Providing Palliative Care in the Primary Health Care Setting:
An Australian Rural and Remote Perspective

Australian General Practice Network

Aim

The Rural Palliative Care Project 2008 - 2010 aims to increase the capacity of primary health care providers, in partnership with other services, to provide quality palliative care to rural and remote Australia.

In doing so the project will:

- Address barriers of remoteness and isolation, and the siloing effect between multi-disciplinary service providers, by developing and implementing an integrated system of communication and education enhancing the skill base required in rural and remote areas
- Engage service providers in a shared effort to address the need for culturally appropriate palliative care in rural and remote Indigenous and CALD communities
- Support evidenced based best practice palliative care services, and to continue to evaluate and progress the coordinated palliative care provided to rural and remote communities throughout this project
- Enhance the agency of the palliative patient and their carer/s
- Strengthen the links between specialist palliative care services and mainstream health service delivery.

Methodology

The Rural Palliative Care Project 2008-2010 (RPC Project) is funded by the Australian Government Department of Health and Ageing through the Australian General Practice Network (AGPN). The RPC Project is being implemented through 40 rural and remote general practice networks.

The RPC Project is implementing eight successful elements of the model developed from the Griffith Area Palliative Care Services (GAPS) Project and the pilot Rural Palliative Care Program 2003-2006.

The RPC Project aims to resource general practice networks across Australia to provide models of palliative care service delivery that can be adapted to address the local needs of rural communities. Through collaboration and coordination of key stakeholders at the local and regional level, the RPC Project seeks to translate the objectives of the National Palliative Care Strategy into a sustainable model that complements a rural setting.

Findings

Via the implementation of the elements in each of the local projects, the RPC Project has developed flexible models of palliative care service delivery that are adapted to address local needs.







Governance

Each RPC Project site is required to have a local multi-disciplinary governance committee that guides the direction and focus of the project. The committees bring together a wealth of diverse local experience and knowledge relevant to palliative care in their region.

"By using the local expert knowledge, palliative care services in our region have been strengthened; they are safer, more accessible, appropriate, effective, efficient and accountable."

Vicki Atkinson, RPCP project officer, Eyre Peninsula Division of General Practice

Specialist palliative care services

Formal partnerships are a proven mechanism to improve the quality and coordination of services to vulnerable and complex care groups. Through the RPC Project, generalist and specialist palliative care providers can work together to ensure quality palliative care to even the most rural and remote regions.

“This project is really helping us raise awareness about palliative care and the role of the specialist services. Partnerships are being forged. Working together truly enables quality palliative care to be possible, irrespective of rurality.”

Claudia Giugni, RPCP project officer, NSW Central West Division of General Practice

Sustainability

The improvement of palliative care services within rural environments is likely to require significant change. The key to managing the change is an understanding of culture, behaviours, formal and informal processes, consultation, partnerships and how these apply at the micro and macro level.

“Strategies need to be developed and planning needs to be made at the outset for projects to be supported by sustainable quality improvement measures and processes based on best practice principles. We've found that sustainability is made possible with sufficient organisation support to drive continuing and recurrent quality improvement processes.”

Dr Rohan Vora, Palliative Care Physician

Data collection

Data collection is necessary to measure the impact of the project and to ascertain how further initiatives may be more relevant.

“Data collection gives us information that leads to knowledge. Engaging with GPs and practice staff about palliative care, gives a clearer picture of what is happening in their region.”

Dr Michael Taylor, GP & Chair Rural Palliative Care Project Management Advisory Group

Link nurses

Link nurses act as a communication conduit between all the health providers and the palliative care patients and carers.

“The link nurse network will successfully improve care provision and coordination through empowering health care professionals to provide best practice palliative care. This will be achieved by providing education and peer-support opportunities and through the development of improved communication and relationships between the different service providers.”

Steve Pitman, RPCP project officer, Albury Wodonga General Practice Network

Education

Education is vital to the quality improvement of palliative care service provision and is necessary to build infrastructure and capacity for primary health care providers of palliative care.

“My Program of Experience in a Palliative Approach (PEPA) placement not only provided valuable insight and education, but reassurance and validation that I was providing a beneficial and appropriate service.”

Robyn McInnes, RPCP project officer, Great Southern General Practice Network

Multi-disciplinary team meetings

Palliative care is typically holistic and multi-disciplinary, and multi-disciplinary team meetings provide a method of communication, fitting to the Palliative Care Australia standards, that promote coordinated holistic care.

"Coordination and complimentary care by the team of health service providers has greatly benefitted the palliative care patient and their carers."

Pam de Klerk, Clinical Nurse Consultant, Peninsula Hospice Service (Vic)

Patient held records

Patient held records (PHR) are an empowering innovation that improves the continuity of care and communication, as well as providing families with a record of what happened towards the end of life for their loved one.

“Patients often have to communicate their health history and current situation to numerous health professionals. We have found that PHRs are a sustainable way to make sure the right story is told to the right people in the right way."

Julianne Whyte, RPCP project officer, Riverina Division of General Practice and Primary Health

AGPN acknowledges the financial contribution of the Australian Government Department of Health and Ageing.









