Australian Nursing Home Foundation (ANHF) Home Care

Home Care

Sydney Metropolitan and Greater Sydney, New South Wales

Linkage Strategies Used:

- Role Clarification
- Written and Verbal Communication Pathways
- Multidisciplinary Team Structures and Processes
- Designated Linkage Workers
- Knowledge Exchange and Upskilling
- Continuous Quality Improvement

The Australian Nursing Home Foundation Ltd (ANHF) Home Care Service is a not-for-profit provider providing culturally safe, coordinated and competent care predominately for Chinese, south-east Asian and Vietnamese communities. Clients are supported to live independently in their own home for as long as practical.

Prior to the ELDAC Working Together program, ANHF Home Care conducted a self-assessment audit on compliance against the Aged Care Quality Standards. Advance care planning and palliative care were key areas identified for improvement particularly in navigating cultural barriers surrounding advance care planning discussions. Ensuring staff were able to assess early signs of health care changes was a key area requiring improvement.

"Addressing cultural barriers around advance care planning discussions was really important — we just weren't sure how we could do this well."

The ELDAC Working Together program has helped staff develop links with other palliative care services and upskilled staff significantly – there has been a significant shift from limited knowledge and confidence in our capabilities to deal with advance care planning to confident staff facilitating end-of-life conversations. With a focus on continuous improvement, ANHF also created a resource guide for staff and families that has been translated into three languages around end-of-life care planning. Working in a more collaborative way across the sector and liaising with specialised palliative care services has helped grow staff confidence as well as building workforce capabilities and skills in end-of-life care.

"The ELDAC facilitation process has been exceptional and I can't speak any more highly of our ELDAC facilitator who has been instrumental in coaching the ELDAC Working Party to grow our knowledge and confidence."

Benefits

- Upskilling staff and improved staff confidence.
- Active collaboration with palliative care specialists.
- Development of staff and family resources.
- Reshaped actions, practices and framework for provision of care.
- Clinical acuity in end-of-life care.
- Translated culturally appropriate resources for staff and families.

"*develop links* with other services and *upskilled staff*"

Mr Shu is a 72-year-old man with a diagnosis of renal cancer on level 4 Home Care Package. Mr Shu's health condition has been deteriorating since the end of last year. Both the Home Care Advisor (HCA) and Registered Nurse (RN) have been consulting with Mr Shu and his daughter regarding his ongoing health condition and care plan. The RN has also had a conversation with Mr Shu's daughter regarding an advance care plan and options for palliative care. Based on her father's psychological well-being and to minimise stress placed on him, his daughter decided not to seek palliative care when first offered. However, as a result of subsequent conversations, an advance care plan is now in place and his wishes have been communicated.

The HCA had a follow-up discussion with his daughter regarding Mr Shu's health status, what she might need to do next and the support available if Mr Shu's health worsened. Mr Shu was in and out of hospital, with an unstable health condition.

The HCA met Mr Shu and his daughter at the hospital to offer emotional support and had a conversation about developing an advance care plan and Mr Shu's wishes.

As his health condition stabilised and improved, Mr Shu was discharged from respite and his case under palliative care treatment was closed. He is now being supported in his own home by our Home Care team and allied health specialist. His health continues to improve under our watchful Home Care Clinical team. It has been over a year since the Home Care team first assisted Mr Shu and his family. Mr Shu continues to be stable and he is not in need of an end-of-life care pathway at this time. He now, however, has an advance care plan in place and had the opportunity to make his wishes known discussing this openly with his daughter. Mr Shu and his daughter are better prepared and, well informed about their choices as well as the support we can provide.

James Lim, General Manager Community Care