

Residential Aged Care Newsletter

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We did it!!!!

After a year of consultation, collaboration, consideration and review of other relevant projects and resources, we have drafted a framework for a model to support Residential Aged Care Facilities across the Southern Region in a Palliative Approach to Care. Initially the Aged Care project was funded by the Southern Metropolitan Region Palliative Care Consortium to develop a more consistent and co-ordinated approach to supporting Aged Care Facilities in a Palliative Approach to Care. The roll out and continuation of the project is now supported by the Victorian Department of Health with specific funding for Aged Care allocated to all the Consortia. This highlights the increased recognition by Government bodies and stakeholders of the role of Aged Care Facilities in caring for residents and families in the last chapter of a person's life.

The Principles that underpin the Model

- Not **implementing for ACF's** but **supporting** ACF's to 'build capacity'
- Understanding the unique needs and environment of ACF's
- Ensuring co-ordinated, consistent and sustainable activities to support a palliative approach
- Articulating the role of Specialist Palliative Care Services in supporting Aged Care Facilities
- Engagement and involvement of ACF's and all key stakeholders in project directions and activities

And the Model is?.....

Centred around the concept of Link Nurses/Portfolio holders in Aged Care Facilities.

Education is key to maximising resident outcomes. A comprehensive palliative care education program offered to a maximum of 2 staff per ACF with a passion for palliative care and the ability to influence change provides an ongoing resource within the Aged Care Facility and a conduit for communication, internally and externally. A network of Link Nurses across the region with ongoing support from the Specialist Palliative Care Providers promotes sustainability of the model. Alongside, other activities are planned to support education of staff and support for residents and families in a palliative approach. Cross training/education is an important element to ensure that there is understanding of the needs of different environments.

Vital to the success of this programme is the awareness, involvement and support of Senior Management of ACF's.

Note: Initially there will be a 'cap' on the number of participating facilities in each sub-region but the program will be ongoing

The ROSS team and Peninsula Hospice Service have been running a similar programme over the past year. The Consortium will be working closely with those teams to ensure consistency across the Peninsula area.

Over the next few weeks.....

We will invite expressions of interest from Aged Care Facilities
Further information will be shared with interested parties

Your comments are warmly welcomed. There will be further opportunity for input when further details are drafted.
Please do not hesitate to ring for further information

Robyn Allan
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Accessing the Guidelines

The Guidelines along with Education and Training Resources can be downloaded through the Palliative Care Australia website:

Aged Care/Aged Care Resources
www.palliativecare.org.au/Default.aspx?tabid=2117

Recent developments acknowledging ACF's role in a Palliative Approach

- The Productivity Commission's final report into *Caring for Older Australians* argues that palliative care should be the core business of aged care (August 2011)
- The Victorian Government's, 'Strengthening palliative care: Policy and strategic directions 2011-2015' Strategic Direction (3): Working together to ensure people die in their place of choice prioritizes the importance of strengthening links between Specialist Palliative Care Services and Aged Care Services and implementing processes that support better resident outcomes for end of life care such as Advance Care Plans and End of Life Pathways.
- The 'draft' Aged Care Standards (March 2011) require more demonstrated outcomes that a palliative approach to care is delivered, including meeting the needs of residents through advance care planning