P01: Palliative Care - General

Jennie Helmer

Updated: December 01, 2020
Reviewed:

Introduction

Paramedics are often called for emergency medical issues for people with life-limiting conditions. Access to, and availability of, comprehensive palliative care can be difficult, particularly in remote and rural areas of the province. When sudden changes occur, families can feel afraid or unsure how to support their loved one, and often believe they have few options other than to call 9-1-1. Paramedics provide a rapid response to medical emergencies, but traditionally assess, treat and transport patients to hospital emergency rooms. For individuals in palliative care at home and their families, the transportation of the patient to an emergency department should be the exception rather than the rule. The person's wishes are usually to die at home; this should be confirmed at the time of interventions with the patient, family, or palliative care team.

Paramedics providing palliative care should practice "relationship-based care" by adopting a humble, self-reflective clinical practice, and positioning themselves as a respectful and curious partner when providing care. In particular, paramedics should seek to respect and learn about Indigenous (First Nations, Métis and Inuit) and different cultural approaches to palliative care, while reflecting on their own values and beliefs. Acknowledging the differences and the effect a paramedics' values and beliefs can have on others is an important step towards cultural humility.

Essentials

- The purpose of the palliative care clinical practice guidelines is to provide paramedics with guidance in managing symptoms for people who are currently undergoing palliative care or end of life experience, and who call 911 due to new or escalating symptoms. These symptoms are most likely to be nausea and vomiting, pain, delirium or agitation, or dyspnea. Family members may also react to severe distress by calling 911 because they experience spiritual or emotional crisis from their loved one's suffering or changing status.
- Subcutaneous administration of drugs is most commonly used in the palliative patient population
- Drug and non-drug therapies are equally important
- Palliative care is an approach that aims to reduce suffering and improve the quality of life for people who are living with life-limiting illness
- The intent of this care is to provide relief from distressing symptoms, not the treatment of any underlying disease process
- Palliative care patients are sometimes transported to hospital by ambulance when they would have preferred to remain in their own home. The aim of the palliative care pathway is to ensure that palliative care patients receive the most appropriate care for their condition and remain in their own home as per their wishes, when appropriate.
- Patients approaching end of life may experience pain or other symptoms that cause severe distress. These symptoms are usually managed very well by appropriate interventions and medications administered by the primary care, community health, specialty palliative care teams, and sometimes by family members.
- Patients who are beneficiaries of the BC Palliative Care Benefits Program have a life expectancy of up to 6 months
- Hospices services are available in many communities and can serve to offer additional services to people and their families

Additional Treatment Information

- Consult with patients' usual care team for the creation of a collaborative symptom management plan. If the patients' usual care team is not available, contact the After Hours Palliative Nursing Service (AHPNS). If neither is available or the patient is not under a care team, contact CliniCall (1-(833)-829-4099 or 604 829-4099) for the creation of a collaborative symptom treatment plan.
- Where the patient has not followed their symptom management plan, paramedics may encourage the patient/carer to administer any medications recommended as part of that plan, prior to management under this guideline. Paramedics can only administer the patient's own medications where the symptom management plan is clear and they are trained and experienced in the technique of administration, and where such administration is

within the scope of practice for their license. Paramedics should not use in situ subcutaneous access devices unless they are educated in their use.

- A patient may be recognized as a palliative patient or at end of life by one or more of the following:
  - Person is diagnosed with a life limiting illness
  - Care is currently focused on comfort and symptom management rather than curative interventions
  - Person presents with Goals of Care Designation consistent with treatment in place
  - Person is under care of a physician and/or home care providing palliative care services

Referral Information

All palliative/end of life patients can be considered for inclusion with the BCEHS Palliative Clinical Pathway (treat and refer) approach to care.

General Information

Refer to the Palliative Clinical Pathway for a complete explanation

- If there is a medication directive for the patient, signed by his/her GP, in the home and the medications prescribed for the required symptoms are available, consider supporting the family in the administration of the medication prescribed for that symptom as per the directive, in accordance with BCEHS policy and license scope of practice.
- If there is no medication directive for the patient in the home:
  - Contact the patient's palliative care team (if available) and identify a collaborative care plan
  - If neither the patient's usual care team nor the After Hours Palliative Nursing Service is available, Contact CliniCall/EPOS for the creation of a collaborative symptom treatment plan. Follow the appropriate BCEHS palliative care CPG to manage the symptom.
  - Consider transport to ED if the symptoms cannot be managed at home and this is the expressed preference of the individual and family
- Give appropriate support to the family members present
- Recognize when patients are entering the final stages of life
- Reassess the patient to ensure the patients' needs are met and treatment provided meets goals of care
- Complete an ePCR and ensure documentation follows the palliative clinical pathway requirements
- If patient goals of care are available, ensure a photo of the document (advanced care plan, do not resuscitate instruction, medical order for scopes of treatment, goals of care) is uploaded to the ePCR

References

1. Alberta Health Services. AHS Medical Control Protocols. 2020. [Link]
2. Ambulance Victoria. Clinical Practice Guidelines: Ambulance and MICA Paramedics. 2018. [Link]
3. BC Centre for Palliative Care. B.C. Inter-Professional Palliative Symptom Management Guidelines. 2017. [Link]
4. Nova Scotia Health Authority. Nova Scotia Palliative Care Competency Framework. 2017. [Link]
5. Pallium Canada. Learning Essentials Approach to Palliative Care. 2019. [Link]

P02: Palliative Care - Delirium

Jennie Helmer

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Introduction

Delirium is a syndrome of abrupt fluctuating disturbances in attention and awareness that represents a change from baseline status. It is typified by cognitive dysfunction along with changes in psychomotor behaviour, mood, and sleep-wake cycle, and may include hallucinations. Delirium can be either hypoactive, hyperactive, or mixed. It is a common phenomenon in palliative care, occurring in anywhere from 20% to 88% of cancer patients.

Although delirium often occurs 24 to 48 hours before death, it should not be considered a normal part of the dying process. Management of delirium symptoms may allow for a more peaceful death. Prompt recognition and treatment of delirium is essential to improve patient and family outcomes.

Essentials

- Establish goals of care in consultation and conversation with the patient, family, and care team
- Prevent over-stimulation and promote relaxation
- Avoid the use of physical restraints as they can increase the risk of delirium

Referral Information

All palliative and end-of-life patients can be considered for inclusion in the Palliative Clinical Pathway (treat and refer) approach to care. Paramedics must complete required training prior to applying this pathway.

General Information

- The signs and symptoms of hyperactive delirium may include:
  - Attention disturbances
  - Restlessness and agitation
  - Hallucinations
- Signs and symptoms of hypoactive delirium may include:
  - Drowsiness
  - Emotional or physical withdrawal
  - Depression
  - Lethargy
  - Decreased levels of consciousness
- Common causes of delirium:
  - Sepsis
  - Metabolic or electrolyte disturbances
  - Hypoxia
  - Organ failure
  - Withdrawal from alcohol or medications
  - Unmanaged or undermanaged pain
  - Sleep deprivation
  - Constipation or urinary retention
  - Dehydration
  - Changes to the patient’s environment or psychosocial situation

Interventions

Emergency Medical Responder – All FR interventions, plus:

- Establish goals of care in consultation and conversation with the patient, family, and care team
- Prevent over-stimulation and promote relaxation. Consider repositioning.
- Reassure the patient
- Provide supplemental oxygen if hypoxia is a potential cause of delirium

Primary Care Paramedic – All FR and EMR interventions, plus:

- Assist family with the administration of any medications that are recommended as part of an established care plan.
  - Paramedics can only administer the patient's own medications where the symptom management plan is clear, they are trained and experienced in the technique of administration and are operating within BCEHS scope. Contact CliniCall to discuss options.

Advanced Care Paramedic – All FR, EMR, and PCP interventions, plus:

- If the patient has delirium and agitation that is moderate to severe (RASS +2 to +4), is unmanageable, pose concerns of harm to self/caregivers, and/or is causing distress to the patient and family:
- First line: MIDAZOLam SC for temporary sedation
  - Lorazepam 1 mg SL (only if prescribed for patient). ACP must have appropriate Schedule 2 (4(b)) license endorsement. Mandatory call to EPOS for consultation.
- Second line:
  - KetAMINE SC/IM
- Patients requiring MIDAZOLam or ketAMINE for management of agitation should have follow-up from their palliative care team. If care team unable to attend within acceptable time frame, consider transport to hospital for further support.

Evidence Based Practice

Agitation

References

1. Alberta Health Services. AHS Medical Control Protocols. 2020. [Link]
2. Ambulance Victoria. Clinical Practice Guidelines: Ambulance and MICA Paramedics. 2018. [Link]
3. BC Centre for Palliative Care. B.C. Inter-Professional Palliative Symptom Management Guidelines. 2017. [Link]
4. Nova Scotia Health Authority. Nova Scotia Palliative Care Competency Framework. 2017. [Link]
5. Pallium Canada. Learning Essentials Approach to Palliative Care. 2019. [Link]
6. Pre-Hospital Emergency Care Council. Palliative Care by PHECC registered practitioners. 2016. [Link]
7. University of Colorado Denver. Delirium & RASS. 2002. [Link]

P03: Palliative Care - Pain

Jennie Helmer

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Introduction

Pain is a common palliative or end-of-life complaint in patients seeking treatment in the prehospital environment. It can be well controlled in up to 90% of patients using standard therapies, but remains under-recognized and under-treated in many palliative scenarios.

The objective of care is to reduce suffering associated with the experience of pain and to improve patient comfort. The adequacy of analgesia may be assessed through a variety of mechanisms, including physiological signs of pain, verbal numerical ratings, and overall appearance (whether distressed or not). Frequent reassessment and repeat administrations of medication are essential components of pain management.

Essentials

- Establish goals of care in consultation and conversation with the patient, family, and care team
- The total daily dose is the 24-hour total of a specific drug that is taken for regular and breakthrough pain
- Breakthrough pain is a transient exacerbation of pain against a background of relatively stable and adequately controlled pain
- The breakthrough or rescue dose is an additional dose of medication used to control breakthrough pain. It does not replace or delay the next routinely scheduled dose. Breakthrough doses of pain medication are generally 10% of the total regular daily opioid dose.
- Paramedics should consider referring patients with pain emergencies to acute hospital care for treatment of the underlying cause. Pain emergencies include fractures, spinal cord compression, superior vena cava obstruction, and an obstructed or perforated viscus.

Additional Treatment Information

- Treatment of pain is guided by use of the 0-10 pain intensity scale
- The dose of subcutaneous morphine to be administered can be calculated by converting each of the patient's regular opioid analgesics to a total equivalent daily dose of oral morphine
  - Where the total equivalent daily dose of oral morphine is <50 mg, the patient should receive morphine 2.5 mg subcutaneously
  - Where the total equivalent daily dose of morphine of oral morphine is >50 mg, 10% of that dose will be calculated and converted to a subcutaneous dose
  - Calculated doses of morphine >10 mg should be discussed with the clinician. The maximum subcutaneous dose of morphine is 20 mg. Patients who do not respond to this dose should consult CliniCall and/or be transported to hospital for further management.
- Breakthrough Dosing Principles:
  - Breakthrough doses are generally 10% of the total regular daily opioid dose
  - Use immediate release opioids every hour orally or every 30 minutes subcutaneously PRN
  - Use of the same opioid for breakthrough pain doses and the regularly scheduled opioid improves the ease and clarity for determining future dose titrations
  - Reassess when 3 or more breakthrough doses used per 24 hours (see titration section)
- Titration Principles:
  - Calculate total daily dose (TDD) for the past 24 hours
    - TDD = Regular dose + all breakthrough doses (BTD)
- Regular dose q4h for the next 24 hours = past TDD/6
- Breakthrough dose (BTD) = new regular dose X 10% Increase the opioid proportionally whenever the regular dose is increased

Referral Information

All palliative and end-of-life patients can be considered for inclusion in the Palliative Clinical Pathway (treat and refer) approach to care. Paramedics must complete required training prior to applying this pathway.

Interventions

Emergency Medical Responder – All FR interventions, plus:

- Establish goals of care in consultation and conversation with the patient, family, and care team
- Complete a comprehensive pain assessment
  - For those unable to communicate verbally, assess for restlessness, rigidity, grimacing, and distressed vocalizations
- Promote non-pharmacological pain strategies such as positioning and reassurance

Primary Care Paramedic – All FR and EMR interventions, plus:

- Assist family with the administration of any medications that are recommended as part of that plan
  - Paramedics can only administer the patient's own medications where the symptom management plan is clear, they are trained and experienced in the technique of administration and are operating within BCEHS scope
  - Contact CliniCall to discuss options
- Consider acetaminophen (patient pain rating of 1 to 6/10)
- Consider nitrous oxide

Advanced Care Paramedic – All FR, EMR, and PCP interventions, plus:

For severe (7/10 to 10/10) pain:

- First line:
  - MORPHine SC
- Second line:
  - KetAMINE SC or IN
- Consider patients' usual opioid regimen and whether opioid naïve
- Patients' own prescribed pain medication may be administered if the ACP has completed the appropriate Schedule 2 (4(b)) license endorsement. A mandatory call to EPOS for consult is required prior to the administration of any out-of-scope medications.

Evidence Based Practice

Analgesia

References

1. Alberta Health Services. AHS Medical Control Protocols. 2020. [Link]
2. Ambulance Victoria. Clinical Practice Guidelines: Ambulance and MICA Paramedics. 2018. [Link]
3. BC Centre for Palliative Care. B.C. Inter-Professional Palliative Symptom Management Guidelines. 2017. [Link]
4. Nova Scotia Health Authority. Nova Scotia Palliative Care Competency Framework. 2017. [Link]
5. Pallium Canada. Learning Essentials Approach to Palliative Care. 2019. [Link]
6. Pre-Hospital Emergency Care Council. Palliative Care by PHECC registered practitioners. 2016. [Link]
7. University of Colorado Denver. Delirium & RASS. 2002. [Link]

P04: Palliative Care - Dyspnea

Jennie Helmer

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Introduction

Dyspnea is the uncomfortable feeling of being short of breath. By definition, it is a subjective sensation, and may or may not be associated with hypoxia. The prevalence of dyspnea in palliative patients is high, and the intensity of the sensation tends to worsen towards the end of life. Opioids are the first-line pharmacological therapy, but several other, non-medication-based therapies exist.

Essentials

- Establish goals of care in consultation and conversation with the patient, family, and care team.
- Dyspnea may not necessarily be due to hypoxia. Improving airflow to the patient with fans can sometimes be as effective as oxygen administration. Paramedics should focus on relaxation and other non-pharmacological techniques before escalating to medications.
- Sit the patient upright, avoiding compression of the chest and abdomen. Consider positions that allow optimal lung expansion. If the patient cannot tolerate sitting upright, positioning with the affected (i.e., poorly ventilating) lung down may relieve the sensation of breathlessness.
- In cancer patients who are dyspneic, consider opioids as a first-line agent.
- Oxygen is generally only required in hypoxic patients.

Additional Treatment Information

- Subcutaneous morphine can be given to alleviate the sensation of dyspnea.
  - The dose of subcutaneous morphine is calculated by converting each of the patient's regular opioid analgesics to a total equivalent daily dose of morphine. (See https://ipalapp.com/manage/dyspnea/ for additional information on equianalgesic calculations.)
  - If the patient is not prescribed morphine, begin with 2.5 mg SC.
  - Where the total equivalent daily dose of morphine is over 50 mg, 10% of the dose can be converted to and given as a subcutaneous dose. The maximum subcutaneous dose of morphine is 20 mg. Consultation should be sought in cases where patients do not experience relief from these doses, and transport should be considered.
  - Calculated doses of morphine in excess of 10 mg should be discussed with a clinician, either as part of the palliative care team or through CliniCall.
  - If the patient is unable to have morphine, an equivalent does of fentanyl should be administered. (As an example, 2.5 mg of morphine is equivalent to 25 mcg of fentanyl; 20 mg of morphine is equivalent to 200 mcg of fentanyl.)

Referral Information

All palliative and end-of-life patients can be considered for inclusion in the Palliative Clinical Pathway (treat and refer) approach to care. Paramedics must complete required training prior to applying this pathway.

Interventions

Emergency Medical Responder – All FR interventions, plus:

- Establish goals of care in consultation and conversation with the patient, family, and care team.
- Complete a comprehensive dyspnea assessment.
- Provide supplemental oxygen in cases where SpO2 ≤ 94%, or differ significantly from patient's normal oxygen

saturation.

- Apply other methods to provide fresh air when SpO2 measurements do not indicate hypoxia. Fans, windows, and improved airflow should be attempted for at least five minutes.
- Promote non-pharmacological pain management strategies such as repositioning to more upright postures, relaxation, and reassurance.

Primary Care Paramedic – All FR and EMR interventions, plus:

- Assist family with administration of any medications that are part of the patient's care plan. Paramedics shall only administer patient medications where the symptom management plan is clear, and practitioners are properly trained, and the intervention is within the scope of practice. Contact CliniCall for consultation.
- Consider salbutamol via nebulizer for suspected bronchospasm.

Advanced Care Paramedic – All FR, EMR, and PCP interventions, plus:

- In moderate to severe dyspnea:
  - Consider ipratropium via nebulizer
  - Consider mORPHine SC
  - Consider MIDAZOLam SC for anxiety
- Titrate opioid dose incrementally by 25% according to effectiveness and PRN usage in prior 24 hours. Goal is patient comfort.

Evidence Based Practice

Breathlessness

References

1. Alberta Health Services. AHS Medical Control Protocols. 2020. [Link]
2. Ambulance Victoria. Clinical Practice Guidelines: Ambulance and MICA Paramedics. 2018. [Link]
3. BC Centre for Palliative Care. B.C. Inter-Professional Palliative Symptom Management Guidelines. 2017. [Link]
4. Nova Scotia Health Authority. Nova Scotia Palliative Care Competency Framework. 2017. [Link]
5. Pallium Canada. Learning Essentials Approach to Palliative Care. 2019. [Link]
6. Pre-Hospital Emergency Care Council. Palliative Care by PHECC registered practitioners. 2016. [Link]

P05: Palliative Care - Nausea

Jennie Helmer

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Introduction

Nausea and vomiting can profoundly affect the quality of life for palliative patients. The prevalence of nausea and vomiting is high in this group, affecting 40-60% of all individual receiving palliative care. Gastroparesis and chemical disturbances are the most common cause.

Essentials

- Establish goals of care in consultation and conversation with the patient, family, and care team
- Non-pharmacological interventions provide the best relief for mild and moderate nausea and vomiting
- Keep air and room fresh, and eliminate strong odors
- Nausea and vomiting are separate, but related, phenomena that are present in many life-limiting conditions

Additional Treatment Information

- A single dose of antiemetic is sufficient in the majority of patients
- Antiemetics tend to suppress vomiting more readily than nausea. An increase in the antiemetic dose may improve control of nausea.

Referral Information

All palliative and end-of-life patients can be considered for inclusion in the Palliative Clinical Pathway (treat and refer) approach to care. Paramedics must complete required training prior to applying this pathway.

General Information

- Underlying causes can be classified into 6 broad groups:
  - Chemical
  - Cortical
  - Cranial
  - Vestibular
  - Visceral
  - Gastric stasis (impaired gastric emptying)

Interventions

Emergency Medical Responder – All FR interventions, plus:

- Establish goals of care in consultation and conversation with the patient, family, and care team
- Complete a comprehensive nausea and vomiting assessment
- Promote fresh air in the patient's room, and eliminate strong odors where possible
- Promote non-pharmacological pain strategies such as positioning and reassurance

Primary Care Paramedic – All FR and EMR interventions, plus:

- Assist family with administration of any medications that are part of the patient's care plan. Paramedics shall only administer patient medications where the symptom management plan is clear, and practitioners are properly trained, and the intervention is within the scope of practice. Contact CliniCall for consultation.

- For mild nausea, consider dimenhyDRINATE PO/SC
- Consider intravenous fluids as appropriate to correct hypotension or dehydration
- Consultation with CliniCall is recommended

Advanced Care Paramedic – All FR, EMR, and PCP interventions, plus:

- Paramedics should not use in situ subcutaneous access devices unless they are educated in their use and within their scope of practice.
- For moderate to severe nausea, consider
  - Metoclopramide 5 mg SC
  - Ondansetron SC
  - DimenhyDRINATE PO/SC
  - Paramedics should consider patient's existing regimen of drugs. ACPs may administer patients' own prescribed medication only if the ACP has completed the appropriate Schedule 2 (4(b)) license endorsement. A mandatory call to EPOS for consult is required, prior to the administration of any out-of-scope medications.

Evidence Based Practice

Nausea & Vomiting

References

1. Alberta Health Services. AHS Medical Control Protocols. 2020. [Link]
2. Ambulance Victoria. Clinical Practice Guidelines: Ambulance and MICA Paramedics. 2018. [Link]
3. BC Centre for Palliative Care. B.C. Inter-Professional Palliative Symptom Management Guidelines. 2017. [Link]
4. Nova Scotia Health Authority. Nova Scotia Palliative Care Competency Framework. 2017. [Link]
5. Pallium Canada. Learning Essentials Approach to Palliative Care. 2019. [Link]
6. Pre-Hospital Emergency Care Council. Palliative Care by PHECC registered practitioners. 2016. [Link]

P06: Palliative Care - Secretions

Jennie Helmer

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Introduction

Secretions and respiratory congestion produce noisy breathing as the movement of mucus and phlegm disrupts the flow of air in the upper airway. Patients who are dying, or who have reduced levels of consciousness or profound weakness, often suffer from excessive oral secretions from the salivary glands. These secretions predict death for up to 75% of patients, often within 48 hours of onset. Bronchial secretions can be caused by respiratory pathologies such as lung infections, aspiration, or pulmonary edema.

Secretions are a common, and expected, symptom in the dying patient. Although the sound can be distressing to family and practitioners, there is no evidence that the sound alone is associated with respiratory distress.

Essentials

- Establish goals of care in consultation and conversation with the patient, family, and care team
- Although the sound of respiratory congestion can be disturbing to hear, determine if the patient is distressed by observing other indications, such as wincing, and provide reassurance to the family
- If the patient seems distressed from their secretions, start medication early for best effect
- Positioning is the most effective non-pharmacological intervention. Reposition the patient in a side-lying position with the head of the bed elevated.
- Deep suctioning may not relieve congestion however, in the event of copious secretions in the oropharynx, gentle anterior suction may be helpful

Additional Treatment Information

- Oxygen has no known patient benefit for respiratory congestion
- Anticholinergics may be more effective when started early, as these drugs do not dry up secretions that are already present

Referral Information

All palliative and end-of-life patients can be considered for inclusion in the Palliative Clinical Pathway (treat and refer) approach to care. Paramedics must complete required training prior to applying this pathway.

Interventions

Emergency Medical Responder – All FR interventions, plus:

- Establish goals of care in consultation and conversation with the patient, family, and care team. Inform families that noisy breathing may occur as a normal part of the dying process
- Positioning (side-lying with the head of the bed elevated) is the most effective non-pharmacological intervention

Advanced Care Paramedic – All FR, EMR, and PCP interventions, plus:

- Consider atropine IM
- Consider glycopyrrolate IM
- ACPs may administer patients' own prescribed medication only if the ACP has completed the appropriate Schedule 2 (4(b)) license endorsement. A mandatory call to EPOS for consult is required prior to the administration of any out-of-scope medications.

Evidence Based Practice

Secretions

References

1. Alberta Health Services. AHS Medical Control Protocols. 2020. [Link]
2. Ambulance Victoria. Clinical Practice Guidelines: Ambulance and MICA Paramedics. 2018. [Link]
3. BC Centre for Palliative Care. B.C. Inter-Professional Palliative Symptom Management Guidelines. 2017. [Link]
4. Nova Scotia Health Authority. Nova Scotia Palliative Care Competency Framework. 2017. [Link]
5. Pallium Canada. Learning Essentials Approach to Palliative Care. 2019. [Link]
6. Pre-Hospital Emergency Care Council. Palliative Care by PHECC registered practitioners. 2016. [Link]

P07: Palliative Care - End of Life

Jennie Helmer

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Introduction

Patients who are at the end of their lives can be recognized by one, or more, of the following features:

- The patient is diagnosed with a life-limiting illness
- Care is currently focused on comfort and symptom management, rather than curative interventions
- The patient has a current document outlining their goals for care
- The patient is under the care of a physician, or a home care team providing palliative care services

When death is imminent, the individual may be provided with supportive care and comfort measures, with the goal of avoiding medical interventions where appropriate.

Essentials

- Establish goals of care in consultation and conversation with the patient, family, and care team
- It is important to recognize that dying may take hours or days and diagnosing dying is a complex process
- Imminent death can sometimes be recognized by any, none, or all of the following:
  - Patient uncommunicative, unresponsive, and difficult to arouse
  - Cold, purple, blotchy feet, and hands
  - Drowsiness, impaired cognition
  - Decreased urine output
  - Restlessness
  - Congestion and gurgling in the chest
  - Change in breathing patterns

Additional Treatment Information

- When death is imminent, the patient may be provided with supportive care such as positioning, suctioning, fans as necessary. Avoid medical interventions when appropriate.
- *Integrity in palliative care practice* refers to the importance of respecting the patient's values, needs, and wishes in the context of a life-limiting condition
- Recognize and respect that people may have a spiritual and/or religious belief at end of life, and that such beliefs may be different from the paramedics' beliefs
- For patients nearing the end of their lives, transfer to the ED can be inappropriate
- When a clear "Do Not Resuscitate (DNR)" or Medical Orders for Scope of Treatment (MOST) instruction is in place, paramedics should not start resuscitation when the patient progresses to respiratory or cardiac arrest. If clear documentation is not available (e.g., a verbal do-not-resuscitate order), contact CliniCall immediately for guidance.
- Follow the BCEHS procedure for pronouncing death of the patient
- Witnessing the end of life often elicits a variety of responses from those present. Cultural beliefs, age, and the nature of the incident may influence the response.
- Once the decision to withhold or discontinue resuscitation has been made, be prepared to console the family, friends or bystanders at the moment of death
- Allow the family space to grieve and when appropriate, attempt to cover the body and close the patient's eyes

Referral Information

All palliative and end-of-life patients can be considered for inclusion in the Palliative Clinical Pathway (treat and

refer) approach to care. Paramedics must complete required training prior to applying this pathway.

References

1. Nova Scotia Health Authority. Nova Scotia Palliative Care Competency Framework. 2017. [Link]
2. Pallium Canada. Learning Essentials Approach to Palliative Care. 2019. [Link]
3. Harman SM, et al. Palliative care: The last hours and days of life. In UpToDate. 2020. [Link]

P08: Medical Assistance in Dying (MAID)

Jennie Helmer
Updated: April 1, 2020
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Introduction

In June 2016, the federal government amended the Criminal Code and passed Bill C-14, providing legal protection for persons who aid physicians and nurse practitioners, who provide services for medical assistance in dying (MAiD).

This new legislation includes the protection of paramedic practitioners. Paramedics are categorized alongside other healthcare professionals and are provided further protection under sections 241 (5.1) and 227 (2) of the Criminal Code: 241(5.1)

Definitions:

Medical assistance in dying is defined as:

Medical assistance in dying occurs when an authorized doctor or nurse practitioner provides or administers medication that intentionally brings about a person's death, at that person's request. This procedure is only available to eligible patients.

Bill C-14 defines a medical practitioner as a person who is entitled to practice medicine under the laws of the province (e.g. physician).

Liability:

Only physicians or nurse practitioners are enabled to determine and confirm that a patient is eligible for the MAiD program. The patient must meet all the criteria in order to receive MAiD:

- Be eligible health services publicly funded by a government in Canada;
- Be at least 18 years old and capable of making decisions about their health; ☐
- Have made a voluntary request for MAID that, in particular, was not made as a result of external pressure;
- Have given informed consent to receive MAiD after being informed of the means that are available to relieve their suffering, including palliative care; and
- Have a grievous and irremediable medical condition

Guidelines

Under Bill C-14, Paramedics are categorized alongside other healthcare professionals and are provided further protection under sections 241 (5.1) and 227 (2) of the Criminal Code: 241(5.1). For greater certainty, no social worker, psychologist, psychiatrist, therapist, medical practitioner, nurse practitioner or other healthcare professional commits an offence if they provide information to a person on the lawful provision of medical assistance in dying. 227(2) No person is party to a culpable homicide of they do anything for the purpose of aiding a medical practitioner or nurse practitioner to provide a person with medical assistance in dying in accordance with section 241.2

Under the Emergency Health Services Act, the Emergency Medical Assistants (EMA) Licensing Board is responsible for examining, registering and licensing all EMAs in British Columbia. The Board, under the authority of the Emergency Health Services Act, sets license terms and conditions. The EMALB policy is that a qualified EMA may initiate an intravenous line that has been ordered by a physician or nurse practitioner for MAiD. An EMA may not administer medication for MAID in any circumstance.

Given the nature of paramedic practice, it is anticipated that BCEHS paramedics will be called to assist with a MAiD event. In these circumstances, it is expected that the paramedic practices within their defined scope of practice and in accordance with the Code and all legislations, EMALB policies and BCEHS operational scope of practice. BCEHS recognizes the complexity of MAiD and encourages the use of this guideline in conjunction with all legislation and current regulations.

It is also anticipated that patients may inquire about MAiD, with paramedics. In these circumstances, it is expected that paramedics will refer such patients to their primary health care professionals for further information.

Specific situations where paramedics may be called to assist in a MAiD event include the following:

1. Inserting an Intravenous line that has been ordered by a physician or nurse practitioner for MAiD.
2. Transporting a patient from one destination to another for the purposes of MAiD. Paramedics are NOT permitted to administer medication for MAiD in any circumstance.

Paramedics are NOT considered health professionals for the purposes of witnessing an eligibility assessment, nor for death confirmation.

BCEHS recognizes that the MAiD program may conflict with an individual paramedic's belief or value system, and will attempt to make suitable arrangements where this occurs. Paramedics are expected to take all reasonable steps to ensure that the continuity and quality of care is not compromised.

Resources:

1. BC Ministry of Health: Medical Assistance in Dying□ [Link]
2. EMALB: Medical Assistance in Dying [Link]
3. Legislative Background: Medical Assistance in Dying (Bill C-14 2016)[Link]

P09: Palliative Care - Medications Prepared for Deferred Subsequent Use

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Introduction

In November 2020, the Emergency Medical Assistant Licensing Board (EMALB) provided direction and support with regards to the preparation of medications for deferred, subsequent use. Medication administration and assistance are permitted under the EMA Regulations, while dispensing is a controlled act performed by various professions under the authority of other statutes and regulations.

Essentials

Under this guideline, advanced care paramedics (ACPs) are permitted to prepare a palliative care medication for parenteral use and administration by a family member or household caregiver, after the paramedic has left the scene.

An ACP with the appropriate license endorsements (Schedule 2, Section 4(b)) is permitted to prepare a palliative care medication for parenteral use and administration by a family member or household caregiver after the paramedic has left the scene under the following conditions:

1. The medication is specified and prepared in accordance to a palliative care management plan developed and authorized by a physician or nurse practitioner;
2. The medication has already been prescribed to the patient and is in the possession of the patient (i.e., the paramedic is not providing the medication from BCEHS supply); and,
3. Authorization from an EPOS physician has been obtained if the medication is not specified in the Regulation; and
4. The ACP has successfully completed the BCEHS - Schedule 2 Endorsement: Palliative Medication on the PHSA Learning Hub; and
5. The ACP has received the EMA Regulation Schedule 2, Section 4(b) endorsement for administration of drug therapy on the direct order of a medical practitioner who is designated by BCEHS as a Transport Advisor.

Additional Treatment Information

- Paramedics will complete a full history, obtain a full set of vital signs, and conduct a patient assessment prior to the preparation of palliative medications for administration by a family member or household caregiver.
- Paramedics will complete a full ePCR, documenting the nature of the call, any collaborative care, and ensure that the patient signs the refusal of transport or referral of care section (as appropriate).

Referral Information

Clinical Pathway: Palliative Clinical Pathway (ASTaR link forthcoming)

Interventions

First Responder

Not authorized.

Emergency Medical Responder – All FR interventions, plus:

Not authorized.

Primary Care Paramedic – All FR and EMR interventions, plus:

Only authorized to administer medications under existing scope.

Advanced Care Paramedic – All FR, EMR, and PCP interventions, plus:

CliniCall consultation required.

Authorized to prepare palliative medication for administration by a family member or household caregiver, following EPOS consult, under the provisions of a Schedule 2, Section 4(b) endorsement.

Community Paramedic (CP) Interventions

Authorized to administer medications under existing scope.

Critical Care Paramedic – All FR, EMR, PCP, and ACP interventions, plus:

Authorized as per operational scope.