



End of Life Directions for Aged Care

## ELDAC Linkages Program Case Stories



*Building capacity and capability in the provision of quality palliative care across aged care services for all older Australians.*

## Acknowledgement of Country

ELDAC acknowledges the Traditional Custodians of the many ancestral lands and waters throughout Australia. We recognise the knowledge, strength, and resilience of Aboriginal and Torres Strait Islander Peoples, and their continuing spiritual and cultural connections to land, water and community. ELDAC pays respect to Elders past, present and emerging.

**WARNING:** Aboriginal and Torres Strait Islander peoples are warned content and photographs within this publication may contain images or names of deceased persons.

## Disclaimer

This resource was produced by the ELDAC Linkages program (formerly known as the Working Together program), which sits within the ELDAC project. While every attempt has been made to ensure the accuracy of the information at time of printing, ELDAC disclaims any and all liability for any errors in or omissions from the information in this publication.

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# About ELDAC

*Palliative care is a national health priority. To enable the delivery of quality palliative care for all older Australians, the Australian Government Department of Health and Aged Care established the End of Life Directions for Aged Care (ELDAC) project in 2017. ELDAC provides aged care providers and older Australians with information, advice and practical support to enable access to high quality palliative care and Advance Care Planning services.*

One key component of ELDAC is a program of activities designed to build linkages between service providers in specialist palliative care services, primary care and the aged care sector: the ELDAC Linkages program, formerly known as the Working Together program.

Building such partnerships ensures we optimise the capacity of services to provide the best possible care at end of life in a timely way. This care addresses the unique needs for all in our community, including people from culturally and linguistically diverse backgrounds, Aboriginal and Torres Strait Islander people and lesbian, gay, bisexual, transgender and intersex groups. This booklet provides an overview of the activities undertaken by services participating in this important linkage component of the ELDAC project.

The stories presented in this booklet illustrate the wide-ranging goals, activities and outcomes achieved by the participating services. They demonstrate how services have used practical and sustainable strategies to improve the quality of care provided to older people in residential and community settings who are nearing the end of life.

## ELDAC is delivered by a national consortium of seven partner organisations:

- Queensland University of Technology (QUT)
- Flinders University of South Australia (FUSA)
- University of Technology Sydney (UTS)
- Palliative Care Australia (PCA)
- Ageing Australia
- Catholic Health Australia (CHA)



# Participating Services



## Australian Capital Territory

- The Butler Canberra



## New South Wales

- Whiddon Home Care
  - Tamworth
  - Glenfield
- Ashwood Residential Care Service
- Royal Freemasons' Benevolent Institution – Bellingen Masonic Village
- BaptistCare Central West and Mid State
- McLean Care - Mackellar Alkira
- Glow Health Care Australia
- Prestige Inhome Care - Sydney
- Southern Cross Care NSW & ACT
  - St Joseph's Residential Care
  - St Martha's Residential Care
- Inasmuch Community Ltd - Home Care
- Coffs Harbour Legacy Nursing Home – Legacy on Victoria
- Omnicare Alliance Ltd
- SydWest Multicultural Services
- Lifebridge Australia – Home Care
- Valmar Support Services
- Woolgoolga & District Retirement Village (WDRV)



## Queensland

- Nazareth Care - Nazareth House Wynnum
- Infin8 Care
  - Ashmore
  - Cornubia
- Kewarra Aged Care
- Akooramak Care of Older Persons
- Wowan/Dululu Multi-Purpose Centre (WDMPC)



## South Australia

- Bene Aged Care - St Paul's
- Jallarah Homes Inc.
- North Eastern Community Hospital Aged Care (NECH)
- HenderCare Home Care
- Lutheran Homes Group - Home Care
- Clayton Church Homes Magill



## Tasmania

- Uniting AgeWell
  - Rosetta Community, Strathglen
  - Rosetta Community, Strathaven
- Celebrate Health Care - Aminya

All participating services are to be congratulated for their commendable efforts to strengthen their provision of quality palliative care. This publication includes a collection of some service case stories highlighting their successes.



## Victoria

- Polish Community Council of Victoria (PCCV)
- Prestige In Home Care Melbourne
- Jacaranda Village
- Heathcote Health
- Vasey RSL Care
  - Bundoora
  - Frankston South
- CO.AS.IT Italian Assistance Association Melbourne



## Western Australia

- Chung Wah Community Care – Balcatta Hub
- Catholic Homes
  - Ocean Star Residential Care
  - Sister Mary Glowrey Residential Care
  - Castledare Residential Care
- Amana Living
  - Home Care (Perth)
  - Hale Hostel
  - James Brown Care Centre
  - Wearne House
- RAAFA
  - Alice Ross King Care Centre
  - Gordon Lodge
- Rosewood Leederville
- The Carers
- Home And Lifestyle Options (halo)
- Regents Garden
  - Bateman
  - Lake Joondalup
  - Four Seasons - Booragoon
- CPE Group - Home Care Service



# The Butler Canberra



Home Care



Higgins,  
Australian Capital Territory

## Highlights

- Increased staff confidence and capability in palliative care and Advance Care Planning
- Improved access to education, training, and resources across all staff roles
- Development of palliative care resources and a directory to guide staff and clients
- Stronger collaboration with specialist palliative care services and general practitioners
- Improved communication with clients and families about care preferences

## Goal

To strengthen staff capability in palliative care and Advance Care Planning, build meaningful connections with local specialist services, and improve systems that support clients and families to experience coordinated, person-centred care at the end of life.

With decades of experience supporting seniors, our organisation is built on a simple principle: listening. We take the time to understand each individual's needs, values, and preferences, delivering tailored, reliable support that ensures the best outcomes and value.

The Butler Canberra helps people thrive at home, promoting independence and quality of life. By building genuine relationships, we go beyond basic care, becoming a trusted support network that champions your goals and empowers you to live well where you feel most comfortable.



The Butler Canberra chose to participate in the ELDAC Linkages Program after identifying gaps in staff confidence, resources, and connections with specialist palliative care services, and recognising the need to strengthen Advance Care Planning and end-of-life support for clients and families.

Before participation, the service experienced limited staff confidence and knowledge in palliative care and Advance Care Planning, along with challenges accessing clinical advice, referrals, and appropriate resources. These gaps impacted the service's ability to provide consistent, coordinated end-of-life care.

## Key outcomes and benefits

- Increased staff confidence and capability in palliative care and Advance Care Planning
- Improved access to education, training, and resources across all staff roles
- Development of palliative care resources and a directory to guide staff and clients
- Stronger collaboration with specialist palliative care services and general practitioners
- Improved communication with clients and families about care preferences



## Our journey

The Butler Canberra is committed to supporting clients to live well in the homes they love, recognising that quality end-of-life care is a vital part of this commitment. Prior to participating in the ELDAC Linkages Program, the organisation identified challenges in staff confidence, access to specialist advice, and the absence of streamlined processes to support clients approaching the end of life.

Participation in the ELDAC Linkages Program provided a structured pathway to address these gaps. With guidance from the ELDAC facilitator, The Butler focused on building staff knowledge, strengthening internal processes, and developing partnerships with local specialist palliative care services and general practitioners. Training opportunities were identified for staff across all roles, from carers to leadership, ensuring a shared understanding of palliative care and Advance Care Planning.

A key focus was supporting staff to feel confident initiating difficult conversations and responding to changing client needs. The service implemented tools and frameworks to improve identification and response to clients approaching the end of life, enabling earlier support and reducing the risk of late hospital transfers. Internal and external communication processes were strengthened to promote coordinated, person-centred care.

The impact of these changes was reflected in staff engagement and enthusiasm for learning. Team members demonstrated a strong commitment to developing their skills, recognising how improved knowledge translated into better support for clients and families. One staff member reflected that participating in ELDAC and associated education provided valuable exposure to a multidisciplinary approach to palliative care, highlighting the importance of collaboration across medical, allied health, pastoral, and volunteer services.

Through the ELDAC Linkages Program, The Butler Canberra strengthened its systems, partnerships, and workforce capability. These improvements have supported more confident staff, clearer communication, and enhanced care experiences for clients and families navigating palliative and end-of-life care.



# Whiddon Home Care - Tamworth



Home Care



Tamworth,  
New South Wales

## Highlights

- Built workforce capability through structured, mandatory palliative care and Advance Care Planning education
- Strengthened Advance Care Planning processes and resources to support timely, meaningful conversations with clients and families
- Improved collaboration with local specialist palliative care services, supporting shared care and clearer referral pathways
- Enhanced communication with local hospital discharge planning to support safer transitions back to home
- Embedded quality improvement tools to support reflection, learning, and continuous improvement

## Goal

To strengthen our ability to support older people to remain at home at end of life through confident staff, strong Advance Care Planning, effective palliative partnerships, and reduced avoidable hospital admissions.

Whiddon Home Care - Tamworth provides community home care services across Tamworth, Gunnedah, and surrounding regional and remote areas in New England and Central West NSW. Operating since at least 2015, the service has grown steadily to meet the needs of an ageing population. Care is delivered by a multidisciplinary team including registered nurses (RN), care coordinators, and care workers. The service supports older people with varying care needs to live safely at home, recognising the cultural diversity of the community, including Aboriginal and Torres Strait Islander peoples, and responding to the challenges of workforce shortages and limited access to training in regional areas.

The service participated in the ELDAC Linkages program to better support clients to remain at home, reduce avoidable hospital admissions, strengthen Advance Care Planning, and build staff capability to provide quality palliative and end-of-life care in a regional and remote context.

Prior to participation, workforce turnover required frequent re education of staff, and limited time and staffing capacity made sustained improvement activities challenging. Hospital admissions often disrupted continuity of care, contributing to functional decline and difficulties supporting clients to return home safely.



## Key outcomes and benefits

- Improved staff knowledge and confidence in palliative care, Advance Care Planning, and end-of-life care through structured education
- Stronger Advance Care Planning processes with clear guidelines, resources, and regular review points
- Enhanced access to resources to support clients, families, carers, and staff
- Clearer referral pathways and strengthened working relationships with the local specialist palliative care team
- Improved communication and shared understanding with local hospital discharge planning teams
- Embedded quality improvement practices, including use of ELDAC audits and structured reflection

“Participating in the ELDAC Linkages program has allowed us to re-evaluate the care and support we provide customers and their families when someone requires palliative and end-of-life care.”

*Tanya Downes, Registered Nurse*



## Supporting a peaceful death at home

We supported a client diagnosed with a life limiting illness six months earlier. They were clear about their wish to stay at home and had declined services. A week before their death, their family contacted us — overwhelmed and unsure where to turn. Thanks to what we’d learned through the ELDAC Linkages program, we were ready.

We quickly identified staff who felt confident to assist, with an RN and coordinator on site that day, visiting up to four times daily to provide personal care. The client had no equipment or basic supplies, so we immediately used their care package to arrange essentials through a local provider, delivered within hours.

We then worked closely with the local palliative care team. Staff adjusted rosters to ensure consistent care, and we shared ELDAC resources with the family to help them understand what to expect. This eased their anxiety and helped them feel more confident and involved.

One urgent challenge was that the client hadn’t seen their GP in over eight months. Working in partnership with the GP and palliative care team, we ensured everything was in place so they could die at home, as they wished.

As time got closer, our RN remained on-call to be available when needed. When the client was deteriorating, the family called us. We guided them through the next steps and coordinated end-of-life care and their end stage with dignity and calm. A few days later, the family visited to thank us personally.

The client’s husband later shared that the coordinated care and clear communication gave the peace of mind and allowed them to focus on precious time with their partner. Staff also reported increased confidence in providing end-of-life care, supported by the structured tools and guidance from ELDAC.

This experience highlighted how far we’ve come. Before ELDAC Linkages Program, we wouldn’t have had the confidence, tools, or partnerships to respond so quickly or compassionately. Now, our staff feel empowered, care is better coordinated, and families feel supported through one of life’s hardest moments

\*Resident/Client names have been de-identified and are gender neutral to preserve confidentiality.



# Whiddon Home Care - Glenfield



Home Care



Glenfield,  
New South Wales

## Highlights

- Strengthened staff confidence and capability in palliative care and Advance Care Planning
- Improved communication and collaboration with local general practitioners, palliative care teams, and other health services
- Established clearer systems for documenting and sharing end-of-life care preferences
- Increased awareness of culturally sensitive approaches to palliative care across the service

## Goal

To strengthen palliative and end-of-life care in home care by building staff confidence, improving Advance Care Planning, and enhancing collaboration with local health services to deliver culturally responsive, person-centred support.

Whiddon Community Care is a home care service based in Glenfield, providing in home support across South West Sydney. The service aims to support older Australians to remain living independently and safely at home while promoting dignity, autonomy, and quality of life through flexible, person-centred care. A team of 42 care workers and four coordinators deliver personal care, domestic assistance, and social support. Whiddon Community Care supports approximately 250 clients, including 113 people receiving Home Care Packages. The client group is culturally diverse and spans the South West Sydney region from Bankstown to Wollondilly Shire.

The service chose to participate in the ELDAC Linkages program to strengthen its ability to deliver coordinated, high-quality palliative and end-of-life care. The program offered practical tools and structured support to build workforce capability, improve early identification of need, and enhance collaboration with external health services.

Prior to participation, staff reported limited confidence in initiating Advance Care Planning conversations and recognising palliative care needs early. Communication and coordination with external health services were inconsistent, affecting continuity of care. The diverse cultural needs of clients also required additional guidance to support appropriate end-of-life discussions.

The team upskilled staff in palliative care and Advance Care Planning through targeted training, increasing confidence in recognising palliative needs and initiating First time mentioned in story so need to change to: Advance Care Planning (ACP) and Advance Care Directive (ACD) conversations. They began developing a practical toolkit to support consistent, high quality

“Family meetings or case conference protocols have enhanced communication, ensuring families are better informed and involved.”

discussions and worked closely with local palliative care services to strengthen staff capability and shared approaches. The service established referral pathways and partnerships with external palliative teams, enabling joint care planning and timely input for complex cases. They embedded a more consistent palliative focus into care plan reviews and family meetings to improve communication and family involvement, supported staff wellbeing through access to grief and loss counselling, and progressed work on early identification of deterioration through collaboration with specialist services.

## Key outcomes and benefits

- Increased staff confidence in having Advance Care Planning and end-of-life conversations
- Improved consistency in recognising and responding to palliative care needs
- Strengthened communication pathways with local general practitioners and palliative care services
- Improved documentation and sharing of client preferences to support person-centred care
- Greater awareness of culturally sensitive approaches to end-of-life care across the workforce



## A Transformative Experience

Participating in the ELDAC Linkages program has been a transformative experience for our service. Before engaging with the program, our staff often felt uncertain when supporting clients with end-of-life needs, particularly when it came to initiating Advance Care Planning conversations or coordinating with external providers.

Through the linkages program, we developed stronger relationships with our local specialist palliative care services, and we were able to identify opportunities to enhance our processes. The support and resources provided through ELDAC helped us build staff knowledge and confidence, improve communication pathways, and embed a more proactive approach to end-of-life care. By working together without specialist palliative care services, we were able to improve our confidence in end-of-life conversations and ensure our clients receive the care they truly want and need at the final stages of life.

One of the key improvements has been in our team's ability to recognise early signs of palliative care needs and respond in a timely and coordinated way. Staff now feel better supported and more confident in having meaningful discussions with clients and families about care preferences, which has led to more consistent and person-centred care.

We have also seen a stronger sense of teamwork, with regular case discussions, clearer documentation, and more effective handovers. These changes have had a direct impact on the quality of care we provide in regard to palliative care.

By working together with palliative care services, and completing the intensive palliative care education program, we were able to embed a culture of collaboration, compassion and confidence in our approach to palliative care and end-of-life care. The ELDAC program has given us the tools to ensure that every client is supported with dignity, respect and care that truly reflects their values and wishes.



# Ashwood Residential Care Service



Residential Aged Care



Pendle Hill,  
New South Wales

## Highlights

- Established a structured, service-wide palliative approach supported by clear systems and processes
- Built staff capability through targeted education, learning pathways, and competency development
- Introduced new clinical assessment tools and strengthened Advance Care Planning systems
- Developed palliative care champion roles to support practice, culture, and peer learning
- Strengthened collaboration with local specialist palliative care, in reach services, and networks

## Goal

To strengthen its palliative approach by building staff capability, improving assessment and planning processes, embedding evidence-based tools, and strengthening partnerships to support quality, person-centred end-of-life care.

As one of six residential aged care services operated by Fresh Hope Communities, Ashwood Residential Care Service is a 132-bed high level residential aged care facility providing permanent, dementia specific, and respite care. The service supports older people with complex care needs in a supportive environment, with a focus on dignity, comfort, and continuity of care across the ageing and end-of-life journey. Care is delivered by registered nurses and care workers who work closely with residents and families to support individual preferences, choice, and quality of life.

Ashwood Residential Care Service chose to participate in the ELDAC Linkages program to review and strengthen its approach to palliative care. The service recognised an opportunity to upskill staff, improve clinical processes, and build confidence across the care team. Participation offered structured facilitation, access to evidence-based resources, and support to embed improvements across Advance Care Planning, assessment, and care delivery.

Prior to participating in the ELDAC Linkages program, Ashwood Residential Care Service faced challenges related to limited staff and financial resources, competing care priorities, and restricted time to implement new initiatives. These pressures made it difficult to prioritise and consistently embed improvements in Advance Care Planning and palliative care processes across the service.

With support from the ELDAC facilitator, the service focused on strengthening staff capability, reviewing clinical processes, and embedding a more proactive, person-centred approach. Upskilling their staff became a key driver of change, with learning pathways developed to support registered nurses and care workers in recognising palliative needs, undertaking assessments, and contributing confidently to case conferences.

Participation in the ELDAC Linkages program helped Ashwood Residential Care Service move

from fragmented practice to a more cohesive, team based approach to palliative care. Staff reported feeling better supported and better equipped to deliver care that aligns with residents' wishes.



"Staff reported feeling better supported and better equipped to deliver care that aligns with residents' wishes."

## Key outcomes and benefits

- Introduced a systematic approach to Advance Care Planning supported by updated documentation and processes
- Improved staff knowledge, skills, and confidence in identifying palliative care needs and responding appropriately
- Established palliative care champion roles to support team learning and practice development
- Strengthened communication pathways across the multidisciplinary team and external providers
- Enhanced coordination of care through clearer referral pathways to specialist palliative care services
- Reviewed and strengthened bereavement assessment and follow-up processes

### The Heart of Care: Strengthening a palliative approach at Ashwood Residential Care Service

At Ashwood Residential Care Service (Ashwood), a quiet transformation was underway. The team had committed to elevating palliative care — not just through policy, but through people, learning, and compassion. The results of this commitment came to life in the story of an 84-year-old resident with advanced heart failure and early-stage dementia.

The resident had lived at Ashwood for nearly five years. Their condition had slowly declined, and while their physical symptoms were managed, their emotional and spiritual needs were often harder to pinpoint. That changed when the staff began applying new learning and introduction of a suite of new clinical tools and systems.

Thanks to improved training and awareness, the resident's nurse, Grace, recognised subtle signs of distress that prompted immediate response. Grace used a newly introduced clinical assessment tool to evaluate the resident's symptoms and documented her findings in the updated information system. This triggered a multidisciplinary review, where the resident's care plan was revised to better reflect their goals and comfort.

The resident's family was invited to a case conference, where Grace confidently facilitated a discussion about the resident's wishes, prognosis, and care options. The team introduced the Advance Care Directive form, helping the family articulate the resident's preferences.

Meanwhile, one of Ashwood's Palliative Care Champions, Analyn, began regular check-ins with the resident and their family. She helped them understand the palliative approach and ensured that the resident's care remained person-centred. Analyn also coordinated with the Palliative In-reach services, ensuring the resident had access to specialist support when needed.

When the resident passed away peacefully several months later, the bereavement process was handled with grace. Their family received a needs assessment and follow-up support, guided by the bereavement process through the support of the Chaplains. Staff felt confident and supported, knowing they had the tools and knowledge to care for resident with dignity.

The resident's story becomes a quiet but powerful example of what happens when a team commits to learning, collaboration, and compassion. It wasn't just about systems; it was also about people. And at Ashwood Residential Care Service, those people along with our palliative care improvement journey made the difference.

\*Resident/Client names have been de-identified and are gender neutral to preserve confidentiality.



# Royal Benevolent Freemasons' Institution - Bellingen Masonic Village



Residential Aged Care



Bellingen,  
New South Wales

## Highlights

- Improved staff confidence in recognising deterioration and initiating Advance Care Planning discussions
- More consistent Advance Care Planning documentation embedded into routine practice
- Earlier and more proactive engagement with residents and families about goals of care
- Stronger collaboration with local medical practitioners and external palliative care services
- Improved systems and processes to support palliative care coordination

## Goal

To strengthen Advance Care Planning and palliative care practices in response to the increasing complexity of residents' needs. The service aimed to embed a more consistent, proactive and evidence-based approach to recognising deterioration, supporting timely conversations, and ensuring end-of-life care is coordinated and aligned with resident wishes.

Bellingen Masonic Village, part of the Royal Freemasons' Benevolent Institution (RFBI), is a residential aged care service providing 24-hour clinical care to approximately 50 residents. The service is supported by a multidisciplinary team of registered nurses, care staff, allied health professionals, and visiting medical practitioners. Located in a regional and rural community, residents often have complex needs including frailty, chronic disease, and increasing palliative care requirements. The service prioritises dignity, respect, early recognition of deterioration, and enabling residents to remain in a familiar environment throughout all stages of ageing, including end of life.

Bellingen Masonic Village was keen to strengthen and formalise its approach to palliative care in the form of a clear framework. Increasing clinical complexity highlighted the need for greater consistency, improved staff capability, and stronger linkages with external palliative care services to support proactive, person-centred care delivery. We saw the far-reaching opportunities for renewing our connections with the local hospital located close to our facility.

Before joining the ELDAC Linkages Program, staff knowledge and confidence in Advance Care Planning and palliative care varied. Recognition of early deterioration and initiation of end-of-life conversations were inconsistent, contributing to a more reactive model of care. Advance care planning was not consistently embedded, resulting in gaps in documentation and missed opportunities for meaningful discussions with residents and families. Coordination with external palliative care services could also be variable.



## Key outcomes and benefits

- Clearer, more consistent Advance Care Planning processes across the service
- Increased staff capability in recognising deterioration and initiating timely conversations
- Improved confidence in coordinating care with residents, families, and medical practitioners
- A more proactive, structured approach to palliative and end-of-life care delivery
- Greater consistency in care aligned with residents' preferences and wishes
- Referral pathways to supporting end-of-life care
- A toolbox of resources to support care and communication with families

"The ELDAC program has empowered our team to deliver proactive, person-centred end-of-life care - ensuring dignity, comfort, and clarity for both residents and their families."

### Our journey

The ELDAC Linkages Program gave us a chance to reflect deeply on our end-of-life care at Bellingham Masonic Village. While care remained compassionate, there were opportunities to strengthen a more structured, proactive approach to ensure residents' preferences were consistently identified and respected.

Through the program, our service implemented a number of key strategies, including embedding Advance Care Planning into routine clinical practice, improving documentation processes, and introducing a structured end-of-life pathway. Staff education was prioritised to build confidence in recognising clinical decline, initiating conversations with families, and coordinating care with general practitioners.

A notable example involved a resident with multiple chronic conditions who began to show signs of gradual deterioration. Using the frameworks and tools introduced through ELDAC, staff were able to identify these changes early and initiate timely discussions with the resident and their family. Advance care planning was reviewed and updated, ensuring care decisions were aligned with the resident's wishes.

As the resident's condition progressed, the end-of-life pathway was activated. Anticipatory medications were charted, non-pharmacological comfort measures were prioritised, and communication between the care team, family, and medical providers was consistent and clear. The resident was able to remain in the familiar environment of the village, supported by staff who felt confident and equipped to provide high-quality palliative care.

The outcome was a calm and dignified end-of-life experience, with the resident passing peacefully. The family expressed appreciation for the clear communication, preparedness, and compassionate care provided throughout the process.

Participation in the ELDAC Linkages Program has enabled our service to transition from a reactive model of care to a proactive, structured approach, resulting in improved staff capability, enhanced collaboration, and better outcomes for residents and their families.

\*Resident/Client names have been de-identified and are gender neutral to preserve confidentiality.



# BaptistCare Central West and Mid State



Home Care



Orange, Parkes, Cowra and  
Dubbo,  
New South Wales

## Highlights

- Increased staff confidence to initiate Advance Care Planning conversations earlier and consistently
- Improved consistency and accuracy of care planning documentation
- Strengthened communication and care coordination through clearer processes
- Enhanced collaboration with local palliative care and primary health providers
- Embedded a proactive, confident palliative care approach across home care teams

## Goal

To strengthen the delivery of high quality, person-centred end-of-life care by building staff confidence and capability in Advance Care Planning and palliative care, improving documentation and communication, and strengthening collaboration with local health and palliative care partners.

BaptistCare at Home – Central West and Mid State is a largely rural and regional home care service supporting older people to maintain independence, dignity, and quality of life in their own homes. Delivered across four sites, the service supports nearly 900 clients with a workforce of almost 200 staff, including 140 care workers. Services include personal care, domestic assistance, medication support, meal preparation, social support, clinical care, and access to allied health professionals. The service supports communities with high levels of chronic illness, socio economic disadvantage, and strong reliance on full pension support.

The service enrolled in the ELDAC Linkages program to build workforce capability in Advance Care Planning and palliative care, strengthen partnerships with local services, and embed best practice approaches that support continuous quality improvement and more coordinated care for clients and families.

Prior to participation, the service identified opportunities to build staff confidence and capability in initiating Advance Care Planning conversations. Documentation practices varied, and earlier discussions with clients were not always embedded. The team recognised that introducing palliative care earlier in care planning would strengthen shared understanding, improve consistency of processes, and enhance support for clients and families

Through the ELDAC Linkages Program, BaptistCare strengthened outcomes by investing in comprehensive workforce development, including palliative care training for care workers, care facilitators, clinical staff, managers, and allied health professionals through external and internal education. Palliative care was embedded into staff orientation, supported by clear role definitions, practical resources, and culturally responsive

materials. The service formalised processes, strengthened multidisciplinary collaboration, introduced a consistent care worker model for end-of-life clients, and built strong partnerships with local palliative care services, hospitals, Primary Health Networks, and educators.

"I am genuinely proud of our team for wholeheartedly embracing the ELDAC Linkages Program and making the most of the valuable resources and support it offers."

*Area Manager, Donna O'Brien*

## Key outcomes and benefits

- Staff demonstrated increased confidence and competence in Advance Care Planning and palliative care discussions
- Advance care plans were completed earlier, documented more consistently, and shared more effectively across teams
- Clients and families were supported to engage in meaningful conversations about preferences and goals of care
- Clearer communication processes improved coordination and continuity of care
- Sustainable practice change was supported through ELDAC facilitation, tools, and reflective quality improvement

### Our journey

A key outcome of participation in the ELDAC Linkages program was the early focus on strengthening relationships with local primary health providers. This relationship building phase highlighted the program's impact, supporting closer collaboration and improving the coordination and delivery of end-of-life care for clients and the broader community.

At the outset, the team identified gaps in communication and shared understanding with specialist palliative care services. Through ELDAC Linkages, practical tools and frameworks supported clearer role definition and more open communication. Through the implementation phase, we were supported to identify key contacts and establish regular, purposeful conversations focused on client care. These structured discussions improved the ability to address clinical updates, Advance Care Planning, and timely palliative care responses, with clear guidance ensuring actions were documented and followed up.

This initial phase of participation in the ELDAC Linkages program did not just improve our processes; it fostered a culture of collaboration and mutual respect. It demonstrated, even in these early steps, how structured partnership development could build a strong foundation for continuous improvement in palliative and end-of-life care.

One of the most notable achievements of the ELDAC Linkages program has been the increased confidence of Care Facilitators when initiating Advance Care Planning conversations. As they have become more comfortable leading these discussions, there has been a clear increase in conversations and Advance Care Plans completed and documented. This shift reflects strengthened skills and has positively influenced care quality, ensuring clients' preferences and wishes are clearly recorded, understood, and respected.

During an Advance Care Planning information session, the daughter of a client shared a deeply moving experience, recalling the distress she felt when required to make critical decisions for their parent, who could no longer communicate their wishes. The family member described the situation as frightening and overwhelming, highlighting how difficult it was to navigate choices without a clear Advance Care Plan. Their story reinforced the importance of early conversations, so families understand their loved ones' preferences and feel prepared and supported.

Through participation, we gained stronger collaboration between aged care and palliative care services, supporting more seamless care pathways for clients and families. Staff developed greater confidence and competence in end-of-life care planning, supported by practical tools and tailored resources. Improved communication, regular interdisciplinary meetings, and a shared commitment to best practice fostered a more supportive, compassionate care environment, contributing to higher quality care outcomes. These advances have ultimately contributed to higher quality of care for our clients.

\*Resident/Client names have been de-identified and are gender neutral to preserve confidentiality.



# McLean Care - Mackellar Alkira



Residential Aged Care



Gunnedah,  
New South Wales

## Highlights

- Increased completion of advance care directives across all residents
- Improved staff confidence to initiate and lead end-of-life conversations
- Earlier recognition of palliative care needs and timely escalation
- Stronger collaboration with local medical practitioners and emergency services
- Greater ability to support residents to remain in their home at Alkira at the end of life

## Goal

To build staff confidence and capability in recognising deterioration, strengthen collaboration with local stakeholders, and support residents and families to experience a dignified, peaceful, and person-centred end-of-life journey.

McLean Care Alkira is a residential aged care service located in the rural town of Gunnedah in north central New South Wales. The service provides care for 41 residents, many of whom have lived in the region for most of their lives and have strong ties to the local farming and coal industries. Alkira employs 50 staff and provides residential aged care to support the wellbeing and clinical needs of older people within the Gunnedah Shire community of approximately 8,500 residents.

Alkira chose to participate in the ELDAC Linkages Program to empower staff, strengthen confidence in end-of-life discussions, and improve the service's ability to partner with residents and families to deliver care that supports dignity, comfort, and choice at the end of life.

Before participating, staff found end-of-life conversations challenging and often avoided due to concerns about upsetting residents and families. Limited engagement in Advance Care Planning contributed to fewer than half of residents having advance care directives in place and increased risk of unnecessary hospital transfers.





## Key outcomes

- One hundred per cent completion of advance care directives for all residents
- Integration of a palliative care plan as part of the admission process
- Increased staff confidence to discuss Advance Care Planning and palliative care
- Improved identification of early palliative signs and timely escalation
- Greater ability to provide pain-free end-of-life care within the service

## Our journey

McLean Care Alkira is deeply connected to its rural community, caring for residents who have contributed to the life and identity of the Gunnedah region for decades. Prior to participating in the ELDAC Linkages Program, staff recognised that conversations about Advance Care Planning and palliative care were often avoided or delayed. Families frequently expressed concerns about upsetting their loved ones, which resulted in fewer than half of residents having documented advance care directives. This created challenges in supporting residents to remain at Alkira at the end of life and increased the likelihood of hospital admissions.

Through participation in the ELDAC Linkages Program, Alkira focused on building staff confidence to approach end-of-life conversations in a respectful, clear, and person-centred way. With support from the ELDAC facilitator, staff developed skills to recognise deterioration and initiate timely discussions with residents and families. This shift enabled conversations to occur earlier, when residents were better able to express their wishes and preferences.

Working with the ELDAC facilitator, Alkira strengthened partnerships with local medical practitioners and emergency services. These relationships have supported shared understanding and clearer communication, ensuring residents are able to remain in their home at Alkira wherever possible throughout their end-of-life journey. Families are encouraged and supported to stay with residents, knowing that staff are confident and prepared to provide compassionate and comfort-focused care.

As a result of these changes, Alkira now has advance care directives completed for all residents, with palliative care plans embedded into the admission process. Nursing staff confidently identify early palliative signs and escalate care in a timely manner, engaging key stakeholders to support residents' wishes. Families have shared their gratitude for the peaceful, respectful, and dignified care provided to their loved ones, reinforcing the positive impact of participation in the ELDAC Linkages Program.



# Glow Health Care Australia



Home Care



Parramatta,  
New South Wales

## Highlights

- Embedded a structured, culturally responsive Advance Care Planning process across assessments and care planning
- Strengthened staff knowledge, confidence, and skills in holistic palliative care through targeted education and practical tools
- Improved systems for case conferencing, referral pathways, and coordinated care planning
- Established stronger linkages with specialist palliative care services, primary health networks, and local care providers
- Reduced stigma and discomfort around palliative and end-of-life conversations across the workforce

## Goal

To embed consistent, quality palliative care by strengthening workforce capability, supporting Advance Care Planning, implementing integrated end-of-life care pathways, improving care coordination, and strengthening collaboration across the sector.

Glow Health Care Australia provides Home Care Packages predominantly across Western Sydney. The service supports a diverse population older Australians to live independently and with dignity at home, delivering person-centred, coordinated, and culturally responsive care. The multidisciplinary team comprises around 50 staff, including care workers, care managers, nurses, and allied health. The service supports 108 Home Care Package clients including multicultural, culturally and linguistically diverse, and rural populations with complex needs.

Glow Health Care Australia chose to participate in the ELDAC Linkages Program to strengthen staff capability, systems, and confidence in delivering coordinated, person-centred palliative and end-of-life care, and to build stronger, more effective partnerships across the palliative care sector.

The team was keen to build on their gaps in Advance Care Planning processes, staff training documentation and linkage with specialist palliative care providers. Challenges existed in their care approach due to cultural taboos around life limiting illness, death and dying, which created discomfort for both multicultural staff and the diverse communities they supported. This impacted on care planning and staff confidence in supporting clients and families at end of life was reduced.

“Palliative care is now fully integrated into our care delivery, no longer viewed as a “no-go zone” but as an essential part of the client journey.”

*Meble Kyeyune Nabbona*

Participation in the ELDAC Linkages Program enabled the service to implement a structured, system wide approach to strengthening palliative and end-of-life care. With guidance from the ELDAC facilitator, staff capability and confidence were enhanced through targeted education and ongoing learning in holistic, person-centred care. Advance care planning was embedded into routine assessments and care planning, supported by GP involvement, multilingual resources, and updated policies to facilitate timely, culturally appropriate conversations. Practical tools, including Stop and Watch, SPICT, and tailored resources, supported early identification and proactive planning. Formalised case conferencing, continuous improvement processes, and strong referral pathways with specialist palliative care services improved care coordination, reduced stigma, and strengthened client, family, and staff experiences.

## Key outcomes and benefits

- Improved Advance Care Planning processes embedded across assessments, care plans, and reviews
- Increased staff knowledge, skills, and confidence in holistic palliative and end-of-life care
- Strengthened systems for case conferencing, documentation, and early identification of deterioration
- Established clear referral pathways and stronger working relationships with specialist palliative care services and primary health networks
- Enhanced capacity to deliver culturally safe, coordinated, person-centred care at end-of-life



### Breaking the taboo: building confidence in culturally safe end-of-life care

Before joining the ELDAC Linkages Program, Glow Health Care Australia's approach to Advance Care Planning (ACP) was informal and limited. While we delivered compassionate care, our team often lacked the tools and confidence to initiate meaningful end-of-life conversations — particularly with clients and families from culturally and linguistically diverse (CALD) backgrounds, where death can be a taboo subject.

One case that stands out involved a Care Manager, Farrah, supporting a client with a terminal illness who had clearly entered the end-of-life phase. Discussions about their wishes were avoided, as their family — coming from a culture where death is rarely discussed — refused to engage in ACP. Farrah felt unequipped and uncomfortable raising the topic, fearing she might cause distress or cultural offence.

Through the ELDAC Linkages Program, Farrah attended staff development sessions focused on culturally sensitive ACP and holistic palliative care. With guidance from our ELDAC facilitator and clinical mentoring from our Registered Nurse, she gained confidence and used ELDAC resources to support understanding and conversation prompts. With RN support, she initiated a gentle, respectful discussion with the family, focusing on the client's comfort, dignity, and values.

Working collaboratively with the GP and specialist palliative care team, the team assessed the client's end-of-life needs. This enabled open communication, symptom management, medication review, and emotional and spiritual support planning. The client's preferences were documented in an Advance Care Directive, with a clear care pathway established.

As a result, the client remained at home, supported by loved ones and a coordinated care team. Their symptoms were well managed, cultural and spiritual needs respected, and they died peacefully and with dignity.

This experience was transformative for Farrah and team. The ACP engagement rates have since increased significantly, and the Care Manager now mentors other staff. The service is more confident and better equipped to deliver person-centred, culturally responsive palliative care.

\*Resident/Client names have been de-identified and are gender neutral to preserve confidentiality.



# Prestige Inhome Care - Sydney and Melbourne



Home Care



North and East Sydney,  
New South Wales



Greater Melbourne,  
Victoria

## Highlights

- Improved awareness and understanding of palliative and end-of-life care across care and office teams
- Strengthened staff confidence through structured training and assessment tools
- Enhanced consistency and accuracy of palliative care education content
- Supported timely recognition, escalation, and response to palliative care needs at home

## Goal

To strengthen workforce capability in palliative care, improve end-of-life assessment and care planning, and ensure clients receiving care at home are supported with dignity, comfort, and confidence at the end of life.

Prestige Inhome Care is a home care provider supporting individuals to maintain independence and wellbeing in their own homes. The service employs approximately 800 care staff and provides personalised support including assistance with daily activities, medication management, nursing care, and companionship. Operating across Greater Melbourne, North and East Sydney, and the Sunshine Coast, Prestige Inhome Care supports around 1,700 clients through Home Care Packages, the National Disability Insurance Scheme, and privately funded arrangements, prioritising dignity, respect, and safety in all care.

Prestige Inhome Care chose to participate in the ELDAC Linkages Program in response to the growing need for palliative care in the community and a commitment to ensuring staff had the knowledge, skills, and confidence to support clients receiving end-of-life care at home.

Prior to participation, the service identified limited availability of staff with specialised palliative care knowledge, along with gaps in end-of-life assessment tools and resources, which impacted consistent identification and response to clients' palliative care needs.

## Key outcomes and benefits

- Improved awareness of palliative and end-of-life care across direct care and office staff
- Clearer, more accurate palliative care training content and assessment tools
- Increased staff confidence to assess comfort needs and escalate concerns appropriately
- Improved care planning and coordination for clients receiving end-of-life care at home



## Our journey

Prestige Inhome Care supports people to live well at home, recognising that end-of-life care is an important part of person-centred support. Prior to participating in the ELDAC Linkages Program, the organisation identified a growing demand for palliative care within the community and the need to strengthen staff confidence, assessment, and escalation practices for clients approaching the end of life.

Through the ELDAC Linkages Program, Prestige Inhome Care introduced structured palliative care assessment tools and enhanced staff education to better support clients and families during this time. Shortly after completing in-house training aligned with the program, a direct care worker was asked to support a client following discharge from hospital to receive end-of-life care at home.

The care worker had an established relationship with the client and their family, having provided ongoing support through a Home Care Package. The client expressed a clear wish to remain at home, surrounded by family. Working closely with the case manager, hospital discharge coordinator, and the client's family, the Prestige Inhome Care team supported a comfortable transition home with appropriate services in place.

As the client's condition declined, the care worker was able to confidently use the palliative care assessment tools introduced through the ELDAC Linkages Program to identify changes in comfort, nutrition, alertness, and overall wellbeing. These assessments supported timely escalation to the on-call team and enabled collaborative decision-making to ensure comfort and care preferences were respected.

The care worker reflected that the education and tools helped them feel better prepared to support both the client's physical comfort needs and the emotional needs of the family during the final days. Through strengthened assessment, communication, and collaboration, Prestige Inhome Care was able to support the client to remain at home, experiencing compassionate, respectful end-of-life care aligned with their wishes.

\*Resident/Client names have been de-identified and are gender neutral to preserve confidentiality.



# Southern Cross Care NSW & ACT - St Martha's Residential Care



Residential Aged Care



Banora Point,  
New South Wales

## Highlights

- Embedded Advance Care Planning discussions within routine care
- Strengthened communication pathways with local palliative care services
- Increased confidence among staff to recognise deterioration and provide end-of-life support
- Improved family engagement through timely conversations and structured case conferencing
- Enhanced team coordination supported by clearer processes and ELDAC resources

## Goal

To strengthen Advance Care Planning processes, increase staff capability, and deepen partnerships with local palliative care services to ensure residents receive coordinated, person-centred end-of-life care aligned with their wishes.

St Martha's Aged Care provides 24/7 residential aged care to 40 older adults, many with complex care needs including dementia, chronic illness and end-of-life requirements. The service is supported by around 47 staff including registered nurses, care workers, lifestyle and support staff, who work closely with allied health providers and local general practitioners. Many residents come from rural or regional areas, often with strong family involvement. St Martha's is committed to delivering high quality, person-centred care focused on dignity, comfort and resident choice at every stage of life.

The service sought to strengthen Advance Care Planning, improve communication with families, and build stronger connections with local palliative care providers. The ELDAC Linkages Program offered the structured guidance needed to build team capability and enhance the quality of end-of-life care.

Advance care plans were inconsistently documented or reviewed, making it difficult to ensure residents' preferences were clearly understood. Staff felt uncertain initiating end-of-life conversations, and limited engagement with local palliative care services affected continuity of care. These challenges contributed to unplanned hospital transfers and increased emotional strain for families and staff.

## Key outcomes and benefits

- Advance care planning embedded into standard care processes
- Clearer communication pathways established with local palliative care services
- Greater staff confidence in recognising and responding to deterioration
- Strengthened multidisciplinary teamwork guided by ELDAC resources
- Improved family communication through earlier, more meaningful conversations

"I have witnessed the growth and confidence in my staff, especially their proactiveness around the delicate situation"

*Facility manager*



## Our journey

Participation in the ELDAC Linkages Program has strengthened how St Martha's Aged Care responds to residents requiring end-of-life support. One recent experience demonstrates how these improvements translated into calm, coordinated and compassionate care.

A long term resident living with multiple chronic conditions began showing subtle signs of decline during a routine medical review. Although they reported simply "feeling unwell," staff observed clinical changes consistent with end stage disease. Guided by knowledge and confidence developed through the ELDAC Linkages Program, staff identified the deterioration early and initiated a case conference to ensure their goals of care were honoured.

Severe weather and an impending cyclone meant that this case conference occurred by phone. Despite the challenges, the conversation enabled the resident's family to clearly reaffirm their wish to remain at St Martha's and avoid hospital transfers. With medical support, the care team aligned their treatment plan with a comfort-focused approach.

Non-essential medications were safely discontinued to minimise treatment burden, and anticipatory prescribing ensured access to symptom relief medications despite potential delivery delays caused by the cyclone. Staff prepared and administered medications as clinically appropriate, and continued offering gentle, personalised comfort measures such as hydration, eye care and familiar routines that mattered deeply to the resident.

The atmosphere remained calm, steady and dignified—reflective of the improved capability, communication and teamwork fostered through the ELDAC Linkages Program. The resident was able to remain in their home environment, supported by familiar staff who understood their wishes and were confident in providing compassionate end-of-life care.

This experience captured the significant shifts achieved through the program: earlier recognition of deterioration, clearer communication with families, stronger multidisciplinary teamwork and increased confidence in providing personalised end-of-life care.

\*Resident/Client names have been de-identified and are gender neutral to preserve confidentiality.



# Southern Cross Care NSW & ACT St Joseph's Residential Care



Residential Care



Tweed Heads,  
New South Wales

## Highlights

- Improved understanding of the palliative approach and the role of clinical caregivers
- Strengthened staff confidence through education on palliative and end-of-life care
- Integration of evidence-informed tools to support earlier identification of deteriorating health
- Enhanced communication with residents and families through facilitated discussions and community engagement activities such as the Living well, Leaving well morning tea

## Goal

To strengthen staff capability in recognising and responding to deterioration, embed a collaborative approach to palliative care, and identify sustainable improvements that enhance residents' comfort, dignity and choice throughout their palliative and end-of-life journey.

St Joseph's is a residential aged care service supporting 101 residents with diverse clinical, emotional, spiritual, cultural and social needs. Guided by HEART values—Honesty, Empathy, Acceptance, Respect and Teamwork—the service is committed to person-centred, dignified care. With 146 staff members, the team provides holistic support including comprehensive assessment, care planning, Advance Care Planning and end-of-life care aligned with resident goals. The service works to recognise and honour each resident's preferences, ensuring that their comfort, wellbeing and dignity remain central to care delivery.

The service joined the ELDAC Linkages program to enhance staff capability in responding to resident deterioration, strengthen teamwork across disciplines, and embed an integrated, high quality approach to palliative and end-of-life care.

Prior to participation, staff were unsure when and how to initiate Advance Care Planning and felt discomfort discussing serious illness. Limited knowledge and confidence meant conversations were often delayed, reducing opportunities for timely planning and optimal palliative and end-of-life care.

"I will always remember the day I left mum to start her new life at St Joseph's... thanks to the lovely staff whose arms were around me and promised me mum would be well looked after."

## Key outcomes and benefits

- Increased staff knowledge and confidence in palliative and end-of-life practices
- Earlier identification of deterioration through consistent use of evidence-informed assessment tools to recognise end of life
- Improved understanding of the differences between palliative care and end-of-life care
- Stronger communication with residents, families and representatives
- Integration of evidence-based resources and education
- Improved self care awareness for families and staff
- More proactive planning and tailored support for residents nearing end of life

“To all the staff at St Josephs, thank you... The many hugs you gave me and the wiping of my tears over the past three years will never be forgotten.”



## Our journey

St Josephs' participation in the ELDAC Linkages program marked a significant step in strengthening its capability to support residents nearing the end of life. The service identified early that uncertainty about when to begin Advance Care Planning discussions, coupled with staff discomfort discussing serious illness, limited the opportunity for meaningful and timely planning. Through the program, the ELDAC facilitator provided structured guidance, education and evidence-based tools to build new levels of staff confidence, competence and clarity.

A key advancement was the introduction of an evidence-informed assessment tool to support earlier recognition of deterioration. Staff reported that using this tool enhanced their ability to identify declining health sooner, enabling more proactive conversations and planning with residents and families. These insights were supported by education focused on disease trajectories, stages of care and the distinction between palliative care and end-of-life care — areas previously identified as challenging.

The service strengthened collaboration with local specialists and drew on evidence-based resources to guide practice. A strong focus on self care encouraged staff, residents and families to acknowledge and attend to their wellbeing needs, both during and after a resident's final days.

A highlight of the journey was the “Living Well, Leaving Well” morning tea. This event created a safe and compassionate space for residents and representatives to explore palliative care in a supportive environment, share their reflections, and better understand available supports. This community-centred approach enhanced openness and understanding among families.

Through participation in the ELDAC Linkages program, St Joseph's has strengthened its palliative care approach across all levels of staff. The team is now more confident, collaborative and prepared, ensuring that residents receive compassionate, dignified, person-centred care during one of the most significant stages of life.



# Inasmuch Community Ltd - Home Care



Home Care



Sussex Inlet,  
New South Wales

## Highlights

- Strengthened staff confidence and clarity of roles when supporting palliative clients approaching the end of life
- Improved linkages with local SPC services, primary health network, and GPs
- Embedded palliative care and Advance Care Planning education into staff induction, orientation, and mandatory training
- Introduced clearer systems to recognise deterioration and respond to changing client needs
- Improved coordination of care for clients and families through collaborative, team-based approaches

## Goal

To improve the knowledge and skills of our staff to help us optimise the services we provide for our clients who are palliative or end of life.

Inasmuch Community Ltd Home Care is a not-for-profit, locally owned and operated service based in the small rural town of Sussex Inlet on the South Coast of New South Wales. A team of 20 locally based care workers provides tailored home care services, supporting 66 clients across the Sussex Inlet district. Inasmuch has a strong reputation for providing care rooted in community connection, locals caring for locals.

The service chose to participate in the ELDAC Linkages program to build workforce capability and confidence in supporting clients who were palliative or at the end of life. Inasmuch recognised the need to strengthen systems, training, and external partnerships to ensure staff felt supported and prepared to provide calm, compassionate, and coordinated care in complex and emotionally challenging situations.

Prior to participation, staff had varying levels of knowledge and confidence in palliative care and Advance Care Planning. Some staff were unsure how to recognise deterioration, communicate with families, or understand their role when a client's condition changed. These challenges sometimes led to uncertainty or discomfort when providing care for palliative or end-of-life clients, impacting staff confidence and the consistency of care responses.

"ELDAC Linkages has given us an additional means of support to help build up a training program for staff and strengthen our Advance Care Planning process."

*Janette McGlynn Home Care Manager*



## Key outcomes and benefits

- Increased awareness and customer uptake of advance care directives
- Re-established relationships with local palliative care services
- Developed a multi-cultural resource folder available to all staff
- Introduced palliative champions

“This program has helped our team to build confidence and build on skills to assist our clients who are palliative/end of life.”



### Providing care and support at home

We recently saw one of our clients pass away at home following a terminal illness.

Our client was assigned a home care package early in the month while in hospital. They were discharged home approximately two weeks later with palliative care services in place. The palliative care team arranged for a hospital bed in their home. Over the next couple of weeks, our client rapidly declined and passed away before the month was out.

The seamless interaction between the palliative care team, family and care staff meant that our client had a holistic care experience. This experience was enhanced by the learnings and resource gained from the ELDAC program, the relationship we have built on with the palliative care team and knowing what we would do as the Clients Care Workers and what the palliative care team would do. Understanding the roles and responsibilities was key to working together.

Our carer's commented that it was one of the best situations they had experienced during their careers. The family was extremely grateful for the support and care both they and their loved one were given. They praised the caring professional approach shown by both the Inasmuch and palliative team. The care and support they received was amazing, and together, they gave the family the confidence to do the right things to support their husband and father to pass away at home, surrounded by their family, as per their final wish.

A direct comment from our carer Odette was: “It was very beautiful. It was kind, caring and loving as the family was so involved. When you walked in the front door, the client was centre stage, and the entire experience was all about them. There was a diffuser burning, it smelt lovely, the environment was calm – it was just beautiful.”

This positive experience was strengthened by the learnings gained through the ELDAC program, the confidence grown, the resources discovered, relationships built with the specialist palliative care team, and a shared understanding of roles. The increased awareness of our team on their roles and responsibilities and a well-trained staff who knew what to do is now evident. In addition, clear role clarity between Inasmuch care workers and the palliative care team was central to working together effectively for a comprehensive quality support for our client and family.

\*Resident/Client names have been de-identified and are gender neutral to preserve confidentiality.



# Coffs Harbour Legacy Nursing Home – Legacy on Victoria



Residential Aged care



Coffs Harbour,  
New South Wales

## Highlights

- Strengthened Advance Care Planning processes, supporting earlier and more consistent conversations with residents and families
- Allied health linkages that led to the introduction of weekly Multidisciplinary Team Meetings (MDT) meetings for high-risk residents
- Standardised Case Conferencing Procedures to ensure effective care planning
- Improved staff confidence and capability in recognising deterioration and responding to changing palliative care needs
- Stronger connections with local health and specialist palliative care providers, improving care coordination

## Goal

To support ongoing improvements in palliative and end-of-life care ensuring residents, families, and staff feel supported throughout the end-of-life journey.

Legacy on Victoria is a small, not-for-profit residential aged care service operated by the Coffs Harbour Legacy Welfare Fund. The service provides high level care and supports 49 residents, primarily from the local Coffs Harbour community. Grounded in the Legacy philosophy of compassion, respect, and community service, the service delivers inclusive, person-centred care that recognises residents' clinical, emotional, social, cultural, spiritual, and gender related needs.

As a small, regional service supporting residents with increasingly complex needs, Legacy on Victoria recognised the value of structured facilitation to improve care coordination, build confidence in Advance Care Planning, and embed sustainable, best practice approaches aligned with its community based, not-for-profit ethos.

Whilst there were challenges identified early on the team identified pathways to overcome them. Primarily these included a need for additional external palliative care support, family's reluctance to engage in conversations about ACP, and varied approaches to palliative care across clinicians externally and internally.

Legacy on Victoria set out to improve its palliative and end-of-life care approach using a multi-focused approach by reviewing and strengthening policies, improving Advance Care Planning processes, upskilling their care team, reviewing their clinical tools, enhancing case conferencing. They strengthened linkages with external palliative care providers to support more coordinated, person-centred care.

A shift toward more inclusive multidisciplinary care planning ensured the care team, residents and families were actively involved in decision making. Stronger relationships with their GPs, gaining additional medical support, and increased allied health referrals has enabled a more holistic, coordinated, and person-centred approach to care delivery.

"This program has been really good for opening everything up and thinking about palliative care in a broader sense"

*Deputy Director of Nursing*



## Key outcomes and benefits

- Stronger organisational practices through improved care planning and closer partnerships with GPs and local hospital clinicians
- Fewer avoidable hospital admissions through earlier recognition of deterioration and clear assessment, referral, and collaborative management processes
- Increased staff confidence and capability through targeted education, mentoring, and support from SPC, allied health, and Clinical Nurse Consultants (CNC)
- Improved quality end-of-life care through more person-centred, culturally inclusive, and responsive approaches
- Introduction of a coordinated, multidisciplinary, and holistic approach to end-of-life care

"The ELDAC experience has expanded my horizons of how I look at palliative care, and I wish for all physios to have this opportunity."

*Physiotherapist*

## The Role of Allied Health in Palliative Care

As a physiotherapist, I had very limited experience in palliative care prior to participating in the ELDAC Linkages Program. The program, together with the ELDAC Allied Health Toolkit, supported my understanding of a palliative care therapeutic approach. It highlighted the importance of recognising deterioration, responding proactively to changing needs, and aligning therapeutic goals with an individual's values, preferences, and quality of life.

During the program, our ELDAC facilitator connected us with an interstate allied health team that was also participating. This connection developed into a community of practice, where ideas, experiences, and approaches were shared through regular online meetings. Through this collaboration, I connected with other allied health practitioners and gained insight into diverse therapeutic approaches within a palliative context.

This opportunity supported me to embed a palliative care approach into everyday practice, rather than viewing it as a last minute response. As a result, my therapeutic approach evolved to align clinical decisions more closely with each person's values, goals, and stage of decline. A recent experience supporting a previously very active 89-year-old resident, whose needs changed as their health declined, helped define my role as a physiotherapist across the palliative journey. As their needs shifted, I learned to move my focus from outcomes to comfort, reassurance, and presence. This reframing strengthened my confidence and reinforced those respecting preferences and being present is valuable clinical work.

Collaboration with other allied health teams also guided our service to introduce weekly multidisciplinary meetings focused on residents identified as being at higher risk. These meetings have significantly improved care planning and strengthened a truly multidisciplinary approach. I am now actively involved in case conferences, providing opportunities to discuss Advance Care Planning, explore personal values, and build stronger therapeutic relationships with residents and their families. Being part of this multidisciplinary group has influenced both my practice and the direction of my career, clarifying and strengthening my role as a physiotherapist within palliative care.

*Physiotherapist Nicolas Bohlen*

\*Resident/Client names have been de-identified and are gender neutral to preserve confidentiality.



# Omnicare Alliance Ltd



Home Care



Port Macquarie,  
New South Wales

## Highlights

- Established clear pathways for identifying, escalating, and responding to changes in participant needs using validated assessment tools
- Strengthened collaboration with a local community specialist palliative care team, including agreed referral processes
- Embedded palliative care education into staff induction and refresher training to build confidence across all roles
- Improved documentation and visibility of palliative and end-of-life needs within the client management system

## Goal

To strengthen palliative care and Advance Care Planning through skilled staff, clear systems, and coordinated, person-centred care.

Omnicare Alliance Ltd is a home care provider delivering Support at Home services across the Mid North Coast of New South Wales. The service aims to empower participants to live safely and comfortably at home for as long as they choose. Omnicare employs 134 staff across a range of roles, including 69 support workers providing direct care, and is supported by more than 170 volunteers. Omnicare Home Care teams are supporting participants across urban, rural, and remote communities.

Omnicare Alliance Ltd participated in the ELDAC Linkages program to strengthen its palliative care and Advance Care Planning approach within home care. The service aimed to clarify processes and develop effective pathways that support participants to remain at home with coordinated, high quality, person-centred care, up to and including the end of life.



Through internal review and gap analysis, Omnicare identified opportunities to strengthen end-of-life care processes and improve integration with specialist palliative care services. Participation in the ELDAC Linkages program provided structured support to review practice, build workforce confidence, and enhance collaboration, ensuring participants experience consistent and coordinated care as their needs change.

Before the ELDAC Linkages program, Omnicare had limited direct engagement with specialist palliative care services. Referrals were usually initiated by general practitioners, and care was often delivered concurrently rather than collaboratively. This created potential confusion for participants and carers, delayed escalation of changing needs, and resulted in inconsistent coordination across services.

## Key outcomes and benefits

- Developed a clear, service-wide palliative care pathway with defined assessment, escalation, and referral points
- Improved staff confidence in recognising deterioration and initiating Advance Care Planning conversations
- Embedded palliative and end-of-life identifiers within the client management system
- Introduced consistent use of palliative assessment tools and care plans
- Strengthened linkages with the local community specialist palliative care team to support shared care

"I feel I have the tools to use as reference points and be able to direct them on the right pathways. The visit from the Palliative care team was also great with their holistic caring approach."

"The ELDAC training has given me confidence in having discussions with family and participants at the pinnacle time of need."

## Our journey

Participating in the ELDAC Linkages Program has given us a strong foundation to build and embed palliative care within our home care service. The program supported us to take a structured approach to reviewing our practices, strengthening internal processes, and developing external partnerships that enhance care for participants and their carers.

A key aspect of our journey was meeting with the local community specialist palliative care team. These early discussions helped clarify service roles and improve our understanding of how our services work together. Through shared conversations, we gained greater confidence in referral pathways and developed a more integrated approach to care coordination.

Engagement with the specialist palliative care team provided valuable insight into the clinical assessment tools they use and reinforced the importance of shared language and consistent documentation. We gained clarity around when and how to refer, what happens following referral, and how assessments, visit schedules, and discharge processes are managed. Learning about the multidisciplinary team strengthened our understanding of available supports, while direct registered nurse contacts enabled timely communication and collaborative problem solving.

The ELDAC Linkages Program also supported us to strengthen pathways for Advance Care Planning, early identification of changing needs, and care through to end of life. Guidance from our ELDAC facilitator and access to ELDAC resources were invaluable in shaping staff education, developing practical tools, and refining processes to support consistent practice.

A significant improvement was the introduction of a direct referral pathway from our registered nurses to specialist palliative care services. This replaced reliance on general practitioner initiated referrals, leading to smoother transitions, timely support, and reduced anxiety for participants and families.

Training delivered through the program equipped support workers and care partners with the language and confidence to initiate meaningful Advance Care Planning conversations. This has helped ensure participants' values and wishes would remain central throughout their care journey.



# SydWest Multicultural Services



Home Care



Blacktown,  
New South Wales

## Highlights

- Upskilled a culturally diverse workforce in palliative care and Advance Care Planning
- Strengthened linkages with hospitals and community health services
- Identified barriers to Advance Care Planning for CALD communities
- Developed culturally responsive Advance Care Planning resources
- Improved coordination and consistency of care for clients and families

## Goal

To strengthen staff capability in Advance Care Planning and palliative care, particularly for culturally and linguistically diverse communities, and to build effective partnerships that support coordinated, person-centred end-of-life care.

SydWest Multicultural Services is a leading organisation supporting cultural diversity across Greater Western Sydney and parts of the Inner West and City of Sydney. The service employs 190 staff and delivers home care through Home Care Packages and the Commonwealth Home Support Program, alongside settlement, disability, housing, youth, women's, and family services. SydWest supports almost 1,200 aged care clients across Western Sydney, with many clients from culturally and linguistically diverse backgrounds, including Arabic, Hindi, Farsi, Chinese, and Filipino speaking communities.

The service chose to participate in the ELDAC Linkages Program to upskill its culturally and linguistically diverse workforce and improve the way palliative care and Advance Care Planning are understood, discussed, and delivered within CALD communities.

Before participation, limited resources, variable understanding of palliative care, and difficulties accessing Advance Care Planning contributed to

fragmented care. Limited linkages with health services and cultural barriers made it challenging for staff to explain end-of-life care options, resulting in low uptake of Advance Care Planning and frequent hospital use.

## Key outcomes and benefits

- Comprehensive education and upskilling of staff across service areas
- Improved confidence in discussing palliative care and Advance Care Planning
- Stronger partnerships with hospitals and community health services
- Development of CALD specific Advance Care Planning resources
- Improved coordination of care and client and family satisfaction



### Team Leader - In-Home Care

SydWest Multicultural Services supports a large and diverse population across Western Sydney, many of whom face cultural, linguistic, and systemic barriers when accessing palliative care and Advance Care Planning. Prior to participating in the ELDAC Linkages Program, palliative care was often viewed as the responsibility of clinical staff, and Advance Care Planning conversations were difficult to initiate and sustain within CALD communities.

Participation in the ELDAC Linkages Program provided SydWest with structured education, guidance, and opportunities to strengthen workforce capability across all staff roles. Training supported staff to better understand palliative and end-of-life care, recognise their role in these conversations, and confidently explain the benefits of Advance Care Planning to clients and families in culturally appropriate ways.

A meaningful outcome from the program involved a client's daughter who, after receiving education about Advance Care Planning and palliative care, felt empowered to make informed decisions about their parent's end-of-life care. This knowledge supported clearer communication, reduced uncertainty, and enabled a smoother transition to appropriate palliative care services.

Through the facilitation process, SydWest also identified key barriers preventing CALD individuals from engaging in Advance Care Planning. Insights gained through the ELDAC Linkages Program informed the development of culturally responsive Advance Care Planning resources that consider language, cultural, and religious needs. These resources aim to support CALD individuals and families to understand their options, express their preferences, and participate confidently in healthcare decision making.

Participation in the ELDAC Linkages Program strengthened collaboration with hospitals and community health services, improved coordination of care, and increased satisfaction for clients and families. By building staff confidence and addressing cultural barriers, SydWest has enhanced its ability to deliver inclusive, person-centred palliative and end-of-life care that respects the diverse communities it serves.

\*Resident/Client names have been de-identified and are gender neutral to preserve confidentiality.



# Lifebridge Australia – Home Care



Home Care



Kingscliffe,  
New South Wales

## Highlights

- Built workforce confidence and death literacy to support Advance Care Planning (ACP) and a palliative approach
- Established strong working relationships with local specialist palliative care services, improving referral pathways
- Embedded Advance Care Planning into routine intake, review, and reassessment processes
- Introduced practical assessment tools to support early recognition of deterioration

## Goal

To strengthen workforce capability, systems, and partnerships to deliver high quality, person-centred palliative and end-of-life care for older people.

Located in Kingscliffe, Lifebridge Australia is a community aged care provider supporting older people across the northern NSW region. The service employs approximately 100 care staff, supported by 10 Care Partners. Lifebridge supports older people living at home who require flexible, responsive care to maintain independence and quality of life through the Commonwealth Home Support and Support at Home Programs.

When joining the ELDAC Linkages Program, Lifebridge recognised an opportunity to strengthen its palliative care foundations by building staff knowledge, confidence, and community connections. The program provided a structured framework to enhance processes, deliver targeted education, and strengthen the service's capacity to support clients and families through to end of life.

Through the ELDAC assessment phase, Lifebridge identified opportunities to develop their staff confidence and shared understanding of palliative care, particularly around Advance Care Planning conversations. Palliative care was often viewed as something introduced very late in life, and formal connections with specialist palliative care services were still developing.

*"The benefits of participating in the ELDAC program have been significant. Staff have more confidence and capacity to discuss ACP and palliative care."*

Participation in the program supported Lifebridge to build on these foundations by strengthening resources, systems, and care planning processes. A planned and staged approach enabled sustainable improvements, embedding Advance Care Planning and strengthening partnerships to better support older people to remain at home and live according to their wishes. External linkages were strengthened through planned meetings between services so as to ensure a more coordinated approach, support and the opportunity for a more integrated approach to care.



## Key outcomes and benefits

- Increased staff confidence and capability to initiate Advance Care Planning conversations
- Advance care planning discussions offered routinely, with consistent documentation
- Assessment tools introduced to support early recognition of deterioration
- Practical guidelines and resources developed for staff, clients, and families
- Increased staff confidence in delivering services under the End-of-Life, Restorative Care and Transitional Care funding pathways

“The ELDAC toolkit has been fundamental in building our framework for effective and quality driven end-of-life care in the home.”

## Our journey

Participating in the ELDAC Linkages Program has been a transformative experience for Lifebridge Australia. Through this initiative, we've embedded meaningful and sustainable changes that have strengthened our ability to provide high quality, person-centred palliative and end-of-life care in the community.

A key success has been building the capability of our workforce. Monthly education sessions were delivered to a newly formed group of Palliative Care Champions, including support workers, care managers, and office staff. These sessions increased confidence in recognising deterioration and applying a palliative approach, while fostering strong team connections and shared purpose. Conversations about dying, once avoided, are now approached with confidence, compassion, and clarity. Staff are more comfortable initiating Advance Care Planning discussions with clients and families, reflecting a significant uplift in death literacy across the organisation.

Advance care planning is now embedded as a core component of our service. All clients are introduced to ACP at intake, with Advance Care Directive (ACD) status clearly documented and reviewed. We developed a simple ACP flowchart and resource folders for clients, families, and staff, covering grief and loss, signs of dying, and practical care at home. This has helped ensure end-of-life care is approached as a deeply human experience.

Strengthened partnerships have also been a major outcome. We established strong linkages with the local Specialist Palliative Care team, creating clear referral pathways and shared case management processes. Owing to our strategic visits and sharing of ELDAC resources, to the local GP clinics, relationships with local GPs have also improved, enabling more coordinated care and supporting more people to remain at home at end of life.

Internally, we embedded clinical tools to provide a consistent approach to recognise and escalate early signs of deterioration, and case conferencing templates into everyday practice and staff onboarding. Sustainability remains a priority, with palliative care education now part of orientation and plans for intensive and ongoing palliative care education and family information sessions.

Most importantly, the program has shifted our culture. Palliative care and end-of-life care is now viewed as a shared responsibility, with carers embracing their vital role in comfort, dignity, and holistic support at end of life.



# Valmar Support Services



Home Care



Cootamundra, Goulburn,  
Yass, and surrounding  
Riverina regions,  
New South Wales

## Highlights

- Upskilled home care teams in providing a palliative care approach
- Strengthened linkages with specialist palliative care providers
- Integrated Advance Care Planning and palliative care resources into everyday practice.
- Introduced practical tools, including deterioration recognition prompts and Stop and Watch resources, to support early identification of change
- Embedded practical approaches and systems for initiating Advance Care Planning

## Goal

To strengthen our approach to palliative care and Advance Care Planning through building linkages and upskilling our aged care workforce across a large regional home care service.

Valmar Support Services is a well-established, community-based not-for-profit organisation with more than 50 years of experience supporting older people. Valmar operates across large regional and rural areas of New South Wales, including Tumut, Cootamundra, Goulburn, Yass, and surrounding Riverina regions. A coordinated team of 120 staff across different locations supports older people in maintaining their independence at home.

Prior to participating in the ELDAC Linkages program, Valmar faced several challenges common to regional home care services. These included workforce capacity pressures, limited access to specialist palliative care services in some locations, and the need for more consistent training to support sensitive conversations. Staff also managed complex client needs across wide geographical areas, which made coordination, communication, and documentation of Advance Care Planning more challenging.

For Valmar, embarking on the ELDAC Linkages Program was a journey that enabled the service to explore its needs and gaps as a regional home care provider in a practical way. Valmar recognised the

importance of building capability and confidence in palliative care and Advance Care Planning, particularly across geographically-dispersed teams.

The organisation sought guidance to strengthen systems, introduce deterioration recognition processes, embed consistent policies, and build stronger collaborative links with external services to support clients with complex and changing needs. While distance remains a challenge, establishing linkages has provided greater clarity about who to contact and how to work together for the benefit of clients. Referral processes are now clearer, and established contacts support timely onward referrals where required.

The palliative care education implemented across the service has built a strong foundation of knowledge, skills, and confidence among aged care workers. Practical palliative care resources now support staff to communicate confidently and provide care for clients and families in the home care setting. With support from the ELDAC Linkages facilitator, Valmar has established important connections with specialist palliative care teams to enable improved care delivery overall.

## Key outcomes and benefits

- Improved staff confidence and capability in initiating Advance Care Planning discussions with clients
- More consistent use of Advance Care Planning documentation and processes
- Introduction of deterioration recognition and reporting tools, including Stop and Watch
- Strengthened referral pathways and collaboration with local health, primary care, and specialist palliative care services
- Updated policies to embed a palliative approach and Advance Care Planning into routine practice



"Our ELDAC journey has helped us grow as an organisation. We now feel more confident, more connected, and better equipped."

At Valmar Support Services, we have always been deeply committed to helping older people remain living independently in their own homes. With our central office based in Tumut and smaller offices across our other service locations, our home care teams support clients across vast regional and rural areas. Our 122 aged care home care staff work daily in people's homes, often independently, building trusting relationships with clients and families over time.

Participating in the ELDAC Linkages program gave us the opportunity to pause, reflect, and strengthen how we support people as their needs change. As a service, we recognised that while our teams were compassionate and committed, many staff wanted more confidence when talking about Advance Care Planning and palliative care. We also saw the need for clearer, more consistent systems that could support staff working across different locations.

Through the ELDAC Linkages program, we focused on building confidence and capability across our workforce. We accessed practical education, tools, and resources that helped our staff feel more supported to start conversations, recognise deterioration, and respond early. Introducing tools such as Stop and Watch, ISBAR prompts, and laminated palliative care 'reminder cards' gave care workers simple, practical guidance they could carry with them into every home.

Equally important was the opportunity to strengthen our links with local health services, general practitioners, and specialist palliative care providers. These relationships improved communication and helped us work together more effectively for the benefit of our clients.

Our ELDAC journey has helped us grow as an organisation. We now feel more confident, more connected, and better equipped to provide person-centred, compassionate palliative care, supporting clients and their families with dignity and respect throughout their journey.



# Woolgoolga & District Retirement Village (WDRV)



Residential Aged Care



Woolgoolga,  
New South Wales

## Highlights

- Strengthened linkages with local primary care, palliative care, pharmacy, and virtual care services
- Improved after-hours access to medical advice through virtual consultations and clearer escalation pathways
- Increased staff confidence and capability in palliative care across all roles
- Embedded Advance Care Planning into pre-admission and ongoing care conversations
- Improved communication with residents and families about death, dying, and end-of-life preferences
- Enhanced staff confidence around grief support for both residents and their families

## Goal

To strengthen palliative care through improved staff confidence, better after hours and external clinical support, and the integration of Advance Care Planning aligned to residents' wishes.

Woolgoolga & District Retirement Village is a 66-bed residential aged care facility located between Coffs Harbour and Grafton. The service provides residential care to older people from a culturally diverse regional community, including a large Indian population. The workforce also reflects this diversity, with many staff members from culturally and linguistically diverse backgrounds. WDRV delivers personal, nursing, and end-of-life care within a close-knit coastal community and is committed to providing person-centred care that respects residents' values, culture, and preferences.

As a small regional stand-alone facility, WDRV faced challenges accessing timely palliative care support and education. Participation in the ELDAC Linkages program provided an opportunity to strengthen external connections, improve staff capability, access after-hours support, and support compliance with accreditation requirements.

Prior to participation, staff had limited access to offsite education, challenging after hours clinical pathways, and challenges in end-of-life conversations due to language and cultural differences, impacting confidence, consistency, and timely palliative care support.

Through the ELDAC Linkages Program, the team implemented a comprehensive program of improvement to strengthen palliative care. Advance Care Directives were embedded into admission processes, staff education and annual training were expanded, and evidence-based tools were integrated. Access to 24/7 medical support was strengthened, clinical monitoring systems refined, Registered Nurse (RN) competencies enhanced, family resources improved, and timely case conferencing and triage supports introduced, resulting in more confident staff, reduced family anxiety, and more holistic, person-centred end-of-life care.

## Key outcomes and benefits

- Improved palliative care knowledge and confidence across staff at all levels
- Clearer escalation pathways and increased confidence in accessing after-hours medical support
- Improved access to education through local and virtual opportunities
- Strengthened communication with residents and families about Advance Care Planning and end-of-life care
- Improved cultural confidence among staff when discussing death and dying



“With the help from ELDAC we have started the journey, and we are continuing to move forward, building our capacity and confidence in providing best practice, person-centred quality palliative care services.”

### Our journey

Participating in the ELDAC Linkages program has been a significant and positive step forward for Woolgoolga & District Retirement Village (WDRV) in strengthening palliative and end-of-life care for residents. As a small regional residential aged care service, access to external support had often been limited, particularly outside of business hours. The ELDAC Linkages program provided both the structure and support needed to address these challenges in a practical and sustainable way.

Early in the program, WDRV identified the importance of strengthening external linkages to support residents whose needs were changing. With guidance from our ELDAC facilitator, we established stronger connections with local primary health and palliative care providers, pharmacy services, and after-hours medical supports. The introduction of virtual care technology enabled face-to-face consultations after hours, allowing timely clinical decision-making, shared case conferencing, and clearer communication with families.

Education and workforce capability were a strong focus throughout the program. Access to evidence-based palliative care education, combined with local education opportunities, improved staff knowledge and confidence across all roles. This was particularly important for a workforce where English is often a second language. Staff report feeling better equipped to have meaningful and culturally sensitive conversations with residents and families about death, dying, and what matters most to them. Expanded grief support resources have further strengthened staff confidence in supporting residents and families through loss and bereavement.

Advance Care Planning was embedded more consistently into our care processes. Advance Care Directives were incorporated into pre-admission packs, supporting earlier and clearer conversations about residents' wishes. Where residents were unable to complete a formal directive, Emergency Care Directives were reviewed in collaboration with residents and their support people, ensuring preferences were documented and respected.

Medication management and after-hours response processes were also reviewed and strengthened. By working collaboratively with our pharmacy provider and integrating virtual care systems that could access clinical records, we have improved our ability to respond quickly to changes in residents' conditions. These improvements have reduced uncertainty for staff and improved continuity of care for residents and families, particularly during evenings and weekends.

Throughout program, the consistent support and guidance of the ELDAC facilitator was critical. Practical advice, encouragement, and access to resources helped us maintain momentum and confidence in making changes. Participation in the ELDAC Linkages program has strengthened our systems, built staff confidence, and improved collaboration, supporting WDRV to deliver quality, person-centred palliative and end-of-life care for residents now and into the future.



# Nazareth Care - Nazareth House Wynnum



Residential Aged Care



Wynnum,  
Queensland

## Highlights

- Provided guidance, resources, and structured frameworks to support improvement goals and implementation
- Connected the service with key external stakeholders and training providers
- Facilitated regular check-ins and working group meetings to maintain momentum
- Supported staff engagement through practical tools and tailored education pathways
- Helped embed sustainable change by aligning improvements with quality and compliance systems

## Goal

To strengthen approach to Advance Care Planning and palliative care provision.

The beautiful heritage-listed Nazareth House Wynnum is on a hilltop location with views out to spectacular Moreton Bay Brisbane and has been providing care for the elderly since 1921. The 120-bed home has over 175 staff providing comprehensive person-centred care to a diverse population of older Australians. Both respite and permanent care are offered, and includes complex care management, dementia support, symptom management, palliative care and emotional/spiritual support for clients and their families.

Nazareth House Wynnum joined the ELDAC Linkages program with an aim to strengthen the approach to Advance Care Planning and palliative care provision. Nazareth House Wynnum objectives included improved coordination with external providers (communication was ad hoc and unstructured), upskilling staff capacity and confidence in Advance Care Planning and palliative care, and embedding consistent, high-quality practices to ensure quality in care provision.

Participation offered access to structured support, tools, and education to help staff feel more confident in managing end-of-life care and supporting residents and families with compassion and clarity.

Nazareth House Wynnum staff reported increased confidence and clarity in managing deteriorating residents and subsequent family discussions, noting that the presence of Advance Care Planning and palliative care champions made a significant difference in practice. The introduction of resources (resident, family and staff), updated palliative care trolley stock and additional education have equipped staff with practical tools and experiences to manage end-of-life care more effectively.

Through the program, Nazareth House Wynnum has embedded sustainable systems into its orientation and ongoing training schedules. ELDAC After Death Audits are now routine, and bereavement support has been formalised with meaningful resources for families.

## Key outcomes and benefits

- Improved staff confidence and capability in Advance Care Planning and palliative care
- Established structured processes and clearer documentation for Advance Care Planning and end-of-life care
- Strengthened partnerships and processes with external providers including specialist palliative care providers and educators
- Embedded ongoing education and quality improvement into daily practice
- Enhanced support for residents and families, particularly during bereavement

“The ELDAC Linkages Program has transformed the way we approach palliative care – from early planning to family support – and empowered our team to deliver care with greater compassion and confidence.”

“The partnerships we’ve built and the tools we’ve implemented through ELDAC have made a real difference to our residents and families at the most important times in their lives.”

One experience that stands out during Nazareth House Wynnum’s participation in the ELDAC Linkages program involved a long-term resident with advancing dementia who began to show signs of clinical deterioration. In the past, staff may have hesitated to initiate Advance Care Planning conversations or delay specialist referrals. However, due to improved processes and education through ELDAC Linkages, Nazareth House Wynnum team confidently engaged the resident’s family early using the updated Advance Care Planning checklist and structured flowcharts.

A Registered Nurse, newly upskilled through training, led a sensitive and thorough discussion with the family, ensuring the resident’s values and preferences were captured and documented. The referral pathway to specialist palliative care team was followed effectively, and support was provided in a timely manner. The resident remained in familiar surroundings, with appropriate symptom management and spiritual support provided. The family later expressed gratitude for the compassionate care and clear communication during such a difficult time.





# Infin8 Care - Ashmore



Residential Aged Care



Ashmore,  
Queensland

## Key highlights

- Increased staff confidence in recognising deterioration and end of life
- Strengthened partnerships with psychology, palliative care, and clinical education providers
- Improved access to evidence-based tools, resources, and medication advice through external partners
- Enhanced teamwork, communication, and staff engagement
- Better understanding of grief, loss and bereavement among staff

## Goal

To strengthen staff capability in recognising deterioration, improve confidence in identifying end of life, enhance the quality and timeliness of palliative care assessments, and embed consistent use of the SPICT tool to support early, person-centred decision making.

Infinite Aged Care – Ashmore is a 152-bed residential aged care facility located in Ashmore on the Gold Coast. The service provides 24-hour nursing care for older people with complex health needs, including frailty, dementia and chronic conditions. A dedicated workforce of 222 staff delivers person-centred care focused on dignity, empathy and safety. The facility supports a diverse group of residents with varying levels of care needs, ensuring continuity of clinical, emotional and lifestyle support. Staff work collaboratively to respond to changing health status, ensuring residents and families receive compassionate and well coordinated care.

The service sought support to strengthen early recognition of deterioration, improve consistency in escalation, build staff confidence in timely decision making regarding person-centred palliative



and end-of-life care, and enhance palliative and bereavement support for residents, families and staff.

Infection outbreaks, increased care needs and greater reliance on agency staff limited time for education and consistent practice change. These pressures made it difficult to embed early recognition and escalation processes, resulting in delays in initiating Advance Care Planning conversations and inconsistent responses to deterioration.



## Key outcomes and benefits

- Improved staff competence and confidence in recognising deterioration
- Earlier escalation and more structured clinical responses
- Enhanced teamwork through clearer communication pathways
- Increased staff understanding of grief, loss and bereavement
- Strengthened partnerships enabling timely medication advice and access to specialist resources
- Integration of SPICt training into induction and clinical meetings for sustained practice change

### Our journey

Infinite Aged Care – Ashmore embarked on the ELDAC Linkages program with a commitment to strengthen its palliative care approach and ensure residents received compassionate, timely and person-centred support as their needs changed. While staff were dedicated and experienced, internal review showed that early recognition of deterioration varied, escalation pathways were not always consistent, and Advance Care Planning conversations were sometimes delayed until residents were already experiencing significant decline.

Through the ELDAC Linkages program, the service deepened its connections with external resource and support organisations, including specialist palliative care advisory services, psychology services, and education providers. These partnerships expanded access to expert clinical advice, evidence-based tools and psychological support. Staff developed stronger skills in recognising subtle changes in residents' condition, enabling earlier escalation and more structured clinical responses. The program also improved understanding of end-of life indicators, bereavement needs and the importance of timely communication with families.

Education was central to the service's progress. Targeted sessions enriched staff knowledge of palliative approaches, deterioration cues and comfort-focused care. SPICt training was embedded into induction processes and reinforced through regular Registered and Enrolled Nurse meetings. This ensured both new and existing staff had ongoing exposure to evidence-based tools that guide early identification of residents approaching end of life.

The impact of these changes is reflected in the care provided to a long term resident. As their health declined, staff used ELDAC resources to initiate timely Advance Care Planning discussions, ensuring their wishes were documented and respected. Regular communication with their family helped them understand their changing care needs and prepare for the final stages of life. The resident remained in their familiar surroundings, supported by people they knew and trusted, and received calm, dignified care aligned with their preferences.

Following their death, the team continued to support the family through their grief, drawing on ELDAC bereavement guidance to provide compassionate follow up. Staff also acknowledged their own emotions, contributing to a healthier, more supported workplace culture. The resident's family expressed heartfelt gratitude for the care provided, reinforcing the profound impact of strengthened collaboration, clearer processes and skilled, compassionate staff.

\*Resident/Client names have been de-identified and are gender neutral to preserve confidentiality.



# Infin8 Care - Cornubia



Residential Aged Care



Cornubia,  
Queensland

## Highlights

- Increased completion and accuracy of Statements of Choices, improving understanding of resident wishes
- Strengthened family awareness of the palliative journey and available supports
- More than 60 staff accessed intensive education workshops, improving capability in palliative and end-of-life care
- Care staff equipped with a consistent, whole-of-workforce approach to recognise and escalate early signs of deterioration
- ELDAC facilitation provided structure, clearer communication pathways and strengthened linkages across local service networks

## Goal

To strengthen coordination with local palliative and primary care providers, enhance support for residents and families, and build staff confidence, knowledge and emotional resilience to deliver a consistent, person-centred palliative care approach.

Infinite Care Cornubia is a 137-bed residential aged care home in the Cornubia–Logan region, staffed by approximately 220 team members. The service supports an ageing community with complex health needs requiring 24/7 care. Providing permanent, respite and palliative care, the home prioritises safety, comfort and holistic wellbeing, while promoting independence wherever possible. Care is delivered through a person-centred, multidisciplinary approach that responds to the needs of residents with low to high care requirements and supports families through all stages of the care journey.

The service sought to strengthen coordination with external care providers, enhance support for residents and families — including grief and bereavement support — and build workforce capability and emotional resilience in palliative and end-of-life care.

Prior to participation, staff confidence in understanding palliative care varied, early signs of deterioration were often missed, documentation of Statements of Choices was inconsistent, and administering anticipatory medicines felt daunting. These challenges impacted symptom relief, communication, continuity of care and occasionally led to avoidable external transfers.

“The combined expertise of the ELDAC facilitator and onsite project champions resulted in the site being able to not only improve palliative care but also improve funding and care minute allocation which means more staff to spend more time, giving the right care.”

*A team member*

## Key outcomes and benefits

- Improved completion and filing of Statements of Choices
- Increased capability among registered nurses and care workers following intensive education workshops
- Earlier recognition of deterioration through consistent, whole-of-workforce use of an early warning tool
- Strengthened communication and shared understanding of the palliative journey for residents and families
- Enhanced coordination with local providers supporting consistent, timely, person-centred care
- A more informed, confident and collaborative approach to palliative and end of life care across the service

## Our journey

Before participating in the ELDAC Linkages program, Infinite Care Cornubia recognised that many staff associated palliative care only with the final days of life. This limited view made it difficult to identify early signs of deterioration and contributed to hesitancy when initiating conversations with residents and families about changes in condition. Low confidence in administering anticipatory medicines and inconsistent documentation of Statements of Choices also affected the team’s ability to deliver timely and coordinated care.

Participation in the ELDAC Linkages program helped the service shift to a more structured, collaborative and holistic approach. With guidance from the ELDAC facilitator, the team established clearer processes for recognising deterioration, documenting resident preferences and communicating effectively with families and external providers. This support helped build internal accountability, strengthen partnerships and embed consistent messages across the service.

A significant achievement was the increase in completed Statements of Choices — from 67% to over 87%. This improvement ensured resident wishes were better understood and honoured. Staff capability increased markedly, with more than 60 team members participating in intensive education workshops delivered by external providers. These sessions improved understanding of palliative, end-of-life and last days of life care, strengthened clinical confidence and helped staff feel more comfortable discussing goals of care with residents and families.

The implementation of an approach to recognising deterioration empowered care workers to identify subtle changes sooner and advocate for residents, enabling earlier escalation to clinical staff. Families also reported feeling more informed and supported, describing clearer explanations of the palliative journey and improved communication during times of uncertainty.

The combined expertise of the ELDAC facilitator and onsite project champions strengthened care quality, improved collaboration with local services and contributed to better outcomes for both residents and staff.

Through its participation in the ELDAC Linkages program, Infinite Care Cornubia has established a sustainable, person-centred and compassionate approach to palliative care — one that supports residents, families and staff throughout the end-of-life journey.



# Kewarra Aged Care



Residential Aged Care



Kewarra Beach,  
Queensland

## Highlights

- Improved awareness and uptake of Advance Care Planning across the service
- Strengthened early recognition of residents approaching end of life
- Supported earlier access to specialist palliative care services
- Reduced stress for residents, families, and staff through more structured processes
- Enhanced the quality and coordination of end-of-life care delivery

## Goal

To strengthen palliative care practice, improve early recognition of end of life, and enhance Advance Care Planning so residents can be supported to remain comfortably in their home during their final days.

Kewarra Aged Care is a 94-bed residential aged care facility located in Far North Queensland, supporting residents with mixed dementia and high care needs. The service employs more than 100 staff since 2026 who are committed to providing safe, compassionate, and person-centred care. Kewarra Aged Care supports older people requiring complex clinical care and values a home-like environment that promotes dignity, comfort, and quality of life for residents and their families.

The service chose to participate in the ELDAC Linkages Program to enhance palliative care capability and ensure residents are supported to remain in familiar surroundings at the end of life, with care that reflects their values, preferences, and needs.

Prior to participation, the service identified opportunities to strengthen early recognition of end of life, improve timely access to specialist support, increase engagement in Advance Care Planning, and enhance documentation processes during critical periods. Addressing these areas aimed to reduce stress for residents, families, and staff.

## Key outcomes and benefits

- Improved awareness and understanding of Advance Care Planning
- Stronger early identification of residents approaching end of life
- More timely access to specialist palliative care supports
- Improved documentation and review processes
- Increased staff confidence in supporting residents and families during end-of-life care



## Our journey

Kewarra Aged Care supports residents with complex needs, including mixed dementia and high care requirements, and is committed to delivering high quality palliative care within the resident's home. Prior to participating in the ELDAC Linkages Program, the service identified opportunities to enhance early recognition of end-of-life needs and strengthen timely, meaningful Advance Care Planning. Addressing these areas aimed to improve access to specialist services and support documentation during periods of deterioration.

Participation in the ELDAC Linkages Program provided a structured opportunity to reflect on existing practices and strengthen the service's approach to palliative and end-of-life care. With support from the ELDAC facilitation process, Kewarra Aged Care focused on increasing awareness of Advance Care Planning and improving early intervention. Staff were supported to view end-of-life care as a proactive and ongoing conversation, rather than a task undertaken during a crisis.

Through enhanced guidance and regular support, the service strengthened its ability to recognise residents entering the end-of-life phase earlier. This enabled more timely engagement with specialist palliative care services and improved coordination of care for residents and their families. Structured approaches to Advance Care Planning helped reduce the stress associated with rushed decision making and supported clearer communication about residents' wishes and goals of care.

The ELDAC Linkages Program also fostered valuable connections beyond the facility, encouraging broader collaboration and shared learning. Staff reported greater confidence in discussing Advance Care Planning and responding to residents' changing needs, resulting in more consistent, supportive, and well-coordinated care across the service.

Through participation in the ELDAC Linkages Program, Kewarra Aged Care strengthened its systems and practice, enabling residents to remain in the comfort of their home with care that is thoughtful, well planned, and centred on dignity at the end of life.



# Akooramak Care of Older Persons



Residential Care



Warwick,  
Queensland

## Highlights

- Upskilled teams on palliative approach to care
- Built confidence in new graduate Registered Nurses (RNs)
- Strengthened communication and emotional support to resident and their families
- Improved access to evidence-based palliative care resources and information

## Goal

To improve palliative care.

Our facility is a community run not-for-profit service. We have been part of the community since 1972, so we are well known in Warwick, a regional town near the NSW border. We provide residential and home care services to the surrounding areas and currently employ approximately 100+ staff. The local population is aging, but we are lucky that we are attracting younger families and professionals looking for a lifestyle change. With this though comes the challenge of proving our reputation to them, as they do not know our history.

As a result of the pandemic, there have been huge changes in the care industry and a lot of senior staff have moved on. We needed to revitalise and modernise and identified our palliative care as a focus area.

At Akooramak, we were keen to improve palliative care. As an aged care facility, we always saw palliative care as our greatest area of service, recognising the importance of ensuring people have a good death as well as enabling them to have quality of life for the time they live with us.

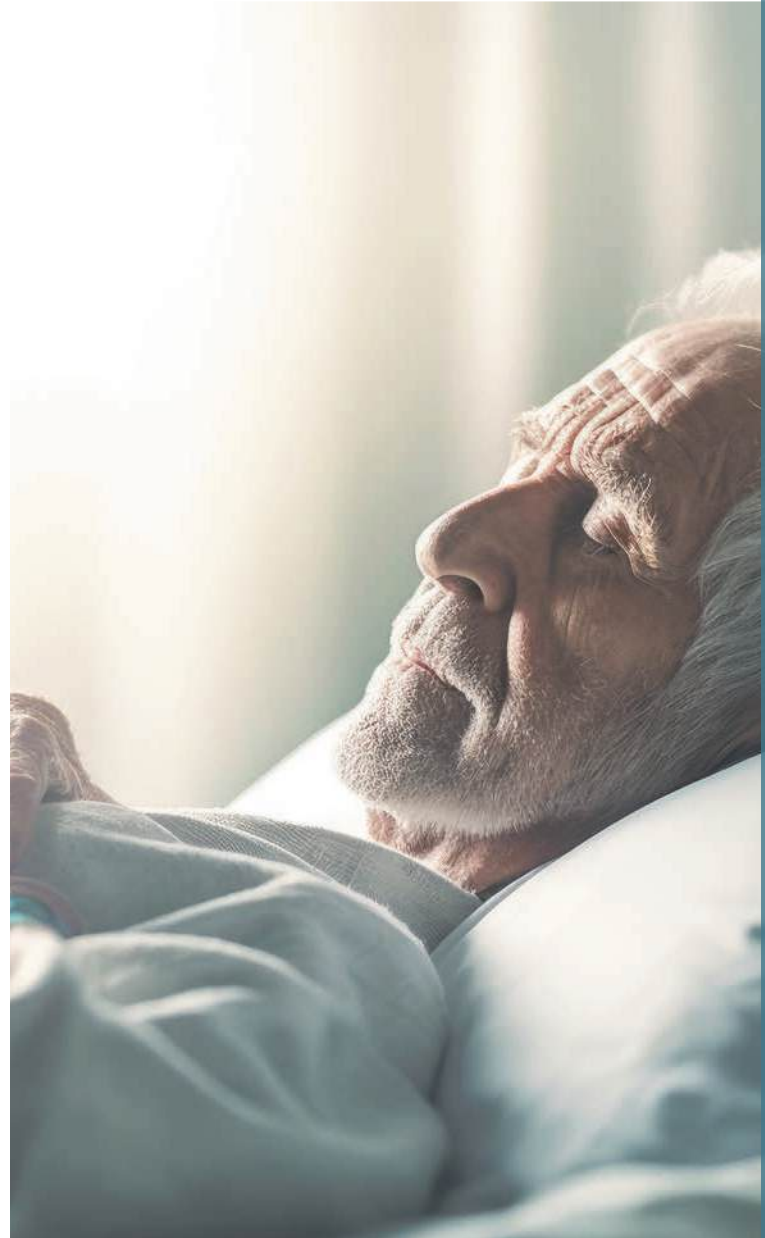
Long established staff leaving became our greatest challenge. They have been replaced by people new to the area and new to aged care. The local development of a contentious wind farm and the

associated influx of workers caused a generalised air of distrust in the community, so this made it harder to establish new relationships. We also wanted to build networks with other local and regional services and providers – to find out who to go to and who to contact to help optimise our care and collaboration.

ELDAC has allowed the service to grow and mature in the way we present and deliver palliative and end-of-life care. Our staff are more comfortable with this care now and want to deliver it in a way that really matters.

One significant change we've instituted is in engaging a Death Doula as our end-of-life liaison person; this has been invaluable. Deb is able to bridge that gap between a good life and a good death with grace and understanding. She talks comfortably about the end of life, about Advance Care Planning, and what to expect. This has been very well received by residents and families and has improved understanding and comfort within our care team too.

Without the support of the ELDAC program we would not have been able to implement the strategies and resources we have. It allowed us to embed changes to practice at the facility. If we had to sum up the experience - when our best wasn't good enough, we worked to make it better. In a way we have normalised dying as part of our care. Our residents know no matter what type of care they are receiving it will be the best.





# Wowan/ Dululu Multi- Purpose Centre (WDMPC)



Home Care



Wowan,  
Queensland

## Highlights

- Vastly improved connections with external palliative care providers/educators
- Staff training and community education affecting growth and positive feedback
- Improved capacity discussing palliative, end-of-life care and Advance Care Planning

## Goal

To improve capacity and linkages to deliver, facilitate and support end-of-life care in our community.

The Wowan/Dululu Multi-Purpose Centre (WDMPC) is a community owned and run not-for-profit organisation. Established in 1992 by the community, for the community – the service is fundamental not only to in home aged care in the area, it is also a central point of care and reference for the community in general. WDMPC are rurally based and sit within a large, complex health service region.

Participation in the ELDAC Linkages program provided an opportunity to achieve WDMPC identified goals, including: -

- Improve linkages, processes and pathways that impact the provision of palliative, end of life and Advance Care Planning
- Upskill staff capacity, knowledge and confidence
- Improve Advance Care Planning approach including team responsibility considerations, resources, tools, policy and culture
- Build a compassionate community to support people and families at the end of life and in bereavement

The ELDAC Linkages facilitator guided WDMPC through the program:- self-assessment audits were conducted, a meaningful improvement plan developed, capacity building activities and linkage improvements, connecting to the right teams, were undertaken. As all of the improvement, capacity and linkage activities came together WDMPC confidence grew. Linkages with external stakeholders, including specialist palliative care providers and educators produced significant and meaningful benefit. WDMPC now have active, beneficial relationships with a number of external services that can support clients and staff in a variety of ways – from routine staff training, clinical care and advice, to supporting management of in-house documents.

WDMPC are normalising conversations about death and dying, staff confidence facilitating discussions, with clients being able to honestly communicate their wishes, has grown immensely. Improved processes now also ensure the reliability and availability of documents of Advance Care Planning. Reviewed and updated policies, procedures and client resources are readily accessible and available.

Participation in the ELDAC Linkages Program brought about systemic change in the WDMPC service, from onboarding through to the end of a clients life. WDMPC now provides better quality care and staff feel more capable, confident and connected!



Suzie Peacock, Co-ordinator  
Wowan/Dululu Multi-Purpose Centre



### Reflection on ELDAC Linkages facilitation

Our ELDAC Linkages facilitator/mentor cannot go unmentioned. From our initial meeting through to completion of the project she was a constant and reliable source of information and direction. She provided real insight and resource, and the linkages that were facilitated proved relevant to our situation and ultimately the ongoing success of our goal – ‘can the WDMPC realistically provide care to clients at the end of their life, at home?’. We feel that the ELDAC Linkages facilitator appreciated and understood our geographical situation and the predominant demographic of our clientele (rural). She ‘got’ the barriers and challenges we face regarding our ability to provide holistic, quality care, as well as the inherent qualities of our clients and how that (generally) influences their attitudes and values regarding end of life. She has, without doubt, facilitated a positive, enriching and appropriately paced learning opportunity for our team that has benefited us all – staff, clients and community – both professionally and personally. Thank you!”

*Coordinator, WDMPC*



# Bene Aged Care - St Paul's



Residential Aged Care



Handorf,  
South Australia

## Highlights

- Established a shared vision for quality palliative and end-of-life care, strengthening leadership alignment and teamwork
- Improved staff capability through education, tools, and clear escalation pathways for managing deterioration
- Strengthened Advance Care Planning processes to support consistent, person-centred decision-making
- Enhanced collaboration with local specialist palliative care, primary health, spiritual care, and general practitioners

## Goal

To strengthen the quality and consistency of palliative and end-of-life care across the service. The goals were to build staff confidence and capability, improve Advance Care Planning practices, align care with residents' wishes, and strengthen partnerships with local health and specialist palliative care services to support a holistic, person-centred approach.

Bene St Paul's Hahndorf is an 80-bed not-for-profit residential aged care service located in the historic village of Handorf in the Adelaide Hills. The service aims to provide welcoming, nurturing, and safe care that respects each person's cultural, spiritual, and social needs. Residents are primarily from Hahndorf and surrounding rural communities, with strong connections to family and community.

Bene St Paul's Hahndorf recognised the need to strengthen end-of-life care, build staff capability, improve Advance Care Planning and coordination, and connect with specialist services. Early vision-setting aligned the management team and strengthened their approach to achieving these goals.

Prior to participating in the ELDAC Linkages program, Bene St Paul's Hahndorf identified limited staff confidence in palliative care, inconsistent Advance Care Planning, and fragmented communication with external services. Care was often reactive, leading to variability in end-of-life practices and increased emotional burden for families and staff. These challenges prompted the service to develop a shared vision: 'Quality palliative care and end-of-life care – the St Paul's Way'.

Through participation in the ELDAC Linkages program, Bene St Paul's Hahndorf strengthened end-of-life care by improving recognition of deterioration, clinical confidence, and care coordination.

Key improvements included consistent use of SPICT and PainChek, enabling earlier identification of decline, better pain management, and clearer communication with families. Education increased registered nurses' confidence in assessment, symptom management, and escalation of care.

Systems were strengthened through updated policies, clear care pathways, defined staff roles,

and embedding an end-of-life care plan into the clinical software system.

Staff capability, external partnerships, bereavement support, and continuous improvement were reinforced through structured communication, comfort rounds, after-death audits, and a trauma-informed, person-centred approach.

## Key outcomes and benefits

- Introduced structured clinical tools, including the Supportive and Palliative Care Indicators Tool (SPICT) and improved pain assessment practices
- Reviewed and updated policies, pathways, and procedures related to palliative care, end-of-life care, Advance Care Planning, and hydration and nutrition
- Clarified roles and responsibilities for all staff within the end-of-life care pathway
- Increased staff confidence in recognising deterioration, managing symptoms, and escalating care appropriately
- Strengthened partnerships with local specialist palliative care, primary health networks, general practitioners, and spiritual care providers
- Embedded continuous quality improvement through after-death audits, comfort rounds, and reflective team practices

“Moving forward, our service is now educated and committed to strengthening the quality, consistency and compassion of palliative care and Advance Care Planning.”

“The program has given us the opportunity to reflect and rebuild, by embedding best practices, empowering our staff, engaging families, and building strong partnerships with external providers.”

*Melinda Hartley*



Before we began the ELDAC program, end-of-life care was something our staff often approached with hesitation. While we always aimed to provide compassionate care, there were gaps in confidence, communication, and Advance Care Planning.

By working together with our specialist palliative care service, we were able to increase staff confidence and clinical skills in delivering high quality palliative care.

By focusing on our Advance Care plans and Directives we were able to guide staff in making confident, consistent care decisions, even during afterhours or emergency situations.

One experience that stands out during our time with ELDAC involved a long-term, 87-year-old resident with late-stage heart failure. Before ELDAC, conversations about end-of-life preferences were often delayed or avoided due to discomfort or uncertainty.

However, after beginning ELDAC training, our staff felt more empowered to initiate these conversations with both empathy and clarity. With support from the ELDAC Advance Care Planning toolkit and our GP, we sat down with the resident and their daughter to discuss their goals, wishes, and fears.

They expressed a strong desire to stay in the comfort of the home rather than be transferred to hospital during their final days. With a clear plan documented, we were able to manage their symptoms effectively in-house. Our staff coordinated with the local palliative care team and maintained regular communication with the family.

In their final days, the resident was surrounded by familiar staff and their daughter, in their own room, with spiritual care provided by our chaplain. Their daughter later shared how grateful she was for the peaceful, respectful way their parent was cared for — and how involved they felt in the process.

This experience highlighted how empowered, well-informed staff and structured planning can dramatically improve the quality of dying — for residents and their families.

\*Resident/Client names have been de-identified and are gender neutral to preserve confidentiality.



# Jallarah Homes Inc.



Residential Aged Care



Meningie,  
South Australia

## Highlights

- Built staff confidence by accessing palliative care education and networking with peers
- Improved communication with families through clearer, earlier discussions about end-of-life wishes
- Introduced the new Advance Care Directive (ACD) and embedded earlier ACP conversations at admission
- Enhanced comfort and family engagement with a refreshed palliative care trolley and updated resources

## Goal

To strengthen staff confidence in recognising deterioration, improve access to reliable palliative care support, and embed clearer Advance Care Planning processes to ensure residents' wishes are understood, respected, and integrated into daily care.

Jallarah Homes Inc is a residential aged care service committed to providing high quality, holistic care in partnership with residents. With approximately 45 staff, including a registered nurse on every shift supported by enrolled nurses and personal care assistants, the service offers high, low, dementia and NDIS-related care. Located in a small outer regional community, Jallarah supports around 30 residents from the Coorong Council area and beyond. The service's focus on safety, wellbeing and person-centred support reflects the diverse and changing needs of residents living with increasing frailty and complexity.

Jallarah joined the ELDAC Linkages Program to strengthen support for a transient and often novice nursing workforce, particularly after hours. With limited access to specialist palliative care and inconsistent Advance Care Planning (ACP) documentation, the service sought reliable resources, stronger pathways, and confidence building tools to support best practice palliative and end-of-life care.

Key challenges included a transient workforce, limited professional development opportunities, and reliance on inexperienced nurses, particularly after hours. One third of residents lacked clear or clinically useful ACP documents. Leadership changes during the project also disrupted momentum and impacted staff confidence and continuity.





## Key outcomes and benefits

- Embedded palliative and end-of-life care into continuous quality improvement processes
- Refreshed and expanded end-of-life resources, including a new palliative care trolley for residents and families
- Strengthened ACP capability with staff training, proactive checks, and improved communication with families
- Introduced early palliative care education and supported more in depth learning opportunities
- Developed a planned training calendar to sustain capability building
- Identified the need for a Designated Linkage Worker to support ongoing connections with external providers

## Our journey

Participation in the ELDAC Linkages Program gave Jallarah Homes a clear pathway to strengthen palliative and end-of-life care in a small regional setting where staff often work with limited support. With many nurses new to both aged care and palliative care practice, uncertainty in recognising deterioration and initiating end-of-life conversations had been a longstanding challenge. The program offered structured guidance, practical tools, and the reassurance of having reliable evidence-informed resources immediately accessible to staff.

One of the most meaningful improvements was the introduction of a dedicated palliative care trolley. Previously, comfort items were stored on bedside tables and over way frames, unintentionally encroaching on residents' personal space and making it difficult for staff to locate what they needed quickly. The new trolley has transformed this experience. It centralises comfort care supplies, provides informative brochures for families, and offers a practical, respectful way to open conversations about how residents and families are coping. Staff reported that the trolley has become a catalyst for gentler communication and more coordinated care.

The value of the program became especially clear in the care of a resident who passed away in October. With their three adult children living far away, Jallarah staff recognised the importance of maintaining regular, supportive contact. Guided by new knowledge gained through networking and education opportunities, nurses felt more confident communicating about symptom management, comfort care and interactions with local medical practitioners. Staff also initiated grief support for the family — something many nurses had previously felt unsure about. The family expressed deep appreciation for the care, communication, and compassion provided.

At the same time, the service strengthened the way ACP is approached. With many existing documents unclear or prepared without clinical context, nurses have begun implementing the new ACD much earlier in the admission process, ensuring residents' wishes can guide decision making before deterioration occurs.

Through its participation in the ELDAC Linkages Program, Jallarah has laid foundations for a more confident workforce, stronger family partnerships and more coordinated end-of-life care — ensuring every resident is supported with dignity, comfort, and compassion.

\*Resident/Client names have been de-identified and are gender neutral to preserve confidentiality.



# North Eastern Community Hospital Aged Care (NECH)



Residential Aged Care



Campbelltown,  
South Australia

## Highlights

- Developed a comprehensive palliative and end-of-life care framework to guide consistent practice
- Introduced a structured multidisciplinary case conference model centred on residents and families
- Strengthened staff confidence and capability through planned education and workforce development
- Improved collaboration with local specialist palliative care services and the co-located hospital
- Embedded continuous quality improvement through After Death Audits and policy review processes

## Goal

To improve palliative and end-of-life care through a coordinated, whole of service approach, building staff capability and consistent processes that support culturally responsive, person-centred care.

North Eastern Community Hospital Aged Care (NECH) is a not-for-profit, community owned residential aged care service co-located with North Eastern Community Hospital in Campbelltown, South Australia. It provides permanent high care and respite for up to 84 residents, including a 23-bed Memory Support Unit. NECH supports a culturally diverse population, with around 65% of residents from an Italian background, and is guided by a strong commitment to dignity, safety, wellbeing, and person-centred decision making throughout the palliative and end-of-life journey.

NECH Aged Care chose to participate in the ELDAC Linkages Program to achieve meaningful and sustained improvements in palliative and end-of-life care. The service identified the need to strengthen staff confidence, embed consistent systems and education, and enhance culturally responsive practice. Participation also supported the service's aspiration to develop a coordinated, multidisciplinary approach underpinned by clear frameworks, processes, and external linkages.



Prior to participation, NECH Aged Care lacked a formal palliative care framework, had inconsistent case conferencing, and limited multidisciplinary involvement. Staff confidence varied in Advance Care Planning and palliative conversations, particularly with culturally and linguistically diverse residents and families, and sparse links with specialist palliative care services limited sustainable practice improvement.

## Key outcomes and benefits

- Established a comprehensive, service-wide palliative and end-of-life care framework
- Embedded a structured multidisciplinary case conference process into routine practice
- Increased workforce confidence and competence in palliative care and Advance Care Planning
- Improved communication and trust between staff, residents, and families
- Strengthened collaboration with specialist palliative care services, local hospital services, and primary health networks
- Introduced After Death Audits to support reflection, governance, and continuous improvement

"Thank you to ELDAC for providing us the opportunity to be part of the ELDAC Linkages Program. We have achieved so much that we would not have achieved otherwise."

*Sarah Dobrota, Care and Quality Manager – Aged Care*

"Bringing us all together for education, has reinvigorated our passion for palliative care... all coming together to do the training has also been about team building and team bonding."

*Sarah Dobrota, Care and Quality Manager – Aged Care*

## Our journey

Participating in the ELDAC Linkages Program gave us the opportunity to pause and reflect on how we were delivering palliative and end-of-life care at North Eastern Community Hospital Aged Care. While we were deeply committed to supporting residents and families, the program encouraged us to examine the purpose, structure, and consistency of our care practices more closely.

Working alongside our ELDAC Linkages facilitator, we identified the need for a more organised, systematic, and collaborative approach that supported staff across all roles and better reflected person-centred care within our culturally diverse community. This reflection led to the development of the NECH Aged Care Palliative and End-of-Life Framework, which now underpins practice across our service.

A central feature of the framework is the multidisciplinary case conference model. Prior to the program, case conferences were not always structured or inclusive of all disciplines involved in a resident's care. With ELDAC support, we developed a clear, step-by-step process that places residents and families at the centre of decision making.

Nursing staff, care workers, allied health professionals, general practitioners, and leaders are now actively involved in care planning. This collective approach has strengthened communication, clarified roles, and supported a shared understanding of residents' needs, goals, and preferences. Families are better supported to participate in palliative and end-of-life planning, building trust and shared decision making.

The ELDAC Linkages Program also supported more sustainable systems through the development of policies, procedures, templates, tools, and flowcharts, with key processes integrated into existing software systems. Education and upskilling were embedded across the workforce from induction through ongoing learning.

Continuous quality improvement was strengthened through After Death Audits, creating regular opportunities to reflect on care delivery and inform improvement. Overall, the program enabled a shift from variable practice to a coordinated, whole of service approach, strengthening teamwork, staff confidence, and the quality and consistency of palliative and end-of-life care.



# HenderCare Home Care



Home Care



Adelaide CBD,  
South Australia

## Highlights

- Embedded advance care directive discussions into intake and review processes, supporting earlier, person-centred conversations
- Strengthened organisational palliative care policies and procedures aligned with best practice
- Delivered tailored education that improved staff confidence to recognise deterioration and respond appropriately
- Introduced practical tools, including Stop and Watch and a Palliative Care Passport, to support consistent care delivery
- Established a cohesive, sustainable palliative care program supported by strong facilitation and leadership

## Goal

To strengthen palliative care and Advance Care Planning through participation in the ELDAC Linkages program, supporting staff confidence and embedding consistent best practice processes across Hendercare Home Care.

Hendercare Home Care provides community based aged care services across metropolitan and rural South Australia. The service aims to enhance the lives of people through high quality, responsive care delivered by connected and committed staff. Hendercare employs 63 aged care support workers, three coordinators (including a registered nurse), and two clinical compliance registered nurses. Services include personal care, domestic assistance, social support, home and garden support, and allied health input. Hendercare supports almost 600 aged care clients through Home Care Packages, the Commonwealth Home Support Programme, privately funded arrangements, and Veterans' Home Care.

Hendercare identified areas where palliative care and Advance Care Planning practices could be strengthened and chose to participate in the ELDAC Linkages program to support continuous improvement and ensure both staff and clients were well supported throughout the palliative journey.

Prior to participation, competing organisational priorities and workforce changes impacted consistency in palliative care and Advance Care Planning practices. Staff reported uncertainty and fear around end-of-life conversations, recognising deterioration, and supporting clients and families during dying and bereavement.

"The ELDAC program is a fantastic opportunity to identify what we do well and where we need to improve and then supports us with guidance and follow up."

## Key outcomes and benefits

- Improved alignment of organisational policies and procedures with best practice palliative care
- Increased staff confidence through targeted, practical education and open discussion
- Stronger recognition and escalation of deterioration using the Stop and Watch tool
- Improved information sharing through the introduction of a Palliative Care Passport
- Sustainable systems that continue beyond the formal ELDAC Linkages program period

“Participating in the program has expanded not only our understanding of roles and responsibilities, available resources, but has improved the conversations we are having.”



### Our journey

Our ELDAC Project team has worked in aged care for more than 80 years combined and we had heard many fears from staff about end-of-life care such as:

‘What do I say to a client who is dying?’, ‘What should I expect to see in a client at the end of their life?’, amongst various other questions.

ELDAC gave us a unique opportunity to support these staff - who are at the forefront of dealing with loss in our company – our support workers. Their ability to form bonds with clients makes the care they provide more courageous and compassionate, and losses are felt that much more acutely.

We delivered 18 workshops that provided opportunities for open discussion about what is a palliative diagnosis, how to support client’s to maintain a their quality of life in the face of a life-limiting illness, what to expect as someone dies [including what happens if they die when you’re there!], how to talk to a palliative client, the course of grief and risk factors for complicated grief.

The impact of the education was immediate for our staff, with our facilitator nominated for a positive feedback award, reflecting the positive responses from staff who expressed increased confidence, reassurance, and understanding of palliative care. The program was delivered with skill and experience, and staff were most keen to attend. A willing participant stated: ‘I feel confident that I don’t need to ask my palliative client’s not to die during my shift. If they do pass away, I am much more confident on processes.’

The positive reports continued to be heard loud and clear – our care teams have benefited greatly from their education. As a result, we have embedded palliative care into our annual training and as a resource for anyone who wishes to learn more.

Participating in the program has expanded not only our understanding of roles and responsibilities, available resources, but has improved the conversations we are having with our aged care clients, and our aged case managers have greater confidence in supporting our clients during their palliative journey. It has been invaluable for our support workers to not only have access to information but to have the space to ask questions during the training sessions.

I’m sure our journey won’t stop here. There’s always more to achieve, and to support our staff and clients along the way!

*Kirsty Masters, Clinical Practice Educator*



# Lutheran Homes Group (LHG)



Home Care



Adelaide,  
South Australia

## Highlights

- Increased the knowledge and confidence in working with and referring to local palliative care teams
- Increased resources to provide education to both staff and clients around recognising frailty and client deterioration

## Goal

To enhance our team's ability to identify frailty and palliative care needs early and to better support both the staff clients they serve.

Lutheran Homes Group - Home Care provides home care support to 240 clients, primarily in the northeastern suburbs of Adelaide. They support clients on Home Care Packages levels 1-4 and provide services such as personal care, social support, allied health, medication management, transport, gardening, domestic and in home respite care. Most of their clients are over 85 years of age.

With an increasing number of consumers requiring in-home support, their objective in launching the program was clear: to enhance our team's ability to identify frailty and palliative care needs early, and to better support both our staff and the 240 clients they serve across metropolitan Adelaide. Their workforce of sixty community-based staff plays a vital role in maintaining quality of life for clients at home, making the need for accessible, practical tools and training even more essential.

LHG Home Care initiated their ELDAC project following the success of a similar initiative implemented within their residential care teams. Encouraged by positive feedback and improved outcomes in that setting, we they were eager to extend these learnings into their home support services.

Completing the project for their Home Care service aligned with the continuous improvement culture of the organisation.

"Our ELDAC facilitator understood the complexities in working in the community setting and was able to provide guidance that was practical and ideas that were easy to implement and resources that were relevant to our service."



## Our journey

Before embarking on this project, LHG – Home Care faced several challenges. The main challenges were around feeling confident in linking in with the palliative care networks and having the appropriate resources and tools to identify the deterioration in our clients. Also, staff lacked consistent tools and up-to-date information to help them recognise signs of frailty or a shift toward palliative needs for clients. Community-based services often operate outside the structured support offered by GPs and hospital-based palliative care teams, creating a knowledge and resource gap. The service had limited guidance available for staff on how to respond to the evolving needs of clients in a community setting, especially those approaching end-of-life care.

Our key outcomes included:

- Collaboration with a project lead from ELDAC who understood the unique challenges of community care, proved invaluable. This partnership provided us with relevant, easy-to-implement resources and information that complemented our existing processes.
- One particularly impactful component was the opportunity for our nurses to participate in palliative care placements. These hands-on experiences allowed them to see how palliative care teams operate in collaboration with other care providers, fostering a holistic and person-centred approach that prioritises not only clinical needs but also the wishes and values of the consumer.
- Community engagement was another highlight. We hosted an education session for clients and their representatives, focusing on the principles and benefits of palliative care planning. Feedback from participants revealed deep appreciation for the opportunity to ask questions in a supportive environment and to better understand what palliative care entails. For many, this session helped break down stigma and opened the door for more open, informed discussions about future care preferences.

The changes we've implemented have already shown tangible benefits. Staff have reported feeling more confident in recognising early signs of health decline and are now more proactive in their reporting. Previously, care adjustments often occurred only after a significant health event. With new tools and training in place, staff are identifying and responding to subtle changes earlier, which allows for timely interventions and better outcomes for our clients.

Ultimately, this program has strengthened our team's capability and confidence, improved care continuity. We are now better positioned to meet the changing needs of our clients with dignity and compassion.



# Clayton Church Homes Magill



Residential Aged Care



Magill,  
South Australia

## Highlights

- Strengthened linkages with local specialist palliative care services and the local Primary Health Network, with clearer referral pathways established
- Increased staff confidence to recognise and respond to deterioration using evidence based tools and resources
- Improved communication with families and external providers through the consistent use of ISBAR and structured case conferencing
- Expanded access to practical palliative care resources to support clinical decision making and family discussions

## Goal

To strengthen the service's palliative care approach by building staff capability and confidence, embedding consistent communication and education practices, improving recognition and response to deterioration, and strengthening collaboration with GPs, families, and external palliative care partners.

Clayton Church Homes is an independent, not-for-profit aged care organisation with more than fifty years' experience delivering services to older South Australians. Clayton Church Homes Magill is a 96-bed two-story residential aged care facility located in Magill, approximately seven kilometres from Adelaide's CBD, and has recently completed the ELDAC Linkages Program. The service provides aged care along with a dedicated memory support unit, supporting older people with a range of care needs, and is committed to delivering person centred care in a supportive and respectful environment for residents, families, and staff.

Clayton Magill chose to participate in the ELDAC Linkages program to support staff to build confidence, knowledge, and skills in palliative and end-of-life care. The service identified a need to strengthen communication with families, improve staff confidence with end-of-life medications, and enhance conversations around deterioration. Leadership was keen to achieve consistent improvements across all aspects of palliative care provided to residents and families.

Prior to participating in the ELDAC Linkages program, staff experienced variable confidence in discussing deterioration and end-of-life care, particularly when caring for residents from diverse cultural backgrounds. Some staff were anxious about managing end of life situations and having sensitive conversations with families. The service also identified a need to strengthen linkages with specialist palliative care services and streamline communication processes to better support Advance Care Planning and coordinated care.

The service strengthened its palliative approach by connecting and learning more about Specialist Palliative Care and the Primary Health Network (PHN) establishing clear referral pathways. GPs were engaged early through shared ELDAC information, gaining gradual buy in. Staff capability improved through education on palliative care,

education supported improved recognition and response to deterioration. The team reintroduced clinical tools they recognised needed more embedding in practice. Communication was prioritised by embedding ISBAR, trialling case conference tools, and supporting improved family discussions. Evidence based resources from a range of evidence-based sources were introduced, alongside targeted staff education. This enhanced communication with families and supported the clinical team. Palliative care was embedded into meetings, family resources, and everyday practice across the service during the ELDAC program.

## Key outcomes and benefits

- Increased staff confidence and capability to recognise and respond to clinical deterioration using structured tools and shared resources
- Improved consistency and clarity of communication with families and external providers through embedding ISBAR
- Established and strengthened referral pathways with local specialist palliative care, GPs, and the local PHN
- Expanded access to evidence based palliative care resources, including guidance on end-of-life medications and symptom management
- Greater staff engagement with palliative care education and ongoing learning opportunities

“Participating in the ELDAC program as strengthened our compassionate care approach.”

## Our journey

Participating in the ELDAC Program has been invaluable in supporting our staff to feel more confident and capable in delivering high quality palliative care. The program helped us strengthen our approach and provided clear direction for meaningful improvement.

Several key factors contributed to these positive outcomes. Guidance from our ELDAC facilitator, combined with a clear implementation plan, helped us stay focused on our goals and the actions required to achieve them. Regular, dedicated team meetings with our facilitator were particularly beneficial. While it was sometimes challenging to balance these meetings alongside competing priorities, we were still able to make steady progress and achieve important improvements.

Building staff confidence, skills, and knowledge in palliative care was a significant achievement. This was supported through the delivery of foundation education sessions for staff, as well as access to external education opportunities, both of which proved highly beneficial.

Having palliative care resources readily available has also been extremely valuable, particularly in supporting clear and compassionate communication with families. We have received very positive feedback from families, including high levels of satisfaction with the end of life care provided to their loved ones, which has been most encouraging.

We continue to build on our processes and further enhance our palliative approach by utilising the resources, knowledge, and learnings shared through the ELDAC Program.





# Uniting AgeWell - Rosetta Community, Strathglen



Residential Aged Care



Berriedale,  
Tasmania

## Highlights

- Strengthened partnerships with local specialist palliative care services to support proactive, coordinated care
- Built staff confidence and capability through targeted education and practical learning opportunities
- Established a dedicated group of Palliative Care Advocates to mentor and support colleagues
- Improved care processes through regular comfort care meetings and after death audits.
- Increased access to practical resources for staff, residents and families to support palliative care conversations and care delivery

## Goal

To strengthen our palliative and end-of-life care approach by building staff capability and confidence, improving collaboration with external providers, and embedding sustainable quality improvement to enhance care experiences for residents and families.

Uniting AgeWell Rosetta Community, Strathglen is a 45-bed residential aged care facility providing 24-hour care to older people. The service has been operating for more than 30 years and supports residents from Berriedale, Hobart and surrounding areas. Approximately 65 staff work across care, lifestyle and clinical roles to meet residents' diverse needs. Strathglen's aim is to deliver high quality, person-centred care that supports residents to live well, with comfort, dignity, and respect throughout their care journey.

The decision to participate in the ELDAC Linkages program was strongly supported by leadership experience with the program within the organisation. Staff recognised opportunities for improvement in palliative care delivery and saw the program as a way to gain focused support, momentum and access to resources to turn improvement ideas into meaningful, sustainable change for residents and staff.

Prior to participation, Rosetta Community, Strathglen faced challenges related to difficulty in recruiting experienced registered nurses. Increasing regulatory and clinical demands reduced the capacity of available clinical resources to implement improvement initiatives and placed added pressure on senior staff, impacting their ability to mentor and support clinical oversight. Consistency of practice was also affected due to the use of agency nurses, limiting the service's ability to progress enhancements in Advance Care Planning and palliative care.

Through participation in the ELDAC Linkages program, Rosetta Community, Strathglen has strengthened its palliative care approach in ways that are person-centred, collaborative and sustainable. The areas they chose to focus on included improving processes and systems for Advance Care Planning to ensure all residents with capacity had discussions and support for decision making; clarifying and embedding approaches for

residents without capacity for their own decision making into policy; upskilling staff to build confidence and capability in palliative care and Advance Care Planning; strengthening cross-sector linkages to enhance care delivery; and developing and consolidating resources to support effective communication with families.

They have been able to create a core group of knowledgeable palliative care leaders and champions within the team who are now well placed to support and guide others, contributing to a culture of shared learning and improvement.

Participating in the program has helped to embed a holistic approach to care for Rosetta Community, Strathglen that recognises the importance of comfort, dignity, and quality of life for residents, while also supporting staff to feel confident, connected and supported in their roles.

## Key outcomes and benefits

- Improved staff knowledge and confidence in palliative and end-of-life care practice
- Stronger collaboration with local specialist palliative care services, general practitioners and other providers
- Establishment of regular comfort care meetings to review residents' needs and reflect on practice
- Creation of a core group of trained Palliative Care Advocates to support ongoing mentoring and quality improvement
- Enhanced use of after death audits to inform continuous improvement and strengthen care processes
- Increased availability of information resources for staff, residents, and families

"To improve practices, you need to critically observe from the outside looking in. By seizing an opportunity to do this, you open the minds of your organisation and staff to see what can be done better. The ELDAC Linkages Program has provided Strathglen with this opportunity."

*Wendy Chamberlain, Senior Care Manager*

## Empowering care at Uniting AgeWell, Rosetta Community, Strathglen

With the opportunity to roll out an education program (that included a practical observation component within a palliative care setting), a small group of staff within the facility are now equipped with knowledge and a sense of increased confidence.

To ensure knowledge sharing, these staff were given the opportunity to become "Palliative Care Advocates" of the facility.

A special badge identifies them as an advocate, and they have been introduced to the staff, residents and visitors by way of a noticeboard. Below this noticeboard is a display of resources to be utilised by all.

The role of the Palliative Care Advocates includes being allocated to provide care for residents receiving end-of-life care. They mentor staff who are supporting residents during end-of-life care and maintain the facility's palliative care trolleys. They also attend comfort care meetings as part of their ongoing contribution to quality palliative care. A specific email address enables all staff the opportunity to send through questions, concerns and ideas directly to this team.

Another group of staff has recently undertaken the education program adding to the team's longevity and strength.

Our ongoing monthly comfort care meetings are the focal point for reviewing after death audits, discussing improvements and learnings, sharing ideas and continuing to focus on what we have started during this program.

The enthusiasm to provide high quality palliative care can be directly linked with our participation in the ELDAC Linkages Program. Overall, it has reinforced and inspired us to achieve a holistic, person-centred approach to our palliative care at Rosetta Community, Strathglen, embedding sustainable practices that continue to benefit our residents, families, and staff.





# Uniting AgeWell - Rosetta Community, Strathaven



Residential Aged Care



Strathaven,  
Tasmania

## Highlights

- Increased completion of advance care directives through structured audits and supported conversations with residents and families
- Strengthened partnerships with local specialist palliative care services, supporting shared planning and ongoing reviews
- Improved staff confidence and capability through targeted education and multidisciplinary learning opportunities
- Reinvigorated Comfort Care Committee, embedding regular reflection, learning, and quality improvement
- Enhanced focus on quality of life, comfort care planning, and reducing unnecessary hospital transfers

## Goal

To strengthen its palliative care approach by building staff capability, improving Advance Care Planning, strengthening collaboration, and embedding a sustainable, person-centred approach to end-of-life care.

Uniting AgeWell Rosetta Community, Strathaven is a 112-bed residential aged care service supported by approximately 150 staff working across nursing, care, and lifestyle roles. Strathaven aims to deliver high quality, person-centred care that supports residents' dignity, comfort, and individual preferences across all stages of ageing.

Participation in the ELDAC Linkages program was informed by positive experiences shared by other Uniting AgeWell services. As a collective, staff identified opportunities to improve palliative care practices and Advance Care Planning and recognised that the ELDAC Linkages program would provide the structure, facilitation, and resources needed to drive meaningful and sustainable change.

Before the ELDAC Linkages program, advance care directives were not consistently completed on admission, limiting clarity around a residents' end-of-life wishes. Significant recruitment of new and less experienced staff following a site redevelopment and expansion highlighted the need for education in palliative care. In addition, the Comfort Care Committee required revitalisation to reflect changed staffing and to support ongoing learning and staff wellbeing.

"The ELDAC Linkages program has enabled us to reinvigorate our palliative care services at Strathaven, benefiting both our residents and our staff."

## Key outcomes and benefits

- Improved processes for Advance Care Planning, supported by internal audits and education for residents and families
- Increased staff capability and confidence to support palliative and end-of-life care across nursing, care, and lifestyle roles
- Strengthened collaboration with local specialist palliative care services, including regular needs rounds and shared care planning
- Reinvigorated Comfort Care Committee providing a structured forum for reflection, after death audits, and continuous improvement
- Enhanced education pathways, including strong staff engagement in intensive palliative care training

### Our journey

Participation in the ELDAC Linkages program provided Rosetta Community, Strathaven with the opportunity to pause, reflect, and rebuild its approach to palliative and end-of-life care in a structured and collaborative way.

At the commencement of the program, staff identified several areas where small but meaningful improvements could significantly enhance resident and family experiences. Advance care directives were not always completed at admission, creating uncertainty at critical moments. At the same time, redevelopment of the site had resulted in a significant number of new staff who were motivated and committed, but in need of education and confidence building in palliative care.

Supported by the ELDAC Linkages facilitator, Rosetta Community, Strathaven focused first on strengthening its foundations. An internal audit of advance care directives was undertaken, accompanied by dedicated time with residents and families to explore barriers, provide education, and support informed decision making. This structured and respectful approach resulted in a noticeable increase in completed advance care directives and clearer documentation of residents' preferences.

Education was a core component of the journey. Participation in a two-day intensive palliative care education workshop generated strong interest across nursing, care, and lifestyle teams. Staff reported increased confidence and a shared understanding of palliative care as a holistic, person-centred approach rather than care limited to the final days of life.

A key milestone was the reinvigoration of the Comfort Care Committee. With over 30 staff members now involved, the committee meets quarterly to review residents requiring end-of-life care, reflect on after death audits, share learnings, and identify opportunities for improvement. This forum has become central to embedding learning, supporting staff, and maintaining focus on quality of life and comfort care.

The ELDAC Linkages program also enabled Strathaven to strengthen relationships with local specialist palliative care services. Monthly palliative care needs rounds now provide valuable opportunities for shared review of residents' needs, proactive medication planning, and coordinated support with general practitioners. These partnerships have enhanced care continuity and reduced unnecessary hospitalisation.

One of the most enduring outcomes has been the growth of internal leadership. A registered nurse at the service completed postgraduate studies in palliative care and has since taken on a dedicated specialist role within Strathaven. This role supports ongoing education, audits, equipment management, resident assessments, and active participation in comfort care processes, ensuring that improvements continue beyond the program.

Through participation in the ELDAC Linkages program, Uniting AgeWell Rosetta Community, Strathaven has embedded a shared, proactive approach to palliative care — one that values collaboration, reflection, and continuous improvement, and places the resident and their wishes at the centre of care.



# Celebrate Health Care - Aminya



Residential Aged Care



Scottsdale,  
Tasmania

## Highlights

- Building confident, skilled staff through structured palliative care education and orientation
- Strengthened partnerships with local specialist palliative care services through regular contact and monthly visits
- Embedded Advance Care Planning discussions into admissions and routine practice
- Improved access to anticipatory prescribing and timely end-of-life medications
- Established clearer referral pathways, including urgent support when GP access is limited

## Goal

To strengthen the quality and consistency of palliative and end-of-life care for residents by building staff capability, improving Advance Care Planning processes, and strengthening linkages with local specialist palliative care, primary care, pharmacy, and primary health network partners.

Celebrate Health Care – Aminya is a 61-bed rural residential aged care facility located in the north east of Tasmania. The service supports residents with medium to high care needs and provides care to people with varying levels of cognition, mobility, and function. Residents come from both the local community and surrounding regions. The service employs staff across a range of roles, including extended care assistants, registered nurses, enrolled nurses, and leisure and lifestyle staff. Celebrate Health Care is committed to providing person-centred, compassionate care across all stages of ageing, including palliative and end-of-life care.

The service chose to participate in the ELDAC Linkages Program after identifying the need to strengthen palliative care delivery and improve end-of-life outcomes for residents, with a focus on understanding strengths, addressing gaps, and learning from proven approaches used in other services.

As a rural service, Celebrate Health Care – Aminya faced challenges relating to access to resources, workforce pressures, limited GP availability, and after-hours support. There were also complexities in supporting residents and families to understand Advance Care Planning and its importance early in the care journey.

The service achieved its goals by embedding a consistent palliative approach across systems, workforce and partnerships. Improvements included electronic storage and mandatory use of Advance Care Directives, strengthened induction and ongoing education, compassionate admission and end-of-life practices, staff wellbeing supports, improved medication access, and respectful death-honouring rituals. Strong linkages with Specialist Palliative Care, Primary Health Network, pharmacy and allied health enhanced timely, coordinated, person-centred palliative and end-of-life care for residents and families, while building staff confidence, clinical decision making capability and sustainable best practice across the organisation.

“A highlight for us was watching staff grow in confidence and knowledge, expanding on something they were truly passionate about, and becoming leaders within our team to deliver peer to peer education and support.”

*Blade Manders, Director of Facilities*

## Key outcomes and benefits

- Improved Advance Care Planning processes embedded into admission and care review practices
- Increased staff knowledge and confidence in palliative care, supported by structured orientation and education
- Clear referral pathways with local specialist palliative care services for urgent and non urgent support
- Strengthened collaboration with pharmacy, improving access to end-of-life medications
- Reduced delays in symptom management through anticipatory prescribing and Imprest review



## Our journey

Prior to participating in the ELDAC Linkages Program, we recognised several challenges: staff confidence in recognising palliative symptoms varied; communication between care teams and external providers was inconsistent; and documentation around end-of-life care and advance planning was often fragmented.

Located in a rural area, our team also faced limited access to face-to-face education and specialist palliative support. As a result, palliative care practices sometimes felt reactive rather than proactive, and opportunities for earlier intervention were occasionally missed.

The ELDAC Linkages Program gave us the structure and support to turn these challenges into strengths. With ELDAC’s guidance, we developed clear clinical pathways, tailored training resources, and comprehensive orientation packs that are now embedded into our everyday practice. Staff education focused on recognising early signs of deterioration, initiating timely comfort measures, and engaging families in advance care discussions before crises occurred.

One particularly meaningful example involved a long-term resident whose condition declined. Because of the new systems and improved confidence among our staff, changes were recognised early, and we could implement systems and management plans promptly. The resident’s family later shared, “I am so happy with the care that Mum has received. The communication has been incredible, and I’m so thankful for the efforts staff have gone to in making Mum comfortable.”

Since completing the program, we have seen visible improvements in teamwork, communication, and overall confidence. Collaboration with the Specialist Palliative Care Team, general practitioners, and after-hours services has strengthened considerably, ensuring residents receive timely, coordinated care even in complex circumstances.

While workforce limitations and competing demands remain ongoing challenges, the ELDAC Linkages Program has given our staff the tools and confidence to approach palliative care with skill, compassion, and purpose. It has helped us move from reacting to deterioration to anticipating it – ensuring every resident’s final journey is dignified, comfortable, and supported.



# Polish Community Council of Victoria (PCCV)



Home Care



Victoria

## Highlights

- Strengthened multidisciplinary collaboration between home care, hospice, and families
- Enhanced staff confidence in delivering person-centred end-of-life care at home
- Improved comfort-focused care through coordinated symptom management
- Supported families with emotional, practical, and spiritual care
- Enabled older people to remain at home, aligned with their wishes

## Goal

To strengthen end-of-life care delivered at home, support coordinated palliative care partnerships, and ensure older people and their families experience comfort, dignity, and personalised care during the final stages of life.

The Polish Community Council of Victoria (PCCV) Home Care Program provides in-home support to older people with complex and end-of-life care needs. Services include personal care, emotional support, practical assistance, and care coordination, working in partnership with hospice services and families. Personal care workers and case managers support clients to remain at home wherever possible, focusing on comfort, dignity, and individual preferences. Care is delivered through a collaborative, holistic approach that recognises the importance of family involvement, spiritual wellbeing, and culturally respectful care.

The service chose to participate in the ELDAC Linkages Program to strengthen end-of-life care capability, improve coordination with specialist palliative care, and support staff and families to navigate complex end-of-life decisions with confidence and compassion.

Before participation, balancing increasing care needs with a person's wish to remain at home was challenging. Supporting families through emotional distress at end-of-life also required stronger coordination, clearer communication, and structured approaches to comfort-focused care.

## Key outcomes and benefits

- Improved coordination between home care, hospice, and families
- Increased staff confidence in comfort-focused end-of-life care
- More consistent emotional and spiritual support for families
- Enhanced ability to respect individual wishes and preferences
- Positive feedback from families about care quality and compassion



## Our journey

An older client receiving care through the PCCV Home Care Program was approaching the end of life following a terminal illness. As their condition deteriorated, the focus of care shifted from active treatment to comfort, dignity, and quality of life. Remaining at home, surrounded by family, was their clear preference.

Through participation in the ELDAC Linkages Program, staff were equipped with the tools and understanding to support coordinated end-of-life care at home. Personal care workers, the hospice team, and the client's family worked together to create a supportive environment tailored to their needs. Comfort-focused care prioritised pain relief, appropriate positioning, and calm, familiar surroundings.

Care extended beyond physical needs. Emotional support was provided through regular companionship and attentive listening, helping to ease fear and loneliness. Personal preferences were respected, including playing meaningful music and facilitating visits from close family members. Creative expression continued to be encouraged, providing moments of peace and connection during their final days. Spiritual support was also arranged in line with their wishes.

As care needs increased, close collaboration between the hospice team and the case manager ensured ongoing safety and comfort while honouring their desire to remain at home. The family was supported through counselling and guidance, helping them navigate difficult conversations and prepare for what lay ahead.

The older person passed away peacefully at home, surrounded by their family. The family later expressed deep gratitude for the compassionate care provided, sharing that the consistent presence and support of familiar carers allowed them to focus on spending meaningful time together. Participation in the ELDAC Linkages Program supported coordinated, person-centred care, ensuring that their final days were marked by comfort, dignity, and love.

\*Resident/Client names have been de-identified and are gender neutral to preserve confidentiality.



# Jacaranda Village



Residential Aged Care



Red Hill,  
Victoria

## Highlights

- Developed a clearer, user friendly Advance Care Plan supported by an educational information sheet
- Strengthened families' understanding of Advance Care Planning and decision making
- Introduced evidence-based assessment and planning tools for palliative care to identify deterioration earlier and support timely conversations
- Improved collaboration across staff groups through a palliative care working group
- Enhanced resident and family experience at end of life through more planned, peaceful care

## Goal

To strengthen its palliative care approach by improving the readability and usability of Advance Care Plans, increasing understanding among residents and decision-makers, enhancing bereavement support for staff and families, and introducing evidence-based assessment and planning tools for palliative care to recognise deterioration earlier so that care could be better planned and communicated.

Jacaranda Village is a community-focused, not-for-profit residential aged care service providing ageing-in-place for 75 residents. Supported by approximately 100 staff, the service offers two accommodation models: a nursing home style area designed for higher care needs, including dementia-friendly design and overhead tracking, and cottage style living with private rooms and shared home-like environments. Residents predominantly come from the Red Cliffs region, a horticultural and agricultural community where many have farming backgrounds. The team provides comprehensive personal, nursing and supportive care tailored to the changing needs of older people.

Jacaranda Village joined the ELDAC Linkages program seeking support, resources and sector connections to improve palliative care, enhance Advance Care Planning processes, and strengthen

staff confidence through networking and shared learning with other services.

Families often returned Advance Care Directives incomplete, reflecting limited understanding of their purpose and implications. Staff recognised deterioration but not always early enough to prepare residents and families. Rapid declines sometimes left families unprepared, creating emotional distress and difficulties with decision making during highly sensitive moments.



## Key outcomes and benefits

- Created an accessible, user-friendly Advance Care Plan with an accompanying information sheet
- Increased family understanding of Advance Care Planning and its importance
- Introduced evidence-based assessment and planning tools for palliative care to support early identification of deterioration
- Enabled more timely, person-centred conversations with families and residents
- Improved staff insight through a multidisciplinary palliative care working group
- Strengthened knowledge through resources, networking and guidance from the ELDAC facilitator, including access to legal education around Advance Care Planning requirements

## Our journey

Participation in the ELDAC Linkages program marked an important turning point for Jacaranda Village as the team sought to refine its palliative and end-of-life care processes. Early in the program, the service established a palliative care working group that brought together registered nurses, enrolled nurses and personal care workers to examine the existing Advance Care Plan. Through this collaborative review, staff realised that although clinicians found the form workable, many personal care workers did not. This insight shifted the team's perspective: if staff without a clinical background found the form difficult to interpret, families completing it during emotional and unfamiliar circumstances were likely to struggle even more.

This prompted a complete redesign of the Advance Care Plan to ensure it was user friendly, clearly written and supported by an educational information sheet. The new format helped residents and decision makers understand the purpose of the document, how to complete it and why advance care planning matters. Staff feedback, along with positive responses from families, confirmed that the revised approach was making a meaningful difference.

A pivotal part of Jacaranda Village's journey was the introduction of evidence-based assessment and planning tools for palliative care to support early recognition of deterioration. Previously, staff often relied on their intuitive understanding of residents' health but lacked an objective measure to initiate timely conversations. With these tools, the team could present clear clinical evidence when discussing changes with families. One resident's story highlighted this shift: while nurses sensed the resident was declining, the scores within the tools provided tangible indicators that helped staff engage the family in essential conversations. As a result, the resident's final days were peaceful, planned and aligned with their goals of care, giving both family and staff reassurance.

Guided by the ELDAC facilitator, Jacaranda Village benefited from tailored resources, sector connections and specialist legal support on Advance Care Planning. The program strengthened team confidence, enhanced processes and supported earlier, more compassionate communication with families. Most importantly, it enabled residents and their loved ones to spend meaningful time together, with clarity and comfort, during the end-of-life journey.

\*Resident/Client names have been de-identified and are gender neutral to preserve confidentiality.



# Heathcote Health



Home Care



Heathcote,  
Victoria

## Highlights

- Strengthened collaboration with local specialist palliative care services
- Improved staff confidence in palliative and end-of-life assessments
- Introduced structured palliative care assessment tools into practice
- Clarified roles and improve communication across care teams
- Enhanced support and information for patients and families

## Goal

To strengthen knowledge and confidence in palliative and end-of-life care, improve collaboration with specialist palliative care services, and enhance continuity and clarity of care for older people supported in the community.

Heathcote Health is a government funded public hospital providing acute and urgent care, aged care, and community services in regional Victoria. The service's aim is to improve the health and wellbeing of its community through excellent healthcare and innovation. Heathcote Health's community services support more than 300 people aged over 65, with care needs ranging from low to moderate acuity. Clients represent diverse social, cultural, and identity backgrounds, including veterans, Aboriginal and Torres Strait Islander people, culturally and linguistically diverse communities, and socially disadvantaged groups.

Heathcote Health chose to participate in the ELDAC Linkages Program to strengthen its foundational understanding of palliative and end-of-life care and use this knowledge to improve the quality and coordination of care for patients and their families for home care.

Before participation, limited communication and misalignment with specialist palliative care services made it difficult to maintain strong working relationships. This impacted care continuity and left patients unsure about Heathcote Health's role alongside other healthcare providers.

## Key outcomes

- Establishment of a strong working relationship with the local Community Palliative Care Service
- Implementation of new palliative care assessment tools
- Improved staff confidence to identify concerns and report changes
- Clearer understanding of the community team's role in palliative care
- Development of a new Dying and Bereavement resource for patients and families



## Our journey

Heathcote Health supports older people with diverse needs through its hospital and community services. Prior to participating in the ELDAC Linkages Program, many members of the community services team were unclear about their role in providing palliative care. Palliative care was often seen as the responsibility of specialist services, with local teams believing they had a limited role beyond providing practical assistance.

Through participation in the ELDAC Linkages Program, the community team began to re-examine this perspective. Engagement with the ELDAC facilitator supported staff to recognise the importance of each team member in delivering comprehensive, person-centred palliative care. Education and discussion helped build understanding that local community services play a vital role in recognising changes, communicating concerns, and supporting patients and families alongside specialist teams.

As part of this journey, new palliative and end-of-life assessment tools were introduced. Staff developed greater confidence in identifying concerns, reporting abnormal findings, and sharing timely information with the specialist palliative care service. Over time, this contributed to the development of the positive, collaborative working relationship the service had been striving for.

A defining moment came when staff received feedback from the specialist palliative care service acknowledging the value of their assessment of a shared patient. This recognition reinforced that meaningful progress can be made through consistent, collaborative practice. Improved communication clarified roles across services and strengthened mutual trust.

As a result, patients now experience better continuity of care and clearer communication about who is involved in their support. Families have access to improved information, including a new Dying and Bereavement resource. For staff, participation in the ELDAC Linkages Program has fostered confidence, purpose, and a shared understanding that their contribution makes a real difference in the lives of patients receiving palliative and end-of-life care.



# Vasey RSL Care – Bundoora



Residential Aged Care



Bundoora,  
Victoria

## Highlights

- Improved staff confidence and communication in Advance Care Planning and care conversations
- Strengthened coordination and collaboration with local specialist palliative care services
- Increased access to evidence-based resources and tools to support high quality care
- Reduced unnecessary hospital admissions and improved in facility end-of-life care
- Enhanced support for families and carers through education, resources and dedicated spaces

## Goal

To strengthen its palliative care and Advance Care Planning practices by building staff capability, recognising deterioration earlier, and improving communication with residents, families and local service providers. Through the ELDAC Linkages program, the service sought to embed sustainable, person-centred approaches.

Vasey RSL Care Bundoora is a 90-bed residential aged care facility in inner Melbourne, dedicated to caring for veterans and the broader aged care community. Its philosophy, *Serving those who Served*, guides a person-centred approach to residents aged 73 to 103 with low to high care needs, including a dedicated 10-bed memory support unit. The service employs a multidisciplinary workforce including a Residential Manager, care coordinators, registered and enrolled nurses, personal care workers, lifestyle staff and contracted allied health practitioners. Residents often present with complex medical conditions, requiring coordinated care and strong clinical capability.

A 2022 audit identified the need to strengthen early recognition of deterioration and embed a structured palliative approach. Vasey RSL Care Bundoora joined the ELDAC Linkages program seeking targeted support, project guidance and practical tools to improve end-of-life planning and align practice with best practice standards.



Staff availability for training, limited confidence, inconsistent documentation, fragmented communication and family resistance made Advance Care Planning and palliative care delivery difficult. These challenges created gaps between theoretical expectations and the lived experiences of residents and families, impacting timely recognition of deterioration and coordinated end-of-life care.

## Key outcomes and benefits

- Improved quality and consistency of end-of-life care
- Increased staff confidence in communication and symptom management
- Stronger coordination with local palliative care services
- Enhanced access to resources, apps and tools to support practice
- Clearer documentation processes for resident preferences
- Dedicated family spaces and culturally informed materials to support comfort and understanding
- Reduced transfers to hospital and improved onsite care outcomes



Vasey RSL Care Bundoora entered the ELDAC Linkages program with a clear intention: to enhance its ability to recognise deterioration early, strengthen staff capability and embed a proactive, person-centred palliative approach. A previous audit had highlighted gaps across communication, confidence and documentation, and the service wanted to ensure veterans and other residents experienced dignified, coordinated care aligned with their wishes.

Through the support of the ELDAC Linkages facilitator, the team began building skills, establishing processes and embedding resources to guide practice. Staff who were initially hesitant became more confident in holding sensitive conversations, using the language, tools and structured approaches introduced through the program. By working through the program, the project lead said that even as a senior nurse, they experienced a profound shift in their communication style and clinical confidence, enabling them to have open, compassionate discussions with residents and families about care preferences.

They recalled the journey of a resident, whose family felt unsure and fearful when faced with end-of-life decisions. With improved communication skills and structured guidance, The nurse was able to facilitate meaningful conversations that supported the resident's wishes. As a result, the resident received comfort-focused care consistent with their preferences and died peacefully, surrounded by family. This experience strongly influenced the nurse's career direction, inspiring them to pursue the Palliative Nurse Practitioner model of care.

The program also contributed to broader organisational improvements. Staff gained access to evidence-based materials, translated resources, digital tools and strengthened partnerships with specialist providers. Bedside practices improved through enhanced clinical intensity during the terminal phase, and a dedicated family room was created to support relatives staying overnight.

Residents and families expressed deep gratitude. One resident shared, 'I'm not afraid of what's next. I've lived a full life, and now I'm ready for the next step in the journey.' Families recognised the compassion and respect shown, and staff voiced renewed pride in their work.

For Vasey RSL Care Bundoora, the ELDAC Linkages program strengthened knowledge, improved care processes and created lasting cultural change — ensuring residents experience dignity, comfort and personalised support at end of life.

\*Resident/Client names have been de-identified and are gender neutral to preserve confidentiality.



# Vasey RSL Care - Frankston South



Residential Aged Care



Frankston South,  
Victoria

## Highlights

- Strengthened collaboration with the local community specialist palliative care team, enabling timely advice and improved clinical decision-making
- Reduced unnecessary hospital transfers through improved recognition of deterioration and earlier initiation of palliative and end-of-life pathways
- Improved staff confidence — particularly among nurses and visiting GPs—to initiate and manage palliative care within the residential environment
- Enhanced communication pathways, leading to clearer, shared understanding of goals of care between staff, GPs, and families

## Goal

To strengthen its palliative care approach by building confidence across its workforce, improving collaboration with local care partners, and establishing consistent processes to ensure residents' wishes were known, respected, and supported through to the end of life.

Vasey RSL Care Frankston South is a residential aged care service providing personalised, high quality support for older people with increasingly complex needs, including those requiring a palliative approach. The service is supported by a multidisciplinary workforce of registered nurses, enrolled nurses, personal care workers, and a dedicated quality and leadership team. Residents represent diverse cultural and clinical backgrounds, many living with chronic disease or progressive cognitive decline. The service focuses on early recognition of care needs, clear communication with families and medical practitioners, and providing comfort, dignity, and continuity throughout the palliative care journey.

The service joined the ELDAC Linkages Program to improve clinical confidence, strengthen partnerships with specialist palliative care providers, and ensure residents and their families had access to timely, compassionate, and well coordinated palliative care.

Before participating, staff faced delays in initiating palliative and end-of-life pathways, variable communication with GPs, and uncertainty in recognising deterioration. These challenges hindered early planning and at times led to unnecessary transfers to hospital.

## Key outcomes and benefits

- Earlier recognition of palliative trajectories and improved initiation of symptom management
- Reduced emergency referrals and avoidance of unwanted hospital transfers
- Strengthened communication pathways between care staff, GPs, and specialist palliative care providers
- Improved confidence among nurses and GPs to provide end-of-life care onsite
- Embedded palliative care champions and sustainable quality improvement processes



### A peaceful goodbye

Through the ELDAC Linkages Program, Vasey RSL Care – Frankston South strengthened its relationships with local specialist services and built the capability and confidence of its team. These improvements became profoundly evident during the final days of one of our residents.

The resident had been living with progressive cognitive decline, often expressing confusion and a deep longing to see their family. As their health deteriorated, a local general practitioner recommended hospital transfer. However, the resident made it clear they did not want to leave the familiar surroundings of the home they had grown to trust. With no reachable next of kin at the time, the decision carried emotional and ethical weight for staff.

Drawing on the strong partnership cultivated through the ELDAC Linkages Program, the Facility Care Coordinator sought guidance from the local community specialist palliative care team. Together with the GP, they reviewed the resident's situation and agreed that their expressed wishes should guide their care. Supported by specialist advice and improved internal processes for recognising and responding to deterioration, the team initiated anticipatory medications to ensure comfort and symptom relief.

As staff continued to provide gentle, person-centred care, the resident's sibling was located interstate and able to travel to be with them. Supported by the service's strengthened communication pathways, staff helped facilitate meaningful time between the family. The resident died peacefully within the residential home, surrounded by care, dignity, and the reassuring presence of their family.

This experience demonstrated the value of the ELDAC Linkages Program in strengthening collaboration, increasing staff confidence, and enabling compassionate, person-centred care. Through improved communication, clearer processes, and strong partnerships, Vasey RSL Care Frankston South was able to honour the resident's wishes and support a peaceful, familiar, and dignified end of life.

\*Resident/Client names have been de-identified and are gender neutral to preserve confidentiality.



# CO.AS.IT Italian Assistance Association Melbourne



Home Care



Carlton,  
Victoria

## Highlights

- Built staff capability in palliative care and Advance Care Planning through targeted training
- Established clearer roles, documentation, and frameworks to support consistent practice
- Strengthened collaboration with specialist palliative care and allied health providers
- Improved coordination and communication across services, clients, and families

## Goal

To enhance workforce capability and confidence in palliative care and Advance Care Planning, embed clear palliative care frameworks, and improve coordination with specialist services for clients receiving care in their home.

CO.AS.IT Italian Assistance Association (Melbourne) provides culturally responsive, person-centred aged care services to older members of Victoria's Italian community, particularly in Melbourne's northern suburbs. The service delivers Commonwealth Home Support Programme services, Home Care Packages, in home assistance, social support groups, and a large volunteer visitation program. Care is provided by approximately 190 staff and supported by 220 volunteers, enabling older people to remain independent, connected, and supported in their own homes.

CO.AS.IT chose to participate in the ELDAC Linkages Program to build on knowledge, confidence, and systems related to palliative care and Advance Care Planning. The program offered structured support to build workforce capability, strengthen linkages with specialist services, and improve the quality and consistency of care for clients wishing to remain at home during their palliative journey.

Prior to participation, CO.AS.IT recognised opportunities to strengthen its palliative care approach, including developing more consistent frameworks, building staff confidence in palliative care and Advance Care Planning, clarifying roles, and improving communication with specialist services. An early challenge was determining how best to address these areas of need. Participation in the ELDAC Linkages Program provided the structure, guidance, and support to navigate these priorities and move forward in a coordinated and planned way.

"The ELDAC Linkages Program strengthened our ability to provide proactive, coordinated palliative care, helping our client stay safely at home longer while her family felt supported and informed."

## Key outcomes and benefits

- Upskilled 126 staff in palliative care and Advance Care Planning principles through a set training program
- Introduced Advance Care Planning tools and documentation to support consistent practice
- Clarified staff roles and responsibilities within a palliative care framework
- Improved internal communication and care coordination processes
- Strengthened partnerships with specialist palliative care and allied health providers
- Increased staff confidence to recognise deterioration and escalate concerns early



## Our journey

Our service supported an older person with advanced cancer who was living alone and experiencing persistent nausea, poor sleep, restless legs, fatigue, dry mouth, and reduced appetite. At the outset, communication between oncology, specialist palliative care, and community services was fragmented. This left the client and their family uncertain about who to contact when symptoms changed and support was urgently needed.

Using the ELDAC Linkages approach, our Registered Nurse (RN) and care partner worked collaboratively to provide more coordinated and proactive care. Together, they completed structured assessments, identified early signs of deterioration, and clarified roles and responsibilities across services. They maintained regular communication with the specialist palliative care team and the oncology service, escalating concerns promptly, clarifying medication plans, and advocating for timely allied health input, including occupational therapy, physiotherapy, and speech pathology.

Alongside clinical coordination, practical and safety issues were addressed through close collaboration between the RN and case manager. This included arranging urgent intercom repairs, supporting safe access to medications overnight, and promoting strategies to improve hydration, nutrition, equipment use, and overall home safety.

The client and their family reported feeling more supported and confident as a result of these changes. Symptom management improved, communication between all providers became clearer, and care felt more coordinated and responsive. Importantly, the client was able to remain safely at home for longer, in line with their preferences.

When their condition later deteriorated, the established relationships and clear care pathways enabled a planned and supported transition. The coordinated efforts of the registered nurse, case manager, oncology team, and specialist palliative care service supported a smooth transfer to hospital and, eventually, residential care, avoiding a crisis-driven response.

Overall, participation in the ELDAC Linkages Program strengthened our service's ability to deliver coordinated, high quality palliative care at home, supported by partnership, shared learning, and a focus on what matters most to each person.

\*Resident/Client names have been de-identified and are gender neutral to preserve confidentiality.



# Chung Wah Community Care – Balcatta Hub



Home Care



Balcatta,  
Western Australia

## Highlights

- Improved identification of clients with palliative care needs through revised documentation and new client management system
- Enhanced staff confidence via palliative care education and workshops, including training delivered onsite and through an intensive palliative care education program
- Strengthened partnerships with external providers, including local specialist palliative care services and community organisations
- Increased community awareness and uptake of Advance Care Planning through talks, consultations and social media campaigns
- Embedded sustainable quality improvements within policies, procedures, and routine assessments

## Goal

To review current practices, address gaps, and strengthen sustainable systems for improved palliative care. The service aimed to build staff capability, enhance communication, and support culturally inclusive care, ensuring clients' wishes are understood and honoured.

Chung Wah Community Care (CWCC) is a not-for-profit home care and disability care provider in Western Australia, supporting culturally diverse communities to live well and stay connected. Operating since 1909 through the broader Chung Wah Association, the service offers culturally appropriate social support, home care and wellbeing programs across multiple hubs. The organisation employs a multidisciplinary team of care workers, nurses, coordinators, volunteers and support staff. CWCC serves a large population of older people from culturally and linguistically diverse communities, offering person-centred support that respects culture, language and community connections.

CWCC sought support to strengthen palliative care knowledge, improve organisational processes, and increase community understanding of Advance Care Planning. Participation offered the opportunity to refine systems, enhance staff capability, and ensure culturally-responsive support for clients and families.

CWCC identified cultural taboos around discussing death, family driven medical decision making, and community beliefs that families will make the “right” choice on their behalf. These challenges limited conversations about Advance Care Planning and complicated early recognition and communication of palliative care needs.

## Key outcomes and benefits

- Updated policies and procedures to embed end-of-life considerations and Advance Care Planning (ACP) guidelines
- Introduced processes to identify palliative care clients and support person-centred care planning
- Improved staff confidence through internal training and intensive palliative care education workshops
- Increased community engagement with ACP via hub presentations and one-on-one consultations
- Strengthened relationships with local specialist palliative care providers and multicultural peak bodies
- Improved communication with families and enhanced support throughout changing care needs



## Our journey

Chung Wah Community Care (CWCC) participated in the ELDAC Linkages program to strengthen its palliative care approach across the organisation. Early in the program, the team identified opportunities to refine policies, align end-of-life processes with standards, and build staff confidence in delivering culturally responsive care. During this period, CWCC supported a complex palliative care journey for a long standing client at the Balcatta Hub.

Since joining the Hub in 2015, we had been supporting an active and much loved member of the community. A former dance teacher, they had shared their talents with others and enjoyed cultural celebrations, food, dancing and Mah jong. As the chronic illness progressed to a palliative stage in 2023, the client wished to continue attending the Hub to maintain their social connections and sense of belonging.

In response, CWCC’s case coordinator and clinical nurse met with the client and their family to develop a palliative care plan that enabled safe participation at the Hub. Staff were informed of their individual care needs, including medication management, relevant clinical considerations, and approaches to support their comfort and wellbeing. With support from the ELDAC resources and training, staff undertook palliative care education, learnt emergency response procedures specific to their health conditions, and ensured volunteers were aware of their support needs.

Throughout the client’s changing health, the team provided compassionate, culturally informed care. Staff shared photos and videos with their daughter, celebrated their birthday early at the family’s request, and maintained open communication with carers. When the client was hospitalised again in September, CWCC arranged flowers and visited the client, ensuring continuity of care and emotional support. The client passed away peacefully in November at the age of ninety.

Following their death, CWCC offered condolences, ongoing support to the family, and information about carer services and counselling. The family expressed deep appreciation for the professional, heartfelt care provided throughout their family member’s journey.

Participation in the ELDAC Linkages program strengthened CWCC’s ability to provide culturally inclusive, person-centred palliative care. It also equipped the organisation with sustainable systems, stronger partnerships and greater confidence to support clients with dignity and compassion.

\*Resident/Client names have been de-identified and are gender neutral to preserve confidentiality.



# Catholic Homes - Ocean Star Residential Care



Residential Aged Care



Bunbury,  
Western Australia

## Goal

To strengthen our palliative care in both direct and non-direct ways.

Ocean Star in Bunbury, WA, is part of Catholic Homes Inc. They use a values-based 'Care with Purpose' Model that aims to encourage their residents to do what brings them joy. Everyone in the facilities are supported to make choices and take the opportunities that give them greater fulfilment and happiness.

Participating in the ELDAC Linkages program provided us with a valuable opportunity to reflect on palliative care practices and build a shared understanding of palliative and end-of-life care across the service. Ocean Star recognised the importance of improving both knowledge and culture, particularly as many staff had limited exposure to palliative care education before the project.

With guidance from the ELDAC Linkages facilitator and using their project grant, staff participated in hands-on training such as toolbox sessions to build their knowledge and confidence and create consistent language and understanding around palliative and end-of-life care. This enabled them to bridge the gap between clinical and pastoral care, to ensure a holistic care approach.

The team improved connections with local community specialist palliative care services. In one example, when a resident was referred to the palliative care team by her oncologist, the team's triage identified that Ocean Star had already implemented the recommended actions. This provided reassurance that current practices were aligned with best practice and strengthened confidence in ongoing care delivery.

## Key outcomes and benefits

- Promoted a culture of holistic palliative and end-of-life care.
- Empowered our team by improving knowledge and building collaborative relationships with other services
- Increased knowledge and confidence in staff, creating consistency across all levels of care through hands-on skills, mandatory training, and toolbox information sessions
- Bridged the gap between clinical care and pastoral care to ensure holistic care approach for our residents
- Strengthened our confidence in palliative and end-of-life care
- Stronger links with community palliative care, improving collaboration, clinical reviews, and staff support – they confirmed we provide all the care a resident near the end of life would need and which they would recommend
- Used National Palliative Care Week to run information sessions with a focus on our residents completing their 'goals of care' with clinical and pastoral staff





# Catholic Homes - Sister Mary Glowrey Residential Care



Residential Aged Care



Belmont,  
Western Australia

## Highlights

- Established clear, documented evidence of family case conferences to support shared decision making
- Built staff capability to recognise deterioration and support residents and families with confidence
- Introduced practical palliative care resources, including care trolleys and an information hub
- Strengthened partnerships with local specialist palliative care services
- Increased awareness and understanding of palliative care among staff, residents, and families

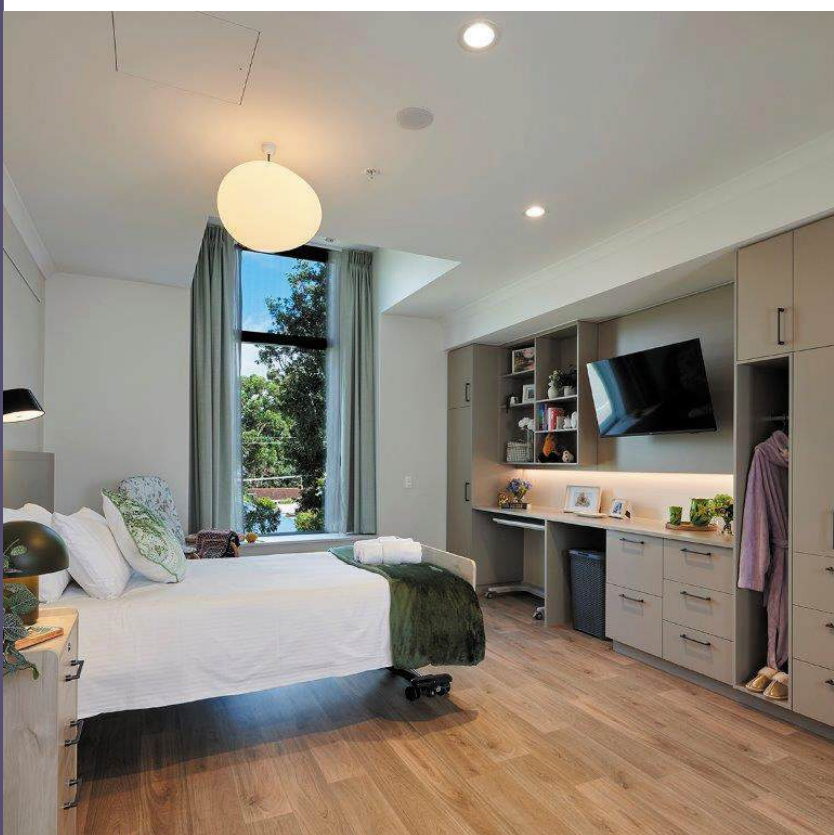
## Goal

To embed best practice in Advance Care Planning and palliative care from the outset, building staff capability, strengthening partnerships, and ensuring residents and families feel informed, supported, and confident throughout the end-of-life journey.

Sister Mary Glowrey (SMG) is a residential aged care service providing care for 96 residents within a modern, home-like environment. Guided by a "Care with Purpose" approach, SMG supports residents to remain active, engaged, and connected, while fostering belonging and wellbeing. The service employs 144 staff and provides 24-hour nursing support, dementia care, and palliative care. Residents range in age from 65 to almost 100 years and include both privately funded and government supported individuals.

Sister Mary Glowrey chose to participate in the ELDAC Linkages program after observing positive outcomes at two smaller sister services, with the aim of embedding best practice from the beginning of providing support to residents.

Prior to participation, there was limited evidence of family case conferences, reduced psychosocial support for families, and a workforce that included many new staff requiring training. These challenges affected the experience of residents and families at end of life.



## Key outcomes and benefits

- Improved documentation and consistency of family case conferences
- Increased staff knowledge and confidence in recognising deterioration and responding appropriately
- Practical resources introduced to support quality palliative care delivery
- Enhanced staff capacity to identify residents and families needing additional psychosocial support
- Strengthened working relationships with local community specialist palliative care services



### Our journey

At the time of the program, as a newly opened residential aged care service, Sister Mary Glowrey recognised the importance of establishing a strong foundation for Advance Care Planning and palliative care from the outset. Building on the success of ELDAC Linkages participation at smaller sister services, the service viewed the program as an opportunity to embed best practice early, rather than retrofitting change later.

Participation in the ELDAC Linkages program occurred during a period of considerable challenge. Internal changes, staff turnover, and the size of the service meant it was difficult for team members to dedicate consistent time to the project. COVID-19 and parainfluenza lockdowns disrupted training schedules, while rostering education sessions for a large workforce required significant coordination. Despite these pressures, the service remained committed to improving end-of-life care.

With support from the ELDAC facilitator, Sister Mary Glowrey introduced a number of practical and sustainable initiatives. Palliative care trolleys and a central information hub were developed to ensure staff, residents, and families had timely access to resources. Deterioration training increased the confidence of both clinical and care staff, enabling earlier recognition of change and timely escalation to registered nurses.

One meaningful outcome was the increased confidence of staff when speaking with residents about palliative care. In one example, a staff member spoke with a resident who had concerns about what palliative care looked like within the service. By drawing on the three-stage approach adopted at Sister Mary Glowrey, the staff member was able to clarify the difference between palliative care and end-of-life care, explain how staff were being upskilled, and reassure the resident that additional information would soon be available through the palliative care hub. The conversation left the resident feeling listened to and reassured, and the staff member feeling empowered and capable.

Participation in the ELDAC Linkages program also strengthened relationships with local community specialist palliative care services and improved evidence of family case conferences. Over time, there was a noticeable 'consciousness raising' across the service, with staff, residents, and families becoming more informed and engaged in conversations about end-of-life care.

While the journey was not without challenge, Sister Mary Glowrey has seen clear improvements in practice, confidence, and collaboration. The ELDAC Linkages program has supported the service to build strong foundations that will continue to guide high quality, person-centred end-of-life care into the future.



# Catholic Homes - Castledare Residential Care



Residential Aged Care



Wilson,  
Western Australia

## Highlights

- Strengthened staff confidence to initiate and lead Advance Care Planning conversations with residents and families
- Improved consistency in palliative care practices, documentation, and communication across teams
- Introduction of practical, dignity focused initiatives such as Compassion Carts to support families at the bedside
- Dedicated palliative care leadership through the appointment of a Palliative Care Champion
- Enhanced collaboration and reflective practice supported by the ELDAC Linkages facilitator

## Goal

To strengthen its approach to Advance Care Planning and palliative care by embedding consistent, best practice processes. Through participation in the ELDAC Linkages program, the service sought to enhance staff confidence, improve communication with residents and families, and deliver compassionate, person-centred end-of-life care.

Castledare Residential Care aims to provide a modern, home like environment that supports residents to remain active, engaged, and connected. Guided by a "Care with Purpose" approach, the service focuses on joy, hospitality, dignity and excellence. Approximately 100 staff deliver care to 73 residents, offering 24-hour nursing support alongside dementia and palliative care. Residents range in age from 65 to almost 100 years, with most being financially supported residents and a small number receiving government assistance.

Castledare chose to participate in the ELDAC Linkages program after seeing strong outcomes from implementation across other organisational sites. The program aligned closely with Castledare's commitment to quality improvement, workforce capability, and strengthening person-centred end-of-life care through structured guidance and collaboration.

Prior to participation, staff experience and confidence in Advance Care Planning and palliative care varied. Difficult conversations were challenging, documentation was inconsistent, and communication across teams could be fragmented, impacting the delivery of consistent, person-centred end-of-life care.

"In a time when everything felt beyond our control, the Compassion Cart gave me a sense of choice and comfort, allowing me to shape how I spent those precious moments with mum."

*Resident's Family Member*

## Key outcomes and benefits

- Improved staff confidence and capability in Advance Care Planning and palliative care conversations
- More consistent documentation and communication of residents' end-of-life preferences
- Allocation of a dedicated Palliative Care Champion to support practice improvement
- Implementation of structured palliative care education, including adoption of evidence-based assessment and planning tools for palliative care
- Enhanced resident and family experience through compassionate, holistic support initiatives



### Our journey

Castledare set out to improve both the resident and family experience at the end of life, recognising that this stage of care is not only clinical but deeply personal. Participation in the ELDAC Linkages program provided the structure, resources, and facilitation needed to reflect on existing practice and strengthen a shared, person-centred approach across the service.

Before joining the program, staff understanding of palliative care and Advance Care Planning varied. Some team members felt unsure about initiating difficult conversations or navigating family expectations, while documentation and communication practices were not always consistent. Through the ELDAC Linkages program, Castledare was supported to build staff capability, embed best practice approaches, and strengthen confidence in delivering compassionate end-of-life care.

One initiative that stands out is the introduction of Compassion Carts. During the final days of one resident's life, her family was experiencing significant emotional distress and uncertainty. With implementation supported by trained care workers, the Compassion Cart offered simple, thoughtful resources that created space for calm, connection, and comfort at the bedside. It helped transform an overwhelming experience into one marked by dignity, reflection, and meaningful time together. This moment reinforced the value of small, intentional changes in shaping how families experience end-of-life care.

Alongside these practical initiatives, staff confidence grew through education, reflective practice, and guidance from the ELDAC facilitator. The service strengthened consistency in Advance Care Planning conversations and documentation, supporting clearer understanding of residents' wishes. As a result of this work, Castledare established a dedicated Palliative Care Champion role to maintain focus and momentum, and implemented evidence-based assessment and planning tools to further support effective and meaningful palliative care practice.

The ELDAC Facilitation process played a central role throughout Castledare's journey. The facilitator provided expert guidance, practical tools, and curated resources, supporting staff to overcome barriers, strengthen teamwork, and embed improvements into everyday practice. This collaboration helped foster a culture where compassionate, consistent, and personalised palliative care is shared responsibility.

Through participation in the ELDAC Linkages program, Castledare has strengthened its foundations for high quality end-of-life care, ensuring residents feel respected, families feel supported, and staff feel confident and empowered in their roles.



# Amana Living



Residential Aged Care  
and Home Care



Perth and Mandurah,  
Western Australia

## Goal

To strengthen palliative and end-of-life care across residential care and home care.

“ELDAC helped us move from reactive to truly proactive palliative care across both residential and home care. Our teams feel more confident, our families feel more supported, and our residents experience greater dignity at end of life.”

*Amana Living Clinical Leadership Team*

Amana Living is one of Western Australia’s largest not-for-profit aged care providers, delivering person-centred, dignified, and compassionate care across residential care, home care and community settings.

Three of Amana Living residential care centres and Perth home care service participated in the ELDAC Linkages program, these were:

- James Brown Care Centre (Osborne Park, Perth)
- Hale Hostel (Coolbellup, Perth)
- Wearne House (Mandurah), and
- Home Care (Perth)

Amana Home Care Service Perth supports more than 4,000 clients across the metropolitan area. Recognising that many people wish to remain at home as their health declines, it was important to ensure this service had the opportunity to participate in the ELDAC Linkages program to enhance palliative care capability and support clients to live safely and comfortably in their own homes for as long as possible.

Whilst committed to providing high-quality care, similar challenges are faced by staff across both residential and home care, including:

- Variable confidence and skill initiating Advance Care Planning (ACP) conversations
- Inconsistency in recognising deterioration
- Inconsistent documentation of client or resident preferences
- Ad-hoc or reactive links with external palliative care providers

Across services nurses often felt uncertain initiating end-of-life conversations, and in home care specifically, Client Service Managers struggled to identify signs of deterioration early, and communication with specialist providers was limited.

Amana Living joined the ELDAC Linkages program with the shared organisational aim to improve the quality and consistency of care for residents and clients approaching the end of life by:

- Strengthening staff capability and confidence
- Embedding and strengthening consistent, evidence-based palliative care systems and processes

- Enhancing communication with families and external providers
- Embedding a more proactive and holistic approach to palliative and end-of-life care

The ELDAC Linkages program's structured facilitation, access to evidence-based tools, and ongoing support helped each service review its current practice, identify improvement opportunities, and implement sustainable change.

Dedicated Palliative Care and Advance Care Planning Working Groups were established at each participating service to guide improvement activities, identify education needs, and support early recognition of deterioration. These groups also played an essential role in embedding consistent practices and monitoring progress over time.

All Amana Living services participating in the ELDAC Linkages program appointed Palliative Care and ACP Champions, who helped translate training into everyday practice, reinforce the use of best-practice tools, and support colleagues in applying new skills with confidence.

Staff accessed targeted palliative education, ELDAC toolkits and resources, reflective practice sessions, and other palliative care and Advance Care Planning supports. Targeted education significantly boosted confidence in recognising symptoms, initiating conversations, and applying a palliative approach to care across settings. Reflective learning tools were integrated to deepen staff understanding of the emotional and human aspects of palliative care.

In addition, Amana Living participating services implemented validated early-warning and deterioration-recognition tools thereby contributing to more proactive identification of changes in residents' and clients' health. Improvements were also made to documentation, communication pathways, and case conferencing processes, ensuring more coordinated, timely, and person-centred care across residential and home care settings.

Amana Living's participation in the ELDAC Linkages program led to a coordinated, organisation-wide uplift in palliative and end-of-life care capability.

## Home Care Specific Improvements and Impacts

Home Care integrated nationally recognised early-warning and deterioration tools into everyday practice, these tools helped support the goal of reducing avoidable hospital transfers and supporting clients to remain at home when this was their preference.

Before participating in the ELDAC Linkages program, home care nurses lacked confidence in having Advance Care Planning conversations. After training, staff reported greater confidence initiating:

- Advance Care Planning discussions
- Conversations about "what matters most"
- Early planning and symptom recognition

Another truly significant improvement was achieved through ELDAC Linkages facilitation, improving connection and collaboration with the specialist palliative care service. We now have direct contact, regular scheduled case review meetings together and a tracking system for shared-care clients. These linkages greatly improved shared care and communication between providers. Our regular meetings are a highlight of our achievements and demonstrate that together we can achieve more!

Staff reported a major cultural shift: a more confident, capable workforce that sees palliative care as "a beautiful and special space to work within."

Ongoing activities include:

- Policy and procedure updates.
- After-Death Audits.
- New assessment templates.
- Education programs for all home care staff.
- Integrating palliative care topics into care support worker team meetings and toolboxes.

## Key outcomes across Amana Living

Participation in the ELDAC Linkages program resulted in meaningful improvements across residential and home care services:

- Earlier, more confident Advance Care Planning discussions with residents and families.
- Stronger family engagement and support resulting in more informed, and empowered families.
- Greater staff capability in symptom recognition and management
- Empowered, educated, and emotionally prepared staff
- Consistent use of validated, best-practice tools and documentation
- Strengthened working relationships with specialist palliative care services
- Reduced avoidable hospital transfers
- Improved communication and collaboration across multidisciplinary teams

Most importantly, residents across Amana Living are now experiencing more personalised, proactive, and dignified palliative and end-of-life care.

Amana Living has now established an organisation-wide Palliative Care Working Group to ensure the improvements made by those service that participated in the ELDAC Linkages program become embedded across all Amana Living Residential and Home Care Services. The working group will unify and sustain best-practice approaches across all services linked to:

- Strengthened Aged Care Quality Standards
- The End-of-Life and Palliative Care Pathway
- Ongoing staff education and capability development

### Key outcomes: Wearne House

Wearne House introduced one of the most impactful initiatives through an event called "Dying to Know", an evening forum fostering open, honest discussions about death, dying, and end-of-life choices. Residents and families valued the opportunity to talk freely, and the event made subsequent Advance Care Planning conversations easier and more meaningful. It has since been added to the service's annual program.

One registered nurse was formally recognised by families for her exceptional guidance supporting a resident to complete an Advance Health Directive. As a result, the resident's care later aligned closely with her preferences, avoiding unnecessary transfers and ensuring a dignified, comfortable end-of-life experience.

Wearne House also strengthened staff skills through:

- Upskilling initiatives
- Increased use of validated deterioration assessment tools
- Integrated accessible educational resources





### Key outcomes: James Brown Care Centre (JBCC)

The transformation was significant and measurable:

- ACP and Advance Health Directive completion rates increased from below 10% to 40%, with numbers still rising
- Almost every resident had multiple family conferences within a 12-month period
- Staff reported markedly improved confidence initiating palliative and ACP discussions
- Stronger linkages with external clinicians enabled timely advice, reducing last-minute crises
- Families provided heartfelt feedback, expressing gratitude for being supported, informed and involved – especially during residents' final stages of life

### Key outcomes: Hale Hostel

Substantial improvements in proactive, person-centred care planning were observed. Compassionate communication and early identification of deterioration helped avoid unnecessary hospital transfers and enabled smooth transitions to end-of-life care.

Other achievements included:

- 80% of residents having multiple case conferences
- Establishment of monthly Palliative Training Toolbox sessions
- Strengthening of the service's Palliative Care Trolley, including updated equipment, comfort items, and a standardised checklist published on Amana Living's SharePoint for use across multiple services

These changes ensured staff were better equipped, practically and emotionally, to deliver timely, high-quality end-of-life care.





# RAAFA Alice Ross King Care Centre



Residential Aged Care



Bull Creek,  
Western Australia

## Highlights

- Increased staff confidence to discuss palliative care and ACP with residents and families
- Strengthened relationships with external palliative care providers, improving timely support and referrals
- Enhanced knowledge through intensive palliative care education workshops, mentoring and onsite education
- Improved documentation processes and introduced revised ACP and palliative care paperwork
- Greater family involvement and positive feedback about end-of-life care experiences

## Goal

To strengthen staff confidence and capability in palliative care and Advance Care Planning, increase the number and quality of Advance Care Plans, and improve documentation and processes to better support residents' wellbeing and end-of-life care.

Alice Ross King Care Centre is a 102-bed residential aged care facility, including a 12-bed Memory Support Unit, located at RAAFA's Air Force Memorial Estate on the banks of Lake Howard in Bull Creek. Supported by proximity to major hospitals and mobile specialist services, the Centre provides comprehensive care for older residents, including those with dementia and high clinical needs. The multidisciplinary team aims to deliver compassionate, person-centred support throughout each resident's ageing journey, focusing on wellbeing, comfort and continuity of care.

The service sought to enhance staff skills in palliative care and Advance Care Planning (ACP), increase ACP completion rates, and improve documentation to ensure residents' care needs and preferences were clearly understood and supported.

Staff turnover created gaps in palliative care capability and confidence. Documentation processes did not fully support consistent palliative care planning, and staff required greater knowledge and comfort in having end-of-life discussions with residents and families.

## Key outcomes and benefits

- Improved staff confidence to recognise deterioration and communicate effectively with residents and families
- Increased ACP completion, supported by revised admission materials and updated forms
- Strengthened connections with Specialist Palliative Care, Intensive Palliative Care Education workshops and mentoring, and state-based palliative care organisations to enhance support and education
- Established a Palliative Care Registered Nurse (RN) portfolio to support quality improvement
- Improved documentation, including revised care plans and inclusion of ACP brochures
- Greater family engagement, resulting in more meaningful case conferences and positive feedback



### Our journey

Alice Ross King Care Centre joined the ELDAC Linkages program to strengthen staff capability in palliative care and Advance Care Planning and to improve the systems that support residents at end of life. Supported by access to specialist mobile services, the Centre recognised the opportunity to enhance confidence, knowledge and collaboration across the multidisciplinary team.

The service identified education as a major priority. Through external palliative care placements, onsite intensive palliative care education and mentoring, and training delivered by state-based palliative care organisations and specialist palliative care, staff developed deeper understanding of palliative care principles, symptom recognition and communication with families. This learning directly contributed to the service's ability to deliver more proactive, holistic care. One team member reflected that before mentoring they "didn't know what to say to families who had just lost their loved one," but now felt confident and supported.

The Alice Ross King Centre invested in strengthening clinical leadership with the development of a Palliative Care RN portfolio role. This role supports continuous learning, recognition of gaps in care, and alignment with current palliative care resources and best practice.

Advance Care Planning (ACP) became a central focus of improvement. Staff, residents and families were invited to an ACP workshop facilitated by the state-based palliative care organisation leading to increased awareness, more confident conversations, and a rise in completed Advance Care Plans. Admission processes were also strengthened with the inclusion of state-government ACP brochures, revised forms and improved documentation pathways.

Participation in the ELDAC Linkages program also enhanced relationships with external providers. Staff developed stronger links with specialist palliative care and local specialist services, improving access to timely advice and support. These strengthened partnerships contributed to more effective case conferences, greater clarity in care planning and increased family involvement.

Families expressed gratitude for the compassion shown during end-of-life care. One family shared appreciation for "the care for Dad in his last hours," noting the kindness shown through small gestures that supported both comfort and dignity.

Through education, strengthened partnerships and improved processes, Alice Ross King Care Centre has embedded sustainable change. Staff continue to discuss palliative care more openly, use resources actively, and maintain a strong focus on wellbeing and respect at the end of life.



## Key outcomes and benefits

- Improved capability of staff to recognise deterioration using validated clinical tools
- Increased confidence among care workers and nurses in applying palliative care pathways
- Increased staff confidence to engage in Advance Care Planning discussions with residents and families, supported by stronger and more consistent documentation
- Improved relationships with families through more consistent communication and family meetings and discussions
- Enhanced bereavement support and social work referral pathways



## Our journey

Participation in the ELDAC Linkages program gave Gordon Lodge the opportunity to transform its approach to palliative care and strengthen the capability of staff, residents and families to engage in early, meaningful planning. At the outset, there was hesitation from residents and loved ones about discussing palliative care, often due to the belief that it related only to the final days of life. Staff shared similar concerns, which made conversations challenging and limited access to early supports.

Through education, reflective practice and guidance from the ELDAC facilitator, Gordon Lodge began reframing palliative care as a holistic approach focused on comfort, quality of life and understanding what mattered most to residents. Staff developed greater confidence in initiating conversations, leading to richer engagement with residents and their loved ones about values, preferences and goals for care.

A powerful example of this change occurred when a locum doctor reviewed a resident who was deteriorating and recommended transfer to hospital. Because Advance Care Planning conversations had already occurred, the family was able to clearly communicate their parent's wishes, explaining that hospital transfer would not align with their parent's goals of care. The clarity and confidence shown by the family demonstrated the impact of their earlier discussions and reinforced the importance of timely planning. It highlighted how the ELDAC Linkages program had strengthened Gordon Lodge's communication processes and supported families to make informed decisions.

Throughout the program, the service enhanced pastoral and spiritual connections, broadened psychosocial and activity supports, and improved pathways for earlier identification of deterioration. Bereavement supports also became more structured, with clearer processes for assessing risk and connecting families with social work when needed.

The passion and commitment of Gordon Lodge staff shone throughout the journey. The ELDAC Linkages program has equipped the service with stronger processes, deeper linkages and a renewed confidence in delivering compassionate, person-centred palliative care. Gordon Lodge looks forward to continuing this journey and building on the foundations established through the program.

\*Resident/Client names have been de-identified and are gender neutral to preserve confidentiality.



# Rosewood Leederville



Residential Aged Care



Perth,  
Western Australia

## Highlights

- Improving our core skills in recognising decline and deterioration, including implementing a validated early detection tool, integrating this into our assessment practice and into our care software
- Opportunities for staff education and development, including dedicated time / reimbursement for attendance and completion
- Providing resources and equipment for a dedicated space for palliative learning
- Developing proficiency in using syringe drivers to optimise symptom support at the end of life
- Building our communication skills for talking about end-of-life needs (and to have these conversations earlier)
- Working with the Specialist Palliative Care Service, building our team's confidence and competence in areas such as symptom assessment and medication management
- Enhanced communication with families and community partners, building trust and improving our holistic care

## Goal

To improve end-of-life care, through staff development and by raising awareness of palliative care.

Rosewood Leederville is committed to ensuring everyone can enjoy a way of life that provides security, comfort, love, and happiness. This commitment is reflected in the service's high standard of care and holistic approach to residential aged care.

The service's ethos is to create an environment that meets residents' individual medical, personal, and social needs, enabling them to continue enjoying a rich, well-balanced life.

Rosewood Leederville employs a total of 230 staff to support 121 residents.

## Benefits of working together

Collaboration was a key strength of the project and played an important role in supporting progress toward the service's goals. Regular project team meetings provided structure and momentum, helping staff stay focused and aligned as they worked to improve the recognition and response to resident decline, build confidence in using syringe drivers, and strengthen communication skills.

Partnerships beyond the service also made a meaningful difference. Working with the state-based palliative care association enabled the team to host a catered information evening for staff and the local community. The session featured a specialist guest speaker and included a discussion on Quality of Life Care in the later stages of life. This created a valuable opportunity to share information about what palliative care involves, how planning occurs, and how residents and families are supported as care needs change.

The event was well-attended, with more than 30 residents' family members participating. It generated thoughtful questions, open discussion, and a shared learning experience in a relaxed and informal environment. Feedback from attendees was overwhelmingly positive, and the service plans to continue offering these sessions annually as part of its commitment to education, collaboration, and community engagement.



"We wanted to participate in the ELDAC program to help develop resources to better inform and prepare our staff, residents, and their families for the end of life, dedicating time to orientation and ongoing training, providing information and learning materials and by working to better anticipate and support changing care needs."





# The Carers



Home Care



O'Connor,  
Western Australia

## Highlights

- Built staff confidence and capability through targeted education in palliative care, Advance Care Planning, and grief and bereavement
- Established palliative care champions to support care workers and mentor peers in practice
- Developed service resources and clear linkages to strengthen support for clients, families, and staff
- Improved organisational readiness to deliver high-quality, person-centred palliative care at home

## Goal

To establish a structured and sustainable palliative care approach that strengthens staff capability, confidence, and consistency in Advance Care Planning and end-of-life support, while improving access to palliative care resources, training, and service partnerships for clients and families.

The Carers is a home care service based in O'Connor, Western Australia that supports older people living in the community. The service aims to build staff capability in palliative care, Advance Care Planning, grief and bereavement, and self-care, while strengthening service linkages to better support clients and families. Care is provided by a multidisciplinary team that includes care workers, registered nurses, allied health professionals, and administrative staff. The Carers supports a diverse group of older clients receiving home-based care, including individuals with increasing palliative and end-of-life support needs.



Participation in the ELDAC Linkages program provided an opportunity for The Carers to establish a structured palliative care program, improve staff confidence and skills, and develop the systems, resources, and partnerships needed to enhance the quality of end-of-life care delivered in the home.

Prior to participation, the service had limited palliative care structure and external linkages. Access to specialist partners and grief and bereavement resources was restricted, and staff roles, communication pathways, and capability around palliative and Advance Care Planning required strengthening.

## Key outcomes and benefits

- Increased staff knowledge and confidence following palliative care and Advance Care Planning training
- Established palliative care champions to support team learning and practice
- Improved access to internal and external resources to guide care delivery
- Strengthened organisational structure and model of care for clients with palliative needs
- Enhanced staff engagement and leadership support for ongoing quality improvement

### Our journey

Through participation in the ELDAC Linkages program, The Carers undertook a focused and collaborative journey to strengthen its approach to palliative care and Advance Care Planning within a home care setting. With support from the ELDAC facilitator, the organisation worked to build a structured and sustainable model that would support staff, clients, and families throughout the end-of-life journey.

A key early focus was staff education. Introductory and refresher training was delivered across palliative care, grief and bereavement, Advance Care Planning, and self-care. Training drew on a combination of in-house education and evidence-based resources, including palliative care learning modules, to ensure learning was practical and accessible for staff across roles. These activities helped demystify palliative care and increased confidence in supporting clients approaching end of life.

Two palliative care worker champions were identified to provide practical support and peer mentoring. The champions offered buddy shifts to less experienced care workers, particularly when supporting clients new to the service with palliative needs. This approach supported knowledge sharing, built confidence, and strengthened team cohesion.

To embed learning and maintain momentum, The Carers introduced regular communication strategies. An ELDAC information board and monthly service tips kept staff informed of progress against action plan goals. Updates were also included in staff meetings and a quarterly newsletter to reinforce key messages and celebrate progress.

With guidance from the ELDAC facilitator, the service developed a comprehensive palliative care resource folder. This included key internal information, referral pathways, and links to external resources through state and federally funded health and condition-specific support organisations and programs. The service also initiated contact with local providers to strengthen partnerships, including establishing a direct link with a specialist community care organisation to explore future collaboration.

The ELDAC facilitation process played a critical role in guiding planning, identifying priorities, and supporting the development of a sustainable model of care. Regular meetings supported accountability and ensured that quality improvement activities could be embedded into everyday practice.

Through participation in the ELDAC Linkages program, The Carers has strengthened staff capability, increased confidence in palliative care delivery, and enhanced its readiness to support clients and families with compassionate, person-centred end-of-life care at home.



# Home And Lifestyle Options (halo)



Home Care



Aramdale (Perth),  
Western Australia

## Highlights

- Strengthened policies, pathways and care planning processes to support consistent, person-centred end-of-life care
- Increased workforce confidence and capability to recognise deterioration and initiate Advance Care Planning conversations
- Improved collaboration and referral pathways with local specialist palliative care services
- Greater alignment with aged care reforms, including the Support at Home Program and End-of-Life Pathway

## Goal

To strengthen its approach to Advance Care Planning and palliative care so people could be supported to remain at home, with comfort, dignity and choice, as their needs changed. Participation focused on improving workforce confidence, strengthening systems and policies, and building collaborative partnerships to support end-of-life care in the community.

Home and Lifestyle Options Inc (halo) is a community based, not-for-profit aged and disability care provider delivering home based support across the south metropolitan region of Perth. Halo provides a broad range of services, including domestic assistance, personal care, nursing and allied health, care coordination and social supports. The service supports approximately 1,700 people with varying care needs, including older adults and people with disability, from lower support requirements through to palliative and end-of-life care. Halo employs around 170 staff across frontline support, care coordination, nursing, allied health and corporate roles, delivering inclusive, person-centred care for people from diverse backgrounds.

Halo chose to participate in the ELDAC Linkages Program to strengthen Advance Care Planning and palliative care within a community care context, and to ensure systems, workforce capability and partnerships were well prepared to support people choosing to remain at home at end of life.

Prior to participation, halo had limited formal connections with specialist palliative care services, emerging policies and care planning processes, and varying staff confidence in having Advance Care Planning conversations. These factors made coordinated end-of-life care in the community more complex and less consistent.

*"At halo, being part of the ELDAC Linkages Program has allowed us to truly walk alongside the people we support and their families, providing care that honours their life, their choices, and their unique journey."*

*Working Party Lead*

## Key outcomes and benefits

- Implemented clearer policies, procedures and pathways to guide end-of-life care in the home
- Improved workforce confidence in recognising deterioration and initiating respectful conversations about goals and preferences
- Strengthened referral pathways and shared care with specialist palliative care services
- Embedded tools and education to support consistent practice and continuous improvement



## Our journey

Over recent years, halo has been navigating significant change across aged care, including the introduction of the Support at Home program, the End-of-life Pathway, and the strengthened Quality Standards under the Aged Care Act 2024. These reforms reinforced halo's commitment to supporting people to remain living at home, including through the final chapter of life, with care that is compassionate, coordinated, and person-centred.

The introduction of the Support at Home Program and End-of-Life Pathway highlighted the importance of strong systems, skilled staff and effective partnerships. While halo had long supported people with complex needs in the community, participation in the ELDAC Linkages Program provided structure, guidance and momentum to strengthen its approach to Advance Care Planning and palliative care across the organisation.

Working alongside an ELDAC facilitator, halo reviewed and enhanced policies, procedures and care planning processes, including developing clearer guidance for recognising deterioration and responding appropriately in the home. Advance Care Planning was embedded more intentionally into routine practice, helping to ensure that people's values, preferences and goals of care are discussed earlier and revisited as needs change.

A core focus of the journey was building workforce capability. Through education, workshops and practical tools, staff developed greater confidence to initiate sensitive conversations, recognise changes in health, and collaborate effectively with specialist services. This strengthened shared understanding across teams and improved continuity of care for people supported at end of life.

Participation in the ELDAC Linkages Program also strengthened halo's connections with local specialist palliative care services, supporting clearer referral pathways, shared care planning and mutual understanding of roles. These partnerships have enhanced coordinated, multidisciplinary care and supported halo's ability to respond promptly and compassionately when people enter the end-of-life phase.

Overall, the ELDAC Linkages Program supported halo to establish a sustainable framework for community based end-of-life care. Continuous improvement practices, including reflection and review, now underpin ongoing development. This work supports halo's team to walk alongside people and their families, honouring individual choices and ensuring care at end of life is respectful, responsive and grounded in dignity.



# Regents Garden - Bateman



Residential Aged Care



Bateman,  
Western Australia

## Highlights

- Normalised Advance Care Planning and end-of-life conversations across the service
- Increased workforce wide confidence by upskilling nurses to independently lead conversations
- Supported non clinical staff with shared resources to confidently respond to family questions
- Improved recognition of deterioration and timely palliative care responses
- Introduced consistent, compassionate family support before and after a resident's death

## Goal

To strengthen palliative and end-of-life care practices, embed a consistent and person-centred approach, and build workforce-wide confidence in Advance Care Planning by upskilling nurses to lead conversations and equipping all staff, including concierge teams, with resources to support families and discuss end-of-life symptoms with confidence, dignity, and compassion.

Regents Garden Bateman is a residential aged care facility providing holistic care and support to 108 residents aged between 70 and 100 years. We have approximately 180 staff across a range of disciplines providing supports such as personal and day-to-day care, clinical and complex care, palliative and end-of-life care, hospitality services, catering, wellness programs, social work, and community engagement. The resident population is culturally diverse, with approximately 30 per cent from Asian backgrounds and 70 per cent from other ethnic backgrounds.

We chose to participate in the ELDAC Linkages program as part of our commitment to continuous quality improvement and excellence in end-of-life care. A big focus was building confidence and consistency across the entire workforce, ensuring staff at all levels felt supported and capable of contributing to high-quality, compassionate, and person-centred end-of-life care.

Prior to participation, Advance Care Planning and palliative care discussions were often perceived as difficult or avoided altogether. Conversations were typically led by clinical nurse managers, as many staff lacked confidence to initiate or guide discussions independently. There was also no consistent approach to supporting families during end-of-life or following a resident's death. These challenges contributed to delayed conversations, variable recognition of deterioration, inconsistent family experiences, and low completion of Advance Care Plans.



## Key outcomes and benefits

- Increased confidence among nurses to independently lead Advance Care Planning and end of life conversations
- Greater involvement of non clinical staff in supporting families using shared language and resources
- Improved recognition of deterioration and timelier palliative care responses
- More consistent and compassionate support for families during end of life and bereavement
- Increased completion and quality of Advance Care Plans
- A strengthened organisational culture focused on dignity, comfort, and respectful end-of-life care

*"Through ELDAC, we have fostered a culture where end-of-life care is approached with confidence, dignity, and respect, supported by clear processes and a well-trained team."*

*Facility Manager*

## Our journey

Participation in the ELDAC Linkages program marked a significant step forward for Regents Garden Bateman. Working alongside the ELDAC facilitator, the service undertook a structured review of current palliative and end-of-life care practices. A key priority identified was the need to broaden confidence and capability across the workforce, rather than relying on a small number of senior staff.

Targeted education and training were introduced to upskill nurses beyond clinical nurse managers to confidently lead Advance Care Planning and end-of-life conversations. This reduced reliance on individual staff and embedded these discussions into routine care. Increasing workforce capability also created greater flexibility for residents and families, allowing conversations to occur at times that suited them, including evenings and weekends when families were visiting.

In parallel, a whole-of-service approach was adopted. All staff, including concierge team members, were provided with practical resources to help them respond confidently and consistently to families' questions and concerns about end-of-life symptoms. This ensured families received clear, compassionate information regardless of which staff member they spoke with.

These initiatives supported a noticeable cultural shift. Advance care planning and end-of-life conversations became more normalised and were initiated earlier, rather than during times of crisis. Staff reported increased confidence in recognising deterioration, communicating changes sensitively, and supporting residents and families through meaningful discussions focused on comfort and goals of care.

The service also strengthened its approach to family support. More consistent practices were introduced before, during, and after a resident's death, including follow-up phone calls, condolence cards, flowers, and information about bereavement support. Residents were honoured through respectful processes at the time of passing, reinforcing dignity and compassion as core values.

Structured pre- and post-audits through the ELDAC Linkages program provided a foundation for continuous quality improvement, enabling the team to monitor progress, identify opportunities for improvement, and sustain positive change.



# Regents Garden - Lake Joondalup



Residential Aged Care



Wanneroo,  
Western Australia

## Highlights

- Increased awareness and understanding of Advance Care Planning among residents, families, and staff
- Improved recognition and response to resident deterioration
- Reduced end-of-life care complaints through clearer communication and education
- Strengthened bereavement support for families and staff
- Enhanced quality and consistency of end-of-life care delivery

## Goal

To strengthen its approach to palliative and end-of-life care through continuous quality improvement. The service aimed to improve Advance Care Planning awareness, enhance staff capability, and build stronger connections to specialist support to ensure timely, coordinated, and person-centred care.

Regents Garden, Lake Joondalup is a residential aged care service providing permanent, respite, palliative, and end-of-life care alongside clinical, personal, hospitality, wellness, and specialist care services. The service employs 166 staff across clinical, care, and support roles. Regents Garden Lake Joondalup supports 99 permanent residents and one respite resident, aged between sixty-seven and one hundred and three years. The resident group comprises approximately 30 per cent men and 70 per cent women, with residents born primarily in Australia, England, other European countries, and Asia.

Participation in the ELDAC Linkages program aligned with Regents Garden's commitment to continuous improvement. The Lake Joondalup team were looking for structured support to strengthen its palliative and end-of-life care practices, improve Advance Care Planning knowledge, and enhance collaboration with specialist services to better meet the needs of residents and families.

Prior to participation, deterioration was not always recognised or addressed in a timely way. Specialist palliative care access was limited, bereavement support was minimal, and staff understanding of Advance Care Planning varied. These challenges contributed to slower responses to change, increased unplanned hospital transfers, and misunderstanding of end-of-life stages among families, occasionally resulting in complaints.

## Key outcomes and benefits

- Improved staff confidence and capability in Advance Care Planning discussions
- Earlier recognition of deterioration and proactive care responses
- Reduced unplanned hospital transfers at end of life
- Strengthened bereavement support for families and staff
- Improved quality, consistency, and experience of end-of-life care
- Clearer communication and education for families about end-of-life pathways



## Our journey

This case highlights the positive impact of early palliative care involvement, specialist input, and strong collaboration between the resident, family, and care team during end-of-life care whilst undergoing the Linkage Program.

Following recognition of the resident's declining health status, a palliative approach was initiated early. The resident benefited significantly from increased specialist input, which included targeted education for staff and family. This support helped clarify goals of care and ensured symptom management strategies were tailored to the resident's needs. Specialist guidance also enabled timely conversations around the anticipated course of illness.

The family expressed deep appreciation for the clear and compassionate end-of-life education they received. They were supported to understand common signs and symptoms associated with the terminal phase, which helped reduce anxiety and fear as changes occurred. This knowledge empowered the family to feel prepared and involved, rather than overwhelmed, as their loved one's condition progressed.

Staff confidence in managing end-of-life symptoms was noticeably strengthened through this collaborative approach. With support from specialist services, staff worked closely with the resident and family to manage pain, comfort, and emotional needs effectively. Importantly, the family was encouraged and supported to actively participate in care. They were present with the resident during their final moments and expressed gratitude for being able to support their loved one as they passed peacefully. The family shared that this experience was markedly different, and more positive, compared to the end-of-life experience they had previously had with their father.

A key success in this case was the early recognition of the resident's approach toward the terminal phase, which allowed meaningful time for reflection and connection. Together, the resident and family created a "bucket list" of activities to complete before the resident became bedbound. These moments included going for scenic drives, visiting the beach, and returning home for a family gathering. These experiences became treasured memories and contributed significantly to the resident's quality of life in their final months.

Overall, this case demonstrates how proactive palliative care, open communication, and family involvement can lead to a peaceful, dignified, and deeply meaningful end-of-life experience.

Resident/Client names have been de-identified and are gender neutral to preserve confidentiality.



# Regents Garden - Four Seasons



Residential Aged Care



Booragoon,  
Western Australia

## Highlights

- Improved early recognition of deterioration, enabling timely and coordinated palliative care responses
- Increased staff confidence and capability in Advance Care Planning and end-of-life discussions
- Strengthened multidisciplinary collaboration, including regular meetings with specialist palliative care professionals
- Enhanced resident and family end-of-life experiences through respectful communication and supportive resources such as the Serenity Trolley

## Goal

To strengthen the delivery of compassionate, person-centred palliative and end-of-life care by building staff capability, improving Advance Care Planning conversations, and strengthening partnerships with local specialist palliative care services to ensure residents and families receive coordinated, dignified support.

Regents Garden Four Seasons is a residential aged care service in Booragoon, Western Australia, providing clinical, personal, hospitality, lifestyle, and therapy services, including palliative and end-of-life care. The service employs 148 staff members who work collaboratively to support residents across all aspects of daily living and care. Four Seasons supports 100 residents aged between 75 and 102 years. While the majority of residents are Caucasian and English speaking, the community also includes a small number of residents from Asian and other language backgrounds.

Regents Garden Four Seasons chose to participate in the ELDAC Linkages program to strengthen end-of-life care, enhance staff knowledge and confidence, and access structured guidance and best practice resources. The service sought to improve Advance Care Planning processes and build stronger external partnerships to support coordinated, compassionate care.

Prior to participating in the ELDAC Linkages program, Advance Care Planning discussions were often delayed, and deterioration was not always recognised early due to gaps in staff knowledge. Staff lacked confidence in having end-of-life conversations with families, multidisciplinary meetings were not initiated promptly, and resident preferences were not consistently followed, contributing to unplanned hospital transfers and limited family involvement.

## Key outcomes and benefits

- Earlier recognition and reporting of resident deterioration by staff
- Regular multidisciplinary team meetings supported by specialist palliative care professionals
- Improved staff knowledge and confidence in palliative and end-of-life care
- Increased awareness and uptake of Advance Care Planning among residents, families, and staff
- Improved family understanding of the dying process, with care preferences respected and followed
- Establishment of a Palliative Care Champion team to support ongoing practice improvement



## Our journey

Participation in the ELDAC Linkages program provided Regents Garden Four Seasons with the opportunity to reflect on existing practices and strengthen its approach to end-of-life care in a meaningful and sustained way.

Through the guidance of the ELDAC Linkages program, Four Seasons focused on early recognition of deterioration, improving communication, and building staff confidence. Regular multidisciplinary team meetings were introduced, bringing together internal staff with local specialist palliative care professionals. These meetings created space for shared learning, timely decision making, and coordinated planning, ensuring that residents' needs and wishes remained central to care delivery.

One particularly meaningful example of change involved the care of a resident during the final stages of his life. Staff worked closely with his family, maintaining clear and compassionate communication throughout. The introduction of the Serenity Trolley helped create a peaceful and supportive environment, allowing the family to spend quiet, private time together. Following his passing, the family expressed sincere gratitude for the dignity, kindness, and professionalism demonstrated by staff, noting the comfort provided through both end of life and bereavement support.

As part of the ELDAC Linkages journey, Four Seasons also introduced Advance Care Planning Awareness Morning Tea Sessions for residents and their representatives. These sessions supported open conversations about care preferences and encouraged families to document wishes clearly. Feedback from families highlighted the value of these sessions, with many describing increased understanding, reduced anxiety, and reassurance that their loved ones' wishes would be respected, particularly in emergency situations.

The ELDAC Linkages program has also been a catalyst for embedding a more consistent, organisation wide approach to quality improvement. Staff now recognise deterioration earlier, feel supported to initiate end-of-life discussions, and work collaboratively with families and external providers. The establishment of a Palliative Care Champion team has further supported sustained change by promoting shared responsibility and ongoing learning.

Overall, participation in the ELDAC Linkages program has strengthened Four Seasons' ability to provide compassionate, coordinated, and person-centred care, ensuring residents are supported to experience dignity, comfort, and respect at the end of life.



# CPE Group - Home Care Service



Home Care



Osbourne Park,  
Western Australia

## Highlights

- Embedded a more confident, consistent approach to Advance Care Planning within a home care setting
- Strengthened collaboration with local specialist palliative care services to support shared care
- Improved staff confidence in advocating for client wishes and coordinating end-of-life care
- Supported clients and families to prioritise comfort, dignity, and choice at end of life

## Goal

To strengthen staff capability and confidence in Advance Care Planning and palliative care, supporting clients to experience comfort, dignity, and choice at end of life through coordinated, person-centred care delivered in collaboration with families and local specialist palliative care services.

CPE Group provides community-based clinical and home support services for older people living at home, helping them maintain independence and quality of life. Services include domestic assistance, personal care, social support, and allied health.

Care is delivered with a strong focus on person-centred, dignified practice, underpinned by understanding, kindness, and respect. With a solid foundation across multiple areas of community care, CPE Group also supports clients with progressive and life limiting conditions through coordinated, palliative-focused approaches that respond to changing needs over time.

CPE Group participated in the ELDAC Linkages Program to build staff capability and confidence in Advance Care Planning and palliative care. The service sought guidance, resources, and support to strengthen compassionate conversations, align care decisions with client wishes, and enhance comfort and dignity for clients approaching end of life.

Prior to participation, some clients were not ready to engage in Advance Care Planning due to fear, denial, or a focus on managing day to day care needs. The absence of documented plans created uncertainty for staff when care needs changed, sometimes limiting timely adjustments to care that could improve comfort, quality of life, and alignment with a client's preferences.



## Key outcomes and benefits

- Development and refinement of policies and procedures, updated documentation, and a suite of standardised information resources to support consistent, high quality care
- All staff received training in Advance Care Planning and palliative care, with enhanced education for key workers
- Increased staff confidence in initiating, pacing, and revisiting Advance Care Planning conversations with clients and families
- Improved use of shared, evidence-based language to support clear, compassionate palliative care discussions
- Strengthened collaboration with local specialist palliative care services to enable coordinated, shared care
- Enhanced advocacy for client wishes, particularly regarding preferred place of care and death
- More informed, timely, and coordinated responses to escalating care needs at end of life

“ELDAC helped us better understand our role in advocating for clients, building the right care team, and supporting people to live – and die – with dignity.”

### Our journey

We would like to share how our experience with the ELDAC Linkages Program supported CPE Group’s wound care multidisciplinary team — including a Clinical Lead, Registered Nurse, Care Manager, and Support Workers — to work together to recognise changing needs over time and create opportunities for broader end-of-life conversations and care planning.

In April 2025, CPE Group commenced wound care for an older client who was fiercely independent and valued making their own decisions. Their previous palliative care provider could no longer continue wound care services, and CPE Group stepped in to provide ongoing clinical and supportive care in their home.

Over the following months, staff sensitively and respectfully raised Advance Care Planning discussions, recognising the importance of timing, trust, and readiness. Each time, the client expressed that they were “not ready yet.” During this period, the client’s health gradually declined. They continued to self-manage their condition and declined analgesia, despite worsening symptoms.

The client commenced radiation therapy to manage a cancer-related abdominal wound. While this initially offered some benefit, the wound deteriorated following the second treatment. When care began, the wound measured approximately 8–10 cm. By September 2025, it had progressed to involve the entire abdomen, significantly increasing their care needs and symptom burden.

As the client’s condition worsened, their son became more involved in their care and requested additional supports to help maintain comfort at home. With the son’s support, an Advance Care Planning meeting was held. During this conversation, the client clearly expressed their wish to remain at home and to die there.

Drawing on learnings from the ELDAC Linkages Program, CPE Group staff advocated confidently for the client’s wishes and coordinated care across services. The team liaised closely with local specialist palliative care services to optimise pain management and symptom control. Daily supports were increased to prioritise comfort, dignity, and emotional support for both the client and their family.

The ELDAC facilitator played an important role throughout the service’s participation by providing practical guidance, maintaining momentum, and offering an external perspective grounded in best practice. This support strengthened staff confidence and reinforced a collaborative, person-centred approach to end-of-life care.

Through coordinated teamwork and respectful communication, the client’s wishes were honoured. They died peacefully at home in October 2025, supported by care that reflected their values and priorities.

\*Client names have been de-identified and are gender neutral to preserve confidentiality.

## **ELDAC Linkages Program**

The ELDAC Linkages program is a palliative care and Advance Care Planning initiative aimed at enhancing the quality of end-of-life care for all older Australians receiving aged care. The program assists aged care services to develop and strengthen their palliative care and Advance Care Planning delivery, with a focus on fostering stronger connections between aged care, specialist palliative care, primary care, and other local service providers and networks. Participating services receive facilitation support and guidance throughout the program, including access to evidence-based resources, tools, and templates. This tailored program is underpinned by a quality improvement approach to help aged care services achieve their service improvement goals in palliative care and end-of-life care.



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[eldac.com.au](http://eldac.com.au)