Strengthening partnerships between health and aged care services to achieve better end-of-life care for older Australians

The Decision Assist Linkages Project Case Studies
The Decision Assist project is funded by the Australian Government to build capacity, linkages and access to palliative care and advance care planning to assist health professionals caring for older people in receipt of aged care services.

Decision Assist is delivered by a consortium including Austin Health, Aged and Community Services Australia, the Australian and New Zealand Society of Palliative Medicine, CareSearch, Leading Age Services Australia, Palliative Care Australia, Queensland University of Technology and the University of Queensland.

STRATEGIES USED IN TRIAL

INTRODUCTION

FULL LIST OF DEMONSTRATION SITES

360 Health + Community: Project Link 360

Anglican Care: Linkages, networking and clinical leadership

Blue Care: Development of an Advance Care Planning framework

Echuca Regional Health: Improving the palliative care provided to Aboriginal residents of Glanville Village Nursing Home

Far West Local Health District: Palliative Care Linkage nurse in residential aged care: a rural pilot project

Footprints Brisbane: End-of-Life Pathway project

Helping Hand Aged Care: Best outcomes through Linkages project

Little Haven Palliative Care: Strengthening palliative aged care in the community

Maryborough District Health Service: Streamlining processes between palliative and aged care services in Maryborough

mecwacare: Palliative care partnerships

Nambucca Valley Care: Nambucca Valley Care and Mid North Coast Local Health District Palliative Care Linkages project

Northern Health Network: Improving the end-of-life stages for Aboriginal and Torres Strait Islander people living in a residential aged care setting

Peninsula Health: Broaden the horizon – enhancing palliative care services to residential aged care facilities

PresCare Tasmania: Palliative Care Linkages project

PresCare: A proactive and connected Palliative Approach

PresCare: Palliative Care Connect Rockhampton

Rural Northwest Health: Improve and promote the best possible palliative care journey for our residents

Blue Care Metro South Cluster: Linking culturally and linguistically diverse clients with specialist palliative care services

Western Health: Development and trial of a new referral and communication pathway between Western Health’s Care Coordination and Palliative Care Services

The Whiddon Group: Improving palliative care experiences
Strategies identified and used in the Decision Assist Linkages project

A review of the published and grey literature identified evidence to support seven strategies that promote interorganisational linkages. These underpin the Decision Assist Palliative Care Linkages project. In no particular order, these strategies are:

MULTIDISCIPLINARY TEAMS
Input into clinical care is provided through regular scheduled communication between team members from a range of disciplines and services delivering palliative care and aged care.

WRITTEN AND VERBAL COMMUNICATION PATHWAYS
Shared and standardised documentation and communication processes support care delivery, and may include usage of common language, standardised referral forms, agreed assessment tools, and Advance Care Plans.

FORMALISED AGREEMENTS AND PLANS
Formalising linkages through written agreements and governance arrangements can ensure discussion of and commitment to resource allocation, mutual responsibilities, agreed outcomes, and communication processes.

DESIGNATED LINKAGE WORKER
Appointment of a key worker whose responsibility it is to act as a care and linkage coordinator across settings is seen to improve access to services, improve cooperation between services, improve continuity of care and promote shared understanding of the Linkage worker role.

ROLE CLARIFICATION
Clarity of roles and responsibilities for each practitioner involved in the linkage partnership leads to improved continuity of care particularly when transitioning between settings of care.

KNOWLEDGE EXCHANGE AND UPSKILLING
Shared learning opportunities, both formal and informal, increase knowledge and develop capabilities in providing palliative care for older Australians.

CONTINUOUS IMPROVEMENT
Processes for continual review of linkage strategies and their outcomes enable identification of their effectiveness and efficiency.
The Decision Assist Palliative Care Linkages project was a unique project implemented nationally to enable enhancements of linkages between service providers involved in the delivery of palliative and end-of-life care to older Australians. The project is based on the premise that effective, mutually beneficial linkages between a number of agencies have a positive impact on client outcomes.

The value of such linkages is reflected in existing policy frameworks, for example, the Australian Government’s National Palliative Care Strategy 2010*, which emphasises the need to ‘support the evolution of innovative models of palliative care service provision (and) the development of integrated/coordinated models of palliative care service provision.’

Within this context, the QUT project team coordinated a large-scale project to promote linkages between palliative care services and aged care providers. Each demonstration site included at least two organisations, one of which must be funded to provide Australian Government home care or residential services, and one of which must provide dedicated palliative care services.

This booklet provides a snapshot of these 20 demonstration sites – their goals, achievements, challenges, and plans for the future – as they undertook their Linkages project. It showcases their approaches to building partnerships and improving linkages between health care organisations. In it, we hope to demonstrate successful, realistic and sustainable strategies for service providers who support older Australians nearing the end of life.

Each of the 20 demonstration projects undertook to implement a number of pre-defined linkage strategies that were identified in a review of the published literature (see page 2 for a full list of strategies). All projects implemented at least one or more of the linkage strategies. As the projects evolved some demonstration sites implemented more than they originally indicated.

Some key outcomes across the sites as follows:

- All projects successfully demonstrated new linkages with a variety of services and providers to reflect their local needs.
- Project teams used a wide range of local and national resources to support their aims. For example, the Palliative Approach toolkit was modified by some teams to suit their own contexts including adaptations of the statement of choices and referral pathway documents to suit local situations.
- Communication tools including referral pathways on information leaflets were jointly developed between General Practitioners, specialist palliative care providers and aged care providers.
- Many demonstration project teams developed and modified tools to suit their local context including: job descriptions, service agreements and Memoranda of Understanding, referral and communication pathways, flowcharts, checklists, Advance Care Plans and audit tools.

Each demonstration site was asked to develop sustainability plans to ensure the improvements made endure beyond the life of the project. These strategies are described in each demonstration site’s profile in this booklet.

The Decision Assist Linkages project recognises Aboriginal and Torres Strait Islander people as traditional custodians of Australia. The two demonstration sites that involved Indigenous people specifically worked with Residential Aged Care Facilities for Aboriginal Elders. These two demonstration sites are located within the southern states of Australia which have a small number of Torres Strait Islander residents. These sites recognise Aboriginal people in their project titles, however also recognise Torres Strait Islander people within their institutional policy, procedures and documents.

*Commonwealth of Australia (2010), National Palliative Care Strategy: Department of Health and Ageing*
Linkages project – Demonstration sites
Project teams and titles

360 HEALTH + COMMUNITY: PROJECT LINK 360
- Bedingfeld Park Aged Care Facility, Pinjarra
- Quambie Park Pam Corker House, Waroona

ANGLICAN CARE: LINKAGES, NETWORKING AND CLINICAL LEADERSHIP
- Salutogenic Concepts, Newcastle

BLUE CARE: DEVELOPMENT OF AN ADVANCE CARE PLANNING FRAMEWORK
- UnitingCare Health (including The Wesley Hospital, St Andrew’s War Memorial Hospital, Sunshine Coast Private Hospital), Brisbane and Buderim

ECHUCA REGIONAL HEALTH: IMPROVING THE PALLIATIVE CARE PROVIDED TO ABORIGINAL RESIDENTS OF GLANVILLE VILLAGE NURSING HOME
- Glanville Village, Echuca
- Community Palliative Care, Echuca

FAR WEST LOCAL HEALTH DISTRICT: PALLIATIVE CARE LINKAGE NURSE IN RESIDENTIAL AGED CARE – A RURAL PILOT PROJECT
- Southern Cross Care, Broken Hill
- Murray House, Wentworth

FOOTPRINTS BRISBANE: END-OF-LIFE PATHWAY PROJECT
- Karuna Hospice Services, Windsor
- BallyCara, Redcliffe
- St Vincent’s Palliative Care Service, Brisbane

HELPING HAND AGED CARE: BEST OUTCOMES THROUGH LINKAGES PROJECT
- Mary Potter Hospice Calvary, North Adelaide Private Hospital, North Adelaide
- Central Adelaide Palliative Care and Geriatric Services, Central Adelaide Local Health Network, Woodville South

LITTLE HAVEN PALLIATIVE CARE: STRENGTHENING PALLIATIVE AGED CARE LINKAGE IN THE COMMUNITY
- Wesley Mission, Gympie

MARYBOROUGH DISTRICT HEALTH SERVICE: STREAMLINING PROCESSES BETWEEN PALLIATIVE AND AGED CARE SERVICES IN MARYBOROUGH
- District Palliative Care Service, Maryborough

MECWACARE: PALLIATIVE CARE PARTNERSHIPS
- Cabrini Palliative Home Care, Prahan

*Alphabetical by lead organisation
NAMBUCCA VALLEY CARE: NAMBUCCA VALLEY CARE AND MID NORTH COAST LOCAL HEALTH DISTRICT
PALLIATIVE CARE LINKAGE PROJECT

- Mid North Coast Local Health District, Coffs Harbour

NORTHERN HEALTH NETWORK: IMPROVING THE END-OF-LIFE STAGES FOR ABORIGINAL AND TORRES STRAIT
ISLANDER PEOPLE LIVING IN A RESIDENTIAL AGED CARE SETTING

- SA Ambulance Service, Adelaide
- Aboriginal Elders Village, Davoren Park

PENINSULA HEALTH: BROADEN THE HORIZON – ENHANCING PALLIATIVE CARE SERVICES TO RESIDENTIAL AGED
CARE FACILITIES

- Peninsula Home Hospice, Frankston
- Ranelagh Gardens Aged Care Facility, Mt Eliza
- Forest Lodge Aged Care Facility, Frankston North

PRESCARE TASMANIA: PALLIATIVE CARE LINKAGE PROJECT

- Specialist Palliative Care Service North, Launceston

PRESCARE: A PROACTIVE AND CONNECTED PALLIATIVE APPROACH

- Metro South Palliative Care Services, Brisbane

PRESCARE: PALLIATIVE CARE CONNECT ROCKHAMPTON

- Specialist Palliative Care Service, Rockhampton

RURAL NORTHWEST HEALTH: IMPROVE AND PROMOTE THE BEST POSSIBLE PALLIATIVE CARE JOURNEY FOR
OUR RESIDENTS

- Wimmera Hospice Care, Wimmera Health Care Group, Horsham
- Djerrirwarth Health Services Grampians Region Palliative Care Consortium, Ballarat

BLUE CARE METRO SOUTH CLUSTER: LINKING CULTURALLY AND LINGUISTICALLY DIVERSE CLIENTS WITH
SPECIALIST PALLIATIVE CARE SERVICES

- Metro South Hospital and Health Service Palliative Care Service, Logan

WESTERN HEALTH: DEVELOPMENT AND TRIAL OF A NEW REFERRAL AND COMMUNICATION PATHWAY BETWEEN
WESTERN HEALTH’S CARE COORDINATION AND PALLIATIVE CARE SERVICES

- Mercy Palliative Care, Sunshine
- St. Bernadette’s (Catholic Homes), Sunshine North

THE WHIDDON GROUP: IMPROVING PALLIATIVE CARE EXPERIENCES

- South West Sydney Local Health District, Liverpool
- Palliative Aged Care Consultancy Service, Liverpool
Building strong links between residential care facilities and specialist palliative care services has been essential for this Western Australian region that faces a shortage of access to qualified palliative carers. Through developing communication links, knowledge exchanges and referral pathways, this community now has a strategy to enhance the provision of palliative care.

360 Health + Community is Western Australia’s fastest growing primary health care provider with a long history of service delivery in the Perth south coastal region. The agency provides services to assist general practices and allied health professionals to access information, education and training to improve the health and wellbeing of the community. In undertaking this project, 360 Health selected semi-rural residential aged care facilities (RACF) as partners.

Bedingfeld Park is a community owned not-for-profit RACF providing accommodation and nursing care for the frail and aged. Situated on the banks of the Murray River in Pinjarra 85km south of Perth, Bedingfeld Park has 34 single suites for residents with low and high care needs. Quambie Park Pam Corker House in Waroona, some 108km south of Perth, has developed strong links with its surrounding rural and mining communities in the 30 years it has provided RACF, retirement and community services.
The aim of this project was to enhance palliative care in this region, as there was an identified workforce shortage in high quality and specialist palliative care. To overcome this, the project partners sought to build strong links and skills among a selected group of existing care providers. This necessitated the collaboration between project partners and local general practitioners, and a commitment from all parties for continuous knowledge exchange and service improvements.

Outcomes achieved included increasing the knowledge on developing palliative care referral pathways to selected care services and how these services can be applied to individuals in care, and the development of multidisciplinary consultation services resulting in shared case conferencing. But most importantly, the key outcome has been the increased provider knowledge and awareness of palliative care services, brought about through service mapping and enhanced relationships between providers.

This project experienced some changes to key partners during the project’s timeframe. A GP with specialist palliative care knowledge was replaced by a specialised palliative care service at the six-month mark. However, this change was beneficial with the result being strengthened new connections to palliative care services.

Looking to the future, the partners are committed to building their relationships and connections on multiple aspects of aged care. The group is dedicated to their goal of providing multidisciplinary care coordination, with palliative care one of a number of future services.
Anglican Care (NSW)

Developing a team approach to care with an emphasis on wellbeing and comfort were paramount objectives in this Anglican Care led project based in the NSW Hunter Valley. The project sought to engage with families and care professionals allowing for greater sharing of information and skills. Key strategies, including employing a palliative aged care Nurse Practitioner and the implementation of Comfort Care Coordinators within RACFs. This resulted in better care for the elderly, and peace of mind for their families/carers.

Anglican Care has provided a wide choice of quality services to the people of the Hunter since the 1950s when the Anglican Diocese of Newcastle identified increasing care needs for the aged in the community. In the 60+ years since, Anglican Care has committed itself to building on its commitment to the aged by constantly reviewing service delivery and ensuring the 1200 residents and consumers across eight facilities in the Hunter Valley community are well catered for. Working with Anglican Care Hunter in this project was an aged care Nurse Practitioner specialising in palliative aged care, and with strong networking links to the Calvary Mater Palliative Care Service.

Through this project the partner organisations were committed to designing a collaborative model of care led by a palliative aged care Nurse Practitioner and the implementation of Comfort Care Coordinators within RACFs. This resulted in better care for the elderly, and peace of mind for their families/carers.

CONTACT
Karen Best, General Manager
karen.best@anglicancare.com.au

OVERVIEW

PARTNERS
- Anglican Care Aged Care Hunter Region NSW
- Salutogenic Concepts Aged Care Nurse Practitioner

LINKAGE STRATEGIES
- Communication pathways
- Designated Linkage workers
- Knowledge exchange and upskilling
- Role clarification
- Continuous improvement

OUTCOMES
- Staff capacity strengthened via facility champions (Comfort Care Coordinators) providing peer leadership for care workers.
- Anglican Care RACFs have increased use of a palliative approach to care
- Enhanced linkages with GPs
- Empowerment of RNs through the clinical leadership model

LOOKING AHEAD
- Continuing to develop comfort care models and leadership in palliative aged care by nurse practitioners
- Continuous engagement with GPs

Decision Assist Linkages project: Anglican Care
care Nurse Practitioner (Linkage nurse) to promote a team approach to care with an emphasis on wellbeing and comfort. To achieve this, communication pathways were developed to allow the introduction of new roles, role clarification, knowledge exchange and upskilling, and continuous improvement. Referral criteria were established and care tools aimed specifically at palliative care were developed.

‘Quality end of life is now our focus’

To ensure maximum understanding of the new tools and strategies, education programs were undertaken alongside regular clinical meetings, information and discussion sessions for families and care workers, and specific forums aimed at GPs and the Primary Health Network. A series of three breakfast networking meetings, opened to all RACFs in the region, were also organised ensuring a range of opportunities for stakeholders to meet and discuss the new strategic palliative direction. These breakfasts facilitated networking among the key players tasked with implementation.

This project simultaneously introduced a number of key aspects that allowed it to meet its ambitious objectives and implement its multidimensional knowledge pathway. A palliative aged care focus was embedded into each facility. The Nurse Practitioner was tasked with four key requirements including leading the organisational philosophy of the Palliative Approach to care, delivering better practice palliative/comfort focused/hospice type care, optimising end-of-life assessment and symptom management, and providing understanding and knowledge to the community, family, staff, GPs and other allied health professionals.

The development and introduction of a Registered Nurse Clinical Leadership program aimed at increasing the knowledge and skills of a Registered Nurse across advance care discussion, symptom assessment, management and quality of end-of-life care.

The third key element was the creation of a platform for skill utilisation across all levels of staff through the development of a new role of a Comfort Care Coordinator implemented within a RN led clinical model. A lanyard badge was created as a prompt for comfort care (see below).

Bringing many different stakeholders together to see how a new strategy will bring positive change is always a challenge, particularly among people who are already busy. But the future for this project is positive. There is significant commitment and results have been positive with key stakeholders feeling empowered. Communication strategies are in place that keep people well informed. But most importantly, for those on the final life journey, along with their family and carers, wellbeing and increased comfort are being achieved.
Keeping an individual’s wishes at the centre of their care as they transfer from community to hospital and from hospital to community was the central aim of the project.

Project partners Blue Care and UnitingCare Health, with the involvement of three acute Queensland hospitals, developed advance care plans and processes allowing the transfer of a person’s documented wishes for care across UnitingCare’s acute, community and residential care settings.

Key achievements in this project saw 10,000 Blue Care staff having access to seven e-learning modules covering all aspects of the Advance Care Plan. A Blue Care staff survey showed that nearly 90% of staff confirmed that the state-wide adoption of the Statement of Choices form led to conversations being initiated about the Advance Care Plan. Over 70% of staff said adoption of the Statement of Choices form led to greater and better discussion on Advance Care Plan choices. The vast majority of Blue Care staff indicated the Metro South Statement of Choices form should replace Blue Care’s existing form.

The future of this project is promising. Further education of Blue Care staff is planned including a self-directed facilitation guide. Evaluation of staff capabilities and confidence following the release of all educational packages will provide guidance on the project’s take-up.

UnitingCare Queensland provides health and community services to thousands of people every day of the year through its service groups, which include project partners Blue Care and UnitingCare Health. Blue Care is an aged care provider operating in more than 260 centres in 80 communities across Queensland and northern New South Wales. Blue Care collaborated here with UnitingCare Health, one of the largest not-for-profit private hospital groups in Queensland managing three acute hospital sites: the Wesley Hospital, St Andrew’s War Memorial Hospital (both in Brisbane) and the Sunshine Coast Private Hospital (Buderim). All were involved in this project.

The team adopted a multifaceted approach including standardised supporting documentation, and a jointly recognised process of seamless transfer of a person’s documented wishes across the project partners.

A steering committee was formed, consisting of multidisciplinary representatives including Directors of Nursing, a Palliative Care Nurse Practitioner, a Medical Director, the Palliative Care Medical Director, and hospital discharge planners. With consultation from organisations including Queensland Ambulance Service, Queensland Health, Metro South Palliative Care Service and UnitingCare hospital staff, the steering committee developed and trialled the project over a nine month timeframe. A project team was based at each site to ensure the flow of communication.

It was decided to adopt Queensland Health’s Metro South Statement of Choices form to replace the existing Blue Care document, allowing individuals to determine their own wishes and choices for health care into the future. A ‘yellow envelope’ provided a recognisable and consistent process for clients to store their Advance Care Plan documents and wishes for end of life in their home ready when needed for GP Advance Care Plan discussions, or hospital transfer. The ‘yellow envelope’ is utilised in both private and public health systems in Queensland and already symbolises an alert for ambulance personnel. There is increasing provision for electronic storage of this document by Queensland Health. In this way, the Advance Care Planning framework promotes linkage between the community and acute hospital settings.

89% of 10000 Blue Care staff surveyed confirmed that the state-wide adoption of the Statement of Choices form led to conversations being initiated about the Advance Care Plan.

74% confirmed that the adoption of the Statement of Choices led to greater and better discussion on Advance Care Plan choices.
an advance care planning framework

OVERVIEW

PARTNERS

- Uniting Care Health Blue Care
- UnitingCare Health (The Wesley Hospital, St Andrew’s War Memorial Hospital)
- Sunshine Coast Private Hospital

LINKAGE STRATEGIES

- Formalised agreements
- Communication pathways
- Knowledge exchange and upskilling
- Continuous improvement
- Multidisciplinary teams

OUTCOMES

- Online learning modules
- Adoption of Queensland Health Statement of Choices form

LOOKING AHEAD

- Self-education
- Evaluation of staff capabilities and confidence
- Roll out to other sites
Cultural respect and recognition were highlighted as the foundation of the Echuca project – respect for Aboriginal and Torres Strait Islander perspectives of death and dying and that these perspectives may differ to conventional Western beliefs. In this project, the two partners were firm in their intent to learn from past experiences and ensure input from the local Aboriginal community was integrated into palliative care.

This partnership between the Glanville Village Aged Care Facility, managed by project leader Echuca Regional Health and the Echuca Community Palliative Care Service aimed to develop a multidisciplinary care approach, working with an Aboriginal Liaison Officer to ensure culturally appropriate and safe care. Both partners saw this as an opportunity to strengthen the relationship between Echuca Regional Health and the Aboriginal community, building on a previous Aboriginal Gap Analysis project.

Echuca is a regional Victorian town located on the banks of the Murray and Campaspe Rivers on the New South Wales (NSW) border. Echuca Regional Health has served the community for 129 years and now manages 67 acute hospital beds and 68 residential aged care beds in Glanville Village. Echuca Community Palliative Care has recently undergone significant change from generalised palliative care to patients in the home in the Echuca community, to one of a specialist palliative care service.

YARNING

Yarning is an informal conversation that is culturally friendly and recognised by Aboriginal people as a meaningful way to talk about something, someone or provide and receive information.

In this demonstration site yarning replaced formal meetings and questionnaires, as these had been previously unsuccessful due to mistrust and past negative experiences of the Aboriginal community.
Challenges identified included a transient Aboriginal population, a lack of understanding from some Aboriginal people about how the border between Victoria and NSW impacts health service delivery, the need to improve cultural sensitivity from Echuca Regional Health regarding care delivery, and the inherent privacy of cultural customs regarding the Aboriginal end-of-life journey. With the aim to improve palliative care services to the entire Echuca community, the partners selected a number of strategies they believed would best achieve their goals and improve relationships between Echuca Regional Health and the Aboriginal community.

Making use of a pre-existing Aboriginal Gap Analysis, a reconciliation plan was formulated with the assistance of the Aboriginal Liaison Officer’s cultural expertise during the consultation process. Consultation occurred in informal ‘yarning’ meetings and focused on listening to the needs of the Aboriginal community. The Echuca Regional Health also acknowledged their role in the historical grievances surrounding health delivery to the Aboriginal community and asked ‘how can we do it better?’ Throughout the reconciliation process, other elders became engaged, in part due to an existing strong relationship with an Aboriginal corporation.

Outcomes from this project were many and tangible. It resulted in a change to how services are delivered, with palliative care specialist services now available to residential care recipients. The Memorandum of Understanding effectively demonstrated that formal arrangements can bring partners together to achieve mutual goals. This shift in thinking enabled action, including ongoing education by the Community Palliative Care Service to Glanville staff on palliative care and advance care planning, the development of a culturally specific end-of-life pathway, the creation of a cultural action plan, and the development of the ‘Creating a welcoming environment’ tool.

Following the implementation of this project, the Echuca Community Palliative Care Service received their first referral of an Aboriginal resident from Glanville Village.

The partnership will continue with monthly palliative care education sessions hosted by the Echuca Community Palliative Care Service to aged care and health care workers.

CONTACT
June Dyson
Director Nursing Echuca Regional Health
jdyson@erh.org.au

Glanville Residents with aunty Melva Johnson and Mr Leo Edwards - Aunty Melva Johnson is a Yorta Yorta and Wemba Wemba Elder, and a champion of Aboriginal education and health. She has taken a leading role in setting up community services around Echuca, and has been a source of valuable encouragement and guidance to young and old alike. In 1974, Aunty Melva joined with other community members to found the Echuca Aboriginal Co-operative. The Co-op began to address the neglect inherent in local health and education, restoring people’s self-confidence at the same time. Aunty Melva served as administrator for eight years and a member of the Board.
Known as the ‘Capital of the Outback’, Broken Hill was the location for this demonstration site, where three organisations partnered with a strong resolve to improve end-of-life care for residents in aged care facilities. Broken Hill lies to the far west of NSW, and with Adelaide the closest city at over 500kms away, it was the most remote site included in the Linkages project.

The Broken Hill project was led by the Far West Local Health District, who provides specialised palliative care, including nursing and medical support, to patients with complex needs living across diverse settings. The Far West Local Health District cares for over 30,000 people across the second largest geographic area (194,949km²) of all NSW Local Health Districts. According to NSW Health, the proportion of the population within the Far West Local Health District aged 65 years and over is predicted to increase from 18.1% in 2011 to 25.4% by 2026. All partners in this group had identified the main challenges as limited RACF staff knowledge of palliative care, poor identification of patients in the deteriorating/terminal palliative care phase, lack of advance care planning and lack of family education – all leading to unsustainably high referrals to specialised palliative care services.

A strong pre-existing partnership between the Local Health District and Southern Cross Care Broken Hill - who manage...
three aged care facilities in Broken Hill and the Sunraysia district - meant that the team could quickly work to integrate the third partner, the RACF Murray House in Wentworth (270 km to the south of Broken Hill), formalise agreements via a Memorandum of Understanding, and commence the implementation of their three selected strategies.

Prior to the Decision Assist Linkages project, the partnership had identified the need for Linkage workers. The Decision Assist Linkages project provided the first opportunity to implement this logical next step.

The team aimed to facilitate quality end-of-life care for RACF residents by reducing the number of unnecessary hospital transfers (hospital avoidance model), and thereby increase the number of patients dying in their usual place of residence. The strategies best served to fulfil the aim were the incorporation of a Linkage worker, training of staff across various levels and clear communication pathways.

‘Long standing high level partnerships worked well. Members owned the problem; mutual benefit was easily identified.’

Key to the success of this project was the effective integration of the Clinical Nurse Specialist from the Palliative Care Service of the Local Health District. The Clinical Nurse Specialist successfully engaged (via training and mentoring) with the RACF staff, residents and families, GPs and hospital ward staff to better identify people approaching the end of their life. Other methods implemented at the day to day level included diversifying interactions with residents and clarifying roles among the carers. The team also developed improved documentation of end-of-life wishes and advance care plans, and a suite of locally adapted documents and toolkits for RACFs.

This project achieved system change with tangible results. Both RACFs now have a Palliative Approach coordinator and there has been an increase in initiation of end-of-life discussions/advance care documentation by RACF nursing staff and/or palliative care Linkage nurses. There was an increased number of appropriate referrals of RACF residents to specialist palliative care, from 26% in 2013 to 45% in 2015 from GPs, and 13% in 2013 to 21% in 2015 from other sources. There was also a significant reduction in the number of residents dying in hospital, from 40% in 2013 to 22% in 2015.

Based on the success of this project, the team is committed to meeting regularly to sustain the strong relationships. They have secured funding from Southern Cross Care for three Palliative Approach coordinators to work across three RACFs. Far West Local Health District has submitted a translational research grant to NSW Health to transfer the model of the Palliative Approach to other remote sites across the district.

This project enabled the optimisation of a pre-existing strong partnership. By effectively engaging Linkage workers, the partners realised system change throughout their organisations.
Footprints Brisbane, a not-for-profit community based organisation, provides support for people experiencing social and financial disadvantage. Serving the Brisbane North region, which comprises a population of around 930,000, staff identified a need for a formal palliative care approach as the number of older disadvantaged clients increases in the future.

Partnering with Footprints Inc. in this project were community-based charity Karuna Hospice Services, BallyCara - a RACF located 30kms from Brisbane City - and St Vincent’s Palliative Care Service. All organisations in this partnership have a shared vision of providing compassion and support for clients who might otherwise fall through the cracks of conventional services. Providing dignity and quality of life in an appropriate care setting to clients of Footprints was central to the objectives of this partnership.

Project leader Footprints provides support for people with disabilities, older people, their carers and families, people with mental illness, people who are experiencing social and financial disadvantage, and those at risk of homelessness or homeless persons. Organisations such as Footprints face a number of unique challenges. Clients lack conventional networks such as family, friends and reliable social supports to help them navigate the health care system, care for them, or help them to put their affairs in order at the end of their life. Moreover, clients with no permanent address are difficult to assess, and likewise it is difficult to ensure staff safety from a Health and Safety perspective.

To achieve their goals, the partners used a number of strategies, the key strategy being the implementation of a designated Linkage worker. The newly created position of Nursing Care Coordinator, a role that was clearly defined from the outset to ensure mutual benefit among partners, was designed to build links with Karuna, St Vincent’s and BallyCara. The partners also developed flexible and shared care plans and a brochure for staff to help them recognise health deterioration and provide guidelines on the process of palliative care referral. Also significant, and a reflection of the commitments of these partners, was the implementation of the strategies knowledge exchange and upskilling. This included the incorporation of Death Cafés (see deathcafe.com for more information) and professional development (two Footprints staff attended a Decision Assist workshop). Resources for internal ongoing training were also developed.

An important outcome of this project was the relationship created with Karuna Hospice Services who were very responsive to the specific needs of the clients, particularly those with mental illness, which can be prevalent among the homeless community. While implementing some standard procedures and guides for staff, the individual needs of the clients and their unique circumstances will continue to be catered for by adopting a case manager merit approach for clients. The linkage role will also be incorporated as a permanent role into Footprints, ensuring a sustainable and successful partnership with Karuna, St Vincent’s and BallyCara into the future.

CASE STUDY

Kampong was a lady living in a room in a local boarding house in Brisbane’s inner city. With the diagnosis of lung cancer and subsequent treatment she became quite unwell and was at risk of being evicted by the boarding house manager due to her deteriorating health. Kampong was referred to Footprints and accepted for social support, receiving assistance with personal care, meal preparation and attendance to her medical appointments. Through referral to Karuna Hospice Services, Kampong was also able to die in her home.

CONTACT

Lynne Megginson
LynneM@footprintsinc.org.au
OVERVIEW

PARTNERS
- Footprints Brisbane
- Karuna Hospice Services
- BallyCara RACF
- St Vincent’s Palliative Care Service

LINKAGE STRATEGIES
- Formalised agreements
- Role clarification
- Communication pathways
- Multidisciplinary teams
- Designated Linkage worker
- Knowledge exchange and upskilling
- Continuous improvement

OUTCOMES
- Shared/flexible care plans
- Case manager merit approach
- Nurse care coordinator
- Death Café
- Guidance brochure for palliative care

LOOKING AHEAD
- Linkage role incorporated permanently into Footprints
- Ongoing relationship with Karuna based on individual client needs
Helping Hand Aged Care (SA)

OVERVIEW

PARTNERS

- Helping Hand Aged Care
- Central Adelaide Local Health Network – Palliative Care Service
- Mary Potter Hospice Calvary North Adelaide Private Hospital

LINKAGE STRATEGIES

- Role clarification
- Communication pathway
- Designated Linkage worker

OUTCOME

- Connected with the Nurse Practitioner of another RACF and developed personal care worker specific education including the Palliative Approach

LOOKING AHEAD

- Informal partnerships will continue to enable ongoing education of personal care workers and GPs
- This project has highlighted the need for RACFs to provide palliative care and easy access to specialised support from acute care facilities. Helping Hand is investigating setting up two dedicated palliative care units with site redevelopment.

CONTACT

Megan Corlis
mcorlis@helpinghand.org.au

Recognised as one of the most progressive aged care service providers in Australia, Helping Hand partnered with local health and hospice services to ensure that the elderly receive suitable care in the place that they and their family choose. Helping Hand saw this project as an opportunity to improve in house palliative care services through the development of an inter-professional shared care model.

Helping Hand is a not-for-profit organisation operating in metropolitan and regional South Australia and manages nine RACFs. In this project they partnered with the palliative care service of the Central Adelaide Local Health Network, which included a team of nurses, doctors and social workers, and the Mary Potter Hospice. The Mary Potter Hospice is a purpose built unit of Calvary North Adelaide Hospital featuring 14 private rooms. Symptom control and respite for home carers are the principal services of the hospice.

Having recognised a need to incorporate palliative care into their services, Helping Hand were already in the process of rolling out a Palliative Approach toolkit prior to commencement of the Decision Assist Linkages project. The toolkit includes basic training for all staff and the identification/training of nurse and care worker champions. The Decision Assist Linkages project provided a formal framework and extra resources, through which Helping Hand could formalise their toolkit and integrate specialised partners into their strategy.

Applying the strategies role clarification and communication pathways, their specific approach was to develop multi-disciplinary roles and communication tools across the three partners to enable better access to clinical advice, medications and consumables. It was identified that an important step in achieving their aim was to clearly define the role of the Central Adelaide Local Health Network and Mary Potter Hospice in treating residents of the Helping Hand RACFs. A hospital avoidance program was put into place, beginning with SA Ambulance Service Extended Care Paramedics who provide treatment at the RACF rather than transferring the resident to hospital. A global broadcast distribution list was also developed to facilitate rapid communication among the partners.

Outcomes included the development of an admission document, based on the results of after death audits, which highlighted the gaps in documentation and lack of
knowledge in identifying residents approaching end of life. Via an informal partnership, Helping Hand connected with a Nurse Practitioner of another RACF and developed personal care worker specific education after identifying a need to increase knowledge transfer from Decision Assist workshops. The Nurse Practitioner will enable ongoing GP engagement in palliative care provision.

This project highlighted the need for dedicated palliative care beds within RACFs, which can be supported from acute care facilities. Helping Hand is now planning to establish two dedicated palliative care units within their sites.

Learning from the limitations of this project, Helping Hand is determined to continue to improve its palliative care services to residents and their families by pursuing informal partnerships, observing that the key to strong collaboration and sustainable partnerships is a shared vision, goals and philosophies with mutual benefit.
The team had an understanding of the reach and change that this project could achieve, and expanded the roles and scope of the project as they developed. Chief among many outcomes was the development of communication tools between palliative and aged care. A ‘shared care’ model that facilitated improved continuity, delivery and quality of care was developed. As with many other sites in the Decision Assist Linkages project, the Linkage worker became the vital driver of education, resources and communication.

Through this project, sustainable networks between palliative and aged care (community and residential) have been established, paving the way for future shared and enhanced care delivery. The formalised agreement will continue beyond this project with a view to extending the formal shared care model with other local care providers in the region.

A partnership between the specialised palliative care provider Little Haven and community aged care provider Wesley Mission set out to enhance existing linkages, streamline referral processes and develop shared care. Through increased collaboration, the care team sought to provide a linked team approach to community based palliative and aged care, further develop strategies to implement a plan of care tailored to individual needs for home care, and develop inter-service provider communication tools.

Little Haven Palliative Care is a community based not-for-profit organisation that provides palliative care and support for patients and their families in the Gympie and surrounding area across a 70 km radius. Wesley Mission, Gympie is one of Queensland’s leading not-for-profit organisations offering aged care community services through packaged care.

Although these two partners had worked together previously, care delivery was at times ad hoc and on occasion, patient care was duplicated. Anecdotally, patients were sometimes confused about the roles of each provider. Other gaps identified included a need to increase access for more people to quality palliative and aged care and advance care planning discussions. Patients with chronic diseases often did not have the opportunity to make their wishes known in the form of advance care planning.

Determined to optimise existing capability and commitment, the partners utilised seven strategies to meet their objectives. In addition to formalised agreements, roles and communication pathways, the partners endeavoured to develop a multidisciplinary care approach via case conferencing, links with local GPs and community health services (including the Sunshine Coast Primary Health Network) and the inclusion of the role of a social worker in care planning. The partners also introduced a designated Linkage nurse role, committed to upskilling, knowledge exchange, and a continuous improvement process through a Memorandum of Understanding.

Through this project, sustainable networks between palliative and aged care (community and residential) have been established, paving the way for future shared and enhanced care delivery. The formalised agreement will continue beyond this project with a view to extending the formal shared care model with other local care providers in the region.

CONTACT
Sue Manton
haven@spiderweb.com.au

Future
Continuing community and residential linkages between palliative care and aged care providers is paving the way for future shared care and enhanced care delivery.
OVERVIEW

PARTNERS

- Little Haven Palliative Care
- Wesley Mission Community Aged Care

LINKAGE STRATEGIES

- Formalised agreements
- Role clarification
- Communication pathways
- Multidisciplinary teams
- Designated Linkage worker
- Knowledge exchange and upskilling
- Continuous improvement

OUTCOMES

- Formalised agreement for shared care
- Development and implementation of shared communication tools
- A ‘shared care’ model facilitating improved quality and continuity of care
- Increased knowledge and confidence for aged care workers in the Palliative Approach
- Improved client satisfaction with organised shared care

LOOKING AHEAD

- Sustainable networks between palliative care and aged care
- Formalised agreement will continue beyond this project
- Opportunities now exist for extending the formalised shared care model with other local care providers in the region
- An increased understanding of Advance Care Planning options and access for aged care in the region
Maryborough District Health Service (VIC)

OVERVIEW

PARTNERS
- Maryborough District Health Service
- Loddon Mallee Palliative Care Consultancy Service
- Visiting Medical Officers – Local GPs

LINKAGE STRATEGIES
- Communication pathways

OUTCOMES
- Implemented Respecting Patient Choices as advance care planning program
- Implemented the Ballarat Care of the Dying Management Plan as end-of-life care program
- Local GPs who had attended the Decision Assist Train-the-Trainer modules in Melbourne led Advance Care Planning session for Maryborough District Health Service staff
- Education undertaken by local GPs on Care of the Dying Management plan and recognition of when to implement the plan

LOOKING AHEAD
- Inclusion of GPs from the onset of the project in decision making processes and choosing of shared documentation has ensured a high level of involvement and lead to a sustainable change in practice

CONTACT
Nicola Allen
Quality Systems and Risk Manager
Maryborough District Health Service
nallan@mdhs.vic.gov.au

This project achieved the implementation of two tools, namely Respecting Patient Choices as the advance care planning program and the Care of the Dying Management Plan as the end-of-life care program. These outcomes were achieved despite a slow project uptake due to existing heavy workloads and previous unsuccessful attempts to implement advance care planning.

Servicing the Maryborough and surrounding towns in the Victorian central goldfields, Maryborough District Health Service manages three campuses that enjoy strong clinical and social links. The services of the Maryborough District Health Service range from acute care to residential aged care and community palliative care. For this project, health services partnered to develop, implement and embed an aligned approach to advance care planning and end-of-life care planning.

The Maryborough District Health Service is one of the largest employers in the Central Goldfields Shire with over 400 staff employed over three campuses - Avoca, Dunolly and Maryborough. Each campus contains a RACF with a total capacity for 92 residents.

Prior to joining the Decision Assist Linkages project, the Maryborough District Health Service had identified a high proportion of their patients requiring palliative care. They had also identified an inconsistent approach to end of life between its community palliative care, acute care and aged care services, which impacted client care and service efficiency as many clients move between these services and have to repeat information. The expertise of the community Palliative Care Service was not well utilised across the region.
Clarifying communication pathways was identified as the best strategy to create an aligned approach to care services and end-of-life planning. This included the Care of the Dying Management Plan (local resource developed by Ballarat Health Service) as the communication pathway to support improved coordination and quality end-of-life care across Maryborough District Health Services (community palliative care, acute and RACFs).

This project has achieved the implementation Respecting Patient Choices as the Advance Care Planning program. Several resources were produced, including information packs for patients, families and carers on advance care planning processes to encourage broader discussions within local community on the importance of advance care planning. Information packs were also developed to support staff in discussing advance care planning and the palliative process.

Learning from previous efforts, the organisation provided specific targeted education for all staff, including GPs. The meaningful involvement of local GPs from the onset of the project, including attendance to training and education sessions, then the facilitation of further training of other GPs and Maryborough District Health Service staff, and uptake of the Care of the Dying Management Plan, led to real change in palliative care practices in the GP sector. This work has led to a sustainable change in practice.
The aim of this project was to ensure quality of life for people in residential and community settings through delivery of quality coordinated palliative care. Partners in the project, mecwacare and Cabrini Palliative Home Care, developed a sustainable palliative care model that was rolled out across mecwacare and Cabrini Palliative Home Care networks, and more broadly to other aged care service networks.

The palliative care partnership was led by not-for-profit organisation mecwacare. Operating for over 55 years and assisting more than 11,000 people per week in Victoria, mecwacare’s services include residential aged care, respite care, in-home care, community housing and support programs, disability and nursing services. mecwacare’s residential services provide a home for over 700 residents through eleven sites across Victoria.

mecwacare acknowledged that it did not have a specific systematic approach for the provision of palliative care within its residential aged care, with previous palliative care patients being managed in an ad hoc manner. mecwacare recognised that with assistance from Cabrini Palliative Home Care they could offer a sustainable model of enhanced care delivery and facilitate access to palliative care services within their residential care setting. The goal was to ensure that residents had choices regarding end-of-life care and would be supported to stay in their home surrounded by familiar staff and avoid the distress of unwanted and unnecessary transfers to hospital. This model would require a new approach and complete system change comprising involvement and enhanced communication between the broad range of stakeholders including GPs and allied health providers, families, carers, residents and staff.

This project offered opportunities to develop formalised agreements via a Memorandum of Understanding. A dedicated executive level steering group with defined roles and responsibilities, including management level and hands-on staff, was formed. A project manager was tasked with driving the change and facilitating communication between partners, troubleshooting, staff training and ensuring project milestones were met.

Communication strategies were essential throughout this project and needed to encompass the GPs involved in the care of mecwacare’s residents, as well as the registered nurses. Some 88 GPs at 55 practices were informed of the project and the new Palliative Approach. A total of 264 staff were trained and updated on the project progress, new policies and relevant resources and guidelines. Clarification of the referral process for mecwacare staff to refer to Cabrini Palliative Home Care was an essential component of the communication strategy, as was collection of baseline data including interviews with residents and families, staff surveys/interviews and after-death audits. This information was used to review practices and further understand the determinants of a good resident and family experience.

The commitment from the partners and the organised approach has seen key successes to this project that have resulted in the development, communication and acceptance of formal systems and processes that are transferable to other sites and even other organisations.

This project has resulted in a complete system change in palliative care provision at mecwacare’s residential aged care sites. The future is bright for this project with mecwacare and Cabrini Palliative Home Care committed to their ongoing relationship and the sharing of knowledge and resources.

‘Commitment of senior management is absolutely key to implementing any change and obtaining any ongoing financial commitment’
RESULTS IN NUMBERS

66% of residents who died within mecwacare facilities between September and 31 December 2015 were placed on the Residential Aged Care End-of-Life Care Pathway. End-of-Life Care Pathways were not in place in mecwacare facilities on project commencement so this demonstrates a substantial change in practice.

55% of all residents in mecwacare facilities had an advance care plan at project completion compared to 41% on project commencement.

23% increase in the number of palliative care case conferences offered to residents prior to their death, a significant change in practice from project commencement.

The number of Cabrini Palliative Home Care clients residing in a RACF rose 46% in the 12 months along with anecdotal reports of improved communication between mecwacare and Cabrini Palliative Home Care staff.

100% increase in the referrals from mecwacare facilities to Cabrini Palliative Home Care in 2015 compared to referrals to the Cabrini service in 2014

After death audits conducted at one mecwacare facility on project completion demonstrated:

- 100% of residents had an advance care plan
- A palliative care case conference was conducted in 80% of cases
- An end-of-life care pathway was in place in 100% of cases

OVERVIEW

PARTNERS

- mecwacare
- Cabrini Palliative Home Care

LINKAGE STRATEGIES

- Formalised agreements
- Communication pathways
- Role clarification
- Designated Linkage worker
- Knowledge exchange and upskilling
- Continuous improvement

OUTCOMES

- Sustainable model of palliative care

LOOKING AHEAD

- Ongoing relationship
- Sharing of resources
- Embed shared strategies into systems, practice and culture

CONTACT

Lisa Reynoldson, General Manager Residential Services
Lisa.Reynoldson@mecwacare.org.au
Nambucca Valley Care is committed to delivering quality care and support in such a way that encourages people to experience the best quality of life possible. Through a very successful partnership with the local health district, the team were highly motivated to realise the aim of their project, namely to improve advance care planning, enabling older people living in residential care to play a more active role in end-of-life choices and decision making.

Nambucca Valley Care opened its first Residential Aged Care Facility (RACF) Autumn Lodge Nursing Home in 1978 and now comprises four RACFs with a capacity for 192 residents. It was the lead agency in this Linkages project, partnering with the Mid North Coast Local Health District. The Local Health District covers an area extending from Port Macquarie in the south to Coffs Harbour in the north and includes public hospitals in Bellingen, Coffs Harbour, Dorrigo, Kempsey, Macksville, Port Macquarie and Wauchope.

Within the context of the NSW State Government Strategic Plan (2012–2016) to increase access to palliative care and the integration of primary care, aged care and specialist care services across the state, this linkage project was highly successful, achieving cultural change in both organisations. Strategies were chosen that were best able to achieve change across all levels of palliative care, including communication pathways, multidisciplinary care, designated Linkage worker and continuous improvement.

Guided by these strategies, a number of clearly defined objectives were agreed upon by the partners. These included improved linkages between aged care and palliative care settings, development of the Palliative Approach within the aged care setting, development of the capacity of aged care staff in the Palliative Approach and delivery, increased knowledge and confidence amongst staff and development of the mentoring role for the palliative nurse for growth and development of staff.

To achieve these objectives the approach focussed on the employment of a Linkage nurse from Nambucca Valley Care (two days per week) and a Palliative Care Clinical Nurse Consultant from Coffs Harbour Palliative Care (under the Mid North Coast Local Health District, two days per month).

As both partners in this project were very committed, a number of outcomes were achieved in a very short time frame.
This Linkages project illustrates the effectiveness of strong partnerships and is an example of what can be achieved when mutual objectives are openly and clearly described from the outset.

Outcomes were numerous and substantial and comprised the development of a number of resources, including the Palliative Approach to Care document on iCare (computerised resident management system), the ‘Nambucca Valley Care Screening Tool’ to identify areas for improvement, the point of care ‘Comfort Care Chart’, and the End-of-Life Care Plan to cover all domains of care. Purple Palliative Care folders were also introduced (containing the Comfort Care Chart) as a way of sharing information with families and carers. Shared care plans are available and are disseminated among partners and ambulance officers when required.

The delivery of these resources was optimised through the appointment of the designated Linkage nurse to Nambucca Valley Care who was able to provide a planned and coordinated approach to the change management process. The Palliative Care Clinical Nurse Consultant mentored and supported the Linkage nurse, with both nurses supporting clinical staff.

Staff at the Nambucca Valley Care facilities now have increased confidence to communicate the clinical status of residents to their GP and the GPs have gained a better insight into the Palliative Approach, which aids the timely prescription of comfort medications when needed.

Going forward, both partners are committed to embedding the Palliative Approach and it has become a standing agenda item on clinical and quality meetings. Feedback from family/carers post death will continue to be collected and incorporated as required.

Nambucca Valley Care went from limited access to embracing palliative care, in part thanks to the high level commitment from the Mid North Coast Local Health District. They have effectively integrated their palliative care approach, including the emergency service and GPs. Nambucca Valley Care has become a leader in their region as a model of palliative care in an aged care facility utilising a proactive approach to palliative care with every resident involved in Advance Care Planning in their first month of admission.

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### RESULTS IN NUMBERS

- 18 care staff trained by Nambucca Valley Care Linkage nurse in using the Palliative Approach
- 6 Recreational Activity Officers have had palliative care training
- Nambucca Valley Care hosted a breakfast forum for all stakeholders to discuss the NSW Ambulance Palliative Initiative (which includes comfort medications prescribed by GPs and able to be administered by paramedics)
- 100% of Registered Nurses (RN), Enrolled Nurses and Allied Health staff report improved understanding and confidence in communicating with and accessing specialist palliative care services
- Nurses from Nambucca Valley Care established a palliative care special interest group which alerts staff to deteriorating and unwell residents to ensure consistent care
- Reduced timeframe required for documentation/end-of-life planning for RNs through streamlining of documentation: reduction from 3 hrs to 20 mins with improved outcomes for residents and more RN ‘resident hands-on time’
- Families involved in the end-of-life care planning with educational information included in identified purple folder and accessible at the bedside

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### CONTACT

Jenny Zirkler, Executive Manager
jenny.zirkler@nvcl.org.au
Ensuring Aboriginal people have access to palliative services that are culturally appropriate and allow fair and equitable treatment was the aim of this project led by the Northern Adelaide Health Network, with partners the Aboriginal Elders Village and the South Australia Ambulance Service’s Extended Care Paramedic Program. Allowing Aboriginal elders to spend their last days in residential aged care that provides comfort and privacy yet with facilities that encourage family and friends, and avoiding unnecessary hospital transport, is of great importance.

Accredited cultural sensitivity training was undertaken by Extended Care Paramedics involving a qualified trainer from Flinders University as well as delivered by the Aboriginal Elders Village. As a result of these enhanced communication and training structures, there is both cultural and operational cooperation and understanding which has led to connections between these providers that had not previously existed.

State-wide year to date data show 76% of Extended Care Paramedics attendances to RACFs have resulted in no transfer to a hospital Emergency Department. Specifically for Aboriginal Elders Village residents, 100% of Extended Care Paramedics attendances have resulted in no hospital transfer.

More outcomes are expected, most importantly the establishment of two palliative care rooms within Aboriginal Elders Village for residents with facilities including specialist equipment that may be utilised by the Extended Care Paramedics in order to provide palliative care. Added to this, a kitchen and lounge area will be incorporated to provide a welcoming place families to visit and stay with their family member.

The greatest outcome achieved through this project is the understanding of Aboriginal culture and how it differentiates from Western society, particularly in the setting of end-of-life care. Through this project SA Ambulance Service can now better plan care for all members of this community.

The Northern Adelaide Health Network has secured funding to continue provision of the Extended Care Paramedics service to the Aboriginal Elders Village and to expand the service to some small non-corporate RACFs across other regions of metropolitan Adelaide.

CONTACT
Nathan Mercurio
nmercurio@northernhealth.net
OVERVIEW

PARTNERS
- Northern Adelaide Health Network
- Aboriginal Elders Village
- South Australia Ambulance Service

LINKAGE STRATEGIES
- Communication pathways

OUTCOMES
- Cultural training of Extended Care Paramedics
- 100% of Extended Care Paramedics attendance to the Aboriginal Elders Village resulted in residents being treated not transported to hospital

LOOKING AHEAD
- Funding secured to continue Aboriginal Elders Village service
- Expansion of service to non-corporate RACF
To enhance links between project partners through the Victorian Mornington Peninsula, a gap analysis was undertaken to identify where capabilities and services could be improved. Each partner’s commitment to their identified four-point strategy ensured enhanced care delivery for the region’s older citizens.

Lead partner Peninsula Health’s Residential In-Reach team is a multidisciplinary team that, together with a full-time medical physician, has a strong commitment to palliative care. With links to local palliative services, the team provides advance care planning to 40 residential aged care facilities (RACFs) in the region. Partnering with Peninsula Health in this project were Peninsula Home Hospice, established on the Peninsula in 1984, providing community palliative care and specialist health care to people living at home with a terminal illness. Forest Lodge, a 180 bed RACF, and Ranelagh Gardens a 30 bed RACF, both with a commitment to the Palliative Approach, also partnered in this project.

Providing a supporting role in this project were South East Melbourne Primary Health Network. Further support came from the Southern Metropolitan Region Palliative Care Consortium, an alliance of palliative care service providers that aims to support improvements in the integration and coordination of palliative care services. The consortium includes services that work in the community (caring for people in their homes), in acute settings (caring for people in hospital) and in inpatient settings (hospices and palliative care units). The Southern Metropolitan Region Palliative Care Consortium has a strong project management capacity and record in effecting change in RACFs.

Pre-existing informal relationships between the lead and partner organisations, shaped from previous projects, facilitated the establishment of formalised agreements between the medical and nursing staff, GPs and pharmacists. Detailed project scoping exercises were undertaken to determine clarity of service roles and responsibilities. The partners agreed on the terms of reference and these led to the development of communication pathways. Key project objectives were also
agreed upon with the overall aim of the project to enhance linkages through the region by building relationships between service providers including GPs, palliative care services, RACFs and hospitals. Each partner committed themselves to achieving this aim via four key strategies:

1. Care management operational referral pathway for palliative care for RACFs and GPs
2. Education and support of best practice palliative care management in RACFs
3. GP engagement in supporting the Palliative Approach in RACFs
4. Medication Imprest system in the two partner RACFs through pharmacy engagement.

Palliative Care Pathway Maps for RACFs were developed and communicated with all RACFs and GPs in the region. Through this crucial communication phase, an additional outcome saw Peninsula Home Hospice redevelop their referral process and criteria for improved triage.

The importance of whole of region communication was imperative to this project. One full day was committed to a palliative care education workshop, which included 22 regional RACFs. Content included empowerment, skill development and enhancing knowledge. In addition to the workshop, palliative care forums for GPs in RACFs were held. These forums enabled networking and formation of links across the multiple stakeholders involved in this project. GP engagement was achieved through a consultation evening held to share project aims and strategies.

Two part-time designated Linkage workers were tasked with project coordination and facilitation, and provided the foundation for this project’s success. These professionals took responsibility for coordinating monthly project meetings, developing relationships and ensuring the continued flow of the project. They sought to continuously improve the quality of services, and regularly attended project team meetings and RACF meetings within the catchment.

As a result of this project clear direction is now available to GPs and RACF staff on accessing specialist palliative care 24 hours per day; a streamlined referral system is now also in place offering RACF residents a timely informed response.

The future of this project will see more RACFs in the Mornington Peninsula have access to the pathways. Palliative care is now on the agenda of the South East Melbourne Primary Health Network’s hosted bi-monthly residential care development group for ongoing exchange, and palliative nurse positions have been allocated to all RACFs from Peninsula Home Hospice allowing greater continuity and linkage.

STAFF HIGHLIGHTS

‘We learnt so much more about each other’s organisations – we are using each other’s services better’

‘Having the right people at the table, people that were invested in it’

Overall vision ‘a bigger dream than individual drivers’

‘Huge improvement to the care of residents – being able to respond rapidly to changing statuses’
This project focussed on providing RACF staff with knowledge, skills and confidence in caring for palliative residents. Prescare Launceston sought to create a culture within its facilities that takes staff beyond the mere facts of palliative care to a level of understanding that distils self-assurance in both staff and the families of dying residents.

Information brochures, booklets and pamphlets were sourced through Better Access to Palliative Care and Palliative Care Australia and brought into Prescare’s facilities.

A further six workshops were undertaken for 23 key staff encompassing the themes: Introduction to Palliative Care; Clinical Care; Tools; Communication; Supporting Families Including End-of-Life Care of the Body; and Self-Care. These workshops and the knowledge imparted to staff are already paying dividends, with staff now having the skills, tools and confidence to initiate conversations with residents and their families.

‘Better care saves money in the long run’

The team is determined to achieve cultural change within their RACF facilities. To this end, they are working towards education days to examine aged palliative care at other RACFs and continuing to build communication pathways that provide knowledge, skills and confidence to RACF staff in dealing with palliative care throughout Tasmania.

Presbyterian Care Tasmania is an accredited provider of aged and supported accommodation services, with staff that are skilled in clinical care. They provide their clients with a quality environment, including those with advancing dementia and palliative care needs. The organisation continues to adopt latest aged care technology to facilitate easier and more enjoyable living for the residents. This project was based in Launceston and centred around Prescare’s facilities in Legana and Norwood, which together have a capacity for 200 residents. Partnering with Prescare on this initiative was Palliative Care North Tasmania, a division of the state Department of Health and Human Services, which provides palliative care to residents of northern Tasmania.

To realise the project aims, the partners established a working group consisting of senior registered nurses from Prescare, a project manager, a specialist palliative care social worker and a Clinical Nurse Consultant. External experts included a RN coordinator from the University of Tasmania, a RN manager from TAFE and a Nurse Practitioner from a local doctor’s surgery.

Ideas for a central communication pathway came from the working group, including the development of an application (App) suitable for iPhone and Android, and the introduction of the Karnofsky Assessment Tool, which provides a guide to classifying individuals according to their functional impairment.

Contact
Anita Fahey
afahey@prescaretas.org.au
OVERVIEW

PARTNERS

- Prescare Launceston residential and community aged care services
- Palliative Care North Tasmania

LINKAGE STRATEGIES

- Communication pathways
- Multidisciplinary teams

OUTCOMES

- Development of an App as a communication tool
- Introduction of brochures into facilities
- A series of knowledge workshop
- Introduction of the Karnofsky Assessment tool

LOOKING AHEAD

- Roll out of communication tools to other RACFs
- Holding education days across RACFs
PresCare Brisbane (QLD)

OVERVIEW

PARTNERS

- PresCare Community Care
- Metro South Palliative Care Services

LINKAGE STRATEGIES

- Formalised agreements
- Communication pathways
- Knowledge exchange and upskilling

OUTCOMES

- Development of an Advance Care Planning booklet
- Advance Care Planning introduced by PresCare as part of their home care packages available to all home package clients

LOOKING AHEAD

- Community clients can complete advance care planning
- Palliative care training to new staff

Project partners sought strategies to improve client and carer outcomes around end-of-life care through a planned approach.

Palliative and end-of-life planning is recognised by project lead PresCare as a key component of the care they provide their Queensland aged clients. However, a gap was identified in the planning for end-of-life care across community services, and through this Linkages project community clients now have the option to articulate their wishes through advance care planning.

Under the Ministry of the Presbyterian Church, Queenslanders have had access to the services of PresCare for over 85 years. With close to 1,200 dedicated staff and volunteers, PresCare supports more than 5,500 clients in communities as far north as Cairns to South East Queensland, with this particular project focusing on the Brisbane South area. Partner organisation Metro South Palliative Care Services within the Metro South Hospital and Health Services is the major provider of specialist palliative care services in the Brisbane south side, Logan, Redlands and Scenic Rim regions of Queensland. In 2015 the Metro South Office of Advance Care Planning was established as a service within the Metro South Palliative Care Services.

Project partners sought strategies to improve client and carer outcomes around end-of-life care through a planned approach. Improving knowledge, understanding and enhancing the confidence of the community staff were important first steps and a mentorship arrangement was established for the community nursing staff to help build their knowledge and confidence. This included the community nurses attending palliative case conferences and receiving one-on-one onsite training and ongoing telephone advice. Increased confidence was evident in the community nurses following palliative care training and Decision Assist workshops provided by Brisbane North Palliative Care using the train-the-trainer method.

Queensland Health’s ‘My Care, My Choices’ Statement of Choices document was adopted by PresCare for clients to document their Advance Care Plans. As a sign of the joint partnership, approval was given for the PresCare logo to be added to the Queensland Health document for PresCare clients. Another significant development has been opening up communication channels through the ability to transfer the Advance Care Plan information between the community and acute sectors. A pathway has also extended to emergency services staff, with clients displaying Advance Care Plan fridge magnets and wallet cards to alert paramedics to the presence of a completed Advance Care Plan.

CONTACT

Dee Jeffrey
djeffrey@prescare.org.au

Decision Assist Linkages project: PresCare Brisbane
This project was introduced in line with PresCare’s adoption of the Australian Government’s Consumer Directed Care approach for clients receiving home care packages. This has enabled PresCare to offer Advance Care Planning as part of the suite of services they offer to clients under Consumer Directed Care. The project has been identified that completing an Advance Care Plan in the community requires recognition that these discussions take time, and may require multiple visits before completion.

The future of this project looks promising. In addition to PresCare’s residential aged care residents, community clients now have the opportunity to complete Advance Care Plans. Likewise, as more training is offered to new staff in palliative care, the level of care in the community will improve as confidence grows among staff, carers and clients.
OVERVIEW

PARTNERS

- PresCare Rockhampton Community Services
- Central Queensland Hospital and Health Service Specialist Palliative Care Service

LINKAGE STRATEGIES

- Multidisciplinary teams
- Communication pathways
- Designated Linkage worker

OUTCOMES

- Development of specified communication pathway demonstrating palliative trajectory and staff roles
- Development of specific information aimed at clients and families
- Implementation of the Statement of Choices Form from Metro South Palliative Care Services which is a part of the Queensland Health My Care My Choices Advance Care Planning initiative
- Allowed for clients involved in the project to die at home

LOOKING AHEAD

- Specialist Palliative Care Services to continue providing a vital supportive role to the community and palliative clients
- The Linkage worker plays a pivotal role in the community palliative care program in terms of building relationships with services and resource development
- Community Care workers are willing but providing palliative care is emotionally challenging. They require ongoing resources of support, briefing and debriefing

PresCare Rockhampton (QLD)

Optimising quality of life and quality of death for elderly community clients in the Fitzroy region was the principal theme of this project led by PresCare Community Services. Through a pilot community palliative care model using a Linkage worker, elderly clients were able to attain their wish to die in their place of choice.

PresCare has been part of the Rockhampton (800km north of Brisbane with a population of 80,000) community for over 50 years. Collaborating with PresCare as a partner organisation on this project was Central Queensland Hospital and Health Service Specialist Palliative Care Service, which delivers health services from Gladstone in the south, inland to the Southern and Central Highlands and north along the Capricornia Coast, serving a population of around 228,000.

The project partners set themselves the objective to improve client, carer and community staff knowledge, understanding and confidence regarding palliative care. The focus centred around palliative trajectories, assessment and multidisciplinary care planning, pain and symptom management, bereavement and carer self-care. This objective was driven by the belief that by increasing understanding and knowledge of the palliative pathways, RACF workers and carers would be able to assist their elderly clients optimise their quality of life, and just as importantly, quality of death.

To achieve these objectives, a Palliative Care Steering Committee was formed including local GPs, pharmacists, a Nurse Practitioner and a specialist palliative care nurse. Communication pathways were established to streamline assessment and referral processes, including introduction of the Palliative Care Outcomes Collaboration Assessment Tool to determine the palliative care phase and the Palliative Care Service Needs Assessment Tool: Progressive Disease as the guide for referral to the specialist palliative care services referral form. The Queensland Health Statement of Choices form developed by Metro South Palliative Care was also implemented.

Central to the success of this project were the introduction of a dedicated Linkage worker who facilitated connections between the diverse partners and a triage system to determine funding sources and management services required, be it a community nurse or a more specialised palliative care service.
With positive local relationships already existing between the partners, and other local community services along with the introduction of a project Advisory Committee, no official partnership agreement was deemed necessary during the project timeframe.

Central Queensland University was engaged to better understand the perceptions of the Linkage worker and community care workers in providing palliative and end-of-life care in the home. Key findings highlighted the pivotal role that the Linkage worker played in terms of building relationships with services and the early identification of clients who may require palliative care; Community care workers are willing but providing palliative care is emotionally challenging and they require ongoing resources of support, briefing and debriefing. The clarity of roles, training and the innovative application of a communication pathway resulted in a positive outcome, namely that the clients involved in this project were able to die in their preferred location - at home.

Specialist Palliative Care Services will continue to provide a significant supportive role to the community and palliative clients in the Rockhampton region and as a result of the project a local Palliative Network has now been established.

CONTACT
Dee Jeffrey
djeffrey@prescare.org.au
For the residents in the Yarriambiack Shire 330km north-west of Melbourne, being a small community does not mean that those on the palliative journey should be without expert care and information. By employing specialist Linkage workers as part of this project, residents and their families now have the information and skills to communicate their wishes for their final journey.

This project was led by Rural Northwest Health, a Victorian public sector health service with responsibility for a population of approximately 4900 people within the Yarriambiack Shire. Two Rural Northwest Health residential aged care facilities (RACFs) were involved in the project – Hopetoun (24 bed facility) and Yarriambiack Lodge (60 bed facility) at Warracknabeal. Two partner organisations collaborated with Rural Northwest Health on this project: Wimmera Hospice Care, a palliative care service that supports people living with life limiting illnesses and their families and carers; and Grampians Region Palliative Care Consortium, an alliance of health services providing specialist care to people living with life threatening illness, their families and carers.

The project aimed to improve the palliative care journey for its residents. To achieve this five Linkage workers were appointed between the two campuses. The Linkage workers, uniquely in this case, specially trained Enrolled Nurses, provided a conduit between the specialist palliative care services, staff and residents. They distributed information, assisted in developing procedures and promoted best practices in palliative care. Additional to the five Linkage workers, a Linkage nurse Coordinator was engaged working one day per week.

Knowledge exchange and upskilling were the principal activities undertaken with information shared between the nursing staff at Warracknabeal and Hopetoun, the Wimmera Hospice Care palliative care nurses, and the resource nurse of the Grampians Regional Palliative Care Consortium, who visited the RACFs one day a month to attend the Palliative Approach monthly meetings, and conduct education sessions. Outcomes from this shared learning resulted in Advance Care Plans for all the residents in aged care. Information evenings for residents and their relatives on the Advance Care Planning procedure were organised, and Palliative Approach case conferences that included relatives were initiated.

The establishment of a Palliative Approach Steering Committee, in which the Grampians Consortium resource nurse shared experiences in palliative care with the committee, has been highly valued.

A death audit committee led by the Aged Care Manager allowed for further reflection on the end-of-life practices with the view to continually reassessing procedures and policy.

The Rural Northwest Health project has been unique in its appointment of enrolled nurses as Linkage workers and the roles they have had in this project. This project provided resources and was a catalyst to improve palliative care in this region. Efforts will continue to sustain the practices put into place with the five Linkage workers continuing to work one day a fortnight.

CONTACT
Wendy Walters
wendy.walters@rnh.net.au
### OVERVIEW

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The City of Logan lies between Brisbane and the Gold Coast and is home to the second highest culturally and linguistically diverse population in Queensland. This proved the ideal location for lead organisation Blue Care and its partners to develop a ‘How To’ access guide with a cultural profile tool allowing the documentation of a culturally and linguistically diverse client’s wishes including religion, cultural customs and practices important at end of life.

For over 60 years Blue Care has provided a diverse range of aged and community care services to over 80 communities across Queensland and northern New South Wales. Partnering in this project were Blue Care’s Yurana RACF based in the Logan suburb of Springwood, Community Palliative Care Team Eastern Hub, and the Metro South Palliative Care Service. This Health Service provides a specialist palliative care service with consultancy, that includes shared and direct care support in collaboration with primary and tertiary care providers to enhance quality of death.

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The establishment of a Memorandum of Understanding was a main step in aligning the lead and partner organisations in their commitment to assisting their culturally and linguistically diverse population members in Logan. The partners identified a gap in access to palliative care services for culturally and linguistically diverse population members in Logan. What did exist were myths and misunderstandings around palliative care, end of life and the services being offered. A project was needed that would develop trust and build relationships within the medical and cultural stakeholder groups that represent the culturally and linguistically diverse community. This project aimed at acknowledging that culturally and linguistically diverse clients have strong and diverse religious and cultural wishes they would like recognised in their end-of-life journey.

The development of a Cultural Profile Tool, which allowed facility and community staff to communicate and interact with individual clients to document personalised care plans, was one significant outcome of this project. To ensure the tool’s success and consistency in staff/patient approach, a ‘How to’ guide was developed for service providers along with training. Three components were included in the ‘How to’ guide: culturally and linguistically diverse resources, Palliative Care Referral Pathway, interpreter pathway.

Another step was to establish a multicultural consultative network through the Logan community to generate greater links and ownership of the project. This stage included linking with the cultural and spiritual community leaders with direct channels to their represented groups. Additionally, it was imperative to link culturally and linguistically diverse communities with GPs, community nurses and other palliative care providers to ensure they also had access to the information via the ‘How to’ guide. Cultural competency training was implemented with residential aged care facilities (RACF) and community providers for registered health workers, and cultural exchanges occurred between culturally and linguistically diverse communities and community providers about palliative and end-of-life care.

A number of key concepts were developed through this project. The multi-pronged communication pathways that were created brought together aged care, community, medical, cultural and spiritual stakeholders with a shared commitment to bring peace of mind for patients on the end-of-life journey and for their families. Individual personal end-of-life wishes were captured through the Cultural Profile Tool. Together with the ‘How to’ guide and its training curriculum, this provided a knowledge transfer pathway to educate stakeholders on the journey. This document will continue to be shared between RACFs and the community sector ensuring these outcomes continue into the future.
Servicing a population of approximately 800,000 in Melbourne’s west, Western Health was eager to develop a clear referral and communication pathway for linkage between hospitals, community palliative care services and Residential Aged Care Facilities (RACF), with the ultimate goal of improving the care for older people in RACFs. Through this linkage project, the team was able to align what were previously fragmented services through a partnered approach to providing palliative care services.

Western Health, lead partner of the three participating organisations, manages three acute public hospitals and operates day services as well as a wide range of community based services. Partner organisation Mercy Palliative Care is a 24-hour service providing palliative care in the patient’s place of residence. Villa Maria Catholic Home, St Bernadette’s in Western Melbourne, is a 95 bed RACF. St Bernadette’s acted as an advisor for the aged care sector in this partnership. A total of 59 RACFs in this region are connected to Western Health and Mercy Palliative Care and all require linkage to palliative care services.

Western Health has an inpatient palliative care unit and provides a palliative care consulting service throughout the hospital. Western Health’s Immediate Response Service also delivers residential in-reach palliative care services, which includes the provision of support to RACF staff to assist with caring for their patients. With the growth in patient demand outstripping the growth in Western Health palliative care staffing and resources, the team have sought partnerships with other services to ensure all patients and their families are cared for comprehensively. This has resulted in the development of positive and cohesive working relationships, most notably with Mercy Palliative Care, whereby their community-based nurses provide specialist consulting services to Western Health patients in the community. The nurses also attend Western Health Symptom Management Assessment Referral Team outpatient clinics, enabling a seamless transfer of care from hospital to the community.

This project aimed to develop a referral and communication pathway between Western Health’s Care Coordination Teams and Mercy Palliative Care to provide linkages between RACFs in the western region, and palliative care services with the ultimate goal of improving the quality of end-of-life care for older people in residential settings.

Following the careful negotiation between stakeholders, an Memorandum of Understanding was established, which formalised service provision (including after hours / weekends) and an ongoing commitment to partnership, resulting in shared service plans. All teams agreed to share care for residents requiring palliative care, stating “there is no such thing as an inappropriate referral”, with all referrals accepted and triaged. The agreement of service provision between agencies was a key feature to overcome the siloed approach that existed prior to this project.

A communication pathway was similarly developed. The approach uses a list of end-of-life symptoms to encourage the Palliative Approach in aged care settings and for aged care facility staff to recognise symptoms that could be supported by specialist palliative care services. The communication pathway also enabled RACFs to understand how to contact palliative care service providers where and when they need it, 24 hours a day, seven days a week.

Six pilot sites were identified to pilot the communication pathway. Site-based feedback from participating RACFs reported on the improved communication between palliative care services.
new referral & communication pathway

care service providers. Feedback indicated that processes are now more streamlined and effective in reducing barriers to care.

Upskilling was an important aspect of this project, with the aim to update health providers in the area on palliative care clinical issues and to inform the region of the new communication pathway linking aged care services with palliative care. A number of opportunities were created, including a GP education evening and staff education at each pilot site.

This partnership led to system change among the stakeholders. It provided a platform to generate new ideas towards health system innovation and share resources and knowledge between key stakeholders. The program has an adequate allocation of resources to sustain the linkage plan into the future. Importantly, a palliative care governance meeting has been developed for ongoing review, linkage, and communication across different providers. Western Health has developed a strategic plan to widen the dissemination of the referral pathway to the remaining RACFs in the western region of Melbourne with assistance from North Western Melbourne Primary Health Network and North and Metropolitan Region Palliative Care Consortium.

OVERVIEW

PARTNERS
- Western Health
- Mercy Palliative Care
- St Bernadette’s (Catholic Homes)

LINKAGE STRATEGIES
- Formalised agreements
- Communication pathways
- Multidisciplinary teams
- Knowledge exchange and upskilling

OUTCOMES
- Communication pathway Introduced
- Collaborative partnership developed with sustainable platform
- Formalised agreements developed
- Upskilling creating a platform of knowledge and skills

LOOKING AHEAD
- Adequate allocation of resources to sustain linkage plan for the future
- A palliative care governance meeting has been developed for ongoing review, linkage and communication across different providers
- Strategic plan to widen the dissemination of the Referral Pathway to the remaining RACFs in the western region of Melbourne with assistance from the palliative care consortium and North Western Melbourne Primary Health Care Network
To provide satisfactory training and increase knowledge of their staff, The Whiddon group collaborated with Palliative Aged Care Consultancy Service, taking unique advantage of the Aged Care Funding Instrument. This provided resources for a Clinical Nurse Consultant who could build capacity of the RACF staff through education, mentoring and case conferencing. As with other demonstration sites in the Decision Assist Linkages project, access to an engaged Clinical Nurse Consultant had a great positive impact on RACF staff, building confidence and basic clinical knowledge for end-of-life care.

This partnership pursued a hospital avoidance program with South West Sydney Local Health District, resulting in an increase in patients returning to the RACF (of 60 deaths, 25% of patients presented to hospital, with half returning to RACF) and specialist training on requirements for LGBTI accreditation. This partnership achieved real organisational change. In-house palliative care is now regarded as a genuine philosophical position of The Whiddon group, with the support of the local health and palliative care services. Looking to the future, The Whiddon Group is working toward LGBTI accreditation (the Rainbow Tick) by 2017.

The central tenet of the Whiddon project is aimed at providing the Palliative Approach to all clients who were nearing the end of life.

This was achieved by a multifaceted method to: improve end-of-life care by implementing an End-of-Life Care Pathway, providing education focused on End-of-Life Care, recognising the dying client in a RACF setting, and education to GPs on the use of the End-of-Life Care Pathway.

In addition to these project aims The Whiddon Group recognised that the lesbian, gay, bisexual, transgender or intersex clients that live within The Whiddon Group’s homes had specific needs and requirements centred on end-of-life care and advance care planning.

Partnering with the South West Sydney Local Health District and the Palliative Aged Care Consultancy Service, The Whiddon Group (a large not-for-profit organisation with 23 community and residential aged care facilities varying in capacity from 8 – 500 beds) had three very clear aims for this project: to improve end-of-life experience for clients and carers, to improve continuity of care for clients and their families, increase clients’ and carers’ understanding of end-of-life care, and to provide knowledge and confidence to their staff. To accomplish these goals, and build internal knowledge and capacity, The Whiddon Group recognised a need to connect more formally with their palliative service provider.

The group nominated a number of strategies they thought would best achieve these outcomes, including role clarification, referral pathways, communication pathways, and knowledge exchange and upskilling.

As a first step, the team conducted an audit across their RACFs of the top five reasons residents were transferred to hospital. This provided a clear picture of the Palliative Approach used by each site and reasons for resident transfer to acute facilities (top reason being care preference of families). With this knowledge, the team developed and implemented an end-of-life communication pathway, which, following a trial at the Glenfield RACF, will be disseminated across the other Whiddon Group RACFs. The teams have also developed consumer brochures ‘What to expect when someone is at the end of life’ and ‘Bereavement care’. These brochures have already been distributed throughout all Whiddon facilities.

**CONTACT**

Laurie Leigh - Whiddon Group
l.leigh@whiddon.com.au

Jane Mahony - Palliative Aged Care Consultancy Service
jane.mahony@bigpond.com

**ENGAGEMENT AT ALL LEVELS**

During the project’s life, Palliative Aged Care Consultancy Service staff engaged with all levels of clinical, administrative and ancillary staff. At times it was noted that the receptionist at the trial site could often correctly identify who was deteriorating and may be coming to the end of their life by very practical observations i.e. mobility deterioration, communication ability, increasing visitors to the client, increased forgetfulness, increased need to see the GP.

The Whiddon Group, a philanthropic organisation that has been caring for older Australians in NSW for nearly 70 years, partnered with the local health and palliative care services to improve care to dying residents in their aged care facilities. In this study, the Whiddon Residential Aged Care Facility ‘Glenfield’ was chosen as the trial site.
improving palliative care experiences

OVERVIEW

PARTNERS
- The Whiddon Group
- South West Sydney Local Health District
- Palliative Aged Care Consultancy Service

LINKAGE STRATEGIES
- Role clarification
- Communication pathway
- Knowledge exchange and upskilling

LOOKING AHEAD
- Pathway implemented at Glenfield to be rolled out across Whiddon’s 18 RACFs
- Ongoing palliative aged care service onsite weekly using Aged Care Funding Instrument
- Aim for achievement of Rainbow Tick in LGBTI accreditation by 2017

OUTCOMES
- Hospital avoidance program with South West Sydney Local Health District (60 deaths, 25% of patients presented to hospital, with half returning to the RACF)
- Education requirements for LGBTI accreditation, GPs regarding project and end-of-life pathway, palliative care Clinical Nurse Consultant onsite education for RACF staff
- Palliative Aged Care Consultancy Service onsite weekly
- Each client that died had an end-of-life conversation and/or a completed Advance Care Plan
- Overall increase in awareness/recognition of end-of-life
The Decision Assist Linkages Project has strengthened and encouraged links between palliative care services and aged care providers in both residential and community settings around Australia.

For more information about Decision Assist and the Linkages Project please visit www.decisionassist.org.au