CP 4.14: Intravenous Initiation by Community Paramedics

Updated:
Reviewed:

Purpose

The Community Paramedic (CP) works together with primary care providers to support patient self-care in the community whenever possible. In some cases, patients who would otherwise self-cannulate or require cannulation for the purpose of self-administration of their medications may request assistance from the CP through the normal referral process.

Policy Statements

In response to a referral from a primary health care provider and following the standardized procedures for CP home visits, the CP may attend a client's residence to initiate intravenous access for the purposes of patient self-administration of medications. This procedure does not include CP administration of any medications.

Such patient interactions will follow the same patient referral, intake, management, and documentation processes as any other CP wellness check.

It is expected that the CP will document the procedure, including all findings, and report them to the primary health care provider and collaborate with other health care team members to provide support as appropriate.

Procedure

1. **OBTAIN** and **REVIEW** patient's health history and care plan prior to appointment.
2. **REFER** to Request for Service form and care plan with respect to assessment, patient specific care interventions, and patient teaching as required.
3. **EXPLAIN** the purpose of the visit and **OBTAIN** verbal consent prior to undergoing any procedure, including vital signs.
4. **PERFORM** physical exam including:
   - Vital signs (T, P, RR, BP)
   - Pulse oximetry
   - Level of consciousness
5. **ASSESS** patient's understanding of the procedure and **DISCUSS** any concerns the patient may have prior to cannulation.
6. **CONFIRM** patency of IV access by flushing with normal saline and secure the catheter. **REVIEW** possible complications with patient and verify understanding of when follow up care from the primary care provider would be required.

   If first 2 attempts to secure IV access are unsuccessful, contact the patient's care team for revised care plan (i.e., direction to continue/discontinue, higher level of care, alternate strategies).
7. **DOCUMENT** the visit and all assessments/treatments on your ePCR as per standard procedure.
8. **COMMUNICATE** with the primary care provider or health care team as noted on care plan or if any other concerns arise.

Documentation

DOCUMENT details of the visit on the CP progress notes and notify primary health care provider or health care team of findings and any concerns.

References

	*** Infection Prevention and Control PPE poster***

BCEHS IPAC 100	**Policy IPAC 100** **Cleaning & Disinfection Policy** **Procedure IPAC 100.2** **Cleaning Disinfection Criteria** **Procedure IPAC 100.3** **Routine Post-Transport Cleaning** **Procedure IPAC 100.4** **Routine Cleaning of Ambulance at Each Shift** **Procedure IPAC 100.5** **Blood & Bodily Fluids Spill** **Procedure IPAC 100.7** **Clean and Sterile Supply Storage Guidelines**
6.4.7-v2	**Patient Consent (Competent Adults)**
2.1	**Providing Patient Care within Scope of Practice**
BCEHS OPS 006	**Patient Care Reports**
3.3.4	**Safe Use of Medical Needles**