Caring Communities Program -Project Overview

Organisation: Tasmanian Palliative Care Service, Community Population & Rural Health, Department of Health and Human Services

Name of Project: Collaborative Palliative Care in Rural Communities

Length of Project: 2.5 years

Project Summary:
Primary practitioners in rural areas (nurses, GPs & social workers), Palliative Care consultants (nurses, medical specialists & social workers), and Palliative Care Volunteer Coordinators are the key stakeholders in this project to:

1. Create, implement and evaluate an agreed model of collaborative practice that places people in need of palliation and their families at the centre of care, respects the unique skills and autonomy of each of the professions and ensures continual improvement of standards of palliative care.
2. Enhance practice standards of the palliative care alliance.
3. A cooperative system of activity and evaluation that informs continual improvement in palliative care for the benefit of clients and their families.

Project Objectives:
1. To enhance a collaborative approach between palliative care and primary care practitioners to the delivery of palliative care services in rural communities.
2. To develop and implement relevant and accessible strategies that is supportive of primary care practice in rural areas.
3. To develop an ongoing partnership of activity monitoring, and trend analysis that assists client-focused care, service planning and development.
4. To implement a mentoring strategy within the project that will strengthen networks and enable support and advise beyond the life of this project.

Project Activities:
1. Education Networks
   - Develop a process for identifying learning needs and developing an education plan.
   - Design and implement the first of an annual education program that will maintain existing skills and develop new knowledge and skills.
   - Develop linkages for ongoing primary and specialist partnerships in education through a variety of media i.e. video conferencing etc.
2. Communication Networks
   - Facilitate the development of palliative care advice and support in and out of business hours through a number of mechanisms such as internet, telephone and video conferencing.
3. Monitoring Networks
   - With the guidance of a specialist with expertise in evaluation design and statistical analysis develop activity and outcomes monitoring strategies of mutual benefit. This will include clinical indicators and service activity indicators such as referrals.
4. Cross-Culture Access and Equity Networks
   - Work with organisations representing indigenous people and people of non-English speaking backgrounds to develop tools for people who require palliative care.

5. Clinical Leadership Networks
   - Identify, review and revise collaborative practice guidelines where there are inter-sectoral relationships such as referral, case conferences, reviews, discharge planning to enhance palliative care of people in rural areas. Identify the specific requirements with regard to:
     - A palliative care client assessment kit
     - Palliative care clinical pathways
     - Palliative care clinical practice guidelines
   - Acquire and adapt existing instruments or develop new instruments to meet client care needs i.e. enhanced primary care assessment tools.
   - Strengthening collaborative partnerships.

Main Message

What did we do?

- Developed and implemented a strategy to improve collaborative palliative care practice in rural areas.
- Developed resources to support collaborative practice.
- Developed collaborative partnerships with primary care providers in rural communities.

What has been learnt?

- That specialist and primary care services need to collaborate to provide optimum palliative care to clients.
- Roles and responsibilities need to be clearly defined and understood by all.
- That primary care providers need to be supported by the specialist palliative care service through: 1) specialist clinicians being readily available to provide advice and information; and 2) provision of resources and education.

What is useful to other projects/communities?

- The palliative care service delivery model and other resource tools are likely to be useful for other palliative care services.

What have been the benefits of disseminating information about the project?

- Disseminating information, the extensive networking and consultation have helped to develop relationships between the specialist palliative care service and primary care providers throughout the State.
- The project has helped to raise awareness about:- palliative care, who provides palliative care (whole of health care sector approach) and the role of specialist and primary care providers.

What needs to happen in order to sustain the key achievements of this project?

- Ongoing support for primary care providers needs to occur.
- Ready availability of contemporary resources through the Service's web site.
- Access to ongoing education.
- State and National funding bodies need to adequately resource specialist palliative care services to support primary care providers to provide palliative care.

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What resources did we develop and are they available to others?

- A framework for a collaborative approach to the delivery of a whole-of-health sector palliative care and a guide to collaborative palliative care practice.
- Referral and registration process.
- Clinical assessment tools for primary and specialist use.
- Tool and process for assessing the psychosocial needs of both client and/or caregiver.
- Template for a collaborative care planning approach to shared clients.
- A comprehensive client data set.
- The resources developed will be made available through the Service's web site.