Guiding Lights: Expert Perspectives on Palliative Care and End-of-Life Support

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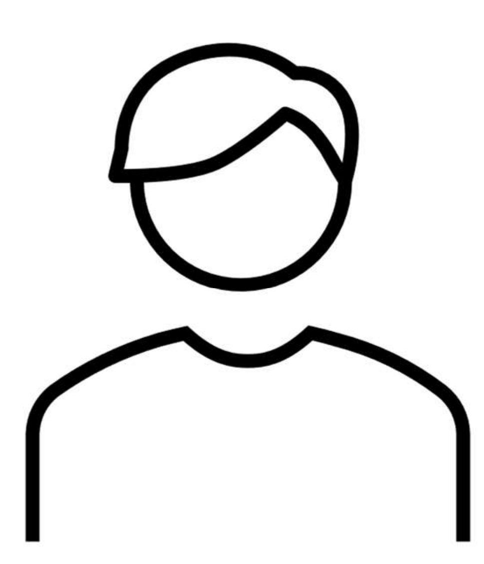
ELDAC is funded by the Australian Government Department of Health and Aged Care

Joseph

- Joseph is an 79 year old man living at home with his 75 year old wife and is receiving a home care package
- He worked hard running his own car mechanic shop after coming to Australia in experiencing difficult times due to war.
- He takes pride in his garden and wants to share time with his grandchildren
- He has been unwell for some time and has had 4 hospital admissions in the last 18 months with exacerbations of his chronic obstructive pulmonary disease. On one occasion he needed respiratory support with BiPAP but made a good recovery. He has been a long term diabetic.
- He more recently has been diagnosed with prostate cancer and has widespread bone metastases
- He has two daughters who live some distance away who provide support.
- His wife has severe rheumatoid arthritis which affects her mobility and has been suffering with some cognitive issues, but is yet to have a formal diagnosis



Knowing Joseph as a **person**

Communicating with Joseph and his family

Planning ahead

Assessment and re-assessment - and asking 'Why'

Building a team

Delivering care - symptoms, maintaining function, responding to deterioration and dying

Common barriers to effective communication

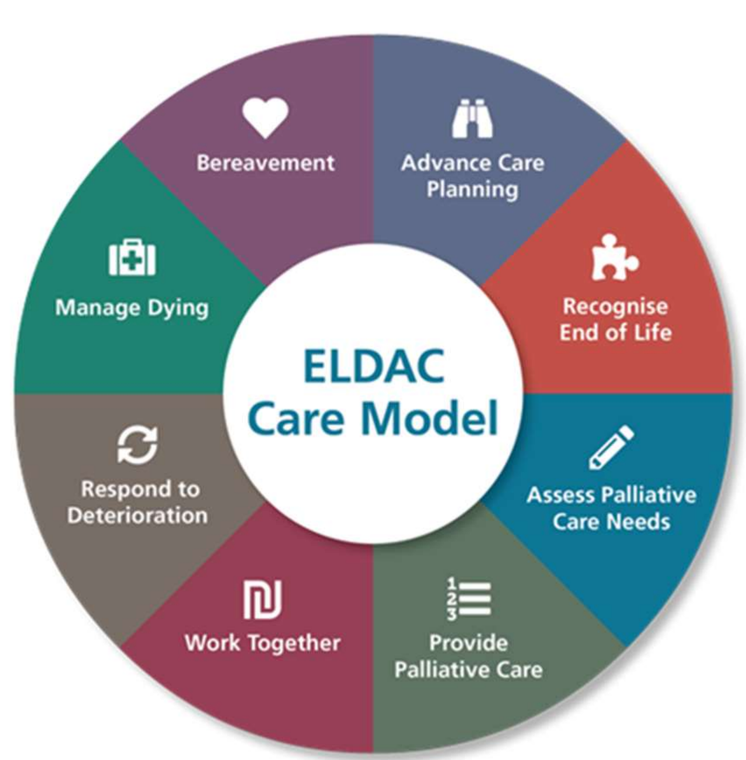
- Feeling you are responsible for maintaining the person’s hope
- Ignoring your own feelings
- Making assumptions about what the person does and doesn’t know
- Assuming that cure or longer life is the goal of all people
- Talking too much
- Focusing on your agenda

Clayton MJA 2007

Build a toolkit of questions to elicit values when initiating conversations about palliative care ‘Conversation starters’

- What do you enjoy doing now?
- What is life like since you left hospital?
- What is important to you right now?
- What is the hardest part of this for you and your family?
- What do you think about the future, and what concerns you most?
- What are your goals at this time?
- Who would you like me to talk to if you were unable to talk to me about important medical treatment decisions?

Back 2005, Advance Care Planning.org.au



- The ELDAC Care Model outlines eight care domains that should be considered.
- Identifies that care needs will change over time.
- Each domain has information and quick links to tools and resources

ELDAC Toolkits

www.eldac.com.au

ELDAC Toolkits

ELDAC toolkits help you in providing palliative care and advance care planning to older Australians.

Toolkits are a collection of information, resources and tools around a particular topic or practice area. They provide users with meaningful and practical materials to care for older Australians at end of life. They can help users to develop a plan and organise their efforts to follow evidence-based recommendations or practices.

Primary Care

Evidence-based resource for people working in primary care

Primary Care Toolkit

Home Care

Information to support clients and families

Home Care Toolkit

Residential Aged Care

Information to support residents and families

Residential Aged Care Toolkit

End of Life Law

The law at end of life for the aged care sector

End of Life Law Toolkit

Linkages

Linkages between aged, primary and palliative care services

Linkages Toolkit

Dementia

Information to support people with dementia and their families

Dementia Toolkit

Allied Health

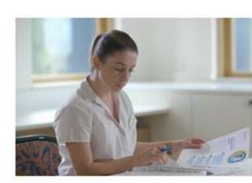
Practical resources and information to support allied health professionals

Allied Health Toolkit

Managing Risk

COMING SOON

Coming Soon



Toolkit Educational Videos

Improve your skills in end of life care by learning from palliative care experts and clinicians

Watch Toolkits Videos

Focused Toolkits – Care Settings

- Primary Care
  - Clinical Action
  - Team Action
  - Health Pathways
- Residential Aged Care and Home Care
  - Clinical Care
  - Education and Learning
  - Organisational Support

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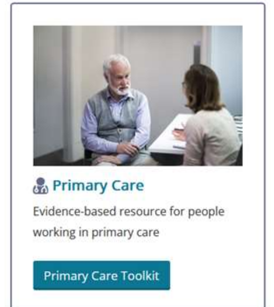
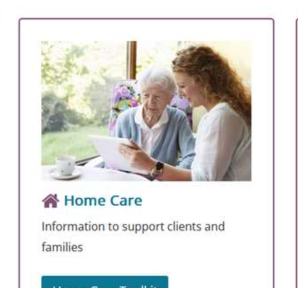




Peter, a war veteran is widowed with no family locally. Living with

Advanced Dementia and is bedbound with minimal oral intake

Savitri is an Indian lady who has heart failure and also significant arthritis. She has a large family and her son is the main decision-maker

Betty is a proud Wiradjuri women and has had a series of strokes over the past few years. She fractured her hip last year and needed surgery.

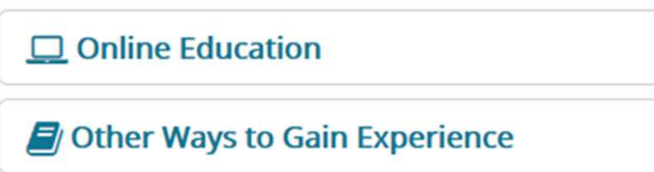
Maria is a Greek lady who has severe Parkinson's disease. Her family has noticed more recently significant changes in her cognition. She also has had breast cancer.

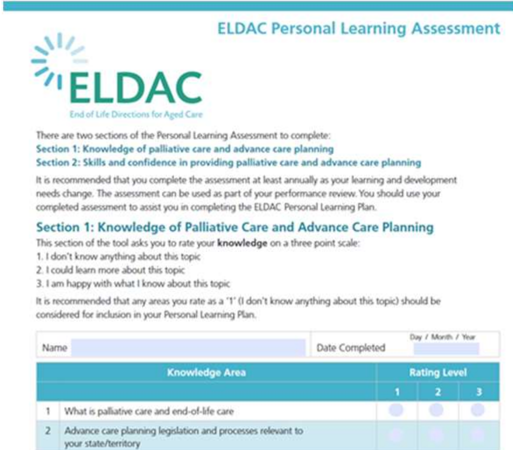
Tuan is a Vietnamese man who has end stage liver disease due to hepatitis C. He also has chronic respiratory disease and has had a recent admission to hospital with pneumonia

Reflections

- Building shared language through assessment
  - ‘BEING HEARD’ care staff can communicate concerns to EENs and RNs who can communicate to GP, allied health or specialist staff
- ‘Learning on the run’
  - Find teachable moments on the floor
  - Short moments around the care of a client builds experience and confidence
  - Garner stories from staff to inform training
- Systems to effectively point resources to those at most need and learn from collective resident/client experience
  - Data, ‘red flags’, timepoints for re-assessment, visibility through digital dashboard, audits

Education and training





ELDAC Personal Learning Assessment

ELDAC
End of Life Directions for Aged Care

There are two sections of the Personal Learning Assessment to complete:

Section 1: Knowledge of palliative care and advance care planning

Section 2: Skills and confidence in providing palliative care and advance care planning

It is recommended that you complete the assessment at least annually as your learning and development needs change. The assessment can be used as part of your performance review. You should use your completed assessment to assist you in completing the ELDAC Personal Learning Plan.

Section 1: Knowledge of Palliative Care and Advance Care Planning

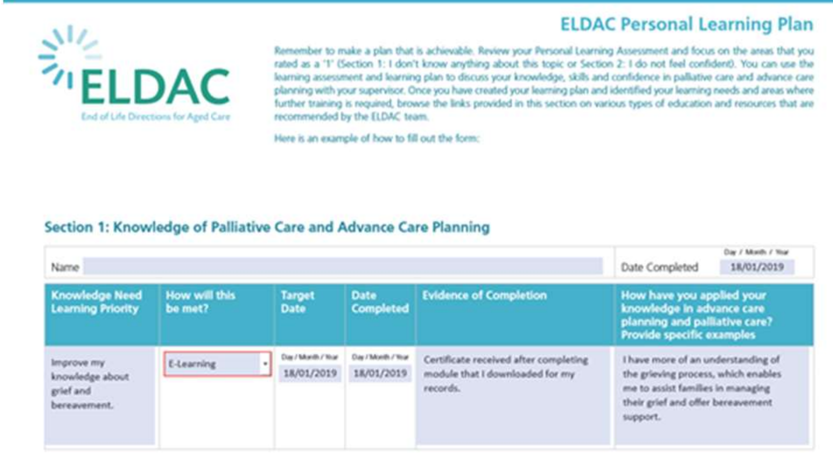
This section of the tool asks you to rate your **knowledge** on a three point scale:

1. I don't know anything about this topic
2. I could learn more about this topic
3. I am happy with what I know about this topic

It is recommended that any areas you rate as a '1' (I don't know anything about this topic) should be considered for inclusion in your Personal Learning Plan.

Name | Date Completed (Day / Month / Year)

	Knowledge Area	Rating Level		
		1	2	3
1	What is palliative care and end-of-life care			
2	Advance care planning legislation and processes relevant to your state/territory			



ELDAC Personal Learning Plan

ELDAC
End of Life Directions for Aged Care

Remember to make a plan that is achievable. Review your Personal Learning Assessment and focus on the areas that you rated as a '1' (Section 1: I don't know anything about this topic or Section 2: I do not feel confident). You can use the learning assessment and learning plan to discuss your knowledge, skills and confidence in palliative care and advance care planning with your supervisor. Once you have created your learning plan and identified your learning needs and areas where further training is required, browse the links provided in this section on various types of education and resources that are recommended by the ELDAC team.

Here is an example of how to fill out the form:

Section 1: Knowledge of Palliative Care and Advance Care Planning

Name | Date Completed (Day / Month / Year) 18/01/2019

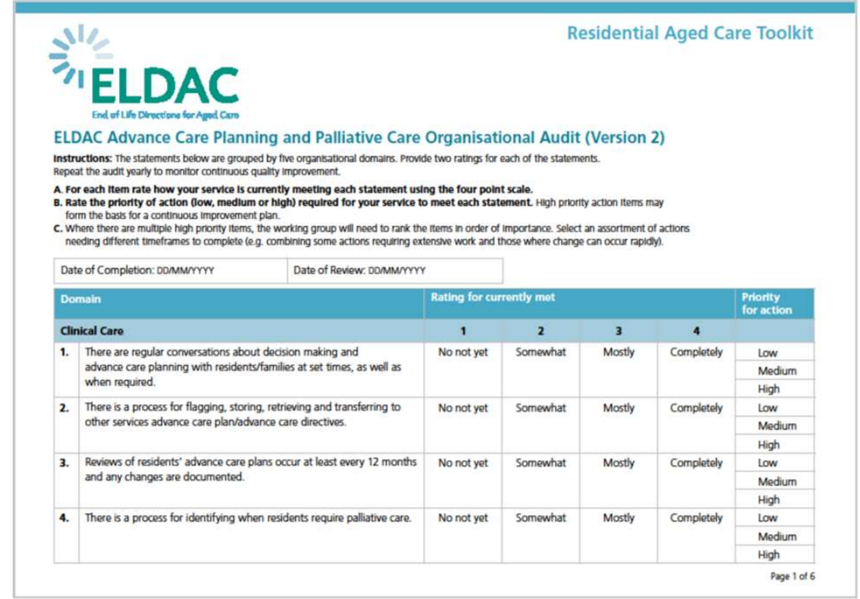
Knowledge Need Learning Priority	How will this be met?	Target Date	Date Completed	Evidence of Completion	How have you applied your knowledge in advance care planning and palliative care? Provide specific examples
Improve my knowledge about grief and bereavement.	E-Learning	Day / Month / Year 18/01/2019	Day / Month / Year 18/01/2019	Certificate received after completing module that I downloaded for my records.	I have more of an understanding of the grieving process, which enables me to assist families in managing their grief and offer bereavement support.

Residential Aged Care Toolkit - Organisational Support

Quality Improvement

Standards and Funding

Working Together



Residential Aged Care Toolkit

ELDAC
End of Life Directions for Aged Care

ELDAC Advance Care Planning and Palliative Care Organisational Audit (Version 2)

Instructions: The statements below are grouped by five organisational domains. Provide two ratings for each of the statements.
Repeat the audit yearly to monitor continuous quality improvement.

A. **For each item rate how your service is currently meeting each statement using the four point scale.**
B. **Rate the priority of action (low, medium or high) required for your service to meet each statement.** High priority action items may form the basis for a continuous improvement plan.
C. Where there are multiple high priority items, the working group will need to rank the items in order of importance. Select an assortment of actions needing different timeframes to complete (e.g. combining some actions requiring extensive work and those where change can occur rapidly).

Date of Completion: DD/MM/YYYY	Date of Review: DD/MM/YYYY

	Domain	Rating for currently met				Priority for action
	Clinical Care	1	2	3	4	
1.	There are regular conversations about decision making and advance care planning with residents/families at set times, as well as when required.	No not yet	Somewhat	Mostly	Completely	Low Medium High
2.	There is a process for flagging, storing, retrieving and transferring to other services advance care plan/advance care directives.	No not yet	Somewhat	Mostly	Completely	Low Medium High
3.	Reviews of residents' advance care plans occur at least every 12 months and any changes are documented.	No not yet	Somewhat	Mostly	Completely	Low Medium High
4.	There is a process for identifying when residents require palliative care.	No not yet	Somewhat	Mostly	Completely	Low Medium High

Page 1 of 6

Linkages program

- Supports services to navigate resources and build partnerships using evidence based strategies
  - PLAN: Identifying and preparing
  - Do: Implementing
  - Check: Assessing and revising
  - Act: Sustaining

What is the ELDAC Digital Dashboard?

The ELDAC Digital Dashboard (the dashboard) is a system application designed to provide you a comprehensive framework for palliative and End of Life [EOL] care planning and provisioning. The dashboard is based on the ELDAC Care model, and it can be integrated into clinical care systems of aged care services.

The Dashboard helps

Clinical staff: Prompt & prioritise care, reduce gaps in documentation.

Managers: Track performance and carry out audits/self-assessment.

Organisation: Report service level EOL care.

The Dashboard tracks the following key elements of EOL care

Element	Tracked
Advance Care Planning	• Residents with/without an ACP document. • ACP review date. • Substitute decision maker review date.
Recognise End of Life	• Residents assessed/not-assessed as being in their EOL stage.
Assess Palliative Care Needs	• Residents across different stages of their decline trajectory.
Provide Palliative Care	• Residents with/without a palliative care plan.
Work Together	• Residents receiving some form of expert palliative care input. • Family conference and review dates.
Respond to Deterioration	• Hospitalization trend and reasons.
Manage Dying	• Residents on EOL care pathway or plan.
Bereavement	• Residents or families provided with some form of bereavement or grief support.
Death related data	• Place of death, resident's stage classification on the day of their death.

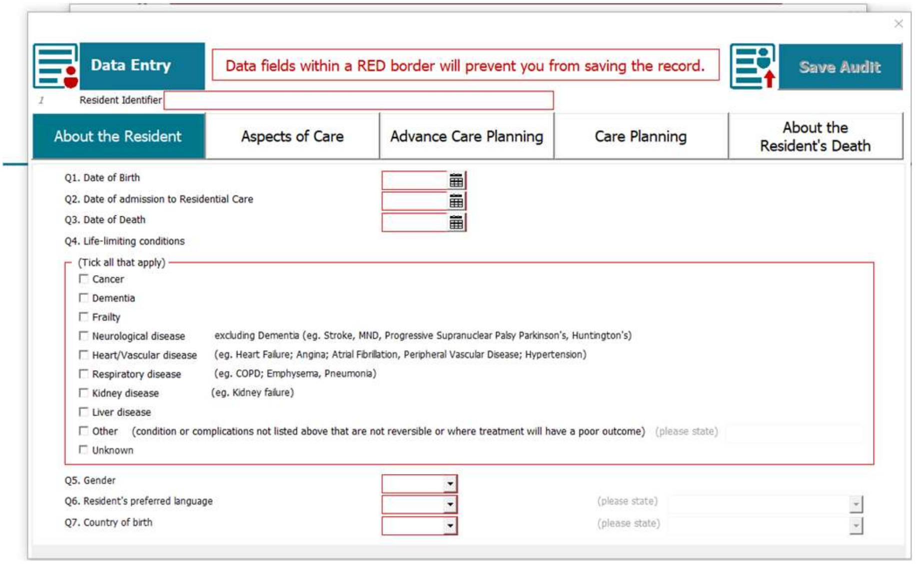
ELDAC is funded by the Australian Government Department of Health

After Death Audit - Analytics
Residential Aged Care
ADA - Analytics is compatible with ELDAC After Death Audit V2 RAC PDF

Advance Care Planning and Palliative Care Organisational Audit V2 - Analytics
Residential Aged Care

Main Menu

Audits | Analytics | Data


Data Entry

Data fields within a RED border will prevent you from saving the record.

Save Audit

Resident Identifier

About the Resident | Aspects of Care | Advance Care Planning | Care Planning | About the Resident's Death

Q1. Date of Birth
Q2. Date of admission to Residential Care
Q3. Date of Death
Q4. Life-limiting conditions

(Tick all that apply)
- Cancer
- Dementia
- Frailty
- Neurological disease excluding Dementia (eg. Stroke, MND, Progressive Supranuclear Palsy Parkinson's, Huntington's)
- Heart/Vascular disease (eg. Heart Failure; Angina; Atrial Fibrillation, Peripheral Vascular Disease; Hypertension)
- Respiratory disease (eg. COPD; Emphysema, Pneumonia)
- Kidney disease (eg. Kidney failure)
- Liver disease
- Other (condition or complications not listed above that are not reversible or where treatment will have a poor outcome) (please state)
- Unknown

Q5. Gender
Q6. Resident's preferred language (please state)
Q7. Country of birth (please state)

Audit 7 Date

Date & all ratings must be completed to save the record

Save Audit

Clinical Q1-8	Clinical Q9-16	Education & Workforce Development Q17-23	Policies & Procedures Q24-27	Information Systems Q28-30	Continuous Improvement Q31-35

Domain	Rating for currently met 1	2	3	4	Priority for action
Clinical Care					
1. There are regular conversations about decision making and advance care planning with residents/families at set times, as well as when required.	No not yet	Somewhat	Mostly	Completely	Low / Medium / High
2. There is a process for flagging, storing, retrieving and transferring to other services advance care plan/advance care directives.	No not yet	Somewhat	Mostly	Completely	Low / Medium / High
3. Reviews of residents' advance care plans occur at least every 12 months and any changes are documented.	No not yet	Somewhat	Mostly	Completely	Low / Medium / High
4. There is a process for identifying when residents require palliative care.	No not yet	Somewhat	Mostly	Completely	Low / Medium / High
5. Tools are available to staff for assessing common symptoms in palliative care.	No not yet	Somewhat	Mostly	Completely	Low / Medium / High
6. There is a process for conducting family meetings/case conferences about palliative and/or end of life care.	No not yet	Somewhat	Mostly	Completely	Low / Medium / High
7. Care plans have capacity to include the palliative care needs of residents/families.	No not yet	Somewhat	Mostly	Completely	Low / Medium / High
8. There is a process for conducting multidisciplinary team case conferences for people requiring palliative and/or end of life care.	No not yet	Somewhat	Mostly	Completely	Low / Medium / High