Palliative Care and Aged Care

Stronger Connections

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MCM acknowledges the Traditional Owners of the waterways and lands where we work. We pay our respects to Elders past and present. We are committed to ensuring everyone we work with is safe, empowered, supported and respected. We support and celebrate diversity of race, culture, ability, age, gender, sexuality and gender identity

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Department of Health and Aged Care

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Contents

Purpose

To report on the Comprehensive Palliative Care in Aged Care (CPCiAC) project, including development, implementation, findings, and recommendations.

This report will detail consolidated findings of the project data including Melbourne City Mission Palliative Care (MCMPC) catchment area demographics, palliative care needs rounds evaluation, and interview themes.

Key deliverables achieved and future recommendations to address identified barriers will be provided in relation to the project charter purpose and objectives.

Project Plan

Prior to the commencement of the project coordinator, a project steering committee and initial project brief had been developed. The purpose of the steering committee, which met monthly, was to provide a platform for collaboration on the direction of the project based on progress and outcomes.

A further monthly CPCiAC progress meeting with the project sponsor, project coordinator and project manager was implemented to support and review the achievement of key deliverables. A detailed project charter was developed outlining objectives and key deliverables. The project plan focused on 2 main elements: interview development and the Aged Care Home (stakeholder) engagement plan.

Background

MCMPC received a 12-month non-recurrent funding allocation that formed part of the joint Commonwealth / Victorian Comprehensive Palliative Care in Aged Care initiative (CPCiAC). The funding was provided to support working with Aged Care Homes to improve resident's palliative care outcomes.

This is aligned with the findings of the Royal Commission into Aged Care, where there is an identified need to improve access to and quality of palliative and end of life care in Aged Care Homes.

The availability and standard of palliative care in aged care is variable and complex. Through its dedicated Aged Care Team, MCMPC have recognised these challenges and therefore developed its project charter with the objective to strengthen clinical partnerships with Aged Care Homes in the MCMPC catchment.

This has been addressed by examining the barriers and enablers of palliative care in homes, as well as seeking to further understand the unique characteristics of each home that may influence palliative care outcomes.

MCMPC Aged Care Team consists of clinical nurse consultants and allied health (counselling) that are solely dedicated to providing services to Aged Care Homes within MCMPC catchment area. Services are provided on a referral basis to residents, families, and clinical staff within the home.

The MCMPC catchment provides services to 52 Aged Care Homes across the Local Government Areas (LGA) of Merri-bek, Darebin, Hume and Yarra. The catchment area also intersects with multiple Residential In-Reach services including, Royal Melbourne, Austin, Northern, St. Vincent's and Western Health.

Interview Development and Planning

The steering committee endorsed the development of 2 interview streams for homes based on operational involvement and frequency of service. Stream 1 were homes with a higher level of engagement with MCMPC services evidenced through reporting on the number and frequency of referrals via PalCare (PalCare is an electronic client record management system), and involvement with palliative care needs rounds. Stream 2 were homes that typically had lower levels of engagement and referrals for MCMPC Aged Care Team support.

Stream 1 was developed to have open-ended questions directed through a 1:1 interview with clinical leadership staff within the home. This stream considered the value obtained through already strong professional engagement.

Stream 2 focused on the homes reported understanding of MCMPC as a specialised service, the homes processes in addressing palliative care needs, and attempted to identify rationale for lower levels of referrals and service engagement.

Additionally, **both interview streams** sought to gain insight into current training and education practices, practices around completion of goals of care, policies, and processes for assessment of and identifying deteriorating residents and trigger points for referral to MCMPC.

A survey directed at the MCMPC Aged Care Team was also developed to reflect their experiences in relation to needs rounds processes, the delivery of education and training, and perceived barriers and enablers with working with Aged Care Homes and staff.

01

Interview Stream 1
Higher levels of engagement

- Value for staff
- Value for residents
- Value for families
- Needs rounds evaluation

02

Interview Stream 2
Lower levels of engagement

- Understanding of MCMPC services
- Reasons for infrequent referrals
- Introduction to needs rounds

01 02

Interview Stream 1 & 2

- Training and Education
- Goals of Care
- Trigger for Referral
- Assessment tools
- Access to GP's

Stakeholder Engagement Strategy

A stakeholder engagement plan was developed to ensure efficient engagement and effective communication. Homes were mapped and grouped according to LGA with the aim to complete four to six interviews weekly.

Homes were contacted via phone with the aim to schedule an interview with the clinical coordinator / care manager. A script was developed to ensure consistent messaging to all homes. The objective was to gain high level of buy-in from homes within the catchment.

The majority of homes were receptive and welcoming of onsite visits and a willingness to participate was demonstrated. Interviews were mostly achieved via attending the home with some completed virtually via MS teams.

Profiling of each home was completed to gain a foundational understanding.

This included the following:

A review of the home or organisational website was conducted seeking to understand:

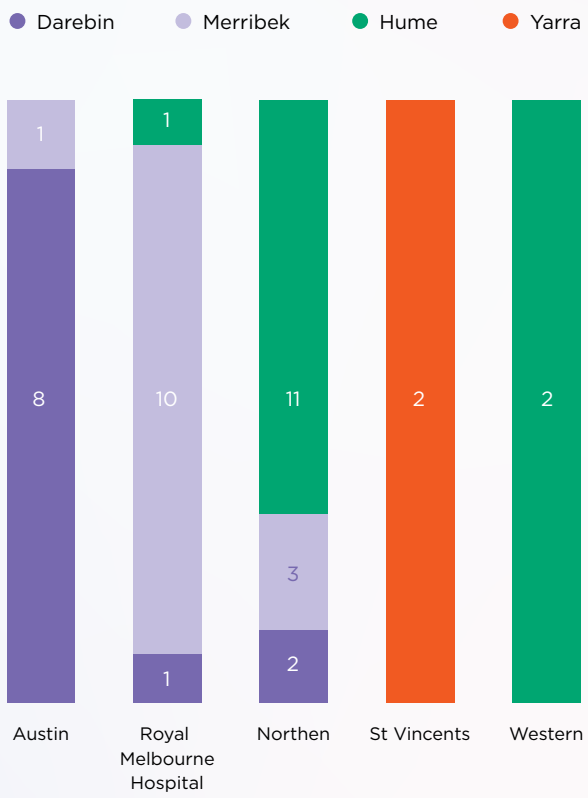
* Whether palliative care was listed under the services offered.
* Latest accreditation results- had the home achieved accreditation or had existing sanctions.
* Meeting of care and nursing minutes- signified if the home is appropriately staffed.
* If available, the homes star rating.

Review of engagement with hospital provided Residential In-Reach (RIR) services according to Local Government Area (LGA) supported planning by areas

Experiences of the Aged Care Team and reflection on partnership with the home

In Reach services by LGA

This table represents the number of homes co-located within RIR and MCMPC catchment according to LGA.



Data Collection and Storage

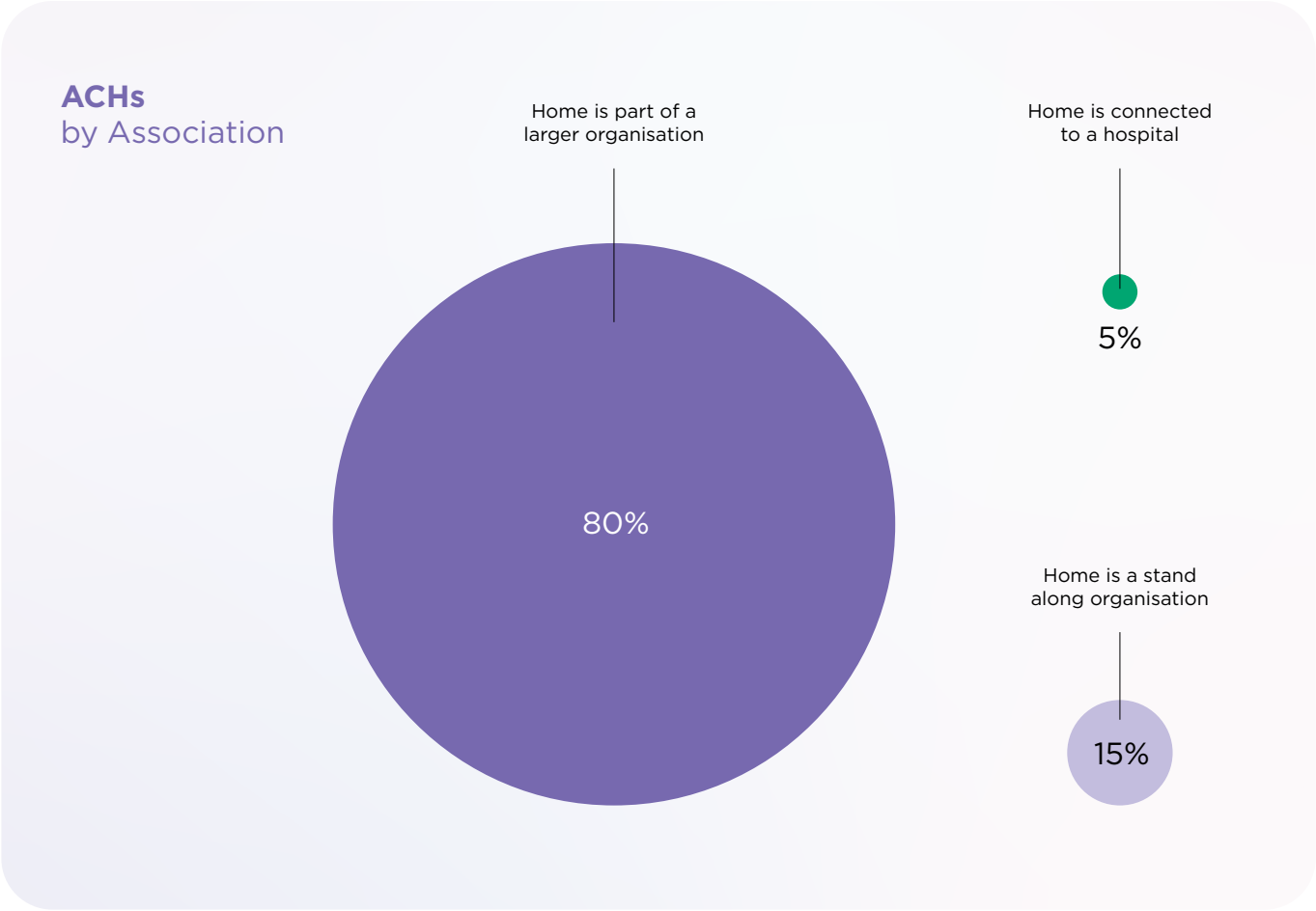
Interviews were developed using the smartsheet program (smartsheet is a software platform with a range of project management tools that allows for project management data storage). The interview was completed via taking notes against the set questions and then later transcribing to data sheets. All interview notes were kept ensuring they could be double checked prior to report completion to ensure accurate data entry.

Utilising smartsheet as a project management platform allowed the project sponsor and manager to view progress against the engagement strategy.

Stakeholder Engagement

There were 52 Aged Care Homes within the MCMPC catchment area at the time the engagement strategy was undertaken. Aged Care Homes operating models range from homes managed by private organisations, not for profit organisation, standalone (1 home), and state-based homes (attached to hospital catchment).

In total 41 out of 52 homes, 79% of homes, participated in the interviews. The interviews were completed between July-December 2023. Results from both interview streams are presented with support from current literature where necessary.



Data Evaluation

Providing palliative care support into Aged Care attempts to bring together services from vastly different funding and governance streams. Care coordination is complex when considering the variable nature and involvement of services including Residential In-Reach, General Practice, and Palliative Care service providers.

The values of Aged Care organisations and models of care delivered can produce vastly different operating environments (Department of Health, 2021) further contributing to complexities experienced by key consultation stakeholders.

Interview Stream 1

22 homes were identified with high-level engagement with MCMPC and participated in interview stream 1. The focus was on understanding the impact and value of MCMPC services in relation to families, staff, and residents.

Barriers and enablers of palliative care in aged care were able to be identified through a qualitative approach.

Impact with Families
as observed by aged care staff

There was universal agreement that MCMPC Aged Care Team involvement delivered immense support to families of loved ones in an Aged Care Home.

Main points identified include:

Eases the burden on nursing staff when the Aged Care Team able to spend greater amounts of time with families.

Families often have a better understanding of palliative care once they've met with the Aged Care Team.

Staff can learn from the Aged Care Team when they are involved family conversations.

Helps family's preparedness to accept death of loved one.

It can be identified that family support acts as an enabler to delivering palliative care in Aged Care Homes. The support from MCM often reduces the time staff are required to spend with families allowing that time to be spent on direct care delivery.

However, it was identified that homes would like resources to give to families. Some homes report when families have asked for information on palliative care, they were unable to give them anything, or when response times (although minimal) have taken longer than anticipated staff would be able to give families the information they are seeking.

Impact with Staff

Nursing and Allied Care support are provided through the MCMPC Aged Care Team. Homes interviewed expressed great value and appreciation in the support staff receive from the MCMPC Aged Care Team. There is clear evidence indicating the support provided from a dedicated Aged Care Team acts as an enabler to improving the delivery of quality palliative care.

Data samples included:

Guidance on symptom management provided is reliable clinical advice.

Able to reassure that nursing staff are making the right decisions.

Value in having a dedicated Aged Care Team, has made staff feel more comfortable contacting palliative care services.

Great support provided with GP's that may not want to prescribe anticipatory medications.

Approachable and supportive teams.

Barriers to engaging with MCMPC and service concerns were also identified through this stream. Multiple homes interviewed discussed concerns in not being able to access a Doctor through MCMPC yet are often told to reach out to MCMPC as first point of contact.

As Aged Care Home staff movement within organisations and across regions is evident, some staff interviewed were able to point out that other palliative care services have doctors available for consultation or assistance with medication prescriptions if no GP is available. This can lead to staff not engaging with MCMPC and subsequently sourcing medical led services to fulfill what they were needing.

Multiple homes indicated the amount of phone calls was a concern and did not believe it was achieving anything (Phone assessment is a warranted approach to consultation to deliver higher volume request according to resident needs within the MCMPC model of care).

Aged Care Homes also indicated they did not understand the reason for ongoing phone calls when a resident is stable and what may trigger an onsite visit. It was indicated that this system may not always achieve anything for staff and residents and greater visibility onsite was a more effective way to engage with staff. This may also lead to referrals being made very late in thepalliative care trajectory.

Impact with Residents

Commonly the impact for residents was viewed through the support provided to staff. When staff have support with managing symptoms this was associated with positively enhanced outcomes for residents. Home staff didn't always perceive the phone calls (assessment) to be of benefit for residents. Onsite visits and in person engagement with residents and staff were felt to have greater impact with improving outcomes. It was also identified that residents may be stable for some time but continue to receive phone calls for updates and there may not be great benefit from this. A model including a triage system with clearer admission and discharge criteria may be considered.

Interviews completed with the MCMPC Aged Care Team identified accurate and timely communication to often be a barrier. When an onsite visit has been completed there are not always Aged Care Home staff members available to discuss this with or provide recommendations to. This can result in Aged Care Home staff believing that the resident has not been seen frequently enough and contributes to the concerns regarding the ongoing visibility of the MCMPC Aged Care Team within the home.

Interview Stream 2

19 of the 30 remaining Aged Care Homes considered in stream 2 participated in interviews. The second stream consisted of homes that had been identified as having less engagement and infrequent referrals to MCMPC.

The interview focused on attempting to understand why this may be occurring including whether these homes understood the services available through the MCMPC Aged Care Team. The main reason for lesser engagement identified was in relation to the size of the Aged Care Homes, most were significantly smaller on average, ranging from 30-60 beds.

Most of these homes reported infrequent death occurrence with some only averaging 2 or 3 a year. Some of the smaller homes operating with 30 beds also appeared to have more robust and advanced palliative care systems in place, therefore did not feel the need for frequent specialised palliative care services.

It was also found that majority of these staff did have a sound understanding of MCMPC services. However, the suite of MCMPC services was still discussed with all staff and often there were parts that people were not aware of such as, what needs rounds were and the availability of ongoing bereavement support for families.

Services were asked to quantify the average number of deaths per month/year (this is reported as an estimate only and all homes reported to experience peaks and troughs in deaths). This can highlight the demand for specialist palliative care services.

Large size homes
100–140 beds

2-4 deaths
per month

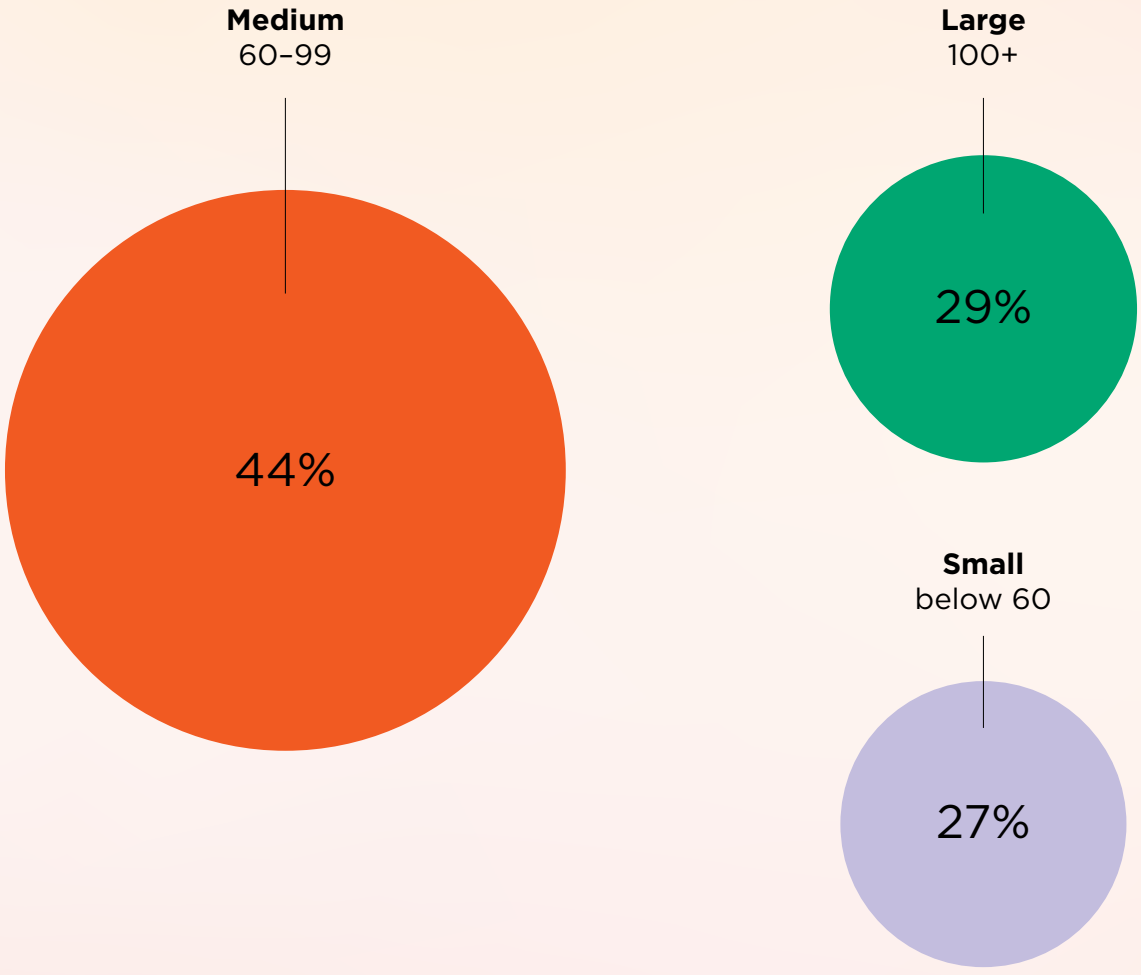
Medium size homes
60–99 beds

1-2 deaths
per month

Small size homes
less than 60 beds

2-3 deaths
per year

ACHs Capacity
% no of beds



Interview Stream 1 & 2: Targeted Questions

Both interview streams had common areas for discussion to aid understanding and to gain insight into current practices and systems in place within the home.

These include:

- Access to GPs (General Practitioners)
- Assessment Tools
- Goals of Care (GOC)
- Trigger points for referral
- Education

There are many issues that contribute to developing barriers in respect to delivering quality palliative care within residential aged care. These identified barriers are common areas of concern and supported by a review of the barriers into delivering palliative care completed by Erel, Marcus and Dekeysser-Ganz, 2017.

Further barriers and enablers have been identified through expansion of discussion with these topics. These will be discussed separately.

Access to GP's

Access to home visiting GPs was not a significant issue noted across the Aged Care Homes interviewed. Only 6 out of 41 homes identified that they struggled with having enough GP access which often resulted in heavy reliance on Residential In-Reach services.

Most homes indicated access to GP's is ok, rather it's GP's engagement, knowledge, understanding of goals of care and palliative care application that were identified as a barrier.

Some common themes identified include:

- **GPs not actively involved with completion of goals of care (this is particularly important as only a doctor can complete GOC and needs to be an active part of family conversations)**
- **GP's not understanding anticipatory medications and may only prescribe with written recommendations from MCM.**
- **GP's not having a locum service which results in over reliance of RIR and often results in poor care coordination.**

Home's that reported difficulty with accessing enough GPs to service the home were encouraged to engage with the Primary Healthcare Network as they may be able to support better connection with appropriate GP services. Whilst tracking engagement with recommendations is a limitation to the project most homes were welcoming of advice and were mostly unaware of what Primary Healthcare Networks may be able to help with.

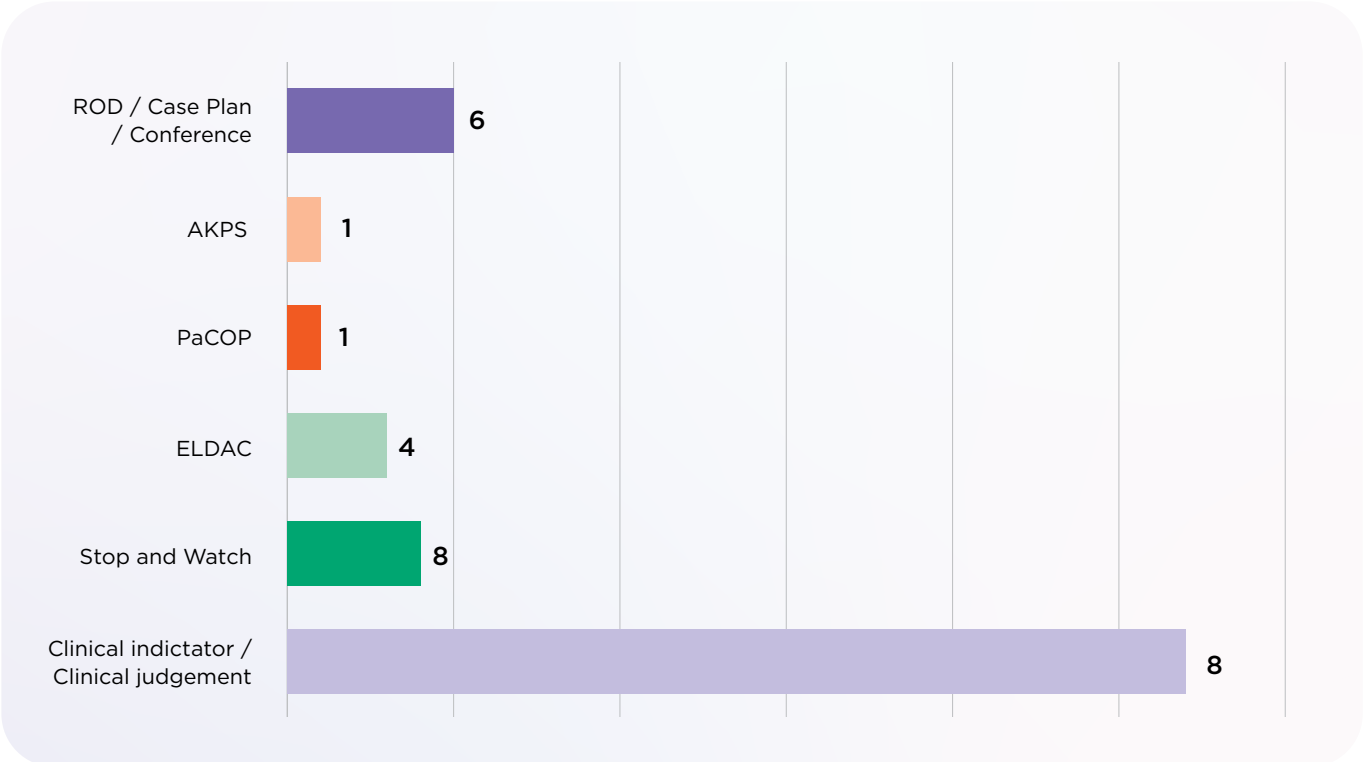
Assessment Tools

All homes had a digital system that utilises assessment tools for different clinical issues. Most staff reported having some sort of process in place that reviews deterioration or changes in a resident presentation, such as resident of the day (ROD), resident case conference or care plan reviews. However, the use of evidence-based assessment tools or systems such as PACOP (Palliative Aged Care Outcomes Program) or ELDAC (End of Life Decisions for Aged Care) to identify resident deterioration and translate this as a prompt for meaningful actions and outcomes (such as changes in GOC) is limited.

In total, 8 out of 41 homes reported using tools such as Stop and Watch Early Warning Tool or the Supportive and Palliative Care Indicators Tool (SPICT). One home report attempting to implement PACOP and another home reported using AKPS (The Australia-modified Karnofsky Performance Status) as a measure of the residents overall functional capabilities scoring for identifying deterioration which prompted a palliative care case review.

Most homes reported utilizing clinical indicators such as weight loss or increasing falls or utilizing clinical judgement to recognise a resident's deterioration which often resulted in a palliative trajectory being identified in the terminal stages of life. This led to higher incidence of hospital transfer or Residential In-Reach being called upon due to the unplanned nature of care, for episodes that were often then identified as within a palliative trajectory. In discussions with staff there were minimal occasions when there was an intended link between changes in clinical indicators and a review in goals of care.

Some homes indicated using multiple tools and the total number reflected is greater than 41.



Goals of Care

The nature and purpose of goals of care in Aged Care came across as poorly understood. Often homes did not understand the difference between GOC and an Advanced Care Directive or believed GOC could only be completed within the hospital setting or by Residential In Reach.

Without GOC planning in place, it makes delivery of resident-centered palliative care very challenging in the Aged Care Home setting.

However, it was evident through the ongoing support and education through engagement with MCMPC Aged Care Team some homes were advancing processes and practices around GOC. Homes that had supportive and active GP's completing GOC with residents and family early on and early engagement with MCMPC reported having better outcomes and less crisis situations during end-of-life care.

Aged care staff described difficulties with having conversations with families regarding GOC, palliative care, and death and dying. There were many reports of staff not having the confidence, skills, and knowledge on how they may facilitate this better. Some homes identified significant challenges with cross-cultural values around palliative care and death and dying.

It can be suggested that robust understanding, knowledge and confidence, and accurate and timely completion of GOC can act as both a barrier and enabler to both access and quality palliative care delivery in Aged Care Homes.

Trigger Points for Referral

Responses to the question; what triggers a referral to MCMPC were relatively similar with two main trigger points identified. A large portion (26) homes reported they will refer all residents to MCMPC once a palliative trajectory has been confirmed.

The need for family support was the other main trigger, often considered above the need for symptom management support and assistance for Aged Care Home staff. A small portion of staff indicated that they may not refer to MCM in certain circumstances such as:

There is a clear plan in place with the GP and family.

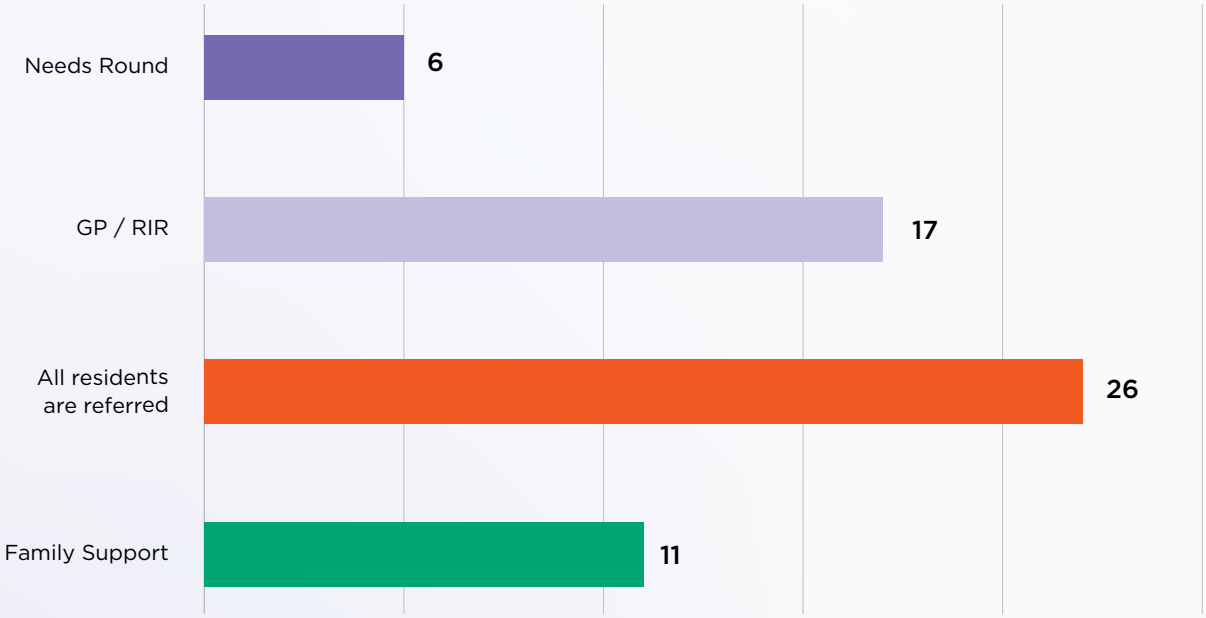
Family is accepting of palliative trajectory.

Sudden deterioration that has resulted in death occurring in a few days.

Ongoing involvement from external residential in-reach teams

A total of 17 out of 41 homes had indicated that they rely on RIR services to advise them to refer to MCMPC. This is also correlated with RIR identifying a palliative trajectory and completing goals of care. It was identified that a small number of homes had referrals triggered by a GP and 2 homes indicated referrals are largely nursing led. All 6 homes participating in palliative care needs rounds indicated that referrals happen through completion of needs rounds.

Trigger points to referral to MCMPC



Some homes indicated more than one trigger for referral, the total number reflected is greater than 41.

Since the implementation of AN-ACC (Australian National Aged Care Classification system) as of 1st October 2022 some homes have reported increasing numbers of residents admitted under a class 1, admitted for palliative care (expected to die within 3 months). Staff have described that these types of admissions have typically been direct from hospital with palliative care referrals already in place.

The MCMPC Aged Care Team interviews described inappropriate referrals from the range of referrers as a regular issue. Inappropriate referrals have been described by the Aged Care Team as referrals that:

Have occurred to late and the residents passed away before initial assessment was able to be completed, this is described as coming from Residential In Reach.

Referrals made when there is no indication that specialised palliative care is required, with the expectation that the resident will be admitted to MCMPC.

Referrals made and the resident's family is not aware.

Training

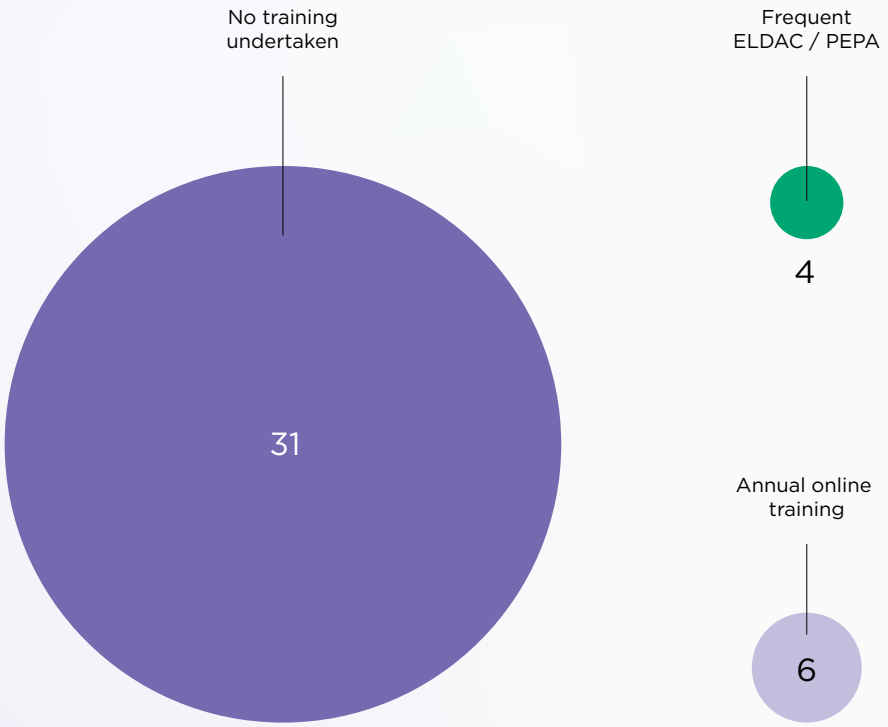
All Aged Care Homes across both streams were asked if they have regular palliative care training.

Only 4 homes out of 41 indicated they have frequent and meaningful palliative care education and all four indicated this was through ELDAC (End of Life Directions for Aged Care) and PEPA (Program of Experience in the Palliative Approach) connections. A further 6 homes indicated they have some form of online mandatory annual training.

Discussion with most staff regarding training indicated there was a poor understanding of sector resources and most stated that it was overwhelming in considering what resources are available.

Furthermore, there was a lack of definition on what staff believed training and workforce development to be and that isolated training sessions delivered from MCMPC would not have much impact in staff development efforts. The MCMPC Aged Care Team all agreed that the method of delivering a traditional education/ training session was unlikely to have much impact on staff development.

Palliative Care Training Types



Palliative Care Needs Rounds

Research conducted by Calvary Health in conjunction with Sterling University (2020), indicated that palliative care needs rounds improve end of life care for residents by improving staff knowledge and capacity to provide good symptom management and supportive care.

The approach also has shown to improve residents' life and death by reducing avoidable hospital presentations and enabling residents to die in their preferred place with dignity, comfort and support.

Needs Rounds are a monthly hour-long 'triage' meeting in which the intention is to discuss up to 6 residents who are at risk of dying in the next six months and who may not have a clear plan in place. It provides an opportunity for case-based education for staff on symptom and medication management, advance care planning and communication skills.

Currently MCMPC completes needs rounds with six homes (with expressed interest from further four homes). There was a positive response from all six homes that indicate needs rounds are valuable and assist with identifying residents who may be better suited for a palliative approach to care.

Some feedback included:

Believe needs rounds bring value to supporting the development of best practice in palliative care.

Value the platform of discussion and can bring a broad scope of clinical issues to discuss.

Help commence palliative care earlier and avoid unnecessary hospitalizations.

This feedback indicates that needs rounds act as an enabler to the delivery of quality palliative care, this is supported by the Calvary Health and Sterling University (2020), publication of the palliative care needs rounds implementation guide. Barriers in the delivery and implementation of needs round have also been identified through interviewing both the Aged Care Homes and the MCMPC Aged Care Team.

Barriers identified by the Aged Care Home staff include:

Homes not being sure of service obligations.

Don't always have new residents to discuss and feel guilty for either wasting MCMPC Aged Care Teams time or cancelling the session.

It took a long time for needs rounds to be beneficial as were very unsure of what to do at the start.

How needs rounds may function such as who leads a needs round.

Barriers identified by the MCMPC Aged Care Team include:

Greater benefit when have a multidisciplinary approach and more Aged Care Home staff present, more than just the clinical coordinator.

The same resident can be discussed over multiple needs rounds and follow-up is not always understood or recommendations are not actioned.

Scope of needs rounds & what can be discussed / achieved such as incorporating death audits

Research conducted by Koener et al (2021) indicates palliative care needs rounds can act as an enabler to improving palliative care outcomes and that an adaptable approach is warranted to meet the needs of the homes. The findings from the interviews have a strong correlation with current published research on the overall benefits and improved outcomes of undertaking needs rounds.

Other Identified Barriers and Enablers

Through stakeholder engagement and completion of interviews further barriers were identified as:

- Aged Care Homes organisational policy and culture relating to palliative care.
- Staff turnover within the home
- Communication pathways and the Aged Care Team having a go to person.
- Care coordination with Residential In Reach services and GP's

Similarly, further enablers were identified as

- Stakeholder engagement and partnership management
- Consistency and number of staff within the home
- Organisational policies and approach to palliative care
- Engagement with sector resources such as training, primary healthcare networks, palliative care consortium

Unique Aged Care Home characteristics

Participating homes were also asked to describe the unique characteristics of each home that may influence palliative care outcomes. The following describes the commonly reported issues.

Dementia and Specialist Services

Dementia is well known to be a life limiting illness and currently only 2.4% of people with a dementia diagnosis within Aged Care Homes and the community receive a referral to a specialised palliative care service, in comparison to 75.4% for a malignancy diagnosis (Parker, Lewis, and Gourlay, 2017). Though the amount of elderly people who pass away because of dementia is not well known, often cause of death will not be attributed to the dementia diagnosis. Parker, Lewis, and Gourlay, (2017) as published by Dementia Australia indicate a palliative approach to care in the setting of advanced dementia is warranted. With further consideration to a palliative approach in the stages of moderate dementia also recommended

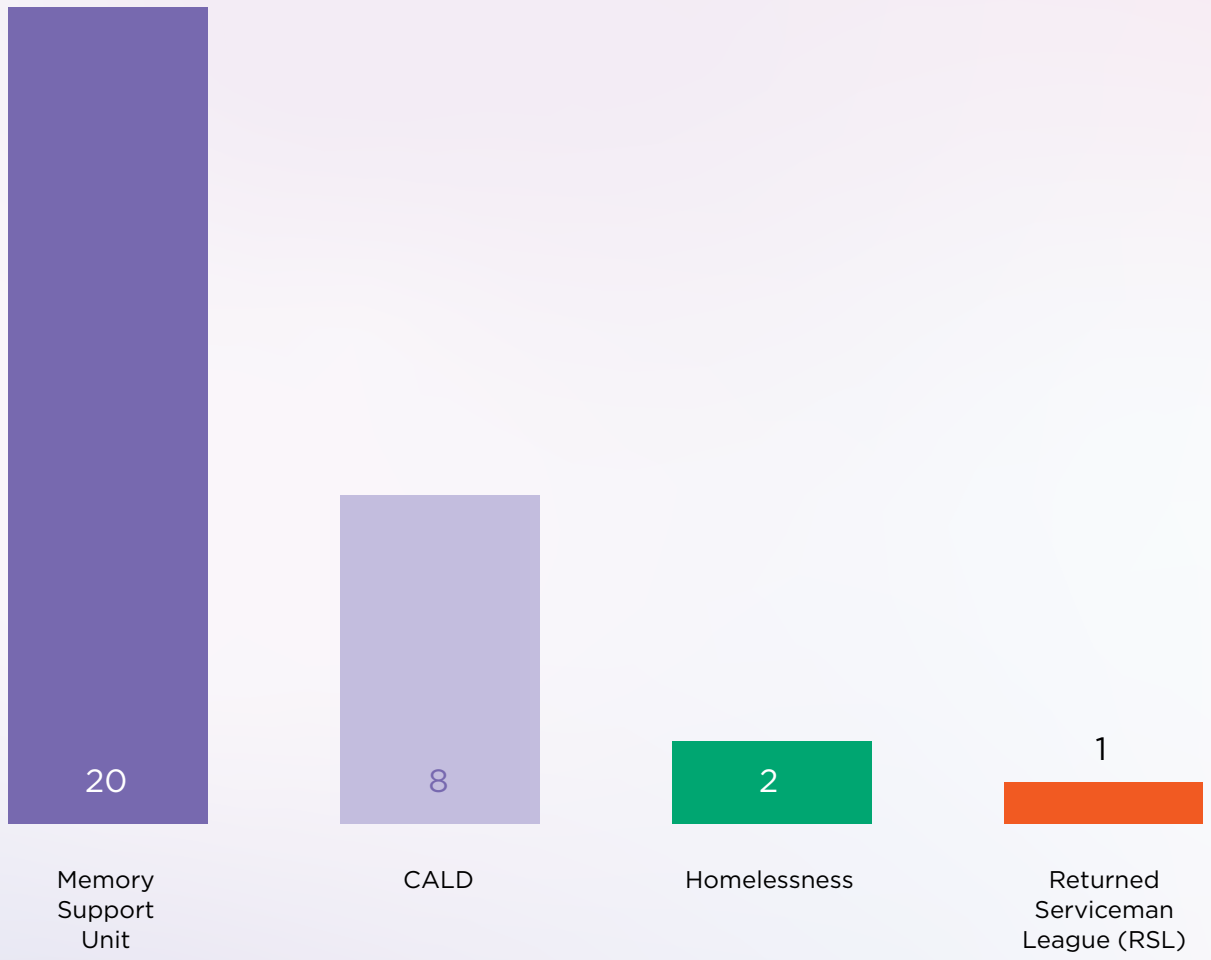
All interviewed homes were asked to estimate the percentage of residents had a diagnosis of dementia. The estimated figure averaged out across the 41 homes was 60% of residents having a diagnosis of dementia. Further to this, of the 41 homes interviewed, 20 reported having a specialised memory support unit (MSU). A memory support unit is also commonly known as a dementia unit and are locked or secure units within the home providing care and support to residents with more advanced dementia.

With no known dementia specific palliative care program for aged care residents currently existing in Victoria, the aged care setting presents an opportunity for MCMPC services to dedicate further research and advocacy within this field. In addition, Aged Care Home staff reported on other specialised services available, this included specialised services with a focus on:

- **Culturally and linguistic (CALD) support, with 8 homes identifying this as a service they provide.**
- **Homelessness support with 2 homes identifying the provide aged care services specifically to people from homeless backgrounds.**
- **Returned serviceman league (RSL), 1 home offering RSL specific services.**

The graph on the following page represents the portion of Aged Care Homes with specialised services within the home.

Specialised service provision



Limitations

As has been identified within the project charter there are limitations in being able measure what improving outcomes and quality palliative care, or a good death may look like within the aged care setting. Further to this it is recognised that findings are representative of discussion often completed with one representative from the home and which may not always be an accurate representation of organisational policies and practice.

Project/Resource Duplication Risks

The Comprehensive Palliative Care in Aged Care measure has seen funding distributed to multiple organisations who have a part to play in the National Strategy to improve access and delivery of palliative care outcomes in aged care. The project charter highlights several related projects and draws attention to the risk of duplication from these identified organisations.

Summary of deliverables

The project findings and deliverables are considered in a staged approach in accordance with the duration of the project. Key deliverables 1-8 listed here, and referenced throughout the earlier documentation, are those which formed part of the implementation and engagement plan occurring in the first 6 months of the project.

These include:

* Mapping of catchment ACHs
* Evaluation of Palliative Care needs care rounds operating in Aged Care Homes
* Develop Interview questions to ascertain barriers and enablers to provision of palliative care in Stream 1, Aged Care Homes with existing needs rounds or more active service engagement
* Collation and analysis of Stream 1 interview data, themes and trends, unique environments and perspectives
* Development of Stream 2 interview for remaining Aged Care Homes
* Engage with ACF's in MCM catchment area to undertake interview and data collection
* Collation and analysis of Stream 2 interview data, themes and trends, unique environments and perspectives
* Present analysis to PC Leadership Team and Aged Care Team

It can be summarised that MCMPC catchment encompasses a highly diverse population of people residing in residential aged care homes. Further to this it can also be recognised that MCMPC provides services to 52 homes from an exhaustive list of aged care providers each representing different values and operating environments.

The project plan was developed and continuously reviewed within established support mechanisms. Implementation of the engagement plan resulted in 79% of homes being interviewed over a 6-month period. Evaluation of needs rounds indicated that whilst all participating homes and the MCMPC Aged Care Team subscribed to the value of enhancing palliative care practices, there could be improvements. Interviews completed through stream 1 indicated that staff believed that MCMPC deliver immense value and support for families of loved ones who are dying in residential aged care. This is despite some identified barriers reflected in both the residential aged care and MCMPC Aged Care Team operating environments.

Further questions and conversation aimed to gain insight into areas of concern that can impact palliative care outcomes detected multiple gaps for most homes within the palliative care setting.

They highlighted variances in GP access and engagement, and knowledge of palliative care to the use of evidence-based assessments tools for identifying deteriorating residents. Furthermore, with dementia widely known as a life limiting illness, and the prevalence of dementia and homes operating a memory support unit gives rise to a concern that there are no dementia specific palliative care programs currently offered for these residents.

Key deliverables 9-11 are presented upon completion of the 12-month Comprehensive Palliative Care in Aged Care project as a series of appendices to highlight the processes and outcomes achieved for each one.

Key deliverables 9-11 as per the project charter are presented below:

* Develop resource strategy including review of existing resources for relevancy or appropriateness to use in an ongoing basis to build the capacity of Aged Care Home staff.	**Appendix B** represents a review of sector resources that are considered relevant and appropriate to draw upon for use in supporting Aged Care Homes to build their capacity and capabilities for delivering palliative care in their Aged Care Homes.
* Develop and produce tailored resources to address common and unique themes, i.e handbook production, av resource production, care vignettes.	**Appendix C** represents the implementation plan for the development of a family resources tailored for the use of supporting families with family members receiving palliative care in Aged Care Homes.
* Build clinical partnerships with secondary stakeholders relevant to project and achieving objectives. Attend communities of practice, participate in forums/ summits, establish regular communication/ collaboration meetings.	**Appendix D** table represents the strengthened clinical partnerships with secondary stakeholders.

Recommendations

Recommendations have been provided to address some of the barriers identified through the interview results and existing evidence. Recommendations have been thoughtfully considered and influenced by the changing landscape and focus on palliative care in aged care.

The project charter purpose, key deliverables, current literature, project findings, other related CPCiAC projects and the new Aged Care Standards relating to palliative and end of life care have also been drawn upon. Recommendations are presented as either in scope or out of scope of the Comprehensive Palliative Care in Aged Care project charter.

Palliative Care Needs Rounds

There is extensive evidence around the benefits of palliative care needs rounds but also the challenges of implementation within Aged Care Homes. All homes interviewed regarding needs rounds expressed they found value in the process. However, the implementation of needs rounds faces challenges that have not been explored within the project.

Multiple homes expressed interest in commencing needs rounds and understanding the barriers to implementation would be of benefit. Utilizing existing evidence to further develop needs rounds presents an opportunity to implement an evidence-based approach to supporting Palliative Care in Aged Care outcomes for MCMPC.

Further considerations for developing needs rounds include:

Consider stakeholder engagement and management processes to support greater buy-in and commitment to needs rounds from Aged Care Homes.

Consider expanding scope and flexibility around what can occur through needs rounds and how often they may occur.

Develop and implement quality measures to allow for ongoing review and monitoring for continuous improvement.

Refer to **appendix A** for Palliative Care Needs Rounds recommendation package.

Service Delivery and Model Review

Whilst not within the scope of the project it is acknowledged that the presence of a dedicated Aged Care Team within MCMPC services is unique and creates a significant opportunity to influence the delivery of specialised palliative care services to Aged Care Homes.

Based on the project data and the issues surrounding assessment tools, goals of care, access to GP's, referrals, education, and the evidence offered it is recommended that a review of the model of service delivery could be undertaken to enhance its operations, with focus on:

Ensuring the sustainability of current capacity of the Aged Care Team to meet the growing demands for specialised palliative care in aged care.

Support efforts to improve quality palliative care outcomes in Aged Care Homes and bolster the capabilities and capacity of aged care services to deliver generalised palliative care to residents.

Allow for the greater measurement of service outcomes with the development and implementation of a quality framework that reflects any new service model.

Research or Developmental Opportunity

As has been highlighted the prevalence of Memory Support Units' to deliver support and care to people with advanced dementia symptoms and the high percentage of dementia diagnosis raises concern that there are no adequate dementia specific palliative care programs available for these residents.

This present MCMPC with an opportunity for further research and advocacy to improve palliative care outcomes for elderly residents impacted by dementia through developing and implementing a dementia specific palliative care program applicable in the aged care home setting.

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Appendix A

Memorandum of Understanding

Memorandum of Understanding (MoU) between:

Date:

and Melbourne City Mission Palliative Care.

The purpose of this MoU is to provide a common understanding and commitment to working together to implement the Palliative Care Needs Round Model of Care in your Aged Care Home. **This MOU is not a legally or financially binding document.**

Background and Purpose:
Why partnership is important

MCMPC is a state government funded community health program that provides specialist palliative care services to people residing in the community, including residents of Aged Care Homes.

MCMPC recognises and commends the ongoing commitment from Aged Care Homes to improve outcomes for residents receiving palliative and end of life care. MCMPC is equally committed to providing support to Aged Care Homes and residents to improve end of life outcomes. We believe strengthening our clinical partnership with your Aged Care Home will support working towards this shared goal.

Objectives and Outcomes:

Broadly, this MOU sets out to deliver on the following objectives

- Support the delivery of palliative and end of life care that improves quality of life outcomes for residents and their families
- Support Aged Care Home staff to build their capacity and capability to deliver palliative and end of life care
- Support and strengthen communication, collaboration and coordination with key stakeholders involved with a residents receiving palliative and end of life care care, including but not limited too Residents, Families/Carers, Aged Care Home, General Practitioners, Hospital Residential In-reach / RAPID services and MCMPC.

Key Roles and Responsibilities:

As established in the Implementation Plan document, appendix 1, each service commits to the mutually agreed roles and responsibilities in order to implement Palliative Care Needs Round Model.

Evaluation and Reporting:

Evaluation and reporting on the operation of the Palliative Care Needs Round model is agreed by both parties as an important ongoing function of measurement. Methods and rationale are established in appendix 2, 3, and 4 . MCMPC will be primarily responsible for the collection and collation of data that will focus on two key elements:

- Resident outcomes
- Operation of the Palliative Care Needs; process and system outcomes

Outcome data will be available to both parties and may be used to for quality improvement initiatives, as evidence for accreditation against relevant standards, and for sector wide information sharing opportunities.

Funding:

Participation in the Palliative Care Needs Round Model of Care is free of charge.

Duration:

This MOU is entered into in good faith by both parties. It will become effective upon signature by both parties. The MOU will remain in effect until modified by mutual agreement and/or terminated by mutual consent. The MOU will be reviewed annually by both parties.

Privacy and Confidentiality:

Both parties to this MoU agree to be bound by Privacy Legislation in respect of all personal information obtained during and as a result of Palliative Care Needs Rounds Model of Care.

- Only residents with complex needs who are admitted to the community palliative care service will have access to out of hours' services.
- Confidential Medical records and data are securely maintained at Melbourne City Mission Community Palliative Care Service within a protected Client Record Management System

Signature of authorised ACH representative:

Print name of authorised ACH representative:

Position of authorised ACH representative:

Date:

Signature of authorised Palliative Care Service representative

Print name of authorised Palliative Care Service representative

Position of authorised Palliative Care Services representative

Date:

Appendix A

Implementation Plan for Palliative Care Needs Rounds

As set out in the MoU, implementation of the Palliative Care Needs Round Model is based on stated objectives, outcomes, roles, and responsibilities. Each is described in more detail below.

Objective 1

Support the delivery of palliative and end of life care that improves quality of life outcomes for residents and their families.

Outcomes

Improved symptom management planning and interventions to meet resident needs
Improved planning and coordination that reduces unplanned transfer to hospital
Improved planning and coordination that reduces unplanned calls to RiR/RAPID for assessment and intervention
Reduced transfers to hospital
Resident dies in preferred place of death
Improve resident and carer experience outcomes
Improve staff satisfaction outcomes

Measures

Death in preferred place for resident
Number of (reduction) in unplanned transfer to hospital

Objective 2

Support Aged Care Home staff to build their capacity and capability to deliver palliative and end of life care

Outcomes

Increasing staff participation in needs round sessions

Uptake of available workshops and education sessions

Implementation of utilizing evidence-based assessment tools

Increase in reflective practice and death audits through needs rounds

Monitoring the number of class1 AN-ACC funded residents entering the home.

Improve resident and carer experience outcomes

Improve staff satisfaction outcomes

Measures

Number of sessions and staff attendance at needs rounds

Objective 3

Support and strengthen communication, collaboration and coordination with key stakeholders involved with a resident's receiving palliative and end of life care care, including but not limited too Residents, Families / Carers, Aged Care Home, General Practitioners, Hospital Residential In-reach / RAPID services and MCMPC.

Outcomes

Increase in Goals of Care completion

Early prescribing of anticipatory medications

Improved planning and coordination that reduces unplanned transfer to hospital

Improved planning and coordination that reduces unplanned calls to RiR/RAPID for assessment and intervention

Improve resident and carer experience outcomes

Improve staff satisfaction outcomes

Measures

Number or residents with prescribed anticipatory medications to support symptom management

Number of residents with completed Goals of Care

Roles and Responsibilities

Each party agrees to the actions set out below, as appropriate to the circumstances of the Palliative Care Needs Rounds per Aged Care Home.

Actions	Rationale	Aged Care Home	MCMPC
Hosting the meeting:			
Provide an appropriate place to meet within the home	Ensure there is a place for open discussion away from residents and visitors	✔	
Enable appropriate staff available to attend needs rounds	Availability of appropriate staff attending from both services will support staff learning and development and positively impact resident care and outcomes	✔	✔
Chair the palliative care needs rounds	Ensures a consistent approach to the delivery of needs rounds		✔
Provide a minimum 24hours notice if needs rounds to be cancelled	Time can be reorganised for all parties	✔	✔
Preparation for the meeting:			
Identify residents with deteriorating functional and health status, (examples include; declining mobility, increased falls, reduced oral intake, poor symptom management , recent unplanned hospital presentations, recent unplanned call out's to RiR teams)	Supports staff development and recognising palliative needs early	✔	
Complete SPICT tool assessment	Supports building the capacity of Aged Care Home staff to identify deteriorating residents	✔	
Review previous meeting action items for residents discussed to ensure completion of required actions	Promotes accountabilities for all parties and ensures agreed responsibilities are completed	✔	✔
If no residents identified to discuss, consider time to be used for education or quality review opportunity	Supports staff development and promotes the partnership between our organisations	✔	✔

Actions	Rationale	Aged Care Home	MCMPC
During the meeting:			
Review previous meeting action items for residents discussed to ensure completion of required actions	Promotes accountabilities for all parties and ensures agreed responsibilities are completed	✔	✔
Present and discuss residents of concern assessed using the SPICT tool	Supports staff development and recognising palliative needs early. SPICT tool education may support understanding and use	✔	✔
Complete minutes for residents discussed, including action items for completion.	Promotes care coordination and communication, anyone reviewing the resident from other services such as GP or RiR can see notes from the needs rounds	✔	✔
Determine the need to participate in family case conferences and support GOC completion	Supports the home in ensuring complex and challenging scenarios are supported to achieve an outcome	✔	✔
Determine the need for a coordinated care case conference (including, resident/family, Aged Care Home, GP, RiR, MCMPC)	Supports the home in ensuring complex and challenging scenarios are supported to achieve an outcome.	✔	✔
After the end of the meeting:			
Complete the session evaluation	Contributes to understanding how needs round are working and to make improvements where we need, and if these needs rounds are achieving our mutual goals	✔	✔
Email resident minutes and action items them to the ACH staff responsible for logging into resident file	Promotes care coordination and communication, anyone reviewing the resident from other services such as GP or RiR can see notes from the need's rounds		✔
ACH staff member receiving Resident notes and action items to place in resident file and assign actions for completion (will be emailed to you from MCM)	Promotes care coordination and communication, anyone reviewing the resident from other services such as GP or RiR can see notes from the needs rounds	✔	

Appendix A

Meeting Aged Care Quality Standards with Palliative Needs Rounds

Standards with outcomes and Associated Actions	Standard 3: The Care and Services
	Outcome 3.1 Assessment and planning
	Associated Actions 3.1.6, 3.4
Evidence	SPICT Tool Implementation, Needs Rounds Meeting Minutes, Provides referral pathway for Resident support to understand advanced care planning with a CPC practitioner
Supporting Standards	A core principle of needs rounds focuses on timely and accurate assessments of residents who are nearing end of life and addresses care planning with all stakeholders.
	Needs rounds will support the Aged Care Home to implement evidence-based assessment tools that greater support staff to identify deterioration and guide the most appropriate clinical response.
	The needs rounds approach to assessment and appropriate care planning is multidisciplinary with the core focus being the resident.
	Needs rounds can provide a referral pathway for residents and families who are struggling with advanced care planning with appropriate practitioners being available to support these discussions.
Considerations for Practice	The Aged Care Home may consider implementing and utilizing other resources available to support achieving ACQSS
	Implementing **dignified and respectful decisions (DARD) toolkit** to promote conversations and assist families with goals of care.

Standards with outcomes and Associated Actions	Standard 5: Clinical Care
	5.7 Outcome Palliative Care and end-of-life care
	Associated actions 5.7.1, 5.7.2, 5.7.3, 5.7.4
Evidence	Referrals, Needs rounds meeting minutes
Supporting Standards	The palliative care specialist role is to support other healthcare teams and professionals through consultation, advice and support to provide end of life care to residents.
	Needs rounds has a specific goal to improve the Aged Care Home staff capabilities, the implementation of SPCIT tool, and needs rounds focuses on early identification of end-of-life period.
	Implementation of needs rounds allows the Aged Care Home to engage in regular discussion with concerns about advanced care planning. This supports a referral process for case conferencing with a multidisciplinary team for residents and their families.
	Needs rounds offers a platform for Aged Care Home staff to discuss resident specific care needs and receive support from palliative care specialists to ensure the resident care planning is comprehensive. Needs rounds often identifies palliative care needs and offers greater preparation for terminal phase care.
Considerations for Practice	Implementing **after hours toolkit** from PHN
	Consider implementing evidence base tools or programs such as **Palliative Aged Care Outcomes Program** (PACOP)

Appendix A

Evaluation Framework: Needs Rounds Implementation

Staff Evaluation Survey
To be completed after attendance to needs Rounds

01 **This is my first time participating in palliative care needs round?**

- ☐ Yes
- ☐ No

02 **Using the SPICT tool is helping me identify deteriorating residents?**

- ☐ Agree
- ☐ Strongly Agree
- ☐ Neither agree nor Disagree
- ☐ Disagree
- ☐ Strongly Disagree

03 **Participating in needs rounds is supporting the development of my knowledge and palliative care practice?**

- ☐ Agree
- ☐ Strongly Agree
- ☐ Neither agree nor Disagree
- ☐ Disagree
- ☐ Strongly Disagree

04 **Implementing needs rounds is supporting the development of my team in delivering better palliative care to our residents?**

- ☐ Agree
- ☐ Strongly Agree
- ☐ Neither agree nor Disagree
- ☐ Disagree
- ☐ Strongly Disagree

05 **I have more confidence talking to families about the palliative care of their family member?**

- ☐ Agree
- ☐ Strongly Agree
- ☐ Neither agree nor Disagree
- ☐ Disagree
- ☐ Strongly Disagree

06 **I feel valued and supported to contribute to the needs rounds discussion?**

- ☐ Agree
- ☐ Strongly Agree
- ☐ Neither agree nor Disagree
- ☐ Disagree
- ☐ Strongly Disagree

Appendix A

Evaluation Framework: Needs Rounds Implementation

MCMPC Needs Rounds Data Collection
To be completed after completion of each needs rounds

01 Calls received to MCMPC for review of resident:

02 Needs round cancellation and reason:

03 How many staff participated in needs rounds session?

04 How many residents discussed at needs rounds that had assessments using SPICT tool?

05 How many residents were identified as palliative?

06 How many residents admitted from this needs rounds?

07 Were recommendations from previous needs rounds completed?

- [ ] Yes
- [ ] No

08 Workshops/training delivered?

- [ ] Yes
- [ ] No

Aged Care Home Weekly Data Collection – Care Coordination

To be completed for all residents admitted to MCMPC services individual and or needs rounds.

Data collection relates to palliative care residents who are admitted to MCMPC services only. Ensuring data collection is timely and accurate allows us to continuously monitor the needs rounds to ensure our goals are being met and, if not how we can make changes where necessary.

This data is intended to reflect care coordination efforts and ensuring the resident is receiving timely, accurate and coordinated care.

Resident Name	Time Frame	Reviewed by GP for	Reviewed by RiR/ RAPID for	Reviewed by RiR/ RAPID for	Transferred to Hospital	Concerns
Eg. Frank Mane	Eg. June 1 - July 1	Eg. X3 for pain management	Eg. X2 concerns of acute infection	Eg. X2 concerns of acute infection	Eg. X1 for pain management	Eg. Nil

Appendix B

MCMPC Resource Toolkit

Presented are 5 of the core elements that support the delivery of quality Palliative Care in Aged Care Homes. The toolkit aims to provide clinicians with an understanding of core elements and the resources available to support improving practice.

Goals of Care

Goals of care are the aims for a person's medical treatment, as agreed with their family, carers and medical team. Goals of care may include attempting to cure a reversible condition, a trial of treatment to assess reversibility of a condition, treatment of deteriorating symptoms, or the primary aim of ensuring comfort during the terminal phase of life.

Understanding will support earlier identification of resident's palliative care requirements and contribute to improving care coordination efforts.

The **Dignified & Respectful Decisions Toolkit** is a good starting point for all Aged Care Homes to implement.

There are other resources that can also be drawn upon:

NWMPH – Advanced Care Planning

Palliaged – Goals of Care

Clinical Deterioration: Evidence Based Assessment Tools

Deterioration in Aged Care refers to signs of a person's declining function or reduced state of health. They may become bedbound, spend more time sleeping or resting, have reduced intake of food, difficulty with swallowing or fluctuating consciousness.

The use of evidence-based assessment tools in Aged Care varies.

Introducing tools such as stop and watch or SPICT tool will help support the development of clinical staff.

There are also other resources that can be drawn upon to assist clinical staff to identify and understand the reasoning for clinical deterioration.

Palliaged - Tips for Nurses: Recognising Deterioration

Palliaged -Tips for Careworkers: Recognising Deterioration

Becoming familiar with the **NWMPHN After-Hours Health Care Toolkit** will support your home in being greater prepared to respond to deteriorating residents when the usual clinical supports are not around.

Referrals and Triage

A standardised approach is important to ensure that the most vulnerable residents who are least able to advocate for themselves are assessed fairly, so that all residents receive the care they need in an accurate and timely manner.

There are no developed triage criteria for referrals to community palliative care from an Aged Care Home. Most Aged Care Homes as a default will refer every resident who is requiring palliative care but is not always necessary as high-quality palliative care can be delivered by nursing and care staff in the home.

Consider implementing evidence-based tools such as **SPICT** or, programs such as PACOP (Palliative Aged Care Outcomes Program).

University of Wollongong - Palliative Aged Care Outcomes Program

Linking in with a Needs Rounds Model of Care through your local community palliative care provider is another option.

Palliative Care Victoria – Service Directory

Training

The value of regular palliative care training and education should not be underestimated. However, the resources available a vast and can be overwhelming.

The resources and programs here are provided through The Department of Health and Ageing and The Aged Quality and Safety Commission and focus on palliative care skills and competencies that are common to everyone.

The BERTIE program through the ACQSS is a good starting point and covers palliative and end of life care, clinical deterioration and managing other Aged Care-related clinical issues.

Better lives for residents through innovative education (BERTIE)

Aged Care Quality and Safety Commission – Online learning

Department of Health and Aged Care – Education and Training

The North and West Palliative Care Consortium have regular training and education opportunities for Aged Care Home Staff. **Subscribe to their newsletter for regular updates.**

GP's

GPs' understanding of what constitutes palliative care and end of life care varies widely and that differing palliative care settings have very different requirements in terms of best practice.

GP's make up a critical part of the resident's primary care circle. A collaborative and coordinated approach with GP's is warranted to ensure resident needs are met in an appropriate and timely manner.

The resources listed here are aimed at supporting GP's development in palliative care.

The Northwest Primary Health Care network has resources to support GP development.

Australia Institute of Health & Welfare – Palliative Care Services in Australia

NWMPH – Advance care planning

NWMPH – Palliative care in general practice

Appendix C

Implementation Plan Family Resource Development

What?	Why?	How?	Who?	Outcomes?
Draw together existing resource content as starting point for aged care resource	Provide grounding work to build aged care resource from	Review of current client information pack and aged care brochures	Project Coordinator	Completed in timeframe allocated ready to present at first CPCiAC steering committee meeting
Draw upon MCM principles of client voice lived experience framework	Adhere to MCM organisational values and enhance quality and relevance of document	Follow the process of The MCM client voice lived experience framework.	Quality Coordinator	Client feedback received through surveys and mail back, one client participating in review and providing feedback
Co-design from Aged Care Homes who expressed interest in contributing to a family resource design	Ensure resource remains appropriate for audience and is well received by Aged Care Homes	Email EOI for Aged Care Homes that expressed interest in participating	Project coordinator	Return EOI from 1 Aged Care Home who then participated in development of family resource
Schedule content design workshop	Provide opportunity for Aged Care Team and others to contribute to content design	Develop agenda and schedule meeting to be held and MCMPC office and offered via teams attendance	Project Coordinator	Aged Care Team contributions provided valuable guidance for further content development, recommendations to be actioned and presented through steering committee meetings
Present the continued development of resource content	To ensure all teams members are agreeable and timely outcomes achieved	Next 2 CPCiAC steering committee meetings to be utilised for ongoing feedback and content development	Project coordinator	Final content for resource agreed after review at x3 steering committee meetings
Liaise with comms team regarding handbook development	Ensures a professionally developed resource	Senior manager to provide initial project briefing and request to comms team	Senior Manager	Comms team received final content to then have developed into handbook format
Present finalised family resource handbook in project presentation.	Ensures all team members involved are presented with resource at the same time	Incorporate resource into final presentation slides to present to wider team	Project coordinator	Final family resource achieved

Appendix D

Key Stakeholders' Clinical Partnerships

Build clinical partnerships with secondary stakeholders relevant to project and achieving objectives.

What?	Why?
Participation within the North and West Metropolitan Region Palliative Care Consortium:	To collaborate on concurrent projects and assess risk of project duplication. To assess if concurrent projects can provide support with achieving overall shared objectives.
• Aged Care Advisory Group	
• Regular meetings with North and West Palliative Care Consortium project officer aged care and disability strategy	
• Participation working group for end-of-life care plans for Aged Care Homes	
• Communities of practice for needs rounds	
• Attendance at consortium training session	
Established project partnerships with Palliative Care Victoria's dignified and respectful decisions project (DARD).	To support and strengthen palliative care in aged care efforts. To support driving implementation of DARD project into Aged Care Homes. Draw upon DARD within MCMPC developed content for family resources.
Stakeholder engagement with network Residential In Reach operators.	To support improving care coordination efforts across the multiple service streams entering Aged Care Homes.
Collaboration with other CPCiAC project streams across Victorian Community Palliative Care Organisations.	Develop stronger partnerships with other community palliative care providers.
Participation with ELDAC Linkages Northwest Melbourne Region roundtable connections.	Support linking Aged Care Homes with community palliative care and other key stakeholders.
Consultation with PACOP implementation team	Understand PACOP program and plan to support implementation efforts in Aged Care Homes within catchment area

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