Te Whatu Ora
Health New Zealand

Reference Guide for Comprehensive Primary and Community Teams Employing Extended Care Paramedics

Introduction

This reference guide has been developed by the Te Whatu Ora Early Actions Team to assist regional change leads, locality facilitators, and Comprehensive Primary and Community Teams (CPCTs) when implementing Extended Care Paramedics (ECPs) in CPCTs as part of the Primary, Community and Rural Early Actions Programme.

The purpose of this guide is to provide a general overview of the ECP role in CPCTs and its critical enablers, success factors, and limitations. This guide has been informed by feedback from primary care teams that currently employ ECPs.

This guide does not seek to provide an exhaustive overview of all paramedic roles in primary care, nor does it intend to formally define role titles, scopes of practice, or prescribed qualifications. It is important to acknowledge that the ECP role in primary care is very new, is not tightly defined, and the role of ECPs varies between primary care teams. Te Kaunihera Manapou Paramedic Council is currently considering implementing a paramedic specialist scope of practice, which would formally define the ECP role including role title, prescribed qualifications, and scope of practice. Implementation of a paramedic specialist scope by Te Kaunihera Manapou is likely to require the information in this reference guide to be updated.

Please also note that not all primary care teams utilising paramedics elect to use ECPs. Approximately one third of primary care teams that have integrated paramedics into their team employ 'generalist' paramedics, many of whom are undertaking postgraduate study to become an ECP.

Overview of the ECP role

Also referred to internationally as Advanced Community Paramedic or Community Care Paramedic, an ECP is commonly characterised as a registered paramedic who has completed a Postgraduate Diploma in Health Science (Paramedicine) with ECP specialisation, or equivalent. ECPs typically have extensive emergency ambulance experience before moving into a primary care role.

ECPs perform comprehensive clinical assessment of people with generally low acuity and often high complexity clinical conditions and use an extensive set of Standing Orders to administer and supply medicines. They perform a range of procedures to enable people to be clinically managed in the community, such as wound closure. ECPs typically make independent treatment, referral, and discharge decisions, and consult with a doctor or nurse practitioner (NP) as required. Because ECPs are new to primary care, significant initial clinical support and supervision is required.

In New Zealand, paramedics are currently registered in a single scope of practice that is broad and enabling. The ECP role falls within this scope and has not been separately defined by Te Kaunihera Manapou Paramedic Council. Te Kaunihera is considering implementing a paramedic specialist scope of practice. If implemented, ECPs would be required to work within and adhere to the new specialist scope of practice.

Roles and responsibilities of ECPs working in primary care teams

Examples of possible roles and responsibilities of ECPs working in CPCTs are listed below. The exact role of ECPs in each team will vary depending on the needs of the community and the care team, and the qualifications, clinical experience, and skills of the ECP. The role and responsibilities of ECPs in CPCTs is likely to evolve over time as the ECP role becomes embedded in the primary care setting, and due to any regulatory changes occurring such as the introduction of a paramedic specialist scope.

Examples of ECP roles and responsibilities

- Undertaking telephone triage (following appropriate training) to determine which people need to be seen face-to-face, how quickly, and by whom, and managing appropriate clinical problems over the phone.
- Providing comprehensive clinical assessment, for example ear, nose, and throat examination, limb assessment, falls risk assessment, and use of appropriate diagnostics supported by required training.
- Providing same day appointments and in or out of hours urgent care, both independently (including treatment, referral, and discharge decisions) and in consultation with a doctor or NP, as appropriate.
- Providing extended care to support hospital avoidance. For example, urinary catheterisation, wound care and closure, management of constipation, and supply of oral antibiotics (under Standing Orders) for bacterial infection.
- Providing phone consultations for people who do not require a face-to-face assessment, following appropriate training.
- Supporting clinical processes in the Practice such as inbox management, including follow up of test results, referral letters and filing documentation that does not require further action, in collaboration with other clinicians.
- Providing home visits to people and whānau who are clinically appropriate to be seen in their home and where transport is a barrier to access. This may also include assessing people post-discharge who are at risk of re-admission and providing treatment to enable them to stay well in their home.
- Providing care to people who present to the Practice with life-threatening/time-critical conditions, including taking the lead when required.
- Supporting local ambulance responses in rural areas, in collaboration with local ambulance services (as required/agreed).
- Providing informal education and information regarding the management of high acuity clinical conditions to other clinicians within the practice team, and to people and their whānau (as appropriate).
- Extensive collaboration with other community health providers, ARC, hospice, urgent care, hospital clinicians, district nursing, frequent presenter groups, and local ambulance services.

Paramedics

CPCTs may utilise ‘generalist’ paramedics, in addition to/instead of ECPs. To gain registration, paramedics must have completed a 3-year Bachelor of Health Science (Paramedicine), or equivalent. Paramedics moving into primary care ideally have at least two years of experience working in an emergency

ambulance service. Paramedics working in primary care commonly complete a postgraduate diploma to become an ECP.

In the primary care setting, paramedics typically work less autonomously than ECPs. They usually assess, treat, and refer people in consultation with other health professionals and provide initial assessment and treatment prior to the person being seen by a doctor or NP. Examples of roles that paramedics perform in CPCTs include:

- Providing face-to-face triage (for example, in an urgent care clinic) following formal training, to determine how quickly a person needs to be seen.
- Providing initial face-to-face clinical assessment and initiating treatment (utilising Standing Orders and charted medicines) prior to the person being seen by a doctor or NP.
- Supporting other clinicians with clinical tasks, for example IV cannulation, administering medicines, setting up infusions, wound care, and performing health checks (e.g., blood pressure and point of care testing).
- Administering vaccinations after completing authorised vaccinator training (or under Standing Orders).
- Providing home visits where transport is a barrier to access, on behalf of/in conjunction with other health professionals. This could include setting up a telehealth consultation between the person and a doctor/NP from the persons' home.
- Managing clinical emergencies within the Practice, including taking the lead when required.
- Supporting local ambulance responses in rural areas in collaboration with local ambulance services (as required/agreed).

Because paramedics typically have less clinical responsibility than ECPs, they usually do not require the same duration of clinical supervision. However, this depends on the paramedic's clinical experience, education, and exact role within the care team.

As paramedics become more experienced and skilled in primary care, they typically progress to working more autonomously, supported by appropriate clinical governance. For example, making treatment and referral decisions for simple presentations without the person needing to be seen by a doctor or NP, and presenting patients to a doctor or NP for a prescription or charted medicines. Progression to top of scope working requires high trust relationships being formed between the paramedic, their clinical supervisor, and other clinicians within the team.

Emergency Medical Technicians

It some cases, CPCTs may elect to utilise Emergency Medical Technicians (EMTs). EMTs are unregulated members of the paramedicine profession who have completed a New Zealand Diploma in Ambulance Practice (Level 5), or equivalent. EMTs are trained to perform basic clinical assessment, focused on identifying threats to life. EMTs perform patient monitoring (for example, acquiring vital signs), administer simple medicines under direction, and provide safe transport to a medical facility. In the primary care setting, EMTs work under the direction of registered health practitioners.

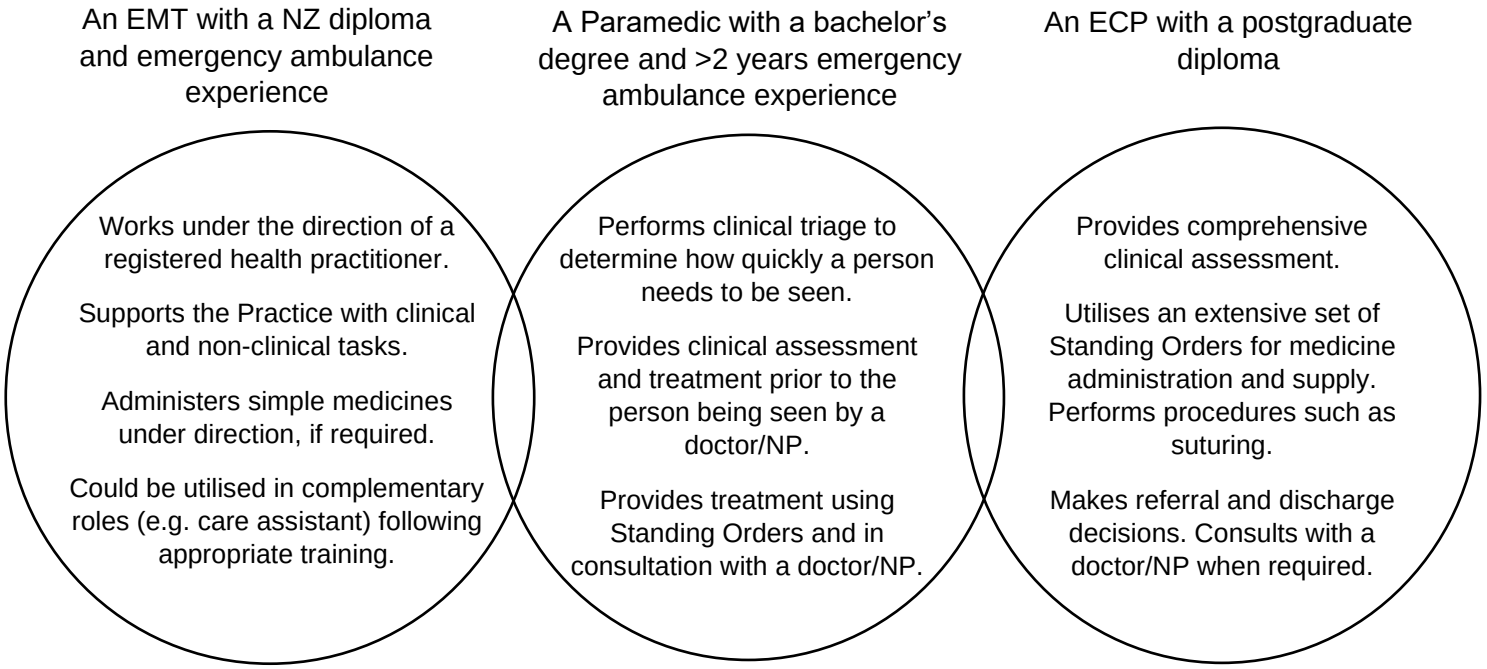
Within a CPCT, EMTs could be utilised to:

- Support health practitioners with clinical tasks. For example, assisting with fracture casting, preparing equipment/medications, measuring vital signs, and commencing clinical documentation.

- Transport people to/from the Practice where transport is a barrier to access.
- Perform other roles, such as working as a care assistant and performing phlebotomy (following appropriate training/micro-credentialing).
- Support local ambulance responses in rural areas where the ambulance service requires additional support (as agreed).

Summary: Differences between ECPs, Paramedics and EMTs

A summary of the general differences between ECPs, Paramedics and EMTs in CPCTs is summarised below.



Examples of successful models of care utilising ECPs

To assist CPCTs that are considering utilising ECPs, examples of successful models of care have been summarised below.

Example 1: ECPs supporting a provincial practice's acute care team

- ECPs have been employed by Te Mata Peak Practice in Havelock North as part of the practice's Acute Care Team.
- The ECPs clinically assess and treat people with acute care needs and support flow within the Practice by performing the following tasks:
  - Monitoring the Practice's inbox for lab results, referral letters and discharge summaries that require follow up and filing clinical documentation that does not require further action, in collaboration with other clinicians.
  - Providing phone triage/consultations to clinically manage people over the phone who do not require a face-to-face assessment, and determining which patients need to be seen by an ECP, doctor, or NP (and how quickly).
  - Providing in and out-of-hours urgent care, with access to a GP for advice (by phone) if required.
  - Seeing patients requiring a same day appointment and escalating care to a GP/NP as required.
  - Providing a voice in the multi-disciplinary Practice leadership team.
- ECPs utilise the Ambulance Sector ECP Clinical Procedures and Guidelines and the Practice's Acute Care Medication Standing Orders (developed by the Practice's pharmacist and GPs) to provide care.
- Utilising ECPs within the Practice has reduced wait times for a GP appointment from three weeks to one week and has reduced pressure on GPs to provide after-hours care.

Example 2: Provision of after-hours care in rural North Canterbury

- Hanmer Medical Centre employs an experienced paramedic, who trained as a paramedic practitioner in the UK and works at an equivalent level to ECP.
- The paramedic uses the Ambulance Sector ECP Clinical Procedures and Guidelines, and Standing Orders developed by the Practice to provide out-of-hours care. He is supported by a GP who is available to provide advice by phone, if required.
- The paramedic has been trained to utilise the Practice's x-ray machine to obtain plain films and will shortly complete a course in x-ray interpretation.
- The paramedic has been trained to administer vaccinations, which helped enable local rollout of the COVID-19 vaccine in North Canterbury.
- Utilising a paramedic has reduced the burden on existing clinicians to provide after-hours care and enhanced the sustainability of primary care in Hanmer Springs.

Example 3: ECP supporting urgent care in a rural hospital and local emergency ambulance responses

- An ECP based in Rawene is co-funded by Hato Hone St John and Hauora Hokianga to work in the hospital's urgent care clinic and respond to emergency ambulance callouts when required.
- While working in the clinic, the ECP undertakes triage and assesses, diagnoses, and treats patients with urgent primary care needs, escalating care to another clinician (e.g. a GP) when required.
- The ECP supports the management of high acuity cases and provides mobile care in the community. This includes home visits for people who are unable to travel to the clinic and assessing at-risk patients in their home following discharge from hospital.
- To start with, the ECP supported/assisted other clinicians within the Practice and then progressed to seeing their own patients.
- This model is a great example of one clinician supporting the provision of both urgent care within a rural hospital, and local ambulance responses.

Questions to consider prior to utilising an ECP in a CPCT

This section recommends some important factors to consider when introducing an ECP into the team.

1. What is the role of the ECP?

- Which patients will be targeted for care by the ECP? The roles the ECP could potentially perform are outlined above, but it is likely not feasible for the ECP to undertake all the roles listed.
- Similarly, there may be roles that the care team requires the ECP to undertake that are not listed.
- How will autonomous practice (within the ECP's scope) be supported, to avoid duplicate consultations?

2. Are any changes to workflow or clinical layout required?

- Which clinical space will be allocated for the ECP to work in?
- Is there a workspace for the ECP to use for non-patient facing work such as phone triage?
- Are any changes to clinical layout or care allocation processes required to optimise patient flow and enhance multidisciplinary working?

3. How will the ECP and other clinicians communicate?

- How will the ECP refer to and utilise other clinicians?
- Who will the ECP consult with when they require clinical advice?
- How will other clinicians refer people to the ECP?
- Does the ECP require 'write' access to clinical record systems?

4. How will the ECP's role be socialised with other clinicians to enable engagement and understanding?
    - How will staff members' feedback be considered when developing the ECP role within the Practice?
    - How will any issues be addressed?
5. Differences in salaries between ambulance services and primary care.
    - How will potential salary differentials be addressed?
6. What Standing Orders will be issued?
    - Does the Practice have appropriate Standing Orders, or will new (or additional) Standing Orders need to be developed?
    - Alternatively, will the Practice issue the Ambulance Sector ECP Clinical Procedures and Guidelines (available here) as Standing Orders?
    - What training and assessment in the use of Standing Orders is required to ensure competency?
    - What is the Practice's audit process for medicines that are administered/supplied under Standing Orders?
7. What knowledge gaps and training needs are there?
    - What clinical experience and qualifications does the ECP have? What are their likely knowledge gaps?
    - Is any training or micro-credentialing required to support the ECP's role in the Practice? For example, triage, point of care diagnostics, and fracture casting.
    - What will the ECP's orientation involve and who will facilitate it?
    - How will the ECP learn about the role of each staff member in the team and vice versa?
    - What ongoing professional development will be provided/supported?
8. Who is the ECP's clinical supervisor and how will they work together?
    - What protected time has been allocated for the clinical supervisor to observe the ECP's consultations, 1-1 clinical discussions, teaching sessions, audit, and case review?
    - How often will catch ups occur between the ECP and their supervisor?

Critical success factors

Below is a summary of critical success factors for integrating an ECP into a primary care team. Considering these prior to implementation will help enable the successful integration of ECPs into the care team.

1. Confirming the ECP's role and responsibilities

It is important to confirm the role and responsibilities of the ECP within the team and incorporate these in a position description, while allowing for flexibility and growth of the role. Position

descriptions are available on the Early Actions Programme website. Sample position descriptions are also available from HealthyPractice.

ECPs are a useful addition to the team when they are utilised to provide care that people currently have limited access to. Resistance to new roles in primary care is often due to a lack of trust from other healthcare professionals and team members feeling disempowered due to the new role being poorly defined. Education regarding the new role and its place within the Practice, and adequate socialisation of the role prior to implementation will help to enable buy-in.

2. Culture within the primary care team

New models of care are most successfully introduced in Practices with strong interpersonal relationships between clinicians and a positive, forward thinking, and inclusive culture. Clinicians within primary care teams are more likely to embrace new models of care and be invested in their success when there is a respectful, open culture and top of scope working is supported.

3. Change management

Because ECPs are a new addition to primary care, it is critical to take the whole team 'on the journey' prior to employing an ECP. This includes articulating what the clinical and business need is, why ECPs are being considered, and how they will benefit patients and the primary care team.

Existing team members benefit from understanding the purpose and limits of new roles when they are introduced. This is to ensure clarity for team members and minimise the likelihood of clinicians feeling that their role is being undermined, replaced or replicated.

4. ECP selection

Paramedics have historically been trained to work independently in uncontrolled environments. Working as part of a multi-disciplinary team will be a new experience for most ECPs. It is important that the 'right' person is recruited who can effectively integrate into the team. During candidate selection, Practices should consider:

- The ability of the person to learn to work within a multi-disciplinary team.
- The person's insight into their professional competencies and knowledge gaps.
- The person's drive to 'own' the role and make it a success.
- The person's interpersonal skills and whether they are the right team 'fit'.

5. Issuing fit-for-purpose Standing Orders that support the ECP's role within the care team

Standing Orders should align with the ECP's skills, experience, and education. They should be developed in conjunction with the ECPs using them and enable ECPs to utilise their full scope.

ECPs who are enabled to practise autonomously are more likely to be satisfied working in primary care. If the ECP's role is limited to clinical assessment without the ability to make autonomous clinical decisions, this will likely result in duplicate consultations and lead to lower levels of job satisfaction.

6. Ensuring sufficient clinical supervision, mentoring and support

ECPs who have not previously worked in primary care require a robust orientation, a dedicated clinical supervisor, and a significant period of in-practice clinical supervision, mentoring and support (typically

6-12 months). Clinical supervision enables ECPs to feel supported as they adjust their skillset to the primary care context and gives them confidence in their new role.

ECPs new to primary care also benefit from engaging with other ECPs working in primary care to share their experiences, discuss learnings, and to gain collegial/professional support.

7. Patient and whānau acceptance

The addition of an ECP to the team should be communicated to patients and their whānau, to enable them to become familiar with the ECP's role.

Patients may be uncertain about the role of the ECP to begin with. For example, people seen by an ECP may initially think that the Practice considers their problem to be an emergency. Conversely, some people may feel that they are a lower priority if they are not seen by a doctor. With effective engagement, patients will become more familiar with the ECP role.

Standing Orders

Overview

ECPs administer and supply medicines using Standing Orders. Standing Orders must be issued by a doctor or NP. They specify the medicines that may be administered or supplied, and in what circumstances. Standing Orders should align with the ECP's knowledge, experience, and education, and support their role within the primary care team. They should be developed in conjunction with the ECPs using them.

Standing Orders used by ECPs working in ambulance services are available in web-format here. They are also available in app-form from the Apple Store and Google Play Store. After opening the app, tap 'Level' and select 'Extended Care Paramedic'. These Standing Orders can be issued to ECPs by the Practice if required. Alternatively, Practices can develop their own Standing Orders.

Assessing competence

Standing Orders must specify the level of competency (including training) that is required. The competency of each person using Standing Orders must be assessed each year. Assessing competence in the use of Standing Orders is particularly important for ECPs who work independently (for example, providing out-of-hours care) and have limited immediate access to a doctor or NP.

Practices should develop a process for assessing the competence of ECPs to use Standing Orders. This could involve a combination of:

- Observing the ECP's consultations.
- Participation in Practice teaching sessions.
- Audit of clinical notes.
- Case review or peer review.

Auditing the use of Standing Orders

Practices must have a process to audit the administration/supply of medicines under each Standing Order. One of the ways to do this is to set up an 'audit' profile within the Practice Management System

(PMS) and to send all cases where a Standing Order is used to this profile. This enables the issuer of Standing Orders to audit a sample of cases each month.

For further guidance about Standing Orders, refer to the Medicines (Standing Orders) Regulations 2002 and the Manatū Hauora Standing Order Guidelines.

Medication supply and Practitioner's Supply Order

Medicines that commonly need to be administered/supplied by ECPs under Standing Orders should be held within clinic stock. A Practitioner's Supply Order (PSO) enables designated rural Practices to order medicines for acute administration/supply. Having medicines available in clinic stock is important when providing out-of-hours care, and in areas where the nearest pharmacy is a significant distance away.

It is important that courses of medicines supplied to patients by ECPs from clinic stock (under Standing Orders) have been appropriately pre-packaged by a pharmacist. Re-packaging of medicines by ECPs is illegal.

Clinical supervision and support

ECPs require a dedicated clinical supervisor who has protected time to provide regular clinical supervision, mentoring and feedback. It is recommended that the clinical supervisor is the doctor or NP that issues the ECP's Standing Orders.

Adequate clinical supervision and support enables ECPs to become familiar with the primary care context, develop their clinical assessment skills, and become proficient performing procedures (such as suturing). It also helps ECPs and their clinical supervisor to form trusting relationships, embeds the ECP's role within the team, enables ECPs to identify their own knowledge gaps, and supports autonomous practice.

The necessary duration of clinical supervision and the level of support an ECP requires will depend on their role within the care team, previous clinical experience, and education. Feedback from primary care teams currently utilising ECPs in New Zealand is that at least 6-months of formal clinical supervision/support is required.

Clinical supervision and support typically involves a combination of:

- Regular 1-1 teaching sessions and case review with the clinical supervisor.
- Peer review.
- Audit of ECP clinical notes.
- Audit of the ECP's referrals to other health providers, and requests for diagnostics.
- ECP consultations regularly being observed.
- Gaining intuitive feedback from other clinicians regarding the ECP's clinical practice.
- Procedures performed by the ECP being observed.
- ECPs observing consultations being led by other clinicians.
- Participation in Practice teaching sessions (including presenting cases).

- The clinical supervisor (or another senior clinician) being available to answer questions and observe assessments/procedures, as required.
- Linking the ECP with ECPs in other primary care teams to build a professional relationship and discuss and reflect on their practice.

System-related barriers to ECP clinical practice

ACC Cost of Treatment Regulations

Paramedics are not currently listed as treatment providers in ACC Cost of Treatment Regulations. Therefore, Practices cannot claim for treatment provided by ECPs, and ECPs are unable to respond as part of the PRIME service (which is co-funded by ACC). ECPs also cannot refer people for ACC-related investigations (e.g., x-ray for a suspected fracture).

ACC is currently considering adding Paramedics to Cost of Treatment Regulations. This process is anticipated to take up to two years.

Vaccinations

To become an authorised vaccinator, health professionals must complete an IMAC authorised vaccinator course and be approved by the local Medical Officer of Health. There is variability across the motu as to whether Medical Officers of Health will approve paramedics to become authorised vaccinators. The Te Whatu Ora National Immunisations Team is currently developing a national pathway for pharmacists to become authorised vaccinators, which will not require local Medical Officer of Health approval. Paramedics may also be included in this pathway.

Until this pathway is established, if an ECP is required to administer vaccinations and authorised vaccinator status is not granted by the local Medical Officer of Health, a doctor or NP can issue Standing Orders that include the administration of vaccines.

Requesting laboratory tests

Paramedics are not currently included as approved referrers in contracts between laboratory providers and Te Whatu Ora. Work is currently underway with the Te Whatu Ora Directors of Allied Health to obtain clinical endorsement for paramedics to be added to laboratory contracts as approved referrers for defined tests. Until paramedics become approved referrers, ECPs working in primary care teams can request laboratory tests under a doctor or NP.

Requesting radiology

Paramedics are not able to refer people for basic radiology (e.g., ultrasound and plain film x-ray) in most areas of New Zealand. Approved referrers are listed in a mix of community radiology contracts between Te Whatu Ora and radiology providers, HealthPathways, hospital clinical policies (e.g. for nurse-initiated x-ray), and ACC Cost of Treatment Regulations.

Until paramedics are enabled to refer people for basic radiology, ECPs can refer people for imaging under a doctor or NP.

Links to useful resources

- Te Kaunihera Manapou Paramedic Council website.
- HealthyPractice position description templates.
- Manatū Hauora Standing Order Guidelines.
- Medicines (Standing Order) Regulations 2002.
- Ace Hub Courses for Primary Care.
- Practitioner's supply order (PSO).
- New Zealand Ambulance Sector Clinical Procedures and Guidelines (app also available on Google Play and the Apple App Store).
- Te Whatu Ora Primary, Community, and Rural Early Actions Programme website.

Appendix 1: Example induction/orientation checklist

This checklist is designed to assist the integration of ECPs moving into CPCTs. It can be tailored to the specific CPCT and/or used in addition to the Practice's usual induction/orientation.

	Induction and orientation
Role within the primary care team	
	The role of each clinician within the primary care team
	ECP's clinical role and responsibilities within the team
	Interacting, referring to, and seeking support from other health professionals
Clinical practice and models of care	
	Models of care and services provided by the practice
	HealthPathways
	Standing Orders, including any training and assessment of competence required
	Point of care diagnostics (i-STAT, Emerald)
	Referring to other health providers
	Requesting imaging and laboratory tests
	Process for arranging a prescription in consultation with a prescriber
	Phone triage/consultations
Patient management system and documentation	
	Introduction to PMS
	Opening patient files, adding notes, and recording vital signs
	Documenting interventions
	Documenting administered/supplied medications
	Documenting the authority under which medicines are given
	Completing ACC M45
	Accessing discharge summaries, laboratory results and imaging
Clinical supervision, support, and training	
	Clinical supervisor
	Protected time for teaching, mentoring, audit, and case review
	Seeking clinical advice and support
	Any required additional training or micro-credentialing (e.g. fracture casting, wound care, interpreting lab results)
	Ongoing professional development and Practice teaching sessions
	Clinical audit
Information technology	
	Full clinical access rights and logons to all relevant clinical systems (including remote access if required), e.g.:

	• Shared care record systems • E-referral systems • HealthPathways • Patient portals • NZ Formulary and other decision support tools