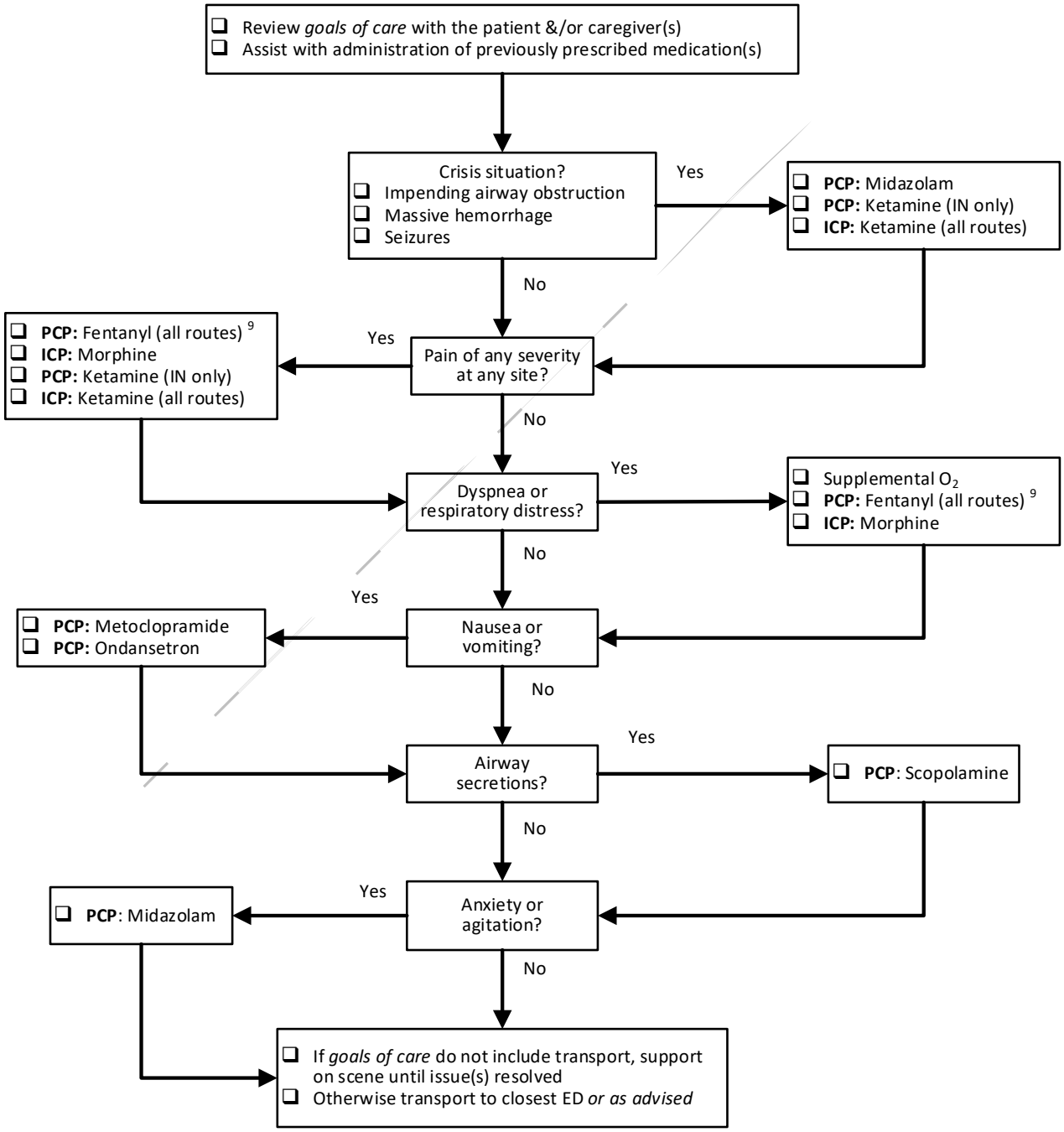
Shared health Soins communs Manitoba	**E30A - PALLIATIVE CARE IN THE HOME**	
	Adult	MEDICAL
PCP - Paramedics with the primary and intermediate work scopes will follow this protocol, except where indicated by **ICP** (intermediate only).		
Version date: 2022-08-22		Effective date: 2022-08-22 (0700 hrs)
This care map is for the IERHA Paramedics Providing Palliative Care in the Home (PPPCaH) pilot project only.		



INDICATIONS

- Patient is currently enrolled in the Interlake Eastern Regional Health Authority (IERHA) palliative care program, regardless of the patient's point of origin.

CONTRAINDICATIONS

- Patient's condition is due to an unexpected cause such as an accident, suicide attempt or assault.
- Patient's current goals of care include resuscitative measures.
- For the purposes of this care map only true allergy to a medication is the only absolute contraindication to its administration.

NOTES

1. **Paramedics may contact the on-line medical support (OLMS) physician at any time for clinical advice or decision-support.**
2. Enrollment in the IERHA palliative care program must be confirmed to apply this protocol.
3. If the patient's goals of care have changed to include resuscitative measures, discontinue the use of this protocol, and refer to the appropriate general care map.
4. A patient's *health care directive* or *advanced care plan* may be used to guide the discussion and decisions around the goals of care.
5. The patient or their health care proxy may indicate a change in the goals of care verbally, without requiring the completion of new documentation.
6. Paramedics may perform any and all steps required to assist the patient to take a prescribed medication.
7. Vital sign measurements are not required for the application of this care map and should not be routinely obtained.
8. Management of symptoms (eg. pain, nausea, dyspnea) should be carried out using pharmacologic and, where appropriate, non-pharmacologic measures in accordance with the patient's subjective report as to the severity of the symptom(s).
9. Medications should generally be administered by the subcutaneous (SC) route.

   Intravenous (IV) access is not required to administer intranasal (IN) medications.

   If multiple doses are required, paramedics should switch from the IN route to SC or IV administration.

   If an SC line has been established by paramedics it *should* be left in place when EMS departs the scene, unless the patient or family specifically requests its removal. If an IV line has been established by paramedics it must be removed after use by paramedics.
10. Paramedics do not require the signature of the patient or their health care proxy to treat and release (not transport).
11. If not transporting, document the date and time that EMS attended in the integrated progress note (IPN) and leave the hospital copy of the patient care record (PCR) with the chart.

12. If transporting, document the date and time, reason for transport and the name of the receiving facility in the IPN, along with the names and license numbers of both providers. The hospital copy of the PCR should accompany the patient to the hospital.
13. Fax a copy of all PCRs to the Palliative Care Team at **204-785-4895**.
14. If a patient registered with either the WRHA or IERHA palliative care programs has an admission to a palliative care bed arranged, paramedics will bypass the emergency department and transport directly to the palliative care unit as advised. Paramedics may consult with OLMS for confirmation.

TABLE A: MEDICATIONS QUICK REFERENCE GUIDE

MEDICATION	ROUTE	INITIAL DOSE	REPEAT DOSE
FENTANYL	**PCP:** Intranasal [9] Subcutaneous Intravenous	2 mcg/kg (no maximum)	Every 5 - 10 minutes as required (no maximum)
		1 - 2 mcg/kg (no maximum)	Every 15 to 30 minutes as required (no maximum)
KETAMINE	**PCP:** Intranasal	0.5 to 1 mg/kg Follow with 0.25 to 0.5 mg/kg after 10 to 15 minutes if necessary to achieve adequate analgesia	0.25 to 0.5 mg/kg every 30 minutes as require maintaining analgesia (max = 1 mg/kg/hr)
	ICP only: Subcutaneous Intravenous	0.5 mg/kg Follow with 0.25 mg/kg after 10 to 15 minutes if necessary to achieve adequate analgesia	
MIDAZOLAM	**PCP:** Intranasal	5 mg	Every 5 minutes as required (no maximum)
	PCP: Subcutaneous	2.5 to 5 mg	Every 15 - 30 minutes as required (no maximum)
	PCP: Intravenous	2.5 mg	Every 10 - 15 minutes as required (no maximum)
METOCLOPRAMIDE	**PCP:** Subcutaneous Intravenous	10 mg	Every 4 - 6 hours as required

ONDANSETRON	**PCP:** Subcutaneous Intravenous	4 mg	Every 6 - 8 hours as required
SCOPOLAMINE	**PCP:** Topical (patch)	One patch (1.5 mg)	None
MORPHINE *MED - morphine equivalent dose (table B)* *IR - immediate release* *SR - sustained release*	**ICP:** Subcutaneous	5 mg if not currently on opioid	Every 30 - 60 minutes as required (no maximum)
		MED if currently on IR opioid	
		MED of <u>breakthrough</u> medication if currently on SR opioid	
	ICP: Intravenous	5 mg if not currently on opioid	Every 10 - 15 minutes as required (no maximum)
		MED if currently on IR opioid	
		MED of <u>breakthrough</u> medication if currently on SR opioid	

TABLE B: CALCULATING MORPHINE EQUIVALENT DOSE (MED)
Use this table for the conversion of <u>immediate-release</u> preparations only.

CURRENT ORAL MEDICATION	EQUIVALENT <u>ORAL</u> DOSE OF MORPHINE	EQUIVALENT <u>IV / SC</u> DOSE OF MORPHINE
Codeine	mgs of codeine **x 0.1**	mgs of codeine **x 0.05**
Morphine	mgs of morphine **x 1**	mgs of morphine **x 0.5**
Oxycodone	mgs of oxycodone **x 2**	mgs of oxycodone **x 1**
Hydromorphone	mgs of hydromorphone **x 5**	mgs of hydromorphone **x 2.5**

APPROVED BY	
	Medical Director - Provincial EMS/PT

VERSION CHANGES (refer to X05 for change tracking)
• Direct PCU admissions will bypass the ED

APPENDIX A: ADMINISTERING A SUBCUTANEOUS INFUSION

INDICATIONS:

- Palliative patient where goals of care include subcutaneous (SC) medication or fluid administration

PROCEDURE:

1. Determine whether there is an existing SC site, or whether one must be established.
2. If a line is already established ensure patency before administering any fluid or medication. If the site is questionable, establish a new SC line, a minimum of 5cm from the previous site.

   If possible, avoid sites with overlying infection and/or burns and/or distal to known injury.
3. To optimize medication absorption and patient comfort, the maximum amount of medication to be administered at one time (excluding flush) is 2 ml.

   To ensure that the 2 ml limit is not exceeded, consider a more concentrated preparation of the ordered medication to ensure that the maximum amount administered does not exceed 2 ml.

   Alternatively, administer in 2 ml increments at 15-20 minute intervals, or start a secondary line.
4. If the medication has not absorbed after 15-20 minutes (i.e. presence of palpable “bump” indicating incomplete absorption), determine if a second site is required for future doses and/or wait another 15- 20 min and then administer the remainder of the medication (no more than 2 ml at one time).
5. Ensure lines are clearly labelled when multiple sites are used for administering different medications.
6. If an SC line has been established by paramedics it should be left in place when EMS departs the scene, unless the patient or family specifically requests its removal.
7. Document on patient file.

APPENDIX B: URINARY CATHETER IRRIGATION

INDICATIONS:

- Patient has an already established indwelling urinary catheter
- Impaired urinary elimination
- Urinary Retention

CONTRAINDICATIONS:

- Patient has had recent transurethral surgery
- Physician order in place that states not to flush urinary catheter

PROCEDURE:

1. Assist patient into a supine position. Expose only the catheter that is connected to the urinary catheter drainage bag. Ensure patient privacy with use of a drape or blanket to cover patient.
2. Perform hand hygiene
3. Wipe the catheter connection to the drainage bag for 30 seconds with an alcohol swab. Allow to air dry.
4. Slowly instill no more than 30 ml of the prescribed irrigation solution into the catheter, using gentle pressure. Excessive volume of solution can cause bladder spasms and/or hemorrhage.
5. If there is resistance against the instillation, apply firm, but not excessive force against the syringe plunger. If greater force is needed, stop the procedure, and remove the syringe.
6. After the solution is instilled, remove the syringe and allow the solution to drain into a collection container by holding the catheter over the container. If the fluid is not draining, assist the patient to lie on his/her side to promote fluid return. Do NOT aspirate the solution, as there is risk for bladder trauma, which can predispose the patient to infection.
7. If irrigation is unsuccessful after two attempts, cease irrigation attempts and discuss other treatment options.
8. Document on patient file: procedure performed along with the amount and type of irrigation solution, amount returned as drainage, characteristics of returns (color, clarity, presence of clots/mucous), patient response to procedure.