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 who require 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 particular difficulties in administering palliative care, because permanent residents often have dementia and/or communication difficulties and complex care needs (AIHW 2017). In addition, there is a high burden of chronic disease and comorbidity in the residential aged care population (Hillen, Vitry & Caughey 2017).

Palliative care provided in a residential aged care service is regulated under the Aged Care Act 1997, within the Quality of Care Principles. Under 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.

It should be noted that the decrease in residential aged care permanent admission and residents appraised as requiring palliative care is most likely related to changes in the application of the Aged Care Funding Instrument (ACFI) for palliative care in recent years.

Key points

- There were about 235,100 permanent residents in Australia in 2015–16 with completed ACFI appraisals, and nearly 1 in 40 of these residents (6,316) 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 appraised need for palliative care among permanent residents was highest in Inner regional areas (49.1 per 100,000 population) followed by Outer regional (25.4) and Major cities (21.6).
- Around one-quarter (26.2%) of permanent residents receiving palliative care had been diagnosed with cancer, with the types of cancer most often recorded being lung cancer (19.3%) and colorectal (bowel) cancer (12.9%).

This section was last updated in October 2017.
Characteristics of residential aged care residents receiving palliative care

There were about 235,100 permanent residential aged care residents in Australia in 2015–16 with completed ACFI appraisals, and nearly 1 in 40 of these residents (6,316; 2.7%) had an ACFI appraisal indicating the need for palliative care.

The age profile of permanent residents who required palliative care and of other residents (those not appraised as requiring palliative care) during 2015–16 was very similar. For example, about 60% of both groups were aged 85 and older and about one-quarter were aged 75–84. For permanent residents who entered care during 2015–16 (permanent admissions) and were appraised as requiring palliative care, a smaller proportion were in the 85 and older age group (56.4%) 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 with 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, 2015–16

Among permanent residents in 2015–16, a higher proportion of males than females were appraised as requiring palliative care (3.4% and 2.3% respectively). There was little difference in the proportions appraised as requiring palliative care between Indigenous residents (2.8%) and other Australians (2.7%), Australian born residents (2.8%) or overseas born residents (2.5%).
Geographical distribution of palliative care in residential aged care

In Major cities a smaller proportion of permanent residents were appraised as requiring palliative care (57.6%) compared with other residents (69.4%) in 2015–16 (Figure AC.2). The population rate of palliative care among permanent residents was highest in Inner regional areas (49.1 per 100,000 population) followed by Outer regional (25.4) and Major cities (21.6). The rate of other care among permanent residents was also highest in Inner regional (1,169.2) areas, followed by Major cities (941.1) and Outer regional areas (875.1).

Figure AC.2: Permanent residential aged care residents by palliative care status, remoteness area, 2015–16

Source: AIHW analysis of 2015–16 ACFI data.

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

Diagnoses

Around one-quarter (26.2%) of permanent residents assessed as requiring palliative care had been diagnosed with cancer. Differences are apparent in the distribution of cancer diagnosis in terms of type of care provided. Among aged care residents who were diagnosed with cancer and who were also assessed as requiring palliative care, the most common cancer diagnoses included lung cancer (19.3%) and colorectal (bowel) cancer (12.9%). Among non-palliative care residents the highest proportion of cancer diagnoses included prostate cancer (18.1%) and colorectal (bowel) cancer (17.6%).

The non-cancer disease categories most often recorded among aged care residents receiving palliative care were circulatory system disease (26.9%) and musculoskeletal disease (13.8%). 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 (22.8%).

Some information on mental and behavioural disorders are also reported through the ACFI. Just under half (44.8%) of residential aged care residents assessed as requiring palliative care were diagnosed with dementia (including Alzheimer’s disease) compared to half (50.2%) of those receiving other care. About one quarter of all ACFI assessed residents were diagnosed with depression, other mood and affective disorders or bipolar disorder (24.8% for palliative and 24.1% for other care). Delirium was also more common among those assessed as requiring palliative care (3.0%) than other care (1.1%).

It should be noted that identifying mental health conditions in older people may be difficult. For example, illnesses such as depression are often under-diagnosed and under-treated in residential aged care and in the
community. In addition, many mental health conditions share similar symptoms, which can present additional challenges in determining diagnosis. Further information is available from the AIHW publication *Depression in residential aged care 2008–2012*.

**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 (97.6% for palliative care and 83.1% 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 (0.3% and 3.6% respectively), returning to the community (1.0% and 2.2%), or moving to another residential aged care facility (0.7% and 8.3%).

**Length of stay**

Among those permanent residents who separated from a residential aged care facility during 2015–16, 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 2015–16 was over 4 times that for other permanent residents (41.1% and 9.3% respectively) (Figure AC.3).

**Figure AC.3: Permanent residential aged care residents by palliative care status, length of stay, 2015–16**

![Graph showing the percentage of permanent residential aged care residents by palliative care status and length of stay.](image)

Source: AIHW analysis of 2015–16 ACFI data.
Source data palliative care in residential aged care Table AC.13

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Australian Institute of Health and Welfare
Palliative care services in Australia
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 2015–16, the proportion of permanent residents requiring palliative care having an episode of hospital leave (27.2%) was similar to other residents (29.0%).

Residential aged care residents and admissions over time

The number of aged care residents and admissions appraised as requiring palliative care has trended downwards since 2012–13 (Figure AC.4). The number of residents appraised as requiring palliative care decreased from 11,178 to 6,316 and admissions from 5,165 to 3,255 between 2011–12 and 2015–16. The number of residents and admissions assessed as requiring other care increased over the same period. It should be noted that the decrease in residential aged care permanent admission and residents appraised as requiring palliative care is most likely related to changes in the application of the Aged Care Funding Instrument (ACFI) for palliative care in recent years.

Figure AC.4: Residential aged care permanent admissions and residents appraised as requiring palliative care, 2011–12 to 2015–16.

Source: AIHW analysis of 2011–12 to 2015–16 ACFI data.

Source data palliative care in residential aged care Table AC.15

Reference

## Key Concepts

### Palliative care in residential aged care

<table>
<thead>
<tr>
<th>Key Concept</th>
<th>Description</th>
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<tbody>
<tr>
<td>Comorbidity</td>
<td><strong>Comorbidity</strong> refers to occurrence of more than one condition/disorder at the same time.</td>
</tr>
<tr>
<td><strong>Palliative care</strong> in residential aged care</td>
<td><strong>Palliative care</strong> 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.</td>
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<tr>
<td>Permanent admission</td>
<td>An admission to residential aged care for expected long-term care.</td>
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<tr>
<td>Permanent resident</td>
<td>A person who is receiving long-term (permanent) care in a residential aged care facility.</td>
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<tr>
<td>Specified care and services</td>
<td>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, <em>Quality of Care Principles 2014</em>) within the <em>Aged Care Act 1997</em>.</td>
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