Primary Care Paramedics certified by the Central East Prehospital Care Program are authorized to use the provincially approved medical directives (Advanced Life Support Patient Care Standards version 3.3 February 1, 2016) specific to their level of certification.

Advanced Care Paramedics certified by the Central East Prehospital Care Program are authorized to use the provincially approved medical directives (Advanced Life Support Patient Care Standards version 3.3 February 1, 2016) specific to their level of certification.

A paramedic receiving delegation from the Medical Advisory Board of Central East Prehospital Care Program (CEPCP) may utilize medical directives only while on duty for a service that receives it’s medical delegation from the Medical Advisory Board of the CEPCP, and only within the Province of Ontario.

It is understood by the MAB of CEPCP that there will be occasions where a paramedic is not able to utilize medical directives under the most ideal circumstances.

Multiple patients, equipment shortages, equipment failures are all circumstances that should not impede a paramedic from delivering clinical care that would otherwise be indicated for a patient.

In these circumstances the Paramedic is expected to apply sound clinical judgment. An alternative available to the paramedic is to contact the Base Hospital Physician for direction in unusual circumstances. In all of these circumstances the paramedic must document the unusual nature of the event and the rationale for decisions made.
In cases where a patient requires additional or ongoing treatment during an off load delay the following procedure is to be followed:

1. On arrival at the receiving facility the paramedic will provide a report to the Triage or Charge Nurse.

2. If the Hospital staff indicate that there will be an off load delay, a Paramedic must remain with the patient until transfer of care has taken place.

3. If the patient requires additional or ongoing treatment the Paramedic will:
   a. Continue to follow the general standards of care as outlined in the BLS Patient Care Standards.
   b. Notify the Hospital staff and inform them of the need for additional or ongoing treatment. Documentation of this notification is required on the ACR.

4. If the Hospital staff are unable to take over primary responsibility for the patient in a timely manner, the paramedic is authorized to provide care as appropriate under their medical directives.

5. Document on ACR with respect to care rendered during off load delay, medical directives used and when transfer of care occurred.
A physician is "a duly qualified medical practitioner who is licensed to practice medicine in Ontario".

When a physician is in attendance at the patient care scene, the physician may assume medical responsibility for the patient.

The physician may provide BLS direction the paramedic. See the Basic Life Support Patient Care Standards, Policies section, Appendix 62-1

Physicians will be considered the highest medical authority when at the scene with a patient. They should be assisted (to the best of the Paramedic’s ability within their scope of Medical Directives) in managing patient care as long as:

- They provide appropriate documentation verifying they are a medical practitioner
- They are willing to take full responsibility for the patient and accompany the patient to hospital

On scene physicians may not delegate to paramedics or alter standing orders. Physicians on scene may be placed in contact with a Base Hospital physician if required for clarification of this policy.
The continuing care of a patient may be transferred from a Paramedic who holds a greater scope of practice to a Paramedic with a lesser scope of practice only under these conditions:

1) The patient is hemodynamically stable.
   
   AND
   
   The patient has not received any Advanced Care, outside of the accepting Paramedic’s Scope of practice beyond: IV of Normal Saline running at TKVO or one of the following medications:
   
   i. Dextrose 50%
   
   ii. Diphenhydramine (Benadryl) IV
   
   iii. Dimenhydrinate (Gravol) IV
   
   AND
   
   It is the judgment of the transferring Paramedic that the patient will not require further advanced interventions contained in the greater scope of practice.
   
   OR
   
2) In the setting of a Multiple Casualty situation where the Paramedic with the greater scope of practice is required to perform advanced skills on more than one patient.

Each Paramedic is responsible for the ACR/ePCR documentation of procedures they have completed. Where circumstances prevent this from occurring, all procedures must still be recorded on the final ACR/ePCR.

Documentation must also include a transfer of care statement between Paramedics.
A manual BP must be auscultated or palpated (when factors prohibit auscultation) as the first assessment of blood pressure in all situations:

Once it has been confirmed that the automated NIBP accurately reflects the manual blood pressure, the paramedic may continue blood pressure monitoring using the automated NIBP. However, if there is a significant change in patient condition or vital signs, a manual blood pressure must again be obtained to confirm the accuracy of the automated NIBP.

**Documentation:**
Any time a blood pressure is obtained using the automated noninvasive blood pressure monitor, "NIBP" must be documented on the ACR next to the obtained value.
PURPOSE

This policy provides the steps the paramedic may take when attending to a patient complaining of continuous cardiac ischemic "chest pain" with a STEMI positive ECG. The application of this policy applies to all paramedics (ACP and PCP) within the CEPCP catchment area.

PROCEDURE

A patient that meets the indications and conditions for treatment according to the Cardiac Ischemia Medical Directive may be a candidate for a STEMI bypass if:

- The patient complains of continuous (defined as, once the pain started, it has not gone away prior to your contact and assessment) pain, and;
- The 12 (or 15) lead is diagnostic for an acute myocardial infarction.

With both continuous pain and a 12 (or 15) lead indicative of an infarct, transport the patient to the closest facility equipped with a Cardiac Catheterization lab (PCI lab), bypassing closer Emergency Departments, when:

- The current episode of pain is less than 12 hours in duration, and
- The patient can be transported to the PCI lab in less than 60 minutes from your initial patient contact time. A STEMI bypass is contraindicated if any of the following apply:
  - The systolic blood pressure is less than 80 mmHg (despite field interventions such as: fluid bolus, inotropes or trans-cutaneous pacing), or
  - A STEMI imitator is present, specifically a Left Bundle Branch Block (LBBB), a Ventricular paced rhythm, Left Ventricular Hypertrophy (LVH) or pericarditis is present, or
  - The airway is unsecured or the patient cannot be adequately ventilated, or
  - The patient has Advanced Directives in place indicating a restriction in care, or they are unable to co-operate or consent due to dementia or other cause

To complete the transfer of care, ensure a print copy of the diagnostic 12 (or 15) lead is provided to the receiving staff.
NOTES

12 lead electrical criteria for presumptive evidence of a STEMI:

- ST elevation of 1 mm or more in two (2) or more anatomically contiguous limb leads, or
- ST elevation of 2 mm or more in two (2) anatomically contiguous precordial leads.

A 15 lead cardiogram should be performed when the 12 lead appears “normal” (posterior wall with V8 and V9 to be evaluated), or demonstrates ST elevation consistent with an inferior myocardial infarction (V4R to be evaluated).

A Right Bundle Branch Block (RBBB) does not prohibit the interpretation of the 12 lead and is not a contraindication to initiating a STEMI bypass.

If a patient does not meet the indications for bypass, a patch to the Base Hospital Physician is NOT recommended. A STEMI bypass may not be indicated for a patient with a valid MOH DNR confirmation form or who is in palliative care.

Once a diagnostic 12 (or 15) lead has been obtained indicating a STEMI, additional 12 leads are unnecessary. Further, it is recommended to replace the monitoring electrodes with defibrillation pads.

Where possible, an intravenous initiation should be performed in the left arm to facilitate right radial artery access by the Code STEMI team.

Ensure a copy of the 12 (or 15) lead is attached to your call report.

PCI Centres

While there are numerous PCI labs that may receive direct from field patients, a process has been established for the transfer of care and information with Southlake, Peterborough and Centenary. Once the decision has been made to transport to one of these facilities, a code STEMI is to be activated as early as possible, by calling the receiving facility:

- Southlake Regional Health Centre at 905-952-2466
- Rouge Valley Health System – Centenary site at 416-287-8364
- Peterborough Regional Health Centre at 705-743-2121 ext “0” (directly or via CACC) and a patch to the Emergency Department should also be made.
and advising:

- You are EMS (identify your service)
- Estimated time of arrival (ETA)
- Patient age and gender and initials (do NOT provide the patient name over phone or radio lines)
- Whether the patient has received treatment with an advanced airway, defibrillation, inotropes or trans-cutaneous pacing.

On arrival at the receiving facility:

**Southlake:**

- Proceed directly to the PCI lab without stopping in the Emergency Department. NOTE – if outside of regular hours and the code STEMI team has not arrived, proceed to the Coronary Care Unit (CCU). Remain with the patient until the transfer of care is complete.

**Centenary:**

- Proceed directly to the PCI lab without stopping in the Emergency Department. NOTE – if outside of regular hours and the code STEMI team has not arrived, proceed to the Coronary Care Unit (CCU). Remain with the patient until the transfer of care is complete.

**Peterborough:**

- Proceed to the Emergency Department and report to the triage staff who will advise if and when the PCI lab is ready to receive the patient.