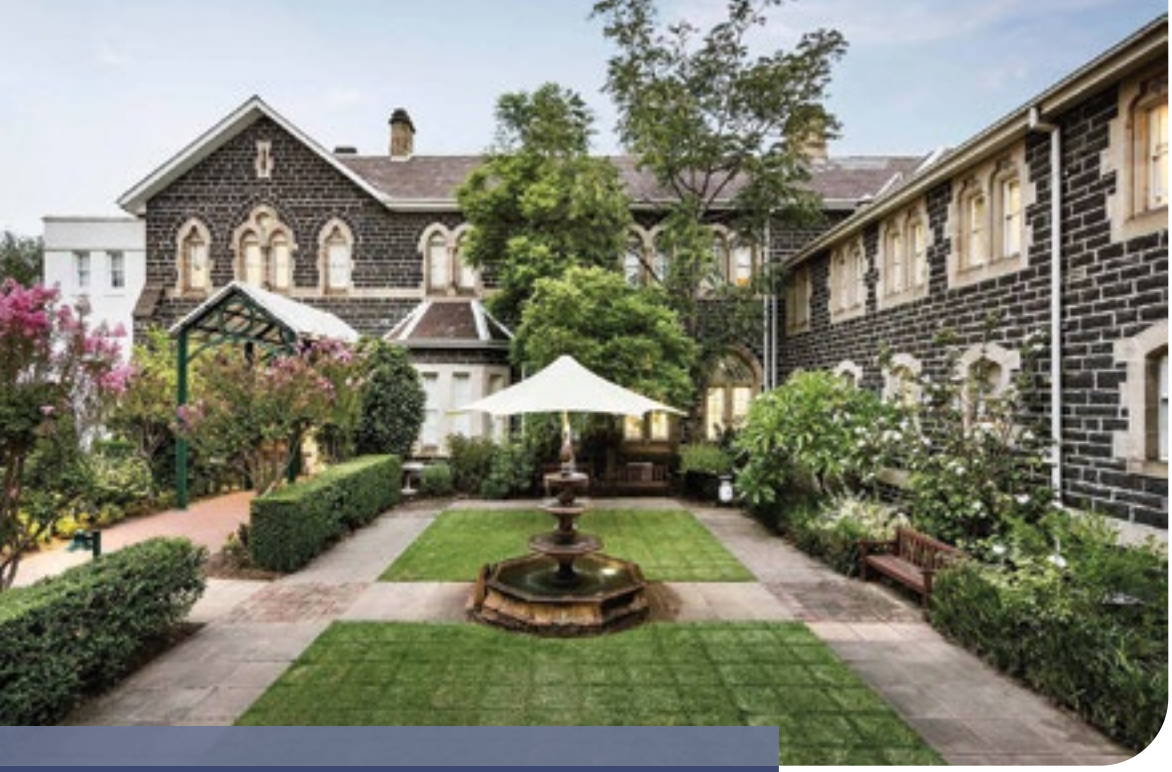

Napier Street Aged Care Services

Residential Aged Care

South Melbourne, Victoria

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

Napier Street Aged Care Service (Napier Street) is a not-for-profit, community-based organisation providing residential and community services for older adults in the South Melbourne area. The organisation provides safe and friendly permanent accommodation for seniors from a diversity of backgrounds. Services include permanent, respite and specialist palliative care.

The Napier Street team often experienced challenges while delivering palliative care and felt they were working in isolation from other services. There were limited linkages with the local Specialist Palliative Care Team (SPCT) and other care providers in the sector. Referrals to the SPCT were minimal and care pathways were undefined. This made it difficult to validate palliative care delivery and decision-making.

Napier Street enrolled in the ELDAC Working Together program to strengthen its linkages with other services in the sector, upskill staff and improve its processes and systems for advance care planning and palliative care. Providing better support for clients and their families during the bereavement process was also a primary goal.

The ELDAC Working Together program significantly improved the palliative care experience for carers, clients and the Napier Street Aged Care Services community. A more supportive environment was created for clients to help them choose how they wanted to spend the end of their lives and say goodbye to loved ones.

Linkages were also strengthened between services which have provided staff with access to qualified advice and referral pathways. The Napier Street team feels more supported to provide quality end-of-life care with a collaborative model involving other care providers and experts.

"Our ELDAC facilitator supported us with multiple resources and ideas to develop our care model. She supported the development and strengthening of our links with cross-sector services and the program opened up opportunities for us to build our capabilities and capacity in our care provision."

Increased understanding and communication between staff, General Practitioners (GPs) and the Calvary Health Care Bethlehem Palliative Care Service (CPCS) working with the CPCS Palliative Care Needs Round (PCNR) framework model, has strengthened care delivery across the organisation.

Stronger connections with the Southern Metropolitan Region Palliative Care Consortium (SMRPCC) led to additional access to education sessions and resources which have provided staff with more skills and knowledge to reduce anxiety for clients and their families. Team members are more confident in supporting and leading the end-of-life process to ensure residents' wishes are considered at all times.

"Our staff are simply more confident in managing the complexity of care and end-of-life for every resident and family here at Napier St. We are prepared to go over and above to support our families and residents.

Our confidence has come from the support and new partnerships and systems we have built into our service through the ELDAC Working Together program. Every one of our partners in care has contributed to helping us improve our confidence and reach our high standard of care. We have grown a lot in the last 12 months."

Benefits

- Staff are more confident and passionate.
- Improved staff upskilling.
- Improved collaboration with local palliative care providers.

"Regular specialist palliative care input through the Palliative Care Needs Round Model has now been established providing mentoring to our staff, clinical support with complex cases and education and upskilling for our staff. This model of care has truly enhanced our care and strengthened our multidisciplinary, collaborative approach."

Being innovative in palliative care

Ian came to us for palliative care and his main goal was to enjoy his time left. He still believed he was going to get better and wanted to visit the market regularly with his wife Anne. We helped him visit once but he became too exhausted to walk around. From then on, the deterioration was clear and Anne was there each day to support him with his needs. The team supported both Anne and Ian in this transition. We had discussed death multiple times and he felt that it was near but wasn't ready to deal with it.

Anne started to prepare herself with her life after Ian. We knew their anniversary was on 12 February and the team developed a plan where Anne and Ian could have a special Valentine's Day and anniversary date in a private area of the building. Ian managed to keep this plan from Anne and surprised her with a bunch of flowers and a big smile on the day. They spent the afternoon enjoying lunch with food Ian ordered for both him and Anne. They were very happy. They knew this was going to be their last anniversary together but they enjoyed their time together. Ian passed away peacefully 15 days later. Our team listened to Ian's wishes and felt so proud to help make this happen for him. The team still talks to Anne and catches up with her for a chat even though Ian has gone.

The learnings from the program showed us it is possible to be innovative in meeting the needs of the person who is palliative and allow them to make key decisions regarding what they want. This helps them achieve their best quality of life.

Marie Crossland, Chief Executive Offlcer
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