Linkage Strategies: Audit for Aged Care Services

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

Role clarification

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

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

Formalised agreements and plans

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

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

Written and verbal communication pathways

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

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

Designated linkage worker

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

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

Continuous quality improvement

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

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

Multidisciplinary team structures

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

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

Knowledge exchange and upskilling

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

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

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