MEMORANDUM

TO: **Ontario Paramedics**

FROM: **Ontario Base Hospital Group Education Subcommittee (OBHG ESC)**

DATE: **July 11, 2023**

RE: **Advanced Life Support Patient Care Standards (ALS PCS) Version 5.2 Update — Impact on Clinical Practice and Educational Summary**

On July 10, 2023, version 5.2 of the ALS PCS was put into effect by the Ministry of Health (MOH). This communication memo will focus on the impact of clinical practice on patient care within the ALS PCS v.5.2 utilized by Ontario paramedics. It is the responsibility of the paramedic to ensure they have reviewed all aspects of the ALS PCS and medical directives in their entirety.

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Preamble

The ALS PCS v5.2 included amendments to various sections of the document to help simplify the wording and provide clarification to ensure paramedic understanding. Paramedics are encouraged to review this section.

CORE MEDICAL DIRECTIVES

1. Opioid Toxicity and Withdrawal

The opioid epidemic is currently a leading health crisis in Ontario, with some communities having high opioid-related mortality rates. Having evidence-based strategies in place supporting treatment options at different care access points is critical in addressing Opioid Use Disorder in the community. Current evidence supports treatment with medication for Opioid Use Disorder as being the most effective treatment strategy to combat this illness. The Opioid Medical Directive now includes the medication buprenorphine/naloxone for patients experiencing withdrawal symptoms. Paramedics must be trained and authorized by their Regional Base Hospital to administer buprenorphine/naloxone.

INDICATIONS (REVISED)

Current	Previous
Suspected opioid toxicity	Altered LOC; **AND** Respiratory depression; **AND** Inability to adequately ventilate; OR persistent need to assist ventilations; **AND** Suspected opioid overdose.

CONDITIONS (REVISED)

Naloxone		
	Current	**Previous**
Age	≥ 24 hours	≥ 24 hours
LOA	Altered	Altered
HR	N/A	N/A
RR	< 10 breaths/min	< 10 breaths/min
SBP	N/A	N/A
Other	Inability to adequately ventilate; **OR** persistent need to assist ventilations;	N/A

CONDITIONS (NEW)

Buprenorphine/naloxone (if authorized)	
	Current
Age	≥ 16
LOA	Unaltered
HR	N/A
RR	N/A
SBP	N/A
Other	Received naloxone for current opioid toxicity episode **AND** Patient is exhibiting acute withdrawal with a COWS score ≥ 8

CONTRAINDICATIONS (NEW)

Buprenorphine/naloxone (if authorized)
Allergy or sensitivity to buprenorphine
Taken methadone in the past 72 hours

TREATMENT (NEW)

Buprenorphine/naloxone	
Route	PO
Initial dose	16 mg
Subsequent dose(s)	8 mg
Dosing interval	10 minutes
Max. cumulative dose	24 mg

2. Nausea and Vomiting

DimenhyDRINATE can now be administered to patients ≥ 65 years old if ondansetron is unavailable. This addition replaces the MOH memo released in early April due to an ondansetron medication shortage.

CLINICAL CONSIDERATIONS (NEW)

– dimenhyDRINATE can be used in patients ≥ 65 years old if ondansetron is not available

3. Seizure – Discharge from Care

The OBHG Education and Companion Document have been updated to clarify the Seizure Medical Directive for Discharge from Care. There is no change to the medical directive itself. The criteria states, “The patient must not have a fever, preceding illness or recently started a new medication.” The intention is to identify new medications or changes (dosage or type) to medications in the past 30 days that can affect the patient’s seizure threshold. These pharmaceutical changes can potentially lower a patient’s seizure threshold. These patients would not qualify for prehospital discharge from care. In the event of unusual circumstances or further consultation is required about the identified medication, patch to your Base Hospital Physician.

AUXILIARY MEDICAL DIRECTIVES – SPECIAL EVENT

The Special Events Auxiliary Medical Directives have been revised to follow the conventional format of auxiliary medical directives. These are for time-limited periods when a mass gathering could potentially strain the resources of the host community. These medical directives shall only be used by paramedics who are trained and authorized by their Regional Base Hospital.

1. Applies to All Special Event Auxiliary Medical Directives

INDICATIONS (REVISED)

Current	Previous
AND A mass gathering that could potentially strain the resources of the host community **AND** The special event directive has been authorized for use by the Medical Director for a specific mass gathering	**AND** Special event: a preplanned gathering with potentially large numbers of people and the Special Event Medical Directives have been pre authorized for use by the Medical Director.

2. Minor Allergic Reaction – PCP and ACP

CONDITIONS – DIPHENHYDRAMINE (REVISED)

Conditions	Current	Previous
HR	N/A	Within normal limits (WNL)
RR	N/A	Within normal limits (WNL)

3. Musculoskeletal Pain – PCP and ACP

TREATMENT – ACETAMINOPHEN (REVISED)

Treatment	Current	Previous
Dose	960 – 1000 mg	325 - 650 mg
Max. Single Dose	960 – 1000 mg	650 mg

4 Headache – PCP and ACP

TREATMENT – ACETAMINOPHEN (REVISED)

Treatment	Current	Previous
Dose	960 – 1000 mg	325 - 650 mg
Max. Single Dose	960 – 1000 mg	650 mg

AUXILIARY MEDICAL DIRECTIVES – CHEMICAL EXPOSURE

The Auxiliary Chemical Exposure Medical Directives are now split into PCP and ACP auxiliary medical directives from a singular medical directive to follow the conventional layout.

Paramedics may only perform the auxiliary delegated acts if trained and authorized to provide chemical exposure treatment and if it is part of their authorized scope of practice. For questions regarding authorization, please contact your Regional Base Hospital.

1. Cyanide Exposure

This medical directive has updated Indications and Conditions to provide better clarity and match conventional medical directives. The medications have remained the same but the dosage charts have been updated for simplicity. PCPs may administer the medications intravenously if authorized for PCP Autonomous IV and, for ACPs, the additional routes of IO/CVAD have been added. Lastly, a mandatory patch point has been introduced for authorization to proceed with the administration of hydroxocobalamin in cases of suspected cyanide toxicity.

INDICATIONS (REVISED)

Current	Previous
Suspected exposure to cyanide **AND** Cardiac arrest, **OR** Altered level of awareness, **OR** Hypotension.	Suspected exposure to cyanide with signs and symptoms of poisoning.

2. Hydrofluoric (HF) Acid Exposure

A couple of additions were added to Clinical Considerations. The reminders include that the administration of ophthalmic anesthetic eye drops should not delay the initiation of eye irrigation, and that nebulizers typically require 2 to 3 mls to ensure appropriate medication administration.

3. Adult and Pediatric Nerve Agent Exposure – Summary

A few changes have occurred to the Nerve Agent Exposure Medical Directive. These include:

1. The indications and conditions in the adult and pediatric directives are now the same.
2. Obidoxime is no longer a treatment option.
3. Midazolam has been added as an alternative treatment option to diazePAM; however, diazePAM is the preferred treatment option if available.
4. Atropine administration is now only administered via intramuscular injection.
5. The auto-injector column has been removed from treatment as it is not a route.
6. Pediatric treatment charts have been simplified and aligned with the adult directive.