



Centre for Palliative Care
Research and Education

Centre for Palliative Care Research and Education

5th Annual Research Conference

Friday 2 June 2006

Education Centre
Royal Brisbane and Women's Hospital
Herston, Brisbane



**Queensland
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Centre for Palliative Care
Research and Education



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2 June 2006

Dear Colleagues

Welcome to the Fifth Annual Conference for the Centre for Palliative Care Research and Education.

The CPCRE Annual Research Conference aims to provide the palliative community in Queensland with an opportunity to discuss some of the latest research in the field of palliative care. The research presented at this year's Conference covers a broad spectrum of issues in palliative care education, practice, and policy.

We hope you find the Conference interesting, challenging, and enjoyable.

Warm Regards

A handwritten signature in black ink that reads "p. yates".

Professor Patsy Yates
Acting Centre Director
Director of Research
Centre for Palliative Care
Research and Education

The Centre for Palliative Care Research and Education

The Centre for Palliative Care Research and Education (CPCRE) is an initiative of Queensland Health that improves Queensland palliative care services through research and education.

To achieve these aims, the CPCRE operates as a 'centre without walls', committed to building and fostering partnerships with the palliative care community in its endeavours.

The key functions of CPCRE are to:

- Develop the capacity of the palliative care work force to provide quality palliative care
- Improve the links between research and practice in palliative care
- Undertake research to enhance the quality of palliative care
- Provide information which supports the delivery of palliative care services



Conference Program

08.30–09.00 Registration

First Morning Session (Main Auditorium) 09.00–09.50
Chair of First Morning Session–Professor Janet Hardy

09.00–09.05 Welcome and Opening Address
Professor Patsy Yates,
Acting Director of CPCRE

09.05–09.50 Keynote Address: Professor Michael Ashby
Director of the Centre for Palliative Care
St Vincent’s Hospital, Melbourne
**Palliative Medicine: A Practice of Evidence
or Experience?**

09.50–10.15 Morning Tea

Second Morning Session (Main Auditorium) 10.15–12.00
Chair of Second Morning Session–A/Prof Geoff Mitchell

10.15–10.35 Associate Professor Liz Reymond
Palliative Care Specialist,
Brisbane South Palliative Care Collaborative
**Palliative Care Service Provision Within
Brisbane South: A Prospective Audit**

10.35–10.55 Mr Tony Hall BPharm, DipMedSci(Pall Care), ADCPT, MSHP
Team Leader, High Risk Medications
and Systems
Safe Medication Practice Unit
Royal Brisbane and Womens' Hospital

**Development of a Continuous Subcutaneous
Infusion Order and Administration Chart
for Opioids and Other Medications Used in
Palliative Care Based on Medication
Safety Principles**

10.55–11.15 Dr Deborah Prior
Director of Learning and Development
CPCRE

**Take Away the Pain but Leave Me Whole:
Aboriginal Perspective on Palliative Care**

11.15–11.30 Professor Janet Hardy
Clinical Research Program Leader, CPCRE;
Director of Palliative Care, Mater Health
Services, Brisbane

**A Pilot Study of Haloperidol for the Control
of Nausea and Vomiting in Cancer Patients
with Advanced Cancer**

11.30–12.00 Official Opening of the Conference
The Hon Stephen Robertson MP
Minister for Health, Queensland Government

12.00–13.00 Lunch

First Afternoon Session (Main Auditorium) 13.00–14.30

Chair of First Afternoon Session–Mrs Margie O’Kane

13.00–13.15 Dr Rosemary Ramsay

Link Medical Officer,
Brisbane South Palliative Care Service
Brisbane South Community Health Service
QEIIHSD

The Medical Link Project

13.15–13.30 Professor Patsy Yates

Acting Director, CPCRE

**Understanding Factors Contributing to
Nausea in Advanced Cancer: Clinical and
Patient Perspectives**

13.30–13.45 Dr Anthony Herbert

Palliative Care Registrar,
Mater Health Services, Brisbane

**Children with Advanced Neuroblastoma –
Two Case Studies of Paediatric
Palliative Care**

13.45–14.00 Dr Rohan Vora

Advanced Trainee Registrar, Chapter of
Palliative Medicine,
Day Oncology Registrar,
Mater Adult Hospital, Brisbane

**Developing a Simple, Integrated, ‘Self
Report’, Multi-Disciplinary Screening Tool to
Assess Symptom Distress, Functional Status
and Level of Social Support for Patients
Attending a Day Oncology Service**

- 14.00–14.15 Ms Letty Burridge**
School of Population Health,
University of Queensland
**Reluctance to Care: A Systematic Review
and Conceptual Framework**
- 14.15–14.30 Discussion with Audience and Session
Speakers**
- 14.30-14.50 Afternoon Tea**

Second Afternoon Session (Main Auditorium) 14.50–16.00
Chair of Second Afternoon Session–Dr Carol Douglas

- 14.50–15.05 Ms Marilyn Tefay**
Acting Director of Occupational Therapy,
Mater Adult Hospital, Brisbane
Ms Ann Crome
Senior Social Worker, Oncology
Mater Adult Hospital, Brisbane
**Assessment of Mater Adult Hospital
Oncology “Right Of Private Practice”
(ROPP or Outpatients Clinic)
Patients Allied Health Professional Needs**

15.05–15.25 Professor Janet Hardy
on behalf of the Queensland Palliative Care
Research Group (QPCRG)
Clinical Research Program Leader, CPCRE;
Director of Palliative Care,
Mater Health Services, Brisbane

**What are the Barriers to the Optimal Care of
the Dying?**

**15.25–15.40 Discussion with Audience and Session
Speakers**

15.40–16.00 Conference Close
Professor Patsy Yates,
Acting Director of CPCRE

Conference Abstracts

Palliative Medicine: A Practice of Evidence or Experience?

Michael Ashby

*Director of the Centre for Palliative Care
St Vincent's Hospital, Melbourne*

This paper will suggest that palliative care medical practice is seldom driven by research findings and if it is, these are unlikely to be from work by the field itself. Practice changes more as a result of case experience, both personal and from case series. Increasingly, innovations (good and not so good) are transmitted by internet groups such as palliativedrugs.com rather than by journal articles and trials. New approaches to patient management are rapidly tested out in practice and transmitted around the world. The expensive and time-consuming nature of clinical trials means that many of these are never tested in this rigorous way. The only arbiter seems to be the Canadian historian Michael Ignatieff's covenant with his readers: "I have found this, now is it true for you?"

The modern evidence-based medicine movement has tried to imbue the whole of medicine with a rigorous approach to practice based on good quality studies and this is clearly correct. However, all good ideas have the potential to overshoot and become oppressive. Many questions and therapies will never be subjected to clinical trials but will rise or fall on personal or local experience. Whilst it seems without question that good quality trials should be designed for important therapeutic questions, it is disastrous, if clinical experience is trivialised or down-graded. Surely the first rule of science is to describe what you see. Informed and self-critical clinical experience is the cornerstone of all that we do, and should be harnessed.

Unlike most other health specialties, palliative medicine does not have its own unique basic scientific grounding, methodology or technology. It offers instead specialist practitioners and teams with unique attitude-knowledge-skill mixes designed to meet the needs and wishes of their clients. These services are in a unique position to assist in the conduct of research and may have valuable ideas for projects, but they are often

poorly equipped to conduct research themselves, and this expertise usually has to be brought in.

Most services have little time or aptitude for research but there are increasing pressures upon them to engage in it. Given the parlous state of the workforce in Australia and other countries, over-ambitious research expectations can be burdensome and often fail to deliver useful results.

The study of palliative care requires collaborative inputs from diverse disciplines and methodologies, depending on the question being asked, a fact that the most productive and successful research groups realised a long time ago. Everyone agrees that research collaborations are the way to go. However, they have to answer relevant questions, with realistic methodologies and time-lines and the resources have to be present at the service level to do the work.

Most importantly, all practitioners and services should ask whether they audit their results, read widely and record their own experiences. A culture of healthy self-criticism and openness to new ideas is essential to the growth of any credible specialty. Furthering of local and global knowledge is everyone's business and not the preserve of a research elite, but not everyone can or should do their own research. Services will join in, if they have the resources to do so and the study is seen to be relevant. This is the challenge.

Palliative Care Services Provision Within Brisbane South: A Prospective Audit

Liz Reymond¹, Fiona Israel² and Margaret Charles³

¹Palliative Care Specialist Brisbane, South Palliative Care Collaborative

²Clinical Nurse Consultant (Research), Brisbane South Palliative Care Collaborative

³Department of Psychology, Sydney University

The number of patients within the QEII Hospital Health Service District requiring palliative care is rising due to acceptance of supportive palliative care for a range of chronic conditions and because of the increasing incidence of cancer in our ageing population. Anecdotal reports have suggested that it is difficult to meet existing, let alone projected, palliative care service requirements in this area. The Brisbane South Palliative Care Collaborative (BSPCC) designed an audit and mapping study to describe current palliative service capacity, client profiles and outcomes. Such information can inform the design and delivery of future services.

The 2-month, prospective snapshot audit included all new palliative admissions across in-patient and community-based sites, hospital re-admissions and hospital out-patient episodes of care for patients referred to any of the six government and non-government service providers covering the catchment area. An episode of care was defined as the period between the admission and discharge of a patient from any service. Information collected included patient demographics such as age, sex, Indigenous status, dominant language and primary diagnosis. Referral patterns including referral source and reason for referral were documented. Service provision characteristics such as initial service provider, numbers of contacts with service providers and lengths of stay were collected. Outcomes of episodes of care such as place of death, transfer to hospice or discharges out of the audit area were also documented. In addition, the study involved other components including mapping of service characteristics and staffing levels against Palliative Care Australia standards, focus groups of staff and bereaved lay-carers and interviews with palliative care patients to explore their satisfaction with current service provision. Ethics approval involved five different committees.

This paper will present some of the process and operational issues associated with the collection of the data and some of the findings.

Development of a Continuous Subcutaneous Infusion Order and Administration Chart for Opioids and Other Medications Used in Palliative Care Based on Medication Safety Principles

Tony Hall

*Team Leader, High Risk Medications and Systems
Safe Medication Practice Unit
Royal Brisbane and Women's Hospital*

The Safe Medication Practice Unit was established in 2005 continuing work that had been undertaken in developing a number of principles and products enhancing a safety-based approach to all aspects of medication practice (i.e., prescribing, dispensing, administration and communication). These products included development of a Queensland Health statewide standard medication chart that has since been chosen as the template for a National Implementation of Medication Chart Project established in all states under the auspices of the then Australian Council for Safety and Quality in Health Care.

The principles used were enshrined in the Medication Safety Collaborative model used by the Council:

- Collaboration
- Use of the PDSA (Plan, Do, Study, Act) cycle
- Basing changes upon iterative observation and study of existing processes and process failures
- Appropriate use of human error engineering principles of forcing function, standardisation, policy development and education

Opiates have long been recognised as medications with High Risk potential for harm. Opioid use is a common therapeutic approach in palliative care and in the use of continuous subcutaneous infusions (csci) of opioids and other medications, including sedative agents, is a common feature of palliative care within Queensland's health care facilities.

A variety of iterations in form design were created, discussed and user-tested with key stakeholders from Palliative Care physician, nursing and

pharmacy focus groups and clinical teams, changes made and observational audits followed the trial of these documents and this process continues using the PDSA cycle. The latest iteration will be presented together with the outcomes from its current trial process.

A mini HEAPS (Human Error and Patient Safety) examination of a large number of clinical incidents involving the administration of opioids and sedatives by continuous sub-cutaneous infusion revealed a number of failure points in currently used prescribing, administration and documentation methods including failures in prescribing, prescribing review, formulation and calculation, administration and patient observation associated with inexperience and conflicting demand on experienced staff.

The current form was designed to address these issues.

Take Away the Pain but Leave Me Whole: Aboriginal Perspective on Palliative Care

Deborah Prior

*Director of Learning and Development
CPCRE*

Epidemiological studies have demonstrated a disproportionate morbidity and mortality rate affecting the Aboriginal population and paradoxically social studies have identified conflicting cultural paradigms as a major barrier to palliative care for this population. These findings are supported by anecdotal and survey evidence that Aboriginal people remain under-represented in the palliative care patient population despite efforts to develop culturally appropriate services. One explanation is that the meaning of ‘cultural appropriateness’ has not been sufficiently defined from the Aboriginal perspective. Culturally appropriate services are informed by an understanding of Aboriginal perspective of concepts such as, palliation, communicating ‘bad news’, grief, spirituality, death and bereavement. Exploring the phenomena of cultural perspectives, particularly relating to end-of-life care, requires a qualitative approach that encourages dialogue about the issues in question.

In this paper, I present the findings of a qualitative study that explored the cultural difference underpinning Aboriginal peoples’ ambivalence toward cancer-palliative care. A key finding of my research was that while Aboriginal people want to take advantage of medical knowledge and treatment in palliative care, they question why cultural values for an holistic approach should be compromised in the process.

A Pilot Study of Haloperidol for the Control of Nausea and Vomiting in Cancer Patients with Advanced Cancer

Janet Hardy¹, Anthony Herbert², Rohan Vora³ and Jane Holt³

¹Clinical Research Program Leader, CPCRE;

Director of Palliative Care, Mater Health Services, Brisbane

²Palliative Care Registrar, Mater Health Services, Brisbane

³Advanced Trainee Registrar, Chapter of Palliative Medicine,

Day Oncology Registrar, Mater Adult Hospital, Brisbane

⁴Research Nurse, Mater Health Services, Brisbane

INTRODUCTION

Nausea and vomiting (N/V) are common symptoms in patients with advanced disease. Haloperidol is often used to manage N/V, especially when no other agent is specifically indicated or where the cause of the N/V is unclear or unknown. There is no evidence, however, other than anecdotal, to support its common use.

AIM

The study aims to determine the efficacy of haloperidol in controlling N/V in patients with advanced cancer.

METHODS

The study has been designed to reflect routine clinical practice in palliative care and the difficulties in conducting research in this patient group. All patients known to the palliative care service, able to consent and complete questionnaires, with N/V for which there is no specific treatment are eligible to enter. Patients may be antiemetic naive or have been exposed to other drugs. Haloperidol is prescribed either orally or parenterally according to the severity of the condition at three dose levels to a maximum of 6mg/day. Breakthrough doses are available to a maximum of 1mg/day. Nausea, vomiting and toxicity are recorded at baseline and daily for 5 days on a 4-point scale from “none” to “very much”. Complete and partial responses are defined as a reduction in baseline score to zero or less than baseline respectively. Patients are withdrawn if N/V is not controlled or side-effects are intolerable.

RESULTS

Interim results will be presented. Recruitment to date has been slow. The primary reason for ineligibility has been the presence of a specific cause of N/V for which a particular antiemetic is indicated. Another observation has been of the day-to-day variability in N/V and the number of changes in concomitant medications during the 5-day trial period that might have a bearing on N/V control.



The Link Medical Officer Project

Dr Rosemary Ramsay

*Link Medical Officer, Brisbane South Palliative Care Service
Brisbane South Community Health Service QEIIHHS*

The primary objective of the project is to decrease the numbers of patients being readmitted to acute care facilities whilst awaiting contact from a Specialist Palliative Care Service. Secondary objectives include improvement in symptom management (including physical, psychosocial and spiritual distress) and support for carers.

Community-based Specialist Palliative Care Services providing home care on a 24-hour basis face increasing difficulties in servicing their patients with the resources available. Patients discharged from acute care facilities referred to Community-based Specialist Palliative Care Service providers may face a delay in commencement of service in our region. The Link Medical Officer and the BSPCS nurses can maintain contact with these clients after discharge. The Link Medical Officer is able to visit clients at home. The patient's choice of place of care is of prime importance. General practitioners and community service providers are also supported.

The outcome of the project will be measured with an audit 6 months after commencement. The audit will provide measures of outcomes such as the number of palliative patients seen by the BSPCS returning to acute hospitals after discharge, numbers of patients seen by the Link Medical Officer and other patient outcomes.

Project funded for 12 months by the Australian Government Department of Health and Ageing-Local Palliative Care Grants Program Round One- Fit-out and Equipping Premises and Transition-to-Home Support for the project "Enhancing Palliative Care Capacity across the Brisbane South Area-Medical Link' Program".

Understanding Factors Contributing to Nausea in Advanced Cancer: Clinical and Patient Perspectives

Patsy Yates¹, Alexandra Clavarino², Geoff Mitchell², Peter Hudson³ and Peter Martin³

¹Acting Director, CPCRE, Queensland University of Technology

²University of Queensland

³Centre for Palliative Care, St Vincent's Hospital, Melbourne

Significant advances have been made in the management of chemotherapy related nausea and vomiting. Less attention has been given to understanding nausea experienced by people with advanced cancer. The purpose of this multi-method study was to identify clinical and psychosocial factors that are associated with advanced cancer patients' reports of nausea. Two tools were developed on the basis of findings from a systematic review of the literature and qualitative interviews. The tools included: a Clinical Assessment Tool completed by clinicians to indicate which of 21 factors were contributing to a patient's nausea and a structured, interviewer-administered questionnaire completed by patients, which comprised numeric rating scales to assess nausea severity and impact (0-10), and checklists to rate on a five point scale (not at all–very much) the extent to which 17 clinical, emotional and environmental factors contributed to nausea. A total of 110 (42.3%) were recruited from three inpatient and five community palliative care services. Of the patients screened during the data collection period, 19.7% had experienced nausea in the past week. Five out of the 12 factors were rated by more than 25% of patients as contributing to nausea somewhat, quite a bit, or very much, including: certain foods (41%), food/cooking odours (40%), stress (28%), anxiety (27%), and movement (25%). Eleven of the 21 potential contributing factors included in the clinical assessment were identified by clinicians as being present in more than 25% of cases. The most common clinical factors identified (in patients with nausea) were: opioid use (91.6%), pain (88.5%), GI cancer or metastases (56.8%), constipation (55.8%), and abdominal distension (42.3%). Nausea in advanced cancer is a complex multi-faceted problem. The data obtained through this study have the potential to enable the development of more targeted assessment and intervention processes.

Children with Advanced Neuroblastoma- Two Case Studies of Paediatric Palliative Care

Anthony Herbert¹ and Helen Irving²

¹Palliative Care Registrar, Mater Health Services, Brisbane

²Director, Haematology; Oncology and Stem Cell Transplant Unit; Banksia Unit, Royal Children's Hospital, Brisbane

We present the case studies of 2 children (a male aged 2 and a female aged 4) with stage IV neuroblastoma who received palliative care at the Royal Children's Hospital, Brisbane, in 2005. One child completed intensive treatment for neuroblastoma (i.e., chemotherapy, surgical debulking, autologous bone marrow transplant and irradiation) before their disease progressed. The other child, whose disease progressed during treatment with chemotherapy, did not undergo an autologous bone marrow transplant because of this. Pain management was difficult in both children but achieved with parenterally-administered morphine (via a central line in one child and subcutaneously in the other child). Both children received palliative radiotherapy to try and alleviate pain symptoms. One child came from a rural location within Queensland, which provided extra challenges in his care. Tele-medicine consultations facilitated communication with the multi-disciplinary team that cared for this boy upon returning home. The importance of cultural factors will also be explored as in the second case in which the parents had grown up in an Asian country before moving to Australia. Developmental issues relevant to each child, particularly in relation to activities which maximized quality of life (holidays, pets, play) will be highlighted. Finally, support of the family during the bereavement process will be emphasized.

Developing a Simple, Integrated, 'Self Report', Multi-Disciplinary Screening Tool to Assess Symptom Distress, Functional Status and Level of Social Support for Patients Attending a Day Oncology Service.

Rohan Vora¹ and Anne Franks²

*¹Advanced Trainee Registrar, Chapter of Palliative Medicine,
Day Oncology Registrar*

²Nurse Unit Manager, Day Oncology Unit

Mater Adult Hospital, Brisbane

BACKGROUND

As Day Oncology services become increasingly busy, 'ad hoc patient reports' or 'staff intuition' is becoming increasingly inadequate to pick up symptom distress, functional decline or social and community support needs of patients and their families or carers. Increased numbers of elderly patients are attending Day Oncology services. The current proportion of persons over 65 in our population is predicted to increase from 12% to 20% over the next 15 years. Hence, having adequate screening tools in Day Oncology services to be able to pick-up and identify 'at-risk' elderly patients is becoming increasingly important. A previous survey in the out-patient department using an Allied Health Professional (AHP) screening tool found that 79% of patients could benefit from an AHP intervention. Many patients are spending more time attending oncology clinics or recovering from chemotherapy as modern treatment is increasing length of survival (LOS) in many cancers. Symptom distress often precludes the ability to engage in meaningful and enjoyable activities between treatments.

AIMS

- To develop a simple and yet comprehensive, integrated, multidisciplinary, 'self report' screening tool for all patients of a busy Day Oncology service.
- To integrate this screening system into daily work routines, with minimal added burden for currently busy Day Oncology staff.
- To maintain the quality of the Day Oncology service by targeting multidisciplinary team interventions to provide care where it is most needed and be able to assess the adequacy of this service in assessing and reducing patient distress.

METHOD

- Analysis of previous work of the Mater AHPs in assessing the needs for AHP interventions in Outpatient Oncology services.
- Literature search for existing, validated tools designed for screening a Day Oncology patient population.
- Collaborative team meetings to derive and implement a comprehensive symptom distress, functional status and social support screening tool for Day Oncology.

FINDINGS

Many barriers exist to implementing screening tools such as time constraints, lack of multidisciplinary care coordination, integration and financing of multidisciplinary team interventions. There is a lack of seamless integration into the community with overstretched, poorly funded and inadequately trained community services. Patients and their family/carers seem enthusiastic in accepting to partake in the “screening tool process”.

CONCLUSION

There is a need for the integration of a screening tool in Day Oncology with further “Care Pathway” processes. This requires the active involvement of a broad multidisciplinary team. Support for the process also needs to come from the ‘top of the service chain’ for any progress to occur. Patients and their families/carers should be involved in the development of symptom screening tools so that important issues affecting their QOL and cancer journey experience can be addressed.

Reluctance to Care: A Systematic Review and Conceptual Framework

Letty Burridge¹, Sarah Winch² and Alexandra Clavarino³

*¹Graduate Student School of Population Health,
University of Queensland*

²Nursing Director Research, Princess Alexandra Hospital, Brisbane

*³Senior Research Fellow, School of Population Health,
University of Queensland*

Primary lay carers are increasingly important in the care of patients with cancer. Many cancer survival rates are increasing, the demands placed upon finite health resources are expanding, and home-based care is growing in popularity. This can make the lay cancer caregiving role both complex and extended. Powerful social norms place people under pressure to care when the need arises, such as at the time of cancer recurrence when the patient's independence is diminishing. The number of older carers is increasing, while the willingness of younger family members to care can no longer be assumed. Potential carers may feel anything from highly committed to not at all interested in the caregiving role, but any reluctance may be hidden to avoid censure. If caregiving reluctance leads to adversity for carers or patients, then it is important to understand what makes potential carers reluctant, how it is dealt with, and the consequences for all concerned, in order to avert undesirable outcomes. Caregiving reluctance is neither rare nor new in Australia, but the topic is under-explored, particularly in the cancer context, and the consequences are relatively unknown. The purpose of this review was to gain insights into caregiving reluctance and its consequences, by asking the question: What is known about lay caregiving reluctance? The findings were organised into four major dimensions: demographic, physical, psychological and social. Three major outcomes were identified. Definitive answers to the review question remain elusive. Choice seems to be a major indicator of caregiving reluctance, although reluctance may not remain static over the caregiving trajectory. Recommendations for future research are identified.

Assessment of Mater Adult Hospital Oncology “Right Of Private Practice” (ROPP or Outpatients Clinic) Patients Allied Health Professional Needs

Merilyn Tefay¹ and Ann Crome²

¹Acting Director of Occupational Therapy

²Senior Social Worker, Oncology

Mater Adult Hospital, Brisbane

AIM

To determine whether oncology patients attending ROPP clinics would benefit from allied health professional (AHP) intervention.

METHODS

Three (3) randomly-chosen half-day clinics were assessed with 64 patients completing the revised ‘Allied Health Oncology Screening Tool’.

RESULTS

Sixty-three (98%) surveys were deemed eligible to be included. Seventy-nine percent of patients screened were assessed as requiring one AHP intervention with 65% of all patients screened required two or more AHP interventions. By discipline, the majority of patients indicated a need for Social Work intervention (78%), followed by Occupational Therapy (66%), Physiotherapy (56%) and Dietetics (40%).

DISCUSSION

Seventy-nine percent of patients attending ROPP clinics indicated a requirement for AHP intervention. These results are supported by previous surveys conducted in day oncology that utilised related screening tools.

CONCLUSION

Patients attending Qld. Radium Institute ROPP clinics for appointments with medical professionals are not currently receiving the multidisciplinary team care that they require. With 79% of patients attending ROPP requiring AHP intervention as indicated through the MHS AHP oncology screening tool the need for designated Allied Health Professional resources to these clinics is clearly indicated.

What are the Barriers to the Optimal Care of the Dying?

Janet Hardy

*on behalf of the Queensland Palliative Care Research Group (QPCRG)
Clinical Research Program Leader, CPCRE;
Director of Palliative Care, Mater Health Services, Brisbane*

INTRODUCTION

There have been significant improvements in the care of the dying over recent years co-incident with the development of palliative care as a specialty. However, it is acknowledged, especially by health professionals in the field, that deficiencies remain. It is hoped that the identification of barriers to a good death, can lead to system change and hence improvement in end-of-life care.

METHOD

A list of potential barriers to optimal end-of-life care was provided by a multi-professional focus group within a local palliative care service. Those barriers considered most important were selected and refined by those attending QPCRG meetings. The barriers were grouped into 7 categories (i.e., those considered most relevant to patients, carers/relatives, society, health professionals [non palliative care], health systems, care in the community and residential aged-care facilities). QPCRG members developed a survey that asked respondents to rate the level of importance of the barriers in each category and to identify 3 barriers considered most important over-all. Demographic information that included information on the experience and health care setting of each professional was also requested. Following ethics approval, the survey was sent to all those listed as members of Palliative Care Queensland.

RESULTS

The barriers to optimal care of the dying considered most important to a range of health care professionals will be presented and correlated with the age, sex, work experience and care setting of each respondent.



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