

Paediatric and neonatal palliative care

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The focus of this edition of Centre Line is neonatal and paediatric palliative care, a world that can be far away from the experiences of the rest of the palliative care community. The articles here help to enlighten us all about this very specialised area of palliative care. The lead neonatal palliative care article is longer than we would usually run. Its story is important and powerful, however, so we have chosen to run it over two issues.

Neonatal Palliative Care

By Dr Elizabeth Hurrion
Neonatologist, Mater Mothers Hospital Brisbane

Despite considerable advances in perinatal medicine impacting on mortality, one third of all childhood deaths occur in the neonatal period (birth to 27 days of life)¹.

Statistics from large tertiary Neonatal Intensive Care Units² reveal the causes of death as:

- Extreme prematurity (below 28 weeks gestation) and its complications in 51%
- Respiratory failure in more mature infants in 27%
- Hypoxic-ischaemic encephalopathy in 5%
- Congenital / chromosomal anomalies in 17%

And that death follows^{2,3,4,5}:

- withdrawal of life-supporting technology in 40%
- "DNR" orders or setting a limit of intervention in 15%
- withholding resuscitation / life-supporting technologies in 3%
- despite maximal intervention in 42%.

The reasons given for the decision to withdraw/withhold/limit intervention are futility of treatment in 74% (along with quality of life concerns in 50%) and solely quality of life concerns in 23%⁶. Most commonly infants in whom intervention is withdrawn/ withheld/ limited are extremely premature (often at the limits of viability at 22/23 weeks gestation) or have neurological damage^{2,6}.

General palliative care principles apply to neonatal palliative care: symptom management, psycho-social and spiritual

support of the family, advance care planning and assistance with practical issues. However, given that the infant is unable to understand what is happening, the emphasis is strongly directed towards supporting the family, including siblings and grandparents. In addition there are many issues specific to neonatal palliative care:

- The change from "cure" to "care" can be quite sudden.
- Parents may not yet have bonded with their baby. Anticipatory grief issues.
- The dying process is often very short.
- As the infant's life is very short there is a need to create memories and mementoes which provide tangible evidence of the baby's existence.
- Symptom management is complicated by difficulty in assessing pain.
- Lactation suppression; practical and psychological issues.
- Issues of a surviving twin (or multiple birth siblings).
- The mother may be hospitalised after birth and/or have physical health needs herself.
- Sibling involvement is often forgotten.

Perhaps the greatest difference between neonatal palliative care and palliative care at other ages is that parents may not yet have bonded with their baby. While parents may bond with their baby during the pregnancy or instantly at the time of birth, research shows that parents develop deep attachment bonds through providing routine physical care for their baby. When babies are in intensive care the physical care parents can provide is limited. Cuddling the baby, bathing and dressing them are all rituals which may not have been possible in the period of "cure" but are important aspects of palliative care in the minutes or hours before death.

Anticipatory grief has particular relevance when a diagnosis is made in pregnancy which predicts death soon after birth. Anticipatory grief means that parents begin their journey of grief while their child is still alive - as the pregnancy progresses. Modern ultrasound scanning, now even with 3-D enhanced pictures, means that attachment bonds are forged

stronger and at even earlier gestations than previously. This normal process of attaching and bonding with a baby is confronting for parents who know their baby will die. Some parents consciously or unconsciously try to hold back this attachment, hoping that in doing so the pain of separation will be less when death does come. Other parents don't hold back and allow themselves to fall deeply in love with their dying child, treasuring every moment, but often living in fear that their time is so short.

The dying process is often very short. If life-sustaining technologies are withdrawn the time to die is usually 15 minutes to several hours, but may be a few days^{2,7}. It is very rare for parents to have regrets when death comes quickly⁸. However neonatal research has shown that if the dying process took longer than expected parents find this very distressing and may question whether they made the right decision, a concern that may stay with them⁸.

When the prognosis is known in pregnancy, there is the opportunity for advance care planning. If parents decide to withhold resuscitation & life-supporting technologies and the infant is able to feed they may live for weeks or months; for example Trisomy 18 / hypoplastic left heart syndrome. If the infant shows no interest in feeding then without medically administered feeding they may live for a week or so.

The infant's life is very short; the average age at death is 7.2 days if intervention is withdrawn/ withheld/ limited, or 9.7 days if the baby died despite full intervention⁹. Parents may have only a few photographs of their baby in intensive care at the point when "cure" changes to "care". Neonatal research has shown that parents have a need to create memories and mementoes which provide tangible evidence of the baby's existence, and this is very important in helping parents cope with the death in the months and years to come¹⁰.

Hence another focus of neonatal palliative care is to encourage parents to spend time with their infant in a way that is meaningful to them, and to have mementoes of those experiences together. Often this is cuddles with parents and family, bathing and dressing. Photos are very popular mementoes, and so are hand and footprints and a lock of hair. Parents may choose to have a baptism service / prayers / naming ceremony at the bedside before life-support is withdrawn. However, this is one of the most culturally sensitive areas. Traditionally Indigenous Australians do not keep photographs of deceased people. For some Muslim women it is not appropriate to see or hold the baby after death, or keep mementoes other than photographs of the baby when alive.

Symptom management is an important aspect of neonatal palliative care and even the most extremely premature infant feels pain. However, dying infants may be too ill to exhibit behavioural signs of pain, either in facial expressions or body movements, making assessment of pain extremely difficult. In general one must assume that an infant is in pain if the condition is known to be painful in older children or adults.

Support and advice regarding lactation suppression is very important. The techniques are different if the baby dies soon after birth before lactation is established versus

after establishing lactation. A lactation consultant is a vital member of the neonatal palliative care team. Psychological support regarding lactation suppression is also important as continued lactation after the baby has died may be seen as another loss (the experience of breastfeeding) or a cruel reminder of the baby.

Prematurity is more common among multiple pregnancies and so while one baby is dying there may be a twin (or multiple birth siblings) surviving. They may also be critically ill in the case of extreme prematurity, or may be well. It is enormously difficult for parents to grieve for the twin who is dying but rejoice in the twin who is surviving, feeling guilt both ways.

Sibling involvement is often forgotten in neonatal palliative care. In Paediatric palliative care the child is an established member of the family with strong sibling relationships; hence involvement of siblings is intuitive for parents. However for infants dying in the neonatal period siblings are often toddlers who, though they may be anticipating a "new baby", do not have a strong existing relationship with the baby. They are also not easy to keep entertained in an intensive care environment, and require constant attention which grieving parents are unable to provide. Parents may believe siblings "will not understand", "don't need to know" or "will be upset" by seeing the baby dying. Hence many parents' first instinct is not to involve them. Children below 2 years of age have no concept of death, and from 2-6yrs believe death to be temporary and reversible¹¹. Hence young children are very accepting of events and not upset by the death per se. Yet they can easily feel left out and abandoned by their parents, and may feel responsible for the death¹¹. So we encourage sibling involvement, but also strongly recommend someone other than the parents is available and takes responsibility for them.

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The Children and Young People's Bereavement Centre, Mt Olivet Hospital

September 2007 marks the 4th year of operation of The Children and Young People's Bereavement Centre. It was established in 2003, after a need for such a service was identified by a 2001 University of Queensland research project commissioned by Mt Olivet Community Services in Brisbane. It was therefore decided to widen the existing Mt Olivet bereavement services with a children's bereavement service to assist the greater community.

Since its establishment, the Centre has achieved an outstanding result in continuing to offer supportive counselling for children, young people and their families, who are experiencing bereavement. The Centre also offers support and child sensitive counselling for families preparing for a death in the family.

The Centre continues to be used by a growing number of external referral sources and community members. Referrals for counselling can come from all health professionals, school guidance officers, teachers, other community agencies, or families can refer themselves.

When children visit the bereavement Centre, they will receive counselling, which is delivered in a very safe, friendly and child focussed manner to ensure that they feel at ease very quickly. Various expressive mediums are used with the children, such as sand tray work, using symbols, art, clay and family therapy. The counsellors will adopt an approach that is welcoming and inclusive of families. This means that the Centre will endeavour to provide support to families in ways that are accessible to them, whether that is within the Centre, via the telephone, hospital or home visits. Additionally, we can participate in community education, where we may visit the school or other networks to which the child belongs. These different approaches ensure that relevant caretakers and other practitioners involved with the family feel comfortable and capable of supporting them in their own environment.

The options for creativity are endless when working with expressive therapies. The focus of the grief counselling is designed to give permission to children to express and release their emotions and, secondly, to encourage them to form a "continuing bond" with the deceased. This continuing bond can be encouraged by engaging the child in memory making activities. Some examples of these are memory boxes, memory albums, writing letters to the deceased, making a memory jar with coloured sand and writing stories.

The Centre continues to provide training and awareness to other health care providers and community agencies, by offering staff training and professional development to practitioners involved in supporting children and families through illness and death. Additionally, we offer group programs for children who may

benefit from meeting other like-minded children who are also living through grief. This year we have successfully facilitated two groups - "Remembering my Mum" and "Remembering my Dad". These have coincided with Mother's day and Father's day, as these times of the year can be extremely difficult for children whose parents have died. Children have reported great benefits from participating in these supportive workshops. We will continue to offer these groups and various other workshops throughout the year.

The Centre continues to be the only one of its kind in Brisbane, therefore the demand on its services continues to increase. Over the last 24 months, client profiles highlight a shift in the ages of children seeking counselling from the service. In 2005, the demographic that predominantly used the Centre's services were children between the ages of 7-10 years (at 49%). Interestingly, in relation to children aged 11 years and over, there has been a rise in utilisation of the services (41% in 2006 compared to 37% in 2005). Furthermore, 2006 figures show that there was an increase of children aged between 3-6 who were seeking counselling and parenting related support services from the Centre (23% in 2006 compared to 14% in 2005).

Our statistics also show a greater than 150% increase in counselling appointments in the 6 month period February to July 2007, when compared to the same period in 2006. These signs are very encouraging for the Centre and demonstrate the increasing awareness and use of its services.

The Centre continues to be funded by Mt Olivet Trust under the administration of the Sisters of Charity Mt Olivet Advisory Committee. Staff of the Centre include a Coordinator/counsellor, part-time counsellor, and administration support. As a privately owned, not-for-profit organisation, donations to the Centre are gratefully received, and help us to continue the mission of the Sisters of Charity.

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Xavier Children's Support Network

Xavier Children's Support Network provides support for children between the ages of 0 and 16 years who have complex high support needs arising from a combination of physical, sensory and intellectual disabilities. Historically, Xavier has always provided a palliative care service as an integral part of its support for families.

Some children are referred to Xavier requiring palliative care from the beginning and others move into palliative care due to deterioration in their disability/medical condition. Referrals come to us from families self referring, hospitals, other disability support agencies and the Department of Child Safety.

Supports we are able to offer to families whose child is requiring palliative care include:

- Information, consultancy and training through a multidisciplinary approach. Staff provide physical, psychological and emotional support for children with a disability who are terminally ill, and their family and carers. Services are coordinated and delivered in the

environment of the family's choice, which is usually the family's home. The service aims to promote the child's quality of life until death, promote the right of families to make their own health care decisions, and offer grief and bereavement support for the family and carers following the child's death.

- Direct Family Allowance to purchase their own supports such as respite, in-home support, equipment and consumables.
- Equipment loan pool is available for families to access based on availability.
- 'Beachcomber' program allows the whole family to have a short 'getaway' for rest and recreation.
- Nursing consumables and continence aids
- Registered Nurse On-call Service 24 hours a day, 7 days a week.

Xavier will appoint a team to be coordinated by a Clinical Nurse Consultant with experience in the palliative care of children. The team includes the following staff with extensive experience in palliative care who can give advice and support as required:

- Registered Nurse
- Social Worker
- Occupational Therapist
- Physiotherapist
- Paediatrician
- Key Worker representative – may be one of the above professionals
- Community Team (direct support worker)
- Other e.g. clergy, counsellor, experts to be co-opted.

Because most families need to access both hospital and community services, Xavier assists children to remain in their own homes for as long as possible. We therefore seek to ease movement across home/hospital boundaries and help with the process of community linkages.

Early intervention can ensure continuity of care and reduction of suffering by children and their families. "The preference among both patients and carers for home care and a home death has been well documented" (Clarke & Maison 1995, pp 54-55) and it has been Xavier's experience that most families choose to have their child die at home.

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Perinatal Palliative Care – providing palliative care before life begins.

Introduction

With the increase in both sophistication and uptake of antenatal screening, more and more families are being faced with the devastating news that their baby has a life-limiting abnormality. Traditionally, once these diagnoses have been made, families are offered counselling support as they decided whether to continue with the pregnancy or seek a termination.

For those who choose to continue with the pregnancy, some hospitals in Queensland offer on-going counselling and pregnancy support from specialised units who employ genetic counsellors or midwifery case managers. However, not all hospitals have these specialist staff, nor are they located close to where the mother lives. This is where a perinatal palliative care service would be of great benefit to these women. Loss in the prenatal time is often an unspoken loss, an unacknowledged loss for the mother and family. The potential here is for her grief and that of her family to become unresolved as well.

Perinatal Palliative Care

Palliative Care Australia defines 'palliative care' as "specialised health care of dying people which aims to maximise quality of life and assist families, carers and their communities during and after death" (Palliative Care Australia, 2003). This definition is currently applied to children and adults; however it is our argument that it should be broadened to encompass the prenatal arena.

Currently, more than 90% of urban Australian pregnant women undergo at least one ultrasound scan (Garcia et al., 2002). With such a proliferation of testing available to pregnant women, epidemiologists have noted an escalation in the uptake of prenatal technologies, with now an estimated 99% of all pregnant Australian women being offered some form of prenatal ultrasound screening in their pregnancy. Consequently, it is a rare occurrence for women to go through their pregnancy without using some form of prenatal technology (Rapp, 1998). However, whilst our ability to diagnose many more fetal conditions has advanced, medicine's ability to remedy or provide treatment has not progressed at the same pace (Calhoun, Hoeldke, Hinson, & Judge, 1997).

For some families, the best response to a diagnosis of a lethal abnormality is to seek a termination. However for some, this is not an option, either on religious or philosophical grounds. Traditionally, the care offered to these families has lacked the holistic approach needed. In 2004, 44% of all perinatal deaths resulted from lethal abnormalities (Queensland Health, 2006). That equates to over 240 families who potentially would have benefited from a comprehensive perinatal palliative care service.

The notion of perinatal palliative care and perinatal hospices is an emerging one in the literature, particularly in the United States. In the US, the focus is primarily on perinatal hospices.

What parents need

Of course, health care settings need to supply technical skills and knowledge along with specialised care and an understanding of best-practice medicine and nursing in the area of maternal fetal medicine. The concept of anticipatory grief cannot be underestimated in this setting. Fitzsimons and Seyda (2007) argue that families need other equally vital kinds of support from the team. Sacred space for their baby, having a sense of control over their baby's delivery and subsequent care and support and guidance for the extended family are a few of their suggestions (Fitzsimons & Seyda, 2007).

These palliative care nurses also argue for health care teams to be mindful of how they provide this care and support and to whom they provide it, with fathers rating a mention as being one of the important members of the family to support and

care for. The creation of a protocol for care at the time of death should consider allowing the family to take the lead in how their baby is cared for. The family is not merely visiting the baby, nor are they treated as such; rather it is their baby, with whom they have limited time.

Planning begins when the diagnosis is confirmed. Centres in the USA, such as Deeya Perinatal Loss Unit in Minneapolis, help the family to develop an overall advanced care plan that is medically and ethically appropriate and consistent with the goals and values of the family. As is often the case, these plans include what the family does not wish to happen, such as resuscitation or artificial feeding, however these plans also include what the family can anticipate and plan for, such as who receives the baby, where the baby should go after delivery and the inclusion of any rituals or ceremonies that are important to the family. The difficult topics such as further testing, autopsy and organ or tissue donation are part of these critical pre-delivery conversations.

Obstacles

Gale and Brooks (2007) surveyed the parents who used the services at the Alta Bates Summit Medical Centre in 2006. They reviewed the ten most common obstacles found to be present for families needing to access good quality perinatal palliative care in a timely manner. Midwives indicated that they felt unfamiliar with the services available to families; poorly educated about neonate discomfort and its assessment and management; reluctant to administer pain relief to neonates and finally, that as their primary focus is often transferring the mother to a postnatal unit, they may inadvertently prevent the mother from spending precious time with their newborn (Gale & Brooks, 2007).

It is hoped that with the ability to travel to these centres next

year as a Bob and June Prickett Churchill fellow, I will be able to understand more about how these obstacles have been overcome.

Conclusion

By offering these families emotional, spiritual and physical care during this time, perinatal palliative care providers will help to make their experiences easier to bear. As American philosopher George Santayana said "There is no cure for birth and death save to enjoy the interval". For these families, it is the interval that is the most precious time of all.

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CPCRE ACTIVITY REPORT

Developing and promoting the use of evidence based resources

Practice Guidelines

CPCRE has published the following guidelines and information resources:

- The management of syringe drivers guidelines (with accompanying summary card and on line education package)
- Paediatric Loss and Grief Information Resources

Copies of these resources are available from the CPCRE Website <www.cpcre.com>.

A priority setting activity was undertaken to identify the focus of CPCRE guideline development projects for 2007. Guidelines for the management of dyspnoea are currently being developed. Plans are underway to collaborate with staff from the RBWH Palliative Care team to develop mouth care guidelines.

Promoting access to high quality palliative care education

PEPA (Program of Experience in the Palliative Approach): (Funded by the Department of Health and Ageing through the National Palliative Care Program)

CPCRE will offer a further 140 PEPA placements from 2007 to 2010. Additional placements for Indigenous Health Workers will also be offered.

Applications for the program are now being received.

A workshop was held on the 17th August in Brisbane, and was attended by more than 30 allied health professionals. Further workshops are planned for November as part of the PEPA program. Please check the CPCRE Calendar and website for further information.

Palliative Care Curriculum for Undergraduates (PCC4U) (A joint initiative between Queensland University of Technology, CPCRE, Flinders University, Charles Darwin University, and Curtin University with funding from the Department of Health and Ageing through the National Palliative Care Program).

CPCRE ACTIVITY REPORT

The consortium is continuing to promote uptake of the curriculum resources in all health courses across the country. Coordinators for 84 undergraduate courses in the health professions have been contacted this year and invited to participate in the project.

GP Education Program

Applications submitted for the Queensland Health GP Education Program awarded for 2007-2008 have been reviewed, and successful projects are expected to commence by October 2007. Further information about the projects will be included in the next CPCRE newsletter.

CARESOURCES and the Queensland Palliative Care Education Calendar

The 2007 Education Calendar was distributed in February 2007 and is available from the CPCRE website. CARESOURCES, the Queensland Palliative Care Education Directory can be accessed on <www.cpre.com>.

Karuna-RBWH-CPCRE Specialist Palliative Care Nursing Education Program

CPCRE is continuing to work in partnership with Karuna and RBWH staff to develop a strategy for making the program accessible to a wider group of nurses.

CPCRE Annual Research Conference

Plans are underway for the 2008 Research Conference. A call for abstracts will be made later this year.

Palliative Care Update

CPCRE Annual Research Conference

The 2007 Annual CPCRE Research Conference was held on May 25th 2007. The keynote speaker was Professor Afaf Girgis from the Centre for Health Research and Psycho-oncology at the University of Newcastle. Professor David Currow and Professor Janet Hardy also presented on developments in the Palliative Care Clinical Trials Collaborative.

Undertaking research

CPCRE Research Programs

Research programs involving Centre staff address areas including:

- Health services delivery
- Symptom management and supportive care
- Professional Practice Development
- Person centre palliative care

For further details of specific projects, publications, reports and conference presentations please visit <www.cpre.com>.

Palliative Care Clinical Studies Collaborative (PaCCSC)

The collaborative is a national initiative funded by the Australian Government Department of Health and

Ageing, and led by a team from Flinders University. Professor Janet Hardy is chairperson for the Trials Subcommittee, and is working with partners in the collaborative to develop protocols for trials to commence later this year.

Establishing and facilitating partnerships

Palliative Care Clinical Networks.

CPCRE is represented on Area Health Service Palliative Care Networks, and is actively supporting activities of the networks.

The Prince Charles Hospital Heart Failure Palliative Care Nurse Project

CPCRE is a key member of the group leading a project funded by the Commonwealth Local Palliative Care Grants Scheme. The team has received additional funding from the Queensland Nursing Council to undertake a qualitative investigation into the experiences of people with heart failure.

Brisbane South Collaborative Supporting People at Home Project (Funded through the Australian Government Department of Health and Ageing)

CPCRE staff will collaborate with Brisbane South Palliative Care Collaborative on a recently funded project to support carers with medication administration in the home.

Syringe Drivers Project

The Centre is currently facilitating a group of clinicians and biomedical engineers from Queensland Health and the wider palliative care community in reviewing various devices for administering continuous subcutaneous medication. CPCRE is working with Palliative Care Australia to develop information to guide services in this area.

Identifying trends in palliative care service delivery and their implications for Queensland

CPCRE Staff Representative Activities:

Acting Director:

- Member, Palliative Care Australia Standards and Quality Committee
- Member, Palliative Care Australia Executive Committee

Director of Learning and Development:

- Chairperson, Palliative Care Queensland Education Committee
- Member, Queensland working group for The Supporting Primary care Providers in Palliative Care Project.

Clinical Research Program Leader:

- Member, Cancer Council Queensland Medical and Scientific Committee
- Member, Palliative Care Medications Working Group

PALLIATIVE PROFILE: ZOE'S PLACE HOSPICE FOR CHILDREN

Zoe's Place is Queensland's first and only purpose built specialist Paediatric Palliative Care Centre. The need for such a specialised facility was recognised by Nigel and Erica Reed who tragically lost their daughter to Cystic Fibrosis at 11 years of age in 1994. Years of fundraising finally led to the establishment of the centre in 2005 which began admitting children in May 2006. To date there are 145 children registered with Zoe's Place.

The approach to paediatric palliative care encompasses and supports the whole family from the time of diagnosis to bereavement and beyond and recognizes the physical, psychological, emotional and spiritual strains that are placed on the family when one or more of their children are suffering from a life threatening illness. It is well documented



Main entrance to the hospice

that the impact of these strains are usually significant with family breakdown, divorces, depression, financial pressures and psychosocial issues commonly occurring as a real consequence of such a harrowing experience. Due to this, the support at Zoe's Place is usually flexibly tailored to meet the unique needs of each family.

The families registered with Zoe's Place now have access to medically supported care for the children whether the admission is for palliative, end of life care or for a period of 24/7 respite to give the family a much deserved break. Children can have an extremely prolonged palliative period which begins at diagnosis and extends for the period of the child's life. This can be years, dependent on the diagnosis that the child receives.

Zoe's Place also offers a further option at the terminal phase of the child's life where families can choose whether their child will die in the hospital environment, at home with the support of Zoe's Place staff or at our centre surrounded by family.



One of the colourful murals

PALLIATIVE CARE RESEARCH

Zernikow B, Michel E, Anderson B. 2007. Transdermal fentanyl in childhood and adolescence: a comprehensive literature review. J Pain 8(3):187-207

The fentanyl 12.5µg/h patch aligns with lower dosing requirements of cancer pain control in children. Within this systematic review, 11 observational clinical or pharmacokinetic studies were identified. There are no paediatric randomised or controlled cohort studies. Time to reach steady-state serum drug concentrations seems longer, clearance higher, and elimination half-life shorter in children than in adults. The study concluded there are no fundamental differences in effect or profile of adverse effects compared with adults.

The study also concluded that younger patients tended to have higher fentanyl requirements, while parents and medical professionals tended to be more satisfied with fentanyl than other analgesics, and that transdermal fentanyl in children may exhibit fewer side effects when compared with other opioids, especially constipation.

Ramnarayan P, Craig F, Petros A, Pierce C. 2007. Characteristics of deaths occurring in hospitalised children: changing trends. J Med Ethics 33: 255-260

Despite a gradual shift in the focus of medical care among terminally ill patients to a palliative model, many children with life-limiting chronic illnesses continue to die in hospital

after prolonged periods of inpatient admission and mechanical ventilation. This study, conducted in a large tertiary-level UK children's hospital over a seven year period, concluded that a greater proportion of hospitalised children are dying in an ICU environment. Professional ethical guidance alone may be inadequate in reversing the trends observed in this study. The authors recommended that implementation of innovative and multifaceted strategies is essential at a national and local level to reverse trends shown in the study.

Goldberg R, Morrison RS 2007. Pain management in hospitalized cancer patients: a systematic review. J Clin Oncol 25:1792-1801

A systematic review of pain assessment and treatment interventions in hospitalised cancer patients identified five interventions - professional and patient education, instituting regular pain assessment (pain as a vital sign), audit of pain results and feedback to clinical staff, computerized decisional support systems, and specialist-level pain consultation services. Most studies were small in size and used quasiexperimental pre-post test designs.

Successes were reported in increasing patient satisfaction, increasing documentation of pain intensity, and improving nurses' knowledge and attitudes. No study reported successful interventions that consistently improved patients' pain severity.

No systematic, hospital-wide intervention has yet to be associated with improvement in pain severity.

FORTHCOMING EVENTS

Queensland

5 September

Sexuality – Education Session
Oncology Nurses Group – Gold Coast
Cancer Council Queensland
Contact: 07 5591 1500

7 September

Carers' Health and Wellbeing
Carers Queensland – Cairns
Contact: 07 4031 0163

11 September

Stress Management for Palliative Care Staff
Mt Olivet Hospital
Contact: 07 3240 1165

10 October

Pain Management in Palliative Care for
Enrolled Nurses
Mt Olivet Hospital
Contact: 07 3240 1165

11 October

Palliative Care; Patient, Family and Nurse
Logan Hospital
Contact: 07 3299 9173

11–12 October

Advanced Palliative Care
Elements for the Enrolled Nurse
Mt Olivet Hospital
Contact: 07 3240 1165

12 October

Spirituality and Bereavement Counselling
Australian Centre for Grief and Bereavement
Contact: 1800 642 066

17 October

Education Dinner - Breast Cancer
Oncology Nurses Group - Gold Coast
Contact: 07 5591 1500

24 October

Pain Management in Palliative Care for
Registered Nurses
Mt Olivet Hospital
Contact: 07 3240 1165

25–26 October

Advanced Palliative Care
Elements for the Registered Nurse
Mt Olivet Hospital
Contact: 07 3240 1165

29 October–2 November

Cancer Care Course for Aboriginal & Torres
Strait Islander Health Workers
Qld Cancer Fund - Brisbane
Contact: 07 3258 2263

8-9 November

Cancer Council Queensland
30th Anniversary Oncology Nurses Group
Conference
Contact: 07 3258 2200

22 November

Breakfast Seminar
PCQ - Brisbane
Contact: 07 3633 0096

International

6 October

World Hospice and Palliative Care Day
Palliative Care Australia
Contact (02) 6232 4433 or www.pallcare.org.au

**See the CPCRE web site <www.cpcpre.com>
for the 2007 Education Calendar and for
details of other events later in the year or
notified recently.**

CPCRE RESOURCES AVAILABLE

The following Palliative Care resource booklets are available from CPCRE:

- Guidelines for Syringe Driver Management in Palliative Care
- When a Child Dies – A Guide to Working with Bereaved Parents after the Death of a Child from Illness.

Printing costs dictate that limited copies are available per request.

- Community resource booklet: 'Palliative Caring at Home – The Ultimate Gift of Love – A guide for carers who are caring for a terminally ill person at home' prepared by Palliative Care Information Service, available by contacting freecall: 1800 772 273 or <www.pcis.org.au>.

CENTRE LINE

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The Centre

The Centre for Palliative Care Research and Education is an initiative of Queensland Health and is a collaboration of the Royal Brisbane and Women's Hospital and Health Service District, The Prince Charles Hospital and Health Service, Queensland University of Technology, Karuna Hospice Inc., and the Queensland Divisions of General Practice.

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