Paramedic Community of Practice

Feeling empowered in the grey zone

Project ECHO
Palliative Care - Canada
BY Pallium Canada

Presenter: Dr. Jitin Sondhi

Date: March 3, 2023

Panelists: Dr. David Henderson,
Lisa Weatherbee, RN
Stuart Woolley, Paramedic
Kristina Anton, Paramedic
Karen O'Brien, 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.

Stay connected: www.echopalliative.com

The Palliative Care ECHO Project is supported by a financial contribution from Health Canada. The views expressed herein do not necessarily represent the views of Health Canada.

Health Canada Santé Canada

Project ECHO Palliative Care - Canada BY Pallium Canada

LEAP Paramedic

- Learn the essentials for providing a palliative care approach
- Ideal for Paramedics and Emergency Medical Service professionals

- **Key features:**
  - Created and reviewed by Canada's leading palliative care experts
  - Taught by local paramedic experts and experienced palliative care practitioners
  - Nationally recognized certificate
  - Evidence-based and case-based

Pallium Canada LEAP PARAMEDIC

Learn more about the course and topics covered by visiting

https://www.pallium.ca/course/leap-paramedic/

Introductions

Presenter:

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

Panelists:

Kristina Anton, BScN, 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

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

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

Lisa Weatherbee
BN RN CHPCN©
Pallium Master Facilitator/Coach

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 be able to:

- Understanding Community Paramedicine Scope of Practice
- Understanding Delegation and Quality assurances
- Using existing tools and procedures to navigate challenging cases
- Review existing polices that may need to change as provision of Palliative Care Evolves.

Agenda

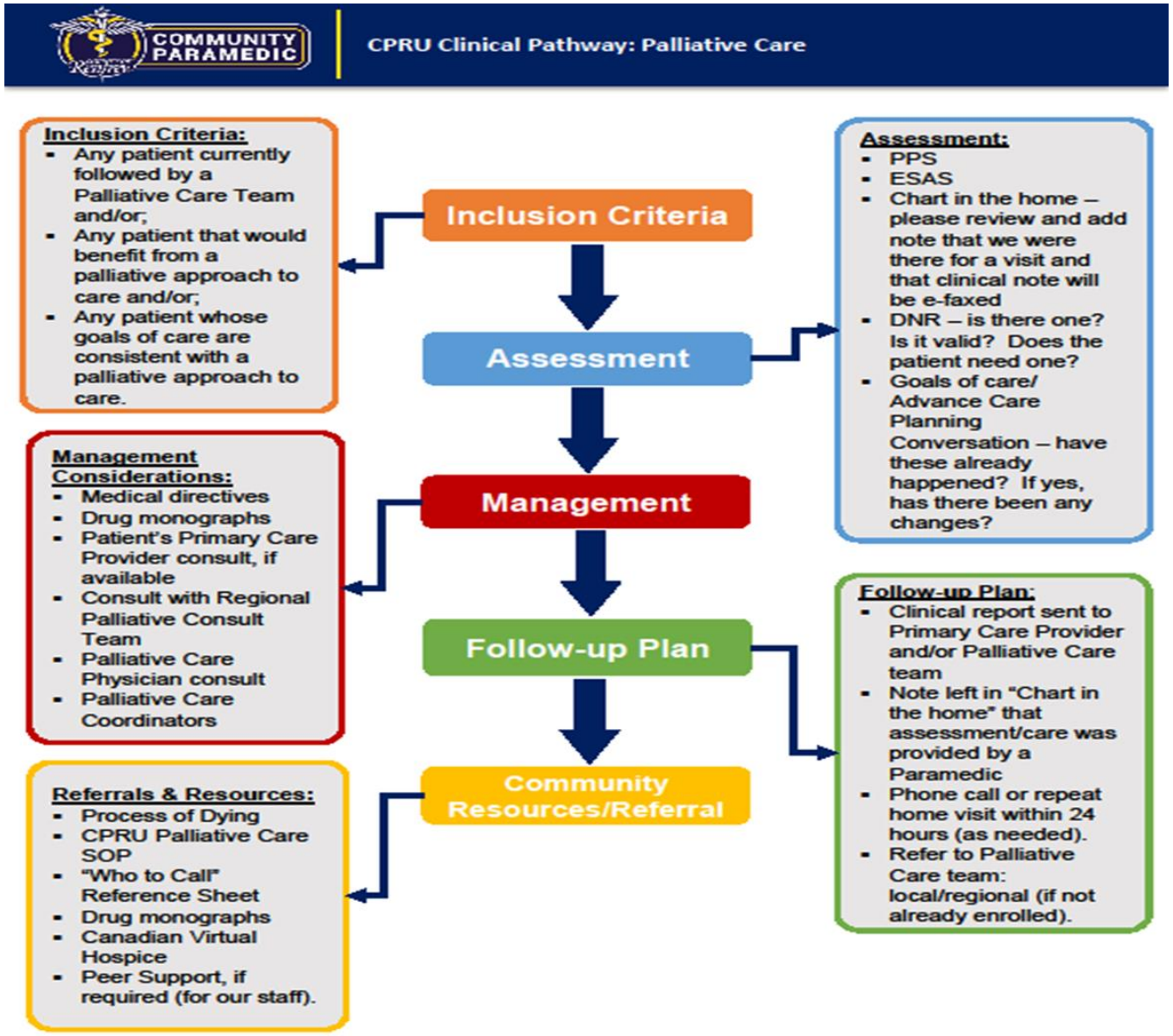
Community Paramedicine

- Scope of Practice
- Delegation
- Quality Assurance and Safety
- Cases

Scope of Practice

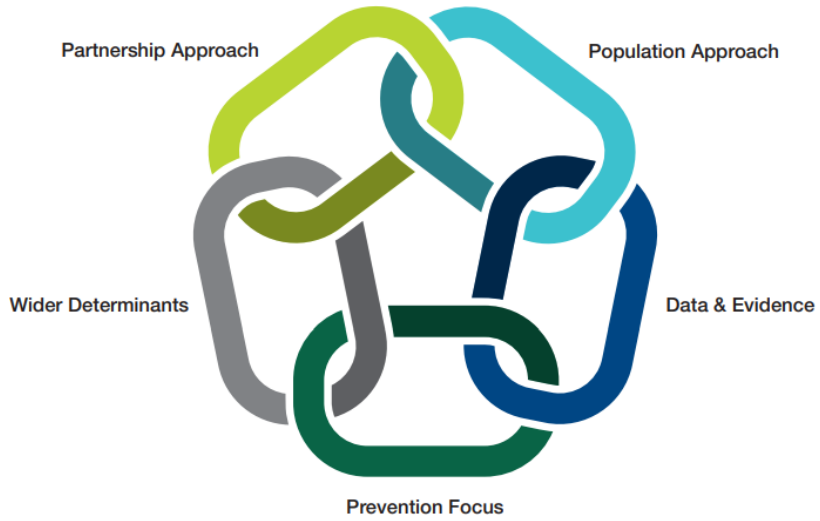
Advanced Care Paramedics	Primary Care Paramedics	Community Paramedics
Current State Medications Procedures & Controlled Medical Acts Including:		
• 12 Lead ECG, Posterior, Right & STEMI Diagnosis • Advanced Airway (Endotracheal Intubation) • Advanced Airway • Advanced Airway (Tracheal Tube Introducer Device) • Airway Foreign Body Removal (McGill Forceps) • Airway Suctioning & Deep Suctioning • Capnometry & Capnography (ETCO2) • CPAP Therapy (PEEP) • CVAD Infusion • Defibrillation (Manual External) • Intraosseous Therapy • **Intravenous Therapy*** • Needle Cricothyrotomy • Needle Thoracostomy • **SpO2 / SpCO*** • Synchronized Cardioversion • Taser Probe Removal • Transcutaneous Pacing • Evidence Based Research • **Advance care planning and goals of care discussions*** • **Initiating Serious Illness Conversations***	• 12 Lead ECG & STEMI Diagnosis • Advanced Airway • Airway Suctioning Capnometry (ETCO2) • CPAP Therapy (PEEP) • Defibrillation (Semi-Automated External) • **Intravenous Access & Monitoring*** • **SpO2 / SpCO *** • Taser Probe Removal • Evidence Based Research • **Advance care planning and goals of care discussions*** • **Initiating Serious Illness Conversations***	Expanded scope of practice operating under the delegated authority of independent medical doctor (MD) • **Expanded medication administration*** • Immunizations • Urine chemistry testing • **IV access and maintenance*** • Point of care blood testing • **Advanced physical assessments*** • **Advance care planning and goals of care discussions*** • **Initiating Serious Illness Conversations***

Table


COMMUNITY PARAMEDIC
CPRU Clinical Pathway: Palliative Care
Inclusion Criteria:
Any patient currently followed by a Palliative Care Team and/or;
Any patient that would benefit from a palliative approach to care and/or;
Any patient whose goals of care are consistent with a palliative approach to care.
Inclusion Criteria
Assessment
Management
Follow-up Plan
Community Resources/Referral
Assessment:
PPS
ESAS
Chart in the home – please review and add note that we were there for a visit and that clinical note will be e-faxed
DNR – is there one? Is it valid? Does the patient need one?
Goals of care/ Advance Care Planning Conversation – have these already happened? If yes, has there been any changes?
Management Considerations:
Medical directives
Drug monographs
Patient's Primary Care Provider consult, if available
Consult with Regional Palliative Consult Team
Palliative Care Physician consult
Palliative Care Coordinators
Follow-up Plan:
Clinical report sent to Primary Care Provider and/or Palliative Care team
Note left in "Chart in the home" that assessment/care was provided by a Paramedic
Phone call or repeat home visit within 24 hours (as needed).
Refer to Palliative Care team: local/regional (if not already enrolled).
Referrals & Resources:
Process of Dying
CPRU Palliative Care SOP
"Who to Call" Reference Sheet
Drug monographs
Canadian Virtual Hospice
Peer Support, if required (for our staff).

Quality Assurance and Safety

- Quality assurance for community paramedicine occurs through several mechanisms including:
  - Delegation* of controlled acts (policy of College of Physicians and Surgeons) when required
  - medical direction guidance (e.g., care pathways, guidelines, process)
  - procedural guidelines (e.g., phlebotomy, subcutaneous line insertion)
  - paramedic services internal policies and procedures (e.g., HR, recertification, referral monitoring, etc.)
  - training and continuing education (e.g., palliative care training, Paramedic Learning Essentials in a Palliative Approach to Care LEAP)
- Delegation* occurs when required from physicians who are managing this patient population (i.e., chronic conditions). Physicians remain accountable and responsible for the patient care provided through delegation process and policy.
- Work within community teams not in isolation to support development and implement care plans (e.g., RCM).
- Augment current structures, do not replace normal service providers.
- Majority of referrals come from primary care and HCCSS.



Quality Assurance and Safety

Community Paramedics are supported by the following:

- Internal program policies and monitoring (e.g., risk management)
- Assessments
- Medical Directives
- Clinical pathways
- Clinical practice guidelines
- Standard operating procedures
- Procedural guidelines
- **Palliative Care program**
- Community resources
- Continual professional development

Oversight of quality assurance occurs through reflection, evaluation (minimum data set), development and improvement of program delivery, patient and partner experience.

Quality assurance processes incorporate responsibility, consistency of standards and procedures, accountability, assessment of outcomes, evaluations, and effective communication.

Case based discussion

Case 1: Ms. Park

- 76 year old female with metastatic lung cancer
- Is followed by local PCOT and known to the team
- Family noted her struggling with breathing and called 911

Case 1: Ms Park

On assessment:

- Sitting up and appears breathless.
- Has pleurex drain visible from right chest.
- Has oxygen on board.
- Patient states she is not in any discomfort and does not feel SOB.

Case 2: Daphne

- 6-day old baby with hypoplastic left heart
- Came home to palliate as expected to die in the next 7 days
- No nursing available to provide homecare and assessments to the family or patient until 10 days.
- Team meeting to discuss how to provide management and care for this patient.
  - Who can we ask for help?
  - What can be interventions are possible by providers involved?

Case 3: Mr. Singh

- 88 year old male with esophageal cancer.
- Becomes unresponsive and family calls 911.
- Review course of action if 911/EMS Paramedics on scene:
  - If patient is actively dying with DNRc present.
  - If patient actively dying with no DNRc present.
  - If VSA with no DNRc present.
  - If known to a PCOT and known on rounds to CP team to have DNR status but no DNRc on site.

Case 3: Mr. Singh

Review course of action if CP on scene:

- If patient is actively dying with DNRc present.
- If patient actively dying with no DNRc present.
- If VSA with no DNRc present.
- If known to a PCOT and known on rounds to CP team to have DNR status but no DNRc on site.

Case 4: Ms. Ramirez

- 70-year-old female with COPD on 3L of oxygen at home.
- CP called as part of PCOT due to worsening SOB and chest discomfort.
- Has productive cough, with noted increased work of breathing.
- Wants to know if she should go to the hospital?

Case 4: Ms. Ramirez

Hospital

- Chest xray, blood work, BiPap, highflow
- Can have work up and not have to be admitted
- ED vs Direct admission?

Home

- Management based on clinical assessment
- IV antibiotics, lab work (delayed by 20 hours)
- Risk of rapid deterioration and death

Case 5: Mr. Cheng

- 66-year-old male with sudden onset of chest pain and syncopal episode.
- Family calls 911 and crew arrives on scene to find STEMI on 12 leads.
- Mr. Cheng refuses to be transported to hospital and indicates he is part of a Palliative Care team and hands the Paramedics a business card for local PCOT.
- Wife demands he be taken to hospital and have his heart managed.
- Mr. Cheng: “Leave me alone… I am dying of cancer anyways”.

Case 5: Mr. Cheng

- What information do you need?
- What can you do?
- Who can you call?

Case 5: Mr. Cheng

- He was seen by PCOT physician and at that time refused to be placed on PCOT roster.
- Patient does have life limiting disease, however, is not enrolled in a Palliative Care Model/Team.
- Has had a 2-week rapid decline during which time he has discontinued therapy due to ongoing disease progression (Stage 3 rectal cancer).
- Does not want to go to hospital and wants to be managed at home for his disease progression.

Session Wrap-Up

- Please fill out our feedback survey! A link has been added to the chat.
- This is the last session of our series.
- Stay tuned by visiting our website www.echopaliative.com for a possible second series!

Thank You

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