager/Director Approval Signature

CPER POLICY MANUAL	
Date Issued: **October 31, 2011**	Policy Number: **2019-A-006**
Revision History Dates: May 2013, August 2014, August 2017, July 2019	
Title: **Response to Customer Inquiries**	

1.0 Policy

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

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

2.0 References

2.1 PE&S – Managing Patient/Family Concerns & Compliments Protocol

2.2 Regional Base Hospital Performance Agreement

3.0 Procedure

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

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

3.3 The Regional Program Manager/Director will facilitate contact with the appropriate CPER staff and the individual who has brought the concern forward.

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

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

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

3.7 A written summary of the information gathered will be forwarded to the Senior Field Manager annually within ninety (90) days of the end of the Fiscal Year.

3.8 Concerns involving privacy breeches are handled through the HHS Privacy Office.

4.0 Appendices

None

5.0 Regional Program Manager/Director Approval Signature

CPER POLICY MANUAL	
Date Issued: **August 1, 2010**	Policy Number: **2019-A-007**
Revision History Dates: October 31, 2011 May 2013, August 2014, August 2017, July 2019	
Title: **Conflict of Interest**	

1.0 Policy

1.1 The Centre for Paramedic Education and Research (CPER) are to perform their duties and functions impartially, responsibly, diligently, efficiently with integrity and in a manner that bears public scrutiny.

2.0 References

2.1 Regional Base Hospital Performance Agreement

2.2 HHS Conflict of Interest – Code of Conduct

3.0 Procedure

3.1 No conflict of interest should exist where a CPER staff, Medical Council or delegate engages in a private or personal activity that advances/potentially advances or may be perceived to advance the individual's private interests at the expense of or to the prejudice of the interest of the MoH, Host Hospital, and/or CPER.

3.2 When notified, the CPER Regional Program Manager/Director will ensure that staff, Medical Council or representatives do not engage in any identified private or personal activity that will, may or may be perceived to be in a Conflict of Interest, for example:

3.2.1 Conflict with the duties or obligations owed to CPER.

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

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

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

3.4 The CPER staff, Medical Council or representative shall disclose the conflict of interest to the CPER Regional Program Manager/Director as soon as they become aware of such circumstance and shall take all steps to avoid the conflict.

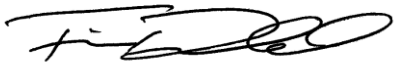
3.5 The CPER Regional Program Manager/Director will take immediate actions to end any actual, potential or perceived conflict of interest and will report such actions and findings to the Host Hospital.

3.6 This policy aligns with the Hamilton Health Sciences Policy entitled "Conflict of Interest – Code of Conduct".

4.0 Appendices

None

5.0 Regional Program Manager/Director Approval Signature



CPER POLICY MANUAL

Date Issued: **June 2019**	Policy Number: **2019-C-001**
Revision History Dates: Sept. 2009, Sept. 2011, Aug 2014, July 2019	
Title: **Certification Policy**	

1.0 Preamble

1.1 A person employed and/or volunteering as a Paramedic must be authorized by the Medical Director of a Base Hospital Program designated by the Ministry of Health (MoH) to perform Controlled Acts as described in the Regulations. The College of Physicians and Surgeons of Ontario's Delegation of Controlled Acts acknowledges the Provincial Base Hospital standard for Paramedic Certification in the performance of Controlled Acts. Thus through this process, the Medical Director of a designated Regional Base Hospital Program may authorize a Paramedic to be able to perform Controlled Acts with specific requirements for new Certification and Maintenance of Certification (MoC).

2.0 References

2.1 Advanced Life Support Patient Care Standards (ALS PCS)
2.2 Basic Life Support Patient Care Standards (BLS PCS)
2.3 Ambulance Act Ontario Regulation (O.Reg.) 257/00
2.4 CPER Policy (C-001)

3.0 New Certification Process

3.1 The following requirements apply with respect to Paramedics who are seeking Certification from a RBHP and who are not currently certified at that level by another RBHP, including Paramedics who have been previously certified in Ontario.

3.2 **Eligibility**

The Paramedic candidate must be employed or retained or have a pending offer of employment by a licensed Ontario Emergency Medical Paramedic Service Provider under the Regulations of the *Ambulance Act*. The Employer is responsible for ensuring the Paramedic candidate has met the requirements of employment and for forwarding a written confirmation of the intent to offer employment to the Paramedic candidate at a specific level pending Certification with CPER.

3.3 **Documentation**

The Employer shall forward the following information to CPER a minimum of 10 business days prior to any scheduled orientations/evaluations:

1. Completed New Certification Request Form (PCP and ACP candidates)

3.4 **Provincial Exam verification**

The Paramedic or Employer will provide an attestation or evidence of successful completion of the provincial examination within 210 days (PCPs) or 180 days (ACPs).

Failure to provide proof may result in Decertification or Deactivation.

3.5 **CPER Orientation/Evaluation:**

The Paramedic shall successfully complete an evaluation by CPER and any orientation and training required. The evaluation may include:

3.5.1 an assessment of knowledge and skills

3.5.2 scenario evaluation; and

3.5.3 oral interview or clinical evaluation with the Medical Director or delegate

3.6 **Final Certification: - SEPARATE POLICY**

After completion of steps 1 to 5, CPER Medical Council or delegate will decide if the Paramedic candidate has met the requirements for Certification; the Paramedic and Employer will be notified regarding the decision within 3 business days.

If the Paramedic candidate is unsuccessful, the Employer can choose to represent the candidate for a re-evaluation.

3.7 **Consolidation:**

3.7.1 See CPER Policy No. C-017

3.7.2 In special circumstances i.e. Mass Casualty Incident (MCI), where the Consolidating Paramedic is separated from his/her partner and is required to attend to a patient, the Consolidating Paramedic may practice to the level of his/her Certification. Following the completion of the call, the Consolidating Paramedic must notify CPER via the self-report system within 24 hours, providing details of the call and the management of their patient.

4.0 Cross-Certification Process:

The following requirements apply with respect to Paramedics who are already Certified in another RBHP and who are seeking Certification by CPER Medical Counsel. See CPER Policy C-018

4.1 **Documentation**

The Employer shall forward the following information to CPER a minimum of 10 business days prior to any scheduled orientations/evaluations:

3.9.1 Completed New Certification Request Form (PCP and ACP candidates)

4.2 **Final Certification:**

CPER will notify the Paramedic and Employer of the results in writing within three (3) Business Days.

4.3 **Consolidation:**

4.3.1 See CPER Policy No. C-017

4.3.2 In special circumstances i.e. Mass Casualty Incident (MCI), where the Consolidating Paramedic is separated from his/her partner and is required to attend to a patient, the Consolidating Paramedic may practice to the level of his/her Certification. Following the completion of the call, the Consolidating Paramedic must notify CPER via the self-report system within 24 hours, providing details of the call and the management of their patient.

5.0 Maintenance of Certification (MoC) Process

The following requirements apply with respect to Paramedics regarding the Maintenance of Certification (MoC):

5.1.1 The Paramedic shall demonstrate competency in the performance of Controlled Acts and other advanced medical procedures, compliance with the ALS PCS, and the provision of patient care at the Paramedic's level of Certification. Competency and compliance shall be determined by the Medical Director and may include chart audits, field evaluations, and RBHP patch communication review.

5.1.2 The Paramedic shall not have an absence from providing patient care that exceeds ninety (90) consecutive days.

5.1.3 The Paramedic shall either,

a) provide patient care to a minimum of ten (10) patients per year whose care requires assessment and management at the Paramedic's level of Certification, or

b) where a Paramedic is unable to assess and manage the minimum of ten (10) patients per year, demonstrate alternate experience, as approved by the Medical Director, that may involve 1 or more of the following:

i. other patient care activities;
ii. additional CME;
iii. simulated patient encounters; and
iv. clinical placements.

5.1.4 The Paramedic shall complete at least 1 evaluation per year at the appropriate level of Certification, which may include: an assessment of knowledge and evaluation of skills; scenarios; and on-line learning and evaluation.

5.1.5 The Paramedic shall complete a minimum of CME hours per year as follows: eight (8) hours for PCPs, twelve (12) hours for PCP Flight, twenty-four (24) hours for ACPs, and seventy-two (72) hours for ACP Flight and Critical Care Paramedic (CCP). CME hours include hours completed as part of an evaluation required by Appendices 7.0

5.1.6 Upon meeting the above requirements for Maintenance of Certification, the Medical Director shall Certify the Paramedic.

6.0 Appeal Process

A Paramedic candidate who is unsuccessful at the CPER Certification process, with an ongoing offer of employment may appeal their results by submitting a written request to CPER. This submission must be made and received within five (5) business days of the Paramedic candidate receiving their results and must clearly outline the reasons for the appeal. A Paramedic candidate may submit an appeal based on one or both of the following:

a) In the opinion of the Paramedic candidate, due process was not followed by the Base Hospital facilitators,

OR

b) New information has become available which may have a bearing on the Certification decision.

Appeal decisions are considered final and will be communicated in writing within five (5) business days to the candidate and sponsoring Employer upon the review and decision from Medical Council.

7.0 Appendices

7.1 Annual Maintenance of Certification Requirements Chart:

	PRIMARY CARE PARAMEDIC	**ADVANCED CARE PARAMEDIC**
Employment	Be employed or retained by an Employer.	
Clinical Activity	Paramedic shall not have an absence from providing patient care at their certified level that exceeds 90 consecutive days. Minimum 10 patients per year whose care required an assessment and management at the Paramedic's level of Certification, including a Delegated Medical Act.	
Annual CME (Minimum)	8 CME credits	24 CME credits
Annual Educational Requirements	APR - 8 hours (8 CME credits) – written, skills, and scenario evaluation; Additional education packages/modules/teaching that is required, as approved by the Medical Council.	
Skills Maintenance Program	Optional; may be required if ongoing minimal clinical activity only: Documentation of a proactive skills maintenance program or other EMS / medical related activity.	

8.0 Clarification of Terms and Conditions

8.1 Terms defined in the *Ambulance Act,* Ontario Regulation 257/00 and the ALS PCS Certification Standard shall have the same meaning in this procedure document.

9.0 Regional Program Manager/Director Approval Signature

CPER POLICY MANUAL

Date Issued: **November 8, 2013**	Policy Number: **2019-C-002**
Revision History Dates: June 2014, August 2017, August 2018, August 2019	
Title: **Return to Practice (RTP)**	

1.0 Policy

1.1 Return to Practice (RTP) offers a Paramedic an opportunity to reintegrate into the workforce, after a period of absence. RTP is required as per the current Ministry of Health and Long Term Care (MoHLTC), Advanced Life Support Patient Care Standards (ALS PCS), Appendix 6. This process will be initiated upon request by the Employer.

2.0 References

2.1 Ministry of Health and Long Term Care (MoHLTC); Emergency Health Regulatory and Accountability Branch (EHRAB) Advanced Life Support Patient Care Standards, Appendix 6 as amended from time to time

2.2 Ambulance Act Ontario Regulation (O.Reg.) 257/00

3.0 Procedure

3.1 The Employer will notify CPER, by submitting the completed RTP form, when the Paramedic's RTP date has been confirmed.

3.2 An Individual Needs Self-Assessment Form must be downloaded, filled out and submitted by the Paramedic to CPER. It is the responsibility of both the Paramedic and Employer to ensure that this form is completed in a timely manner. Until this form is received, an RTP plan cannot be developed by CPER.

3.3 Upon receipt and review of the form, a CPER Paramedic Educator will develop and distribute an RTP plan to the Paramedic and the Employer within ten (10) business days. The CPER Paramedic Educator may request a phone conversation with the Paramedic at this stage.

3.4 Once all the requirements have been met the Paramedic will be reactivated. Dependent on the type of RTP plan that is developed, the Paramedic could receive Certification with restrictions and/or conditions.

3.5 If Consolidation is a requirement of the RTP plan, the Paramedic will be Certified with the condition that the Paramedic must work with a partner of the same Certification level or higher as defined in the ALS PCS, Appendix 6.

3.6 An RTP plan could include the condition of having to complete a reflective practice assignment, using Gibb's Reflective Cycle involving a clinical case. Once the assignment has been completed, the Paramedic will be required to contact a CPER Paramedic Educator for review and feedback of the assignment.

3.7 Upon verification of completion of all conditions, the Paramedic and Employer will be notified in writing. Non compliance of any condition placed on Certification could result in Deactivation of the Paramedic.

3.8 Paramedics who require Consolidation as a part of their Return to Practice (RTP) plan have 90 days to complete their Consolidation from the date of RTP Certification. If an extension is required, Paramedics must provide written request no later than 10 business days of RTP certification expiry date.

4.0 Appendices

4.1 Appendix A – PCP/ACP RTP Table 1.0

5.0 Regional Program Manager/Director Approval Signature

Appendix A – PCP/ACP RTP Table 1.0

The potential requirements/conditions for Paramedics returning to practice after an absence are described in Table 1.0. This table is meant to be used as a guide given individualized plans are developed based on need identified.

Length of Absence	Primary Care Paramedic (PCP)	Advanced Care Paramedic (ACP)
180 to <365 Days	1. Individual Needs Self-Assessment 2. Completion of identified mandatory CME(s) missed during absence 3. Up to one (1) day of review and evaluation with a CPER representative or designate 4. Additional requirements identified during the one day review at the discretion of CPER	1. Individual Needs Self-Assessment 2. Completion of identified mandatory CME(s) missed during absence 3. Up to one (1) day of review and evaluation with a CPER representative or designate 4. Additional requirements identified during the one day review at the discretion of CPER
366 to <547 Days	1. Individual Needs Self-Assessment 2. Completion of identified mandatory CME(s) missed during absence 3. Up to two (2) days of review and evaluation with a CPER representative or designate 4. (48) hours of Consolidation with a Paramedic of equal or greater certification level. 5. A reflective practice assignment may be required as determined by a CPER representative. 6. Additional requirements identified during the two day review at the discretion of CPER	1. Individual Needs Self-Assessment 2. Completion of identified mandatory CME(s) missed during absence 3. Up to two (2) days of review and evaluation with a CPER representative or designate 4. (72) hours of Consolidation with a Paramedic of equal or greater certification level. 5. A reflective practice assignment may be required as determined by a CPER representative. 6. Additional requirements identified during the two day review at the discretion of CPER
548 to 1095 Days	1. Individual Needs Self-Assessment 2. Completion of identified mandatory CME(s) missed during absence 3. Up to three (3) days of review and evaluation with a CPER representative or designate 4. 84 hours of Consolidation with a Paramedic of equal or greater certification level. 5. A reflective practice assignment may be required as determined by a CPER representative. 6. Additional requirements identified during the three day review at the discretion of CPER	1. Individual Needs Self-Assessment 2. Completion of identified mandatory CME(s) missed during absence 3. Up to three (3) days of review and evaluation with a CPER representative or designate 4. 168 hours of Consolidation with a Paramedic of equal or greater certification level. 5. A reflective practice assignment may be required as determined by a CPER representative. 6. Additional requirements identified during the three day review at the discretion of CPER
1096 Days or Greater	The plan will be created based upon a discussion with the Paramedic, Employer, CPER Education and CPER Medical Council. The final decision of content of the RTP plan will be determined by CPER	The plan will be created based upon a discussion with the Paramedic, Employer, CPER Education and CPER Medical Council. The final decision of content of the RTP plan will be determined by CPER

CPER POLICY MANUAL	
Date Issued: **October 31, 2011**	Policy Number: **2019-C-003**
Revision History Dates: May 2013, June 2014, August 2017, July 2019	
Title: **Reassignment of Paramedic Level of Certification**	

1.0 Policy

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

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

1.3 Conditions:

1.3.1 A Certified Advanced Care Paramedic (ACP) may request Certification as a Primary Care Paramedic (PCP) as per Policy C-006.

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

2.0 References

CPER Policy C-006 – ACP/PCP Scope of Practice

3.0 Procedure

3.1 The reassignment of Certification level must coincide with a reclassification of the Paramedic by the Employer. Supporting documentation (CPER Request for Certification Form to be completed with change in Scope of Practice) from the Employer must be provided.

3.2 Paramedic will confirm by email that they have reviewed and fully understands CPER Policy C-003.

3.3 CPER will provide official notification of the reassignment of Certification level to the Paramedic and the Employer in writing.

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

3.5 Upon reassignment of Certification level, the Paramedic is Certified and authorized to perform those delegated acts that fall within the reassigned scope of practice.

3.6 A Paramedic who has been reassigned may request to have his or her previous level of Certification reinstated provided the request is made in writing within 90 days of the original reassignment. The reassignment of Certification level must coincide with a reclassification of the Paramedic by the Employer. Supporting documentation from the Employer must be provided in advance.

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

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

4.0 Appendices

None

5.0 Regional Program Manager/Director Approval Signature

CPER POLICY MANUAL

Date Issued: **August 1, 2010**	Policy Number: **2019-C-004**
Revision History Dates: October 31, 2011, May 2013, August 2014, August 2017, July 2019	
Title: **Adherence to Provincial Medical Directives**	

1.0 Policy

1.1 The Centre for Paramedic Education and Research (CPER) provides delegation of Controlled Acts to Paramedics in accordance with the Advanced Life Support Patient Care Standards (ALC PCS) as recommended by the Provincial Medical Advisory Committee and approved by the Director, Emergency Health Services Branch.

2.0 References

2.1 *Ambulance Act* Ontario Regulation (O.Reg.) 257/00
2.2 CPER Medical Directives
2.3 Regional Base Hospital Performance Agreement
2.4 Advanced Life Support Patient Care Standards (ALS PCS)

3.0 Procedure

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

4.0 Appendices

None

5.0 Regional Program Manager/Director Approval Signature

CPER POLICY MANUAL

Date Issued: **October 31, 2011**	Policy Number: **2019-C-005/C-006**
Revision History Dates: May 2013, June 2014, August 2017, July 2019	
Title: **Advanced Care Paramedic Scope of Practice**	

1.0 Policy

1.1 The Advanced Care Paramedic (ACP) scope of practice includes all core medical directives and any auxiliary skills within the core directives or the auxiliary Medical Directives authorized by the CPER Medical Director. The auxiliary scope of practice must be requested by the affiliated Employer and approved by the CPER Medical Director.

1.2 Advanced Care Paramedics (ACPs) are only Authorized to use the approved medical directives as outlined in this policy.

2.0 References

2.1 Advanced Life Support Patient Care Standards (ALS PCS)
2.2 Basic Life Support Patient Care Standards (BLS PCS)
2.3 CPER Medical Directives

3.0 Procedure

3.1 Advanced Care Paramedic Scope of Practice:
- 3.1.1 All procedures as described in the Basic Life Support Patient Care Standards
- 3.1.2 All procedures as described in the Advanced Life Support Patient Care Standards, that the Paramedic is currently certified and authorized to perform

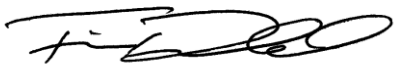
3.2 The Advanced Care Paramedic scope of practice may also include:
- 3.2.1 See Appendix A Medication administration as described in Appendix B.

4.0 Appendices

4.1 ACP Medical Directives

4.2 Identified ACP Auxiliary Medical Directives

5.0 Regional Program Manager/Director Approval Signature



1.0 Policy

1.1 The Primary Care Paramedic (PCP) scope of practice includes all core medical directives and any auxiliary skills within the core directives or auxiliary medical directives authorized by the CPER Medical Director. The auxiliary scope of practice must be requested by the affiliated Employer and approved by the Regional Medical Director.

1.2 Primary Care Paramedics (PCPs) are only Authorized to use the approved medical directives as outlined in this policy.

2.0 References

2.1 Advanced Life Support Patient Care Standards (ALS PCS)
2.2 Basic Life Support Patient Care Standards (BLS PCS)
2.3 CPER Medical Directives

3.0 Procedure

3.1 Primary Care Paramedic Scope of Practice:
- 3.1.1 All procedures as described in the Basic Life Support Patient Care Standards (BLS PCS)
- 3.1.2 All procedures as described in the Advanced Life Support Patient Care Standards (ALS PCS), that the Paramedic is currently Certified and Authorized to perform.

3.2 The Primary Care Paramedic scope of practice may also include:
- 3.2.1 See Appendix A

4.0 Appendices

4.1 PCP Medical Directives
4.2 Identified PCP Auxiliary Medical Directives

5.0 Regional Program Manager/Director Approval Signature

Appendix A

- End tidal CO_2 monitoring
- Other Medical Directives as certified and authorized from time to time

Appendix B

- Sodium Bicarbonate

CPER POLICY MANUAL

Date Issued: **January 01, 2011**	Policy Number: **2019-C-007**
Revision History Dates: October, 2011; May 2013; June 2014, August 2017, July 2019	
Title: **Provision of Care in an ACP/PCP Crew**	

1.0 Policy

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

2.0 References

2.1 Advanced Life Support Patient Care Standards (ALS PCS)

2.2 Basic Life Support Patient Care Standards (BLS PCS)

2.3 CPER Medical Directives

2.4 CPER Policy C-005/006 – ACP/PCP Scope of Practice

3.0 Procedure

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

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

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

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

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

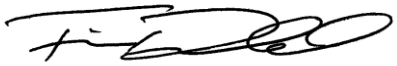
3.5 The ACP will provide care for the patient under the following conditions:

- 3.5.1 The patient requires interventions or assessment beyond that which the PCP is Certified and Authorized;
- 3.5.2 The patient is reasonably expected to require treatment beyond that which the PCP is Certified and Authorized; and
- 3.5.3 The patient deteriorates en route to the point that ACP care is required

4.0 Appendices

CPER Provision of Care Guideline

5.0 Regional Program Manager/Director Approval Signature



APPENDIX A

Guideline for Provision of Care During Transport

As an extension of Policy C-007: Provision of Care in an Advanced Care Paramedic / Primary Care Paramedic (ACP/PCP) Crew, this accompanying guideline will outline conditions when it is reasonable for a PCP to assume care or continue to provide care to a patient during transport when working as an ACP/PCP crew. The guiding principle is that on-going communication between the ACP and the PCP must occur during every patient encounter, so as to ensure that all decision-making reflects what is in the best interest of the patient. This guideline also outlines the provision of care in the situation of crew configurations at the same level (ACP/ACP or PCP/PCP) with the presence of one Paramedic being Certified and Authorized to perform specific auxiliary medical directives.

PCP Care may be appropriate en-route:

- Where the patient is NOT LIKELY to deteriorate en-route and will NOT LIKELY require ACP intervention. This would be determined following advanced assessment and through communication between the ACP and PCP on the expected clinical course of the patient. Some examples include but are not limited to:

Salbutamol	The patient has been given Salbutamol for asthma/COPD exacerbation where the patient is unlikely to require CPAP/ventilation
Non-Cardiac Chest Pain	The patient has suspected non-cardiac chest pain without concern for deterioration
Extremity or other injuries	The patient has extremity or other injuries where opioids are not indicated and other serious trauma is not suspected

- Where an ACP intervention or advanced assessment has occurred and where the expected clinical course of the patient has shown improvement. Some examples include but are not limited to:

Dextrose (D50W)	The patient has been given dextrose IV for hypoglycemia with resolution of symptoms and blood glucose level improvement
Diphenhydramine (Benadryl)	The patient has been given diphenhydramine IM/IV for a single system local allergic reaction
Dimenhydrinate (Gravol)	The patient has been given Dimenhydrinate IM/IV for nausea and/or vomiting
Normal Saline TKVO	An IV has been initiated TKVO as a means for a drug administration route
Resolved chest pain	The patient is currently pain free with unremarkable 12 lead ECG

CVA	The patient presents with stroke symptoms, meets guidelines for bypass, IV TKVO initiated

ACP Care would be appropriate en-route:

- Where an ACP intervention or advanced assessment has occurred and continued ACP intervention is required
  OR
- Where communication between the ACP and the PCP regarding the results of the advanced assessment deems that the clinical course of the patient may result in deterioration en-route, the ACP is to provide care during transport.

Controlled Substances	The patient requires or has received controlled substance medications (any morphine or midazolam administration)
Synchronized Cardioversion	The patient has received or is anticipated to receive synchronized cardioversion
Needle Thoracostomy	The patient may require or has received needle thoracostomy

*As well as other procedures and skills that are outlined in Policy C-005: Advanced Care Paramedic Scope of Practice and all appendices pertaining to the ACP Scope of Practice.

Note that this guideline is predicated on what is reasonable to expect en-route. Not all concerns and changes in patient condition can be anticipated. As such, in an ACP/PCP configuration, if the PCP cares for the patient en-route and the patient's condition changes, communication en-route is paramount. The crew may need to pull over and change providers en-route in the best interest of the patient.

After communicating with the PCP, as the senior medical authority on scene in an ACP/PCP crew configuration, the ACP will make the decision as to who attends the patient en-route to hospital.

PCP/PCP or ACP/ACP Crew Configuration with Auxiliary Directives:

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

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

Hamilton Health Sciences CENTRE FOR PARAMEDIC EDUCATION AND RESEARCH	**Appendix A**
CPER POLICY MANUAL	
Date Issued: **January 01, 2011**	Policy Number: **2019-C-007**
Revision History Dates: October, 2011; May 2013; June 2014, August 2017, July 2019	
Title: **Provision of Care in an ACP/PCP Crew**	

PCP or ACP (not certified in a specific auxiliary directive) care would be appropriate en-route:

- Where the patient is NOT LIKELY to deteriorate en-route and will NOT LIKELY require further auxiliary intervention. This would be determined following advanced assessment and through communication between the crew on the expected clinical course of the patient.
  OR
- Where an auxiliary intervention has occurred and where the expected clinical course of the patient has shown improvement. Some examples include but are not limited to:

Dextrose (D50W)	The patient has been given dextrose IV for hypoglycemia with resolution of symptoms and blood glucose level improvement
Diphenhydramine (Benadryl)	The patient has been given diphenhydramine IM/IV for a single system local allergic reaction
Dimenhydrinate (Gravol)	The patient has been given Dimenhydrinate IM/IV for nausea and/or vomiting
Normal Saline TKVO	An IV has been initiated TKVO as a means for a drug administration route
Resolved chest pain	The patient is currently pain free with unremarkable 12 lead ECG
CVA	The patient presents with stroke symptoms, meets guidelines for bypass, IV TKVO initiated

CPER POLICY MANUAL

Date Issued: **January 01, 2011**	Policy Number: **2019-C-008**
Revision History Dates: October 31, 2011, May 2013, June 2014, August 2017, August 2019	
Title: **Provision of Care in the Presence of Auxiliary Medical Directives**	

1.0 Preamble

1.1 The situation may exist where two Paramedics of the same level (PCP/PCP or ACP/ACP) are working together where only one Paramedic is Certified and Authorized to perform a specific auxiliary medical directive.

1.2 The Paramedic who is Certified and Authorized in the auxiliary medical directive will care for the patient when it has been determined that the patient may or will require treatment under the auxiliary medical directive.

2.0 References

2.1 Advanced Life Support Patient Care Standards (ALS PCS)
2.2 Basic Life Support Patient Care Standards (BLS PCS)
2.3 CPER Medical Directives

3.0 Policy

3.1 In the case of two or more Paramedics of the same level where one Paramedic has been Certified and Authorized in any auxiliary medical directive; this Paramedic will be responsible for all aspects of patient care should the patient require or possibly require application of the auxiliary medical directive.

4.0 Appendices

CPER Provision of Care Guideline

5.0 Regional Program Manager/Director Approval Signature

APPENDIX A

Guideline for Provision of Care During Transport

As an extension of Policy C-007: Provision of Care in an Advanced Care Paramedic / Primary Care Paramedic (ACP/PCP) Crew, this accompanying guideline will outline conditions when it is reasonable for a PCP to assume care or continue to provide care to a patient during transport when working as an ACP/PCP crew. The guiding principle is that on-going communication between the ACP and the PCP must occur during every patient encounter, so as to ensure that all decision-making reflects what is in the best interest of the patient. This guideline also outlines the provision of care in the situation of crew configurations at the same level (ACP/ACP or PCP/PCP) with the presence of one Paramedic being Certified and Authorized to perform specific auxiliary medical directives.

PCP Care may be appropriate en-route:

- Where the patient is NOT LIKELY to deteriorate en-route and will NOT LIKELY require ACP intervention. This would be determined following advanced assessment and through communication between the ACP and PCP on the expected clinical course of the patient. Some examples include but are not limited to:

Salbutamol	The patient has been given Salbutamol for asthma/COPD exacerbation where the patient is unlikely to require CPAP/ventilation
Non-Cardiac Chest Pain	The patient has suspected non-cardiac chest pain without concern for deterioration
Extremity or other injuries	The patient has extremity or other injuries where opioids are not indicated and other serious trauma is not suspected

- Where an ACP intervention or advanced assessment has occurred and where the expected clinical course of the patient has shown improvement. Some examples include but are not limited to:

Dextrose (D50W)	The patient has been given dextrose IV for hypoglycemia with resolution of symptoms and blood glucose level improvement
Diphenhydramine (Benadryl)	The patient has been given diphenhydramine IM/IV for a single system local allergic reaction
Dimenhydrinate (Gravol)	The patient has been given Dimenhydrinate IM/IV for nausea and/or vomiting
Normal Saline TKVO	An IV has been initiated TKVO as a means for a drug administration route
Resolved chest pain	The patient is currently pain free with unremarkable 12 lead ECG

CVA	The patient presents with stroke symptoms, meets guidelines for bypass, IV TKVO initiated

ACP Care would be appropriate en-route:

- Where an ACP intervention or advanced assessment has occurred and continued ACP intervention is required
  OR
- Where communication between the ACP and the PCP regarding the results of the advanced assessment deems that the clinical course of the patient may result in deterioration en-route, the ACP is to provide care during transport.

Controlled Substances	The patient requires or has received controlled substance medications (any morphine or midazolam administration)
Synchronized Cardioversion	The patient has received or is anticipated to receive synchronized cardioversion
Needle Thoracostomy	The patient may require or has received needle thoracostomy

*As well as other procedures and skills that are outlined in Policy C-005: Advanced Care Paramedic Scope of Practice and all appendices pertaining to the ACP Scope of Practice.

Note that this guideline is predicated on what is reasonable to expect en-route. Not all concerns and changes in patient condition can be anticipated. As such, in an ACP/PCP configuration, if the PCP cares for the patient en-route and the patient's condition changes, communication en-route is paramount. The crew may need to pull over and change providers en-route in the best interest of the patient.

After communicating with the PCP, as the senior medical authority on scene in an ACP/PCP crew configuration, the ACP will make the decision as to who attends the patient en-route to hospital.

PCP/PCP or ACP/ACP Crew Configuration with Auxiliary Directives:

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

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

PCP or ACP (not certified in a specific auxiliary directive) care would be appropriate en-route:

- Where the patient is NOT LIKELY to deteriorate en-route and will NOT LIKELY require further auxiliary intervention. This would be determined following advanced assessment and through communication between the crew on the expected clinical course of the patient.
  OR
- Where an auxiliary intervention has occurred and where the expected clinical course of the patient has shown improvement. Some examples include but are not limited to:

Dextrose (D50W)	The patient has been given dextrose IV for hypoglycemia with resolution of symptoms and blood glucose level improvement
Diphenhydramine (Benadryl)	The patient has been given diphenhydramine IM/IV for a single system local allergic reaction
Dimenhydrinate (Gravol)	The patient has been given Dimenhydrinate IM/IV for nausea and/or vomiting
Normal Saline TKVO	An IV has been initiated TKVO as a means for a drug administration route
Resolved chest pain	The patient is currently pain free with unremarkable 12 lead ECG
CVA	The patient presents with stroke symptoms, meets guidelines for bypass, IV TKVO initiated

CPER POLICY MANUAL

Date Issued: **October 31, 2011** | Policy Number: **2019-C-009**

Revision History Dates: May 2013, June 2014, August 2017, December 2017, July 2019

Title: **Medical Delegation from a Regulated Health Professional**

1.0 Policy

1.1 Paramedics should work cooperatively with regulated health professionals to provide quality patient care within their scope of practice as outlined in the BLS PCS, ALS PCS, and/or CPER Medical Directives but will not accept medical delegation from a regulated health professional other than the on-duty CPER Base Hospital Physician (BHP).

2.0 References

2.1 Advanced Life Support Patient Care Standards (ALS PCS)
2.2 Basic Life Support Patient Care Standards (BLS PCS)
2.3 CPER Medical Directives

3.0 Procedures

3.1 If a Paramedic encounters a patient under the care of a regulated health professional (physician, nurse, midwife, etc.1) the Paramedic should work cooperatively to provide quality patient care within their scope of practice as outlined in the BLS PCS, ALS PCS, and/or CPER Medical Directives and as authorized by the CPER Medical Director. Refer to the BLS PCS regarding verification and documentation.

3.2 If a Paramedic is asked to provide care that is not directly indicated by the BLS PCS, ALS PCS, and/or CPER Medical Directives, inform the regulated health professional that Paramedics are only able to accept direct medical orders from the on-duty CPER Base Hospital Physician (BHPs).

3.3 The Paramedic may contact the CPER BHP for advice or additional orders if necessary. The Paramedic will advise the CPER BHP that there is a regulated health professional requesting specific care. The Paramedic could suggest that the on scene regulated health professional consult with the CPER BHP.

3.4 Any orders that are discussed between the regulated health professional and the CPER BHP must be confirmed by the Paramedic through discussion with the CPER BHP.

4.0 Appendices

None

5.0 Regional Program Manager/Director Approval Signature

[1] *Please see http://www.health.gov.on.ca/en/pro/programs/hhrsd/about/regulated_professions.aspx for a list of all regulated health professions.*

CPER POLICY MANUAL

Date Issued: **October 31, 2011** | Policy Number: **2019-C-010**

Revision History Dates: May 2013, June 2014, August 2017, December 2017, July 2019

Title: **Auxiliary Medical Directive/Auxiliary Medication Launch**

1.0 Preamble

1.1 The following policy was created to outline the procedure to be followed when an Employer, in collaboration with CPER, elect to launch an auxiliary medical directive and/or auxiliary medication.

2.0 References

2.1 Advanced Life Support Patient Care Standards (ALC PCS)
2.2 Basic Life Support Patient Care Standards (BLS PCS)
2.3 CPER Medical Directives

3.0 Procedure

3.1 The Employer will submit a written request to CPER of their desire to utilize a medical directive in their region. The request must contain the following:

- 3.1.1 Name of auxiliary medical directive/ medication requested
- 3.1.2 Proposed date of auxiliary medical directive/medication launch
- 3.1.3 Confirmation that the Employer will have all necessary equipment/consumables available prior to the launch of the auxiliary medical directive/medication
- 3.1.4 A statement confirming their ability/plan to provide ongoing support to their Paramedics, in order for them to maintain their skills
- 3.1.5 Confirmation of an agreement with partner hospitals in order to facilitate clinical training

3.2 The Employer and CPER will work collaboratively to develop a training plan and ensure all training and/or evaluation has been completed by Paramedics prior to the launch date.

3.3 CPER will release all relevant correspondence to BHPs, local hospitals and Employers outlining the details of the launch and educational points for implementation.

3.4 The Employers and/or CPER will discuss any clinical implications of the new directive with local hospitals, allied agencies and/or any other parties the new directive may impact.

3.5 Any Employer who has not met the educational training components by the launch date of auxiliary medical directive/medication will be administratively deactivated until training is complete.

4.0 Regional Program Manager/Director Approval Signature

CPER POLICY MANUAL

Date Issued: **February 01, 2010**	Policy Number: **2019-C-011**
Revision History Dates: May 2013; June 2014, August 2017, July 2019	
Title: **Discontinuing Cardiac Monitor Use**	

1.0 Purpose

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

1.2 To provide guidance for when a Paramedic may discontinue cardiac monitor use.

2.0 References

2.1 Advanced Life Support Patient Care Standards (ALS PCS)

2.2 Basic Life Support Patient Care Standards (BLS PCS)

2.3 CPER Medical Directives

3.0 Policy

3.1 As per the ALS PCS , BLS PCS and, CPER Medical Directives;
Paramedics will apply the cardiac monitor to the patient.

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

3.3 At the receiving facility, the Paramedic will transfer the care of the patient to staff of the receiving facility as per the BLS PCS – and associated references in the ALS PCS, and CPER Medical Directives.

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

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

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

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

3.7 If there is a difference of opinion between the Paramedic and the staff at the receiving facility that the cardiac monitor is no longer required, the Paramedic may contact the CPER Base Hospital

Physician (BHP) for medical direction. The Paramedic may need to facilitate dialogue between the staff at the receiving facility and the CPER BHP.

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

3.9 After removal of the cardiac monitor, the Paramedic must still reassess the patient and perform vital signs at intervals appropriate for the patient's condition until formal transfer of care has occurred.

4.0 Appendices

None

5.0 Regional Program Manager/Director Approval Signature

CPER POLICY MANUAL

Date Issued: **October 31, 2011**	Policy Number: **2019-C-012**
Revision History Dates: May 2013; June 2014, August 2017, July 2019	
Title: **Paramedics Starting Intravenous Therapy (IVs) in the Emergency Department**	

1.0 Policy

1.1 CPER recognizes that IV Certified Paramedics may not have an opportunity to start enough IVs in the field to maintain their skills level. In order to assist those IV Certified Paramedics, CPER will Authorize Paramedics to start an IV in specific circumstances in the Emergency Department

1.2 There must be a written agreement between the receiving hospital, the affiliated Employer, and CPER.

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

2.0 References

2.1 Advanced Life Support Patient Care Standards (ALS PCS)

2.2 CPER Medical Directives

3.0 Procedure

3.1 Upon arrival to the Emergency Department, the Paramedic will provide receiving facility staff with a patient report.

3.2 In consultation with the triage nurse or the nurse who will be assuming patient care and the Paramedic, a decision will be made regarding the patient's need for IV access.

3.3 If it is decided that the patient requires IV access, the Paramedic may initiate IV access.

3.4 For the in-hospital IV initiation, the Paramedic will utilize service provided IV catheters and hospital provided IV tubing and IV fluid.

3.5 The Paramedic will be allowed to attempt one IV site.

3.6 In patients where a difficult IV initiation is anticipated, ED staff will use their discretion in whether or not to allow the Paramedic to attempt an IV start.

3.7 Paramedics will document any IV attempt/initiation performed in the ED on their ACR/ePCR as per the documentation standards.

4.0 Appendices

None

5.0 Regional Program Manager/Director Approval Signature

CPER POLICY MANUAL

Date Issued: **August 2015** | Policy Number: **2019-C-014**

Revision History Dates: August 2017, July 2019

Title: **Guideline for Resuscitation in Locations with Difficult Access**

1.0 Preamble

1.1 This policy applies for patients that are vital signs absent, from either trauma or medical causes, which have occurred in locations with difficult access (i.e. falls into a gorge or from the Niagara Escarpment or medical cardiac arrests in remote locations accessible only by ATV, bicycle or on foot.) This policy may also apply in CBRNE cases. Most of these rescue operations also involve the Fire Department and some cases involve locations where mobile phone and radio service is poor.

2.0 References

2.1 Advanced Life Support Patient Care Standards (ALS PCS)

2.2 Basic Life Support Patient Care Standards (BLS PCS)

2.3 CPER Medical Directives

3.0 Procedure

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

3.1.1 If safe to do so, begin CPR and full resuscitation. If access to a cardiac monitor/AED is possible, continue resuscitation and contact the Base Hospital Physician (BHP) after the appropriate number of analyses (1 if trauma, 3 if medical).

3.1.2 If access to a cardiac monitor/AED is not possible in the first 10 minutes of making patient contact, then two rescuers should confirm that the patient is VSA and contact the BHP. If only one rescuer is able to access the patient, then the single rescuer may confirm VSA.

3.1.3 If ongoing CPR puts the providers' safety at risk or is not possible during transport/extrication for any period > 5 minutes, contact the BHP.

3.1.4 If time to hospital is > 30 minutes and ongoing CPR is difficult or impossible, contact the BHP.

3.1.5 If the above does not apply, then continue resuscitation and transport.

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

3.3 On occasions when Paramedics cannot access the patient and the rescuers are Firefighters, the information as above can be transmitted to the BHP by a third party at the scene.

3.4 If a Paramedic receives BHP orders for a TOR, the coroner must be called.

4.0 Appendices

None

5.0 Regional Program Manager/Director Approval Signature

CPER POLICY MANUAL

Date Issued: **October 2017**	Policy Number: **2019-C-015**
Revision History Dates: July 2019	
Title: **Paramedic Requirements for Patient Care**	

1.0 Policy

1.1 This policy/procedure will serve as an interim policy/procedure until such time that a standard provincial base hospital policy/procedure is introduced.

1.2 In accordance with requirements in the Certification Standard. This document will outline the procedure to be followed to identify and assist Paramedics who have an absence from providing patient care that exceeds ninety (90) consecutive days or less than 10 patient contact within a certification year.

2.0 References

2.1 Advanced Life Support Patient Care Standards (ALS PCS)

2.2 CPER Medical Directives

2.3 CPER Maintenance of Certification Policy C-001

3.0 Procedure

3.1 CPER will run monthly reports that provide the name and OASIS number of Paramedics that have no reported patient care contacts in a ninety (90) day period.

3.2 For the duration of this policy a patient care contact will be defined as the Paramedic's name and OASIS number appearing on an ACR/ePCR in the document field denoting official Paramedic role on scene.

3.3 The query will be run monthly to determine patient care within a ninety (90) day period with a one (1) month lag integrated to allow for fulsome receipt of the data.

3.4 Employers who do not transfer the data to CPER will be contacted in accordance with the above timeline to run a query on their system.

3.5 The query results from all sources will be combined to evaluate the results on a regional basis.

3.6 For any Paramedic whose name appears on the monthly report, with no patient care in $\geq$ 180 days (name not on an ePCR for $\geq$ 180 days consecutively or any two (2) 90 day periods or less than 10 patient contact within the certification year).

3.6.1 If the Paramedic is off work on leave or is on modified duties, the Paramedic will be administratively Deactivated so that an appropriate gap analysis can be performed and actioned per Regional Base Hospital (RBH) return to practice process.

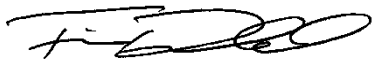
3.6.2 If the Paramedic is clinically active, the Paramedic will remain Certified and Authorized to function in full capacity at their level of Certification and will be monitored internally until the next query results are evaluated.

3.7 A Paramedic who appears on a consecutive 90-day report or a second report within the certification year will have their file reviewed by CPER Medical Council. Medical Council will review the reports and decide on any action as necessary.

4.0 Appendices

None

5.0 Regional Program Manager/Director Approval Signature



CPER POLICY MANUAL

Date Issued: **October 2019**	Policy Number: **2019-C-016**
Revision History Dates: October 2019	
Title: **Remediation Policy**	

1.0 Purpose

1.1 Remediation may be required by a Paramedic because of a Patient Care Concern, or to address a concern related to Certification or the maintenance of Certification. Remediation is a customized plan developed by the Regional Base Hospital Program (RBHP), designed to address the identified concerns with the Paramedic. After successful completion of the Remediation process, the Paramedic may practice independently at the qualified level of their Certification and Authorization.

2.0 References

2.1 Regional Base Hospital Performance Agreement

2.2 Ministry of Health, Emergency Health Regulatory and Accountability Branch Advanced Life Support Patient Care Standards version 4.6, Appendix 6 as updated from time to time.

2.3 *Ambulance Act* Ontario Regulation (O.Reg.) 257/00

3.0 Policy

3.1 The Ministry of Health (MOH) Emergency Health Regulatory and Accountability Branch (EHRAB) publishes the Advanced Life Support Patient Care Standards (ALS PCS) with amendments from time to time. The Certification Standard is Appendix 6 of the ALS PCS and outlines definitions, processes and requirements of parties involved in the Certification and Authorization of Ontario Paramedics. The ALS PCS Appendix 6 will serve as the policy as related to Remediation.

4.0 Procedure

4.1 Remediation may be required as a result of:

4.1.1 Deactivation (clinical or administrative);
4.1.2 Identification of an ALS PCS related Patient Care Concern via:
4.1.3 Quality assurance activities;
4.1.4 Incident analyses/reviews/investigations;
4.1.5 Observation of clinical practice (e.g. CME performance, rideouts);
4.1.6 Failure to successfully complete the requirements for the maintenance of Certification.

4.2 Written notification of a Remediation will be provided to the Paramedic and the Employer as soon as possible after the concern is identified.

4.3 Remediation will include:

4.3.1 Identification of the concern related to knowledge, patient care or maintenance of Certification;

4.3.2 Determination of the goals and objectives based on the identified concerns;
4.3.3 Determination of the process to obtain the specified goals and objectives;
4.3.4 Consultation with the Employer and Paramedic to further develop the goals and objectives;
4.3.5 Determination of measures to demonstrate that the goals and objectives have been achieved;
4.3.6 The potential consequence(s) for failure to successfully complete the Remediation as prescribed.

4.4 The completion of Remediation should not normally exceed ninety (90) days.

4.5 Extensions to Remediation will be granted at the sole discretion of the Medical Director, taking into consideration events such as but not limited to: vacation, injury and absences from work. Extensions to Remediation are exceptions, and not an inherent right. In situations where an extension to Remediation has been granted, the Paramedic and the Employer will be notified in writing by the Medical Director within two (2) Business Days of this decision. Notification will include acceptance of the request for the extension and the length of time for this extension. If at any time the Paramedic has questions or concerns regarding their Remediation, they may contact the Regional Base Hospital Program (RBHP).

4.6 The Medical Director shall notify the Paramedic and Employer in writing within three (3) Business Days of the successful completion of the Remediation.

5.0 Appendices

None

6.0 Regional Program Manager/Director Signature

CPER POLICY MANUAL

Date Issued: **October 2019**	Policy Number: **2019-C-017**
Revision History Dates: October 2019	
Title: **Consolidation Policy**	

1.0 Purpose

1.1 Consolidation provides the opportunity for the Paramedic to integrate all components of assessment, treatment plans, critical thinking, skills, mentorship and confidence while providing a support mechanism as they transition to independent practice in the clinical setting. After successful completion of the Consolidation period, the Paramedic may practice independently at the qualified level of their Certification and Authorization.

2.0 References

2.1 Regional Base Hospital Performance Agreement

2.2 Ministry of Health, Emergency Health Regulatory and Accountability Branch Advanced Life Support Patient Care Standards version 4.6, Appendix 6 as updated from time to time.

2.3 *Ambulance Act* Ontario Regulation (O.Reg.) 257/00

3.0 Policy

3.1 The Ministry of Health (MOH) Emergency Health Regulatory and Accountability Branch (EHRAB) publishes the Advanced Life Support Patient Care Standards (ALS PCS) with amendments from time to time. The Certification Standard is Appendix 6 of the ALS PCS and outlines definitions, processes and requirements of parties involved in the Certification and Authorization of Ontario Paramedics. The ALS PCS Appendix 6 will serve as the policy as related to Consolidation.

4.0 Procedure

4.1 The Medical Director shall require Consolidation on all new Certifications. A Medical Director may require Consolidation with respect to a Paramedic's Certification where the Paramedic is returning to practice, a Patient Care Concern has been identified in respect of the Paramedic, or as identified in the Paramedic's customized plan for Remediation.

Consolidation provides for the opportunity to acquire more skills and confidence while ensuring that a support mechanism is in place for the Paramedic. The Medical Director shall determine the requirements for the Consolidation, which includes the presence of another Paramedic, the level of qualification of that other Paramedic, and the restrictions of the Paramedic's practice in relation to the presence of that other Paramedic.

The Medical Director, in consultation with the Employer, shall determine the duration for the Consolidation. However, the duration for Consolidation on all new Certifications shall be a minimum of 36 hours for a Primary Care Paramedic (PCP) and a minimum of 168 hours for an Advanced Care Paramedic (ACP) or Critical Care Paramedic (CCP). The Medical Director shall provide notice of Consolidation and the requirements thereof in writing to the Paramedic and Employer

within two (2) Business Days. Any changes to the Consolidation by the Medical Director shall be communicated to the Paramedic and Employer immediately and any changes to the requirements thereof shall be provided in writing as soon as possible.

4.2 Paramedics in Consolidation may practice to the level of their Certification and Authorization only when they are partnered with a Paramedic of the same or higher level of Certification and Authorization whom also has a minimum of six (6) months of full-time equivalent experience. The partner of the Paramedic in Consolidation must be fully certified and authorized and in good standing with the Regional Base Hospital, and cannot have any Patient Care Concerns which is under ongoing investigation. The partner's role is to ensure appropriate patient care by providing support to the Paramedic in Consolidation for the duration of the patient contact.

4.2.1 In any rare or unforeseen event, e.g., an MCI, where the Paramedic in Consolidation is separated from their partner and is required to attend to a patient, the Paramedic in Consolidation may practice to the level of their Certification and Authorization. Following the completion of the call, the Paramedic in Consolidation must immediately notify their Regional Base Hospital, through the self-report process, and provide details of the circumstances surrounding this event and the management of their patient in this situation.

4.3 Number of Hours and Expected Length of Time to Complete Consolidation;
For all newly certified and authorized Paramedics, including Paramedics employed on a part-time or casual basis, the minimum number of hours of Consolidation in a clinical patient care role will be thirty six (36) hours for a PCP and one hundred and sixty eight (168) hours for an ACP or CCP. The maximum time allowed for a Paramedic to complete Consolidation, without a specified exemption from the Medical Director, is ninety (90) days following the Certification event.

Where the Consolidation is related to a Patient Care Concern that has been identified, or as part of a customized Remediation plan, the number of hours for Consolidation shall be determined by the Medical Director and will be completed as soon as possible.

The Consolidation period should not exceed ninety (90) consecutive days. Factors to consider in these situations may include the length of time away from active clinical patient care practice, the level of Certification and Authorization of the Paramedic, or the gravity of the incident that may have been under review where a Patient Care Concern has been identified.

4.4 Extensions to Consolidation;
Extensions to Consolidation will be granted at the sole discretion of the Medical Director, taking into consideration events such as but not limited to: vacation, injury, absences from work, identified clinical care concern(s). Extensions to Consolidation are exceptions, and not an inherent right. In situations where an extension to Consolidation has been granted, the Paramedic and the Employer will be notified in writing by the Medical Director within two (2) Business Days of this decision. Notification will include acceptance of the request for the extension and the length of time for this extension. If at any time the Paramedic has questions or concerns regarding their Consolidation, they may contact the Regional Base Hospital Program.

4.5 Tracking Documents and Reporting;
The Employer will submit that the Paramedic completed the required Consolidation hours in writing, to the Medical Director within three (3) Business Days of completion of the last scheduled shift of the Consolidation period.

4.6 Special Circumstances;
Where a Paramedic is employed with more than one Employer during Consolidation, the Paramedic will notify all respective Employer(s) and Regional Base Hospital Program(s) that they are in Consolidation, and will submit their hours completed from each Employer towards their Consolidation requirements.

4.7 Concluding Consolidation;
The Medical Director will determine whether or not to remove the condition of Consolidation on the Certification and Authorization of the Paramedic. If the Medical Director deems that the Paramedic has completed the Consolidation hours in a clinical patient care setting, the Paramedic and the Employer will be notified in writing within three (3) Business Days of receipt of the documentation outlining that the Paramedic can practice independently to the level of their Certification and Authorization. Should the Medical Director deem that the Paramedic has not met the requirements of Consolidation, the Paramedic and the Employer will be notified in writing outlining the rationale for the decision, required next steps and the Certification and Authorization status of the Paramedic within three (3) Business Days of receiving the documentation from the Employer or Paramedic.

5.0 Appendices
None

6.0 Regional Program Manager/Director Signature

CPER POLICY MANUAL

Date Issued: **October 2019**	Policy Number: **2019-C-018**
Revision History Dates: October 2019	
Title: **Cross Certification Policy**	

1.0 Purpose

1.1 To allow Cross Certification for core and auxiliary medical directives from another Regional Base Hospital Program (RBHP) in Ontario. Cross-Certification applies to Paramedics who are currently certified and in good standing with a RBHP and has no unresolved patient care investigations in that RBHP, who are seeking certification from another RBHP.

2.0 References

2.1 Regional Base Hospital Performance Agreement

2.2 Ministry of Health, Emergency Health Regulatory and Accountability Branch Advanced Life Support Patient Care Standards version 4.6, Appendix 6 as updated from time to time.

2.3 *Ambulance Act* Ontario Regulation (O.Reg.) 257/00

3.0 Policy

3.1 The Ministry of Health (MOH) Emergency Health Regulatory and Accountability Branch (EHRAB) publishes the Advanced Life Support Patient Care Standards (ALS PCS) with amendments from time to time. The Certification Standard is Appendix 6 of the ALS PCS and outlines definitions, processes and requirements of parties involved in the Certification and Authorization of Ontario Paramedics. The ALS PCS Appendix 6 will serve as the policy as related to Cross Certification.

3.2 The following requirements apply with respect to Paramedics who are already certified and who are seeking Certification by a Medical Director in another RBHP.

3.2.1 The Paramedic shall be employed or retained by an Employer within the specified catchment area.

3.2.2 The Paramedic shall complete a form provided by the RBHP that includes the following:

3.2.2.1 a list of all RBHPs under which the Paramedic has received Certification within the ten (10) year period immediately preceding the application;

3.2.2.2 a declaration of the dates of all previous Deactivations and/or Decertifications that have occurred within the ten (10) year period immediately preceding the application;

3.2.2.3 status of all current Certifications from all RBHPs; and

3.2.2.4 written permission for the prospective RBHP to obtain information in writing from other physicians, other programs, etc. regarding the Paramedic's previous practice.

3.2.3 The Paramedic shall successfully complete an evaluation by the RBHP and any orientation and training required by the RBHP. The evaluation may include:
- 3.2.3.1 an assessment of knowledge and skills;
- 3.2.3.2 scenario evaluation; and
- 3.2.3.3 oral interview or clinical evaluation with the Medical Director or designate.

3.3 Upon meeting the above requirements for Cross Certification, the Medical Director shall certify the Paramedic.

4.0 Procedure

4.1 The Employer will notify their RBHP in writing or through an online form where available at the earliest opportunity to confirm any new Paramedics being employed who may be eligible for Cross Certification, and the earliest date they will be available for orientation (at least ten (10) Business Days advanced notice is requested).

4.2 If the Paramedic being employed or retained by the Employer is currently certified with another RBHP, a new Certification form must be completed at least ten (10) Business Days prior to the scheduled Certification event. A Regional Base Hospital Program may choose to integrate this form within a local electronic process. Add link where relevant.

4.3 Each application for Cross Certification will be reviewed by the Regional Base Hospital Program. The RBHP will perform a gap analysis based on the Paramedic's current level of Certification and the requested level of Certification as it relates to auxiliary medical directives.

4.4 This may result in an individualized education plan that will be facilitated at a mutually agreed upon time between the Employer and the RBHP. The Certification requirements (if any), based on the gap analysis will be provided in writing to each Paramedic and Employer within ten (10) Business Days upon the receipt of the completed new Certification form.

4.5 The RBHP will provide any required pre-course materials to each Paramedic once the orientation is confirmed. Materials may be distributed in a format as determined by the RBHP. Successful completion of all pre-course materials is required prior to attending the orientation day.

4.6 RBHP orientation may include:

4.6.1 an introduction to RBHP policies applicable to the Paramedic;

4.6.2 all auxiliary medical directives performed by Paramedics in that service, excluding PCP Autonomous IV and associated Medical Directives;

4.6.3 Medical Director or delegate directed scenarios; and/or

4.6.4 skills assessment.

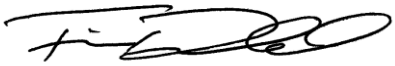
4.7 The RBHP will notify the Paramedic and Employer of the results in writing within three (3) Business Days.

4.8 A Certification and Authorization document will be issued for the Paramedic and Employer, which will include the Paramedic scope of practice and Certification expiry date.

5.0 Appendices

None

6.0 Regional Program Manager/Director Signature



CPER POLICY MANUAL

Date Issued: **October 31, 2011**	Policy Number: **2019-D-001**
Revision History Dates: May 2013, August 2014, August 2017, July 2019	
Title: **Confidentiality of Information**	

1.0 Policy

1.1 All CPER staff, Medical Council or delegate will keep patient information confidential as per the *Personal Health Information Protection Act* (PHIPA).

2.0 References

2.1 *Ambulance Act* Ontario Regulation (O.Reg.) 257/00

2.2 Basic Life Support Patient Care Standards (BLS PCS)

2.3 MOHLTC Documentation Standards

2.4 *Personal Health Information Protection Act* (PHIPA)

2.5 Regional Base Hospital Performance Agreement

3.0 Procedure

3.1 All CPER staff, Medical Council or delegate will maintain all information whether written or oral confidential as per the CPER Confidentiality Agreement and the PHIPA.

3.2 All CPER staff, Medical Council or delegate will sign the "CPER Confidentiality Agreement" as identified in the Appendix upon commencement of employment.

3.3 Any breach of confidentiality by any CPER staff, Medical Council or delegate must be immediately reported to the CPER Regional Program Manager/Director.

3.4 It is the responsibility of the CPER Regional Program Manager/Director to monitor and enforce this policy. In the event of a breach in policy, the event will be reported to Hamilton Health Sciences (HHS), the host hospital.

3.5 HHS has incorporated the requirements of PHIPA into its policies and procedures for the access and treatment of confidential patient and staff information. It is the responsibility of all employees accessing patient information to become familiar with and adhere to these provisions. Any fraudulent application, violation of confidentiality or any other violation of the above provisions may result in disciplinary action up to and including termination from employment, and/or, fines for liability under PHIPA.

4.0 Appendices

4.1 CPER Confidentiality Agreement

5.0 Regional Program Manager/Director Approval Signature

Hamilton Health Sciences CENTRE FOR PARAMEDIC EDUCATION AND RESEARCH	**Appendix A**
CPER POLICY MANUAL	
Date Issued: **October 31, 2011**	Policy Number: **D-001**
Revision History Dates: May 2013, August 2014, August 2017, July 2019	
Title: **Confidentiality of Information**	

Confidentiality Agreement

1. During, and after the performance of my duties at the Center of Paramedic Education Research, I shall not disclose to any person or entity any Confidential Information or use any Confidential Information, or cause such Confidential Information to be disclosed or used, except.

    a. as required by my job specification or functions at the Base Hospital; or

    b. with the prior written authorization of the Director, Emergency Health Services Branch (the "Director"), Ministry of Health and Long-Term Care (the "Ministry"); or

    c. with respect to disclosure, as is required by law.

2. In this Confidentiality Agreement, "Confidential Information" means information that comes within either section 2(a) or section 2(b):

    a. information, material, data and items, in any form or format and whether written or oral or otherwise transcribed ("information"), that,

        i. is related in any way to the business or activities of the Base Hospital; and

        ii. is not generally available to the public; and,

        iii. if disclosed or used by me, in breach of section 1, could result in any kind of prejudice, loss or damage to the Ministry, the Government of Ontario, or to any person or entity to whom the information relates, or could give the person or entity to whom the Confidential Information is disclosed an improper or unfair advantage or benefit;

    b. the following information, acquired by me during the course of the performance of my duties at the Base Hospital:

        i. "personal information", as defined under the *Freedom of Information and Protection of Privacy Act*, R.S.O. 1990, c. F.31;

        ii. "personal health information", as defined under the *Personal Health Information Protection Act, 2004*; and

iii. "quality of care information", as defined under the *Quality of Care Information Protection Act, 2004*.

3. Except as otherwise provided above, Confidential Information does not include information that,

    a. is known to the public at the time such information is made available to me other than through any breach by me of this Confidentiality Agreement;

    b. becomes known to the public only after the time such information is made available to me other than through any breach by me of this Confidentiality Agreement.

By signing this Confidentiality Agreement, below, I confirm that I fully understand the terms of the Confidentiality Agreement and agree that I will abide by all such terms.

_____
Signature

_____
Print Name & Position

_____
Date

_____
Witness's signature

_____
Print Witness's name

CPER POLICY MANUAL

Date Issued: **October 31, 2011**	Policy Number: **2019-D-002**
Revision History Dates: May 2013, August 2014, August 2017, July 2019	
Title: **Security of Confidential Information**	

1.0 Policy

1.1 CPER complies with the *Personal Health Information Protection Act* (PHIPA).

1.2 All information containing Personal Health Information (PHI) must be kept secure at all times.

1.3 Security measures for PHI include locking information, ensuring all exterior doors are securely locked when the office is closed.

1.4 All PHI information that is stored electronically is secured by a firewall, antivirus software, in a locked room, and backups of the information are saved on tapes and retained as per **HITS – Acceptable Use of Information and Information Technology Policy**
(HITS – Acceptable Use of Information and Information Technology Policy)

2.0 References

2.1 Regional Base Hospital Performance Agreement
2.2 Personal Health Information Protection Act (PHIPA)
2.3 ICT – Acceptable Use of Information and Information Technology Policy - HHS

3.0 Procedure

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

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

3.3 All ACRs that contain any information are considered confidential and must be secured at all times.

3.4 CPER will immediately report any unauthorized use or disclosure of confidential information to Hamilton Health Sciences (HHS), the host hospital and the MoH Emergency Health Services (EHS).

4.0 Appendices

None

5.0 Regional Program Manager/Director Approval Signature

CPER POLICY MANUAL

Date Issued: **October 31, 2011**	Policy Number: **2019-D-003**
Revision History Dates: May 2013, August 2014, August 2017, July 2019	
Title: **Release of Confidential Information**	

1.0 Policy

1.1 Requests for release of confidential information will be directed to the CPER Regional Program Manager/Director.

1.2 The CPER Regional Program Manager/Director will contact the Hamilton Health Sciences (HHS) Chief Privacy Officer.

2.0 References

2.1 *Personal Health Information Protection Act*
2.2 Regional Base Hospital Performance Agreement
2.3 Hamilton Health Sciences PRI-Privacy Policy

3.0 Procedure

3.1 Requests for confidential information will be directed to the HHS Privacy Office at privacy@hhsc.ca by the CPER Regional Program Manager/Director.

3.2 Confidential Information will be released to the Requestor, provided the request is approved by the HHS Chief Privacy Officer.

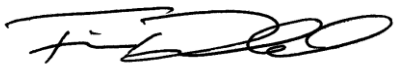
3.3 All release of information will be conducted via the office of the CPER Regional Program Manager/Director (or his/her designate).

3.4 Any appeal or concern to these procedures will be forwarded by the CPER Regional Program Manager/Director to the Hamilton Health Sciences' Chief Privacy Officer at privacy@hhsc.ca.

4.0 Appendices

None

5.0 Regional Program Manager/Director Approval Signature



CPER POLICY MANUAL

Date Issued: **October 31, 2011**	Policy Number: **2019-D-004**
Revision History Dates: May 2013, August 2014, August 2017, July 2019	
Title: **Electronic ACR Data / ACR PDF**	

1.0 Policy

1.1 The Centre for Paramedic Education and Research (CPER) receives ACR data from Employers for integration into the CPER database. In addition, CPER receives a copy of the Ambulance Call Report (ACR) PDF file.

2.0 References

2.1 ACR Documentation Standard
2.2 *Ambulance Act* Ontario Regulation (O.Reg.) 257/00
2.3 Ontario Emergency Medical Services Minimum Data Set
2.4 Regional Base Hospital Performance Agreement

3.0 Procedure

3.1 CPER will receive electronic ACR data via a VPN connection to the data source in order to integrate the data into the CPER database. CPER will retain a copy of the ACR PDF within a secure server.

3.2 CPER will monitor and provide feedback to Employers with regards to the timeliness of their electronic ACR data and ACR PDFs reaching CPER's servers.

3.3 CPER will monitor the quality of electronic ACR data that is received to ensure that all required data points are available.

3.4 Once the designated provincial warehouse database has been developed, CPER will forward the applicable minimum set to the designated provincial data warehouse.

4.0 Appendices

None

5.0 Regional Program Manager/Director Approval Signature

CPER POLICY MANUAL	
Date Issued: **September 2014**	Policy Number: **2019-D-005**
Revision History Dates: August 2017, July 2019	
Title: **Retention of Base Hospital Information**	

1.0 Policy

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

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

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

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

2.0 References

2.1 Regional Base Hospital Performance Agreement
2.2 Hamilton Health Sciences CORP – Information and Records Management Guidelines
2.3 Freedom of Information and Protection of Privacy Act (FIPPA)

3.0 Procedure

3.1 Hard Copy Ambulance Call Reports

3.1.1 Retained in a date order filing system for a minimum of 32 years from call date or date of death

3.2 Electronic Ambulance Call Reports

3.2.1 Onsite – Previous year plus current quarter

3.3 Paramedic Files

3.3.1 Retained for a minimum of 10 years after departure of Paramedic tenure with Employer

3.4 Audit Clarifications / Follow up with Paramedic

3.4.1 Retained for a minimum of 10 years in the audit database and/or on email electronic file

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

3.5.1 Retained for 7 years plus current fiscal year.

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

3.6.1 Retained in the CPER office and/or on CPER / HHS servers for a minimum of 3 years.

3.7 Base Hospital Human Resource Documents – including staff files

3.7.1 Retained in the CPER office and/or on CPER/HHS servers for a minimum of 3 years from the date of departure

4.0 Appendices

None

5.0 Regional Program Manager/Director Approval Signature

CPER POLICY MANUAL

Date Issued: **July 2019**	Policy Number: **2019-E-001**
Revision History Dates: September 2014, July 2019	
Title: **Service Request for CME Credits**	

1.0 Policy

1.1 The Centre for Paramedic Education and Research (CPER) values ensure adherence to the MoH Performance Agreement. Congruent to this statement, CPER offers education with Continuing Medical Education (CME) credits both in class and by distance education.

1.2 Employers deliver education to Paramedics during the course of the year that may include medical content. Employers may elect to apply to CPER for CME credit for this medical content on behalf of all Paramedic participants.

1.3 CME credits may be awarded for Employer delivered education when the information is medically relevant to Paramedics, medically accurate and enhances Paramedic practice.

1.4 In order for curriculum to be considered, Employers must submit a written request for CME credits to the CPER Education department within 16 weeks of the first scheduled date of instruction. This will provide enough time for review, feedback, edits and material approval from CPER Medical Council.

1.5 Minimum credit of 2 hours will be considered.

2.0 References

2.1 Advanced Life Support Patient Care Standards (ALS PCS)

2.2 Basic Life Support Patient Care Standards (BLS PCS)

2.3 CPER Medical Directives

3.0 Procedure

3.1 Topics/Objectives: Employers must submit a list of CME topics and objectives to the CPER Education Department within 16 weeks of the first scheduled date of instruction. CPER will respond with endorsement and/or feedback from CPER Medical Council within 2 weeks.

The course name, starting date, and amount of CME credits requested should be included with the topic/objective request.

3.2 Curriculum:
Following Topic and Objective approval, all supporting material(s) which include medical content must be forwarded to CPER Education for review within 12 weeks of the first scheduled training date.

3.3 CPER will respond with endorsement, feedback and/or edits to material from CPER Medical Council within 4 weeks of receipt of information.

3.4 The number of credits may or may not equal the hours actually spent completing the CME depending on course content. CPER is the only organization authorized to allocate CME credits for maintenance of Certification.

3.5 Approval of CME credits needs to be received prior to starting these educational activities if the Employer is seeking credit on behalf of all participants.

4.0 Regional Program Manager/Director Approval Signature

CPER POLICY MANUAL

Date Issued: **October 2014**	Policy Number: **2019-E-002**
Revision History Dates: August 2017, August 2019	
Title: **Maintenance of Training Equipment**	

1.0 Policy

1.1 The Centre for Paramedic Education and Research (CPER) offers education events onsite and at Paramedic Service training locations. Equipment used for these events may require maintenance after each educational event.

2.0 References

2.1 Regional Base Hospital Performance Agreement

3.0 Procedure

3.1 Training equipment will be inspected prior to use when training is conducted onsite in the CPER Training Room.

3.2 Training equipment will be inspected prior to loading for transport when training is conducted offsite at Paramedic Service training locations.

3.3 Any equipment that is deemed unsafe shall be immediately removed from service, tagged and reported to the Lead Paramedic Educator as soon as possible.

3.4 Any equipment that is damaged and able to be repaired immediately shall be repaired and returned to service.

3.5 Any equipment that is damaged and not able to be repaired immediately shall be removed from service, tagged and reported to the Lead Paramedic Educator as soon as possible.

3.6 All equipment shall be cleaned, inspected and properly stored following all educational events.

4.0 Appendices

None

5.0 Regional Program Manager/Director Signature

CPER POLICY MANUAL

Date Issued: **May 2019**	Policy Number: **2019-E-003**
Revision History Dates: May 2019	
Title: **Inclement Weather Policy**	

1.0 Purpose & Goal

1.1 Inclement weather has been the cause of course cancellation at the Centre for Paramedic Education and Research (CPER) education events. While every effort is made to deliver these courses, under some circumstances, it is simply unsafe for CPER Educators/Instructors to travel within our geographical area. CPER also recognizes that a considerable amount of time, effort and planning is put into the development and scheduling of these educational events, not to mention the associated financial impacts to all parties. In recognition of the aforementioned, CPER will make every effort to run these educational events as scheduled.

1.2 CPER offers education events onsite and at Employer training locations. When delivering CPER education events the Instructors are legally CPER employees and therefore CPER must mitigate safety concerns.

2.0 References

2.1 Environment Canada Weather Information: www.weather.gc.ca

3.0 Policy

3.1 In the event of concern of inclement weather, the decision to cancel an event will be at the discretion of CPER's Regional Program Manager/Director, in collaboration with CPER's Lead Paramedic Educator. This decision will be based on the use of a variety of information sources including, but not limited to the following:

3.1.1 Environment Canada Weather Information www.weather.gc.ca

3.1.2 Reports of road and highway conditions/closures in the area

3.1.3 School boards and/or bus routes closures in the area

3.2 Every effort will be made to communicate event cancellations within 24 hours prior to the start of the event. As this may not always be possible, CPER reserves the right to cancel the event up to and including, the start of the event.

3.3 If the educational event has already begun and there is severe or worsening weather in the area, CPER reserves the right to cancel an event while in progress. This decision will be made in consultation with the Employer(s) affected.

3.4 Once a decision to cancel has been made, CPER's Regional Program Manager/Director or CPER's Lead Paramedic Educator will contact the affected Employer(s) of the decision. CPER will not be held financially responsible for any Paramedic wages related to the cancellation.

3.5 If a mandatory educational event has been cancelled due to inclement weather, CPER will make every effort to reschedule the event to a future date that is mutually agreeable to CPER and the Employer(s) affected. If it is not possible to reschedule the event, CPER will ensure that there is alternative means for completion of the event (i.e. eModules, viewing a recorded version of the event).

3.6 CPER reserves the right to cancel the event entirely, but will attempt to reschedule the event to a future date that is mutually agreeable to CPER and the Employer(s) affected. Regular class attendance requirements must be met.

4.0 Appendices

None

5.0 Regional Program Manager/Director Signature

CPER POLICY MANUAL

Date Issued: **January 1, 2011**	Policy Number: **2019-Q-001**
Revision History Dates: October 31, 2011 May 2013, August 2014, August 2017, July 2019	
Title: **Regional Quality Assurance (QA) and Continuous Quality Improvement (CQI) Program**	

1.0 Policy

1.1 The Centre for Paramedic Education and Research (CPER) is responsible for ensuring that a Quality Assurance (QA) and Continuous Quality Improvement (CQI) program is in place. This program must encompass each Paramedic that is employed or engaged by an Employer.

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

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

2.0 References

2.1 ACR Documentation Standard
2.2 Advanced Life Support Patient Care Standards (ALC PCS)
2.3 Basic Life Support Patient Care Standards (BLS PCS)
2.4 CPER Medical Directives
2.5 Regional Base Hospital Performance Agreement
2.6 CPER Policy - Q-005 Investigation P&P

3.0 Procedure

3.1 CPER will regularly receive ACRs and/or eACRs from all Employers under their designated jurisdiction as per the ACR Documentation Standard.

3.2 Upon receipt of the ACRs and/or eACRs, CPER will perform clinical audits according to a statistically relevant sample that Paramedics have performed. Any individual Patient Care Concern of an ALS PCS nature may be subject to an investigation process as outlined in Policy Q-005.

3.3 Any BLS PCS concerns that are found during the clinical audit will be forwarded to the appropriate Employer.

3.4 If during the clinical audit there is a Patient Care Concern discovered, the Paramedic may be contacted with regards to the concern via email, telephone and the local Employer will be notified as agreed upon.

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

4.0 Appendices

None

5.0 Regional Program Manager/Director Approval Signature

CPER POLICY MANUAL

Date Issued: **October 31, 2011**	Policy Number: **2019-Q-002**
Revision History Dates: May 2013; June 2014, August 2017, July 2019	
Title: **Patient Care Omission or Commission Reporting**	

1.0 Policy

1.1 In the event of a patient care, Omission or Commission the Paramedic will report the incident to the Emergency Department Physician, Base Hospital and their Employer.

2.0 References

2.1 Advanced Life Support Patient Care Standards (ALS PCS)

2.2 Basic Life Support Patient Care Standards (BLS PCS)

2.3 CPER Medical Directives

2.4 CPER Policy Q-006 Paramedic Interview Policy

3.0 Procedure

3.1 When an Omission or Commission involving a Controlled Act is recognized, the Paramedic will closely observe the patient for any adverse reaction and prepare to intervene to treat the patient. In the event of a medication, Commission the Paramedic will check for allergies to the medication.

3.2 The Paramedic should consider consulting with the Base Hospital Physician (BHP) for guidance if the patient is still under the care of the Paramedic when the Commission is recognized.

3.3 When an Omission is recognized, the Paramedic will move forward with the appropriate treatment plan if it is safe and reasonable to do so.

3.4 If the patient care Omission or Commission is recognized by the non-attending Paramedic, they will immediately notify the attending Paramedic of the incident.

3.5 Upon arrival at hospital, the Paramedic will advise the Emergency Department staff or physician upon transfer of care report, of the Omission or Commission and any efforts to treat the effects of the incident.

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

3.7 The Paramedic will concurrently notify the Employer and CPER of the incident. The notification to CPER may be accomplished by the CARE report system, email, voicemail or by speaking directly to a Quality Specialist. The Paramedic will include the call date and run number in any communication concerning the incident.

3.8 Refer to the CPER Quality Program Process Map and CAREreport Process Map for further details regarding Paramedic communication to CPER (Quality Program Map, CAREreport Process Map).

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

3.10 The call will be evaluated via the call review process. The review may include an interview with the Paramedics, allied agencies, patient, patient's family and the Emergency Department staff (see CPER Policy Q-006)

3.11 After review of the incident, one or more courses of action will occur:

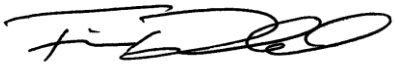
3.11.1 Close the file after providing feedback to the Paramedic
3.11.2 Provide remediation to the Paramedic
3.11.3 Conduct a clinical evaluation of the Paramedic
3.11.4 Deactivate the Paramedic pending remediation
3.11.5 Other appropriate action

3.12 Upon completion of the recommendation, the file will be closed and a copy of the final report may be forwarded to the Emergency Health Services (EHS) Field Office where applicable.

4.0 Appendices

None

5.0 Regional Program Manager/Director Approval Signature



CPER POLICY MANUAL

Date Issued: **October 31, 2011**	Policy Number: **2019-Q-004**
Revision History Dates: May 2013, August 2014, August 2017, July 2019	
Title: **Investigation of Patient Care Complaints**	

1.0 Policy

1.1 CPER will work cooperatively with the Employer(s) to investigate patient care complaints.

1.2 Any complaint that is reported to CPER by an external stakeholder will be shared with the Employer. CPER's primary responsibility will be to investigate patient care that is performed under the ALS PCS.

2.0 References

2.1 Advanced Life Support Patient Care Standards (ALS PCS)
2.2 Basic Life Support Patient Care Standards (BLS PCS)
2.2 CPER Medical Directives
2.3 Regional Base Hospital Performance Agreement

3.0 Procedure

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

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

3.3 If the complaint involves the ALS PCS, CPER will initiate the Call Review process as outlined on the CPER website (CPER Call Review Process Map)

3.4 The Employer may request that CPER review complaints involving BLS PCS at their discretion.

4.0 Appendices

None

5.0 Regional Program Manager/Director Approval Signature

CPER POLICY MANUAL

Date Issued: **October 31, 2011**	Policy Number: **2019-Q-005**
Revision History Dates: May 2013, August 2014, August 2017, July 2019	
Title: **Investigation Policy**	

1.0 Policy

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

1.2 CPER will gather all relevant information in order to fully review the patient care. Information reviewed may include; ACR or eACR, incident reports, patch and dispatch audio, ECG strips and uploaded ECG files. The review may include an interview with the Paramedics, allied agencies, patient, patient's family and the Emergency Department staff.

2.0 References

2.1 Advanced Life Support Patient Care Standards (ALS PCS)
2.2 Basic Life Support Patient Care Standards (BLS PCS)
2.3 Regional Base Hospital Performance Agreement
2.4 CPER Remediation Policy – C-016

3.0 Procedure

3.1 Upon receiving an internal or external concern, CPER will review the event to decide if the concern is in regards to a delegated medical act or ALS PCS. Concerns that relate to Employer operational issues or BLS PCS issues will be forwarded to the Employer. Concerns that involve delegated medical acts or ALS PCS may be investigated by CPER in collaboration with the Employer.

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

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

3.4 The CPER Quality Specialist will compose a draft investigation report.

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

3.6 During the Quality Review Committee (QRC) meeting, identified concerns will be reviewed and Omissions or Commissions (if applicable) will be assigned. If no Omissions or Commissions are assigned, the case will be closed and feedback will be provided to the Paramedic and Employer.

3.7 Remediation based on ALS PCS will follow CPER Policy (C-016) and will be communicated in writing to the Paramedic and Employer.

3.8 Upon completion of the Remediation by the Paramedic, the CPER Educator will complete the Remediation report and send the report to the CPER Quality Specialist.

3.9 The CPER Quality Specialist will close the file and inform the Paramedic and the Employer in writing that the Remediation is complete and that the file is closed.

4.0 Appendices

None

5.0 Regional Program Manager/Director Approval Signature

CPER POLICY MANUAL

Date Issued: **September 2014**	Policy Number: **2019-Q-006**
Revision History Dates: September 2014, August 2017, July 2016, July 2019	
Title: **Paramedic Interviews**	

1.0 Policy

1.1 The purpose of the Paramedic interview is to gather information related to a Paramedic's practice. A Paramedic interview may be requested to be completed with CPER's Quality Team and/or Medical Council or delegate.

2.0 References

2.1 Advanced Life Support Patient Care Standards (ALS PCS)

2.2 Basic Life Support Patient Care Standards (BLS PCS)

2.3 CPER Medical Directives

2.4 CPER Investigation Policy Q-005

3.0 Procedure

3.1 This process is initiated when CPER's Quality Review Committee (QRC) and/or CPER's Medical Council identifies that an interview is necessary.

3.2 When a Paramedic interview is required, the CPER Quality Specialist or delegate will request via email that the Paramedic(s) identified is interviewed to further evaluate potential concerns. The Paramedic(s) will be notified about the nature of the interview and requirement for information.

3.3 The Paramedic(s) will also be notified that all corresponding documents required for the interview will be provided with the opportunity to review. This initial request will be sent to the main contact email address as provided by the Paramedic(s) with the Employer copied on the e-mail.

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

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

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

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

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

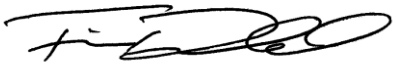
3.8.1 If a response is received from the Paramedic, an extension to the time frame may be granted upon written request of the Paramedic for extenuating circumstances.

3.8.2 If no response is received, dependent upon the seriousness of the concerns identified, the Paramedic may be deactivated until the interview is completed.

4.0 Appendices

None

5.0 Regional Program Manager/Director Approval Signature



CPER POLICY MANUAL

Date Issued: **January 1, 2011**	Policy Number: **2019-Q-007**
Revision History Dates: October 31, 2011 May 2013, August 2014, August 2017, July 2019	
Title: **Online Medical Control Quality Review**	

1.0 Policy

1.1 CPER will review a sample of Base Hospital Physician (BHP) contacts between the Paramedic and the BHP.

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

2.0 References

2.1 *Ambulance Act* Ontario Regulation (O.Reg.) 257/00
2.2 Advanced Life Support Patient Care Standards (ALS PCS)
2.3 Basic Life Support Patient Care Standards (ALS PCS)
2.4 CPER Medical Directives
2.5 Regional Base Hospital Performance Agreement
2.6 CPER Policy – Regional QA and CQI Q-001

3.0 Procedure

3.1 Each month, the Base Hospital receives a predetermined number of patch audio recordings from each of the 3 dispatch centers in the CPER catchment area.

3.2 Patch recordings are electronically filed by dispatch center / year / month for reference.

3.3 The patches will be matched to the corresponding eACR; findings of the Medical Quality Review are forwarded to the CPER Medical Director for subsequent BHP Continuing Medical Education (CME), as required.

3.4 If an individual finding requires BHP attention, the CPER Medical Director will advise the identified BHP accordingly for Remediation. The CPER Medical Director will log details of the Remediation in the BHP file.

3.5 If an individual finding requires Paramedic attention, the CPER Quality team will review for appropriate action as per CPER Policy (Q-001)

4.0 Appendices

4.1 Copy of BHP Patch Form
4.2 CQI Process for Base Hospital Physician Patches

5.0 Regional Program Manager/Director Approval Signature

Hamilton Health Sciences CENTRE FOR PARAMEDIC EDUCATION AND RESEARCH	**Appendix A** **Q-007** **Medical Control Log Quality Review**

Hamilton Health Sciences
CENTRE FOR PARAMEDIC EDUCATION AND RESEARCH

430 McNeilly Road, Unit 201
Stoney Creek, L8E 5E3
Telephone: (905) 643-1103
Fax: (905) 643-1104

Date: _____ **Time of Call:** _____

☐ ACP ☐ PCP Paramedic ID (OASIS #): _____

EMS Service:

☐ Brant	☐ Dufferin	☐ Guelph-Wellington
☐ Haldimand	☐ Hamilton	☐ Niagara
☐ Norfolk	☐ Six Nations	☐ Waterloo

Call Information:

Age: _____ ☐ Male ☐ Female
☐ VSA ☐ CP ☐ SOB ☐ SEIZURE
☐ OTHER: _____

Patient information and/or paramedic management:

Orders by BHP:

☐ Termination of Resuscitation (TOR) **Time:** _____

For PCP Medical TOR, must meet all three of the following:

☐ Unwitnessed (by EMS) ☐ No Shocks ☐ No ROSC

BHP Name: _____

BHP Number: _____

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

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

↓

Patch audio is selected for review in three ways:

Random selection by matching the call report with the patch audio	Selected based on concerns received by the BHP or Paramedic involved in the call	As part of a formal internal or external investigation into a call
↓	↓	↓
During the call review process the patch audio will be matched for a proportion of calls where a Base Hospital Physician patch was performed. A random selection will be reviewed by the chart reviewer or designate.	Upon receipt of a concern from a BHP or Paramedic the call report will be located and the patch audio will be reviewed in conjunction with the call. Should there be further review required an investigation may be initiated.	During the course of a formal investigation into a call the patch audio may be reviewed in order to provide additional details for the investigation. Review of patch audio during investigation is on an as needed basis.

↓

Review of the BHP patch will include:

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

The End