Palliative care in residential aged care

The Australian Government subsidises residential aged care services for older Australians whose care needs are such that they can no longer remain in their own homes. Residential aged care services provide accommodation and services to people requiring ongoing health and nursing care due to chronic impairments and a reduced degree of independence in activities of daily living. They provide nursing, supervision or other types of personal care required by the residents.

Residential aged care services face unique difficulties in administering palliative care, with permanent residents often having dementia and/or communication difficulties and comorbidities (AIHW 2015). Patients in hospices (a specialist facility delivering palliative care services) are more likely than permanent residents in residential aged care services to have a cancer diagnosis; conversely, permanent residents are more likely than hospice patients to have a diagnosis of a chronic degenerative disease(s) (Gribich et al. 2005).

Palliative Care provided in a residential aged care service is regulated under the Aged Care Act 1997, within the Quality of Care Principles. Within the schedule of specified care and services, an Approved Provider is responsible for providing access to a qualified practitioner from a palliative care team, and the establishment of a palliative care program, including monitoring and managing any side effects for any resident that needs it.

The AIHW's National Aged Care Data Clearinghouse contains information gathered via a number of data collections. Data collected from the Aged Care Funding Instrument (ACFI), which is used to determine the level of Australian Government subsidies for permanent residents, has been used for the analyses presented here. Permanent residents who have been appraised as requiring palliative care under the ACFI are included in the 'palliative care' group described in this section.

Key points

- Nationally, there were 231,500 permanent residents in Australia in 2014–15 with completed ACFI appraisals, and about 1 in 25 of these residents (9,144) had an ACFI appraisal indicating the need for palliative care.
- The proportion of ACFI appraisals resulting in palliative care within aged care facilities increases with the age of the resident.
- The population rate of palliative care among permanent residents was highest in *Inner regional* areas (69.0 per 100,000 population) followed by *Outer regional* (38.8) and *Major cities* (32.2).
- Around one-quarter (23.2%) of permanent residents receiving palliative care had been diagnosed with cancer, with the types of cancer most often recorded being prostate cancer (21.9%) and lung cancer (17.4%).

This section was last updated in October 2016.

References

Gribich C, Maddocks C, Parker D, Brown M, Willis E & Hofmeyer A 2005. Palliative care in aged care facilities for residents with a non-cancer diagnosis: results of a survey of aged care facilities in South Australia. Australasian Journal on Ageing 24(2):108–13.

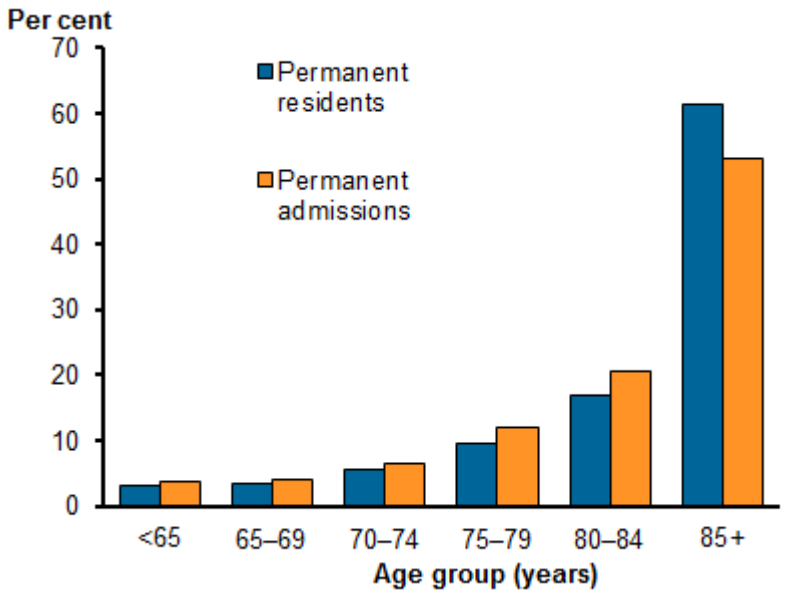
AIHW 2015. Residential aged care and Home care 2013–14. Canberra: AIHW. Viewed 5 May 2016, http://www.aihw.gov.au/aged-care/residential-and-home-care-2013-14/.

Characteristics of residential aged care residents receiving palliative care

There were about 231,500 permanent residents in Australia in 2014–15 with completed ACFI appraisals, and 1 in 25 of these residents (9,144; 4.0%) had an ACFI appraisal indicating the need for palliative care (Table AC.1).

The age profile of permanent residents who required palliative care and of other residents during 2014–15 was very similar. For example, about 60% of both groups were aged 85 and older and about one–quarter were aged 75 to 84. For permanent residents who entered care during 2014–15 (permanent admissions) and were appraised as requiring palliative care, a smaller proportion were in the 85 and older age group (53.2%) compared with permanent residents appraised as requiring palliative care (Figure AC.1). For all other age groups, the proportion of permanent admissions was higher, indicating the slightly younger age of admissions compared to permanent residents where palliative care is required.

Figure AC.1: Permanent residential aged care residents and permanent admissions appraised as requiring palliative care, by age group, 2014–15



Source: AIHW analysis of 2014–15 ACFI data.

Source data palliative care in residential aged care Table AC.6 & AC.7

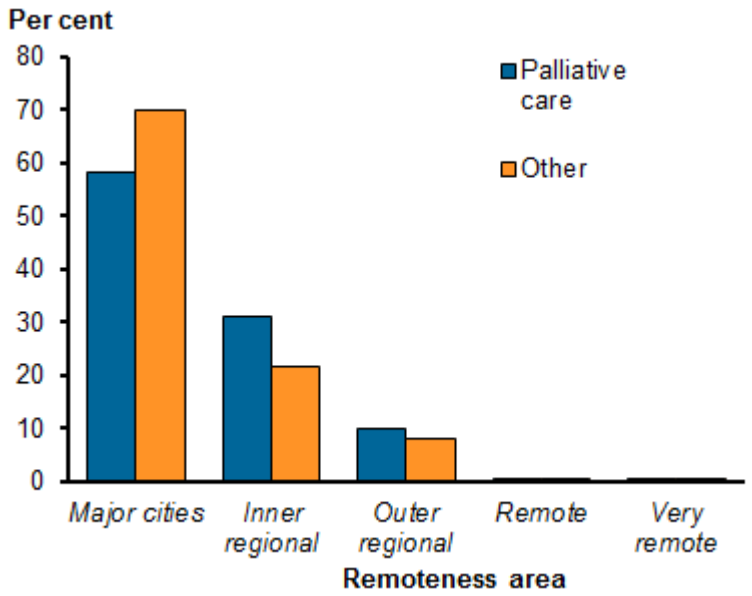
Among the permanent residents in 2014–15, a higher proportion of males than females were appraised as requiring palliative care (4.7% and 3.6% respectively). Slightly lower proportions of Indigenous residents (2.6%) and overseas born residents (3.6%) were appraised as requiring palliative care compared with Other Australians (4.0%) and Australian born residents (4.1%). There were some small differences for marital status, with a higher proportion of palliative care versus other residents being married (35.3% and 23.3% respectively) and a slightly lower proportion never married (6.7% and 8.8% respectively) (Table AC.8).

Geographical distribution of palliative care in residential aged care

A smaller proportion of permanent residents appraised as requiring palliative care resided in *Major cities* (58.5%) compared with other residents (69.7%) in 2014–15 (Figure AC.2). The population rate of palliative

care among permanent residents was highest in *Inner regional* areas (69.0 per 100,000 population) followed by *Outer regional* (38.8) and *Major cities* (32.2). The rate of other care among permanent residents was also highest in Inner regional (1,132.9) areas, followed by *Major cities* (932.9) and *Outer regional* areas (841.8).

Figure AC.2: Permanent residential aged care residents by palliative care status, remoteness area, 2014–15



Source: AIHW analysis of 2014−15 ACFI data.

Source data palliative care in residential aged care Table AC.8

Diagnoses

Around one-quarter (23.2%) of permanent residents receiving palliative care had been diagnosed with cancer. Differences are apparent in the distribution of cancer diagnosis in terms of type of care provided. Specifically, those cancer diagnoses most likely to involve palliative care included prostate cancer (21.9%) and lung cancer (17.4%). The highest proportion of cancer diagnoses among non-palliative care residents included colorectal (bowel) cancer (18.1%) and skin cancer (17.0%). The non-cancer disease categories most often recorded as requiring palliative care were circulatory system disease (27.3%) and musculoskeletal disease (13.4%). The distribution of care type for non-cancer diseases did not differ greatly across diagnoses, except for musculoskeletal disease which was more likely among non-palliative care residents (21.6%) (Table AC.13).

Separation mode

A separation from residential aged care occurs when a permanent resident stops receiving residential aged care from a particular facility. The reasons for separation (called the separation mode) indicate the destination of a resident at separation and are categorised as:

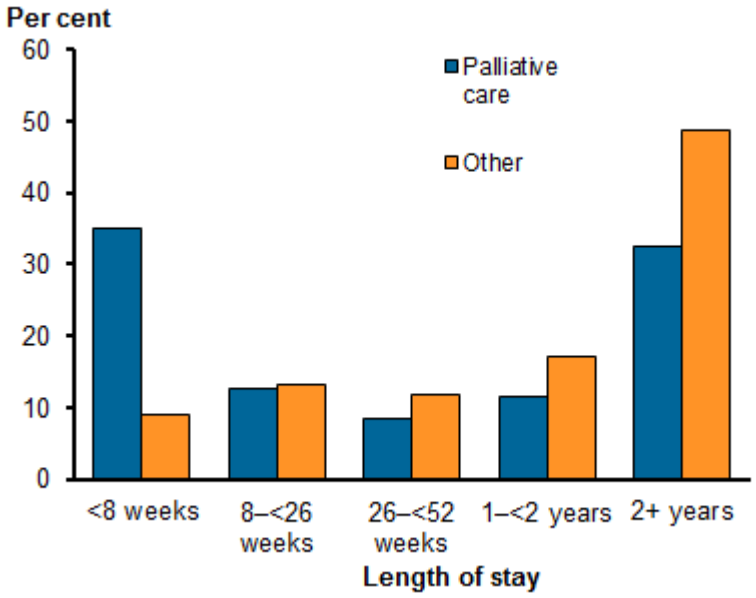
- death
- admission to hospital (note that a separation is not counted where the resident is granted 'hospital leave')
- return to community (such as to family or home)
- move to another residential aged care facility
- other.

Unsurprisingly, death was the mode of separation for the majority of residents, whether or not they received palliative care (97.1% for palliative care and 83.4% for other care). Consistent with these findings, those permanent residents receiving palliative care were less likely than others to have a mode of separation of going to hospital (1.1% and 2.2% respectively), returning to the community (0.5% and 3.5%), or moving to another residential aged care facility (0.8% and 8.1%) (Table AC.4).

Length of stay

Individuals frequently access residential aged care in order to manage the end of life (terminal) period (Queensland Health 2013). Among those permanent residents who separated from a residential aged care facility during 2014–15, those appraised as requiring palliative care were more likely to have a shorter length of stay than other residents. For permanent residents with a length of stay of less than 8 weeks, the proportion requiring palliative care during 2014–15 was nearly 4 times that for other permanent residents (35.1% and 9.0% respectively) (Figure AC.3).

Figure AC.3: Permanent residential aged care residents by palliative care status, length of stay, 2014–15



Source: AIHW analysis of 2014–15 ACFI data.

Source data palliative care in residential aged care Table AC.14

Hospital leave

A permanent resident may require 'hospital leave' (a temporary stay in hospital which does not involve permanent discharge from aged care) in order to receive treatment in hospital. In 2014–15, 1 in 18 permanent residents requiring palliative care (5.5%) and about 1 in 5 other residents (19.2%) had an episode of hospital leave (Table AC.15).

Reference

Queensland Health 2013. Brisbane South Palliative Care Collaborative Guide to the Pharmacological Management of End of Life (Terminal) Symptoms in Residential Aged Care Residents. Brisbane: Queensland Health.

Key Concepts

Palliative care in residential aged care

Key Concept	Description
Comorbidities	**Comorbidity** refers to occurrence of more than one condition/disorder at the same time.
Palliative care in residential aged care	**Palliative care** in residential aged care is ongoing care involving very intense clinical nursing and/or complex pain management in the residential care setting. The need for this type of care is identified in the complex health-care domain of the resident's ACFI appraisal.
Permanent admission	**Permanent admission** is an admission to residential aged care for expected long-term care.
Permanent resident	**Permanent resident** is a person who is receiving long-term (permanent) care in a residential aged care facility.
Specified care and services	**Specified care and services** are the care and services that all approved providers of residential aged care must provide to any resident as needed, as set out by the Schedule of specified care and services for residential care services (Schedule 1, *Quality of Care Principles 2014*) within the *Aged Care Act 1997*.