CGNA Community of Practice Series 2 | The development and implementation of a Paramedicine Program that addresses the needs of older adults living in the community | Part 2

Host: Roslyn Compton

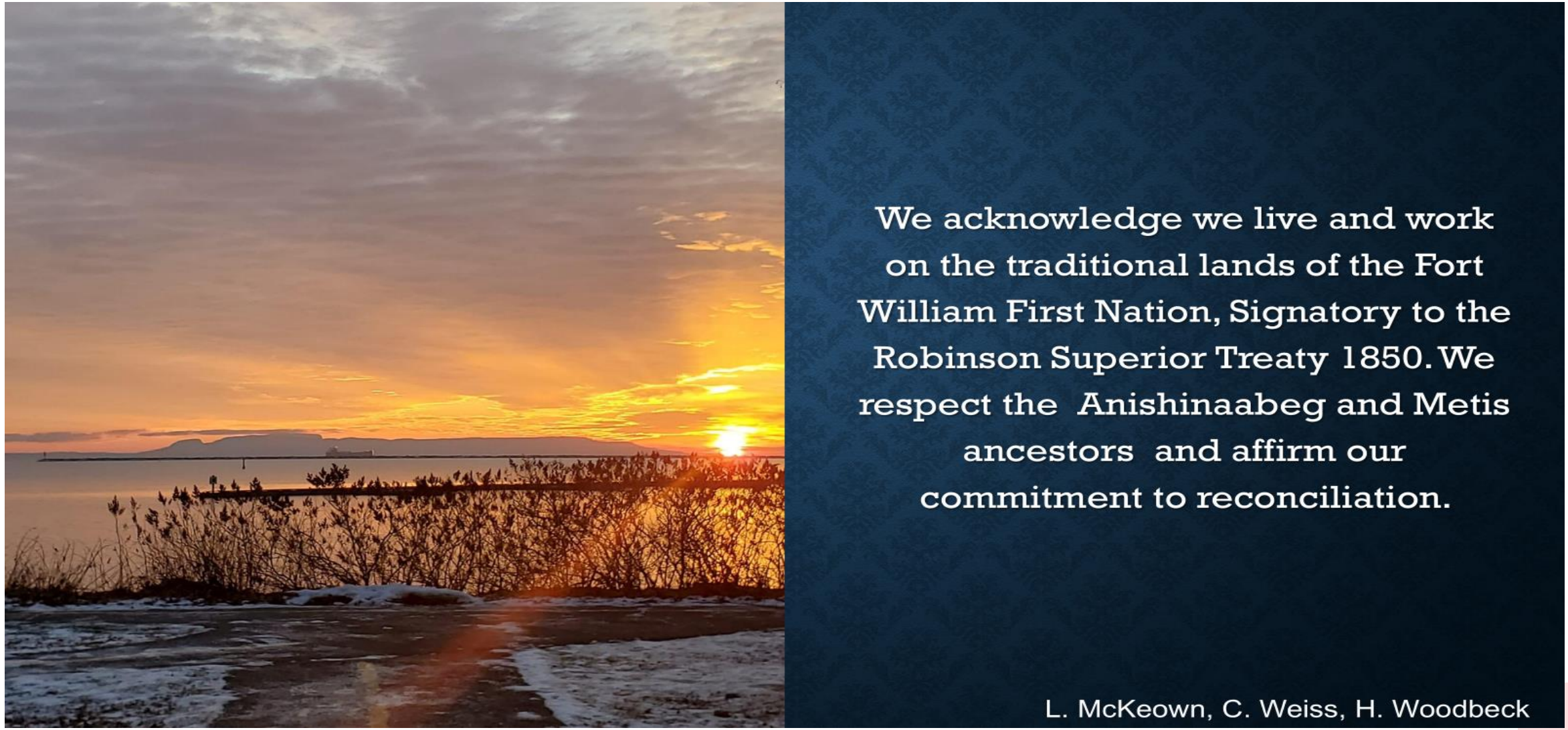
Presenters: Debbie Lashbrook

Date: 13 November 2025

Project ECHO
Palliative Care - Canada
BY Pallium Canada

CGNA Canadian Gerontological Nursing Association

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

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.

Welcome and Reminders

- Please introduce yourself in the chat!
- Your microphones are muted. There will be time during this session for questions and discussion.
- You are also welcome to use the Q&A function to ask questions
- Use the chat function if you have any comments or are having technical difficulties.
- This session is being recorded and will be emailed to registrants within the next week.
- Remember not to disclose any Personal Health Information (PHI) during the session

Introductions

Host and Moderator

Roslyn Compton, PhD RN GNC (C)
Director of Education
Canadian Gerontological Nurses Association

Presenters

Debbie Lashbrook BScN, RN GNC(C)
Experienced RN educator, with expertise in psychogeriatrics. Recently retired from Emergency Services, educating paramedics to be community paramedics in Simcoe County, ON.

Learning Objectives

By the end of the session, participants will be able to:

- Apply community resources into your practice
- Discuss application of shared decision making into your practice
- Discuss application of interprofessional collaboration into practice

Brief Overview from last week

1. Discussed the role of Community Paramedicine in Simcoe County, ON related to chronic, life-limiting diseases such as COPD, CHF and Diabetes and how this service improves quality of life of individuals, honouring their autonomy of end-of-life decisions.
2. Shared Decision Making as a process in serious illness conversations.
3. Interprofessional Collaboration and how working together, and breaking down silos enhances both quality of life of the patient, but efficiency of the health care system as well.

Community Paramedicine in practice

- Paramedics with additional education to support in-home support of those with COPD, CHF and Diabetes
- Assessment skills, ECG readings, Chem-8 bloodwork with results in 2 minutes, Medical Directives and physician consult to leave medications with the patient, saving them a trip to the hospital for exacerbations.
- Emergency phone line to triage symptoms and need, diverting patients from using ER services, and keeping them at home. Can assess within 1-4 hours of phone call.

"Shared Decision-Making is a process that allows everyone to collaborate on medical decisions in a way that is evidence-based and puts a patient's/caregiver's values at the forefront."

Dr. Craig Campbell

lhsc, (nd)

Interprofessional Collaboration

- Who are the players involved in care in your community?
- Is the system streamlined and collaborative or do silos exist?
- How can you and your community increase collaboration?
- Is technology assisting your communication or hindering it?

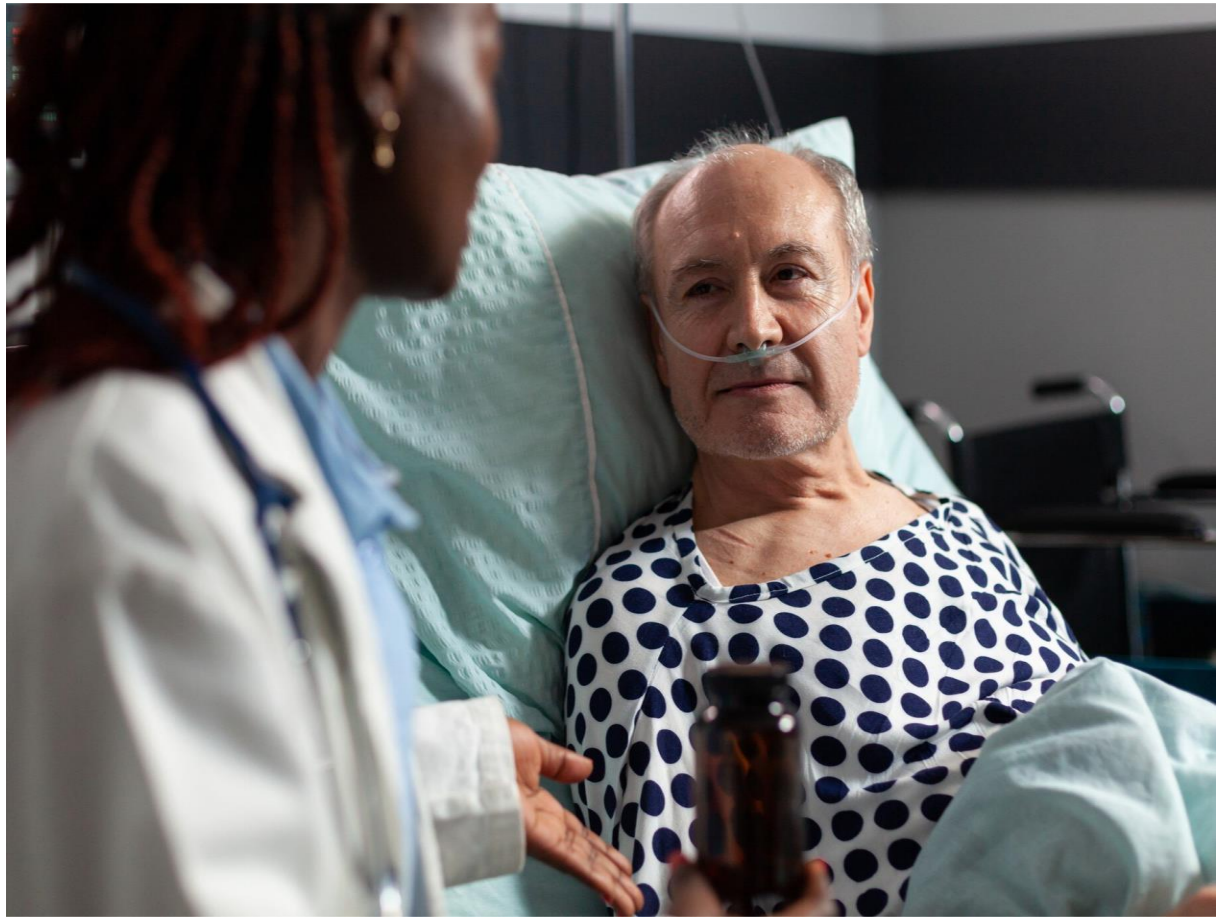
Case Study: Whose goal is it, anyway?

Meet George – a 77-year-old male living with his spouse with end stage COPD.

We will exam 2 pathways regarding Georges' final wishes:

a. To die at home
b. To go to Hospice

Applying principles of shared decision making, interprofessional collaboration and community support systems available, we will examine how to respect his autonomy in his final days.



L.McKeown, C.Weiss, H.Woodbeck

Autonomy and Shared Decision Making

- What does George want?
- What does his wife/family want?
- What has been discussed? Has a back-up plan been developed?

Partners in Community Practice

All the following have been involved in supporting George's care:

- Community Paramedics
- Home Care nursing staff – CCA/PSW support 3x per week for 3 hours each visit
- Primary responsible care provider – MD/NP
- Palliative Care Nurse
- Respiratory therapy

Informal supports:

- Neighbours
- Church friends/groups
- Legion members

Pathways: Discussion

1. To pass away at Home

2. To pass away at Hospice

Questions to Consider

Have serious illness conversations started early enough?

Do you feel you are comfortable discussing end-of-life conversations?

Who is involved?

What is the unified goal?

What is the back-up plan?

Conclusions

Community care is cost-effective, and when discussing end-of-life with patients, most wish to die at home.

Have options been discussed? Hospice is a great option, and in ON MAID can be conducted at Hospice.

Shared-decision making is discussing options, pros/cons, risks/benefits. What does the individual wish and are family members on the same page?

Interprofessional Collaboration is paramount. Each specialty has a specific area of expertise and must work together to achieve the highest quality of care and life for the patient.

Q & A

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Session Wrap Up

- Please fill out our feedback survey, a link has been added into the chat.
- A recording of this session will be emailed to registrants within the next week.
- Thank you for your participation!

Thank You

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