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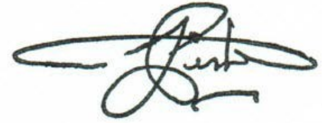
All clinical policies included in this package are approved by the Provincial Medical Director, Ambulance Services Unit, New Brunswick Department of Health.



Dr. Tushar Pishe, MD, CCFP(EM), FCFP
Provincial Medical Director/ directeur médical provincial
Ambulance & Transport Services Planning / Plannification des services d'ambulance et de transport
Department of Health / Ministère de la Santé

Policy No.: 2100.01	Policy Title: Essential Competencies	Type: Policy
Effective Date: December 2007	Latest Review Date: January 2021	

1. Purpose
1.1. To provide

2. Definitions
None

3. Policy
Primary Care Paramedic (PCP)

1. Professional Responsibilities
   1.1. Function as a professional.
   1.2. Participate in continuing education.
   1.3. Possess an understanding of the medicolegal aspects of the profession.
   1.4. Recognize and comply with relevant provincial and federal legislation.
   1.5. Function effectively in a team environment.
   1.6. Make decisions effectively.
2. Communication
   2.1. Practice effective oral communication skills.
   2.2. Practice effective written communication skills.
   2.3. Practice effective non-verbal communication skills.
   2.4. Practice effective interpersonal relations.
3. Health and Safety
   3.1. Maintain good physical and mental health.
   3.2. Practice safe lifting and moving techniques.
   3.3. Create and maintain a safe work environment.
4. Assessment and Diagnostics
   4.1. Conduct triage.
   4.2. Obtain patient history.
   4.3. Conduct complete physical assessment demonstrating appropriate use of inspection, palpation, percussion and auscultation, and interpret findings.
   4.4. Assess vital signs.
   4.5. Utilize diagnostic tests.
      4.5.1. Conduct oximetry testing and interpret findings.
      4.5.2. Conduct glucometric testing and interpret findings.
      4.5.3. Conduct 3-lead electrocardiogram (ECG) and interpret findings.
5. Therapeutics
   5.1. Maintain patency of upper airway and trachea.
      5.1.1. Use manual Maneuvers and positioning to maintain airway patency.
      5.1.2. Suction oropharynx.
      5.1.3. Utilize oropharyngeal airway.
      5.1.4. Utilize nasopharyngeal airway.
      5.1.5. Remove airway foreign bodies (AFB).
   5.2. Prepare oxygen delivery devices.
   5.3. Deliver oxygen and administer manual ventilation.
   5.4. Utilize ventilation equipment.
   5.5. Provide oxygenation and ventilation using bag-valve-mask.
   5.6. Recognize indications for mechanical ventilation.
   5.7. Implement measures to maintain hemodynamic stability.
   5.8. Conduct cardiopulmonary resuscitation (CPR).
   5.9. Control external hemorrhage through the use of direct pressure and patient positioning.

- 5.10. Maintain peripheral intravenous (IV) access devices and infusions of crystalloid solutions without additives.
- 5.11. Conduct automated external defibrillation.
- 5.12. Provide routine care for patient with urinary catheter.
- 5.13. Provide basic care for soft tissue injuries.
- 5.14. Immobilize actual and suspected fractures.
- 5.15. Administer medications.
  - 5.15.1. Recognize principles of pharmacology as applied to the medications listed in Appendix 5.
  - 5.15.2. Follow safe process for responsible medication administration.
  - 5.15.3. Administer medication via subcutaneous route.
  - 5.15.4. Administer medication via intramuscular route.
  - 5.15.5. Administer medication via sublingual route.
  - 5.15.6. Administer medication via oral route.
  - 5.15.7. Administer medication via inhalation.

6. Integration
   - 6.1. Utilize differential diagnosis skills, decision-makings skills and psychomotor skills in providing care to patients.
   - 6.2. Provide care to meet the needs of unique patient groups.
   - 6.3. Conduct ongoing assessments and provide care.
7. Transportation
   - 7.1. Prepare ambulance for service.
   - 7.2. Drive ambulance or similar type vehicle.
   - 7.3. Transfer patient to air ambulance.

Appendix 5 Medications

- A. Mediations affecting the central nervous system.
  - a. Opioid Antagonists
  - b. Non-narcotic analgesics
- B. Medications affecting the autonomic nervous system.
  - a. Adrenergic Agonists
  - b. Antihistamines
- C. Medications affecting the respiratory system.
  - a. Bronchodilators
- D. Medications affecting the cardiovascular system.
  - a. Antianginal Agents
- E. Medications affecting blood clotting mechanisms.
  - a. Platelet Inhibitors
- F. Medications used to treat electrolyte and substrate imbalances.
  - a. Antihypoglycemic Agents

“E-Skill s”

Performance of E-Skills must be endorsed by the Provincial Medical Director. Only practitioners licensed as a Primary Care Paramedic are eligible for E-Skill endorsement.

Emergency Medical Technician (EMT)

1. Asses and manage the health crisis scene.
2. Perform a primary patient survey.
3. Maintain the patency of the upper airway, and if necessary, use oropharyngeal airway adjuncts and suctioning.
4. Perform basic management of breathing dysfunctions including:
   - a. Administration of oxygen using mask or nasal cannula,
   - b. Use of bag-valve-mask unit.
5. Recognize external and internal hemorrhage and apply basic management techniques.
6. Administer cardiopulmonary resuscitation (CPR) to an adult, child or infant.
7. Recognize the indications for and demonstrate the application of automatic external or semi-automated defibrillation.

8. Take, record and communicate an organized and appropriate patient history.
9. Perform a secondary patient survey.
10. Perform chest auscultation to assess the presence and equality of air entry.
11. Provide appropriate psychological support to a patient.
12. Provide basic care for wounds and environmental injuries.
13. Perform appropriate immobilization techniques for actual and suspected fractures.
14. Recognize and provide basic management of medical emergencies, including recognizing indications for rapid transport.
15. Maintain peripheral intravenous locks or infusions without medications or blood products; calculate, monitor and adjust flow rates; recognize and manage complications of intravenous catheters and infusions.
16. Provide routine care during transport for common drainage or feeding tubes, excluding chest tubes.
17. Recognize the indications for and administer oral glucose.
18. Manage emergency childbirth, including postnatal, maternal and neonatal care and transport.
19. Demonstrate rapid triage skills and abbreviated clinical assessment and rapid transport in management of trauma patients.
20. Use appropriate management techniques for a patient undergoing an emotional and/or possible mental health crisis.
21. Demonstrate basic understanding of extrication principles, and apply techniques for appropriate packaging and safe removal of an entrapped patient.
22. Use lifting and moving techniques (biomechanics) essential to appropriate patient care and safety of the prehospital care practitioner.
23. Operate an ambulance in accordance with patient needs and public safety.
24. Demonstrate an understanding of the concept of medical control and medical direction in the provision of prehospital care.
25. Demonstrate a basic understanding of the legal considerations in the provision of prehospital care.

4. Appendices

None

5. References

7.1 Competency Requirements for Graduates of Educational Programs in Paramedicine (Levels I, II and III), 1997. A publication of the Canadian Medical Association and the Conjoint Committee for the Accreditation of Educational Programs in Paramedicine.

7.2 National Occupational Competency Profiles for Paramedic Practitioners, Paramedic Association of Canada, June 2001.

Policy No.: 2101.03	**Policy Title:** Concerns with On-Line Medical Consultation Directives	**Type:** Policy
Effective Date: December 2007	**Latest Review Date:** January 2021	

1. Purpose

1.1. To provide a means of resolution of any conflict between the calling paramedic and the On-Line Medical Consultation (OLMC) physician.

2. Definitions

None

3. Policy

3.1. OLMC must be considered when advice is necessary for complicated patient conditions, when deviation from protocol may be required, or as directed by protocol.

3.2. OLMC physicians are to be considered the primary decision maker when consulted. If agreement cannot be reached on a course of action, communicate this to the OLMC physician and stay within your scope of practice and operational policies, and transport patient.

3.3. If you feel the physician's orders will exceed your scope of practice or compromise the patient's condition, communicate this to the OLMC physician and stay within your scope of practice and operational policies, and transport patient.

3.4. Upon completion of the call document case in writing, sign it and send in a Special Case Envelope to the Training and Quality Assurance Department who will consult with the Provincial Medical Director (PMD).

3.5. The PMD and Training and Quality Assurance Department will investigate all reported incidents received in writing and report back to the paramedics involved and OLMC.

4. Appendices

None

5. References

None

Policy No.: 2102.03	**Policy Title:** Loss of Communication or Inability to Access On-Line Medical Consultation	**Type:** Policy
Effective Date: December 2007	**Latest Review Date:** January 2021	

1. Purpose

1.1. To provide guidance to paramedics and a means of tracking loss of communication or inability to access On Line Medical Consultation (OLMC).

2. Definitions

None

3. Policy

3.1. When a technological communication failure or the inability to obtain guidance from OLMC occurs, the written protocols should be followed. If no protocols exist paramedics must stay within their scope of practice and operational policies.

3.2. Upon completion of the call document the case in writing, including times, sign it and send in a Special Case Envelope to the Training and Quality Assurance Department who will consult with the Provincial Medical Director (PMD).

3.3. The PMD and Training and Quality Assurance Department will investigate all reported incidents received in writing and report back to the paramedics involved and OLMC.

4. Appendices

None

5. References

None

Policy No.: 2103.03	**Policy Title:** Reporting Patient Safety Incidents	**Type:** Policy
Effective Date: December 2007	**Latest Review Date:** January 2021	

1. Purpose

1.1. To ensure the prompt reporting and investigation of occurrences involving deviation from patient care standards.

2. Definitions

2.1. Patient Safety Incident means an unintended event that:

2.1.1. Occurs when health services are received by a patient, and

2.1.2. Contributes to or results in, or could have contributed to or resulted in, harm to the patient or the death of the patient.

3. Policy

3.1. Occurrences that must be reported include, but are not limited to:

3.1.1. Unexpected death while under the care of paramedics;

3.1.2. Unintended deviation from standard protocols, guidelines, policies, procedures and/or medication profiles;

3.1.3. Failure of equipment that results or could have resulted in care less than the accepted standard.

4. Procedure

4.1. Monitor the patient closely during and after an occurrence;

4.2. Contact On-Line Medical Consultation for direction if there are concerns regarding the patient's condition;

4.3. Consider diversion to the nearest hospital if appropriate;

4.4. Report the situation to the receiving facility staff;

4.5. Document the occurrence on the PCR and Supplemental Form (if required) and have receiving facility staff sign the document(s) to acknowledge the occurrence was reported;

4.6. Report the incident to immediate supervisor upon completion of the call.

5. Appendices

None

6. References

6.1 Health Quality and Patient Safety Act

Policy No.: 2105.03	**Policy Title:** Medical Documentation	**Type:** Policy
Effective Date: December 2007	**Latest Review Date:** January 2021	

1. Purpose
1.1. To outline the standards for medical documentation.

2. Definitions
None

3. Policy
3.1. A Patient Care Report (PCR) must be completed on all calls where there is patient contact. This includes all patients assessed, transported, DOA and patient refusals.

3.2. PCRs must accurately document all assessment findings and treatment rendered as well as any special circumstances encountered pertinent to each patient; and in accordance with the ANB Patient Care Record Manual.

3.3. A Refusal Form must be completed and attached to the PCR in all cases where a patient refuses assessment and/or treatment and/or transport

3.4. The white copy of the PCR is to be left at the receiving facility for all transported patients. The pink copy is to be maintained by the Service Provider.
3.5. For DOA see policy 2116
3.6. ECG strips (12 Lead) are to be attached to the PCR.
3.7. In cases where an Advanced Care Paramedic has transferred care to the PCP crew, the ACP's documentation must be attached to the PCP crew's PCR.
3.8. When the destination is not a hospital or Nursing Home, the white and pink copy are to be retained by the Service Provided.

REMEMBER: Your records are medicolegal documents that may be very important in a court of law.

4. Appendices
None

5. References
5.1. Policy 2116: Death in the Field – Mandatory Coroner, Police, or Extra-Mural Contact

Policy No.: 2107.03	**Policy Title:** Standardized Communication	**Type:** Policy
Effective Date: December 2007	**Latest Review Date:** January 2021	

1. Purpose

1.1. To outline expectations for transmitting relevant patient information to the receiving hospital by radio in a brief, concise manner.

2. Definitions

None

3. Policy

3.1. **Keep it brief!** Advise the emergency department **as early as possible** of your pending arrival, especially with trauma patients.

3.2. **Report details:**

3.2.1. Unit number.
3.2.2. Age and sex of patient.
3.2.3. Chief complaint.
3.2.4. Brief history of current presentation.
3.2.5. Treatment and effects.
3.2.6. Vital signs**.**
3.2.7. Estimated Time of Arrival (ETA).

4. Appendices

None

5. References

None

Policy No.: 2108.03	**Policy Title:** Verbal Report During Hand Off Care	**Type:** Policy
Effective Date: December 2007	**Latest Review Date:** January 2021	

1. Purpose

1.1. To outline expectations for providing relevant patient information to the receiving nurse and/or physician.

2. Definitions

None

3. Policy

3.1. **Report details:**

3.1.1. Identification.

3.1.2. Mechanism.

3.1.3. Injuries/Illness.

3.1.4. Sings (Vitals).

3.1.5. Treatment and trends.

3.1.6. Allergies.

3.1.7. Background information.

3.1.8. Other information.

3.2. Provide a copy of the Patient Care Record and any other documentation regarding the patient (i.e. 12 lead ECG, test results, etc.).

4. Appendices

None

5. References

None

Policy No.: 2109.03	**Policy Title:** Treatment of Minors	**Type:** Policy
Effective Date: December 2007	**Latest Review Date:** January 2021	

1. Purpose

1.1. To provide the policy for dealing with minors.

2. Definitions

A person attains a particular age, expressed in years, at the commencement of that anniversary of the date of his or her birth.

2.1. Medical consent of minors: persons who have attained the age of majority applies, in all respects, to minors who have attained the age of sixteen (16) years.

3. Policy

3.1. Paramedics may be called to treat a young patient when there is no parent or qualified guardian present who is responsible for the minor.

3.2. The paramedic may treat and/or transport, under the doctrine of implied consent, any minor who requires immediate care to save a life or prevent serious injury.

3.3. Minors who have attained the age of sixteen (16) years are able to provide consent when the paramedic believes the minor is capable of understanding the nature and consequences of the medical treatment, and the medical treatment is in the best interest of the minor.

3.4. If a minor refuses care but in the paramedic's judgement needs that care, the paramedic should attempt to contact the parent or qualified guardian and OLMC, and/or police for assistance if necessary.

3.5. Parents or qualified guardians and minors are to be kept together whenever possible.

4. Appendices

None

5. References

5.1. Age of Majority Act.
5.2. Medical Consent of Minors Act
5.3. Infirm Persons Act.
5.4. Mental Health Act.

Policy No.: 2110.04	**Policy Title:** Health Care Professional On Scene	**Type:** Policy
Effective Date: August 2008	**Latest Review Date:** January 2021	

1. Purpose

1.1. To outline the rules and responsibilities of paramedics and physicians/nurses at the scene of any emergency.

2. Definitions

None

3. Policy

3.1. Control of an emergency situation should be the responsibility of the individual in attendance who is most appropriately trained and knowledgeable in providing pre-hospital emergency stabilization and transport. On your arrival, a paramedic/patient relationship is established between the patient and the paramedic providing Care. The paramedic is responsible for the management of the patient and acts as a patient advocate unless the patient's personal physician is present.

3.1.1. Physician or Nurse On Scene:

- If the physician only wishes to help or orders are in agreement with protocols decide on roles and work collaboratively.
- If the on-scene physician deviates from ANB protocol give card (see Appendix A) to physician/clinician with brief explanation.
    - The on-scene physician must agree to take responsibility for patient care and accompany patient to hospital. This may not be possible in a multiple casualty situation.
    - The on-scene physician will be asked to sign the Patient Care Report (PCR).
- If paramedic has concerns regarding the physician's care and/or directives, and/or patient safety, contact OLMC for consultation with the on-scene physician.
- If a nurse wishes to help, it must be according to ANB protocols. If the nurse wishes to deviate from ANB protocols give card (see Appendix A) to nurse with brief explanation that paramedics must maintain primary responsibility for the patient and continue to follow the protocols.

4. Appendix

4.1 "Physician-On-Scene" Card and "Nurse-On-Scene" Card

5. References

None

Appendix: 4.1	**PDN**: 2110.03	**Last Updated**: January 2021	**Subject**: Health Care Professional On Scene	**Page 1 of 1**

"Physician-On-Scene" Card

ANB

As a physician at an emergency scene you may assume or decline responsibility for the patient.

The Paramedics are fully qualified and are working under Protocols.

If you wish to be involved we welcome your help. If your treatment differs from our protocols you will be required to sign the Patient Care Record and accompany the patient to the hospital.

"Nurse-On-Scene" Card

ANB

Registered nurses, who choose to stop at an accident scene to provide emergency medical assistance, can be of assistance to Paramedics. RNs are responsible and accountable for their actions and can be used as a resource at the scene.

Provincial Medical Director
Emergency Health Services
NB Department of Health

Policy No.: 2111.05	**Policy Title:** No Transport	**Type:** Policy
Effective Date: October 2023	**Latest Review Date:** September 2022	

1. Purpose

1.1 To provide paramedics with guidelines for circumstances where no transport takes place.

2. Definitions

2.1 Patient refusal:

2.1.1 A *patient refusal* describes the situation whereby a fully informed and competent adult patient (greater than or equal to 16 years), with no outside influence or coercion, chooses against treatment and/or transport to hospital. Legal guardians for patients under 16 years old or those with medical decision-making capabilities may make a refusal determination on behalf of the patient.

2.2 Pre-ALRT:

2.2.1 Paramedic-led no-transport decisions are based on low-acuity presentations. Paramedics apply the Prehospital Early Warning Score (PHEW), and either the Medical Pathway or the Trauma Pathway document and may be directed to consult with a Clinical Support Practitioner (CSP) to determine if a patient should be transported by ambulance or consider alternative care options.

2.3 Other:

2.3.1 Other patient types such as those referred to colloquially as “treat & release”, “lift-assist” or “wellness check” must be treated like all other patients. They all require an appropriate assessment, but ultimately will fall into one of the following categories:

- Treated & transported (PCR);
- Patient Refusal (PCR & Refusal Form);
- Pre-ALRT (PCR, PHEW).

3. Policy

3.1 Patient Refusal:

3.1.1 The paramedic must determine whether the patient has the necessary capacity to provide consent;

3.1.2 As is the case with consent, refusal of treatment and/or transport to hospital must be informed;

3.1.3 If the patient has decision-making capacity, the paramedic must clearly inform the patient of their medical condition, the paramedic’s advice, and the consequences of refusing treatment and/or transport;

3.1.4 When an informed patient continues to refuse, and in the paramedic’s judgement requires the treatment and/or transport, the paramedic should enlist the help of family/friends whenever possible;

3.1.5 If unsuccessful, the paramedic may wish to call the Clinical Support Practitioner (CSP) to determine the patient’s CTAS score. Calling On-line Medical Consultation (OLMC) is also an option. Note: While OLMC physicians offer medical advice, CSPs will only offer their opinion regarding transport based on an appropriate assessment and the resulting CTAS score (Canadian Triage and Acuity). Neither the OLMC physicians nor the CSPs speak directly with the patient;

3.1.6 Discuss alternative healthcare options including a call back to 9-1-1 if the condition changes;

3.1.7 Paramedics may treat and/or transport a patient without consent only when the illness or injury is life or health-threatening and requiring immediate attention, the patient is incapable of giving consent, and no qualified family or guardian is immediately available to provide consent;

3.1.8 In cases where the paramedic believes the patient is at risk of harming themselves or someone else, police must be contacted;

3.1.9 Social Services is requesting transport of a person who refuses:

3.1.9.1 A person who is not competent may be transported against their will if the Public Trustee requests (based on Part III of the Family Services Act). It is advisable to involve police in most, if not all, of these cases.

3.2 Pre-ALRT:

3.2.1 Paramedics who feel their patient may be better served by seeking an alternative clinical pathway other than ambulance transport and whose presentation appears low-acuity may apply Pre-ALRT;

3.2.2 Complete a full assessment and apply the vital signs to the PHEW. If the patient's total score is five or greater post assessment and/or treatment(s), the patient is to be transported. If the initial total score changed from five (or greater) to four (or less) as the result of treatment, a call to the CSP is required;

3.2.3 If the PHEW score is four or less, apply either the Medical Pathway or the Trauma Pathway document and follow its direction;

3.2.4 If it is necessary to consult with the CSP, provide detailed assessment findings including vital signs, the PHEW score, and any relevant history. The consult process and application of the Prehospital CTAS will determine transport decisions. CTAS 1, 2 and 3 are to be transported. CTAS 4 and 5 are eligible for non-transport.

3.2.4.1 When making transport decisions, paramedics should take into account other factors such as the patient's age, their ability to independently maneuver through alternative healthcare options, and their level of home support.

3.2.5 If it is necessary to consult with the CSP, provide detailed assessment findings and be collaborative in the decision-making process;

3.2.6 If non-transport by ambulance is the determination, provide the patient with the rationale and a copy of the Government of New Brunswick post-assessment instructions document. Remind them that they may call 9-1-1 at any time if their condition changes.

4. Documentation:

4.1 Patient Refusal

4.1.1 A PCR must be filled out and must include all scene and physical assessment details, including vital signs, relevant patient history, and any treatment provided;

4.1.2 A Refusal Form must be completed by the paramedic and signed by the patient and submitted with the PCR. The form must include:

- Possible diagnosis;
- Possible prognosis;
- Consequences of refusal of assessment, treatment, transport;
- A detailed description of physical findings and any treatment provided;
- The paramedic's recommended treatment and/or for transport;
- Confirmation of the patient's capacity to refuse;
- The patient's reason(s) for refusal, and
- Any other advice (i.e. follow-up) given by the paramedic.

4.2 Pre-ALRT

4.2.1 A PCR must be completed and include all scene and physical assessment details, including vital signs, PHEW score, consult details, relevant patient history and any treatment provided.

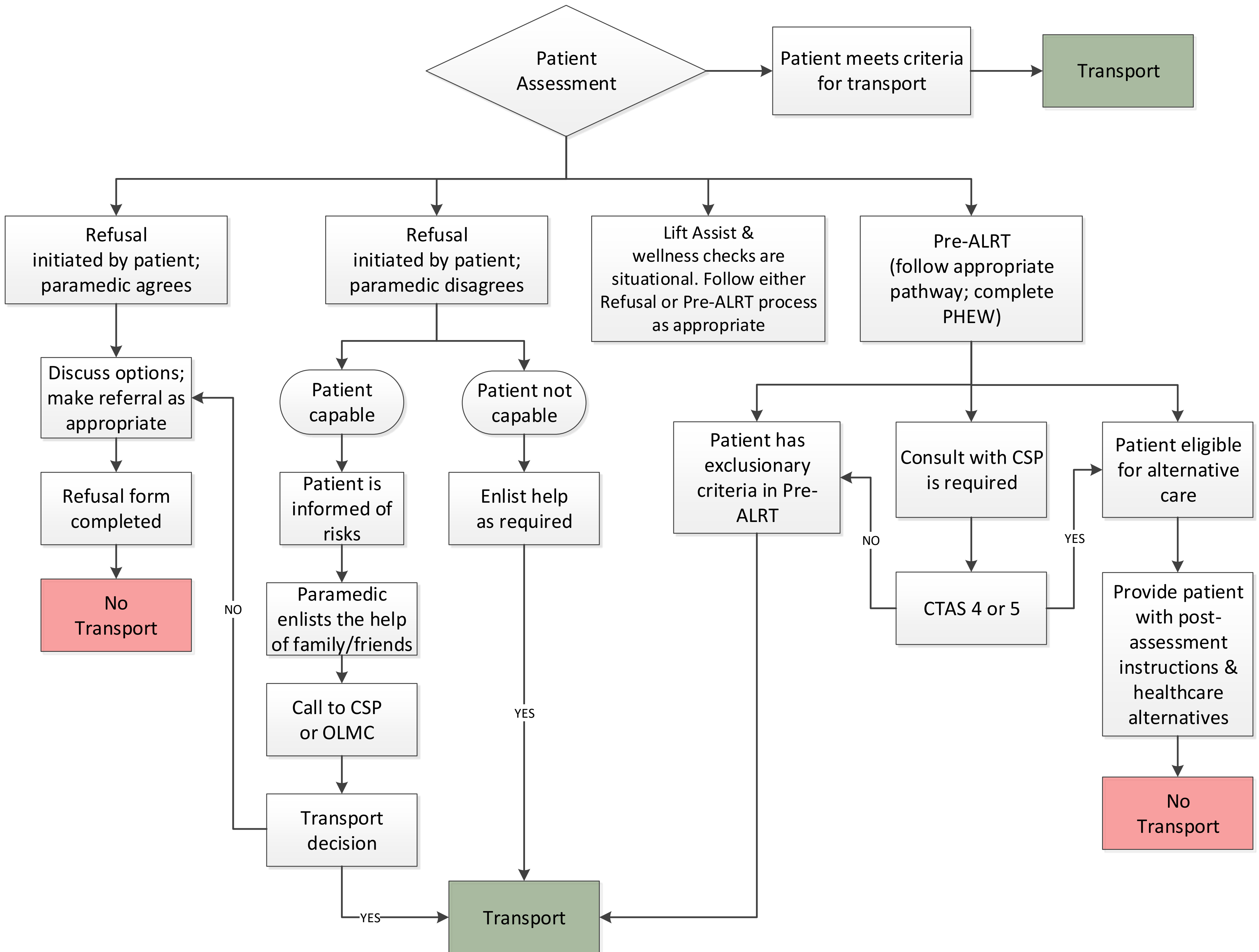
4.2.1.1 Place the documentation in a Special Case envelope at the end of shift.

4. Appendices

4.1 Prehospital Early Warning Score (PHEW)
4.2 Medical and Trauma Pathway documents
4.3 No transport algorithm

5. References

None



September 27, 2022

Policy No.: 2112.04	**Policy Title:** Advance Health Care Directive	**Type:** Policy
Effective Date: January 2008	**Latest Review Date:** January 2021	

1. Purpose

1.1. To provide appropriate care to patients with an Advance Health Care Directive.

2. Definitions

2.1. **Advance Health Care Directive:** outlines the degree of care or treatment (from full resuscitation to comfort care) to be provided to the associated patient, and may include a proxy, applicable notifications, and any other information regarding the patient's values, beliefs, and wishes. A Do Not Resuscitate (DNR) order may be considered an Advance Health Care Directive. An Advance Health Care Directive comes into effect when the patient no longer has capacity to make, or to communicate informed decisions,

2.2. **Proxy** is a person appointed by the maker of a health care directive to make decisions on their behalf.

3. Policy

3.1. If you are presented with, an Advance Health Care Directive that is signed and dated, honor it,

3.2. If a copy available, attach it to the Patient Care Record,

3.3. If you are made aware of an Advance Health Care Directive but the document is not available, the paramedic may honor it. The details provided must be documented on the PCR as well as the name of the individual providing the information,

3.4. If, in the paramedic's opinion, the validity of the directive is questionable, or the directive(s) are unethical, the paramedic is not obligated to comply with the directive(s).

4. Appendices

None

5. References

5.1. Advance Health Care Directive Act

Policy No.: 2114.07	**Policy Title:** Withholding Resuscitation	**Type:** Policy
Effective Date: January 2008	**Latest Review Date:** January 2021	

1. Purpose

1.1. To offer options for withholding resuscitation efforts in the prehospital setting for patients meeting defined criteria associated with negative outcomes.

2. Definitions

2.1. Resuscitation is defined as basic and/or advanced airway management and CPR.
2.2. ROSC is return of spontaneous circulation.

3. Policy

3.1. In circumstances where one or more of the following criteria is met, resuscitation efforts may be withheld. **There is no need to contact OLMC**:

3.1.1. Risk to the health and safety of the EMS providers;

3.1.2. Evidence of prolonged cardiac arrest (e.g. rigor mortis, decomposition, post mortem lividity);

3.1.3. Injuries incompatible with life;

3.1.4. Confirmation of an Advance Health Care Directive that states no resuscitation;

Special Considerations:
Unless clear evidence of irreversible death exist, resuscitation efforts may be undertaken and continued en route in the following circumstances:

- Patients under 18 years of age
- Possible SIDS (Sudden Infant Death Syndrome)
- Evidence of Hypothermia
- Pregnancy

Note: It is appropriate to withhold resuscitation for hypothermic patients in the following circumstances:

- Submersion for greater than one hour;
- Temperature less than 10° C;
- The patient exhibits signs of being frozen (such as ice formation in the airway);
- Chest wall rigidity such that compressions are impossible;

3.2. Paramedics must stay on scene until responsibility for the deceased has been transferred to law enforcement or EMP personnel in the case of expected death.

3.3. As necessary, provide support to family members / bystanders and provide options for support services (i.e. community support group, clergy, family services agency) and provide explanation of procedure for the deceased (i.e. transfer of responsibility to law enforcement or EMP, transport of deceased by appropriate agency, reason for withholding of resuscitative efforts).

3.4. Documentation requirements:

3.4.1. Patient presentation, physical findings and circumstances of the incident in addition to the usual patient care report information;

3.4.2. Reason for withholding efforts;

3.4.3. Time and date of assessment;

3.4.4. Action / treatment completed;

3.4.5. Name and agency of professional accepting responsibility for the deceased.

4. Appendices

None

5. References

5.1. Policy 2116: Death in the Field – Mandatory Coroner, Police, or Extra-Mural Contact
5.2. Policy 2112: Advance Health Care Directive
5.3. Guidelines for Withholding or Termination of Resuscitation in Prehospital Traumatic Cardiopulmonary Arrest: A National Association of EMP Physicians Position Paper. Prehospital & Emergency Care, Jan/March 2003, 7(1) p 141-6.

Policy No.: 2115.10	**Policy Title:** Cessation of Resuscitative Efforts	**Type:** Policy
Effective Date: June 2016	**Latest Review Date:** January 2021	

1. Purpose

1.1. To offer options for the cessation of resuscitative efforts in the prehospital setting for patients meeting defined criteria associated with negative outcomes.

2. Definitions

2.1. ROSC: return of spontaneous circulation.

3. Policy

3.1. At the 20-minute mark, $EtCO_2$ readings should be measured following two full breaths without chest compressions.

3.2. Resuscitative efforts may be ceased after approval from on-line medical consultation (OLMC) as outlined in the algorithm.

3.3. In some cases where the criteria for ceasing resuscitation are met, the paramedics may choose to continue resuscitation efforts and transport the patient if they are of the opinion that these efforts would be in the best interest of the patient, family or the general public.

3.4. Paramedics may choose to access OLMC for circumstances that are not described in these guidelines; however, resuscitation efforts must continue until OLMC approval is obtained.

3.5. Scene procedures:

3.5.1. Note circumstances surrounding the incident.

3.5.2. In cases where illegal activities and foul play is suspected, the scene should not be disturbed unnecessarily until law enforcement agencies take responsibility.

3.5.3. During resuscitation, if criteria are met to cease resuscitative efforts, contact OLMC to authorize the cessation of care and have MCMC contact the appropriate law enforcement agency.

NOTE: Resuscitation efforts <u>must</u> be continued until authorization for cessation of efforts has been received from the OLMC physician.

3.5.4. Paramedics should stay on scene until responsibility for the deceased has been transferred to law enforcement personnel.

3.5.5. Paramedics may disconnect ancillary equipment but must leave *in situ* devices in place for coroner's examination.

3.5.6. As necessary, provide support to family members/bystanders and provide options for support services (i.e. community support group, clergy, family services agency) and provide explanation of procedure for the deceased (i.e. transfer of responsibility to law enforcement, transport of deceased by appropriate agency, reason for cessation of efforts).

3.6. Documentation requirements:

3.6.1. Patient presentation, physical findings and circumstances of the incident in addition to the usual patient care report information;

3.6.2. Reason for the cessation of resuscitative efforts;

3.6.3. $EtCO_2$ level after 20 minutes of resuscitative efforts;

3.6.4. Time and date of cessation of resuscitative efforts;

3.6.5. Action/treatment completed prior to cessation of resuscitative efforts;

3.6.6. Name of OLMC physician;

3.6.7. Name of law enforcement agency personnel accepting responsibility for the deceased.

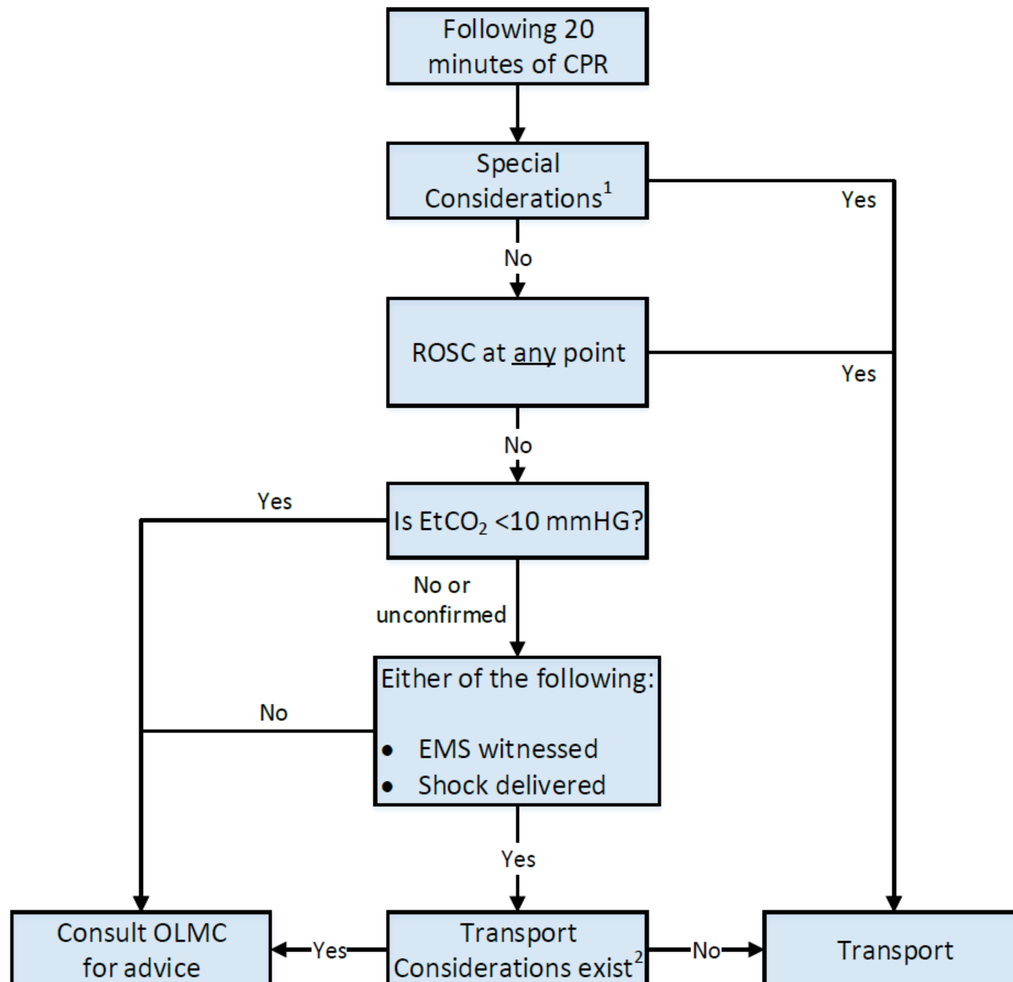
4. Appendices

4.1. Cessation of Resuscitative Efforts – Algorithm

5. References

5.1. Policy 2116: Death in the Field – Mandatory Coroner, Police, or EMP Contact
5.2. Policy 2112: Advance Health Care Directive
5.3. Guidelines for Withholding or Termination of Resuscitation in Prehospital Traumatic Cardiopulmonary Arrest: A National Association of EMP Physicians Position Paper. Prehospital & Emergency Care, Jan/March 2003, 7(1) p 141-6.

Appendix: A	2115.02	Last Updated: September 2019	Subject: Cessation of Resuscitative Efforts - Algorithm	Page: 1 of 1



[1]Special Considerations:
The following specific cases or circumstances should be given special consideration since they may alter the prognosis of the arrest. Unless clear evidence of irreversible death exists, resuscitative efforts must be undertaken and continued en route:

- Patients under 18 years of age
- Possible SIDS (Sudden Infant Death Syndrome)
- Evidence of hypothermia
- Pregnancy

[2]Transport Considerations:
In the even that your transport time (including extrication) is greater than 30 minutes, and no special considerations exist, contact OLMC for advice.

Policy No.: 2116.03	**Policy Title:** Death in the Field – Mandatory Coroner / Police Contact		**Type:** Policy
Effective Date: January 2008		**Latest Review Date:** September 2017	

1. Purpose

1.1. To discuss the many variations of pronouncement of death in the field and the situations when the Coroner must be involved.

2. Definitions

2.1. The Coroners Act Chapter C-23 is quoted for reference in the relevant sections:

4. Every person who has reason to believe that a person died
(a) as a result of:
(i) violence,
(ii) misadventure,
(iii) negligence,
(iv) misconduct, or
(v) malpractice;
(a1) during pregnancy or following pregnancy in circumstances that might reasonably be attributed to pregnancy;
(a2) suddenly and unexpectedly;
(a3) from disease or sickness for which there was no treatment given by a medical practitioner
(b) from any causes other than disease or natural causes; or
(c) under such circumstances as may require investigation;

shall, unless he knows that a coroner has already been notified, immediately notify a coroner of the facts and circumstances relating to the death.

9(4) A coroner may direct any peace officer to assist him in his investigation.

9(5) Every peace officer required under this section to assist a coroner in the investigation of a death shall, within such time as the coroner directs, submit to the coroner a report of the results of any investigation he may have conducted in respect to that death in a form acceptable to the coroner.

9.1(1) A coroner or a peace officer required under section 9 to assist him in the investigation of a death, where he believes on reasonable grounds that it is necessary to do so for the purposes of an investigation under section 9, may
(a) …
(b) inspect information in any records relating to the deceased or his circumstances, notwithstanding that the information or records may be confidential under the Act.

3. Policy

3.1. When a death occurs during transport from the scene following a 911 response paramedics will continue the transport to the intended destination and the necessary contact with the Coroner's office will be made with the assistance of the personnel at the destination facility.

3.2. When a death has occurred at the scene following a 911 response, and in accordance with the circumstances of the death described in section 4 of the Coroners Act, the following procedure will be followed:

- Paramedics will inform MCMC of the presumption of death.

- MCMC will contact local (or appropriate) law enforcement to respond to the scene.
- The Coroner will be notified of the death by MCMC.
- Paramedics are required to remain on-scene until the arrival of the Coroner or police unless remaining at the scene is a danger to themselves or others or there is an additional patient **at the same scene** that requires immediate transport.
- Paramedics are required to complete a PCR and submit the White Copy to either the Coroner at the scene or to a police officer who will relay the form to the Coroner.
- Paramedics may be required to provide additional information to the Coroner with respect to any death where they have attended (Coroners Act Section 9.1(1)).

3.3. Paramedics may disconnect ancillary equipment but must have *in situ* devices in place for Coroner's examination.

3.4. Special Circumstances:

3.4.1. Extra Mural Program Patients

- As soon as paramedics identify that the patient is with EMP, they must notify MCMC in order for other responding agencies (such as police) to be cancelled.

EMP professionals are responsible for managing their patients' care and have important information on the patients' wishes and care. When called for assistance, paramedics become part of the healthcare "team", and shall work collaboratively with EMP professionals to provide optimal care to the patient.

The Extra-Mural Program has policies and procedures related to a patient's death at home that were developed in collaboration with the Chief Coroner and physicians. The goal of the policies and procedures is to reduce undue strain and assist the family in the event of the patient's death.

The procedures provide clarity to EMP professionals when an EMP patient death occurs at home, and there is a Do Not Resuscitate/Do Not Attempt Resuscitation (DNR/DNAR) order on the patient's file, and the death is:

(1) Expected/explained,
(2) Unexpected/explained, or
(3) Unexpected/unexplained.

These procedures provide guidance to EMP professionals on when notification of the Coroner is required.

It is the responsibility of the EMP professional to determine whether contact with the Coroner's office is required.

- In cases identified as (1) or (2) above, the appropriate EMP Unit manager must be informed of the death by paramedics (if not already on scene) by obtaining the contact phone number from the family.

- In a case where the death is unexpected/unexplained (3) above, and which meets the notification requirements set out in Section 4 of the *Coroners Act*, it is reportable to the Coroner and police as per section 3.2 of this policy.

3.4.2. Foul Play Suspected

If foul play is suspected in the death of a patient in the field paramedics must ensure that minimal disturbance of the possible crime scene occurs consistent with delivering necessary care and determining that death has occurred.

3.4.3. On-Line Medical Control (OLMC) Involvement

Certain clinical circumstances mandate the involvement of OLMC. When OLMC has been involved in a termination of resuscitation in the field, the OLMC physician may also be involved in providing information to the Coroner.

3.4.4. Patients "Expected to Die"

The presence of an Advance Directive, Living Will, or Do Not Resuscitate (DNR) documents as well as information available at the scene may lead the paramedic to believe that the death was expected as a consequence of a disease process. In this case contact with the Coroner must still occur by the method outlined in 3.2; unless 3.3.1 applies.

4. Appendices

n/a

5. References

5.1. Policy 2112: Physician Do Not Resuscitate (DNR) Order or Advance Directives
5.2. Policy 2114: Withholding Resuscitation
5.3. Policy 2115: Termination of Resuscitative Efforts
5.4. Policy 2117: Palliative Care Patients
5.5. *Coroners Act*
5.6. Extra-Mural Policies (VI-A-10, VI-A-012, VI-A-040)

Policy No.: 2117.04	**Policy Title:** Palliative Care Patients	**Type:** Policy
Effective Date: January 2008	**Latest Review Date:** January 2021	

1. Purpose

1.1. To provide optimal and appropriate care to palliative care patients.

2. Definitions

2.1. Proxy: a person appointed in a health care directive to make decisions on behalf of the patient.

3. Policy

3.1. With these patients it is essential to determine the goals of care. Often, but not always, prolongation of life may not be appropriate.

3.2. If these patients are in extremis follow ANB protocols unless an Advance Health Care Directive exists or a proxy, or next of kin requests otherwise.

3.2.1. If the patient is an EMP palliative patient, please refer to Policy 2118.

3.3. When called to transport a patient in extremis to a palliative care bed in a Health Care Institution, and you wish to divert to an Acute Care setting for resuscitation, divert according to regular procedure. This will rarely be indicated as the goal of such a patient is death with dignity and comfort and not prolongation of life.

3.4. Do not use lights and siren.

3.5. If the patient dies while en route to hospital, continue to hospital. Do not remove patient from ambulance until clarifying with the Emergency Department how to proceed.

3.6. Paramedics may disconnect ancillary equipment but must have *in situ* devices in place for Coroner's examination.

4. Appendices

None

5. References

5.1. Policy 2112: Advanced Health Care Directive

Policy No.: 2118.00	**Policy Title:**	EMP Palliative Patients	**Type:** Policy
Effective Date: January 2020		**Latest Review Date:** January 2021	

1. Purpose

1.1. To outline the standards of patient assessment, care, reporting and documentation for Extra-Mural Program (EMP) palliative patients as part of an EM/ANB collaborative practice model.

2. Definitions

2.1. Extra-Mural Program palliative patient - an EMP patient diagnosed with a life-limiting illness who is palliative (life expectancy less than six months).

2.1.1. This does not include any other palliative patients.

2.2. EMP healthcare provider - any regulated healthcare practitioner affiliated with EMP, most commonly will be a Registered Nurse.

3. Policy

3.1. Paramedics will identify the EMP patient with a palliative diagnosis.

3.2. Paramedics will review the Shared Care Plan **when available** and consult with the patient's caregivers.

3.3. Paramedics will perform Primary and Secondary Assessments in accordance with Policy 2104: Clinical Responsibilities of Paramedics.

3.4. Paramedics will contact MCMC to consult with the EMP healthcare provider who is familiar with the patient.

3.4.1. If unable to contact the appropriate EMP healthcare provider, paramedics will follow the Shared Care Plan **when available** and may consult On-Line Medical Consultation (OLMC) if needed.

3.5. All paramedics will adhere to their scope of practice as defined by Policy 2100: Essential Competencies.

3.6. Paramedics will collaborate with the EMP healthcare provider to develop a Care Plan for symptom relief according to the Provincial Medical Protocols, Policy and Procedure Manual with the following considerations:

3.6.1. Where the patient has not followed their symptom management plan, paramedics may request that the EMP healthcare provider give advice to the patient or caregiver regarding medication administration.

3.6.2. If appropriate, medication may be administered via subcutaneous injection (Procedure 3020)

3.6.3. Paramedics will not operate any EMP equipment or devices.

3.6.4. The use of Naloxone (Narcan) is not recommended for palliative patients. In the case of respiratory depression related to opioid use, provide supportive care which may include oxygen and assisted ventilation with Bag-Valve-Mask (BVM).

3.6.5. Intubation / insertion of a supra-glottic airway is generally not appropriate in this patient population.

Dyspnea & Breathlessness

3.6.6. Oxygen is usually only administered to EMP palliative patients when SpO_2 is less than 90%;

3.6.7. Consider the implications of initiating oxygen therapy and the need for ongoing therapy.

Pain Management

3.6.8. Consider the use of Nitrous Oxide prn.

Secretions

3.6.9. In the event of copious secretions in the oropharynx, gentle anterior suction may be useful.

End-of-Life Care

3.6.10. Where there are no clear ‘Do Not Resuscitate’ (DNR) orders in place, follow Policy 2112, Physician Do Not Resuscitate (DNR) Order or Advanced Directive. Otherwise, follow the patient’s DNR or Advanced Directive as outlined in the Shared Care Plan;

3.6.11. Follow Policy 2116, Death in the Field - Mandatory Coroner / Police Contact following the death of an EMP palliative patient.

3.7. Paramedics will provide a verbal report to the EMP healthcare provider either in person or by telephone in accordance with Policy 2108, Verbal Report During Hand Off Care.

3.8. Documentation is to be completed in accordance with Policy 2105, Medical Documentation. Note that the following applies to EMP palliative patients who are not transported:

3.8.1. A Refusal Form is not required unless the paramedics feel transport is necessary and the family/patient state otherwise.

3.8.2. The **PCR** white copy will be kept by ANB paramedics, unless the EMP healthcare provider is present;

3.8.2.1. When the EMP healthcare provider is present, the white copy of the PCR will be given to them.

3.8.3. The PCR will be placed in a Special Case Envelope and mailed to head office.

4. Appendices

None

5. References

5.1. Policy 2104: Clinical Responsibilities of Paramedics

5.2. Policy 2100: Essential Competencies

5.3. Procedure 3020: Medication administration - subcutaneous

5.4. Policy 2112: Physician Do Not Resuscitate (DNR) Order or Advanced Directive

5.5. Policy 2116: Death in the Field - Mandatory Coroner / Police Contact

5.6. Policy 2108: Verbal Report During Hand Off Care.

5.7. Policy 2105: Medical Documentation

5.8. Policy 2111: Refusal of Care

5.9. Policy 2117: Palliative Care Patient

Policy No.: 2119.02	Policy Title: Trip Destination	Type: Policy
Effective Date: January 2021	Latest Review Date: January 2021	

1. Purpose

1.1. To provide guidance to paramedics on the choice of an appropriate destination for patients.

2. Definitions

None

3. Policy

3.1. Patients transported as a result of an emergency response (9-1-1) are routinely transported to the closest appropriate hospital.

3.2. Destination choices will also be in accordance with any provincial or local guidelines for specific patient types or conditions, or for incidences requiring diversion.

3.3. Requests from the patient, family or physician to not be transported to the nearest hospital may be accommodated provided the patient's outcome would not be adversely affected and approved by MCMC.

3.4. If in the paramedic's opinion accommodating the request will put the patient at risk, this must be clearly explained to the patient. If the patient continues to insist on the alternate destination, the paramedic must clearly document their opinion and that the patient was informed of the risk, however insisted upon the alternate destination, and have the patient sign the PCR.

3.5. Special patients will be transported according to directives on their Special Patient Card as applicable.

4. Appendices

None

6. References

None

Policy No.: 2120.04	**Policy Title:** Child Abuse	**Type:** Policy
Effective Date: January 2008	**Latest Review Date:** January 2021	

1. Purpose

1.1. To provide appropriate care, identify and report any child you suspected as a victim of child abuse.

2. Definitions

2.1. Child Abuse can include sexual abuse, physical abuse, physical neglect and emotional maltreatment. All residents of New Brunswick have a duty to report suspicions that a child may be abused or neglected. It is mandatory to report suspected child abuse and neglect of children under the age of nineteen (19)

3. Policy

3.1. You must report any child whom you have reasonable cause to suspect has been abused.

3.2. **POSSIBLE** Indications of abuse and neglect:

- Any injury – especially head or facial injuries – or bruising to a baby who is not yet crawling or walking;
- Injuries where there is no explanation, the explanation does not seem to fit with the injuries, or the story keeps changing;
- Bruising in unusual places
- The child not getting proper medical attention;
- Inadequate clothing to protect child from the weather;
- The child is looking unwell or hungry, or who complains of hunger, or who is unusually thin or malnourished;
- Child appears extremely aggressive, or withdrawn;
- Fear.

3.3. Professionals who report their suspicions are protected by law so that no legal action, based on breach of confidentiality or otherwise arising from release of the information, can be brought against them as long as they do not provide the information for a malicious reason and have reasonable and probable cause to believe the person is "in need of protection".

3.4. If you suspect child abuse:

3.4..1. Treat any medical concerns first – follow applicable medical protocols,

3.4..2. Do not question or accuse the caretaker,

3.4..3. Protect the child. If there is "refusal of care" by caretaker, the police should be contacted,

3.4..4. If you believe there is an immediate threat to the child, remain on-scene until police arrive,

3.4..5. If patient is transported, report suspicious findings to receiving hospital staff,

3.4..6. In cases of sexual assault, refer to Policy 2146 "Sexual Assault",

3.4..7. To report a case of a child whom you suspect has been abused, contact Child Protection Services/Department of Social Development at 1-888-99-ABUSE (1-888-992-2873) or after-hours emergency service line at 1-800-442-9799,

3.4..8. Document findings as impartial observations on physical exam and note that authorities were contacted (date, time, and name and agency of person spoken to).

4. Appendices

None

5. Reference

5.1. *Family Services Act*, Department of Social Development
5.2. *Age of Majority Act,* Office of the Attorney General
5.3. “Be Vigilant”, Child Protection, Department of Social Development; www.gnb.ca/socialdevelopment

Policy No.: 2121.04	**Policy Title:** Adult Abuse	**Type:** Policy
Effective Date: January 2008	**Latest Review Date:** January 2021	

1. Purpose

1.1. To provide appropriate care, identify and report any adult suspected as a victim of abuse.

2. Definitions

2.1. Abuse is defined as any action/inaction which jeopardizes another's health or well-being. It may include psychological/emotional abuse, physical, sexual or financial abuse/exploitation, chemical abuse and neglect.

2.2. Adult: a person who has reached the age of majority and ceases to be a minor on attaining the age of nineteen (19) years.

2.3. Elderly person or senior: one who has reached the age of 65 years, and, in the absence of positive evidence of age, means a person who apparently has reached that age.

3. Policy

3.1. **Possible** general indicators of abuse or neglect:

- Recurring physical ailments with no apparent explanation;
- Eating disorders;
- Extreme, unusual behavior (aggression, compliance, depression, or withdrawal)
- Unusual fear of a particular person or people
- Sudden change in feelings about a particular person or place;
- Self-destructive behavior;
- Lack of attachment to caregivers;
- Compulsive lying and/or confusion regarding personal reality;
- Regression to infantile behavior.

3.2. Professionals who report their suspicions are protected by law so that no legal action, based on breach of confidentiality or otherwise arising from release of the information, can be brought against them as long as they do not provide the information for a malicious reason and have reasonable and probable cause to believe the adult is "in need of protection".

3.3. If you suspect adult abuse:

3.3.1. Treat any medical concerns first.

3.3.2. Do not question or accuse the caretaker.

3.3.3. Whenever possible it is important to discuss the abuse/neglect issue privately with the patient. Document conversation on PCR and supplemental form (if required).

3.3.4. Be supportive.

3.3.5. In cases of sexual assault, refer to Policy 2146 "Sexual Assault".

3.3.6. If the patient **is capable** of consent and provides consent, a report shall be made to the receiving facility of any suspicions and observations.

3.3.7. If the patient **is capable** of consent however does not provide consent, information on resource options available should be provided to the victim for future reference ("Adult Victims of Abuse Protocols", section 10, appendix D).

Freedom of choice and confidentiality:
At all times paramedics should be sensitive to the patient's freedom of choice, and the need for confidentiality, however, paramedics must also be aware of their responsibility for reporting.

3.3.8. If the patient **is NOT capable** of consent a report shall be made to the receiving facility and/or Social Development of any suspicions and observations.

3.3.8.1. Protect the patient. If you suspect abuse and there is "refusal of transport", contact Access and Assessment Unit, Department of Social Development at 1-888-992-2873 or 1-800-442-9799 or Police.

3.3.8.2. The *Family Services Act* provides legal protection for a professional who uses a victim's name in a report without written consent. Physical and sexual abuse is assault and falls under the Criminal Code. Neglect also falls under the Criminal Code. Contact police if you suspect any of these or the patient is in danger of being harmed.

3.3.8.3. Document findings as impartial observations on PCR and note that authorities were contacted (date, time, and name and agency of person spoken to).

4. Appendices

None

5. References

5.1. *Family Services Act*, Department of Social Development
5.2. *Age of Majority Act,* Office of the Attorney General
5.3. "Adult Victims of Abuse Protocols", Department of Social Development; www.gnb.ca/socialdevelopment

Policy No.: 2122.04	**Policy Title:** Violent / Agitated Patients	**Type:** Policy
Effective Date: December 2007	**Latest Review Date:** January 2021	

1. Purpose

1.1. To provide optimal patient care while preventing harm to patients, caregivers and the public.

2. Definitions

None

3. Policy

3.1. Whenever possible protect patients' rights and dignity; treat the patient with respect.

3.2. Maintain a safe distance from the patient while attempting verbal intervention to calm and reassure the patient. If this fails, call Operational Manager and police for help/advice.

3.3. Be honest about your intentions and communicate in simple terms.

3.4. Be alert to warning signals of impending outbursts of violence – tense posture, loud threatening speech, increased agitation or hyperactivity, hostile body language.

3.5. Maintain your ability to escape a dangerous situation.

3.6. Assess safety to transport. If unsafe to transport without restraint, request police assistance.

3.7. Ensure every attempt is made to treat any medical conditions that may be contributing to the aggression/confusion (i.e. hypoxia, hypoglycemia, stroke, drug ingestion etc.).

3.8. If an unrestrained patient becomes violent during transport, stop the ambulance and summon assistance. If your safety is in danger, remove the keys and vacate the ambulance. Manage traffic and pedestrians accordingly until help arrives.

3.9. Always fully document the situation and the rationale for your interventions.

4. Appendices

None

5. References

None

Policy No.: 2123.02	**Policy Title:** Level of Practice in the Pre-Hospital and Inter-Facility Environment.	**Type:** Policy
Effective Date: January 2014	**Latest Review Date:** January 2021	

1. Purpose

1.1. To provide a clear description of a Paramedic's level of practice with Ambulance New Brunswick in the pre-hospital and inter-facility transfer environment.

2. Definitions

2.1. PCP – Primary Care Paramedic.

2.2. ACP – Advanced Care Paramedic.

2.3. Level of Practice – refers to the level of care to be provided by the practitioner as defined by the Office of the Provincial Medical Director for Ambulance New Brunswick.

2.4. New Brunswick License – is the scope of practice for which paramedics are licensed to practice by the Paramedic Association of New Brunswick.

2.5. Pre-Hospital Environment – means any Emergency or Non-Emergency call that apparently requires immediate response by an ambulance.

2.6. Inter-Facility Environment (otherwise referred to as "Transfer") – means any transport assigned to an ambulance crew that is to be performed to or from a designated health care institution that is medically required and is other than an Emergency Call or a Non-Emergency Call.

3. Policy

3.1. Ambulance New Brunswick (ANB) provides both 911 and Inter-Facility Transfer service within the Province of New Brunswick. All ANB ambulances are staffed with paramedics. All ANB paramedics must be registered with the Paramedic Association of New Brunswick.

3.2. The level of practice for Ambulance New Brunswick is established by the Office of the Provincial Medical Director, which includes Medical Oversight Physicians and the Provincial EMS Medical Advisory Committee.

3.3. The Pre-Hospital Environment level of practice is clearly defined by the Provincial Medical Protocol, Policy and Procedure Manual.

3.4. The Inter-Facility transfer level of practice allows PCPs to maintain and monitor patients with additional interventions and medications than is expected within the pre-hospital environment.

3.5. Appendix A describes the functions permitted within both environments.

3.6. At no time shall an ANB Paramedic exceed the defined levels of practice.

4. Appendices

4.1. Pre-Hospital Level of Practice Comparison for PCP and ACP
4.2. PCP Level of Practice Comparison for Pre-Hospital and Inter-Facility Environment

5. References

5.1. Paramedic Association of New Brunswick – "Scope of Practice" www.panb.ca.

5.2. Provincial Medical Protocol, Policy, and Procedure Manual (Office of the Provincial Medical Director, NB Department of Health).

Medication Comparison

PCP Medications	ACP Medications
Acetaminophen	All PCP Medications, plus:
ASA	Adenosine
Diphenhydramine	Amiodarone
Dextrose D10w	Atropine
Epinephrine 1:1000	Calcium Chloride
Glucagon	Dopamine
Ketorolac (January 2021)	Epinephrine 1:10000
Naloxone	Fentanyl
Nitroglycerin	Ketamine
Oxygen	Magnesium Sulfate
Salbutamol	Metoprolol
Ibuprofen	Midazolam
Ipratropium Bromide	Norepinephrine
Nitrous Oxide	Oxytocin
Ondansetron (January 2021)	Sodium Bicarbonate
Tetracaine	Tranexamic Acid

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PCP Procedures	ACP Procedures
Bag-Valve Mask	All PCP Procedures, plus:
Capnography Monitoring	Capnography Waveform Interpretation
CPAP	Central Venous Catheter Access
Glucometry	Chest Tube Drainage
Intramuscular/Subcutaneous Injections	Cricothyrotomy
IV Initiation	Endotracheal Intubation by Direct/Video Laryngoscopy
IV fluid administration	Endotracheal and Tracheostomy Suctioning
IV medication administration	External Jugular Venous Cannulation
Supraglottic Airway Devices (i-Gel)	External Pacing
Gastric Tube insertion	Intraosseous Vascular Access
Direct Laryngoscopy for removal of Foreign Body Airway Obstruction	IV Pump Utilization
Semi-Automated External Defibrillation	Manual Defibrillation
Pulse Oximetry	Needle Cricothyrotomy
3-Lead ECG monitoring	Needle Thoracostomy
12-lead ECG acquisition	PEEP
	Synchronized Electrical Cardioversion
	Vagal Maneuvers
	12 lead ECG Interpretation

Appendix: 4.2	**PDN**: 2123.02	**Last Updated**: January 2021	**Subject**: PCP Level of Practice Comparison for Pre-Hospital and Inter-Facility Environment	**Page 1 of 1**

Primary Care Paramedic Level of Practice

Pre-Hospital Environment

Medication:
- ASA
- Ipratropium Bromide
- Diphenhydramine
- Dextrose D10W
- Epinephrine 1:1,000
- Glucagon
- Ipratropium Bromide
- Naloxone
- Nitroglycerine
- Oral Glucose
- Oxygen
- Salbutamol
- Non-Narcotic Analgesic:
  - Ibuprofen
  - Acetaminophen
  - Nitrous Oxide
  - Ketorolac (January 2021)
- Antiemetic:
  - Ondansetron (January 2021)
- Tetracaine (E)

Assessment Tools & Interventions:
- BVM
- Glucometer
- Injections (Intra-muscular/Subcutaneous)
- IV Initiation:
  - Fluid administration (Normal Saline)
  - Medication administration
- Supraglottic airway
- Gastric Tube (E) (with supraglottic airway)
- Magill Forceps with direct laryngoscopy (E)
- Semi-Automated Defibrillation
- SpO2 Monitoring
- Capnography Monitoring
- 3-Lead ECG and 12-Lead ECG
- CPAP

(E) – Endorsed Skill by Provincial Medical Director

Inter-Facility Environment

*In addition to the scope of practice in the Pre-Hospital environment, **PCPs may also transfer patients** with the following:*

Medications administered PRIOR to transfer and approved by Sending Physician:
- Antiparkinsonian agents
- Anxiolytics
- Opioid analgesics & antagonists
- Adrenergic agonists & antagonists
- Antihypertensive agents
- Diuretics
- Class 1,2,3,4 Antidysrhythmics
- Antiemetics
- Vitamin & Electrolyte supplements
- Insulin
- For treatment and prevention of Inflammatory response & infections
- Antibiotics

IV Lines:
- Maintain peripheral IV access devices and infusions of crystalloid solutions without additives:
  - Normal Saline (0.9%)
  - Lactated Ringer's
  - Dextrose 5% in water
  - Dextrose 5% in Normal Saline
  - 2/3 Dextrose / 1/3 Saline
  - Dextrose 5% in Lactated Ringer's
- Maintain direct pressure infusion devices with IV infusions of crystalloid solutions without additives (same as above)
- Patient controlled infusions (PCIs) / Ambulatory infusion pump of prescribed medication (ie. analgesic, insulin)
- Maintain IV line connected to PICC or Portacath
- Maintain Capped Central Lines only

Tubes (for monitoring):
- One-way chest drainage tubes, Naso/Gastric tubes, Foley Catheter, Tracheostomy

Other:
- Radial Artery Compression device (e.g. Hemostop or VASC band)

Policy No.: 2124.04	**Policy Title:** Inter- Facility Transfer of Agitated or Potentially Violent Patients	**Type:** Policy
Effective Date: January 2008	**Latest Review Date:** January 2021	

1. Purpose

1.1. To identify clear guidelines to be followed for the transfer of agitated or potentially violent patients to ensure optimal patient care while preventing harm to the patient and caregivers.

2. Definitions

None

3. Policy

3.1. The responsibility for the care and safety of any patient being transferred is shared between:

3.1.1. The sending physician.

3.1.2. The sending facility and its staff.

3.1.3. Transporting agency.

3.1.4. The transporting agency's medical direction.

3.1.5. The receiving physician and facility having agreed to accept the patient and having offered clinical advice on the patient's condition.

3.2. Information regarding the patient being transported shall be requested both verbally and in writing by the transporting paramedics from the sending physician or health care facility staff. The written documentation should include:

3.2.1. Presenting problem with preliminary diagnosis.

3.2.2. Past and present medical history, including recent vital signs, etc.

3.2.3. Brief past (and present) psychiatry history (if applicable).

3.2.4. Any relevant history of sexual or physical assault or self-injury that may impact the outcome of this transport.

3.2.5. Current medications, including any recently administered.

3.2.6. Physician orders that may be required during transport.

3.3. Any medication or physician orders must be in writing, dated and signed by the sending physician.

3.4. Paramedics should use the Risk Assessment Tool (Appendix A) for involuntary patients. If resolution cannot be achieved, MCMC should be contacted.

3.5. Paramedics have the right to refuse the transfer if they believe their safety or that of the patient is at risk.

3.6. If the concerns cannot be resolved and the transfer is not completed, the rationale must be

documented by the paramedic on the Patient Care Record. A copy must be left with the sending facility and a copy submitted in a Special Case Envelope to the Training & Quality Assurance Department who will consult with the Provincial Medical Director.

3.7. If an unrestrained patient becomes violent during transport and there is a risk of harm to the patient or personnel, stop the ambulance and summon assistance. If your safety is in danger, remove the keys and vacate the ambulance. Manage traffic and pedestrians accordingly until help arrives.

4. Appendices

4.1. Risk Assessment Tool

5. References

5.1. "Facility to Facility transportation of involuntary patients by ambulance services" by Mental Health Services, Department of Health (October 2010).
5.2. *Mental Health Act*, Province of New Brunswick

Risk Assessment Tool

Subject Area	Y/N	Score	Comments
Any known medical or criminal history of violence to persons or property?		10	
Any expressions of anger, frustration or agitation during course of hospital admission or preceding 24 hours?		5	
Multiple expressions of anger, frustration or agitation during current care, requiring special nursing or security measures or chemical restraint/sedation?		20	
Signs of intoxication/withdrawal from drugs or alcohol during course of hospital admission or preceding 24 hours?		10	
Known history of substance abuse (alcohol, opioids, amphetamines, marijuana)?		5	
Known environmental stressors in last 7 days (personal loss, relationship crisis, financial crisis etc.) but excluding hospital admission?		5	
History within the last 6 months of organic or traumatic brain pathophysiology affecting behavior and/or requiring interventions or treatment?		5	
Total Score:			

The Risk Assessment Result is:

HIGH (>25) Patient should be sedated (moderate to deep) and restrained, IV access obtained post-sedation to maintain sedation during transfer. Law enforcement escort recommended. Consider intubation and ventilation if failed adequate trial of pre-transport sedation.

MEDIUM (10-25) Patient should be sedated (drowsy to moderate) and restrained (if necessary), IV access obtained post-sedation to maintain sedation during transfer. Law enforcement escort is discretionary based on clinical judgement.

LOW (5) Transfer is generally possible without sedation. However, drowsy sedation may be considered based on clinical judgement.

Sedation route and depth (see reverse for guide) is determined in consultation with the sending physician in order to facilitate safe and dignified transport of the patient.

This risk assessment tool is a dynamic instrument and does not replace clinical judgement for a given clinical situation. The risk may change as a result of medical intervention/management prior to transfer.

Additional Remarks:

Sedation Guide

The Richmond agitation-sedation scale is a validated scoring system in the ICU setting and is recommended to be used to assess agitation and target a sedation level appropriate for the disturbed patient's transport. A RASS score should be documented **prior** to any sedation administration and a target RASS score should be clearly documented or communicated to other team members as a major goal of the sedation plan.

The recommended target RASS score for sedation is between 0 to -3. At times during a transport, periods of brief but intense environmental stimuli may necessitate a deeper level of sedation, a RASS score to -4 may be appropriate. It is considered inappropriate to target a RASS score of -5 at any time for planned sedation unless the decision to intubate and ventilate has been made.

The RASS score should be documented regularly throughout the transport process as frequently as the vital sign observations are recorded.

Richmond Agitation-Sedation Scale		
Score	**Term**	**Description**
+4	Combative	Overtly combative, violent, immediate danger to staff
+3	Very Agitated	Pulls or removed tube(s) or catheter(s); aggressive
+2	Agitated	Frequent non-purposeful movement
+1	Restless	Anxious but movement not aggressive
0	Alert & Calm	
-1	Drowsy	Not fully alert, but has sustained awakening (eye-opening / eye contract) to voice (>10 seconds)
-2	Light sedation	Briefly awakens with eye contact to voice (<10 seconds)
-3	Moderate sedation	Movement or eye opening to voice (but no eye contact)
-4	Deep sedation	No response to voice, but movement or eye opening to physical stimulation
-5	Unarousable	No response to voice or physical stimulation

The score is determined based on the "Description" that best fits the patient's presentation:

The RASS is to be used as a tool to guide sedation targets however it does not replace clinical judgement on a case by case basis as to the level of sedation required for a given and situation.

Policy No.: 2125.04	**Policy Title:** Accepting Care of a Patient from other Health Care Providers	**Type:** Policy
Effective Date: January 2008	**Latest Review Date:** January 2021	

1. Purpose

1.1. To ensure optimal patient care while at the same time providing an efficient transfer of care from other health care providers.

2. Definition

2.1. A **health care provider** is an individual that provides preventive, curative, promotional, or rehabilitative services in a systematic way to individuals, families or communities.

3. Policy

3.1. The responsibility for the care and safety of any patient being transferred is shared between:

3.1.1. The sending health care provider.

3.1.2. The sending facility and its staff (if applicable).

3.1.3. Transporting agency.

3.1.4. The transporting agency's medical direction.

3.1.5. The receiving physician and facility having agreed to accept the patient, and having offered clinical advice on the patient's condition for transportation purposes (if applicable).

3.2. Any medication or orders must be in writing, dated and signed by the attending health care provider.

3.3. Paramedics are not to transport a patient requiring care or medication(s) beyond their Level of Practice without the accompaniment of another healthcare provider who is responsible for the medical procedures that are outside the level of practice of the paramedic. Receiving an order from a health care provider does not allow a paramedic to practice beyond his/her level of practice.

3.4. Perform a brief exam to establish if any interventions are required urgently.

3.5. At least one set of vital signs (V/S) **must** be documented on each transfer however the frequency of V/S monitoring shall be dictated by the clinical acuity of the patient or as ordered by the sending health care provider.

3.6. Paramedics **must** obtain the sending health care provider's contact information prior to leaving the health care facility with the patient. If questions or concerns arise during the transfer the paramedic will contact the sending health care provider. If not possible, the paramedic will contact OLMC.

Medical Staff Accompanying

3.7. Both the health care provider and paramedic share responsibility and should provide care collaboratively within their respective level of practice.

3.8. Any conflict of opinion that occurs during transport regarding patient management should be referred to the sending health care provider.

3.9. Any concerns a paramedic has regarding patient care that arise from a conflict within the medical team **must** be documented in writing and sent in a Special Case Envelope to the Training & Quality Assurance Department who will consult with the Provincial Medical Director.

4. Appendices

None

5. References

None

Policy No.: 2140.03	**Policy Title:** Special Patients	**Type:** Policy
Effective Date: December 2007	**Latest Review Date:** January 2021	

1. Purpose

1.1. To provide optimal care to patients with complex and/or extensive conditions in accordance with their own medical care protocols which have been developed by care givers and specialists with extensive knowledge of the patient.

2. Definitions

2.1. A **Special Patient** is an individual whose unique medical requirements fall outside of normal practice necessitating a specific and defined treatment plan.

3. Policy

3.1. This policy encompasses all patients designated as "Special Patient" by an ANB Identification (ID) card.

3.2. The "Special Patient" ID Card is white in color with the ANB logo and displays the patient's name, address, condition, special clinical needs and any relevant instructions, as well as the signature of the Provincial Medical Director (PMD).

3.3. Referrals of patients who wish to become part of this program should become so by application to the PMD at:

Provincial Medical Director
New Brunswick Department of Health
PO Box 5100
Fredericton, NB E3B 5J8

4. Appendices

None

5. References

None

Policy No.: 2146.03	**Policy Title:** Sexual Assault	**Type:** Policy
Effective Date:	**Latest Review Date:** January 2021	

1. Purpose

1.1. To outline the management of patients who have been sexually assaulted.

2. Definitions

None

3. Policy

3.1. Sexual assault is a crime of violence, not of sex.

3.1.1. Victims most frequently feel traumatized, powerless, violated and self-blame. They have a great need for validation, assurance the sexual assault was not their fault, emotional support and respect from the pre-hospital and hospital providers.

3.2. Provide emotional support and a safe environment for the patient. Be aware of how your actions and comments can cause further trauma for the patient.

3.2.1. Treat patient with respect, kindness, gentleness and understanding. Refrain from making judgements. It is not your role to investigate or determine if a sexual assault has occurred.

3.3. Allow patient to determine gender of care-provider if requested, unless the clinical condition of the patient would be compromised where a delay would occur to obtain requested gender.

3.3.1. Examination of genitalia is only warranted where bleeding is posing a significant risk to the patient.

3.3.2. Explain all care, procedures, treatments, etc. prior to initiating.

3.3.3. Request permission prior to initiating any examination or treatment.

3.4. Assess for other illnesses or injuries.

3.5. If patient's clinical condition allows, request consent to contact police.

3.6. Preserve all evidence.

3.6.1. Explain to the patient why preserving the evidence is necessary.

3.6.2. Maintain the chain of evidence by documenting who was in receipt of any articles or clothing. This information is very important in court proceedings.

3.6.3. Handle clothing as little as possible.

3.6.4. Discourage the patient from changing clothes or bathing. Advise the patient that, if possible, they should collect extra clothing to change into at the hospital.

3.6.5. Advise the patient to do nothing that might destroy the evidence. This includes changing clothes, bathing or drinking any liquids.

3.6.6. Do not disturb the crime scene.

3.7. Carefully chart all patient complaints, your observations and treatments.

3.8. Maintain and ensure patient confidentiality. Patient information cannot be shared outside of the healthcare team without the patient's consent. Consent is not required if the patient is under sixteen (16) years of age, is in a life-threatening situation and/or unable to give consent; or is a threat of harm to self or others.

3.9. The victim may be fearful, not feel safe and be uneasy around strangers. Reassure the patient there is no longer any immediate danger and that you are there to help.

3.10. A request from the patient to have family / friend accompany them in the ambulance should be accommodated.

4. Appendices

None

5. References

None

Policy No.: 2147.02	**Policy Title:** Conductive Energy Weapon	**Type:** Policy
Effective Date: September 2011	**Latest Review Date:** January 2021	

1. Purpose

1.1. To provide guidance for the management of individuals who have been subjected to a Conductive Energy Weapon.

2. Definitions

2.1. Autonomic Hyperarousal State (AHS): A contemporary definition for excited delirium which has been associated with the use of a CEW and sudden death.. Signs of AHS may be similar to cocaine or methamphetamine ingestion, psychosis as a result of untreated schizophrenia, severe bipolar mania or other disease entities. Signs may include:

- extreme agitation and restlessness;
- aggressive/combative behavior;
- paranoia or delirium;
- incoherent and rambling speech;
- extraordinary strength, numbness to pain;
- profuse sweating.

2.2. CEW: includes Tasers, Stun Guns and Control Belts.

2.3. EMD System: Electro-muscular disruption systems override the central nervous system (CNS) and take direct control of the skeletal muscles. The result is strong involuntary muscle contraction causing the individual to lose the ability to control his/her body.

2.4. Direct Injury: The propelled darts can cause contusions, skin abrasions, first degree burns and lacerations at sites where they hit. Because the barbs at the ends of the darts have hooks similar to fishhooks they can lacerate the surrounding skin when they are spontaneously pulled out during the fall of the individual.

2.5. Indirect Injury: Injuries which relate to the fall of the individual after being "Tasered'.

2.6. Taser: The Thomas A. Swift Electric Rifle (Taser) differs from a stun gun in that it is effective from a distance, firing probes attached to fine wires, while a stun gun must physically contact the subject. Tasers rely on disruption of the nervous system while a stun gun relies on pain compliance.

3. Policy

3.1. Whenever possible protect patient's rights and provide care with the same respect and dignity as any other patient.

3.2. Ensure the wires are disconnected from the conductive energy weapon prior to touching the patient.

3.3. Ascertain the time interval between CEW deployment and your arrival.

3.4. Be alert to warnings signs of outburst of violence (hyper motor/muscular activity, aggressive body language, loud threatening speech) and always position yourself to have an escape route.

3.5. If a decision is made to restrain the patient, ensure adequate personnel and equipment are

available to complete this task as quickly as possible. Extended duration of exertion increases the incidence of sudden death. Material other than tape, towels and gauze as outlined in the Restraints Procedure (3010) may be necessary because of the patient's strength and numbness to pain.

3.6. Be alert to patient exhibiting signs of AHS as these individuals have a higher risk of sudden death.

3.7. The police must be requested to accompany the patient in the ambulance. If police refuse, document the refusal to accompany. Paramedics may transport the patient without police if they feel safe to do so, if not, document your rational to consider it an unsafe transport.

3.8. If police refuse to allow paramedics to transport the patient, advise police the patient needs a medical evaluation by a physician and they should transport to the nearest emergency room. Document the refusal on a Refusal Form (Policy 2111) including advice to police and have the police officer sign the form.

4. Appendices

None

5. Reference

5.1. Refusal of Care Policy 2111.

Policy No.: 2148.02	**Policy Title:** Spinal Protection Safe Practice	**Type:** Policy
Effective Date: December 2015	**Latest Review Date:** January 2021	

1. Purpose

1.1. To provide guidance for safe practice and management of patients having experienced an actual or suspected spinal injury.

2. Definitions

2.1. Spinal Protection is replacing the term spinal immobilization and means limiting the movement of the axial spine. This is achieved using a variety of protective devices and includes the ambulance stretcher.

3. Policy

3.1. Optimal trauma care requires a structured approach to the patient.

3.2. Spinal protection is indicated for all patients with suspected spinal injury and in all trauma victims with impaired consciousness.

3.3. The initial assessment of a patient having sustained a traumatic injury includes determining whether a cervical collar is required (see procedure 3038 – C-Spine Clearance). If indicated, a c-collar is to be appropriately sized and applied.

3.4. Ambulatory patients with a c-collar may be safely placed supine on the ambulance stretcher and secured in place using the shoulder and cross straps.

3.5. Non-ambulatory patients are to be extricated utilizing the appropriate equipment based on the situation and patient size. Whenever possible it is preferable to utilize the scoop stretcher when moving patients to and from the ambulance stretcher as this device lessens manipulation of the patient.

3.6. The Pedi-Pac® will remain the standard of care for children who are between 9 – 41 kilograms (20 – 90 pounds) or 70 – 137 centimeters (28 - 54 inches) in height. Once they exceed this limit, they are to be treated as per the adult population.

3.7. The patient must be removed from the extrication device and secured to the ambulance stretcher as soon as reasonably possible.

NOTE: Patients who are unconscious will have a c-collar per the C-Spine Clearance Procedure. These patients can be safely secured to the ambulance stretcher in the supine position utilizing the shoulder and cross straps.

3.8. Patients who vomit, whether conscious or unconscious, may be log rolled and suctioned.

3.9. In the case of immediate clinical interventions taking priority over removal from the extrication device, the paramedics should assist the hospital personnel with the removal of the extrication device within15 minutes of arrival and document the clinical rationale and the total time interval the patient spent on the extrication device.

4. Appendices

None

5. Reference

5.1. New Brunswick Trauma Program Consensus Statement on Pre-hospital and Inter-hospital Use of Long Spine Boards, November 2014.

Policy number: 2149	**Policy Title:** COVID-19 Treat and Release/Refer	**Type:** Policy
Effective date: March 24, 2020	**Last review date:** January 2021	

1. Purpose

1.1. To inform paramedics of 'no-transport' procedures for suspected, probable, and confirmed COVID-19 cases in the out-of-hospital environment.

1.2. To describe the roles, responsibilities and expectations of paramedics, On-line medical consultation physicians (OLMC), 811 Telecare, Medical Communications Management Center (MCMC) and the public in relation to supporting self-isolation practices in the community.

1.3. To ensure safety of paramedics, other health care workers and the public by supporting self-isolation practices and therefore reducing the extent of COVID-19 transmission in New Brunswick communities and health care facilities.

2. Definitions

2.1. **Suspected case:** A person under investigation (PUI) with fever and/or acute respiratory illness who meets the exposure criteria for COVID-19 as determined by the OCMOH and for whom a laboratory test has been or is expected to be requested.

2.2. **Probable case:** A person with fever (over 38.0°C) and/or new onset of (or exacerbation of chronic) cough; who meets the COVID-19 exposure criteria, and in whom laboratory diagnosis of COVID-19 is not yet confirmed.

2.3. **Confirmed case:** A person with laboratory confirmation of infection with the virus that causes COVID-19 as performed at a reference laboratory (i.e., National Microbiology Laboratory or a provincial public health laboratory).

2.4. **Self-isolation:** The practice of a suspected, probable or confirmed COVID-19 case remaining in the person's place of residence for 14 days, or until directed by the OCMOH, in attempt to reduce possible transmission of the virus to others in the community.

2.5. **Paramedic:** A person registered with the Paramedic Association of New Brunswick to practice emergency medical care in New Brunswick.

3. Policy

3.1. With the help of the screening tool, and in coordination with on-line medical consultation (OLMC), paramedics shall not transport any suspected, probable, or confirmed COVID-19 cases to hospital if they are physiologically stable and with no clinical signs predictive of imminent deterioration. These directives are in place to support self-isolation practices recommended by New Brunswick's Chief Medical Officer of Health (OCMOH) and/or mandated by the Minister of Public Safety's Declaration of a State of Emergency and Mandatory Order.

4. Procedure

4.1. Paramedics shall determine if any patients on scene have previously been identified as suspected, probable or confirmed COVID-19 cases.

4.2. For patients not previously screened, paramedics will determine if they meet exposure criteria using the On-scene Paramedic Screening Tool for COVID-19.

4.3. Following assessment, paramedics will determine if patients are physiologically stable and assess the relative risk of not transporting (concern for deterioration) compared to transporting to hospital (concern for viral transmission).

4.4. Paramedics shall consult with an OLMC physician if there is any uncertainty about any patient's physiological status (i.e., stable v. unstable), concern for deterioration, or disagreement between the patient and paramedics; OLMC physicians shall direct on-scene paramedics as required.

4.5. Paramedics shall educate all patients described in this policy about the benefits of remaining on self-isolation and risks of unnecessary transport to hospital.

4.6. Paramedics shall describe the options available to patients including the self-assessment tool on the Department of Health website, calling 811 if symptoms worsen or making an appointment with their family physician.

4.7. Paramedics are encouraged to show compassion and be diplomatic and respectful when discussing the implications of this policy with patients and should make every effort to empower patients to remain at home on self-isolation.

4.8. Paramedics shall ensure that all patients understand their expectations while on self-isolation and receive a Government of New Brunswick *How to Self-Isolate* information sheet before leaving the scene.

4.9. Paramedics will contact the MCMC Support Line (833-920-0789) to assist in the referral process.

4.10. Paramedics shall initiate and complete their PCR after removing and disposing of Personal Protective Equipment (PPE), disinfecting relevant equipment, performing hand hygiene, and leaving the scene.

Note: Due to the extenuating circumstances involving COVID-19 and the associated concern for infection control measures, paramedics will not be required to obtain signatures from patients for refusal forms. When prompted, paramedics shall write "COVID-19" for all patient signatures.

5. Application

5.1. This policy applies to all Ambulance New Brunswick paramedics involved in ground ambulance operations during the COVID-19 global pandemic

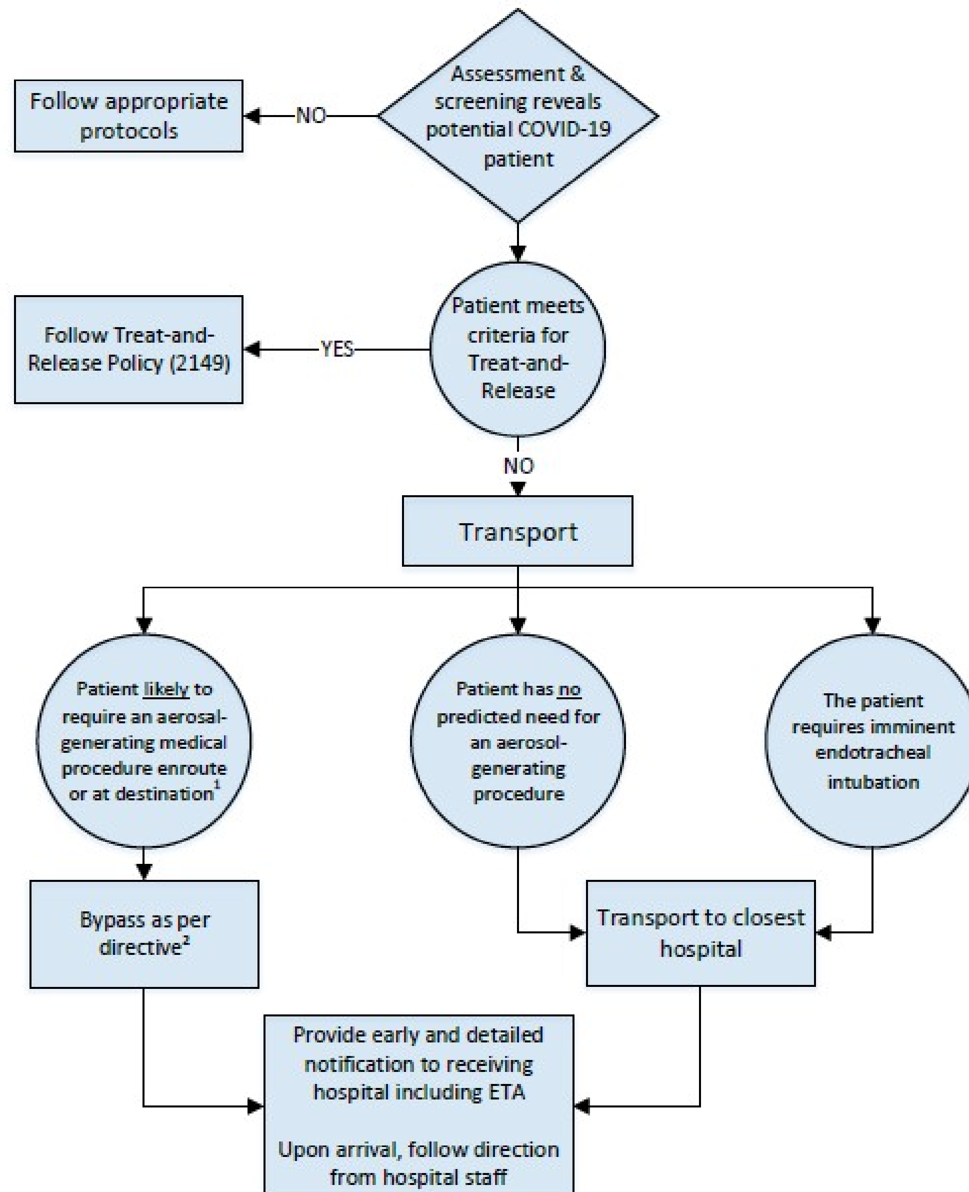
6. Monitoring

6.1. Since the current situation involving COVID-19 is rapidly evolving, this policy will be continuously monitored and updated as required to reflect best evidence-based recommendations and guidelines.

7. References

- www.GNB.ca
- www.WHO.int
- www.CDC.gov

COVID-19 Bypass Directive v2	2149-A	Last Updated: March 30, 2020	Category: Transport	Page: 1 of 1



[2] Bypass details:

- Sackville bypass to Moncton Hospital or Georges L. Dumont
- Oromocto bypass to Dr. Everett Chalmers
- Charlotte County bypass to Saint John Regional
- Sussex Health Centre bypass to Saint John Regional
- Hôtel-Dieu St. Joseph (Perth) bypass to Upper River Valley or Edmundston
- Hôtel-Dieu St. Joseph de Saint-Quentin bypass to Edmundston or Campbellton
- Stella-Maris-de-Kent Hospital bypass to Moncton or Miramichi
- Grand Falls General Hospital bypass to Edmundston or Upper River Valley
- Enfant-Jésus RHSJ Hospital bypass to Chaleur Regional
- Tracadie Hospital bypass to Chaleur Regional Hospital or Miramichi

[1] Aerosol generating medical procedures (AGMP):

- High-flow oxygen
- Nebulized medication
- CPAP
- Endotracheal intubation

Policy number: 2150	**Policy Title:** Immunization administration		**Type:** Policy
Effective date: February 1, 2021		**Last review date:**	

1.1 Purpose

1.2 To ensure that paramedics properly and safely administer vaccinations when called upon by Public Health to participate in immunization initiatives.

2.0 Definitions

Cold chain: Temperature-controlled supply chain. An unbroken cold chain is an uninterrupted series of refrigerated production, storage and distribution activites and associated equipment which maintain a given low-temperature range.

3.1 Policy

3.2 While immunization practices may be similar among various vaccines and between the Regional Health Authorities, differences will exist. Paramedics shall follow the direction of Public Health, the Office of the Provincial Medical Director (OPMD), and ANB management by administering according to each vaccine's unique characteristics and set of established procedures;

3.3 Paramedics will complete any additional requisite training and monitoring prior to participating in vaccine clinics;

3.4 Paramedics will follow each vaccine's monograph, the principles of safe medication administration, and will adhere to all operational policies such as the those relating to consent, confidentiality, personal protective equipment (PPE) and aseptic practices.

3.5 Unless specified otherwise, paramedics will observe all vaccine recipients for signs of anaphylaxis for a minimum of 15 minutes following immunization;

3.6 For patients experiencing anaphylaxis post-vaccine, paramedics will follow established treatment guidelines;

3.7 Paramedics will respect the cold chain guidelines and the handling, distribution and transportion of vaccines;

3.8 Paramedics will complete and distribute the appropriate documentation as per direction.

4.0 Appendix

None

5.1 References

5.2 Policy 2128 – Medication Administration

5.3 Procedure 3016 – Medication Administration – Intramuscular

5.4 Procedure 3022 – Drawing up medication

5.5 Protocols 1020, 1190 – Anaphalaxis

5.6 Medication Profile 4105 - Epinephrine

Policy number: 2151	**Policy Title:** ACP Transferring Care to PCP Crew	**Type:** Policy
Effective date: September 2018	**Last review date:** January 2021	

1. Purpose

1.1. To define when Advanced Care Paramedics (ACP) providing specific advanced treatment may transfer patient care to a Primary Care crew (PCP) for ongoing treatment and transport.

2. Policy

2.1. Following the administration of fentanyl, an ACP may transfer the care of a patient to a PCP crew if:

2.1.1. The patient is stable and—in the best judgment of the ACP—expected to remain stable from a hemodynamic and respiratory point of view;
2.1.2. All ongoing patient-care requirements are within the scope of the attending PCP;
2.1.3. All paramedics involved are comfortable with the decision for hand-off of care;
2.1.4. The ACP medication is completely administered by the ACP prior to hand-off of care;
2.1.5. Vital signs are completed pre and post-intervention.

2.2. Documentation requirements:

2.2.1. While on scene, the ACP documents on the patient's PCR:
2.2.1.1. At least two patient identifiers;
2.2.1.2. The intervention performed (including times);
2.2.1.3. The protocol code 1350;
2.2.1.4. A brief but adequate description of the ACP's involvement;
2.2.1.5. All relevant vital signs pre and post intervention;
2.2.1.6. Details of any conversation with on-line medical consultation (if applicable);
2.2.1.7. Their signature as 'Assisting personnel'

3. Appendices

None

4. References

4.1. Medication profiles (4000)
4.2. Policy 2100.01 (PNB): Essential Competencies
4.3. Policy 2104.03 (PNB): Clinical Responsibilities of Paramedics
4.4. Policy 2105.02 (PNB): Medical Documentation
4.5. 2107.02 (PNB): Radio reports to emergency departments
4.6. 2108.02 (PNB): Patient report to nurse and/or physician in receiving unit
4.7. Policy 4047 (ANB): Advanced care paramedic intercepts/responses