Hospice 8.9

This protocol is specific to those patients enrolled in Hospice.
Treatment should be based on consultation with their Hospice team.

Introduction

The treatment goals of hospice patients differ significantly from those of other patients. Maintaining patient dignity and quality of life, rather than treating medical conditions, is the objective. If a specific cause of discomfort is identified (e.g., bronchospasm), traditional EMS treatment may be appropriate depending on the invasiveness of the therapy and the patient's preferences. Hospice patients generally wish to remain at home and transport to the hospital should be the exception.

If the patient is unable to make medical decisions and the hospice team cannot be contacted, determine the patient's wishes and contact **Medical Control.**

EMS providers should avoid the following interventions:

- Sirens, lights or aggressive interventions with family or caregivers.
- IV therapy (except where other forms of medication administration are not possible).
- Cardiac resuscitation: CPR, resuscitation medications, BVM ventilations.
- Cardiac pacing, cardioversion, and defibrillation.
- Hospice patients should not be transported to the hospital except where transport is specifically requested by the patient or his healthcare agent or surrogate, and preferably only after consultation with the hospice team and exhaustion of other treatment pathways that do not require transport to the hospital.
- Many hospice patients will have a hospice comfort kit that contains medications that patient's caregivers are instructed to use to treat commonly encountered medical issues.

EMT/ADVANCED EMT STANDING ORDERS

E/A

- Routine Patient Care.
- Contact the hospice team (preferred) or Medical Control to coordinate care and determine administration of hospice kit medications.
- Consider paramedic response for medication administration.
- Breakthrough Pain: Suggest administration of breakthrough pain medication by patients / families. For pain of sudden onset, seek to determine and ameliorate or treat the underlying cause (e.g., pathological fracture).
- Anxiety: Consider potential causes for patient's anxiety, such as increased pain and shortness of breath.
- Dyspnea: Administer oxygen via nasal cannula to relieve shortness of breath and achieve a respiration rate of < 20. Use a fan to blow air directly at the patient's face.
- Constipation: Suggest administration of constipation medication by patient/family.
- Nausea/Vomiting: Suggest administration of nausea medication by patient/family.
- Terminal Secretions: Reassure family that noisy breathing is generally not distressing to the patient. Suggest administration of medication by patients/families.
- Terminal Dehydration: Moisten lips with petroleum jelly; use artificial saliva/mouth sponges and ice chips.
- Confusion/Delirium: Speak slowly and calmly to the person. Remind the patient of where they are, and who you are. Avoid contradicting the patient's statements. Ensure a patient's hearing aid and glasses are available. Limit activity/noise in the room.

Protocol Continues

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PARAMEDIC STANDING ORDERS

P

Consider following the written orders for medications in hospice kit.
As an adjunct to the hospice kit medication consider:

Breakthrough Pain:

- See Pain Protocol 2.15 (All IV formulated opiates may be given PO for hospice patients.)

Anxiety:

- Midazolam: 2.5 mg IN, repeat every 10 - 15 minutes as needed to a maximum of 6mg
- Lorazepam: 0.25 - 2 mg PO or SL.

Dyspnea:

- Morphine or other opiate, dosing per Pain Protocol 2.15, maintaining respiratory rate above 8 bpm.
- Bronchospasm: See Asthma/COPD 2.3, subject to patient's goals.
- Heart Failure: See Congestive Heart Failure Protocol 3.3, subject to patient's goals.

Nausea / Vomiting:

- See Nausea/Vomiting Protocol 2.11

PEARLS

- Breakthrough Pain assessment and management is important in patients with advanced disease as they may have a high burden of pain, be opiate tolerant, and already be receiving high doses of opioids.
- Anxiety ranges from mild to severe, is common in patients nearing death, and should be treated promptly.
- Terminal Secretions are noisy, gurgling respirations caused by secretions accumulating in the lungs or oropharynx.
- Terminal Dyspnea is exhibited by patients that are expected to die within hours to days. Individuals experiencing dyspnea often experience heightened anxiety.
- Constipation is a frequent cause of nausea and vomiting. Opioid-related constipation is dose-related, and patients do not develop tolerance to this side effect. Surgical treatment is often not appropriate.
- Nausea / Vomiting can be extremely debilitating symptoms at the end of life. Effective control of nausea can be achieved in most patients.
- Fever and Infection treatment should be guided by an understanding of where the patient is in the dying trajectory and goals of care. Overwhelming sepsis may be a sign of active death not to be reversed.
- Delirium is common at end of life and is often caused by a combination of medications, dehydration, infections or hypoxia. It is distressing to families. It often heralds the end of life and may require active sedation.