Palliative care in the ED
Heart failure, a common presentation in the ED is associated with significant morbidity and mortality. This is a patient group that have a poor quality of life and would benefit from early palliative care but it’s not often considered in the ED for various reasons. So, it was interesting to read a study by Lewinski and colleagues from Canada, they sought to evaluate the use of palliative care services in patients with heart failure presenting to the ED. The primary outcome studied was palliative care involvement. Secondary outcomes of the study were: (1) 1 year mortality, (2) ED visits, (3) hospital admissions, and (4) Heart Failure Clinic involvement. They conducted a health records review of 500 heart failure patients who presented to two Canadian academic hospital EDs. Unsurprisingly, they found that few heart failure patients had palliative care services. Additionally, the majority of those that had palliative care involvement did not meet current recommendations for early palliative care involvement in heart failure. The authors suggest that the Emergency Department may be an appropriate setting to identify and refer high risk heart failure patients who could benefit from earlier palliative care. Although a small study of only two hospitals, this thought provoking paper is worth a read as it raises questions about the function of emergency care in the future. There is little doubt that increasing longevity and more effective management of chronic disease calls for greater palliative care knowledge and skills in ED Clinicians. Thus we will need to engage more with the palliative specialty as there is much we can learn from them.

Performing sit down medicine in a stand up place, Is it time for palliative care in the emergency department?
Do also read this well considered commentary on the Lewinski paper by Eric Adler from the USA. Adler acknowledges the need for palliative care for heart failure patients and suggests possible reasons why so few benefit from palliative care. Perhaps more pertinent to ED clinicians, he discusses the challenges in terms of time and the resources needed in initiating palliative care discussions in the pressured environment that is most EDs and proposes possible solutions. This is something most ED clinicians will identify with.

Pre-drawn medication syringes collected for culture were ketamine, midazolam, fentanyl, thiopentone, rocuronium, suxamethonium, metaraminol and normal saline. The samples were incubated and cultured at a tertiary hospital patholgy laboratory using best-practice methodology for non-tissue samples. None of the 299 cultured samples yielded significant micro-organisms. One sample of suxamethonium with a syringe dwell time of 34 hours grew Bacillus cereus but was likely a contaminant introduced during sample collection. They concluded that pre-drawing of the eight studied medications for urgent prehospital procedures appears to be a microbiologically safe practice with syringe dwell times up to 48 hours. This may be a safety initiative worth considering for our pre-hospital teams.

How safe are pre-drawn medications?
Prehospital medical teams frequently need to administer a range of medications for urgent stabilisation and treatment. Preparing such medications safely takes time and requires attention to detail and the potential for error in resuscitation and urgent scenarios is always a concern.

In one HEMS and two road prehospital services in Australia which deploy physician-paramedic prehospital medical teams, medication errors are mitigated by pre-drawing commonly used medications to set concentrations daily. To date it’s not known if such practice is microbiologically safe. So, it was intriguing to read a study by Soeyland et al sampling and performing microbiological cultures of pre-drawn medications used by these two prehospital services. A convenience sample of 299 pre-drawn medication syringes with syringe dwell times up to 48 hours were collected at the end of their operational deployment.