



# PALLIATIVE CARE

Health Waikato

Rural Hospitals and  
Community Based Services  
Palliative Care Project 2008

NGĀ PEEHITANGA TĀNGATA O TE AO HURUHURI  
NGĀ WHAKARITENGA MO TE TIKĀ ME TE ORA MORIMORIMATAWHAI

THE TRIALS PEOPLE FACE IN A CHALLENGING WORLD  
CAN BE OVERCOME BY CARING FOR AND LOVING ONE ANOTHER





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November 2008

### **Acknowledgements**

Acknowledgement and thanks to the many people who made time to respond to the stock take through site visits and/or telephone contact and shared knowledge and ideas regarding the palliative care service delivery in the rural hospitals and community based services of the Waikato District Health Board.

## Executive Summary

There is increased recognition from providers and the public that access to health care for individuals living in rural and remote areas of the Waikato can be problematic.

The Waikato District Health Board (Waikato DHB) Executive Group approved one off funding for 2007-08 to complete a stock take and review of Waikato rural hospitals and Health Waikato community based services palliative care. The project coverage included the rural hospitals and community based services of Tokoroa, Te Kuiti, Thames and Taumarunui and Matariki and Rhoda Read continuing care facilities for adult palliative care patients.

The review is in response to the Waikato Palliative Care Strategy Plan 2005 – 2010 that provides strategic direction for an integrated and co-ordinated Waikato palliative care service to ensure that all people with palliative care needs and their family/whānau have access to essential palliative care services provided in a co-ordinated and culturally appropriate way. The strategy plan recommends:

Key results area – patient focus on improved access and equity to palliative care services. Recommendation 2.3 – Waikato rural communities to have improved access to palliative care services, (b) district hospitals to be included in the collaborative care service review.

Most palliative care patients prefer to remain / die in their home. The Waikato palliative care strategy promotes a community based philosophy.

In partnership with the stakeholders the following was completed:

- stocktake of palliative care services and providers for each organisation
- analysis of variation and strengths and weaknesses of the current services
- a framework that describes the different levels of palliative care services, roles and responsibilities and the systems and processes that link and integrate the patient pathway.

Waikato rural hospitals and Health Waikato community based services do not provide specialist palliative care services. Rural hospitals do facilitate specialist palliative care outreach clinics / services and community based services do work with Hospice Waikato. Palliative care patients may require admission to a rural hospital to manage a clinical need (symptom control, respite care) that requires additional nursing care and support than can be provided within a persons home. Referral for admission is usually made by the GP, patient and carer and supporting team such as the district nurse.

Key themes of findings of the review included:

- each Waikato rural hospital and Health Waikato community based palliative care service is configured and managed in a different way, except for Matariki and Rhoda Read
- need to reduce duplication of effort, share developed initiatives across the district
- some staff are unsure of the after hours palliative care services pathway, whether to make contact with the patients GP and/or specialist palliative care medical or nursing
- community equipment management is fragmented
- Tokoroa has less access to specialist palliative care in the community, with no collaborative care model
- need to continue roll out of the end of life LCP implementation plan
- under utilisation and recognition of the value of Hospice Waikato collaborative care model in some areas across the district
- need to improve hospital discharge planning
- continue to strengthen the multiple service providers relationships and working as a multi disciplinary team.

A detailed action plan supporting rural palliative care service improvement is provided in the body of the report. Key recommendations include:

- a horizontal network approach for the rural hospitals and community based services is required to link and standardise the systems
- equitable access and provision across the Waikato
- improved integration of services with each area to have documented mechanisms of working together that includes a list of services and providers and associated links
- Tokoroa community to have equal access to collaborative care services
- the existing collaborative care steering group (Health Waikato rural hospitals and community based services, PCU and Hospice Waikato) extends its terms of reference to include the standardisation of palliative care processes and systems, e.g. discharge checklists
- improved discharge planning systems and processes of palliative care patients from rural and Waikato hospital(s)
- a formalised palliative care education and training framework to support the rural hospitals and community based services. Specialist palliative care providers have commenced developing a core education package for generalists
- clear, transparent and formalised out of hours patient care plan, specialist palliative care support and advice service
- continue the end of life Liverpool Care Pathway implementation plan rollout with completion of Thames and then commence Taumarunui.

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## 1.0 Introduction

The Waikato District Health Board (Waikato DHB) executive group approved 2007-08 one-off funding to stock take and review palliative care in Health Waikato rural hospitals and community based services. The aim of the review is:

- all health professionals and the public understand what palliative care services are available and how to access
- to improve the integration of palliative care services.

The rural hospitals and community based services<sup>1</sup> covers:

- Thames hospital and community based services in Thames, Coromandel and Hauraki
- Tokoroa hospital and community based services
- Te Kuiti hospital and community based services
- Taumarunui hospital and community based services
- Matariki continuing care facility (based Te Awamutu)
- Rhoda Read continuing care facility (based Morrinsville)
- Health Waikato Central and Northern community based services.

This report summarises:

- the background and project methodology and links with other projects
- describes the current situation regarding palliative care within rural Waikato hospitals and community based services
- outlines the desired level of palliative care services and makes recommendations.

Exclusions:

The review has proven to be complex and time consuming than originally anticipated; therefore this report only covers adult palliative care. Consideration of child services and providers will need to be considered at a later stage.

GPs and general practice team were not included as stakeholders in the review as the focus was Health Waikato rural hospitals and community based services care to be addressed initially.

## 2.0 Background

The Waikato DHB Palliative Care Strategy Plan 2005 – 2010 provides strategic direction for integrated and co-ordinated palliative care services within the Waikato district. The Waikato palliative care goal is to ensure that all people with palliative care needs and their family/whānau have access to essential palliative care services provided in a co-ordinated and culturally appropriate way.

Care is provided in a variety of settings and a full range of essential services ensures access for people to choose the option of dying at home and having access to a range of hospital and community based services and access to specialist services when required.

This project responds specifically to the palliative patients and family/whānau in the rural Waikato and ensuring they have access and equity of palliative care services, both generalist and specialist. The Waikato DHB spans a large geographical area which presents a challenge in the delivery of palliative care services to rural and remote areas and highlights the need for a planned and integrated approach based on an understanding of the current situation.

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<sup>1</sup> Community based services means Waikato DHB funded services such as district nursing services

There is a need for a shared common language and understanding between providers that describes palliative care services at the various levels and how they link.

The Waikato Palliative Care Strategy Plan key result area and recommendation related to this review are:

Key result area - patient focus on improved access and equity to palliative services  
Recommendation 2.3. Waikato rural communities to have improved access to palliative care services

(b) Waikato DHB district hospitals included in the collaborative care service review.

The rural hospitals project review commenced January 2008 supported with a project officer (refer project brief appendix a). Methodology included:

- consultation with key stakeholders<sup>2</sup>
- literature review of palliative care frameworks / role delineation models
- stock take of current services and providers
- SWOT analysis.

### **Links with other projects**

There are numerous projects / initiatives in progress that link to this project. The following summarises the key related projects to this review which are:

- Waikato palliative collaborative care project
- Waikato DHB 24/7 After Hours Planning and Funding Strategy
- New Zealand Specialist Palliative Care Service Specifications (draft)
- Waikato Palliative Care Liverpool Care of the Dying Pathway programme (LCP)
- Waikato specialist palliative care on-call advice service nursing and medical
- National project to improve professional development for nurses in palliative care and cancer specialities.

The project linkages are summarised in appendix b.

### **3.0 Waikato rural hospitals & Health Waikato community based palliative care service**

The national specialist palliative care service specifications clearly outline the standards and expectations of a desired specialist palliative care service. There is no generalist palliative care service specification. The New Zealand Palliative Care Strategy (2001) does provide some guidance in relation to generalist palliative care.

The NSW Department of Health in collaboration with the Palliative Care Association of NSW developed a palliative care role delineation framework (NSW Health, 2007) (refer [www.health.nsw.gov.au/policies](http://www.health.nsw.gov.au/policies)) in an attempt to classify palliative care services according to role and resource capability.

The aim of developing and adopting a role delineation framework for the delivery of palliative care services in the rural hospitals and community services is to establish a clear and shared understanding of the needs of the palliative population, including their needs for generalist and specialist palliative care. A framework can assist in developing access policies and referral criteria ensuring that patients are able to move between care providers based on clinical need with little disruption to their clinical care or support.

The role delineation framework incorporates generalist and specialist palliative care providers and seeks to:

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<sup>2</sup> Key staff at each rural hospital, Thames, Tokoroa, Te Kuiti and Taumarunui District Nurse Services, Matariki and Rhoda Read, Tokoroa Community Hospice Trust, Palliative Care Unit, Health Waikato

- ensure palliative care is based on assessment of needs
- encourages providers to see themselves as part of a single continuum system delivering palliative care
- ensures delivery of care accords with evidence based protocols
- formalises links between palliative care services/providers at all levels that is understood by all, allowing seamless patient flow
- better understand the utilisation of palliative care services and plans for future need, manage demand and increase service capacity efficiently and effectively.

The above principles need to be incorporated into future service improvement. The framework recognises the unique contribution of each provider and can guide service delivery between multiple providers to reduce duplication of effort and to improve outcomes for patients and their families/whānau.

A further description of the role delineation framework (refer to Waikato Palliative Care Steering Group Project report, 2005) promotes a population based model of collaboration between services to implement systems and processes of care that improve outcomes for populations as well as individuals. Access to palliative care services should ideally be based on complexity of patient need and established assessment and referral protocols. Patients' episodes of care will move in and out of the different levels through the total journey.

As indicated in the Waikato palliative care strategy plan there are three levels:

1. generalist – is the largest group who do not require direct access to specialist care – however support and advice is available as required from specialist services<sup>3</sup>
2. generalist / specialists – is where patients will have sporadic exacerbation of pain / symptoms and require temporary increase in the level of need and may require access to specialist palliative care for consultation and advice. They continue to receive care from their primary care provider.
3. specialist – is a small group of people that has increased needs that are complex and do not respond to simple or established protocols of care. This group requires highly individualised plans, implemented by knowledgeable and skilled specialist health professionals in partnership with primary providers.

The palliative data for patients in the rural hospitals indicates low volumes per site per annum (appendix c). For Waikato rural hospital and community based services palliative care is level 1 generalist palliative care, moving to generalist / specialist level when there is integration of Hospice Waikato and community based services collaborative model is in place, and / or either hospital and / or community based services seek support and advice from specialist palliative care consultancy or outreach visiting service.

Most palliative care patients prefer to remain / die in their home. The Waikato palliative care strategy promotes a community based philosophy. Waikato rural hospitals and community based services do not provide specialist palliative care services. Rural hospitals do facilitate specialist palliative care outreach clinics / services and community based services do work with Hospice Waikato. Palliative care patients may require admission to a rural hospital to manage a clinical need (symptom control, respite care) that requires additional nursing care and support than can be provided within a persons home. Referral for admission is usually made by the GP patient and carer and supporting team such as the district nurse.

Matariki and Rhoda Read provide respite care. Te Kuiti provides GP supported respite and symptom management. Waikato rural hospitals may have facilities such as rooms suitable for palliative care patients, but these are not managed under a palliative care

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<sup>3</sup> Australia predicts two thirds of all deaths is expected to fall into this category



inpatient beds / contract. Funding for generalist palliative care within Waikato rural hospitals and community based services is via the medical / surgical service specification and community based services contract.

Specialist palliative care outreach clinics held at the rural hospitals have a different purchasing unit.

### **3.1 Recommended Essential Elements**

The following summaries essential elements required to care for palliative patients within the rural hospital and community based services (appendix d).

#### **Assessment, care coordination and clinical care**

- referral protocols to/from primary care and Waikato hospital
- comprehensive multidisciplinary care plan agreed between patient and staff teams
- care plan states the name of the lead generalist palliative care health professional for the episode of care
- suitable facilities and equipment, such as syringe drivers
- adequate trained nursing, medical and ancillary staff
- if at home and under the district nursing services to have an agreed out of hours plan of care including access to medication
- community based services have access to specialist palliative care collaborative services with Hospice Waikato
- palliative care clinical protocols and audit
- discharge planning back to community and primary services
- end of life tools
  - Liverpool care pathway (rural hospital and district nursing)
  - preferred place of care (community based services)
- continuity of care between:
  - rural community based services and rural hospital
  - rural hospital and community based services and primary care

#### **Patients**

Meet the physical needs of patients:

- effective symptom control
- pain relief, including systematic assessment, provision of appropriate drug therapy
- nutritional needs
- comfortable environment, including access to single rooms where preferred, equipment such as lazy boy chairs
- psychological and spiritual needs

#### **Families and friends**

- social / practical needs including time with patient, comfortable overnight accommodation, minimum self catering facilities i.e. tea/coffee
- psychological and spiritual needs

#### **Health professionals**

- training and education from specialist palliative care
- psychological and spiritual support
- access to specialist palliative care medical and nursing support and advice 24/7.

## **4.0 Current Situation**

This section provides a summary of the stock take of each area and an analysis of the strengths and weaknesses. The stock take of the rural hospitals and community based palliative care services providers, summarises their roles and responsibilities and details

how the current generalist services and providers link with other generalists and specialist palliative care.

Services can access Disability Support Link (DSL) who administers the palliative care funds<sup>4</sup> for:

- respite / end of life care access to a rest home or continuing care facility for a bed, for a maximum of six weeks.
- carer support for day / night relief – for carer support for two nights per week or the funding equivalent to be used as desired by the client to meet the family's need for carer support.

#### **4.1 Thames Hospital and community based services in Thames, Coromandel and Hauraki**

Palliative care patients and their families/whānau access to generalist primary services through general practice (GP). GP services and Thames hospital emergency department together provide after hours primary health services as per the Waikato DHB after hour's planning and funding strategy.

District nursing services (DNs) provide clinical home based care as referred by GP or Waikato/Thames hospitals. A Hospice Waikato nurse was introduced 2006-07 to extend the collaborative care nurse model which provides psycho-social support and information for palliative patients and families/ whānau.

Support and advice for DN's is sought from the patients GP and /or PCU during working hours and Hospice Waikato after hours (as per the previously mentioned pilot project).

Palliative patients have access to Thames hospital via the medical / surgical services (inpatient and ambulatory), including specialist visiting services e.g. neurology, renal.

PCU holds a weekly specialist palliative care clinic at Thames hospital as well as home visits as required.

Thames Community Cancer Support group provide equipment and volunteers. Whangamata Hospice Trust provides equipment, managed by the Waikato DHB. They have a small number of family support volunteers and are independent from Hospice Waikato.

#### **4.2 Tokoroa Hospital and community based services**

Palliative care patients access generalist primary health services through general practice (GP). GPs access specialist palliative care support and advice via PCU and the palliative care consultant on call 24/7.

District nursing services supports patients in the community as referred by GP. The district nursing service access support and advice during working hours via the patients GP and/or PCU, and after hours Hospice Waikato nursing advice and support (as per the pilot project).

Hospice Waikato provides collaborative care to patients in the Putaruru area.

Tokoroa hospital emergency department provide after hours primary health services as per the Waikato DHB after hour's planning and funding strategy from 8pm to 8am.

PCU holds monthly clinics at the Tokoroa hospital, home visits as necessary and lunchtime staff education sessions.

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<sup>4</sup> Refer Waikato Palliative Care DSL Review (2006)

Tokoroa Community Hospice Trust provides patient and family support volunteer services and supply equipment.

There is no palliative collaborative care model established in Tokoroa as in the rest of the rural Waikato.

#### **4.3 Te Kuiti hospital and community based services**

Palliative care patients are managed by their GPs both in the community and when admitted to hospital for symptom management or respite care as necessary.

GPs in Te Kuiti also provide out of hours care to patients. Te Kuiti hospital emergency department (ED) provides out of hours primary care, the difference in Te Kuiti is triage is provided by the ED nurses and the doctor (GP) is on call.

District nursing services (DNs) provide clinical home based care as referred by GP or Te Kuiti / Waikato hospitals. A Hospice Waikato collaborative care nurse provides psycho-social support, grief and bereavement support and provides information for palliative patients and families/ whānau as required. Equipment is managed by Hospice Waikato volunteers.

PCU holds a monthly clinic at the hospital and home visits for patients and family/ whānau. Staff education is provided by PCU on the same visit. Support and advice for DNs is provided by the patients GP and/or PCU during working hours and Hospice Waikato nursing after hours service (as per the pilot project).

Patient management and care is discussed at weekly meetings either at hospital multidisciplinary meetings or community based services meetings.

#### **4.4 Taumarunui hospital and community based services**

Palliative care patients are managed by their GP who refer to DNs. GPs and DNs often do joint home visits to patients.

Out of hours care is provided by the Taumarunui hospital emergency department from 8pm – 8am.

PCU holds a monthly consultant and CNS clinic and provides an education session. In 2008 the frequency of the medical specialist increased from bi monthly to monthly.

Taumarunui hospital weekly multi disciplinary meetings are held to discuss palliative care patient's, inpatient or in the community, GP and Hospice not included.

Equipment is sourced from the Taumarunui hospital via OTs and DNs.

A Hospice Waikato collaborative care nurse is available to provide psycho-social support, grief and bereavement support equipment and provides and information for palliative patients and families / whānau as required.

#### **4.5 Matariki continuing care facility (based Te Awamutu) and Rhoda Read continuing care facility (based Morrinsville)**

Admission is available to these facilities for carer relief, short term symptom management and end of life care via the DSL contract. Three GPs have admitting privileges to Matariki. A PCU clinic and education session is held monthly at Matariki hospital. Out of hours medical care is provided by the continuing care facility doctors with support and advice from PCU.

Rhoda Read liaises with the PCU for medical advice and support and Hospice Waikato provides bereavement and grief support to families / whānau after death.

## 5.0 S.W.O.T. Analysis

The summary key themes from the SWOT analysis (appendix c) are:

### **Strengths**

- staff are committed and passionate about providing good care to their patients
- staff in the Waikato DHB rural hospitals and community based services currently work independently to develop relationships and networks within their communities to respond to palliative care patients and families / whānau
- district specialist palliative care medical and nursing advice and support service developed, but not necessarily well utilised or known about
- there is a lot of good work and developments that could be shared / standardised across the district
- GP and PCU relationships and practice enhanced through annual GP palliative care training opportunities delivered by the PCU.

### **Weaknesses**

- Waikato does not have a population based model approach to palliative care services with clear systems and processes for the different levels of need supported by transparent protocols
- each area in Waikato is working in isolation to improve services and as result there is district variation with less standardisation of palliative care systems and processes
- fragmentation of services, predominantly due to approach, both locally and across the district, perception 'that its someone else's responsibility to fix'
- some generalists and community perception is that increasing specialist palliative care visiting services and opening rural hospital beds (dedicated for end of life palliative care) is going to resolve the local palliative care issues
- late referrals to specialist palliative care services
- discharge planning of palliative patients from hospital to community has been identified as problematic
- access to after hours medication, requires a district standardised approach, especially if discharged late from hospital
- specialist palliative care services need to develop a core education programme for generalists as per the specialist palliative care service specifications
- implementation of the LCP programme has not commenced in Taumarunui, Te Kuiti and Tokoroa
- under utilisation and recognition of the value of the Waikato Hospice service within rural Waikato
- management of community equipment for palliative care is fragmented
- access to carer support is limited and is left predominately to the patient / family to arrange
- there is a perception that some rest homes are struggling with caring for respite / end of life patients, for a variety of reasons. Note: need to consider this issue alongside the Waikato Agewise Strategy and link with the Gerontology Clinical Nurse Specialist
- Tokoroa doesn't have access to the full range of Hospice services as other areas do
- Lack of recognition that the palliative care continuum is more than just end of life care
- there is a lack of understanding by mainstream providers of the whānau model of health and illness. Clinicians in hospices and hospitals do not always work with the wider whanau or Maori providers when coordinating care, yet the whānau is the main support for the Maori person who is dying (refer Waikato palliative care

Maori provider stocktake). There is also lack of education to Maori providers on the palliative care services.

In summary, the stock take of services and SWOT analysis key themes are:

- a horizontal network approach for Waikato rural hospitals and community based services. A need to link the local services and standardise the systems across the Waikato
- reduce duplication of effort, share developed initiatives across the district
- some staff unsure of after hours palliative care services pathway, whether to make contact with the patients GP and/or specialist palliative care medical or nursing
- community equipment management is fragmented
- Tokoroa has less access to specialist palliative care in the community, with no collaborative care model
- need to continue LCP implementation plan
- under utilisation and recognition of value of Hospice Waikato collaborative care model in places across the district
- need to improve hospital discharge planning
- process to initiate the conversation in the community on the preferred place of care
- continue to strengthen the multiple service providers relationships and working as a multi disciplinary team.

## **6.0 Recommendations**

This document serves to direct the development of a complimentary and efficient model for delivery of palliative care to the patients and families/whānau within the rural hospitals and community based services discussed. There is a need to have a consistent and standardised response to palliative care delivery in the rural hospitals and community based services. New and ongoing initiatives such as the palliative care specialist on-call advice service (nursing and medical) and the LCP implementation plan that are currently or in the near future being rolled out to the rural areas will support standardisation of practice. It is important that any initiatives and responses take into account the level of generalist palliative care capacity and potential for sustainability in the rural districts.

The journey continues with the need to review the road map regularly. A horizontal network approach for the rural hospitals and community based services is required to link and standardise the systems across the Waikato. The following is a starting point for rural hospitals and community based services to focus on the following recommendations:

### ***Improved integration of services***

- each area to have documented list of services and providers and links to access
- establish links and improve integration with other new positions e.g. gerontology services.
- centralisation of equipment management for palliative care patients

### ***Tokoroa access to collaborative care service***

- Tokoroa community to have equal access to collaborative care services. This will require Hospice Waikato collaborative care model extending into Tokoroa and a collaborative working relationship with Hospice Tokoroa, Hospice Waikato and DNs needs to be established.

### ***Collaborative Care Steering Group***

The existing collaborative care steering group continues, with a quality focus:

- to develop a palliative care manual including: national definitions of palliative care, referral processes, links etc
- standard documentation such as assessment, care plans, discharge checklist from local and Waikato hospitals to community



- management of palliative care patients guidelines for district nurses (in draft).

### ***Discharge Planning***

- improve and standardise discharge planning systems, processes and tools related to the discharge of palliative care patients from Waikato hospital.
- patients care plan needs to indicate out of hours plan.

### ***Formalised education and training framework***

- specialist palliative care providers are developing a core education package for generalists in 2008-09
- generalist providers contribute to education needs analysis to develop the above
- generalist palliative care providers identify and access ad hoc in-service as required.

### ***Formalised out of hours support and advice service***

- promote 24/7 specialist palliative care medical support and advice for generalist providers
- promote specialist palliative care nursing out of hours service for generalist providers
- clear and transparent generalist palliative care out of hours pathway and supporting information for the patient and family/whānau, that is documented in the care plan
- a palliative care medications out of hours plan is developed and implemented, that outlines how each area can access medications.

### ***LCP implementation plan rollout***

- 2008-09 Thames fully implemented, monitor and evaluate
- 2008-09 Implement in Taumarunui hospital and community
- 2008-09 Commence implement Te Kuiti hospital and community
- 2009-10 Implement Tokoroa hospital and community.

## 7.0 Waikato Rural Hospitals and Community Based Services Palliative Care Action Plan


Objectives	Specific tasks	Responsibility	Timeframe	Performance measures
<b>To establish a cross sector/multidisciplinary approach to palliative care</b>	<ul style="list-style-type: none"> <li>Each rural area develops a documented list of services and providers for their area</li> <li>Each area identifies and formalises communication mechanisms to assist with relationship development and patient care between providers</li> </ul>	Clinical team leaders of FHCT Designated palliative care representative for the area (quality nursing group rep)		All generalist palliative care providers have a list of services and providers available and know how to access and link
<b>To standardise palliative care processes and systems</b>	<ul style="list-style-type: none"> <li>The existing collaborative care working group extends its terms of reference to include the standardisation of palliative care processes and systems, e.g. discharge checklists</li> </ul>	PCU Rural and community services Hospice Waikato		Palliative care manual is available including: <ul style="list-style-type: none"> <li>NZ definitions of palliative care</li> <li>referral pathways</li> <li>clinical protocols</li> <li>communication mechanisms with other providers</li> </ul>
<b>To develop a formalised core education and training package for generalists</b>	<ul style="list-style-type: none"> <li>Undertake an education needs analysis with generalists</li> <li>Promote and inform the availability of education</li> </ul>	PCU Waikato Hospice Managers of rural and community services		Waikato palliative care education programme developed, implemented monitored and evaluated
<b>To formalise out of hours support and advice services for generalists</b>	<ul style="list-style-type: none"> <li>Continue to promote specialist medical and nursing advice and support services</li> </ul>	PCU and Hospice Waikato Rural health and community services		Palliative care manual includes; <ul style="list-style-type: none"> <li>out of hours services</li> <li>access to out of hours medication</li> </ul>
<b>To improve and standardise discharge planning systems for the discharge of palliative patients from rural and Waikato hospitals</b>	<ul style="list-style-type: none"> <li>PCU CNS to continue work with Ward 25 on discharge planning checklist and process</li> </ul>	PCU and Hospice Waikato Rural health and community services Waikato Hospital rural liaison		Palliative care manual includes discharge planning standards and processes

Objectives	Specific tasks	Responsibility	Timeframe	Performance measures
<b>Tokoroa access to collaborative care services</b> Tokoroa community to have a equal access to collaborative care services	<ul style="list-style-type: none"> <li>This will require Hospice Waikato collaborative care model extending into Tokoroa and a collaborative working relationship with Hospice Tokoroa, Hospice Waikato and DNs needs to be established</li> </ul>	Rural and community based services Waikato Community Hospice Tokoroa Community Hospice PCU	2009-2010	Consistent palliative care approach across the Waikato, including Tokoroa A collaborative working relationship with Hospice Tokoroa, Hospice Waikato and DNs needs is established
<b>To realise the Waikato LCP implementation plan</b>	<ul style="list-style-type: none"> <li>Thames fully implemented, monitor and evaluate</li> <li>Implement in Taumarunui hospital and community</li> <li>Implement Te Kuiti hospital and community</li> <li>Implement Tokoroa hospital and community.</li> </ul>	Lead LCP facilitator PCU link nurse Rural hospital managers	2008-09 2008-09 2009-10 2009-10	LCP implemented into the rural hospitals and community based hospital

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## Appendix a – project brief

 <b>Waikato District Health Board</b>	<b>Project Brief</b>
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<b>Title</b>	<b>Waikato Rural Hospitals and Community Based Services Palliative Care Review</b>
<b>Prepared by</b>	Chris Cowley
<b>Group</b>	Waikato Palliative Care Operations Network
<b>Date</b>	31/09/2007
<b>Version</b>	Final

**Background  
Strategic  
Context**

The New Zealand Palliative Care Strategy (2001) set in place a systematic and informed approach to future provision and funding of palliative care services. This strategy emphasised the need for all people who are dying and their family / whānau have timely access to quality palliative care services.

The New Zealand Cancer Control Strategy (2003) provides a framework for reducing the incidence and impact of cancer in New Zealand along the whole cancer control continuum including palliative care (both cancer and non-cancer palliative care). The Waikato District Health Board (Waikato DHB) Palliative Care Strategy Plan 2005 – 2010 (2005) provides strategic direction for an integrated and co-ordinated Waikato palliative care services. The Waikato palliative care goal is that all providers of palliative care in the Waikato work together with the community to ensure that the New Zealand Palliative Care Strategy (2001) is implemented in the most optimal way for the Waikato district. This is to ensure that all people with palliative care needs and their family / whānau have access to essential palliative care services provided in a co-ordinated and culturally appropriate way. The Waikato DHB Cancer Control Action Plan 2005 – 2010 (2007) incorporates the Waikato Palliative Care Strategy Plan recommendations.

The Waikato Palliative Care Strategy Plan recommends:

- 1.3 To establish formal links between the various service levels and providers
- 2.3 Waikato rural communities to have improved access to palliative care services
- 2.4 To strengthen the palliative care links and partnership with General Practice
- 2.8 To maximise scarce specialist care resource and reduce duplication.

The endorsed Palliative Care Progress Report 2007; Action Plan 2007-2008 recommended development of a rural hospital / community palliative care role delineation model, including a stocktake and review. In June 2007 Waikato DHB Executive Group approved one off funding for a project officer to assist with the development of the above recommendation.

This project has links to:

- Integrated specialist palliative care nurse 24 hour / 7 day week on-call project
- Implementation plan for End of Life Liverpool Care Pathway
- Link nurse service with rest homes and continuing care organisations
- Maori health provider palliative care review project
- Waikato DHB Psycho-Oncology Model of Care and Plan (draft)
- Midland Adolescent / Young Adult Oncology / Haematology Service project
- National Specialist Palliative Care Service Specifications (draft)
- Waikato DHB Rural Hospitals Sustainability project



	<ul style="list-style-type: none"> <li>For further information on the above projects refer to:</li> <li>The Waikato Palliative Care Progress Report 2007; Action Plan 2007-2008</li> <li>The Waikato Cancer Control Action Plan 2007-2010</li> <li>The Midland Cancer Network interim work programme.</li> </ul>
<b>Project Statement</b>	To develop a Waikato rural hospital / community palliative care role delineation model.
<b>Objectives</b>	<ol style="list-style-type: none"> <li>To complete a stock take of rural hospital and community based services for: <ol style="list-style-type: none"> <li>Thames / Coromandel / Hauraki districts</li> <li>Tokoroa / South Waikato district</li> <li>Te Kuiti / Otorohanga district</li> <li>Taumarunui / Waitomo / Part Ruapehu district</li> <li>Hamilton / Cambridge / Ngaruawahia</li> </ol> </li> <li>To undertake a literature search on palliative care role delineation models. Define role delineation and model within the context of palliative care. The Waikato role delineation model will describe the various levels of service, delineates expected resources and capability of generalist and specialist providers for rural hospitals and community based services.</li> <li>To complete a comparison of the national specialist palliative care service specifications (draft) and stocktake of services for each rural area as defined above.</li> <li>Following the stocktake and development of the role delineation model describe the detail aspects of the model in relation to referral processes, support systems and processes, participation and interaction between services / providers of the different levels of the role delineation model.</li> <li>Strengths, weaknesses and opportunities analysis (SWOT analysis).</li> <li>Final report with recommendations for future service development.</li> </ol>
<b>Target Population</b>	<p>Target Population:</p> <ul style="list-style-type: none"> <li>Waikato district palliative care patients and family / whānau who are eligible to receive palliative care.</li> </ul> <p>Specialist palliative care providers:</p> <ul style="list-style-type: none"> <li>Waikato District Community Hospice Trust.</li> <li>Palliative Care Unit, Health Waikato, Waikato DHB.</li> </ul> <p>Generalist palliative care providers:</p> <ul style="list-style-type: none"> <li>Tokoroa District Community Hospice.</li> <li>Rural Hospitals (Thames, Te Kuiti, Tokoroa, Taumarunui, Matariki &amp; Rhoda Read).</li> <li>Waikato DHB Community Services – Family Health Teams.</li> <li>General Practice teams.</li> <li>Non-Government Organisations i.e. Rest homes, Māori health providers, True Colours, Canteen, Child Cancer, Cancer Society.</li> <li>Non-cancer services i.e. renal, motor neurone disease.</li> </ul>
<b>Timeframe, Resources and Project Structure</b>	<p><b>Completion Criteria - 30 June 2008</b></p> <p>A stock take of Waikato Rural palliative care services available from Rural hospitals and / or Family Health Teams and the links with primary, community and specialist palliative care services is completed and a role delineation model developed. A final report is published with recommendations for future service delivery.</p>

## **Roles, Responsibilities and reporting**

The Project Sponsor reports to the Waikato DHB Executive Sponsor.

- The Project sponsor will take a leadership approach to ensure the success of the project and will make decisions and address and resolve escalated project issues. The manager Rural Services will Chair the Project Working Group.

The Waikato Palliative Care Operations Network ('Network') reports to the Waikato DHB Executive Sponsor.

- The Network will monitor and evaluate project progress to ensure alignment with the Strategic Plan, provide expert advice and support as required to the Working Group.

The Project Lead reports to the Project Sponsor.

The Project Lead will be a member on the Project Working Group and will facilitate and coordinate the project through a 'hands on' approach to ensure achievement of the project aim and objectives.

- The Project Lead will facilitate meetings, manage correspondence (electronically) and reporting. The Project lead will prepare a monthly project brief on progress and key issues.
- The Project Lead will ensure that there is a more detailed project brief for each phase and will produce an end of phase report.
- There will be monthly progress report to the Project Sponsor and the Waikato Palliative Care Operations Network.
- The Project Lead will produce an end of project report (no later than two months after the completion of the pilot project and no later than 30 June 2008).

The Working Group reports to the Waikato Palliative Care Operations Network via the Project Sponsor.

- The Working Group members are responsible for ensuring that they are prepared and respond within agreed timeframes.
- The Working group members on request must make themselves available to the Project Lead to ensure that the project objectives and tasks are achieved.
- The Working Group members are responsible for attending meetings and representing their service, organisation, professional views.
- The Working Group will make recommendations to the Waikato Palliative Care Operations Network.

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## **Reducing inequalities**

There is considerable evidence of inequalities in health between socio-economic groups, ethnic groups, genders and people living in different geographical regions. The Waikato District Strategic Plan identifies four population priorities; people of low socio-economic status; Māori; Pacific people and older persons and in addition improving child and youth health.

The Waikato DHB HNA, The Waikato Palliative Care Strategic Project Steering Group Report (2005) and the Waikato Cancer Control Review and Analysis (2006) identifies information in terms of the burden of cancer for Māori in terms of ethnic disparities in cancer risk, incidence and outcomes.

Cancer is a leading cause of morbidity and mortality among Māori and there are disparities between Māori and non - Māori in relation to the incidence, mortality rates and utilisation of cancer services. Research into access to cancer services for Maori identified three broad categories of factors influencing Māori access; health system level, health care process factors and patient level factors.

The cancer burden in New Zealand is also unequally distributed according to socio-economic status. The Māori and Pacific peoples disparity is significantly worse than for the Waikato district overall.

The Waikato Palliative Care Strategic Project, Steering Group Report (2005) identified a number of issues affecting access to palliative care for Māori (p26). The increasing concentration of Māori living in deprived areas requires attention to reducing health disparities and ensure access and Māori preference for services.

He Huarahi Oranga<sup>5</sup> has been written in line with the pathways in He Korowai Oranga<sup>6</sup>.

To ensure inequalities are being addressed and reduced, the Health Equity Assessment Tool (HEAT) will be applied to Waikato DHB policy and funding decisions.

<b>Stakeholders</b>	<ul style="list-style-type: none"> <li>• Waikato District Community Hospice Trust</li> <li>• General practice teams</li> <li>• Tokoroa Community Hospice</li> <li>• Waikato Palliative Care Operations Network</li> <li>• Palliative Care Unit, Health Waikato, Waikato DHB</li> <li>• Waikato Rural Services (Rural Hospitals and Continuing Care Hospital's &amp; Family Health teams)</li> <li>• Generalist palliative care providers (primary and community based palliative care services)</li> <li>• Palliative care nurses working for specialist palliative care providers</li> <li>• Waikato Clinical Records Committee</li> <li>• Waikato Regional Referral Centre</li> <li>• Waikato Legal and Risk Service</li> <li>• Waikato DHB Planning &amp; Funding service</li> <li>• Te Puna Oranga (Māori Health Service)</li> </ul>	
<b>Information Services (IS) Implications</b>	At this point in time there are minimal implications for IS in regard to this project.	
<b>Key milestones and timeline</b>	<p>20 August 2007 – 30 June 2008</p> <p>Establishment of the Rural Hospital manager's project working group.</p> <p>Completion of the stock take of rural palliative care services</p> <p>Development of the role delineation model</p> <p>Completion of the final report with recommendations for the future delivery of services</p>	
<b>Financial Summary</b>	<p><b>One time cost</b></p> <p>One off funding support from the Waikato DHB Cancer Control/ Palliative Care Target 2007/08 funds as approved by the Waikato DHB Executive Group 4th June 2007.</p> <p><b>Ongoing cost</b></p> <p>N/A at this point in time, ongoing funding costs will be identified in the final report</p> <p><b>Cost Savings</b></p> <p>The development of a rural services delineation model will reduce duplication of services and provide more efficient and effective visits in the community and reduce unnecessary hospital visits.</p>	
<b>Risk management</b>	<p><b>The key risks:</b></p> <p>Teams unable to work collaboratively</p> <p>Bringing together of different organisational cultures requiring staff to work collaboratively and as a team</p>	<p><b>Key risk mitigation:</b></p> <p>Key stakeholders identified and strategies to ensure appropriate engagement and mutual recognition of each organisations value.</p> <p>Key stakeholders identified and strategies to ensure appropriate engagement and mutual recognition of each organisations value</p> <p>Communication plan</p> <p>Staff communication, education and</p>

<sup>5</sup> Waikato DHB Strategic Maori Health Plan

<sup>6</sup> Ministry of Health, 2001. He Korowai Oranga: NZ Maori Health Strategy

Project not completed within timeframe due; to limited resources; staff not ready for change; unforeseen issues; distraction from external sources due to interest in project

development programme to support  
Process developed to identify, investigate and resolve issues during the project  
Workable sized project team, focused and committed  
Full change management protocols and processes used during project  
Communication and consultation process with key stakeholders  
Risk register including mitigation strategies  
Communication of project methodology and results released to outside parties once project complete

**Risks we are exposed to if we do not proceed with the project.**

The risk of not proceeding with this project is with this project is not meeting the Waikato

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**Constraints**

The key area of constraint with regard to this project is time and resources.

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**Communication Plan**

- Six weekly working group meetings and individual contacts with key people
- Monthly Waikato Palliative Care Operations Networks meeting
- Monthly progress reports
- Project lead
- Final report

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**Sign-off  
(signatures  
required)**



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Jan Hewitt, Project Sponsor  
Manager, Midland Cancer Network

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## Appendix b – project linkages

### **Waikato palliative collaborative care project**

In 2006 the Waikato palliative care network endorsed the review of the collaborative care nursing model between district nursing services, Hospice Waikato and the palliative care unit. There were numerous quality recommendations. The review identified that Waikato had four palliative care community nursing models within the Waikato. In January 2008 a project officer was employed to facilitate implementation of the recommendations. This project has strong links and overlaps with the collaborative care review recommendations, these are summarised in the Waikato Palliative Care Progress Report 2008; Action Plan 2008-09.

### **Waikato DHB 24/7 After Hours Plan**

The Ministry of Health requires all DHBs to have a plan outlining the approach to providing sustainable after hours primary health care in their districts.

The Waikato DHB 24/7 After Hours Planning and Funding Strategy (2008) acknowledges the large rural population and need to develop strategies and activities that enable accessible, effective and resilient after hours primary health care services for all service users. In essence the rural hospitals are responsible for overnight primary after hours service.

Strategies in relation to the palliative care after hours plan are included in the recommendation section of this report.

### **New Zealand Specialist Palliative Care Service Specifications**

New national specialist palliative care service specifications describe minimum service levels and identify key areas of specialist services that should be provided. The specifications also include common national definitions. There are three new service components that have a strong link to the rural hospitals and community based services project, these are:

- Last days of life programme (refer to LCP section below).
- Education programme for generalists and support services.
- 24/7 telephone advice and support for generalist providers (refer to specialist palliative care after hours medical and nursing service to generalists for advice and support project section below).

### **LCP**

The Waikato palliative care operations network endorsed the LCP implementation plan. 2007-08 roll out plan included implementation to a number of areas, however in relation to this report LCP implementation roll out included Thames Hospital and community based services, GP and residential facilities within the Thames-Coromandel district. Progress on implementation is summarised in the Waikato Palliative Care Progress Report 2008; Action Plan 2008-09. Findings of this project have been considered for the 2008-09 Waikato palliative care operations network action plan.

### **Waikato specialist palliative care advice service nursing and medical project**

The Waikato Palliative Care Strategy Plan recommended a specialist palliative care medical out of hours on-call service for generalist health providers. This has been achieved with the employment of a third palliative care consultant. Implementation of LCP is dependant on links with specialist palliative care providers.

The Strategy Plan and the collaborative care review recommended a project to develop a specialist palliative care nursing after hour's telephone consultancy service for generalist health providers. A pilot project has run parallel to this project, with Hospice Waikato providing the after hours telephone service. Findings and recommendations on the pilot is summarised in the Waikato Palliative Care Progress Report 2008; Action Plan 2008-09. The key link is that the rural hospitals and community based services have after hours access and links to specialist palliative care nursing and medical services.



### **Professional development of cancer and palliative care nurses**

The palliative care and cancer nursing education working group was established by the Ministry of Health to plan the improvement of professional development for nurses in the palliative care and cancer specialities. A proposal (28/10/08) is out for consultation to establish dedicated nursing professional development leadership roles for palliative care and cancer specialities within each regional cancer network.

Such positions would support the development of palliative care nursing workforce in the Waikato rural hospitals and community based services.

## Appendix c – Waikato DHB rural hospitals morbidity and mortality data

### Waikato DHB - Rural Hospitals - Morbidity and Mortality Data

Source : Costpro

#### **Qualifications :-**

ICD-10-Diagnosis code : Z515

ICD-10-Diagnosis description : **Palliative care**

Time frame : Between 2003 and 2007

Hospitals : 4811, 5011, 5313, 5323, 5330 and 5331

Discharge Type : DD (Discharge Deceased) or DO (Dead - Sustained for organ donation)

Count of epEpisodeNo	Years					
Hospital	2003	2004	2005	2006	2007	Grand Total
Matariki				4	8	12
Rhoda Read				1	4	5
Te Kuiti	7	6		1	2	16
Thames	3	30	11	14	13	71
Tokoroa	4	8	5	3		20
Taumarunui	2	3	1	1	1	8
Grand Total	16	47	17	24	28	<b>132</b>

### Oncology patients - Rural Hospitals - Morbidity and Mortality Data

#### **Qualifications :-**

ICD-10 broad group : C00-D48

ICD-10 broad group description : **Neoplasms**

Time frame : Between 2003 and 2007

Hospitals : 4811, 5011, 5313, 5323, 5330 and 5331

Discharge type : DD (Discharge Deceased) or DO (Dead - Sustained for organ donation)

Count of epEpisodeNo	Years					
Hospital	2003	2004	2005	2006	2007	Grand Total
Matariki				22	28	50
Rhoda Read				9	29	38
Taumarunui	23	28	21	24	28	124
Te Kuiti	14	27	27	25	20	113
Thames	79	88	55	84	71	377
Tokoroa	18	37	15	37	32	139
Grand Total	134	180	118	201	208	<b>841</b>

The Waikato palliative care strategic project steering group report referred to the health needs of specific population groups and the changing demographics. Waikato rural population are defined<sup>7</sup> as people residing in areas that have less than a population of 10,000. This means the entire Waikato district excluding Hamilton, Cambridge, Te Awamutu and Tokoroa zones and is currently 40% of the Waikato DHB population.

For the 40% of the Waikato population living in rural and remote Waikato there are greater access issues for palliative care and support services, however many people prefer to be cared for in their own home. Health care in rural settings is provided by primary practitioners, who require support to ensure quality palliative care. Primary health practitioners may not be required to provide palliative care very often, and the shortage of health professionals in rural areas has a major impact on access and delivery of health services. The Waikato Strategy Plan was cognisant that people in rural areas need to:

- Receive effective front line care in their own community wherever possible.
- Flexibility to organise palliative care services around the patient and family/whānau needs.
- Support the rural workforce to develop and maintain palliative care knowledge and skills.
- Build capability and capacity of local communities and offer greater certainty about access to palliative care services.

People with disabilities will often require more support care and resources such as equipment and flexible packages of support to maintain them in their home and support family/whānau.

The majority of people requiring palliative care are older people. Approximately 80% of the Waikato DHB palliative care patients are aged 65 years or more and the growth of older people is projected to continue. The prevalence of cancer and multiple comorbid chronic disease conditions is higher among older people. With changes in the structure of the population, families are smaller and often more dispersed, resulting in fewer family members able to provide support and care. People dying in residential care may increase because of the ageing population and less support due to changing family structure (Edwards, Hirst, 2005). The number of deaths occurring in residential / continuing care facilities is increasing and it is anticipated that with increasing awareness of services, older people will increasingly access palliative care services.

Inequalities in the use of specialist palliative care were identified in Australia (University of Western Australia, 2004) as the following:

- People over 84 years
- Women
- Indigenous population
- People living in rural and / or remote areas
- People who were most socio-economically disadvantaged.

The review was unable to identify all palliative patients discharged from the Waikato rural hospitals. The numbers of deaths per facility are small in total.

In summary in planning for enhancing palliative care services within the rural hospitals and community services consideration needs to incorporate the key population themes and characteristics which are:

- Growth in ageing population with increasing numbers of cancer and multiple comorbid chronic disease conditions
- Changes in the rural family structures coupled with the ageing and declining specialist workforce and limited access to supporting services

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<sup>7</sup> The Waikato DHB Health Needs Assessment and Analysis 2005

- Increasing concentration of Maori living in rural deprived areas, requiring extra attention to ensure access and preference for service
- Increased number of deaths in residential / continuing care facilities.

## Appendix d – essential elements in a palliative care service system

Services	<b>Essential elements in a palliative care service system (work in progress)</b>
<b>Rural hospitals</b>	<ul style="list-style-type: none"> <li>• Acute assessment.</li> <li>• Ensure the availability to refer to specialist services as required for assessment and periodic review.</li> <li>• Guaranteed 24 hour access to support and advice from specialist palliative care service in all settings.</li> <li>• Regular contact between specialist and generalist palliative care providers to support processes and reinforce timely and appropriate referral patterns.</li> <li>• Access to education about symptom control and supportive care.</li> <li>• Seamless service availability with timely transitions from one service to another.</li> <li>• Care coordination processes to ensure patient and family / whānau needs and wishes are met.</li> <li>• Emergency after hours services including availability of medication for district nurses caring for patients in their homes.</li> <li>• Inpatient admission for complex medical cases that exceed the level of care of generalist providers' (e.g., symptom control).</li> <li>• Outpatient services that support generalist specialty services such as cardiac, renal.</li> <li>• Access to allied health services, occupational therapists, physiotherapists, social workers (inpatient and community).</li> </ul>
<b>District nursing services</b>	<ul style="list-style-type: none"> <li>• Home visit.</li> <li>• Assessment.</li> <li>• Care coordination.</li> <li>• Collaborative care with Hospice Waikato.</li> <li>• Clinical care 24/7 if required.</li> <li>• Graseby pump management.</li> <li>• Arrange through DSL and/ or other sources: <ul style="list-style-type: none"> <li>✓ equipment</li> <li>✓ personal care</li> <li>✓ respite care</li> <li>✓ meals on wheels</li> <li>✓ home help</li> </ul> </li> </ul> <p><b>NB/ In Hamilton, Cambridge and Ngaruawahia home based clinical nursing care is primarily provided by Hospice Waikato.</b></p>
<b>Disability Support Service (DSL)</b>	<ul style="list-style-type: none"> <li>• Administers fund for respite care and end of life care (less than 6 weeks).</li> <li>• Administers fund for carer relief.</li> </ul>
<b>General Practice services</b>	<ul style="list-style-type: none"> <li>• Assessment.</li> <li>• Clinical management using palliative approach.</li> <li>• Care coordination.</li> <li>• Provide patients and family / whānau with information on how to access medical assistance after hours.</li> <li>• Home visits entitlement (Waikato Primary Health).</li> <li>• Formal links with specialist palliative care for purposes of referral, consultation, education and 24/7 support and advice.</li> <li>• Continues to have involvement in the patients care throughout the patient's illness.</li> <li>• Identifies advanced care plans with patient and family.</li> </ul>
<b>Rest homes</b>	<ul style="list-style-type: none"> <li>• Provide respite care.</li> <li>• Provide palliative end of life care (less than 6 weeks).</li> <li>• Formal links with specialist palliative care for purposes of referral, consultation, education and 24/7 support and advice.</li> </ul>



<b>Hospice collaborative care nurses</b>	<ul style="list-style-type: none"> <li>• Home visit.</li> <li>• Assessment.</li> <li>• Emotional support for patients and their families through illness, dying and bereavement.</li> <li>• Provision of high quality information materials for patients and families.</li> <li>• Access to volunteers.</li> <li>• Access to Biographers.</li> <li>• Service links with Rainbow Place for supporting children.</li> <li>• Access to community based equipment.</li> </ul>
<b>Hospice Waikato</b>	<ul style="list-style-type: none"> <li>• Out of hours i.e. 1700 to 0830 specialist nursing advice and support service.</li> <li>• Carer and pump education packages in collaboration with specialist palliative care service.</li> </ul>
<b>Specialist Palliative Care unit</b>	<ul style="list-style-type: none"> <li>• Interdisciplinary team including a medical director, clinical nurse consultant and clinical nurse practitioners.</li> <li>• Formalised liaison and educator to acute hospital, aged care and community for the Liverpool Care pathway implementation.</li> <li>• Provide assessment and periodic review complex care needs ongoing care in conjunction with the primary health care provider.</li> <li>• Outreach clinics and home visits by clinicians and clinical nurse specialists</li> <li>• End of life care pathway (LCP) facilitator.</li> <li>• Support and advice for generalists in normal working hours.</li> <li>• 24/7 telephone access to specialist palliative care advice and support service.</li> <li>• Education for generalists.</li> <li>• Formalised liaison position with residential aged care facilities.</li> <li>• Ward 25, support for known palliative care patients and family / whānau.</li> </ul>
<b>Key practice principles</b>	<ul style="list-style-type: none"> <li>• Every palliative care provider should be able to identify a full network of specialist palliative care providers (medical, nursing, allied health), bereavement support, psychological support, advice and consultation even if not in close geographical proximity.</li> <li>• An identified MDT is in place to assist the patient and family in dealing with the end of life issues, including bereavement support.</li> <li>• Clear communication channels exist between the patient/families and care providers.</li> <li>• Agreed referral processes are in place between services discharging to palliative care services, both generalist and specialist.</li> <li>• Planned patient care includes 24 hour access to appropriate advice or service provision to respond to emergency or crisis situations.</li> <li>• Respite care exists in the patient's home or in an appropriately skilled inpatient unit or day respite facility.</li> <li>• Ensure the availability of formalised access to medication and equipment in an anticipatory way.</li> </ul>

## Appendix e – current strengths and weaknesses

*Key themes of SWOT analysis of the Rural Hospitals and community based services of Taumarunui, Te Kuiti, Thames and Tokoroa and continuing care facilities Matariki and Rhoda Read are as follows.*

### **Strengths are:**

#### *Access to essential services*

- Committed and dedicated staff
- Staff have a passion and willingness to improve palliative care services
- Good working relationships between PCU and DNS in all rural areas
- PCU provide outreach clinics and home visit as necessary
  - Thames - weekly
  - Tokoroa - monthly
  - Te Kuiti – monthly
  - Taumarunui – CNS monthly, consultant 2 monthly – as of July 2008 monthly

#### *Assessment*

- Well organised, pre-empted discharge planning from the Waikato Hospital Medical CNS/ and social worker
- Effective discharge includes fax prior to discharge highlighting additional equipment needs, medications and other medical needs such as colostomy cares
- Discharge planning guidelines have been developed both by the PCU and Waikato hospital medical unit
- Paediatric Shared Care Model in place with Starship Hospital

#### *Care coordination*

- DNS provides 24/7 cover in the rural communities
- Strong relationships between Thames/Coromandel DNS and aged care facilities through Age Wise Hauraki network meetings
- Thames hospital social work service have developed and implemented a Family satisfaction survey regarding local palliative care service

#### *Clinical Care*

- Specialist palliative care after hours nursing and medical telephone advice service for generalists(GPs, DNS, rest homes and rural hospitals)
- Waikato Hospice collaborative care nursing service expanded to cover the Waikato district (except Tokoroa)
- A generalist multidisciplinary working group has been in place in Thames hospital for the last 2 years with the aim of improving systems and processes for the care of palliative patients, particularly addressing the stream lining of patients between the inpatient and community services
- Thames hospital and community have developed processes for:
  - After hours access to emergency medication is available to district nurses via the hospital emergency department. A documented procedure for dispensing has been developed
  - A fast track admission form has been implemented in ED for known palliative patients
  - A bright pink cover sheet in the front of palliative patients charts indicates to staff that the patient is receiving care from the PCU
  - A discharge checklist for palliative patients between hospital and community services has been developed
  - The community Liverpool care pathway training has been delivered to DNS in Thames in March 2008. LCP was established in Thames Hospital inpatient units in September 2007, 80% of staff educated. Post implementation audit completed, waiting on an audit report from Liverpool.

- 24/7 cover by district nurses in the rural regions, including the management of Graseby pumps
- DNS and rural hospital inpatient wards report very effective relationships with the Waikato Palliative Care Unit
- Regular education forums are held by the PCU with DNs, hospital staff, practice nurses and GPs attending in most areas
- A monthly Hospice national network phone conference is well attended by GPs, practice nurses, community and hospital staff in Thames
- Thames DNS report that they are well supported by DSL
- Generalist palliative care multidisciplinary meetings are held in Te Kuiti and Taumarunui
- Thames area have developed data base of equipment available and criteria for allocation from the Thames community cancer support group
- Communities continue to support fund raising for palliative projects, e.g. equipment or other resource e.g. Te Kuiti hospital have utilised funds to decorate and make comfortable the hospital palliative care patient and family areas
- Te Kuiti hospital utilise the palliative care booklet for patients and families. Visits by the DN and PCU consultant are recorded in this booklet
- PCU consistently refer to Waikato Hospice collaborative care nurses
- The Clinical Nurse Director (CND), Primary assists nurses to identify gaps in the standards of care for patients and coordinate a streamlined approach to service delivery
- The CND, Primary has worked with the DNS in Tokoroa to support them in training the rest home staff to manage Graseby pumps as required
- Clinical Nurse Specialist, Gerontology to be appointed. This position will identify quality initiatives to improve standards of care in aged residential care facilities and assist the sector to develop sustainable solutions

**Weaknesses are:**

*Access to essential services*

- Variation and fragmentation of services across the district
- Differences in roles, responsibilities and relationships due to the historical establishment and development of palliative care in the district
- Variation in practice, systems and processes
- DSL Quality process recommendations (2006) not implemented

*Assessment*

- Poor discharge planning to rural communities from some clinical areas at Waikato hospital
- Thames DNs perception is that there is a lack of information on many referrals from Waikato hospital about the medical condition and patients needs
- Inadequate consideration from Waikato hospital discharge area regarding the time required to put in place support services, for example home help and equipment
- No crisis care plan on discharge from hospitals, which leaves patients and families/whanau unsure who to contact if needed in the transition between services
- Patients with a palliative diagnosis are not always referred to DNs by hospital outpatient services as they do not have a specific medical need at that time
- As a consequence DNs are sometimes contacted by families for advice out of hours when in a crisis situation as they have had no referral to another service (families know the DN in the district)
- Duplication of effort and development of systems with no standardisation across the district eg. Separate discharge checklist developed by Thames, PCU, and Medical ward
- All good but all different

- Referrals received too late, the patients death is imminent neither patient or family/whanau are known to the provider, for example GP to DNS or DNS to Waikato Hospice (Collaborative care)
- PCU deliver monthly palliative care education sessions in Tokoroa hospital, local GPs do not attend education sessions
- Tokoroa Hospice coordinator does not know of these sessions and has not met the PCU staff who hold Tokoroa clinics
- The Genesis Oncology Lecture series provided by Hospice NZ is not known to all stakeholders across the district
- Not all providers are involved in multidisciplinary meetings and some are either hospital focused or community focused
- DNS time being used educating rest homes on how to manage pumps
- Lack of knowledge of services and resources for young people with cancer/chronic illness
- Education and training for generalist providers on palliative care tends to be more self managed rather than a formalised response from the organisation
- Lack of a consistent involvement and referral to collaborative care, Hospice service and subsequent communication for those shared patients and families
- Lack of consideration of bereavement support for spouses and families following a death and discontinued involvement with the district nursing service
- Collaborative care terminology confusing to patients and families as a concept

#### *Support services*

- Continued difficulty in accessing night relief support throughout the district
- Difficult to access equipment for those patients who are palliative for longer than 6 months.