



PALLIATIVE CARE CONVERSATIONS

PROJECT EVALUATION

SOUTHERN METROPOLITAN PALLIATIVE CARE CONSORTIUM

JULY 2017

SMRRPCC Contact Details

Southern Metropolitan Region Palliative Care Consortium (SMRPCC)
Consortium Manager email: tanja.bahro@smrpcc.org.au
Telephone: 0418 584 106
Website: www.smrpalliativecare-consortium.org.au

Project Team

Christine Pedley – Project Consultant
Robyn Reid – Author of the training program
Tanja Bahro – Oversight
Stephenie Cook – Evaluation support
Tess Storr – Administration/Layout

TABLE OF CONTENTS

1. INTRODUCTION.....	1
2. EXECUTIVE SUMMARY	2
3. CONTENT AND STRUCTURE OF THE PCC PROGRAM	3
4. PROCESS.....	4
4.1 Initial contact and setup.....	4
5. CHALLENGES	6
6. RESULTS.....	7
6.1 Participating organisations by type	7
6.2 Evaluation findings (pre/post session survey).....	7
6.2.1 Identification of role.....	7
6.2.2 Place of work.....	7
6.2.3 Referrals to Palliative Care/Palliative Care Conversations	8
6.2.4 Session learning outcomes (pre/post survey questions)	8
6.2.5 Learning needs met and relevancy of training.....	9
6.2.6 Changed work practices (anticipated).....	10
6.2.7 Key take home message.....	10
6.2.8 How can the program be improved?	11
6.2.9 Additional training topics.....	11
7. FOLLOW UP TELEPHONE SURVEY: 4 & 6 WEEK POST TRAINING	12
7.1 Demographics	12
7.2 Key take home message.....	13
7.3 Has your practice changed?	15
7.4 Barriers to having the palliative care conversation.....	17
7.5 What can help?	17
8. PROJECT WORKER OBSERVATIONS	19
9. RESOURCES	20
10. CONCLUSION AND POINTS FOR CONSIDERATION	21
11. APPENDIXES	23
I. Initial Survey template	23
II. Pre/Post Evaluation template	25
III. Post session telephone interview template	27

1. INTRODUCTION

In 2014, the Southern Metropolitan Region Palliative Care Consortium (SMRPCC) identified the need to assist non-palliative care health professionals in the region to gain an improved understanding and skills in referring to palliative care. The consortium established an advisory group comprising a range of health professionals within and outside the palliative care sector. A comprehensive training resource, including a facilitators guide, PowerPoint slides, a timetable, handouts and a pre-and post-evaluation was developed. The program was piloted, evaluated and a train-the-trainer workshop presented at the 2015 Palliative Care Australia Conference in Melbourne. Following the conference, the program was made available for free to interested organisations.

In 2016, the Department of Health and Human Services released the 'Victoria's End of Life and Palliative Care Framework' and within this document determined their priority areas. Priority Four, *'Quality end of life and palliative care is everyone's responsibility'* emphasises the responsibilities of the whole health sector to possess the skills to have appropriate conversations about end of life and understand how to initiate care and support for people with a terminal illness, their family and caregivers.

In order to address Priority Four of the Framework, the consortium decided to undertake a project to roll out the 'Palliative Care Conversation' training across the southern metropolitan region and evaluate not only the individual sessions, but also undertake a follow up evaluation to ascertain whether participation in the training resulted in practice change and to identify any additional barriers.

"I had to explain to a patient what Palliative Care was when the doctor didn't have time (he had a meeting). The training made a difference as to how and what to say to the patient."

2. EXECUTIVE SUMMARY

1. Between February and May 2017, 30 sessions with 345 participants were conducted across the southern metropolitan region.
2. Session evaluations were returned by 95% of participants and identified demographics, experience in having conversations around palliative care and learning outcomes.
3. There were significant improvements in each of the training learning objectives and 100% of participants found the session either fully or partially met their training needs and was fully or partially relevant to their work.
4. Follow up interviews (4-6 weeks post training) were conducted with 29% of participants and of those interviewed 85% identified a take home message, 73% had integrated the take home message into their practice and 77% identified that they had changed their practice as a result of the training.
5. The initiative was delivered beyond scope, under budget and within the timeline. Outcomes exceeded expectations.

*“The training was very sought after –
it should be a regular refresher.”*

3. CONTENT AND STRUCTURE OF THE PCC PROGRAM

The program is aimed at all non-palliative care specific health workers, including nurses, doctors, allied health and associated staff within any health setting. It is a 1.5-hour interactive session with learning objectives to:

- better understand what palliative care is and how it is delivered in different settings
- how to make a referral to specialist palliative care providers
- how to facilitate a conversation with clients / families on referral to palliative care
- where to obtain further information and training

“The things I learned in that session will come in handy for all interaction with patients - in many circumstances. Definitely, my listening skills have improved - I have stopped finishing people's sentences for them”

4. PROCESS

In order to determine the interest of health providers in the region, the SMRPCC sent a survey to health services within the Southern Region asking for expressions of interest in the training.

In response to this survey, conducted using Survey Monkey (see appendix), 21 agencies registered their interest. The organisations ranged from hospitals, both public and private, residential aged care facilities, HACC services, community health centres and a GP Practice (who responded from NSW, so was not eligible).

With such a positive response, SMRPCC seconded a project officer with many years palliative care and training experience, to promote this training further and conduct the Palliative Care Conversations training within the Southern Metro Region. The project officer commenced late December 2016. In conjunction with the consortium manager a workplan was developed, with an initial roll out until June 2017. The plan included:

- contacting survey participants to set up sessions
- confirming session evaluation materials and developing post session survey questions
- contacting other relevant agencies to offer training
- conducting and evaluating sessions
- conducting post session and writing evaluation report

4.1 INITIAL CONTACT AND SETUP

Contact was initially made with all those who had responded to survey, offering meetings for further discussion regarding the training. The majority of organisations declined the face to face meeting but asked for further printed information. A flyer was developed, along with an introductory letter and distributed to those requesting.

There was also a promotion article placed in the Southern Melbourne Primary Care Partnership Newsletter on the 1st of February 2017. This did not result in any inquiries.

From the original 20 survey responses, three came from the same organisation, one from interstate, and a number of survey participants had left their place of work and their replacements were unfamiliar with the initiative.

The consortium manager and project officer attended a meeting on 19 January at Bunurong Health Services (an Aboriginal health organisation) to explain the Consortium and the training. Whilst there was an expression of interest to participate, numerous follow up phone calls and emails did not eventuate in a booking for the training.

An additional 12 organisations were contacted beyond those who had responded to the survey, offering the opportunity of training. Nine requested to proceed with the training. These were mainly Local Councils within the region, a Community Health Centre, Community based Care Package Provider and an Aged Care Assessment Service. All of the services were interested to learn more about palliative care despite this not being their core business.

In total, 23 organisations requested training. One organization, a Residential Aged Care Facility, was not evaluated due to the disorganisation of planning for this training.

The week before each booking, the appropriate organisation was contacted by phone, confirming all details, followed then by an email containing the session handouts, requesting the organisation to print those for all attendees. Organisations were also emailed additional information for distribution to attendees following training (see appendix).

An attendance sheet template was created and distributed at each session, requesting both phone number and email. All attendees were asked if they agreed to be contacted by the presenter, by phone, for a five-minute conversation regarding the training approximately six weeks post training. Attendees had an opportunity to decline this additional contact.

At every training session, there was additional information available for all attendees to browse through following the training. A copy of 'Dying to Know – Bringing Death to Life' was available and also 'The Dreamers – Life, Death and dreams'. There were also various articles relating to both palliative care and having difficult conversations on display. Details of material on display was included in additional information which was emailed to all attendees. This included organisations offering additional training and additional resources e.g. bi-lingual brochures on palliative care from Palliative Care Victoria.

5. CHALLENGES

The duration of the workshops was 90 minutes. This was to balance the ability of organisations to release staff for training with the need to provide enough time for the delivery of the content, in particular with the inclusion of an interactive element. Depending on current skills and knowledge, as well as the diversity of the training group, it was at times difficult to deliver all the content within the set time.

At times, the interactive component of the session could not be fully delivered. This was regretful, as many people later commented that they found the role play to be very valuable. About 10% of attendees felt that the training was too short in length or that the training felt rushed. One organization requested an additional session to spend more time on the interactive component.

One session, which was specifically advertised to doctors, was cancelled due to lack of enrolments. In another session all participants either arrived late or left early. This session was not included in the final evaluation.

Another challenge was the problem with the technical set up. Availability of a projector was always confirmed by phone before the training. The project officer carried her own laptop but was frequently able to use equipment on site. There were times, unfortunately, when there was no projector available or was inoperable. At these sessions, the attendees were required to view the handouts or the small screen of the laptop. This did not seem to influence learning or discussion but required a flexible and confident approach to training.

Another issue was that some participants became upset during the session, possibly because it reminded them of difficult times in their own lives. It is important to have a confident facilitator who is able to read the participants reactions and is able to address any presenting issue as well as having time after the session to provide some debriefing should this be required.

6. RESULTS

6.1 PARTICIPATING ORGANISATIONS BY TYPE

Below is a breakdown of number of sessions and participants by service type.

Type of Agency	Sessions	Participants
RACF	7	111
Hospitals	7	97
Councils	6	43
Other (including ACAS, Community health)	6	94

6.2 EVALUATION FINDINGS (PRE-POST SESSION SURVEY)

Each attendee was asked to complete a pre-program evaluation before the session and a post-program evaluation after the session (see appendix). 329 participants handed in the evaluations. The evaluation contained questions about participants' demographics, their experience, their skills before and after the session and some open questions. Some participants did not answer all the questions, which resulted in the numbers of answers not always adding up to the total numbers of evaluations received.

6.2.1 IDENTIFICATION OF ROLE

From the 329 responses, participants identified their role/profession as follows:

*Nurse = 114 (37%); Doctor = 9 (3%); Allied Health Profession 60 = (19%);

Case Manager 7 = (2%); PCA = 3 (1%); **Other 119 = (38%)

** No distinction was made between an Enrolled Nurse or a Registered Nurse.*

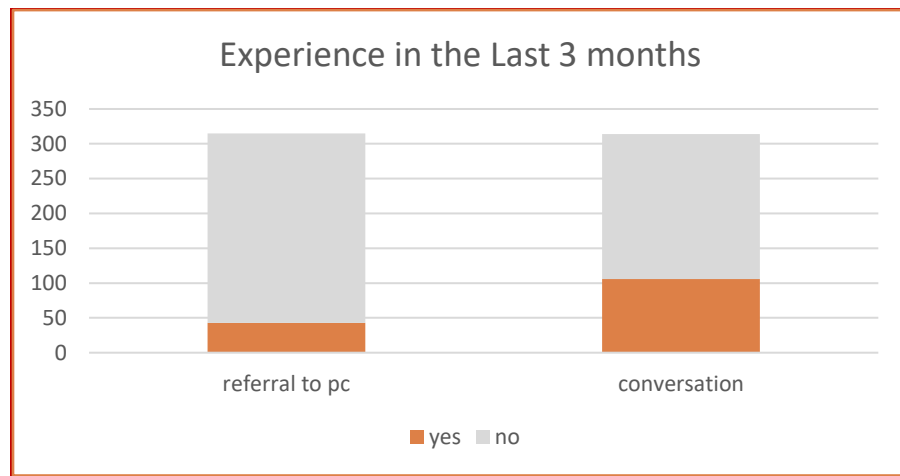
*** There were at least six sessions that included attendance of students on placement. For some, this was their initial introduction to palliative care.*

6.2.2 PLACE OF WORK

Of the 318 participants who identified their place of work, 133 (42%) were from Community Care, followed by 103 (32%) from Aged Care, 63 (20%) identified Acute Care and 19 (6%) identifying 'other' as their place of work.

6.2.3 REFERRALS TO PALLIATIVE CARE/PALLIATIVE CARE CONVERSATIONS

43 (14%) of the 315 participants who responded to the question on palliative care referral had made a referral in the past three months. 106 (34%) of the 314 who responded to the question concerning palliative care conversations had had a palliative care conversation with a patient/client in the past 3 months. There was a large number of participants who had not made a referral, 272 (86%) or who had not had a palliative care conversation in the past 3 months, 208 (68%).



6.2.4 SESSION LEARNING OUTCOMES (PRE/POST SURVEY QUESTIONS)

The attendees were asked to complete the same five questions before and after the training to gauge increased learning or knowledge (please see below)

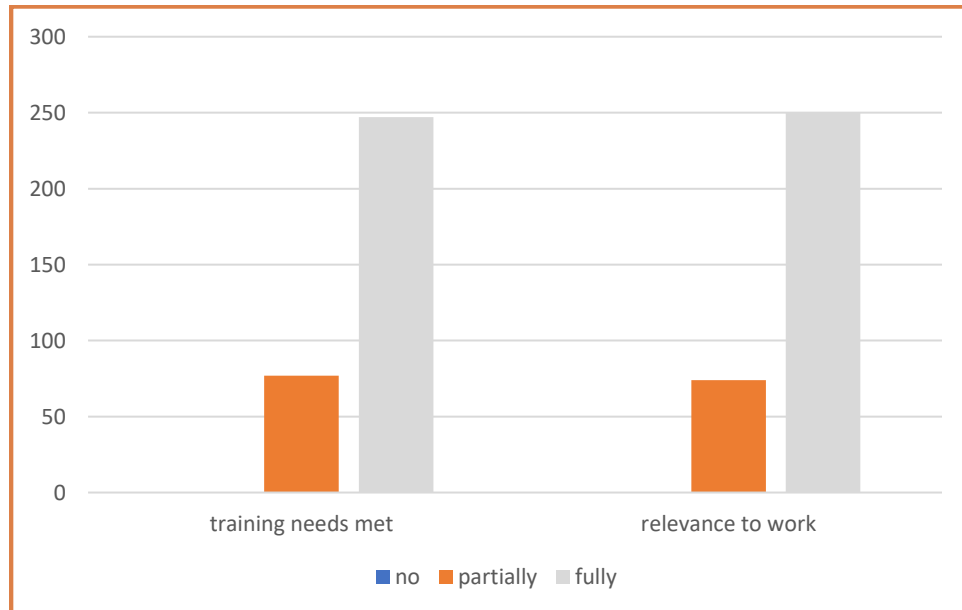
Statement	Completely agree	Somewhat agree	Do not agree
1. I can confidently explain at least 2 services provided by palliative care.			
2. I can confidently identify at least 2 settings where palliative care is delivered.			
3. In addition to patient name, address and diagnosis, I am confident to identify at least 2 further pieces of information required when making a referral to palliative care.			
4. I would feel confident about facilitating a conversation with a patient regarding a referral to palliative care.			
5. I know where to go for further training to ensure effective communication skills for difficult conversations.			

Only two participants did not identify any increase in knowledge as a result of the training. These were very skilled practitioners with significant experience in referral to palliative care. All other participants recorded increased knowledge in at least one area. All five questions together indicated a substantial increase in confidence or knowledge ranging from 177 (55%) being more confident explaining palliative care, to 98 (65%) who now knew where to go for further training to ensure effective communication skills for difficult conversations.

6.2.5 LEARNING NEEDS MET AND RELEVANCY OF TRAINING

Of the 324 attendees who responded to whether their learning needs were met during this training, 100% responded affirmatively. 247 (76%) indicated their needs were fully met, while 77 (24%) indicated their needs were partially met.

Of the 324 attendees who responded to the relevance of the training to their work, again 100% agreed it was relevant to their work. 250 (77%) indicated it was fully relevant and 74 (23%) indicated it was partially relevant.



6.2.6 CHANGED WORK PRACTICES (ANTICIPATED)

Attendees were asked what changes to work practices they were considering as a result of the training.

223 (69%) listed changes. The most frequent responses are listed below:

- gaining knowledge
- increasing confidence
- not being afraid to have that conversation
- use silence more
- listen better
- use open-ended questions
- make more referrals to palliative care
- didn't know I could refer to palliative care
- more Advance Care Planning
- not being afraid to talk about ACP
- ask more questions about what people want
- exercising more tolerance and compassion
- develop my own way of self-care
- additional support from SMRPCC
- good refresher for what is already practiced

6.2.7 KEY TAKE HOME MESSAGE

Attendees were asked to identify their key take home message. There were 250 responses. Whilst these were varied, the top four themes were as follows:

1. *Aspects of Palliative Care that was new information.* This included how to make referrals; anyone can make a referral; that it is so much more than just dying; that it can improve quality of life
2. *The importance of having the courageous/difficult conversation.* This also included messages about the importance of communication and not being afraid to talk about death and dying.
3. *The importance of listening.* This included 'with the heart', and 'everyone deserving respect'.
4. *Many aspects of Advance Care Planning.* This included understanding and accepting choices of patients/clients and acknowledgement that every client is unique.

6.2.8 HOW CAN THE PROGRAM BE IMPROVED?

The majority of participants (71%) did not have any suggestions for improvement. There were 91 suggestions for improvement which have been grouped as follows:

- have more time for both the training and the role play
- more case studies, examples and practical tips
- include videos – some suggesting health professionals interacting with the dying person
- incidental suggestions included: more medical attendees; more interaction with participants – particularly with students; a reminder at the beginning of the session that it may trigger emotions; debriefing after the training; include more information on physical symptoms
- a number of participants misunderstood the question and included suggestions about how the palliative care program within their workplace could be improved

6.2.9 ADDITIONAL TRAINING TOPICS

61 participants identified further training they would be interested in. Most suggestions were around more specific communication skills or counselling, followed by medical aspect of palliative care including wound management; role of nurse; delivering palliative care; pharmacological interventions; pain management; process of dying. Advance Care Planning or having a conversation with patients/clients regarding organ donation were also mentioned and a number of participants suggested bereavement and grief as an area of future training. One-off mentioned topics were family conflict; dementia; MND; plain English, chronic pain; pastoral care; interacting with GP's; dealing with intense emotion and having conversation with clients re organ donation.

7. FOLLOW UP TELEPHONE SURVEY: 4 & 6 WEEK POST TRAINING

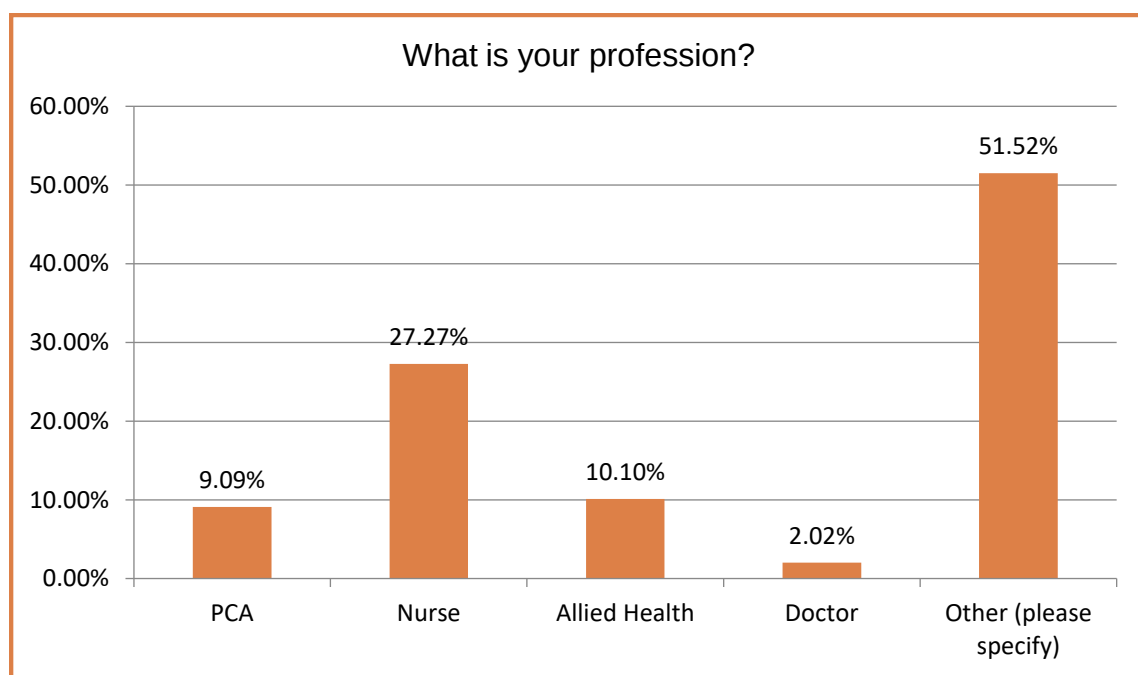
As a way of assessing outcomes and gaps with participating organisations and individuals, a further questionnaire was developed on Survey Monkey (see appendix).

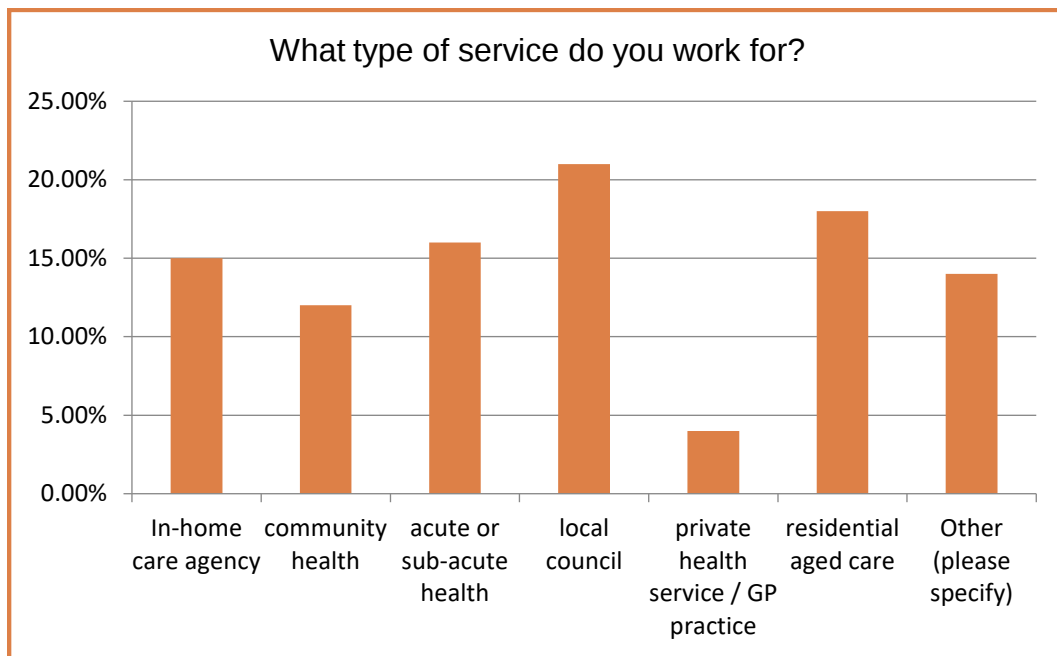
Initially, the plan was to contact attendees with a follow-up phone call 6 weeks after training and again 4 weeks later. There was a delay with the first phone calls because the initial six week follow up came at a time where the project officer was delivering a large number of training sessions. Two issues emerged: six weeks felt too long before initial contact and requesting an additional phone call felt intrusive and unnecessary.

The decision was then made to only make one follow up call and this phone call was made as close to four weeks after training as possible. A number of attendees declined the survey due to their own time constraints. Overall, the phone call process was very time intensive due to participants not being available (up to 2 messages were left with any individual).

7.1 DEMOGRAPHICS

Follow up calls were made to 100 training participants (29%). The graphs below indicate responses on demographic information provided in the post session survey.





7.2 KEY TAKE HOME MESSAGE

Attendees were asked if they could remember their Key Take Home messages or ‘the most important thing you can remember learning at that training’.

For the 86% who could identify a take home message/key learning, the responses could be categorised into four themes: Palliative Care; Communication; Death and Advance Care Plans.

Within the Palliative Care theme, statements included:

- good refresher to existing knowledge
- process of referral to palliative care
- knowledge of what palliative care is and the different types of services offered
- Importance of early referral
- discharged from palliative care services is possible
- services are not just for ‘the end’

Within the Communication theme, the take home messages included:

- having honest conversations
- importance of language
- importance of open-ended questions
- really listening
- affirming messages included: being brave to have the conversation; no reason for hang-ups; not to feel nervous; Yes! I can do it; we often don’t take death seriously often minimising it

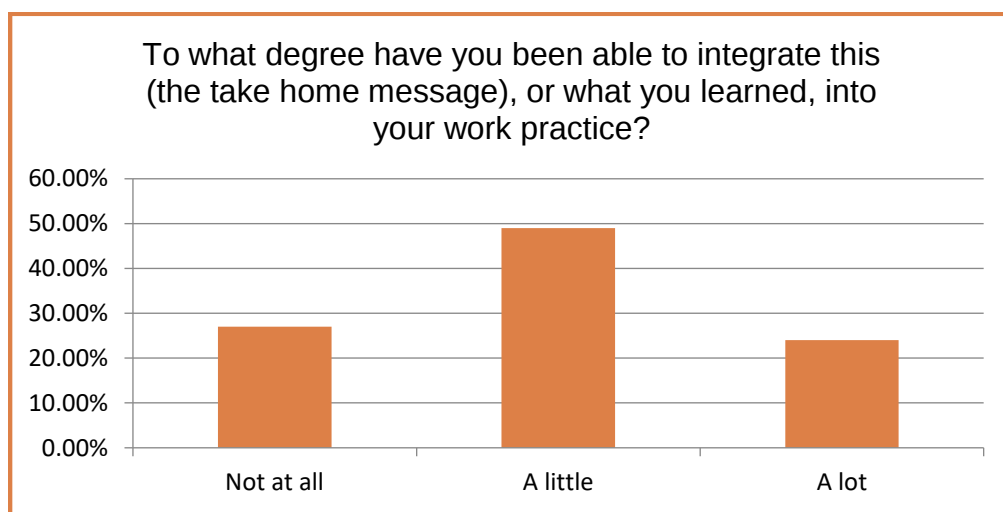
Advance Care Planning featured as an important theme, including:

- the importance of making sure a plan was completed
- personal choice
- one organisation takes ACP brochures when they visit clients as a result of the training

The theme of communication around death and dying included the messages below:

- not avoiding or being scared about discussing death and palliative care with patients
- should make discussion around death and dying part of life
- the importance of living life until the end
- death is a normal part of our experience
- one participant said it was good preparation for when her mother died unexpectedly after the training

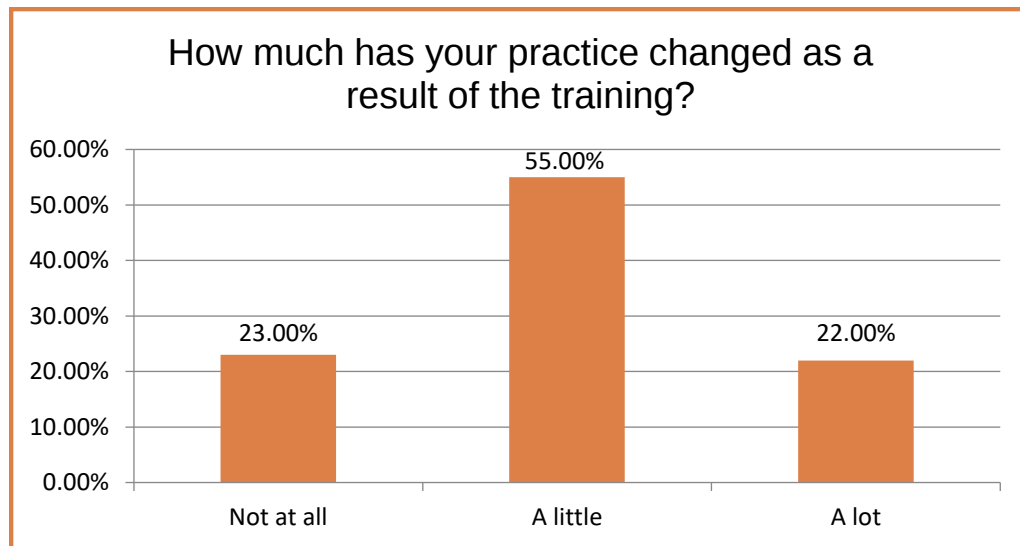
Participants were also asked to what degree they have been able to integrate the take home message into their practice and the results are shown in the graph below.



“I am more vigilant about providing information. I can also use the word death more comfortably. I encourage my client's more on decision making. I don't have many palliative clients but have been able to use the information with many of my clients in terms of making plans for the future”

7.3 HAS YOUR PRACTICE CHANGED?

Participants were asked about how much (if at all) their practice has changed as a result of the training. Results are shown below. 77 % of participants indicated that their practice had changed.



Participants who answered in the affirmative were then asked how their practice had changed.

A number of participants stated that they had not been in a position to implement their practice change yet, either because their work role did not provide them with much opportunity or because they had been on leave. These participants still made general comments:

- feeling confident to seek advice from palliative care services
- more comfortable in my communication
- using techniques I learnt in everyday communication

When considering the change of clinical practice, attendees responded either reflecting on their practice broadly or reflecting on their communication improvements.

Issues pertaining to improved practice could be divided into practical changes and emotional clinical responses.

Changes in practice:

- new knowledge such as deeper awareness of services
- one attendee made an appointment to meet with community palliative care service for future referrals
- several comments related to now having regular discussions about palliative care and end of life issues within team meetings
- approaching practical cultural issues differently
- feeling more comfortable raising palliative care with doctors
- undertaking Advanced Care Plan discussions with clients

Changes that related to emotional clinical responses were highlighted with statements such as:

- more caring
- providing greater comfort
- increased care and support for both patient and family
- being more patient
- much more present
- increased confidence and increased awareness about client needs at end of life

The responses that related to communication, had different aspects to them. Whilst some acknowledge their listening skills had improved, the majority responded with the ease they felt in raising the subject of palliative care or end of life issues generally with both client and their carers. Several said they felt much more comfortable talking to other staff about these issues, including the medical teams.

7.4 BARRIERS TO HAVING THE PALLIATIVE CARE CONVERSATION

The attendees were then asked if they felt there were barriers and if there was anything the consortium could do to address these. 23 responses (23% of all those asked the question) did not identify any barriers, either because of their existing experience or as a result of the training.

The remaining barriers raised could be divided into three themes:

Client / family related

- family often does not wish to discuss issues around referral to palliative care
- cultural incongruence between health provider and client meant that there is uncertainty on how to approach the discussion, because of a fear around offending the other
- the words *palliative care* had a negative connotation and people who were not imminently dying did not wish to discuss it
- cognitive issues and dementia

System related

- time limits on the amount of time health professionals were able to allocate to the discussion or not wanting to open up something they would not have time to follow through
- doctors still don't/won't consider palliative care

Practitioner related

- need to improve listening skills
- dealing with own emotions
- fear of offending or touching a raw nerve
- lack of experience

7.5 WHAT CAN HELP?

Continuing on with the theme of barriers, attendees were asked to consider whether there was anything their employer could do to make it easier. 33% (n=33) stated that there was nothing more they could do. Participants generally felt supported by their organisations. This included offering professional development such as the palliative care conversations training from the SMRPCC.

36% of total responses made reference to their work place providing additional training, either regular refresher training or inclusion of the palliative care conversations training into orientation for all staff, including doctors.

There were some suggestions for additional training topics, including: cultural issues, how to 'ask the difficult question' and nursing skills for palliative care.

Participants also mentioned the need for more written information, either produced by their health service or existing information/brochures from PCA or PCV (both resources were provided following training).

Another issue was having time to have these discussions, suggesting if staff had more administrative support it would enable them to spend more time with clients. Increased paperwork was cited for the stretch on client discussion time. One participant stated they had only one hour to be with clients and often this did not allow time for a proper conversation and suggested that time constraints had a big impact on the depth of conversation with clients.

*"We have to look after the palliative care person.
Need to follow what they want. what their needs
are - not what we think they need."*

8. PROJECT WORKER OBSERVATIONS

In addition to an increased understanding of palliative care, there were several other benefits of this training as observed by the project officer. A number of people stated in conversations with the project officer that they felt more comfortable about having discussions about death generally and stated that they were going to have discussions with their family and were planning to complete their advance care plan.

The project officer also found that the training needed to be prefaced with a discussion on self-awareness and self-care as a number of participants found it emotionally challenging. This has resulted in changes to the original facilitators guide, which now alerts facilitators to this issue.

“We can have life until the end. We can provide a comfortable farewell - even prepare the family for their loss. There should be the dignity of living till the end.”

9. RESOURCES

The initial project plan included a three day per week project officer for 6 months at cost of approximately \$30K. The project officer subsequently agreed to work up to three days per week depending on project requirements.

Consortium staff also contributed to project components within their normal working hours and these hours have not been specifically recorded. The approximate total cost was \$25K which is made up of \$17,773 for the project officer (including travel) and the hours spent by consortium staff. Below is a table indicating the approximate hours.

Personnel	Activity	Approximate hours
Project officer	organisation and facilitation of sessions, evaluation	300
Consortium manager	project management, delivery of some sessions, supervision, editing of final document	50
MND shared care worker	initial induction, follow-up meetings with project officer, phone survey	20
Training consultant	evaluation support, setting up post session, data analysis	20
Admin officer	data entry, phone survey, email follow up of participants, report design	15

The project delivered a higher than expected outcome with 10 more sessions delivered than planned and approximately \$5k under budget.

10. CONCLUSION AND POINTS FOR CONSIDERATION

This initiative was far-reaching, effective and efficient and met a clear need in the southern metropolitan region. The evaluation has shown that participants received great benefits from this short and relatively inexpensive training and found that conducting the training on a regular basis with new participants is a need in the region.

Any future initiative should consider providing a firmer framework around organisation of the sessions, potentially with the trainer bringing their own equipment. It should also be considered giving organisations the option to extend session time if they are in a position to do so.

The Southern Metropolitan Region Palliative Care Consortium will deliberate if there will be similar activities within and beyond the region after having considered this report.

Options are:

- to offer sessions upon demand
- to undertake an annual project similar to this one
- to make the findings available to an audience beyond the region
- to offer train the trainer workshop within and outside the region

The Palliative Care Conversations resource has proven to support Victoria's End of Life and Palliative Care Framework, Priority 4. Implementing the resource enables health care professionals improve their confidence and skills in discussing death and dying with client and their families.



Appendix 1: INITIAL SURVEY TEMPLATE

11. APPENDIXES

OVERVIEW

The Southern Metropolitan Region Palliative Care Consortium is planning to roll out training on how to best refer to specialist palliative care services. The training program is called “Palliative Care Conversations” and has been trialed and evaluated extensively.

The program runs for 90 minutes and has the following learning objectives:

For participants to:

- understand what palliative care is
- understand how to make an appropriate palliative care referral
- understand the settings in which palliative care takes place
- understand how to have difficult conversations using basic communication skills
- identify where to get additional training and skill development

The training could be useful for General Practice, Community Health, Home and Community Care and Specialist Services. There are no training costs involved but venue and catering (if needed) would have to be supplied by your organisation.

In order to appropriately and sufficiently plan the roll-out, we would like to assess the level of interest in this training across the Southern Metropolitan Region.

If you are interested in having this training delivered please help us by filling in this form.

Appendix 1: INITIAL SURVEY TEMPLATE

EXPRESSION OF INTEREST – YOUR DETAILS

1. * What is your first name?
2. * What is your last name?
3. What is your role?
4. * At what email address would you like to be contacted?
5. * What is the name of your organisation?
6. * What type of organisation is it?
 - Community Health
 - General Practice
 - Home and Community Care
 - Local Government
 - Private Clinic
 - Sub-acute Health Service
 - Other (please specify)
7. * What type of health professionals would you invite and/or expect to attend?
 - Allied Health Professionals
 - General Practitioners
 - Nurses
 - Specialist Doctors
 - Other (please specify)
8. * How many people would you expect to attend?
 - Less than 10
 - 10 - 15
 - 15 - 20
 - 20+
9. Do you have a preferred day for delivery * of the program?
 - No preference
 - Monday
 - Tuesday
 - Wednesday
 - Thursday
 - Friday
10. Do you have a preferred MONTH (during 2016 or first half of 2017) for delivery of the program?
 - No preference
 - No preference for month but would prefer delivery in 2016
 - No preference for month but would prefer delivery in 2017 (first half of the year)
 - Yes, my preferred month is

Appendix 2: PRE/POST EVALUATION TEMPLATE

Pre- program evaluation Session Summary Palliative Care Conversations



Date of Session: _____

Venue/organisation: _____

Presenter: _____

Number of participants: _____ Number of evaluations returned: _____

PLEASE RATE THE FOLLOWING STATEMENTS (please tick the most appropriate response):

Statement	Completely agree	Somewhat agree	Do not agree
I can confidently explain at least 2 services provided by palliative care			
I can confidently identify at least 3 settings where palliative care is delivered			
In addition to patient name, address and diagnosis, I am confident to identify at least 2 further pieces of information required when making a palliative care referral			
I would feel confident about facilitating a conversation with a patient regarding a referral to palliative care			
I know where to go for further training to ensure effective communication skills for difficult conversations			

Please tell us a little about yourself:

I am a:

- ☐ Nurse
- ☐ Doctor
- ☐ Allied Health Professional
- ☐ Other

I work in:

- ☐ Acute Care
- ☐ Community Care
- ☐ General Practice
- ☐ Aged Care
- ☐ Other

Have you made a referral to palliative care in the past 3 months?

☐ Yes ☐ No

Have you had a palliative care conversation with a patient/client in the past 3 months?

☐ Yes ☐ No

Thank you & please remember to complete the other side at the end of the program

Appendix 2: PRE/POST EVALUATION TEMPLATE

Post - program evaluation Session Summary Palliative Care Conversations



1. PLEASE RATE THE FOLLOWING STATEMENTS (please tick the most appropriate response):

Statement	Completely agree	Somewhat agree	Do not agree	Change?
I can confidently explain				
I can confidently identify...settings where PC is delivered				
In addition to ... I am confident to identify at least 2 further pieces of information required when making a palliative care referral				
I would feel confident about facilitating a conversation ...regarding a referral to PC				
I know where to go for further training...				

2. Please rate the degree to which this program met your learning needs

☐ Fully met ☐ Partially met ☐ Not met

3. Please rate the degree to which this program was relevant to your work

☐ Fully relevant ☐ Partially relevant ☐ Not relevant

4. As a result of today's program, what changes to your work practices are you now considering?

5. What is your key take-home message from today's program?

6. How could this program be improved?

7. Please list any additional training topics you're interested in

8. Any other comments?

Thank you!

Recorded by:

Date:

Appendix 3: POST SESSION PHONE INTERVIEW

Session identification:

1. What is your profession?
☐ PCA
☐ Nurse
☐ Allied Health
☐ Doctor
☐ Other (Please specify):
2. What type of service do you work for?
☐ In home care agency
☐ Community health
☐ Acute or sub-acute health
☐ Local council
☐ Private health serve/GP practice
☐ Residential aged care
☐ Other (please specify):
3. Can you remember your key take home message from the training?
☐ Yes ☐ No
If yes, it was:
4. To what degree have you been able to integrate this (the take home message), or what you learned, into your work practice?
☐ Not at all ☐ A little ☐ A lot
5. How much has your practice changed as a result of the training
☐ Not at all ☐ A little ☐ A lot
If a little or a lot, how?
6. Do you feel there is anything that makes it difficult for you to have the palliative conversation?
☐ Yes ☐ No
If Yes, go to Question 7
7. Can you describe the barrier and is there anything the Consortium can do to assist?
.....
8. Is there anything, your employer could do to make it easier?
.....
9. Can I contact you again in another month to see how things are going?
☐ Yes ☐ No