REGIONAL PARAMEDIC PROGRAM FOR EASTERN ONTARIO

MedicNEWS

Insight for paramedics in Eastern Ontario

May 2025

ALS PCS v5.4

IN FORCE JUNE 2, 2025

GET READY FOR YOUR NEW SCOPE OF PRACTICE

CASE STUDIES

"NO PATIENT FOUND"
WITH DEADLY CONSEQUENCES

WHEN INCOMPLETE DOCUMENTATION LEADS TO TOUGH QUESTIONS.

The Call:
Paramedics respond with police to an unconscious male in his 30s. Bystanders administer naloxone, and the patient wakes up. He refuses assessment or care and walks away. The call is documented as "code 71, no patient found."

What Happened Next:
An hour later, the same patient is found unconscious again, with no vital signs. Resuscitation is unsuccessful. Police report that paramedics spoke with the patient earlier and cleared him medically - but documentation said "patient found."

Lessons:
"patient found" is not enough.
When a patient refuses care, EMRs must assess, document thoroughly, explain risks, and record the plan.
Protect the patient, inform other providers, and protect you.

THE LIFT ASSIST
THAT WASN'T

HOW A SIMPLE CALL TURNED INTO A CRITICAL MISSED OPPORTUNITY.

The Call:
An 82-year-old woman falls at home—she says she's fine. The call is labeled "lift assist." Paramedics help her up and document "no patient found."

case study

What Happened Next:
Hours later, another crew finds her in severe pain with a hip fracture. At hospital, she's diagnosed with:
- Rapid atrial fibrillation (AFib)
- Hip fracture requiring surgery
- Urinary tract infection (UTI)

These conditions contributed to her fall - and were missed during the initial visit.

The Lessons:
- A more thorough assessment might have revealed the irregular heart rhythm or signs of infection.
- In elderly patients, a missed hip fracture carries up to a 30% mortality rate within one year.
- This case is a reminder that every call deserves a complete assessment, regardless of how minor it seems.

PARAMEDIC SERVICES WEEK 2025

WHY EVERY CALL AND EVERY NOTE MATTERS

NO PATIENT FOUND?

May 2025

In This Issue

As paramedics, staying informed means staying ready. In this edition of *MedicNEWS*, we spotlight several developments shaping your practice this spring.

🆕 **ALS PCS v5.4 Comes Into Force – June 2, 2025**

One of the most significant updates in recent years, ALS PCS v5.4 introduces new directives, revised protocols, and clarifies standards around interventions such as analgesia, nausea/vomiting, cardiac arrest, and traumatic hemorrhage. We walk you through what's new, what it means for your scope of practice, and what to expect next.

🦠 **Measles Management: Clinical Bulletin Released**

With a measles outbreak in Ontario, our updated bulletin helps paramedics focus on the clinical signs, documentation, and hospital notification procedures that matter most. Learn how to assess risk, identify mimics, and document effectively.

📚 **Case Studies from the Front Lines**

Medical Director Dr. Mike Austin shares two insightful case studies with real-world implications for paramedic assessment and documentation. His reflections in this month's BHP Corner explore how even routine-seeming calls carry critical clinical weight.

🎓 **CME Update: Final Trauma Day of 2025 Coming Soon**

Don't miss your last chance this year to join the hands-on Level 2 Trauma Day. Build your trauma care confidence with dynamic, scenario-driven learning.

As always, if you've come across clinical insights or stories worth sharing, send them to **info@RPPEO.ca** with "MedicNEWS" in the subject line. We love hearing from you. Enjoy the issue—and thank you for everything you do.

Erratum - In an earlier version of the May 2025 issue of *MedicNEWS*, we incorrectly stated that there were changes to the **Hypoglycemia Medical Directive** anticipated in the June 2, 2025 ALS PCS v5.4. This was an error. **There are no changes to the Hypoglycemia Medical Directive.**

The digital and PDF versions have been updated to reflect this correction. We regret the oversight and appreciate your understanding. – *Charlene Vacon, Editor*

Celebrating the Heart of Paramedic Care **| May 18–24, 2025**

This Paramedic Services Week, we pause to honour the work of paramedics across Eastern Ontario and beyond—clinicians who respond with skill, compassion, and commitment in some of life’s most critical moments.

The national theme for **Paramedic Services Week 2025**, *"We Care. For Everyone."*, is a powerful reminder that **care knows no boundaries—age, location, circumstance, or complexity.** It is about showing up with purpose, for every patient, every time.

Paramedics today are not just responders—they are collaborators in system-wide care, professionals shaping the future of health delivery, and innovators solving real-time challenges in complex environments.

This evolution of paramedic practice is being carried forward by **paramedics themselves—through curiosity, courage, and a deep connection to the communities they serve.** At every level, we are seeing leadership emerge from within the profession: in clinical judgment, in compassionate care, and in the pursuit of excellence.

"showing up with purpose, for every patient, every time"

Whether providing advanced care on scene, advocating for vulnerable patients, or mentoring the next generation, paramedics continue to raise the bar. Your role is expanding, your impact is growing—and your work matters.

To all paramedics: **thank you for the care you deliver, the voice you bring to the profession, and the future you are helping to build.**


WE CARE.
FOR EVERYONE.
PARAMEDIC SERVICES WEEK
MAY 18 - 24, 2025

Medical **Direction**

Clinical Bulletin Update | May 2025

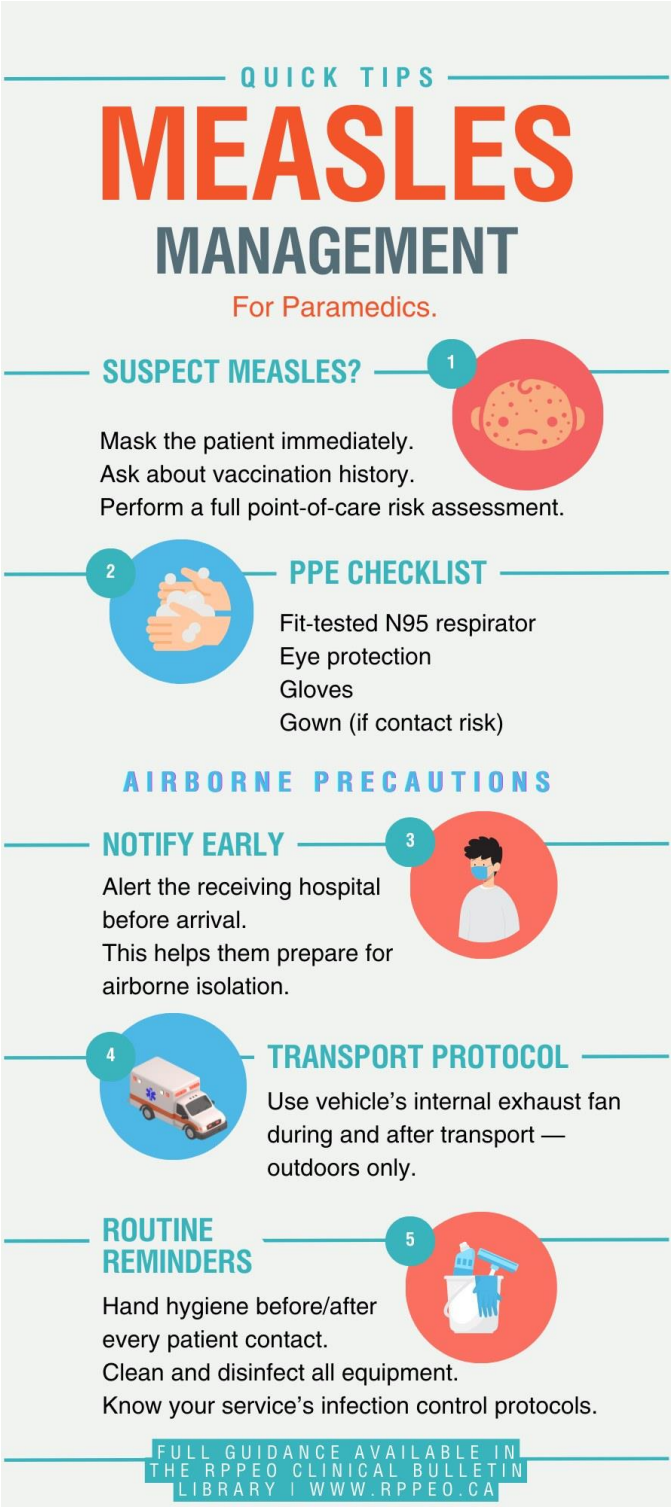
Measles Management: Best Practices for Assessment and Transport

As Ontario responds to a confirmed measles outbreak in 2025, the Regional Paramedic Program for Eastern Ontario (RPPEO) has released an updated Clinical Bulletin on Measles Management, now available in the RPPEO Clinical Bulletin Library.

This resource was developed in collaboration with regional paramedic services, with special thanks to **Ottawa Paramedic Service, CHEO, TOH,** Ottawa Public Health**,** Eastern Ontario Health Unit**, Queensway, and Monfort Hospital** for providing information and their input on infection control procedures.

Why It Matters

Measles is one of the **most highly contagious** viruses. Prompt recognition, airborne precautions, and hospital coordination are critical to reducing transmission and protecting both patients and providers.



A Clinical Role in a System Response

What Paramedics Should Focus On

1. Early Clinical Suspicion

- Ask about recent **travel** or **exposure to illness**.
- Ask about **vaccinations like MMR**.
- Be alert for classic progression: **fever → cough/conjunctivitis → rash**.
- The **prodrome phase** (fever, malaise, cough, runny nose) may occur **before the rash appears**, and should not be overlooked.

2. Clear, Detailed Documentation

- Include any red flags (immunocompromised, unvaccinated, pregnancy).
- If measles is in your differential, document your **working impression clearly**.

3. Proactive Hospital Communication

- If measles is **suspected**, alert the receiving facility as early as possible.
- Early notice helps ED teams implement appropriate clinical precautions—**your handoff makes a difference.**

4. Clinical Thinking: Don't Rule Out Too Soon

- Consider common mimics: rubella, roseola, drug reactions, COVID-19, scarlet fever.
- Use your exam and reasoning to guide your provisional impression.

While each paramedic service is responsible for implementing PPE and transport protocols, your **clinical awareness, judgment, and communication** are vital links in the system-wide response to measles.

Find the Full Clinical Bulletin

The **RPPEO Clinical Bulletin on Measles Management** provides in-depth guidance and is available now:

🔗 Access the Bulletin in the RPPEO Library

Let's stay informed and ready to respond safely. Your vigilance makes a difference.

REGIONAL PARAMEDIC PROGRAM FOR EASTERN ONTARIO

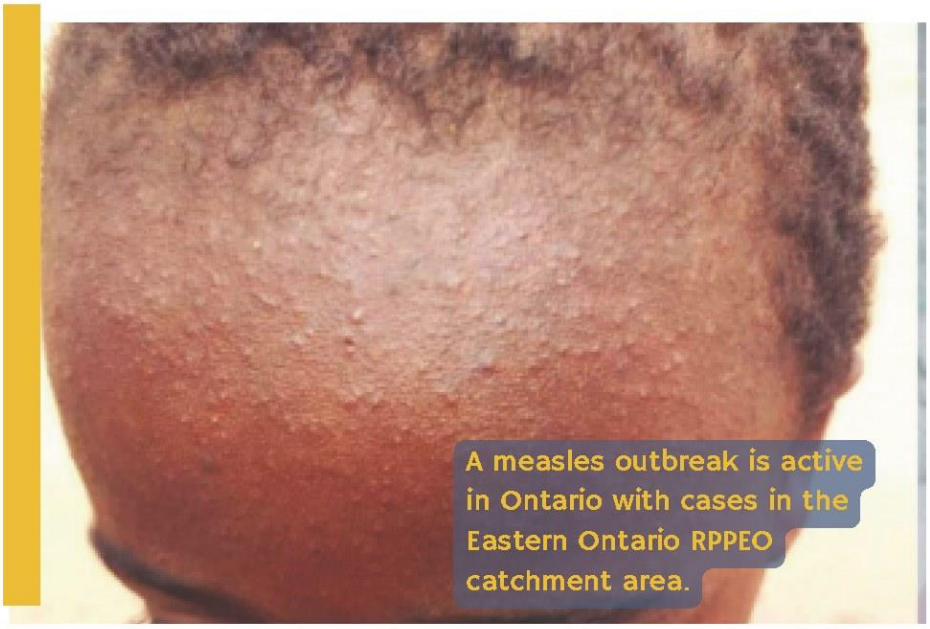
MAY 14, 2025

VOLUME 2
ISSUE 1

Clinical Bulletin

RPPEO Guidance for Paramedics on Measles During the 2025 Ontario Outbreak

Dr. Michael Austin, Regional Medical Director



A measles outbreak is active in Ontario with cases in the Eastern Ontario RPPEO catchment area.

Measles is one of the most contagious infectious diseases, primarily transmitted through the airborne route. Once in the air, measles virus particles can remain infectious for up to two hours — making early identification and containment essential.

In the current Ontario outbreak, paramedics are on the front lines, providing not only urgent care but also serving as the first barrier to further spread. Vaccination is highly effective — unlike some other infectious diseases — but even vaccinated individuals can occasionally be affected. Your careful assessment, infection control actions, and communication with hospitals is key to limiting measles

Practice Highlights

Mask symptomatic patients promptly.

Use appropriate PPE for airborne precautions, as defined by your service.

Gather and document vaccination and exposure history.

Notify receiving hospitals without delay.

Protect vulnerable people by minimizing exposure risks.

MAY 14, 2025

REGIONAL PARAMEDIC PROGRAM FOR EASTERN ONTARIO VOLUME 2.1

Recognizing Measles: Clinical Presentation

Paramedics should be alert to several hallmark signs when suspecting measles:

- Fever ≥38.3°C (oral)
- Upper respiratory symptoms: cough, runny nose (coryza), or red eyes (conjunctivitis), that present like a typical cold
- Generalized, erythematous, maculopapular rash lasting at least three days

In measles, the fever and "cold-like" symptoms appear first, followed by the rash 2–4 days later.

- If the rash appears earlier, measles is less likely.
- The rash typically starts on the face, then spreads to the neck and torso, followed by the extremities.

This progression pattern is a valuable clue for paramedics in differentiating measles from other viral illnesses during the assessment.

Key Practice Points for Paramedics

Patient Assessment Essentials

Incorporate vaccination and exposure history into your assessments:

- Ask about MMR vaccination history.
- Check for **recent travel** to areas with known outbreaks or **known contact** with measles cases.
- Document findings thoroughly, even if the patient reports being vaccinated.

Infection Prevention and Control

Because measles is an airborne pathogen, using appropriate PPE for **airborne precautions** is non-negotiable.
Paramedics must use the appropriate PPE as defined by their service's protocols for airborne diseases. Importantly:

- Ensure the patient is masked (if tolerated) as soon as measles is suspected.
- Limit nonessential staff exposure and minimize the patient's movement during care and transport.
- Clean and disinfect vehicles and equipment according to standard protocols after transport.

Hospital Notification

- Notify the receiving hospital early when measles is suspected, so they can prepare an Airborne Infection Isolation Room (AIIR) or private room.

Why Notification is Crucial

Transporting a suspected measles patient without advance notice can trigger an ED shutdown due to airborne exposure, disrupting care for all other patients. This is not just an infection control issue — it's a critical system risk.

ALS PCS v5.4 | June 2, 2025

What Paramedics Need to Know

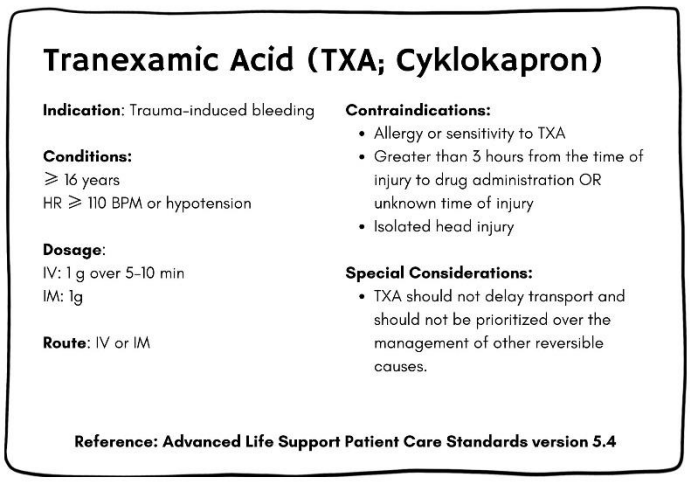
The **Ministry of Health** has officially released **Advanced Life Support Patient Care Standards (ALS PCS) Version 5.4**, which will come **into force on June 2, 2025**.

This version includes **revised core directives and several new auxiliary directives** reflecting important continuing evolution in clinical evidence-based best practices and scope of paramedic care. Training and regional reviews have been underway since Fall 2024. The information provided below is meant to help orient you to changes, but it's not exhaustive. We've worked to identify what's new and important, and - if you are practising under these Standards - you'll want to do the same!

🔍 What's New?

Highlights of ALS PCS v5.4 include:

- **Updated Directives:** PCP & ACP Analgesia, PCP & ACP Nausea/Vomiting, Medical Cardiac Arrest (Vector Change supported; DSED implementation pending service adoption and paramedic training)
- **New Core Directives:** Advanced Airway and Tracheostomy Suctioning (PCP & ACP)
- **New Auxiliary Directives:** Lateral Patellar Dislocation Reduction (PCP & ACP), Traumatic Hemorrhage (PCP & ACP), Tachydysrhythmia (PCP). Paramedic services will inform their staff about whether they are adopting these auxiliary directives.



🩹 Analgesia Medical Directive Updates

For Advanced Care Paramedics (ACPs):

- **Ketamine Added**: An option for severe pain, offering an alternative analgesic pathway when opioids are contraindicated or insufficient. Ketamine may be administered **IV or IN** for analgesia, with Base Hospital Physician (BHP) consultation required before use in patients less than 18 years of age.
- **Clinical Judgment Emphasis**: Paramedics are encouraged to use clinical judgment when selecting analgesics, considering factors such as patient condition, contraindications, and potential side effects.

🫀 Medical Cardiac Arrest Directive Updates

1. Reinforced High-Quality CPR

- Continuous chest compressions with minimal interruptions remain central.

2. Vector Change and DSED

Vector Change

- **Authorized now** for shock-refractory VF.
- Refers to **changing pad placement to an anterior-posterior placement** after multiple unsuccessful defibrillation attempts.
- Recommended to use a new set of pads because of risk of tearing, breaking the ones already placed.

DSED (Double Sequential External Defibrillation)

- **Authorized for paramedics who participated in the clinical research trial,** but **not yet in effect for others in the region**.
- Requires **local implementation planning by each paramedic service**.
- Requires **training for each paramedic** to be authorized.
- DSED involves delivering **two sequential shocks using two defibrillators**.
- Until DSED is operationalized, **Vector Change is the recommended strategy** for refractory VF.

3. Medications & Intervals

- **Epinephrine** every 4 minutes remains unchanged.

- Medication administration should not delay defibrillation or CPR.

4. Termination of Resuscitation (TOR) Criteria

- Criteria reaffirmed: No ROSC. No shocks delivered. Arrest not witnessed by EMS.
- **Patch required to Base Hospital Physician** for TOR authorization.

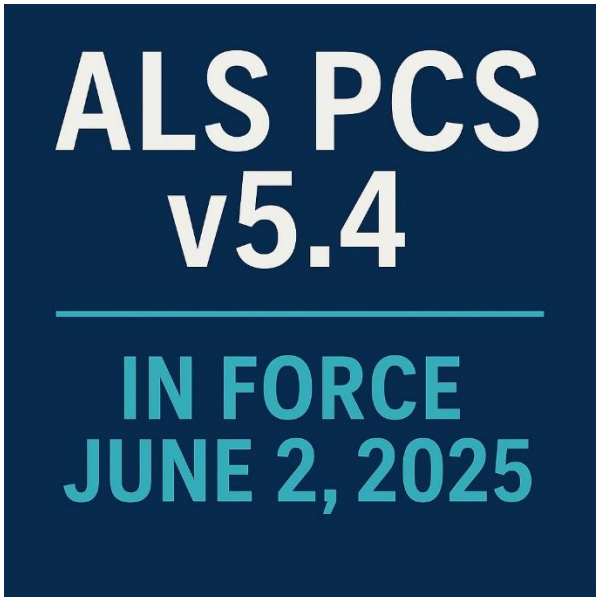
These changes:

- Emphasize **early recognition of refractory VF**.
- Provide clear next steps for treatment escalation (Vector Change now, DSED later).
- Encourage precise rhythm interpretation, structured interventions, and documentation.

🤢 **Nausea/Vomiting Medical Directive Updates**

For Primary Care Paramedics (PCPs) and Advanced Care Paramedics (ACPs):

- **Expanded Use of dimenhyDRINATE**: The **biggest change in ALS PCS v5.4** regarding **dimenhyDRINATE** is the **removal of the age-based contraindication** for patients 65 and older. DimenhyDRINATE 25 mg is now **considered low-risk in single doses**, and **may be administered for older adults** if ondansetron is not available. Greater emphasis is placed on paramedic point-of-care assessment.
- **Administration Routes**: Both **intravenous (IV)** and **intramuscular (IM)** routes for dimenhyDRINATE and ondansetron may be authorized, providing flexibility based on patient needs and clinical judgment.

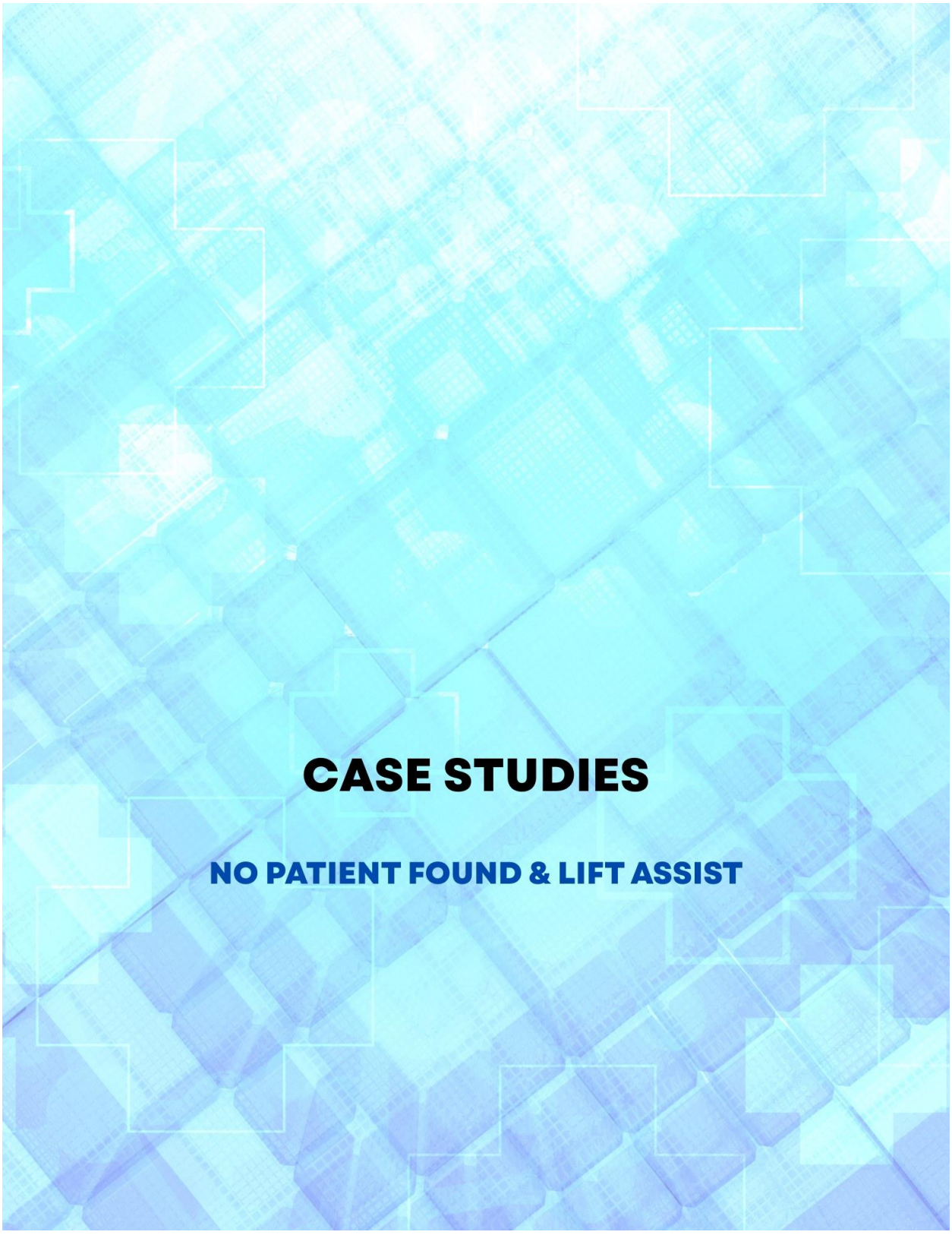


💬 **What's Next?**

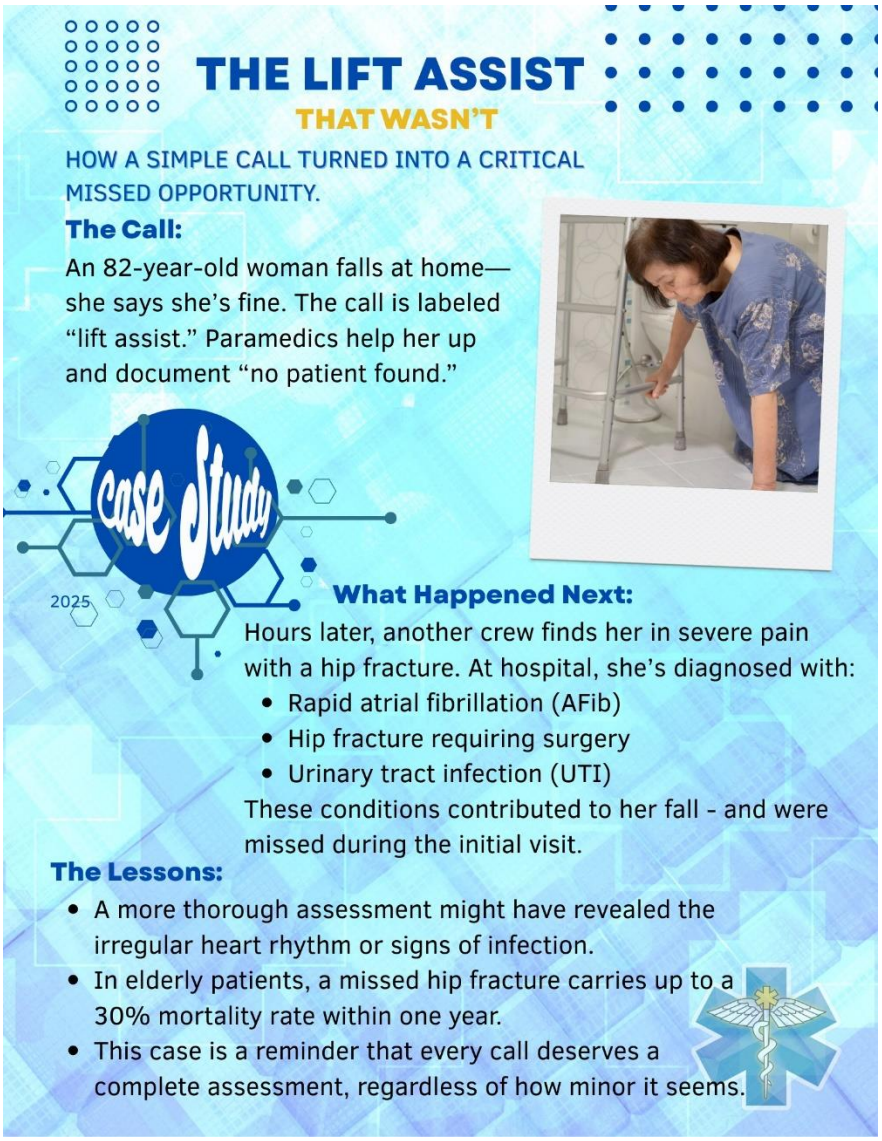
- All **core directives (except DSED)** are authorized for use by RPPEO-certified and trained paramedics as of **June 2**.
- **DSED remains pending** local deployment and training plans and is not yet in force across the region (study collaborators are authorized for DSED).
- Your **paramedic service** will inform you of their plans for any of the **new auxiliary directives:** patellar reduction, TXA, and Valsalva manouevre.

- Not sure if you're trained and authorized for an intervention? Check your latest **certification letter** in your email or on MedicNET.
- Paramedics should check familiarity with **scope changes**.
- Remember that **Online Medical Consultation is available at all times to support you** with these many changes to practice.
- Be sure to review the full directives and connect with your **training team or RPPEO** for any clarification on **scope and rollout**.

Case Studies by Dr. Mike Austin, Medical Director



Case Study: Missed Diagnosis After a "Lift Assist"



Consider the following case from my early days as a paramedic:

One winter night, my partner and I responded to a call for an 82-year-old woman who had fallen in her living room. The call was categorized as a "lift assist," which often means simply helping someone back to their feet with no further medical intervention needed. Upon arrival, we found the patient embarrassed, reassuring us that she was fine and had just lost her balance. After a brief visual check, we helped her up and left. We documented the call as a "lift assist" with "no patient found."

A few hours later, another crew was dispatched to the same patient, who was now in severe pain from a fall and had a suspected hip fracture. She was treated and transported to the hospital, where she was diagnosed with rapid atrial fibrillation (AFib), a left hip fracture requiring surgery, and a urinary tract infection (UTI). The rapid AFib and UTI had contributed to her earlier fall, ultimately leading to the hip fracture. Had we taken a few extra moments to perform a more detailed history and full assessment, we might have detected the irregular heart rhythm or signs of infection.

The missed diagnosis delayed her treatment and worsened her condition. In elderly patients, hip fractures carry a significant mortality rate of approximately 20-30% within one year, highlighting the importance of early detection and intervention in cases like these.

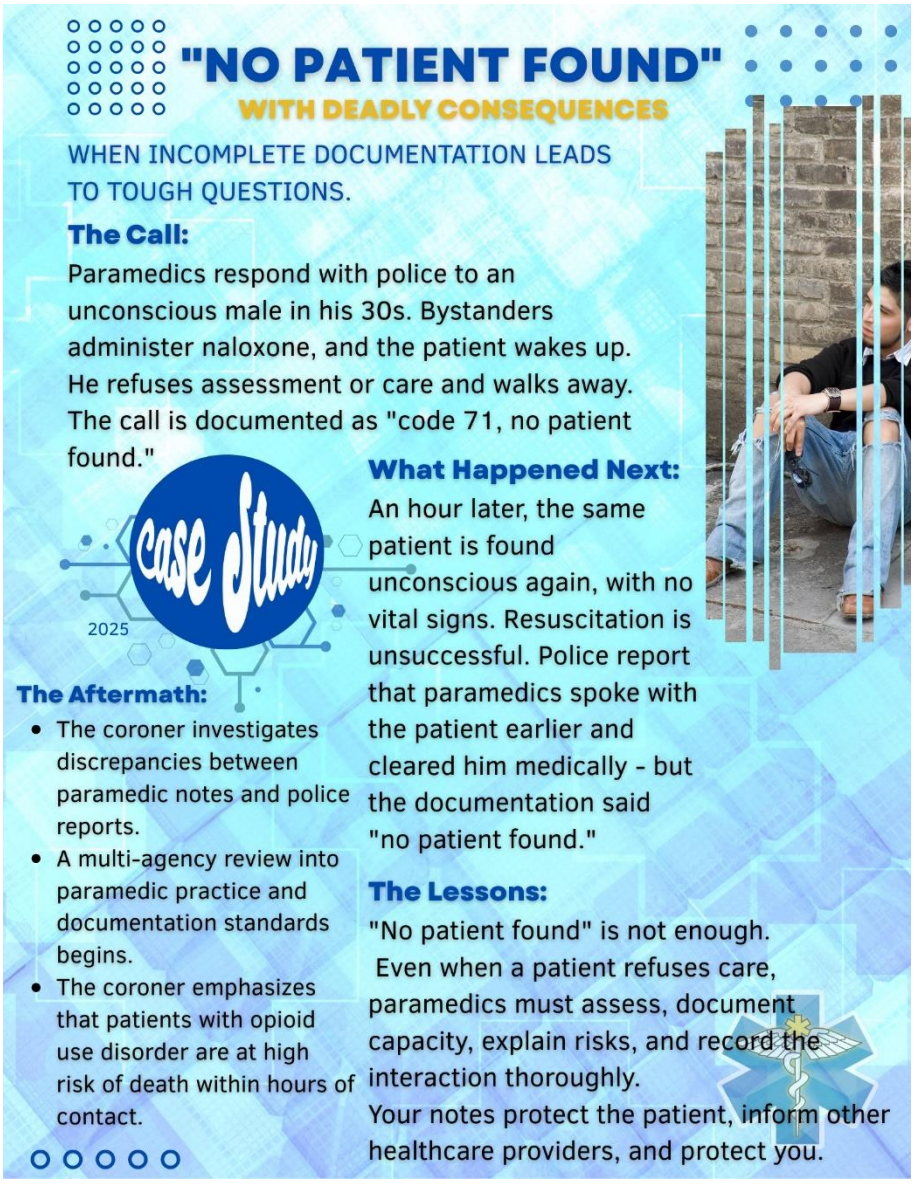
As a paramedic, I felt the burden of this oversight deeply. And now, as a physician, I understand even more how crucial that initial interaction was and how a full assessment could have changed the trajectory of her care.

Case Study: Documentation Discrepancy After "No Patient Found"

Consider the following case of a negative outcome after an encounter is documented as "no patient found." Paramedics respond with police for a male in his 30's who is reportedly unconscious on the street.

On paramedic arrival police are already on scene and report that the male was given naloxone by bystanders and is awake and alert. Paramedics speak with the male and ask him what happened and if he would like an assessment. After a brief discussion he refuses any more involvement in the interaction and walks away. Paramedics clear the scene reporting "code 71, no patient found."

An hour later police and a different paramedic crew are called for the same male patient who is found unconscious on the street. He has no vital signs and resuscitation is not successful. He is pronounced deceased at the scene.



Police inform the coroner that they assessed the male for a similar presentation an hour earlier, and that paramedics were involved and assessed the patient as well. When the coroner reviews the ACR for the previous encounter, it reads "no patient found." Police confirm for the coroner that they observed paramedics speaking with the patient and the notes from attending officers even report the patient was "medically cleared."

The coroner makes inquiries to the paramedic service and Ministry of Health to understand what standards are in place for documenting patient assessments, the informed refusal process, and what the treatment approach is for patients found by paramedics after resuscitation from opioid toxicity. The family of the

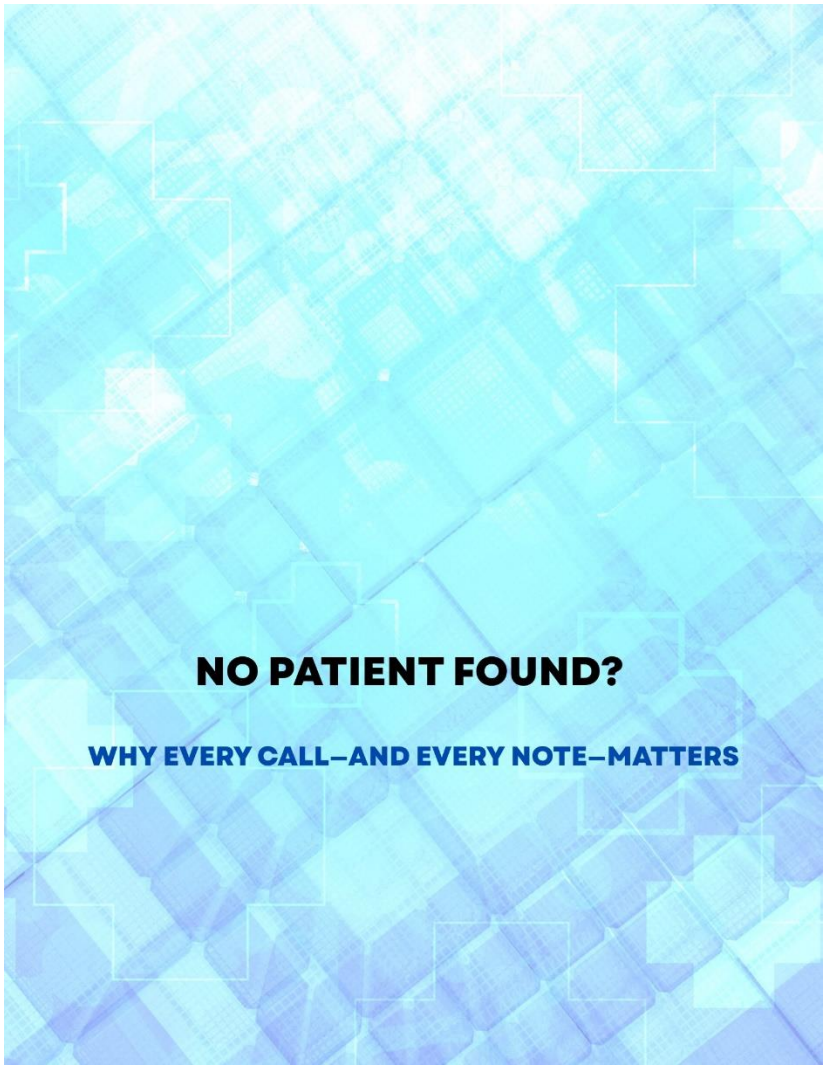
deceased asks the coroner for the outcome of the initial assessment by paramedics and what help was offered. A multiagency investigation into paramedic practice in this case ensues.

The coroner concludes that appropriate documentation standards do exist, but that they were not followed in this case. The coroner's investigative report states "People with opioid use disorder are at high risk of accidental death, often within hours of contact with a healthcare provider. Proper documentation of patient assessments, capacity, risks discussed, and treatments offered, is essential to ensure patients make informed decisions about their care, inform other care providers about the encounter so that risks can be identified and conditions managed appropriately, and ultimately to ensure best practices in patient safety."

After you reflect on the case studies, read this issue's BHP Corner. I wrote the BHP Corner article this month examining these cases and the insights I've found in them. I hope you find it helpful!

BHP Corner: **Where Science Meets Practice**

Bringing you the evolving state of emergency health care, BHP Corner is where RPPEO's Base Hospital Physicians share the clinical science, emerging trends, and real-world challenges shaping paramedic practice across our region.



It's easy to view certain calls as routine or low risk - like lift assists or calls where patients refuse care. But these encounters can hide serious medical issues, and incomplete assessments or documentation can have real consequences for both patients and paramedics. In this edition of BHP Corner, we highlight why every call deserves a full assessment, why documentation is part of patient care, and how your actions protect both your patients and your practice.

by Mike Austin

As a paramedic-turned-physician, specializing in prehospital and transport medicine, I have a unique perspective on the crucial link between care delivered in the field and the broader healthcare system. I've experienced firsthand the challenges paramedics face on the front lines—where time is short, situations are unpredictable, and the documentation load can feel overwhelming. Yet, I also understand the profound importance of every patient encounter, assessment, and treatment decision. This dual perspective shapes my belief that paramedics play an essential role in patient safety, but only when they follow the best practices and standards that ensure no patient is overlooked.

"paramedics play an essential role in patient safety"

This article examines how failing to perform thorough assessments—particularly when documenting cases as “no patient found” or “lift assist only”—can jeopardize both patient outcomes and professional responsibilities. Drawing from both my personal experiences and standards outlined in the *Ambulance Act* of Ontario and *Basic Life Support Patient Care Standards* (BLS-PCS), I’ll explain why thorough patient assessment and complete documentation are non-negotiable for paramedics. If you haven't yet read the two case studies above, go ahead and check them out before you read through this article.

The Importance of Assessment

The *Ambulance Act* of Ontario and BLS-PCS are clear in their guidelines for paramedics: **every patient encounter must involve a thorough assessment, regardless of the initial reason for the call**. The standards are not just bureaucratic red tape—they exist to ensure that we don't overlook any underlying conditions that could harm the patient later.

In the case of our elderly patient in the case studies in this issue, for example, a more thorough assessment might have revealed key indicators of her deteriorating condition:

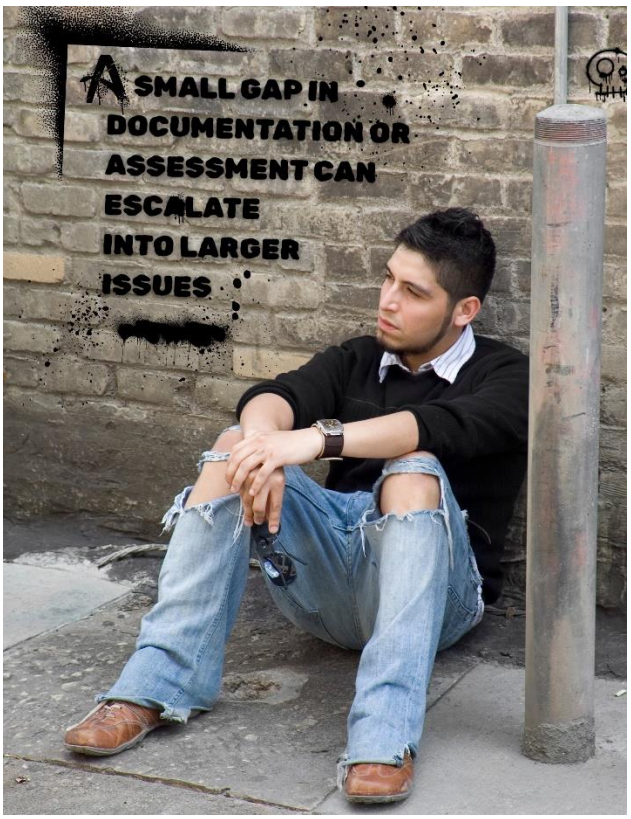
1. **Irregular Pulse**: A quick check of her pulse could have shown signs of AFib, a serious condition that increases the risk of stroke if untreated.
2. **Infection Signs**: Asking my patient simple questions about recent symptoms like fever or confusion, or conducting a thorough physical exam, could have pointed to a urinary tract infection, which is a common but serious problem in elderly patients and often leads to confusion or falls.
3. **Fall Risk**: Falls in the elderly are rarely just about losing balance. They often signal an underlying medical issue, such as cardiovascular problems or infections, which we are trained to detect but can easily miss when pressed for time or when a patient downplays their symptoms.

The Risks of “No Patient Found” and Incomplete Documentation

Documenting an encounter as “no patient found” or “lift assist” without conducting a full assessment not only endangers the patient but also exposes paramedics to professional risks. I have witnessed, as

both a paramedic and a physician, how a small gap in documentation or assessment can escalate into larger issues.

1. **Patient Safety**: As seen in the case studies above, had we performed even a basic physical exam, our patients' serious underlying conditions might have been identified earlier. A missed diagnosis can delay life-saving treatment and worsen the patient's overall outcome.
2. **Professional Responsibility**: Paramedics have a duty to assess every patient thoroughly. Even when the patient insists that they're fine, our training tells us to verify this through careful observation and assessment. The BLS-PCS outlines a clear process for patient assessment, starting with airway, breathing, circulation, and continuing to evaluate other factors like neurological status and medical history. This process is critical, even when it feels routine.



3. **Legal and Regulatory Implications**: In the event of an adverse outcome, such as the ones described in this issue's case studies, incomplete documentation could leave paramedics exposed to legal and regulatory consequences. The *Ambulance Act* holds paramedics accountable to provincial standards, and a failure to assess and document properly could lead to significant professional consequences. As a physician, I now better understand how vital it is to have that documentation trail to ensure accountability and transparency in patient care.

The Documentation Burden: Why It Matters

I understand the feeling that documentation can seem like "just paperwork," especially after a long call or when a situation feels minor. As a paramedic, I often felt that the real work happened with my hands, not with my pen. But with the perspective I've gained as a physician, I now see documentation differently: it is an extension of the care I provide.

Every note we make builds a safety net — for our patients, for our colleagues, and for ourselves. Thorough documentation ensures that others can pick up where we left off, recognize risks we observed, and deliver care that's informed by the full story available to us. It also protects paramedics when outcomes are scrutinized later. A few extra moments spent documenting an assessment, a

refusal, or an informed conversation can mean the difference between clear understanding and the appearance of dangerous gaps in care.

Good documentation isn't about bureaucracy — it's about doing the job completely and leaving nothing to chance when it comes to patient safety.

"every patient interaction, no matter how minor it seems, deserves a full assessment"

In coming years regional base hospital programs are planning to work with paramedic services and the Ministry of Health to expand access to paramedic medical records for family physicians, clinics, hospitals, specialists, and paramedics (for subsequent 911 calls), to ensure healthcare providers have access to the information they need to provide the best patient care. The importance of thorough documentation of your medical encounter will continue to grow and be impactful for high quality patient care.

Imagine a time when the first patient in our story has every aspect of their care—your assessment, interventions, and discussions—logged in a shared network accessible to their entire healthcare team. Despite your concerns about possible infection and serious injury, the patient refuses transport to the hospital. Later that same day, another 911 call is placed. This time, your colleagues arrive at the scene already informed of the earlier call, your clinical findings, and your recommendation for hospital care. Armed with this information, they are better equipped to act decisively. In the emergency department, your documentation is available to the care team, giving them a full understanding of the situation—vital context that would otherwise be lost, as the patient is now confused and you are not part of the transporting crew. Your record is also forwarded to the patient's primary care team, who can now intervene with fall-prevention strategies, aware that a serious incident has occurred.

Now picture the second patient. He gives you his demographic information before walking away. You document your conversation: your recommendation to seek hospital care, the provision of a naloxone kit, and the availability of local walk-in addiction clinics, with a copy made to the patient's addictions care team. This time, the record of a code 71-no patient found doesn't sit idle. Before a coroner ever needs to review it, the patient care record reaches the patient's addictions care team. They call him directly, inviting him to come in for a follow-up discussion and to begin opioid agonist therapy. In this case, the documentation serves not only as a legal record, but as a vital link in a chain of proactive, compassionate care.

Safe, seamless, and effective care like this is possible—but only when healthcare providers document their encounters thoroughly, accurately, and in a way that can be shared across the system.

Lessons Learned

My own experiences highlight lessons that I carry with me every day: every patient interaction, no matter how minor it seems, deserves a full assessment. A “lift assist” can mask serious conditions like infections or cardiovascular issues, and our job is to ensure those aren’t overlooked. “No patient found” because a patient doesn’t ask for assessment can expose paramedics to uncomfortable questions about what assessments were performed, what discussions were had, and what care was provided – even if all were exemplary. I have seen the consequences of incomplete assessments firsthand, and as someone who bridges the worlds of prehospital care and in-hospital medicine, I know that paramedics are a critical link in ensuring patient safety.

"My own experiences highlight lessons that I carry with me every day: every patient interaction, no matter how minor it seems, deserves a full assessment."

Even when a patient refuses further treatment or transport, it is our responsibility to ensure that decision is based on a comprehensive assessment, one that is documented properly in accordance with the standards set out in the BLS-PCS.

Conclusion

Paramedics are at the front lines of patient care, often encountering patients in the most critical moments of their lives. As a physician specializing in prehospital and transport medicine, I know how critical those initial assessments are. Avoiding a “no patient found” resolution and instead conducting and documenting a thorough assessment could mean the difference between life and death for the patient. It’s not just about following protocols—it’s about ensuring that every patient gets the care they deserve, and every paramedic has the tools to provide it.

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

OMC Activity Update April to November 2024

5,704 Calls to OMC

Over 50% of calls were for patients 65 years of age and older.

36% of Patients Were Not Transported

This represents a savings of over $1m in the first 8 months.

62.7% of Calls Were Medical Consultations

28.9% of calls were mandatory patches.

25.2% of Calls Were for VSA

General medical consultations were 23.7% and 12.2% of calls were for neurological reasons.

94% of Patches Had Good Quality

3.3% had poor quality, and only 1.8% experienced disconnections.

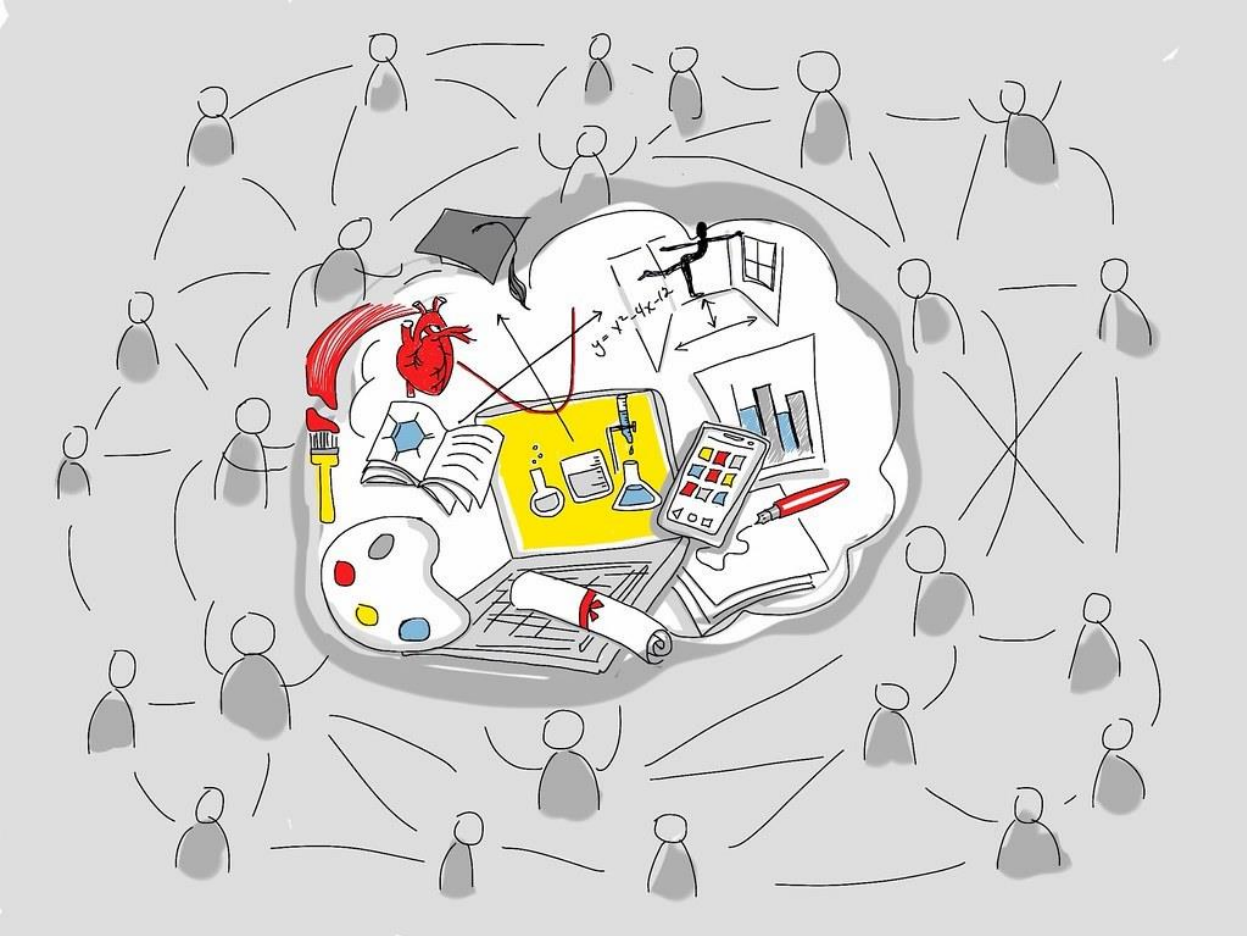
30.7% of Calls Involved Informal Education

91% of learning opportunities were provided by telephone.

302 Paramedics Responded to the Survey

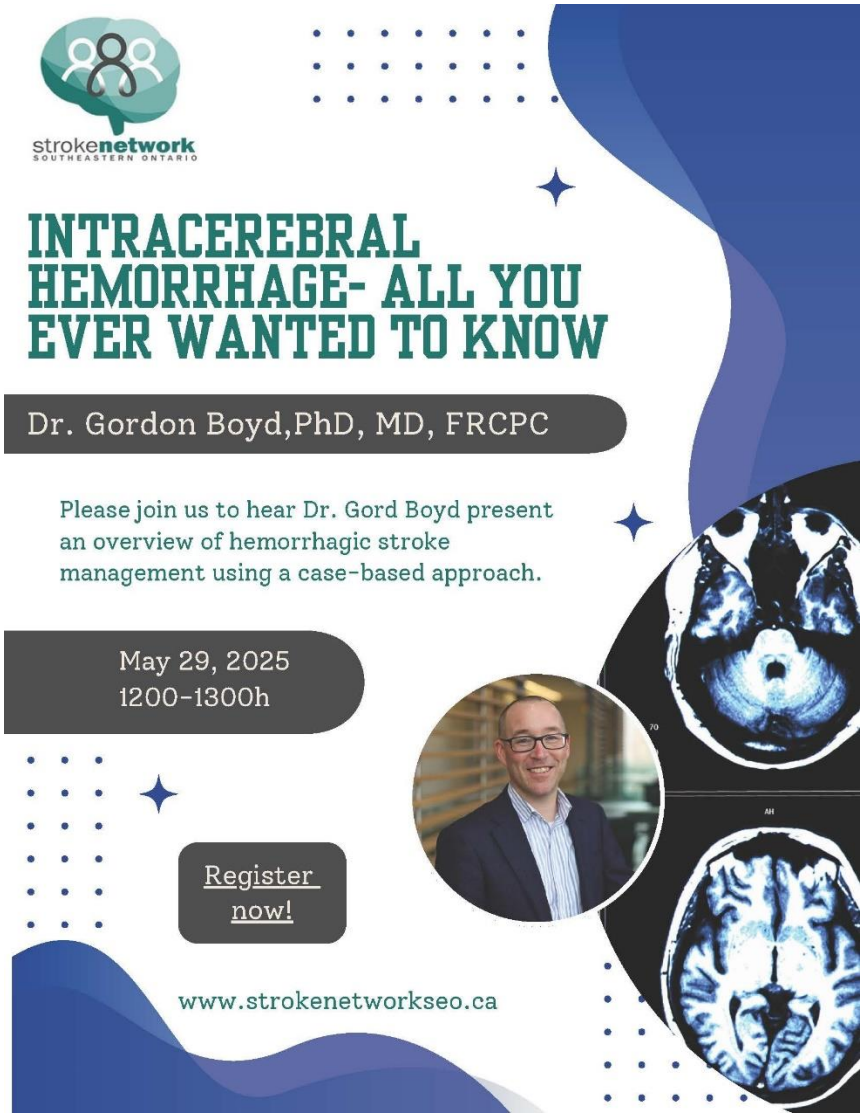
Thank You!
Over 96% of paramedics valued the new patch system, focused attention from the physician, support for front line experience and knowledge of paramedic scope of practice.

Continuing Education



Elective CME

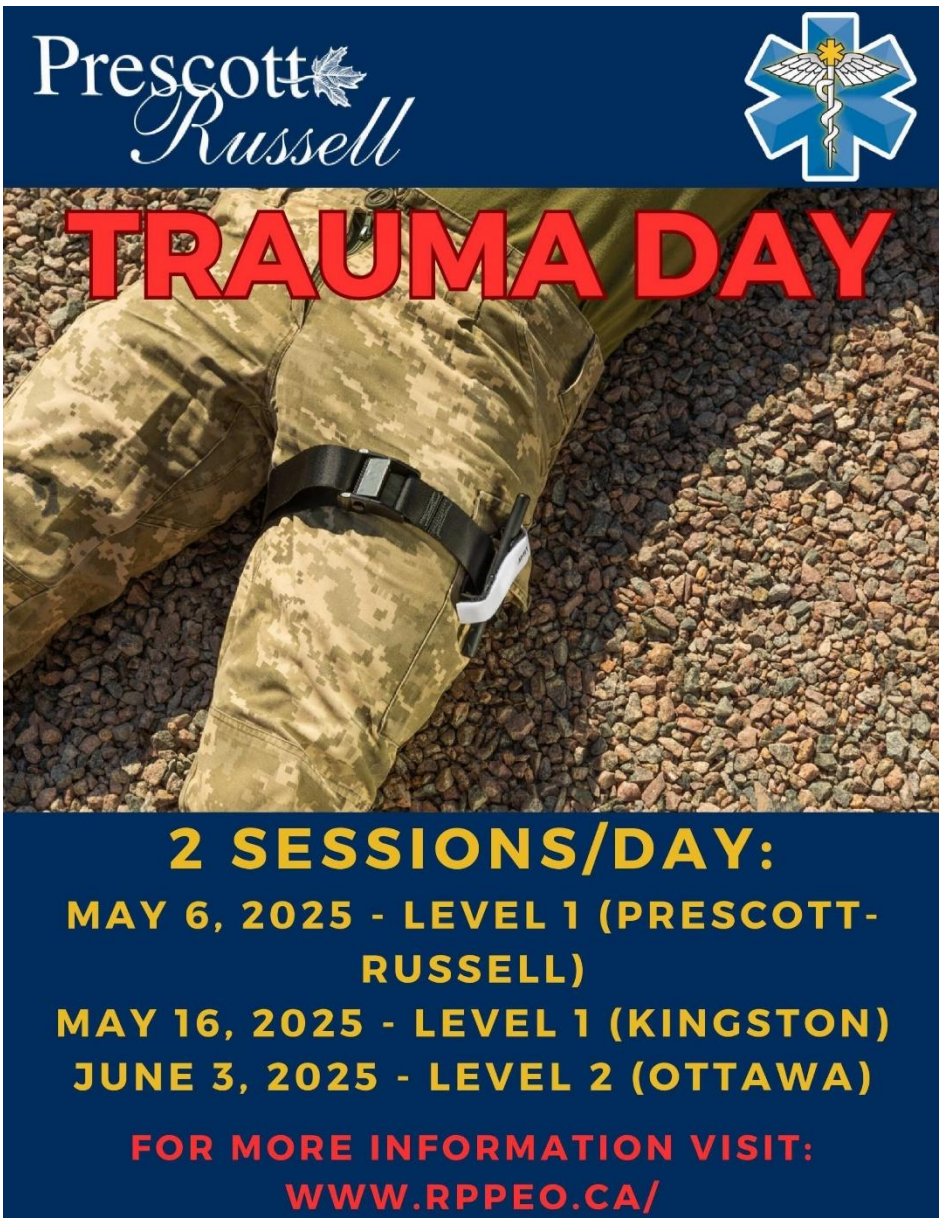
See RPPEO's Education Events listings for pre-approved elective CME courses, workshops, seminars, and more! Here are a few upcoming events you'll find are available for credit. Visit RPPEO.ca for registration details and more info!



Trauma Days 2025 – Final Session Coming in June!

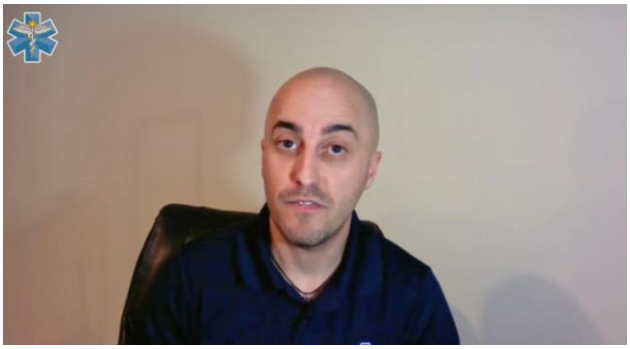
The Regional Paramedic Program for Eastern Ontario (RPPEO) is excited to share that Trauma Days 2025 has already seen two successful sessions this year, with paramedics from across the region participating in these dynamic, hands-on Continuing Medical Education (CME) events.

Following the continued success and positive feedback, **Eric Gagnon** returns once more to deliver the final Trauma Day Level 2 session in June. This will be an opportunity for paramedics to build on the skills and knowledge explored in earlier sessions and continue advancing their trauma care expertise.



***NEW* - Level 1 Trauma Day & Level 2 Trauma Day**

We recognize that there is a varying level of training across paramedics in our region. With this, we want to ensure that you can attend a day that best suits your learning needs and wants so that you can get the most out of the day. Below is a breakdown of the differences between the different levels of Trauma Day. All paramedics can sign up for either level, but we encourage you to look at and follow our recommendations. We also encourage you to watch the following video (click on the caption) for further explanation:



1 - Eric Gagnon presents Trauma Days 2025!

About Levels

Level 1

- Recommended for those who have not attended a previous Trauma Day
- New entry-to-practice paramedics (<5 years recommended)
- Higher focus and time spent on skills review and practice
- Less focus on scenarios

Level 2

- Recommended for those who have attended previous Trauma Days
- Experienced paramedics (5+ years recommended)
- Higher focus and time spent on bringing a variety of skills together
- Higher focus on scenarios with high fidelity simulations

Continued Hybrid Format for Greater Accessibility

To make the training accessible to more learners, Trauma Days will continue to be offered in a hybrid format. This includes:

- **4 hours of online pre-learning**
- **4 hours of in-class hands-on practice and scenarios**

How to Register

1. **Complete the Online Pre-Learning** Begin by completing the 4-hour online pre-learning module: MedicLEARN>>Elective CME>>2025>>Trauma Days 2025
2. **Register for the In-Class Portion** After completing the online modules, you can register for the in-class session. The registration form can be found within the online course in MedicLEARN.

Earn CME Credit

- **In-Class Participation:** Earn a total of 8 CME credits by completing both the online and in-class components.

- **Online-Only Option:** If you are unable to attend the in-class portion, you can still earn 4 elective CME hours by completing the online modules.

In-Class Course Details and Locations

Each session is limited to 12 paramedics.

Session Times:

- Morning: 8:00 AM - 12:00 PM
- Afternoon: 1:00 PM - 5:00 PM

Available Date and Location:

- **Tuesday, June 3, 2025 - Level 2:** RPPEO Ottawa 2475 Don Reid Dr., Ottawa, ON K1H 1E2

If the session is full, you can request to be placed on the waiting list through the registration form.

Don't miss out on this valuable opportunity to enhance your trauma care skills with hands-on practice and expert guidance. Head over to MedicLEARN>>Elective CME>>2025>>Trauma Days 2025 to complete the online portion and register for the class. Sign up today!

News **Nuggets**

Easily digestible short summaries of news impacting paramedic clinical care, from the region, the country and around the globe.

Victoria's Paramedic Practitioners: A New Frontier in Paramedicine

In a landmark move, Victoria has passed the Drugs, Poisons and Controlled Substances Amendment (Paramedic Practitioners) Bill 2024, establishing a new class of healthcare professionals: Paramedic Practitioners.

Key Highlights:

- **Prescribing Authority**: Paramedic Practitioners are authorized to obtain, possess, use, sell, and supply certain scheduled medicines.
- **Educational Pathway**: To qualify, paramedics must complete a prescribed postgraduate qualification and meet specific experience requirements.
- **Regulatory Oversight**: The role is regulated under the Australian Health Practitioner Regulation Agency (AHPRA), ensuring adherence to national healthcare standards.

Implications for Canadian Paramedics:

This development signifies a progressive shift in paramedic practice, highlighting the potential for expanded scopes of practice and increased autonomy. It underscores the importance of advanced education and could serve as a model for similar initiatives in Canada, especially in enhancing healthcare access in underserved areas.

***FRONTIER* Trial: Prehospital Stroke Treatment Yields Hope — and Questions**

Published in *The Lancet* (Feb 2025), the FRONTIER trial explored whether paramedics could safely and effectively administer the neuroprotective drug **nerinetide** to patients experiencing suspected acute ischemic stroke — all **within the first 3 hours of symptom onset**.

🟢 **Promising Findings:**

- **Feasibility**: Paramedics in Ontario and B.C. successfully identified eligible patients and initiated treatment before hospital arrival.
- **Safety confirmed**: No increase in adverse effects compared to placebo.
- **Potential benefit**: Subgroup analyses suggest improved outcomes in patients who went on to receive clot-busting therapies (like alteplase or thrombectomy).

🔴 **Important Limitations:**

- **No overall efficacy**: The trial did **not demonstrate significant clinical benefit** of nerinetide across the full study population.
- **Resource-intensive**: The model required advanced paramedic training, 24/7 coordination, and close integration with stroke centers.
- **Diagnostic uncertainty**: Without imaging, there was a risk of treating patients who did not actually have a stroke (stroke mimics), which could affect safety and cost-effectiveness.
- **Broad applicability questioned**: The logistics of this model may be challenging to implement in rural or under-resourced systems.

⚖️ **Bottom Line**: While the FRONTIER trial shows that paramedics can safely deliver early stroke interventions, its findings raise questions about real-world effectiveness, resource demands, and the scalability of such protocols without stronger clinical benefits.

To read more about the findings, see this University Health Network article.

***Charlene Vacon**, BA(H), MA, PhD, AEMCA is an RPPEO EMS Specialist focused on culture and communication.*

Send your bite-sized news items to MedicNEWS! If you find interesting news relative for the clinical practice of paramedicine, send it along to info@RPPEO.ca for consideration in an upcoming issue of MedicNEWS. Please include the link to the original story (if there is one) and mention "MedicNEWS" in the subject line of your message.

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.