Emergency Medical Assistants Licensing Board

British Columbia Provincial Examination Guidelines

Primary Care Paramedic and Emergency Medical Responder

Ministry of Health
Authored by EMA Licensing Branch
January 2019
# Table of Contents

## Introduction

- Scope of Practice (services & endorsements) ................................................................. 4
- Patient Assessment Model ............................................................................................... 5
- Patient Assessment Model – Guidelines .......................................................................... 6
- Patient Assessment Model - Primary/Initial Survey Assessment Interventions ................ 7
- Critical History Questions ............................................................................................... 8
- Assessing LOC Using AVPU ........................................................................................... 9
- Glasgow Coma Scale ..................................................................................................... 11
- Abbreviations .................................................................................................................. 12
- Patient Care Report ........................................................................................................ 14

## Treatment Section ........................................................................................................ 16

- References ..................................................................................................................... 16
- Wound Care ................................................................................................................... 17
- Preservation of Amputated Parts .................................................................................... 18
- Fracture Management .................................................................................................... 19
- Fracture Management – Traction Splint .......................................................................... 20
- Spinal Management ....................................................................................................... 22
- Burn Management .......................................................................................................... 24
- Hypothermia .................................................................................................................... 26
- CVA – Stroke – Flowchart .............................................................................................. 27
- Abdominal Injuries - Flowchart ...................................................................................... 29
- Chest Trauma – Flowchart ............................................................................................. 31
- Electrical Contact – Flowchart ....................................................................................... 32
- Heat Exhaustion/ Heatstroke – Flowchart ..................................................................... 33
- Drowning/Near Drowning – Flowchart ......................................................................... 34

## Treatment Protocols ..................................................................................................... 35

- IV Procedures .................................................................................................................. 35
- IV Maintenance ................................................................................................................ 36
- IV Maintenance Rate Calculation .................................................................................. 36
- Adult CPR/AED ............................................................................................................... 37
- Child Infant CPR/AED .................................................................................................... 38
- Foreign Body Airway Obstruction ................................................................................... 42
- Cardiac Chest Pain PCP/EMR ....................................................................................... 43
- Nausea – Vomiting PCP .................................................................................................. 44
- Shortness of Breath (SOB) With History of Asthma/COPD – PCP ............................... 45
- Oxygenation Management – Pulse Oximeter PCP/EMR ............................................... 46
- Continuous Positive Airway Pressure (CPAP) PCP ....................................................... 48
Entonox PCP/EMR ................................................................. 50
Hypovolemia – PCP ............................................................... 51
Anaphylaxis – PCP ............................................................... 53
Unconscious Not Yet Diagnosed (NYD) – PCP ............................ 55
Suspected Narcotic Overdose – PCP/EMR ............................... 56
Diabetic Emergencies – EMR .................................................. 57
Diabetic Emergencies – PCP ................................................... 58
Aspirin (ASA) ........................................................................ 59
D_{10}W (Dextrose 10% in Water) .............................................. 60
Dimenhydrinate .................................................................... 61
Diphenhydramine ................................................................. 62
Entonox (Nitrous Oxide) ......................................................... 63
Epinephrine .......................................................................... 64
Glucagon ............................................................................... 64
Naloxone (Narcan) ............................................................... 65
Nitroglycerin ........................................................................ 66
Oral Glucose .......................................................................... 67
Salbutamol (Ventolin) ........................................................ 68
Tranexamic Acid ................................................................... 68

EMA Licensing Board Examinations ........................................ 69
Practical Examination Grading Criteria ................................... 70
Star Weighting ....................................................................... 71
Practical Exam Appeals .......................................................... 73
Exam Reviews ........................................................................ 73
EMR Examination Requirements ........................................... 74
Scheduling EMR Examinations ............................................... 75
PCP Examination Requirements ............................................. 76
Scheduling PCP Examinations ................................................ 78

Applying for a Licence ............................................................ 79
Licence Fees .......................................................................... 79
How to Pay your Licence Fees ................................................ 80
Licence Applications .............................................................. 80

EMA Licensing Board Examination Policies ............................ 81
EMALB 2011-01 Candidate Code of Conduct ............................ 81
EMALB2012-02 Failure to Attend or Late Notice of Cancellation 84

Change Index ........................................................................ Error! Bookmark not defined.
Introduction

For the purposes of licensure and licensing examinations, the information contained within this document supersedes all previous applicable protocols and procedures.

Research and development in emergency health services is continuous and these guidelines will be updated to reflect best practice. The most current version of this document is available through the EMA Licensing Branch website.

The Board identifies an EMR candidate as someone who has completed a Board recognized EMR certification program and a PCP candidate as someone who has completed a Board recognized PCP certification program. To find a Board recognized training program click here.

This document covers:

- treatment guidelines for EMR and PCP levels
- examination policies
- examination requirements and scheduling instructions
- medication policies
- licence application instructions

Email Contact: clinicaladvisor@gov.bc.ca or getanexam@gov.bc.ca
### Scope of Practice (services & endorsements)

<table>
<thead>
<tr>
<th>Patient Care Skills</th>
<th>EMA-FR</th>
<th>EMR</th>
<th>PCP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scene assessment</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Assessment LOC, skin color, temp, pulse, resp</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>RBS to attend any life-threatening injuries</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Primary and Secondary assessment, physical examination, medical and incident history and vital signs</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Cardio pulmonary resuscitation (CPR)</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Maintenance of airways and ventilation</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Use of airway management techniques including oropharyngeal airways, oral suction devices and oxygen-supplemented mask devices to assist ventilation</td>
<td>Endorsement</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Use of automatic or semi-automatic external defibrillator (AED)</td>
<td>Endorsement</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Cervical collar application/spinal immobilization</td>
<td>Endorsement</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Administration of oxygen</td>
<td>Endorsement</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Administration of oral glucose</td>
<td>Endorsement</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Emergency childbirth</td>
<td>Endorsement</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Ventilation using pocket mask and BVM</td>
<td>Endorsement</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Lifting/loading, extrication/evacuation and transportation</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Blood pressure assessment by auscultation and palpation</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Emergency fracture management/immobilization</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Soft tissue injury treatment</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Maintenance of intravenous lines without medications or blood products while transporting persons between health facilities</td>
<td>Endorsement</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Use and interpretation of a pulse oximeter</td>
<td>Endorsement</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Administration of the following oral, sublingual or inhaled medications: anti-anginal, anti-hypoglycemic agent, analgesia, and platelet inhibitors</td>
<td>Endorsement</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Use and interpretation of a glucometer</td>
<td>Endorsement</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Chest auscultation</td>
<td>Endorsement</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Insertion and maintenance of nasopharyngeal airway</td>
<td>Endorsement</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Administration of the following intravenous, oral, sublingual, subcutaneous, inhaled, intra-muscular or nebulized medications: narcotic antagonist, bronchodilator anti-histaminic, sympathomimetic agent, procoagulant, and anti-hypoglycemic agent</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Insertion and maintenance of airway devices not requiring visualization of the larynx</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Maintenance of intravenous lines using intermittent infusion devices, including saline locks and IV pumps</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Initiation of peripheral intravenous lines</td>
<td>Endorsement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Administration of isotonic crystalloid solutions</td>
<td>Endorsement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Endotracheal intubation</td>
<td>Endorsement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Electrocardiogram acquisition</td>
<td>Endorsement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Initiation and maintenance of non-invasive positive pressure airway devices</td>
<td>Endorsement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Administration of the following intravenous, oral, sublingual, subcutaneous, inhaled, intra-muscular or nebulized medications: anti-emetic — anti- nauseant, and vitamins</td>
<td>Endorsement</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Patient Assessment Model

Rescue Scene Evaluation
| Primary Survey
| Secondary Survey, consisting of:
| History
| Vital signs
| Head-to-toe examination
| Protocols
| Treatments
| Load and Transport
| Records and Reports

1This model depicts a generic management approach without consideration for patient condition. Depending upon patient condition (i.e. stable vs unstable) and the ability to provide definitive care, as outlined in protocols, load and transport may be appropriate any time after the “decision point”.

Page 6 of 86
Patient Assessment Model – Guidelines

The Patient Assessment Model consists of seven components, each of which has multiple steps. The following table lists the steps and the purpose of each component.

<table>
<thead>
<tr>
<th>COMPONENT</th>
<th>STEPS</th>
<th>PURPOSE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rescue Scene Evaluation</td>
<td>• Hazards</td>
<td>The purpose of the RSE is to ensure that the scene is safe for the crew and patient and to provide information about the nature and extent of the patient’s injuries or condition.</td>
</tr>
<tr>
<td></td>
<td>• Environment</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Mechanism of injury</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• People</td>
<td></td>
</tr>
<tr>
<td>Primary Survey</td>
<td>• LOC</td>
<td>The purpose of the primary survey is to identify and manage life- and limb-threatening injuries and conditions.</td>
</tr>
<tr>
<td></td>
<td>• Spinal Precautions</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Airway</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Breathing</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Circulation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Rapid Body</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Survey interventions</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Skin</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Oxygen</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Airway</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Position</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Transport Decision</td>
<td></td>
</tr>
<tr>
<td>Secondary Survey</td>
<td>• History</td>
<td>The purpose of the secondary survey is to identify the patient’s chief complaint, establish a baseline set of vital signs and gather information about the patient’s injuries and condition.</td>
</tr>
<tr>
<td></td>
<td>• Vital signs</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Head-to-toe examination</td>
<td></td>
</tr>
<tr>
<td>Treatments</td>
<td>• Wound Care</td>
<td>Treatments are first aid procedures that do not require direct physician supervision.</td>
</tr>
<tr>
<td></td>
<td>• Fracture management</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Spinal management</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Burn management</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Management of specific injuries and conditions</td>
<td></td>
</tr>
<tr>
<td>Protocols</td>
<td>• Various</td>
<td>Protocols allow the EMA to perform medical procedures that are normally in the domain of a physician.</td>
</tr>
<tr>
<td>Load and Transport</td>
<td>• Stretcher</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Reassessment</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Equipment</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Transport mode</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Notification</td>
<td></td>
</tr>
<tr>
<td>Records and Reports</td>
<td>• Forms</td>
<td>Reports are used to gather or give information regarding the patient’s status and treatment. Forms are used to record assessment and treatment of a patient.</td>
</tr>
<tr>
<td></td>
<td>• Reports</td>
<td></td>
</tr>
</tbody>
</table>
### Patient Assessment Model - Primary/Initial Survey Assessment

<table>
<thead>
<tr>
<th>PRIMARY SURVEY INTERVENTION</th>
<th>INDICATIONS</th>
</tr>
</thead>
</table>
| Cervical spine stabilization                         | • Mechanism of injury in which injury to the head and neck is possible  
  • Obvious injury above the level of the clavicles  
  • Unconscious patient where trauma cannot be reasonably ruled out                                      |
| Obstructed airway procedures                         | • Absence of respiration  
  • Inability to ventilate the patient                                                                  |
| Airway maintenance and suctioning                    | • Decreased level of consciousness (LOC)  
  • Presence of fluids or potential obstructions in upper airway                                         |
| Ventilating the non-breathing patient                | • Absence of respirations                                                                                                                      |
| Assisting inadequate or failing respirations         | • Abnormally fast or slow respirations  
  • Distressed respirations  
  • Shallow or labored respirations, especially in the presence of decreasing LOC or cyanosis         |
| Sealing open chest wounds                            | • Open chest wounds                                                                                                                             |
| Performing CPR                                       | • Absence of carotid pulse                                                                                                                     |
| Controlling hemorrhage                               | • Major hemorrhage                                                                                                                              |
| Stabilizing fractures                                | • Suspected fractures                                                                                                                         |
| Realigning limb fractures                            | • Fractured limbs that are grossly deformed or with no distal pulses                                                                         |
| Initiating cooling of burns                          | • Major burns                                                                                                                                  |
| Oxygen                                               | • Altered LOC  
  • Respiratory distress  
  • Pain  
  • Trauma  
  • Evidence of shock (e.g., tachycardia, tachypnea, pallor, cyanosis)                        |
| Gradual warming                                      | • Hypothermia                                                                                                                                  |
| Rapid cooling                                        | • Hyperthermia                                                                                                                                  |
Critical History Questions

**MVA**
- Location of patient
- Which vehicle was the patient in?
- How many vehicles involved
- Type of vehicle(s)
- Impact speed
- Exterior damage
- Interior damage/Compartment Intrusion
- Type of restraints
- Initial position and condition of patient
- Loss of consciousness
- Condition of other patients – fatality in same vehicle
- Vehicle equipped with airbags – were they deployed

**Fall**
- Where from
- Height
- Free fall or hit other objects during fall
- Landing surface
- Position of patient at impact – what hit first
- Initial position and condition of patient
- Has the patient moved or been moved since incident?
- Any loss of consciousness
- Cause of fall

**Pedestrian Struck**
- What hit them – size, weight
- Velocity of vehicle
- What part of the vehicle hit what part of patient?
- Damage to vehicle
- Distance patient thrown
- Initial position and condition of patient
- Has the patient moved or been moved since incident?
- Loss of consciousness
- Condition of vehicle occupants
Shooting
- Type of firearm
- Range
- Angle of shot
- Type of bullet if possible
- Entrance and exit wounds
- Initial position and condition of patient
- Loss of consciousness

Stabbing
- Type of weapon/object
- Size – length and width of weapon
- Type of wound – slashed or stabbed
- Number of wounds
- Other injuries
- Initial position and condition of patient
- Loss of consciousness
Assessing LOC Using AVPU

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Alert</td>
<td>Patient is awake, talking and should be able to maintain own airway. May need help if there is a c-spine concern and complaining of nausea or has an oral bleed.</td>
</tr>
<tr>
<td>V</td>
<td>Verbal</td>
<td>Patient responds to verbal stimulus but is drowsy. May consider placing patient semi-prone, if injuries permit.</td>
</tr>
<tr>
<td>P</td>
<td>Pain</td>
<td>Patient responds only to pain stimuli. Must monitor airway closely and intervene, as necessary. Should be semi-prone, injuries permitting.</td>
</tr>
<tr>
<td>U</td>
<td>Unresponsive</td>
<td>No response to stimuli. This patient is unable to protect own airway. You must intervene and very closely monitor patient’s airway.</td>
</tr>
</tbody>
</table>

Glasgow Coma Scale

<table>
<thead>
<tr>
<th>Eyes Opening</th>
<th>Best Verbal Response</th>
<th>Best Motor Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>4 - Spontaneously</td>
<td>5 - Oriented</td>
<td>6 - Obeys Commands</td>
</tr>
<tr>
<td>3 - To Speech</td>
<td>4 - Confused</td>
<td>5 - Localizes pain</td>
</tr>
<tr>
<td>2 - To Pain</td>
<td>3 - Inappropriate Words</td>
<td>4 - Withdraws from Pain</td>
</tr>
<tr>
<td>1 - No Response</td>
<td>2 - Incomprehensible Sounds</td>
<td>3 - Flexion (Decorticate) to pain</td>
</tr>
<tr>
<td></td>
<td>1 - No Response</td>
<td>2 - Extension (Decerebrate) to pain</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 - No Response</td>
</tr>
</tbody>
</table>


### Abbreviations

<table>
<thead>
<tr>
<th>Gender</th>
<th>Description</th>
<th>Abbreviation</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>♂</td>
<td>Female</td>
<td>COPD</td>
<td>Chronic obstructed pulmonary disease</td>
</tr>
<tr>
<td>♀</td>
<td>Male</td>
<td></td>
<td></td>
</tr>
<tr>
<td>↓</td>
<td>Diminished, decreased, lower</td>
<td>CP</td>
<td>Chest Pain</td>
</tr>
<tr>
<td>↑</td>
<td>Elevated, increased, upper</td>
<td>CPR</td>
<td>Cardiopulmonary resuscitation</td>
</tr>
<tr>
<td>&gt;</td>
<td>Greater than</td>
<td>CSF</td>
<td>Cerebral spinal fluid</td>
</tr>
<tr>
<td>&lt;</td>
<td>Less than</td>
<td>CT (CAT)</td>
<td>Computed tomography</td>
</tr>
<tr>
<td>=</td>
<td>Equals</td>
<td>CVA</td>
<td>Cerebrovascular accident</td>
</tr>
<tr>
<td>≠</td>
<td>Not equal</td>
<td>D5w</td>
<td>Dextrose 5% in water</td>
</tr>
<tr>
<td>i, ii, iii</td>
<td>One, two, three</td>
<td>D10w</td>
<td>Dextrose 10% in water</td>
</tr>
<tr>
<td>∅</td>
<td>None, not present, not found</td>
<td>DOA</td>
<td>Code 4, Dead on arrival</td>
</tr>
<tr>
<td>abd</td>
<td>Abdomen</td>
<td>DPU</td>
<td>Discharge planning unit</td>
</tr>
<tr>
<td>AED</td>
<td>Automatic external defibrillator</td>
<td>Dx</td>
<td>Diagnosis</td>
</tr>
<tr>
<td>AE, A/E</td>
<td>Air entry</td>
<td>ECG, EKG</td>
<td>Electrocardiogram</td>
</tr>
<tr>
<td>ac</td>
<td>Before meals</td>
<td>ECU</td>
<td>Extended care unit</td>
</tr>
<tr>
<td>am</td>
<td>Before noon</td>
<td>EEG</td>
<td>Electroencephalograph</td>
</tr>
<tr>
<td>ANU</td>
<td>Ambulance not used</td>
<td>EP</td>
<td>Emergency physician</td>
</tr>
<tr>
<td>AOB</td>
<td>Alcohol on breath</td>
<td>ER, ED</td>
<td>Emergency room, department</td>
</tr>
<tr>
<td>approx</td>
<td>Approximately</td>
<td>ET</td>
<td>Endotracheal</td>
</tr>
<tr>
<td>ASA</td>
<td>Acetylsalicylic acid, Aspirin</td>
<td>ETA</td>
<td>Estimated time of arrival</td>
</tr>
<tr>
<td>ASAP</td>
<td>As soon as possible</td>
<td>FR</td>
<td>First responder</td>
</tr>
<tr>
<td>bG</td>
<td>Blood glucose</td>
<td>Fx, #</td>
<td>Fracture</td>
</tr>
<tr>
<td>bid</td>
<td>Twice a day</td>
<td>GI</td>
<td>Gastrointestinal</td>
</tr>
<tr>
<td>BP</td>
<td>Blood pressure</td>
<td>GOA</td>
<td>Gone on arrival</td>
</tr>
<tr>
<td>c</td>
<td>With</td>
<td>Gtt</td>
<td>Drop</td>
</tr>
<tr>
<td>°C</td>
<td>Degree centigrade</td>
<td>Hb</td>
<td>haemoglobin</td>
</tr>
<tr>
<td>C-section</td>
<td>Caesarean section</td>
<td>Hct</td>
<td>Hematocrit</td>
</tr>
<tr>
<td>CP</td>
<td>Chest pain</td>
<td>H2O</td>
<td>Water</td>
</tr>
<tr>
<td>C/C</td>
<td>Chief complaint</td>
<td>Hg</td>
<td>Chem symbol for Mercury</td>
</tr>
<tr>
<td>c/o, c/o</td>
<td>Complain of</td>
<td>Hr</td>
<td>hour</td>
</tr>
<tr>
<td>Ca</td>
<td>Cancer</td>
<td>Hs</td>
<td>Evening, at bedtime</td>
</tr>
<tr>
<td>CABG</td>
<td>Coronary artery bypass graft</td>
<td>Hx</td>
<td>History</td>
</tr>
<tr>
<td>CAD</td>
<td>Coronary artery disease</td>
<td>ICN</td>
<td>Intensive care nursery</td>
</tr>
<tr>
<td>cath</td>
<td>Catheter</td>
<td>IDDM</td>
<td>Insulin dependent diabetes mellitus</td>
</tr>
<tr>
<td>CBC</td>
<td>Complete blood count</td>
<td>IM</td>
<td>Intramuscular</td>
</tr>
<tr>
<td>cc</td>
<td>Cubic centimeter</td>
<td>IV</td>
<td>Intravenous</td>
</tr>
<tr>
<td>CCU</td>
<td>Cardiac care unit</td>
<td>Kg</td>
<td>Kilogram</td>
</tr>
<tr>
<td>CHF</td>
<td>Congestive heart failure</td>
<td>q am</td>
<td>Every morning</td>
</tr>
<tr>
<td>CIS</td>
<td>Critical incident stress</td>
<td>QID/qid</td>
<td>Four times per day</td>
</tr>
<tr>
<td>Abbreviation</td>
<td>Full Form</td>
<td>Description</td>
<td></td>
</tr>
<tr>
<td>--------------</td>
<td>------------</td>
<td>-------------</td>
<td></td>
</tr>
<tr>
<td>CNS</td>
<td>Central nervous system</td>
<td>q1h, q2h Every hour, every two hours</td>
<td></td>
</tr>
<tr>
<td>CO₂</td>
<td>Carbon dioxide</td>
<td>R, resp Respirations</td>
<td></td>
</tr>
<tr>
<td>L₁</td>
<td>First lumbar vertebrae</td>
<td>RBC Red blood cells</td>
<td></td>
</tr>
<tr>
<td>L₁, L</td>
<td>Litre</td>
<td>RLQ Right lower quadrant</td>
<td></td>
</tr>
<tr>
<td>lg</td>
<td>Large</td>
<td>RUQ Right upper quadrant</td>
<td></td>
</tr>
<tr>
<td>LLQ</td>
<td>Left lower quadrant</td>
<td>per through, by</td>
<td></td>
</tr>
<tr>
<td>LOC</td>
<td>Level of consciousness</td>
<td>PERL Pupils, equal, react to light</td>
<td></td>
</tr>
<tr>
<td>LUQ</td>
<td>Left upper quadrant</td>
<td>PERLA Pupils, equal, round, react to light and accommodation</td>
<td></td>
</tr>
<tr>
<td>MCG, mcg</td>
<td>Microgram</td>
<td>PO By mouth, oral</td>
<td></td>
</tr>
<tr>
<td>MCI</td>
<td>Multi-casualty incident</td>
<td>post-op Post operative</td>
<td></td>
</tr>
<tr>
<td>mEq/L</td>
<td>Milliequivalents per litre</td>
<td>pre-op Pre-operative</td>
<td></td>
</tr>
<tr>
<td>mg</td>
<td>Milligram</td>
<td>prn As needed, as required</td>
<td></td>
</tr>
<tr>
<td>MI</td>
<td>Myocardial infarction</td>
<td>pt Patient</td>
<td></td>
</tr>
<tr>
<td>ml, mL</td>
<td>Millilitre</td>
<td>Rx Medications</td>
<td></td>
</tr>
<tr>
<td>MO</td>
<td>Mental observation point</td>
<td>R/O Rule out</td>
<td></td>
</tr>
<tr>
<td>MRI</td>
<td>Magnetic resonance imaging</td>
<td>s, w/o Without</td>
<td></td>
</tr>
<tr>
<td>MVA</td>
<td>Motor vehicle accident</td>
<td>SA Sinoatrial node</td>
<td></td>
</tr>
<tr>
<td>NIDDM</td>
<td>Non-insulin dependant</td>
<td>SC, sc Subcutaneous diabetes mellitus</td>
<td></td>
</tr>
<tr>
<td>Nitro</td>
<td>Nitroglycerin</td>
<td>SCN Special care nursery</td>
<td></td>
</tr>
<tr>
<td>NKA</td>
<td>No known allergies</td>
<td>SIDS Sudden infant death syndrome</td>
<td></td>
</tr>
<tr>
<td>NPO</td>
<td>Nothing by mouth</td>
<td>SOB Shortness of breath</td>
<td></td>
</tr>
<tr>
<td>NS, N/S</td>
<td>Normal Saline</td>
<td>SL, sl Sublingual</td>
<td></td>
</tr>
<tr>
<td>NYD</td>
<td>Not yet diagnosed</td>
<td>Stat Immediately</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>SV Stroke volume</td>
<td></td>
</tr>
<tr>
<td>N₂O₂</td>
<td>Nitrous Oxide (Entonox)</td>
<td>Tab Tablet</td>
<td></td>
</tr>
<tr>
<td>O₂</td>
<td>Oxygen</td>
<td>T-2 Second thoracic vertebrae</td>
<td></td>
</tr>
<tr>
<td>OB, OBS</td>
<td>Obstetrics</td>
<td>TIA Transient ischemic attack</td>
<td></td>
</tr>
<tr>
<td>od</td>
<td>Once per day</td>
<td>tid Three times per day</td>
<td></td>
</tr>
<tr>
<td>OD</td>
<td>Overdose</td>
<td>TPR Temperature, pulse, respiration</td>
<td></td>
</tr>
<tr>
<td>OR</td>
<td>Operating room</td>
<td>TKO/TKVO To keep vein open</td>
<td></td>
</tr>
<tr>
<td>OTC</td>
<td>Over the counter</td>
<td>TIA Transient ischemic attack</td>
<td></td>
</tr>
<tr>
<td>U/K</td>
<td>Unknown</td>
<td>TPN Total parenteral nutrition</td>
<td></td>
</tr>
<tr>
<td>P</td>
<td>Pulse</td>
<td>Tx Treatment</td>
<td></td>
</tr>
<tr>
<td>palp</td>
<td>Palpation</td>
<td>Tx Transmit</td>
<td></td>
</tr>
<tr>
<td>PAU</td>
<td>Psychiatric assessment unit</td>
<td>Vag Vaginal</td>
<td></td>
</tr>
<tr>
<td>pc</td>
<td>After meals, after food</td>
<td>Yr Year</td>
<td></td>
</tr>
</tbody>
</table>
# Patient Care Report

## Patient Name

**Patient Name**

**Age**

**Doctor**

**Date of Evaluation (MM/DD/YYYY)**

**Chief Complaint/Description of Incident**

**Attendant Name**

**Time of Call/Dispatch**

**Time at Scene**

**Time to Hospital**

**Time at Hospital**

**Time Clear**

**Mechanism of Injury/History of Illness**

**Level Applied For**

**Training Institution**

**Relevant Past Medical History**

**Physical Exam**

**State of Consciousness**

**H & N**

**G宴**

**C.V.S.**

**Air**

**Back**

**Ext.**

**S.N.S.**

**Blood Loss**

## Care Given

<table>
<thead>
<tr>
<th>Care Given</th>
<th>Airway</th>
</tr>
</thead>
<tbody>
<tr>
<td>CELLULOSE BLEEDING</td>
<td>CLEARED</td>
</tr>
<tr>
<td>DEEP WOUND</td>
<td>POSITIONED</td>
</tr>
<tr>
<td>CPR</td>
<td>SUCTIONED</td>
</tr>
<tr>
<td>AIR</td>
<td>ASSISTED</td>
</tr>
<tr>
<td>SPINAL IMMOBILIZATION</td>
<td>ORAL AIRWAY</td>
</tr>
<tr>
<td>N THERAPY</td>
<td>NASAL CANULA</td>
</tr>
<tr>
<td>PATIENT COMFORT/HEALING</td>
<td></td>
</tr>
<tr>
<td>TRAUMA MORT</td>
<td></td>
</tr>
</tbody>
</table>

## Oxygen

<table>
<thead>
<tr>
<th>Oxygen</th>
</tr>
</thead>
<tbody>
<tr>
<td>MASK</td>
</tr>
<tr>
<td>BVM</td>
</tr>
<tr>
<td>OXYGEN</td>
</tr>
</tbody>
</table>

## Pain Assessment

## Front and Back

## Pupils

## Vital Signs

<table>
<thead>
<tr>
<th>Time</th>
<th>E</th>
<th>V</th>
<th>M</th>
<th>Total Pulse</th>
<th>Respiration</th>
<th>So2</th>
<th>BP</th>
<th>Skin</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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<td></td>
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</tr>
</tbody>
</table>

## Protocols

## Additional Treatments and Comments

---

*Medical document providing details on patient care, including medical history, physical examination results, and treatments administered.*
Patient Care Report – Cont.

**PATIENT ASSESSMENT GUIDE**

**RESCUE SCENE EVALUATION**
- Personal Protective Equipment
- Environment
- Hazards
- Mechanism of injury

**PRIMARY SURVEY**
- LOC
- Delicate Spine
- Airway
- Breathing
- Circulation
- Rapid Body Survey
- 

**SECONDARY SURVEY**

**HISTORY**
- Chief Complaint
- History of Chief Complaint
- Relevent Medical History
- Medications
- Allergies

**VITAL SIGNS**
- LOC
- Respiration
- Pulse
- Skin
- BP

**HEAD-TO-TOE ASSESSMENT**
- Head
- Neck
- Chest
- Breath Sounds
- Bowel Sounds
- Abdomen
- Hips/Pelvis
- Back
- Lower Extremities
- Upper Extremities

**HAND-OFF REPORT**
- Age
- Chief Complaint
- History of Chief Complaint
- Medical History
- Medications
- Vital Signs
- Allergies
- Relevant Physical Findings
- Treatments/Protocols

**FUNCTIONAL INQUIRY**
- General
- CNS
- Respiratory
- Cardiac
- GI/GU
- Endocrine
- Muscular/Skeletal

**DOCUMENTATION INFORMATION AND COMMON ABBREVIATIONS**

**GLASGOW COMA SCALE: TOTAL SCORE = /15**

<table>
<thead>
<tr>
<th>Eyes Open</th>
<th>Best Verbal Response</th>
<th>Best Motor Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>4 Spontaneously</td>
<td>5 Oriented</td>
<td>6 Obey commands</td>
</tr>
<tr>
<td>3 To Speech</td>
<td>4 Confused</td>
<td>5 Localizes to pain</td>
</tr>
<tr>
<td>2 To Pain</td>
<td>3 Inappropriate words</td>
<td>4 Withdraws from pain</td>
</tr>
<tr>
<td>1 No Response</td>
<td>2 Incomprehensible sounds</td>
<td>3 Flexion to pain (decorticate)</td>
</tr>
</tbody>
</table>

| A Alert         | V Verbal             | P Pain              | U Unresponsive      |

**PAIN ASSESSMENT**

<table>
<thead>
<tr>
<th>P Position</th>
<th>L Location</th>
</tr>
</thead>
</table>

**MEDICAL ASSESSMENT**

<table>
<thead>
<tr>
<th>S Signs &amp; Symptoms</th>
<th>A Allergies</th>
</tr>
</thead>
<tbody>
<tr>
<td>T Type of Pain</td>
<td>M Medications</td>
</tr>
<tr>
<td>R Releiving/Radiating</td>
<td>P Previous Hx</td>
</tr>
<tr>
<td>S Severe</td>
<td>L Last Oral Intake</td>
</tr>
<tr>
<td>P Precipitating event</td>
<td>E Events Precipitating</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Abdomen</th>
<th>Abd</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdominal pain</td>
<td>Abd pm</td>
</tr>
<tr>
<td>As needed</td>
<td>pm</td>
</tr>
<tr>
<td>Automatic External Defibrillator</td>
<td>AED</td>
</tr>
<tr>
<td>Alcohol</td>
<td>ST/GH</td>
</tr>
<tr>
<td>Bag Valve Mask</td>
<td>BVM</td>
</tr>
<tr>
<td>Basic Life Support</td>
<td>BLS</td>
</tr>
<tr>
<td>Blood Pressure</td>
<td>BP</td>
</tr>
<tr>
<td>Body Surface Area</td>
<td>BSA</td>
</tr>
<tr>
<td>Cardiopulmonary Resuscitation</td>
<td>CPRS</td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>CV</td>
</tr>
<tr>
<td>Central Nervous System</td>
<td>CNS</td>
</tr>
<tr>
<td>Chief Complaint</td>
<td>CC</td>
</tr>
<tr>
<td>Chest Pain</td>
<td>COPD</td>
</tr>
<tr>
<td>Complains of</td>
<td>O2O</td>
</tr>
<tr>
<td>Chronic Obstructive Pulmonary Disease</td>
<td>COPD</td>
</tr>
<tr>
<td>Congestive Heart Failure</td>
<td>CHF</td>
</tr>
<tr>
<td>Coronary Artery Disease</td>
<td>CAO</td>
</tr>
<tr>
<td>Dead on Arrival</td>
<td>DOA</td>
</tr>
<tr>
<td>Decreased</td>
<td>Diastol</td>
</tr>
<tr>
<td>Duration</td>
<td>EMT</td>
</tr>
<tr>
<td>Ear, Nose, and Throat</td>
<td>ENT</td>
</tr>
<tr>
<td>Equal</td>
<td>EKG</td>
</tr>
<tr>
<td>Estimated time of arrival</td>
<td>ETI</td>
</tr>
<tr>
<td>Female</td>
<td>OB</td>
</tr>
<tr>
<td>Foreign body obstruction</td>
<td>FRB</td>
</tr>
<tr>
<td>Glaucoma</td>
<td>GSW</td>
</tr>
<tr>
<td>History</td>
<td>Hx</td>
</tr>
<tr>
<td>Hypertension</td>
<td>HTN</td>
</tr>
<tr>
<td>Immediately</td>
<td>STAT</td>
</tr>
<tr>
<td>Increased</td>
<td>VVC</td>
</tr>
<tr>
<td>Insulin Dependent Diabetes Mellitus</td>
<td>IDDM</td>
</tr>
<tr>
<td>Left Lower Quadrant</td>
<td>LLQ</td>
</tr>
</tbody>
</table>
Treatment Section

The intent of the Treatment Section is to provide algorithms for many of the treatments that are carried out on a regular basis where protocols do not normally exist. If you require further information or detail you should refer to the appropriate training manual or references below.

References

American Heart Association


Canadian Red Cross – Emergency Care

Nancy Caroline’s Emergency Care in the Streets Canadian Edition 7th Edition

The National Occupational Competencies Profile (NOCP) for Paramedics

Emergency Medical Assistants Regulation
Wound Care

**INDICATIONS**
- Open and closed wounds

**IN THE PRIMARY SURVEY**
- Expose and examine
- Control major hemorrhage
- Cover with sterile dressing
- Assess distal circulation
- Continue with assessment and treatment

**IN THE TREATMENT COMPONENT**
- Bandage major wounds (if not already done)
- Clean and dress minor wounds
- Apply cold if required
- Elevate if appropriate

---

2 Methods of hemorrhage control, in order of preference, include:
Direct pressure
Positioning the part (elevation of the injured part). Should be done only if it will not aggravate other injuries or conditions.
Positioning the patient (at rest and supine if other injuries and conditions permit)
Tourniquet (note time and do not release once applied)

3 Absence of distal circulation may indicate a limb-threatening injury or condition. Consider managing the patient as unstable and initiating rapid transport. Realign grossly deformed limbs to the anatomical position only once if needed to facilitate transport attempt realignment to anatomical position once if limb is found to be pulseless

4 Cold may be applied if the distal circulation is not impaired. Cold may be applied earlier (i.e. at the end of the primary survey) provided the attendant has checked and compared the circulation in the injured limb with the circulation in the uninjured limb.

5 Embedded objects should be stabilized in place. Immobilize limbs if there are large wounds or wounds over joints.
Preservation of Amputated Parts

When a part of the body is completely avulsed (torn off) or amputated (cut off) it is important to try and preserve the amputated part in optimal condition to maximize the chances of successful reattachment. Once the patient’s injuries have been stabilized, turn your attention to the amputated part, which will also require careful care, as outline below:

Procedure

1) Rinse the amputated part with cool sterile water to remove any gross contaminates/debris
2) Wrap the part loosely in saline-moisten sterile gauze.
3) Place the amputated part inside a plastic bag and keep it cool in a protective container.
4) Transport with the patient.

Key Points

1) Do not warm an amputated part.
2) Never place the part in water.
3) Never place the part directly on ice.
4) Never use dry ice to cool the part.
Fracture Management

**INDICATIONS**
- Suspected limb
- Joint fractures
- Dislocations
- Severe sprains

**IN THE PRIMARY SURVEY**
- Expose and examine
- Control major hemorrhage
- Stabilize fractured limb(s)
- Check distal pulse(s)\(^6\)
- Realign grossly deformed or pulseless limb(s)\(^7\)

**IN THE PROTOCOL COMPONENT**
- Analgesia (Entonox) if appropriate

**IN THE TREATMENT COMPONENT**
- Check distal circulation, sensation and function\(^7\)
- Apply cold
- Provide pain relief prior to movement
- Apply traction if appropriate
- Realign grossly angulated long-bone fractures if appropriate
- Immobilize the joints above and below the injury site\(^8\)
- Reassess distal circulation, sensation and function\(^7\)
- Reapply cold if appropriate\(^6\)
- Elevate if appropriate

---

\(^6\) Cold may be applied if the distal circulation is not impaired. Cold may be applied earlier (i.e., at the end of the primary survey) provided the attendant has checked and compared the circulation in the injured limb with the circulation in the uninjured limb.

\(^7\) Absence of distal circulation may indicate a limb-threatening injury or condition. Manage the patient as unstable and initiate rapid transport if distal circulation cannot be restored.

\(^8\) Commercially available splints and/or padded wooden splints or splint anatomically as appropriate.
Fracture Management – Traction Splint

INDICATIONS
- Suspected mid-shaft femur fractures.

PROCEDURE
1. Assess distal circulation, sensation, and function.
2. Apply cold, if appropriate, ice on for 10 minutes, off for 5.
3. Ensure that patient is supine with the injured leg in line with the body.
5. Place splint beside injured leg.
7. Apply ankle harness above the malleoli.
8. Apply traction: (once traction is applied, do NOT release traction)
   a. Closed, mid-shaft fractures: 10% of patient's body weight to a maximum of 15 lbs. (7 kg).
   b. Open, mid-shaft fracture: Maximum 5lbs.
9. Reassess distal pulse.
10. Ensure adequate padding.
11. Stabilize limb and splint by applying three elasticized straps.
12. Reassess distal circulation, sensation, and function.
13. With each movement/reassessment of ABC’s or vitals, traction should be reassessed and corrected if necessary.
Pelvis binding

The important principle is that the pelvis should be stabilized prior to transport. Support the pelvic area by applying three overlapping broad triangular bandages around the pelvis. The top of the superior bandage should be just inferior to the iliac crests. Tie the bandages tightly enough to support the pelvis but not cause pain. Do not roll the patient when applying the bandages. Use a commercial pelvic binder if available, it offers ease / speed of application and is effective at compressing the intra-pelvic space.

Hip Dislocation/Fracture

Management

A patient with a hip dislocation/fracture is considered to have a limb-threatening injury and is in the Rapid Transport Category.

Quickly support the injured limb using helpers, rolled blankets, or pillows and ties.

Move the patient onto a firm, blanketed stretcher or spinal device. Secure the patient to the stretcher or spinal device to eliminate motion in the affected hip. Early medical reduction of this dislocation is essential to avoid serious long-term complications.

Conduct any remainder of the secondary survey en route to medical aid. Maintain a regular check of the vital signs, the patient’s general condition, and the state of distal pulses and neurological function in the affected limb. If a dislocation is suspected and if the hip spontaneously reduces during treatment or transportation, notify the attending physician.
Spinal Management

INDICATIONS

- Follow the Nexus Criteria

IN THE PRIMARY SURVEY

- Manually stabilize the head and neck

IN THE TREATMENT COMPONENT

- Apply hard collar
- Place patient on a spinal immobilization device
- (if required) Loosen hard collar and align head and neck to neutral position
- (if required) Re-apply hard collar
- Secure patient's body to spinal immobilization device if appropriate

TRAUMATIC BRAIN INJURIES

Any patient with head trauma and any altered level of consciousness, should be suspected of having a traumatic brain injury.

Minimize scene time if possible

- Ensure adequate oxygenation (SpO₂ > 95%).
- If the patient is having difficulty maintaining respirations, assist with ventilations keeping the SpO₂ at > 95%.
- Maintain a blood pressure of > 120mmHg systolic
- Maintain normal blood sugar levels (4.0-8.0 mmol/L)
- IV – TKVO if systolic BP is > 120mmHg.
Adult Cervical SMR Decision Matrix
Patients Aged 16 - 65

- Multi-Trauma?
  - Yes: Full SMR Warranted
  - No
    - Meets Nexus criteria?
      - Yes: Simple SMR Warranted
      - No
        - High Risk Patient?
          - Yes: Simple SMR Warranted
          - No: No SMR Required

High Risk Group:
- Age >65
- Osteoporosis
- Pre-existing spinal condition (e.g., ankylosing spondylitis)

Simple SMR: Cervical collar on – head not taped; patient on mattress not clamshell; head of stretcher up 30° only if head injured

Multi-trauma: more than one simultaneous injury, such as multiple bone fractures, major lacerations and damage to internal organs or major blood vessels.

Modified NEXUS

1. Is there midline tenderness?
2. Is there an altered LOC?
   - Must be alert and oriented x 3 (or 4)
3. Are there new focal neurological deficits?
4. Are they intoxicated?
   - Judgement and pain sensation must be intact
5. Is there a major distracting injury?
   - Significant enough to interfere with their ability to assess pain response when palpating spine

No to ALL FIVE questions – SMR is not warranted.

Thoracolumbar Injuries
If the patient does not require SMR as per NEXUS criteria, but has any of the following findings, do not sit the patient up or raise the head of the stretcher on the assumption that T/L spine injuries may be present:
- Dangerous mechanism of injury
- Fall from height>3m
- Axial load to head or base of spine
- High speed MVC (>100kph)
- Roller MVC
- Pre-existing spinal pathology
- New back deformity, bruising, or bony midline tenderness or laceration
Burn Management

Burns can come from a variety of sources such as hot water (scalds) and fire. It is known that applying ice directly to a burn can cause tissue ischemia. The 2015 ILCOR systematic review of the evidence for cooling of burns evaluated agents that were cool or cold, but not frozen. Cooling was found to reduce risk of injury and depth of injury. Cool thermal burns with cool or cold potable water as soon as possible. If cool or cold water is not available, a clean cool or cold, but not freezing, compress can be useful as a substitute for cooling thermal burns. Care should be taken to monitor for hypothermia when cooling large burns. This is particularly important in children, who have a larger body surface area for their weight than adults have.

Rule of Nine’s
INDICATIONS

• All burn injuries

IN THE PRIMARY SURVEY

• Expose and examine
• Initiate cooling
• High-flow oxygen
• Calculate BSA

IN THE TREATMENT COMPONENT

• Dress wounds
• Use pain control measures (e.g. cold, Analgesia {Entonox} if appropriate)

9 Cool major burns for a total of 2 minutes on scene, transport and continue cooling enroute.
10 After cooling is complete, cover wounds with dry, sterile burn dressings
11 Cold may be applied if the distal circulation is not impaired. Cold may be applied earlier (i.e. at the end of the primary survey), provided the attendant has checked and compared the circulation in the injured limb with the circulation in the uninjured limb.
Hypothermia

INDICATIONS

• Suspected hypothermia because of mechanism of injury, history, presentation of the patient.

IN THE PRIMARY SURVEY

• Assess and maintain the ABCs as necessary
• Ventilate the non-breathing, severely hypothermic patient at a rate of 8 - 10 per minute
• Take up to 30-45 seconds to determine pulselessness in the severely hypothermic patient.
• Remove wet and cold clothing and cover with blankets or dry clothing
• Oxygen
• Take temperature if appropriate
• In the event of cardiac arrest analyze once with the AED and shock if indicated, continue with CPR and rapid transport to the hospital.

IN THE TREATMENT COMPONENT

Mild hypothermia (>30°C and <35°C) - Actively rewarm patient:

• Mild activity (if appropriate)
• Preheat the interior of ambulance to 30°C
• Use hot packs wrapped in towels
• Warm blankets

Severe hypothermia (<30°C) - Do not actively rewarm patient

• Insulate patient to prevent further heat loss
• Heat ambulance to 30°C
• Avoid rough handling

12 Administer oxygen using caution in severe hypothermia regarding its potential cooling effects.
CVA – Stroke – Flowchart

HAZARDS

ENVIRONMENTAL CONSIDERATIONS

FINDINGS IN THE STABLE PATIENT
- Alert and oriented
- Clear airway, adequate breathing
- Strong regular radial pulse
- Warm, dry skin

FINDINGS IN THE UNSTABLE PATIENT
- Any neurological deficits
- Altered LOC or unconscious
- Difficulty maintaining airway
- Shortness of breath, noisy or absent respirations
- Weak, rapid or absent radial pulse

CRITICAL INTERVENTIONS
- AVPU
- Assess and manage ABC’s
- Position of patient
- Accurate recognition, and timely management and transport of a possible stroke patient
- Blood glucose check

NOTES:
If patient experienced a TIA that has resolved itself, may be considered stable

DECISION POINT

STABLE
Secondary Survey
- History
- Vital Signs
- Head to toe

Transport/notify hospital
Monitor vital signs

UNSTABLE
Transport
Notify hospital
Secondary Survey
- History
- Vital Signs
- Head to toe
- Monitor vital signs
CVA – Stroke – Continued

As soon as possible utilize the **FAST-VAN** pre-hospital stroke tool.

**Face** – Right droop? Left droop?

**Arm** – Right weak? Left weak?

**Speech** – Slurred

**Time** - < 6 hours or awoke with symptoms

- If “Yes” to one or more above and < 6 hours or awoke with symptoms, proceed with “VAN”
- If “NO” transport to nearest hospital

**Vision** – Right gaze? Left gaze?

**Aphasia** – Naming difficulties

**Neglect** – Ignoring left body?

- One or more “VAN” signs notify receiving hospital with possible large vessel occlusion.
Abdominal Injuries - Flowchart

HAZARDS
- Environmental Considerations

FINDINGS IN THE STABLE PATIENT
- Alert and oriented
- Clear airway, adequate breathing
- Strong regular radial pulse
- Warm, dry skin

FINDINGS IN THE UNSTABLE PATIENT
- May have altered LOC
- Rapid, shallow breathing
- Weak, rapid, or absent radial pulses
- Pale, cool, clammy skin
- Life threatening injuries

CRITICAL INTERVENTIONS
- Expose injury
- Control hemorrhage
- Keep patient warm
- Position of comfort

DETECTION POINT

STABLE
- Secondary Survey
  - History
  - Vital Signs
  - Head to toe

UNSTABLE
- Transport
- Notify hospital
- Secondary Survey
  - History
  - Vital Signs
  - Head to toe
  - Monitor vital signs

PATIENT CARE REPORT/HANDOFF
- Monitor vital signs

Notes:
- TXA if indicated
Congestive Heart Failure or Pulmonary Edema – Flowchart

HAZARDS

PATIENT CARE

REPORT/HANDOFF

FINDINGS IN THE STABLE PATIENT
- Conscious
- Able to maintain airway
- Mild, respiration distress
- Strong, regular radial pulse
- Warm, dry skin

DECISION POINT

FINDINGS IN THE UNSTABLE PATIENT
- Altered LOC or unconscious
- Difficulty maintaining airway
- Respiration distress
- Accessory muscle use
- Noisy respirations
- Weak, rapid or absent radial pulse
- Peripheral edema
- Cool, clammy skin

CRITICAL INTERVENTIONS
- Position of comfort
- Assist ventilations if altered LOC

ENVIRONMENTAL CONSIDERATIONS

ADDITIONAL RESOURCES

TRANSPORT/NOTIFY HOSPITAL

NUMBER OF PATIENTS

SECONDARY SURVEY

- History
- Vital Signs
- Head to toe

STABLE

PATIENT CARE REPORT/HANDOFF

MONITOR VITAL SIGNS

UNSTABLE

TRANSPORT

NOTIFY HOSPITAL
Chest Trauma – Flowchart

HAZARDS

NUMBER OF PATIENTS

ENVIRONMENTAL CONSIDERATIONS

MECHANISM OF INJURY

ADDITIONAL RESOURCES

FINDINGS IN THE STABLE PATIENT
- Alert, orientated
- No accessory muscle use
- Strong radial pulse
- Warm, dry skin
- Minor chest wound

LOC
D
A
B
C
RBS
SKIN
O2

FINDINGS IN THE UNSTABLE PATIENT
- May have altered LOC
- Difficulty maintaining airway
- Accessory muscle use
- Weak, rapid or absent radial pulse
- Life threatening injuries
- Pale, cool and clammy skin
- Major chest wound

CRITICAL INTERVENTIONS
- Seal open chest wound
- MANUALLY Stabilize flail chest
- Position patient ASAP
- Assist ventilation if necessary
- Control any bleeding

NOTES:
Open Chest: use a vented occlusive dressing or commercial chest seal
Flail Chest: use abd. pad large enough to cover flail segment, upon full inspiration, no larger, taped firmly enough to stop paradoxical movement. Large adhesive taped using cross action to fully cover pad.

STABLE

Secondary Survey
- History
- Vital Signs
- Head to toe

Transport/notify hospital

Monitor vital signs

UNSTABLE

Transport

Notify hospital

Secondary Survey
- History
- Vital Signs
- Head to toe
- Monitor vital signs

DECISION POINT

PATIENT CARE REPORT/HANDOFF
Electrical Contact – Flowchart

FINDINGS IN THE UNSTABLE PATIENT
- May have altered LOC
- Cardiac Arrest
- Difficulty maintaining airway
- Respirations may require assistance
- Irregular, or absent radial pulse
- Muscle spasms
- Major burns

FINDINGS IN THE STABLE PATIENT
- Alert, orientated
- Able to maintain airway
- Strong, regular radial pulse
- Minor burns

CRITICAL INTERVENTIONS
- Expose injuries
- Cool burns ASAP

HAZARDS
- Investigate amperage/source of electrical contact

ENVIRONMENTAL CONSIDERATIONS
- Monitor vital signs
- History
- Vital Signs
- Head to toe

ADDITIONAL RESOURCES
- History
- Vital Signs
- Head to toe
- Monitor vital signs

NUMBER OF PATIENTS
- Secondary Survey
- Transport
- Notify hospital
- Monitor vital signs

STABLE
- History
- Vital Signs
- Head to toe

UNSTABLE
- History
- Vital Signs
- Head to toe
- Monitor vital signs

REPORT/HANDOFF
- History
- Vital Signs
- Head to toe
- Monitor vital signs
Heat Exhaustion/Heatstroke – Flowchart

**HAZARDS**

**ENVIRONMENTAL CONSIDERATIONS**

**MECHANISM OF INJURY**

**NUMBER OF PATIENTS**

**FINDINGS IN THE STABLE PATIENT**
- Conscious, may be agitated or confused
- Able to maintain airway, breathing
- Strong radial pulse
- Warm, pink, or sweating skin

**FINDINGS IN THE UNSTABLE PATIENT**
- Fainting spells or unconsciousness
- Irregular or panting respirations
- Weak radial pulse
- Hot, dry or ashen skin

**LOC**

**D**

**A**

**B**

**C**

**RBS**

**SKIN**

**O₂**

**CRITICAL INTERVENTIONS**
- Move patient to cool area if appropriate
- Remove clothing
- Cool rapidly

**NOTES:**
All suspected heatstroke patients are treated as unstable

**DECISION POINT**

**STABLE**

**UNSTABLE**

**Secondary Survey**
- History
- Vital Signs
- Head to toe

**Transport**

**Notify hospital**

**Transport/notify hospital**

**Monitor vital signs**

**PATIENT CARE REPORT/HANDOFF**

**ADDITIONAL RESOURCES**
Drowning/Near Drowning – Flowchart

HAZARDS

ENVIRONMENTAL
CONSIDERATIONS

FINDINGS IN THE
UNSTABLE PATIENT

• Altered LOC or unconscious
• Possible C-spine injury
• Difficulty maintaining airway
• Shortness of breath, noisy or absent respirations
• Weak, rapid or absent radial pulse
• Cyanosis, seizure activity, chest pain

FINDINGS IN THE
STABLE PATIENT

• Conscious, may be confused
• Stable C-spine
• Able to maintain airway and breathing
• Strong radial pulse

DECISION
POINT

PATIENT CARE
REPORT/HANDOFF

CRITICAL INTERVENTIONS

• If respirations are inadequate or below 10, assist with BVM asap
• Non-humidified oxygen
• Avoid rough handling
• Maintain body temperature
• Remove wet clothing
• Provide blanket

NUMBER OF
PATIENTS

MECHANISM OF
INJURY

HAZARDS

TRANSPORT/notify hospital

Secondary Survey

• History
• Vital Signs
• Head to toe

Notify hospital

Transport

Secondary Survey

• History
• Vital Signs
• Head to toe
• Monitor vital signs

Monitor vital signs

LOC
D
A
B
C
RBS
SKIN
O₂

STABLE

UNSTABLE

ADDITIONAL
RESOURCES

INCREASED
RISK

Current to May 29, 2020
Treatment Protocols

IV Procedures

IV Initiation

INDICATIONS

In pre-hospital care, the primary indications for IV therapy are to:

- Replace fluid and electrolytes due to hypovolemia and burns
- Administer medications

Please refer to the relevant training level for specific indications within a protocol.

PROCEDURE

1. Gather and prepare equipment:
   a. Select and inspect the catheter device
   b. Select and inspect the IV solution and administration set
   c. Prime the IV tubing
2. Choose and prepare an appropriate site
3. Initiate IV
4. Connect IV tubing and infuse solution
5. Calculate and maintain an appropriate flow rate
6. Secure the IV
IV Maintenance

1. Ensure that the appropriate solution is running\(^{13}\).
2. Calculate and maintain the appropriate flow rate.
3. Monitor flow rate and amount of solution.
4. Reassess patient condition and IV on a regular basis (i.e. q 5–15 min):
   a. Reassess ABCs and injury sites.
   b. Reassess vital signs.
   c. Inspect IV site, tubing and solution bag.
   d. Observe for complications and take appropriate measures as necessary.
   e. Maintain appropriate flow rate.
   f. Change solution bag if required.
5. Intravenous solutions that can be maintained at normal TKVO rates for the purpose of inter-facility transfers, include:
   a. Normal Saline
   b. 2/3 – 1/3
   c. Ringers Lactate
   d. D\(_5\)W

IV Maintenance Rate Calculation

Some protocols may contain a reference to a maintenance rate. This maintenance rate is approximately 75 mL/hr. Two common administration sets are used: 10 gtts/mL and 60 gtts/mL.

To calculate flow rates, the following formula is used:

\[
gtts \text{ per minute} = \frac{\text{volume to be infused} \times \text{set rate}}{\text{time in minutes}}
\]

Examples:
- To infuse 500 ml NS over 12 hours using a macro-drip set (10 gtts/mL):
  \[
  500 \text{ mL} \times 10 \text{ gtts/min.} = \frac{5000}{720} = 7 \text{ gtts/min}
  \]
- To infuse 25 mL 5% D\(_{50}\)W in 60 minutes using a micro-drip set (60 gtts/mL):
  \[
  25 \text{ mL} \times 60 \text{ gtts/min.} = \frac{1500}{60} = 25 \text{ gtts/min.}
  \]

\(^{13}\) EMR, PCP and PCP - IV attendants are not to manage patients in cases where medications or other additives outside of their scope of practice have been introduced to the IV solution.
**Adult CPR/AED**

**Indications:**
- Patient in cardiac arrest

**Contraindications:**
- Verifiable Do Not Resuscitate (DNR) or No CPR orders

**Determine patient is in cardiac arrest:**
- Assess breathing and check pulse simultaneously no more than 10 seconds.
- No pulse or breathing, or gasping breathing, begin CPR

**Perform CPR**
- Position AED and analyze as soon as possible

**Shock Advised?**

**No shock advised:**
- Start 2 minutes of CPR
- Analyze
- Repeat

**If shock advised:**
- Defibrillate
- 2 minutes CPR
- Analyze
- Repeat

**Continue CPR/AED until:**
- Care is transferred over to more advanced providers
- There are signs of life (patient movement, coughing, breathing)
Child Infant CPR/AED

**Indications:**
- Patient in cardiac arrest

Determine patient is in cardiac arrest:
Assess breathing and check pulse simultaneously no more than 10 seconds.
No pulse or if pulse is < 60 with inadequate perfusion, begin CPR

Perform CPR
1 Rescuer 30:2 / 2 Rescuers 15:2
Position AED and analyse as soon as possible

Shock Advised?

**No shock advised:**
- Start 2 minutes of CPR
- Analyze
- Repeat

**If shock advised:**
- Defibrillate
- 2 minutes CPR
- Analyze
- Repeat

Continue CPR/AED until:
- Care is transferred over to more advanced providers
- There are signs of life (patient movement, coughing, breathing)
CPR/AED

Basic concepts:

- Early CPR is an essential component to successful outcome from cardiac arrest.
- CPR should be provided with as few interruptions as possible (keep interruptions to less than 10 seconds).
- Change operators every 2 minutes (where possible) to maintain maximum efficiency.
- No pulse checks after your initial assessment, until directed by advanced care providers or the patient begins to move (e.g. spontaneous breaths, cough, eyelid movement, vocalization).
- CPR is more effective while you are stationary (i.e. trying to move the patient while performing CPR results in a deterioration of effective CPR).
- Move a victim early in your management while performing CPR only if the victim is in a dangerous environment or if you believe you cannot perform CPR effectively because of the victim’s position or location.
- Early defibrillation is an essential component to successful outcome from cardiac arrhythmias that are responsive to defibrillation.
- The concepts of early CPR and early defibrillation should coexist, and one should not impede the other.
- Complete recoil after each compression.
- Avoid hyperventilation.

Adult CPR/AED Basics:

- Immediately activate the emergency response system (if appropriate) and get an AED (if available).
- Optimum chest compression rate is 100-120 per minute with a depth of 5.0 to 6.0 cm in a normal adult (adjust to 1/3 to ½ the chest diameter for smaller and bigger patients).
- Ratio is 30:2 (one or two rescuers).
- Apply and use the AED as soon as possible.
- Single shocks – resume CPR immediately following delivery of a shock.
- No Shock Advised – resume CPR immediately.
- Continue resuscitation efforts on scene as long as one is capable (or, if AED is employed, until the patient recovers, advanced care providers take over (e.g. BCAS, physician) or you are presented with a valid “Do not Resuscitate” or No CPR order.
- Initiate a call to the emergency room physician after 15 minutes of high-quality CPR to determine transport or other treatments.
Infant/Child CPR/AED Basics

- Due to the size of an infant’s head in relation to its body, use a pad (if available) under the shoulders to facilitate the head tilt-chin-lift maneuver.
- Effective ventilation/oxygenation is very important for optimal CPR.
- Assess for pulse using the brachial rather than the carotid artery.
- If alone, immediately start CPR for 5 cycles (about 2 minutes) before activating the emergency response system (if appropriate) and applying the AED (NOTE: for a witnessed sudden collapse – alone or not, immediately activate the emergency response system [if appropriate] and get an AED [if available]).
- Start CPR if there is no pulse or if the heart rate is less than 60 beats per minute with signs of poor perfusion (e.g. pale skin color or severe mottling, cyanosis, usually accompanied by a decreased or falling level of consciousness and extremely unwell or toxic appearance, often with a history suggestive of respiratory illness or sepsis).
- Optimum chest compression rate is 100 - 120 per minute with a depth of 1/3 to ½ the chest diameter.
- Ratio is 30:2 for one rescuer and 15:2 for two rescuers.
- Single shocks – resume CPR immediately following delivery of a shock.
- No Shock Advised – resume CPR immediately.
- For a child 0 - 8 years of age, switch to child AED pads (if available). If not available, you may use the adult pads and deliver the adult dose.
- If the defibrillation pads, when placed in the normal anterior/lateral chest position, are within 2.5 cm (one inch) of each other, they may need to be shifted to an anterior/posterior configuration.

Child (1 year of age to puberty) Sudden Cardiac Arrest

- Most cardiac arrests in children are not due to sudden rhythm disturbances. On rare occasions a child is in ventricular fibrillation. Specifically, cases with a history of previous cardiac problems or a sharp blow to the precordial area followed by sudden collapse (commotio cordis).
Asphyxial arrest

- Asphyxial arrest is due to hypoxia. Causes may include overdose, hanging, airway obstruction, smoke inhalation and drowning. If alone with an AED, give 5 cycles of CPR (about 2 minutes) before applying the AED. If two rescuers: apply the AED while providing one-person CPR for 5 cycles (about 2 minutes) then analyze.

Advanced Airway considerations

- For all age categories, when assisting an advanced care paramedic with an advanced airway in place, the ventilation rate is 1 breath every 6 seconds interspersed between compressions (i.e. do not pause chest compressions to provide breaths).
- It is acceptable to perform continuous compressions when an advanced airway is in place.

Treatable causes of cardiac arrest and transporting

- CPR should be continued until ROSC is achieved, further efforts are deemed futile, or the rescuers can no longer continue resuscitation due to fatigue or scene hazard.
- The main principle is that the decision to transport is multi-factorial, relies on available history and physical examination to give clues about reversible causes, and consultation with medical oversight.
- The exception to the above is consideration of transport with CPR in progress at the 15 min mark where a consultation with ER should occur to discuss any suspected reversible cause. If that consultation results in an apparent reversible cause, then transport can be considered. Such causes include but are not limited to:
  - Hypothermia
  - Cardiac tamponade
  - Pulmonary embolus
  - Hypovolemic (Trauma, GI Bleed, ruptured AAA, etc.)
  - Poisoning

Suctioning

- Suction should be applied for 10-15 seconds in the adult
- Less than 5 seconds in the pediatric patient.
Foreign Body Airway Obstruction

- Stabilize head and neck, if necessary.
- Assess Level of Consciousness (AVPU scale)
- Assess & manage ABC’s as required
- Suction, AED and BVM with OPA ready.

Unwitnessed Unconscious FBAO

If respirations absent:
- Attempt one ventilation, if no air entry or air blows back, reposition head and attempt ventilation, if no air entry, begin chest compressions.
- Continue cycle of 30 compressions to 2 vents inspecting for object in mouth prior to ventilating.

Witness Conscious to Unconscious FBAO

- Partial obstruction, have patient cough forcefully
- Full obstruction, although chest thrusts, back slaps, and abdominal thrusts are feasible and effective for relieving severe foreign body airway obstruction in conscious (responsive) adults and children >1 year of age, for simplicity in training it is recommended that abdominal thrusts be applied in rapid sequence until the obstruction is relieved.
- An infant, deliver repeated cycles of 5 back blows followed by 5 chest compressions until the object is expelled
- If abdominal thrusts are not effective, consider chest thrusts
- Patient collapses, start CPR with chest compressions (do not perform a pulse check)
- After 30 compressions, open the airway
- Do not perform blind finger sweeps
- Attempt to give 2 breaths and continue with cycles of chest compressions, checking airway.

Complete RBS
Transport
Cardiac Chest Pain PCP/EMR

INDICATIONS
- Patients whose presentation is suggestive of cardiac chest pain, who have a history of heart disease, and who would normally take their prescribed Nitroglycerin for chest pain.

CONTRAINDICATIONS
Aspirin
- Inability to swallow
- Allergy to Aspirin
- Active peptic ulcer or gastrointestinal bleeding
- Pediatric patient
- Patient has already taken their recommended Aspirin dose prior to your arrival.

Nitroglycerin
- If the patient has taken Viagra or Levitra in the last 24 hours, or Cialis in the last 48 hours
- B.P. < 90 mmHg

Before initiating the treatment, you must have done the following:
- Performed a primary
- Ruled in the CP is cardiac in nature
- Investigated the pain complaint, including severity
- Obtained a baseline set of vital signs

Administration
- 2 chewable 81 mg Aspirin PO
- 0.4 mg Nitroglycerin SL q 3 min
- Load and transport\(^{14}\) after the first Nitroglycerin\(^{15,16}\)

If pain is completely relieved, but returns:
- Re-initiate Nitroglycerin administration\(^{17}\)
- Continue with assessment, treatment and vital signs q 5 minutes.

If pain persists or BP < 90 mmHg:
- Administer Entonox 5 minutes after last dose of Nitroglycerin.
- Continue with assessment, treatment and vital signs q 5 minutes
- After 30 minutes from first dose of Nitroglycerin, this protocol may be repeated after stopping Nitrous Oxide for 5 minutes

\(^{14}\) Patient outcome is better if definitive hospital treatment is provided as soon as possible, hence early transport is highly desirable. When equipment is ready load and transport, do not delay until after the first Nitroglycerin if everything else is ready to go; load and go and treat en route.

\(^{15}\) Ensure that BP > 90 mmHg and check whether pain still persists before administrating repeat Nitroglycerin. Contact ER if needing to go beyond 3 doses or if patient condition changes.

\(^{16}\) If patient is not on Nitroglycerin, systolic pressure >100; HR >50 and <150 Nitroglycerin may be administered after mandatory call to ER

\(^{17}\) If pain is completely relieved for more than 5 minutes, you may re-initiate the Nitroglycerin component, (but not the Aspirin component) of the Chest Pain Protocol if the patient's pain returns.
Nausea – Vomiting PCP

**INDICATIONS**

Patients experiencing the sensation of nausea or vomiting.

Before initiating the Nausea Vomiting protocol, you must have done the following:
- Completed a primary survey
- Obtained a baseline set of vital signs
- Rule out any contraindications for the use of an anti-emetic

**Administration**

Stable patients may be treated with Dimenhydrinate (Gravol) on scene. Unstable patients will be treated enroute to hospital.

Dimenhydrinate
25-50 mg IM/IV *
12.5 in the frail elderly patient

Continue to manage and be aware of possible vomiting, position patient appropriately and have suction ready.

*non-IV PCP will manage by IM only
Shortness of Breath (SOB) With History of Asthma/COPD – PCP

INDICATIONS
Chief complaint of shortness of breath in a patient with a history of asthma or chronic obstructive pulmonary disease (COPD)\(^\text{18}\).

CONTRAINDICATIONS
Allergy to Ventolin

Before initiating the protocol with Ventolin, you must have done the following:

- Performed a primary survey
- Auscultated the chest\(^\text{19}\)
- Transport
- Obtained a chief complaint of shortness of breath\(^\text{20}\)
- Obtained a history of asthma or COPD
- Checked for drug allergies
- Obtained a baseline set of vital signs including oximetry

\[\text{If patient is } \geq 15kg\]
Administer 5.0 mg Ventolin in 5.0 mL NS
Continue with assessment and treatment

\[\text{If patient is } < 15kg\]
Administer 2.5 mg Ventolin 2.5 mL NS
Continue with assessment and treatment

When Ventolin is finished or after
10 minutes, reassess the patient

Patient has improved
If patient has a history of COPD,
initiate low flow \(0\)^{2,21}

Patient has not improved
If patient has a history of Asthma,
initiate high flow \(0\)\(^2\)

Repeat dose of Ventolin
Consider assisting ineffective respirations

\(\text{18}\) Consider other causes of shortness of breath, such as: congestive heart failure, dysrhythmia, risk of myocardial infarction, pulmonary embolism and pneumothorax. These patients may not improve with Ventolin. Consideration of CPAP

\(\text{19}\) Once the primary survey is complete and all primary survey interventions have been initiated, the paramedic should auscultate the chest. Note and document air entry, breath sounds, bilateral comparison, degree of respiratory distress and use of accessory muscles before and after administration of Ventolin. Rapid transport is a priority for these patients. Do not delay at the scene to initiate Ventolin.

\(\text{20}\) Patients who are short of breath should receive high-flow oxygen. Consider assisting respirations for patients who are acutely short of breath experiencing signs of hypoperfusion or in respiratory failure.

\(\text{21}\) Low flow oxygen is defined as 1-3 L/min and should be delivered by nasal cannula.
Oxygenation Management – Pulse Oximeter PCP/EMR

**INDICATIONS**
For monitoring $O_2$ on all patients.

**CONTRAINDICATIONS**
Children $<$ 10kg

**UNRELIABLE READINGS**
Carbon monoxide Poisoning
Other conditions\(^{22}\)

---

**Assess Patient**
Initiate high flow $O_2$
Apply Pulse Oximeter\(^{23}\) as per procedure

<table>
<thead>
<tr>
<th>$\text{SpO}_2 &gt; 95%$</th>
<th>$\text{SpO}_2 &lt; 95%$</th>
</tr>
</thead>
<tbody>
<tr>
<td>➢ Decrease flow rate(^{24}) to maintain $\text{SpO}_2 &gt; 95%$</td>
<td>➢ Increase $O_2$ flow rate to maximum 15 L/min(^{25})</td>
</tr>
<tr>
<td></td>
<td>➢ Switch to 100% $O_2$ via non-rebreather to maintain $\text{SpO}_2 \geq 95%$</td>
</tr>
<tr>
<td></td>
<td>➢ Consider assisted ventilation</td>
</tr>
<tr>
<td></td>
<td>➢ Record the $\text{SpO}_2$</td>
</tr>
</tbody>
</table>

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\(^{22}\) Sickle Cell Anemia, severe Anemias.

\(^{23}\) Do not delay any part of the primary survey / intervention to apply the pulse oximeter. The oxygenation management procedure is described on the next page.

\(^{24}\) Use lowest amount of Oxygen flow to maintain the $\text{SpO}_2$ at $>95\%$. Adjust Oxygen by turning it up or down by 1 L/min each minute and monitor the oximeter reading. For adult face mask, rate is 6-15 L/min; for nasal prong, rate is 2-5 L/min.

\(^{25}\) For COPD patients, maintain the $\text{SpO}_2$ in the range of 92% to 95%.
Oxygenation Management (Cont.)

**Oxygenation Management Procedure**
1. Apply oxygen as per usual practice ensuring the following type of patient gets high flow oxygen immediately:
   - Seriously ill patient
   - Short of Breath patient
   - Moderate to severely traumatized patient who may be bleeding
   - Patient who may be having internal bleeding
   - Smoke and carbon monoxide poisoning patient (maintain high oxygenation - NRB)
   - Patient with chest pains
2. Apply pulse oximeter to adequately perfusing finger;
3. Ensure the proper application of the finger probe;
4. Activate the unit;
5. Ensure the unit is detecting a pulse;
6. Compare pulse on pulse oximeter to pulse by auscultation or by palpation;
7. If pulse oximeter and palpation pulse differ by <10 BPM, the reading for the SpO₂ is reliable.
8. If pulse oximeter and palpation pulse differ by >10 BPM then:
   - Remove pulse oximeter
   - Remove nail polish
   - Use another or a warmer digit
   - Use an ear lobe (if probe available) or toe
   - Re-apply pulse oximeter and compare pulse

**Oxygen Administration**
Do not use an adult face mask with a flow rate less than 6 L/min, as this would deliver less oxygen to the patient than room air.
Nasal cannula should not be used with greater than 5 L/min O₂ as this may cause discomfort and drying of mucosa and does not increase O₂ concentrations any further.
A non-rebreather mask is indicated for carbon monoxide poisoning and smoke inhalation.
Administration of oxygen to COPD patients is by nasal cannula at 1-3 L/min (following acute care treatment with high flow oxygen, if required). Use of high flow oxygen for COPD patients complaining of chest pain is indicated.
Oxygen should be titrated based on pulse oximetry aiming for an O₂ Saturation of 95% if the patient is not SOB or in shock. Patients who are SOB or in shock require high flow O₂
Continuous Positive Airway Pressure (CPAP) PCP

CPAP is a non-invasive means to increases the oxygen diffusion across the alveolar membrane by increasing the functional residual capacity and increasing alveolar surface area.

This can help to decrease a patient’s work of breathing, and decrease oxygen consumption, while increasing their oxygen supply.

CPAP application has been shown to reduce intubation requirements and mortality.

CPAP should be considered in patients who remain short of breath with low oxygen saturation despite administration of a bronchodilator, or in patients who present with other causes of shortness of breath (CHF, pulmonary edema, near drowning, pneumonia).

Any patient who is unable to maintain their own respiratory effort is unlikely to benefit from CPAP.

These patients will require assisted ventilation via BVM. It is important to monitor the patient closely for any deterioration as CPAP will no longer be the appropriate therapy for these patients.
CPAP Guidelines

**INDICATIONS:**

Any patient ≥ 13 years of age in significant respiratory distress
- Awake and following commands
- Maintains a patent airway
- Exhibits all of the following
  - RR > 24
  - SpO₂ < 94% (on O₂)
  - Accessory muscle use

**CONTRAINDICATIONS:**

- Decreased LOC
- Respiratory arrest – Hypoventilation
- Vomiting – Risk of aspiration
- Unable to fit mask
- Traumatic cause of SOB
- Pneumothorax
- SBP < 90 mmHg

Call medical oversight (PCP)

### CPAP Use

1. Start at 5L/min with CPAP valve @ 5 cm/H₂O
2. Obtain facial seal
3. Once manual seal obtained, increase CPAP valve to 5 cm/H₂O
4. Reassess patient and vitals
5. Repeat to max. CPAP of 10 cm/H₂O

### If patient deteriorates:

Remove CPAP and use BVM with assisted ventilations (consider PEEP valve if indicated)

<table>
<thead>
<tr>
<th>CPAP Setting (cmH₂O)</th>
<th>5</th>
<th>6</th>
<th>7.5</th>
<th>10</th>
<th>12.5</th>
<th>15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Set oxygen flow (LPM)</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td>10</td>
</tr>
</tbody>
</table>
Entonox PCP/EMR

**INDICATIONS**
- Pain

**CONTRAINDICATIONS**
- Inability to ventilate an enclosed treatment area
- Inability to comply with instructions
- Suspected inhalation injury\(^{26}\)
- Suspected air embolism or pneumothorax
- Patient has taken Nitroglycerin within the last 5 minutes
- Decompression sickness

**CAUTIONS**
- Depressant drugs
- Maxillo-facial injuries
- COPD
- Distended Abdomen
- Shock

*Before initiating the Pain Using Entonox protocol, you must have done the following:*
- Completed a primary survey
- Investigated the pain complaint, including severity
- Obtained a baseline set of vital signs, including oxygen saturation
- Conducted a history and physical examination sufficient to rule out the contraindications for use of Entonox
- Invert cylinder 3 X
- (If in the ambulance) Turn on vehicle ventilation system (intake and output)

*Note:*
- Let patient use bite stick or apply mask to own face, do not assist.
- Mask/bite stick may fall away as patient becomes sedated, do not replace mask.
- Patients should receive high-flow oxygen when Entonox is discontinued.
- Discontinue if cyanosis develops.

\(^{26}\)Entonox may be administered to patients with suspected inhalation injuries if \(O_2\) saturation is 100%.
Hypovolemia - PCP

**INDICATIONS**
Patients with all of the following:
- Hypovolemia\(^{27}\)
- Systolic BP < 90 mmHg\(^{28}\)
- Other clinical signs of shock

Patients with burns > 20% BSA (second- and third-degree)

**CONTRAINDICATIONS**
- None

**CAUTIONS**
- Shortness of breath

Before initiating the Hypovolemia protocol, you must have done the following:
- Completed a primary survey
- Loaded and begin transport
- Obtained a baseline set of vital signs
- Auscultate chest (Base of the lungs)

---

\(^{27}\)Obtain evidence of loss of a significant quantity of blood or body fluids to support diagnosis of hypovolemia.

\(^{28}\)The Hypovolemia protocol may be used for patients with BP > 90 mm Hg if shock is anticipated because of the mechanism of injury, the nature and extent of the injuries or the patient’s condition.

\(^{29}\)After each 500 mL NS, auscultate the lung bases and reassess BP. If signs and symptoms of pulmonary edema are present, stop fluid bolus and administer N/S at maintenance rate.

\(^{30}\)After each 500 mL NS, reassess the BP. While the BP < 90 mm Hg, continue administering 500 mL NS
- Start a second IV, if appropriate
- Maximum 2000 mL without further orders
- Contact medical oversight for further orders
Trauma Management - TXA

**INDICATIONS**

- Trauma with signs of shock/hypoperfusion in association with injury suggestive of occult of ongoing bleeding
- >16 years
- Systolic pressure < 90 mmHg
- Heart rate > 110 beats per/minute
- Within 3 hours from time of injury and on route to receiving hospital

*Before initiating the TXA protocol, you must have done the following:*

- Completed a primary survey
- Loaded and begin transport
- Obtained a baseline set of vital signs
- Initiated the Hypovolemia protocol

**TXA** – Piggyback 1 gram (1000 mg) infused in 50 mL bag of NS and deliver at a rate of 60 gtts/min

**TXA** – Deliver 1 gram (1000 mg) in 10 mL NS slow IV push administered over 10 min (1mL/min)

Continue assessment and treatment
Anaphylaxis – PCP

**INDICATIONS**

Patient with suspected anaphylaxis, including all of the following:
- Signs of anaphylaxis
- History of an allergy
- Exposure to an allergen
- Unstable: decreased LOC, or hypotension (BP < 90 mmHg), or respiratory distress

**CONTRAINDICATIONS**

Diphenhydramine is contraindicated in patients with a known allergy to Diphenhydramine. Tablets are contraindicated in unconscious patients.

**Before initiating the Anaphylaxis Protocol, you must have done the following:**

- Completed a primary survey
- Obtained a history sufficient to establish a history of an allergy
- Obtained signs and symptoms of an allergic reaction or anaphylaxis
- Obtained a baseline set of vital signs

If anaphylaxis is anticipated because of prior history, nature of exposure or patient’s condition, you may consider contacting medical oversight for orders.

Urticaria, and/or angioneurotic edema, and/or hypotension/shock.

The thigh is the preferred site for administration of the IM Epinephrine. In case the thigh is not available or is inappropriate, the shoulder may be used.

Diphenhydramine causes drowsiness. Alcohol may potentiate its effect and add the risk of accidental injury. Advise patient of this.

Diphenhydramine PO tablets are not to be used in children < 2 years.

For patients > 12 years of age:
- Administer 25-50 mg Diphenhydramine PO (2-4 chewable tablets)
- Transport
- Initiate IV NS
- Reassess vital signs

For patients 6 - 11 years of age:
- Administer 25 mg Diphenhydramine PO (2 chewable tablets)
- Transport

For patients 2 - 5 years of age:
- Administer 12.5 mg Diphenhydramine PO (1 tablet crushed)
- Transport

Administer 0.01 mg/kg Epinephrine 1:1000 IM (to maximum 0.5 mg)

BP ≥ 90 mmHg
- Administer IV NS at maintenance rate

BP < 90 mmHg
- Administer 500 ml NS, rapid infusion
- Continue with assessment and treatment

**31** If anaphylaxis is anticipated because of prior history, nature of exposure or patient’s condition, you may consider contacting medical oversight for orders.

**32** Urticaria, and/or angioneurotic edema, and/or hypotension/shock.

**33** The thigh is the preferred site for administration of the IM Epinephrine. In case the thigh is not available or is inappropriate, the shoulder may be used.

**34** Diphenhydramine causes drowsiness. Alcohol may potentiate its effect and add the risk of accidental injury. Advise patient of this.

**35** Diphenhydramine PO tablets are not to be used in children < 2 years.

**36** After each 500 mL NS, auscultate the lung bases and reassess BP. If signs and symptoms of pulmonary edema are present, stop fluid bolus and administer NS at maintenance rate.

**37** Reassess BP after 500 mL N/S; administer IV NS at maintenance rate. If BP < 90 mmHg, contact medical oversight for further orders.
**DOSAGE CALCULATION - Epinephrine**

If the weight of the patient is known, calculate the appropriate dose using the formula:

\[
0.01 \text{ mg/kg Epinephrine Hydrochloride 1:1000 IM (to a maximum dose of 0.5 mg)}
\]

In cases where the patient's weight is not known and the patient is > 1 year old, the table on the left below may be used to obtain an approximate weight and dosage for patients < 30 kg (formula: age x 2 + 8). Note that patients 11 years of age and over are estimated to receive the maximum dose of 0.5mg Epinephrine 1:1000 IM. For infants (i.e. < 1 year of age), refer to the table on the right below.

<table>
<thead>
<tr>
<th>AGE</th>
<th>APPROXIMATE WEIGHT</th>
<th>DOSAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>10 kg (22 lbs)</td>
<td>0.10 mg</td>
</tr>
<tr>
<td>2</td>
<td>12 kg (26 lbs)</td>
<td>0.12 mg</td>
</tr>
<tr>
<td>3</td>
<td>14 kg (31 lbs)</td>
<td>0.14 mg</td>
</tr>
<tr>
<td>4</td>
<td>16 kg (35 lbs)</td>
<td>0.16 mg</td>
</tr>
<tr>
<td>5</td>
<td>18 kg (40 lbs)</td>
<td>0.18 mg</td>
</tr>
<tr>
<td>6</td>
<td>20 kg (44 lbs)</td>
<td>0.20 mg</td>
</tr>
<tr>
<td>7</td>
<td>22 kg (48 lbs)</td>
<td>0.22 mg</td>
</tr>
<tr>
<td>8</td>
<td>24 kg (53 lbs)</td>
<td>0.24 mg</td>
</tr>
<tr>
<td>9</td>
<td>26 kg (57 lbs)</td>
<td>0.26 mg</td>
</tr>
<tr>
<td>10</td>
<td>28 kg (62 lbs)</td>
<td>0.28 mg</td>
</tr>
<tr>
<td>11</td>
<td>30 kg (66 lbs)</td>
<td>0.30 mg</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>WEIGHT (KG)</th>
<th>WEIGHT (LB)</th>
<th>DOSAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 kg</td>
<td>6.6 lbs</td>
<td>0.03 mg</td>
</tr>
<tr>
<td>4 kg</td>
<td>8.8 lbs</td>
<td>0.04 mg</td>
</tr>
<tr>
<td>5 kg</td>
<td>11 lbs</td>
<td>0.05 mg</td>
</tr>
<tr>
<td>6 kg</td>
<td>13.2 lbs</td>
<td>0.06 mg</td>
</tr>
<tr>
<td>7 kg</td>
<td>15.4 lbs</td>
<td>0.07 mg</td>
</tr>
<tr>
<td>8 kg</td>
<td>17.6 lbs</td>
<td>0.08 mg</td>
</tr>
<tr>
<td>9 kg</td>
<td>19.8 lbs</td>
<td>0.09 mg</td>
</tr>
</tbody>
</table>
Unconscious Not Yet Diagnosed (NYD) – PCP

**INDICATIONS**

- Decreased/Altered LOC, Not yet diagnosed

**CONTRAINDICATIONS**

- Naloxone Hydrochloride is contraindicated in patients with a known Naloxone allergy
- Glucagon is contraindicated in patients with a known Glucagon allergy

Before initiating the Unconscious NYD protocol, you must have done the following:

- Completed a primary survey
- Obtained a history sufficient to rule out contraindications for this protocol
- Obtained a baseline set of vital signs
- Obtain Blood Glucose reading and GCS

---

38 Altered LOC is a continuum ranging from mild to deep unconsciousness with absent responses. This protocol should be used when there is a reasonable doubt as to the cause of the LOC

39 Reassess BP after 500 mL NS, administer IV NS at the maintenance rate. If BP < 90 mmHg, contact ER for further orders.

40 After each 500 mL NS, auscultate the lung bases and reassess BP. IF signs and symptoms of pulmonary edema are present, stop the fluid bolus, administer NS at the maintenance rate and contact ER for further orders
Suspected Narcotic Overdose – PCP/EMR

**INDICATIONS**
- Decreased LOC in a patient with a history that suggests narcotic overdose
- Difficulty in maintaining the patient’s airway
- Respiratory rate <10 per minute

**CONTRAINDICATIONS**
- Naloxone Hydrochloride is contraindicated in patients with a known Naloxone allergy

**Treatment**
- Primary airway management is paramount by ensuring the patient’s airway is protected, open and clear.
- Ensure the patient is well oxygenated and/or ventilated with a BVM
- Primary survey
- A history sufficient to suggest narcotic overdose as the cause of unconsciousness
- A history sufficient to rule out contraindications for the suspected narcotic overdose protocol
- A baseline set of vitals

**Administer 0.4 mg Naloxone Hydrochloride IM**
- Load and transport

If no improvement:
- Administer 0.4 mg Naloxone Hydrochloride IM

If no improvement:
- Administer 0.8 mg Naloxone Hydrochloride IM

If no improvement:
- Administer 2.0 mg Naloxone Hydrochloride IM
- Also consider assessing blood glucose level
- If blood glucose ≤ 4mmol/L, consider diabetic protocol

---

41 Repeat q 3 minutes as needed to reverse respiratory depression
42 Do not give to neonates
Diabetic Emergencies – EMR

INDICATIONS

Known diabetic patients with decreased LOC whose history suggests hyperglycemia or hypoglycemia.

Before initiating the Diabetic Emergencies protocol, you must have done or obtained the following:

- Request equipment be prepared for rapid transport
- A primary survey
- A history of diabetes
- A baseline set of vital signs
- Signs and symptoms sufficient to suggest hypoglycemia or hyperglycemia

When equipment is ready load and transport, do not delay if everything else is ready to go; load and go and treat en route.

If repeat glucometer result is ≤ 4.0 mmol/L, give oral glucose again.

Consider other causes of unconsciousness and contact the ER for further orders.

Only if patient is able to maintain airway

If able to follow commands apply approx. 15 gr. oral glucose it provides immediate treatment for the patient.

If no improvement, consider other causes of unconsciousness, contact ER for further direction.
Diabetic Emergencies – PCP

INDICATIONS
Known diabetic patients with decreased LOC whose history suggests hyperglycemia or hypoglycemia.

CONTRAINDICATIONS
Glucagon is contraindicated in persons known to be allergic to Glucagon

Before initiating the Diabetic Emergencies protocol, you must have done or obtained the following:
- A primary survey
- A history of diabetes
- A baseline set of vital signs
- Signs and symptoms sufficient to suggest hypoglycemia or hyperglycemia

49 If repeat glucometer result is ≤ 4.0 mmol/L, give additional D10W - 100ml rapid infusion.
### Aspirin (ASA)

<table>
<thead>
<tr>
<th>Classification</th>
<th>Platelet inhibitor Antiplatelet</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mechanism</td>
<td>Inhibits the formation of platelets from clumping together to form clots</td>
</tr>
<tr>
<td>Indication</td>
<td>Chest pain or atypical symptoms consistent with cardiis ischemia/AMI</td>
</tr>
<tr>
<td>Contraindications</td>
<td>Known hypersensitivity or allergy to ASA or other (NSAIDS) agents Asthma Patients with a history of asthma induced by the administration of salicylates or NSAIDS. Pediatric patients with viral symptoms</td>
</tr>
<tr>
<td>Onset</td>
<td>20 minutes- 1 hour if chewed</td>
</tr>
<tr>
<td>Dose</td>
<td>160 mg PO</td>
</tr>
<tr>
<td>Route</td>
<td>Oral</td>
</tr>
<tr>
<td>Cautions</td>
<td>Recent internal bleeding Known bleeding diseases Patient is currently taking anticoagulant agents Recent surgery Possibility of pregnancy</td>
</tr>
</tbody>
</table>
D_{10}W (Dextrose 10% in Water)

| Classification: | Anti-hypoglycemic agent  
Carbohydrate substrate |
| Mechanism:       | Immediate source of glucose and H_2O for nutrient deprived cells  
Transient osmotic diuretic |
| Indication:      | Suspected or known hypoglycemia  
Altered level of responsiveness  
Coma or seizure NYD |
| Contraindications: | None |
| Onset            | IV - Immediate |
| Dose             | 10-25 g (100-250 ml of 10% solution) |
| Route            | IV |
| Cautions:        | Extravasation causes tissue necrosis |
**Dimenhydrinate**

| Classification: | Anti-Emetic  
|                | Anti-Histamine  
|                | Anti-Cholinergic  
|                | Anti-Vertigo |
| Mechanism:     | Diminishes vestibular (labyrinth) stimulation from motion  
|                | Inhibits cholinergic stimulation in vestibular and reticular system |
| Indication:    | Prevention or control of nausea, vomiting, and vertigo |
| Contraindications: | Known hypersensitivity or allergy to Dimenhydrinate |
| Onset          | IM 20-30min.  
|                | IV – Most immediate |
| Dose           | 1 mg/kg to a maximum dose of 50mg  
|                | Contact ER if patient appears to be under 25kg |
| Route          | IM – Administered undiluted  
|                | IV – Dilute with NS and inject over 1-2 minutes. If administering 50 mg of Dimenhydrinate for IV injection, draw up 50mg of Dimenhydrinate using a 10 mL syringe then draw up the additional 9mL of NS. Mix the medication and administer slowly over 2 minutes. (25 mg/min) |
| Metabolism:    | Metabolized in the liver  
|                | Excreted in the urine |
| Adverse Effects: | CVS: tachycardia, palpitations  
|                | Respiratory: thickening of bronchial sections  
|                | CNS: Dizziness, drowsiness, excitation, headache, restlessness  
|                | GI: Anorexia, dry mouth  
|                | GU: Dysuria  
|                | Ocular: Blurred vision |
| Cautions:      | Glaucoma (increased intraocular pressure)  
|                | Asthma/COPD  
|                | Cardiovascular disease (Hypertension, ischemic heart disease)  
|                | Prostatic hyperplasia ad urinary obstruction  
|                | Elderly  
|                | Pregnancy |
Diphenhydramine

<table>
<thead>
<tr>
<th>Classification:</th>
<th>Anti-Histamine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mechanism:</td>
<td>Antihistamine with anticholinergic and sedative side effects. Antihistamines appear to compete with histamine for cell receptor sites on effector cells.</td>
</tr>
<tr>
<td>Indication:</td>
<td>Adjunct treatment of allergic reactions Motion sickness</td>
</tr>
<tr>
<td>Contraindications:</td>
<td>Known hypersensitivity or allergy to antihistamines Neonates</td>
</tr>
<tr>
<td>Onset</td>
<td>IM Rapid</td>
</tr>
<tr>
<td>Dose</td>
<td>25- 50 mg</td>
</tr>
<tr>
<td>Route</td>
<td>25 – 50 mg IV , 25-50 mg PO</td>
</tr>
<tr>
<td>Adverse Effects:</td>
<td>Urticaria, drug rash Hypotension</td>
</tr>
<tr>
<td>Cautions:</td>
<td>Narrow angle glaucoma Stenosing peptic ulcer</td>
</tr>
</tbody>
</table>
Entonox (Nitrous Oxide)

<table>
<thead>
<tr>
<th>Classification:</th>
<th>Non narcotic analgesia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mechanism:</td>
<td>Potent analgesic and a weak anaesthetic</td>
</tr>
</tbody>
</table>
| Indication:     | Relief of moderate to severe pain  
|                 | Cardiac related chest pain where nitroglycerin will be of no value or is contraindicated  
|                 | Isolated extremity injuries, pain associated with burns. |
| Contraindications: | Ability to comply  
|                  | Decompression sickness  
|                  | Altered level of Consciousness  
|                  | Pneumothorax  
|                  | Air embolism  
|                  | Inhalation injury  
|                  | Nitroglycerin used in the last 5 minutes |
| Onset | Rapid |
| Dose | Inhalation – Self administered |
| Route | PO – Self administered |
| Adverse Effects: | Light-headedness, dizziness, sedation, drowsiness, disorientation  
|                  | Nausea and / or vomiting |
| Cautions: | Shock  
|           | Abdominal distention  
|           | Depressant drugs  
|           | COPD  
|           | Facial injuries |
Epinephrine

<table>
<thead>
<tr>
<th>Classification:</th>
<th>Sympathomimetic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mechanism:</td>
<td>α 1 effects - Vasoconstriction</td>
</tr>
<tr>
<td></td>
<td>β 1 effects – Increased HR, increased force of cardiac contraction</td>
</tr>
<tr>
<td></td>
<td>β 2 effects - Bronchodilation</td>
</tr>
<tr>
<td>Indication:</td>
<td>Anaphylaxis</td>
</tr>
<tr>
<td>Contraindications:</td>
<td>Significant tachyarrhythmias</td>
</tr>
<tr>
<td>Onset:</td>
<td>IM 5 – 15 minutes, IV Immediate</td>
</tr>
<tr>
<td>Dose:</td>
<td>1:1000 IM (0.01 mg/kg to a maximum of 0.5 mg)</td>
</tr>
<tr>
<td>Route:</td>
<td>0.3 - 0.5 mg 1:1000 IM q 5 min x 3</td>
</tr>
<tr>
<td>Cautions:</td>
<td>Further hypotension if administered too quickly</td>
</tr>
</tbody>
</table>

Glucagon

<table>
<thead>
<tr>
<th>Classification:</th>
<th>Glucose elevating agent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mechanism:</td>
<td>Accelerates the breakdown of glycogen to glucose in the liver</td>
</tr>
<tr>
<td>Indication:</td>
<td>Hypoglycemia</td>
</tr>
<tr>
<td></td>
<td>When IV access attempts have been unsuccessful</td>
</tr>
<tr>
<td>Contraindications:</td>
<td>Allergy of hypersensitivity to glucagon</td>
</tr>
<tr>
<td>Onset:</td>
<td>IM – 8-10 minutes</td>
</tr>
<tr>
<td>Dose:</td>
<td>0.5 - 1 mg IM</td>
</tr>
<tr>
<td>Route:</td>
<td>IM</td>
</tr>
<tr>
<td>Cautions:</td>
<td>Nausea or vomiting, hypokalemia, urticaria, respiratory distress, hypotension</td>
</tr>
</tbody>
</table>
## Naloxone (Narcan)

<table>
<thead>
<tr>
<th>Classification:</th>
<th>Narcotic antagonist</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mechanism:</td>
<td>Reverses the effects of opioids including respiratory depression, sedation, hypotension. Antagonizes the opioid effects by competing for the same receptor sites.</td>
</tr>
<tr>
<td>Indication:</td>
<td>To reverse respiratory depression/depressed mental status secondary to actual or suspected narcotic use.</td>
</tr>
<tr>
<td>Contraindications:</td>
<td>Allergy or known hypersensitivity</td>
</tr>
<tr>
<td>Onset</td>
<td>IV – 1 minute, IM 3-5 minutes</td>
</tr>
<tr>
<td>Dose</td>
<td>0.4mg/ml IM q 3 mins as needed</td>
</tr>
<tr>
<td>Route</td>
<td>IM, IV</td>
</tr>
<tr>
<td>Cautions:</td>
<td>Patient combativeness. May precipitate withdrawal symptoms</td>
</tr>
</tbody>
</table>
## Nitroglycerin

<table>
<thead>
<tr>
<th>Classification:</th>
<th>Antianginal, vasodilator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mechanism of Action</td>
<td>Reduces cardiac oxygen demand primarily by dilating blood vessels resulting in decreased blood flow (preload) to the heart from the body, decreased resistance to the heart’s pumping (after load). Dilation of coronary arteries results in increased blood flow to cardiac tissue.</td>
</tr>
<tr>
<td>Indications:</td>
<td>Chest discomfort that appears cardiac in nature.</td>
</tr>
<tr>
<td>Contraindications:</td>
<td>• Systolic BP &lt; 90 mmHg, known allergy or sensitivity to Nitrates, and if patient has used Viagra or Levitra in the past 24 hours or Cialis in the last 48 hours.</td>
</tr>
<tr>
<td>Onset, Dose, Route:</td>
<td>Rapid onset via sublingual route (60 seconds) with 30-minute duration. Dose depends on strength of patient’s prescription. EMAs are to give one dose (q 3 min) provided systolic blood pressure remains above 90 mmhg.</td>
</tr>
<tr>
<td>Metabolism:</td>
<td>Rapidly metabolised in the body by the liver and excreted by the kidneys.</td>
</tr>
<tr>
<td>Adverse Effects:</td>
<td>• Induces hypotension, dizziness, weakness, headache, nausea, and vomiting</td>
</tr>
</tbody>
</table>
| Cautions: | • Hypotension frequently occurs, especially in the elderly and must be expected. Ensure patient is not at risk to fall.  
• Repeat vitals and drug until pain is relieved, to a maximum of 3 doses in any 30-minute period (providing the systolic BP remains above 90; irrespective of any Nitro taken by the patient prior to your arrival).  
• The patient has used Viagra at any time in the past, (beyond the 24-hour contraindication limit) there may be some cause for very careful monitoring of the patient’s blood pressure. |
| Notes: | If using Nitro spray, do not shake the container prior to administration. Nitroglycerin comes in forms other than spray and/or tablet, none of which are approved for EMA use. If your patient has a Nitro patch applied, it does not change the Nitroglycerin protocol.  
If you have given Nitro and are now using Entonox, if hospital arrival is not imminent 20 min following your last Nitro, discontinue Entonox, resume high flow O₂ and administer additional Nitro as per protocol.  
If pain is completely relieved for more than 5 min, you may initiate the chest pain protocol again if the pain returns. This is considered a new episode and Nitro can be given. This is applicable even if Nitro has already been administered for the initial episode. |
## Oral Glucose

<table>
<thead>
<tr>
<th>Classification:</th>
<th>Caloric</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mechanism:</td>
<td>Absorbed into the bloodstream resulting in increased blood glucose levels, thereby providing an increased level of glucose for use by cells.</td>
</tr>
<tr>
<td>Indications:</td>
<td>Oral Glucose gel is indicated for a patient with a decreased LOC with a known diabetic history</td>
</tr>
<tr>
<td>Contraindications:</td>
<td>If airway management cannot be maintained, oral Glucose is contraindicated.</td>
</tr>
<tr>
<td>Onset, Dose, Route:</td>
<td>Via the buccal/sublingual route, glucose is absorbed slowly into the blood stream. EMAs administer one half of the package (approx. 12 g) prior to transport.</td>
</tr>
<tr>
<td>Metabolism:</td>
<td>Glucose enters cells where it is used to provide energy. It is oxidized (broken down) into carbon dioxide and water and excreted through the lungs and kidneys.</td>
</tr>
<tr>
<td>Adverse Effects:</td>
<td>May increase airway management problems</td>
</tr>
<tr>
<td>Cautions:</td>
<td>Patient must be placed semi-prone prior to administration; if this position cannot be achieved due to other related complications, administration is contraindicated due to the possibility of causing aspiration.</td>
</tr>
<tr>
<td></td>
<td>Place gel into dependent buccal pouch (lower cheek)</td>
</tr>
<tr>
<td>Note:</td>
<td>There are a number of different brands of oral Glucose containing 25 grams 40% dextrose. Using a tongue depressor may help with administration.</td>
</tr>
</tbody>
</table>
Salbutamol (Ventolin)

| Classification: | Bronchodilator
<table>
<thead>
<tr>
<th></th>
<th>Sympathomimetic</th>
</tr>
</thead>
</table>
| Mechanism:      | Selective β2 stimulation resulting in bronchodilation and some degree of vasodilation
|                 | Some β1 effects with repeated doses. |
| Indication:     | • Bronchospasm associated with asthma, bronchitis, or emphysema.
|                 | • Bronchospasm and wheezing secondary to other causes, such as anaphylaxis |
| Contraindications: | • Known hypersensitivity or allergy to Salbutamol
|                 | • Hemodynamically significant tachyarrhythmias |
| Onset           | 5 minutes |
| Dose            | 5 mg in 5 ml NS or H₂O nebulized (with O₂ at 6-8 L/min) |
| Route           | Nebulized |
| Cautions:       | Coronary disease
|                 | COPD patients with degenerative heart disease
|                 | Diabetes |

Tranexamic Acid

<table>
<thead>
<tr>
<th>Classification:</th>
<th>Hemostatic agent/Antifibrinolytic Agent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mechanism:</td>
<td>Prevents clot degradation by competing for TPA receptor sites</td>
</tr>
</tbody>
</table>
| Indication:     | • Major trauma patients after initiation of the hypovolemia protocol
|                 | • Signs of shock in association with mechanism of injury or physical findings suggestive of occult or ongoing bleeding |
| Contraindications: | • Known hypersensitivity or allergy to TXA
|                 | • If time is greater than 3 hours after injury
|                 | • Patient under 16 years of age |
| Onset           | Immediate |
| Dose            | 1 gram – 1000 mg |
| Route           | Piggyback 1 gram infused in a 50 mL bag of NS, delivered at a rate of 60 gtt/min.
|                 | 1 gram in 10 mL NS IV push; deliver over 10 minutes (rate of 1 ml/min) |
| Cautions:       | Further hypotension if administered too quickly |
EMA Licensing Board Examinations

The EMA Licensing Board (Board) licenses candidates that have completed a training program recognized by the Board and passed the examinations approved by the Board. The Board also licenses applicants licensed in jurisdictions outside of British Columbia (BC) and may require an applicant to complete an examination when the Board determines that the applicant’s qualifications, examinations or training required for their authorization to practice in the other jurisdiction are not equivalent to those required in BC for the category of licence sought. In addition, the Board may require that a former EMA successfully complete examinations in order to have a licence suspension removed or a licence reinstated.

The purpose of the examination process is to ensure that candidates possess the necessary knowledge, abilities, skills, aptitudes and judgements for entry to practice into the paramedic and first responder professions in BC.

Candidates have **three attempts** to successfully complete each of the required examinations. Candidates that are unsuccessful at the examinations after three attempts are required to submit proof of successful completion of a new recognized training program to be eligible to begin the exam process again. If candidate has failed the practical exams 3 times and taken a new program, they can be exempt from the written and/or jurisprudence exam under the following circumstances:

- The candidate has completed the written and/or jurisprudence exams within 6 months of successfully completing the new training program, and
- The candidate received 85% or higher on their first attempt at the written and/or jurisprudence exams.
Practical Examination Grading Criteria

In order to ensure accurately marked performance based practical exams the EMA Licensing Board uses the “star weighting” for practical examinations. The star weighting system uses either a three star (***) , two star (**) , or one star (*) to determine a candidates performance during a practical evaluation.

The practical exam marking sheet lists generalized performance criteria containing the steps required in a full call scenario or skill test simulation (EMR only). The grading criterion allows each evaluator to mark each criteria item in a standardized manner that ensures consistency for all examination candidates.

Evaluators should focus their assessment on the concept of “outcome based” candidate performance. This identifies key performance criteria that a candidate must demonstrate to effectively assess, manage or treat a patient. This means a broader perspective of the candidate’s performance is observed allowing evaluators to focus on the patient treatment outcomes rather than the completion of steps in a sequential pattern unless deviation from a sequential pattern would result in life threatening consequences for the patient.
Star Weighting

Three stars (*** represents a skill that constitutes critical behavior. Failure to perform the skill could have life threatening consequences for the patient and/or the EMA. Two stars (**) represents a skill that must be performed to provide an accurate assessment of the patient, prevent patient deterioration, or prevent serious injury aggravation. Failure to perform such a skill could have detrimental, but not life-threatening consequences to the patient and/or the EMA. One star (*) represents skills that are required to provide optimal care. Failure to perform the skill would pose minor discomfort to the patient or minimally aggravate the injury but not make the condition or injury worse. For each star weighting a candidate can lose percentage points based on the degree of deficiency performed. Marks deducted are accumulative throughout the examination. In order to pass a candidate must obtain 70% or more on the full call scenario or skill station.

<table>
<thead>
<tr>
<th>Star Weighting</th>
<th>Percentage Deduction</th>
</tr>
</thead>
<tbody>
<tr>
<td>***</td>
<td>100% - the skill is not performed at any time during the examination which results in a serious negative impact or is performed incorrectly with a serious negative impact.</td>
</tr>
<tr>
<td></td>
<td>15% - the skill is performed out of sequence which may negatively affect patient care or is performed incorrectly with a minor negative impact.</td>
</tr>
<tr>
<td></td>
<td>5% - the skill is performed with minor deficiencies (eg. Late, self-correct, 1 prompt, performed out of sequence) with no impact to patient care.</td>
</tr>
<tr>
<td></td>
<td>0% - skill is performed correctly and in a timely manner or the skill is not applicable to the examination.</td>
</tr>
<tr>
<td>**</td>
<td>15% - the skill is not performed at any time during the examination which results in a serious negative impact or is performed incorrectly with a serious negative impact.</td>
</tr>
<tr>
<td></td>
<td>5% - the skill is performed out of sequence which may negatively affect patient care or is performed incorrectly with a minor negative impact.</td>
</tr>
<tr>
<td></td>
<td>3% - the skill is performed with minor deficiencies (eg. Late, self-correct, 1 prompt, performed out of sequence) with no impact to patient care.</td>
</tr>
<tr>
<td></td>
<td>0% - skill is performed correctly and in a timely manner or the skill is not applicable to the examination.</td>
</tr>
<tr>
<td>*</td>
<td>5% - the skill is not performed at any time during the examination which results in a serious negative impact or is performed incorrectly with a serious negative impact.</td>
</tr>
<tr>
<td></td>
<td>3% - the skill is performed out of sequence which may negatively affect patient care or is performed incorrectly with a minor negative impact.</td>
</tr>
<tr>
<td></td>
<td>1% - the skill is performed with minor deficiencies (eg. Late, self-correct, 1 prompt, performed out of sequence) with no impact to patient care.</td>
</tr>
<tr>
<td></td>
<td>0% - skill is performed correctly and in a timely manner or the skill is not applicable to the examination.</td>
</tr>
</tbody>
</table>
### OVERALL PATIENT CARE (Knowledge, Critical Thinking, and Treatments)

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Performance Standards</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication and Overall patient care</td>
<td>100% deduction if the candidate performs an act that may jeopardize the life of the patient that is not already captured in the major performance criteria</td>
</tr>
<tr>
<td></td>
<td>15% the skill is performed out of sequence which may negatively affect patient care or is performed incorrectly with a minor negative impact.</td>
</tr>
<tr>
<td></td>
<td>5% the skill is performed with minor deficiencies (eg. Late, self-correct, 1 prompt, performed out of sequence) with no impact to patient care.</td>
</tr>
<tr>
<td></td>
<td>0% deduction if the candidate does not perform any acts that would be detrimental to overall patient care</td>
</tr>
</tbody>
</table>

**Comments:**
- Deductions within this performance criteria should only occur if the candidate’s performance cannot be captured elsewhere
- Some examples may include but are not limited to managing shock; burn management; and minor bleeding control
- Comments/justification is required for this section on the feedback form
Practical Exam Appeals

If a candidate does not agree with their practical exam results they can request a review of their practical exam by contacting the clinical advisor. The candidate should include all of the details of their practical exam and why they feel their results are invalid. The clinical advisor will review the candidate’s practical exams, the candidate’s explanation of the practical exam and discuss the practical exam with the examiner before making a final decision.

If the candidate is still unsatisfied and believes they have been treated unfairly, they can contact the Office of the Ombudsperson using their online complaint form.

Exam Reviews

If an EMR candidate is unsuccessful twice in either the written exam or an EMR or PCP is unsuccessful twice on the practical exam, their exams will be reviewed by the clinical advisor and feedback on areas of weakness will be sent to the candidate. Review and feedback can take up to three weeks to receive. Final remedial exams may not be attended until after the exam review is complete and the candidate has received their feedback. The candidate can refuse an exam review by contacting the clinical advisor.
EMR Examination Requirements

**Jurisprudence Examination**
All licensing candidates at the EMR, PCP, ITT, ACP, or CCP level are required to successfully complete the jurisprudence examination. The jurisprudence examination consists of 100 questions with two hours to complete. 80% is required to pass.

The jurisprudence examination consists of:
- multiple choice questions and True/False (98 marks).
- 2 matching question (39 marks). Between the two matching questions there are 39 items to match.

When you have completed your examination, you will receive your mark. In the interest of examination security, you **will not** be able to view the full examination once it has been completed. If you are unsuccessful on your first attempt, you may re-attempt the exam at any time. If you are unsuccessful on your second attempt, you will be required to wait **5 days** before attempting the exam for a third and final time.

**Written Examination**
Board approved written examinations for EMRs are administered by the EMA Licensing Branch.

EMRs that are trained in BC and applying for initial licensure are required to successfully complete the online written examination.

EMRs applying for licence reinstatement or applying from out of country may also be required to successfully complete the online written examination.

The EMR written examination consists of:
- 81 multiple choice questions (81 marks)
- 1 matching question (20 marks)
- 1 matching question (5 marks)
- 2 matching questions (10 marks each)
- 12 multiple choice questions with multiple answers (49 marks)
- 1 rank in numerical order questions (21 marks)

When you have completed your examination, your results will be available immediately. In the interest of examination security, you **will not** be able to view the full examination once it has been completed. If you are unsuccessful on your first attempt, a remedial exam will be assigned to you within **5 business days**. If you are unsuccessful on your second attempt, a remedial exam will be assigned to you within **7 business days**.
Practical Examination
EMR candidates are required to successfully complete two practical scenarios, which consist of one medical and one trauma call.

When a candidate is unsuccessful in a practical scenario, only one remedial exam is assigned as follows:

<table>
<thead>
<tr>
<th>When an EMR candidate fails:</th>
<th>The EMR candidate is assigned:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• a practical medical scenario</td>
<td>➢ another medical scenario if the candidate fails a critical component of the scenario (note: the scenario will not be of the same nature as the previous exam)</td>
</tr>
<tr>
<td>• a practical trauma scenario</td>
<td>➢ another trauma scenario if the candidate fails a critical component of the scenario (note: the scenario will not be of the same nature as the previous exam)</td>
</tr>
</tbody>
</table>

Scheduling EMR Examinations

1. Read the Board examination policies
2. Contact your training provider and ensure they have your consent to send your certificate to getanexam@gov.bc.ca
3. Submit electronically the Request for Evaluation form
4. Obtain a BCeID. Please use only lowercase characters in your BCeID username. (If you already have a BCeID and password you may skip this step)
5. Please use your BCeID username and password to create a new account in the online learning system (it may take up to 2 weeks to be granted access)
6. Review the Applicant Guide to the B.C. Jurisprudence Examination
PCP Examination Requirements

Jurisprudence Examination

All licensing candidates are required to successfully complete the jurisprudence examination. The jurisprudence examination consists of 100 questions with two hours to complete. 80% is required to pass.

The jurisprudence examination consists of:

• multiple choice questions and True/False (98 marks).
• 2 matching questions (39 marks). Between the two matching questions there are 39 items to match.

When you have completed your examination, you will receive your mark. In the interest of examination security, you will not be able to view the full examination once it has been completed. If you are unsuccessful on your first attempt, you may re-attempt the exam at any time. If you are unsuccessful on your second attempt, you will be required to wait 5 days before attempting the exam for a third and final time.

Written Examination

Board approved written examinations for PCPs are administered by the Canadian Organization of Paramedic Regulators (COPR) entry to practice written examination.

PCPs that are trained in BC and applying for initial licensure are required to successfully complete the COPR entry to practice written examination.

PCPs that are applying from out of country may also be required by the Board to complete the entry to practice examination provided by COPR as part of the licensure requirements.

The COPR entry to practice written examination is offered 4 times per year. Candidates can choose to write the entry to practice exam in Victoria, Nanaimo, Burnaby, Richmond, Surrey, Vancouver, Kelowna or Prince George. Below is the COPR exam schedule and the exam events that take place leading up to the exam and after the exam.

6 weeks prior to the exam - Preliminary Registry to YAS (Regulators are to highlight the entire line of candidates who have not provided evidence of completing their course of study and copy Exam Manager).

5 weeks prior to the exam - Booking Window Opens (one week only)

4 weeks prior to the exam - Booking Window Closes (Candidates will not receive a reminder email)

2 weeks prior to the exam - Regulators send email to Yardstick and Exam Manager to advise which candidates did not provide evidence of completing course of study. Those candidates are removed from the roster – refund policy applies

3 to 4 weeks after exam date - The Emergency Medical Assistants Licensing Branch will distribute the
Canadian Organization of Paramedic Regulators exam results via email to all candidates. The COPR entry to practice examination is developed and assembled according to the examination blueprint. The examination handbook and study guide are available on the COPR exam page. In addition, COPR offers preparatory tests that are designed to simulate the actual entry to practice examinations on a smaller scale. The preparatory tests are available here.

**COPR Written Examination and Preparatory** fees are established by, and payable to, COPR.

Candidates that require special accommodation for the COPR entry to practice examination should read the Guidelines Regarding Special Accommodation for Candidates with Disabilities. Please note: except in unusual circumstances, such as a recent injury, requests for accommodation must be received by COPR 35 business days before the examination.

<table>
<thead>
<tr>
<th>COPR Entry to Practice Written Examination Schedule</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registration and Accommodation Request Deadline</td>
</tr>
<tr>
<td>2-Jan-20</td>
</tr>
<tr>
<td>25-Mar-20</td>
</tr>
<tr>
<td>1-Jul-20</td>
</tr>
<tr>
<td>30-Sep-20</td>
</tr>
<tr>
<td>30-Dec-20</td>
</tr>
<tr>
<td>31-Mar-21</td>
</tr>
<tr>
<td>1-Jul-21</td>
</tr>
<tr>
<td>29-Dec-21</td>
</tr>
<tr>
<td>28-Dec-22</td>
</tr>
<tr>
<td>29-Mar-23</td>
</tr>
</tbody>
</table>
Practical Examination

BC trained candidates seeking initial licensure at the PCP licence category that started a PCP program before July 1, 2019 and successfully completed the COPR entry to practice exam and jurisprudence exam before March 1, 2020 are exempt from completing the EMALB practical examinations.

PCP candidates are required to successfully complete three practical scenarios, which consist of two medicals and one trauma call.

When a candidate is unsuccessful in a practical scenario, only one remedial exam is assigned as follows:

<table>
<thead>
<tr>
<th>When an PCP candidate fails:</th>
<th>The PCP candidate is assigned:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• a medical/trauma scenario</td>
<td>➢ a medical/trauma mixed call if the candidate fails a critical component of the scenario (note: the scenario will not be of the same nature as the previous exam)</td>
</tr>
</tbody>
</table>

Scheduling PCP Examinations

1. Read the Board examination policies
2. Submit electronically the entry to practice examination application form
3. Review the COPR website for the following:
   1. Read the Entry to Practice Examinations Handbook
   2. Read the Guidelines Regarding Special Accommodation for Candidates with Disabilities
   3. Read the COPR Examination Study Guide
4. Obtain a BCeID. Please use only lowercase characters in your BCeID username. (If you already have a BCeID and password you may skip this step)
5. Please use your BCeID username and password to create a new account in the online learning system here (it may take up to 2 weeks to be granted access)
6. Review the Applicant Guide to the B.C. Jurisprudence Examination
Applying for a Licence

Licence Fees

Payment of the licence fees as set out in the Emergency Health Services Regulations is required to obtain your licence. Licence fees are required when you have successfully completed all examinations but can be paid at any time throughout the application process. In order to speed up the licensing process, you may also complete all the licensing requirements at any time during your evaluation process. You may request a refund in writing for any licence fees you submit, if you are unsuccessful in the evaluation process.

<table>
<thead>
<tr>
<th>Licence Category</th>
<th>Licence Fee (if written examination is required)</th>
<th>Licence Fee (if practical examination is required)</th>
<th>Licence Fee (if both written and practical examinations are required)</th>
<th>Licence Renewal Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Medical Responder</td>
<td>$50.00</td>
<td>$400.00</td>
<td>$450.00</td>
<td>$50.00</td>
</tr>
<tr>
<td>Primary Care Paramedic</td>
<td>$50.00</td>
<td>$400.00</td>
<td>$450.00</td>
<td>$50.00</td>
</tr>
<tr>
<td>Advanced Care Paramedic</td>
<td>$50.00</td>
<td>$500.00</td>
<td>$550.00</td>
<td>$50.00</td>
</tr>
<tr>
<td>Critical Care Paramedic</td>
<td>no fee</td>
<td>no fee</td>
<td>no fee</td>
<td>$50.00</td>
</tr>
<tr>
<td>Infant Transport Team</td>
<td>no fee</td>
<td>no fee</td>
<td>no fee</td>
<td>$50.00</td>
</tr>
</tbody>
</table>

There are no licence fees associated with emergency medical assistant first responder licensing, student licensing, or initial licensing for applicants transferring from another province.
How to Pay your Licence Fees

Licence fees can be paid using the following methods:

- Visa, Visa Debit, MasterCard, or American Express
  - at the time you complete the Application for Licence form, or
  - by completing the EMA Licence Payment form at any time
- Cheque or Money order made payable to the Minister of Finance, including your full name, licence level and current mailing address.

Regular mail to:
Emergency Medical Assistants Licensing Branch
Ministry of Health
PO Box 9625 Stn Prov Govt
Victoria BC V8W 9P1

Or courier to:
EMA Licensing Branch
Ministry of Health
1515 Blanshard Street, 1st Floor
Victoria BC V8W 3C8

Licence Applications

Emergency medical responder and primary care paramedic licenses are valid for five years and require yearly continuing competence submissions.

You are eligible for a licence when you have successfully completed all exams for your licence level.

To apply for your licence, follow these steps:

1. Complete and electronically submit an Application for Licence.
2. Pay the applicable fees (see above).
EMA Licensing Board Examination Policies
Emergency Medical Assistants Licensing Board

**EMALB 2011-01 Candidate Code of Conduct**

| Responsible Branch: Emergency Medical Assistants (EMA) Licensing Branch |
| Reference Information (Manual, page number, chapter): |
| Replaces former policy: N/A |
| Date Effective: July 13, 2011 |
| Last Update: November 23, 2018 |
| Next Review Date: January 2020 |

Contact:
Exam Coordinator
getanexam@gov.ca.ca

Keywords
E.g. examinations, regulation, licensure etc.

1. **Policy Rationale & Purpose:**
   It is in the best interest of all EMA Licensing candidates to co-operatively ensure examinations are conducted in a safe, appropriate and orderly manner in accordance with the Code of Conduct for EMA Licensing Examination Candidates.

2. **Policy Scope**
   This policy applies to all candidates attending BC EMA Licensing examinations.

3. **Policy Statement:**
   By accepting placement into the examination process, all candidates are considered to have agreed to abide by this Code of Conduct. All candidates agree to follow the direction of evaluators who have the right, at their discretion, to stop an examination at any time, require candidates to leave the premises or any other remedy as may be deemed appropriate.

**Examination Code of Conduct:**

1. Candidates are expected to conduct themselves in a respectful and professional manner and should follow the [EMA Code of Ethics](#) at all times.
2. Any form of cheating, plagiarism, copying or reproduction of examinations (including screen shots and pictures), impersonation or falsification of documents will not be tolerated.
3. Without limiting the generality of the above, the following actions are unacceptable:
   a. Inappropriate communication with another candidate
   b. Any behaviour or activity which causes disruption to other candidates, patients or evaluators including, but not limited to, talking during written examinations, foul language or threats, gestures and acts of violence
   c. Being intoxicated through use of alcohol or being under the influence of drugs including, but not limited to, cannabis and cannabis products.
d. Any departure from the examination room without the knowledge and permission of the evaluator.

e. Pausing an examination for any reason, including being called out to an incident. If you are completing the examinations within work hours, you must ensure that there is enough time set aside to complete the examination in full without interruption.

f. Use of any electronic devices including phones, cameras, or other communication or recording equipment

g. Bringing into the examination room books, bags, notes or other material unless prior approval is granted by the EMA Licensing Branch

h. Bringing weapons of any kind into the examination centre (e.g. knives, guns, etc.)

4. For the purposes of identification and registration at examinations, candidates are required to produce government, employer or training agency issued photo identification

5. Candidates should arrive at least 15 minutes prior to the designated examination start time

**Practical Examination Dress Code:**

Clothing, footwear and related requirements are:

- Footwear must be of closed-toe and sturdy design (e.g., athletic shoes, employer or training agency issued footwear)
- Long hair must be securely tied back
- Long pants or capris covering the knees must be worn (no shorts, skirts or dresses)
- Shirts, T-shirts and blouses must be of a non-revealing and professional nature
- No fragrances may be worn during the evaluation process
- For safety reasons, accessories that may be caught in equipment or which may be hazardous to others are not permitted

The EMA Branch reserves the right to require a candidate to provide medical certification indicating ability to undertake the examination process.

Any concerns or complaints regarding examinations should be immediately brought to the attention of the evaluator and/or EMA Licensing Branch. Please note that all parties involved in a complaint will have the opportunity to respond.

Any violation of this Code of Conduct may be referred to the EMA Licensing Branch/Board for enquiry. Penalties may be imposed by including discontinuation of the examination process, requiring a candidate to attend a different examination site or other penalties as appropriate.

If, due to a violation of this Code, your exam is discontinued, it may be considered to be an attempt by the Branch.
4. **Legal Authority:**
   - [Emergency Health Service Act Section 6(5)(a)]
   - [Emergency Medical Assistants Regulation Section 2(ii)]
   - [Emergency Medical Assistants Regulation Section 3(3)(a) and (b)]
   - [Emergency Medical Assistants Regulation Section 9.2(b)]

5. **Key Stakeholders:**
   - EMA Licensing candidates

Reviewed by the EMA Licensing Board on: July 13, 2011
Approved (director name & signature): N/A
Date approved: July 13, 2011
Drafted by: N/A
### EMALB2012-02 Failure to Attend or Late Notice of Cancellation

<table>
<thead>
<tr>
<th>Responsible Branch: Emergency Medical Assistants (EMA) Licensing Branch</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contact: Exam Coordinator <a href="mailto:getanexam@gov.bc.ca">getanexam@gov.bc.ca</a></td>
</tr>
<tr>
<td>Keywords: examinations</td>
</tr>
</tbody>
</table>

#### Reference Information (Manual, page number, chapter):

<table>
<thead>
<tr>
<th>Replaces former policy: EMALB 2012-02 Exams - No show and late cancel of exams</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date Effective: April 1, 2012</td>
</tr>
<tr>
<td>Last Update: January 17, 2018</td>
</tr>
<tr>
<td>Next Review Date: January 2020</td>
</tr>
<tr>
<td>E.g. examinations, regulation, licensure, etc.</td>
</tr>
</tbody>
</table>

#### 6. Policy Rationale & Purpose:

Practical examinations are scheduled on a first come first served basis and the branch maintains a waitlist for candidates that are unable to be scheduled for a preferred session. The branch is unable to accommodate the waitlisted candidates when space becomes available in the session with less than 7 days’ notice. Candidates that fail to show up or cancel an examination with less than 7 days’ notice are affecting other candidate’s ability to complete their examinations in a timely manner.

The purpose of this policy is to minimize the number of examination candidates who fail to attend their scheduled practical examination session or provide less than 7 days’ notice of cancellation. Minimizing the number of cancellations maximizes the utilization of the branch’s examination resources (exam facilities, examiners, and exam equipment).

#### 7. Policy Scope

This policy applies to all candidates scheduled for EMA practical examinations.

#### 8. Policy Statement:

Candidates who do not attend their scheduled practical examination session, or cancel with less than 7 days’ notice, will be advised by email that the non-attended session will be considered an attempt at the exam process.

If a candidate believes that they have a valid reason for not attending their scheduled practical exam, they may request an exemption for an unattended practical examination within two weeks of being notified of the missed scheduled practical exam. The request will be reviewed by the Exam Coordinator and/or the Manager, Branch Operations as per the guidelines below.
Guidelines for Exemption from Failure to Attend or Late Notice of Cancellation Policy:

The following reasons may be considered acceptable as exemptions to the policy:

- Candidate was ill or injured and unable to attend (a doctor’s note must be provided)
- Sick family member that the candidate needed to provide care to
- Motor vehicle or bicycle accident
- Death in immediate family
- Travel delay due to weather
- Household/Family emergencies
- Other reasons may also be taken into consideration

9. Legal Authority:
   Emergency Health Service Act Section 6(5)(a)
   Emergency Medical Assistants Regulation Section 2(ii)
   Emergency Medical Assistants Regulation Section 3(3)(a) and (b)
   Emergency Medical Assistants Regulation Section 9.2(b)

10. Key Stakeholders:
    - Examination candidates

   Reviewed by the EMA Licensing Board on: September 28, 2011
   Approved (director name & signature): N/A
   Date approved: September 28, 2011
   Drafted by: N/A
# Change Index

<table>
<thead>
<tr>
<th>Date</th>
<th>Page# Reference</th>
<th>Author</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>2020-01-24</td>
<td>Page 25</td>
<td>Kfiege</td>
<td>Updated footnote 9 to “Cool major burns for a total of 2 minutes on scene, transport and continue cooling enroute” instead of “Cool all burns 1-2 minutes.”</td>
</tr>
<tr>
<td>2020-01-24</td>
<td>Page 32</td>
<td>Kfiege</td>
<td>Removed stray Asterix on chart</td>
</tr>
<tr>
<td>2020-01-24</td>
<td>All pages</td>
<td>Kfiege</td>
<td>Revised date removed from footer. All revisions and dates will be noted in the change index.</td>
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<tr>
<td>2020-01-24</td>
<td>Page 33</td>
<td>Kfiege</td>
<td>Removed “dry” reference from the stable patient findings</td>
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<td>Page 42</td>
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<td>Added missing word “airway” at the end of the last bullet.</td>
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<td>41</td>
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<td>added bullet under advanced airway &quot;it is acceptable to perform continuous compressions when an advanced airway is in place.</td>
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<td>Updated footnote font size and color for consistency.</td>
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<td>2020-03-17</td>
<td>70-73</td>
<td>Kfiege</td>
<td>Added missing sections on grading criteria, star weighting, exam appeals and exam reviews.</td>
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<td>2020-04-16</td>
<td>85-86</td>
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<td>Added policy - EMALB2012-02 Failure to Attend or Late Notice of Cancellation</td>
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<td>Updated EMR remedial exam table to remove skill tests as a remedial exam option</td>
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<td>53, 55, 57, 58</td>
<td>CColeman</td>
<td>Updated charts and footnotes</td>
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<td>71,72</td>
<td>Kfiege</td>
<td>Updated star rating chart</td>
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