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Specialist palliative care in care homes

Integrating care could improve quality of life and reduce costs

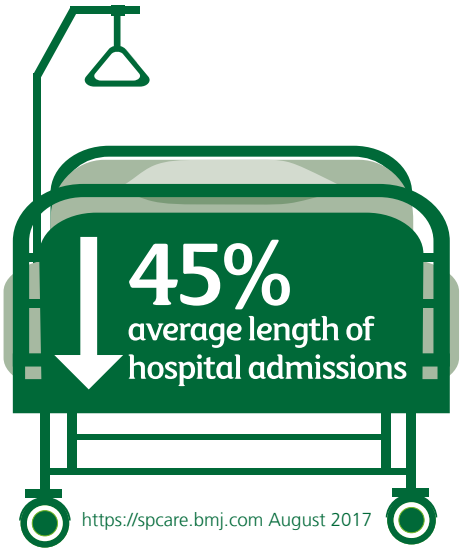
The Scottish Government's **Strategic Framework for Action on Palliative and End of Life Care** sets out a vision of universal access to palliative care by 2021. This includes individuals, families and carers having timely and focussed conservations with appropriately skilled professionals to plan end of life care, in accordance with their needs and preferences. The vision will be achieved by widening the range of health and care staff providing palliative care, delivering appropriate training, and supporting clinical and health economic evaluations of palliative and end of life care models.

Despite care homes being a key location where older people die, access to specialist palliative care is limited. Staff often feel inadequately trained or prepared to look after people who are dying. Consequently, care home residents are more likely to die in hospital, with uncontrolled symptoms, or without adequate care planning in place.

The Palliative Care Needs Rounds model

Palliative Care Needs Rounds are 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. A simple checklist is used to support the integration of specialist palliative care into care homes, driving up quality care, providing staff with focused, case-based education, and maximising planning to reduce symptom burden at end of life.

Researchers measured the impact of Needs Rounds, assessing the impact on hospitalisation, symptom management, and whether participants in the study died in their place of preference – a key marker of quality care.



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.
- The intervention improved confidence in discussing death and dying with families, and planning for symptoms and care goals at end of life.
- The pilot study saw a 45% reduction in the average length of hospital admissions.
- Reduced hospitalisation from four care homes in the pilot study saved an equivalent of £53,000 over three months.
- Participants were more likely to die in their preferred place of death.

Pilot Study

A pilot study was conducted in Australia between 2014-15, testing a new model of specialist palliative care in four care homes. 104 residents received the new model of care, and were compared against a control group of 173 residents, in a quasi-experimental study. Qualitative interviews were conducted with care home staff.

The new model of care led to a 45% reduction in the average length of admission, compared to the control group. This meant people spent an average of 3.22 fewer days in hospital (a decrease of 67% in admitted days). The cost saving of these saved bed-days was estimated at $115,000 (Australian dollars), an equivalent of £53,000 during the three month assessment period.

During the study, 44 residents died having stated their preferred place of death. All 44 were able to die in their preferred place.

Policy implications:

1. The Scottish Government should consider whether Palliative Care Needs Rounds can provide a model for achieving its vision set out in the Strategic Framework for Action on Palliative and End of Life Care.
2. Healthcare Improvement Scotland and partners should consider what modifications might be required to introduce the model within in Scotland.
3. Localised trials or rollouts of Palliative Care Needs Rounds can assess the impact of the model in a Scottish care context.

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. 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/bmjspcare-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/bmjspcare-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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