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August 9, 2021

Mr. Ryan Sinden, Chair
Emergency Medical Assistants Licensing Board
Ministry of Health
PO Box 9625 Stn Prov Govt
Victoria BC V8W 9P1

Dear Mr. Sinden;

Re: Ambulance Paramedics & Emergency Dispatchers of BC (APBC) Submission

The APBC is pleased to present the enclosed submission on the potential for expanded scopes of practice for Emergency Medical Assistants (EMAs) for the Board's consideration.

It is our position that there are two (2) major issues that need to be addressed by the Ministry of Health in order to modernize the regulations; 1) we believe that Schedule 1 and 2 of the regulations should be removed completely, converted into board policy and supported by enabling language in the regulation. 2) we also believe that the designation of "Community Paramedic" needs to be taken out of the Ministerial Order and formalized within the regulations.

As both of these proposed solutions require legislative change, we have included a briefing document on what scopes could be expanded via a ministerial order.

We hope that the Board's recommendations to the Minister on expanded scopes, follow best practices, are grounded in sound medical evidence supporting the change and take into account the relevant competency profiles and foundational educational underpinning of each license level.

Thank you for the opportunity to provide our recommendations. We remain available to provide any clarifying information or additional documentation.

Sincerely,

Dave Deines MStJ CD
Provincial Vice President
Ambulance Paramedics & Emergency Dispatchers of British Columbia
CUPE Local 873

CC: Provincial Executive Board

DD/km/MoveUp



Overview

The following document has been prepared and submitted to provide feedback to the Emergency Medical Assistants Licensing Board (EMALB) on suggested scope of practice changes as a result of the Minister of Health's announcement on July 14th, 2021.

The Ambulance Paramedics and Emergency Dispatchers of British Columbia (APBC) represent over four-thousand, five hundred (4,500) paramedics and dispatchers employed by the British Columbia Emergency Health Services (BCEHS). In addition to the above, as a founding chapter of the Paramedic Association of Canada (PAC), the APBC is the professional voice of paramedicine in British Columbia and advocates for advancement of the profession.

Stakeholder Engagement

As the first step of this submission, the APBC canvassed its entire membership, who represent all levels of BCEHS practitioners.

In addition to practitioner input, we canvassed educators, field mentors, supervisors, managers and other regulators.

Lastly, the National Executive of the Paramedic Association of Canada were involved in the creation of this submission. All suggested scope of practice changes are in line with the National Occupational Competency Profile (NOCP) and are practised throughout other parts of Canada and the world.

Guiding Principles

The following principles have guided the development of this submission:

1. The implementation of any scope of practice addition must be in the best interest of patient care, patient safety and supported by the relevant medical evidence.
2. Any additions must be realistically in line with the education and experience level of Emergency Medical Assistants (EMAs) at a given license level.
3. As much as possible, scope of practice additions should be in line with the Paramedic Association of Canada's 2011 NOCP document.
4. Practice should remain in line with other jurisdictions as much as possible.

Core Guidance Documents

The following sources have been referenced as core guidance documents in support of this submission:

1. BC Emergency Health Services Act
2. BC Emergency Medical Assistants Regulations
3. Paramedic Association of Canada National Occupational Competency Profile
4. Dalhousie University Prehospital Evidence Based Practice Database
5. Other references listed in Appendix A

Suggested Emergency Medical Assistant – First Responder (EMA-FR) Scope Additions:

At this time, we are not suggesting any additional scope for EMA-FRs. This is based on the very limited (approximately 40 hours) educational foundation in addition to the focus (life threatening interventions) of First Responder programs. Due to the narrow focus and length of foundational education programs, this category may also lack the unification of care policies, clinical judgement and critical thinking that organizations like the Canadian Patient Safety Institute (CPSI) reference as needed for additional scope¹.

Adding additional scope to first responders has been the subject of much discussion over the past many years, with the “fire-medical” proposal in Ontario in 2015 being the last major one. The proposed expanded scope at that time was not supported by many key stakeholders, including the Ontario Base Hospital Group².

Suggested Emergency Medical Responder (EMR) Scope Additions:

1. **Add “use automatic injection device (autoinjector) for epinephrine in anaphylaxis” to Schedule 2, 2, G (new)**

This would allow endorsed EMRs to utilize autoinjectors for the treatment of anaphylaxis.

The educational required would be limited to a short academic and simulation setting as EMR’s have taken Intramuscular (IM) naloxone training that would support this.

Suggested Primary Care Paramedic (PCP) Scope Additions:

¹ Canadian Patient Safety Institute – Patient Safety in EMS Full Report,

² July 8th, 2015 Ontario Base Hospital Group correspondence to the Ministry of Health
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2. Under Schedule 1, 3 (b) for Primary Care Paramedic (PCP), **add “Intraosseous (IO)” and “intra-nasal (IN)”** to the available delivery routes for medication administration.

This would allow for the use of Mucosal Atomization Devices (MAD) to deliver intranasal medications, such as Ketamine and Naloxone. The addition of Intraosseous allows for any current and future IO medications.

This would only require minimal additional education specific to the delivery routes as pharmacology and medication administration are part of the foundational educational base for PCPs.

The education required to add these would be very minimal and covered in any associated IN and/or IO training.

3. Under Schedule 2, 3 for Primary Care Paramedics, **add G (new) “Chest Decompression” and remove schedule 1, 4 (g) “needle thoracentesis”** for Advanced Care Paramedics (ACP)

This would allow for chest decompression by endorsed PCPs and above in the case of confirmed or suspected pneumothorax. This reflects best practice across the country (including the Canadian Armed Forces – CAF), is a recommended treatment by the Committee on Tactical Combat Casualty Care (Co-TCCC) is captured in section 5.5s of the NOCP for PCP’s and is supported by many research articles³.

The use of the specific wording “chest decompression” would allow for employers to specify what *type* of decompression and at what license level it could be utilized at. For example, PCPs could be permitted to use simple needle thoracentesis, while higher licensed levels could be permitted to perform finger thoracotomy.

The education required for this additional skill would be minimal as this is currently covered in an academic environment for PCPs as well as in the simulated settings in Continuing Professional Development courses, such as ITLS, PHTLS, TCCC, TECC, etc. It is also captured in the academic, simulated and clinical settings for ACP and CCPs.

4. **Move “initiation and maintenance of intraosseous needle cannulation”** from Schedule 1, 4 (c) in the ACP schedule to Schedule 2, 3 H(new) in the PCP endorsements.

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<https://www.jsomonline.org/TCCC/06%20TCCC%20Reference%20Documents/TCCC%20Butler%20Extension%20Pneumothorax%20JSOM%202018.pdf>



This would allow endorsed PCP's and higher to initiate and maintain intraosseous access on patients. This reflects best practice for PCPs across the country (including the Canadian Armed Forces – CAF), is captured in Section 5.5 E of the National Occupancy Competency Profile (NOCP) for PCPs and supported by many research articles.⁴⁵⁶

The education required for this additional skill would be minimal as this is currently covered in an academic environment for PCPs as well as in the simulated settings in Continuing Professional Development courses, such as ITLS, PHTLS, TCCC, TECC, etc.

5. **Move “electrocardiogram interpretation, and manual defibrillation from Schedule 1, 4 (b) from the ACP schedule to replace Schedule 2, 3 (d) in the PCP schedule.** Update schedule 1, 4(b) for ACPs to read “cardioversion and external pacing”.

This would allow endorsed PCPs to acquire (already an endorsement), interpret lethal arrhythmias and manually defibrillate. This reflects best practice across the country and is captured in Section 5.5 J of the National Occupancy Competency Profile.

The education required to add this endorsement would require a combination of academic and simulated practice environments. The British Columbia Emergency Health Services (BCEHS) has already produced the virtual and in-person learning to facilitate this endorsement.

6. **Move “use and interpretation of End Tidal Carbon Dioxide (EtCO2) monitoring devices” from Schedule 1, 4(K) for ACP to Schedule 1, 3 I(new) for Primary Care Paramedics.**

This would allow for the use and interpretation of EtCO2 for patients with and without supraglottic devices in place. This reflects best practice across the country and is captured in Section 5.4 D of the National Occupancy Competency Profile.

The education required to add this endorsement is minimal and already exists in many virtual learning platforms.

7. **Move “anti-pyretic” from Schedule 1, 4 (m)(vi) of the ACP schedule to Schedule 1, 3(b) vii (new) for PCP.**

⁴ <https://www.sciencedirect.com/science/article/abs/pii/S030095721200891X>

⁵ <https://www.sciencedirect.com/science/article/abs/pii/S0099176712001092>

⁶ <https://pubmed.ncbi.nlm.nih.gov/27494435/>



This would allow all PCP licensed Emergency Medical Assistants (EMA) and higher to administer a medication they are currently licensed to use (acetaminophen) for the purpose of fever management.

The education required would be minimal as this medication is already included in the PCP scope.

8. **Add “analgesia” to Schedule 1, 3 (b) viii (new) for PCP.**

This would allow PCP licensed EMAs and higher to administer analgesia via all medication administration routes, which is currently only available through the oral, sublingual and inhaled route as a function of the EMR schedule 2, 2 (c) iii.

The education required would be minimal as this class of medication is already included in the PCP scope. Additional medications and delivery routes could be added with minimal academic information.

9. **Add “corticosteroids” to Schedule 1, 3 (b) ix (new) for PCP.**

This would allow PCP licensed EMAs and higher to administer steroid therapies for specific treatment modalities like Asthma, COPD and Croup. This is supported by National advocacy groups such as: Addison’s and Asthma Societies Canada.

The education required would be minimal as pharmacology, pathophysiology and medication administration is already within the PCP scope and could be added with minimal academic information.

10. **Add “immunizations” to Schedule 1, 3 (b) x (new) for PCP.**

This would allow PCP licensed EMAs and higher, including those that are providing community paramedic services, to provide vaccinations as needed. This is converting the current Provincial Health Order - *EMERGENCY MEDICAL ASSISTANTS SARS-CoV-2 IMMUNIZATION – March 18, 2021*, that will eventually be rescinded into a normal service that EMA’s can provide for all immunizations.

The education required would be minimal as the virtual academic information has been developed and taken by some EMAs.

11. **Remove “Isotonic” from Schedule 2, 3 (b) for PCPs**



This would allow all PCP licensed EMAs, who are endorsed, and higher to administer all crystalloid intravenous solutions in the emergency, community and interfacility paramedic practice environments.

12. Add the following to the Ministerial Order (MO):

A person who is employed by the corporation, as defined in the Emergency Health Services Act, R.S.B.C. 1996 c.182, and who is licensed by the Licensing Board in the license category:

- a) Primary Care Paramedic;*
- b) Advanced Care Paramedic;*
- c) Infant Transport Team Paramedic; or*
- c) Critical Care Paramedic*

May administer a drug therapy or implement a therapeutic or diagnostic service, not included in Schedule 1 or 2 of the regulations, providing the EMA has completed a training program approved by the Emergency Medical Assistants Licensing Board (EMALB), is acting on the direct order of a medical practitioner who is designated as a Transport Advisor by the corporation and maintains such training.

The above enabling language would allow PCP, ACP, ITT and CCP license holders, who are performing inter-facility transports via air and/or ground for the corporation a greater scope. The regulator would still control approval of training opportunities and the corporation would be responsible for training and the designation of the transport advisors.

Suggested Advanced Care Paramedic (ACP) Scope Additions:

13. Add “acquire and interpretation of point of care Ultrasound” in Schedule 1, 4 C (new)

This would allow ACP licensed EMAs and higher to provide POCUS diagnostic services for emergency, community and interfacility practice environments.

This is supported by best practice in Canada for such things as Focused Abdominal Sonography in Trauma (FAST), cardiac arrest treatment, trauma, etc., is captured in Section 4 5 P in the NOCP’s and supported by research.⁷⁸⁹

⁷ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8232846/>

⁸ <https://academic.oup.com/milmed/article/185/5-6/e601/5736347?login=true>

⁹ <https://ojs.library.queensu.ca/index.php/pocus/article/view/13302/8679>



The education required would be a combination of academic, simulated and clinical settings. The curriculum currently exists withing BCEHS.

14. Add “acquire and interpretation of point of care laboratory testing” in Schedule 1, 4 N (new)

This would allow ACP licensed EMAs and higher to provide laboratory diagnostic services for emergency, community and interfacility practice environments.

This is supported by best practice in Canada and is reflected in Section 4 5 L of the National Occupancy Competency Profile as well as Appendix 6.

The education required would be a combination of academic, simulated and clinical settings. The curriculum currently exists withing BCEHS.

15. Add “Basic suturing and/or skin stapling and removal for wound closure and/or tube securing” to Schedule 2, 4 N (new)

This would allow ACP licensed EMAs and higher to provide basic wound closure and tube securing services for emergency, community and interfacility practice environments.

This is supported by other practices in Canada and is reflected in Section 5 6 F of the National Occupancy Competency Profile and supported by research¹⁰.

The education required would be a combination of academic, simulated and clinical settings.

16. Add “Fibrinolytics” to Schedule 1, 4, M xiii (new) for ACPs

This would allow ACP licensed EMAs and higher to routinely use fibrinolytics for common cardiac emergencies, suggestive of ST Elevation Myocardial Infarction (STEMI)

This is supported by best practice across the country as well as within targeted studies in British Columbia, is captured in Appendix 5, E 2 of the NOCPs and has level 1 evidence for support.¹¹

The education required would be limited to academic and simulated and already exists within BCEHS.

¹⁰ <https://onlinelibrary.wiley.com/doi/full/10.1111/j.1553-2712.2008.00156.x>

¹¹ Dalhousie University (2021). *Prehospital Evidenced Based Practice Database*. Retrieved from <https://emspep.cdha.nshealth.ca/> on 04 August 2021



17. Add “Uterotonics” to Schedule 1, 4, M xiv (new) for ACPs

This would allow ACP licensed EMAs and higher to treat common post-partum hemorrhages.

This therapy is captured in Appendix 5 G 1 of the NOCPs

The educational requirement would be minimal as ACPs already have pharmacology, pathophysiology and medication administration to support this medication.

18. Add “Antibiotics” to Schedule 1, 4, M xv (New) for ACPs

This would allow ACP licensed EMA’s and higher to routinely use antimicrobial therapy for common conditions in the emergent, community and interfacility practice environments.

This is supported by best practice in other jurisdictions and is captured in Appendix 5 I 3 of the NOCPs.

The educational requirement would be minimal as ACPs already have pharmacology, pathophysiology and medication administration to support this medication.

Suggested Critical Care Paramedic (CCP) Scope Additions:

19. Move “paralytics” to schedule 1, 5 D (new) for CCP

Currently, CCPs must consult a Physician under Schedule 2, prior to performing rapid sequence intubation (RSI) in an emergent situation. The suggested move resolves this issue.

This is supported by best practice and current scope with CCPs.

There would be no additional education, other than a notification, required.

20. Add “perform pericardiocentesis” to Schedule 1, 5, E (new) for CCP

This is supported by best practice and current scope with CCPs.

There would be no additional education, other than a notification, required.

21. Add “Chest Tube Insertion” to Schedule 1, 5, F (new) for CCP

This is supported by best practice and current scope with CCP’s.



There would be no additional education, other than a notification, required.

22. Add “Central Line insertion and monitoring” to Schedule 1, 5, G (new) for CCP

This is supported by best practice and current scope with CCPs.

There would be no additional education, other than a notification, required.

23. Add “Escharotomy” to Schedule 1, 5, H (new) for CCP’s

This is supported by best practice and current scope with CCPs.

There would be no additional education, other than a notification, required.



References:

- 1) Prehospital Ultrasound
<https://www.sciencedirect.com/science/article/abs/pii/S1067991X19301804>
- 2) Paramedic Student FAST
<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8232846/>
- 3) Military Medic FAST
<https://academic.oup.com/milmed/article/185/5-6/e601/5736347?login=true>
- 4) Paramedic POCUS
<https://ojs.library.queensu.ca/index.php/pocus/article/view/13302/8679>
- 5) Assessment of Paramedic Ultrasound
<https://www.sciencedirect.com/science/article/abs/pii/S1067991X15001923>
- 6) Steroids for Asthma
<https://www.thennt.com/nnt/systemic-steroids-for-asthma-attack/>
- 7) Steroids for Croup
<https://www.thennt.com/nnt/steroids-for-croup/>
- 8) Diltiazem for Atrial Fibrillation
<https://pubmed.ncbi.nlm.nih.gov/31043186/>
- 9) Calcium Channel Blockers
<https://www.aliem.com/calcium-channel-blockers-stable-svt-alternative-to-adenosine/>
- 10) Simple Thoracostomy
<https://www.jems.com/training/simple-thoracostomy-moving-beyond-needle/>
- 11) Finger Thoracostomy by Paramedics
(<https://pubmed.ncbi.nlm.nih.gov/32564497/>)
- 12) Ultrasound for Critical Care
<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4047692/>
- 13) Emergency pericardiocentesis
https://www.uptodate.com/contents/emergency-pericardiocentesis?search=pericardiocentesis&topicRef=351&source=see_link

- 14) Thoracostomy tubes and catheters
https://www.uptodate.com/contents/thoracostomy-tubes-and-catheters-placement-techniques-and-complications?search=finger%20thoracostomy&source=search_result&selectedTitle=1~150&usage_type=default&display_rank=1#H511031688
- 15) Thoracostomy Tubes & Catheters
https://www.uptodate.com/contents/thoracostomy-tubes-and-catheters-placement-techniques-and-complications?search=finger%20thoracostomy&source=search_result&selectedTitle=1~150&usage_type=default&display_rank=1#H160279803
- 16) Intraosseous Infusion
https://www.uptodate.com/contents/intraosseous-infusion?search=intraosseous%20access§ionRank=1&usage_type=default&anchor=H17936215&source=machineLearning&selectedTitle=1~150&display_rank=1#H17936215
- 17) Escharotomy
https://www.uptodate.com/contents/emergency-care-of-moderate-and-severe-thermal-burns-in-adults?search=escharotomy&source=search_result&selectedTitle=1~13&usage_type=default&display_rank=1#H25
- 18) Massive blood transfusion
https://www.uptodate.com/contents/massive-blood-transfusion?search=BLOOD%20ADMINISTRATION&source=search_result&selectedTitle=5~150&usage_type=default&display_rank=5
- 19) Central Venous Access
https://www.uptodate.com/contents/overview-of-central-venous-access-in-adults?search=central%20line%20placement&source=search_result&selectedTitle=1~150&usage_type=default&display_rank=1#H177530200
- 20) Thoracostomy
https://www.uptodate.com/contents/thoracostomy-tubes-and-catheters-placement-techniques-and-complications?search=chest%20tube%20placement&source=search_result&selectedTitle=1~150&usage_type=default&display_rank=1