



London Health Sciences Centre

Southwest Centre for Prehospital Medicine

Southwest Centre for Prehospital Medicine

Medical Directives, Guidelines & Policies

Version 1.1 A



Medical Director Information

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Note from Medical Directors

As a part of the London Health Sciences Centre (LHSC) Southwest Centre for Prehospital Medicine (SCPM), I am proud to serve as the Medical Director for your Police Service. Over time, prehospital care evolves as new evidence is produced that impacts patient outcomes. As such, the directives contained within will evolve over time to ensure that police officers are providing the most up to date and evidence-based care that has a positive impact on patient morbidity and mortality. The SCPM strives to provide optimal evidenced-based medical care for patients before paramedic arrival.

Authorization for Delegation of Medical Directives

The medical directives contained within this handbook have been approved for use for police officers certified by Dr. Matthew Davis.

Delegation of the medical directives is under the direction of Dr. Matthew Davis.

Dated: January 21, 2025

Authorized By:

A handwritten signature in black ink, appearing to read 'Matthew Davis', with a stylized, cursive script.

Dr. Matthew Davis

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Preamble



Preamble

Medical Direction and Oversight

Controlled Acts

Controlled acts are specified in the *Regulated Health Professions Act, 1991 (RHPA)* as acts which may only be performed by authorized regulated health professionals. Of the 14 controlled acts, physicians are authorized to perform 13 and may, in appropriate circumstances, delegate the performance of those acts to other individuals who may or may not be members of a regulated health profession.

Delegation

Delegation is a mechanism that allows a physician who is authorized to perform a controlled act to confer that authority to another person (whether regulated or unregulated) who is not independently authorized to perform the act. AED use is a controlled medical act. The police officer provides care according to medical directives, under the authority of their Medical Directors. The police officer may not accept delegation from another on-scene physician, nor should the police officer delegate these acts to another provider or citizen.

Medical Directive

Medical directives are written orders by physicians to other health care providers that pertain to *any patient* who meets the criteria set out in the medical directive. When the directive calls for acts that will require delegation, it provides the authority to carry out the treatments, procedures, or other interventions that are specified in the directive, provided that certain conditions and circumstances exist.

Use of Medical Directives/Guidelines

These medical directives and guidelines are not intended to cover all situations and are not a substitute for good judgment. It is the police officer's responsibility to assess the situation and use their knowledge and skills to benefit the patient while remaining within their scope of practice.

PPE

Police officers will protect themselves and others from illness or injury while providing patient care. The police officer will also assess the risk of communicable diseases by asking about signs of illness and travel history, observe the presence of, and attempt to avoid unnecessary contact with body fluids, and utilize appropriate personal protective equipment (PPE) to limit personal exposure and disease transmission.

Age and Corresponding Vital Signs

The general age cut off between adults and pediatrics is 18 years. There is a wide range of “normal” for vital signs in adults and especially pediatrics. As much as possible, ages for pediatrics and cut off points for vital signs have been kept consistent throughout the Medical Directives. However, clinical research and expert opinion have resulted in a number of exceptions, which in each case has been deliberately chosen and is clearly noted in each Medical Directive. There is a deliberate gap in the definition of normotension and hypotension in both adults and pediatrics.

Adults (18 ≥ years old)

Normotension: SBP ≥ 100 mmHg (SBP = Systolic Blood Pressure)

Hypotension: SBP < 90 mmHg

Bradycardia: HR < 50 BPM

Tachycardia: HR ≥ 100 BPM

Bradypnea: RR ≤ 10 breaths/min

Tachypnea: RR ≥ 28 breaths/min

Pediatrics (< 18 years old)

Age	Respiratory Rate	Heart Rate
0 – 3 months	30 – 60	90 – 180
3 – 6 months	30 – 60	80 – 160
6 – 12 months	25 – 45	80 – 140
1 – 3 years	20 – 30	75 – 130
6 years	16 – 24	70 – 110
10 years	14 – 20	60 – 90

Normotension: SBP ≥ 90 mmHg + (2 x age in years)*

*Once calculation equals 100 mmHg this would be used as the threshold for normotension

Hypotension: SBP < 70 mmHg + (2 x age in years)*

*Once calculation equals 90 mmHg this would be used as the threshold for normotension

Weight (kg): (age x 2) + 10

Newborn Definition

A newborn is a patient who is less than 24 hours of life. The neonatal cardiac arrest protocol applies to patients less than 24 hours of life only.

Level of Awareness (LOA)

Patient can be described as Awake (normal level of awareness), Altered (confused, not normal level of awareness), or Unconscious (non-responsive to verbal, tactile stimuli).

Preamble

Southwest Centre for Prehospital Medicine
Cardiac/Circulation

Medical Cardiac Arrest Medical Directive

Re-Arrest Medical Directive

Trauma Cardiac Arrest Medical Directive

Foreign Body Airway Cardiac Arrest Medical Directive

Newborn Resuscitation Medical Directive

Transfer of Care from an AED-Equipped Public Lay Responder Therapy
Medical Directive

Medical Cardiac Arrest Medical Directive

Indications

Patient presenting in cardiac arrest (vital signs absent)

Conditions

Vital Signs Absent/Pulseless

Age > 24 hours

Contraindications

Valid DNR form

Obvious death

Treatment

1. Establish level of alertness. Open the airway and simultaneously check for breathing and pulse. If there is no pulse, immediately announce the patient is VSA, initiate CPR, apply defib pads and turn on AED. There may be abnormal breathing for a few minutes after the heart stops and this should not be confused with signs of life. If the patient is found to have a pulse, the AED may be turned off.
2. Apply defibrillation pads as quickly as possible while chest compressions are continuing. It is vital that good pad adherence is achieved. This may require prepping the patient's chest via shaving, and towels. Chest compressions may be interrupted transiently during this process.
3. The AED will announce "Don't touch patient. Analyzing."
4. If the AED announces "Press flashing shock button" prepare for shock delivery. Ensure no personnel are touching the patient when the shock is being delivered. Deliver the shock safely and resume CPR immediately. No pulse check is needed.
5. If the AED announces "No shock advised", resume CPR immediately. No pulse check is needed.
6. While one police officer is providing chest compressions, another will set up oxygen and airway equipment. As soon as feasible, apply the bag-valve mask with a one-handed or two-handed seal if feasible. Ventilate at a ratio of 2 breaths to every 30 compressions (ventilations remain at 2 breaths for every 15 compressions for infants or children)

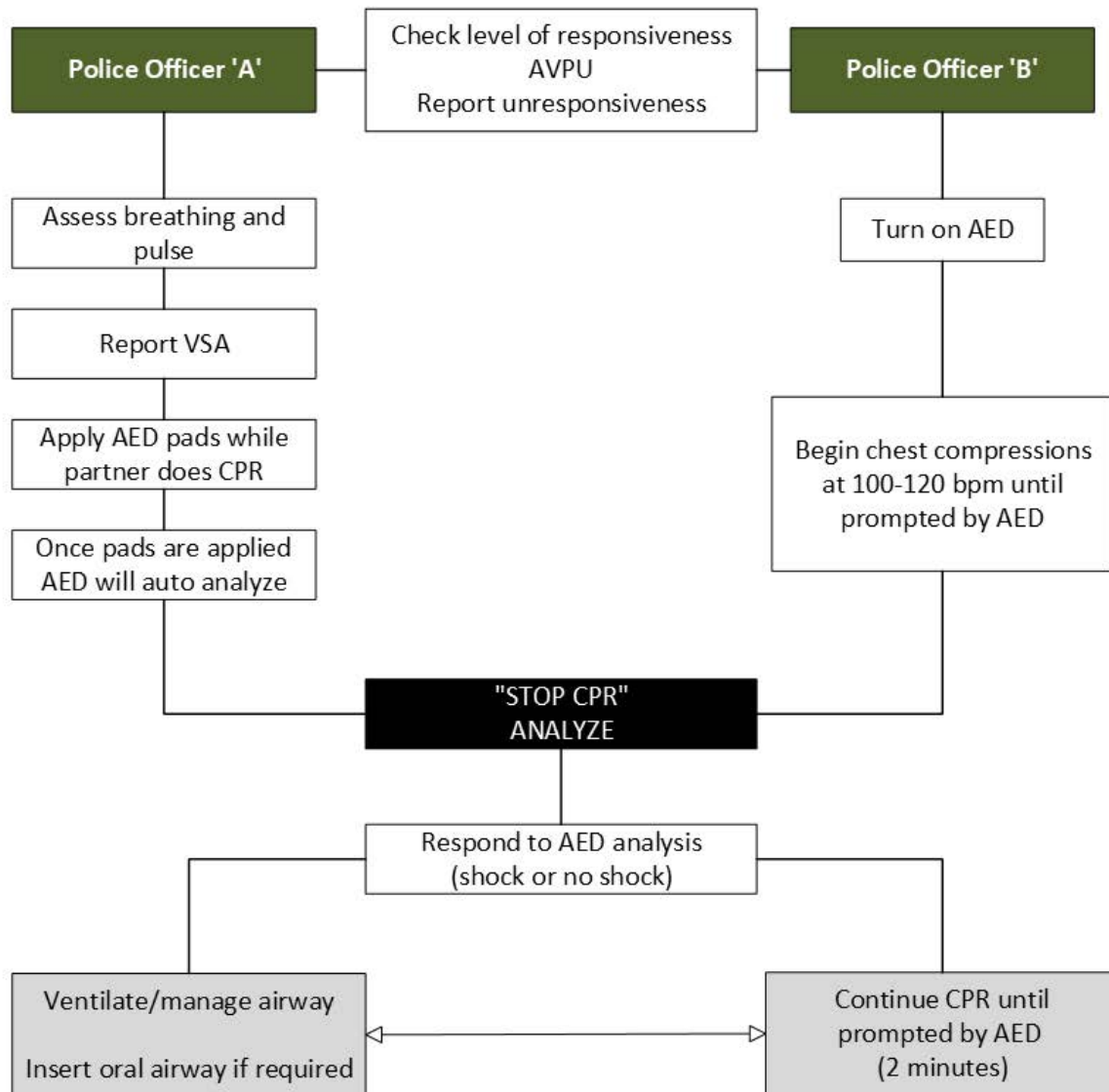
7. Rescuers will switch roles every 2 minutes when the AED advises “Don’t touch patient. Analyzing.” The rescuer doing chest compressions moves to the airway position and vice versa.
8. Continue CPR, stopping only to analyze and shock if prompted, or when paramedics assume responsibility for the patient.
9. CPR may be stopped if there are obvious signs of life (normal breathing or moving). Presence of a pulse must be confirmed at this point. Note that VSA patients may continue to breathe abnormally (called ‘agonal respirations’). In a patient with agonal respirations, a pulse must be checked. Resume CPR if a patient has agonal respirations but no pulse.
10. If there is a return of pulse, turn off the AED but leave the pads on the patient. Recheck the pulse every 60 seconds because there is a high risk of re-arrest. Obtain a set of vital signs as soon as possible after a return of spontaneous circulation (ROSC).

Clinical Considerations

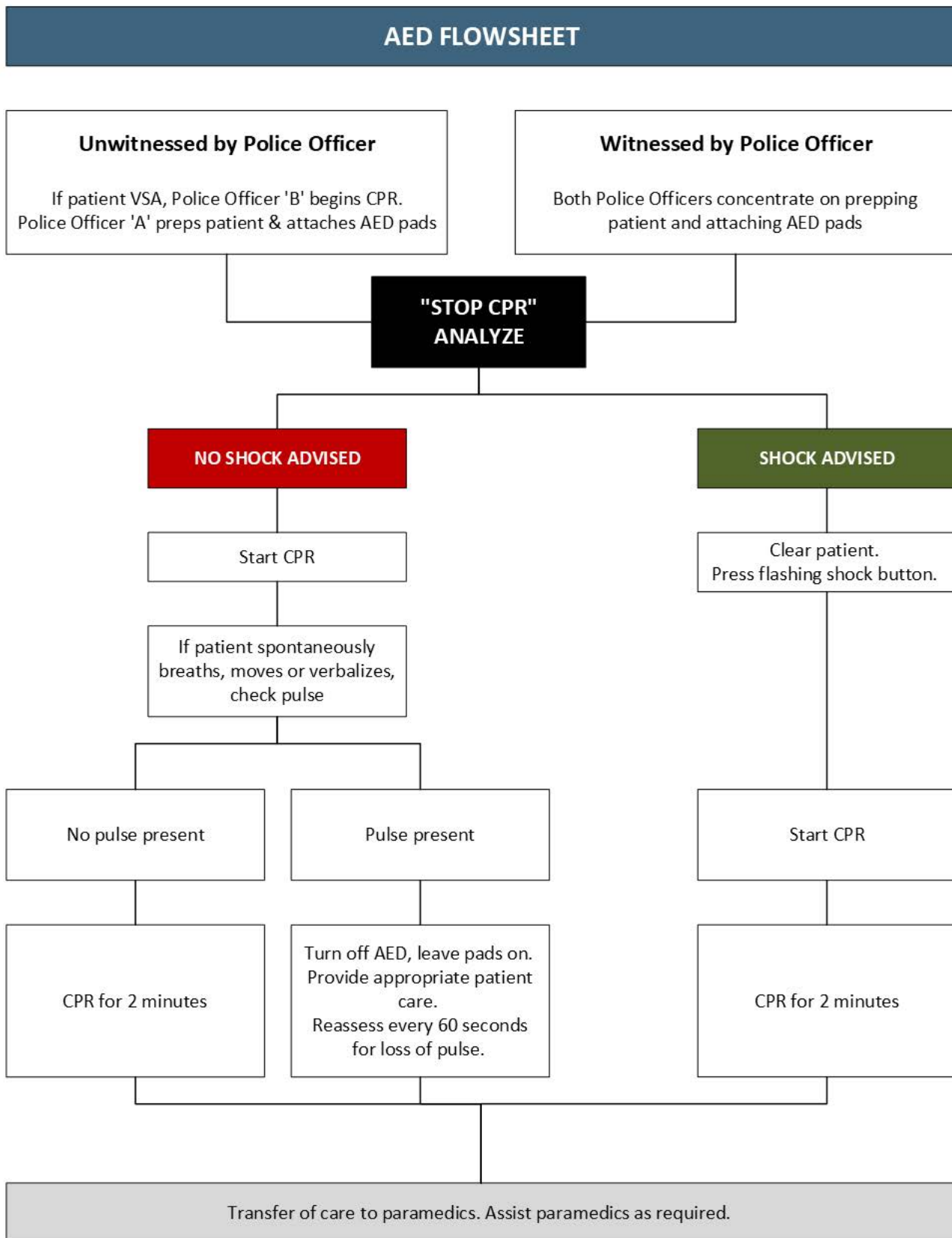
In pediatric patients, if the pulse is less than 60 with signs of poor perfusion (altered mental status, mottling, cyanosis) despite support of adequate oxygenation and ventilation, start chest compressions.

For hypothermic cardiac arrest, If possible, remove or protect the patient from exposure to the elements. Immediately initiate measures to reduce heat loss. Cut off all wet clothing and cover the patient as quickly as possible with blankets if available.

CARDIAC ARREST FLOWSHEET



NOTE: Switch Police Officer 'A' and Police Officer 'B' at each analyze



Re-Arrest Medical Directive

Indications

Re-arrest after a non-traumatic cardiac arrest ROSC

Conditions

Vital Signs Absent/Pulseless

Age > 24 hours

Re-arrest occurs after implementation of **Medical Cardiac Arrest Directive**

Contraindications

Cardiac arrest as a result of trauma

Treatment

1. Provide CPR until AED turned on.
2. As the defibrillation pads will still be on the patient, the AED will auto analyze when turned on again.
3. Once analysis is complete deliver shock if indicated.
4. Once the shock is delivered, continue with your **Medical Cardiac Arrest Directive**.

Clinical Considerations

Ensure your update to firefighters and/or paramedics includes the number of shocks administered in the “new” arrest, not total shocks given.

Trauma Cardiac Arrest Medical Directive

Indications

Suspected of having a traumatic cardiac arrest, defined as obvious severe injuries to the head or torso, or a mechanism of injury likely to cause severe injury (fall from a significant height, motor vehicle collisions, etc.).

Conditions

Vital Signs Absent/Pulseless

Age > 24 hours

Blunt or penetrating trauma

Contraindications

Valid DNR form

Obvious death

Treatment

1. Use the ***Medical Cardiac Arrest Directive Treatment*** At any point in the treatment, if “No shock advised” voice prompt occurs, turn off the defibrillator after receiving the “Start CPR” voice prompt. Continue CPR and ventilations once a “No shock advised” voice prompt occurs and do not do any further analysis.
2. If possible, protect the patient from exposure to the elements. Cover the patient as quickly as possible with blankets.
3. Always maintain C-spine precautions and avoid unnecessary movement of the patient.

Clinical Considerations

NA



Foreign Body Airway Cardiac Arrest Medical Directive

Indications

Cardiac arrest secondary to presumed airway obstruction from a foreign body

Conditions

Vital Signs Absent/Pulseless

Patient ≥ 24 hours of age

Contraindications

Valid DNR form

Obvious death

Treatment

1. Follow the ***Medical Cardiac Arrest Directive***.
2. At any time in your care prior to ventilating the patient, ensure you visualize and clear the airway.
3. If a foreign body is visualized, do not insert any airway adjunct until you are able to clear the airway and successfully ventilate the patient. If no foreign body is visualized, an airway adjunct may be used if unable to adequately ventilate with BVM alone.
4. If you are unable to clear the airway, continue with your directive and update paramedics.

Clinical Considerations

NA

Newborn Resuscitation Medical Directive

Indications

Newborns less than 24 hours of age and in need of resuscitation

Conditions

Age < 24 hours

Contraindications

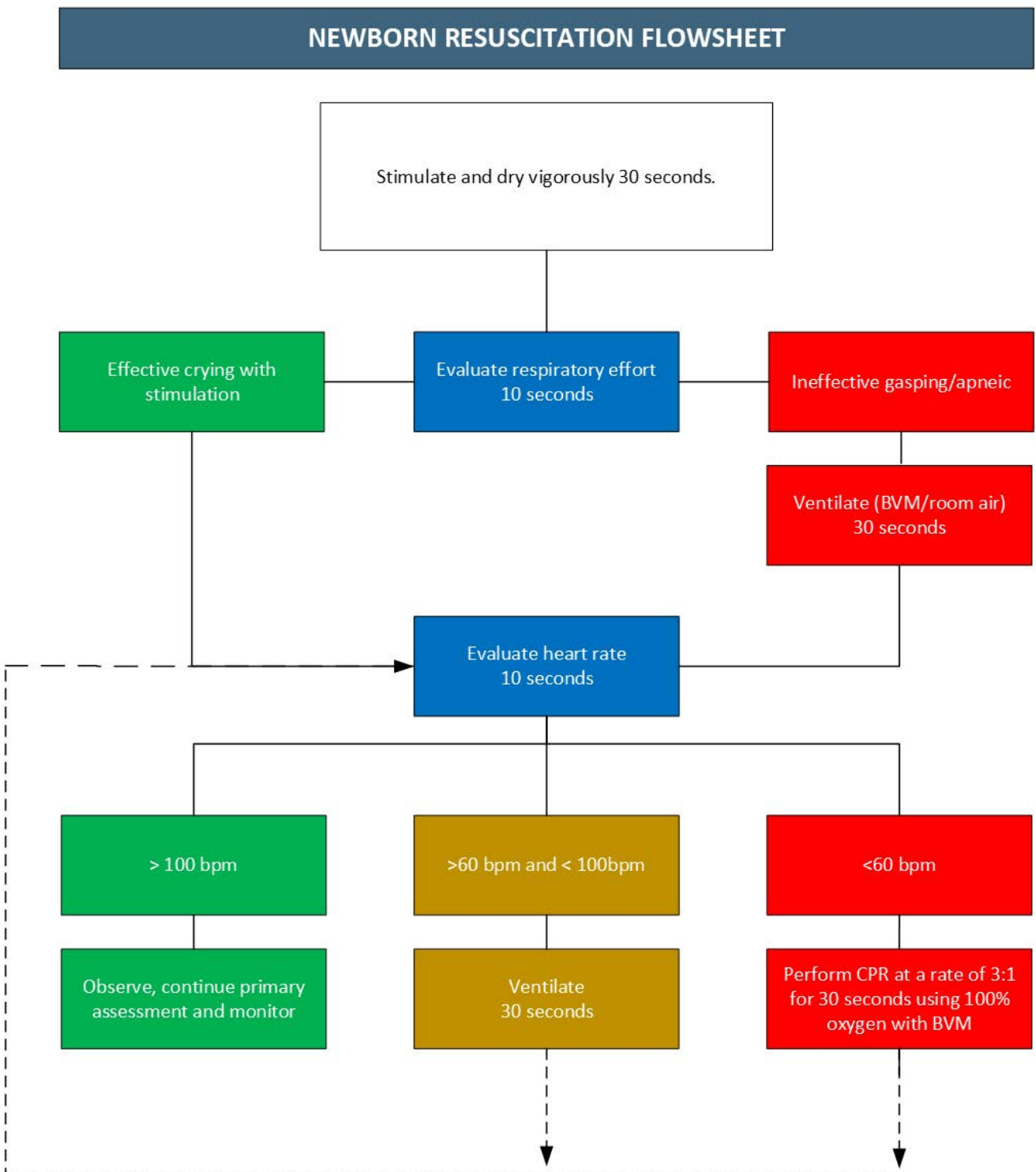
Obvious death

Treatment

1. Assess newborn for the presence of meconium, breathing, crying, muscle tone, and colour.
2. If resuscitation required, clamp umbilical cord with 2 clamps and cut umbilical cord between the clamps.
3. Provide warmth, position, and clear the airway.
4. Dry, stimulate and reposition the airway.
5. Evaluate respiration, heart rate and colour.
6. Provide positive pressure ventilation if newborn is apneic or HR < 100.
7. If HR < 60 despite adequate oxygenation and ventilation, continue to provide positive pressure ventilation and administer chest compressions at a ratio of 3:1 (compression/ventilation).

Clinical Considerations

NA.



Cardiac Arrest Special Consideration

Compression Only CPR

Compression-only CPR means performing only uninterrupted chest compressions at a rate of 100 to 120 compressions per minute without administering ventilations. Circulating the blood without ventilations uses the blood's own store of oxygen which can last several minutes. It is performed only until the defibrillation pads have been attached and all airway equipment is readied. Following this, CPR with ventilations will be used.

High Quality CPR and Defibrillation

AEDs can provide real-time CPR feedback to help deliver at least two inch chest compressions, at a rate of 100 compressions per minute, with full chest recoil between compressions.

There are several key elements to providing high quality CPR:

- Minimize delays. Rapidly move the patient to a flat/firm area, start CPR, and apply the AED.
- Minimize interruptions in CPR. Every interruption in CPR decreases blood flow to vital organs.
- If there is a "No shock advised", resume CPR without a pulse check. This increases the amount of time spent providing blood flow to the brain and vital organs.
- Provide deep compressions, allowing full chest recoil so that blood is pumped out of the chest with each compression, and flows back with each up-stroke.
- Follow the CPR feedback prompts. Listen for the "Good compressions" prompt. Match the compressions to the rate of the metronome beeps and watch the depth gauge on the AED to provide at least two-inch chest compressions.
- Follow the voice prompts. Stop CPR only when prompted by the defibrillator, and resume immediately when prompted to do so.

Cardiac Arrest Witnessed by Police Officers

The priority is to immediately apply the AED and deliver a shock as soon as possible if prompted. Turn on the AED when the patient arrests. Start CPR if it takes more than a few seconds to apply the AED electrodes.

Transfer of Care from a Public Lay Responder Using an AED to a Police Officer

Assess the patient's level of awareness and pulse.

- If the patient has **no pulse**, follow the ***Transfer of Care from an AED Equipped Public Lay Responder*** and the ***Medical Cardiac Arrest Medical Directives***.

- If the patient has **a pulse and has received shocks**, apply the Police Service AED but do not turn it on. Be prepared in the event of a re-arrest.
- If patient has **a pulse and has received no shocks** they may not have ever been VSA.

Provide medical care appropriate for the patient's condition.

Pacemaker

If possible, avoid putting the defibrillator pads over or near the pacemaker as the AED may damage the implanted pacemaker.

Infant and Child Cardiac Arrests

The AED 3 may be used on children and infants of any age. Newborn (under 24 hours old) are treated according to protocols outlined in the ***Newborn Resuscitation Directive*** (no AED needed for under 24 hours old).

If a child or infant suffers a cardiac arrest, start compression-only CPR at 100-120 compressions per minute and apply the AED. When ready, start ventilations at a compression to ventilation ratio of 15:2. Use only enough air for ventilation to achieve visible chest rise.

For children over one year, use the heel of one hand for chest compressions. Compress the chest so that it is depressed one-third to one-half its original depth. For infants (< 1 year), use two fingers and compress the chest so that it is depressed one-third to one-half its original depth.

Postpartum Cardiac Arrest

In a situation whereby a cardiac arrest occurs in a postpartum patient and the neonate is still attached to the patient via the umbilical cord, a police officer may place 2 clamps on the umbilical cord and cut between the clamps. This can be done at the discretion of the police officer in order to provide cardiac arrest care to the postpartum patient.

Conductive Surfaces

It is safe to proceed with cardiac arrest protocols on ice, snow, wet grass or concrete/ pavement, etc. However, if a patient is lying on metal or in a puddle, move the patient to a suitable surface and begin cardiac arrest protocols.

CPR Pearls

	Patient	Patient Definition	CPR	Patient Reassessment
HR < 60 with signs of poor perfusion = CPR	Newborn	< 24 hours old	3:1	q 30 seconds
	Infant/Child	≥ 24 hours old to no signs of puberty	1 rescuer 30:2	q 2 minutes
			2 rescuers 15:2	
	Adult	Puberty and beyond	30:2	q 2 minutes

Puberty: Breast development in females & the presence of axillary hairs in males.

Once 100% O2 via PPV has been initiated (with HR < 60 & initiation of CPR) continue to deliver 100% O2 until monitored HR is ≥ 100; we no longer discontinue 100% O2 once HR > 60. Once HR ≥ 100 supportive care only.



Transfer of Care from an AED-Equipped Public Lay Responder Therapy Medical Directive

Indications

Potential cardiac arrest patient where an AED has been applied by a lay responder

Conditions

Potential cardiac arrest

Contraindications

N/A

Treatment

1. Assume care of the patient immediately. Do not operate any AED other than the Police Service supplied AED, except to turn off and remove a lay responder AED.
2. Identify yourselves as a police officer to the lay responder and determine how many shocks (if any) have been delivered.
3. When taking over care, check responsiveness and check for a carotid pulse. Simultaneously, assist the lay responder to turn off and remove their AED and defibrillation pads
4. If no carotid pulse is present, follow **Medical Cardiac Arrest Directive**.
5. If a carotid pulse is found, and the patient has previously been shocked by the lay responder, apply your AED. These patients are very likely to arrest again. Support ventilation, monitor the patient closely for chest rise, and perform frequent carotid pulse checks. Obtain a set of vital signs. If the patient re-arrests, immediately turn on the Police Services' AED and push the "ANALYZE" button, and begin chest compressions. Follow the appropriate medical cardiac arrest directive.
6. If a carotid pulse is found, and the lay responder has delivered no shocks, do not assume the patient was VSA. Do not apply your AED. Support ventilation if necessary and perform frequent carotid pulse checks and assess vital signs. Be prepared to initiate the cardiac arrest medical directives if the patient loses their carotid pulse.
7. Obtain history from the lay responder. Use the lay responder if necessary in other aspects of scene management (e.g. translation).
8. Instances may occur where an advanced-trained lay responder (such as an off duty paramedic, nurse, or health care worker) is providing advanced care beyond the police officers' scope of practice. In these rare cases, the police officer should offer assistance and assume a supportive role.

Clinical Considerations

NA

Southwest Centre for Prehospital Medicine

Airway/Breathing

Suspected Opioid Toxicity Medical Directive

Suspected Opioid Toxicity Medical Directive

Indications

Suspected opioid toxicity

AND

Altered LOC

AND

Respiratory depression

Conditions

≥ 12 years of age

Has an altered LOC

RR < 10 breaths per minute

Contraindications

NA

Treatment

1. Assess level of responsiveness, airway, breathing and carotid pulse. no carotid pulse, initiate CPR and follow cardiac arrest directive. **Naloxone is not to be administered during a cardiac arrest.**
2. Stimulate patient and determine if there is a change in responsiveness. Stimulation alone may reverse respiratory depression and restore adequate breathing. Ensure airway patency if needed.
3. If after stimulation the respiratory rate is < 10 breaths per minute prepare to administer naloxone. The police officer should ventilate the patient with the BVM while the naloxone is being prepared to be given. BVM should continue until the patient's RR is greater than 10 or patient no longer tolerates it.
4. Administer 4 mg naloxone intranasal into one nostril.
5. Document time of administration and which nostril was utilized.
6. Reassess patient's level of responsiveness, airway, breathing, carotid pulse.
7. A second dose of naloxone can be administered 5 min after the first dose if the patient continues to have a decreased LOC and a RR of <10

Transfer care to firefighters or paramedics. Report the time medication administered, dose administered, nostril utilized and the patient's response to treatment.

Clinical Considerations

Naloxone may take three to eight minutes to take effect. It is shorter acting than most narcotics, so patients are at risk of recurrence of opioid toxicity when it wears off.

In a mixed overdose situation, the use of naloxone may be ineffective or may unmask the effects of other drugs the patient may have used, which may lead to the patient experiencing seizures, severe high blood pressure or becoming extremely combative. Police officers should protect themselves accordingly.

Gastrointestinal (GI) symptoms such as nausea, vomiting and movement of the patient's bowels sometimes occur following naloxone administration. The police officer should be prepared to manage the patient's airway in the event of vomiting when the patient has a decreased level of consciousness.

References



References

Commonly Used Abbreviations

A

ACP	advanced care paramedic
AED	automated external defibrillation

B

BLS	basic life support
BPM	beats per minute
BVM	bag-valve-mask

C

cm	centimetre
CPR	cardiopulmonary resuscitation

D

DNR	do not resuscitate
-----	--------------------

E

ED	emergency department
----	----------------------

F

FBAO	foreign body airway obstruction
------	---------------------------------

G

GCS	Glasgow coma scale
-----	--------------------

H

HR	heart rate
----	------------

I

IN	intranasal
----	------------

J

J	joule
---	-------

K

kg	kilogram
----	----------

L

LOA	level of awareness
LOC	level of consciousness

M		
max.	max.	maximum
MOH	MOH	Ministry of Health
N		
N/A	N/A	not applicable
NPA	NPA	nasopharyngeal airway
O		
OPA	OPA	oropharyngeal airway
P		
PCP	PCP	primary care paramedic
PEA	PEA	pulseless electrical activity
PPE	PPE	personal protective equipment
R		
ROSC	ROSC	return of spontaneous circulation
RR	RR	respiratory rate
S		
SBP	SBP	systolic blood pressure
T		
TOR	TOR	termination of resuscitation
V		
VF	VF	ventricular fibrillation
VSA	VSA	vital signs absent
VT	VT	ventricular tachycardia

DNR Confirmation Form



Ministry of Health
and Long-Term Care



Office of the
Fire Marshal

Serial Number _____

Do Not Resuscitate Confirmation Form To Direct the Practice of Paramedics and Firefighters after February 1, 2008 *Confidential when completed*

When this form is signed by a physician (M.D.), registered nurse (R.N.), registered nurse in the extended class (R.N. (EC)) or registered practical nurse (R.P.N.), a paramedic or firefighter **will not** initiate basic or advanced cardiopulmonary resuscitation (CPR) (see point #1) and **will** provide necessary comfort measures (see point #2) to the patient named below:

Patient's name – please print clearly

Surname

Given Name

1. "Do Not Resuscitate" means that the paramedic (according to scope of practice) or firefighter (according to skill level) **will not** initiate basic or advanced cardiopulmonary resuscitation (CPR) such as:
 - Chest compression;
 - Defibrillation;
 - Artificial ventilation;
 - Insertion of an oropharyngeal or nasopharyngeal airway;
 - Endotracheal intubation;
 - Transcutaneous pacing;
 - Advanced resuscitation drugs such as, but not limited to, vasopressors, antiarrhythmic agents and opioid antagonists.
2. For the purposes of providing comfort (palliative) care, the paramedic (according to scope of practice) or firefighter (according to skill level) **will** provide interventions or therapies considered necessary to provide comfort or alleviate pain. These include but are not limited to the provision of oropharyngeal suctioning, oxygen, nitroglycerin, salbutamol, glucagon, epinephrine for anaphylaxis, morphine (or other opioid analgesic), ASA or benzodiazepines.

The signature below confirms with respect to the above-named patient, that the following condition (check one ☒) has been met and documented in the patient's health record.

- ☐ A current plan of treatment exists that reflects the patient's expressed wish when capable, or consent of the substitute decision-maker when the patient is incapable, that CPR not be included in the patient's plan of treatment.
- ☐ The physician's current opinion is that CPR will almost certainly not benefit the patient and is not part of the plan of treatment, and the physician has discussed this with the capable patient, or the substitute decision-maker when the patient is incapable.

Check one ☒ of the following:

☐ M.D. ☐ R.N. ☐ R.N. (EC) ☐ R.P.N.

Print name in full

Surname

Given Name

Signature

Date (yyyy/mm/dd)

- Each form has a unique serial number.
- Use of photocopies is permitted only after this form has been fully completed.

The following 4 areas must be completed to validate the DNRC Form:

Ontario Ministry of Health and Long-Term Care Office of the Paramedics

Do Not Resuscitate Confirmation Form
To Direct the Practice of Paramedics and Firefighters after February 1, 2008
Confidential when completed

When this form is signed by a physician (M.D.), registered nurse (R.N.), registered nurse in the extended class (R.N. (EC)) or registered practical nurse (R.P.N.), a paramedic or firefighter will not initiate basic or advanced cardiopulmonary resuscitation (CPR) (see point #1) and will provide necessary comfort measures (see point #2) to the patient named below.

Patient's name – please print clearly
Surname _____ Given Name _____

1. "Do Not Resuscitate" means that the paramedic (according to scope of practice) or firefighter (according to skill level) will not initiate basic or advanced cardiopulmonary resuscitation (CPR) such as:

- Chest compression;
- Defibrillation;
- Artificial ventilation;
- Insertion of an oropharyngeal or nasopharyngeal airway;
- Endotracheal intubation;
- Transcutaneous pacing;
- Advanced resuscitation drugs such as, but not limited to, vasopressors, antiarrhythmic agents and opioid antagonists.

Unique Serial Number

epinephrine, glucagon, epinephrine for anaphylaxis, morphine (or other opioid analgesic), ASA or benzodiazepines

1. Must have Unique Serial Number

Ontario Ministry of Health and Long-Term Care Office of the Paramedics

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Patient's name – please print clearly
Surname _____ Given Name _____

2. Patient must be identified and positive ID made

Ontario Ministry of Health and Long-Term Care Office of the Paramedics

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Patient's name – please print clearly
Surname _____ Given Name _____

3. One of tick boxes must be completed

Ontario Ministry of Health and Long-Term Care Office of the Paramedics

Do Not Resuscitate Confirmation Form
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Confidential when completed

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Patient's name – please print clearly
Surname _____ Given Name _____

4. All areas must be completed

Ontario Ministry of Health and Long-Term Care Office of the Paramedics

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To Direct the Practice of Paramedics and Firefighters after February 1, 2008
Confidential when completed

When this form is signed by a physician (M.D.), registered nurse (R.N.), registered nurse in the extended class (R.N. (EC)) or registered practical nurse (R.P.N.), a paramedic or firefighter will not initiate basic or advanced cardiopulmonary resuscitation (CPR) (see point #1) and will provide necessary comfort measures (see point #2) to the patient named below.

Patient's name – please print clearly
Surname _____ Given Name _____

5. Intervention Options

Guidelines & Policies

Guidelines for Interaction with a Physician on Scene

Purpose

On occasion, a physician may be on scene rendering care to a patient. The police officer will continue to treat the patient following accepted directives unless the attending physician wishes to deviate from accepted protocols and the physician assumes full medical responsibility for the patient. If a physician indicates he/she would like the police officers to deviate from their protocol, police officers need to communicate the following to the physician:

Procedure

1. If the caregiver identifies themselves as a physician, identify yourself as police office certified by a medical director to use the AED.
2. If police officers have already initiated care, give the physician a brief verbal report that includes the following information:
 - Witnessed or unwitnessed cardiac arrest
 - The number of shocks you have delivered, if any
 - Whether there has been a ROSC.
3. Request permission to continue your directive using the AED (Do not assume the physician knows how to use it).
4. Follow instructions given to you by the physician on-scene within the limits of your training and SWCPM Medical Directives.
5. Allow the physician to use the Police Service AED at his/her request.
6. Be prepared to resume your Medical Directives at any time upon the request of the physician.
7. Document the physician's name.

Guidelines for Cardiac Arrest Transfer of Care to Firefighters and/or Paramedics

Purpose

Optimal patient care depends on resource coordination and communication. It is the responsibility of all police officers to assist firefighters and/or paramedics with ongoing Basic and Advanced Life Support Protocols and to ensure a smooth transfer of patient care to the paramedics.

Procedure

1. A police officer will provide a verbal report that includes the following:
 - Witnessed or unwitnessed arrest
 - Presence or absence of bystander CPR, who initiated CPR, how long CPR had been performed
 - Time patient was last seen before collapse/arrest
 - Total number of shocks
 - Total number of “No shock advised” prompts that were received
 - Presence or absence of a return of spontaneous circulation
 - Vital signs, if obtained on a patient with a pulse
2. Firefighters and/or paramedics will switch to their own defibrillator at next Police Service AED analysis. If first on scene, police officers must attempt to COMPLETE AT LEAST ONE ANALYZE CYCLE before handing over care. Once the analysis has begun, police officers will complete the analysis and shock if indicated.
3. A police officer who is completing compression-only CPR, waiting for the AED to perform a rhythm analysis, or delivering a shock shall continue until completion of that task before handing over care.

Guidelines for Determination of Obvious Death

Purpose

On occasion, police officers may respond to a call where the patient has experienced a cardiac arrest and given the length of time between the onset of the arrest and police officers arrival, or mechanism of death, any resuscitative efforts would be futile. The police officer may withhold cardiac arrest care if obvious death has occurred.

Conditions

Means death has occurred if gross signs of death are obvious, including by reason of:

1. Decapitation, transection, visible decomposition, putrefaction; or
2. Absence of vital signs and:
 - a. a grossly charred body;
 - b. an open head or torso wound with gross outpouring of cranial or visceral contents;
 - c. gross rigor mortis (i.e. limbs and/or body stiff, posturing limbs or body); or
 - d. dependent lividity (i.e. fixed, non-blanching purple or black discolouration of skin in dependent areas of body)

Procedure

1. The police officer must be certain that obvious death has occurred.
2. Resuscitation efforts can be withheld.
3. Full resuscitative efforts must be made immediately if any doubt exists.
Always err on the side of resuscitation if you are uncertain whether obvious death exists.

Clinical Considerations

Hypothermic patients can exhibit many signs of rigor mortis. Never assume death in a hypothermic patient.

Guidelines for Prehospital DNR and Expected Death

Purpose

If a MOH DNR is available, stopping unwanted resuscitation efforts is a compassionate response to patients at the end of their lives.

Procedure

1. When police officers arrive at the scene of a cardiac arrest, they will initiate patient care as per their directives.
2. If presented with a MOH DNR Confirmation Form (or photocopy), police officers (usually the Officer in Charge) will verify that it bears a serial number in the upper right, and that **all** of the following four items are completed correctly:
 - Correct name of patient
 - A check mark in one of the boxes indicating CPR is not part of the plan of treatment
 - Name and profession of the health care provider
 - Signature and date when the form was completed
3. No other type of DNR form may be accepted by police officers.
4. Verbal orders to discontinue resuscitative efforts made by a physician at the scene will be respected. The police officer must be satisfied that the person making the request is indeed a physician licensed to practice in Ontario. Before the police officer authorizes stopping resuscitation, the physician must indicate that s/he will assume responsibility for the patient. If the physician does not comply with the requests of the police officer, the **Medical Cardiac Arrest Directive** will be initiated.

Clinical Considerations

Despite the presence of a valid MOH DNR form, the Power of Attorney (POA) can decide to reverse the DNR status. In these cases, listen to the POA. The POA should be assumed to be acting in the best interests of the patient.

Guidelines for Expected Death in the Home When There is No DNR Confirmation Form

Purpose

These guidelines are intended to provide police officers with clear procedures to follow when faced with caregivers or family members who refuse to allow resuscitation of a patient.

Conditions

These guidelines are intended for use only in cases of expected death in residences and only when there is no accompanying MOHLTC DNR Confirmation Form. Various factors at the scene can substantiate the expected nature of a death. These may include but are not limited to:

- history of a terminal illness presented to the police officer,
- evidence of physical wasting (e.g. gaunt or emaciated appearance)
- catheters in place in the patient (plastic tubes leading from the patient's nose, mouth, chest or abdomen)
- presence of home care equipment in the home (hospital-type bed, intravenous equipment, bedpans, urinals, etc.)
- presence of highly potent narcotic analgesics such as morphine, hydromorphone or oxycodone in tablet or intravenous form.

Procedure

1. In all cases where a VSA patient is encountered, full resuscitation, including defibrillation if indicated, must be initiated.
2. If a family member or caregiver refuses to allow resuscitation, or requests the police officer not resuscitate the patient, the police officer will ask if the family has a MOH DNR Confirmation Form. If they do not produce one, the officer will explain the obligations of the police officers to resuscitate.
3. If the family member or caregiver again refuses resuscitation, or again asks that no resuscitation occur, the officer will again explain the obligation to resuscitate and proceed with resuscitation.
4. If the officer determines that continuing or attempting resuscitation could result in physical or verbal confrontation, resuscitation attempts can be discontinued.
5. Report family's refusal to paramedics arriving on scene.
6. Complete documentation is essential in these cases. Full documentation of the incident including circumstances of the call, observations at the scene, assessment of the patient, discussions with the family member(s) or caregiver(s), and actions taken should occur.

Police Officer Certification Policy

Ongoing competence in the medical directives is demonstrated by meeting the standards set out below by the Medical Director. A police officer must be certified by the Medical Director to perform medically delegated acts. Certification and on-going training is provided through the Training Division.

Procedure

To demonstrate continuing competency in the medical directives, the following must take place:

1. The police officer must re-certify every year to the standards set by the Medical Director.
2. Protocols must be followed at all times.
3. The police officer must not have had two or more major infractions to protocols, policy or procedures in any 12-month period.

Failure to meet any of the above criteria may result in deactivation of the police officer until a meeting has been held with Medical Director.

MAJOR INFRACTION TO A MEDICAL DIRECTIVE

A major infraction to a protocol is defined as a procedure or omission that could have a potentially detrimental impact on either patient outcome or provider and bystander safety. Two or more major infractions to protocols, policy or procedures in any 12-month period may result in decertification. Examples include:

- Not shocking a patient when instructed to do so by the AED when patient is in a shockable rhythm.
- Not taking the AED to patient in cardiac arrest.
- Injury to bystander when shocking a patient.

If a major infraction to protocol, policy or procedure has occurred, the Medical Training Officer must contact the police officer within 10 calendar days of being made aware (holidays and vacation notwithstanding). Verification of clinical protocols, policies and procedures will take place between the police officer and the Medical Training Officer.

Deactivation and Decertification Policy

The Medical Director has the right to deactivate a police officer for any obvious or suspected major infraction at any time, pending an investigation. The Medical Director is the only one that has the authority to decertify a police officer.

SWCPM will consider a police officer to be deactivated if he/she has had a hiatus from working in the field as a police officer for a period of 1 year or longer, or has not participated in the yearly re-certification.

Procedure

1. Deactivation will be initially communicated to the police officer in person if possible or by phone. Follow-up written notification will come from the Medical Director or his designate.
2. Recertification of the police officer will be granted at the discretion of the Medical Director or his designate and once the police officer has demonstrated competence.
3. The Medical Training Officer, following direction of the Medical Director, will provide the appropriate training:
 - a. Informal re-fresher or follow-up training.
 - b. Review of yearly Continuing Medical Education (CME).
4. Deactivation will be communicated to the police officer by phone and in writing as part of the back to work procedure as dictated by the Police Service.
5. The Medical Training Officer will provide a re-activation course for the deactivated police officer if indicated by the Police Service in the back to work procedure.
6. Decertification/Deactivation and Recertification/Reactivation of a police officer will be communicated to the Police Chief or their designate.
7. Decertification/Deactivation, remedial activities and Recertification/Reactivation of a police officer will be recorded and appropriate files will be maintained by the Police Service Training Division.

SWCPM Documentation Standards

Documentation Standard

- Medical Assist Records (MAR) should be submitted in either written or electronic format
- Information contained in reports shall be of a completeness and quality suitable for use as evidence in an investigation or legal proceeding
- A Medical Assist Record (MAR) shall be completed for each instance where a firefighter or police officer performs a medically delegated act or attends a medical call. This includes documentation of at least one full set of vitals to the scope of the providers practice (heart rate, blood pressure, respiratory rate, SpO2 and temperature).
- Each Fire Service or Police Department may use their own approved MAR or the Southwest Centre for Pre-Hospital Medicine (SWCPM) provided MAR.
- The Fire Service or Police Department is required to provide biometric data to the SWCPM for calls where the AED is utilized
- In each instance a firefighter or police officer performs a medically delegated act a MAR must be completed and contain the below information:
 - Incident number
 - Date
 - Name of firefighter or police officer completing the form
 - Location of event
 - Platoon
 - Vehicle number
 - Time on scene
 - Time of patient contact
 - Time of transfer of care
 - Patient name
 - Patient date of birth
 - Patient sex
 - Patient address
 - Chief Complaint:
 - Medical VSA *or*
 - Trauma VSA *or*
 - Suspected Opioid Overdose *or*
 - Anaphylaxis *or*
 - Other: _____
 - Level of Consciousness
 - Alert *or*
 - Rouses to verbal stimuli *or*
 - Rouses to painful stimuli
 - Incident History

- Full set of Vitals (patient is not in cardiac arrest) to the scope of the responder's practice
 - Heart Rate
 - Blood pressure
 - Respiratory Rate
 - SpO2
 - Temperature (If equipment available)
 - SpCO (If equipment available and suspicion for CO toxicity)
- Any additional pertinent information related to the call
- In instances of Trauma VSA or Medical VSA the below information must be included:
 - Time CPR initiated
 - Who initiated CPR:
 - Firefighter *or*
 - Bystander *or*
 - Police Officer
 - Arrest witnessed by:
 - Not witnessed *or*
 - Fire *or*
 - Police *or*
 - Bystander
 - Defibrillation
 - Time AED applied
 - 1st shock provided by
 - Fire *or*
 - Police *or*
 - Bystander
 - Additional defibrillation attempts
 - Include "Shock" and "No Shock" prompts from AED
- In the instance of airway interventions, the below interventions must be included:
 - Amount of oxygen provided
 - Type of airway utilized
 - OPA (including size inserted) *and/or*
 - BVM *and/or*
 - Oxygen mask:
 - Nasal Prongs *and/or*
 - Non-rebreather mask
- In the instance of medication administration (if authorized), the below information must be included:
 - Name of medication
 - Route of Medication
 - Intramuscular – include location of injection
 - Intranasal – include which nares
 - Dose of medication
 - Time medication administered



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