

Abstracts of Oral Presentations-WADEM Congress on Disaster and Emergency Medicine 2019

PALLIATIVE CARE

Palliative Care Training for Work in an Austere Environment After a Natural Disaster

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Introduction: Healthcare professionals working in a disaster face destroyed physical infrastructures, scarce supplies, and a limited-in-training peer group. During a mass casualty event, disaster victims are triaged to the “expectant” category of care because either their injuries are not survivable or the resources needed to care for them are not available.

Aim: To examine the challenges that disaster responders face in caring for dying patients in the field, and advocate for basic palliative care training prior to deploying to a disaster.

Methods: The world’s literature was reviewed to identify challenges for disaster teams in providing compassionate end-of-life care and to find training exercises for pre-deployment competency building.

Results: Training Topics in Palliative Care Prior to Disaster Deployment include the following:

1. Symptom Management Protocols:
 - Pain
 - Anxiety
 - Respiratory distress
 - Delirium
 - Nausea and Vomiting
2. Spiritual Management
 - Grief
 - Identify meaning
3. Cultural Training specific to the location of the disaster
 - The meaning of death in the culture
 - Who are the decision makers in the family
4. Training for difficult conversations
 - Delivering Bad News
 - Managing a grieving family
5. Self-Care Training
 - Develop a system for debriefing
 - Develop a buddy system
 - Self-care exercises: deep breathing, prayer, meditation, yoga

Discussion: Challenges to the care of the dying during a disaster include a loss of medical infrastructure and scarce medical or physical resources. Palliative care training for non-palliative care specialists can be instructive for the development of palliative care training for medical care responders after disasters. Applying standards, identifying goals of care for the expectant

patient, communication to the patient and family members, if available, can help reduce suffering of this group of devastatingly vulnerable patients. In addition, peer support, on-site discussions and debriefing, and problem-solving when resources are limited will help alleviate moral distress among the providers.

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Unsuccessful, Unwanted, and Unwarranted Resuscitation: Exploring Ambulance Personnel Preparation and Support for Death in the Field

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Introduction: In many countries, ambulance personnel are authorized to start or stop resuscitation efforts in accordance with clinical guidelines. Research shows that decisions to withhold or terminate resuscitation and manage patient death scenes can be particularly challenging.

Aim: To identify preparation and support mechanisms for ambulance personnel who are authorized to withhold or terminate resuscitation efforts, and manage patient death in the field.

Methods: A scoping review provided an overview of international research in this area. A qualitative exploratory study was then undertaken. Focus groups were held with senior ambulance personnel currently working in clinical education, managerial, or pastoral support roles across New Zealand.

Results: Well-supported clinical experiential learning and resolved personal experiences with grief and death were considered most useful to increase self-efficacy and coping with patient death. Participants felt some of the personal and interpersonal skills needed to manage death in the field were difficult to teach. Relatively little time is spent preparing ambulance personnel for the non-technical skills associated with resuscitation decision-making, particularly communicating with family and bystanders. Ambulance personnel responses and support-needs during or after the event are idiosyncratic. Ambulance personnel appear to primarily rely on