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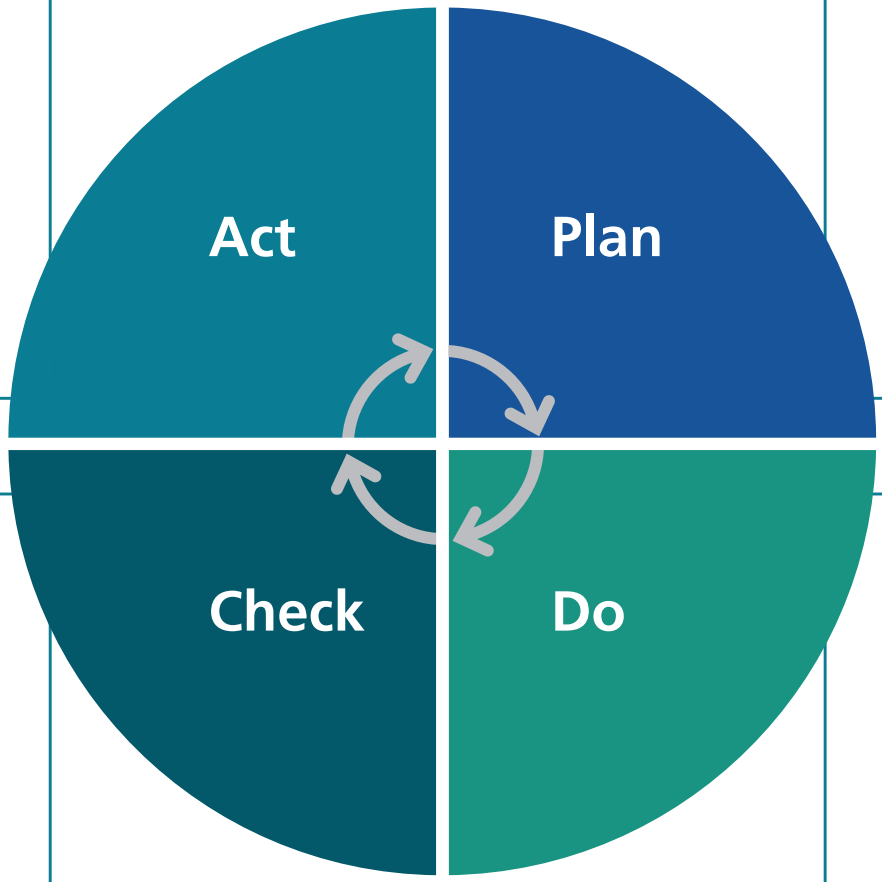
Sustaining

- Embed and maintain
- Spread improvement
- Increase impact

Identifying and Preparing

- Identify areas for improvement
- Would partners assist?
- Identify potential partners
- Agree to partner
- Develop a plan



Adapted from: KPMG International, 2015

Assessing and Revising

- Monitor and report
- Generate solutions
- Review the partnership
- Review your outcomes
- Check and repeat

Implementing

- Mobilise your partners
- Mobilise your people
- Implement plans
- Key Service Partnering Activities
- Utilise Linkage Strategies
- Utilise ELDAC toolkits

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SWOT Template

Internal Factors	
Strengths	**Weakness**
What is **working well** in the delivery of palliative care and advance care planning for older people in your care?	**What could be improved** in the delivery of palliative care and advance care planning for older people in your care?

External Factors	
Opportunities	**Threats**
What can you do to **overcome weaknesses and build on strengths** to deliver the best possible palliative care and advance care planning for older people in your care?	What are the **challenges and constraints** that may arise when implementing the range of opportunities to deliver the best possible palliative care and advance care planning for older people in your care?

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ELDAC – Linkages: Service Mapping Template

This template is to help you undertake a service mapping exercise in your area. It is a guide only and you may adapt it to suit your context and needs.

A Service Mapping exercise can assist you in:

- identifying demographic groups in your area and what providers and services you already have key connections with
- increasing your knowledge of other referral and treatment options
- identifying the contributions that various service providers make to providing palliative care and advance care planning
- helping to identify any gaps in existing services and barriers to access, helping you to identify opportunities for working together with specialist palliative care services, health and primary care providers.

Demographics of your service area:

What am I looking for?	How do I find the information?	Information available:	Other information/comments:
What is the total population in the area?	Primary Health Network (PHN), Local Health Service, Local Government		
What is the **aged** population in the area? (Defined as over 65yrs or for Aboriginal and Torres Strait Islanders over 50yrs)	PHN, Local Health Service, Local Government		
What is the **gender split of the aged** population?	PHN, Local Health Service, Local Government		

Demographics of your service area:

What am I looking for?	How do I find the information?	Information available:	Other information/comments:
What percentage of the **aged** population comprise the following: - Aboriginal and Torres Strait Islander peoples	PHN, Local Health Service, Local Government		
- People from Culturally and Linguistically Diverse (CALD) backgrounds			
- Rural, remote or very remote areas			
- Financially or socially disadvantaged			
- Veterans			
- Homeless, or at risk of becoming homeless			
- Lesbian, gay, bisexual, transgender, gender diverse, intersex and queer and questioning (LGBTIQ+) people			
What are the predominant religious groups?	PHN, Local Health Service, Local Government		

Information about your service:

Details:	Please provide relevant information:
Who are your aged care recipients? - Number - Age range (youngest/oldest) - Acuity (Levels in community) - Target groups as listed previously: (Aboriginal and Torres Strait Islander, CALD, rural/remote/very remote, financially or socially disadvantaged, veterans, homeless, LGBTIQ+) - Religious groups	
Identify other care providers your organisation is in contact with through eg brokerage or partnerships etc.	
What other organisations are providing services to your clients? (eg combined care service provision?)	
List networking meetings / special interest groups that your service/facility attends:	

Health Services in your area:

Type of Service	Name, Location, services used	Who do you have contact/connection with and for what reasons? How does this contact/connection occur? Are there services that you currently don't access or have a contact/ connection with?	
Public Hospitals:			
Private Hospitals:			
GP practices: How many? Are there practices you have more to do with? Why?			
Allied Health: Physiotherapy, Occupational Health, Psychologist, Social Worker, Speech Pathology, Other			
Palliative Care Services/Providers: Inpatient units, community services, Hospice, Others			
Nurse Practitioners – Aged Care / Palliative Care / Other:			
Pharmacies:			
Primary Health Network (PHN):			

Service directories:

The following service directories can assist you to complete a comprehensive service mapping exercise:

- Find a health service or health professional **https://about.healthdirect.gov.au/nhsd** – including general practices, hospitals, pharmacies, allied health.
- Primary Health Networks (PHN) **http://www.health.gov.au/internet/main/publishing.nsf/Content/PHN-Contacts**
- Specialist Palliative Care Services **http://palliativecare.org.au/directory-of-services**

List references to information/documents sourced when completing service mapping:

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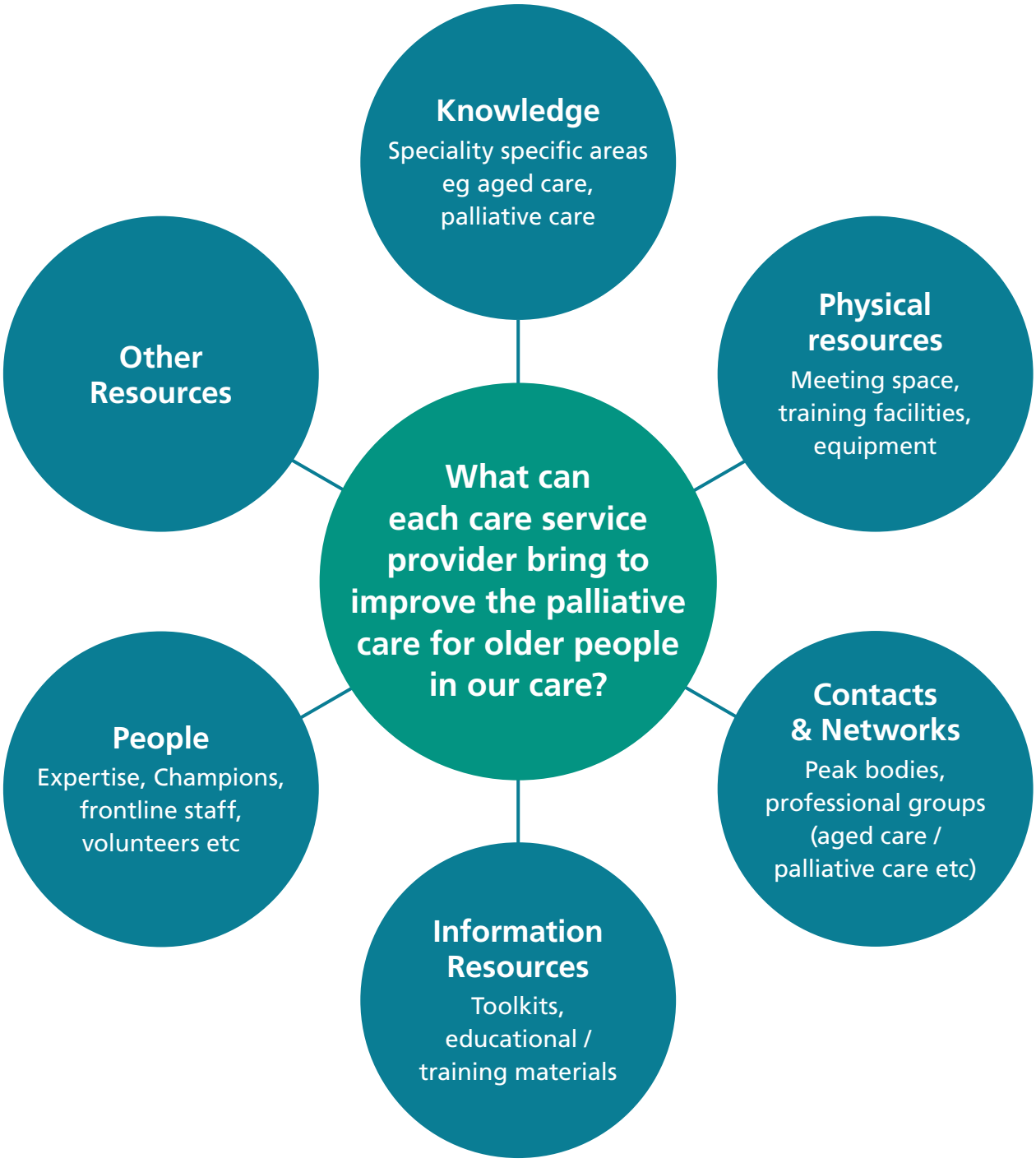
Resource Mapping



Adapted from: Tennyson, R. (2011). The Partnering Toolbook.
Retrieved from https://thepartneringinitiative.org/publications/toolbook-series/the-partnering-toolbook/

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Action Plan Template

Improvement	Activities / Actions	Resources, Person/s responsible	Start and completion dates	Related Residential / Home Care Standard Which standards does this relate to?	Evaluation strategy for your palliative care initiative How will you know your work has been effective?

Adapted from: Morey, W., Pavelic, S., Habel, L., Adams, V., Xiao, L., & Verbeeck, J. (2015). *Aged Care Clinical Mentor Model of Change: Six Steps to Better Practice*. Unley, South Australia: Resthaven Inc.

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Risk Plan Template

Risk #	What is the Risk?	Likelihood (High, Medium, Low)	Impact (High, Medium, Low)	Strategy to reduce risk/deal with realised risk
1.		Select One	Select One	
2.		Select One	Select One	
3.		Select One	Select One	
4.		Select One	Select One	
5.		Select One	Select One	

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Communication Plan Template

#	Audience	Key information Purpose of message	Communication channel (Email, newsletter, etc)	Frequency (One-time, weekly etc)	Date of communication (Ongoing, 1/1/11 etc)	Person/s responsible for developing communication	Person/s responsible for delivery
1.							
2.							
3.							
4.							

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Activity Report Template

Organisation:

Activity	Actions (report only on actions you are responsible for)	Timeframe	Expected achievements this reporting period	Actual achievements this reporting period

Please describe any deviations from the action plan? Reason for the deviation? Was governance approval obtained?

Please describe any improvement successes?

Are there any follow up actions required to sustain change as a result of this activity (e.g., changes to current policies and procedures)? If so please detail below.

Were there any implementation challenges during the reporting period? Were these resolved? And if so how?

Have you identified any further clinical issues as a result of conducting this activity?

Please attach all literature, learning materials, evaluation sheets and other related information to this activity report.

Adapted from: Morey, W., Pavelic, S., Habel, L., Adams, V., Xiao, L., & Verbeeck, J. (2015). *Aged Care Clinical Mentor Model of Change: Six Steps to Better Practice.* Unley, South Australia: Resthaven Inc.; Victorian Council of Social Service. *Guide 2: Commencing the Partnership.*

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Linkage Strategies: Audit for Aged Care Services

This audit has been developed to identify and prompt your use of linkage strategies in service partnering with specialist palliative care. Linkage strategies include: role clarification, written and verbal communication pathways, multidisciplinary team structures, formalised agreements and plans, a designated linkage worker, knowledge exchange and upskilling, and continuous quality improvement. Please answer every item to provide a clear picture on areas of linkage in place at present.

Role clarification

Item No:		Strongly Agree	Agree	Not sure	Disagree	Strongly Disagree	N/A
1.1	We have a clear understanding of our aged care service's role and responsibilities when working with specialist palliative care.	○	○	○	○	○	○
1.2	We have a clear understanding of the role and responsibilities of the specialist palliative care service.	○	○	○	○	○	○
1.3	We communicate with specialist palliative care services to clarify our respective roles and responsibilities.	○	○	○	○	○	○
1.4	We are satisfied with the specialist palliative care service's role and responsibilities when working with our age care service.	○	○	○	○	○	○

Comment on the factors that enable or constrain role clarity between your aged care service and specialist palliative care:

Formalised agreements and plans

Item No:		Strongly Agree	Agree	Not sure	Disagree	Strongly Disagree	N/A
2.1	We have formalised partnership arrangements with specialist palliative care services e.g. a partnering agreement, memorandum of understanding, or terms of reference.	◯	◯	◯	◯	◯	◯
2.2	The formalised agreement clarifies the purpose of the partnership.	◯	◯	◯	◯	◯	◯
2.3	We have adequate allocation of resources to sustain these arrangements.	◯	◯	◯	◯	◯	◯

Comment on the factors that enable or constrain formalised agreements and plans between your aged care service and specialist palliative care:

Written and verbal communication pathways

Item No:		Strongly Agree	Agree	Not sure	Disagree	Strongly Disagree	N/A
3.1	We have regular contact with local specialist palliative care services.	◯	◯	◯	◯	◯	◯
3.2	We have a clear referral process with specialist palliative care services.	◯	◯	◯	◯	◯	◯
3.3	We communicate effectively about palliative care and advance care planning with the specialist palliative care service.	◯	◯	◯	◯	◯	◯
3.4	We use technologies, such as zoom or skype, to communicate with specialist palliative care services.	◯	◯	◯	◯	◯	◯
3.5	We provide continuity of care between our aged care service and specialist palliative care.	◯	◯	◯	◯	◯	◯
3.6	Both our aged care service and specialist palliative care have easily accessible contact and process information concerning their partner organisation e.g, visiting protocols, chief contact.	◯	◯	◯	◯	◯	◯

Comment on the factors that enable or constrain communication pathways between your aged care service and specialist palliative care:

Designated linkage worker

Item No:		Strongly Agree	Agree	Not sure	Disagree	Strongly Disagree	N/A
4.1	We have a clear understanding of the role of the linkage worker between our aged care service and specialist palliative care.	◯	◯	◯	◯	◯	◯
4.2	Management actively supports and promotes the designated linkage worker role.	◯	◯	◯	◯	◯	◯
4.3	All staff are aware of the designated linkage worker and their role.	◯	◯	◯	◯	◯	◯
4.4	The designated linkage worker is appropriately resourced to carry out his/her role.	◯	◯	◯	◯	◯	◯

Comment on the factors that enable or constrain utilsing a designated linkage worker between your aged care service and specialist palliative care:

Continuous quality improvement

Item No:		Strongly Agree	Agree	Not sure	Disagree	Strongly Disagree	N/A
5.1	We routinely monitor the extent to which these linkage strategies are integrated into our aged care service.	◯	◯	◯	◯	◯	◯
5.2	We routinely monitor and evaluate our aged care service's capacity building interactions (e.g., mentoring, education) with specialist palliative care.	◯	◯	◯	◯	◯	◯
5.3	We routinely collect and report minimum data about specialist palliative care access for our clients/residents.	◯	◯	◯	◯	◯	◯
5.4	We routinely collect and report evaluation service data linking client/resident outcomes to specialist palliative care access.	◯	◯	◯	◯	◯	◯
5.5	All of our quality improvement activities are tied into the plan-do-check-act cycle.	◯	◯	◯	◯	◯	◯

Comment on the factors that enable or constrain continuous quality improvement activities relating to measuring the success of your aged care service partnership with specialist palliative care:

Multidisciplinary team structures

Item No:		Often	Some-times	Rarely	Never	N/A
6.1	We utilise shared care plans or documentation with specialist palliative care services.	◯	◯	◯	◯	◯
6.2	We work with specialist palliative care to provide advance care planning for our clients/residents.	◯	◯	◯	◯	◯
6.3	We undertake case conferencing with specialist palliative care services about client/resident care.	◯	◯	◯	◯	◯
6.4	We work with specialist palliative care on end of life care plans or pathways for our clients/residents.	◯	◯	◯	◯	◯
6.5	We have meetings with specialist palliative care services to create and maintain our partnership.	◯	◯	◯	◯	◯

Comment on the factors that enable or constrain multidisciplinary care between your aged care service and specialist palliative care:

Knowledge exchange and upskilling

Item No:		Often	Some-times	Rarely	Never	N/A
7.1	We participate in professional development activities focused on palliative care and/or advance care planning with specialist palliative care.	◯	◯	◯	◯	◯
7.2	Specialist palliative care provide mentoring opportunities for our staff.	◯	◯	◯	◯	◯
7.3	We use multidisciplinary team meetings with specialist palliative care to provide learning opportunities for our aged care service staff.	◯	◯	◯	◯	◯
7.4	We upskill specialist palliative care on our role and responsibilities as aged care providers, our client/resident target group, and our aged care service structure and practices.	◯	◯	◯	◯	◯

Comment on the factors that enable or constrain knowledge exchange and upskilling between your aged care service and specialist palliative care:

(Adapted from Decision Assist Organisational Audit: https://www.advancecareplanning.org.au/docs/default-source/da-resource-library/linkages-project/palliative-and-aged-care-linkages-manual_decisionassist_2018.pdf?sfvrsn=8)

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SBAR analysis template

Using the SBAR method will assist to accurately define the issues and the factors influencing your service's palliative care and advance care planning performance. It will support you in identifying solutions to improve your clinical care.

Situation • What concerns do you have currently about your provision of advance care planning and palliative care to your client/ resident? • What do you want to correct or improve?	**Your notes**
Background • What has led to this situation or issue?	**Your notes**

Assessment	**Your notes**
• What do you think the problem is? • Does it fit into a skills, communication, system, or clinical care delivery area?	
Requirement / Recommendation	**Your notes**
• What could you do to correct or improve the issue? • Who needs to be involved?	

Adapted from: FBA Joint Policy Committee. (2009). Let's Talk, A guide for collaborative structured communication. (p8).
https://www.health.gov.bc.ca/library/publications/year/2010/LPNGuide_collaborative_structured_communication.pdf

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Communication checklist

Think about the purpose (**why**) for communicating the improvements to palliative care and advance care planning for older people in your care, **how** the information needs to be shared and with **who**. It is important to consider how to share the information in the most appropriate way for the intended audience.

Purposes (Why)	Communication Channels (How)	Audiences – internal / external (Who)
☐ Engaging interest	☐ Face-to-face conversations	☐ Older people in your care (residents/clients/patients)
☐ Confirming agreements	☐ Meeting (internal, public)	☐ Aged care & palliative care organisations
☐ Recording commitments	☐ Presentations - conferences, seminars	☐ All Staff (at all levels) form care service providers involved in the partnering
☐ Record of meetings	☐ Workshops	☐ Government including policy makers, public health (Commonwealth, State & local)
☐ Information sharing	☐ Story-telling	☐ Aged care & palliative care community groups
☐ Care improvement descriptions	☐ Written minutes/notes	☐ Peak aged care & palliative care bodies
☐ Tracking progress	☐ Email	☐ Media / general public
☐ Capturing the story	☐ Phone calls	☐ Local community
	☐ Video/audio/photographs	☐ Other aged care/palliative care providers (including those who might join the partnership or who might develop their own partnership inspired by this one)
	☐ Site visits	
	☐ Print media	
	☐ Radio/TV	
	☐ Video/DVD	
	☐ Internet – aged care & palliative care websites, blogs, forums, newsletters	
	☐ Written case studies	
	☐ Newsletters	
	☐ Publications	
	☐ Formal reports	
	☐ Evaluation reports	

Tip: Communication responsibilities can be shared across partners to encourage project ownership and increase promotional opportunities.

For a sample Communication Plan, **click here**

Adapted from:
Tennyson, R. (2011). *The Partnering Toolbook*. 26/02/2018 https://thepartneringinitiative.org/publications/toolbook-series/the-partnering-toolbook/
Tennyson, R., Huq, N., & Pyres, J. *Partnering Step by Step*. Bangladesh: the partnering initiative. Accessed on 26/02/2018 from https://thepartneringinitiative.org/wp-content/uploads/2014/08/partneringstepbystep.pdf

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Report Template

Background

Objectives

Methods

Results

Discussion, conclusions and recommendations

Key messages

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Case Study Template

Introduction/Background

Objectives

Activities

People involved and their role

Achievements

Challenges

Lessons Learned

Looking ahead

Contact Details