

A group of healthcare professionals including NS Minister of health sat in Shelburne at the Community Health Matters meeting and stated that every proposal would be looked at and encouraged the community to come up with a plan that would help the residents of Shelburne County. More than one proposal has been brought forward and still our services continue to decline.

I would like to present this proposal for Roseway but could be implemented in other rural ED settings, this is not a new concept but one used throughout Canada in northern remote areas as well as in other countries with success. Some of the concepts are already in place in Nova Scotia. We can no longer wait or standby as rural areas lack the basics of healthcare. People are waiting 24 hours in an ED due to no family physician for a UTI, prescription refills, lyme disease, even the basics of having a medical done for a license is now a concern. True emergencies where time is critical such as with a cardiac problem, MVC's. Waiting hours for an ambulance and it is still happening in rural NS as larger areas are stripping rural areas of ambulances.

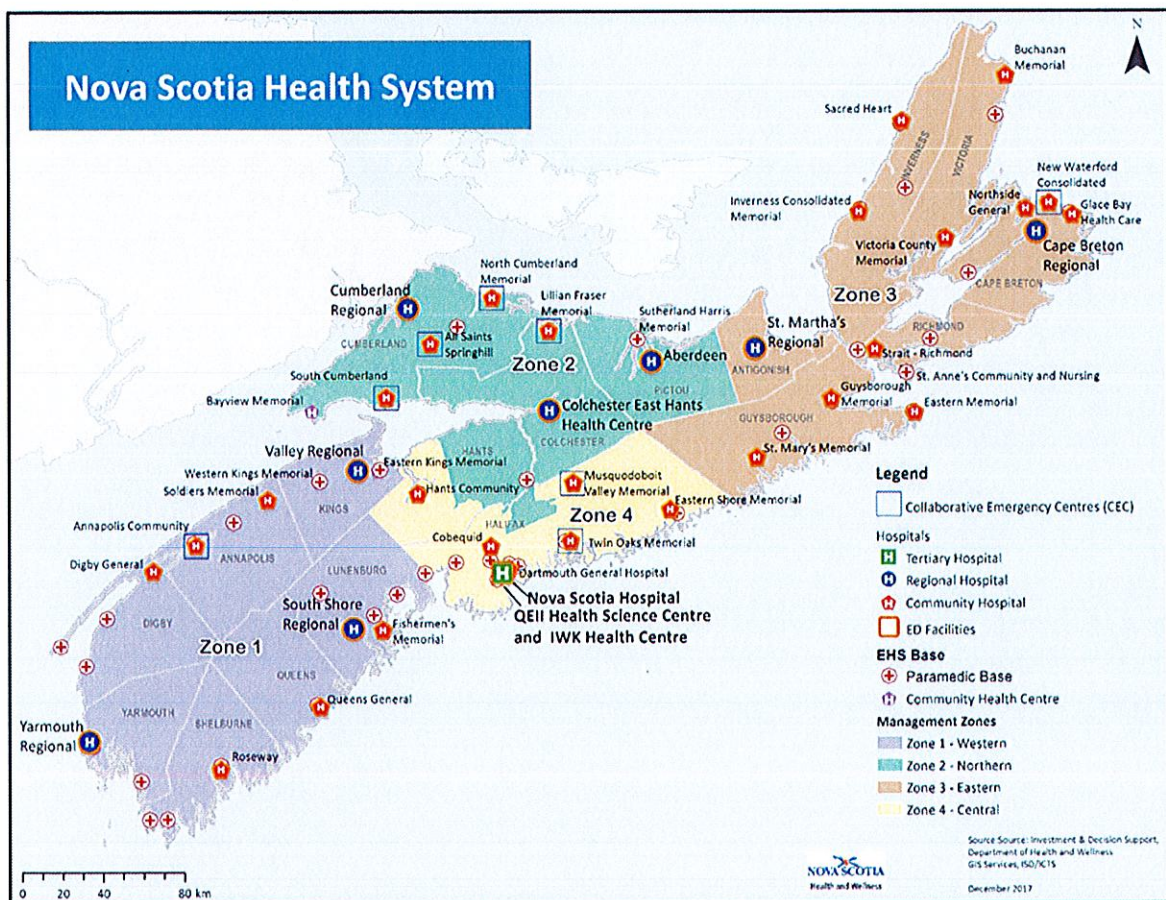
Emergency Care in Nova Scotia

EDs and their staff are an essential part of the province's healthcare system, quickly assessing and managing patients with unexpected illness or injury. EDs in NS are part of a single integrated network of emergency care consisting of:

- Two tertiary care EDs
- Ten geographically distributed Level 2 EDs
- And a series of community Level 3 and 4 EDs

97% of Nova Scotians live within a one-hour drive of a Level 1, 2, or 3 ED, with 88% living within 30 minutes. Further resilience is built into this system with multiple smaller rural Level 4 facilities, and a world class 911, ambulance and communication centre to coordinate pre-hospital care, inter-facility transport and tele-health support.

While certain smaller sites (Level 3 or 4) can be closed from time to time, the overall emergency system is always expected to respond to emergencies (24 hours a day/7 days a week). NSHA and IWK work with their teams in specific sites and zones, and across the province to achieve coverage when faced with a site closure.



In addition, the province has a telecare service (811) to provide nursing advice and help callers determine the most appropriate level of care for their needs, a mobile mental health line to support people in crisis, urgent care centres, and virtual care.

Public Consultation: Roseway Hospital, Shelburne

Date	Chair/Speakers	Attendance
June 6, 2022*	Warden, Hospital Site Leader, Zone Vice President, Executive Medical Director, Primary Health Care Director, Emergency Services Director	16
Summary of discussion: <ul style="list-style-type: none">• Community partner conversation on improving access to care, virtual care, recruitment activity, Need a Family Practice registry, and COVID-19. ED dashboard data discussed, including closure frequency, causes and impact, and patient demo data.• Better understanding of community needs identified, as local industries (ex. Shipbuilding) have workplace safety plans tied to local ED.		
Action (specific to EDs): <ul style="list-style-type: none">• Utilize other health professionals, i.e., Advance Care Paramedics, to provide care in ED.• Maximize scope of other health care providers, such as pharmacists.• Enhanced promotion of other care options, such as virtual care, to reduce burden on ED.• Explore how incentives for ED physician shifts might be offered earlier in scheduling process.• Make it as easy as possible for international medical graduates to practice.		

June 6, 2022 there was with Public Consultation. The outcome was to utilize other healthcare professionals, maximize scope and better understand community needs.

Healthcare does not need to be non-existent or of lesser quality in rural Nova Scotia, we need to change our approach. The pandemic has forced us to adapt to be ever-changing and improving. We have an opportunity to be creative and innovative in our approach to healthcare in rural areas.

As healthcare leaders you face continual uncertainty, new leadership challenges that warrant ideas for ongoing service delivery to best serve patients, families, healthcare workers, and essential partners.

Agile and adaptive leadership is required to move systemic change forward more quickly. Taking an inclusive and partnered approach to planning and designing health services with all involved will assist in implementing effective and responsive policies and practices. Maintaining focus on the features and needs of a community will lead to better outcomes and optimal use of the resources at hand.

Proposal – Outpatient ER Hybrid – Roseway

This proposal is used only if no physician is staffing the ER. Only to be utilized in event of rural ED closure so services can continue to be available. This would be a pilot project, starting with a 2 year window to see what worked and what didn't, what could be improved what could be

revamped. I am proposing 2 years as this time frame will allow for data collection and provide reference materials for benefit vs risk.

The OER (Outpatient ER model) enables rural Emergency Departments remain open and operational to provide care for life threatening and non-life-threatening emergencies, in rural communities when no Emergency physician is available

The OER model staffs the Emergency Dept with a Nurse Practitioner, an Advanced Care Paramedic, possibly a Primary Care Paramedic (Triage), two Registered Nurses, 2 Licensed Practical Nurses. With an on-call Physician in event of further discussion for treatment options.

Benefits

- Ensures timely access to primary and emergency care in rural areas.
- Cost effective solution to an ever-increasing issue in NS, no in-person physician availability due to shortages.
- Decreases fatigue and overworked staff, leading to fewer missed diagnoses and better patient outcomes
- Lessens the burden on regional facilities.
- Lessens the burden on EHS. With local ED's open, transport time to facility is decreased and rural availability increases.
- Increased patient satisfaction, faster service and ability for care expectations to be met.

The Nurse Practitioner is the team lead, and the other healthcare professionals take direction from the team lead, but all work within their (expanded) scope of practice. For this model an on call or virtual physician is used when consultation is needed. As with current models, any patients, based on CTAS, if critical or need immediate physician intervention will be transported to a higher-level hospital.

- Creates a pathway for healthcare professionals to increase skills as well creates spots for nurses and paramedics that can no longer work on ambulance or busy ED's. This opens up a pathway for highly trained paramedics/nurses that are leaving the profession or the province to stay in the province and continue practicing.
- More satisfaction in people that are seeking care.
- Reduces wait time in regional facilities.
- Retains staff in Nova Scotia.
- Decreases staff burnout.
- Creates confidence or will in taxpayers that this government is committed to provide alternative solutions to an ever-increasing problem.
- Allows for time for more physicians to be trained.
- Can be used in other rural facilities facing closures.

Training

- ACP's increase training in house. NS already has an Extended Care, Community Care, as well as ACP's working in Regional hospitals with Expanded Scopes of Practice. These models and training could be utilized to increase the scope of ACP's hired into OED roles.
- Allow Scope of practice to be fully utilized. (See attached charts for Expanded Scope information)

Table 1 Matrix of rural and remote specific paramedic role developments

Ambulance Service	Role title	Role description	Clinical skills/description	Education requirements
Remote Alberta ,BC, Yellowknife	Extended Care Paramedic (ECP)	<ul style="list-style-type: none"> • Treat patients on scene, provide self-management advice; and where available and appropriate, to refer to other health services. • ECPs have multiple referral options and thereby provide a greater choice for patients regarding the most appropriate access to health care service/s. • In addition to current emergency management capacity, ECPs have greater access to pharmaceuticals and interventions that better meet the needs of patients with subacute / non-acute needs. 	<ul style="list-style-type: none"> • Physical examination and history taking • Administration of IV medications • Phlebotomy • Arterial gas sampling • Urinalysis • Peak flow • C-spine assessment • Aseptic techniques • Wound care and suturing • Tissue adhesives • Local and regional anaesthesia • Gastric tube insertion, catheterisation (IDG/SPC) • Splinting and plastering • Dislocation assessment and management • Multiple system assessments including home, ADL, mobility, falls and cognitive. • Administer several ECP only medications including analgesics, antibiotics, antihistamines, topical medications and vaccinations. 	<ul style="list-style-type: none"> • A nine week highly integrated course conducted within a clinical (medical) school environment involving significant practical experience in acute, subacute, non-acute, primary care and community settings. • There are plans to articulate the ECP program with higher education sector (tertiary) sector qualifications as the program progresses (potentially) to a practitioner model of care.

These are from areas that have adopted and use paramedics in remote rural areas with success, these are their scopes of practice and knowledge base.

Approved skills and medications

Credentialed paramedics receive approval to perform various procedures with additional in-house training and administer a range of medications. The following lists include skills and medications that have been approved, some with stipulations as noted.

Approved skills

- 12-lead ECG acquisition, transmission, interpretation
- 15-lead ECG acquisition
- Airway adjuncts
- Arterial access—blood draw
- Blind insertion airway device
- Capnography (waveform)
- Carbon monoxide measurement (noninvasive)
- Cardiac monitoring and pacing
- Cardiopulmonary resuscitation
- Cardioversion
- Carotid massage
- Central venous pressure line maintenance
- Chest compression (external device and needle)
- Chest tube maintenance
- Childbirth
- Cricothyrotomy (needle and surgical)
- Decontamination
- Defibrillation (automated and manual)
- Endotracheal tube introducer
- Epidural catheter maintenance
- Foreign body airway obstruction
- Gastric intubation
- Glucose measurement
- Hemostatic agent
- Injections (subcutaneous and intramuscular)
- Intraventricular catheter maintenance
- Intubation (nasotracheal and orotracheal)
- Intubation confirmation—Capnography (color)
- Nebulizer inhalation therapy
- Noninvasive positive pressure ventilation
- Orthostatic blood pressure
- Oxygen administration
- Patient assessment
- Pulse oximetry
- Reperfusion checklist
- Respiratory operation
- Restraints
- Specimen collection
- Spinal motion restriction
- Splinting
- Stroke screen
- Swan-Ganz catheter maintenance
- Taser probe removal
- Temperature measurement
- Tourniquet application
- Urinary catheterization
- Venous access (blood draw, existing

- catheters, femoral lines, intraosseous, peripheral)
- Ventilator operation
- Wound care

Approved skills with stipulations

- Drug-assisted intubation
- Suction (basic and advanced)
- Tracheostomy tube change

Approved medications

- ACE inhibitors
- Acetaminophen
- Adenosine
- Aminophylline
- Amiodarone
- Anti-arrhythmic
- Antibiotics
- Anti-emetic preparations
- Antivirals
- Aspirin
- Atropine
- Barbiturates
- Benzodiazepine preparations
- Beta agonist preparations
- Beta-blockers
- Bretylium
- C1 Esterase-inhibitors
- Calcium channel blockers
- Calcium chloride/gluconate
- Charcoal
- Clonidine
- Clopidogrel
- Crystalloid solutions
- Cyanide poisoning antidote kit
- Digoxin
- Diphenhydramine
- Diuretics
- Dobutamine
- Dopamine
- Droperidol
- Epinephrine
- Etomidate
- Flumazenil
- Glucagon
- Glucose oral and solutions
- Haloperidol
- Heparin (unfractionated and low molecular weight)
- Histamine H2 blockers
- Hydroxocobalamin
- Immunizations
- Insulin
- Ipratropium
- Isoproterenol
- Levetiracetam
- Lidocaine

- Magnesium sulfate
- Mannitol
- N-acetylcysteine
- Narcotic analgesics and antagonists
- Nasal spray decongestant

- Nitroglycerin
- Nitroprusside sodium
- Nitrous oxide
- Nonprescription medications
- Nonsteroidal anti-inflammatory
- Norepinephrine
- Octreotide
- Oxygen
- Oxytocin
- Phenothiazine preparations
- Phenylephrine
- Phenytoin preparations
- Plasma protein fraction
- Platelet g-II/IIIa inhibitors
- Potassium chloride
- Pralidoxime
- Rocainamide
- Rocaine
- Proparacaine
- Phenothiazine preparations
- Phenylephrine
- Phenytoin preparations
- Plasma protein fraction
- Platelet g-II/IIIa inhibitors
- Potassium chloride
- Pralidoxime
- Rocainamide
- Rocaine
- Proparacaine
- Proton pump inhibitors
- Sodium bicarbonate
- Steroid preparations
- Thiamine
- Thrombolytic agents
- Tropical hemostatic agents
- Total parenteral nutrition
- Tranexamic acid
- Tuberculosis skin test
- Valproic acid
- Vasopressin
- Vasopressor
- Whole blood and components

Approved medications with stipulations

- Ketamine
- Paralytic agents
- Propofol

- Registered Nurses and Licensed Practical Nurses— training in Sutures, casting, increased knowledge of all scopes that work together.
- Orders for medical reasons aka bloodwork, diagnostics etc...