REDEFINING END-OF-LIFE CARE: A CLINICALLY SUPPORTED RELATIONAL CARE MODEL FOR INTEGRATED COMMUNITY-BASED SYSTEMS

Anne Kubiak (RN) [1], Dr Clay Spencer [2]
Full Circle - End of Life Matters, Sydney, NSW, Australia

KEYWORDS

End-of-life care; relational care; public health palliative care; integrated care; community-based care; health systems innovation.

EXECUTIVE SUMMARY (100 words maximum)

Despite advances in palliative care, relational, practical and navigational support can remain fragmented across services. This abstract introduces a clinically supported relational care model establishing a structured interface between clinical services, families and community-based care. Full Circle currently applies the model through an end-of-life doula workforce operating within defined governance, scope of practice and escalation pathways. The defining feature is the relational continuity function and governed interface, complementing existing clinical care while preserving clinical responsibility. The model aligns with public health palliative care principles by strengthening community capacity and continuity across settings. Evaluation will assess feasibility, integration and system-level impact.

INTRODUCTION

Highlights

- Introduces a clinically supported relational care model that integrates health, community and family systems.
- Establishes relational continuity as a structured component of end-of-life care.
- Demonstrates governance mechanisms enabling safe integration of a relational workforce.
- Strengthens community capacity while supporting care in the preferred place.

METHODOLOGY/ PROCESS

Model Development

The model was developed through iterative practice-based design informed by more than 30 years' experience across clinical nursing, health policy, governance and community-based end-of-life care. It responds to persistent system challenges including fragmented transitions, variable relational continuity and inconsistent support for families navigating end-of-life care.

Framework Overview

The Full Circle implementation framework was developed to operationalise a governed relational continuity model that connects the person-family unit with existing clinical, community and support systems. The framework comprises four interconnected domains: governance; workforce and practice; operational systems; and quality, evaluation and continuous improvement.

Within the current Full Circle application, the model is delivered through an end-of-life doula workforce practicing within defined scope, supervision and escalation arrangements. The framework is designed to support implementation alongside existing clinical services, preserve clinical responsibility and strengthen continuity across transitions in care.

System Alignment

The model aligns with public health palliative care principles and contemporary health system priorities including integrated care, person-centred care, community capacity building and more appropriate use of hospital and health services. It provides an implementation framework capable of integration across primary care, specialist palliative care, hospitals and aged care while maintaining clear governance and accountability.

RESULTS/ OUTCOMES

Formal evaluation is planned to examine:

Person outcomes

- Preferred place of care and death
- Experience of care
- Relational continuity.

Family outcomes

- Preparedness, confidence, navigation of services.

Clinical/service outcomes

- Improved coordination across services
- Enhanced communication between providers
- Earlier identification of support needs

Health system outcomes

- Potentially avoidable emergency presentations
- Hospital utilisation
- Patterns of health-service utilisation
- Implementation costs and modelled economic value

Workforce outcomes

- Safe integration of relational care workers
- Workforce sustainability
- Governance effectiveness

Hypothesised system-level impacts

By integrating structured relational care within existing health systems, the model aims to shift end-of-life care from reactive, fragmented and hospital-centred responses towards more proactive, coordinated, person-centred care delivered in partnership with families and communities.

CONCLUSION

A clinically supported relational care model offers a practical and scalable approach to strengthening the interface between clinical services, families and communities. Rather than replacing existing services, it complements clinical care while preserving clear governance, clinical accountability and continuity of care.

As demand for end-of-life care increases, clinically supported relational care models have the potential to improve person and family experience, strengthen integrated care and support health system sustainability.