MedicNEWS

Insight for paramedics in Eastern Ontario

November 2026

HYDROmorphone Safety

Small volumes. Big safety considerations.



Modernizing Advanced Airway Management

What's changing and what comes next

Opportunity Awaits!

RPPEO Quality Specialist

OBHG Paramedic Liaison opportunities

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Safer medication use

Why RPPEO is changing the regional HYDROmorphone concentration... and why concentration is only one piece of the safety puzzle.

Making LAD decisions visible

What a recent review tells us about assessment, clinical reasoning, consent and documentation when using alternative care pathways.

NTI is retiring

Why nasotracheal intubation is leaving the ACP airway toolbox, what comes next and how to join the December town hall.

Worth another look

Refresh the SET Protocol and DOPES approach to advanced-airway security and troubleshooting.

Certification check-in

A timely refresher on annual maintenance requirements - and a reminder - as January 31 approaches.

Opportunity awaits

Provincial Paramedic Liaison opportunities and an opening to join RPPEO's quality team.

Pediatric analgesia: what are we learning?

Six months of field experience are beginning to show what it takes to bring pediatric-friendly analgesia into routine paramedic care.

Quality & Patient Safety



Paramedics make clinical decisions one patient at a time. RPPEO's quality and patient-safety work looks across those encounters to understand what is working well, where practice is challenging, and where the system can better support paramedics. In this section, we share some of what we are learning and what those findings may mean for practice.

HYDROmorphone Safety

Small Volumes, Big Safety Considerations

Medication safety rarely comes down to one safeguard.

This month, RPPEO issued a new Medical Advisory following patient-safety incidents involving HYDROmorphone, including selection of HYDROmorphone when another medication was intended and errors calculating or preparing the required volume.

Paramedic Services that currently stock a 10mg/ml concentration of HYDROmorphone will transition to a 2mg/ml concentration. But the concentration change is only one part of the safety response.

Download the Medical Advisory and supporting resources on RPPEO.ca.

Here is some of the thinking behind the recommendations and what they mean for your practice.

Why Change the Concentration?

Regional utilization data provided an important piece of the answer.

RPPEO reviewed 399 patient encounters involving HYDROmorphone. The median total dose administered was 1 mg, 58.3% of patients received 2 mg or less, and 85.2% received 4 mg or less. Almost 88% received no more than two doses.

At 10 mg/mL:

- 0.5 mg requires just 0.05 mL
- 1 mg requires just 0.1 mL

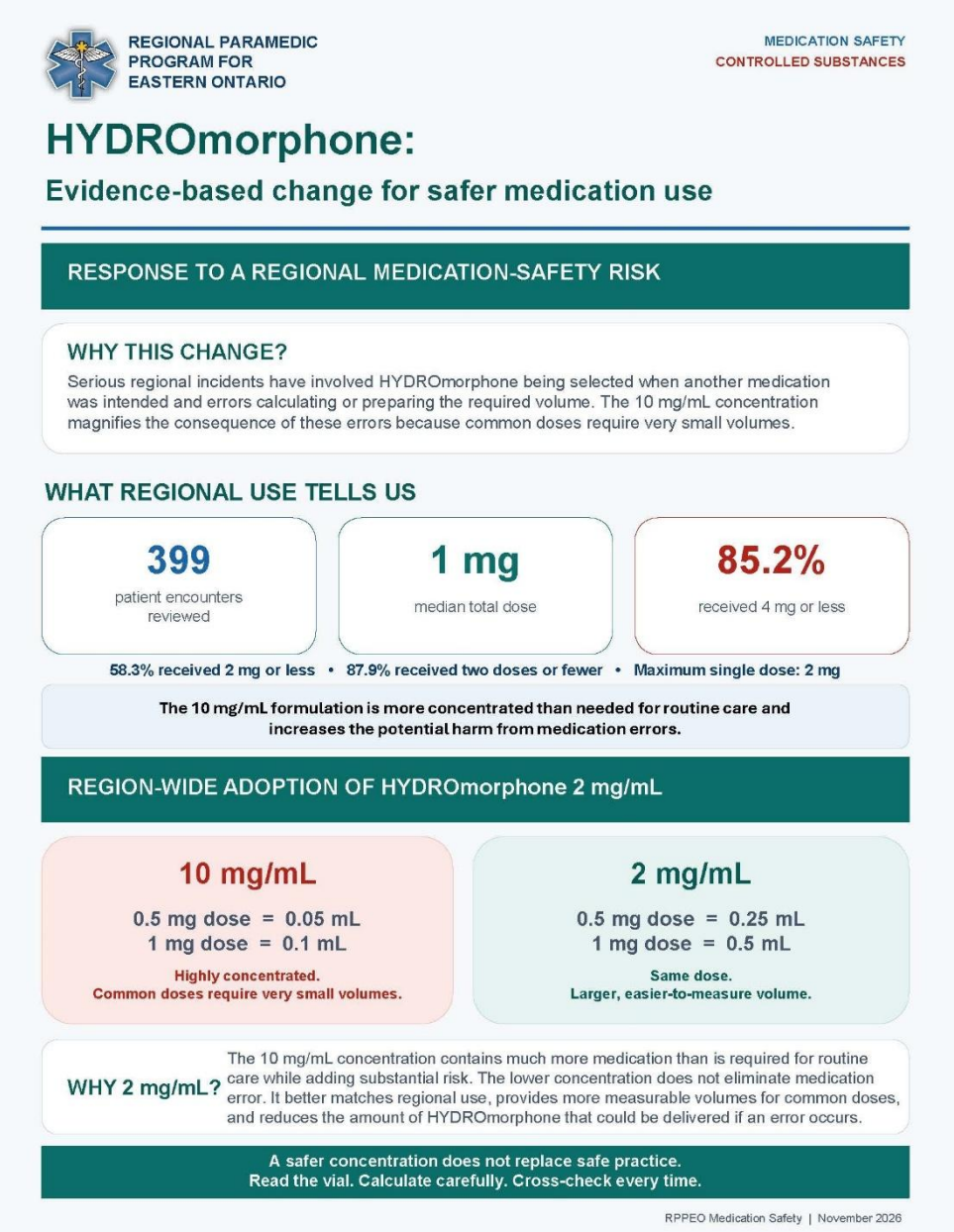
At 2 mg/mL:

- 0.5 mg is 0.25 mL
- 1 mg is 0.5 mL

The dose has not changed. What changes is the volume that must be measured.

The 2 mg/mL concentration better matches how HYDROmorphone is actually being used in our region, while making common doses easier to measure and reducing the amount of drug that could be delivered if an error occurs.

[Download the evidence behind the regional concentration change](#).



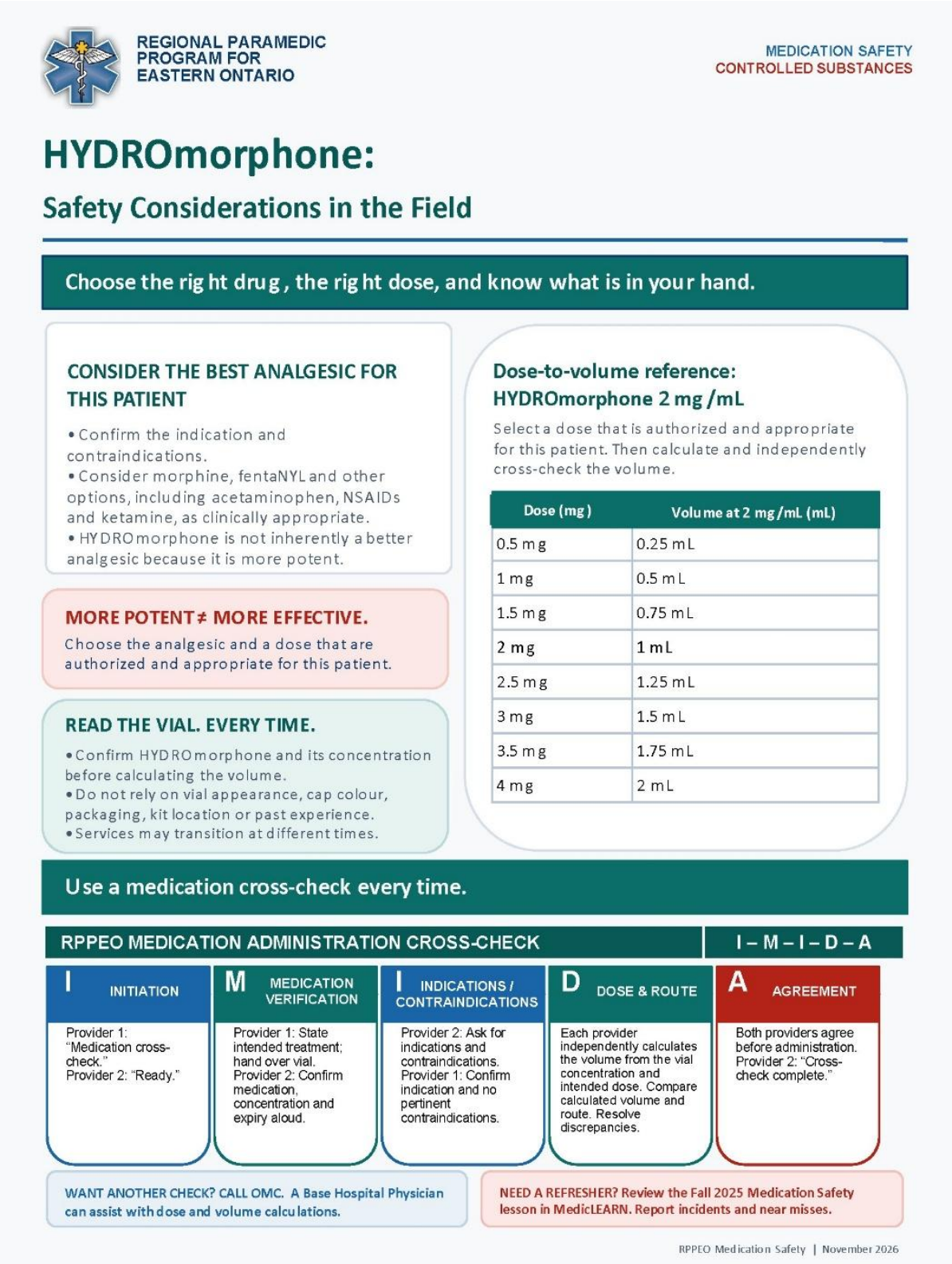
There is an important subtlety, though: 2 mg/mL is safer, not error-proof.

Changing the concentration cannot prevent the wrong vial from being selected, an incorrect dose from being chosen, or a calculation error from occurring. That is why the concentration change sits alongside the other safeguards in the Medical Advisory.

More Potent Does Not Mean More Effective

HYDROmorphone is a potent opioid. But greater potency does not mean that it is inherently a better analgesic.

RPPEO's Clinical Practice Evidence Panel (CPEP) conducted a broad review of analgesia, considering the effectiveness, safety and practical use of HYDROmorphone



REGIONAL PARAMEDIC PROGRAM FOR EASTERN ONTARIO

MEDICATION SAFETY
CONTROLLED SUBSTANCES

HYDROmorphone:

Safety Considerations in the Field

Choose the right drug, the right dose, and know what is in your hand.

CONSIDER THE BEST ANALGESIC FOR THIS PATIENT

- Confirm the indication and contraindications.
- Consider morphine, fentaNYL and other options, including acetaminophen, NSAIDs and ketamine, as clinically appropriate.
- HYDROmorphone is not inherently a better analgesic because it is more potent.

MORE POTENT ≠ MORE EFFECTIVE.
Choose the analgesic and a dose that are authorized and appropriate for this patient.

READ THE VIAL. EVERY TIME.

- Confirm HYDROmorphone and its concentration before calculating the volume.
- Do not rely on vial appearance, cap colour, packaging, kit location or past experience.
- Services may transition at different times.

Dose-to-volume reference: HYDROmorphone 2 mg/mL

Select a dose that is authorized and appropriate for this patient. Then calculate and independently cross-check the volume.

Dose (mg)	Volume at 2 mg/mL (mL)
0.5 mg	0.25 mL
1 mg	0.5 mL
1.5 mg	0.75 mL
2 mg	1 mL
2.5 mg	1.25 mL
3 mg	1.5 mL
3.5 mg	1.75 mL
4 mg	2 mL

Use a medication cross-check every time.

RPPEO MEDICATION ADMINISTRATION CROSS-CHECK — **I – M – I – D – A**

I INITIATION	M MEDICATION VERIFICATION	I INDICATIONS / CONTRAINDICATIONS	D DOSE & ROUTE	A AGREEMENT
Provider 1: "Medication cross-check." Provider 2: "Ready."	Provider 1: State intended treatment; hand over vial. Provider 2: Confirm medication, concentration and expiry aloud.	Provider 2: Ask for indications and contraindications. Provider 1: Confirm indication and no pertinent contraindications.	Each provider independently calculates the volume from the vial concentration and intended dose. Compare calculated volume and route. Resolve discrepancies.	Both providers agree before administration. Provider 2: "Cross-check complete."

WANT ANOTHER CHECK? CALL OMC. A Base Hospital Physician can assist with dose and volume calculations.

NEED A REFRESHER? Review the Fall 2025 Medication Safety lesson in MedicLEARN. Report incidents and near misses.

RPPEO Medication Safety | November 2026

and morphine. The evidence did not establish a clinically important analgesic advantage for HYDROmorphone.

Medication choice should reflect the individual patient and clinical circumstances. Morphine remains an appropriate alternative when clinically indicated.

For paramedics, the practical message is simple: choose an authorized analgesic that fits the patient, not necessarily the one with the highest potency.

Download HYDROmorphone Safety Considerations for Paramedics.

Read the Vial, Even When You Think You Know What Is There

Familiarity is not a safety check.

Before preparing HYDROmorphone:

- read the medication name directly from the vial
- confirm the concentration from the vial
- do not rely on cap colour, packaging, kit location or what that service usually carries
- calculate the volume from the dose and concentration in front of you
- complete the medication cross-check
- resolve any disagreement before proceeding

The habits we build around the medication are more durable than familiarity with its packaging.

The Cross-Check Is Deliberately Independent

There is another small distinction that matters.

The RPPEO medication-administration cross-check is not meant to be one paramedic doing the calculation and another simply agreeing with it. Each provider independently calculates the volume from the intended dose and vial concentration, then the results are compared.

That independence is what makes the second calculation useful as a safety check.

If the answers differ, pause. Resolve the discrepancy before the medication is administered.

Cross Check Procedure for Medication Administration

	Provider 1	Provider 2
Initiation	"Medication Cross Check." (1)	"Ready."
Medication Verification	"I am going to give medication for [condition]. Please check: medication, concentration, expiry." (hands vial) (2) (3)	"This is [medication]. It is [xx mg in xx mL], and expires [expiry date]." ☑ Drug name ☑ Concentration ☑ Expiration date (4)
Indications / Contraindications	Explains indications and contraindications. Confirms patient has none. (5)	"What are the indications and contraindications?"
Dose & Route Confirmation	States: • Drug concentration & volume • Total dose • Route of administration • Shows container for verification (6) (7) Example: "I am going to give [dose] of [drug name] via [route] for [indication]."	"What is your dose and what route?"
Agreement	"No concerns. I am going to give [dose] of [medication] for [indication] by [route]." (8) (9)	"I agree that the concentration of [medication] and [dose] is the right volume for this patient. Any concerns before you give it?" "Go ahead and give it. Cross check complete."

Memory Anchor: I-M-I-D-A

I – Initiation
M – Medication Verification
I – Indications/Contraindications
D – Dose & Route
A – Agreement

BHP Support Is Another Safety Check

An Online Medical Consultation can provide another check when a HYDROmorphone calculation warrants additional support. During the regional transition, Base Hospital Physicians have been briefed on the concentration issue and can help review the intended dose and calculated volume with paramedics during relevant OMC calls.

This is not intended to replace the paramedic medication cross-check. It adds another layer when one would help make administration safer.

And HYDROmorphone Is Not the Whole Pain-Management Toolbox

The attention being given to safer HYDROmorphone administration raises another patient-safety consideration: could emphasizing one medication inadvertently promote its use when other analgesic options may be more appropriate?

This guidance is not intended to favour HYDROmorphone.

The Medical Advisory emphasizes consideration of the full range of analgesic options authorized for the patient. The supporting resource identifies morphine, fentaNYL and other appropriate options, including non-opioid agents, depending on the applicable directive and clinical circumstances.

And medication is not the whole toolbox either. Pain management should continue to include appropriate non-pharmacologic interventions alongside medication when they can help the patient.

Patient-Safety Reporting Helped Drive This Change

There is one final part of this story worth emphasizing.

This initiative grew from patient-safety reporting, regional quality review, utilization data, consultation with Paramedic Services, and evidence deliberation. The reported incidents were treated as signals about the system and opportunities to strengthen safeguards, rather than simply as individual errors.

That is why good catches and near misses matter too. Paramedics are encouraged to continue reporting medication incidents, near misses, good catches and medication hazards through the RPPEO Patient Safety Incident Report. Those reports help RPPEO and Paramedic Services see patterns that may not be apparent from an individual event and identify where systems, education or clinical guidance can be made safer.

Questions?

Have a clinical-practice question? Send it through MedicASK. Questions about the patient-safety initiative can also be sent to quality@RPPEO.ca.

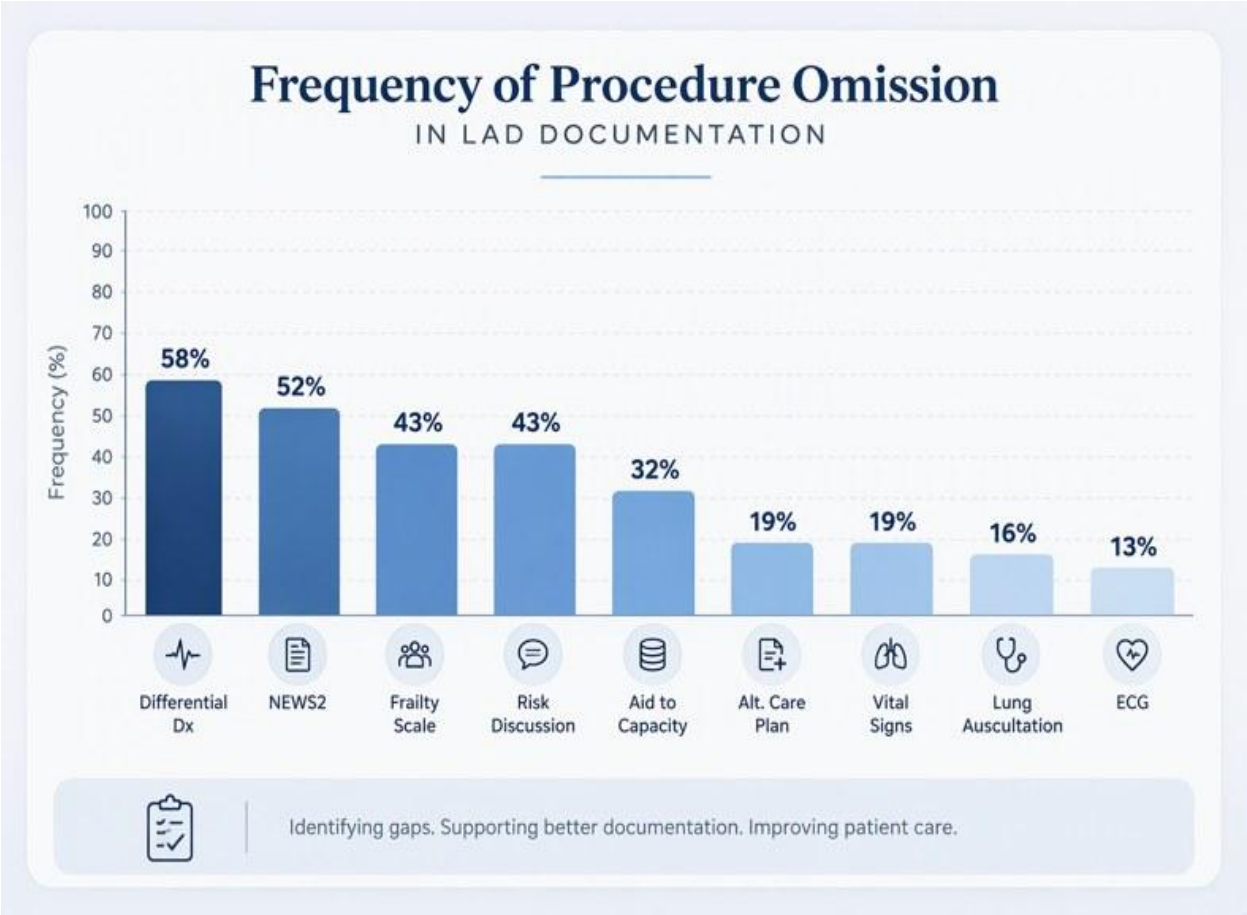
LAD/Smart is working. Help keep the pathway safe.

The Low Acuity Disposition (LAD) program, also known as "Smart" at Ottawa Paramedic Service, has successfully diverted hundreds of patient transports and emergency department visits across our region.

By using these alternative care pathways, paramedics can reduce time on task, help relieve pressure on crowded emergency departments and, most importantly, provide patient-centred care that better matches individual needs.

The continued success of LAD depends on its safe and consistent use.

A recent two-month review of 31 LAD cases identified recurring gaps in assessment and documentation. This matters because choosing LAD asks more of your assessment than simply deciding on a destination.



1 - For each item, the denominator includes only LAD cases in which that assessment or procedure was clinically indicated. Percentages show how often the indicated assessment or procedure was not documented as completed.

Why does LAD require a comprehensive assessment?

When you transport a patient to the ED, some diagnostic uncertainty can be resolved through further assessment, testing and observation at the hospital.

LAD is different. Before recommending an alternative care pathway, you and the consulting physician need enough information to determine not only what is likely happening, but also what else could be happening that would make ED assessment the safer choice.

That is where a broad differential diagnosis matters.

Ask yourself:

- What could explain this patient's presentation?
- What else could reasonably account for these findings?
- Could weakness, dizziness, nausea, mild shortness of breath, a fall or another potentially low-acuity presentation in a well-looking patient have a more significant underlying cause?
- Do repeat vital signs, auscultation, an ECG or other assessment findings change the clinical picture?
- Is there anything here that needs further investigation in the ED?

A comprehensive assessment helps uncover those possibilities before the disposition decision is made.

Clinical Eligibility Is Only Part of the Decision

A patient can meet the clinical requirements for LAD and still choose hospital assessment. LAD is not a decision a paramedic makes for the patient.

Before proceeding, the patient or substitute decision-maker must receive enough information to make an informed choice. That includes the reason LAD is being proposed, its risks and benefits, reasonable alternatives, and what additional assessment, testing, treatment or observation may be available at the hospital.

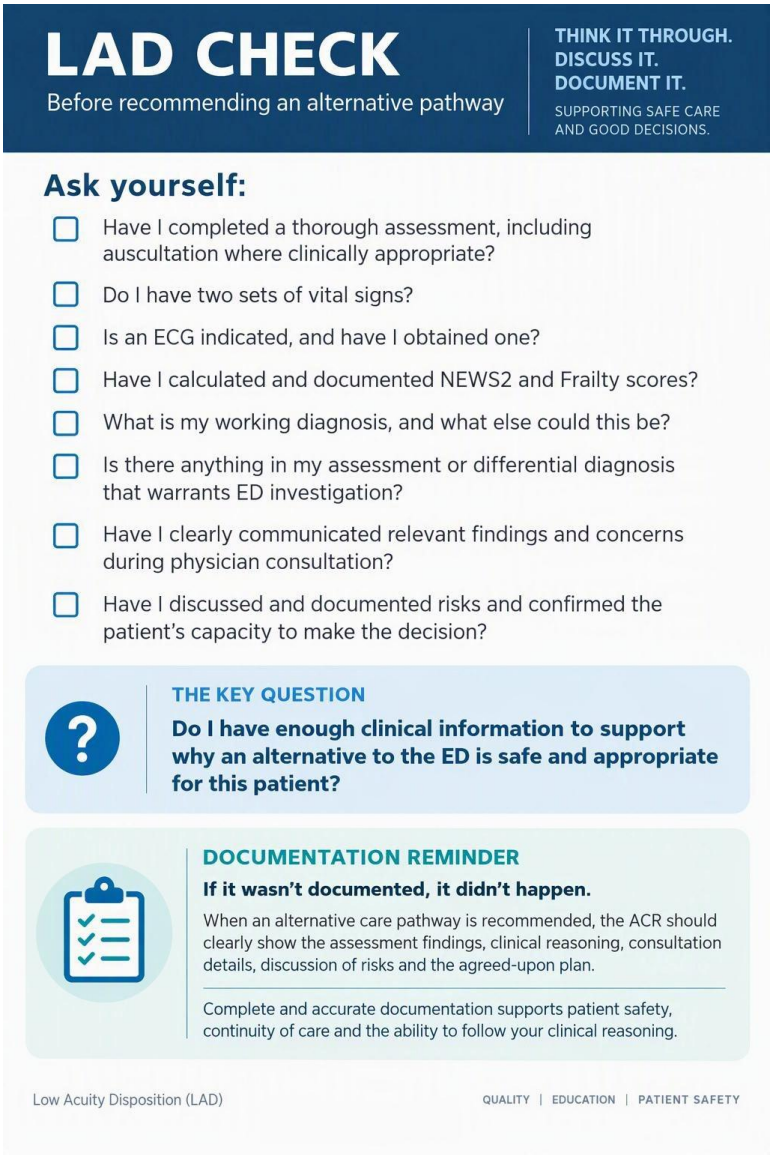
The patient should understand those options and agree with the alternative disposition. Clinical suitability makes LAD an option; informed consent is what allows that option to proceed. Document the discussion and decision clearly, including the options presented, the relevant risks and benefits discussed, and the patient’s or substitute decision-maker’s agreement with the alternative disposition.

With LAD, your assessment needs to support not only what you think is happening, but why it is safe for this patient to follow a pathway other than the emergency department.

Make the clinical reasoning visible

A thorough assessment is only part of the picture. When clinically appropriate, the ACR should also tell the story of why LAD was a reasonable and safe disposition.

Make sure the documentation captures:



- Relevant assessment findings, including repeat vital signs and focused assessments such as lung auscultation or ECG when indicated.
- The differential diagnosis, including important alternative or higher-risk causes that were considered.
- NEWS2 and frailty assessment, where applicable, and how those findings informed the decision.
- Aid to Capacity findings when decision-making capacity is relevant.
- Consent and Risk discussion, including the risks and benefits of LAD and the patient's understanding of the proposed plan.
- Consultation with the BHP, including relevant information provided, clinical discussion and direction received.
- The alternative care or follow-up plan, including where, when and how the patient is expected to obtain further care.
- Safety-netting, including what changes or symptoms should prompt the patient to seek further assessment or call 911 again.

Medical Direction



Medical direction is woven into paramedic practice in Ontario. It includes the medical directives that authorize and guide care, advice and clinical guidance that help translate those directives into practice, and real-time consultation with Base Hospital Physicians when a patient or situation calls for it. In this section, RPPEO's Medical Director, Associate Medical Directors and Base Hospital Physicians help unpack the clinical thinking behind the care paramedics provide, explore the grey areas that do not always fit neatly into a directive, and connect evolving evidence and medical guidance with decisions made in the field.



NTI: The End of an Era

After years in the ACP airway toolbox, NTI is getting ready for retirement.

As of February 1, 2027, RPPEO will no longer delegate nasotracheal intubation (NTI). And while we couldn't quite arrange a gold watch and a cake, we do think an old clinical tool deserves a proper send-off.

NTI's retirement reflects something that happens throughout medicine: evidence evolves, practice changes, and sometimes a procedure that once had a useful role no longer makes sense to maintain.

NTI is infrequently performed. Opportunities to maintain real-world proficiency are limited. Contemporary airway management gives paramedics effective ways to manage oxygenation, ventilation and airway patency without relying on this increasingly uncommon procedure.

So we're saying goodbye.

But here's the important bit: NTI is retiring. Airway management isn't.



First Things First: This Isn't About a Supply Shortage

Some of the discussions in the 2020s about NTI involved the availability of the specialized equipment traditionally used to perform the procedure. The trigger tube is absolutely necessary for this procedure and we learned that there were concerns about

the ongoing availability. That was an important signal, but it is not the reason for the change.

The decision is fundamentally about clinical practice and patient safety.

As RPPEO looked more closely at NTI, the bigger picture became difficult to ignore: the procedure is infrequently used, opportunities to perform it and maintain competency are limited, success is variable and overall low, and contemporary airway management offers other approaches without relying on NTI.

RPPEO Medical Director Dr. Michael Austin put the clinical judgment plainly, "NTI is no longer considered a standard of care and, at a system level, its risks now outweigh its benefits."

That is ultimately the basis for the decision.

"NTI is no longer considered a standard of care and, at a system level, its risks now outweigh its benefits."

- Dr. Michael Austin, Regional Medical Director

Rare Skills Create a Bit of a Paradox

We train for rare events because they matter.

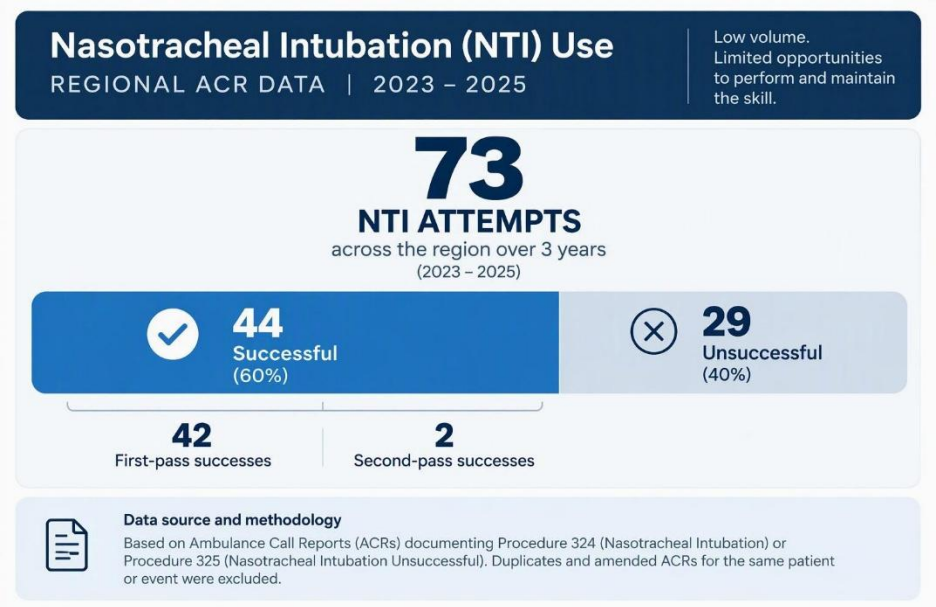


Figure 2 - Regional data identified 73 NTI attempts from 2023 to 2025, including 44 successful and 29 unsuccessful attempts.

But procedural competency also depends on exposure and practice. When a technically demanding procedure is performed very infrequently, maintaining reliable competency becomes increasingly difficult.

RPPEO's three-year review found

73 NTI attempts from 2023 through 2025, with annual success rates ranging from approximately 47% to 69%. Those numbers need to be interpreted carefully, and we will explore them in context at the town hall. They do, however, help illustrate the challenge of maintaining a complex skill that is seldom performed. That raises a reasonable question for a Base Hospital: does continuing to delegate the procedure still improve our ability to manage difficult airways, or are patients better served by concentrating on approaches that paramedics can use more consistently?

RPPEO has concluded that it is time to move on from NTI.

So What Happens to Advanced Airway Management?

It isn't going anywhere.

Removing NTI does not make airway management less important, nor does it diminish the importance of ACP airway skills.

If anything, this change gives us an opportunity to put more attention on the airway strategies you are actually most likely to need.

That means reinforcing strong BLS airway management, thoughtful airway decision-making, and the other authorized airway approaches already available to paramedics.

It also means recognizing the important role of CPAP for appropriately selected patients who need positive-pressure respiratory support while maintaining their own airway.

The increased availability and use of non-invasive positive-pressure ventilation, including CPAP and BiPAP, is one of the reasons NTI is now rarely used in hospital. CPAP gives paramedics another strategy for some patients who need positive pressure but may not tolerate BVM ventilation or a supraglottic airway.

We don't want the message to be simply, “You can't do this anymore.”

The more useful conversation is: How do you access the strongest possible airway-management toolbox for the situations you actually encounter?

And that is a conversation worth having together.

Let's Talk About It

On Thursday, December 10, from 1:00 to 2:00 p.m., Dr. Michael Austin and the RPPEO team will host the Modernizing Advanced Airway Management: NTI Practice Update online.

We'll take a closer look at:

- the evidence and regional experience that informed the decision

- what we have learned from NTI use in practice
- the clinical considerations behind moving away from the procedure
- airway-management approaches after NTI
- what this means for certification and practice
- your questions

The plan is intentionally not an hour-long lecture. A short evidence-based presentation will set the stage, followed by discussion and questions with the team. Questions submitted in advance will help us identify common themes and make sure the things paramedics actually want to know get addressed.

December 10, 2026 | 1:00 to 2:00 p.m. | Microsoft Teams

When registering, please use your service email address so your attendance can be recorded correctly. You may receive 1 hour of CME credit for attending this important discussion.

Click >>> REGISTER FOR THE NTI TOWN HALL

One Last Thing

If NTI is something you have used, taught, practised or simply kept tucked away in your mental airway algorithm for years, you may have questions about this change.

Good.

Bring them.

The point of the transition period between now and February 1 isn't simply to give everyone enough notice that NTI is leaving. It is to make sure we have talked through what its departure means and that paramedics have the information and support they need to manage airways confidently without it.

NTI may be leaving the toolbox.Airway management most definitely is not.

Join the RPPEO Town Hall

December 10, 2026, 1:00 to 2:00 p.m., Microsoft Teams.

Dr. Michael Austin and the RPPEO team will explain the evidence in context, review practical airway approaches and answer questions.

Advance questions can be submitted through the registration form. Learn more at RPPEO.ca.

FAQ: Modernizing Advanced Airway Management and the NTI Transition

What is changing and when?

RPPEO will no longer delegate nasotracheal intubation (NTI) after January 31, 2027. Renewed certification letters beginning February 1, 2027 will not include NTI.

Why is NTI being withdrawn?

The decision reflects patient safety, contemporary airway practice, infrequent use of NTI and the difficulty of maintaining reliable competency in a procedure that is rarely performed. Earlier concerns about the availability of specialized NTI equipment helped prompt review of the practice, but a supply shortage is not the reason NTI is being removed.

Who does this change affect?

The removal of NTI primarily affects Advanced Care Paramedics (ACPs) because NTI is an advanced delegated procedure. The broader conversation about effective airway management matters to everyone. Both Primary Care Paramedics (PCPs) and ACPs have effective airway-management strategies, including airway positioning, suction, bag-valve-mask (BVM) ventilation, airway adjuncts and supraglottic airways. ACPs also have additional advanced airway options within their authorized scope.

Does removing NTI reduce my ability to manage an airway?

No. NTI is one procedure within a much larger airway-management toolbox. Both PCPs and ACPs have effective ways to establish and maintain oxygenation and ventilation. Removing NTI is an opportunity to focus on airway strategies that can be performed effectively and reliably. The goal is not to find a procedure that “replaces NTI.” It is to identify the airway strategy that best addresses the patient's needs.

Aren't BVM ventilation and supraglottic airways just fallback options?

No. BVM ventilation and supraglottic airways are effective airway-management strategies in their own right. They should not be thought of simply as fallback options when an endotracheal airway is unavailable or unsuccessful. Successful airway management is about achieving and maintaining effective oxygenation and ventilation, then continually reassessing whether the chosen strategy is working.

What should I refresh before NTI is removed?

For both PCPs and ACPs, this is a good opportunity to revisit the fundamentals of airway management, including:

- airway assessment and positioning

- airway manoeuvres and maintaining airway patency
- suction and secretion management
- appropriate use of airway adjuncts
- effective BVM technique
- optimizing mask seal and ventilation
- supraglottic-airway insertion, confirmation and reassessment
- recognizing ineffective oxygenation or ventilation
- monitoring the effectiveness of airway interventions
- reassessing after every intervention and whenever the patient's condition changes

ACPs should also refresh the advanced airway approaches that remain within their authorized scope and consider how those interventions fit within the broader airway-management strategy.

I'm an ACP. How should I think about a patient for whom I might previously have considered NTI?

A useful shift is from asking: “What do I use instead of NTI?” to: “What does this patient need me to accomplish?” Consider:

- Is the airway patent?
- Is the patient oxygenating adequately?
- Is the patient ventilating adequately?
- What is threatening one or more of those functions?
- Can positioning, suction or an airway adjunct address the problem?
- Can I oxygenate and ventilate effectively with a BVM?
- Would a supraglottic airway provide an effective airway?
- Is another authorized advanced intervention indicated?
- How will I confirm that my strategy is working?
- What will I do if it stops working?

There does not need to be a one-for-one procedural replacement for NTI. The focus is on selecting an effective strategy for the airway problem in front of you.

Do BLS airway skills still matter for ACPs?

Absolutely. Advanced airway management does not mean starting with the most advanced procedure available. Strong airway management includes recognizing what the patient needs, choosing an appropriate intervention, performing it well, monitoring its effectiveness and changing course when necessary. BVM ventilation, positioning, suction and supraglottic airways remain important tools for ACPs as well as PCPs.

When should I be thinking about respiratory support rather than an advanced airway?

Not every patient with significant respiratory distress needs an advanced airway.

Start by identifying the problem you are trying to solve. Is the patient failing to oxygenate, failing to ventilate, unable to protect their airway, or experiencing a condition that can be managed while maintaining their own airway?

For appropriately selected patients, interventions such as positioning, oxygen therapy and CPAP may support oxygenation and ventilation while the patient continues to maintain their own airway. For others, effective BVM ventilation, a supraglottic airway, or an authorized advanced-airway intervention may be required.

The important skill is recognizing what the patient needs and choosing an airway or respiratory strategy that addresses that problem, rather than equating effective airway management with placement of an endotracheal tube.

What about supraglottic airways?

Supraglottic airways remain an important airway-management strategy available to both PCPs and ACPs within the applicable standards and scope.They should not be viewed as a lesser airway simply because they are not an endotracheal tube. What matters is whether the selected airway strategy provides effective ventilation and oxygenation and can be reliably maintained and monitored.

What about the patient who needs positive pressure but is not tolerating BVM ventilation or a supraglottic airway?

CPAP provides another option for appropriately selected patients who need positive-pressure respiratory support while maintaining their own airway.

CPAP can be well tolerated and can support oxygenation in patients who may not tolerate BVM ventilation or a supraglottic airway.

For these patients, removing NTI does not mean removing positive-pressure support. It means considering CPAP as part of the out-of-hospital airway and respiratory-management toolbox.

What should I review about $ETCO_2$?

Airway management does not end when a device is placed. Paramedics should be comfortable using the monitoring available to them to assess the effectiveness of ventilation and, where applicable, to confirm and continually monitor an advanced airway. RPPEO is also doing related work on quantitative waveform capnography and airway confirmation. Additional education and practical resources are being considered as part of the broader modernization of airway management.

Will there be more airway training?

RPPEO is considering additional education and practical supports as part of the transition.

Potential areas for reinforcement include:

- BLS airway strategies
- BVM technique
- supraglottic-airway management
- airway decision-making
- advanced airway strategies for ACPs
- $ETCO_2$ principles and troubleshooting
- airway confirmation and reassessment
- responding when the initial airway strategy is not working

Questions and feedback from paramedics during the transition and at the December 10 town hall will also help identify where additional practical education would be most useful.

Should I review my service's airway equipment?

Yes. Paramedics should be familiar with the airway and monitoring equipment carried by their service, including how to use and troubleshoot it. RPPEO can provide common clinical guidance and education, while services may provide additional hands-on training related to their particular monitors, airway devices and other equipment.

What if I encounter a difficult airway after February 1 and wish I still had NTI?

Difficult airways will still be difficult. Removing NTI does not change that reality. The objective is to make sure paramedics approach these situations with a reliable strategy using the effective airway-management options that remain available. If there are

particular patient presentations or difficult-airway scenarios that concern you, bring them forward during the transition. These are exactly the questions that can help shape practical education and discussion.

Is RPPEO saying that paramedics who previously performed NTI were practising incorrectly?

No. NTI has been an authorized procedure, and removing it now is not a judgment on paramedics who appropriately used NTI under previous standards.

Clinical practice evolves as evidence, experience, equipment and available strategies change. The decision reflects where airway-management practice is going, not a retrospective judgment about appropriate care provided in the past.

Where can I learn more and ask questions?

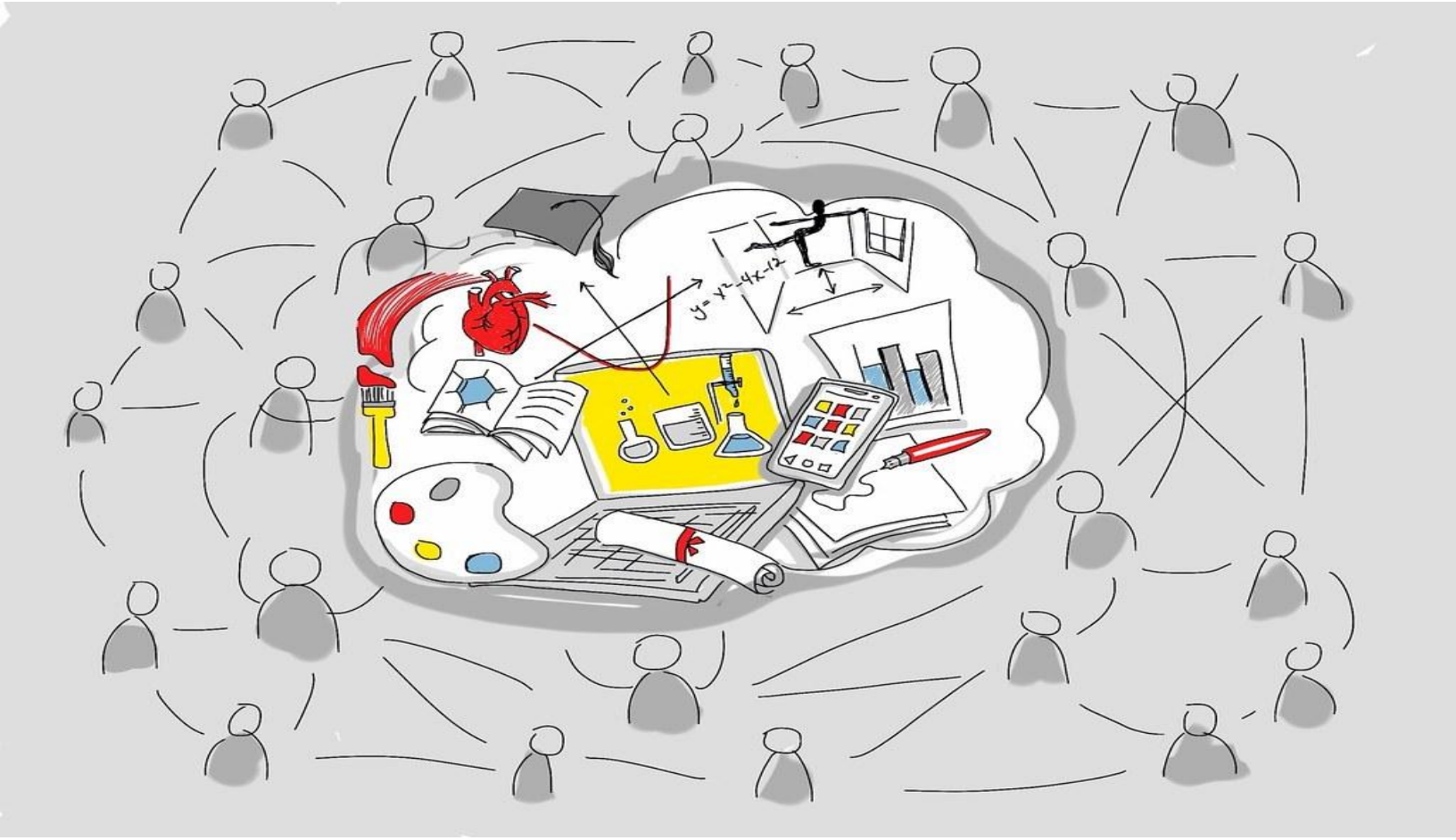
Join the Modernizing Advanced Airway Management: NTI Practice Update town hall on: December 10, 2026, 1:00 to 2:00 p.m. Microsoft Teams

The session will provide the evidence and clinical context behind the decision, discuss practical airway management as NTI is withdrawn, and provide an opportunity for questions and discussion. Advance questions can be submitted through the registration form. Practical resources and approved questions and answers will also be shared following the event.

Modern airway management is a decision-making process, not a hierarchy in which the most invasive procedure is automatically the best one.



Continuing Education



Paramedic practice depends on both keeping up with change and keeping familiar knowledge and skills ready for use. Core and elective CME create opportunities to revisit important clinical concepts and procedures, practise skills that may be used infrequently, and explore new evidence or evolving practice. RPPEO develops and shares education and resources to support that ongoing learning. In this section, consider what is new, what is worth revisiting, and what you want to carry with you into the next patient encounter.

Worth another look: SET Protocol & DOPES Pneumonic

The SET Protocol

Successful intubation is only the beginning of managing an advanced airway. Once an ETT is placed, confirm its position, secure it carefully and continue to monitor the airway



throughout patient care and transport. Continuous waveform capnography provides an ongoing window into the airway and ventilation, while the SET protocol helps reduce the risk of tube movement or displacement. Take a few minutes to revisit this familiar protocol and the fundamentals of keeping an established airway secure.

Why It Matters

Unplanned ETT displacement can result in loss of airway control, hypoxia, aspiration, and cardiac arrest. The SET Protocol helps paramedics keep the airway secure throughout patient movement and transfer.

S = Secure

Immobilization Required

- ✅ Cervical Spine Collar Applied
- ✅ Patient Secured to Spinal Board / Transfer Device
- ✅ Commercial Tube Holder Secure
- ✅ Ventilator / BVM Tubing Supported

E = Endotracheal Tube

Confirm Placement Before Every Move

- ✅ Continuous Waveform Capnography Present
- ✅ Bilateral Chest Rise
- ✅ Equal Breath Sounds
- ✅ ETT Depth Verified
- ✅ Tube Holder Intact

T = Transfer

No Displacement During Movement

Before EACH movement:

1️⃣ CLEAR

Everyone knows the plan.

2️⃣ PLAN

Assign roles and identify hazards.

3️⃣ COMMAND

One person directs the movement.

Document the airway journey

Every patient movement or transfer is a reason to reconfirm the ETT. The ACR should show when the patient was moved, how tube placement was reconfirmed, and what you found.

“ETT placement confirmed” records the conclusion. Documenting the methods used and the findings observed shows how that conclusion was reached.

After any patient movement or transfer, reconfirm ETT placement and security. The ACR should identify:

- the movement or transfer;
- the presence and findings of continuous waveform capnography;
- the secondary confirmation methods used, if applicable, and the findings from each;
- ETT depth and tube security;
- any change identified and action taken.

Example

Instead of documenting only:

"ETT placement confirmed after transfer."

Document the supporting evidence:

"Following transfer to the stretcher, ETT remained at 22 cm and secure. Continuous waveform capnography remained present with a consistent waveform."

The DOPES Pneumonic

A sudden deterioration in a patient with an established advanced airway requires prompt assessment and intervention. Changes in oxygenation, ventilation or airway pressures may indicate a problem with the tube, the equipment or the patient's underlying condition. The DOPES mnemonic provides a systematic approach to identifying and troubleshooting common causes of deterioration: Displacement, Obstruction, Pneumothorax, Equipment failure and Stacked breaths. Take a few minutes to revisit this familiar mnemonic and the importance of recognizing and addressing airway complications throughout patient care and transport.

REGIONAL PARAMEDIC PROGRAM FOR EASTERN ONTARIO

SERVING TOGETHER FOR A HEALTHIER TOMORROW

DOPE(S) ADVANCED AIRWAY TROUBLESHOOTING

Sudden Deterioration in a Patient with an Advanced Airway?

THINK D.O.P.E.(S)

Reassess the Airway. | Identify the Cause. | Correct the Problem.

A rapid assessment tool for identifying reversible causes of hypoxia and ventilation failure in patients with advanced airway devices.

D DISPLACEMENT

Has the airway device moved?

Look For:

- Change in airway device depth or position
- Loss of $EtCO_2$ waveform
- Unilateral breath sounds
- Accidental extubation or airway dislodgement
- Poor chest rise



Immediate Actions:

- Check airway device position
- Verify capnography
- Reconfirm placement
- Re-secure the airway device

O OBSTRUCTION

Is airflow blocked?

Possible Causes:

- Mucus plug
- Blood
- Kinked airway tubing
- Patient biting the tube
- Bronchospasm



Immediate Actions:

- Pass suction catheter
- Inspect airway device and tubing
- Straighten kinks
- Treat bronchospasm



P PNEUMOTHORAX

Is the lung compressed?

Clues:

- Sudden hypoxia
- Unequal chest rise
- Absent breath sounds
- Increased airway pressures
- Hypotension



Collapsed lung with mediastinal shift

Immediate Actions:

- Compare breath sounds
- Assess chest movement
- Consider chest decompression

S STACKED BREATHS / PATIENT FACTORS

Is the patient the problem?

Consider:

- Auto-PEEP
- Air trapping
- Pulmonary edema
- Atelectasis
- Pulmonary embolism



Air trapping (Auto-PEEP)

Immediate Actions:

- Allow longer exhalation time
- Assess for air trapping
- Evaluate underlying pathology
- Treat the underlying cause

E EQUIPMENT FAILURE

Is the equipment functioning properly?

Check For:

- Oxygen source failure
- Circuit disconnection
- Loose airway connections
- Faulty PEEP valve
- Damaged BVM
- Leaking cuff or pilot balloon
- Failed suction equipment
- Disconnected capnography tubing

Immediate Actions:

- Trace oxygen flow from source to patient
- Reconnect loose connections
- Replace faulty equipment
- Switch oxygen sources if required
- Manually ventilate with a functioning BVM



Certification



Certification comes with rules, requirements and, yes, some paperwork. But behind the administration is a straightforward goal: making sure paramedics remain authorized and ready to practise. RPPEO works to make those requirements clear and help paramedics stay ahead of important dates and responsibilities. Think of this section as your regular check-in on what needs attention, what may be changing and what you need to do to keep your certification on track.

Annual Maintenance of Certification

The RPPEO Certification Year runs from February 1 through January 31. Each paramedic must complete annual maintenance of certification requirements by the end of the day of January 31 each year. For more details, see the RPPEO Certification Policy or visit RPPEO.ca.

The Advanced Life Support Patient Care Standards outline the requirements for paramedic annual maintenance of certification in Section 5. In brief, paramedics need ten 911 patient contacts each year as well as no more than 90 days out of service. Those who have more than 90 days away from practice undergo a Return to Clinical Practice to maintain their Certification. In addition to the requirements set out in the Patient Care Standards, the RPPEO requires the following each year:

Each Advanced Care Paramedic (ACP) must

- Be employed by a Paramedic Service
- Have participated in Cycle 1 Spring and Cycle 2 Fall CME
- Have 8 hours of an elective from RPPEO-approved electives (see electives for 2026 and other years in MedicLEARN), or RPPEO-approved paramedic submitted electives (submit for approval via our Elective CME Pre-approval request form).

Each Primary Care Paramedic (PCP) must

- Be employed by a Paramedic Service
- Have participated in one cycle of annual RPPEO CME (usually Cycle 2 CME)



Opportunity Awaits!



Sometimes an opportunity is a career move. Sometimes it is a committee, a volunteer role or a chance to lend your experience to something that matters. Opportunity Awaits brings together ways to participate, contribute and explore what else is happening across paramedicine. You do not have to be looking for something new to find something worth considering.

Eastern Ontario, let's get a seat at the table!

Here's an opportunity to take your frontline experience beyond your service and into provincial conversations about paramedic care.

It's been some time since paramedics from this region have been represented on these OBHG committees, and RPPEO would love to see our region represented again.

OBHG currently has four Paramedic Liaison positions available:

- Medical Advisory Committee: 1 ACP and 1 PCP
- Data Quality Management Subcommittee: 1 PCP
- Educational Subcommittee: 1 PCP

Paramedic Liaisons bring the realities of frontline practice into committee discussions, review proposed initiatives and resources, and help connect provincial work with what is happening in the field.

And you don't need to be a seasoned committee veteran. Previous committee or leadership experience is helpful, but it isn't required.

If you have ideas, experience and a perspective worth sharing, consider putting your name forward.

Applications close January 5, 2027.

Read the OBHG Paramedic Liaison Recruitment Memo to learn more and apply.

RPPEO Quality Specialist

The Regional Paramedic Program for Eastern Ontario (RPPEO) is looking for a Specialist 1, Quality to join our team.

We are looking for someone with strong experience in quality improvement and patient safety who can help turn data, evidence and operational experience into meaningful improvements in care. The role includes quality improvement initiatives, project planning and implementation, evaluation and reporting, and working collaboratively with health-care professionals, leaders and partners.

Experience in paramedicine or another health-care discipline will help bring important clinical and system context to the work. Just as important is the ability to analyze complex information, identify opportunities for improvement, manage projects and support change across a complex health-care environment.

Position Details

- Full-time, regular position
- Days, 8-hour shifts
- Location: Home office in Ottawa or Kingston, ON
- Salary: $97,301.10 to $118,378.65 annually
- Job ID: 113313

Basic Requirements

- Completion of three (3)-year community college program in paramedicine, or a degree in a related health-care discipline (e.g., nursing, occupational therapy, respiratory therapy, etc.)
- Minimum four (4) years of experience working in a health-care environment
- Current related experience pertinent to quality assurance and/or quality improvement (e.g., patient safety initiatives, process improvement, etc.)
- Experience in project planning, implementation, evaluation and reporting

- Demonstrated ability to manage competing priorities and adapt effectively to changing demands and unexpected situations
- Identify potential for patient or institutional risk and provide recommendations for appropriate intervention
- Provide accurate, relevant and timely information as required
- Be an effective change agent and work collaboratively with a broad range of health-care professionals, leaders, educators and other partners
- Develop and deliver presentations and abstract submissions, program proposals and written reports
- Advanced proficiency with Microsoft 365 and other digital tools used for quality improvement, data analysis, reporting and information management
- Demonstrated organizational, interpersonal, problem-solving and decision-making skills, with the ability to lead and facilitate groups, collaborate across diverse teams and work independently

Preferred Qualifications

- Completion of four (4)-year undergraduate university degree in Paramedicine, Nursing, Health Sciences or related field
- Master's degree in Science, Healthcare Quality, Health Administration, Business Administration, Paramedicine, Nursing or related field
- Additional training in quality improvement, project management and/or patient safety (e.g., Lean Six Sigma, project management certification, patient safety certification, human factors in healthcare, etc.)
- Demonstrated proficiency with data analysis, reporting and visualization tools, with the ability to analyze complex data, identify trends and translate findings into meaningful insights to support quality improvement and decision-making
- Abstract submission, program proposal and report writing
- Knowledge of current trends and legislation pertaining to the delivery of pre-hospital care and emergency health services
- Knowledge of pre-hospital patient care standards and best practices

- Evidence of progressively increasing leadership responsibilities, with strong facilitation and coaching skills

How to Apply

Applications must be submitted online through The Ottawa Hospital Careers site. Deadline for application: November 20, 2026.

Evidence-Based Updates to Scope of Practice

CLINICAL PRACTICE evidence PANEL

Regional Paramedic Program for Eastern Ontario

Paramedic practice evolves as evidence grows and our understanding of care changes. Through the Clinical Practice Evidence Panel (CPEP), RPPEO brings paramedics and clinical experts together to examine the science behind questions arising in practice and consider what it means for patient care. In this section, follow the evidence from the questions being explored and projects underway to the findings that may ultimately shape medical directives and paramedic practice.



Pediatric Analgesia

From Feasibility Project to Future Practice

For the past six months, paramedics in four Eastern Ontario services have been helping RPPEO answer a practical

question: can pediatric-friendly formulations of acetaminophen and ibuprofen be safely and reliably incorporated into paramedic care?

The Pediatric Analgesia Feasibility Project launched in the field in May with Cornwall, Hastings-Quinte, Lanark County and Prescott-Russell. Participating paramedics completed project-specific education and began using liquid and chewable pediatric formulations of acetaminophen and ibuprofen with children aged 1 to 12. The project was designed to examine more than medication administration. It looked at weight-based dosing, consent, contraindication screening, pediatric pain assessment, documentation, medication storage and replenishment, and how the formulations fit into everyday ambulance operations.



What are we learning?

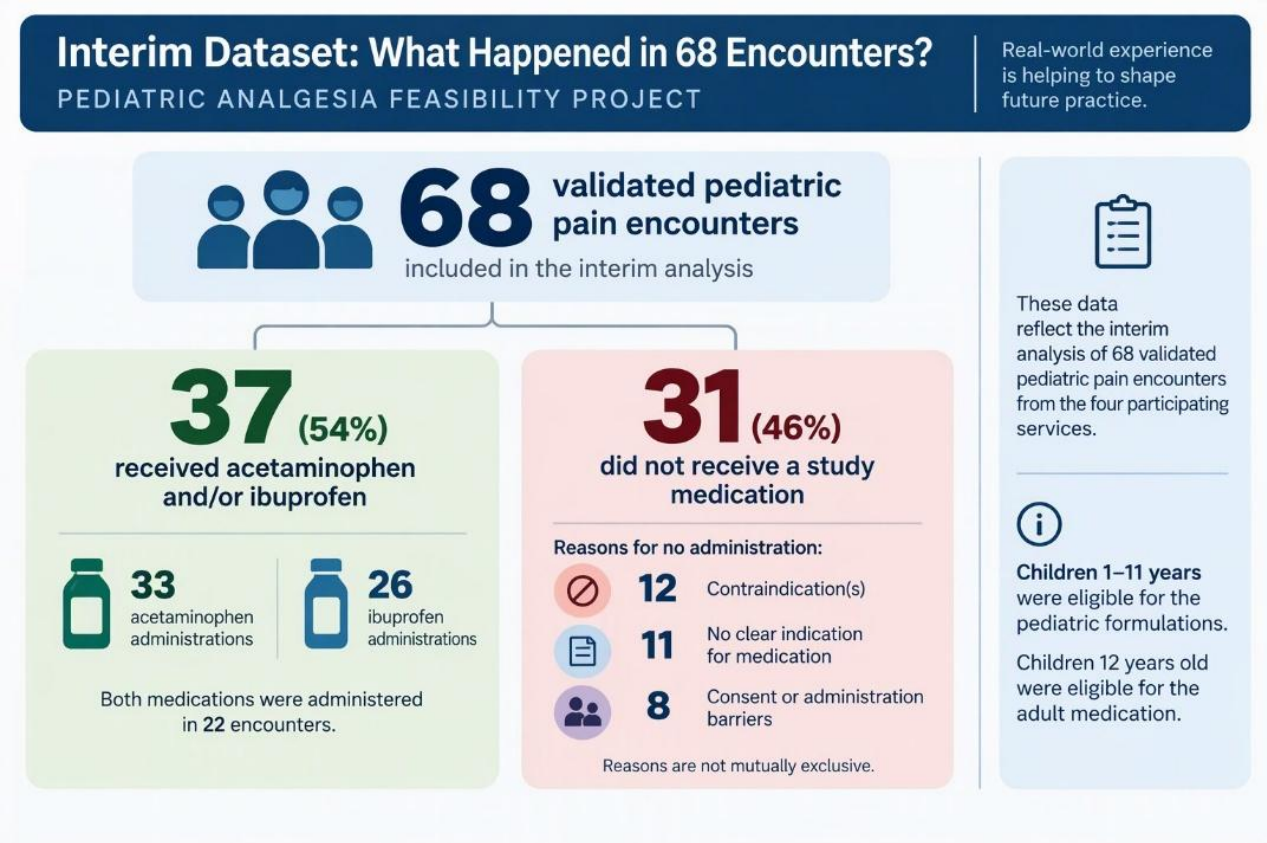
The interim analysis is encouraging, while also giving the project team some useful homework.

The interim dataset included 68 validated pediatric pain encounters, with medication administered in 37 cases. When medication was not administered, reasons included contraindications, lack of indication and consent or administration barriers.

Early experience suggests that pediatric formulations can be incorporated into paramedic care and ambulance operations. No adverse events had been reported at the time of the interim review, and feedback from participating services, paramedics, patients and families has been positive.

The project has also highlighted areas that deserve a closer look before the final analysis. These include:

- consistent identification and documentation of the pediatric pain scale used;
- documentation of consent and caregiver acceptance;
- confirming and documenting previous acetaminophen or ibuprofen doses;
- reassessment following treatment;
- contraindication screening, especially clinical decision-making around ibuprofen and suspected head injury;
- confirming whether the intended dose was actually consumed; and
- practical issues such as medication packaging, expiry, storage and replenishment.



That is, in many ways, exactly what a feasibility project is meant to uncover. The question is not simply whether acetaminophen and ibuprofen work. These are familiar

medications. The harder question is how to put appropriate pediatric formulations into a paramedic system safely, consistently and practically.

What happens next?

The formal field phase is now winding down, but the work is not. RPPEO has asked to continue pediatric acetaminophen and ibuprofen use in the four participating services while broader provincial work proceeds. Dr. Austin has advised the Ministry that the participating services are interested in continuing and that RPPEO can maintain quality oversight during the interim period.

The project is also feeding directly into the Comprehensive Medical Directive Review. Dr. Austin is bringing forward a revised Analgesia Medical Directive that incorporates pediatric analgesia options, as well as a new directive addressing fever management. Both pieces of work draw on lessons from this project about medication choice, pediatric formulations and the practical realities of bringing these treatments into paramedic care.



The project team will now complete the final analysis, reconcile the clinical, quality and operational findings, and capture the experience of participating paramedics and services. That final work will help turn six months of field experience into

recommendations that can support decisions about pediatric pain and fever management beyond the original four services.

For the participating paramedics, the project has been relatively small in numbers. Its potential influence is much larger.



MedicNEWS Back Issues

You can browse the MedicNEWS catalogue or find articles on topics you're interested in by visiting the MedicNEWS page on RPPEO.ca.