Policy & Procedure: **ACUTE MEDICAL EVENTS**

Performed by: Residence Care Team
Approved by: Clinical Leadership Team
Date Approved:

PURPOSE:

To provide clarification regarding medical and nursing roles in acute medical events or emergencies which might occur in hospice residence

BACKGROUND:

Patients with life-limiting illnesses admitted Hospice Care Ottawa residence can require urgent symptom management or experience a symptom crisis due to complications of their underlying disease. These include severe shortness of breath, severe pain, hyper or hypo active delirium, seizures or severe bleeding. Most often, there is no medical intervention that can reverse the underlying etiology of the symptom, rather a focus on quality of life and symptom management ensures patient comfort.

In certain situations in hospice residence, patients might develop an acute medical event or complication which is potentially reversible with resources available in HCO hospice residence, and if not acted upon, could change or impact the trajectory of illness and lead to a rapid in palliative performance status and death.

POLICY: All medical and nursing staff are to identify and respond to acute medical events or complications which are potentially reversible with resources available in HCO hospice residence. These conditions include:

- Suspected acute upper airway obstruction, ex. choking (appendix 1)
- Suspected anaphylactic reaction (appendix 2)
- Opioid overdose, ex. medication error (appendix 3)
- Hypoglycemia due to insulin administration (appendix 4)
- Epistaxis (appendix 5)

PROCEDURE:

- If an acute medical event or complication is identified in a Hospice residence client by Hospice staff, the most responsible physician (MRP) should be notified immediately for direction. Under the physicians orders, nursing staff should follow Hospice Nursing protocols for Opioid or insulin overdose, choking and anaphylaxis. Epistaxis treatment is performed by the MRP.

- In the event that the MRP is not immediately available, the Hospice Medical Director / Medical Site lead should be consulted for direction.

- There are situations in HCO hospice residence where it would be appropriate for hospice staff to call Emergency Medical Services (911). The Hospice Medical Director should be immediately contacted in almost all circumstances before calling 911 to review the acute medical emergency as the Medical Director is available 24 hours/d. The Imme-

diate supervisors /ED should be notified as soon as possible. In situations where hospice staff are uncertain whether to initiate emergency response, the HCO medical director and/or the site medical lead should be immediately consulted.

- Situations in which it would be appropriate might to call emergency medical services include an acute medical event or symptom occurring to person other than a patient in hospice residence such as a syncopal episode, chest pain or cardiac arrest. Staff are to follow protocol for emergency response (e.g. CPR and ALS) as appropriate.
- Consistent with Hospice Palliative Care Ontario (HPCO) quality standards, HCO will track acute medical incidents listed above which occur in hospice residence. The frequency and etiology of these events will be discussed and reviewed by the clinical leadership team.

Appendix 1: Nursing Administration of Naloxone

BACKGROUND

Naloxone is an opioid antagonist and is used to reverse a life-threatening central nervous system/respiratory depression induced by opioids.

The goal for using naloxone in a palliative care patient is to reverse the respiratory depression without the reversal of analgesia.

Recognition of opioid overdose/excessive dose:

- If respiratory rate <6-8, difficult to arouse, evidence of poor ventilation, likely need to intervene
- If respiratory rate >8 and easily arousable and not cyanotic, adopt a ``wait and see`` policy and consider reducing or omitting the next dose of opioid

Indication for use of naloxone:

- Depressed mental status: somnolent, difficult to arouse or unarousable (not asleep). This will be **a marked change of status** not expected as part of the current disease process and has a related medication administration precipitator.
- Shallow respirations or rate less than 8/minute, associated with evidence of inadequate ventilation—low O2 sat, hypotension
- Pin-point pupils

Clinical Assessment

- Review goals of care— In general, would not recommend reversal for patients who are imminently dying.
- Goal is to reverse respiratory depression without reversal of analgesia
- Naloxone should not be used in response to a physiologically normal opioid-induced decrease in respiratory rate or mild sedation.
- It is normal to have a lower respiratory rate during sleep, especially on opioids. However, the hallmark of significant opioid-induced CNS depression requiring naloxone is the change in the level of consciousness.

POLICY

Hospice Care Ottawa nurses may administer naloxone for opioid-induced respiratory depression with an order from the most responsible physician after the physician has reviewed the case and the indication for administration with the Hospice Care Ottawa medical director or site lead.

Naloxone should be administered at Hospice Care Ottawa hospice residence according to the following guidelines and procedures

The use of naloxone **requires a physician order to initiate** and cannot be given without an order.

Nursing is responsible

- to ensure that there is a minimum of five (5) naloxone ampoules in the opioid cabinet
- the ampoules expiry date has not been exceeded
- follow up with the medical director to obtain a new prescription for stock as required if a vial is used from the emergency stock or if the ampoules have or will expire.

PROCEDURE

Step	Action
1	Maintain a minimum of five (5) naloxone ampoules on site.
2	Monitor all residents receiving opioids for the potential risk of opioid induced life-threatening respiratory depression and
3	Contact the most responsible physician to obtain a Naloxone administration order when: • Depressed mental status: Somnolent, difficult to arouse or unarousable (not asleep). This will be **a marked change of level of consciousness or palliative performance scale,** not expected as part of the current disease process associated with a recent increase in opioid dose. • Shallow respirations or rate less than 8/minute, associated with evidence of inadequate ventilation—low O2 sat, hypotension • Pin-point pupils
4	Follow the steps outlined in the naloxone administration guideline

PROCEDURE FOR GIVING GNARCAN
Hospice Care Ottawa Medical Director is available 24hours/d and should be notified by the most responsible physician, after a discussion with the patient's RN, prior to giving naloxone as per the following guideline.

1. Hold regular and PRN prescribed opioid.
2. Consider starting oxygen therapy if able to obtain oxygen saturation demonstrating hypoxemia (oxygen saturation <90%)
3. Provide light stimulation to patient and remind the patient to breathe (although narcotized, patients often report hearing concerned staff and being unable to open their eyes or respond. Reminders to "take a deep breath" are often followed.)

Open emergency stock cupboard and obtain the contents of the HCO emergency Narcan kit (narcan 0.4m/ml ampule, 1cc syringe, 22G 1 inch needle)

4. Prepare and administer 0.2mg (ampule 0.4mg/ml, 0.2mg=0.5ml) subcutaneous or intramuscular. Wait 5 minutes. If person still not responding administer another 0.2 mg(0.5ml). Repeat every 5 minutes until there is an improvement in the patients level of consciousness and an increase in RR. *A typical response is noted after 0.2mg is deeper breathing and a greater level of arousal.*
   Note: Naloxone can be given intranasal (take-home naloxone kits) but the current policy limits the route of administration to subcutaneous or intramuscular at hospice residence.

5. *Gradual naloxone administration should prevent acute opioid withdrawal.*
6. *If the individual does not respond to a total of 0.8 mg naloxone (2 x 0.4mg/ml ampoules), consider other causes of sedation and respiratory depression*
7. Continue to monitor patient, as the duration of action of naloxone is approximately 2 hours and is considerably shorter than the duration of action of most short-acting opioids. A repeat dose of naloxone may be needed.
8. Monitor the patients level of consciousness and vital signs as appropriate, most importantly patients RR
9. Wait until there is sustained improvement in consciousness before restarting opioids at a lower dose in consultation with most responsible physician.