"Provide Them What They Need Until the Last Minute": Experiences of Palliative Care and Palliative Care Needs in Humanitarian Crises

Lisa Schwartz PhD[1], Matthew Hunt PhD[2], Elysee Nouvet PhD[3], Sonya de Laat PhD[1], Rachel Yantzi RN, MPH[1], Olive Wahoush PhD[1], Wejdan Khater PhD[4], Emmanuel Musoni Rwililiza MD[5], Ibraheem Abu-Siam MSc[6], Corinne Schuster Wallace PhD[7]

1. McMaster University, Hamilton, Canada
2. McGill University, Montreal, Canada
3. Western University, London, Canada
4. Jordan University of Science and Technology, Irbid, Jordan
5. University Teaching Hospital of Kigali (CHUK), Kigali, Rwanda
6. Migration Studies, Granada University, Granada, Spain
7. University of Saskatchewan, Regina, Canada

Introduction: Access to palliative care, and more specifically the alleviation of avoidable physical and psychosocial suffering is increasingly recognized as necessary in humanitarian response. Palliative approaches to care can meet the needs of patients for whom curative treatment may not be the aim, not just at the very end of life but also more broadly. Humanitarian organizations and sectoral initiatives have taken steps to develop guidance and policies to support integration of palliative care. However, it is still sometimes regarded as unfeasible or aspirational in crisis contexts; particularly where care for persons with life threatening conditions or injuries is logistically, legally, and ethically challenging. We present a synthesis of findings from five qualitative sub-studies within a R2HC-funded research program on palliative care provision in humanitarian crises that sought to better understand the ethical and practical dimensions of humanitarian organizations integrating palliative care into emergency responses.
Method: A multi-disciplinary, multi-national team conducted an exploratory mixed-methods study and presented findings from semi-structured interviews with international and local health care providers, patients, and families that explored experiences of palliative care in different humanitarian responses: protracted refugee crisis (Rwanda n=17), acute refugee crises (Jordan and Bangladesh n=20), a public health emergency (Guinea n=16), and natural disasters (various countries n =17)
Results: Four themes emerged from descriptions of the struggles and successes of applying palliative care in humanitarian settings: 1) justification and integration of palliative care into humanitarian response, 2) contextualizing palliative care approaches to crisis settings, 3) the importance of being attentive to the 'situatedness of dying', and 4) the need for retaining a holistic approach to care. The findings are discussed relation to the ideals embraced in palliative care and corresponding humanitarian values.
Conclusion: Though challenging, palliative care in humanitarian response is essential for responding to avoidable pain and suffering consistent with humanitarian principles.

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Challenges Introducing a Novel Health Assessment System in Disaster-prone Japan: Community-Oriented Approach for Comprehensive Healthcare in Emergency Situations (COACHES)

Mari Kinoshita PhD, MPH, PHN, RN, Mikiko Nakai RN, CNS, Ikuko Shimada PhD, RDN
University of Kochi, Kochi, Japan

Introduction: Collecting real-time individual health data of all disaster-affected populations is usually considered impossible. The University of Kochi's team and its partners conceived a novel health assessment system named "Community Oriented Approach for Comprehensive Healthcare in Emergency Situations (COACHES)." It collects individual health data anonymously and records such data in a cloud-based database. The system runs on any personal mobile device by scanning a personal identification code (QR code). It is expected that anyone on site with qualifications in healthcare will run this system as a volunteer to ensure data reliability. The COACHES app development is in process, and its prototype is currently available. This study aimed to assess how people react to the novel system and see the feasibility of installation in Japan.
Method: Two focus group interviews (FGI) were conducted in a small coastal village in western Japan. The village anticipates severe damages with days of isolation once a large-scale earthquake followed by a tsunami hits the area. The first FGI was held with nine purposively recruited participants. The second FGI was held one month after and included seven of the first FGI participants with one of the absent participants providing a written response. FGI was for one-hour each, with discussion following the system demonstration. The voice data during the FGI were recorded and analyzed. The research was approved by the University of Kochi IRB.
Results: Some showed intense interest in the system, whereas concerns such as the privacy violation for using personal devices, the availability of healthcare personnel, or a fear that anonymous data collection may delay identifying a person in need of assistance.
Conclusion: Further studies are proposed, particularly in recruiting volunteers, data storage in case of technical damage, and how to make people with limited IT literacy comfortable using the new system.

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The Impact of COVID-19 Patient Surges on the Burn Care System

Randy Kearns DHA, MSA[1,2], Jeffrey Carter MD[3]

1. University of New Orleans, New Orleans, USA
2. University of North Carolina, Chapel Hill, USA
3. Louisiana State University, New Orleans, USA

Introduction: Burn mass casualty incident (BMCI) planning efforts have been in practice and publication for 40+ years. While COVID-19 has no direct connection to burn injuries, the impact of COVID-19 on the healthcare system including burn care was and remains significant.
Method: A retrospective analysis of data was conducted voluntarily submitted to the American Burn Association from March 2020 to June 2021 which generally coincides with the first three waves of the pandemic. We focused on the self-reported data specific to the three critical components in managing a surge of patients: staffing, space, and supplies (to include pharmaceuticals and equipment).
Results: Staff: These data were collected over a period that coincided with the first three waves seen in the USA. Staffing shortages were noted during each of the surges but were most excessive when a regional surge paralleled surges in other parts of the country (November-December 2020).

Space: Late November and early December 2020, space was in short supply with the surge of patients for more of the region than at any other time during the 28 weeks of reporting. While single facilities reported other episodes of limited space or supplemented with temporary structures, the peak was early December.

Supplies: As the first surge began to subside, the supply shortages were abated. However, as additional surges occurred; the supply chain had not recovered. Supply shortages were reported in greater numbers than either space or staffing needs through the multiple waves of the pandemic.
Conclusion: The COVID-19 pandemic directly led to a diminished available capacity for burn care in such a way that it compromised the ability to confront a surge of burn-injured patients. Future BMCI planning efforts must consider this aspect of the process. Crisis Standards of Care may come into play during such an event.

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Description of Patients with Out-of-Hospital Cardiac Arrest within 24 Hours of EMS Transport Refusal.

Howard Klausner[1], Andrea Curtin MD[2], Robert Dunne MD[3], Erin Brennan MD[2], Marc Rosenthal DO[2], Ryan Reece MD[4], Damon Gorelick[5]
1. Henry Ford Hospital, Detroit, USA
2. Sinai Grace Hospital, Detroit, USA
3. St. Johns Hospital, Detroit, USA
4. Detroit Receiving Hospital, Detroit, USA
5. Detroit East Medical Control Authority, Detroit, USA

Introduction: Patients refusing transportation is common EMS practice with potentially fatal outcomes. Determining which patients are at high risk for poor outcomes is poorly defined. This study described patients who experienced an out-of-hospital cardiac arrest (OHCA) within 24 hours of refusing transportation.
Method: This is a retrospective, descriptive study of patients who had an OHCA within 24 hours of refusing EMS transportation between 2019 to 2021. Data was obtained from a large, urban medical control authority seeing 175,000 EMS calls annually. We reviewed patient demographics, EMS events when transportation was refused, and cardiac arrest outcome.
Results: There were 6, 30, and 28 EMS refusals resulting in OHCA in 2019, 2020, and 2021. Patients who had OHCA were 65.7 (range 28-103) years old, and African American (54/64). Patients had HTN (36/64), diabetes (19/64), COPD (11/64), and CHF (7/64). Common complaints included breathing problems (17/64), near syncope (8/64) however chest pain was uncommon (4/64). One (28/64) or two (13/64) abnormal vital signs were present and missing vital signs (28/64) were common. Tachycardia (32.8%, 21/64), HTN (29.7%, 19/64), and hypotension (17.2%, 11/64) were more prevalent in the OHCA population compared to all refusal patients (Tachycardia 0.33% [1,978/598,416], HTN 2.27% [13,601/598,416], and hypotension 0.04% [218/598,416]). Patients were seen by both ALS (29/64) and BLS (35/64) providers. Most providers documented risk including death (38/64) though few contacted medical control (14/64). Return encounter for OHCA resulted in obvious deaths (23/64) or field termination (20/64). Few patients achieved ROSC (7/64).
Conclusion: Patients who had an OHCA within 24 hours of refusing transport had underlying comorbidities and abnormal or missing vital signs. The patients experienced tachycardia, hypertension, and hypotension at a higher rate than the overall refusal population. Few patients obtained ROSC. Further research is needed to determine methods to mitigate poor outcomes and decrease refusals.

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Creating a Disaster Ready Pharmacy Workforce: Evaluation of a Disaster Tabletop Exercise

Elizabeth McCourt PhD[1], Kaitlyn Watson PhD[2]
1. Royal Brisbane and Women's Hospital, Brisbane, Australia
2. University of Alberta, Edmonton, Canada

Introduction: While the importance of pharmacists' involvement in disaster management is becoming increasingly recognized in the literature, there are few mechanisms by which pharmacists can prepare themselves for emergencies. This project aimed to determine the effectiveness of a disaster tabletop exercise (TTX) in preparing pharmacy staff for disasters.
Method: A TTX was held at the American Society of Health-System Pharmacists Summer Meeting which was held in Phoenix, Arizona in June 2022. The workshop incorporated an evolving emergency scenario in which participants worked through activities pertaining to the mitigation, preparedness, response, and recovery cycle. The scenario involved a hypothetical storm and landside scenario across fictional towns in Arizona, US. Workshop attendees worked in small groups on one of two provided hospital profiles. The attendees were invited to complete a pre-post survey assessing their perceptions of disaster management including perceived preparedness. This survey was previously developed, piloted, and published. The paper surveys were collected at the end of the workshop and inputted into RedCap. Data were descriptively summarized