Palliative Care in Aged Residential Care: How does it effect staff?

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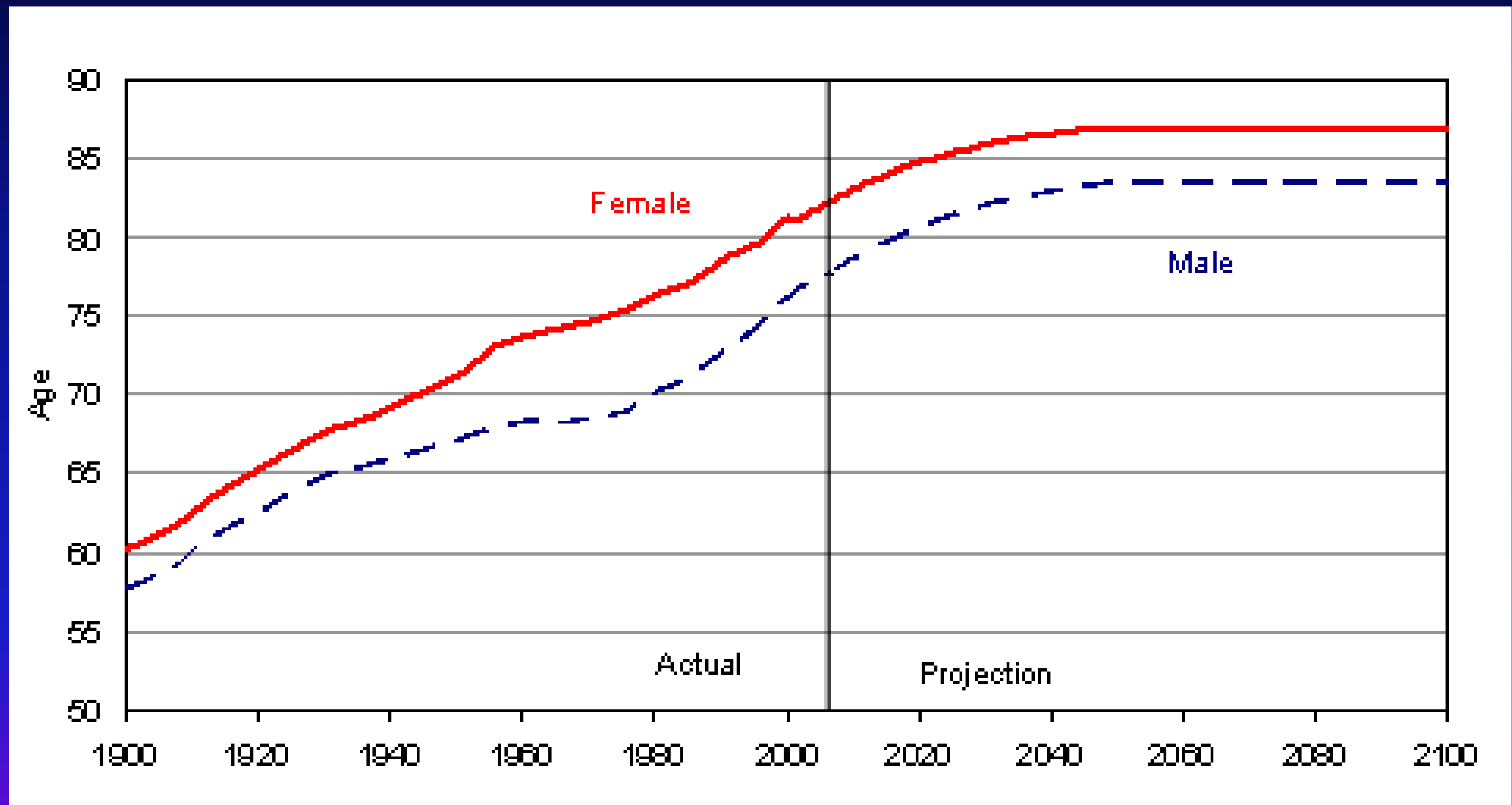
New Zealand Life Expectancy

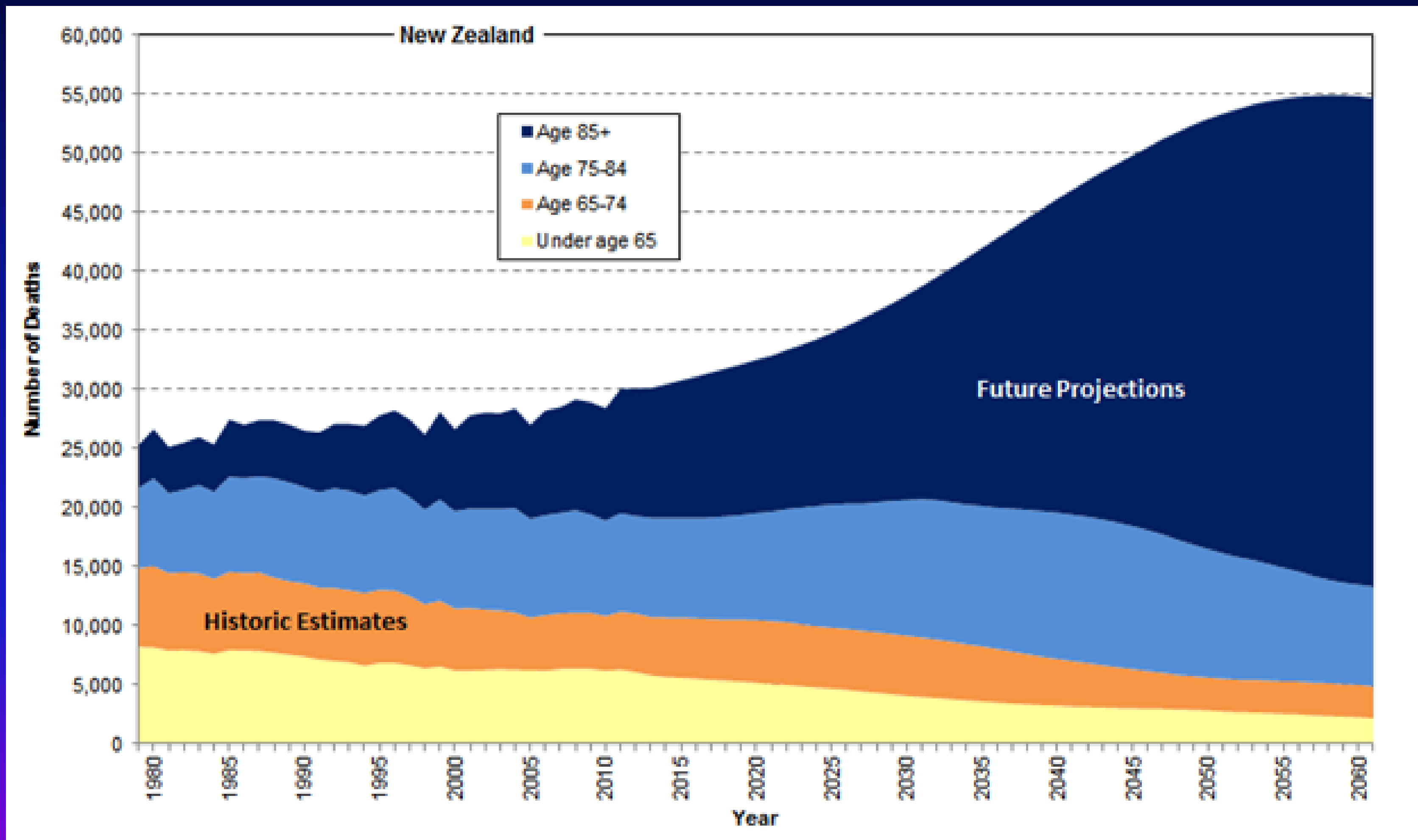


New Zealand Treasury

Increasing life expectancy is one of the greatest achievements of the last century.

It also has changed how we die.

Historic Deaths and Future Projections by Age Band



Heather McLeod, Palliative Care Council, July 2013. Drawn using data from Statistics New Zealand; personal communication Joanna Broad.

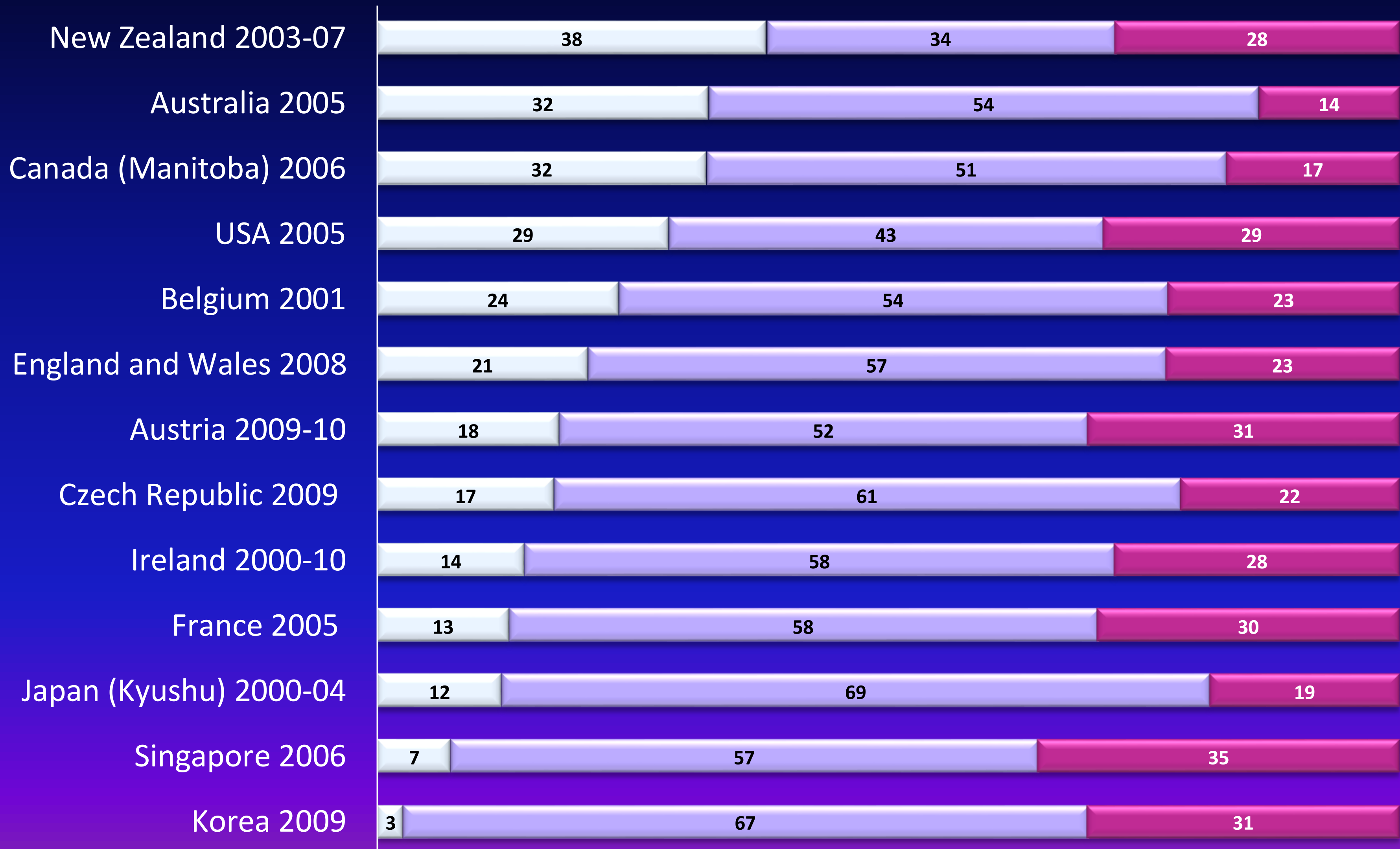
Being Mortal

"Our reverence for independence takes no account of the reality of what happens in life: sooner or later, independence will become impossible. Serious illness or infirmity will strike. It is as inevitable as sunset."

– *Atul Gawande*

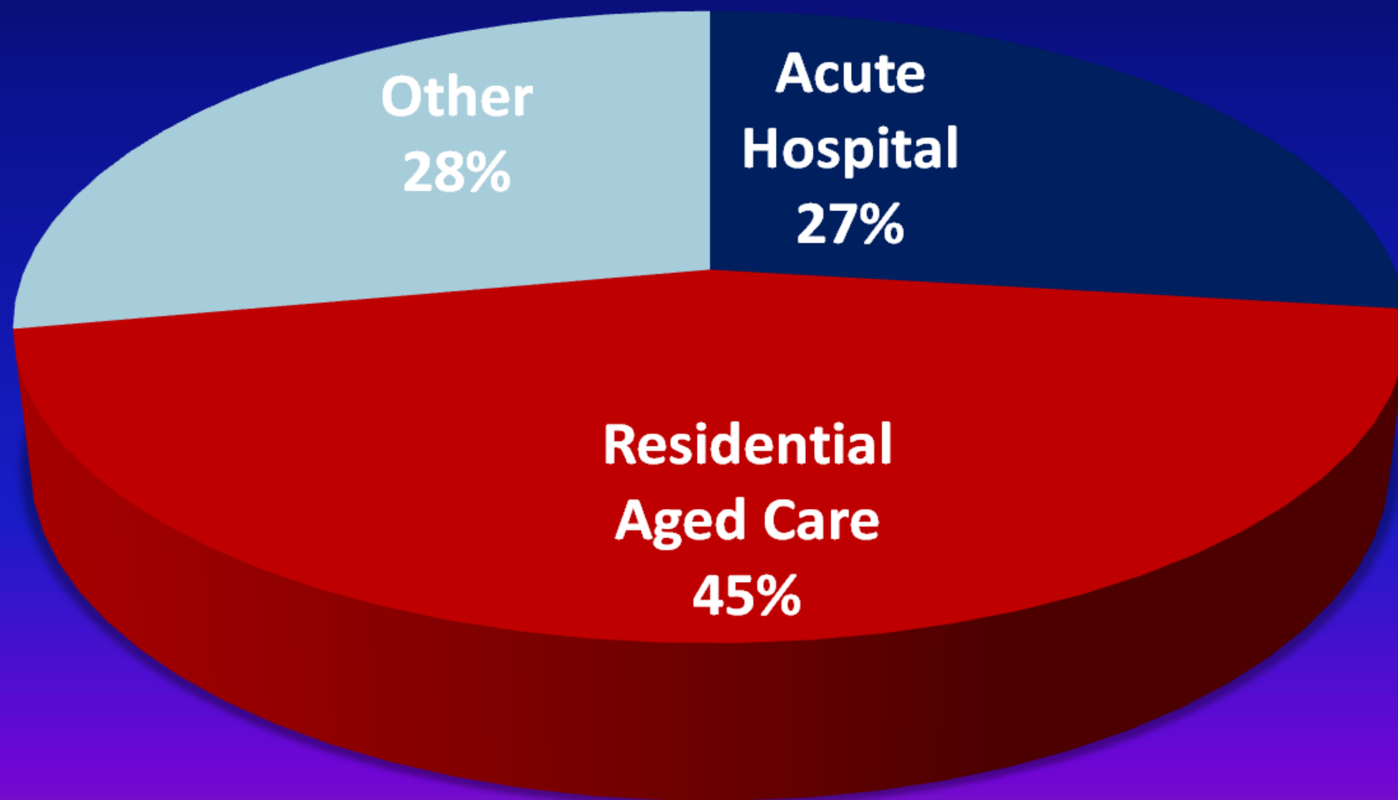
International Comparison of Place of Death for those >65

JB Broad, et al. 2012



Where People Over 65 Years Old Die: 2003 to 2007

Percent of Total Deaths for Those >65 years with those (30%) that died in hospital currently residents of aged

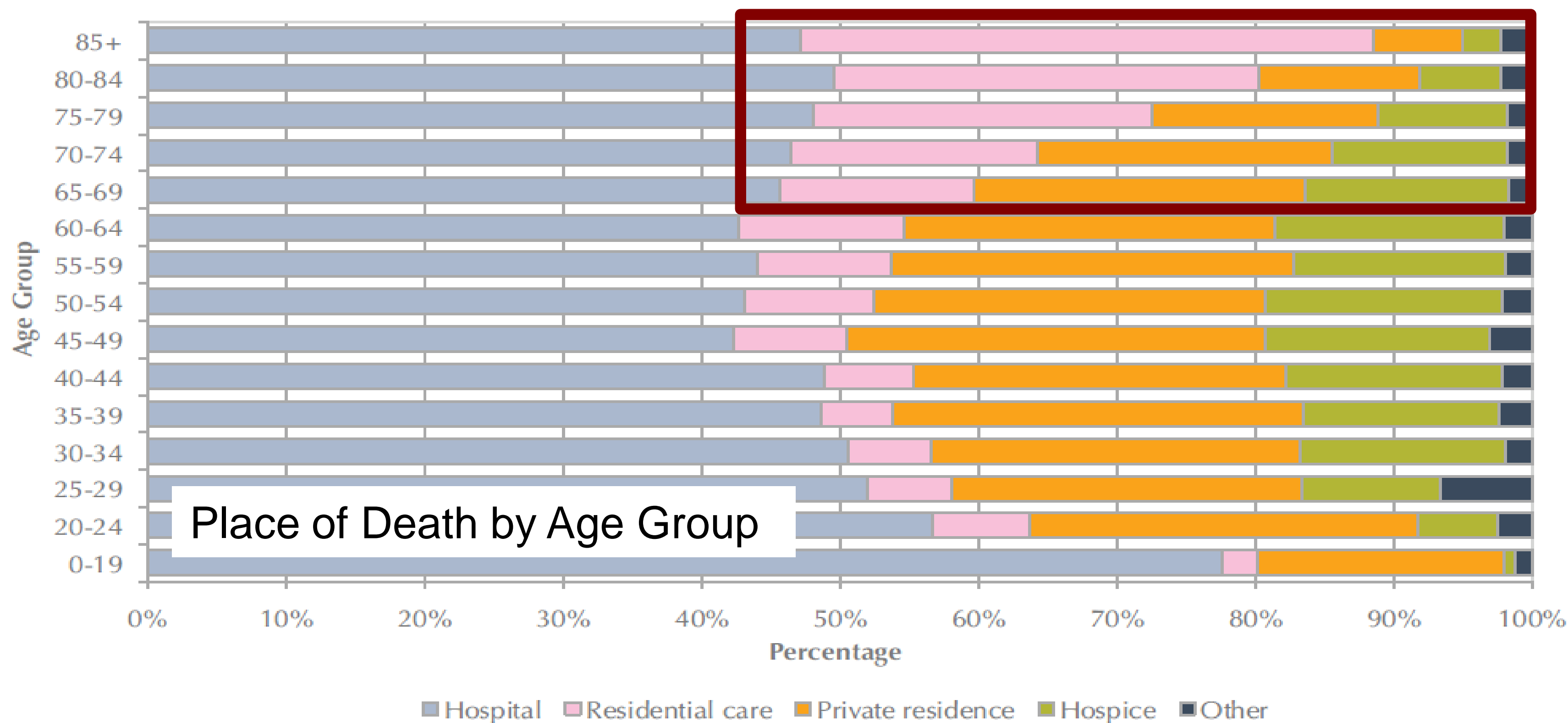


Broad, 2011 ANZGSM

National Health Needs Assessment for Palliative Care Part 1: 2011

National Palliative Care Council (Wayne Naylor)

Place of death	Percent of all deaths (03-07)
Hospital	34%
Residential care	31%
Private residence	22%
Hospice (inpatient)	6%
Other	7%

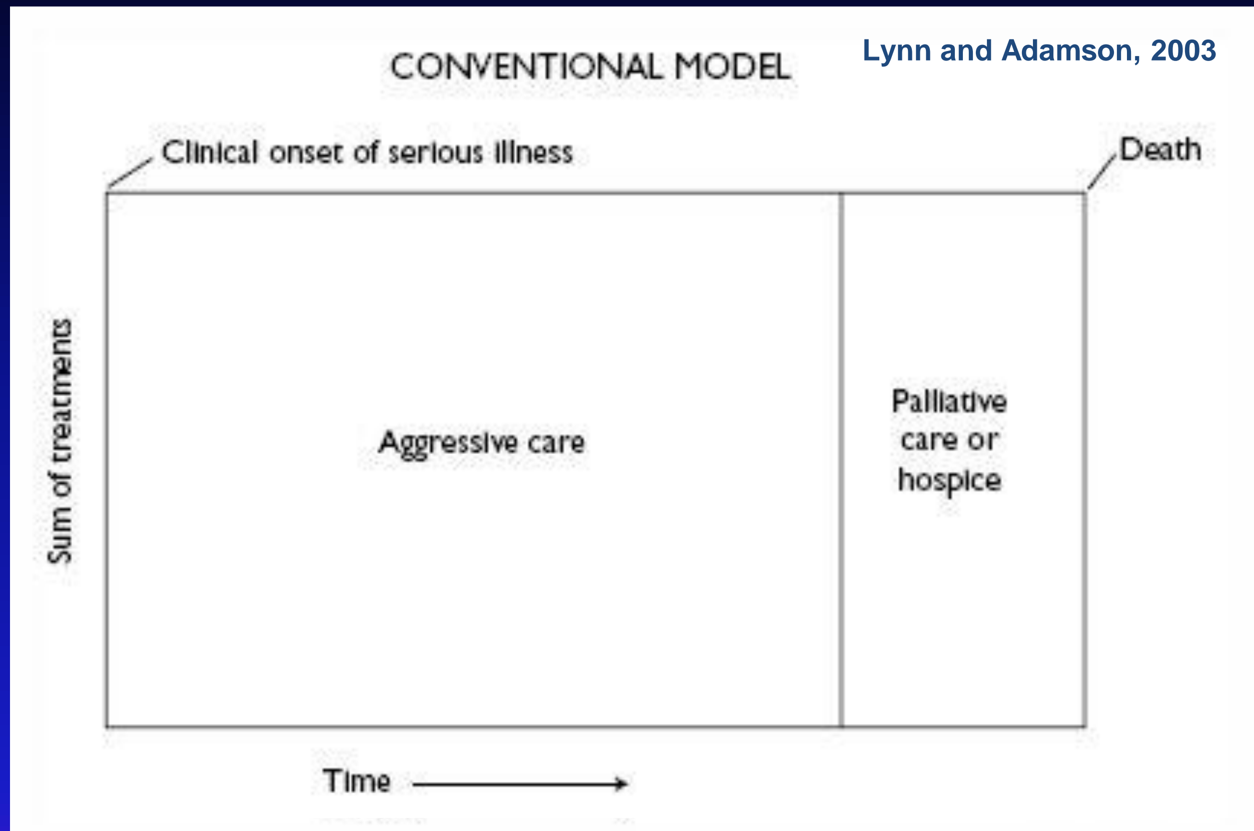


Barriers to Dementia Palliative Care

(Ouldred and Bryant, (2008). 17(10), 308, British Journal of Nursing)

- Dementia is not recognized as terminal disease
- Difficult recognising when care becomes palliative
- Symptom management is difficult because of communication difficulties
- Lack of advanced care planning
- Lack of skills and knowledge re palliative care for advanced dementia
- Lack of access to specialist palliative care consultation
- Limited treatment options encourages loved ones to request admission to hospital and aggressive interventions (Koopmans et al, 2003)

PALLIATIVE APPROACH TO CARE



The transition to a palliative approach to care is not a "transition" from one form of care to another but is the last phase in the continuum of good care for patients with multimorbidity (Burge & Mitchell, BMJ, *2012:345)*

Residential Aged Care

- RN to Resident ratio:
  >20 to 1
- GP availability variable
  55% without 24 hour
  ‘On call’ GP
- High Staff Turnover
  Few Multi-Disciplinary Team Members available

Hospice

- RN to Patient Ratio:
  2-3 to 1
- Palliative Care Consultant or GP usually available
- Social Worker, Chaplain, Volunteers
  Complimentary Therapy,
  Counselling

Palliative Care Education for Aged Residential Care Staff

Claire Hatherell, 2012

- Staff recognised the benefit of the Palliative Approach, and that it was not restricted to end of life care.
- Recognised need to involve the family/whānau in their resident's care.
- Increased confidence, improved assessment and communication skills
- Less fearful to engage directly with dying residents and their family/whānau.
- Staff reporting that their practice had changed

Palliative Care Education is good but not enough

- Increased availability of palliative care education is a necessary but not sufficient step to improve the quality of care delivery.
- Level of support, workplace culture and psychological factors that can either hinder, or enhance the uptake of educational initiatives.

WILLINGNESS TO UNDERTAKE FORMAL PALLIATIVE CARE TRAINING
Frey et al. 2014

- Logistic regression analysis of factors that influence willingness to engage in formal palliative care training:

  – 1) palliative care experience (odds ratio 1.55*)
  – 2) support service accessibility (odds ratio .96*)
  – 3) level of burnout (odds ratio .41*)

  *p < .05

SHARE Pilot Project

Rosemary Frey, Michal Boyd, Jackie Robinson, Sue Foster

- Model of Care Development Pilot
- Two pilot facilities
- Hospice outreach

SHARE Pilot Project

Lead: Dr Rosemary Frey

- Goals of Care Summary
  - Assessment of palliative care need
  - Advanced Care Planning documentation
- Proactive outreach from Specialist Palliative Care and Specialist Gerontology Care
- Supporting staff with on-site clinical coaching for palliative care needs of residents
- Supporting staff to discuss recent deaths

Goals of Care Summary

Section 1: Goals of Care Registry Criteria following Gold Standards Framework (GSF) Assessment	
1.1 Date of Initial Assessment:	**1.2 Initial Assessment Lead** Print Name:________________________________Role:___________________ Signature:____
1.3 GSF Prognostic Indicator positive? (see page 2) Yes ☐ No ☐	**1.4 Main Life Limiting Health Issues:**
1.5 Ability of Resident to participate in Goals of Care planning	____Fully capable – no or mild cognitive impairment (Mild CI) ____Capable of expressing wishes in a limited way (moderate CI) ____Unable to express wishes (severe CI)

Section 2: Advanced Directives	
2.1 EPOA for health and welfare	__ None documented __Documented but not activated __Documented and activated Designated EPOA___________________________Relationship____________
2.2 CPR Status	Date of Last Review________________ ____ Not for Resuscitation____For Resuscitation

Goals of Care Summary

Section 3: Overall Goals of Care[1]

A. Comfort measures, no hospitalisation: • Keep me warm, dry and pain free. • Do not transfer to hospital unless absolutely necessary. • Only give measures that enhance comfort or minimise pain e.g. morphine for pain. • Subcutaneous line started only if it improves comfort e.g. for dehydration. • No x-rays, blood tests or antibiotics unless they are given to improve comfort.	**B. Comfort measures, and hospital intervention if needed, no surgery or ICU:** • May or may not transfer to hospital. • Intravenous therapy may be appropriate. • Antibiotics should be used sparingly. • A trial of appropriate drugs may be used. • No invasive procedures e.g. surgery. Do not transfer to Intensive Care Unit.
C. Comfort measures, hospital intervention, and surgery if needed, no ICU or ventilation: • Transfer to acute care hospital (where patient may be evaluated). • Emergency surgery if necessary. • Do not admit to Intensive Care Unit. • Do not ventilate (except during and after surgery e.g. tube down throat and connected with machine).	**D. Comfort measures, hospital intervention, and surgery, ICU or ventilation if needed:** • Transfer to acute care hospital without hesitation. • Admit to Intensive Care Unit if necessary. • Ventilate me if necessary. • Insert central line e.g. main arteries for fluids when other veins collapse. • Provide surgery, biopsies, all life support systems and transplant surgery. • Do everything possible to maintain life.

Section 4: Care concerns from resident, family and MDT team's perspective

4.1 Initial Assessment Care Concerns		**Any other issues that need to be included in the Goals of Care plan:**
☐ a. Pain ☐ b. Depression/anxiety /social connectedness ☐ c. Agitation/delirium ☐ d. skin integrity ☐ e. Shortness of breath/Respiratory infection ☐ f. Nutrition/weight loss/dental/swallowing	☐ g. incontinence/UTI ☐ h. mobility/falls ☐ I Signs/symptoms of disease processes ☐ i. constipation ☐ J. Other (please list):	1st (Initial) assessment Issues:

4.2 New or Change in Needs: Assessed each quarterly or ANY TIME there is a change in care concerns

What is new or changed?	**Action taken?**	**Outcome?**
Signature______________________ Date/time______________________	Signature______________________ Date/time______________________	Signature______________________ Date/time______________________

SHARE: Early Results

- It is all about relationships
  - Between staff, families and hospice
- Palliative understanding was not universal
  - Last days?
  - Last months?
  - For those that can't speak for themselves?
- Chart review mostly done by managers, did not include HCA
  - Managers liked documentation
- Weight loss education was helpful
- Bedside teaching was difficult because the staff are so busy
- Internationally qualified nurses – difficult to have conversations with families due ESL issues

SHARE: Early Results

- Palliative care definition
  - Hospice see it as good care, with no timeframe
  - ARC staff view it more in timeframes
- Nutrition very important for ARC, but not for hospice patients
- Hospice had more difficulty identifying those in the last year of life than ARC staff
- Mutual learning between ARC and Hospice

The Way Forward

The development of evidence-based guidelines for palliative care

A palliative care approach

Advance care planning in the early stages of chronic illness and dementia

Consultation with specialists and multidisciplinary teams at end of life

More research into palliative care needs of older people

Continuity of care and collaboration between healthcare professionals and families is critical

Adapted from Hancock K, Chang E, Johnson A et al (2006) *Alzheimer's Care Quarterly* **7**(1): 49–57

Thank You.