

# The relevance of psychosocial indicators in community palliative care: A pilot study

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## KEY WORDS

Psychosocial indicators, community palliative care,  
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## ABSTRACT

### Objective

The objective is to discuss a framework in psychosocial care in community palliative care and the outcomes of a pilot study. This study adds to the existing body of knowledge in palliative care especially in psychosocial aspects of community care.

### Design and Setting

Prior to pilot testing the psychosocial indicators for use in community palliative care, a twelve item framework in psychosocial care was developed and validated using the Delphi technique and group consensus from ten experts in community palliative care. The study setting was the community palliative care services consisting of multidisciplinary health professionals.

### Subjects

A purposive sample of six participants comprising of palliative care nurses and allied health professionals participated in the pilot study. Using the psychosocial framework in community palliative care participant views on what constitutes psychosocial care in community palliative care was determined. Interview transcripts were the data sources that informed the pilot study.

### Main outcome measure

The main outcome was the pilot study results validating the psychosocial framework consisting of 12 indicators in community palliative care. The study findings demonstrate the appropriateness of psychosocial indicators discerning patient and caregiver needs in community palliative care. All participants in the pilot study independently confirmed evidence of the 12 psychosocial indicators in their practice.

### Conclusion

The pilot study shows that by incorporating psychosocial care in community palliative care improves decision making in the terminally ill. The implication for practice is that psychosocial aspects of palliative care can indicate patient's care needs leading to better satisfaction.

## INTRODUCTION

This paper reports the outcomes of a pilot study undertaken to establish the relevance of a framework in psychosocial care in community palliative care. Rapid improvements in health and longevity are recognised as dramatically changing the burden of illness throughout the world. In developed countries changes in life style and improvements in the treatment of major causes of morbidity have aged the population and increased the prevalence of chronic diseases (Higgins 1999).

The ageing of the Australian population will continue into the future with the proportion of people aged 65 years and over projected to increase between 26% and 28% of Australia's population by 2051 (Australian Government Department of Health and Ageing 2000). The proportion of younger people is projected to decrease from 20% in 2004 to between 13% and 16% by 2051. These population projections are similar to other western countries. Both the United States of America (USA) and the United Kingdom for example, project a doubling of their populations over 65 year olds by 2050.

The ageing population in Australia will affect Australian economic social systems (Australian Bureau of Statistics 2006). This change will of course include the health sector, although at present there seems to be no consensus as to the extent to which the health sector will be affected (Richardson and Robertson 1999).

The National Health Priority Areas have identified health areas in Australia through a combined government effort, which contributes significantly to the burden of illness and injury. The current priorities cover chronic disease which includes the top 10 causes of disease burden in Australia. These are arthritis and musculoskeletal conditions, asthma, cancer, cardiovascular health and diabetes mellitus (National Health Priorities Area 2005).

A study of hospital costs in New South Wales for older people in the last years of life (Kardamanidis et al 2007) found that the number of days spent in hospital and inpatient costs increased sharply in the

three months before death. The study confirmed that a major part of the end of life morbidity burden was carried shortly before death. The study concluded that, 'population ageing is likely to result in a shift of the economic burden of end-of-life care from the hospital sector to the long-term care sector, with consequences for the supply, organisation and funding of both sectors' (Kardamanidis et al 2007).

End-of-life care is a social, economic, and political problem (Friedenberg 2003). Our health system is still generally focused on dealing with crises and health problems through short and poorly integrated or coordinated interventions. This approach is hospital and illness oriented rather than individual or community oriented. With the increase in chronic illness and its associated incidental needs for high levels of care and unpredictable disease projections, death or recovery is no longer easy to predict. Patients with chronic illnesses go through cycles of hospitalisation, followed by home care and eventually into palliative care (Brumley et al 2003).

## MULTIDISCIPLINARY COMMUNITY PALLIATIVE CARE

Inherent in a multidisciplinary palliative health care team approach is a team that embraces principles of holistic care, with its inclusion of all types of psychosocial care as well as physical care (Palliative Care Australia 2003; 2005b). The unit of care is the whole person, both the patient and significant others, with the quality of life being the goal (Edith Cowan University et al 2004). Multidisciplinary teams involved with palliative care include medical, nursing and allied health professionals (including social workers) as well as other providers such as chaplains and pastoral care workers. Team work across disciplines is essential in palliative care and good teams can accomplish more than the sum of their individual contributions (Crawford and Price 2003).

Much of the literature reviewed has been based on the premise that health costs in the future will be unsustainable as the population ages. By their very

nature chronic diseases are not cured completely and need to be managed. Chronic diseases remain in a person's life and this affects the quality of life. In the USA health spending figures are expected to rise from current expenditure by 15% in 2010 to 60% by 2050 compared with current levels mainly due to the increasing prevalence and cost of chronic disease (Glasgow Orleans and Wagner 2001). The authors make the point that much of this cost due to the ageing population could be saved through the effective prevention and management of chronic diseases in the community. There is evidence that older people use hospital in-patient services more and use more health services generally. Increasing health costs in the USA are of great concern especially when access to health services and treatment is largely dependent on the ability to pay for medical insurance. In the USA, Collins et al (2006) found that an increasing number of people aged 50 to 64 years and older had high rates of chronic health conditions as well as inadequate medical insurance, all affecting their access to health care.

In Australia it was found that the rate of older Australians using the services of general practitioners was more than double that of younger people and those rates increased with age (Older Australians at a glance 2007). Hospital costs increase with age with Australians 65 years and over representing 35% of all hospital visits. Length of stay in hospitals also increased with age accounting for 48% of in hospital patient days for older people (p.115). Hospitals in general though are a major part of Australia's healthcare system accounting for over a third of recurrent health expenditure.

Figures in Australia show that hospital expenditure for the treatment of chronic diseases accounts for 48% of all expenditure in the National Health Priority Areas. Spending on acute or crisis care for chronic diseases is a major proportion of the expenditure on Australia's health. With an increase in the incidence of chronic health, this expenditure can only increase over time. Hospitalisation rates for people aged between 65 and 84 are double the rate for those aged between 25 and 64 years of age. For those

people over 85 the rate triples (Australia's Health 2008, p. 265). It is reported that the total allocated health expenditure increased five times for 25 - 64 years of age with costs rising sharply for older people over the ages of 64 (p. 412).

Although life limiting diseases and conditions occur across the generations and sexes, the increase of an ageing population does affect the use of medical care, services and facilities. Australian statistics show that for older Australians chronic diseases requiring varying periods of medical care and eventual end-of-life care that cause the greatest burden. The ageing population and increasing health care costs challenges the sustainability of existing models of care for chronic diseases and eventual end-of-life care in an era where more and more individuals wish to be cared for in the community by their loved ones. Research is needed to investigate quality indicators in psychosocial care within the community context, in particular because inherent in community palliative care is psychosocial care and there is a need to determine the notion of 'quality' from the perspective of palliative care professionals as has been proposed in this study.

The literature shows that end-of-life patients' preference is to die at home. Higginson and Sen-Gupta (2000) in a systematic review of the literature found that between 49% and 100% of the respondents in various studies wanted a home death. The review showed that home care was the most common preference with inpatient hospice care as second. Community palliative care may become increasingly more relevant as the number of elderly people living with a serious chronic illness increases (Rabow et al 2004).

Current palliative care provision has grown out of the hospice movement of providing a place of hospitality at the end of life. In the USA palliative medicine as a specialty is not established to the same extent as in the United Kingdom and Australia (Kuebler et al 2005). 'Hospice at home' is a term often used for the provision of palliative care in a home setting. In the USA, the hospice model has been mainly a home based provision (Kuebler et al 2005). In Canada the

term 'hospice palliative care' is used to indicate, "... the convergence of hospice and palliative care into one movement that has the same principles and norms of practice" (Ferris 2002). Changes to the World Health Organisation definition of palliative care have produced changing views over the years, and developments both in Australia and elsewhere have been ad hoc (Bruera and Sweeney 2002, Currow and Nightingale 2003, London et al 2005).

The Gold Standards Framework for community palliative care was developed to assist consistent and high quality palliative care in the United Kingdom (King et al 2005, Munday et al 2007, Walshe et al 2008). The framework presents guidelines, mechanisms and assessment tools for community palliative care. It consists of a three step model of good practice for practitioners to identify their palliative care patients, assess their needs and plan care to support those needs. The framework centres on seven key areas that need to be addressed to provide good holistic care. They are: communication, coordination, control of symptoms, continuity, continued learning, carer support and care of the dying. While these seven key areas are important for good palliative care, the framework does not include those aspects of psychosocial care that are vital for holistic care. These aspects include counselling consistent with quality of life issues, advanced directive in palliative care, cultural, religious and spiritual support for patients and families, supporting the patients, and their families and caregivers through grief, loss and bereavement. The pilot study reported in this paper set out to validate the psychosocial indicators for use in community palliative care from the perspective of health professionals.

## AIM

The aim of this research was to (1) determine indicators of psychosocial care in community palliative care that are accepted as the norm by health professionals; (2) identify gaps in perceptions related to indicators of psychosocial care from those health professionals whose practice currently involve community palliative care.

## RESEARCH QUESTION

How important are the psychosocial indicators in articulating patient's needs in community palliative care?

## METHOD

Two key aspects of the study are discussed under methods; the Delphi technique which preceded the validation of psychosocial indicators in community palliative care and the pilot testing of the psychosocial framework.

Delphi method was used in this study as a research tool to investigate the relevance of psychosocial indicators for use in community palliative care prior to the pilot study. Delphi was considered the most appropriate because this method allows identifying the most important issues of interest by soliciting qualified experts (Okoli and Pawlowski 2004; McKenna 1994; Williams and Webb 1994; Strauss and Zeigler 1975), specifically for determining indicators of psychosocial care in community palliative care. As a tool Delphi was useful in attaining expert independent thought in the gradual formation of expert opinion. A diversity of viewpoints was represented in the expert panel of 10 members made up of practitioners, organisations, academics and specialists in the field selected for the task. The panel while anonymous to each other was not anonymous to the researcher.

Following the interrogation of the literature, concepts in psychosocial care in community palliative care informed the first round of questions to the panel of experts. The first round of questions in the Delphi process to the expert panel was circulated by email and was framed as; in your opinion how important are the psychosocial care aspects in community palliative care for the practice of health professionals? Please consider the following concepts presented as representing psychosocial care in community palliative care. Do these concepts adequately represent a view of community palliative care as perceived by health professionals? What other concepts would you like to include in psychosocial aspects of community palliative care?

Included in the expert group were medical specialists, clinical nurses, palliative care coordinators, bereavement counsellors and hospital chaplains involved with palliative care patients and their families. Following this process, a second tool based on the experts' responses to the first tool was administered to the panel which required them to revise the list of concepts presented as holistic aspects of psychosocial care in community palliative care. In addition, they were asked to rank these according to importance and add or eliminate less important concepts from the list which resulted in a psychosocial framework being put forward. Next, the experts were required to revise their responses to the set of questions and answer other questions pertaining to the triggers (see appendix 1) supporting each of the 12 items.

The expert group's input in to the Delphi process was valuable in developing the interview tool on psychosocial indicators for use in community palliative care and these experts in palliative care communicated via email with the researcher. For example, symptom management was suggested to be included by one of the reference group members following the first round which was subsequently framed as comfort and enhancing quality of life through symptom management which gained the group's consensus. Following the second round advanced care directives issues in palliative care; supports patient, family and caregiver through grief, loss and bereavement; care support following death were included in psychosocial indicators which gained group consensus. The process was repeated once more to include three rounds whereby a consensus was reached by the expert panel on the psychosocial indicators in community palliative care, and the order in which these were ranked and used in the design of the health professional interview tool. Following is a response justifying the inclusion of the above from a hospital chaplain who participated in the Delphi process; we shouldn't rule out cultural, religious and spiritual support to the patient and the family although they may not ask about these matters directly. Comforting family members and caregiver

following death is a primary concern to me and I think all aspects of psychosocial care we have agreed upon are important, our mandate is to provide holistic care in psychosocial community palliative care and I wouldn't rule out anything from this list.

The purpose of the health professional interview tool was to develop a framework consisting of indicators in psychosocial aspects of community palliative care deemed useful in articulating psychosocial care. The expert panel was asked to validate the researchers' interpretation and categorisation of these indicators. Because the expert panel is not anonymous to the researcher the process provided opportunity to follow up for clarification of the data which resulted in accepting the indicators as evident in psychosocial aspects of care in community palliative care.

These psychosocial indicators in community palliative care can assist in determining care that is accepted as the norm by health professionals in caring for palliative care patients and their families.

Purposive sampling was used to select the study participants and the criteria for participation were: exclusively working in community palliative care, in a multidisciplinary team, caring for patient and family (caregiver) at the time of study. Following institutional ethics approval six participants were chosen for the pilot study and in-depth interviews were conducted with them using the Psychosocial Indicators tool. The interview setting was the community palliative care services. The interviews were conducted during 2007 with the participants that lasted approximately 90 minutes with each individual. They were also asked to discuss any gaps in perceptions related to psychosocial care from their practice perspective. Each participant carefully reflected on their practice during the conversation with the researcher.

## DATA AND ANALYSIS

A qualitative interpretive approach was used to analyse the data in the pilot study. The study sample consisted of six participants comprising of nurses and allied health professionals in community palliative care. Interview transcripts with the six participants comprise the study data.



The interviews were digitally recorded with the permission of participants which were later transcribed. The participants were given the opportunity to review the interview transcripts for accuracy. The data analysis process employed sequential conceptual steps and a pattern of analysis to identify and categorise the data (themes) by combining associated data and patterns into meaningful units according to the relatedness to the psychosocial framework. Following these processes sub-themes were identified and a determination was made as to how these related to patterns and themes in synthesising several small themes. For example, participants when considering question 9 (Appendix 1) reflected on symptoms including spiritual distress. The interview process allowed the researcher to probe as necessary for further information from the participants and allowed for the documentation of comments and or other points during interview enabling the researcher to make a judgment about the psychosocial care indicators in community palliative care. These indicators were considered necessary in determining care that was accepted as the norm by participants and by which actual attainments were judged.

Ultimately, a comprehensive view in formulating participants' perspectives confirmed the following psychosocial indicators.

1. Professional practice
2. Communicating with patient and caregiver/s on palliative care and end-of-life issues
3. Comfort and enhancing quality of life through symptom management
4. Effective counselling approaches consistent with quality of life issues
5. Ethical issues in palliative care
6. Advanced directive in palliative care
7. Cultural, religious and spiritual support for patient and family
8. Supporting patient, family and caregiver through grief, loss and bereavement
9. Care and support following death
10. Palliative care team support
11. Professional and personal development of palliative care team members
12. Evidence based practice in palliative care

The following interview extracts are presented to illustrate how some participants explored the relevance of psychosocial indicators to their practice. They were unanimous in their opinion that professional practice underpins psychosocial aspects of care in community palliative care. As one participant suggested; *I believe professional practice should be the beginning point when we talk about quality in psychosocial care. I would like to see all of these indicators used to determine psychosocial aspects of care as my practice is informed by all of them* (clinical nurse).

A medical practitioner suggested the following by stating; *I would suggest that symptom management is crucial as this is integral to psychosocial care because you can't separate the physical from the patient's psyche; it is the holistic aspects of care that results in quality psychosocial care.*

A bereavement counsellor who is also a social worker spoke of their experience in supporting the patient, family and the caregiver through grief, loss and bereavement. *We need to be mindful of the parameters of normal and abnormal grief and be prepared to refer the client to other resource people so that they get the best possible care. I think the list of triggers in the interview tool sums this up for me.*

There was overwhelming support from the small group of participants in the pilot study for the indicators of psychosocial aspects of care as determinants of community palliative care. As a palliative care coordinator who participated in the pilot study reflected; *the framework you have derived is highly relevant to our work and I believe that all 12 aspects of psychosocial care offer a framework for practitioners. I can't think of anything else to add to the list. I believe the triggers were useful in focusing on specific aspects during interview which ensured we did this in a systematic way by validating how we go about achieving these care indicators.*

## DISCUSSION

The study findings confirm that the indicators of psychosocial aspects of care are important determinants of community palliative care. Data from the in-depth interviews conducted with the participants revealed that all 12 psychosocial indicators were evident in community palliative care practice. Moreover, the participants were able to relate to each of these indicators stating that these were representative of their practice. In their opinion, the 12 psychosocial indicators inherent in their practice were accepted as the norm by the health professionals who participated in the pilot study. Interestingly, they did not describe any gaps in perceptions related to the psychosocial indicators from their practice. Consequently, no new psychosocial indicators emerged from the practice of six participants who participated in this study, which included a palliative care clinical nurse (RN), a palliative care coordinator (RN), social worker, bereavement counsellor, hospital chaplain and a medical practitioner.

Comparisons were made between the findings from the interview data generated on the 12 indicators from participants to determine congruence. The literature was interrogated against the data to validate psychosocial indicators in community palliative care (previously ratified by the expert group). The participants in the pilot study did not identify new indicators in psychosocial care that might be considered as important in their practice. When questioned about other possible areas that might be included in psychosocial care that might extend the 12 indicators they responded by stating these indicators inclusively illustrated their practice and they were unable to suggest otherwise. The end result was the confirmation of 12 indicators representing a psychosocial framework accepted as the norm by which actual attainments of care are judged by health professionals. The study findings demonstrate the appropriateness of psychosocial care in discerning community palliative care from health professionals' perspectives.

The Gold Standards Framework (2005) for community palliative care was developed to assist consistent and high quality palliative care in the United Kingdom based on seven key areas to be addressed to provide good holistic care. The pilot study reported herein goes beyond the seven key areas of the Gold Standards Framework. It is inclusive of other areas which address advanced directives, bereavement, and cultural, religious, spiritual support for patient and family, ethical issues in palliative care, care and support following death, and evidence based practice in palliative care. The study reported in this paper was borne out of the need to develop a comprehensive set of indicators that best represent the psychosocial aspects of community palliative care that might constitute holistic practice to which health professionals could relate.

Naturally, as a pilot study this research set out to identify psychosocial indicators of community palliative care from the perspective of a small group of participants. This preliminary work needs to be developed to incorporate a large sample as well as patient and carer opinions on the usefulness of psychosocial aspects in determining best practice from the end-user perspective. A major study is planned in collaboration with health services responsible for delivering community palliative care to enable research outcomes to translate into service delivery initiatives.

## LIMITATIONS

The sample was necessarily small in the pilot study and the focus was limited to health professionals. There is a need for meaningful performance indicators in psychosocial aspects in community palliative care to be determined through best practice guidelines ensuring that services match patient's care needs. This can only be achieved through the involvement of end-users and health professionals in determining what constitutes best practice. This was not possible to achieve in a pilot study where the focus was limited to developing and trialling a framework to determine psychosocial indicators of community palliative care among nurses and allied health professionals.

## CONCLUSION AND RECOMMENDATIONS

In summary, it is evident that the national palliative care strategy framework (2000) for service development is increasingly relevant to community palliative care involving multidisciplinary health professionals because of partnerships involved in planning and service delivery, and policy development which are essential for service coordination. Palliative Care Australia (2005) released a national policy document on palliative care service development calling for an adoption of a population based approach. This study is timely given the developments in the national palliative care strategy 2000 and 2005 planning and service delivery, and partnerships in policy development initiatives.

Importantly, the Palliative Care Australia submission to the Prime Minister's 2020 Summit (2008) called for meaningful performance indicators to ensure that services match patient's care needs by asserting that "to create a new and better reality for quality care at the end of life, health planning and financing must rank palliative care as a priority area for adequate funding, facilitate enhanced care services to support 'dying-in-place', and attach meaningful performance indicators to ensure that services match patients' care needs and, where possible, their care preferences".

In this paper the author has expressed a need for meaningful indicators in psychosocial aspects of care in community palliative care ensuring that services match patient's care needs. Further work is necessary to develop a model of best practice through the input of health professionals and end-users which has relevance and the likelihood to influence health and research policy in palliative care. A larger study is planned to be conducted involving health services, multidisciplinary health professionals, patients and their carers in the near future.

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### Psychosocial Indicator in Community Palliative Care 1

Professional practice

Q1. How do you maintain professional practice in palliative care?

Demonstrates professional practice standards in palliative care:

Triggers	Checks
Utilising knowledge of advanced illness coupled with palliative care to inform a comprehensive assessment of patient's needs	
Integrates Legal, Ethical and professional issues of informed choice, consent and empowerment in practice.	
Prime resource for providing advice, information and support to team members	
Independent in seeking positive outcomes for patients.	
Actively seeks new knowledge innovations for change	
Other points made:	

### Psychosocial Indicator in Community Palliative Care 2

Communicating with client, family and care givers on palliative care and end of life issues

Q2. How do you make your communication effective and appropriate?

Communication is effective and appropriate and involves patient, family and caregiver about:

Triggers	Checks
Disease Trajectories	
Treatment effects	
Therapeutic Care impacting patient, family and caregiver	
Relationships with patient, family and caregiver and health professionals	
Helping with personal or psychological matters	
Other points made:	

### Psychosocial Indicator in Community Palliative Care 3

Comfort and enhancing quality of life through symptom management

Q3. How do you ensure comfort for the patient and family to enhance quality of life through symptom management?

Enhances comfort and quality of life:

Enhances comfort and quality of life.		
<b>Triggers</b>		<b>Checks</b>
Supports patient and family		
Anticipates changes in patient's condition and informs the palliative care team		
Consults with specialist support services		
Monitors client condition and takes appropriate action.		
Utilises therapeutic support intervention on symptom management		
<b>Anticipates the following symptoms:</b>	<b>Checks</b>	<b>Anticipates the following symptoms:</b>
Pain management		Nausea and vomiting
Dyspnoea		Anxiety
Emergencies		Constipation
Fatigue		Anorexia
Oral Hygiene		Depression
Spiritual Distress		Other
Initiates social support to meet the needs of patient and family		
Demonstrates knowledge of benefits/financial support		
Provides care and support for caregiver		
Offers practical support		
Utilises community support agencies		
Other points made:		

**Psychosocial Indicator in Community Palliative Care 4**

Utilises effective counselling approaches consistent with quality of life issues

Q4. How do you maintain a client-centred approach consistent with quality of life issues ?

Utilises a client-centred approach that fosters genuineness, unconditional positive regard for the client and family and reflects accurate empathy:

Triggers	Checks
Shows genuine concern	
Communication with family and others about grief, impending death and bereavement	
Shows empathy	
Unconditional positive regard for all	
Exercising information judgement	
Providing clarity of information	
Other points made:	

**Psychosocial Indicator in Community Palliative Care 5**

Ethical issues in palliative care

Q5. How do you engage in ethical decision making in palliative care?

Engages in ethical decision making process:

Triggers	Checks
Anticipates ethical issues impacting patient, family and caregiver	
Understands ethical decision making process	
Anticipates ethical dilemmas	
Utilises a consultative process in ethical decision-making	
Manages pain ethically	
Other points made:	

**Psychosocial Indicator in Community Palliative Care 6**

Advance directive issues in palliative care

Q6. How do you take care of advance directive issues in palliative care?

Considers advance directive issues:

Triggers	Checks
Working knowledge of advance directives	
Consults with team members including medical practitioner	
Discusses advance directive with patient, family and caregiver exercising judgement on information given	
Full documentation of patient and family wishes	
Implements advance directive as appropriate	
Other points made:	

**Psychosocial Indicator in Community Palliative Care 7**

Cultural, religious and spiritual support for patient and family

Q7. How do you provide cultural, religious and spiritual support to the patient and the family?

Considers cultural, religious and spiritual support to the patient and the family:

Triggers	Checks
Cultural, religious and spiritual needs discussed with patient and family	
Displays cultural sensitivity	
Accommodates cultural practice	
Understands the importance of cultural procedures/rituals	
Uses knowledge of different cultural groups in order to anticipate specific needs of patient and family	
Supports patient and family to engage in observance of actions and procedures of the ceremonial activities	
Other points made:	

**Psychosocial Indicator in Community Palliative Care 8**

Supports patient, family and caregiver through grief, loss and bereavement

Q8. How do you support the patient, family and the caregiver through grief, loss and bereavement?

Provides support in grief, loss and bereavement:

Triggers	Checks
Recognises distinction between normal and abnormal grief	
Acknowledges the support boundaries and makes appropriate referral	
Possesses comprehensive knowledge of bereavement services	
Uses advanced counselling skills	
Draws on coping and support strategies	
Refers appropriately to other agencies and services	
Acts as a bereavement care resource provision	
Other points made:	

**Psychosocial Indicator in Community Palliative Care 9**

Care and support following Death

Q9. How do you support the family and caregiver following death?

Comforts family and caregiver following death:

Triggers	Checks
Preparation of family and caregiver for imminent loss	
GP involvement	
Procedure following death discussed	
Funeral director's involvement	
Completion of necessary documentation	
Considers bereavement support and counselling	
Attendance at funeral	
Initiate bereavement support	
Provides care for family and caregiver/s	
Other points made:	

**Psychosocial Indicator in Community Palliative Care 10**

Palliative care team support

Q10. How do you foster palliative care team support?

Facilitates team support:

Triggers	Checks
Acts as a change agent	
Participates in case conference	
Evidence of decision-making to reflect the changing patient/family situation	
Cognizant of variety of services available	
Identifies limits of service provision	
Generates proposals for service development	
Collates and uses health data to inform policy and health care practice	
Other points made:	

**Psychosocial Indicator in Community Palliative Care 11**

Professional and personal development of palliative care team members

Q11. How do you ensure the professional and personal development of palliative care team members?

Promotes professional and personal development through consultation and research:

Triggers	Checks
Peer consultation	
Empowerment of colleagues	
Understands the research process	
Draws on research literature	
Engages in research	
Contributes to knowledge capital (palliative care)	
Considers funding opportunities	
Engages in reflexive thought	
Other points made:	

**Psychosocial Indicator in Community Palliative Care 12**

Evidence based practice in Palliative Care

Q12. How do you utilise evidence based practice in palliative care?

Demonstrates an awareness in evidence based practice in palliative care:

Triggers	Checks
Draws on General and discipline specific professional issues knowledge base in palliative care	
Understands principles of research and EBP	
Acts as a resource on different approaches to palliative care	
Uses EBP as a rationale for prescribed care	
Understands implications and limitations	
Engages in efficient and effective resource management	
Engages in critical self-evaluation through reflection and analysis.	
Utilises research findings	
Supporting evidence on recording/documentation available	
Other points made:	