

CP 4.1: Home Visits

Updated:
Reviewed:

Purpose

- To outline the standardized procedure for all home visits performed by the Community Paramedic
- To describe the difference between initial and repeat visits for the same diagnosis
- To describe the difference between medical and non-medical/educational visits

Policy Statements

The Community Paramedic (CP) will provide home visits for patients in response to a Request for Service from a primary health care provider or a Health Authority.

The Request for Service form must be received from an appropriate referral source and contain requests for appropriate services to be provided by the CP based on the CP's scope of practice and permitted services.

The referral will include the patient's name, date of birth (DOB), contact information, diagnosis, reason for visit, the requested services to be provided by the CP and the reporting expectations based on the results founds.

Procedure

1. **REVIEW** the patient's health history, care plan, lab results, list of current medications and any other pertinent information as provided by the referring agency or health care provider. *NOTE: It is important that the CP become familiar with the patient's condition and needs as much as possible prior to the first visit.*
2. **SCHEDULE** the CP visit with the patient within the first 24 hours. Suggested verbiage for the encounter is, "Your physician has requested that I stop by your home and check in on you, what time would be convenient?"
3. **ARRIVE** at the patient's home in a marked vehicle.
4. **ARRIVE** at the visit wearing an official BCEHS uniform and official BCEHS identification.
5. Upon arrival, **EXPLAIN** the purpose of the visit and **OBTAIN** verbal consent.
6. **PERFORM** a home safety screen in conjunction with a falls risk screen on initial visit and report any concerns to health care team.
7. **COMPLETE** the initial assessment screen as outlined on the Community Paramedicine Initial Assessment Screen form. The screen and accompanying assessments may be conducted over a few visits based on patient's tolerance, time and condition.
8. **PERFORM** head-to-toe assessment and **OBTAIN** a set of vital signs (HR, RR, BP, T, SpO₂) and any additional assessments (e.g. weight, glucometer reading, cap refill, pain score, etc.) as requested on Request for Service form/careplan.
9. **PROVIDE** treatment, care and/or other assessments as outlined on the Request for Service form/careplan.
10. For initial Non-Medical/Educational Visits: **FOLLOW** the same procedures as medical visits without vital signs, physical assessment or treatment services. In consultation with the health care team, the CP may suggest adding more services if indicated after the initial assessment is completed.
11. **COMPLETE** services as requested. If more services are indicated, **CONTACT** the primary health care provider to obtain additional direction.
12. **SCHEDULE** follow-up visit(s) as necessary or as per primary care provider direction.
13. For subsequent visits under same referral, **PERFORM** focused assessment based on findings from previous visit(s) and **COMPLETE** services as requested or as per care plan.

Documentation

DOCUMENT on appropriate records:

- Initial health assessment screen on Community Paramedicine Initial Assessment Screen form
- Head to Toe assessment on Physical Assessment form
- Vital signs can be plotted on vital sign graphic record if trending of vital signs is desired
- Arrival time, departure time, visit summary, care provided, any additional assessments or services provided and who/when notified of any concerns on Community Paramedicine Client Visit Progress Notes

References

1. Eagle County Paramedic Services. Community Paramedic Protocols Manual. 2013. [[Link](#)]
2. Tri-County Health Care Emergency Medical Services. Community Paramedic Policy & Procedure Manual. 2016. [[Link](#)]
3. Vancouver Coastal Health. Vancouver Community AOA Practice Guidelines. Initial Assessment Tool – Guidelines for Use. March

CP 4.2: Initial Assessment Screen

Updated:
Reviewed:

Purpose

To assist the community paramedic in observing and documenting objective and subjective information for the purpose of identifying the patient's state of health and comparing it to the ideal. It should be noted that CPs are not authorized to make a diagnosis or clinical assessment. Any findings that are outside the expected range must be reported immediately to the primary health care provider/team unless specified otherwise in the care plan.

Policy Statement

The Community Paramedic (CP) will respond to a request for CP care and will perform a patient health assessment screen during the initial visit to a patient's home. The initial health assessment screen will be documented on the Community Paramedicine Initial Assessment Screen Form. Parts of this screen may be omitted, depending on the situation and the instructions given in the Request for Service/care plan. A more targeted screen may be required based on the individual needs of the patient and the care plan.

Procedure

1. **OBTAIN** verbal consent from patient to conduct screen. Be clear regarding signal for "YES" and "NO" for non-verbal patients and use of communication aids or devices. Ensure translator is present if required.
2. **ASK** questions of patient and/or caregiver if present and complete pertinent sections of Initial Assessment Screen form as applicable. If specific items not assessed, ✓ column and document in additional comments/exceptions reason for not assessing (e.g. patient refused, assessment not indicated, etc.).
3. **UTILIZE** supplementary tools as required: Falls Risk Screen, Braden Scale, Home Safety Assessment Screen, Pain Assessment Tool, and Mental Health Screening Tools.
4. **NOTIFY** health care provider/team of concerns that arise from screen or for any assessments requiring follow-up.

References

1. Eagle County Paramedic Services. Community Paramedic Protocols Manual. 2013. [[Link](#)]
2. Tri-County Health Care Emergency Medical Services. Community Paramedic Policy & Procedure Manual. 2016. [[Link](#)]
3. Vancouver Coastal Health. Vancouver Community AOA Practice Guidelines. Initial Assessment Tool – Guidelines for Use. March

CP 4.3: Patient Home Safety Assessment

Updated:
Reviewed:

Purpose

The home safety assessment is designed to provide a detailed walkthrough of the patient's home, identify safety hazards to the patient and make recommendations when needed.

Using the Home Safety Assessment Checklist (appendix A), the assessment begins at the driveway or walkway and ends at the back yard. It is designed to focus on things such as trip hazards, kitchen safety, adequate lighting in the home and in walk areas, grab bars and lift handles if applicable, and other notable safety features or lack thereof. This assessment is not a mechanical inspection of the home and is not designed to look at the safety of electrical wiring, hot water heaters, plumbing or any other mechanical features of the house.

Policy Statements

The Community Paramedic (CP) will provide home safety assessments for patients in response to a Request for Service from a health authority or primary health care provider. It is expected that the CP will make recommendations following these assessments, report findings to the primary health care provider and collaborate with other health care professionals to provide support as appropriate.

Procedure

1. **COMPLETE** the Home Safety Assessment Checklist including inspection of the following areas of the home:
 - outside the home
 - living room
 - kitchen
 - stairs
 - bathroom
 - bedroom
 - general
2. If any safety hazards found, **MAKE** recommendations and/or referrals as appropriate.
3. **DISCUSS** findings and recommendations with patient and caregiver.
4. **HAVE** patient/caregiver sign the report with the understanding that they understand the recommendations.

Documentation

DOCUMENT home safety assessment on Home Safety Assessment Checklist and indicate that home safety assessment completed on Initial Assessment Screen form.

References

1. Eagle County Paramedic Services. Community Paramedic Protocols Manual. 2013. [[Link](#)]
2. Tri-County Health Care Emergency Medical Services. Community Paramedic Policy & Procedure Manual. 2016. [[Link](#)]
3. Vancouver Coastal Health. Vancouver Community AOA Practice Guidelines. Initial Assessment Tool – Guidelines for Use. March

CP 4.4: Falls Risk Assessment

Updated:
Reviewed:

Purpose

To assist the Community Paramedic to conduct a falls risk assessment using a variety of falls risk screening tools.

Policy Statements

The Community Paramedic (CP) will conduct a falls risk assessment on clients in response to a referral from a health authority or primary health care provider. It is expected that the CP will document findings and report them to the primary health care provider and collaborate with other health care team members to provide support as appropriate.

The falls risk screen should be conducted in conjunction with a home safety assessment screen to determine if there are any safety hazards that may impact the client's risk for falls within the home environment.

If for whatever reason (cognitive, psychological or physical), the client is unable to perform the screening tests or demonstrates confusion in following instructions, the CP will discontinue testing, document findings and contact the primary health care provider or team for direction.

A CP does not perform the role of a physical therapist or occupational therapist and will therefore not be analyzing the persons gait or movement, nor advising about exercises or physical therapy. If a CP notices the client is having difficulty moving around, they will bring it to the attention of the primary health care provider, as well as other members of the health care team as appropriate. In addition to connecting the client with the primary health care provider so that appropriate referrals, such as to a physical therapist or occupational therapist, the CP may make suggestions with respect to necessary referrals to organizations that can provide walkers, canes and other mobility devices.

Definitions

Falls Risk is based on:

- Falls history – a history of falls in the past three months increases falls risk
- Timed Get Up and Go (TUG) – clients with time greater than 15 seconds are at higher risk for falls
- Romberg test positivity increases falls risk
- Chair stand test – below average rating indicates a high risk for falls
- Tandem stance test – inability to hold stance for 10 seconds indicates a high risk for falls
- Clinical judgment based on observations

Timed Get Up and Go (TUG) test: a quick and simple test to assess an individual's gait and balance by having them rise from a chair, walk a designated distance and return to the chair and be seated. It measures, in seconds, the time taken by an individual to perform the test. The greater the time, the higher the risk for falls.

Romberg test: a tool used to diagnose sensory ataxia. The test is done by requesting the client to keep his/her feet firmly together, arms by his/her side and eyes open. Balance is noted for 15 seconds. Then the client is asked to close his/her eyes and balance is again noted for 15 seconds. If with eyes open, balance is not good, it may indicate cerebellar ataxia. If closing the eyes causes worsening balance, the test is said to be Romberg positive and indicates that the client is excessively reliant on vision to maintain balance and may indicate sensory ataxia. Clients with either cerebellar or sensory ataxia are at higher risk of falls.

Chair stand test: a short, easy and simple to administer test to assess a client's leg strength and endurance. It is also useful for tracking improvements in strength and falls risk because it can easily be repeated after implementing interventions. To perform the test, the client sits in a straight back chair against a wall, with their feet shoulder width apart, flat on the floor and with arms crossed over their chest. From the sitting position, the client stands completely up, then completely back down, and this is repeated for 30 seconds. The total number of complete chair stands (up and down equals one stand) are counted and recorded. A below average rating indicates a high risk for falls.

Tandem Stance Test: a short, easy and simple to administer test of balance. It is also useful for tracking improvements in balance and falls risk because it can easily be repeated after implementing interventions. To perform this test, the client is instructed to stand with one foot in front of the other, heel to toe and to hold this stance for 10 seconds without holding on or taking a step. An individual who cannot hold the tandem stance for at least 10 seconds is at increased risk of falling.

Procedure

1. **ASK** question: "Have you had a fall in the past 3 months?" If yes, **EXPLORE** further as to what happened, how fall occurred, what were the circumstances that caused the fall, etc.
2. **PERFORM** one or more of the following screening tests to determine the client's falls risk.
 1. **Timed Up and Go test:**
 1. Client should wear their regular footwear and use a walking aid if needed. Select an appropriate chair and mark out a 3 metre

walking

2. **GIVE** client instructions on how to do test and allow them to have a practice before timing.
3. Using a stopwatch or second hand on a clock/watch, **RECORD** time it takes patient to get up from chair, walk 3 metres and return to chair and sit.
4. **OBSERVE** how client stands up, with/without using arms; observe stability on turning and any assistance required; observe postural stability, gait pattern and sway; hearing, vision & cognition; proper use of walking aid if used.

2. **Romberg test:**

1. Instruct client to stand with feet together, arms at the side, and eyes open and observe for postural sway or break in position for 15 seconds. If client sways considerably or breaks position, do not continue
2. If minimal/no sway and no break in position, instruct client to maintain that position and close his or her eyes for 15 seconds (Reassure client that you will stand close by to catch him/her should he/she start to fall).
3. Individuals with normal balance may sway slightly upon closing their eyes, but it is usually minimal, and they do not break position. The Romberg test is positive (abnormal) if the sway is considerable and the client breaks position.

3. **Chair stand test:**

1. Instruct client to sit with back straight in the middle of a chair with hands on the opposite shoulder crossed at the wrists and feet flat on the floor.
2. Instruct client rise to a full standing position and then sit back down again on the word "go" and to repeat this for 30 seconds.
3. On "Go", begin timing and count the number of times the client comes to a full standing position in 30 seconds. If he/she is over halfway to a standing position when 30 seconds have elapsed, count it as a stand.
4. Record the number of times the client stands in 30 seconds.

4. **Tandem Stance Test:**

1. Demonstrate how to stand with one foot in front of the other, heel to toe. Client can hold onto a chair until he/she feel
2. Instruct client to let go when you say "Go" and to keep his/her feet in this position without holding on or taking a step until you say "Stop".
3. Say "Go" and begin timing. After 10 seconds, say "Stop".

Documentation

DOCUMENT falls risk screen and screening test results on BCEHS Community Paramedicine Falls Risk Screen Record.

DOCUMENT details of the visit on the CP Initial Assessment Form and/or progress notes and notify primary health care provider or health care team of findings and any concerns.

References

1. Eagle County Paramedic Services. Community Paramedic Protocols Manual. 2013. [\[Link\]](#)
2. General Practice Services Committee. Chronic Disease Management Tools and Resources: Fall Prevention Resources. [\[Link\]](#)
3. McMichael KA, et al. Simple Balance and Mobility Tests Can Assess Falls Risk When Cognition Is Impaired. 2008. [\[Link\]](#)
4. Tri-County Health Care Emergency Medical Services. Community Paramedic Policy & Procedure Manual. 2016. [\[Link\]](#)

CP 4.5: Blood Pressure Monitoring

Updated:
Reviewed:

Purpose

- To provide guidelines for monitoring of patients with suspected or actual hypertension
- To assist the health care team in diagnosis of hypertension or to evaluate effectiveness of treatment for hypertension

Policy Statements

In response to a referral from a health authority or primary health care provider, the Community Paramedic (CP) will follow the monitoring guidelines as outlined below when a request for Blood Pressure Monitoring is made on the Request for Service form and care plan.

Procedure

1. **OBTAIN** and **REVIEW** patient's health history and care plan prior to appointment.
2. **REFER** to Request for Service form and care plan for direction with respect to assessments requested and acceptable blood pressure (BP) ranges for systolic and diastolic BP.
3. **OBSERVE** patient's physical state/general well-being. Ensure patient has voided their bladder, and that they are sitting quietly and relaxed for at least 2 minutes with both feet flat on the floor with their arm outstretched and supported at heart level. If patient is bed-bound, have him/her lay face up in bed with arm supported and no contact between cuff and bed or patient.
4. **For orthostatic hypertension evaluation: MEASURE** BP in lying (L) position and then immediately on standing (Std), report to primary care provider if systolic drops greater than 20 mm Hg or if patient is symptomatic. If patient complains of dizziness when going from lying (L) to sitting (S) take and record BP. Do not proceed to standing
5. **MEASURE** blood pressure: for each BP recording, at least 2 consecutive measurements, at least 2 minutes apart, should be taken. Additional measurement should be taken when the first 2 measurements are quite different. Record the last 2
 - **Monitoring Schedule: timing, frequency and duration**
 - **MEASURE** BP twice daily (morning and late afternoon, prior to antihypertensive medications if patient on any) at about the same times every day or every other day for 6 to 7 measurements over 2 weeks
 - **RECORD** readings on BP Monitoring Log
 - **CALCULATE** average of readings, ignoring the 1st day
6. **REPORT** readings to Health Care Provider if outside acceptable ranges as per care plan

Documentation

RECORD date, right (R) or left (L) arm, time, BP, pulse (P), patient position (S or L) or any changes in position (L → Std), and patient symptoms in log.

NOTIFY primary health care provider of findings and any concerns.

Example documentation on log:

| Date | Limb & Position | Morning | | Symptoms | CP Initials | Limb & Position | Late afternoon | | Symptoms | CP Initials |
|--------------------------------|------------------|----------------------------|----------------------------|--------------------------|-------------|-----------------|------------------------|----------------|----------|-------------|
| | | #1 | #2 | | | | #1 | #2 | | |
| orthostatic evaluation example | R arm L → Std | 1015 (L) 152/92 P 60 | 1016 (S) 120/90 P 60 | Dizziness (std not done) | PD | | | | | |
| BP monitoring example | L arm S | 1000 152/90 P 70 | 1005 148/88 | none | PD | L arm S | 1600 138/84 P 66 | 1604 138/88 | none | PD |

| | | | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| | | | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|

References

1. American Heart Association. Home Blood Pressure Monitoring. 2016. [\[Link\]](#)
2. British Hypertension Society. Home Blood Pressure Monitoring Protocol. 2017. [\[Link\]](#)
3. National Institute for Health and Clinical Excellence. The clinical management of primary hypertension in adults: Clinical Guideline. 2011. [\[Link\]](#)
4. Singh, V. (2015). Home blood pressure monitoring, practical aspects. 2015. [\[Link\]](#)

CP 4.6: Home Medication Self-Management

Updated:
Reviewed:

Purpose

- To determine if the patient and/or caregiver is managing their home medications
- To refer any concerns or questions about the patient's medication self-management to the health care team

Policy Statements

The Community Paramedic (CP) will respond to a request for CP care and will assess a patient's ability to self-manage their medications as part of the initial home visit assessment screen or as specifically requested on the Community Paramedicine Request for Service.

CPs are not authorized to administer medications to a patient or advise the patient with respect to any changes. It is expected that the CP will document findings and report them to the primary health care provider and collaborate with other health care team members to provide support as appropriate.

Procedure

1. **OBTAIN** and **REVIEW** patient's health history, current medication list (if available), and care plan prior to appointment.
2. **ASK** patient and/or caregiver questions re: medication self-management as outlined on Initial Assessment Screen form. Use open-ended questions to elicit responses. Some examples include:
 1. What medications do you take?
 2. How do you take your medications? Is that different from how you took them before? How is it different?
 3. What changes have there been to your medications in the last month?
 4. How many times per week do you skip, miss or forget to take your medications?
 5. Which medications do you take more than 3 times/day?
 6. When was the last time your doctor/NP or pharmacist went over your medications with you?
3. **GENERATE** list of medications (name, dosage, frequency) patient is currently taking and compare to current medication list provided to detect any discrepancies. **NOTIFY** health care provider/team if discrepancies found.

NOTE: Client may report their medications using brand names and medication list provided by HCP may use generic names.
4. **ASK** the patient and/or caregiver if there are any other medications, vitamins or herbal supplements they take that might be from another health care provider or self-prescribed over the counter and include these on list as well.
5. **ASK** patient and/or caregiver to show you their medications and system they use for organizing them.
6. **CONTACT** referring health care provider if paramedic or patient and/or caregiver have any concerns.

Documentation

DOCUMENT on appropriate records;

- Medication self-management section on Community Paramedicine Initial Assessment Screen form.
- Medication list and discrepancies on Progress Notes.

References

1. Dorman M, et al. Medication Management of the Community-Dwelling Older Adult. In *Patient Safety and Quality. An Evidence-Based Handbook for Nurses*. 2008.
2. Eagle County Paramedic Services. Community Paramedic Protocols Manual. 2013. [\[Link\]](#)
3. Tri-County Health Care Emergency Medical Services. Community Paramedic Policy & Procedure Manual. 2016. [\[Link\]](#)
4. Vancouver Coastal Health. Vancouver Community AOA Practice Guidelines. Initial Assessment Tool – Guidelines for Use. March

CP 4.7: Diabetic Follow-Up

Updated:
Reviewed:

Purpose

To ensure the proper maintenance of blood sugar and insulin levels in the diabetic patient to be accomplished through patient's ability to self-manage their blood glucose monitoring, appropriate prescription drug usage, recognition of desired drug effects, recognition of hypo/hyperglycemia and treatment of same.

Policy Statements

In response to a referral from a health authority or primary health care provider, the Community Paramedic (CP) will follow guidelines outlined on the Request for Service form and care plan for follow-up on diabetic patients. It is expected that the CP will document findings and report them to the primary health care provider and collaborate with other health care team members to provide support as appropriate.

Procedure

1. **OBTAIN** and **REVIEW** patient's health history and care plan prior to appointment.
2. **REFER** to Request for Service form and care plan for direction with respect to assessment, patient specific care parameters and patient teaching required.
3. **REVIEW** history and physical including health care providers plan for diet, blood glucose targets and medications.
4. **OBSERVE** patient's physical state/general well-being.
5. **INSPECT** patient's feet and **DISCUSS** foot care with patient and review information as required. Proper footcare is critical for diabetic patients because they are prone to foot problems caused by neuropathy and poor circulation which can lead to loss of feeling in their feet, changes in the shape of their feet and foot ulcers or sores that do not heal. According to the National Institute of Health, simple daily footcare can prevent serious problems. **REVIEW** the following information about footcare with the patient as necessary:
 - **Check Your Feet Every Day**
 - Check your feet for cuts, sores, red spots, swelling, and infected toenails. You may have foot problems, but feel no pain in your feet.
 - Check your feet each evening when you take off your shoes.
 - If you have trouble bending over to see your feet, use a mirror to help. You can also ask a family member or caregiver to help you.
 - Call your doctor right away if a cut, blister, or bruise on your foot does not begin to heal after a few days.
 - **Wash Your Feet Every Day**
 - Wash your feet in warm, not hot, water. Do not soak your feet because your skin will get dry. **INSPECT** patient's feet and **DISCUSS** foot care with patient and review information as required. Proper footcare is critical for diabetic patients because they are prone to foot problems caused by neuropathy and poor circulation which can lead to loss of feeling in their feet, changes in the shape of their feet and foot ulcers or sores that do not heal. According to the National Institute of Health, simple daily footcare can prevent serious problems. **REVIEW** the following information about footcare with the patient as necessary:
 - Before bathing or showering, test the water to make sure it is not too hot. You can use a thermometer (32° to 35° C is safe) or your elbow to test the water.
 - Use cornstarch to keep the skin between your toes dry to prevent infection.
 - **Keep the Skin Soft and Smooth**
 - Rub a thin coat of skin lotion or cream on the tops and bottoms of the feet
 - Do not put lotion between your toes, because this might cause infection
 - **Smooth corns and calluses**
 - Thick patches of skin called corns or calluses can grow on the feet. If you have corns or calluses, check with your foot doctor about the best way to care for them.
 - If your doctor tells you to, use a pumice stone to smooth corns and calluses after bathing or showering. Pumice stone is a type of rock used to smooth the skin. Rub gently, only in one direction, to avoid tearing the skin.
 - Do not cut corns and calluses.
 - Do not use razor blades, corn plasters, or liquid corn and callus removers - they can damage your skin and cause an infection.
 - **If you can see, reach, and feel your feet, trim your toenails regularly**
 - Trim your toenails with nail clippers after you wash and dry your feet.
 - Trim your toenails straight across and smooth the corners with an emery board or nail file. This prevents the nails from growing into the skin. Do not cut into the corners of the toenail.
 - Have a foot doctor trim your toenails if:
 - you cannot see or feel your feet

- you cannot reach your feet
 - your toenails are thick or yellowed
 - your nails curve and grow into the skin
- **Wear Shoes and Socks At All Times**
 - Wear shoes and socks at all times. Do not walk barefoot when indoors or outside. It is easy to step on something and hurt your feet. You may not feel any pain and not know that you hurt yourself.
 - Make sure you wear socks, stockings, or nylons with your shoes to keep from getting blisters and sores.
 - Choose clean, lightly padded socks that fit well. Socks that have no seams are best.
 - Check inside your shoes before you put them on. Make sure the lining is smooth and that there are no objects in your shoes.
 - Wear shoes that fit well and protect your feet
 - **Protect Your Feet From Hot and Cold**
 - Wear shoes at the beach and on hot pavement. You may burn your feet and may not know it.
 - Put sunscreen on the top of your feet to prevent sunburn
 - Keep your feet away from heaters and open fires
 - Do not put hot water bottles or heating pads on your feet
 - Wear socks at night if your feet get cold. Choose socks carefully. DO NOT wear socks with seams or bumpy areas. Choose padded socks to protect your feet and make walking more comfortable.
 - Wear lined boots in the winter to keep your feet warm. In cold weather, check your feet often to keep your feet warm avoid frostbite.
 - **Keep the Blood Flowing to Your Feet**
 - Put your feet up when you are sitting.
 - Wiggle your toes for 5 minutes, 2 or 3 times a day. Move your ankles up and down and in and out to help blood flow in your feet and legs.
 - Do not cross your legs for long periods of time.
 - Do not wear tight socks, elastic, or rubber bands around your legs. Do not wear restrictive footwear or foot products. Foot products that can cut off circulation to the feet, such as products with elastic, should not be worn by diabetics.
 - Do not smoke. Smoking can lower the amount of blood flow to your feet.
 - **Be More Active**
 - Being active improves blood flow to the feet. Ask your health care team for safe ways to be more active each day. Move more by walking, dancing, swimming, or going bike riding.
 - If you are not very active, start slowly
 - Find safe places to be active
 - Wear athletic shoes that give support and are made for your activity.
6. **MEASURE** and **RECORD** blood pressure and weight.
 7. **ASSESS** patient's understanding of disease and impact of diet and exercise. **ENSURE** patient is using medications as prescribed and inform the primary care provider if they're not. If patient is on insulin, ensure correct use of devices and storage of vials (i.e. ensure patient can visualize the proper amount of insulin they are to inject, correct injection sites, injection technique and site rotation, changing needles with each injection, not keeping opened/active insulin in the fridge, ensuring insulin is not exposed to temperature extremes). **REVIEW** information with patient as required. **INSPECT** injection sites for redness or irritation.
 8. **ENQUIRE** about hypoglycemia episodes at each visit. **DISCUSS** recognition and treatment of hypoglycemia as needed.
 9. **INSPECT** glucose meter to ensure it turns on when a strip is inserted and does not provide error messages. If not working, **REFER** to pharmacy for new meter.
 10. **OBSERVE** patient as he/she performs blood glucose reading on personal home glucose meter. **ASK** patient to read out loud the glucometer reading. **REVIEW** usage with client if required. **ENCOURAGE** patient to use a new lancet with each poke.
- NOTE:** patients should follow SPECIFIC directions from their health care provider regarding frequency of blood glucose monitoring. In the absence of those directions and if not using insulin, testing is only recommended when suspecting hypoglycemia, or if feeling sick.
11. If blood glucose (BG) is less than 4 mmol/L or if patient experiencing signs & symptoms of hypoglycemia:
 1. **ASSESS** vital signs and level of consciousness
 2. If airway, breathing or vital signs are compromised, immediately initiate emergency response
 3. **ASSIST** patient with treatment including 15-20 grams of carbohydrate – some suggestions include:
 - 15 g of glucose in the form of glucose tablets/gel (preferred choice) **OR**
 - 15 mL (3 teaspoons) sugar dissolved in water **OR**
 - 175 mL (3/4 cup) of juice or regular soft drink **OR**

- 6 LifeSavers® (1=2.5 g of carbohydrate) **OR**
 - 15 mL (1 tablespoon) of honey
4. **REPEAT** blood glucose in 10-15 If BG remains less than 4 mmol/L, repeat step III
 5. If their next meal is more than one hour away, they should eat a snack, such as a half- sandwich or cheese and crackers (something with 15 grams of carbohydrate and a protein source)
 6. **CONTACT** health care provider for further direction
12. **RECORD** patients concerns about treatment (e.g. Insulin levels, blood sugar levels, foot problems)
 13. **COMMUNICATE** with health care provider or health care team if blood glucose falls outside acceptable parameters as noted on care plan or if any self-care difficulties are noted or suspected such as vision problems or inability to perform own footcare due to mobility, co-ordination, diminished sensation or other difficulties.

Patient Education Resources

[Canadian Diabetes Association – Diabetes and You](#)

[Canadian Diabetes Association – Health Living Resources](#)

[Diabetes – Take Care of Your Feet for a Lifetime](#)

Documentation

DOCUMENT details of the visit on the CP progress notes and notify primary health care provider or health care team of findings and any concerns.

References

1. Canadian Diabetes Self-Management Education - Help your patient take charge. [\[Link\]](#)
2. Eagle County Paramedic Services. Community Paramedic Protocols Manual. 2013. [\[Link\]](#)
3. National Institute of Diabetes and Digestive and Kidney Diseases. Diabetes - Take Care of Your Feet for a Lifetime. 2014. [\[Link\]](#)
4. Tri-County Health Care Emergency Medical Services. Community Paramedic Policy & Procedure Manual. 2016. [\[Link\]](#)
5. Vancouver Coastal Health. Hypoglycemia in Diabetes: Adult Management Protocol – Acute and Residential. 2013.

CP 4.8: Heart Failure

Updated:
Reviewed:

Purpose

The Community Paramedic will, in collaboration with the health care team, provide education and regular monitoring of patients with heart failure with the goals of reducing hospitalizations, reducing mortality and improving the patient's quality of life.

Policy Statements

In response to a referral from a health authority or primary health care provider, the Community Paramedic (CP) will visit a patient with heart failure and in addition to performing a focused cardiac assessment, will assess patient's self-management of disease including an understanding of their underlying disease, compliance with medications, dietary (well-balanced low salt/no salt diet, avoidance of processed foods and trans fats) and fluid restrictions and exercise.

It is expected that the CP will document findings and report them to the primary health care provider and collaborate with other health care team members to provide support as appropriate.

Procedure

1. **OBTAIN** and **REVIEW** patient's health history and careplan prior to appointment.
2. **REFER** to Request for Service form and care plan for direction with respect to assessment and patient teaching required. **REVIEW** prescribed parameters for target weight and sodium and fluid restrictions.
3. **ASSESS** patient's/caregiver's understanding of heart failure and rationale for treatment modalities and **REVIEW** any factors known to precipitate or exacerbate heart failure (e.g. non-adherence to dietary sodium restriction, fluid restriction, medication or exercise, continuation of smoking, excessive alcohol use, use of non-prescription NSAIDs – ibuprofen, naproxen). **REVIEW** patient's record of daily weights.
4. **PERFORM** focused assessment including:
 - Temperature, pulse, respiratory rate, oxygen saturation
 - Heart rate and rhythm (regular or irregular)
 - Blood pressure (supine and standing). Note if patient unable to lie supine due to shortness of breath (orthopnea).

NOTE: patient should be in each position for 2-3 minutes before measurement

NOTE: when reporting recording, indicate if manual or electronic reading taken
 - Body weight (compare to previous measurements)
 - Cardiac auscultation (heart sounds)
 - Pulmonary auscultation (air entry, crackles, respiratory effort)
 - Check for edema in the most common dependent area e.g. if standing, check for edema in the feet, ankles, lower legs; if sitting check for sacral edema
5. **ENSURE** patient has had their annual flu vaccine and their pneumococcal vaccine.
6. **NOTIFY** primary health care provider if concerns arise and for direction on diuretic adjustment for weight changes above/below parameters.
7. **DISCUSS** with patient/caregiver patient's self-management strategies: dietary sodium restriction, fluid restriction, exercise, smoking cessation, prescribed medication adherence. **DISCUSS** with patient the importance of monitoring and recording daily weights at the same time each day. **REVIEW** with the patient their diuretic management plan if weight is above target. **REVIEW** with patient/caregiver their primary care contact and follow-up plan if patient/caregiver become concerned regarding their condition.
8. **PROVIDE** patient/family with the daily weights information sheet and log (if they don't already have one and any additional resources available via [BC Heart Failure Network](#) as needed/requested.
9. **RECORD** patient's/caregiver's concerns about disease and/or treatment and/or self-management strategies.

Documentation

DOCUMENT details of the visit on the CP assessment form and progress notes and notify primary health care provider or health care team of findings and any concerns.

Patient Education Resources

[BC Heart Failure Network Understanding Heart Failure – Basics](#)

[Learning to Live with Heart Failure](#)

[Heart Failure Zones](#)

[Sodium Restriction](#)

[Fluid Restriction](#)

[Activity](#)

[Exercise](#)

[Daily Weights Log](#)

References

1. American Heart Association. Living with Heart Failure. 2001. [\[Link\]](#)
2. BC Heart Failure Network. Co-Management Resources for Patients and Families. [\[Link\]](#)
3. British Columbia Guidelines and Protocols Advisory Committee. Chronic Heart Failure – Diagnosis and Management. 2015. [\[Link\]](#)
4. Nicholls MG, et al. Disease monitoring of patients with chronic heart failure. 2007. [\[Link\]](#)

CP 4.9: Chronic Obstructive Pulmonary Disease

Updated:
Reviewed:

Purpose

The Community Paramedic will work together with the health care team in meeting goals of COPD management which include:

- Prevention of disease progression
- Reduction in frequency and severity of exacerbations
- Alleviation of dyspnea and other respiratory symptoms
- Improvement of exercise tolerance
- Prompt treatment of exacerbations and complications
- Improvement in health status
- Reduction in mortality

Policy Statements

In response to a referral from a health authority or primary health care provider, the Community Paramedic (CP) will visit a patient with stable COPD and in addition to performing a focused chest assessment, will assess patient's self-management of disease including an understanding of the need to stop smoking (if applicable), recognition of signs and symptoms of an exacerbation, correct use of inhaler(s), need for flu and pneumococcal vaccinations and daily exercise.

It is expected that the CP will document findings and report them to the primary health care provider and collaborate with other health care team members to provide support as appropriate.

Procedure

1. **OBTAIN** and **REVIEW** patient's health history, [COPD flare-up action plan](#) (if available) and care plan prior to appointment.
2. **REFER** to Request for Service form, care plan and/or COPD flare-up action plan for direction with respect to assessment, patient specific care parameters/interventions and patient teaching required.
3. If patient is a smoker, **ENCOURAGE** him/her to quit smoking and suggest smoking cessation strategies such as nicotine replacement therapy which can be initiated at the community pharmacy level or suggest he/she speak to their primary care provider for other medications that may help.
4. **ASSESS** patient's current level of dyspnea using a quantitative rating scale (e.g. numeric scale): On a scale 0-10 – indicate how much shortness of breath you are having right now, 0=no shortness of breath and 10=shortness of breath as bad as can be.
5. **PERFORM** physical exam including:
 - vital signs (T, P, RR, BP)
 - pulse oximetry, level of consciousness
 - chest auscultation
 - chest wall movement and shape/abnormalities.
 - accessory muscle use
 - ability to complete full sentence
 - presence of peripheral edema
 - note worsening of concurrent conditions such as angina or diabetes.
6. If patient's self-report of current dyspnea is worse than usual and/or physical exam shows worsening work of breathing (increased RR, HR, increased or decreased BP, decreased breath sounds, end expiratory wheeze and/or crackles, shallow inspiratory depth with reduced chest wall expansion, respiratory accessory muscle use, sputum and cough change), or there is worsening of concurrent conditions, **REVIEW** patient's current flare-up action plan for direction. If patient does not have an action plan, **CONTACT** health care provider for direction.

NOTE: All patients with COPD should have a flare-up action plan, which often includes having access to steroids and antibiotics that can be initiated at first sign of exacerbation, and does not require a visit to their primary care provider.
7. If no change in usual or current level of dyspnea (RR within normal limits, breath sounds reduced with or without end expiratory wheeze and/or crackles, adequate inspiratory depth and chest wall expansion, minimal or no respiratory accessory muscle use, may have clear or white sputum and daily cough), **CONTINUE** with interventions.
8. **ASSESS** patients understanding of COPD and disease process and **REVIEW** patient's current flare-up action plan and ensure that the patient would be able to access medications if needed (i.e. medications or prescription on file at the pharmacy). Reinforce to patient that should a flare-up occur, he/she should notify health care provider for follow-up.

9. **ENSURE** patient has had their annual flu vaccine and their pneumococcal vaccine.
10. **ASSESS** current use of inhaled medications with patient, and re-inforce directions on prescription labels for each inhaler.
11. **OBSERVE** patient using their inhaler device and **REVIEW** technique as needed. If using an aerosolized metered-dose inhaler (MDI), a spacer is strongly recommended. **REVIEW** priming/preparation of inhalers for those that are not used regularly and cleaning instructions for inhaler device (weekly rinse to prevent medication build-up) and for spacer (wash in warm soapy water weekly and leave to air dry to reduce static). If using a spacer, **CHECK** device for cracks, broken valve.
12. **ASSESS** self-management strategies: exercise, stress management, nutrition, sleeping patterns, breathing and coughing exercises.
13. **REVIEW** triggers for exacerbations of symptoms (e.g. poor air quality, smoke, strong fumes, scents, cold air, hot/humid air) and early warning signs of an exacerbation (worsening dyspnea and work of breathing, change in cough or sputum).
14. **COMMUNICATE** with health care provider or health care team if parameters if parameters have deviated from patient's normal parameters as noted on care plan or if any other concerns arise.

Documentation

DOCUMENT details of the visit on the CP progress notes and notify primary health care provider or health care team of findings and any concerns.

Patient Education Resources

[COPD – A Guide for Patients](#)

[BREATHE – The Lung Association: COPD](#)

[BC Smoking Cessation Program](#)

References

1. Bailey LB, et al. Patient Information: Asthma Inhaler Techniques in Adults. In UpToDate. 2015. [\[Link\]](#)
2. BC Guidelines. Chronic Obstructive Pulmonary Disease. 2011. [\[Link\]](#)
3. O'Donnel DE, et al. Canadian Thoracic Society Recommendations for Management of Chronic Obstructive Pulmonary Disease - 2008 Update - Highlights for Primary Care. 2008. [\[Link\]](#)
4. RNAO Nursing Best Practice Guideline. Nursing Care of Dyspnea: the 6th Vital Sign in Individuals with Chronic Obstructive Pulmonary Disease. 2005. [\[Link\]](#)
5. RX Files. COPD: New Drugs, New Devices and Considerations for Best Practice. 2015. [\[Link\]](#)
6. World Health Organization. Chronic Respiratory Diseases – COPD Management. 2016. [\[Link\]](#)

CP 4.10: CPAP, BiPAP, Oxygen Therapy, and Oximetry

Updated:
Reviewed:

Purpose

To assist the health care team in observing and documenting recently diagnosed/chronic sufferers of obstructive sleep apnea or other conditions requiring oxygen therapy to ensure proper ventilation of the patient for the purpose of avoidance of long term pathologic outcomes and to ensure that patients are aware of the proper functioning of equipment.

Policy Statements

In response to a referral from a health authority or primary health care provider, the Community Paramedic (CP) will follow guidelines outlined on the Request for Service form and care plan for follow up on patients requiring CPAP, BiPAP or oxygen therapy.

It is expected that the CP will document findings and report them to the primary health care provider and collaborate with other health care team members to provide support as appropriate.

Definitions

BiPAP: Supports spontaneous respiration by providing a positive pressure on inspiration (IPAP – inspiratory positive airway pressure) and a positive pressure on expiration (IEAP) – expiratory positive airway pressure).

CPAP: Supports spontaneous respirations by providing one continuous positive pressure on inspiration and expiration to help stent open obstructive airways.

Sleep apnea: a common sleep disorder in which a person has one or more pauses in breathing or shallow breaths while sleeping. Breathing pauses can last from a few seconds to minutes and can occur 30 times or more per hour. As a result, the quality of sleep is poor, which leads to daytime sleepiness.

Obstructive sleep apnea is the most common type of sleep apnea and occurs when the airway collapses or becomes blocked during sleep. Central sleep apnea is less common and occurs if the area of the brain that controls breathing doesn't send the correct signals to the breathing muscles. As a result, no effort to breathe is made for brief periods (NIH – National Heart, Lung and Blood Institute, July 10, 2012).

Procedure

1. **OBTAIN** and **REVIEW** patient's health history and care plan prior to appointment.
2. **REFER** to Request for Service form and care plan for direction with respect to assessment and patient teaching required.
3. **REVIEW** equipment usage including equipment care, cleaning, and use of distilled water for humidification with patient/caregiver as required.
4. If patient is recently diagnosed and new to using CPAP/BiPAP, **MONITOR** for hemodynamic instability (changes in vital signs, capillary refill, urine output).
5. **CONDUCT** assessment:
 - Vital signs including RR, SpO₂ and pulse (check for signal strength on the oximeter, ensuring the SpO₂ and heart rate correlate with pulse rate).
 - Assess sleep habits (shift work? irregular work schedule?)
 - Assess alcohol/recreational drug use
 - Assess use of medication that may affect oxygenation such as benzodiazepines, OTC sleep aids
6. **ASSESS** quality of life and whether there are noticeable changes after usage.
7. **COMMUNICATE** immediately with health care provider or health care team if concerns arise.
8. **INSPECT** equipment and **TROUBLESHOOT** if necessary including ensuring proper fit of mask and use of machine as well as general condition of machine.
9. **ENSURE** that patient is connected with necessary resources (oxygen supply company, etc.).

Documentation

DOCUMENT findings and details of the visit on the CP progress notes and notify primary health care provider or health care team of findings and any concerns.

References

1. Eagle County Paramedic Services. Community Paramedic Protocols Manual. 2013. [[Link](#)]
2. Tri-County Health Care Emergency Medical Services. Community Paramedic Policy & Procedure Manual. 2016. [[Link](#)]
3. Vancouver Coastal Health. *Oximetry Management Guidelines for Community Settings & Residential Care*. 2013.

CP 4.11: Palliative Care

Updated:
Reviewed:

Purpose

The Community Paramedic will work together with the health care team in supporting goals of palliative and end of life care which include:

- Supporting the local palliative / home care team members by being the eyes and ears on the ground.
- Supporting patients and their care givers (family/friends) on understanding around progression of the disease and how to support the patient's wishes for care - includes discussions around ACP (advanced care plans) and goals of care, including MOST (medical orders for scope of treatment).
- Identifying patients who could benefit from palliative care approach (using the iPall-advanced disease tool) and report to the local care
- Completing assessments, including reporting back to palliative/home care team:
 - Edmonton Symptom Assessment System Revised (ESAS-r tool)
 - Palliative Symptom Assessment (OPQRSTUV tool)
 - Palliative Performance Scale (PPSv2 tool)
 - Pain Assessment in Advanced Dementia (PAINAD)
 - Confusion Assessment Method (CAM with PRISME tool)
 - Supportive and Palliative Care indicators Tool (SPCIT)
- Providing support with pain and symptom management:
 - Provide comfort care measures (e.g. repositioning, use of fans for air circulation)
 - Medication self-management (or as managed by family care givers)
 - Provide patient/caregiver teaching on supporting measures
- Supporting navigation of access to other community supports for the patient and family/friend care givers.

Policy Statements

In response to a referral from a health authority or primary health care provider, the Community Paramedic (CP) will visit a palliative patient to assess and support symptom management, and discussions around advanced care plans and the patient's goals of care.

It is expected that the CP will document findings and report them to the primary health care provider and collaborate with other health care team members to provide support as appropriate.

Procedure

1. **OBTAIN** and **REVIEW** patient's health history, including MOST form and previous palliative documentation available prior to appointment.
2. **REFER** to Request for Service and care plan for direction with respect to assessment, patient specific care parameters/interventions and patient and/or caregiver education/support required.
3. **ASSESS** patient's current level of pain, hydration, comfort, nutrition, functional status (Patient Palliative Scale) as guided by the referring professional.
4. **PERFORM** physical exam, as required, including:
 - vital signs (T, P, RR, BP)
 - pulse oximetry, level of consciousness
 - chest auscultation
5. **PERFORM** assessments, as required, using:
 - Symptom assessments: ESAS-r, OPQRSTUV
 - Pain Assessment in Advanced Dementia (PAINAD)
 - Confusion Assessment Method (CAM) with PRISME
 - Palliative Performance Scale (PPSv2 tool)
6. **SUPPORT** navigation of health system by accessing other support and resources as identified by family/caregivers and **ENGAGE** in conversations, as required, around:
 - Advanced care planning
 - MOST form
 - Palliative care

7. **PROVIDE** comfort measures as determined by the patient, family or caregivers such as:
 - repositioning
 - use of fans for air circulation
8. **SUPPORT** medication self-management or as managed by family or caregivers.
9. As determined by assessments completed, **CONTINUE** with interventions outlined in the patient's care plan.
10. **COMMUNICATE** with health care provider or health care team for changes in patient status and if any other concerns arise.

Documentation

DOCUMENT details of the visit on the palliative assessment forms (where appropriate) and CP Progress Notes, and notify primary health care provider or health care team of findings and any concerns.

Patient Education Resources

1. British Columbia. Advanced Care Planning Resources. [\[Link\]](#)
2. British Columbia. My Voice Guide. [\[Link\]](#)
3. BC Aboriginal Health. Advanced Care Planning Brochure. [\[Link\]](#)

References

1. Government of British Columbia. My Voice Advance Care Planning Guide Quick Tips. [\[Link\]](#)
2. Government of British Columbia. After Hours Palliative Tele-nursing Support. [\[Link\]](#)
3. Pallium Canada. LEAP Course Learning Materials. [\[Link\]](#)
4. University of Edinburgh. *Supportive and Palliative Care Indicators Tool (SPCIT)*. [\[Link\]](#)

CP 4.12: Home Health Monitoring

Updated:
Reviewed:

Purpose

To support the Community Paramedic in using Community Paramedicine Home Health Monitoring (CPHHM).

Policy Statements

In response to a request for service from a health authority or primary health care provider, the Community Paramedic (CP) may enroll a patient into the CPHHM program. In the absence of an external referral, the CP may enroll the patient into the program, provided that:

1. There is no change in the frequency of patient visits without consultation from the patient's primary health care
2. CPHHM summary reports are made available to the patient's primary health care provider on a regular
3. The primary health care provider is made aware that the patient is enrolled in the CPHHM program

Eligibility

- **PATIENTS** >65 years old
- **PATIENTS** under the care of a Primary Health Care Provider
- **CONFIRMED DIAGNOSIS** of:
 - **HEART FAILURE** (NB: Currently heart failure CPHHM is not offered in Interior Health's regional jurisdiction.)
 - **COPD** (Chronic Obstructive Pulmonary Disease)
 - **DIABETES**
 - **PALLIATIVE**
- **COVID-19**
 - COVID-19 questions may also be added to any of the above HHM protocols, based on the clinical assessment of the Community Paramedic. These questions should be in addition to the patient's own monitoring protocol. Patients with confirmed or presumptive diagnosis of COVID-19 should be referred to public health for monitoring.
- **SUITABILITY** assessment:
 - Willingness to participate in 3 months self-management program
 - Able to manage Home Health Monitoring equipment or has a capable caregiver
 - Understands and speaks English or has access to a translator
 - Can stand on a scale unsupported
 - Can follow written instructions
 - Can respond to questions and teaching over the phone
 - Has internet connection, or lives in an area with cellular service
 - Consents to participation in HHM Service
- **EXCLUSION** assessment:
 - Does not speak or understand English and has no access to a translator
 - Lives in a Residential Care Facility
 - However, residents of Assisted Living would be appropriate for enrolment
 - Lives outside of HHM Service geographical boundaries (if unsure, call the TELUS HHM service desk)
- **IF THE CLIENT IS NOT** eligible or suitable for CPHHM:
 - Notify originating referral source
 - May keep on CP caseload for regular CP services
 - Refer client to other services as required
- **IF THE CLIENT IS** eligible and suitable for CPHHM:
 - Obtain HHM consent for participation in the HHM Service
 - Read the full consent form content to the client as required by Government of BC
 - If the client does not provide consent, consider the client unsuitable and follow the steps as listed above

Documentation

REPORTS may be printed from the Triage manager software, and should be delivered to the Primary Health Care Provider on a regular basis.

Patient Education Resources

1. BCEHS Community Paramedicine. Home Health Monitoring. [\[Link\]](#)
2. BCEHS Community Paramedicine. Home Health Monitoring Brochure. [\[Link\]](#)
3. TELUS Health. Someone to Watch Over Me. [\[Link\]](#)
4. TELUS Patient and Consumer Health Platforms. [\[Link\]](#)

References

1. American Heart Association. Classes of Heart Failure. [\[Link\]](#)
2. Michigan Institute for Care Management and Transformation. LACE Index Scoring Tool for Risk Assessment of Hospital Readmission [\[Link\]](#)

CP 4.13: Community Paramedicine Telehealth

Updated:
Reviewed:

Purpose

To support Community Paramedics in the use of Zoom and FaceTime as a modality to provide client care, group conferences and to communicate with staff members.

Scope

In response to Ministerial Order No. M085, Zoom and FaceTime are approved methods to facilitate video conferencing between patients, other health care providers, community members and staff members for the duration of the COVID-19 pandemic. While both solutions are available, each has their own benefits and limitations.

Telehealth Responsibilities

- **PARAMEDICS** must comply with the following policies prior to using virtual health technology:
 - [Patient Consent](#)
 - [Privacy & Confidentiality Policy](#)
 - [Network Acceptable Use Policy](#)
 - [Virtual Health Policy](#)
- **PARAMEDICS** must ensure that they have the latest iOS version. This will ensure that the device has all the latest security features.
- **PARAMEDICS** must not connect to any cloud application when using FaceTime. The iCloud must be turned off. Apple does not store FaceTime on their servers and messages are encrypted end-to-end during transmission. Since iCloud will be turned off, there will be no back up of the FaceTime exchange. Instructions to turn off iCloud can be found [here](#).
- **PARAMEDICS** must comply with any professional standards and practice guidance by the EMALB. For example, privacy and confidentiality, documentation standards and practice standards for managing personal/professional boundaries.
- **PARAMEDICS** will ensure that the patient is comfortable with using Zoom (or alternatively FaceTime) before using as a modality to provide patient care
- **DOCUMENTATION** of patient specific care must be included in the patient care record
- **ZOOM ACCOUNT** creation must be completed through the PHSA Office of Virtual Health
 - CP must configure their account to give clerk scheduling privileges to the CP Coordinators

Zoom Procedure

1. INTRODUCE VIRTUAL HEALTH TO THE PATIENT

- Introduce Virtual Health to patients by phone/email/text
- Check the technical readiness of your patients
- Obtain the patient's personal email and send an initial email to validate their email address and provide notification of risks:
 - Under the Provincial Digital Communications Policy, verbal or digital consent from the patient is acceptable before use of all Virtual Health solutions; however, requirements are:
 - Notification of risks have been provided. See [Client Notification Form](#) below.
 - Reasonable efforts have been made to validate the patient's identity. See [Patient Email Notification Script](#) below.
- Healthcare version of ZOOM - hosted in Canada with end-to-end encryption. Meeting privacy and security requirements in BC.
- Patients can join a meeting from their internet browser without needing to download anything. To join, patients simply click the meeting link provided in their email. The link will open their default browser and take them to the meeting.
- Supported browsers:
 - Windows: IE 11+, Edge 12+, Firefox 27+, Chrome 30+
 - Mac: Safari 7+, Firefox 27+, Chrome 30+
 - Linux: Firefox 27+, Chrome 30+

2. COMMUNICATE VIRTUAL VISIT INFORMATION

- Log into Zoom to schedule the patient's visit(s). A link will be emailed to the patient at this time.
- Recurring meeting can be set for ease-of-use

3. CONDUCT VIRTUAL VISIT

- Prior to the visit, choose a private location with reliable internet access (i.e. BCEHS Station) and ensure that there is nothing confidential posted or people moving behind you
- At the time of the appointment, click the link in your email invitation or copy and paste the link to your browser
- In the unlikely event of technical issues, please switch to a telephone visit with the patient
- Supporting materials can be sent to the patient via email or SMS
- After the visit, document the encounter in the patient record as usual, and report findings to the requesting provider

Client Notification Form (advised by phone or email prior to virtual health visit)

Notification for the use of Digital Communications

Digital communications can be a convenient way to communicate with your care team between visits, but there are risks when using these technologies to send personal information. We'll do what we can to confirm that any personal information we send is being received by you and only you, but it's never possible to have 100% certainty who we are communicating with outside of a face-to-face visit.

You need to be aware that we cannot control what happens to information once it is stored:

1. On your device;
2. By telecommunications providers;
3. By software or application providers; or
4. By other applications that may have access to your

You are responsible for the security of your own computer/tablet, email service and telephone

Risks of using Digital Communications

The information could be requested, viewed, changed or deleted if others are allowed access to your phone, tablet, or email account. Information may be vulnerable if stored on a computer/device that has been compromised by viruses or malware.

Organizations may have to disclose information where required by law or under court order. Electronic communications can be intercepted by third parties.

Your data may be stored and/or accessed outside of Canada.

What can you do? The below are suggested best practices meant to help you protect your information once it is in your control. It is important to note that these are general best practices and will not guarantee your information won't be accessed by a third party.

- Protect your passwords! Someone could pose as you by sending us a request from your device or email account
- Use downloaded Apps from trusted sources (Google Play, Apple App Store). If the info you are wanting to communicate is of a sensitive nature, you may want to seek a more secure method of communication
- Delete emails and texts you no longer require
- Use your device settings to control what information your Apps have permission to access
- Avoid sending personal information while using public Wifi
- Use permission controls on your device to ensure that none of your applications (Apps) have unnecessary access to your text messages and/or emails
- Use virus protection on your computer or device, and regularly scan

Patient Email Notification Scripts

Hello,

The BC Emergency Health Services Community Paramedicine program would like to share information with you.

Please respond to this message with the last 4 digits of your Personal Health Number (PHN) to confirm that you are the correct individual and that you consent to these records being sent to [insert patient's email address].

Before you respond, it is important that you understand the potential risks associated with the use of digital communications by reviewing our [Notification for the Use of Digital Communications](#). If you have any questions, please contact me at [CP phone number].

Email tips:

- Do not email or text us if you have an emergency. If you have an emergency, call 9-1-1 or go to the nearest emergency
- This email account is not continuously

Regards,

[Community Paramedic email signature]

References

1. BCEHS Orientation to Telehealth for CPs. [\[Link\]](#)
2. BCEHS Policies and Procedures – Patient Consent (Competent Adult). [\[Link\]](#)
3. Emergency Health Services Act. Emergency Medical Assistants Regulation. [\[Link\]](#)
4. Freedom of Information and Protection of Privacy Act Ministerial Order No. M085. [\[Link\]](#)
5. PHSA Network Acceptable Use Policy. [\[Link\]](#)
6. PHSA Privacy and Confidentiality. [\[Link\]](#)
7. PHSA Virtual Health COVID-19 Accessible Solution Toolkit. [\[Link\]](#)
8. PHSA Virtual Health Policy. [\[Link\]](#)
9. Vancouver Coastal Health – FaceTime Use Clinical. [\[Link\]](#)
10. Vancouver Coastal Health – Zoom Use. [\[Link\]](#)

CP 4.14: Intravenous Initiation by Community Paramedics

Updated:
Reviewed:

Purpose

The Community Paramedic works together with primary care providers to support patient self-care in the community whenever possible. In some cases, patients who would otherwise self-cannulate or require cannulation for the purpose of self-administration of their medications may request assistance from the Community Paramedic (CP) through the normal referral process.

Policy Statements

In response to a referral from a primary health care provider and following the standardized procedures for Community Paramedic (CP) home visits, the CP may attend a client's residence to initiate intravenous access for the purposes of patient self-administration of medications. This procedure does not include CP administration of any medications.

Such patient interactions will follow the same patient referral, intake, management and documentation processes as any other CP wellness check.

It is expected that the CP will document the procedure, including all findings, and report them to the primary health care provider and collaborate with other health care team members to provide support as appropriate.

Procedure

1. **OBTAIN** and **REVIEW** patient's health history and care plan prior to appointment.
2. **REFER** to Request for Service form and care plan with respect to assessment, patient specific care interventions and patient teaching as required.
3. **EXPLAIN** the purpose of the visit and **OBTAIN** verbal consent patient prior to undergoing any procedure, including vital signs.
4. **PERFORM** physical exam including:
 - vital signs (T, P, RR, BP)
 - pulse oximetry
 - level of consciousness
5. **ASSESS** patients understanding of the procedure and **DISCUSS** any concerns the patient may have prior to cannulation.
6. **CONFIRM** patency of IV access by flushing with normal saline and secure the catheter. **REVIEW** possible complications with patient and verify understanding of when follow up care from the primary care provider would be required.

If first 2 attempts to secure IV access are unsuccessful, contact the patient's care team for revised care plan (i.e. direction to continue/discontinue, higher level of care, alternate strategies).

7. **DOCUMENT** the visit and all assessments/treatments on your ePCR as per standard procedure.
8. **COMMUNICATE** with the primary care provider or health care team as noted on care plan or if any other concerns arise.

Documentation

DOCUMENT details of the visit on the CP progress notes and notify primary health care provider or health care team of findings and any concerns.

References

| | |
|----------------|--|
| BCEHS IPAC 100 | <p>*** Infection Prevention and Control PPE poster***</p> <p>Policy IPAC 100 Cleaning & Disinfection Policy</p> <p>Procedure IPAC 100.2 Cleaning Disinfection Criteria</p> <p>Procedure IPAC 100.3 Routine Post Transport Cleaning</p> <p>Procedure IPAC 100.4 Routine Cleaning of Ambulance at Each Shift</p> <p>Procedure IPAC 100.5 Blood & Bodily Fluids Spill</p> <p>Procedure IPAC 100.7 Clean and Sterile Supply Storage</p> |
|----------------|--|

| | <u>Guidelines</u> |
|---------------|---|
| 6.4.7-v2 | <u>Patient Consent (Competent Adults)</u> |
| 2.1 | <u>Providing Patient Care within Scope of Practice</u> |
| BCEHS OPS 006 | <u>Patient Care Reports</u> |
| 3.3.4 | <u>Safe Use of Medical Needles</u> |

COVID CP 100.1: Attending Community Events During COVID-19 Pandemic

Updated:
Reviewed:

Applicability

A. Rationale

Community paramedics may take part in community outreach programs and health promotion opportunities whenever an appropriate request is received, and the activities requested are within the CP's scope of practice and permitted activities. Safety precautions for participants during the COVID-19 pandemic are also included.

B. Scope

This procedure applies to all paramedics when fulfilling the role of a community paramedic who are arranging attendance at a community event, outreach program or health promotion during Phase 3 of BC's Restart Plan.

Purpose

A. Standard Operating Procedure

To provide a standard operating procedure that all community paramedics *must* follow for community events.

B. COVID-19 Precautions

To provide extra guidance on COVID-19 precautions and considerations required for community events.

Procedure

The Request

Confirm the Request for Outreach Service is completed including:

1. Signature(s)
2. Anticipated location
3. Safety Precaution (as detailed below)

Safety Protocols

Review the safety protocols in place for the location of the event, which may include, but not limited to:

1. Physical distancing measures
2. Hand hygiene policies
3. Cleaning and disinfecting products – see Resource 5.vi below
4. Regular cleaning and capacity limits in washrooms, community/event rooms, kitchens, etc.

COVID-19 Precautions

Confirm the following COVID-related conditions are in place:

1. Limit the number of participants to small groups of 2 – 6 people
2. Maintain 2 meters of physical distance when possible
3. Increase protective measures for vulnerable populations
4. Ensure that layouts are rearranged to support safe distancing including markers on the floor/ ground to designate areas and directions to move through spaces. Increase environmental cleaning (common spaces, high- touch surfaces, shared equipment). Tissues/waste baskets are required.
5. Follow hand hygiene practices prior to and upon conclusion of the event:
 1. Provision of access to hand hygiene products, i.e. soap and water and paper towels or an alcohol-based hand sanitizer (at least 70% alcohol).
6. Increase ventilation (e.g. outside spaces preferred, open windows/doors in rooms, etc.)
7. Screening/assessment will be in place for monitoring participant's symptoms of COVID-19 upon day of the event. Coordinating/hosting facility/group is responsible for this screening, unless event is organized by the CP in which case the CP is responsible for the screening. **REFERENCE:** Point-of-care Risk Assessment (PCRA) for COVID-19
8. PPE:
 1. Appropriate PPE is required for community events with NO contact with attendees (procedural masks).
 2. Events WITH attendee contact, a risk assessment must be conducted, if a paramedic determines there is no apparent

risk of COVID-19 or influenza-like illness (ILI), they can revert to standard PPE as per the BCEHS Exposure Control Plan

9. Discourage participants from gathering prior to or after the event.
10. The following individuals should not participate in organized events:
 1. Any person who receives a diagnosis of COVID-19. Individuals must comply with the current mandated self-isolation policy as per the BC Ministry of Health (www.gov.bc.ca).
 2. If any symptoms of COVID-19 (fever, cough, sore throat, runny nose, headache, or shortness of breath) are present, the individual cannot participate.
 3. Any person who lives in a home with or has been in close contact with someone with symptoms of COVID-19.
 4. Any person who has arrived in British Columbia from outside of Canada within the last 14 days as they are mandated to self-isolate and monitor for symptoms for 14 days upon their arrival.

Approval and Scheduling

1. During the COVID-19 pandemic, all requests must be sent to CommunityParamedicine@bcehs.ca for approval prior to scheduling
2. Once approved, schedule the event in iScheduler (via CP Coordinators) and proceed with next steps

Event Preparation

1. Ensure to document the request and approval (printed copy of email) in the community event file
2. Research the topic and/or look in the [CP Team Site \(SharePoint\) Shared Content Library](#) for existing resources
3. Gather equipment required and/or develop presentation
4. Practice presentation delivery
5. Prepare a Community Event Attendance Record

Event Promotion

Information shared should include:

- Event date, time, location
- Intent of event and target audience/participants
- Health & safety precautions in place for COVID-19
 - Encourage use of non-medical mask by participants (will not be supplied by BCEHS) – see below.
 - If any attendee(s) are feeling sick, they must stay home. No exceptions.
 - A reminder that International travelers returning to C. must have completed a period of [self-isolation for 14 days and complete a self-isolation plan](#) as required by law prior to attending the event.
 - Contact and/or sign-up information.
 - Further information/details about the event, as required.

Event Setup

1. Arrive at the venue wearing an official BCEHS uniform, an employer supplied procedural mask and official BCEHS identification.
2. Greet any co-facilitators and discuss the session's plan.
3. Ensure safety precautions are in place, as outlined in your event planning and in collaboration with any event partners. If precautions are not adhered to, CPs will be unable to attend.
4. Setup any tables, seating, equipment and/or materials required.

During the Event

1. Greet attendees
2. Ensure each attendee is screened (see prior to entering the room/site)
3. Have each attendee perform hand hygiene upon entry
4. Have each attendee sign the Community Event Attendance Record and assess for any COVID-19 related health concerns
5. Share safety information about the session including COVID-19 precautions (i.e. hand hygiene practices, physical distancing, etc.)
6. Acknowledge the ancestral lands where the event is taking place
7. Provide services as agreed upon

Closing the Event

1. Thank attendees and remind them to clean their hands upon exiting the session
2. Clean and disinfect all equipment, tables, chairs, ensure wet contact time of the product is achieved prior to packing away

Document the Event

1. Update Community Event paper file with any additional information
2. Place the Community Event Attendance Record into the paper file
3. Close out the event in iScheduler

Documentation

Document on appropriate records:

1. Community Event Attendance Record
2. CP Community Event File

Resources

1. BCCDC. COVID-19: Infection Prevention and Control Guidance for Community- Based Allied Health Care Providers in Clinic Settings. [[Link](#)]
2. BCCDC. Environmental Cleaning. [[Link](#)]
3. BCCDC. Masks. [[Link](#)]
4. BC Ministry of Health. COVID-19 (Novel Coronavirus). 2020. [[Link](#)]
5. BC Ministry of Health. Order of the Provincial Health Officer: [Mass Gatherings Order](#). May 22
6. BC Ministry of Health. Order of the Provincial Health Officer: [Workplace COVID-19 Safety Plans](#). May 14
7. Community Paramedicine Policy ## Community Paramedics Attending Community Events during COVID-19. July 2020.
8. Community Paramedicine Policy 3.3 Community Paramedicine Service Delivery. Nov 2016.
9. COVID-19: Information for BCEHS Staff. 2020. [[Link](#)]
10. Exposure Control Plan (Part 2) - Infection Prevention and Control (EPC-IPAC). 2016. [[Link](#)]
11. Government of Canada. Risk Mitigation Tool. 2020. [[Link](#)]
12. Public Health Agency of (2020). Coronavirus Disease. [[Link](#)]

Purpose

The Community Paramedic (CP) works together with primary care providers to support patients in the community whenever possible. In some cases, Registered Nurses, Nurse Practitioners (NP) or Physicians may request assistance from the CP through the normal request for service process to help administer influenza vaccines to patients.

Policy Statements

The CP should demonstrate the attitudes, knowledge, and clinical skills necessary to provide safe and effective immunization administration. CPs must complete the BCCDC online Immunization Competency Course (ICC) that is available to Registered Nurses, Registered Psychiatric Nurses, Licensed Practical Nurses, Pharmacists and other immunization providers. Course content is based on the Immunization Competencies for BC Health Professionals. CPs must successfully complete the ICC course for pharmacists prior to any immunization administration.

This will consist of a phased approach beginning in rural and remote communities in BC. The first phase will include supporting Public Health Nurses (PHNs), NPs, or Physicians at flu-clinics that are already running. Therefore, CPs will not be responsible for documentation or logistics themselves. Phase 2 will include providing immunizations to patients following a request for service from a Physician or NP, which would be delivered autonomously by the community paramedic.

Guideline

This guideline is applicable to any patient aged 4 years and older.

Phase 1:

In response to a request for service from a primary health care provider, and following the standardized procedures for CP patient visits, the CP may attend the community clinic for the purposes of assisting with the administration of influenza vaccines under the guidance of the primary health care provider running the clinic. This procedure does include CPs, who have successfully completed the BCCDC Immunization Competency Course, to administer the flu-vaccine in adjunct with a primary health care provider.

The primary health care provider will be responsible to check for patient eligibility for the vaccine and reporting documentation records to public health in phase 1.

It is expected that the CP will document the procedure, including all findings and reactions, and report them to the primary health care provider and collaborate with other health care team members to provide support as appropriate.

Phase 2 and 3:

In response to a request for service from a primary health care provider, and following the standardized procedures for CP patient visits, the CP may administer the influenza vaccine to eligible patients following a request for service from a Physician or Nurse Practitioner.

1. **OBTAIN** applicable Request for CP Service form as determined by implementation.
 - Phase 1: **REVIEW** Request for Outreach Service form. During clinic, **OBTAIN** patient immunization record for influenza vaccine administration from the primary health care provider running the community flu clinic.
 - Phase 2 and 3: **REVIEW** Request for Patient-Specific Service form and care plan from primary health care provider to administer influenza vaccine. Make sure all prescreening and vaccine counselling is done by the primary health care provider. **CHECK** to make sure the patient's immunization history and vaccine schedule has been checked to ensure the appropriate vaccine is being administered at the appropriate time.
2. **EXPLAIN** the purpose of the vaccine, and **ASSESS** the patient's understanding of the procedure, and discuss any concerns the patient may have prior to immunization administration. ([Influenza Vaccine Frequently Asked Questions](#))
3. **REVIEW** possible [complications or reactions](#) with the patient and **VERIFY** understanding of when follow-up care from the primary health care provider would be required. **REFER TO** and **FOLLOW** the [British Columbia Centre for Disease Control \(BCCDC\) immunization manual](#) for best practice guideline to direct provision of immunization services. **REFER** to the [BCCDC guideline for influenza vaccine delivery in the presence of COVID-19](#) for guidance during the fall 2020 flu season, when ongoing COVID-19 activity may continue to stress public health capacity and affect clinic operations and attendance.
4. **OBTAIN** verbal consent prior to undergoing any procedure.
5. **REVIEW** and **FOLLOW** the [guideline for the administration of biological products as per the BCCDC](#).
6. **WASH** your hands with soap and water, or use alcohol-based hand sanitizer.
7. **CHECK** [three times](#) that it is the correct product: when removing from the refrigerator or biological cooler, when drawing up or reconstituting, and prior to administration. Be sure to check the expiry date. **PRACTICE** the **8 RIGHTS** to safe medication administration:
 - Right patient
 - Right drug
 - Right dose
 - Right route
 - Right time

- Right reason
- Right frequency
- Right documentation

8. **VACCINE ADMINISTRATION:**

◦ **Intramuscular injection technique:**

- Expose the area for injection to be able to landmark properly. (Deltoid or vastus lateralis only.)
- Select the appropriate syringe and needle for the IM site chosen.
 - Recommended needle size and volume for patients > 19 years:
 - Deltoid: 1-1.5", maximum volume 2 mL
 - Vastus lateralis: 1-1.5", maximum volume 5 mL
 - May use smaller needle sizes (5/8" to 1") for those who appear to have smaller frames or muscle size.
- Draw up vaccine or biological per product instruction.
- Always read the product-specific page in the BC Immunization Manual, Part 4 -- Biological Products.
- Palpate the site as the vaccine should not be administered where there is poor muscle mass, existing inflammation, itching, scars, nodules, sensitivity, induration, or pain.
 - **Deltoid:** Define the site by drawing a triangle with its base at the lower edge of the acromion and its peak above the insertion of the deltoid muscle. The injection site is in the centre of this triangle.
 - The upper border of the deltoid muscle is located one to two finger widths below the acromion process. The bottom point of the deltoid muscle can be located by drawing an imaginary line across the arm from the crease of the axilla at the front to the crease of the armpit in the back. The target zone for injection is 4 cm below the acromion for adults.
 - **Vastus lateralis:** When immunizing an adult, position the client in a seated, supine, or side-lying position. Define the site by dividing the space between the trochanter major of the femur and the top of the knee into three parts; draw a horizontal median line along the outer surface of the thigh. The injection site is in the middle third, just above the horizontal line.
- Cleanse the injection site with new alcohol swab by circling from the centre of the site outward for 1-2 inches. Let dry.
- Place your thumb and forefinger of non-dominant hand on either side of the injection site and press the area flat. Insert the needle at a 90 degree angle. Aspiration is not necessary, however if blood is noticed in the needle hub, the needle should be immediately withdrawn and discarded. A new syringe and needle with vaccine should be prepared.
- Remove the needle. Activate the safety mechanism and discard into the sharps container.
- Use gauze and apply gentle pressure to the injection site.
- Use of bandage is not routinely recommended but may be preferred by the client.
- Once all documentation is complete, discard all empty vials into the sharps container.

9. **COMMUNICATE** with the primary care provider if any other concerns arise. It is recommended that all immunized clients remain in the clinic for 15 minutes post-immunization. This may facilitate the management of any adverse reactions.

10. **REVIEW** [BCCDC Immunization Manual For BC -- Part 5: Adverse Events Following Immunization](#). **REFER** to the [BCEHS Anaphylaxis Guideline](#) in the event of a severe adverse reaction.

11. **REPORT** any adverse events following immunization immediately to the primary health care provider.

- Phase 1: Adverse events will be reported to the public health unit by the primary health care provider running the flu clinic.
- Phase 2: Adverse events will be reported to the public health unit by the Community Paramedic and/or BCEHS.

Documentation

Phase 1: DOCUMENT on patient immunization record provided by primary health care provider. See below for required documentation. Use the card provided from the primary health care provider to give to the patient for their personal immunization record.

Phase 2: DOCUMENT in Siren ePCR on the CP Immunization form.

DOCUMENT on appropriate records as noted above.

Please note, as per the BC Immunization Manual, Appendix B - Administration of Biological Products, the following should be documented:

- Name of the biological product
- Date
- Route of administration
- Anatomical site
- Name of the biological product manufacturer
- Lot number
- Name and title of the person administering the biological product

- Any reactions following immunization
- Any recommended biological products that were not given (i.e., declined, deferred, or contraindicated)
- Informed consent for immunization obtained

PROVIDE the patient a personal immunization record card with the following information:

- Name of vaccine
- Dose or amount given
- Route
- Initials and title of person administering the vaccine

Record any additional assessments, reactions, or follow-up care on appropriate records.

References

1. [BCCDC Immunization Manual](#)
 1. [Informed Consent](#)
 2. [Immunization Schedule](#)
 3. [Administration of Biological Products](#)
 4. [Reducing Immunization Injection Pain](#)
 5. [Contraindications and Precautions for Immunizations](#)
 6. [Principles of Immunology](#)
 7. [Adverse Events Following Immunization](#)
 1. [Management of Anaphylaxis in a Non-hospital Setting](#)
2. [BCEHS Anaphylaxis Guideline](#)
3. [Vaccine Safety \(BCCDC\)](#)
4. [Canadian Immunization Guide \(Government of Canada\)](#)
5. [2020/21 Seasonal Influenza Vaccine Eligibility](#)

