



Palliative  
Care  
Australia

## Residential Aged Care Palliative Approach Network : **Newsletter**



**December 2009 : Fifteenth Edition**

### Welcome

Welcome to the 15th edition of the RACPAN newsletter – back in printed form as requested by RACPAN members.

As we share experiences from the sector in implementing the *Guidelines for a palliative approach in residential aged care*, Palliative Care Australia is pleased to continue this newsletter for two editions with the support of the Australian Government Department of Health and Ageing.

The RACPAN newsletter is a useful forum for sharing your experiences in implementing the guidelines in your service. Maximising quality of life at the end of life is a major focus for the aged care sector. According to the Australian Institute of Health and Welfare there are more than 175,000 residential aged care

places in Australia across almost 2,800 facilities. Over half the residents in aged care services (55%) are aged over 85 years, and over one-quarter (27%) are aged ninety years and over.

In this edition of the newsletter, people share their experiences in implementing the guidelines from three different perspectives:

- approaches to education in residential aged care facilities
- caring for people from culturally and linguistically diverse backgrounds
- models for providing care, such as link nurses and multidisciplinary teams.

Your ongoing commitment and professionalism is invaluable and crucial in realising quality care at the end of life. Once you have read this newsletter, please feel free to pass it on to others in your service.

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## Education in residential aged care facilities – Are we using the right approach?

There are many approaches to education in residential aged care facilities including case-conferencing and in-servicing. A recent research study investigated whether case-conferencing or in-service education was more effective for integrating the palliative approach, supported by the *Guidelines for a palliative approach in residential aged care*, into residential aged care facilities.

### Overview

The findings of this study were based on a 12 month program of in-services and case-conferences across five RACFs in the central west of NSW using quantitative and qualitative research methodologies.

Residential aged care facilities are caring for an older, frailer population of people. The care of this group is unique and challenging, often managed by a team that predominately consists of assistant nurses. People requiring palliative care will have unique needs and differing illness experiences. Therefore, empowering staff to problem solve, identify issues, communicate effectively and refer for specialist support when needed will allow the successful integration of the palliative approach in practice.

Case-conferencing supports this through the development of a supportive learning environment, responsive to student need, relevant to real time practice and through fostering problem-based learning. Case-conferencing seeks to empower staff with the ability to form alternate views in their workplace, to troubleshoot and discuss as a team best-practice principles. Case-conferencing in this study was more effective than in-servicing in integrating the palliative approach into rural RACFs.

### Outcomes

This study demonstrated that case-conferencing was more effective than in-servicing in relation to:

- increasing and enabling clinically appropriate referrals to specialist palliative care services
- increasing the understanding of the role of the specialist palliative care team
- creating practice changes
- increasing communication between team members.

### Implementing this model

This research used the following approach to commence case-conferencing in RACFs.

1. Discussion with RACF management and agreement to trial this approach was obtained.

2. Monthly dates, times and venues (held at the RACF) were decided upon for 12 months.
3. Discussion with the team was held stating that a case-conference would consist of them informally presenting for discussion, a resident who had complex needs. This could be led by any member of the team (AIN, EN, EEN, RN, other). This presentation was not structured but staff were asked to bring the resident's file with them in case further information was required.
4. The specialist palliative care nurse attending would write notes about the resident and their needs on a flip chart. They would organise these into categories of physical, psychosocial, and family/carer needs.
5. Following the presentation, the specialist palliative care nurse would facilitate an inclusive discussion about how to manage these needs.
6. Any records made would be left with the aged care team to use to support future discussion/work and they were able to feed back on outcomes at the next case conference, if they wanted to (this was not an expectation).

### Research title

*A comparative study looking at the effectiveness of two different teaching methods used to improve the integration of the palliative approach into rural residential aged care facilities.*

The report is available at [www.ircst.health.nsw.gov.au](http://www.ircst.health.nsw.gov.au) under the completed projects section of the Rural Research Capacity Building Program.

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“Looking at the person, looking at someone we can identify with. I feel it is heaps better than just an in-service on no-one. I felt staff could relate to the symptoms, to the treatment, to the management process”

– case-conference participant

## Making the connection – Cultural diversity in aged care

Increasingly, clients in residential aged care facilities are from a cultural background other than Anglo-Australian – communities are diversifying.

At the end of a person's life, it is important for health professionals to make connections with the resident and

their family. This can be difficult when staff and resident don't speak the same language and have different life experiences and expectations about what is about to happen. Because many residents and families might have had negative experiences in the healthcare sector, they might also be apprehensive and mistrustful.

Establishing a connection through communication is the only way these obstacles can be overcome.

**Chapters 10 and 11 of the Guidelines contain information about patients from culturally and linguistically diverse backgrounds.**

### Simple steps

Sometimes, simple steps can help an RACF become more responsive to the needs of residents.

- Cultural awareness training: it is important that staff are aware that their own culture impacts on the care they provide, and how to communicate across cultures.
- Working with interpreters: it is essential to work with professional interpreters and avoid using family members for important conversations. Staff training in working with interpreters can eliminate difficulties and fears.
- Staff and environment: consider employing staff from backgrounds that reflect those of your residents. Consider putting up welcome signs, pictures, music, magazines (try your local library for old editions) from the countries your residents come from.

There are many resources that can assist to make your service more responsive. A good start is [www.culturaldiversity.com.au](http://www.culturaldiversity.com.au).

**Tatjana Bahro** - Consortium Manager - Southern Metropolitan Palliative Care Consortium

**Lizz Hamilton** - Palliative-Aged Care Consultant Nurse

**Dr Sandeep Bhagat** - Senior Medical Officer - South East Palliative Care

## Case study

*Mrs Varkopolous was very ill when she moved into Pinegrove Nursing Home. She had dementia and advanced COPD. Her first language was Greek and she could not speak English any more.*

*Soon after moving in to Pinegrove, Mrs Varkopolous refused food and drink. While the RACF staff understood that it may now be futile to actively treat her medically, her family insisted that she should be sent to hospital and fed intravenously. The charge nurse contacted the local GP, who agreed with the assessment of the RACF staff. However, when asked if he could talk to the family he said that because the family was Greek he wasn't able to talk to them about the death of their loved one and that therefore Mrs Varkopolous should be sent to hospital.*

*The charge nurse decided to call the local palliative care service and soon after Jack, a palliative care nurse, assessed Mrs Varkopolous. He decided to call a meeting with the family and arranged for an interpreter.*

*At the meeting, he explained why it might be best to leave Mrs Varkopolous at Pinegrove and let her die peacefully and with dignity. He told them it was now the time for them to focus on her comfort and symptom control in the dying phase of her life and that procedures in hospital would be uncomfortable for her and unlikely to restore her health.*

*The family was upset but agreed that the best option was to keep Mrs Varkopolous at Pinegrove. They had the opportunity to ask questions and resolve any spiritual issues.*

*Two days later, Mrs Varkopolous passed away peacefully with most of her family present. The family later expressed their gratitude to the RACF staff for their support.*

This story illustrates that we can intervene in family decisions when we have the best outcome for the patient at heart. Communicating with individual residents and families about their needs is important. This scenario would not necessarily have required specialist palliative care

intervention, but it helped to open the channels of communication and achieved the best outcome for the resident.

Building structures that support communication in a context where provider and resident are from different cultural backgrounds is essential and systems and policies can help to build bridges.

## Palliative care plan development

There is little doubt that with population ageing, aged care facilities are increasingly the place of death for the most frail and vulnerable people in our society. In many respects, residential aged care facilities are fast becoming the 'hospices of the future' (Abbey, J. et al, 2006).

### The project

The Palliative Care Plan Development project was conducted across three residential aged care facilities, comprising 180 beds in a large regional town on the New South Wales north coast.

The goals of the project were to develop, implement and evaluate a flexible model of palliative care service delivery that meets the requirements of each resident; improve collaboration between aged and palliative care service providers; and support smooth transition of residents between care settings. One of the major initiatives of the project was the establishment of a multidisciplinary team (MDT) approach to care planning.

The project contributed to and adopted the 'Mid North Coast Division of General Practice Aged Care GP Panels/Integrated Network Palliative Care Project MDT Toolkit' to establish a structured approach to planning, coordinating and facilitating the MDT meetings, and establishing them as a routine part of practice.

Aged care nurses (palliative care link nurses) who had palliative care training (another initiative of the project) were the drivers of this process in their respective RACFs.

## Multidisciplinary team meetings

Formal criteria for scheduling MDT meetings included: on admission, a recent deterioration in clinical condition, increased falls, return from a hospital admission, family/carer stress, unstable symptom management issues, transition to the dying phase, and annually in accordance with ACFI guidelines.

Once the meeting was scheduled, participants were invited to contribute issues for discussion to the agenda. A range of issues such as recent deterioration, pain and other distressing symptoms, advance care planning, and family/carer stress were included.

End-of-life care wishes were frequently discussed and documented, encouraging the resident and their family to openly discuss preferences for end-of-life care, such as preferred place of death, return to hospital, and specific cultural and spiritual preferences.

A formal template was used to summarise the meeting, minimising paperwork. Copies were sent to the general practitioner and placed in the resident's notes, and the resident's care plan adjusted accordingly.

Participants in the meetings included, but were not restricted to: the resident, their family, nursing and care staff, the general practitioner, and representatives of catering, activities and spiritual care services.

Plenty of advance notice, strict adherence to meeting schedules, and the use of teleconferencing have promoted a high level of general practitioner participation in these case-conferences.

## Evaluation

This initiative was evaluated through nursing and care staff focus groups and revealed that the MDT process was 'very holistic' and 'gave staff and families an opportunity to review what has happened (to the resident) in the last 12 months' and discuss 'where to from here'.

Unanimously, participants of the focus groups believed that a palliative approach to care should begin at admission.

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References available upon request or from [www.palliativecare.org.au](http://www.palliativecare.org.au). This project was funded under the Care Planning Sub-Program of the Local Palliative Care Grants Program, by the Australian Government Department of Health and Ageing, and conducted by Catholic Healthcare Limited.

## Link nurses in rural palliative care

One-third of Australians live in rural areas and another half-million reside in remote regions of the country. There is evidence and government recognition that access to health care in rural and remote regions of Australia is problematic.

### Rural model of care

In rural areas, health services, including palliative and end-of-life care are typically provided by primary care professionals, specifically general practitioners and nurses.

The Rural Palliative Care (RPC) project through forty rural and remote general practice network organisations is enhancing relationships and collaboration among existing palliative care service providers within the primary, secondary and tertiary sectors.

### Link nurse model

The RPC project is looking to sustainable and transferable strategies and activities within local communities to address service and systems gaps specifically in relation to the delivery of palliative care. One strategy is the implementation of the link nurse model. Some projects have implemented the link nurse model in residential aged care facilities.

The link nurse concept is not new; they have been used traditionally within the acute sector in areas such as infection control, wound care and diabetes. Within the RPC project, the different link nurse models all have one thing in common: they revolve around the link nurse as a resource person and communication conduit, a person who supports and forms direct links with the whole of the multidisciplinary team delivering holistic palliative care.

A link nurse is not a new clinical position, rather it is the expansion of the role of an existing nurse to 'link' all professionals required and involved in the care of the patient

The link nurse roles tend to involve:

- increased education in palliative care issues
- disseminating information to the primary workplace
- participating in multidisciplinary team meetings
- mentoring other workplace colleagues
- championing system reform
- liaising with patients and carers
- formalising a system of communication between palliative care service providers.

Link nurses are also able to support and create stronger linkages between RACF staff, general practitioners and specialist palliative care services with the aim of providing quality care at the end of life.

### A local solution

The link nurse is a local community resource designed to support local needs. By being the local communication conduit for the multidisciplinary palliative care team, the link nurse addresses issues in quality coordinated palliative care service delivery.

Whilst the RPC project has not yet been formally evaluated, the anecdotal feedback indicates positive results for the link nurse element.

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## GPs and residential aged care facilities

The NSW Central West Division of General Practice (CWDGP) has been working to facilitate greater general practitioner and allied health involvement in RACFs. The funding structure within aged care is complex and many staff across our region commented that their lack of knowledge in how to utilise these systems was a barrier to increased involvement in aged care work.

### Complex funding structures

Increasing general practitioner and allied health time within RACFs supports a proactive person-centred approach, thus assisting a palliative approach to care. Understanding of Medicare supports within RACFs, the Enhanced Primary Care Program for RACFs, the Aged Care Access Initiative, the Aged Care Act and facilities' responsibilities according to this, the Department of Veterans' Affairs supports, private health supports and Commonwealth aged care funding systems is important to enable optimal person-centred and flexible care planning for residents (high or low care).

The CWDGP has created a reference guide to help general practitioners navigate this complex system. It describes the care that a general practitioner can provide based within a business structure whereby their time is adequately reimbursed through Medicare. This care is structured into a 12 month review of a resident where they have the options for a Comprehensive Medical Assessment, Medication Management Review, Case Conference, Contribution to a Care Plan, Linkage to the Enhanced Primary Care Planning items, and general consults.

*“The nurse-link model has already enhanced the palliative care delivered to our residents. An added advantage is its potential to greatly reduce transfers to hospital”*

– Mary Anne Edwards, owner/operator,  
Resthaven on Quarry, Mackay, Queensland.

The guide is written in plain language and explains Medicare requirements for such work. It has been reviewed by Medicare Australia and the Australian General Practice Network with consideration now underway for modification for national use with supportive education modules to further complement this work.

## Elements of the reference guide

This resource guide has four sections:

- **Section 1** - Medicare information for residents of aged care facilities
- **Section 2** - IT support options
- **Section 3** - Clinics within residential aged care facilities
- **Section 4** - Useful links and resources.

The CWDGP has printed this guide as a portable file with a stand creating a flip-style tool to enhance usability within a clinic style forum. An electronic version of the guide is available from the CWDGP website.

## Outcomes

Evaluation of this resource has been positive with many practitioners stating they will alter their practice in line with the suggested care planning approach. It supports general practitioners and allied health to adopt a palliative approach within RACFs through detailing a care model approach supported by Medicare Australia. It allows staff an understanding of how to use existing Medicare structures to support general practitioner and allied health work within aged care facilities. This furthermore enables innovative approaches to care for residents in line with sustainable funding (Medicare) and relevant guidelines for providing the palliative approach.

## Project Title

*Aged Care Access and Quality Project* - available at [www.cwdgp.org.au](http://www.cwdgp.org.au) - search for the 'Aged Care Access Initiative'.

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## News and events

### OBE campaign

*Beyondblue* has launched its 'OBE - Over B.... Eighty' campaign. Through the OBE campaign, *beyondblue* wants to let people know that in spite of the changes people experience as they get older, depression is not a normal part of ageing. For more information see the *beyondblue* website: [www.beyondblue.org.au](http://www.beyondblue.org.au) or call 1300 22 4636.

### AIHW reports

The Australian Institute of Health and Welfare has released the following reports on aged care:

- Residential aged care in Australia 2007-08: A statistical overview
- Pathways through aged care services: A first look
- Aged care packages in the community 2007-08: A statistical overview

These reports are available at [www.aihw.gov.au](http://www.aihw.gov.au).

## Events

### National Dementia Congress

23-24 February 2010  
Melbourne  
[www.iir.com.au](http://www.iir.com.au)

### International Federation on Ageing

10th Global Conference  
*Climate for change: Ageing into the future*  
3-6 May 2010  
Melbourne  
[www.ifa2010.org](http://www.ifa2010.org)

### ACSA 3rd National Community Care Conference

1-4 June 2010  
Gold Coast  
[www.agedcare.org.au](http://www.agedcare.org.au)

### Information Technology in Aged Care 2010

*Smart aged care: The e-health revolution*  
26-27 July 2010  
Melbourne  
[www.itac2010.com.au](http://www.itac2010.com.au)

### ACSA 23rd National Conference and Trade Exhibition

19-23 September 2010  
Tasmania  
[www.agedcare.org.au](http://www.agedcare.org.au)

## Interested in contributing?

Have you undertaken a project or have experiences you wish to share with other RACPAN members. Contact the editor: [editor@palliativecare.org.au](mailto:editor@palliativecare.org.au) or call 02 6232 4433.

To learn more about the palliative approach in aged care see [www.palliativecare.org.au](http://www.palliativecare.org.au).