DURHAM REGION HEALTH DEPARTMENT

Paramedic Services

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REGION of DURHAM PARAMEDIC SERVICES

Region of Durham Paramedic Services Community Paramedic Program

Current Services and Supports:

- Respond as a 911 paramedic, if the individual shall require emergency based care, the Community Paramedic will provide care based on established BLS & ALS PCS
- Thorough patient assessments including – cardiac, respiratory, neurologic, GI, GU and other body systems
- Vital signs assessments (GCS, Temp, RR, BP, HR, PUPILS, sp02)
- Cardiac monitoring: Lead ll, 12, & 15 -lead ECG capabilities
- blood glucose testing
- COVID-19 nasopharyngeal swabbing as well as administration and documentation related to COVID 19 swabbing
- Administration of Influenza Vaccinations with appropriate consent form completion
- Environmental scan of the individual's residence for safety hazards or concerns (smoke alarms functioning/access/egress/ hoarding/infestations)
- Fall prevention assessments – slips/trips/hazards/mobility aids – watch the individual ambulate through their residence to determine if OT/PT/ additional supports and equipment are required to assist in activities of daily living. (bathroom adjuncts, bed rails, commode, 2-wheeled, 4- wheeled walkers)
- History gathering surrounding ADL's – bathing, toileting, dressing, eating – completion of a paramedic referral through the CE LHIN for "failing of daily activities" for possible PSW care to assist in completion of these daily tasks to function independently and safely in their residence
- Referrals to the CE LHIN via existing paramedic referral process focusing on– wound care, system navigation, palliative care, social isolation, caregiver burnout, cognitive impairment, medication reconciliation, rapid response nursing (RRN)
- Education and understanding on the purpose of the RRN program and when to complete a paramedic referral for the RRN to attend to the patient
- Assistance with individuals who are in the polypharmacy situation with education surrounding when to take and why they are taking those medications. Contact pharmacist if required and check for drug to drug interactions- especially OTC.
- Knowledge and familiarization with the resource website for system navigation via CE LHIN https://centraleasthealthline.ca
- Distribute and educate individuals with Health care connect phone number to possibly obtain a family physician 1-800-445-1822

- DIVERT score/cheat sheet/sticker for suggestions and understanding the process that when a CE LHIN patient (with greater than or equal to 2 ED visits in 90 days) or a DIVERT score of 4,5,6, identified review the STEPS 1-8 to assist the individual in avoiding an ED visit
- Review and screen the patient for potential depression/dementia/delirium utilizing the Geriatric Depression scale/ SIG E CAPS/Cognitive screening/ Confusion assessment method/ MINI cog screen
- Mental Health assessments and experience with individuals with substance abuse/addictions/unsheltered population/vulnerable individuals – Education on the RAAM clinics/pinewood
- Chronic disease management for COPD, CHF, Diabetes – advanced physical assessments, history obtaining, clinical exam findings – when to refer them for TELEHOMECARE program for COPD/CHF. Green/Yellow/Red information sheets surrounding their chronic disease to allow the patient to understand their own condition and when to call a CP/911
- Referral completed for a diabetic who could benefit from a dietician/nutrition/chiropody/podiatry. Understanding and knowledge on foot care DO's and DON'T's
- Education and health coaching on self-monitoring of blood glucose/sheets to document BG levels
- Education and understanding on A1C levels and target BPs with individuals living with Diabetes
- Motivational interviewing with the understanding that the patient may determine their own goals after a CP visit. They can work together using the stages of contemplation/accountability/SMART principles to obtain these goals to improve quality of life.
- Health coaching/teaching surrounding BP monitoring, exercise, diet/salt intake especially if CHF
- Complete appropriate documentation requirements SOAP/ISBAR
- High Utilization Users – currently respond and complete a paramedic referral for assistance in the residence.

Future Additions to RDPS CP Services:

- Addition of comprehensive Medical Directives that would allow Community Paramedics to provide supportive in-home treatment for:
    - Chronic Disease Management – CHF, COPD, Diabetes
    - Dehydration
    - Pain Relief
    - Nausea/Vomiting
    - Bronchoconstriction
    - IV therapy
    - Analgesia

    - Musculoskeletal Pain
    - Headache
    - Endotracheal and Tracheostomy Suctioning & Reinsertion
    - Wound Care
- Point of Care bloodwork analysis and urinalysis
- Community Paramedic Team access to CELHIN CHRIS/HPG
- Community Paramedic Team access to Connecting Ontario – Clinical Viewer

NOTE: The scope of our CP program is flexible and scalable. Additional skills, treatments, and diagnostic assessments can be added upon determination of need.