

Specialist palliative care in nursing homes

Integrating care to improve quality of life and reduce costs

The Australian government's **National Palliative Care Strategy** sets a vision for palliative care which:

- improves awareness and understanding
- is appropriate and effective
- has high quality leadership and governance
- builds capacity and capability

The **National Palliative Care Standards** re-assert the need for palliative care to be available to all people living with progressive or advanced disease.

Increases in the number of older people in Australia will lead to the number of aged care residents to rise by 150% from 1998-2031. However, aged care staff often feel inadequately trained or prepared to look after people who are dying. Consequently, nursing home residents are more likely to die in hospital, with uncontrolled symptoms, or without adequate care planning in place. The **2018 Federal budget measure** focused on improving palliative care in aged care facilities.

The Palliative Care Needs Rounds model

Palliative Care Needs Rounds are monthly triage meetings that have been introduced in residential care for older adults to help identify and prioritise care for those most at risk of unplanned dying, with inadequately controlled symptoms.

Case-based education is given to staff, to build their capabilities. Advance planning, including medicines, goals of care and power of attorney are all discussed to reduce avoidable hospitalisations and increase dying in preferred place.



Key findings

- Regular Needs Rounds meetings identify residents most at risk of dying without an adequate care plan in place. A specialist clinician can then provide advice, education and support to the care home staff.
- Participation in the study saved an equivalent of \$3,507,148 AUD in reduced hospitalisation.
- The intervention improved staff confidence in discussing death and dying with families, and planning for symptoms and care goals at end of life.
- Participants were more likely to experience a better quality death (including better symptom control, advance planning, closeness with relatives, and spiritual care).
- Participants were more likely to die in their preferred place of death.

Definitive Study

A randomised, stepped wedge control trial was conducted in 12 care facilities in the Australian Capital Territory in 2017-8, with a total of 1700 residents involved in the trial. In stepped wedge trials, all participants move from the control to intervention condition. Consequently, with the exception of newly admitted residents, and those who died in the trial, the analysis examines hospitalisations on all residents across time to examine whether hospitalisations reduced in length or number.

Adherence to the model varied, with two sites rated as low adherence. Flexibility in adopting the model improves uptake.

Policy implications:

1. Palliative Care Needs Rounds should be adopted without delay, in order to help meet national palliative care strategy goals.
2. The model should be adapted to allow for telemedicine, to meet the needs of people in rural and remote settings.

About this research

This briefing is based on research undertaken by:

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If citing this research, please reference the following papers:

Forbat, L., et al. (2018) Integrating specialist palliative care into residential care for older people: a stepped wedge trial (INSPIRED trial). *Final report*. Australian Catholic University.

Forbat, L., et al. Improving specialist palliative care in residential care for older people: a checklist to guide practice. *BMJ Supportive and Palliative Care*. 10.136/bmjSPACE-2017-001332

Chapman, M. et al. Avoiding costly hospitalisation at end of life: Findings from a specialist palliative care pilot in residential care for older adults. *BMJ Supportive and Palliative Care*. 10.1136/bmjSPACE-2015-001071

Johnston, N. et al. Normalising and planning for death in residential care: Findings from a qualitative focus group study of a specialist palliative care intervention. *BMJ Supportive and Palliative Care*. 10.1136/bmjSPACE-2016-001127

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Palliative Care Needs Round Checklist

Triggers to discuss resident at needs rounds

One or more of:

- 1 You would not be surprised if the resident died in the next six months
- 2 Physical or cognitive decline or exacerbation of symptoms in the last month
- 3 No plans in place for last six months of life/no advance care plan
- 4 Conflict within the family around treatment and care options
- 5 Transferred to our facility for end of life care

1. Reviews

- Have all actions been implemented?
- Have any new symptoms or concerns emerged?
- Give positive feedback on actions that the staff managed well
- Decide if the resident should be kept on the specialist palliative care list, for on-going review

2. New Referrals

- What are the resident's diagnoses and co-morbidities?
- What are their palliative care needs (including physical, psychosocial and spiritual symptoms)?
- What are staff current concerns around treatment or goals of care?
- Who supports the resident outside the facility (eg family/friends)?
- Provide case-based education (eg recognising deterioration and dying, bowel management, pain assessment, talking to GPs)

Actions

- Medication review (eg change meds, anticipatory meds)?
- Organise surrogate decision maker?
- Develop an advance care plan?
- Organise a case conference?
- External referrals (eg pastoral care, dementia support services, wound care)?
- Refer to specialist palliative care?

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