MedicNEWS

Insight for paramedics in Eastern Ontario

September 2026

Be part of the first cohort.

RPPEO is recruiting new **Certification Raters** across Eastern Ontario.

Fall **CME**

Tiny Patients, Big Decisions

Explore the assessment, treatment, and clinical judgement needed to care for children in emergency situations, with online learning, hands-on activities, and a live webinar with Dr. Sara-Pier Piscopo.

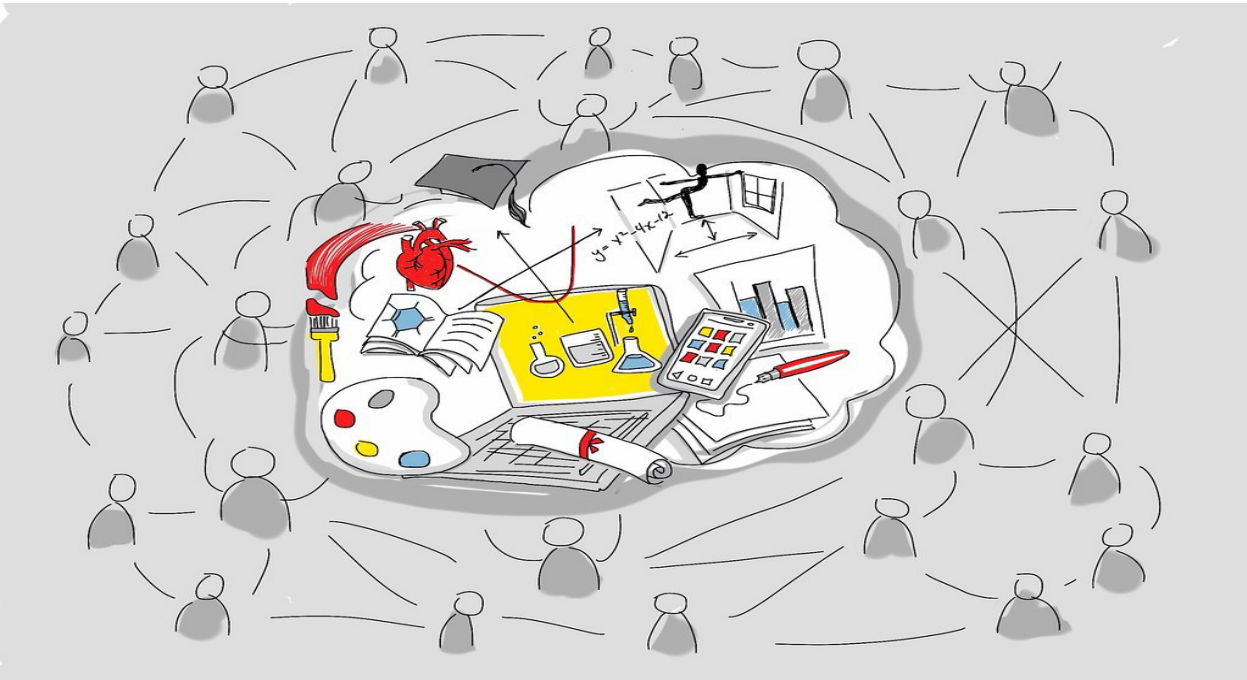
The call may be over, but the care isn't.

Discover how the Sacred Pause helps paramedics honour patients, support families, and find meaning in difficult moments.

September 2026 | In This **Issue**

- Tiny Patients, Big Decisions: Fall 2026 CME launches with a pediatric-focused programme, hands-on learning, and a live webinar featuring Dr. Sara-Pier Piscopo.
- The ALS PCS Companion Document has been updated. Learn what's new and why this practical resource belongs in every paramedic's toolkit.
- Dr. Michael Austin explores the Sacred Pause, a simple practice that honours patients, families, and clinicians following a death in care.
- RPPEO is enhancing oversight of the 90-Day Patient Contact Standard. Find out what monthly reviews mean for certification and clinical recency.
- Interested in shaping the next generation of paramedics? RPPEO is recruiting Certification Raters across Eastern Ontario.
- How can real-world experience influence provincial medical directives? See how the Pediatric Analgesia Pilot is helping inform evidence-based discussions about pediatric pain management.

Continuing Education



Fall 2026 CME

"Tiny Patients, Big Decisions: Practical Pediatric Emergency Care for Paramedics" is your Fall CME programme launching this September with online learning, classroom applications, and a special live webinar from Pediatric Emergency Physician Dr. Sara-Pier Piscopo.

Children make up a relatively small proportion of paramedic patient encounters, but they often present some of the most challenging clinical situations. Subtle assessment findings, anxious caregivers, rapidly changing conditions, and emotionally charged circumstances can make pediatric calls uniquely demanding.

When RPPEO reviewed feedback from Spring 2026 CME, pediatric care emerged as the topic paramedics most wanted to revisit in future clinical education. This fall, RPPEO is responding with Tiny Patients, Big Decisions: Practical Pediatric Emergency Care for Paramedics, a comprehensive CME programme focused on pediatric assessment, treatment, medication administration, and clinical decision-making.

Why a Pediatric Focus?

Pediatric patients are not simply small adults. Effective care requires strong assessment skills, thoughtful clinical judgement, and confidence applying evidence-informed practices in situations that many paramedics encounter infrequently. Fall 2026 CME is designed to strengthen those skills by exploring common pediatric emergencies while creating opportunities for discussion, reflection, practical application, and hands-on learning.

What You'll Learn

Fall 2026 CME content includes:

Pediatric Respiratory Emergencies Review of pediatric croup, bronchoconstriction, asthma, and bronchiolitis, with attention to assessment, treatment priorities, and clinical decision-making in high-risk, lower-frequency presentations.

Fever, Seizures, and Anaphylaxis Focused review of fever management, seizure care, and anaphylaxis, including recognition, treatment priorities, and practical application through classroom activities and scenarios.

Medication Delivery Skills Practical review of intranasal medication delivery, mini-bag medication administration, and IV medication techniques supported by skills videos and hands-on practice.

These topics reflect current evidence, regional patient safety learning, and areas of paramedic practice that benefit from deliberate review and discussion.

A Hybrid Learning Experience

Fall 2026 CME follows RPPEO's established hybrid educational model, combining online learning with classroom application.

The online learning component provides the foundation for classroom discussions, practical skill stations, and scenario-based activities. Depending on local delivery plans, some services may schedule the online and classroom components separately, while others may combine them into a facilitated learning day.

Either way, learners will move from foundational knowledge to practical application and discussion as they progress through the programme.

Featured Webinar

A key component of Fall CME will be a live webinar featuring RPPEO Associate Medical Director and CHEO Pediatric Emergency Physician Dr. Sara-Pier Piscopo.

The Challenging Pediatric Exam: Finding the Clues

September 10, 2026 | 1400 EDT

Register Now!

This interactive, case-based one-hour session will explore:

- Practical pediatric assessment strategies
- Recognition of important examination findings
- Child abuse and neglect considerations
- Documentation practices
- Real-world case discussion and learner questions

The webinar provides an opportunity to learn directly from one of RPPEO's pediatric content experts while engaging in discussion with colleagues from across the region.

Learners who attend live will not be required to complete the corresponding online module.

Key Dates

📅 September 10, 2026 Live Webinar The Challenging Pediatric Exam: Finding the Clues

📅 Week of September 21, 2026 Online CME modules become available through MedicLEARN

📅 Week of October 5, 2026 Classroom sessions begin across participating services

Looking Ahead

Whether you are refreshing familiar concepts or building confidence in less common pediatric presentations, Fall 2026 CME is designed to provide opportunities to learn, practise, ask questions, and apply knowledge in a supportive educational environment. Watch for additional information from your service and be sure to register for the live webinar.

Tiny Patients, Big Decisions begins September 10 with the webinar and September 21 online. We look forward to learning with you this fall.

Updated ALS PCS Companion Document Released

At the end of August, 2026, the Ontario Base Hospital Group (OBHG) released an updated Companion Document for ALS PCS v5.4, along with a memo announcing the latest changes.

The Companion Document serves as an educational resource for Ontario paramedics, providing clinical context, background information, and practical considerations to support the application of the Advanced Life Support Patient Care Standards.

The document does not introduce new directives or expand scope of practice. Instead, it helps explain the rationale behind existing standards and provides additional guidance for situations where clinical judgement is required. Topics are organized to make information easier to find during day-to-day practice, continuing education, and certification preparation.

The Companion Document helps translate provincial standards into practical guidance that supports consistent, evidence-informed patient care across Ontario.

RPPEO posts the Companion Document and release memo at RPPEO.ca for future reference.

Bottom line: If you have not reviewed it yet, the updated Companion Document is worth a look. It provides valuable insight into the "why" behind the standards and can help strengthen clinical decision-making in the field.

Medical Direction

One Breath Between Life and Death: The Sacred Pause in Paramedicine

Paramedicine is changing. While emergency response to life-threatening events remains foundational, the profession continues to evolve into a broader healthcare role, one that includes re-triage, prevention, discharge planning, navigation, chronic care, and, importantly, end-of-life support. With this evolution comes responsibility not just for clinical decision-making, but for how we honour patients, families, and ourselves at the most profound moments of care.

One such moment is the Sacred Pause.

by Michael Austin

The call was a routine cardiac arrest.

A 75-year-old male. Home setting. Family present.

High-quality CPR. Airway managed. Medications given. Rhythms checked. Everything done by the book. After 20 minutes of resuscitation, the patient met termination of resuscitation (TOR) criteria, with a less than 1% chance of survival. A patch was made following a two-

step approach. Step 1: TOR confirmation. Step 2: Pronouncement verification of no signs of life. Both were confirmed at 08:10.

Monitors were silenced. Hands came off the patient. The room felt suddenly loud in its quiet. The patient's wife stood frozen in the doorway, trying to understand what had just happened.

Before anyone moved toward cleaning up, documentation or the radio, the lead paramedic spoke softly:

"We're going to take a moment to honour this person and the life they lived."

No one said anything else.

Ten seconds passed. Maybe fifteen.

And then the work of supporting the family began.

That small, intentional, and human moment is known as the Sacred Pause.

The resuscitation is over. The care is not.

The Sacred Pause is a brief, intentional moment of stillness following the termination of resuscitation and pronouncement of death. First described in 2009 by Jonathan Bartels, RN (Bartels J. The pause. Crit Care Nurse. 2014;34(1):74-75. doi:10.4037/ccn2014311), it was created as a way for healthcare teams to acknowledge the humanity of the person who has died, to honour the effort given, and to support those left behind; both families and clinicians. While initially described in hospital settings, the practice has increasing relevance in out-of-hospital care, where paramedics often pronounce death alone: in homes, long-term care facilities, on roadways, and in the presence of grieving families.

More Than a TOR

Termination of resuscitation is often framed operationally: patching for TOR, phrases like "we can stop now - we've got the TOR," recording a time of death, completing documentation, making notifications, handing over to police, and clearing for the next call.

But for the patient, this is not operational. It is the end of a life.

For families, it may be the worst moment they will ever experience.

And for paramedics, it can be one of the most emotionally complex aspects of the job, especially when pronouncing death is something we may do one patient at a time, repeatedly, across a career.

The Sacred Pause creates space between doing and being. It is typically 10–30 seconds. There is no script, no religious requirement, no mandated words. It may include a simple statement from the lead paramedic such as, "We're going to take a moment to honour this person and the life they lived." Or, it may occur in shared silence. What matters is intention.

"Honouring death is part of honouring life."

Why It Matters: Evidence and Experience

Research in emergency medicine, nursing, and palliative care supports the value of brief reflective practices after patient death. Studies show they can:

- Improve team cohesion and communication
- Reduce moral distress and emotional exhaustion
- Support healthy grieving and meaning-making
- Reinforce patient-centred values
- Normalize emotional responses among clinicians

Clinicians who participate in the Sacred Pause often describe it as grounding. A reset. A reminder that despite algorithms, monitors, and protocols, the patient was a person, someone loved, known, and valued.

As someone who practiced this as a paramedic and continues to do so as an emergency physician, I can say the setting doesn't matter. The moment does. Whether in a resuscitation bay or a living room, the pause changes how the death is experienced, for families and for the clinicians involved.

In paramedicine, where pressure exists to clear scenes and return to service quickly, the pause can feel countercultural. Yet those few seconds do not meaningfully delay operations. What they do is change the emotional trajectory of the call.

A Marker of a Healthcare Profession

As paramedics increasingly define themselves as healthcare providers rather than purely emergency responders, practices like the Sacred Pause signal maturity in the profession. Honouring death is part of honouring life. Supporting families through the immediate aftermath of death is care. Supporting peers who just worked a difficult code is leadership.

End-of-life care is not a failure of medicine. It is an inevitable and deeply human outcome. How we behave in those moments reflects our values as a profession.

"The Sacred Pause reminds us that while resuscitation may end, our responsibility to the patient and those who love them does not."

How the Sacred Pause Shows Up in Practice

There is no single "right" way to do a Sacred Pause, no medical directive required and that flexibility is part of its strength. It is not requirement, but it is an option. Experiences across settings highlight common themes:

- Explicit vs. organic: Some pauses are announced; others arise naturally in shared silence. Both can be meaningful.
- Planned vs. in-the-moment: Some services introduce it in training; others adopt it informally.
- Setting: Used effectively in homes, long-term care, ambulances, emergency departments, and on scene.
- Inclusion: Families may be invited to participate, or the pause may occur quietly among the care team, depending on context and wishes.

What matters most is cultural permission: permission to stop, to acknowledge, and to feel.

Returning to the Moment

Back in that living room, after the pause ended, the paramedics turned their full attention to the family. Questions were answered more slowly. Voices were softer. No one rushed.

Nothing about the outcome changed.

But everything about how it felt did.

The Sacred Pause does not change the result of a cardiac arrest. But it changes us. It reminds us why professionalism includes compassion, why clinical excellence includes humanity, and why being present at the end of life is as important as saving it.

Sometimes, the most meaningful care we provide is not another intervention, but a moment of stillness, respect, and honour.

One breath.

One pause.

One life acknowledged.

Dr. Michael Austin, MD, FRCPC, DRCPSC (PTM), is RPPEO's Medical Director.

Certification

90-Day Patient Contact Standard

Enhanced Monitoring and Monthly Reviews of Clinical Recency

The Ontario Ministry of Health requires all certified paramedics to maintain a qualifying patient contact every 90 days in order to remain clinically certified. This requirement in the ALS PCS forms part of Ontario's paramedic certification framework and applies to all certified paramedics, regardless of role, employment status, seniority, or practice setting.

RPPEO has enhanced its monitoring of the 90-Day Patient Contact Standard and is now conducting regular monthly reviews of patient contact activity. These reviews are intended to identify paramedics who may be approaching or exceeding the 90-day threshold and to apply the Ministry standard consistently across all certified paramedics.

As part of this initiative, several paramedics were administratively deactivated in August after exceeding the 90-day threshold without meeting the patient contact requirement. Monthly reviews will continue moving forward, and additional administrative deactivations may occur where certification requirements are not met.

Be sure to monitor your work email for important notices related to your certification. RPPEO sends an email notification when a paramedic has gone 60 consecutive days without documented 911 patient care. If the paramedic reaches 90 consecutive days without documented patient care, RPPEO sends a notice that the Certification Standard has not been met and proceeds with administrative deactivation.

If you have been administratively deactivated, you may be eligible to return to active certification through the Return to Clinical Practice (RTCP) process. Requests for RTCP must be initiated by your employing paramedic service. Paramedics who have been deactivated, or who believe they may be approaching the 90-day threshold, should speak with their service leadership and contact the RPPEO Certification Team to discuss available options.

Maintaining active certification is a shared responsibility. Staying current with certification requirements and routinely reviewing your MedicNET profile can help avoid unexpected interruptions and support continued readiness for practice.

Questions regarding the 90-Day Patient Contact Standard or Return to Clinical Practice may be directed to certification@rppeo.ca.

New Opportunity!

New Certification Raters Wanted

RPPEO is recruiting its first cohort of Certification Raters to support Entry-to-Practice Certification Events and Return-to-Clinical-Practice activities across Eastern Ontario. Experienced PCPs and ACPs interested in contributing to the assessment and development of future and returning paramedics are encouraged to apply.

Certification Raters will participate in case-study simulations, evaluate candidates using the Global Rating Scale, and support fair, consistent, and evidence-informed assessment processes throughout the region.

To learn more about the role, qualifications, and application process, visit RPPEO.ca or see the full posting below. Applications close 25 September 2026.

WE'RE HIRING!

RPPEO Certification Rater

The Regional Paramedic Program for Eastern Ontario (RPPEO) is seeking highly qualified Primary Care Paramedics (PCPs) and Advanced Care Paramedics (ACPs) to join our team as Certification Raters.

Position Summary

In this new role as a Certification Rater, you will participate in Entry-to-Practice Certification Events by conducting case-study simulations and evaluating candidates using the Global Rating Scale (GRS). You will be responsible for completing timely, accurate, and thorough GRS documentation for ACP and PCP candidates in both virtual and in-person settings.

Additional opportunities are available to facilitate Return-to-Clinical-Practice Peer Sessions for paramedics returning to active practice following an absence.

For in-person Certification Events, you will also supervise volunteers acting as patients and partners during simulation scenarios.

Certification Raters contribute to fair, consistent, and evidence-informed evaluation of paramedic competence across Eastern Ontario.

Position Details

- Annual contract position with opportunity for renewal
- Compensation: $43.00 per hour
- Minimum commitment of 10 certification and/or Return to Clinical Practice days per year
- Certification events are currently delivered primarily in a virtual environment
- Future opportunities may include in-person certification activities throughout Eastern Ontario
- Certification schedules are established in advance to support operational planning
- Ability and willingness to travel throughout Eastern Ontario

Qualifications

- Certified paramedic in good standing with RPPEO
- Minimum of three (3) years of paramedic experience

- Strong interpersonal, organizational, critical-thinking, decision-making, and conflict-resolution skills
- Demonstrated ability to exercise professional judgment
- Excellent written and verbal communication skills
- Proven ability to work collaboratively within a team environment
- Strong time-management and organizational skills
- Ability and willingness to travel throughout Eastern Ontario
- Previous experience using the Global Rating Scale (GRS) is considered an asset

How to Apply

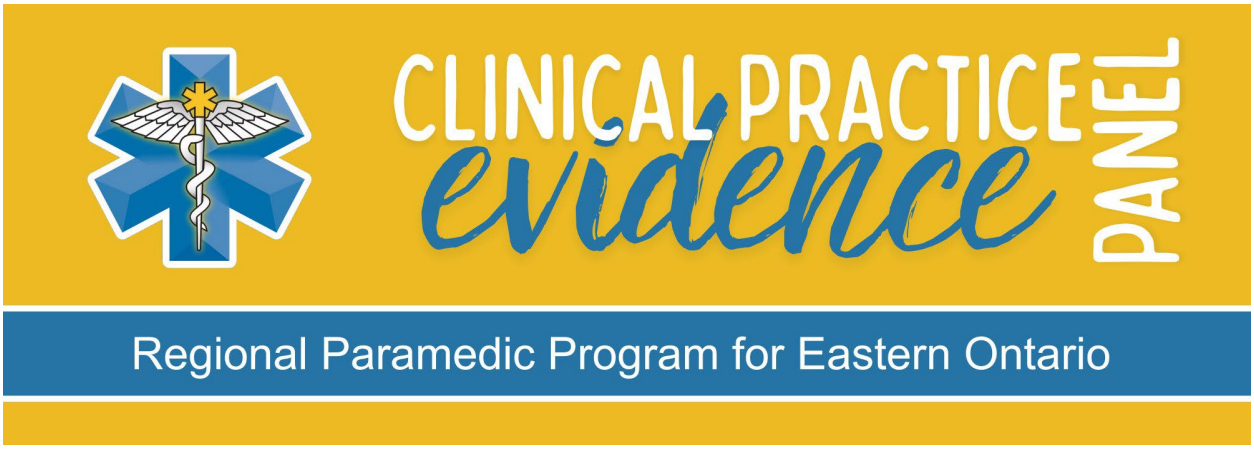
If you are interested in joining our team, please submit your resume and cover letter to Certification@RPPEO.ca no later than **Friday, September 25, 2026, at 11:59 p.m.**

We thank all applicants for their interest. However, only those selected for an interview will be contacted.

For more about the RPPEO, visit https://www.rppeo.ca/rppeo-our-story/work-with-us/2057-certification-rater .

Quality & Patient Safety

Evidence-Based Updates to Scope of Practice



Informing the Future of Pediatric Pain Management

While oral acetaminophen and ibuprofen are widely used to manage pain in children, Ontario paramedic services have had limited options for providing pharmacological pain relief to younger patients.

As the Clinical Practice Evidence Panel (CPEP) reviews the evidence related to pediatric pain management, findings from RPPEO's Pediatric Analgesia Pilot are helping to inform the discussion. The pilot is evaluating the feasibility of introducing pediatric oral formulations of acetaminophen and ibuprofen in participating ambulance services, examining operational considerations such as medication procurement, clinical guidance, education, documentation, dosing accuracy, and quality assurance.

Preliminary findings suggest that participating services were able to successfully implement standardized pediatric analgesia kits and supporting clinical resources. The project has also generated valuable insights into medication administration practices, documentation requirements, and paramedic experience with pediatric analgesia in the prehospital setting.

Feasibility Study: Pediatric Analgesia Pilot

Piscopo, SP. MD[1,2,3]; Vacon, C. BA(H), MA, PhD, AEMCA[1]; Germano, G. MScHQ, MBA, RN[1]; Lapointe, B. ACP[4]; Picknell, J.[1] ACP; Quesnel, P. ACP[5] ; Spitzig, D. ACP[6]; St-Jean, F, AEMCA[1]; Ricard, P. ACP[7]; Robbins, J.[1]; ACP; Austin, MA, MD, FRCPC DRCPSC (PTM)[1,3]

[1]Regional Paramedic Program for Eastern Ontario, Ottawa, ON, Canada; [2] Children's Hospital of Eastern Ontario, Ottawa, ON; [3] Department of Emergency Medicine, University of Ottawa, Ottawa, ON Canada, [4] Lanark County Paramedic Service, [5] United Counties of Prescott and Russell Paramedic Service, [6]Hastings-Quinte Paramedic Services, [7]Cornwall Paramedic Services

Background

Pediatric pain management in prehospital care remains a significant gap. Inadequate pain control has negative implications in pediatric patients including alterations to pain perception and response, psychological trauma, and avoidance of future healthcare contact[1,2]. Studies in Europe suggest that 50% or fewer children with a pain score documented in an ambulance care record received analgesia prior to arriving to the emergency department[3,4]. Some of the barriers identified in the literature include provider anxiety, unfamiliarity or discomfort with pediatrics or the protocols and concerns for adverse effects[5-7]. Current ground ambulance standards in Ontario offer multimodal analgesia for adults but leave pediatric patients underserved with opioids as the only pharmacological management available for children <12 years. As a result, paramedics have limited non-opioid options to manage common pediatric pain presentations. Pediatric formulations of ibuprofen and acetaminophen are widely available outside of ground ambulance services, and evidence already supports their safety and efficacy.

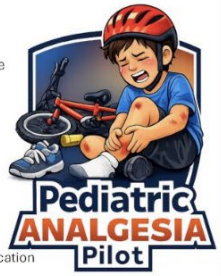
The Ottawa Health Science Network Research Ethics Board (Project ID 2026022C) assessed the project and determined that it was a quality improvement initiative not requiring formal REB review.

Project Aim

Evaluate the feasibility of introducing pediatric oral formulations of acetaminophen and ibuprofen in ambulance services.

Inclusion criteria

- Ages 1-11 years old with pain
- Cared for by participating paramedic service
- Parent or caregiver agreed to medication administration



Measurable Outcomes

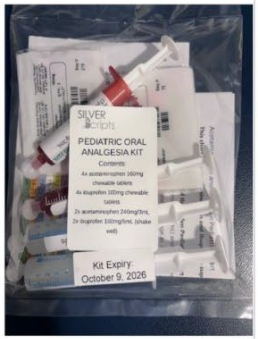
Primary outcome:
Operational feasibility of implementing pediatric acetaminophen and ibuprofen formulations in participating ambulance services. **Measured by**

- Proportion of eligible patients who receive medication
- Dosing accuracy
- Documentation completeness
- Adverse events
- Paramedic usability and confidence

Methods and steps to implementation

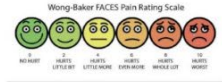
Operational implementation

- Services volunteered to participate
- Identification & costing of pediatric formulations
- Clinical decision guideline
- Parental consent conversation cues
- Dosing charts



Education

1-hour online module



- Pre-test and knowledge assessment
- Pediatric pain assessment and clinical significance
- Pharmacology, formulations and administration strategies
- Medical math module
- Documentation requirements
- Operational guidance

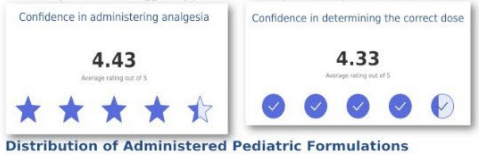
Quality Assurance

- Quality and safety review for all study cases
- Single reviewer for all pilot cases
- Escalated for further review per reviewer discretion per usual clinical criteria with a flag to project manager and principal investigator

Results to date

This is an active ongoing study with the following preliminary results:

- Standardized pediatric analgesia kits (~$20.00 per kit) were easily implemented across participating services.
  - Logistics teams reported simple stocking and restocking processes.
  - Reuse of medications from partially used kits minimized waste and reduced replacement costs.
- 29 ACR cases reviewed
  - Average age: 6 years
  - 4 cases noted for medication administration despite contraindications
  - Most pain related to injury
  - Inconsistent documentation of parental consent to treatment
- 60 paramedic survey logs reviewed
  - 91% strongly agree or agree that pediatric analgesia formulations improved their capacity to provide safe and effective patient care.
  - Safety concerns flagged by paramedics: 3 patients spat or vomited the dose.



Distribution of Administered Pediatric Formulations

Limitations and Hurdles

- Identification of cases relies on QA filters or paramedic survey completion
- Ambulance Call Report transition period

References

- Zempsky, W. T., Cravero, J. P., & American Academy of Pediatrics Committee on Pediatric Emergency Medicine and Section on Anesthesiology and Pain Medicine. Relief of pain and anxiety in pediatric patients in emergency medical systems. *Pediatrics* **114**, 1348–1356 (2004).
- Society, C. P. Best practices in pain assessment and management for children | Canadian Paediatric Society. https://cps.ca/en/documents/position/pain-assessment-and-management.
- Rutkowska, A. & Skotnicka-Klonowicz, G. Prehospital pain management in children with traumatic injuries. *Pediatr. Emerg. Care* **31**, 317–320 (2015).
- Murphy, A. *et al.* A Prevalence and Management Study of Acute Pain in Children Attending Emergency Departments by Ambulance. *Prehosp. Emerg. Care* **20**, 52–58 (2016).
- Williams, D. M., Rindal, K. E., Cushman, J. T. & Shah, M. N. Barriers to and Enablers for Prehospital Analgesia for Pediatric Patients. *Prehosp. Emerg. Care* **16**, 519–526 (2012).
- Tsao, H. S. *et al.* Barriers and Enablers in Prehospital Pediatric Analgesia. *Prehosp. Emerg. Care* **29**, 789–795 (2025).
- Rahman, A. *et al.* Emergency medical services provider comfort with prehospital analgesia administration to children. *Prehospital Disaster Med.* **30**, 66–71 (2015).

Acknowledgments: Melissa Camuso for providing support as a consulting pharmacist; All paramedics who engaged in this study

recommendations related to pediatric pain management, the findings are providing real-world implementation evidence to complement the scientific literature under review. Together, these sources of evidence will help inform recommendations brought forward through the Clinical Medical Directive Review (CMDR) process for consideration in future revisions to the Analgesia Medical Directive. The Pediatric Analgesia Feasibility Project continues through 2026.The poster below will be presented at the 2026 Ontario Base Hospital Group Annual General Meeting and highlights the project's background, implementation approach, and preliminary findings.

Paramedicine Research

RPPEO has approved participation in this event for 8 CME credits. Participants seeking CME credit must submit proof of attendance to education@RPPEO.ca following the event.

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