
Palliative Care in the Burns Setting ANZBA Conference 2019

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Palliative Care

Multidisciplinary pursuit of quality of life
(Dr BJ Miller)

Palliative Approach

Aims to improve the QoL of patients with incurable disease (& their families) through early identification and treatment of physical symptoms and other issues.

Origins

1960's in London, focussed on patients with end stage cancer



What is Palliative Care?

Elements of practice:

- Communication skills *
- Patients and families
- Impeccable assessment and treatment of symptoms
- Physical, psychosocial and spiritual elements
- Not defined by the illness or the prognosis
- Terminal care is a subset
 - Care of the patient (and family) in the last stages of disease, usually hours or days

How is Burns Palliative Care Different?

- ~50% of our 'usual' palliative care patients have malignancy as the primary diagnosis
- 40+% Organ failure
 - Disease trajectory of months (years)
 - Most of the time, we 'diagnose dying' after some days/weeks in hospital
- Burns
 - Acute change in status
 - Short term (hours to days or short weeks)

How is Burns Palliative Care Different?

Route of drug administration:
Syringe drivers vs IV medication

Procedures are important:
Specialty dressings

Pain management led by APS

Role of Palliative Care in Burns Setting



Role of Palliative Care in Burns Setting

- Communication with patient and family
 - Decision making
 - Assistance when withdrawing treatment
- Symptom management
- Potential discharge home to die
- Staff support

Decision-making & Communication

Decision-making

Sometimes it's (relatively) easy...

Sometimes it's more complicated...



Guideline for Management of Unsurvivable Burns

Decision made by Burns consultant + Another Consultant + Senior Nurse

Pall Care informed

The Guideline covers:

- Patient presentation (how they appear when the family come in)
- Airway and decisions re intubation, extubation
- Pain management
- Emotional care of patient and family
- Staff support
- Organ & Tissue donation
- Coroner/Police investigation
- Ongoing care

Insert for use with 'Care of Dying Patient Plan' CDPP Care check list for patients cared for at Alfred Health under guideline 'Management of patients with acute unsurvivable burn injury'			
Please indicate below if burns specific plans have been made. Refer to 'Management of Patients with Unsurvivable Burns' guideline on prompt. To be used with Care of the Dying Patient Plan CDPP.			
	Yes (<input type="checkbox"/>)	No (<input type="checkbox"/>)	Rationale / Comments if "No"
Has the decision to palliate been made by Burns Consultant, + 1 Consultant & Senior Nurse?			
Has the patient been referred to the Palliative Care Unit?			
Has the patient been commenced on the CDPP & supportive Burn Plan Checklist?			
Are the burn wounds covered?			
Is the patient presentable for visitors?			
Is there a plan for social support for both the family & patient?			
Is there a plan for airway management clearly documented?			
Is an adequate pain management plan in place?			If 'no' refer the patient to Acute Pain Service
Is there PRN medication prescribed for symptom control and patient comfort?			If 'no' refer to 'prescribing algorithm for the Care of the Dying Patient plan' on prompt
Are frequent pain assessments being performed?			
Is there a formal plan for staff support ?			Discuss with direct line manager
Has organ / tissue donation been considered by the Medical Team?			
Is there a plan for ongoing wound care?			
Are family and patient aware of the coroners process?			
At day 3 has a clear plan for ongoing management been established?			Consult Palliative Care Unit / Senior Burns Nursing

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Conversations

Excellent communication is a key element of the Palliative Care skillset

EoLC audit:

For patients believed to be dying in the next few days:

Discussions far more likely to be had with carers (94%) than with the patient (18%)

Burns – patient may well be awake and able to be informed 😞

Conversations

These are often challenging

SPIKES' – Protocol for Breaking Bad News

S: Set Up

P: Perception of condition

I: Invitation

K: Knowledge

E: Emotions

S: Strategy & Summary

Decision-making

When the outcome is in the 'grey' zone:

- Explore options with the Burns team
- Talk to the family and patient;
 - Who is Mr/s X?
 - What are his/her values?
- What the treatment path might look like
- What the comfort path might look like
- Allow time (as possible)

Decision-making

Trial of life/trial of care

- 'Active' treatment commenced
- May set limits to escalation
- Establish agreed goals
 - What does improvement look like?
- Establish time frame for review
- Sign post what will happen if there is a deterioration

Withdrawing treatment

Often a more difficult conversation

- More investment
- Staff feel more connected with the patient and family
- Possible feeling of 'failure'
- Family have had hope
- Feels 'wrong'

Use the relationship trust you have developed

Discharge option

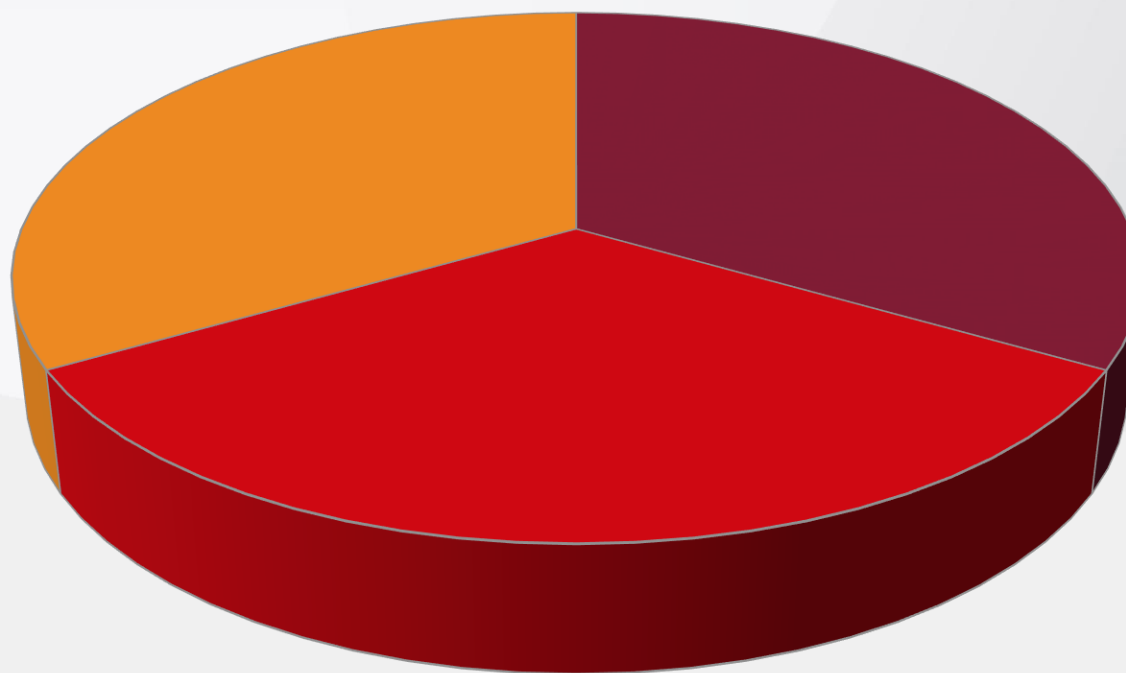
Discharge home to die

For some individuals/groups, dying at home is especially important

Often possible, depending on needs

- 'Reverse retrieval'
- Local supports
- Pain management etc

Palliative Care Services



■ Community ■ Inpatient Palliative Care Unit ■ Acute Hospital Consultancy

Symptom management

Pain Management

APS lead:

- Opioids
- Burns Procedural Analgesia Protocol

Burns team:

- Dressings modified as appropriate
- Ward staff administer analgesia and change dressings
- Designated room on the Burns ward

Palliative Care:

- Other symptoms

How do I introduce Palliative Care?

- Team we call on to provide extra support /help with symptoms etc
 - ‘AND’ not ‘OR’
- Parallel processing – “Hope for the best and plan for the worst”
- Routine part of care when our patients ...



Staff Support