Shared health Soins communs Manitoba	E16 - PALLIATIVE CARE	
	Adult	MEDICAL
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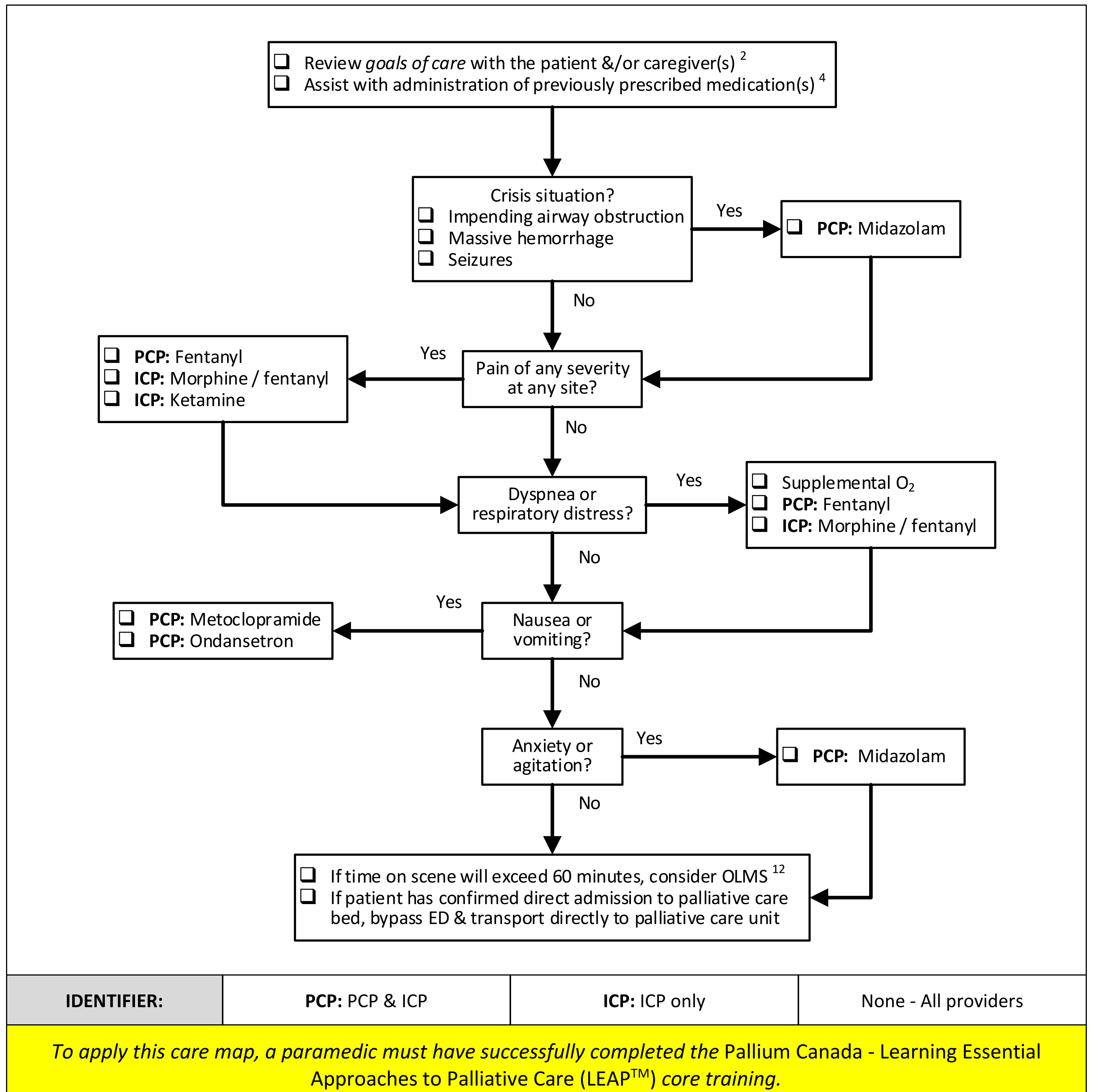

IDENTIFIER:	**PCP:** PCP & ICP	**ICP:** ICP only	None - All providers

To apply this care map, a paramedic must have successfully completed the Pallium Canada - Learning Essential Approaches to Palliative Care (LEAP™) *core training.*

INDICATIONS
• Patient is enrolled in the Interlake Eastern Regional Health Authority (IERHA) palliative care program, regardless of the patient's point of origin [1]

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 [3] • For the purposes of this care map only true allergy to a medication is the only absolute contraindication to its administration

Some drugs and medical functions in this care map exceed the usual EMS work scope (A06) and standing orders (M-documents). This protocol supersedes all other care maps for patients enrolled in the IERHA palliative care program.

NOTES

1. Enrollment in the IERHA palliative care program must be confirmed to apply this protocol.
2. A patient's *health care directive* or *advanced care plan* may be used to guide the discussion and decisions around goals of care. A patient or their proxy may indicate a change in the goals of care <u>verbally</u> without completion of a new written document.
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 care map.
4. Paramedics may perform any and all steps required to assist the patient to take <u>any</u> prescribed medication.
5. Vital sign measurements are not required for the application of this care map and should not be routinely obtained.
6. 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 <u>subjective</u> report symptom severity.
7. Medications should generally be administered by the subcutaneous (SC) route.
8. Intravenous (IV) access is not required to administer intranasal (IN) medications. If multiple doses are required, paramedics should switch from the IN to SC or IV route of administration.
9. If necessary, remind loved ones in attendance that the sounds of excess secretions are due to small amounts on the vocal cords, do not indicate choking, and are not harmful or distressing to the patient.
10. If a paramedic establishes an SC catheter it *should* be left in place unless the patient or their proxy requests removal. If a paramedic starts an IV line remove it before departure, or consult OLMS.
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. The patient / proxy does not need to sign anything to not be transported.

If transporting, document the date and time, reason for transport and the name of the receiving facility in the IPN. The hospital copy of the PCR should accompany the patient to the hospital.

Fax a copy of all PCRs to the Palliative Care Team at **204-785-4895**.

12. Paramedics may consult on-line medical support (OLMS) at any time.

MEDICATION QUICK REFERENCE GUIDE			
MEDICATION	**ROUTE**	**IINITIAL DOSE**	**REPEAT DOSE**
FENTANYL (PCP & ICP)	INTRANASAL [8]	2 mcg/kg (no maximum)	Every 5 - 10 minutes as required (no maximum)
	SUBCUTANEOUS INTRAVENOUS	1 - 2 mcg/kg (no maximum)	Every 15 to 30 minutes as required (no maximum)
KETAMINE (ICP ONLY)	SUBCUTANEOUS INTRAVENOUS	0.5 mg/kg; follow with 0.25 mg/kg after 10 min 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)
MIDAZOLAM (PCP & ICP)	INTRANASAL	5 mg	Every 5 minutes as required (no maximum)
	SUBCUTANEOUS	2.5 to 5 mg	Every 15 - 30 minutes as required (no maximum)
	INTRAVENOUS	2.5 mg	Every 10 - 15 minutes as required (no maximum)
METOCLOPRAMIDE (PCP & ICP)	SUBCUTANEOUS INTRAVENOUS	10 mg	Every 4 - 6 hours as required
ONDANSETRON (PCP & ICP)	SUBCUTANEOUS INTRAVENOUS	4 mg	Every 6 - 8 hours as required

MORPHINE		
ROUTE	**INITIAL DOSE**	**REPEAT DOSE**
SUBCUTANEOUS (ICP ONLY)	5 mg if not currently on any opioid	Every 30 - 60 minutes as required (no maximum)
	Morphine-equivalent dose if currently on immediate-release opioid	
	Morphine-equivalent dose of breakthrough medication if currently on sustained-release opioid	
INTRAVENOUS (ICP ONLY)	5 mg if not currently on any opioid	Every 10 - 15 minutes as required (no maximum)
	Morphine-equivalent dose if currently on immediate-release opioid	
	Morphine-equivalent dose of breakthrough medication if currently on sustained-release opioid	

CALCULATING MORPHINE-EQUIVALENT DOSE		
CURRENT ORAL MEDICATION	**EQUIVALENT ORAL DOSE OF IMMEDIATE-RELEASE MORPHINE**	**EQUIVALENT IV / SC DOSE OF IMMEDIATE-RELEASE 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	
EMS Medical Director	EMS Associate Medical Director

VERSION CHANGES (refer to X05 for change tracking)
• Replaces E30A from pilot project • Indications include requirement for LEAP training • Flow chart corrected to indicate PCP can administer fentanyl by any route • IN ketamine removed • Removal of scopolamine patches for secretions (ineffective & no longer available) • Identifier legend at bottom of flow chart replaces work scope statement in header

APPENDIX A: PROCEDURE FOR ADMINISTERING A SUBCUTANEOUS INFUSION

INDICATIONS:

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

CONTRAINDICATIONS:

- Overlying infection at proposed insertion site

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.