EMS Palliative and End of Life Care Assess, Treat and Refer Program
Frequently Asked Questions (FAQ)
For EMS Practitioners

Who is this program for?

The program is for any patient receiving palliative or end of life care in the community setting (private home, supportive living site, long term care facility, and/or hospice). For the program to be activated, the following inclusion criteria must be met:

- The patient is recognized as palliative and/or end of life by one or more of the following:
  - The patient is diagnosed with a life limiting illness,
  - Care is currently focused on comfort and symptom management rather than curative interventions,
  - The patient presents with a Goals of Care Designation consistent with treatment in place, and/or
  - The patient is under the care of a physician and/or homecare who is providing palliative care services
- The patient/family agrees to treatment in place
- The patient is at least 18 years old

How can the program be accessed?

Any registered healthcare professional may activate the program for their patient if they meet the inclusion criteria. This includes EMS professionals who arrive at the patient's home through a routine 911 event or community clinicians who may or may not be in the home at the time of the event and identify that the patient could benefit from EMS involvement for urgent symptom management.

How will I know that I am going to a Palliative and End of Life Care Assess, Treat and Refer Event?

When the program is activated by a clinician (either in the home or remotely), you will be notified of the event type through the data terminal in the ambulance (MDT). The event may be coded as "33A10P" and written text entered by the Emergency Communications Officer may also include "Palliative Patient Pathway" to notify you that you are responding to a Palliative and End of Life Care Assess, Treat and Refer event where a healthcare clinician is on scene or available to be consulted via phone.

If the patient or family calls 911 directly, or the script is not followed, the event will be routinely evaluated and could have any event code depending on the patient's symptoms and what information is given to the Emergency Communications Officer. Therefore, it is important to note that you may arrive at other 911 events where assess, treat and refer may be appropriate after you conduct an assessment, gather a history and discuss the patient's/family's wishes for care.

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How will I know what scope of practice the clinician on scene can provide in their setting?

Various professions who work within continuing care have been trained on the program (RNs, LPNs, RTs, NPs, physicians, etc.) and may activate the assess, treat and refer program. When EMS arrives in the home, EMS and the clinician should engage in a discussion around each healthcare professional's scope of practice and what support can be provided in the home for the patient at that time. EMS should be aware that the ongoing care that can be provided in each setting may be guided not only by the clinician's scope of practice, but also by local policy.

How do I access the program for my patient if I arrive through a routine 911 call from the patient or family?

EMS may identify patients appropriate for treatment in place under the PEOLC Assess, Treat and Refer program once they arrive in the home. EMS should gather a complete history from the patient to determine if they meet the inclusion criteria. Patients may be recognized as palliative and/or end of life by one or more of the following:

- The patient is diagnosed with a life limiting illness,
- Care is currently focused on comfort and symptom management rather than curative interventions,
- The patient presents with a Goals of Care Designation consistent with treatment in place, and/or
- The patient is under the care of a physician and/or homecare who is providing palliative care services

In addition, patients must be 18 years of age and want to be treated at home. If the patient meets the inclusion criteria, EMS will discuss the option to provide treatment in place with the patient's clinician (primary/palliative care team) and online physician (collaborative care model) as detailed in the protocol. If the patient would prefer to be transported to hospital, EMS will provide treatment as necessary and transport.

How does Advanced Care Planning and Goals of Care (ACP/GCD) fit into the program?

The program aims to align the care we provide with our patients' current wishes including their Advanced Care Plan or Goals of Care Designation. Most patients accessing this program will likely have a C1 or C2 Goals of Care designation; however **a formal Goals of Care Designation is not needed to activate the program** as long as the EMS or the clinician can confirm the patient is known to be receiving palliative and end of life care.

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Are there any medications commonly used in palliative and end of life care symptom management that EMS does not carry?

EMS carries a fairly comprehensive drug formulary, however there are a number of drugs that are used routinely in palliative and end of life care symptom management that EMS does not currently carry:

- Lasix (furosemide)
- Nozinan (methotrimeprazine)
- Glycopyrrolate or scopolamine – EMS carries atropine which can sometimes be used instead
- Dilaudid (hydromorphone)

Although these drugs are not carried, many patients' symptoms have been successfully managed at home using drugs available in the current EMS formulary as temporary substitutions while arrangements are made to get pharmacology into the home for ongoing in-home administration.

Why is physician contact mandatory?

Palliative medicine is a specialized area of care where EMS does not have specific training or experience. Collaboration with a physician will ensure that an individualized care plan incorporating EMS's scope of practice is developed for each patient. The physician will also assist in determining if it is appropriate for the patient to be treated and left at home or if transport is required.

The protocol states that EMS can call the patient's family or palliative physician, the zone's palliative physician on call or an EMS online medical consultation (OLMC) physician for medical direction. How do I know who to call?

EMS OLMC is available 24 hours a day, 7 days a week for all EMS practitioners throughout the province, however if the clinician has already made contact with another physician regarding the patient's current presentation (family or palliative physician), it may be of benefit to maintain continuity of care with that physician. You and the clinician will decide who is the most appropriate to call.

The patient's most responsible prescriber is a Nurse Practitioner, not a physician. Can I take orders from the patient's NP?

Currently, EMS is only able to take orders from physicians (as per legislation). However, you are encouraged to involve the patient's most responsible prescriber in the development of the treatment plan if they are available at the time of the event. Treatments that are suggested by an NP can be discussed with the EMS OLMC physician to ensure you are in compliance with current legislation.

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Are there palliative specific protocols for us to follow for this program?

No. For Phase I and II of the program, you will receive direction and orders from a consulting physician (patient's family or palliative physician, the zone's palliative physician on call or the EMS OLMC physician). Palliative specific protocols for EMS may be developed in the future.

What kinds of treatments can I expect to be providing to these patients?

Care under the PEOLC ATR program is directed at comfort and symptom management. Although EMS often provides symptom management to patients in acute and emergent situations, there are some differences in the standard of care when managing symptoms for PEOLC patients that may be unfamiliar to EMS professionals.

- Opioids are a mainstay of treatment in palliative care for patients presenting with dyspnea.
- For patients on significant doses of routinely administered opioids, larger doses of medication may be required.
- Metoclopramide (Maxeran) is the most commonly administered antiemetic in palliative care.
- Haloperidol (Haldol) is routinely used in palliative care in the management of delirium and nausea/vomiting.
- Oral medication administration is preferred, with subcutaneous medication administration as the primary route if patients are unable to take oral meds. Many patients do not have adequate muscle mass for intramuscular medication administration and intravenous medications are not routinely given in the home setting.

Can I leave equipment with the clinician in the patient's home such as oxygen tanks and regulators?

Yes, you may leave oxygen on scene with the clinician if it is required for a short duration while more permanent arrangements are made. This decision will be made in consultation with the on scene clinician, consulting physician and your operations supervisor.

Can I leave medications in the home for subsequent administration until medications become available from community pharmacy?

No, under current legislation, EMS cannot dispense medications. Extra medication may not be left in the home with the clinician or with the patient or family for later administration.

What if the patient cannot sign the PCR (patient care report)?

A family member and/or the clinician (if on scene) may sign the PCR for the patient.

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Are there any specific documentation requirements for a PEOLC Assess, Treat and Refer Event?

Yes. All assess, treat and refer protocols have additional documentation requirements.

If using ePCR for documentation:

- Use "Treated and Referred" as your response outcome (rather than "Refusal of Care and/or Transport")
- Complete the additional palliative ATR fields found on the ePCR (similar to those for hypoglycemia and SVT)
- Leave the Refusal/Assess, Treat and Refer Brochure with the patient/family
- Transmit PCR to the appropriate zone hub so it can be forwarded to the appropriate case manager BEFORE finalizing your ePCR

If using paper PCRs for documentation:

- Complete the PEOLC Assess, Treat and Refer form (similar to refusal, hypoglycemia or SVT assess, treat and refer form)
- Leave a copy of the PEOLC ATR form with the patient/family
- Fax the ATR form and your PCR to the number on the bottom of the form for the event to be captured by the program team and forwarded to the appropriate case manager

Why do I have to try to connect to the patient's primary or palliative care team (home care) to be able to do treatment in place? Can I not just call OLMC for orders?

Although EMS calls OLMC routinely to be able to discuss non-transport events and consult on patient treatment when needed, the role of the clinician (primary/palliative care team) in the long term management of the patient is very important.

Early involvement of the patient's primary/palliative care team ensures arrangements may be initiated to support the patient at home after the event. In some cases, a clinician may also be available to come to the scene to help support EMS and take over patient care.

In addition, EMS does not currently have access to any other patient information systems (Netcare, Meditech/Paris (continuing care's documentation systems)) that may provide a more robust and complete patient history when building a tailored treatment plan or identifying if treatment in place is appropriate. Connecting to the patient's primary/palliative care team who knows the patient (or has access to these systems) will help EMS obtain full understanding of the patient history to ensure an informed, collaborative care plan is pursued.

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Why am I to transmit or fax my PCR after the call? I don't forward my PCR for any other calls where patients are not transported, so why is this required for PEOLC Assess, Treat and Refer events?

When transferring care to another healthcare provider in a facility, EMS leaves a copy of their patient care record with the facility staff as part of the transfer of care. Currently, EMS does not routinely provide the same documentation to family physicians or case managers for patients seen in the community and not transported. To support continuity of care for the patient and also to ensure the patient's most responsible healthcare provider is aware that EMS was in the home and provided treatment in place, EMS will be responsible to forward their patient care record at the end of the event either electronically (if using ePCR) or by fax (if using paper PCRs).

Where can I get more information if I have questions?

Program training materials and documents have been loaded onto www.AHSEMS.com.

You may also access program information on the Palliative Framework's website at www.myhealth.alberta.ca/palliative-care or email us directly at EMS.Palliative@albertahealthservices.ca.