**Having Community Readiness for**

**Palliative Care Program Development**

**Worksheets**

**Community Readiness**

Discuss the following questions as a group. Fill out the tables as you go along to help you organize your answers.

1. What care is available now to people who are dying in your community? How is it accessed by patients and families?
2. Who provides care to people who are dying in your community? Where is this care provided?
3. Is palliative care organized in your community? If yes, how does it work? How is it being led and managed? How did it get started? What resources do you currently have?

Tables 1 and 2 can be used to help you brainstorm and organize your answers for questions 1 – 3.

1. What are real strengths in the way that care is currently provided to dying people in your community? What things would you not want to lose as the program develops?
2. What is the quality of dying in your community now?

Table 3 can be used to help you answer questions 4 and 5.

1. What are the greatest challenges you have in providing care for people who are dying?
2. What do you think needs to happen to address these challenges?
3. Is there anything in your community that will/could prevent you from implementing a palliative care program?

Table 4 can be used to help you organize your answers for question 6, 7, and 8.

1. What is your vision for change in relation to palliative care in your community? Do you have any particular goals as a community for palliative care?

Table 5 can be used to come up with a work plan to help you achieve your vision and goals.

**Table 1: Assessment of local health infrastructure & palliative care services**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of Agency/Provider** | **What services do they provide?** | **How can they be accessed?** | **Do they have a representative on the team?**  |
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**Table 2: Where are palliative care services being provided?**

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| --- | --- | --- |
| **Location of services** | **List of services that are provided here** | **Any gaps?** |
| **In the client’s home** |  |  |
| **In the community** |  |  |
| **In the hospital / clinic** |  |  |
| **In long-term care** |  |  |
| **Outside the community** |  |  |

**Table 3: Assessing Community Strengths**

Make a list of the strengths that you and your community have that impact the way that palliative care is provided.

|  |  |
| --- | --- |
|  | **Strengths** |
| **Community Characteristics** | *e.g. closeknittedness, level of volunteerism* |
| **Service/Care Provider Characteristics** | *e.g. existing relationships, knowledge, skills, experience* |
| **Type/Quality/Accessibility/****Delivery of Services**  |  |

**Table 4: Assessing & Prioritizing Gaps in Services and Challenges to Overcome**

Think about the gaps in service and challenges that your community faces. Identify which gaps are the most important for your team to address (e.g. what gaps do we need to work on filling right away?). Next, identify which challenges will be most important for your team/community to overcome in order for you to “succeed.”

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **1****Most Important** | **2** | **3** | **4** | **5** **Least Important** |
|  |  |  |  |  |  |
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**Table 5: Plan for Action**

Think about your long-term vision and what you will need to do to see it realized. Make a list of all of the goals that you need to be working on in order to transform your vision into reality. To keep from being overwhelmed, start out by listing 2 or 3 short-term goals that are both specific and achievable.

|  |  |  |  |
| --- | --- | --- | --- |
| **Goal** | **Actions That Need to Be Taken to Achieve Goal** | **Timeline**  | **Who is Responsible?** |
|  |  |  |  |
|  |  |  |  |
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