

**Development of Innovative Care
Planning Tools to Facilitate Best
Practice Ageing in Place in Rural
Aged Care Hostels.**

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INTRODUCTION

- Project Officer in Local Palliative Care Planning Program – Northern New England Palliative Care Planning Project.
- A goal of the Project - develop a care planning document.
- All resources/tools that relate to residential aged care facilities were to be developed in line with the '*Guidelines for a Palliative Approach in Residential Aged Care*'

- o Steering committee decided that the Care Planning Tool would:
 - a) sit along-side an existing care plan to guide and prompt holistic care plan development,
 - b) emphasise advance care planning, pain management and end of life care.
- o Interpret the information
- o Development of the Care Planning Guidance Tool – *IF and THEN Model.*

ACTIVITY

- Implementation follows development
- Work closely with hostels within the host facility
- 90 beds including an older facility of 52 beds, 2 dementia specific areas of 13 beds each and a small rural facility of 12 beds in a satellite village.

GROWING AWARENESS

o Issues

- ❖ Staffing

- ❖ Residents

- ❖ Documentation

- ❖ Workloads

- ❖ Need for innovative approach

DISCOVERY

- Currently, “practicing” ageing in place – caring for a resident through the final transitions
- Previously: deterioration = transfer to nursing home bed or local hospital
- Results in a number of implications for residents, staff and the facility

AGEING IN PLACE

- This model offers many advantages for the residents of hostels
 - ❖ Less disruption
 - ❖ Continuity of care
 - ❖ Familiar environment
 - ❖ Familiar staff and other residents

AGEING IN PLACE

- Advantages for staff
 - ❖ Able to care for much loved resident till they died
 - ❖ Some reduction in resident turn-over
 - ❖ ** less disruption for staff
 - ❖ However.....

AGEING IN PLACE - DISADVANTAGES

- Low skill mix ratio in hostel staff, poor assessment skill and knowledge base –
- Older workforce - implications around heavier workload
- Rural area does not offer a large pool of skilled / experienced staff
- Equipment often not appropriate (beds, mattresses etc)

SITUATION

- Increased resident dependency and higher care needs including palliative care → end of life care
- Documentation requirements increased
- Staff ill-equipped to meet the new challenges – knowledge, skills, capacity
- Small rural community = caring for friends, neighbours, relatives

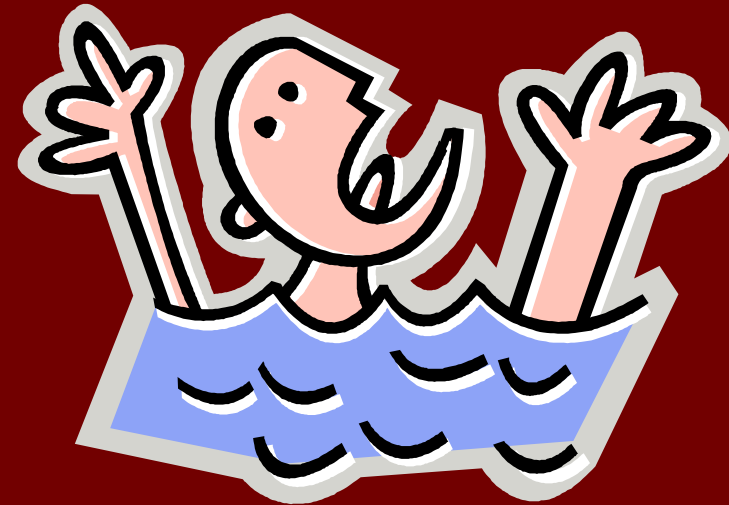
ISSUES

- Care workers are mostly ain/pca,
- Literacy issues particularly in areas of precise documentation
- One RN - worked business hours with on-call RN in nursing home
- Staffing numbers and ratios

REAL SITUATION

- Staff were really struggling
- Stressed and overwhelmed
- Implications for resident care
- Resistance + + + + +

Drowning, not waving!!!



FIRST STEP

- Identified trial area for implementation
- New area 14 beds
- Young, enthusiastic supervisor
- Keen to embrace and implement best practice into the workplace



RETROSPECTIVE

DEVELOPMENT OF APPROPRIATE TOOLS

Two Prongs

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graph TD; A[Two Prongs] --> B[1]; A --> C[2]; B --> B1[• Timely recognition of change of condition]; B --> B2[• Development of symptom assessment tool]; B1 --> B2; C --> C1[• Development of tools for holistic assessment]; C --> C2[• 24 hour TICK & SIGN care plan];
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1

- Timely recognition of change of condition
- Development of symptom assessment tool

2

- Development of tools for holistic assessment
- 24 hour TICK & SIGN care plan

Prong 1 - SYMPTOM ASSESSMENT

- PCOC Phraseology- transitions of care

- ❖ stable, unstable, deteriorating, terminal phases

Change the culture from respond to & treat a symptom to care workers could understand

Viewing changes holistically in context of whole person

- Symptom assessment tools available mostly rely on patient self-assessment,

- Could be adapted but
 - Wanted to make assessment relevant to RACF residents and user friendly for staff.

RESEARCH

- literature search to ascertain documentation of symptoms indicating change of care phase

(Abbey J, 2003; Parker, Grbich, Brown and Maddocks et al, 2005)

Poor appetite,
Weight loss
Recumbence
Lassitude
Failure of
physiological systems
Progress of disease

Oral discomfort
Fatigue/weakness
Dyspnoea
Constipation
Nausea, vomiting
Restlessness
Cough
Anorexia
Anxiety
Dysphagia
Pain

SYMPTOM ASSESSMENT TOOL - initial

Assess for Stable Care Phase	0=not at all 10=worst possible										
Difficulty sleeping ,	0	1	2	3	4	5	6	7	8	9	10
Drowsiness – nods off ++ or hard to rouse	0	1	2	3	4	5	6	7	8	9	10
Fatigue & weakness, lethargic	0	1	2	3	4	5	6	7	8	9	10
Appetite problems- refuses food, hungry++	0	1	2	3	4	5	6	7	8	9	10
Swallowing & feeding difficulties	0	1	2	3	4	5	6	7	8	9	10
Disorientation (not related to dementia)	0	1	2	3	4	5	6	7	8	9	10
Confusion & anxiety	0	1	2	3	4	5	6	7	8	9	10
Breathing problems	0	1	2	3	4	5	6	7	8	9	10
Bowel problems (constipation, diarrhoea)	0	1	2	3	4	5	6	7	8	9	10
Urinary problems (incontinence, retention)	0	1	2	3	4	5	6	7	8	9	10
Nausea & / or vomiting	0	1	2	3	4	5	6	7	8	9	10
Pain (as per assessment Abbey or Numerical)	0	1	2	3	4	5	6	7	8	9	10
Skin integrity, repositioning needs	0	1	2	3	4	5	6	7	8	9	10
Other eg: (infections, oral health, wounds)	0	1	2	3	4	5	6	7	8	9	10
Comments:											

SYMPTOM ASSESSMENT TOOL – re-assess

Assess for Changes in Care Phase	0=not at all				10=worst possible							
Difficulty sleeping: ↑ sleepiness or ↓ sleep	0	1	2	3	4	5	6	7	8	9	10	
Drowsiness: nods off or increasingly hard to rouse	0	1	2	3	4	5	6	7	8	9	10	
Fatigue & weakness— ↑ bedrest, slumping in chair	0	1	2	3	4	5	6	7	8	9	10	
Appetite problems: weight loss >1/2-1kg/wk	0	1	2	3	4	5	6	7	8	9	10	
Swallowing, feeding difficulties, holding food in mouth, unable to swallow, choking, coughing	0	1	2	3	4	5	6	7	8	9	10	
Disorientation (not related to dementia)	0	1	2	3	4	5	6	7	8	9	10	
Confusion & anxiety, restlessness, calling out	0	1	2	3	4	5	6	7	8	9	10	
Breathing problems, changes to breathing, noisy	0	1	2	3	4	5	6	7	8	9	10	
Bowel problems – constipation, diarrhoea/ loose	0	1	2	3	4	5	6	7	8	9	10	
Urinary problems - retention, decreased output	0	1	2	3	4	5	6	7	8	9	10	
Nausea & / or vomiting	0	1	2	3	4	5	6	7	8	9	10	
Pain (as per assessment Abbey or Numerical) ↑↑	0	1	2	3	4	5	6	7	8	9	10	
Skin integrity- marking, breakdown, re position↑	0	1	2	3	4	5	6	7	8	9	10	
Other eg: (infection, oral health, wounds, poor healing)	0	1	2	3	4	5	6	7	8	9	10	
Comments:												

USING THE SAT

Instructions for Use:

- Assess resident on admission or current condition
- Highlight each score. **EDUCATION.....**
- Transition through stages is not necessarily linear. Reassess with each change of condition, to establish deterioration leading to terminal or Palliative (end of life) Care phase.
- an increase of 2 points → 10, may indicate deterioration

UTILISATION

- o Academic detailing



o Academic detailing



o Demonstration



o Demonstration



o In-services



o At the bedside



o Documented examples



Peer-to-peer



Activity	Frequency	Frequency No. (1-24)	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	
Assessment	1																										
Medication	1																										
Wound Care	1																										
Eye Care	1																										
Wound dressing	1																										
Other (Specify)	1																										
Documentation	1																										
Education	1																										
Wound Management	1																										
Other (Specify)	1																										
Wound Care	1																										
Wound Management	1																										
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Prong 2 – holistic assessment

- HOLISTIC Palliative-care-phase assessment / care plan development tool.
 - ❖ Various end of life pathways consulted including Liverpool Pathway
 - ❖ Utilised topics addressed in Guidelines to a Palliative Approach in RAC.

DIGNITY AND QUALITY OF LIFE
ADVANCE CARE PLANNING
RESPIRATORY &
CARDIOVASCULAR
SKIN CONDITION / INTEGRITY
PERSONAL & ORAL HYGIENE
PAIN
SENSORY

FOOD (NUTRITION) AND FLUIDS
URINARY/BOWEL MANAGEMENT
COGNITIVE FUNCTION / MENTAL
HEALTH / SPIRITUAL &
CULTURAL WELLBEING
END of LIFE CARE, GRIEF, LOSS
and BEREAVEMENT
E-o-L ASSESSMENT CHECKLIST

Baseline/initial assessment when entering palliative care phase: Date

1. Illness and ageing related:

Physical: symptoms assessed , interventions planned & documented , comfort care given

Psychological: support given , time taken to listen , volunteer support offered

Medical Uncertainty & Anxiety about Dying:

ensure information provided someone to talk to

2. Independence related:

Physical: resident is/has been involved / included in medical & personal decision-making

Cognitive: confusion/behaviour changes (infection, constipation, pain, medications) assess'd

Functional: assessed (eg physio) encourage full use of capacity (as able / desired)

3. Psychological, Social & Spiritual Considerations:

Sense of Self, Autonomy: dignity ensured has been involved in decision-making

Legacy: participated in life review photos, discussion family involvement in stories

Hopefulness, Acceptance, Pride: participate in activities while able sense of achievement

Spiritual & Social Support: access pastoral/religious support contact with friends / family

Sense of Burden: counsel re concerns advance care planning discussion & documentation

FOOD (NUTRITION) AND FLUIDS (tick box beside appropriate answers)

Baseline/initial assessment when entering palliative care phase: Date

ADVANCE CARE PLANNING (circle appropriate answers)

Does the resident have any of the following? (circle appropriate answers) Inability to swallow related to condition Food refusal Loss of interest in food Fluctuating appetite **Y N n/a**

Resident has completed an advance care plan (has capacity) **Y N n/a**

Dysphagia (difficulty with speaking) Dysphagia (difficulty with swallowing) Resident's family have completed a Plan of Treatment (lacks capacity) **Y N n/a**

Reduced nutritional intake Decreased taste & smell

Person responsible (EG) / substitute decision-maker is identified **Y N n/a**

Does the resident have special dietary needs? Small frequent meals pureed meals Thickened food & fluids extra nutritional supplements (two-cal, Sustagen) diabetic diet sips of water ice chips to moisten mouth the resident's notes **Y N n/a**

Person responsible/substitute decision-maker is aware of resident's care choices **Y N n/a**

Does the resident require: full feeding some assistance independent

Does an Advance Care Plan or a Plan of Treatment outlining feeding preferences? **Y N**

If No then discuss with resident or with person responsible to gain resident's wishes.

Discussion with resident if able or 'person responsible' about: feeding (artificial hydration & nutrition) **Y N**

(already recorded or Record discussion in green Record of Discussion form.)

Section for Medical Practitioner to complete:

Name of Medical Practitioner:.....

Signature:.....

ASSESSMENT CHECKLIST	YES	NO	n/a
Current medications assessed and non essential medication ceased			
Appropriate oral drugs converted to the subcutaneous route			
PRN and regular medications written up for:			
• Pain – analgesia (regular and breakthrough / PRN)			
• Nausea / vomiting -antiemetic			
• Agitation and restlessness - sedative			
• Respiratory tract secretions - anticholinergic			
• Syringe driver commenced if appropriate			
Inappropriate interventions ceased:			
Antibiotics <input type="checkbox"/> IV/Subcutaneous fluids <input type="checkbox"/> tube feeds (NG/PEG) <input type="checkbox"/>			
ALWAYS refer to the advance care plan / plan of treatment for guidance re:			
Level of care to be provided <input type="checkbox"/> preferred place of death <input type="checkbox"/> nutrition <input type="checkbox"/> CPR <input type="checkbox"/>			
other therapies wanted <input type="checkbox"/> spiritual care <input type="checkbox"/> persons to be present <input type="checkbox"/>			

PROCESS

Following identified changes in care phase using the SAT....

- Referral to CNS Palliative / RN / supervisor
- Completion of assessment
- If condition of resident is thought to be deteriorating or entering the terminal care phase, then
- Commence use of 24hr TICK & SIGN Care Plan

Care Plan

24 hr TICK and SIGN

- ❖ Covers all aspects of holistic care needs
- ❖ Is reviewed daily
- ❖ Care staff tick all interventions and sign
- ❖ Enables all episodes of care to be captured without the burden of documentation
- ❖ Sits at the bedside of the resident
- ❖ Reassures family about care delivery
- ❖ Involves the family in care provision

Documentation requirements

MINIMAL:

Daily documentation into resident notes-

- Completion of care plan
- Fluid balance chart/food diary
- Any changes in condition
- Visits by GP
- Changes in medications etc.

OUTCOMES

- Demonstrated excellence in care
 - ❖ Staff able to focus more energy on care provision
 - ❖ Are prompted about all aspects of care
 - ❖ Ensure pain free and dignified end of life journey

COMMENTS

o Staff report an increase in

❖ knowledge,

❖ capacity,

❖ confidence

in being able to competently meet the care needs of much loved care recipients who now remain in their care till death;

COMMENTS cont...

- care recipients welcome the opportunity to age in place, and
- family report great satisfaction with all care delivered to their loved ones.

Case Study

- Mrs X - deteriorating condition
- ACP all comfort care in RACF
- Staff provided impeccable care for the last 3 weeks of the end of her life
- Family supported and wrote an individual letter to each staff member commending the level of care delivered.

References:

- Abbey, J 2003 Ageing Dementia and Palliative care in O'Connor M and Aranda S Palliative Care Nursing: A guide to Practice. 2nd Edition.
- Australian Government, Guidelines to a Palliative Approach in Residential Aged Care, 2006
- Parker D, Grbich C, Brown M, Maddocks I et al. "A Palliative Approach or Specialist Palliative Care? What Happens in Aged Care facilities for Residents with a Non-cancer Diagnosis." *Journal of Palliative Care* 2005; 21: 80-87