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