UNIVERSITY of STIRLING

Calvary

# PALLIATIVE CARE NEEDS ROUNDS:

## THE IMPLEMENTATION GUIDE

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# INTRODUCTION TO THE IMPLEMENTATION GUIDE

We are delighted that you're interested in learning more about Palliative Care Needs Rounds and using them in your area.

We developed this guide and the complementary videos to help relevant stakeholders to use this approach.

There are some 'quick start' guides that summarise the core elements of the approach, including the Checklist which guides Needs Rounds discussions. A further section draws on our learning, as the clinical academic research team, to outline how implementation may vary across settings and contexts.

We also present some case studies which outline the difference that using Needs Rounds can make to residents and staff in care facilities.

You will notice that throughout the resources we use the language of 'care homes' and 'residential care' since these terms are used widely internationally. Users in Australia will be more familiar with the language of 'aged care', 'nursing homes' and 'residential aged care'. Throughout these resources, we are referring to residential facilities caring for people over the age of 60.

We hope that you find the materials useful in adopting Needs Rounds to support the delivery of high quality care to older people living in residential care. Do get in touch if you have feedback on the materials or want to let us know about your local use of Needs Rounds on: pcnr@calvarycare.org.au

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# 1. WHAT ARE PALLIATIVE CARE NEEDS ROUNDS?

Palliative Care Needs Rounds (hereafter called **Needs Rounds**) are monthly **60 minute staff triage** meetings, where 8-10 residents are discussed at care homes. A checklist has been developed to guide Needs Rounds, and this Checklist is in the Implementation Pack.

The choice of residents to discuss is based on those most in need. The idea is to focus on those who are at greatest risk of dying without a plan in place and who have a high symptom burden. Focusing on these residents promotes **equitable** and **efficient** distribution of specialist palliative care services.

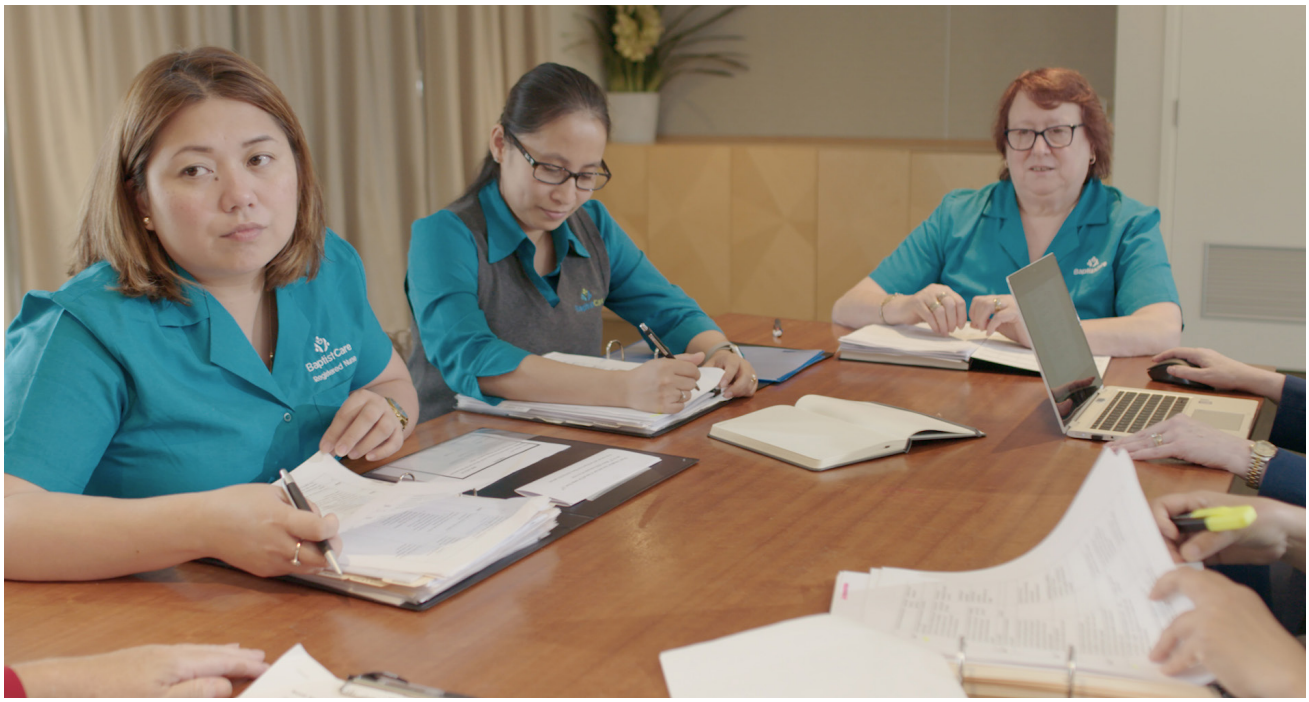
Care home staff are asked to **prioritise** residents for discussion in Needs Rounds who, for example, have been transferred from hospital while actively dying, or where staff would not be surprised if the resident died within six months.

Needs Rounds integrate **case-based education**, with a discussion of each resident's bio-psycho-social status to promote symptom management and identify opportunities to reinforce and extend staff knowledge. Discussion of residents at Needs Rounds frequently leads to initiating **case conferences** (attended by the specialist palliative care clinician, resident, GP, and care home staff), conducting **advance care planning** with resident input, management of current and anticipatory medicines, and **identifying legally appointed alternate decision makers**.

Prior to commencement of the Needs Rounds, staff at each site can be provided with a briefing regarding the aims and practicalities of how it would function, including recommendations to develop a system for identifying residents to discuss. Site briefing notes are included in these implementation materials (Section 3.2 and 3.3 and in the accompanying videos).

Needs Rounds are run by specialist palliative care staff (for example nurse practitioners or a clinical nurse consultant).

Care facility staff attending Needs Rounds include registered nurses, enrolled nurses, nursing aides, activities coordinators and managers.



# 2. WHAT IS THE EVIDENCE BASE FOR NEEDS ROUNDS?

We have run several studies to evaluate the impact of Needs Rounds. We have found the following:

- **Residents spend less time in hospital** (unadjusted difference: 0.5 days; adjusted difference 0.22 days with 95% C.I. -0.44, -0.01 and p=0.038).
- **Residents are admitted to hospital less often**. In the pilot study, we saw length of stay reduce by an average of 3.22 days which was a 67% decrease (p<0.01 and 95% CI −5.05 to −1.41). In the full trial we saw a 23% decrease in hospital admissions.
- A conservative estimate of the **net cost-saving** from reduced admissions over the course of a year was AUD$1,759,011 (US$1·3m; UK£0·98m).
- Residents have **better quality of death and dying** (p<0.01, 95%CI: 1.83-12.21).
- The greater the adherence to the checklist, the better the outcomes on residents' death/dying (p<0.01, 95%CI: 6.37-13.32).
- **Staff feel more capable** to look after people who are dying (p<0.01, 95%CI: 2.73, 6.72).
- **Staff feel more confident,** and recognise dying as a normal part of life.
- As well as measuring the changes noted above, we also interviewed staff at the residential care facilities about their experiences of using Needs Rounds. **Staff found the approach useful** and were positive about the impact on their own learning and support of residents.

## 2.1 How did we assess these outcomes?

These data come from an initial pilot study where we ran Needs Rounds for six months and compared the outcomes of residents to a historical control group. We conducted an ethnography of Needs Rounds to distil the core components and from this created the Needs Rounds Checklist (Section 3.1). Subsequently, we then ran a randomised control trial with 1700 residents.

## 2.2 Where can I find the published evidence base?

The references are included in this pack (Section 6) and give clear accounts of how the studies were run and data were analysed. If your local library cannot provide a copy of the papers then please email the corresponding author of each paper for a copy.

# 3. QUICK START GUIDES

## 3.1 Palliative Care Needs Rounds 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

### Actions

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

### 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)

*If citing this checklist please reference the following paper: Forbat, L,. et al. (2018) Improving specialist palliative care in residential care for older people: a checklist to guide practice. BMJ Supportive and Palliative Care. 8(3): 347-353. 10.136/bmjspace-2017-001332*

## 3.2 Specialist palliative care team preparations for first Needs Rounds

Specialist palliative care teams can use the following as core processes to help plan for the first Needs Rounds.

1. Contact the residential care facilities that you'll be using Needs Rounds in. You may wish to use the template letters included in this Implementation Guide.
2. Agree with the facility the date and time of their first Needs Round.
3. The day before the Needs Round, call your key contact at the facility and provide a reminder. Confirm a room has been set aside, and that they have a small number of staff ready to attend.
4. Take a copy of the Needs Rounds Checklist with you. A copy of it is in this Implementation Guide (Section 3.1).
5. Take your diary with you. Often Needs Rounds lead to case conferences and it works best if these are set-up soon after the Needs Round.

## 3.3 Residential care staff preparations for first Needs Rounds

Residential care home teams can use the following as core processes to help plan for the first Needs Rounds.

1. Confirm the date and time with the specialist palliative care team the day before your first Needs Round.
2. Book a meeting room for the Needs Round.
3. Set aside an hour for the meeting.
4. Ensure that several key staff are available to attend the Needs Round. This can be between 2-10 people depending on your organisation and the residents being discussed. The specialist palliative care team won't mind who attends as long as they know the resident.
5. Consult with staff about residents who they are most concerned about dying without a plan in place. Some organisations have a sheet of paper on the office wall that any staff can contribute to with names of people they're worried about. You can see a template for this in Section 7.3.
6. On the day, remember to take patient notes and medication charts, or set-up a projection screen so that you can all see residents' notes together. If advance care plans and legal documents such as enduring power of attorney are not stored in the patient notes, then also bring those to the meeting.
7. Nominate someone to note down what has been agreed and what actions need to happen. If you do this during the Needs Round then the notes will be up to date, and staff not attending the Needs Round will know what has been decided.
8. Think about whether there are other ways to share learning and hand over outcomes/decisions from the Needs Round with staff who weren't able to attend.
9. Remember that most specialist palliative care teams will be happy to hear from you between Needs Rounds too.

## 3.4 Frequently Asked Questions

### 3.4.1 Who attends Needs Rounds?

Who attends Needs Rounds will vary a bit depending on your local context. At a minimum you'll need one person from specialist palliative care, and one staff member from the care home.

In our work we had Nurse Practitioners and Clinical Nurse Consultants from specialist palliative care run the Needs Rounds. Other studies have had palliative care doctors run them.

Having several people attend from the care home can help ensure that the learning is spread throughout the team. In our research, we were very inclusive and invited care homes to think broadly about who they wanted to attend. This included registered and enrolled nurses, nursing assistants, team leaders, activities co-ordinators, and allied health practitioners. Other clinicians involved in resident care, such as GPs, may also wish to attend.

Depending on the size of the facility, you may wish to have up to eight staff attend. In our research developing and testing Needs Rounds, between two and eight staff from the care homes attend. Often the people attending from care homes changed each month with one or two core members. This meant the learning was spread throughout the staff group, and staff who knew the resident best were able to attend and talk about their concerns.

### 3.4.2 Does the care home need a Needs Rounds champion or lead?

In order to get the most from Needs Rounds, it is worth considering having someone relatively senior involved. Having a manager or senior nurse engaged in Needs Rounds will lead to better outcomes for residents. They may not be able to attend each month, but the leadership role is important in implementing this new approach to care. This person's role is to work closely with the specialist palliative care clinician to adapt Needs Rounds to fit with their local context. This might include working together to decide which staff to invite and how many.

### 3.4.3 What skill-set should the specialist palliative care clinicians have?

The staff from specialist palliative care should be able to operate as relatively autonomous independent practitioners.

Specialist palliative care staff running Needs Rounds should:

- **Provide leadership on Needs Rounds**
  The specialist palliative care clinician should link with the senior person from the care facility. The specialist palliative care clinician needs to provide leadership around change, since introducing Needs Rounds is a new intervention for the care home. Changes you might expect are an increase in staff communication, and improved staff confidence in managing palliative symptoms. Models from implementation science suggest that this leadership or facilitation is key to enabling new ideas to be taken-up. Needs Rounds should be used to fit your particular context so if there is a need to adapt the checklist or approach, then do this.

- **Provide responsive education and clinical care**
  Case based education is woven into Needs Rounds. As residents are discussed, opportunities will present themselves to provide education to the care home staff. In our research which led to the Checklist (Section 3.1) we identified a number of core topics which frequently recur, such as pain assessment, bowel management, and delirium. The specialist palliative care clinician should be

sufficiently skilled and ready to provide brief education sessions to care home staff on such topics, to enable staff to understand how to respond and improve their practice. Often this education enables care home staff to manage residents' symptoms and ensure they are more comfortable in the care home. Education also helps staff identify when transfer to acute care is needed and when it is not. Education builds care home staff expertise in recognising residents most likely to die without a plan in place, and identifying when a resident is actively dying.

Staff should also have core skills to advise on effective complex pain and symptom management strategies, provide direct resident care, use their expert knowledge and skills to act as a resource to everyone looking after the resident, draw on their training to assess and support complex psychosocial and spiritual needs, and work as part of a multi-disciplinary team. This should be linked with their level of registration and training.

- **Tailor their communication**
  Care home staff attending Needs Rounds will be a diverse group. The specialist palliative care clinician will need to be able to balance providing information and case-based education in a way that it is accessible to a wide range of educational backgrounds of staff, for example registered nurses and activities coordinators.

- **Facilitate multi-disciplinary case conferences**
  In Needs Rounds it is common to identify residents who need a case conference. In our work, we found that specialist palliative care clinicians chaired many of these initially. Over time, care home staff became more confident with running them, including being able to discuss the residents' symptoms and what their deterioration might look like with the family. Care staff also felt more confident to talk with relatives about the benefits and burdens of transferring people to hospital when they were in their last few days of life. The specialist palliative care clinician therefore will need to be able to run these case conferences, but also mentor others so that care home staff gain confidence in running their own.
- **Understand the demographic and illness profile of care home residents**
  Since many specialist palliative care staff will have trained in the acute healthcare sector, there is a need to develop insight into the demographic and illness profile of care home residents. Many residents will have multiple morbidities and / or cognitive impairment. Consequently, staff from specialist palliative care providing Needs Rounds should be familiar with the clinical needs of this population.

### 3.4.4 How do I get key stakeholders on board?

As well as thinking through local priorities (see Section 4.2), you might also want to provide opportunities for staff to learn more about Needs Rounds. You can do this via:

- in-service sessions to discuss the approach,
- having a journal club discussion focused on the evidence base of Needs Rounds,
- sharing links to the videos in this Implementation Guide.

# 4. IMPLEMENTING AND ADAPTING NEEDS ROUNDS IN YOUR SETTING

## 4.1 Introduction

Care contexts vary and it might be useful to think through how you might want to use and adapt Needs Rounds to suit your service. Using Needs Rounds may lead to changes in how residential care home staff care for residents and influence how the facility and other services, like the specialist palliative care team, work together. In the following sections we draw on our experience in developing and testing Needs Rounds as well as implementation science literature.

## 4.2 What are our local priorities?

A first step towards implementing Needs Rounds is to determine what sorts of information you need to successfully commence them at your facility. In addition to this Implementation Guide you may wish to gather policy documents or accepted practice standards that are relevant to your context.

It is wise to talk through how you will use Needs Rounds with anyone who might be affected by their planned use including: the specialist palliative care team, residential care facility managers, residential care facility staff, general practitioners, residents and their families. You may also wish to discuss Needs Rounds with other facilities who use them.

When you are discussing the use of Needs Rounds consider the following:

- How would you like Needs Rounds to benefit the organisations providing care (such as residential care facilities, and specialist palliative care services), your team members, other clinicians, facility staff, your residents, and their families? Do you think these benefits will be easy for them to notice? Can you think of any evidence, data or ideas that might make these benefits clearer?
- Do Needs Rounds align with what your healthcare organisations, the healthcare staff, the residents, and the families feel is important? Can this alignment be clarified?
- Are there any challenges, risks, or costs for your local organisations, staff, residents and their families if you begin to use Needs Rounds?

Gathering evidence, experience and opinions through discussion and collaboration, to inform your plan to use Needs Rounds will put you in a strong position to move forward.

### 4.2.1 What should we have in place?

When you have identified your local priorities, you may wish to consider the following questions which will help you refine your plan:

- Who are the people in senior positions that will influence the implementation locally? Key local people might include care managers, the clinical leads or managers of specialist palliative care services, and the practice managers of primary care.
- What evidence are these key local people likely to be interested in? For example, care facilities will want to know how Needs Rounds help them meet care quality standards. Specialist palliative care teams will want to know that Needs Rounds help with proactive planning and hence reduce emergency referrals. Acute hospitals and GPs will want to know that the approach reduces unnecessary hospitalisations.

- If local leaders are positive about using Needs Rounds, find out what support they can provide. For instance, are they willing to be a part of the team planning how Needs Rounds will be used or evaluated, or are they able to support others (such as your implementation team) by releasing them from other duties or providing other resources? Will leaders agree to prioritising Needs Rounds?
- How will you keep people informed as plans progress? Having a communication plan might be useful. This might involve an email circulation list of key stakeholders, and brief monthly updates.
- What is your organisation's readiness for change? The culture of your local services, particularly the prevailing views regarding "how things are done here" will impact how successful Needs Rounds can be. The results of past attempts at practice change might provide some insight into this. Are there key ideas, people, collaborations or teams, or approaches from these past attempts that contributed to their success or hampered their progress? Guidance or support (such as input from researchers, experts or senior clinicians) might have been available in the past for some change processes. If so, was this helpful, and is that support still available to you? What can you learn from all of this to support implementing Needs Rounds?
- How might you adapt Needs Rounds to fit your local setting and resources? For instance, determining where and when Needs Rounds are held and whether to use tele or videoconferencing if the practicalities of everyone being in the same room are too complex.

#### 4.2.2 Finding the right facilitators

Successfully implementing a new approach, such as Needs Rounds, requires a person - or people - who are tasked with supporting the required changes in practice. The facilitator might be a facility manager who is interested in improving palliative care. The skills and capacities of the people who will be required to facilitate the adoption of Needs Rounds in your setting will depend on your local context.

- Your facilitator(s) will need to perform a number of small but important tasks to keep your implementation of Needs Rounds on track. They will need to:
    - Support regular communication about your implementation plan to keep others up to date and gather feedback on the process.
    - Provide a link between your local team and any external supports, such as researchers or experts, that might be helping you begin to use or evaluate Needs Rounds.
    - Be a responsive "go to" person to provide support to your team and to identify and help solve any difficulties arising throughout your implementation.
    - Help communicate to GPs, families, or other parties how using Needs Rounds is improving care.
- Depending on the role and experience of your facilitator they may also contribute to role modelling the Needs Rounds process. For example, they can help facilities in identifying suitable residents to discuss at Needs Rounds.
- Ideally your facilitator is likely to need a variety of skills and attributes including:
    - the flexibility and adaptability to recognise what's needed in a situation and to call on others for support when required.

- authenticity and openness.
- credibility and respect within your local context.
- accessibility, approachability and empathy through being open to being contacted, supporting others and responding non-judgmentally.
- being responsive and reliable.
- self confidence.
- communication skills.
- organisation skills.

### 4.2.3 What does success look like in your organisation?

A final consideration is how you will determine the success of your implementation of Needs Rounds, and how these link with your local priorities (Section 4.1.2). For example, your priority may be to support residents to be able to die in the facility, or to enable staff to feel better prepared for caring for residents at end of life.

You may want to agree on a plan to evaluate your use of Needs Rounds and whether they are helping you meet these goals. Some ideas for assessing how you are using Needs Rounds are:

- How many residents die without being discussed at Needs Rounds? If this is a high number, then it's possible you would want to have more frequent Needs Rounds or adjust how you decide who to discuss.
- Have the reasons for residents' transfers to hospital changed? The reasons for hospital transfer could indicate the facility`s capacity to plan and manage residents` end of life care.
- How soon after arrival should new residents be discussed in Needs Rounds? This will depend on how unwell residents are on admission, and whether advance care plans are routinely and fully completed on admission.
- Which care staff should attend Needs Rounds? You may wish to experiment with who attends, and how they share their learning with others.

As you determine what success looks like for your site, you may want to refine how you're using Needs Rounds.

## 4.2 Buy-in from key people and organisations

For Needs Rounds to be effective, a small team - which likely involves different organisations and services - will need to be involved. Building this team or connecting with the right people will be a necessary first step.

The following sections are intended to act as a guide to engage people and organisations that might need to be involved in Needs Rounds. We will describe issues that may be important to these groups, and therefore might be helpful for you to consider when you are trying to build your team.

We recommend that you adapt these ideas to suit your local context.

### 4.2.1 Residential care homes/care facilities for older people

***Why would they be interested?***

Care homes are under significant pressure to provide quality health care to their residents. Residents may have many serious chronic diseases and often die quite soon after admission to care homes. Care home staff are therefore often looking after people approaching end of life. Needs rounds provide an evidence-based approach to enhance the quality of living and dying for residents.

***How can their residents benefit?***

Residents who have access to Needs Rounds are more likely to stay out of hospital, or if admitted to hospital, have shorter stays. Residents are also more likely to die in their preferred place, and have better controlled symptoms meaning they have a better death.

***How can the service benefit from being involved?***

The care homes also benefit from having Needs Rounds. Staff report greater capability when looking after residents at end of life, and gain greater insights into symptom management and understanding of what normal dying looks like. Needs Rounds can therefore enhance the care culture, in ways that are likely be consistent with the quality standards that apply in your area.

***What challenges have arisen elsewhere and how have they been responded to?***

Section 4.2 has already covered key challenges, but additionally you may wish to consider the following challenges and solutions:

- What is the care home's medicine management policy? Some care facilities are able to hold some medicines 'just in case'. Would your facility benefit from thinking through what might be needed to provide quicker and easier access to medicines at end of life? Do staff need education on specific medicines or administration methods?
- What other collaborations might be useful? Getting the most benefit out of Needs Rounds for your residents and your staff will require close collaboration with other care providers such as the specialist palliative care service and local GPs and primary care providers. You might want to make time to discuss Needs Rounds with them to make sure that your goals and plans are clear and shared.

- How will you enable staff to attend? Plan the timing of Needs Rounds with clinical and managerial staff to ensure that key people are able to attend. This may mean that meetings need to align with shift change.

### 4.2.2 Specialist Palliative Care services

***Why would they be interested?***

It is challenging for specialist palliative care services to meet the needs of older people in care homes within their available resources. New approaches to meet these needs are required. Needs Rounds offer an evidenced-based approach to improve the living and dying of residents in care homes, and are focused on proactive support to residents, their families and care home staff.

***How can the service benefit from being involved?***

Needs Rounds improve outcomes through proactive planning for residents. Consequently, specialist palliative care teams are likely to see a reduction in urgent referrals, making their input more efficient. This may increase remuneration for some services depending on the service's current level of involvement in supporting care facility residents and how service funding is determined.

***How can their patients benefit?***

Not all care home residents have equitable access to specialist palliative care. Traditionally specialist palliative care has focused on people residing in their own homes, often with a diagnosis of advanced cancer. Adopting the Needs Rounds model allows more equitable access to specialist symptom management for an under-served population.

There are clear benefits for residents in reducing hospitalisation and improving staff capability to care for residents at end of life, facilitating dying in preferred place, and improving quality of dying.

***What challenges have arisen elsewhere and how have they been responded to?***

We know from the literature on implementation, and from our experience, that the following factors are likely to need consideration when implementing Needs Rounds:

- Who will run Needs Rounds? Our approach used a specialist palliative care nurse practitioner physically attending care homes for Needs Rounds every month. This approach has excellent support from the evidence (see Sections 2 and 6), however, it may not easily fit your local context. You may want to think about other clinicians such as doctors or a member of the community team.
- How often and how should we meet? Our approach was based on monthly face-to-face meetings, but it may suit you better to meet more or less frequently, and to use video-conference technology. You may wish to talk to other services who are using Needs Rounds to learn from any adaptions that they have made.
- How can this approach to care be sustained? Sustainable approaches to Needs Rounds have been achieved by developing new models and policies, and through leveraging resources. Discussing the sustainability of your plan, what would be required to maintain it, and who will be involved in achieving this will be important.
- What implications might this have for our service? Supporting Needs Rounds may have flow on implications for your service's workloads. Our initial work indicated that improved awareness of

resident's palliative care needs could also result in additional tasks such as prescribing medications for residents and involvement in case conferences. It will be useful to consider how involved your services will be in supporting residents beyond attending Needs Rounds and discuss this with other local service providers.

- How do we support staff to be involved? Specialist palliative care staff will need time to attend Needs Rounds and further time to co-facilitate case conferences. You may wish to consider how this will be achieved, and have flexibility in workload management to enable this proactive approach to be used.
- How do we embed support for Needs Rounds in our service? Clinicians and managers will need to be on-board for Needs Rounds to be practically supported by your service. Providing opportunities to discuss Needs Rounds, and access to resources such as publications, supporting videos, and this manual may be helpful in achieving this.

### 4.2.3 General Practice Clinics or General Practitioners

***Why should they be interested?***

Multi-disciplinary team working is central to medicine, and working with the specialist palliative care team will enable them to provide optimal support to their patients.

Needs Rounds enable GPs to deliver an evidence based approach to clinical care to aged care residents approaching end of life.

***How can the service benefit from being involved?***

GP services can benefit from involvement in Needs Rounds due to the focus on proactive, quality care. Resident needs may be able to be identified earlier and with more efficiency. This may help GPs to predict when their input will be needed making it more efficient with their time. These improvements may also lead to enhanced service remuneration (depending on local factors such as how involved GPs are in care homes currently and how remuneration is determined in your context.)

Providing general practice and primary care that is recognisably best-practice is a challenge in care homes. Involvement in Needs Rounds allows a clear evidenced-based strategy to improve quality of care for residents.

***How can their patients benefit?***

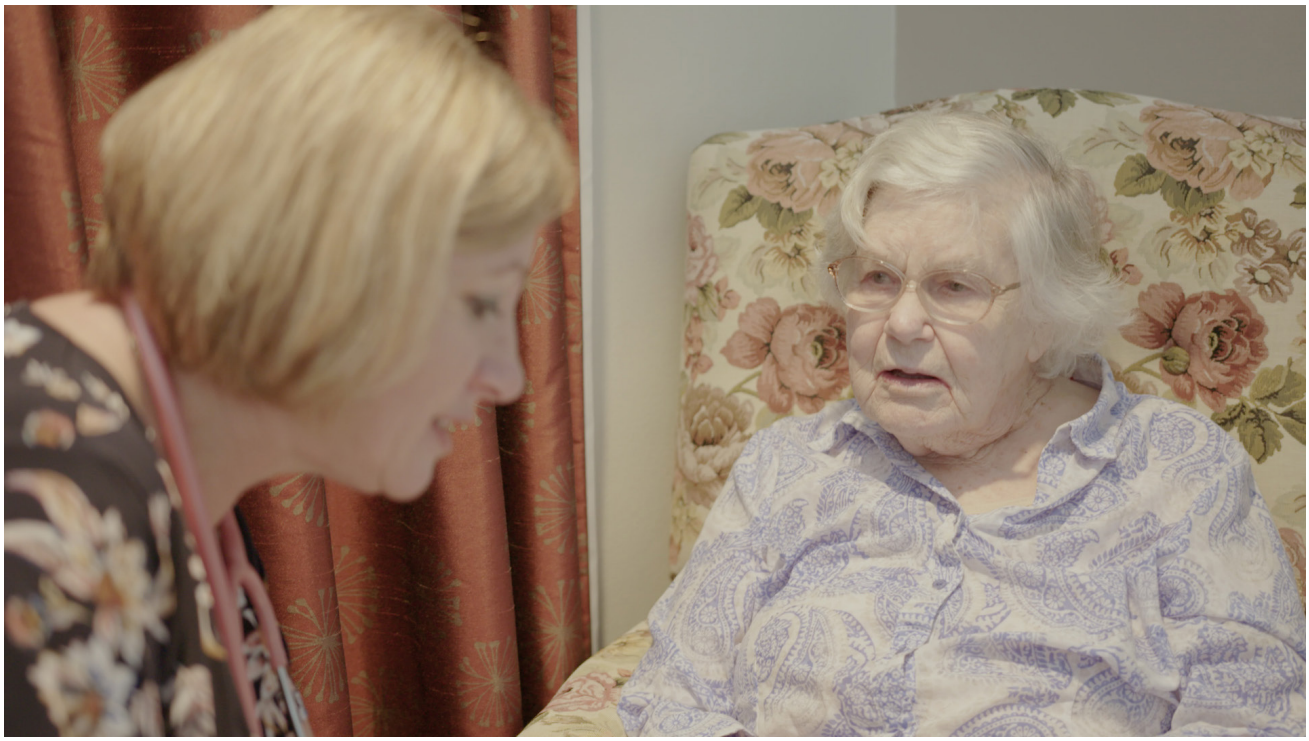
As noted above, this approach has clear benefits for patients in reducing hospitalisations, improving quality of death and advance care planning. GPs who support Needs Rounds for their patients are therefore facilitating a best-practice approach to care.

***What challenges have arisen elsewhere and how have they been responded to?***

- How do we facilitate GP buy-in? You can use the 'introductory' letter included in this pack to tell the GP about Needs Rounds and the likely benefits for their patients. Keeping in touch with the

GPs after Needs Rounds with a brief update can be helpful. Inviting GPs to case conferences also importantly keeps them apprised of their patient's status and any changes in medical decision-making. Relationship building with GPs is important for the Needs Rounds to succeed. Even with a nurse prescriber running Needs Rounds, involvement of GPs is critical. For example, GPs participating in case conferences, adjusting medications, and providing primary care to residents.

- How should we to respond to additional care requirements identified using Needs Rounds? Needs Rounds led to the identification of requisite interventions in some instances such as case conferences, anticipatory prescribing and consideration of the goals of future hospitalisation from our work. It would be useful to discuss who will be involved in providing these interventions among any involved local services.
- Can GPs attend Needs Rounds? Although Needs Rounds were developed with care home staff and specialist palliative care, you may wish to have the GP attend too. If the GP practice has more than one GP, then it may be relevant to consider whether one GP will attend Needs Rounds for all residents, or just for their patients. Will the same clinicians attend each time or is it possible to have a roster? A roster of clinician representatives who will attend Needs Rounds from the clinic may diminish the time required from individual clinicians, and make it easier to prepare for periods of leave or other absences.



# 5. CASE STUDIES

In this section we introduce two case examples that demonstrate how Palliative Care Needs Rounds improve outcomes for residents, their families, the staff that work in care homes and the staff working in specialist palliative care.

Each case study is presented twice, the first time is an example of end of life care *without* the Palliative Care Needs Rounds intervention and the second is *with* the Palliative Care Needs Rounds intervention. These are fictionalised case studies based on composites of common scenarios.

## 5.1 Case 1: Hui

Hui is an 86 year old woman with advanced vascular dementia. She is no longer mobile and requires full assistance with activities of daily living including bathing, eating and toileting. She recognises her adult children, one son and two daughters. They are very concerned about their mother's health and want to speak regularly to staff at the nursing home about her care.

### 5.1.1 Scenario without using Needs Rounds

Individual staff who have known Hui for some time are concerned that Hui does not seem well, is losing weight and is not drinking as much as she used to. They wonder whether she might be getting closer to dying but there is no clear way to share this information with each other, and the staff members are not sure what to say to the GP and the family, and so very few changes are made to her care.

The family are also concerned that Hui seems to be getting sicker. They ask the facility to weigh her weekly and monitor her oral intake as they want her to get better and no one seems able to tell the family why Hui is continuing to lose weight. The three siblings take turns in coming in daily to try and feed their mother as they worry whether she is being fed enough, but her appetite remains poor. Hui's mouth is dry, and she has bad breath. Her skin is dry and flaky.

Hui becomes unwell, she has a cough and her breathing is laboured. An after-hours doctor is called by an agency nurse and comes to review her. The doctor diagnoses aspiration pneumonia. There is no plan in place, no advance care plan, no injectable medication. The after-hours doctor calls the family to discuss care options, but the only choice seems to be hospital and Hui is sent to hospital by ambulance.

Whilst in hospital Hui's children feel that they need to stay with her overnight as she is very agitated and is hitting out and trying to climb out of bed. She receives five days of intravenous antibiotics, requiring multiple cannulas to be inserted as she keeps pulling them out, and she becomes very confused. Hui's health continues to decline. She dies in hospital after several weeks without being able to return back to her facility. Her family are left with questions about the reasons for her declining health, and whether there were other options that could have allowed her more comfort in her final weeks.

### 5.1.2 Scenario using Palliative Care Needs Rounds

At the monthly Palliative Care Needs Rounds, Hui identified as being at risk of dying without a plan in place. Staff say they would not be surprised if Hui died in the next six months due to losing weight and reduced thirst.

At Needs Rounds staff learn how to recognise dying and what dying from dementia looks like. They learn how to support Hui and her family through the last months of her life. There is a discussion about the risks of vascular dementia, including aspiration pneumonia and stroke. The benefits and burdens of medical treatment and hospitalisation are also discussed.

Staff identify Hui's son Hsiang as her legally appointed alternative decision maker. They feel that he should participate in decision making with Hui now as she is no longer capable of making decisions about her health care. Hui's daughters are very involved in her care and also important for decision making.

One staff member says that they feel that Hui's family believe that the facility are not providing enough food, and the staff member finds this challenging. Case-based education explores the reduction in appetite when people are dying, and decreased swallow function, the potential negative consequences of artificial hydration and nutrition near dying, and how to discuss this with family members.

As there is no advance care plan, a multidisciplinary case conference is arranged and attended by the general practitioner, Hsiang (son and medical power of attorney), two daughters, the palliative care nurse practitioner and a registered nurse from the facility.

Hui's goals of care are discussed. When asked whether there is anything else meaningful to Hui living well, her family said her that Christian faith is important and the team discuss having a priest visit.

An advance care plan is completed. The family are happy for her to have a trial of oral antibiotics for aspiration pneumonia if she can swallow them and said they want her to receive relief for pain and suffering at end of life. The family decide that transferring her to hospital will be unnecessarily burden due to the confusion Hui is likely to experience. Anticipatory injectable medications are charted and prescriptions provided for symptoms she is likely to experience.

Later Hui contracts aspiration pneumonia. As there is a clear plan in place and injectable medicines are available, the staff at the facility collaborate with the GP, and are able to care for Hui's needs at end of life. Hui dies peacefully in her home. The care staff feel confident and competent to do this work and a referral to the specialist palliative care team for clinical care at end of life is not needed

## 5.2 Case 2: Jean

Jean is an 88 year old woman with end stage heart failure, she has survived all her brothers and sisters and one of her children. Jean is able to speak for herself and the public advocate has been appointed for medical decision making. She does not want to be a burden to her busy family. Her son has helped her to make an advance care directive that says 'not for CPR' but she still wants antibiotics and transfer to hospital if appropriate. She has a cardiac pacemaker and defibrillator.

### 5.2.1 Scenario not using Needs Rounds

Jean has told care home staff that she thinks she is dying and that she is ready to die. Staff feel unsure how to respond. They also feel that Jean is getting sicker, but try and reassure her by saying "you will be ok." Jean feels brushed off.

Jean takes many tablets for her heart condition and she finds this hard. Staff notice that her breathing seems to be worse and reassure Jean that the tablets are to "make you better". Jean becomes more unwell and starts losing weight because she is not eating. Her symptoms are not well controlled; she cannot breathe properly and gets very anxious. Her GP visits her and prescribes injectable morphine for breathlessness and midazolam for her anxiety and distress. She tells staff that she does not think Jean has very long left to live, and asks them to contact her if Jean stops eating and drinking so that she can start a syringe driver.

At 2am on a Saturday morning an agency nurse on her second shift in the nursing home walks into Jean's room and notices she is not breathing. Jean does not respond when she talks to her. The nurse presses the call button to get help and commences CPR. She is unaware that Jean has a defibrillator that is giving her heart regular shocks. Another staff member calls an ambulance. At the hospital, staff determine that she has died and stop chest compressions.

### 5.2.2 Scenario with Palliative Care Needs Rounds

Jean has told the staff that she thinks she is dying. She tells staff that she does not want her life prolonged. The staff at the facility discuss Jean at the Palliative Care Needs Rounds as they agreed that she is in the last months of her life and her symptoms are not well controlled. She is breathless and her anxiety is worsening. In previous Needs Rounds, staff have discussed how to manage these symptoms and are aware that some medication changes may be needed. In talking about Jean at the Needs Rounds, staff recognise that she has a defibrillator that may need to be deactivated prior to her death.

A case conference is held with Jean, her son, the GP, specialist palliative care Nurse Practitioner, a registered nurse and a member of the care team from the facility. Jean tells everyone that she doesn't want to go to hospital anymore and that she wants to die at the care home, with the people she knows. Everyone supports this decision and it is documented on the appropriate paperwork, and Jean signs it. The general practitioner writes up anticipatory medications in the form of injections so that the staff have the medicine they need to keep her comfortable at the facility. The facility submits a referral to the specialist palliative care service for ongoing support with Jean's symptom management.

Jean is now very weak and is being cared for in bed. Staff learned in the Needs Rounds case-based education, that they need to have the head of the bed raised and use continuous oxygen. Her breathing deteriorates and becomes laboured. Jean begins to struggle to take tablets but specialist palliative care organise a syringe driver to maintain her comfort. They deactivate her defibrillator. The staff feel confident to speak to Jean and her son about her end of life and feel well-equipped to care for her. Jean dies peacefully in her preferred place with people she knows.

# 6. PUBLICATIONS ABOUT THE NEEDS ROUNDS APPROACH

Forbat, L,. Liu, W-M, Koerner, J,. Lam, L,. Samara, J,. Chapman, M,. Johnston, N. (2020) Reducing time in acute hospitals: a stepped wedge randomised control trial of a specialist palliative care intervention in residential care homes. Palliative Medicine.

Rainsford, S,. Johnston, N,. Forbat, L,. Glasgow, N,. Liu, W-M. (2019) Palliative care needs rounds in rural residential aged care: a mixed-methods study exploring experiences and perceptions of staff and general practitioners. Progress in palliative care.

Liu, W-M, Koerner, J,. Lam, L,. Johnston, N,. Samara, J,. Chapman, M,. Forbat, L. (2019) Improved quality of death and dying in care homes: a palliative care stepped wedge randomised control trial in Australia. Journal of the American Geriatrics Society.

Johnston, N,. Lovell, C,. Liu, W,. Chapman, M,. Forbat, L. (2019) 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. 9(1) 10.1136/bmjspcare-2016-001127

Forbat, L,. Chapman, M,. Lovell, C,. Liu, W,. Johnston, N. (2018) Improving specialist palliative care in residential care for older people: a checklist to guide practice. BMJ Supportive and Palliative Care. 8(3): 347-353.

Chapman, M,. Johnston, N,. Lovell, C,. Forbat, L,. Liu, W. (2018) 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. 8(1):102-109.

# 7 RESOURCES

## 7.1 Introductory letter template: Residential care facilities

*[Letter head]*

Dear *{insert name of manager}*

RE: a new palliative care approach to support facilities and residents

We are writing to let you know that we will soon begin to use a new evidence-based approach, called Palliative Care Needs Rounds.

Palliative Care Needs Rounds improve end of life care for residents, staff knowledge and capacity to provide good symptom management and supportive care. The approach also has shown to improve residents' quality of dying, and keeps residents out of hospital.

Needs Rounds are a monthly hour-long 'triage' meeting. A specialist palliative care clinician will come to your facility at a time that suits you, for one hour. During the Needs Rounds the intention is discuss up to 10 residents who are at risk of dying in the next six months who don't have a plan in place. These residents are discussed in the meeting and this provides an opportunity for case-based education for staff on symptom and medication management, advance care planning and end of life law, and communication skills. The outcomes from residents discussed at Needs Rounds may include anticipatory prescribing, a multidisciplinary case conference, or a clinical referral to the specialist palliative care service.

Ideally we'd like the meeting to be attended by a few of your staff (e.g. clinical managers, registered and/or enrolled nurses, care assistants, other care staff).

Palliative Care Needs Rounds will become part of our usual model of care for {*Insert name of your service here}.*

The proposed schedule for implementation for your facility is during the month of _____.

Could you please provide me with two or three options of suitable day of the month and time for Palliative Care Needs Rounds meetings so that we can find a mutually agreeable time (eg, first Thursday of each month at 1pm).

If you have any questions or concerns, or require further information, please contact me via email or phone.

Yours sincerely

*[Insert name of clinician]*

*[Insert name of Manager]*

## 7.2 Introductory letter template from specialist palliative care to GPs

Letter head

Date

Dear Dr [*insert name*]

Re: Palliative Care Needs Rounds

The team at [*name of your organisation*] are implementing a new approach to improve our support to residents in residential care who are approaching end of life.

We wanted to let you know about this, and the anticipated positive impacts of using Palliative Care Needs Rounds[1-2]:

1. Reducing number of hospitalisations and length of stay in acute care
2. Increasing anticipatory care planning
3. Increasing residential care staff capacity to care for people at end of life.

Some of your patients may receive this new approach to care, which is a triage system for ensuring quality anticipatory care.

As a consequence of using Needs Rounds, you may be invited to:

1. Attend multidisciplinary case conferences (Medicare item numbers 735 to 758)
2. Support anticipatory prescribing (which will help reduce hospitalisations and use of acute care beds)

We expect to start using this new approach [*name month or date*]. If you'd like to know more about Needs Rounds, you can watch a short video on them here: [*insert bitly URL link to videos].* We would welcome any queries or questions, and look forward to continuing to work with you.

Regards

*[Insert name of clinician]*

*[Insert name of Manager]*

1 Forbat L et al. Reducing time in acute hospitals: a stepped wedge randomised control trial of a specialist palliative care intervention in residential care homes. Palliative medicine 2020
2 Liu WM et al. Improved quality of death and dying in care homes: a palliative care stepped wedge randomised control trial. Journal of the American Geriatric Society 2020

## 7.3 Palliative Care Needs Rounds recording sheet

The following sheet can be used for facilities to: (i) identify residents for discussion at Needs Rounds, (ii) record actions required after the Needs Rounds.

The sheet can be pinned up in a clinical office, for staff to write names of residents who meet the criteria for discussion. The sheet can then be brought to the Needs Rounds to record core actions triggered by the meeting. The sheet also allows recording the staff member who will be responsible for organising any activities required, e.g. organising a referral or a case conference.

**Date of Needs Rounds:** _____

**Specialist Palliative Care Clinician Name:** _____

**Facility staff names:** _____

_____

| Resident name | Case conference required? Y/N | Refer to specialist palliative care? Y/N | Other referrals? (please specify) | Action by (insert name) |
|---|---|---|---|---|
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |
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In collaboration with