ELDAC

End of Life Directions for Aged Care

Supporting **health and aged care workers to** *provide best quality* **care for older Australians.**

About ELDAC

Palliative care is a national health priority. To enable the delivery of quality palliative care for all older Australians, the Australian Government Department of Health established The End of Life Directions for Aged Care (ELDAC) project in 2017. ELDAC provides aged care providers and older Australians in all areas of the country with information, advice and practical support to enable access to high quality palliative care and advance care planning services.

One key component of ELDAC is a program of activities designed to build linkages between service providers in specialist palliative care services, primary care and the aged care sector. Building such partnerships ensures we optimise the capacity of services to provide the best possible care at end-of-life in a timely way. This care addresses the unique needs for all in our community, including people from culturally and linguistically diverse backgrounds, Aboriginal and Torres Strait Islander people and lesbian, gay, bisexual, transgender and intersex groups.

This booklet provides an overview of the activities undertaken by services participating in this important linkage component of the ELDAC project. The stories presented in this booklet illustrate the wide-ranging goals, activities and outcomes achieved by the participating services. They demonstrate how services have used practical and sustainable strategies to improve the quality of care provided to older people in residential and community settings who are nearing the end-of-life.

ELDAC was developed by a national consortium of eight partner organisations:

- Queensland University of Technology (QUT)
- Flinders University of South Australia (FUSA)
- University of Technology Sydney (UTS)
- Palliative Care Australia (PCA)
- Aged & Community Services Australia (ACSA)
- Leading Age Services Australia (LASA)
- Australian Healthcare and Hospitals Association (AHHA) and
- Catholic Health Australia (CHA).

Aboriginal and Torres Strait Island Acknowledgement

End of Life Directions for Aged Care (ELDAC) would like to acknowledge the Traditional Custodians across the lands, waters and seas that we work and live on and pay our respects to Elders past, present and future and thank them for their continuing custodianship.

WARNING: Aboriginal and Torres Strait Islander peoples are warned content and photographs within this publication may contain images or names of deceased persons.

Disclaimer

This resource was produced by the ELDAC Working Together program, which sits within the ELDAC project. While every attempt has been made to ensure the accuracy of the information at time of printing, ELDAC disclaims any and all liability for any errors in or omissions from the information in this publication.

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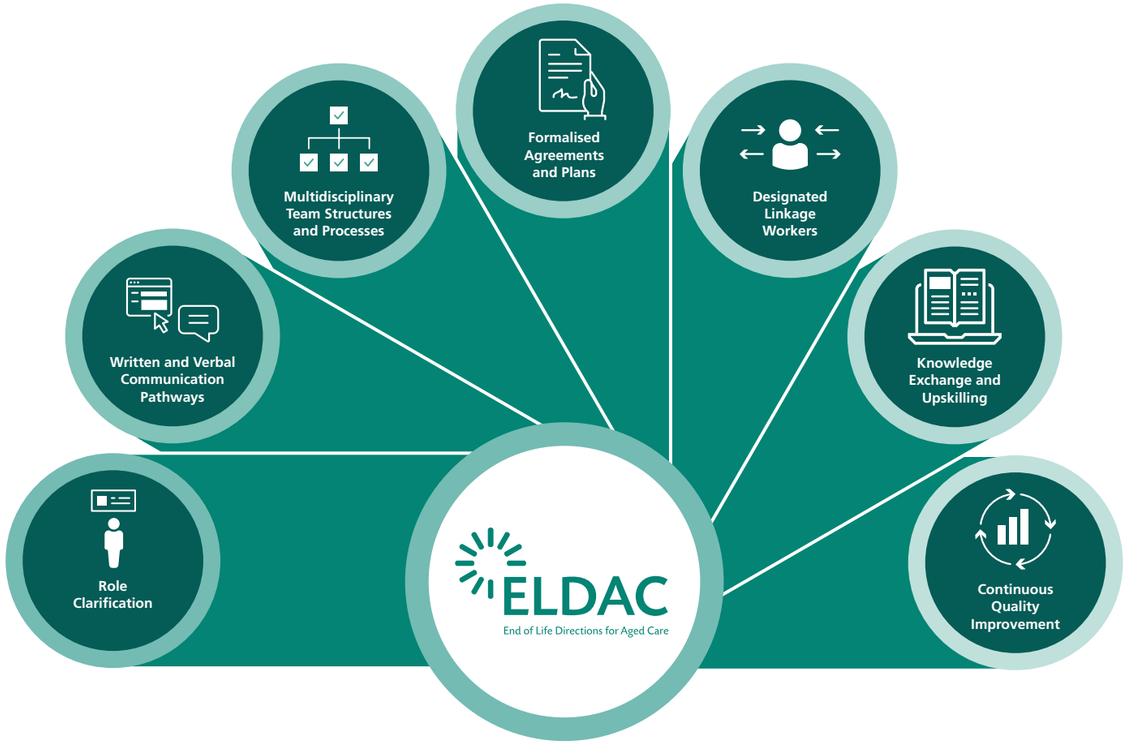
Linkage Strategies

The ELDAC Working Together program uses evidence-based practices to promote inter-organisational linkages. This includes linkage strategies which include practical methods and resources that can be employed across services of all sizes, locations and serving all populations.

Within each Linkage Strategy a range of activities can be undertaken to realise the strategy. For example, improved communication pathways can include implementation of handover forms and tools, standardised referral forms, referral pathways and shared care plans. Role clarification can be a formal, facilitated process involving large teams, or can be an intentional structured discussion between two providers.



Role Clarification

Understanding the roles and responsibilities of each service provider to increase effectiveness of the team, and improve communication and continuity of care, particularly when transitioning between settings. Helps identify gaps and overlaps in care provision.

Written and Verbal Communication Pathways

Shared and standardised documentation and communication processes that support care delivery. Examples include using common language and assessment tools, standardised referral forms, care pathways, and advance care plans.

Multidisciplinary Team Structures and Processes

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.

Formalised Agreements and Plans

Formalising linkages through written agreements and governance arrangements.

Designated Linkage Worker

Appointment of a key worker whose responsibility it is to act as a care and linkage co-ordinator 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.

Knowledge Exchange and Upskilling

Service partners share their knowledge and experiences, resulting in increased knowledge and improved confidence and capabilities.

Continuous Quality Improvement

Processes for continual review of improvement efforts and outcomes to embed sustainable positive change.

Gain, W., Rosenberg, J.P., Harrison, D., Brown, C., Parks, A. and Yates, P. (2017). *Decision Assist Palliative and Aged Care Linkages Manual.* Queensland University of Technology, Brisbane, Queensland, Australia.

ELDAC *Working Together* **program**

The ELDAC Working Together program has a national reach with enrolled sites in each of Australia's states and territories. The greatest numbers of sites are located in New South Wales, Victoria, Queensland and South Australia, and **over 45% of sites provide care for older Australians living in Rural and Regional Australia.**

Australia is a diverse nation and this is reflected in the services participating in the ELDAC Working Together program. **11% of enrolled sites specialise in services for Culturally and Linguistically Diverse (CALD) people.***

100%

100% of participating sites used the ELDAC Knowledge Exchange and Upskilling linkage strategy.^ This investment in the Australian aged care workforce through specialised palliative care training and education as well as shared learning opportunities has increased knowledge and developed confidence and capabilities among frontline care staff.

Facilitating linkages between aged care, palliative care and primary care is central to the ELDAC Working Together program. **41% of enrolled sites have appointed a Designated Linkage Worker** through participation in the program, and a third now have formalised agreements and plans with service partners.

*Australian Bureau of Statistics (2018). ^ Status or final reports from enrolled sites produced 30 September 2020.

Participating Sites

Queensland

- Carinity
  - Carinity Home Care, Rockhampton
  - Carinity Shalom, Rockhampton
- Ezyas@Home, Bundaberg
- Good Shepard Lodge, East Mackay
- Kaloma, Goondiwindi
- Lutheran Services
  - St Paul's Aged Care Lutheran Services, Caboolture
  - Tabeel Aged Care Lutheran Services, Laidley
- MultiLink Community Services Inc., Logan Central
- Opal Raynbird Place, Carseldine
- Ozcare De Paul Villa, Southport
- Pinaroo Roma Inc, Roma
- Sarina Aged Care, Sarina
- Shalom Elders Village, Townsville

New South Wales

- Amaroo Aged Care, Berrigan
- Anglicare At Home, Eurobodalla
- Australian Nursing Home Foundation (ANHF)
  - Bernard Chan Nursing Home, Burwood
  - Chow Cho Poon Nursing Home, Earlwood
  - Lucy Chieng Aged Care Centre, Hurstville
  - Home Care, Sydney
- BaptistCare
  - George Forbes House, Queanbeyan
  - Orana Centre for Aged Care, Point Clare
- CatholicCare Wollongong, Illawarra
- Cooinda Coonabarabran
  - Cooinda Community Care, Coonabarabran
  - Cooinda Nursing Home, Coonabarabran
- Multicultural Aged Care Illawarra, Illawarra
- Multicultural Care, Campsie
- Opal Aged Care
  - Opal Blacktown, Blacktown
  - Opal Maitland, Rutherford
- Rathgar Lodge, Ulmarra
- St Sergius Aged Care, Cabramatta
- Woodhaven Aged Care, Lockhart

Australian Capital Territory

- BaptistCare Carey Gardens, Red Hill

Victoria

- Illoura Residential Aged Care, Wangaratta
- Lifeview Willow Wood, Cranbourne
- Napier Street Aged Care Services, South Melbourne
- Rangeview Private Nursing Home, Wangaratta
- St Catherine's Hostel, Wangaratta
- Villa Maria Catholic Homes (VMCH)
  - VMCH Berwick, Berwick
  - VMCH Bundoora, Bundoora
  - VMCH Corpus Christi, Clayton
  - VMCH John R Hannah, Mulgrave
  - VMCH Providence, Bacchus Marsh
  - VMCH Shanagolden, Pakenham
  - VMCH Star of the Sea, Torquay
  - VMCH St Bernadette's, Sunshine North
  - VMCH St Catherine's, Balwyn
  - VMCH Wantirna, Wantirna South
  - VMCH Willowbrooke, Upper Ferntree Gully
  - VMCH Justin Villa, Balwyn
- Woods Point Aged Care, Yarrawonga

Tasmania

- Huon Regional Care, Franklin
- Uniting AgeWell
  - Home Care, South Tasmania
  - Kings Meadows Community, Aldersgate, Launceston

South Australia

- AnglicareSA Community Aged Care, Adelaide
- Barossa Village, Nuriootpa
- Bene St Clair, Woodville
- Boneham Aged Care Services, Millicent
- Fullarton Lutheran Homes Inc., Fullarton
- Lerwin Nursing Home, Murray Bridge
- Longridge Aged Care, Naracoorte
- My Care Solution, Adelaide and Victor Harbor
- St Basil's Aged Care
  - St Basil's Croydon Park
  - St Basil's St Peters
- Willochra Aged Care, Crystal Brook

Western Australia

- Coolibah Care, Mandurah
- Manjimup Home and Community Care, Manjimup
- Opal Geraldton, Geraldton
- TPG Aged Care, Perth

Northern Territory

- Southern Cross Care (SA, NT & Vic) Inc.
  - Home Support Services, Darwin
  - Pearl Supported Care, Darwin

** Participating sites appear in booklet in order of enrolment.*

Case Stories from the **ELDAC** *Working Together* **program.**

"I think the greatest revelation has been for all involved in the ELDAC Working Together program is the realisation that a good palliation experience starts long before the process of dying begins. That it is about living just as much, if not more, then about dying. I know for staff, the experience has not only had impact on their work practice, but also their personal lives."

Kathleen Lawrie, Facility Manager, Ozcare De Paul Villa

"Collaboration with the ELDAC facilitator has been a richly rewarding opportunity from the organisational perspective and a unique growth experience at each home. Enhancing linkages between the ELDAC Working Together program best practice information ensures Registered Nurses and medical practitioners are able to access relevant and up-to-date information at any time."

Carolyn Moir (Bourke) Registered Nurse, Palliative Lead and Care Improvement Consultant, BaptistCare

"To be involved with a resident's end stage of life is an honour and a privilege."

Yvonne Richards, Registered Nurse Div.1, Rangeview Private Nursing Home

"Through the ELDAC Working Together program we have been able to implement strong guidelines, policies and principles with a strong focus for our ELDAC champion and improved communication processes for our families, residents and staff."

Jan Marlborough, Residential Site Manager, Southern Cross Care Pearl Supported Care

"Undertaking the ELDAC Working Together program is advisable for all aged care facilities to empower them to build capacity, undertake training, and embed policies in their practice."

Heather Wickham, Palliative Care Nurse, Northeast Health - Wangaratta

"It has been a career highlight for me to be involved in the ELDAC Working Together program and witness real change."

Kathleen Wurth, Palliative Care CNC, Palliative Care Port Kembla

Villa Maria Catholic Homes (VMCH)

Residential Aged Care

Victoria:
Berwick, Berwick
Bundoora, Bundoora
Corpus Christi, Clayton
John R Hannah, Mulgrave
Providence, Bacchus Marsh
Shanagolden, Pakenham
Star of the Sea, Torquay
St Bernadette's, Sunshine North
St Catherine's, Balwyn
Wantirna, Wantirna South
Willowbrooke, Upper Ferntree Gully
Justin Villa, Balwyn

Linkage Strategies Used:

- Role Clarification
- Written and Verbal Communication Pathways
- Multidisciplinary Team Structures and Processes
- Formalised Agreements and Plans
- Knowledge Exchange and Upskilling
- Continuous Quality Improvement

Villa Maria Catholic Homes (VMCH) has 12 residential aged care services across regional Victoria and metropolitan Melbourne. Of the 12, eight of these residences have a dedicated memory support wing, which is designed to provide specialist care for residents with dementia.

Each of VMCH's homes has residents from a variety of religious and cultural backgrounds, and with varying care needs.

Prior to the involvement of VMCH in the ELDAC Working Together program there were a number of key challenges for the organisation around advance care planning and the provision of palliative care.

While each residence had their own procedures and preferences, there was no organisation-wide policy and procedure on end-of-life care or advance care planning – nor did all staff have the knowledge and confidence in having conversations around planning and dying.

VMCH staff are very knowledgeable, committed and caring, however there was collectively a lack of knowledge on the specifics of providing quality palliative care. This may be due to the lack of linkages with specialist palliative care services in the community, or support from GPs in providing palliative care services on-site, or in completing advance care plan directives for residents.

The impact of these challenges meant that there were no streamlined processes or guidelines on delivering palliative care, and how to complete the appropriate documentation. For resident documentation that was completed, there were often gaps regarding resident wishes on palliative care and end-of-life.

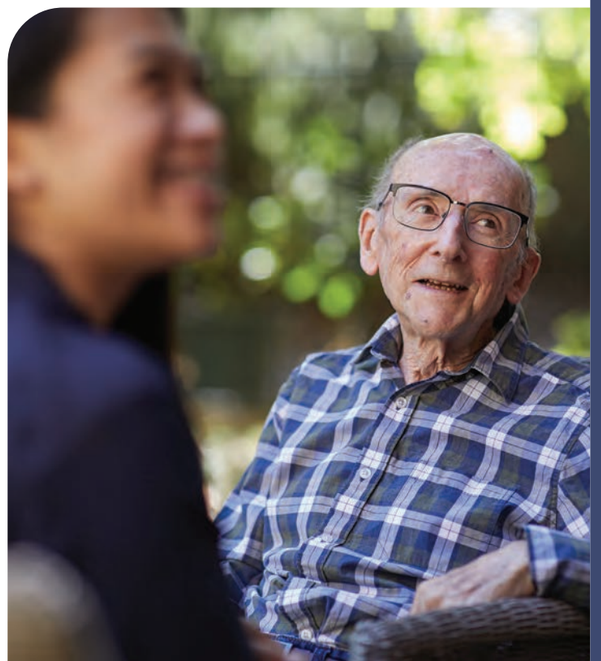
This has then led to some miscommunication between the care staff, the resident and their family about what their wishes were in regards to transfer to hospital, palliative care and symptom management – as staff were also unaware of how to contact specialist palliative care services when required for advice and directions.

With the support of the ELDAC Working Together program, VMCH commenced and developed strong linkages with their local palliative care services and ensured staff had an awareness of the referral process for these services. VMCH have now embedded the practice of having regular palliative care review meetings with key external palliative care service providers to discuss new referrals and / or complex cases and to share important information. VMCH has also developed stronger communication pathways with local GPs to assist them in planning for residents who enter the end-of-life phase.

"Having ELDAC involvement has really brought end-of-life care into the open and I know we now all understand and manage it better."

Through the ELDAC facilitation process, VMCH established policies and procedures on palliative care and advance care planning, in line with recommended practices. VMCH were also able to embed the practice of completing post death audits for those who passed-away in the residence, in order to review staff practices and identify areas for improvement.

"stronger communication"



VMCH believes that talking about palliative care has helped to 'demystify' it. VMCH has six residential aged care homes that fall under the Eastern Region. These include Corpus Christi, Clayton; John R Hannah, Mulgrave; St Catherine's, Balwyn; Wantirna; and Willowbrooke, Upper Ferntree Gully, and Justin Villa, Balwyn.

Prior to the ELDAC Working Together program, these six individual residences were experiencing inconsistencies in the referral process and creating and maintaining linkages with the local specialist palliative care service – Eastern Palliative Care Association Incorporated (EPC).

Through ELDAC the residences had first-hand experience in how working together with EPC could provide real, tangible benefits to their services – as well as ensuring residents (and their families) were able to experience 'a good death'.

VMCH's Justin Villa Aged Care Residence, specifically designed for retired Catholic priests, is an example of how this new partnership has been strengthened. Prior to the project Justin Villa had not referred to EPC, or had any involvement from their service for residents who were palliative.

Michelle Narandan, Justin Villa Residential Services Manager, said that the introduction of the ELDAC project allowed the home to explore the possibility of staff being able to provide palliative care services to residents. This led the team to be able to fulfil the wishes of one of their residents, who became the first resident to pass away at Justin Villa.

"It provided our team with confidence and skills to ensure that our resident was cared for in the most appropriate and peaceful way."

"We have been fortunate to be part of this network, with all very skilled and compassionate individuals. We have found even greater collaboration and teamwork amongst staff members around a resident's end-of-life trajectory since being involved in these ELDAC meetings."

Star of the Sea Aged Care Residence

"We have turned a sad time into a celebration of how we can preserve our residents' dignity and advocate for them right to the end. The staff have really lifted and are working with a real team attitude to get the best outcomes for the residents and their representatives."

Willowbrooke Aged Care Residence

"Being part of the ELDAC project has enabled me to start to focus more on the deterioration that indicates the palliative trajectory, and preparing the resident, their family and the staff, to assist them at their end-of-life in a way that provides choices and quality in care delivery."

Berwick Aged Care Residence

"Staff are much more aware when we commence the end-of-life pathway, and what this means."

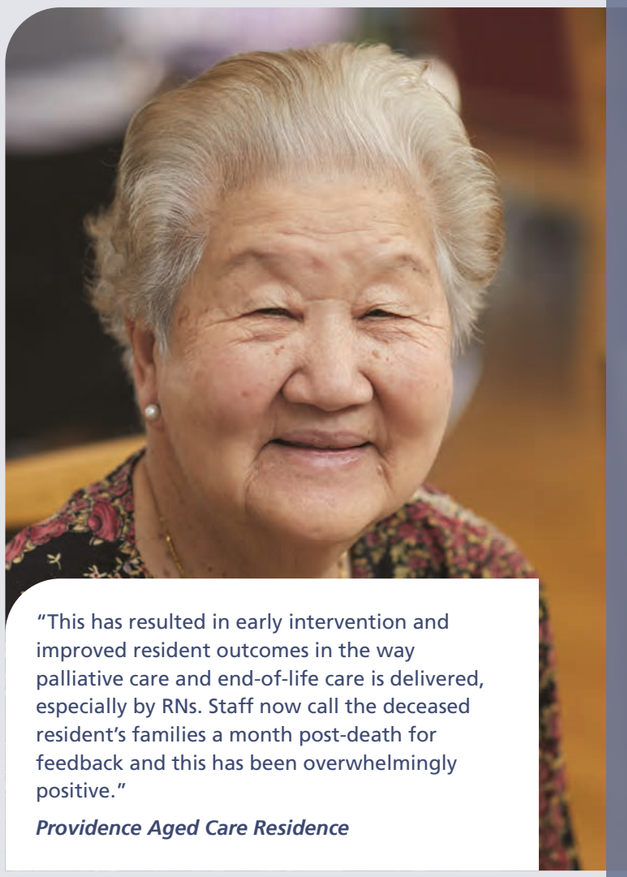
Shanagolden Aged Care Residence

"The sharing of knowledge was given a high priority and the communication from ELDAC has been great."

Wantirna Aged Care Residence

"ELDAC has supported the health care worker in aged care by providing information and toolkits for palliative care and advance care planning for the final stages of an illness which can be highly challenging."

St Catherine's Aged Care Residence



"This has resulted in early intervention and improved resident outcomes in the way palliative care and end-of-life care is delivered, especially by RNs. Staff now call the deceased resident's families a month post-death for feedback and this has been overwhelmingly positive."

Providence Aged Care Residence

"Recognising that allowing our residents to have a 'good death' in their home, surrounded by loved ones and nursing staff who know and understand their needs, is an integral part of what an aged care residence should offer."

Berwick Aged Care Residence

Multicultural Aged Care Illawarra

Residential Aged Care

Illawarra,
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

Multicultural Aged Care Illawarra (MACI) is a not-for-profit aged care and retirement service for people from culturally and linguistically diverse backgrounds. The facility provides person-centred care and ensures resident wishes are at the forefront of all palliative care decisions.

The ELDAC Working Together program provided MACI with an opportunity to review its palliative care systems and implement improvements to further support staff and residents.

The facility wanted to expand its capacity to care for residents and avoid unnecessary transfers to hospital. Staff also required further training to confidently discuss end-of-life care with residents and develop advance care plans. Diverse cultural backgrounds meant it was often difficult to initiate these conversations as residents and their families were reluctant to discuss palliative care. Stronger relationships with other service providers in the region were also needed to improve continuity of care and referral pathways.

The dedicated ELDAC facilitator helped MACI develop a more collaborative partnership with local palliative care services by increasing communication and understanding. This mutually-beneficial relationship and associated mentoring by the Specialist Palliative Care Clinical Nurse Consultant, provided valuable support for a range of new initiatives. These have included upskilling of all staff, network building in the Illawarra region, staff support for grief and loss, clinical support and mentoring and, system improvements.

MACI supported its new approach to palliative care by nominating inhouse champions to support their peers and provide high-quality end-of-life care for residents. Additional training and education also increased the facility's capacity and improved staff confidence with increased skills and resources to support their decision-making.

The facility introduced an innovative program to facilitate more comfortable conversations with residents about palliative care. At the 'Dying to Know Café', residents and their families discuss their end-of-life decisions in a relaxed conversational setting. This approach supports resident's choices and has increased the number of advance care plans.

Benefits

- Increased numbers of advance care directives.
- Networks have been strengthened and expanded.
- Upskilling and resources continue to support staff decision-making.
- Residents and their families are more involved in end-of-life care discussions.
- Residents are transferred to hospital less frequently.

> *"ELDAC enabled us to highlight palliative care and has given us more of a passion to provide appropriate quality care for our residents."*

Testimonial from local palliative care nurse

As a palliative care nurse, I was involved as a stakeholder with Multicultural Village Aged Care Illawarra at Warrawong, NSW and ELDAC.

We introduced an afternoon tea to provide opportunities for small discussions on choices, wishes and living well. We invited a few residents and held what would become our first 'Dying to Know Café' in a residential aged care facility. A resident called Dorothy inspired us to try the idea when she mentioned she had difficulty hearing information at a community forum about advance care planning.

MACI organised afternoon tea and we talked about what we hoped would happen as we approach our dying time. Dorothy was calm and wise in her conversation and had obviously thought about this before. Dorothy said she hoped to die at MACI with her family present and with hymns playing. The team spoke to Dorothy's son and they talked through Dorothy's advance care planning revisions. Everyone was on the same page including the GP.

A few months later, Dorothy had a change in health and was admitted to hospital. Her advance care directive was clear and respected. Dorothy returned to MACI with the biggest smile on her face and said, "I am home."

MACI staff were ready to use their skills and expertise, and felt confident in supporting Dorothy. She was relieved and thrilled to be back at MACI. Generations of her family visited and spent time, having cuppas and keeping her company. Dorothy also wanted her MACI family to be around her. We followed her wishes and residents, kitchen staff, cleaning, administration and care staff said their goodbyes and were able to comfort Dorothy. She was delighted that everyone came to spend time with her. She had no fear facing her end and was at peace. Dorothy died listening to her favourite hymns snuggled in her own bed. I am told it was magical.

Since then, other MACI residents have reviewed their own advance care plans and one resident has written his own eulogy. Several Dying to Know Cafés have also been held in other residential aged care homes and when I am sitting with people talking through their wishes and preferences, I think of Dorothy. I am so glad she was sweet and assertive enough to tell me that she didn't hear a word I said in the first place! The smaller groups are informal, friendly and intimate. It is because of Dorothy that we run Dying to Know Cafés in residential aged care homes.

I was grateful for the ELDAC facilitation and encouragement, and inspired by the work and commitment of the MACI team to serve their residents with skill and compassion.

Kathleen Wurth, Palliative Care Clinical Nurse Consultant, Palliative Care, Port Kembla

Anglicare At Home – Eurobodalla

Home Care

Eurobodalla,
New South Wales

Linkage Strategies Used:

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

Anglicare At Home provides home based care and palliative care to communities in the Eurobodalla region. Provision of the home based service is underpinned by Anglicare's focus on person-centred care as the foundation of quality aged care. Eurobodalla has a large retirement community and many clients do not have family members living nearby.

Prior to the commencement of the ELDAC Working Together program, the Anglicare At Home team provided palliative care and guidance for clients but were often unclear about referral pathways for additional support. In recognising the need for a specialist palliative care skillset to deliver an integrated care model, the Anglicare team connected with the ELDAC Working Together program.

"I felt that locally I didn't know who to turn to for guidance and support when caring for our palliative clients.

I couldn't provide the specialised palliative care that I felt our clients should be receiving, as I wasn't aware of all the services available and particularly the contacts to access them when needed.

Now the level of specialist care we are able to provide makes me feel at ease and the new relationships we have established are fantastic. Our clients are receiving the specialist palliative care, and I am supported to care for them and their families."

The ELDAC Working Together program connected Anglicare At Home with other services to foster healthcare network connectivity in the Eurobodalla region. The ELDAC facilitator supported meetings that brought key stakeholders together to clarify roles and develop care pathways involving palliative care specialists. Anglicare At Home also developed relationships with the palliative care team at the local health service providing staff with access to expert advice, resources and education.

"Prior to ELDAC, we did what we thought we could do but needed support. ELDAC helped provide both a pathway and direction so we could identify the problems and rectify them."

Benefits

- Increased support and expert guidance from palliative care specialists.
- Case conferencing enabled staff to develop new skills and expand their palliative care knowledge.
- Increased staff confidence in managing palliative care.

"makes me feel *at ease*"

I first met Bruce* when I was attending to his wife's wound care prior to her passing in a residential facility.

I remember how distressed Bruce was at losing his beloved wife, and he was very distressed that she died in a facility and not at home surrounded by her loved ones.

Several months after Bruce's wife passed away, he was diagnosed with bowel cancer. The decision to surgically remove the tumour was difficult because Bruce was in his 90s. However, eventually the tumour blocked Bruce's bowel and he was given the surgery then sent home with a colostomy bag. Further investigations revealed Bruce's cancer had spread to other organs and he would require palliative care.

His son agreed to care for his dad at home as Bruce was adamant that he would not be going to a nursing home. Bruce's son was apprehensive about caring for his father but he didn't want his dad to spend his days in a nursing home.

As Bruce began to deteriorate, we arranged to have several home visits with the Palliative Care Specialist Team. Prior to participating in the ELDAC Working Together program, I would have done the best I could to manage Bruce's symptoms. I also didn't realise that the palliative care specialist team existed or how they could help both the client and myself.

With ongoing support, Bruce outlived the predicted three to four weeks of life, and lived at home for another three months. During this time, Bruce always greeted me with a big smile and would tell me he was, "Great, thanks sweetheart." He enjoyed the occasional beer and roast dinner on the days he was feeling brighter. He also spent invaluable time with his children, grandchildren and friends.

Bruce's son found the palliative care support invaluable. The specialist team and my support over the phone or in the house gave him the confidence to care for his dad. The last couple of months of Bruce's life were a beautiful time of father and son bonding.

Bruce's son used his father's Ambulance Care Plan several times in the last week of Bruce's life. On the last night, Bruce became agitated and delirious, and tried to climb out of bed. He was taken to hospital and passed away peacefully 11 hours later.

I truly believe that Bruce had a "good" death. He spent his dying days surrounded by loved ones and with quality care and support. Through the ELDAC Working Together program, pathways and relationships were formed which definitely improved the quality of care that Bruce and his son received.

*Names have been changed to maintain confidentiality.

Shannon Bill, Anglicare At Home RN

St Basil's Aged Care

Residential Aged Care

South Australia:

St Basil's Croydon Park,
Croydon Park

St Basil's St Peters,
St Peters

Linkage Strategies Used:

- Role Clarification
- Written and Verbal Communication Pathways
- Knowledge Exchange and Upskilling
- Continuous Quality Improvement

The personalised level of care provided at St Basil's acknowledges that residents have spent a lifetime building families and community and are committed to ensuring residents can live well at any age, once they're home at St Basil's.

The introduction of the ELDAC Working Together program complemented the nurturing and quality care environment already established at St Basil's. It was particularly effective in supporting staff to address specific challenges including bereavement and the end-of-life process for culturally and linguistically diverse clients. Cultural barriers translated into a lower level of uptake of advance care plans from residents and families and minimal connection with specialist palliative care services. A revised approach to providing culturally appropriate resources to support staff, residents and their families was recommended.

"Our staff have a lot to contend with culturally to ensure the cultural, religious and spiritual beliefs of our residents and families are respected – especially surrounding palliative and after death care."

By implementing an end-of-life pathway process, St Basil's Croydon Park and St Basil's St Peters were able to provide staff training and a greater level of support to residents and families. In addition, the ELDAC facilitator supported enhanced linkages between St Basil's and the Central Adelaide Palliative Care Service, which provides staff with additional education on and access to end-of-life care resources.

The ELDAC Working Together program helped St Basil's evolve the end-of-life process and introduce a greater level of support to families and residents.

Benefits

- Systemic change through the introduction of advance care pathway, associated documentation and training.
- Established relationships with Adelaide Palliative Care Service and specialists.
- Education of GPs through formal GP Forum.
- Upskilling St Basil's staff in palliative care and advance care planning.
- Increase in uptake of advance care plans.
- Improved ability for staff to identify deterioration and improvements.

"Providing both families and residents with a culturally appropriate understanding of the end-of-life process and how staff could assist in supporting a good death was a wonderful outcome of the program. As a result we have experienced an increase in the uptake of advance care plans."

"a *greater level of* *support* to residents"

Mr Stavrianos* was a 90yr old resident with a very supportive and actively involved family. Tests recently conducted at hospital determined an acute life-limiting diagnosis.

The GP confirmed that he may sustain a sudden deterioration and our staff also identified changes in his function. Family conferences and discussions with the GP were held to ensure the family was aware and understood the resident's situation as he was approaching his end-of-life. They attended the formal case conference in the previous weeks and this helped them to understand the situation and refine their perspective accordingly. Simultaneously, this approach helped the family to enhance their trust in the care provided by St Basil's at this important part of life. The family was grateful to be made aware of Mr Stavrianos' circumstances, which enabled them to share precious time and create new memories in the short time they had.

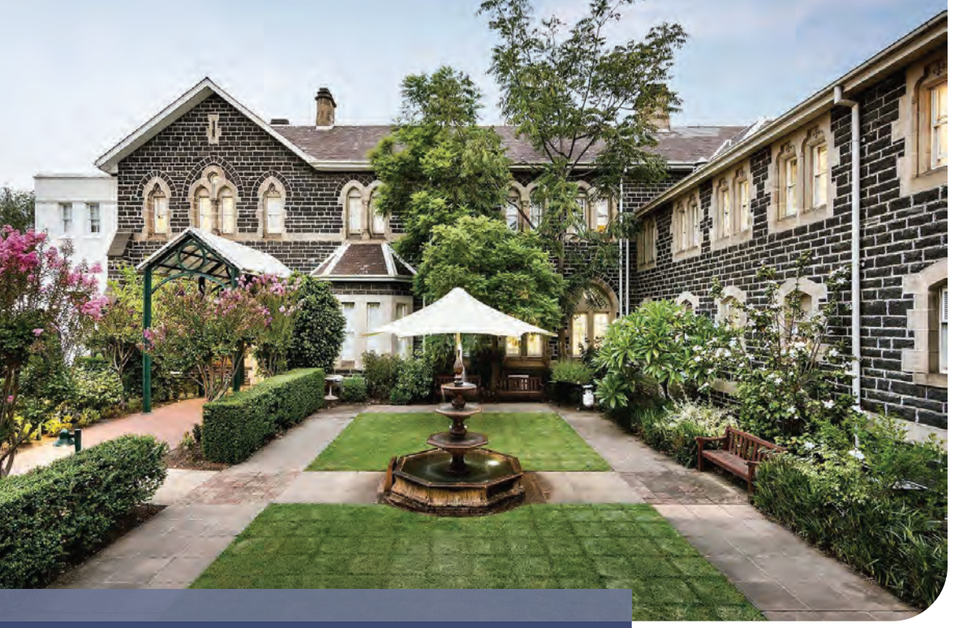
His family and our staff took relief from seeing that Mr Stavrianos experienced a peaceful death, in the presence of his daughter. With new skills, our staff were able to provide culturally sensitive support and comfort.

On reflection, we identified the role our improved skills had in identifying Mr Stavrianos' early needs noting that his family was better able to plan their time with their father. As a team, we were able to start the end-of-life pathway in a timely manner which gave the family more time to reach acceptance. With our recent education and introduction of clinical tools, our staff were more aware of the signs of deterioration and worked with more comprehensive processes in place. It was clear that this well-planned approach contributed significantly to Mr Stavrianos' good, peaceful death and the family's management of their grief.

The ELDAC Working Together program helped to reinforce the skills of our team in dealing with culturally and emotionally sensitive situations with empathy and appropriate support, providing great benefit to families and staff.

*Names have been changed to maintain confidentiality.

Quality and Clinical Support Team



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."

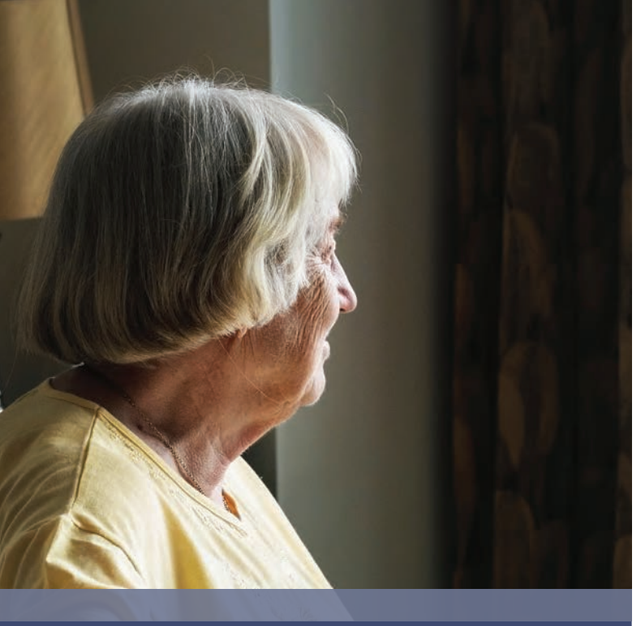
Being innovative in palliative care

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
Gabriel Vila–or, Clinical Care Manager



Cooinda Community Care

Community Care

Warrumbungle, New South Wales

Linkage Strategies Used:

- Role Clarification
- Written and Verbal Communication Pathways
- Knowledge Exchange and Upskilling
- Continuous Quality Improvement

Cooinda Community Care is a not-for-profit, community-owned organisation providing aged care to the population of the Warrumbungle Shire in North-West New South Wales.

The organisation provides person-centred services to residents in local towns and on rural properties with Home Care Packages and the Commonwealth Home Support Program. These customised packages support client goals and help them live independently at home.

Working in rural and remote communities presents challenges for staff accessing palliative care networks, expertise and resources. The organisation identified the need to improve linkages with other providers and partners to optimise advance care planning and palliative care decision-making. Clients and families had a limited understanding of advance care planning and end-of-life decision-making. Care outcomes may not have always aligned with client / family wishes resulting in transfer to hospital or residential care instead of receiving palliative care at home.

The ELDAC Working Together program helped Cooinda Community Care implement comprehensive end-of-life and palliative care processes for clients and staff. New collaborative relationships with organisations and individuals, and revised staff education programs also supported the organisation's revised approach.

Resources from the ELDAC Toolkits have been incorporated into the orientation process for new staff and some education modules have been added to the mandatory annual program.

"We now have an excellent education plan and program for our staff and also provide education and support for our clients, their carers and families."

"Staff report great benefits from the education and continue to complete modules of interest in end-of-life and palliative care."

A new collaborative process involving a local General Practitioner (GP), General Practice Nurse (GPN) and staff has also been implemented. This involves weekly rounds, regular documentation updates and case conferences for all clients. The Cooinda Community Care team work closely with the GP and GPN to support clients requiring in-home palliative care.

Benefits

- Stronger partnerships with organisations and individuals who can provide our team with expert advice and support.
- Clients and their families are more informed and feel more in control of their end-of-life outcomes and choices.
- The ELDAC Toolkits provide valuable resources and information to support clinical and care decision-making.
- Increased awareness of and access to online resources provide support to clients, carers and families assisting their loved one.

"Our ELDAC facilitator has been the driving force for our success and continues to be our go-to person, our wealth of knowledge and our call me anytime support."

"given our team so much *understanding* and *knowledge*"

This project has given our team so much understanding and knowledge about end-of-life planning and assisting themselves, clients and families through the dying process and beyond.

I am confident the positive benefits of the project will continue with all future staff and clients of our organisation ensuring better outcomes for all involved in end-of-life care and decision-making.

The ELDAC Working Together program enabled us to enhance our working relationship with a local GP medical practice. This connection allows us to provide best practice, ongoing care to clients at home and is especially important to those clients who wish to palliate in their home environment.

Joan Robinson, Community Care Co-ordinator

Opal Aged Care

Residential Aged Care

New South Wales:
Maitland, Rutherford
Blacktown, Blacktown

Queensland:
Raybird Place, Carseldine

Western Australia:
Geraldton, Geraldton

Linkage Strategies Used:

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

Opal Aged Care – Maitland

Opal Maitland provides aged care services with a strong focus on empathy, quality of life and belonging. This starts with high-quality clinical care, social and recreational programs, and community connections, and extends to residents' health, wellbeing and independence. The care home provides a friendly and inviting atmosphere for all residents and their families.

Opal Maitland has a diverse workforce with Registered Nurses and carers from many backgrounds and levels of clinical experience. Through the ELDAC Working Together program the team identified that further education, additional resources and networks would help establish more consistent and effective palliative care pathways.

The ELDAC Working Together program enabled Opal Maitland to develop collaborative, multidisciplinary relationships with the local palliative care network. These relationships were facilitated through partner meetings which helped clarify roles and communication pathways, and improved how the care home worked with other providers.

Stronger partnerships with the specialist palliative care team and area health service providers also delivered benefits for residents and team members.

Opal Maitland team members undertook palliative care and advance care planning training and accessed development opportunities through the implementation of a new education plan. This was supported with an internal working party and champions to help implement changes and facilitate information sharing.

> *"Access to valuable resources on the ELDAC website also empowered team members with information, and After Death Audits have been implemented as part of routine processes."*

Benefits

- Improved team confidence and knowledge through education.
- Clear referral pathways have been established.
- Established multidisciplinary partnerships.
- Improved role clarification and communication pathways with key external care providers.

ELDAC tools empower staff to have end-of-life conversations

A new Registered Nurse (RN) at our care home was caring for her first resident who was deteriorating and demonstrating signs of approaching end-of-life. Following a discussion of the signs and symptoms, I referred the RN to the resource tools we had collated into a folder through our participation in the ELDAC Working Together program. These tools helped her confirm she was making the correct assessment.

Together we were able to access additional information on the ELDAC website as we talked through the next stages of end-of-life and the considerations for the resident and their family. Following our conversations, the RN felt empowered to have the necessary conversations. She also liaised with the General Practitioner and specialist palliative care service (engaged earlier in the resident's care pathway) to ensure the resident had the best possible care outcomes.

The RN is now a member of the internal working party established during the ELDAC project. This ongoing working party will ensure the valuable ELDAC project work continues at Opal Maitland.

Julie Lewis, General Manager

Opal Aged Care – Blacktown

Opal Blacktown is a state-of-the-art, residential care home located in Sydney's Greater West. The care home provides permanent and respite care to residents from 14 different cultural backgrounds and is designed with lifestyle in mind. Residents enjoy generous accommodation, luxurious living areas and outdoor terraces along with music therapy and other group programs.

The ELDAC Working Together program enabled Opal Blacktown to expand its capacity and improve its ability to provide high-quality palliative care.

Prior to engaging in the ELDAC Working Together program the care home's Registered Nurses (RNs) had different levels of knowledge and skills regarding advance care planning and end-of-life care. Opal Blacktown also recognised there was an opportunity to establish new linkages with local heath and palliative care providers to enhance referral pathways.

The ELDAC facilitator helped Opal Blacktown improve linkages with other local providers including specialist palliative care, local primary health, General Practitioners and pharmacy. These relationships identified opportunities for collaborative care to deliver the best possible outcomes for residents.

Staff training provided valuable upskilling for team members who now feel more confident when caring for palliating residents. Staff know the indicators to look for during end-of-life care, have resources to support their decision-making and understand the referral pathways available for advice.

"Our ELDAC facilitator provided us with a huge amount of support to achieve our goals. From the beginning, we worked together and were able to change and improve our palliative approach across the home."

Benefits

- Increase in staff confidence and knowledge.
- Improved internal palliative care and advance care planning processes.
- Improved mutually beneficial relationships with key external providers.
- Role clarification and communication pathway improvements.

Opal Aged Care – Geraldton

Opal Geraldton provides high-quality clinical care, generous accommodation, and enjoyable social and recreational programs for elderly residents. The care home maintains strong links with the community and a significant number of residents come from Indigenous backgrounds. Staff use a multi-disciplinary, culturally aware approach to ensure emotional, physical and spiritual needs are considered in all interactions with residents and their families.

The Opal Geraldton team saw the ELDAC Working Together program as an opportunity to educate and upskill their staff on the application of residents' advance care plans as well as provide team members with communication tools and strategies to facilitate end-of-life discussions.

Prior to their participation in the ELDAC Working Together program, the care home had established relationships with other key external care providers, however identified these could be strengthened to enhance the delivery of palliative care to their residents.

The ELDAC Working Together program empowered team members with the education and resources they needed to increase their understanding and skills for end-of-life care. As a result, they are now proactive when discussing advance care planning with residents and their families.

Service mapping and partner meetings have also created stronger linkages with other key external providers including specialist palliative care.

Benefits

- Increase staff confidence in participating in end-of-life discussions.
- Empowerment of residents and families.
- Improved linkages with local community health providers.

"The ELDAC facilitator enabled us to identify the areas where we could improve and develop a proactive approach that has resulted in a meaningful program which improves our end-of-life care through a multi-disciplinary approach."

Opal Aged Care – Raynbird Place

Opal Raynbird Place is a residential care home located in the Brisbane North region. Its comprehensive lifestyle program encourages mental and physical health, socialising and fulfilling opportunities to enable residents to live an enriched life. This is supported with exceptional and personalised care delivered by medical and allied health professionals.

The ELDAC Working Together program provided opportunities to improve the home's approach to palliative care. Together with the dedicated ELDAC facilitator and our identified partners we have enhanced staff skills and knowledge of advance care planning. Opal Raynbird Place have also been able to access new tools and resources to support decision-making regarding end-of-life care pathways.

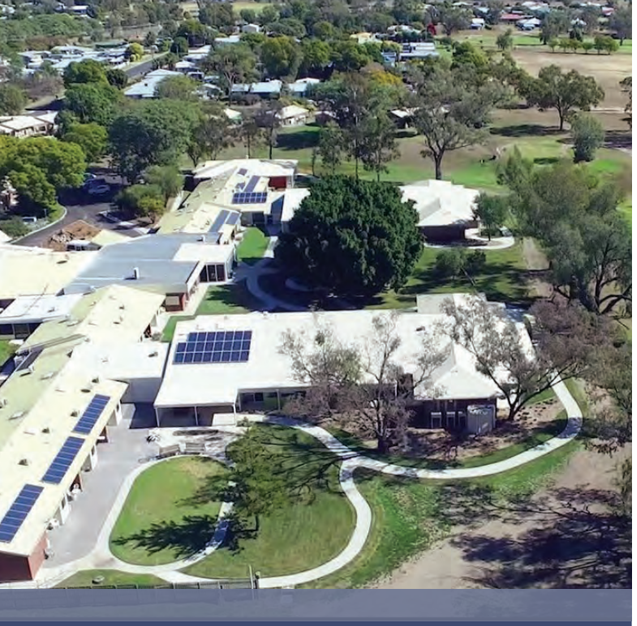
Closer working relationships with the local palliative care network and service providers have also facilitated a more effective and multi disciplinary approach to end-of-life care.

"Strengthened relationships have resulted in new and stronger linkages with the care home's pharmacy, and local primary and palliative care providers."

Benefits

- An internal working party was established to focus on end-of-life care and continuous improvement.
- Tools and resources are available to support staff decision-making and conversations with residents and their families.
- Collaborative and mutually beneficial relationships have been developed or improved with other key external care providers.
- Improved communication with the local pharmacy means end-of-life and rarer medications are well-stocked and available for our staff when needed.
- After Death Audits are now incorporated into routine processes.

"ELDAC has provided us with a platform and framework to continuously review our practices and education. This will benefit our team members, residents and families."



Kaloma Goondiwindi

Residential Aged Care

Goondiwindi, Queensland

Linkage Strategies Used:

- Written and Verbal Communication Pathways
- Multidisciplinary Team Structures and Processes
- Knowledge Exchange and Upskilling
- Continuous Quality Improvement

Kaloma is an 80-bed rural aged care home located in Goondiwindi offering all levels of care including palliative and dementia care. With strong links to the local community, Kaloma is passionate about ensuring those in care have the opportunity to remain and be cared for in Kaloma and to consider it 'home'.

"We were doing end-of-life care well but we found we could do it even better."

Prior to the commencement of the ELDAC Working Together program, Kaloma staff were wanting confidence in approaching advance care planning, palliative care and after death care especially for Aboriginal and Torres Strait Islander residents and their families. Kaloma was keen to build on their systems, their networks and staff capacity to provide quality palliative care for residents and families With limited direct access to specialist palliative care services, Kaloma staff relied on support from the community health nurse (via the hospital) and experienced resource challenges often evident in rural communities. Upskilling resident nurses to improve their confidence in symptom management and assessment and, advocating for the resident (to the doctor) became a key priority.

Participating in the ELDAC Working Together program helped Kaloma improve the documented clinical pathway for end-of-life care as well as improving network connectivity. A palliative care focus group has been established to support and embed palliative care as core business at Kaloma introducing service level changes to improve quality palliative care outcomes.

"There is certainly power in everyone working towards a common agenda – to look after our community and their families. Building capacity with staff through mentoring is providing more than qualitive palliative care outcomes for their residents and extended families. Quite simply, it is inspiring!"

The provision of tools and resources, as well as resource support, has allowed staff to provide a higher level of culturally aware safe care through advance care planning, palliative care and after death care.

With a focus on community connection and country town hospitality, many residents now consider Kaloma their home and part of their family network.

"Providing our staff with the tools to confidently facilitate what can traditionally be difficult conversations has been one of the many benefits of participating in the program."

Benefits

- Increased staff awareness, confidence and education.
- New resources, tools, policies and guidelines for resident care planning and management.
- Increased General Practitioner (GP) confidence in anticipatory prescribing with increased RN skills.
- Networks developed to support integrated care.

"improving *network connectivity*"

The value of palliative care and bereavement support for loved ones.

Mrs Carter had lived in Kaloma for many years and her family, particularly her son visited her regularly and they had enjoyed many happy family occasions together. As Mrs Carter approached her end-of-life, we discussed her deterioration with her son who was distressed by the thought of losing his mum and of her evident signs of deterioration.

In our Palliative care focus group, we discussed the complexity around Mrs Carter and her son and his distress with presenting end-of-life symptoms. We were able to put into practice our recent focus group discussions on managing symptoms at end-of-life. We recognised the needs of both Mrs Carter and her son and made a plan forward that could support them. We planned with our team that we would approach and explain symptoms that presented and provide optimal emotional support.

Our staff had learnt to recognise when a family member may need extra support and to identify the possible emotional cues presenting. Our team were clear how to manage this if identified, who and how they could escalate support to help the family. We had identified the importance of a consistent approach and discussed this together as a team. We ensured that our team had the opportunity to express their concerns and provided extra information and resources to support any staff distress or concerns.

Mrs Carter died peacefully at sunrise one early morning. She was calm and family were by her side and at peace. Her family expressed how extremely grateful and appreciative they were for the care of their mother and the strong professional support they received.

The Palliative Care Focus Group has provided us with unexpected outcomes such as a support to one another and a consistent approach and the opportunity to share our own concerns and discuss them openly.

Tenneille Aguilar, Director of Nursing / Facility Manager, Kaloma

Ozcare De Paul Villa

Residential Aged Care

Southport, Queensland

Linkage Strategies Used:

- Role Clarification
- Written and Verbal Communication Pathways
- Knowledge Exchange and Upskilling
- Continuous Quality Improvement

Ozcare De Paul Villa is a large facility that provides dementia specific, emergency respite and call out care to our neighbouring Retirement Village. The facility's staff are supported by volunteers including residents from the retirement village. One of the defining characteristics of care at De Paul Villa is the community support.

"Everyone is willing to pitch in and help no matter what our formal roles are."

Ozcare De Paul Villa is committed to continuous improvement. Building links to other key service providers has been something De Paul Villa has been focused on over the past few years.

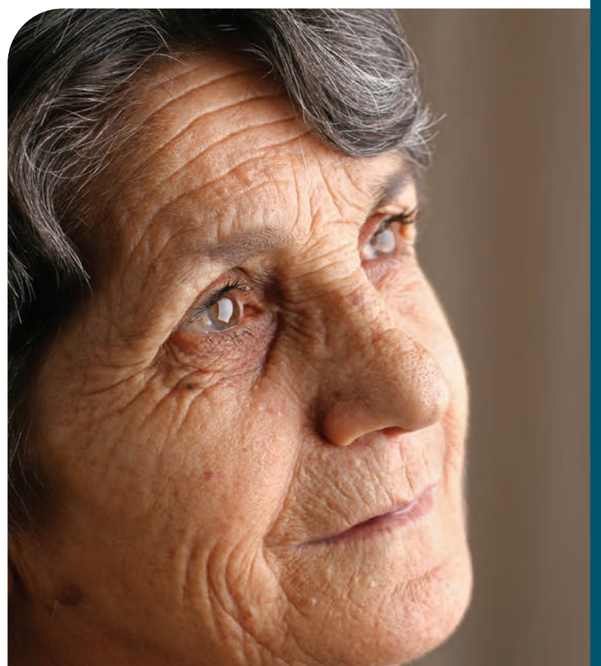
Through participating in the ELDAC Working Together program, key network links have been established with palliative care specialists. All residents now have an advance care directive, staff confidence is on the rise with strong role delineation and, the systems and processes that underpin quality palliative care and support our staff have been improved.

"Having provided a good standard of palliative care for many years, building on this strong foundation through the ELDAC Working Together program was important. We now have a team of palliative care champions at De Paul Villa. What ELDAC gave us was a much greater awareness that there was more that we could be considering and adding into our palliative care design."

Benefits

- Introduced a dedicated link nurse.
- Established a staff learning program, tools and guidelines.
- Provided staff with access to support, mentoring and training resources.
- Introduced an end-of-life care pathway.
- Improved Multi-Disciplinary Team approach.
- Increased staff confidence.
- An increase in the number of residents with advance care plans.

"staff confidence is on the rise"



The power of connection.

Establishing key service links and building a greater network has provided so much more than a clinical connection to services. Our team participated in a round table meeting with the local teams earlier in the year. This meeting helped provide a cross disciplinary context across both the different levels of care, the services provided and the support residents receive when they transfer to an acute care setting.

With all relevant stakeholders participating at the round table meeting we were able to clarify our roles, the scope of service provision and highlight how a linear service provision for clients may be better provided.

This was the first time many of our aged care staff had had the opportunity to speak directly with palliative care physicians, specialist palliative and acute service providers. Having both a seat and voice at the table to share challenges, ideas and our vision for better care was empowering. Conversely, the palliative specialists noted that they left with a much greater level of understanding about the challenges in residential aged care in our specific area.

With the central objective to improve care provisions, meeting together has provided us with a deeper understanding of the services that work alongside us. It has also offered our staff a key networking opportunity with greater access to support services and clinical pathways to support our residents. A big thanks to our ELDAC facilitator who helped us to achieve this positive opportunity.

Kath Lawrie, Facility Manager

Multicultural Care

Home Care

Inner West, North, South West and South East Sydney regions, New South Wales

Linkage Strategies Used:

- Role Clarification
- Written and Verbal Communication Pathways
- Knowledge Exchange and Upskilling
- Continuous Quality Improvement

Multicultural Care is a leading not-for-profit provider of culturally and linguistically-tailored aged care services across the Inner West, North, South West and South East Sydney regions. The organisation helps clients live independently with support services. Clients come from more than 20 different cultural and language groups and all services are 100 per cent culturally-tailored.

Multicultural Care has a diverse workforce, 83% of which speak a secondary language other than English and are specifically recruited to align with the clients we support, providing many benefits for the organisation and clients alike. Varying skillsets, backgrounds, experiences, and poorly-defined advance care planning and palliative care pathways can influence consistent care delivery.

Staff required upskilling and access to resources to gain a clearer understanding of systems, responsibilities and the key actions required for end-of-life care.

The ELDAC Working Together program provided team members with access to valuable education, resources and training. All client-facing staff attended an introductory palliative care training session and a team of staff was established to focus specifically on caring for clients requiring palliative care.

Benefits

- Training and resources to support staff decision-making.
- Development of consistent end-of-life and palliative care practices across the organisation.
- Establishment of a palliative-focused support team to work specifically with clients requiring end-of-life care.

When I started as Manager, Client Services, I had little experience working with clients needing palliative care. I also didn’t fully understand the level of oversight and processes required to effectively deliver services to these clients.

Through our participation in the ELDAC Working together program, it became clear that our processes were adequate but required further focus. The skills and knowledge-base of staff within the organisation needed further development.

It was also important to deepen understanding within the organisation and across our teams about how we could play a more active and positive role in assisting our clients through end-of-life care.

To facilitate this, we focussed on palliative care and advance care planning training. A new palliative-focussed support staff team was also established to support clients during their end-of-life journey.

The ELDAC Working Together program highlighted a need to review and strengthen our partnerships with other service providers in our area. This will provide more support and referral pathways for our staff and clients.

Stephen Lowe, Manager

MultiLink Community Services Inc.

Community care

Logan Central, Queensland

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

MultiLink Community Services Inc. (MultiLink) is a government-funded neighbourhood centre supporting migrant, refugee and mainstream communities. The organisation supports diverse communities across seven local government areas with programs designed to meet and respond to client needs.

Seventy per cent of the organisation's clients are from culturally and linguistically diverse backgrounds and most have limited English or don't speak English at all. As a result, communications can be difficult and residents may not understand the support available for palliative care and end-of-life decisions. People from various cultures are also reluctant to discuss end-of-life and prefer to keep these matters private.

The ELDAC Working Together program facilitated MultiLink's assessment of its palliative care approach and identified five priority areas. These were clinical care, education and workforce development, policies and procedures, information systems and continuous improvement.

With the support and guidance from the dedicated ELDAC facilitator professional networks have been expanded through a partnership with local health services across the sector which have resulted in the sector working more collaboratively to deliver palliative care for multicultural clients. All support workers have completed training in advance care planning and end-of-life care through ELDAC champions are embedding these new practices into staff induction processes.

"The ELDAC facilitator was invaluable in supporting us to implement the program. Her guidance and linkages to resources and services helped transform our approach to palliative care."

MultiLink's revised approach to palliative care is supported with new end-of-life directions, a care policy and related procedures. Clients are supported to complete the Statement of Choice and other advance care plan documentation as part of their end-of-life documentation. This information is also incorporated into MultiLink's systems to ensure client wishes are met.

Benefits

- More guidance, resources and assistance for clients.
- Increased capacity within the organisation's workforce.
- Increased knowledge regarding attitude to end-of-life processes from diverse communities.
- New processes incorporated into routine processes to inform continuous improvement.

"helped transform our approach to palliative care"

"the ELDAC facilitator was *invaluable*"

There is a high need for increased awareness for clients and communities from non-English speaking backgrounds in regard to end-of-life decisions. We need to raise their awareness about advance care planning and the palliative care services available to them in Australia. Since undertaking the ELDAC Working Together program and continuing to work with our individual clients, we recognise the importance of continuing to implement the policies and procedures and embedding this into everything we do.

Home Care Services Co-ordinator † Aged Care and Disability Services

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

Australian Nursing Home Foundation (ANHF)

Residential Aged Care

New South Wales:

Bernard Chan Nursing Home, Burwood

Chow Cho Poon Nursing Home, Earlwood

Lucy Chieng Aged Care Centre, Hurstville

Linkage Strategies Used:

- Role Clarification
- Written and Verbal Communication Pathways
- Formalised Agreements and Plans
- Designated Linkage Workers
- Knowledge Exchange and Upskilling
- Continuous Quality Improvement

Established in 1980, the Australian Nursing Home Foundation (ANHF) is one of the largest providers of culturally and linguistically diverse aged care in Australia. ANHF's residents are predominately of Chinese, south-east Asian and Vietnamese backgrounds.

ANHF's vision was to create a vibrant environment and inclusive culturally appropriate care for our residents, so that they did not feel segregated by society due to language barriers, or their ability to communicate their needs.

Prior to commencing the ELDAC Working Together program the ANHF facilities found it culturally challenging to discuss the "taboo" topics of end-of-life documentation and death and dying with residents and their families. This cultural challenge often resulted in a residents end-of-life care being administered in a hospital when families did not understand what kind of care and support they could obtain if they decide for the residents to remain in the facility during end-of-life stage.

Through engaging with the ELDAC Working Together program the ANHF facilities took the opportunity to upskill staff and implement practical communication strategies to support the palliative care journey of their residents.

"Basic communication practices such as a targeted notice board helped us by raising the awareness of staff and our families with regular changes of information to educate and provide greater understanding about the underlying principles of palliative care and advance care planning."

With the support of the dedicated ELDAC facilitator, significant improvements were also made by developing policies and procedures including palliative care and managing deterioration and developing Palliative Care Pathways providing holistic and practical guidance.

"The ANHF facilities also developed guidelines for care and the selection of appropriate resources that are supported by introducing palliative care committees."

Benefits

- New system approach to advance care planning.
- Implementation of new guidance resource for care management.
- Established new Palliative Care Champion role.
- Improved processes and pathways to manage complex problems.
- Enhanced relationships with specialist palliative care services.
- Positive approaches to cultural barriers.
- Introduced palliative care committees.
- Improved clinical tools and pathways.

Introduced Palliative Care Champion and the Palliative Care Teams

Before we had palliative care teams at each site, we knew that death or dying was hidden from view and only rarely discussed in our culture due to beliefs it would bring grief, sadness and fear to people. This is despite the fact that our staff have been providing the care to residents who required palliative care at the facility. Staff indicated that they found it hard to bring up the topic, and were unsure about the different terminology they heard about palliative care, for example advance care directive, advance care plan and end-of-life care.

Through participation in the ELDAC Working Together program, we have gained the resources and support to develop a consistent approach in our palliative care system. With the grant from the ELDAC Working Together program, we appointed a Palliative Care Co-ordinator providing leadership at organisational level which drives the growth and development in each facility's knowledge and skills in the delivering of palliative care.

The forming of a Palliative Care team at each site has helped us to keep a focus on palliative care where before we did not. We introduced the palliative care champion role and developed a role description. The champion has brought great awareness of palliative care to the facility team.

The palliative care teams have an important role in each facility, and they are recognised amongst our team as a specialty area to support others including family members and to grow the passion, interest and knowledge. The team meet regularly, develop continuous improvement plans and evaluate action.

Grace Liu was a newly graduated Registered Nurse with less than one-year aged care experience when she was nominated and supported by her Facility Manager to take up the Palliative Care Champion role. We witnessed her growth in confidence, knowledge and skills in palliative care this year as she is now the facility's "go-to" person for advice and information.

Jenny Chua, General Manager, ANHF Residential Aged Care

St Paul's Aged Care Lutheran Services

Residential Aged Care

Caboolture, Queensland

Linkage Strategies Used:

- Role Clarification
- Written and Verbal Communication Pathways
- Designated Linkage Workers
- Knowledge Exchange and Upskilling

St Paul's Aged Care Lutheran Services provides personalised aged care services focused on individual wellbeing and enriched quality of life. The Caboolture facility includes high-quality dementia care, medication support and palliative care services with dedicated 24-hour nursing staff and aged care specialists. Residents enjoy living in a country environment and spend quality time with their families in gardens and outdoor areas.

Prior to the ELDAC Working Together program it was difficult for the St Paul's team to navigate external referrals and to know who supported specialist palliative care services within the local area. Further training and access to resources regarding referral pathways would also enable staff to act earlier in the palliative care process.

Enriching the linkages with the local hospital and health services, St Paul's worked with the dedicated ELDAC facilitator to form mutually-beneficial relationships with the local health services palliative and residential aged care team. These foundations provided staff with access to valuable advance care planning resources and specialist training to facilitate discussions with residents and families.

As a direct result of the services participation in the ELDAC Working Together program, St Paul's now has a robust advance care plan process embedded into its administrative processes.

Additionally, service mapping helped St Pauls develop new palliative care procedures with clear referral pathways. These ensure staff know who to call when assistance is needed. This is supported with a new linkage worker role which focuses on palliative care policy, procedures and education, and supports champions within the facility.

Benefits

- Strong working relationships have been developed.
- Staff receive expert advice and support from the local hospital referral team service.
- Registered Nurses have been upskilled with clinical skills education.
- Resources and training have improved conversations between staff, residents and their families regarding end-of-life care.
- Clear referral pathways have been developed and staff have access valuable resources and tools.

> *Our ELDAC facilitator has been extremely supportive and encouraging. She is a driving force in keeping us on-task and motivated.*

"*guidance* and *support* for staff"

ELDAC helped us create clear palliative care pathways and provided increased comfort for residents and their families. If a resident deteriorates after-hours, our staff work with the palliative care Nurse Practitioner who reviews the patient's needs, prescribes medications and talks to the family. The local health services dedicated palliative and residential aged care team also liaises with the General Practitioner (GP) and our staff until business hours when the GP takes over. The support and care from the multidisciplinary team is exceptional.

Initiating early conversations with residents regarding advance care planning has provided relief and comfort for families during end-of-life care.

Tabeel Aged Care Lutheran Services

Residential Aged Care

Laidley, Queensland

Linkage Strategies Used:

- Role Clarification
- Knowledge Exchange and Upskilling
- Designated Linkage Workers

Tabeel Aged Care offers personalised aged care services focused on individual well-being and an enriched quality of life. The facility is surrounded by gardens where residents can relax and spend time with their families. Tabeel Aged Care offers residential, respite and at-home care and has animals living on-site to help address loneliness and boredom by providing companionship.

"We have always done palliative care well but needed to have conversations earlier so residents had the chance to document their wishes before it was too late."

Prior to the ELDAC Working Together program, Tabeel Aged Care maintained positive relationships with local health care providers and were dedicated to address the end-of-life care needs for their residents.

The ELDAC Working Together program provided opportunities to access educators skilled in palliative care, formalise systems and resources for advance care planning, create communication pathways for staff and adopt a continuous improvement approach.

Two palliative care linkage nurses were upskilled to facilitate the organisation's approach through staff training and linkages to other service providers. A dedicated Registered Nurse was also allocated to work with residents and their families on their Statements of Choice. This resulted in a Certificate of Appreciation from a national advance care planning body which recognised the facility's proactivity in working with residents to complete end-of-life documentation.

"Staff have grown in the area of nursing. They can now take the lead in end-of-life discussions and are able to prepare families and allow residents to experience a good death."

A Palliative Care Team was also established to review resident care and a communications pathway provides staff with additional decision-making support. After Death Audits have been integrated into routine practices to facilitate a culture of continuous improvement and learning across the facility.

The introduction of new technologies and devices has also built inhouse capacity with designated iPads for palliative in-room activities, telehealth appointments and online resources to support staff and residents.

Benefits

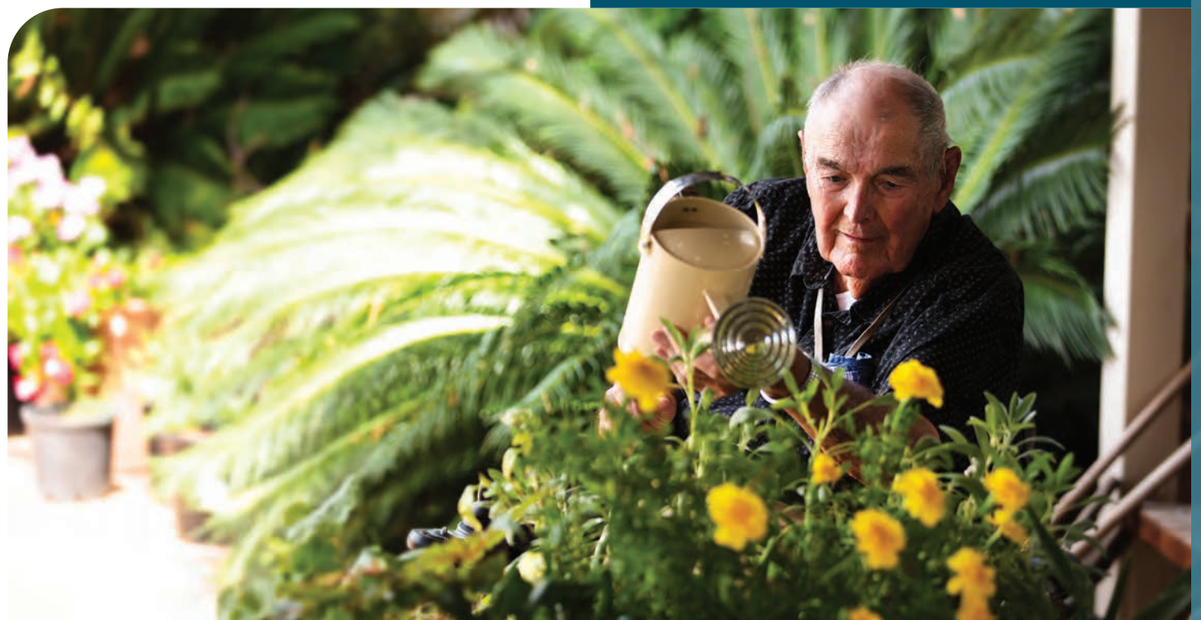
- Increased training for care workers and clinical staff.
- Improved policies and advocacy for residents.
- Enhanced staff confidence.
- Access to resources.
- Clear communication and referral pathways established with local services.

Education and knowledge

We were looking after a gentleman who had lived in our facility for a very long time. His family were supportive but really struggled with the idea of him being palliative and dying. We undertook a significant amount of education with the family and had several meetings which included the General Practitioner and our staff. This included sharing education materials with the family which we sourced through the ELDAC Working Together program, including the end-of-life pamphlets. Our Registered Nurse also walked the family through the resident's Statement of Choice.

The family felt reassured that the resident's wishes were at the forefront for all of us. Through upskilling and embedding procedures as part of our End-of-life Policy, our staff had the confidence to advocate for the resident through transparent communication with the family. The family were grateful and provided positive feedback. The final step in this journey involved our Chaplain who checked in with the family to provide support during bereavement.

Clinical and Operations Manager



Woodhaven Aged Care

Residential Aged Care

Lockhart,
New South Wales

Linkage Strategies Used:

- Role Clarification
- Written and Verbal Communication Pathways
- Multidisciplinary Team Structures and Processes
- Knowledge Exchange and Upskilling

Woodhaven Aged Care provides residential aged care, non-dedicated respite and palliative care services. As a smaller bed and community orientated facility, staff are able to establish great relationships with residents and their families to accommodate individual requests for palliative care and advance care planning. A strong volunteer group helps to support staff and residents in a largely farming based community.

Prior to involvement in the ELDAC Working Together program, the rural and remote location of the Woodhaven Aged Care facility presented some small challenges to deliver palliative specific training.

"Being in a rural and remote location always presents some small challenges particularly in being able to connect with palliative care specialists."

The ELDAC Working Together program has helped facilitate greater connection with both the palliative care and community nurses as well as local doctors.

"Before the program we didn't have clear pathways – we were aware of palliative care teams but not how to access assistance. We have now built relationships with nurses, as well as local doctors, who come into Woodhaven to see palliative care residents."

Benefits

- Established clear pathways for end-of-life care through development of a new advance care directive in conjunction with the local palliative care service and community nurses.
- Fostered relationships with local and regional palliative care teams.
- Empowered residents, and their families, to be actively involved in end-of-life care options including the completion of advance care directives.
- All staff have been trained in and are more confident in the delivery of palliative care.
- Improved communication with all stakeholders.

"a level of *certainty* for staff"

Strive to improve palliative and end-of-life care for residents and families

Prior to participating in the ELDAC Working Together program, a few new younger and less experienced staff were genuinely concerned about caring for a resident who was in need of end-of-life care.

Additional training, through a recognised certificate in palliative care from the local training provider, has allowed amazing discussions to be held with residents and care plans to be developed. It has also provided a level of certainty for staff that they are able to follow the resident and family's wishes during the palliative care process.

In July, we lost a beautiful resident who has been diagnosed with pancreatic cancer. After he passed, his sons came in with the most amazing morning tea for staff. This small, thank you gesture was an acknowledgement of the staff's work in helping this resident – their dad had an 'amazing death'. The brothers acknowledged that their dad had said right up until the end that moving into Woodhaven was the best decision he had made in years and the way we looked after him was more than he could have ever hoped for, or expected.

The level of care we were able to provide this gentleman was made possible through the work that the staff had done, collectively through the ELDAC Working Together program.

Facility Manager, Woodhaven Aged Care

St Sergius Aged Care

Residential Aged Care

Cabramatta,
New South Wales

Linkage Strategies Used:

- Role Clarification
- Written and Verbal Communication Pathways
- Knowledge Exchange and Upskilling

St Sergius Aged Care provides an aged care home-like environment for residents predominately from Russian and Slavic backgrounds. Tailored cultural and religious requirements for residents are met by replicating, as far as practical, the home environment through the provision of home-style cooked meals, observing religious feasts and other cultural customs.

Dedicated St Sergius staff strive to treat all our residents with kindness and dignity and maintain their quality of life at the highest level. Prior to the ELDAC Working Together program St Sergius staff were often presented with the challenge of co-ordinating multiple cultural end-of-life needs and bereavement requirements for their residents and their families.

"Resident choice and family involvement are extremely important for our residents and their wellbeing. It is always important for residents to make their own choices and to make informed decisions."

With assistance from the ELDAC facilitator our communication pathways improved with specialised palliative care services, new policy and procedure guidelines were created, and staff were also more effectively educated through the establishment of a train the trainer program. These enhanced procedures empowered staff to meet the cultural needs of the residents while supporting the grief and bereavement requests of families and communities.

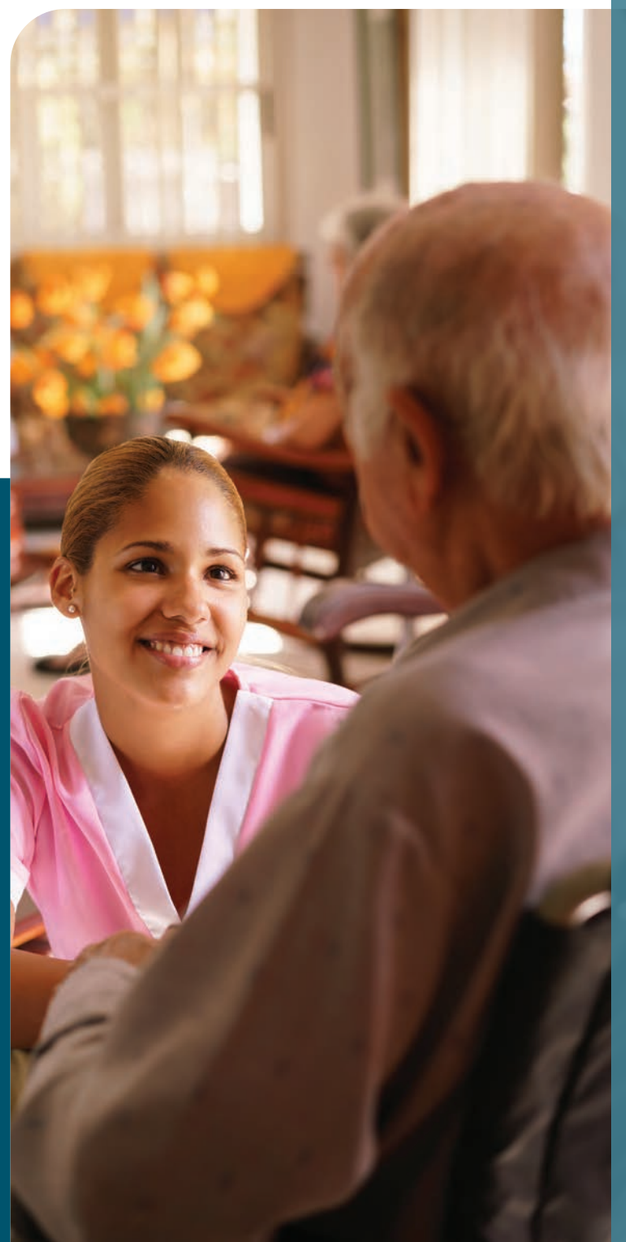
The experience and expertise of the dedicated ELDAC facilitator bought to the management of the cultural requirements of the St Sergius residents has been and continues to be of great assistance.

"Our ELDAC facilitator was extremely positive, encouraging, understood many of the nuances relevant to our facility and remains extremely supportive."

Benefits

- Communication pathways improved across all services.
- New policy and procedure guidelines were developed and implemented.
- Improved identification of staff roles.
- Improved education and upskilling of palliative care staff.
- Review and enhancement of advance care planning systems.
- Capacity building and working together with palliative care services.
- Working within a multidisciplinary team to achieve quality palliative care and advance care planning.

"our *communication* *pathways* improved"



Showing a more personable approach to meeting cultural needs

Following the documented advance care plan, St Sergius staff were able to continue with keeping our resident comfortable and also implement a palliative care kit to show a more personable approach to meeting her cultural needs and supporting the family through the bereavement process.

"Our participation in the ELDAC Working Together program made our staff more aware of what we needed to update. I can now say that we are more confident in the management of palliative and end-of-life care while respecting the cultural needs of our residents"

Clinical Care Co-ordinator,
St Sergius Aged Care

St Catherine's Hostel

Residential Aged Care

Wangaratta, Victoria

Linkage Strategies Used:

- Written and Verbal Communication Pathways
- Multidisciplinary Team Structures and Processes
- Designated Linkage Workers
- Knowledge Exchange and Upskilling

St Catherine's Hostel is a residential aged care facility that provides services to residents in need of both high and low level care. St Catherine's is one of three facilities in Wangaratta participating in the ELDAC Working Together program and provides respite and palliative care, as well as many ancillary and allied health services including speech pathology and dental care in a friendly, social and inclusive setting. Backed by a vision to enrich life through the ageing journey, St Catherine's provide an environment where families are welcome and often become friends.

While St Catherine's pain management and palliative care provisions were very good for residents prior to involvement in the ELDAC Working Together program, processes weren't streamlined and there wasn't a clearly defined palliative care team.

"We are well known locally for providing great palliative care and pain management provisions. However, improving our palliative care processes and procedures hadn't been a priority area for us for some time."

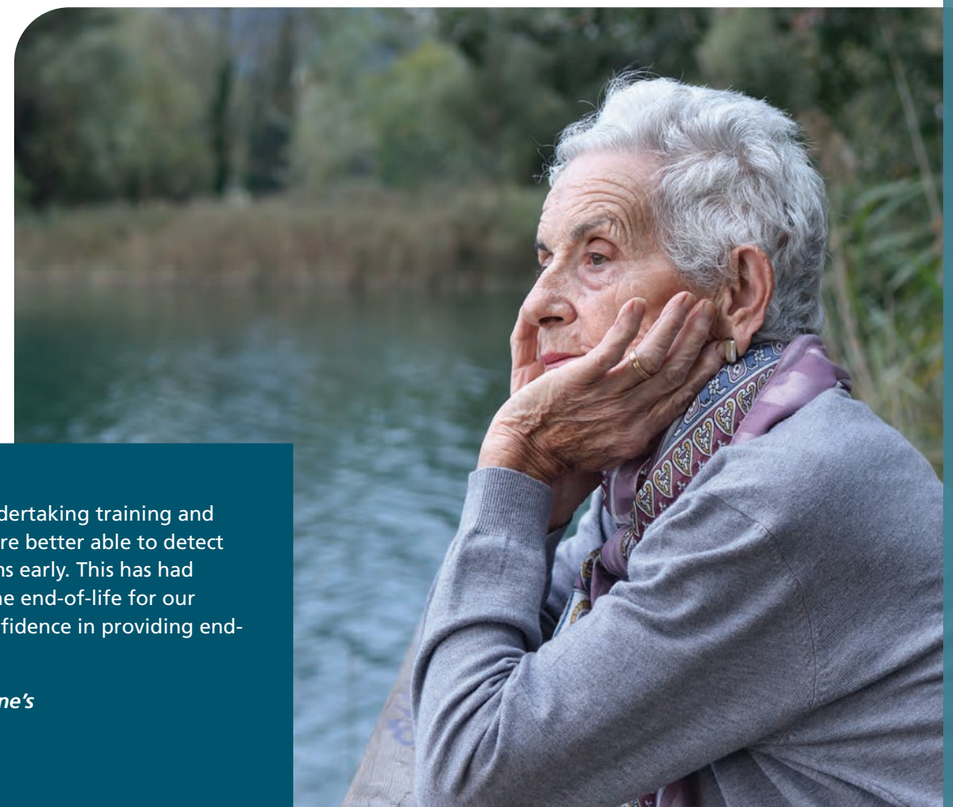
With a dual focus on inclusive clinical quality improvement and improving residential care, St Catherine's has been able to improve its service provision through strengthening connections with local palliative care and aged care providers, the formation of a working group and development of palliative care resources, guidelines and toolkits. The introduction of comprehensive, mandatory palliative care training has also translated into a greater number of goals of care documentation completed for residents as well as improved staff confidence in detection of deterioration.

"Strengthening our connection with other palliative care service providers has been one of the fabulous outcomes of participating in the ELDAC Working Together program. We've even been sharing the resources we've been able to develop with other local aged care facilities and we're proud that we have been able, in a small way, to improve the care for all aged care residents in our local area."

Benefits

- Fostered a stronger connection with other palliative care service providers.
- Improved care pathways and resources use.
- Formed a multidisciplinary working group with broad representation across the organisation.
- Offered comprehensive, mandatory staff training on advance care planning and palliative care service delivery.
- Developed staff resources, forms and guidelines for advance care planning.

"*improved* staff confidence in *detecting deterioration*"



"Through our staff undertaking training and using our forms they are better able to detect deteriorating symptoms early. This has had a positive impact on the end-of-life for our residents and staff confidence in providing end-of-life care."

Cathy, AEN, St Catherine's

Illoura Residential Aged Care

Residential Aged Care

Wangaratta, Victoria

Linkage Strategies Used:

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

Illoura Residential Aged Care is a rural health care provider in North East Victoria providing services for residents who are frail, have complex medical conditions or dementia. Illoura is the Aboriginal word for a pleasant place. Illoura's provision of care is reflected both in the name meaning and core values of care, excellence, respect, integrity and fairness. Illoura is one of three facilities in Wangaratta participating in the ELDAC Working Together program and provides both single and twin rooms that can accommodate married couples or family members.

Prior to the implementation of the ELDAC Working Together program, only a small number of residents had advance care plans and staff required support to identify when it was appropriate to refer a resident to an external palliative care service. Communication with other service providers and staff engagement in education wasn't proactive – rather undertaken on an immediate need basis.

"Our staff are extremely passionate. We've had a number of key environmental events in our region that have impacted our staff– most notably bushfires. It's a credit to our staff that we have been able to continue to provide the best possible care even in the most trying of personal circumstances."

Participation in the ELDAC Working Together program has helped increase staff engagement, inspired a thirst for learning and improved relationships – both with external palliative care services and families. Staff are also proactively reviewing residents ensuring advance care plan discussions are being undertaken. The provision of a dedicated clinical resource to support learning and to help drive program outcomes has been key to the success of the program implementation.

"Facilitation through the ELDAC Working Together program kept us on track to achieve our goals. We were able to identify our strengths and weaknesses and, had access to the tools to improve those areas. The funding provided by ELDAC has assisted our facility to allow nursing staff dedicated time to focus on the project."

Benefits

- Improved staff education and training.
- Access to a dedicated clinical resource focused on quality improvement.
- The introduction of ELDAC resources to support staff.
- Increased review of residents by staff including palliative care service.
- Improved partnership with the external palliative care service.
- Improved relationships with families.

"key to the *success* of the *program* *implementation*"

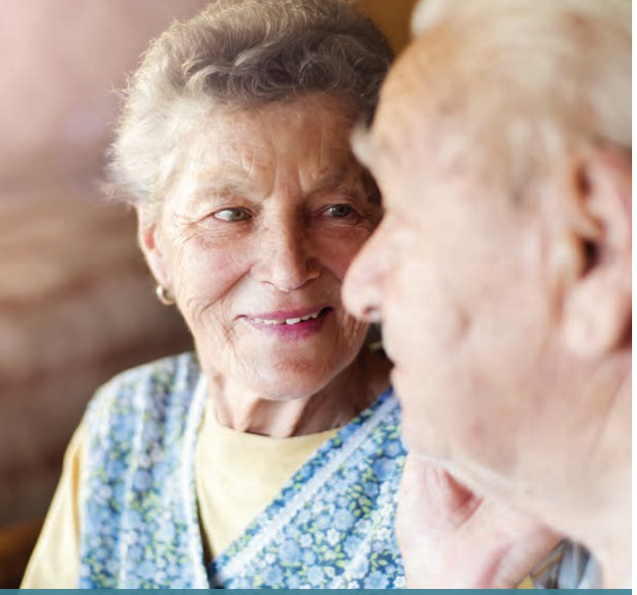
Growing our palliative care service

One of the first quality improvement tasks was to re-establish the Illoura Palliative Care Working Party – a group made up of 20 staff members. I was overjoyed that so many staff from different disciplines wanted to be involved. The volume and range of staff who wanted to participate was impressive – it really speaks to our community camaraderie and our want to truly meet our resident's needs. Meeting every 4 to 6 weeks, the group looked at the quality improvements that could be made and each staff member took on tasks to achieve these goals.

It is our collective responsibility to make sure our residents enjoy their experience at Illoura and that all their needs are met. I'm really proud of the level of staff involvement and that each resident continues to be treated as an individual with respect and kindness. We take immense pride in looking after the families. Our involvement in the ELDAC Working Together program has allowed us to do this more effectively through improving relationships with residents, families and palliative care providers in our region.

I cannot express how incredibly proud I am of the Illoura team for the outstanding care they provide to our residents, and the wonderful quality improvements that have come from our involvement with the program.

Jennifer Tull, Nurse Unit Manager, Illoura



Rangeview Private Nursing Home

Residential Aged Care

Wangaratta, Victoria

Linkage Strategies Used:

- Written and Verbal Communication Pathways
- Multidisciplinary Team Structures and Processes
- Knowledge Exchange and Upskilling
- Continuous Quality Improvement

Rangeview Private Nursing Home is a private, residential aged care facility providing respite services in the largely farming district of Wangaratta. Rangeview is one of three facilities participating in the ELDAC Working Together program in Wangaratta providing a combination of both high and low needs care. Resident-centred care and a holistic approach underpins the service offerings.

"We knew acute or hospital facilities were generally not the ideal setting for our elderly residents who had a preference to stay in a familiar environment and maintain their routines. However, without documenting their wishes early and well, we were unable to support their care at a critical time."

The ELDAC Working Together program provided the tools and framework to establish the ELDAC Focus Group, form links with local, specialised palliative care providers and, equipped staff with the skills and knowledge to ask for help. Staff are also now confident in discussing and consulting, with both residents and their families, on end-of-life choices which has decreased unnecessary acute setting admissions.

"Our staff are now able to talk about death like it is another part of life which has helped promote the importance of planning. Staff conversations are openly supported by ELDAC tools."

Benefits

- Provided the tools and framework to establish a multi-disciplinary ELDAC Focus Group.
- Established contact with specialised palliative care services at the local hospital.
- Equipped staff with the skills and knowledge.
- Provided staff with the confidence to consult with the resident, their medical decision-maker, family, GP and nursing staff regarding their end-of-life wishes.
- Decreased unnecessary admissions to acute setting.
- Ensured residents choices are being enacted.
- Increased understanding of the palliative care provision for all staff, residents and families.
- Provided ongoing education opportunities including resources, workshops and short courses in palliative care and end-of-life care.

"staff conversations are now *openly supported* by ELDAC tools"

Franks Story

Frank*, an 89-year-old male resident was in our facility for 4-5 years. Initially he required supervision only with his daily living activities. Our staff used different tools to detect changes as his condition was declining. Frank was of sound mind so we started conversations early on advance care planning and the importance of documenting his wishes.

Frank's family were his priority, his daughters were very close to their dad. Through many conversations we discussed comfort management and acute interventions. Frank decided he would rather stay at Rangeview with a palliative approach and comfort care with his family with him. We had a series of discussions to introduce the palliative approach to the family members to provide reassurance and transparency.

As the family were very close, we identified they would need grief counselling and were able to link into our local palliative care service in advance through our partnership. With the advance care directive complete, we were all on the same page. We were able to refer Frank to the specialised palliative care team for symptom management given an increasing shortness of breath and his sensitivity to morphine. This provided Frank and his family with relief and an inspired confidence that his pain would be well managed.

The ELDAC Working Together program equipped our staff with the tools to ensure Frank had a good death. Planning ahead enabled the difficult questions to be addressed early. We worked together with his family to create a peaceful environment. Frank's final day was just as he wished it to be. He was nursed in his room and his wishes were respected. Frank chose how he wanted to live his life until the very end and he passed peacefully with his family by his side.

At Rangeview Private Nursing Home our staff often become attached to our residents, they become part of our family. We also provide spiritual care and debriefing for our staff after a resident death - We as staff often felt like we had also lost a "family member".

To be involved with a resident's end stage of life is an honour and a privilege. This is such an emotional and private time for the resident and their loved ones. To be invited to care for them is humbling. Over the years I have had the privilege of guiding many residents, families, and staff through this emotional occasion.

*Names have been changed to maintain confidentiality.

Yvonne Richards, RN Div.1

Barossa Village

Residential Aged Care

Nuriootpa,
South Australia

Linkage Strategies Used:

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

Barossa Village provides residential care, community care packages and independent living support to aged people living in the Barossa region. The organisation has an integrated care model which supports people at all stages of their ageing journey.

Before commencing in the ELDAC Working Together program, Barossa Village Residential Aged Care had limited connections with the local palliative care network and a lack of clear referral pathways for specialist support. Upskilling was also needed for staff along with an evidence based clinical deterioration tool that could be easily used to assess residents. The ELDAC Working Together program enabled Barossa Village to identify gaps in its palliative care pathways and strengthen care delivery.

"We needed new guidelines and tools to help our staff identify deterioration indicators and facilitate conversations about end-of-life choices with residents and their families."

As part of their participation in the ELDAC Working Together program, Barossa Village hosted a palliative care symposium to bring together the region's specialists in end-of-life care, General Practitioners and other local service providers. Speakers discussed innovative programs and best practice for end-of-life care. The event encouraged networking with other acute care and community palliative care services, and gave Barossa Village an opportunity to showcase its achievements through the ELDAC Working Together program. The symposium helped the organisation establish mutually-beneficial relationships to increase staff support and improve care pathways.

"Our participation in the ELDAC Working Together program helped us to identify best practice and to plan how it was applicable in our environment."

A new link nursing role to lead and coordinate initiatives and support best practice has been an integral part of the organisation's transformation. The role liaises with families and other care providers, provides clinical support and education to staff, monitors palliative care pathways for residents, and conducts After Death Audits to identify opportunities for improvement.

A Palliative Care Module has been integrated into the orientation program for all new staff. Allied health is now incorporated into end-of-life care for a multidisciplinary approach that supports our residents.

Barossa Village has also integrated an updated Palliative Care Pathway into its software systems and developed a daily assessment tool to help staff implement and monitor palliative care as part of routine practices.

Benefits

- Enhanced engagement with local General Practitioners (GPs) and palliative care services.
- More opportunity for position upskilling.
- Improved palliative care pathway.
- Increased support to residents and their families through the end-of-life care.
- Improved bereavement care.

A foundation of relationships and linkages

We believed we had a strong and effective approach to palliative care. We based this on our everyday practices and the feedback we received from our residents' families. As an aged care provider we have always listened to the feedback of our residents and their families and were excited to participate in the ELDAC Working Together program to continue to grow and improve.

The most significant achievement from this project was our Barossa Palliative Care Symposium. Keynote speakers included Dr Chris Moy President, Australian Medical Association (SA) who spoke about the Seven-step Pathway. Juliane Samara, Nurse Practitioner, Calvary Health (ACT) also presented compelling research about the value of palliative care rounds. The expert speakers gave our staff access to best-practice knowledge and the event was attended by medical staff, and clinical and management teams from other aged care facilities and hospitals in the region. This created opportunities for our services to take a more collaborative approach. We also shared our ELDAC Working Together program achievements for other aged care facilities to learn from. The connections we made through the symposium will help ensure our team members receive the specialist palliative care support they need to deliver high-quality, evidence-based care for our residents.

Thanks to our ELDAC Working Together program experience we will continue to develop connections and opportunities for the advancement of palliative care in the Barossa region.

Matt Kowald, General Manager, Residential Care Services

Bene St Clair

Residential Aged Care

Woodville, South Australia

Linkage Strategies Used:

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

Bene St Clair provides quality aged care services that specifically address the cultural, spiritual and social needs of the older Italian community and all those in the facility's care. Bene St Clair provides a welcoming, nurturing and safe environment for residents, clients, carers, staff, volunteers and visitors.

Bene St Clair recognised an opportunity to develop a stronger structure and framework to refine its palliative care processes, systems and clinical tools. The ELDAC Working Together program was the perfect initiative to achieve this. Key focus areas included staff training, cross-sector networks and continuous improvement strategies.

Upskilling and additional resources were developed to help staff navigate the cultural barriers and conversations regarding palliative care. This has supported advance care planning, with staff more comfortable to initiate these conversations.

"Mentoring from the ELDAC facilitator has given us confidence and a framework of contemporary current practice."

The dedicated ELDAC facilitator helped Bene St Clair strengthen connections and improve communication with other service providers. This created a stronger understanding of services across the local palliative care network and increased staff access to expert advice and referral pathways.

A new Bene clinical link nurse role was also established to further develop relationships with partners.

"The ELDAC Working Together program enriched Bene St Clair's approach to palliative care. Our ultimate focus is the experience for the resident and their family. The ELDAC Working Together program and resources have supported our clinical approach to care for our residents, families and staff."

Benefits

- Upskilling for more confident staff and consistent care.
- Team access to best practice resources and referral pathways.
- Increased confidence and trust from residents and their families.
- Stronger connections with care partners including the local Specialist Palliative Care Service.
- Central resources for care staff supporting decision-making.
- Improved clinical governance and systems.

.....made me realise how lucky we were to be given Bene as a nursing home. I still feel the friendship, caring, love from each and every one of you. That is everyone from the kitchen, cleaners, carers, maintenance, nursing, you all work so well together, I take my hat off to you, you have a hard and emotional job and it takes special people to do that every day, and you are all special.

By doing your job as good as you do has helped me grieve Mum's passing, because the last memories I have of her were nice memories. We had sad times in the home, but we also had funny times, this has made the journey so much easier.

Extract from a letter from Peggy's daughter, 8 July

Peggy's Story

Mrs Peggy Chappell was admitted to Bene St Clair following a recent diagnosis of terminal cancer. Her family believed she needed to receive care in the hospital palliative care ward and were concerned about her staying in a residential aged care facility.

Through the ELDAC Working Together program, we had given our staff training and upskilling which empowered them to provide best practice palliative care. This meant our initial conversations were more confident with Peggy, her family and the multidisciplinary team. Clinical staff also felt more confident to request the early involvement of Palliative Care Services with their supportive General Practitioner (GP). Staff had more tools to help support the resident and her family members throughout the process.

When we received a letter from the family, we were all moved and many tears were shed. As a team, we reminisced about Peggy's time with us and the difference we made to her last days. We felt very proud that our staff had the skills and confidence to contribute to this best outcome for Peggy and her family.

Moving forward, we are excited to build on the foundations of the program. We intend to continue embedding the processes that we have started and feel we have even more goals to achieve in the future.

We appreciate the opportunity to be included and supported through the ELDAC Working Together program. We feel the benefits that we have already received have provided increased satisfaction with experiences surrounding death for residents, families, staff and everyone that is involved.

Louisa Broadstock, Residential Care Manager
Amy Edwards, Clinical Nurse Bene St Clair

Pinaroo Roma Inc.

Residential Aged Care

Roma, Queensland

Linkage Strategies Used:

- Role Clarification
- Written and Verbal Communication Pathways
- Knowledge Exchange and Upskilling
- Continuous Quality Improvement

"The ELDAC Working Together program has enabled Pinaroo to raise community awareness and build trust, confidence and greater understanding of the services and support the facility provides in end-of-life care."

The Pinaroo Aged Care Facility is a community-owned and operated provider of rural and regional aged care services in Roma, South-Western Queensland. Overseen by the Rotary Club of Roma, the facility provides exceptional care by considering the physical, emotional, spiritual and social needs of each resident.

Historically, Pinaroo Roma Inc. provided care independently from other local aged and palliative care networks. Participating in the ELDAC Working Together program brought the opportunity to meet with local service providers to explore how they could all work better together. Participating also increased confidence and gave opportunities for upskilling our staff which resulted in the facility increasing the number of advance care plans. In addition it also prompted Pinaroo to hold a palliative care evening for families and staff opening up proactive conversations regarding palliative care and end-of-life choices.

"Now we can be more confident that the individual end-of-life care we provide is in line with the resident's choice and wishes."

The ELDAC Working Together program transformed Pinaroo's management of palliative care through strengthening their services existing links. The program provided resources and knowledge to upskill staff along with the development of strong collaborative relationships with local networks.

Palliative care education sessions for staff were delivered by an external provider and new resources were introduced to support internal training. This provided staff with the tools and information they needed to confidently perform clinical assessments.

"The ELDAC facilitator provided ongoing guidance, support and motivation, and linked us to many resources online including evidence-based clinical tools that we now use in practice."

A dedicated ELDAC facilitator managed a number of aged care network meetings to help foster relationships with local services including the Palliative Care Team at the local hospital. This has enabled Registered Nurses (RNs) to discuss cases, access ongoing education and obtain expert advice and guidance from the Specialist Palliative Care Service.

Clear processes have also been implemented in collaboration with the supportive General Practitioners (GPs) to work with families to complete advance health directives with residents and their families.

Benefits

- Mutually-beneficial relationships have been developed with local networks.
- RNs have clinical tools to guide their decision-making.
- Improved end-of-life documentation for care staff.
- Our staff know who to call when assistance is needed.
- Significant increase in completed advance health directives and statements of choices.
- Team members more confident with a stronger understanding of the palliative care process.

"We now have a team of staff who are more understanding of death and dying and have the confidence and tools to provide excellent palliative care."

Through the stronger relationships forged between Pinaroo and local providers we started to see an increase in palliative care patients being transferred to our facility.

One particular patient transfer was that of a female resident whose family was reluctant to agree to the transfer from hospital, due to her desire to have 24 hour bedside nursing care, and uncertainty about the end-of-life care that could be provided at Pinaroo. The Palliative Care Clinical Nurse Consultant became an advocate for Pinaroo where she worked closely with us, along with the residents' family and other care team to ensure the transfer of care was safe and well supported. Although the resident was given three weeks to live when she arrived in our care she surprised us all and enjoyed her days at Pinaroo for a further three months. This gave us time to build a relationship with our new resident and her sister.

In implementing our new knowledge and confidence in hosting end-of-life conversations we worked closely with the resident's sister, sharing resources and encouraging discussions around end-of-life care. By working together and ensuring the resident was the priority, the sister's concerns were alleviated.

Having the Palliative Care Clinical Nurse Consultants input contributed to the end-of-life care provided for our resident. This support has given our staff confidence and extra guidance to ensure the best outcomes for the resident and her family.

Melanie Calvert, Manager Pinaroo

Manjimup Home and Community Care

Home Care

Manjimup,
Western Australia

Linkage Strategies Used:

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

Manjimup Home and Community Care (MHCC) provides support services to enable consumers to live independently in their own home and remain connected to their community. Located in the South West of Western Australia, Manjimup Home and Community Care provides aged care support services to over 500 people in the shires of Manjimup and Bridgetown, as well as disability support via NDIS for individuals under the age of 65.

Manjimup is a rural town 130KM south of the South West regional centre of Bunbury and as a result, MHCC faced challenges in forming strong connections with other health care providers to support palliative care communication and referral pathways.

The ELDAC Working Together program and assistance from the ELDAC facilitator has improved key network relationships, helped us develop best practice guides and facilitate training opportunities. This assistance has markedly improved the continuity of care for consumers and our staff capability in dealing with end-of-life care.

"Our ELDAC facilitator guided and facilitated the team through the project implementation and her support was invaluable. Regular email, phone, video conferences and an in person visit (from Queensland) helped keep us on track, meet our goals and identify any service gaps."

With the support of the ELDAC Working Together program and dedicated facilitator, MHCC have developed a training program facilitated by our Registered Nurses for support workers. The training program provides staff with the opportunity to attend a palliative care workshop, complete a certificate IV palliative care unit, participate in supervised placements and access to ELDAC support materials to enhance their care skills in the palliative care domain.

"This level of support, the facilitator's active encouragement and ability to connect us with other organisations has been a big key to our success – particularly in connecting with a regional network of service providers and in accessing training opportunities."

Benefits

- Fostered connectivity between key stakeholders.
- Current quality improvement practices were enhanced.
- An awareness of the delineation of roles.
- Easy access to in-person and electronic training resources.
- Development of effective key networks locally and regionally.
- The identification and then development of policies / procedures relevant to ensure best practice guides service delivery in terms of end-of-life and palliative care.
- The development of a dedicated handover / transfer form for use by the key stakeholders achieved with consultation by all parties.

"Working together with local palliative care services provides our consumers with strengthened palliative care options."

Liz Lockyear, Manager

"in-person and electronic *training resources"*

Support Worker feedback

Having recently completed my Palliative Care training, I now feel that I have the skills and confidence to provide care for people in their last days of life.

The ELDAC training has helped develop my communication skills when talking with individuals who are in a palliative stage and their families. I now understand more about a health care plan and directive and, this helps me to both know and be able to help facilitate the wishes of the individual. I am also more confident in being able to recognise the changes in a person's health condition, can readily document these changes and know who to pass these observations on to.

Being able to understand what the palliative care hospital team do and how other allied health professionals are involved in a person's care helps me understand how valuable my role is in the provision of support for someone who is palliative and how I fit into the health team.

I'm confident that I can provide respite support for consumers, at our facility or in the home, which allows their carer to have a break and means that the consumer doesn't have to be admitted to hospital. I have supported a number of consumers who stated they did not want to go to a hospital. Previously respite at the hospital or in a nursing home was their only option. By working together with the palliative care service, we have been able to support nine palliative care patients to die at home – which was according to their wishes.

Jayne Smith, Support Worker

Woods Point Aged Care

Residential Aged Care

Yarrawonga, Victoria

Linkage Strategies Used:

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

Woods Point Aged Care provides residential care for people in the rural community of Yarrawonga, Victoria. The state-of-the-art facility offers a wide range of services including low, high and respite care to meet the changing needs of elderly and retired people.

The facility had identified gaps in the continuity of care for residents at end-of-life and a lack of inhouse capacity and staff training. Registered Nurses (RNs) require upskilling to enable them to confidently initiate conversations with residents and their families about palliative care. Additionally, previous training did not include the policies and information staff needed to continue discussions with residents, their representatives or medical staff once they entered a palliative care pathway.

The ELDAC Working Together program helped Woods Point Aged Care develop collaborative and mutually-beneficial partnerships with local palliative care service providers and clinical specialists. This has built trust and created greater understanding of staff roles and abilities.

Further education and upskilling have also increased inhouse knowledge and confidence about palliative care and referral pathways. Team members now initiate early, open and transparent conversations with residents and their representatives to develop advance care plans. Resources from the ELDAC Toolkits are used to provide information and support to families while having these conversations.

The introduction of the end-of-life care pathway as a result of training and support provided by Karen Richards (West Hume Aged and Disability Palliative Care Resource Nurse, Seymour Health) and Annette Cudmore (Palliative Care Clinical Nurse Consultant, Goulburn Region Palliative Care Consultancy Service) has empowered staff to take appropriate steps when a resident deteriorates quickly.

Local palliative care consultants also attend regular review meetings to discuss individual residents and provide additional support.

Specialist palliative care providers have acknowledged the complexity of cases managed by team members and praised the quality of care delivered to residents at the end-of-life. This is the result of a coordinated approach to care within the facility and collaborative partnerships with external service providers.

"The ELDAC Working Together program has greatly benefited Woods Point Aged Care in terms of skill enhancement and improved coordination of care."

Benefits

- RNs have improved assessment skills and increased confidence when managing palliative care.
- Staff feel empowered to discuss care with General Practitioners (GPs) and specialists and ensure it is managed appropriately.
- Unnecessary treatment and transfers to hospital have been reduced.
- Improved communication and connections with palliative care services.
- Improvement in the management of palliative care residents through the implementation of end-of-life pathway.
- Improvement in results of After Death Audits.
- Referral pathways are clearly defined and used when support is required.

> *"The ELDAC facilitator's backing and background gave validity for what we were trying to achieve, particularly when we were dealing with the local hospital. She facilitated the improved relationship with the hospital, playing a vital role in establishing these partnerships."*

The ELDAC Working Together program has increased our team's sense of confidence and the continuity of care within our organisation. This has provided significant benefits for our residents. Conversations about end-of-life care are open and transparent, and our staff feel confident to start palliative conversations early to support residents.

This was demonstrated in a recent case involving a elderly resident called Anne*.

Anne required palliative care but her daughter wanted full and active treatment for her mother. However, Anne did not want this and, as she was of sound cognition, she was able to make her own choices. The staff were amazing in having conversations with the daughter and responding to her requests. For example, the daughter asked for speech referrals and our care staff responded with the question, "What does Anne want?" The staff would never have done this 12 months ago, so it is quite extraordinary.

In this instance, it was very much about Anne's wishes rather than her daughter's requests. The staff were confident they knew what they were doing, and had the support of the Registered Nurses and management. This meant they could confidently manage Anne's care per her wishes.

*Names have been changed to maintain confidentiality.

Director of Nursing

AnglicareSA, Community Aged Care

Home Care

Adelaide,
South Australia

Linkage Strategies Used:

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

AnglicareSA supports older people to live independently in their own homes in Adelaide and the Gawler / Barossa region. The organisation provides in-home support including personal care, domestic assistance, social support and transport, and home and clinic-based allied health services. Customers are supported through the Commonwealth Home Support Program, Home Care Packages, a Transition Care Program and private payment arrangements.

As part of the ELDAC Working Together program, AnglicareSA identified an opportunity to improve frameworks and procedures in the management of end-of-life care for customers. AnglicareSA also expressed a willingness in wanting to improve linkages with specialised palliative care services to improve referral pathways.

The ELDAC Working Together program transformed the program's approach to palliative care and equipped team members with the tools, resources and skills to have advance care planning conversations with customers and their families. Stronger linkages have been developed with external specialist palliative care services that provides staff with access to expert advice and referral pathways. Increased levels of understanding between AnglicareSA and other service providers has led to a more collaborative and multi-disciplinary care approach for customers.

"The new structures help our staff feel more comfortable and confident. The ELDAC tools and training has supported staff, enabling them to have difficult end-of-life conversations. That's a great achievement for our team. Our ability to work well in this space will continue to grow from here."

With support of the dedicated ELDAC facilitator, AnglicareSA provided training and upskill opportunities to staff to complete palliative care placement at an external service provider and built organisational capacity by mentoring service co-ordinators, therapists and care workers.

The program enabled one of the sites Registered Nurses (RNs) to complete a practical placement program, providing her with increased knowledge and connections to specialist services. We have strengthened our knowledge in many ways which will lead to further growth and learning into the future.

"The support from the ELDAC facilitator has been fantastic, especially in the development stage when we were getting started."

Customers, families and carers are also supported with iPads featuring ELDAC tools, grief and bereavement resources, video conferencing to speak directly with the RN, and rest and relaxation videos.

Benefits

- All staff received training regarding their roles for end-of-life care and advance care planning.
- Education sessions increased staff confidence in advance care planning.
- An end-of-life framework with procedures, guidelines and care plans has been implemented and embedded.
- A suite of tools and resources specific to our setting provides staff with the information and confidence to act.
- A working group has been established to assess and continually improve practices.
- Improved After Death Audits.
- Clear communication pathways with specialist palliative care services.

> *"We have implemented a learning culture around end-of-life conversations and care, and we are continuing with After Death Audits and sharing our learnings from each conversation."*
>
> *Kathy Binks - Head of Community Aged Care*

"sharing our learnings

from each conversation"

Coolibah Care

Residential Aged Care,
Home Care

Mandurah,
Western Australia

Linkage Strategies Used:

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

Coolibah Care is an independent, not-for-profit aged care provider for the Mandurah community. The organisation provides residential support, including specialised dementia and palliative care, home care, respite services and independent living options. Coolibah Care aims to make every day the best it can be for their residents and clients, and supports people to live well as they age.

The organisation had well-established processes for palliative and end-of-life care. However, it was difficult to evaluate and identify further improvements due to a lack of focused dedicated resources and assessment tools. There was also a lack of cohesiveness within the multidisciplinary team resulting in different experiences for every resident. Staff knowledge and confidence in this area could be improved and required upskilling to feel more comfortable in their roles.

Through the ELDAC Working Together program, Coolibah Care gained access to valuable tools and educational resources, and achieved more cohesiveness within their multidisciplinary team.

Staff training and upskilling also expanded the organisation's capacity to review and improve palliative and end-of-life care.

Palliative Link Team meetings have been initiated as part of the new approach and these provide opportunities for staff to debrief and revise care approaches.

Benefits

- Access to resources and tools to conduct reviews and support decision-making.
- Referral pathways and common goals for residents are now clearly communicated. This has resulted in a more cohesive approach by the multidisciplinary team.

"The ELDAC facilitator provided expert knowledge particularly in relation to best practice guidelines and resources."

Miriam's Story

Miriam joined Coolibah Care Residential Aged Care Facility more than four years ago when she began working with residents in a low-care wing. This has evolved into an area that cares for residents from admission through to end-of-life.

I really love my job as a carer to our residents. It is very rewarding when you can connect with them and make them smile. However, when it came to palliative and end-of-life care, I wasn't really sure what those words meant. I lacked confidence and even doubted my abilities. I really welcomed the opportunity to do further training because I needed more guidance in this sensitive area of care.

I found the training changed my ideas about my role as carer. I developed more clarity and a clear vision that didn't exist before. I am much more confident in providing not only physical care but also emotional and spiritual care. This is very rewarding. I also feel more comfortable with the residents I care for as well as their family and friends.

I have learnt so much and try to share this knowledge with my colleagues, especially when we are delivering end-of-life care. I believe it has really benefited the whole team which is great for everyone, especially residents and their families.

The newly-introduced Palliative Link Team meetings have enabled me to learn from peers and to transfer the information I'm learning, such as communicating signs and symptoms, to my manager. The meetings are invaluable and also provide opportunities to debrief when residents have passed away and we can identify anything we could have improved.

I now feel much more confident with residents, their families and my peers. I feel more at ease and the program has provided the guidance and ongoing mentorship I needed. This isn't something I could have learnt in a classroom and it was really important to have everyone working together to improve our end-of-life care at Coolibah.

Miriam, Care Worker

Longridge Aged Care

Residential Aged Care

Naracoorte, South Australia

Linkage Strategies Used:

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

Longridge Aged Care offers a seamless transition between village independent living for more than 50 residents: who can then transition into high level care within the adjacent residential care home.

With an ageing demographic, Longridge Aged Care provides palliative care services to the aging for both the community members of the small rural town and their extended family should they wish to return home at any point through their palliative care journey.

While Longridge clinical staff were well versed in end-of-life care, the ELDAC Working Together program provided care workers with the opportunity to be trained and upskilled in the provision of palliative care.

One of the primary focuses of the ELDAC Working Together program for Longridge Aged Care was to empower their staff through knowledge translation and upskilling. Through the program, the facility strived to deliver a high-level palliative and end-of-life care.

"Our care staff are at the forefront of our care every day and being able to upskill them by building on their skills, knowledge and confidence has allowed our team to work seamlessly providing quality end-of-life care."

Longridge Aged Care provided targeted in-house training for their care staff which provided them with the opportunity to stay within the aged care home and receive real world training.

The implementation of a formal assessment framework and provision of the corresponding tools through the ELDAC Working Together program provided a consistent and timely palliative care guide. In addition, access to onsite training and the provision of education resources helped staff identify, the actions and critical milestones of end-of-life care.

"The After Death Audits identified those things we needed to set 'in train' earlier – ensuring our care planning was structured, proactive and holistic.

Upskilling all care staff as the 'eyes and ears' of Longridge combined with a guiding framework and support tools has provided a level of care that has exceeded expectations."

Staff themselves have conveyed the pride and confidence they now have in both recognising deterioration and in communicating with residents and families.

"Through the ELDAC Working Together program we've been able to both identify and overcome challenges that allow our multidisciplinary team to deliver quality palliative care."

Longridge took a systematic approach to embedding a palliative care culture into their workplace through the ELDAC Working Together program which include:

- Improved end-of-life care plan documents, systems and processes.
- Access to the ELDAC website and residential toolkit provided resources, linkages, and education, targeting all levels of staff.
- The after death audits were an effective tool that we will continue to use and embed into our practice.
- We reviewed and updated our grief and bereavement approach for families.

Through the experienced and dedicated ELDAC facilitator Longridge Aged Care were able to identify regional networks and develop improved linkages between the various services including specialist palliative care, local acute services, local medical practice, and other aged care homes in the area. Through these networks we have been able to make real progress building knowledge and support between various sites operating independently.

The knowledge we gained through our ELDAC experience and the resources and tools have provided Longridge with the professionalism to steer our residents to a peaceful end-of-life – for both the residents and their families.

Our staff are feeling more comfortable with increased confidence to deal with the care.

ELDAC has been a wonderful project for us and changed our practice forever!

Elizabeth Broadstock, Executive Offlcer, Director of Care

Benefits

- A comprehensive review of all palliative care policies and procedures undertaken.
- Developing and growing regional networks and local partnerships.
- Improved understanding and education for all levels of staff.
- Review and enhancement of bereavement system.
- Embedding the seven-step pathway.
- Increased staff confidence and empowerment.

"The facilitation was outstanding. We were engaged through resources and continually motivated."

Huon Regional Care

Residential Aged Care

Franklin, Tasmania

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

Huon Regional Care (Huon) is a not-for-profit organisation providing high-quality care for older people in the Tasmanian community. Team members work in partnership with General Practitioners, allied health workers, pharmacists and the local palliative care service to provide ageing people with the care, dignity and respect they deserve.

The ELDAC Working Together program provided staff with an opportunity to assess the care, systems, service needs and networks used for palliative care. The team identified areas for improvement including relationships with stakeholders, staff upskilling, resources to support palliative care, and connections with the local specialist care service.

"The hands-on support and guidance of the ELDAC facilitator enabled us to introduce new ways of working and a planning day helped us reflect on our challenges and identify the way forward."

Huon had established valuable partnerships with some local services. However, there were opportunities to develop stronger relationships and further support care delivery. The ELDAC facilitator helped identify shared education opportunities, clarify roles and improve referral pathways. They also helped to formalise and enhance the existing partnership with the local Specialist Palliative Care Clinical Nurse who was keen to help develop pathways and service clarification.

Upskilling in palliative care and advance care planning was needed to help staff embrace the philosophy of palliative care. The ELDAC Working Together program supported access to training and resources to support clinical decision-making. A linkage worker role was also created to facilitate organisational changes and act as a key contact for external agencies. This Registered Nurse supports staff to implement continuous improvement initiatives including After Death Audits to assess end-of-life processes.

"Our team's capacity to provide high-quality, end-of-life care has been enhanced by integrating palliative care education into staff orientation and in-service."

The organisation's transformation is further supported with a Palliative Care Committee and new policies and procedures for palliative care and advance care planning.

Resources which outline Huon's approach to palliative care are now available for clients and staff to have the confidence to initiate conversations about end-of-life choices.

Benefits

- Improved staff engagement and enthusiasm for palliative care.
- New mutually beneficial relationships with multidisciplinary services.
- Improved communication between team members and stakeholders.
- Upskilling and education for staff.
- Enhanced relationships with other palliative care services.

"implement *continuous improvement*"

The importance of a dedicated palliative care portfolio

Through the ELDAC Working Together program, a dedicated staff member was allocated to manage the Palliative Care Portfolio for our service. The scope of this role is still developing with the primary aim of strengthening our internal and external palliative care processes. Our team have also embraced the formation of a Palliative Care Committee which supports linkages with key stakeholders and palliative care networks throughout our region. The committee is a valuable resource for end-of-life care and helps lead change and develop processes while providing a supportive framework for our caring and passionate staff. The following email from a resident's granddaughter illustrates our staff's compassion while providing end-of-life care.

Angela Bradley, Executive Manager Clinical Services

Hi there,

I just want to share my deepest gratitude to the staff at your Franklin facility. My grandma was there for several years and always received wonderful care. Whenever I went to visit, the staff would offer me tea and coffee, and were generally very kind and friendly. Sadly, my nan passed away.

I was told that when she passed, your team kindly opened the curtains as she always liked, laid a daffodil in her hands and even lined the halls as her body was escorted out. I am so deeply moved by and grateful for this final act of utter respect and kindness. It has brought me a lot of comfort and will stay with me for the rest of my life. So, thanking the Franklin Huon Care team from the bottom of my heart.

Extract from letter from resident's granddaughter

My Care Solution

Home Care

Adelaide and Victor Harbor, South Australia

Linkage Strategies Used:

- Role Clarification
- Written and Verbal Communication Pathways
- Formalised Agreements and Plans
- Designated Linkage Workers
- Knowledge Exchange and Upskilling

My Care Solution provides in-home aged care services for those seeking to live independently in their own home. Clients range from those requiring basic support with housekeeping through to those requiring highly complex care who wish to remain in their own home. From everyday tasks to complex needs, My Care Solution provides personal care, housekeeping, social support, transport, in-home respite care, post-discharge care, nursing, overnight care and 24-hour care.

Traditionally, resources for palliative care are tailored for clinical environments and training doesn't often translate into in-home or community care environments easily. There are often significant differences in access to resources, equipment and specialist providers between in-home and clinical environments. As a result My Care Solution, targeted their palliative care training needs to the role and responsibilities of a Caregiver.

"For some time, we have found it difficult to access training tools specific to the in-home care environment that would help us better prepare families in their time of need."

My Care Solution's involvement in the ELDAC Working Together program has improved the overall understanding of palliative care and the role of the non-clinical caregiver. Upskilling caregivers has been a key component of the program's success with caregivers now skilled in loss and grief, changes in conditions and care needs, communication skills in palliative care and approaches to treatment and care.

"The Homecare tools and resources provided through the ELDAC Working Together program have helped improve staff knowledge, skills and confidence in providing palliative care."

Benefits

- Improved overall understanding of palliative care and the role of a non-clinical caregiver.
- Improved knowledge and provision of staff training in all aspects of palliative and end-of-life care.
- Collaboration with the palliative care Nurse Practitioner to develop and release a training resource – My Care Solution Palliative Care Caregiver Manual.

Following the rollout of the Palliative Care Caregiver Manual and training, My Care Solution was contacted by Jane* requesting urgent assistance for her husband, Donald*. Donald had Parkinson's disease, was experiencing a significant decline and Jane was severely burnt out from her carer duties. Within half an hour, a Manager and Client Care Co-ordinator met with Jane and Donald in their home to discuss care and how My Care Solution may be able to provide support.

Resources developed with the assistance of the ELDAC Working Together program were instrumental in identifying Donald's end-of-life care needs. This was a difficult discussion for staff to have with Jane. However, our staff credit the loss and grief section of the training combined with the section on emotions and communication as having helped them facilitate this conversation with empathy and understanding. With Jane's permission My Care Solution was able to refer Donald to the local palliative care team.

An overnight care service was organised on this night to support Jane. The palliative care team came to undertake an assessment on the next day putting in services and liaising with Donald's General Practitioner.

The My Care Solution team worked with the palliative care team and Donald's General Practitioner (GP), eventually increasing Donald's in-home support to 24 / 7 two-person assist. One of Donald's caregivers, Denise*, stated that the palliative care training she received was an invaluable learning tool, and the other caregiver, Lauren*, stated that the training helped her understand her role and the best way to communicate with members of the client's family.

The My Care Solution Regional Care Manager identified that the delivery of the ELDAC Working Together program helped their team enormously, ensuring they had the confidence, knowledge and skills to deliver quality palliative care in the home and support members of the client's family in the process.

Jane knew she was not alone and had people that cared for her emotional wellbeing as well as the care of her husband. Not everyone gets to experience making this much of a difference.

*Names have been changed to maintain confidentiality.

Gabby McBriarty, Director of Marketing and Brand Strategy, My Care Solution

Boneham Aged Care Services

Residential Aged Care

Millicent, South Australia

Linkage Strategies Used:

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

Boneham is a not for profit residential aged care facility located in rural South Australia that was established and continues to be run by a local community board. The closest regional centre is 50km away meaning the provision of a local aged care services is important to the community. The organisation's mission is to deliver "excellence in aged care services that meet or exceed the needs and expectations of our clients."

Boneham saw the ELDAC Working Together program as an opportunity to review the development and management of the facility's advance health care directives, upskill staff and improve information available for all families.

"Residents were often asked to make decisions around advance healthcare directives when they were acutely unwell."

The ELDAC Working Together program helped improve the collaboration and case management of palliative care residents to ensure that interventions were timely and appropriate. Strong community links were also built with the regional specialist palliative care team and a dedicated palliative care nurse who became the staff group champion.

"The end-of-life pathway knowledge coupled with palliative care training helped staff to recognise early symptoms, undertake end-of-life discussions early and support the needs of the resident and their families more effectively."

Benefits

- Enhanced training and establishment of end-of-life pathways.
- Established referral pathways and connections with palliative care service.
- Implement new care initiatives.
- Provided resources to educate and support families through the palliative care processes.
- Increase confidence of the dedicated palliative care nurse.

Improved process and initiatives provides a holistic approach to end-of-life care

Boneham is proud of the standard of end-of-life care we provide but were extremely thankful to have the opportunity to evaluate our processes, improve effectiveness of symptom management to residents and provide end-of-life care with a holistic approach to residents and their family.

Earlier this year when we started to implement improvements to our end-of-life processes, a new resident came to us for end-of-life care. She had a terminal illness and a life expectancy of a few weeks. However, we were blessed to be able to care for her for 5 months.

This resident helped provide us with the opportunity to implement the changes to our end-of-life process, to educate staff and in turn to improve resident and family outcomes.

Not only did we develop a strong relationship with the resident but also with her loved ones. Her daughter, who had been her initial carer was reluctant about accessing care but found that it freed her from direct care and enabled her to spend quality time with her mother during her final days. She visited frequently and spent the time talking, playing the ukulele and singing to her mother. Sometimes the resident was able to sing too – a great, lifetime passion.

The palliation of the resident was case managed in collaboration with the local Palliative Care team. The team were instrumental in providing initial social support to the daughter to deal with grief and bereavement, as well as being a knowledgeable contact for our staff. They also paved the way for the daughter to feel comfortable about our service.

The family of the resident were extremely thankful for the care their mother received and valued the nurturing care provided by our staff. We attribute this to the linkages, training and tools implemented to improve end-of-life processes.

Director of Care, Boneham Aged Care Services

Amaroo Aged Care

Residential Aged Care

Berrigan,
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

Amaroo Aged Care is a small, locally operated aged care facility providing for residents of the Berrigan community. Amaroo Aged Care provide a home-like environment for the community where aging family members are cared for – this provision of community care in the country is central to the ethos of Amaroo.

"Being situated in a rural and remote area can, at times, present challenges in accessing resources and connecting with services. However, we always strive to provide the best service and quality of life to the residents that entrust their care to us."

Prior to undertaking the ELDAC Working Together program we had recognised the need to deliver a more in-depth palliative care service and, needed some guided support to train staff to ensure residents were well supported in their end-of-life care needs and wishes.

"Through participating in the program, we have been able to achieve positive outcomes for both residents and staff. Being able to help families come to terms with what is occurring and how to ensure wishes are met is a true benefit of the training."

These outcomes have been achieved through the introduction and partnership with local palliative care service providers and through staff training.

Benefits

- All residents have a current advance care directive.
- Staff have forged a working partnership with the palliative care nursing service.
- Staff training has helped staff recognise when a resident is approaching end-of-life and how to assist the resident and their families.
- The palliative care nurse visits the facility on a regular basis, meeting with staff to discuss individual resident care and to further staff training.

Our palliative care nurses are an important part of our story

The specialist palliative care nurse and facility staff now meet regularly to discuss individual resident care through regular communication pathways and meetings. The palliative care nurse and staff also meet regularly with residents and their families to discuss end-of-life needs and help ensure the residents needs are met. This linkage with the specialist palliative care nurse and service has provided a foundation for a sustainable high-quality palliative care approach at Amaroo, encompassing building strong relationships and connections.

Through partnerships with services a Memorandum of Understanding was able to be established to strengthen relationships and provide high quality end-of-life care as a team. This has allowed our residents to remain in their local community surrounded by their loved ones.

Through undertaking the ELDAC Working Together program we have been able to strengthen our Palliative program to continue to work with the resident, families and local medical services through their end-of-life journey.

Barbara Rennick, Quality and Lifestyle Manager, Amaroo Aged Care

Carinity Home Care

Home Care

Rockhampton, Queensland

Linkage Strategies Used:

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

Carinity Home Care is a community-based health care service that provides a full range of support services to seniors to remain living independently at home and connected to their local community. Regional care teams provide localised client management and care – each team includes Registered Nurses supporting care delivery teams.

Just under 5,500 people living in Rockhampton are 75 years and older, making up 6.9% of the city's population. Compared to the State's average, the Rockhampton region has a slightly higher proportion of the population aged 75+ (Australian Bureau of Statistics – 2016 Census). While general ageing and decreased mobility issues are a key factor in seeking support, changes in health conditions and carer requirements also see a need for home-based care in this region.

Carinity Home Care identified that staff had variations in knowledge, experience and capacity in the provision of palliative care and advance care planning. Through participation in the ELDAC Working Together program and the implementation of an education plan, staff have built their knowledge and capabilities through online training, and guidance and support from partners – Carinity Home Care accessed new education and opportunities that they were previously unaware of.

"Our staff feel empowered to access training and learn about palliative and end-of-life care, and are confident in discussing this topic with clients."

As a direct result of participating in the ELDAC Working Together program, Carinity Home Care were able to establish multidisciplinary teams in the region and undertake process improvement initiatives to ensure advance care documentation (including advance care plans and health directives) were discussed with clients and their families.

Resource support and the recruitment of a nurse whose primary focus is end-of-life care considerations was invaluable. This nurse works proactively with clients to help them and their families understand the benefits of an end-of-life care plan. Even those who were initially reluctant to discuss this topic became engaged in the process. Staff – both Registered Nurses and lifestyle co-ordinators have begun engaging in conversation surrounding end-of-life care when conducting reviews.

Staff are also now actively encouraged to share their learnings and experiences, with palliative care listed as a regular agenda item in staff meetings. Significant areas of need are also being identified for regular discussion. For example, multicultural needs during end-of-life care is listed on next month's agenda.

Benefits

- Improved service delivery response.
- Improved staff capability.
- Improved understanding of referral pathways and partners.
- Staff feel empowered and have improved confidence.

> *"We have built strong working relationships that help facilitate better outcomes for our clients and their families."*

"our staff *feel empowered"*

Our care team members now have the skills and experience to assist both the client and family members through their personal journey in end-of-life care. As a previous care worker, I know first-hand how difficult it can be to watch a client that you have looked after for many years become palliative.

It is a privilege to assist a client and their family members through the end-of-life and grieving process. However, when a client passes you may grieve for them like you would a family member.

The ability to debrief and have the support of other healthcare professionals in a multidisciplinary team is of great benefit.

Feedback from staff that undertook the training has been overwhelmingly positive and given them valuable skills. It has also allowed them to understand how important self-reflection is, not only when dealing with a client in end-of-life stages but with every client that they encounter.

Lifestyle Co-ordinator, Home Care

Carinity Shalom

Residential Aged Care

Rockhampton, Queensland

Linkage Strategies Used:

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

Carinity Shalom provides high-quality residential aged care, catering for varying levels of care including dementia specific and respite care for older people in Central Queensland. Carinity Shalom is co-located with a retirement village, enabling couples to remain connected should one partner require a higher level of care.

End-of-life care is a priority for Carinity Shalom and the ELDAC Working Together program supported this strategic focus.

Historically, Carinity Shalom was supported by external providers to manage and coordinate end-of-life care for residents. In-turn, this external support lessened in-house capacity, resources, knowledge, and a reduced focus on palliative care in staff training. To increase team members skill and confidence in palliative care further education and resources was required.

Through participation in the ELDAC Working Together program Carinity facilitated the review and improvement of palliative care and advance care planning policies and procedures.

Additionally, a new education plan, including training and resources for palliative care and advance care planning, was implemented. This provided staff with the communication skills they needed to initiate conversations with residents about their end-of-life wishes.

Stronger linkages with primary and palliative care service providers and networks were also needed to expand Carinity Shalom's ability to provide improved integrated and multidisciplinary care. These relationships were facilitated through partner meetings with a focus on role clarification and communication pathways. As a result, new collaborative partnerships are improving outcomes for residents and providing development opportunities for team members.

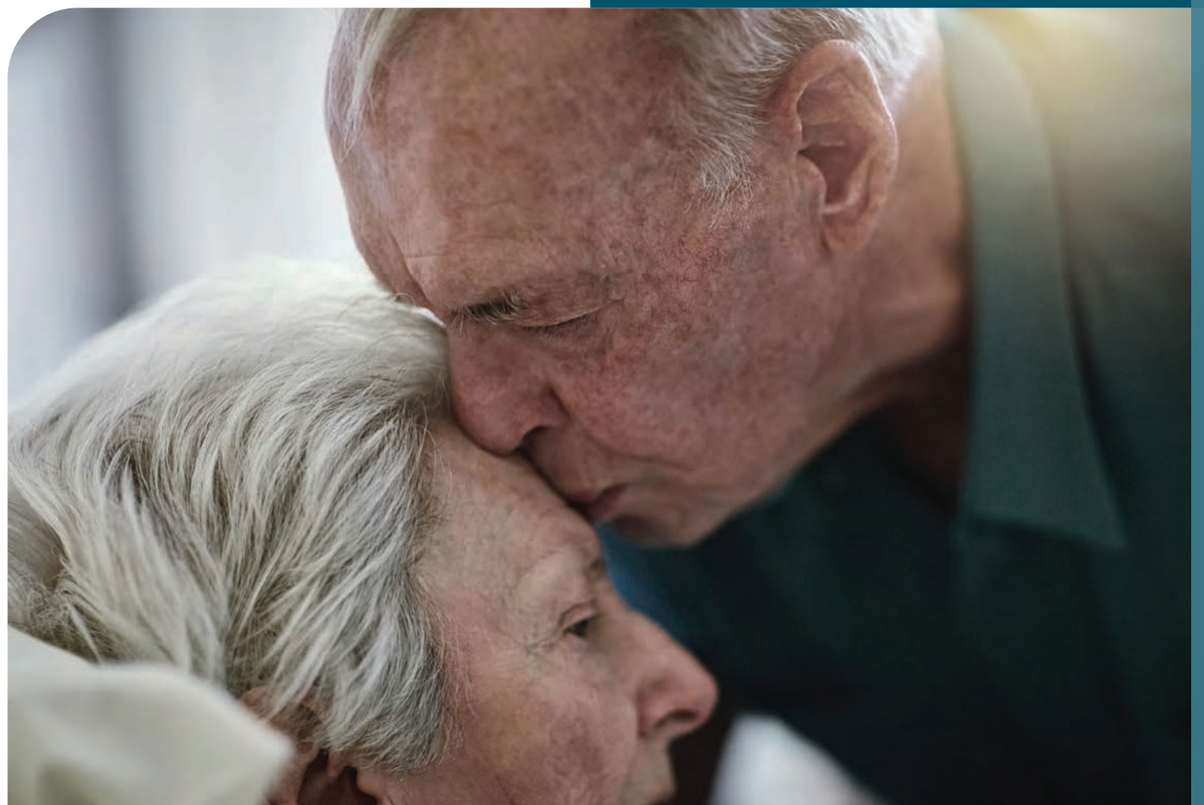
Benefits

- Improved staff confidence managing conversations about palliative care with residents and their families.
- Increase uptake in residents advance care planning.
- Improved education and staff orientation processes.
- Improved After Death review processes.

"provide *integrated* and *multi-disciplinary* care"

ELDAC resources are now an integrated part of our care plan and technology platform

The implementation of ELDAC tools has enhanced our palliative care operations across the organisation. We are also in the process of incorporating the Supportive and Palliative Care Indicators Tool (SPICT) to assist staff with assessing the palliative phase.



Southern Cross Care (SA, NT & Vic) Inc. Pearl Supported Care

Residential Aged Care

Darwin,
Northern Territory

Linkage Strategies Used:

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

Southern Cross Care Pearl Supported Care is committed to seeing people "Live better for life." They provide person centred care to enable their residents to live happy, healthy lifestyles.

Prior to undertaking the ELDAC Working Together program, Southern Cross Care Pearl Supported Care recognised there was not a clear understanding of, or relationship with other key providers in the provision of palliative care. They wanted to improve role clarification, documentation, communication and palliative care referral processes.

"We knew that enhancing our palliative care process would lead to improved continuity of care for our residents."

Through participation in the ELDAC Working Together program, Southern Cross Care Pearl Supported Care have achieved many improvements including, but not limited to:

Benefits

- Clear referral pathways for palliative care.
- Improved role clarification and communication with key partners.
- Implementation of palliative care champions improving care continuity and communication.

"Our whole palliative care process is now underpinned by robust policies, practices, and responsibilities."

"improved *continuity*

***of care* for**

our residents"

Championing the end-of-life wishes for our residents

One of the biggest impacts achieved has been the introduction and designation of palliative care champions at Pearl. This can be demonstrated by the case of an 87-year-old female resident living with advanced dementia. Having identified deterioration in her condition, our care team alerted the General Practitioner, who referred to the specialist palliative care team using the new referral process.

The palliative care champion became involved at an early stage in the process and assisted with development of the resident's end-of-life care plan through discussions with the palliative care nurse specialist, the next of kin and the directions detailed in the residents advance personal plan.

The palliative care champion had a pivotal role throughout the resident's end-of-life process as they maintained contact with the next of kin, facilitated continuity of care for the resident and supported staff in the provision of care through sharing knowledge.

"Our palliative care champion was an excellent key person liaising between medical, nursing, care staff and the next of kin, ensuring the resident's wishes were maintained."

Residential Services Manager

Southern Cross Care (SA, NT & Vic) Inc. Home Support Services

Home Support Services

Darwin,
Northern Territory

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

Southern Cross Care (SA, NT & Vic) Inc. Home Support Services provides quality home care services to Darwin's community to enable them to live their best life at home. This home support organisation provides services to a diverse population across a large catchment area in Darwin.

Home Support Services identified that participation in the ELDAC Working Together program presented an opportunity to develop strong linkages with other local aged and palliative care providers, that would allow them to collaborate to meet the heath and palliative care needs of new and existing clients.

"We wanted to enhance our skills to enable us to support our clients through their palliative care journey with a sustainable and holistic approach to end-of-life care."

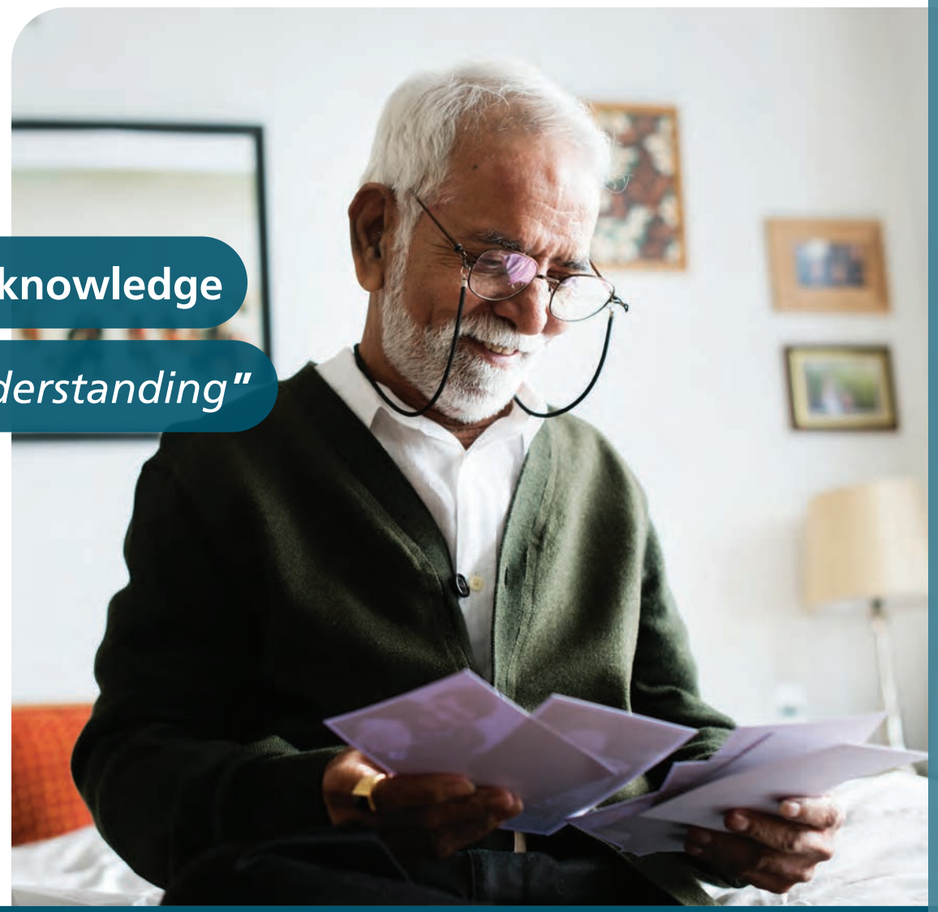
As a result of participation in the ELDAC Working Together program, Home Support Services have improved understanding of, access to and communication with key stakeholders, resulting in improved outcomes for clients and their families.

Benefits

- Enhanced staff understanding and confidence.
- Improved referral pathways.
- Strengthened linkages with palliative care networks.
- Improved policies and processes.

"Education has been implemented into our mandatory training which supports sustainability."

"*improved* knowledge and *understanding*"



Providing Home Support with Confidence

We had a client whose husband had unfortunately been diagnosed with terminal cancer and she was caring for him at home. We provided weekly services to support her with domestic duties so that she didn't have the burden of these chores and could focus on her caring role.

Thanks to the training our staff received through the ELDAC Working Together program to expand our skills and knowledge in palliative care, our home care staff were able to recognise that the clients husband was deteriorating and that they both needed more support and care.

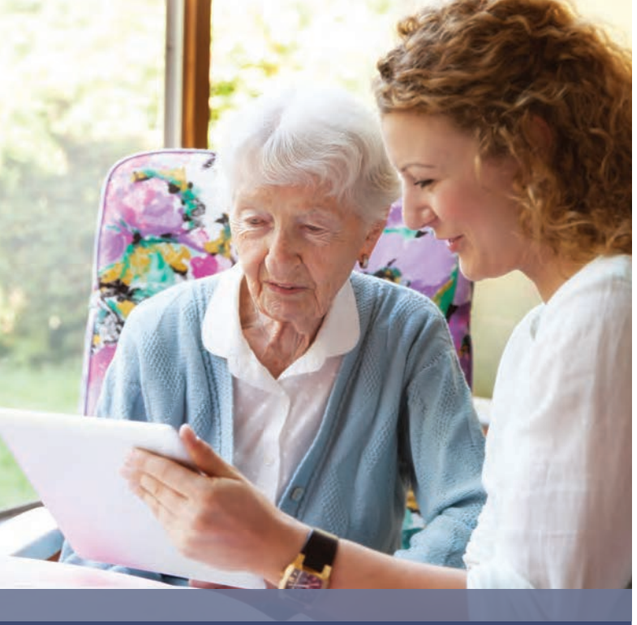
We used our improved linkage with the local specialist palliative care team to refer the husband, who also became our client. We then worked together to support and care for both husband and wife. Newly developed communication strategies and processes facilitated prompt and appropriate care provision.

We were able to draw on insights into the palliative care approach to further support our client and his family. Our staff felt confident, supported and educated. Our client's wish, to die at home with his wife by his side was met, through working together.

We feel that participating in the ELDAC Working Together program has improved our knowledge in palliative care and our processes and relationships with other key care providers.

With the education provided to our staff and support in implementing specific end-of-life processes in our organisation we are confident in continuing to provide positive outcomes to our clients and support others in the community with quality services.

Manager Community Care Services



Ezyas@Home

Home Care

Bundaberg, Queensland

Linkage Strategies Used:

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

Ezyas@Home is an independently-owned, government-approved aged care provider for residents in Bundaberg and the surrounding area. The service uses a small and carefully-selected team to provide personalised and coordinated in-home care.

The Bundaberg region has an ageing demographic with a large number of people aged 60 years and over. Many clients live alone and have multiple morbidities with high care needs. An acute shortage of General Practitioners (GPs) in the region makes it difficult for clients to access palliative care in the home, particularly after hours.

Historically, the connections between Ezyas@Home and other local service providers were informal and did not provide clear palliative care pathways or support. These informal links resulted in reduced referral pathways, limited advance care plans and reduced capacity to train or upskill staff. The ELDAC Working Together program significantly improved Ezyas@Home's linkages and processes with local networks. As part of the program, the organisation undertook an extensive service mapping process and consulted with local service providers. These included a local nursing service, nurse navigators and a specialist palliative care provider. As a result, roles are more clearly defined and communication pathways have been improved.

Additional education and training also expanded staff knowledge about end-of-life care including the benefits of advance care planning, the delivery of care, and local services, resources and support.

Ezyas@Home staff now have a more coordinated approach for advance care planning and work collaboratively with other health professionals to meet client care and treatment goals.

Benefits

- Improved communication and sharing of resources with other primary and aged care providers.
- Enhanced information sharing with clients and families about advance care planning.
- An in-house education plan for palliative care and advance care planning has improved staff-client communication regarding end-of-life care.
- Interactions between clients and staff have been enhanced through the use of the ELDAC Toolkit, particularly the home care and legal components.

"a more *coordinated approach* for advance care"

A long-time client had been bed-ridden for 22 months and was cared for by his wife. The family's passionate wish was for the client to remain at home and avoid hospitalisation.

Previously, this care would have been difficult for our small organisation to manage. Knowledge sharing outside the public health pathways to community services was minimal, with non-existent access outside business hours.

Our participation in the ELDAC Working Together program has helped to strengthen existing and / or create new, strong working partnerships with other local aged, primary and palliative care providers.

These collaborative relationships helped reduce distress and suffering for the client, family and carer, and ensured our care was consistent with clinical, cultural, spiritual and ethical standards.

Working with local providers, Ezyas@Home developed a plan with the client and their family to facilitate their wishes. This included:

- Extensive care plan review.
- Discussion with the family.
- Meeting with a palliative care nurse.
- Communication with a specialist palliative care team member.
- Palliative Care Specialist General Practitioner (GP) was contacted.
- Identification of end-of-life symptoms and appropriate nursing care.
- Peaceful death with family in attendance.
- Post-passing debriefing with carers, facilitating attendance at the funeral and continuing care for the client's wife.

Through ELDAC, our organisation had improved our linkages with local providers and were able to achieve the client and family wishes of a peaceful home death.

Judith Allen, Director

Sarina Aged Care

Residential Aged Care

Sarina, Queensland

Linkage Strategies Used:

- Role Clarification
- Written and Verbal Communication Pathways
- Knowledge Exchange and Upskilling
- Continuous Quality Improvement

Sarina Aged Care offers residential aged care in its rural location south of Mackay and was established as a result of community efforts close to 30 years ago. The facility is proud of its Ageing in Place Model that provides coordination of healthcare services in the one location so that residents do not need to move across levels of care to another provider as their healthcare needs increase.

"As a rural and remote facility, the provision of care comes with challenges not faced by metropolitan facilities. Ready access to medical staff trained in palliative care and the resources required to train staff can be difficult to access."

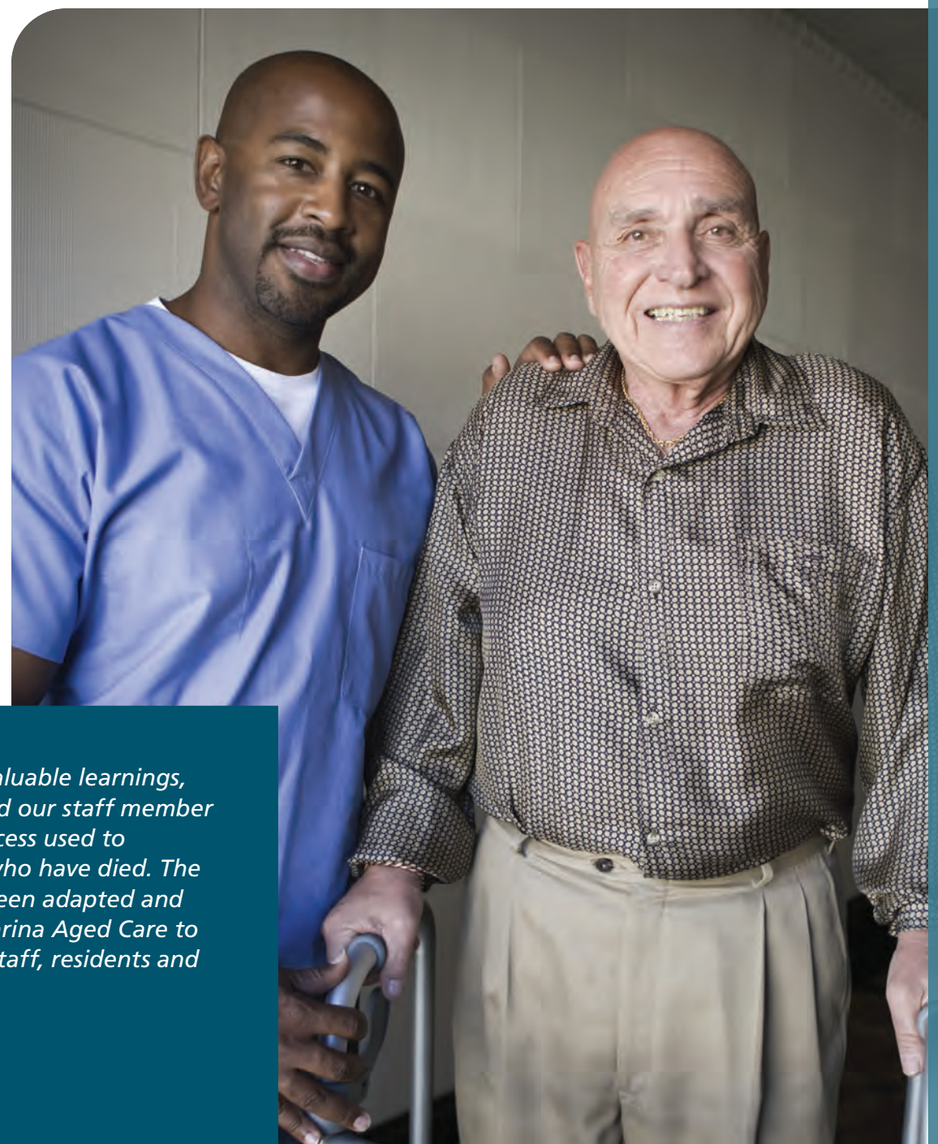
Operationally, there is also a greater reliance on generalist medical providers, for example General Practitioners (GPs) or support workers to provide end-of-life and palliative care provisions for residents and their families given the remote location.

With a community-based focus on improving both the quality of life and end-of-life experience for residents and their families, the ELDAC Working Together program helped us develop and improve supportive networks and implement new processes.

"We really only dared to dream about the supportive networks we have now been able to access. We're arriving at destinations that weren't even on our map before we started this project."

Benefits

- Significantly improved levels of communication have fostered exceptional relationships and network support.
- A greater understanding around service roles has heightened empathy and we are all focused on the same thing.
- Use of the After Death Audits has provided a means of reflection on our practice.
- Upskilling the workforce through education.



"Amongst many valuable learnings, this also introduced our staff member to a memorial process used to remember those who have died. The process has now been adapted and implemented at Sarina Aged Care to the benefit of all staff, residents and their families."

Clinical Manager

Fullarton Lutheran Homes Inc.

Residential Aged Care

Fullarton,
South Australia

Linkage Strategies Used:

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

Fullarton Lutheran Homes Inc. (Fullarton) is a residential aged care facility providing permanent, respite and transitional care. The facility seeks to maintain the dignity and independence of all residents by encouraging self-help and a caring concern for others. Fullarton's reputation is built on exceptional service and care for its residents.

The facility entered the ELDAC Working Together program to increase staff confidence and knowledge regarding palliative care and facilitate stronger linkages with the specialist palliative care team and other providers in the sector. Staff had opportunities to improve their knowledge and skills in the areas of advance care directives and were initially uncomfortable starting conversations about end-of-life care with residents and their families. Team members also did not pro-actively participate with external services due to lack of understanding about the services.

"The ELDAC project has enabled staff to increase their knowledge about advance care planning, recognise end-of-life indicators and assess palliative care needs, work with other service providers, respond to deterioration, and manage dying and bereavement in alignment with best practice."

The ELDAC facilitator instigated meetings with other services to increase understanding about care pathways and specialist support. This helped establish linkages across the sector and more than 60 staff have undertaken palliative care training with health care providers. Registered Nurses also participated in a palliative care placement program with the local specialist palliative care service to gain further knowledge and expertise.

"The ELDAC facilitator closely engaged with our teams and provided us with clear guidance to help drive the project in the right direction and achieve our goals."

Education and networking has facilitated a more collaborative approach to palliative care and referral pathways are now accessed more frequently. Staff also feel more confident initiating conversations with residents and their families regarding Advance Care Directives (ACDs). A new ACD registry has helped improve staff engagement with residents and their families to access a person-centred approach to managing end-of-life care.

"The ELDAC Working Together program significantly increased the education and engagement of all staff in best practice palliative care."

Updated policies and procedures now incorporate referral pathways involving General Practitioners and other service providers. The Supportive and Palliative Care Indicators Tool (SPICT) also assists staff with the identification of end-of-life indicators and palliative care decision-making.

Benefits

- Staff received valuable upskilling and education regarding palliative care.
- ELDAC champions drive continuous improvement.
- Advance care directives and end-of-life care plans are integrated into routine systems.
- ELDAC tool kits provide staff with support for decision-making.
- Clear communication and referral pathways with services.
- Developed clear communication pathways and palliative care networks.

One change we have made at Fullarton following our participation in the ELDAC Working Together program has been the employment of a dedicated Registered Nurse who was appointed as ELDAC Champion to mentor staff about the new care model. The champion conducted toolbox sessions to educate staff and, continues to provide support and identify opportunities for continuous improvement.

Shani Liyanage, Acting Director of Care

Lifeview Willow Wood

Residential Aged Care

Cranbourne, Victoria

Linkage Strategies Used:

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

Lifeview Willow Wood is a family focused aged care facility that provides care and wellness in a supported social environment. A small house-based model of care, Home2Home, provides an environment where multiskilled staff constantly work with the same group of residents to foster stronger relationships. This inclusive model enables residents to choose how they would like to live and allows for the resident's involvement in key decision-making.

Willow Wood saw the ELDAC Working Together program as an opportunity to review current palliative care practices and enhance training opportunities for staff and to better engage with local palliative care providers.

The ELDAC Working Together program helped strengthen relationships between Willow Wood and the local palliative care team. With a wealth of knowledge regarding advance care directives and palliative care, direct assistance was provided and has been invaluable. The ability to be aware of and to access resources such as the screening of the short film Dignity of Risk, was also made possible through the formation of network relationships.

As a result of the ELDAC Working Together program, facility care policies and procedures have been updated, direct local relationships strengthened, advance care plans are being completed more fully with the correct forms being used and staff, residents and their families are becoming more comfortable about what to expect with palliative and end-of-life care.

"Staff are now both more knowledgeable and confident in being able to identify the signs of deterioration and to enact end-of-life care."

Benefits

- Strengthened relationships between Willow Wood and palliative care clinical support.
- Provided access to training, education and resources.
- Staff are better equipped to recognise the pathways and signs of deterioration.
- Increased advance care plans knowledge and resources.
- Building and strengthening relationships with services including General Practitioners (GPs).
- Creating clear communication and referral pathways.

Care provided in accordance with residents wishes

An almost 90 year-old resident had been at Willow Wood for over a year.

A Goal of Care was in place for this resident that indicated their preference to stay at Willow Wood if comfort measures could be provided without causing the resident distress. Hospital transfer was to occur only if the resident's symptoms could not be managed at the home.

All medical conditions were managed by the staff at Willow Wood until a gradual deterioration was evident. Around this time, staff were able to identify, through the training provided, that the resident was showing signs of deterioration.

Consultation occurred regularly with the resident's family in relation to a wellbeing and management plan. Hospitalisations were becoming more frequent and on return to Willow Wood the resident was displaying a significant decline. The family decided, through further consultation, that their preference was for the resident to stay at Willow Wood and avoid further hospitalisation, if possible. Willow Wood staff liaised with the geriatrician and hospital in-reach services to optimise symptom management and comfort for the resident. The resident remained comfortable in the lead up to their passing.

Staff were able to attend effectively to the needs of this resident due to the support and training received via the ELDAC Working Together program. Frequent family discussions were facilitated, and staff were also liaising regularly with palliative care services.

The resident's wishes were fulfilled in relation to their end-of-life choices. When it became clear that hospitalisation was no longer resulting in an improved quality of life, a review was undertaken, and the end-of-life pathway was commenced.

The regular collaboration and communication between all staff involved in the resident's care, and a jointly formulated plan for symptom management, enacted and respected this resident's end-of-life wishes. Open communication with the family and collaborative consultation with health professionals ensured an approach consistent with what the resident wanted.

Izabela, Resident Wellness Co-ordinator

Lerwin Nursing Home

Residential Aged Care

Murray Bridge, South Australia

Linkage Strategies Used:

- Written and Verbal Communication Pathways
- Multidisciplinary Team Structures and Processes
- Knowledge Exchange and Upskilling
- Continuous Quality Improvement

Lerwin Nursing Home is a not for profit facility that provides residential, palliative and respite care to the surrounding district. Servicing many farming and rural districts and providing supported care for a broad range of community members including Aboriginal and Torres Strait Islander peoples, Lerwin was named by Uncle Herbert, one of the Traditional Owners of the Ngarrindjeri people and means to 'sit and rest'.

We acknowledge the Ngarrindjeri people as the traditional owners of this land on which we meet and work. We respect and acknowledge their spiritual connection as the custodians of this land and that their cultural heritage beliefs are still important to the living people today.

Prior to involvement with the ELDAC Working Together program, Lerwin staff had identified some service delivery needs and support improvement initiatives around training, documentation, and the use of clinical system / software. Through the ELDAC Working Together program, Lerwin saw opportunities for clearer connections with the local palliative care service and other services.

"Access to senior clinicians in a rural setting is always challenging. We didn't have strong connections with palliative care services in our wider community and we saw this as very valuable to our care provision. Through our new links, the Specialist Palliative Care Clinical Consultant has supported us with education and mentoring."

Through involvement in the ELDAC Working Together program and service mapping activity, staff have been better able to identify and strategically pinpoint services to work with that would help ensure a more integrated approach for residents. Families are also now more closely considered during the bereavement stage and staff are initiating conversations confidently and earlier with residents, families and General Practitioners (GPs). These early stage conversations are translating into a more holistic end-of-life experience for residents.

"Our families being truly considered and involved in the decision-making around end-of-life care is helping us provide a more holistic level of care for residents and their families."

Benefits

- Established stronger connections with the specialist palliative care service.
- Provided education opportunities upskilling staff.
- Developed care pathway processes.
- Developed resources to provide families with bereavement care.

The following case story has been reproduced with the consent of the resident's family. ELDAC acknowledge that the person has passed away and offers thanks to the family for allowing the story to be shared.

A more holistic approach

Edith was a resident at our Lerwin facility who brought joy to all. A true character, she was a proud Ngarrindjeri woman. We all agreed she was very happy living at Lerwin.

After her passing, the family asked if they could come and speak at a staff meeting. They especially wanted to let us know how grateful they were for our support and care of their mother. Four of her children spoke at the meeting and presented a gift to our staff.

The children spoke lovingly of their mother and emphasised how much they appreciated the level of care our staff were able to provide. They acknowledged that our team knew their mother as well as they did and said they were happy that our team had made it possible for her to reside with her partner right through to the end.

They commented on the care and attention their mother had received during her time at Lewin and the love that she had received too. 'We saw the love, she told us about it and it was clear she loved it at Lerwin,' they said. Her son also spoke and explained the deep family connection with Lerwin – their uncle had given the name Lerwin meaning: to come, sit down and rest.

The family expressed their gratitude:

"We think of what you have done for us as a family. We understand how challenging care can be. Mum didn't have to come; she chose to come to Lerwin with her partner because she would never let him go. We knew it was her choice and she wanted to come. Edith and her partner were happy sharing their time together here at Lerwin."

Over the week when Edith was close to end-of-life, many family members came to see her – at times there were many, many visitors overflowing out of the room – all there to say their goodbyes. Old and young, all grateful that their family was able to be together. When there wasn't enough space in Edith's room, the staff found seating in the passages, children played, families laughed and shared. They shared their time with Edith. All the time our staff were respectful of creating a culturally appropriate and safe place for the family.

During this time, we were able to consult with the Specialist Palliative Care Clinical Consultant to provide advice and symptom management support. We cared for Edith with all our heart, knowledge and skills.

The family expressed their appreciation for what the staff do and what they were able to do for their mum. It meant a lot to our staff to have Edith's family come back to Lerwin, express their gratitude and share memories of Edith. Caring for Edith, her partner and her family provided a rich learning experience for our staff. We were touched that they came to speak at our formal meeting. It was indeed a gift to care for Edith who brought so much joy to Lerwin and gave us the gift of confidence in our care.

Ruby Ash, Manager and Clinical Care Team, Lerwin

BaptistCare Carey Gardens

Residential Aged Care

Red Hill,
Australian Capital Territory

Linkage Strategies Used:

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

Set within landscaped gardens, the facility and team provide a real sense of community. Here the emphasis is on individuality towards an improved quality of life while maintaining the connections within the broader community. Supported by a qualified and experienced care team, the home is able to care for residents who have complex care needs.

Historically, Carey Gardens had ongoing challenges in relation to communication between services surrounding the current and emerging needs of residents with complex palliative care needs. This included access to after hour and on-call medical practitioner services. Opportunities were identified to undertake a review of processes, communications and escalation plans where a number of stakeholders are involved in planning and delivery of end-of-life care.

"We sought to improve management of nurses' capacity development in caring for deteriorating residents at Carey Gardens."

By engaging with the ELDAC Working Together program and with the support of the dedicated ELDAC facilitator, the team at Carey Gardens sought to work hand-in-hand with the local community specialist palliative care services to implement monthly palliative care case review meetings. A specialist palliative care educator also worked with the team to support employee education in the BaptistCare Palliative Approach to ensure that consistent and competent palliative care delivery occurred.

"Embedding best practice at the grass roots was made easier through education and using a specialist palliative care staff member in the home to facilitate and embed new knowledge and skills through experiential learning."

Benefits

- Increased Registered Nurses' capacity.
- Skills and knowledge development.
- Competency skills assessments attained.
- Introduction of palliative care case reviews.
- Palliative care case conferences completed by Registered Nurses.
- Strengthening of advance care planning skills and confidence.

Feedback received during a conversation between chaplain and the family of a resident:

"During this conversation they praised the care that the staff had given to their parent as a team, including our facility manager and myself (chaplain). They used terms like "Brilliant" several times during the conversation and they were ever so grateful that their parent died in an environment that was far homelier and more comfortable compared to a hospital.

They also expressed their appreciation of our night supervisor and how she enabled the family to be present when their parent passed."

Carey Gardens ensures safety, connection and enables dignified ageing in place

The ELDAC Working Together program provided an opportunity for Registered Nurses (RNs) and their team to increase their knowledge and skills in palliative care. RNs have increased their confidence and initiate / complete palliative care case conferences, complete palliative care assessments and provide a high level of palliative care services to each resident and their family.

The ELDAC Working Together program has facilitated the strengthening of our linkages with our hospitals, community palliative care in-reach team and community specialist palliative care services. While completing palliative care case reviews, individualised end-of-life plans are developed for each resident according to their needs and requests. The majority of residents request to receive end-of-life / comfort care at the home, however, one resident requested to be transferred to hospital for end stage palliative care upon his request. This was facilitated through our improved linkage with the local hospital and the resident transferred to hospital, received end stage palliative care and passed away peacefully with family in attendance.

In this resident's case we were able to meet his wishes as expressed and captured in his advance care planning record. Supported through the development of our strong linkages (developed through the ELDAC Working Together program) we were able to facilitate his wish to go to hospital for end stage palliative care services.

Through effective communication the hospital was aware of his choice, the medical practitioner was supportive as was his respiratory physician, supported by the palliative care consultant from the hospice. This informed decision surrounding *choice of place to die* was made by the resident during his palliative care case conference and further developed as an outcome of the regular case review meetings. The resident's end-of-life choices were also supported by his family.

Residential Manager

BaptistCare George Forbes House

Residential Aged Care

Queanbeyan, New South Wales

Linkage Strategies Used:

- Role Clarification
- Multidisciplinary Team Structures and Processes
- Knowledge Exchange and Upskilling

George Forbes House offers sweeping views over the countryside, with the surrounding bushland providing the serenity of nature for residents. Life at George Forbes House revolves around the residents who enjoy the convenience of an onsite hairdresser, library, podiatrist, physiotherapist, and regular community outings. Supported by a qualified and experienced care team (Residential Manager, Care Team Manager, Registered Nurses, Allied Health, Care Supervisors and Care Workers), George Forbes House provides aging with respect and quality of care.

Established in a semi-rural environment, George Forbes House faced multiple challenges linked to physical location and demographics. At this home a number of the Registered Nurses are from multicultural backgrounds and many are early practitioners or new graduates keen to develop skills and knowledge in aged care and end-of-life care. Through the ELDAC Working Together program, improving access to current palliative care frameworks and best practice resources were identified. Opportunities were taken to develop a relationship with the local community specialist palliative care team towards furthering in-reach capacity with the facility to review, assess and consult on all current residents requiring palliative care and end-of-life care planning. In addition, the medical practitioner service was keen to develop an improved communication strategy.

Through the guidance of the ELDAC facilitator, an education program was formulated to include basic BaptistCare palliative care framework, skills and knowledge in end-of-life medication delivery.

"Our facilitator worked with us to identify education and training programs to enhance the capacity of the Registered Nurses and care workers in delivering palliative care."

Benefits

- Increased Registered Nurses' capacity.
- Skills and knowledge development.
- Enhanced internal and external networks.

Management of end-of-life symptoms while supporting spiritual needs

Through the ELDAC Working Together program the whole team developed an appreciation of the palliative approach within the home and a confidence in supporting palliative care delivery. By engaging in regular meetings with the local community specialist palliative care team, the leadership team were able to enhance and develop the in-reach support and more broadly review deteriorating cases.

An intensive education workshop onsite in an enhanced learning environment enabled 17 key Registered Nurses and allied staff to increase their skills, knowledge and capacity around death and dying within a palliative approach, including competencies in utilising syringe driver technology. The team were supported in applying the palliative approach in a culturally appropriate manner across various settings including the dementia specific unit. Access and communication with medical practitioners and the specialist palliative care team was enhanced through regular meetings and shared actions.

The onsite training program enabled six key Registered Nurses to develop increased awareness of the benefits of timely and appropriate recognition of deterioration using ELDAC resources and supporting access to a palliative approach including implementing the Residential Aged Care – end-of-life care pathway, applying pain assessments and understanding end-of-life medications. Key learnings include improved management of end-of-life symptoms relative to each individual's life limiting-illness, based on advance care planning preferences, while supporting spiritual needs.

Residential Manager

BaptistCare Orana Centre for Aged Care

Residential Aged Care

Point Clare,
New South Wales

Linkage Strategies Used:

- Role Clarification
- Written and Verbal Communication Pathways
- Knowledge Exchange and Upskilling
- Continuous Quality Improvement

Located opposite the beautiful Brisbane Waters in Point Clare, the BaptistCare Orana Centre has comfortable living at its heart. The home is dotted with private sitting rooms, barbeque areas, landscaped gardens and numerous courtyards for residents, their families and friends to enjoy. This centre is supported by a qualified and experienced care team enabling the delivery of complex health care.

Across several levels and 128 beds, Orana Centre offers care services including palliative care, dementia care and respite care. Orana boasts refurbished shared gardens and a vibrant coffee shop supported by a caring community which puts the residents' well-being and individual care first.

As the Central Coast has limited access to in-house palliative care, Orana Centre has a unique reputation in the community for quality end-of-life care provision. BaptistCare developed and tested an electronic documentation checklist to support efficient palliative care for palliating residents from date of admission (admission for Comfort Care). Prior to commencing in the ELDAC Working Together program, opportunities were identified to enhance communication and referral pathways with the area specialist palliative care team and improve emergency department discharge information sharing with the home.

The ELDAC Working Together program strengthened the Orana Centre commitment to new graduate and emerging Registered Nurses who were seen to support professional development opportunities to enhance palliative care knowledge and skills.

Through the ELDAC Working Together program, Orana Centre developed an education plan including BaptistCare Palliative Approach refresher training for Registered Nurses and separately to care workers using evidence-based resources and introducing a common clinical assessment tool to identify residents with deteriorating health and unmet palliative care needs. An intensive palliative care immersion program using the support of a palliative care Nurse Practitioner was undertaken on site to enable key Registered Nurses the opportunity to set learning outcomes and develop capacity in palliative care assessment.

"Our ELDAC facilitator was integral in achieving the key benefits and outcomes at each home. They provided structured and clear guidance face-to-face and via regular video meetings and demonstrated a broad knowledge of the palliative care model and frameworks including supporting and enabling relationship development with key external stakeholders in the specialist palliative care teams and other government departments."

Through the ELDAC Working Together program Orana Centre was provided with new and emerging information and research throughout the project.

Benefits

- Increased Registered Nurses' capacity.
- Skills and knowledge development.
- Clinical assessment and recognising deterioration practical application.
- Application of common tools when communicating with local medical practitioners.

Training, education and upskilling are key

Following testing at Orana Centre, the new streamlined BaptistCare Palliative Care Checklist for residents admitted in the Comfort Stage has been implemented across all homes for use.

Through support from the ELDAC Working Together program, ten Registered Nurses participated in an intense 1.5 day onsite palliative care education program which included introducing the ELDAC tools.

An intensive palliative care immersion program using the support of a palliative care Nurse Practitioner onsite for 2.5 days was delivered, enabling four Registered Nurses the unique opportunity to set personal learning goals and develop capacity in palliative care assessment.

The engagement and feedback from the participating nurses were both positive and motivating:

"I had the pleasure of attending the program at Orana in July 2020. This was a most enjoyable learning experience for me that was presented in a relaxed manner that I felt safe to express personal experiences without judgement.

The greatest lesson I learnt was that the preparedness for death is important and will affect the experience that the resident, their family and the staff caring for the resident, will endure throughout the dying process. The more knowledge that is gained in the resident's wishes and expectations of their death prior to their end-of-life, means the likelihood of a better death for the resident. Advance care planning and having a palliative care case conference and care planning means that the information is gained and the people involved are well-informed and staff are aware of what the resident wants and expects are thus more confident in providing care needs.

In doing the program, I gained confidence in assessing a resident to commence end-of-life pathway and feel more confident in discussing the process of dying with the resident and their family. I learnt that the gaining of knowledge regarding the eventual death, starts at admission. I learnt the importance of documenting and reporting the resident's wants and preferences, and being an advocate for the resident, ensures wherever possible that their preferences are met. If we are prepared for death and can meet residents' requirements, then their death will be more peaceful, family will be calmer, and staff will be confident that they are doing the best job possible."

Registered Nurse, Orana Centre

TPG Aged Care

Home Care

North, East and South Eastern Perth, Western Australia

Linkage Strategies Used:

- Role Clarification
- Written and Verbal Communication Pathways
- Multidisciplinary Team Structures and Processes
- Formalised Agreements and Plans
- Knowledge Exchange and Upskilling
- Continuous Quality Improvement

TPG Aged Care (TPGAC) is a community, aged care service provider operating across the north, east and south-eastern metropolitan areas of Perth. The organisation provides practical help and support to promote independence, improve quality of life and reduce the need for residential care.

Before connecting with an ELDAC facilitator and committing to the ELDAC Working Together program, TPGAC experienced challenges when staff worked with multiple high-needs palliative clients at one time. TPGAC recognised the difficulties in meeting patient palliative care goals when faced with competing priorities and committed to an organisational review to improve future practices.

TPGAC enrolled in the ELDAC Working Together program to improve the organisation's care delivery and provide staff with additional support and knowledge. The goals were to improve quality end-of-life care in a community setting and provide high-quality palliative care through teamwork, partnerships and collaboration. Additionally, the organisation aimed to develop a sustainable model for the provision of in-home, end-of-life care with a multidisciplinary team and improve linkages with other local providers.

Through a process of service mapping and partnership meetings with other providers, TPGAC further clarified roles and responsibilities, and increased knowledge exchange and upskilling through collaboration with the multidisciplinary team. Partners included a specialist palliative care provider, Nurse Practitioner, General Practitioner with palliative care expertise, and an affiliated pharmacy.

ELDAC facilitated collaboration with other providers in the primary health care sector which strengthened TPGAC's clinical position. Staff morale and knowledge was significantly increased with members of the nursing team undertaking palliative care and advance care planning education and training.

The ELDAC Care Model and Home Care Toolkit provided a framework and resources to assess end-of-life domains and audits were conducted to identify gaps in the organisation's practice. This led to improvements in the assessment of palliative care needs, a review of staff training and increased knowledge across the organisation. End-of-life policies, procedures and associated documentation processes were also developed and implemented to address review findings and expand the client uptake of advance health directives.

Benefits

- Mutually-beneficial partnerships were developed with palliative care specialists and other local service providers.
- Staff morale and palliative care knowledge was significantly increased across the organisation.
- New policies and procedures were implemented to expand client uptake of advance health directives.

"The ELDAC Working Together program has expanded TPGAC's ability to sustain and grow our service offerings, staff knowledge and improved linkages and processes with other care providers. Continued collaboration, sharing of resources, expertise, knowledge and experiences will benefit us, our clients and their families to achieve their goals at the end-of-life."

Patricia Tassell – Director TPG Aged Care

Rathgar Lodge

Residential Aged Care

Ulmarra,
New South Wales

Linkage Strategies Used:

- Role Clarification
- Designated Linkage Workers
- Knowledge Exchange and Upskilling

Rathgar Lodge is situated in the town of Ulmarra near Grafton. Nestled on the banks of the Clarence River Rathgar Lodge provides several levels of care – from a purpose-built hostel, dementia specific 12 bed unit through to 4 self-care units. Residents have access to allied health services and a General Practitioner (GP) clinic on-site.

Undertaking the ELDAC Working Together program provided Rathgar Lodge with the opportunity to identify and over-come challenges associated with the rural location of the facility. Opportunity to further define palliative care roles and responsibilities with other local health care providers were also identified.

"Participation in the ELDAC Working Together program provided a framework to help identify how we can enhance the Rathgar Lodge's Palliative Care Strategy."

Service partner connectivity and role clarification in a resource constrained regional environment has improved the provision of palliative care services. Discovering these services has provided better links for Rathgar to implement best practice palliative care arrangements.

Benefits

- Improved communication pathways between all services including role clarification and responsibilities within the local and regional sector.
- Enhanced education and training opportunities for staff.
- Improved continuity of care.

"a great way to *educate staff, residents and families"*

The ELDAC Working Together program has been instrumental in improving our processes around end-of-life care, specifically around planning care needs and providing education for carers and Registered Nurses. We have been able to recognise and establish a network with other area service providers to facilitate better communication, support and resources for residents, their families, and staff.

We have established role clarification and responsibilities with local palliative care services and supporting General Practitioners (GPs). Discovering these services has provided an opportunity and linkages to provisions that has helped Rathgar implement best practice for end-of-life.

The ELDAC Working Together program has additionally provided access to current resources and educational pathways to educate staff, residents, and families on the 8 domains of the ELDAC care model. Education has been and continues to be provided to key stakeholders.

At Rathgar Lodge we will continue to develop, with the plan to implement, an updated end-of-life pathway as a tool to provide a comprehensive plan of care, with consideration to all potential symptoms and ways to meet residents needs during the final stage of life; including, establishing better bereavement support for residents' families and carers.

Sara Diab, Registered Nurse

CatholicCare Wollongong

Home Care

Illawarra,
New South Wales

Linkage Strategies Used:

- Role Clarification
- Written and Verbal Communication Pathways
- Formalised Agreements and Plans
- Knowledge Exchange and Upskilling
- Continuous Quality Improvement

CatholicCare Wollongong provides in-home and community-based support for aged residents in the Illawarra region. The organisation helps people live independently in their own homes and communities for as long as possible. Clients come from diverse cultural backgrounds and access in-home and community-based services ranging from domestic assistance, and nursing and respite care, through to regular monitoring and reviews.

The organisation had limited relationships with palliative care services in the region and this made it difficult to deliver integrated care for clients in their own homes. There was no partnership with the local Palliative Care Clinical Nurse Consultant or palliative specialists, and no team members were allocated to develop these relationships. As a result, local hospital and medical staff may not have understood fully the role CatholicCare Wollongong could play during the palliative process and this made it difficult for team members to advocate for their clients.

Additionally, staff were keen to build their skills with training and resources to strengthen palliative care and undertake advance care planning. With new skills and resources they realised staff could be more confident and equipped, initiating conversations and planning end-of-life care with clients and their families in a home setting.

The ELDAC Working Together program provided CatholicCare Wollongong with a new approach along with the tools, training and support to transform its palliative care and improve continuity of care for its clients.

The ELDAC facilitator helped the organisation connect with other providers in the sector and develop mutually-beneficial relationships. This led to improved end-of-life care for clients and provided staff with access to expert advice and referral pathways. A Registered Nurse was also allocated to link with external palliative care specialists and further develop collaborative care pathways.

"ELDAC has significantly increased staff awareness about palliative care and encouraged a strong focus on building quality improvement processes into our systems."

Team members received training in advance care planning and learned how to approach these conversations with clients. Access to resources and tools also enhanced the organisation's capacity to manage palliative care and provide client support.

Benefits

- Upskilling has increased the confidence and competence of team members.
- Opportunities are available for direct care staff to specialise in palliative support.
- Improved focus for the wishes of palliating clients.
- Development of inhouse resources.
- Strong linkages have been developed with the specialist palliative care team and this has resulted in a more integrated care approach.
- Care workers can more easily recognise signs of deterioration and use referral pathways to gain early support.

"Our ELDAC facilitator was accessible and committed to our success – assisting with providing resources, making the links in our area with the specialist palliative care providers, negotiating for their support of our work and keeping us focused on the aims of a better approach to palliative care for older people within specified timeframes."

The Power of Love – George

Sylvia, a CatholicCare Community Support Worker, was one of George and Suzi's primary workers. She was fluent in Serbian and provided their only communication channel because English wasn't their first language.

George's initial aged care assessment stated he was suffering from malnutrition and fatigue. Staff noticed he and his wife were living off very basic foods with nothing substantial such as meat or vegetables. Suzi was also experiencing early signs of dementia. We started cooking with them and reintroduced meat and green vegetables.

Suzi was eventually placed in a dementia care facility. George was suffering from Myselodysplasia. Without Suzi, George was not himself. He was constantly overwhelmed with tears and loneliness from being separated from her. He visited Suzi once or twice a week. When George's health began to deteriorate, he was placed into palliative care and was no longer well enough to see Suzi. Both George and Suzi had been placed in alternative permanent caring arrangements and no longer required in-home assistance from CatholicCare. However, George had one last wish - he wanted to see Suzi.

CatholicCare's Aged Care Team were determined to fulfil George's dying wish to see his beloved Suzi for the last time.

George could receive a gate pass from palliative care if he was accompanied by a nurse. CatholicCare's Registered Nurses Charmaine and Sylvia, and Case Manager Deb accompanied George in a special taxi organised to accommodate George's wheelchair, on his final journey to see Suzi.

"When I told Suzi we were here to see her, she came over to George and remembered him," said Sylvia.

"They were just staring at each other and Suzi was picking some fluff off his top. It was as if he was drinking her in…inhaling her…especially their last kiss. He was just totally inhaling her feel and everything about her. He was home," said Deb.

George died peacefully not long after the visit. It was a stark reminder of the importance of others knowing your wishes, the fragility of life and the power of love.

The tools, resources and skills gained through the ELDAC Working Together program helped staff to identify points of deterioration throughout George's end-of-life journey. Conversations with him about advance care planning were also able to facilitate CatholicCare's support for the implementation of his wishes. This led to positive outcomes for George in his last days including visiting his wife in residential care.

*(This story was shared with George's permission, told by Case Manager Debra Carryer Kemp.)

Kate Nolan, Executive Manager, Aged and Disability Services

Uniting AgeWell – Kings Meadows Community, Aldersgate

Residential Aged Care

Launceston, Tasmania

Linkage Strategies Used:

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

Kings Meadows Community, Aldersgate is a residential aged care facility owned and operated by not for profit organisation Uniting AgeWell. With 107 staff, Aldersgate provides an environment of choice, empowerment and wellness where residents are able to access support and care as they choose – including palliative and end-of-life care.

With skilled staff in high demand, accessing and retaining a workforce that has best practice palliative and end-of-life skills, ready access to evidence based resources for these staff as well as maintaining regular contact with and between local palliative care networks has been a challenge for Uniting AgeWell.

The ELDAC Working Together program has helped foster stronger local network, referral and specialist palliative care agency connections, empowered staff through best practice education and resource access and, improved staff skills, knowledge and confidence in palliative care.

Internally, improved rigour in the multi-disciplinary communication, review and care planning has provided a more comprehensive integrated planning and delivery for residents. Stronger external linkages to local networks, referrers and specialist palliative care agencies are also a direct outcome of being involved in the program.

Staff engagement in service of palliative care also increased as they identified they wanted to build on their current knowledge and skills to further support and improve meaningful palliative care service delivery for residents and their families. In conjunction with Palliative Care Tasmania, Uniting AgeWell's Palliative Care Specialist and pharmacy consultants developed a twelve-week learning program. The program included sessions on communication, grief and loss, clinical care and purposeful connections. Staff reported they loved the education program and resources provided highlighting the training increased their knowledge and improved their understanding of the resident journey, care needs and the importance of good communication, sensory elements and the environment itself.

Reconnecting the local network of palliative care agencies and providers re-established and strengthened links. These network links also helped to facilitate resource and knowledge transfer from those with current expertise and best practice in palliative care with a focus on creating a positive interface between acute and aged care services.

"Connecting in a more deliberate, stronger way with our stakeholders – particularly palliative care specialists – has resulted in new opportunities for developing our program and upskilling our staff. Access to support resources has provided staff with the confidence to develop our systems and communication pathways."

Benefits

- Established and strengthened local network, referral and specialist palliative care agency network connections.
- Provided a comprehensive, best practice platform to educate and empower staff including both an ongoing education and orientation programs.
- Improved rigour in multidisciplinary communication, review and care planning with weekly meetings.
- Provided access to resources that has improved staff skills, knowledge and confidence in palliative care including the development of health professional and staff resources to support care planning.

"The family spoke of the amazing care and support staff provided, describing the end as 'a beautiful ending to a good life and good memories for the family'."

Following our participation in the ELDAC Working Together program, staff have felt empowered and better able to anticipate changes in residents as well as, plan and communicate with residents and their loved ones.

This change has enabled an environment which is individual, comforting, and peaceful for the resident during their end-of-life journey while providing comfort to their loved ones.

Suezanne Horder, Residential Services Manager, North Tasmania

Uniting AgeWell – Home Care South Tasmania

Home Care

Tasmania

Linkage Strategies Used:

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

Uniting AgeWell's home care service delivers aged care and support to clients living in Southern Tasmania. These services are designed to offer continuity of care and peace of mind, and support people to experience a sense of wellbeing, choice and independence at every age and stage of their life. The organisation's home care clients are predominantly females living alone in rural settings.

The home care service was experiencing difficulties due to inconsistent palliative care approaches and limited access to support networks. Specific challenges included a lack of forward planning and clinical pathways, inconsistent advance care directives and limited access to General Practitioners and specialist palliative care services. After death and palliative care audits were also needed to identify opportunities for improvements, and the organisation wanted to incorporate bereavement and counselling for families into care pathways.

"Following the ELDAC workbook pathways and building a foundation in understanding our gaps through the ELDAC tools was invaluable. It created an understanding of our gaps and a recognition of how to build a pathway and implement the actions needed to introduce real and sustainable change across the teams and into the organisation for the future."

The ELDAC Working Together program enabled the Home Care Team to review their current practices, partnerships and understanding of the palliative elements in their service provision. The partnership gap analysis and staff survey encouraged staff to consider a culture change by highlighting the positive outcomes of a multidisciplinary approach to palliative care.

Additional training and upskilling also helped staff gain confidence and develop a more comprehensive understanding of the palliative care process.

Benefits

- Upskilling of staff.
- Improved anticipatory care and care planning for early interventions.
- Strengthened General Practitioner engagement and palliative care partnerships.
- Updated policies and procedures to support palliative care delivery.
- Improvements in clinical governance.

Through the support of the Working Together program provided by ELDAC we established a program that would support direct care workers and build a stronger palliative care culture and awareness within the organisation. This, in turn, would further support clients and their families.

All staff were engaged in the education process.

"I have learned how to adequately approach the situation when working with someone in palliative care and what to expect" and "understanding how 'loss of control' can affect a person's behaviour, shows it is important for a person to be involved in planning their goals and wishes for end-of-life."

Following consultation with our ELDAC facilitator we have taken a bottom-up approach to ensure we deliver palliative care differently and engage in a partnership framework. The culture of delivering services within a palliative approach has had a marked turnaround. Staff are engaged in the conversations and in the multidisciplinary nature of delivering services with a palliative approach. We have now been recognised by the wider organisation for what we have achieved in the delivery of a culture shift regarding palliation. The Victorian and Northern Tasmania Home Care Teams are exploring how to follow our lead and deliver a palliative approach in their teams.

We aim to use the ELDAC tools and build a future partnership model as we move forward. In doing so, we will be building on our learnings and providing a platform for sustainability. We have leveraged the training given to direct care workers and created a cultural change that is supported by senior management. It is an amazing outcome for the team in Southern Tasmania and for the wider organisation, to adopt a new approach and culture in delivering palliative services in a home care setting.

Fiona Onslow-Agnew, Regional Manager

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ELDAC

End of Life Directions for Aged Care

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