KIMBERLEY PALLIATIVE CARE SERVICE

Executive Summary

'Accessing Palliative Care in the Kimberley's remote Aboriginal communities'

A project funded under
The Caring Communities Program
by the Australian Government Department of Health & Ageing

Project Officer:	Wendy Scott
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Project completion date:	December 2005
Fund holder:	WA Country Health Service- Kimberley
Name of service conducting the project:	Kimberley Palliative Care Service, WA

Background

Kimberley Palliative Care Services (KPCS) were revitalised in 2002 through a new partnership between the Western Australian Country Health Service-Kimberley (WACHS-K), the Cancer Council of WA and other key stakeholders.

Williamson (1996) stated there was a lack of coordinated palliative care services to remote Aboriginal communities. In most cases Aboriginal people who required palliative care were transported to regional centres or to Perth. Key stakeholders recognised the need to enhance the 'regional reach' of the newly restructured Kimberley Palliative Care Service and improve the delivery of services to people living in remote communities.

Objectives

The project aim was to address the lack of access to a comprehensive palliative care service to remote communities in the Kimberley region, increase the knowledge of palliative care services and establish support systems to enable the provision of palliative care in remote Aboriginal communities within the Kimberley region.

Methodology

The KPCS was responsible for the evaluation of the project. The evaluation process involved utilising assessment tools, surveying community members and key stakeholders twice in the course of the project. Information from KPCS annual reports was also used to assess client activity and service delivery.

Project goals, the related key activities and evaluation methods were separated into 2 parts.

1. Consultations with and visits to remote communities, to build trusting relationships, assess awareness, provide information, training and support to enhance opportunities for people with life limiting illness to access palliative care service and 'finish up' in country.

Nineteen (19) communities were chosen based on variables such as population, community interest, access to a health clinic or HACC service and the involvement of other visiting services. Resource tools were developed, including a ten-minute video, and used to assist in enhancing awareness regarding palliative care and support the community in the development of local and appropriate resources.

The Regional Coordinator and an Indigenous Support Worker, visited each community up to six times to gather information, provide information and complete surveys.

2. Establish and develop partnerships with key stakeholders and heath care providers in the Kimberley to increase their awareness of the service, their knowledge of the palliative approach and support systems available, in order to improve the access to services, clarify roles and enhance continuity of care.

An Information Manual for Health Care Providers in the Kimberley was developed and distributed. A communication strategy to assist in the dissemination of information to key stakeholders was developed and implemented.

Results

Most of the project goals were met, although evaluation indicated there remains a lack of equity of service throughout the region. Developments of local support systems, for people who wish to die in their community were limited due to many complex issues at community level.

In remote communities, there was an increase to 47% of respondents verbalising knowledge of services, with an increase from two to 19% of people identifying the KPCS specifically. Most people (88%) stated that going to hospital in the nearest town (usually more than 200km away) was necessary if care was required at nighttime, due to limited resources in the community. A large majority of community members stated sick people should be bought to country to 'finish up' but stated success it depended on strong families.

Key stakeholders have an increased knowledge of the service, the use of the manual and the satisfaction of KPCS service delivery, although very few have knowledge of services in remote communities. The demands for palliative care services grew throughout the Kimberley region in the first year of the project. The number of new referrals from remote communities was 30% (9),decreasing to 17%(9) in the second year of the project. Referrals were received from both east and west remote communities. There has been vast service growth in the region since 2003.

Discussion

This project addressed the National Palliative Care Strategy goals of enhancing *awareness and understanding* in the general community and of care providers, and also to improve *partnerships of care* between key stakeholders.

Although there was great 'support' at community level there were limitations in community development. It was difficult to gain community support when there was limited knowledge in what the KPCS wanted the community to be involved in. Difficulties lay in gaining support for a service that had not been required previously, was not needed at the time or when recognising the full benefits it may have.

The survey results may not be a true indication of the enhanced awareness and understanding amongst community members The project officer and the Indigenous support worker do suggest, however, that the results are not a true reflection of the success of the newly developed resources or promotion of the project through the media.

It also identified some 'gaps' that may reduce continuity of quality care. There is a new staff member within WACHS-K every 4 months, with many agency staff used in some areas. Vast distances, transport and climate also affected project implementation.

Conclusion

There has been vast growth in client activity since 2001. There was up to 12 times the amount of service demand in a similar 6-month period in 2005, which indicated an enhanced understanding of palliative care amongst key stakeholders and referral sources.

An Aboriginal Health Worker/support worker, working in palliative care in the Kimberley, is vital to ensure cultural brokerage. In this project it enhanced success when sharing and receiving information.

Community members and families need training and support, which will improve community capacity. Training and support needs to occur when there is a 'current need', commencing prior to discharge from acute services, and supported during the transition home. Partnerships with key stakeholders need to be maintained. The 'linkages' of care providers requires ongoing development to ensure equity of access.

The challenges with project implementation, unique to remote areas, need further recognition by funding bodies to ensure support and project successes in the future.