

Can the national palliative care framework work in a rural area?

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In September 2000, the Commonwealth released (as part of its National Palliative Care Strategy under the Australian Health Care Agreements) a National Framework for Palliative Care Service Development. The new national framework enunciated an important set of values to guide models of palliative care delivery and articulated three National goals:

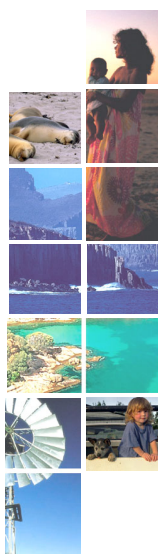
- awareness and understanding
- quality and effectiveness
- partnerships in care.

In 1998 a review of the GMAHS Palliative Care services (The Sach report) identified numerous shortcomings in the Griffith-based service benchmarked to National standards. They included:

- access for non-oncological palliative care was problematic
- no operational links with community nursing
- no formal volunteers network, except that provided by the Cancer Patients Assistance Society (CPAS)
- inadequate data collection which failed to meet National Standards requirement for a minimum data set (MDS).

The findings included:

- palliative care patients were not clearly identified. There was no actual medical record
- palliative care patients were largely concealed
- GP involvement variable and not co-ordinated. No after-hours service
- specialist services are not well co-ordinated
- specialist palliative care nurses were overloaded with work, including after-hours
- role of district and private nursing was not acknowledged
- no core management, poor communication, medicine/nursing
- no available reference material
- no dedicated palliative care beds at GBH
- patients had no clearly defined pathway to follow after-hours. As a result, most ended up in A&E.



The development process thus far represents a first for our region.

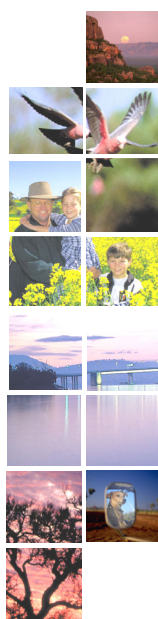
For the first time (Area Health – GBH, Community Health), Commonwealth (Division of General Practice, GPs), Private Nursing and consumers have come together to resolve the problems *collaboratively*.

AIMS

- To increase access to an integrated palliative care service for terminally ill people, their cares and families within the Griffith and Carathool Shires.
- To demonstrate measurable improvements in the quality of service provided benchmarked against national standards.
- To evaluate the model of care in order to assess:
- Its impact on consumers, carers, providers and the system as a whole
- Whether the evaluation findings can be generalised to other rural areas, and if so, whether this model of care would be appropriate for implementation elsewhere.

MODEL OF CARE

- Appointment of a Care Co-ordinator.
- Weekly case management review involving palliative care, community nurses, private nursing agency, GP representatives, allied health and liaising with emergency department and pastoral care.
- Joint intake options by case management team.
- Integrated continuous medical records across all services.
- Introduction and use of the Snapshot/PalCIS palliative care information system as a patient registration and clinical information system.
- Collection of baseline data, monthly monitoring and evaluation.
- Provision of a 24-hour 1800 number.
- Formal GP on-call roster after-hours (organised and managed by MDGP) includes attendance for ED presentations.
- Trained volunteer program with program co-ordinator.
- Formal agreement with GBH VMOs for palliative care patient transfer to palliative care team medical officer on emergency admissions.
- Education programs for medical officers, registered nurse, ED Staff, pastoral care and volunteers.



MEDICAL RECORD

- Implementation of patient centred medical record.
- Single record accessible to all health care providers.
- One single medical record number.
- Patient held ensuring all concerned, including the patient are aware of all the information.
- Paper based not technology driven, everyone can use, requires no education.
- Ensures data collection at point of care.
- Patients have taken the record as far as New Zealand.

PROVISION OF "ON CALL"

- Rostered team of general practitioners providing on call service.
- Over 70 per cent of local general practitioners.
- Rostered team of registered nurses providing on call service.
- Service provided at home and upon presentation at the emergency department.

CASE CONFERENCE MEETINGS

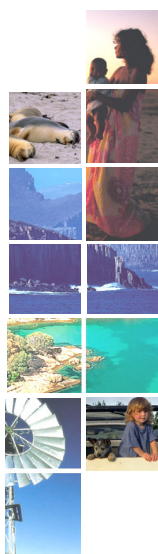
- Provision of weekly case conference meeting.
- Formulation and facilitation of EPC case conferencing.
- To present we have completed over 80 EPC case conferences.
- This is out of 1157 GP team attendances.
- GP reimbursement is via EPC claims
- Attendance is interdisciplinary.

DATA BASE

- Implementation of PalCIS database.
- Provision of SNAP data.
- Palm pilot portability.
- Developed over six years in WA.

Includes:

- symptom assessment scores
- RUG ADL scores
- ICD 0 and ICD 10
- ability to track patients over their illness.



PALM PILOTS

- Currently have five palm pilots in operation.
- Data can be synchronised on the main data base by a simple “hot sync”.
- Data can be compiled during the home visit.

Palm pilots currently being used by:

- Kookora Street Surgery.
- Griffith Nursing Service.
- District Nursing.
- Oncology/Palliative Care Department.
- Palliative Care Co-ordinator.

EVALUATION

Being undertaken by the Centre for Health Service Development, University of Wollongong.

OUTCOMES

- The structures and relationships that underpin them, are strongly linked with mainstream services, consumer and community interests.
- There are management and governance systems in place which allow management to take place and ensure that the project, and the service, are properly managed.
- The project has performance indicators and targets and there are systems to assess progress and take action if necessary.
- The project is strongly documented which is vital given the significance of the multi-disciplinary collaboration at its heart.
- The project is placed within a broad education framework designed to enhance quality and develop common understandings between participants in a system of rural palliative care.

