Paramedic Community of Practice

When is it okay to leave? Setting of care choices, patient and family education

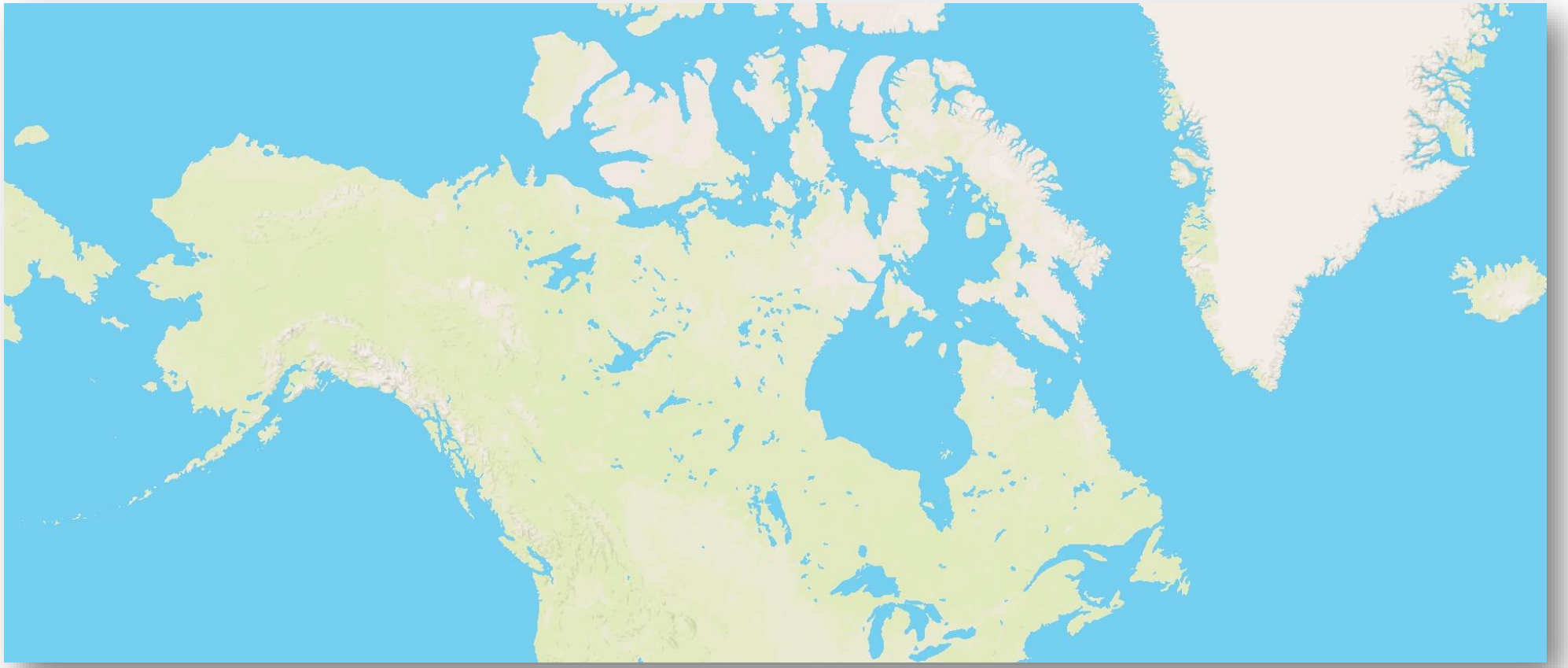
Project ECHO
Palliative Care - Canada
BY Pallium Canada

Facilitators: Kristina Anton and Karen O'Brien

Date: December 2nd , 2022

Panelists: Dr. David Henderson,
Lisa Weatherbee, RN
Dr. Jitin Sondhi
Stuart Woolley, Paramedic

Territorial Honouring



The Palliative Care ECHO Project

The Palliative Care ECHO Project is a 5-year national initiative to cultivate communities of practice and establish continuous professional development among health care providers across Canada who care for patients with life-limiting illness.

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Health Canada Santé Canada

Introductions

Facilitators:

Kristina Anton, ACP
Paramedic Specialist, BC Emergency Health Services

Karen O'Brien
Frontline paramedic since 1999, with a side of community paramedicine.
SWORBHP Associate Instructor
Pallium Facilitator

Lisa Weatherbee
BN RN CHPCN©
Pallium Master Facilitator/Coach

Dr. Jitin Sondhi, MD, CCFP (PC), FCFP
Regional Clinical Co-Lead, Palliative Care, OH West Adult and Pediatric Palliative Care

Stuart Woolley
Paramedic since 2003 in UK & Canada, current Paramedic Practice Leader in BCEHS leading Palliative Care, Low Acuity Patient management & Paramedic Specialist support.

Panelists:

Dr. David Henderson
Senior Medical Director Integrated Palliative Care NSHA
Medical Director Colchester East Hants Palliative Care Service

Welcome and Reminders

- Please introduce yourself in the chat!
- Your microphones are muted. There will be time during this session when you can unmute yourself for questions and discussion.
- You are welcome to use the chat function at any time to ask questions and add comments
- Remember not to disclose any Personal Health Information (PHI) during the session
- This session is being recorded and will be emailed to registrants within the next week

Session Learning Objectives

Upon completing the session, participants will:

- Have increased comfort when making decisions about the most appropriate setting for care
- Develop a system to assess the educational needs of patients and their families and address their needs
- Anticipate potential crises that may develop and plan for mitigation
- Be comfortable assisting patients to connect with local resources and ensure ongoing care continuity after the call

What prompted todays call?

- Getting to the bottom of the issue. Who called and the “Why”?
- Are the patient’s needs not being managed effectively?
- Is the family overwhelmed or burnt out?
- Is there a new complication that requires a change in the care plan?

Setting of Care

- This is often a complex decision that requires honest and sensitive communication while keeping in mind goals of care and current status of illness
- Would admission/transport to hospital improve symptom control and quality of life?
- Collaborate with regional clinical resources such as physician advisor, paramedic clinical support, as well as the patients care team (may include palliative clinician or family physician) to assist with care plan decisions

Setting of Care

Is the goal to die at home?

Is there a reason to transport to hospital or a hospice?

Has the patient or family changed their mind or wishes?

Does the care plan need to be updated?

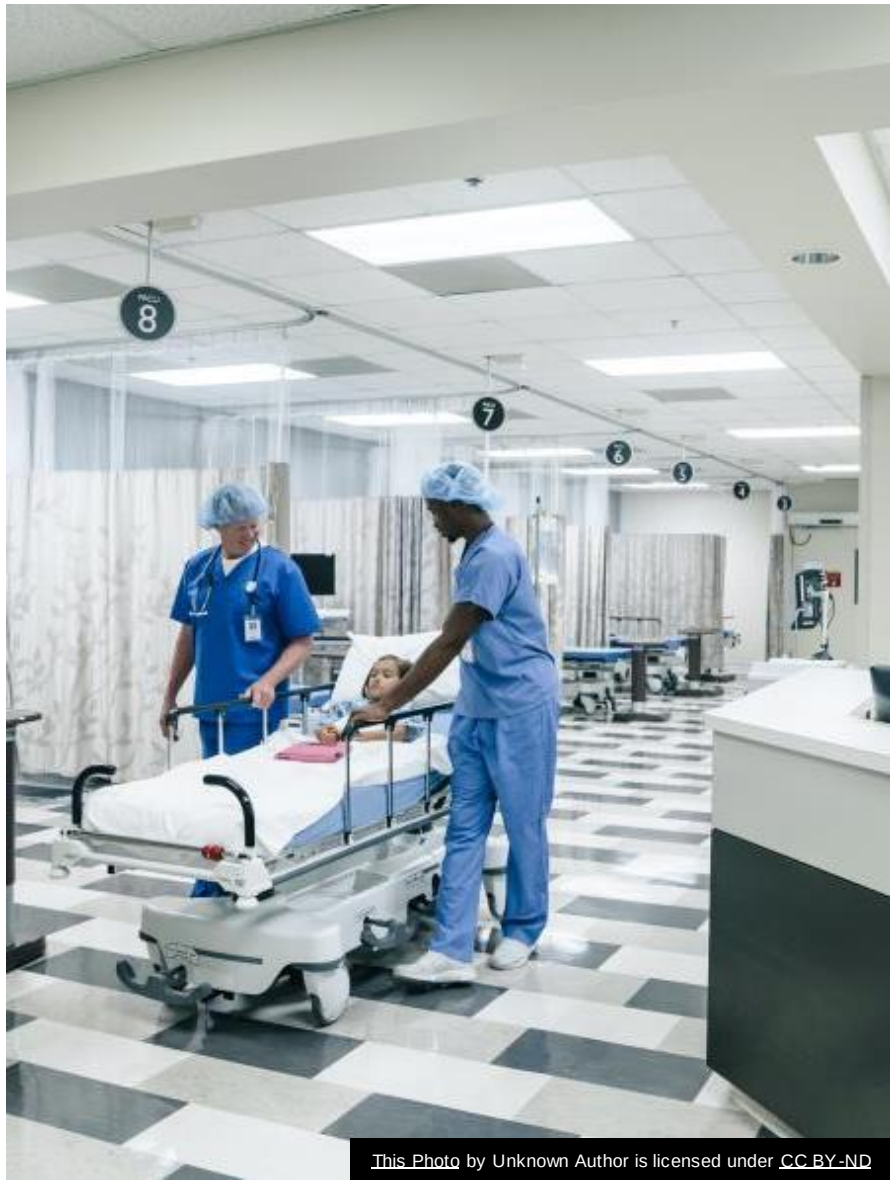
Factors to consider

- Some patients or families may wish to remain at home despite their condition potentially being reversible
- Compare the likely benefits against the potential burdens to aid decision making
- Some rural patients may wish to stay in their home community as there may be reduced access to treatments in their community facility

Setting of Care

- Is this an “acute reversible event” or a “terminal irreversible event”

- Examples of “acute reversible event” might include:
  - PE
  - Sepsis
  - Bowel obstruction
  - Spinal compression
  - Delirium
  - Status Epilepticus



Do you/they have all the necessities for managing at home?

- How long do you expect they will need to manage until they can be seen or reassessed by their care team ? 24 hrs? Over the weekend?
- Do you have access to the right drugs or therapies to manage the problem?
- Are the available drugs most appropriate for the patient's clinical condition (Is PO still working? Will parenteral be required?)
- Is there sufficient drug available to manage symptoms until the patient can be seen by their team or reassessed?
- What nonpharmacological options can you utilize such as fans, positioning?
- What is your organization's policy? Can you prepare medications and leave them for the family to administer?

Patient and Family Education

- Assess for patient and family educational needs
- Are they comfortable with care plan and care instructions?
- Do they understand how to administer medications and how often?
- Are they familiar with possible adverse effects of medications and ways to manage?
- Possibly reaffirming that this is a normal progression of illness and not a sign that they are failing to provide quality care to their loved one.

Other factors to consider when evaluating appropriateness of remaining at home:

- Is there family available? What support systems are currently in place?
- Does the family have the capacity to provide care?
- Do they live close enough?
- Are there signs of caregiver burnout?
- Can they meet the physical demands of care?
- Is there adequate manpower to provide 24 hour care if required?

Patient and Family Education

- Keep in mind during these conversations and interactions that this is likely a very vulnerable moment for both the patient and their family
- Take extra care with tone and choice of words
- Go the extra mile to ensure patient and family are comfortable with the care plan

Patient and Family Education

Educational needs when patients are in their last days or hours and death is believed to be imminent.

- What to expect? – altered breathing, decreased consciousness, mottling of periphery, cold extremities, profuse airway secretions
- Discuss with the patient and family so that they feel empowered and prepared to manage these scenarios
- Ensure appropriate advanced directives are in place and easily available
- Investigate religious or cultural needs of patient and family and assist in addressing these needs
- Ensure family know whom to contact at time of death. Is there an Expected Death In The Home (EDITH) form or Home Pronouncement Plan (HPP)

Follow-up Care

- How does your organization connect with other health providers?
- How will you ensure the patient has follow up arranged post-call?
- Will you connect with the patient's care team?
- Can you provide support and empower the patient or family to contact their provider when possible for ongoing care and reassessment
- Ensuring that after you have dealt with the immediate problem, that you develop a plan for longer term care

Case based discussion

Case

Details: You are dispatched for a 54-year-old female with SOB. Upon arrival you find a moderate-severe SOB pt, supine in a hospital bed. She is conscious and lethargic LOCx3. Her family is visiting. Your patient lives alone with advanced lung cancer, with metastasis to the brain.

Her medications are: Synthroid, Dexamethasone, metoclopramide, Dilantin, Ramipril, oxycodone.

History: Lung Cancer, Hypothyroidism, Hypertension, Seizures.

Allergies: Sulfa

Social situation: Family isn't coping well

- **Where do you start?**
- **What are the challenges you currently face?**
- **What can we strive to do differently?**

- Have you encountered similar situations in your community?
- What do you think worked well?
- Do you have other suggestions?
- Any Questions?

Session Wrap-Up

- Please fill out our feedback survey! A link has been added to the chat.
- Help us spread the word! A copy of our flyer for this COP has also been added to the chat.
- Join us for our next session on January 6th 2023, from 12-1pm ET.

Thank You

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