# 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***