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