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The Caring Communities Evaluation
Tool Kit: A compendium of tools to aid
in the evaluation of palliative care
projects

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the evaluation of palliative care
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Introduction

This Tool Kit is part of the Caring Communities Palliative Care (CCP) Evaluation Strategy. It will allow evaluation assessment at the project level (see Evaluation Framework on pages 2 and 3 below). The tools are designed to assess the impact and outcomes of palliative care for 'consumers' (patients, families, carers, friends, communities) and providers (professionals and volunteers), as well as the impacts on the system as a whole (ie, structures and processes, networks, relationships) in a way that is systematic across the program.

The CCP Evaluation Framework and the Tool Kit were initially discussed at the first national CCP workshop held in Canberra in May 2003. Following feedback from that workshop, each of the tools was field tested during the period June 2003 to November 2003 and the final versions included in this tool kit are based on the results of those field tests. The CHSD gratefully acknowledges the assistance of the various CCP projects that assisted us in the field tests.

The proposed use of each tool is set out in the table on page 4.

Guidelines for each of the tools are included in the section starting on page 4. Each tool described in the toolkit has been developed on the basis of the best evidence available on its reliability and validity. The tools are expected to prove useful in assisting the Caring Communities Program projects to monitor their impacts and manage their activities.

The tool kit aims to achieve a greater commonality in the approaches to measuring activities within the different projects. The extent to which common tools can be used across projects with similar aims will assist the program as a whole to achieve a better picture of the generalisability of the findings of individual projects to the larger field of the palliative care community.

Caring Communities Evaluation Framework

The Caring Communities Program Evaluation involves the evaluation of the Caring Communities Program and the 37 different Projects that have been funded within the Program.

The one evaluation framework is being used for both the program-level and the project-level evaluations. This evaluation framework is shown below. The next page shows the framework at the project level.

EVALUATION HIERARCHY	What did you do? PROJECT DELIVERY	How did it go? PROJECT IMPACT	Can you keep going? PROJECT SUSTAINABILITY	What has been learnt? PROJECT CAPACITY BUILDING	Are your lessons useful for someone else? PROJECT GENERALISABILITY	Who did you tell? DISSEMINATION
Level 1	Impact on, and outcomes for, consumers (patients, families, carers, friends, communities)					
<i>Baseline, Process & Outcome Indicators</i>	▪ Project level	▪ Project level	▪ Project level	▪ Project level	▪ Project level	▪ Project level
Level 2	Impact on, and outcomes for, providers (professionals and volunteers)					
<i>Baseline, Process & Outcome Indicators</i>	▪ Project level	▪ Project level	▪ Project level	▪ Project level	▪ Project level	▪ Project level
Level 3	Impact on, and outcomes for, the system (structures and processes, networks, relationships)					
<i>Baseline, Process & Outcome Indicators</i>	▪ Project level ▪ Program level	▪ Project level ▪ Program level	▪ Project level ▪ Program level	▪ Project level ▪ Program level	▪ Project level ▪ Program level	▪ Project level ▪ Program level

Caring Communities – Project-Level Evaluation Framework

EVALUATION HIERARCHY	What did you do? PROJECT DELIVERY	How did it go? PROJECT IMPACT	Can you keep going? PROJECT SUSTAINABILITY	What has been learnt? PROJECT CAPACITY BUILDING	Are your lessons useful for someone else? PROJECT GENERALISABILITY	Who did you tell? DISSEMINATION
Level 1 Impact on, and outcomes for, consumers (patients, families, carers, friends, communities)						
<i>Baseline, Process & Outcome Indicators</i>	<ul style="list-style-type: none"> ▪ Project Schedules & plans ▪ Project Progress reports 	1.1 Patient / client palliative care stage of illness data set 1.2 Patient / client experiences – patient questionnaire 1.3 Patient / client experiences – staff-completed questionnaire 1.4 Carer experiences with palliative care 1.5 Community awareness of palliative care 1.6 Community awareness: remote ATSI communities	4. Sustainability Tool	5. Capacity Building Tool	6. Generalisability Tool	7. Dissemination log
Level 2 Impact on, and outcomes for, providers (professionals, volunteers, organisations)						
<i>Baseline, Process & Outcome Indicators</i>	<ul style="list-style-type: none"> ▪ Project Schedules & plans ▪ Project Progress reports 	2.1 Palliative care providers 2.2 Volunteers currently working in palliative care 2.3 New palliative care volunteers 2.4 People ending their time as a palliative care volunteer 2.5 Health professionals not working in palliative care services 2.6 Health workers in remote Aboriginal communities	4. Sustainability Tool	5. Capacity Building Tool	6. Generalisability Tool	7. Dissemination log
Level 3 Impact on, and outcomes for, the system (structures and processes, networks, relationships)						
<i>Baseline, Process & Outcome Indicators</i>	<ul style="list-style-type: none"> ▪ Project Schedules & plans ▪ Project Progress reports 	3.1 Palliative care service self-assessment 3.2 General organisation survey 8 System level impacts and outcomes of the Caring Communities Project	4. Sustainability Tool	5. Capacity Building Tool	6. Generalisability Tool	7. Dissemination log

Numbers indicate standard evaluation tools developed by the National Evaluation Team (NET) for use by local projects. All projects will use tools 4, 5, 6 and 7. Tool 8 is optional but projects are strongly encouraged to use it at the end of the project. Use of tools for evaluating impact and outcomes for consumers (tools 1.1-1.6), providers (tools 2.1-2.6) and system (tools 3.1-3.2) is optional and is being resolved on a project by project basis.

Caring Communities Evaluation Tool Kit – guidelines for each tool

No	Tool	Source	Proposed use*
1. Impact on and outcomes for consumers (patients, families, carers, friends, communities)			
1.1	Patient / client palliative care stage of illness data set	AAHPC (PCA)	Optional - as decided by project
1.2	Patient /client experiences – patient questionnaire	Modified from The Patient Outcome Scale (Higginson, I) and the McGill QoL Scale (Cohen R)	Optional - as decided by project
1.3	Patient /client experiences – staff-completed questionnaire	Modified from The Patient Outcome Scale (Higginson, I) and the McGill QoL Scale (Cohen R)	Optional - as decided by project
1.4	Carer experiences with palliative care	1 st section by CHSD based on interviews with carers in the GAPs project. 2 nd section are from the NSW/Qld ONI tool	Optional - as decided by project
1.5	Community Awareness of Palliative Care	CHSD	Optional - as decided by project
1.6	Community Awareness: Remote Aboriginal and Torres Strait Islander Communities	Wendy Scott, Kimberley Region Palliative Care Service, Broome, WA and CHSD	Optional - as decided by project
2. Impact on, and outcomes for providers (professionals and volunteers)			
2.1	Palliative Care providers	Promoting Excellence in End-of-Life Care (modified by the CHSD)	Optional - as decided by project. It is suggested that Palliative Care providers in the local area be asked to complete twice – in the first half of the project and at project end. Providers who resign or leave the area throughout the project to also be asked to complete
2.2	Volunteers currently working in palliative care	CHSD	Optional - as decided by project
2.3	New Palliative Care Volunteers	CHSD	Optional - as decided by project
2.4	People ending their time as a Palliative Care Volunteer	CHSD	Optional - as decided by project
2.5	Health Professionals Not Working in Palliative Care Services	CHSD	Optional - as decided by project
2.6	Health Workers in Remote Aboriginal Communities	Wendy Scott, Kimberley Region Palliative Care Service, Broome, WA and CHSD	Optional - as decided by project
3. Impacts on the system (structure and processes, networks, relationships)			
3.1	Palliative Care Service Self-Assessment	US Center to Advance Palliative Care (modified by the CHSD)	Optional - as decided by project
3.2	General health care organisational survey	CHSD	Optional - as decided by project
4	Sustainability Tool	Modified from: Hawe H, King L, Noort M, Jordens C and Lloyd B. NSW Health indicators to help with building capacity	To be completed at project start and end by projects going 12 months. To be completed at start, mid point and end by projects going over a

No	Tool	Source	Proposed use*
		in health promotion (January 2000) NSW Department of Health	year
5	Capacity Building Tool	CHSD	To be completed at project start and end by projects going 12 months. To be completed at start, mid point and end by projects going over a year
6	Generalisability Tool	CHSD	To be completed at project start and end by projects going 12 months. To be completed at start, mid point and end by projects going over a year
7	Dissemination Log	CHSD	Each project to set up own system and provide a copy in the 6 monthly progress report
8	System level impacts and outcomes of the Caring Communities Project	Modified from the NSW HACC Comprehensive Assessment Pilots by the CHSD	Optional - as decided by project. It is suggested that Palliative Care providers in the local area to be asked to complete at project end. Providers who resign or leave the area in the last year of the project to also be asked to complete.

Please consult a member of the Evaluation team if in doubt about any of the above tools.

How to use the tools

The following is a guide for each tool in the kit. The guide briefly outlines the purpose of the tool, when it should be used, and how to administer the tool.

Evaluation Level 1 **Impact on and outcomes for consumers (patients, carers, friends, communities)**

Tool 1.1 Patient / client palliative care stages of illness data set

Purpose

Palliative care phase is a clinical tool that measures a patient's stage of illness. It comprises five stages: stable, unstable, deteriorating, terminal and bereaved. Definitions of each phase and a Phase Change Validation flowchart are provided with the tool. When used in conjunction with the definitions of each phase, the flowchart provides clinicians with a systematic method of correctly assigning palliative care phases.

The Palliative Care Problem Severity Scale, the Karnovsky Rating Scale and the Resource Utilisation Groups/Activities of Daily Living (RUG-ADL) score provide additional functional, psychosocial and symptom severity information relating to each palliative care phase. These tools allow a complete clinical profile of the patient/client to be established.

When will the tools be used?

Palliative care phase should be reviewed at each visit. The Palliative care phase, Palliative Care Problem Severity Scale, the Karnovsky Rating Scale and RUG-ADL should be administered each time there is a change in palliative care phase.

How to administer this tool?

The palliative care phase should be assigned based on an overall assessment of the patient/clients condition. Formal training in the use of the Palliative Care Problem Severity Scale, the Karnovsky Rating Scale and RUG-ADL is not required.

Tool 1.2 AND 1.3 Patient / Client experiences – patient questionnaire & staff- completed questionnaire

Purpose

This tool is based on the Patient Outcome Scale (POS). The original POS was devised following a systematic review of outcome measures used in palliative care. This review concluded that there was a paucity of clinical questionnaires that could adequately reflect the holistic nature of palliative care (Hearn & Higginson, 1997). The POS was designed to overcome some of the limitations associated with existing outcome measurement scales in palliative care. It evolved using a literature review of measures, work by a multi-professional project group with individuals who worked in different palliative care settings and a patient representative. The POS was then piloted in hospice, home, hospital and other community settings. The questionnaire covers: physical symptoms, psychological symptoms, spiritual considerations, practical concerns, emotional concerns and psychosocial needs.

When will the tools be used?

The tool will be used by projects with a focus on improving the outcomes for palliative care patients in an active phase of their engagement with a service provider. It should be only used by those projects with a suitable level of ethical approval for administering the questions to patients under the care of a palliative care service.

How to administer these tools?

There are two versions of the questionnaire, one for patients to complete and the other for staff. Bringing together these two complementary perspectives allows the POS to identify patient's problems and enables staff to provide individualised care. It is a flexible tool, the usage of which can be determined by the needs of local services.

The POS showed acceptable validity when used in a variety of settings, such as, home care, hospice in-patient and day care and hospital inpatient care as well as outpatient and community services. It has also been shown to be a credible, clinical, research and audit tool, which is acceptable to both patients and staff (Hearn & Higginson, 1999). The POS can be used routinely to guide clinical practice and monitor service interventions. Moreover, the POS is a valuable audit tool that can help meet the current statutory requirements on clinical governance.

The CHSD has modified the POS for the CCP by deleting the original question 11 in the scale and substituting it with a question from the McGill Quality of Life Scale (Cohen 1997). CHSD has renamed these tools as the Patient/Client Experiences – patient questionnaire and the Patient/Client Experiences – staff-completed questionnaire.

Tool 1.4 Carer experiences with palliative care

Purpose

The items in this tool were developed as a result of work with the patients and carers involved with the Griffith Palliative Care Service (GAPS), they were field tested by CHSD. These items are supplemented with items from the QLD/NSW ongoing needs assessment tool.

How to administer this tool

This tool is designed to be used with a carer while they are looking after the patient rather than retrospectively. It is designed to be brief and simple in order to minimise respondent burden.

When using this tool it is essential that you advise the carer that their participation is voluntary, their responses are confidential and that their responses will not effect the quality of the service they receive. Ethical permission will be needed to elicit information on the experiences of carers.

Tool 1.5 Community Awareness of Palliative Care

Purpose

The purpose of this tool is to obtain an understanding of general community awareness of palliative care in the communities where projects have a focus on influencing organisations and individuals not directly concerned with palliative care activities and services. This focus might include awareness raising in local community service agencies, schools, sporting or recreational clubs or in organisations or business groups that might find information on palliative care to be relevant to their activities, such as funeral directors or solicitors with an interest in advance care directives.

When will the tool be used?

The tool will be best used before and after some form of promotional activity, media campaign or after specific presentations by speakers. Ideally the tool might be administered a second time in a form of 'follow up' approach after a suitable period of time has elapsed from a campaign being undertaken, to see what impact might have been made.

How to administer this tool?

The tool would be used in a survey style approach in a local community, targeted at people who are intended to have some exposure to the educational or promotional material.

Tool 1.6 Community Awareness: Remote Aboriginal and Torres Strait Islander Communities

Purpose

The purpose of this tool is to obtain an understanding of general community awareness of palliative care in Aboriginal communities. It was developed through a review of the literature and through consultation with agencies who have experience in providing palliative care to Aboriginal communities. The tool has been field tested in a remote Aboriginal community and the results indicate that the language and concepts included in the tool are appropriate and understandable.

When to use this tool?

This tool is designed to be exploratory and can be used from the time that work begins with Aboriginal communities. Given the nature of the consultation process, and the developing network of contacts that evolve, it may be necessary to re-visit this tool throughout the duration of the project.

How to administer this tool?

These questions are designed to be used as a guide for community discussions, small group and individual interviews. It may be necessary to work with a local community member or translator to ensure that there is understanding of the concepts in the tool. Palliative care may be a concept that is not widely understood in some communities. Each question has a series of prompts that help the person leading the discussion or interview to obtain the information that is desired.

Evaluation Level 2

Impact on and outcomes for providers (professionals and volunteers)

Tool 2.1 Palliative Care Providers

Purpose

This tool is designed to assess the level of knowledge and awareness of palliative care of Palliative Care Providers who are working in specialist palliative care services. It also assesses their attitudes and confidence of providing palliative care in their profession.

When will the tools be used?

This tool is ideal for before and after comparisons in an attempt to gauge how awareness, attitudes, confidence and knowledge may have changed during the life of the project.

How to administer this tool?

This questionnaire is designed to be brief to minimise disruption to busy professionals. It can be administered either face to face or it can be sent to individuals to complete themselves.

Tool 2.2 Volunteers currently working in palliative care

Purpose

This tool is designed to explore the perceptions and experiences of volunteers currently working in palliative care. It asks volunteers about their motivations to become involved in palliative care, their training, and how long they expect to continue in this role.

How to administer this tool?

This tool can be administered to volunteers at any stage of their involvement. It could be administered during a regular volunteers' meeting or opportunistically with individuals. It is important to advise the respondents their participation is voluntary and that their responses will be treated confidentially.

Tool 2.3 New Palliative Care Volunteers

Purpose

This tool is designed for people who are beginning their time as palliative care volunteers. It explores their understanding of palliative care, their perceptions of the role of volunteers in palliative care and their expectations of being a volunteer.

How to administer this tool

This tool should be administered to newly recruited volunteers, and could be administered during a training session. It is important to advise the respondents their participation is voluntary and that their responses will be treated confidentially.

Tool 2.4 People ending their time as a Palliative Care Volunteer

Purpose

This tool is designed for people who are completing their time as a palliative care volunteer. It asks them about their experience of being a volunteer and if the experience corresponded with the expectations they had. The tool also asks volunteers to provide a reason for discontinuing their services.

How to administer this tool

This tool can be administered as part of an exit interview with volunteers who are discontinuing their service. It is important to advise respondents that their participation is voluntary and that their responses will be treated confidentially.

Tool 2.5 Health Professionals Not Working in Palliative Care Services

Purpose

This tool is designed to assess the level of knowledge and awareness of palliative care of health professionals who are not working in specialist palliative care services, for example General Practitioners.

When will the tools be used?

This tool is ideal for before and after comparisons in an attempt to gauge how awareness and involvement may have changed during the life of the project.

How to administer this tool?

This questionnaire is designed to be brief to minimise disruption to busy professionals. It can be administered either face to face or telephone interview or it can be sent to individuals to complete themselves.

Tool 2.6 Health workers in remote Aboriginal communities

Purpose

This tool evaluates the level of confidence and familiarity that health workers in remote Aboriginal communities have in the delivery of palliative care. It may be used with clinic staff (both Aboriginal and non-Aboriginal), Aboriginal Health Workers, GPs, aged care providers, and people responsible for health education and promotion in the community.

The tool was developed through a review of the literature and through consultation with agencies that have experience in providing palliative care to Aboriginal communities. The tool has been field tested in a remote Aboriginal community and the results indicate that the language and concepts included in the tool are appropriate and understandable.

When to use this tool?

This tool is designed to be exploratory and can be used from the time that work begins with Aboriginal communities. Given the nature of the consultation process, and the developing network of contacts that evolve, it may be necessary to re-visit this tool throughout the duration of the project.

How to administer this tool?

These questions are designed to be used as a guide for discussions with health workers in the community and may be used for small group and individual interviews. It may be necessary to work with a local community member or translator to ensure that there is understanding of the concepts in the tool. Palliative care may be a concept that is not widely understood in some communities. Each question has a series of prompts that help the person leading the discussion or interview obtain the information that is desired.

Evaluation Level 3 Impacts on the system (structure and processes, networks, relationships)**Tool 3.1 Palliative Care Service Self-Assessment****Purpose**

This tool is a modified form of an instrument called 'Supportive Care of the Dying: A Coalition for Compassionate Care Organisational Assessment: System Grid and Assumptions' developed by The Center to Advance Palliative Care. The modifications made by CHSD involve slight changes to the language used in the tool to make it appropriate for use in an Australian setting.

The objective of this tool is stated by the developers as:

- ◆ to provide a tool for organisations and systems to use as they assess themselves looking at supportive structures which make it possible to deliver outstanding services and are not unintentionally maintaining structures that inhibit such services.

The system assessment tool will allow organisations to self-rate their structures as supportive, inhibitive, or not present. Given this rating, they will also be able to self rate their own perception of actual effectiveness in assisting to meet the stated objective or outcome. This self-analysis, along with data from patients, families, bereaved families, and professionals, will assist organisations to target interventions for rapid cycle improvement. Systems may not personally offer specific services or programs, but have a method in place to refer persons in a manner that maintains continuity of care.

How to administer this tool

The tool is designed to be completed during a meeting or group discussion. The designers estimate that the process requires 2-4 hours and suggest that it should be done in at least 2 different sessions. This could be done with existing committees, eg, palliative care committees, ethics committees, quality committees, etc., or could be done as a structured focus group within your organisation. Every effort should be made to include direct care providers with much experience in caring for those affected by life-threatening illness as well as those direct care providers with little experience..

Tool 3.2 General organisational survey**Purpose**

This tool is designed to capture information about the level of awareness and involvement that a particular organisation has about palliative care.

When will the tools be used?

This tool is ideal for before and after comparisons in an attempt to gauge how awareness and involvement may have changed during the life of the project.

How to administer this tool?

Ideally this tool is completed during a team meeting, and as a result reflects a consensus of opinion among the team. In the case of individuals with opinions that are very different to the rest of the group it is possible for them to complete the tool alone. It is important to indicate in the box provided which method was used.

Tool 4 Sustainability tool

Please note that it is compulsory for all projects to complete this tool at least twice:

- In the case of projects with a life of 12 months this form should be completed twice, at project commencement and at project completion.
- In those projects lasting 18 months the form should be completed three times, at project commencement, after 12 months and at project completion.
- In those projects lasting 24 months the form should be completed three times, at project commencement, after 12 months and at project completion.
- In those projects lasting 36 months the form should be completed three times, at project commencement, after 18 months and at project completion.

Purpose

This tool has been developed to assess the organisational and system level impact of your project and is about your project's sustainability (keeping going the projects goals and objectives).

When will the tools be used?

This tool will be used at the beginning of the project, at a midpoint and at the end. It is very important to rate your project **as it is now**, and not how you want it to be at some point in the future. Therefore at the beginning of the project it is likely that there may be a greater proportion of lower scores or answers of "don't know" than there will be at the mid and end points of the project.

What can this tool tell us?

This tool will be useful in indicating whether there have been any changes in the factors affecting the sustainability of your project's activities in support of its goals or objectives over time.

Tool 5 Capacity Building tool

Please note that it is compulsory for all projects to complete this tool at least twice:

- In the case of projects with a life of 12 months this form should be completed twice, at project commencement and at project completion.
- In those projects lasting 18 months the form should be completed three times, at project commencement, after 12 months and at project completion.
- In those projects lasting 24 months the form should be completed three times, at project commencement, after 12 months and at project completion.
- In those projects lasting 36 months the form should be completed three times, at project commencement, after 18 months and at project completion.

Purpose

This tool has been developed to help assess the organisational and system level impact of your project and is about your project's ability to build capacity (developing skills and knowledge to do the job in local systems).

When will the tools be used?

This tool will be used at the beginning of the project, at a midpoint and at the end. It is very important to rate your project **as it is now**, and not how you want it to be at some point in the future. Therefore at the beginning of the project it is likely that there may be a greater proportion of lower scores or answers of "don't know" than there will be at the mid and end points of the project.

What can this tool tell us?

This tool will be useful in indicating whether there have been any changes over time in the ability of your project to build the capacity for local systems to provide good quality palliative care.

Tool 6 Generalisability tool

Please note that it is compulsory for all projects to complete this tool at least twice:

- In the case of projects with a life of 12 months this form should be completed twice, at project commencement and at project completion.
- In those projects lasting 18 months the form should be completed three times, at project commencement, after 12 months and at project completion.
- In those projects lasting 24 months the form should be completed three times, at project commencement, after 12 months and at project completion.
- In those projects lasting 36 months the form should be completed three times, at project commencement, after 18 months and at project completion.

Purpose

This tool has been developed to assess the organisational and system level impact of your project and is about your project's generalisability (developing lessons that are useful for others).

When will the tools be used?

This tool will be used at the beginning of the project, at a midpoint and at the end. It is very important to rate your project **as it is now**, and not how you want it to be at some point in the future. Therefore at the beginning of the project it is likely that there may be a greater proportion of lower scores or answers of "don't know" than there will be at the mid and end points of the project.

What can this tool tell us?

This tool will be useful in indicating whether there have been any changes in the generalisability of the lessons from your project over time.

Tool 7. Dissemination Log

Purpose

The dissemination log is a record of how information about a particular CCP project is shared with others; both within the CCP community and beyond. The log asks for information about the following dissemination activities: the person or organisation who was responsible for the dissemination, the date of the activity, the estimate of the number of people affected by the activity and an indication of the number of people who requested follow up information.

How to administer this tool?

The log should be updated after each dissemination activity and should be included with the six monthly report.

Tool 8 System level impacts and outcomes of the Caring Communities Project

Purpose

This tool is designed to assess the wider impacts that a particular Caring Community Project has on the local palliative care system. The first part of this tool asks individuals or agencies to assess how the project influenced the way they delivered services and how the project went for clients with special needs. The second part of the tool examines the inter-agency and system effects of the project. It contains a range of attitudinal statements addressing factors such as perceptions of team work, communication between agencies and so on.

When will the tools be used?

This tool should be used during a period close to the completion of the Caring Communities Project as it asks people to make their assessment based on their knowledge of the project as a whole and the changes it engendered.

How to administer this tool?

Ideally this tool is completed during a team meeting, and as a result reflects a consensus of opinion among the team. In the case of individuals with opinions that are very different to the rest of the group it is possible for them to complete the tool alone. It is important to indicate in the box provided which method was used.

The Caring Communities Program Evaluation Tools

CCP Evaluation Tool 1.1

Patient/client palliative care stage of illness data set

Name
Unique Record Number
Date of birth dd/mm/yyyy ____/____/____ or affix label here

	Date of Phase or Phase Change	PC Phase	Reason for phase change	PC Pain Score	PC Other Symptom Score	PC Psych/Spiritual Score	PC Family/Carer Score	RUG ADL Score at start of Phase				Karnofsky Score
								Bed Mobility	Toilet	Transfer	Eating	
Initial Phase												
1 st Phase change												
2 nd Phase change												
3 rd Phase change												
4 th Phase change												
5 th Phase change												
6 th Phase change												
7 th Phase change												
8 th Phase change												
9 th Phase change												

PALLIATIVE CARE (PC) PHASES

- | | | |
|--------------------|-------------------------|--------------------|
| 1 - Stable Phase | 3 - Deteriorating Phase | 5 - Bereaved Phase |
| 2 - Unstable Phase | 4 - Terminal Care Phase | |

Reason for Phase Change

- | | | | |
|------------------|----------------------------|----------|---------------------------|
| 1 - Phase change | 2 - Discharge/case closure | 3 - Died | 4 - Bereavement phase end |
|------------------|----------------------------|----------|---------------------------|

PALLIATIVE CARE (PC) PROBLEM SEVERITY SCORE

PC Pain

The degree of overall pain symptoms.

PC Other Symptom

Record the degree of overall other symptoms. The following list may be used as a guide:

Nausea/vomiting, anorexia, itch/irritation, constipation/diarrhoea, wound/ulcer, dysphagia, incontinence, weakness/fatigue, oedema, dyspnoea, confusion/delirium.

PC Psychological/Spiritual

Record the score for overall degree of psychological/spiritual problems of the patient. The following list may be used as a guide:

Anxiety/fear, anger, unrealistic goals, agitation, request to die, depression/sadness, confusion.

PC Family/Carer

Record score for the overall degree of family/carer problems. The following list may be used as a guide:

Denial, care giver fatigue, unrealistic goals, anger, difficult communication - non-English speaking-sensory impairment, financial, family/carer conflict, legal, family/carer anxiety, accommodation, cultural.

FOR ALL (PC) PROBLEM SEVERITY ITEMS SCORE: 0-absent 1-mild 2-moderate 3-severe

RUG-ADL SCORE

For bed mobility, toileting & transfers:

- 1 Independent or supervision only
- 3 Limited physical assistance
- 4 Other than 2 person physical assist
- 5 2 person physical assist

For eating:

- 1 Independent or supervision only
- 2 Limited assistance
- 3 Extensive assistance/total dependence/ tube fed

Karnofsky Rating Scale

- | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>100 Normal with no complaints or evidence of disease.</p> <p>90 Able to carry on normal activity but with minor signs of illness present.</p> <p>80 Normal activity but requiring effort. Signs and symptoms of disease more prominent.</p> <p>70 Able to care for self, but unable to work or carry on other normal activities.</p> <p>60 Able to care for most needs, but requires occasional assistance.</p> | <p>50 Considerable assistance and frequent medical care required; some self-care possible.</p> <p>40 Disabled, requiring special care and assistance.</p> <p>30 Severely disabled; hospitalisation required but death not imminent.</p> <p>20 Extremely ill; supportive treatment and/or hospitalisation required.</p> <p>10 Imminent Death.</p> <p>0 Death.</p> |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

Definitions of Palliative Care Phases

(1) Stable Phase

All clients not classified as unstable, deteriorating, or terminal.

- The person's symptoms are adequately controlled by established management. Further interventions to maintain symptom control and quality of life have been planned.
- The situation of the family/carers is relatively stable and no new issues are apparent. Any needs are met by the established plan of care.

(2) Unstable Phase

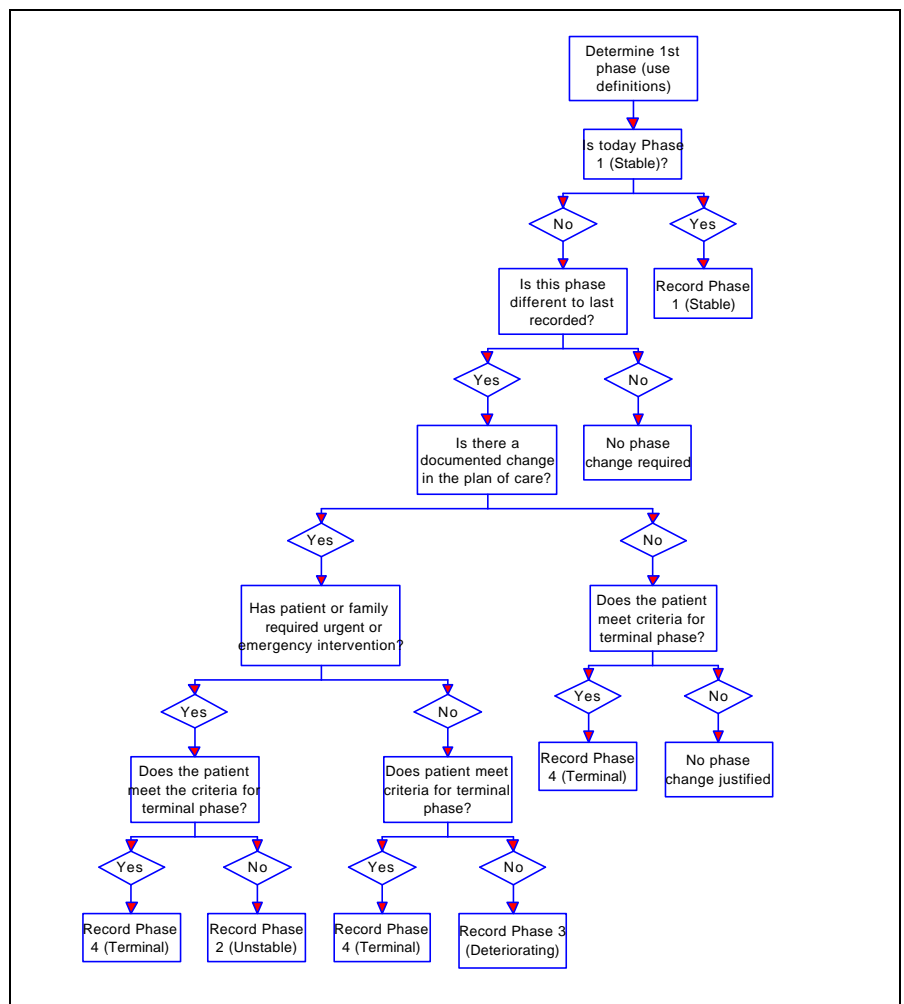
The person experiences the development of a new problem or a rapid increase in the severity of existing problems, either of which require an urgent change in management or emergency treatment

- The family/carers experience a sudden change in their situation requiring urgent intervention by members of the multi-disciplinary team.

(3) Deteriorating Phase

- The person experiences a gradual worsening of existing symptoms or the development of new but expected problems. These require the application of specific plans of care and regular review but not urgent or emergency treatment.

- The family/carers experience gradually worsening distress and other difficulties, including social and practical difficulties, as a result of the illness of the person. This requires a planned support program and counselling as necessary.



(4) Terminal Care Phase

Death is likely in a matter of days and no acute intervention is planned or required. The typical features of a person in this phase may include the following:

- | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> Profoundly weak Essentially bed bound Drowsy for extended periods Disoriented for time and has a severely limited attention span | <ul style="list-style-type: none"> Increasingly disinterested in food and drink Finding it difficult to swallow medication This requires the use of frequent, usually daily, interventions aimed at | <ul style="list-style-type: none"> physical, emotional and spiritual issues. The family/carers recognise that death is imminent and care is focussed on emotional and spiritual issues as a prelude to bereavement |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

(5) Bereaved Phase

Death of the patient has occurred and the carers are grieving. A planned bereavement support program is available including counselling as necessary.

CCP Evaluation Tool 1.3

Patient experiences – staff rated version

About the patient

Office Use Only

Project URN: _____

Date: _____

Sex Male Female Age _____

Does the patient identify as Aboriginal or Torres Strait Islander? Yes No

Does the patient identify with a particular ethnic origin or cultural background? Yes No

If yes, please specify ethnic origin or cultural background: _____

About how the patient feels

Please answer the following questions by ticking the box next to the answer that you think most accurately describes how the patient has been feeling. Thank you.

1. Over the past 3 days, has the patient been affected by pain?

Not at all, no effect
 Slightly – but not bothered to be rid of it
 Moderately – pain limits some activity
 Severely – activities or concentration markedly affected
 Overwhelmingly – unable to think of anything else

2. Over the past 3 days, have other symptoms (eg, feeling sick, having a cough or constipation) been affecting how they feel?

Not at all
 Slightly
 Moderately
 Severely
 Overwhelmingly

3. Over the past 3 days, has the patient been feeling anxious or worried about their illness or treatment?

Not at all
 Occasionally
 Sometimes – affects their concentration now and then
 Most of the time – often affects their concentration
 Patient does not seem to think of anything else - completely pre-occupied by worry and anxiety

4. Over the past 3 days, have any of their family or friends been anxious or worried about the patient?

Not at all
 Occasionally
 Sometimes – it seems to affect their concentration
 Most of the time
 Yes, they are always preoccupied with worry

5. Over the past 3 days, how much information has been given to the patient and their family or friends?

Full information – patient feels free to ask
 Information given but not always understood by patient
 Information given on request – patient would have liked more
 Very little given and some questions have been avoided
 None at all

6. Over the past 3 days, has the patient been able to share how they are feeling with family or friends?

Yes, as much as they wanted to
 Most of the time
 Sometimes
 Occasionally
 No, not at all with anyone

Have you had someone to help you with practical tasks?

- Yes, I've had all the help I need yes, but not enough I haven't needed help No

Did anyone give you information on whether you would qualify for a Carer Payment or Allowance?

- Yes, I was given all the information I need Yes, it was mentioned but not in any detail I haven't needed any financial help No

Did someone give you information about available support services?

- Yes, I was given all the information I need Yes, it was mentioned but not in any detail I haven't needed any help No

Did someone give you practical training in lifting, managing medicine or other tasks?

- Yes, I was given all the training I need Yes, I was given a bit, but not enough I haven't needed any help No

This is the end of the survey. If you would like to add any comments about your experience, please do so in the box below. Thank you for your time.

Comments about your experience

7. Where did you learn about palliative care? (tick all that apply)

- | | | | | | |
|----------------------|--------------------------|-------------------------|--------------------------|---------------------------|--------------------------|
| General Practitioner | <input type="checkbox"/> | Community health centre | <input type="checkbox"/> | Community nursing service | <input type="checkbox"/> |
| Nursing home | <input type="checkbox"/> | Hospital | <input type="checkbox"/> | Hospice | <input type="checkbox"/> |
| Television/radio | <input type="checkbox"/> | Relatives/friends | <input type="checkbox"/> | Internet | <input type="checkbox"/> |
- Other (please describe):

8. Have you ever looked after someone who was dying?

- Yes No *If no, move straight to Question 12*

9. In what capacity have you looked after someone who was dying? (tick all that apply)

- | | | | | | |
|--------------------------|--------------------------|---------------------|--------------------------|----------------------|--------------------------|
| Relative | <input type="checkbox"/> | Friend | <input type="checkbox"/> | Volunteer | <input type="checkbox"/> |
| Health care professional | <input type="checkbox"/> | Manager of services | <input type="checkbox"/> | Member of the Clergy | <input type="checkbox"/> |
- Other (please describe):

10. How confident did you feel when looking after the person who was dying?

- | | | | | |
|---------------------------|----------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Confident all of the time | Confident most of the time | Undecided | Somewhat confident | Not at all confident |

11. Did you feel that you had enough support to undertake this role?

- Yes No Don't know

12. How important is each of the following in palliative care? Please use a scale from 1 to 6 to rank the importance of each service. Please write '1' next to the most important service, '2' against the next most important and so on.

- | | | | | | |
|----------------------------------------|--------------------------|-------------------------------------------------|--------------------------|--------------------------------|--------------------------|
| Choice for the patient | <input type="checkbox"/> | Home based care | <input type="checkbox"/> | 24 hour a day call out service | <input type="checkbox"/> |
| The provision of information/education | <input type="checkbox"/> | The provision of equipment / home modifications | <input type="checkbox"/> | Hospice care | <input type="checkbox"/> |
- Other (please describe):

This is the end of the survey. Thank you for your time

CCP Evaluation Tool 1.6 - Community Awareness, Remote Aboriginal and Torres Strait Islander Communities

1. Have you ever heard of palliative care before? What do these words mean to you?

Prompt: Sometimes people get sick and they can't get better. Care for people who are like this is called palliative care.

2. Is there any support in the community to help people who are not going to get better? (people who are finishing up?)

Prompt: People who have this kind of sickness may want to stay on their country and be looked after by their families. Do you know anyone like this? Do you know if their families are getting any help? What sort of help are they getting?

3. Do you know that there are services that can help people and their families?

Prompt: The Palliative care service can provide help for people and their families. They can provide things like wheelchairs and comfortable beds. They can make sure that the sick person doesn't have any pain.

4. What sort of help do you think people who are finishing up might want in this community?

Prompt: Help to stay at home, perhaps making the house more safe to move around, help to move around, perhaps getting a wheelchair.

5. What sort of help do you think that the people looking after them might need?

Prompt: How to keep the sick person comfortable, what sorts of food to give them, who do I ask for help?

6. If a sick person needs lots of care, like care all through the night, where is the best place for them to go?

Prompt: Do you think they could be cared for at home, or do you think they would need to go to a hospital?

7. When a person is dying (finishing up) in hospital, do you think they should be able to come home to their community?

Prompt: How important is it for people to die on their own country with their families?

8. Do you think that there are people in this community who would be interested in getting training to look after dying people (people who are finishing up) in this community?

Prompt: Find out people's names, if they have volunteered themselves or another person, and if they have had any prior caring experience.

9. Do you think that the Council here would support a program to train local people to care for people who are dying (finishing up)?

10. Is there anyone who can share a story about caring for someone who was finishing up?

Prompt: Did you look after them at home. Who helped? Did you think you needed more help?

What could be done to make things easier for you and the person you were looking after?

CCP Evaluation Tool 2.1

Palliative Care Providers

About you

Your sex Male <input type="checkbox"/> Female <input type="checkbox"/>		Your age _____	
Your discipline:	Your Palliative care training (tick all that apply)	Specialist qualification <input type="checkbox"/>	On the job training only <input type="checkbox"/>
		Short courses or other formal training not leading to a specialist qualification <input type="checkbox"/>	No training <input type="checkbox"/>
Do you identify as Aboriginal or Torres Strait Islander?		Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do you identify with a particular ethnic origin or cultural background?		Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, please specify your ethnic origin or cultural background: _____			

About your views on palliative care

Please rate your degree of confidence with the following patient / family interactions and patient management topics, by ticking the relevant box below

1 = Need further basic instruction	2 = Confident to perform with close supervision / coaching
3 = Confident to perform with minimal consultation	4 = Confident to perform independently

No	Patient/family interactions and clinical management	1	2	3	4
1	Answering patients questions about the dying process				
2	Supporting the patient or family member when they become upset				
3	Informing people of the support services available				
4	Discussing different environmental options (eg hospital, home, family)				
5	Discussing patients wishes for after their death				
6	Answering queries about the effects of certain medications				
7	Reacting to reports of pain from the patient				
8	Reacting to and coping with terminal delirium				
9	Reacting to and coping with terminal dyspnoea (breathlessness)				
10	Reacting to and coping with nausea / vomiting				
11	Reacting to and coping with reports of constipation				
12	Reacting to and coping with limited patient decision-making capacity				

Please continue over the page

Views about death and dying

Please indicate how much you agree or disagree with each of the following statements, by ticking the box that best describes how you feel. (There are no right or wrong answers).

No	Statement	Agree Strongly	Agree	Unsure / Mixed	Disagree	Disagree Strongly
1	The end of life is a time of great suffering.					
2	Little can be done to help someone achieve a sense of peace at the end of life.					
3	The use of strong pain medication can cause the person to stop breathing.					
4	I am not comfortable caring for a dying patient.					
5	I am not comfortable talking to families about death.					
6	When a patient dies I feel that something went wrong.					
7	Feeding tubes should be used to prevent starvation at the end of life.					
8	Nursing homes/hospitals are not good places to die.					
9	Families have the right to refuse a medical treatment, even if that treatment prolongs life.					
10	Dying patients should be referred to a hospice or acute care.					

Attitudes towards Palliative Care

No	Statement	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Disagree Strongly
1	Pain at the end of life is an inevitable part of the dying process					
2	Pain medication should be given as needed to terminally ill patients					
3	Spiritual care should include counselling the terminally ill patient					
4	I do not like talking about death and dying with patients					
5	Palliative care should be the standard medical treatment for patients who are suffering from a terminal illness					
6	Patients should have the right to determine their own degree of medical intervention					
7	Addiction to oral morphine is not a serious issue given that terminally ill patients have a short time to live					
8	Opening discussions of end-of-life care should be deferred until there is no further effective curative treatment available					
9	Estimation of pain by an MD or RN is a more valid measure of pain than patient self-report					
10	Complete pain relief is a reasonable goal even when the pain is not caused by a terminal condition such as cancer					
11	Patients have the right to determine their own degree of psychosocial intervention					
12	The most appropriate person to make end-of-life decisions is the patient's primary care provider					
13	A patient should experience discomfort prior to receiving the next dose of pain medications					
14	Patients should be maintained in a pain-free state					
15	As a rule, terminally ill patients prefer not to talk about death and dying					

Please indicate the importance of the issues below in terms of the problems they create for you in caring for a dying patient by ticking the box that best describes your feelings. (There are no right or wrong answers).

No	Statement	Very important	Important	Unsure	Less important	Not important
1	Control of pain					
2	Managing depression					
3	Legal concerns					
4	Ability to meet spiritual needs					
5	The patient's emotional needs					
6	Communication with family					
7	Communication with other palliative care staff					
8	Communication with (other) doctor/s					
9	Uncertainty about what is best care					
10	Other (please describe)					

Please tick the boxes to indicate whether you would like future education on any of the following topics:

Pain assessment and management		Dealing with terminal delirium	
Dealing with nausea and vomiting		Dealing with terminal dyspnea	
Dealing with constipation		Use of intravenous hydration and/or non-oral feeding in end-of-life care	
End-of-life communication skills - giving bad news, talking with family, discussing prognosis, discussing various treatment options		End-of-life ethics: DNR orders, advance directives, decision-making capacity	
Spirituality and cultural aspects of end-of-life care		Other (please specify below)	

Please list any other topics here

*This is the end of the survey. Thank you for your time.
If you wish to make any further comments, please do so over the page*

Other comments:

9. Did you receive any training before beginning as a volunteer?

Yes, a formal training program Yes, on the job/informal program No

10. What do you think are the most important elements of a training package for volunteers in palliative care? Please use a scale from 1 to 6 to rank the importance of each element. Please write '1' next to the most important, '2' against the next most important and so on.

General awareness of palliative care Dealing with grief/anxiety Dealing with bereavement

Assistance with activities of daily living Spiritual issues First Aid

Other (please describe): _____

11. How much support do you receive from the organisation where you work as a volunteer?

None at all Some support, but not enough As much as I want

12. Do you know who to contact if you have any problems?

No Sometimes Yes

13. How long are you planning to continue to work as a volunteer in palliative care?

For years I don't know. It will depend on how I feel about it when I'm actually working as a volunteer

For a year or so I don't know. It will depend on other things happening in my life such as my family responsibilities and other activities I'm involved in

For less than a year I don't know, for other reasons (please describe):

14. What is the best part of being a palliative care volunteer? _____

15. What is the worst part or the thing that most concerns or worries you about being a palliative care volunteer?

This is the end of the survey. Thank you for your time.

CCP Evaluation Tool 2.3 - New Palliative Care Volunteers

About you

Your sex	Male <input type="checkbox"/>	Female <input type="checkbox"/>	Your age	_____
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Do you identify as Aboriginal or Torres Strait Islander?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do you identify with a particular ethnic origin or cultural background?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, please specify your ethnic origin or cultural background: _____		

1. Why did you decide to become a volunteer? _____

2. Have you any previous experience as a volunteer? Yes No

3. If yes, what sort of volunteering have you done? (please describe) _____

4. Have you been in the role of a carer for a person with a disability or a frail older person in the past? Yes No

5. If yes, please tick the box that best describes your role:

Health professional Family member Friend

6. How much time are you prepared to commit to volunteering? (Please estimate the number of hours per month). _____

7. What sort of volunteer work would you feel most comfortable undertaking?

Home based visits Hospital/Hospice based visits Assistance to visit the doctor

General assistance with transport Shopping assistance Recreation/leisure activities

All of the above

Other (please describe): _____

8. What do you think are the most important elements of a training package to assist you in your role? Please use a scale from 1 to 6 to rank the importance of each element. Please write '1' next to the most important, '2' against the next most important and so on.

General awareness of palliative care Dealing with grief/anxiety Dealing with bereavement

Assistance with activities of daily living Spiritual issues First Aid

Other (please describe): _____

9. How long are you planning to work as a volunteer in palliative care? (tick all that apply)

For years I don't know. It will depend on how I feel about it when I'm actually working as a volunteer

For a year or so I don't know. It will depend on other things happening in my life such as my family responsibilities and other activities I'm involved in

For less than a year I don't know, for other reasons (please describe):

10. What are you most looking forward to in your role as a volunteer? _____

11. Is there anything that worries you about becoming a palliative care volunteer?

Yes No

If yes, please describe

This is the end of the survey. Thank you for your time.

8. How much support did you receive from the organisation where you have been working as a volunteer?

- None at all
 Some support, but not enough
 As much as I wanted

9. Did you know who to contact if you had any problems?

- No
 Sometimes
 Yes

10. Why are you ending your time as a volunteer in palliative care? (tick all that apply)

For reasons directly related to my experience as a volunteer

For reasons that have nothing to do with palliative care such as family responsibilities and other activities I'm involved in

Comments on why you are ending your time as a palliative care volunteer

11. What was the best part of being a palliative care volunteer? _____

12. What is the worst part or the thing that most concerned or worried you about being a palliative care volunteer?

13. Would you recommend being a palliative care volunteer to your friends?

- Yes, definitely
 Maybe, it would depend on the person
 Don't know
 No, definitely not

14. Is there anything that the palliative care service could have done that would have influenced your decision to give up being a palliative care volunteer?

- Yes, definitely
 Maybe
 Don't know
 No, definitely not

If so, please identify what the palliative care service could have done or done differently

This is the end of the survey. Thank you for your time

CCP Evaluation Tool 2.5 - Health Professionals Not Working in Palliative Care Services

About you

Your sex	Male <input type="checkbox"/>	Female <input type="checkbox"/>	Your age	Your country of birth _____
Your discipline:	Have you ever had any palliative care training? (tick all that apply)	Specialist qualification <input type="checkbox"/>	Short courses or other formal training not leading to a specialist qualification <input type="checkbox"/>	On the job training only <input type="checkbox"/>
				No training <input type="checkbox"/>

About your views on palliative care

1. How would you rate your knowledge of palliative care?

No knowledge General knowledge only Professional / extensive knowledge

If you ticked 'no knowledge', please skip the next questions and move straight to Question 5. Otherwise, please proceed with the questions below.

2. What services or organisations provide palliative care in the community?

(tick all that you know provide palliative care in the community in which you work)

Hospital <input type="checkbox"/>	Community Health Centre <input type="checkbox"/>
Nursing homes/residential aged care <input type="checkbox"/>	Community nursing services <input type="checkbox"/>
Hospice <input type="checkbox"/>	General Practitioners <input type="checkbox"/>
Other (please describe): _____	

3. Do you think these services meet local palliative care needs?

Yes, local needs are fully met Most local needs are met Don't know / undecided Some local needs are met No, the needs are not met at all

4. If local needs are not being met now, how could palliative care be improved in your community?

Please use a scale of 1 to 6 to rank the following possible ways that services might be improved, with 1 being the most important improvement required and 6 being the least important.

This community needs a hospice or dedicated palliative care beds at the hospital <input type="checkbox"/>	The hospital needs to be more aware of the needs of palliative patients <input type="checkbox"/>
This community needs more home based care <input type="checkbox"/>	This community needs a 24 hour a day telephone service <input type="checkbox"/>
More volunteers in palliative care <input type="checkbox"/>	The local hospice or hospital needs more palliative care beds <input type="checkbox"/>

Other (please describe below): _____

5. Have you ever looked after someone who was dying?

Yes

No *If no, move straight to Question 9*

6. In what capacity have you looked after someone who was dying? (tick all that apply)

Relative Friend Volunteer

Health care professional Manager of services Member of the Clergy

Other (please describe):

7. How confident did you feel when looking after the person who was dying?

Confident all of the time

Confident most of the time

Undecided

Somewhat confident

Not at all confident

8. Did you feel that you had enough support to undertake this role?

Yes

No

Don't know

9. What do you think are the essential elements of a palliative care program? How important is each of the following in palliative care? Please use a scale from 1 to 6 to rank the importance of each service, with 1 being the most important element and 6 being the least important.

Choice for the patient

Home based care

24 hour a day call out service

The provision of information/education

The provision of equipment / home modifications

Hospice or hospital care

Multidisciplinary service provision

Bereavement support

Other (please describe below):

10. Please use the box below to record any other comments you would like to make about palliative care services in the area where you work

This is the end of the survey. Thank you for your time.

CCP Evaluation Tool 2.6 – Health Workers in Remote Aboriginal Communities

Use this tool to evaluate how confident community carers (including clinic staff and health workers) are in delivering palliative care.

These questions are intended to be used as a guide for discussions with carers in the community. Please ask them in a way that you feel will be most appropriate/effective.

1. Have you ever heard of palliative care before? What do these words mean to you?

Prompt: Sometime people get sick and they can't get better. Care for people who are like this is called palliative care.

2. What is the word you use to talk about the time when someone is dying?

Prompt: Some people round here call it slow sickness or finishing up

3. Have you looked after someone who is dying (finishing up)?

Prompt: what did you do for that person, did anyone help you?

4. Did you have everything you needed to look after the sick person?

Prompt: what could have made it easier for you? Did you need equipment to help the person, did you need training so that you knew what to do and what to expect?

5. Did you feel confident looking after this person?

Prompt: Did you always feel that you knew what to do for this person? Or did you feel that you needed some help?

6. What sorts of medicine did the person you were looking after have?

Prompt: What did they have to stop their pain? What did they have when they were vomiting?

7. What sort of training would you like to have?

Prompt: How often, who to deliver such training?

8. Do you know about the Regional Palliative Care Service?

Prompt: Do you know how to contact them and who to ask for?

9. Do you have a information manual?

Prompt: Do you know where it is kept? Have you used it? Is it useful?

CCP Evaluation Tool 3.1

Palliative Care Service Self-Assessment

ITEM	P=Present, NP=Not Present	Rate the degree to which the statement is true of your service 0= Not at all 10 = Fully implemented and effective	Rate priority for future action 0= Not at all – no action required 10= Undertake as a matter of urgency
Vision and Management Standards			
We have a vision for excellence in end of life care			
Our service objectives include a focus on end of life care			
Administrative executive staff support implementation of initiatives to improve care at end of life			
Medical staff support implementation of initiatives to improve care at end of life			
Management objectives include a focus on end of life care			
Education resources are designated to support development of competencies and practices in end of life care			
Excellent caregivers (both formal and informal) and caregiving examples are honoured and their stories made visible			
Practice Standards (procedures, policies, care protocol)			
The population we served is defined and communicated			
Confidentiality standards are clearly communicated			
Cultural / religious guidelines are integrated			
Organ / tissue donation guidelines are implemented			
Comfort, care and palliative care standards are implemented. Includes guidelines for pain and symptom management, and hydration / nutrition			
Hospice care is available			
Complementary or integrative therapies are supported			
Space Standards (inpatient/hospice services only)			
Patient room is comfortable, homelike, supports family visiting, and confidentiality			
Family homelike or living room type space is available			
Visiting Standards (inpatient/hospice services only)			
Welcoming for Families			
Support for family ADL's available			
24 hour visiting with number, hours and age, for close friends / family as defined by ill person / family with respect of other patient care needs			
Families participate in care as desired			
Children are welcomed with supervision			

ITEM	P=Present, NP=Not Present	Rate the degree to which the statement is true of your service 0= Not at all 10 = Fully implemented and effective	Rate priority for future action 0= Not at all – no action required 10= Undertake as a matter of urgency
Pet visiting with supervision and respect of other patient care needs is welcomed			
Spiritual, Religious, and Cultural Standards			
Support is available 24 hours a day			
Links / communication with community established			
Prayer and other spiritual / religious practices overtly available			
All staff are expected to integrate spiritual / cultural care within practice			
Support for professional caregivers readily available			
Bereavement Support Standards			
Bereavement support groups offered			
Follow-up is available for 100% who have died			
Follow-up contact to address clinical questions initiated by clinicians / primary care providers within 2-4 weeks of death			
Memorial services conducted for staff and families			
Bereavement support 1:1 for families is available			
Bereavement support 1:1 for professionals is available			
Psychosocial and Emotional Standards, including Pastoral Care			
Referral and support is available 24 hours			
Support available for professional caregivers			
Support groups for patient / families easily accessible			
Virtual support groups available (eg. chat groups, telephone conference groups)			
Communication Standards			
Care preference, values, spiritual, emotional, and relationship needs as well as decisions routinely and accurately communicated and honoured			
Doctor communication during the dying process occurs frequently			
Transfer of care occurs with communication of preferences, values, spiritual / emotional, and relationship needs and patient / family care decisions.			
Standards and expectations about excellent end-of-life care routinely communicated to community			
Communication with community spiritual care providers routine as well as specific			

ITEM	P=Present, NP=Not Present	Rate the degree to which the statement is true of your service 0= Not at all 10 = Fully implemented and effective	Rate priority for future action 0= Not at all – no action required 10= Undertake as a matter of urgency
<p>Professional Experiential Education during Orientation and as Continuing Education</p> <p>The following issues are addressed in initial and ongoing education and training programs provided to the leadership team, employed staff and visiting doctors</p>			
Organisation values and strategic objectives			
Ethics – End of life Care			
Practice standards			
Quality improvement standards			
Communication			
Grief and Bereavement			
Patient / Family supports			
Professional caregiver / staff support			
Spiritual / religious / cultural standards			
Individual performance expectations			
<p>Quality Improvement Standards</p>			
Routine feedback from patients, family caregivers and bereaved family, and community partners is obtained			
Quality priorities include response to above			
Significant events are assessed for learning and quality improvement			
"Stories" are shared and used to teach about care and to set standards			
Research to continue developing new ways to improve care is developed or findings are applied to practice change initiatives			
Annual objectives and priorities include focus on end of life care			
<p>Staff Support Standards</p> <p>(This area includes items to support palliative care providers as professional caregivers and as ill person, caregiver, or bereaved family)</p>			
There are systems and policies that support bereavement leave for those the person defines as close or family			
There are systems and policies that allow flexibility in work time during illness, caregiving and bereavement			
Palliative care providers are supported in reaching out to fellow providers with practical help			
Acuity and patient assignments provide time to "be with" the patient and family during the process of dying			
Professional caregiver is supported to attend memorial / funeral service of patients.			

ITEM	P=Present, NP=Not Present	Rate the degree to which the statement is true of your service 0= Not at all 10 = Fully implemented and effective	Rate priority for future action 0= Not at all – no action required 10= Undertake as a matter of urgency
Community Network and Partnerships			
	Palliative care is available within the community to the extent that patients and their families want it		
	Healthcare and church ministry linked in meeting care needs at end of life		
	Partnerships with community assist community to meet support needs		
	Services are provided that achieve continuity of care within and between community and health care organisations		
	Education and information about palliative care is integrated within schools, workplaces, parishes, and other community areas		

This is the end of the self-assessment. Thank you for your time.

Use this space to record any actions arising from the self-assessment

CCP Evaluation Tool 3.2

General health care organisational survey about palliative care

Agency name (optional)	This survey was completed (tick one)	
Location (optional)	Through an agency / group meeting to consolidate one response	<input type="checkbox"/>
Date completed	By an individual expressing their own views, and not necessarily those of the agency	<input type="checkbox"/>

Description of your agency/service

- Hospital Community health service Community nursing service
 General practice, medical centre Community organisation Training organisation
 Multipurpose health centre Other (please describe):

1. How does your organisation define Palliative Care?

2. What services or organisations provide palliative care in the community?

(tick all that you know provide palliative care in the community in which you work)

- Hospital Community Health Centre
 Nursing homes/residential aged care Community nursing services
 Hospice General Practitioners
 Other (please describe):

3. What information sources about Palliative Care are recommended by your organisation?

- | | | | | | |
|----------------------|--------------------------|-------------------------|--------------------------|---------------------------|--------------------------|
| General Practitioner | <input type="checkbox"/> | Community health centre | <input type="checkbox"/> | Community nursing service | <input type="checkbox"/> |
| Nursing home | <input type="checkbox"/> | Hospital | <input type="checkbox"/> | Hospice | <input type="checkbox"/> |
| Television/radio | <input type="checkbox"/> | Relatives/friends | <input type="checkbox"/> | Internet | <input type="checkbox"/> |
- Other (please describe):
-

4. To what extent does your organisation provide information about Palliative Care?

- | | | | |
|------------------------------------|--------------------------|--------------------------------------------------------------------|--------------------------|
| Not an information provider | <input type="checkbox"/> | Provides information in some areas of Palliative Care | <input type="checkbox"/> |
| Provider of general knowledge only | <input type="checkbox"/> | Provides professional/ extensive information about Palliative Care | <input type="checkbox"/> |

5. How is your organisation involved in Palliative Care?

- | | | | | | |
|--------------------------------|--------------------------|--------------------------------------------|--------------------------|-----------------------------------------------|--------------------------|
| Carer support | <input type="checkbox"/> | Direct care provider | <input type="checkbox"/> | Providing specialist palliative care services | <input type="checkbox"/> |
| Volunteer training and support | <input type="checkbox"/> | Providing general palliative care services | <input type="checkbox"/> | This organisation is not involved | <input type="checkbox"/> |
- Other (please describe):
-

6. To what extent does your organisation coordinate with (other) Palliative Care services in your community?

- | | | | |
|-------------------------------------------------------------------------|--------------------------|----------------------------------------------------------------------|--------------------------|
| Do not coordinate with Palliative Care services (no others exist) | <input type="checkbox"/> | Coordinate with a limited number of (other) Palliative Care services | <input type="checkbox"/> |
| Do not coordinate with other Palliative Care services (others do exist) | <input type="checkbox"/> | Coordinate extensively with (other) Palliative Care services | <input type="checkbox"/> |

This is the end of the survey. Thank you for your time.

CCP Evaluation Tool 4

Palliative Care Program Sustainability Checklist

About the person completing this assessment

Project Title: _____ Name: _____

Date Completed: ____/____/____

What is your goal after project funding ends?

The project will be over and its impact will end soon after

The project will be over but it will keep having an impact

By the time funding ends, we will have found other ways to keep the project going

If your goal is for your project, or its effects, to continue after funding ends, please circle the number that best describes your situation.

The first set of items is about project design and implementation factors				
1 People with a stake in the project - funders, administrators, consumers/beneficiaries, other agencies – have been aware of the project and/or involved in its development	2	1	0	DK
2 The project has shown itself to be effective. Effects are visible and acknowledged	2	1	0	DK
3. The organisation which you intend to host the project in the future has been making some real or in kind support to the project in the past	2	1	0	DK
4. Prospects for the project to acquire or generate some additional funds or resources for the future are good	2	1	0	DK
The next set of items is about factors within the organisational setting which are known to relate to the survival of a project				
5. The organisation that you intend to host the project in future is mature (developed, stable, resourceful). It is likely to provide a strong organisational base for the project	2	1	0	DK
6. The mission of the project is compatible with the mission and activities of the intended host organisation	2	1	0	DK
7. Part of the project's essential 'business' is integrated into other aspects of the host organisation eg. in policies, practices, responsibilities etc. That is, the project does not simply exist as an entirely separate entity	2	1	0	DK
8. The project is well supported in the organisation. That is, it is not under threat and there are few rivals in the organisation who could benefit from the closure of the project	2	1	0	DK
9. The intended host organisation has a history of innovation or developing new responses to situations in its environment	2	1	0	DK
The next set of items is about factors in the broader community environment which affect how long projects last				
10. There is a favourable external environment for the project, that is, the values and mission fit well with community opinion, and the policy environment	2	1	0	DK
11. People in the community, or other agencies and organisations, will advocate for and maintain a demand for the existence of the project should it be threatened	2	1	0	DK

2 = yes, fully

0 = no

1 = yes, in part

DK = don't know

Goals, Objectives and Strategies for Sustainability

Project Title: _____

Name: _____

DATE COMPLETED: __/__/____

Write a set of goals, objectives and strategies for your project about sustainability: eg, to keep the impact of your project going after funding ceases.

Goal/s for Sustainability

Remember:

- ◆ A goal is an overarching statement about the desired outcome - not usually directly measurable.

Objective/s for Sustainability

Remember:

- ◆ Objectives (sometimes called aims) dissect a goal into a series of action statements that say what is going to be different, are specific, have time frames and are measurable.
- ◆ Objectives are evaluated (including the analysis of PI's) to ascertain whether a goal has been achieved, partially achieved or not achieved at all.

Strategies for Sustainability

Remember:

- ◆ Strategies are the detail of what you need to do to achieve each objective. A strategy need not be linked to only one objective, but can be used to achieve multiple objectives.

CCP Evaluation Tool 5

Capacity Building Checklist

Project _____ Name _____ Date Completed: ____/____/____

The first set of items is about project design and implementation factors				
1. People with a stake in the project – consumers/ beneficiaries, other agencies, health care providers – have been able to contribute to the development of the project.	2	1	0	DK
2. People involved with the project have been able to establish links with other organisations and providers of palliative care in the community.	2	1	0	DK
3. People involved with the project have taken a leadership role in the local community with regard to palliative care.	2	1	0	DK
4. People involved with the project have been able to resolve conflicting interests in the area of palliative care in the community.	2	1	0	DK
5. This project has been able to engage the local media in promoting relevant palliative care issues.	2	1	0	DK
6. The project has involved formal and/or informal training of people whose skills and interests are retained in the project or its immediate environment	2	1	0	DK
The next set of items is about factors within the organisation's setting that relate to capacity building				
7. This organisation has been able to establish agreed policies or memoranda of understanding with other organisations regarding the provision of palliative care services in this community.	2	1	0	DK
8. This organisation has generated and supported community skills to direct, provide, lead or otherwise contribute to the provision of palliative care services in this community.	2	1	0	DK
9. More organisational resources have been directed to the area of palliative care services in this community.	2	1	0	DK
10. There is someone in authority or seniority, other than the director of the project itself, who is an advocate for the project at high levels in the organisation	2	1	0	DK
The next set of items is about factors in the broader community that affects the community's capacity to support the provision of palliative care services.				
11. Community coalitions have formed to promote and advocate for palliative care services in this community.	2	1	0	DK
12. Community coalitions and organisations have a shared view of what comprises palliative care services in this community.	2	1	0	DK
13. Key community leaders have engaged in critical appraisal of the need for palliative care services in this community.	2	1	0	DK
14. Community members have taken a leadership role to promote palliative care services in this community.	2	1	0	DK
15. Community events have occurred to acknowledge, promote or provide funds for palliative care services.	2	1	0	DK
16. Community members directly involved in or affected by palliation are actively engaged in the oversight of the development, provision or management of palliative care services in this community.	2	1	0	DK
17. People in the community, or other agencies and organisations, will advocate for and maintain a demand for the existence of the project should it be threatened	2	1	0	DK
18. Community organisations that are similar to the intended host organisation have taken the step of supporting projects somewhat like your project	2	1	0	DK

2 = yes, fully

1 = yes, in part

0 = no

DK = don't know

Goals, Objectives and Strategies for Capacity Building

Project Title: _____

Name: _____

Date Completed: __/__/__

Write a set of goals, objectives and strategies for your project on capacity building, eg to develop knowledge and skills to do the job.

Goal/s for Capacity Building

Remember:

- ◆ A goal is an overarching statement about the desired outcome - not usually directly measurable.

Objective/s for Capacity Building

Remember:

- ◆ Objectives (sometimes called aims) dissect a goal into a series of action statements that say what is going to be different, are specific, have time frames and are measurable.
- ◆ Objectives are evaluated (including the analysis of PI's) to ascertain whether a goal has been achieved, partially achieved or not achieved at all.

Strategies for Capacity Building

Remember:

- ◆ Strategies are the detail of what you need to do to achieve each objective. A strategy need not be linked to only one objective, but can be used to achieve multiple objectives.

CCP Evaluation Tool 6

Generalisability Checklist

Project _____ Name _____ Date Completed: ____/____/____

Please circle the number that best describes your situation.

1 Our project is designed specifically to meet our own local needs	2	1	0	DK
2. Other regions/services/organisations will learn useful lessons/information from our project	2	1	0	DK
3. It is reasonable to expect that the outcomes of our project could be replicated elsewhere	2	1	0	DK
4. Our project will depend on how sensitive and appropriate it is to our target population	2	1	0	DK
5. Our project is designed to develop capacity (skills and/or knowledge) in palliative care in our region/service/organisation	2	1	0	DK
6. Our project is designed to enable people not directly involved in our project to develop capacity (skills and/or knowledge) in palliative care	2	1	0	DK
7. We already have a strategy in place to ensure that our experience and findings are shared with other people who want to develop and improve palliative care	2	1	0	DK
8. By the time the project ends, we will have a strategy in place to ensure that our experience and findings are shared with other people who want to develop and improve palliative care	2	1	0	DK

2 = yes, fully

1 = yes, in part

0 = no

DK = don't know

Goals, Objectives and Strategies for Generalisability

Project Title: _____

Name: _____

Date Completed: __/__/____

Write a set of goals, objectives and strategies for your project on generalisability: eg, to make your project's lessons useful for someone else

Goal/s on Generalisability

Remember:

- ◆ A goal is an overarching statement about the desired outcome - not usually directly measurable.

Objective/s on Generalisability

Remember:

- ◆ Objectives (sometimes called aims) dissect a goal into a series of action statements that say what is going to be different, are specific, have time frames and are measurable.
- ◆ Objectives are evaluated (including the analysis of PI's) to ascertain whether a goal has been achieved, partially achieved or not achieved at all.

Strategies on Generalisability

Remember:

- ◆ Strategies are the detail of what you need to do to achieve each objective. A strategy need not be linked to only one objective, but can be used to achieve multiple objectives.

CCP Evaluation Tool 8

System level impacts and outcomes of the Caring Communities Project

Agency name (optional)	This survey was completed (tick one)	
Location (optional)	Through an agency / group meeting to consolidate one response	
Date completed	By an individual expressing their own views, and not necessarily those of the agency	

Description of your agency/service

- Hospital Community health service Community nursing service
 General practice, medical centre Community organisation Training organisation
 Multipurpose health centre Other (please describe):

How did the palliative care project go?

Did it change the way you deliver services? Yes, positively Yes, negatively No change

Was the impact on consumers acceptable? Yes No Don't know

Comments?

How did the project go for people with special needs?

Did the project have any impact or outcomes for people from culturally and linguistically diverse backgrounds, Aboriginal people, people with dementia, financially disadvantaged people or people living in remote areas?

Yes No

If yes, please specify:

If yes, are there any specific issues relating to these groups that you encountered during the project? (please describe).

Agency, inter-agency and system effects of the project

Please tick the appropriate boxes. Where a statement is irrelevant to your project, tick the box marked 'Irrelevant'.

Impact statement	Agree	Unsure/ don't know	Disagree	Irrelevant	Comment
Different professionals and services now work better as a team to improve the services that people receive.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
The project has improved the way that professionals providing palliative care in our area communicate with each other.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
The project was effective in improving information sharing between professionals providing palliative care.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
The project has resulted in more patients receiving palliative care.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
The project has resulted in a more streamlined and efficient referral process for our clients/patients.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
The project has resulted in better treatment and support for our clients/patients.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
The project has resulted in better volunteer services.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
The project has resulted in better support for volunteers.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
The project has raised community awareness about palliative care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
The project has increased the skills and knowledge of staff working in palliative care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
The project has increased the palliative care skills and knowledge of staff working in other parts of the health system	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
The project has increased the palliative care skills and knowledge of staff working in the community care sector	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
The project has resulted in better services and support for carers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
The project has improved the availability of bereavement support	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
The project has improved the quality of bereavement support services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
We want the changes that the project has achieved to continue.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Add any further comments on consumer, agency or system-level issues raised by any of the questions above (note the number of the question) or on any other matters not already covered in this feedback sheet.

This is the end of the survey. Thank you for your time.