Palliative and Aged Care Linkages Manual

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

5 October 2017
You are welcome to refer to this Manual in your own documents. We ask that you acknowledge it by referencing it appropriately.

Care at the end of life for older Australians

Older people at the end of their life often have unique and complex health and support needs. To address these needs, palliative care can be provided in many different settings including community and residential aged care services.

Many different health professionals and community service providers are involved in providing this care.

TO ENSURE HIGH QUALITY AND WELL-COORDINATED PALLIATIVE CARE, TEAMWORK, PARTNERSHIPS, CONNECTION AND COOPERATION ACROSS SERVICES AND CARE PROVIDERS IS NEEDED.

Using this Manual to implement Linkage strategies

This Manual is designed to provide you with detailed guidance and resources to implement one or more of seven Linkage strategies.

These seven linkage strategies are:
- Role clarification
- Written and verbal communication pathways
- Multidisciplinary team structures
- Formalised agreements and plans
- Designated linkage workers
- Knowledge exchange and upskilling
- Continuous quality improvement.

These are explained in detail in the pages that follow.

The material in these first few pages gives you important context for using the Manual. Once these fundamentals are understood, you can choose the parts of the Manual that are relevant to your specific needs.
Connections in Aged and Palliative Care: the Decision Assist Linkages project

The Decision Assist Palliative Care Linkages project was a unique national project to enable connections – or ‘linkages’ – between service providers involved in the delivery of palliative and end-of-life care to older Australians.

The project was based on the idea that effective, mutually beneficial linkages between a number of agencies benefit dying older Australians receiving aged care services.

A number of policy frameworks support this idea. The Australian Government’s National Palliative Care Strategy 2010\(^1\) 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.’

The QUT project team coordinated a large-scale project to promote linkages between palliative care services and aged care providers.

Twenty demonstration sites undertook Linkages projects to build partnerships and improve the linkages between aged care providers and palliative care services. Each site implemented at least one of seven evidence-based linkages strategies that were identified in a review of the published literature. You can read about these in the Case Study booklet and the workshop videos on the website at decisionassist.org.au/decision-assist/linkages-and-other-projects/linkages-project.

Some of the key outcomes across the sites were:

- Sites 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\(^2\) was modified by some teams to suit their own needs, including adaptations of advance care planning processes, and referral pathway documents to suit local situations.
- Communication tools including referral pathways were jointly developed between General Practitioners, specialist palliative care services, and aged care providers.
- Many demonstration sites developed or modified tools to suit their local contexts, including job descriptions, service agreements and Memoranda of Understanding, referral and communication pathways, flowcharts and checklists.

‘... THE WORK THAT HAS RESULTED FROM THIS LINKAGES PROJECT IS CHANGING THE NATURE OF AGED CARE AND PALLIATIVE CARE FOR THE FUTURE!’ — LINKAGES WORKSHOP PARTICIPANT, 2016.
How to use the Linkage strategies to work with the palliative care service

When you find your local palliative care service you can work together on undertaking one or more of the linkage strategies.

When you link your service with a palliative care service you can achieve much more together than you can do separately.

The first step in working together is getting to know each other. You will need to ask questions of each other, like:

- Who delivers what type of care, and who receives that care?
- When can that care be provided?
- When can the palliative care service visit? When should you call them?

Getting to know each other is the linkage strategies known as Role Clarification.

When you have clarified who does what and where, you will be able to see the multidisciplinary team who is involved in the care of older persons. Multidisciplinary Team Structures is another of the linkages strategies.

When your multidisciplinary team decides how they can work together to improve care you may choose to document how everyone will work together in a Service Agreement or a Memorandum of Understanding (MoU). This is the Formalised Agreements and Plans linkage strategy.

When you get to know each other you will need to know how and when to contact each other. This information will be helpful in developing a referral pathway. A referral pathway is a helpful guide for you and will show you how to refer an older person to a palliative care service. Referral pathways are an example of the Written and Verbal Communication Pathways linkage strategy. An end-of-life pathway is another useful written communication pathway to guide the care of an older person who is at the end of their life. The palliative approach toolkit in your RACF has an end-of-life pathway that you can use. Palliative care services can help RACF staff identify residents/clients who need to start an end-of-life pathway.

The palliative care service can also teach you how to use the pathways and how to recognise residents/clients that need to start an end-of-life pathway. The palliative care service will support you in knowing how to discuss end-of-life with residents/clients, their families, and their GPs. These are examples of the Knowledge Exchange and Upskilling linkage strategy.

In some cases the best way to bring in these strategies is through a key worker whose job it is to act as a care coordinator and link across the multidisciplinary team. This is the Designated Linkage Worker strategy.

You’ve started this journey with a view to improving the care for your residents/clients and this is the beginning point for the Continuous Improvement linkage strategy. The use of After Death Audits\(^3\) will assist you to identify areas for improvement. Sharing these improvement areas with palliative care services will give you a starting point for joint improvement activities. The changes you make to the way that you care for your residents/clients can be measured for their effectiveness and efficiency.
Seven steps to using Linkage strategies

To implement the Linkage strategies effectively, we suggest you follow this seven-step process. Each step is explained in detail in the pages that follow and includes information about the resources available in this Manual to assist you to take each step.

As you work your way through these seven steps, you will see icons that indicate further action for you to take:

- This icon tells you that there is an action for you to complete the steps in this process.
- This icon tells you that there are external online resources available to you.
- This icon tells you that there are references to research evidence you can investigate.
Step 1: Measure the baseline

To get baseline data for comparison later on, there is a range of tools you can use:

- Resource 1: After death audit – Residential Aged Care Facilities
- Resource 2: After death audit – Community Aged Care Services
- Resource 3: Staff survey.

You can enter the data from these tools into a spreadsheet such as Microsoft Excel to tally the scores and compare baseline with later data.

Step 2: Connect with others

One of the ways you can improve how you look after your residents or community clients in their end-of-life care is to connect with your local palliative care service.

Inviting a palliative care service to visit your service can result in fewer older people being unnecessarily transferred to hospital near the end of their lives.

Your local palliative care service can help you to review the needs of these older persons and with you, come up with plans for caring for them. The palliative care service does not take over the care but works alongside the care staff to ensure good palliative care for older people at the end of their lives.

The palliative care service can help staff feel more confident about the care they give to dying people and support them to improve their knowledge and skills.

How to find your local palliative care service

- The GPs that visit your residents or clients have a list of all of the services that are available locally.

Also on your Primary Health Network’s homepage there is a service finder tab which can also help in finding your local palliative care service. The PHN may also have an Aged Care Coordinator who can help you.

- The webpage of Palliative Care Australia (PCA) – palliativecare.org.au – lists all palliative care services in Australia.

You can read more about partnerships and how they benefit Linkages between aged care and palliative care in Resource 4: The imperative to partner.
## Step 3: Identify desired outcomes

When you have connected with your local palliative care service, you can begin the conversation with them about what outcomes you wish to achieve. The table below can help you map this out.

<table>
<thead>
<tr>
<th>What are the outcomes you’re seeking?</th>
<th>Linkage strategies that can achieve the outcome</th>
<th>What type of tool is this?</th>
</tr>
</thead>
</table>
| Improved communication across service providers (GPs, Allied Health, palliative care services, aged care staff) | Role Clarification  
Multidisciplinary Team Structures  
Communication Pathways  
Designated Linkage Worker  
Knowledge Exchange and Upskilling                                                                 | Collaborative                                                                                                                                                                       |
| Clarity and transparency about the roles and responsibilities for each service provider              | Role clarification                                                                                                                                                              | Collaborative                                                                                                                                                                       |
| Written agreements and plans outlining roles and responsibilities of care providers, resource allocation and agreed outcomes | Formalised agreements and plans                                                                                     | Collaborative  
Go to Resource 5: Sample Palliative Care Service Level Agreement                                                                                                                                                               |
| Increased palliative care case conferencing                                                          | Multidisciplinary Team Structures  
Designated Linkage Worker  
Communication Pathways                                                                                       | Practice  
Use Resource 1: After death audit – Residential Aged Care Facilities or Resource 2: After death audit – Community Aged Care Services  
For an example of an EoLC pathway, go to metrosouth.health.qld.gov.au/raceolcp                                                                                                      |
| Increased Advance Care Plans                                                                         | Communication pathways                                                                                                                                                           | Practice  
For an example of an Advance Care Plan, go to Resource 6: Sample Advance Care Plan OR www.advancecareplanning.org.au/                                                                 |
| Increased knowledge, skills and confidence of service providers in delivering palliative care        | Knowledge Exchange and Upskilling                                                                                    | Continuous improvement  
Use Resource 3: Staff survey                                                                                                                                                     |
| Improved coordination between services                                                               | Designated Linkage worker                                                                                                                                                        | Continuous improvement  
Use Resource 7: Organisational Audit                                                                                                                                              |
| Improved palliative care outcomes                                                                    | Continuous improvement                                                                                                                                                           | Continuous improvement  
Use Resource 1: After death audit – Residential Aged Care Facilities OR Resource 2: After death audit – Community Aged Care Services                                                                 |
Step 4: Choose Linkage strategies

In the earlier section titled ‘How to use the Linkage strategies to work with the palliative care service’, there were brief definitions of each of the seven strategies. Now that you have identified your desired outcomes, you can double check that the strategies you’ve selected are the best match for your goals.

You will find detailed descriptions of each of the Linkage strategies in the Resources section of this Manual. These descriptions provide the evidence base identified during the Decision Assist Linkages Project integrative literature review and examples from the project that illustrate how each strategy was successfully used.

These examples can be located in the Linkages Project Case Studies Booklet on the website at DA Linkages Project – decisionassist.org.au/decision-assist/linkages-and-other-projects/linkages-project.

To learn more about each of the seven strategies, go to Resource 8: The Strategies in more detail.

Step 5: Develop the Activity Plan

Once you have identified and confirmed the strategies that address your goals, you now think about the concrete steps you need to make to put the Linkage strategies into action.

The Activity Plan document enables you to map out three important aspects of planning for the implementation of your selected Linkage strategies:

- Note the strategies you wish to put in place
- Identify the measures of success
- Identify the resources required to achieve success.

You will find sample Activity Plans for six of the seven Linkage strategies in the Resources section of this Manual. These templates can be adjusted by you to suit your particular setting:

- Resource 9: Sample Activity Plan for Role Clarification
- Resource 10: Sample Activity Plan for Multidisciplinary Team Structures
- Resource 11: Sample Activity Plan for Written and Verbal Communication Pathways
- Resource 12: Sample Activity Plan for Formalised Agreements and Plans
- Resource 13: Sample Activity Plan for Knowledge Exchange and Upskilling
- Resource 14: Sample Activity Plan for Continuous Improvement.

A sample Activity Plan for the Designated Linkage Worker role isn’t provided here. In the Decision Assist Palliative Care Linkages project the participating sites had highly varied contexts and the roles were specifically designed for the particular requirements of that site.

To see an example of a project site that developed an Activity Plan for this Linkage strategy, go to the Decision Assist YouTube channel at DA Linkages YouTube – https://youtu.be/Y4NLp2PEC7Q
Step 6: Implement the Activity Plan

Implement the Activity Plan to guide you in undertaking the Strategies.

A key element of achieving your goals for each selected Linkage strategy is the monitoring of your progress towards the stated measures of success. Again, Resource 4: The imperative to partner provides more detail about the important steps in partnering. Regular meetings between you and the partnering organisations will help you see if you are on track, identify early any problems, and put strategies in place to get back on track.

Step 7: Measure the outcomes

Repeat the data collection using exactly the same tool you used to get baseline data:
- Resource 1: After death audit – Residential Aged Care Facilities
- Resource 2: After death audit – Community Aged Care Services
- Resource 3: Staff survey.

Remember, you can enter the data from these tools into a spreadsheet such as Microsoft Excel to tally the scores and compare baseline with this later data. This will enable you to compare any changes during the time you've been putting the Linkages strategies into place.

Some things to consider

These seven strategies don’t stand alone. They are connected to each other and to other strategies you may have in place that aim to link your service with others to improve end-of-life care. For example:
- Multidisciplinary team structures are more effectively put in place when Role Clarification has taken place.
- Knowledge exchange and upskilling can be a key role of the Designated Linkage Worker – not just ‘running workshops’ but through mentoring, one-on-one clinical teaching, and the provision of other learning resources.
- Quality improvement is the glue that can hold together the changes you make.

You will notice that the Seven steps to using Linkage strategies are in a circle. This means that you can begin again in identifying ways in which you can strengthen the linkages you have with other organisations. In this way, you can put in place ongoing processes to improve the end-of-life care you give to those older people supported by your service.
## Resources

### Resource 1: After death audit – Residential Aged Care Facilities

<table>
<thead>
<tr>
<th>Facility name:</th>
<th>Facility postcode:</th>
</tr>
</thead>
</table>

1. Facility assigned resident ID*  
   (*Please enter the resident’s unique identifier assigned by your facility)

2. Resident’s date of admission (dd)/(mm)/(yyyy): ______ / ______ / ______

3. Resident’s date of birth (dd)/(mm)/(yyyy): ______ / ______ / ______

4. Resident’s date of death (dd)/(mm)/(yyyy): ______ / ______ / ______

5. Was this a sudden, unexpected death?  
   - Yes  
   - No

6. Place of death  
   - Residential aged care facility  
   - Hospital  
   - Other, please specify: 

7. Was the resident transferred to hospital in the last week of their life?  
   - Yes  
   - No (if No, skip to question 11)

8. Principal reason for hospitalisation  
   - Symptom management  
   - Sudden, unexpected deterioration or event  
   - Following a fall  
   - Other, please specify: 

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*Resources*
9. Person requesting admission
   - Request of resident
   - Request of family
   - Request of the general practitioner
   - Request of the nursing staff

10. Length of hospital stay
   - Not admitted
   - 1 to 3 days
   - Greater than 3 days

11. Were the resident's preferences for future health care wishes documented?
    (N.B. Documentation of a funeral provider is not sufficient to check 'Yes' for this item.)
    - Yes
    - No (if No, skip to question 15)

12. What's the name of the document that these wishes were recorded on? **Tick as many as applicable.**
    - Progress notes
    - Aged care specific Advance Care Directive/Plan
    - Your facility Advance Care Directive/Plan
    - Your state or territory's statutory Advance Care Directive/Plan
    - Other, please specify:

13. When were these wishes documented? **Tick as many as applicable.**
    - Before admission to the residential aged care facility
    - At time of admission to the residential aged care facility
    - While living at the residential aged care facility
    - Other, please specify:

14. Were these wishes followed?
    - Yes
    - No
    - Unsure

15. Was a palliative care case conference** conducted within the last six months of the resident's life?
    (**A palliative care case conference focuses on end of life issues. The resident and/or family should be in attendance.)
    - Yes
    - No (if No, skip to question 20)
16. Date of palliative care case conference (dd)/(mm)/(yyyy): ______ / ______ / ______

17. Was the palliative care case conference attended by a GP?
   - Yes
   - No

18. Was the palliative care case conference attended by a specialist palliative care nurse?
   - Yes
   - No

19. Was the palliative care case conference attended by a representative from your local palliative care service?
   - Yes
   - No
   - No service available

20. Was the resident commenced on an end of life care pathway?
   - Yes
   - No (if No, skip to question 22)

21. Date commenced end of life care pathway (dd)/(mm)/(yyyy): ______ / ______ / ______

22. Did the facility claim Complex Health Care Palliative Care through ACFI for this resident?
   - Yes
   - No, as already claiming maximum
   - No
Resource 2: After death audit – Community Aged Care Services

1. Service assigned client ID*
   (*Please enter the client’s unique identifier assigned by your service.)

   

2. Client’s date of admission to your service (dd)/(mm)/(yyyy): ______ / ______ / ______

3. Client’s date of birth (dd)/(mm)/(yyyy): ______ / ______ / ______

4. How did this client permanently separate from your service?
   ○ Died (If Died, skip to question 6)
   ○ Admitted to residential aged care facility (permanent admission)
   ○ Admitted to hospice or inpatient palliative care bed
   ○ Transferred to another community aged care service
   ○ Other, please specify:

5. Would you be surprised if this client died within the next six months?
   ○ Yes
   ○ No

6. Client’s date of death or date of permanent discharge from your service (dd)/(mm)/(yyyy):

   ______ / ______ / ______

   (If your client did NOT die before separating from your service, skip to Question 16)

7. Was this a sudden, unexpected death?
   ○ Yes
   ○ No

8. Place of death
   ○ At client’s home
   ○ Hospital
   ○ Hospice or inpatient palliative care bed
   ○ Other, please specify:
9. Was the client transferred to hospital, hospice or inpatient palliative care bed in the last week of their life?
   - Yes
   - No (if No, skip to question 14)

10. Where was the client transferred?
    - Hospital
    - Hospice or inpatient palliative care bed
    - Other, please specify:

11. Principal reason for transfer
    - Symptom management
    - Sudden, unexpected deterioration or event
    - Following a fall
    - Other, please specify:

12. Person requesting transfer
    - Request of client
    - Request of family
    - Request of the general practitioner
    - Request of the nursing staff

13. Length of stay in hospital, hospice or inpatient palliative care bed
    - Not admitted
    - 1 to 3 days
    - Greater than 3 days

14. Was the client commenced on an end of life care plan?
    - Yes
    - No (If No, skip to question 16)

15. Date commenced end of life care plan (dd)/(mm)/(yyyy): ______ / ______ / ______

16. Were the client’s preferences for future health care wishes documented prior to, and/or during their time with your service?
    - Yes
    - No (if No, skip to question 20)
17. What's the name of the document that these wishes were recorded on? **Tick as many as applicable.**

- [ ] Progress notes
- [ ] Aged care specific Advance Care Directive/Plan
- [ ] Your service’s Advance Care Directive/Plan
- [ ] Your state or territory’s statutory Advance Care Directive/Plan
- [ ] Other, please specify:

18. When were these wishes documented? **Tick as many as applicable.**

- [ ] Before admission to your service
- [ ] At time of admission to your service
- [ ] While client was registered with this service
- [ ] Other, please specify:

19. Were these wishes followed?

[N.B., if the client is still alive, please advise whether his or her wishes have been followed in relation to their discharge/separation from your service.]

- [ ] Yes
- [ ] No
- [ ] Unsure

20. Was a palliative care case conference** conducted within the last six months of the client’s life or within the last six months prior to *permanent* discharge?

[**A palliative care case conference focuses on end of life issues. The client and/or family should be in attendance.**]

- [ ] Yes
- [ ] No (if No, this concludes the survey)

21. Date of palliative care case conference (dd)/(mm)/(yyyy): ______ / ______ / ________

22. Was the palliative care case conference attended by a GP?

- [ ] Yes
- [ ] No

23. Was the palliative care case conference attended by a representative from your local palliative care service?

- [ ] Yes
- [ ] No
- [ ] No service available
### Resource 3: Staff survey

<table>
<thead>
<tr>
<th>QUESTION</th>
<th>ANSWER</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. A palliative care case conference should be conducted for a resident/client who has an estimated prognosis of less than six months to live</td>
<td>True/False</td>
</tr>
<tr>
<td>2. Treatment preferences cannot be recorded for a resident/client who has advanced dementia and did not express their wishes on a legal document when they still had mental capacity.</td>
<td>True/False</td>
</tr>
<tr>
<td>3. Approval to proceed with an Aged Care End of Life Care Pathway must be obtained from the resident/client's GP or a specialist palliative care doctor within 48 hours of commencement.</td>
<td>True/False</td>
</tr>
<tr>
<td>4. Advance care planning should only occur prior to the resident/client's admission to the service.</td>
<td>True/False</td>
</tr>
<tr>
<td>5. A nurse, in conjunction with the family, has the right to decide whether a competent resident/client should attend their palliative care conference on the grounds that it might upset him/her.</td>
<td>True/False</td>
</tr>
<tr>
<td>6. If a competent client/resident tells you they have pain, it is good practice to ask how severe it is on a scale of 0 to 10.</td>
<td>True/False</td>
</tr>
<tr>
<td>7. A combination of changes in breathing patterns, profound weakness and irreversible weight loss may be signs of approaching death.</td>
<td>True/False</td>
</tr>
<tr>
<td>8. A substitute decision-maker can override a resident/client's statutory advance care directive.</td>
<td>True/False</td>
</tr>
<tr>
<td>9. Do you provide advance care planning for future health care to resident/clients in your service?</td>
<td>Always/Sometimes/Mostly/Never</td>
</tr>
<tr>
<td>10. Do you conduct palliative care case conferences for resident/clients in your service with a prognosis of less than six months?</td>
<td>Always/Sometimes/Mostly/Never</td>
</tr>
<tr>
<td>11. Do you use an end of life care pathway for resident/clients who are terminal (less than one week to live)?</td>
<td>Always/Sometimes/Mostly/Never</td>
</tr>
<tr>
<td>QUESTION</td>
<td>ANSWER</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
<td>--------</td>
</tr>
<tr>
<td>12. How would you rate your knowledge in advance care planning?</td>
<td></td>
</tr>
<tr>
<td>Please rate from 0 to 5 (0 = not knowing anything, 5 = knowing everything)</td>
<td>0 1 2 3 4 5</td>
</tr>
<tr>
<td>13. How would you rate your knowledge on palliative care case conferences?</td>
<td></td>
</tr>
<tr>
<td>Please rate from 0 to 5 (0 = not knowing anything, 5 = knowing everything)</td>
<td>0 1 2 3 4 5</td>
</tr>
<tr>
<td>14. How would you rate your knowledge on using an end of life care pathway?</td>
<td></td>
</tr>
<tr>
<td>Please rate from 0 to 5 (0 = not knowing anything, 5 = knowing everything)</td>
<td>0 1 2 3 4 5</td>
</tr>
<tr>
<td>15. End of life care discussions should be deferred until there is no further effective curative treatment available. Please rate from 0 to 5 (0 = strongly disagree, 5 = strongly agree)</td>
<td>0 1 2 3 4 5</td>
</tr>
<tr>
<td>16. A palliative approach should be the standard approach for resident/clients who are suffering from a terminal illness. Please rate from 0 to 5 (0 = strongly disagree, 5 = strongly agree)</td>
<td>0 1 2 3 4 5</td>
</tr>
<tr>
<td>17. The most appropriate person to make end-of-life decisions is the resident/client's doctor? Please rate from 0 to 5 (0 = strongly disagree, 5 = strongly agree)</td>
<td>0 1 2 3 4 5</td>
</tr>
<tr>
<td>18. How would you rate your confidence in discussing advance care planning with a resident/client? Please rate from 0 to 5 (0 = not confident at all, 5 = extremely confident)</td>
<td>0 1 2 3 4 5</td>
</tr>
<tr>
<td>19. How would you rate your confidence in conducting a palliative care case conference for a resident/client who has a prognosis of less than six months to live? Please rate from 0 to 5 (0 = not confident at all, 5 = extremely confident)</td>
<td>0 1 2 3 4 5</td>
</tr>
<tr>
<td>20. How would you rate your confidence in using an end of life care pathway? Please rate from 0 to 5 (0 = not confident at all, 5 = extremely confident)</td>
<td>0 1 2 3 4 5</td>
</tr>
</tbody>
</table>

**Correct answers**

Resource 4: The imperative to partner

The definition of Partnership is an ongoing working relationship in which risks and benefits are shared.

The goal of partnership is to achieve more than individual organisations can achieve on their own.

The degree to which service providers can connect, formally link or form a partnership will vary. In undertaking one or more of the strategies, the service providers can form linkages which will enable them to achieve more than what can be achieved by the service provider working alone. Partnerships need to be built on trust, equity, mutual benefit, courage and diversity.


For further reading on Partnerships and the development of successful partnerships refer to the extensive work in the links below developed by Victorian Council of Social Service (VCOSS).

Guide 1: Preparing to Partner
VCOSS Partnership Guide 1

Guide 2: Commencing the Partnership Guide
VCOSS Partnership Guide 2

Guide 3: Sustaining the Partnership
VCOSS Partnership Guide 3
Resource 5: Sample Palliative Care Service Level Agreement

Palliative Care Service Level Agreement

Objective:
To provide palliative care support for Aboriginal older persons by providing appropriate specialist care, using a multidisciplinary approach. Also working with the Aboriginal Liaison Officer and focussing on providing culturally safe care for Aboriginal residents, this being a high a priority for all services.

With strict adherence to all enforceable standards set by Aged Care Quality system, Palliative Care Standards (set by Palliative Care Australia) and Bereavement Standards and in line with Strategic plans, and utilisation of the Palliative Care Consortium of Governance Support.

Values:
- Respect and Honesty – Treat People with dignity and be truthful.
- Inclusion – Include everyone.
- Empathy and Compassion – Understand other people’s feeling and needs.
- Excellence and Best Practice – Aim high.
- Access and Equity – Open to everyone – same for all.
- Commitment and Accountability – Work hard, be loyal and responsible for own actions.

Multidisciplinary team:
- RACF staff
- Palliative Care Service staff
- Aboriginal Liaison Officer
- Occupational Therapist
- Physiotherapist
- Social Services.

Responsibilities:
1. All Aboriginal residents requiring a palliative approach to care will be referred to the Palliative Care Service.
2. Fortnightly review/meeting with RACF Senior Nurse and Palliative Care Nurse to review all resident/clients and discuss the need for referral to palliative care of non-Aboriginal persons for the end-of-life palliative care, referrals will be completed by RACF post-resident review. This meeting will also be the forum to discuss if there is a need for palliative care to offer bereavement support sessions to the RACF Staff, this will be assessed fortnightly on a needs basis and referral pathway through verbal request by Senior RN at this meeting or via phone call.
3. All identified resident/clients determined to be requiring specialist palliative care services will be assessed by the multidisciplinary team comprising specialist palliative care nurses, social work, allied health, a senior nurse from RACF and the Aboriginal Liaison Officer (where necessary).
4. The multidisciplinary team will meet monthly and review all resident/clients referred for multidisciplinary input and provide recommendations for ongoing care/management. This will be documented in the resident/clients individual care plan by RACF Senior Nurse after team meeting.
5. The ALO will document in contacts, relevant concerns/follow-up, appointments or relevant information that may assist staff in the resident/clients’ care.
6. The Palliative Care team will provide regular education and training for RACF nursing staff in relation to palliative care. The sessions will be held monthly at the education centre and will be open to all aged care staff within the Region.

7. The ALO will provide regular scheduled cultural safety training for RACF staff and Palliative Care Service staff.

8. The ALO/Palliative Care Service/RACF will review resources offered to staff and patients, to make sure the information is both current/relevant and in accordance with Aged Care Quality System, Palliative Care Australia, Palliative/Bereavement standards and in line with Strategic objectives.

Performance Assessment:
The operation of the performance accountability assessment, reporting and management process will involve:
- Participation by all the multidisciplinary team, working together collaboratively.
- The internal referral system is used and information documented is accurate and relevant.
- History review per month with audit tool to assess outcomes.
- Monitor progress against activity levels as reported by Palliative Care Service.

Management of Service Level Agreement:
Variation to Service Level Agreement:
- After the trial period, the effectiveness of the agreement will be assessed via feedback from staff, review of histories of patients following the palliative pathway, using a history audit tool and learnings to direct appropriate changes if necessary.
- Once the agreement has been finalised and implemented the process for any changes will be:
  - Advice must be given to the other services e.g. if project steering group still in operation or if not the Key stake holders of the service level agreement – RACF Unit Manager, Palliative Care Service Unit Manager, Aboriginal Liaison Officer and Executor Director of Nursing.
  - The reasons for the proposed amendment.
  - The precise drafting for proposed amendment.
  - Any information or document relating to the proposed amendment.
  - Details and explanation of any financial, activity of service delivery impact of the amendment.

Dispute Resolution process:
It is envisaged that all parties will work together in the spirit of the agreement to deliver an appropriate specialist palliative care to all residents, placing cultural safety for the Aboriginal older person as the highest priority.

If one service believes that the service level agreement is not being fulfilled, they will initiate discussions with other service. If either party is dissatisfied with the outcomes of the initial discussions the following process with be initiated:
1. The raised issues will be escalated to the RACF Unit Manager, Palliative Care Unit Manager and Aboriginal Liaison Officer (if necessary), for discussion and outcome.
2. If resolution in not achieved with these discussion then it is to be escalated to the Executive Director of Nursing, who will make a determination post discussion, with above service managers.
## Resource 6: Sample Advance Care Plan

**Advance Care Plan / End of Life Care Plan**

This Advance Care Plan applies to ____________________________ (Resident),
DOB: _____/____/______.

**My Enduring Guardian is:** Business Hours □ All Hours □
Name __________________________ Phone __________________________ Mobile __________________________
Relationship to resident ____________________________________________

**My Person Responsible is:** Business Hours □ All Hours □
Name __________________________ Phone __________________________ Mobile __________________________
Relationship to resident ____________________________________________

**Other contact person:** Business Hours □ All Hours □
Name __________________________ Phone __________________________ Mobile __________________________
Relationship to resident ____________________________________________

The following people are to be included in health care decisions if there is time:


I have a current signed Advance Care Directive: YES □
Copy Obtained □ NO □

If my condition acutely deteriorates and is potentially reversible with treatment, I would like:
Transfer / Admission to hospital

<table>
<thead>
<tr>
<th>YES □</th>
<th>NO □</th>
</tr>
</thead>
</table>
| Explanation Note: This involves transport to the Emergency Department by Ambulance Paramedics.
Acute Phase: Reversible e.g. UTI, Delirium, Fall, Fracture, etc OR Unexpected Unstable Phase or unexpected Deterioration Phase |

If my condition deteriorates: I would like to stay at the Residential Aged Care Facility

<table>
<thead>
<tr>
<th>YES □</th>
<th>NO □</th>
</tr>
</thead>
<tbody>
<tr>
<td>Explanation Note: This involves the joint care by the Registered Nurses, Enrolled Nurses, Care staff at the Home and visits by my GP. *DO NOT ASK IN TERMINAL PHASE.</td>
<td></td>
</tr>
</tbody>
</table>

I have a current Adult Resuscitation Not For Resuscitation (NFR) order: YES □ NO □

NSW Signed Resus Plan
GP reviewed on transfer from hospital
Revisited discussion with resident/family

Note: Valid for 12 months following GP signature

GP completed NSW Resus Plan CPR or No CPR section only YES □ NO □

If my heart or breathing stops due to old age or irreversible (not curable) health problems my choice, □ Please try to restart my heart / breathing (Attempt CPR)
□ Please allow me to die a natural death. Do not try to restart my heart or breathing (No CPR)
□ I cannot answer this question so:
Let my Person Responsible/family member OR Nurse OR Doctor make the right decision in my best interest.

CPR is used when the heart stops beating. It may include mouth to mouth/mask to mouth resuscitation & heart massage, drugs and IV line for fluids via a needle in the veins, electric shocks to the heart, and a breathing tube down the throat.

Prompts for staff: “What is your understanding of resuscitation?” and explanation of NFR by RN/PAC.
**PART ONE: Aged Care Services (Resident/cliential or Community)**

**ONLY COMPLETE IF YOU ARE REPRESENTING AN AGED CARE SERVICE**

**DEMOGRAPHIC DATA**

As an aged care service, you are asked to provide information about your service and its linkage partners to improve the care provided to older people at the end of life.

<table>
<thead>
<tr>
<th>What is the postcode of your organisation's location?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What type of aged care organisation is it?</th>
</tr>
</thead>
<tbody>
<tr>
<td>○ Residential aged care facility</td>
</tr>
<tr>
<td>○ Community aged care service</td>
</tr>
<tr>
<td>○ Other (please describe)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What number of beds OR aged care packages does it have?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>In the past 3 months:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What percentage of clients/residents received specialist palliative care consults?</td>
</tr>
<tr>
<td>○ 0% (none)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What percentage of clients/residents had a shared care plan?</th>
</tr>
</thead>
<tbody>
<tr>
<td>○ 0% (none)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What percentage of clients/residents had an advance care plan?</th>
</tr>
</thead>
<tbody>
<tr>
<td>○ 0% (none)</td>
</tr>
</tbody>
</table>
**PART TWO: Organisational Audit – Specialist Palliative Care Services**

**ONLY COMPLETE IF YOU ARE REPRESENTING A SPECIALIST PALLIATIVE CARE SERVICE**

**DEMOGRAPHIC DATA**

As a Specialist Palliative Care service, you are asked to provide information about your service and its linkage partners to improve the care provided to older people at the end of life.

<table>
<thead>
<tr>
<th>What is the postcode of your organisation's location?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What type of aged care organisation is it? (Tick all that apply.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>○ Specialist palliative care inpatient facility (hospital)</td>
</tr>
<tr>
<td>○ Specialist palliative care inpatient facility (hospice)</td>
</tr>
<tr>
<td>○ Specialist palliative care consultation service</td>
</tr>
<tr>
<td>○ Specialist palliative care community service</td>
</tr>
<tr>
<td>○ Generalist community service providing palliative care support</td>
</tr>
<tr>
<td>○ Other (please describe)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What number of patients has it provided care to in the past three months?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>In the past 3 months:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What percentage of your new referrals were for older* clients/residents who required specialist palliative care from your service?</td>
</tr>
<tr>
<td>*65 and over, or 50 or over for indigenous patients/resident/clients</td>
</tr>
</tbody>
</table>

| ○ 0% (none) | ○ 1–20% | ○ 21–40% | ○ 41–60% | ○ 61–80% | ○ 81–100% |

| What percentage of these resident/clients' referrals had an existing/resulted in a shared care plan? |

| ○ 0% (none) | ○ 1–20% | ○ 21–40% | ○ 41–60% | ○ 61–80% | ○ 81–100% |

| What percentage of these clients/residents had an existing/resulted in an advance care plan? |

| ○ 0% (none) | ○ 1–20% | ○ 21–40% | ○ 41–60% | ○ 61–80% | ○ 81–100% |
PART THREE: AUDIT QUESTIONS

PLEASE COMPLETE WHETHER YOU ARE REPRESENTING AN AGED CARE SERVICE OR A SPECIALIST PALLIATIVE CARE SERVICE

The following items have been developed to understand linkage strategies that exist in your service. Please answer every item, even if it is not a focus of your selected linkage project strategy/ies.

<table>
<thead>
<tr>
<th>Item number</th>
<th>How would you describe the frequency of your linkage arrangements with specialist palliative care/aged care services at this time?</th>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Mostly</th>
<th>Always</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Communication pathways</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.1</td>
<td>We have regular contact with local palliative care/aged care services</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>1.2</td>
<td>We have meetings with palliative care/aged care services to create and maintain linkages</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>1.3</td>
<td>We undertake case conferencing with palliative care/aged care services about care</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>1.4</td>
<td>We utilise technologies to communicate between with palliative care/aged care services</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>1.5</td>
<td>We routinely provide consumer information about palliative care/aged care services</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>

Comment on the factors that enable or constrain communication pathways between palliative care/aged care services:
<table>
<thead>
<tr>
<th>Item number</th>
<th>How would you describe the frequency of your linkage arrangements with specialist palliative care/aged care services at this time?</th>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Mostly</th>
<th>Always</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.</td>
<td><strong>Formalised agreements and plans</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.1</td>
<td>We have formal linkage partnerships</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>2.2</td>
<td>We have adequate allocation of resources to sustain linkage plans</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>2.3</td>
<td>We routinely retrieve evaluation service data for continuous improvement of linkages between palliative care and aged care services</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>

Comment on the factors that enable or constrain formalised agreements and plans between palliative care/aged care services:

<table>
<thead>
<tr>
<th>Item number</th>
<th>How would you describe the frequency of your linkage arrangements with specialist palliative care/aged care services at this time?</th>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Mostly</th>
<th>Always</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.</td>
<td><strong>Role descriptions</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.1</td>
<td>We have an accurate understanding of roles and responsibilities of each partner</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>3.2</td>
<td>We provide continuity of care between palliative care and aged care services</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>3.3</td>
<td>We communicate effectively about palliative care/aged care with other partners</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>

Comment on the factors that enable or constrain role clarity between palliative care/aged care services:
### Item number 4. Multidisciplinary Care

<table>
<thead>
<tr>
<th>Item number</th>
<th>How would you describe the frequency of your linkage arrangements with specialist palliative care/aged care services at this time?</th>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Mostly</th>
<th>Always</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1</td>
<td>We have regular multidisciplinary interactions with palliative care/aged care services</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
</tr>
<tr>
<td>4.2</td>
<td>We routinely use shared care plans with palliative care/aged care services</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
</tr>
<tr>
<td>4.3</td>
<td>We have confidence in partnering with palliative care/aged care services</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
</tr>
</tbody>
</table>

Comment on the factors that enable or constrain multidisciplinary care between palliative care/aged care services:

### Item number 5. Designated linkage worker

<table>
<thead>
<tr>
<th>Item number</th>
<th>How would you describe the frequency of your linkage arrangements with specialist palliative care/aged care services at this time?</th>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Mostly</th>
<th>Always</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.1</td>
<td>We have a clear understanding of the role of the linkage worker between palliative care/aged care services</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
</tr>
<tr>
<td>5.2</td>
<td>We have effective communication across between palliative care/aged care services</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
</tr>
</tbody>
</table>

Comment on the factors that enable or constrain the establishment or maintenance of the key linkage worker role between palliative care/aged care services:
<table>
<thead>
<tr>
<th>Item number</th>
<th>How would you describe the frequency of your linkage arrangements with specialist palliative care/aged care services at this time?</th>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Mostly</th>
<th>Always</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.</td>
<td>Knowledge exchange and upskilling</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.1</td>
<td>We routinely provide professional development sessions focused on palliative care/aged care</td>
<td>○</td>
<td>○</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
</tr>
</tbody>
</table>

Comment on the factors that enable or constrain knowledge exchange and upskilling with palliative care/aged care services:

<table>
<thead>
<tr>
<th>Item number</th>
<th>How would you describe the frequency of your linkage arrangements with specialist palliative care/aged care services at this time?</th>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Mostly</th>
<th>Always</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.</td>
<td>Continuous improvement</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.1</td>
<td>We routinely participate in quality activities with palliative care/aged care services</td>
<td>○</td>
<td>○</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
</tr>
<tr>
<td>7.2</td>
<td>We routinely collect and report minimum data with palliative care/aged care services</td>
<td>○</td>
<td>○</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
</tr>
</tbody>
</table>

Comment on the factors that enable or constrain continuous improvement with palliative care/aged care services:
Resource 8: The Strategies in more detail

A note about ‘evidence’

It’s important to remember what ‘evidence’ is in this context. It’s not the same things as ‘proof’. A systematic review of the published research literature will tell us what is already known about the effectiveness of a particular approach to care. Sometimes the evidence is strong and sometimes not. Sometimes the information that is available doesn’t tell the full story.

What we provide here is the evidence we drew from our own literature review of the existing research into linkages between organisations. It’s provided here to show you what is already known about linkage strategies. Each of the numbers refers to a research study – you’ll find the details in the References.

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.

What’s the evidence?

Two studies provide good examples of what happens where roles are not clarified in different RACF staff and their experiences providing end-of-life care.\(^1\)\(^2\) Mismatched expectations between residential aged care staff and community palliative care services was a barrier to good care; when roles are not clear, residential aged care staff can believe all dying patients should be under the care of a community palliative care service, and palliative care staff believe only complex cases require their input.\(^1\)

Aged care staff reported feeling ambiguous about who is responsible for starting end-of-life care discussions, with many care staff feeling this was the responsibility of the visiting healthcare professionals (district nurses and GPs)\(^2\). Once it was clear that the end of life was near, they found that roles and responsibilities between home care staff, visiting district nurses and GPs remained unclear, with ‘silos’ very strong. The exception to this was the one RACF that was Gold Standards Framework-accredited and used shared care documentation.

Another study identified differing role expectations as creating confusion across care settings and how the clarification of roles and responsibilities can stop professional territorialism.\(^3\)

What outcomes can I expect from using the Role Clarification strategy?

- Improved understanding of roles and responsibilities of each partner service provider.
- Improved communication about care.
- Improved continuity of care.

Role Clarification in action

Take a look at the Linkages project Case Study booklet at https://www.decisionassist.org.au/decision-assist/linkages-and-other-projects/linkages-project

This strategy was a first step for the Linkages project at mecwacare. They clarified the roles of aged care and specialist palliative care services within their partnership which then informed the development of their
formalised agreement. Other Linkage projects clarified the roles of the specialist palliative care services within RACFs and their role within End of Life pathways.

In another site, the Far West Local Health District Linkage project at Broken Hill developed detailed roles and responsibilities for care staff and the Palliative Approach coordinator for stable, deteriorating, terminal and bereavement phases of care for older persons.

**Multidisciplinary Team Structures**

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.

**What’s the evidence?**

A multidisciplinary team can be made up of various professionals from different partner organisations. A team can have members from the aged care provider, the palliative care provider the local health district and a GP practice. Regular, scheduled meetings with representatives of the whole treating team were seen as an important strategy to promote linkages and provide support for aged and primary care settings, resulting in improved communication and sharing information between services.\(^4\)\(^-\)\(^9\) Utilising media such as FaceTime, SKYPE and webinar facilities can assist geographically isolated team members to case conference and plan care.

Improved confidence in partner organisations was reported as an outcome of multidisciplinary activities\(^7\)\(^,\)\(^8\)\(^,\)\(^10\)\(^,\)\(^11\), in some ways countering the professional territorialism reported above who observed a failure of multidisciplinary liaison due to a lack of consensus on respective roles of team members; this is addressed further below in considering role clarification\(^3\).

Multidisciplinary teams were linked to improved symptom control in two studies\(^6\)\(^,\)\(^11\) that both reported a measurable decrease in symptom distress as a result of liaison between linkages between specialist services and other providers of end-of-life care to older people.

**What outcomes can I expect from using the Multidisciplinary Team Structures strategy?**

- Improved symptom control
- Increased number of scheduled multidisciplinary interactions
- Improved communication between providers
- Sharing of information
- Increased number of shared care plans
- Increased confidence in partner organisations and their staff.

**Multidisciplinary Team Structures in action**

This Linkage strategy illustrates how the strategies are interconnected. Multidisciplinary teams work best when the roles and responsibilities of each team member are made clear. Again, the Linkages project Case Study booklet on the website gives a number of examples; in particular, the Echuca Linkages project developed a Memorandum of Understanding that outlines the roles and responsibilities of each member of the multidisciplinary team and their meeting schedules. See [https://www.decisionassist.org.au/decision-assist/linkages-and-other-projects/linkages-project](https://www.decisionassist.org.au/decision-assist/linkages-and-other-projects/linkages-project)
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, End of Life pathways, agreed assessment tools, and Advance Care Plans.

What’s the evidence?

The need for clear communication between services is viewed as particularly necessary during transition of aged persons across settings of care; poor communication practices were seen as a threat to continuity of care and were linked strongly to poor quality end-of-life care. In the UK, advanced communication skills were seen as essential in promoting success in optimal patient outcomes including continuity of care. There was evidence of improved communication through information sharing within the multidisciplinary setting. Clarity of organisational roles and mechanisms to communicate information were fundamental linkage strategies; communication was again the key to reciprocal care planning and role clarification, with joint planning between services resulting in improved symptom assessment and continuity of care.

Strategies that use both verbal and written communication, especially shared documentation between services, were strongly evident. Written communication between nurses following a period of hospitalisation was reported to be effective, unlike physician to physician contact (particularly between hospital and primary care settings) where some participants reported delays even up to of a number of weeks between discharge and arrival of the discharge summary.

Access to 24-hour specialist advice for primary care through the use of an established communication protocol resulted in improved care coordination and carer support for patients at home. In particular, it was noted to provide anticipatory care, reducing the risk of preventable readmission to hospital. A standardised referral form was identified as a valuable strategy in one study although its effectiveness was hindered by difficulties with multidisciplinary practice, as noted above.

Mechanisms for interagency communication are clearly prioritised in discussion of Linkage strategies in the grey literature, including both formal and informal engagement throughout the sector. Successful operationalisation of these strategies requires good communication among care providers to help coordinate care when older adults need to move from one care setting to another.

What outcomes can I expect from using the Written and Verbal Communication Pathways strategy?

- Improved continuity of care
- Increased possibility of meeting patient choices
- Established contact with local services
- Increased meetings arranged to create and maintain linkages
- Developed shared documentation
- Increased use of shared care plans
- Increased continuity of care
- Increased case conferencing and communication about care
- Increased use of technologies (ie. telehealth and ehealth records)
- Provided consumer information
- Improved understanding by consumers.
Written and Verbal Communication Pathways in action

Shared and standardised documentation and communication processes that support care delivery includes several tools and documents for client and staff use. Here are some examples.

Referral pathways

Referral pathways were developed by the case study sites during the project using different approaches/decision points depending on the structure of the organisation. These included decisions by operational hours, staff availability and symptom-based criteria. Examples of these referral pathways are the 360 Health (South Perth) and the Peninsula Health (VIC) projects in the Case Study booklet at DA Linkages Project.

Communication Management tools

An example of a comprehensive communication and management tool developed by the Linkages case study site was at Prescare Tasmania. This tool was further transformed into an app for both Smart phone and Android. The Palliative Care Communication tool won a 'Highly Commended' award at the Aged & Community Services Tasmania (ACST) Aged Care Awards ceremony in December 2016: Prescare Tasmania news – http://www.prescaretas.org.au/about-us/news-and-events/. Another example of a Linkages project site that has embedded communication pathways into practice – and at a systems level – is found at Western Victoria PHN – https://www.westvicphn.com.au/health-professionals/palliative-care#specialist-palliative-care-services-in-the-grampians-region. It provides a comprehensive description of triggers for referral, referral criteria, and detailed descriptions of the geographical jurisdiction and the services within it.

Advance Care Plans (ACP)

The ACPs developed by the case study sites during the linkages project were based upon the ACP adopted by the state/territory or PHN. A link to the components of ACP in each state or territory can be found at http://advancecareplanning.org.au/. Supporting ACP tools to assist health service staff in discussions and the process of completion were also developed by the Linkages case study sites. There are a number of examples of in the Case Study booklet at https://www.decisionassist.org.au/decision-assist/linkages-and-other-projects/linkages-project. A culturally appropriate ACP for Aboriginal older persons was developed during the Echuca Linkages project.

End of Life Pathways (EoL)

Ensuring Aboriginal and Torres Strait Islander people have access to palliative care services that are culturally appropriate was the aim of the Northern Adelaide Health Network Linkages project. Accredited cultural sensitivity training was undertaken by Extended Care paramedics involving qualified trainers. As a result of these enhanced communication processes, there is both cultural and operational cooperation and understanding which has led to connections between these providers. This project is described by its leaders in the video at DA Linkages YouTube – https://www.youtube.com/watch?v=1NE52k9ByPA


Consumer information about palliative care


Footprints Brisbane is a not-for-profit community-based organisation serving a population of around 930,000 in Brisbane’s north. Many Footprints clients are either homeless or live in marginalised accommodation such as boarding houses, supported accommodation or public housing and their deteriorating health needs frequently go undetected until crisis point is reached. The goals of Footprints and
its partners for this project were to enhance linkages between community, residential care and palliative care service providers to ensure clients have access to the most appropriate care setting now and in the future. You can hear more about this project on DA Linkages YouTube – https://www.youtube.com/watch?v=fMWrR8KAx4Q

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.

What’s the evidence?

The operationalisation of linkage strategies was reliant upon endorsement and support at executive level and seen to work most effectively when implemented systemically within health regions. Integrated networks of primary care, specialist palliative care, aged care and community services were identified as key goals for health service planning. In one UK NHS jurisdiction, a need for commissioning arrangements to be built into system frameworks to promote improved integration was specifically noted and described elements of their success as including good liaison between different agencies, and more cross agency/cross border working.

Formalised service arrangements for collaboration between specialist palliative care services and disease-specific nurses revealed themes for promoting linkages between health services included development of referral criteria and care pathways, and standardised assessment criteria. A number of benefits of these linkage strategies for patients included improvements in quality of end-of-life care for people with dementia, and enhanced coping in patients with end-stage malignant disease. Further, these linkage strategies resulted in improvements in referral communication, providing guidance regarding assessment, and clarification of roles.

What outcomes can I expect from using the Formalised Agreements and Plans strategy?

- Evidence of formal linkage partnerships established, including formal agreements (e.g. MOUs) and shared service plans.
- Adequate allocation of resources to sustain linkage activity plan.
- Evaluation service data to provide information for continuous improvement.

Formalised Agreements and Plans in action

Examples from the Linkages projects include service level agreements, Memoranda of Understanding and Terms of Reference of reference/steering groups for the projects. Determining the level of formalisation of the agreement will differ from organisation to organisation.

As part of the Linkages project, a Knowledge Exchange workshop was held. A discussion about Formalised Agreements and Plans is available on DA Linkages YouTube. Also take a look at Resource 5: Sample Palliative Care Service Level Agreement.

During the Linkages project at Whiddon, the South Western Sydney Local Health District developed their strategic plan for Advance Care Planning, End of Life and Palliative Care. Consultation with RACFs within the catchment for the Health District was incorporated into the final document. The plan contains specific strategies for linking with RACFs and community aged care in the provision of end of life care, advance care planning and palliative care and can be viewed at https://www.swslhd.nsw.gov.au/pdfs/ACP_StratPlan.pdf
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.

What’s the evidence?

There is evidence of benefit in having a key worker whose responsibility it is to liaise between services, act as a care coordinator between acute and primary care settings, and monitor the patient’s health status and need for support. In our literature review, these key workers were nurses, although in two European studies and an Australian pilot study, these were identified as most suitably general medical practitioners. In three cases, the key worker role was seen as best allocated to the disease-specific nurse specialist in non-malignant illness, rather than the specialist palliative care nurse, with greater utilisation of disease-related knowledge to guide effective care. Of benefit in one study was the employment of Nurse Practitioners to fulfil the role of case coordinator who undertakes the coordination of care for all patients with complex needs at the end of life to assist with navigation, transition and utilisation of services.

The use of a link nurse has also been incorporated into the Victorian Policy Strengthening palliative care: Policy and strategic directions 2011–2015. In South Australia, Nurse Practitioners working within a palliative care-specific scope of practice planned to facilitate linkages between aged care and palliative care services.

What outcomes can I expect from using the Designated Linkage Worker strategy?

- Improved communication across settings
- Shared understanding of the linkage worker role
- Increased confidence among linkage partners
- Improved continuity of care.

The Designated Linkage Worker in action

The benefits of a designated linkage worker have been identified as having a key worker responsible to liaise between services. During the Linkages projects Enrolled Nurses, Registered Nurses, Clinical Nurse Specialists and Clinical Nurse Consultants were engaged as designated linkage workers at a number of project sites.

The role of the designated linkage worker was outlined in a number of position descriptions. The Far West Local Health District Linkage project integrated Clinical Nurse Specialist (CNS) link nurses from the palliative care service of the Health District into RACFs in the region. The CNS link nurse would successfully engage (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 carers. The team also developed improved documentation of end-of-life wishes and advanced care plans and a suite of documents for ongoing use.

You can read more about these roles in the DA Linkages Project Case Study booklet – https://www.decisionassist.org.au/decision-assist/linkages-and-other-projects/linkages-project
Knowledge Exchange and Upskilling

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

What’s the evidence?

Educational activities to address lack of training in palliative care and the development of professional relationships were seen as joint strategies to promote linkages. The inclusion of interprofessional learning – both formalised and informal – was reported in three studies.

Further, the need for learning was noted where the specialist palliative care personnel did not necessarily possess the specialist knowledge in a new field of practice, such as heart failure. One study reported the perception that professional education for those providing end-of-life care to disease-specific patient populations should be integral to the nurse specialist.

One study in particular views professional education to be a key function of the link nurse in nursing homes, observing improvements in the knowledge and skills of care home staff; however they cite difficulties such as a lack of management support, a transient workforce and inadequate preparation of link nurses for their role. There was improvement in staff confidence in discussing death and dying, improved symptom management and an increased trust between GPs and registered nurses through education and capacity building of residential aged care staff by a SPC nurse practitioner.

What outcomes can I expect from using the Knowledge Exchange and Upskilling strategy?

- Improved knowledge, skills and confidence of service providers in providing palliative care to older Australians.

Knowledge Exchange and Upskilling in action

Benefits of knowledge exchange and upskilling have been identified as improvement in staff confidence in discussing death and dying, improved symptom management and an increased trust between GPs and registered nurses. Many of the sites utilised learning programs such as the Program of Experience in the Palliative Approach: PEPA – http://pepaeducation.com/
Continuous Improvement

Processes for continual review of linkage strategies and their outcomes enable identification of their effectiveness and efficiency.

What’s the evidence?

Five studies reported improved quality of care for patients and families resulted from Linkage strategies.\textsuperscript{4,6,10,11,14} Whilst measurable outcomes (such as symptom scores) were specifically measured in two studies\textsuperscript{6,11}, they were otherwise reported in descriptive language, not always from patient/carer study participants. However, improvements in quality of care for patients, including improved symptom assessment and decreased symptom distress were widely reported.

Outcomes of Linkage strategies were reported in detail in one study\textsuperscript{9} in their systematic review of hospice integration in residential aged care. They observed a decrease in the number of hospitalisations of residents for end-of-life care and in the frequency of life-prolonging interventions, such as artificial hydration and nutrition.

There was a measurable increase in the conduct of discussions of changing goals of care and the uptake of advance care planning processes.\textsuperscript{6} A positive impact on patients’ sense of security in services providing their care was noted where a clear linkage arrangement was in place.\textsuperscript{5} One study\textsuperscript{14} suggested that there is a link between poor interagency linkage and negative outcomes for patients and carers. Another\textsuperscript{7} reports an increase in the articulation of preferred place of death by patients and families, although they do not report the extent to which these preferences were fulfilled.

Overall, improved satisfaction with care amongst patients and their families where interorganisational linkages were implemented was reported.\textsuperscript{9,11,14} One study speculated that a broader outcome of linkage strategies is the promotion of a more informed wider population which in turn allows for an improved carer experience.\textsuperscript{7}

What outcomes can I expect from using the Knowledge Exchange and Upskilling strategy?

- Evidence of strategy embedded into organisational quality processes (e.g. PCOC).
- Minimum data requirements collected and reported.

Continuous Improvement in action

The demonstration sites utilised Resource 1: After death audit – Residential Aged Care Facilities and Resource 2: After death audit – Community Aged Care Services throughout the projects to determine evidence of advance care plans; palliative care case conferences and as a continuous improvement activity. The after death audit tool was based on the audit tool contained in the Palliative Approach Toolkit – https://www.caresearch.com.au/Caresearch/tabid/3580/Default.aspx

You can read more about Continuous Improvement in the DA Linkages Project Case Study booklet – https://www.decisionassist.org.au/decision-assist/linkages-and-other-projects/linkages-project. For example, 360 Health and their partners developed a tool to assist care workers to reflect on the care of older persons. The tool was similar to an After Death audit but captured staff debriefing and bereavement issues as well as process improvement opportunities.
## Resource 9: Sample Activity Plan for Role Clarification

Rework this document as needed for your workplace.

<table>
<thead>
<tr>
<th>(Organisations' roles in undertaking this activity)</th>
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<tbody>
<tr>
<td>RACF/Community Aged Care</td>
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<tr>
<td>Palliative Care Service</td>
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<td>GPs</td>
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<td>Primary Health Network</td>
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<td>Other</td>
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</table>

### Steps in implementation:

- **Activity**: Role Clarification for aged and palliative care service provision

### Evidence of success:

1. Document/flowchart on roles, responsibilities, and expectations of roles in service delivery
2. Available on local Health Service Directory; Health Pathways; Primary Health Network – healthPathways and websites

### Resources required to achieve this strategy:

- Access to online resources
Resource 10: Sample Activity Plan for Multidisciplinary Team Structures

Rework this document as needed for your workplace.

<table>
<thead>
<tr>
<th>Activities</th>
<th>RACF/Community Aged Care</th>
<th>Palliative Care Service</th>
<th>GPs</th>
<th>Primary Health Network</th>
<th>Other</th>
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<tbody>
<tr>
<td>Steps in implementation:</td>
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<tr>
<td>Activity: Multidisciplinary Team Structure for aged and palliative care service provision</td>
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<tr>
<td>Evidence of success:</td>
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<tr>
<td>(i) Document/flowchart on multidisciplinary team members' roles, responsibilities and expectations in service delivery</td>
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<td>(ii) Regular, scheduled meetings including all team members</td>
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<td>(iii) Case conferences/care plans documented</td>
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<td>(iv) After death audits show evidence of multidisciplinary team meetings through case conferences/shared care plans</td>
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<td>(v) Improvement in symptom assessment scale (SAS) and palliative care problem severity score (PCPSS)</td>
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<tr>
<td>Resources required to achieve this strategy:</td>
<td>Facility space for face to face meetings</td>
<td>After death audit documentation</td>
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<tr>
<td>Steps in implementation:</td>
<td>RACF/Community Aged Care</td>
<td>Palliative Care Service</td>
<td>GPs</td>
<td>Primary Health Network</td>
<td>Other</td>
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<tr>
<td><strong>Activity:</strong> Written and verbal communication pathways for aged and palliative care service provision</td>
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<td><strong>Evidence of success:</strong></td>
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<tr>
<td>(i) Conduct desktop audit of current referral pathways both formal and informal</td>
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<td>(ii) Facilitated workshop to map services and develop referral pathway</td>
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<td>(iii) Conduct trial of referral pathway and review pathway to determine any modifications required</td>
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<td>(iv) Develop evaluation for trial of pathway</td>
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<td>(v) Develop a communication plan for the dissemination of the referral pathway.</td>
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<tr>
<td><strong>Resources required to achieve this strategy:</strong></td>
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<tr>
<td>Access to equipment for desktop review.</td>
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<tr>
<td>Administration support for arranging workshop and collating information.</td>
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</tbody>
</table>
# Resource 12: Sample Activity Plan for Formalised Agreements and Plans

Rework this document as needed for your workplace.

<table>
<thead>
<tr>
<th>(Organisations' roles in undertaking this activity)</th>
<th>Evidence of success</th>
<th>Resources required to achieve this strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>RACF/Community Aged Care</td>
<td>(i) Document developed outlining roles, expectations and deliverables of partners in the agreement. (ii) Agreement or MoU as standing agenda item on partnership/project meeting agenda.</td>
<td>Executive representatives’ time, Legal review of proposed Agreement</td>
</tr>
<tr>
<td>Palliative Care Service</td>
<td></td>
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<tr>
<td>Other</td>
<td></td>
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<tr>
<td>Primary Health Network</td>
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<td></td>
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<tr>
<td>GPs</td>
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</tbody>
</table>

**Steps in implementation:**

- **Activity:** Developing a formalised agreement or service plan for aged and palliative care service provision.

**Evidence of success:**

1. Document developed outlining roles, expectations and deliverables of partners in the agreement.
2. Agreement or MoU as standing agenda item on partnership/project meeting agenda.

**Resources required to achieve this strategy:**

- Executive representatives’ time
- Legal review of proposed Agreement
**Resource 13: Sample Activity Plan for Knowledge Exchange and Upskilling**

Rework this document as needed for your workplace.

<table>
<thead>
<tr>
<th>RACF/Community Aged Care</th>
<th>Palliative Care Service</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Steps in implementation:</strong></td>
<td><strong>Evidence of success:</strong></td>
<td><strong>Resources required to achieve this strategy:</strong></td>
</tr>
<tr>
<td>Developing a Knowledge exchange and upskilling plan for aged and palliative care service provision</td>
<td>Provision of learning activities: (i) Group learning, in-service (ii) 1-on-1 mentoring (iii) Completion of Online learning (iv) Use of free placements in palliative care services</td>
<td>PEPA, online information, PCC4U, online information, COMPAC, online resources</td>
</tr>
</tbody>
</table>
## Resource 14: Sample Activity Plan for Continuous Improvement

Rework this document as needed for your workplace.

<table>
<thead>
<tr>
<th>Organisations’ roles in undertaking this activity</th>
<th>Evidence of success</th>
<th>Resources required to achieve this strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>RACF/Community Aged Care</td>
<td>(i) After death audits completed for 5 or more most recent deaths.</td>
<td>After death audit tools.</td>
</tr>
<tr>
<td>Palliative Care Service</td>
<td>(ii) Discussion and review of the results of the after death audits discussion across partners in aged and palliative care service provision.</td>
<td>Access to files of most recent deaths in partner facilities.</td>
</tr>
<tr>
<td>GPs</td>
<td>(iii) Action items from discussion recorded, disseminated, and listed for review on agenda for partnership meetings.</td>
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<tr>
<td>Primary Health Network</td>
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<td>Other</td>
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</table>

### Steps in Implementation:

**Activity:** Continuous improvement for aged and palliative care service provision

- Evidence of success:
  1. After death audits completed for 5 or more most recent deaths.
  2. Discussion and review of the results of the after death audits discussion across partners in aged and palliative care service provision.
  3. Action items from discussion recorded, disseminated, and listed for review on agenda for partnership meetings.

**Resources required to achieve this strategy:**

- After death audit tools.
- Access to files of most recent deaths in partner facilities.
References

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

Decision Assist: An Australian Government initiative.