South Central Ambulance Service NHS
NHS Foundation Trust

End of Life Care – Frequently Asked Questions

This document supersedes all previous 'End of Life Care – Frequently Asked Questions'.

Who is this aimed at?

- SCAS staff who deliver any aspects of patient care or have questions relating to End of Life / Palliative Care (including Call Centre staff, PTS, 111 and 999)

We hear the terms 'end of life' and 'palliative care' being used, but what is the difference between them?

- The term end of life usually refers to the last year of life, although for some people this will be significantly shorter.
- The term palliative care is often used interchangeably with end of life care. Which is fine, however, this causes frequent confusion for PTS staff.

Isn't palliative care just for people with cancer?

- No, palliative care is for people living with a terminal illness where a cure is no longer possible. It's not just for people diagnosed with terminal cancer, but for any terminal condition.

What is the difference between Basic Palliative Care and Specialist Palliative Care?

- Basic Palliative Care is something that all clinicians should be aware of and able to provide to the extent of their competence.
- Specialist Palliative Care is provided by a multi-disciplinary team used to dealing with difficult end of life symptoms and situations. They will see a small proportion of EoL patients and support other teams, via advice and teaching, to provide good general palliative care to many more.

Is the aim of palliative care to stop people dying?

- No, dying is the one certain thing in life – we will all die!
- The aims of palliative care it to maximize 'Quality of Life for a patients' remaining life. Making people as comfortable as possible, by managing their pain and other distressing symptoms. It also involves psychological, social and spiritual support for them and their family or carers. This is known as a holistic approach, because it deals with people as a "whole" person.

Why do we need to know about palliative care?

- Approximately 1% of the population of the UK die each year, which is approximately half a million people - Around 75% of these deaths are expected (i.e. they have terminal illness).
- Specialist clinicians caring for palliative care patients (Hospital Consultants and Specialist Nurses) are unlikely to work outside of normal working hours. Therefore, patients and families will make contact with SCAS for assistance outside of these times.
- Due to the aging population and an expected 17% increase in annual deaths by 2030 there will be an increasing demand for high quality end of life care: this will undoubtedly be reflected in the workload of the ambulance service. Palliative care is unlike conventional areas of ambulance

service provision, because;

- Patient's wishes and needs may often need to breech clinical pathways; including remaining at home when their symptoms would usually mean you transporting to hospital
- Patient and family distress often doesn't relate to just a clinical emergency episode, it may be ongoing and often triggers an emergency
- Accessing information is the single best way of dealing with these situations. That information is increasingly available if you take the time to look.
- Often hospital is not a place of safety, it can be a drafty corridor in which to die
- It is likely that there may be a number of calls made by a palliative patient or their family, the latter stages of their life.

- Conversations and awareness relating to end of life are becoming more common; it is therefore important that staff have a good understanding of the pathways and care options that are in place.
- The focus in managing end of life care situations should always aim to enable a person to achieve care according to their needs and wishes.
- For those who are nearing the terminal phase of illness the aspirational outcome would be for that person to have a 'good death'; to die in a place of their choosing, with dignity and respect, without pain, in a calm and familiar atmosphere surrounded by loved ones, this is commonly in their community setting.
- And, you have told us; in a recent survey (SCAS EOL Survey monkey, Summer 2017) 76% (of 291 respondent's) staff said they have seen or experienced an EoL episode of care that did not go as well as they thought it could have

One of our main concerns is resuscitation; we work for an ambulance service, shouldn't we be attempting to resuscitate everybody?

- CPR was originally developed to save the lives of people dying unexpectedly when acute myocardial infarction (AMI) caused sudden cardiac arrest in ventricular fibrillation (Beck 1961). As awareness of CPR increased and resuscitation equipment became more widely available and more portable, attempts at CPR became very common in situations other than a sudden cardiac arrest due to AMI.
- Not everyone wants to receive attempted CPR when they go into cardio pulmonary arrest, so it is important to respect people's wishes and to make sure that they are offered a chance to make choices that are right for them.
- To be clear, when someone suffers sudden cardiac arrest due to a sudden problem with their heart, immediate CPR can offer a chance of restoring them to a length and quality of life that they value.
- However, when someone's heart and breathing stop because they are dying from an advanced and irreversible condition, CPR will subject them to a vigorous physical intervention that deprives the patient a dignified death and those important to them, the knowledge that the patient had a supported and dignified death. For some people CPR may prolong the process of dying and, in doing so, prolong or increase suffering.
- The vast majority of patients with End of Life conditions, particularly when elderly, have other medical conditions. A patient who has been deteriorating month by month, and possibly faster, has no chance of being successfully resuscitated. They may however, survive long enough to be transferred to hospital, appreciate their fractured ribs, suffer pain, display brain damage and develop a chest infection before they die.

How do we know if somebody does or does not want CPR?

- The aim is also to avoid inflicting CPR on people who do not want it or on those who will not benefit from it and may be harmed by it.

- Making and recording a decision about CPR in advance and communicating it to those who need to know it can help to ensure that, as far as is possible, inappropriate CPR is avoided
- By making and recording a 'Do not attempt cardiopulmonary resuscitation' (DNACPR) decision in advance it will guide those present if a person subsequently suffers sudden cardiac arrest.

There are many different documents in use, what's the difference between a DNACPR /DNR/ DNAR/ ADRT?

- The term 'DNR' (Do not resuscitate) was used in the past, however that gave a false impression that all those who received CPR would be resuscitated (i.e. would recover) therefore that was changed to 'DNAR' (Do not attempt resuscitation).
- However, with DNAR's (Do not attempt resuscitation) health professionals use the word 'resuscitation' when referring to other forms of treatment, for example 'fluid resuscitation' when treating a person who is severely dehydrated. Because a 'DNAR decision' is only about CPR and not about withholding any other treatment that a person may need or benefit from, this was changed to using 'DNACPR' to make it clear that the decision referred only to CPR
- Currently we use DNACPR; where a decision is made and recorded by a clinician to guide the decisions and actions of those present should the person suffer cardiac arrest.
- An ADRT (Advance decision to refuse treatment) (as defined in the Mental Capacity Act 2005 – England & Wales) is a legally binding document that the person has drawn up (when they had capacity to make decisions) and in which they have stipulated certain treatments that they would not wish to receive, and the circumstances in which those decisions would apply. Where a properly drawn-up ADRT refuses CPR (despite acknowledging that their life would be at risk) a healthcare professional who attempts CPR on that person in full knowledge of the valid ADRT would be at risk of being charged with assault.

Is there a standard form for Advance Decisions to Refuse Treatment (ADRT) / SPNs or Care Plans?

- No there are no 'standard' forms
- All types of forms vary by locality and have different names

We also hear about Advance Care Plans (ACP) is there a standard form for Advance Care Plans (ACP)?

- There are many types of Advance Care Plans and care plans are put in place where there is an anticipated deterioration in the person's condition, depending on locality. There are sometimes a statement of the person's wishes or can be a special note (SPN) written by a clinician to direct the patient's care. They are not a legal document and have no set format. Anyone with a condition prone to acute exacerbations may have an Advance or Emergency Care Plan. The two terms are used interchangeably and are normally found within the patient's care notes (paper or electronic). They help to provide insight to patient's needs (or identify EOL patients) when deciding whether a death is expected or not.

Am I legally bound by an ADRT refusing life sustaining treatment?

- Yes, an ADRT is a legal binding document that allows patients to make decisions about their treatment should they lose capacity and cannot give consent. A healthcare professional is legally bound to follow a valid and applicable Advance Decision. To treat a patient contrary to their wishes could result in criminal charges being brought upon the professional.

Am I legally bound by a DNACPR?

- Unless there is a valid and applicable advance decision to refuse treatment (ADRT), specifically refusing CPR, a DNACPR decision form is not legally binding.
- The form however should be regarded as an advance clinical assessment and decision, recorded to guide immediate clinical decision-making in the event of a patient's death or cardiorespiratory

arrest. The final decision regarding the application or not of the CPR decision in an emergency rests with the healthcare professionals responsible for managing the patient's immediate situation. These healthcare professionals may on attending an arrest, make a clinical assessment resulting in a different decision from the one on the CPR decision form; for example suicide attempt, choking, anaphylactic reaction. As with any clinical decisions, healthcare professionals must be able to justify their decision and actions. In particular, clinicians should be cautious of overriding a DNACPR decision where the CPR decision form records that the patient has expressed a clear wish (this clear wish is a legal ADRT) not to receive attempted CPR.

Can an ADRT be written in the back of an ambulance and witnessed by a member of ambulance staff?

- An ADRT does not have to be prepared by a solicitor. An ADRT could be written on the back of an envelope, in the back of an Ambulance on route to hospital or even verbalized providing a patient has full capacity. Any patient that refuses treatment must ensure that they state " I am refusing treatment even if my life is at risk or may be shortened as a result"
- Ambulance staff can witness an ADRT as long as the person has capacity to make the decision and fully understands the consequences, this should be fully documented in the patients record.

If I find a person Cheyne stoking and they have a terminal illness, do I have to resuscitate?

- No, though all people are entitled to your care whilst they are still breathing and their heart is beating. It may not be appropriate to convey such people to the ED, especially if their ACP (also means admission avoidance plan in some localities) states they would prefer to be cared for at home. Rapid response teams (accessible via GP or OOH) accept referrals from the ambulance service and will support these people and their relatives to enable the person to be left at home. If you witness a respiratory or cardiac arrest, JRCALC states resuscitation can be ceased/not started if the person is terminally ill. Provided you have all the medical history and it is known that it is an expected death (DNACPR, ACP or ADRT) then we are not expected to attempt resuscitation. These people, their families and carers should be supported to experience a dignified natural death.

Do I have to attempt resuscitation on all patients in cardiac arrest if there is no DNACPR?

- The default is to always to attempt resuscitation. However, this may not always be in the person's best interests. In the event of a clinician or care assistant finding a person dead and there is no DNACPR decision or ADRT to refuse CPR, the clinician must rapidly assess the case as to whether it is appropriate to commence CPR. Consideration of the following will help to form a decision, but it must be stressed that professional judgement that can be justified and later documented must be exercised:

    - What is the likely expected outcome of undertaking CPR?
    - Is the undertaking of CPR contravening the Human Rights Act (1998) where the practice could be inhuman and degrading if futile?
    - Providing the clinician has demonstrated a rational process in decision making in accordance with trust policies and best practice, the trust will support the member of staff if this decision is challenged.

This means that for example, if you attend a person with multi co-morbidities, poly pharmacy, who is asystolic, and you deem, as a clinician, that CPR is unlikely to be successful then you will be supported in your decision making, not to commence resuscitation, as it is not in the patient's best interest. Bear in mind that this person in this example has less than a 1% of surviving intact to leave hospital or experience any quality of life, if you do try to resuscitate them; if they have an End of Life

condition with a clear history of deterioration, then that drops to zero. For further reading please review the 'Decisions relating to cardiopulmonary resuscitation guidance'.

If a person has a DNACPR decision, do I have to treat them for other conditions?

- **YES,** DNACPR only applies to CPR. All other treatments and actions should be carried out as per normal treatment protocols. The DNACPR applies **ONLY** if the person is not breathing and/or their heart has stopped (Cardio Pulmonary Arrest).

What happens when a person who has capacity is discharged and has a DNACPR form?

- If a person is being discharged home with a DNACPR form, the ambulance crew must ensure that the person or next of kin (if inappropriate for patient) has been informed of this decision. It is not the responsibility of the ambulance crew to inform the patient of the decision. The patient should already know of the existence of the document and have already been consulted.
- Given that the DNACPR form would need to be seen by an attending crew in a resuscitation situation, advice should be given that the form should be kept in an easily accessible place, so that it could be easily viewed in an emergency situation.

What do I do if the family have insisted on resuscitation, but the person has a DNACPR?

- In England and Wales the family does not have legal rights to make decisions on behalf of their relative unless they have a signed and registered Lasting Power of Attorney (LPA). If the written DNACPR form has been signed by a GP/Consultant and it is documented that the patient has been involved in that decision making, resuscitation should not be instigated. You will need to be sensitive and explain the situation to the family.
- Patients have no legal right to treatment that is clinically inappropriate. Sometimes patients or those close to them will try to demand CPR in a situation where it is clinically inappropriate. If the healthcare team has good reason to believe that CPR will not re-start the heart and breathing, this should be explained in a sensitive but unambiguous way and the decision making process should be fully documented within the patient's records.
- These decisions, and the subsequent discussions informing the patient of the healthcare team's decision, can be difficult, but should have taken place by law, prior to ambulance intervention.
- It is widely recognised that communicating DNACPR decisions can be particularly challenging for healthcare professionals. However, failure to explain clearly to patients or those close to them why decisions about CPR are needed, that a DNACPR decision has been made (in consultation with a patient with capacity), and the basis for it, can lead to misunderstanding, potentially avoidable distress and dissatisfaction, and in some instances complaint or litigation. As with any other aspect of care, healthcare professionals must be able to justify their decisions and ensure that the decision making process is recorded within the medical records.
- Some patients or those close to them may struggle to understand why a decision about CPR is relevant, if the person is not known to have a specific problem with their heart or breathing. Careful explanation will be needed to help them to understand that:
    - Breathing and the heart, slowing and finally stopping are part of the natural process of dying.
    - CPR is unlikely to be successful when someone is dying from an advanced and irreversible or incurable illness
    - Healthcare professionals may start CPR inappropriately when someone dies unless a DNACPR decision has been made and recorded.
- Prolonging life is not always beneficial. The courts have confirmed that it is lawful to refrain from an attempt at CPR on the basis that it would not be in a person's best interests.
- Balancing benefits against harms and burdens in these cases also involves balancing rights under the Human Rights Act 1998. The Act guarantees protection for life (Article 2) but also declares that "no one shall be subjected to torture or to inhuman or degrading treatment or punishment"

(Article 3). This terminology is intended to apply to situations in which people are deliberately ill-treated or have severe indignities inflicted upon them. However, some people do not wish to be kept alive in a state of total dependency or permanent lack of awareness, or to have an undignified death.

- If people express such views, healthcare professionals should take these into account when decisions about CPR are being considered. They should not attempt to prolong life if it is clear that the person would not want this or would consider the likely outcome unacceptable. The duty to protect life must be balanced with the obligation not to subject the person to treatment that they would regard as inhuman or degrading.

If the person has a form prior to uDNACPR and a new lilac form has not been completed, is the old form still valid?

- Forms written before the launch of the uDNACPR forms should be adhered to, providing they have the correct information on them. If in doubt, consider utilising JRCALC, if the person is terminal, or the document 'Decisions relating to cardiopulmonary resuscitation guidance'. If these are applicable, resuscitation can cease or not be started. If the person is being admitted, take a copy of the old form with you and show this to the receiving staff so a lilac form can be written. All versions 1, 2, 3 & 4 of the SCSHA uDNACPR forms are all valid.
- Remember to report any issue on the Datix system.

What if the address on the DNACPR document is not correct, but it has been signed and in date?

- As long as the form has the correct patient details (Name and date of birth), is legible and has been signed and dated by a registered health care professional then the form should be adhered to; it is accepted that patients may have changed address since the document was completed.

I have been informed by control there is a DNACPR form; do I actually have to see the form?

- No. If control can confirm the person's name and details on the DNACPR then the crew does not need to see the form. The trust follows a robust and approved governance process for a DNACPR form to be placed onto the system and a valid form has been seen for the alert to be put onto the system. Control will be able to see an image of the form to confirm the details. If the person has died and you are unable to find the form, consider utilising JRCALC or 'Decisions relating to cardiopulmonary resuscitation guidance' or contact control for support, if the person is terminal. If these are applicable, resuscitation can cease or not be started.

What do I do if I cannot find the DNACPR form, or I can find the 'Message in a bottle' slip and not the form?

- You need to see the whole form. If you are unable to locate the form and the person has died, consider utilising JRCALC, and 'Decisions relating to cardiopulmonary resuscitation guidance' if the person is terminal. If these are applicable, resuscitation can cease or not be started.

What if the form has not been completed properly?

- In order for the form to be valid, the personal details, section 1 and section 2 need to be complete. All other sections on the form are optional. If sections 1 and 2 are not complete, for example, no box ticked in section 1, or section 2 signed, but no position or date, then the form is invalid. If the person has died, consider utilising JRCALC, and 'Decisions relating to cardiopulmonary resuscitation guidance' if the person is terminal. If these are applicable, resuscitation can cease or not be started.

Can I accept the DNACPR form if it is on white paper?

- Yes, the forms should be on lilac paper for ease of finding in an emergency, but the forms are still valid if they are on any colour paper.

Can I accept a photocopy of the DNACPR form?

- Yes, provided that it has been filled in correctly and signed by the decision maker.

Does Section 5 need to be completed?

- No, if not completed the form remains valid.

In what situations will Section 5 be completed?

- If there is a risk of the person deteriorating during transfer, and discussion has taken place to establish where the persons preferred place of death is, this should be inserted into Section 5. The next of kin needs to be aware of the transfer and be ready to accept the person if they deteriorate. This could be their home, or the transfer destination, or the area they have been transferred from.

Is there an expiry date on a DNACPR?

- No, the DNACPR form is valid indefinitely. If the healthcare professional making the decision deems that a review is necessary then they can use Section 3 - Review will be completed. A form is still valid if this section is not complete.

What if the medicine chart is not present but the Just in Case Box medicines are?

- If this is the case, then the medicines may not have been formally prescribed for the patient. In this situation, the SCAS Clinician is advised to contact the GP, OOHGP or Hospice to discuss the potential for the doctor to provide a verbal instruction (remote prescribing) for the administration of a medicine that may be available at the address. This does not include Controlled Drugs such as diamorphine, fentanyl, morphine and oxycodone.

What is the Governance for remote prescribing?

- The General Medical Council guidance offers the following advice to doctors;
  "Remote prescribing is a recognized method of ensuring that patients receive appropriate drugs in urgent or emergency situations".

  "Before you prescribe for a patient via telephone, fax, video-link or online, you must satisfy yourself that you can make an adequate assessment, establish a dialogue and obtain the patient's consent".

  You may prescribe only when you have adequate knowledge of the patient's health, and are satisfied that the medicines serve the patient's needs. You must consider:

  a. The ways in which your communications with the patient may be restricted by the use of telephone or other technology
  b. The need for physical examination or other assessments.
  c. Whether you have access to the patient's records.

  The role of the SCAS Clinicians in ensuring the doctor/independent prescriber has sufficient information to make an informed decision is crucial to the patient receiving appropriate timely care. The Trust "Directions for Care" Clinical Directive must be followed.

If the patient goes into respiratory arrest at the time of me administering opioid analgesia, do I give naloxone or not?

- Administration of medicines in EoLC is where possible via the subcutaneous (SC) route. As a guideline morphine takes 15–20 minutes to take effect post SC administration. Where 'just in case' doses are prescribed in addition to any syringe driver opioids that may also be running,

then a patient that arrests at the time of morphine administration should not be associated with an opioid overdose.
If however you are in the unlikely situation post administration in which you believe that an opioid overdose is a possibility the following guidelines should be used:

- If a patient is opioid naive (i.e. not on regular opioids) then it is quick and safe to reverse the opioid effect immediately and completely with 400micrograms as a single dose.
- If a patient is taking regular opioids, then reversal of their opioids with 400micorgrams is likely to cause withdrawal effects ("cold turkey") with abdominal cramps, agitation, mental distress and recurrence of any treated pain – which cannot be treated with more opioid until the naloxone wears off. This is extremely distressing in a patient with advanced cancer etc.

Four principles in patients on regular opioids:

- If time allows seek Specialist Palliative Care advice via the local hospice, EoL line or information held in the Directory of Services.
- Aim to reverse harmful respiratory depression only. If < 6 breaths per minute with reduction in O2 saturation below 94% (< 88% in a person with a known respiratory illness).
- Confirm as far as possible that the respiratory slowing is not part of natural dying.
- Give the naloxone diluted and slowly e.g. 400mcg in 10mL given via IV cannula titrated to effect.

Do not give naloxone just for drowsiness/reduced conscious level if the respiratory function is satisfactory.

- **Remember-** The objective of treatment is patient comfort and dignity
- In adults with known terminal disease, at end of life, when death is expected, the patient may die before, during or after administration of any medication. Death will be from the terminal disease and not due to the medication
- The aim of medication in this situation is to palliate, to enable comfort and dignity to be maintained and to control distressing symptoms

What medicines can I give in EoLC?

- SCAS registered clinicians, qualified ambulance technicians and qualified Associate Ambulance Practitioners can administer EOL medicines prescribed for a patient when the doses are in line with a Trust protocol. It is important to note that currently the trust will not support the administration of controlled medications (such as morphine sulphate) by qualified ambulance technicians / Associate Ambulance Practitioners

What if the patient is on a syringe driver, should I still give a 'Just in Case' (JIC) medicine subcutaneously?

- Yes, if a 'JIC' medicine is indicated and the shared decision making process has been followed then the active use of a syringe driver does not alter the 'JIC' medicine dose. If you are receiving a telephone prescription, exercise caution, and ensure you inform the doctor/independent prescriber involved in the shared decision that the patient is on a syringe driver.

If the patient is suffering from breakthrough pain, I've taken a routine set of observations on arrival and the blood pressure records a systolic of less than 90, JRCALC contraindicates morphine. What should I do?

- If following a shared decision with a doctor or independent prescriber, they state that morphine is the correct next course of action, you can administer if the morphine dose is consistent with

the Trust protocol and the morphine has been prescribed. Where the morphine has not been prescribed you cannot administer more morphine than specified in the JRCALC. Pain in a dying patient is a symptom that cannot be left untreated.

- A dying patient with a systolic blood pressure over 90 may be a rarity. However Hospices and Specialist Palliative care teams don't know if this is true, as they very rarely check blood pressures.

Can I be confident the Trust will support me?

- Yes; providing your decision is appropriate and in the best interests of the patient. The whole purpose of developing this shared care model, is to ensure EoLC patients receive timely care, but in a shared and considered way. We do not want our staff to work in isolation but to share decision-making working with other medical professionals.

  - Always fully assess patients information
  - Access and review the 'Shared Care Record' (SCR) before arriving on scene for 999 calls
  - Consider reversible presentations
  - Where available seek further information via the CCC through Specialist Practitioners.
  - Consult and communicate your findings with the patients GP/OOH provider to reach a shared decision on treatment options and document this on the ePRF. You may have to consult a palliative care team, particularly if they already know the person.
  - If administering a 'JIC' medicine follow the Trust protocol.
  - Document details of who you had discussions with, what was decided and what information was used to make that decision.

It must be recognised that for EoLC patient's death is an expected consequence of their condition. It is entirely possible that a patient may die whilst in our care or shortly after an intervention we have provided under the shared care model. In these cases death is not a failure and your intervention may have just provided comfort or relief for a person's last moments. Families and carers, though distressed at the time, are likely to look upon your support with gratitude. Doing nothing or little or just being there is often the best "Emergency" support you can provide.

As **SCAS Clinicians** we should be prepared for this, but it's also important to explain to any relatives or carers present, that the purpose of any intervention, whether pharmacological or not, is to relieve symptoms, not advance death. Providing the **SCAS Clinicians** follows the set process for the shared model of care, then it would be entirely unreasonable to conclude that any subsequent death was attributable to the treatment provided. It is far more reasonable to conclude administration of a 'JIC' medicine made their last few days/hours more comfortable.

- Remember- The objective of treatment is patient comfort, reduce distress suffered by patient and dignity
- In adults with known terminal disease, at end of life, when death is expected, the patient may die before, during or after administration of any medication. Death will be from the terminal disease and not due to the medication
- The aim of medication in this situation is to palliate, to enable comfort and dignity to be maintained and to control distressing symptoms

I'm an Ambulance Technician / Associate Ambulance Practitioners (APP), is the new EoLC guidance applicable to me?

- Yes, as an ambulance technician / APP, you are able to provide support to EoLC patients. Patient specific information (Care plans, ReSPECT, DNACPR) will be accessible via CCC, within the property or via the ePRF and locality systems. Just in Case (JIC) box medicines can be

administered by qualified ambulance technicians and qualified Associate Ambulance Practitioners, providing that the medications are prescribed for the patient and the doses are in line with a Trust protocol. **It is important to note that currently the trust will not support the administration of controlled medications (such as morphine sulphate) by qualified ambulance technicians / APP;** however non pharmacological intervention can be carried out. For example patient positioning is a key element in managing respiratory secretions; it may also help to reduce pain. A calm and reassuring approach plays a big role in caring for EoLC patients.

What does a Just in Case box look like?

- This will vary across the organisational footprint, depending on the clinical commissioning group; some will be present in a pharmacy bag and others within an individual storage box.

Can I still use SCAS morphine for pain or should I use 'JIC' box analgesia?

- 'JIC' box medicines are the preferred option. If a delay occurs in making contact with another health professional for a shared decision you can still use SCAS morphine as per JRCALC guidelines on EoLC, but bear in mind that it may not be as effective in an opioid tolerant patient. If you are administering SCAS morphine in EoLC (subcutaneous) then remember not to dilute it as you would when administering IV. The administration of SCAS morphine in EoLC does not necessitate the need to convey to hospital (See Clinical Directive "Morphine and Patient Conveyance"); always act in the patients' best interest.

Why are EoLC medicines given SC and not IV?

- Administration of 'JIC' medicines is wherever possible subcutaneous. Giving a medicine intravenously will work more quickly but its effects also tail off quicker. A SC administered drug will take a little longer to take effect, but the therapeutic effects will last much longer. The SC route also reduces the potential for unwanted side effects like respiratory depression and decreased consciousness that can be associated with IV administration. Using the IM route is an acceptable alternative when you have not been trained to administer a SC injection.

How long does it take for subcutaneous medicines to work?

- Not all medicines will be the same, but as a guide the effects of morphine SC will start after 15-20 minutes.

What's the maximum volume that can be given subcutaneously?

- No more than 2ml per injection site.

Do I have to give these new medicines?

- HCPC Standards of proficiency states; "2.1 - *Registrant Paramedics must understand the need to act in the best interests of service users at all times"* and *"14.6 – be able to modify and adapt practice to meet the clinical needs of patients in emergency and urgent care environment"*
- Giving 'JIC' box medicines will likely benefit the patient. Acute or escalating pain is a medical emergency requiring a prompt response, and the patient is unlikely to want to go to the ED. Making these medicines available for administration to SCAS paramedics is giving you more options for treatment and allowing you to give a higher standard of care to a dying patient.

References:

Decisions relating to cardiopulmonary resuscitation guidance (2016); Guidance from the British Medical Association, the Resuscitation Council (UK), and the Royal College of Nursing. 3rd Edition

South Central Ambulance Service (2016); Resuscitation Policy v5

Joint Royal Colleges Ambulance Liaison Committee (2016); Clinical Practice Guidelines

HCPC (2014); Standards of Proficiency - Paramedics

NHS Choices (http://www.nhs.uk/Planners/end-of-life-care/Pages/End-of-life-care.aspx)

Marie Curie (https://www.mariecurie.org.uk/help/support/terminal-illness/diagnosed/palliative-care-end-of-life-care)

Royal College of Nursing (https://www.rcn.org.uk/clinical-topics/end-of-life-care)

Resuscitation Council (UK) (https://www.resus.org.uk)

https://www.resus.org.uk/resuscitation-guidelines/prevention-of-cardiac-arrest-and-decisions-about-cpr/

https://www.resus.org.uk/dnacpr/

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