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

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 do I access the program for my patient?

EMS is accessed through 911 using the "Clinician Dispatch Script." The script is detailed within the program training presentation, on the clinician lanyard card and also within the Supplemental Process Document. Clinicians should use the "Clinician Dispatch Script" if they are activating the program while in the patient's home, or if they are activating the program remotely on behalf of the patient or family.

I've called 911 to access EMS before. Why do I need to use the "Clinician Dispatch Script" to activate this program?

The dispatch script has been developed for a number of reasons. Use of the script will ensure:

- That the most appropriate resource available will be sent
- That the ambulance is sent without lights and sirens
- That no allied services will be sent to the event (no fire, no police)
- That the EMS crew is aware they are responding to a palliative and end of life care assess, treat and refer event, rather than a standard EMS event
- That the event is coded correctly for program evaluation purposes

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How will EMS be notified that this is 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), EMS will be notified of the event type through the mobile data terminal in the ambulance (MDT). A specific dispatch code and written text entered by dispatch will advise that they 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.

What is the difference between a BLS and ALS ambulance?

Basic life support (BLS) ambulances are staffed with Emergency Medical Technicians (EMTs) and advanced life support (ALS) ambulances are staffed with a combination of EMTs and Paramedics.

What treatments can basic life support provide for my patient?

EMTs (basic life support) can provide the following treatments that may be beneficial in a palliative emergency:

- Assessment and diagnostics including vital signs, oxygen saturations (Sp02), blood glucose levels, end tidal $C0_2$ monitoring ($ETC0_2$), and basic ECG interpretation
- Oxygen administration
- Administration of bronchodilators including salbutamol and ipratropium bromide
- Intravenous initiation and fluid administration

What treatments can advanced life support provide for my patient?

Paramedics (advanced life support) can provide the following treatments that may be beneficial in a palliative emergency:

- Assessment and diagnostics including vital signs, oxygen saturations (Sp02), blood glucose levels, end tidal $C0_2$ monitoring ($ETC0_2$), basic and 12/15 lead ECG interpretation
- Oxygen administration
- Administration of bronchodilators including salbutamol and ipratropium bromide
- Intravenous initiation and fluid administration
- Administration of narcotics including morphine and fentanyl
- Administration of antiemetics including dimenhydrinate, metoclopramide and odansetron
- Administration of sedative agents such as lorazepam, haloperidol and midazolam

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How will I know what level of care the responding ambulance can provide?

All EMS units in the province have been trained on the program and may be dispatched to respond to assess, treat and refer events. When EMS arrives in the home, the clinician and EMS 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.

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.

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.

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 does EMS determine 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 for EMS to maintain continuity of care with that physician. EMS and the clinician will decide who is the most appropriate to call based on their zone's capacity.

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

Currently, EMS is only able to take orders from physicians (as per legislation). However, EMS is 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 EMS is in compliance with current legislation.

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

Yes, EMS 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 EMS operations supervisor.

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

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

As the clinician, how long do I need to remain at the home after EMS leaves?

Follow your local policies and procedures regarding when it is reasonable to leave the patient after a home care visit.

Will EMS leave any documentation in the home or provide any documentation to home care?

EMS will leave either a copy of the PEOLC Assess, Treat and Refer form or the Refusal/Assess, Treat and Refer brochure with the patient or family, however home care should complete their own documentation on the event as per local procedures. EMS will be forwarding their documentation after the event to the appropriate zone hub for further forwarding to the patient's case manager.

Where can I get more information if I have questions?

Program training materials and documents have been loaded onto Continuing Care Desktop and My Learning Link for community clinicians to access.

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.