Kalgoorlie- Boulder Palliative Care Co-ordination Project

Final Report

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under

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Name of service conducting the project:	Silver Chain Nursing Association

Part C – Executive Summary

1 Background

Identifying Information: Kalgoorlie–Boulder Palliative Care Coordination Project, implemented from April 2003 to 30 June 2005, by Silver Chain Nursing Association in partnership with the Eastern Goldfields Medical Division of General Practice, Kalgoorlie Regional Hospital, Little Sisters of the Poor and Edward Collick Nursing Homes.

Setting: The project co-ordinated an interagency multidisciplinary team to improve clinical management of palliative clients by case conferencing, and creating a seamless transition between services through in reach to both nursing home and hospital, within Kalgoorlie –Boulder.

Background: Kalgoorlie–Boulder is a city of over 33,000 people located 600 kms East of Perth in the Goldfields region of Western Australia. Six per cent (1980 people) are Indigenous. Kalgoorlie-Boulder is difficult to staff and hard to serve region of the State that has been significantly under funded in the delivery of palliative care in recent years. Very limited palliative care service options were available or had been delivered to dying people for many years in the area. Very little interpretation and customisation in the delivery of palliative care services to the sizeable Indigenous community has been provided.

Provision of co-ordination, education, cultural awareness and Indigenous liaison and interpretation would support the development of an integrated and co-operative palliative care service and greatly enhance the delivery of Palliative Care to the Kalgoorlie-Boulder area of Western Australia.

2 Project Objectives:

- To support the co-ordination of care for the person who is dying and their family and or carers.
- To develop strong partnerships between palliative care providers, other health service providers and the service system infrastructure to ensure the delivery of palliative care is geographically accessible and integrated across service delivery settings.
- To support the educational needs of the specialist palliative care workforce and primary health practitioners and enhance the skills of both groups in working collaboratively across professional boundaries.
- To improve the knowledge and skills of families, carers and community groups so that they can better support relatives, loved ones or individuals within the community who are dying and to support them through their bereavement.
- To enhance community awareness of the role and benefits of palliative care in meeting the needs of people who are dying and their families.
- To improve the awareness of a broad range of health care providers to the role of palliative care as an integral part of health care system and their role in this area.

- To conduct and evaluation of the project.

- To ensure the sustainability of the project beyond May 2005

3 Methodology/Description

The project was implemented in four stages with simultaneous development of multidisciplinary clinical team, procedures and operational guidelines, and an Advisory Committee to promote and strengthen partnerships. Educational programs were developed and implemented, Volunteers were recruited trained, and Indigenous cultural issues explored. Health professionals were targeted to improve their professional awareness and understanding of the role of palliative care and their knowledge to improve capacity of quality care delivery within Kalgoorlie. The community was targeted to increase awareness and understanding, gain support and engage volunteers to improve long term sustainability with the town. Indigenous groups were engaged to identify cultural issues and areas of need for palliative care to improve access and quality outcomes in palliative care for Indigenous people.

Satisfaction surveys were used to measure the clients and the family's perception of the service and participants of educational events provided evaluation feedback as to the quality and applicability of the material. Finally, data was collected to examine referral rates, types of service, numbers of clients and Indigenous client access.

4 Results

- 79 referrals were received, 55 received palliative care both in the community and as in-patients, and one received bereavement social and emotional support.

- 25% of community clients received end of life care at home.

- 15 referrals were received from clients based in hospital who needed consultation symptom advice and family conferences to examine their option and make end of life choices. Of those, five went to nursing homes, three returned to their home towns outside of Kalgoorlie, and six passed away as in-patients.

- There were four nursing home clients referred for symptom management with both hospitalised symptom review and in-reach support.

- The Indigenous population is 6% of the total population. The referral rate to the Palliative Care Service is at 15%. Good links have been made with a number of Aboriginal services that offer cultural liaison and support and assistance with education of health professionals.

- All participants of the educational program responded positively to the content and applicability of the courses.

- Clients overall were very satisfied with the service they received and the families surveyed after the client had passed away reinforced their satisfaction. Participation at case conference is good all disciplines are represented at meetings including general practitioners.

- In-spite of more than 50% turnover in the advisory team attendance at meetings is about 50% of membership and excellent working partnership continues to exist.

- The project and Silver Chain were successful in obtaining an equipment grant and made physical modifications to create a purpose built storage facility for electric beds and a small number of other items to support the palliative client dying at home.

- An MOU was developed with the EGVT to transport the beds within Kalgoorlie-Boulder city limits free of charge.

5 Discussion

The major achievements of the project are:

- Successful multidisciplinary multi-agency team that meets regularly for case conferences and professional development.

- 25% of community clients are able to die at home as desired.

- Sound improvement in engagement of Indigenous clients for palliative care, and better understanding of the cultural influences on palliative care delivery.

- Successful volunteer program delivering 61 hours of support to palliative clients and their families.

- Strong partnerships maintained with the advisory committee membership.

Factors that contributed to the success of the project and/or helped to meet the project's objectives:

- One committed Palliative Care Co-ordinator for the duration of the project, providing stability and continuity.

- High turnover of staff new people with a need to develop collaborative networks thus being open to the development of a service with seamless boundaries and no empires to protect.

- One hospital and one community service provider reduces competition for funding and improves collaboration, communication and co-operation.

- Commitment from key service providers; the EGMDGP the LSOP, Silver Chain and the Kalgoorlie Regional Hospital.

- The Palliative Care Co-ordinator implementing both this project and a Rural Palliative Care project for the EGMDGP that engages general practitioners in the program.

- MOU development formalising relationships between Kalgoorlie Regional Hospital, EGMDGP, EGVT, ESWC for sustained support in key areas of business activity that provides continuity in-spite of the high turnover of personnel.

Negative effects on the success of the project, limiting ability to meet the project's objectives:

- Difficulty employing an Indigenous Liaison Officer.
- Isolation impacts on the importation of resources to Kalgoorlie much more time consuming, and harder to find.
- Competition for resources such as training leave and course subsides.
- High turn over whilst being a blessing is also a weakness as much more time is needed to keep up relationships, networking, and effort to develop clear MOUs to keep existing relationships and work practices in place.

Other problems the project faced:

- System level impacts on Silver Chain operations required some modification to allow the Project Palliative Care Co-ordinator to be able to manage referrals, data collection, bereavement programs, and implementation of educational /training events.

Recommendations for ways in which the project could have been improved:

- A corporate steering committee or project management team that met regularly with the project officer could have pre-empted the system level impacts and developed strategies to manage them before they create difficulties. Silver Chain recognises this and has appointed a new Corporate Manager to address this issue.
- Wherever possible the Palliative Care Co-ordinator should be involved in the development of the project plan implementation program and have a position title that reflects scope and responsibility of the work that is being undertaken.

Aspects of the project that are going to be sustained:

- Domiciliary nursing has been separately funded and will be sustained after the project concludes.
- The equipment program and volunteers will be managed by Silver Chain's general business.
- Positive negotiations are continuing with the Regional Health Service to fund an ongoing Palliative Care Co-ordination position for clinical, education, and volunteer management.

Lessons other regions/services/organisations can learn from the project:

- Networking and building relationships, and documenting the agreed terms of any relationship in an MOU is imperative to success.
- There is no room for competitiveness when these things are removed can open negotiations and progress towards common goals become achievable.

- Buy in from general practitioners is essential any primary health focussed service, where their in-put is required for success. The areas most affected in this project are case conference participation, after hours support for home deaths, and direct admissions for palliative clients,

- Participants in advisory or reference groups must be committed if they are to support the relationships and progress of the project.

Circumstances in which the outcomes of this project could be replicated elsewhere:

- This model is similar to others operating in small West Australian towns, as well as the GAPS project in Griffith, NSW. The similarities are a rural town only one domiciliary and one or two hospital services, general practitioner support is high and the Regional Health Service is committed to palliative care. All major stakeholders agreed at the outset that such a service is needed ensuring commitment for its ongoing support.

Dissemination activities:

- Media articles, newsletter articles, presentations at community groups, national workshops, WA State Palliative Care Conference, local service networking events, participation in National awareness campaigns, community forums and radio interviews, were all used with various success

This Project links with The National Palliative Care Strategy by addressing all three of the gaols:

- Increased community, and professional awareness of palliative care, and the many options available, to support people needing palliative care, including cultural issues for Aboriginal people.

- Incorporating quality review into the practice and outcomes of care.

- Development of sound partnerships and collaboration across key service settings that support the care of people who are dying and their families.

6 Conclusion

Recommendations from the project:

- MOUs are imperative to maintenance of collaborative services in areas of high turnover.
- Service providers should ensure consultation and support from general practitioners before undertaking any projects where their in- put is required for success.
- Participants in advisory or reference groups must be committed.
- Wherever possible the Palliative Care Co-ordinator should be involved in the development of the project plan and have a position title that clearly reflects scope and responsibility of the work that is being undertaken.
- Palliative professional development courses should be available externally or through tele-health at a subsidised rate for remote health professionals.