Palliative Care in Critical Trauma Patients: Challenges and Nursing Roles

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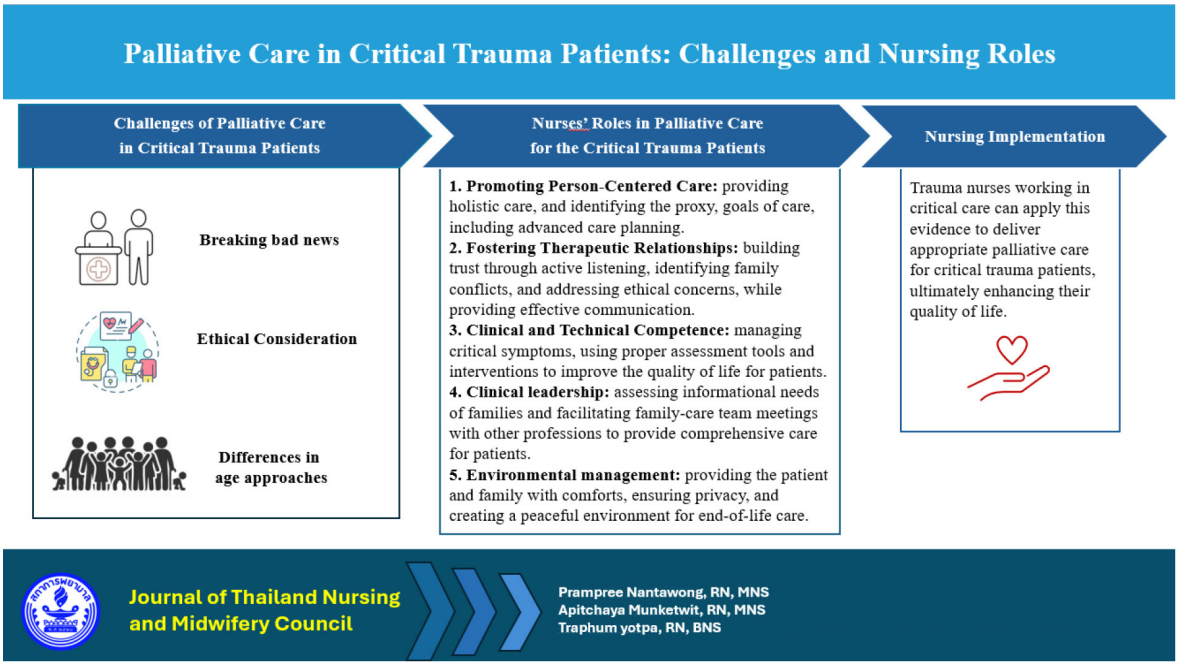

Extended Abstract

A critical trauma is a life-threatening condition that can lead to sudden death. When curative treatment is unresponsive, palliative care becomes a viable alternative that can enhance quality of life from the onset of care to the end of life. However, providing palliative care in critical trauma-intensive care settings remains a significant challenge due to the complex, sudden, unpredictable, and rapidly evolving nature of traumatic injuries. This article aims to identify multidimensional challenges and nurses' roles in delivering palliative care to critical trauma patients in trauma-intensive care units. One of the initial challenges in trauma palliative care is the communication of bad news to families following sudden and severe incidents. Nurses must be attuned to the psychological and emotional states of families, requiring advanced communication skills and the ability to observe and respond to emotional cues. Ethical considerations are paramount when patients and families opt for palliative care. Nurses must uphold the principle of autonomy in obtaining informed consent. In cases where patients are unconscious, it is essential to establish goals of care (GOC) and advance

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care planning (ACP) through surrogate decision-makers. Nurses must ensure care aligns with the principles of beneficence and non-maleficence, adhering to the patient's goals and ACP, while also ensuring justice by providing equitable care comparable to other critically ill patients. Age-related differences present another layer of complexity. In pediatric patients under 18 years, societal expectations of growth and development contrast with the elderly, who may have already prepared for end-of-life care. In Thailand, palliative decisions for minors require parental consent, unlike older adults who can make autonomous healthcare decisions. Nurses must therefore understand the unique challenges across age groups. Although the American College of Surgeons, through its Trauma Quality Improvement Program (TQIP), has developed specific guidelines for palliative care in trauma patients focusing on symptom management, patient- and family-centered care, psychosocial and spiritual support, and effective interdisciplinary communication, the role of nurses in this context remains underdefined. By integrating the autonomous role of nurses with TQIP recommendations and the ongoing care process for critically injured trauma patients, this article outlines five key nursing roles: 1) Promoting Person-Centered Care: Nurses must deliver holistic care that addresses both physical and emotional needs. This includes identifying a proxy decision-maker within 24 hours and establishing GOC and ACP within 72 hours of hospital admission. Nurses should provide continuous information about the patient's condition and palliative options and assess religious or spiritual needs at the end of life; 2) Fostering Therapeutic Relationships: Nurses should build trust through active listening, allowing families to express grief and identify conflicts regarding palliative care decisions. Ethical considerations must be addressed, and nurses should act as mediators to ensure effective communication among interdisciplinary teams and families; 3) Clinical and Technical Competence: Nurses must manage critical symptoms such as pain, dyspnea, and thirst using evidence-based practices. Accurate assessment tools and interventions are essential to improve the quality of life for critically ill patients; 4) Clinical Leadership: Nurses should assess the informational needs of families and facilitate family-care team meetings. In complex cases, nurses must coordinate with palliative care specialists for appropriate referrals, and 5) Environmental Management: Nurses should ensure privacy and create a peaceful environment for end-of-life care, family meetings, or the delivery of bad news, providing necessary amenities for both patients and families. Some patients may survive the critical phase, and palliative care should not be viewed solely as end-of-life care. Sustainable palliative care systems require collaboration with families and communities. Nurses play a central role in coordinating interdisciplinary teams and must continuously develop their knowledge, empathy, and sensitivity to cultural contexts, particularly in Thailand, where palliative care is often misunderstood as a sign of hopelessness. Institutions should support structured training programs to enhance nurses' competencies in delivering high-quality, specialized palliative care. Critical care nurses, particularly those caring for trauma patients, must also engage in research to inform policy development, as evidence-based support for trauma palliative care remains limited.

Keywords palliative care/ critical trauma patients/ nursing roles

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การดูแลแบบประคับประคองในผู้ป่วยที่ได้รับบาดเจ็บทางอุบัติเหตุในระยะวิกฤต: ความท้าทายและบทบาทของพยาบาล

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บทคัดย่อขยาย

ภาวะบาดเจ็บวิกฤตทางอุบัติเหตุเป็นภาวะที่อาจทำให้ผู้ป่วยเสียชีวิตได้ในทันทีทันใด เมื่ออาการของผู้ป่วยไม่ตอบสนองต่อการรักษา การให้การดูแลแบบประคับประคองจึงเป็นแผนการรักษาทางเลือกที่สามารถพัฒนาคุณภาพชีวิตของผู้ป่วยได้ตั้งแต่เริ่มต้นของการดูแลไปจนถึงระยะสุดท้ายของชีวิต อย่างไรก็ตามการดูแลผู้ป่วยบาดเจ็บทางอุบัติเหตุในระยะวิกฤตยังคงเป็นความท้าทาย เนื่องจากลักษณะของภาวะบาดเจ็บมีความซับซ้อน เกิดขึ้นอย่างกะทันหัน เปลี่ยนแปลงตลอดเวลา และไม่สามารถคาดการณ์ได้ บทความฉบับนี้มีวัตถุประสงค์เพื่อระบุความท้าทายในหลากหลายมิติ และระบุบทบาทของพยาบาลในการดูแลผู้ป่วยบาดเจ็บวิกฤตทางอุบัติเหตุแบบประคับประคองที่เข้ารับการรักษาในหอผู้ป่วยวิกฤตทางอุบัติเหตุ การดูแลผู้ป่วยวิกฤตทางอุบัติเหตุแบบประคับประคองมีความท้าทายตั้งแต่เริ่มต้น คือ การพิจารณาเรื่องการแจ้งข่าวร้ายจากเหตุการณ์ร้ายแรงที่เกิดขึ้นอย่างกะทันหันให้กับครอบครัว และญาติ พยาบาลจะต้องคำนึงถึงภาวะทางจิตใจ และอารมณ์ โดยจะต้องมีทักษะในการสื่อสาร และสังเกตความรู้สึกของครอบครัว และญาติเป็นระยะ อีกทั้งต้องคำนึงถึงมาตรฐานจริยธรรมเมื่อผู้ป่วยและครอบครัวได้เลือกที่แนวทางการรักษาประคับประคอง โดยพยาบาลจะต้องใช้จริยธรรมหลักในแง่มุมของความเป็นอิสระในการยินยอมเพื่อให้ได้รับการดูแลรักษา ในกรณีที่ผู้ป่วยไม่รู้สึกตัว จำเป็นต้องระบุเป้าหมายของการรักษาและการวางแผนการดูแลล่วงหน้าโดยผู้ตัดสินใจแทน พยาบาลจะต้องให้การดูแลโดยคำนึงถึงหลักประโยชน์สูงสุดของผู้ป่วย และไม่ก่อให้เกิดอันตราย ซึ่งจะต้องเป็นไปตามเป้าหมายของการรักษา และแผนการดูแลล่วงหน้า รวมถึงคำนึงหลักความยุติธรรม โดยผู้ป่วยจะต้องได้รับการดูแลที่เท่าเทียมกับผู้ป่วยวิกฤตอื่น ๆ นอกจากนี้การดูแลที่มีความแตกต่างในช่วงวัย ถือเป็นความท้าทายอีกประเด็น เนื่องจากช่วงทารกจนถึงอายุ 18 ปี บริบทของสังคมส่วนใหญ่มีความคาดหวังถึงการเจริญเติบโต ซึ่งแตกต่างจากวัยผู้สูงอายุที่อาจมีการเตรียมความพร้อมสำหรับวาระสุดท้ายของชีวิตไว้แล้ว และการตัดสินใจที่จะได้รับการดูแลแบบประคับประคองในผู้ป่วยกลุ่มอายุน้อยกว่า 18 ปี ในบริบทของสังคมไทยนั้นจะต้องได้รับการยินยอมจากผู้ปกครองอีกด้วย เมื่อเทียบกับผู้ป่วยสูงอายุที่ช่วงวัยนี้มีสิทธิ์ในการตัดสินใจเรื่องการดูแลรักษาสุขภาพของตน ดังนั้นพยาบาลควรมีความเข้าใจถึงปัจจัยความท้าทายที่แตกต่างกันของแต่ละช่วงอายุ แม้ว่าวิทยาลัยศัลยแพทย์แห่งอเมริกาจะจัดทำโครงการพัฒนาคุณภาพการดูแลผู้บาดเจ็บทางอุบัติเหตุ และได้พัฒนาแนวทางปฏิบัติสำหรับการดูแลแบบประคับประคองในผู้ป่วยบาดเจ็บทางอุบัติเหตุโดยเฉพาะ ซึ่งได้รับการอธิบายและสรุปประเด็นสำคัญในสี่ด้าน ได้แก่ การจัดการอาการ การดูแลที่มุ่งเน้นผู้ป่วยและครอบครัว และแนวทางการดูแลสุขภาพจิตและสังคม-จิตวิญญาณ รวมถึงการสื่อสารอย่างมีประสิทธิภาพระหว่างทีมสหวิชาชีพและครอบครัว แต่บทบาทของพยาบาลในการดูแลผู้ป่วยที่ได้รับบาดเจ็บทางอุบัติเหตุในภาวะวิกฤตยังขาดความชัดเจน เมื่อบูรณาการบทบาทอิสระของพยาบาลเข้ากับข้อเสนอแนะจากโครงการพัฒนาคุณภาพการดูแลผู้บาดเจ็บทางอุบัติเหตุในการดูแลผู้ป่วยแบบประคับประคอง ควบคู่ไปกับกระบวนการดูแลผู้ป่วยบาดเจ็บทางอุบัติเหตุในระยะวิกฤตอย่างต่อเนื่อง บทความนี้ได้สรุปบทบาทของพยาบาลที่เกี่ยวข้องไว้ 5 ด้านคือ 1) บทบาทในการส่งเสริมการดูแลที่

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ให้ความสำคัญกับตัวบุคคล โดยจะต้องให้การพยาบาลที่มุ่งเน้นผู้ป่วยและครอบครัว รวมถึงการส่งเสริมแนวทางการดูแลแบบองค์รวม ทั้งทางด้านร่างกายและจิตใจ เช่น การระบุผู้มีอำนาจในการตัดสินใจแทนผู้ป่วยภายใน 24 ชั่วโมง ระบุเป้าหมายของการรักษาและการวางแผนล่วงหน้าเกี่ยวกับการดูแลภายใน 72 ชั่วโมงตามลำดับหลังเข้ารับการรักษาในโรงพยาบาล พยาบาลควรให้ข้อมูลความเจ็บป่วยของผู้ป่วย การดำเนินของโรค แก่ผู้มีอำนาจในการตัดสินใจแทน และครอบครัวอย่างต่อเนื่อง รวมถึงการให้ข้อมูลการรักษาทางเลือกแบบประคับประคอง อีกทั้งการประเมินความต้องการในการประกอบพิธีความเชื่อทางศาสนาในระยะสุดท้ายของตัวผู้ป่วย และครอบครัว 2) บทบาทในการสร้างปฏิสัมพันธ์เชิงบวก โดยเน้นการดูแลของพยาบาลที่ส่งเสริมความสัมพันธ์เพื่อการบำบัด รับฟังอย่างตั้งใจ เพื่อให้ผู้มีอำนาจในการตัดสินใจแทนผู้ป่วยและครอบครัวได้ระบายความรู้สึก ความเศร้าโศกเสียใจหลังจากเกิดเหตุการณ์ทางอุบัติเหตุอย่างกระทันหัน รวมถึงระบุความขัดแย้งต่อการได้รับการรักษาแบบประคับประคอง เพื่อให้ครอบครัวสามารถมองเห็นถึงสภาพปัญหา และสามารถก้าวข้ามความขัดแย้งไปได้ อีกทั้งให้การดูแลโดยคำนึงถึงประเด็นด้านจริยธรรม และพยาบาลจะต้องเป็นตัวกลางระหว่างทีมสหวิชาชีพเพื่อให้การสื่อสารเป็นไปอย่างมีประสิทธิภาพ และบรรลุตามเป้าหมายการรักษาของผู้ป่วย 3) บทบาทด้านสมรรถนะทางการพยาบาลและเทคนิค รวมถึงการส่งเสริมความปลอดภัย ซึ่งเกี่ยวข้องกับการจัดการอาการของผู้ป่วยในช่วงวิกฤต โดยเฉพาะอาการปวด หายใจลำบาก และกระหายน้ำ โดยพยาบาลจะต้องมีการใช้หลักฐานเชิงประจักษ์จากงานวิจัยเพื่อให้การพยาบาลที่มีคุณภาพ เช่น มีการเลือกใช้เครื่องมือและการประเมินที่แม่นยำนำไปสู่การดูแลที่เหมาะสม และเพิ่มคุณภาพชีวิตของผู้ป่วยที่อยู่ในภาวะวิกฤต 4) บทบาทความเป็นผู้นำทางคลินิก พยาบาลจะต้องประเมินความต้องการรับทราบข้อมูลของผู้มีอำนาจตัดสินใจแทนและครอบครัว ส่งเสริมให้เกิดการประชุมระหว่างครอบครัวและบุคลากรผู้ดูแล เพื่อให้มีการรับทราบข้อมูลความเจ็บป่วย และการดำเนินโรคของผู้ป่วยเป็นระยะ รวมถึงการให้คำปรึกษาในการดูแลแบบประคับประคอง กรณีที่ผู้ป่วยและครอบครัวมีความซับซ้อน พยาบาลจะต้องประสานงานกับผู้เชี่ยวชาญด้านดูแลแบบประคับประคองโดยตรงเพื่อการปรึกษาส่งต่อ และ 5) บทบาทในการจัดการสิ่งแวดล้อม พยาบาลควรประเมินความต้องการของผู้ป่วยและครอบครัวเกี่ยวกับความเป็นส่วนตัว และควรจัดสรรพื้นที่เพื่อให้ผู้ป่วยที่ได้รับการดูแลแบบประคับประคองในระยะสุดท้ายใช้เวลากับครอบครัว รวมถึงเมื่อมีการประชุมระหว่างครอบครัวและบุคลากรผู้ดูแล หรือการแจ้งข่าวร้าย พยาบาลควรดูแลจัดสถานที่ให้มีความสงบและเตรียมสิ่งอำนวยความสะดวกแก่ผู้ป่วย และครอบครัว อย่างไรก็ตามผู้ป่วยบางรายอาจมีชีวิตรอดหลังพ้นช่วงวิกฤต และการดูแลแบบประคับประคองมิได้สิ้นสุดลงเพียงแค่การเสียชีวิตของผู้ป่วยเสมอไป ดังนั้นการวางแผนการดูแลจึงควรมีฐานที่ตั้งอยู่บนความร่วมมือของชุมชนและครอบครัวร่วมด้วย เพื่อการสร้างระบบการดูแลแบบประคับประคองอย่างยั่งยืนสามารถประสบความสำเร็จได้ด้วยความร่วมมือของทีมสหสาขาวิชาชีพโดยมีพยาบาลเป็นผู้ประสานงาน อีกทั้งแนวทางการดูแลแบบประคับประคองเป็นกระบวนการที่ต้องใช้ความละเอียดอ่อน โดยเฉพาะอย่างยิ่งในบริบทของวัฒนธรรมไทย ซึ่งมักมีการตีความว่าการดูแลแบบประคับประคองเป็นเรื่องเลวร้ายหรือเป็นสัญญาณของจุดจบ ด้วยเหตุนี้ พยาบาลจึงจำเป็นต้องพัฒนาตนเองอย่างต่อเนื่อง ทั้งในด้านองค์ความรู้ การมีความเห็นอกเห็นใจ และความสามารถในการแสดงความเข้าอกเข้าใจในสถานการณ์ที่ยากลำบาก นอกจากนี้องค์กรควรส่งเสริมให้มีการจัดอบรมหรือหลักสูตรเกี่ยวกับการดูแลแบบประคับประคองอย่างเป็นระบบ เพื่อพัฒนาศักยภาพของพยาบาลในการให้การดูแลที่มีคุณภาพและตอบสนองต่อความต้องการเฉพาะทางของผู้ป่วยและครอบครัวได้อย่างเหมาะสม ในส่วนของพยาบาลหอผู้ป่วยวิกฤต โดยเฉพาะกลุ่มผู้ป่วยอุบัติเหตุ จำเป็นต้องมีการพัฒนาองค์ความรู้อย่างสม่ำเสมอ รวมถึงมีบทบาทในการดำเนินงานวิจัยเพื่อสนับสนุนการจัดทำนโยบายด้านการดูแลแบบประคับประคอง เนื่องจากหลักฐานเชิงประจักษ์ที่สนับสนุนนโยบายด้านการดูแลแบบประคับประคองยังมีค่อนข้างจำกัด

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คำสำคัญ การดูแลแบบประคับประคอง ผู้ป่วยบาดเจ็บทางอุบัติเหตุระยะวิกฤต บทบาทพยาบาล

วันที่ได้รับ 21 พ.ย. 67 วันที่แก้ไขบทความเสร็จ 30 พ.ค. 68 วันที่รับตีพิมพ์ 30 พ.ค. 68

Introduction

Critical trauma is a life-threatening event. The fatal experience potentially occurs with a trauma victim at any time during a critical period, especially in severe trauma and uncontrollable clinical conditions such as hemodynamic instability. Critical trauma also results in several complications, including infection, sepsis syndrome, and multiple organ dysfunction syndrome. All those complications can be the cause of death. Unfortunately, the challenges of acceptable death in trauma patients remain because their critical status is complex, sudden, dynamic, and unpredictable. Thus, Palliative care (PC) is a critical trauma not only for dying, but healthcare professionals should focus on various aspects that involve patient and family quality of life (QOL).[1]

Palliative care (PC) is an alternative type of care that can improve the patient's QOL for both chronic and sudden diseases, especially in patients with health conditions that are potentially life-threatening, including those that do not respond to curative treatments. Palliative care is the most common approach in the early stage after illness diagnosis and before trajectories leading to the termination of the illness. The concept of PC was generated in several traits, which included interdisciplinary teamwork, holistic care approach, compassionate value, mutual respect, and patient-family based care. Furthermore, PC results in better coping skills, increases human dignity, improves self-care, and raises the patients and their families' QOL.[2] Therefore, the early delivery of PC in the healthcare system is suggested by the World Health Organization (WHO) due to the burden of an aging population, communicable disease, and non-communicable disease, including trauma injury, which has been increasing nowadays. Also, PC may decrease long-term patients' suffering and unnecessary costs of hospitalization.[1, 3]

Among polytrauma patients admitted to the Intensive Care Unit (ICU), the mortality was shown at a high rate, approximately 2.8% without complications and 10.2% with complications.[4] That number of deaths led healthcare providers (HCPs) to recognize more about PC due to the high number of trauma patients who need to receive care. In the trauma service center, the American College of Surgeons, as part of the Trauma Quality Improvement Program (TQIP), recommended the implementation of PC in parallel with curative treatments during life-sustaining interventions by identifying the goals of care (GOC) and Advance Care planning (ACP) in the potential case immediately.[5] Almost 72.1 % of trauma patients met the palliative criteria, which were related to older age, serious illness, and high injury severity score (ISS); however, only 18.9 % were approached by PC and setting GOC within 72 hours after hospitalization in the United States of America.[6] Moreover, the prevalence of PC needed in the critical trauma was found to be 51 % in Peru, and the need for intensive PC consultation was seen.[7] The situation of PC in Thailand has been studied mostly in the field of emergency and chronic medicine, and in the trauma population is rare. However, the perception of PC in Thai culture is considered as the study by Kunakornvong et al., which reported that PC awareness, including knowledge and attitude, in the Thai population is rather low (24%). Also, the previous study results showed that 88% of study participants thought that the PC could be performed on EOL patients specifically, and only 5 % of them were aware that PC is life-threatening.[8]

Regarding critical trauma, which is life-threatening and sudden, the role of PC in trauma is supposed to be considered because PC is a sensitive issue based on culture and perception, especially in Thailand. Even if the decision of PC may be primarily based on age and frailty,[9] the acceptance of PC has remained a challenge because trauma can occur at all ages. A nurse is the crucial person who provides care closely with the patient and family during a critical period. Thus, nurses should have knowledge, skills, and strategies based on nursing roles to improve the QOL during PC, EOL, and terminal care.[10] The American

College of Surgeons, as part of the Trauma Quality Improvement Program (TQIP), has not been directly displaying the nursing role in critical trauma, although it has contributed the best practice guideline of PC in trauma, particularly. The current study compiled relevant nursing roles in various aspects to integrate the nurse's role and PC suggestion by TQIP with continuum trauma care in tandem for optimal care in palliative trauma in a critical period.

Objective

This article aims to describe the challenges of palliative care in critical trauma and nurses' roles in delivering palliative care to critical trauma patients in trauma-intensive care units.

The Challenges of Palliative Care in Critical Trauma

1) Breaking bad news: Traumatic events can cause individuals to die suddenly or become significantly disabled for the rest of their lives. After trauma resuscitation is not successful or cannot save a patient's life and disability, HCPs need to provide special meetings to inform the patients' families or their loved ones about catastrophic illness, illness trajectory, patient's health outcomes, including death. When informing the family all that information after resuscitation and unresponsive curative treatments under the feeling of commotion, expectation, demand, and emotional toll may make the family more stressed; resulting in the difficult PC acceptance, but it is a necessary aspect of HCPs' responsibilities. Not only is HCP's experience important, but also managing the environment, summarizing expectations and goals, including building a harmonious relationship, are needed to perform because those factors affect breaking bad news in major trauma.[11] Therefore, HCPs are supposed to practice their conversation skills by recognizing, validating feelings, and sympathetic reactions as well as manage an environment before providing bad news to the family.

2) Ethical consideration: The components of PC include EOL and terminal care, which refer to the significant mean as "Do not resuscitate (DNR)"; however, it does not include withdrawal of care delivery. There is a curiosity about the meaning of DNR because some patients in this status still need curative care aggressively, but exclude the specific interventions that lead to the risk of cardiac arrest. Life support during the dying process and PC are important, and those are run by HCPs and families' decision makers, while the consideration of principal ethics in aspects of autonomy, beneficence, nonmaleficence, and justice is commonly considered.

2.1) Autonomy: Individuals have a right to their determination of health; they can decide to receive or deny the treatment or care as they desire. In critical trauma patients who were unconscious or unable to make decisions, HCPs can use the advance directive (AD), which is a legal document that the patients have made with a capacity for proper management of their preferences for receiving medical treatment and care. If AD has not been prepared, the GOC and ACP documentation are supposed to be discussed between the HCP team and the surrogate, such as the patient's proxy and family. The point of autonomy is respecting the patient's wish; however, the difficulty is that HCPs should balance the autonomy ethical consideration with the beneficence of treatment and intervention to achieve a result that simultaneously benefits the patient's well-being.[12] Thus, the details of treatment and medical care are consented; it is supposed to be stated in GOC and ACP clearly. Therefore, the challenge of autonomy is a basic ethic that was evidenced in a previous study because more than 70% of HCPs in trauma encountered uncomfortable situations in decision-making while the trauma patients were in a critical and emergency scenario. Especially, working experiences are a factor to help HCPs handle this issue of interest.[13]

2.2) Beneficence and non-maleficence: According to the beneficence ethic, medical intervention and care are chosen after their respective risks and benefits to the patient are assessed. However, avoiding the conflict of implementation, HCPs should follow the patient's autonomy as well as GOC and ACP.[12] Furthermore, the concept analysis on non-maleficence principles means that HCPs need to weigh the dilemmatic situations between advantages and disadvantages of care, and avoid harm in order to enhance patients' comfort, patients' safety, and prevent needless suffering; resulting in improved patients' QOL.[14] The ethical challenges which are related to beneficence and non-maleficence occur most in a simultaneous situation, especially in the ICU. For example, the principle of trauma surgery is operation the injured organ of injury and perform invasive interventions for saving life, such as tracheostomy tube insertion for airway management; however, aggressive treatments do not improve or change the patients' QOL in palliative cases sometimes [15]

2.3) Justice: The ethical principle of justice is ensuring a fair distribution of health resources and requiring impartiality in the provision of health care. HCPs need to provide equality in potential palliative care patients by considering the economic power of care to improve the end outcomes of their lifespan. In a case study related to justice ethics, it is reported that trauma is a criminal situation; sometimes, HCPs provide care to both the wrongdoer and the victim. The standard of care and treatment is supposed to be provided to them equally in any situation, including PC.[15]

3) Differences in age approaches: There is a similarity in goal and optimum care of PC in all ages, but it has been challenging in the distinguished consideration. Mortality in pediatric patients is rare among trauma injuries, as well as uncommon in human perception and norm. As a family's logic, the parents may expect children to grow instead of die, even though 5.3% of this patient group consulted the specialty for PC.[16] ACP in a childhood is complex regarding the legality. For instance, it is not only the patient's autonomy that is an essential component of PC, but also an infant until the age of 18 may need consent from their parents in the Thai context. Therefore, family meetings and psychosocial support need to be performed in all cases. In contrast with geriatric patients, this age absolutely has the right to their determination of health. It is easy in the process of EOL if the patient has an AD. However, frailty conditions are the key consideration when the ACP is dependent on the proxy. In addition, a suitable time for the PC performing in the trauma role was evidenced by comparing the patient's age and frailty conditions. It was found that older age with frailty was the easiest scenario for PC approaches and comfort care transitions. However, AD was a significant factor for provider decision making in PC,9 whereas AD perspectives have not been commonly generated in some cultures and norms, such as the Thai context. Therefore, PC may be a challenge for HCPs' roles in Thailand.

Nurses' Roles in Palliative Care for Critical Trauma Patients

Regarding the patient and family's GOC and PC in trauma patients during the critical period, they are supposed to be assessed at an appropriate time 17 The American College of Surgeons stated the principle of PC and guidelines for EOL approaches that HCPs need assistance with spiritual, social, and psychological problems as a holistic care.[13] Also, the American College of Surgeons, as part of the Trauma Quality Improvement Program (TQIP), has contributed the best practice guideline of PC in trauma specifically. The guideline suggests the processes of PC providing at the beginning of PC assessment, the EOL care until terminal care by considering patient-family based and specific traumatic injury in difficulty group approaches. The essential components of PC are described and summarized

in four aspects, which are symptom management, patient-family centered care, and mental and social-spiritual health approach, including effective communication between the interdisciplinary team and family.

The nurse is a professional healthcare provider who provides care closely to patients and their families. Therefore, nurses should have the ability to perform a fundamental nursing role and contribute to caring for patients with PC. The elements of person-centered care, positive interpersonal behaviors, nursing and technical competence, clinical leadership, environmental management, and safety promotion are depicted in the scoping review based on the autonomous nursing role.[10] All those will be integrated with the PC approaches by TQIP suggestion to contribute nursing practices for optimal care and a continuum of trauma care, parallelly to increase patients' QOL as follows:

1) Promoting person-centered care: The unit of PC is meant for patient-family-centered care. Family members and the patient's proxies are the key people who can make the decision on the patient's life, thereby patients may be unconscious and disabled in their self-determination of health when an emergency, serious injury, or life-threatening condition occurs. It leads families to face uncomfortable feelings, such as stress, anxiety, burnout, and fatigue, that may present at any time during a critical period. The nurse should provide nursing care as holistic care as follows:

1.1) Assessing and screening the patient and family's background and need to process for identifying the proxy within 24 hours and demonstrating GOC, and ACP in 72 hours after PC approaches.

1.2) Providing information about the patient's illness, illness progression, including PC information, to aid in understanding this alternative care definition.

1.3) Supporting holistic care, both physical and emotional aspects, to fulfill the patient's wishes and the family's needs.

1.4) Approaching mental and social-spiritual health, cultural diversity, and religion. Nurses should identify the patient's and family's needs in EOL and terminal care. For example, the majority of people in Thai culture believe in Buddhism. For helping the individuals to have a calm transition to their next life, the family will desire a monk to pray by the patient's bed, etc.

1.5) Encouraging patient-family based care. Nurses are supposed to have a sense of compassionate care and awareness of the resilience factor, as well as to promote family participation in bedside care in EOL.

1.6) Providing quality nursing care: Nurses must have knowledge about the patient's diseases and illness trajectories, including signs and symptoms, which will be demonstrated in the critical phase. Nonetheless, they need to have a good attitude and healthy mindset about palliative care, with an awareness of diversity in patients' characteristics and culture. For example, in pediatric palliative patients, the proxy may be the parents, so nurses must inform them about illness information by using effective communication, positive outlook, respectfulness, and empathy regarding their situation. Moreover, the parents may feel guilty about trauma incidents related to parents being careless; therefore, nurses need to understand their difficulty and guilt. In adult palliative patients, the nurse should let the family comprehend the age-related decline, which impacts the patient's condition, leading to worse health outcomes.

2) Fostering therapeutic relationships: Nurses who practice with palliative patients during a critical period should improve their skills to achieve positive interpersonal behaviors and PC acceptance. Due to each patient having their own background and preference, nurses and HCPs need to have responsibility for the patient's history as well as perform nursing care as follows.

2.1) Building up the therapeutic relationship to destroy personal and professional boundaries.

2.2) Increasing active listening skills in response to the emergence of critical period, the proxy and family are going to encounter grief and loss processes. Especially when breaking bad news, they may express feelings of shock and denial. The nurses should listen to them without bias and give them an opportunity to express their sadness and anger.

2.3) Finding the conflict on PC approaches, such as the death and PC in pediatric patients, may differ in acceptance. Thus, the nurse is supposed to help parents and families to identify conflict resolution.

2.4) Providing honest care based on ethical approval and dealing with ethical dilemmas. Nurses should advocate for palliative patients to receive beneficence and non-maleficence care.

2.5) Giving effective communication between interdisciplinary teams and the family. The primary PC may be provided by an interdisciplinary team, such as a physician, nurse, social worker, and psychologist, so the direction of care must be clear and followed by GOC and ACP. When giving the family clinical information, it should be simple and easy to understand, and the level of topical severity should be explained. Also, HCPs need to give patients' families and proxies information about the option of PC and allow them to communicate using a "two-way communication technique" to decrease their pressure. The proxy and family may request the nurse's experience to plan for the patient's care; therefore, the nurse should share any positive experiences with them and practice developing empathy and emotional intelligence.

3) Clinical and technical competence: Pain, dyspnea, and thirst are the common symptoms in a critical period that need management to provide the patient's comfort. During PC approaches, nurses are supposed to focus on symptom management to improve the patient's QOL as well as use research and evidence-based practice to support nursing care.

3.1) Pain management: Nurses must use the appropriate tools for pain measurement, such as applying the Critical Care Pain Observation Tool (CPOT) in critical patients who are unconscious and cannot communicate for pain assessment, resulting in providing options to secure a patient's pain.

3.2) Dyspnea management: Nurses should assess the signs and symptoms of dyspnea, such as tachypnea, oxygen desaturation, etc. Moreover, providing enough oxygen supplements to prevent dyspnea symptoms. In critical patients, they may have an endotracheal tube or tracheostomy for maintaining their airway. Therefore, nurses should practice by suctioning clear airways.

3.3) Thirst management: Nurses need to assess the patient's thirst feeling, such as dry mouth, because some patients in the EOL stage may not receive an enteral feeding. Thus, nurses should provide parenteral nutrition and intravenous fluids to patients as the doctor orders.

4) Clinical leadership: A professional nurse who works directly with patients should be a leader in collaborating with other professions to provide comprehensive care for PC patients, which will be delivered by the interdisciplinary team. The following are the key roles that nurses are expected to fulfill

4.1) Assessing the proxy and family information needed. During a critical period, patients' health status can change in a minute, so the status should be updated to the proxy and family periodically. Nurse is supposed to be collaborators to promote the meeting between interdisciplinary professions and families every 24, 48, and 72 hours.

4.2) Providing the knowledge and information about the illness trajectory to promote the discharge planning process in palliative cases.

4.3) Being a consultant and supporting a proxy and family in holistic aspects. Nurses should have the ability to identify the complex cases and what they need during PC, including management. Moreover, a nurse must be a coordinator

to collaborate with other multi-disciplinary professionals for transferring complicated cases to receive special care from specialists. For instance. In patients who have PC conflict, the nurse should consult a palliative care specialist to approach them and their family. Also, some families faced with financial difficulties should approach a social worker to find a certain subsidy.

5) Environmental management: Patient-family comfort is concerned with providing care. Most critical patients will be admitted to the ICU; the manipulation for the minimization of noise, appropriate temperature, and lighting is requested during the PC approaches. Therefore, the following practices are essential for nurses to perform.

5.1) Assessing the patient-family needs about the level of privacy: Nurses should allocate and manage the beds to locate the palliative patients in a private zone. It may allow the patient's family to spend time together in EOL in a peaceful environment.

5.2) Having a family meeting or breaking bad news: The setting should maintain a quiet, distraction-free environment. Nurses should ensure the availability of essential comfort items, including facial tissues, chairs, and water, to support a conducive atmosphere during the meeting. HCPs are advised to position themselves at the same level as the patient to foster engagement. Additionally, measures should be taken to keep the door closed and minimize interruptions, such as silencing phone notifications.

5.3) Providing care for the family with flexible hospital policies and rules: During ICU admission, families may experience restrictions on visitation time. Nurses should navigate these regulations with resilience, fostering family bonding and meaningful engagement during the patient's final moments. In cases where family members cannot remain with the patient, nurses must identify the key person responsible for initiating communication when end-of-life decisions become imminent.

A Case Study of Palliative Care in TICU

A girl aged 7-year-olds experienced a high-level fall. She was diagnosed with 1) severe traumatic brain injury, subdural hematoma, subarachnoid hemorrhage, brain swelling with brain herniation; 2) multiple right rib fractures, lung contusion, pneumo-hemothorax; 3) open book pelvic fracture (unstable type), and 4) multiple facial fractures. She presented with unconsciousness (Glasgow coma score = 3), hemodynamic shock, and desaturation.

At emergency room, the patient received the major treatment about 1) intubation endotracheal tube with ventilator support for maintain respiration, 2) wearing pelvic birder for immobilization and control bleeding, 3) resuscitation, receiving blood transfusion and intravenous volume therapy, and 4) receiving vasoconstrict and inotropic drug in high concentration. For overall time around 1 hour of resuscitation, the patient could not overcome the hemorrhage, and the shock stage also had unresponsive treatment. At that time, neurosurgeons, trauma surgeons, and orthopedic surgeons agreed that undergoing surgery would be a risk more than a benefit, and the patient needed to be approached with conservative treatment and palliative care. However, the parent and family still denied that alternative treatment; therefore, the physician decided to admit the patient to the ICU for continuing resuscitation until the family could accept the patient's condition.

During a critical time in the ICU, the patient's condition worsened (Glasgow coma score = 3; E1M1V1), and she presented with disseminated intravascular coagulation (DIC). However, the conservative treatments, such as blood component replacement, the high concentration and volume of inotropic drugs for hemodynamic maintenance, were provided to support the patient and family. At that time, the nurse encouraged the HCP team to do a family meeting to identify GOC and ACP.

The results were to know the proxy, but the family still denied the best supportive and palliative care. After identifying the complexity of PC acceptance, the nurse consulted a palliative care specialist to approach the patient's family. When the family agreed to receive PC, the ACP was identified as "no surgery, no CPR, no tracheostomy, no renal replacement, no blood transfusion, full medication, full IVF, full feeding, fix on inotropic rate and concentration, fix on ventilator setting." Hence, the physician ordered the treatment as 1) on ventilator full support mode: FiO2 0.4, PEEP 5, IP 10, RR 14/min; 2) Norepinephrine (4:100) IV rate 30 ml/hr. (Max dose); 3) IVF as NSS 1000 ml IV rate 60 ml/hr. (plan feeding after 24 hrs. of injury); and 4) Fentanyl (25:1) IV rate 2 ml/hr. with PRN dose 25 mcg q 1 hr. In addition, this family had financial difficulties that could require hospital subsidization. The nurse also consulted the social welfare staff to assist with this problem. After admission to the ICU for 8 hours, the patient presented with desaturation, persistent hypotension, bradycardia, and cardiac arrest.

Identifying challenges The patient presented with severe multiple injuries (Injury severity score = 75). After aggressive curative treatments were done, the patient had unresponsiveness to the given treatments; the health care team decided to provide the patient with palliative care and best supportive treatment. However, the conflict was between parents and family, which they could not handle or accept. This case presents challenges in various aspects that nurses need to address. Firstly, the challenge of age is the crucial factor because the parent expects clinical improvement highly. Secondly, the parents and family were in a denial stage in the grief and loss process; informing them of bad news could make them angry and shocked. Lastly, ACP in this case could be performed based on her parents' decision. Even if the patient's condition is so severe that there is a high risk of termination and death, HCPs may provide them full, aggressive treatment until her parents agree for palliative care. Also, medical treatment should be done with ethical consideration in beneficence and non-maleficence, including justice.

Nursing care provision

1. Information needs: Nurses conducted comprehensive assessments of both the patient's and family's backgrounds to identify their specific informational needs. They provided clear and compassionate explanations regarding the patient's illness trajectory, including the principles and goals of palliative care, to foster understanding of this alternative approach. In collaboration with physicians, nurses facilitated interdisciplinary family meetings within the first 24 hours of admission and continued these discussions daily when feasible. Critical decisions, such as the identification of a proxy decision-maker and the establishment of goals of care, were prioritized within 24 hours, while advance care planning (ACP) was initiated within 72 hours.

2. Holistic care in complicated cases: Nursing care includes both physical and psychological dimensions, emphasizing a holistic approach. Nurses cultivated therapeutic relationships through active listening, allowing families to express emotions and ask questions in a supportive environment. In cases involving complex palliative care issues, nurses consulted with palliative care specialists to explore underlying concerns and resolve conflicts. Once ACP was established, healthcare providers aligned care with the family's values and preferences, ensuring the delivery of optimal supportive care. Environmental adjustments were made to support end-of-life care, including transferring the patient to a private room and allowing family members to remain with the patient. Cultural and spiritual needs were respected, such as facilitating religious rituals and merit-making practices in accordance with the family's Buddhist beliefs. Nurses encouraged family presence during the EOL phase by offering flexible visitation, thereby promoting meaningful time together.

3. Symptom management: Pain assessment in pediatric patients, particularly those aged seven, typically involves tools such as the FACES Pain Scale-Revised (FPS-R) or the Critical-Care Pain Observation Tool (CPOT). However, in this case, the patient was non-communicative and had a Glasgow Coma Scale (GCS) score below the threshold for CPOT use. Consequently, nurses relied on physiological indicators—such as tachycardia, hypertension, and dyspnea—to infer pain levels and administered analgesics as prescribed. Respiratory care included ventilator management and airway suctioning, performed with sensitivity to minimize discomfort. Nurses vigilantly monitored for signs of respiratory distress, including tachypnea, audible secretions, and oxygen desaturation. Intravenous fluid therapy was continued with medical orders, with additional attention to signs of dehydration and thirst. Oral care was provided to maintain comfort and dignity.

4. Family support: Following the patient's death, nurses offered psychosocial support to the family, creating space for emotional expression and grief. They also provided guidance on post-mortem procedures, including autopsy protocols in cases of non-natural death and the process of obtaining a death certificate. Nurses assumed the role of care coordinators, liaising between the family and social welfare personnel to explore available financial and social support resources. This collaborative approach ensured that the family received comprehensive assistance during a profoundly difficult time.

Conclusion

A critical trauma is life-threatening and sudden; the role of PC in trauma patients should be considered. The nurse is a key person who can promote and improve the palliative patient's QOL at the beginning of the PC approach until EOL and terminal care. However, PC in the critical trauma is complex due to the patient's characteristics, and the challenges may occur in PC processes at any time; thereby, trauma nurses need to have the competency and skill to provide care and practice as a professional nursing role. The integration between the PC approach by nursing role and the TQIP suggestion in PC is described in five roles: 1) promoting person-centered care, 2) fostering therapeutic relationships, 3) clinical and technical competence, 4) clinical leadership, and 5) environment management.

Nursing Implementation and Suggestions

An integrated nursing role for palliative care in trauma patients during a critical period was provided in the present article. There is guidance to perform nursing care that trauma nurses in critical fields can apply the evidence based on proper nursing practice to improve the patient's QOL. However, the area of improvement should be discussed since PC approaches are sensitive and complex.

1. A sustainable system in palliative care can be successful through cooperation in multi-disciplinary teams. Also, the system may link to the hospital, community, and home because a certain patient, after a critical period, may survive, and PC does not end with the patient dying, sometimes. Therefore, the palliative plan needs to be made by community-family-based as well. Nurses are professionals who provide care closely to the patients and their families; they should possess multifunctional skills that aim to be the collaborative mediators among multidisciplinary teams to improve the QOL during PC.

2. A nurse is an important professional who can promote the patient and family's QOL during PC, EOL, and terminal care. The PC approach is sensitive, especially in Thai culture, where people justify the PC as a catastrophe; therefore, nurses need to do self-development as well as emphasize knowledge, and emotions such as empathy, including sympathy in difficult situations. Moreover, the organizational unit should promote PC training for

nurses to encourage them to have more ability to provide quality care, specifically. Additionally, trauma nurses need to renew and update their knowledge frequently and also conduct research on policy management, which is related to practice development, because the previous study noticed that the evidence-based PC policy is rare.[18]

Declaration Statements

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